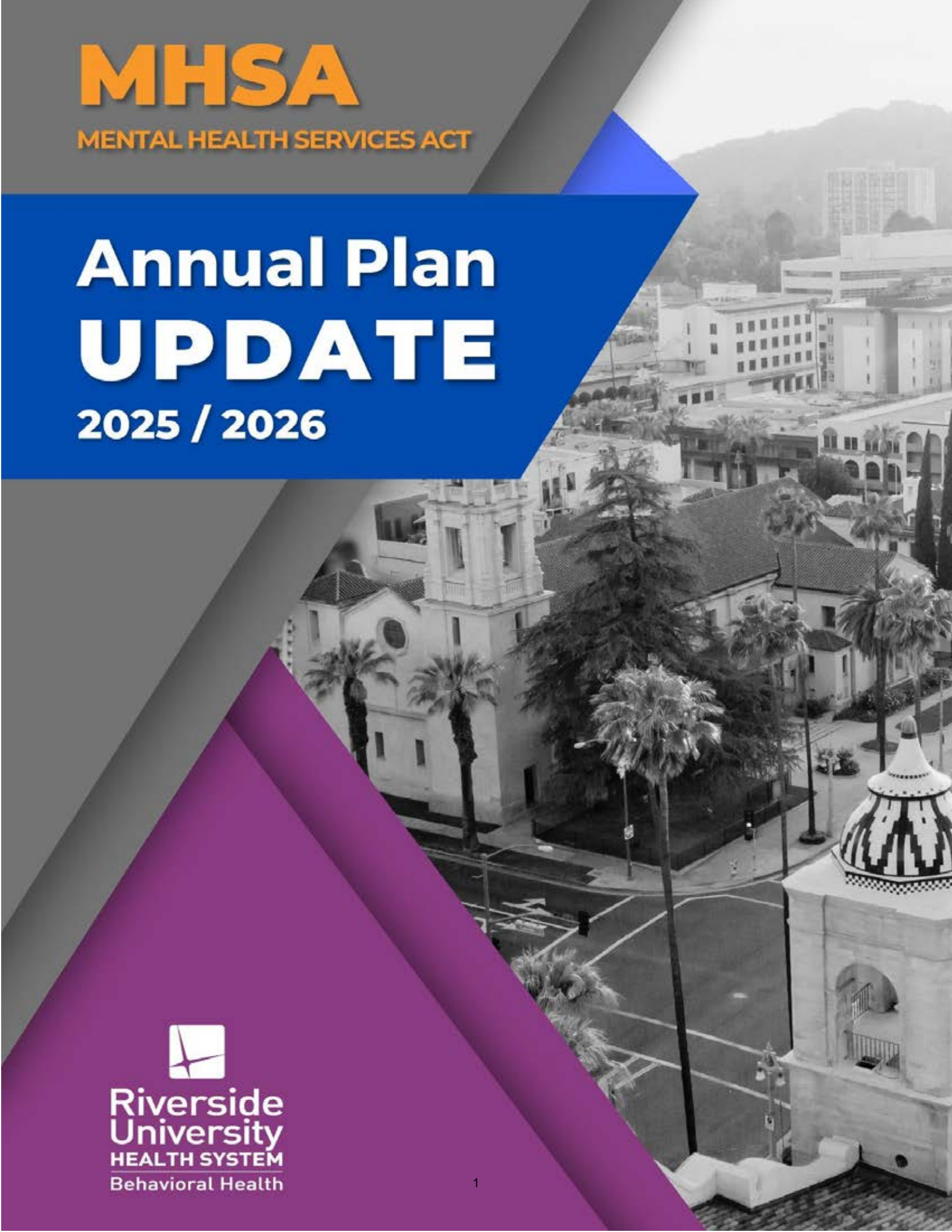
MHSA

MENTAL HEALTH SERVICES ACT

Annual Plan UPDATE

2025 / 2026



Riverside University HEALTH SYSTEM Behavioral Health

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Land Acknowledgement[1]

Land Acknowledgement

The Cahuilla (Íviullatem), Cupeño (Kúupangaxwichem), Luiseño (Payómkowichum), Serrano (Marra'yam), Gabrieleño (Tongva), and Chemehuevi (Nuwuvi) Peoples, and their ancestors have been here since time immemorial. Riverside University Health System-Behavioral Health (RUHS-BH) acknowledges the traditional, ancestral, and contemporary homelands of the first Native Americans of Southern California whose land it occupies and serves. The Cahuilla, Cupeño, Luiseño, Serrano, Gabrieleño, and Chemehuevi Peoples have cared for people, land, water bodies, animals, plant beings, with great integrity, reciprocating care to each other.

RUHS-BH acknowledges the reciprocal relationship of caring for one another and extends wellness and behavioral health services to: Cahuilla, Cupeño, Luiseño, Serrano, Gabrieleño, and Chemehuevi Peoples, all Indigenous Peoples, and all underserved residents of Riverside County.

RUHS-BH wants to create relationships built on trust and accountability with its community members. With this land acknowledgment, RUHS-BH will be respectful and mindful to tribal sovereignty, culture, and beliefs of the Native Americans of this land.

[1] Land acknowledgment was developed by Dr. Sean Milanovich the Cultural Community Liaison for Cultural Community Program

MHSA County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Riverside County

Local Mental Health Director	Program Lead
Name: Matthew Chang, MD.	Name: David Schoelen
Telephone Number: 951-358-4501	Telephone Number: 951-955-7106
E-mail: Matthew.chang@ruhealth.org	E-mail: DSchoelen@ruhealth.org
County Mental Health Mailing Address: 4095 County Circle Drive Riverside, CA 92503	

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 _____.

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

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

Matthew Chang, MD.

Local Mental Health Director/Designee (PRINT)

Signature

Date

County: Riverside

Date: 5/15/25

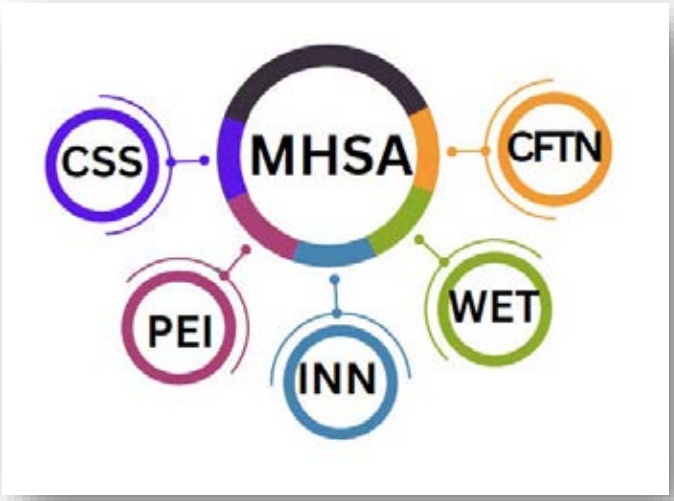
Introduction

MHSA QUICK LOOK

What is the Mental Health Services Act (MHSA)?

The Mental Health Services Act (MHSA) was a ballot measure passed by California voters in November 2004 that provided specific funding for public mental health services. The Act imposed a 1% taxation on personal income exceeding $1 million. This funding provided for an expansion and transformation of the public mental health system with the expectation to achieve results such as a reduction in incarcerations, school failures, unemployment, and homelessness for individuals with severe mental illness.

The programs funded through MHSA must include services for all ages: Children (0-15), Transition Age Youth (16-25), Adults (26-59), and Older Adults (60+). Though program implementation may be integrated into the Department's existing



management structure, the MHSA Administrative unit manages the planning activities related to the five MHSA components, which are:

1. Community Services and Supports (CSS)
2. Prevention and Early Intervention (PEI)
3. Innovation (INN)
4. Workforce Education and Training (WET)
5. Capital Facilities and Technology (CFTN)

MHSA funds cannot be used to supplant programs that existed before November 2004.

The primary components of MHSA are CSS and PEI. These two components receive active funding allocations based on the State distribution formula. INN funds are

derived from a portion of the CSS and PEI allocations and require an additional State approval process to access. WET funds were a one-time allocation that could last for 10 years; those funds have been exhausted, and ongoing WET Plan funding is derived from the CSS allocation. The last CF/TN funds were allocated in the Fiscal Year. Some funds—called a Prudent Reserve—can also be saved as a rainy-day fund to sustain programming during periods of economic fluctuation that impact this tax revenue.

Where does MHSA fit in funding Riverside University Health System – Behavioral Health (RUHS-BH)?

MHSA is only one of the funding streams for RUHS-BH. The MHSA Plan does not represent all public behavioral health services in Riverside County and is not meant to serve as a guide to all service options. Not all services can be funded under MHSA.

What is the purpose of MHSA's 3-year Program and Expenditure Plan (3YPE)?

The 3YPE serves like a consumer's care plan in a clinic program. It describes goals, objectives, and interventions based on the stakeholder feedback and the possibilities and limits defined in State regulations.

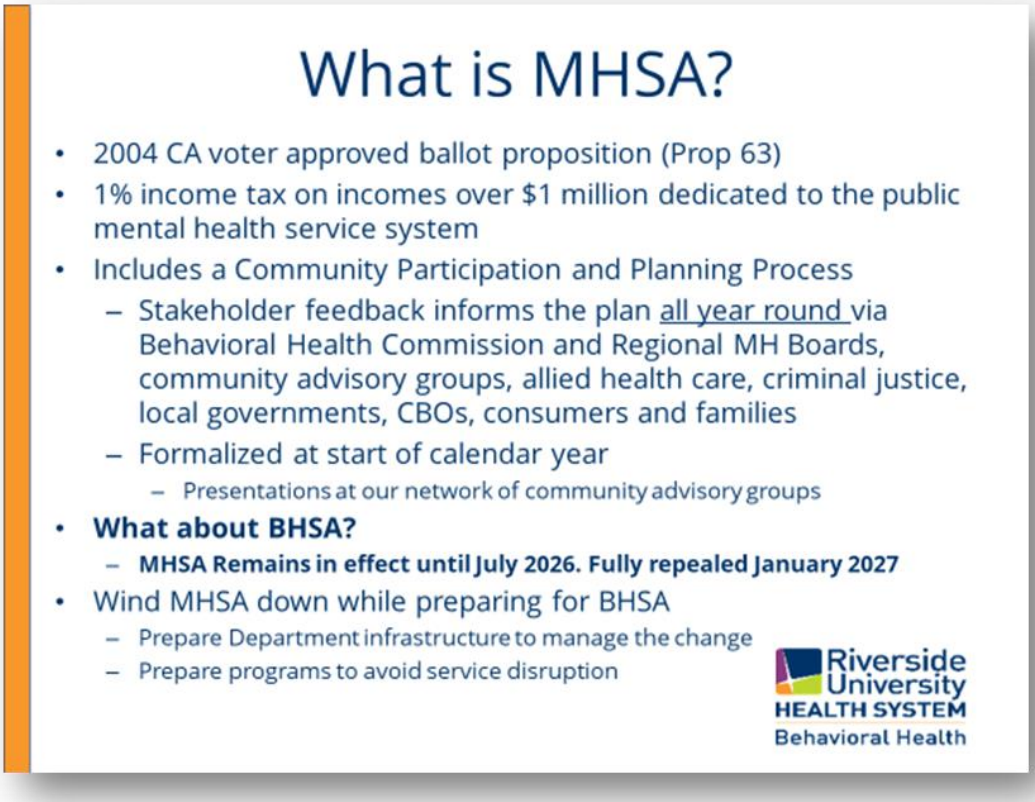
Every three years, Riverside County is required to develop a new Program and Expenditure Plan for MHSA. The 3YPE outlines and updates the programs and services to be funded by MHSA and creates a new three-year budget plan. It also allows the County to re-evaluate programs and analyze performance outcomes to ensure the services being funded by MHSA are effective. A single fiscal year begins on July 1st and ends the following calendar year on June 30th. The current 3-year plan is dated FY 23/24 – FY 25/26 and was approved last year. This will be the final MHSA 3-year plan before the new Behavioral Health Services Act (BHSA) Plan is due in July 2026.

What is an Annual Update?

MHSA regulations require counties to provide community stakeholders with an update to the MHSA 3YPE on an annual basis and provide education on MHSA regulation, the act, and the components. Therefore, Riverside County engages community stakeholders by providing them with an update on the programs being funded in the 3YPE and foundational knowledge on MHSA's mission, purpose, and compliance. The community process allows stakeholders to provide feedback from their unique perspectives about the programs and services being funded through MHSA. This year's plan is an Annual Update.

Annual MHSA Education PowerPoint





What is the MHSA Plan?

- A big report that goes to the Board of Supervisors and State Department of Health Care Services
- Authorizes MHSA expenditures
- Provides progress and outcomes on existing MHSA funded programs
- Two types of MHSA plans
  - 3-Year-Plan (FY 23/24 -25/26)
  - **Annual Update**







Riverside University HEALTH SYSTEM Behavioral Health

MHSA Frame

- 5 Components:

1. Community Services and Supports **(CSS)**
2. Prevention and Early Intervention **(PEI)**
3. Innovation **(INN)**
4. Workforce Education and Training **(WET)**
5. Capital Facilities and Technology **(CFTN)**

Riverside University HEALTH SYSTEM Behavioral Health

CSS

- Largest Component – 76%
- Includes Full Service Partnerships (FSP), Housing/HHOPE, Crisis System of Care, and Mental Health Courts/Justice Involved programs, Peer programs

PEI

- Next largest component – 19%
- Reduce stigma related to seeking services, reduce discrimination against people with a diagnosis, prevent onset of a SMI
- Early intervention for people with symptoms for 1 year or less or do not meet criteria for a diagnosis; low intensity, short term intervention

Riverside University HEALTH SYSTEM Behavioral Health

Riverside Co CSS and PEI Highlights

- Our crisis system of care includes 24/7 crisis support center (951-686-HELP) providing access to our around-the-clock BH mobile crisis teams, and 3 regional 24/7 walk-in Mental Health Urgent Care clinics (Riverside, Perris and Palm Springs).
- Community Assistance, Recovery, and Empowerment Act, known as CARE Court, launched in 10/2023. This collaborative court team serves consumers with schizophrenia spectrum disorders who are court ordered into supportive treatment. The program celebrated its first graduate in 12/2024; one of the first graduations in the State! As of 01/2025, over 400 people were referred and 116 became clients.
- PEI funded Suicide Prevention Coalition pioneered clinical bereavement support for survivors of suicide loss. Community based therapists were trained using a manual developed specifically for Riverside County by Dr. Sally Spencer-Thomas, a nationally recognized leader in the field. Sessions are no-cost for participants. Additionally, in partnership with American Foundation of Suicide Prevention, community volunteers were trained to facilitate suicide loss support groups, which were nearly non-existent before this initiative.

Riverside University HEALTH SYSTEM Behavioral Health

INN

- Funded out of 4% CSS and 1% PEI
- Used to create "research projects" that advance knowledge in the field; not just fill service gaps
- Time limited: 3-5 years
- Requires additional State approval process to access funds

WET

- Funded from a portion of CSS dollars.
- Recruit, retain, and develop the public behavioral health workforce

CF/TN

- Funded from a portion of CSS dollars
- Improve the infrastructure of public mental health services: buildings and electronic programs.

Riverside University HEALTH SYSTEM Behavioral Health

Riverside Co INN, WET & CFTN Highlights

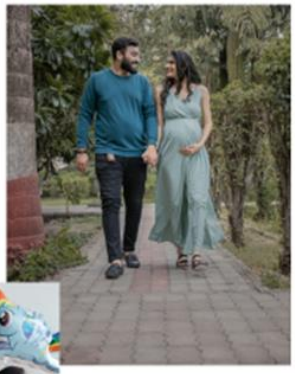
- In 02/2024, MHSA Admin successfully completed the State review process to receive $29M MHSA Innovation plan funds for the Mindful Body and Recovery Program, an eating disorder intensive outpatient and education program. This level of care had missing in public BH. Early implementation started in 09/2024.
- WET centrally coordinates one of the largest BH internship programs in the IE. Last year, WET received 120 applications and accepted 37 MA and BA students from 10 different universities. 42% were bilingual with over 50% being Spanish speakers. RUHS-BH hires a majority of the graduates.
- Renovation is complete on an augmented adult residential care facility on Franklin Ave. in the City of Riverside. The facility has 84 beds and integrated, on-site FSP services. Facility is scheduled to open 03/2025.
- Mead Valley Wellness Village broke ground in 2024! The Village is a campus of BH services providing a continuum of BH care from outpatient to residential in a single location. In addition, the village will provide some physical health care services and employment support.

Riverside University HEALTH SYSTEM Behavioral Health

What's Next for Community Stakeholders?

Public Posting & Hearings

- **April 2024 : 30 day website posting**
  - Give written feedback on draft plan
- **May 2024: Public Hearings**
  - Provide your opinion to the BHC
  - In-person: MIMHM
    - May 01 Desert
    - May 08 Mid-Co
    - May 15 Western
  - Virtual 24/7 videos on-line

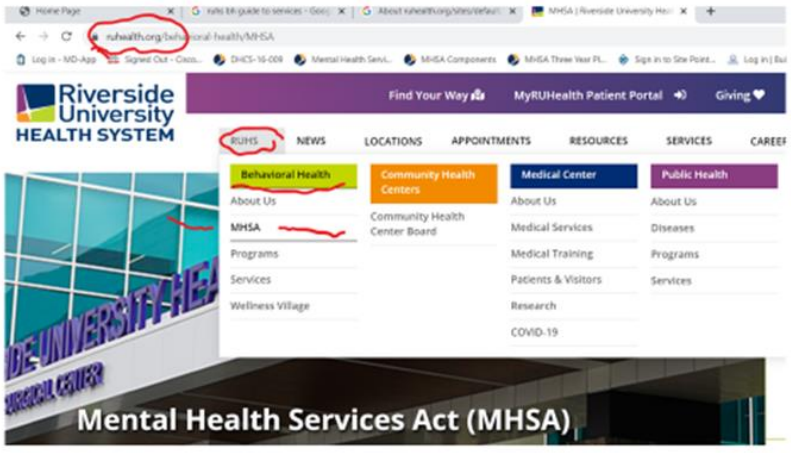






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Behavioral Health

ruhealth.org



Riverside University HEALTH SYSTEM
Behavioral Health

Does my feedback do anything?

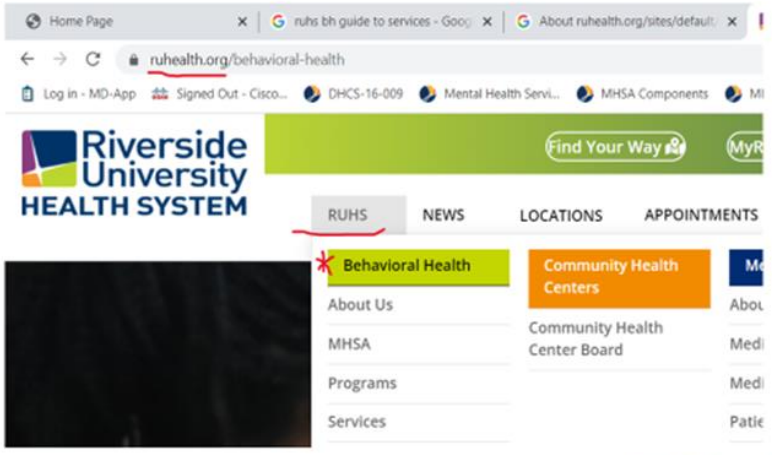
- Yes! Does every comment lead to a change? No.
- Staying and being informed helps. Asking questions is encouraged.
- Understand the BH Continuum of Care that is already offered. Be as specific as you can about what you like or what you'd like to see changed.
- Connect to a Department advisory group so your voice can be amplified:
  - Behavioral Health Commission and related committees, MH Regional Boards
  - Cultural Competency Reducing Disparities and related community subcommittees
  - PEI and regional TAY collaboratives





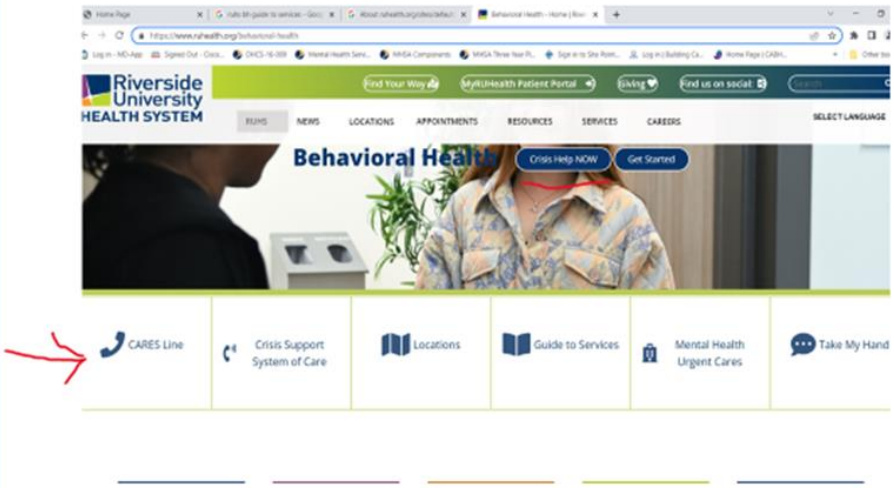
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Riverside University HEALTH SYSTEM
Behavioral Health

Contact Info

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- INN: (Planning lead) Leah Newell
  - LMNewell@ruhealth.org
  - bhculturalcomp@ruhealth.org

Riverside University HEALTH SYSTEM
Behavioral Health

What is BHSA?

- Behavioral Health Services Act (BHSA)
- Proposition 1 (March 2024 ballot)
  - Became law January 2025
  - Prop 1 also included $6.4 billion bond for BH residential care and supportive housing
  - Embedded timelines: 1st new Integrated Plan 7/2026
- Not just a MHSA crosswalk. New components, regulations, reporting, and oversight.





Riverside University HEALTH SYSTEM Behavioral Health

The BHT Process

State guidance, direction, and legislative refinement is currently, actively being developed.

This is a slow-going process that includes dialogue between State and Counties to negotiate how the laws will be applied.

Some of what is presented today may change with future State updates.

Riverside University HEALTH SYSTEM Behavioral Health

Guiding Principles Change

MHSA

- Funds of last resort. Can be used for non-billable services
- Strong focus on peer support and MH recovery
- County had more independence
- Serious Mental Illness (SMI)
- Reach people before they have consequences of SMI and promote MH recovery
- Early Intervention designed to prevent onset of SMI
- Outreach based on stigma reduction, education, and awareness

BHSA

- Still funds of last resort, but prioritize Medi-Cal and commercial payor billing
- Focus on homelessness, especially encampments
- State has more oversight
- SMI AND Serious SUD
- Address the consequences of untreated BH disorders and prevent exacerbation
- Early intervention designed to prevent disorders from becoming severe and disabling.
- Outreach based on connecting people to care

Riverside University HEALTH SYSTEM Behavioral Health

Planning and Reporting Changes

MHSA

- Annual Community Planning and Participation Process (CPPP)
- Each county set own goals
- County had no EBP restrictions
- Component funding percentages were rigid
- Prudent reserve max is 33% of CSS
- Report contained only programs and budget for MHSA funds
- No strong sanctions for non - compliance
- Annual Review and Expenditure Report (ARER)

BHSA

- CPPP every 3 years but mandates list of stakeholders to include 5 largest cities, local health jurisdictions, manage care plans
- State to define success metrics
- State to provide menu of approved EBP and CDEBP for program model
- Funds can be moved between components with State approval
- Prudent reserve max is 20% of total
- Report contains ALL BH funds
- State can direct plan revisions and provide sanctions
- Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

Riverside University HEALTH SYSTEM Behavioral Health

Component Changes

MHSA

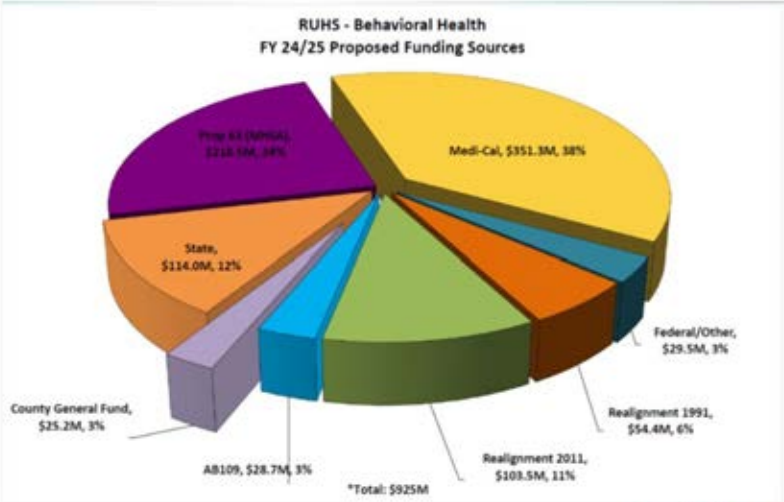
- State Allocation: 5% OTT
  - Admin costs
- CSS: 76%
  - FSP
  - GSD, Crisis, Criminal Justice,
  - Outreach and Peer Programs
  - Housing
- PEI: 19% (51% on youth < 25)
  - Prevention
  - Early Intervention
- INN: 5%
  - Encumbered funds good through life of current ED-IOP plan 2029
- WET (funds from CSS)
- CFTN (funds from CSS)

BHSA

- State Allocation: 10% OTT
  - Population based Prevention
  - INN partnership fund
  - Workforce initiatives
  - Admin costs
- Housing: 30%
  - No treatment, support svs
  - Includes (CFTN) housing developments
- FSP: 35%
- BHS: 35%
  - Early Intervention (50%)
    - Definition change
    - 51% on youth < 25
  - WET, INN, CFTN (except housing)

Riverside University HEALTH SYSTEM Behavioral Health

RUHS-BH Funding Sources



Riverside University HEALTH SYSTEM Behavioral Health

Where is Riverside's BHT at?

- Key Department leadership attend workgroups with California Behavioral Health Directors Association (CBHDA)
- State has released two Behavioral Health Transformation policy manual modules in late 2024. More to come.
- Department created a BHT Workgroup:
  - Creating an internal timeline
  - Unbraiding MHSA funds to help understand which programs are at most risk based on BHSA regulations and community priorities
  - Develop and plan for the new expanded stakeholder process
  - Transform MHSA Admin into BHSA Admin
  - Prepare for the new reporting procedure and document





Riverside University HEALTH SYSTEM Behavioral Health

BHSA Timeline

By June 30, 2026

- Board of Supervisors approves FY 26-29 Integrated Plan
- Submit FY 26-29 Integrated Plan to DHCS and BHSOAC

July 01, 2026

- FY 26-29 Integrated Plan becomes effective

June 30, 2027

- FY 27/28 Annual Update is due

January 20, 2029

- FY 26/27 BH Outcomes, Accountability, and Transparency report is due



Riverside University HEALTH SYSTEM Behavioral Health

Introduction



MHSA Plan Highlights Fiscal Year 25/26

Community Services and Supports (CSS)

General System Development

- Riverside County Mobile Crisis Response for Behavioral Health is now available 24/7. The Mobile Crisis Teams include clinical therapists, case managers, addiction counselors, and peer support specialists. This team is dispatched where the behavioral health crisis is occurring with the goal to deescalate the situation, link to ongoing care, and avoid unnecessary emergency department care, psychiatric hospitalizations, and law enforcement involvement. The Mobile Crisis Teams are countywide, and have successfully diverted 70% of contacts from law enforcement and inpatient admissions, demonstrating their effectiveness in handling crises without traditional enforcement methods. The Mobile Crisis Teams can be accessed by calling 951-686-HELP

- Community Assistance, Recovery, and Empowerment (CARE) Act more commonly known as CARE Court launched in October 2023. This new collaborative court team provides engagement, assessment, care planning, linkage, and wraparound case management services to consumers with schizophrenia spectrum disorders who are court ordered to engage in supportive treatment. The program celebrated its first graduate in 12/2024; one of the first graduations in the State! As of 01/2025, over 400 people were referred and 116 became clients.

Peer Support Service

- Peer Administration successfully supported RUHS-BH Peer Support employees to pass the Medi-Cal Peer Support Certification Program. 99% of incumbent peer employees have successfully completed the certification process.

- Parent Support and Training successfully implemented a new training support for fathers called, “Nurturing Fathers.” The program includes individual and group sessions

Prevention and Early Intervention (PEI)

The intent of Prevention & Early Intervention is to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment. There are seven work plans with several programs and services in each. PEI providers continued to show success in meeting program goals and objectives and reaching the target populations.

Work Plan 1: Mental Health Outreach, Awareness, and Stigma Reduction – includes several different strategies that focus on mental health stigma reduction, education about mental health symptoms, and increasing access for underserved communities.

- The Community Mental Health Promoter programs focus on target populations including Latino/a/x, Native American, Asian/PI, and Middle Eastern/North African. Providers engaged with 13,973 community members delivering 3,666 1-hour presentations with information about: anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, and bipolar disorder.

- PEI Administration continued to offer trainings, virtually and in-person, available to the general community focused on mental health awareness, self-care and wellness, trauma and resiliency, and suicide prevention. Additionally, in-person suicide prevention trainings were offered throughout the fiscal year. Trainings are free and available every month. In total for FY 23/24 1,506 participants attended the 91 trainings that were offered.

- PEI, in partnership with the Suicide Prevention Coalition, has launched short-term grief counseling for survivors of suicide loss at no cost to residents of Riverside County. This pilot project will offer 6-8 free sessions to suicide loss survivors through community-based clinicians who are trained in a specific approach to support suicide bereavement. PEI partnered with IEHP and Molina to train several of their providers to offer this as a benefit to their members. Suicide Loss survivors can request this service by visiting the TIP website at: https://tiprivco.org/bereavement-counseling/.

Work plan 2: Parent Education and Support—includes services that assist parents and families in building protective factors and reducing their risk of developing mental health problems.

- The Triple P program offers a multi-level system of parenting and family support strategies for families with children aged 2-12 and for families with teens aged 12-16. Triple P is designed to prevent children's social, emotional, behavioral, and developmental problems by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. During FY23/24, the provider for this program increased their services, aiming for twice the numbers served to better meet community need. They nearly met that goal for this fiscal year, serving 686 families countywide.

- The Strengthening Families Program is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children. This program brings together families for 14 weeks, for 2 ½ hours each week. In FY23/24 the program served 117 families with 144 parents attending with an 85% completion rate; 80% were Hispanic/Latinx.

Work plan 4: Transition Age Youth – outreach, stigma reduction, and suicide prevention activities for (TAY) at highest risk of self-harm. This includes targeted outreach for LGBTQ TAY, TAY in or transitioning out of the foster care system, runaway TAY, and TAY transitioning into college.

- The Directing Change Statewide Program and Film Contest for FY23/24 included 203 Film Submissions from 26 schools & CBOs by 580 youth. The partnerships with RCOE and RUHS-PH continued to make the event a success. In addition, a local rotary was able to sponsor the event, contributing to cash prizes for this year's winners. Riverside County's Eleanor Roosevelt High School won 1st place in the Suicide Prevention Category titled "Speaking Up" for both our local recognition ceremony and the statewide contest. The Riverside County recognition ceremony also featured an Art Gallery Walk, recognizing the youth who submitted and won the state's monthly Hope & Justice contests throughout the academic year.

- Stress and Your Mood is an evidence-based early intervention program used to treat transition-age youth who are experiencing depression. In FY23/24, the program served 244 TAY with 68% completion. Outcomes include a statistically significant reduction in depression, and all participants showed improvement overall.

Workplan 5: First Onset for Older Adults - includes services to reduce the first onset of depression and to reduce the impact of depression in the older adult population.

- The programs within this work plan include Cognitive Behavioral Therapy for Late-Life Depression (CBTLLD), Program to Encourage Active Rewarding Lives for Seniors (PEARLS), and partnership with the Riverside County Office on Aging to deliver Caregiver Support Groups, Healthy IDEAS, and mental health liaisons to assist Office on Aging staff via consultation, outreach, and early intervention service delivery. These programs served 403 participants with overall reductions in depression and anxiety along with improved quality of life.

Workplan 6: Trauma-Exposed Services – provides services to reduce the negative impact of trauma for individuals, families, and the behavioral health service system.

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based group intervention (for grades 5-12) that has been shown to reduce PTSD and depression symptoms and psychosocial dysfunction in children who have experienced trauma. CBITS served 313 youth with 84% completion. Outcomes include improvement in depressive symptoms and 64% of youth trauma symptoms dropped below clinical significance. Bounce Back is an adaptation of the CBITS model for elementary school students (K-5). This adaptation is currently out for competitive bid.

Work plan 7: Underserved Cultural Programs—This work plan includes programming for each of Riverside County's underserved ethnic populations. The programs include evidence-based and evidence-informed practices that are effective with the populations identified for implementation.

- Building Resilience in African American Families project (BRAAF) utilized a multi-intervention strategy with the primary program goals of reducing the risk of developing mental health problems and increasing resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. This program faced many challenges over the years regarding program recruitment, retention, and fidelity to the program curriculums. After strategic supports, additional trainings, and technical assistance, it was determined that this program was no longer meeting the needs of the African American community in Riverside County. Furthermore, it was determined by community stakeholders that the County needs to understand better what the current needs are of this underserved population. Currently, we are in the competitive bid process for a Qualitative Community Engagement Project to select a culturally specialized research agency that can assist with conducting a comprehensive and strategic community needs assessment to inform the development of more appropriate programs and supports for the African American population in Riverside County across the continuum of behavioral healthcare.

- Mothers & Babies/Mamás y Bebés: The Mothers & Babies program worked to increase engagement and service delivery to African American women throughout Riverside County. For FY23/24, the program served 255 women with 91% completion, 83% served were Latina, and 3.5% were African American; overall outcomes showed a statistically significant reduction in depressive symptoms. All three contract providers actively increase strategic outreach and partner with other African American serving organizations/workgroups, including the Perinatal Equity Initiative and The Amani Project. One of the providers, Riverside Community Health Foundation, is aiming to further this work by holding a focus group with previous African American participants to learn from them how to make the curriculum more culturally relevant and will be piloting a group for African American moms lead by African American facilitators, that will incorporate the feedback from the focus group.

Innovation (INN)

- Our 5-year Innovation Plan, **Help@Hand** (Help at Hand), ended in February 2024. The Help at Hand Innovation Plan explored the best ways to bring technology-based mental health tools into the public mental health service system. Riverside County planned and implemented nine (9) projects aligned with the initial goals and objectives. Eight of the nine projects have been transitioned into our standard system of care to continue serving the Riverside County community, with the ninth continuing

to inform our work with the Deaf and Hard-of-Hearing Community (DHoH). Information on the Help at Hand project can be accessed at **https://HelpatHand.info**. Highlights from the H@H project include:

DHoH—Riverside County's needs assessment and resulting work have provided a path for learning about DHoH community needs and how to help them better access mental health services technology. The information generated by this effort makes an invaluable contribution to one of Riverside's diverse communities.

1. I translated the Digital Mental Health Literacy (DMHL) video series on the Help@Hand website in ASL and found that the DHOH community benefited.
2. Launched a needs assessment survey to gain more insight into the specific needs of the DHoH community.
3. Administered ASL-inclusive Peer Support Specialist Training, with two participants completing the course and eligible for the Medi-Cal certification exam.
4. Launched the Peer-supported TakemyHand video chat pilot using Peer Support Specialists who are deaf or hard of hearing.
5. Riverside adapted the DHoH Needs Assessment so that other Collaborative members could adopt and use to tool in their own communities
6. Help at Hand will produce two research papers in collaboration with UCI. The first, Understanding the Potential of Mental Health Apps to Address Mental Health Needs of the Deaf and Hard of Hearing Community: Mixed Methods Study, was published on November 11, 2022. The second is set for publication later this year. These research publications contribute to advancing knowledge in digital mental health technology for the DHoH community, provide educational value to other research organizations, and can help inform public policy and decision-making, ultimately driving societal improvements.

TakemyHand™ - The Live Peer Chat is now under RUHS BH Peer Support Services, and continues to provide free, peer-to-peer live chat interface using real-time conversations for individuals 16 or older seeking non-crisis emotional support. It remains available online at TakeMyHand.co. or TomamiMano.co for Spanish speakers and via iPhone and Android Apps.

1. The mobile app was approved by Google Play in 2024
2. The Emotional Wellness Check-In Tracker feature was added to the mobile app
3. Univision/NBC Interviews created and ran TV campaigns in https://vimeo.com/showcase/11106848 (English) and https://vimeo.com/showcase/11106895 (Spanish).
4. Between 2021 – 2023, Total users ranged from 5,362-33.4 K and total sessions from 4,867 – 39.4 K.

La CLAve - a mental health awareness education program created to help individuals and their families recognize the symptoms of serious mental illness, was well-embraced by the community. This program continues as part of the Prevention and Early intervention plan.

1. Univision/NBC Interviews and "Break Stigma" videos promoted La CLAve in the Desert region to educate and help reduce stigma in the desert community, which has a large percentage of Spanish-speaking residents: https://vimeo.com/showcase/11106748 (English) and https://vimeo.com/showcase/11106770 (Spanish)
2. The Prodromal Questionnaire Brief (PQB) was integrated into the TakemyHand™ website and mobile app under the Learn La CLAve section.
3. Riverside realized the benefits of its efforts by the end of 2024 with 52,952 engagements.

Man Therapy - a mental health engagement campaign geared specifically for men was also well-embraced by the community. This program also continues as part of the Prevention and Early intervention plan. Man Therapy also now has an active Spanish website option that went live in February 2024.

1. The Spanish website went live in February 2024.
2. By the end of 2023, the partnership supported 56,444 participants through 64,889 website sessions and completed 16,033 screenings for users from Riverside County.
3. Riverside grassroots efforts reached other community members outside the county with 26,692 screenings completed in California.

The App for Independence or A4i - a mobile app used to support the recovery process of individuals living with schizophrenia or psychosis is now also managed under Peer Support Services.

1. Piloted over two (2) years for high-risk populations such as adults, older adults, and transitional aged youth (TAY)
2. For more information visit the Hearts Showcase website: https://vimeo.com/showcase/11000292
3. An animated video was created in partnership with Dreamsyte to encourage adoption of the A4i app among the pilot participants A4i Animated Video

T**he Whole Person Health Score** - a screening tool that can help a person and their health care team determine areas of health strength and risk across six domains: physical health, emotional health, resource utilization, socioeconomics, ownership, and nutrition and lifestyle. Our Help @ Hand partners separately assisted in the digitization for virtual platforms and validation of the tool, ensuring a reliable measure that is easily accessible by the community and their healthcare providers.

1. Initially, the tool was digitized to facilitate a survey assessment
    a. The tool was distributed by three different departments: Medical Center/Community Clinics, Behavioral Health, and RivCoONE
    b. The 28-question assessment provides a "snapshot" of an individual's health

    c. There were 1,863 WPHS assessments completed during February 2023 and February 2024: MC/CC (301); BH (1,066); RivCoONE (496)
2. Later, the holistic, patient-centered adult tool developed by RUHS was validated to evaluate the measurement performance of WPHS domain and composite scores
    a. The analytic sample included 58,055 patients who completed at least one WPHS survey between August 2019 and February 2024.
    b. The dataset included demographic and clinical characteristics, WPHS responses and scores, types of clinical visits, and diagnosis indicators of chronic health conditions.
    c. data quality assessment provided actionable recommendations for further refinement and implementation.
    d. Further evaluation is encouraged to ensure the WPHS continues to evolve as a valuable tool for patient-centered care and quality improvement within RUHS.

90 interactive **Kiosks**, installed in waiting areas throughout Riverside County, provided a wide range of information on healthcare access.

1. Kiosks were deployed in clinics and community organizations across the different geographic regions
2. A kiosk locator is present on the H@H website to help consumers find where to learn more about available resources via the closest kiosk
3. They remain active as points of service navigation and education for people seeking care.

The **Recovery Record App assists with eating disorder management and was** piloted as part of the Help at Hand Innovation project.

1. Providers that worked with clients using Recovery Record found it easy to use and valuable in tracking client emotions and behaviors.
2. This eating disorder tracking and support mobile app continues to be utilized as a part of the new Eating Disorder Innovation project.

Help@Hand Summary project - Here is the story map with the latest **numbers** related to the 2024 reporting period. “Transforming Emotional Wellness across Riverside County and beyond with Technology”: https://arcg.is/1SW0Dz

- As Help@Hand ended, a new plan began. Over the past year, we have actively shaped a new Riverside County Innovation plan, an Eating Disorder Intensive Outpatient and Training Program, entitled **The Mindful Body and Recovery Program**. This Five-Year, $29 Million plan was approved by the State in February 2024. Designed to address the challenges of treating eating disorders, this project is creating an Eating Disorder Hub where we can examine how to best treat, train, and educate our Riverside County Community through an integrated care approach.
    - The Intensive Outpatient Program (IOP) will serve adolescents ages 12 to 18 years old who require this higher level of care. This project aims to address

the critical need for improved treatment and care for individuals with eating disorders, which have the second-highest mortality rate among mental health conditions. By focusing on enhancing treatment practices, increasing access for underserved populations, and raising community awareness, we aim to improve both the quality and availability of care. This approach includes training practitioners and providing a level of care previously non-existent in public behavioral health.

Workforce Education and Training (WET)

- The department is invested in having well trained paraprofessionals and professionals thus offering trainings department wide and to our contracted providers. Also supporting community members and retirees to be trained. In the last year 158 trainings were offered, which was an increase from the 98 trainings that were offered the previous year. Collectively 402 continuing education (CE) units were provided. 2,646 attendees were trained. Trainings offered were, Cognitive Behavioral Therapy for PTSD, Dialectical Behavioral therapy, Lehman center lead Square Model Training which was revised to be consistent with Cal AIM. Trainings on Suicide Harm and Trauma as well as Seeking Safety in which there were 79 staff trained this year. In addition, Lehman offered competency trainings for Clinical Supervisor. Culturally specific trainings were offered such as Disability Training for the Generalist Clinician and Gender Affirming Care. Staff safety is important thus 16 NCI trainings were offered and 332 staff were trained which was an increase from 267 the previous year. Lastly, Lehman center has provided trainings to the TOPPS program in connection with Hemet Unified School District.

- Recruitment outreach efforts increased reaching approximately 2,205 students and community members, inclusive of two outreach events called, Get Psyched, that were in collaboration with Vista Del Lago High School and Moreno Valley College reaching 200 Highschool students and secondly, the first Get Psyched event in Palm Desert reaching approximately 230 high school students. Both events centered on the education and career pathways into public behavioral health service system. Also, as it relates to students, provided support doing Mock interviews with the school's health academy programs. WET/Lehman programs have participated in May is Mental Health Month Fair at Fairmount Park and Indio, public forum for the Mental Health Service Act (MHSA) plan, the Norco College Health, Wellness, and Safety Fair, supported other programs by participating in the Directing Change event and Lehman participated in a community focused Halloween Drive Thru Event.

- Retention is important. To support pre-licensed clinical workforce, CLAS has been expanding its services and increased applicants from 29 last year to 31 this year. 24 Clinical Licensure Advancement and Support (CLAS) participants became licensed and promoted to Clinical Therapist II (CTII) positions which was an increase from 16 last

year. The Lehman Center and WET staff have provided clinical supervision. Also, WET acquired a grant from Kaiser Permanente which funding would offset staff salary, support in hiring diverse staff, and unlicensed staff to achieve licensure. Lehman Senior CTs have offered clinical support to clinical supervisors, provide group supervision, and oversee interns. The program also provided coaching/mentoring to managers and supervisors. WET is in full implementation of the centralized support program for Clinical Supervisors to be able to ensure consistency county wide.

- The WET Internship programs continue to be one of the largest behavioral health internship programs in the Inland Empire. The Graduate Internship, Field, and Traineeship (GIFT) Program received over 120 applications and accepted 37 master or bachelor students into the program. Students were from 10 different universities. 42% of the students were multi-lingual with over 50% of being Spanish speakers. Many had lived experience (as a consumer or family member). Demographically, 51% identified as Hispanic or Hispanic mixed with another race, 21% Caucasian or white, 11% as African American, and 3 % identified as other races (Asian or Multiple Mixed Races).

Capital Facilities and Technology (CFTN)

- Mead Valley Wellness Village broke ground in 2024. Full service Behavioral Health Campus that serves as a safe, monitored, and therapeutic community and living space while simultaneously delivering high quality, person-first, treatment for Behavioral Health. The Village will be architecturally designed and landscaped and offer a full continuum of behavioral health care in one location. Consumers and their families move through the campus' continuum of care from intensive oversight and treatment activities, to decreased therapeutic contact enabling consumers to prepare for a self-sustained recovery grounded in their own community. The Village is schedule to open in December 2026.

- Renovation has completed on an augmented adult residential facility on Franklin Avenue in the City of Riverside. This adult residential facility provides 84 beds with integrated, onsite full-service partnership (FSP) services. This facility provides a level of service comparable to the department's existing adult residential and care facility location in Palm Springs (Roy's Desert Springs & Windy Springs Wellness Center combination).

Regional Grid

Regional Key Program Grid MHSA Annual Update FY 25-26

Community Services & Supports (CSS): Full Service Partnership (FSP)

	Western Region	Mid-County Region	Desert Region
FSP Track in outpatient clinics	X	X	X
FSP Outreach Prior to Acute Hospital Discharge	X	X	X
Children's FSP			
Multi Dimentinal Family Therapy	X	X	X
Wraparound	X	X	X
Youth Hospital Intervention Program (YHIP)	X	X	X
TAY (Transitional Age Youth):			
TAY FSP Program	X	X	X
Adult:			
Adult FSP Program	X	X	X
Older Adult FSP:			
SMART Program	X	X	X

CSS: General Service Development (GSD)

General			
BH Care at Community Health Center	X	X	X
Parent Child Interaction Therapy/Preschool 0-5	X	X	X
DBT, Eating Disorder, NCI, MI, TF-CBT, other EBP	X	X	X
TAY Centers	X	X	X
Crisis System of Care:			
24/7 Mobile Crisis Teams	X	X	X
Mental Health Urgent Care (MHUC)	X	X	X
Crisis Residential Treatment (CRT)	X	X	X
Clinician/Police Partner Teams (CBAT)	X	X	X
Mental Health Court & Justice Related:			
Mental Health Court/Veterans Court	X	X	X
Homeless Court	X		X
Law Enforcement Education Collaboration (CIT)	X	X	X
Youth Treatment Education Center	X		
Juvenile Justice EBP	X	X	X
Adult Detention BH Discharge Preparedness	X	X	X
Laura's Law Assisted Outpatient Treatment	X	x	x
CARE Court (Includes mobile access countywide)	X		

CSS: Outreach and Engagement

Lived Experience Programs:			
Consumer Affairs: Peer Support			
Peer Support and Resource Centers	X	X	X
Peer Support Specialist Certification Classes	X	X	X
WRAP/Facing Up/WELL	X	X	X
Parent Support & Training: Parent Partners			
Educate, Equip & Support	X	X	X
Triple P/Triple P Teen	X	X	X
Nurturing Parenting	X	X	X
Parent Partner Training	X	X	X
Family Advocates:			
Family WRAP (English & Spanish)	X	X	X
Family to Family Classes (English & Spanish)	X	X	X
DBT for Family (English & Spanish)	X	X	X

Regional Grid

Housing & Housing Programs:			
HHOPE Programs	X	X	X
Homeless Outreach Teams	X	X	X
Permanent Housing Property for Chronic Homelessness	X		X
Permanent Supportive Housing Units	X	X	X

Prevention and Early Intervention (PEI)

	Western Region	Mid-County Region	Desert Region
Mental Health Outreach, Awareness & Stigma Reduction:			
Stand Against Stigma (formerly Contact for Change)	X	X	X
Promotores de Salud Mental y Bienestar	X	X	X
Community Mental Health Promotion Program	X	X	X
Integrated Outreach & Screening	X	X	X
Asian/PI Mental Health Resource Center	X	X	
Helpline	X	X	X
Parent Education & Support:			
Triple P - Positive Parenting Program	X	X	X
Mobile MH Clinics & Preschool 0-5 Program	X	X	X
Strengthening Families	X	X	X
Trasistion Age Youth (TAY) Project:			
Stress and Your Mood	X	X	X
TAY Peer-to-Peer Services	X	X	X
Active Minds Chapters (Send Silence Packing)	X	X	X
Outreach to Runaway Youth/Safe Places	X	X	X
Teen Suicide Awareness & Prevention Program	X	X	X
First Onset for Older Adults:			
Cognitive Behavioral Therapy for Late-Life Depression	X	X	X
Program to Encourage Active Rewarding Lives (PEARLS)	X	X	X
Care Pathways - Caregiver Support Groups	X	X	X
Mental Health Liaisons to Office on Aging	X		X
Carelink/Healthy IDEAS	X	X	X
Trauma-Exposed Services:			
Cognitive Behavioral Intervention for Trauma in Schools	X	X	X
Seeking Safety TAY	X	X	X
Seeking Safety Adult	X	X	X
Underserved Cultural Populations:			
Mamas y Bebes (Mothers & Babies)	X	X	X
Native American Project	X	X	X
Asian American Project/KITE	X	X	

Innovation (INN)

	Western Region	Mid-County Region	Desert Region
Tech-Suite (Help @ Hand) Project:	X	X	X
Mindful Body and Recovery Project	X	(But serves county wide)	

MHSA Community Planning and Local Review

Understanding the Stakeholder Process

Who Is a Stakeholder?

Stakeholders are people who have a vested interest in Public Behavioral Health care in Riverside County. A stakeholder can be anyone: a consumer or family member; a care or protection services professional; other private or public service agencies and officials; community-based organizations; community advocates; cultural community leaders; faith-based organizations; schools; neighbors; parents and parent organizations – anyone who cares about behavioral health and the programs developed to meet Riverside County's behavioral health needs and wellness.

Local Stakeholder Process

Mental Health Services Act operates under rules and regulations that were originally established by Proposition 63, the 2004 voter approval ballot measure that created the legislation. At the heart of that legislation is a regulation requiring a "community stakeholder process." Essentially, the people of Riverside County who have a vested interest in public behavioral health care need a guaranteed voice in the planning and review of MHSA programs.

Stakeholder feedback is sought and accepted all year round and can be provided in person, over the phone, in writing, or electronically. MHSA has its own page on the RUHS-BH website, where the MHSA Plan and feedback forms are available. All MHSA Administration employees are trained to seek, listen for, and recognize community feedback regardless of when or how they interact with a Riverside County stakeholder. They are directed to integrate that feedback into all related planning and advocacy

Stakeholder Partner and Participation Directory



Introduction

MHSA Stakeholder Partnership and Participation Structure:
"How Can My Voice Be Heard?"

Riverside University HEALTH SYSTEM
Behavioral Health

BHC & Community Advisory	Collaboratives	Forums	Posting and Public Hearing
Behavioral Health Commission Commission Meetings • Central • Regional (Desert, Mid-County, Western)	**Prevention and Early Intervention** • Steering Committee* • Quarterly Collaborative Meetings (Sign up at PEI@ruhealth.org)	**Focus Groups** Focus Groups are coordinated meetings designed to get specific feedback on community needs. They are sometimes used to initiate planning, sustain planning, or to concentrate feedback from a particular population or group.	**Plan Draft Distribution** • RUHS-BH Clinics/Programs • Residential Housing • Peer Centers • Public Libraries • Requested by community organizations
Behavioral Health Commission Standing Committees • Adult System of Care • Children's Committee • Criminal Justice • Housing • Legislative • Older Adult System of Care • Veteran's Committee	**Workforce Education and Training** • Steering Committee* • Workforce survey, training evaluations, and feedback forms • Academic and community pipeline committees	**MHSA Forums** MHSA forums are an opportunity to learn and ask questions about MHSA-funded programs.	**Public Hearing** Public Hearing provides the community an opportunity to give feedback on a proposed MHSA plan • Typically scheduled in May for annual update • Virtual and/or in-person • Sometimes scheduled at other times of the year based on plan amendments
Cultural Competency • Reducing Disparities • African American • Asian American • LGBTQIA+ • Middle Eastern North African • Deaf and Hard of Hearing • People with Disabilities • Spirituality and Interfaith • Native American` • Hispanic-Latinx			https://bit.ly/3WePulf **MHSA Tab** • Most recent annual update and latest 3-Year plan • Includes electronic feedback forms • MHSA@ruhealth.org • (951)955-7156

*Closed meeting

(Rev 01/2025)

Riverside University HEALTH SYSTEM Behavioral Health

2025 MEETING SCHEDULE

BEHAVIORAL HEALTH COMMISSION & REGIONAL ADVISORY BOARD

(Hybrid Option Available, Meetings and locations subject to change. For further information, please contact the assigned Committee Executive Assistant. Thank you)

BEHAVIORAL HEALTH COMMISSION

1st Wednesday of the month at 12:00 noon at the following location: Riverside University Health System – Behavioral Health, 2085 Rustin Avenue, Riverside, CA 92507- Entrance 1, Conference Room 1051

January 9, 2025	February 5, 2025	March 5, 2025	April 2, 2025
May 7, 2025	June 4, 2025	July 2, 2025	August – DARK
September 3, 2025	October 1, 2025	November 5, 2025	December - DARK

For further information, please contact Sylvia Bishop at (951) 955-7141.

DESERT REGIONAL BOARD

2nd Tuesday of the month at 12:00 noon at the following location: Indio Mental Health Clinic, 47-825 Oasis Street, Indio, CA 92201

January 14, 2025	February 11, 2025	March 11, 2025	April 8, 2025
May 13, 2025	June 10, 2025	July 8, 2025	August – DARK
September 9, 2025	October 14, 2025	November 11, 2025	December - DARK

For further information, please contact Mary Carpio at (760) 863-8586.

MID-COUNTY REGIONAL BOARD

1st Thursday of the month at 3:00 p.m. at varying locations within the Mid-County Region

January 2, 2025	February 6, 2025	March 6, 2025	April 3, 2025
May 1, 2025	June 5, 2025	July 10, 2025	August – DARK
September 4, 2025	October 2, 2025	November 6, 2025	December – DARK

For further information and to confirm location, please contact Hilda Gallegos at (951) 943-8015 or Elizabeth Lagunas at (951) 940-6215.

WESTERN REGIONAL BOARD

1st Wednesday of the month at 3:00 p.m. at 2085 Rustin Avenue, Riverside, CA 92507- Entrance 1

January 9. 2025	February 5, 2025	March 5, 2025	April 2, 2025
May 7, 2025	June 4, 2025	July 2, 2025	August – DARK
September 3, 2025	October 1, 2025	November 5, 2025	December - DARK

For further information, please contact Jocelyn Aleman at (951) 358-8335.

Introduction

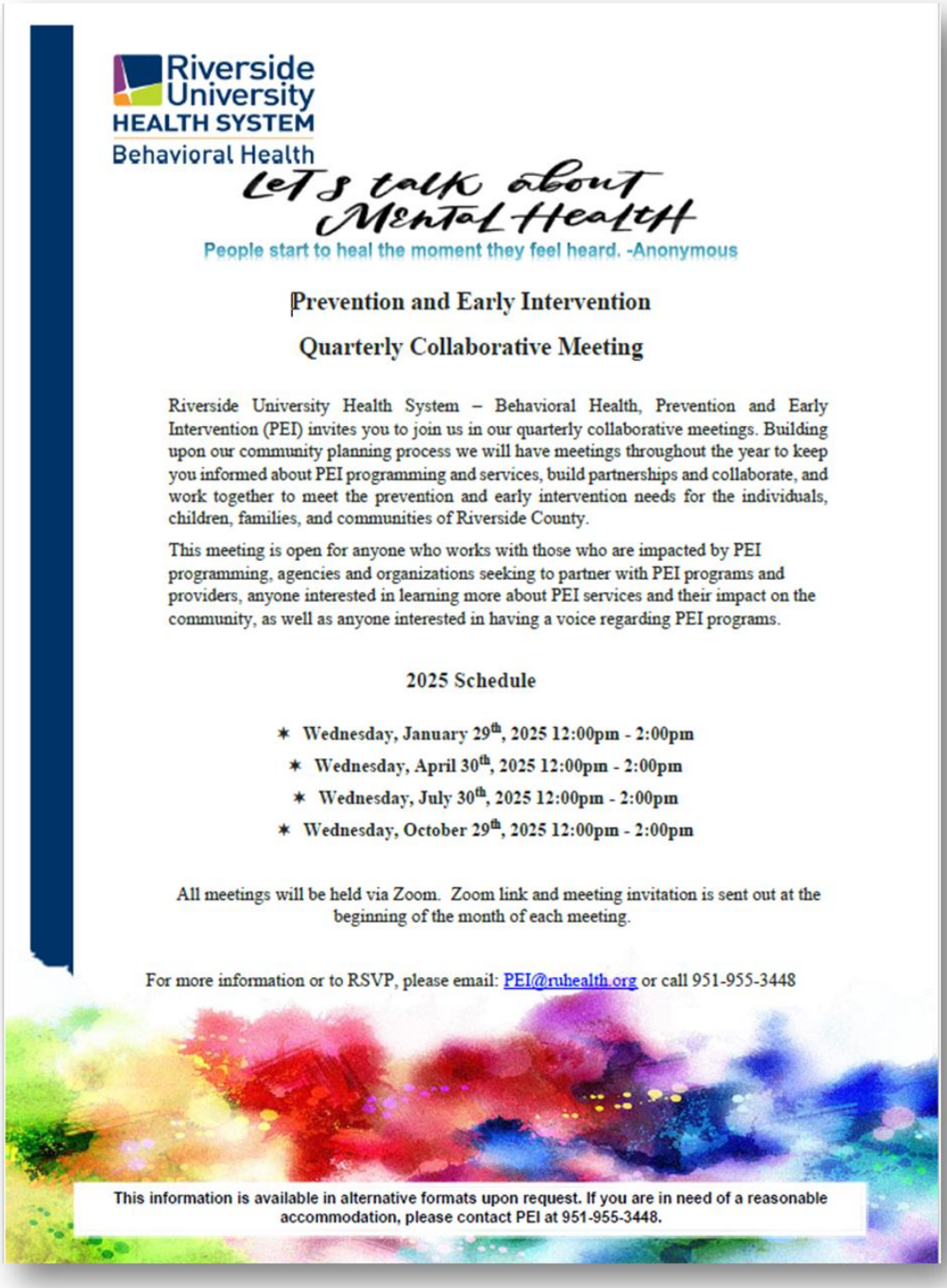
Riverside University HEALTH SYSTEM
Behavioral Health

BEHAVIORAL HEALTH COMMISSION - STANDING COMMITTEES 2025 MEETING SCHEDULE

(Hybrid Option Available, Meetings and locations are subject to change. For further information, please contact the assigned Executive Assistant. Thank you)

ADULT SYSTEM OF CARE COMMITTEE	CHILDREN'S COMMITTEE	CRIMINAL JUSTICE COMMITTEE	HOUSING COMMITTEE	LEGISLATIVE COMMITTEE	OLDER ADULT INTEGRATED SYSTEM OF CARE COMMITTEE	VETERAN'S COMMITTEE
Last Thursday @ 12pm ***(Meeting location rotated between Riverside & Perris)***	*4th Tuesday @ 12:00pm 2085 Rustin Avenue Riverside, CA 92507*	*2nd Wednesday @ 12pm 3625 14th Street Riverside, CA 92501*	*2nd Tuesday @ 11 am 2085 Rustin Avenue Riverside, CA 92507*	*1st Wednesday @ 10:30 am 2085 Rustin Avenue Riverside, CA 92507*	*2nd Tuesday @ 12pm 2085 Rustin Avenue Riverside, CA 92507* ***(Location differs in Feb. & Nov.)***	*1st Wednesday @ 10:00 am 2085 Rustin Avenue Riverside, CA 92507*
January 30, 2025	January 28, 2025	January 15, 2025	January 14, 2025	N/A	January 14, 2025	January 9, 2025
February 27, 2025	February 25, 2025	N/A	February 11, 2025	February 5, 2025	February 11, 2025	N/A
March 27, 2025	March 25, 2025	March 19, 2025	March 11, 2025	N/A	March 11, 2025	March 5, 2025
April 24, 2025	April 22, 2025	N/A	April 8, 2025	April 2, 2025	April 8, 2025	N/A
May 29, 2025	May 27, 2025	May 21, 2025	May 13, 2025	N/A	May 13, 2025	May 7, 2025
June 26, 2025	June 24, 2025	N/A	June 10, 2025	June 4, 2025	June 10, 2025	N/A
July 31, 2025	July 22, 2025	July 16, 2025	July 8, 2025	N/A	July 8, 2025	July 2, 2025
August – DARK	August – DARK	N/A	August – DARK	August – DARK	August – DARK	N/A
September 25, 2025	September 23, 2025	September 17, 2025	September 9, 2025	N/A	September 9, 2025	September 3, 2025
October 30, 2025	October 28, 2025	N/A	October 14, 2025	October 1, 2025	October 14, 2025	N/A
November 20, 2025	N/A	November 19, 2025	November 11, 2025	N/A	**TBA**	November 5, 2025
December – DARK	December 9, 2025	N/A	December - DARK	December – DARK	December – DARK	N/A
Committee Executive Assistant Elizabeth Lagunas (951) 940-6215	**Committee Executive Assistant Saida Spencer (951) 358-7348**	**Committee Executive Assistant Dinah Navarro (951) 955-1530**	**Committee Executive Assistant Rachel Zapata (951) 210-1459**	**Committee Executive Assistant Sandy Awad (951) 955-7156**	**Committee Executive Assistant Cynthia Peterson (951) 358-5891**	**Committee Executive Assistant Miriam Resendiz (951) 955-7138**

2025 Meeting Schedule



Riverside University HEALTH SYSTEM Behavioral Health

Let's talk about Mental Health

People start to heal the moment they feel heard. -Anonymous

Prevention and Early Intervention

Quarterly Collaborative Meeting

Riverside University Health System – Behavioral Health, Prevention and Early Intervention (PEI) invites you to join us in our quarterly collaborative meetings. Building upon our community planning process we will have meetings throughout the year to keep you informed about PEI programming and services, build partnerships and collaborate, and work together to meet the prevention and early intervention needs for the individuals, children, families, and communities of Riverside County.

This meeting is open for anyone who works with those who are impacted by PEI programming, agencies and organizations seeking to partner with PEI programs and providers, anyone interested in learning more about PEI services and their impact on the community, as well as anyone interested in having a voice regarding PEI programs.

2025 Schedule

- **Wednesday, January 29th, 2025 12:00pm - 2:00pm**
- **Wednesday, April 30th, 2025 12:00pm - 2:00pm**
- **Wednesday, July 30th, 2025 12:00pm - 2:00pm**
- **Wednesday, October 29th, 2025 12:00pm - 2:00pm**

All meetings will be held via Zoom. Zoom link and meeting invitation is sent out at the beginning of the month of each meeting.

For more information or to RSVP, please email: PEI@ruhealth.org or call 951-955-3448

This information is available in alternative formats upon request. If you are in need of a reasonable accommodation, please contact PEI at 951-955-3448.


TAY ARENA COLLAB
2025
JOIN US FOR A MONTHLY MEETING OF COMMUNITY PARTNERS, TRANSITIONAL AGE YOUTH (TAY), AND RIVERSIDE COUNTY PROGRAMS TO ADDRESS THE NEEDS OF TAY IN MID-COUNTY.
✨ NETWORK | COLLABORATE | DISCUSS
MEETINGS ARE THE 4TH WEDNESDAY OF EVERY MONTH FROM 3-4:30 PM
LOCATED AT:
THE TAY ARENA
2560 N. PERRIS BLVD, STE. N-1, PERRIS
AND
VIRTUALLY ON MS TEAMS
(EMAIL: LAADAMSON@RUHEALTH.ORG FOR INVITE)
JANUARY 22, 2025
FEBRUARY 26, 2025
MARCH 26, 2025
APRIL 23, 2025
MAY 28, 2025
JUNE 25, 2025
JULY 23, 2025
AUGUST 27, 2025
SEPTEMBER 24, 2025
OCTOBER 22, 2025
NOVEMBER 26, 2025
DECEMBER IS DARK (NO MEETING)

RUHS Desert COLLABORATIVE - 2025

DATE: Wednesday, January 8, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Honor Moore – 417 Recovery

DATE: Tuesday, February 4, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Erika Edney & James Gaylor – First Episode Psychosis

DATE: Wednesday, March 5, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Julie Hirsh – Jewish Family Services

DATE: Wednesday, April 2, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Michelle Salado – Alzheimer's Association

DATE: Wednesday, May 7, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Bryan Kneiding- California Family Life Center

DATE: Wednesday, June 4, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Melissa Vasquez – Take My Hand

DATE: Wednesday, July 2, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter: Renae Punzalan – LGBTQ+ Youth Drop-In center

DATE: Wednesday, August 6, 2025 / 2:00 – 3:30 PM
Building: IN0735
Room: Rooms 402/402A

Task Description: RUHS Desert Collaborative 2:00pm – 3:30pm
Contact: Ashley Jean w/ RUHS Behavioral Health phone # 760-863-7067

Guest Presenter:

*ALL dates confirmed w/Amber Norman

Cultural Competency MEETINGS

AAFWAG
African American Family Wellness Advisory Group
10:00 a.m. to 11:30 a.m.
Meets on the 3rd Wednesday of every month.

APIDANH
Asian, Pacific Islander, Desi American, & Native Hawaiian
3:30 p.m. to 5:00 p.m.
Meets Bi-monthly on the 2nd Tuesday.

CAGSI
Community Advocating for Gender and Sexuality Inclusion
2:30 p.m. to 4:00 p.m.
Meets Bi-monthly on the 3rd Tuesday.

CCRD
Cultural Competency Reducing Disparities Committee
9:00 a.m. to 11:00 a.m.
Meets on the 2nd Wednesday of every month.

DCAN
Deaf Collaborative Advisory Network
4:00 p.m. to 6:00 p.m.
Meets Bi-monthly, rotating virtually on Mondays and in-person on Saturdays.

HISLA
Hispanic, Latinx
3:00 p.m. to 5:00 p.m.
Meets the last Thursday of every month.

MECCA/MENA
MECCA/Middle Eastern & North African
2:30 p.m. to 3:30 p.m.
Meets Bi-monthly on the 3rd Wednesday.

NATIVE AMERICAN
Native American Wellness Advisory
3:30 p.m. to 5:00 p.m.
Meets on the 3rd Monday of every month.

WADE
Wellness & Disability Equity Alliance
1:00 p.m. to 2:30 p.m.
Meets on the 1st Friday of every month.

SPIRITUALITY and FAITH-BASED
Interfaith and Spirituality
10:00 a.m. to 11:30 a.m.
Meets on the 2nd Tuesday of every month.

Let's break the stigma.

CCRD

CULTURAL COMPETENCY REDUCING DISPARITIES COMMITTEE



CCRD is a coalition of community leaders representing the diverse cultural groups in Riverside. They are united in a shared strategy to effectively address the behavioral health care needs of traditionally underserved communities. The CCRD stands by the following values:

- Inclusion
- Respect
- Community Collaboration
- Access
- Safety

Date: Meets on the 2nd Wednesday of every month.
Time: 9 - 11am
Location: Virtual
Register: https://bit.ly/RUHS-CCRD



Let's shine a light on mental health together. See you there!

Riverside University HEALTH SYSTEM Behavioral Health
Cultural Competency

MHSA Administration collaborates with existing community advisory and oversight groups. MHSA Administration employees attend these committees, and the committees were included in the MHSA 3-year planning and annual update process. These committees often advocate for the needs of a particular at-risk population or advocate for the needs of the underserved. The following are the groups that serve as key advisors in Riverside's stakeholder process:

- **Riverside County Behavioral Health Commission (BHC) and Regional Mental Health Boards**: The BHC acts as a community focal point for behavioral health issues by reviewing & evaluating the community's mental health needs, services, facilities, & special problems. Members are appointed by the Riverside County Board of Supervisors (BOS) and represent each of the Supervisorial Districts. Each region of Riverside County (Western, Mid-County, Desert) has a local Mental Health Board that serves in a similar capacity and helps to inform the greater BHC. The BHC advises the Board of Supervisors & the Behavioral Health Director regarding any aspect of local behavioral health programs. BHC meetings are held monthly and are open to the community.

  - The BHC also hosts subcommittees designed to seek community feedback and recommendations on specific service populations or higher-risk communities. These committees meet monthly and are open to the community and welcome community participation. A member of the BHC chairs the subcommittees. MHSA Administration relies on these subcommittees to advise on program areas related to the committees' special attention:
    - Adult System of Care
    - Children's System of Care (includes Children, Parents/Families, and TAY)
    - Older Adult System of Care (includes caregivers)
    - Criminal Justice (includes justice-involved consumers, and the need of law enforcement to intervene with consumers in the justice system)
    - Housing (addresses homelessness and housing development)
    - Legislative Committee (examines BH related legislation)
    - Veteran's Committee (includes the behavioral health needs of US Veterans and their families)

- **RUHS Cultural Competency Program:** The Cultural Competency Program provides overall direction, focus, and organization in implementing the system-wide Cultural Competency Plan aimed at enhancing service delivery and workforce development. The plan concentrates on integrating the languages, cultures, beliefs, and practices of consumers into Behavioral Health Care service delivery. Cultural Competency encompasses underserved ethnic populations, the LGBTQ community, the Deaf and Hard of Hearing, the physically disabled communities, and faith-based communities.

  - Cultural Community Liaisons: Contracted ethnic and cultural leaders that represent identified underserved populations within Riverside County. Liaisons provide linkage to those identified populations. The primary goals of the consultant are:

(1) to create a welcoming and transparent partnership with community-based organizations and community representatives to eliminate barriers to service.

(2) to educate and inform the community about behavioral health and behavioral health services to reduce disparity in access to services, recovery, and wellness.

- Cultural Populations Advisory Groups: The Cultural Community Liaisons chair or co-chair a related committee that is respective of each of the underserved communities they represent. The advisory groups counsel RUHS-BH on culturally informed engagement and service delivery. These advisory groups meet on a regular schedule and welcome community participation:

- Community Advocacy for Gender and Sexuality Inclusion and Equity (CAGSIE)
- African American Family Wellness Advisory Group (AAFWAG)
- Asian, Pacific Islander, Desi American, & Native Hawaiian (APIDANH)
- Hispanic-LatinX (HISLA)
- Middle Eastern North African (MENA)
- Deaf Collaborative Advisory Network (DCAN)
- Wellness & Disability Equity Alliance (WADE)
- Spirituality and Faith-Based
- Native American Wellness Advisory (NAWA)
- RUHS-BH has an existing Veteran's Services Liaison who was reorganized under Cultural Competency and attends the Veteran's Committee under the Behavioral Health Commission

- Cultural Competency Reducing Disparities Committee (CCRD): A collaboration among community leaders representing Riverside's diverse cultural communities, united in a collective strategy to better address the behavioral health care needs of traditionally underserved populations. CCRD is chaired by a mental health professional from the Cultural Competency Program and is overseen by the RUHS-BH Cultural Competency Manager. CCRD meets monthly and is open to the public.

- **RUHS-BH Lived Experience Programs**: RUHS-BH is recognized for its peer programming. We have programs based on lived experience across various care populations: consumer peer, family member, and parent. Each program is led by a Peer Planning and Policy Specialist, a department manager with corresponding lived experience. As part of our developing peer management, we hired a Deputy Director of Peer Support Services, who has lived experience in all three areas, and the managerial positions now report to her. Not only are peer staff integrated into clinic programs throughout Riverside County, but they also coordinate and engage in outreach activities to help educate others about recovery, reduce stigma, and support wellness. They play an essential role in our planning process, not only from their peer perspective but also due to their daily involvement in the community with individuals affected by behavioral health challenges.

- **Steering Committees, Collaboratives, and Community Consortiums:** Members of Steering Committees are subject matter experts or community representatives who are dedicated to expanding their knowledge of a MHSA component to provide an informed perspective during plan development. Collaboratives are regularly scheduled mini-conferences where stakeholders of MHSA components gather to hear about regulatory updates and share progress reports. Community Consortiums are meetings hosted by community or partner agencies that convene similar stakeholders to collaboratively address, plan for, and meet community needs. The MHSA Administration coordinates steering committees for Workforce Education and Training (WET) and Prevention and Early Intervention (PEI), and hosts a PEI Collaborative. Staff from MHSA administration also participate in the RUHS-BH TAY Collaborative and consortiums that include members from academic institutions, community-based organizations, sister county MHSA programs, school districts, public health and allied county departments, and justice-involved agencies.

MHSA Annual Plan Update Stakeholder Education and Feedback

Representatives from MHSA Administration provide annual MHSA education and plan updates to our network of community advisory groups at the beginning of the calendar year. The representative used a PowerPoint curriculum that is part of the "MHSA Toolkit" also attached to the email announcing the community participation process. The PowerPoint curriculum can also be found on the MHSA Annual Update landing page of the Department's website. A copy of the PowerPoint is included in the introduction of this document under "MHSA Quick Look." In addition, MHSA regularly attends or has a standing point on the agenda for feedback, education, and program updates at the following meetings:[2]

- Behavioral Health Commission
- Cultural Competency Reducing Disparities Asian American Task Force
- African American Family Wellness Advisory Group Community Advisory on Gender and Sexuality Issues, Hispanic-Latinx Advisory Group
- Middle Eastern North African Advisory Group Deaf and Hard of Hearing Advisory Group Wellness and Disability Equity Alliance
- Native American Advisory Group
- Spirituality and Faith-Based Advisory Group
- Children's System of Care
- Adult System of Care Older Adult System of Care
- Transitional Age Youth Collaborative Veterans' Committee

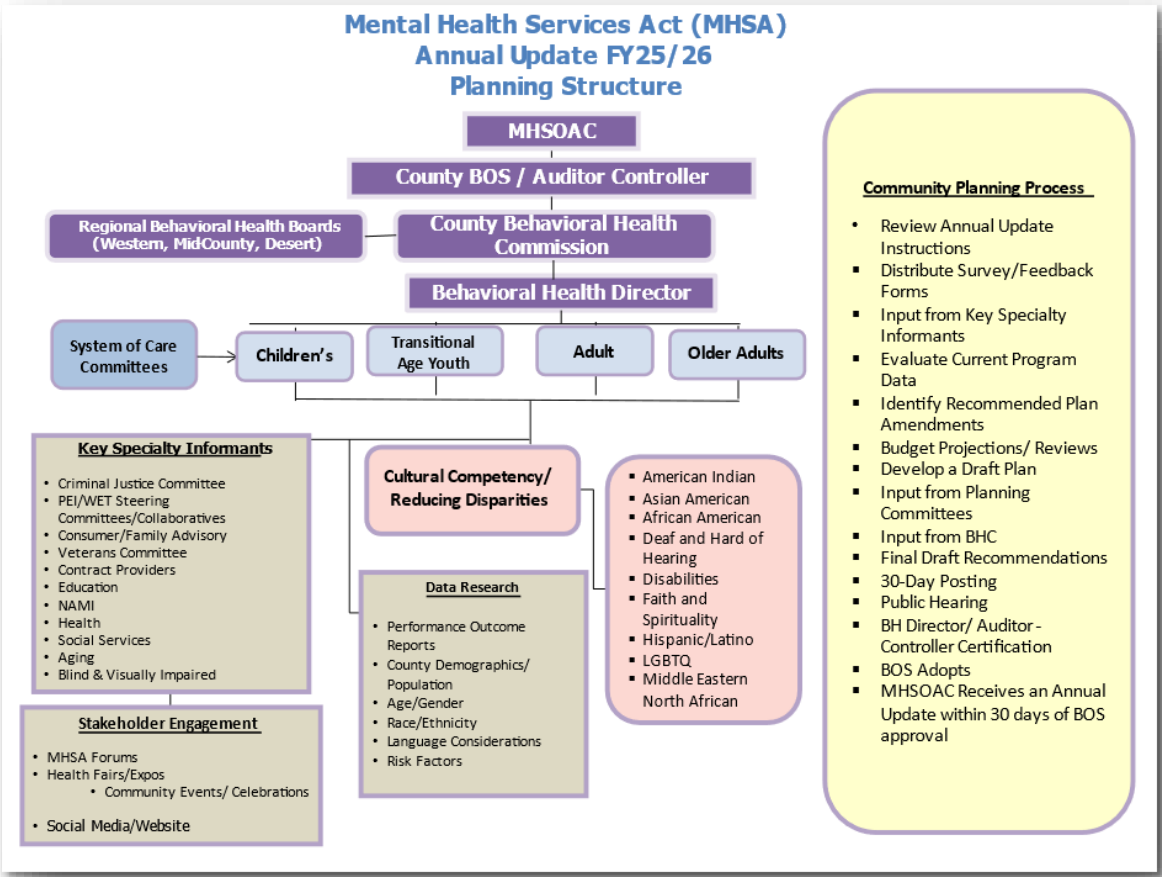
[2] Meeting dates and time are included in this Introduction under the Stakeholder Partner and Participation Directory

All meetings took place in 2025[3]

Deaf and Hard of Hearing	1/27/2025
Prevention and Early Intervention Collaborative	1/29/2025
Western Regional Mental Health Board	2/5/2025
Legislative Committee	2/5& 6/3,2025
Behavioral Health Commission	2/5/2025
Desert Regional Mental Health Board	2/11/2025
Children's Coordinators	2/11/2025
Children's Providers	2/13/2025
Transitional Age Youth Desert Collaborative	3/4/2025
Veteran's Committee	3/5/2025
RUHS-BH Manager's Meeting	3/10/2025
Housing Committee	3/11/2025
Older Adult System of Care	3/11/2025
Asian American Task Force	3/11/2025
Cultural Competency Reducing Disparities	3/12/2025
Transitional Age Youth Western Collaborative	3/13/2025
Community Advocating for Gender and Sexuality Issues	3/18/2025
Middle Eastern North African Advisory Group	3/19/2025
African American Family Wellness Advisory Group	3/19/2025
Children's Committee	3/25/2025
Transitional Age Youth Mid-County Collaborative	3/26/2025
Adult System of Care	3/27/2025
Behavioral Health Collective	3/31/2025
Mid-County Regional Board	4/3/2025
Wellness & Disability Equity Alliance	4/4/2025
Spirituality And Faith-Based Advisory Group	4/8/2025
Western Regional Collaborative	4/14/2025
Native American Advisory Group	4/21/2025
Hispanic Latinx	4/24/2025
Healthcare Discussion with Veterans	4/27/2025
Family Advocate Program	4/30/2025
Criminal Justice Committee	5/14/2025

[3] All meetings can be found in the Stakeholder packet

MHSA Annual Update Planning Structure



30-Day Public Comment

The Draft MHSA Annual Update FY 25/26 was posted for a 30-day public review and comment period from April 1, 2025, to May 30. 2025.

Public Hearing

MHSA regulations require that Riverside County post our draft plan for a 30-day public review and comment period, followed by a Public Hearing conducted by the Riverside County Behavioral Health Commission. This process typically begins months before and involves coordinating plan updates with RUHS-BH program managers, the Riverside County Behavioral Health Commission, our research department, program support, and fiscal units, as well as meeting with the stakeholder groups that comprise our primary advisory voices.

A public hearing was planned for the MHSA Annual Update FY 25/26 in an in-person format as follows:



Virtual Format: "Public Hearing in your Pocket"

1. Announce the 30-day Public Posting Period via repeated email distribution, our Department Webpage, and our social media accounts: X, Facebook, and Instagram. Announcements were provided in English and Spanish, including a link to the whole plan and an electronic feedback form. Videos are accessible 24 hours a day, seven days a week.

2. Attached to the email is a Riverside County "MHSA Toolkit," quick reference documents requested by our stakeholders that summarize plan changes, highlights, and goals. The kit also includes a grid organizing the service components by region, an orientation to MHSA, and a Stakeholder Directory to inform the community about year-round meetings where they can participate.

3. After the 30-day review period, a video presentation ("Public Hearing in Your Pocket") of the MHSA Plan overview, like the introduction of a standard public hearing, was posted daily on the RUHS-BH website from May 01 to May 25 and included a link to the whole plan, the electronic feedback form, and a voice mail telephone number. The presentation was conducted in both English and Spanish. The English and Spanish videos included an interpretation of American Sign Language.

4. DVDs of the presentation were also available for mail or pickup. They included a copy of the MHSA Toolkit and a stamped envelope to mail completed feedback forms. The DVDs can be closed-captioned in various languages.

In-Person Public Hearing

In-person, public hearings were planned to coincide with our popular community engagement festivals during May, which is Mental Health Month. They were scheduled in each county region as follows:

- Desert Region, May 1st, 2025
- Mid-County Region, May 8th, 2025
- Western Region, May 15th, 2025

MHSA Forums preceded Public Hearings. Forums were designed in "science fair" layouts, with each MHSA component represented at an education station hosted by related MHSA administration staff. Community members could move among the stations to learn more about MHSA, the plan, and the related programs/services, seek information, and discuss initial thoughts or ideas.

At the close of the forum, the formal public hearing began, conducted by a member of the Riverside County Behavioral Health Commission (BHC). The plan was reviewed visually, and public comments were initiated.

Public Comment Documentation and Responses

All comments received virtually and in person were compiled and reviewed by the BHC for a response. Comments and responses were added to this plan as a chapter in this document.

Results of Virtual Public Hearing Process

A total of 530,142 (in Spanish and English) saw the MHSA Annual Update FY 25/26 Public hearings promoted on Facebook, Instagram, YouTube, and Next-Door news feeds, Countywide. People engaged with the posts over 25 days, and the increase in impressions from Calendar year 24/25 was over 500%.

Results of the In-Person Public Hearing Process

In-person public Hearings were held in the three service delivery regions: Western, Mid-County, and Desert. A marketing campaign was created to advertise participation. It included a press release sent to all major local media, social media, website postings, announcements

sent on MHSA-related email distribution lists, and email notifications to all department employees with encouragement to share with clients and families. A total of 113 people attended the in-person forum, where the community could engage with the MHSA Administration Team and learn more about each of the five components of the plan. Behavioral Health Services Act and program access information were also available.

An Ad Hoc Committee of the Behavioral Health Commission met on June 16th, 2025, reviewed all public comments, and developed responses. Those comments and responses serve as a chapter in this annual update. The Behavioral Health Commission approved the final plan on July 02, 2025.



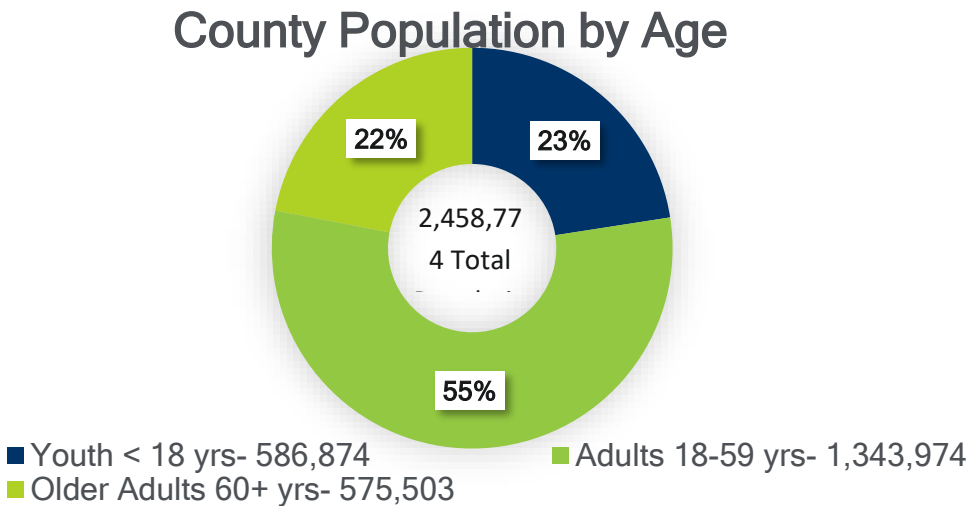
MHSA Capacity Assessment



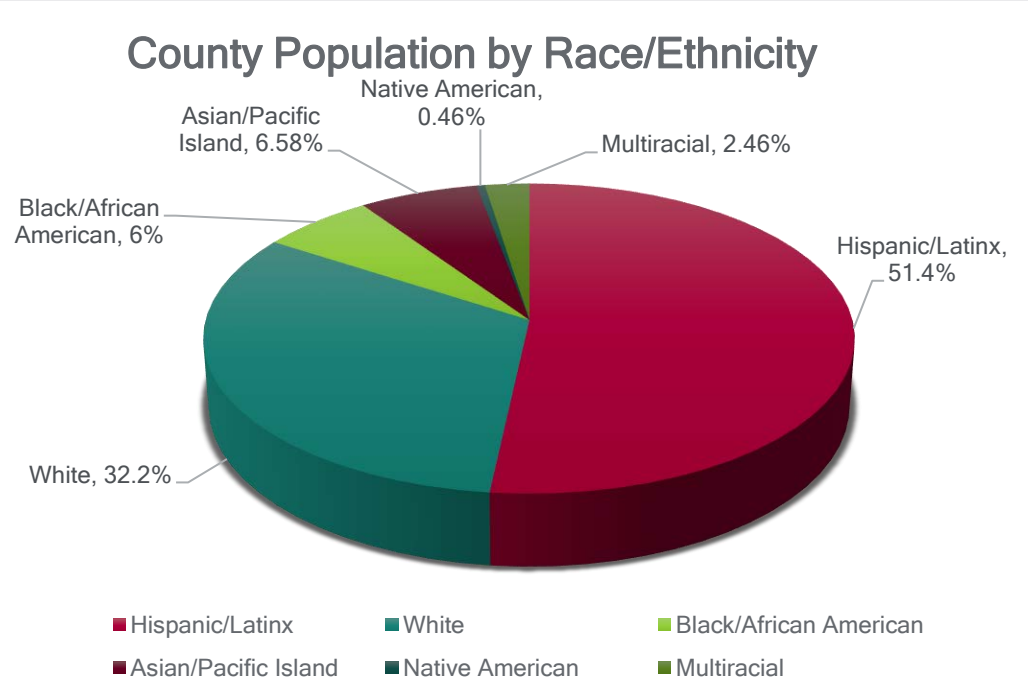
Riverside County Population

Riverside County is the fourth most populous County in California and the 10th most populous county in the United States. The County at 7,208 square miles spans nearly the width of California with service areas in the metropolitan western portion of the county to the rural community of Blythe at the Arizona border.

The County population has grown each year from 2010 to 2023. Youth under the age of 18 comprise nearly a quarter of the population (23.4%). Older Adults are almost a quarter of the population (22.9%). The Older Adult population has been increasing and the youth under age 18 has been decreasing over the last 5-10 years. Transition Age Youth (TAY), aged 16-25, represent 14.6% of the population, totaling 360,846 youth.



Riverside County has two large Race/Ethnic groups representing 83.6% of the population, Hispanic/Latinx and White. The Hispanic/Latinx group is the largest group in Riverside County. Asian/Pacific Islander groups have grown over time from 4% to 6.5% of the population currently. Black/African American has remained steady at 6% of the population. A number of tribes are spread throughout Riverside County with Native Americans representing less than 1% of the population.



Spanish is the only threshold language in Riverside County. More than a third of the County population 34.98% reported speaking Spanish and of these Spanish speakers 34% reported they speak English less than “very well”.

The California Health Interview Survey (CHIS) data was used to report the population identifying as Lesbian, Gay or Bisexual (LGB). Pooling the last 3 years of available data showed 7% of the adult population reported they identified as LGB. CHIS data was also used to identify the adult Transgender or gender Non-Conforming population, slightly more than one half of one percent (0.6%) of adults reported they identified as Transgender or Gender Non-Conforming. CHIS data among Teens surveyed showed 4.1% reported they identified as Transgender or Gender Non-Conforming.

Economic status for people living in Riverside County derived from the U.S Census showed 11.1% of the population (266,955) is living below the federal poverty level. The federal poverty level is $30,000 or less per year for a household of four people and $14,580 for a single person household. Living below the poverty level is higher for youth under the age of 18 at 14.1%. Additionally, 17% of the population (419,756) has income that is 200% above the poverty level, which qualifies many for social safety net benefits. The population at 200% and those living below the poverty line represent 28.4% of the County population. The median household income for

Riverside County, for those working full-time year-round, reported in U.S. Census data for 2023 was $75,340 in 2022, which means one-half the population is below $75,340 and one-half the population is at $75,340 or above. Census data on earnings for the last year for those working year-round full time (175,310 people) showed 22.4% (175,310) of those working full time earned $34,999 or less per year.

The Department of Health Care Services (DHCS) data on Medi-Cal eligibility for the most recent month showed the County has nearly 1 million Medi-Cal recipients (995,532). The Medi-Cal beneficiaries 42% of the overall County population. Children and youth age 0-18 represented 38% of the Medi-Cal eligible population, while adults accounted for 55% and older adults 65+ were 7% of the Medi-Cal population.

The 2023 Point in Time Homeless Count for Riverside County indicated 3,725 homeless people both sheltered and unsheltered; 65% (2,441) were unsheltered and 35% (1,284) were sheltered. The 2023 count was an overall increase of 12% from the previous year. However, most of that increases was in the homeless unsheltered population. Homeless families with children with children increased 12% (143) from the previous year. Riverside and Indio were the two cities with the highest homeless count. The Desert region in District 4 had the highest total number of homeless persons. The top three primary factors reported as contributing to unsheltered homelessness were Family disruption, lack of income, and unemployment. A Point in Time Count was not conducted in 2024, the results of the 2025 count were not yet available to include the results in this MHSA Annual update.

Identifying Underserved and Unserved Populations

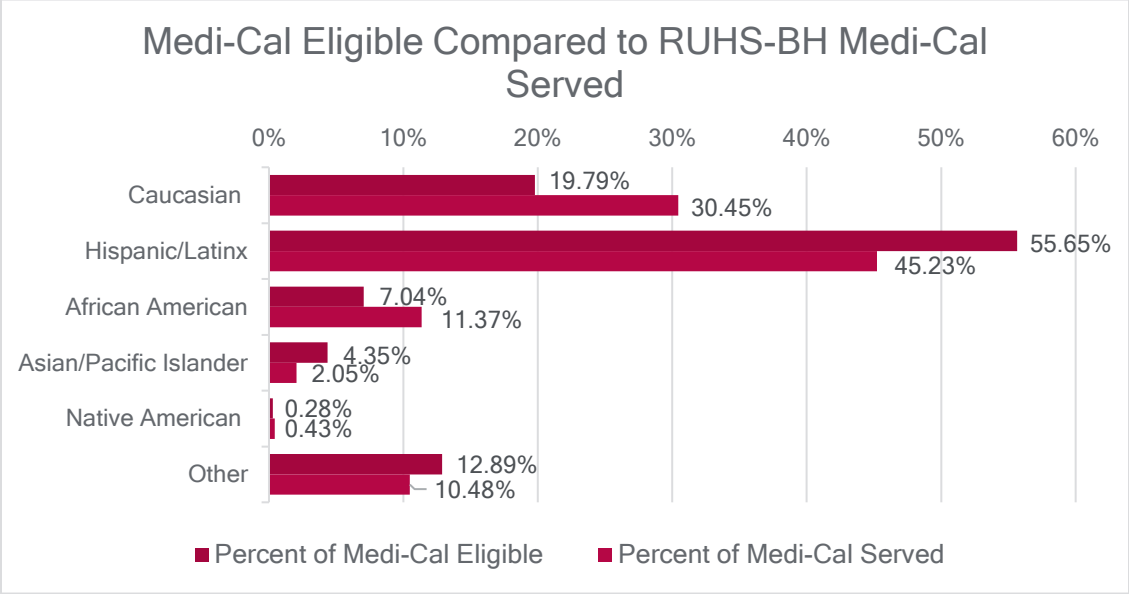
Unmet need is an estimate of how many mentally ill individuals there are in the county who may not be receiving the mental health services they need. Unmet need is calculated based on the difference between 1) known prevalence rates of mental illness and 2). How many consumers receive mental health services. RUHS-BH completed a detailed analysis of Unmet Need when drafting the initial MHSA proposal in 2003-2004; and has examined changes using the initial benchmarks. Since the implementation of MHSA, RUHS-BH has served 52% more consumers. Services to Youth under the age of 18 has increased by 30%, and services to adults has increased by 52%. Services to Older Adults have increased dramatically by 195%. Decreases in unmet need have been found for all age groups.

Disparities can be identified by utilizing Medi-Cal penetration rates. This is calculated as the proportion of Medi-Cal consumers served out of the total number of people with Medi-Cal eligibility. The California Department of Health Care Services uses Medi-Cal paid claims to provide penetration rates for each county. Data on penetration rate by age groups is shown in the following table.

	County Rate	Large Counties	Statewide Rate
Youth <18	5.64%	7.86%	9.11%
Adults 18-59	4.71%	4.72%	5.06%
Older Adults 60+	2.92%	2.56%	2.92%

Penetration rates for Adults and Older Adults are similar to other large counties and the statewide rates. Youth rates are lower than other large counties and the statewide rate, despite steady increases in the number of youth served this age group is somewhat underserved. Overall Medi-Cal penetration rates are impacted by the increases in Medi-Cal beneficiaries.

Comparisons between Medi-Cal population of beneficiaries to mental health clients served provides useful information on disparities. The following figure below shows Medi-Cal Eligible Compared to RUHS-BH Medi-Cal Served.

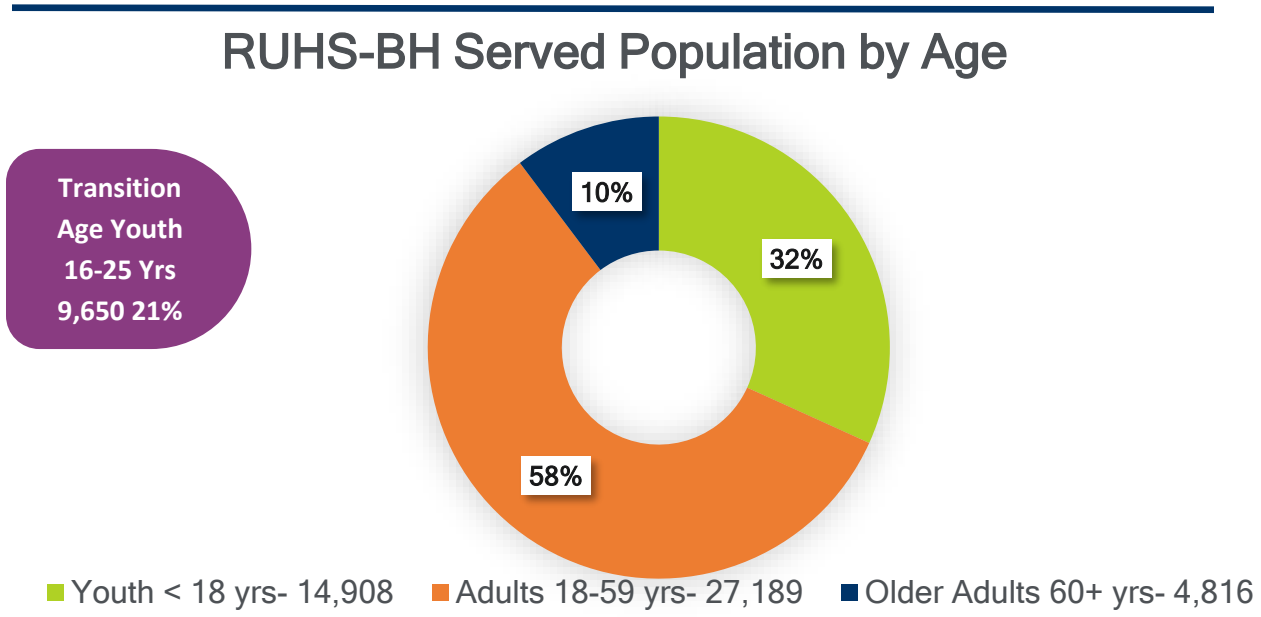


- The proportion of Caucasians served was nearly 1.5 times the respective Medi-Cal eligible proportion.
- Hispanic/Latinx represented over half of the county Medi-Cal eligible population, but their proportion in the Medi-Cal served population was under-represented by over 23%. The number of Hispanic/Latinx served has increased over time with the percentage served increasing from
- African Americans showed an over-representation by 38% in the Medi-Cal served population.
- Asians/Pacific Islanders were the second smallest racial group among the county Medi-Cal eligible population. They were severely underserved by over 112%.

- Native Americans were the smallest racial group among the Medi-Cal eligible population in Riverside County. They were over-represented in served population by 34%.

Capacity to address disparities has been implemented across the department from outreach and community engagement to Workforce development. These efforts are described further within this plan update.

RUHS-BH Population Served CSS





Estimated FSP population to be served				
	Children	TAY	Adults	Older Adults
FY 24/25	1325	650	925	450
FY 26/27	1350	700	950	460

Strengths

The department has multiple County-run clinics spread across the County's large geographic. Each region has increased capacity by adding contracted providers in each region of the County. Newer contractors including the Latino Commission and Special Services for Groups (SSG) have been established to broaden access especially for Latinx and Asian /Pacific Islanders. SSG primarily services Asian/Pacific islander families which is a growing demographic in the County; and as shown previously has a greater service disparity than other groups. RUHS-BH through PEI funding established Community Mental Health Promotor programs (CMHPP) for multiple race/ethnic groups and sub populations. The CMHPP program activities are further described in the PEI section of his report. The main goal of these program is to increase access, reduce barriers through mental health educational presentations and outreach. The groups served by CMHPP include; Latinx, Black/African American, Asian/Pacific Islander, Native American, Middle Eastern North African, LGBTQ+. Additional initiatives include contracting with cultural liaisons to support outreach to each race/ethic group and additional populations. These additional populations include; people with disabilities, deaf and hard of hearing (Riverside County has a significant Deaf Hard of Hearing community), faith-based community.

Additionally, RUHS-BH for many years has supported the implementation of evidenced based practices and has increased the infrastructure and capacity to provide evidenced-based interventions in various levels of the department's service array. MHSA Prevention and Early Intervention has implemented multiple evidenced based practices or evidenced informed interventions across the PEI service array. In CSS the RUHS-BH outpatient clinics provide the following Evidenced-Based Practices; including Dialectical Behavior Therapy (DBT), Seeking Safety, Trauma Focused-CBT, Wraparound, Multidimensional Family Therapy, First-Episode Psychosis coordinated Specialty Care model, Parent Child Interaction Therapy (PCIT) and Family Based Therapy (FBT) for eating disorders.

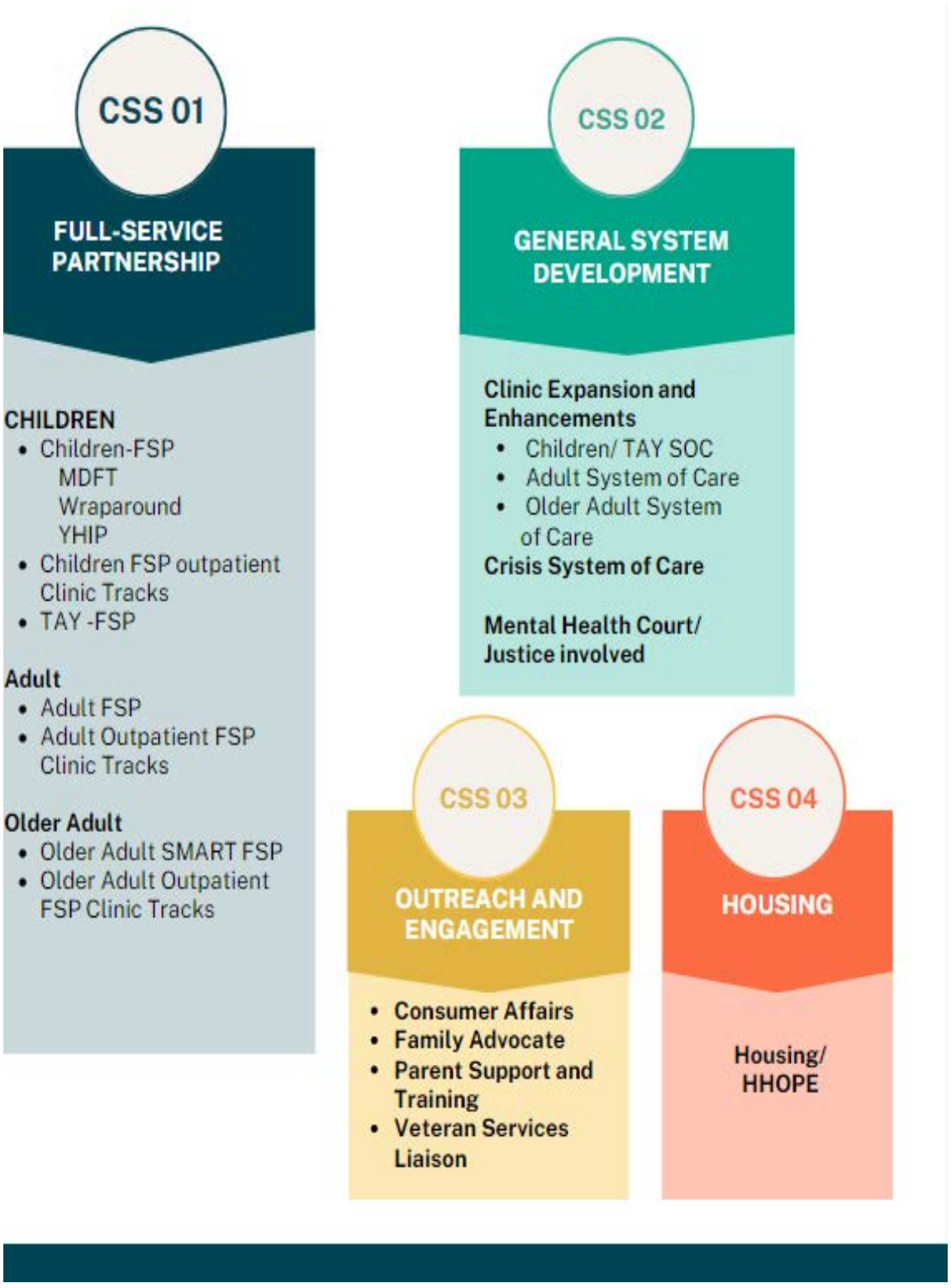
Challenges: Staff recruitment and retention has been a challenge over last few years, particularly post pandemic. Retaining staff that have been trained in evidenced based practices continues to be a challenge. Stigma and transportation are known barriers to accessing services.

Section II

Community Services and Supports

MHSA Annual Updates FY25/26

Community Services and Supports



Community Services and Supports

What is community services and supports (CSS)?

CSS is the largest of the MHSA components. It is designed to provide all necessary mental health services to children, TAY, adults, and older adults with the most profound emotional, behavioral, or mental health challenges and for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. CSS contains provisions for Full-Service Partnership (FSP), Outreach and Engagement & Housing, and General System Development (GSD), which includes specialized programming for the Crisis System of Care, Justice Involved programs, and expansion and enhancement of the outpatient service system.

CSS-01 Full-Service Partnerships

what is a Full-Service Partnership (FSP)?

Children Consumers, or youth and their families, enroll in a voluntary, intensive program that provides a broad range of supports to accelerate recovery or align with healthy development. FSP includes a "whatever-it-takes" commitment to progress on concrete behavioral health goals. FSP serves clients with a serious behavioral health diagnosis AND who are underserved and at risk of homelessness, incarceration, or hospitalization.

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

Full-Service Partnership Children FSP Outcomes Report FY 2023-2024

Background

The following report is a summary of outcome data for the Children's Full Service Partnership (FSP) programs. The Childrens FSP programs provide intensive mental health services and are available in the Childrens County clinics and through a contracted provider. In addition an FSP providing Multi-Dimensional Family Therapy (MDFT) is available in each region of the County. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains.

Outcome reporting is based on comparisons between baseline and post-enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Children's FSP programs beginning July 1, 2023, and ending June 30, 2024. Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form, the history of events for the 12 months before a consumer began the FSP program.

Follow-up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data have been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in a Children's FSP program.

FSP Program

The Children's Full Service Partnership (FSP) programs provide intensive mental health services for Children aged 0-15 and their families. FSP is a comprehensive and intensive mental health program and utilizes a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals.

Executive Summary

Children's FSP Enrollment and Demographics —During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 1099 youth were served across 1157 enrollments which includes re-enrollments and transfers to one or more of the Children's FSP programs. The race/ethnicity of enrollees for this fiscal year was 565 (48.8%) Latinx, 164 (14.2%) White, and 103 (8.9%) African American/Black. Countywide, the most common diagnoses among YHIP FSP consumers was major depression 360 (33.1%). Countywide the largest proportion of consumers were between the ages of 11-14 (35%) and the majority enrolled were female (60%).

Children's FSP Discontinuances —Across all of the Children's FSP programs the most frequently reported discontinuance reason was 'Met goals' (41%).

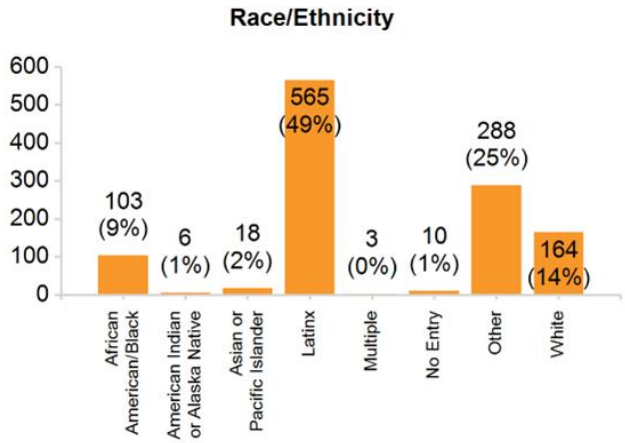
Children's FSP Services —In the 2023/2024 fiscal year, on average more than 42% of the Children's FSP consumers received 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for intensive care coordination services (16.88 hours), individual therapy (12.26 hours) and intensive home based services (10.48 hours).

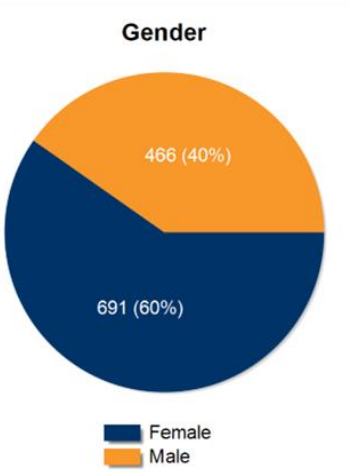
Children's FSP Outcomes —Follow-up data for all children's programs combined showed a decrease in arrests (92.52%), physical health emergency department visits (86.97%) and hospital admissions (15.70%) . The use of mental health crisis facilities increased slightly from intake to follow up.

A small percentage of consumers did not have a primary care physician at the beginning of the program (6.57%), however, more than half of those (50.67%) obtained one while in the FSP program. Of the youth with a co-occurring substance use problem who were not receiving treatment at intake,(35.00%) participated in substance use services while in partnership. An Additional 40 consumers were identified as having an active substance abuse problem during their participation in the FSP program.
Grades Improved or stayed above average from intake to follow-up: 65.53%. Attendance Improved or stayed above average from intake to follow-up:69.26%.

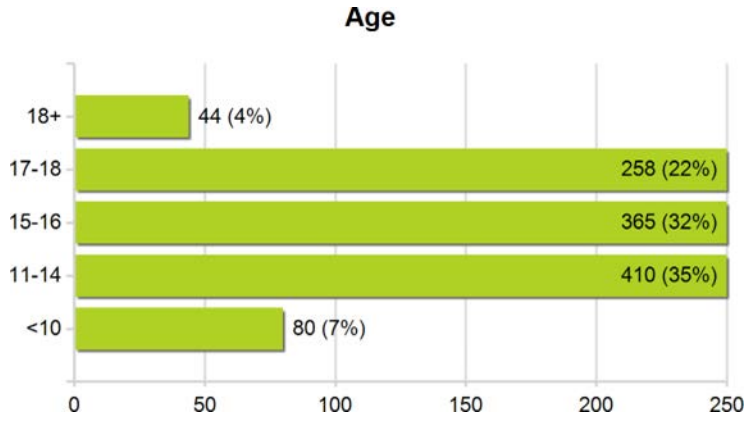
Demographics & Diagnosis

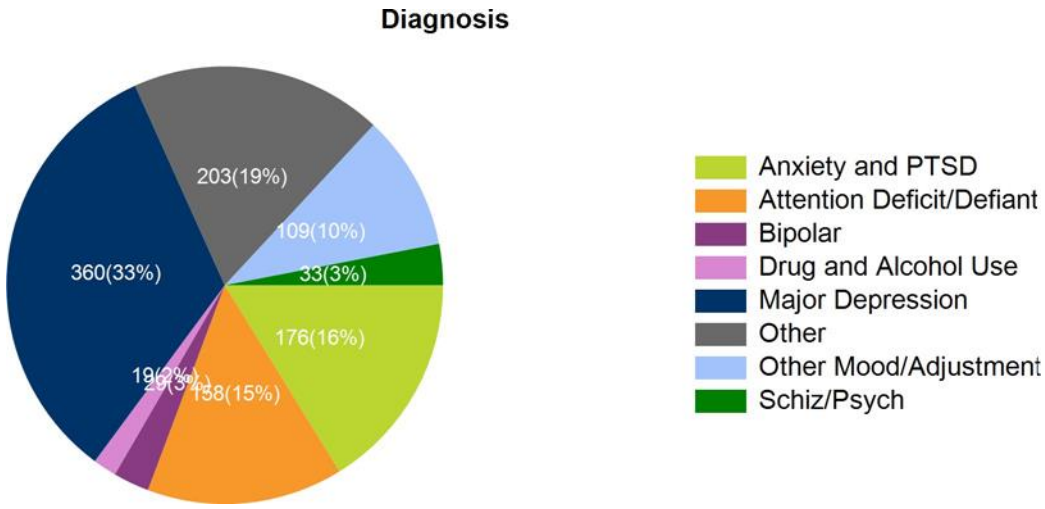
The majority served in the Children's FSP program in the 2023/2024 fiscal year were Latinx 49%, followed by Other Race, at 25%. The proportion of African American/Black participants was 9%. Also, more females (60%) have enrolled in the Children's FSP program than males (40%).





Most individuals served were between the age of 11-14 (35%) followed by 15-16 (32%). A large proportion of those served were diagnosed with Major Depression (33%).





Length of FSP Partnership

The length of stay in years for those **1157** enrolled in Children's FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of children with an active/open case having time in partnership longer than one year was 21%, while 84% of those without an open episodes have a time in partnership shorter than one year. Most of the Children's FSP consumers served in FY 2023/2024, had a length of stay less than two years (96%).

FSP re-entry: Of these **1157** FSP enrollments, 82 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership and 4 of them re-established partnership more than one time over their total time in partnership. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 27.

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	102	55	157	14%
>= 2 Years and <3 Years	24	17	41	4%
>= 3 Years and < 4 Years	1	1	2	0%
>= 90 days and < 1 Year	268	158	426	37%
Under 90 days	418	113	531	46%
Total Consumer Enrollments	**813**	**344**	**1157**	

Average Years in Partnership	1.79	0.77	0.56
Median Years in Partnership	0.24	0.42	0.29
Maximum Years in Partnership	3.23	3.15	3.23

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

Note: Active cases include those with an open episode in an Children's FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024 . While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.

Reason for Discontinuance of FSP

Upon termination of partnership a reason for discontinuance is selected. For recorded cases, consumers most often closed because the consumer met goals (41%). The next highest proportion of consumers were noted to have voluntarily left the program. (30%). Partner cannot be located accounted for 14% of discontinuance reasons. If a consumer terminated partnership more than once, each instance was recorded in this table.

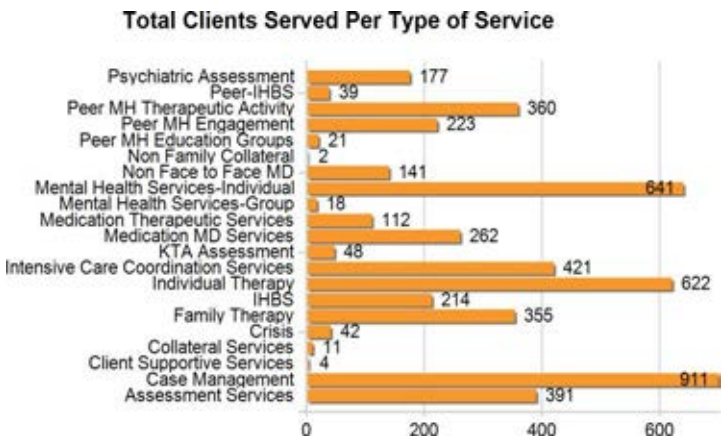
Discontinuation Reason	Count	%
Justice system	2	0%
Met goals	275	41%
Moved out of county/area	72	11%
Needs residential care	9	1%
Other	4	1%
Partner cannot be located	94	14%
Partner left program	206	30%
Target criteria not met	14	2%
Total	**676**	**100%**

Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 8-13, or 4-7 services per month within the fiscal year. On average, more than 42% of Children's FSP consumers received 8 or more services per month.

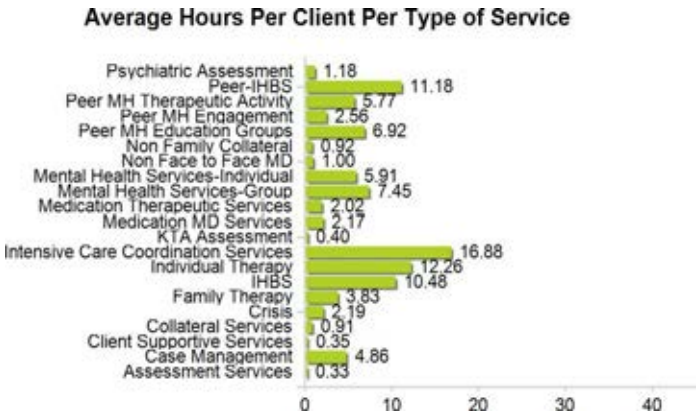
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	63 (14%)	53 (12%)	47 (12%)	42 (10%)	45 (12%)	44 (11%)	41 (10%)	48 (12%)	36 (9%)	58 (14%)	41 (10%)	49 (13%)
2-3	98 (22%)	59 (13%)	81 (20%)	84 (21%)	63 (17%)	86 (22%)	75 (19%)	75 (19%)	91 (22%)	68 (16%)	69 (17%)	83 (22%)
4-7	125 (28%)	113 (25%)	83 (21%)	114 (28%)	107 (29%)	115 (29%)	102 (26%)	105 (26%)	106 (26%)	118 (28%)	126 (30%)	109 (30%)
8-13	90 (20%)	117 (26%)	116 (29%)	82 (20%)	85 (23%)	91 (23%)	93 (24%)	102 (26%)	95 (23%)	89 (21%)	88 (21%)	71 (19%)
14-19	33 (7%)	54 (12%)	46 (11%)	48 (12%)	33 (9%)	35 (9%)	36 (9%)	36 (9%)	40 (10%)	40 (9%)	51 (12%)	29 (8%)
20-25	20 (5%)	28 (6%)	18 (4%)	17 (4%)	21 (6%)	18 (5%)	24 (6%)	16 (4%)	25 (6%)	24 (6%)	24 (6%)	17 (5%)
26-31	8 (2%)	15 (3%)	6 (1%)	16 (4%)	13 (4%)	3 (1%)	11 (3%)	9 (2%)	9 (2%)	13 (3%)	6 (1%)	5 (1%)
32+	7 (2%)	10 (2%)	5 (1%)	3 (1%)	3 (1%)	3 (1%)	11 (3%)	9 (2%)	12 (3%)	16 (4%)	10 (2%)	6 (2%)
Monthly Total	444	449	402	406	370	395	393	400	414	426	415	369

Service Detail



During the 2023/2024 fiscal year, case management, individual mental health services and individual therapy were the three services that served the most consumers.

The average number of hours consumers received of each type of service while in Children's FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in intensive care coordination services (16.88 hours).



Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Assessment Services	391	34%	504	1.29
Case Management	911	79%	7,350	8.07
Client Supportive Services	4	0%	4	1.00
Collateral Services	11	1%	17	1.55
Crisis	42	4%	69	1.64
Family Therapy	355	31%	1,725	4.86
IHBS	214	18%	1,997	9.33
Individual Therapy	622	54%	8,517	13.69
Intensive Care Coordination Services	421	36%	10,985	26.09
KTA Assessment	48	4%	76	1.58
Medication MD Services	262	23%	912	3.48
Medication Therapeutic Services	112	10%	606	5.41
Mental Health Services-Group	18	2%	109	6.06
Mental Health Services-Individual	641	55%	4,323	6.74
Non Face to Face MD	141	12%	374	2.65
Non Family Collateral	2	0%	4	2.00
Peer MH Education Groups	21	2%	98	4.67
Peer MH Engagement	223	19%	402	1.80
Peer MH Therapeutic Activity	360	31%	2,534	7.04
Peer-IHBS	39	3%	343	8.79
Psychiatric Assessment	177	15%	195	1.10

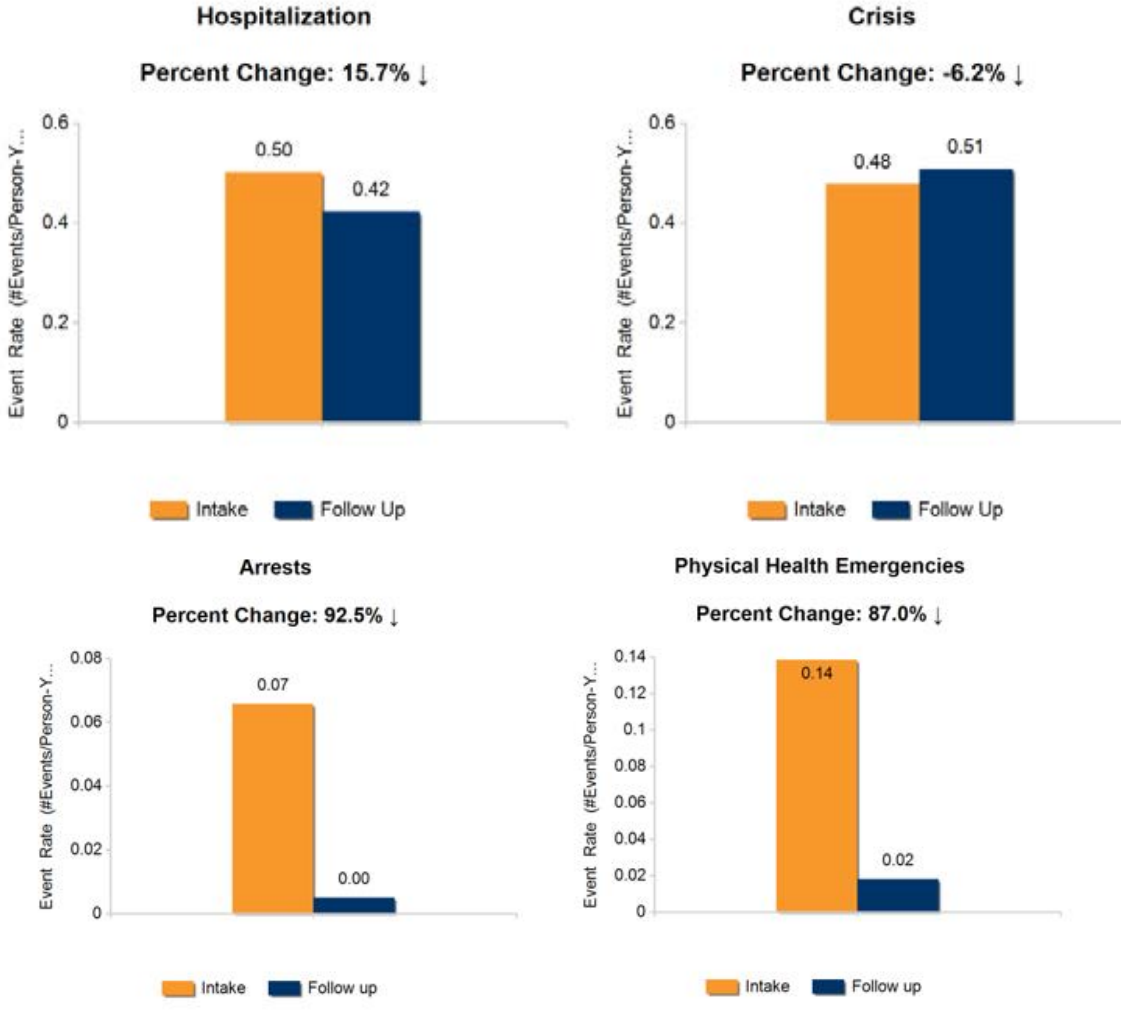
Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled was summed and divided by the years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 12.

Overall, hospitalizations, arrests, and physical health emergency visits have reduced.

Outcomes

Additional primary outcomes of interest include expulsion and suspension rates. Grades achieved in school are another outcome measure for FSP youth. Intake data reflects the grades reported on the PAF form upon enrollment. Data on grades is recorded quarterly with the first follow-up data collection point 90 days after enrollment in the FSP. Follow-up data on grades used in these analyses is the most currently reported quarterly data.

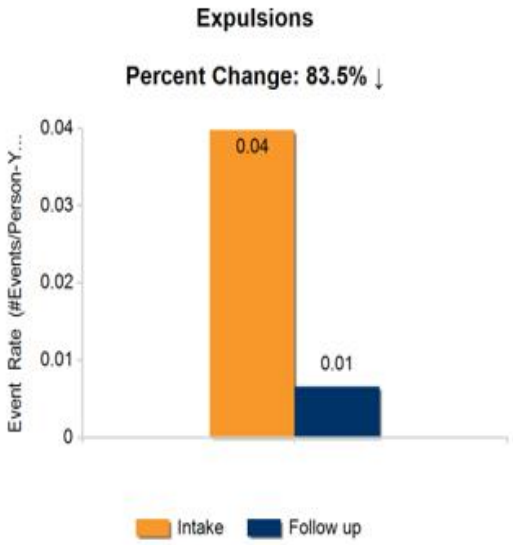


Arrests decreased 92.5% from intake to follow-up.

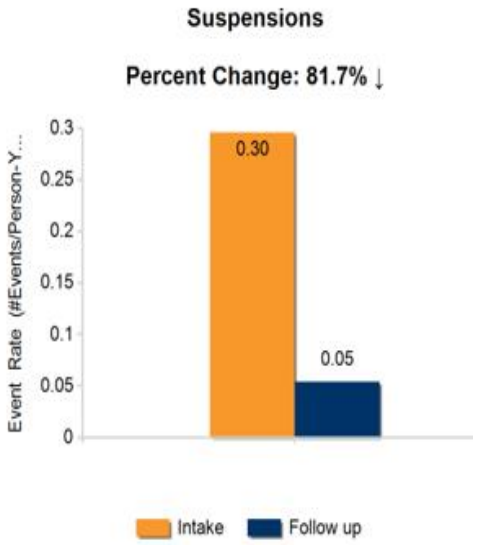
Physical Health Emergency visits decreased 87.0%.

Outcomes: Residential

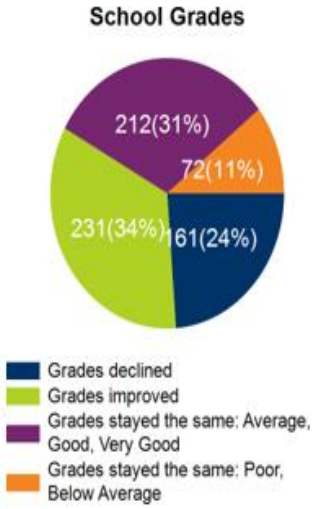
Overall, expulsions and suspensions both decreased. Analysis of school grades at follow-up is done using pre-to post matched pairs and reflects directional change from baseline to follow- up. In some cases follow-up data is missing.



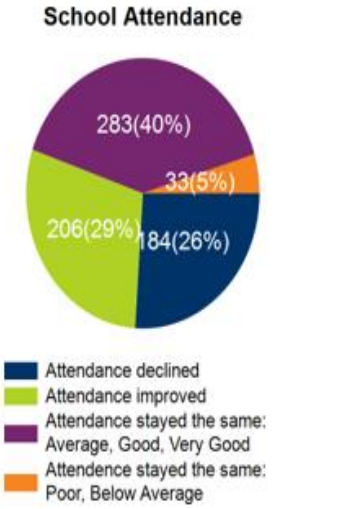
Expulsions decreased 83.5% from intake to follow-up.



Suspension decreased 81.7% from intake follow-up.



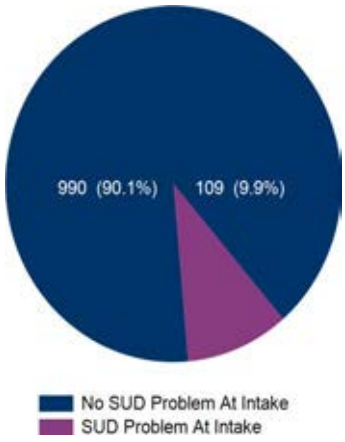
Grades Improved or stayed above average from intake to follow-up: 65.53%

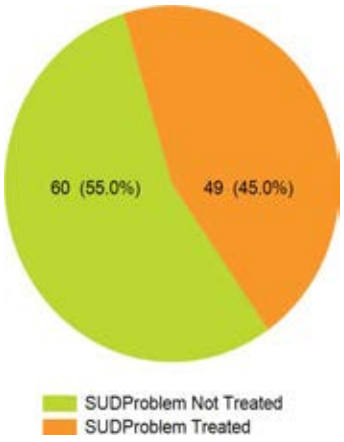


Attendance Improved or stayed above average from intake to follow-up:69.26%.

Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (9.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

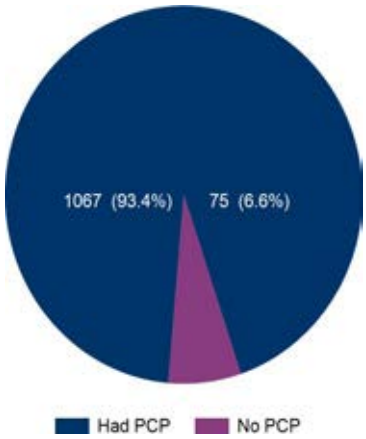




Follow-up: Based on follow-up data reported quarterly, 35.0% (21) of the 60 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 40 consumers not identified at intake were noted to have an SU problem on follow-up and 60.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician

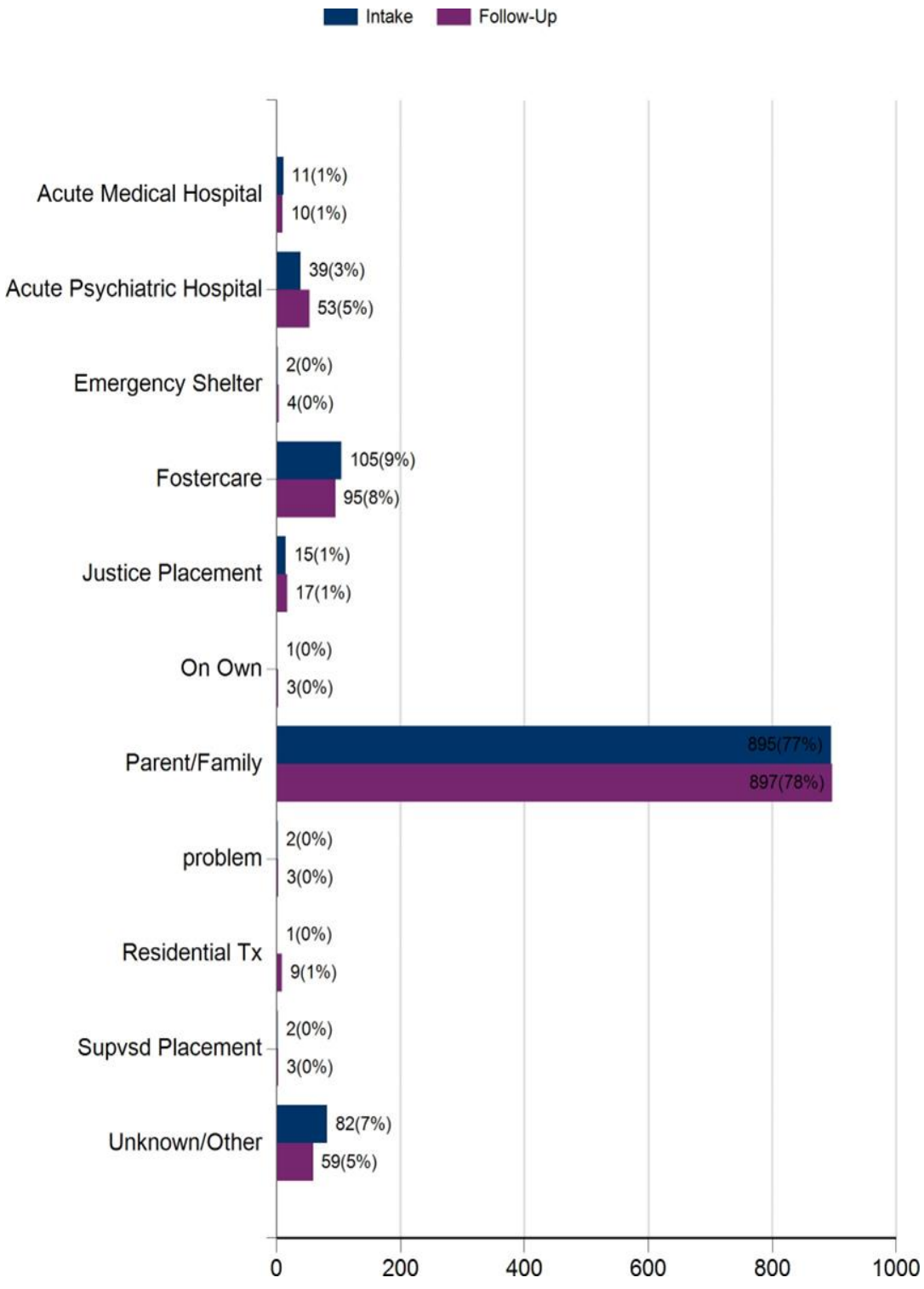
Intake: (6.6%) of youth did not have a primary care physician (PCP) at intake.



Follow-up: Of the 75 consumers that did not have a PCP at intake, 38 (50.7%) obtained a PCP while in the program.

Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all Children's FSP reporting

CSS


Intake
Follow-Up
Acute Medical Hospital
11(1%)
10(1%)
Acute Psychiatric Hospital
39(3%)
53(5%)
Emergency Shelter
2(0%)
4(0%)
Fostercare
105(9%)
95(8%)
Justice Placement
15(1%)
17(1%)
On Own
1(0%)
3(0%)
Parent/Family
895(77%)
897(78%)
problem
2(0%)
3(0%)
Residential Tx
1(0%)
9(1%)
Supvsd Placement
2(0%)
3(0%)
Unknown/Other
82(7%)
59(5%)
0
200
400
600
800
1000

Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their first enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential

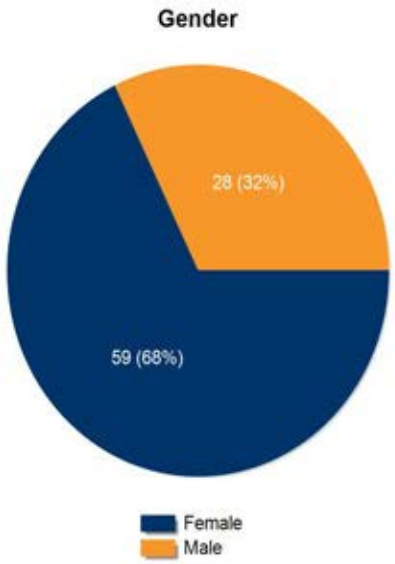
days during enrollment has been annualized.

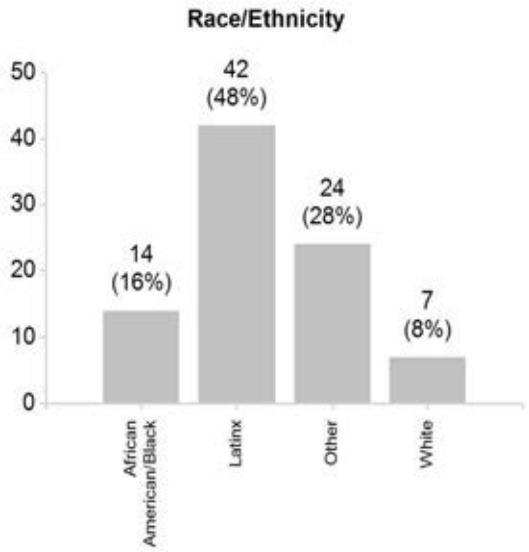
	12 Months Prior to Enrollment		Annualized Days During Enrollment		
Living Situation	**# of Days**	**Count (n)**	**# of Days**	**Count (n)**	**Percent change (%)**
Acute Medical Hospital	1,064	51	1,459	17	37%
Acute Psychiatric Hospital	2,988	390	8,517	125	185%
Community Treatment Facility	45	3	271	2	502%
Emergency Shelter	816	6	632	6	-23%
Fostercare	18,990	73	36,032	73	90%
Homeless	437	4	-	0	-100%
Jail/Prison	31	2	-	0	-100%
Justice Placement	5,536	42	3,353	24	-39%
On Own	730	2	1,375	6	88%
Parent/Family	341,457	986	304,314	985	-11%
Residential Tx	557	10	1,535	12	176%
State Hospital	199	13	-	0	-100%
Supervised Placement	924	4	1,501	8	62%
Unknown/Other	48,532	138	42,410	138	-13%

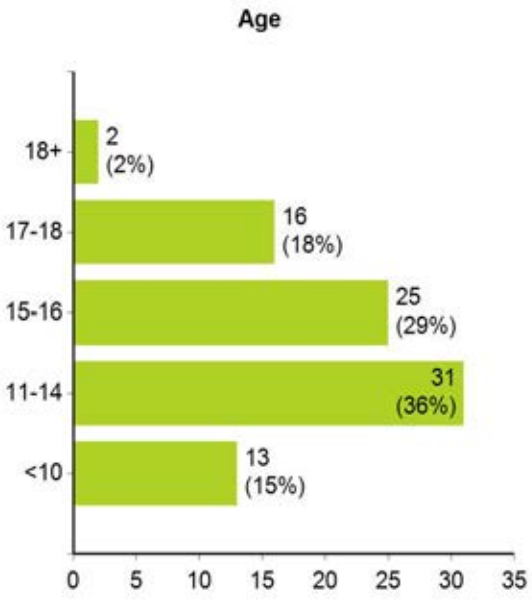
Children's FSP demographics and Outcomes for: 33AHFC
Served by this reporting unit: 84 Enrollment: 87

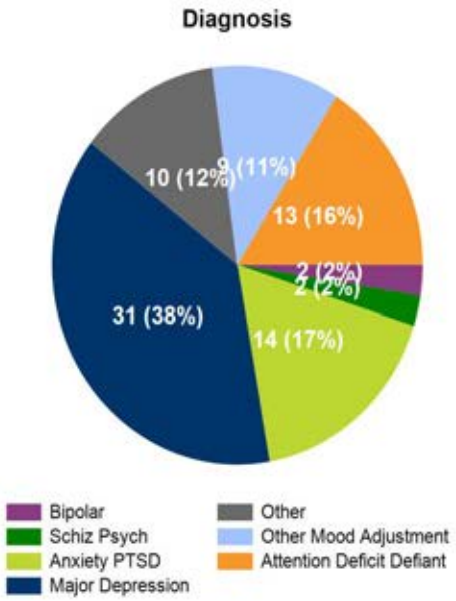
Demographics

32% of consumers were male and 68% were female.
48% of consumers were Latinx, 8% of consumers were White and 16% of consumers were Black/African American.
29% of consumers were 15 to 16 years old.



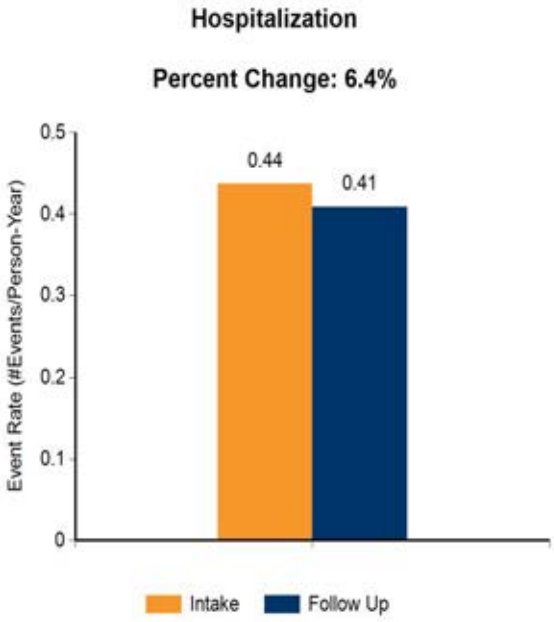


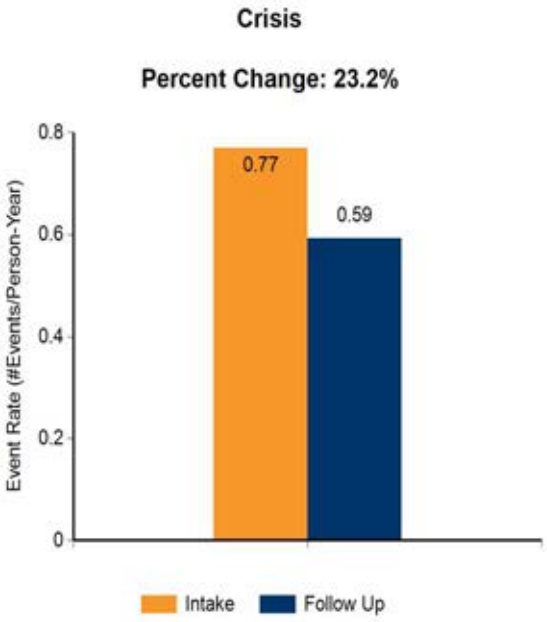


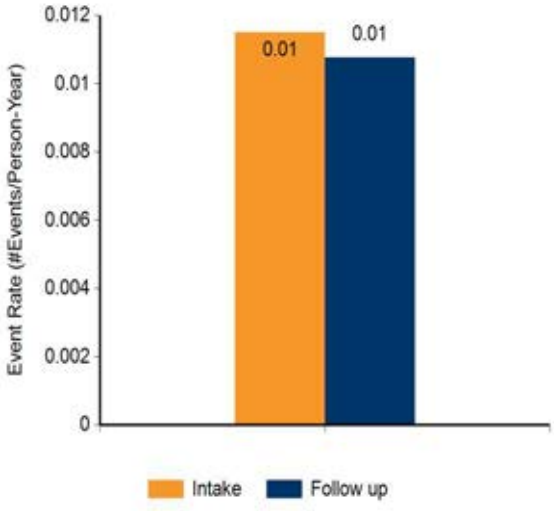


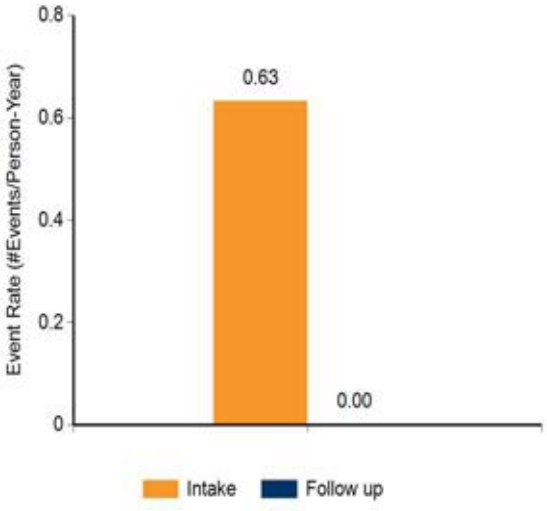
Outcomes for 33AHFC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



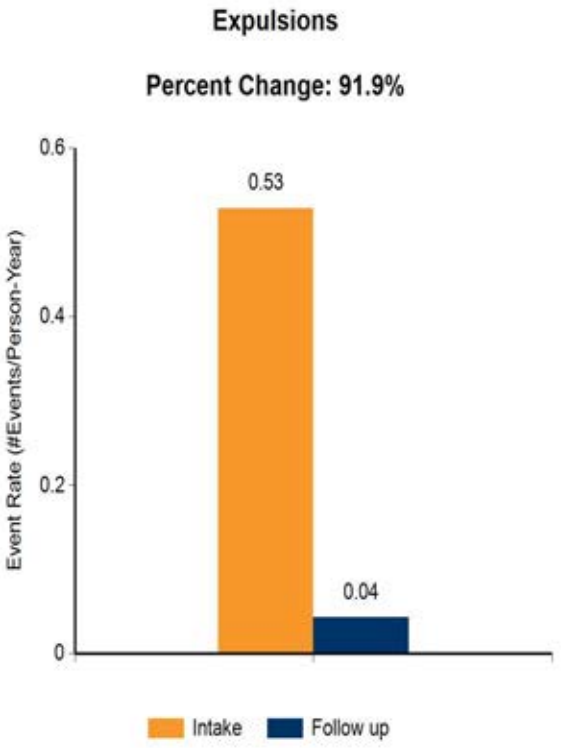


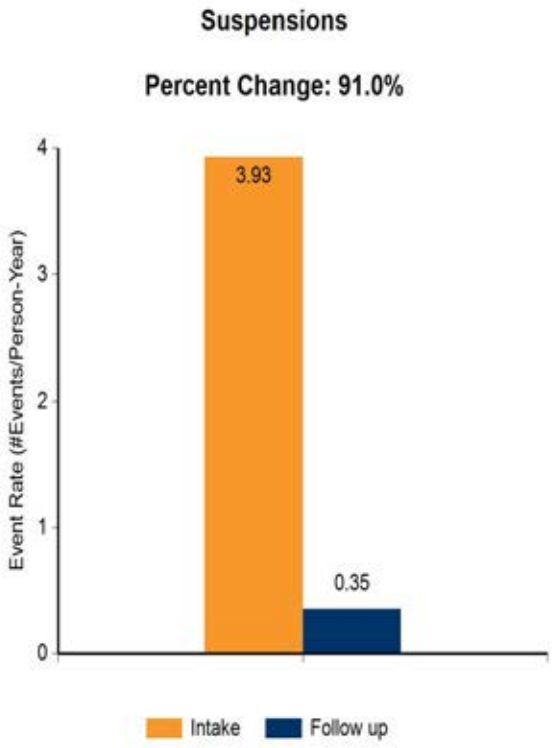


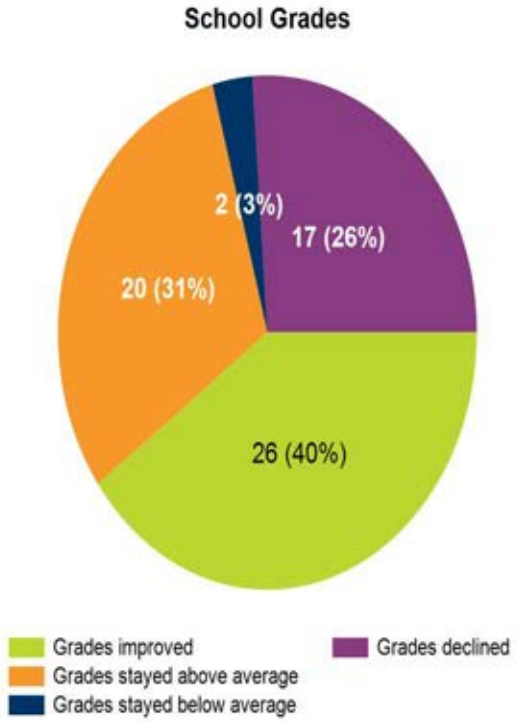


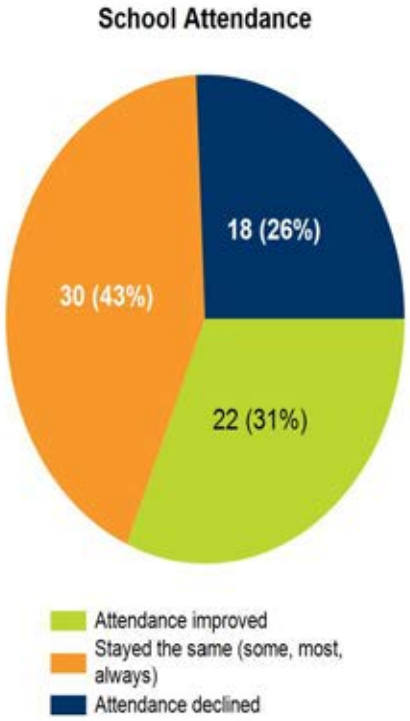
Outcomes for 33AHFC (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.

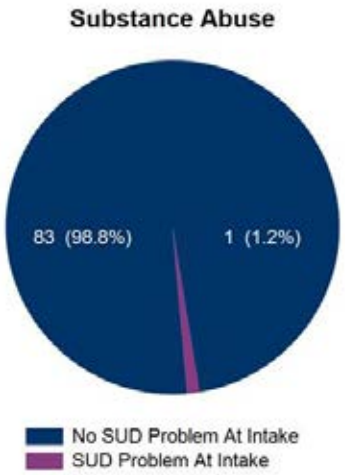


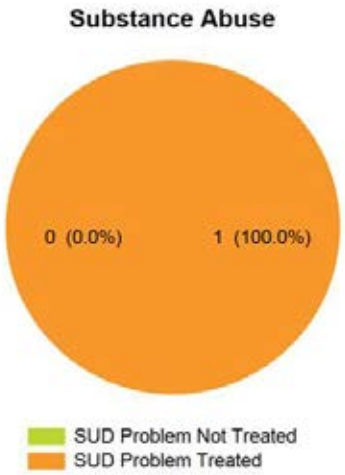






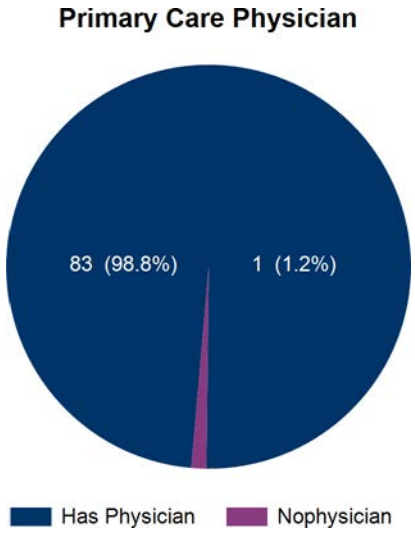
Outcomes: Substance Use 33AHFC





Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (1.2%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.
An additional 4 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

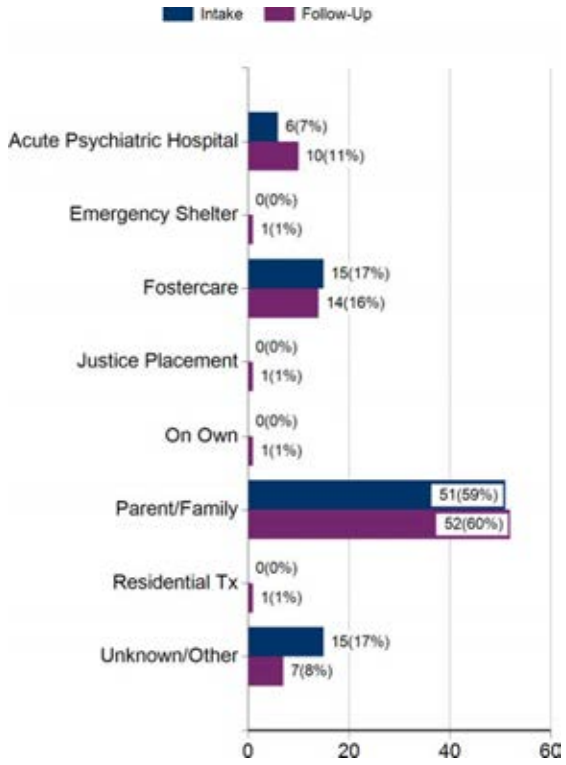
Outcomes: Primary Care Physician 33AHFC



Intake: Most consumers (1.2%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumers that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33AHFC)



Discontinuation Reason	Count	%
Met goals	43	62%
Moved out of county/area	5	7%
Needs residential care	1	1%
Partner cannot be located	10	14%
Partner left program	10	14%
Total	**69**	**100%**

Length of FSP Partnership for: 33AHFC

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	28	2	30	34.48%
>= 2 Years and <3 Years	9	1	10	11.49%
>= 3 Years and < 4 Years	1	0	1	1.15%
>= 90 days and < 1 Year	21	11	32	36.78%
Under 90 days	8	6	14	16.09%
Total Consumer Enrollments	**67**	**20**	**87**	

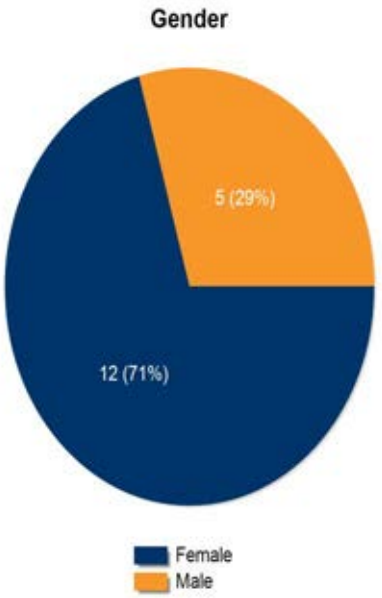
Service Detail: 33AHFC

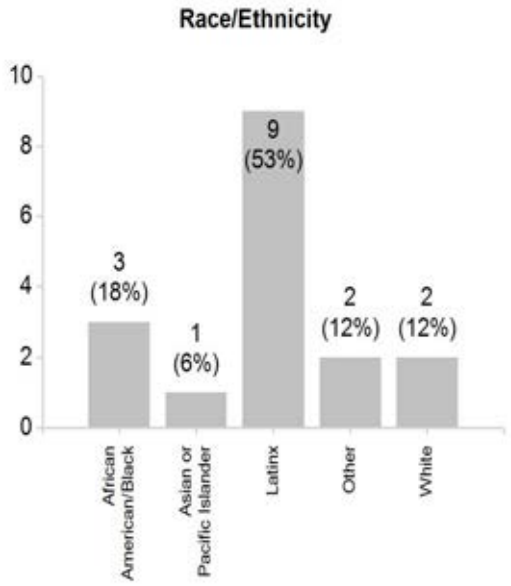
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	7 (13%)	6 (11%)	9 (17%)	5 (11%)	6 (18%)	6 (18%)	7 (21%)	0 (0%)	1 (3%)	1 (4%)	1 (3%)	1 (5%)
2-3	21 (38%)	8 (14%)	12 (23%)	13 (30%)	7 (21%)	11 (32%)	12 (35%)	10 (32%)	11 (38%)	4 (16%)	6 (21%)	5 (24%)
4-7	17 (30%)	23 (40%)	17 (32%)	17 (39%)	14 (42%)	11 (32%)	8 (24%)	14 (45%)	11 (38%)	13 (52%)	15 (52%)	9 (43%)
8-13	9 (16%)	14 (25%)	14 (26%)	6 (14%)	5 (15%)	6 (18%)	4 (12%)	6 (19%)	5 (17%)	5 (20%)	3 (10%)	5 (24%)
14-19	1 (2%)	5 (9%)	1 (2%)	2 (5%)	1 (3%)	0 (0%)	3 (9%)	1 (3%)	1 (3%)	2 (8%)	2 (7%)	1 (5%)
20-25	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)	0 (0%)
26-31	1 (2%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)	0 (0%)
Monthly Total	56	57	53	44	33	34	34	31	29	25	29	21

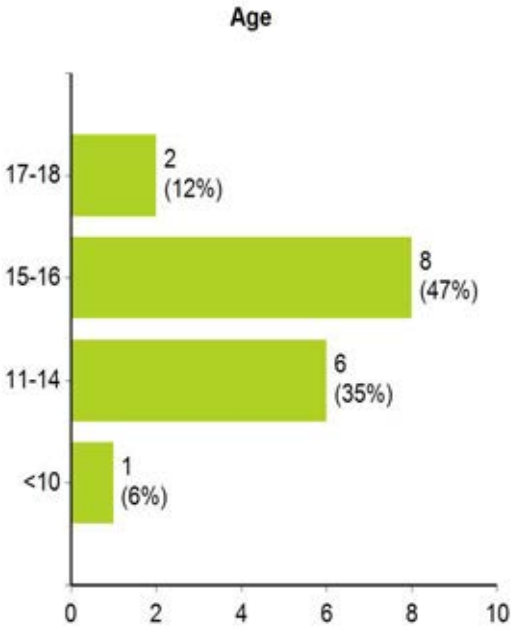
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Case Management	74	19%	433	5.85
Crisis	2	1%	2	1.00
Family Therapy	30	8%	78	2.60
IHBS	1	0%	2	2.00
Individual Therapy	75	19%	947	12.63
Intensive Care Coordination Services	25	6%	165	6.60
Medication MD Services	34	9%	86	2.53
Medication Therapeutic Services	36	9%	104	2.89
Mental Health Services-Group	6	2%	75	12.50
Mental Health Services-Individual	27	7%	92	3.41
Non Face to Face MD	40	10%	170	4.25
Peer MH Education Groups	4	1%	15	3.75
Peer MH Engagement	5	1%	5	1.00
Peer MH Therapeutic Activity	27	7%	210	7.78
Peer-IHBS	1	0%	1	1.00
Psychiatric Assessment	3	1%	3	1.00

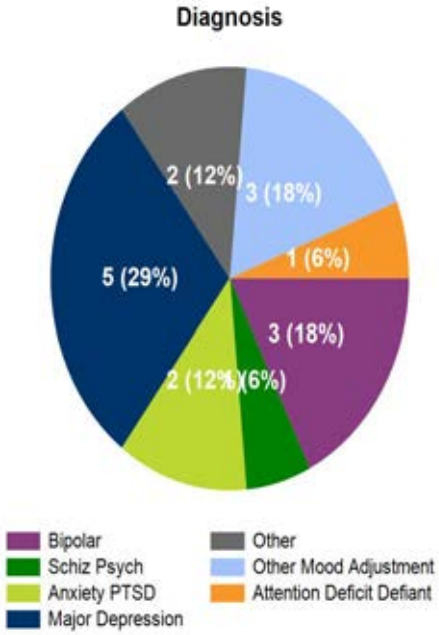
Children's FSP demographics and Outcomes for: 3357FC
Served by this reporting unit: 17 Enrollment: 17

29% of consumers were male and 71% were female.
53% of consumers were Latinx, 12% of consumers were White and 18% of consumers were Black/African American.
47% of consumers were 15 to 16 years old.



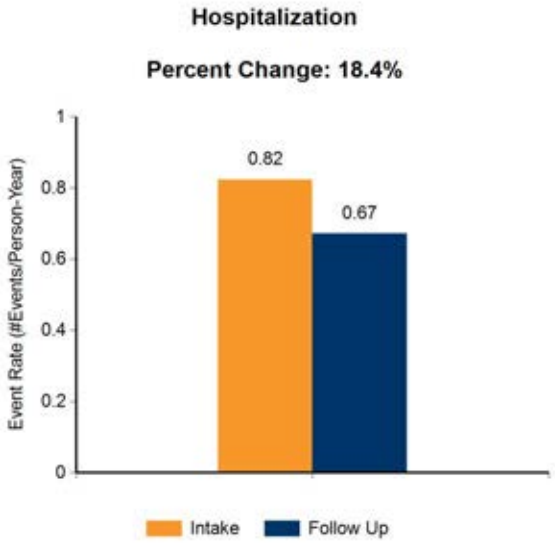


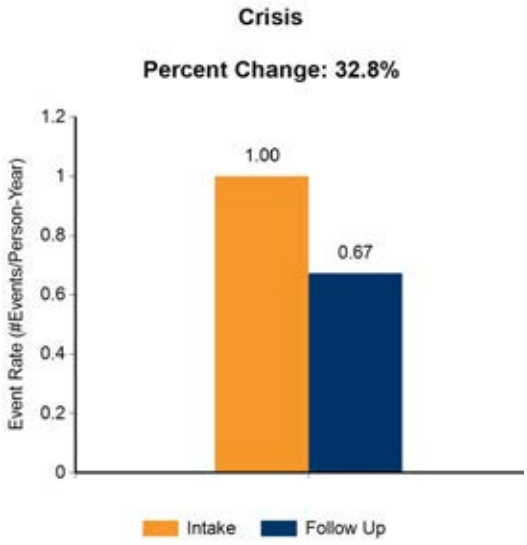


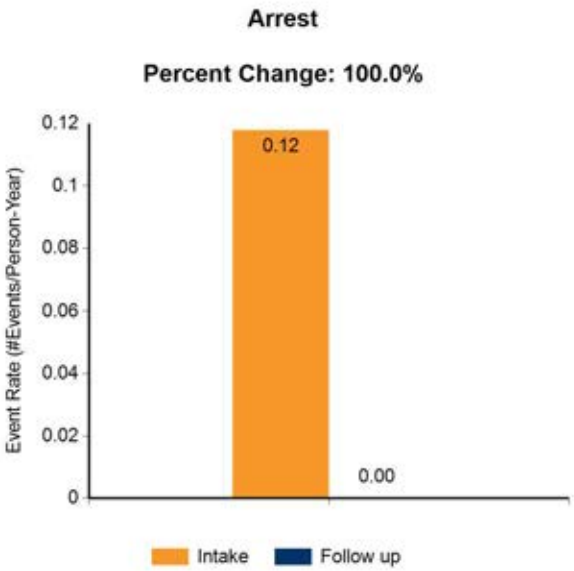


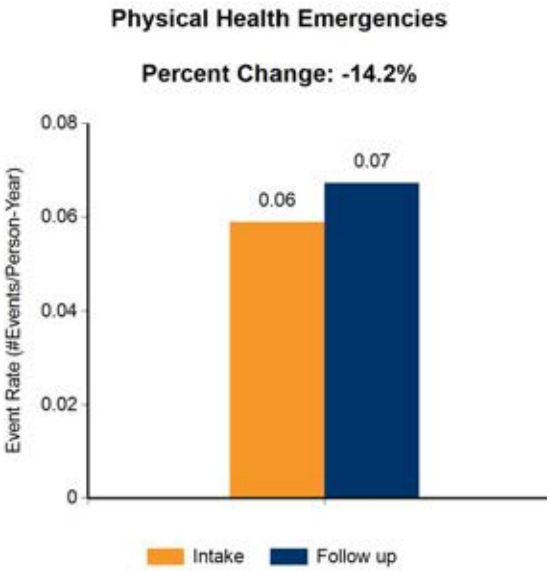
Outcomes for 3357FC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.





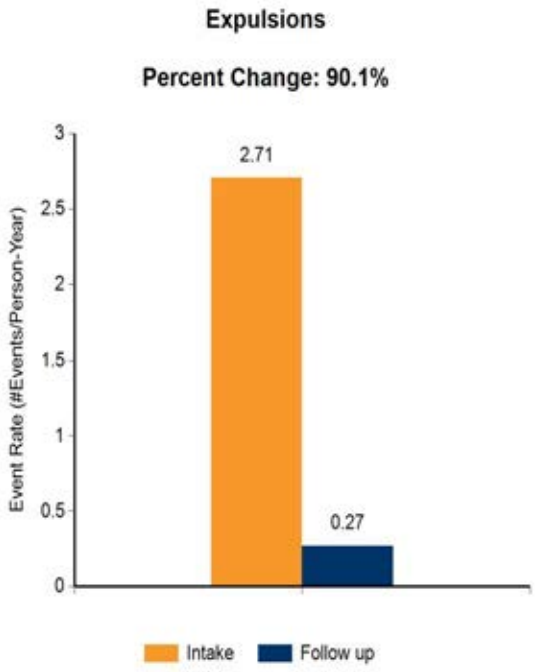


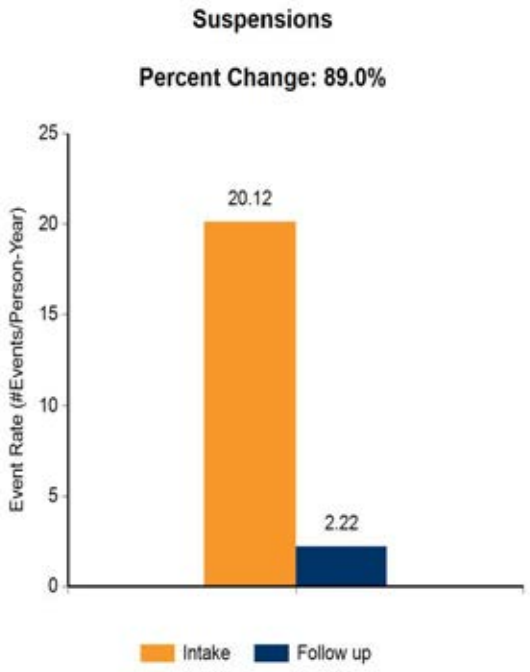


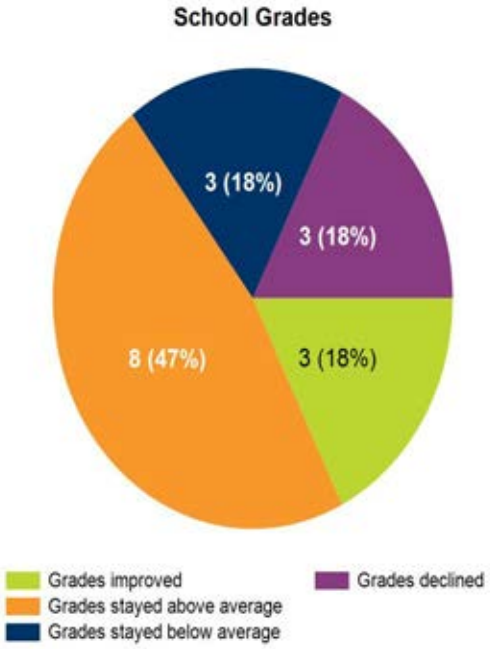
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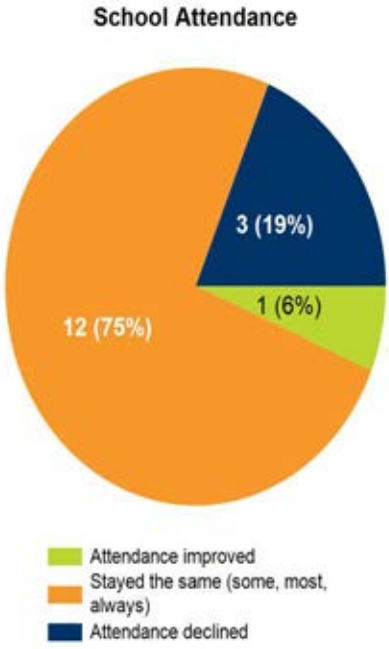
Outcomes for 3357FC (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.

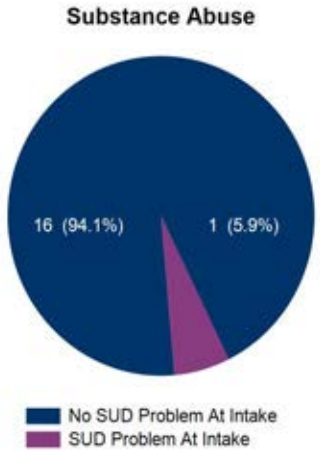


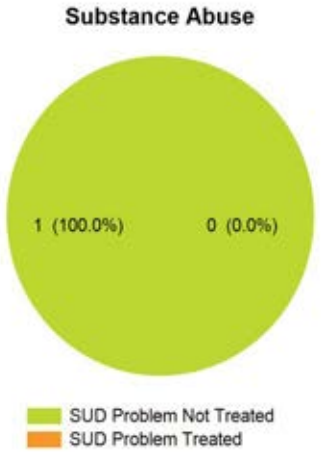






Outcomes: Substance Use 3357FC

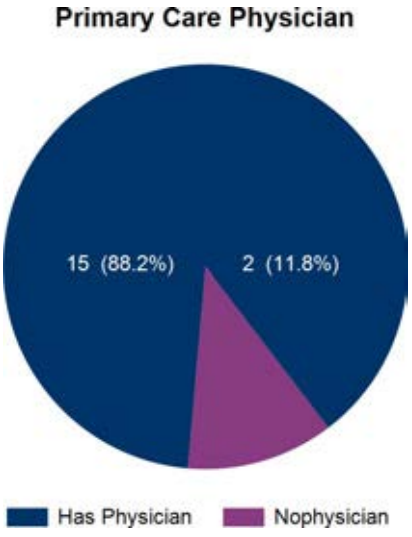




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (5.9%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

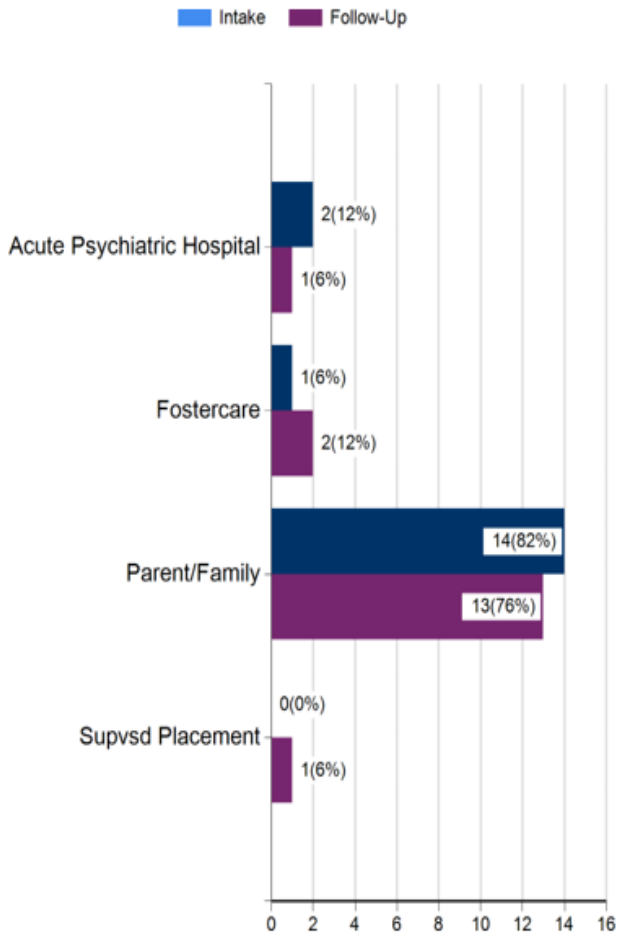
Outcomes: Primary Care Physician 3357FC



Intake: Most consumers (11.8%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 2 consumers that did not have a PCP at intake, 2 (100.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (3357FC)



Discontinuation Reason	Count	%
Met goals	1	17%
Moved out of county/area	1	17%
Partner cannot be located	2	33%
Partner left program	2	33%
Total	**6**	**100%**

Length of FSP Partnership for: 3357FC

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	1	0	1	5.88%
>= 2 Years and <3 Years	3	0	3	17.65%
>= 90 days and < 1 Year	5	5	10	58.82%
Under 90 days	2	1	3	17.65%
Total Consumer Enrollments	**11**	**6**	**17**	

Service Detail: 3357FC

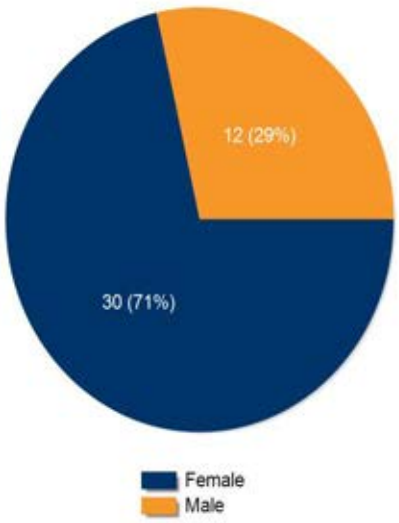
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	1 (25%)	1 (25%)	0 (0%)	1 (20%)	2 (33%)	2 (33%)	3 (38%)	1 (13%)	3 (27%)	3 (27%)	2 (22%)	1 (20%)
2-3	1 (25%)	1 (25%)	1 (50%)	1 (20%)	2 (33%)	1 (17%)	2 (25%)	2 (25%)	3 (27%)	2 (18%)	1 (11%)	2 (40%)
4-7	2 (50%)	2 (50%)	0 (0%)	2 (40%)	2 (33%)	3 (50%)	2 (25%)	4 (50%)	5 (45%)	5 (45%)	5 (56%)	2 (40%)
8-13	0 (0%)	0 (0%)	1 (50%)	1 (20%)	0 (0%)	0 (0%)	1 (13%)	1 (13%)	0 (0%)	1 (9%)	1 (11%)	0 (0%)
Monthly Total	4	4	2	5	6	6	8	8	11	11	9	5

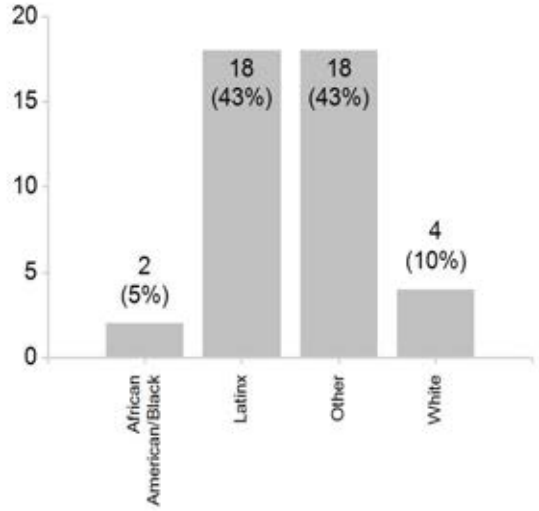
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Assessment Services	1	1%	1	1.00
Case Management	8	11%	29	3.63
Crisis	1	1%	1	1.00
Family Therapy	7	10%	8	1.14
IHBS	1	1%	2	2.00
Individual Therapy	9	13%	123	13.67
Intensive Care Coordination Services	7	10%	21	3.00
Medication MD Services	9	13%	11	1.22
Mental Health Services-Individual	13	19%	55	4.23
Non Face to Face MD	6	9%	21	3.50
Peer MH Therapeutic Activity	7	10%	24	3.43
Peer-IHBS	1	1%	1	1.00

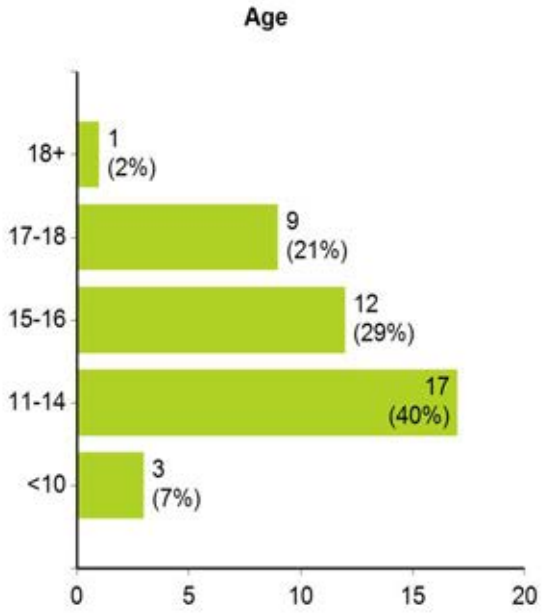
Children's FSP demographics and Outcomes for:
33MOFC Served by this reporting unit: 42

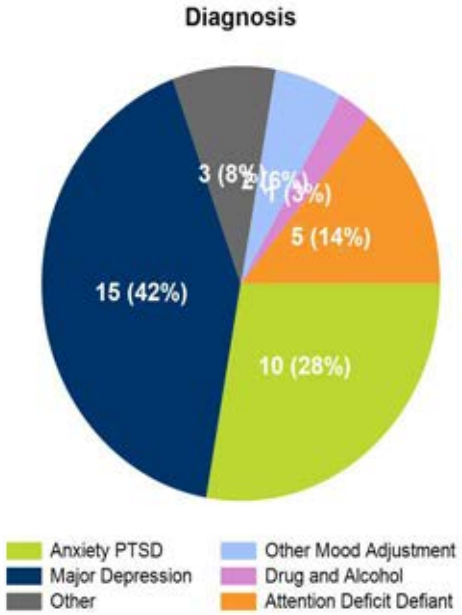
Demographics

29% of consumers were male, and 71% were female.
43% of consumers were Latinx, 10% of consumers were White, and 5% of consumers were Black/African American.
29% of consumers were 15 to 16 years old.



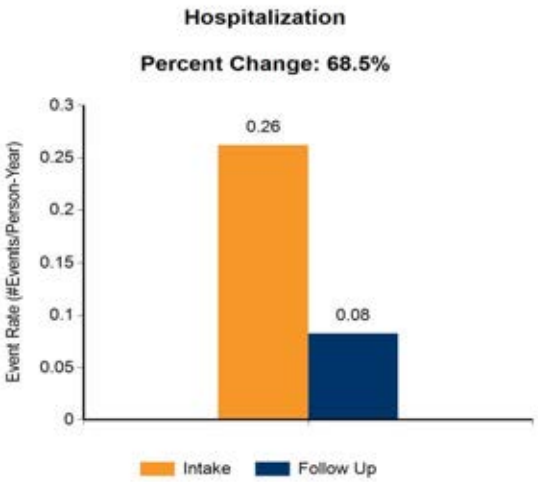


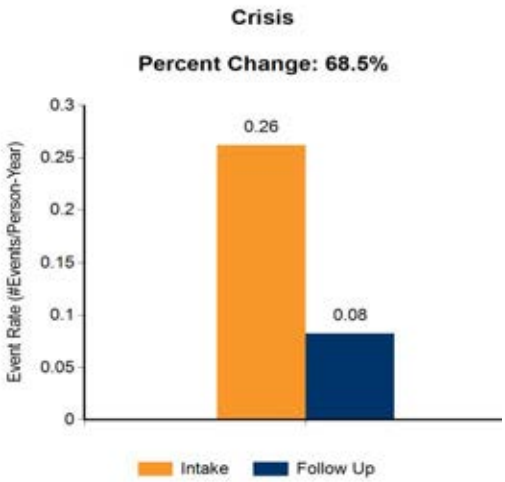


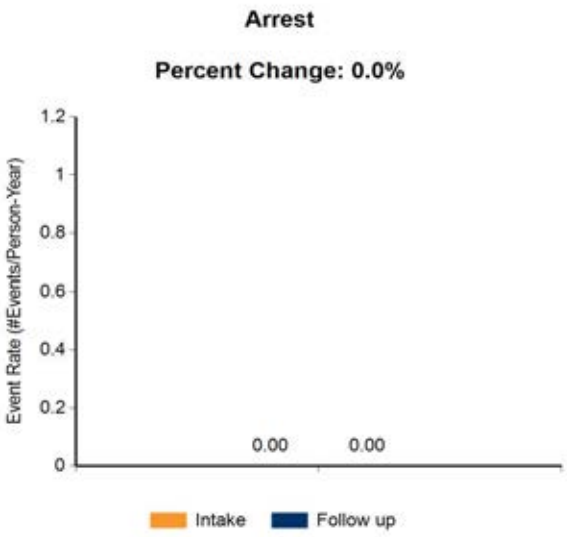


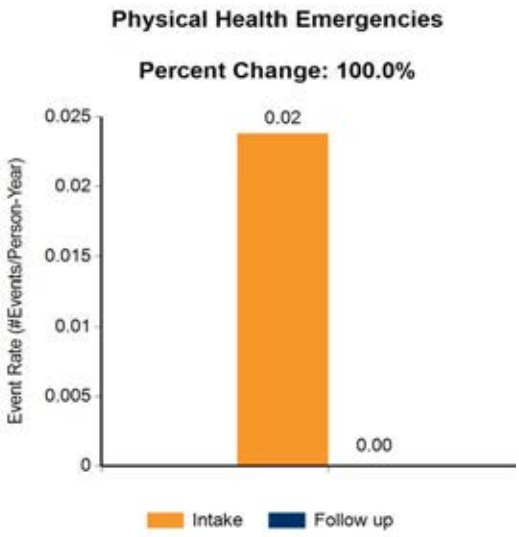
Outcomes for 33MOFC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



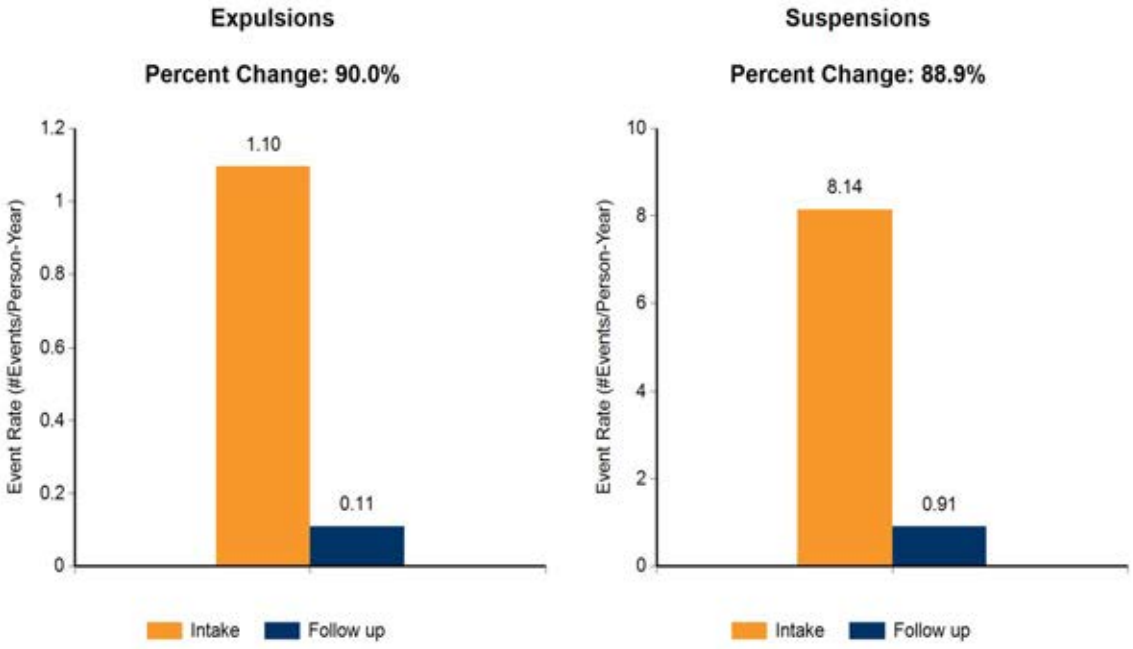


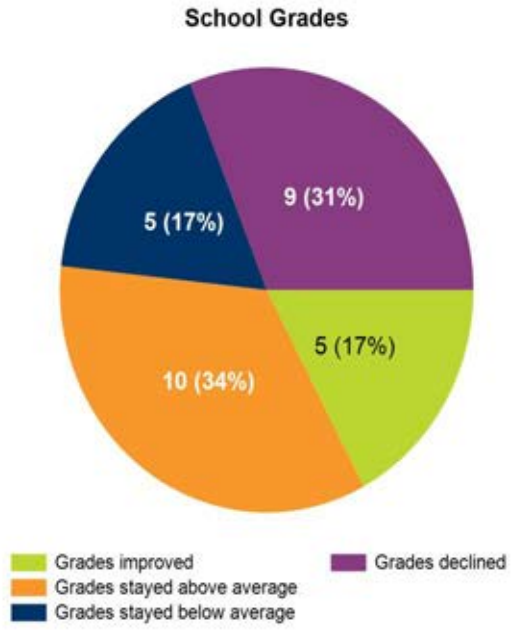


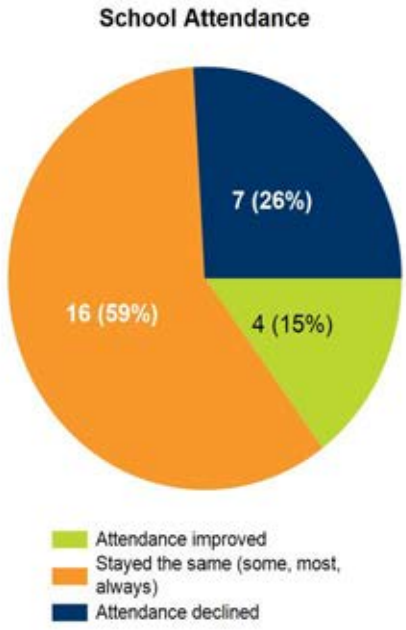


Outcomes for 33MOFC (cont.)

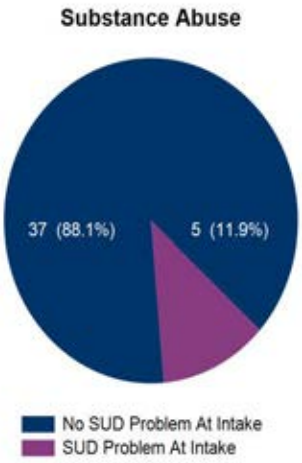
Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance

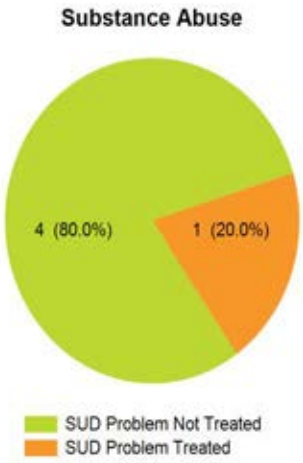






Outcomes: Substance Use 33MOFC

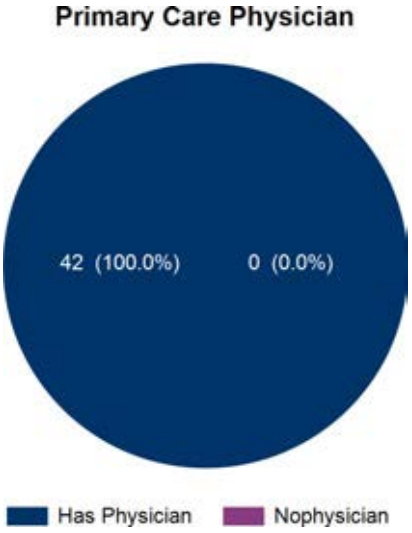




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (11.9%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 4 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

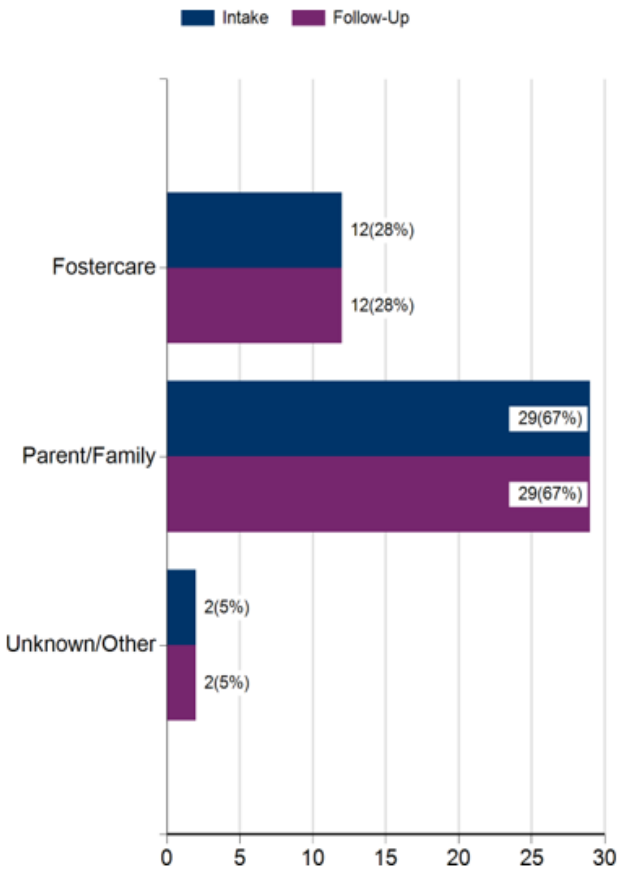
Outcomes: Primary Care Physician 33MOFC



Intake: Most consumers (0.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 0 consumers that did not have a PCP at intake, 0 (0.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33MOFC)



Discontinuation Reason	Count	%
Met goals	9	50%
Moved out of county/area	4	22%
Partner cannot be located	3	17%
Partner left program	2	11%
Total	**18**	**100%**

Length of FSP Partnership for: 33MOFC

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	3	3	6	14.29%
>= 2 Years and <3 Years	4	3	7	16.67%
>= 90 days and < 1 Year	5	10	15	35.71%
Under 90 days	5	9	14	33.33%
Total Consumer Enrollments	**17**	**25**	**42**	

Children's FSP demographics and Outcomes for: 33H8FC Served by this reporting unit: 38

Demographics

54% of consumers were male and 46% were female.

59% of consumers were Latinx, 5% of consumers were White and 13% of consumers were Black/African American.

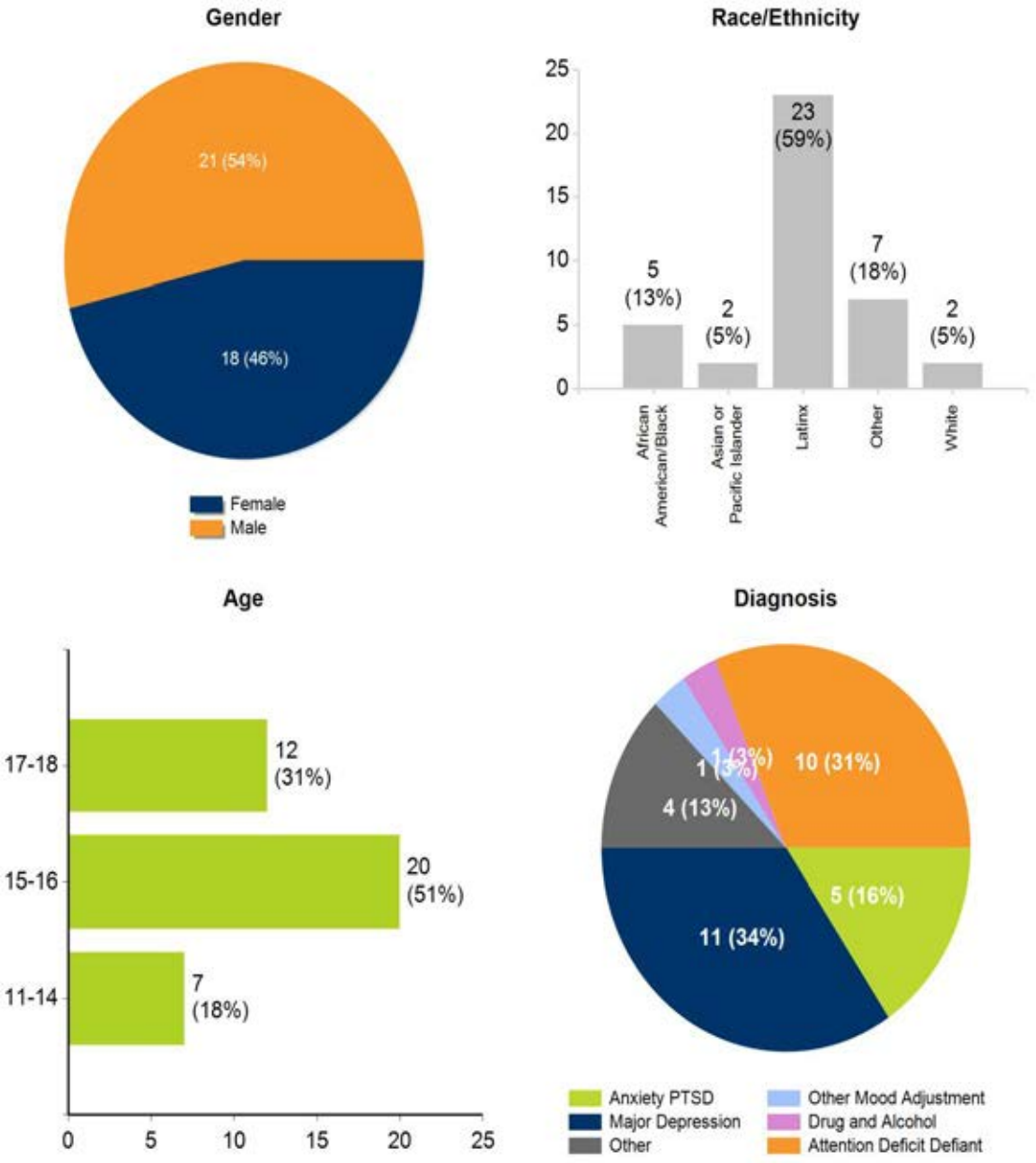
51% of consumers were 15 to 16 years old.

Service Detail: 33MOFC

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	0 (0%)	0 (0%)	1 (8%)	1 (7%)	3 (25%)	1 (8%)	1 (8%)	2 (15%)	5 (28%)	0 (0%)	1 (5%)	2 (10%)
2-3	6 (33%)	1 (6%)	1 (8%)	5 (36%)	3 (25%)	5 (42%)	2 (17%)	2 (15%)	2 (11%)	3 (19%)	1 (5%)	5 (25%)
4-7	5 (28%)	5 (29%)	5 (38%)	3 (21%)	3 (25%)	3 (25%)	5 (42%)	4 (31%)	7 (39%)	5 (31%)	7 (37%)	5 (25%)
8-13	2 (11%)	4 (24%)	4 (31%)	4 (29%)	3 (25%)	2 (17%)	2 (17%)	5 (38%)	2 (11%)	7 (44%)	7 (37%)	6 (30%)
14-19	4 (22%)	3 (18%)	2 (15%)	1 (7%)	0 (0%)	1 (8%)	1 (8%)	0 (0%)	1 (6%)	1 (6%)	2 (11%)	2 (10%)
20-25	1 (6%)	4 (24%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	1 (6%)	0 (0%)	1 (5%)	0 (0%)
Monthly Total	18	17	13	14	12	12	12	13	18	16	19	20

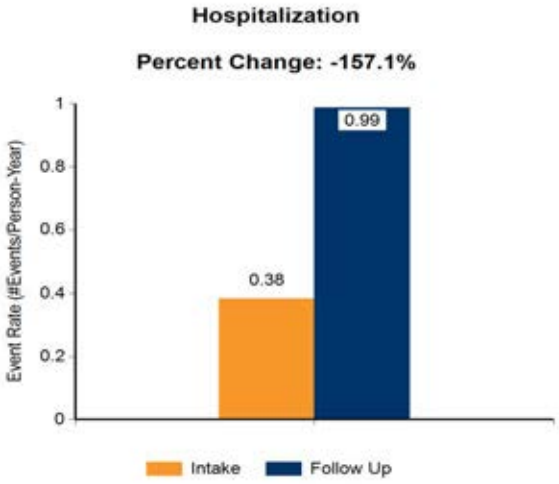
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Case Management	12	5%	20	1.67
Crisis	2	1%	2	1.00
Family Therapy	10	4%	13	1.30
IHBS	18	8%	113	6.28
Individual Therapy	30	13%	157	5.23
Intensive Care Coordination Services	35	15%	321	9.17
Medication MD Services	11	5%	23	2.09
Medication Therapeutic Services	28	12%	141	5.04
Mental Health Services-Individual	23	10%	77	3.35
Non Face to Face MD	1	0%	1	1.00
Peer MH Engagement	12	5%	31	2.58
Peer MH Therapeutic Activity	32	14%	281	8.78
Peer-IHBS	15	7%	67	4.47
Psychiatric Assessment	1	0%	1	1.00

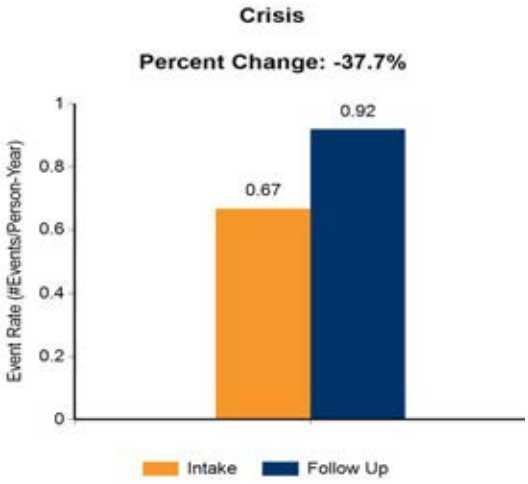
Outcomes for 33H8FC (cont.)

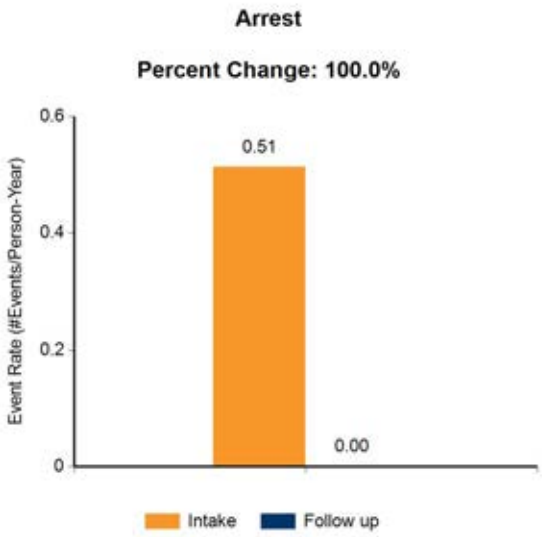


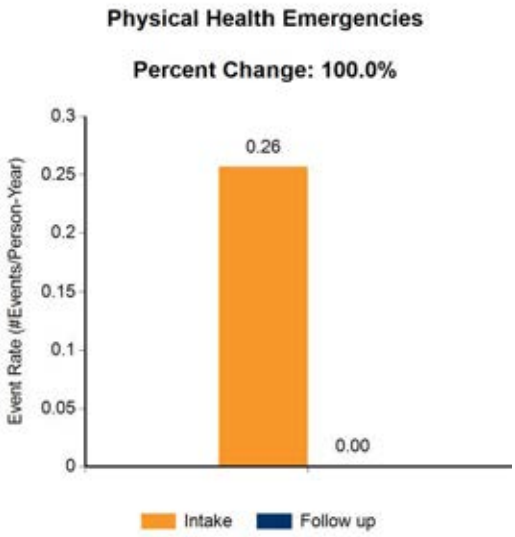
Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

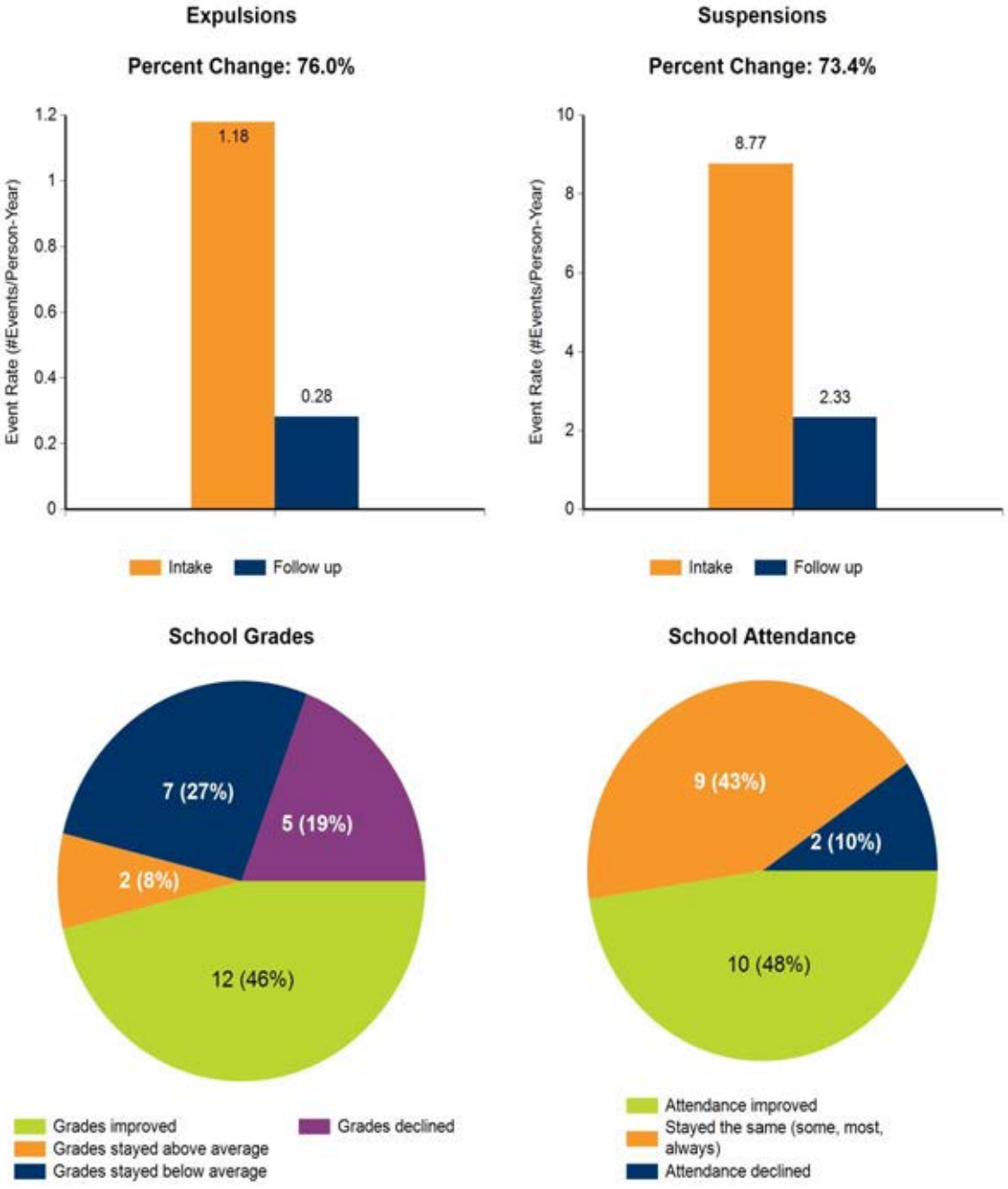
Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and attendance.





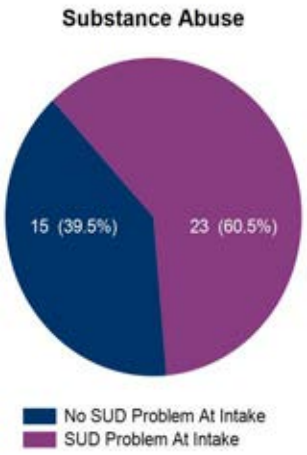


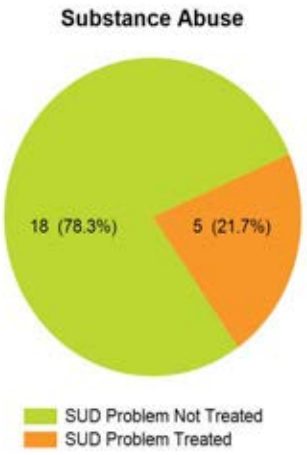




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (60.5%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

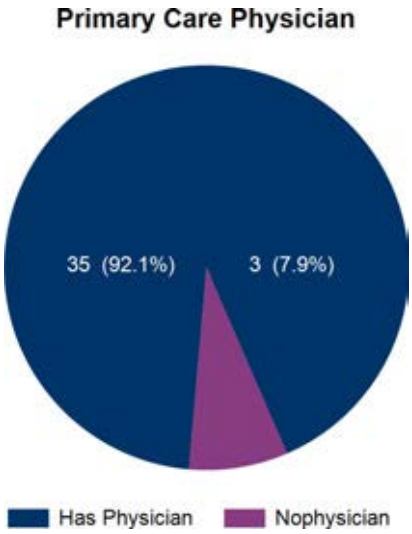
Outcomes: Substance Use 33H8FC





An additional 3 consumers not identified at intake were noted to have an SU problem on follow-up and 67.0% of them were reported to be in SU services on follow-up.

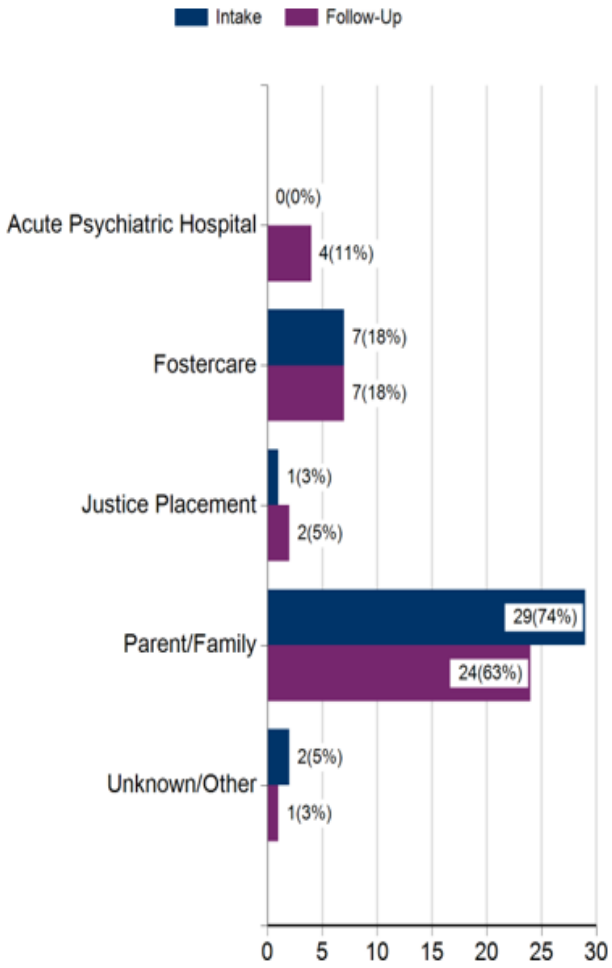
Outcomes: Primary Care Physician 33H8FC



Intake: Most consumers (7.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 3 consumers that did not have a PCP at intake, 1 (33.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33H8FC)



Discontinuation Reason	Count	%
Met goals	10	40%
Moved out of county/area	1	4%
Needs residential care	2	8%
Other	3	12%
Partner cannot be located	1	4%
Partner left program	5	20%
Target criteria not met	3	12%
Total	**25**	**100%**

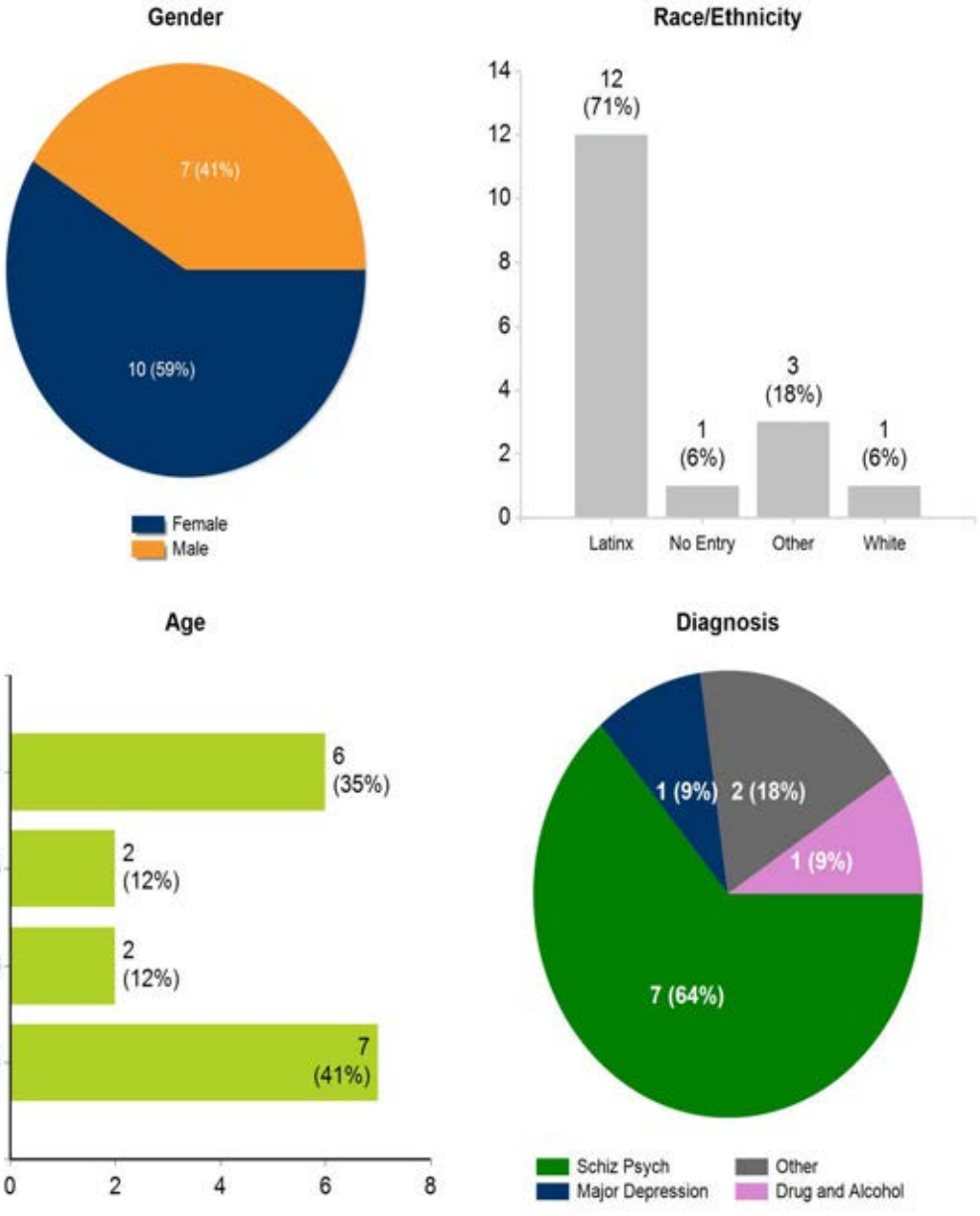
Length of FSP Partnership for: 33H8FC

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 90 days and < 1 Year	19	6	25	64.10%
Under 90 days	10	4	14	35.90%
Total Consumer Enrollments	**29**	**10**	**39**	

Children's FSP demographics and Outcomes for: 33MOFEP Served by this reporting unit: 17

Demographics

41% of consumers were male and 59% were female.



71% of consumers were Latinx, 6% of consumers were White and 0% of consumers were Black/African American.

12% of consumers were 15 to 16 years old.

Outcomes for 33MOFEP

Service Detail: 33H8FC

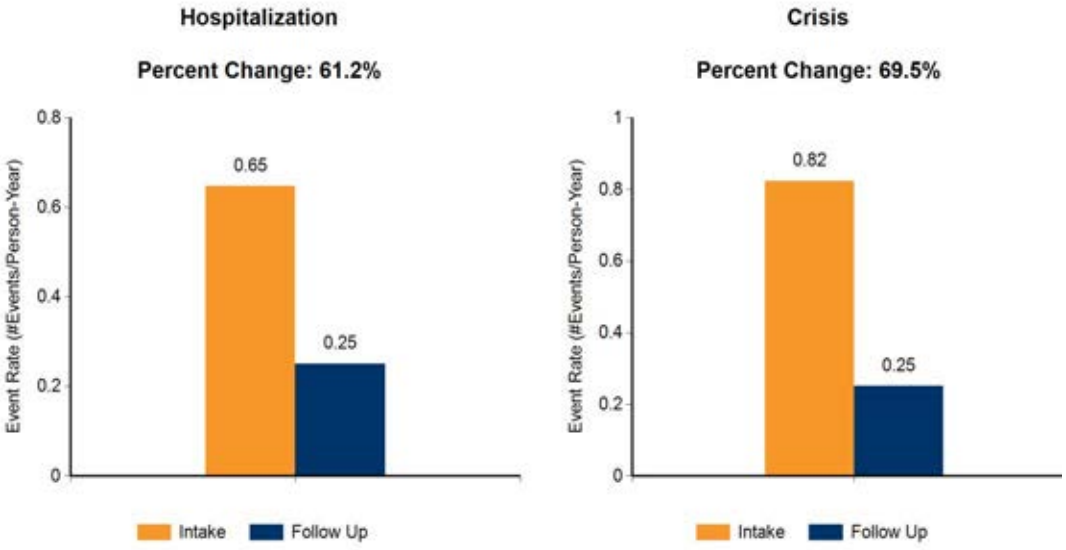
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	1 (7%)	2 (13%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)	0 (0%)	2 (13%)	0 (0%)	1 (7%)	0 (0%)	1 (8%)
2-3	1 (7%)	1 (6%)	2 (15%)	2 (13%)	0 (0%)	0 (0%)	3 (20%)	2 (13%)	2 (14%)	2 (13%)	0 (0%)	0 (0%)
4-7	0 (0%)	0 (0%)	1 (8%)	1 (7%)	1 (7%)	3 (20%)	0 (0%)	0 (0%)	3 (21%)	2 (13%)	1 (8%)	2 (15%)
8-13	4 (27%)	5 (31%)	6 (46%)	5 (33%)	7 (50%)	8 (53%)	4 (27%)	7 (44%)	1 (7%)	0 (0%)	2 (15%)	2 (15%)
14-19	1 (7%)	2 (13%)	4 (31%)	4 (27%)	5 (36%)	2 (13%)	1 (7%)	0 (0%)	1 (7%)	2 (13%)	2 (15%)	4 (31%)
20-25	5 (33%)	2 (13%)	0 (0%)	1 (7%)	1 (7%)	2 (13%)	2 (13%)	3 (19%)	3 (21%)	3 (20%)	5 (38%)	3 (23%)
26-31	2 (13%)	2 (13%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)	3 (20%)	0 (0%)	2 (14%)	1 (7%)	2 (15%)	0 (0%)
32+	1 (7%)	2 (13%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (13%)	2 (13%)	2 (14%)	4 (27%)	1 (8%)	1 (8%)
Monthly Total	15	16	13	15	14	15	15	16	14	15	13	13

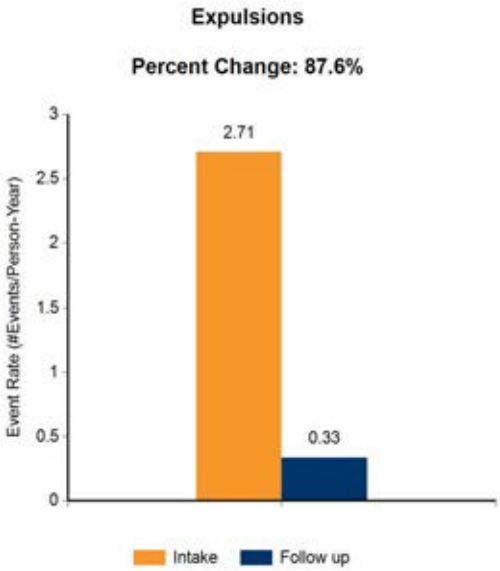
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Assessment Services	16	7%	17	1.06
Case Management	24	11%	81	3.38
Collateral Services	3	1%	9	3.00
Crisis	8	4%	24	3.00
Family Therapy	33	15%	312	9.45
IHBS	24	11%	76	3.17
Individual Therapy	35	16%	485	13.86
Intensive Care Coordination Services	38	18%	1,609	42.34
Mental Health Services-Individual	33	15%	146	4.42
Non Family Collateral	2	1%	4	2.00

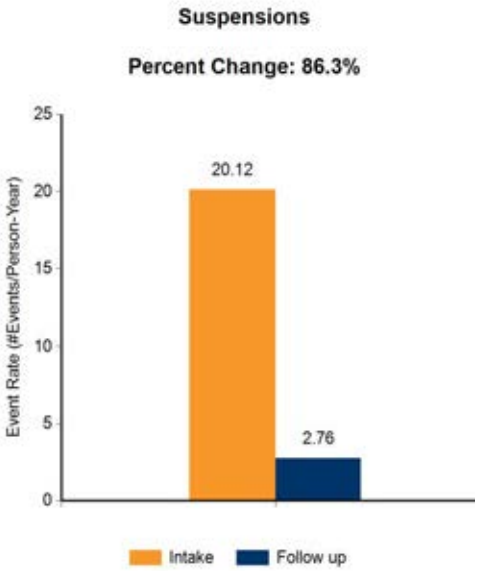
Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

Outcomes for 33MOFEP (cont.)

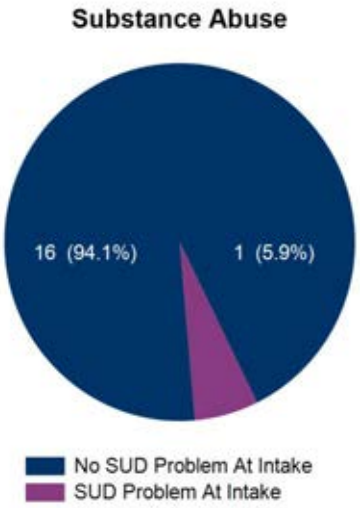
Additional primary outcomes of interest include expulsion and suspension rates, along with school grades and school attendance.

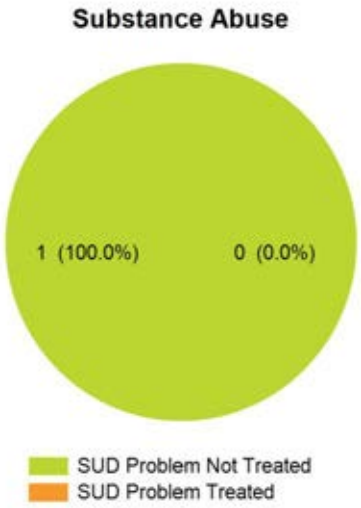






Outcomes: Substance Use 33MOFEP

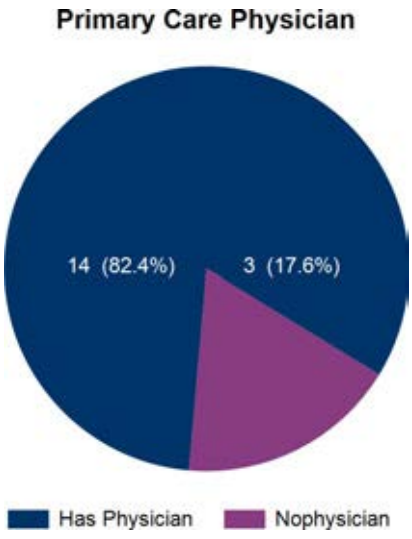




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (5.9%). The majority of those who had co-occurring MH and SU problems had been receiving SU treatment services at intake.

An additional 1 consumer not identified at intake was noted to have an SU problem on follow-up, and 100.0% of them were reported to be in SU services on follow-up.

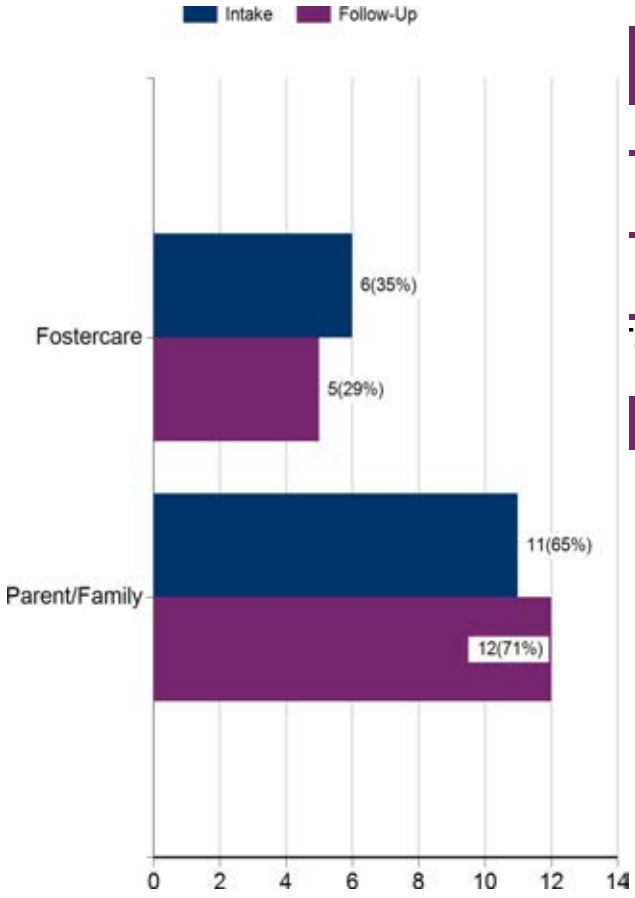
Outcomes: Primary Care Physician 33MOFEP



Intake: Most consumers (17.6%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 3 consumers that did not have a PCP at intake, 2 (67.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33MOFEP)



Discontinuation Reason	Count	%
Met goals	1	17%
Moved out of county/area	2	33%
Partner left program	2	33%
Target criteria not met	1	17%
Total	6	100%

Length of FSP Partnership for: 33MOFEP

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	2	3	5	29.41%
>= 90 days and < 1 Year	4	4	8	47.06%
Under 90 days	3	1	4	23.53%
Total Consumer Enrollments	9	8	17	

Service Detail:33MOFEP

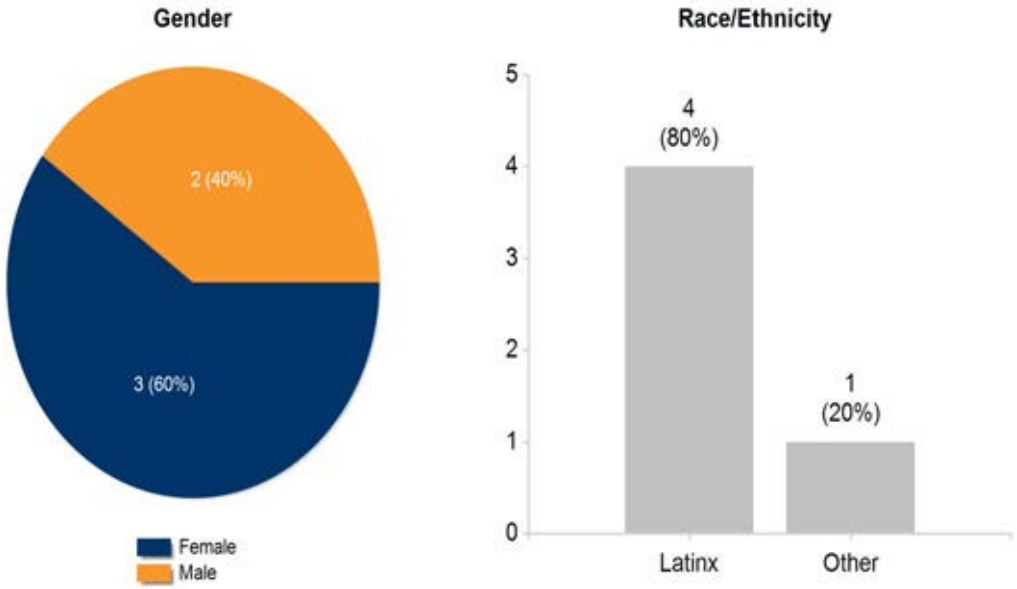
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	0 (0%)	0 (0%)	1 (9%)	0 (0%)	0 (0%)	0 (0%)	1 (8%)	2 (17%)	0 (0%)	0 (0%)	1 (8%)	1 (9%)
2-3	2 (22%)	0 (0%)	1 (9%)	1 (8%)	1 (9%)	1 (8%)	1 (8%)	0 (0%)	2 (18%)	1 (9%)	1 (8%)	1 (9%)
4-7	1 (11%)	2 (20%)	0 (0%)	3 (25%)	2 (18%)	2 (17%)	1 (8%)	2 (17%)	2 (18%)	2 (18%)	1 (8%)	2 (18%)
8-13	0 (0%)	3 (30%)	3 (27%)	3 (25%)	3 (27%)	3 (25%)	6 (50%)	4 (33%)	4 (36%)	4 (36%)	2 (17%)	3 (27%)
14-19	2 (22%)	1 (10%)	4 (36%)	2 (17%)	1 (9%)	4 (33%)	1 (8%)	2 (17%)	2 (18%)	3 (27%)	4 (33%)	4 (36%)
20-25	4 (44%)	2 (20%)	2 (18%)	3 (25%)	3 (27%)	1 (8%)	2 (17%)	1 (8%)	1 (9%)	1 (9%)	3 (25%)	0 (0%)
26-31	0 (0%)	2 (20%)	0 (0%)	0 (0%)	1 (9%)	1 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Monthly Total	9	10	11	12	11	12	12	12	11	11	12	11

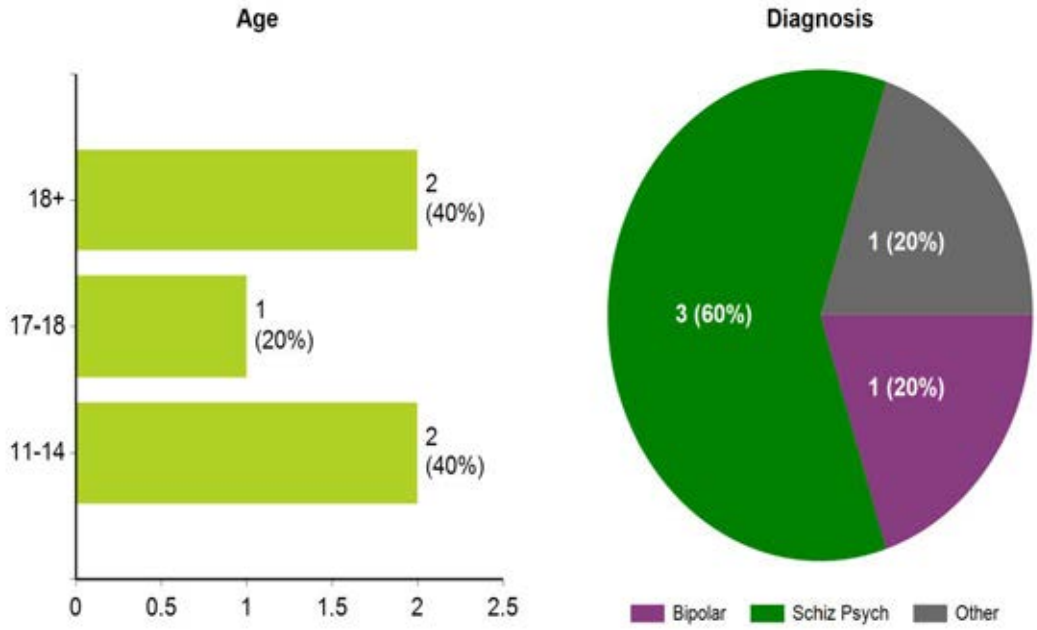
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Case Management	15	9%	129	8.60
Client Supportive Services	1	1%	1	1.00
Crisis	2	1%	4	2.00
Family Therapy	9	5%	33	3.67
IHBS	13	8%	103	7.92
Individual Therapy	14	8%	173	12.36
Intensive Care Coordination Services	16	9%	313	19.56
Medication MD Services	14	8%	93	6.64
Medication Therapeutic Services	12	7%	220	18.33
Mental Health Services-Group	5	3%	14	2.80
Mental Health Services-Individual	13	8%	61	4.69
Non Face to Face MD	12	7%	39	3.25
Peer MH Education Groups	8	5%	33	4.13
Peer MH Engagement	5	3%	7	1.40
Peer MH Therapeutic Activity	15	9%	289	19.27
Peer-IHBS	14	8%	168	12.00
Psychiatric Assessment	5	3%	5	1.00

Children's FSP demographics and Outcomes for: 33OPFEP
Served by this reporting unit: 5 Enrollment: 5

Demographics

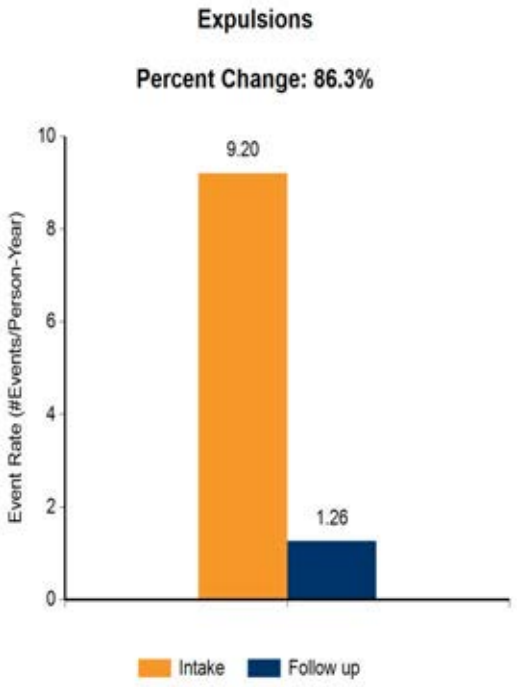
40% of consumers identified as male, while 60% identified as female. 80% of consumers were Latinx, with 0% being White and 0% being Black/African American. Additionally, 0% of consumers were aged 15 to 16 years.

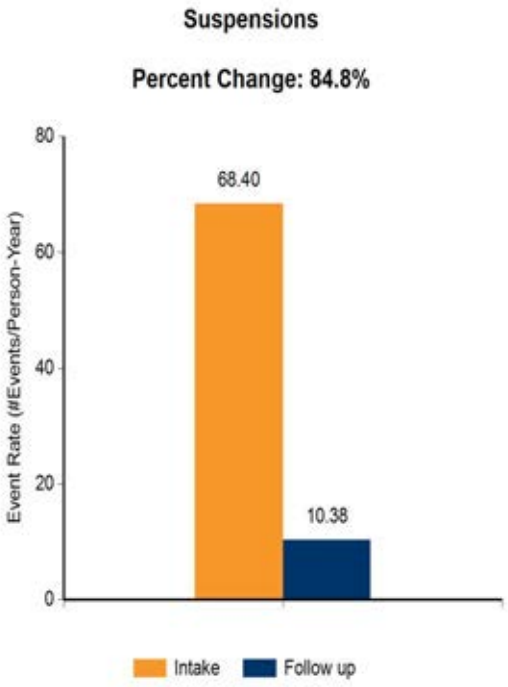


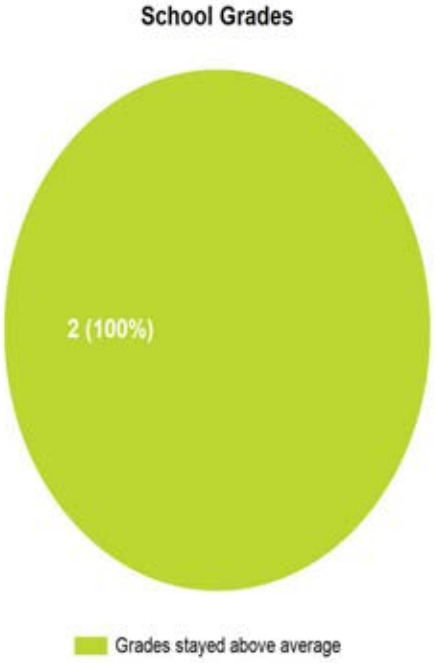


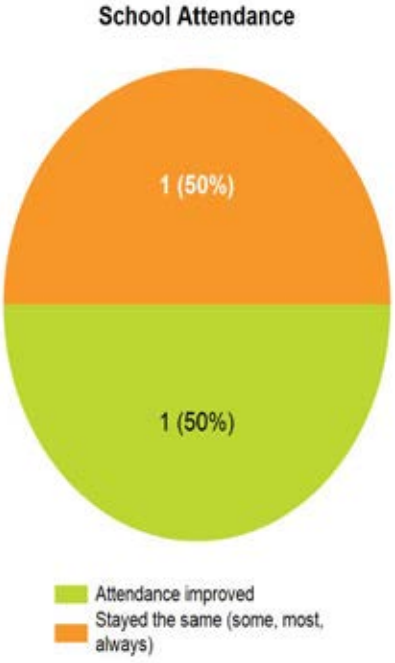
Outcomes for 33OPFEP

Additional primary outcomes of interest include explusion and suspension rates, along with school grades and school attendance.

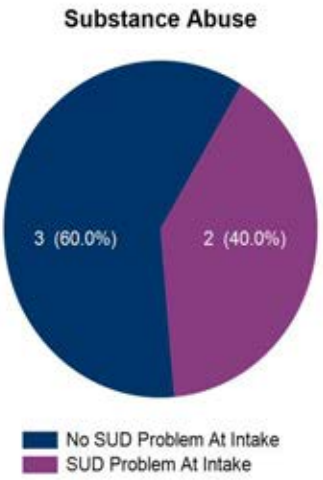


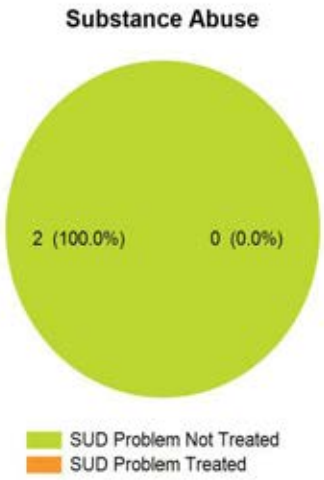






Outcomes: Substance Use 33OPFEP

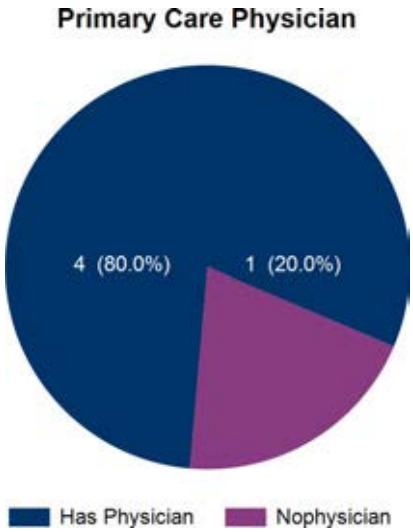




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (40.0%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 1 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

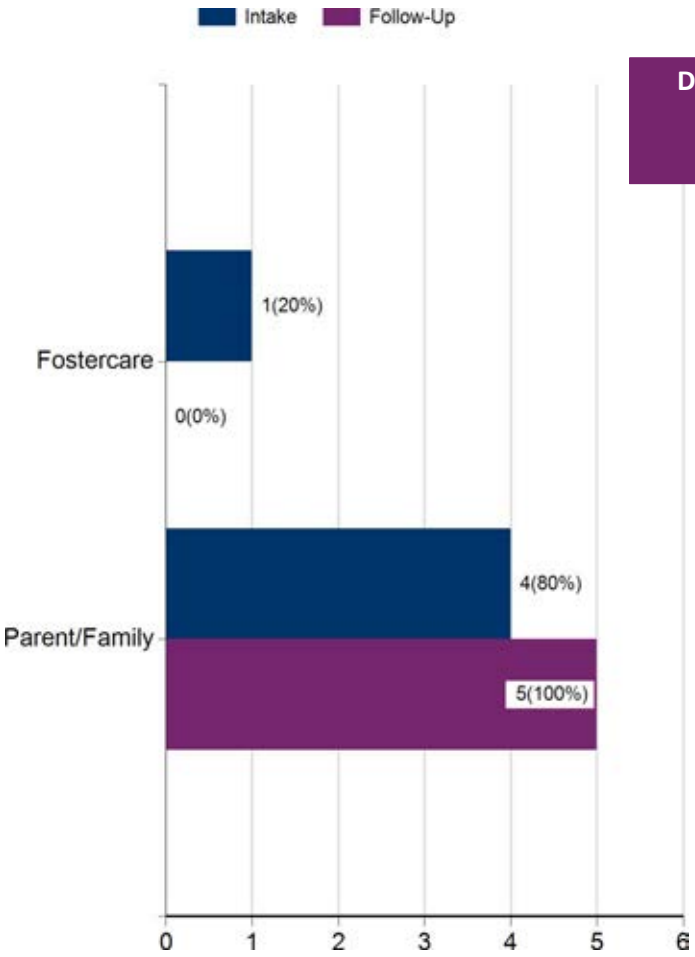
Outcomes: Primary Care Physician 33OPFEP



Intake: Most consumers (20.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumer that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33OPFEP)



Discontinuation Reason	Count	%
Total	0	100%

Length of FSP Partnership for: 33OPFEP

Youth Time in Partnership	Open	All Consumers	% of Total
>= 90 days and < 1 Year	4	4	80.00%
Under 90 days	1	1	20.00%
Total Consumer Enrollments	**5**	**5**	

Service Detail:33OPFEP

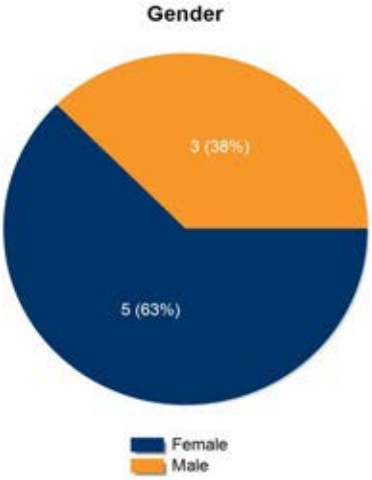
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	1 (50%)	0 (0%)	0 (0%)	2 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
2-3	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (20%)
4-7	1 (50%)	1 (50%)	0 (0%)	0 (0%)	1 (33%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (20%)	0 (0%)
8-13	0 (0%)	1 (50%)	1 (50%)	0 (0%)	0 (0%)	2 (50%)	1 (25%)	1 (25%)	1 (25%)	0 (0%)	1 (20%)	4 (80%)
14-19	0 (0%)	0 (0%)	1 (50%)	1 (25%)	1 (33%)	1 (25%)	1 (25%)	1 (25%)	1 (25%)	1 (25%)	3 (60%)	0 (0%)
20-25	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	0 (0%)	2 (50%)	0 (0%)	2 (50%)	1 (25%)	0 (0%)	0 (0%)
26-31	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)	2 (50%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Monthly Total	2	2	2	4	3	4	4	4	4	4	5	5

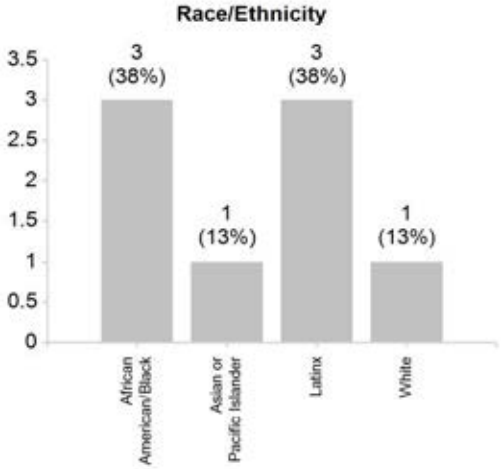
Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Case Management	5	10%	85	17.00
Crisis	1	2%	1	1.00
Family Therapy	1	2%	3	3.00
IHBS	4	8%	28	7.00
Individual Therapy	4	8%	52	13.00
Intensive Care Coordination Services	4	8%	75	18.75
Medication MD Services	5	10%	36	7.20
Medication Therapeutic Services	5	10%	80	16.00
Mental Health Services-Individual	2	4%	4	2.00
Non Face to Face MD	4	8%	7	1.75
Peer MH Education Groups	2	4%	2	1.00
Peer MH Engagement	2	4%	3	1.50
Peer MH Therapeutic Activity	5	10%	136	27.20
Peer-IHBS	4	8%	99	24.75
Psychiatric Assessment	1	2%	1	1.00

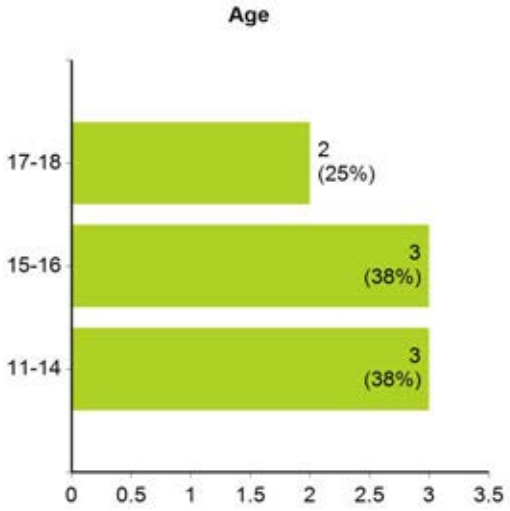
Children's FSP demographics and Outcomes for: 33A2FC Served by this reporting unit: 8

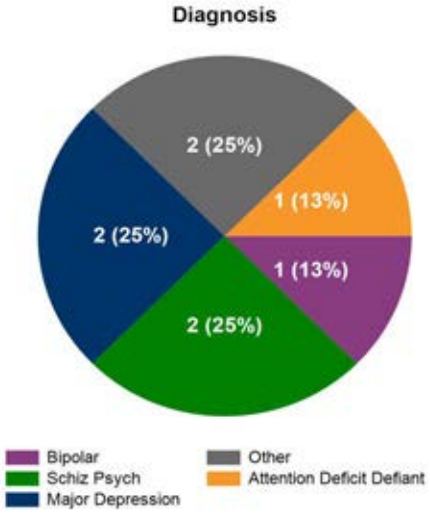
Demographics

38% of consumers were male and 63% were female.
38% of consumers were Latinx, 13% of consumers were White and 38% of consumers were Black/African American.
38% of consumers were 15 to 16 years old.



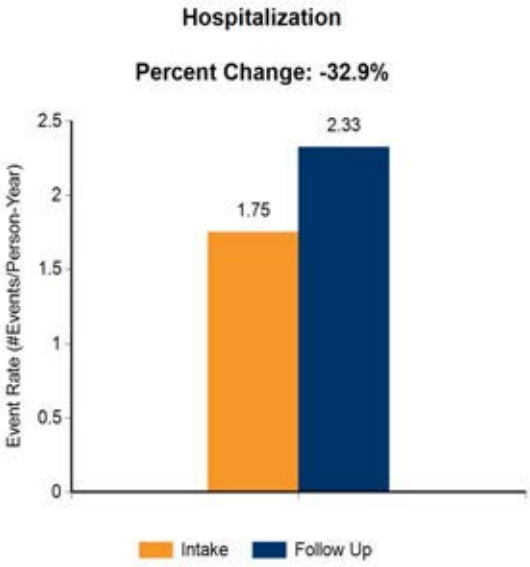


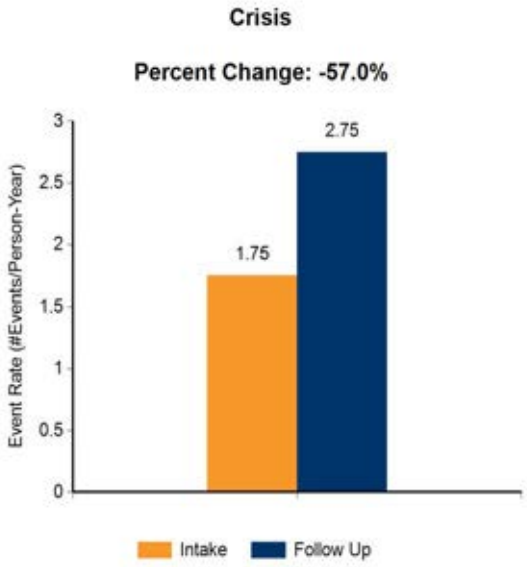


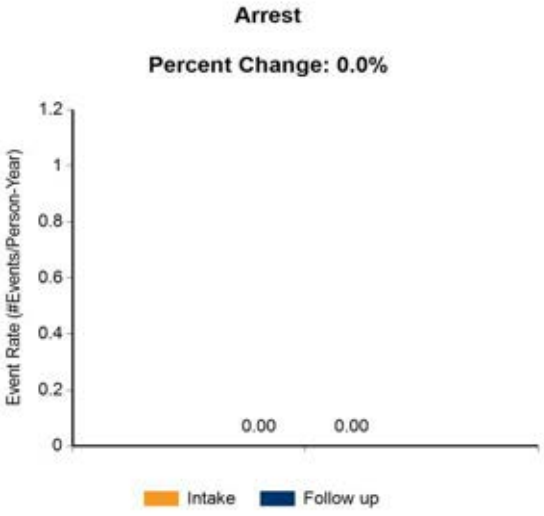


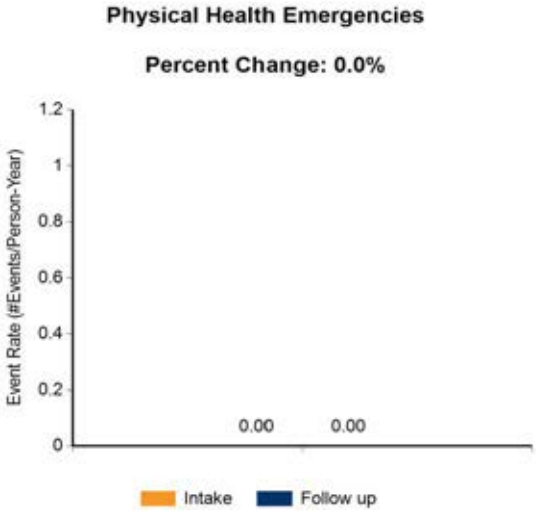
Outcomes for 33A2FC

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



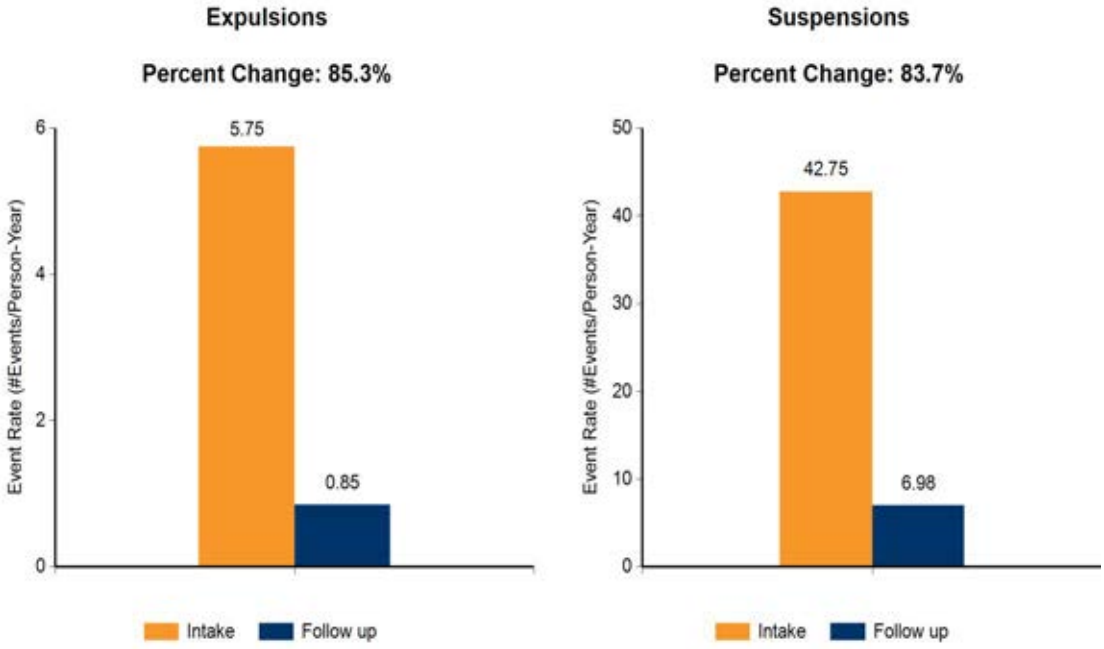


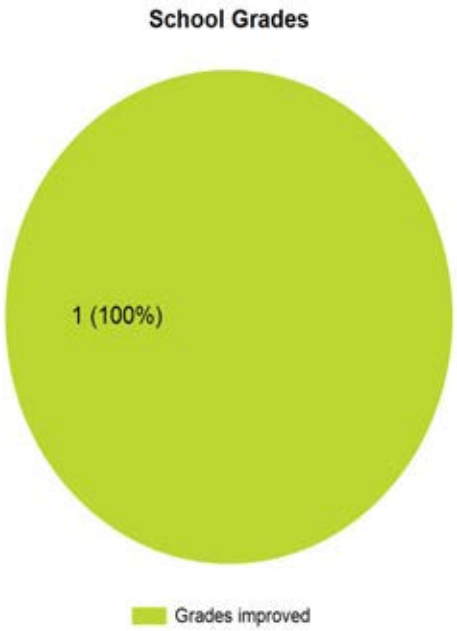


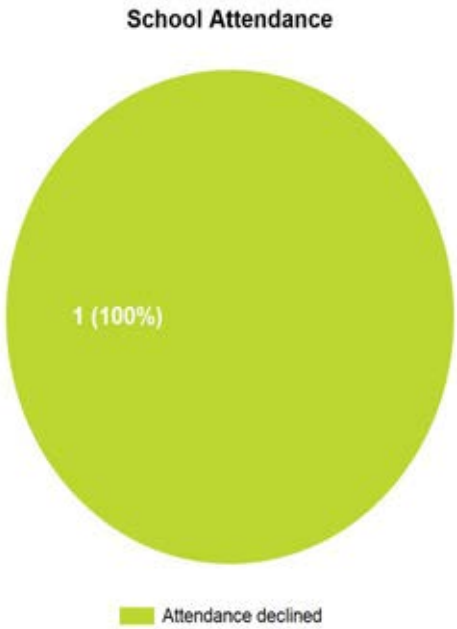


Outcomes for 33A2FC (cont.)

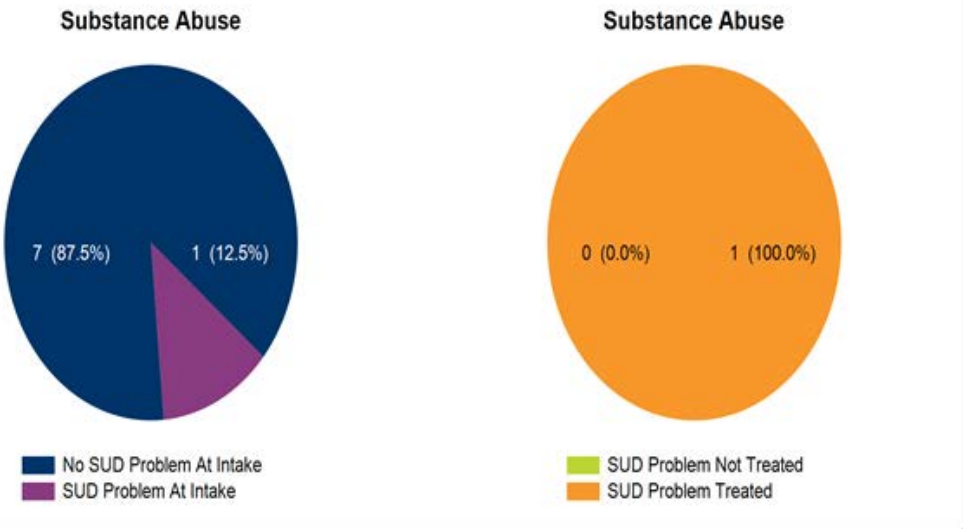
Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and attendance.





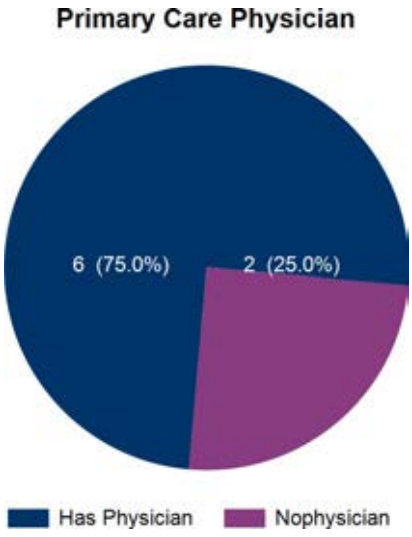


Outcomes: Residential & Discontinuance (33A2FC)



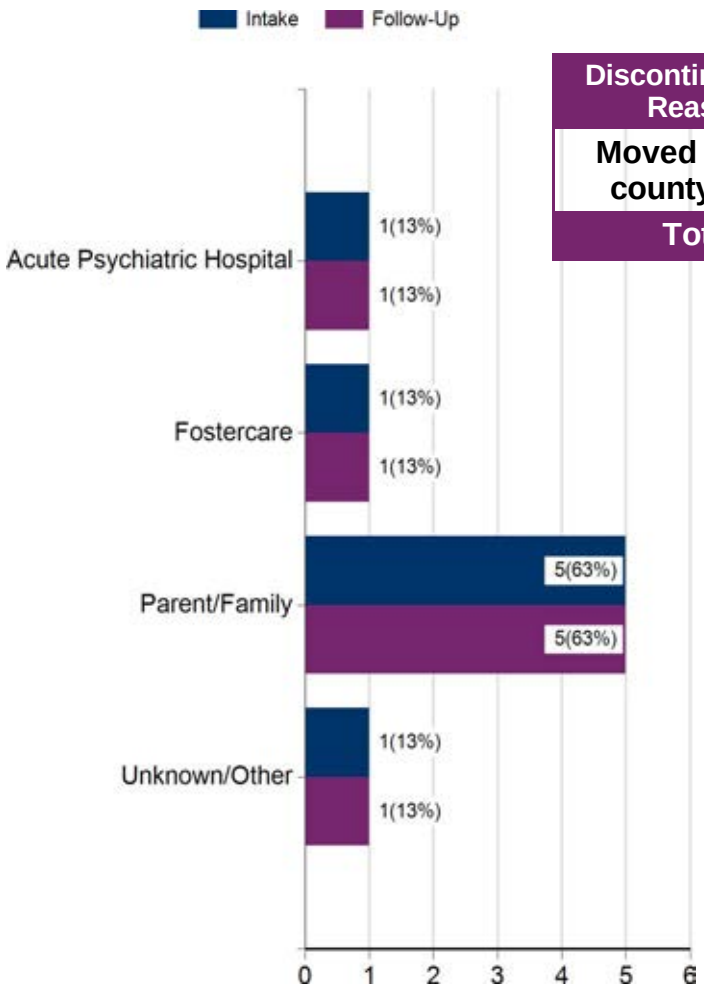
Intake: A considerable proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) issues (12.5%). Most of those with co-occurring MH and SU problems had been receiving SU treatment services at intake. An additional 0 consumers who were not identified at intake were found to have an SU problem during follow-up, and 0.0% of them were reported to be receiving SU services at that time.

Outcomes: Primary Care Physician 33A2FC



Intake: Most consumers (25.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 2 consumers that did not have a PCP at intake, 1 (50.0%) obtained a PCP while in the program.



Discontinuation Reason	Count	%
Moved out of county/area	2	100%
Total	2	100%

Length of FSP Partnership for: 33A2FC

Youth Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	0	1	1	12.50%
>= 90 days and < 1 Year	1	4	5	62.50%
Under 90 days	1	1	2	25.00%
Total Consumer Enrollments	2	6	8	

Service Detail: 33A2FC

Service Frequencies	Aug	Sep	Oct	Jan	Feb	Mar	May	Jun
0-1	1 (100%)	2 (100%)	1 (100%)	1 (100%)	1 (50%)	1 (50%)	0 (0%)	0 (0%)
2-3	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	1 (50%)	3 (100%)	0 (0%)
4-7	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)
Monthly Total	1	2	1	1	2	2	3	1

Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Assessment Services	1	6%	1	1.00
Case Management	2	13%	4	2.00
Intensive Care Coordination Services	1	6%	1	1.00
Medication MD Services	3	19%	7	2.33
Medication Therapeutic Services	2	13%	2	1.00
Mental Health Services-Individual	2	13%	2	1.00
Non Face to Face MD	1	6%	1	1.00
Peer MH Engagement	1	6%	1	1.00
Peer MH Therapeutic Activity	1	6%	1	1.00
Psychiatric Assessment	2	13%	2	1.00

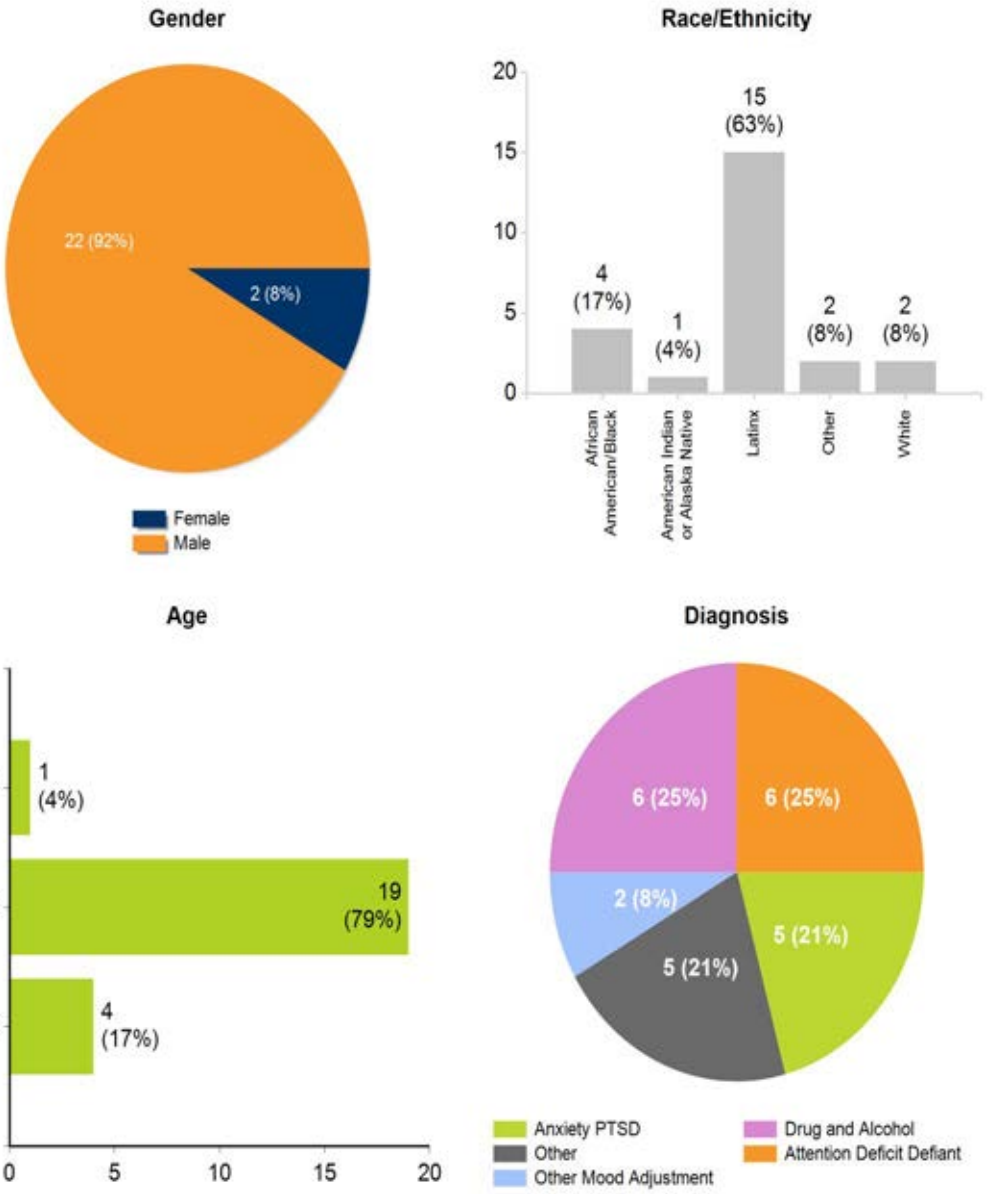
Children's FSP demographics and Outcomes for: 33OZNCF Served by this reporting unit: 24

Demographics

92% of consumers were male and 8% were female.

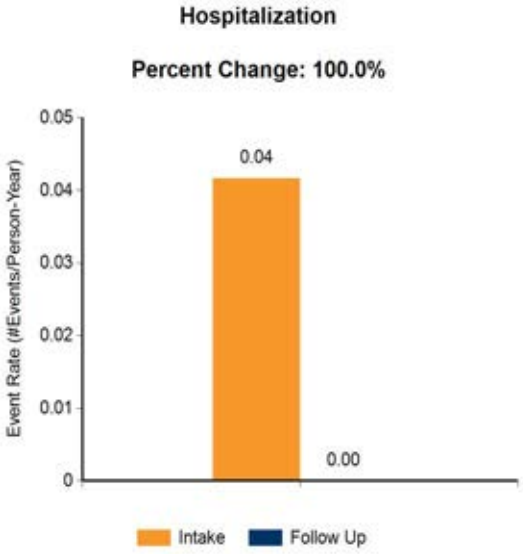
63% of consumers were Latinx, 8% of consumers were White and 17% of consumers were Black/African American.

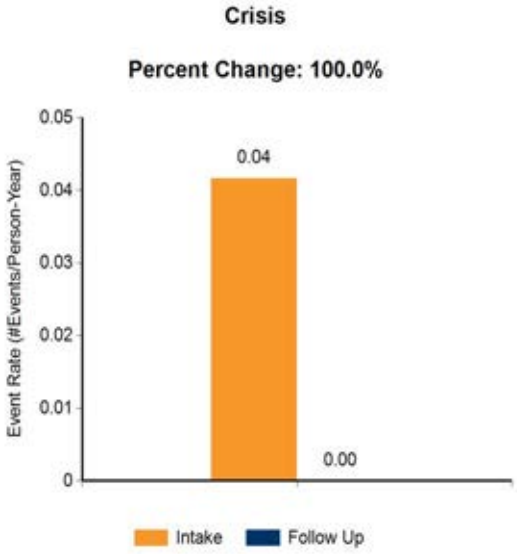
17% of consumers were 15 to 16 years old.

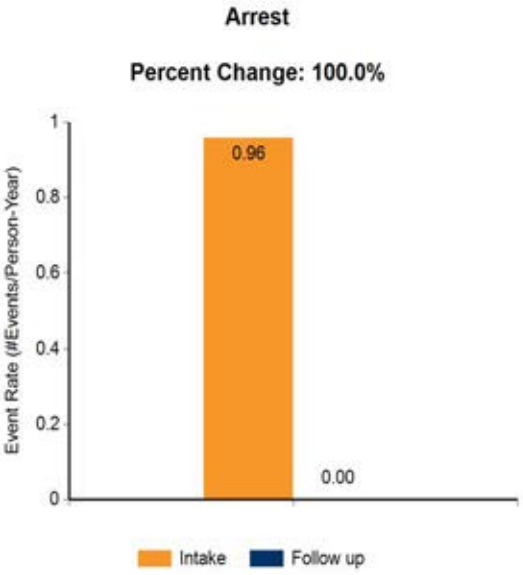


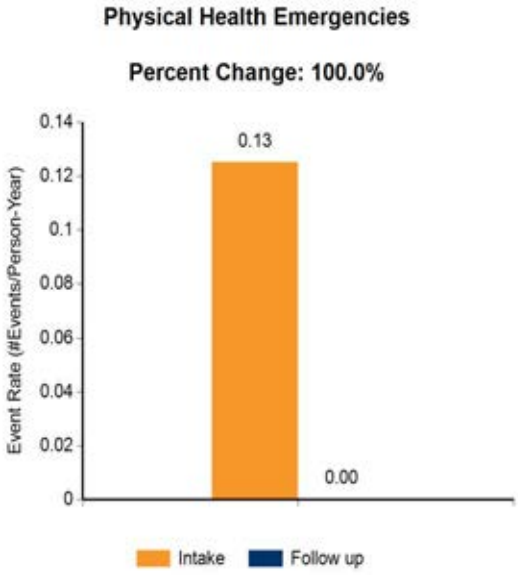
Outcomes for 33OZNCF

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



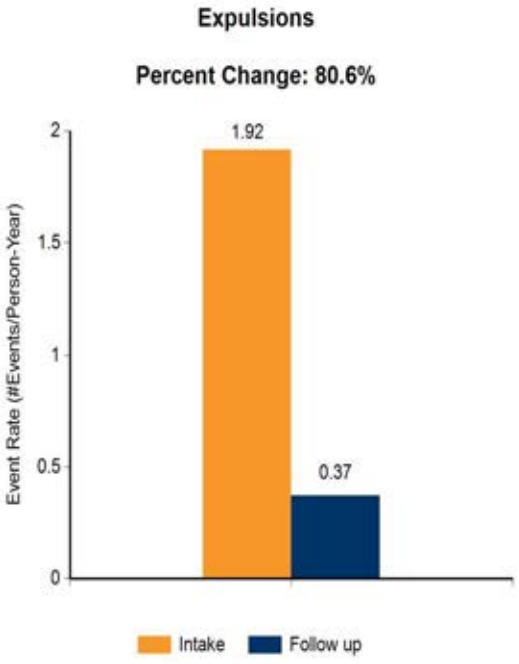


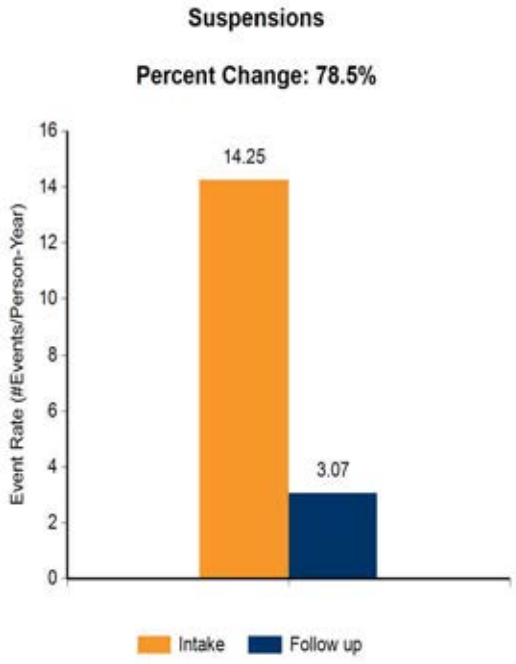


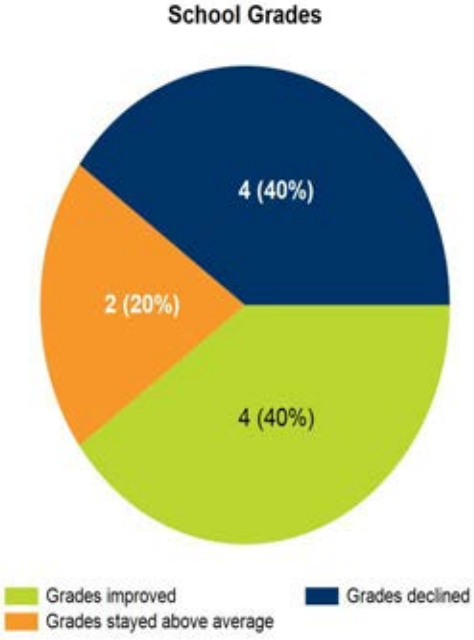


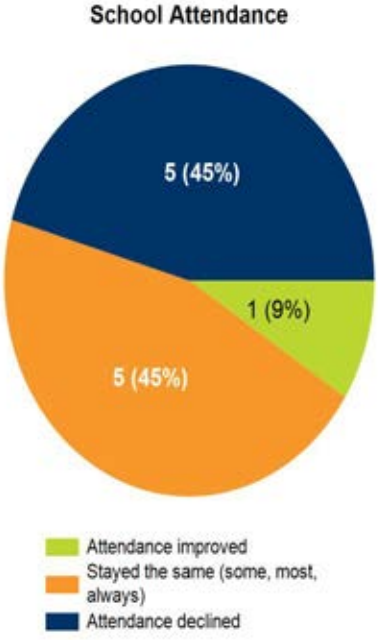
Outcomes for 33OZNCF (cont.)

Additional primary outcomes of interest include expulsion and suspension rates, as well as school grades and school attendance.

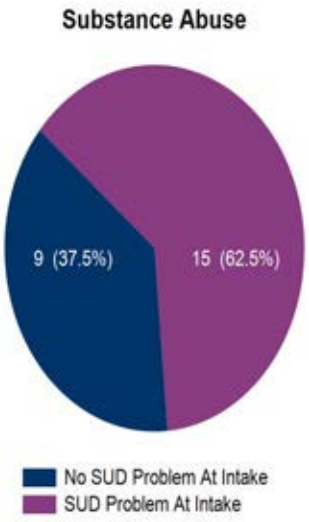


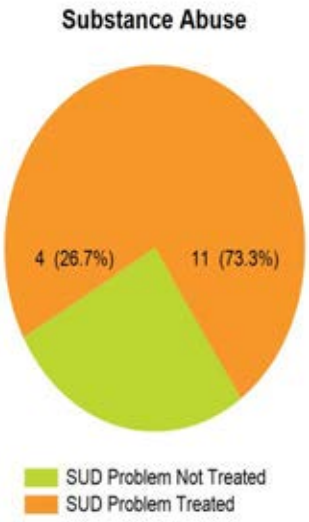






Outcomes: Substance Use 33OZNCF

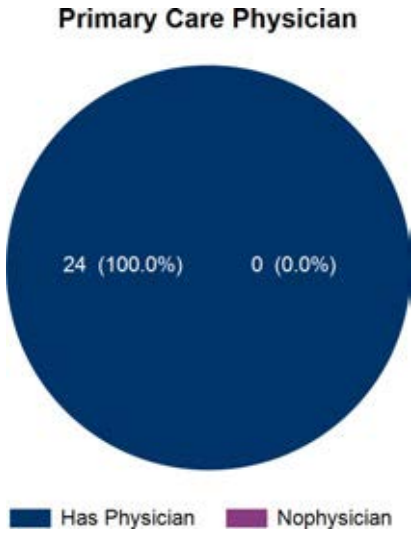




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (62.5%). The majority of those who had co-occurring MH and SU problems, had been receiving SU treatment services at intake.

An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

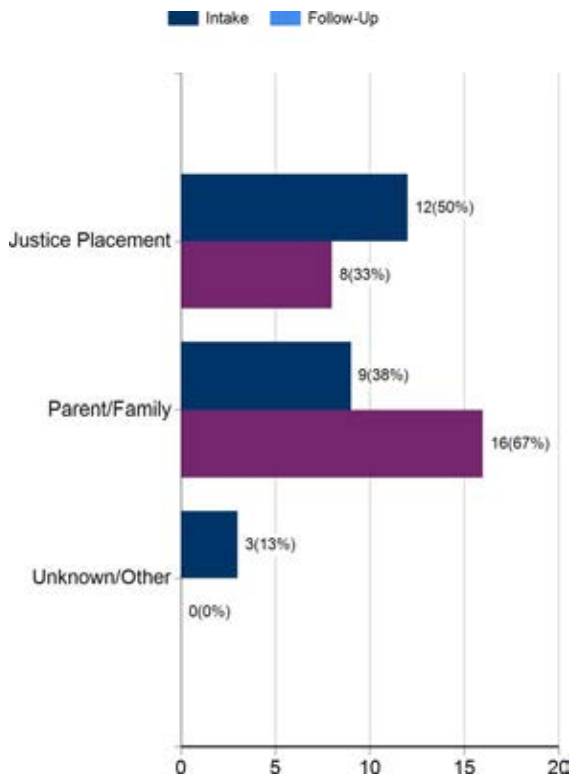
Outcomes: Primary Care Physician 33OZNCF



Intake: Most consumers (0.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 0 consumers that did not have a PCP at intake, 0 (0.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33OZNCF)



Discontinuation Reason	Count	%
Justice system	1	10%
Met goals	4	40%
Moved out of county/area	2	20%
Partner cannot be located	2	20%
Partner left program	1	10%
Total	10	100%

Length of FSP Partnership for: 33OZNCF

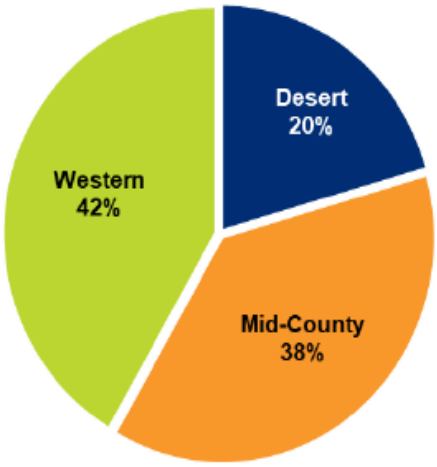
Youth Time in Partnership	Closed	All Consumers	% of Total
>= 1 Year and < 2 Years	4	4	16.67%
>= 90 days and < 1 Year	10	10	41.67%
Under 90 days	10	10	41.67%
Total Consumer Enrollments	24	24	

Service Detail: 33OZNCF

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
0-1	1 (17%)	1 (9%)	1 (10%)	6 (40%)	1 (13%)	0 (0%)	1 (50%)	2 (50%)	0 (0%)	0 (0%)
2-3	2 (33%)	5 (45%)	3 (30%)	4 (27%)	4 (50%)	5 (100%)	1 (50%)	2 (50%)	3 (75%)	1 (50%)
4-7	2 (33%)	2 (18%)	3 (30%)	5 (33%)	2 (25%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)
8-13	1 (17%)	2 (18%)	2 (20%)	0 (0%)	1 (13%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)
14-19	0 (0%)	1 (9%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
20-25	0 (0%)	0 (0%)	1 (10%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Monthly Total	6	11	10	15	8	5	2	4	4	2

Type of Service	# of Youth	% of Youth	# of Svcs	Avg. # Svcs
Case Management	14	26%	60	4.29
Collateral Services	5	9%	5	1.00
Family Therapy	3	6%	3	1.00
IHBS	1	2%	1	1.00
Individual Therapy	10	19%	37	3.70
Intensive Care Coordination Services	21	39%	158	7.52

Children FSP



Children served in FSP program was mostly provided by the Western region with 42% (476) of the clients for the FY 23/24. Followed by Mid-County 38% (432) and Desert with 20% (235). For a total of 1,143 in the FY 23-24.

The table summarizes the number of clients served by RU and region.

Rus	Desert	Mid-County	Western	Totals
3301FC	16			16
33GYFC	21			21
3385FC	27			27
3357FC			17	17
33A2FC			8	8
33AHFC			84	84
33MOFC			42	42
33MOFEP			17	17
33H8FC			38	38
33AMFC		63		63
33HUFC1		65		65
33JPFC		135		135
33PCFC		142		142
33GXFC		27		27
33ADFC			246	246
3349FC	166			166
33OPFEP	5			5
33OZNCF			24	24
Grand Total	**235**	**432**	**476**	**1143**

Multidimensional Family Therapy Program

Western Region: MDFT Expansion

Western Region MDFT Expansion serves the cities of Riverside, Moreno Valley, Corona, Norco, Eastvale, and the unincorporated areas of Jurupa Valley, Lake Matthews, Home Gardens, and parts of Mead Valley. MDFT Western Region Expansion team currently consists of three Clinical Therapists, one Supervisor, and one Office Assistant II. The Behavioral Health Specialist II position is presently vacant. The Behavioral Health Services Supervisor (BHSS) for MDFT Western Expansion is also the Supervisor of Mid the county MDFT program.

Noted trends in the Western Region service area include the continued use of sprayed Marijuana by youths in the program. This form of consumption leads to higher intoxication, reduced appetite, increased anxiety and depression, and lack of ability to regulate emotions, leading to more volatile behaviors that include physical aggression and destruction of property. In addition, there was a decrease in fentanyl use by youths but an increase in nicotine vaping and consumption of eatable substances. The program continues to have difficulty accessing members when they're in school. The program also consistently saw youth with a trauma history (sexual abuse, immigration-related trauma, and other cultural issues).

Goals for the next three years include the following:

1) Cross-train staff to use other intervention models to address trauma issues. Have staff be trained in the Dialectical Behavioral Therapy model to address emotional dysregulation.

2) Continue doing live supervisor or DVD reviews every month.

3) Create an MDFT leadership committee responsible for planning and implementing a yearly booster that brings together MDFT teams in the county for training and support purposes.

4) Collaborate with school officials to get access to members at school during school hours to provide services.

Notable Data Points:

- 38 consumers were served for FY23/24
- 54% of consumers were male and 46% were female
- 51% of consumers were 15 and 16 years old
- Increase in hospitalization (157% change)
- Decrease in arrest (100% change)
- Decrease in school expulsions (76% change) and suspensions (73% change)

Mid-County MDFT

Mid-County MDFT currently has four Clinical Therapists (1 Clinical Therapist II, 2 Clinical Therapist I, and 1 Clinical Therapist III). The Clinical Therapist III recently completed the MDFT International Trainer Course and is now a certified MDFT trainer. The program also has two Behavioral Health Specialists. One of the BHSII recently completed the 20/20 program that allowed her to pursue a master's program in Social Work and is expected to move on from this position. There is a Certified Nurse's Assistant performing the role of a Community Services Assistant, and the vacant Office Assistant Position II was recently filled. The program is supervised by one Supervisor who also oversees the Western Expansion MDFT program. The mid-county MDFT team serves the cities of Perris, Murrieta, Temecula, Wildomar, Lake Elsinore, Hemet, San Jacinto, and the unincorporated area of Anza.

A noted trend in Mid-County is there are more adolescents using fentanyl. In addition, more adolescents are using sprayed Marijuana, which results in being overwhelmed with toxicity that leads to no appetite, anxiety, depression, and lack of ability to regulate emotions. All of the above resulted in adolescents being opened to programs with more severe emotional and behavioral disturbances. Another challenge is adolescents being raised by non-biological parents (aunts/uncles, other relatives); Parent has their own mental illnesses and substance use; adult caretakers working longer hours and are unavailable for family or parent sessions; staff is not able to see consumer at school due to school district prioritizing school instructions over counseling; difficulty getting adolescent to stop marijuana use given change in drug enforcement priority by probation partner.

Goals for the next three years include the following:

1) Maintain fidelity to the model by filling out vacant positions quickly and training them accordingly so the team can have a sense of cohesiveness.

2) Continue having clinical therapists do live supervision and taping of sessions for review on a regular basis.

3) Increase staff exposure to models that address what's new in terms of street drugs, toxicity, anxiety, and depression. Newer staff that were hired are less experienced in treating co-occurring diagnoses such as depression and anxiety.

4) Plan and develop an MDFT semi-annual summit to bring together the three different MDFT teams for training and support purposes. This was a previous goal, but it was postponed when the Department MDFT trainer retired.

Notable Data Point: Research needs to fill in this section

Desert Region MDFT Program

MDFT Desert Region is now fully staffed with three Clinical Therapists, one Behavioral Health Specialist II, one Community Service Assistant, one half-time Office Assistant III, and one Supervisor. The MDFT Supervisor also supervises the TAY Desert Flow Drop-In Center. MDFT Desert Region serves the Coachella Valley areas, including Indio, Desert Hot Springs, Palm Springs, La Quinta, Palm Desert, and the Salton Sea community.

Noted trends for Desert Region MDFT saw consistent referrals from the probation department and county clinics and increased referrals of youth with aggression whose parents work long hours or who are being cared for by other family members. The Desert MDFT team also had an increase in youth with depression and suicidal ideations, along with youth with increased ADHD diagnoses and those dealing with cultural stress and trauma. The desert MDFT program also had a reduction in gang-involved youth.

Goals for the next three years include the following:

1) Increase LIVE and DVD supervision.

2) Cross-train staff to other models of intervention to address trauma issues. Have staff be trained in the Dialectical Behavioral Therapy model to address emotional dysregulation.

3) Create an MDFT leadership committee responsible for planning and implementing a yearly booster that brings together MDFT teams in the county for training and support purposes.

4) Increase staff knowledge on navigating the school system for resources such as testing for learning disability.

Notable Data Points:

- 21 consumers served during FY23/24
- 73% of consumers were male and 27% were female
- 50% of consumers were 15 and 16 years of age
- Significant decrease in hospitalization and arrest (100% change)
- Significant reduction in expulsion (80.6% change) and suspension (78.5% change).

Wraparound Program

Wraparound provides eligible youth and their families an alternative to congregate or higher levels of care (such as STRPs and out-of-state placement). Wraparound intends for children and adolescents to remain/return to a lover level of care in a family setting. In Riverside County, Wraparound began in 2003 with the Riverside University Health System- Behavioral Health (RUHS-BH) serving children at risk for high-level placement. Wraparound was provided to youth on probation, who voluntarily participated, and were diagnosed with a Severe Emotional Disturbance (SED).

The foundation of Wraparound is based on partnering with families to provide individualized support based on their unique strengths. It is needed in order to promote success, safety, and permanence within the home, school, and community. Program staff work with the family to develop a Wraparound team, which is comprised of a Facilitator, Behavioral Health Specialist, Parent Partner, and in some cases, a TAY Peer and a Therapist from RUHS-BH, a Public Health Nurse, and a Probation Officer. The team also includes anyone the family sees as essential in their lives, such as extended family members, friends, or other community members. As part of the Wraparound process, the team develops a family plan based upon "family voice and choice", to guide the process focusing on ten life domains:

1. Family
2. Housing
3. Safety
4. Social Recreational
5. Medical/Health
6. Financial
7. Spiritual
8. Legal
9. Emotional/Psychological
10. School/Work

Wraparound has operated as an FSP Since October 2018 and provides a majority of services to the families and youth in the community (schools, home, other locations) with 3-5 services a week. In the past year, Wraparound programs have expanded to increase SED service to Medi-CAL recipients, clinical Therapists received training in Trauma-Focused Cognitive Behavioral Therapy and added Substance Abuse intervention support with BHS III positions. Also, the team is preparing for upcoming training in High-fidelity Wraparound from the Heroes Initiative with a three day "Wrap Camp" to meet regulatory expectations and enhance fidelity across regions.

Overall/ County wide accomplishments for 2023/2024, please see individual program reports below.

Western Region Interagency Services for Families (ISF) Wraparound:

Progress from 3-year plan.

- Expand services to non-minor dependents returning from probation placement.
    - Wraparound services have been offered to non-minor dependents, and the supervisor has reached out to various probation offices, but ISF has not received many referrals for non-minor dependents.

- Expand services to Medi-Cal recipients who are on informal probation
    - The Probation Department has been made aware that we can provide Wraparound services to youth on information probation, but the Probation Department has not started sending referrals over yet for kids on informal probation.

- Filling staff vacancies to support three complete teams in fidelity with the model and support increased service provision.

- The ISF Wraparound Program is fully staffed currently

- Continued participation in the Wraparound Training Collaborative to expand regularly scheduled Wraparound basic and advanced training and ensure the provision of high-fidelity Wraparound services.
    - The ISF Wraparound staff continuously receive training from the UC Davis training site on Wraparound topics.

- Cross-train staff in all roles to ensure flexibility and continuity of service.
    - All ISF Wraparound staff have been cross-trained and can facilitate cases.

- Collaborate with probation to ensure the second probation officer position is filled to expand the capacity to serve probation youth.
    - The number of probation referrals has been low in the past year, so we have not been able fully utilize the capacity of our one probation officer.

- Reorganize ISF Wraparound team assignment structure to increase capacity for service delivery.
    - ISF Wraparound team structure has been adjusted so that Clinicians are devoting more of their time to provide individual, group, and family therapy for our Wraparound members, and the Wraparound facilitation role has been covered by other positions.

- Fill position of TAY Peer to provide peer support services for youth.
    - The TAY peer position was filled, but ISF still has a need for additional TAY peer positions, especially to work with gang-involved youth.

- Resume regular youth outings for social skill building and resume Wraparound events such as Honor Night and Unity Day to acknowledge family's successes.
    - The ISF Wraparound Program has hosted several youth activities over the last year and plans to host an Honor Night and Unity Day in the next few months.

- Participate in "Riverside Partnership" meetings with other Wraparound programs for mutual support and sharing of learning regarding best practices.
    - The ISF Supervisor participated in several Riverside Partnership meetings in the past year to get additional ideas on innovation from other Wraparound Programs.

Mid-County Region Interagency Services for Families (ISF)

The Mid-County Wraparound Team has continued to expand services, including outpatient clinic, IEHP, and non-ward Probation referrals. The Mid-County team is comprised of one Behavioral Services Supervisor, 1 Office Assistants, 3 Clinical Therapists, 1 Behavioral Health Specialist III, 5 Behavioral Health Specialist II, 6 Peer Support Specialists (Parent Partners), 2 Peer Support Specialist (TAY), 1 Community Services Assistant (position currently vacant), 1 Public Health Nurse

and 2 Probation Officers. The Mid-County team provides 90% of their services in community settings such as the family home, schools and other community options (local clinics, libraries, etc.).

Notable trends in Mid-County services include a continued increase in utilization of our safety line, primarily from non-SB families. Services continued to increase to non-SB children, providing early intervention to these families. Referrals for non-SB children continue to surpass referrals for SB children. Non-SB referrals have been expanded to include referrals from IEHP and non-ward probation youth who have Medi-Cal. In particular, referrals from System of Care clinics have increased drastically this year. Since beginning to receive non-ward referrals last year, we have provided a presentation for the SPARK program which partners with probation and have seen a drastic increase in referrals from this source, some of whom were found to be wards and were able to be transferred to the SB caseload. Requests for therapeutic services through Wraparound have continued for both identified client and family members.

Progress on 3-Year Plan Goals:

- Improve collaboration with local clinics and providers for Non-SB referrals and services.
  The previous year's referral level has increased for this group of youth. CalAim has allowed for better collaboration and streamlining of services for these referrals. Relationships with IEHP case managers and supervisors at System of Care Clinics have improved, and referrals have increased from these sources.

- All staff attain proficiency in high-fidelity Wraparound.
  Wraparound topics continue to be discussed weekly in staff meetings and case reviews. We utilize a wraparound-specific case review sheet to ensure principals are addressed when consulting. We are taking the whole program through the Wraparound process and have developed a mission statement and goals. Facilitators have regularly met with Jennifer Hunter for coaching, which appears beneficial. Many staff have also attended online trainings sponsored by UC Davis throughout the year.

- Increase direct contact with local Probation offices to improve collaboration and services.
  Continued staff turnover at Probation has made ensuring they are well-informed about Wraparound challenging. Still, we are working with the local supervisors to help identify appropriate youth earlier. Probation has shifted from a regional Wraparound Probation Officer to having a designated Wraparound Probation Officer at each location. There has been an adjustment period in creating clear lines of communication and maintaining probation attendance in consults and staff meetings. A team of Wraparound staff completed a presentation at one probation site that was well received and is coordinating a presentation at the other site. They plan to continue these presentations regularly.

- Build community partnerships via contact with Churches and community centers.
  Currently on hold due to vacancy in Community Services Assistance position

Desert Region Interagency Services for Families (ISF)

2023/24 Accomplishments

- Seven successful Wraparound graduations and many other cases progressed while with us.
- Increase in more field-based services as a result of reduced Covid fears – this resulted in an increase in IHBS billed services
- Increase focus, teaching, and implementation of the Wraparound Principles with families.
- Improved working relationships with the Probation Department. The newly assigned probation supervisor and our assigned probation officers attend most Wraparound staff meetings. She is included in case consultations as needed. Probation has been very open to learning more about the Wraparound Program, its principles, and the overall Recovery Model. It's been wonderful!

There has been an increase in community engagement, leading to youth and families being exposed to new experiences, healthier activities, services, and local resources. Here are a few highlights:

1) The team established a relationship with the manager at the Indio Municipal Golf Course, which resulted in a complimentary golf driving range for our kids. Three youths discovered golf for the first time and love it!

2) Following our meeting with the manager, Living Desert Zoo and Botanical Gardens now provides us with a free "chaperone" ticket, maintaining a 1:1 youth-staff ratio! Peers and BHSs took four youths there for their first visit, and they all enjoyed it immensely.

3) We met with Birth Choice of the Desert staff and learned about their services. They have strongly supported our expecting teen, both before and after the birth and long after her successful WA graduation.

Jennifer Hunter started providing regular individual coaching sessions with our facilitators this past year. This has resulted in the facilitators feeling well supported, increasing their self-confidence, learning, and adherence to the high-fidelity Wraparound model.

The TAY Peer Support Specialist was hired this past year, marking the first time we had one in many years. He was heavily involved in gangs and drugs during his youth and into adulthood. Our kids involved in gangs' bond and connect with him exceptionally well. He has truly helped them realize that a new life path is possible. He bridged a significant gap that we had experienced for a long time. Our youth show great trust and respect for him.

2025 Goals

- Continue to strive towards establishing new local vendors
- Increase number of referrals by educating both POs and other BH programs about our services
- Continue to strive towards decreasing financial stress on staff in terms of accessing our funding and being able to deliver those services to families. Hoping for availability of Gift Cards to reduce staff needing to put consumer goods on their own credit cards.
- First time - TAY PSS position now open to Blythe. Will be interviewing soon!!!

- Increase Senior Peer involvement in Wraparound, including 1:1 and group coaching with PPs and TAY PSSs. Senior Peers will be presenting Recovery Language presentation at the March All-Staff meeting, which will include POs and PHN.
- At the monthly all-staff meeting, each of the four clinics will rotate presenting activities/icebreakers to everyone that they can take back to their Wraparound families to make sessions more fun, interesting, and engaging. More sharing of ideas with each other will increase team bonding.
- Increase community engagement by attending more community events and collaboratives.
- Acquire more county cars to be able to deliver needed IHBS service
- Strive towards getting staff approved for the Wraparound conference, June 12-14 in Garden Grove.
- Continue with Wraparound facilitator coaching by Jennifer Hunter
- Improve coworker relationships through team-building activities once per quarter.

Youth Hospital Intervention Program (YHIP)

Western Region YHIP

Western YHIP team works collaboratively to provide intensive full-service partnership (FSP) outpatient mental health services for youth at risk for psychiatric hospitalization and/or post-discharge for suicide attempts and self-injurious behaviors. YHIP's primary goal is to decrease inpatient admission and crisis psychiatric emergency department recidivism by increasing stabilization and enhancing safety. Areas of catchment for Western YHIP are Moreno Valley, Riverside, Corona, Jurupa Valley, Eastvale, and Norco.

Western YHIP collaborates with the consumer to develop treatment plans and goals. The program encourages the participation of support persons (family or others) to increase support systems and to help members achieve and maintain their mental and behavioral goals. Western YHIP offers a variety of options for treatment, including individual psychotherapy and family therapy, parent support and psychoeducation, transportation, linkage to medication management, case management, and crisis support after office hours.

Western YHIP proudly reports that we are fully staffed with one Behavioral Health Service Supervisor, four Clinical Therapists, two Parent Partners, one TAY Peer, one BHS II, and one Office Assistant. All clinicians are trained to use the Child Adolescents Needs and Strengths Tool (CANS), and all staff members are trained in cultural competency.

Since September 2024, Behavior Health Specialist II and Certified Medi-Cal Peer Support Specialist have provided a weekly support group for teenagers. The goal is to provide a safe place where youth can feel heard and validated while acquiring life skills. Youth sharing everyday experiences helps them to feel less isolated and lonely and increases trust in forming healthy connections. The team empowers members to increase their independence by assisting them to develop effective coping strategies for their symptoms and gain valuable skills to reinforce healthy mental gains.

Western YHIP currently has two clinicians enrolled in TFCBT training. Three clinicians are 5150 certified to help clients who are dangerous to themselves or others. The Certified Medi-Cal Peer Support Specialists continue to use their story to offer support, information, and guidance based on their lived experience to help families make positive transformations for themselves and their children.

Goals for the next three years include the following:

1. Strengthen community connections by inviting representatives of community organizations to give presentations to promote learning and increase resources.
2. Increased in-home and community-based services.
3. Increase collaboration between school districts and YHIP to reinforce support for youth encountering academic difficulties and social struggles and address barriers to school attendance due to mental health challenges.
4. Continue to increase collaborative work and care coordination with contract providers to ensure timely linkage and support of mental health services.

Mid- County Region YHIP

Mid-County YHIP services children and youth hospitalized or at high risk for hospitalization. We also support children and youth who are stepping down from residential placement and need a full-service partnership (FSP) level of support as they transition. Riverside University Health System—Behavioral Health provides this service.

Mid-County YHIP is one of three YHIP programs throughout the County that provides crisis stabilization for children and youth. YHIP's primary purpose and goal is to decrease children's return to or cycling in and out of hospitalization. YHIP seeks to support the child or youth until they can enter an appropriate lower level of support (e.g., a County clinic, SAPT services, other specialty services, or a community provider).

The program faced challenges in staff retention and referrals in the 2023/2024 reporting period. With the loss of staff and the program supervisor, the program was "paused" in February 2024, and the remaining staff dispersed into other programs while restructuring and hiring could occur. With that, progress to goals was minimal for the reporting period.

The following are the goals for Mid-County YHIP and the updates associated with those goals:

1. More training and collaboration from other agencies such as DPSS, Probation, other County & contract providers,

Mid-County YHIP made marginal progress on this goal for 2023/2024. The dominant collaboration was internally with Youth Connect and externally with IEHP-Inland Empire Health Plan. The increase in this area with the program "restart" will expand referral sources and collaboration.

2. Increase collaboration with SAPT

No notable gains in this area.

3. Improve outcome data through training
Ongoing training for improved completion of the collection of FSP data proceeded throughout the time the program was operating.

4. Increase collateral support for all partners
Staffing shortages and a lack of referrals created barriers to growth in this area.

5. Increase linkage to primary care physicians
With increased regular contact with Case Managers at IEHP, this goal showed improvement in linkage and follow-through for "Well Child" visits and other physical health services.

Current staffing:
0.5-Behavioral Health Service Supervisor
0.5-Senior Clinical Therapist
1-Office Assistant III
1-Office Assistant II
4- Clinical Therapists
2- Behavioral Health Specialists
2- Parent Partners
1-Transitional Age Youth Peer

Desert Region YHIP

Desert YHIP (fully staffed) comprises four Clinical Therapists, two Parent Partners, two TAY Peer Specialists, one Behavioral Health Specialist III, and one Office Assistant III. Desert YHIP currently serves the following areas: Banning, Palm Springs, Desert Hot Springs, Palm Desert, La Quinta, Indio, Coachella, Thermal, and other surrounding Desert Cities. Services are offered in person, field-based, clinic settings, and/or through telehealth for individual, family, collateral, and/or group services. Parent Partners provide individual services for parents in both English and Spanish as supportive services and an introduction to the program. Our TAY Peers facilitate individual skill-building sessions using the WRAP Model (Wellness Recovery Action Plan). Services are delivered weekly with 2-3 contact sessions per week by one of the staff members utilizing evidence-based models such as Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy. The program continues to assist individuals and their families in reducing hospitalizations by equipping them with the knowledge and skills to lower at-risk behaviors and understand mental health challenges. One challenge during this update is that the only clinician assigned to the program transferred, which caused new referrals to be paused while we worked to backfill clinical positions.

The goals will be as follows:
1. Adding groups such as a SAFE/Urgent Care group, LGBTQI+ group, Anger Management group, DBT group, and parenting groups, both in English and Spanish, to decrease symptoms and

provide psychoeducation on symptomology when the program is staffed. Update: The goal was not met due to low staff, but the goal will continue to be a focus.

2.Increased utilization of the CANS (Child Adolescent Needs & Strengths) tool in Child and Family Team Meetings, as well as using the CANS to help navigate the course of treatment. Update: The team continues to ensure that CANS can be implemented and reviewed during CFTMs. The treatment team has been working on completing CFTMs at the beginning of treatment to assist with meeting the requirements of the FSP program. Challenges continue to be CFTMs being done promptly and challenges with parent/guardian availability and participation.

3.More integration of substance abuse services and groups for youth who struggle with co-occurring disorders. Update: The program has a BHS III that has been working on getting consumers linked to services and provides support and psychoeducational treatment to youth and parents/guardians but has struggled due to low census.

4.Reduce the no-show rate by offering home, community, and/or school services. Update: The goal has been met; the team has done a good job of providing services where the consumer is to avoid any barriers to treatment.

5.Link youth and families to appropriate community resources, identifying any cultural and linguistic special needs the family may have to assist with treatment success and forming more community relationships. Update: The goal continues to be ongoing, but there has been success in ensuring linkage between the program and community resources to ensure support and success for the youth served.

6.Provide TF-CBT, EMDR, and/or DBT training for all staff. Update: This goal continues to be a priority. A previous clinician was trained in TF-CBT, but the program is currently without a clinician. All staff is currently trained in DBT.

Outpatient System of Care Children's FSP Tracks

Western Region Children's Clinics FSP Tracks

The Western Region Children's Clinic FSP tracks are located at Moreno Valley Children's Interagency Program (MVCHIP), Children's Treatment Services (CTS), and Riverside Family Wellness Center. These tracks are designed for youth that need intensive, specialty mental health services including but not limited to Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Behavioral Services (TBS), individualized treatment planning, care coordination with outside agencies (e.g., DPSS, School Districts, Probation, IRC), psychiatric, therapeutic, and group services. The youth identified for FSP services are our most vulnerable youth with complex conditions such as trauma and suicidal ideation, or youth who are in foster care, justice-involved, or homeless, or at risk of homelessness.

Annual Update:

98 youth enrolled in the Western Region Children's FSP tracks for FY23/24. Children's Treatment Services (CTS) Clinic FSP track enrolled and served 17 children. Most children served were between 15 to 16 years old (47%). CTS had an 18% reduction in Hospitalizations and a 33% reduction in Crisis emergency room visits. Arrests were down 100%. Both expulsions and suspensions were down 90% and 89%, respectively. The Moreno Valley Children's Interagency Program (MVCHIP) FSP track enrolled and served 42 children. 29% of members were aged 15 and 16 years of age. Hospitalizations and crisis emergency room use decreased by 68%. MVCHIP members had a 90% reduction in school expulsions and a 89% reduction in suspensions. Riverside Family Wellness FSP track enrolled and served 39 children. 54% of the children served were male, and 51% were between the ages of 15 and 16. There was a decrease in hospitalization and crisis emergency room visits (68%). Suspensions and expulsions decreased, and school grades and attendance improved.

FSP consumers in the Western Region needing after-hours support are connected to the Mobile Crisis Unit or CARES line for additional support. For the extremely high-need and high-risk FSP consumers, the Western Region children's program continues to utilize internal resources. CTS, MVCHIP, and Family Wellness have access to MDFT, YHIP, and ISF Wraparound's after-hours support line. The close collaboration between the outpatient and field-based programs allowed for better coordination and awareness of the specific needs of the FSP consumers.

FSP level of care requires much time outside the traditional outpatient clinic, serving consumers in more natural supportive environments (e.g., home, school). The Western Region Children's goal for the year is to continue increasing Intensive Case Management (ICC) services and Intensive Home Base Services (IHBS). The region has hired additional support staff to address the need for more ICC and IHBS services.

Progress Data for FY23/24 (Countywide): The Children's FSP served 1099 youth in the Children's FSP tracks. Overall, 42% of the Children's FSP consumers received 8 or more monthly services. Combined outcome data for all children's FSP programs showed a decrease in arrests (92.52 %), physical health emergency department visits (86.97%), and hospital admissions (15.70%).

Mid-County Region Children's Clinics FSP

Mid-County: Victor Community Support Services Children's FSP

Victor Community Support Services (VCSS) Children's Full-Service Partnership (FSP), contracted with Riverside University Health System-Behavioral Health, serves youth ages 0-21 in the mid-county region of Riverside County from offices in Perris and Hemet. Our primarily community- and home-based services address high-risk needs, including psychiatric hospitalization, housing/school instability, removal/risk of removal from home, substance use, juvenile justice involvement, suicidality/violence risk, eating disorders, and the need for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), or Therapeutic Behavioral Services (TBS). Using a strength-based approach and evidence-based practices like TF-CBT, our multi-disciplinary teams provide comprehensive mental health services, including individual, family, and group therapy; medication support; rehabilitation/behavioral support; skill building; case management; parenting support; and substance abuse/TBS referral and linkage.

Program Goals:

1) Reduce Referral Wait Times

- Target: Meet access to care timelines.
- Current Performance (January- December 2024):
    - Hemet: 33.2 days
    - Perris: 27.5 days

2) Maintain Treatment Goal Achievement

- Target: 75% or higher.
- Current Performance (January - December 2024):
    - Hemet: 82%
    - Perris: 86%

3) Increase Utilization of ICC, IHBS, and CFTMs

- Target:
    - Hemet: 70%
    - Perris: 50%
- Current Performance (January - December 2024):
    - **ICC Services:**
        - Hemet: 94%
        - Perris: 39%
    - **IHBS Services:**
        - Hemet: 53%
        - Perris: 16%
    - **CFTMs:**
        - Hemet: 39%
        - Perris: 9%

4) Other Notable Data

(January - December 2024):

Clients Served:

- Hemet: 222 clients
- Perris: 178 clients

DEMOGRAPHICS

- VCSS Hemet
    - 46% Male
    - 54% Female
    - 15% African American/Black
    - 26% Caucasian

- 48% Hispanic/Latinx
- VCSS Perris
  - 35% Male
  - 64% Female
  - 10% African American/Black
  - 10% Caucasian
  - 52% Hispanic/Latinx

AVERAGE LENGTH OF STAY

- VCSS Hemet: 7.2 months
- VCSS Perris: 11.7 months

3-Year Plan Goals:

1) Models of Care Implementation:

Implement a robust Model of Care framework to improve service delivery, ensure consistency, utilize best practices, and ultimately enhance consumer outcomes. Our framework provides a roadmap for effective and efficient service delivery, prioritizing service excellence by addressing the specific needs of the populations we serve. A key component is the use of standardized assessment tools to track client progress and identify areas requiring additional support.
We leverage the following assessments:

- Child and Adolescent Needs and Strengths (CANS): Assesses the mental health needs of children and adolescents.
- Client Assessment of Reintegration Scales (CAIR): Assesses the functional abilities of consumers with mental illness.

CAIR scores play a critical role in our Models of Care, enabling us to:

- Stratify consumers: Match consumers to the most appropriate model of care/program.
- Determine service frequency: Tailor service intensity to individual needs.
- Monitor treatment progress and length of service (LOS): Track client progress over time.
- Evaluate client outcomes: Measure the effectiveness of interventions.

2) Improving Outcome Data through Training:

We are committed to improving outcome data through ongoing staff training in evidence-based practices (EBPs). Over the past year, we have made significant progress in this area, providing training in:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Family-Based Therapy (FBT)
- Incredible Years
- Family Seeing (Family Finding Model)

This investment in staff training ensures the delivery of high-quality, evidence-based care and contributes to improved client outcome

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

FULL-SERVICE Partnership TAY Outcomes Report

FY 2023-2024

Background

The following report summarizes outcome data for the TAY Full-Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected continuously for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains.

Outcome reporting is based on comparisons between baseline and post-enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collected from consumers enrolled in and served by the TAY FSP programs, starting July 1, 2023, and ending June 30, 2024. The baseline data for this report relies on responses from each consumer's Partnership Assessment Form, alongside the history of events from the 12 months prior to a consumer beginning the FSP program. Follow-up data utilized in this report comes from two sources. Psychiatric Hospital and crisis emergency room data have been drawn from actual hospital or crisis emergency room admissions. All other follow-up data included in this report is derived from Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet during these consumers' enrollment in the TAY FSP program.

FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Integrated Service Recovery Centers (ISRC) for Adult and TAY consumers and Specialty Multidisciplinary Aggressive Response Treatment (SMART) for older adults. However, the following report only presents statistics and figures from the TAY FSP programs.

Three TAY ISRCs provide intensive case management services with support and crisis response services available 24/7. ISRCs include our three programs, which are located regionally and serve consumers who are unengaged and homeless or at risk of homelessness. The program also targets consumers with a history of cycling through acute or long-term institutional treatment settings. These centers collaborate with community resources and agencies to meet consumers' vocational, educational, social, and housing needs. Services are provided by a multidisciplinary team that embraces the principles of recovery and resilience. The services and support staff available within the ISRC include psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

Executive Summary

TAY Enrollment and Demographics —During the 2023/2024 fiscal year, from July 1, 2023, to June 30, 2024, a total of 689 youth were served through 705 enrollments, which include re-enrollments and transfers to one or more of the TAY FSP programs. The race and ethnicity of enrollees for this fiscal year were 319 (45.2%) Latinx, 87 (12.3%) White, and 63 (8.9%) African American/Black. Countywide, the most common diagnosis among TAY FSP consumers was Major Depression, with 193 (29.2%) cases. Additionally, the most significant proportion of consumers was between the ages of 18 and 21 (53%), and the majority of those enrolled were male (57%).

TAY Discontinuances —Across all of the TAY programs, the most frequently reported discontinuance was that the partner could not be located (36%). Partner left program accounted for (23%) of discontinuance reasons.

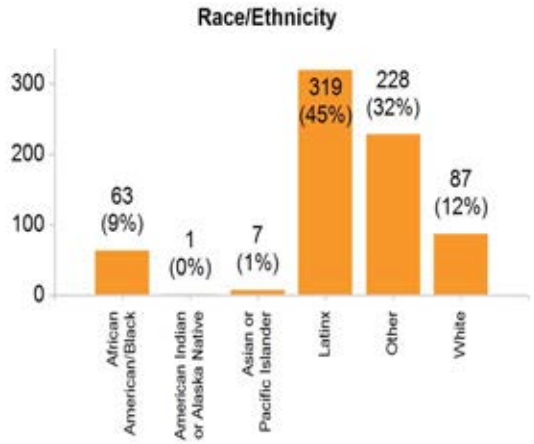
FSP Services —In the 2023/2024 fiscal year, more than half of the FSP consumers received 2-3 or 4-7 services a month. The highest average hours of services during the 2023/2024 fiscal year were for individual mental health services (8.32 hours), in-home behavioral services (6.23 hours), and individual therapy (10.47 hours).

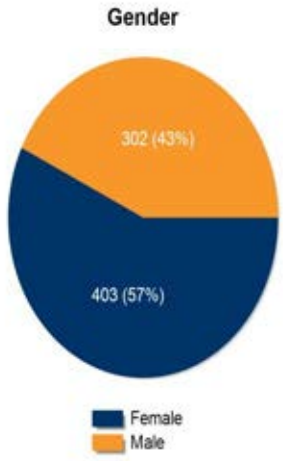
TAY Outcomes —Follow-up data for all TAY programs combined showed a decrease in hospitalizations (31.4%), arrests (79.8%) , physical health emergency (82.2%), and mental health emergency department visits (30.1%). A small percentage of consumers did not have a primary care physician at the beginning of the program (21.21%). However, more than half of those (53.7%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, many (25.0%) participated in substance use services while in partnership. Of the 50 additional consumers who were identified as having an active substance abuse problem during their participation in the TAY programs,4(8.0%) was reported to be participating in substance use treatment services while in the FSP program.

Residential Status—Comparisons of intake status and most recent residential status showed that while the majority of consumers continued living with their parent/family, the percentage of consumers reported as living on their own, in supervised placement***,*** or in a residential treatment facility increased.

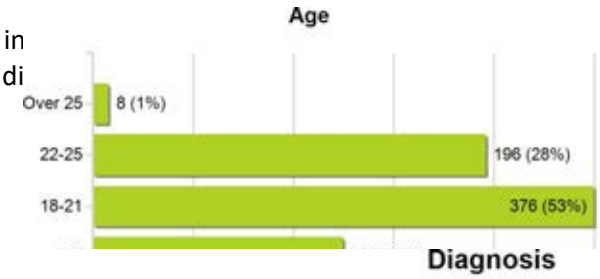
Demographics & Diagnosis

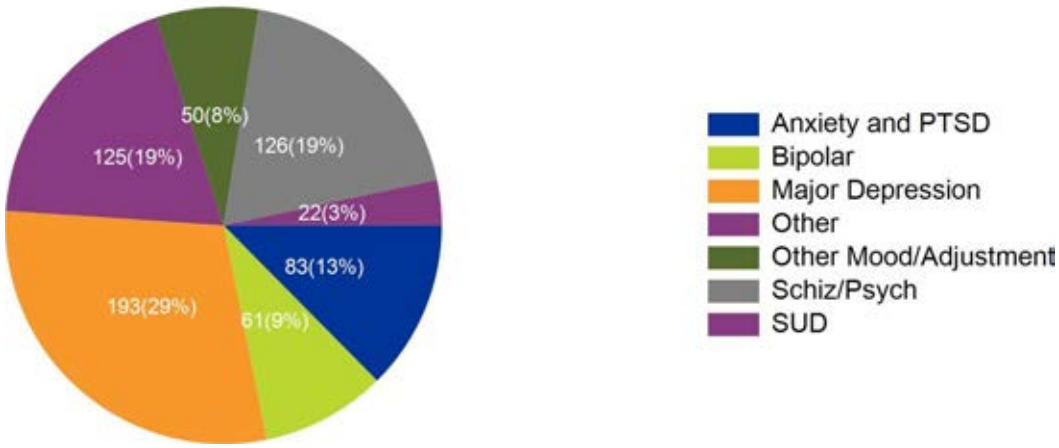
The majority served in the TAY FSP program in the 2023/2024 fiscal year were Latinx 45%, followed by Other Race, at 32%. The proportion of African American/Black participants was 9%. Also, more females (57%) have enrolled in the TAY FSP program than males (43%).





Most in (53%). A large proportion of those served were di phrenia/Psychosis disorders (19%).





Length of FSP Partnership

The tables below show the length of stay in years for the 705 consumers enrolled in TAY FSP programs during the 2023/2024 fiscal year. The total time a consumer spent in each enrollment is included for reporting time in partnership.

The percentage of TAY with an active/open case having time in partnership longer than one year was 43%, while 63% of those without an open episode have a time in collaboration shorter than one year. Of all TAY FSP consumers served in FY 2023/2024, over two-thirds have a longer stay of less than two years (78%).

FSP re-entry: Of these **705** TAY FSP enrollments, 71 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnerships, and 2 of them re-established partnerships more than once over their total time in partnership. The number of consumers who returned to an FSP program after more than a year had passed since discharging from an FSP program was 27.[4]

TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	61	61	122	17%
>= 2 Years and <3 Years	43	36	79	11%
>= 3 Years and < 4 Years	14	17	31	4%
>= 4 Years and < 5 years	7	10	17	2%
>= 90 days and < 1 Year	127	111	238	34%
>=5 Years and < 6 years	8	7	15	2%
>=6 Years+	6	10	16	2%
Under 90 days	109	78	187	27%
Total Consumer Enrollments	**375**	**330**	**705**	
Average Years in Partnership	2.76	2.46	1.31	
Median Years in Partnership	0.64	0.74	0.70	
Maximum Years in Partnership	9.14	9.60	9.60	

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

Reason for Discontinuance of FSP: All TAY

Upon termination of the partnership, a reason for discontinuance is selected. For recorded cases,

[4] Active cases include those with an open episode in a TAY FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave the partnership and later reestablish the collaboration in the same or different FSP program, this report does not include time spent inactive.

consumers most often closed because they were Unable to Locate (36%). The next highest proportion of consumers were noted to have left the program (23%). Met Goals accounted for 21% of discontinuance reasons. Each instance was recorded in this table if a consumer terminated a partnership more than once.

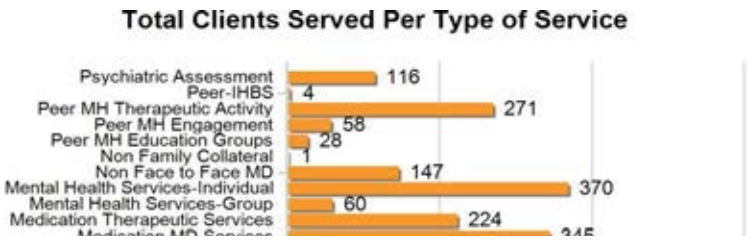
Discontinuation Reason	Count	%
Justice system	3	1%
Met goals	73	21%
Moved out of county/area	39	11%
Needs residential care	8	2%
Other	1	0%
Partner cannot be located	122	36%
Partner left program	78	23%
Target criteria not met	17	5%
Total	**341**	**100%**

The table below shows the number of individuals receiving various amounts of services per month for each

Service Frequency By Month

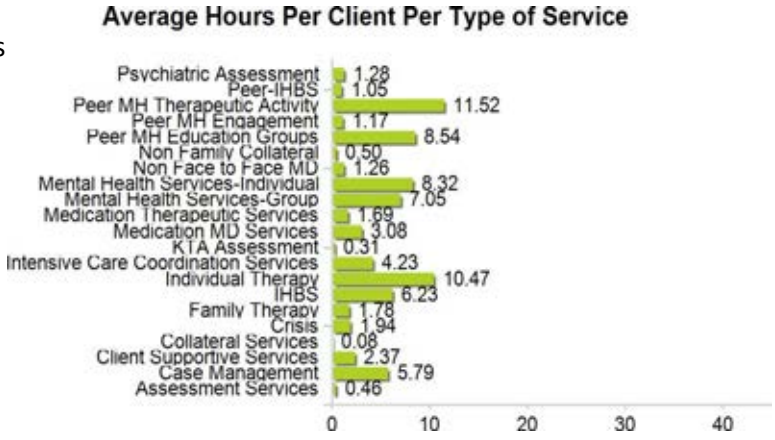
month of the 2023/2024 fiscal year. Most consumers received either 2-3 or 4-7 or more services per month within the fiscal year. On average, more than 25% of TAY FSP consumers received eight or more services per month.

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	63 (18%)	66 (18%)	75 (24%)	83 (26%)	75 (23%)	66 (21%)	64 (21%)	60 (19%)	46 (16%)	55 (17%)	52 (16%)	51 (16%)
2-3	106 (31%)	91 (25%)	79 (25%)	80 (25%)	88 (27%)	89 (28%)	82 (26%)	83 (27%)	74 (25%)	70 (22%)	89 (27%)	92 (29%)
4-7	98 (28%)	109 (29%)	83 (27%)	74 (23%)	95 (29%)	91 (29%)	89 (29%)	100 (32%)	99 (34%)	106 (33%)	94 (29%)	98 (31%)
8-13	62 (18%)	76 (20%)	60 (19%)	55 (17%)	47 (14%)	51 (16%)	48 (15%)	46 (15%)	48 (16%)	58 (18%)	58 (18%)	37 (12%)
14-19	13 (4%)	22 (6%)	9 (3%)	21 (7%)	14 (4%)	12 (4%)	20 (6%)	13 (4%)	19 (6%)	18 (6%)	22 (7%)	25 (8%)
20-25	4 (1%)	5 (1%)	4 (1%)	7 (2%)	6 (2%)	2 (1%)	6 (2%)	5 (2%)	7 (2%)	10 (3%)	8 (2%)	6 (2%)
26-31	0 (0%)	1 (0%)	0 (0%)	0 (0%)	3 (1%)	1 (0%)	1 (0%)	2 (1%)	0 (0%)	5 (2%)	2 (1%)	2 (1%)
32+	1 (0%)	1 (0%)	1 (0%)	3 (1%)	1 (0%)	1 (0%)	1 (0%)	0 (0%)	1 (0%)	3 (1%)	3 (1%)	1 (0%)
Monthly Total	347	371	311	323	329	313	311	309	294	325	328	312



During the 2023/2024 Fiscal year case management, client supportive services and individual therapy were the three services that served the most consumers.

The average number of hours consumers received of each type of service while in TAY FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in Peer MH Therapeutic Activity (11.52 hours).

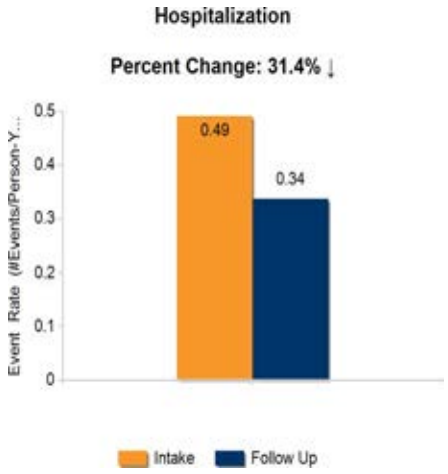


Type of Service	# of TAY	% of TAY	# of Svcs	Avg. # Svcs
Assessment Services	102	17%	117	1.15
Case Management	436	74%	6,125	14.05
Client Supportive Services	5	1%	6	1.20
Clinical Group	1	0%	1	1.00
Crisis	41	7%	73	1.78
Family Therapy	1	0%	1	1.00
Individual Therapy	144	24%	1,068	7.42
Medication MD Services	309	52%	953	3.08
Medication Therapeutic Services	339	57%	3,577	10.55
Mental Health Services-Group	45	8%	334	7.42
Mental Health Services-Individual	418	71%	5,663	13.55
Non Face to Face MD	200	34%	502	2.51
Peer MH Education Groups	35	6%	181	5.17
Peer MH Engagement	49	8%	95	1.94
Peer MH Therapeutic Activity	223	38%	2,380	10.67
Psychiatric Assessment	63	11%	64	1.02

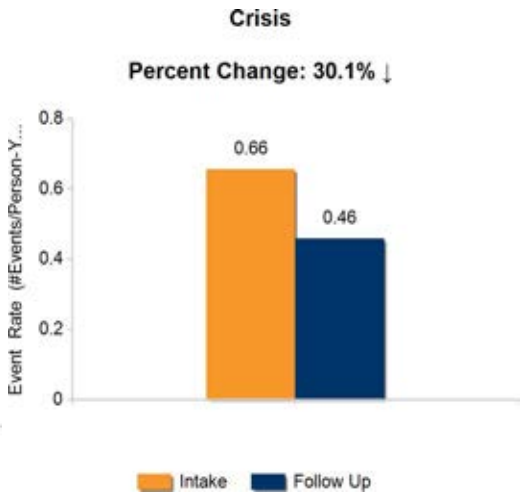
Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations, and long-term care. The number of events in the 12 months before FSP enrollment is compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled was summed and divided by the years all individuals had been in the program. Actual counts for each outcome overall and by the program can be found after page 11.

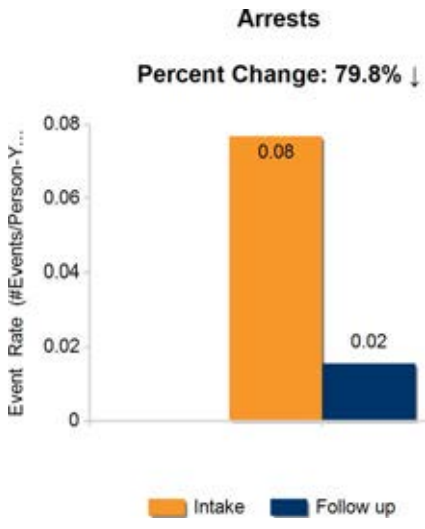
Overall, psychiatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies were reduced.



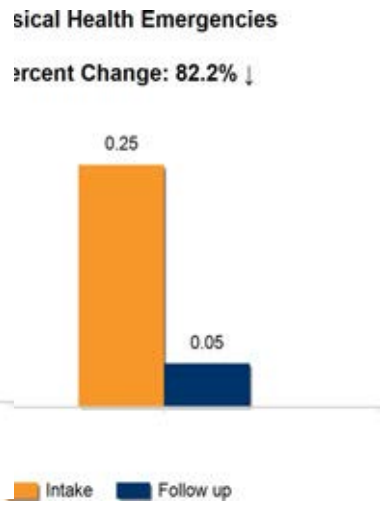
Hospitalizations decreased by 31.4% from intake to follow-up.



Crisis decreased by 30.1% from intake to follow-up.



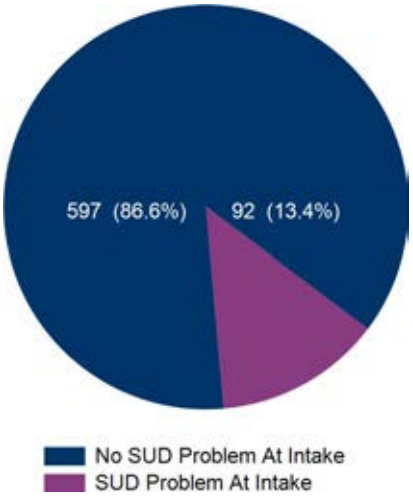
Arrests decreased by 79.8% from intake to follow-up.

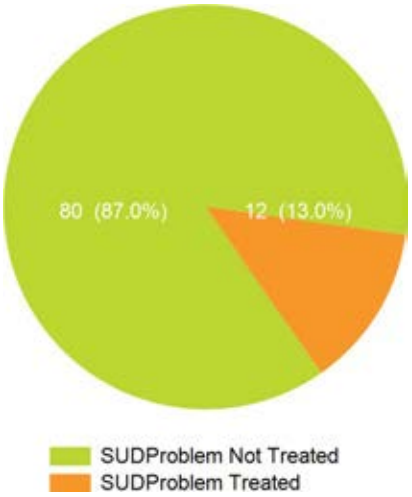


Physical Health Emergency visits decreased by 82.2%.

Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (13.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

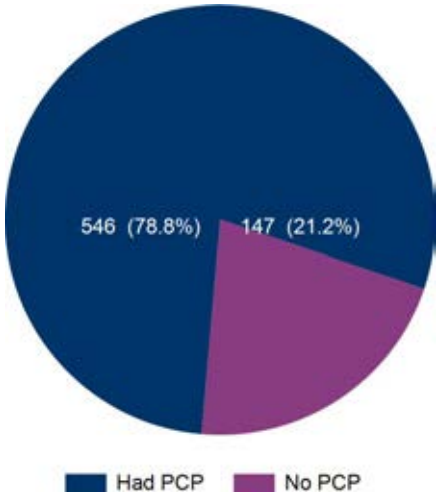




Follow-up: Based on follow-up data reported quarterly, 25.0% (20) of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 50 consumers not identified at intake were noted to have an SU problem on follow-up, and 8.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician

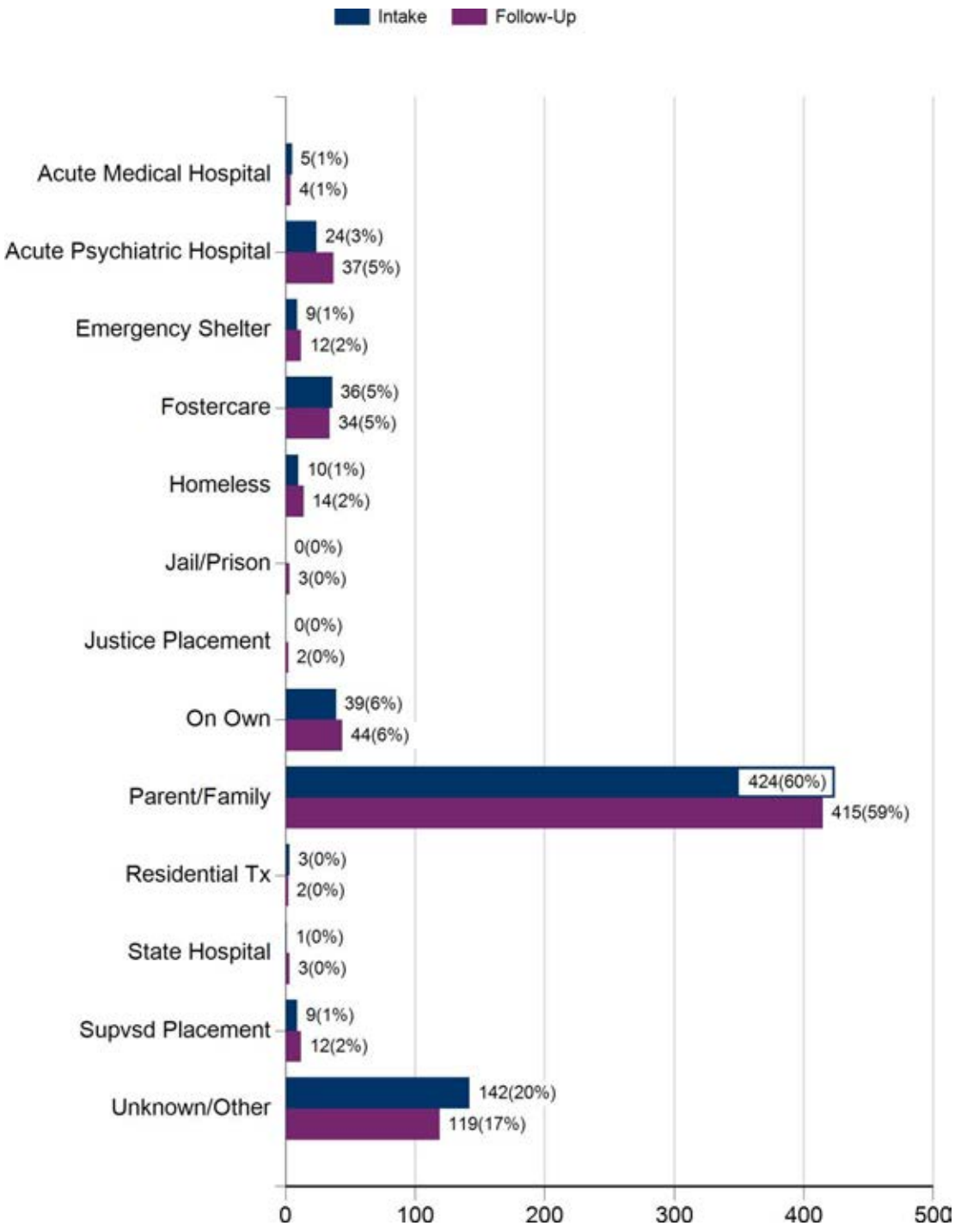
Intake: Some Consumers (21.2%) did not have a primary care physician (PCP) at intake.



Follow-up: Of the 147 consumers who did not have a PCP at intake, 79 (53.7%) obtained one while in the program.

Outcomes: Residential

Overall, the TAY FSP consumers had a decrease in the proportion of homeless or in emergency shelters and an increase in the percentage of consumers living on their own. Residential settings were calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



Outcomes: Residential Days

The following compares consumers' living arrangements in the year before FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. This analysis aims to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form, which includes the number of days consumers spent in each residential setting during the 12 months immediately before enrollment. Note that these 12 months preceded their **first** enrollment to any FSP program.

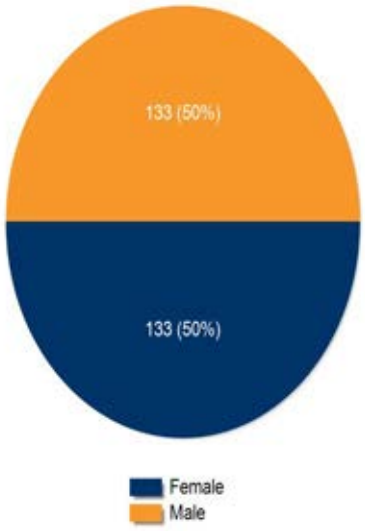
The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it is considered unknown. To accurately compare a year of pre-enrollment with a year of post-enrollment, data for residential days during enrollment has been annualized.

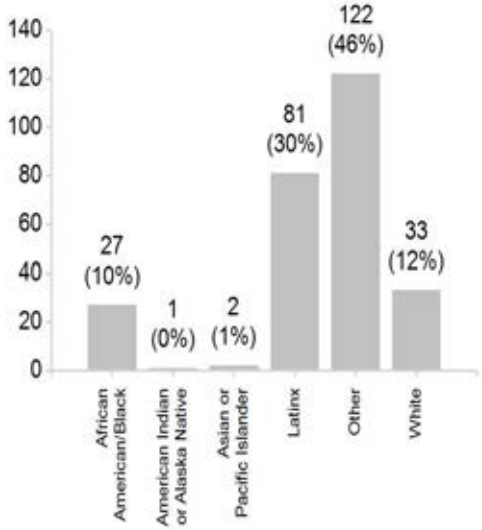
	12 Months Before Enrollment		Annualized Days During Enrollment		
Living Situation	**# of Days**	**Count (n)**	**# of Days**	**Count (n)**	**Percent change (%)**
	0	0	23,556	101	0%
Acute Medical Hospital	205	27	663	19	223%
Acute Psychiatric Hospital	1,903	108	5,324	98	180%
Community Treatment Facility	395	3	-	1	-100%
Emergency Shelter	1,999	19	4,821	24	141%
Fostercare	4,210	15	4,108	13	-2%
Homeless	4,588	23	2,872	20	-37%
Jail/Prison	281	10	460	7	64%
Justice Placement	129	4	17	1	-87%
On Own	13,062	46	18,906	67	45%
Parent/Family	160,914	481	170,371	504	6%
Residential Tx	544	22	5,705	28	949%
State Hospital	33	3	146	4	342%
Supervised Placement	2,175	16	6,547	13	201%
Unknown/Other	66,887	187	6,694	78	-90%

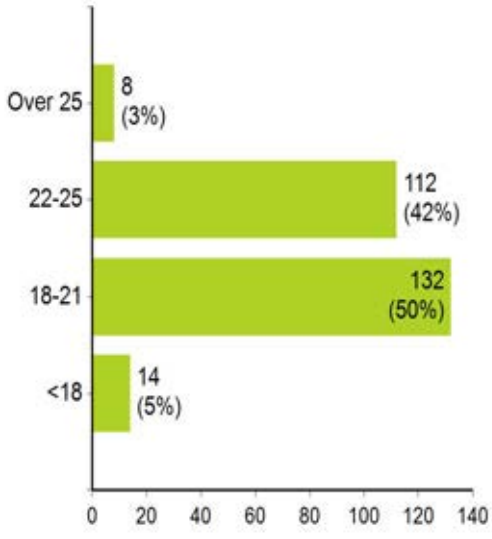
FSP TAY demographics and Outcomes for:
33G2FT Served by this reporting unit: 261

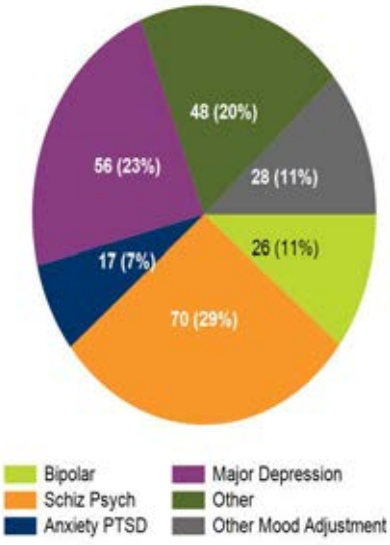
Demographics

50% of consumers were male and 50% were female.
12% of consumers were White, 30% were Latinx, and 10% were Black/African American.
50% of consumers were 18 to 21 years old.



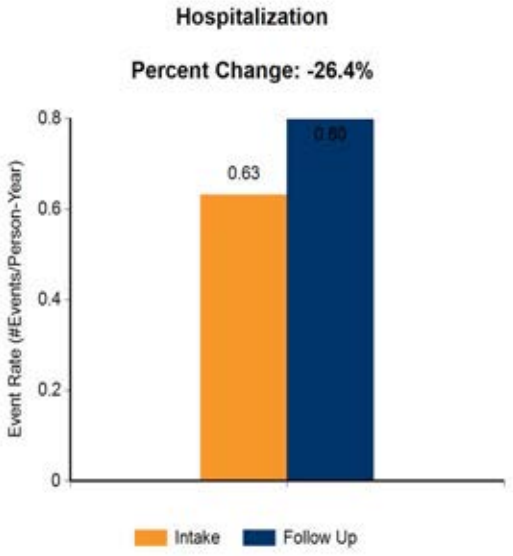


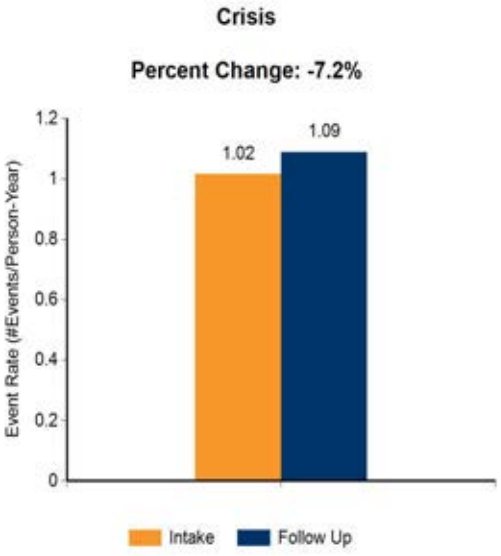


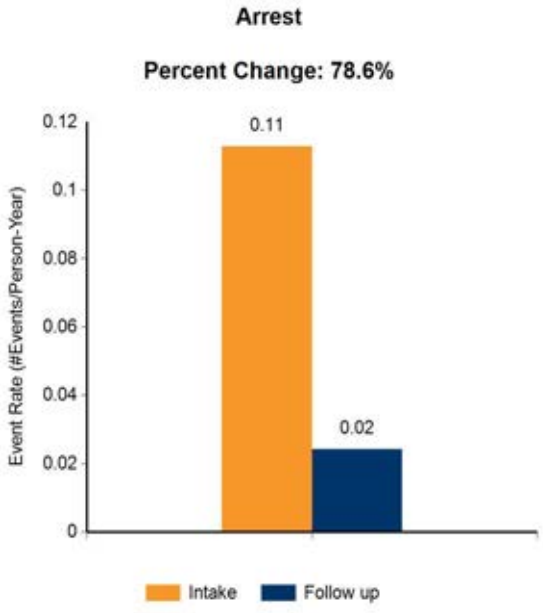


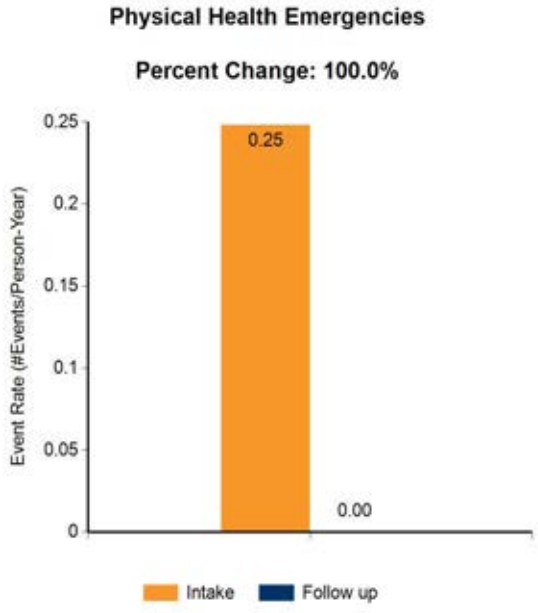
Outcomes for 33G2FT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

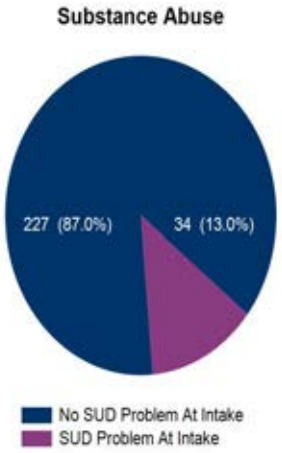


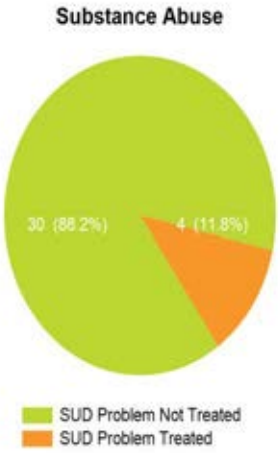






Outcomes: Substance Use (33G2FT)

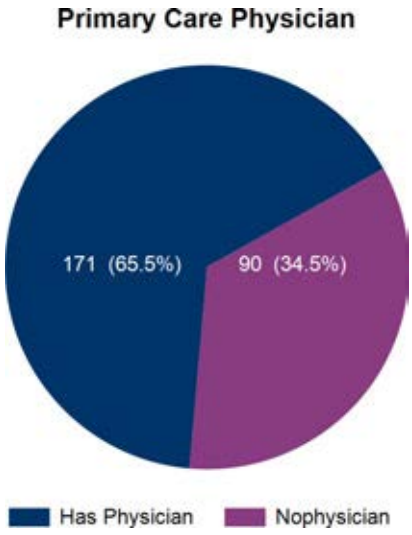




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (13.0%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 23.3% (7) of the 30 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 16 consumers not identified at intake were noted to have an SU problem on follow-up, and 13.0% were reported to be in SU services on follow-up.

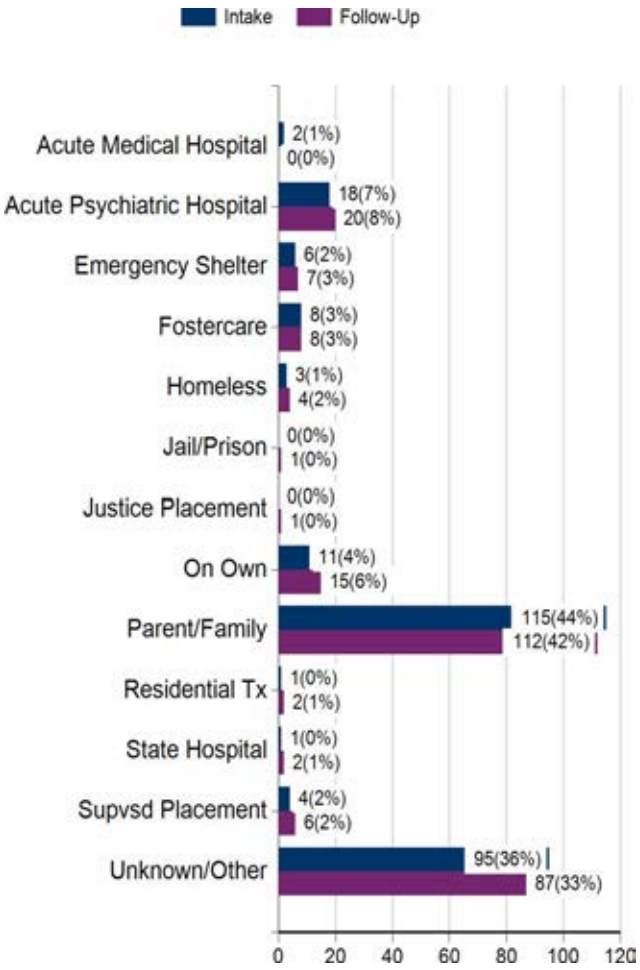
Outcomes: Primary Care Physician (33G2FT)



Intake: Most consumers (34.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 90 consumers who did not have a PCP at intake, 37 (41.0%) obtained one while in the program.

Outcomes: Residential & Discontinuance (33G2FT)



Discontinuation Reason	Count	%
Justice system	2	1%
Met goals	26	15%
Moved out of county/area	19	11%
Needs residential care	1	1%
Other	1	1%
Partner cannot be located	69	41%
Partner left program	48	29%
Target criteria not met	2	1%
Total	**168**	**100%**

Length of FSP Partnership for: 33G2FT

TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	21	20	41	15.41%
>= 2 Years and <3 Years	9	7	16	6.02%
>= 3 Years and < 4 Years	5	3	8	3.01%
>= 4 Years and < 5 years	2	1	3	1.13%
>= 90 days and < 1 Year	44	22	66	24.81%
>=5 Years and < 6 years	2	2	4	1.50%
>=6 Years+	1	5	6	2.26%
Under 90 days	85	37	122	45.86%
Total Consumer Enrollments	**169**	**97**	**266**	

Service Detail: 33G2FT

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	30 (32%)	29 (25%)	32 (50%)	48 (61%)	39 (47%)	27 (33%)	31 (37%)	20 (27%)	14 (19%)	17 (18%)	17 (17%)	23 (24%)
2-3	36 (38%)	37 (32%)	21 (33%)	22 (28%)	25 (30%)	28 (35%)	26 (31%)	22 (29%)	21 (29%)	20 (21%)	26 (26%)	26 (27%)
4-7	20 (21%)	37 (32%)	9 (14%)	8 (10%)	16 (19%)	21 (26%)	21 (25%)	20 (27%)	20 (28%)	37 (39%)	30 (30%)	29 (31%)
8-13	8 (8%)	10 (9%)	2 (3%)	0 (0%)	2 (2%)	5 (6%)	3 (4%)	9 (12%)	10 (14%)	17 (18%)	18 (18%)	10 (11%)
14-19	1 (1%)	2 (2%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	2 (3%)	6 (8%)	2 (2%)	6 (6%)	6 (6%)
20-25	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)	0 (0%)	2 (2%)	1 (1%)	1 (1%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	2 (2%)	0 (0%)
Monthly Total	95	115	64	79	83	81	83	75	72	95	100	95

Type of Service	% of TAY	# of Svcs	Avg. # Svcs

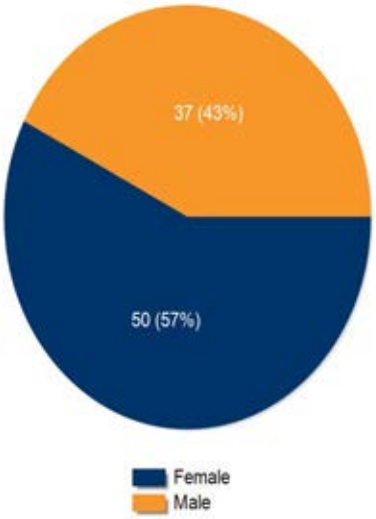
FSP TAY demographics and Outcomes for:
33H6FT Served by this reporting unit: 85
Enrollment: 87

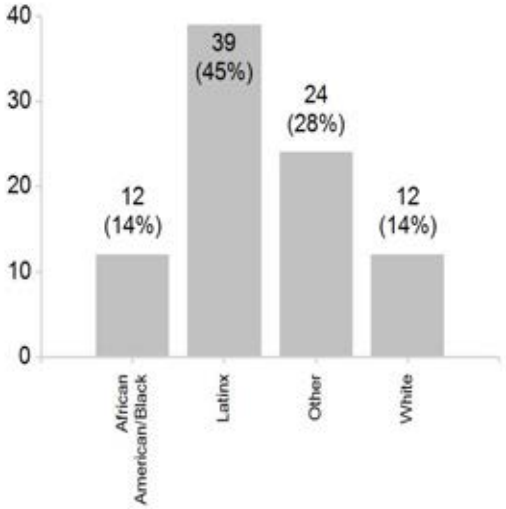
Demographics

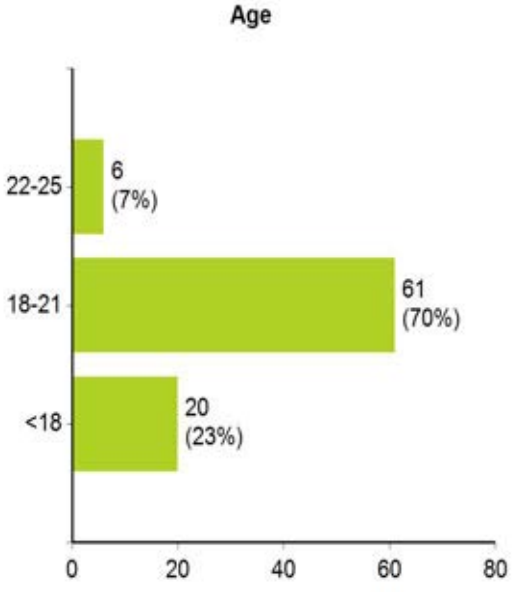
43% of consumers were male and 57% were female.

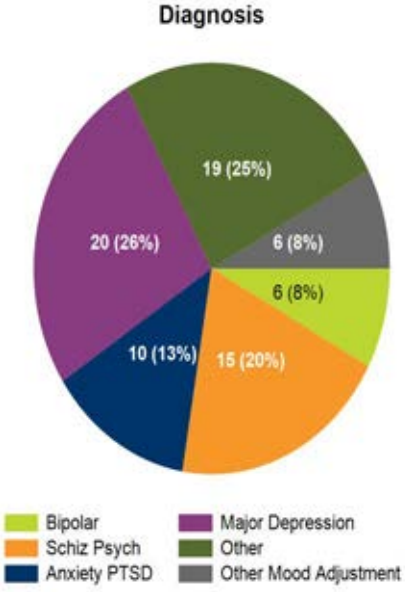
14% of consumers were White, 45% were Latinx, and 14% were Black/African American.

70% of consumers were 18 to 21 years old.



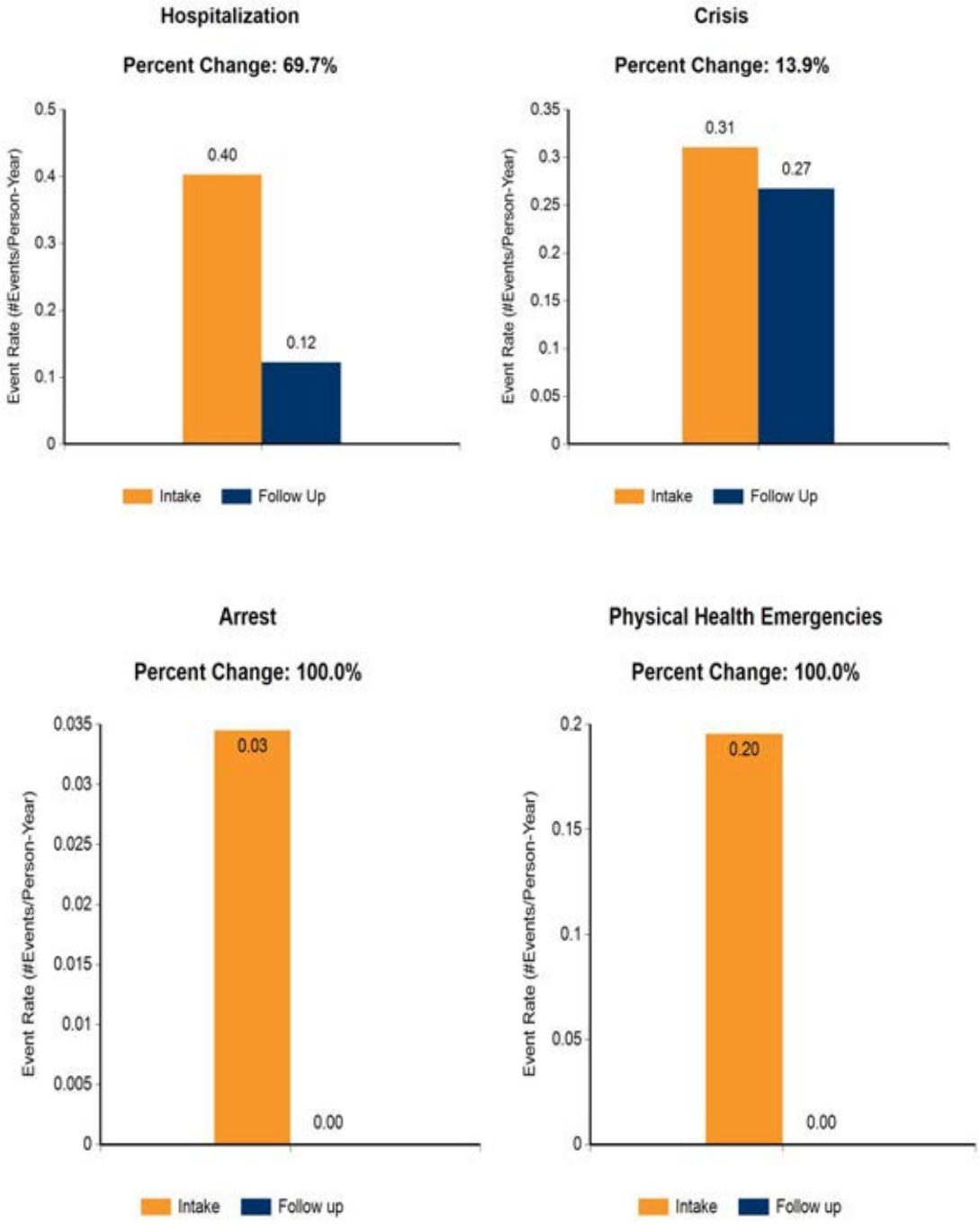






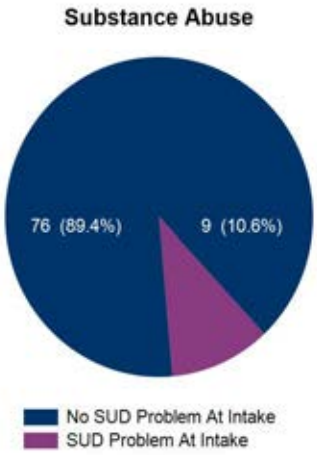
Outcomes for 33H6FT

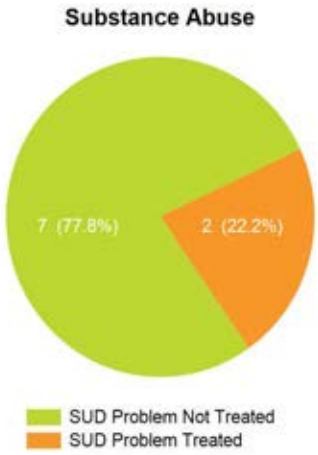
Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.



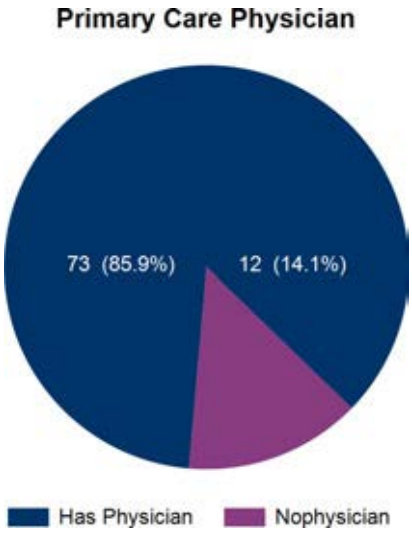
Intake: a significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) issues (10.6%). The majority of those with co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Outcomes: Substance Use (33H6FT)





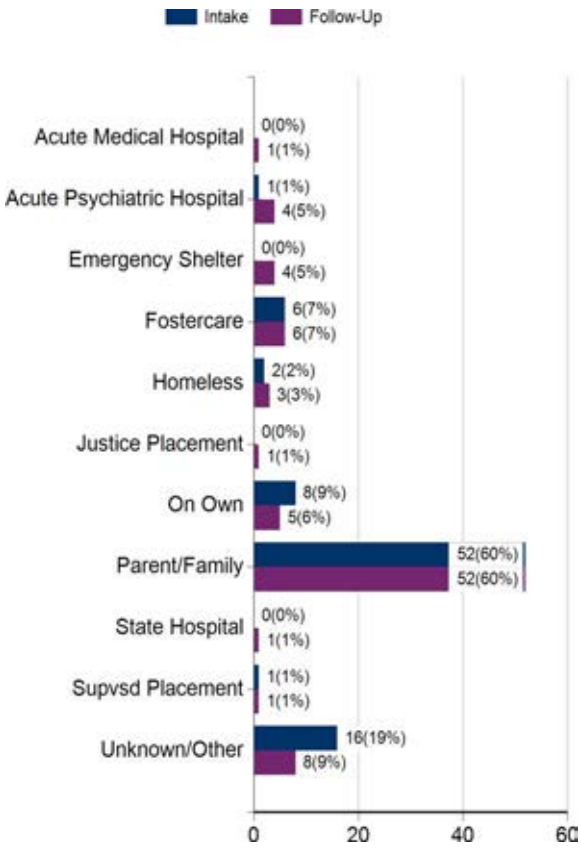
Follow-up: Based on quarterly follow-up data, 42.9% (3) of the 7 individuals with a co-occurring problem and no participation in SU services at intake were now involved in SU services. Additionally, 3 consumers who were not identified at intake were found to have an SU issue during follow-up, and 0.0% of them were reported to be in SU services on follow-up.



Intake: Most consumers (14.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 12 consumers who did not have a PCP at intake, 12 (100.0%) obtained one while in the program.

Outcomes: Residential & Discontinuance (33H6FT)



Discontinuation Reason	Count	%
Justice system	1	2%
Met goals	25	45%
Moved out of county/area	7	13%
Partner cannot be located	8	14%
Partner left program	7	13%
Target criteria not met	8	14%
Total	**56**	**100%**

Length of FSP Partnership for: 33H6FT

TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	13	4	17	19.54%
>= 2 Years and <3 Years	10	2	12	13.79%
>= 3 Years and < 4 Years	5	2	7	8.05%
>= 4 Years and < 5 years	3	3	6	6.90%
>= 90 days and < 1 Year	14	16	30	34.48%
>=5 Years and < 6 years	4	0	4	4.60%
>=6 Years+	3	0	3	3.45%
Under 90 days	4	4	8	9.20%
Total Consumer Enrollments	**56**	**31**	**87**	

Service Detail: 33H6FT

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	5 (8%)	2 (3%)	2 (4%)	0 (0%)	5 (9%)	1 (2%)	2 (4%)	2 (4%)	2 (5%)	2 (5%)	3 (8%)	1 (3%)
2-3	5 (8%)	6 (10%)	5 (9%)	8 (15%)	6 (11%)	9 (17%)	10 (19%)	10 (21%)	7 (16%)	5 (13%)	3 (8%)	2 (6%)
4-7	19 (32%)	12 (21%)	17 (30%)	12 (22%)	16 (29%)	16 (30%)	14 (26%)	15 (32%)	10 (23%)	5 (13%)	9 (25%)	8 (24%)
8-13	25 (42%)	28 (48%)	25 (44%)	20 (36%)	18 (32%)	19 (36%)	16 (30%)	15 (32%)	14 (32%)	17 (43%)	9 (25%)	8 (24%)
14-19	4 (7%)	7 (12%)	6 (11%)	9 (16%)	5 (9%)	6 (11%)	6 (11%)	3 (6%)	7 (16%)	5 (13%)	7 (19%)	8 (24%)
20-25	1 (2%)	2 (3%)	1 (2%)	3 (5%)	2 (4%)	0 (0%)	4 (7%)	1 (2%)	4 (9%)	4 (10%)	4 (11%)	3 (9%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (5%)	1 (2%)	1 (2%)	1 (2%)	0 (0%)	2 (5%)	1 (3%)	2 (6%)
32+	1 (2%)	1 (2%)	1 (2%)	3 (5%)	1 (2%)	1 (2%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)
Monthly Total	60	58	57	55	56	53	54	47	44	40	36	33

Type of Service	% of TAY	# of Svcs	Avg. # Svcs

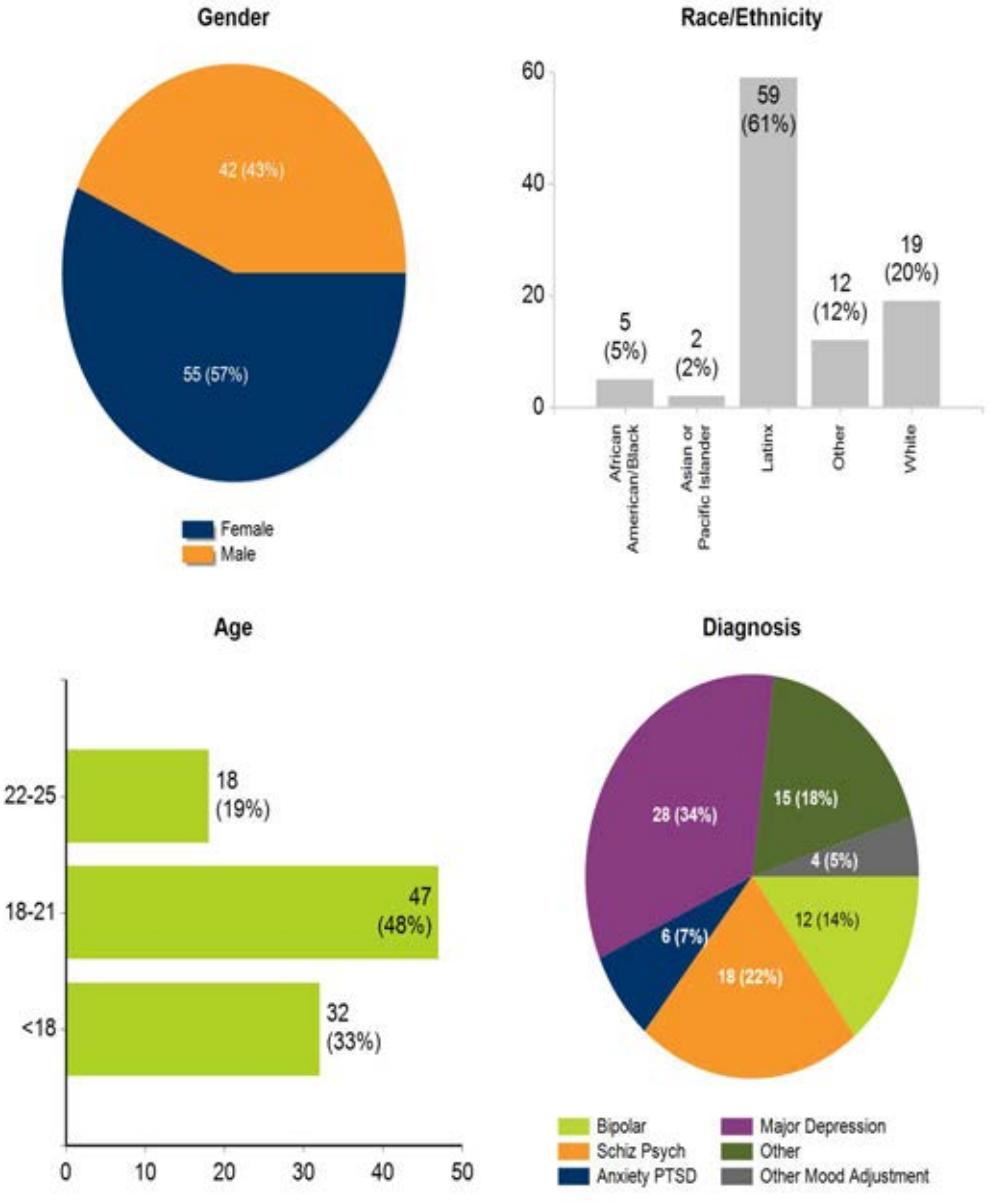
FSP TAY demographics and Outcomes for: 33HWFT Served by this reporting unit: 95

Demographics

43% of consumers were male and 57% were female.

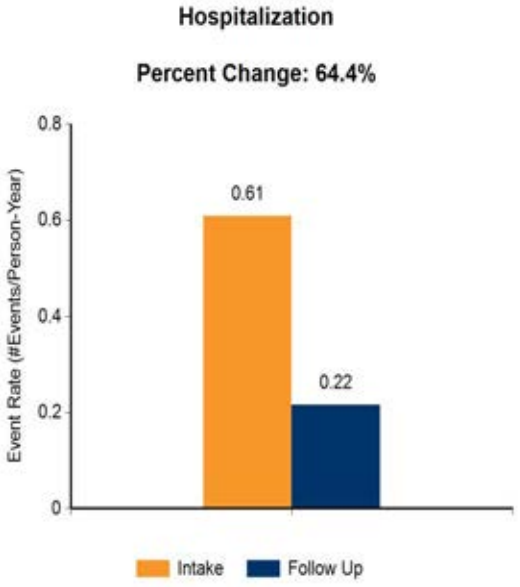
20% of consumers were White, 61% of consumers were Latinx and 5% of consumers were Black/African American.

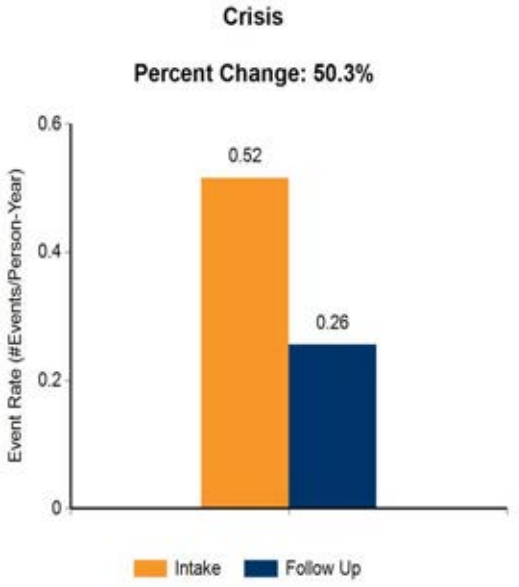
48% of consumers were 18 to 21 years old.

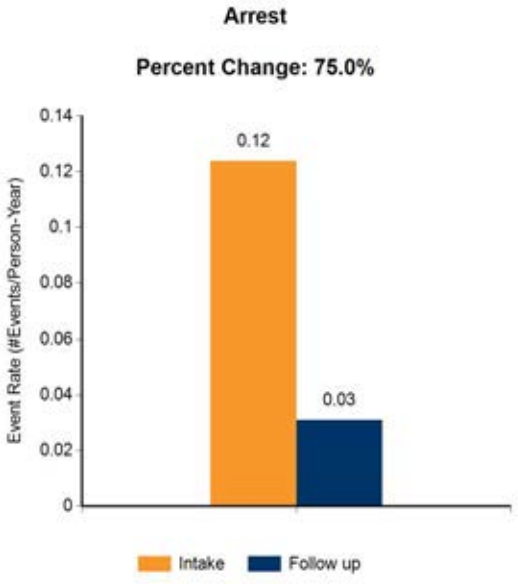


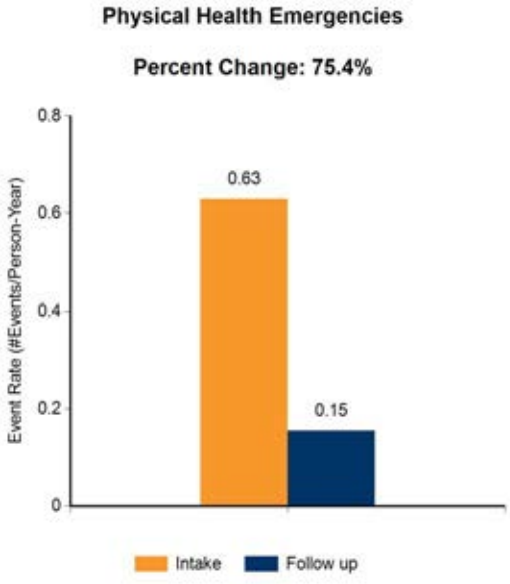
Outcomes for 33HWFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

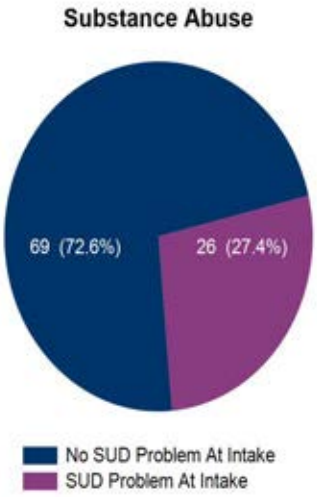


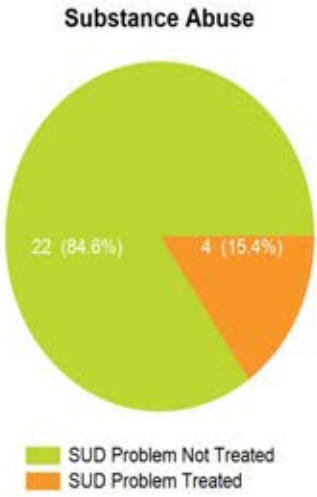






Outcomes: Substance Use (33HWFT)

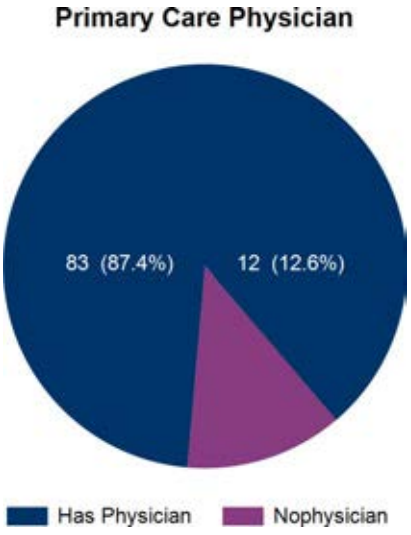




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 31.8% (7) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up, and 8.0% were reported to be in SU services on follow-up.

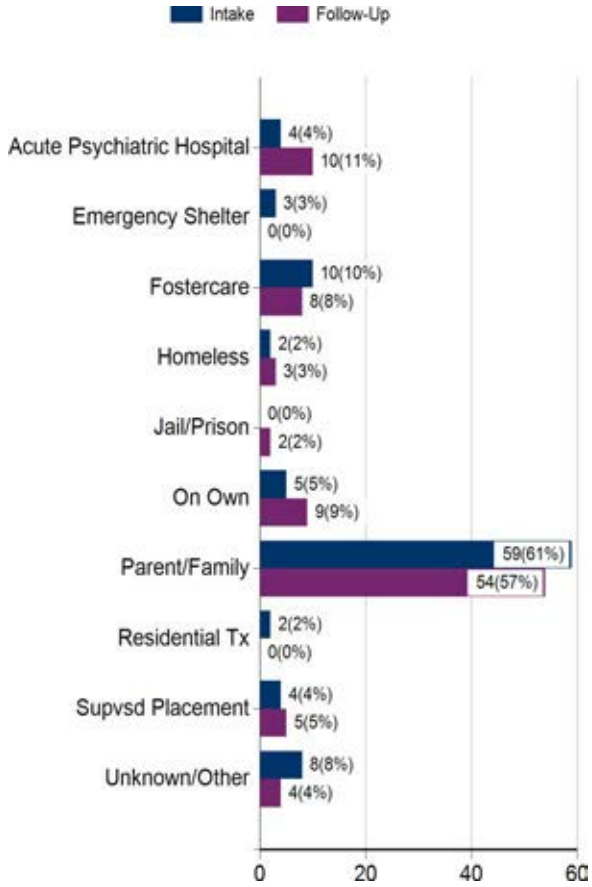
Outcomes: Primary Care Physician (33HWFT)



Intake: Most consumers (12.6%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 12 consumers that did not have a PCP at intake, 11 (92.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33HWFT)



Discontinuation Reason	Count	%
Met goals	6	18%
Moved out of county/area	8	24%
Needs residential care	1	3%
Partner cannot be located	7	21%
Partner left program	9	26%
Target criteria not met	3	9%
Total	34	100%

Service Detail:33HWFT

TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	9	10	19	61.29%
>= 2 Years and <3 Years	4	9	13	41.94%
>= 3 Years and < 4 Years	3	4	7	22.58%
>= 4 Years and < 5 years	2	6	8	25.81%
>= 90 days and < 1 Year	12	14	26	83.87%
>=5 Years and < 6 years	2	5	7	22.58%
>=6 Years+	2	5	7	22.58%
Under 90 days	0	10	10	32.26%
Total Consumer Enrollments	34	63	97	

Length of FSP Partnership for: 33HWFT

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	11 (17%)	10 (19%)	17 (32%)	11 (23%)	3 (7%)	9 (19%)	5 (10%)	9 (16%)	9 (17%)	9 (18%)	4 (7%)	4 (7%)
2-3	25 (38%)	16 (30%)	16 (30%)	13 (27%)	12 (26%)	14 (29%)	13 (27%)	18 (33%)	11 (21%)	9 (18%)	18 (32%)	16 (29%)
4-7	23 (35%)	17 (31%)	12 (23%)	16 (33%)	24 (52%)	12 (25%)	15 (31%)	16 (29%)	23 (43%)	14 (28%)	16 (28%)	26 (46%)
8-13	5 (8%)	9 (17%)	8 (15%)	4 (8%)	4 (9%)	10 (21%)	15 (31%)	9 (16%)	6 (11%)	6 (12%)	11 (19%)	3 (5%)
14-19	1 (2%)	2 (4%)	0 (0%)	4 (8%)	2 (4%)	3 (6%)	1 (2%)	3 (5%)	4 (8%)	5 (10%)	5 (9%)	5 (9%)
20-25	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (4%)	3 (5%)	2 (4%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (6%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (4%)	0 (0%)	0 (0%)
Monthly Total	65	54	53	48	46	48	49	55	53	50	57	56

Type of Service	% of TAY	# of Svcs	Avg. # Svcs

34 % of consumers were male and 66% were female.

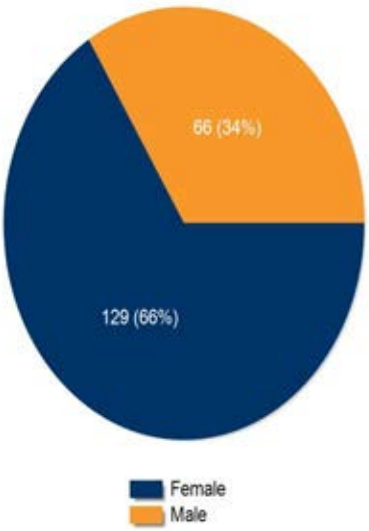
7% of consumers were White, 57% of consumers were Latinx and 8% of consumers were Black/African American.

54% of consumers were 18 to 21 years old.

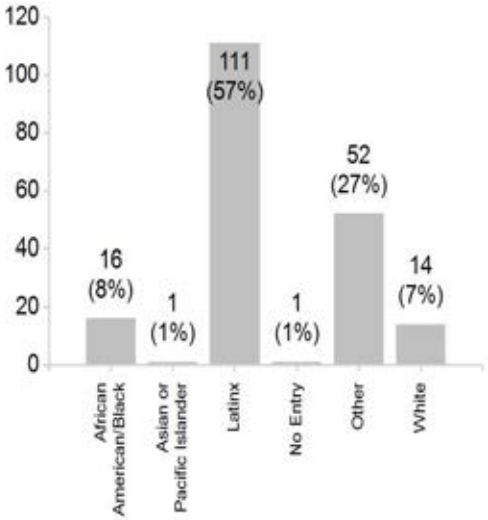
FSP TAY demographics and Outcomes for:
33O2FT Served by this reporting unit: 192
Enrollment: 195

Demographics

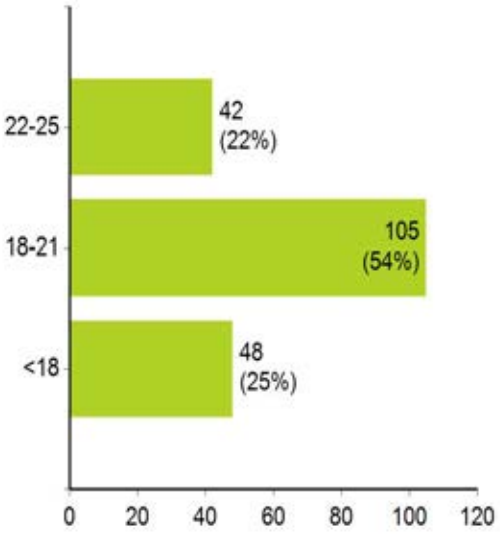
Gender



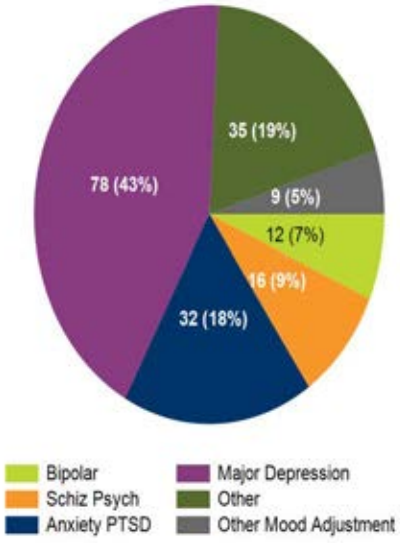
Race/Ethnicity



Age

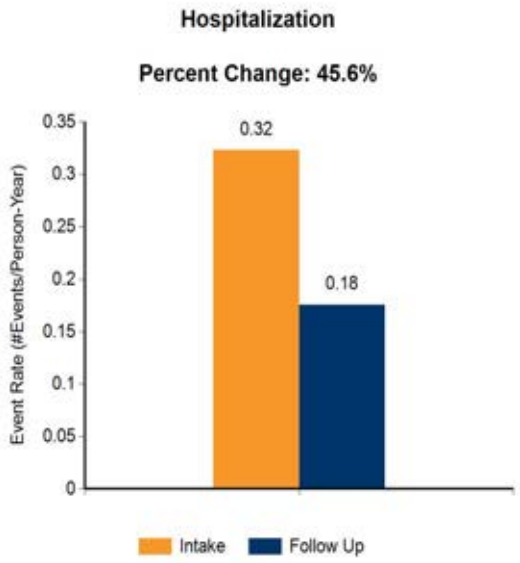


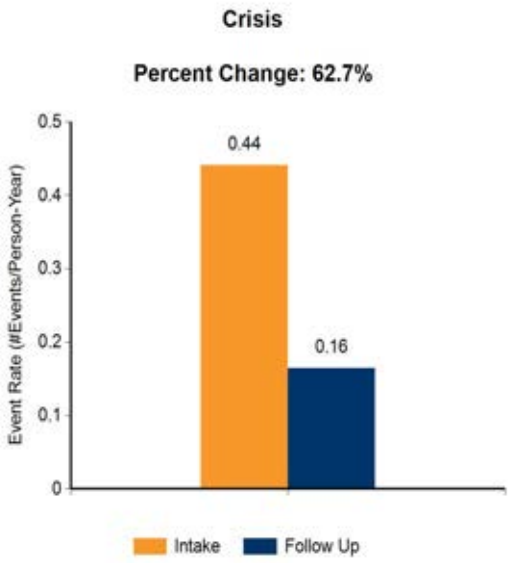
Diagnosis

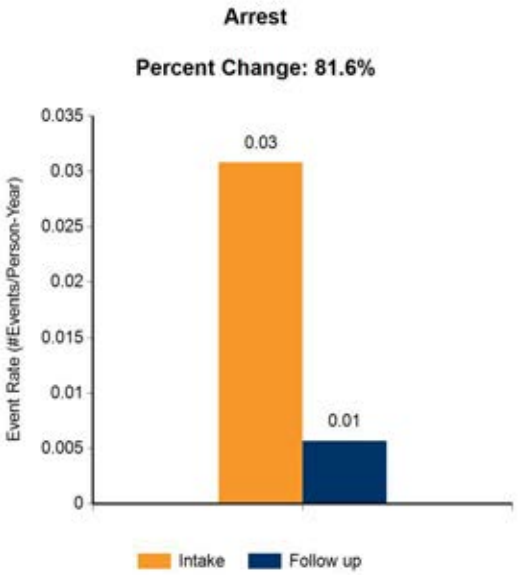


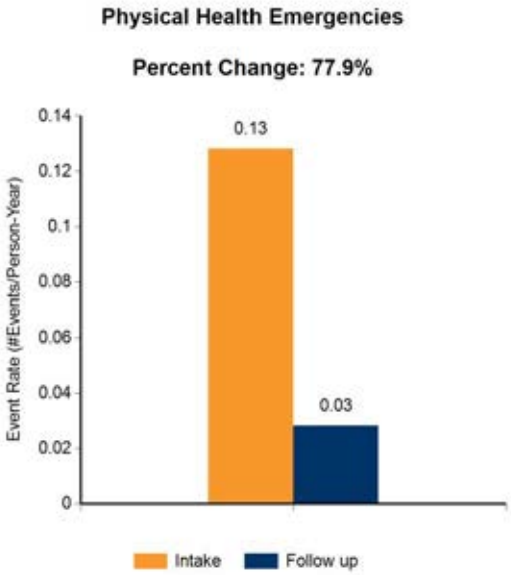
Outcomes for 33O2FT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

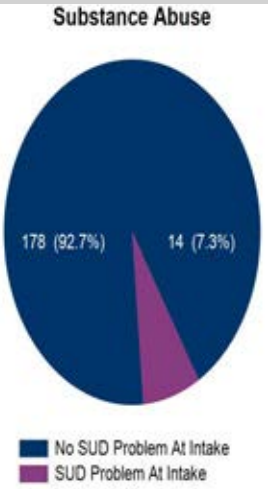


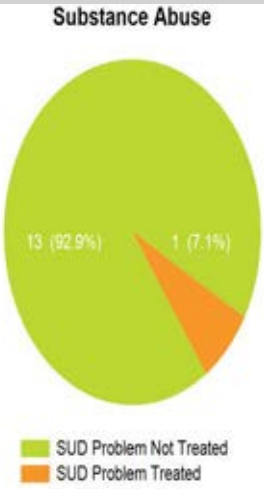






Outcomes: Substance Use (33O2FT)

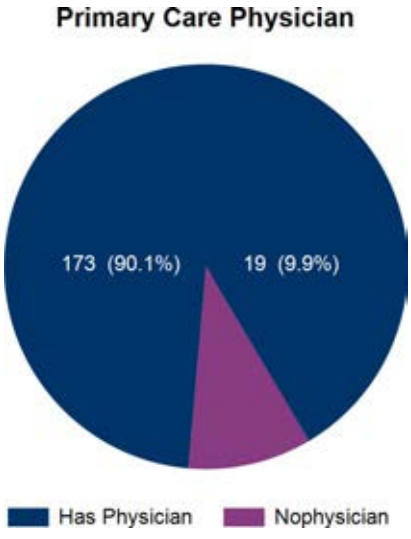




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (7.3%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 7.7% (1) of the 13 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 14 consumers not identified at intake were noted to have an SU problem on follow-up and 7.0% were reported to be in SU services on follow-up.

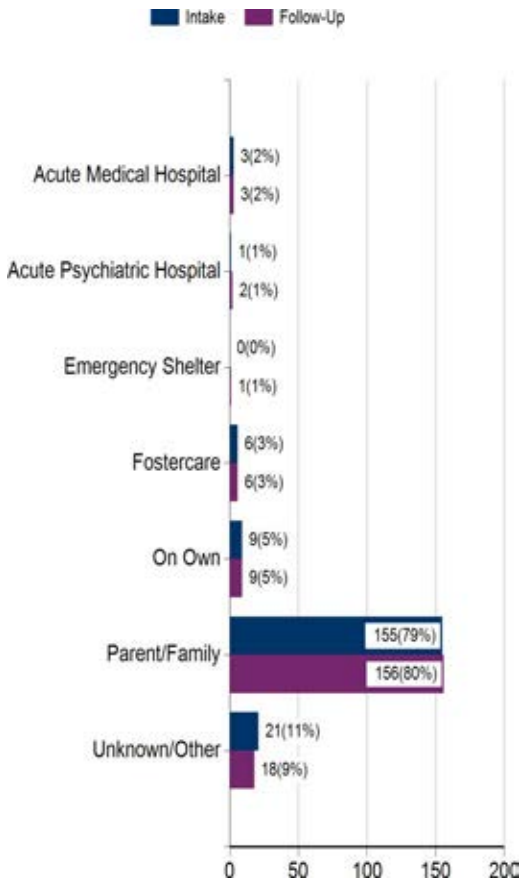
Outcomes: Primary Care Physician (33O2FT)



Intake: Most consumers (9.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 19 consumers that did not have a PCP at intake, 14 (74.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33O2FT)



Discontinuation Reason	Count	%
Met goals	14	19%
Moved out of county/area	5	7%
Needs residential care	6	8%
Partner cannot be located	34	47%
Partner left program	13	18%
Target criteria not met	1	1%
Total	**73**	**100%**

Length of FSP Partnership for: 33O2FT

TAY Time in Partnership
>= 1 Year and < 2 Years
>= 2 Years and <3 Years
>= 3 Years and < 4 Years
>= 90 days and < 1 Year
Under 90 days
Total Consumer Enrollments

Closed	Open	All Consumers	% of Total
11	20	31	15.90%
9	15	24	12.31%
0	4	4	2.05%
44	55	99	50.77%
17	20	37	18.97%
81	**114**	**195**	

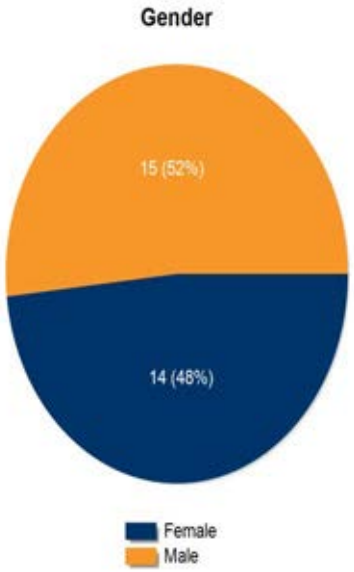
Service Detail: 33O2FT

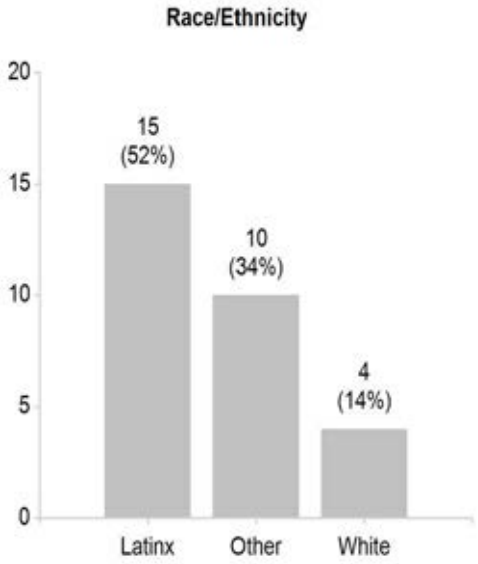
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	10 (11%)	14 (13%)	19 (18%)	21 (19%)	23 (21%)	27 (26%)	22 (23%)	21 (20%)	19 (18%)	22 (19%)	22 (20%)	20 (20%)
2-3	21 (23%)	22 (21%)	26 (25%)	31 (29%)	28 (26%)	25 (24%)	25 (26%)	27 (25%)	31 (30%)	30 (26%)	37 (34%)	38 (37%)
4-7	26 (29%)	29 (28%)	34 (33%)	28 (26%)	31 (29%)	35 (34%)	28 (29%)	42 (39%)	40 (38%)	39 (34%)	31 (29%)	29 (28%)
8-13	24 (27%)	24 (23%)	19 (18%)	20 (19%)	18 (17%)	13 (13%)	12 (13%)	12 (11%)	10 (10%)	17 (15%)	15 (14%)	11 (11%)
14-19	6 (7%)	11 (11%)	2 (2%)	5 (5%)	5 (5%)	2 (2%)	8 (8%)	3 (3%)	2 (2%)	6 (5%)	2 (2%)	4 (4%)
20-25	3 (3%)	3 (3%)	3 (3%)	3 (3%)	2 (2%)	1 (1%)	1 (1%)	2 (2%)	2 (2%)	1 (1%)	0 (0%)	0 (0%)
26-31	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)	0 (0%)
Monthly Total	90	104	103	108	107	103	96	107	104	116	108	102

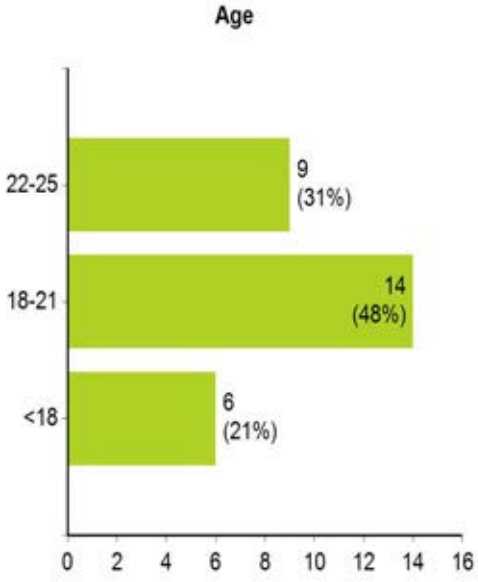
FSP TAY demographics and Outcomes for:
33OPFT Served by this reporting unit: 29
Enrollment: 29

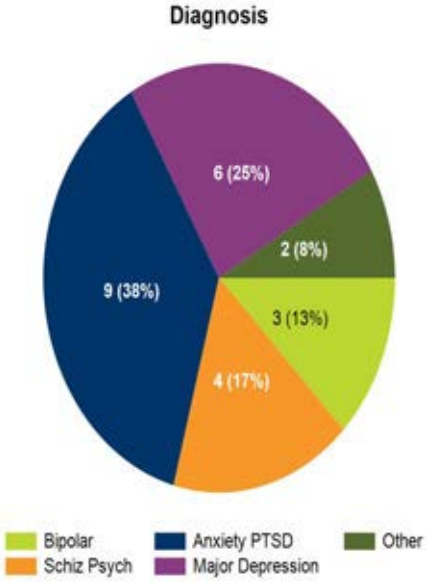
Demographics

52% of consumers identified as male, while 48% identified as female.
14% of consumers were White, 52% were Latinx, and 0% were Black or African American.
48% of consumers were aged 18 to 21 years old.





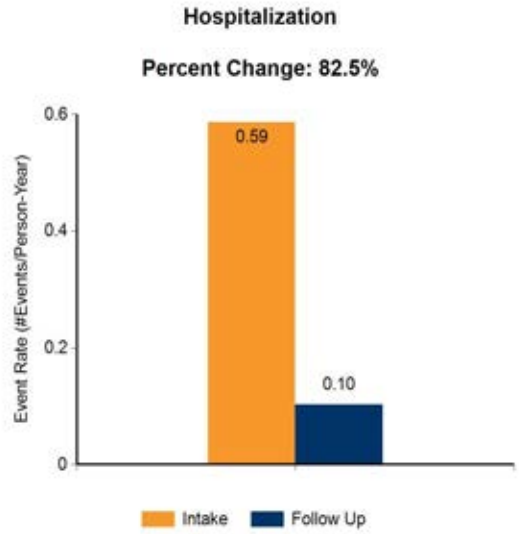


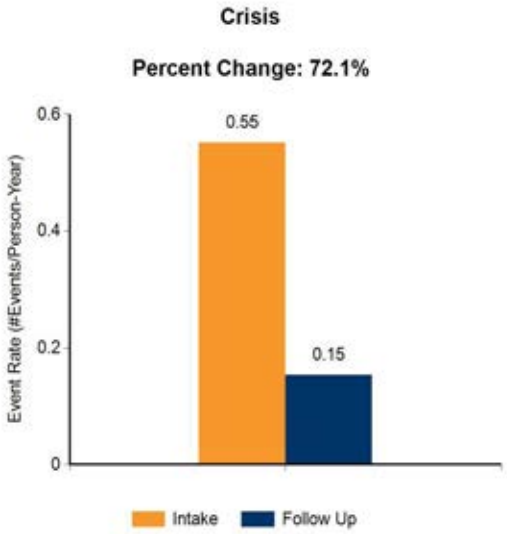


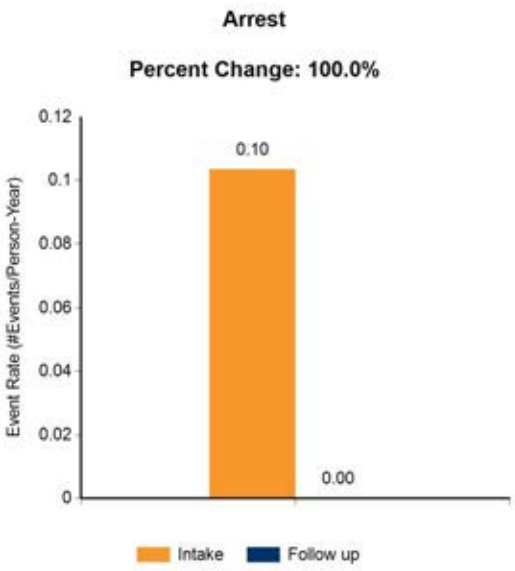
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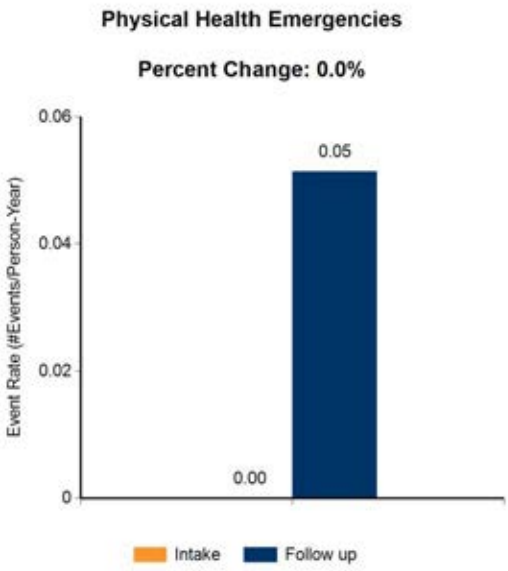
Outcomes for 33OPFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

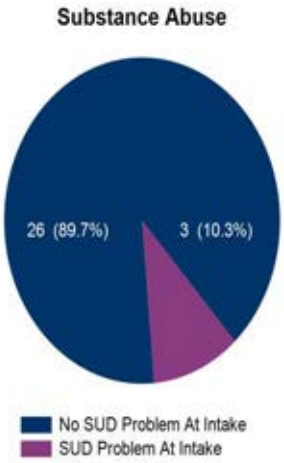








Outcomes: Substance Use (33OPFT)

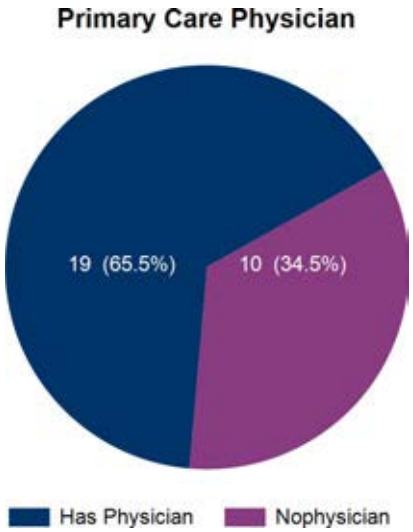




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (10.3%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 0.0% (0) of the 3 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 1 consumer not identified at intake was noted to have an SU problem on follow-up, and 0.0% of them were reported to be in SU services on follow-up.

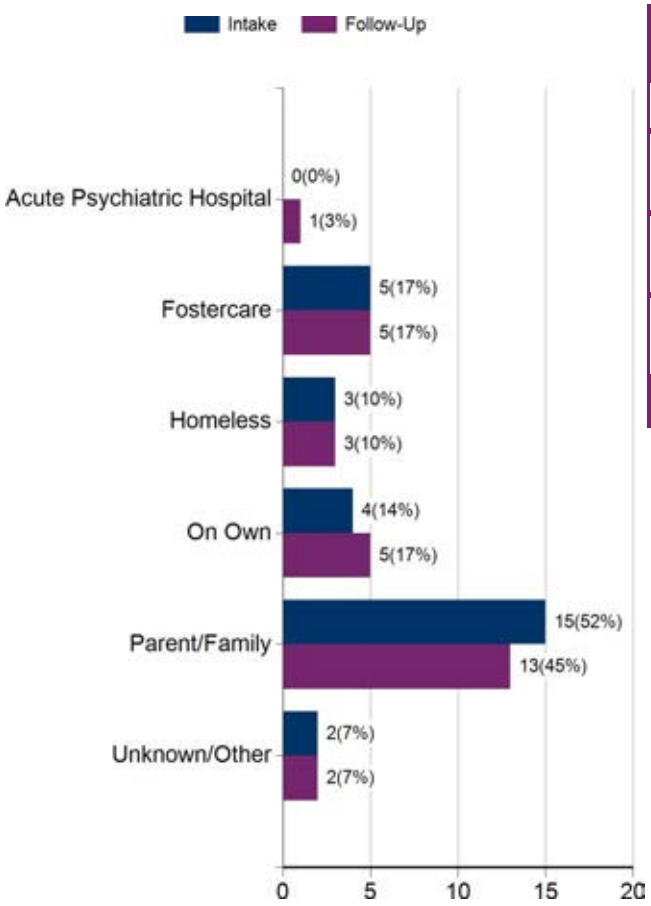
Outcomes: Primary Care Physician (33OPFT)



Intake: Most consumers (34.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 10 consumers that did not have a PCP at intake, 3 (30.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33OPFT)



Discontinuation Reason	Count	%
Met goals	2	20%
Partner cannot be located	4	40%
Partner left program	1	10%
Target criteria not met	3	30%
Total	**10**	**100%**

Length of FSP Partnership for: 33OPFT

TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	5	1	6	20.69%
>= 2 Years and <3 Years	1	0	1	3.45%
>= 90 days and < 1 Year	9	3	12	41.38%
Under 90 days	3	7	10	34.48%
Total Consumer Enrollments	**18**	**11**	**29**	

Service Detail: 33OPFT

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	2 (15%)	4 (31%)	3 (21%)	3 (25%)	4 (27%)	2 (29%)	2 (18%)	3 (33%)	1 (17%)	4 (40%)	3 (23%)	2 (18%)
2-3	7 (54%)	2 (15%)	4 (29%)	1 (8%)	6 (40%)	3 (43%)	6 (55%)	3 (33%)	1 (17%)	3 (30%)	3 (23%)	2 (18%)
4-7	3 (23%)	6 (46%)	5 (36%)	4 (33%)	2 (13%)	1 (14%)	2 (18%)	2 (22%)	3 (50%)	3 (30%)	3 (23%)	3 (27%)
8-13	0 (0%)	1 (8%)	2 (14%)	4 (33%)	1 (7%)	1 (14%)	0 (0%)	0 (0%)	1 (17%)	0 (0%)	1 (8%)	2 (18%)
14-19	1 (8%)	0 (0%)	0 (0%)	0 (0%)	1 (7%)	0 (0%)	1 (9%)	1 (11%)	0 (0%)	0 (0%)	2 (15%)	2 (18%)
20-25	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)
Monthly Total	13	13	14	12	15	7	11	9	6	10	13	11

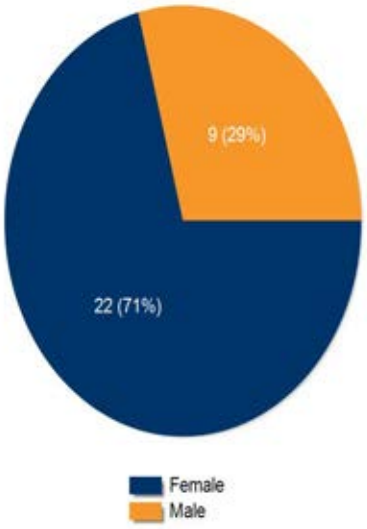
Type of Service	% of TAY	# of Svcs	Avg. # Svcs

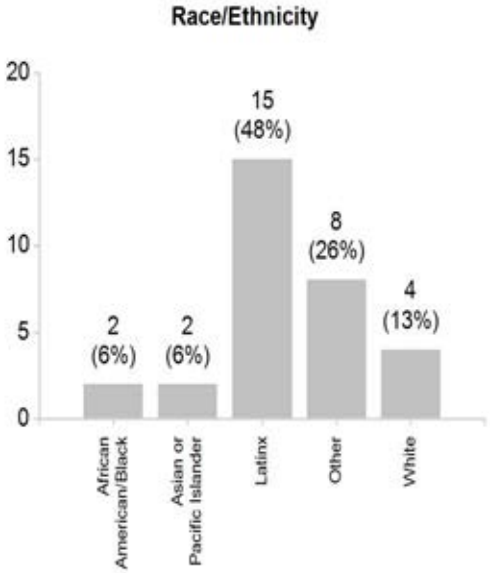
FSP TAY demographics and Outcomes for:
33PBFT Served by this reporting unit: 31
Enrollment: 31

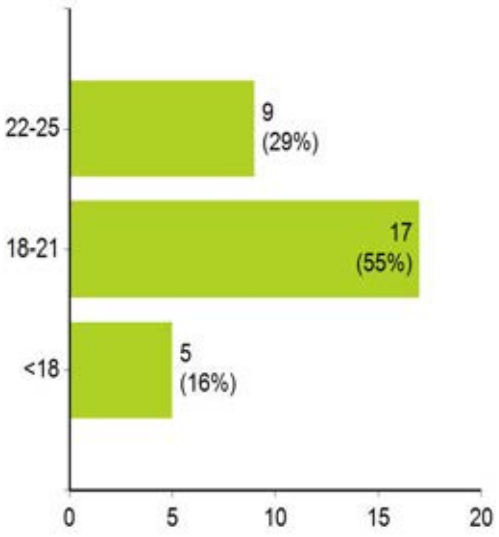
Demographics

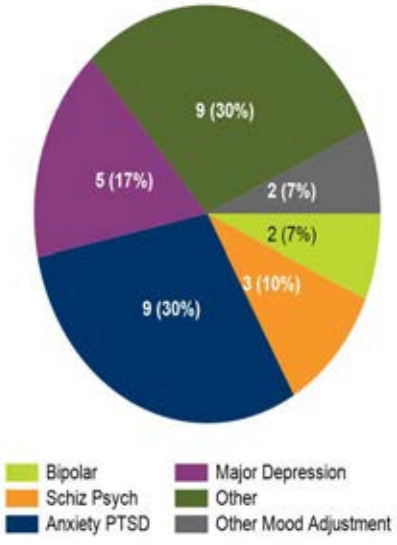
29% of consumers were male and 71% were female.
13% of consumers were White, 48% were Latinx, and 6% were Black/African American.
55% of consumers were 18 to 21 years old.

Outcomes for 33PBF



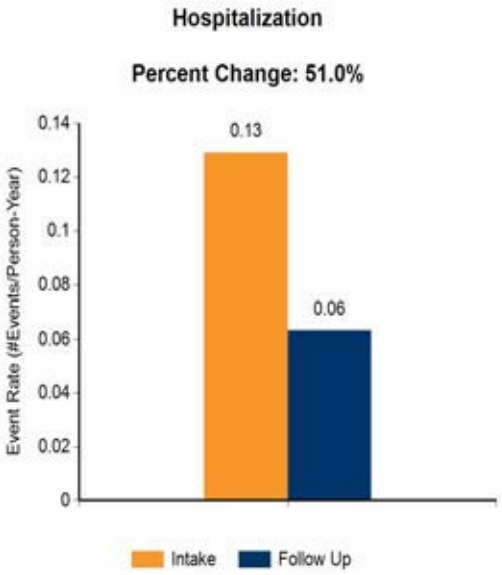


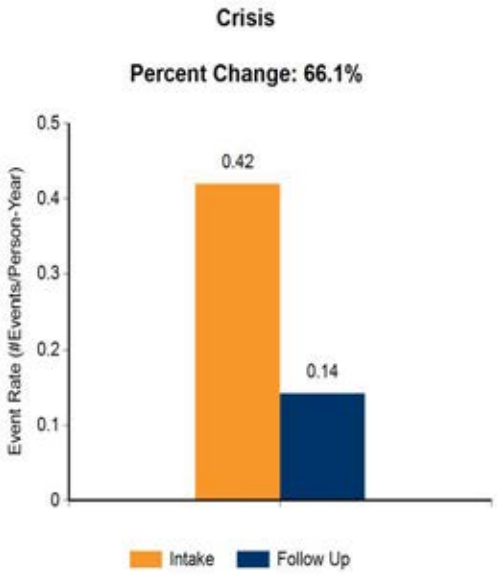


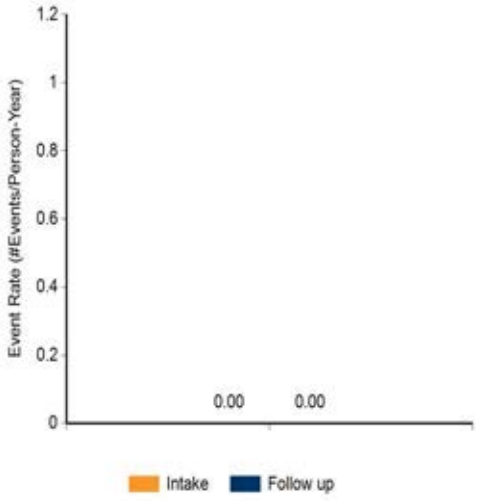


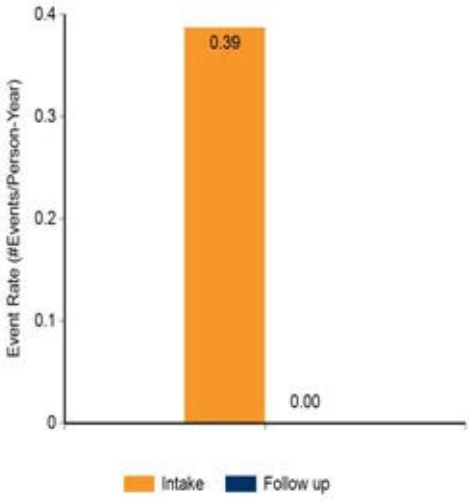
Outcomes for 33PBFT

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

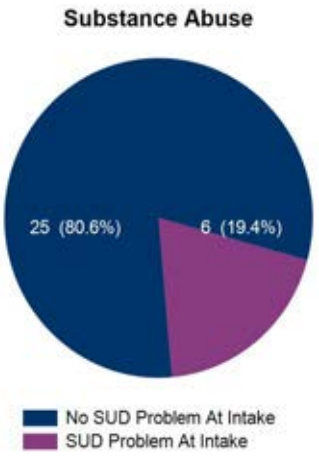


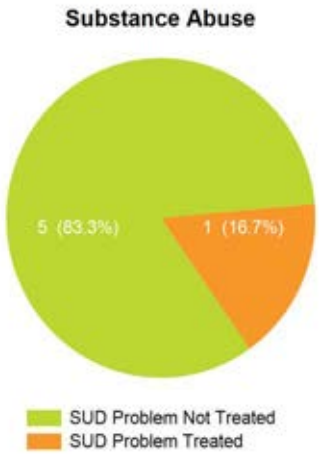






Outcomes: Substance Use (33PBFT)

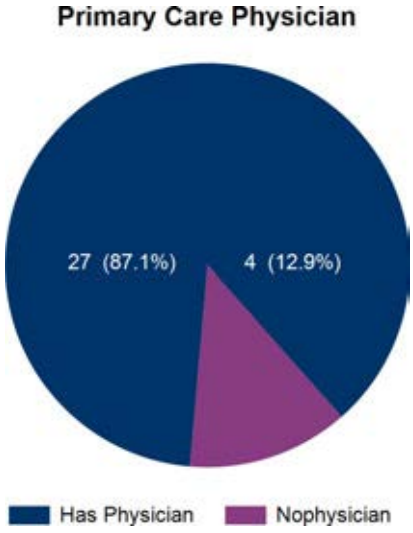




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (19.4%). The majority of those who had co-occurring MH and SU problems had not been receiving SU treatment services at intake.

Follow-up: Based on quarterly follow-up data, 0.0% (0) of the five people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional one consumer not identified at intake was noted to have an SU problem on follow-up, and 0.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33PBFT)

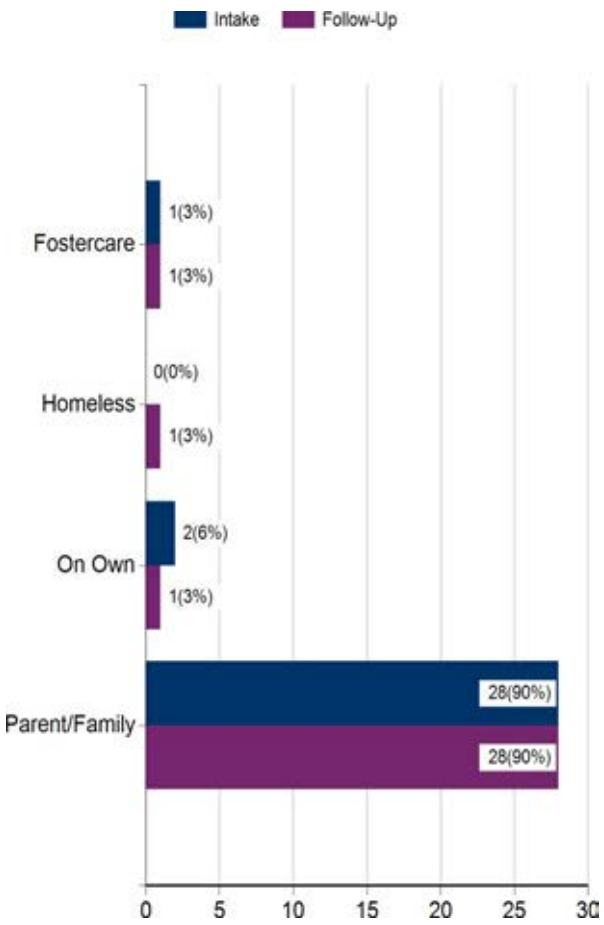


Intake: Most consumers (12.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 4 consumers that did not have a PCP at intake, 2 (50.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33PBFT)

Discontinuation Reason	Count	
Total	0	100%



Length of FSP Partnership for: 33PBFT

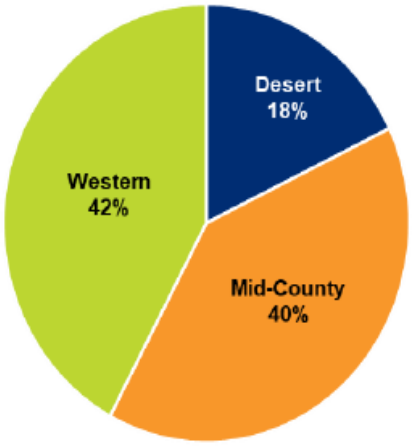
TAY Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	2	6	8	25.81%
>= 2 Years and <3 Years	10	3	13	41.94%
>= 3 Years and < 4 Years	1	4	5	16.13%
>= 90 days and < 1 Year	4	1	5	16.13%
Total Consumer Enrollments	**17**	**14**	**31**	

Service Detail:33PBFT

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	5 (21%)	7 (26%)	2 (10%)	0 (0%)	1 (5%)	0 (0%)	2 (11%)	5 (31%)	1 (7%)	1 (7%)	3 (21%)	1 (7%)
2-3	12 (50%)	8 (30%)	7 (35%)	5 (24%)	11 (50%)	10 (48%)	2 (11%)	3 (19%)	3 (20%)	3 (21%)	2 (14%)	8 (53%)
4-7	7 (29%)	8 (30%)	6 (30%)	6 (29%)	6 (27%)	6 (29%)	9 (50%)	5 (31%)	3 (20%)	8 (57%)	5 (36%)	3 (20%)
8-13	0 (0%)	4 (15%)	4 (20%)	7 (33%)	4 (18%)	3 (14%)	2 (11%)	1 (6%)	7 (47%)	1 (7%)	4 (29%)	3 (20%)
14-19	0 (0%)	0 (0%)	1 (5%)	3 (14%)	0 (0%)	1 (5%)	3 (17%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
20-25	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)	1 (6%)	1 (7%)	1 (7%)	0 (0%)	0 (0%)
Monthly Total	24	27	20	21	22	21	18	16	15	14	14	15

Type of Service	% of TAY	# of Svcs	Avg. # Svcs

TAY FSP



Youth served by TAY FSP was mostly provided by the Western region with 42% (292) of the clients served for the FY 23/24. Followed by the Mid-County 40% (277) and Desert with 18% (124).For a total of 693 clients in the FY 23/24.

The table summarizes the clients served by RU and region

RUs	Desert	Mid-County	Western	Total
33G2FT			261	261
33H6FT		85		85
33HWFT	95			95
33O2FT		192		192
33OPFT	29			29
33PBFT			31	31
Grand Total	**124**	**277**	**292**	**693**

Western Region: Journey TAY FSP

The Journey TAY Program outreaches to youth transitioning from adolescent services to adulthood ages 16 – 25. The program office is located in Riverside, California. Areas served include Norco, Corona, Riverside, Moreno Valley, East Valley, Jurupa Valley, Rubidoux, and adjacent unincorporated areas. Although staffing was challenging for fiscal years 22-23 and 23-24, Journey TAY FSP became fully staffed effective September 2024. The team is comprised of

(1) Behavioral Health Service Supervisor
(2) Office Assistants
(3) Behavioral Health Specialists
(1) Licensed Vocational Nurse
(1) Community Services Assistant
(2) Mental Health Peer Specialists
(3) Clinical Therapists
(.5) Psychiatrist.

3-Year Plan Goal Progress:

• Integrate a substance use counselor into the treatment team to facilitate coordinated care/treatment since half of consumers have substance issues.

- A Substance Use Counselor position was not added to Journey TAY FSP, and this goal was discontinued. The program has been utilizing SU CARES and/or the Substance Use program to provide substance services for Journey TAY consumers who are interested, willing, and able to participate. Additionally, Journey TAY FSP had two staff, one Clinical Therapist and one Family Advocate Peer, trained in Co-Occurring Disorders Treatment in the summer of 2024. The plan is to have these staff develop and facilitate a Co-Occurring consumer group during the summer of fiscal year 24/25.

• Increase partnership with the Family Advocate program to increase support and incorporate family advocate services into the program:

- Journey TAY FSP made referrals, as applicable, to the Family Advocate program until it can hire a Family Advocate for the program.

• Obtain a Family Advocate position, hire and fill the position, and integrate Family Advocate into the treatment team to provide education and support to family members of consumers served.

- A Family Advocate Peer was hired on November 2, 2023. The Family Advocate has been involved in meetings with family members and consumers, the monthly Transition Age Youth (TAY) and Family Focused Housing Collaborative, and the monthly Western Region TAY Collaborative. The Family Advocate attends and translates for families during doctor appointments, helps consumers and families access records through My Health Pointe, and responds to crisis issues in collaboration with the treatment team. The Family Advocate meets with family

members and consumers to assist them in engaging in mental health services, supports family members in attending family mental health presentations, and receives family advocate mental health support groups.

Journey TAY FSP Consumers Served 261 youth FY 23/24. The Journey TAY program had a 25% decrease in hospitalizations in FY 23/24 and a 78% decrease in arrests in FY 23/24. Crisis emergency room use decreased by 7.2%.

Mid-County Region TAY FSP

- Victor Community Support Services TAY FSP

The Victor Community Support Services (VCSS) Transition Age Youth Full-Service Partnership (TAY FSP), located in Perris, offers primarily community and home-based services throughout the region. These services include intensive case management and 24/7 phone support. While some individual services, groups, and medication support are available at the program site, the focus is on reaching youth in their own environments. The program serves young adults aged 16-25 who have long-standing mental health challenges and are at risk of ongoing acute hospitalization, homelessness, or incarceration. A multi-disciplinary team provides comprehensive support and services, encompassing mental health services like individual therapy, medication support, behavioral support, group therapy, and skill building. The team also offers vocational support, housing assistance, peer support services, and family support. Substance abuse referrals and linkages, along with recovery supports, are also integral components of the program.

Program Goals:

1) **Treatment Goal Achievement**

- Target: 70%
- Current Performance: 63%

2) Increase Utilization of ICC, IHBS, and CFTMs

- Target: 50%
- Current Performance:
    - ICC Services- 42%
    - IHBS Services- 21%
    - CFTMs Services- 22%

3) Other Notable Data:

January - December 2024

- Clients Served: 85 Clients

DEMOGRAPHICS

- 44% Male
- 55% Female
- 1% Other
- 10% African American/Black
- 17% Caucasian

- 50% Hispanic/Latinx
- 46% of consumers between 16-19 years old
- 11 clients served with eating disorder diagnosis

3-Year Plan Goals:

1- Models of Care Implementation:

Implement a robust Models of Care framework to improve service delivery, ensure consistency, utilize best practices, and ultimately enhance consumer outcomes. Our Models of Care framework provides a roadmap for effective and efficient service delivery, prioritizing service excellence by addressing the specific needs of the populations we serve. A key component is the use of standardized assessment tools to track client progress and identify areas requiring additional support.

We leverage the following assessments:

- Child and Adolescent Needs and Strengths (CANS): Assesses the mental health needs of children and adolescents.
- Client Assessment of Reintegration Scales (CAIR): Assesses the functional abilities of consumers with mental illness.

CAIR scores play a critical role in our Models of Care, enabling us to:

- Stratify consumers: Match consumers to the most appropriate model of care/program.
- Determine service frequency: Tailor service intensity to individual needs.
- Monitor treatment progress and length of service (LOS): Track client progress over time.
- Evaluate client outcomes: Measure the effectiveness of interventions.

2- Improving Outcome Data through Training:

We are committed to improving outcome data through ongoing staff training in evidence-based practices (EBPs). Over the past year, we have made significant progress in this area, providing training in:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Family-Based Therapy (FBT)
- Family Seeing (Family Finding Model)
- Transition to Independence Process Model (TIP)

This investment in staff training ensures the delivery of high-quality, evidence-based care and contributes to improved client outcomes.

- **TAY Expansion**

We submitted a comprehensive response to a Request for Proposal (RFP) aimed at significantly expanding our Transitional Age Youth (TAY) program. This expansion is crucial, as it would enable us to provide vital services to 120 unduplicated young adults in our community who are currently in need of support. These individuals, facing significant challenges as they transition to adulthood, would gain access to housing assistance, job

training, mental health support; through our expanded program, empowering them to achieve self-sufficiency and a brighter future

Desert Region TAY FSP

Oasis TAY FSP

The Oasis TAY FSP is in Indio and provides an array of services that include a combination of field-based services as well as on-site services to consumers ages 16 – 25. Oasis serves the Desert Region except for Blythe. Oasis provides intensive case management services that offer support and crisis response that is available 24/7. The program serves consumers who have a history of cycling through acute or long-term institutional treatment settings, consumers who are unengaged, and/or homeless (or at risk of homelessness). Services are provided by a multidisciplinary team that embraces the principles of recovery and resilience. The services and supports available through Oasis TAY FSP include but are not limited to psychiatric services, individual and group therapy, skill building, vocational services, housing assistance, substance abuse recovery services, peer support and mentorship, family advocacy, educational support, benefits assistance, and family education. Full staffing includes:

(1) Behavioral Health Service Supervisor
(1) Substance Use Counselor
(4) Clinical Therapists
(1) Mental Health Peer Specialist TAY Peer
(1) .5) Psychiatric Nurse Practitioner
(1) Health Peer Specialist Family Advocate
(1) Date and Records Clerk
(1) Quality Assurance.

Notable Data:

- 55% of consumers served were female, 40 % male, and 5 % transgender.
- 63% of consumers served were Hispanic/Latino; 17% Caucasian; 10 % African American/Black; 3% Asian or Pacific Islander; 1% other and 6% unknown.
- Average length of stay is 2.2 years (median 1.5 years).
- Average enrollment date for non-urgent referrals was 6.6 business days.
- Internalizing Disorders: 70% with mood disorders and 47% with anxiety disorders.
- Major Mental Illness: 37% with schizophrenia and other psychoses NOS

Program Specific Challenges:

- Environmental impacts affecting behavioral health (77%)
- Overall, close to 90% have more than one primary mental health diagnosis. There is also a high prevalence of substance use disorder, 26% overall, with 40% having risk in this area.
- In addition, 20% have overdose and/or self-harm risks.

Program Specific Successes:

- Implemented a comprehensive Dialectical Behavior Therapy program, which includes a beginning skills group, intermediate to advanced group, and individual and family skills sessions.
- Stars Behavioral Health Group was awarded a grant to participate in CBT-P training with Stanford University. One clinician will receive Level III certification in the full formulation training, and one is in the CBT-P skills group. All four therapists have completed Level I training in this program.

3-Year Plan Progress Goals

- Maintain an average monthly census of 85-90. Update: We maintained an average monthly census of 66, below our goal. Ongoing goal.

- Increase the number of clinical and mental health services in the clinical and mental health services groups. Update: Increased group services by 100%, with 341 group service entries for fiscal year 2023-2024. For comparison, only 36 group services were entered from July 1, 2023- to December 31, 2023, and 305 were entered from January 1, 2024, to June 30, 2024. Ongoing goal.

- Increase tracking of no-show rate and decrease no-show rate. Update: Increased monitoring of no-show rate; there was a substantial rate of contact between FSP providers, with only 2.3% of no-shows in the past year.

- Begin using and tracking collaborative documentation. Update: We began completing and tracking collaborative documentation in January 2023 and increased CD to 20%.

Annual Goal Highlights:

- Hired and retained staff, including maintaining four full-time Mental Health Clinicians (2 being bilingual) for 12 months or longer and 2 Peer Support Specialists hired in September 2024. Ongoing goal.

- Increase the number of ICC/IHBS services provided and continue tracking, which is an ongoing goal.

Adult Full-Service Partnership (FSP)

FSP Outreach and Facilitated Care Linkage

We conduct outreach and engagement to clients in acute psychiatric hospital care settings (Emergency Treatment Services, Inpatient Treatment Services, and the Desert Psychiatric Health Facility) by connecting them to Full-Service Partnership (FSP) services prior to hospital discharge. This starts engagement and wraps care around the client before they leave the hospital.

Outpatient program liaisons work with acute inpatient treatment staff and engage directly with consumers. This initiates the connection to help navigate outpatient care and encourage ongoing outpatient services. This early rapport-building creates a link to an FSP team, facilitates dedicated outreach and follow-up for consumers in pre-contemplative stages of change, and establishes a familiar face for those needing multiple outreach attempts before seeking care.

Psychiatric Liaisons from outpatient full-service partnership programs play a vital role in bridging the gap between psychiatric facilities and directly operated county outpatient mental health services, facilitating seamless transitions and continuity of care for individuals in need of psychiatric support. Intended outcomes include reducing homelessness, incarceration, and psychiatric hospitalization and increasing independent living and overall quality of life.

Western Region: Jefferson Wellness Center FSP

For FY 23-24, Jefferson Wellness Center Full-Service Partnership.
The Adult Full-Service Partnership (FSP) program is designed for adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive service program. The foundation of Full-Service Partnerships is doing “whatever it takes” to help individuals on their path to recovery and wellness. The Full-Service Partnership program embraces client-driven services and supports each client in choosing services based on individual needs. Unique to FSP programs are a low staff-to-client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers.

The Adult FSP program assists with housing, employment, and education while also offering mental health services and integrated treatment for individuals facing co-occurring mental health and substance abuse disorders. Services are delivered in individuals' homes, communities, and other locations. Peer support groups are available. A key element of Full-Service Partnerships is the commitment to offering culturally and linguistically competent and appropriate services. Members have 24/7 access to dedicated professionals who are committed to helping them achieve important goals such as health, well-being, safety, and stability.

The focal populations include those with a serious mental and persistent mental illness that results in difficulty functioning and experiencing chronic homelessness, justice involvement, psychiatric hospitalization, or long-term care needs due to mental health impairments. community resources. The FSP Program implemented expansion efforts in December 2022 to focus enrollment efforts on psychiatrically hospitalized patients at the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility for the purpose of the post-discharge continuum of care and appropriate FSP level of care linkage.

The program has integrated and assigned a full-time BHS II staff Liaison at ITF to focus on FSP enrollment after psychiatric hospitalization and prevent future hospitalizations and decompensation in the outpatient level of care.

The FSP uses a multidisciplinary team approach when providing services and support. The FSP team comprises a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists II, a Licensed Vocational Nurse, Peer Support Specialists, a Family Advocate, and a Community Services Assistant. The team also consistently collaborates with other community-based agencies, including local shelters, Probation, Vacation programs, Urgent care, CRT, and hospitals. Examples of multi-disciplinary services that are provided include, but are not limited to, Outreach and Engagement; Case Management, which includes linkage to community resources, Assessment, Crisis Intervention, Behavioral Health Services (Individual, family, and group therapies), Medication support (Psychiatric Assessment, Medication services and Nursing support), Dialectical Behavior Therapy (DBT), Seeking Safety, Care Coordination Plan development, Peer Support Services, that includes WRAP and Wellness groups, Women's and Men's Support groups, and Adjunctive and Collateral services, such as Probation, family, and other outside supports

Enhanced Care Management (ECM):

Enhanced Case Management (ECM) was implemented at Jefferson Wellness Clinic FSP on January 1, 2022, and reassigned to the Forensics / Public Guardian / Housing division HHOPE program effective September 19th, 2024.

Progress Data

Below are data highlights for Jefferson Wellness Center for the FY 23-24. This data is from The Full-Service Partnership Adult Outcomes Report for fiscal year 2023 - 2024.

Jefferson Wellness Center FSP:

• The program served and enrolled FSP 366 clients in FY 23/24 at the Jefferson Wellness program.
• More than a third of clients received 8 or more monthly services.
• The services provided were Individual Mental Health Services, Medication Services, and Case Management.
• Arrests were down 97% for Jefferson Wellness Center clients.

• Acute hospitalizations were down 38% for Jefferson Wellness Center clients, and crisis emergency room use decreased by 30%.
• The percentage of clients living independently increased from 14% to 18%.
• Homelessness decreased from 17% to 15%.

Three-year plan goal:

• Increase the frequency of services provided to enrolled FSP clients so that 85 percent receive an average of 5-8 or more services a month to improve member outcomes.

• Increase enrollment of psychiatric hospitalized patients at the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility to establish a post-discharge continuum of care and appropriate FSP level of care linkage.

• Decrease acute hospitalizations for Jefferson Wellness Center clients and crisis emergency room utilization.

• Continuous focus on lowering criminal justice involvement, reducing homelessness, and fewer hospitalizations and emergency department visits.
• Increase member linkage to housing, substance use disorder services, ECM services, and primary care resources to address physical health needs and adhere to the Cal Aim no wrong door at the point of entry.

Adult Outpatient Clinics FSP Tracks

Western Region: Blaine Street Clinic FSP Expansion

Blaine Street Clinic is an integrated adult outpatient program that provides access to a wide range of recovery and rehabilitation services and supports to adults ages 18 – 59 diagnosed with a severe and persistent mental illness who are living in the Western Region of Riverside County. The clinic offers comprehensive mental and psychiatric treatment services, integrated behavioral health outpatient services, and coordination of medical treatment. Treatment modality includes crisis intervention, psychiatric assessments, recovery management, medication services, case management, and dual-diagnosis treatment. Services are provided by a multidisciplinary staff of mental health professionals: Psychiatrists, Nurses, Clinical Therapists, Clinical Student Interns, Behavioral Health Specialists, Peer Support Specialists, Family Support Specialists, and Community Services Assistants.

Providers collaborate with consumers to develop individualized plans to address each person's goals for recovery. The collaborative care approach encompasses peer-to-peer support, individual and group therapy, recovery-oriented support groups, and specialized group treatment focusing on consumers recovering from both behavioral health and substance use challenges. Additionally, the provision of direct services and collaborative care include but are not limited to building support networks through the inclusion of family and supportive partners in the planning and recovery process, case management to facilitate linkage to community resources, programs, and other agencies as needed, peer and family support services, medical care and health education.

Program:
The FSP target population is adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive outpatient service program. The focal population meets one or more of the following criteria: homeless, justice-involved, and high utilizers of psychiatric hospitals or long-term care facilities due to mental health impairments. In December 2022, the FSP program implemented collaborative care processes with the Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility (ITF) for the purpose of linking psychiatrically hospitalized patients to FSP level of care post-discharge. Embedded in Full-Service Partnerships is a commitment to deliver services in culturally and linguistically competent and appropriate ways. In FY 23-24, the Blaine FSP served, and FSP enrolled 191 consumers. Two-thirds of the Blaine FSP served had 4 or more services each month.

- Psychiatric hospitalizations decreased 48%, and crisis usage decreased 22%. Hospitalizations for Physical Health also decreased by 30%
- Arrests decreased 38%

Program Goals:

• Increase FSP enrollment to reach capacity and maximize service delivery. This includes increasing the high utilization of enrollment through collaboration with Riverside County Regional Medical Center (RCRMC) Inpatient Treatment Facility (ITF).

• Increase the average number of services provided to enrolled FSP clients so that 80% receive an average of 5-8 or more services a month to improve member outcomes.

• Reduce severe mental health symptoms, homelessness, incarceration, and psychiatric hospitalization.

• Continuous focus on lowering criminal justice involvement, reducing homelessness, and fewer hospitalizations and emergency department visits.

• Increase field-based treatment modality individual and group treatment.

• Increase member linkage to housing, substance use disorder services, ECM services, and primary care resources to address physical health needs and adhere to the Cal Aim no wrong door at the point of entry.

Desert Outpatient Adult FSP

Other Desert Region Outpatient programs are developing FSP service tracks in outpatient clinics within the Desert Region. These FSP tracks operate in Children's, Transitional Age Youth, Adult, and Mature Adult programs. The Adult Outpatient Clinic program's current FSP consumer census is as follows:
Indio Outpatient Clinic: 145
Banning Outpatient Clinic: 45
Blythe Outpatient Clinic: 14

These clinics have transitioned appropriate current and future consumers into FSP programming within their services. The process of transitioning consumers who meet the criteria for this higher level of need is based on current staffing levels as well as consumer challenges and their ability to benefit from this higher level of care. The Banning Outpatient Clinic has seen success in creating a distinct FSP team inside of the Outpatient clinic. The Indio Outpatient Clinic has also developed distinct FSP service teams due to a significant increase in identified consumers, including the transition of previous Oasis Case Management FSP consumers. The team comprises a Clinical Therapist, a Behavioral Health Specialist, and a Peer Support Specialist. This has resulted in increased field-based services, improved engagement in treatment services to include psychiatry and therapy (group and individual), and increased facilitation of entry into permanent housing. Another contributing factor in the increase of the FSP census in Desert Adult Outpatient programs is the entry of all consumers who enter ITF and PHF units while the consumer is still in the unit. The outpatient staff works collaboratively with liaisons on ITF and PHF to open consumers into services and complete the PAF for

enrollment into FSP services. Upon discharge from the psychiatry facility, the FSP team works to engage the consumer in services.

Evidence-based Practices utilized in Desert Adult Outpatient clinics include Dialectical Behavior Therapy, CORE, and Seeking Safety. Delivering these EBPs in conjunction with providing these more intensive FSP-level services is intended to decrease psychiatric hospitalization and incarceration, increase support to assist consumers with obtaining and maintaining housing, and assist consumers with developing life skills to create sustainable self-sufficiency.

The consumers who have transitioned to this level of care have verbalized that this level of service has benefited their wellness and recovery, including decreasing barriers to accessing care due to staff engaging in field visits and linkage with community resources such as housing. The staff who have been able to provide this level of care have verbalized their enjoyment in working more intensively with this consumer population and acknowledge the challenges when consumers experience relapses in their recovery. The newly defined FSP team has experienced some challenges as the FSP caseload quickly increased due to ITF entries and improved community engagement.

Desert Adult Outpatient Goals:

1. Increase the number of unique FSP consumers served in outpatient clinics.
2. Increase in the number of field-based services provided.
3. Increase engagement in psychiatry and other therapeutic services as evidenced by an increase in a number of services provided.

Desert: Oasis Case Management Team

The success of the Windy Springs program has fostered an examination of programs that could benefit from enhancement to the FSP level of care. One of these programs is the longstanding program of Oasis Case Management.

A central goal of this program is early engagement in intensive case management services to enhance symptom reduction and assist consumers with meeting longer-term goals. This program provides intensive case management and outpatient care.

The Oasis Case Management Team served 427 FSP consumers. We have increased the Oasis Case Management services to include in-reach services to hospitalized consumers. This program aims to improve follow-up care in outpatient FSP or clinic outpatient care. Outpatient care is provided onsite to 50 board and care consumers and includes intensive case management and group and individual therapy services. Evidence-based Practices utilized include Dialectical Behavioral Therapy.

Goals for Oasis Case Management Program:

- Decrease in psychiatric hospitalizations.
- 2. Maintain housing in the least restrictive setting, including entering community housing vs. board and care.

- 3. Improve linkage and follow-up with both FSP and non-FSP outpatient services, as evidenced by consumers entering outpatient RU and transitioning out of the Oasis Case Management program when appropriate.
    - 44% had a schizophrenia psychosis diagnosis
    - 60% of consumers were male and 40% were female.
    - 27% of consumers were White, 44% were Latinx and 9% were Black/African American.
    - 20% of consumers were 40 to 49 years old
    - Acute hospitalizations were down 19.9%, and crisis emergency room use decreased by 15%.
    - Arrests were down by 100%
    - Based on quarterly follow-up data, 1.8% (4) of the 220 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional six consumers not identified at intake were noted to have an SU problem on follow-up, and 2.0% of them were reported to be in SU services on follow-up.
    - Most adults (76.3%) did not have a primary care physician (PCP) at intake. At follow-up, of the 326 consumers that did not have a PCP at intake, 1 (6%) obtained a PCP while in the program
    -

Desert Region: Windy Springs Wellness Center FSP

Currently located at Windy Springs, 19531 McLane Street, Suite B, Palm Springs, CA 92262. The Windy Springs Program, or Desert Adult Full-Service Partnership (DAFSP), is an intensive psychiatric case management program for Desert Region Riverside County residents with severe persistent mental illness, a history of chronic homelessness, and multiple psychiatric hospitalizations. Full Services Partnership (FSP) programs were designed in the Mental Health Service Act to serve consumers in chronic need of stabilization. The FSP also addresses the needs of consumers who have not responded to traditional outpatient behavioral health programs. These services remain a priority for Riverside University Health System – Behavioral Health. Services include: psychiatric care, medication management, intensive case management, crisis services, 24/7 after-hours hotline, housing assistance, Dialectical Behavioral Therapy (individual and group), substance abuse treatment and relapse prevention, peer support care, and family advocacy. Intensive treatment and after-hours care are focused on symptom reduction, coping skill identification, wellness support, relapse prevention, and reduction of emergency services intervention. The goal of the FSP is to assist the consumer in learning new ways to manage behavioral health crises, maintain current residency, stop jail recidivism, stop psychiatric hospitalization, as well as sustain the current level of recovery. Another key component of care with this population is comorbid medical issues. The Windy Springs FSP treats over 250 consumers a month. Approximately 92 of these consumers reside at Roy's Augmented Board and Care, which is in the suite next to the Windy Springs FSP. Additionally, this program supports the PATH, a Housing First program that has a capacity of 26 residents. The Windy Springs staff collaborate with the Residential Care staff of both programs to support these consumers in pursuing their recovery journey.

Assisting consumers with complex issues and multiple behavioral health and substance abuse challenges involves engaging consumers, addressing consumer setbacks, re-engaging in care, and rediscovering wellness goals. This process is often not linear. Thus, staff are empowered to role model self-care and allow for mercy while holding the hope that consumers will make strong wellness choices. Staff work hard to identify consumer needs and meet them where they are at in their recovery journey. A key aspect of care in these settings is for direct care providers to hold the hope of recovery and show compassion while supporting consumers in acceptance and change.

The extreme weather conditions of the Desert Region climate create significant risk for this population, especially during the summer months. For FSP consumers who are homeless or at risk for homelessness, symptom management and the ability to be successful in supportive housing programs or board and care programs is an essential element in maintaining wellness and safety in their daily lives. These housing programs rely on the assistance of FSP staff to successfully support their residents. This FSP support occurs 24 hours a day, 7 days a week. This care can be rewarding when consumers can make sustained lifestyle changes, but also can be challenging when consumers experience a return of symptoms.

Goals for Windy Springs Wellness Center:

1. Decrease in psychiatric hospitalizations.
2. Increase in housing stability and maintenance as evidenced by fewer consumers returning to unhoused status
3. Decrease in the number of conservatees returning to IMD level of care.
4. Decrease in incarceration as evidenced by data gathered.
5. Increase in accessing SUD services.

The data from these programs continues to show improvement in several key life indicators, including a decrease in hospitalizations, a decrease in interactions with law enforcement, an improvement in housing stability, including maintaining housing in the least restrictive environments, a decrease in behavioral health crises, improved follow-through with medical care, and a decrease in the use of non-prescribed medication or recreational drug use.

The Desert Region Windy Springs FSP served 264 consumers in FY 23/24,

- 64% had a schizophrenia psychosis diagnosis.
- Race/Ethnicity data showed 43% of the served were White, 32% were Hispanic/Latinx, and 10% were Black/African American.
- 69% were male, 31% were female, and 52% were age 40 and older.
- The majority of consumers received eight or more services per month.
- Most of the services provided were individual mental health and case management services followed by medication services.
- Arrests were down 100% for Windy Springs consumers.
- Acute hospitalizations were down 57.2% for Windy Springs consumers, and crisis emergency room use decreased by 51%.
- Homelessness decreased from 12% to 6%.

• Residential placement in a supportive care setting increased from 32% to 48%.
• Of the 126 consumers who did not have a PCP at intake, 120 (95.0%) obtained a PCP while in the program.

• 61.3% of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 61.0% of them were reported to be in SU services on follow-up.

Mid-County Adult FSP

Full-Service Partnership (FSP) aims to provide client-centered care through intensive case management, therapeutic interventions, and a focus on recovery. FSP clients work with clinic staff to become self-reliant by addressing immediate needs and setting personal goals. Staff members assist with creating action plans to address mental health treatment, living arrangements, social relationships/communication, financial/money management, activities of daily living, educational/vocational, legal issues, substance abuse issues, physical health, and psychiatric medications. Each clinic provides personalized services and supports to create a client path to recovery.

Mid-County Adult Clinic Tracks

• Mid-County Behavioral Health Adult Clinics and FSP Tracks
• Hemet Behavioral Health Adult Clinic/ FSP Track-284 enrolled and served.
• Lake Elsinore Behavioral Health Adult Clinic / FSP Track-88 enrolled and served.
• Perris Family Room / FSP Track -73 enrolled and served.
• Temecula Behavioral Health Adult Clinic/ FSP Track-55 enrolled and served.
• Mid-County Behavioral Health Adult clinics served 4,588 consumers in their non-FSP tracks and 500 FSP consumers.
• We have four locations for FSP services throughout the Mid-County region, creating multiple access points and convenience for individuals living outside the county's central metropolitan area. By having FSP services at the clinic sites, there has been an increase in FSP client sustainability.
• All FSP consumers have full access to clinic services, which include clinical and medication assessments, medication management, individual therapy, group therapy, psychoeducational groups, care coordination, and case management. The theoretical models include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, the Family Room Model, Motivational Interviewing, WRAP Around and others.
• Anticipated Changes: Each clinic will work to increase FSP enrollment. As the department has stepped down from mild-to-moderate clients to other care providers, the focus on clients with serious mental illness necessitates more FSP services. Additionally, all clinics will be reaching and engaging the surrounding community to establish community resources.
• Lessons Learned: It has been discovered that FSP services are essential on the road to recovery of the seriously mentally ill and those showing signs of having severe mental health crises/episodes.

• Challenges: Employee retention is the major challenge for the clinics. Due to other companies offering more flexibility and higher pay, keeping staff members who are not vested in the department has been difficult.

Hemet Behavioral Health Adult Clinic / FSP Track Groups

MONDAYS

- Mindfulness/Journal
- Grief Group
- Interpersonal Skills
- RAP
- Trauma/Codependency
- Self-Esteem
- Grupo De Apoyo Familiar

TUESDAYS:

- Mindful Journaling (10-11:30)
- Interpersonal Skills
- The Art of Story Telling
- Life Skills
- Coping Skills
- The Art of Crochet
- Mindfulness journaling (3-4:30)

WEDNESDAYS:

- RAP
- Cafecita Time (Spanish)
- Chair Yoga
- DBT
- Substance Abuse (CORE)
- RAP (Spanish)
- Mommy and Me (Pending)
- Peer Support
- English Family Group

THURSDAYS:

- Kickback Art
- Creative Recovery
- Anxiety/CBT
- Body Keeps the Score
- Spanish Peer Support

Also help on Thursdays at the clinic is:

- Pathways Success
- NAMI

FRIDAYS:

- Chair Yoga
- Creative Recovery
- Coping Skills
- Mindful Horizons
- Women's Group
- Art-E (Bilingual)
- Rhythmic Expressions

Lake Elsinore Behavioral Health Adult Clinic / FSP Track Groups

- Alternative Perceptions
- Art
- Family Empowerment
- Family Support (English & Spanish)
- Peer Support (English & Spanish)
- Planning for Success
- Women's Empowerment
- Pokémon Go (TAY)
- Inside Out
- Music
- Socialization
- Clinic Orientation (starting next month)

Temecula Behavioral Health Adult Clinic / FSP Track Groups

- Dialectical Behavior Therapy (3 separate groups per week)
- Kick Back Art (once per week)
- Clinic Cinema (Peer-led discussion group viewing a mental health theme movie once per week)
- Vinyl's and Validation (Peer-led discussion group based on music as a recovery tool once per week)

Perris Family Room / FSP Track Groups

- CORE I
- Art and Creativity – English and Spanish
- Mastering Anxiety
- Wise Mind (DBT)
- Peer Support - English and Spanish
- Recovery Management
- Family Support – English and Spanish
- Whole Health
- Ecotherapy
- Modern living
- Inside out

Progress Data:

Data collection is an ongoing aspect of evaluating the operation and efficiency of each FSP track. Priorities include staff responsiveness to consumers in crisis and stabilizing clients in the community. Staff retention is also critical for the continuity of care and to preserve the consistency of the FSP team. The designated case managers are trained and experienced in entering and tracking information in ImagineNet. Each FSP track has a weekly meeting related to the consultation and monitoring of consumers.

Collected data in ImagineNet will prove valuable at directing future services. Incoming staff continue to be trained and are learning to enter required data. The Behavioral Health Services Supervisors are highly engaged and involved in overseeing FSP operations as it represents a huge component of clinical care.

7/1/2023 to 6/30/2024

3377NA	2,027
3377FA	433
33MUNA	838
33MUFA	133
3383NA	1,148
3383FA	132
33MTNA	714
33MTFA	66

3-Year Plan Goal:

• Increase FSP client numbers by 20%, each clinic

• Increase community outreach and engagement through participating in community events and collaborating with community groups

- Follow up on goals: Hemet and Perris Mid-County Adult FSP met their goal to increase numbers by 20%. Hemet had an increase of 30%, and Perris had an increase of 31%. Lake Elsinore was also able to meet their goal. They had an increase of 41%.
- Temecula was unable to meet its goal, and it had a decrease of 3% due to staffing challenges. The clinic operates with 2 case managers, and they don't have a Community Services Assistant to provide transportation to needy clients. Current staff are unable to serve more clients as caseloads increase. They could hire a community service assistant and another BHS but towards the end of the year. This should help increase the population served for the next reporting cycle.

• The second goal is to Increase community outreach and engagement through participating in community events and collaborating with community groups; mid-county Adult Clinics were successful with this goal. Below is a list of events that Lake Elsinore and Hemet were able to participate in to increase community outreach and engagement. Temecula joined forces with Pathways, Mature Adults, SAPT, and the peer resource center and hosted a resource fair called A Decade of Difference to celebrate our 10th anniversary at the Temecula site on Aug 14th. They had food, games, raffles, and resources. The staff did a fantastic job. We had about 95 members sign in. It was a very successful event.

Hemet

- Longest Night- December 19, 2024

- May is Mental Health Month Mid-County – May 2024
- Recovery Happens: Fairmont Park- October 2024

Lake Elsinore

- Quarterly member clinic parties for our members
- May is Mental Health Month- May 2024

Temecula

- Resource fair Aug 2024
- May is mental health month- May 2024

Riverside University HEALTH SYSTEM Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

Full Service Partnership Adult Outcomes Report FY 2023-2024

Background

The following report is a summary of outcome data for the Adult Full Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality of life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on comparisons between baseline and post enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Adult FSP programs beginning July 1, 2023 and ending June 30, 2024. Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form, the history of events for the 12 months before a consumer began the FSP program. Follow up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data has been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in an adult FSP program.

FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Integrated Service Recovery Centers (ISRC) for Adult and TAY consumers, and Specialty Multidisciplinary Aggressive Response Treatment (SMART) for Older Adults, however, the following report document presents statistics and figures from the Adult FSP programs ***only***.

There are FSP programs in each region of the County including the West, Mid-County, and Desert region. Adult FSP programs include County clinic FSP expansions which began in 21/22 Fiscal Year. All of the County outpatient clinics added an FSP track within the clinic. The Mid-county region began this process sooner than the West and Deset regions.
The clinic FSPs are located regionally and serve consumers who are unengaged, frequenting the hospitial or are homeless or at risk of homelessness. The program also targets consumers who have a history of cycling through acute or long term institutional treatment settings. These centers collaborate with community resources and agencies to meet the vocational, educational, social and housing needs of Adult consumers. Services are provided by a multi-disciplinary team that embraces the principles of recovery and resilience. Services and supports available within the ISRC include psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

Executive Summary

Adult Enrollment and Demographics —During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 1871 adults were served across 2069 enrollments which includes re-enrollments and transfers to one or more of the adult FSP programs. The race/ethnicity of enrollees for this fiscal year was 651 (31.5%) Latino/Hispanic, 576 (27.8%) White, and 238 (11.5%) African American/Black. In each program and countywide, the most common diagnoses among adult FSP consumers was schizophrenia or other psychotic disorders 776 (49.7%). Countywide the largest proportion of consumers were between the ages of 40 and 49 (24%) and the majority enrolled were males (58%).

Adult Discontinuances —Across all of the adult programs the most frequently reported discontinuance reason was 'Met Goals' (52%).

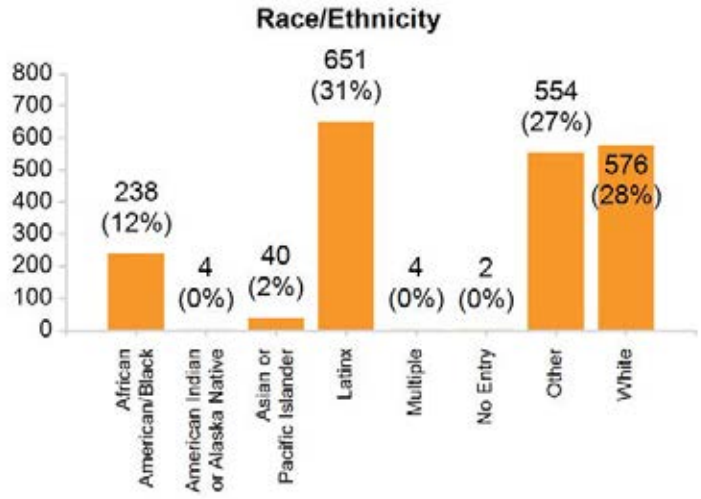
FSP Services —In 2023/2024 fiscal year, more than half of the FSP consumers received 4-7 or 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for mental health group (31.70 hours), individual mental health services (10.04 hours) and case management (7.14 hours).

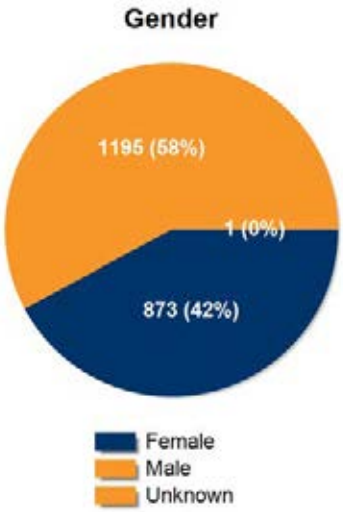
Adult Outcomes —Follow-up data for all adult programs combined showed a decrease in hospitalizations (21.73%), arrests (91.62%) , physical health emergency (90.12%) and mental health emergency department visits (35.16%). Programs had 75 to 100 percent decreases in arrests between intake and follow-up. Most programs had decreases in reported hospitalizations. Emergency department visits for mental health services declined by 47% or more for consumers in most programs. Most consumers did not have a primary care physician at the beginning of the program (67.91%), however, nearly three quarters of those (26.11%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, many (17.09%) participated in substance use services while in the FSP. Of the 216 additional consumers that were identified as having an active substance abuse problem during their participation in the adult programs,134(62.04%) were reported to be participating in substance use treatment services while in the FSP program.

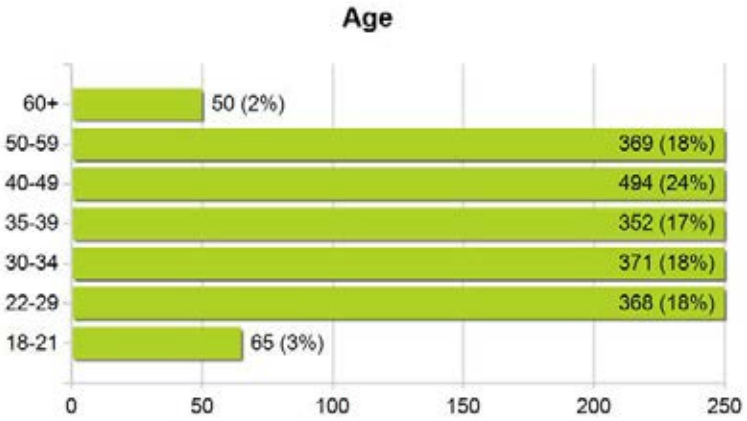
Residential Status — Comparisons of intake status and most recent residential status showed that the percentage of consumers reported as homeless or emergency shelter decreased and the proportion living on their own increased.

Demographics & Diagnosis

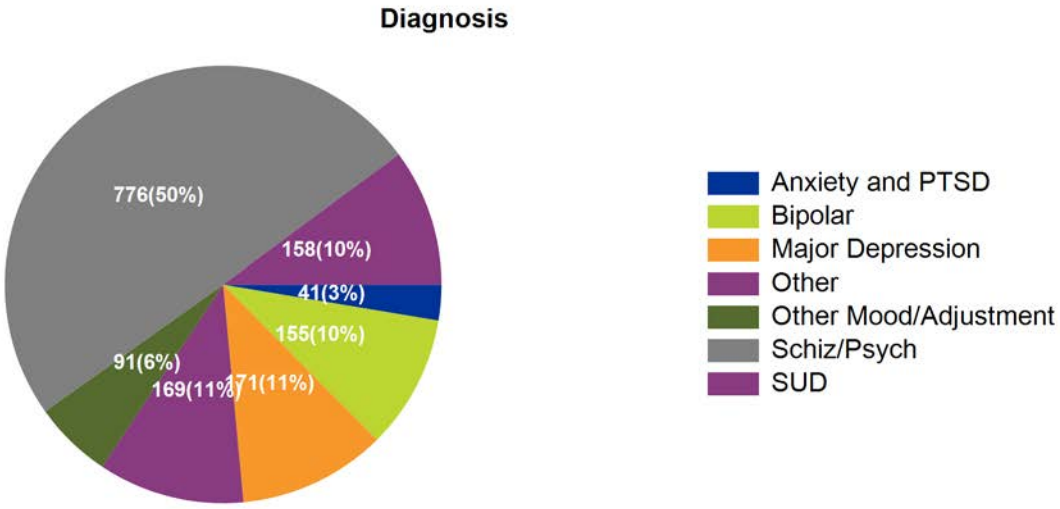
The majority served in the adult FSP program in the 2023/2024 fiscal year were Hispanic/Latinx 31%, which comprise a smaller proportion of those served than their proportion in the Riverside County general population of 51%. The proportion of White, at 28%, was lower than that in the general population of the county at 32%. The proportion of African American/Black participants at 12% was larger than the general population of 6%. Also, more males (58%) have enrolled in the adult FSP program than females (42%).







Most individuals served were between the age of 40-49 (24%) or 50-59 (18%). A large proportion of those served were diagnosed with Schizophrenia/Psychosis disorders (50%), Major depression (11%), or Bipolar disorder (10%).



Length of FSP Partnership

The length of stay in years for those **2069** enrollments in adult FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of adults with an active/open case having time in partnership longer than one year was 39%, while 82% of those with a closed episodes had a LOS in FSP shorter than one year. Of all adult FSP consumers served in FY 2023/2024, over two-thirds have a length of stay less than two years (84%).

FSP re-entry: Of these **2069** adult FSP enrollments, 193 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership and 22 of them re-established partnership more than one time over their total time in FSP. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 221.

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	85	144	229	11%
>= 2 Years and <3 Years	75	60	135	7%
>= 3 Years and < 4 Years	17	117	134	6%
>= 4 Years and < 5 years	9	29	38	2%
>= 90 days and < 1 Year	457	368	825	40%
>=5 Years and < 6 years	3	11	14	1%
>=6 Years+	6	14	20	1%
Under 90 days	447	227	674	33%
Total Consumer Enrollments	**1099**	**970**	**2069**	

Average Years in Partnership	2.14	1.95	1.08
Median Years in Partnership	0.29	0.74	0.45
Maximum Years in Partnership	10.65	13.88	13.88

Length of stay (LOS) for consumers enrolled in each program is described on the following pages. LOS in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

Note: Active cases include those with an open episode in an adult FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.

Reason for Discontinuance of FSP: All Adults

Upon termination of partnership a reason for discontinuance is selected. For recorded cases, consumers most often closed because the consumer was Unable to Locate (21%). The next highest proportion of consumers were noted to have Moved out of County/Area (7%). Met Goals accounted for 52% of discontinuance reasons. If a consumer terminated partnership more than once, each instance was recorded in this table.

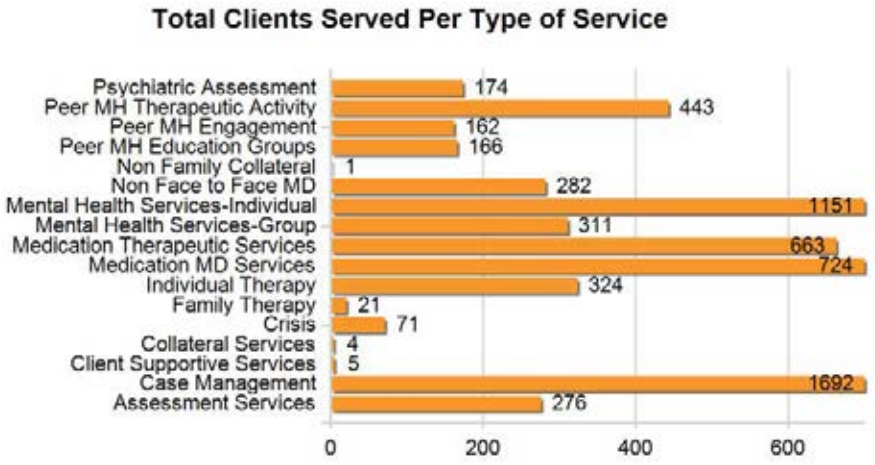
Discontinuation Reason	Count	%
Deceased	14	1%
Justice system	24	2%
Met goals	505	52%
Moved out of county/area	66	7%
Needs residential care	28	3%
Other	3	0%
Partner cannot be located	205	21%
Partner left program	97	10%
Target criteria not met	26	3%
Total	**968**	**100%**

Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 4-7, or 8 or more services per month within the fiscal year. On average, more than 30% of adult FSP consumers received 8 or more services per month.

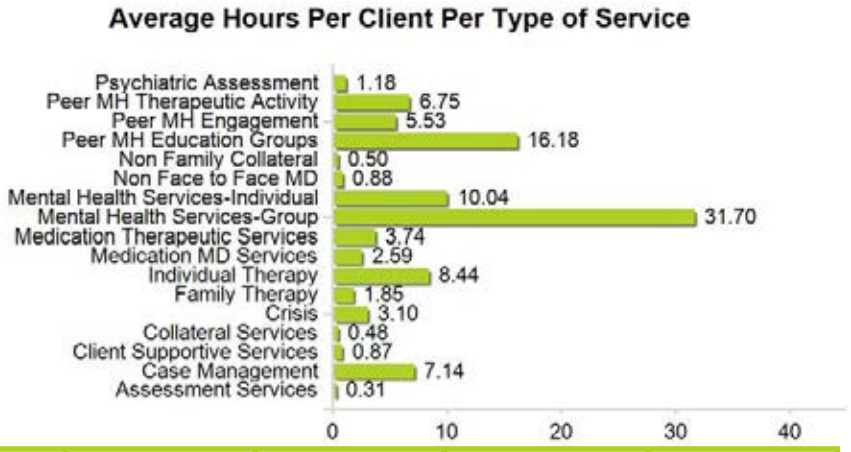
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	163 (21%)	144 (18%)	118 (16%)	157 (21%)	154 (21%)	192 (25%)	179 (22%)	129 (18%)	194 (23%)	159 (19%)	133 (17%)	166 (21%)
2-3	170 (22%)	179 (22%)	170 (23%)	168 (22%)	152 (21%)	181 (24%)	183 (23%)	170 (23%)	223 (26%)	174 (21%)	173 (22%)	188 (24%)
4-7	219 (28%)	209 (26%)	235 (32%)	213 (28%)	220 (30%)	202 (26%)	209 (26%)	199 (27%)	206 (24%)	233 (28%)	211 (26%)	217 (28%)
8-13	138 (18%)	167 (21%)	148 (20%)	150 (20%)	146 (20%)	132 (17%)	145 (18%)	145 (20%)	143 (17%)	142 (17%)	159 (20%)	122 (16%)
14-19	49 (6%)	64 (8%)	43 (6%)	41 (5%)	42 (6%)	35 (5%)	56 (7%)	50 (7%)	48 (6%)	78 (9%)	58 (7%)	52 (7%)
20-25	29 (4%)	22 (3%)	13 (2%)	22 (3%)	14 (2%)	12 (2%)	19 (2%)	18 (2%)	27 (3%)	29 (3%)	36 (4%)	20 (3%)
26-31	3 (0%)	11 (1%)	10 (1%)	6 (1%)	6 (1%)	3 (0%)	11 (1%)	8 (1%)	7 (1%)	8 (1%)	16 (2%)	10 (1%)
32+	8 (1%)	11 (1%)	7 (1%)	6 (1%)	2 (0%)	6 (1%)	5 (1%)	5 (1%)	6 (1%)	13 (2%)	16 (2%)	8 (1%)
Monthly Total	779	807	744	763	736	763	807	724	854	836	802	783

Service Detail



During the 2023/2024 Fiscal Year, more clients received Case Management and Mental Health Individual rehabilitation services, followed by Medication services.

The average number of hours consumers received of each type of service while in adult FSP programs during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in MH Group Services (31.70 hours).

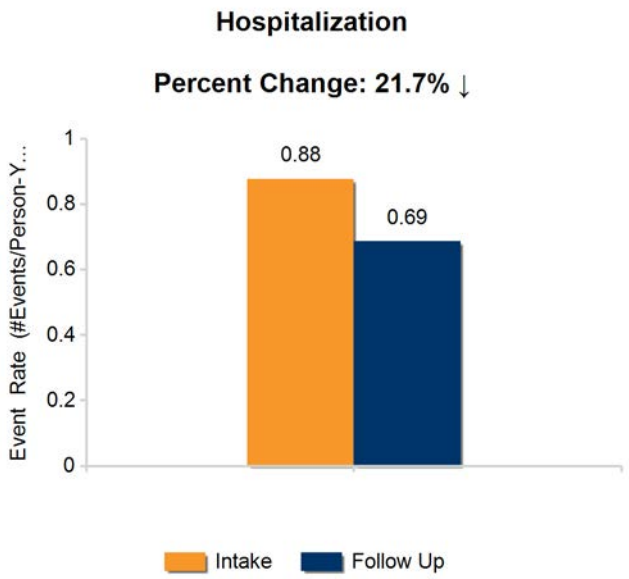


Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	276	13%	322	1.17
Case Management	1692	82%	17,541	10.37
Client Supportive Services	5	0%	7	1.40
Collateral Services	4	0%	5	1.25
Crisis	71	3%	128	1.80
Family Therapy	21	1%	52	2.48
Individual Therapy	324	16%	3,464	10.69
Medication MD Services	724	35%	2,905	4.01
Medication Therapeutic Services	663	32%	5,306	8.00
Mental Health Services-Group	311	15%	6,529	20.99
Mental Health Services-Individual	1151	56%	16,116	14.00
Non Face to Face MD	282	14%	620	2.20
Non Family Collateral	1	0%	1	1.00
Peer MH Education Groups	166	8%	1,638	9.87
Peer MH Engagement	162	8%	889	5.49
Peer MH Therapeutic Activity	443	21%	3,626	8.19
Psychiatric Assessment	174	8%	179	1.03

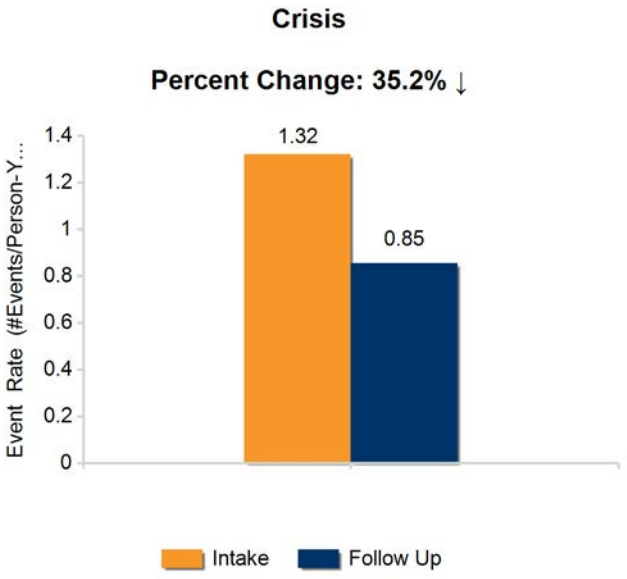
Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled were summed and divided by the number of years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 11.

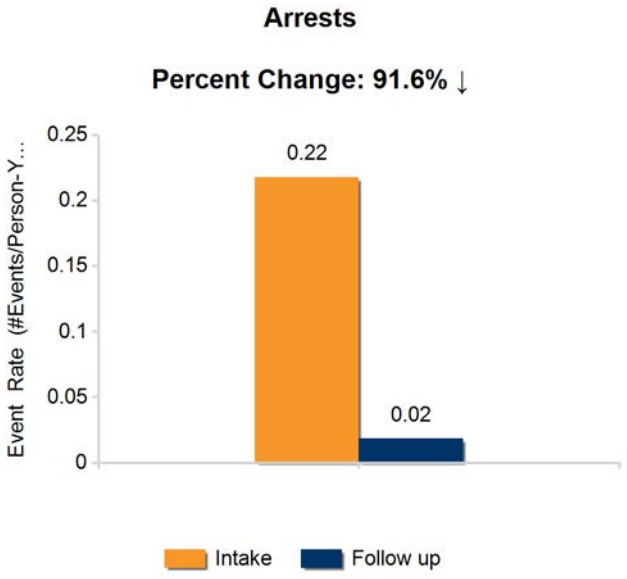
Overall, psychatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies reduced.



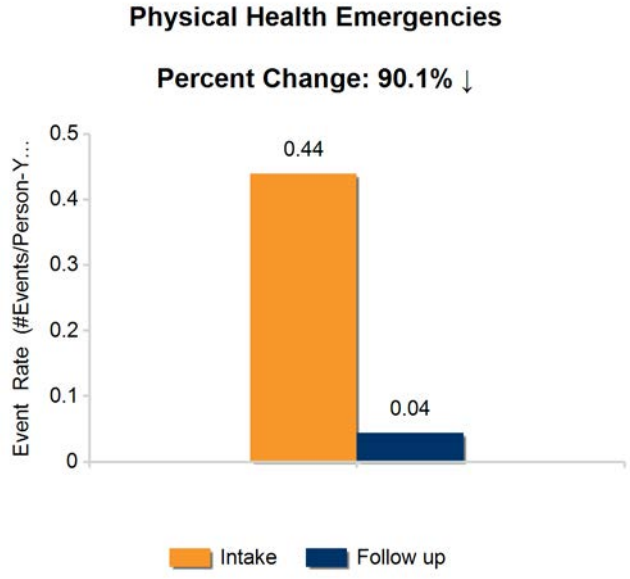
Hospitalizations decreased 21.7% from intake to follow-up.



Crisis decreased 35.2% from intake to follow-up.



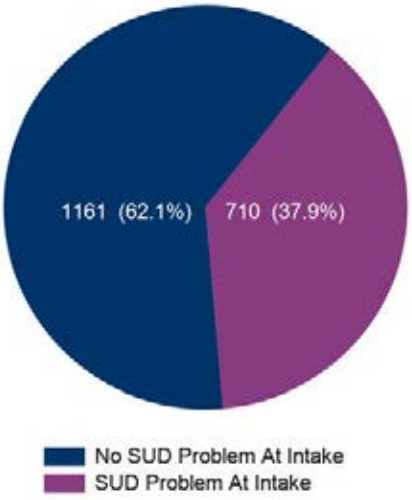
Arrests decreased 91.6% from intake to follow-up.

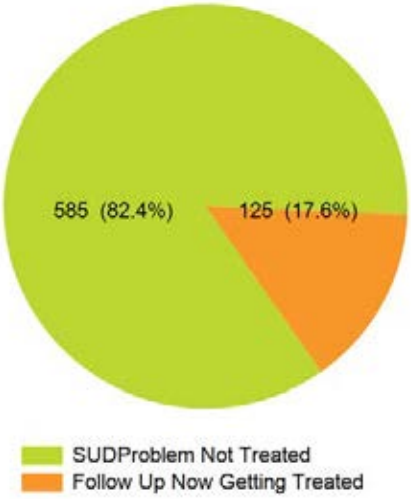


Phyiscal Helath Emergency visits decreased 90.1%.

Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (37.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

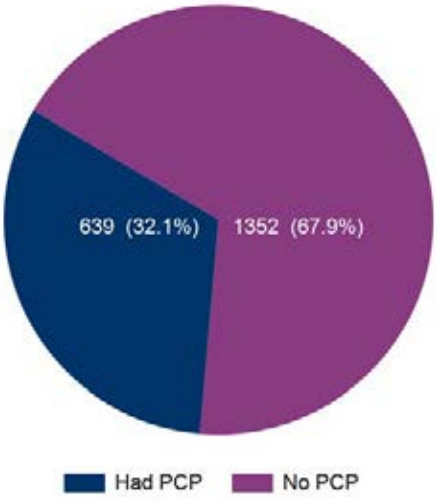




Follow-up: Based on follow-up data reported quarterly, 17.1% (100) of the 585 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 216 consumers not identified at intake were noted to have an SU problem on follow-up and 62.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician

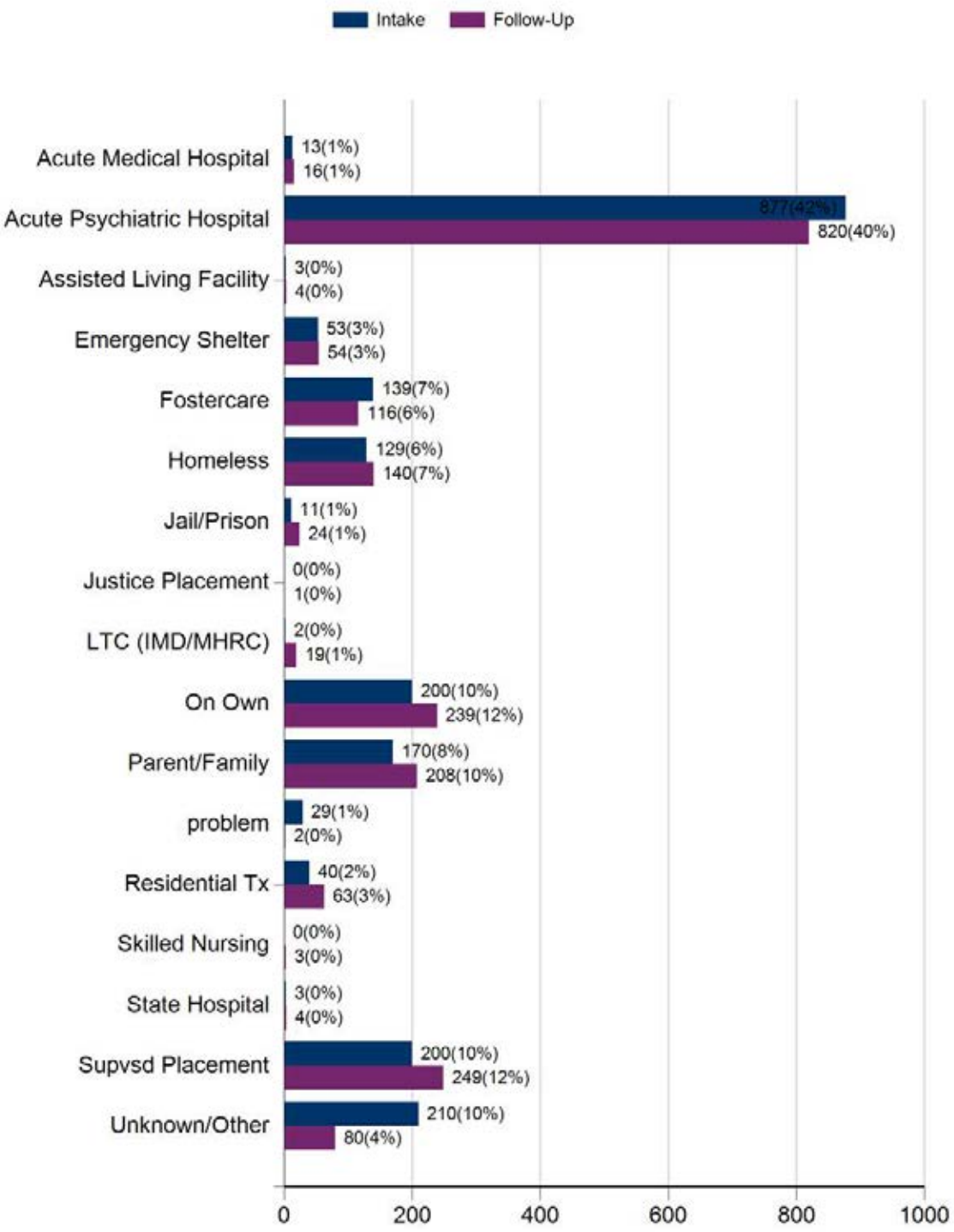
Intake: Most adults (67.9%) did not have a primary care physician (PCP) at intake.



Follow-up: Of the 1352 consumers that did not have a PCP at intake, 353 (26.1%) obtained a PCP while in the program.

Outcomes: Residential

Overall, the adult FSP consumers had a decrease in the proportion homeless or in emergency shelter and an increase in the percentage of consumers living on their own. Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days they spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their **first** enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential days during enrollment has been annualized.

	12 Months Prior to Enrollment		Annualized Days During Enrollment		
Living Situation	**# of Days**	**Count (n)**	**# of Days**	**Count (n)**	**Percent change (%)**
Acute Medical Hospital	2,161	63	3,723	61	72%
Acute Psychiatric Hospital	9,674	1036	109,808	1284	1035%
Assisted Living Facility	1,162	4	1,923	11	65%
Emergency Shelter	15,197	82	20,818	91	37%
Fostercare	200	1	-	0	-100%
Homeless	120,864	386	35,806	220	-70%
Jail/Prison	10,764	120	3,838	40	-64%
LTC (IMD/MHRC)	20,864	68	5,898	35	-72%
On Own	154,816	470	98,312	289	-36%
Parent/Family	171,674	525	80,472	261	-53%
Residential Tx	7,359	89	16,549	111	125%
Skilled Nursing	1,354	5	436	12	-68%
State Hospital	2,100	9	515	5	-75%
Supervised Placement	30,552	189	118,614	333	288%
Unknown/Other	212,284	599	186,653	559	-12%

FSP Adult demographics and Outcomes for: 33IPFA
Served by this reporting unit: 261 Enrollment: 264

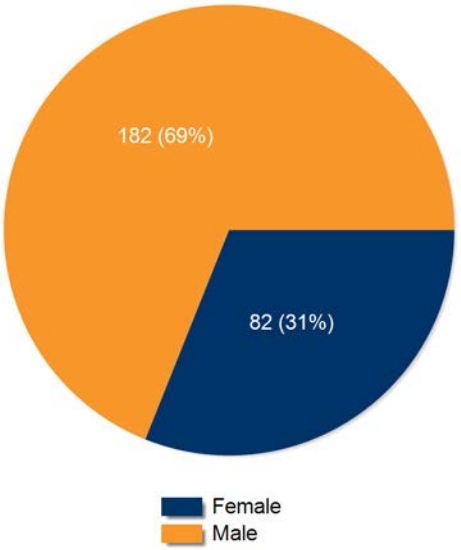
Demographics

69% of consumers were male and 31% were female.

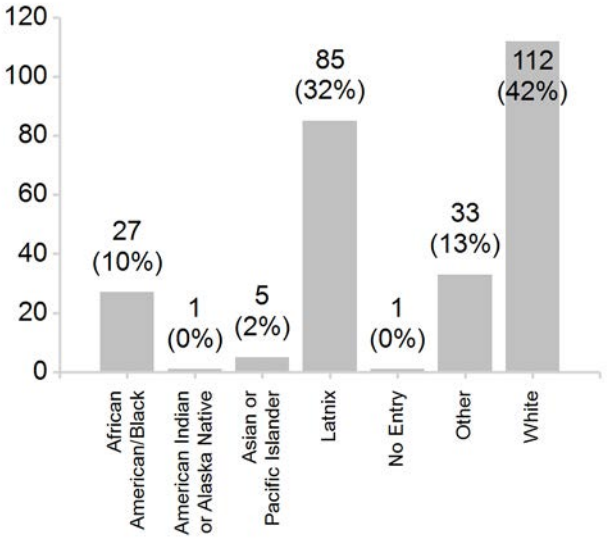
42% of consumers were White, 0% of consumers were Hispanic/Latinx and 10% of consumers were Black/African American.

25% of consumers were 40 to 49 years old.

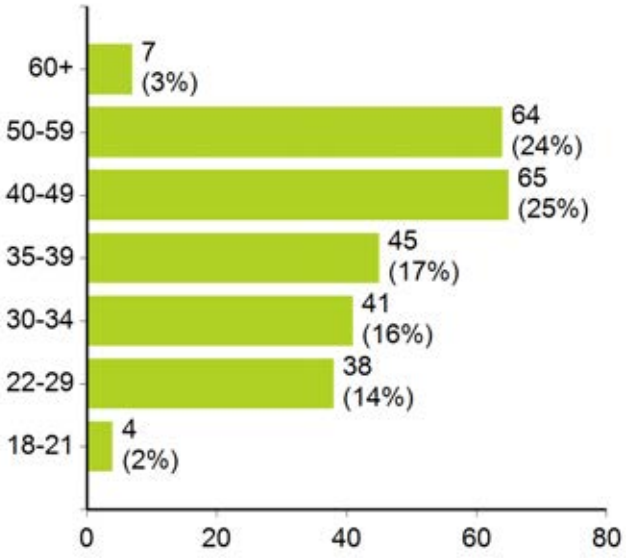
Gender



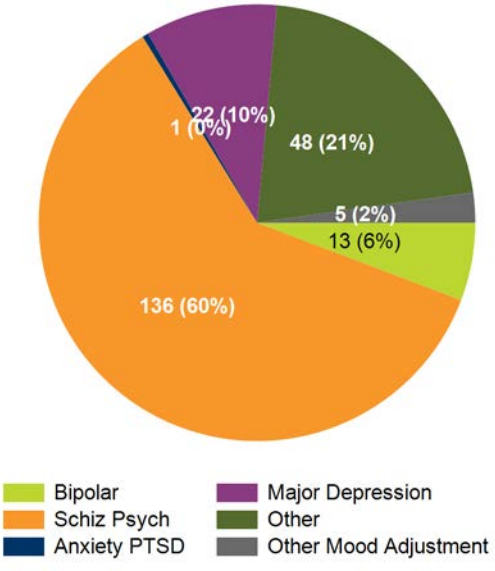
Race/Ethnicity



Age



Diagnosis



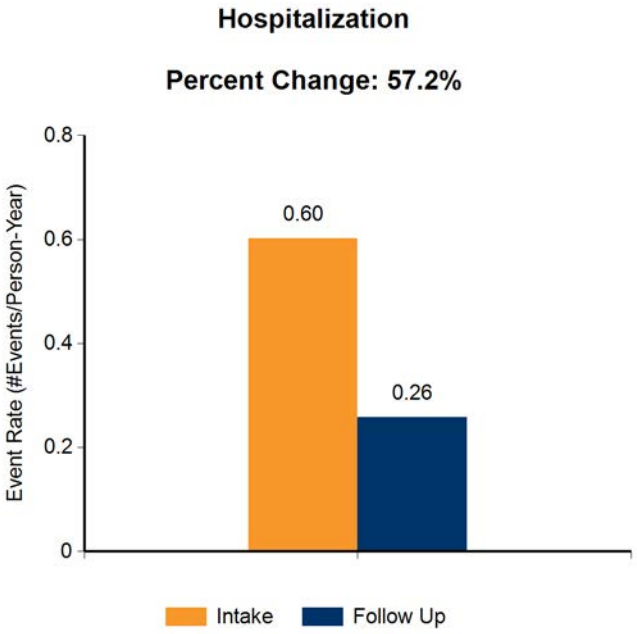
Service Detail: 33IPFA

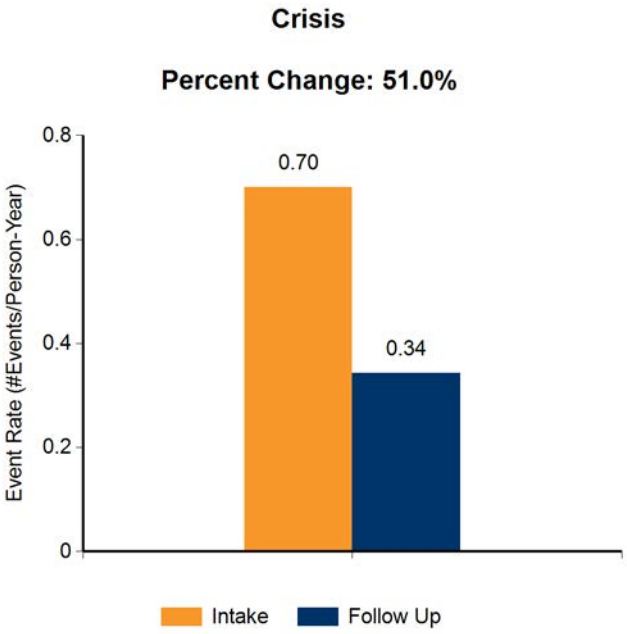
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	7 (4%)	11 (6%)	8 (4%)	6 (3%)	11 (6%)	12 (7%)	5 (3%)	11 (6%)	10 (5%)	7 (4%)	6 (3%)	9 (5%)
2-3	29 (16%)	29 (16%)	23 (13%)	30 (16%)	22 (12%)	29 (16%)	21 (11%)	25 (13%)	41 (22%)	22 (12%)	21 (11%)	33 (18%)
4-7	60 (33%)	66 (36%)	75 (41%)	69 (38%)	70 (38%)	66 (37%)	73 (40%)	65 (35%)	68 (36%)	69 (37%)	77 (42%)	78 (42%)
8-13	45 (25%)	46 (25%)	54 (30%)	47 (26%)	54 (29%)	45 (25%)	47 (26%)	55 (29%)	42 (22%)	53 (28%)	50 (27%)	43 (23%)
14-19	19 (10%)	16 (9%)	9 (5%)	17 (9%)	18 (10%)	15 (8%)	22 (12%)	17 (9%)	6 (3%)	22 (12%)	12 (7%)	11 (6%)
20-25	17 (9%)	11 (6%)	6 (3%)	10 (5%)	6 (3%)	8 (4%)	7 (4%)	7 (4%)	12 (6%)	6 (3%)	7 (4%)	7 (4%)
26-31	2 (1%)	3 (2%)	6 (3%)	3 (2%)	4 (2%)	1 (1%)	6 (3%)	5 (3%)	4 (2%)	2 (1%)	3 (2%)	1 (1%)
32+	2 (1%)	2 (1%)	2 (1%)	2 (1%)	0 (0%)	4 (2%)	2 (1%)	2 (1%)	4 (2%)	5 (3%)	7 (4%)	4 (2%)
Monthly Total	181	184	183	184	185	180	183	187	187	186	183	186

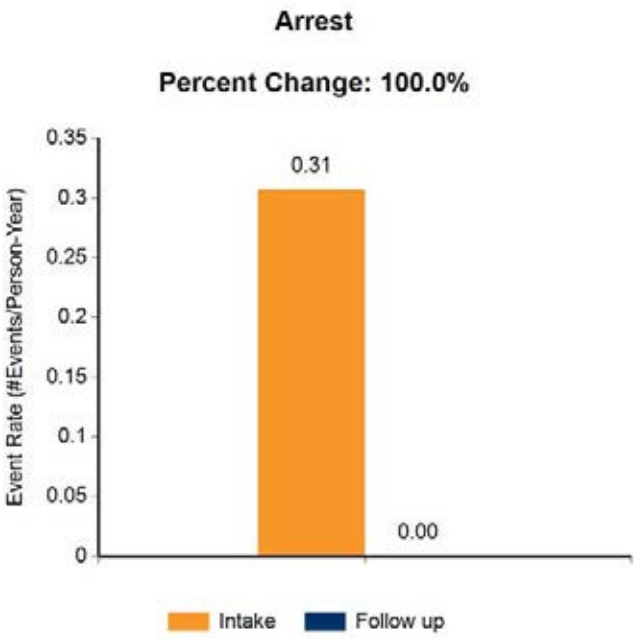
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	56	4%	62	1.11
Case Management	251	16%	3,813	15.19
Crisis	17	1%	27	1.59
Family Therapy	13	1%	39	3.00
Individual Therapy	123	8%	1,714	13.93
Medication MD Services	233	15%	1,147	4.92
Medication Therapeutic Services	213	14%	1,736	8.15
Mental Health Services-Group	133	9%	3,722	27.98
Mental Health Services-Individual	249	16%	4,465	17.93
Non Face to Face MD	75	5%	107	1.43
Peer MH Education Groups	85	5%	1,168	13.74
Peer MH Therapeutic Activity	87	6%	797	9.16
Psychiatric Assessment	21	1%	21	1.00

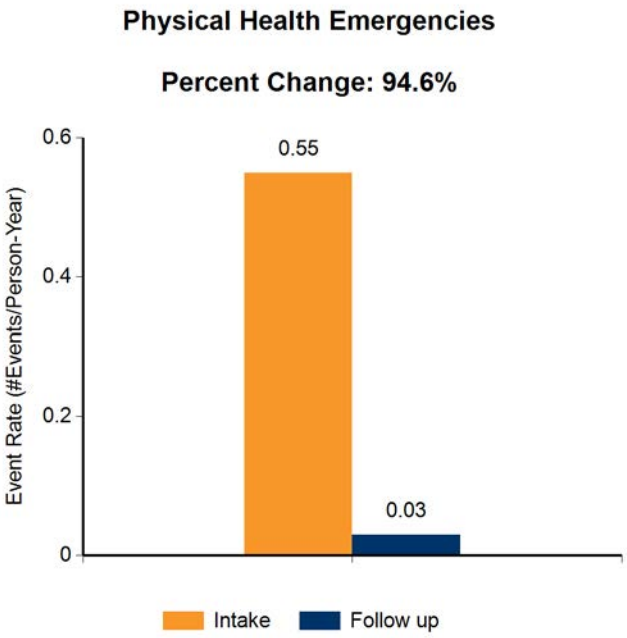
Outcomes for 33IPFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

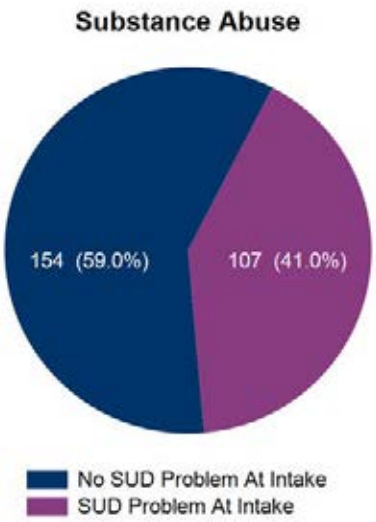


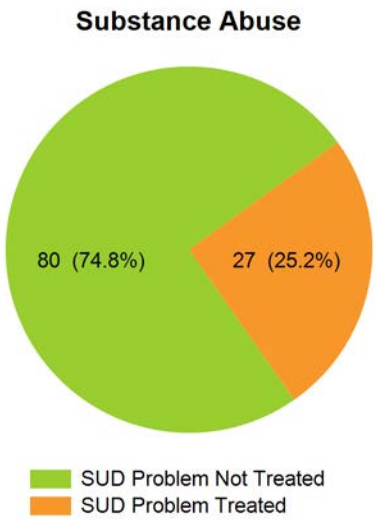






Outcomes: Substance Use (33IPFA)

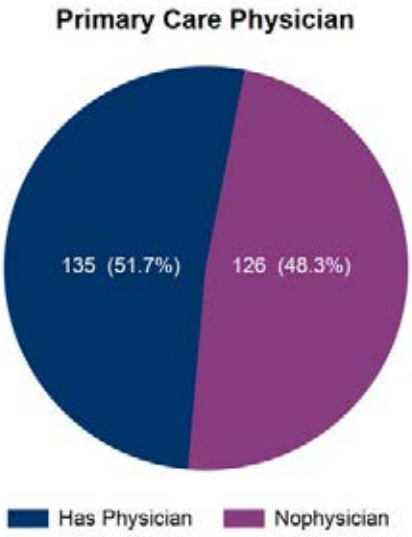




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (41.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 61.3% (49) of the 80 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 61.0% of them were reported to be in SU services on follow-up.

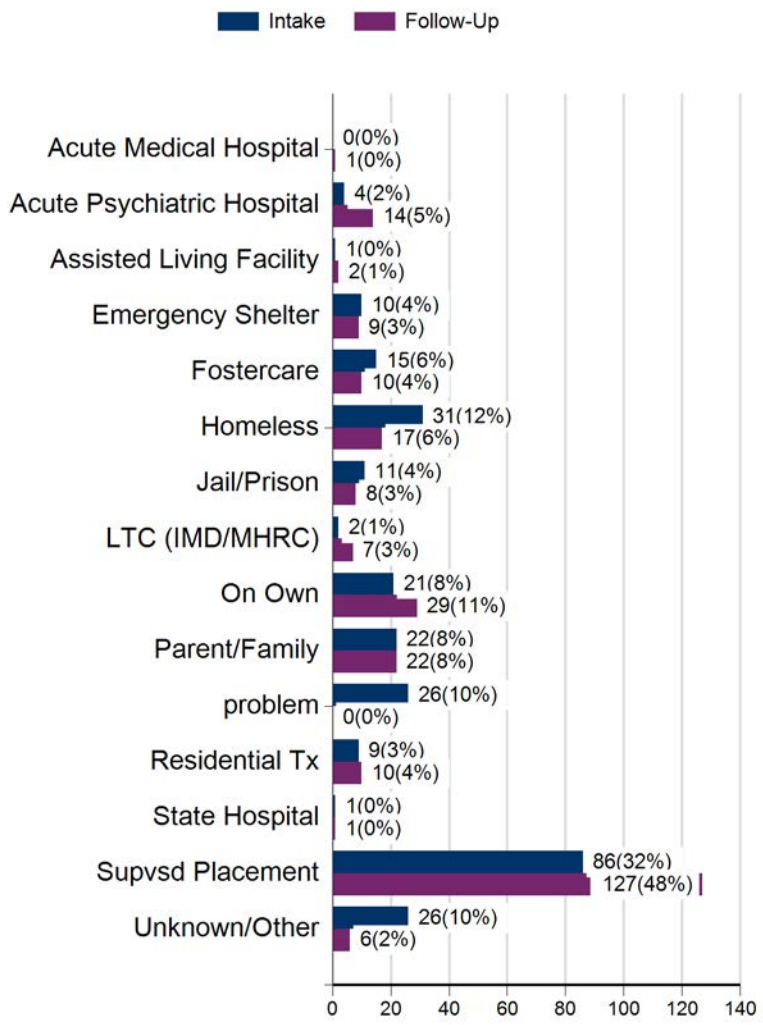
Outcomes: Primary Care Physician (33IPFA)



Intake: Most adults (48.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 126 consumers that did not have a PCP at intake, 120 (95.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33IPFA)



Discontinuation Reason	Count	%
Deceased	3	4%
Justice system	2	3%
Met goals	8	12%
Moved out of county/area	15	22%
Needs residential care	17	25%
Partner cannot be located	12	18%
Partner left program	8	12%
Target criteria not met	3	4%
Total	**68**	**100%**

Length of FSP Partnership for: 33IPFA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	24	27	51	19.32%
>= 2 Years and <3 Years	12	24	36	13.64%
>= 3 Years and < 4 Years	4	53	57	21.59%
>= 4 Years and < 5 years	1	2	3	1.14%
>= 90 days and < 1 Year	31	55	86	32.58%
>=5 Years and < 6 years	0	4	4	1.52%
>=6 Years+	0	3	3	1.14%
Under 90 days	11	13	24	9.09%
Total Consumer Enrollments	**83**	**181**	**264**	

FSP Adult demographics and Outcomes for: 3301FA
Served by this reporting unit: 78 Enrollment: 80

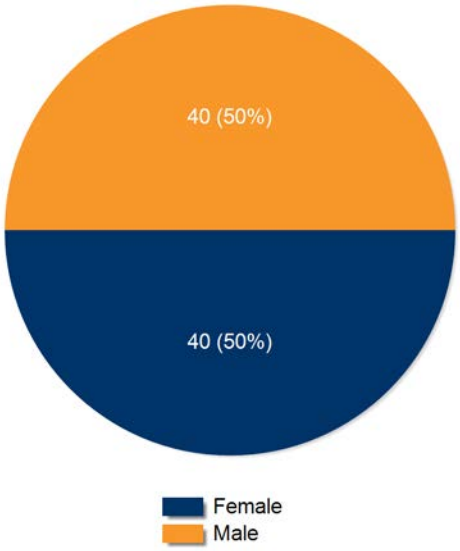
Demographics

50% of consumers were male and 50% were female.

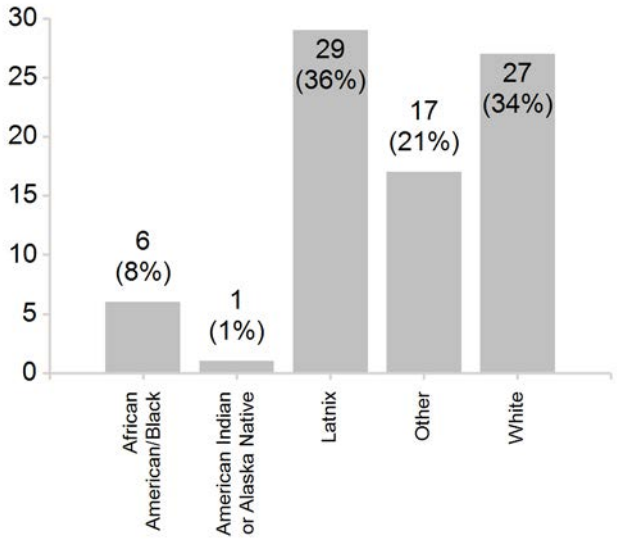
34% of consumers were White, 0% of consumers were Hispanic/Latinx and 8% of consumers were Black/African American.

24% of consumers were 40 to 49 years old.

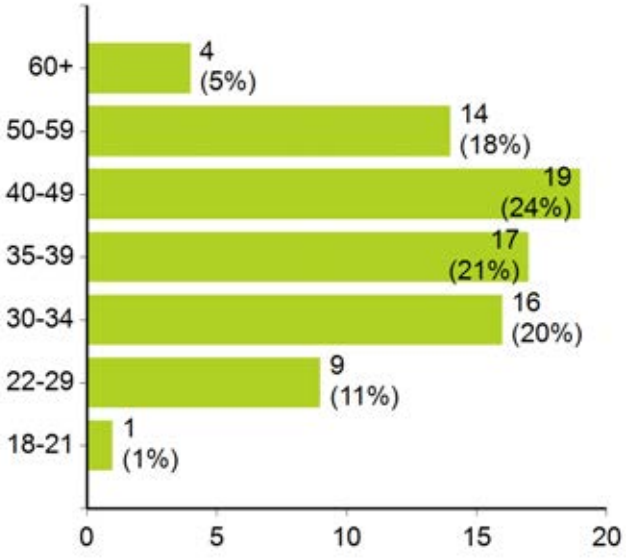
Gender



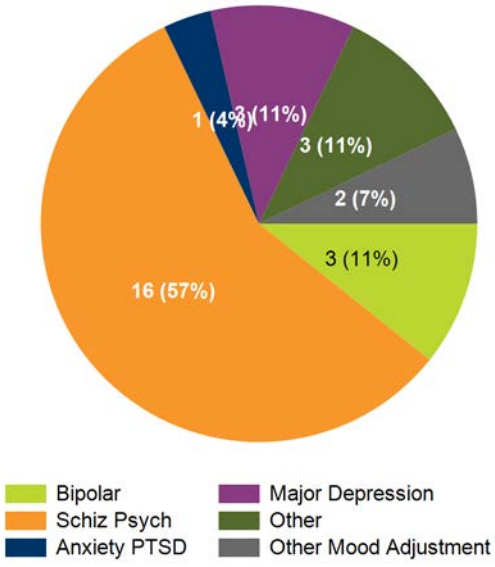
Race/Ethnicity



Age



Diagnosis



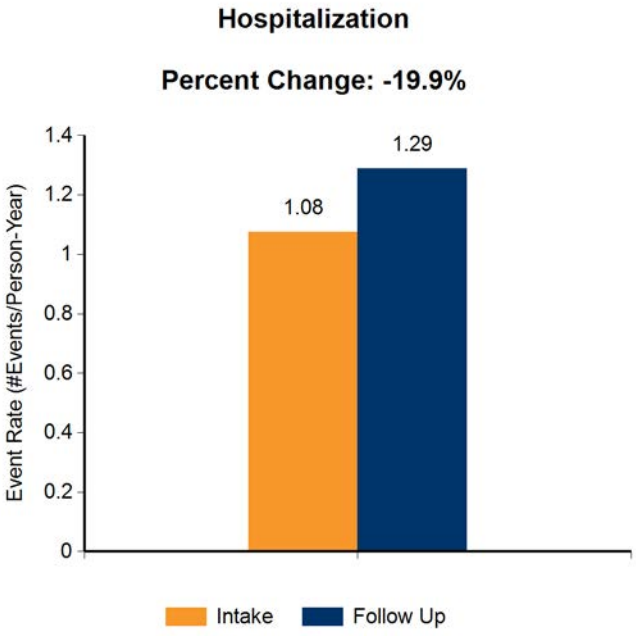
Service Detail: 3301FA

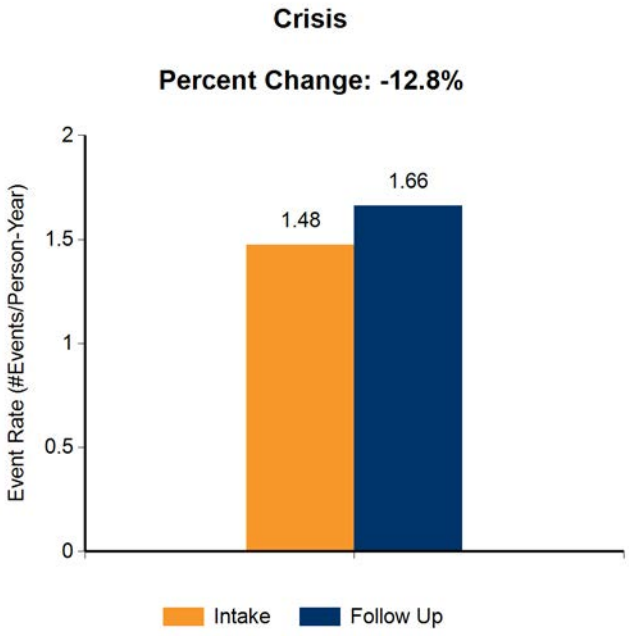
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	2 (67%)	2 (67%)	0 (0%)	2 (67%)	1 (50%)	2 (100%)	1 (50%)	5 (71%)	2 (67%)	2 (67%)	4 (50%)	15 (29%)
2-3	1 (33%)	0 (0%)	3 (100%)	1 (33%)	0 (0%)	0 (0%)	0 (0%)	2 (29%)	1 (33%)	0 (0%)	2 (25%)	14 (27%)
4-7	0 (0%)	1 (33%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	1 (33%)	0 (0%)	19 (37%)
8-13	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (13%)	3 (6%)
14-19	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (13%)	1 (2%)
Monthly Total	3	3	3	3	2	2	2	7	3	3	8	52

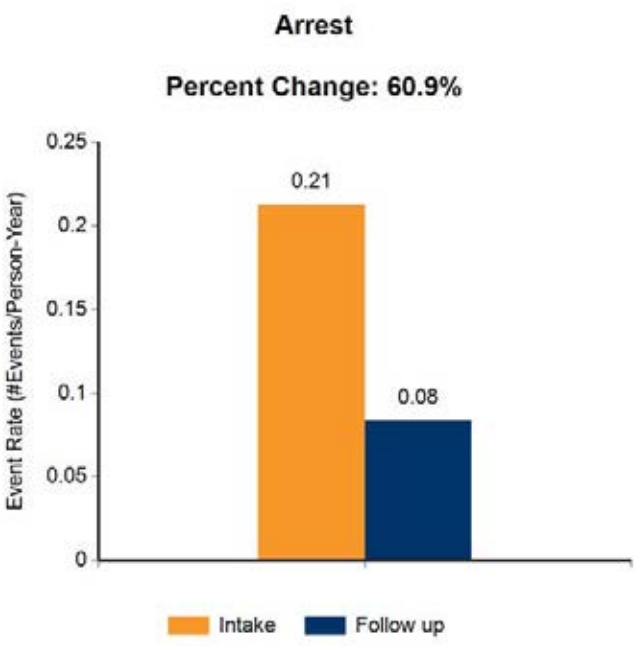
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	2	2%	2	1.00
Case Management	41	34%	74	1.80
Individual Therapy	9	8%	46	5.11
Medication MD Services	8	7%	11	1.38
Medication Therapeutic Services	10	8%	15	1.50
Mental Health Services-Group	20	17%	61	3.05
Mental Health Services-Individual	18	15%	31	1.72
Non Face to Face MD	2	2%	5	2.50
Peer MH Education Groups	3	3%	10	3.33
Peer MH Engagement	2	2%	2	1.00
Psychiatric Assessment	4	3%	4	1.00

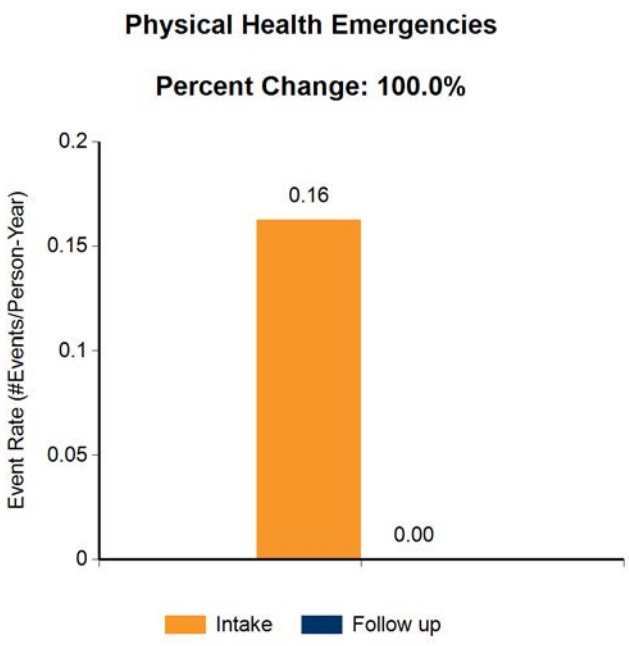
Outcomes for 3301FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

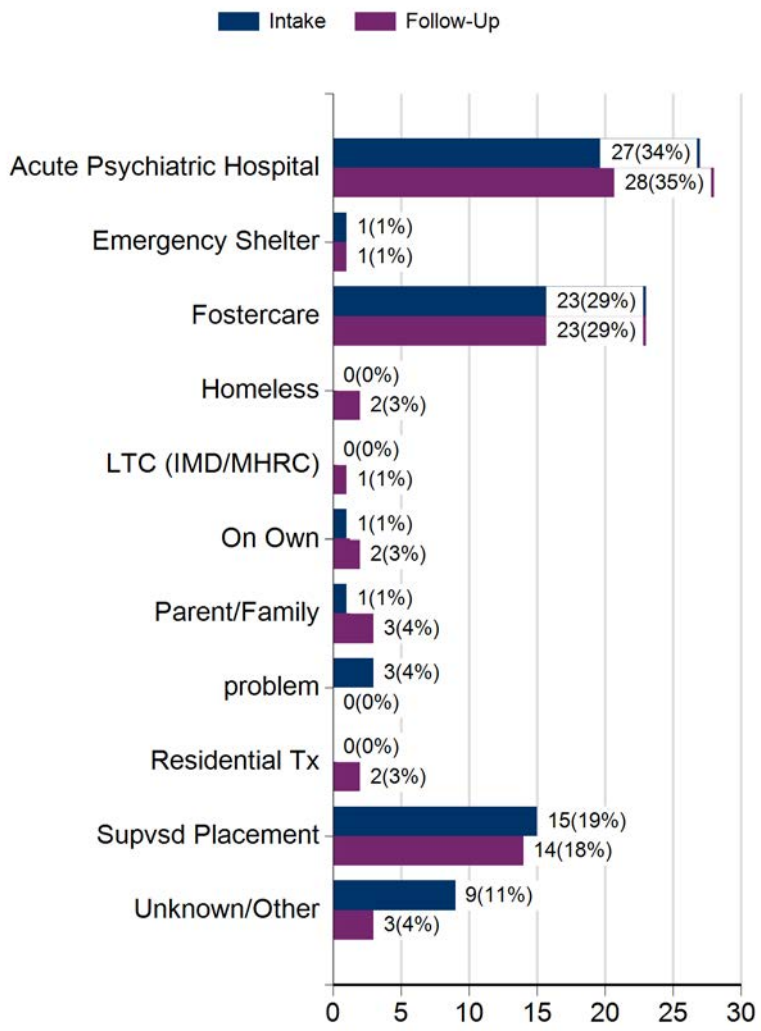








Outcomes: Residential & Discontinuance (3301FA)

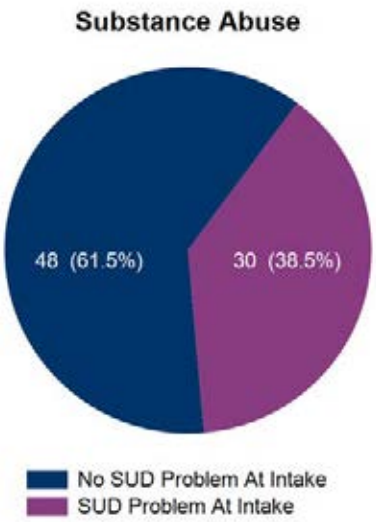


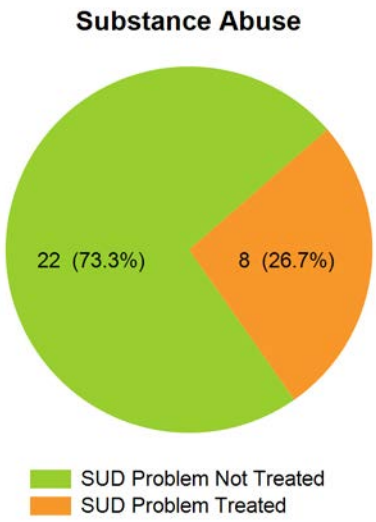
Discontinuation Reason	Count	%
Met goals	1	10%
Partner cannot be located	6	60%
Partner left program	3	30%
Total	**10**	**100%**

Length of FSP Partnership for: 3301FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	1	0	1	1.25%
>= 2 Years and <3 Years	1	2	3	3.75%
>= 3 Years and < 4 Years	0	1	1	1.25%
>= 90 days and < 1 Year	8	4	12	15.00%
Under 90 days	2	61	63	78.75%
Total Consumer Enrollments	**12**	**68**	**80**	

Outcomes: Substance Use (3301FA)

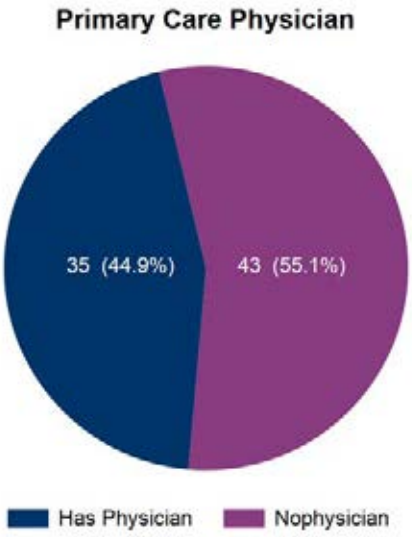




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (38.5%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 4.5% (1) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 5.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (3301FA)



Intake: Most adults (55.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 43 consumers that did not have a PCP at intake, 4 (9.0%) obtained a PCP while in the program.

FSP Adult demographics and Outcomes for: 3301FP
Served by this reporting unit: 427 Enrollment: 457

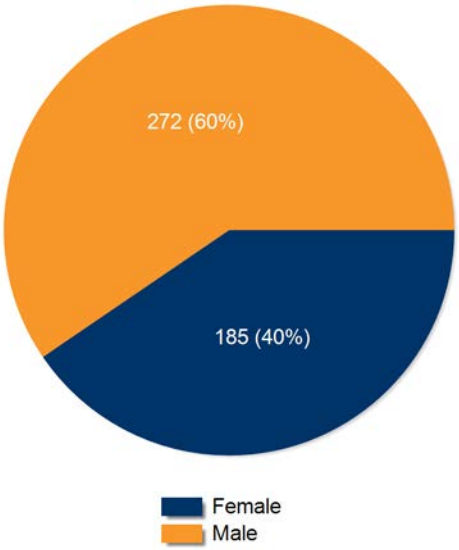
Demographics

60% of consumers were male and 40% were female.

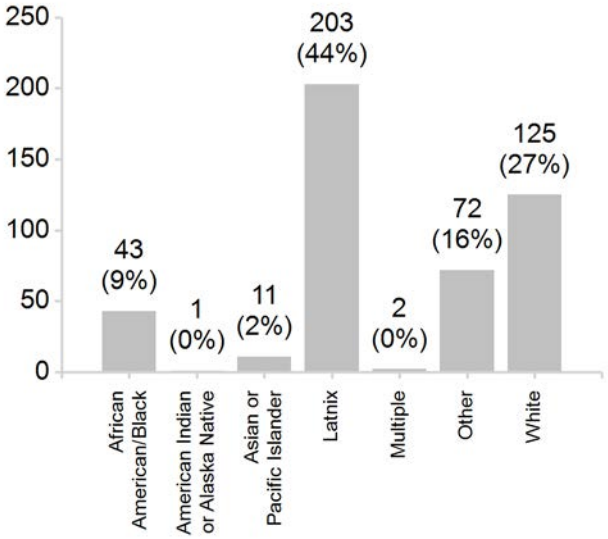
27% of consumers were White, 0% of consumers were Hispanic/Latinx and 9% of consumers were Black/African American.

20% of consumers were 40 to 49 years old.

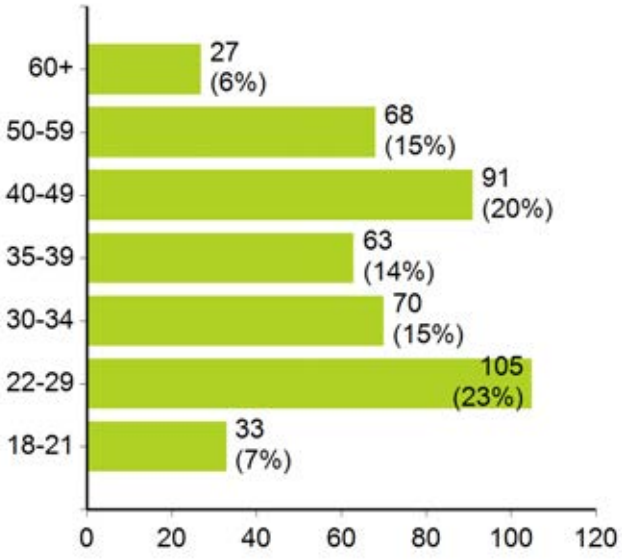
Gender



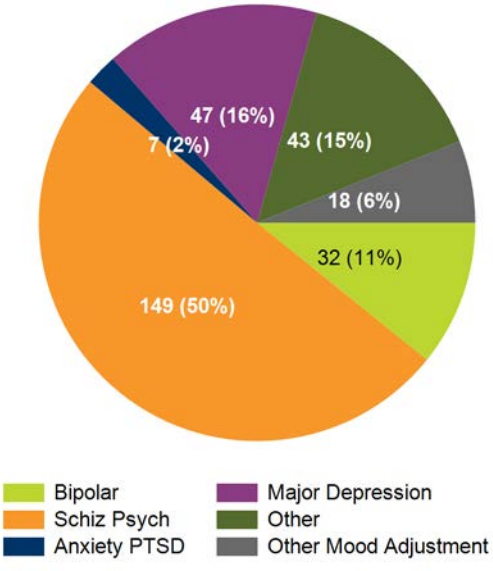
Race/Ethnicity



Age



Diagnosis



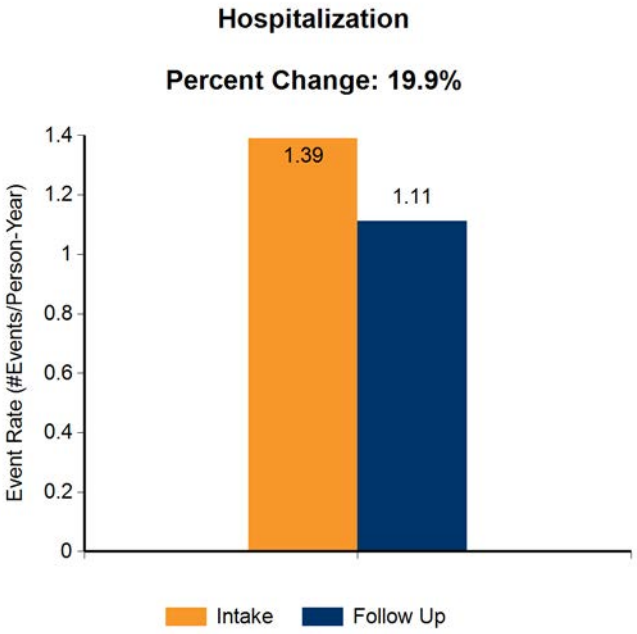
Service Detail: 3301FP

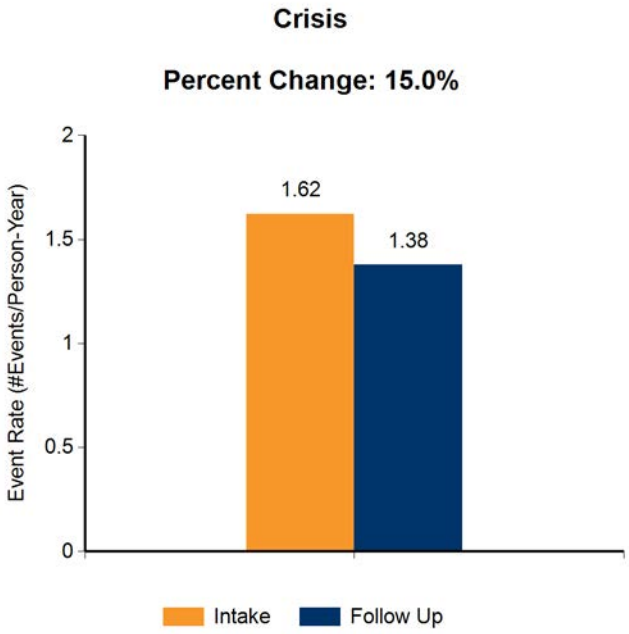
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	50 (41%)	56 (43%)	15 (16%)	32 (30%)	30 (30%)	42 (39%)	63 (48%)	29 (32%)	44 (39%)	15 (21%)	26 (28%)	23 (66%)
2-3	27 (22%)	30 (23%)	32 (35%)	33 (31%)	30 (30%)	32 (30%)	32 (24%)	26 (29%)	39 (35%)	22 (31%)	29 (32%)	10 (29%)
4-7	18 (15%)	11 (8%)	19 (21%)	16 (15%)	14 (14%)	15 (14%)	18 (14%)	15 (16%)	10 (9%)	13 (19%)	13 (14%)	2 (6%)
8-13	15 (12%)	17 (13%)	9 (10%)	11 (10%)	15 (15%)	10 (9%)	8 (6%)	9 (10%)	11 (10%)	14 (20%)	11 (12%)	0 (0%)
14-19	6 (5%)	10 (8%)	11 (12%)	8 (8%)	7 (7%)	5 (5%)	6 (5%)	9 (10%)	5 (4%)	4 (6%)	6 (7%)	0 (0%)
20-25	4 (3%)	3 (2%)	3 (3%)	4 (4%)	3 (3%)	3 (3%)	5 (4%)	3 (3%)	3 (3%)	2 (3%)	2 (2%)	0 (0%)
26-31	1 (1%)	2 (2%)	2 (2%)	1 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (4%)	0 (0%)
32+	0 (0%)	2 (2%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)
Monthly Total	121	131	91	106	100	107	132	91	112	70	92	35

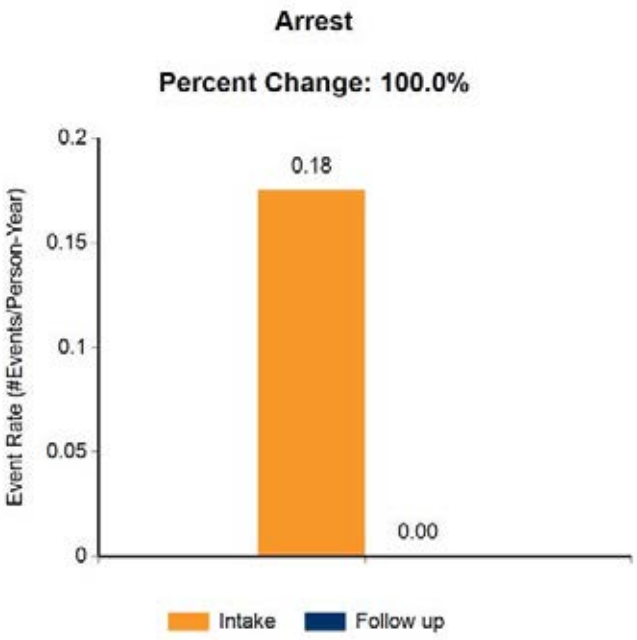
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	14	3%	14	1.00
Case Management	426	79%	2,967	6.96
Crisis	4	1%	5	1.25
Individual Therapy	9	2%	162	18.00
Mental Health Services-Group	39	7%	1,960	50.26
Mental Health Services-Individual	44	8%	685	15.57

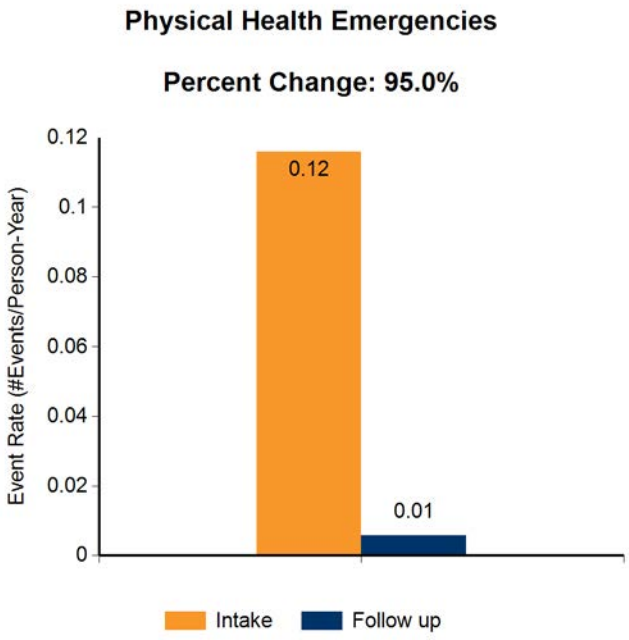
Outcomes for 3301FP

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

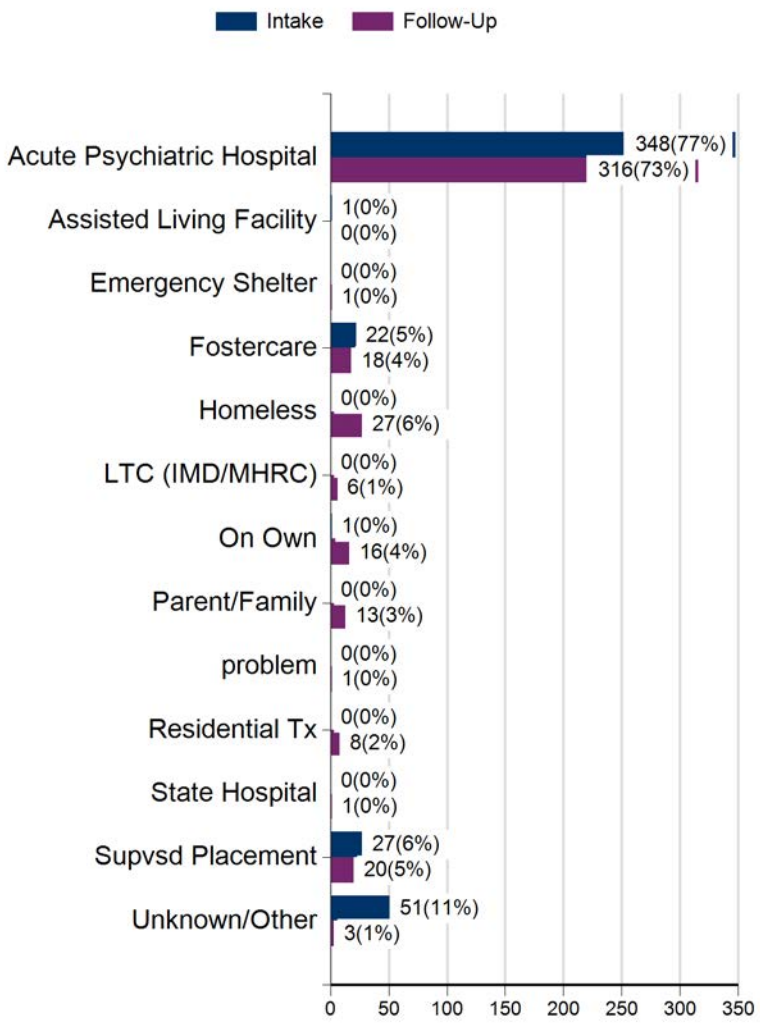








Outcomes: Residential & Discontinuance (3301FP)

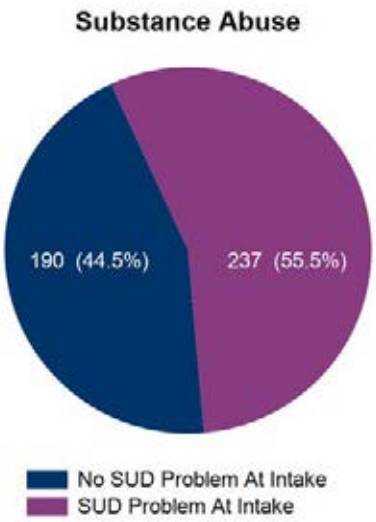


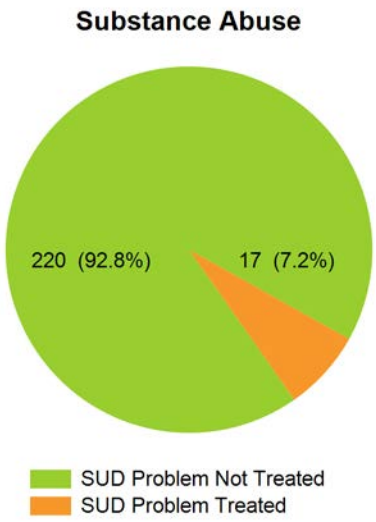
Discontinuation Reason	Count	%
Met goals	436	99%
Moved out of county/area	2	0%
Needs residential care	1	0%
Other	1	0%
Total	**440**	**100%**

Length of FSP Partnership for: 3301FP

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	12	5	17	3.72%
>= 2 Years and <3 Years	22	3	25	5.47%
>= 90 days and < 1 Year	116	14	130	28.45%
Under 90 days	271	14	285	62.36%
Total Consumer Enrollments	**421**	**36**	**457**	

Outcomes: Substance Use (3301FP)

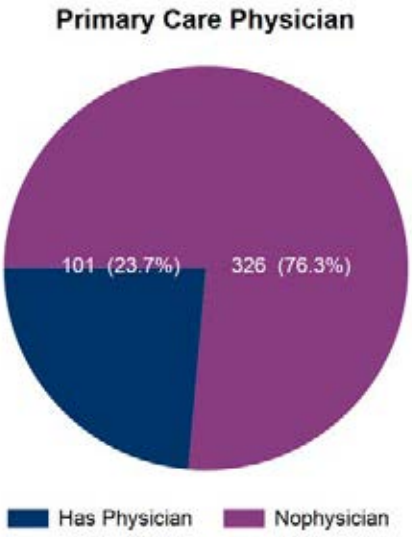




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (55.5%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 1.8% (4) of the 220 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 6 consumers not identified at intake were noted to have an SU problem on follow-up and 2.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (3301FP)



Intake: Most adults (76.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 326 consumers that did not have a PCP at intake, 18 (6.0%) obtained a PCP while in the program.

FSP Adult demographics and Outcomes for: 3385FA
Served by this reporting unit: 65 Enrollment: 65

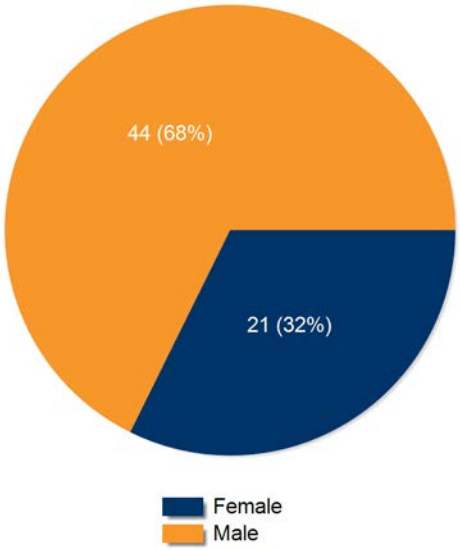
Demographics

68% of consumers were male and 32% were female.

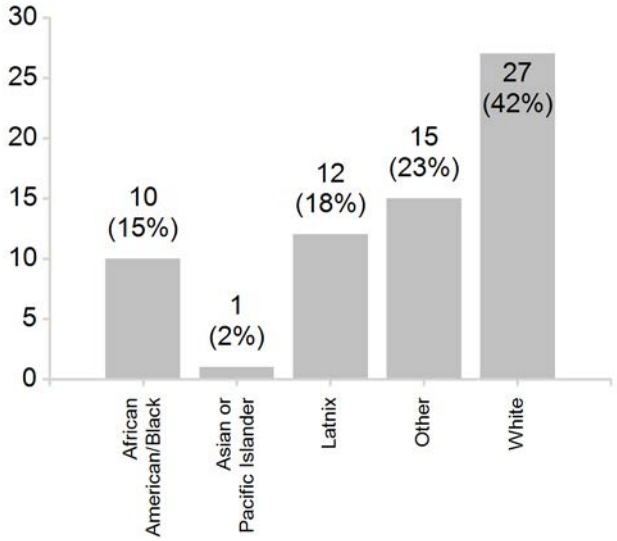
42% of consumers were White, 0% of consumers were Hispanic/Latinx and 15% of consumers were Black/African American.

22% of consumers were 40 to 49 years old.

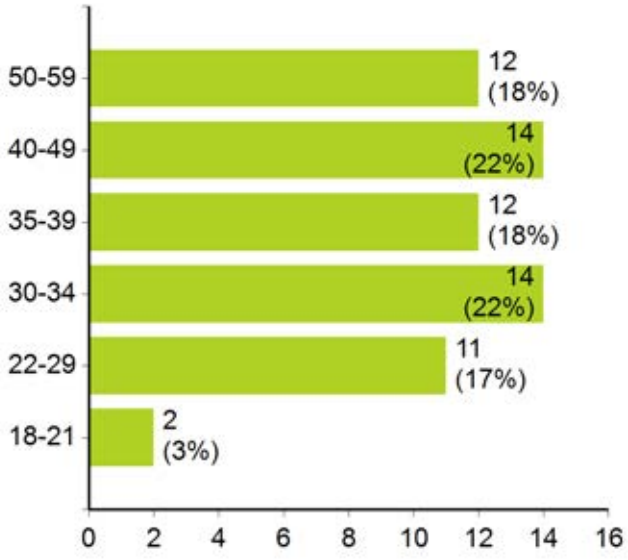
Gender



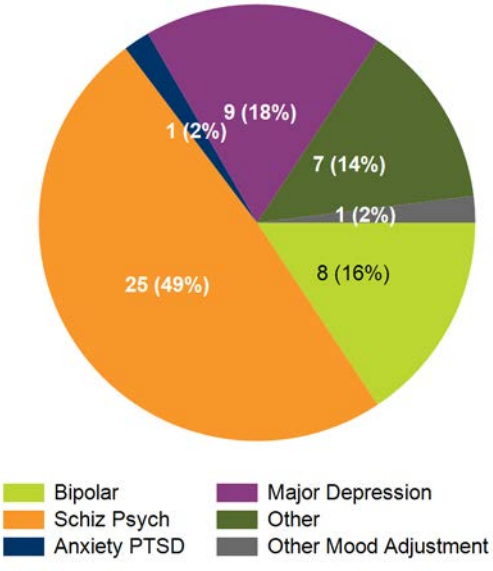
Race/Ethnicity



Age



Diagnosis



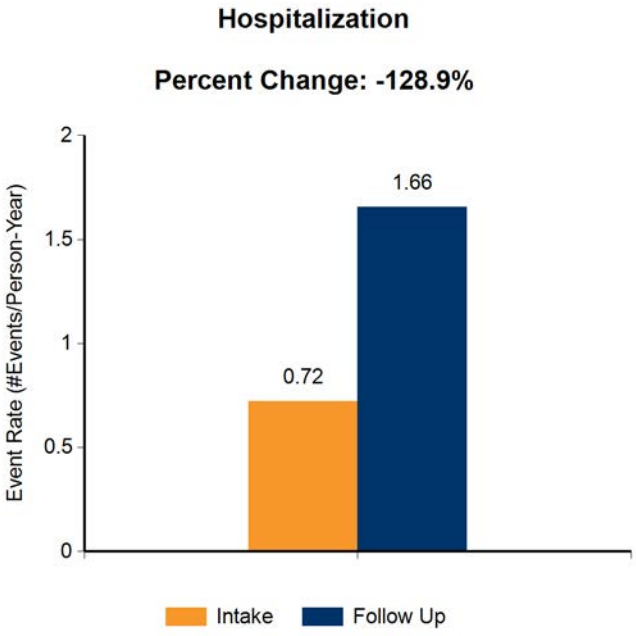
Service Detail: 3385FA

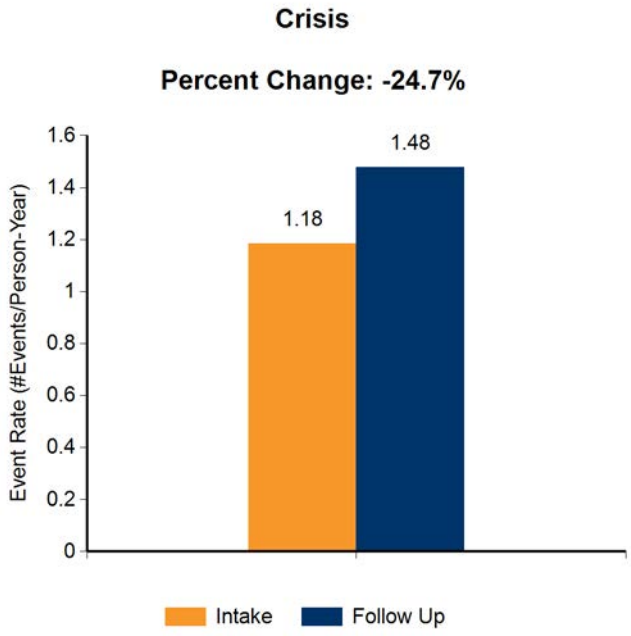
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	3 (25%)	2 (13%)	3 (17%)	5 (21%)	3 (14%)	1 (5%)	5 (22%)	8 (32%)	9 (33%)	8 (27%)	3 (14%)	3 (18%)
2-3	2 (17%)	6 (38%)	5 (28%)	5 (21%)	1 (5%)	9 (45%)	9 (39%)	8 (32%)	8 (30%)	9 (30%)	6 (29%)	6 (35%)
4-7	5 (42%)	4 (25%)	3 (17%)	6 (25%)	10 (48%)	5 (25%)	2 (9%)	4 (16%)	5 (19%)	9 (30%)	9 (43%)	6 (35%)
8-13	1 (8%)	2 (13%)	5 (28%)	6 (25%)	5 (24%)	3 (15%)	4 (17%)	4 (16%)	4 (15%)	2 (7%)	2 (10%)	2 (12%)
14-19	1 (8%)	1 (6%)	0 (0%)	0 (0%)	2 (10%)	2 (10%)	2 (9%)	1 (4%)	1 (4%)	2 (7%)	0 (0%)	0 (0%)
20-25	0 (0%)	1 (6%)	1 (6%)	1 (4%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
26-31	0 (0%)	0 (0%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)
Monthly Total	12	16	18	24	21	20	23	25	27	30	21	17

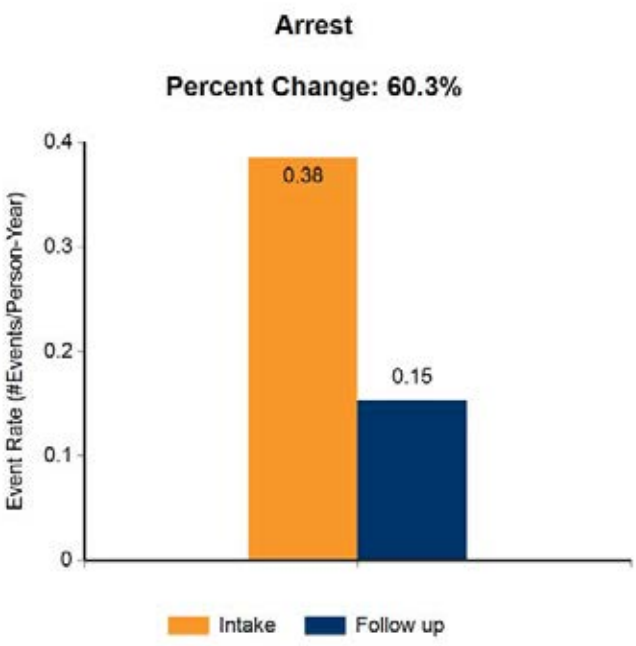
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	12	6%	12	1.00
Case Management	44	21%	490	11.14
Collateral Services	1	0%	1	1.00
Crisis	7	3%	18	2.57
Family Therapy	1	0%	2	2.00
Individual Therapy	18	9%	114	6.33
Medication MD Services	20	10%	61	3.05
Medication Therapeutic Services	29	14%	174	6.00
Mental Health Services-Individual	31	15%	241	7.77
Non Face to Face MD	9	4%	14	1.56
Peer MH Education Groups	5	2%	15	3.00
Peer MH Engagement	9	4%	11	1.22
Peer MH Therapeutic Activity	20	10%	169	8.45
Psychiatric Assessment	1	0%	1	1.00

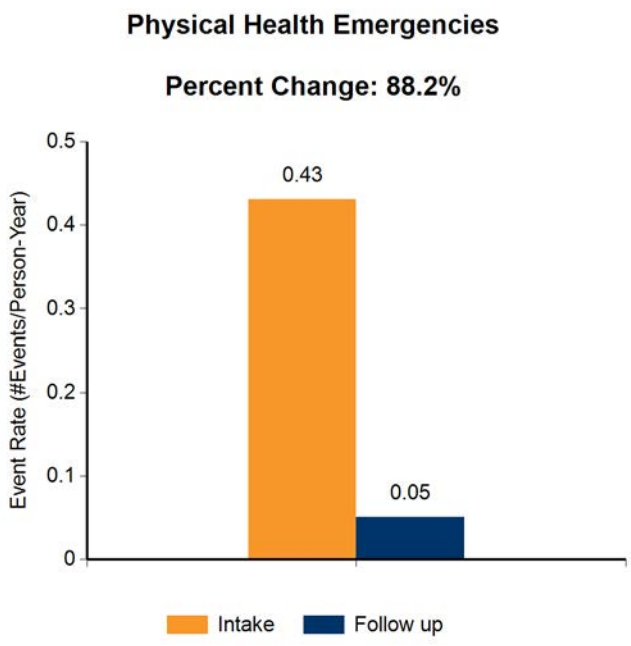
Outcomes for 3385FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

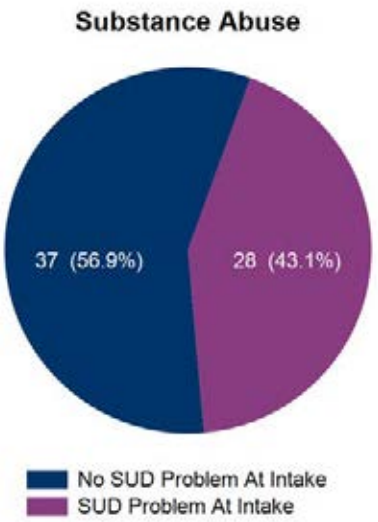


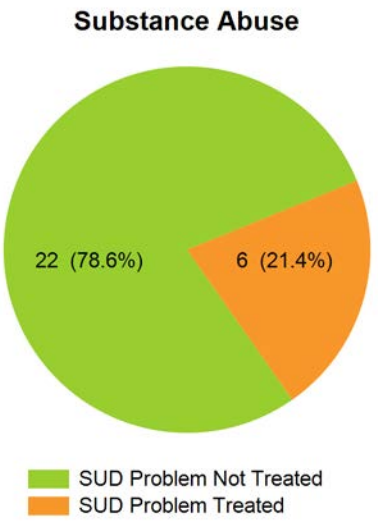






Outcomes: Substance Use (3385FA)

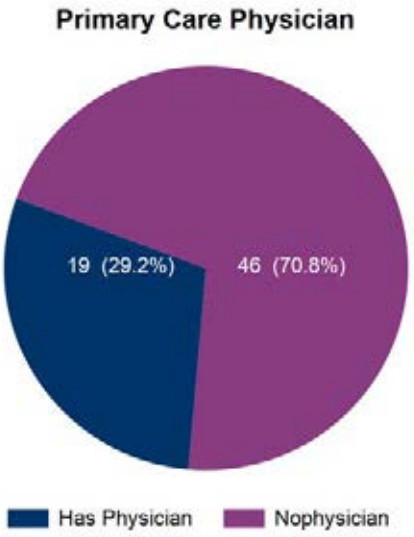




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (43.1%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 9.1% (2) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 5 consumers not identified at intake were noted to have an SU problem on follow-up and 9.0% of them were reported to be in SU services on follow-up.

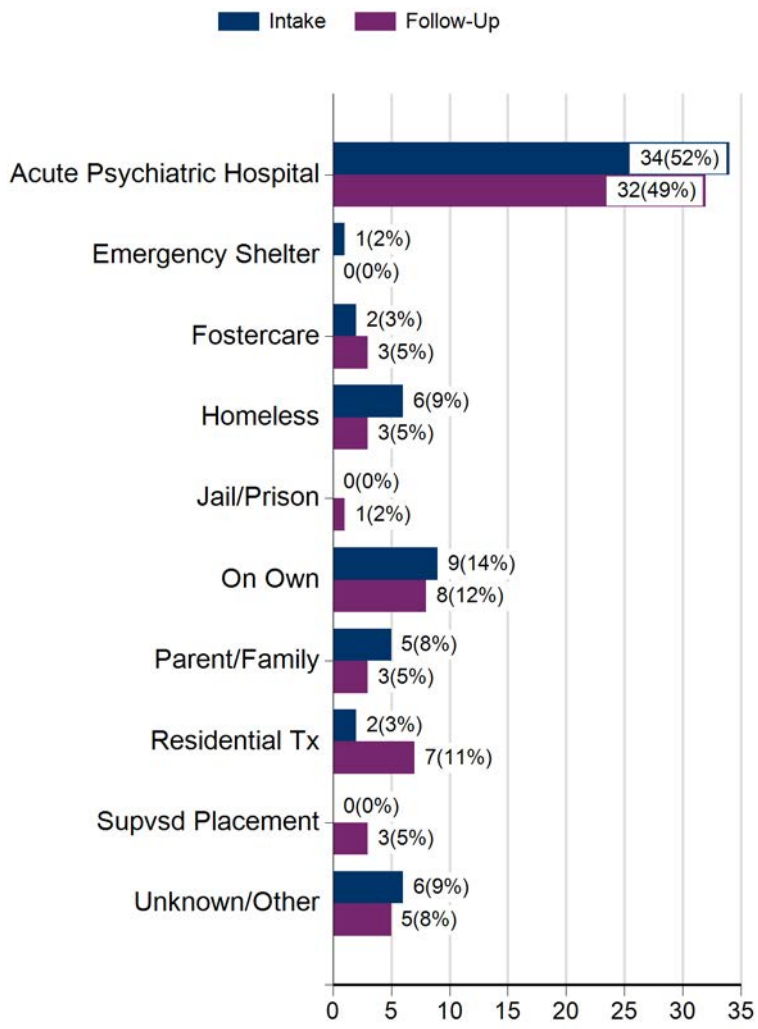
Outcomes: Primary Care Physician (3385FA)



Intake: Most adults (70.8%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 46 consumers that did not have a PCP at intake, 12 (26.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (3385FA)



Discontinuation Reason	Count	%
Deceased	1	3%
Justice system	3	8%
Met goals	2	5%
Moved out of county/area	3	8%
Needs residential care	1	3%
Partner cannot be located	11	28%
Partner left program	12	31%
Target criteria not met	6	15%
Total	**39**	**100%**

Length of FSP Partnership for: 3385FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	3	3	6	9.23%
>= 2 Years and <3 Years	2	1	3	4.62%
>= 3 Years and < 4 Years	1	0	1	1.54%
>= 90 days and < 1 Year	23	12	35	53.85%
Under 90 days	16	4	20	30.77%
Total Consumer Enrollments	**45**	**20**	**65**	

FSP Adult demographics and Outcomes for: 3352FA
Served by this reporting unit: 4 Enrollment: 4

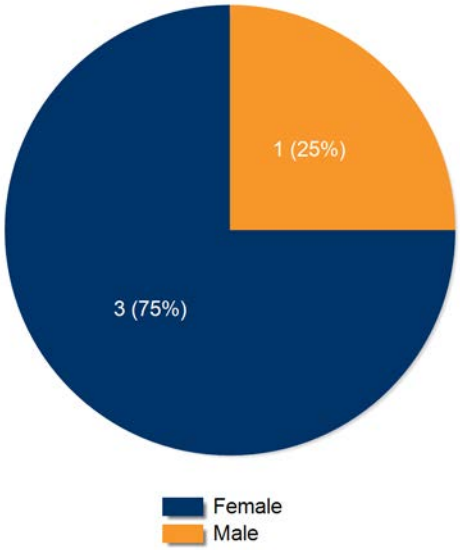
Demographics

25% of consumers were male and 75% were female.

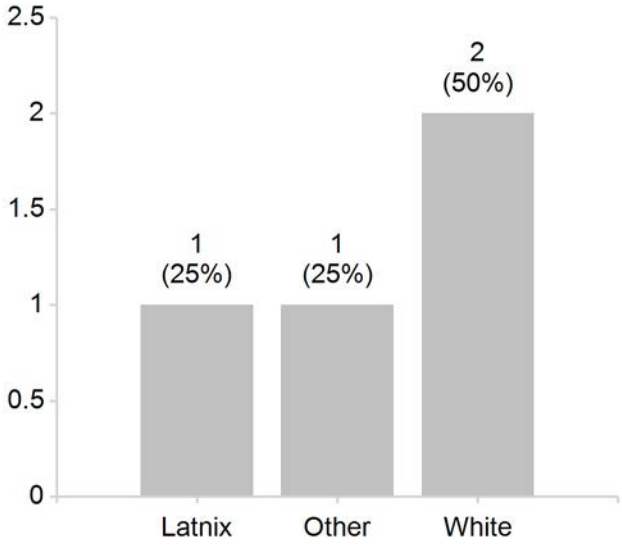
50% of consumers were White, 0% of consumers were Hispanic/Latinx and 0% of consumers were Black/African American.

75% of consumers were 40 to 49 years old.

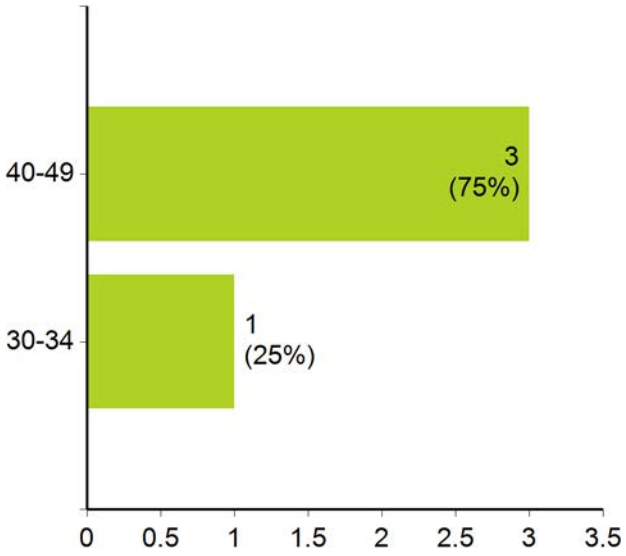
Gender



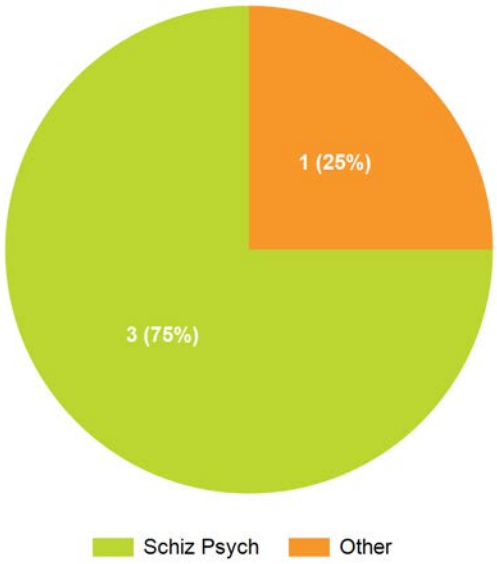
Race/Ethnicity



Age



Diagnosis



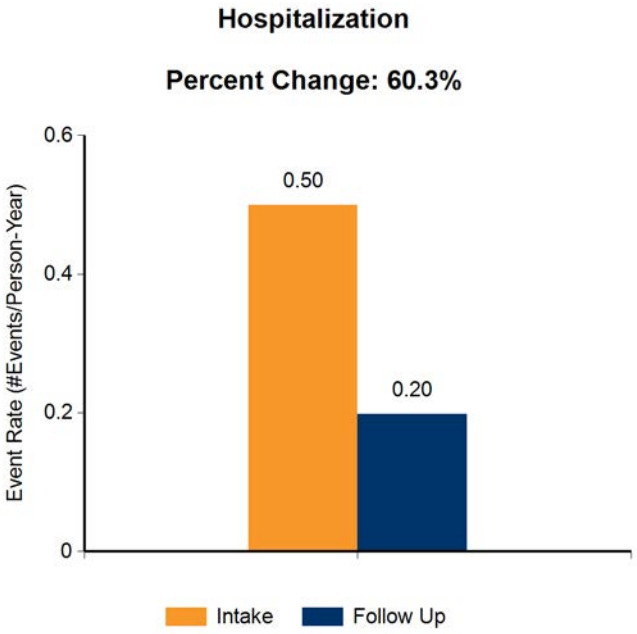
Service Detail: 3352FA

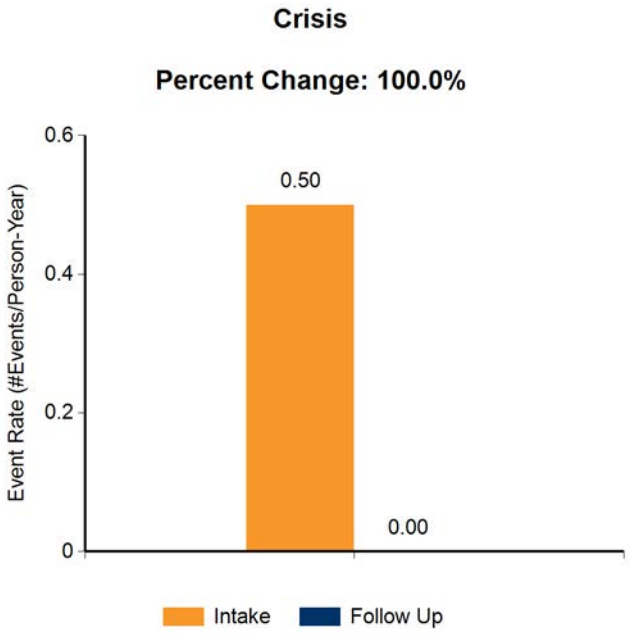
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Feb	Mar	Apr	May
0-1	1 (100%)	2 (100%)	1 (100%)	1 (100%)	2 (100%)	0 (0%)	0 (0%)	1 (100%)	1 (100%)
2-3	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)
4-7	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Monthly Total	1	2	1	1	2	1	1	1	1

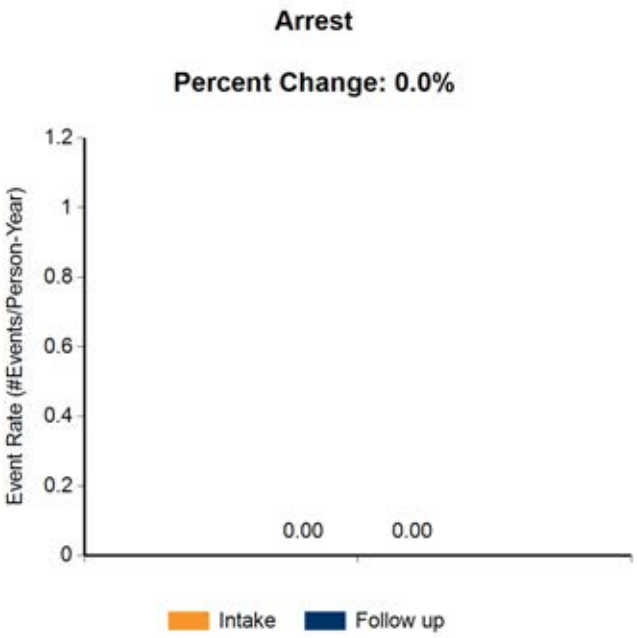
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Individual Therapy	1	20%	2	2.00
Medication Therapeutic Services	4	80%	13	3.25

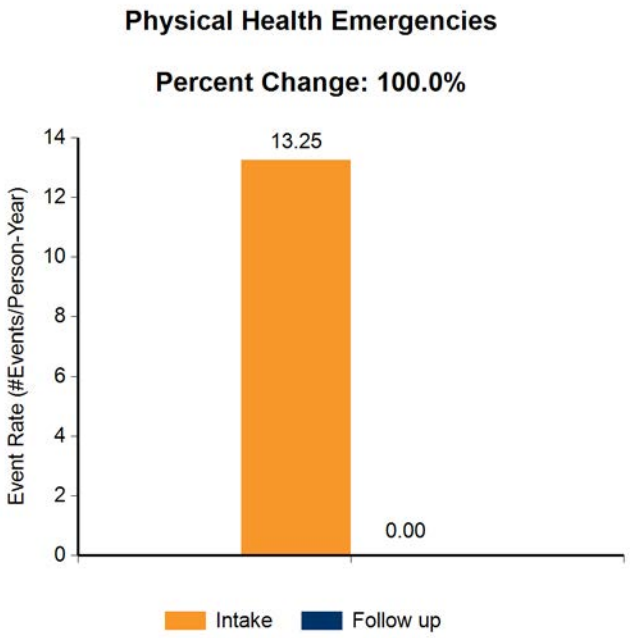
Outcomes for 3352FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

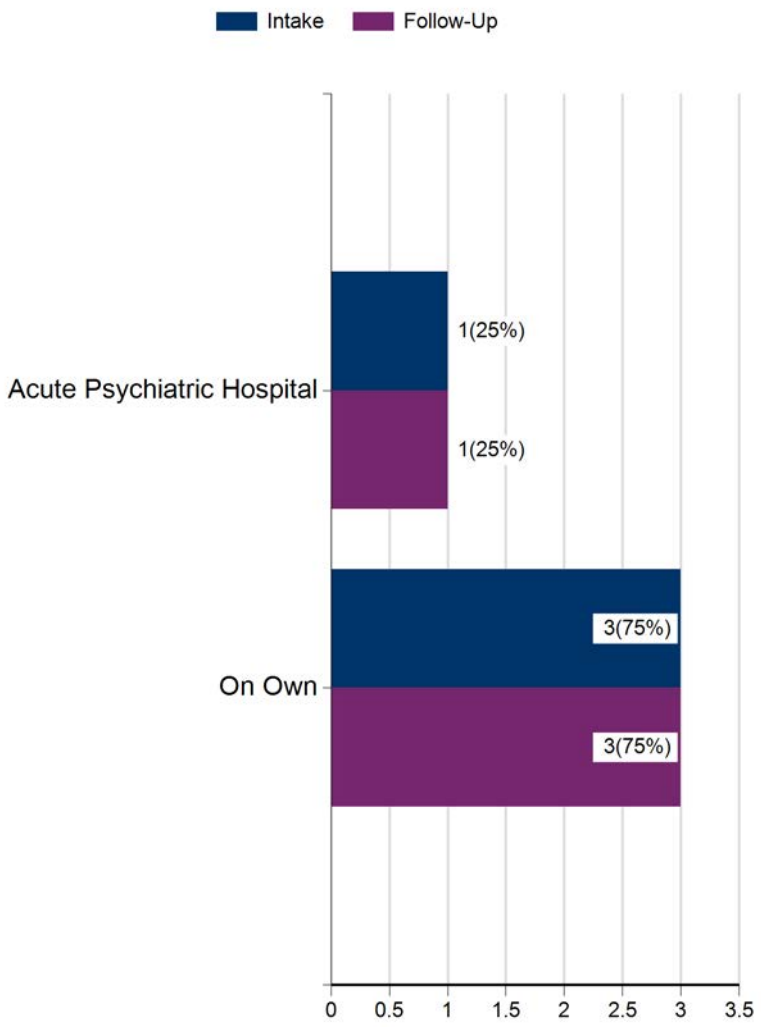








Outcomes: Residential & Discontinuance (3352FA)

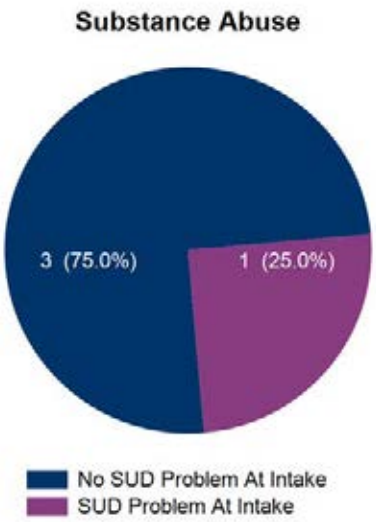


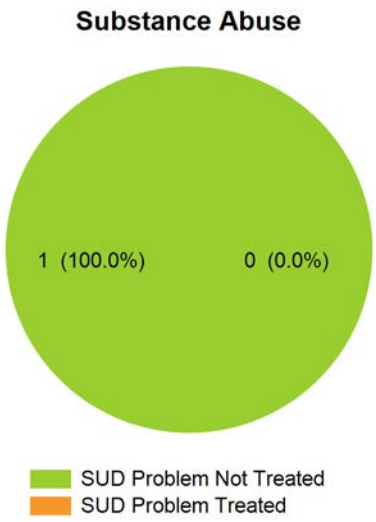
Discontinuation Reason	Count	%
Target criteria not met	2	100%
Total	2	100%

Length of FSP Partnership for: 3352FA

Adult Time in Partnership	Open	All Consumers	% of Total
>= 3 Years and < 4 Years	3	3	75.00%
>= 90 days and < 1 Year	1	1	25.00%
Total Consumer Enrollments	4	4	

Outcomes: Substance Use (3352FA)

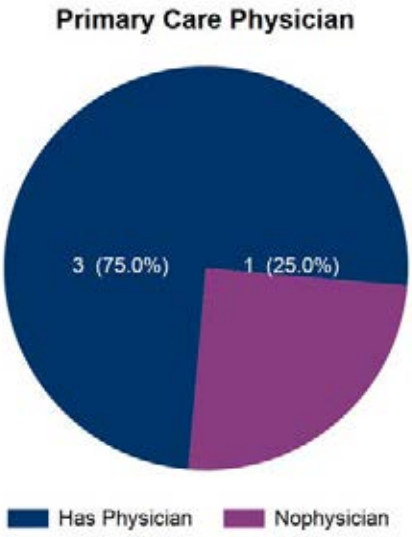




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (25.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 0.0% (0) of the 1 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 0.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (3352FA)



Intake: Most adults (25.0%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 1 consumers that did not have a PCP at intake, 1 (100.0%) obtained a PCP while in the program.

FSP Adult demographics and Outcomes for: 3377FA
Served by this reporting unit: 284 Enrollment: 291

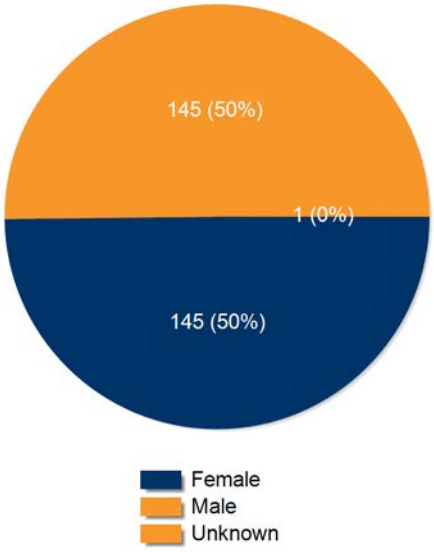
Demographics

50% of consumers were male and 50% were female.

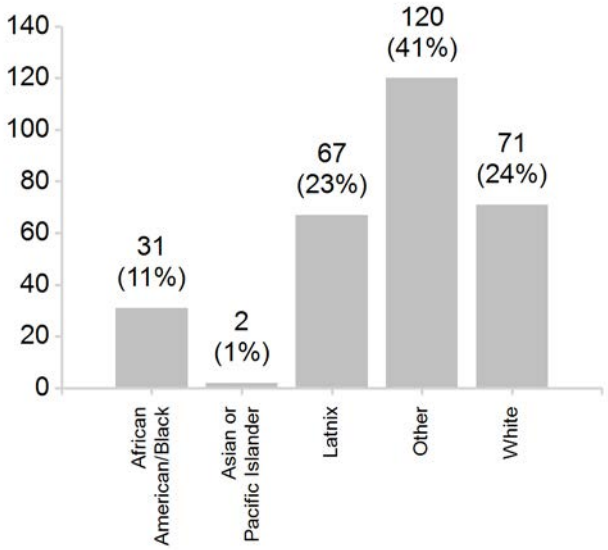
24% of consumers were White, 0% of consumers were Hispanic/Latinx and 11% of consumers were Black/African American.

25% of consumers were 40 to 49 years old.

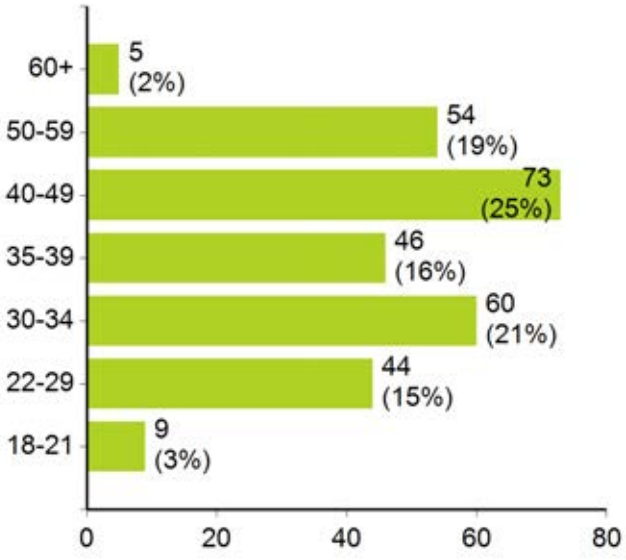
Gender



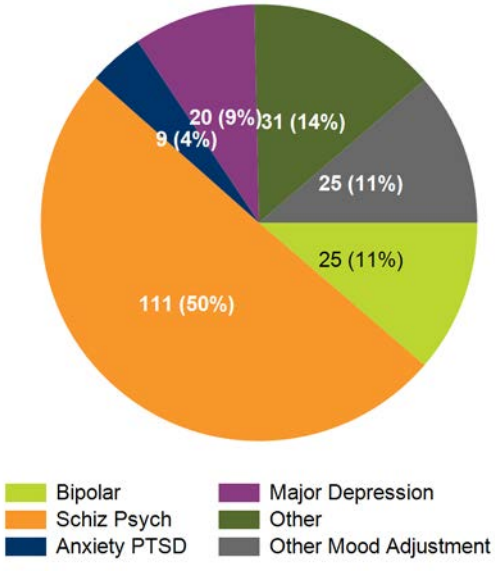
Race/Ethnicity



Age



Diagnosis



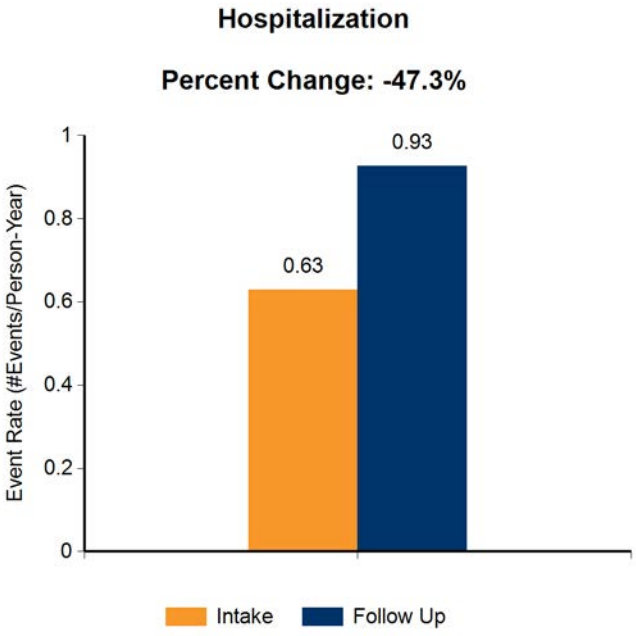
Service Detail: 3377FA

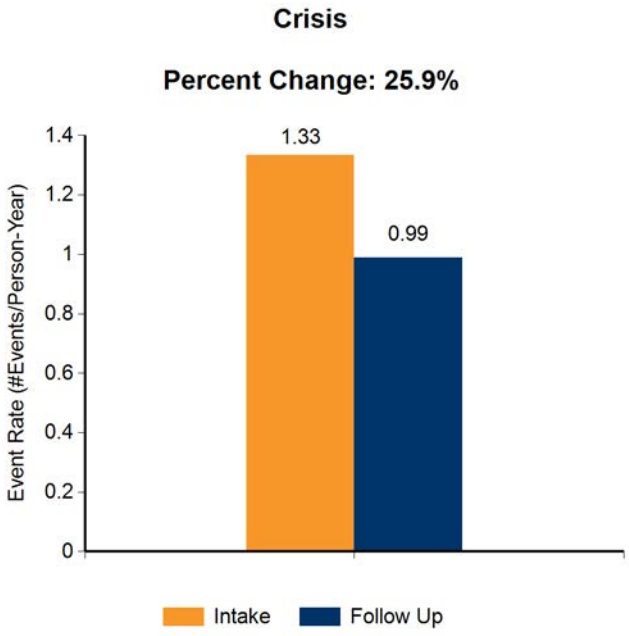
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	39 (31%)	26 (20%)	32 (26%)	41 (38%)	38 (38%)	51 (37%)	43 (32%)	30 (31%)	50 (33%)	41 (26%)	25 (18%)	35 (27%)
2-3	35 (28%)	34 (26%)	36 (29%)	22 (20%)	27 (27%)	54 (39%)	46 (35%)	33 (34%)	47 (31%)	46 (29%)	45 (33%)	44 (34%)
4-7	29 (23%)	39 (30%)	30 (24%)	27 (25%)	24 (24%)	23 (17%)	27 (20%)	15 (16%)	28 (18%)	42 (27%)	39 (29%)	26 (20%)
8-13	15 (12%)	19 (15%)	22 (18%)	16 (15%)	12 (12%)	9 (7%)	12 (9%)	13 (14%)	18 (12%)	14 (9%)	15 (11%)	13 (10%)
14-19	3 (2%)	7 (5%)	3 (2%)	1 (1%)	0 (0%)	0 (0%)	3 (2%)	3 (3%)	7 (5%)	12 (8%)	10 (7%)	9 (7%)
20-25	2 (2%)	1 (1%)	0 (0%)	2 (2%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)	2 (1%)	1 (1%)	0 (0%)
26-31	0 (0%)	4 (3%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	2 (2%)	1 (1%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)
32+	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Monthly Total	124	130	124	109	101	138	133	96	152	157	136	128

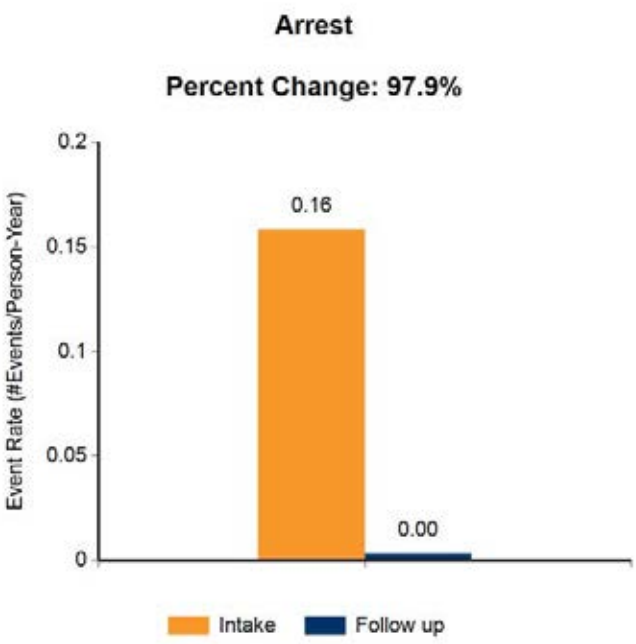
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	20	2%	20	1.00
Case Management	273	32%	3,101	11.36
Client Supportive Services	1	0%	1	1.00
Crisis	4	0%	6	1.50
Family Therapy	1	0%	1	1.00
Individual Therapy	27	3%	160	5.93
Medication MD Services	78	9%	170	2.18
Medication Therapeutic Services	70	8%	527	7.53
Mental Health Services-Group	13	2%	44	3.38
Mental Health Services-Individual	226	27%	2,215	9.80
Non Face to Face MD	43	5%	78	1.81
Peer MH Education Groups	2	0%	2	1.00
Peer MH Engagement	14	2%	22	1.57
Peer MH Therapeutic Activity	54	6%	239	4.43
Psychiatric Assessment	18	2%	18	1.00

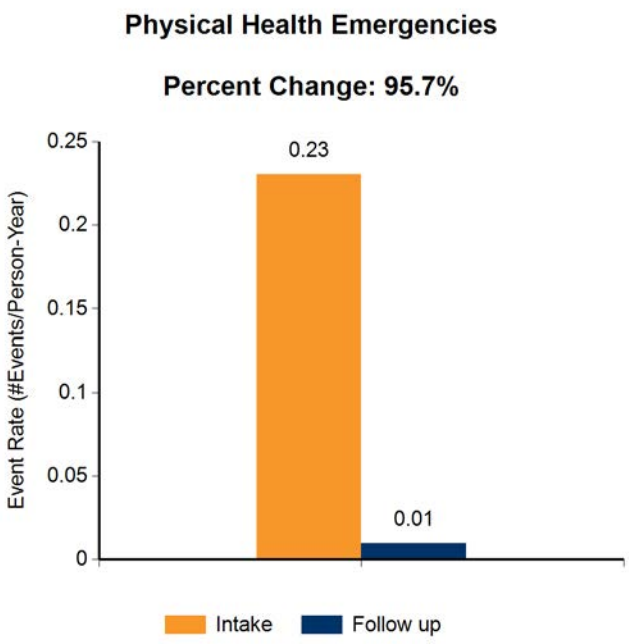
Outcomes for 3377FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

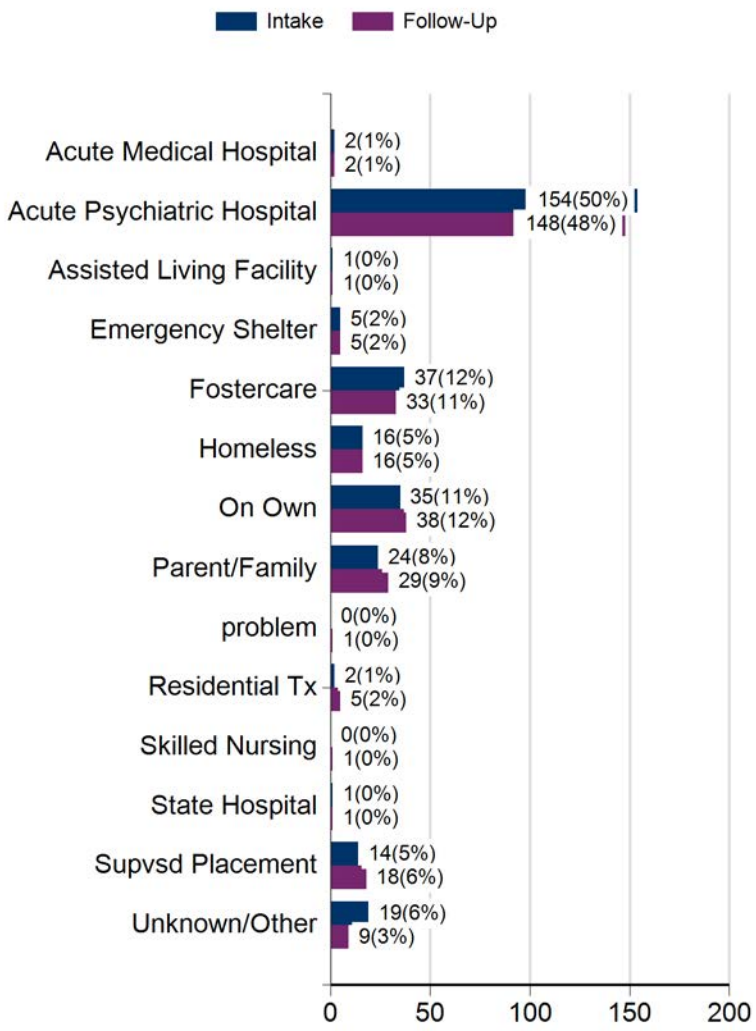








Outcomes: Residential & Discontinuance (3377FA)

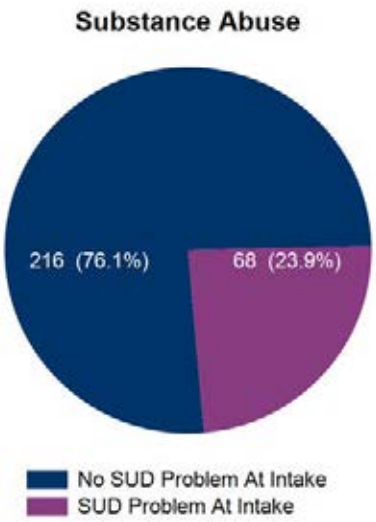


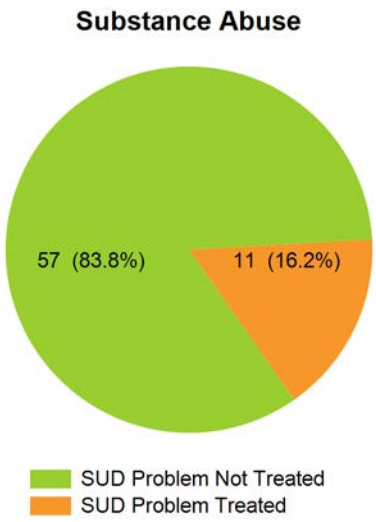
Discontinuation Reason	Count	%
Deceased	2	3%
Met goals	3	4%
Moved out of county/area	9	13%
Needs residential care	1	1%
Partner cannot be located	48	72%
Partner left program	4	6%
Total	**67**	**100%**

Length of FSP Partnership for: 3377FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	17	44	61	20.96%
>= 2 Years and <3 Years	6	7	13	4.47%
>= 3 Years and < 4 Years	1	4	5	1.72%
>= 4 Years and < 5 years	2	17	19	6.53%
>= 90 days and < 1 Year	81	69	150	51.55%
Under 90 days	18	25	43	14.78%
Total Consumer Enrollments	**125**	**166**	**291**	

Outcomes: Substance Use (3377FA)

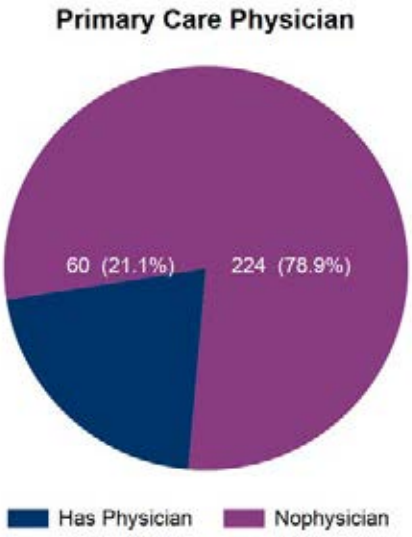




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.9%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 7.0% (4) of the 57 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 21 consumers not identified at intake were noted to have an SU problem on follow-up and 7.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (3377FA)



Intake: Most adults (78.9%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 224 consumers that did not have a PCP at intake, 31 (14.0%) obtained a PCP while in the program.

FSP Adult demographics and Outcomes for: 3383FA
Served by this reporting unit: 73 Enrollment: 75

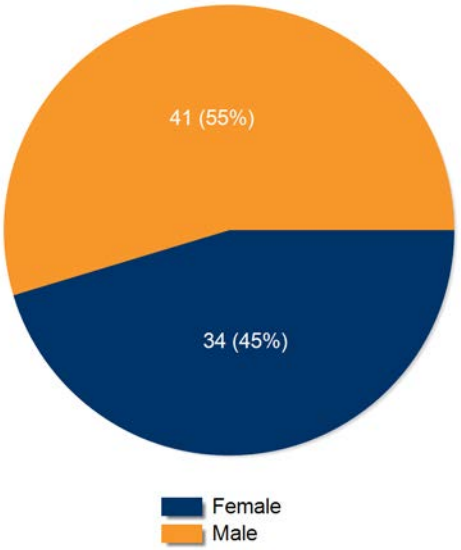
Demographics

55% of consumers were male and 45% were female.

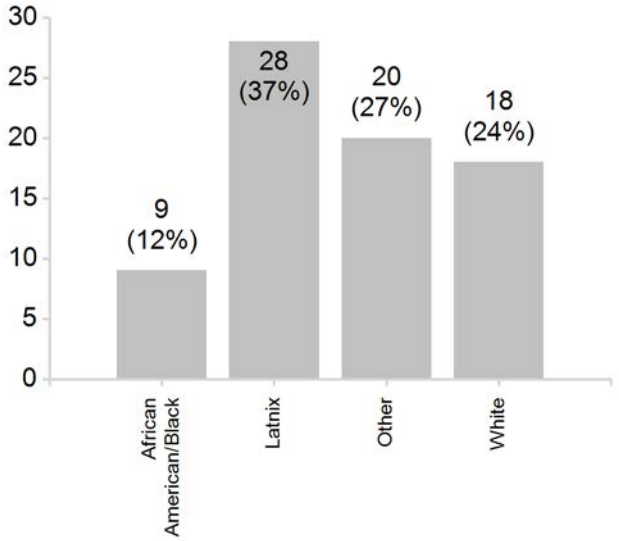
24% of consumers were White, 0% of consumers were Hispanic/Latinx and 12% of consumers were Black/African American.

21% of consumers were 40 to 49 years old.

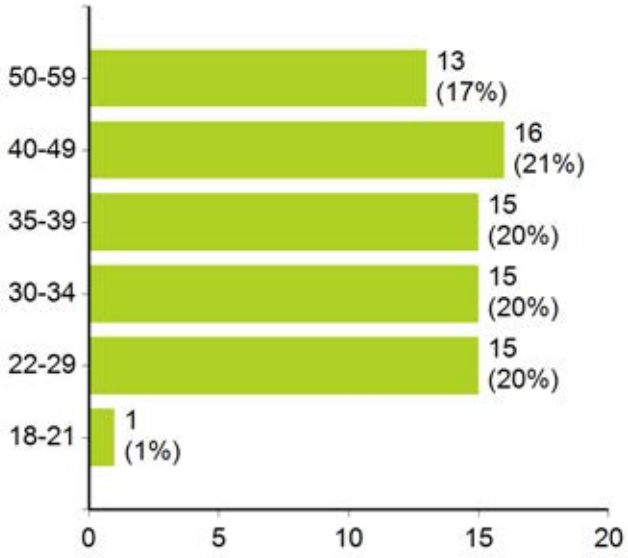
Gender



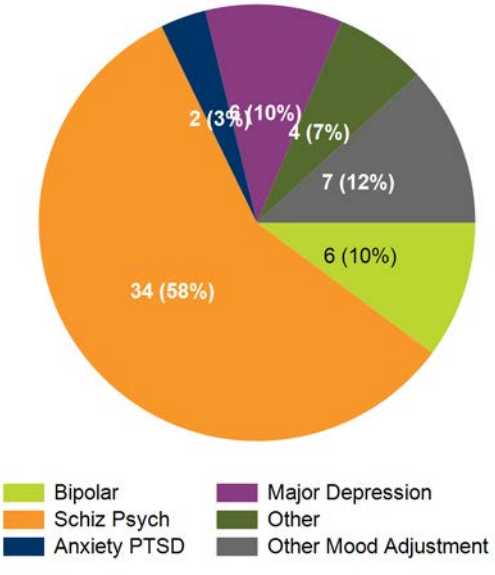
Race/Ethnicity



Age



Diagnosis



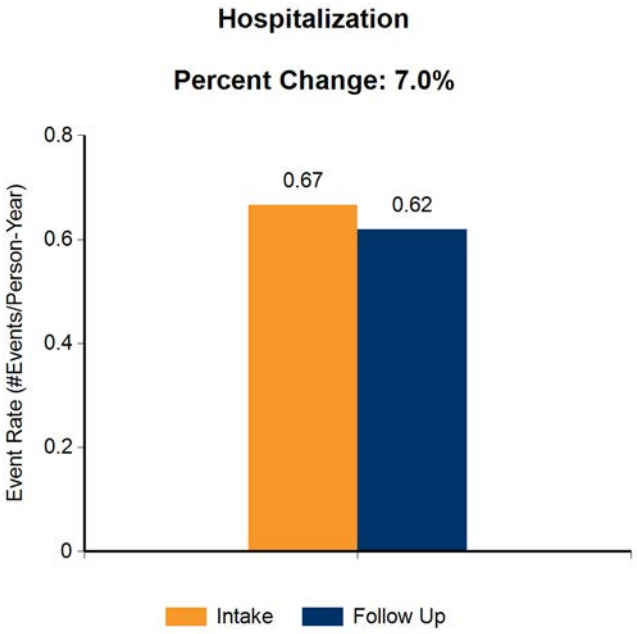
Service Detail: 3383FA

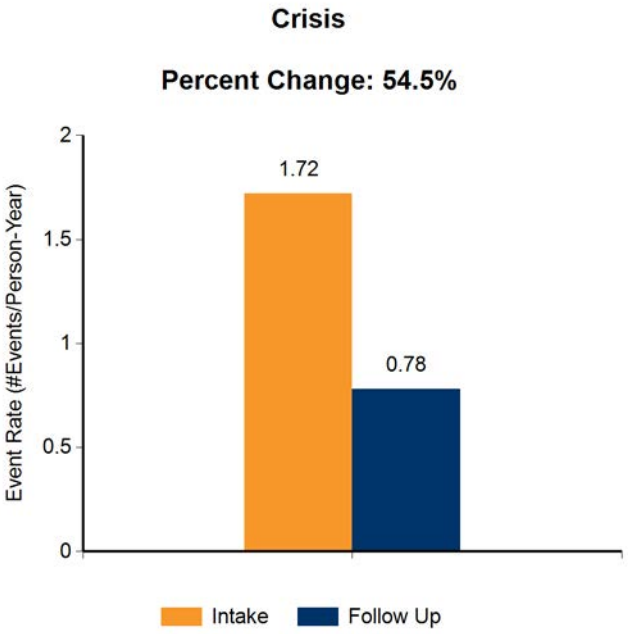
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	13 (33%)	9 (22%)	5 (15%)	11 (28%)	13 (39%)	14 (47%)	14 (33%)	8 (27%)	9 (23%)	13 (35%)	6 (20%)	7 (23%)
2-3	18 (45%)	14 (34%)	11 (32%)	13 (33%)	7 (21%)	5 (17%)	12 (29%)	7 (23%)	14 (36%)	7 (19%)	7 (23%)	4 (13%)
4-7	8 (20%)	13 (32%)	11 (32%)	7 (18%)	7 (21%)	5 (17%)	8 (19%)	12 (40%)	8 (21%)	12 (32%)	9 (30%)	13 (42%)
8-13	1 (3%)	4 (10%)	6 (18%)	7 (18%)	4 (12%)	6 (20%)	6 (14%)	3 (10%)	6 (15%)	2 (5%)	8 (27%)	5 (16%)
14-19	0 (0%)	1 (2%)	1 (3%)	2 (5%)	2 (6%)	0 (0%)	1 (2%)	0 (0%)	1 (3%)	3 (8%)	0 (0%)	2 (6%)
20-25	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	1 (3%)	0 (0%)	0 (0%)	0 (0%)
Monthly Total	40	41	34	40	33	30	42	30	39	37	30	31

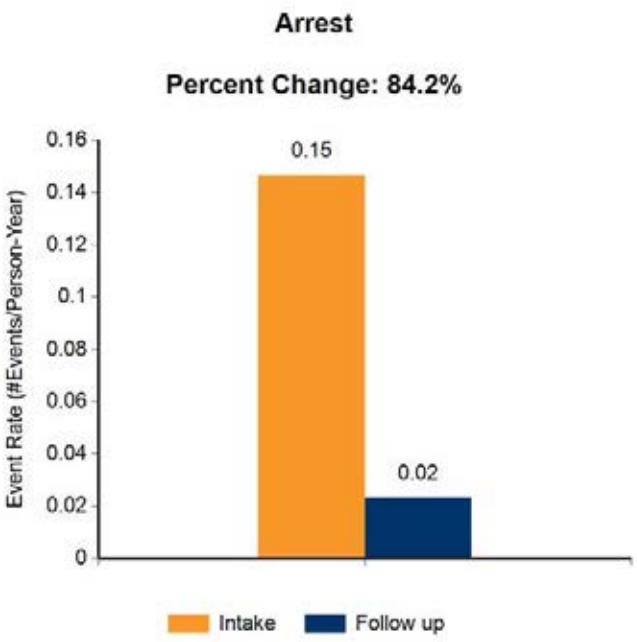
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	4	2%	4	1.00
Case Management	43	21%	851	19.79
Client Supportive Services	1	0%	1	1.00
Crisis	2	1%	2	1.00
Individual Therapy	2	1%	8	4.00
Medication MD Services	47	22%	206	4.38
Medication Therapeutic Services	23	11%	94	4.09
Mental Health Services-Group	1	0%	1	1.00
Mental Health Services-Individual	49	23%	483	9.86
Non Face to Face MD	31	15%	92	2.97
Psychiatric Assessment	6	3%	6	1.00

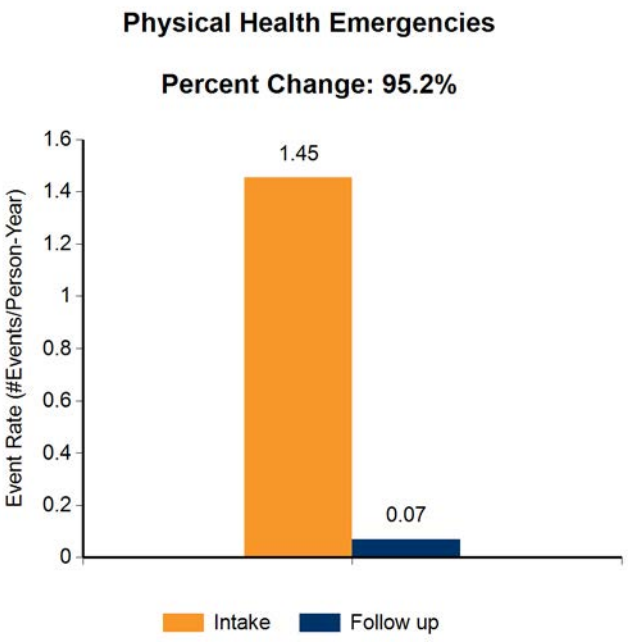
Outcomes for 3383FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

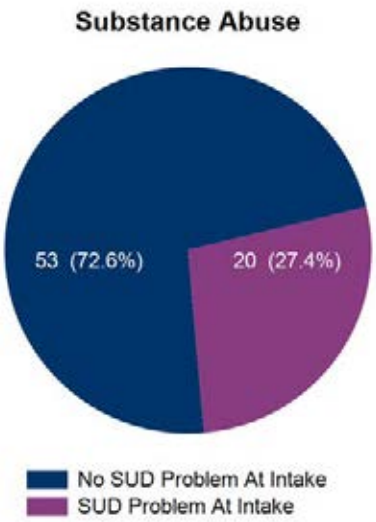


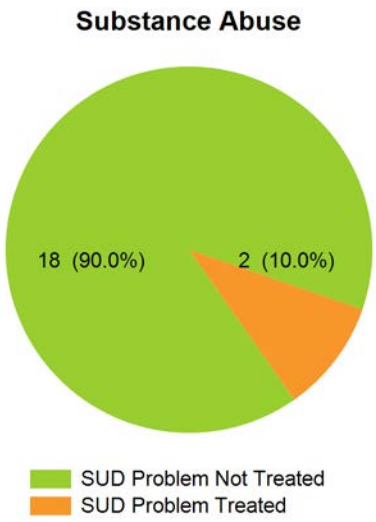






Outcomes: Substance Use (3383FA)

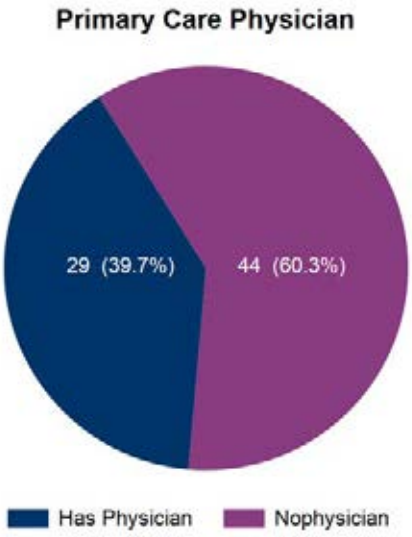




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.4%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 27.8% (5) of the 18 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 11 consumers not identified at intake were noted to have an SU problem on follow-up and 28.0% of them were reported to be in SU services on follow-up.

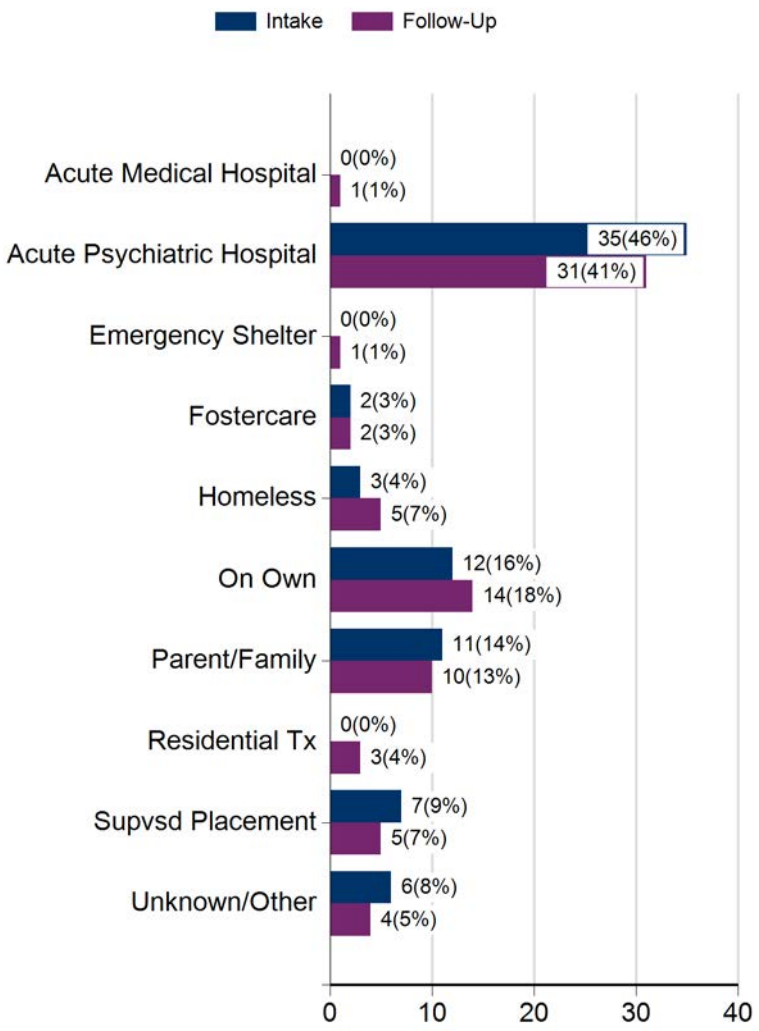
Outcomes: Primary Care Physician (3383FA)



Intake: Most adults (60.3%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 44 consumers that did not have a PCP at intake, 12 (27.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (3383FA)



Discontinuation Reason	Count	%
Justice system	1	13%
Moved out of county/area	3	38%
Other	1	13%
Partner cannot be located	3	38%
Total	**8**	**100%**

Length of FSP Partnership for: 3383FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	3	12	15	20.00%
>= 2 Years and <3 Years	3	4	7	9.33%
>= 3 Years and < 4 Years	4	9	13	17.33%
>= 4 Years and < 5 years	2	5	7	9.33%
>= 90 days and < 1 Year	4	19	23	30.67%
Under 90 days	8	2	10	13.33%
Total Consumer Enrollments	**24**	**51**	**75**	

FSP Adult demographics and Outcomes for: 33MTFA
Served by this reporting unit: 55 Enrollment: 56

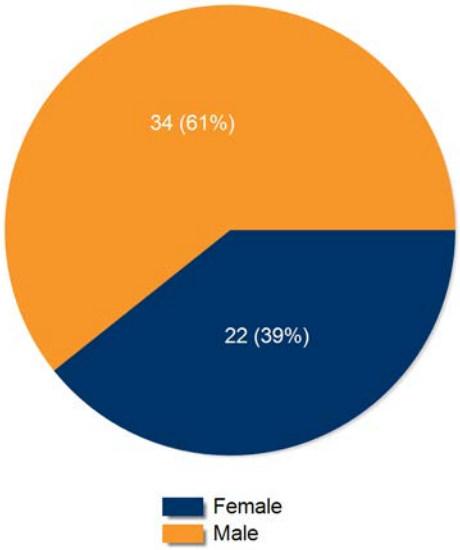
Demographics

61% of consumers were male and 39% were female.

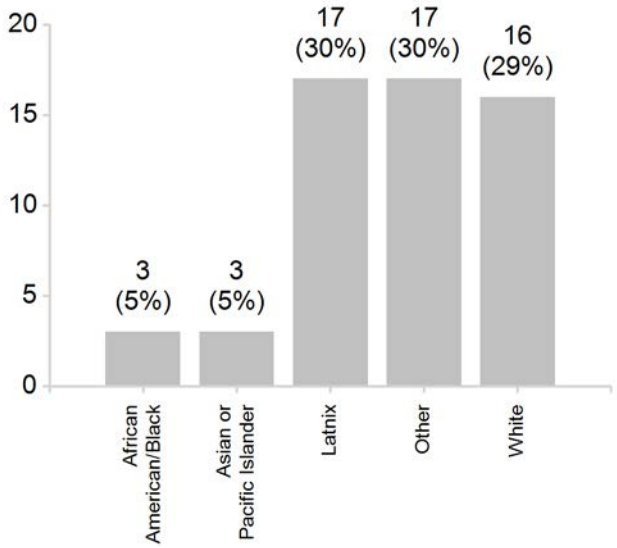
29% of consumers were White, 0% of consumers were Hispanic/Latinx and 5% of consumers were Black/African American.

13% of consumers were 40 to 49 years old.

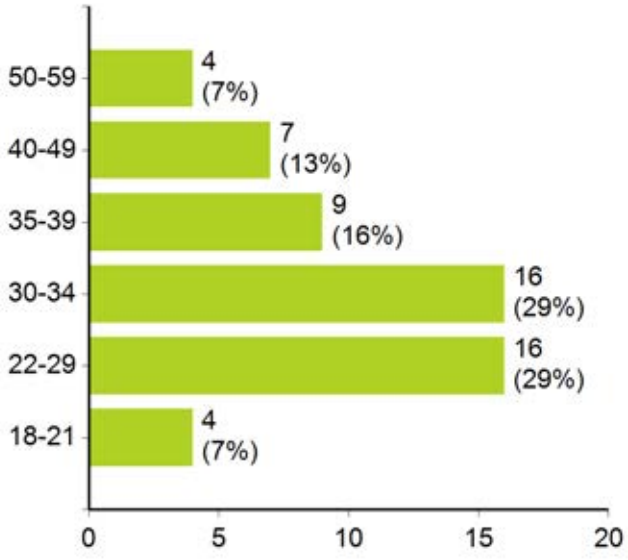
Gender



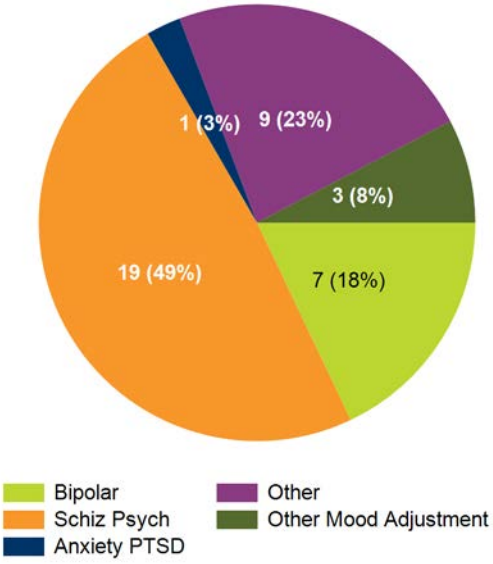
Race/Ethnicity



Age



Diagnosis



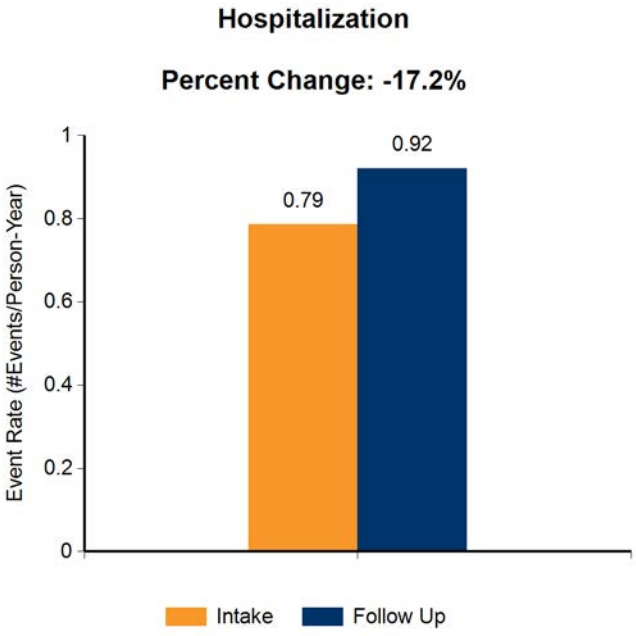
Service Detail: 33MTFA

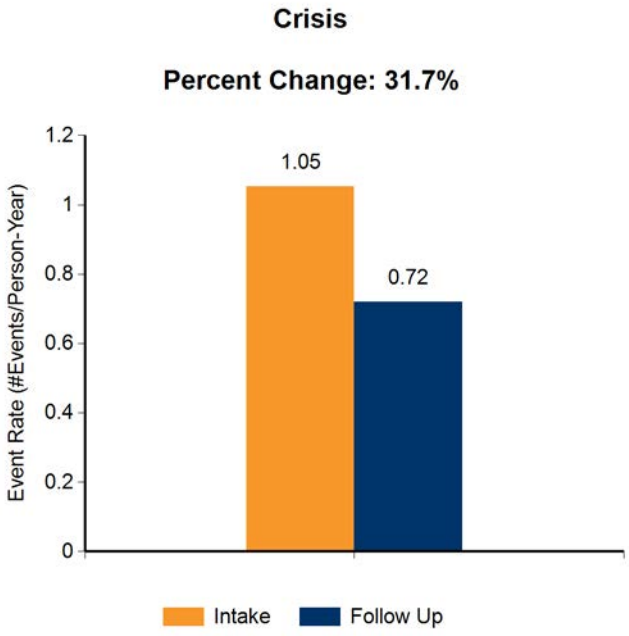
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	2 (8%)	3 (14%)	7 (29%)	3 (14%)	2 (9%)	0 (0%)	1 (5%)	2 (9%)	1 (5%)	1 (5%)	3 (14%)	1 (5%)
2-3	6 (25%)	5 (23%)	4 (17%)	2 (9%)	5 (22%)	6 (32%)	4 (19%)	5 (23%)	4 (19%)	4 (20%)	4 (18%)	5 (24%)
4-7	9 (38%)	7 (32%)	8 (33%)	9 (41%)	12 (52%)	4 (21%)	8 (38%)	10 (45%)	6 (29%)	6 (30%)	7 (32%)	6 (29%)
8-13	7 (29%)	2 (9%)	3 (13%)	7 (32%)	4 (17%)	8 (42%)	8 (38%)	4 (18%)	7 (33%)	5 (25%)	4 (18%)	7 (33%)
14-19	0 (0%)	4 (18%)	1 (4%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)	1 (5%)	3 (14%)	3 (15%)	3 (14%)	2 (10%)
20-25	0 (0%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)
26-31	0 (0%)	1 (5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Monthly Total	24	22	24	22	23	19	21	22	21	20	22	21

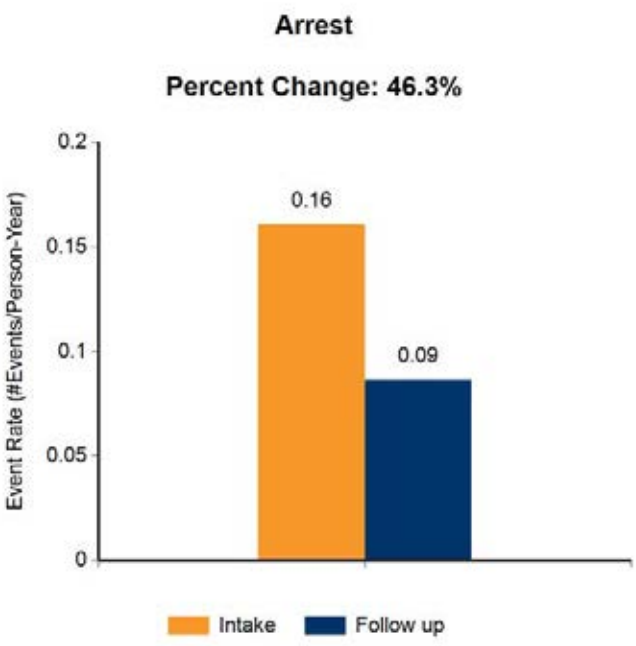
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	8	3%	10	1.25
Case Management	43	17%	362	8.42
Crisis	4	2%	6	1.50
Family Therapy	3	1%	7	2.33
Individual Therapy	19	7%	194	10.21
Medication MD Services	37	14%	169	4.57
Medication Therapeutic Services	42	16%	305	7.26
Mental Health Services-Group	6	2%	14	2.33
Mental Health Services-Individual	37	14%	393	10.62
Non Face to Face MD	27	10%	69	2.56
Peer MH Education Groups	1	0%	5	5.00
Peer MH Engagement	4	2%	8	2.00
Peer MH Therapeutic Activity	23	9%	150	6.52
Psychiatric Assessment	6	2%	6	1.00

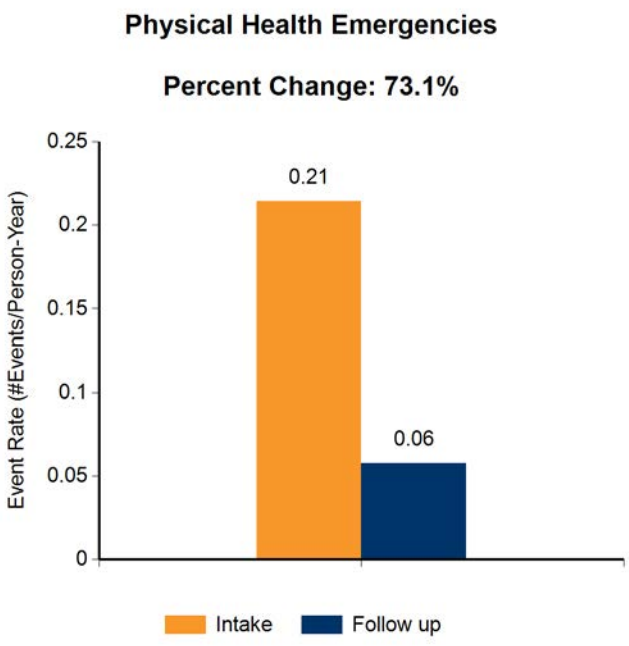
Outcomes for 33MTFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

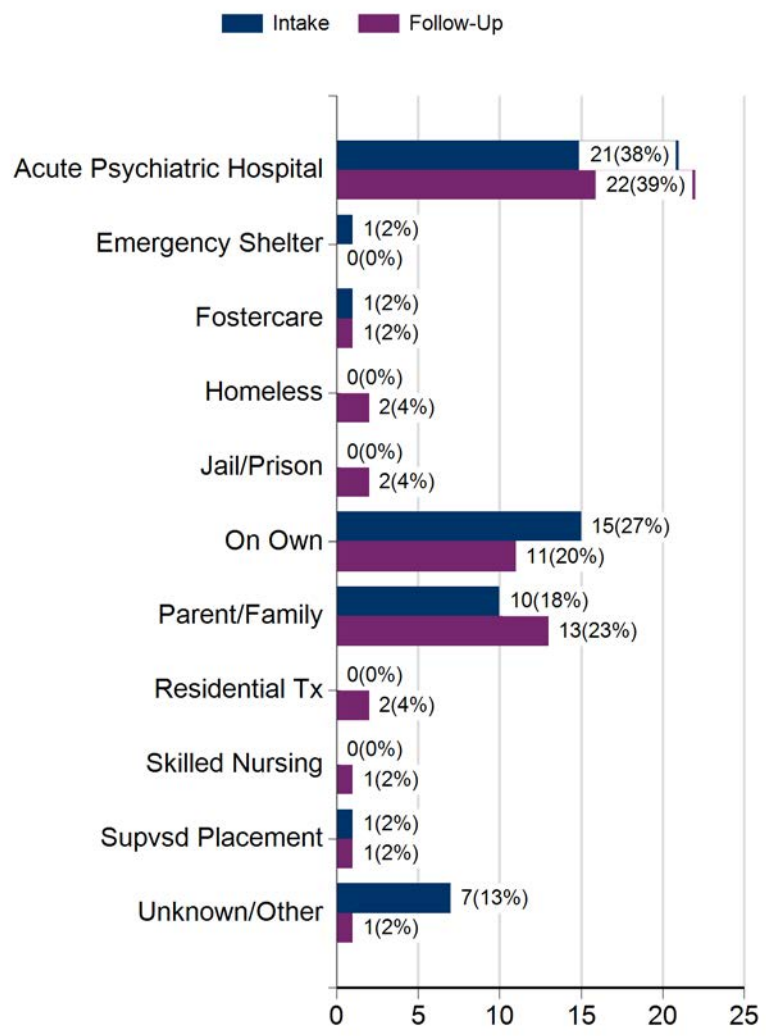








Outcomes: Residential & Discontinuance (33MTFA)

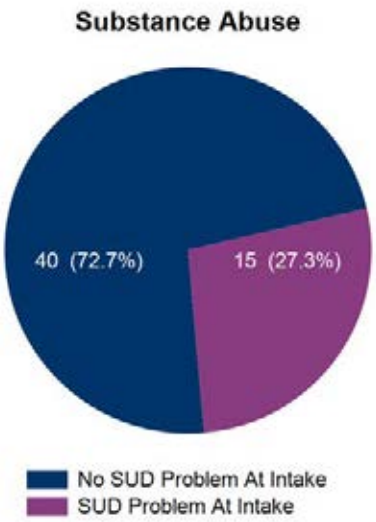


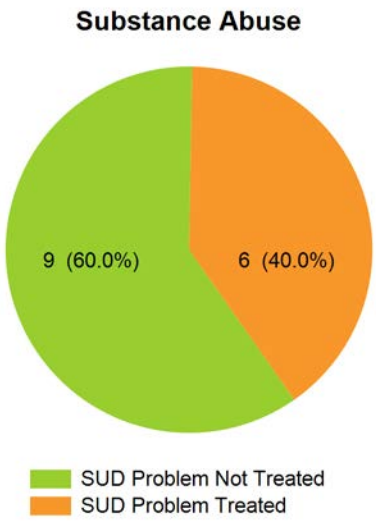
Discontinuation Reason	Count	%
Deceased	1	3%
Justice system	4	11%
Met goals	3	9%
Moved out of county/area	3	9%
Partner cannot be located	9	26%
Partner left program	11	31%
Target criteria not met	4	11%
Total	**35**	**100%**

Length of FSP Partnership for: 33MTFA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	2	5	7	12.50%
>= 2 Years and <3 Years	2	2	4	7.14%
>= 90 days and < 1 Year	17	10	27	48.21%
Under 90 days	15	3	18	32.14%
Total Consumer Enrollments	**36**	**20**	**56**	

Outcomes: Substance Use (33MTFA)

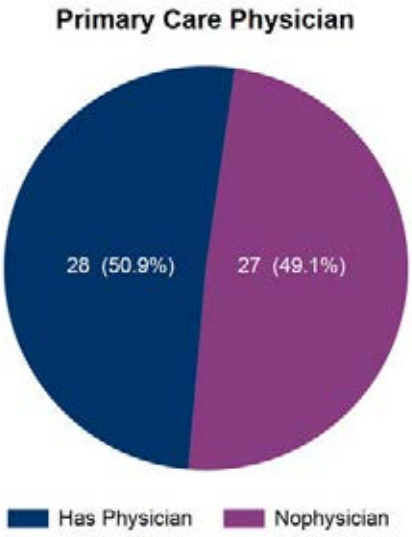




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (27.3%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 11.1% (1) of the 9 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 7 consumers not identified at intake were noted to have an SU problem on follow-up and 11.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33MTFA)



Intake: Most adults (49.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 27 consumers that did not have a PCP at intake, 4 (15.0%) obtained a PCP while in the program.

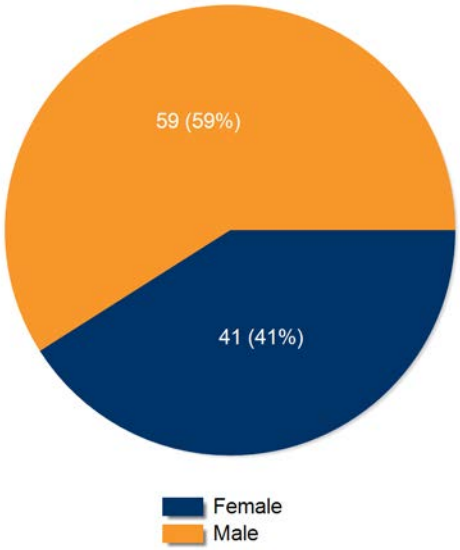
Demographics

59% of consumers were male and 41% were female.

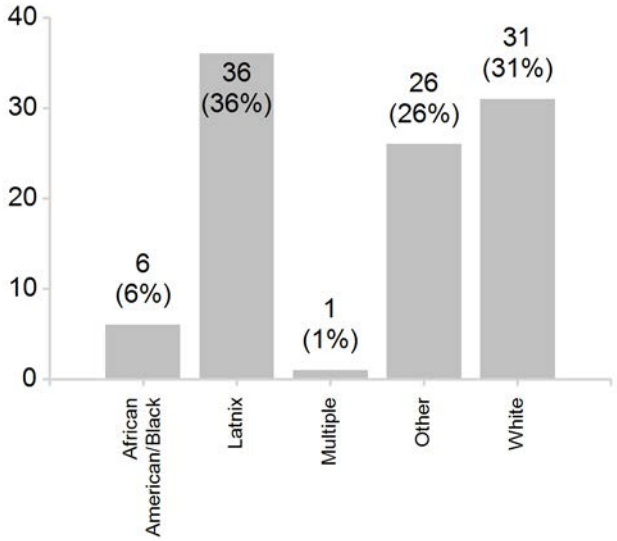
31% of consumers were White, 0% of consumers were Hispanic/Latinx and 6% of consumers were Black/African American.

28% of consumers were 40 to 49 years old.

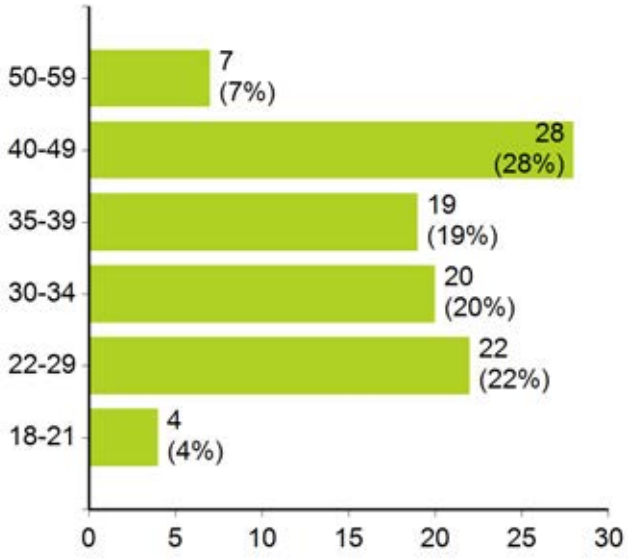
Gender



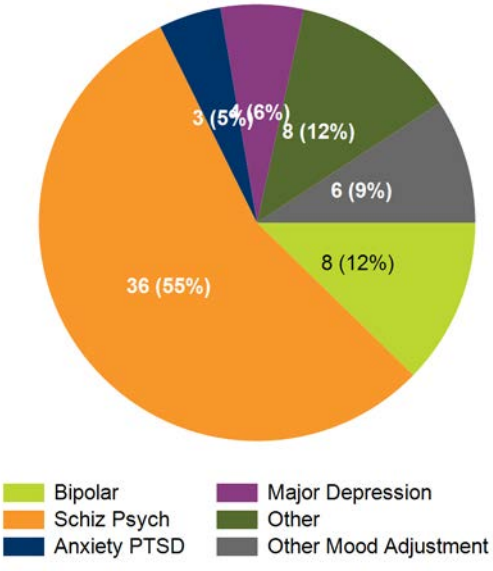
Race/Ethnicity



Age



Diagnosis



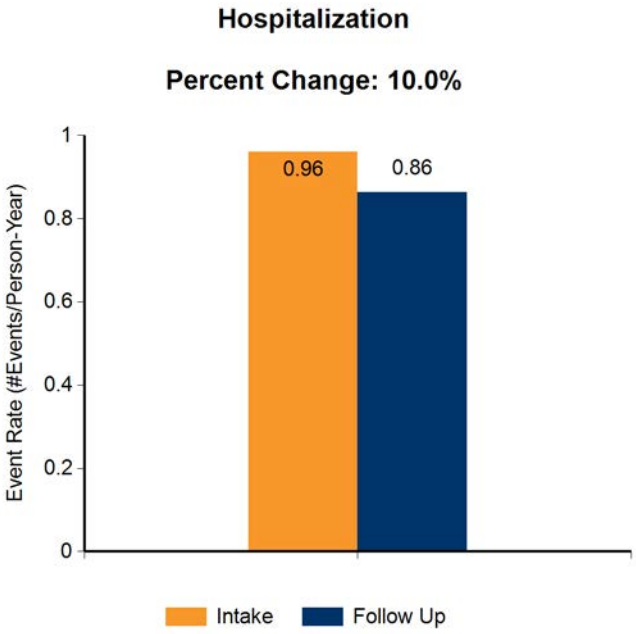
Service Detail: 33MUFA

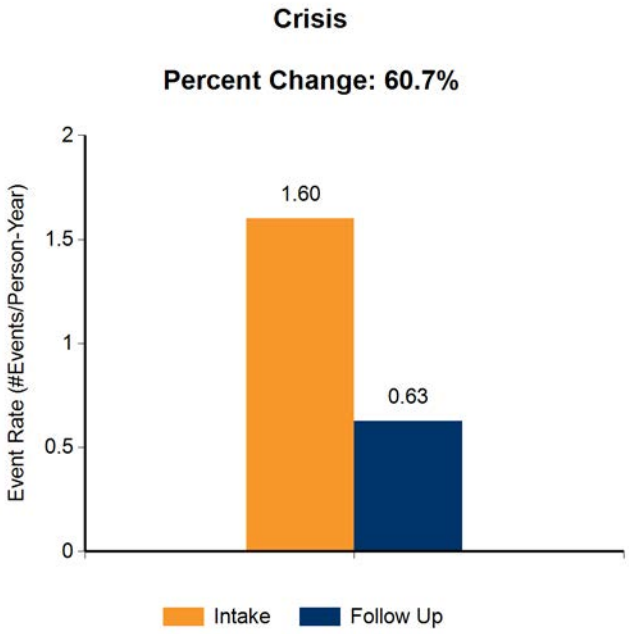
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	6 (15%)	2 (5%)	8 (19%)	8 (18%)	7 (16%)	9 (21%)	4 (9%)	5 (14%)	11 (24%)	12 (27%)	4 (11%)	4 (11%)
2-3	7 (18%)	7 (17%)	8 (19%)	10 (23%)	10 (22%)	9 (21%)	13 (30%)	5 (14%)	7 (16%)	3 (7%)	7 (20%)	6 (16%)
4-7	14 (36%)	13 (32%)	17 (40%)	16 (36%)	16 (36%)	15 (36%)	8 (18%)	16 (43%)	12 (27%)	15 (33%)	8 (23%)	8 (22%)
8-13	8 (21%)	14 (34%)	8 (19%)	8 (18%)	8 (18%)	7 (17%)	12 (27%)	7 (19%)	9 (20%)	4 (9%)	7 (20%)	9 (24%)
14-19	2 (5%)	3 (7%)	0 (0%)	1 (2%)	2 (4%)	1 (2%)	5 (11%)	1 (3%)	4 (9%)	7 (16%)	3 (9%)	4 (11%)
20-25	1 (3%)	1 (2%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	1 (2%)	2 (5%)	1 (2%)	2 (4%)	4 (11%)	4 (11%)
26-31	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (3%)	2 (5%)
32+	1 (3%)	1 (2%)	1 (2%)	0 (0%)	1 (2%)	1 (2%)	1 (2%)	1 (3%)	1 (2%)	2 (4%)	1 (3%)	0 (0%)
Monthly Total	39	41	42	44	45	42	44	37	45	45	35	37

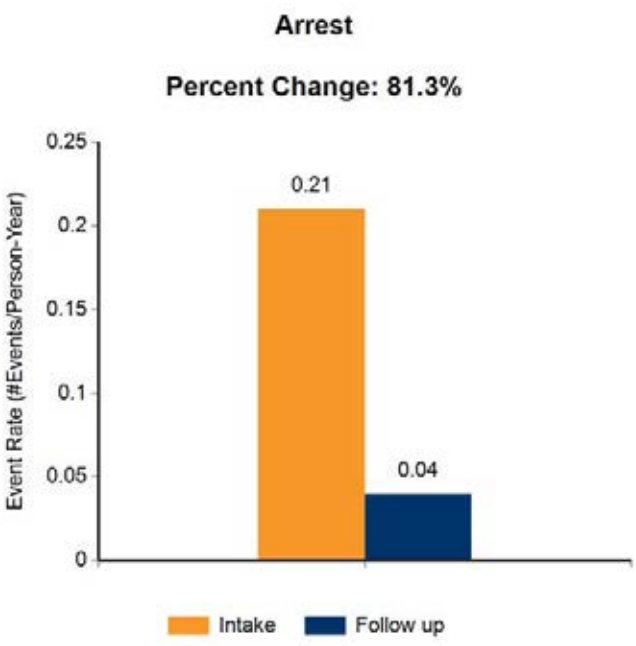
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	13	3%	17	1.31
Case Management	69	16%	779	11.29
Collateral Services	1	0%	1	1.00
Crisis	4	1%	7	1.75
Family Therapy	1	0%	1	1.00
Individual Therapy	12	3%	167	13.92
Medication MD Services	49	11%	252	5.14
Medication Therapeutic Services	59	14%	313	5.31
Mental Health Services-Group	17	4%	99	5.82
Mental Health Services-Individual	69	16%	861	12.48
Non Face to Face MD	37	9%	148	4.00
Peer MH Education Groups	6	1%	18	3.00
Peer MH Engagement	14	3%	19	1.36
Peer MH Therapeutic Activity	68	16%	886	13.03
Psychiatric Assessment	13	3%	14	1.08

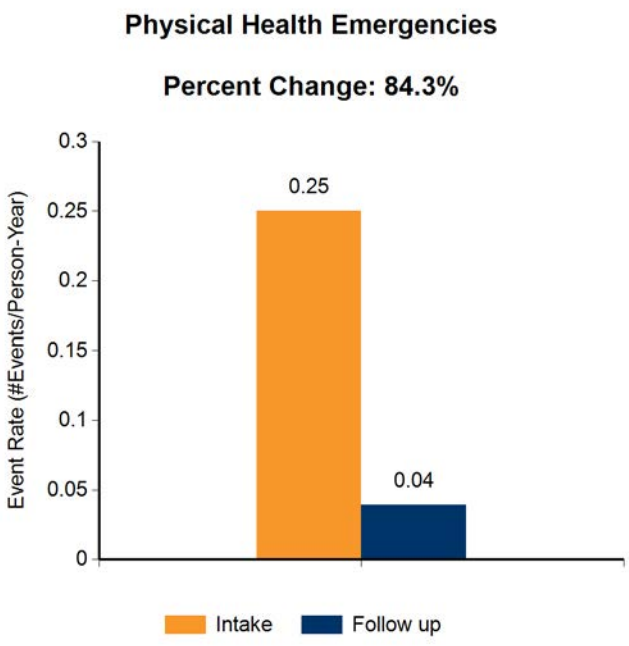
Outcomes for 33MUFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

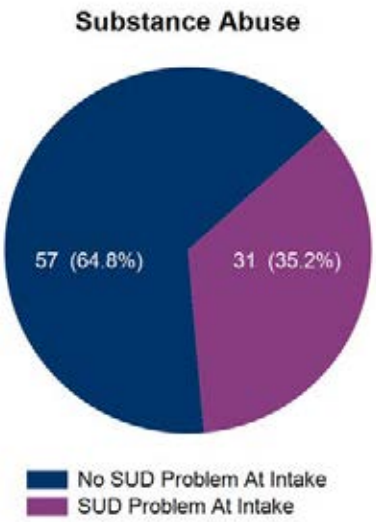


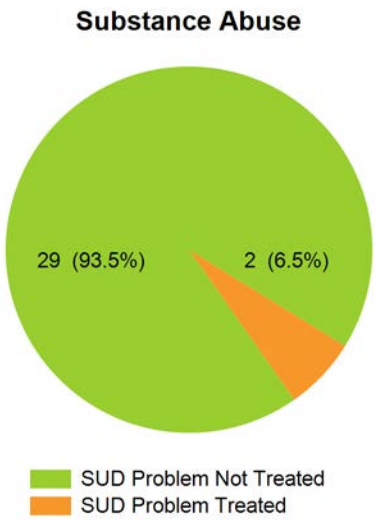






Outcomes: Substance Use (33MUFA)

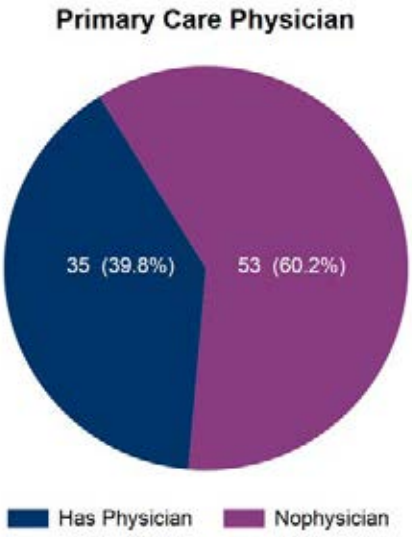




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (35.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 13.8% (4) of the 29 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 17 consumers not identified at intake were noted to have an SU problem on follow-up and 14.0% of them were reported to be in SU services on follow-up.

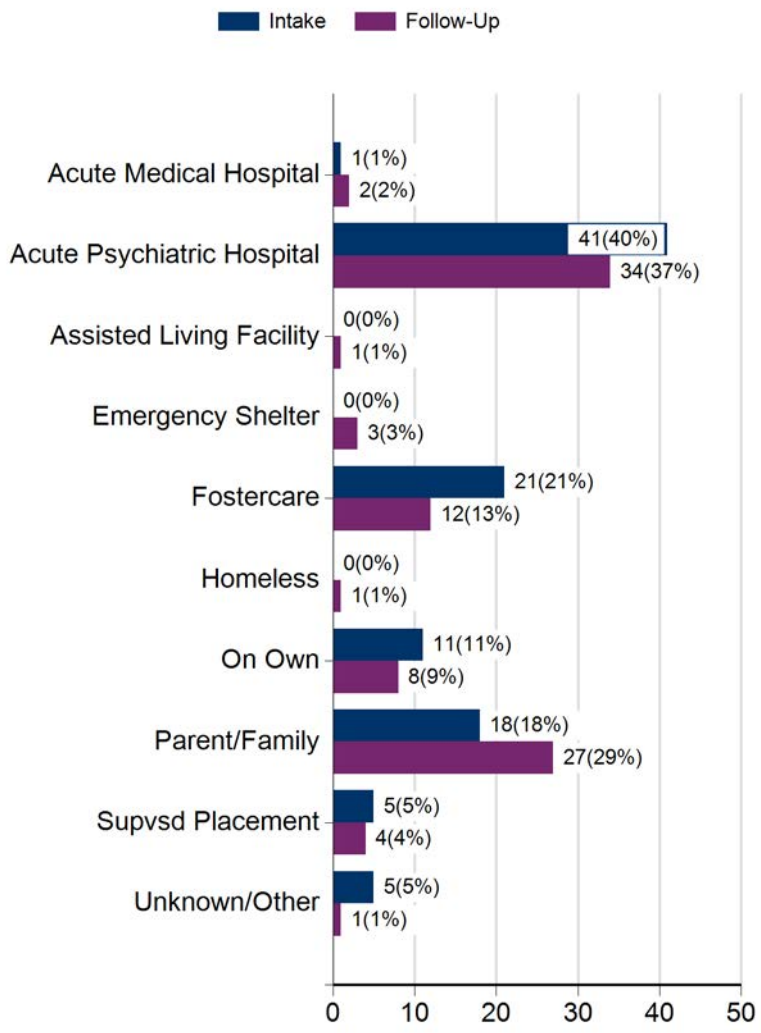
Outcomes: Primary Care Physician (33MUFA)



Intake: Most adults (60.2%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 53 consumers that did not have a PCP at intake, 29 (55.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33MUFA)



Discontinuation Reason	Count	%
Deceased	1	2%
Justice system	1	2%
Met goals	14	30%
Moved out of county/area	7	15%
Needs residential care	1	2%
Partner cannot be located	11	23%
Partner left program	12	26%
Total	**47**	**100%**

Length of FSP Partnership for: 33MUFA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	2	7	9	9.00%
>= 2 Years and <3 Years	4	2	6	6.00%
>= 3 Years and < 4 Years	4	5	9	9.00%
>= 4 Years and < 5 years	1	2	3	3.00%
>= 90 days and < 1 Year	27	19	46	46.00%
Under 90 days	21	6	27	27.00%
Total Consumer Enrollments	**59**	**41**	**100**	

FSP Adult demographics and Outcomes for: 3315FA
Served by this reporting unit: 191 Enrollment: 199

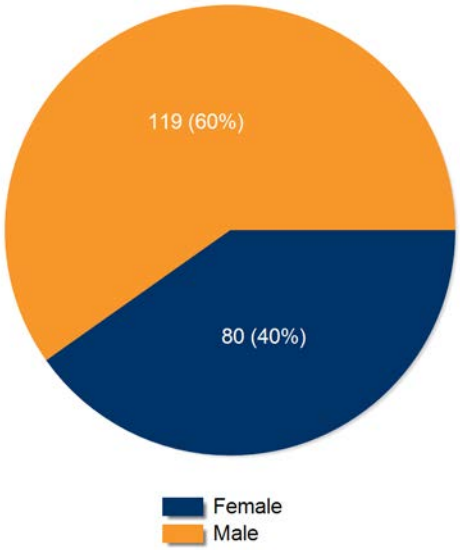
Demographics

60% of consumers were male and 40% were female.

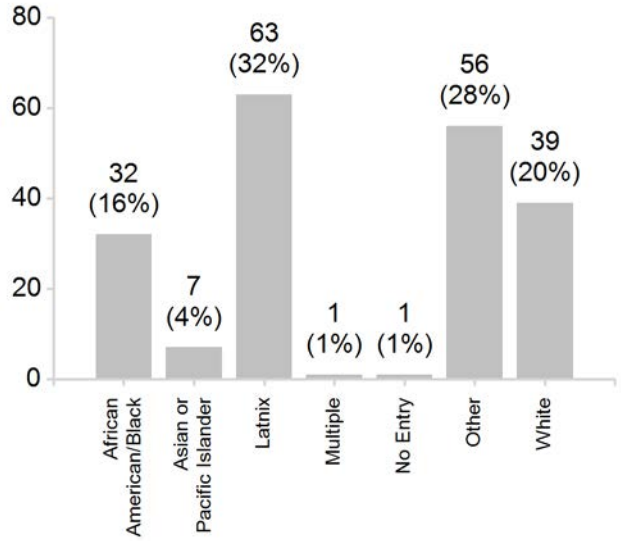
20% of consumers were White, 0% of consumers were Hispanic/Latinx and 16% of consumers were Black/African American.

22% of consumers were 40 to 49 years old.

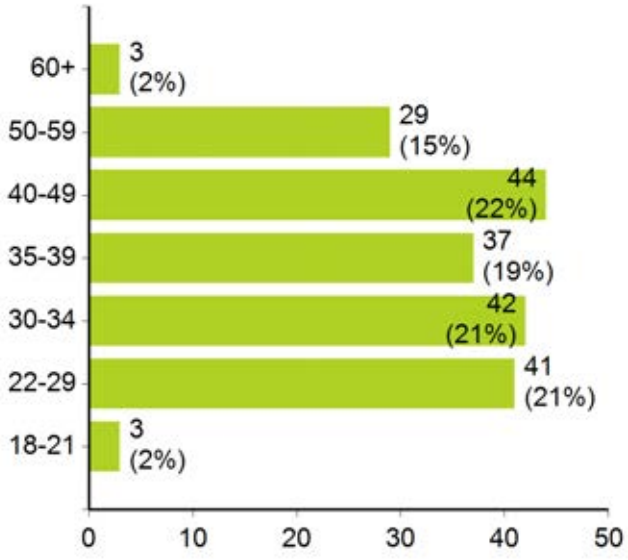
Gender



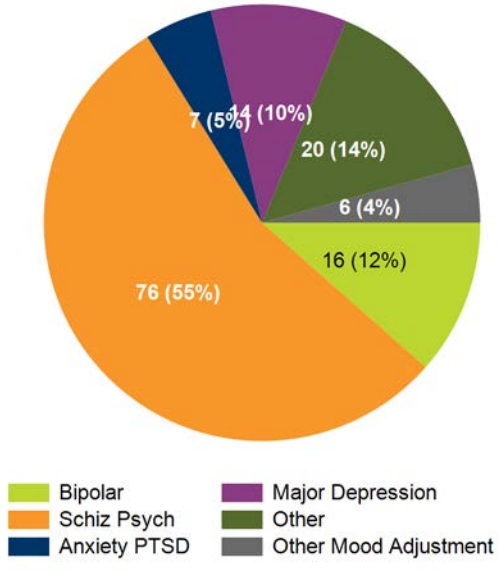
Race/Ethnicity



Age



Diagnosis



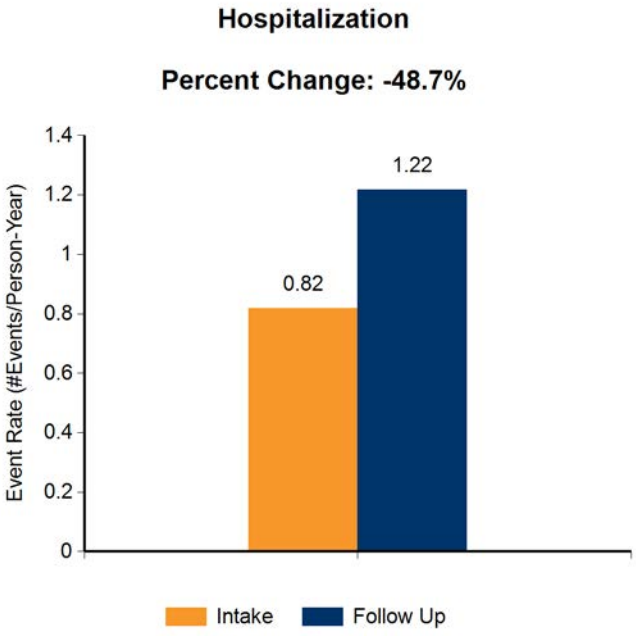
Service Detail: 3315FA

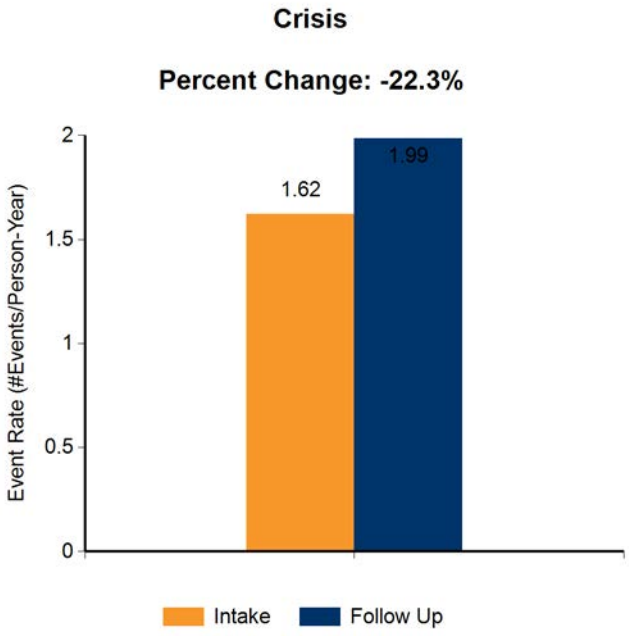
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	6 (11%)	11 (18%)	15 (22%)	12 (19%)	16 (27%)	19 (35%)	19 (30%)	18 (25%)	27 (30%)	23 (28%)	23 (31%)	29 (38%)
2-3	12 (23%)	15 (24%)	20 (29%)	19 (30%)	14 (23%)	12 (22%)	15 (24%)	18 (25%)	27 (30%)	19 (23%)	19 (25%)	20 (26%)
4-7	22 (42%)	19 (31%)	19 (28%)	19 (30%)	21 (35%)	14 (25%)	15 (24%)	17 (23%)	18 (20%)	22 (27%)	13 (17%)	17 (22%)
8-13	10 (19%)	9 (15%)	10 (15%)	8 (13%)	7 (12%)	5 (9%)	9 (14%)	12 (16%)	13 (14%)	10 (12%)	11 (15%)	3 (4%)
14-19	2 (4%)	6 (10%)	3 (4%)	3 (5%)	1 (2%)	4 (7%)	3 (5%)	4 (5%)	5 (5%)	4 (5%)	4 (5%)	3 (4%)
20-25	1 (2%)	0 (0%)	0 (0%)	1 (2%)	1 (2%)	0 (0%)	1 (2%)	3 (4%)	0 (0%)	2 (2%)	4 (5%)	3 (4%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)
32+	0 (0%)	2 (3%)	1 (1%)	1 (2%)	0 (0%)	0 (0%)	1 (2%)	1 (1%)	1 (1%)	1 (1%)	1 (1%)	0 (0%)
Monthly Total	53	62	68	63	60	55	63	73	91	81	75	76

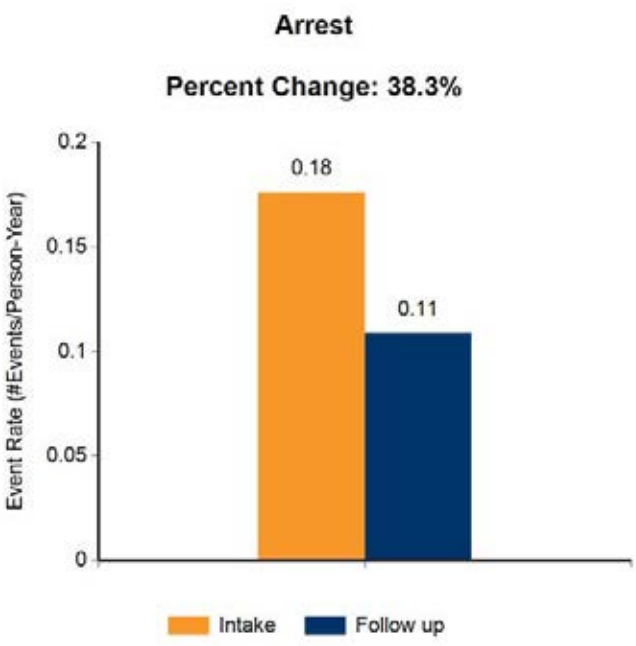
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	23	4%	23	1.00
Case Management	114	19%	610	5.35
Client Supportive Services	3	0%	5	1.67
Collateral Services	1	0%	1	1.00
Crisis	4	1%	8	2.00
Family Therapy	1	0%	1	1.00
Individual Therapy	39	6%	420	10.77
Medication MD Services	89	15%	245	2.75
Medication Therapeutic Services	33	5%	94	2.85
Mental Health Services-Group	2	0%	5	2.50
Mental Health Services-Individual	131	22%	2,092	15.97
Non Face to Face MD	5	1%	5	1.00
Peer MH Education Groups	16	3%	69	4.31
Peer MH Engagement	65	11%	274	4.22
Peer MH Therapeutic Activity	73	12%	436	5.97
Psychiatric Assessment	8	1%	9	1.13

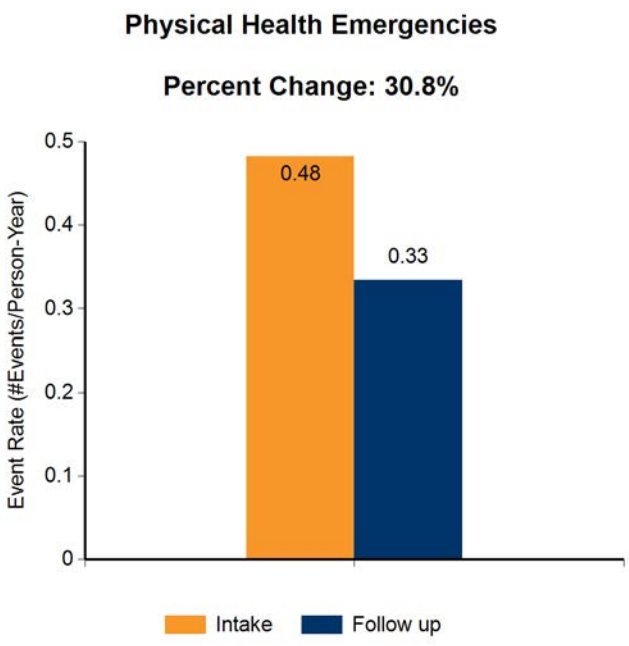
Outcomes for 3315FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

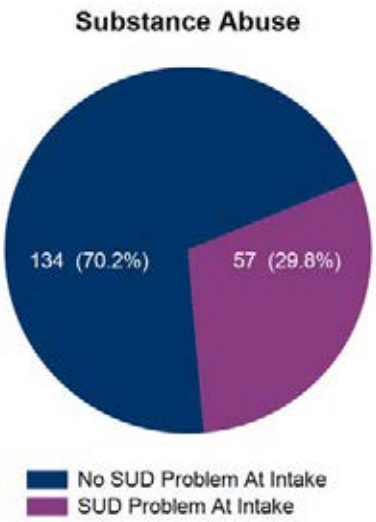


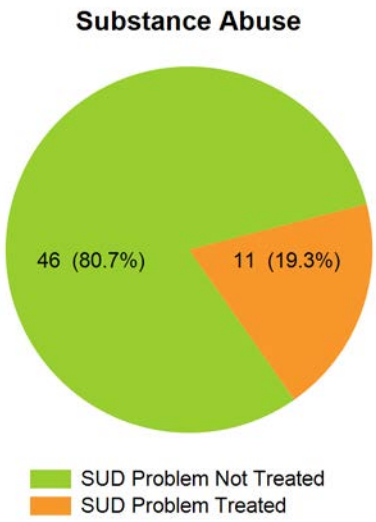






Outcomes: Substance Use (3315FA)

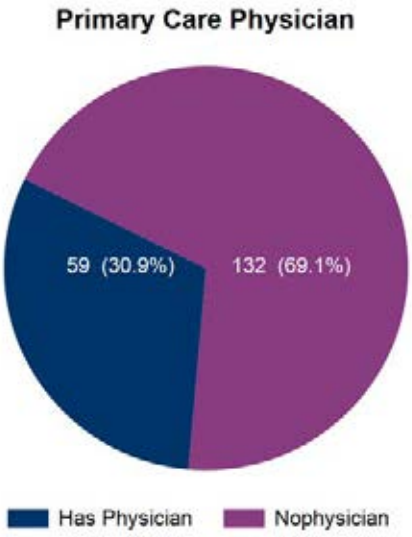




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.8%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 15.2% (7) of the 46 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 15 consumers not identified at intake were noted to have an SU problem on follow-up and 15.0% of them were reported to be in SU services on follow-up.

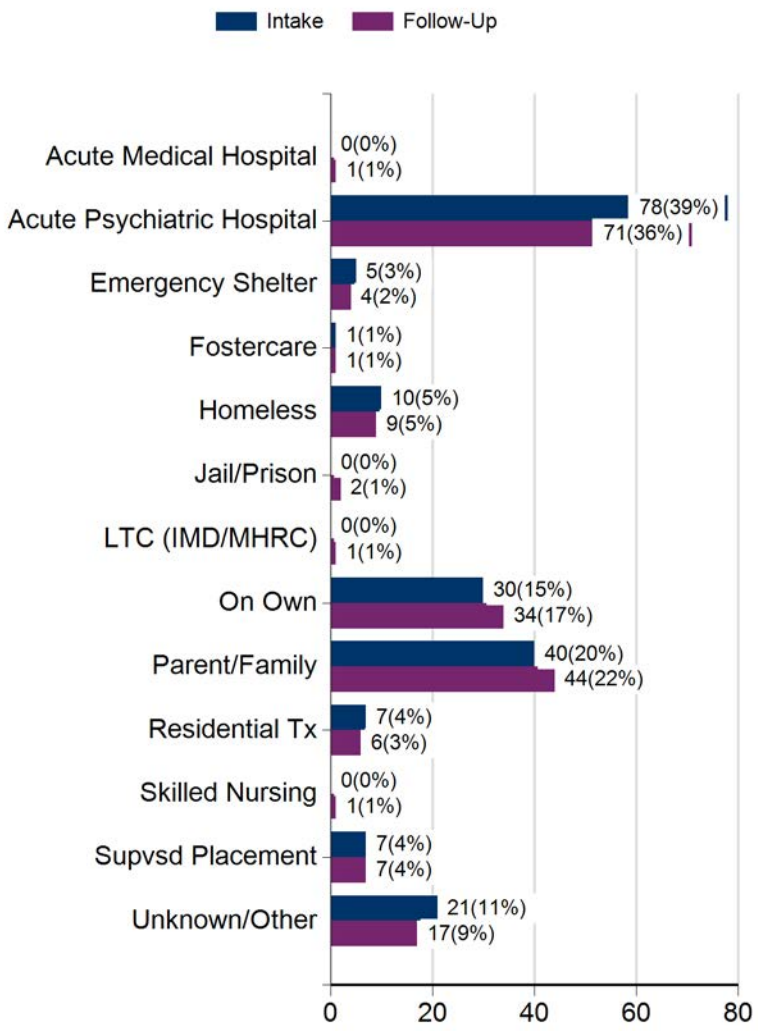
Outcomes: Primary Care Physician (3315FA)



Intake: Most adults (69.1%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 132 consumers that did not have a PCP at intake, 40 (30.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (3315FA)



Discontinuation Reason	Count	%
Deceased	1	1%
Justice system	3	3%
Met goals	8	9%
Moved out of county/area	9	10%
Needs residential care	5	5%
Partner cannot be located	43	47%
Partner left program	23	25%
Total	**92**	**100%**

Length of FSP Partnership for: 3315FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	2	16	18	9.05%
>= 2 Years and <3 Years	2	3	5	2.51%
>= 3 Years and < 4 Years	0	7	7	3.52%
>= 90 days and < 1 Year	54	42	96	48.24%
Under 90 days	39	34	73	36.68%
Total Consumer Enrollments	**97**	**102**	**199**	

FSP Adult demographics and Outcomes for: 3373FA
Served by this reporting unit: 366 Enrollment: 378

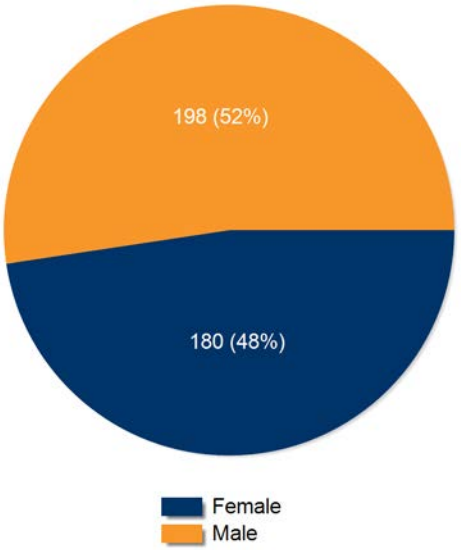
Demographics

52% of consumers were male and 48% were female.

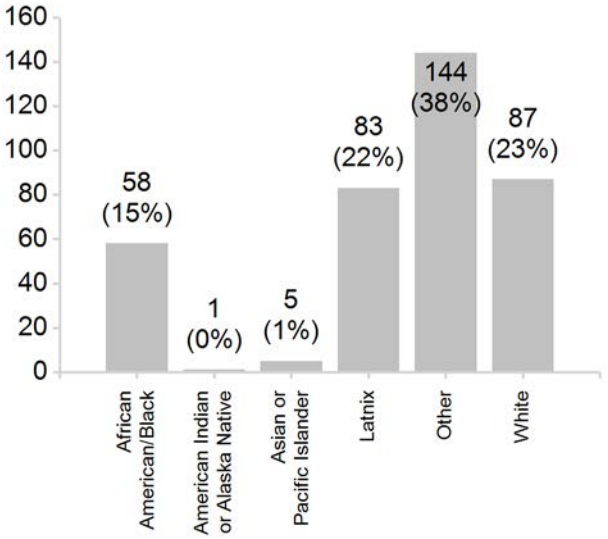
23% of consumers were White, 0% of consumers were Hispanic/Latinx and 15% of consumers were Black/African American.

28% of consumers were 40 to 49 years old.

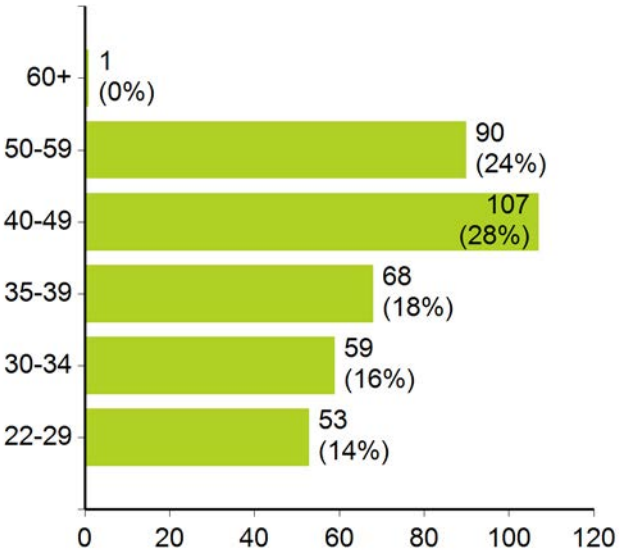
Gender



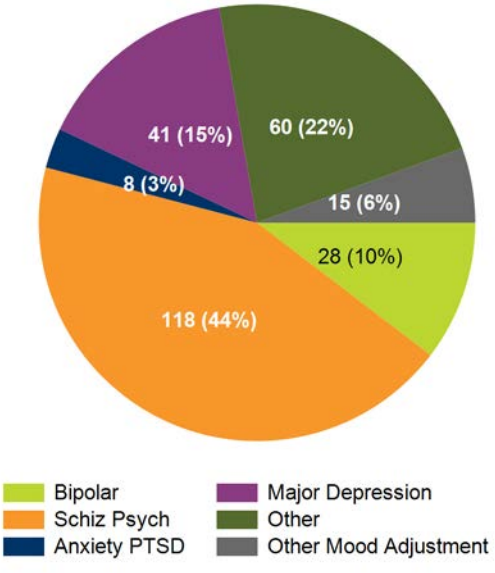
Race/Ethnicity



Age



Diagnosis



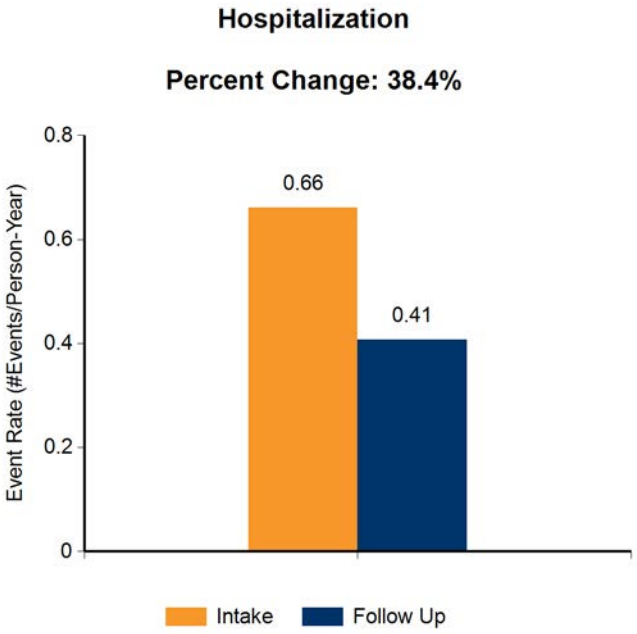
Service Detail: 3373FA

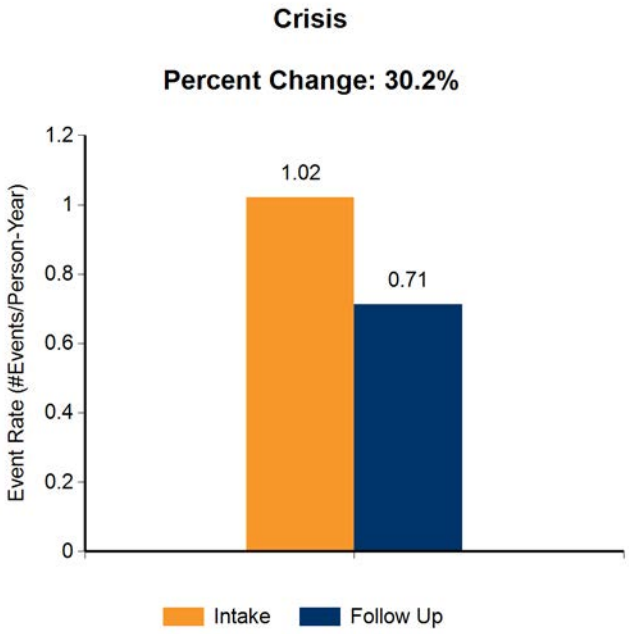
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	25 (16%)	11 (7%)	14 (10%)	20 (14%)	16 (11%)	23 (16%)	21 (14%)	8 (6%)	20 (12%)	29 (16%)	22 (13%)	23 (14%)
2-3	25 (16%)	34 (22%)	28 (19%)	27 (19%)	30 (21%)	25 (17%)	27 (18%)	31 (22%)	33 (20%)	34 (18%)	22 (13%)	36 (21%)
4-7	50 (31%)	33 (21%)	53 (37%)	43 (30%)	44 (31%)	51 (35%)	45 (29%)	43 (31%)	48 (30%)	39 (21%)	32 (18%)	40 (24%)
8-13	35 (22%)	52 (33%)	30 (21%)	40 (28%)	36 (26%)	39 (27%)	39 (25%)	38 (27%)	33 (20%)	37 (20%)	49 (28%)	36 (21%)
14-19	16 (10%)	16 (10%)	15 (10%)	9 (6%)	10 (7%)	7 (5%)	14 (9%)	14 (10%)	16 (10%)	21 (11%)	19 (11%)	20 (12%)
20-25	4 (3%)	5 (3%)	3 (2%)	3 (2%)	3 (2%)	1 (1%)	3 (2%)	2 (1%)	9 (6%)	15 (8%)	17 (10%)	6 (4%)
26-31	0 (0%)	1 (1%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)	3 (2%)	2 (1%)	2 (1%)	5 (3%)	7 (4%)	5 (3%)
32+	4 (3%)	4 (3%)	1 (1%)	2 (1%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)	0 (0%)	5 (3%)	5 (3%)	4 (2%)
Monthly Total	159	156	145	144	141	147	153	139	161	185	173	170

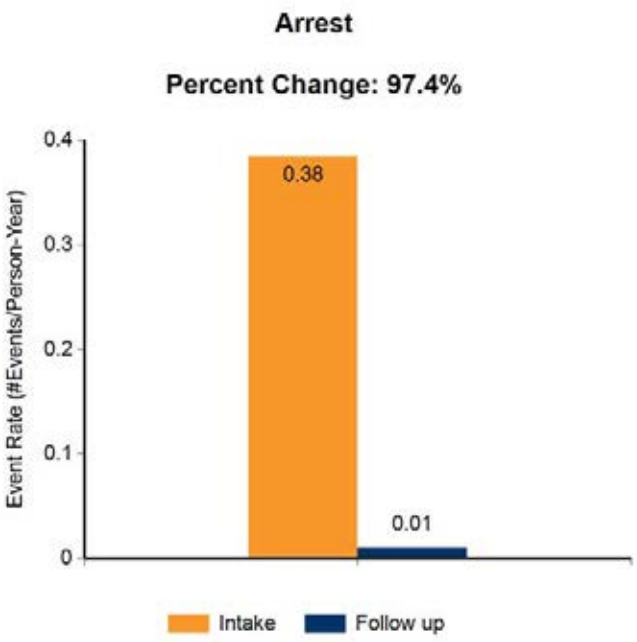
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	123	8%	157	1.28
Case Management	313	21%	4,246	13.57
Crisis	24	2%	47	1.96
Family Therapy	1	0%	1	1.00
Individual Therapy	59	4%	443	7.51
Medication MD Services	143	9%	615	4.30
Medication Therapeutic Services	175	12%	2,028	11.59
Mental Health Services-Group	80	5%	623	7.79
Mental Health Services-Individual	265	18%	4,562	17.22
Non Face to Face MD	42	3%	85	2.02
Peer MH Education Groups	48	3%	351	7.31
Peer MH Engagement	49	3%	545	11.12
Peer MH Therapeutic Activity	102	7%	892	8.75
Psychiatric Assessment	86	6%	89	1.03

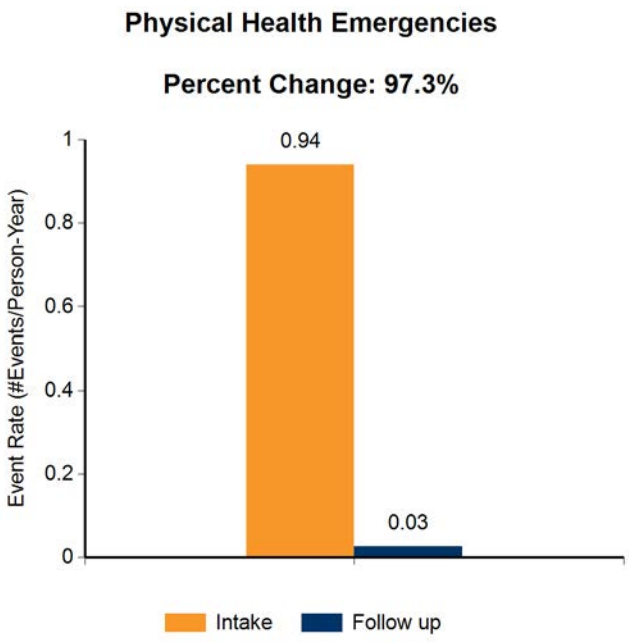
Outcomes for 3373FA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

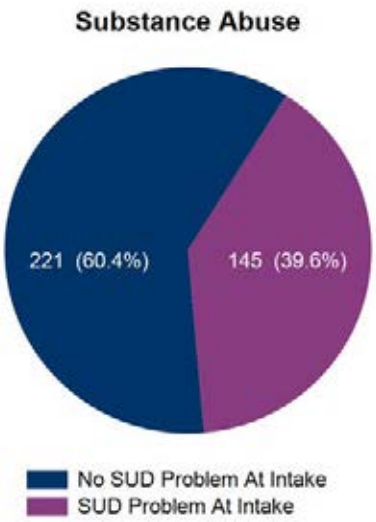


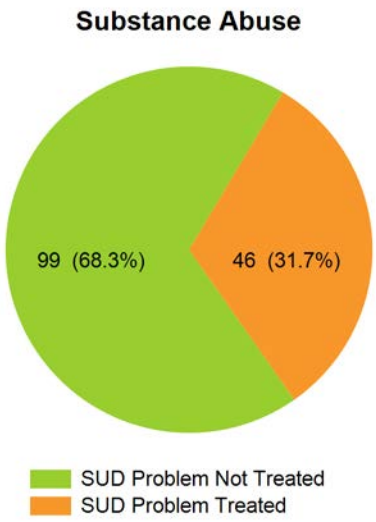






Outcomes: Substance Use (3373FA)

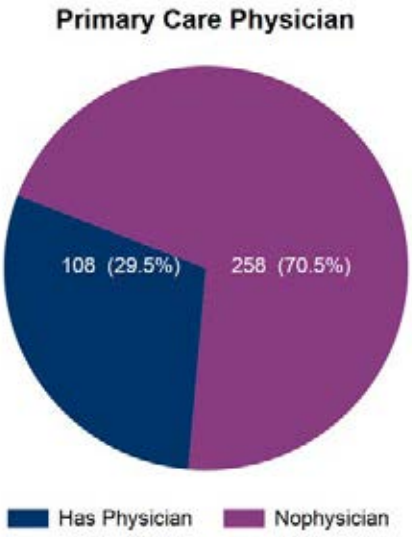




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (39.6%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 17.2% (17) of the 99 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 65 consumers not identified at intake were noted to have an SU problem on follow-up and 17.0% of them were reported to be in SU services on follow-up.

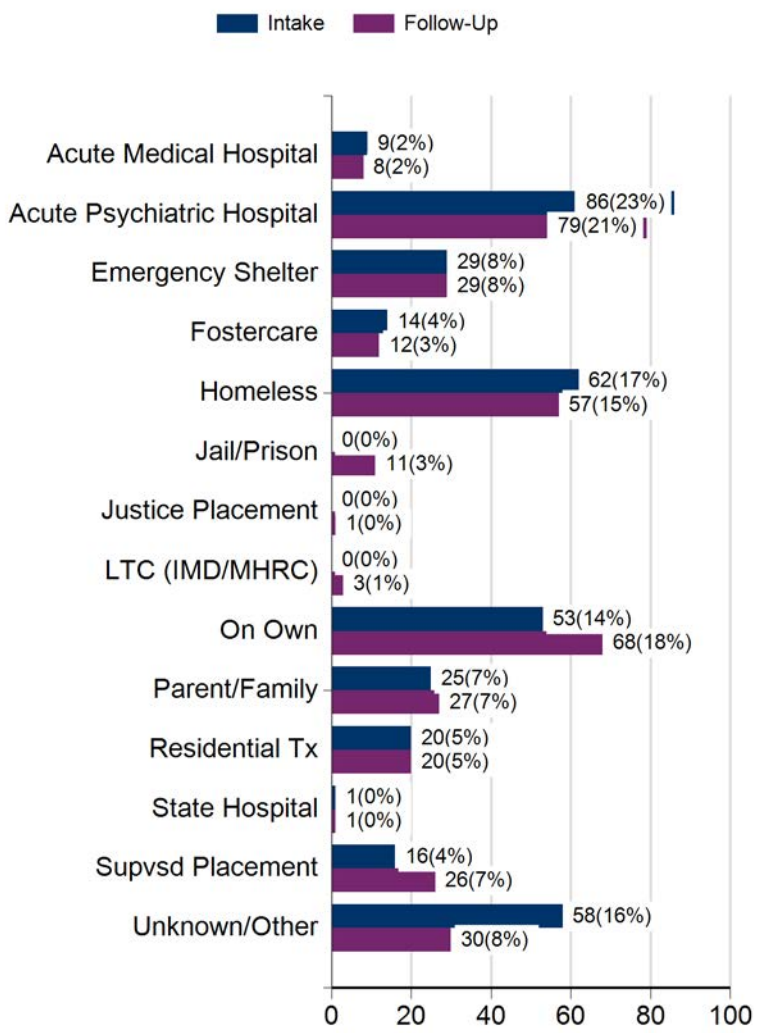
Outcomes: Primary Care Physician (3373FA)



Intake: Most adults (70.5%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 258 consumers that did not have a PCP at intake, 100 (39.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (3373FA)



Discontinuation Reason	Count	%
Deceased	5	3%
Justice system	10	6%
Met goals	30	19%
Moved out of county/area	15	9%
Needs residential care	2	1%
Other	1	1%
Partner cannot be located	62	39%
Partner left program	24	15%
Target criteria not met	11	7%
Total	**160**	**100%**

Length of FSP Partnership for: 3373FA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	19	15	34	8.99%
>= 2 Years and <3 Years	19	11	30	7.94%
>= 3 Years and < 4 Years	3	17	20	5.29%
>= 4 Years and < 5 years	3	3	6	1.59%
>= 90 days and < 1 Year	93	75	168	44.44%
>=5 Years and < 6 years	3	7	10	2.65%
>=6 Years+	6	11	17	4.50%
Under 90 days	44	49	93	24.60%
Total Consumer Enrollments	**190**	**188**	**378**	

FSP Adult demographics and Outcomes for: 33IGFA
Served by this reporting unit: 99 Enrollment: 100

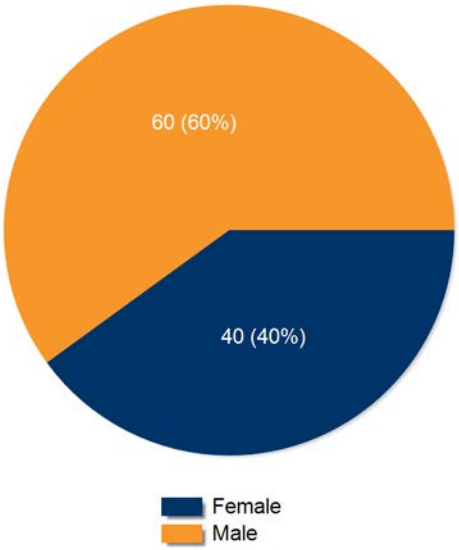
Demographics

60% of consumers were male and 40% were female.

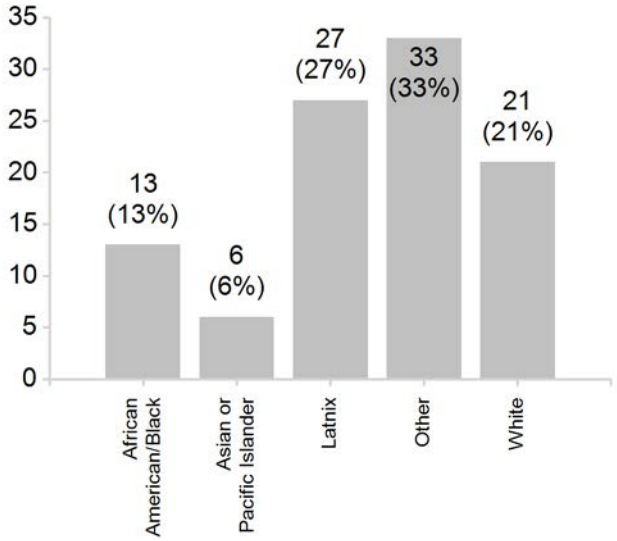
21% of consumers were White, 0% of consumers were Hispanic/Latinx and 13% of consumers were Black/African American.

27% of consumers were 40 to 49 years old.

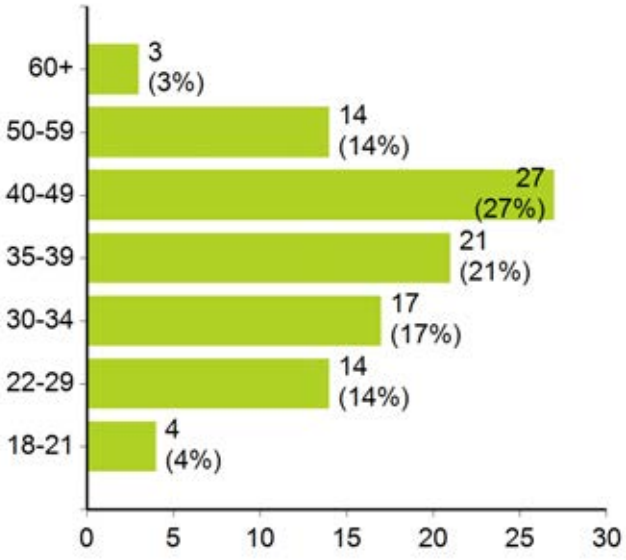
Gender



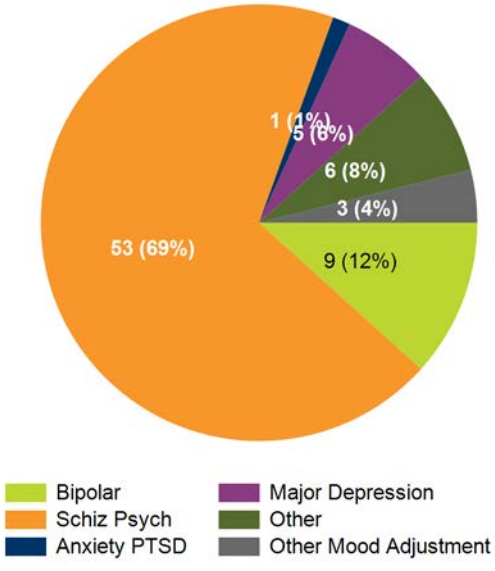
Race/Ethnicity



Age



Diagnosis



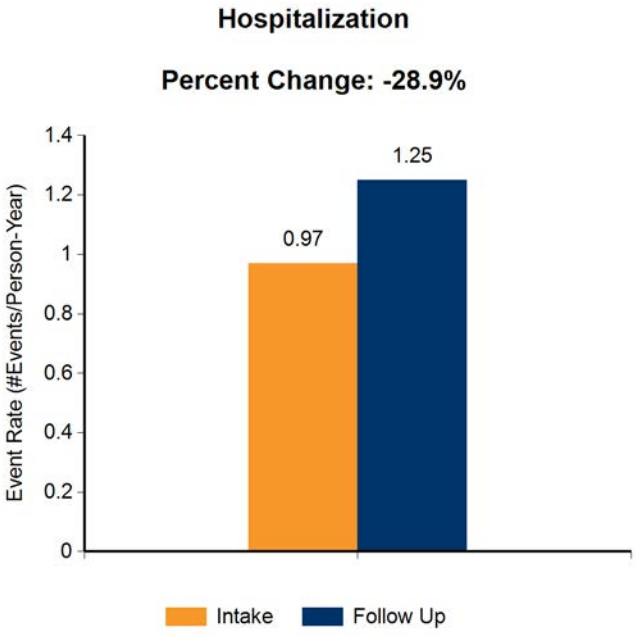
Service Detail: 33IGFA

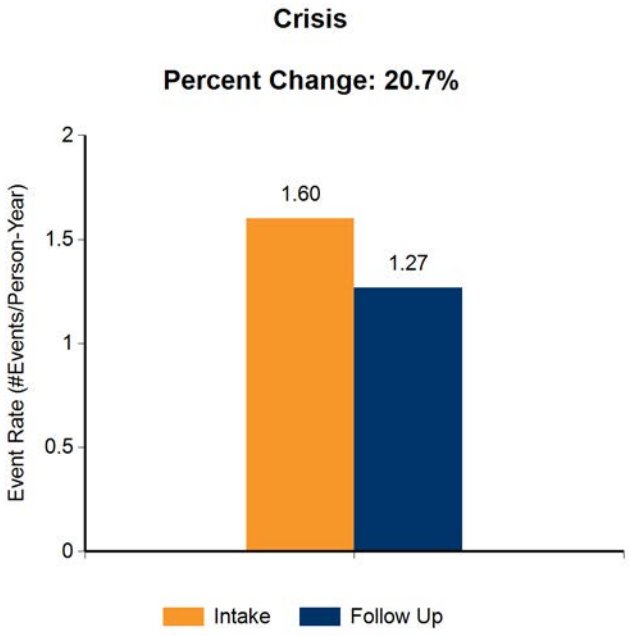
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	9 (41%)	9 (47%)	10 (91%)	16 (70%)	15 (65%)	19 (83%)	3 (27%)	5 (31%)	11 (73%)	7 (33%)	10 (38%)	17 (57%)
2-3	8 (36%)	5 (26%)	0 (0%)	6 (26%)	6 (26%)	0 (0%)	4 (36%)	9 (56%)	2 (13%)	8 (38%)	11 (42%)	10 (33%)
4-7	4 (18%)	3 (16%)	0 (0%)	1 (4%)	1 (4%)	4 (17%)	4 (36%)	2 (13%)	2 (13%)	5 (24%)	4 (15%)	2 (7%)
8-13	1 (5%)	2 (11%)	1 (9%)	0 (0%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	1 (4%)	1 (3%)
Monthly Total	22	19	11	23	23	23	11	16	15	21	26	30

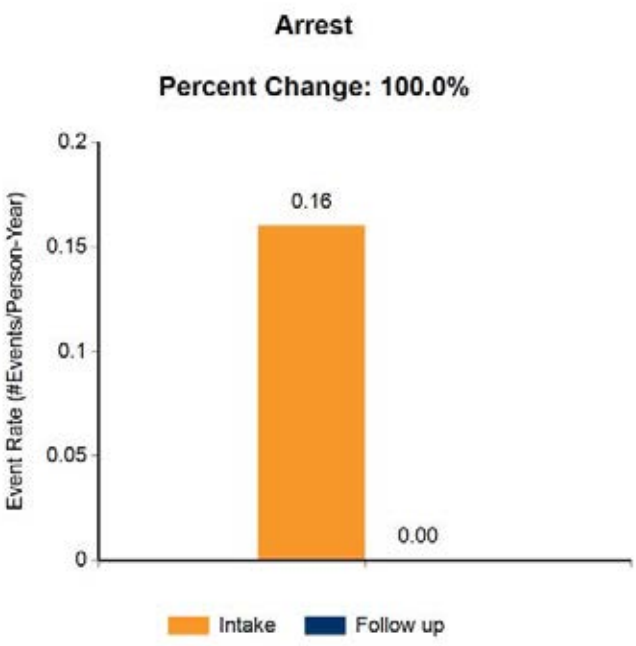
Type of Service	# of Adult	% of Adult	# of Svcs	Avg. # Svcs
Assessment Services	1	1%	1	1.00
Case Management	75	41%	248	3.31
Collateral Services	1	1%	2	2.00
Crisis	1	1%	2	2.00
Individual Therapy	6	3%	34	5.67
Medication MD Services	20	11%	29	1.45
Medication Therapeutic Services	5	3%	7	1.40
Mental Health Services-Individual	32	17%	88	2.75
Non Face to Face MD	11	6%	17	1.55
Non Family Collateral	1	1%	1	1.00
Peer MH Engagement	5	3%	8	1.60
Peer MH Therapeutic Activity	16	9%	57	3.56
Psychiatric Assessment	11	6%	11	1.00

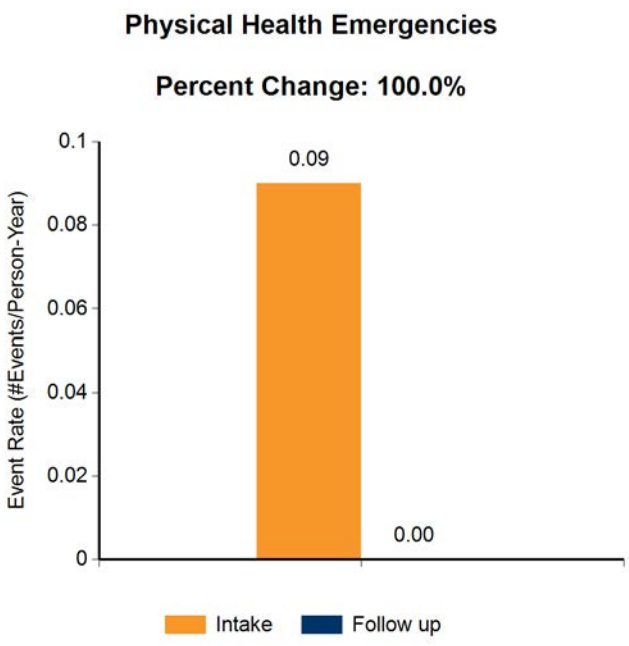
Outcomes for 33IGFA

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

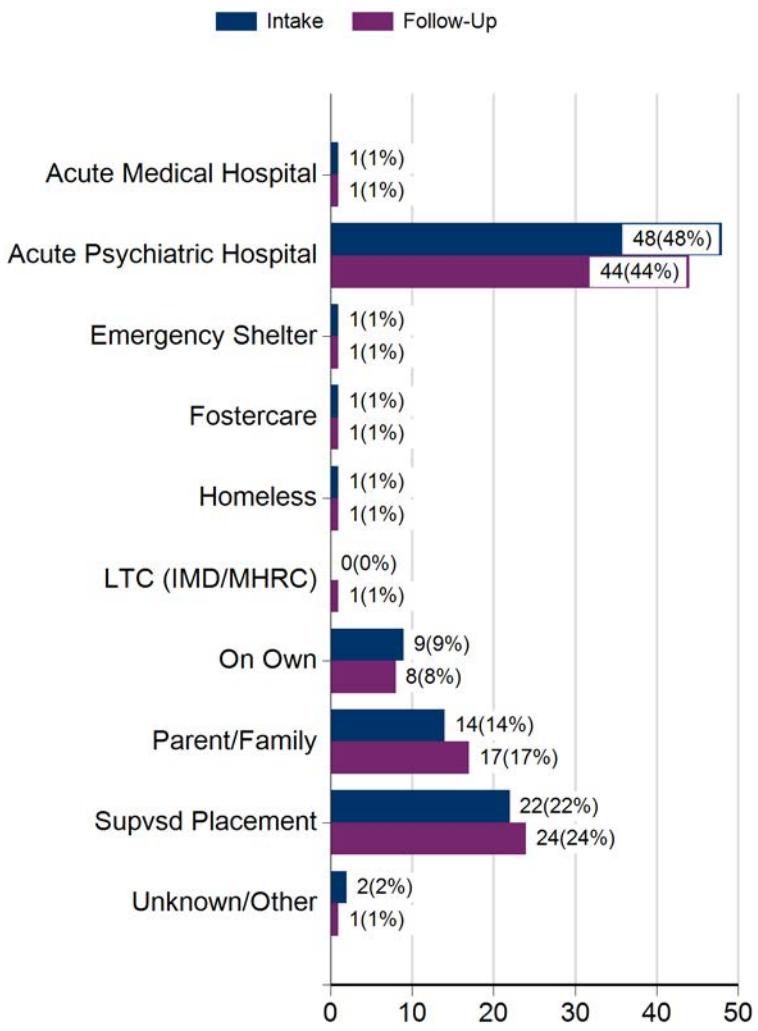








Outcomes: Residential & Discontinuance (33IGFA)

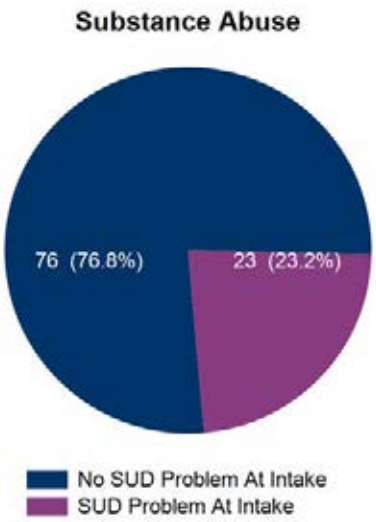


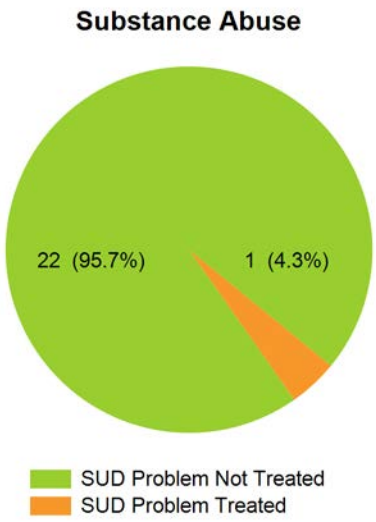
Discontinuation Reason	Count	%
Total	**0**	**100%**

Length of FSP Partnership for: 33IGFA

Adult Time in Partnership	Closed	Open	All Consumers	% of Total
>= 1 Year and < 2 Years	0	10	10	10.00%
>= 2 Years and <3 Years	2	1	3	3.00%
>= 3 Years and < 4 Years	0	18	18	18.00%
>= 90 days and < 1 Year	3	48	51	51.00%
Under 90 days	2	16	18	18.00%
Total Consumer Enrollments	**7**	**93**	**100**	

Outcomes: Substance Use (33IGFA)

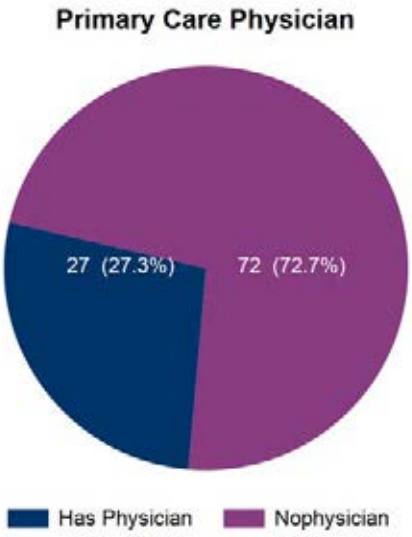




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 4.5% (1) of the 22 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 0 consumers not identified at intake were noted to have an SU problem on follow-up and 5.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33IGFA)



Intake: Most adults (72.7%) did not have a primary care physician (PCP) at intake.

Follow-up: Of the 72 consumers that did not have a PCP at intake, 5 (7.0%) obtained a PCP while in the program.

Older Adults Full-Service Partnership (FSP) /SMART

Western Region Older Adult Full-Service Partnership

The Western Region Older Adult Full-Service Partnership (FSP), also referred to as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in the Western region, is a program that serves approximately 216 members who have a history of difficulty engaging in or sustaining treatment in a traditional outpatient behavioral health setting. This program addresses the needs of older adult members who are homeless or at risk of homelessness and suffer from severe and persistent mental illness. Another focus of service is addressing the complicated needs of community members with a history of intermittent stays in acute and/or longer-term care institutions. The Western SMART FSP team utilized a "whatever it takes approach to meet the members where they are in their recovery, whether it is contemplation, acceptance, readiness, etc. The team collaborates with community resources to address social determinants such as the consumer's social, emotional, vocational, educational, and housing needs and/or their support system. An emphasis is placed on integrated care whereby staff connect members to primary care providers, Community Health Centers (CHCs), and other medical resources such as In-Home Supportive Services (IHSS), Enhanced Care Management (ECM), and Inland Empire Health Plan (IEHP) teams, etc.

Services are provided by a multidisciplinary treatment team that includes a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates and Community Service Assistants. Members are assigned to their specific wellness partners and are encouraged to be coauthors of their recovery plan. When facing the reality of the vicissitudes of pursuing wellness, members are supported and encouraged during their journey in an attempt to assist them with identifying healthier ways of responding to life's ongoing challenges. The Western region staff provides a multitude of therapy groups and individual therapy (DBT, Seeking Safety, Grief & Loss, WRAP, COLOR for co-occurring members, Healthy Relationships, etc.) in addition to intense case management, substance abuse counseling, nursing support, psychiatry follow up, peer support and family advocacy. In addition, the nursing team facilitates a "Living Well with Chronic Conditions" group, utilizing coaching and psychoeducation on various topics, which began during the past year.

The SMART FSP team partners with several community entities every week, including Adult Protective Services (APS) embedded staff, IEHP/Molina/ECM teams for integrated care, the Representative Payee's office, Riverside County HHOPE Housing Program and the Housing Authority, in addition to the Office on Aging, Substance Abuse Prevention and Treatment/Arlington Recovery Center-Riverside (SAPT/ARC) and Sobering Center, etc. The collaboration with housing resources and the supportive aspect of re-engagement are essential elements of this program. Another key feature of this program is that staff are trained to be culturally aware of the unique needs of the older adult population and understand this population's perception of medical and behavioral health care. Fostering autonomy of decision-

making is essential in establishing and maintaining consumer trust in the therapeutic relationship. Clinic Supervisors implemented a quarterly meeting in Fall 2023 with the SAPT supervisors and staff to address barriers to treatment for older adult members. These meetings have been instrumental in communicating needs for discharge planning and ongoing treatment.

The Western Region FSP program currently serves 216 FSP members as of January 9, 2025, with some discharging and re-enrolling. The census increased by about 74 members during the past year as the clinic opened an Inpatient Treatment Facility/Hospital (ITF) and admitted clients into FSP programs. Our clinical therapists collaborate closely with ITF staff social workers to engage members for at least 60 days. The clinic Family Advocate has also recently begun to expand engagement by meeting with members at the hospital before discharge to help facilitate a smoother transition to services post-discharge. Our Senior Clinical Therapist and clinic supervisors have successfully tracked the ITF referrals opened to FSP, which have approached 100 since implementation in January 2023.

Members make consistent attendance in the program a priority in their recovery. Members who participate in this program experience a significant reduction in arrests, mental health emergencies, physical health emergencies, homelessness, and acute hospitalizations. Additionally, these FSP participants exhibit an impressive willingness to begin addressing substance abuse issues, especially since the program has had two dedicated substance abuse counselors who have linked many members to inpatient and outpatient treatment, in addition to 1:1 counseling, coaching, and education. The substance abuse counselors continue to facilitate a “Living in Balance”/COLORs group for Co-Occurring Disorders, which is an evidenced-based curriculum modeled after the 12-step program. A very significant gain is that after members participate in treatment, they often show a decrease in living in emergency shelters or homeless settings, and many can regain stable housing and permanent supportive housing. Once their basic needs are met, members can pursue higher-level goals, such as employment or volunteer work. Our FSP Substance Abuse counselors continue to work 1:1 with the members to assist with linkage to the ARC/Sobering Center and residential treatment. Many members have participated in outpatient/residential treatment and maintained sobriety in the past year.

During the past year, a Family Advocate group called “Food for the Heart” was implemented. This group assists clients who are experiencing food insufficiencies. The Family Advocate links members to food banks and other resources to meet their needs so that they are empowered to maintain independence and self-sufficiency. This is a popular, sought-after group. Members consistently provide feedback that this group offsets their increased living expenses from recent inflationary years.

Plans for FY 2024-2025 are to continue the 3-Year Plan

goal to continue to increase the number of FSP members regionally by at least 10% each year. The program receives between 15 and 20 new referrals each week from various sources, such as APS, Office on Aging, self-referrals, ITF/hospital discharges, transfers from other programs, etc., and has seen an approximate 42% increase in consumer referrals.

We also hope to see new innovative, evidence-based practices implemented for older adults (e.g., mindfulness-based stress reduction, Tai Chi, etc.). Staff continue to introduce members

to technology through our Help@Hand Tech Innovations Dept., including participation in the A4i project, many of whom completed the program and received monetary incentives. With the assistance of staff, members have also been enrolled in the Whole Person Health Portal and have completed surveys to obtain financial incentives for participating. Clinic supervisors are proposing/recommending a request for a clinic Nurse Practitioner (NP) to enhance and increase our integrated care services. Adding a nurse practitioner would be invaluable to the clinic as the psychiatrists could more efficiently step down their less acute clients to manage NPs and decrease caseloads. NPs could assist with prescribing/furnishing medications and perform psychiatric diagnostic assessments, overall physical health assessments, TB tests, etc., which can expedite tasks/forms required for housing, disability, benefits, etc.

Mid-County Region: SMART

The Mid-County Older Adult Full-Service Partnership (FSP) programs, also known as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in Mid-County and Southwest Mid-County, currently serves approximately 275 FSP members as of January 9, 2025, with some discharging and re-enrolling. Overall, outcomes in arrest and mental/physical health emergencies, as well as acute psychiatric hospitalizations, were significantly reduced. Additionally, a booming increase in linkage to primary services supports the success of integrative care and the reduction of key medical crisis events. Both FSP programs for the Mid-County region mirror the services provided in the western region, such as the Older Adult FSP SMART program. The target populations are those who are currently homeless or at risk of being homeless and are cycling in and out of jail or prison, as well as cycling in and out of psychiatric hospitals or long-term care facilities due to mental health impairments. Services are provided by a multidisciplinary treatment team, including a Behavioral Health Services Supervisor, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates, and Community Service Assistants. The Mid-County and Southwest FSP programs service multiple cities and municipalities in the southern and mid-regions of the County, bringing geographically accessible FSP services to a large community. A new resource center has enhanced the core services in the Temecula Older Adult Wellness and Recovery Clinic by adding a member computer library where clinic staff can assist members in accessing technology-based resources while improving their computer knowledge and skills.

The 3-Year Plan goal is to increase the number of FSP members and services regionally by 10% annually. Due to a significant increase in referrals and census over the past three fiscal years, we plan to increase staffing by adding three Clinical Therapists, two Behavioral Health Specialists, and two Peer Support Specialists over the next three fiscal years.

Desert: SMART

The Desert Older Adult Full-Service Partnership (FSP), also referred to as Specialty Multidisciplinary Aggressive Response Treatment (SMART) in the Desert region, is a program that currently serves 101 FSP members as of January 9, 2025, who have a history of difficulty engaging in or sustaining treatment in a traditional outpatient behavioral health setting. The

Desert FSP program addresses the integrated needs of older adult members who are homeless or at risk of homelessness in Riverside County Desert areas who suffer from a severe and persistent mental illness. Another focus of our FSP integrated services is addressing the complicated needs of community members with a history of intermittent stays in acute and/or longer-term care institutions. The Desert SMART FSP team utilizes a "whatever it takes approach" to meet the members where they are in their recovery, whether it is contemplation, acceptance, readiness, etc. The team collaborates with community resources to meet the consumer's social, emotional, medical, vocational, educational, and housing needs and/or their support system. Integrated services are provided by a multidisciplinary treatment team that includes Behavioral Health Services supervisors, Psychiatrists, Clinical Therapists, Behavioral Health Specialists, Registered and Licensed Vocational Nurses, Peer Support Specialists, Family Advocates, and Community Service Assistants. Members are assigned to their specific wellness partners and encouraged to be coauthors and partners of their recovery plan. When facing the reality of the vicissitudes of pursuing wellness, members are supported and encouraged during their journey to assist them with identifying healthier ways of responding to life's ongoing challenges. An emphasis is placed on integrated care whereby staff connect members to primary care providers and other medical resources such as In-Home Supportive Services (IHSS), Enhanced Care Management (ECM) teams, etc.

The extreme weather in the Desert areas also complicates the dangers of not maintaining shelter, not complying with medication regimens, not following through with recommended medical care and other risk behaviors. The collaboration with housing resources and the supportive aspect of re-engagement are essential elements of this program. The Desert FSP team works collaboratively with our Behavioral Health Department's housing program (HHOPE) to provide care and support to members residing in supported living apartments in three of the regional apartment complexes (Cathedral Palm Apartments, Legacy Apartments, and Verbena Crossing Apartments). Another key feature of this program is that FSP staff are trained to be culturally aware of the unique needs of the older adult population and possess an understanding of this population's perception of medical and behavioral health care. Fostering autonomy in decision-making is essential in establishing and maintaining consumer trust in the therapeutic relationship.

The Desert FSP program serves 101 members as of January 9, 2025, with some discharging and re-enrolling. The total enrollment last year was 103. Members make consistent attendance in the program a priority in their recovery. The Desert FSP team continues to provide multiple in-person services. Members who participate in this FSP program experience a significant reduction in arrests, mental health emergencies, physical health emergencies, and acute hospitalizations. Additionally, these FSP participants exhibit an impressive willingness to begin addressing substance abuse issues, and about half initiate medical care with a primary physician. A significant gain is that these members show a decrease in living in emergency shelters or homeless settings, and many can regain stable housing.

The 3-Year Plan goal is to increase the number of FSP members and services regionally by 10% each year, as with the Western and Mid-County regional FSP programs. Therefore, we plan to

increase staffing in the Desert FSP program by adding two Clinical Therapists, two Behavioral Health Specialists, and one Peer Support Specialist over the next three fiscal years.

Goals Older Adult SMART FSP:

Western Region

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

Mid-County Region

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

Desert Region

For the 3YPE plan for FY23/24 – FY25/26, the goal is to continue increasing the number of FSP members and services regionally by 10% each year.

Riverside University HEALTH SYSTEM Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

FULL SERVICE PARTNERSHIP PROGRAM

Full Service Partnership
Older Adult Outcomes Report
FY 2023-2024

Background

The following report is a summary of outcome data for the Older Adult Full Service Partnership (FSP) programs. FSP program outcomes are focused on evaluating changes in a consumer's status relative to several quality of life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on comparisons between baseline and post enrollment status and provides a measure of program effectiveness.

The following report is based on FSP data collection from consumers enrolled and served in the Older Adult FSP programs beginning July 1, 2023 and ending June 30, 2024 Baseline data for this report is based on responses from each of these consumer's Partnership Assessment Form (PAF), the history of events for the 12 months before a consumer began the FSP program. Follow-up data used in this report is based on two sources. Psychiatric Hospital and Crisis emergency room data has been pulled from actual admissions to the hospital or crisis emergency room data. All other follow-up data used in this report was based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet for these consumers during their enrollment in an Older Adult FSP program.

FSP Program

Overall, the FSP programs provide an intensive level of service with regionally placed Specialty Multidisciplinary Aggressive Response Treatment (SMART) programs for Older Adults. The following report presents statistics and figures from the Older Adult FSP programs.

Four Older Adult FSP programs provide intensive case management services that offer support and crisis response services that are available 24/7. The SMART FSPs serve consumers who are unengaged and homeless or at risk of homelessness. The program also targets consumers who have a history of cycling through acute or long-term institutional treatment settings. These centers collaborate with community resources and agencies to meet the vocational, educational, social, and housing needs of consumers. Services are provided by a multi-disciplinary team that embraces the principles of recovery and resilience. The services and support that are available within SMART include: psychiatric services, vocational specialists, housing specialists, substance abuse counselors, peer support/mentorship, family education, family advocacy, educational support, and benefits specialists.

Older Adult Enrollment and Demographics —During the 2023/2024 fiscal year from July 1, 2023 to June 30, 2024, a total of 559 older adults were served across 592 enrollments which includes re-enrollments and transfers to one or more of the older adult FSP programs. The race/ethnicity of enrollees for this fiscal year was 109 (18.4%) Latinx, 249 (42.1%) White, and 83 (14.0%) African American/Black. In each program and countywide, the most common diagnoses among older adult FSP consumers were schizophrenia/psychosis disorder 150 (34.7%). Countywide, the largest proportion of consumers were between the ages of 60 and 69 (80%) and the majority enrolled were females (55%).

Older Adult Discontinuances —Across all of the older adult programs the most frequently reported discontinuance reason was 'Partner left program' (27%).

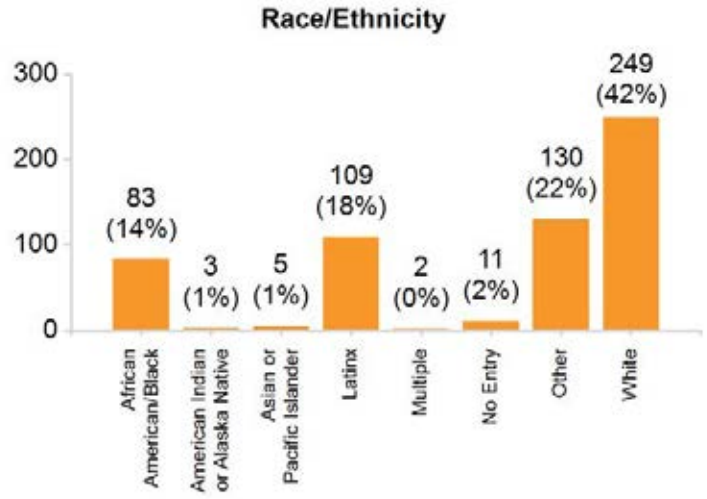
FSP Services —In 2023/2024 fiscal year, more than half of the FSP consumers received 4-7 or 8 or more services a month. The highest average hours of services during 2023/2024 fiscal year were for Mental Health Services-Group (14.92 hours), Individual Mental Health Services (13.06 hours) and Case Management (12.93 hours).

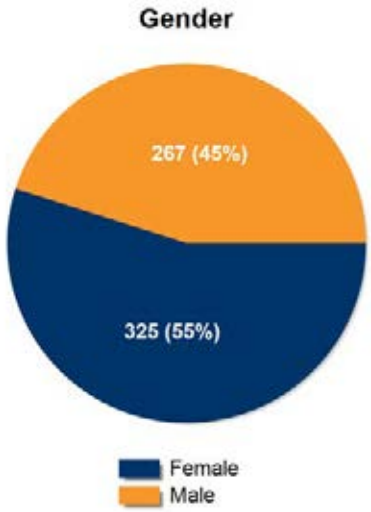
Older Adult Outcomes —Follow-up data for all older adult programs combined showed a decrease in hospitalizations (86.05%), arrests (96.36%), physical health emergency (92.43%) and mental health emergency department visits (76.26%). Programs had 93 to 100 percent decreases in arrests between intake and follow-up. Most programs had decreases in reported hospitalizations. Emergency department visits for mental health services declined by 60% or more for consumers in most programs. Over a quarter of consumers did not have a primary care physician at the beginning of the program (26.96%). For those who did not have a primary care physican at intake, a little over half (55.70%) obtained one while in the FSP program. Although the majority of those with a co-occurring substance use problem were not receiving treatment at intake, over a quarter (28.42%) participated in substance use services while in partnership. Of the 55 additional consumers that were identified as having an active substance abuse problem during their participation in the Older Adult programs, 32(58.18%) were reported to be participating in substance use treatment services while in the FSP program.

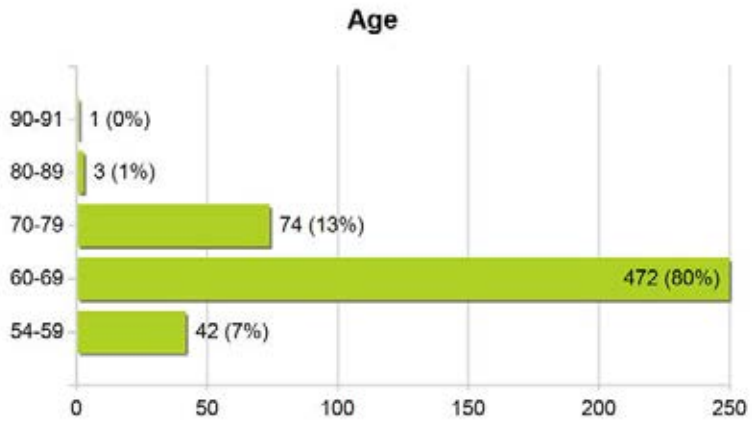
Residential Status — Comparisons of intake status and most recent residential status showed that the percentage of consumers reported as homeless or living in emergency shelters decreased and the proportion living on their own increased.

Demographics & Diagnosis

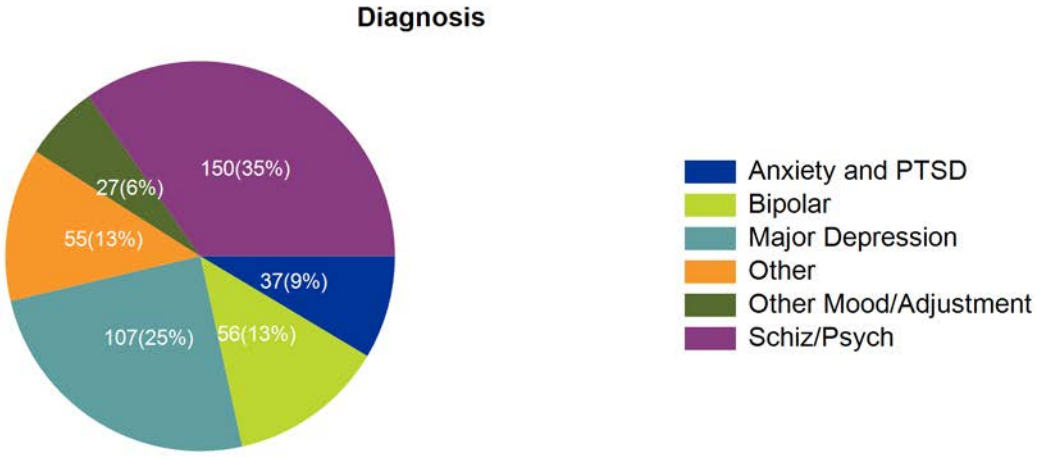
The majority served in the Older Adult FSP program in the 2023/2024 fiscal year were White 42%, which comprise a larger proportion of those served than their proportion in the Riverside County general population of 59%. The proportion of Latinx, at 18%, was lower than that in the general population of the county of 28%. The proportion of African American/Black consumers at 14% was larger than the general population of 6%. Also, more females (55%) have enrolled in the Older Adult FSP program than males (45%).







Most individuals served were between the age of 60-69 (80%). A large proportion of those served were diagnosed with Schizophrenia/Psychosis disorders (35%), Major depression (25%), or Bipolar disorder (13%).



Length of FSP Partnership

The length of stay in years for those **592** enrolled in Older Adult FSP programs during the 2023/2024 fiscal year is shown in the tables below. For reporting time in partnership, the total time a consumer spent in each enrollment is included.

The percentage of older adults with an active/open case having time in the FSP longer than one year was 68%, while 58% of those closed had a length of stay in the FSP shorter than one year. Of all older adult FSP consumers served in FY 2023/2024, almost half had a length of stay less than two years (55%).

FSP re-entry: Of these **592** older adult FSP enrollments, 22 returned to an FSP program after discharging less than a year previously. These consumers are considered to have re-established partnership with 1 client re-establishing partnership more than once over his/her total time in partnership. The number of consumers that returned to an FSP program after more than a year had passed since discharging from an FSP program was 34.

Older Adult Time in Partnership	Closed	Open	All Consumers	% of Total
Under 90 days	42	36	78	13%
>= 90 days and < 1 Year	59	96	155	26%
>= 1 Year and < 2 Years	21	72	93	16%
>= 2 Years and <3 Years	31	48	79	13%
>= 3 Years and < 4 Years	7	86	93	16%
>= 4 Years and < 5 years	8	48	56	9%
>=5 Years and < 6 years	3	5	8	1%
>=6 Years+	4	26	30	5%
Total Consumer Enrollments	**175**	**417**	**592**	

Average Years in Partnership	3.13	7.63	2.28
Median Years in Partnership	0.69	2.15	1.70
Maximum Years in Partnership	13.35	11.63	13.35

Length of stay for consumers enrolled in each program is described on the following pages. The length of stay in a program includes only time enrolled in that specific program. Some consumers were enrolled in more than one program during FY 2023/2024 fiscal year or left and returned within the same fiscal year.

Note: Active cases include those with an open episode in an older adult FSP reporting unit as of 6/30/2024. Closed cases include only those that do not have an open episode in an FSP reporting unit as of 6/30/2024. While some consumers leave partnership and later reestablish partnership in the same or different FSP program, time spent inactive is not included in this report.

Reason for Discontinuance of FSP: All Older Adults

Upon termination of FSP partnership a reason for discontinuance is selected. For recorded cases, the most common reasons for discontinuance were 'Partner left program' (27%), followed by 'Met goals' (22%) and 'Partner cannot be located' (22%). If a consumer terminated partnership more than once, each instance was recorded in this table.

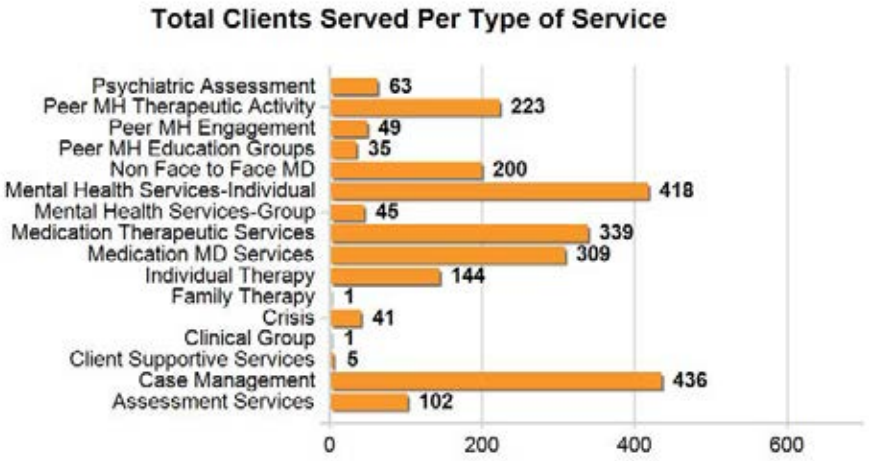
Discontinuation Reason	Count	%
Partner left program	35	27%
Met goals	28	22%
Partner cannot be located	28	22%
Moved out of county/area	20	16%
Deceased	8	6%
Needs residential care	6	5%
Target criteria not met	4	3%
Total	**129**	**100%**

Service Frequency By Month

The table below shows the number of individuals receiving various amounts of services per month, for each of month of the 2023/2024 fiscal year. The majority of consumers received either 4-7, or 8 or more services per month within the fiscal year. On average, more than 23% of older adult FSP consumers received 8 or more services per month.

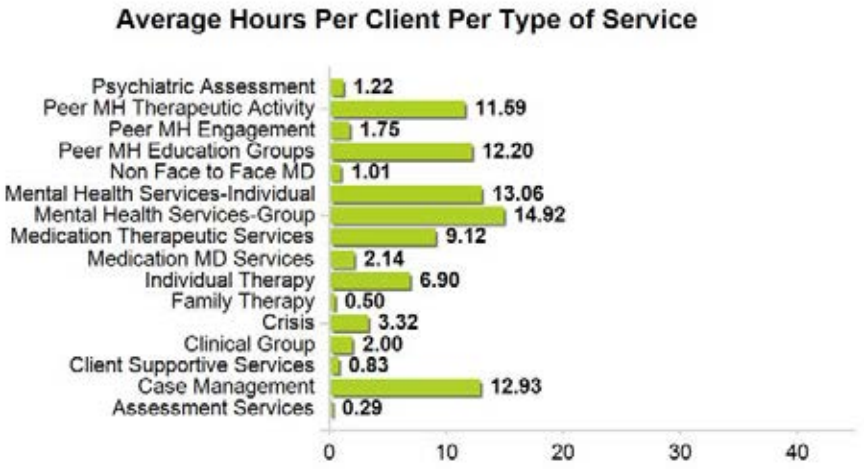
Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	55 (18%)	60 (18%)	62 (19%)	58 (19%)	54 (18%)	70 (23%)	62 (20%)	69 (21%)	69 (19%)	78 (22%)	64 (17%)	59 (17%)
2-3	81 (26%)	77 (23%)	93 (29%)	92 (29%)	93 (30%)	92 (30%)	87 (28%)	92 (28%)	111 (31%)	70 (19%)	79 (22%)	84 (25%)
4-7	96 (31%)	92 (27%)	109 (34%)	96 (31%)	97 (32%)	95 (31%)	84 (27%)	101 (31%)	113 (32%)	127 (35%)	116 (32%)	117 (35%)
8-13	61 (19%)	71 (21%)	39 (12%)	50 (16%)	43 (14%)	41 (13%)	45 (15%)	55 (17%)	45 (13%)	61 (17%)	71 (19%)	53 (16%)
14-19	15 (5%)	23 (7%)	12 (4%)	12 (4%)	16 (5%)	7 (2%)	25 (8%)	10 (3%)	12 (3%)	14 (4%)	24 (7%)	11 (3%)
20-25	5 (2%)	8 (2%)	2 (1%)	4 (1%)	1 (0%)	3 (1%)	4 (1%)	1 (0%)	4 (1%)	6 (2%)	5 (1%)	12 (4%)
26-31	0 (0%)	3 (1%)	2 (1%)	1 (0%)	1 (0%)	2 (1%)	2 (1%)	1 (0%)	2 (1%)	1 (0%)	3 (1%)	2 (1%)
32+	1 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1%)	0 (0%)	2 (1%)	4 (1%)	1 (0%)
Monthly Total	314	335	319	313	305	310	309	331	356	359	366	339

Service Detail



During the 2023/2024 Fiscal year, the top three services clients received were Case Management, Mental Health Services-Individual, and Medication Therapeutic Services.

The average number of hours consumers received of each type of service while in an older adult FSP program during the 2023/2024 fiscal year was calculated. As shown to the right, the average number of hours per consumer was highest in MH Services-Group (14.92 hours).

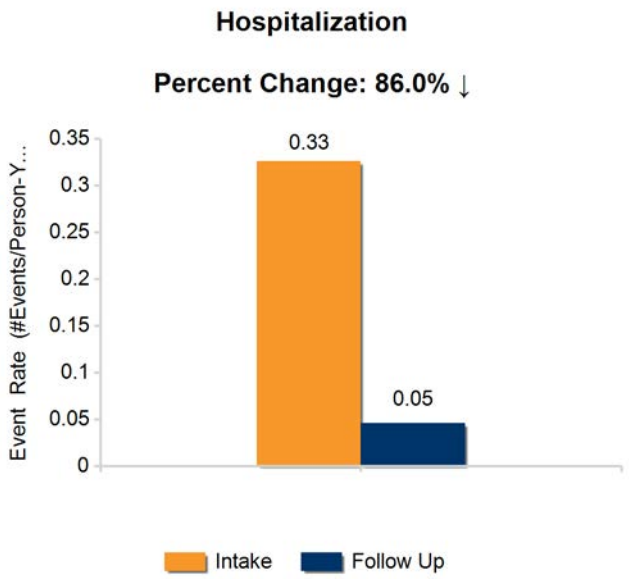


Type of Service	# of OA	% of OA	# of Svcs	Avg. # Svcs
Assessment Services	102	17%	117	1.15
Case Management	436	74%	6,125	14.05
Client Supportive Services	5	1%	6	1.20
Clinical Group	1	0%	1	1.00
Crisis	41	7%	73	1.78
Family Therapy	1	0%	1	1.00
Individual Therapy	144	24%	1,068	7.42
Medication MD Services	309	52%	953	3.08
Medication Therapeutic Services	339	57%	3,577	10.55
Mental Health Services-Group	45	8%	334	7.42
Mental Health Services-Individual	418	71%	5,663	13.55
Non Face to Face MD	200	34%	502	2.51
Peer MH Education Groups	35	6%	181	5.17
Peer MH Engagement	49	8%	95	1.94
Peer MH Therapeutic Activity	223	38%	2,380	10.67
Psychiatric Assessment	63	11%	64	1.02

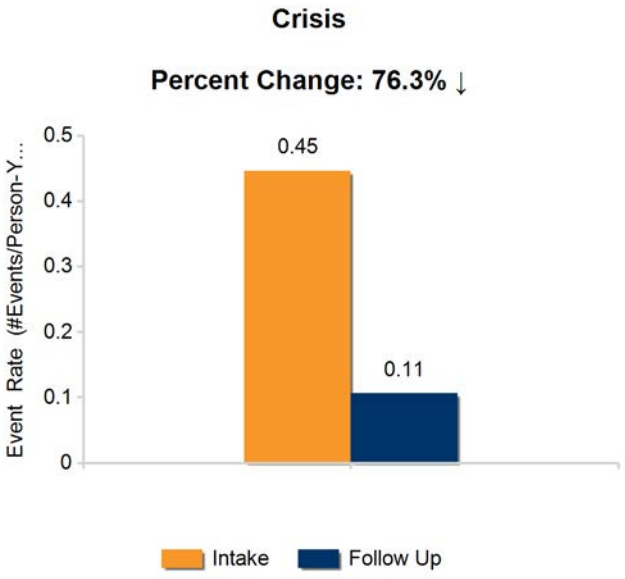
Outcomes

Primary outcomes of interest for FSP include arrests, physical and mental health emergency room visits, incidences of acute hospitalizations and long-term care. The number of events in the 12 months prior to FSP enrollment are compared with the rate of 'number of events per person-year' in the program (i.e., follow-up). At follow-up, the number of outcome events occurring while enrolled were summed and divided by the number of years all individuals had been in the program. Actual counts for each outcome overall and by program can be found after page 11.

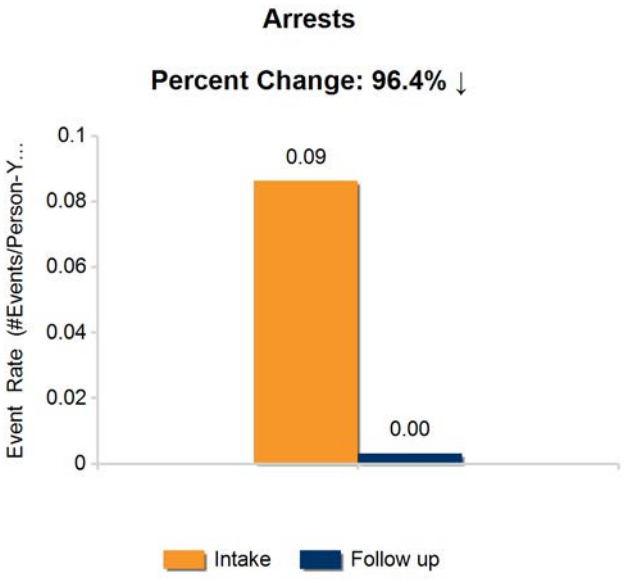
Overall, psychatric hospitalizations, use of mental health crisis facilities, arrests, and physical health emergencies reduced.



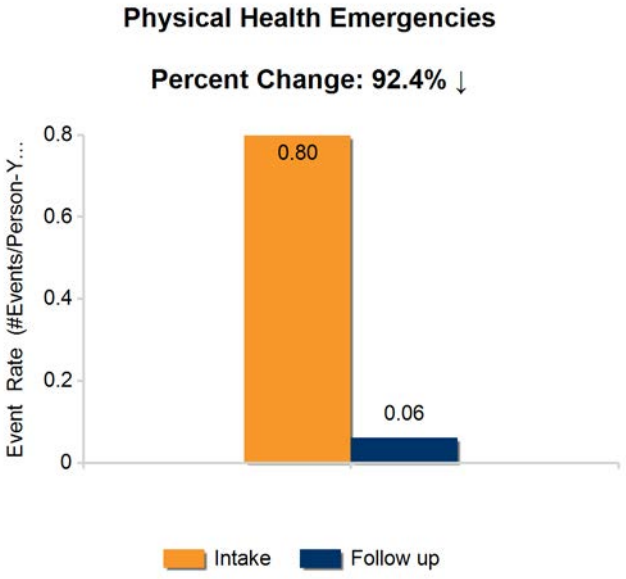
Hospitalizations decreased 86.0% from intake to follow-up.



Crisis decreased 76.3% from intake to follow-up.



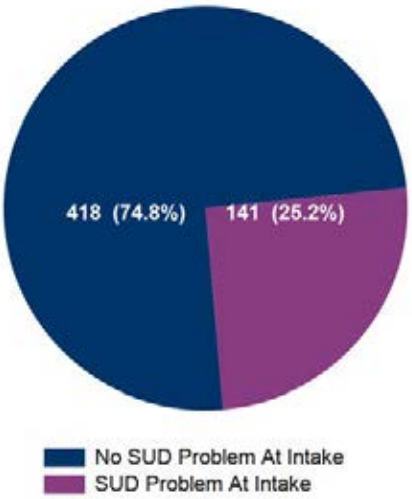
Arrests decreased 96.4% from intake to follow-up.

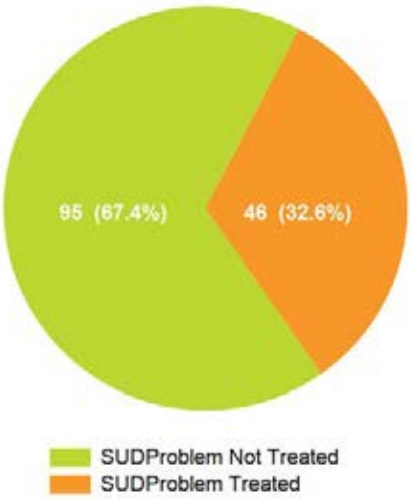


Physical Health Emergency visits decreased 92.4%.

Outcomes: Substance Use

Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (25.2%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

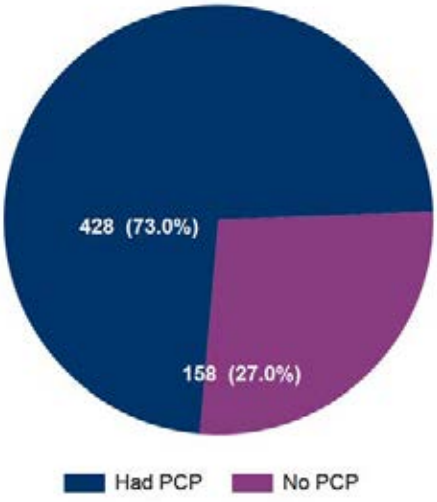




Follow-up: Based on follow-up data reported quarterly, 28.4% (27) of the 95 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 55 consumers not identified at intake were noted to have an SU problem on follow-up and 58.2% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician

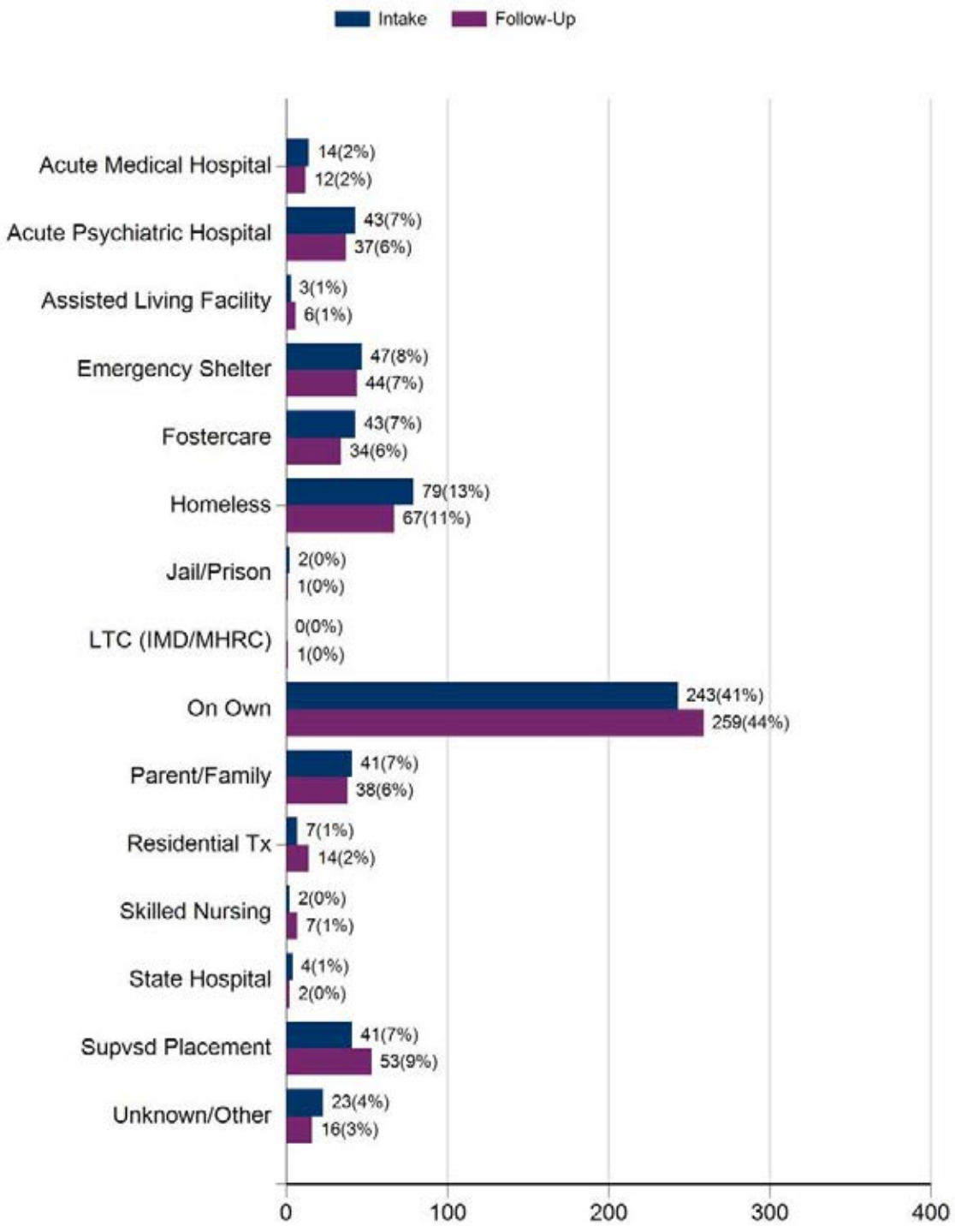
Intake: A little over a quarter of older adults (27.0%) did not have a primary care physician (PCP) at intake.



Follow-up: Of the 158 consumers that did not have a PCP at intake, 88 (55.7%) obtained a PCP while in the program.

Outcomes: Residential

Overall, the older adult FSP consumers had a decrease in the proportion homeless and an increase in the percentage of consumers living on their own. Residential settings was calculated using the residential category from intake to their latest residential status. The percentages below are for all reporting units.



Outcomes: Residential Days

The following compares consumers' living arrangements in the year prior to FSP enrollment to their living arrangements while enrolled in the program. Specifically, the number of days spent in each setting in the year before enrollment is compared to the number of days spent annually in each setting during enrollment. The goal of this analysis is to determine whether days in more stable settings during FSP participation had increased and days in less stable settings had decreased.

Baseline data was obtained from consumers' Partnership Assessment Form which includes the number of days consumers spent in each residential setting during the 12 months immediately prior to enrollment. Note that this 12 months preceded their **first** enrollment to any FSP program.

The number of days the consumers spent in each setting while enrolled in an FSP program was tracked through enrollment changes and residence changes noted on Key Event Tracking (KET) forms. When consumers re-enter an FSP program after a lapse in enrollment, their living arrangement is often noted on a KET form or new PAF, but if not, it was considered unknown. To accurately compare a year of pre-enrollment with a year of post enrollment, data for residential days during enrollment has been annualized.

	12 Months Prior to Enrollment		Annualized Days During Enrollment		
Living Situation	**# of Days**	**Count (n)**	**# of Days**	**Count (n)**	**Percent change (%)**
Acute Medical Hospital	911	39	1,398	64	-53%
Acute Psychiatric Hospital	670	82	4,812	46	-618%
Assisted Living Facility	1,100	4	551	7	50%
Emergency Shelter	11,904	67	12,140	57	-2%
Homeless	34,786	131	15,683	86	55%
Jail/Prison	1,432	10	88	2	94%
LTC (IMD/MHRC)	104	1	-	0	100%
On Own	84,096	257	88,360	296	-5%
Parent/Family	15,348	51	15,043	45	2%
Residential Tx	1,275	16	2,724	13	-114%
Skilled Nursing	49	2	901	10	-1738%
State Hospital	390	5	284	4	27%
Supervised Placement	10,373	48	14,414	52	-39%
Unknown/Other	54,372	152	47,771	145	12%

FSP Older Adult demographics and Outcomes for: 33HJFO
Served by this reporting unit: 124 Enrollment: 126

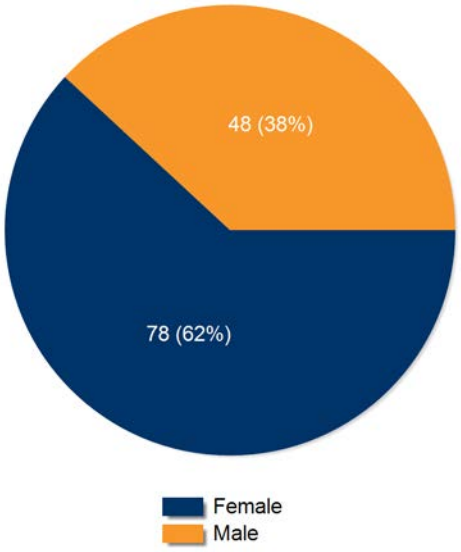
Demographics

38% of consumers were male and 62% were female.

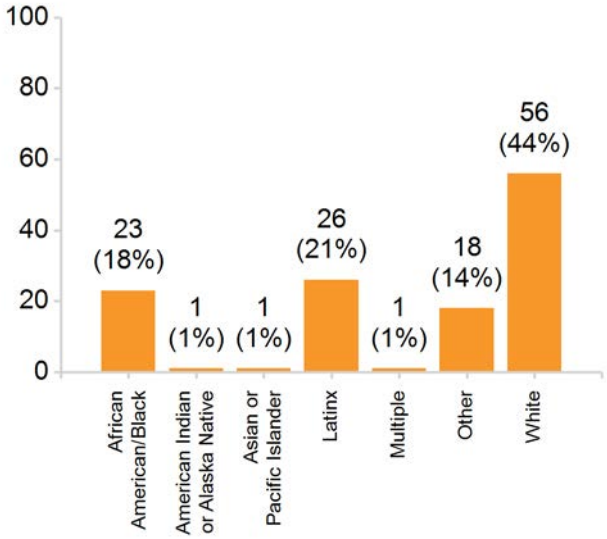
44% of consumers were White, 21% of consumers were Latinx and 18% of consumers were Black/African American.

83% of consumers were 60-69 years old.

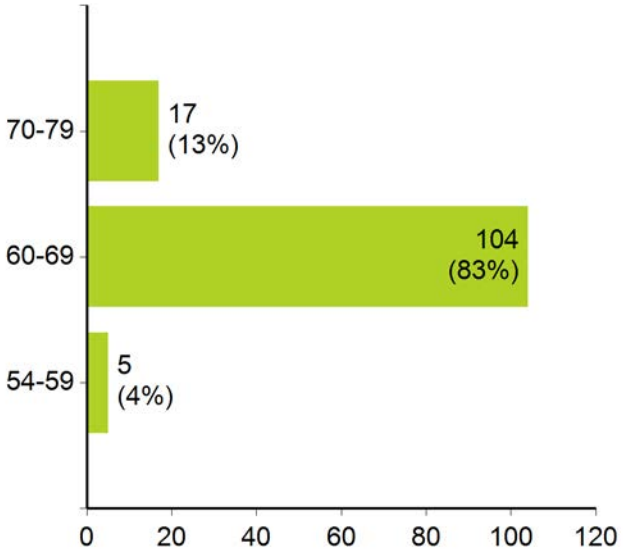
Gender



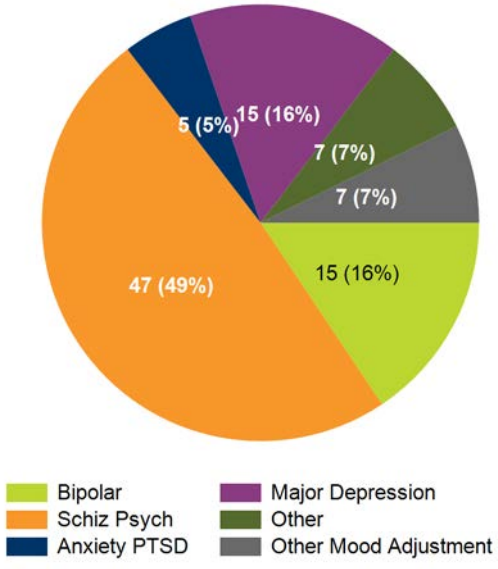
Race/Ethnicity



Age

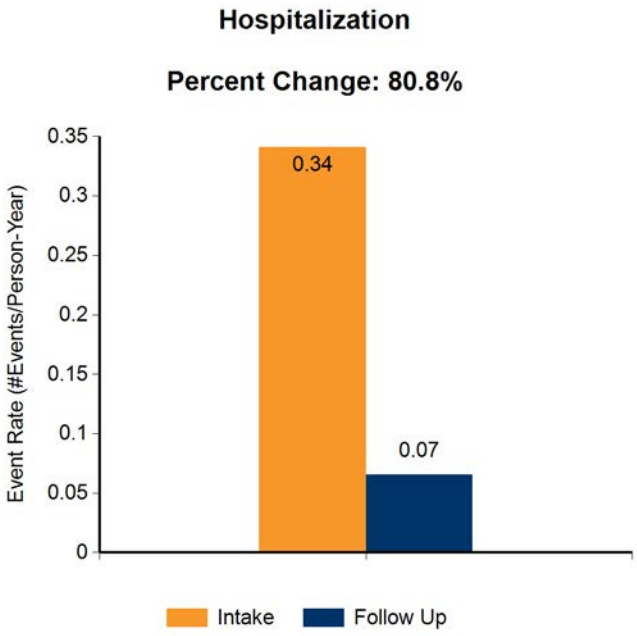


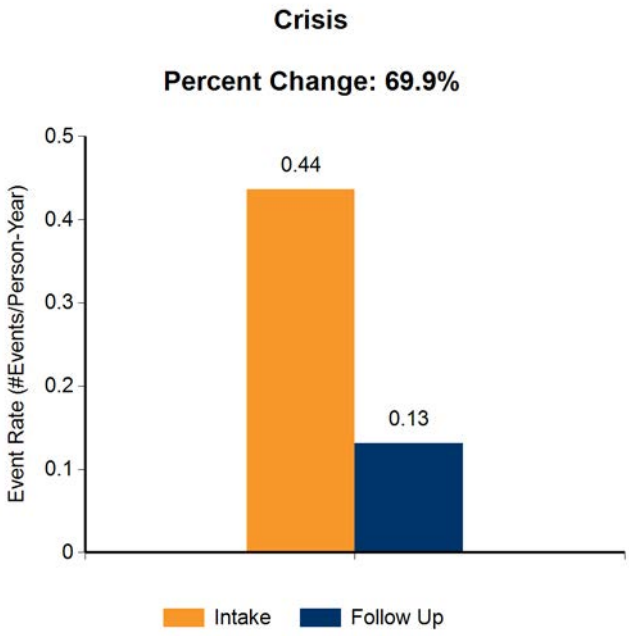
Diagnosis

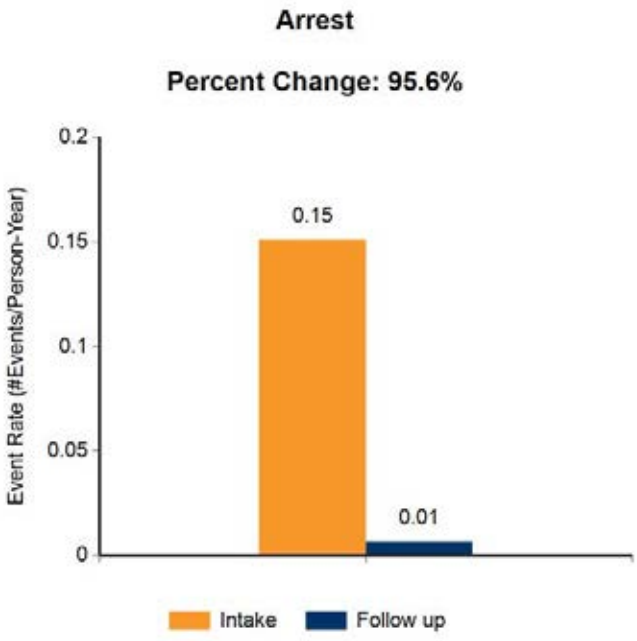


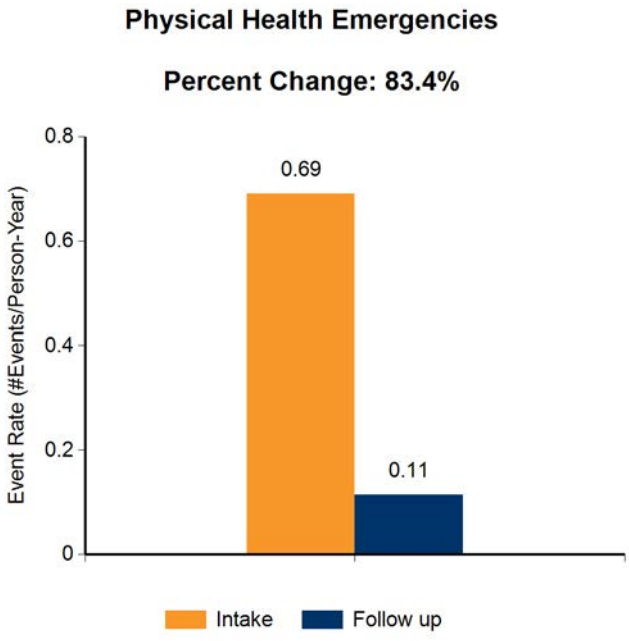
Outcomes for 33HJFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

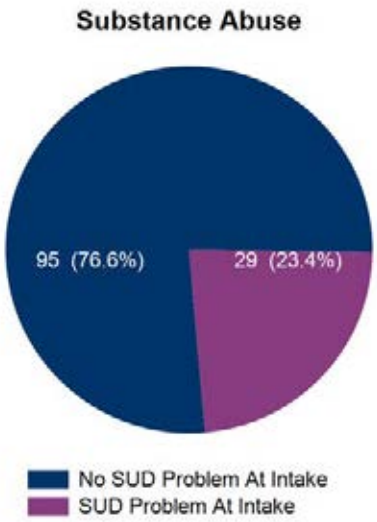


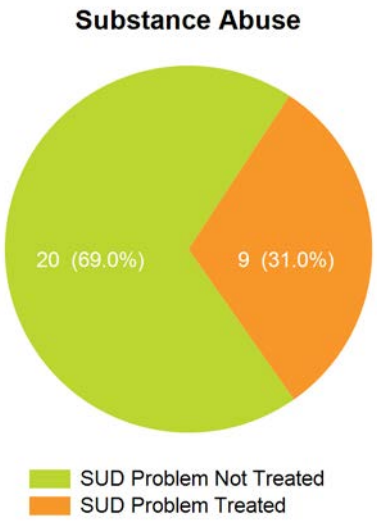






Outcomes: Substance Use (33HJFO)

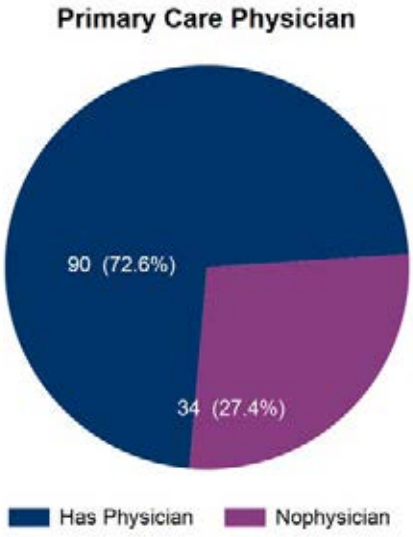




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.4%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 20.0% (4) of the 20 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up and 20.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33HJFO)



Intake: Most adults (72.6%) had a primary care physician (PCP) at intake.

Follow-up: Of the 34 consumers that did not have a PCP at intake, 20 (59.0%) obtained a PCP while in the program.

FSP Older Adult demographics and Outcomes for: 33HKFO
Served by this reporting unit: 101 Enrollment: 101

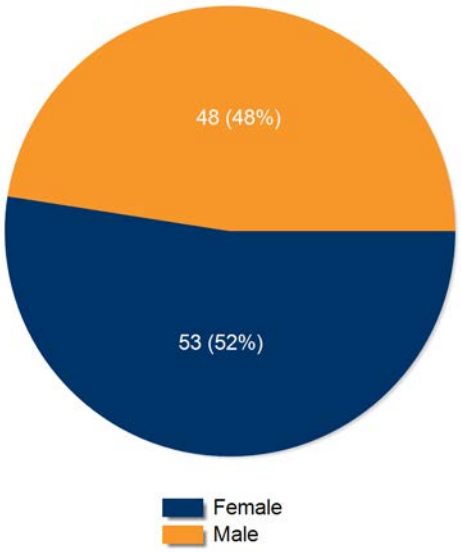
Demographics

48% of consumers were male and 52% were female.

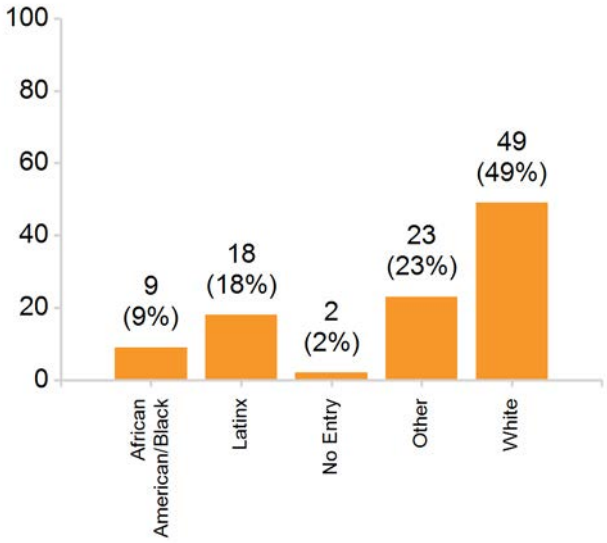
49% of consumers were White, 18% of consumers were Latinx and 9% of consumers were Black/African American.

75% of consumers were 60-69 years old.

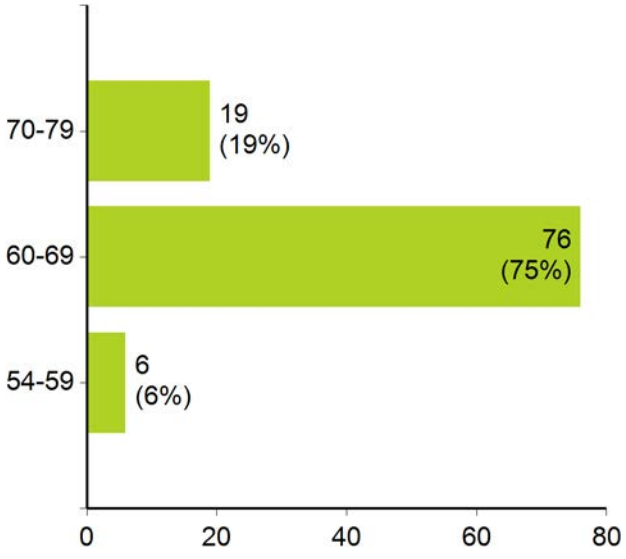
Gender



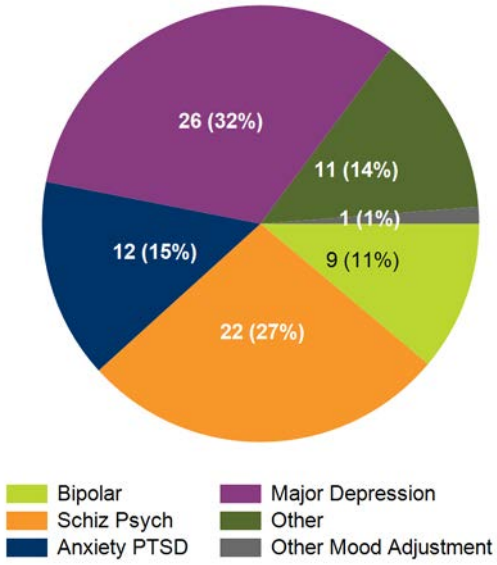
Race/Ethnicity



Age

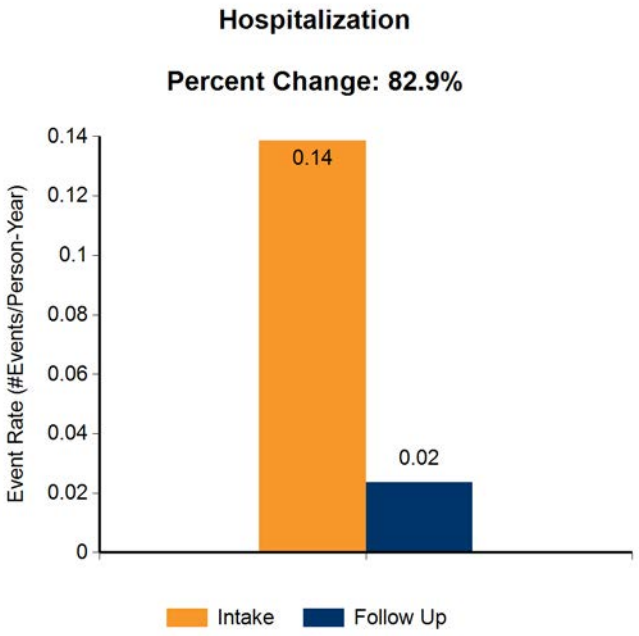


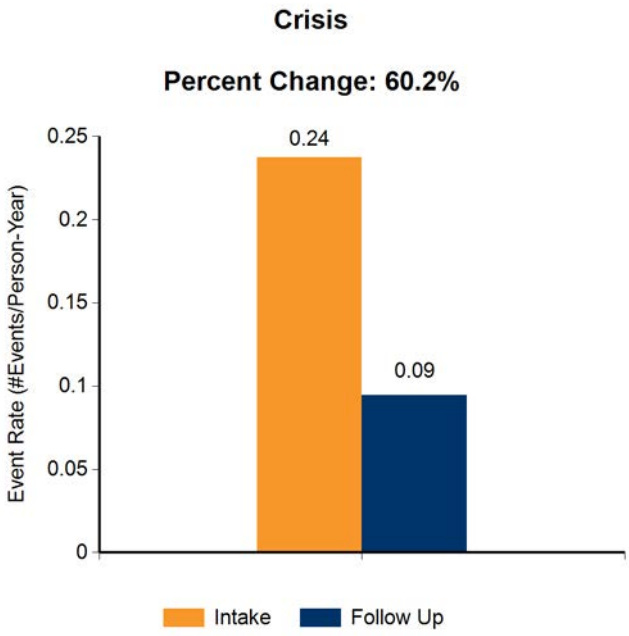
Diagnosis

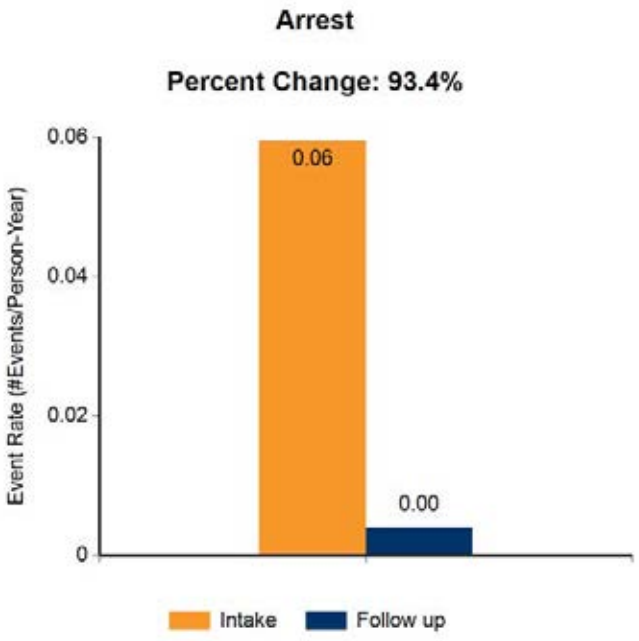


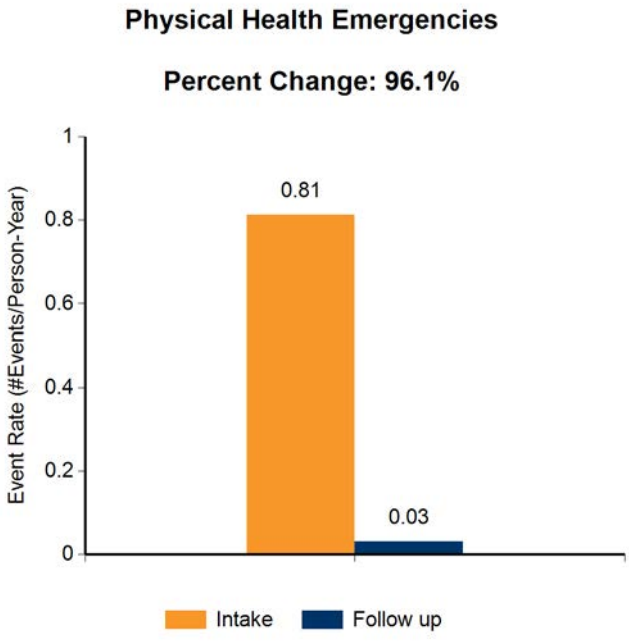
Outcomes for 33HKFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

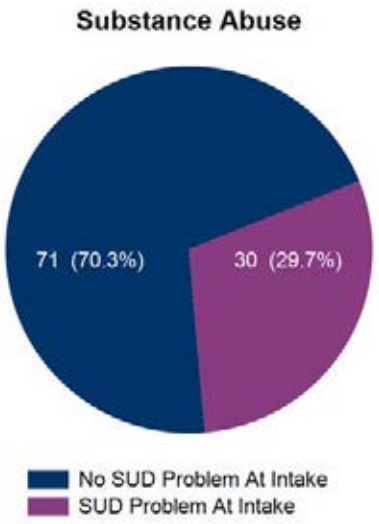


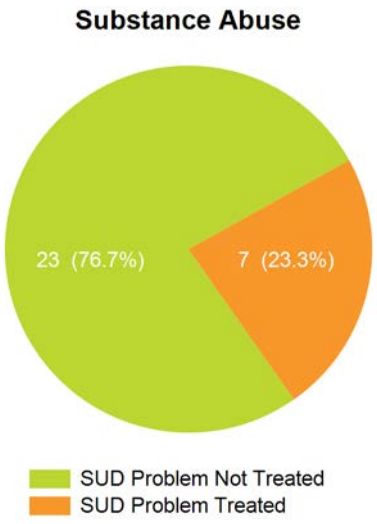






Outcomes: Substance Use (33HKFO)

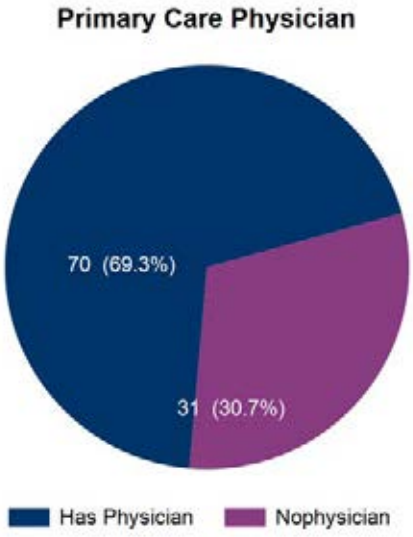




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.7%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 13.0% (3) of the 23 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 10 consumers not identified at intake were noted to have an SU problem on follow-up and 13.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33HKFO)



Intake: Most adults (69.3%) had a primary care physician (PCP) at intake.

Follow-up: Of the 31 consumers that did not have a PCP at intake, 23 (74.0%) obtained a PCP while in the program.

FSP Older Adult demographics and Outcomes for: 33IJFO
Served by this reporting unit: 213 Enrollment: 216

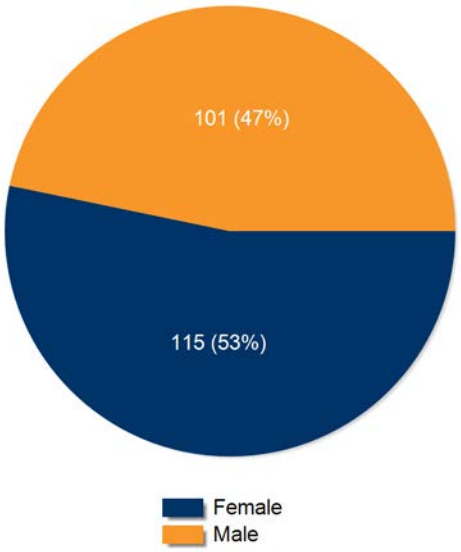
Demographics

47% of consumers were male and 53% were female.

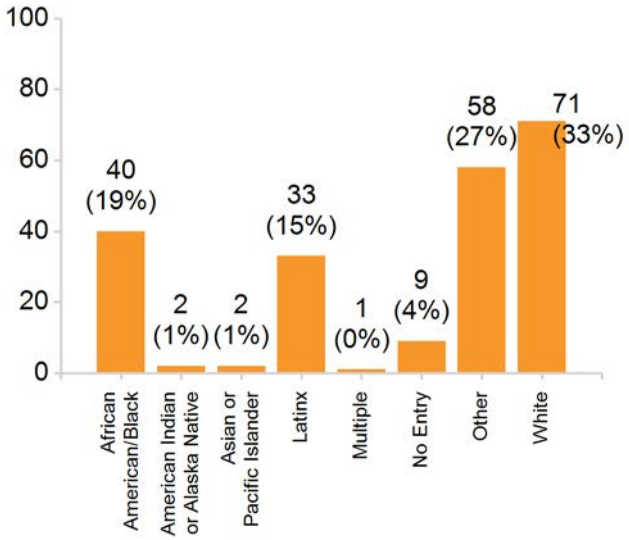
33% of consumers were White, 15% of consumers were Latinx and 19% of consumers were Black/African American.

83% of consumers were 60-69 years old.

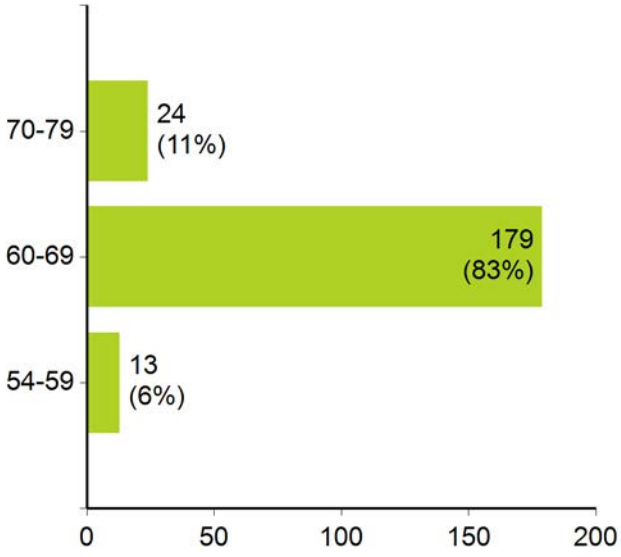
Gender



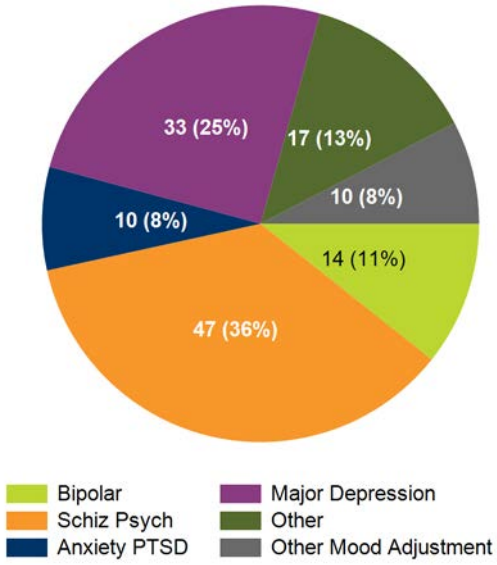
Race/Ethnicity



Age

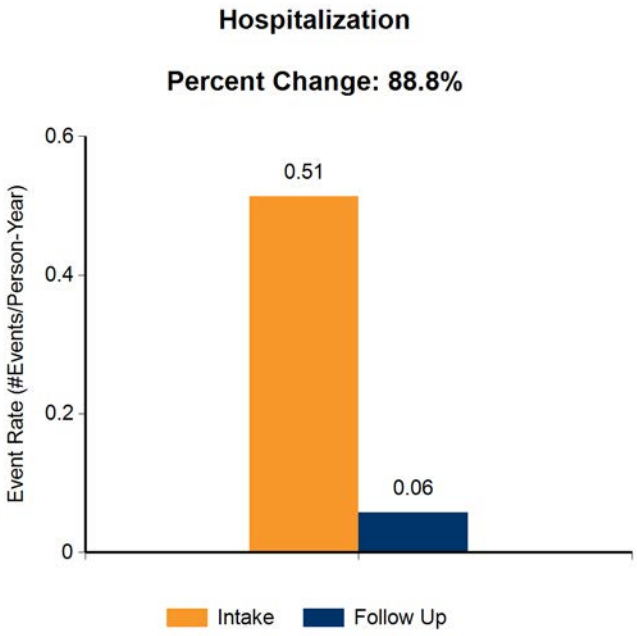


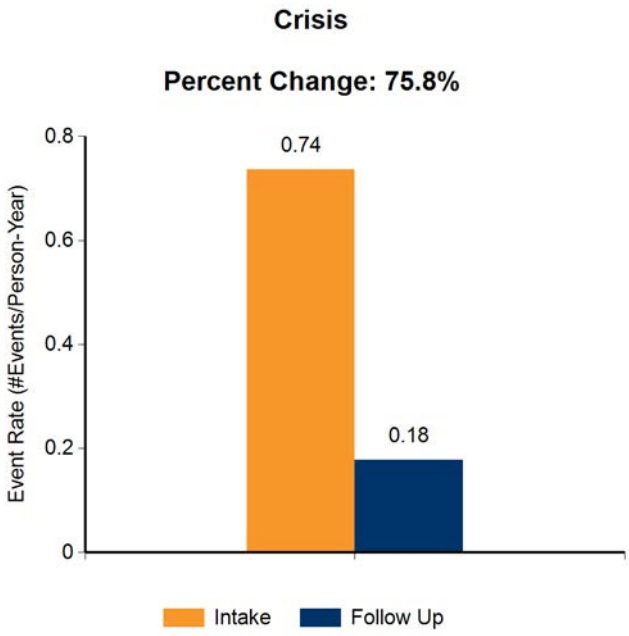
Diagnosis

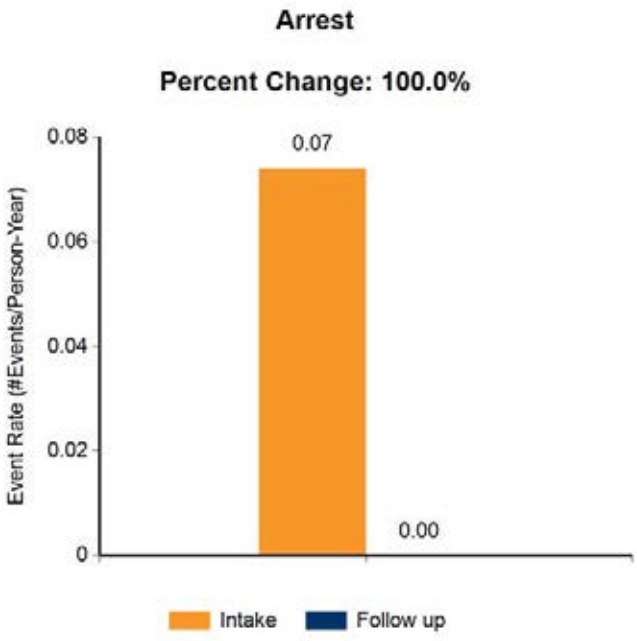


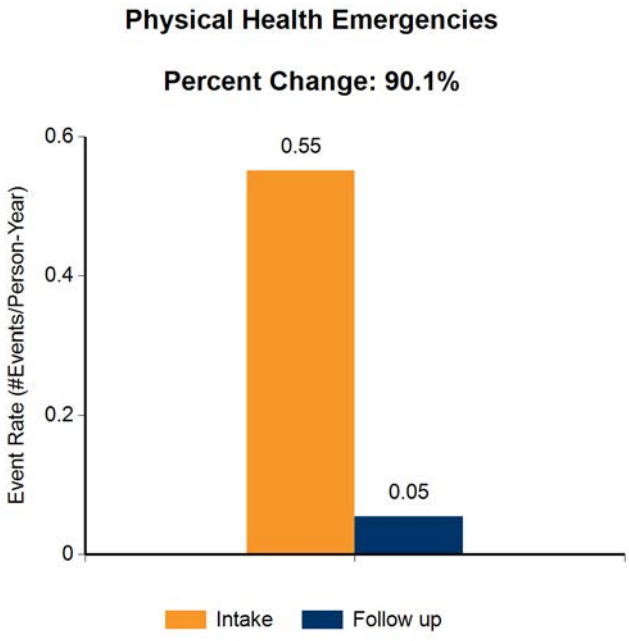
Outcomes for 33IJFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

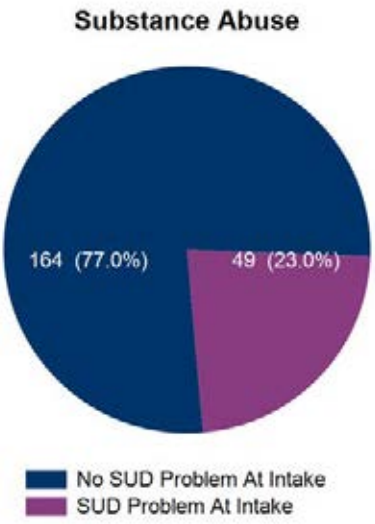


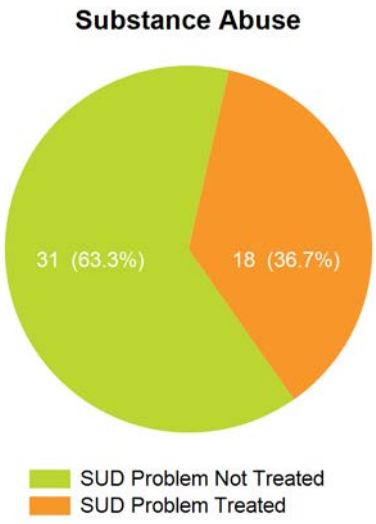






Outcomes: Substance Use (33IJFO)

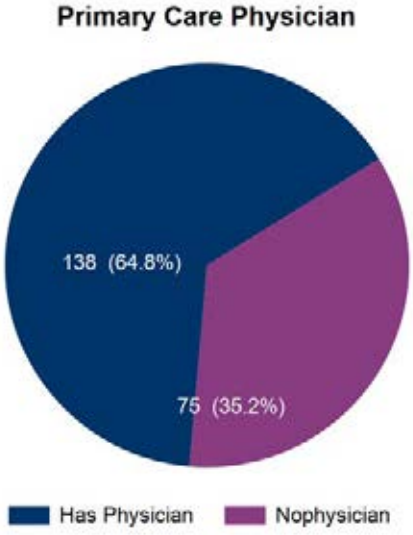




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (23.0%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 38.7% (12) of the 31 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 13 consumers not identified at intake were noted to have an SU problem on follow-up and 39.0% of them were reported to be in SU services on follow-up.

Outcomes: Primary Care Physician (33IJFO)



Intake: Most adults (64.8%) had a primary care physician (PCP) at intake.

Follow-up: Of the 75 consumers that did not have a PCP at intake, 38 (51.0%) obtained a PCP while in the program.

FSP Older Adult demographics and Outcomes for: 33MTFO
Served by this reporting unit: 148 Enrollment: 149

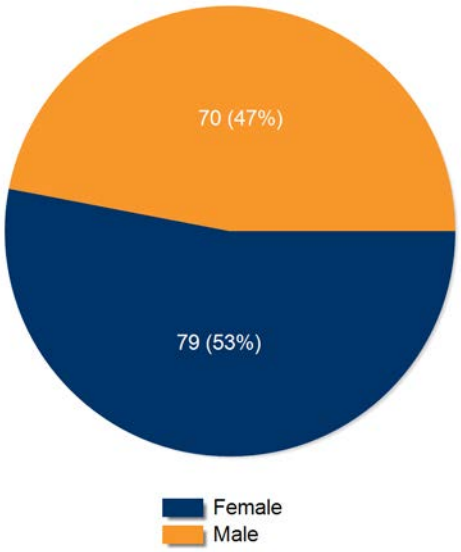
Demographics

47% of consumers were male and 53% were female.

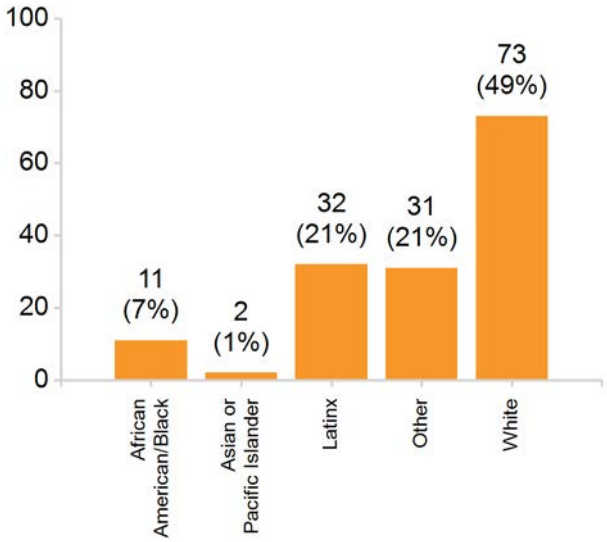
49% of consumers were White, 21% of consumers were Latinx and 7% of consumers were Black/African American.

76% of consumers were 60-69 years old.

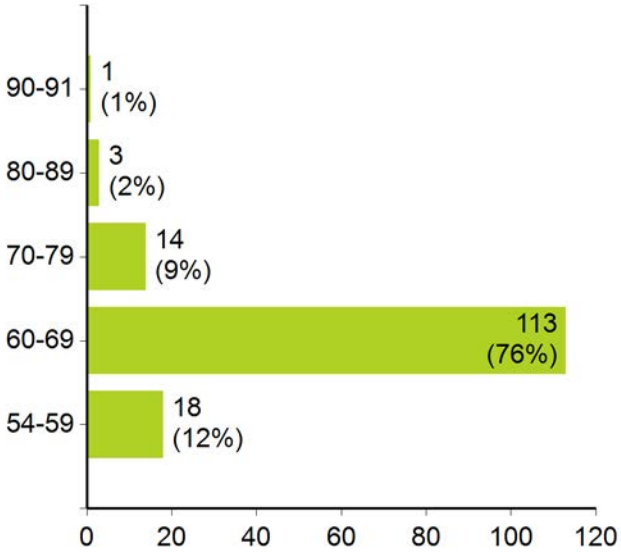
Gender



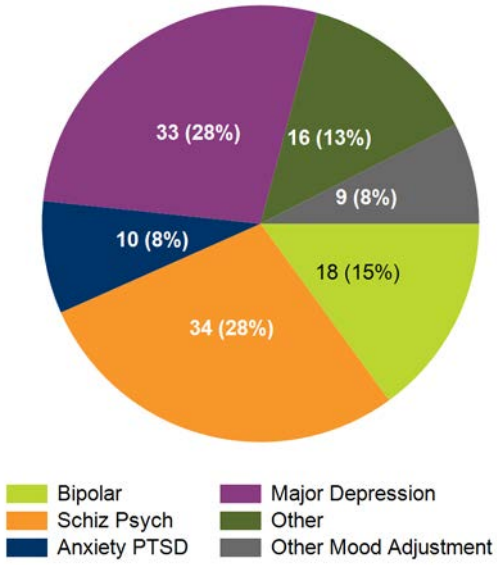
Race/Ethnicity



Age

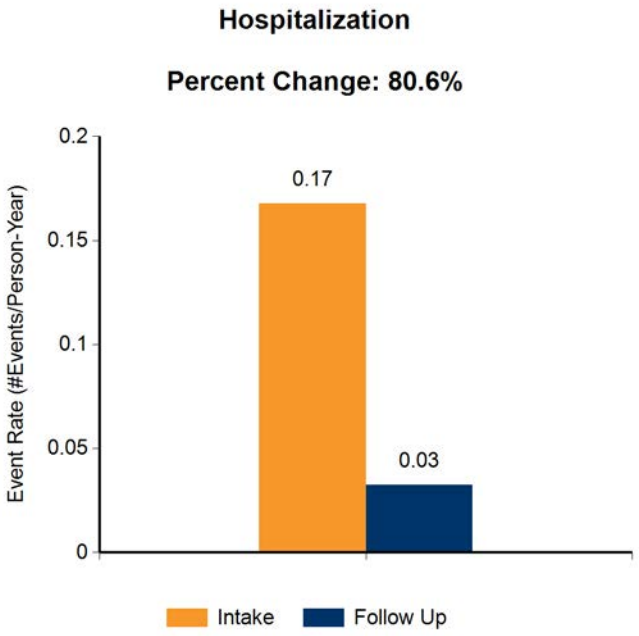


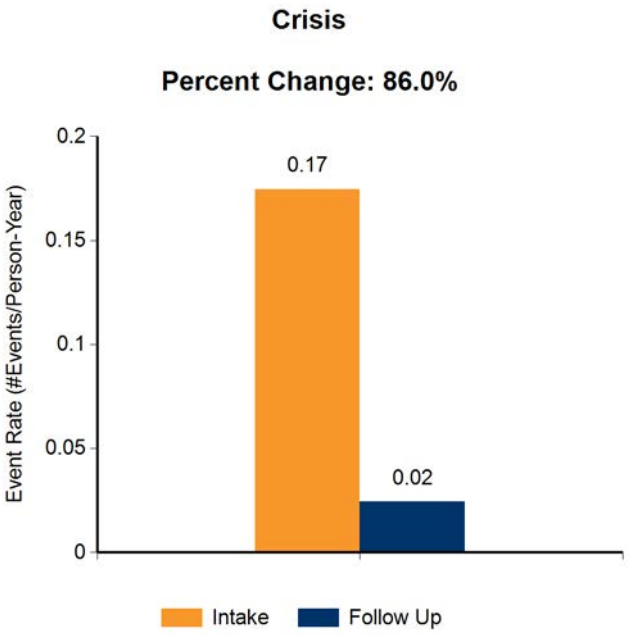
Diagnosis

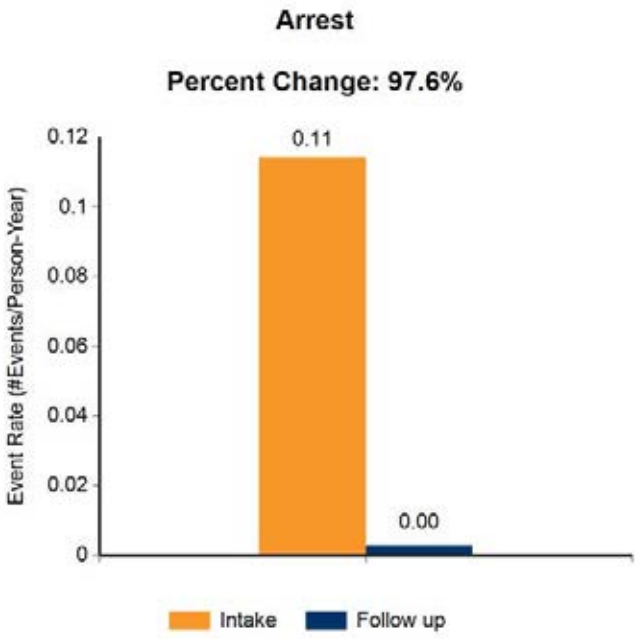


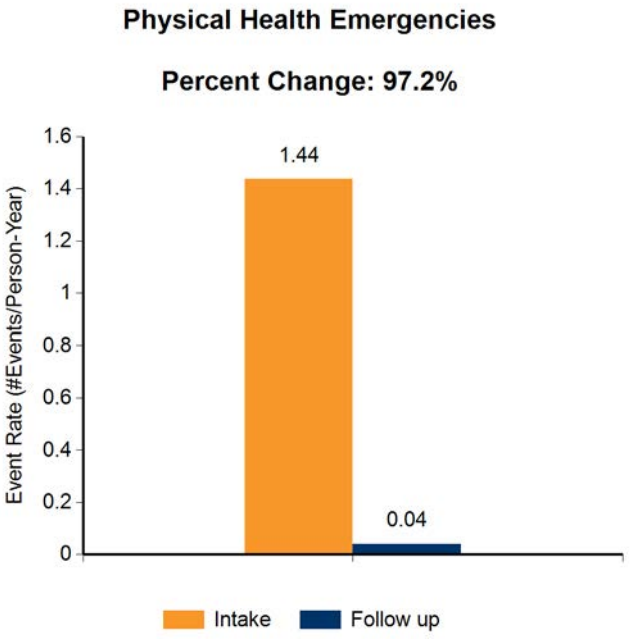
Outcomes for 33MTFO

Primary outcomes of interest for FSP include incidences of acute hospitalizations, crisis intervention, arrests, and physical health emergencies.

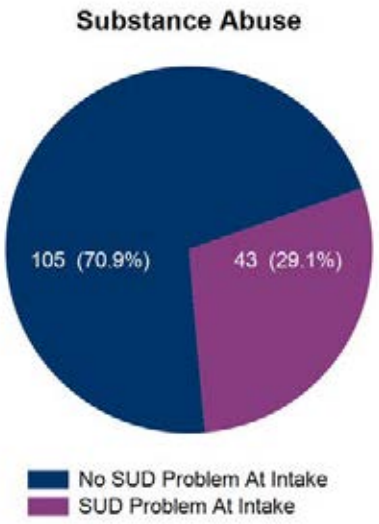


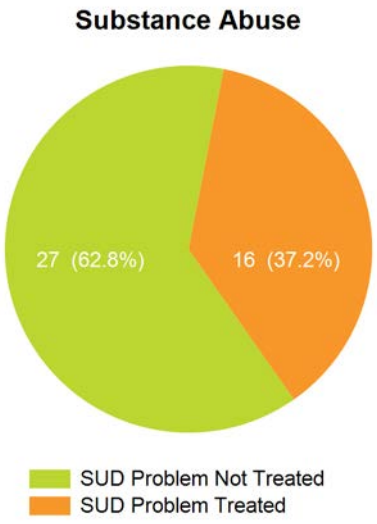






Outcomes: Substance Use (33MTFO)

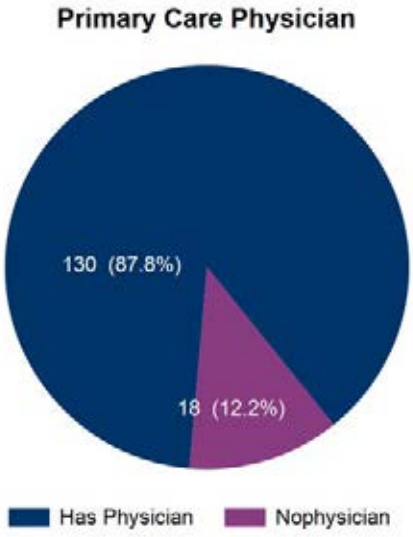




Intake: A significant proportion of consumers enter FSP with co-occurring mental health (MH) and substance use (SU) problems (29.1%). The majority of those who had co-occurring MH and SU problems, had not been receiving SU treatment services at intake.

Follow-up: Based on follow-up data reported quarterly, 29.6% (8) of the 27 people with a co-occurring problem and no participation in SU services at intake were now participating in SU services. An additional 17 consumers not identified at intake were noted to have an SU problem on follow-up and 30.0% of them were reported to be in SU services on follow-up.

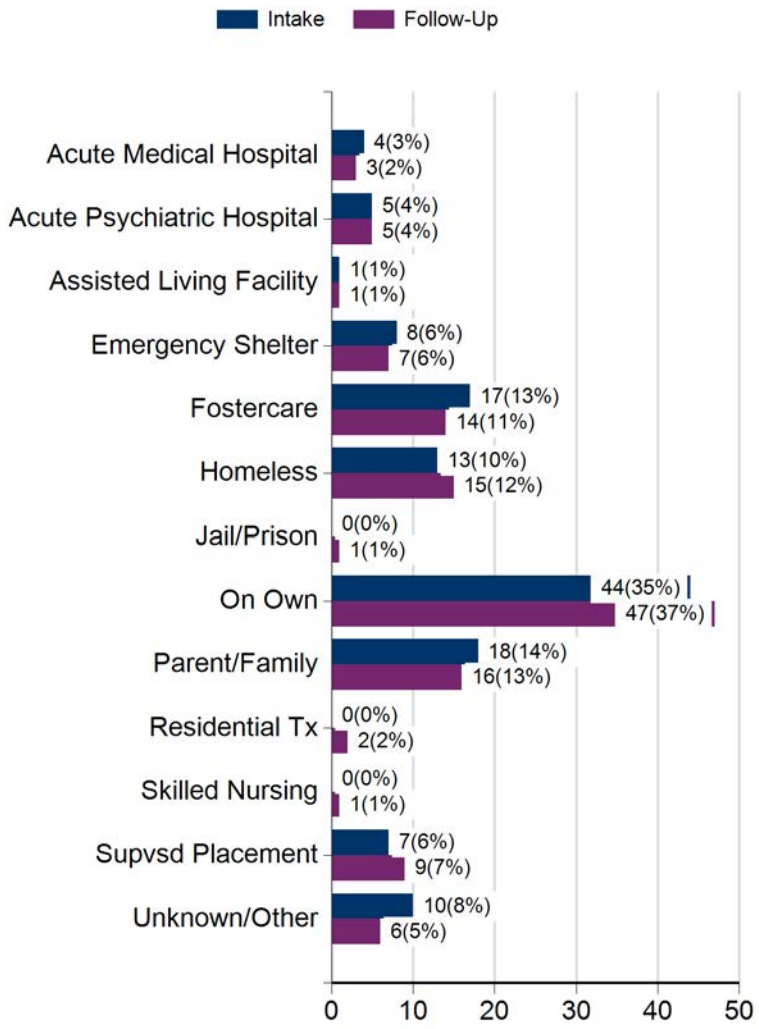
Outcomes: Primary Care Physician (33MTFO)



Intake: Most adults (87.8%) had a primary care physician (PCP) at intake.

Follow-up: Of the 18 consumers that did not have a PCP at intake, 16 (89.0%) obtained a PCP while in the program.

Outcomes: Residential & Discontinuance (33HJFO)



Discontinuation Reason	Count	%
Met goals	12	48%
Partner cannot be located	6	24%
Partner left program	4	16%
Moved out of county/area	2	8%
Needs residential care	1	4%
Total	25	100%

Length of FSP Partnership for: 33HJFO

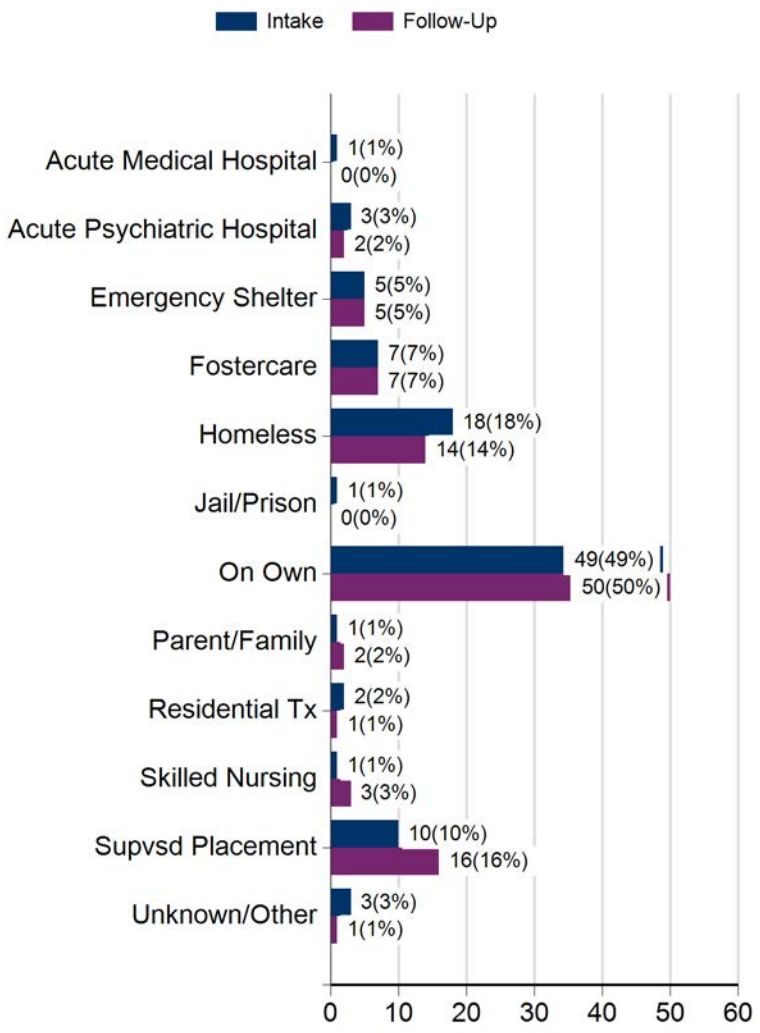
OA Time in Partnership	Closed	Open	All Consumers	% of Total
Under 90 days	6	8	14	11.11%
>= 90 days and < 1 Year	9	29	38	30.16%
>= 1 Year and < 2 Years	0	13	13	10.32%
>= 2 Years and <3 Years	8	12	20	15.87%
>= 3 Years and < 4 Years	1	15	16	12.70%
>= 4 Years and < 5 years	1	6	7	5.56%
>=5 Years and < 6 years	2	1	3	2.38%
>=6 Years+	1	14	15	11.90%
Total Consumer Enrollments	28	98	126	

Service Detail: 33HJFO

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	9 (15%)	13 (19%)	20 (33%)	22 (33%)	17 (25%)	18 (25%)	16 (27%)	24 (32%)	25 (30%)	29 (33%)	11 (13%)	14 (18%)
2-3	21 (34%)	19 (27%)	26 (43%)	25 (37%)	22 (33%)	24 (33%)	20 (33%)	26 (35%)	23 (27%)	21 (24%)	19 (23%)	23 (29%)
4-7	20 (33%)	21 (30%)	10 (17%)	12 (18%)	19 (28%)	26 (36%)	14 (23%)	14 (19%)	24 (29%)	23 (26%)	31 (37%)	26 (33%)
8-13	10 (16%)	13 (19%)	4 (7%)	5 (7%)	8 (12%)	3 (4%)	8 (13%)	9 (12%)	9 (11%)	13 (15%)	20 (24%)	15 (19%)
14-19	1 (2%)	3 (4%)	0 (0%)	2 (3%)	1 (1%)	1 (1%)	2 (3%)	2 (3%)	3 (4%)	2 (2%)	1 (1%)	2 (3%)
20-25	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)	0 (0%)
Monthly Total	61	70	60	67	67	72	60	75	84	89	83	80

Type of Service	# of OA	% of OA	# of Svcs	Avg. # Svcs
Assessment Services	13	3%	13	1.00
Case Management	70	16%	597	8.53
Client Supportive Services	1	0%	1	1.00
Crisis	2	0%	4	2.00
Individual Therapy	8	2%	13	1.63
Medication MD Services	87	20%	273	3.14
Medication Therapeutic Services	70	16%	658	9.40
Mental Health Services-Group	2	0%	22	11.00
Mental Health Services-Individual	103	23%	1,325	12.86
Non Face to Face MD	46	10%	95	2.07
Peer MH Education Groups	2	0%	2	1.00
Peer MH Engagement	10	2%	21	2.10
Peer MH Therapeutic Activity	31	7%	597	19.26

Outcomes: Residential & Discontinuance (33HKFO)



Discontinuation Reason	Count	%
Met goals	6	30%
Deceased	5	25%
Moved out of county/area	4	20%
Partner cannot be located	2	10%
Partner left program	2	10%
Target criteria not met	1	5%
Total	**20**	**100%**

Length of FSP Partnership for: 33HKFO

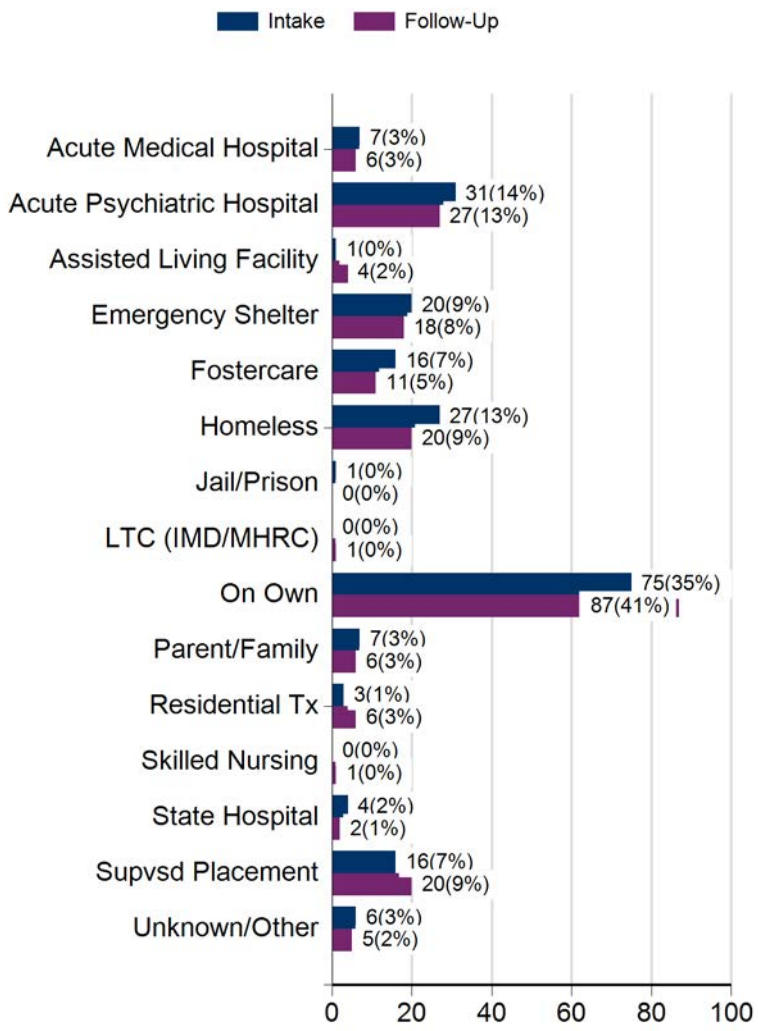
OA Time in Partnership	Closed	Open	All Consumers	% of Total
Under 90 days	2	4	6	5.94%
>= 90 days and < 1 Year	3	12	15	14.85%
>= 1 Year and < 2 Years	4	14	18	17.82%
>= 2 Years and <3 Years	10	11	21	20.79%
>= 3 Years and < 4 Years	3	27	30	29.70%
>= 4 Years and < 5 years	0	4	4	3.96%
>=5 Years and < 6 years	1	1	2	1.98%
>=6 Years+	0	5	5	4.95%
Total Consumer Enrollments	**23**	**78**	**101**	

Service Detail: 33HKFO

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	7 (9%)	9 (12%)	10 (13%)	6 (8%)	4 (6%)	17 (22%)	10 (14%)	12 (17%)	12 (15%)	7 (9%)	13 (15%)	8 (10%)
2-3	19 (24%)	15 (19%)	18 (23%)	26 (34%)	26 (38%)	24 (32%)	26 (37%)	24 (33%)	32 (40%)	16 (21%)	17 (20%)	24 (30%)
4-7	37 (46%)	26 (34%)	39 (50%)	33 (43%)	30 (44%)	27 (36%)	24 (34%)	31 (43%)	28 (35%)	42 (54%)	38 (45%)	42 (53%)
8-13	16 (20%)	26 (34%)	10 (13%)	11 (14%)	7 (10%)	8 (11%)	10 (14%)	5 (7%)	7 (9%)	12 (15%)	14 (17%)	6 (8%)
14-19	1 (1%)	1 (1%)	1 (1%)	1 (1%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	0 (0%)
Monthly Total	80	77	78	77	68	76	71	72	80	78	84	80

Type of Service	# of OA	% of OA	# of Svcs	Avg. # Svcs
Assessment Services	6	1%	6	1.00
Case Management	87	21%	1,335	15.34
Client Supportive Services	2	0%	3	1.50
Clinical Group	1	0%	1	1.00
Crisis	5	1%	6	1.20
Family Therapy	1	0%	1	1.00
Individual Therapy	23	5%	114	4.96
Medication MD Services	54	13%	152	2.81
Medication Therapeutic Services	66	16%	1,059	16.05
Mental Health Services-Group	10	2%	110	11.00
Mental Health Services-Individual	79	19%	1,156	14.63
Non Face to Face MD	54	13%	192	3.56
Peer MH Education Groups	3	1%	3	1.00
Peer MH Engagement	1	0%	1	1.00
Peer MH Therapeutic Activity	24	6%	121	5.04
Psychiatric Assessment	3	1%	3	1.00

Outcomes: Residential & Discontinuance (33IJFO)



Discontinuation Reason	Count	%
Partner left program	27	36%
Partner cannot be located	19	25%
Moved out of county/area	14	18%
Met goals	8	11%
Needs residential care	4	5%
Target criteria not met	3	4%
Deceased	1	1%
Total	**76**	**100%**

Length of FSP Partnership for: 33IJFO

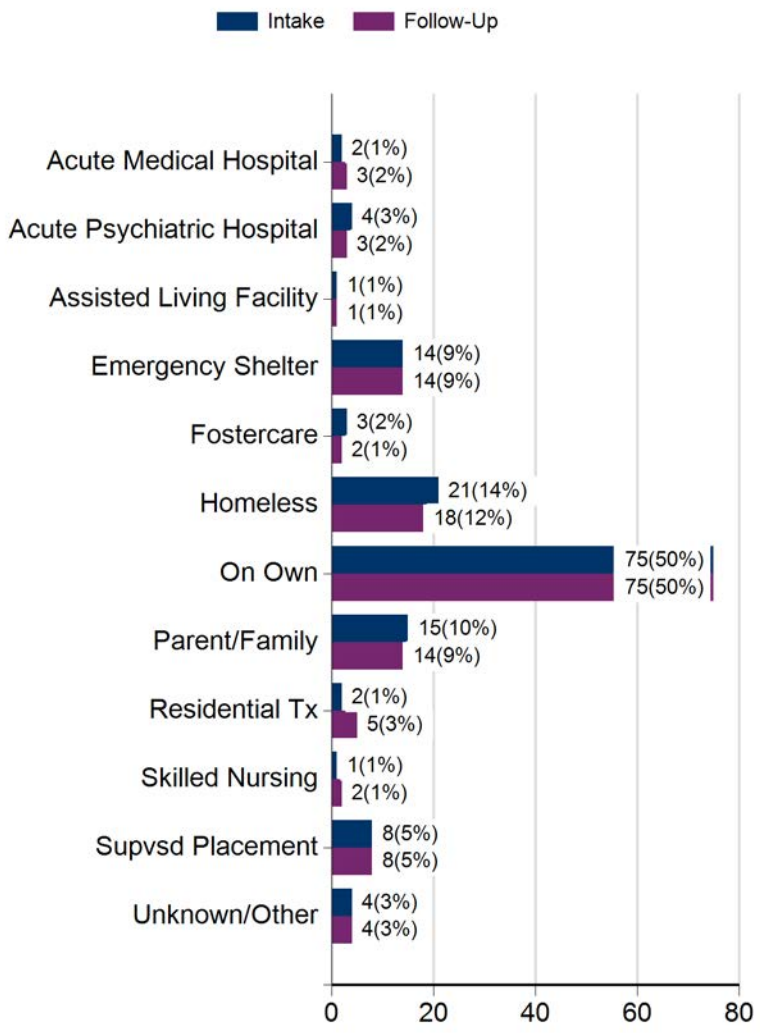
OA Time in Partnership	Closed	Open	All Consumers	% of Total
Under 90 days	32	16	48	22.22%
>= 90 days and < 1 Year	43	35	78	36.11%
>= 1 Year and < 2 Years	14	21	35	16.20%
>= 2 Years and <3 Years	9	5	14	6.48%
>= 3 Years and < 4 Years	1	15	16	7.41%
>= 4 Years and < 5 years	5	7	12	5.56%
>=5 Years and < 6 years	0	3	3	1.39%
>=6 Years+	3	7	10	4.63%
Total Consumer Enrollments	**107**	**109**	**216**	

Service Detail: 33IJFO

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	14 (15%)	13 (13%)	14 (14%)	6 (7%)	10 (11%)	14 (16%)	13 (15%)	10 (11%)	12 (11%)	25 (23%)	22 (20%)	16 (16%)
2-3	13 (14%)	20 (20%)	15 (15%)	18 (20%)	17 (18%)	19 (21%)	13 (15%)	10 (11%)	23 (22%)	14 (13%)	12 (11%)	13 (13%)
4-7	26 (27%)	19 (19%)	42 (43%)	29 (32%)	28 (30%)	26 (29%)	20 (22%)	28 (31%)	36 (34%)	34 (31%)	22 (20%)	25 (25%)
8-13	27 (28%)	22 (22%)	17 (18%)	28 (31%)	25 (27%)	22 (25%)	20 (22%)	33 (37%)	24 (23%)	27 (24%)	29 (26%)	26 (26%)
14-19	11 (12%)	16 (16%)	6 (6%)	7 (8%)	11 (12%)	5 (6%)	18 (20%)	5 (6%)	5 (5%)	6 (5%)	16 (14%)	6 (6%)
20-25	3 (3%)	6 (6%)	1 (1%)	2 (2%)	1 (1%)	2 (2%)	4 (4%)	1 (1%)	3 (3%)	3 (3%)	4 (4%)	10 (10%)
26-31	0 (0%)	3 (3%)	2 (2%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)	1 (1%)	2 (2%)	1 (1%)	3 (3%)	2 (2%)
32+	1 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	3 (3%)	1 (1%)
Monthly Total	95	100	97	91	92	89	89	89	105	111	111	99

Type of Service	# of OA	% of OA	# of Svcs	Avg. # Svcs
Assessment Services	68	8%	82	1.21
Case Management	191	21%	3,358	17.58
Client Supportive Services	2	0%	2	1.00
Crisis	20	2%	39	1.95
Individual Therapy	64	7%	562	8.78
Medication MD Services	71	8%	186	2.62
Medication Therapeutic Services	89	10%	717	8.06
Mental Health Services-Group	25	3%	165	6.60
Mental Health Services-Individual	140	16%	2,594	18.53
Non Face to Face MD	36	4%	65	1.81
Peer MH Education Groups	24	3%	88	3.67
Peer MH Engagement	7	1%	8	1.14
Peer MH Therapeutic Activity	112	12%	1,026	9.16
Psychiatric Assessment	52	6%	52	1.00

Outcomes: Residential & Discontinuance (33MTFO)



Discontinuation Reason	Count	%
Deceased	2	25%
Met goals	2	25%
Partner left program	2	25%
Needs residential care	1	13%
Partner cannot be located	1	13%
Total	8	100%

Length of FSP Partnership for: 33MTFO

OA Time in Partnership	Closed	Open	All Consumers	% of Total
Under 90 days	2	8	10	6.71%
>= 90 days and < 1 Year	4	20	24	16.11%
>= 1 Year and < 2 Years	3	24	27	18.12%
>= 2 Years and <3 Years	4	20	24	16.11%
>= 3 Years and < 4 Years	2	29	31	20.81%
>= 4 Years and < 5 years	2	31	33	22.15%
Total Consumer Enrollments	17	132	149	

Service Detail: 33MTFO

Service Frequencies	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
0-1	25 (32%)	25 (28%)	18 (21%)	24 (31%)	23 (29%)	21 (29%)	23 (26%)	23 (24%)	20 (23%)	17 (21%)	18 (20%)	21 (26%)
2-3	28 (36%)	23 (26%)	34 (40%)	23 (29%)	28 (36%)	25 (34%)	28 (31%)	32 (34%)	33 (38%)	19 (23%)	31 (35%)	24 (30%)
4-7	13 (17%)	26 (30%)	18 (21%)	22 (28%)	20 (26%)	16 (22%)	26 (29%)	28 (29%)	25 (29%)	28 (35%)	25 (28%)	24 (30%)
8-13	8 (10%)	10 (11%)	8 (10%)	6 (8%)	3 (4%)	8 (11%)	7 (8%)	8 (8%)	5 (6%)	9 (11%)	8 (9%)	6 (8%)
14-19	2 (3%)	3 (3%)	5 (6%)	2 (3%)	3 (4%)	1 (1%)	4 (4%)	3 (3%)	3 (3%)	5 (6%)	5 (6%)	3 (4%)
20-25	2 (3%)	1 (1%)	1 (1%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	1 (1%)	2 (2%)	0 (0%)	2 (3%)
26-31	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
32+	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	1 (1%)	0 (0%)
Monthly Total	78	88	84	78	78	73	89	95	87	81	88	80

Type of Service	# of OA	% of OA	# of Svcs	Avg. # Svcs
Assessment Services	15	2%	16	1.07
Case Management	88	14%	835	9.49
Crisis	14	2%	24	1.71
Individual Therapy	49	8%	379	7.73
Medication MD Services	97	15%	342	3.53
Medication Therapeutic Services	114	18%	1,143	10.03
Mental Health Services-Group	8	1%	37	4.63
Mental Health Services-Individual	96	15%	588	6.13
Non Face to Face MD	64	10%	150	2.34
Peer MH Education Groups	6	1%	88	14.67
Peer MH Engagement	31	5%	65	2.10
Peer MH Therapeutic Activity	56	9%	636	11.36
Psychiatric Assessment	8	1%	9	1.13

CSS-02 General System Development (GSD)

What is GSD?

The expansion or enhancement of the public mental health services system to meet specialized service goals or to increase the number of people served. GSD is the development and operation of programs that provide mental health services to:

1) Children and TAY who experience severe emotional or behavioral challenges.
2) Adults and Older Adults who carry a serious mental health diagnosis.
3) Adults or Older Adults who require or are at risk of requiring acute psychiatric hospitalization, residential treatment, or outpatient crisis intervention because of a serious mental health diagnosis.

GSD: Clinic Expansion

GSD: Clinic Expansion/Enhancements: Youth System of Care

The expansion of clinic staff to include Parent Partners and Peer Support Specialists as part of the clinical team has become a standard of care in RUHS-BH service delivery. Though our Lived Experience Programs have essential roles in Outreach and Engagement, they are also integral to general clinic operations.

Parent Partners welcome new families to the mental health system through an orientation process that informs parents about clinic services and offers support/advocacy in a welcoming setting. Parent Partners are advocates assisting with system navigation and education. Parent Partner services are invaluable in promoting engagement from the first family contact, providing support and education to families, and supporting the parent's voice and full involvement in all aspects of their child's service planning and provision of services. Parent Partners provide parenting training such as Nurturing Parenting, Triple P and Triple P Teen, EES (Educate, Equip, Support), the parent portion of IY Dinosaur School, and recently added the Nurturing Father's Program.

Transition-age youth (TAY) Peer Support Specialists also bring the lived experience of behavioral health challenges as young adults. TAY Peers can engage youth and provide supportive services such as rehabilitative services and in-home Behavioral Services.

Children's Integrated Service programs served 10,083 (7,259 youth; 2,824 parents and community members) in FY23/24. Across the entire Children's Work Plan, the demographic profile of youth served was 58% Hispanic/Latino, 10% Black /African American, and 14% White. A large proportion (16%) of youth served were reported as "Other" race/ethnicity. Asian/Pacific Islander youth represented 1%, and Multiracial represented 1% of the youth served. Children's clinics use the Child Adolescent Needs and Strengths measure as required by the state to monitor children's outcomes. Overall, CAN scores showed improvements for children/youth; 53% of children's Behavioral/Emotional Health needs Improved. This includes

children with initial scores reflecting a moderate degree of need (action intervention required) or severe (immediate action intervention required). Life Domain Functioning Improved by 48%, and 41 % increased in the Strengths domain.

Systems development service enhancements, interagency collaboration, and the expansion of effective evidence-based models continue to be central components of the Children's Work Plan.

Team Decision Making (TDM) began as an interagency collaborative service component that supported the Family-to-Family approach adopted in Riverside County as part of Social Services Re-Design. TDMs with Department of Behavioral Health clinical staff and Department of Public Social Service (DPSS) staff were utilized to problem-solve around the safety and placement of the child when at-home risk resulted in removal from their family.

The Department continues to collaborate with DPSS through Pathways to Wellness, which is the name given to the program to screen and provide mental health services to DPSS dependents to meet the Katie A. vs Bonita class action settlement conditions. RUHS-BH clinical staff supported the Department's Pathways to Wellness implementation through the TDM process and Child and Family Teaming collaborative team meetings. RUHS - BH staff collaborated with DPSS staff at 140 TDM meetings serving 140 youth in FY 23/24
In addition, Department staff participated in several hundred Child and Family Team (CFT) meetings with DPSS staff and families to support creating a family plan through a collaborative process.

Service enhancements for Therapeutic Behavioral Services (TBS) provided additional staff to case-manage youth receiving TBS. TBS services are provided to children with full-scope Medi-Cal and a number of youths without Medi-Cal through Behavioral Coaching Services (BCS). TBS and BCS services are supplied to minors at risk of hospitalization or higher-level placements. TBS expansion staff coordinated referrals and provided case management to 247 youth in FY23/24 with the outcome of increasing access to TBS services. Contract providers include Charlee Family Care, ChildNet Youth and Family Services, Community Access Network, New Haven Youth and Families, and McKinley.

Additionally, California has mandated that youth receive specialty mental health services such as ICC (Intensive Care Coordination) and IHBS (Intensive Home-Based Services) services. All programs that provide children and TAY services must also provide these services to youth who meet the criteria and participate in the CFTs required by the state. This has been an area of focus in this past year and will continue to be in the coming year. Reports regarding the number of ICC and IHBS services provided to each youth are available. These reports are monitored at the program and administrative level for county-operated programs. Contract providers are given reports during technical assistance meetings and the annual contract monitoring process. A report specific to CFTs is being developed.

Clinic expansion programs also included mentors in each county region to provide groups and other services addressing the needs of youth with co-occurring disorders. The Mentorship

Program offers youth receiving services from our county clinics/programs under the age of 18 an opportunity to connect with a mentor for 6 – 8 months. The mentors have varied life experiences and education. Several of the mentors have consumer backgrounds in Children's Mental Health. They have been very successful in working with the youth that are assigned. One of the mentor program objectives is to link youth to an interest in the community. Parents of participating youth have commented that this program helped their child with school and has improved their confidence.

A standalone First Episode Psychosis (FEP) Program has been established to serve the three regions of the County. The program serves youth and young adult who are experiencing their first psychotic episodes. The Department had historically provided some focused efforts to serve this population. However, it became clear that a dedicated program implementing the evidence-based Coordinated Specialty Care Model was needed. The program includes Clinical Therapists, Transition Age Youth Peers, Parent Partners, Behavioral Health Specialists, and a Psychiatrist. The teams continue to receive technical assistance from UC Davis. This has included multiple training sessions for staff at all levels. UC Davis supports the program to meet the fidelity requirements of the CSC model. Twenty-two youths were enrolled in the FEP program, a Full-Service Partnership Program. FSP Outcomes showed a 61% decrease in hospitalizations and a 69.5% decrease in crisis emergency room use. Suspension and expulsions in school decreased, and attendance and grades improved.

Evidence-based practices (EBP) expanded in the children's clinics include Parent-Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Family Based Treatment (FBT) for Eating Disorders. All were implemented to address the unique needs of the youth population. Staff trained in TF-CBT and FBT continued to expand in FY 23/24. The number of youth served in TF-CBT was 128 youth. The most recent outcomes report showed 52% completed TF-CBT, and over 82 percent of the clients who completed the program completed all of the coping skills phases of the program. 84% of clients completing the program also completed the trauma narrative and processing phase, 28% in-vivo exposure, and more than 75% completed conjoint sessions and enhanced safety. Even amongst clients who did not complete the program, 82% completed psychoeducation, and 66% completed relaxation.

PCIT will continue as a general system development program with an emphasis on expanding capacity by adding four cargo vans that were converted into Mobile Treatment Units to enhance service provision to families with limited resources, such as transportation, and those with geographical barriers. The benefits of utilizing an alternative to the past PEIMS RV units include decreased program expenses, decreased non-clinical duties to operate the RV units, and increased staff focus on consumer services and productivity. Preschool 0-5 has become resourceful in providing services through telehealth, utilizing space at community-based sites, and providing in-home services to continue meeting families' needs. PEIMS staff continue to provide early identification, prevention, intervention, and treatment services to children ages 0-6 and their families in targeted communities across Riverside County.

In addition, a contract expansion with Victor Community Support Services allowed for an additional 0-5 services in the Desert Region of the county, including the expansion of available PCIT services.

Preschool 0-5 Programs include SET-4-School, Prevention and Early Intervention Mobile Services (PEIMS), and the Growing Healthy Minds Initiative. The program uses leveraged funds, including Medi-Cal, MHSA/PEI, and First 5. All program components are implemented through relationships with selected school districts and community-based organization partners. Evidence-based and evidence-informed services are accessible at clinic sites, on mobile units out in the community, and at school sites across Riverside County. Services include a comprehensive continuum of early identification (screening), early intervention, and treatment services designed to promote social competence and decrease the development of disruptive behavior disorders among children 0 through 6 years of age. Services offered within the program are all intended to be time-limited and include the following: Parent-Child Interaction Therapy (PCIT); Parent-Child Interaction Therapy with Toddlers (PCIT-T); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Incredible Years (IY); Positive Parenting Program (Triple P); Nurturing Parenting; Education Equip and Support (EES); psychiatric consultation and medication evaluation; classroom support for early care providers and educators; community presentations; and participation in outreach events.

The mission of the Growing Healthy Minds Initiative is to work in partnership with the community to increase opportunities for young children across Riverside County to develop skills and abilities that will prepare them for school and life.

A highlight of the Preschool 0-5 Programs is the celebration of the 20th anniversary of implementing PCIT into the program on May 20, 2023.
Preschool staff continues to train staff in Parent-Child Care (PC-CARE) level II to assist with training another system of care providers with low-intensity treatment options for children not requiring high-intensity treatment, such as PCIT or TF-CBT.

The Growing Healthy Minds Collaborative continues to meet monthly via a virtual platform. The collaborative discussions include program updates and training opportunities and provide a networking space for providers who work with the 0 – 5-year-old population. The Collaborative has proven to be a successful effort that includes an average of 40 multidisciplinary participants per month from locations across Riverside County. The collaborative approach is to assist the system of care providers by increasing their knowledge to assist in diagnosing children under the age of 3 using the DC 0-5 manual. The Collaborative continues to discuss meeting the ongoing needs of the community.

Children's clinic staff were also trained to provide the IY Dinosaur School Program in small groups in each outpatient clinic. This program helps children develop positive coping strategies around behaviors related to anger and other intense feelings. Traditionally, this program was only offered in a school setting, but there was an increased service need for children ages 4-8 who have difficulty managing behavior, attention, and other internalizing problems.

RUHS–BH has continued to experience increased demand for services, and the expansion of contracted providers has occurred to expand these services throughout the County of Riverside. There are 44 contract providers supporting the effort to continue expanding services. In addition, with the implementation of AB1051, RUHS-BH is adding contracts with Short-Term Therapeutic Residential Program (STRTP) providers across the state.

Services to youth involved in the Juvenile Justice system have continued even as the County probation department has changed its approach to incarcerating youth. The Juvenile Halls have dramatically reduced their census over the last few years, choosing instead to serve youth in the community. Behavioral Health programming for justice-involved youth was adopted by increasing Wraparound services and converting the Wraparound Program into an FSP program. In addition, RUHS-BH has expanded aftercare services to youth released from the Youth Detention Facility when sentences were completed. In FY 23/24, Wraparound FSP served 161 youth. Outcomes for Wraparound Youth showed that 55% of the youth closing from the program completed the wraparound program. In addition, Wraparound youth showed a 49% decrease in hospitalizations, a 39% decrease in crisis emergency room use, and a 58% decrease in arrests. For youth showing a high need for the CANS measure in Family Functioning, 34% showed improvement, and for those with a high CANS score for Anger Control, 36% showed improved scores. Substance Use and Conduct also improved, with follow-up CANS scores showing a 34% and 32 % improvement, respectively. The State is developing the High-Fidelity Wraparound requirements, and when they are released, the department will ensure that all of the Wraparound requirements are met. This will include, as a part of the Family First Prevention Services Act (FFPSA), that Wraparound is offered to all youth stepping down from the STRTP level of care.

GSD: Clinic Expansion/Enhancements: Adult System of Care

The Comprehensive Integrated Services for Adults (CISA) Work Plan continues to provide a broad array of integrated services and a recovery-focused supportive system of care for adults with serious behavioral health challenges.

Stakeholders' priority issues identified during the CSS planning process for adults were focused on the unengaged homeless, those with co-occurring disorders, forensic populations, and high users of crisis and hospital services. CISA Work Plan strategies included program expansion, full-service partnership programs, and program enhancements throughout the Adult System of Care. Every Adult Clinic now has an FSP tract which has expanded access to more intensive services when needed. The consumer can easily transition from FSP to non-FSP within their home clinic. The Department has committed to expanding crisis and intensive services, which EBP'S In Outpatient Adult includes expansion of full-service partnership tracts in every clinic countywide. These strategies are intended to be recovery-oriented, incorporating cultural competence and evidence-based practices.

This addition of in-patient hospital linkage to FSP and the out-patient system is having a significant impact on clinic volume and capacity. The Department has continued to employ a

full-time Liaison at the In-Patient Facility (ITF) to support consumers' post-hospital discharge linkage to FSP programs and the Out-Patient Clinics.

Recovery-focused support is a key component in the outpatient clinic system. All System Development programs have enhanced services by integrating Peer Support Specialists and Family Advocates into clinics and programs. Peer Support Specialists have continued to serve as an essential part of the clinic treatment team by providing outreach, peer support, recovery education, and advocacy. Planning for Success (Formally known as Wellness Action Recovery Plan) groups have become well established in our adult clinic system due to the work of Peer Support Specialists. Peer Support Specialists working in the clinics as regular Department employees provide continual support for consumers' recovery. See page 116 for more information about all the activities and services that Consumer Affairs and Peer Support Specialists provide.

Family Advocates have been a critical component of enhanced clinic services. They provide families with resources and information on mental health, diagnosis, the legal system, recovery, and health care system navigation. Any family with questions about the mental health care of their adult loved one can consult with Family Advocates when needed. See page 150 for more information about the Family Advocate Program and all the services that they provide in the Adult System of Care.

Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), EMDR, Seeking Safety, and Co-Occurring Disorder groups are evidence-based practices offered in adult clinics and supported through the Adult Work Plan. Additional treatment for adults with eating disorders is provided using a team approach with behavioral health care staff trained to work and treat Eating Disorders. The Department also committed to implementing an adult trauma-focused practice EMDR and trained 30 practitioners to implement the model throughout the Adult System of Care. The first cohort of staff trained in Eye Movement Desensitization Reprocessing (EMDR) therapy served 47 consumers with this evidence-based practice that is specifically designed for adults who have experienced trauma and or have post-traumatic stress disorder. In the Older Adult System of Care, the Go4Life, a practice developed through the National Institute on Aging, offers seniors whole health benefits related to integrated care.

All adult services staff are mandated to be trained in Trauma Informed Services (TIS) to ensure that all staff are providing services in a trauma-informed approach. This implementation in TIS has continued with various practices throughout the department to reinforce this trauma-informed approach. For example, many staff meetings begin with a TIS moment which may be trauma care from a consumer perspective or trauma care to supporting staff as they do their work.

Evidence-Based Practices in Outpatient Adult Mental Health Services

Our Outpatient Adult Mental Health Services utilize evidence-based practices (EBPs) to provide practical, research-backed treatment for individuals experiencing mental health challenges. These practices are grounded in scientific research and clinical expertise, ensuring

high-quality, patient-centered care that leads to meaningful recovery and improved well-being.

Key evidence-based approaches include:

- **Cognitive Behavioral Therapy (CBT):** Helps individuals identify and change negative thought patterns and behaviors.
- **Dialectical Behavior Therapy (DBT):** Supports emotional regulation and distress tolerance, particularly for individuals with mood disorders.
- **Motivational Interviewing (MI**): Encourages individuals to build motivation for positive change.
- **Medication Management:** Provides psychiatric evaluations and medication support tailored to individual needs.
- **Trauma-Informed Care**: Recognizes the impact of trauma on mental health and integrates strategies to foster resilience.
- **Peer Support & Psychoeducation:** Engages individuals in learning coping strategies and building social support networks.

Our commitment to EBPs ensures that clients receive treatments that are proven to be effective. This leads to better symptom management, increased independence, and a higher quality of life overall.

Pathways to Success

Pathways to Success is a Riverside University Health System—Behavioral Health vocational program that provides services in partnership with the California Department of Rehabilitation. It provides vocational services to individuals 18 years of age and older who are receiving services from any RUHS—BH Western or Mid-County Region program or any RUHS—BH contracted Behavioral Health service provider within the Western and Mid-County Region. The program collaborates with the California Department of Rehabilitation (DOR).

The program will participate in a site review with DOR in June 2024 to address the objectives and goals to sustain the program and enhance and maximize service delivery for Riverside County consumers. The program is expanding its collaboration to the transitional-aged youth FSP programs. The program staff is conducting orientation in the western, mid-county, and desert regions.

Telepsychiatry Program

The Telepsychiatry Program provides accessible, high-quality mental health care through secure, virtual platforms. It allows individuals to connect with licensed psychiatrists and mental health professionals from the comfort of their own homes. Designed to reduce barriers to care, our program serves individuals in remote areas, those with limited mobility, and anyone seeking convenient, confidential psychiatric support.

Through video consultations, our psychiatrists offer comprehensive mental health assessments, medication management, therapy referrals, and crisis intervention when

needed. The program is committed to delivering timely, patient-centered care while ensuring privacy and adherence to all healthcare regulations.

By integrating telehealth technology with mental health services, our Telepsychiatry Program enhances access to care, promotes continuity of treatment, and supports individuals in managing their mental well-being effectively.

Telepsychiatry will move to in-person care. Here are some estimates for service data: These are estimates. Roughly 75% in-person/office, 14% phone, 7% field-based, 1-2% Telepsychiatry. We are going to open the Franklin Adult Residential Facility, which has 84 beds, next month. Roy's Jr.

Adult GSD: RUHS-BH Long-Term Care (LTC) Expansion

The RUHS-BH Long Term Care (LTC) program operates under the auspices of the Riverside University Health System – Behavioral Health, Office of the Public Guardian. It serves conserved individuals with severe and persistent mental illness who often require hospitalization or out-of-home placement. LTC, in collaboration with the Public Guardian's Office, strives to ensure that each Conservatee is served in the least restrictive setting/environment in which the consumer's safety, health, and wellness are the priorities.

For Conservatees in need of residential treatment programs, LTC performs and/or participates in biopsychosocial assessments, treatment planning, recommendations, and linkage services. LTC creates daily partnerships with the Conservatees and their respective Public Guardian Conservators, consumers' family members, psychiatrists and medical experts, hospital staff, placement staff, and other collateral resources. LTC endorses treatment and service plans that are clinically effective and cost-effective for the consumer. Overall, the LTC Program's mission is to promote hope, wellness, and recovery for conserved individuals with serious mental illness and other psychiatric disabilities.

The LTC clinicians and case managers provide case management, supportive counseling, and discharge planning services for Conservatees placed at psychiatric hospitals, IMDs, and residential care facilities (also known as board and care facilities). To streamline the continuum of care for the Conservatees, the LTC staff collaborate closely with the Public Guardian – Lanterman-Petris-Short (LPS) Conservators. LPS conservatorships are used to care for adults with a grave disability who need special care and protection. These conservatorships benefit individuals who are often in need of restrictive living arrangements (such as locked mental health facilities) and require intensive mental health treatment and supportive services to complete activities of daily living.

The LTC staff coordinate their case management services with the consumer's LPS Conservator, and together these staff members assist the Conservatees with navigating through the various levels of care, from inpatient acute hospitalization to long-term care facilities and eventually to the community-based residential placements or homes. While the PG LPS Conservators are tasked with advocating for the least restrictive placement for their

Conservatees, establishing and maintaining benefits, managing their finances, marshaling and safeguarding their property and assets, the LTC team is tasked with coordinating placement plans and transfers and monitoring the consumers at the facilities to ensure appropriate client-centered care.

While the LTC program primarily supports the Public Guardian LPS conservatorship program, it also provides placement assistance for the Public Guardian Probate program. Currently, there are over 1,300 conserved individuals in the Public Guardian LPS and Probate programs.

The LTC program maintains placement contracts with facilities that offer a continuum of long-term care, including Inpatient Treatment Facilities, State Hospitals, Institutions for Mental Disease, Mental Health Rehabilitation Centers, specialized Skilled Nursing Facilities, Assisted Living Facilities, Augmented Board and Care facilities, and Adult Residential Treatment facilities. Additionally, in response to the need for additional safe, secure, and appropriate housing for the growing Conservatee population, RUHS-BH has designed, constructed, and implemented placement facilities operated by contract providers primarily for the Public Guardian's Conservatees. These dedicated placement facilities include:

- Riverside County Telecare Mental Health Rehabilitation Center (MHRC), in Riverside, CA – operated by Telecare Corporation – 79 beds
- Restorative Transformation Center, in Riverside, CA – operated by Telecare Corporation – 30 beds with 10 beds to be available to Public Guardian Conservatees
- Roy's Desert Springs Adult Residential Facility, in Indio, CA - operated by MFI Recovery – 92 beds
- Desert Sage Adult Residential Facility, in Indio, CA - operated by MFI Recovery – 49 beds
- Franklin Residential Care and Behavioral Health Clinic, in Riverside, CA – RUHS-BH's newest augmented board and care facility, which is expected to open in March 2025 and will be operated by MFI Recovery – 84 beds

CONSUMER SATISFACTION SURVEY

According to LTC's 2022-23 plan to design and implement a brief client satisfaction survey geared towards the Conservatee population, a Public Guardian Consumer Satisfaction Survey was created and implemented by the RUHS-BH Research and Technology Department in July 2023. A Total of 157 Conservatees, out of 978 Probate and LPS Conservatees, participated in the survey. Participants resided at various levels of care, including mental health rehabilitation centers (MHRC), an Institute for Mental Disease (IMD), an augmented board and care facility, and board and care facilities. The survey contained seven questions, with six of the questions measuring responses on a Likert scale and the seventh employing an open-ended narrative section. While only 16.1% of all Public Guardian Conservatees completed the survey, factors contributing to the low participation rate in the survey include the Conservatees' severe and persistent mental health impairments, cognitive deficits, developmental disabilities, non-verbal or non-responsive status, and survey administration issues.

SURVEY QUESTIONS	AGREED STRONGLY AGREED	NO RESPONSE RECEIVED
1. I am safe and welcome in my living environment.	72.0%	11.5%
2. I feel like my needs are being met.	77.1%	5.7%
3. I feel like my opinions are taken into consideration.	64.3%	13.4%
4. I am visited enough by my Deputy Public Guardian.	51.6%	8.3%
5. I can easily contact my Deputy Public Guardian.	67.5%	7.6%
6. When staff are not able to help me, they help me understand why.	71.3%	13.4%
7. Comments: ➢ Four Conservatees desired more interactions with their Conservator. ➢ Three requested placements at a lower level of care, such as a board and care or room and board. ➢ Three requested resources, including clothing, food, and medicine. ➢ Three were non-verbal but indicated that the Deputy Public Guardian pays their facility payments and monthly personal needs allowance. ➢ Twenty-seven Conservatees requested more facility outings, such as going to the DMV or spending time with their family. ➢ Finally, twelve Conservatees denied having issues they wished to comment on.		

COMMUNITY REINTEGRATION

The LTC program seeks to generate FSP and CARE Act referrals for all conserved consumers residing in adult residential facilities in Riverside County to ensure that each Conservatee receives wraparound services through regional FSP programs and other outpatient programs. The ultimate goal is to optimize each individual's adaptive functioning and facilitate his or her ability to gain self-sufficiency and live independently with assistance from community-based supports and services without the need for being managed by a court-ordered conservator.

In Fiscal Year 2022-2023, LTC implemented a Full-Service Partnership (FSP) track for LPS Conservatees who have been hospitalized in an acute care setting or have been placed in transitional residential care facilities, such as the Riverside County Telecare Mental Health Rehabilitation Center in Riverside. Referrals for FSP services aim to facilitate the Conservatees' access to wraparound services and enhance their overall functioning and capacity for self-sufficiency while living at community-based facilities. In Fiscal Year 2023-2024, 111 Conservatees were linked to FSP wraparound services. While the residential treatment facilities continued to provide wraparound services for each consumer, the LTC program concurrently offered case management, placement coordination, and linkage services for the Conservatees, to transfer the Conservatees into less restrictive, lower levels of care.

In September 2024, the Long-Term Care team-initiated referrals to the RUHS-BH Community Assistance, Recovery, and Empowerment Act, also known as the CARE Act. The CARE Act program is a collaborative civil court process that provides participants with clinically appropriate, community-based services, including medication management, behavioral health treatment and services, assessment and care planning, case management services, psychoeducation, and linkages to other social services, such as supportive housing resources for persons with schizophrenia and other psychotic disorders. The CARE Act presents an ideal, voluntary opportunity for Public Guardian Conservatees to step down to a lower level of care and still receive support from a professional social services network for up to two years. As of February 2025, seventy-five Conservatees have been identified as appropriate candidates for the CARE Act program. All Conservatees being referred are residing in the board and care or augmented board and care placement level and are demonstrating readiness to live independently and re-integrate into the community. While many of these Conservatees initially expressed anxiety and apprehension about leaving the safety net provided by conservatorship, six Conservatees are actively engaging with the CARE Act outreach team to pursue the possibility of conservatorship termination and community reintegration with support from the CARE Act program.

Adult GSD: Representative Payee Program

The goal of the Representative Payee (RP) program is to provide money management services on a voluntary basis to clients of Riverside University Health System – Behavioral Health (RUHS-BH) who are unable to manage their funds effectively as a result of their mental illness. The Representative Payee services are intended to be time-limited and are provided while the client and their treatment team improve the client's money management skills to the point where Representative Payee services are no longer necessary, or another responsible third party can take over the responsibilities.

All clients in the RP program will have an open episode at a County clinic and an assigned case manager. The Public Guardia's RP program staff provides the accounting functions, but does not provide mental health treatment or case management services to clients

Older Adult System Of Care

Clinic Expansion/Enhancements: Older Adult Integrated System of Care
Riverside University Health System-Behavioral Health is dedicated to supporting the programs of the Older Adult Integrated System of Care (OAISOC), which serves individuals with severe behavioral health challenges. The Department is committed to sustaining all other programs listed in the Older Adult Integrated work plan, including Peer and Family Support, Family Advocates, and Clinic Enhancements.

The OAISOC Work Plan includes strategies to enhance services by providing staffing to serve older adult consumers and their families at regionally based older adult clinics (Wellness and Recovery Centers for Mature Adults) and through designated staff expansion located at adult clinics. Older Adult Clinics are in Desert Hot Springs, San Jacinto, Riverside, Lake Elsinore, and

Temecula, and expansion staff are located at adult clinics in Perris, Banning, and Indio. The Wellness and Recovery Centers have continued to innovate by developing enhanced psychological/psychotherapeutic services as part of assessment and evaluation. Older Adult clinic programs and expansion staff combined served 3,369 older adult consumers through a two-track system: Wellness and Recovery Programs (2,810) and (559) Full-Service Partnership (FSP) Programs at each clinic location.

The clinic Wellness and Recovery Programs track is designed to empower mature adults who are experiencing severe and persistent mental health challenges to access treatment and services to maintain the daily rhythm of their lives. The Wellness and Recovery Centers for Mature Adults provide a full spectrum of behavioral health services, including psychiatric services, medication management, physical health screenings, case management, individual therapy, and group therapies. The clinics currently offer over 27 psycho-educational multi-discipline groups led by therapists, nurses, behavioral health specialists, peer support specialists and family advocates. The groups currently offered include SAMSHA Wellness Curriculum, integrated Fit for Life evidenced-practice holistic health groups, traditional group therapy, healing art, Core, Facing Up, Cognitive Behavioral Therapy for Depression, Anger Management, Cognitive Behavioral Therapy for Psychotic Symptoms, Seeking Safety, Dialectical Behavioral Therapy, Bridges, Grief and Loss, Brain Disorders and Mental Health, Creative Arts, Art Therapy, Computers, Chronic Medical Conditions, Coping skills, and Co-Occurring Disorders.

In addition, we have developed Spanish psychoeducational groups, SAMSHA Wellness Curriculum, for monolingual older adults. Moreover, at three of our Wellness and Recovery Centers (Rustin, Lake Elsinore, and Temecula), we have implemented Drop-in Mindfulness Centers, utilizing the family room model for the older adults we serve. Peer Support Specialists work hand in hand with clinicians and other behavioral health staff to provide the full array of groups. A new resource center has enhanced the core services in the Temecula Wellness and Recovery Center by adding a member computer library where clinic staff can assist consumers in accessing technology-based resources while improving their computer knowledge and skills. The mind-brain technological development for the mature adult group is the going forward addition to this center. The center increases access to other agencies that specialize in Older Adult related services such as RUHS Medical Center, Community Health Centers, The Office on Aging, and Adult Protective Services (APS).

Further, it improves access and maintenance of older adult benefits, entitlements, and resources such as Social Security, Medicare, and Medi-Cal, as well as assistance agencies such as the Health Insurance Counseling & Advocacy Program (HICAP), California Healthcare Advocates, and other essential community partners.

All mature adult services staff have been trained in Trauma Informed Services (TIS) to ensure that all staff are providing services using a trauma-informed approach. This approach has been implemented throughout Riverside University Health System-Behavioral Health.

The proportion of older adults served across the county is close to the county population, with 26% Hispanic/Latino served and a county population of Hispanic/Latino older adults at 32%. The Caucasian group served 44%, and the Black/African American group served 11%. The Asian/Pacific Islander group served 3%, which is less than the county population of 8% Asian/Pacific Islander.

Finally, RUHS-BH is committed to sustainable and ongoing efforts to address the unmet needs and social determinants of older adults in Riverside County. The older adult population remains one of the fastest-growing and most vulnerable populations in Riverside County; therefore, we will continue to place much emphasis on expanding services and improving access throughout all regions of the County.

GSD: Crisis System of Care

Behavioral health- mobile crisis response teams (MCRT)

Mobile Crisis Teams have been in operation since 2014 and have continued to expand and evolve. The original stakeholders include Law Enforcement, Hospital EDs, Community Health Care Clinics, Schools, Outpatient programs, Adult Protective Services, Child Protective Services, and many more. Additionally, requests directly from the community are also responded to. As of December 31, 2023, mobile crisis response teams are now available throughout the county 24 hours a day, 7 days a week, and 365 days a year.

Mobile Crisis Response teams meet the needs of the community by providing an immediate supportive crisis response focused on successfully diverting consumers in crisis away from emergency departments, law enforcement, incarceration, and psychiatric hospitalizations whenever possible. Mobile crisis response teams are focused on de-escalating, supporting, collaborating with support persons, and developing strong safety plans for all individuals and families that are served. Mobile crisis response teams are typically teams that include a clinical therapist and a peer support specialist. In addition to the crisis response, the team also conducts follow-up support within 72 hours to ensure that the consumer is using the safety plan and to assist with reducing any barriers to using and linking to referrals that have been provided. These teams have been extremely successful in reducing the number of admissions at our County Emergency Treatment Services (ETS).

In FY 23/24, MCRT teams responded to over 2,200 requests for mobile crisis response. Please see the data in the figure below.

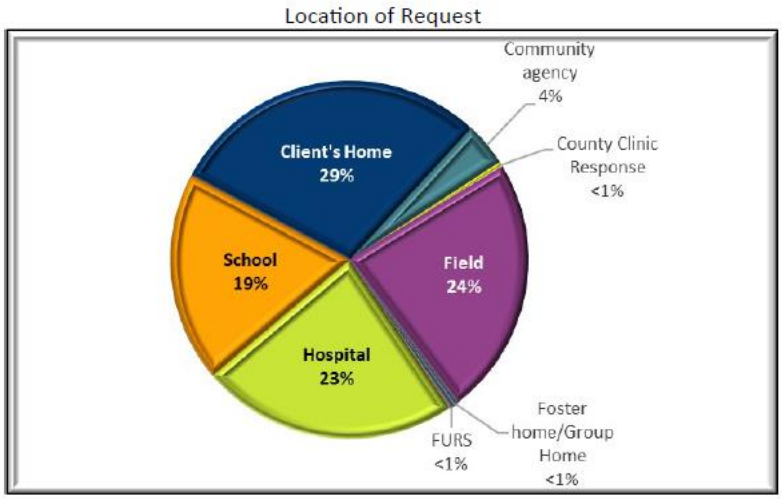
design was to dispatch crisis teams at the request of Law Enforcement and Hospital Emergency Department stakeholders. Over the past few years, the program has evolved to

include dispatching teams to requests from multiple

MCRT Crisis Requests 2,282	
West	843
Mid-County	863
Desert	576

Avg. Num. of Requests per Month
190

Twenty-nine percent of the MCRT requests were to members' homes, followed by 23% at hospitals.



Response times were an hour or less for 58% of responses. A total of 67% of requests for mobile crisis response were diverted from inpatient admission or crisis emergency room use. After MCRT contact, 92% of those served did not show any inpatient psychiatric admissions within 60 days of MCRT team contact. Thirty-four percent (38%) of the consumers MCRT teams served were linked with outpatient care, and 85% of those linked received three or more services.

Goals of the 3-Year Plan:

1. 45% of consumers served will link with outpatient services after contact with the crisis teams.

2. MCRT will increase stakeholders by continuing to promote and outreach to law enforcement, schools, foster homes, group homes, and community colleges.

MCRT will Increase linkage to Mental Health Urgent Cares for youth (13 to 17 years) experiencing a behavioral health crisis.

MCMT=Mobile Crisis Management Teams

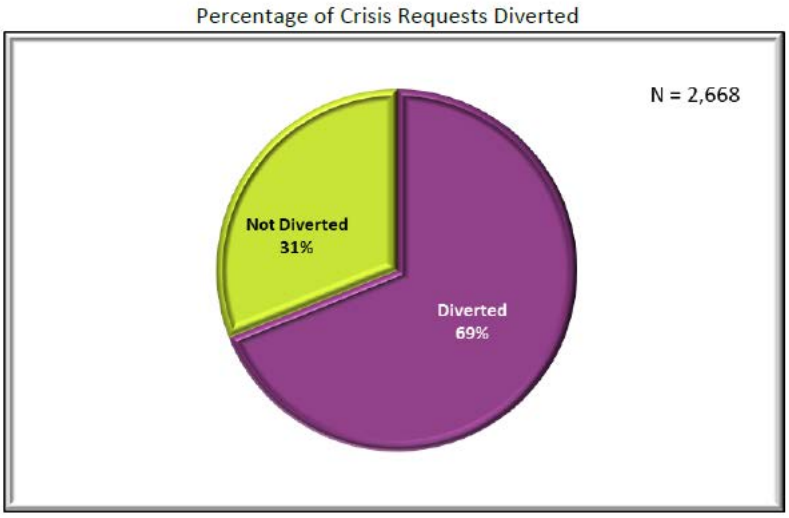
The Crisis Support System of Care expanded in the fiscal year 2021/2022 by planning the addition of 15 Mobile Crisis Management Teams to the four existing teams, resulting in 19 teams. These teams comprise four multidisciplinary staff members: clinical therapists, peer support specialists, behavioral specialists III (substance use counselors), and behavioral health specialists II. These staff have specialty training in crisis intervention, risk assessment, peer support, and intensive case management services to include homeless outreach and housing as well as substance abuse assessment, counseling, and linkage to residential treatment. The MCMT teams respond to crisis calls in the community and provide short-term treatment while assisting consumers in establishing connections to longer-term treatment services.

MCMT staff also engage in outreach activities and events to engage homeless and unengaged individuals in services. In Fiscal Year 23/24, Mobile Crisis Management Teams provided services to all ages and populations throughout Riverside County. An emphasis is placed on collaborating and coordinating with local cities to partner in efforts to engage and prevent crises with vulnerable populations such as homeless individuals and families. The locations for the teams include Perris, Jurupa Valley (2 teams), Desert Hot Springs, Lake Elsinore, Banning (2 teams), Riverside (2 teams), Hemet (2 Teams), Temecula, Menifee, Indio (2 teams), Blythe, Corona, Moreno Valley (2 teams). These teams support the communities and surrounding areas. FY 23/24 was focused on strengthening community partnerships.

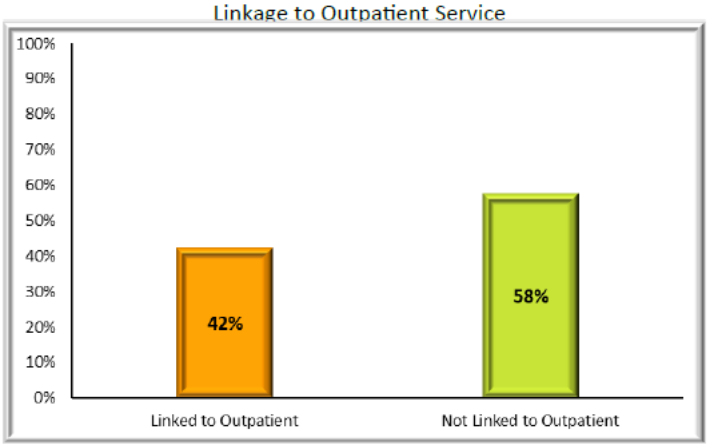
The goals of MCMTs are to be responsive and person-centered and use recovery tools to prevent crisis, support individuals in crisis, and divert unnecessary psychiatric hospitalization whenever possible. Additional goals include engaging and linking individuals and families into behavioral health services and substance use services, as well as reducing law enforcement and emergency department demands from consumers needing behavioral health and substance use services.

During FY 2023/2024, Mobile Crisis Management Teams responded to 3,400 requests for crisis intervention and outreach. They were able to safety plan and divert 69% of crisis requests from an inpatient admission and link 42% of individuals served to outpatient services. Please see the figure below for data.

MCMT Requests 3,411	
Crisis	3,013
Homeless Outreach	296
MCMT Non-Crisis Outreach	97
Welfare Check	5



MCMTs were able to divert 69% of crisis requests from an inpatient admission.



Forty-two percent (42%) of individuals served by MCMTs had an outpatient service after contact with teams. Some of these individuals (n = 421) were participating in outpatient services prior to their contact with teams.

3-Year Plan Goal

e. 55% of consumers served will be successfully linked with outpatient services after contact with the teams.

Community Behavioral Assessment Team (CBAT)

The Community Behavioral Assessment Team (CBAT) is a co-responder team comprised of a clinical therapist and a law enforcement officer (Sheriff or PD). Recognizing the role of law enforcement and the mental health needs of community members, this particular crisis response model was first implemented over 6 years ago with the Riverside Police Department, followed by the Hemet Police Department in 2017. CBAT is a special unit that responds to psychiatric inpatient hospitalizations whenever possible, decreases incarceration, decreases ED admissions, reduces repeated patrol calls, makes appropriate linkages to care and resources, and strengthens partnerships between the community, law enforcement, and behavioral health.

CBAT locations expanded from two teams, Riverside Police Department and Hemet Police Department to three additional sites in FY18/19: Indio Police Department, Southwest Sheriff,

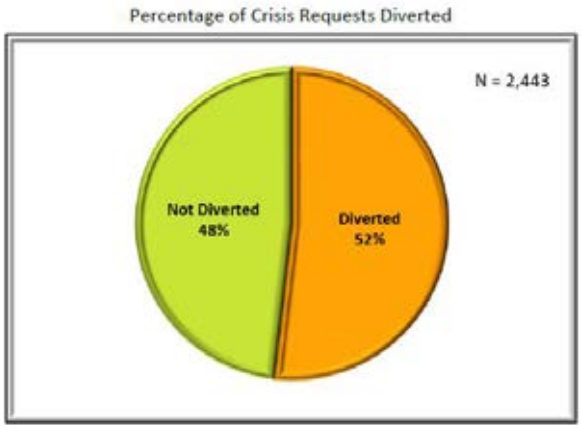
and Moreno Valley Sheriff. FY 19/20, the Riverside Police Department acquired a second CBAT unit, and the Murrieta Police Department with their first.

FY20/21 brought continued CBAT program growth with the approval of 10 additional CBAT units countywide. RUHS BH expanded its collaboration and partnership with the Sheriff's Office (to include) – Perris, Jurupa, Hemet, Palm Desert, Cabazon, Lake Elsinore, and Thermal stations. In addition, 4 Police Departments also adopted the CBAT program – Corona, Menifee, Cathedral City, Murrieta, Banning, and Beaumont Police Departments. (Cabazon, Banning, and Beaumont share a clinician).

The expansion of the CBAT program speaks to its success. The co-responder model has demonstrated the value in emergency response regarding timeliness response to a crisis, the value of two professions working together to address the clinical and legal ramifications, diversion, stigma reduction, and linkage to continued care when possible.

In fiscal year 2023/2024, CBAT responded to over 8200 requests for service. See the data below.

911 behavioral health-related crisis calls, mental health emergencies/5150, substance abuse, and homeless-related crisis. CBAT serves all populations. CBAT provides rapid response field-based risk assessment, crisis intervention, and de-escalation, linkage, and referrals. One of the goals of CBAT is to offer field officers a resource for calls that require more time and specialized attention. In addition, the goal of CBAT is to divert and decrease



CBATs were able to divert 52% of Crisis requests.

CBAT Requests 8,274	
Crisis	3,400
Homeless Outreach	1,710
Welfare Check	3,164

Avg. Number of Calls per Month
690

MPS=Mobile Psychiatric Services

The Mobile Psychiatric Services (MPS) program provides integrated behavioral health (BH) services for consumers with severe and persistent mental illness who are high utilizers of crisis services and frequent hospitalizations with little to no connection to outpatient services. The MPS program strives to provide an accessible, culturally responsive, integrated, and best practice-based system of behavioral health services to support consumers in their recovery.

OVERVIEW

Mobile Psychiatric Services (MPS) provides field-based services to engage and treat high utilizers of crisis services, including hospital-based services, who frequently have not had success in engaging in traditional outpatient services. MPS outreaches and engages consumers who are identified as having frequent crisis services. The goal is to actively engage consumers where they are and eventually initiate intensive case management services. Once consumers are engaged in services and no longer utilizing frequent crisis services, they will be connected to appropriate and existing outpatient services for continuity of care.

This MPS program provides services including mobile response, psychiatric assessment, medication consultation, assessment, and medication management, case management, therapy, and behavioral management services, substance abuse screening, and referral to

outpatient services for any consumer who is a high user of crisis services but not currently engaged in more traditional outpatient BH services.

The goal is to provide a collaborative, cooperative, consumer-driven process for providing quality behavioral health support services through the MPS team's effective and efficient use of resources. The goal is to empower consumers through case management and street-based medication services and draw on their strengths and capabilities. The goal is to promote an improved quality of life by facilitating access to necessary supports to eventually and effectively engage in the variety of outpatient services that are offered throughout the county, thus reducing the risk of hospitalization.

TARGET POPULATION

High-utilizer consumers could be short-term or long-term. They can be seen in a motel, home, room, and board and/or board and care facilities, sober living facilities, or homeless encampments.

In FY 23/24, MPS provided 2,530 services (an increase of 113% from last FY) to 103 consumers. Thirty-seven percent of those services were medication services we provided mainly in the field.

3-Year Plan Goal Progress

1. Increase the total number of consumers served to 150.

Annual Update: Progress Report on 3-Year Plan

Here is the progress update) on MPS for FY 23/24:
Patients engaged by MPS saw a 44% drop in admissions to mental health crisis service units, a 41% drop in admissions to mental health urgent care, and a 16% drop in inpatient hospitalizations. The county saves an average of $20,000 for every inpatient admission avoided from its general fund.

One of the program's greatest successes is its ability to help its patients begin using clinics and obtain rehabilitative care. One internal review of utilization between July 2018 and March 2020 found that 73% of patients were linked to and received services in county outpatient and/or substance use programs.

A big part of the success of MPS is its staff teamwork, and the patients sense that, too, Weigold said. "If it needs to be done, they're happy to do it…. Nobody gets hung up on, 'Well, that's not my job, that's not my classification.'"

MPS serves most patients for an average of six months to two years. When they demonstrate their ability to meet their behavioral health needs, it prompts one of MPS staff's most challenging conversations: telling a patient they've "graduated" from their service.

> "They've never had somebody who would follow them and assist them with every little thing, whether it's trouble with a roommate at the

rehab to being out of food and the food bank is closed," Weigold said. "There's generally some weeping and wailing over having to leave us."

One 40-year-old homeless man turned his whole life around after MPS started him on medication for his mood disorder and also connected him with simultaneous substance use disorder care. The man got a job, was accepted into his family, and returned to living with them. He then launched a small nonprofit, visiting churches in Southern California to tell his inspiring story and encourage others who are struggling similarly.

Now, the patient visits MPS staff about once a month to say, "Thank you."

Consumers Served: The MPS outreach team served 102 consumers from July 1st, 2023, to June 30th, 2024. The team served primarily the Western region of Riverside. Considerable outreach efforts may be needed to locate and engage the consumers in direct services. Not all consumers are found or agree to accept services.

Direct Services Data: 102 consumers received direct services from MPS. Table 1 summarizes the MPS direct services provided. The mobile psychiatry team provided 2,530 services totaling 3,539 hours to 102 consumers between July 1, 2023, and June 30, 2024. Many of these services were mental health rehabilitation (38%), medication services (30%), consumer support services (14.5%), and case management (6.2%).

MPS was recognized in Psychiatry Online Journal for its unique program and services:
https://psychiatryonline.org/doi/10.1176/appi.pn.2025.02.2.10
Here is the exert of the first section of the journal article content:

Mobile Psychiatry Unit Brings 'Concierge-Level' Service to Highest-Need Patients in Riverside
A mobile psychiatry clinic is bringing medications, mental health rehabilitation, and social services directly to a select list of at-risk residents in one California county, reducing inpatient and crisis service utilization and helping them turn their lives around.

When Scott Weigold, M.D., was called into the office of the medical director at Riverside University Health Services-Behavioral Health (RUHS-BH) toward the end of the day eight years ago, he wondered what it was about.

As it turned out, Weigold—who was a staff psychiatrist at RUHS-BH—was briefed on the results of a new utilization analysis: A relatively small number of Riverside, California, residents—about 350—were responsible for $8 million in mental health crisis and emergency services in just one year. Weigold was tasked with solving this unsustainable situation.
"We noticed right away that these people were not utilizing our regular outpatient clinics," he said. "So, we started discussing how we could arrange care for these people in a humane and clinically responsible way that would also reduce their number of crisis visits, which are hugely expensive, intrusive, and don't provide any ongoing, organized, long-term treatment."

They devised the idea for the RUHS-BH Mobile Psychiatric Service (MPS). “They’ve already shown us that they cannot effectively utilize a brick-and-mortar clinic,” Weigold said. “So, we need to take clinic services to them until they are restabilized and able to use a more traditional clinic.”

MPS has four vehicles roving Riverside County, providing on-the-spot mental health rehabilitation and medication services, substance use care, consumer support, and case management in addition to Weigold, psychiatry residents, a dedicated substance use counselor, a therapist, case managers, peer support specialists, and a community service aide staff the mobile team. At most, two or three of them ride around together at one time to not overwhelm patients.

Unlike some mobile services, MPS is not tasked with responding to 911 calls or adding new clients upon request from courts or caregivers. Instead, this specialized team focuses solely on meeting the needs of county-identified “high utilizers” of mental health emergency services.

A recent internal review found that about 58% of MPS patients had a primary diagnosis of schizophrenia or psychosis, while 14% had primary substance use disorder. Weigold estimates that about 80% are homeless.

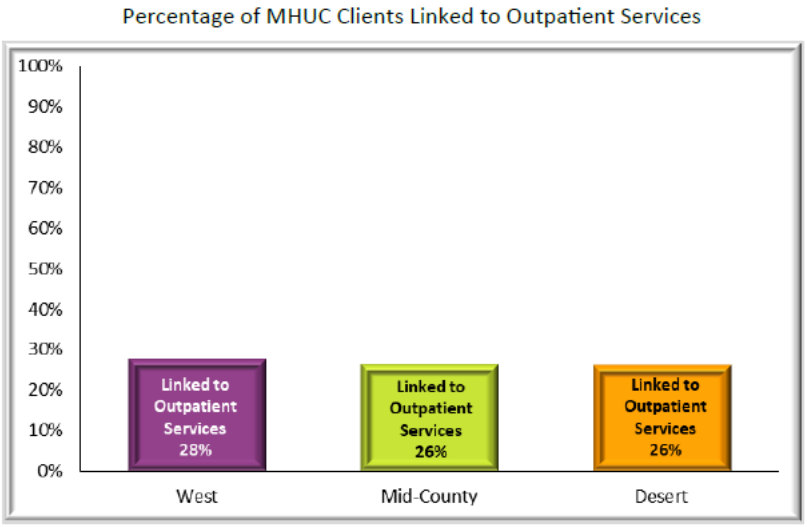
Staff locates patients using old addresses, hangouts, phone numbers, family members, job sites, or prior clinicians. They may also wait until patients appear at various emergency care clinics.

MHUC=Mental Health Urgent Cares

Mental Health Urgent Care (MHUC) is a 24/7 voluntary crisis stabilization unit. The consumers can participate in the program for up to 23 hours and 59 minutes. The average length of stay is 8-14 hours. The consumer and their family receive peer navigation, peer support, counseling, nursing, medications, and other behavioral health services. The goal is to stabilize the immediate crisis and return the consumer to their home or to a Crisis Residential Treatment Program. The secondary goal is to reduce law enforcement involvement, incarceration, or psychiatric hospitalization.

MHUCs serve individuals identified, engaged, and referred by Mobile Crisis Teams, Law Enforcement, Crisis Hotlines, and community-based agencies. MHUCs also serve as crisis support for walk-in self/family referrals. While the facilities primarily serve consumers aged 18 and older, the capacity to serve adolescents (ages 13-17) was added in the Desert and Mid-County MHUCs. This results in a more recovery-oriented service delivery and a cost savings from unnecessary higher levels of care. During the 2023/2024 fiscal year, MHUCs had 12,706 admissions and served 6,630 unduplicated clients.

The MHUCs assist consumers at discharge with linkage to outpatient services. The percentage of consumers linked to outpatient services after an MHUC admission varied by MHUC region. Please see the figure below for data.



Continue 3-year Plan Goals:

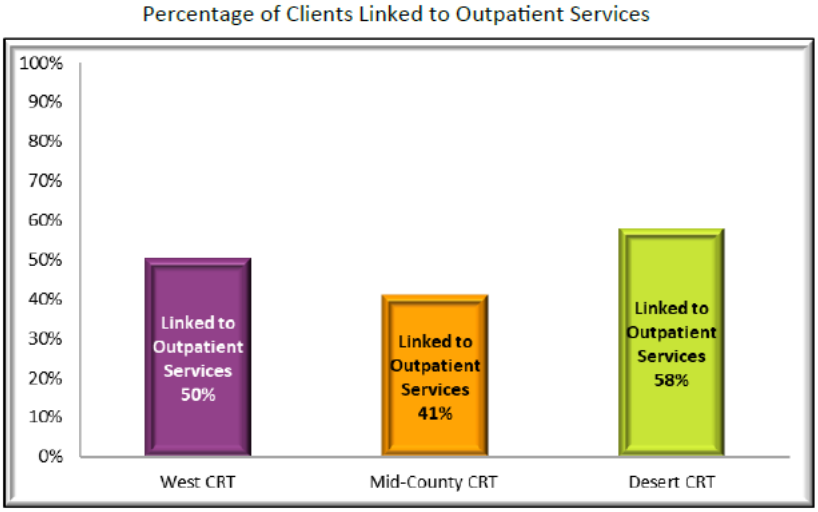
1. 3 year: at least 70% of consumers successfully discharge with referral to mental health or substance use services

2. 3 year: 45% of consumers successfully attended at least one mental health or substance use service post discharge.

CRT=Crisis Residential Treatment

Located in each of the three county regions, Adult CRT facilities are licensed by Community Care Licensing as Social Rehabilitation Programs (SRP). Consumers are offered a 21-day stay, with extensions up to 30 days. The CRT can accommodate 15 to 16 adults aged 18 and older who require crisis stabilization. Nearly 100% of the consumers are Medi-Cal recipients. Emergency Departments, Mental Health Urgent Care centers, Crisis Stabilization Units, Emergency Treatment Services, Psychiatric Hospitals, and the Riverside University Health System – Behavioral Health outpatient system of care refer consumers to this program. It is designed to prevent psychiatric hospitalization, provide a step down from psychiatric hospitalization, and assist consumers in stabilizing their symptoms before transitioning to other forms of treatment, such as residential substance use treatment and traditional outpatient services. Designed to create a home-like service environment, the CRT features a living room with more negligible activity and conversation areas, private interview rooms, a family/group room, eight bedrooms, and cooking and laundry facilities. The goal is to assist consumers with the circumstances leading to their crisis, help them return to a pre-crisis state of wellness, and connect them to peer and other behavioral health services.

During the 2023/2024 Fiscal Year, the Crisis Residential Treatment (CRT) facilities had 928 admissions and served 815 consumers. The CRTs support consumers at discharge by linking them to outpatient services. The percentage of consumers related to outpatient services after admission to a CRT remains consistent across regions and facilities. Please see the figure below for data.



Re-admission rates to the CRTs within 15 days or less were relatively low. See the data below.

Recidivism Rates for CRTs			
Days to Readmission	West	Mid-County	Desert
0 to 15 Days	7%	4%	8%
16 to 30 Days	6%	3%	4%
0 to 30 Days	12%	7%	12%

3-Year Plan Goal

1. 75% of consumers successfully discharge with a referral to mental health or substance use services

2. 60% of consumers will be linked to outpatient services.

Riverside University HEALTH SYSTEM Behavioral Health

Crisis Support System of Care Report

Fiscal Year 2023/2024

Crisis Support System of Care (CSSOC)

Brief Program Overview

RUHS-BH has established a Crisis Support System of Care (CSSOC). Mobile Crisis Response Teams (MCRT), Mobile Crisis Management Teams (MCMT), Community Behavioral Health Assessment Teams (CBAT), Community Assessment Transport Team (CATT), and Behavioral Health Justice Intervention Services (BHJIS) teams provide mobile crisis intervention services at various locations in the community. Mental Health Urgent Cares (MHUC) and Crisis Residential Treatment (CRT) facilities provide crisis support and stabilization. Together, these programs provide crisis support, diversion from emergency psychiatric services, and connection to outpatient services. Beginning in January 2024, MCRT and MCMT teams provide crisis intervention services 24 hours a day, 7 days a week to various locations within the county with follow-up completed within 72 hours of a crisis contact.

Mobile Crisis Response Teams (MCRT)

Designed to decrease law enforcement involvement and inpatient admissions, MCRTs provide mobile based crisis support and connection to outpatient/substance services. Teams consists of a Clinical Therapist II or a Behavioral Health Specialist and a Mental Health Peer Support Specialist. Originally designed to provide crisis services to adults, teams were added specifically to provide services to youth age 21 and younger.

Mobile Crisis Management Teams (MCMT)

MCMTs assess and intervene with individuals experiencing a mental health crisis. Teams consists of four staff members: Clinical Therapist, Behavioral Health Specialist II, Behavioral Health Specialist III, and Peer Support Specialist.

Community Behavioral Health Assessment Teams (CBAT)

Comprised of a specially trained police officer and a RUHS-BH Clinical Therapist II, CBATs respond to requests for law enforcement services involving individuals who are experiencing a mental health crisis and divert these individuals to the appropriate community and behavioral health services.

Community Assessment and Transport Team (CATT)

The CATT team pairs a RUHS-BH Clinical Therapist with an EMT American Medical Response (AMR) to respond to individuals experiencing a mental health crisis in the City of Hemet. The team provides mental health assessment, resource referrals, and transportation when necessary to mental health and substance use facilities as well as to shelters for individuals who are dealing with mental health and/or substance issues.

Behavioral Health Justice Intervention Services (BHJIS)

BHJIS teams provide responsive crisis intervention support, reduce hospitalizations and arrests, and connect students with on-going supports and services at colleges in the community. Two RUHS-BH Clinicians provide crisis services at four college campuses: College of the Desert, Riverside Community College, Riverside Community College-Moreno Valley Campus, University of California, Riverside (UCR).

Crisis Support System of Care (CSSOC)

Mental Health Urgent Cares (MHUC)

The Voluntary MHUCs operate 24 hours a day, 7 days a week, providing clinical and psychiatric assessment, crisis intervention, and supportive therapy as well as peer-to-peer enriched engagement and support. The MHUCs serve individuals 18 years and older with the Desert and Mid-County MHUCs also serving adolescents 13 years and older. Individuals may stay at the facility up to 23 hours.

Crisis Residential Treatment facilities (CRT)

CRTs provide enriched recovery based peer-to-peer support and interventions with the goal of stabilizing clients in acute crises, thereby, eliminating or reducing the need for inpatient hospitalization. Individuals may stay at the facility for up to 14 days.

Data Collection

All Crisis responses were entered into the CSSOC log in the electronic health record. Data is linked to the RUHS-BH electronic health record for further analyses. MHUCs and CRT utilization data is derived from the RUHS-BH electronic health record admissions.

Mobile Crisis Response Teams (MCRT)

Mobile Crisis Response Teams (MCRTs) provide community based mobile crisis support services in the three county regions (West, Mid-County, Desert) with the goal of decreasing law enforcement involvement and inpatient hospitalizations. Originally designed to provide crisis services to adults, the program added teams to provide services specifically for youth age 21 and younger. Each team is comprised of a Clinical Therapist II or Behavioral Health Specialist and a Mental Health Peer Support Specialist. MCRTs are responsible for assessing the individual's needs and providing crisis support with a focus on connecting individuals to outpatient and substance use services. Beginning in January 2024, MCRTs responded to request for crisis services 24 hours a day, 7 days a week.

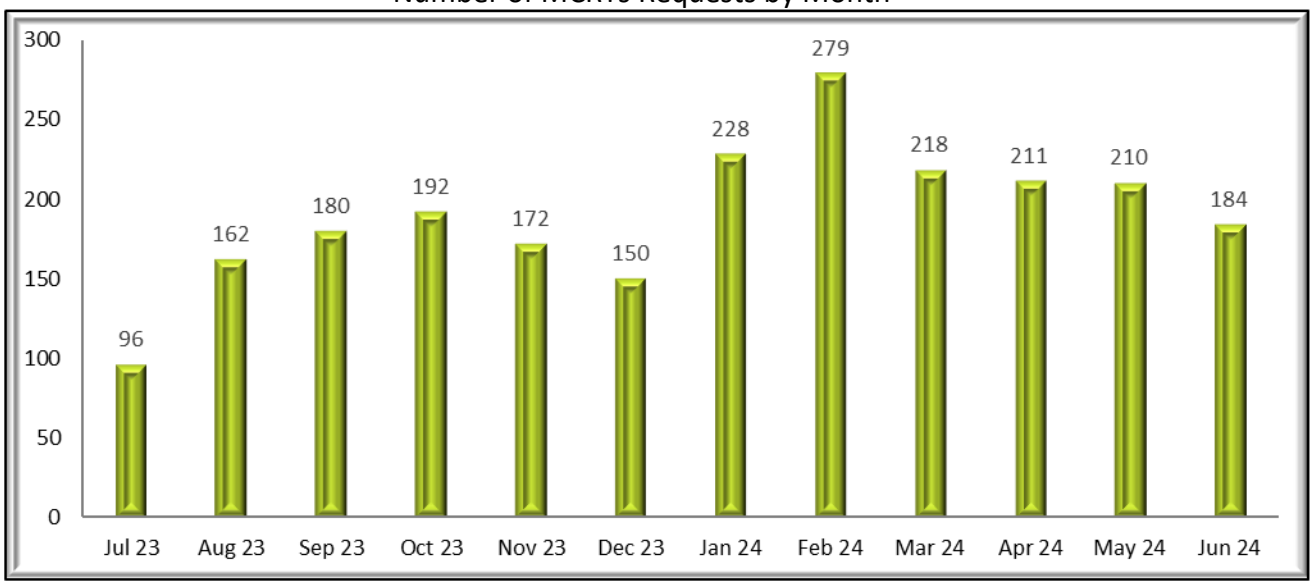
Requests for Service

MCRTs responded to 2,282 requests for mobile crisis response during the 2023/2024 fiscal year (July 1, 2023 through June 30, 2024). MCRTs responded to the most requests from the Mid-County region (n = 904). The average number of requests for MCRTs per month was 190.

MCRT Crisis Requests 2,282	
West	843
Mid-County	863
Desert	576

Avg. Num. of Requests per Month
190

Number of MCRTs Requests by Month

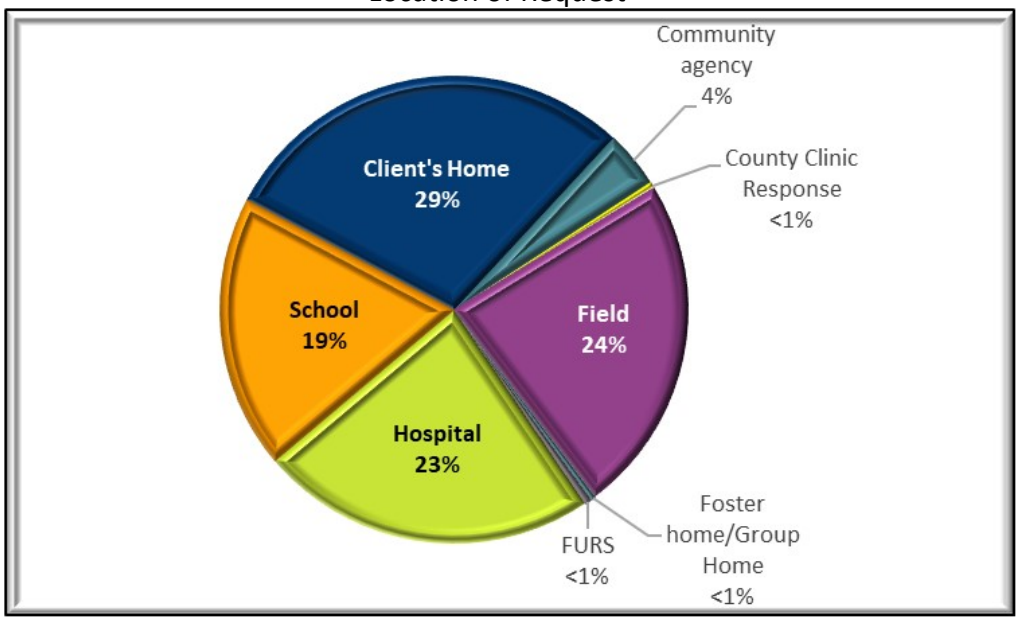


Mobile Crisis Response Teams (MCRT)

MCRTs began primarily as a mobile crisis response to law enforcement requests for assistance with individuals experiencing a mental health crisis. MCRTs have expanded to include mobile crisis requests from hospital emergency departments, community agencies, group homes, and other community locations.

MCRTs responded to requests from client's homes (29%), the Field (24%) and Hospitals (23%) more than other locations. Field refers to locations in the community such as businesses and streets.

Location of Request



Response Times

The average response time for MCRTs requests was 1 hour and 10 minutes.

Avg. MCRT Response Time
1 Hour 10 minutes

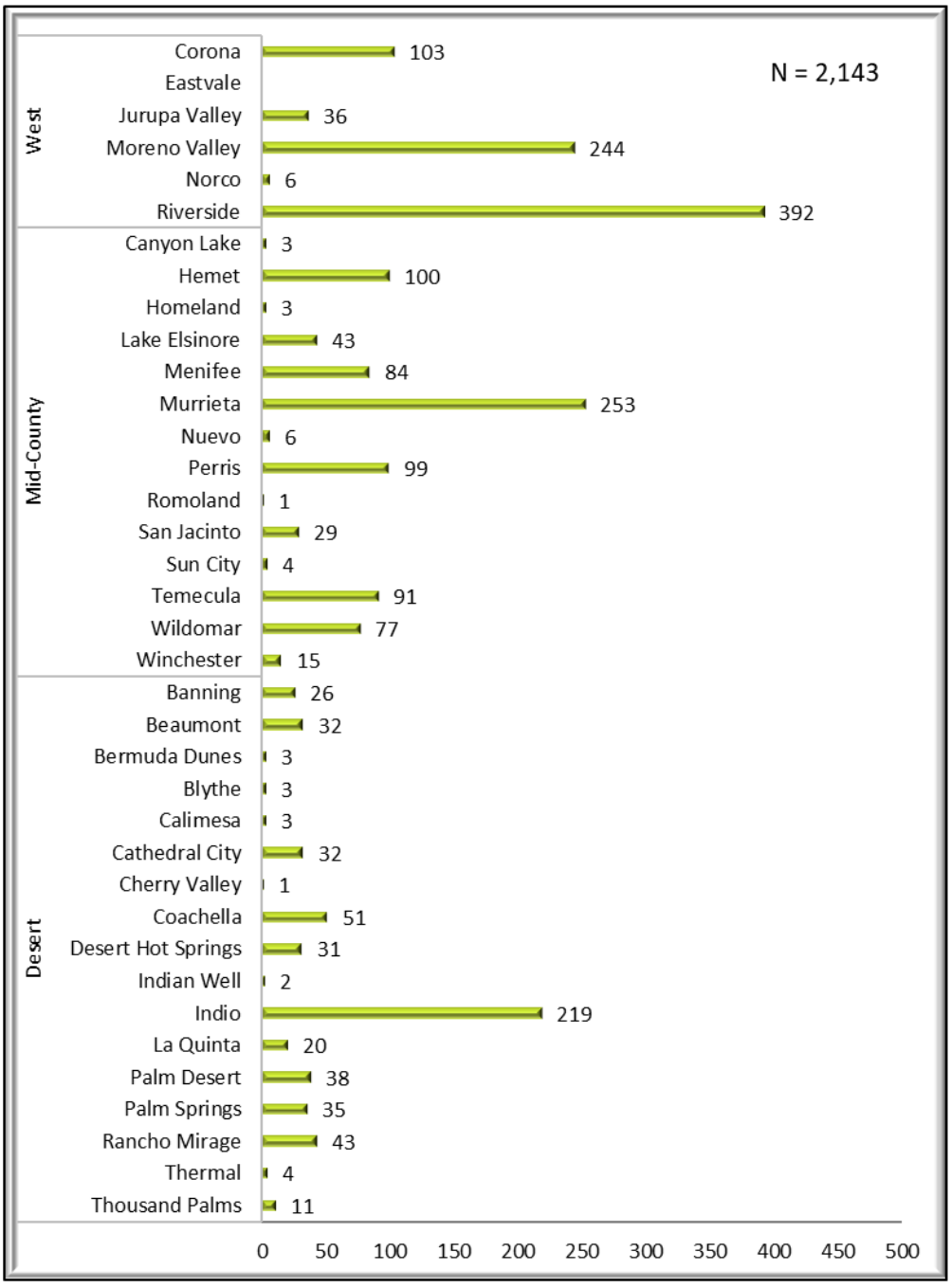
58% of responses were in an hour or less
89% of responses were within 2 hours
95% of responses were within 3 hours

Mobile Crisis Response Teams (MCRT)

Cities and Regions

MCRTs received requests for service from multiple cities, through-out the county. The figure below provides the number of requests per city in each county region. In the Western region, the city of Riverside had the most requests for MCRTs (n = 392). In Mid-County, MCRTs received the most requests from Murrieta (n = 253). Finally, the Desert region received the most requests for MCRTs from Indio (n = 219). Data on city location was not reported for 126 crisis requests.

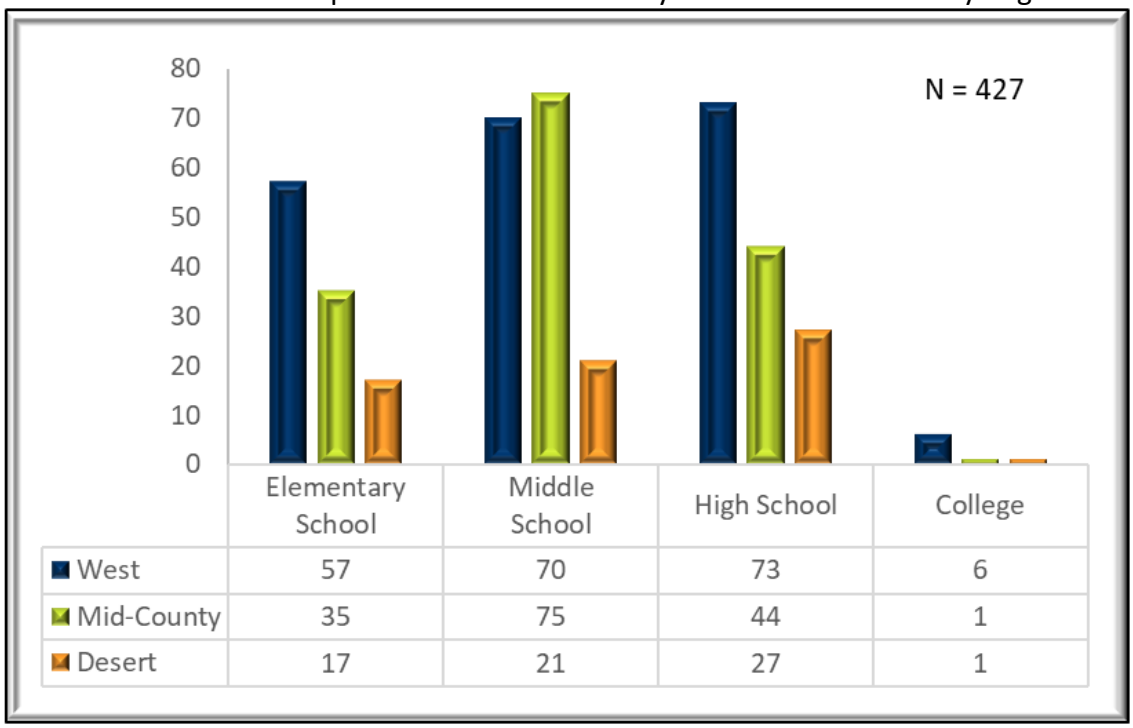
MCRTs Requests by City and County Region



Mobile Crisis Response Teams (MCRT)

In an effort to decrease law enforcement involvement, MCRTs added teams in December 2018 to provide crisis service to youth age 21 and under at schools and other locations. Most requests for MCRTs at schools were made by school resource officers as schools preferred to make requests for MCRTs through their school resource officers rather than allowing other school staff to directly request MCRTs. The figure below shows the number of school requests MCRTs received in each county region during the 2023-2024 Fiscal Year. There was one request in the Western region from a charter school and one request in the Mid-County region from a private school. The Western region received the most requests for service at high schools, while the Mid-county region had the most requests for MCRT teams from middle schools.

Number of MCRTs requests for Service made by Schools in each County Region



	Elementary School	Middle School	High School	College
West	57	70	73	6
Mid-County	35	75	44	1
Desert	17	21	27	1

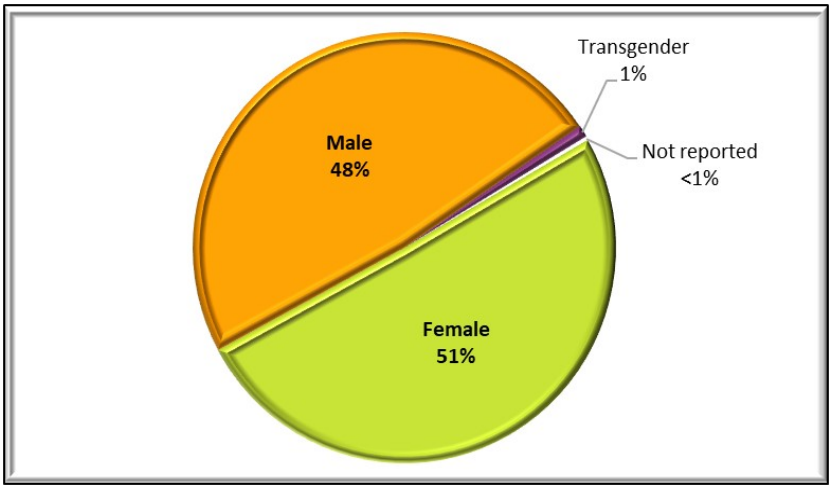
Mobile Crisis Response Teams (MCRT)

Demographics

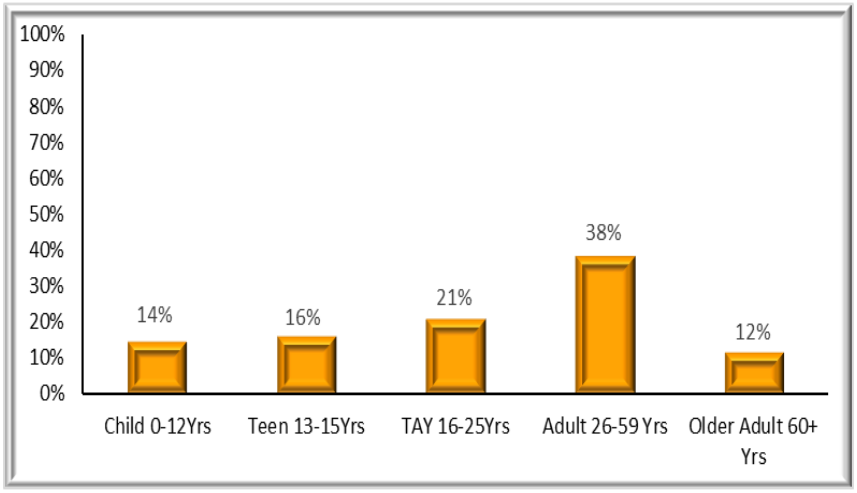
MCRTs served 2,012 individuals during the 2023/2024 fiscal year. Most individuals spoke either English (54%) or Spanish (2%). Language was not reported for 45% of individuals. Nine percent of individuals reported experiencing homelessness and 1.5% were Veterans.

MCRTs served more females (51%) than males (48%), with 1% of individuals identifying as transgender. Gender was not reported for 5 individuals.

Gender of MCRT Clients



Age of MCRT Clients



Over a third (38%) of clients were adults between the ages of 26 and 59 years of age. Age was not reported for 5 clients.

Hispanics/Latinos (44%) and White/ Caucasians (35%) were served the most by MCRTs.

Ethnicity of MCRT Clients

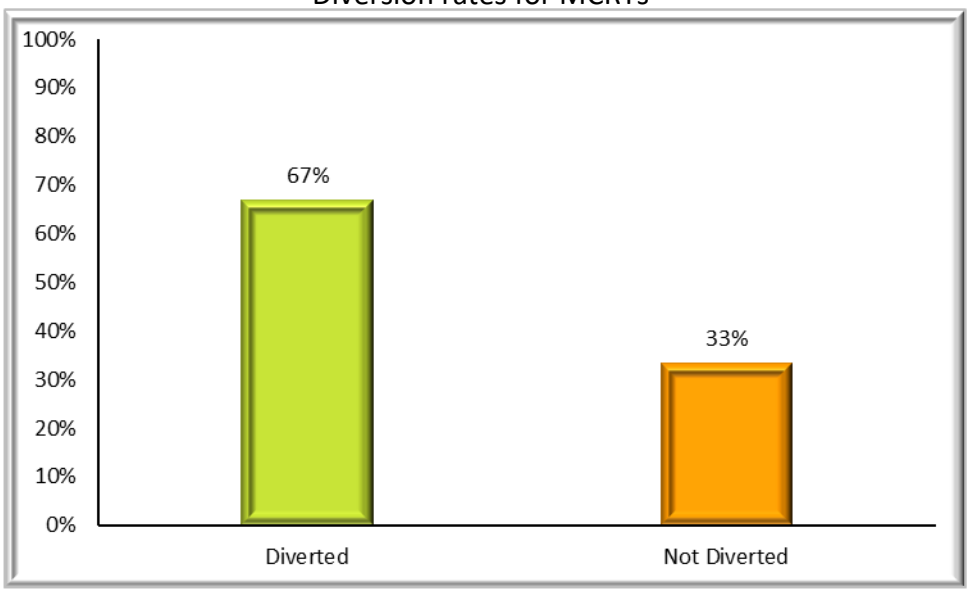
Ethnicity	N	%
Am. Indian/Alaskan Native	11	1%
Asian/Pacific Islander	56	3%
Black/African American	234	14%
Hispanic/Latino	729	44%
Multi-Racial	104	6%
White/Caucasian	579	35%
Not reported	299	18%

Mobile Crisis Response Teams (MCRT)

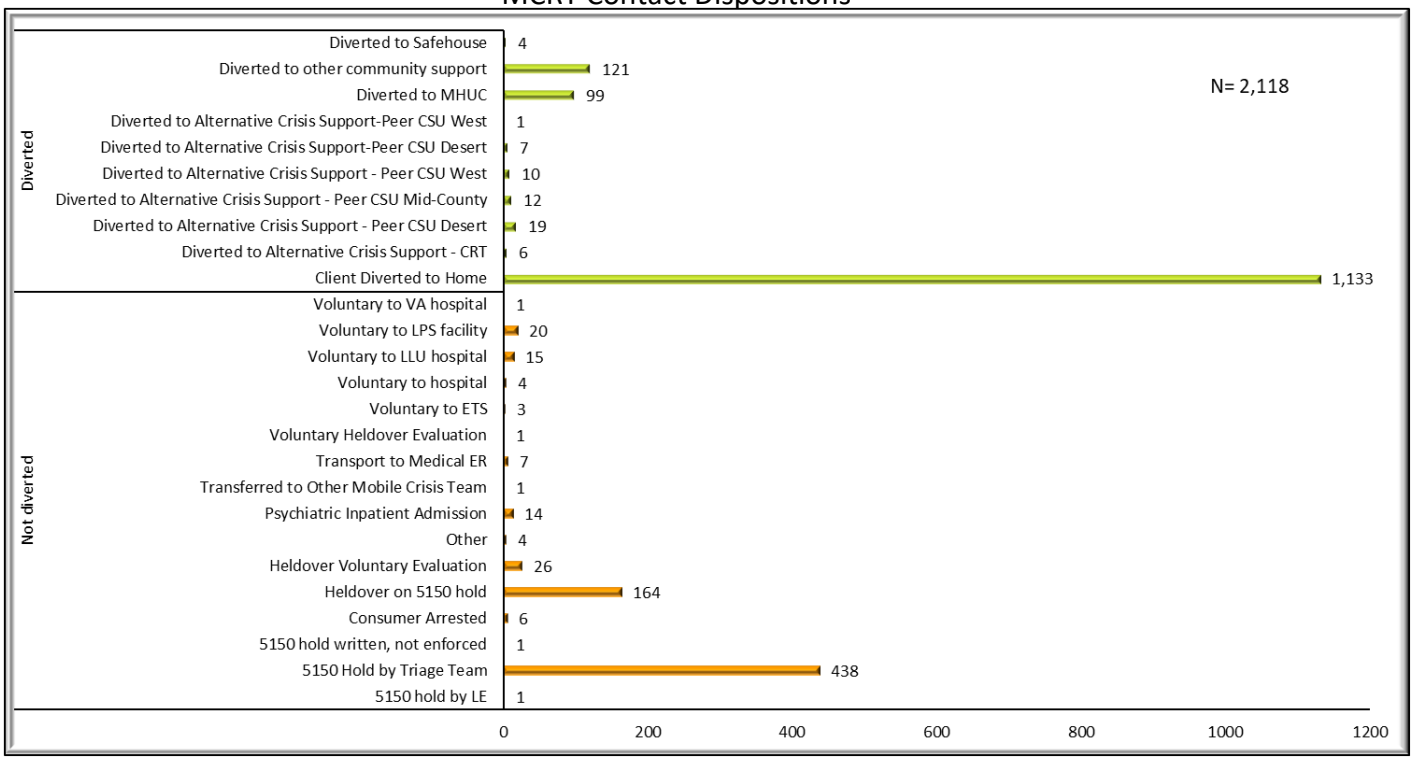
Diversion from Inpatient Admissions

Diversion from an inpatient admission was measured using the disposition of the crisis contact. A contact is considered diverted if the individual returns home, is sent to an MHUC, or is sent to an alternative crisis support. Non-crisis community supports included homeless shelters, emergency housing, and other social services. Contacts in which the client was unable or unwilling to interact with MCRTs (7%, n = 163) or that had a disposition of "Other" (0.1%, n = 3) or a disposition of "consumer arrested" (0.2%, n = 6) were excluded from the calculation of diversion rates. MCRTs were able to successfully divert 67% of crisis contacts in the field. The figure below provides the crisis disposition of MCRT contacts.

Diversion rates for MCRTs



MCRT Contact Dispositions



Mobile Crisis Response Teams (MCRT)

Inpatient Admissions

Engagement in outpatient services should lessen the need for subsequent inpatient admissions. Contacts resulting in a 72 hour legal hold were not used in the calculation of inpatient admissions.
Eight percent (n = 158) of individuals had an inpatient admission within 60 days of contact with MCRTs. Some individuals (n = 28) had more than one admission within 60 days of MCRT contact.

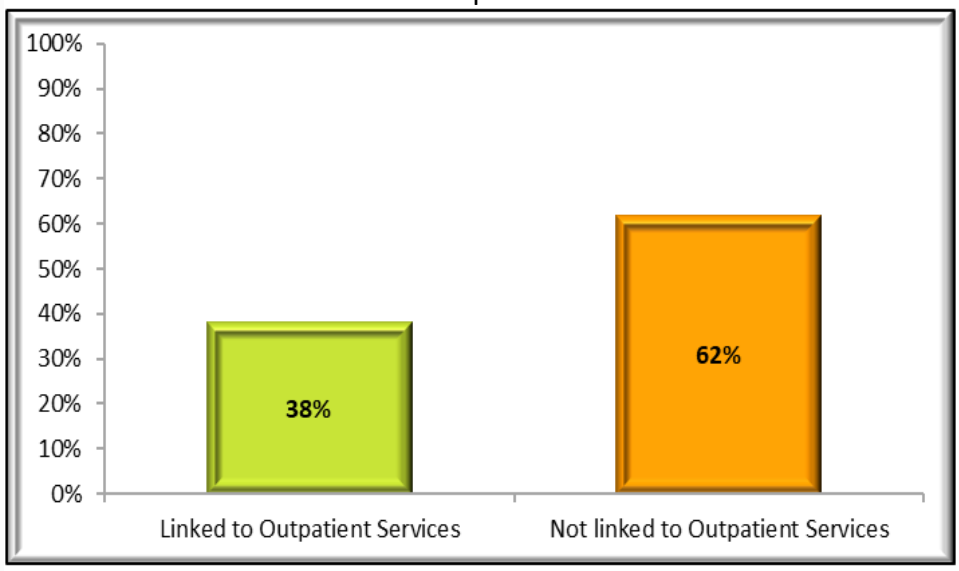
Inpatient Admissions	N	%
Had at least one inpatient admission	130	6%
Had more than one inpatient admission	28	1%
Total Inpatient Admissions	158	8%

Mobile Crisis Response Teams (MCRT)

Outpatient Service

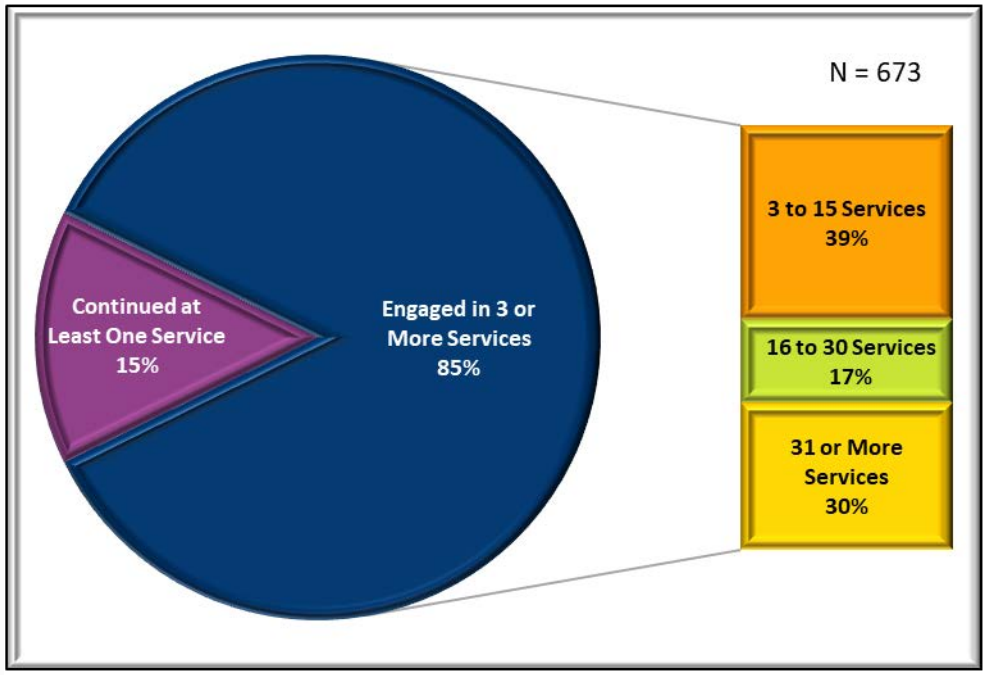
RUHS-BH service data was used to examine outpatient service. Clients were considered to be linked to outpatient services if they had an outpatient mental health, substance use, or youth short-term residential treatment program service record. Individuals who were recorded as being linked to a private provider or who had private insurance were not included in the analysis.

Linked to Outpatient Services



Over a third (38%, n = 673) of individuals served by MCRTs had an outpatient service after contact with teams. Some of these individuals (n = 348) had an outpatient service before having contact with MCRTs.

Engagement in Services



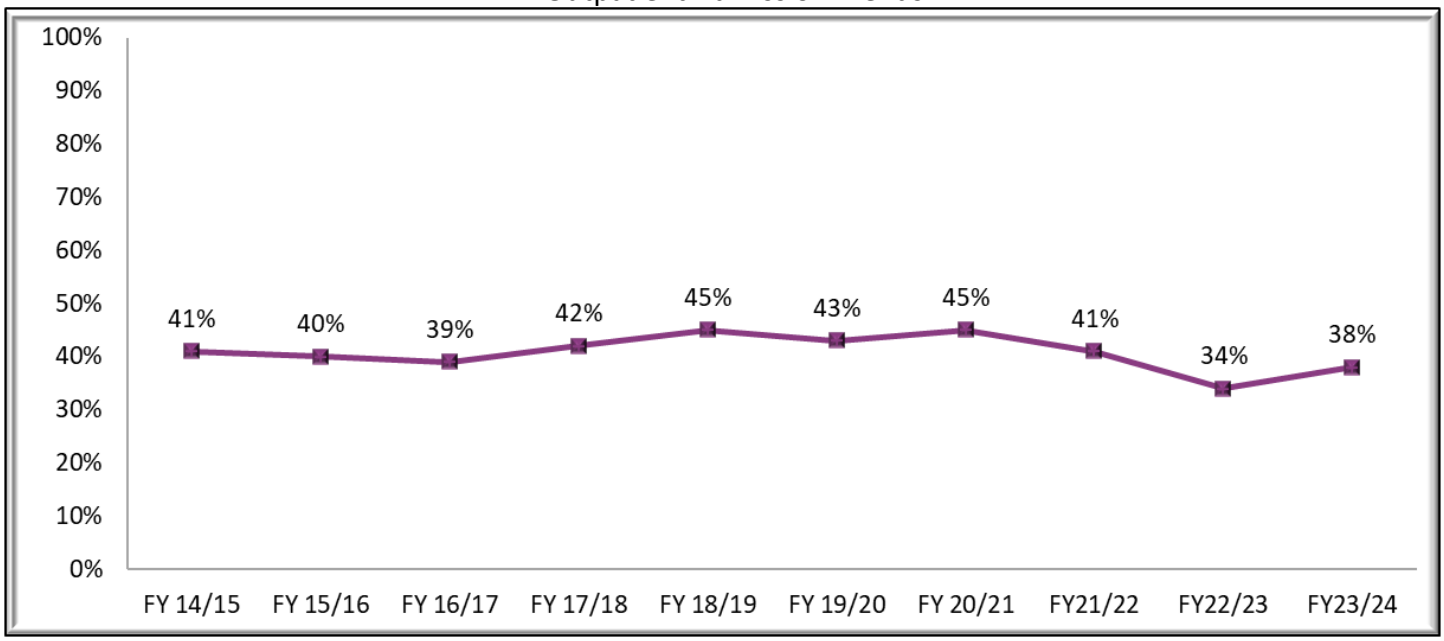
The majority (85%) of individuals linked to outpatient services engaged in three or more services. Over a third (39%) of MCRT clients who were linked to services participated in 3 to 15 services. For clients with 3 or more services, the average number of services was 36.

Mobile Crisis Response Teams (MCRT)

Outpatient Admission Trends

The figure below provides the percentage of clients linked to outpatient services after contact with MCRTs for each fiscal year since the beginning of the Crisis program. MCRTs began serving clients in mid December 2014; therefore, the data for the 2014/2015 fiscal year is from December 18, 2014 through June 30, 2015. Individuals who were recorded as having private insurance were not included in the analysis.

Outpatient Admission Trends



Recidivism Rates

The table below provides the repeat crisis readmission rates at 15 days or less after first crisis contact and at 16 to 30 days after first crisis contact. Both have remained relatively low.

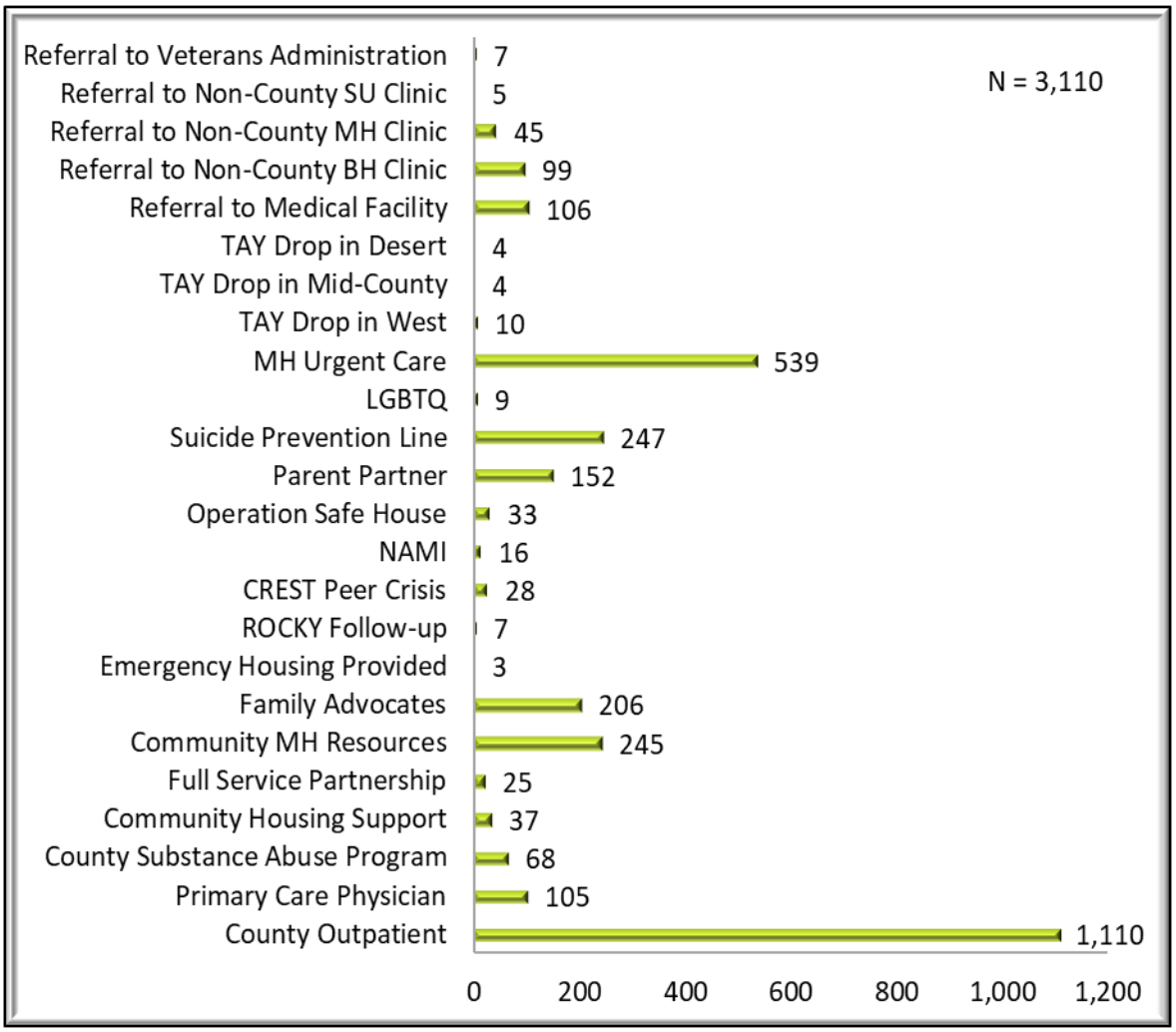
MCRT Readmission Rates	
Days to Readmission	%
0 to 15 Days	4.95%
16 to 30 Days	2.41%
0 to 30 Days	7.36%

Mobile Crisis Response Teams (MCRT)

Service referrals

As part of crisis intervention, MCRTs provide individuals with referrals for various services each time teams have contact with a client. Individuals can receive multiple referrals for different services. MCRTs provided 3,110 referrals to 2,012 individuals.

Service Referrals



Mobile Crisis Management Teams (MCMT)

Mobile Crisis Management Teams (MCMT) serve individuals who are at risk of a mental health crisis or who frequently utilize the crisis response system (e.g., emergency rooms or law enforcement) due to behavioral health needs. The MCMT teams consists of four staff members: Clinical Therapist, Behavioral Health Specialist II, Behavioral Health Specialist III, and Peer Support Specialist. Teams respond to requests from various entities in the county 24 hours a day/7 days a week and assess and intervene with individuals experiencing a mental health crisis. MCMTs provide intensive case management after the initial crisis contact and continued engagement for linkage to ongoing outpatient care. In addition, teams conduct intense, short-term, home-based case management and therapy, substance abuse services, linkage to residential services, and outreach to unengaged youth or adults who are at risk, homeless, or need services to prevent a mental heath crisis.

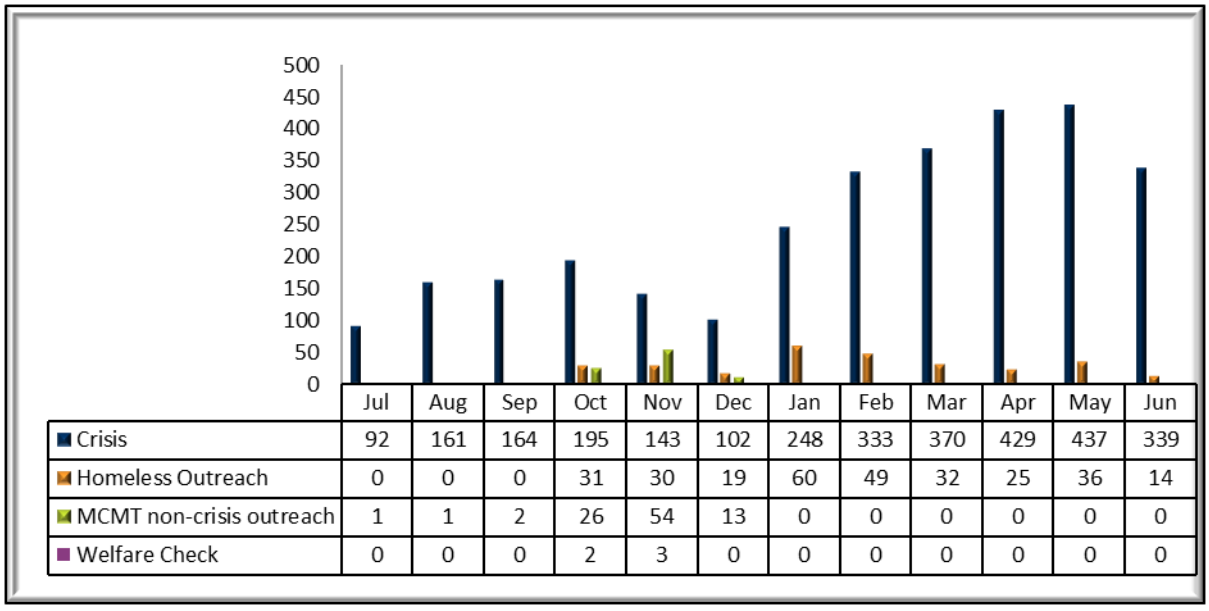
Requests for Service

MCMT began service in August of 2021. During the 2023/2024 fiscal year, 14 MCMT teams responded to 3,411 requests for service (including requests for Homeless Outreach, Non-Crisis Outreach, and Welfare Checks).

MCMT Requests 3,411	
Crisis	3,013
Homeless Outreach	296
MCMT Non-Crisis Outreach	97
Welfare Check	5

The figure below provides the number of requests for MCMTs per month for each type of service (crisis, homeless outreach, welfare checks, non-crisis outreach) for the 2023-2024 fiscal year. MCMTs received an average of 284 request for service per month.

Number of Requests for MCMT teams per month



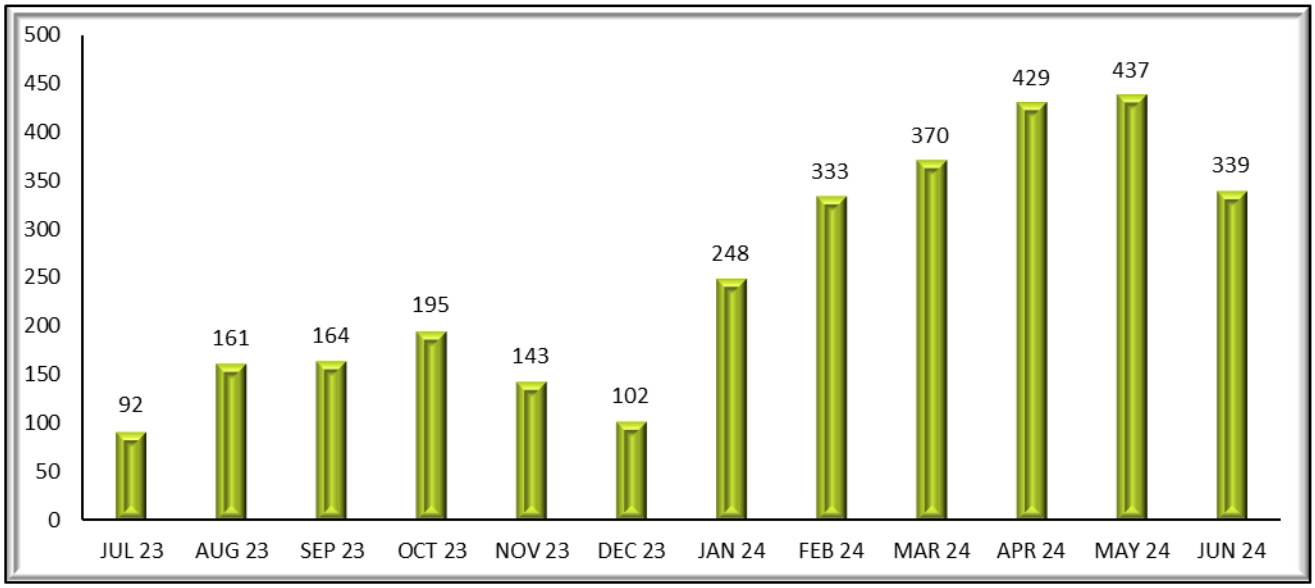
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Crisis	92	161	164	195	143	102	248	333	370	429	437	339
Homeless Outreach	0	0	0	31	30	19	60	49	32	25	36	14
MCMT non-crisis outreach	1	1	2	26	54	13	0	0	0	0	0	0
Welfare Check	0	0	0	2	3	0	0	0	0	0	0	0

Mobile Crisis Management Teams (MCMT)

Crisis Requests

MCMTs received 3,013 requests for Crisis Services during the 2023-2024 fiscal year. The average number of calls per month for Crisis Services for MCMTs was 251.

Number of Crisis Requests per Month



The table below provides the number of crisis requests received by each MCMT team.

MCMT Crisis Requests by Team

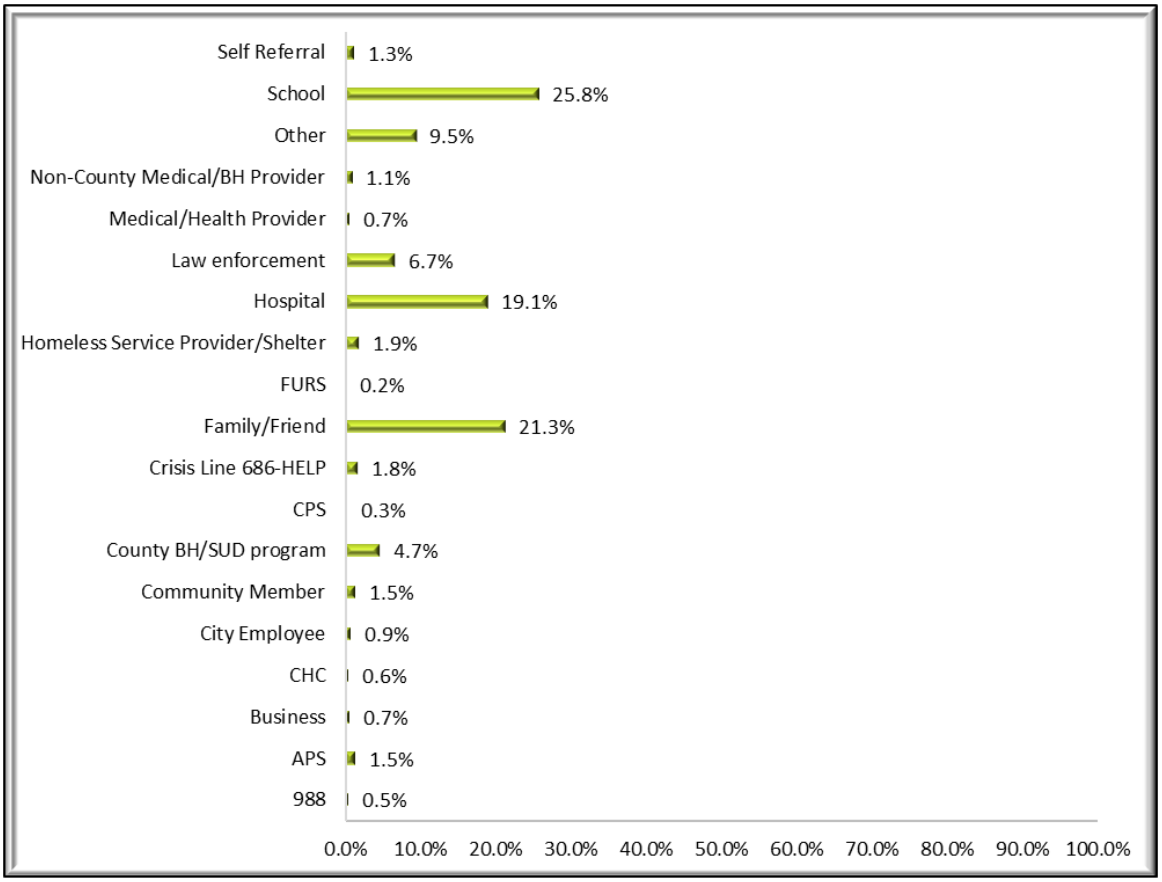
MCMT Team	N	%
Banning MCMT	242	8%
Blythe MCMT	79	3%
Corona MCMT	149	5%
DHS MCMT	159	5%
Hemet MCMT	235	8%
Indio MCMT	211	7%
Jurupa Valley MCMT	200	7%
Lake Els. MCMT	156	5%
Menifee MCMT	128	4%
Moreno Valley MCMT	189	6%
Perris Mid-County MCMT	279	9%
Riverside MCMT	256	8%
Sycamore	592	20%
Temecula MCMT	138	5%

Mobile Crisis Management Teams (MCMT)

Request for Service

MCMT teams receive requests for crisis services from various entities through-out the county. The highest percentage of requests for MCMTs for crisis service came from Schools (25.8%), Family/Friends (21.%) and Hospitals (19.1%).

Entity Requesting Crisis Services

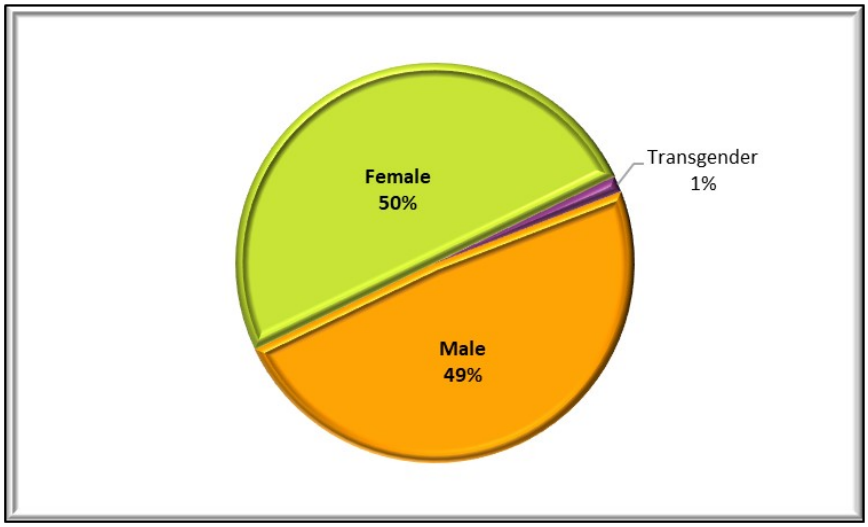


Mobile Crisis Management Teams (MCMT)

Demographics for Crisis Requests

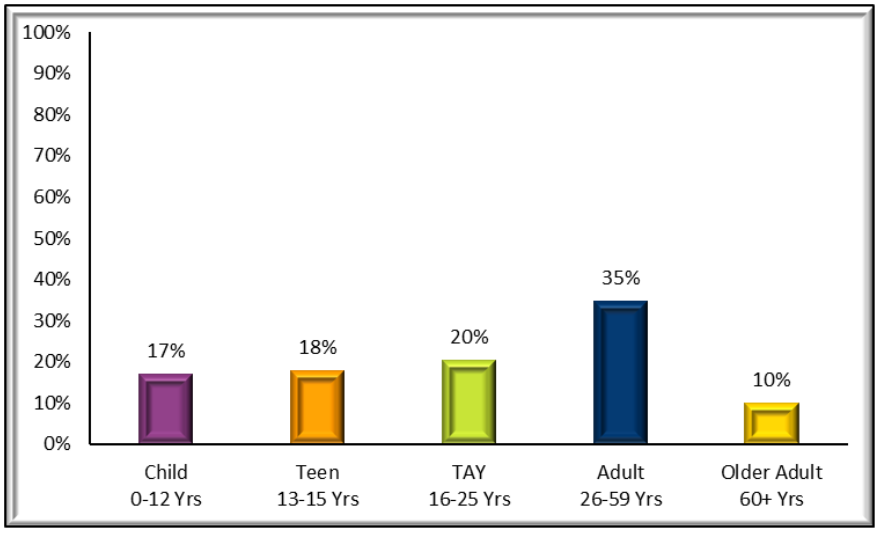
The demographics presented here are for clients who received Crisis services. Clients receiving Homeless Outreach, Welfare Checks, and MCMT Non-Crisis Outreach were excluded from these analyses. MCMT teams provided Crisis services to 2,556 during the 2023/2024 fiscal year.

Gender of Crisis MCMT clients



MCMTs provided crisis services to slightly more females (50%) than males (49%). Individuals identifying as transgender accounted for 1% of all MCMT crisis clients.

Age of Crisis MCMT clients



TAY Youth accounted for one-fifth (20%) of clients served by MCMT crisis teams. Adults (age 26 to 59 years of age) represented over a third (35%) of MCMT crisis clients.

Ethnicity of MCMT clients

Ethnicity	N	%
Am. Indian/Alaska Native	20	1%
Asian/Pacific Islander	83	3%
Black/African American	335	13%
White/Caucasian	856	33%
Hispanic/Latinx	980	38%
Multi-Racial	275	11%
Not Reported	7	-

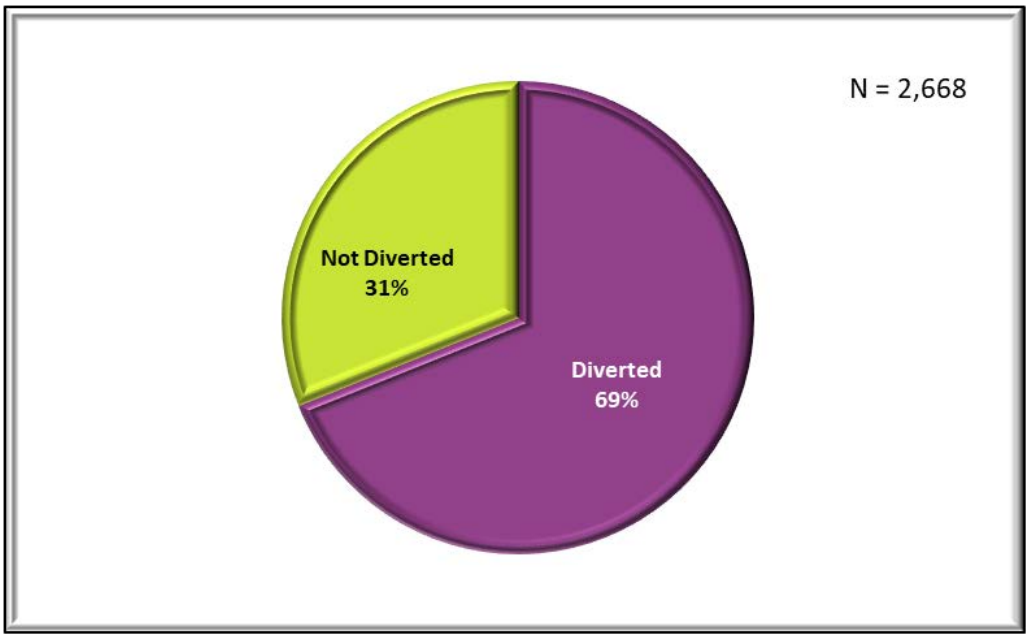
Hispanics/Latinx (38%) and White/Caucasians (33%) were served the most by MCMT teams. Individuals experiencing homelessness accounted for 13% of crisis clients, while 1% of clients were Veterans.

Mobile Crisis Management Teams (MCMT)

Crisis Diversions

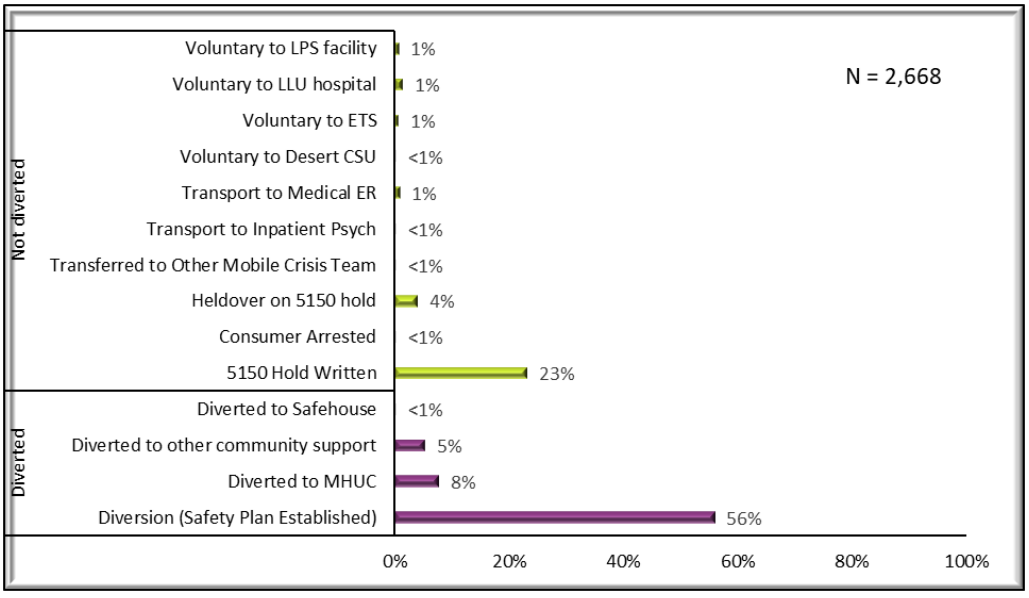
MCMTs divert individuals from inpatient admissions. The figure below provides the diversion rates for requests for crisis service. Requests in which the consumer refused services (6%, n = 177) or had a disposition of "Other" (6%, n = 168) were excluded from diversion rate calculations. Individuals are considered diverted if they were sent home with a safety plan , sent to an MHUC, or sent to some other community support.

Percentage of Crisis Requests Diverted



MCMTs were able to divert 69% of crisis requests from an inpatient admission.

Disposition of Crisis Requests



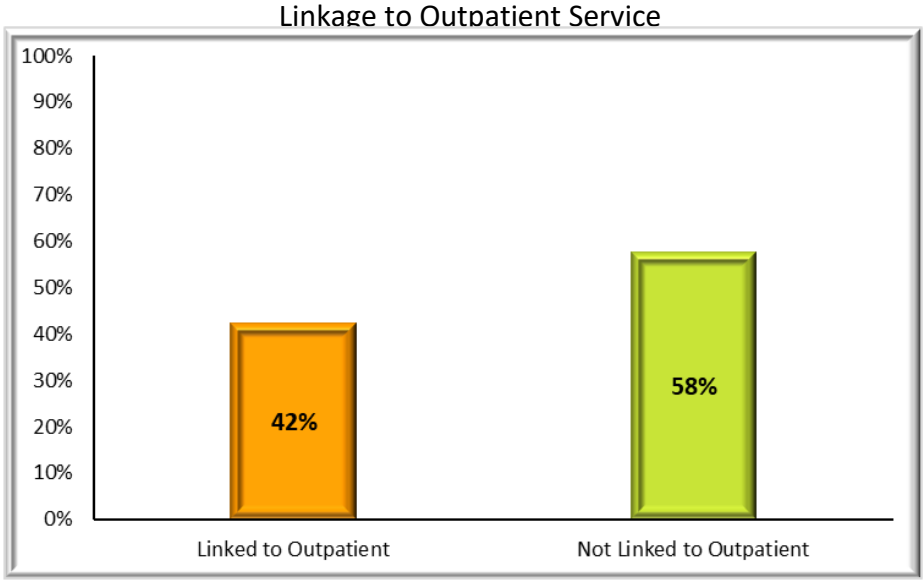
The figure to the left provides the dispositions of MCMT crisis requests. Individuals either were diverted with safety plan, diverted to MHUC, diverted to other community support, or diverted to safehouse.

Mobile Crisis Management Teams (MCMT)

Linkage to Outpatient Services

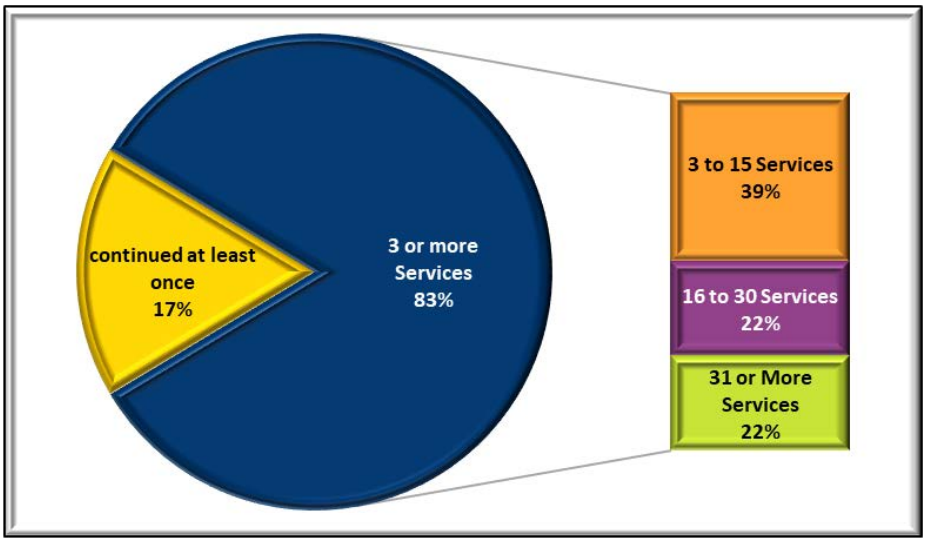
In addition to diverting individuals from an inpatient admission, MCMTs connect individuals to outpatient services. RUHS-BH service data was used to examine service usage after contact with MCMTs. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Linkage to Outpatient Service



Forty-two percent (42%) of individuals served by MCMTs had an outpatient service after contact with teams. Some of these individuals (n = 421) were participating in outpatient services prior to their contact with teams.

Engagement in Services



For those MCMT clients with an outpatient service, 83% had three or more services. Over a third (39%) participated in 3 to 15 services. For clients with 3 or more services, the average number of services was 25.

Readmission Rates for MCMT

Days to Readmission	%
0 to 15 Days	7.33%
16 to 30 Days	2.12%
0 to 30 Days	9.46%

Recidivism

The table to the left provides the repeat crisis encounter rates at less than 15 days after first crisis contact and at 16 to 30 days after first contact with MCMT teams.

Community Behavioral Health Assessment Teams (CBAT)

Community Behavioral Health Assessment Teams (CBAT) respond to law enforcement calls involving individuals experiencing mental health issues in the community. The purpose of the teams is to divert those individuals to community and behavioral health services. Teams consist of a specially trained law enforcement officer, who provides safety and law enforcement expertise, and a RUHS-BH Clinical Therapist II, who assesses the client's behavior.

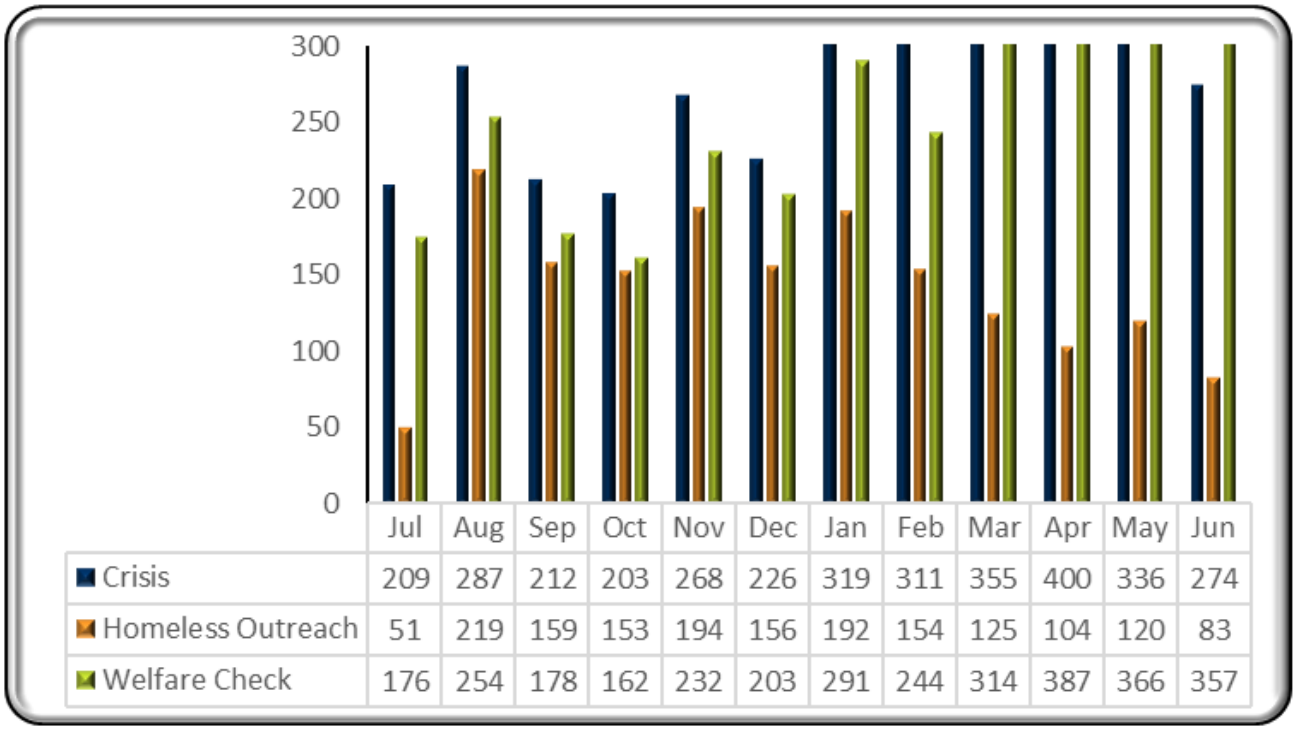
Requests for Service

During the 2023/2024 fiscal year, 18 CBAT teams responded to 8,274 requests for service (including requests for Homeless Outreach and Welfare Checks).

CBAT Requests 8,274	
Crisis	3,400
Homeless Outreach	1,710
Welfare Check	3,164

Avg. Number of Calls per Month
690

Number of requests for CBAT teams per Month



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Crisis	209	287	212	203	268	226	319	311	355	400	336	274
Homeless Outreach	51	219	159	153	194	156	192	154	125	104	120	83
Welfare Check	176	254	178	162	232	203	291	244	314	387	366	357

Community Behavioral Health Assessment Teams (CBAT)

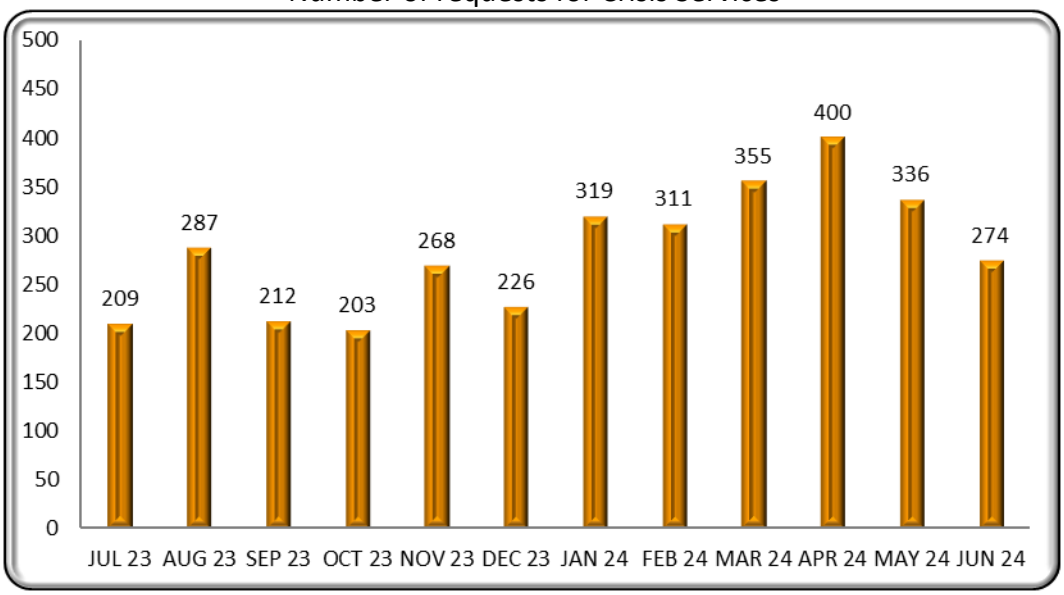
Crisis Requests

CBATs received 3,400 requests for Crisis Services during the 2023-2024 fiscal year. The average number of requests per month for Crisis Services for CBAT was 283.

Avg. Number of CBAT Crisis Requests per Month
283

CBAT Requests for Crisis Service	3,400
West	1,184
Mid-County	1,760
Desert	456

Number of requests for Crisis Services



CBAT Crisis Requests by Team

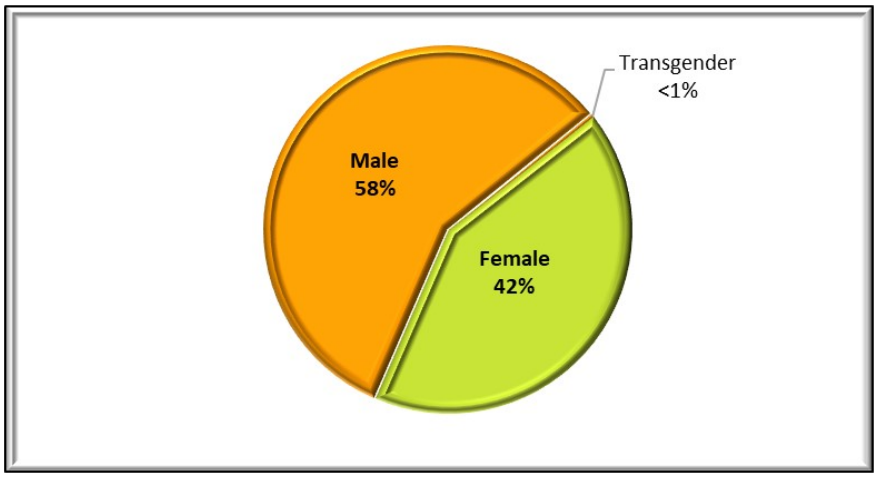
CBAT Team	N	%
Banning PD/Beaumont PD/Cabazon Sheriff/Cathedral City	54	2%
Corona PD	176	5%
Hemet PD	478	14%
Hemet Sheriff	181	5%
Indio PD	74	2%
Jurupa Sheriff	347	10%
Lake Elsinore Sheriff	288	8%
Menifee PD	290	9%
Moreno Valley Sheriff	361	11%
Murrieta PD	195	6%
Palm Desert Sheriff	176	5%
Perris Sheriff	128	4%
Riverside PD	300	9%
Temecula Sheriff	200	6%
Thermal Sheriff	152	4%

Community Behavioral Health Assessment Teams (CBAT)

Demographics

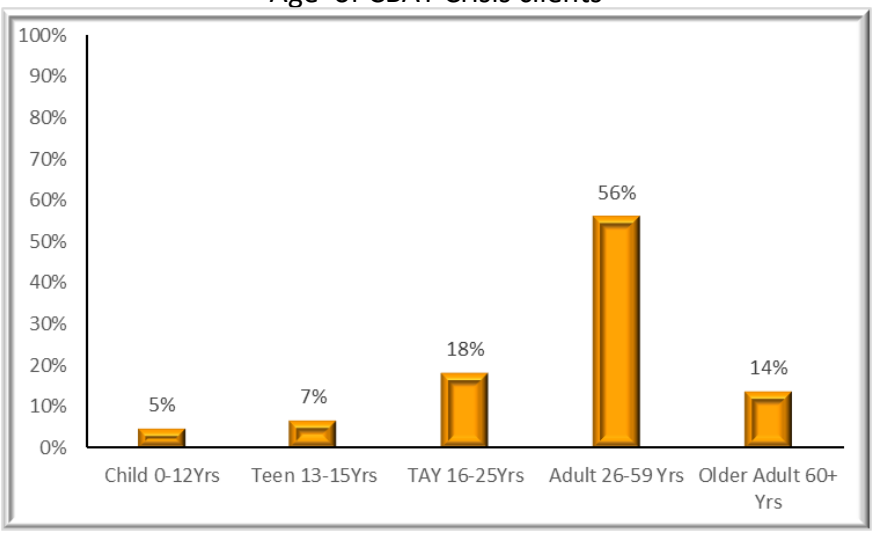
CBATs provided crisis services to 2.861 individuals during the 2023/2024 fiscal year. The demographics presented here are for individuals who received crisis services, all other calls were excluded.

Gender of CBAT Crisis clients



CBAT teams served more males (58%) than females (42%). Less than 1% of individuals (n=8) served by CBAT teams identified as transgender.

Age of CBAT Crisis clients



The majority of CBAT crisis clients (56%) were adults, age 26 to 59 years. Almost a fifth of clients (18%) served by CBAT teams were TAY age (16 to 25 years). Age was not reported for 3 clients.

Ethnicity of CBAT Crisis clients

Ethnicity	N	%
Am. Indian/Alaska Native	20	1%
Asian/Pacific Islander	87	3%
Black or African American	419	15%
Caucasian	1,177	41%
Hispanic or Latinx	989	35%
Multi-Racial	153	5%
Not reported	16	1%

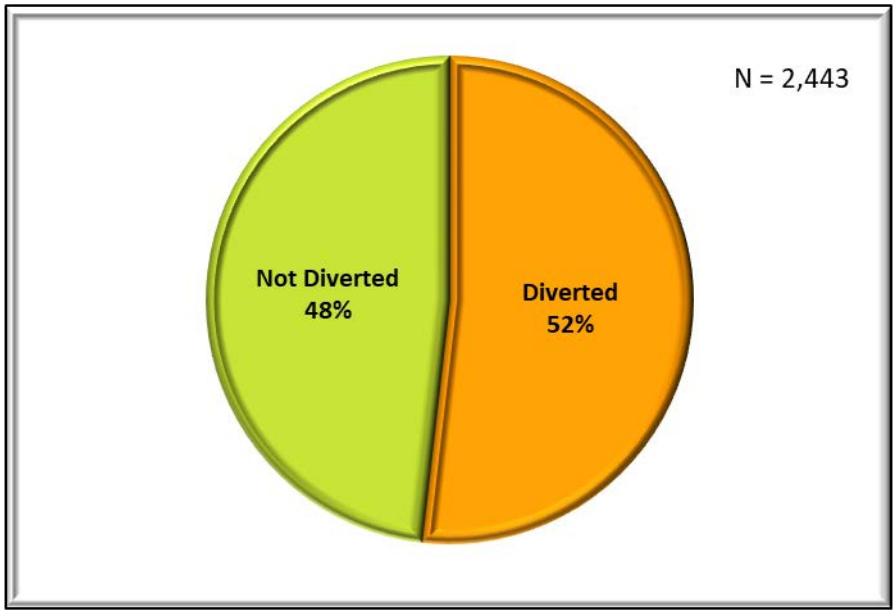
The table to the left provides the ethnicity of CBAT clients. Caucasians (41%), Hispanics/Latinx (35%), and Blacks/African-Americans (15%) were served the most. One fifth (20%) of CBAT crisis clients were reported as experiencing homelessness, while 3% of clients were Veterans.

Community Behavioral Health Assessment Teams (CBAT)

Crisis Diversions

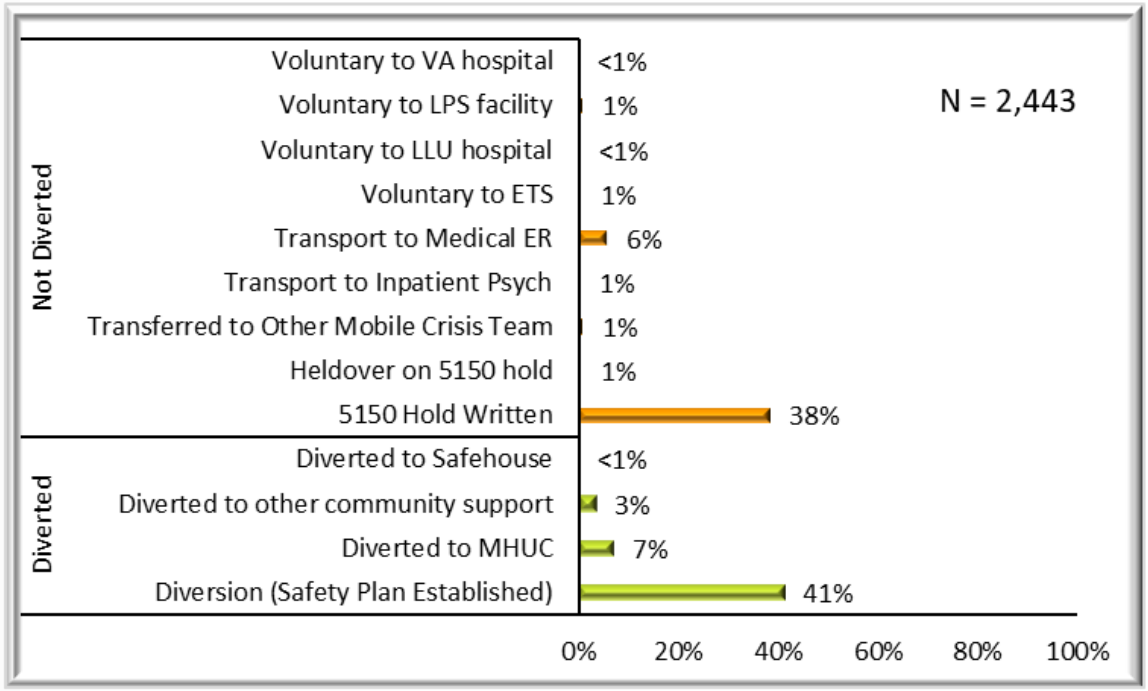
CBATs divert individuals from inpatient admissions. The figures below provide the percentage diverted as well as of the disposition of CBAT crisis contacts. Homeless outreach and welfare checks were excluded from these analyses. Consumers who refused service (12%, n = 412) or who were arrested (10% n = 341) were also excluded from the analyses. Individuals were considered diverted if they were returned home with a safety plan, sent to the MHUC, safehouse, or other community supports.

Percentage of Crisis Requests Diverted



CBATs were able to divert 52% of Crisis requests.

Disposition of Crisis Requests



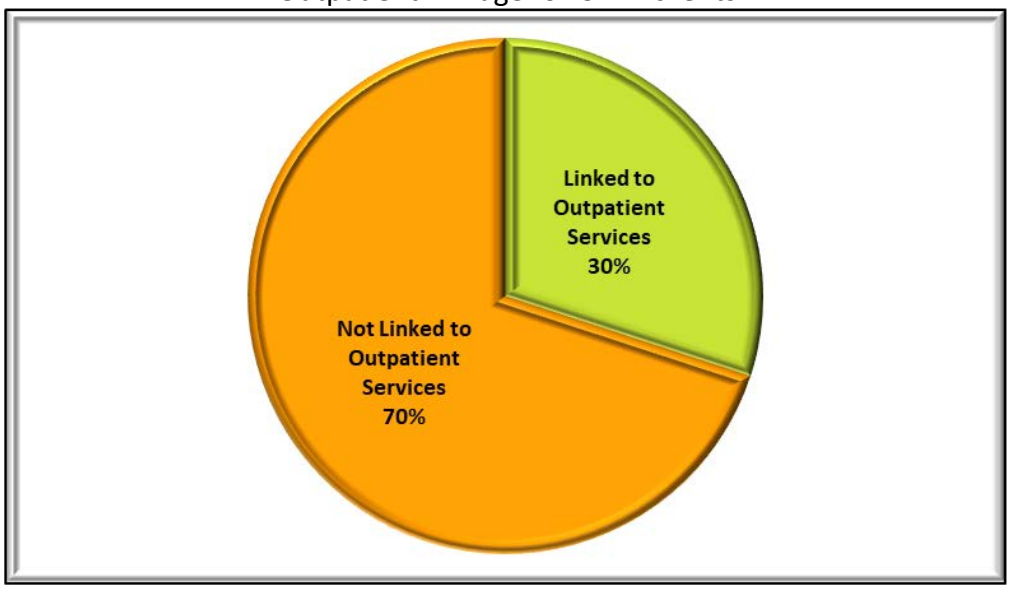
The figure to the left provides the crisis dispositions.

Community Behavioral Health Assessment Teams (CBAT)

Linkage to Outpatient Services

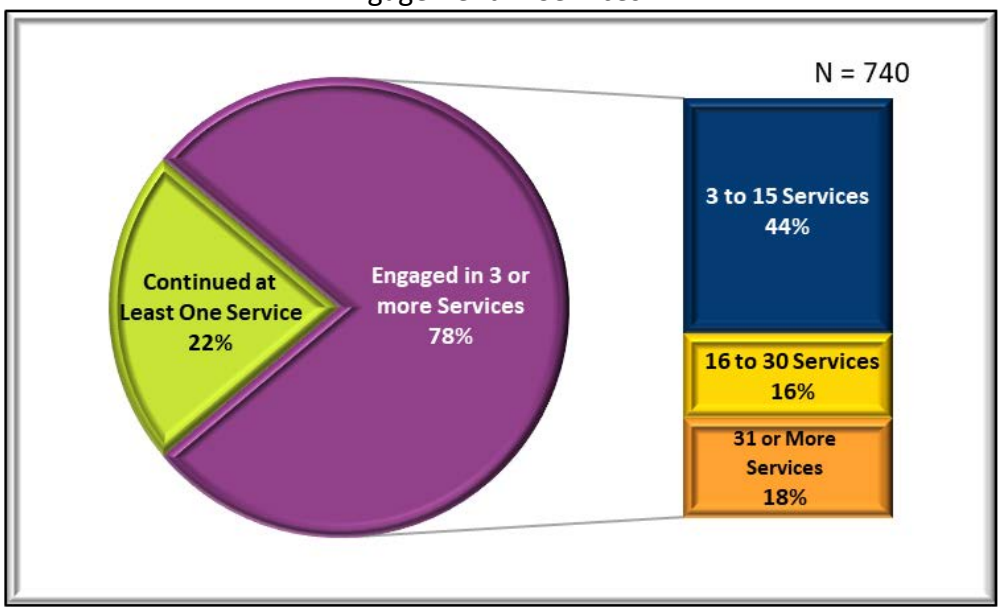
In addition to diverting individuals from inpatient admissions, CBAT teams connect individuals with outpatient services. RUHS-BH service data was used to examine outpatient service after contact with CBAT teams. Clients were considered linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for CBAT clients



Thirty percent (30%) of individuals served by CBAT teams were linked to outpatient services after contact with teams. Some of these individuals (n = 372) were already participating in outpatient services before having contact with CBAT teams.

Engagement in Services



The majority (78%) of CBAT clients linked to outpatient services engaged in three or more services. For clients with 3 or more services, the average number of services was 23.

Readmission Rates for CBAT	
Days to Readmission	%
0 to 15 Days	8.67%
16 to 30 Days	2.90%
0 to 30 Days	11.57%

Recidivism

The table to the left provides the recidivism rates at less than 15 days after first crisis contact and at 16 to 30 days after first contact with CBATs.

Community Assessment and Transport Team (CATT)

The Community Assessment and Transport Team (CATT) pairs a RUHS-BH Clinical Therapist with an EMT American Medical Response (AMR) to respond to individuals experiencing a mental health crisis in the City of Hemet. The team provides mental health assessment, resource referrals, and transportation when necessary to mental health and/or substance use facilities as well as to shelters with the goal of helping individuals who are dealing with mental health and/or substance issues.

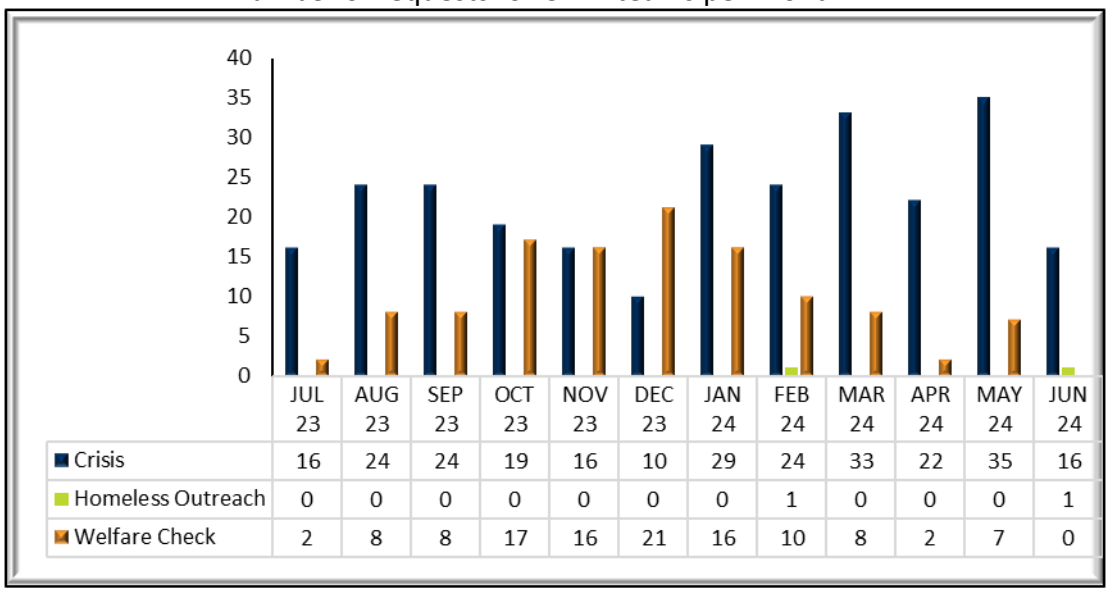
Requests for Service

During the 2023-2024 fiscal year CATT responded to 385 requests for service.

CATT Requests 385	
Crisis	74
Homeless Outreach	1
Welfare Check	41

Avg. Number of Calls per month
32

Number of requests for CATT teams per Month



	JUL 23	AUG 23	SEP 23	OCT 23	NOV 23	DEC 23	JAN 24	FEB 24	MAR 24	APR 24	MAY 24	JUN 24
Crisis	16	24	24	19	16	10	29	24	33	22	35	16
Homeless Outreach	0	0	0	0	0	0	0	1	0	0	0	1
Welfare Check	2	8	8	17	16	21	16	10	8	2	7	0

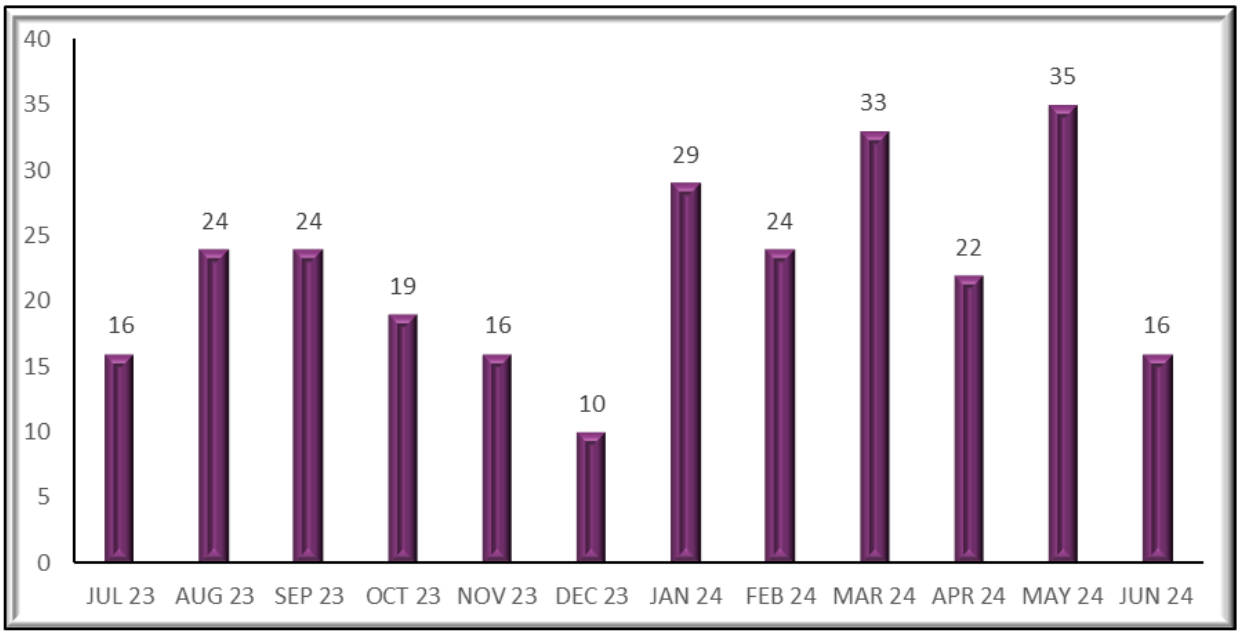
Community Assessment and Transport Team (CATT)

Crisis Requests

CATT received 268 requests for Crisis Services during the 2023-2024 fiscal year. The average number of calls per month for Crisis Services for CATT was 22.

Total Number of Crisis Calls
268

Number of requests for Crisis Services

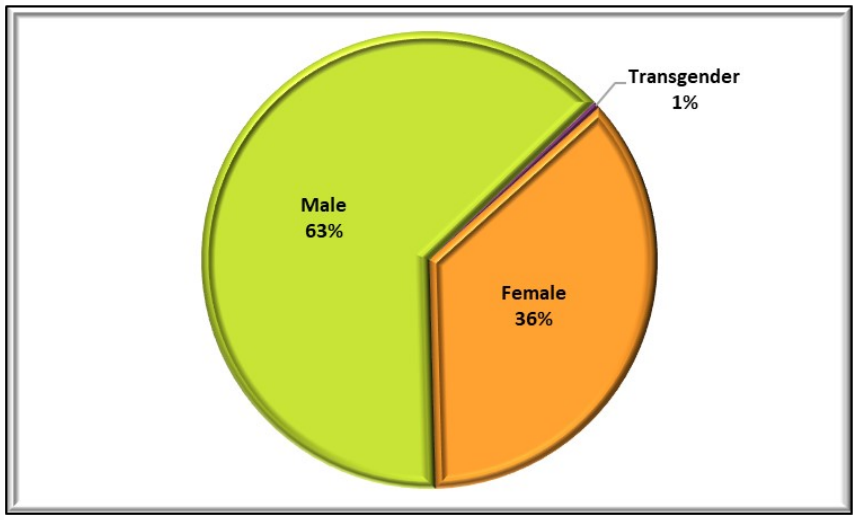


Community Assessment and Transport Team (CATT)

Demographics

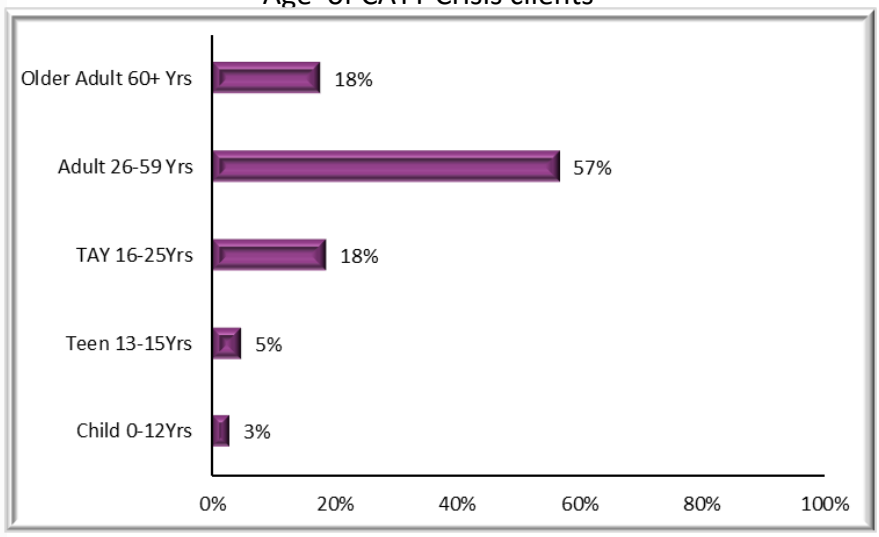
CATT provided crisis services to 218 individuals during the 20232/2024 fiscal year. The demographics presented here are for individuals who received crisis services, all other contacts were excluded.

Gender of CATT Crisis clients



CATT provided crisis services to more males (63%) than females (36%).

Age of CATT Crisis clients



The majority of clients served by CATT (57%) were adults (age 26 to 59 years of age).

Ethnicity of CATT Crisis clients

Ethnicity	N	%
Am. Indian/Alaska Native	1	0.5%
Asian/Pacific Islander	1	0.5%
Black/African American	22	10.1%
White/Caucasian	86	39.4%
Hispanic/Latinx	85	39.0%
Multi-Racial	23	10.6%
Not Reported	1	0.5%

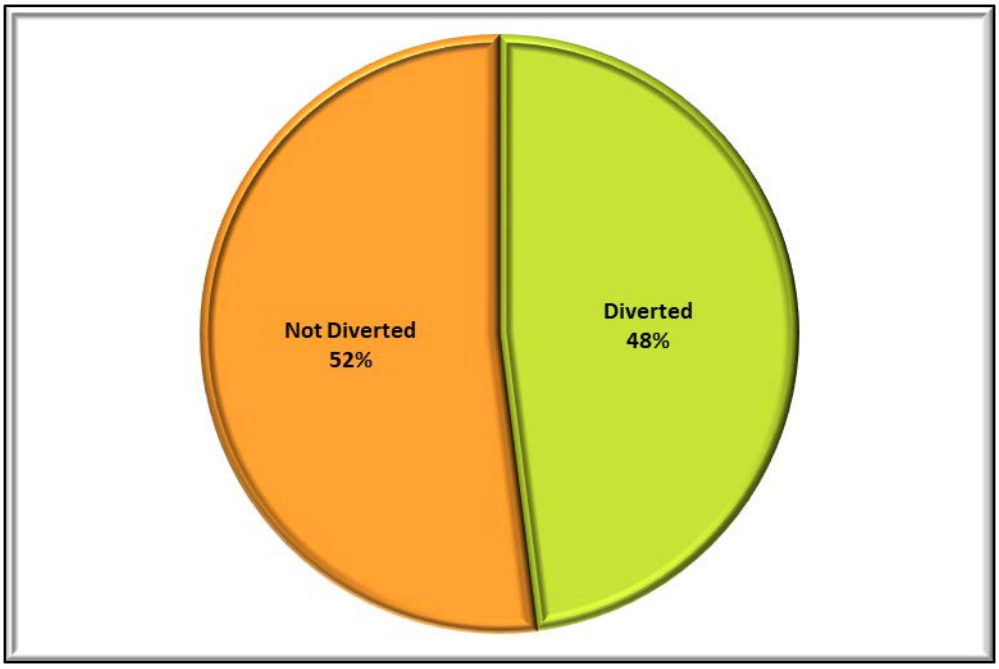
Hispanics/Latinx (39.0%) and White/Caucasians (39.4%) were served the most by the CATT team. Individuals experiencing homelessness accounted for 7.8% of crisis clients, while 1.4% of clients were Veterans.

Community Assessment and Transport Team (CATT)

Diversion from an Inpatient Admission

The CATT team diverts individuals from inpatient admissions. The figures below provide the percentage diverted as well as of the disposition of CATT crisis calls. Homeless outreach and welfare checks were excluded from these analyses. Consumers who refused service (7%, n = 5) were also excluded from the analyses. Individuals were considered diverted if they were returned home with a safety plan, were sent to the MHUC, or other community support.

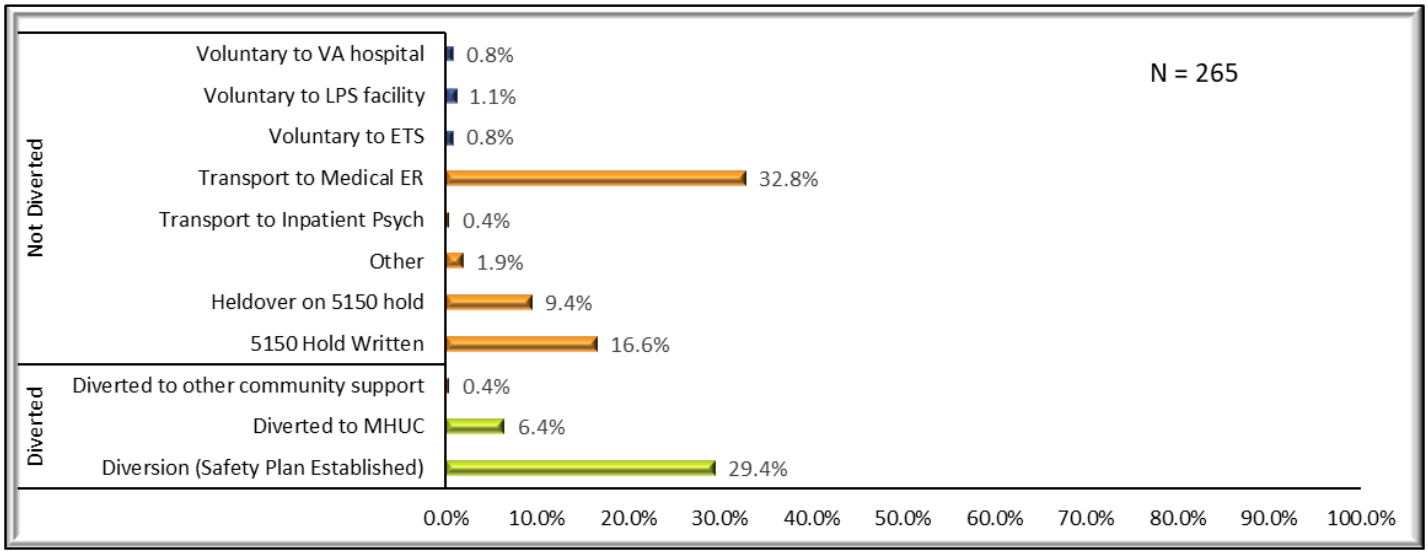
Percentage of Crisis Requests Diverted



CATT was able to divert 48% of Crisis calls.

The figure below provides the dispositions for crisis contacts.

Disposition of Crisis Requests

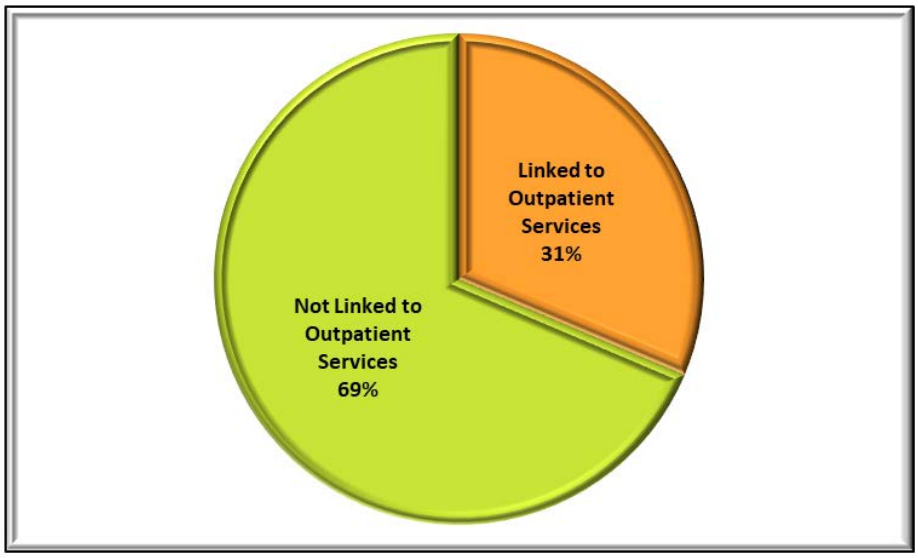


Community Assessment and Transport Team (CATT)

Linkage to Outpatient Services

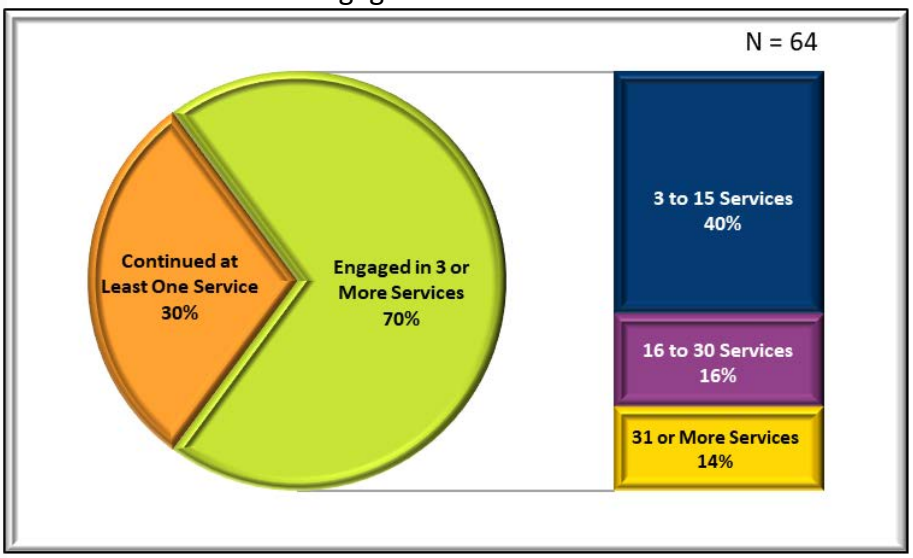
In addition to diverting individuals from an inpatient admission, the CATT team connects individuals to outpatient services. RUHS-BH service data was used to examine service usage after contact with the CATT team. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for CATT clients



Almost a third (31%) of individuals served by the CATT team were linked to outpatient services after contact with teams. Some of the individuals who were linked to outpatient services (n = 29) were already participating in outpatient services prior to their contact with the CATT team.

Engagement in Services



The majority (70%) of CATT clients linked to outpatient services engaged in three or more services. For clients with 3 or more services, the average number of services was 22.

Recidivism Rates for CATT

Days to Readmission	%
0 to 15 Days	16.51%
16 to 30 Days	0.92%
0 to 30 Days	17.43%

Recidivism

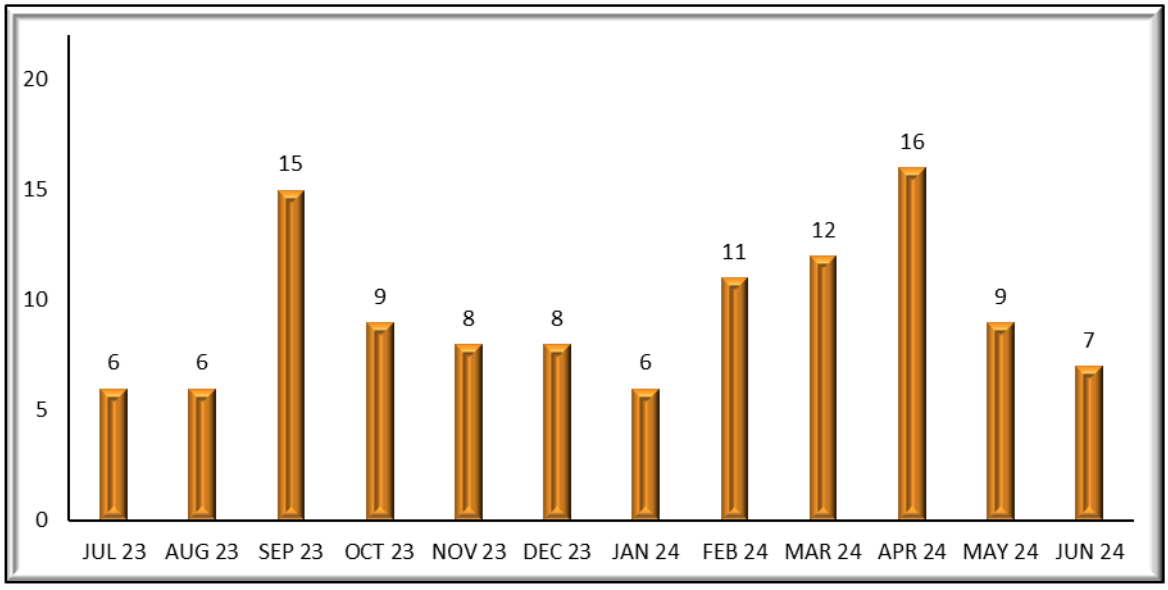
The table to the left provides the recidivism rates for the CATT team.

Behavioral Health Justice Intervention Services (BHJIS)

Behavioral Health Justice Intervention Services (BHJIS) teams provide responsive crisis intervention support to students, reduce unnecessary hospitalizations and arrests, and connect students with on-going supports and services. Two RUHS-BH clinicians provide crisis services at four college campuses: College of the Desert, Riverside Community College, Riverside Community College-Moreno Valley Campus, University of California, Riverside (UCR). BHJIS began providing services in February of 2023. BHJIS had 113 Crisis contacts during the 2023-2024 Fiscal Year.

BHJIS Crisis Contacts	
113	
College of the Desert	70
RCC - Mo Valley	13
RCC - Norco	9
RCC - Riverside	12
UC Riverside	9

Number of Crisis requests for BHJIS



Behavioral Health Justice Intervention Services (BHJIS)

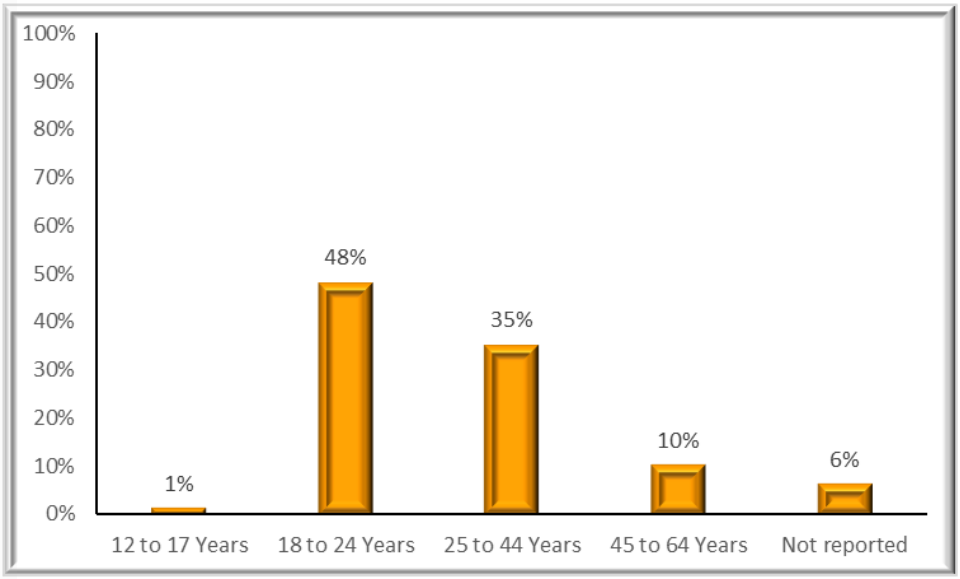
Demographics

BHJIS provided Crisis services to 102 individuals during the 2023-2024 fiscal year. BHJIS teams provided crisis services to more females (53%) than males (45%) Two percent of individuals served by BHJIS teams (n = 2) identified as transgender.

Gender of BHJIS Crisis clients

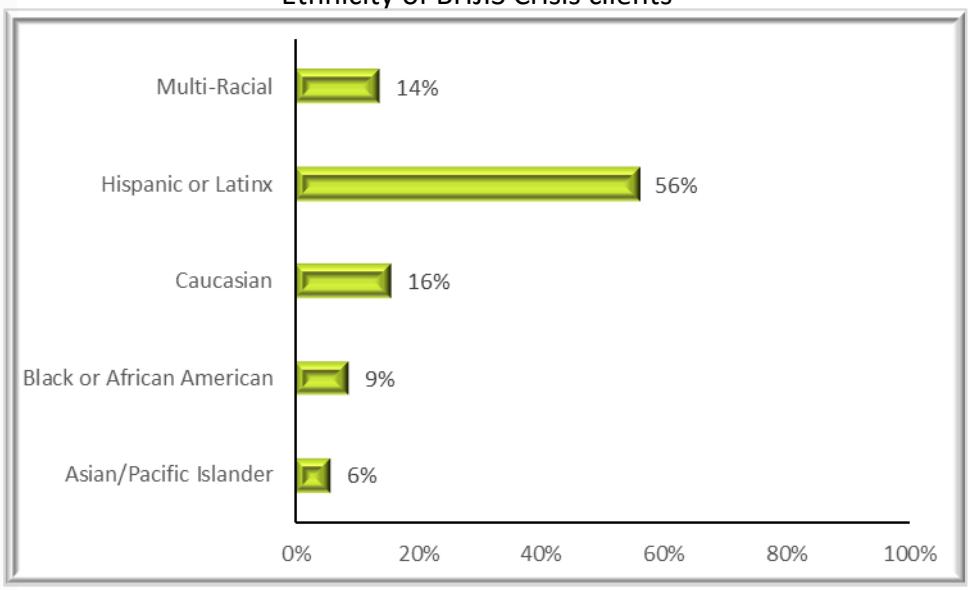
Gender	N	%
Male	46	45%
Female	54	53%
Transgender	2	2%
Total	102	100%

Age of BHJIS Crisis clients



Forty-eight percent (48%) of BHJIS crisis clients were age 18 to 44. Age was not reported for 6 clients.

Ethnicity of BHJIS Crisis clients



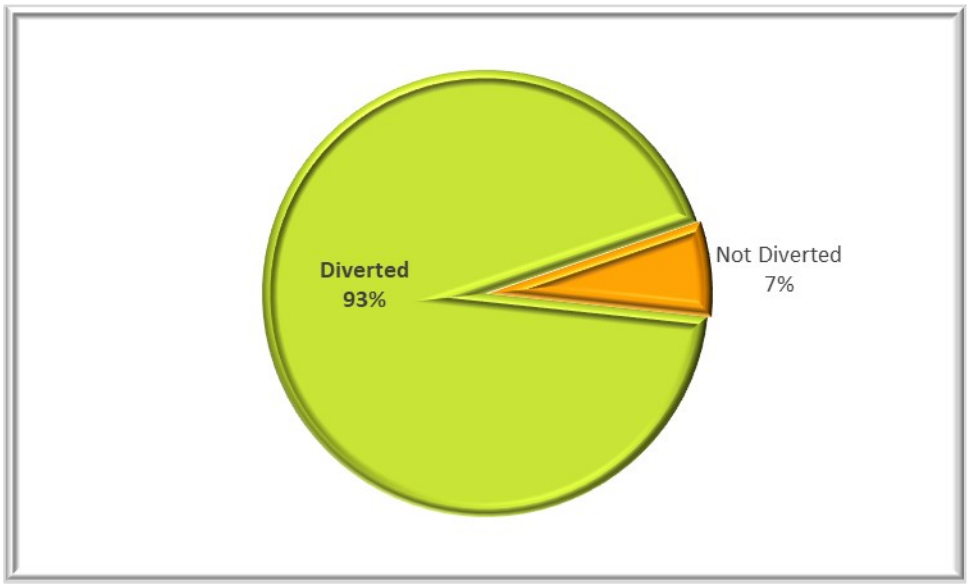
The majority of BHJIS crisis clients were Hispanics/Latinx (56%). Seventeen percent (17%) of BHJIS crisis clients reported experiencing homeless and 7% of clients were Veterans.

Behavioral Health Justice Intervention Services (BHJIS)

Diversion from an Inpatient Admission

BHJIS teams divert individuals from an inpatient admission when possible. The figures below provide the percentage diverted as well as of the disposition of BHJIS crisis calls. Non-crisis contacts were excluded from these analyses. In addition, consumers who refused service (4%, n = 5) or who were arrested (2% n = 2) were also excluded from the analyses. Individuals were considered diverted if they returned home with a safety plan, went to the MHUC, or other community supports.

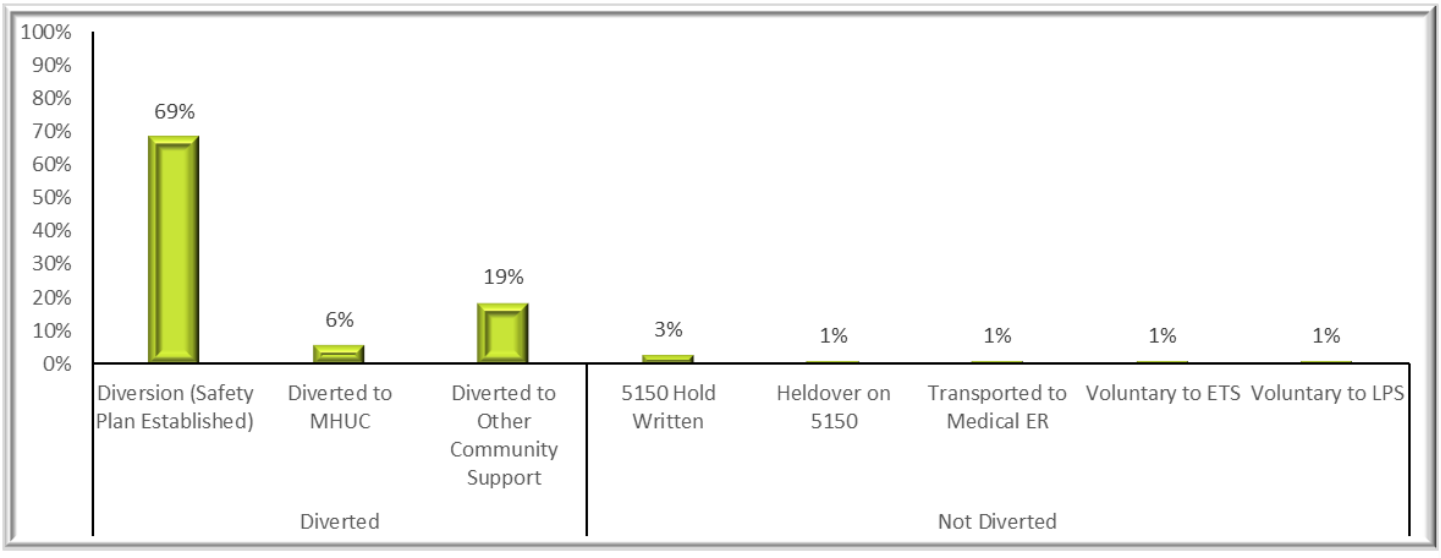
Percentage of Crisis Requests Diverted



BHJIS was able to divert 93% of crisis contacts.

The majority (93%) BHJIS crisis contacts were diverted to home, to an MHUC, or to other community supports.

Disposition of Crisis Requests



Behavioral Health Justice Intervention Services (BHJIS)

Linkage to Outpatient Services

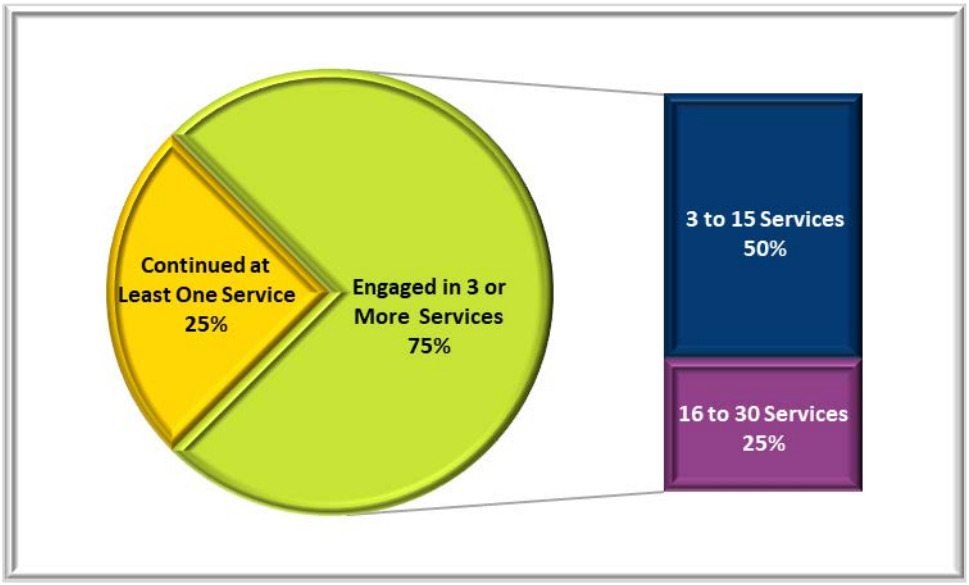
In addition to diverting individuals from an inpatient admission, BHJIS teams connect individuals with outpatient services. RUHS-BH service data was used to examine service usage after contact with BHJIS teams. Clients were considered to be linked to outpatient services if they had an outpatient, substance use, or youth short-term residential program service record. Individuals who were recorded as having private insurance were excluded from these analyses.

Outpatient Linkage for BHJIS clients

Outpatient Services	N	%
Linked to Outpatient Services	8	8%
Not Linked to Outpatient Services	94	92%

Eight percent (8%) of individuals served by BHJIS teams were linked to outpatient services after contact with teams. Some of those linked to outpatient services (n =3) were already participating in outpatient services prior to contact with teams.

Engagement in Services



The majority (75%) of those linked to outpatient services engaged in more than one service.

Readmission Rates for BHJIS	
Days to Readmission	%
0 to 15 Days	6.00%
16 to 30 Days	-
0 to 30 Days	6.00%

Recidivism

The table to the left provides the recidivism rates for BHJIS teams.

Mental Health Urgent Care (MHUC)

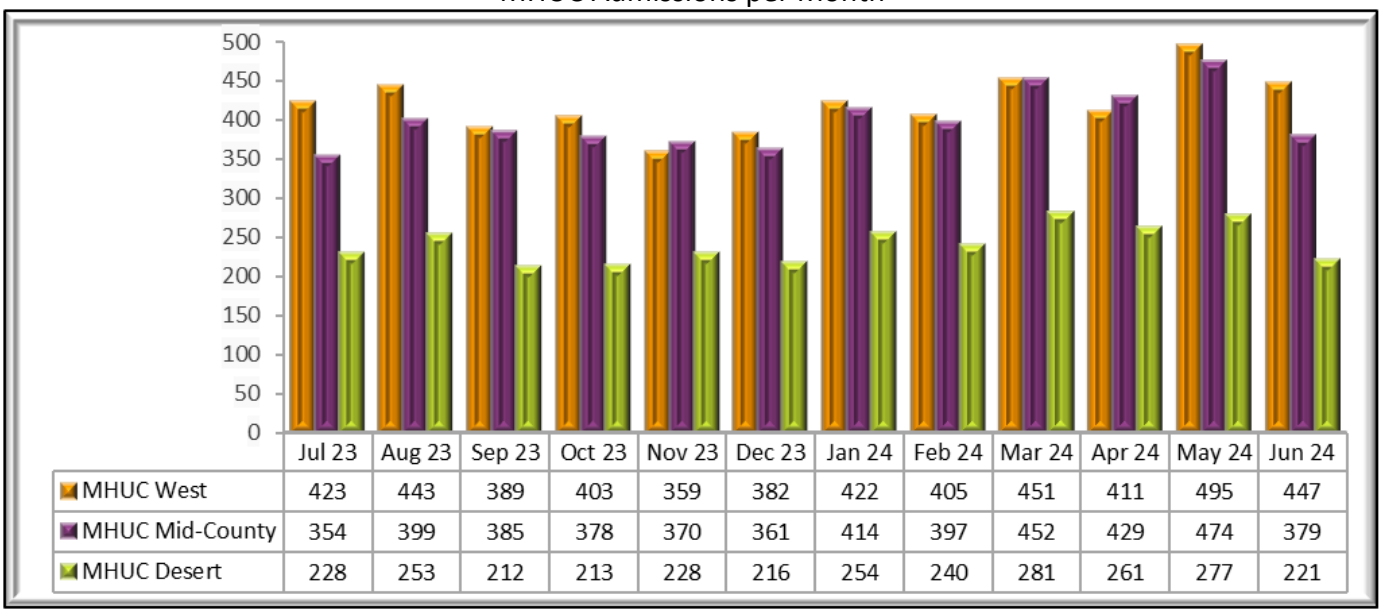
The Crisis Support System of Care includes three regional Mental Health Urgent Care (MHUC) facilities (Riverside, Perris, and Palm Springs). Individuals experiencing a mental health crisis can walk-in to an MHUC and receive individualized support 24 hours a day, 7 days a week. Staffed by a competent, caring team, MHUCs provide a safe, supportive, recovery-oriented environment. The MHUC offers a variety of services such as assessment, peer support, psychiatric and medication support, recovery education, community coordination and follow-up. The MHUCs serve individuals 18 years and older, while the Desert and Mid-County MHUCs serve adolescents 13 years and older.

Admissions

During the 2023/2024 fiscal year, MHUCs had a total of 12,706 admissions (July 1, 2023-June 30, 2024) and served 6,630 unduplicated clients. The figure below provides the MHUC admission per month for each MHUC.

MHUC Admissions 12,706	
MHUC West	5,030
MHUC Mid-County	4,792
MHUC Desert	2,884

MHUC Admissions per Month



	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
MHUC West	423	443	389	403	359	382	422	405	451	411	495	447
MHUC Mid-County	354	399	385	378	370	361	414	397	452	429	474	379
MHUC Desert	228	253	212	213	228	216	254	240	281	261	277	221

Mental Health Urgent Care (MHUC)

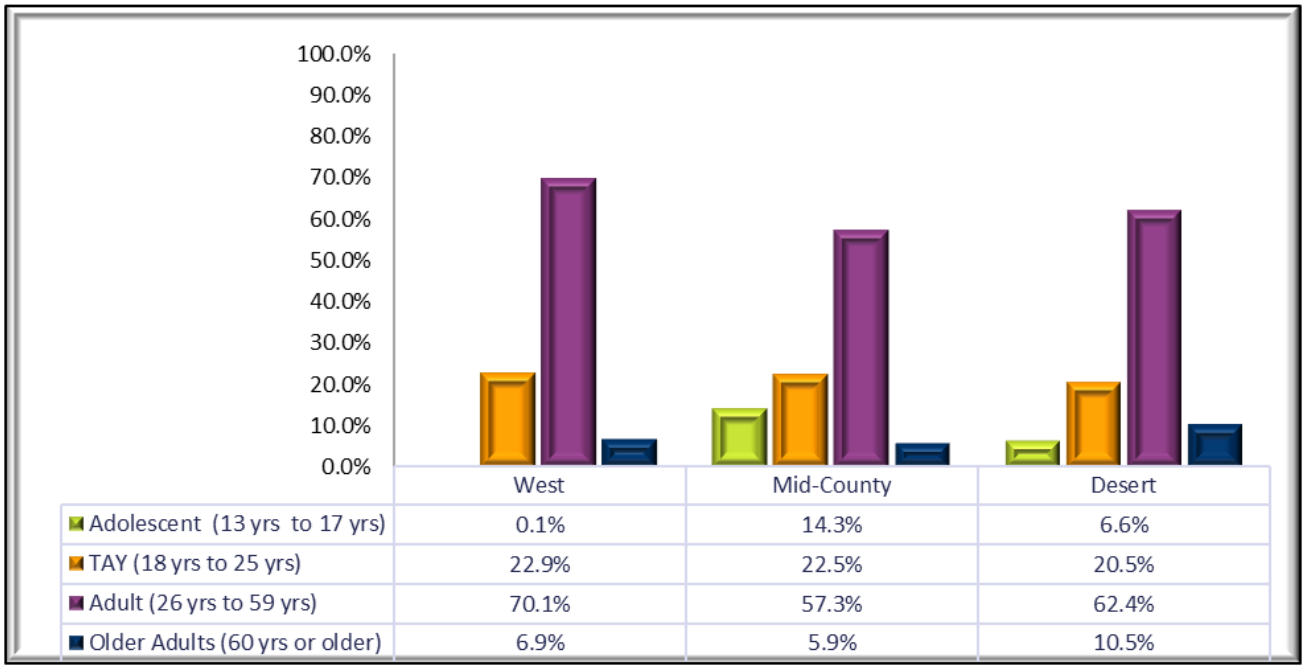
Demographics

MHUC facilities served 6,630 individuals during the 2023/2024 fiscal year. All three MHUCs served more male than female clients. Gender was not reported for 3 individuals.

	Gender		
	Male	Female	Not reported
MHUC	N (%)	N (%)	N (%)
West	1488 (64.1%)	833 (35.9%)	-
Mid-County	1366 (51.1%)	1305 (48.8%)	3 (0.1%)
Desert	905 (55.4%)	730 (44.6%)	-

The Mid-County and Desert MHUCs serve clients 13 years and older, while the West MHUC serves clients 18 years and older. Age was not reported for 2 clients.

Age of MHUC Clients



Ethnicity	West	Mid-County	Desert
Am. Indian/Alaska Native	0.6%	0.4%	1.0%
Asian/Pacific Is.	2.7%	16.5%	1.5%
Black/African Am.	13.0%	13.1%	9.0%
Hispanic/Latinx	22.8%	15.0%	43.4%
Not reported	36.2%	29.1%	3.2%
White/Caucasian	24.8%	25.8%	41.9%

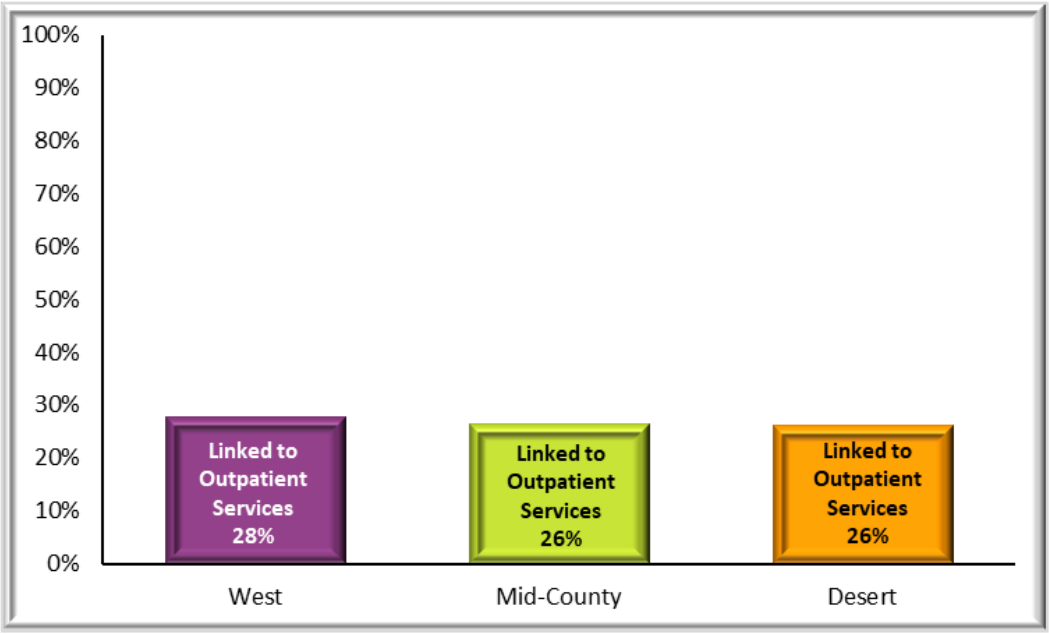
The MHUC Desert had the highest percentage of Hispanic/Latinx clients (43.4%).

Mental Health Urgent Care (MHUC)

Linkage to Outpatient Services

The MHUCs assist consumers at discharge with linkage to outpatient services. Overall, 27% of those served by MHUCs, were linked to outpatient mental health/substance use services. The figure below provides the percent of individuals linked to outpatient mental health/substance use services after an admission at one of the county's MHUCs. Some individuals (n = 22 or 1%) were placed in a County short term Crisis Residential program (CRT) following their MHUC admission.

Percentage of MHUC Clients Linked to Outpatient Services



Recidivism

Recidivism rates for each of the three MHUCs are shown in the table below. Percentages are discharges from the MHUC followed by another admission for the same client 15 days or less or 16 to 30 days after an MHUC admission. Recidivism rates for 15 days or less were highest for the Western MHUC (33%).

Recidivism Rates for MHUCs

Days to Readmission	West	Mid-county	Desert
0 to 15 Days	33%	21%	20%
16 to 30 Days	8%	6%	7%
0 to 30 Days	41%	27%	27%

Crisis Residential Treatment Facilities (CRT)

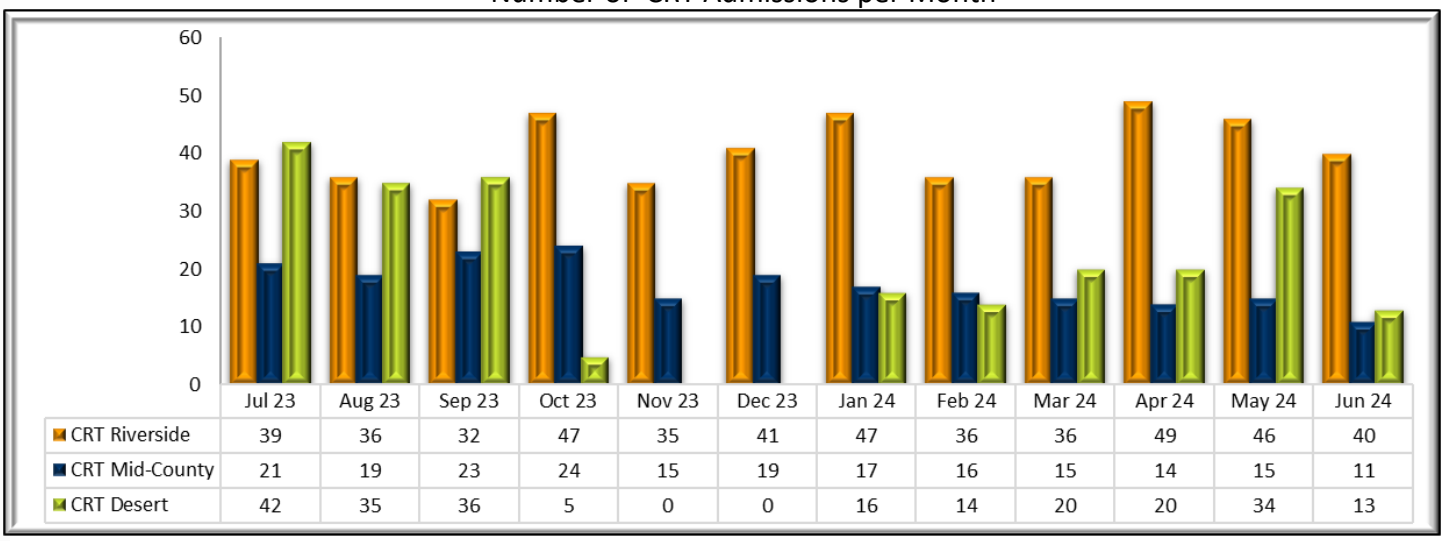
The voluntary Crisis Residential Treatment Facilities (CRT) provide enriched recovery based peer-to-peer support and interventions with the goal of stabilizing clients in acute crises, eliminating or reducing the need for inpatient hospitalization. Located in each of the three county regions, CRTs are designed to provide a home-like service environment. Each facility has a living room set up with smaller activity/conversation areas, private interview rooms, a family/group room, eight (8) bedrooms, laundry and cooking facilities, and a separate garden area. Individuals may stay at the facility for up to 14 days.

Admissions

The CRT facilities had 928 admissions during the 2023/2024 Fiscal Year. The figure below provides the number of CRT admissions per month for each CRT for the 2023/2024 fiscal year. The Mid-County CRT began serving clients in August 2021.

CRT Admissions 928	
West CRT (Lagos)	484
Mid-County CRT (Jackson House)	209
Desert CRT (Indio)	235

Number of CRT Admissions per Month



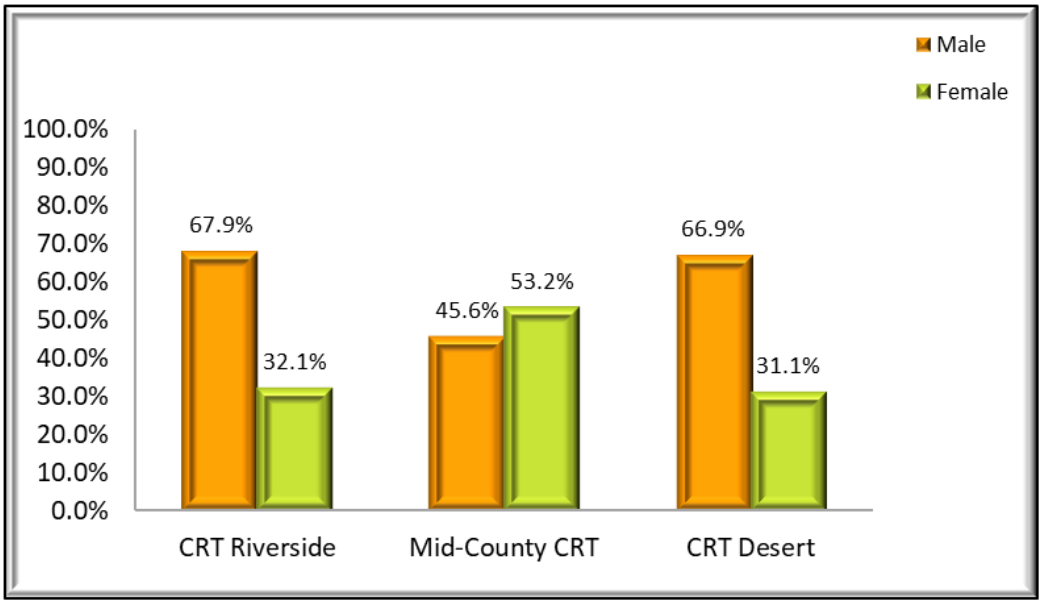
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
CRT Riverside	39	36	32	47	35	41	47	36	36	49	46	40
CRT Mid-County	21	19	23	24	15	19	17	16	15	14	15	11
CRT Desert	42	35	36	5	0	0	16	14	20	20	34	13

Crisis Residential Treatment Facilities (CRT)

Demographics

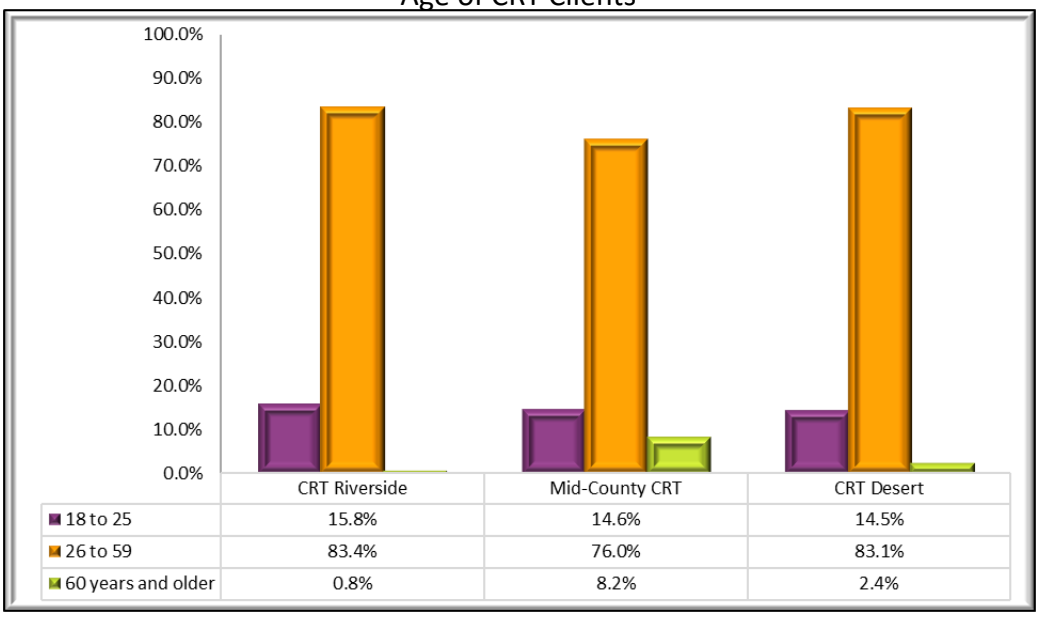
The CRT facilities served 815 individuals during the 2023/2024 fiscal year.

Gender of CRT Clients



More males than females were served by the Western and Desert CRTs. Gender was not reported for 2 individuals.

Age of CRT Clients



The majority of CRT clients were adults (age 26 to 59 years). Age was not reported for 11 individuals.

Ethnicity	West CRT	Mid-County CRT	Desert CRT
Am. Indian/Alaska Native	0.8%	0.0%	0.6%
Asian/Pacific Is.	1.1%	4.1%	2.4%
Black/African Am.	18.9%	14.0%	16.9%
Hispanic/Latinx	35.8%	27.5%	42.8%
Multi-racial	0.6%	0.6%	0.6%
Unknown	13.0%	6.4%	7.2%
White/Caucasian	29.9%	47.4%	30.1%

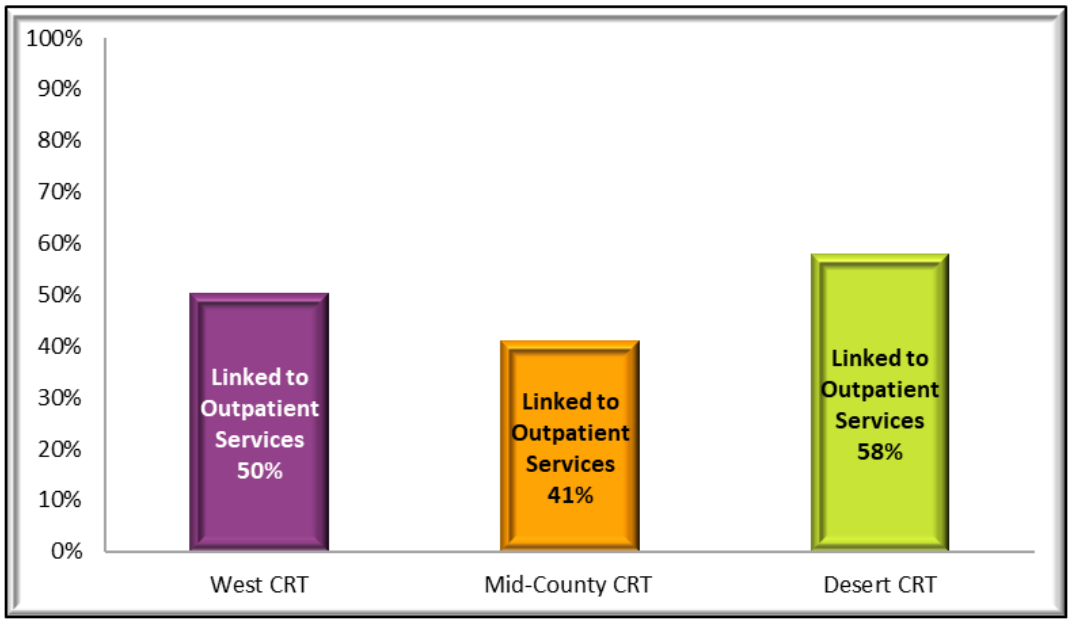
The Desert CRT served the highest percentage of Hispanic/Latinx clients (42.8%), while the Mid-County CRT served the highest percentage of White/Caucasian clients (47.4%).

Crisis Residential Treatment Facilities (CRT)

Linkage to Outpatient Services

The CRTs assists clients at discharge with linkage to outpatient services. The percentage of clients linked to outpatient services after admission to a CRT was highest for the Desert CRT (58%).

Percentage of Clients Linked to Outpatient Services



Recidivism

Recidivism rates for the CRTs are shown in the table below. Percentages are discharges from the CRT followed by another admission for the same client within 15 days, 16 to 30 days, and 30 days or less. The Desert CRT had the highest rate of readmission for 15 days or less (8%).

Recidivism Rates for CRTs

Days to Readmission	West	Mid-County	Desert
0 to 15 Days	7%	4%	8%
16 to 30 Days	6%	3%	4%
0 to 30 Days	12%	7%	12%

GSD: Mental Health Court and Justice Involved

Incompetent To Stand Trial (IST):

For FY 23/24, Riverside County has 168 individuals who were found incompetent to stand trial and are awaiting transfer to a State Hospital for competency restoration with Felonies. These individuals spend an average of 3 months in Riverside County Jail waiting for an available State Hospital bed. The County's mission is to provide intensive community-based psychiatric treatment for these individuals. Rather than allowing them to remain in custody awaiting transfer to a State Hospital for competency restoration, they will be transferred to residential mental health treatment step-down programs where they will receive a wide array of behavioral health services. The ultimate purpose of this program is not restoration for adjudication but rather long-term psychiatric stabilization such that following completion of the Felony Incompetent to Stand Trial (FIST) program, one's legal charges can be dismissed, and he or she may reside in the community with on-going supportive behavioral health services.

During this review period, the IST Diversion program received 40 referrals, of which nine candidates were found to meet the requisite criteria and were accepted into the program. A frequent challenge encountered by behavioral health staff during the assessment and review process is finding out that the client has no interest in receiving mental health/medication services. Knowledge of this is a determining factor for the Court and often leads to a swift rejection of the program so that the Department of State Hospitals is aware that the person will not be diverted and to move forward with placement at one of their facilities.

Laura Law's

The Assisted Outpatient Treatment (AOT) Program, also known as Laura's Law, is a community-based referral initiative for immediate family members, treatment agencies, licensed mental health professionals, peace officers, and judicial officers who believe that someone they know could benefit from court-ordered mental health or substance use services. In this process, a clinical therapist, case manager, and peer support specialist team will engage the consumer and provide outpatient services tailored to their needs. Suppose the consumer continues to decline efforts to involve them in outpatient services. In that case, AOT staff may escalate the referral to the AOT Review Committee and AOT Psychologist for further assessment and decision-making. Suppose the AOT Committee and Psychologist determine that court-ordered services are needed to stabilize the consumer in the community. In that case, a petition will be filed by County Counsel in Civil Court. Should the Court approve the treatment plan submitted with the petition, it will order the consumer to adhere to and participate in the recommended plan for up to six months.

During this reporting period, the AOT program received 99 referrals, of which 13 consumers accessed outpatient services voluntarily, and one was linked through Civil Court proceedings.

HOME (Homeless Outreach, Mediation, and Education) Court –

is an alternative sentencing program developed for those facing criminal prosecution and suffering from homelessness. The program promotes community-based treatment to assist those individuals struggling with homelessness, who are in imminent danger of becoming homeless, and who are facing prosecution for quality-of-life infractions, misdemeanors, and low-level felonies. The overall goal of this program is to reduce recidivism and protect public safety by collaboratively working together with our justice partners, to address and treat the underlying needs of the participants through engagement in FSP-level services, intensive case management, and ongoing support from all members of the program, to ensure that each participant has the resources and opportunity they need to succeed in the community. This will be accomplished by recognizing each participant's accomplishments and efforts to resolve their cases and work towards reintegration as a successful and productive community member. While in the program, participants will focus on gaining residential stability, employment and/or education, substance and mental health rehabilitation, learning life skills, counseling, and family reunification. Throughout FY 23/24, the HOME Court program received 102 referrals from the court.

Overall Program Challenges: Obtaining housing for our consumers participating in the various Mental Health Court programs continues to be a challenge. We are often presented with individuals who are coming directly out of our community jails, who have no income or credit, and/or criminal charges, which causes landlords in an already tight housing market to not rent to them. There is also a constrained supply of beds for individuals for whom we seek institutional housing (such as adult residential facilities).

CARE (Community Assistance, Recovery, and Empowerment) Act

The CARE Act will ensure mental health and other support services are provided to the most severely impaired Californians who too often languish without the treatment they desperately need. CARE will divert and prevent more restrictive conservatorships or incarceration to connect a person in crisis with a court-ordered CARE plan or agreement for up to 12 months, possibly extending for an additional 12 months. Individuals engaged in CARE plans and agreements may be prioritized for various services and programs, including supportive housing. The design of the CARE Act provides support and accountability for individuals with severe, untreated mental illnesses, as well as for local governments responsible for providing behavioral health services. The CARE process functions as a structure for counties to intensively engage individuals who may need additional support to access services consistently over a sustained period.

Specifically, the CARE Act allows certain people, called "petitioners," to request court-ordered treatment, services, support, and a housing plan for certain people 18 years of age or older, called "respondents," who have untreated severe mental illnesses, specifically schizophrenia or another psychotic disorder, and who meet certain health and safety criteria. Petitioners are encouraged to consider alternatives to CARE Act proceedings before filing a petition.

The CARE Act started in Riverside County on October 1, 2023. Over the course of FY 23/24, the CARE Act received 118 Civil Court petitions and 215 Integrated Referrals to assist in linking to it.

Collaborative Courts

Mental Health Court Program:
Riverside County's first Mental Health Court program came into existence in November 2006 under Proposition 63, MHSA funding, and is in the Downtown Riverside area. The Mental Health Court program expanded its service area to include the Desert Region in 2007 and the Mid-County Region in 2009. The Mental Health Court program is a collaborative effort between Riverside University Health System Behavioral Health (RUHS – BH) and our partners in the Riverside Superior Court, Riverside County Public Defender and District Attorneys' offices, local private attorneys, Probation Department, Family Advocate, RUHS-BH community services, as well as private insurance services. Together with our partners, we work to develop a comprehensive 12-month program for each participant (must be at least 18 years of age) consisting of a stable place for the person to live, linkage to outpatient/community services to address their mental health/substance use treatment needs, as well as frequent oversight by the Probation Department and the Court. During FY 23/24, there were a total of 149 referrals received across all three regions, of which 40 were accepted into the program and a total of 76 successfully "promoted" from the program. Certain criteria must be met for the court to consider a participant ready to "promote" from the Mental Health Court program. The criteria require that a participant have a stable place to live, be actively engaged in their outpatient treatment for at least 90 consecutive days, have not produced a positive urinalysis over the last 90 days, and have never been charged with a new crime during their time in the program.

Additional programs under the Mental Health Court include Mental Health Diversion, Veterans Treatment Court, and Military Diversion.

Mental Health Diversion Program:
On July 1, 2018, Penal Code 1001.36, also known as Mental Health Diversion, came into effect as Governor Brown signed the budget. With the passage of this new pretrial diversion law, individuals who are accused of committing a crime may now be eligible to postpone any further action from taking place in their case(s), instead of receiving mental health treatment. During FY 23/24, the Mental Health Court received 641 referrals across all regions from the Riverside County Superior Court to assess individuals and assist the court in determining whether the person met the necessary criteria to be considered eligible for Mental Health Diversion.

As part of the assessment process, Mental Health Court staff will provide the court with a detailed treatment plan, which outlines recommended services for the individual and available housing options. Of the 641 referrals received, the court granted Mental Health Diversion in 226 cases. Because the Mental Health Diversion program may last anywhere from 12 – 24 months, the treatment plan prepared by Mental Health Court staff must also consider this

time when being developed. Should the court find the person eligible for the program and adopt the recommended treatment plan, Mental Health Court staff then work towards implementing the said treatment plan and provide follow-up case management services while the person is in the program. While in the program, participants are expected to be actively engaged in their treatment, remain abstinent from all illicit substances and alcohol, as well as report to the court at least every 30 – 90 days for a progress hearing. During this reporting period, 41 participants completed the Mental Health Diversion program, allowing them to have their charges dismissed and their arrest records sealed.

Veterans Treatment Court/Military Diversion

Veterans Treatment Court continues to positively impact the lives of the men and women who so valiantly served our country, along with those closest to them and the communities in which they live. From July 1, 2023, through June 30, 2024, the Veterans Treatment Court program received 59 new referrals. In addition, 166 referrals were received to assess Active Duty, Reserve, and Veterans interested in the Military Diversion program, which is also offered through the Veterans Treatment Court. Unlike Veterans Treatment Court, Military Diversion allows participants to enter the program without having to plead guilty, which is a unique benefit as it will enable those on Active Duty and in the Reserves to remain serving while they are also receiving treatment. During FY23/24, 82 participants graduated from Veterans Treatment Court or Military Diversion.

Incompetent to Stand Trial (IST) Diversion program

Screening and Assessment

The Incompetent to Stand Trial (IST) Diversion program provides services to justice-involved individuals who are at least eighteen (18) years of age, are being charged with felonies, and have been found incompetent to stand trial by the court. The process begins when a client's defense counsel formally declares a doubt on the record regarding the client's legal competence. The court then appoints at least one doctor (psychologist) to assess the client and determine whether the client is incompetent to stand trial. Should the appointed doctor(s) confirm that the client cannot stand trial, the court will refer the client to the Incompetent to Stand Trial (IST) program for a treatment and placement options recommendation.

Upon referral from the Presiding Judge, the IST clinician will assess the criminal justice-involved individual, either in custody or out, determine the appropriate level of mental health treatment, utilize the HC-20 risk assessment tool, and complete an initial treatment plan to be approved by the Judge. This treatment plan may include a referral to the Mental Health Rehabilitation Center (MHRC) or outpatient mental health services.

Upon the judge's approval of the initial treatment plan, the IST clinician may either refer the individual for outpatient mental health services and follow-up case management services

through the IST program's case manager or place the individual on the waiting list for a bed at the Mental Health Rehabilitation Center.

Sentencing

Because the court has found the person to be "incompetent to stand trial", all court proceedings are suspended until further notice, so the court is unable to sentence the person to participate in the recommended treatment plan; however, the court can order the person to engage in the recommended treatment plan as part of a pre-trial diversionary program, where the person has the opportunity to receive outpatient treatment instead of remaining in custody. If the treatment plan recommends placement at the MHRC, the court will order the person to be released from jail so that RUHS-BH staff may transport the person to the program.

Follow-up and Placement:

Placement for IST Participants is based on an appropriate level of mental health treatment as recommended to the court by the IST clinician. If outpatient services are recommended, the IST case manager will refer the participant to their local clinic to receive mental health/substance use treatment. The participant will also be ordered to return to court at the Judge's discretion, often every 30-60 days. At that time, the IST clinician or case manager will provide the court with a formal written update outlining the client's progress with their treatment plan.

Areas Served:

The IST Diversion program serves Riverside County and is located in the Forensics Administration offices in Downtown Riverside.

Age Range Served:

The Mental Health Court program services criminal justice-involved individuals ages 18 and beyond.

Field-based services include:

- Assessment to determine whether the client should receive services outpatient or within the state hospital.
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

HOME Court program

Screening and Assessment

Potential clients are screened by the District Attorney, Public Defender, and a Superior Court Judge for participation in the HOME Court.

Upon referral from the Superior Court Judge, the HOME Court (HC) clinician will assess the justice-involved individual, either in custody or out, determine the appropriate level of mental health/substance use treatment, and complete an initial plan for services to be approved by the Judge.

Upon the judge's approval of the initial treatment plan, the HC treatment team will collaborate with the community-based outpatient mental health/substance use programs and formalize the recommended strategy to be included in the terms and conditions of probation.

Sentencing

After a Superior Court Judge reviews the recommended treatment plan, the client is sentenced based on a consensus between the Judge, the District Attorney, the Public Defender, and the Candidate. To participate in HOME Court, clients must agree to the terms and conditions of the sentencing.



Follow-up and Placement:

Placement for HOME Court Participants is based on an appropriate level of mental health/substance use treatment as recommended by the HOME Court treatment team (clinicians and case manager). During the assessment phase, the HOME Court clinician will collaborate with the candidate, significant other, family, and/or friends about mental health/substance use treatment and placement options.

HOME Court collaborates with the Riverside Superior Court and our Colleagues in the District Attorney's and Public Defender's office, Probation Department, and Riverside County Sheriff's to address the assessment, sentencing, and placement of criminal defendants suffering from mental health/substance use issues to decrease jail recidivism, provide linkage for mental health/substance use treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance through additional case management services and support from the Riverside County Probation and Sheriff's Department.

Areas Served:

HOME Court program is broken up into four smaller programs designed to cover the whole of Riverside County as follows:

- Riverside HOME Court: Covers the Western region of Riverside County.
- Temecula HOME Court: Covers the Mid-County region of Riverside County.
- Indio HOME Court and Banning HOME Court: Cover the Desert region of Riverside County.

Age Range Served:

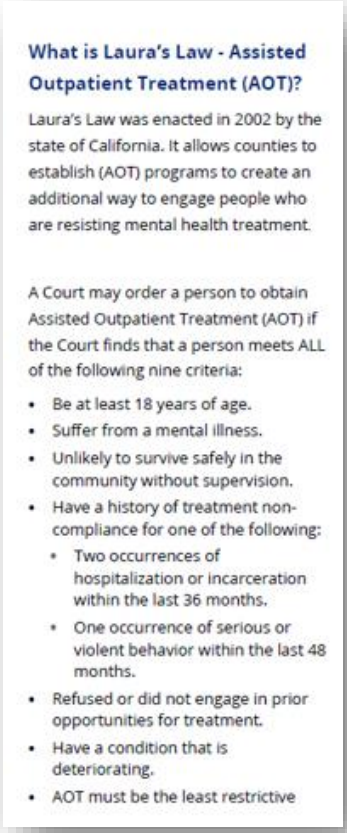
HOME Court program provides services to individuals involved in criminal justice ages 18 and beyond.

Field-based services include:

- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

Laura's Law The Assisted Outpatient Treatment (AOT) program

Laura's Law, also known as Assisted Outpatient Treatment (AOT), is intensive court-ordered community-based treatment for individuals struggling with voluntarily addressing behavioral health symptoms. AOT is only used when an individual has demonstrated difficulty or challenges in voluntarily engaging in behavioral health treatment. AOT serves as a bridge to recovery for those released from inpatient facilities and as an alternative to hospitalization. Assisted outpatient treatment's primary objectives are to re-engage the consumer in behavioral treatment while also helping with the reduction of re-hospitalizations, re-incarceration, and homelessness.



What is Laura's Law - Assisted Outpatient Treatment (AOT)?

Laura's Law was enacted in 2002 by the state of California. It allows counties to establish (AOT) programs to create an additional way to engage people who are resisting mental health treatment.

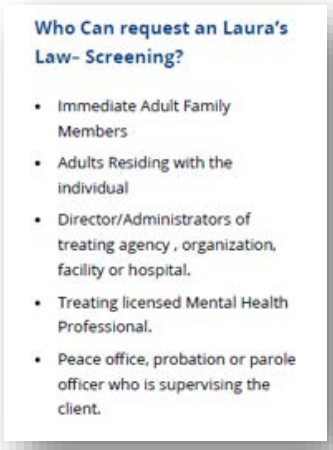
A Court may order a person to obtain Assisted Outpatient Treatment (AOT) if the Court finds that a person meets ALL of the following nine criteria:

- Be at least 18 years of age.
- Suffer from a mental illness.
- Unlikely to survive safely in the community without supervision.
- Have a history of treatment non-compliance for one of the following:
  - Two occurrences of hospitalization or incarceration within the last 36 months.
  - One occurrence of serious or violent behavior within the last 48 months.
- Refused or did not engage in prior opportunities for treatment.
- Have a condition that is deteriorating.
- AOT must be the least restrictive

Riverside University Health System—Behavioral Health (RUHS-BH) staff perform assisted outpatient treatment; referral and linkage are performed to the nearby county-operated outpatient clinic or full-service partnership (FSP).

Laura's Law Program Design/Model

The Laura's Law program is comprised of the following services and curriculum:



Who Can request an Laura's Law- Screening?

- Immediate Adult Family Members
- Adults Residing with the individual
- Director/Administrators of treating agency , organization, facility or hospital.
- Treating licensed Mental Health Professional.
- Peace office, probation or parole officer who is supervising the client.

Mental Health Services

- Behavioral health screening
- Mental health assessment
- Therapy (couple, individual, family)
- Group therapy (PTSD, Anger Management, DBT)
- Case management
- Psychiatric evaluation and medication services

Substance Use Disorder Services

- American Society of Addiction Medicine (ASAM) assessment
- Substance Abuse Intake Assessment
- Therapy (couple, individual, family)
- Psychiatric evaluation and medication services

• Linkage to residential treatment as needed

Program Curriculum	Evidence-Based Rating	Brief Program Description
Anger Management	EBP – Well Supported	Class that helps individuals identify triggers for anger and deal with emotions that may lead to reoffending or relapse. The curriculum includes coping skills to address specific behaviors.
CORE	Emerging Practice	The program combines the ideas of change and recovery to assist the client through the re-entry process. Groups focus on both mental health struggles and substance use issues.
Courage to Change (C2C)	Promising Practice	An interactive journaling system designed to address the "Big Six" criminogenic needs of individuals who are working to successfully reintegrate into their communities.
Criminal and Addictive Thinking (CAT)	Promising Practice	A cognitive-behavioral treatment that focuses on distorted core beliefs to change criminal and addictive thinking patterns which lead to re-offending. This program comes with a corresponding workbook that is completed during the course.
Dialectical Behavioral Therapy (DBT)	EBP – Well Supported	A comprehensive treatment used to address complex mental health problems and regulate emotions.
Educate, Equip, & Support (EES)	EBP – Well Supported	Program offered to parents/caregivers raising a child/youth with mental health and/or emotional challenges. Classes provide parents/caregivers with general education about children's mental health challenges, available supports, and community resources.
Facing Up	Emerging Practice	Class that provides simple suggestions for developing a healthy family environment. Allows caregivers opportunities to share challenges in a supportive environment and discusses how to develop a family wellness plan.
Nurturing Parenting	EBP – Well Supported	An interactive course that helps individuals better understand their role as a parent. Program aims to enhance self-care, empathy, and self-awareness among participants.
Seeking Safety	EBP – Well Supported	Counseling model that addresses trauma and/or post-traumatic stress disorder (PTSD) and addiction exploring the relationship between the two. The curriculum teaches safe

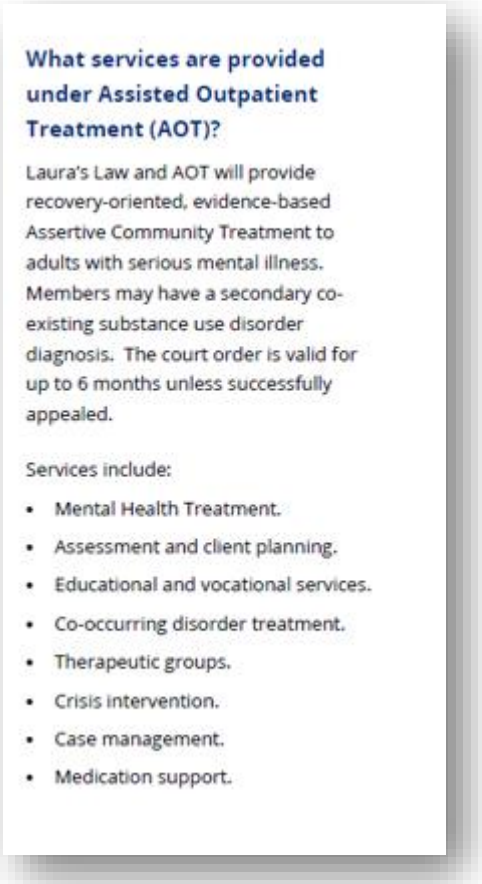
Anticipated changes to Laura's Law Program: RUHS-BH anticipates program growth as the community learns more about the program through our media and marketing outreach, including department social media platforms such as Facebook and Instagram. There have been (12) individuals referred to the Laura's Law program in Riverside County. Over time, we expect the number of individuals referred and treated with the assisted outpatient treatment program to be around 100. Hence, we anticipate additional staffing positions will be required

to ensure caseloads of 10:1 to meet the time and commitment demands to assist individuals in AOT.

Lessons Learned: The positive outcomes or lessons learned thus far is the importance of a strong collaboration with the courts, county counsel, and public defender's office, as well as internal and external partners. In addition, the importance of patient rights advocates in educating the consumers about the Laura's Law program and their rights and offering advocacy to navigate the AOT process. Some challenges are vetting the referrals to explore if a least restrictive approach is available to address the concerns as required by law. The challenge relating to this factor is, at times, the person making the referral (e.g., family or community member) does not understand that Laura's Law has strict guidelines on how to be referred to the court for AOT to ensure voluntary or least restrictive services are considered first.

Progress Data: Laura's Law program outcomes are focused on evaluating changes in a consumer's status relative to several quality-of-life domains. Baseline histories are obtained from consumers at enrollment into the FSP program. Follow-up data is collected continuously for key life events (e.g., hospitalizations) and is assessed periodically for other select life domains. Outcome reporting is based on baseline and post-enrollment status comparisons and measures program effectiveness.

Laura's Law consumers are provided services at New Life FFSP. Below are outcome measures performance for FY 21/22:

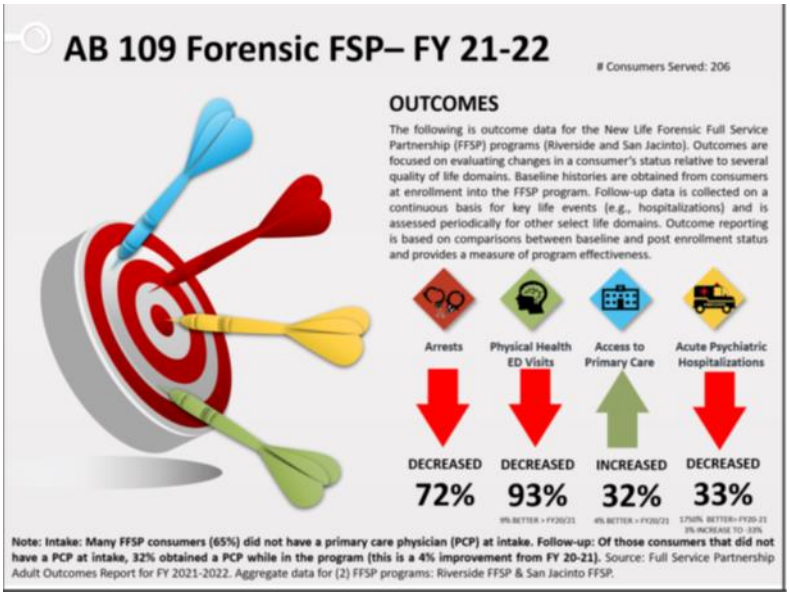


What services are provided under Assisted Outpatient Treatment (AOT)?

Laura's Law and AOT will provide recovery-oriented, evidence-based Assertive Community Treatment to adults with serious mental illness. Members may have a secondary co-existing substance use disorder diagnosis. The court order is valid for up to 6 months unless successfully appealed.

Services include:

- Mental Health Treatment.
- Assessment and client planning.
- Educational and vocational services.
- Co-occurring disorder treatment.
- Therapeutic groups.
- Crisis intervention.
- Case management.
- Medication support.



Outcomes indicate that Laura's Law consumers had a 72% reduction in arrests, a 93% decrease in emergency department visits, a 33% decrease in acute psychiatric inpatient hospitalizations, and a 32% increase in access to primary care.

Referral Information

- To initiate the process of Laura Law referral please call the 24 hours CARES Line number:

  1-800-499-3008
- If appropriate, the LLAOT Screening and Referral Team will conduct the outreach, screening and linkage to services.

In the 2021/2022 fiscal year, more than half of the Laura' Law consumers received 4-7 or 8 or more services a month. The highest average hours of services during the 2020/2021 fiscal year were for mental health group services (27.96 hours), individual mental health services (4.18 hours), and case management (4.26 hours).

3-Year Plans & Goals: The Laura's Law program focuses on (6) primary goals and/or outcome measures:

• Consumer adherence to behavioral treatment in AOT with eventual step-down to voluntary outpatient behavioral health services based on retention and attrition rates
• Increase the number of served to 100 individuals within the 3-year plan
• Reduce hospitalizations
• Reduce arrests
• Reduce physical health emergency admissions
• Reduce mental health emergency department visits
• Increase access to primary care physician

Annual Update: Progress Report on 3-Year Plan

3-Year Plans & Goals: The Laura's Law program focuses on (6) primary goals and/or outcome measures:

• **Goal:** Consumer adherence to behavioral treatment in AOT with eventual step-down to voluntary outpatient behavioral health services based on retention and attrition rates.
Progress Update: In progress. We are continuing to evaluate Laura's Law cases and treatment with the goal of stepdown to voluntary outpatient services. There have been numerous

instances where engagement with our Laura's Law team has led to consumers agreeing to re-engage with outpatient treatment in lieu of their case being sent to courts to mandate treatment.

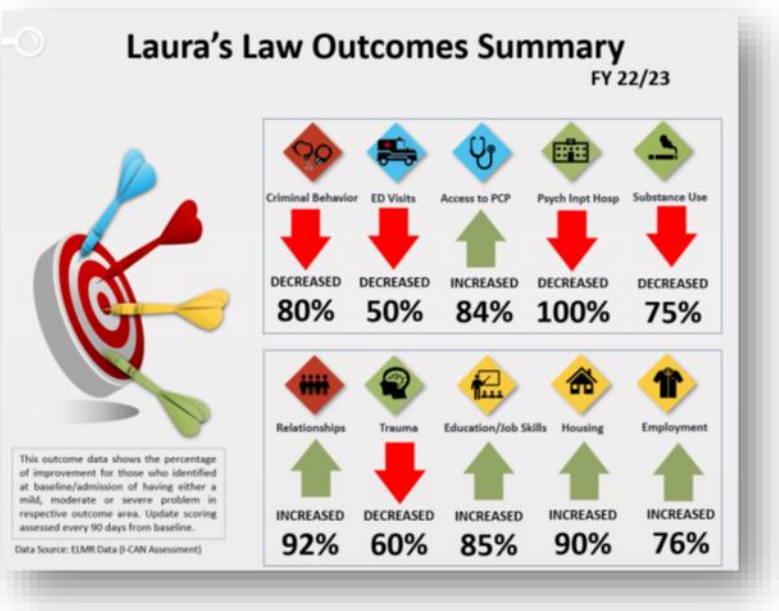
• **Goal:** Increase the number of served to 100 individuals within the 3-year plan. Progress Update: We are on target to surpass our goal of 100 individuals served in Laura's Law within the 3-year plan. We have received (24) referrals for Laura's law in the last two months.
• Goal: Reduce hospitalizations Progress Update: We have prevented psychiatric hospitalizations by 100% by connecting consumers to the least restrictive crisis options, such as linkage to Crisis Stabilization Units, Crisis Residential Treatment, Sobering Centers, and county clinics.

• **Goal:** Reduce arrests Progress Update: We have been able to reduce criminal behavior, including arrests, by 80% compared to consumers' baseline scores.

• **Goal:** Reduce physical health emergency admissions Progress Update: Consumer visits to emergency departments for non-physical health emergencies have decreased by 50%.

• **Goal**: Reduce mental health emergency department visits. Progress Update: This goal was modified and replaced with the following other outcome areas in the table below since the preceding goal above covered the emergency department outcome.
• **Goal**: Increase access to primary care physicians Progress Update: Consumer visits to emergency departments for non-physical health emergencies have improved by 84%.

Below is the Laura's Law Outcomes Summary showing consumer improvements in areas of focus:



Screening and Assessment
Potential referral sources include, but are not limited to, Riverside County Superior Court Criminal/Civil Judges, Attorneys, Law Enforcement, Acute Psychiatric Hospitals, and members of the community.

Upon receipt of a referral, the AOT clinician will attempt to meet with the referred individuals and assess them to determine the appropriate level of mental health/substance use treatment and whether other requisite criteria, such as an unwillingness to engage in outpatient services voluntarily, exist. Suppose the AOT clinician renders a clinical opinion that the client likely meets the necessary criteria for the program. In that case, the case will be forwarded for further review by the AOT Committee. Should the AOT Committee agree with the AOT clinician's findings, the case will be referred to the AOT Psychologist, who will provide a final evaluation of the client and write a formal declaration outlining their conclusions and supporting evidence. The formal declaration is then filed as a petition with the court, who will determine whether the referred individual requires the level of intervention provided by the AOT program.

Sentencing
After a Superior Court Judge reviews the petition and agrees with the findings outlined within, the client is ordered to participate in the treatment plan being recommended for them, which may include but is not limited to, outpatient mental health and/or substance use services.

Follow-up and Placement:
Placement for AOT Participants is based on an appropriate level of mental health/substance use treatment as recommended by the AOT treatment team (clinicians and case manager). During the pre-trial phase, the AOT clinician and psychologist will collaborate with the client, the client's significant other, family, and/or friends about mental health/substance use treatment and placement options.

AOT team collaborates with our outpatient partners/providers to assess those in our community who are suffering from mental health issues to decrease acute hospital utilization and jail recidivism by providing linkage for mental health treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance by implementing intensive case management services.

Areas Served:
The AOT program is broken up into two smaller programs designed to cover the whole of Riverside County as follows:

- Riverside AOT: Covers the Western and Mid-County region of Riverside County.
- Indio AOT: Covers the Desert region of Riverside County.

Age Range Served:
AOT program provides services to mentally ill individuals ages 18 and beyond.

Field-based services include:

- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

CARE Court

Screening and Assessment

Potential referral sources include, but are not limited to, Riverside County Superior Court Criminal/Civil Judges, Attorneys, Law Enforcement, Acute Psychiatric Hospitals, RUHS-BH staff, and members of the community.



Upon receipt of a referral, the CARE court clinician will reach out to the person who made the referral to gather more information and attempt to meet with the referred individuals and assess them to determine the appropriate level of mental health/substance use treatment, and whether other requisite criteria such as an unwillingness to engage in outpatient services voluntarily exist. Suppose the CARE clinician renders a clinical opinion that the client likely meets the necessary criteria for the program. In that case, the clinician will complete the CARE 100 and forward it to the Administrator, who will review it. If approved, the Deputy Director and Assistant Director will send the case for further review. Should the Deputy Director and Assistant Director agree with the findings, the case will be sent to our attorney, who will file the petition with the court.

Petitions are also filed with the court directly from petitioners without going through CARE court staff. Once filed, CARE court receives these petitions along with other documents that need to be completed by CARE court staff.

Sentencing

This is a civil court, and no sentencing is done. A Superior Court Judge oversees the petition and the care plan/agreement and holds RUHS-BH accountable for providing the treatment needed for the client.

Follow-up and Placement:

Placement for CARE Participants is based on an appropriate level of mental health/substance use treatment as recommended by the CARE treatment team and in agreement with the client and attorneys.

CARE court team collaborates with our outpatient partners/providers to assess those in our community who are suffering from mental health issues to decrease acute hospital utilization and jail recidivism by providing linkage for mental health treatment, either in outpatient mental health services, substance abuse services, vocational rehabilitation services or dual diagnosis treatment facilities. The program also strives to increase treatment compliance by implementing intensive case management services.

Areas Served:
The CARE court program is broken up into two smaller programs designed to cover the whole of Riverside County as follows:

- Riverside CARE court: Covers the Western and Mid-County region of Riverside County.
- Indio CARE court: Covers the Desert region of Riverside County.

Age Range Served:
CARE court provides services to mentally ill individuals ages 18 and beyond.

Field-based services include:

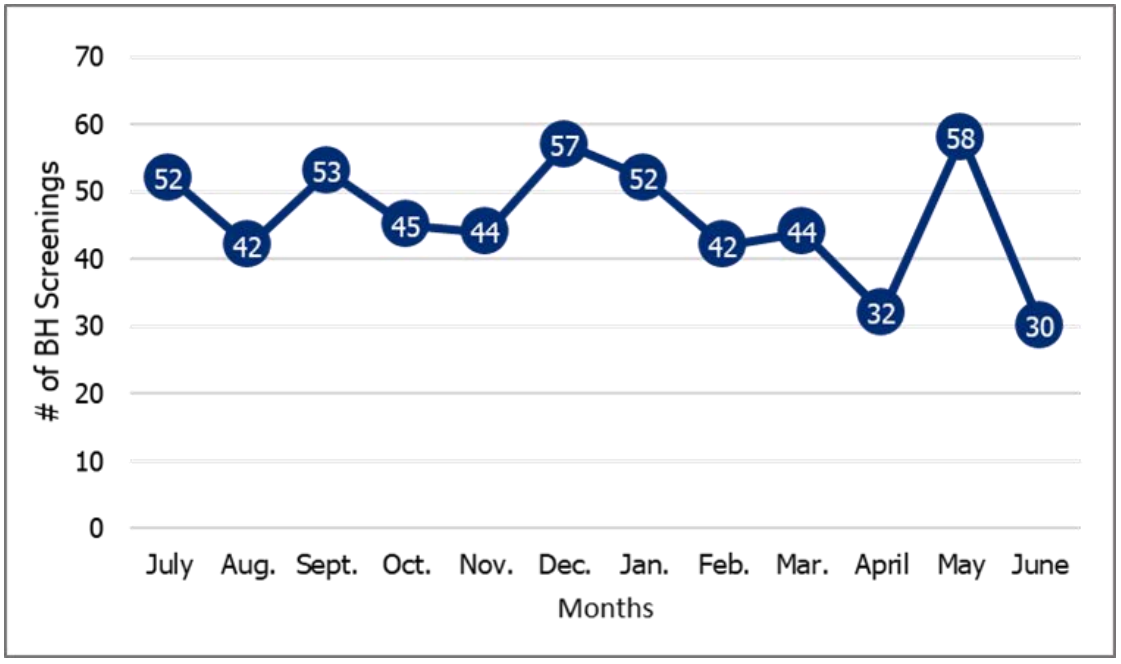
- Assessment to determine program eligibility
- Linkage to outpatient mental health/substance use services and resources
- Follow-up services such as case management and advocacy in the courtroom
- Transportation services to and from various appointments, including but not limited to place of residence, clinic appointments, probation appointments, Social Security/Medi-Cal appointments, and court.
- Housing verification
- Interdisciplinary treatment team meetings

GSD: Juvenile Justice

Behavioral Health Screening

Riverside University Health System-Behavioral Health (RUHS-BH) screens all youth for behavioral health needs at admission into Juvenile Hall. Screening data from Juvenile Justice is collected monthly from the beginning to the end of each calendar month. Between July 1, 2023, and June 30, 2024, 551 screenings were conducted. As shown in **Figure 1**, the number of screenings conducted each month ranged from a low of 30 completed in June to a high of 58 completed in May. Pre-release behavioral health evaluations were also performed for a few youths.

Figure 1: Number of Behavioral Health Screenings Conducted per Month



Behavioral health screenings identify youth with various developmental, behavioral health, and substance abuse issues. **Table 1** shows additional information on screened youth. Very few incoming youth were currently experiencing withdrawal and none were developmentally disabled.

Table 1: Additional Characteristics Screened Youth by Month

	July. 2023	Aug. 2023	Sept. 2023	Oct. 2023	Nov. 2023	Dec. 2023	Jan. 2024	Feb. 2024	Mar. 2024	April. 2024	May. 2024	June. 2024
Substance Abuse History	32	28	33	28	21	26	26	19	18	14	24	13
Current Withdrawal	1	1	1	3	1	1	0	1	0	1	1	0
Developmentally Disabled Youth	0	0	0	0	0	0	0	0	0	0	0	0

Behavioral Health Assessments and Referrals

After screening, some youth are provided with additional assessment services. As shown in **Table 2** below, between 1 and 14 assessments were conducted by RUHS-BH staff monthly within FY 23/24; averaging 3 monthly assessments.

Furthermore, some youth may have already received a behavioral health assessment before their admission into juvenile hall because some youth entering juvenile hall are already receiving behavioral health services when admitted; that information is available to juvenile hall staff via the County Electronic Management of Records (ELMR) system.

Table 2: Number of Assessments Conducted per Month from RUHS-BH Electronic Data System

	July. 2023	Aug. 2023	Sept. 2023	Oct. 2023	Nov. 2023	Dec. 2023	Jan. 2024	Feb. 2024	Mar. 2024	April. 2024	May. 2024	June. 2024
Assessments	3	0	0	1	2	0	1	4	14	6	1	4

Table 3 shows the number of behavioral health referrals, by referral type, that were received each month of FY 23/24 according to the monthly service report. Requests to serve youth come from within the Juvenile Hall itself as well as externally from the court.

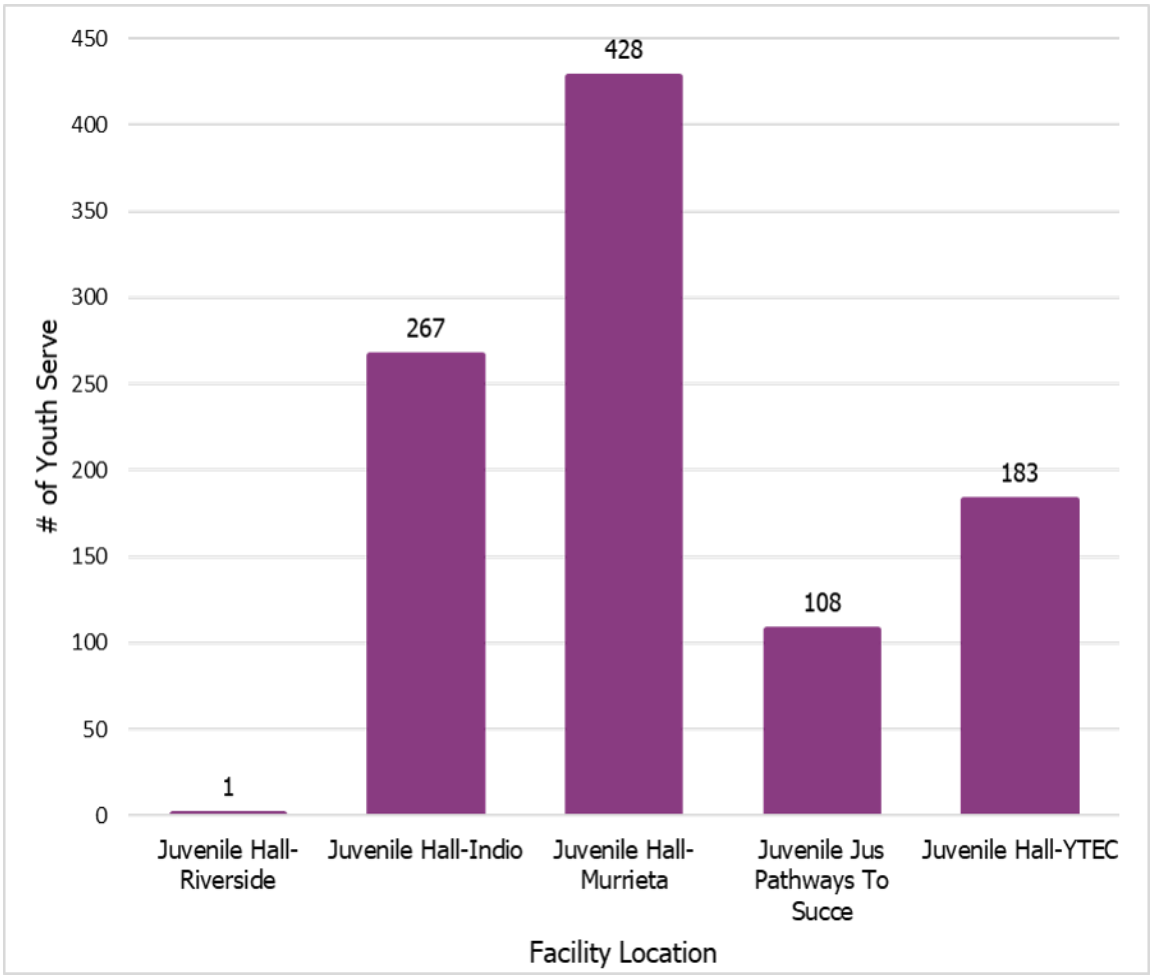
Table 3: Juvenile Hall Referrals per Month

	July. 2023	Aug. 2023	Sept. 2023	Oct. 2023	Nov. 2023	Dec. 2023	Jan. 2024	Feb. 2024	Mar. 2024	April. 2024	May. 2024	June. 2024
Court Referrals	1	1	1	1	0	4	1	1	5	9	17	4
Juvenile Hall Referrals	161	153	103	108	137	113	165	99	142	129	242	117

Behavioral Health Service Data

Service data for all youth served in one of the four Riverside County Juvenile Justice facilities within FY 23/24 was obtained from the RUHS-BH electronic health records (ELMR) system. During FY 23/24, RUHS-BH Juvenile Justice provided behavioral health services to 987 youth. **Figure 2** below shows the number of youth served at each facility. Since, at times, youth are transferred from one facility location to another, youth may be served by more than one facility location over the fiscal year. Also, some youth in the Youth Treatment and Education Centers (YTEC) may start in Juvenile Hall, thus having services in both types of facilities. Due to some youth being served at more than one facility, the total in **Figure 2** below reflects the unique number served at each location and does not sum to the total unduplicated youth (n=647) served within the fiscal year.

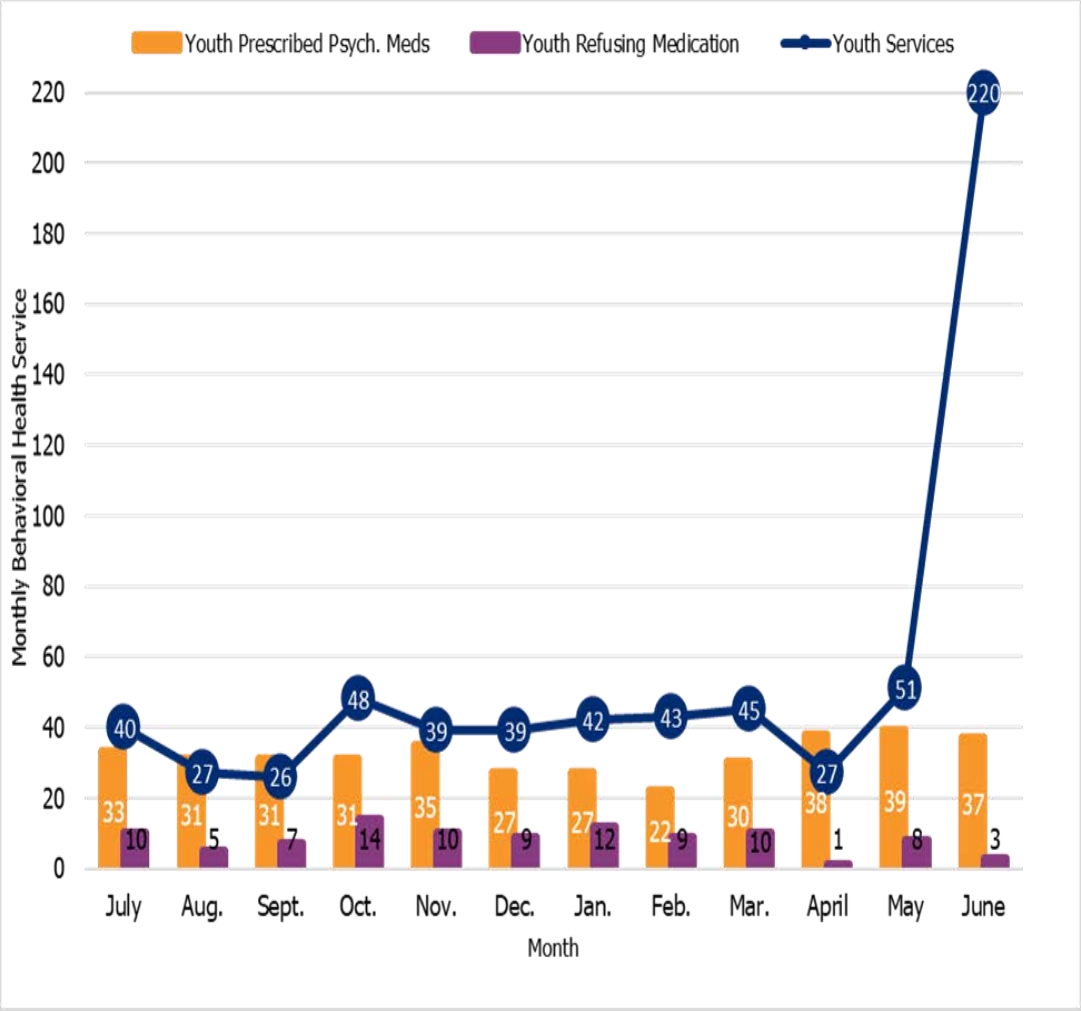
Figure 2. Number of Youth Receiving Behavioral Health Services in FY 23/24 by Facility Location



Behavioral Health Medication Data

Figure 3 illustrates the number of youth served monthly in behavioral health services during FY 23/24. The youth fluctuated between 26 and 220, with notable peaks in October and June. Monthly reports show that 22 to 39 youth were prescribed psychiatric medications, though a portion refused their medication at least once during the month; however, some of those refused their medications at least once during the month.

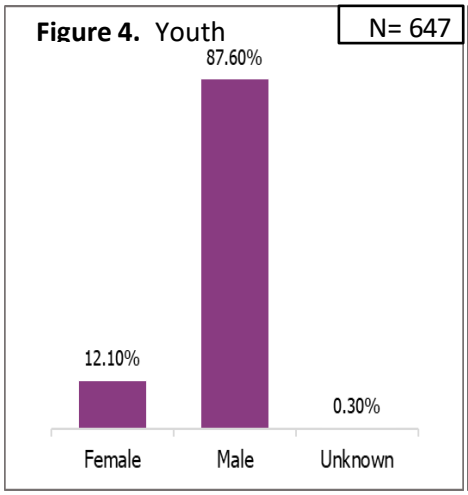
Figure 3. Number of Behavioral Health Cases, Youth Prescribed Medications, and Youth Refusing Medications, per Month

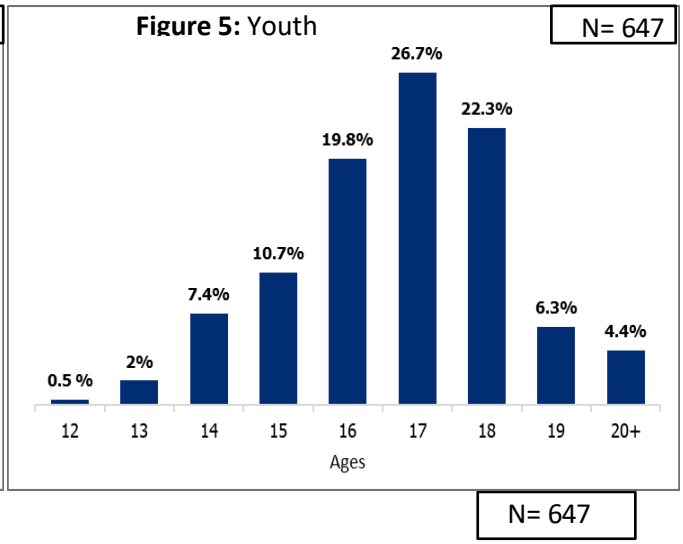


Demographics

Figure 4 shows that during FY 23/24, 87.6% of youth who received services were male, 12.1% were female, and 0.03% were unknown.

Figure 5 illustrates the age distribution of youth served. 68.8% were between the ages of 16 and 18. The largest proportion was 17 years old (26.7%), followed by 16 years old (22.3%). This highlights that there was a concentration of services among older adolescents.

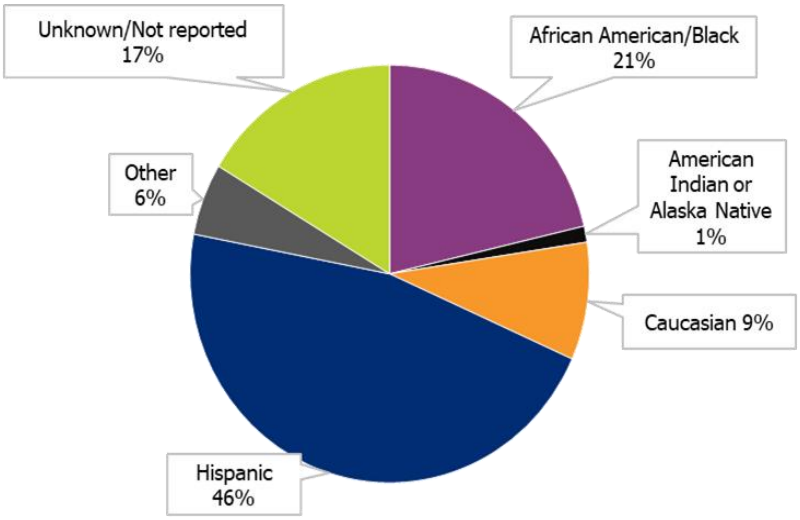




N= 647

Demographic data on the ethnicity of those served within FY 23/24 was gathered from the RUHS-BH electronic health record. As shown in **Figure 6**, the Hispanic/Latino (46%) was the larger group. The next largest reported ethnicities were African American/Black (21%) and 17% unknown/Not Reported. There is some disproportionality of those in Juvenile detention, and that is reflected in the race/ethnicity data for Black/ African American youth, which is a much larger proportion than the 6% of Black/African American youth in the overall County population.

Figure 6. Ethnicity of those Served



Diagnoses

A total of 63% of the 838 youth who accessed RUHS-BH behavioral health services in FY 23/24 had new primary diagnoses available. Since some of the
Youth who were served in juvenile justice had been given more than one primary diagnosis record, and the most recent primary diagnosis is the one that is included in the data reported below.

As shown in **Figure 7**, the most common primary diagnoses were Personality Disorders and Impulse Control, accounting for 50% of the cases. Other prevalent diagnoses include anxiety and Other, both with 13%.

Figure 7. Primary Mental Health Diagnoses of those Served

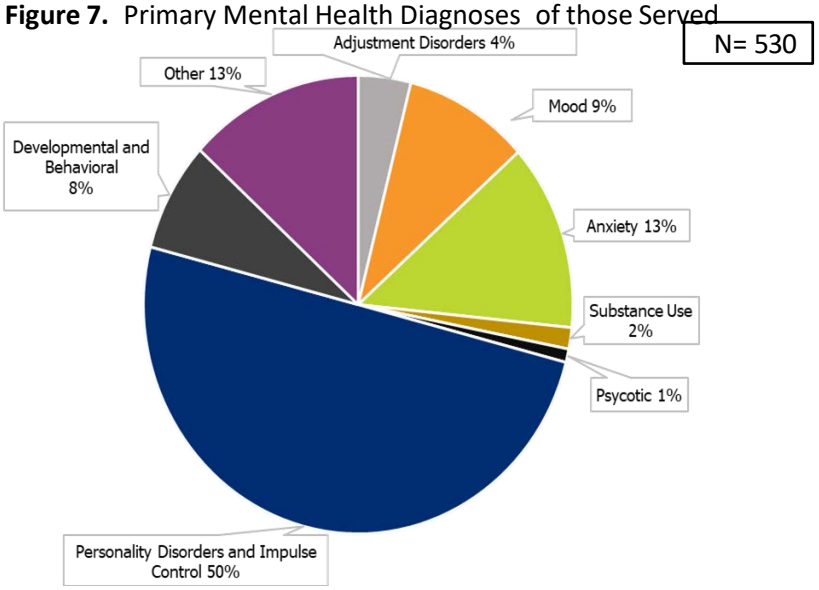
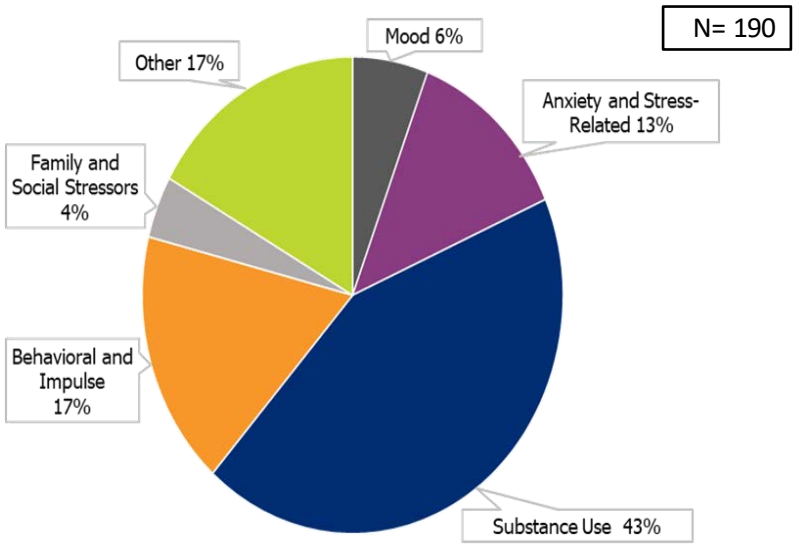


Figure 8 highlights the Primary and Secondary Diagnoses of those youth served. Substance Use constituted the majority at 43%, followed by Behavioral and impulsive (17%) and Anxiety and Stress- Related (13%).

Figure 8. Primary and Secondary SUD Diagnoses of those Served



Service Data

As shown in **Figure 9**, data from the RUHS-BH electronic health record shows that half (72%) of the behavioral health services were provided on an individual and group basis, with case management (14%) being the next most common service provided. Client support services and Psychiatrist Services represent only 0.1% since they had only 9 through 10 services in FY 23/24.

Service Categories	Description
Assessment	Clinical assessment services (non-medication-related)
Psychiatrist Services	Medication-related services, including medication evaluation
Individual Services	Individual sessions with the client and client's family/ non-family
Group Services	Group
Crisis Services	Crisis intervention (75 minutes or more)
Case Management	Case management
Client Supportive Services	Other supportive services

Figure 9. Services Provided by Category

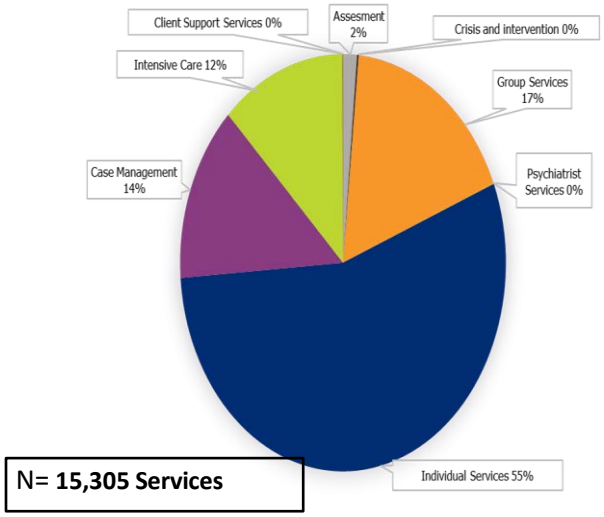
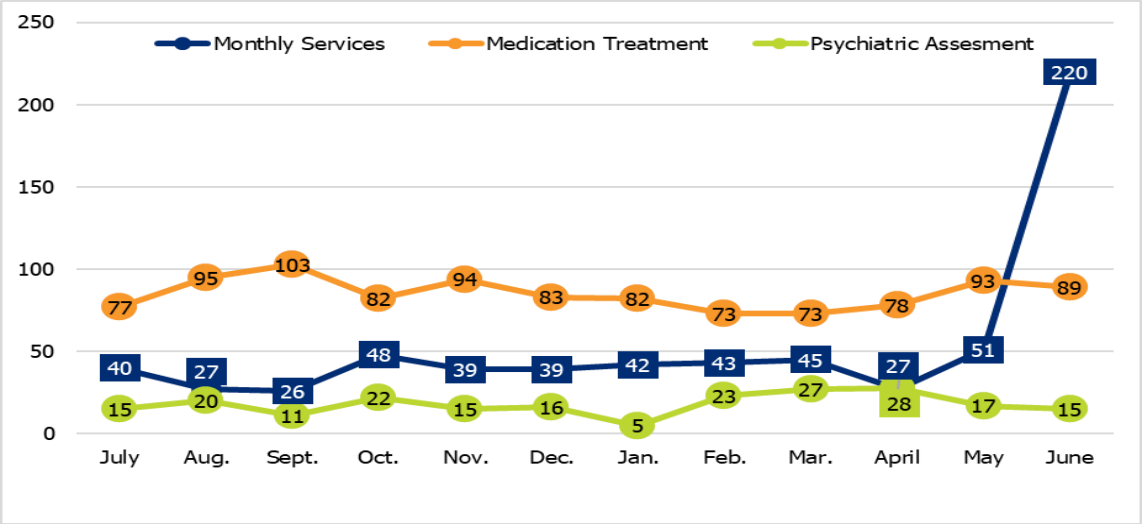


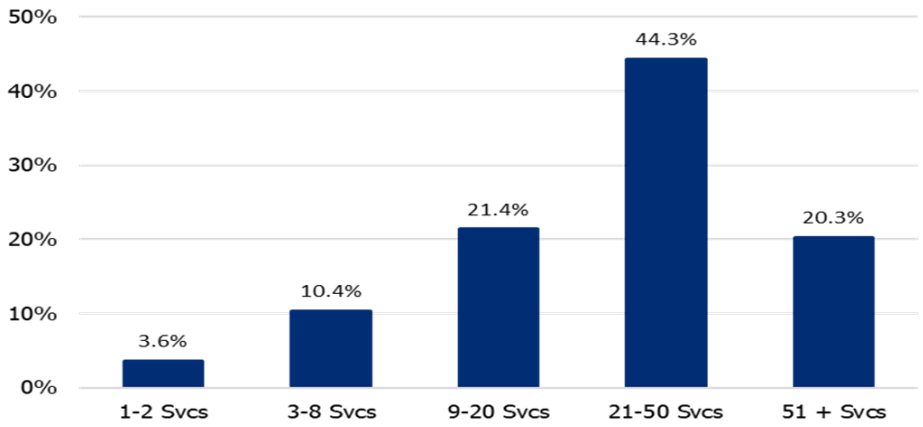
Figure 10 shows that monthly Psychiatric Assessment ranged from 5 to 17 while the medication treatment ranged from 73 to 108 treatments this according to the RUHS-BH electronic health records.

Figure 10 . Number of Psychiatric Services by Month



The number of services each youth receives is influenced by the duration of their stay at Juvenile Hall. As shown in Figure 11 below, 44.3% of youth received between 21 and 50 services, while 20.3% received more than 51 services. Additionally, according to the RUHS-BH electronic health records, 35.4% of the services were combined from 1 to 20 services.

Figure 11. Number of Services Provided to Youth at Juvenile Halls



The hours of service that each youth receives are affected by the duration of their stay at the Juvenile Hall. Figure 12 below shows that 41.5% of the youth received 31+ hours of services. This was followed by 21 to 30 hours, with 23.1%, and 11 to 20 hours, with 16.9%. A combination of 1 to 10 hours had a total of 23% of services that youth received.

Figure 12. Hours of Service Provided to Youth at Juvenile Halls

Service Data YTEC

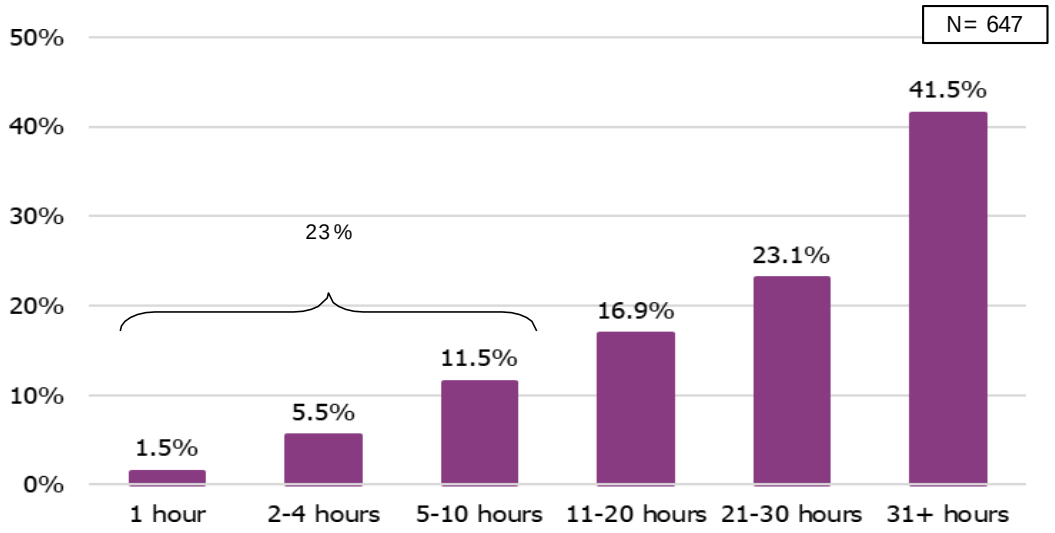


Figure 13 illustrates that 92.3% of youth receiving services at YTEC during FY 23/24 received 21 or more services, according to RUHS-BH electronic health records. Specifically, 62% of youth engaged in 51 or more services, while 29.7% received between 21 and 50 services. Overall, fewer youth accessed lower service levels through FY 23/24, with only 7.7% receiving 20 or fewer services in the year.

Figure 13. Number of Services Provided to Youth at YTECs

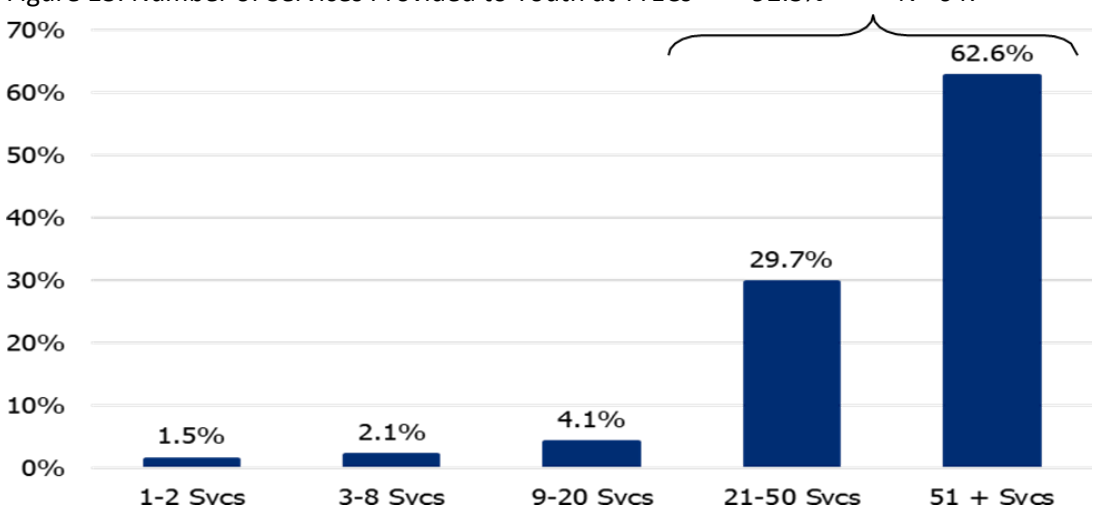
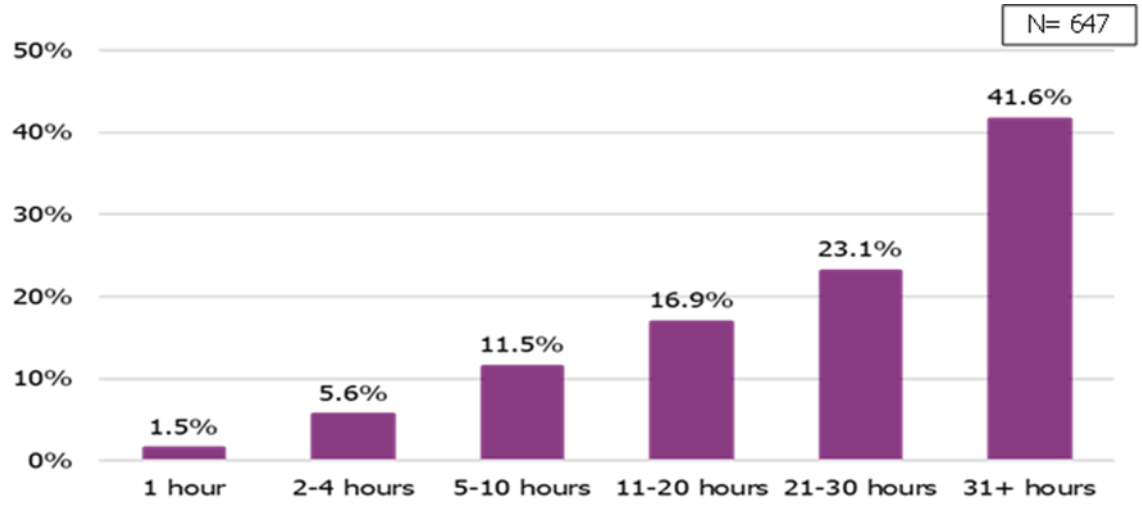


Figure 14 highlights the duration of services provided to youth. Among the participants, 41.6% received 31 or more hours of services, followed by 23.1% receiving 21 to 30 hours of services. Smaller percentages of youth received sorter services durations, with 5.6% receiving 2 to 4 hours and only 10.5% receiving just one hour of services

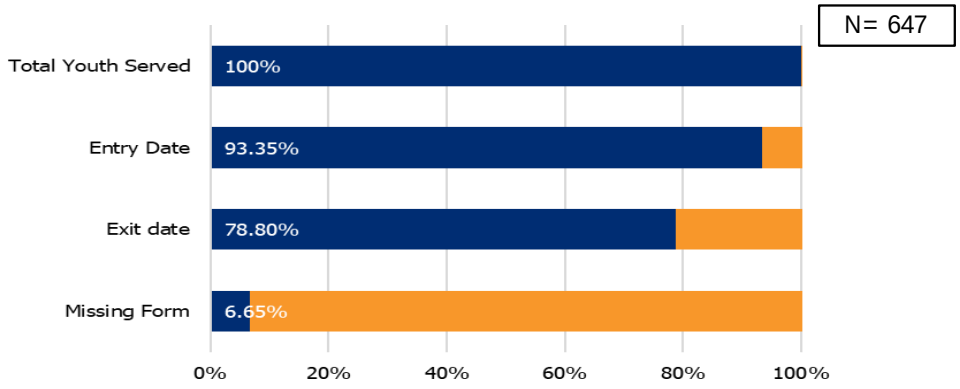
Figure 14. Duration of Services



Behavioral Health Services After JVH/YTEC

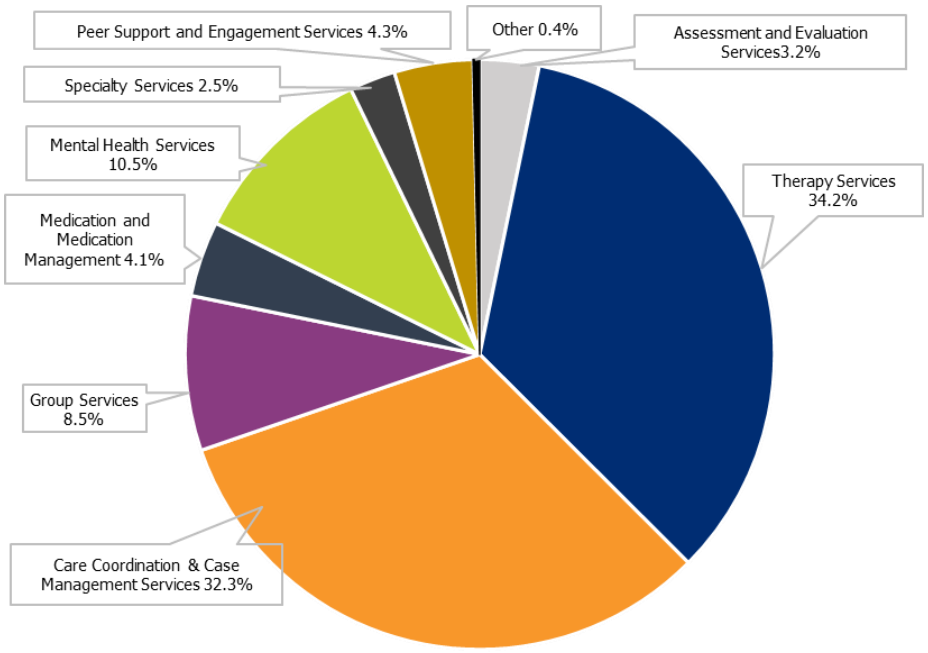
Figure 15 shows that out of the 647 youth served during FY 23/24, 604 individuals had a program entry date in a Mental Health outpatient program, representing 93.35%. Among those, 476 had a closure date, accounting for 78.80% of closures for youth with both entry and exit dates. However, 43 youths were excluded from this calculation as they were not seen in the outpatient system following their JVH/YTEC Mental Health Services discharge. The total close percentage was 73.57% complete closure.

Figure 15. Percentages of youth with Entry and Exit form



Out of the 647 youth served in Juvenile Hall and/or YTEC, 85.8% received behavioral health services at an outpatient RUHS-BH program within 120 days of their last service in custody. Only 7.5% received services during the same period but from the last service day in custody. However, 43 youths were not seen in the outpatient mental health system. According to the RUHS-BH electronic health record (Figure 14), from those who received services, most of the services provided were Therapy Services (34.2%) and Care Coordination & Case Management Services (32.3%), while Specialty Services (2.5%) and Other (0.4%) had fewer services

Figure 16: After Services by Category



Consults: Risk Behaviors / Crisis Issues

RUHS-BH provides Juvenile Justice behavioral health services related to risk behaviors. According to the monthly service report, 0 to 4 School Threat Assessment and Response (STAR) Reports were conducted each month, for 12 reports in FY 23/24, with an average of 1 report per month (See **Table 4**).

Table 4: Youth with STAR Protocol per Month

	July. 2023	Aug. 2023	Sept. 2023	Oct. 2023	Nov. 2023	Dec. 2023	Jan. 2024	Feb. 2024	Mar. 2024	April. 2024	May. 2024	June. 2024
Suicide Watch Consults	17	4	6	23	26	31	10	11	4	14	11	9
Safety Cell Consults	0	0	0	0	0	0	0	0	0	0	0	0
Physical Restraint Consults	0	0	0	0	1	0	0	0	0	0	0	0
4011.6 Consults	0	0	0	0	3	0	0	0	0	0	0	0

	July. 2023	Aug. 2023	Sept. 2023	Oct. 2023	Nov. 2023	Dec. 2023	Jan. 2024	Feb. 2024	Mar. 2024	April. 2024	May. 2024	June. 2024
STAR Reports	0	0	4	2	1	0	1	2	1	0	1	0

GSD: Adult Detention

Behavioral Health – Detention Services provided or offered discharge planning services to over 7,726 consumers during this reporting period. Approximately **1,440 consumers** received Behavioral Health services within **60 days post-release**, reflecting a slight increase from the previous year's total (**N=1400**). Among them, **3.04% (N=336)** were linked to **Full-Service Partnership** services.

Behavioral Health – Detention Services has also expanded its **Medication-Assisted Treatment (MAT)** program to include **Buprenorphine** alongside **Methadone**, partnering with a community **Opioid Treatment Program** to enhance medication treatment options. In collaboration with **Correctional Health Services**, individuals entering custody with an existing MAT prescription (**Buprenorphine or Methadone**) are permitted to continue their medication after being booked into custody. Additionally, those at **high risk of relapse** or experiencing **moderate withdrawal symptoms** can be **initiated on Buprenorphine** as part of their treatment.

Upon release, consumers receive **MAT referrals**, **Narcan Nasal Spray** with education on its administration, and a **five-day prescription** to support their transition to a **Narcotic Treatment Program**. In **Fiscal Year 2023–2024**, Behavioral Health provided MAT medications to **1502 consumers**. As services expand to meet the clinical needs of all eligible individuals, this number is expected to rise significantly.

Behavioral Health – Detention Services remains committed to exploring **innovative and effective strategies** to address the needs of its population. As treatment services grow, the goal remains to provide **critical resources** to those with the greatest needs, ensuring **successful reentry and continuity of care**.

A. **7,726 unique inmates with discharge services (9,612 bookings)**
   - 2,501 unique inmates with discharge planning progress note (2,911)
   - 441 unique inmates with discharge planning group note (460)
   - 7,226 unique inmates offered discharge planning services during MH screening (8,996)

B. **2,070 unique inmates received either individual or group therapy (18,916 services)**
   - 669 unique inmates received individual therapy (1,592)
   - 1,939 unique inmates received group therapy (17,324)

C. **1,502 unique inmates administered at least one dose of MAT classified medication (2,223 bookings)**
   - 1,205 unique inmates administered at least one dose of Buprenorphine HCl-Naloxone HCl Sublingual (1,845)

D. **12,101 bookings with BH service (9,856 unique inmates)**

Row Labels	Count of ID	Percentage of ID I
Mild	4653	38.45%
Moderate	2449	20.24%
Severe	1970	16.28%
None	1945	16.07%
No Rating Provided	593	4.90%
Stepdown_to_Moderate	266	2.20%
Acute	161	1.33%
Minimal	64	0.53%
Grand Total	**12101**	**100.00%**

- **11,071 releases with BH service (8,996 unique inmates)**
  - 336 (3.04%) releases linked to FSP services (based on the new episode)
  - 1,440 (13.01%) of releases linked to MH services within 30 days and 60 days (based on the new episode)
    - 1,210 (10.98%) of releases linked to MH services within 30 days

Row Labels	Count of PATID	Percentage
Severe	385	31.82%
No Rating Provided	262	21.65%
Moderate	212	17.52%
Mild	150	12.40%
Acute	112	9.26%
Stepdown_to_Moderate	51	4.21%
None	38	3.14%
Grand Total	**1210**	**100.00%**

    - 230 (2.08%) of releases linked to MH services within 60 days

Row Labels	Count of PATID	Percentage
Severe	463	32.15%
Moderate	282	19.58%
No Rating Provided	273	18.96%
Mild	201	13.96%
Acute	112	7.78%
None	55	3.82%
Stepdown_to_Moderate	54	3.75%
Grand Total	**1440**	**100.00%**

CSS-03 Outreach, Engagement

Consumer Peer Services: Consumer Peer Services – Adult Consumers, Ages 18 & Up

Consumer Peer Services Vision Statement:

"We create doors, where walls and windows separate people from their promise of a life worth living. We usher in the whole person, their families, and their loved ones, recognizing their value, uniqueness, and the contributions they can make to their community. We promote an affirming environment that recognizes the gifts that all people possess by stepping away from old ways of thinking. Our knowledge and experience are sought to support the entire system to develop and sustain an environment that welcomes and inspires all who pass our threshold."

Program Narrative

Consumer Peer Services Program continued growth within the Behavioral Health Service System. The recovery model and consumer initiatives were implemented in cross-agency training and participation throughout the year. This is the priority of the Consumer Peer Services Program, which remained strong. Peer Support Specialists (PSS) are utilized in various areas and programs to integrate the consumer perspective into treatment teams within the behavioral health system. PSS are people who have experienced significant mental health and/or substance use challenges that have disrupted their lives over lengthy periods and have achieved a level of recovery and resiliency to use their recovery experience, benefiting others who experience behavioral health challenges. PSS has been added to existing programs and is used to develop innovative programs.

During this fiscal cycle, the Consumer Peer Services division continued the implementation of virtual Peer Support programming. The following are examples of how the PSS worked with the behavioral health system to meet those needs one-on-one and in group settings.

Outreach and Engagement: Consumer Peer Services

This reporting year, Consumer Peer Services has focused on the demand for increasing staff. We promoted line staff to fill vacancies in Senior positions and Consumer Peer Services, and added additional Senior Peer Support Specialists to support the entire Department with the following additions:

- SAPT - Desert Region

Peer Operated Programs

Peer-Run Centers Summary:

Peer Support & Resource Centers (PSRC)

Peer Support and Resource Centers operated by RUHS-BH. Peer Support & Resource Centers operate in all three regions of the county. The PSRC provides an open recovery environment for adults and transitional-aged youth (TAY) where they can explore a wide range of mental health and recovery-based services. The centers are consumer-operated support settings for current or past mental health consumers and their families needing support, resources,

knowledge, and experience to aid in their recovery process. Each location offers a variety of support services, including vocational, educational, housing, benefit resources, and activities to support the skill development necessary to pursue personal goals and self-sufficiency. PSRCs are a "step down" from the more intensive programs or levels of care as consumers work toward self-sufficiency and full community integration. This program engages individuals to take the following steps in their recovery process. The PSRCs assist consumers to become less reliant on the costlier Riverside County behavioral health services.

PSRCs also provide alternative levels of care to increase capacity and allow for a lower level in the continuum of care for the Integrated Service Recovery Center's Full-Service Partnership (FSP) clients. Peer-to-peer support continues to be a priority that stakeholders have identified. Peer Support and Resource Centers are a key component of the Peer Support Services Work Plan.

- Recovery-oriented classes are offered five days a week to anyone wishing to connect to natural and community supports.
- Three locations of the Peer Support & Resource Centers
- 261 unique individuals served FV 23/24

Western Region: Downtown Riverside serving 303 Unique Individuals (Staffing - 4 PSS/1 OA/1 SPSS)
2085 Rustin Avenue, Riverside

Mid-County Region: Temecula Re-opened 2/1/23 serving 58 unique individuals (Staffing 3 PSS/1 SPSS)
40925 County Center Drive, Suite 120, Temecula,

Desert Region: Indio – Serving 85 Unique Individuals (Half Staffed) (Staffing 4PSS/1 SPSS)
44199 Monroe Street, Indio, CA

Medi-Cal Peer Certification Program

Building Peer Leaders, A Medi-Cal Peer Support Certification Training (BPL) (Contracted with CalMHSA as a Medi-Cal Peer Support Certification Training Entity)

BPL was successfully re-developed to meet all learning domains as defined under DHCS guidelines for the Medi-Cal certification of PSS. Additional specializations of Family Member/Parent, Unhoused, Crisis, and Justice-Involved training are also provided under contract with CalMHSA.

RUHS-BH and CalMHSA under contract – RUHS-BH Peer Education & Training Team has provided the following training to Riverside County Peer Support Specialists during FY 23/24:

- 101 individuals for Initial Medi-Cal Peer Support Certification
- 0 individuals for Justice-Involved Specialization – 27 Pending 2/2024
- 24 individuals for Family Member/Parent Specialization
- 0 individuals for Crisis Specialization
- 174 individuals in Medi-Cal Code of Ethics

Peer Education & Training Team – 5 positions

- Peer Staff Development Officer
- One Line Staff PSS for Education Program
- Three Senior Peer Support Specialists

The Office of the Riverside Public Guardian has added Consumer Peer Services to their staffing pattern.

RUHS-Medical Center Support

Medical Center continues to call on Consumer Peer Services for individuals receiving palliative care who need extra support

- RUHS-BH Emergency Services
- Consumer Peer Services continues to support Emergency Treatment Psychiatric Hospital by supporting individuals of the Community who seek services with ETS/ITF to normalize the process with stigma reduction interactions and engagements.

MHSA Innovations Technology Suite – Help@Hand Collaborative – Sunset 2/2023

Under the MHSA Innovations Technology Suite, RUHS-BH Research & Technology and the Peer Support Services programs worked collaboratively with a cohort with 14 other counties to explore, plan, develop, and implement technology-based interventions to serve the community, focusing on several populations of focus: LatinX, Rural Communities, the Deaf & Hard of Hearing, Men over 45, LGBTQ+, TAY, and the Re-entry population. These efforts were part of a 5-year grant, where Peer Management and Research & Technology management worked together to meet the community's needs. The TakemyHand Team continues to work within the RUHS-BH system of care to provide the same services to the community.

The Peer Support Specialist Team (Senior PSS, 4 PSS and Peer Program Manager) were heavily involved in the following aspects of this peer-driven project:

- TakemyHand Live Peer Chat https://takemyhand.co – 2021 CSAC Challenge Award Winner
- TakemyHand Peer Operator Training and Marketing Development – Shared with CalMHSA and adopted by CalHOPE and San Francisco County
- A4i (App for Independence), a smartphone app that allows the person experiencing psychosis in the area of auditory hallucinations to see whether sounds are environmental or internal. The app also allows participants to participate in community social media and integrate their activities in the app with their therapy session. The Peer Support Team provided peer-to-peer onboarding of participants and training for clinical care teams in a pilot project – Goal Met
- The Peer Support Team contributed to County wide resource kiosk development, so consumer satisfaction surveys could be completed at the time of each clinic visit in real time and provided training on the use of the kiosk to clinic staff- Goal Partially met, we received some submitted surveys, staff do not seem to be driving consumers to the kiosks to complete surveys.
- The Peer Support Team was an integral part of the UCI Evaluation Team's data collection process for the project, and were the subject of several "spotlight" articles in the UCI Quarterly Evaluation Reports (e.g., LGBTQIAN2+ Spotlight and RUHS-BH TakemyHand Live Peer Chat, etc.) **Goal Met**
- The Peer Support Team began the first Digital Mental Health Literacy classes- – **Goal Met** by providing over 40 classes County wide in our SOC.

- The Peer Support Team developed the RUHS-BH Free Apps Brochure, early Marketing Materials and the Quarterly Newsletter- – Goal Met
- Help@Hand-related Outreach Events – In-person and Virtual - Goal Met

Take My Hand Live Peer Chat

In partnership with MHSA Administration and Research & Technology, the Peer Support Team assigned to the Technology Suite Project continues to work to reach all community members through the TakemyHand Peer Team with the website usable and accessible for the team to continue to develop and adjust training materials and peer support strategies within the scope of SAMHSA core competencies and sustain the integrity of the peer support practice while answering chats.

The Take My Hand Live Peer Chat launched in June 2021 as part of a Statewide technology-based intervention, part of the portfolio of applications in the Help@Hand Collaborative, to reach some of the most difficult-to-engage population groups in the State. During this evaluation period, the Peer Support Team struggled with staffing after the initial staffing structure of utilizing “borrowed” peers from clinics. During the project's rapid deployment, they returned to their assigned Peer positions within the County structure. During this fiscal year, TMH had an average of three (3) full-time Line staff PSS, one (1) Senior PSS, one (1) PSS Supervisor (Consumer Peer Services Program Manager), and one (1) Tech Team Supervisor (MH Services Program Manager) and various staff in Research & Technology assisting with the project. The project's goal is to be fully staffed with 5 full-time Peer Support Specialists and identify project funding sustainability as the funding source ended in February of 2024.

Supporting the Peer Workforce

Since 2006, the Consumer Peer Support Program has been steadfast in the pursuit of providing monthly training and support to the people whose job class is the only class in the RUHS-BH System to have self-disclosure as part of the job duties and expectations.

In this pursuit, Consumer Peer Support Leadership has successfully sustained monthly one-on-one supervision with Senior Peer Support Specialists and Monthly Group Training Supervision for all peer providers.

Peer Support Line Staff Monthly Training & Support Meetings occur at least once a month on a day preselected by the SPSS Team of the Program/Region and the line staff peers of the Program/Region. Each is a 2.5-hour meeting to train on the core competencies, values, and ethics of peer support, explore challenges, provide moral support, practice team building, and provide recovery-oriented education and staff development geared to drive full-time Peer Support Specialist staff to their core competencies of practice on treatment teams. The structured agenda has a recovery theme each month, and the training is oriented to the monthly theme. The goal of the training and education meetings is to increase the skill set and competencies of SAMHSA Core Competencies of Peer Support, National Practice Guidelines for Peer Supporters, and the Medi-Cal Code of Ethics for Peer Support Specialists in California as adopted by DHCS in July of 2021, in preparation of State Certification of Peer Support Specialists, and certificate renewal requirements.

Senior Peer Support Group Supervision Meetings occur each month in a 2-hour session, specifically for Senior Peer Leadership to share learning opportunities and resources, strategize approaches to mentoring line staff Peer Support Specialists (SPSS), and receive coaching and supervision in a group setting. Again, the meetings focus on Core Competencies and Foundational Principles of Peer Support.

Senior Peer Support One-on-one supervision occurs once each month or as needed. This is a thirty-minute to one-hour structured private supervision for the Senior Peer Support Specialist to receive individualized peer support leadership mentoring from the Consumer Peer Support Program Manager. Each session includes updates on program-specific progress and addresses areas of concern. SPSS staff have this opportunity to ventilate challenges, brainstorm solutions, identify growth areas, give and receive feedback, set goals, and plan for future activities. This supervision is focused on assisting the Senior Peer Leader to mentor Peer Support Specialist line staff, utilizing the SAMHSA Core Competencies for Peer Supporters.

Operation Uplift—Extended COVID-19 Response—The Medical Center continues to reach out to Consumer Peer Services to provide peer support services to patients and staff alike.

The Peer Support Services Team extended its presence at the RUHS Medical Center and ETS/ITF to provide additional support to staff and the people served at those locations to mitigate feelings related to anxiety and compassion fatigue under stressful and sometimes traumatizing working conditions.

The Peer Support Services division assembled a team to create an ongoing presence for staff but also was instrumental in supporting staff and people served alike. This service is extended to provide hospitalized community members in the Palliative Care Unit of the RUHS Medical Center, as well as supporting behavioral health consumers in Medical Center Inpatient Settings.

The Public Guardian's office requested support for conserved and 51/50-hospitalized community members with beds at the RUHS Medical Center. The Peer Support Services Team responded by creating a 51/50 Sitters Team. Working with hospital staff, Peer Support Specialists provided much-needed relief to nurses working in units with 51/50 holds.

The Emergency Psychiatric Treatment Services Center (ETS) requested support to consumers. Peer Support Specialists were deployed to provide comfort and support to these consumers for long waiting times as ETS census rose. This support is ongoing, with a partnership and exploration of permanent Peer Support Specialist roles in the units at ETS. - **GOAL MET**

RUHS-BH Peer Services continues to support Medical Center staff with peer support for staff bi-monthly and as requested by Medical Center Executive Team.

Progress has been made at the RUHS Emergency Treatment Services and Inpatient Treatment Services location to place three full-time Medi-Cal Peer Support Specialists to provide direct services in inpatient settings. Personnel Control Numbers have been approved. Meetings to promote recovery-oriented services and integration of peers on the clinical teams are slated for March and April 2024. **Goal Met.**

Senior Peer Support Expansion in WET and Cultural Competency

Statewide Collaboration Efforts

• Peer Support Services leadership and line staff continued participation in the CalMHSA Innovations Technology Suite Help@Hand Project Cohort, in partnership with RUHS-BH MHSA Administration and Research & Technology to bring experienced Peer Support leadership to the collaborative process at the State level. **Goal met**- MHSA Innovation project completed February 2024

- Provided mentorship and training to the leadership of Santa Barbara, Los Angeles, and Merced Counties as they grow their peer support programs locally
- Peer Support Service Deputy Director continues as a permanent member of the RUHS-BH Executive Team to bring the peer voice to the highest level of leadership in Riverside County
- Provided Emergency Operation Committee personnel training and support regarding mental health and substance use self-care for the Emergency Operations Committee or EOC members.
- Provided feedback and training materials to DHCS (Department of Health Care Services) for planning and technical support for Peer Support Certification.
- Provided subject matter expertise as a listening session facilitator for the DHCS Medi-Cal Peer Support Specialist Certification Program.
- Provided feedback and training to Riverside County contract providers wishing to increase or incorporate peer providers in their workforce.
- Provided feedback and training to Inyo, Santa Barbara, and Orange County on how to incorporate peer providers into their workforce.
- Participated in State Conferences to further widespread knowledge of the Peer Support evidence-based practices.
- Provided subject matter experts on Peer Support State Certification at the SCRP Conference
- Provided subject matter expertise for CIBHS exploring behavioral health equity

Peer Opportunities

Lived experience as a behavioral health consumer is a gift to be given back to the communities in which we live. People with lived experience can, and do, get better. With coordinated support and training, a person who struggles with behavioral health challenges can learn to be with people one-on-one or in a group setting, providing Peer Support. Any person with lived experience in treatment and recovery for a mental health and/or substance use challenge can take a pre-employment training course, provided free of charge to residents of Riverside County, RUHS-BH. These services were brought in-house with RUHS-BH, and this fiscal cycle included building peer leaders - A Medi-Cal peer certification training in preparation for the Peer Certification Program implementation with CalMHSA.

GOALS - Consumer Peer Services

To create an Anger Management Group Curriculum that adheres to the Peer Support Recovery Model to be delivered to consumers in all clinic and detention environments – GOAL MET - Taking Action to Manage Anger was launched during the last fiscal cycle. FY 21/22 Many clinics/programs utilized this group curriculum. -**GOAL MET**

To create an Eating Disorders Group Curriculum that adheres to the Peer Support Recovery Model to be delivered to consumers in all clinic and detention environments – Pending

To build upon Peer Support workforce numbers to increase peer provider presence in TAY, specifically in Children's Services System and Detention Environments – still pending- In the recruitment process of 10 additional TAY Peers now. **TAY Peers goal met**- Detention environments still pending

To create a new Peer Support Specialist category for individuals from the Deaf and hard-of-hearing community. To meet the needs of DHH individuals, RUHS-BH Consumer Peer Services is striving to penetrate this hard-to-engage community through peer support. Adding specific Peer Employment Training for DHH consumers to bolster the representation of this community in the peer workforce is still pending. Groundwork with the community liaison is ongoing.

To sustain a "Real Peer Chat" technology instead of leaning on existing Artificial Intelligence programming in smartphone applications and websites. In that creation, the bigger goal is to influence statewide peer support program growth, influencing other Counties to grow peer support programs that assist peer providers to adhere to SAMHSA Core Competencies for Peer Supporters – GOAL MET - with the deployment of the Take My Hand Live Peer Chat under the Innovations Tech Suite Help@Hand Program. A Take My Hand Live Peer Chat smartphone application is currently in production and will be released to the community in the next fiscal cycle. As the Help@Hand statewide collaborative sunsets, Consumer Peer Services and the Research & Technology division are looking to sustain the project after MHSA Innovations funding is concluded. - **GOAL MET**

As a carry-over from FY20/21 Bilingual Spanish PSS Services. With the addition of our new Spanish Language Senior Peers, we will be moving forward to focus energies to the Spanish-speaking community to support and provide more recovery-oriented services in Spanish – This goal was partially met with the hiring of 2 new Senior Peer Support Specialists who are Spanish speaking and will be working to convert all group curricula county vast to Spanish.- In process

Add a new level of Executive Leadership to the Consumer Peer Services Program by creating a Deputy Director position that oversees all Peer Support Services county-wide, to create a structure of training and support for all areas of peer work. This role would provide full oversight of training and compliance of peer support practice for all Adult Consumer Peer Support Specialist and Family Advocates, TAY Peer Specialists and Parent Partners in Children's Services. – **GOAL MET** - with the hiring of the first Deputy Director of Peer Support Services

To increase the Peer workforce by having a minimum of 2 Peers in each of our Behavioral Health and SAPT clinics to serve the community better. Progress made.

Due to capacity restraints of an ever-increasing workforce of peers County Wide positions of SPSS to program-specific and regional vs. simply regional, as we have found the area of Riverside County is too vast to serve efficiently and effectively under the previous model. We have partially met this goal FY21/22 by hiring an additional Senior Peer for SAPT programs. The Consumer Peer Services Program Manager aims to hire additional Senior Peer Support Specialists for Crisis HHOPE and Children's (TAY) ensuring RUHS-BH has region-specific Senior Peers to meet the needs of specific programs. - **GOAL MET**

To retire the “Consumer Affairs” name and unit umbrella from RUHS-BH, and to create one system that supports all disciplines of peer support within the RUHS-BH system of care, the Peer Support Services division. – This goal is partially met by starting the groundwork to rebrand the division and its collaborative efforts. – Progress made.

To minimize and eventually alleviate peer discipline silos. RUHS-BH has a history of sustaining separate programs within the peer support workforce. Peer Support Services is an integrated system that needs to be created as one system instead of completely, separately operated disciplines of peer support. The isolation of each discipline (Consumer Peer, Family Advocate & Parent Partner) has created a lack of inter-disciplinary collaboration and threatens the success of all lived experience peer workers to pass the California State Certification exam. RUHS-BH Peer Support Services understands that all peers practicing peer support under the State Plan will be held to a set of core competencies and a code of ethics required by the State. Efforts have begun to create an integrated team in the Program Management Leadership Team, communicate to the system of this intent, and move forward on training to staff to accomplish this goal. **GOAL MET**

To create a specific interactive Peer Support Services webpage within the new www.ruhealth.org website that provides peer support resources and access to all disciplines of peer support, integrated with all service system programs. **GOAL MET**

To advocate for salary rate increases for line staff PSS, SPSS, and Peer Program Managers, now that State Certification is required, Riverside County has opted in to the State Plan. **GOAL MET**

To incorporate a Staff Development Officer into the Peer Workforce to oversee the Education and Training Program and be the Peer Support and Resource Center staff's onsite supervisor. **GOAL MET**

To expand the leadership team to include a separate Peer Supervisor for the Peer Support & Resource Centers to transition the Staff Development Officer into the sole role of SDO by the end of the three-year plan. **GOAL MET**

To launch the Medi-Cal Peer Support Certification Program by grandparenting all qualified PSS and SPSS current staff and starting the initial certification process for those who do not qualify. **GOAL MET**

To become a CalMHSA Training Entity to provide Medi-Cal Peer Support Certification Training, not only for State certification purposes but also to provide CalMHSA-approved supplemental training in the areas of specialization (Family/Parent/Caregiver, Justice-Involved, Unhoused, and Crisis). GOAL MET

To build capacity for peer support services, recruit staff, and re-open the Temecula Peer Support & Resource Center (**GOAL MET**), and to open three additional Peer Support & Resource Centers regionally placed to increase access to peer support recovery services for individuals not yet engaged in traditional services, or were former behavioral health consumers seeking additional support, education and resources to build upon their recovery. Expansion goal In progress

To update BH Policy 164 – Recruitment, Training & Promotion of Peer Support Specialists to include new language that would change job classification, address the Medi-Cal Peer Support Specialist Certification process, and give new guidance to staff around training and promotion processes**. GOAL MET** – BH Policy 164 has been updated in December 2024.

To establish new job classes more aligned with Medi-Cal Peer Support Certification, seeking automatic promotion for Peer Support Trainees who pass the Medi-Cal Peer Support Certification exam and to change the current job class of Peer Policy & Planning Specialist to Peer Program Manager, as their role in the Department represents. **GOAL MET** - The job class of Peer Policy & Specialist has been upgraded to Peer Program Manager.

To plan develop and launch a peer support workshop for RUHS-BH Medical Center Staff, Supporting Each Other – Peer Support Skills for Healthcare Workers. **Goal in progress**. Training curricula developed and approved.

Contracted Programs

In downtown Riverside, RUHS-BH contracts with RI International to provide peer support and art education in a studio environment. The program "Artworks" Peer Support Specialists provide ongoing support and hands-on assistance to people working toward recovery and resiliency goals with the use of painting, creative writing, multi-media art, crochet and quilling. These services are also offered to area clinics and programs to include art-focused recovery groups, facilitated by Peer Support Specialists.

Parent Support and Training Program: Clinic/Program Parent

The Riverside University Health System – Behavioral Health, Parent Support and Training (PS&T) program was established in 1994 with the aim of developing and promoting client and family-directed nontraditional supportive mental health services for children and their families. The program was created in response to the many obstacles confronting families seeking mental health care for their children and aims to ensure that treatment and support are comprehensive, coordinated, strength-based, culturally appropriate, and individualized.

PS&T programs have been developed across the country to ensure that mental health services for children are family-centered and parent-directed. The program recognizes the importance of engaging and respecting parents and caregivers from the first point of contact. Parents want to be recognized as part of the solution rather than the problem, and PS&T aims to empower them in the care of their children.

The PS&T program emphasizes the importance of meaningful partnership and shared decision-making between parents and staff at all levels. By integrating the parent perspective into the system, services can be improved to better meet the needs of families. The program's strength-based approach recognizes the unique strengths of each family and works to build upon them, rather than focusing solely on deficits or weaknesses PS&T programs provide a range of services, including education, advocacy, and support to parents and caregivers, as well as mental health services to children. These services are culturally appropriate and individualized to meet the specific needs of each family. PS&T programs aim to ensure that families have access to the resources they need to help their children achieve their full potential.

The program emphasizes the importance of family-centered and parent-directed care and works to empower parents and caregivers in the care of their children. By integrating the parent perspective into the system, services can be improved to better meet the needs of families, and children can receive the support they need to achieve their full potential.

Leadership/Coaching - Newly hired Parent Partners are provided training and orientation that includes: How to Facilitate a Support Group; Orienting Parents to the Behavioral Health System; Educate, Equip and Support Facilitator Training; and Nurturing Parenting Facilitator Training. The training is also made available to Parent Partners employed by partner agencies, such as the Department of Social Services, contract service providers, and other community-based agency partners. All trainings/meetings are open to all Parent Partners working within a multitude of systems. Training topics include: Recovery Skills; Telling the Family Story; and Working within the County System as an Employee/Volunteer. A newly implemented training is our Parent Partner supplemental training. The specific content of this supplemental training focuses on more advanced topics, specialized skills, or additional tools and resources to enhance the Parent Partners' ability to support and engage with their peers. It's a positive step to invest in the ongoing professional development of Parent Partners, as it can lead to a more skilled and knowledgeable support network for the community.

There is a monthly county-wide meeting for all Parent Partners (Peer Support Specialists, with Parental/Caregiving of a Minor or TAY aged youth lived experience). There is also a weekly regional Parent Partner meeting to discuss region-specific concerns and to offer additional support. The meeting generally includes a roundtable discussion and updates from each clinic

as well as training and presentations on specific topics. Presentations are provided by both County and contracted providers with topics such as: Community Care Reform (CCR) Implementation, mobile crisis services, Operation SafeHouse, HHOPE (housing), Confidentiality, Mandated Reporting, Team Building, Boundaries, Strengthening Families, CANS and Documentation for Parent Partners. Parent Partners countywide participated in the UACF and UC Davis Parent Partner trainings. Countywide Parent Partner meetings now have an official training component providing opportunities for Parent Partners to earn continuing education credits for their State Peer Certification and are now offered in person or online (hybrid).

Clinic/Program Parent Partners - Parent Partners are hired as County employees for their unique expertise in raising their own child with special needs. At clinic/program sites, in coordination with clinicians, the Parent Partner will work directly with assigned parents, families, and child caregivers whose children receive behavioral health services through the Riverside University Health System – Behavioral Health system of care. Activities include parent-to-parent support, education, training, information and advocacy. This enhances parents' knowledge and builds confidence to actively participate in the process of treatment planning at all levels. Evidence-based programs/classes (listed above) are also provided by Parent Partners at clinic sites. The current number of Parent Partners countywide is approximately 126 including our contracted providers. We have Parent Partner who speak Spanish and one who speaks Punjabi.

Partnerships/Collaboration

PS&T program has continued to partner with the Department of Public Social Services (DPSS) and Probation regarding Pathways trainings for new staff. PS&T along with DPSS have incorporated the changes in both systems to ensure that all children entering the child welfare system are receiving mental health services as needed. This is the avenue, though which, parent and family voices continue to be heard in both systems. PS&T continues to attend Team Decision Making (TDM) and Child Family Team (CFTM) meetings to be a part of the process and a support to the families. PS&T attended 124 CFTM meetings for families. In 23/24, PS&T also was the Provider for DPSS Parent Referrals of approximately 2,500 parents that were referred through DPSS/ACT.

In FY 23/24, PS&T collaborated with Substance Use, Probation and Juvenile Detention programs to provide Triple P parenting classes. 215 parents participated in Triple P through our continued partnership with the Family Preservation Program. 50 parents at the Day Reporting Center (Probation) participated in parenting classes.

PS&T will continue to be a part of the Crisis Intervention Training (CIT) for law enforcement, as a part of the panel presentation, to provide the parent perspective when a child is experiencing a mental health related crisis response from law enforcement.

Parent Support is now partnering with the Youth Training Education Center (YTEC) program through probation in order to provide Parenting classes to youth who are parents and in placement through the Youth Training Education Center. Additionally, we are collaborating

with Probation on a Parenting Support and Resource team for families preparing for their youth to return home from placement through SB 823.

Parent Support and Training Administration

The Parent Support & Training Program is an essential component of Children's Services, designed to provide families with the necessary support and resources to navigate the challenges of raising a child with special needs. One of the most unique aspects of this program is the employment of Parent Partners - individuals who have personal experience raising a child with special needs.

Parent Partners are hired as County employees for their unique expertise and firsthand knowledge of families' challenges and obstacles when raising a child with special needs. These individuals bring a wealth of knowledge and insight into the program, which allows them to connect with families on a deeper level and provide invaluable support and guidance.

The Parent Support & Training Program Manager for Children's Services is responsible for overseeing the Program and ensuring that the parent/family perspective is incorporated into all policy and administrative decisions. The Program Manager works in close partnership with Children's Services Administrators to ensure that the program meets families' needs and provides the highest quality of care.

In addition to the PS&T Program Manager, the program is also staffed by Senior Parent Partners, Parent Partners, a Volunteer Services Coordinator, a secretary, and an Office Assistant. Each Senior/Lead Parent Partner is assigned to a different region of the County to collaborate with the regional Children's Administrator, Children's Supervisors, and regional Parent Partners. They provide coaching and guidance to the regional Parent Partners to ensure best practices while working with families.

The Parent Support & Training Program is an essential resource for families raising children with special needs. By employing Parent Partners and ensuring that the parent/family perspective is incorporated into all policy and administrative decisions, the program can provide families with the support and resources they need to navigate the challenges of raising a child with special needs. Parent Partners are individuals who have firsthand experience with navigating county systems as a parent or caregiver. They play a vital role in supporting other parents going through similar experiences by providing them with information, resources, and emotional support.

One of the agencies that Parent Partners work with is the Department of Public Social Services (DPSS). DPSS provides various services to families, including financial assistance, food assistance, and employment services. Parent Partners can help families navigate these services, provide information on eligibility requirements, and offer support as they go through the application process.

Parent Partners also work with the Probation department to support families involved in the justice system. They can provide parents with information on their legal rights, help them navigate the court system, and connect them with resources that can support their child's rehabilitation or their own.

Parent Partners also collaborate with community centers to offer parenting classes and other educational programs. These classes can cover a range of topics, from child development and behavior management to self-care for parents.

Parent Partners can facilitate these classes, drawing on their own experiences as parents to provide practical advice and support.

Parent Partners work with Children and Youth Mental Health Clinics to provide families with mental health education and 1:1 support. They can help families understand their child's diagnosis, navigate the behavioral health system, and access appropriate services and supports. Additionally, Parent Partners can offer emotional support to parents who may be struggling to cope with their child's behavioral health needs.

Parent Partners play a critical role in supporting families across multiple agencies and programs. By offering a range of services, including parenting classes, mental health education, and 1:1 support, they can help families navigate the child welfare system and access the resources they need to thrive.

The Parent Support & Training Program also employs Senior/Lead Parent Partners who are designated to work with specific populations. These Senior/Lead Parent Partners have specialized expertise in working with families who have unique needs and challenges.

One example is the Senior/Lead Parent Partner who is assigned to “Pathways to Wellness” and works closely with Child Welfare Partners to identify the needs of families. This individual plays a critical role in advocating for the needs of families and ensuring that their voices are heard in the decision-making process.

Another Senior/Lead Parent Partner is housed at one of the Transitional Aged Youth (TAY) Drop-in Centers, (Stepping Stones) working collaboratively with both parents of TAY and TAY who are parents themselves. This Senior/Lead Parent Partner provides support and guidance to these individuals, helping them navigate the challenges of parenting while also dealing with their own unique needs as young adults.

The Parent Support & Training Program also employs a Senior/Lead Parent Partner who is assigned to the Housing Program and works with homeless families. This individual provides critical support and resources to families who are facing the challenge of homelessness, helping them secure safe and stable housing and providing support throughout the process.

In addition, a Senior/Lead Parent Partner is assigned to the Cultural Competency Program, working to engage parents and families of different backgrounds and cultures. This individual plays a vital role in ensuring that services are accessible and inclusive for all families.

Senior/Lead Parent Partner is assigned to several schools in the Hemet Unified School District, assisting students and their families in connecting to necessary resources. This individual plays a critical role in helping families navigate the educational system and ensuring that students receive the support they need to succeed.

Senior Parent Partner has been assigned to SAPT and DRC programs countywide. Facilitating Parenting Classes, providing support to parents in the MOM’s program and Plan of Safe Care and Family Preservation Court.

This fiscal year 23/24, Parent Partners worked to link over 250 families and TAY with our housing partners. Parent Partners within the Administration unit provide support to the

broader community as well. In FY23/24 PS&T reached out to over 3,000 clients including Parents, TAY Youth, community members, and staff with needed information and resources to better advocate for their children, family members, and people they serve.

Services provided include:

Parent-to-Parent Telephone Support Line

The Parent Support & Training Program offers a countywide parent-to-parent support line to provide non-crisis support and education to parents and caregivers who live in Riverside County. This support line is a toll-free 800 number that parents can access for free. It provides an accessible and convenient way for parents to seek support and information without having to attend a support group.

The parent-to-parent support line is staffed by trained Parent Partners who are parents of children with special needs themselves. These Parent Partners are uniquely qualified to provide support, empathy, and guidance to other parents who are experiencing similar challenges.

The support line is available in both English and Spanish, ensuring that all parents can access the support they need regardless of their language preference. Parents can call the support line to ask questions, seek advice, or simply connect with someone who understands what they are going through.

The parent-to-parent support line is a valuable resource for parents who may feel isolated or overwhelmed by their parenting responsibilities. It provides a safe and supportive space for parents to discuss their concerns and receive guidance from experienced Parent Partners. The support line is open during regular business hours, Monday through Friday.

Open Doors Support Group in English and Spanish

The Parent Support & Training Program provides a countywide support group for parents and caregivers who are raising children or young people with mental health, emotional, or behavioral challenges. This support group is open to the community and provides a safe place for parents to share their experiences, receive support, and connect with other parents who are going through similar challenges.

The support group is available in both English and Spanish, making it accessible to all parents and caregivers in Riverside County. The group is facilitated by trained Parent Partners who have firsthand experience raising children with special needs. These Parent Partners provide guidance, empathy, and support to group members as they discuss their concerns and seek solutions to the challenges they face.

The support group provides a space for parents to share resources and information, brainstorm solutions, and support one another in their parenting journey. Group members can ask questions, seek advice, and receive validation and support from their peers. The group also provides an opportunity for parents to develop friendships and social connections with others who understand their experiences.

Due to pandemic era restrictions, classes were provided in a virtual environment.

UPDATE: Open Doors Support group is now in person in both English and Spanish. We have added an Open Doors Support group for TAY aged parents as well. Our newest support group is our Autism Support group which is designed to support parents who have children with Autism Spectrum Disorder.

FY 2023/2024

Current Group locations:

• Open Doors Riverside (Community Parent Support)

- Open Doors Riverside – Spanish (Community Parent Support)
- Open Doors Riverside, TAY parent Support (community parent support)
- Autism Support Group (Community Parent Support)

Resource Library - Offers the opportunity for Department or community members to check out videos and written material, free of charge, to increase their knowledge on a variety of mental health and related topics, including, but not limited to advocacy, self-help, education, juvenile justice, child abuse, parenting skills and anger management. Materials are available in both English and Spanish.

Outreach and Community Engagement –

The Parent Support & Training Program is committed to reducing stigma and building relationships through community networking and outreach. This effort involves providing educational materials, presentations, and other resources to community members, with a focus on access for culturally diverse populations. By engaging, educating, and reducing disparities in access, the program aims to create a more inclusive and supportive community for families raising children with special needs.

In the fiscal year 23/24, the program participated in 80 outreach events countywide. Where we reached out to 3,701 parents, youth, staff and community partners. We provided behavioral Health workshops about parents and children, presentations to staff and community partners.

Community networking and outreach are essential for reducing stigma and building relationships within the community. By providing educational materials, presentations, and other resources, the Parent Support & Training Program helps to educate the public about mental health and behavioral challenges. The program also works to reduce disparities in access to services for culturally diverse populations, creating a more inclusive and supportive community for families.

Outreach Events:

- Back to School Backpack Project 1,500
- Thanksgiving Basket Food Drive 250 baskets delivered
- Snowman Banner Holiday Drive 2,200 gifts delivered countywide
- May is Mental Health Month Events Countywide
- Fall Festival (Children's Celebration) 250 participants
- Holiday Celebration for Families 75 participants

Recovery Happens

Evidence-Based Programs/Classes - The Parent Support & Training program is a vital resource for parents in the community, providing a variety of classes and trainings to support parents in their roles. The program has continued to offer these services at various locations in both English and Spanish, ensuring that all parents in the community have access to the support they need.

During the fiscal year 23/24 the Parent Support & Training program served a total of 4,000 parents in the community through its parenting classes. These classes covered a range of topics, including child development, effective communication, positive discipline, and stress management. The program recognizes that parenting is a difficult job, and it aims to provide parents with the skills and knowledge they need to navigate the challenges that come with it.

In addition to parenting classes, the program also offered parent workshops, which were attended by 300 parents in the community during the fiscal year 23/24. These workshops covered specific topics in more depth, such as building resilience in children, managing challenging behaviors, and supporting children with special needs.

The program also provided educational presentations to the community, with a total of 1000 community members attending these presentations during the fiscal year 23/24 These presentations covered a range of topics, including mental health, substance abuse prevention, and community resources for families.

• Educate, Equip, and Support (EES): Building Hope - The EES education program consists of 13 sessions; each session is two hours and offered only to parents/caregivers raising a child/young person with mental health and/or emotional challenges. Classes are designed to provide parents/caregivers with general education about childhood mental health conditions, advocacy, and parent-to-parent support, and community resources.

• Triple P (Positive Parenting Program) - Triple P is an evidence-based parenting program for parents raising children 0-12 years-old who are starting to exhibit challenging behaviors.

• Triple P Teen – Triple P Teen is an evidence-based parenting program for parents raising young people that are 12 years and older.

• SafeTALK - Most people with thoughts of suicide invite help. Often these opportunities are missed, dismissed or avoided, leaving people feeling more alone and at greater risk. SafeTALK training prepares participants to help by using TALK (Tell, Ask, Listen, and Keep safe) to identify and engage people with thoughts of suicide and to connect them with further help and care.

• Nurturing Parenting - An interactive 10-week course that helps parents better understand their role. It helps to strengthen relationship and bonding with their child, learn new strategies and skills to improve the child's concerning behavior, as well as develop self-care, empathy and self-awareness.

• Strengthening Families – A 6-week interactive course that focuses on the Five Protective Factors. The Five Protective Factors skill-building helps to increase family strengths, enhance child development, and manage stress.

• Mental Health First Aid Youth – Teaches participants to offer initial help to young people with the signs and symptoms of a mental health condition or in a crisis, reviews the unique

risk factors and warning signs of mental health challenges in adolescents ages 12-18. It emphasizes the importance of early intervention and help to adolescents in crisis or experiencing a mental health challenge, and connects them with the appropriate professional, peer, social or self-help supports.

• Parent Partner Supplemental Training - This is a course for parents/caregivers of minor children to navigate mental health, and other systems, to better advise their children. It includes parent-specific peer support practices to prepare parents for possible employment opportunities as Parent Partners in the RUHS-BH system.

• NEW Nurturing Fathers Program – NFP is an evidence-based, 13-week course designed to teach parenting and nurturing skills to men. Each 2 ½ hour class provides proven, effective skills for healthy family relationships and child development.

Special Projects - Donated goods and services benefit children and their families with basic needs such as food, clothing, hygiene items, holiday food baskets, school supplies, gift certificates, as well as cultural and social events. In 23/24 the following projects provided resources to families:

• 20th Annual Back to School Backpack Project: 500 backpacks were distributed to young people at clinics/programs.

• 20th Annual Thanksgiving Food Basket Project:250 food baskets were distributed to families. An additional 22 Holiday meals were distributed as well.

Special Projects (Continued)

• 20th Annual Holiday Snowman Banner Project: 2,200 snowflake gifts were distributed to young people in clinics/programs.

Volunteer Services – PS&T recognizes the importance of community involvement and volunteerism in promoting positive outcomes for young people and their families. We have developed a robust program to recruit, support, and train volunteers from the community, including family members who are engaged in services.

The PS&T Volunteer Coordinator plays a critical role in this process. As a bilingual/Spanish speaker, they are able to reach out to and engage with a diverse range of community members. They coordinate special projects that focus on culturally diverse populations, ensuring that volunteers are equipped with the cultural competency skills necessary to effectively work with these populations.

In terms of recruitment, PS&T actively reaches out to members of the community who may be interested in volunteering. This includes young people who are looking for ways to give back to their community as well as parents who have benefited from the organization's services and want to give back in a meaningful way. PS&T recognizes that volunteers from the community bring a unique perspective and skillset to the table, which can be invaluable in supporting the organization's mission.

Once volunteers are recruited, they are provided with ongoing support and training. This includes regular check-ins with the Volunteer Coordinator to ensure that volunteers are comfortable in their roles and have the resources they need to succeed. Additionally, PS&T provides training to ensure that volunteers have a solid understanding of the organization's mission, as well as the skills necessary to effectively support young people and families.

Volunteering with PS&T provides both parents and young people with an opportunity to "give back" to their community. This not only benefits the community at large but can also be a transformative experience for the volunteers themselves. For young people, volunteering can help them develop valuable skills, build their resume, and give them a sense of purpose and meaning. For parents, volunteering can be a way to deepen their connection to the organization, while also providing them with a sense of fulfillment and accomplishment.

In F/Y 22/23, PS&T had 20 youth volunteers assisting at events 2 parent volunteers working alongside our office assistant, and 1 TAY youth who has dedicated over 200 hours of continuous service.

Workshops/Trainings

Workshops and trainings that focus on parent/professional partnerships and engagement can provide valuable information to staff, parents, and the community about how to effectively collaborate and advocate for services and supports for children with mental health needs. These trainings often include a parent's perspective to address the barriers that parents may face when advocating for their child's mental health needs.

These workshops also address the barriers that parents may encounter when advocating for their child's mental health needs. For example, parents may face challenges in navigating complex systems of care or may feel intimidated or overwhelmed when communicating with mental health professionals. These trainings can provide information and support to parents, empowering them to advocate effectively for their child's needs.

In addition to providing information on parent/professional partnerships and the parent's perspective, these workshops can also address specific topics related to the provision of mental health services to children and families.

GOALS FOR Parent Support and Training

The Parent Support & Training Program is a vital resource for parents, caregivers, and youth in providing education, support, and resources to navigate the challenges of parenting. The program recognizes the changing needs of families and seeks to adapt its services accordingly.

• To continue providing services to parents, caregivers, and youth in a safe and accessible manner. As the pandemic has forced many activities to move online, the program has adapted to ensure that its services remain available virtually. This approach has allowed parents, caregivers, and youth to access services from the comfort of their homes, reducing barriers to participation.

• To keep "COVID babies" in mind. Children born during the pandemic have unique needs and experiences that require special attention. The program recognizes the importance of providing support to parents and caregivers of COVID babies and ensuring that they have access to resources that can help them navigate the challenges of parenting during a pandemic.

• Millennial parents have also been identified as a priority population for the program. This generation of parents faces unique challenges related to work-life balance, financial instability, and the pressures of social media. The program recognizes the need to tailor its services to meet the specific needs of millennial parents and provide them with the tools and resources necessary to raise healthy and resilient children.

• The program seeks to increase engagement with fathers. Fathers play an essential role in child development and parenting, but they are often overlooked or underrepresented in parenting programs. The program recognizes the need to engage fathers and provide them with the support and resources they need to be active and engaged parents.

• The PS&T programs will continue providing the services and support as the previous year as well.

• Homeless families are a continued and very important area of identified need in the community. Families and young people are more successful when housing stabilization is addressed for the entire family. There is a Senior/Lead Parent Partner assigned as a point person to homeless families, assisting to connect them to available housing. Laundry assistance has been a useful engagement strategy. PS&T has a contract with a laundromat to facilitate the ability for families to have continued access to clean clothing. PS&T has also implemented a "Boutique" where families can access a variety of clothing, essential items, and hygiene products when needed.

• One of the main barriers that continue to impact parents/caregivers is the transportation system in our County. PS&T provides classes/trainings to parents in their local area to overcome this barrier. Because of pandemic-era adaptations, we now have virtual capability and can offer a variety of classes/groups remotely.

• The children of parents who are incarcerated are often left out of services and not recognized as being in need. As the parents are released from jail, they transition to the Day Reporting Center (DRC). PS&T provides services on-site (both in person and virtually) at all three of the DRCs in Riverside, Temecula, and Indio. This allows for continuity in their services and facilitates the completion of the Triple P course. Additional services offered at the DRCs include: EES classes and Nurturing Parenting classes in partnership with several agencies that support the AB109 – New Life population.

• PS&T will continue collaborative efforts with the Department of Public Social Services and Probation regarding the Pathways to Wellness (Katie A.) and Continuum of Care Reform (CCR) for the transformation of mental health services to families within systems. PS&T will continue to collaborate on committees, and provide ongoing trainings to staff, community, parents, and young people that are involved with that system. PS&T continues to have a key role in upcoming Child, Family, and Team Meetings, and provides Intensive Home-Based Services to those families. An ongoing need that we are seeing with families, due to COVID-19, is an increase in anxiety, grief, and depression in the children in the community. This is an area of continued awareness and collaboration within the community and school districts for support to families.

• Parent Support & Training is currently advocating to add Parent & Family Support Centers located adjacent to, or within RUHS-BH campuses that provide crisis services to the public. Often, children are placed into care while in crisis inappropriately. The lack of beds for minor children in Riverside County creates challenges for both the child and family members who are seeking help for their child. A minor child can often sit in an Emergency Psychiatric Services Center or ED for hours, and sometimes days, without child-appropriate surroundings. The parents of those children need support when their child is experiencing a crisis, and Parent Partners would be instrumental in supporting the families during that difficult time. PS&T would like to see a minimum of three Parent & Family Support Centers open in the three

regions of Riverside County to provide real-time support, education, and resources, without having to wait for an appointment, when the crisis is developing. This drop-in model would serve families not necessarily engaged in services but provide the vital connections and support they need.

RUHS-BH PS&T is intended to assist families, regardless of whether they are receiving any type of formal mental health services. Assistance will be provided to identify needs, overcome obstacles, and actively participate in service planning for their child and family unit. Focused outreach to specific underserved groups is key. Focus given to African American families, homeless families, and prison-release parents will facilitate increased engagement through outreach, community events, and needed classes or programs (e.g.: anger management classes, building parental advocacy skills on behalf of their children as they navigate multiple public systems, etc.). The ultimate goal is to keep children safe, living in a nurturing environment, and with sustained connection to their families. This will help to avoid homelessness, hospitalization, incarceration, out-of-home placement, and/or dependence on the State for years to come.

Family Advocate Program

The Family Advocate Program (FAP) assists family members to cope with and understand the behavioral health concerns of their adult family members through the provision of information, education, and support. Also, the FAP provides information and assistance to family members in their interactions with service providers and the behavioral health system to improve and facilitate relationships between family members, service providers, and the behavioral health system in general. The FAP provides services in both English and Spanish. Currently, FAP employs eight (8) Senior Peer Support Specialist – Family Advocates (Senior Family Advocate - SFA) and fourteen (14) Peer Support Specialist – Family Advocates (Family Advocate - FA) providing services throughout the three Regions in Riverside County (Western, Mid-County, and Desert). Peer Support is an evidence-based practice for individuals with mental health conditions or challenges. Family Advocate peer support is provided by individuals who self-identify as a family member/caregiver of an adult engaged in behavioral health services or community family member/caregivers who seek assistance with support and systems navigation before having their loved one introduced to available services.
The ten SFAs are assigned regionally to specific sites and countywide. Regionally: two in the Western region, two in the Mid-County region, and two in the Desert region.
Specific sites: one each serving in Lake Elsinore, Hemet, Temecula, San Jacinto, and Perris.
Countywide SFAs provide services with one each assigned to specialized areas: Forensics, Substance Abuse Prevention & Treatment (SAPT), TAY Centers (3 locations), and Outreach & Engagement. The SFA works in collaboration with clinical staff and provides leadership, mentorship, and guidance to FA line staff. The 14 FA line staff work directly with family members of consumers in several clinics, programs, and community sites within Riverside County. Family Advocate Program has added a Crisis email to interact with our Behavioral Health crisis teams. 244 referrals have been made and processed during this fiscal cycle.
The Family Advocate Program offers Support, Education, and Resources in the forms of:

Support Groups
During the height of the pandemic, the FAP responded by fortifying family support through virtual group offerings Countywide. FAP expanded group accessibility by over 100% by allowing the community to access a support group via Zoom 4 times a week, regardless of any clinic affiliation. Each group is formatted to provide a safe space for family members and caregivers to share their experiences, connect to resource information, and receive guidance through an educational process to assist the family member, in building skills, and promoting higher levels of wellness and recovery to the entire family unit.

- Sibling Support Group- All Regions- Online
- Taking Action to Manage Anger- Western- Mid County
- Coffee for the Soul / Café para el Alma- All Regions
- Substance Abuse Family Support- All Region- Online

• Family Planning for Success- All Regions
• Grupo de Apoyo Familiar- Mid County - Dessert
• Crisis Support for Families- All Regions
• Recobrando La Ezperanza- All Regions

Community Presentations

During this fiscal cycle, the FAP hosted numerous informational presentations to family members and the community on topics, including but not limited to:

• "Taking Action to Manage Anger for Families"
• "Empowering Families to Participate"

Community Presentations (continued)

• "Holiday Stress Management"
• "Coronavirus & Mental Health"
• "Advocacy Overview: Education, Support, Resources and Information"
• "Crisis Support Systems"
• "Families, Mental Illness and the Justice System"
• "Meet the Doctor". Through our "Meet the Doctor" series, the FAP collaborates with Riverside University Health System – Behavioral Health (RUHS – BH) psychiatrists to inform and educate families from a provider's perspective on topics such as medication adherence, sleep difficulties, the diagnosis of schizophrenia and bi-polar, among other topics.
• "Meet the Pharmacist"
• "Meet the Clinical Therapist"
• "The In's & Out of Conservatorship"
• "Meet Law Enforcement"

Training

FAP facilitates the following training courses for family members/ caregivers:

• Family WRAP (English and Spanish). Family WRAP is recognized by the Federal Substance Abuse and Mental Health Service Administration (SAMHSA) as an evidence-based practice.
• Family-to-Family (English and Spanish). The National Registry of Evidence-Based Practice (NREPP) listed Family-to-Family as an evidence-based practice.
• DBT for Families (English and Spanish)
• Crisis to Stability
• Real Recovery
• Mental Health First Aid. MHFA is a public education program that introduces participants to risk factors and warning signs of mental health concerns, builds an understanding of their impact and overviews common treatments and supports.

Outreach

FAP networks with community agencies through outreach at local universities, colleges, high schools, and middle schools, providing educational materials and resources to staff and students on mental health and stigma reduction. FAP attends health fairs, and shares information on trainings to culturally diverse populations. Outreach and engagement include May's Mental Health Month Fair, NAMI Walk, Recovery Happens, and numerous public engagements. The Outreach and Engagement Countywide SFA organizes all-inclusive

community mental health events for families to make interpersonal connections to the Mental Health System in Riverside County. FAP hosted its fifth annual "Family Wellness Holiday Celebration" (formerly known as "Posada") attended by approximately 100 family members from diverse communities in a virtual environment. Per community suggestion, the FAP in collaboration with NAMI will explore the implementation of other cultural adaptations of NAMI programs such as "Compartiendo Esperanza" for the Spanish-speaking community, as well as "Sharing Hope" model for the African American community. FAP assists in various anti-stigma campaigns where behavioral health outreach is not traditionally given, such as community centers and faith-based organizations. Outreach takes place in Veteran clinics and hospitals to provide information on NAMI Home Front, an educational program designed to assist military families care for a family member diagnosed with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and other diagnoses

Through Family Advocate presentations, trainings, and outreach efforts, RUHS-BH has learned the importance families place on information and education. Feedback surveys collected from family members/ caregivers show an overwhelming amount of requests for information and education.

Many of the families we serve find information and education important because of the role they play in caring for their loved ones.

Families shared their involvement in their loved one's care. Fifty-six percent reported scheduling and providing transportation to their appointments.

Clinics/Sites

The FA line staff members work directly with family members of consumers within their clinics, sites, and programs. FA line staff members are in various clinic settings as well as our crisis teams throughout the County. FA staff assist in enhancing family support services within the outpatient clinics and work directly with clinical staff to advocate for families' integration into treatment. FA staff provide support at the Blaine, Hemet, Corona Wellness, Lake Elsinore, Perris, Temecula, and Indio Adult Behavioral Health Clinics. By promoting the empowerment of family members, they are better able to assist in their loved one's road through recovery, as well as their own. FAs assigned to the Family Rooms emphasize the engagement of families in treatment by offering support, education, and resources to enhance the family member's knowledge and skills and expand their participation and active role in their loved one's treatment. The FAP continuously implements its commitment to providing support, education, and resources to families in the TAY Centers. Education, information, and engagement of parents, family members, and other supportive persons are included in the services and can receive supportive service from Family Advocates. Throughout Riverside County, FAs hold weekly family support groups, TAY family support groups, and a sibling support group. This includes providing individual family support to family members within the behavioral health system, as well as, in the community.– program active

Justice-Involved

FAP works with the Office of Public Guardian (PG) and Long-Term Care (LTC) programs to assist families within the judicial system, Diversion Court, Care Court, and Mental Health Court. Families experience increased struggles with understanding the complexities within the

criminal justice system, such as incarceration, criminal court proceedings, MH Court, Long Term Care, and Public Guardianship. The SFA assists families of individuals with justice involvement to navigate these programs, offering support, providing a better understanding of the system, and offering hope to their loved ones. This SFA provides support, resources, and education to families whose loved one has been placed on conservatorship and/or is at a Long Term Care Facility. This SFA also acts as a liaison between families and the programs to offer additional support and an understanding of the LTC and PG processes, Veterans Mental Health Court, and Detention. The State of California, Council on Criminal Justice and Behavioral Health (CCJBH), recognized the FAP for the support offered to families in the judicial system and its continued contribution to reducing recidivism rates. The FAP developed several family educational series, such as "Families, Mental Illness, and the Justice System", "My Family Member Has Been Arrested" and "The Conservatorship Process," in both English and Spanish to the library of presentations offered countywide to family members, providers, and the community. Family Advocates Program was recently approved to hire three-line staff Family Advocates to assist in the Forensics Programs to meet the increased needs of the community. Family Advocate Program has been tasked to participate in the California CARE Court Program. This program Rather than cycling through jails and emergency rooms, CARE Court gives vulnerable individuals and those who care for them another path to access key services that can help keep them safe. Family members, roommates, clinicians, and others can petition the court to seek approval for this program. Family Advocate Program has been able to support families of 41 participants in this fiscal cycle.

Collaboration

FAP attends and participates in several Behavioral Health Department Committees. Such as TAY Collaborative, Criminal Justice Committee, Behavioral Health Regional Advisory Boards, Adult System of Care, Veterans Committee, and Cultural Competency Committees, to ensure that the needs of family members are heard and included within our system. FAP is part of the Family Perspective Panel Presentations with several RUHS–BH programs and agencies, such as the Graduate Intern Field and Trainee (GIFT) program, Workforce Education and Training (WET) and the Crisis Intervention Team (CIT) training to Law Enforcement. The CIT training includes the family perspective when called upon to de-escalate a mental health crisis. The FAP remains the liaison between RUHS – BH and the National Alliance on Mental Illness (NAMI) to assist the four local affiliate chapters with the coordination and support of the NAMI Family-to-Family Educational Program and will facilitate classes in both English and Spanish as needed. FAP assisted the Riverside and Hemet NAMI affiliates to start the first two Spanish-speaking NAMI meetings in Riverside County. In partnership with the local affiliates, the Spanish NAMI meetings successfully provide much-needed support to our Spanish-speaking communities. Most recently, FAP in partnership with the Filipino American Mental Health Resource Center to engage, support, and educate family members on mental health services. FAP works in collaboration with the Cultural Competency Program outreach and engagement efforts in all three regions. The FA Program was recently approved to add an SFA to the Cultural Competency team to further the efforts within Riverside County.

Volunteers continue to be an essential part of the FAP. SFA mentor volunteers in the day-to-day activities of an FA line staff. Their activities include attending the NAMI Family-to-Family Education Program and family support groups. Under the direction of the SFA, volunteers, and interns are active in outreach and engagement of the underserved populations, as well as co-facilitating the NAMI Family-to-Family classes and family support groups. The FAP continues to join forces with Consumer Peer Services and Parent Support and Training programs to promote collaboration and foster growth in understanding family and peer perspectives.

GOALS - Family Advocate Program

In the upcoming fiscal year, The FAP proposes to increase its involvement and offer new educational support to families and expand services such as:
• Continue to increase Family Advocate Peer Specialist positions to other clinic sites and programs such as Substance Abuse clinics and TAY – GOAL MET – active support groups in all SAPT clinics, held in-person and on virtual platforms.

• Recovery Management for family members Goal Met- Senior Family Advocate SAPT Program has integrated recovery management for family members through outreach and engagement and monthly support groups. GOAL MET.

• Forensics' support groups – GOAL MET – held on virtual platforms Countywide.

• Have an active role in Mental Health Urgent Care – GOAL MET – Senior Family Advocate leads the Inpatient/Outpatient Collaboration Committee that meets monthly with MHUC, Emergency Treatment Services Staff, and BH Staff to troubleshoot challenges with transitions between levels of care and to collaborate within the teams to facilitate timely to services for the people we serve GOAL MET.

• Expand Family Advocate staff into the Crisis Residential Treatment Facility (CRT) – Pending

• Family Advocate providing support and education at the RUHS-Behavioral Health Moreno Valley Medical Center campus. Also, assist with discharge and after-care planning. Goal in progress – The Family Advocate Program has received referrals from the Medical Center Moreno Valley as an after-care process. – Pending

• Expand the collaboration with law enforcement to provide continued education to the community on how to interact with law enforcement on crisis calls. GOAL MET – Family Advocates participate each month in the Crisis Intervention Training with officers from Riverside PD and Riverside County Sheriff's Department. They charge their lived experiences and other insights for the participants. GOAL MET.

• Develop a Family Advocate Email that will be used to get more referrals from the community and County partners. GOAL MET – Crisis referrals for families are now directed to a Family Advocate email and are addressed daily. This service went live on June 28, 2023.

The FAP believes that recovery is essential in their support services to families. We provide support to the family members as they go through their recovery journey. With continued support, education, understanding, and self-care recovery is possible for all members of the family.

Veteran Services Liaison

Riverside University Health System – Behavioral Health (RUHS-BH) offers veteran-specific services through our Veteran Services Liaison (VSL). The VSL provides outreach, engagement, case management, therapy sessions, and a commonality as a veteran to those who need services and support. Motivated by President Lincoln's Second Inaugural Address, RUHS-BH is dedicated "to care for him who shall have borne the battle, and for his widow and his orphan."

The VSL is a Clinical Therapist who serves as a portal to behavioral health care. After 2 years of recruitment for this specialized position, a candidate was selected in August 2024.

Cultural Community Liaison, Felix Gbagbo

The new Veterans Cultural Community Liaison and Clinical Therapist, Felix Gbagbo, MSW, began in August 2024. He joined the existing Riverside County Behavioral Health Commission's Veterans Subcommittee, attending their monthly meeting before being welcomed by the entire Commission at their public meeting on November 6, 2024. The Cultural Competency Program is excited to have a designated individual to assist Veterans with their behavioral health needs irrespective of their disability status, honorable or dishonorable status, targeting anyone who served our nation.

With approximately 112,000 veterans in Riverside County, Felix and the Veterans Subcommittee are committed to reaching as many veterans as possible to provide them with access to housing, veterans' benefits, and health resources. They also work to link them to and navigate the VA system, improving their well-being and quality of life.

Accomplishments thus far:

Advocacy:

Advocated on veterans' behalf to assist with accessing services, resources, and information relating to a higher level of care:

• Advocated for 5250 Psychiatry Hold for Convalescence/Nursing Home and Emergency Room veterans to improve their well-being and to receive the best care

- Financial resources to decrease the stress of potential homelessness for a wheelchair-bound veteran having challenges paying overdue utility bills by speaking with the Salvation Army and the Low Income Home Energy Assistance Program (LIHEAP) on the veteran's behalf; and
- Participated in a Veterans Day Discussion Panel at Temecula Adult Clinic to discuss topics on Mental Health Challenges for Veterans in the County of Riverside

Networking:

Gained additional contacts and learned more about existing services and resources by attending a series of events to network with County, non-profits, and government groups and individuals interested in serving the needs of veterans, including:

- Congressperson, Dr. Raul Ruiz, (Emergency Room Physician) Veterans University Event (Public Library, Hemet)
- Riverside County Veterans' Advisory Committee Meeting (American Legion Post, Riverside)
- BRIDGING THE GAP – Addressing Intersectional Health Disparities and Strengthening Support in the VETERAN COMMUNITY Meeting (Jurupa Valley)
- 2024 Veterans Expo hosted by Senator Kelly Seyarto (Murrieta)
- California Assemblymember, Dr. Corey Jackson (Peer Support Resource Center, Riverside), Veterans Care access and concerns discussion
- 12th Annual Veterans and Community Expo/Planning and Networking Meeting (Cathedral City)

Outreach:

Reached groups who support veterans and veterans directly, shared resources, and offered services and/or assistance in accessing services via resource tables at:

- Veterans Suicide Awareness event (American Legion, Indio), partnering with the RUHS BH Mobile Crisis Management and Response team
- Veterans Safety Standdown (National Guard Armory, March Air Reserve Base, Riverside), again partnering with RUHS BH Mobile Crisis Management and Response team
- 2024 Veterans Expo hosted by Senator Kelly Seyarto (Murrieta) to receive Mental Health educational resources for veterans

Support:

Provided therapy, transportation, assessments, resources, education, and collaborative care to veterans throughout Blythe, Indio, Banning, Temecula, Hemet, and Riverside:

- Veteran consumers seeking behavioral health care
- Transported veterans to and from the Medical Center Prosthetics Unit, Medical Centers, and Apartment Complexes to receive care and placement
- Collaborated care with a retired Army Sergeant 1st Class/Deacon, and an HHOPE Certified Peer Support Specialist to provide grief counseling
- Provided psychoeducation and resources to veterans at Rustin Peer Resource Center regarding Mental Health and navigating the VA System
- Partnered with the HHOPE Street Outreach team and the HHOPE Veterans Outreach team to house unsheltered/homeless veterans and to provide them with psychoeducation, therapy, and assistance with navigating the VA Disability Claims process

Felix Gbagbo has only just begun to honor the commitment he shares with the U.S. Department of Veterans Affairs, demonstrated by their March 2023 update to their mission statement, "To fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors." As a Navy Veteran and Clinical Therapist, he is well-equipped to inform the Veterans Subcommittee to serve members and veterans in Riverside County.

CSS-04 Housing

Housing

Homeless Housing Opportunities Partnership and Education (HHOPE)

Riverside University Health System – Behavioral Health continues to provide housing and homeless services to our department and the community at large through our Homeless Housing Opportunities, Partnership, and Education (HHOPE) program. HHOPE provides a full continuum of housing and homeless services. These include but are not limited to:

- Coordinated Entry System (CES): a 24/7 hotline and staff to assess and refer those in a housing crisis
- Street Outreach & Case Management
- Emergency Housing
- Rental Assistance
- Transitional / Bridge Housing
- Permanent Supportive Housing
- Augmented Adult Residential Facilities
- Enhanced Care Management & Community Supports

HHOPE staff support all elements of these programs including street-based and home-based case management, clinical therapy, peer support, and all administrative, compliance, fiscal, accounting and oversight activities required for program operations.

HHOPE Program provides resident supportive services to consumers residing in 706 supportive housing apartments/units across Riverside County, which incorporate various funding streams including, U.S Department of Housing and Urban Development (HUD), State California Department of Housing and Community Development (HCD), No Place Like Home (NPLH), and MHSA funds. HHOPE staff also support various landlords in the MHSA-funded apartments and our emergency shelter motel vendors to ensure safe and available housing options are secured. Our staff also support residents residing in our senior housing developments by providing transportation to and from medical appointments as needed, at no cost to the consumer.

Like other RUHS-BH programs, HHOPE benefits from Peer Support Specialists (PSS) to build consumer engagement and rapport. These staff have a lived experience of accessing the behavioral health system for their own need and have been homeless or have experienced a mental health condition and/or substance use disorder at some point in their lives. HHOPE employs PSS staff throughout all our various programs. Additionally, we have a Senior Peer Support Specialist who oversees multiple responsibilities and mentors our Peer Support Specialists. The PSS role is unique from our other staff as they provide lived experience, promote recovery from behavioral health challenges, provide resources to navigate the many systems of the County, and have an inside perspective of consumer struggles. Each of our

peers, including our senior peer, go above and beyond providing efficient services to ensure the needs of the community are met.

HHOPE serves as the County's lead agency for the Coordinated Entry System known as, Home Connect. The Coordinated Entry System (CES) provides a crisis response system, coordinates supportive services, and housing resources across Riverside County to form a collaborative, no-wrong-door system that connects households experiencing a housing crisis to services and housing. HHOPE continues to be very active in the development and operations of the CES program and works to ensure that individuals with disabilities are protected and treated equitably. HHOPE staff provides ongoing support and education to the community regarding the CES system capabilities and works to improve their operating system continually. In 23/24, CES has fielded over 21,107 calls for homeless assistance and has referred over 644 households for housing assistance/vouchers. Additionally, HHOPE CES staff continues to provide training on the County's homeless assessment, known and referred to as the VISPDAT, and has trained assessors who collected more than 5,370 assessments of homeless individuals/households.

The HHOPE program currently has 16 dedicated mobile homeless outreach teams, primarily composed of a Behavioral Health Specialist II and a Peer Support Specialist on each team. These teams are regionally assigned, providing street outreach and engagement, as well as housing navigation, landlord supports, and linkages to our MHSA services. These teams continue to be integral and are key players in the housing of homeless Veterans initiatives in our community as well as engagement of chronically homeless individuals and families. The Veterans initiatives resulted in Riverside County being awarded as the first large community in the nation to achieve functional zero for Veteran homelessness.

Recognized as innovative in our Housing Crisis program development and street engagement programs, RUHS-BH HHOPE continues to work in collaboration with city government and law enforcement to provide contractual street engagement in targeted areas for the Cities of Palm Desert and Menifee. The City of Menifee project, which began in 2021 and has experienced significant success, has resulted in an extension to provide outreach and engagement services through the end of June 2028. Utilizing an innovative Housing Crisis approach and housing plan development initiatives, these teams are key in linking those on the streets to our behavioral health services and system. HHOPE has also worked with local agencies to provide ongoing training to staff on homeless response program development and is working collaboratively with law enforcement agencies as they develop new homeless-specific services in their programs.

MHSA funding for temporary emergency housing and rental assistance was continued and further supplemented with grant funds from EFSP (Emergency Food and Shelter Program) and ESG (Emergency Solutions Grant) to provide access to emergency motel housing and/or rental assistance. These funds also help support our Housing crisis program, which includes homeless prevention services, which are also informed by a Housing First philosophy. Combined EFSP and ESG funds have provided over 50,915 bed nights of emergency housing for consumers in need for Fiscal Year 23/24.

HHOPE began a collaboration with the Family Advocate program to develop a Housing Resource specialist role with the Family Advocate program, to support and navigate our families through the challenges of a Housing Crisis, which can be overwhelming. This continues to be a valuable resource for the HHOPE program.

The HHOPE Program continues to support a unique community-based, very-low-demand permanent supportive housing project. The Path follows a low-demand, drop-in model for providing homeless outreach and permanent supportive housing to homeless individuals with serious mental health conditions. This residence operates through a contract with a nonprofit provider whose program model emphasizes peer-to-peer engagement and support. Those seeking permanent housing must have a diagnosed behavioral health challenge and be chronically homeless. The contractor employs a diverse staff, including Peer Support Specialist staff who may have received behavioral health services themselves, and many have experienced prolonged periods of homelessness. HUD permanent supportive housing grants partially fund the Path. All individuals referred to this housing program, must be referred through the County's Coordinated Entry System, Home Connect. The RUHS-BH HUD grants have been successfully renewed in order to support this program through FY 23/24

The Path, located in Palm Springs, opened in 2009 and provides permanent supportive housing for 25 adults. It is located immediately adjacent to a Full Service Partnership clinic operated by RUHS-BH. The Path maintained an occupancy rate of nearly 94.5% occupancy rate across the year.

The success of The Path, together with the prominent role it plays in the continuum of housing for RUHS-BH consumers, positions these programs for continued success as a valuable contact point for homeless individuals with severe mental illness.

RUHS-BH remains committed to serving the extremely high-barrier individuals including youth, adults and older adults who were formerly chronically homeless with severe and persistent mental health challenges. Many of those we serve are individuals who were high-utilizers of hospitals, jails, and Emergency Medical Services. By continuing to use the Housing First approach without precondition and coordinating matching care with our Full Service Partnership Behavioral Health Clinics we continue to expand our services and provide the needed supports for our target population. As well as proving on-site 24 hr. peer support staff, and 24 hr. on call support to our residents and landlords and a 24 hr. drop in center accessible to those on the streets and law enforcement to avoid incarceration, we were able to assist many residents who were previously some of the highest utilizers in our CoC to maintain stable housing. For FY 23/24, Four hundred and forty-seven (447) residents graduated to living in their own apartments of which two hundred and twenty (220) received no ongoing housing subsidy and the remaining two hundred and twenty-seven (227) received housing subsidy to assist with a portion of their rent.

The HHOPE Program's Mainstream Housing team assists qualified consumers in locating & maintaining housing. Consumers must be between 18-60 years of age with a documentable

disability, transitioning out of institutional or separated settings, or at serious risk of institutionalization, or homeless, or at risk of homelessness, low to no income, and currently receiving services through RUHS-BH clinics. Currently, we are assisting 92 households through this program to receive housing throughout Riverside County.

Both HHOPE Program teams and Mainstream are leveraging MHSA dollars to fund the staff who serve their clients with housing. The use of MHSA funding enables clients to benefit additionally from a Section 8 Mainstream 811. This produces a greater benefit for clients' housing for each MHSA dollar spent.

MHSA Housing Development One Time Funding: RUHS-BH has committed and expended all available MHSA housing development funds held in trust by the California Housing Finance Agency (CalHFA) and will continue to support affordable housing development and development projects as soon as funding becomes available. RUHS-BH leveraged MHSA funds for permanent supportive housing to support the development efforts associated with the creation and planning of more than units of affordable housing throughout Riverside County. Integrated within each MHSA-funded project were units of permanent supportive housing scattered throughout the apartment community.

The MHSA permanent supportive housing program continues to maintain stable housing for over 120 at-risk participants, with each MHSA-funded project consisting of 15 integrated supportive housing units within the larger complex. Each apartment community includes at least one full-time onsite RUHS-BH funded support staff with a dedicated office. Additionally, the HHOPE program staff support the tenants as well as wrap-around support for the landlord to help them with any complications they may experience. The MHSA apartment units operate at 100% occupancy and experience very little turnover, with an ongoing waiting list of more than 500 eligible consumers for housing of this kind. Existing units of MHSA permanent supportive housing will remain available to eligible residents for a minimum period of 20 years from the date of initial occupancy.

HHOPE started offering Enhanced Care Management (ECM) and Community Supports (CS) services in 2022. These two programs follow the CalAIM initiative, which is designed to improve the quality of life and health outcomes of Medi-Cal enrollees, including those with the most complex health and social needs.

ECM is one of the two new HHOPE programs developed which aims to improve Medi-Cal for people with complex needs and who are facing difficult life and health circumstances. ECM focuses on breaking down the traditional walls of health care by extending beyond hospitals and health care settings into communities. This program addresses clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. ECM services meet clients wherever they are – on the street, in a shelter, in their doctor's office, or at home. Clients will have a single Lead Care Manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time. We are excited about the addition of four Justice-Involved Enhanced Care Management

(ECM) teams to our program. These new teams will focus on providing critical support to individuals involved in the justice system, helping them navigate housing, healthcare, and other essential services. By expanding our ECM efforts, we aim to improve outcomes for justice-involved individuals, reduce recidivism, and promote long-term stability within our community.

Additionally, clients are being connected to Community Supports to meet their social needs, including medically supportive foods or housing supports. Community Supports are designed to address social drivers of health (factors in people's lives that influence their health). A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. HHOPE is currently offering 6 of the 14 CS services available through managed care plans: Housing navigation, housing deposit, housing tenancy, recuperative care, short-term post hospitalization, and sobering centers.

HHOPE has been identified as one of the leading providers of supportive housing in our community and as such has provided ongoing consultation services and specialized training to other Behavioral Health staff and community agencies on landlord services and Supportive Housing best practices. HHOPE has provided additional program specific training provided to new PSH agencies. Our HHOPE Deputy Director has been a presenter at the National Alliance on Ending Homelessness, the nation's premier homelessness conference in both FY 18/19, 19/20, and 22/23. This type of platforms allows HHOPE to share learned experiences and educate others on the best service approach and best practices to support our population.

Looking Ahead

The HHOPE staff will continue to provide a unique Housing Crisis Response program with ongoing landlord and supportive housing supports throughout the community.
There are now 706 units of permanent supportive housing provided by the HHOPE program and delivered to behavioral health consumers in Riverside County. Permanent supportive housing, for people with a behavioral health challenge, remains an integral part of the solution to homelessness in Riverside County. The need for this housing continues to outpace the supply. While there remains much community uncertainty about the ability to expand upon the success of the MHSA permanent supportive housing program due to the loss of various state and federal funding, such as Redevelopment Agency funding in recent years (without any viable alternative), together with the continuing transformation of the complex financial structures that are necessary to develop affordable housing, we continue to press forward and seek every opportunity to provide needed housing opportunities. There are ongoing efforts to collaborate and join with developers and community partners to capture any funding opportunity that will support the production of affordable housing, which includes units of permanent supportive housing for MHSA-eligible consumers. One such effort is the No Place Like Home Program.

On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of behavioral health services and

are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). Key features of the program include:

- Counties will be eligible applicants (either solely or with a housing development sponsor).
- Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
- Counties must commit to provide behavioral health services and help coordinate access to other community-based supportive services."

The HHOPE program in collaboration with Riverside County Housing Authority submitted five separate applications to California Housing and Community Development in the amount of $27,688,025 for No Place Like Home (NPLH) Round 1 funding. RUHS-BH was funded for four of these projects for a total award of 23.6M dollars. Round 1 of funding created 162 new units of permanent supportive housing within a total of 419 extremely affordable apartment units. These four projects are now complete and open for occupancy. RUHS-BH also applied for Round 3 and 4 of NPLH funds and was awarded 55.1M dollars for the development of eight additional permanent supportive housing projects. Two of the eight projects are now complete and open for occupancy. Two projects are expected to open in May and June and the remaining four will open between now and the Summer 2026.

Goals

1. HHOPE will diligently work to end homelessness and provide for the housing needs of the individuals we serve.
2. Expand ECM and CS services to serve more households
3. Continue to create innovate and customer service friendly CES tools to improve consumer experience
4. The program anticipates opening the Franklin Residential Care Facility and Behavioral Health Clinic in the next year. This 84 bed facility in Riverside will provide recuperative care and board and care services to adults with severe and persistent behavioral health diagnoses.

Section III

PEI

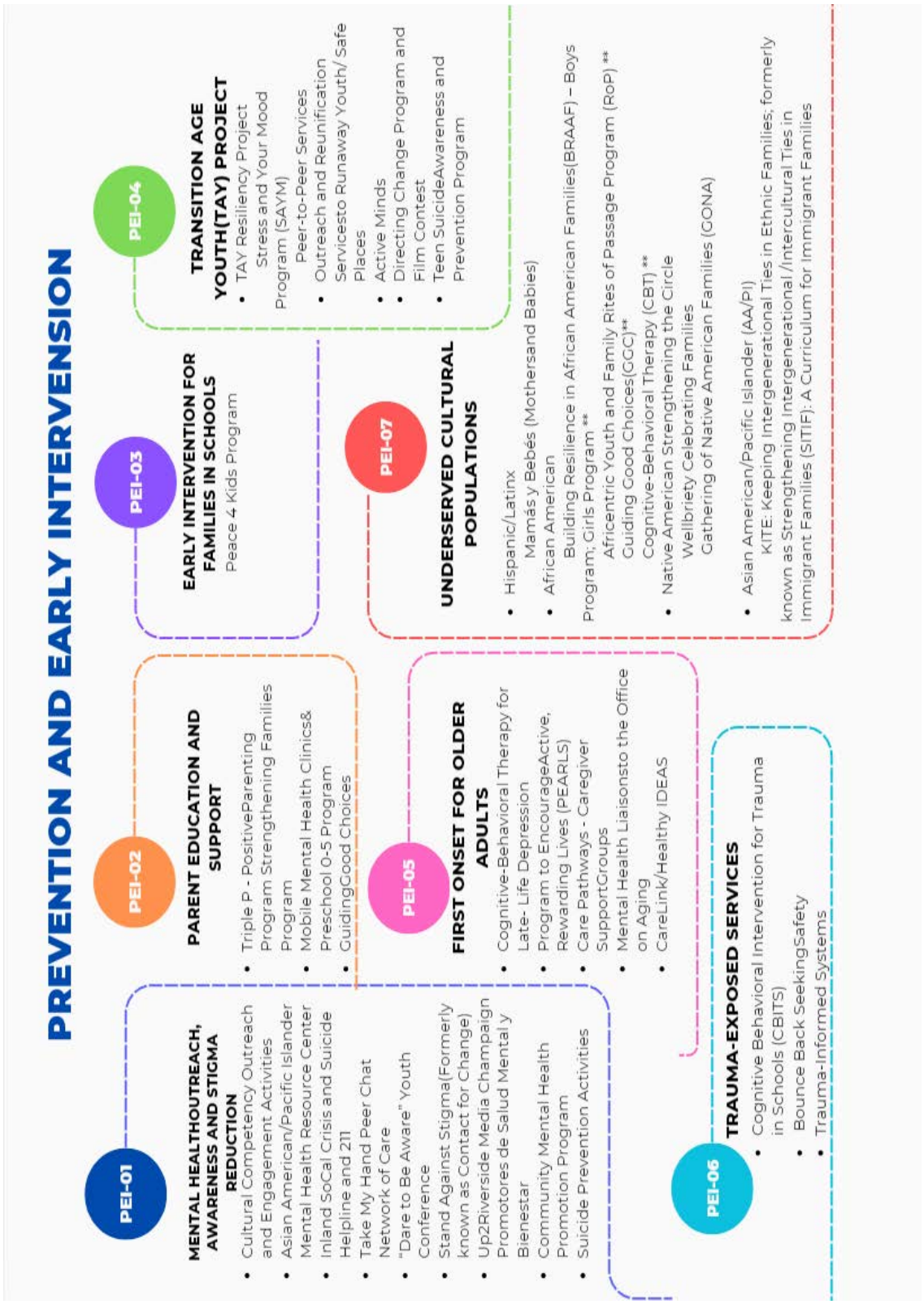
Prevention and Early Intervention

MHSA Annual Updates 25/26

PEI

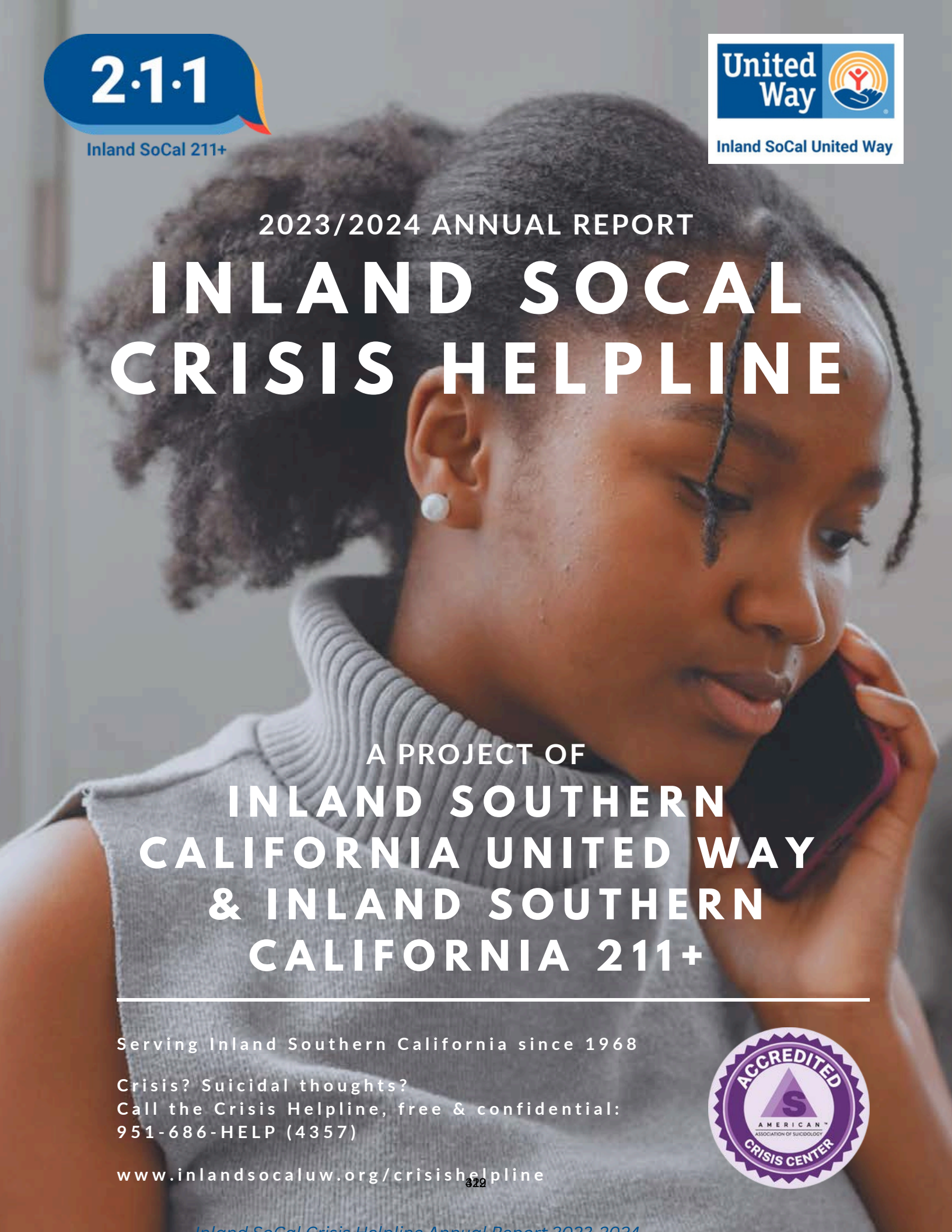
Prevention and Early Intervention

5



[5] ** denotes programs that will be removed from the PEI plan

PEI Progress and Outcome Reports



2·1·1 Inland SoCal 211+

United Way Inland SoCal United Way

2023/2024 ANNUAL REPORT

INLAND SOCAL CRISIS HELPLINE

A PROJECT OF

INLAND SOUTHERN CALIFORNIA UNITED WAY & INLAND SOUTHERN CALIFORNIA 211+

Serving Inland Southern California since 1968

Crisis? Suicidal thoughts?
Call the Crisis Helpline, free & confidential:
951-686-HELP (4357)

www.inlandsocaluw.org/crisishelpline

ACCREDITED AMERICAN ASSOCIATION OF SUICIDOLOGY CRISIS CENTER

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Inland SoCal United Way

Inland SoCal 211+

EXECUTIVE SUMMARY

The Inland SoCal Crisis Helpline (951-686-HELP) is a project of Inland SoCal United Way and Inland SoCal United 211+. Services include 24/7 someone to call, routing to somewhere to go (Mental Health Urgent Care) or warm hand-off to someone to come to you (Riverside County Crisis Mobile). The Inland SoCal Crisis Helpline also provides a statistical dashboard, evidence-based training like Mental Health First Aid and social work field placements via six universities.

The goal of this annual report is to increase access to local data and evidence about community mental health trends and to enhance dialogues for suicide prevention regional planning.

To illustrate the types of situations that require support, this report also includes real stories.

KEY FINDINGS:

- The number of calls to 686-HELP went up by **128%** from July 2023 (407 Calls) to June 2024 (928 Crisis Calls).
- **Calls for Crisis Mobile services increased by 444.2% within two fiscal quarters** from December 2023 (43 Calls) to June 2024 (234 Calls).
- **Calls for Mental Health Urgent Care increased by 351% within two fiscal quarters** from December 2023 (51 Calls) to June 2024 (230 Calls).
- Overall, we had **53% more calls** this year than last year and 67% more calls compared to two years ago. Most of these new calls came after we started the 24/7 mobile service.
- **Active rescues for imminent risk to life only constituted 0.63% of total calls, even though call volume increased.** This is a decrease from all prior years which demonstrates that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations.
- **The number of BIPOC callers in the last 12 months increased by 20% over the previous year** (although there was no proportional increase in crisis callers).
- **Crisis Helpline internships support next generation behavioral health professionals.** 26 social work students having completed a suicide prevention internship in the 2023/2024 school year, 100% of recent program graduates report wanting to continue service in crisis care.

COMMUNITY CRISIS CARE

The Inland SoCal Crisis Helpline (951-686-HELP) is one of the longest running suicide hotlines in California. Our Crisis Workers answer over 8,000 calls and train over 500 residents a year in courses like Mental Health First Aid. Our service is free, confidential, and can be anonymous. Bilingual counselors are available.

Serving Inland Southern California since 1968



TELEPHONIC EMOTIONAL SUPPORT

24/7 Crisis Counseling with highly trained, compassionate Crisis Workers. We make mental health crisis and suicide prevention easily accessible through locally operated tele-help. 951-686-HELP provides active listening, emotional support, suicide prevention, collaborative problem solving, and a connection to in-person support via the verified 211 database.

CRISIS CONTINUUM OF CARE

On January 1, 2024, Riverside County launched a new 24/7 Crisis Mobile Unit, accessible through our Inland SoCal Crisis Helpline, 951-686-HELP. The expanded service, provided by our primary funder, the Riverside University Health System, also offers telephonic crisis intervention and connects callers to three 24/7 Mental Health Urgent Care Centers. Aligned with SAMHSA's Crisis Continuum of Care, Inland SoCal United Way ensures individuals in crisis have someone to call, somewhere to go, and someone to come to them around the clock and for free.

PREVENTION & POSTVENTION

The Inland SoCal Crisis Helpline also trains 500 people a year to help prevent suicide via Mental Health First Aid (8 hours), safeTALK (4 hours), ASIST (16 hours), and QPR (60 minutes). In addition, we partner on postvention services with the Trauma Intervention Team to respond to suicide deaths.

SOCIAL WORK FIELD PLACEMENTS

Social work internships are an invaluable part of practical training and supervised experience to deliver mental health and social services. Since starting the internship program in 2020, the Inland SoCal Crisis Helpline has trained more than 100 graduate and undergraduate students from 6 universities.

United Way
Inland SoCal United Way

2·1·1
Inland SoCal 211+

What's next?

With 56 years of local crisis care service, the AAS and Inform USA Accredited Inland SoCal Crisis Helpline seeks to expand our reach by joining the 988 network. We also seek to expand our service area to the entire Inland Southern California region.

CRISIS CONTINUUM OF CARE

17.81% of calls were referred to Mental Health Urgent Care

The Inland SoCal Crisis Helpline and the Riverside County (RUHS) Crisis Mobile Unit expanded the continuum of crisis care in 2024. **In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to RCCMU for in-person support.**

The Substance Abuse and Mental Health Services Administration (SAMSHA), a Crisis Continuum of Care, consists of three core components: 1) Regional Crisis Call Centers, 2) Local Mobile Crisis Response Teams, and 3) Local Crisis Stabilization Centers. This creates a Continuum of Care, providing community members with Someone to Call, Someone to Come, and Somewhere to Go during a mental health crisis. The model decouples mental health crisis from law enforcement. In Riverside County, the Inland SoCal Crisis Helpline (951-686-HELP) is the front door phone number for community members and helping professionals to request screening and prospective dispatch of the Mobile Crisis Unit or referral to a Mental Health Urgent Care Center.

Chart 1. Crisis Mobile Referrals by Age 2023-2024

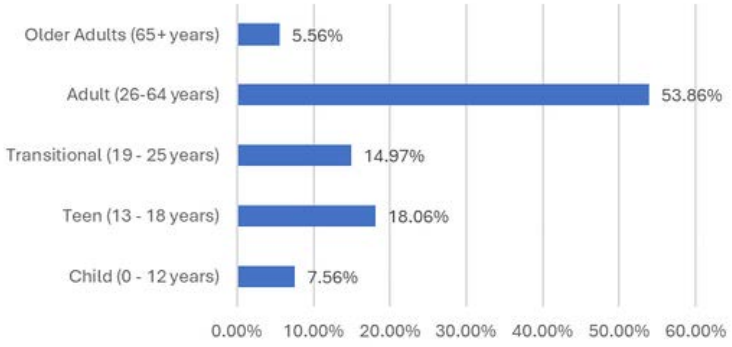
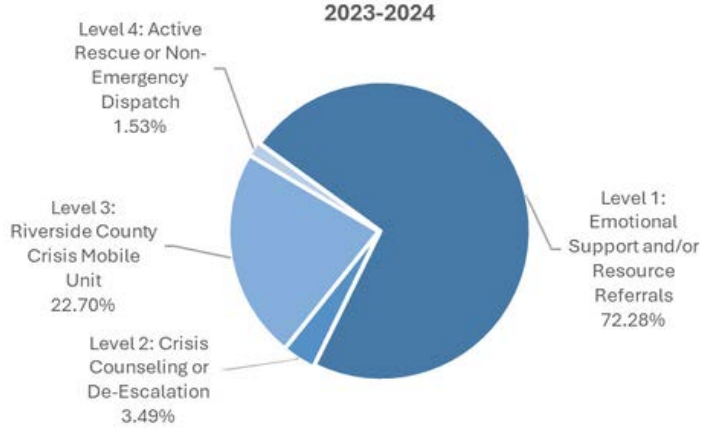


Chart 2. Crisis Continuum of Care 2023-2024



IMPACT

Topics of Crisis/Importance

The following are real-life issues of diverse needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

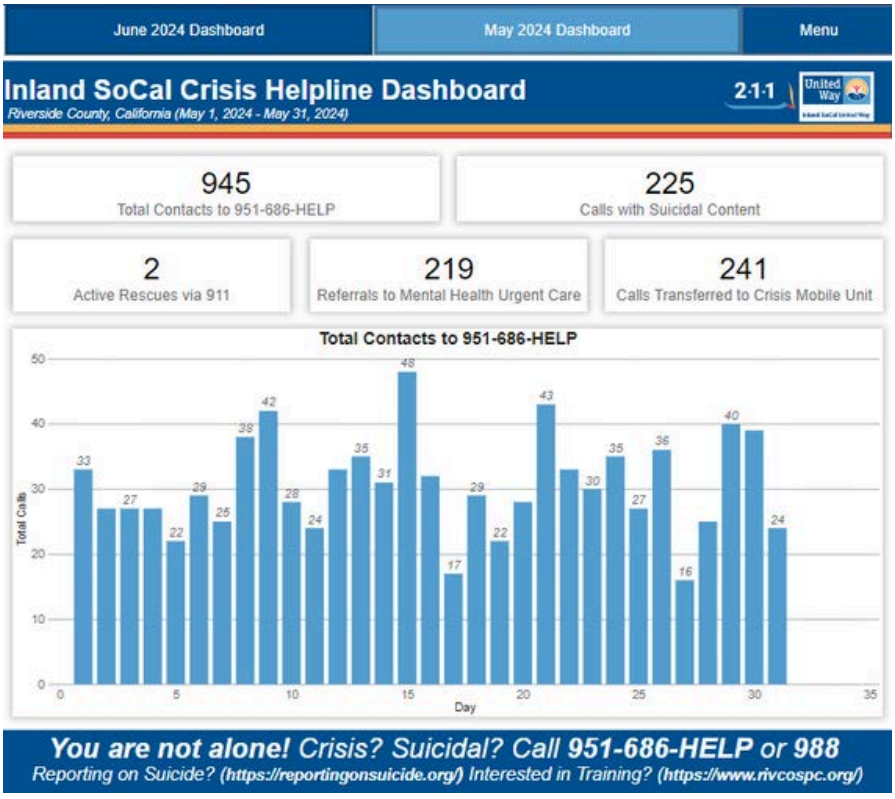
- Economic Despair
- Personal Relationship Conflict
- Substance Misuse Disorder
- Isolation/Loneliness
- Elder/Child Care Stress
- Major Life Events
- Grief/Loss
- Chronic Mental Illness
- Physical Illness/Pain
- Work/School Stress

RAPID REPORTING

Crisis Helpline Annual Report 2023-2024

As part of the Youth Suicide Rapid Reporting and Response Pilot via the California Department of Public Health and Riverside UHS Public Health, Inland SoCal Crisis Helpline launched a dashboard to share with the public data on:

- Total Calls to 951-686-HELP
- Calls with Suicidal Content
- Active Rescues via 911
- Referrals to Mental Health Urgent Care
- Calls Transferred to Crisis Mobile Unit
- Total Calls to 951-686-HELP by Date



EMERGENCIES

Emergencies are about 5% of call volume. These are the most intense, unpredictable calls, ranging from active suicide attempts, child and elder abuse, homicidal intent and other forms of imminent danger.

- **Active rescues have decreased by 16.13% since the prior year.** In 2023-2024, there were 52 active rescues via 911 dispatch for calls involving imminent or active harm to self or others (2022-2023: 62 active rescues).
- **In the role of caring for vulnerable populations, the Crisis Helpline is a mandated reporter of suspected abuse and neglect.** There were 8 reports of child abuse and 19 reports of elder or dependent abuse.

DEMOGRAPHICS

Riverside County is one of the largest counties in the country, the size of Oklahoma. It is also one of the most diverse communities in the country, and our callers reflect this.

- **Gender Identity**: 59.67% Female (4084); 40.08% Male (2743); 0.25% LGBTQIA+ (17)
- **Race/Ethnicity:** 74.66% BIPOC (772); 25.34% White (Non-Hispanic) (262)
- **Age:** 11.47% Youth 0-17 (265); 13.24% Transition Aged Youth 18-25 (306); 32.93% Adults 26-49 (761); 31.33% Older Adults 50-64 (724); 11.03% Older Adults 65+ (255)

ECONOMIC INSECURITY

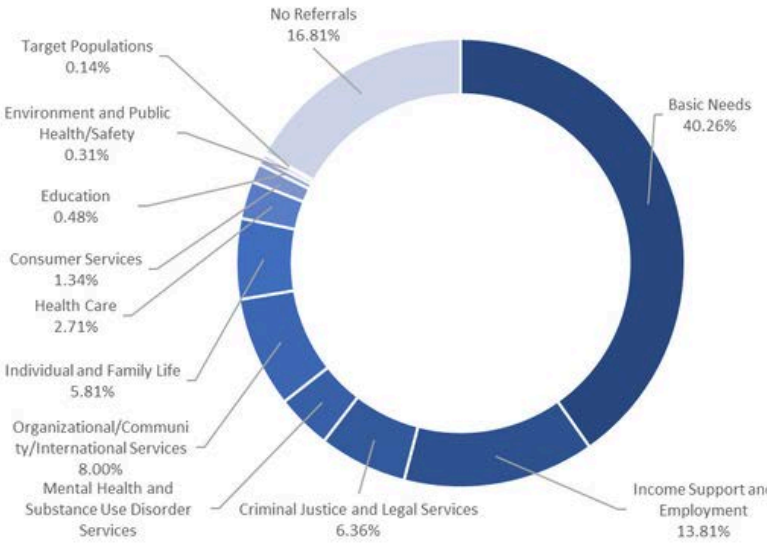
Crisis Helpline Annual Report 2023-2024

Economic security and mobility are protective factors for mental health. Inland SoCal 211+ Callers frequently discuss stressors associated with meeting basic needs, including needing services for food, housing, clothes, and other essentials. Inland SoCal Crisis Helpline (951-686-HELP), a program of Inland SoCal 211+, provides specialized behavioral health crisis support. Callers to this line are primarily individuals experiencing mental health or substance use crises. For callers requiring additional social services, such as food, housing, or utility assistance, 686-HELP Crisis Counselors transfer them to 211 Referral Specialists for appropriate support. Conversely, 211 Referral Specialists transfer individuals presenting with immediate behavioral health crises to 686-HELP. During the last fiscal year, Riverside County residents placed 48,111 calls to 211 seeking social services. Among these, 40.26% expressed urgent needs related to basic necessities like food, utilities, and housing. The United Ways of California Real Cost Measure finds that 1/3 of residents in Riverside and San Bernardino Counties do not have enough income for daily living needs, like food, housing, utilities, and other essentials.

Despair is a feeling of hopelessness, in this case resulting from an external factor over which callers have very little control—their economic position:

- Older adults express that housing unaffordability and homelessness cause suicidal thoughts.
- Parents express that they cannot make ends meet and provide for their children, causing emotional distress.
- Children and teens feel distraught due to financial stress that puts added pressure on families.
- Unhoused crisis calls show that extreme chronic stress damages mental health and causes depression, anxiety, and emotional distress.

Chart 4. Riverside County 211 Calls by Need Category FY 23-24



IMPACT

Topics of Crisis/Importance

The following are real examples of economic despair issues needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Housing (Lack of stable housing or lack of shelter or living with unsafe individuals)
- Employment (unemployment, underemployment, or holding multiple jobs)
- Basic Needs (lack of food, utilities, elder care, child care, or medical care)
- Transportation (lack of transportation to work or medical appointments)

PREVENTION & POSTVENTION

Crisis Helpline Annual Report 2023-2024

In addition to responding to active crises, the Inland SoCal Crisis & Suicide Helpline provides trainings, courses, and workshops to prepare the general public, schools, businesses, and other providers to identify and respond to mental health needs and suicide signs. **In the 2023-2024 program year, Inland SoCal Crisis Trainers conducted 320 hours of training across 39 days to 29 cohorts.**

"I couldn't prevent the suicide of my family member many years ago, but I feel blessed to have new tools from this safeTALK workshop. I now know what to do if someone tells me they have suicidal thoughts."

TRAINING COURSES:

Question Persuade Respond (QPR) is a 90 minute evidence based workshop with three steps anyone can learn to help prevent suicide.

Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive workshop and suicide first aid course. Ages 16+. Available in English.

Mental Health First Aid is an 8-hour course that teaches the public to help someone with mental health needs. Ages 18+. Available in English.

Suicide Alertness/safeTALK is a 4-hour course that helps the public recognize a person with thoughts of suicide and connect life-affirming help. Ages 15+. English and Spanish.

In 2023-2024, we also continued to support postvention services to help individuals heal from suicide loss and other situations. We are proud to partner with the Trauma Intervention Program (TIP) Riverside Chapter. TIP is a dedicated group of everyday people helping everyday people in traumatic crises. Their group of helpful, supportive volunteers is here to serve the needs of anyone when requested by a first responder, hospital personnel, paramedic, or coroner's office to bring emotional first aid to survivors, friends, and family in crisis.

Inland SoCal United Way

Inland SoCal 211+

FIELD PLACEMENTS

Crisis Helpline Annual Report 2023-2024

Mental health services are vital to community wellness. But the number of licensed therapists in California declined by 20% from 2016 to 2020 (CalHHS). This strains mental health care already overburdened by increased needs due to the pandemic, inflation, wildfires, gun violence, racism, the housing crisis, and other stressors. In 2020, to support the need for more mental health workers, the Inland SoCal Crisis & Suicide Helpline launched a workforce development effort. The program gives mental health career track students with a fieldwork site and behavioral health work experience while centering the development of their own protective factors to stay in the field.



Interns and Staff represent Crisis Helpline at the Out of Darkness Suicide Prevention Walk at Fairmont Park, September 2023.

Participating Universities:

- California Baptist University
- La Sierra University
- Grand Canyon University
- Chamberlain University
- Western New Mexico University
- University of Louisville

"I feel like serving at the Inland SoCal Crisis Helpline as a social work intern has prepared me to provide crisis intervention wherever I serve in the future."- Yarrezeth, 2023-2024 Intern; California Baptist University"

Preparing the Next Generation:

- More than 100 students have completed the program since launch.
- 26 students completed a behavioral health internship with Crisis Helpline in 2023-2024.
- 24 of the 26 students were Master's of Social Work graduate student interns. The remaining 2 were undergraduate students completing a Bachelor's degree in social work.
- 100% completed over 60 hours of suicide prevention and crisis intervention training and assisted thousands of community members in crisis.
- 100% of program graduates report having a long-term goal to remain in the behavioral health profession, and many report wanting to work long-term in crisis care.

United Way
Inland SoCal United Way

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Inland SoCal 211+

ACKNOWLEDGEMENTS

Crisis Helpline Annual Report 2023-2024

In recognition of their contributions, the Inland SoCal Crisis & Suicide Helpline acknowledges and is grateful for support from all community partners in the 2023-2024 program year.

With special thanks to:

Riverside County Behavioral Health (RUHS) for their 56 years of funding and partnership support to the Crisis Helpline services in Riverside County.

Kristin Miller of the Riverside County Crisis Mobile Unit for developing and launching our joint effort to make mobile crisis accessible to the general public through the Crisis Helpline.

Riverside County Public Health (RUHS) for their 2023-2025 grant focused on expanding Crisis Helpline awareness and suicide prevention training in Eastern Riverside County.

Dr. Charles Lee-Johnson, Froylana Miller and Judy Latham of California Baptist University's Department of Social Work for our 6th year anniversary of partnership with their department. 75% of the Crisis Helpline's social work interns each year join us from their program. With training and supervision by Crisis Helpline staff, their interns answer roughly half of all calls.

Prof. Daphne Thomas and Dr. Marni Straine of La Sierra University's Department of Social Work for supporting our team with additional training and development opportunities.

Riverside County Suicide Prevention Co-Chairs, Diana Guiterrez (RUHS-BH) and Rebecca Antillon (RUHS-PH) for their ongoing collaboration and support of regional suicide prevention.

Magda Stewart of Riverside Trauma Intervention Program (TIP) for partnering on postvention services to survivors of suicide loss.

United Way
Inland SoCal United Way

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Inland SoCal 211+

Riverside University HEALTH SYSTEM Behavioral Health

Stand Against Stigma

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview and Provider

Program Overview and Provider:

MHSA Prevention and Early Intervention has funded stigma reduction programing focused on specific presentations that are aimed at: (1) reducing stigma regarding mental illness, and (2) increasing community awareness within target populations regarding mental health information and resources. “Stand Against Stigma” is an anti-stigma program based on leading researchers’ previous studies about the importance of increasing community awareness about mental health information and resources, that suggests five principles that effectively decrease the consequences of public stigma, referred to as TLC3 (Targeted, Local, Credible, Continuous, Contact). This program is provided by RUHS-Behavioral Health Prevention and Early Intervention Peer Support Specialists known as PEI Peers. They provide services throughout the three regions of Riverside County: Desert, Mid-County, and Western.

Peer Support Specialists promote the consumer perspective in all their presentations. Stand Against Stigma is designed to provide anti-stigma presentations to individuals and organizations by specifically outreaching and collaborating with schools, businesses, community organizations, and faith-based organizations throughout the county to bring presentations to as many people as possible.

“Stand Against Stigma” presentations are utilized to educate and outreach to target audiences to share the unique stories of those with mental illness with the aim of reducing stigmatizing attitudes. Presentations are evidence-supported and structured to discuss mental health through presenters sharing their lived experience with mental health challenges and including an ‘on-the-way-up’ message to discuss strengths and recovery because of services, supports, and/or treatment. Presentations are aimed at reaching the following target audiences: community members, employers, landlords/housing officials, health care providers, other government-related entities, faith -based communities, and media.

Executive Summary: Key Findings

During the fiscal year 2023-2024, there were a total of 14 “Stand Against Stigma” presentations held by RUHS-Behavioral Health PEI Peers in the Desert (n=8), Mid-County (n=1), and Western (n=5) regions, for a total service of 14 hours. The majority of events targeted the general community.

- There were a total of 248 people who attended “Stand Against Stigma” presentations. The presentations were held either in-person or virtually via Zoom (n=14), the total number includes attendees from outside Riverside County regions. Due to the Stand Against Stigma program being provided to people who reside, work, or study in Riverside County, one (1) individuals who resided outside of Riverside County was excluded for analysis purposes. Additionally, one (1) individual who did not provide information regarding their residence was excluded as well. Moreover, 139 attendees did not complete the demographic and pre/post questionnaires. This resulted in only 109 attendees who were included in the analysis for this report.
- Most attendees resided in the Desert region (n=71, 65.1%).
- The attendees’ ages ranged from 19 to 68 years old, with an average age of 40 years old.
- The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (n=65, 59.6%).
- The majority of attendees were female (n=72, 66.1%).
- Post-test results revealed a statistically significant increase in participants’ affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Paired samples T-test showed statistically significant results for Stigmatizing Attitudes and Care-Seeking Attitudes scales ($p<=0.001$).
- Speaker’s Bureau attendees reported strong satisfaction with the enthusiasm and knowledge of the Speaker’s Bureau presenters, and a high likelihood to recommend the program to others.

Event Statistics

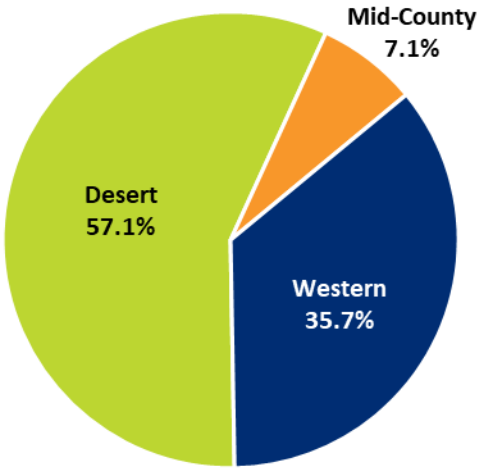
RUHS-Behavioral Health PEI Peers are expected to hold 40 “Stand Against Stigma” presentations per region each year. During FY 2023-2024, a total of 14 presentations were held throughout the County and no region met expectations.

RUHS-BH PEI Peers FY 2023-2024 Speaker’s Bureau Events Countywide			
Presentation Format	**Contract Expectation**	**Current Total**	**Percent Completion**
Speaker’s Bureau	**120**	**14**	**11.7%**

Out of the 14 total "Stand Against Stigma" presentations conducted by RUHS-BH PEI Peers, the majority took place in the Desert region (n=8), followed by the Western region (n=5), and the Mid-County region (n=1).

The presentations were evenly split between virtual and in-person formats, with 7 of each. The PEI Peers collaborated with a variety of community venues, including libraries, family engagement centers, colleges, social services organizations, and other community locations.

Event Statistics by Region



Event Duration by Region

Region	Total Time
Countywide	**14 Hours**
Desert	**8 (57.1%)**
Mid-County	**1 Hour (7.1%)**
Western	**5 Hours (35.7%)**

The total presentation time that was spent on Speaker’s Bureau events across all regions was 14 hours, with the Desert, Western, and Mid-County regions making up 57.1%, 35.7%, and 7.1% of the total time, respectively. The average time was 1 hour for presentations. Most of the presentations were conducted only in English (n=12, 85.7%), while an additional one presentation were conducted in American Sign Language (7.1%), and one more presentations were conducted in Spanish (7.1%).

Event Statistics cont.

City/Zip Code Locations

Region	City and Zip Code	Countywide
Desert		**8 (57.1%)**
	Indio, Palm Desert, Thermal	5 (62.5%)
	Virtual	3 (37.5%)
Mid-County		**1 (7.1%)**
	Virtual	1 (100%)
Western		**5 (35.7%)**
	Riverside, 92507	2 (40.0%)
	Virtual	3 (60.0%)

In FY 2023-2024, a total of 14 “Stand Against Stigma” presentations were delivered by providers, either virtually via Zoom or in-person. Of the seven in-person presentations, five took place in the Desert region and two in the Western region, with one event occurring in the Mid-County region.

Target Population

Target Population	Countywide (n=14)
Community	12 (85.7%)
Peers	1 (7.1%)
Other	1 (7.1%)

Speaker’s Bureau presentations were intended to target particular populations in non-traditional settings. The largest target population reached by the program was to the “Community” (n=12, 85.7%), followed by “Peers” (n=1, 7.1%) and “Other” (n=1, 7.1%). The community was reached through libraries, community organizations, and colleges.

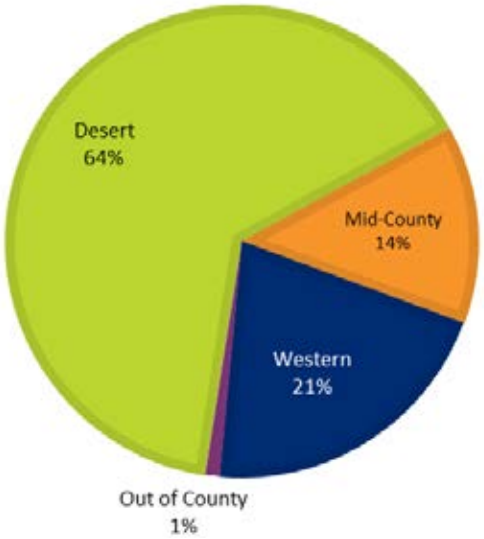
Participant Demographics

Attendance

A total of 248 individuals participated in the 14 “Stand Against Stigma” presentations during the fiscal year 2023-2024. Attendees were asked to complete demographic forms and pre/post surveys at each event. In total, 111 demographic forms and surveys were submitted, including responses from non-Riverside County residents, employees, or students (n=1) and individuals with unknown residency (n=1). Since the program is exclusively available to Riverside County residents, employees, and students, the analysis was based on 109 valid responses. Countywide analysis revealed a small percentage of attendees who identified as LGBTQ+ (n=14, 12.8%) or as having a disability (n=9, 8.3%), with no attendees identifying as veterans.

Residence by Region

Of the 109 total attendees who live, work, or study within Riverside County, most were from the Desert region (n=71, 64.5%), followed by the Western (n=23, 20.9%), and Mid-County regions (n=15, 13.6%) of Riverside County with the remaining living outside of the county (n=1, 1.0%). The figure below shows the total attendance by region of residence.



Language

Language	Countywide (n=109)
English	97 (89.0%)
Spanish	9 (8.3%)
Both	2 (1.8%)
Not Reported	1 (1.0%)

Age

Age Range	Countywide (n=109)
18 to 29 years old	16 (14.7%)
30 to 39 years old	34 (31.2%)
40 to 49 years old	38 (34.9%)
50 to 59 years old	16 (14.7%)
60 to 69 years old	3 (2.8)
70 years or older	0 (0%)
Not Reported	2 (1.8%)

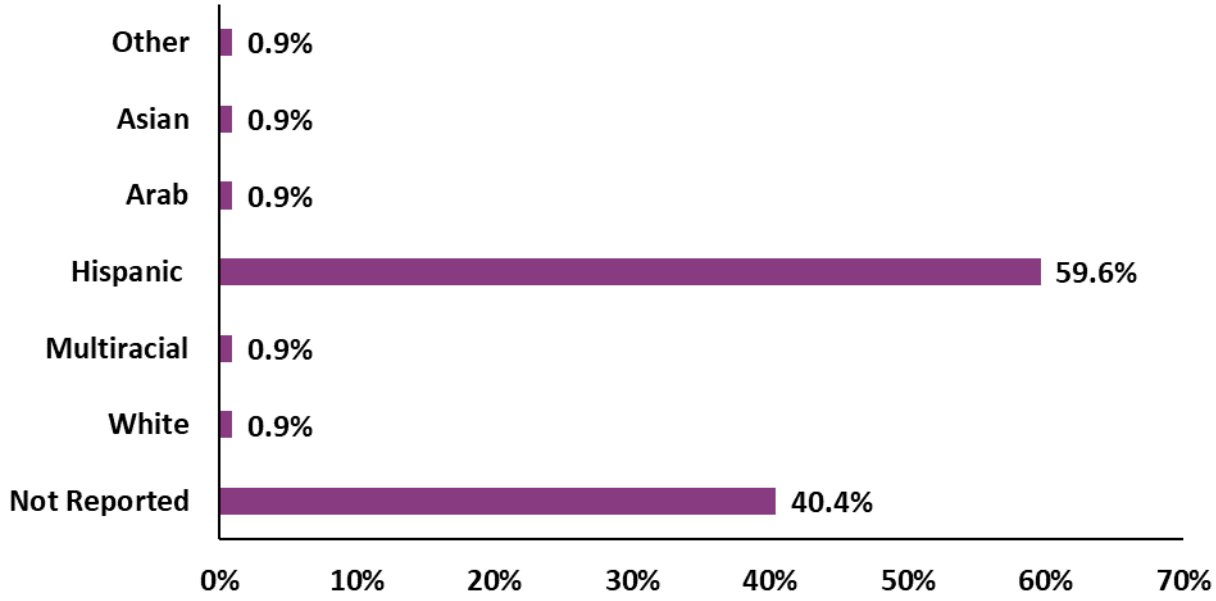
The table above presents the distribution of reported ages. Among the 109 attendees residing, working, or studying within Riverside County, the average age was 40 years, the median age was also 40 years, and the most frequently reported age was 39 years.

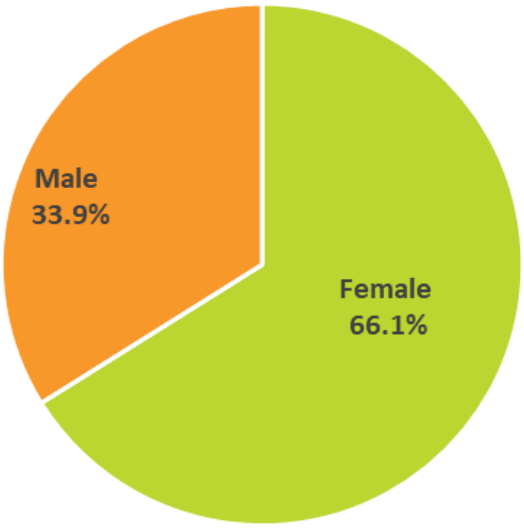
Among the 109 attendees residing, working, or studying in Riverside County, the majority (n=97, 89.0%) indicated that English was their preferred language, while 8.3% (n=9) preferred Spanish. One attendee selected both English and Spanish as their preferred languages, and another declined to respond.

Participant Demographics cont.

Race/Ethnicity

Of the 109 total attendees who live, work, or study within Riverside County, the majority of attendees identified as Hispanic or Latino/Latina (n=65, 59.6%). A small fraction of attendees identified as White (n=1, 1.0%), Asian American (n=1, 1.0%) and Multiracial (n=1, 1.0%). The rest of the attendees declined to report (n=44, 40.4%)





Gender

The majority of attendees identified as female (n=72, 66.1%), followed by male (n=37, 33.9%).

"Stand Against Stigma" Pre/Post Test Questionnaire

Pre-tests and post-tests were administered immediately before and after each "Stand Against Stigma" presentations in order to assess its impact on the attendees. The pre and post questionnaires were designed using a Likert Scale of 1 to 9, where 1 represents "Strongly Disagree" and 9 represents "Strongly Agree". There are a total of 15 questions in the pre and post questionnaires, in which four stigma sections were measured:

- 5 Questions on Stigmatizing Attitudes (AQ-5)
- 3 Questions on Recovery Attitudes (RS-3)
- 3 Questions on Empowerment Attitudes (ES-3)
- 4 Questions Care-Seeking Attitudes (CS-4)

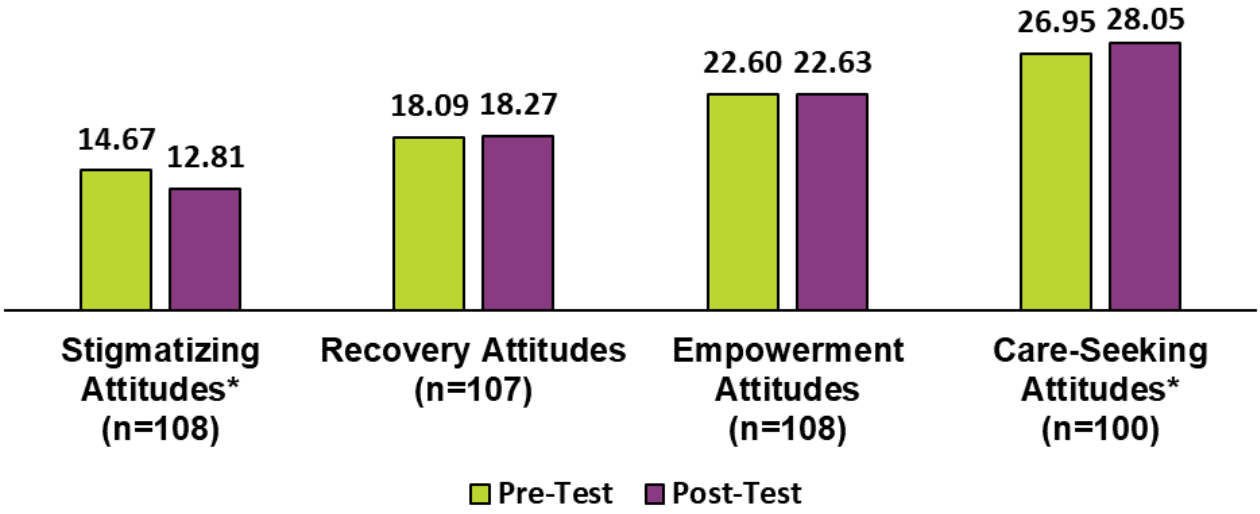
Measures of Stigma	Questionnaire	Rating Scale
Stigma Change (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to people with mental illnesses. *Example: "I think that most people with mental illness are to blame for their problems."*	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "I would speak to a counselor if I were significantly anxious or depressed."*	Score range: 6-54 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

A total of 109 attendees participated in a "Stand Against Stigma" presentation and completed pre- and post-test outcome measures. However, one attendee did not complete all items in the Stigmatizing Attitudes scale (n=108), two attendees did not complete all questions related to Recovery Attitudes (n=107), one attendee did not fully complete the Empowerment Attitudes scale (n=108), and nine attendees did not complete all items on the Care-Seeking Attitudes scale (n=100).

Scores for all items within each of the four questionnaire sections were summed, with pre/post-test comparisons based on the cumulative scores. Higher cumulative scores for the AQ-5 represent greater stigmatizing attitudes and higher cumulative scores on the RS-3, ES-3, and CS-4 represent more positive attitudes toward the described constructs.

"Stand Against Stigma" Average Scores: Pre-Tests vs. Post-Tests

In order to measure the effectiveness of the presentations, ideally there would be a decrease in the average scores of the Stigmatizing Attitudes scale from pre- to post-measures and an increase in the average scores of the Recovery Attitudes, Empowerment Attitudes, and Care-Seeking Attitudes from pre- to post-measures. Overall, the average scores across all scales showed improvements from pre -tests to post-tests. Further analysis using paired samples t-tests shows the improvements were statistically significant (p<=.001) for two scales as shown on graph and table below.



Note: Significance levels * = Numbers indicate statistically significant (p<=.001) change from Pre to Post

Measured Scales	Difference in Average Scores	*t*	df	p
Stigmatizing Attitudes (AQ-5)	1.86	4.200	105	.000
Recovery Attitudes (RS-3)	-0.18	-0.406	105	.685
Empowerment Attitudes (ES-3)	-0.03	-0.080	105	.936
Care-Seeking Attitudes (CS-4)	-1.10	-2.699	99	.008

When comparing the pre- and post-test results across the scales, the Care-Seeking Attitudes scale demonstrated the most significant increase, with an average score change of 1.10 points, followed by a 0.18-point change in the Recovery Attitudes scale. However, the small increase in Recovery Attitudes was not statistically significant. Additionally, the minimal change in scores on the Empowerment Attitudes scale may be attributed to the relatively high baseline scores of attendees (average of 22.60 points, with a range of 3-27), and this change was also not statistically significant.

Overall, statistically significant improvements were observed in both the Stigmatizing Attitudes and Care-Seeking Attitudes scales. These findings suggest that the "Stand Against Stigma" presentations were effective in positively shifting attendees' perceptions of individuals with mental health conditions, increasing their belief in recovery and empowerment, and enhancing the likelihood of attendees seeking help when facing anxiety and/or depression.

Satisfaction Surveys

Additional satisfaction questions were included at the end of the "Stand Against Stigma" post-test questionnaire. Using a scale of 1-9, with 1 representing the poorest satisfaction and 9 representing the greatest positive satisfaction, participants were asked to rate the presenters' level of enthusiasm and knowledge (n=109), and their likelihood to recommend others to participate in a similar "Stand Against Stigma" presentation (n=109). Their responses are summarized below:

- With an average score of 8.25, 72.5% of attendees strongly agreed that the presenters were enthusiastic and knowledgeable when sharing the information
- With an average score of 8.17, 70.6% of attendees strongly agreed that they would recommend others to participate in similar activities

The table below shows the percentages of attendees' responses to each satisfaction survey question. On average, all participants who completed the satisfaction questions reported positive feedback (over 87.6% of attendees chose "6" or higher). Additionally, their comments about the events are shown below and continue on the next page.

		1=Strongly Disagree								9=Strongly Agree	
Countywide (n=103)	**Average**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**No Response**
1. The presenters were enthusiastic and knowledgeable when sharing the information.	8.25	3.7%	-	-	0.9%	4.6%	1.8%	1.8%	11.9%	72.5%	2.8%
2. I would recommend an activity like this to my friends, family members, and colleagues.	8.17	3.7%	-	-	0.9%	6.4%	0.9%	3.7%	11.9%	70.6%	1.8%

Comments

Additional Comments

- I love that the presenters shared true life stories. It was a heartfelt presentation.
- Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful .
- Thank you for sharing. You are so brave and strong.
- Great job ! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone.
- Your honesty and vulnerability are appreciated. Thank you for your time.
- Thank you! This was wonderful to see and hear that there are people fighting the good fight.
- Brave speakers !
- Thank you for sharing.
- Thank you to [facilitator] and [facilitator] for sharing your stories. Thank you for still being here, and congrats on the work you have done so far. I hope the best for the work ahead.
- Presenters were very brave.
- Very touchful stories.
- Each of their stories was very touching and overall highly recommended.
- Life is a miracle if we can experience it.
- Able to change the cycle, learn from it and grow. Be the best person, sibling, parent, wife.
- The experiences with life were very valuable.
- I would love to see PowerPoint from families.
- Thank you for sharing your stories.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention (PEI)

Community Mental Health Promotion Program

FY 2023-24 Annual Report



Introduction

The ethnically and culturally specific Community Mental Health Promotion Program (CMHPP) trains lay workers in the community (promoters) to outreach to their communities, bring awareness to mental health topics, reduce stigma and provide resources and/or referrals to prevention and early intervention services.

The selected promoters go through a 40-hour training in which they are educated on various mental health topics, given a list of culturally competent local resources and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide services in non-stigmatizing community locations such as local churches, community centers, schools and other community locations. The promoters reach out to the Desert, Mid-County, and Western regions of Riverside County, and are especially focused on neighborhoods and communities identified by the MHSA Prevention and Early Intervention (PEI) planning committee as areas of high need. Outreach and education is provided to a range of age groups from middle/high school students, transitional age youth (TAY), adults, and older adults.

Contracted Partner Agencies

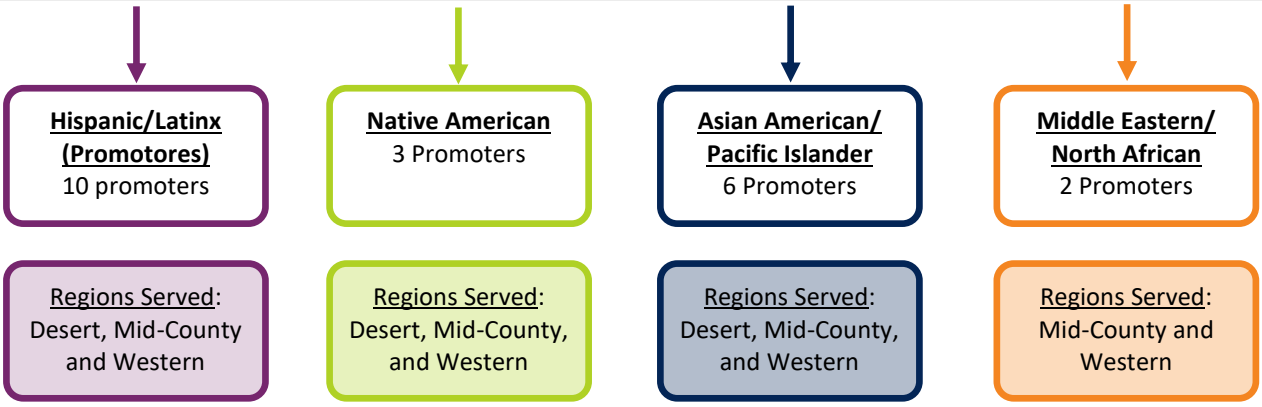
MHSA PEI formed partnerships and contracted with key community agencies. The agencies were responsible for selecting culturally competent promoters who have an understanding of the values, beliefs and language of the community, ensuring that all staffing needs were met and ensuring that the promoters received training as required by MHSA-PEI. They were responsible for program implementation and documentation.

Promotores Latinx/Latino	MHSA-PEI partnered with Visión y Compromiso, who's committed to community well being by supporting Promotores and Community Health Workers. Visión y Compromiso also have a vision towards a healthy and dignified life.
Native American RSBCIHI	MHSA-PEI partnered with Riverside/San Bernardino County Indian Health Inc. The organization advocates on behalf of American Indians through the delivery of quality health care services, which honor spiritual and cultural values.
Asian American/Pacific Islander Asian Pacific Counseling & Treatment Centers is a division of ssg Special Service for Groups	MHSA-PEI partnered with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), specializing in culturally sensitive approaches to address the social and psychological needs of Asian and Pacific Islander communities.
Middle Eastern/North African SAHABA INITIATIVE Sahaba Initiative nurturing healthy families	MHSA-PEI partnered with Sahaba Initiative who outlines a vision for the Middle Eastern/North African (MENA) communities where mental health is valued and acknowledged with an emphasis on the importance of mental health education and ensuring everyone has access to necessary resources.

Other contracted agencies have provided Outreach in the past to the Black African American community and LGBTQI community, these contractors were unable to continue so this report includes the current contracts.

Staffing By Program and Region

Overall in FY 2023-24, **21** promoters provided outreach and presentations across the CMHP programs in the Desert, Mid-County, and Western regions of Riverside County.



Promoter Training Requirements

As mentioned in the introduction, per contract guidelines, all new promoters are required to complete a 40-hour training which includes topics of safety, community outreach, PEI and community resources, the role of a promoter, mental health topics review, promoter presentations review and data collection. Upon completion of the trainings, program directors complete and submit a performance review of the promoter including strengths and areas of improvement. The promoters also complete an evaluation scoring on a scale of 1-5, if the trainings were effective and helpful in their development as a promoter and if they were confident in their ability to provide community resources and answer questions on mental health issues in a culturally competent way.

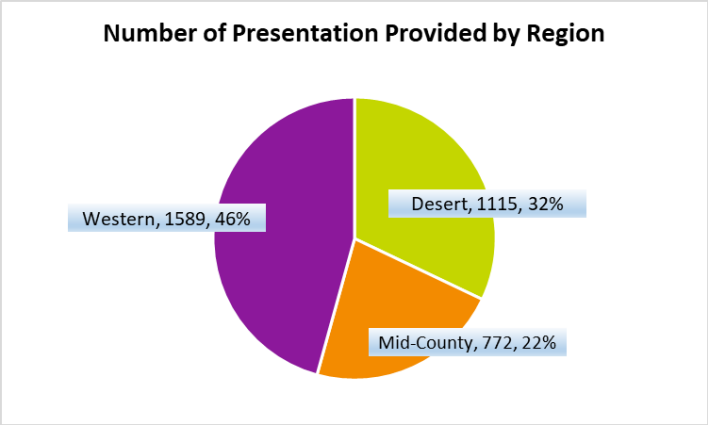
Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Promotores Hispanic/Latinx CMHP program provided a total of **3,476** 1-hour mental health presentations across the Desert, Western and Mid-County regions of Riverside County.

A majority of presentations were provided in the Western region of Riverside County **(46%).** Presentations were available in Spanish and English.

Most presentations were in-person (96%), while presentations were also provided virtually (4%). In-person presentations included residential homes or at public locations such as churches, clinics, community centers, libraries, parks, schools, and shopping centers.



Participants were welcomed to attend more than one presentation. A total of **11,862** people were recorded as attending, which includes those who attended multiple times. Among them, **9,658** reported that attending one of the nine presentation topics was their first time, while **1,879** indicated that they had attended more than one topic, while **325** participants did not response.

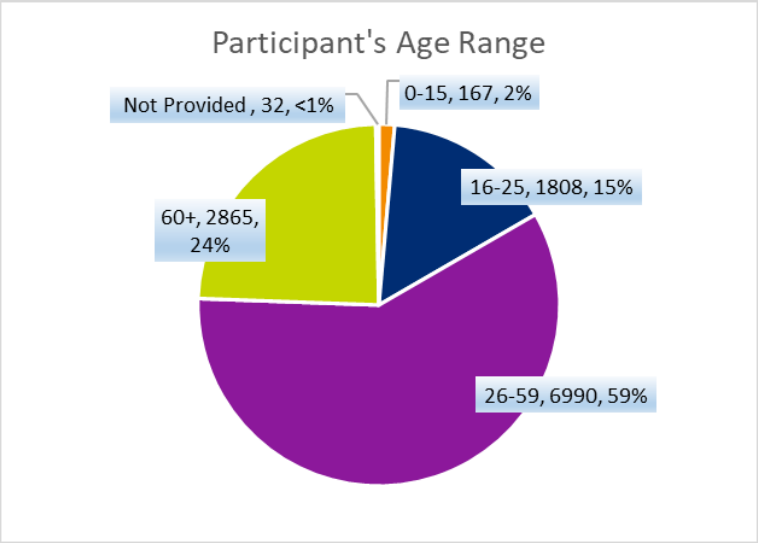
Half of the presentations **(54%)** provided by Promotores CMHPP were on Mental Health, Anxiety, and Depression. The remainder of topics **(46%)** discussed were Trauma, Effects of Drugs and Alcohol, Bipolar Disorder, Suicide Prevention, Grief & Loss and Schizophrenia, collectively.

Topic	n (%)
Anxiety	**577 (16.6%)**
Bipolar Disorder	311 (8.9%)
Depression	**581 (16.7%)**
Effects of Drugs and Alcohol	215 (6.2%)
Grief and Loss	159 (4.6%)
Mental Health	**735 (21.1%)**
Schizophrenia	301 (8.7%)
Suicide Prevention	215 (6.2%)
Trauma	382 (11.0%)



Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All data is based on the total number of participants who have attended presentations, including duplicated counts since participants can attend more than one presentation. The graphs below display totals for those participants that provided a response in the presentation sign-in demographic form.



59% of the participants who attended the presentations reported being adults aged 26 to 59 years old. 15% were youth aged 16 to 25, and 24% were 60 and older, while 2% were 15 years old or younger.

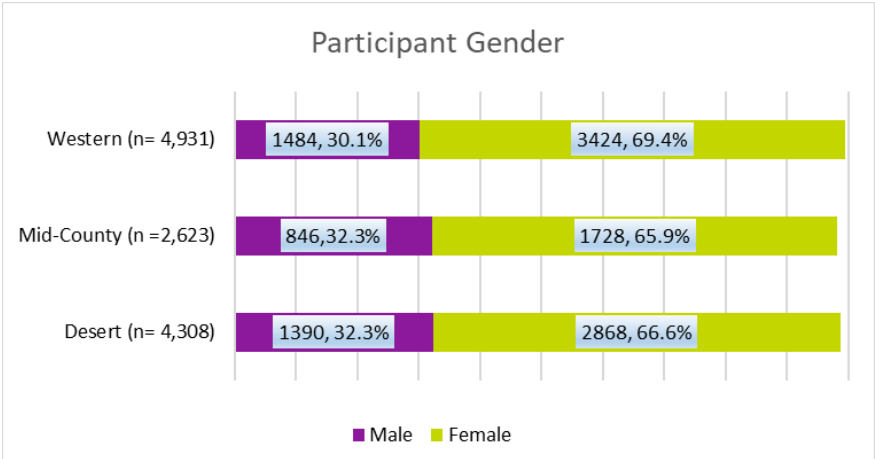
Most participants indicated Spanish as their primary language (85%), 5% selected being fluent in both English and Spanish and 9% of participants spoke only English, while <1% did not provide a response.







Regardless of region, the proportion of females reached was greater than the proportion of males. This occurrence could be by chance or influenced by stigma. Hispanic/Latinx male individuals may be less inclined to talk publicly about challenges at home compared to the female member(s) of the household. Overall (not shown in this graph), across all regions, 115 individuals did not self– identify, 6 participants identified as trans, and 1 participant identified as non-binary. Additionally, a very small percentage of participants identified as Lesbian, Gay, or Bisexual (n=37).

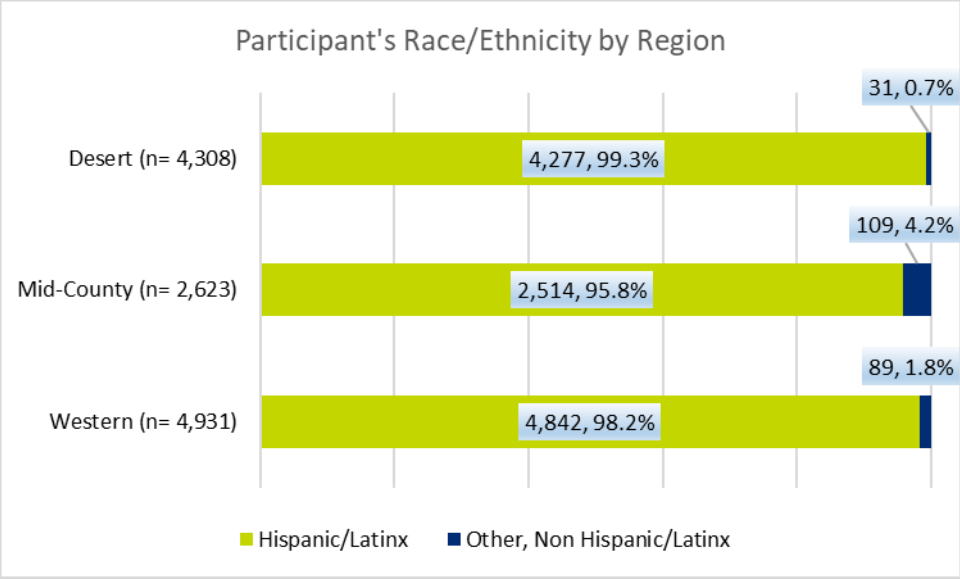


**This data does not include individuals that have self-identified as non-binary, trans, or those who have not provided a gender identity, due to the small number breakdowns. Please refer to text for additional information. Note that totals do not add to 100%.*

Mental Health Presentations: Demographics (cont.)

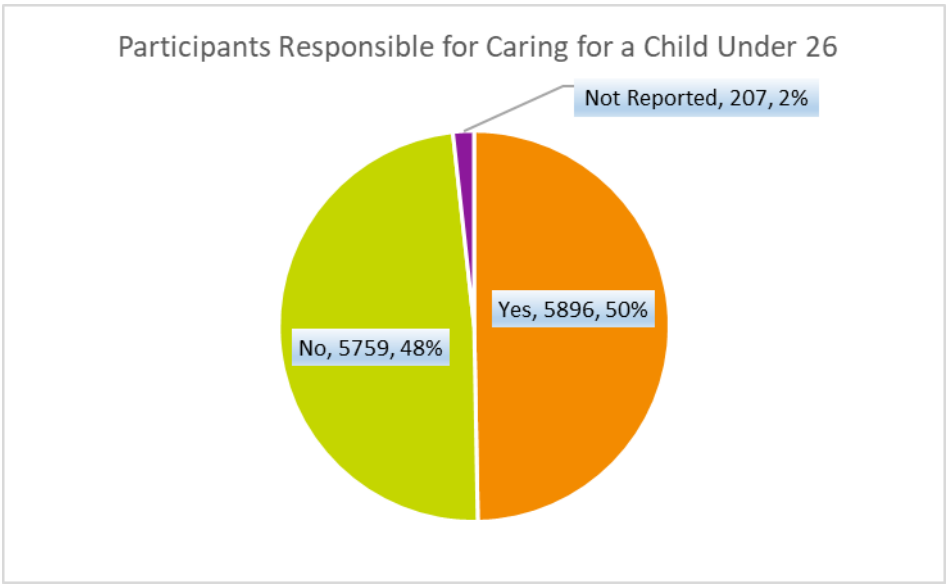
In the Desert, Mid-County, and Western regions, participants in the Promotores CMHP program identified as Hispanic/Latinx (**n=11,633**). Across all regions, 84 self-identified as Caucasian, 23 as Black/African American, 7 as Asian/Pacific Islander, 3 as Native/Indigenous, 48 as Other/Non-Specific, and 48 chose not to self-identify.

While the CMHP program focused on Hispanic/Latinx individuals, it welcomed anyone who felt they would benefit. The graphs below display totals for participants who provided a response on the presentation sign-in demographic form.



**Individuals that did not self-identify as Hispanic/Latinx were categorized as Other, Non Hispanic/Latinx. Please refer to text for additional information regarding racial breakdowns.*

A total of **11,862** responses were submitted regarding caring for a child under 26 years old. Approximately 1 in 2 participants reported having a child under 26. The graph below provides a detailed breakdown of responses across all regions.



Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

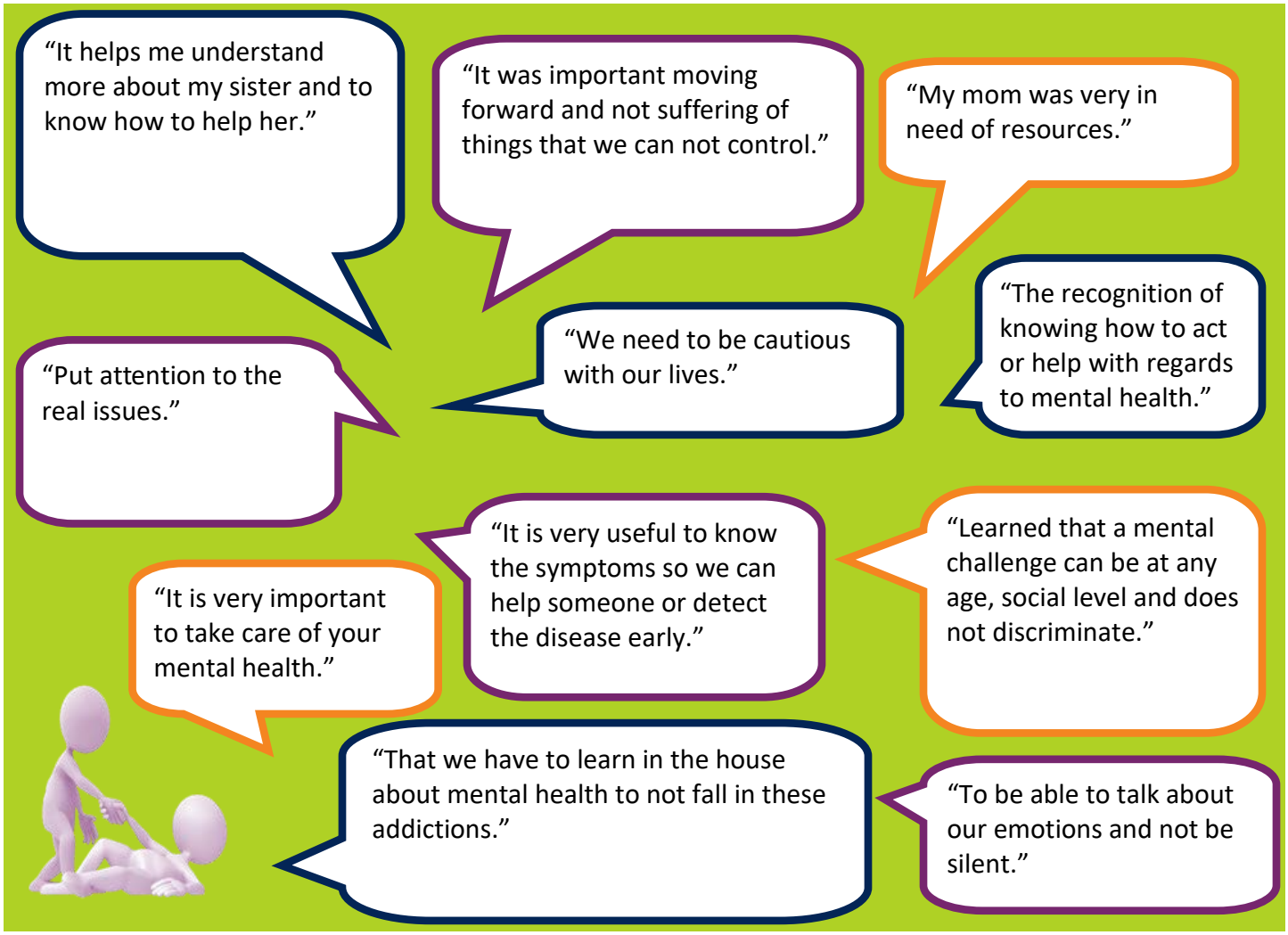
A randomized sample of 500 participants from the 8,527 who completed the satisfaction survey was used to evaluate satisfaction. Surveys from individuals who attended multiple presentations were included, as their experiences may have varied between sessions.

As shown below, a majority of participants strongly agreed with all statements in the survey, indicating they felt confident in seeking help and finding resources, and that they could share the information with family and friends, that they got a better understanding of mental health issues, and that they had a great experience with the promoter.

Questions (n= 500)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
The presenter understands the needs of my community	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.92**	–	1 (0.2%)	5 (1.0%)	29 (5.8%)	**461 (92.2%)**	4 (0.8%)
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.92**	–	1 (0.2%)	4 (0.8%)	27 (5.4%)	**466 (93.2%)**	2 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.85**	–	1 (0.2%)	9 (1.8%)	54 (10.8%)	**433 (86.6%)**	3 (0.6%)
I know mental illness can me managed and treated	**4.87**	–	1 (0.2%)	7 (1.4%)	49 (9.8%)	**440 (88.0%)**	3 (0.6%)
I feel comfortable seeking help for a family member, friend, or myself	**4.87**	–	2 (0.4%)	6 (1.2%)	48 (9.6%)	**442 (88.4%)**	2 (0.4%)
I know where to seek resources for a family member, friend, or myself	**4.90**	1 (0.2%)	1 (0.2%)	4 (0.8%)	37 (7.4%)	**455 (91.0%)**	2 (0.4%)

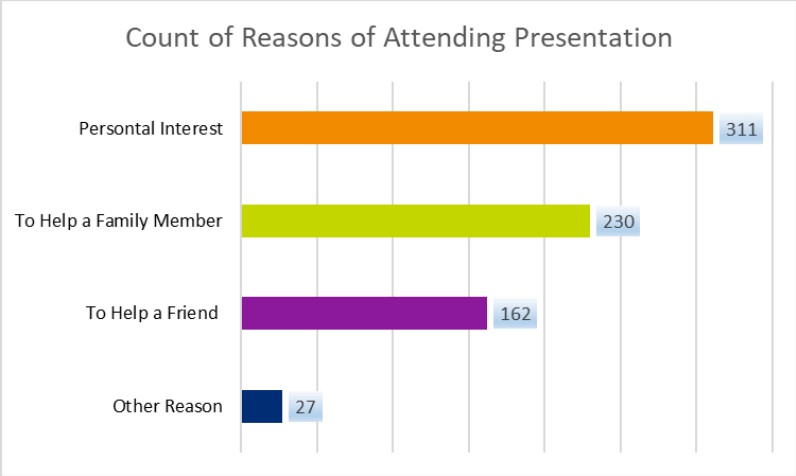
Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Feedback (cont.)

Reasons for Attending



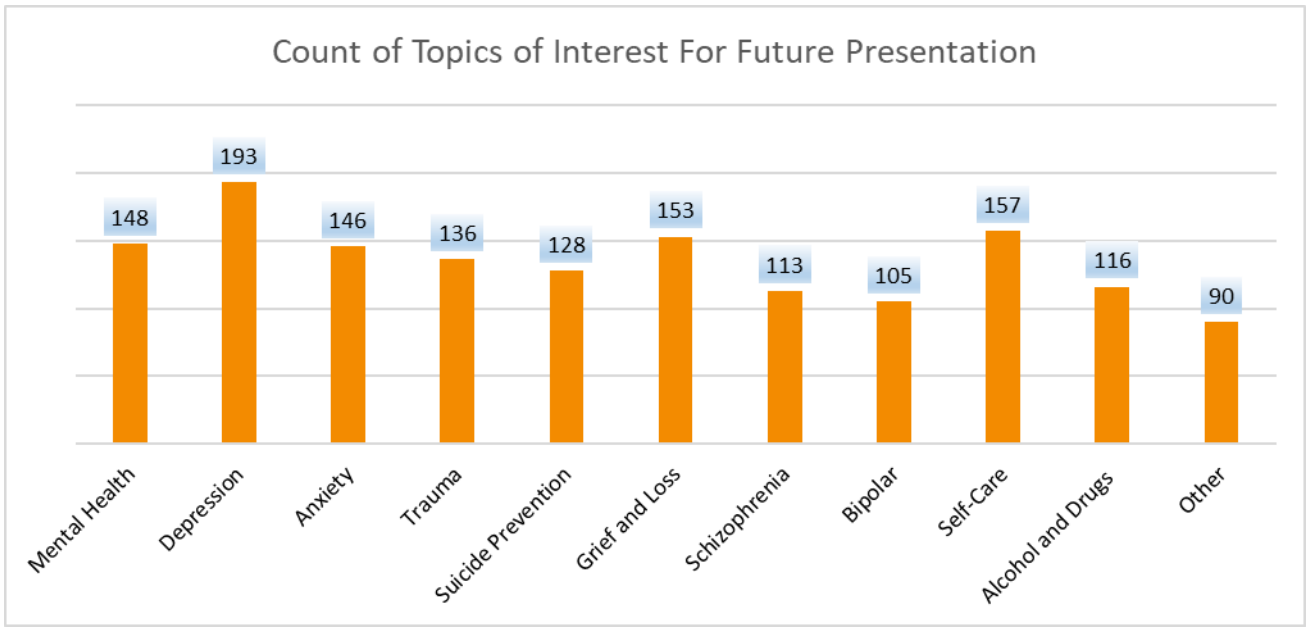
Out of 8,527 participants who completed the satisfaction survey, a randomized sample of 500 provided their reasons for attending the presentation. Participants could select more than one response.

The majority indicated that personal interest was their primary reason for attending, followed by a desire to help a family member. Among those who selected "other reason," the most common response was receiving an invitation from a friend or family member.

Topics for Future Presentations

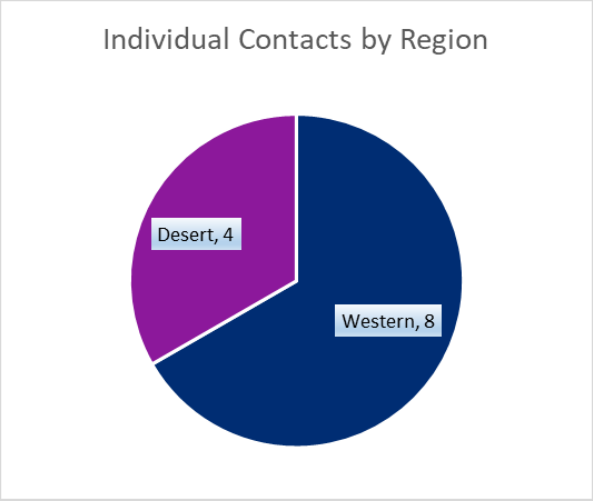
Among sample size of participants who completed the satisfaction survey, a majority expressed interest in learning about Depression, followed by Self-Care, and then Grief & Loss. Additional topics of interest not listed included Autism, Self-Esteem, and Obsessive-Compulsive Disorder. Participants were allowed to select more than one topic.

Feedback from these surveys will be considered by promoters when planning presentations on these topics for the 2024-2025 fiscal year.

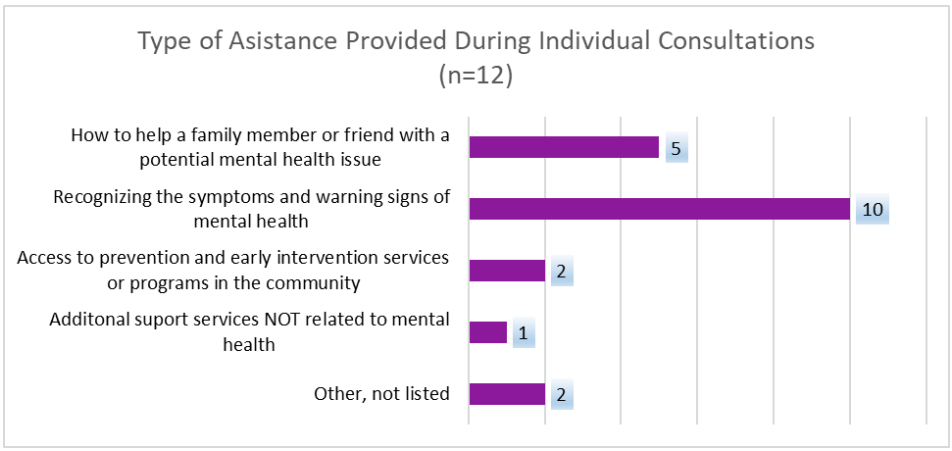


Promotores Hispanic/Latinx CMHPP

Individual Contacts: Type of Assistance



Individual contacts for the CMHP program are defined as when a promoter provides more in-depth one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Promotores Hispanic/Latinx CMHP program completed **12** individual consultations. Although not shown, all twelve individuals contacts were in-person and occurred as a result of presentations.



The chart above summarizes the types of consultation that were provided. A majority of mental health-related consultations involved recognizing the symptoms/warning signs of mental health issues and providing services to help a family member or friend with a potential mental health issue. Additionally, many participants asked for access to prevention and early intervention services or programs in the community. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.

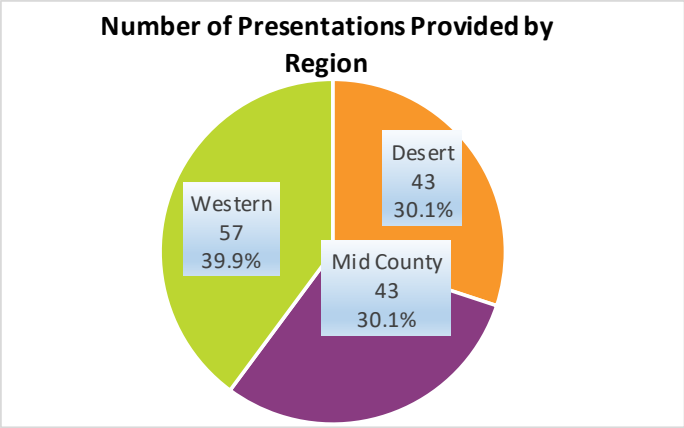
Resources and Referrals Type	Count
Mental Health Education Material	5
Medical Resources	1
Support Groups	1
Housing/Shelter/Homeless Shelter	1
Other Resources *(2-1-1 Connect IE, CARES Line, Take-My-Hand)*	24

The table to the left indicates the frequency of the types of referrals and resources provided as a result of the individual consultations. A total of **32** different resources and referrals were provided during the consultations. Participants requested information on mental health education materials, support groups, housing assistance, and other resources.

Native American CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Native American CMHP program provided a total of **143** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. Most presentations were provided in person (78%) at schools/universities, libraries, coffee shops, recreation centers and tribal offices, with 21% conducted virtually through Zoom. Participants were informed about these presentations through various community outreach methods which included tabling, social media, putting fliers in community areas and reaching out to key community leaders at planning meetings.



A majority of presentations were provided in the Western region (39.9%), followed by the Desert (30.1%) and Mid-County (30.1%) regions. All presentations were provided in English.

Presentations were provided to **1,083** participants. Of these participants, 930 participants attended the presentation for the first time, 122 participants attended presentations two or more times (different presentation topics), and 31 participants did not report how many times they attended the presentation. The majority of participants attended presentations conducted by the Desert region (35.9%, n=389), followed by Mid-County (33.3%, n=361) and Western (30.7%, n=333) regions. While most of the participants were from the target region of the presentations, there were a small number of participants from out of county as well as some participants who attended presentations of a targeted region different than their region of residence. For these reasons, we have included an analysis of the cities of residence of the people (duplicated) that attended the presentations in each region below.

# of people who attended presentations in Desert: 389 Cites of Residence

Banning	208 (53.5%)
Beaumont	84 (21.6%)
Cathedral City	8 (2.1%)
Palm Springs	8 (2.1%)
Thermal	26 (6.7%)
Other Desert	3 (0.7%)
Mid/West Riv.	12 (3.1%)
Out of County	7 (1.8%)
Not Reported	33 (8.5%)

# of people who attended presentations in Mid-County: 361 Cites of Residence

Anza	25 (6.9%)
Hemet	28 (7.8%)
Lake Elsinore	8 (2.2%)
Menifee	7 (1.9%)
San Jacinto	217 (60.1%)
Temecula	31 (8.6%)
Other Mid Cty.	15 (4.2%)
Out of County	2 (0.6%)
Not Reported	28 (7.8%)

# of people who attended presentations in Western: 333 Cites of Residence

Corona	3 (0.9%)
Jurupa Valley	1 (0.3%)
Moreno Valley	41 (12.3%)
Riverside	263 (79%)
Other Desert	1(0.3%)
Other Mid Cty.	1(0.3%)
Out of County	19 (5.7%)
Not Reported	4 (1.2%)

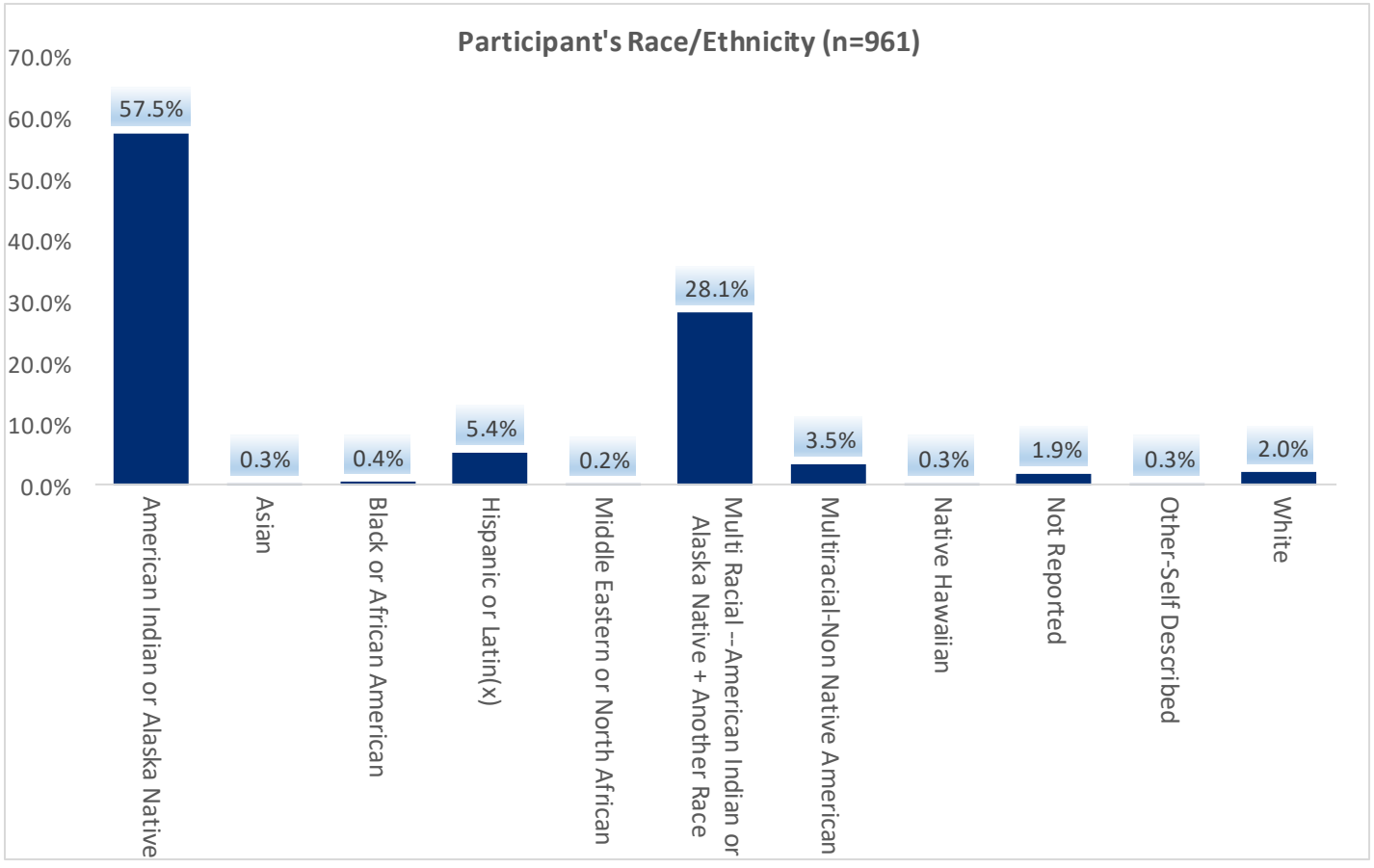
Mental Health Presentations: Topics

Countywide, a majority of the presentations provided by promoters in Native American CMHPP was on General Mental Health (48.3%) followed by Self Care (17%) of presentations.

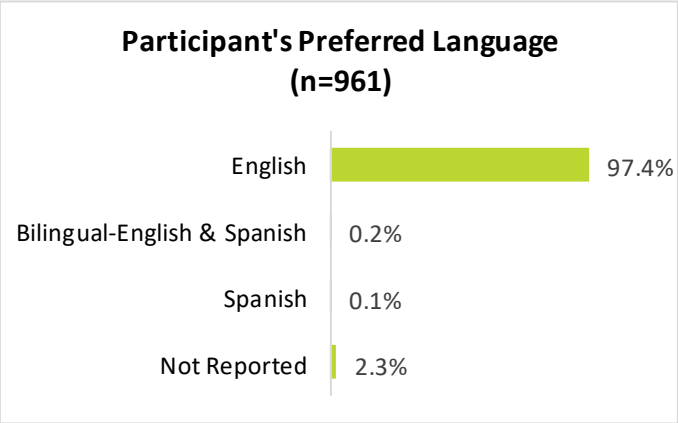
Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	13 (9.1%)	Mental Health and Stigma	7 (4.9%)
Bullying	2 (1.4%)	Self Care	24 (16.8%)
Depression	14 (9.8%)	Substance Use and Abuse	2 (1.4%)
Grief and Loss	7 (4.9%)	Suicide Prevention	2 (1.4%)
Mental Health 101	**69 (48.3%)**	Trauma	3 (2.1%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All numbers are based on the unduplicated count of **961** participants (including participants who did not report the number of times they attended a presentation - Desert n=323, Mid-County n=312, and Western n=326). Countywide 85.6% of the participants served were American Indian or Alaskan Native (or American Indian or Alaskan Native + Another Race). While the program was focused towards individuals from the Native American community, the program welcomed anyone who felt they would benefit.

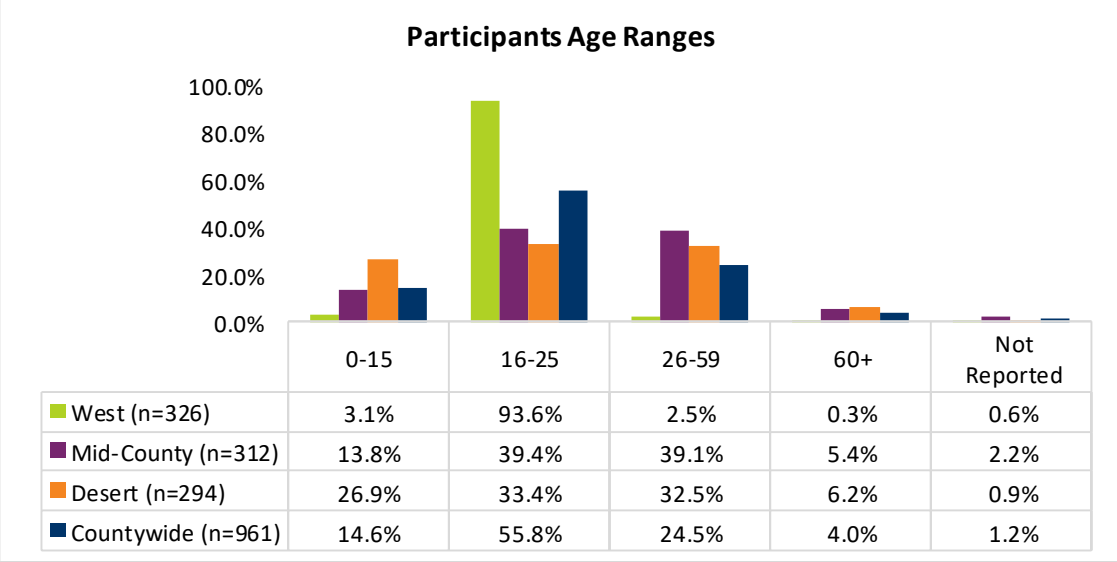


Mental Health Presentations: Demographics cont.



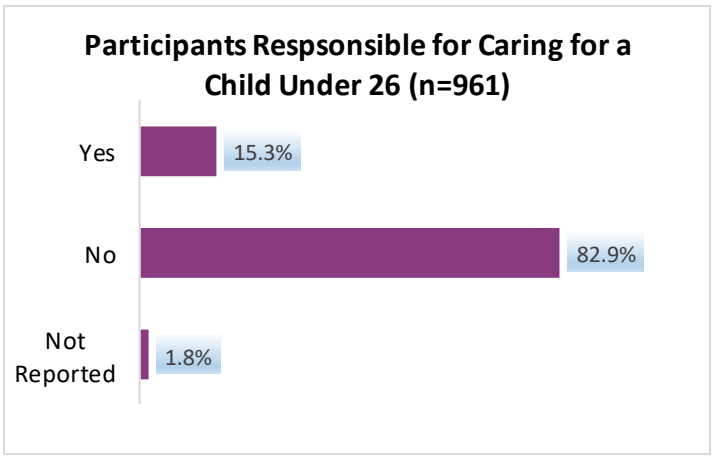
Countywide, a majority of participants indicated English as their primary language (97%).

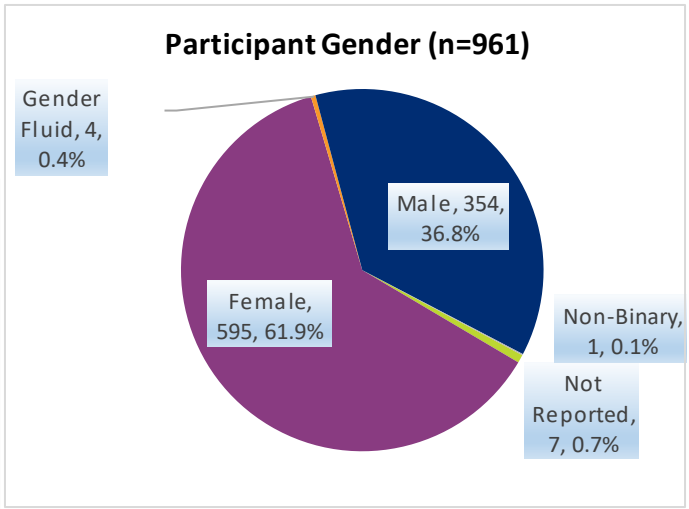
Since there were differences in age demographics by region, the graph below shows participant age by region. Countywide, a majority of participants reported they were 16-25 years old (56%).



	0-15	16-25	26-59	60+	Not Reported
West (n=326)	3.1%	93.6%	2.5%	0.3%	0.6%
Mid-County (n=312)	13.8%	39.4%	39.1%	5.4%	2.2%
Desert (n=294)	26.9%	33.4%	32.5%	6.2%	0.9%
Countywide (n=961)	14.6%	55.8%	24.5%	4.0%	1.2%

Countywide, 15% of participants reported they were responsible for caring for at least one child aged 25 and younger.





Countywide, a majority of participants reached by presentations were female (62%).

Countywide (not shown in this graph) 2.5% of participants identified as LGBTQ.

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the presentation delivery/cultural sensitivity, class content, and their confidence in talking about and seeking help for their mental health or the mental health of family members/friends. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey. 1,080 participants completed the survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time.

As shown below, a majority of participants agreed or strongly agreed with all statements in the survey—that they felt able to find help and get resources, that they could share the information with family and friends, that they got a better understanding of mental health issues in a culturally relevant way.

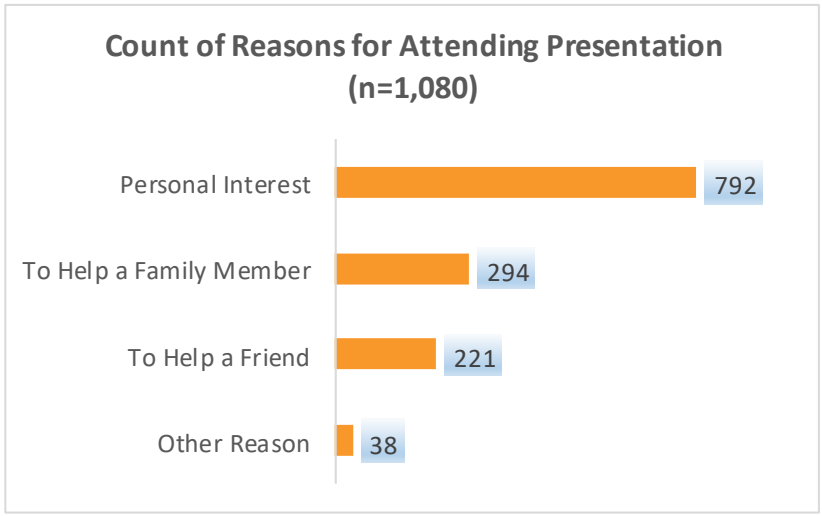
Question (n=1,080)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.66**	—	1 (0.1%)	42 (3.9%)	283 (26.2%)	**754 (69.8%)**	—
The presenter understands the needs of my community	**4.58**	—	2 (0.2%)	51 (4.7%)	343 (31.8%)	**684 (63.3%)**	—
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.55**	—	2 (0.4%)	57 (5.3%)	364 (33.7%)	**655 (60.6%)**	—
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.60**	—	1 (0.1%)	71 (6.6%)	287 (26.7%)	**717 (66.4%)**	4 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.45**	4 (0.4%)	8 (0.7%)	101 (9.4%)	355 (32.9%)	**608 (56.3%)**	4 (0.4%)
I know mental illness can be managed and treated	**4.53**	—	3 (0.3%)	69 (6.4%)	358 (33.1%)	**648 (60.0%)**	2 (0.2%)
I feel comfortable seeking help for a family member, friend, or myself	**4.49**	3 (0.3%)	4 (0.4%)	86 (8.0%)	349 (32.3%)	**633 (58.6%)**	5 (0.5%)
I know where to seek resources for a family member, friend, or myself	**4.63**	1 (0.1%)	—	61 (5.6%)	277 (25.6%)	**737 (68.2%)**	5 (0.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Reasons for Attending

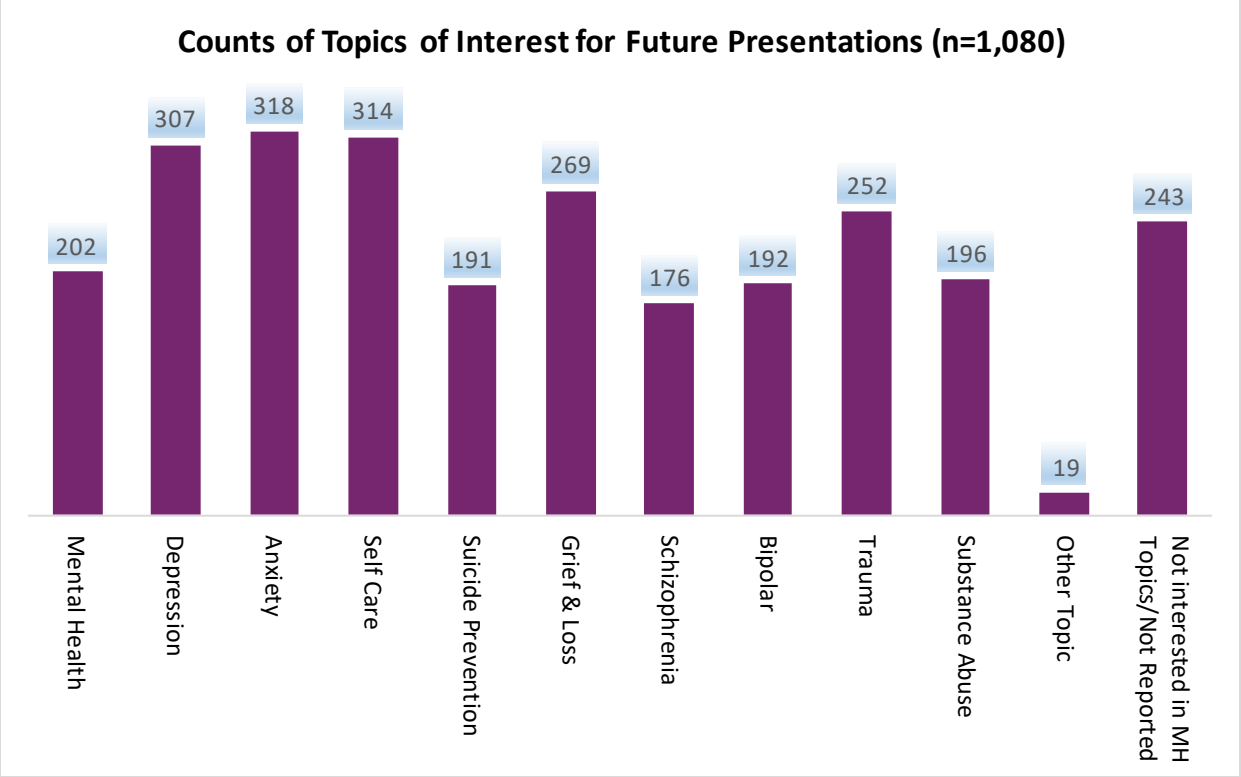


Of the 1,080 people completing the survey, a majority of the people indicated personal interest as a reason for attending the presentation. People were allowed to select more than one response.

For participants that marked "other reason," the most common reasons were that it was required by their school, that they attended with their friend or that they were interested in helping the community.

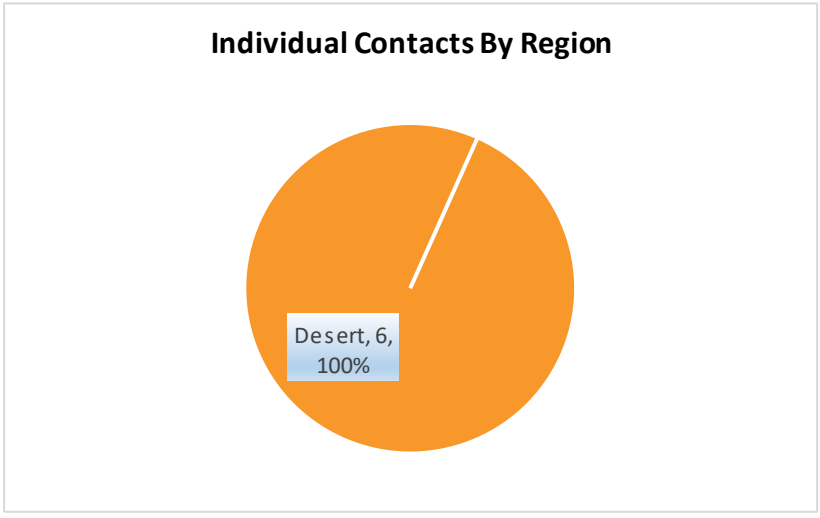
Mental Health Presentations: Topics for Future Presentations

A majority of participants expressed interest in learning about anxiety followed by self care, depression and grief/loss.



Individual Contacts

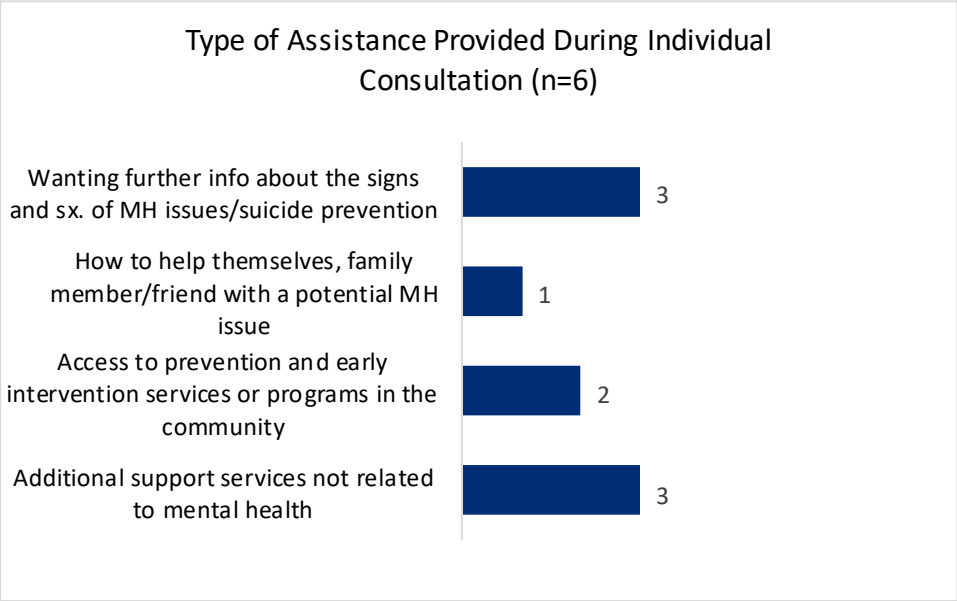
Individual contacts for the CMHP program are defined as when a promoter provides more in depth one-on-one assistance upon outreach or after a presentation to help an individual or family with specific needs and provides referrals to help meet those needs. For FY 2023-24, the Native American CMHP program completed **6** individual consultations. All individual contacts took place face-to-face in person, following the presentations.



The majority of the individual contacts took place in the Desert region of Riverside County (100%).

Individual Contacts cont.

The chart below summarizes the types of assistance that were provided. A majority of mental health related consultations involved wanting further information about the signs and symptoms of mental health issues and suicide prevention. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.



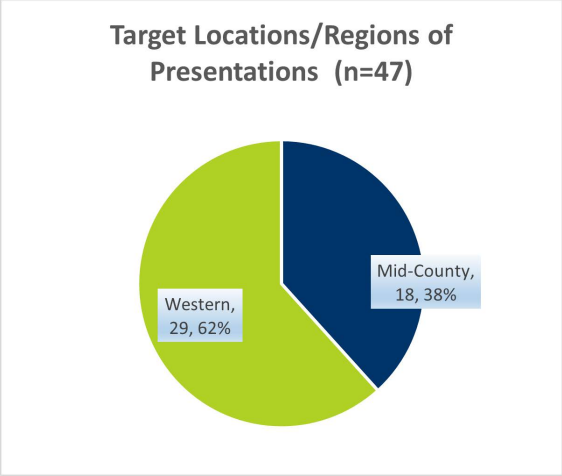
The table below shows the frequency of the type of referrals and resources provided as a result of the individual consultation. A total of **8** different resources and referrals were provided as a result of the consultations.

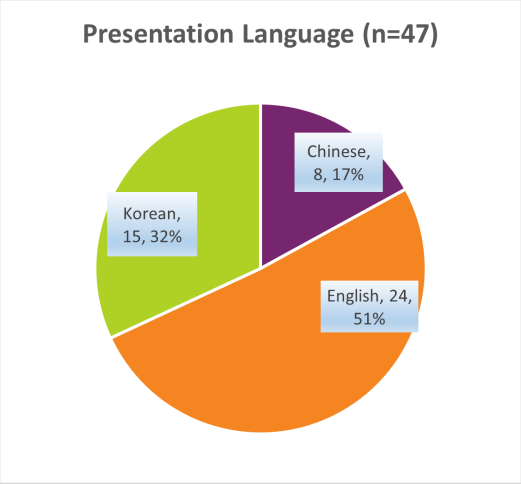
Resources and Referrals Type	Count
Food (*HELP Inc, WIC)*	3
Support Group (*Soboba talking circles*)	1
Cares Line	1
Behavioral Health Specialist (RSBCIHI)	1
Native Challenge	1
PEI Program *(Celebrating Families)*	1

Asian American/Pacific Islander CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Asian American/Pacific Islander CMHP program provided a total of **47** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. The majority of presentations targeted the Western region of Riverside County (61.7%). Additionally, a little over half (51%) of the 47 presentations were targeted for the English-speaking community, followed by the Korean-speaking community (32%), and the Chinese-speaking community (17%).





For FY 2023-24, there was a total of **1,028** attendees for the presentations. Out of the 1,028 attendees, 915 attendees had completed a demographic form with 144 people who had attended more than one presentation. As a result, **771** unique individuals are included within the unduplicated count for the demographics portion of the report.

City of Residence

As some presentations were available virtually, it was possible that participants could have joined from outside of Riverside County. The table below reports on the zip codes of the 771 participants who provided demographic information. Of the people who provided their zip code information, the majority of participants reside in the cities of Corona and Riverside. The Asian American/Pacific Islander CMHP program also reached individuals outside of Riverside County, such as San Bernardino, Los Angeles, Orange and many other counties.

City of Residence Riverside County	n, (%)	City of Residence Outside of Riverside County	n, (%)
Riverside	**188 (24.4%)**	San Bernardino County	28 (3.6%)
Corona	**86 (11.2%)**	Los Angeles County	38 (4.9%)
Murrieta	59 (7.7%)	Orange County	20 (2.6%)
Temecula	40 (5.2%)	Other/Not Reported*	231 (30.0%)
Moreno Valley	20 (2.6%)		
Winchester	15 (1.9%)		
Other Cities in Riverside County	76 (9.9%)		

**Includes participants who did not respond to this question and those who lived outside of the cities/counties of interest above (e.g., Santa Barbara County, etc.).*

Mental Health Presentations: Service Delivery and Attendance cont.

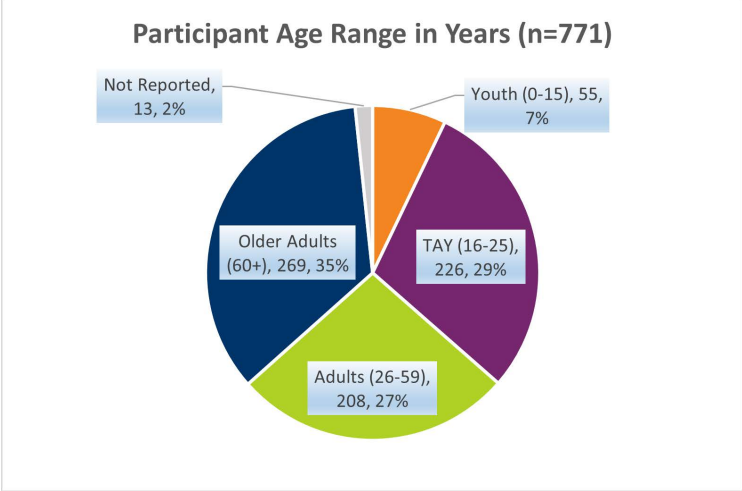
Countywide, most of the presentations that were done by promoters from the Asian American/Pacific Islander CMHP program were on the topic of Mental Health (40.4%), followed by Self-Care (21.3%). Some presentations were tailored to specific audiences. For example, for the Mental Health topic, promoters presented on material for Children's Mental Health.

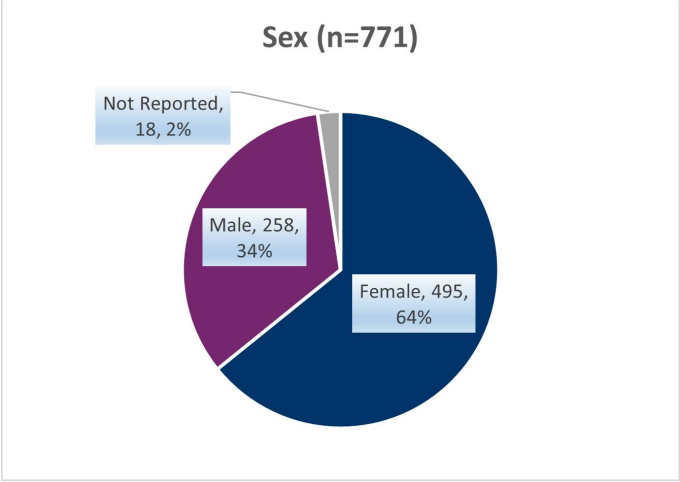


Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	2 (4.3%)	Self-Care	10 (21.3%)
Depression	2 (4.3%)	Stress Management	5 (10.6%)
Mental Health	19 (40.4%)	Suicide Prevention	3 (6.4%)
Psychosis	1 (2.1%)	Trauma	5 (10.6%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. There was a total of 915 individuals who provided demographic information; however, the following demographic data is based on the unduplicated count of participants (**n=771)**. Additionally, all of the demographic data is analyzed on a countywide level.

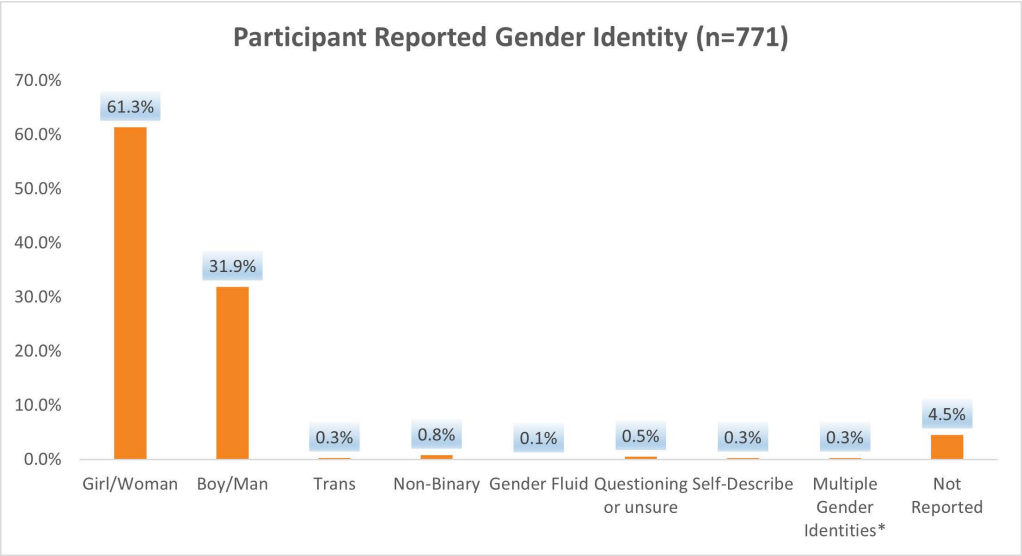


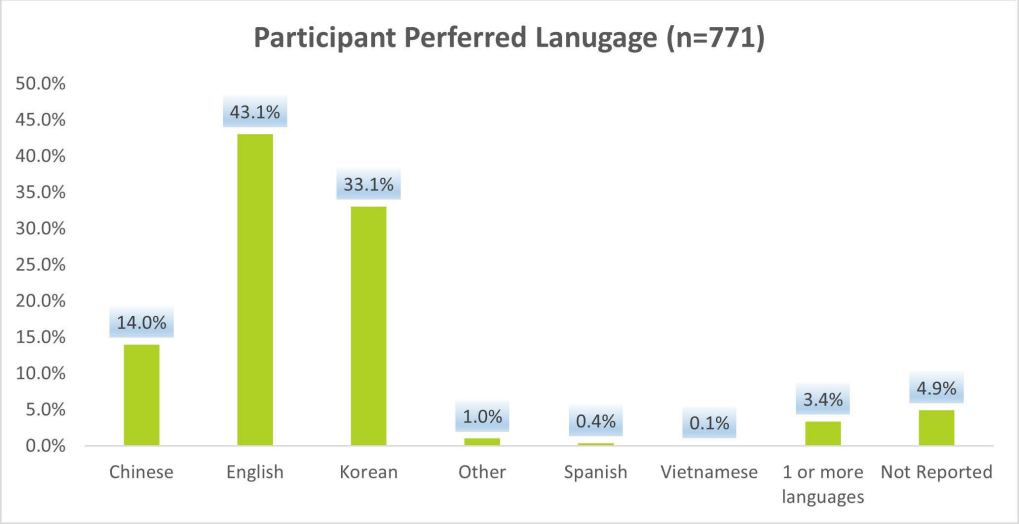


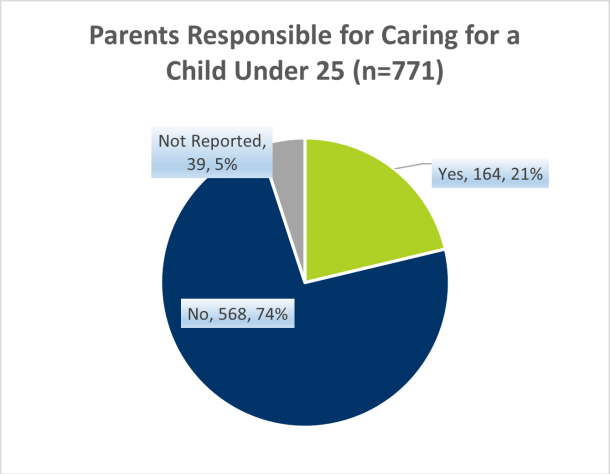
There was a wide variety of ages of those who attended the CMHP Asian American/Pacific Islander presentations. A little over one-third of participants reported being in the 60+ age group (35%), closely followed by the Transitional Age Youth (TAY) age group of 16-25 years old (29%). Almost one-third of participants identified being in the 26-59 age group (27%) and lastly, participants identified being in the 0-15 age group (7%). In addition, the majority of participants who attended the presentations reported their sex as female (64%), followed by male (34%).

Mental Health Presentations: Demographics cont.

Countywide, most participants identified their gender as Girl/Woman (61.3%), followed by Boy/Man (31.9%). In addition, there was variation in participants' preferred languages with about 43.1% of participants having a preference for English, followed by Korean (33.1%), Chinese (14.0%), and more than one language as their preferred language (3.4%). Notably, a majority of participants said that they are not responsible for caring for a child who is 25 years old and under (74%).

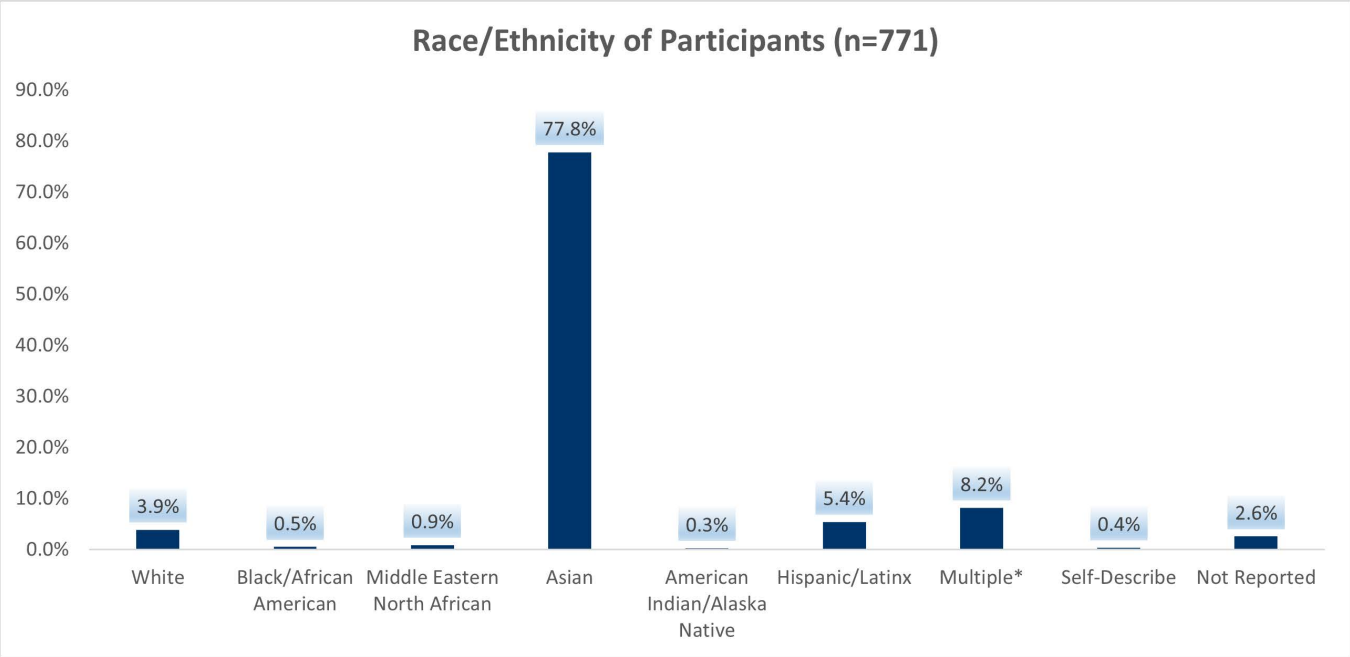




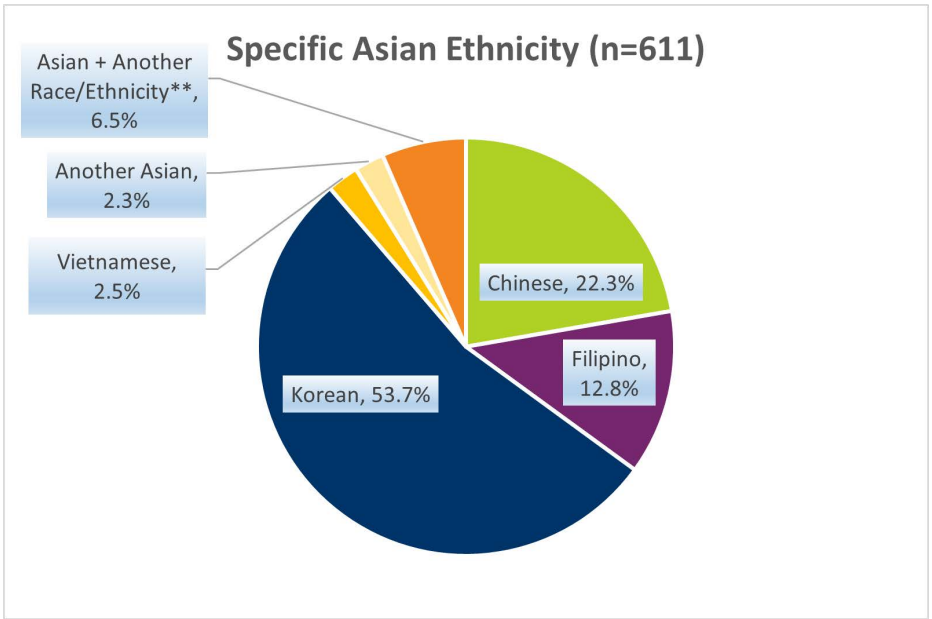


Mental Health Presentations: Demographics cont.

Most respondents identified their race/ethnicity as Asian (77.8%), followed by Multiple Race/Ethnicities (8.2%). Within the breakdown of the categories for the Asian race/ethnicity group, most individuals identified as Korean (53.7%), followed by Chinese (22.3%), Filipino (12.8%), Asian + Another Race/Ethnicity (6.5%), Vietnamese (2.5%), and Another Asian ethnicity (2.3%). Although not shown here, the majority of participants identified as Heterosexual or Straight (70.9%). Lastly, the majority of participants indicated that they did not have a disabling condition (88.2%) nor a veteran (90.8%).



**Includes individuals who identify with multiple race/ethnicities.*



***Includes individuals who identified generally as Asian or a specific Asian identity + another race/ethnicity.*

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 *(1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree*) about how much they agreed with the statements in the survey. There was a total of **913** participants who completed the satisfaction survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time they attended a new presentation.

The average rating scores for all statements in the survey were above a score of 4, indicating that most participants agreed with the statements on seeking help and finding resources, being able to talk about the presentation topic with friends and family, and having a better understanding of mental health issues.

Question (n=913)	Avg Score	1	2	3	4	5	No Resp.
The information presented was easy to understand	**4.44**	11 (1.2%)	5 (0.5%)	27 (3.0%)	158 (17.3%)	**695 (76.1%)**	17 (1.9%)
The presenter was enthusiastic when presenting the information	**4.58**	11 (1.2%)	7 (0.8%)	55 (6.0%)	199 (22.8%)	**629 (68.9%)**	12 (1.3%)
I would recommend to my friends and family members that they attend a presentation like this	**4.58**	9 (1.0%)	7 (0.8%)	67 (7.3%)	184 (20.2%)	**635 (69.6%)**	11 (1.2%)
The material in the presentation gave me a better understanding of the early signs of mental health issues	**4.59**	9 (1.0%)	11 (1.2%)	50 (5.5%)	197 (21.6%)	**631 (69.1%)**	15 (1.6%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.46**	10 (1.1%)	10 (1.1%)	86 (9.4%)	238 (26.1%)	**550 (60.2%)**	19 (2.1%)
I know mental illness can me managed and treated	**4.60**	7 (0.8%)	5 (0.5%)	46 (5.0%)	223 (24.4%)	**612 (67.0%)**	20 (2.2%)
I feel comfortable seeking help for a family member or myself	**4.47**	8 (0.9%)	17 (1.9%)	87 (9.5%)	213 (23.3%)	**569 (62.3%)**	19 (2.1%)
I know where to seek resources for a family member or myself	**4.54**	11 (1.2%)	8 (0.9%)	55 (6.0%)	232 (25.4%)	**584 (64.0%)**	23 (2.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well received the CMHP program was in the community. Below are some of the comments made by participants when asked what was helpful about the presentation and if they had any other comments about the presentations.

"I think that it was very helpful to hear terms such as 'kapwa' and to hear mental health described as affected by the collective history of my community."

"Looking forward to attending many more mental health related seminars in the future. Much appreciated!"

"Learned different ways to cope with stress."

"The mindset to think about things again and make an effort to put into practice."

"Learning about how different Asian communities handle trauma and mental health issues."

"Made easy for children to understand and kept them engaged with game."

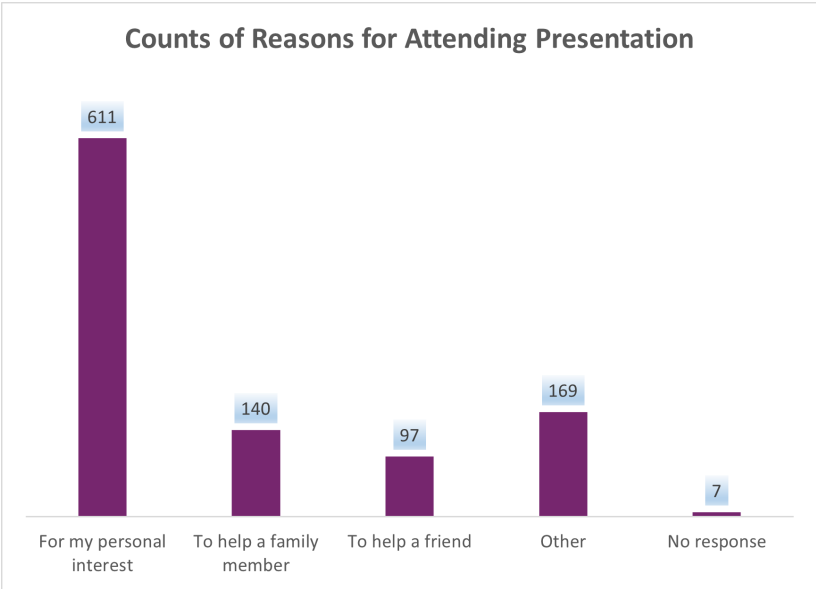
"A warm and welcoming space was created to allow us to be vulnerable and open."

"The presentation was good at bridging some gaps and making the intersectionality between mental health, trauma, and layers of colonization + systemic violence."



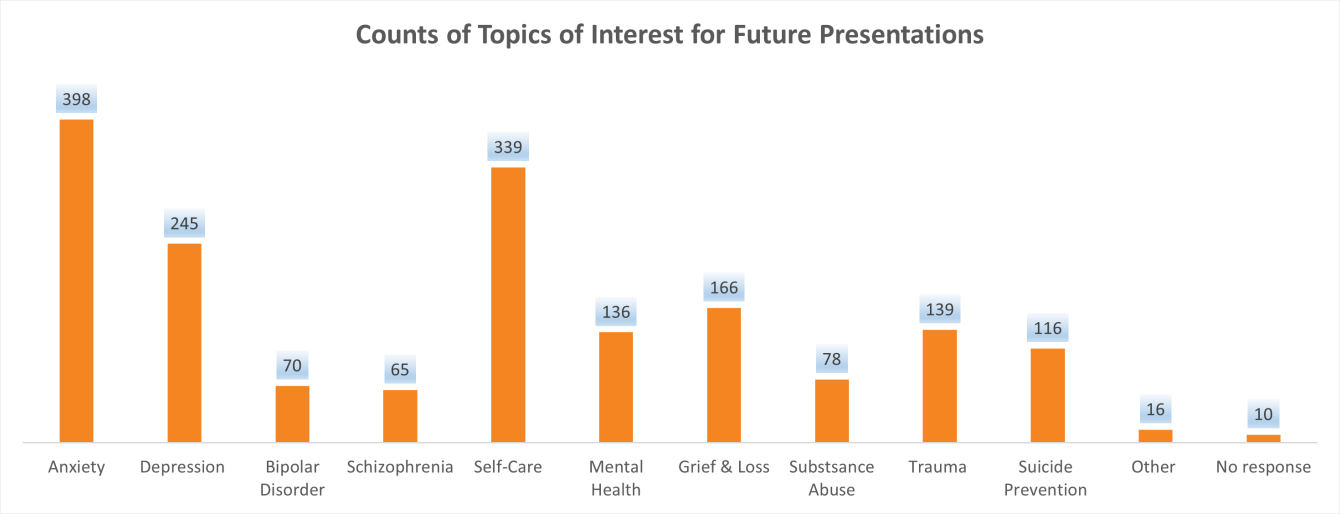
Mental Health Presentations: Reasons for Attending

Of the 913 people who completed the satisfaction survey, **906** participants provided reasons as to why they attended a CMHP AAPI presentation. The most frequently chosen response among participants was "for my personal interest".



Mental Health Presentations: Topics for Future Presentations

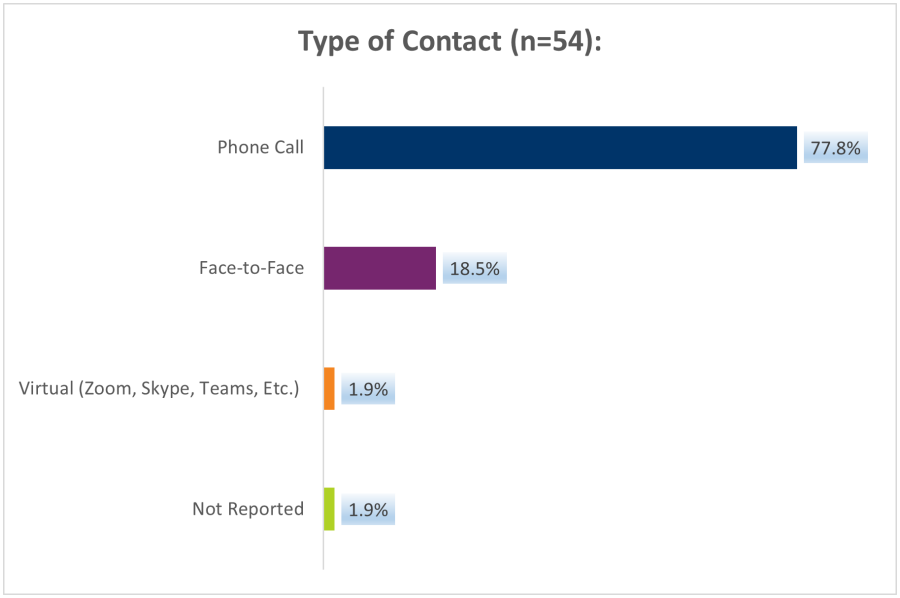
Of the 913 people who completed the satisfaction survey, **903** participants expressed interest in learning about different topics in future presentations. The most frequently chosen response for a topic of interest for future presentations was anxiety, closely followed by self-care.



Individual Contacts

Individual contacts for the CMHP program are defined as when a promoter provides more in-depth, one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Asian American/Pacific Islander CMHP program completed **54** individual consultations.

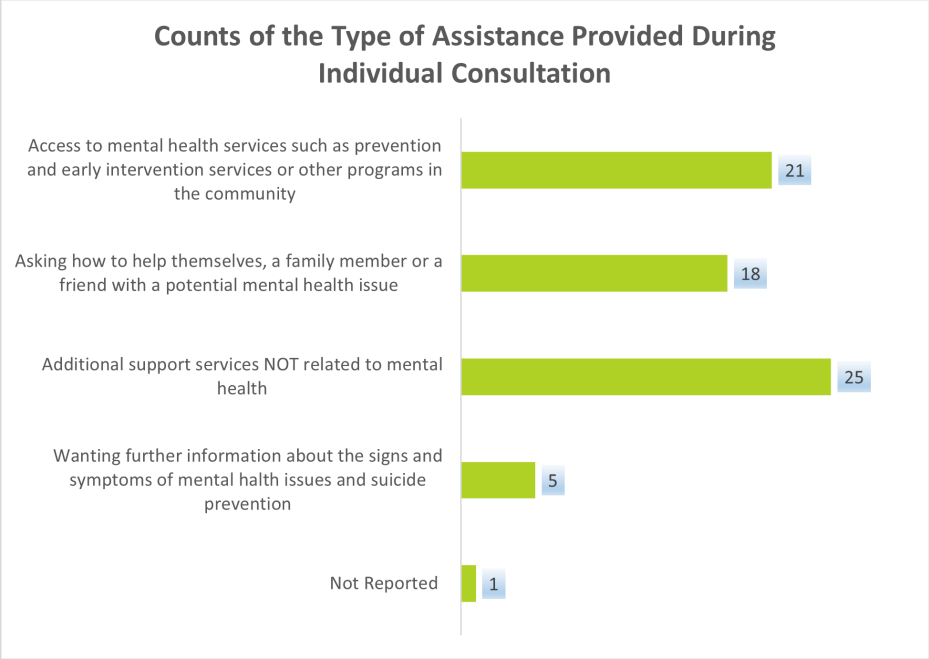
The most frequent type of contact that a promoter made with CMHP participants was through phone call (77.8%), followed by face-to-face interaction (18.5%), and then through virtual platforms such as Zoom, Skype, Teams, etc. (1.9%).





Individual Contacts cont.

Most participants indicated that they received more than one type of assistance during an individual consultation. This means that an individual had assistance with any of the types of assistance listed down below. In addition, the most frequent type of resource/referral that participants received was mental health education material, followed by individuals who were referred to a private mental health service, such as the SSG-APCTC's Riverside Counseling Center.



Resources and Referrals Type	Count
Mental Health Education Material	17
Prevention and Early Intervention Program(s)	9
Housing/Utilities Assistance	3
Food/Clothing Assistance	3
Employment/Education Services	1
Transportation Services	2
Medical Resources	6
Support Groups	3
Referral to Private Mental Health Services *(SSG-APCTC's Riverside Counseling Center)*	16
211	2
CARES	1
988/Helpline	1
Other Resources *(SSDI resources, disability services, legal inquiries, etc.)*	25

Middle Eastern/North African CMHPP

Promoter Training

For FY 2023-24, there were two promoters from Sahaba Initiative's MENA CMHP program who completed all 40 hours of required training as required by RUHS-BH MHSA PEI.

Topics included:

- CMHPP overview
- Community Outreach Strategies
- Presentation Tips
- Mental Health Basics
- Mental Health Needs of MENA
- Suicide Prevention, Anxiety
- Trauma
- Grief and Loss
- Psychosis/Schizophrenia
- Bipolar Disorder
- Depression
- Substance Misuse
- Self-Care and Wellness



Director's Feedback

The program director had a very positive experience training the community mental health promoters and preparing them for program implementation in the community. The promoters were highly engaged throughout the training days and asked thoughtful questions to help deepen their understanding of the material.

One promoter had a reaction of discomfort to the psychosis and bipolar disorder presentations, and shared that the reaction was largely due to learning about more severe case examples of psychosis and bipolar disorder during the discussion portion of the training. The director provided support by welcoming discussion about their reactions, checking in with them on the day of and afterwards, and responding to any questions that came up.

Additionally, the promoters demonstrated great skill when presenting the material back during practice presentations, not only when it came to presentation style and presence, but also in conveying the relevant information appropriately and accurately. The promoters found the training beneficial and they demonstrated great enthusiasm for bringing the presentations to the community. Overall, the director felt the training went well.

Promoter Training cont.

Promoter's Feedback

After completion of their 40 hour training, promoters participated in a survey in which they rated their agreement with statements on a scale from 1-5 (1-strongly disagree to 5-strongly agree). Their responses are shown in the table below. The promoters strongly agreed that the trainings were effective and helpful in their development as a promoter. They are confident in their knowledge of mental health, their ability to work with the community, and answer questions on mental health issues in a culturally competent way. In addition, the promotor provided comments based on the trainings.

Question	Avg. Score
I felt like an active participant in my development as a Promotor.	5
The training will help me to be an effective Promotor.	5
I feel able to utilize the materials presented in the training.	5
The trainers were knowledgeable and communicated clearly and effectively.	5
How would you rate your ability to do community mental health presentations?	5
How would you rate your ability to talk to people and answer questions about mental health issues?	5
How would you rate your knowledge of community resources and your ability to provide these resources to the community?	5
How would you rate your overall knowledge of mental health and about being a Promotor?	5
How would you rate your ability to understand cultural and linguistic diversity issues?	5



Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention (PEI)

PEI Suicide Prevention Trainings

Mental Health First Aid (MHFA)

safeTALK

Know the Signs

Applied Suicide Intervention Skills Training (ASIST)

FY 2023-2024 Annual Report

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OVERVIEW DESCRIPTION OF TRAININGS

Riverside County currently offers four suicide prevention trainings through the help of the Mental Health Service Act Prevention and Early Intervention (MHSA PEI) Department.

- **Applied Suicide Intervention Skills Training (ASIST)** is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed. ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

- **The Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care. Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA. Each certification must be renewed every three years.

- **safeTALK** is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings. This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. safeTALK also helps participants practice the TALK step actions in overcoming these barriers.

- **Know the Signs** is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The goal for MHSA PEI is to have various Riverside County department employees and community-based organizations trained in these suicide prevention courses so that each department or organization has the ability to host the trainings for communities at large.

EXECUTIVE SUMMARY

FY 2023-2024 TOTAL NUMBER OF SUICIDE PREVENTION TRAININGS: 84

Pain Isn't Always Obvious
KNOW THE SIGNS
Suicide Is Preventable.org

17
Total Number of Trainings

Mental Health FIRST AID
from NATIONAL COUNCIL FOR MENTAL WELLBEING

17
Total Number of Trainings

ASIST

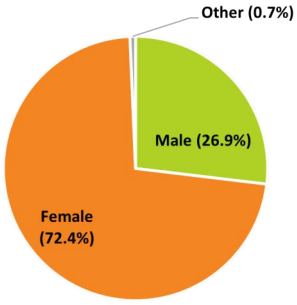
19
Total Number of Trainings

SUICIDE safeTALK

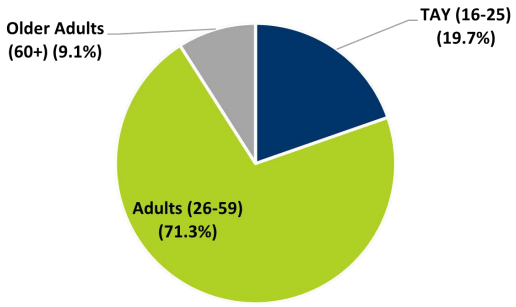
31
Total Number of Trainings

FY 2023-2024 TOTAL NUMBER OF PARTICIPANTS TRAINED: 1,150

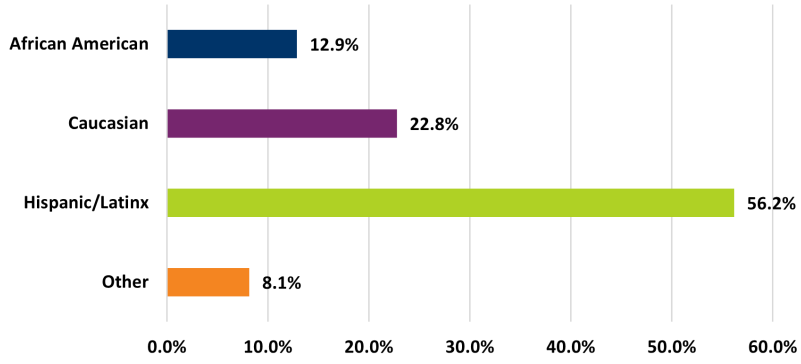
Gender (n=1,030)*



Age Groups (n=1,037)*



Race/Ethnicity (n=970)*



**Note:* Some categories are not shown here, including not reported/unknown.*

EXECUTIVE SUMMARY (cont.)

FY 23-24 PEI SUICIDE PREVENTION TRAININGS OVERVIEW

Mental Health FIRST AID from NATIONAL COUNCIL FOR MENTAL WELLBEING

- Total of 17 trainings for FY 23-24
- Audience reached was 231 participants with 225 participants (97.4%) who completed the training
- The smallest audience size for a training was 6 people while the largest audience size for a training was 28 people

- Total of 31 trainings for FY 23-24
- Total audience reached was 503 with *all* participants completing the training (100%)
- On a scale of 1 (i.e., very bad) to 10 (i.e., very good), the average rating for this training was 9.6

safeTALK

Pain Isn't Always Obvious KNOW THE SIGNS Suicide Is Preventable.org

- Total of 17 trainings for FY 23-24
- Total audience reached was 108 with *all* participants completing the training (100%)
- About 98.1% of Know the Signs participants would agree or strongly agree that they would recommend this training to someone else

- Total of 19 trainings for FY 23-24
- Total audience reached was 327 participants with 314 participants completing the training (96.0%)
- On a scale of 1 (i.e., did not like) to 10 (i.e., liked a lot), participants (n=314) rated the quality of ASIST as 9.4 out of 10

ASIST

MENTAL HEALTH FIRST AID (MHFA)

Program Description

The **Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care.

Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA (YMHFA). Each certification must be renewed every three years.

Program Objective: MHFA teaches about *recovery* and *resiliency*—the belief that individuals experiencing these challenges can and do get better because they utilize their strengths to stay well.

FY 23-24 OVERVIEW

FY 23-24 MHFA Training Overview Summary

All **17 Adult MHFA and Youth MHFA trainings** were conducted in collaboration with **PEI, WET, Public Health, HelpLine, RUHS-BH Crisis, Moreno Valley College** and **other organizations**. Additionally, all trainings took place in either the **Western or Mid-County** regions. Specific audiences/groups that were targeted were the MHSA provider groups, law enforcement, as well as WET interns.



17
Total Number of Trainings



231
Total Number Reached



225
Total Number Completed Training



6
Smallest Audience Size



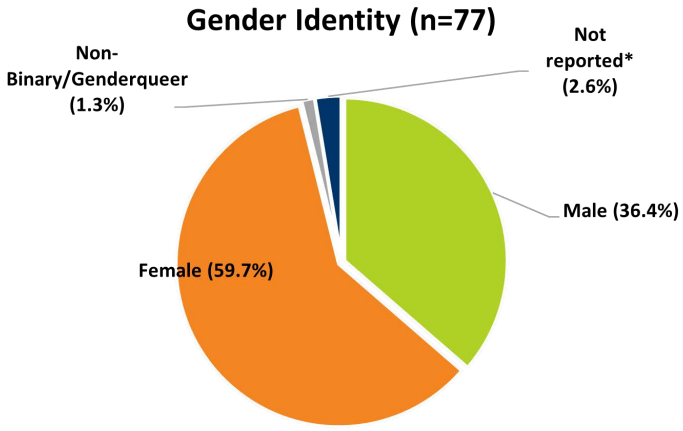
28
Largest Audience Size

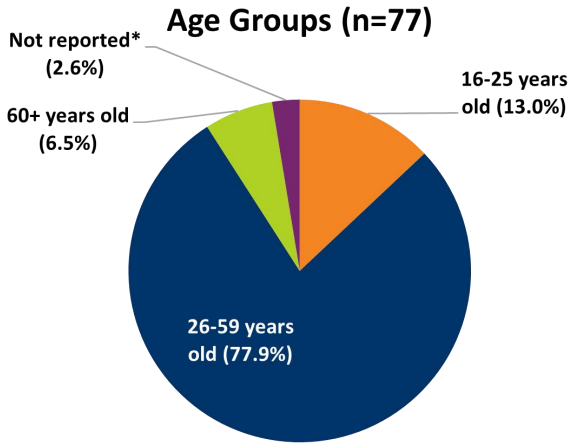
MENTAL HEALTH FIRST AID (MHFA)

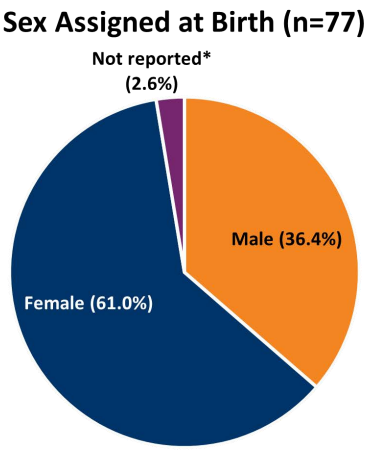
ADULT MHFA DEMOGRAPHICS

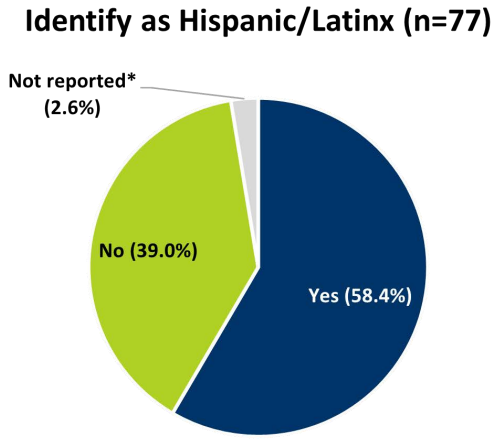
Demographics Summary

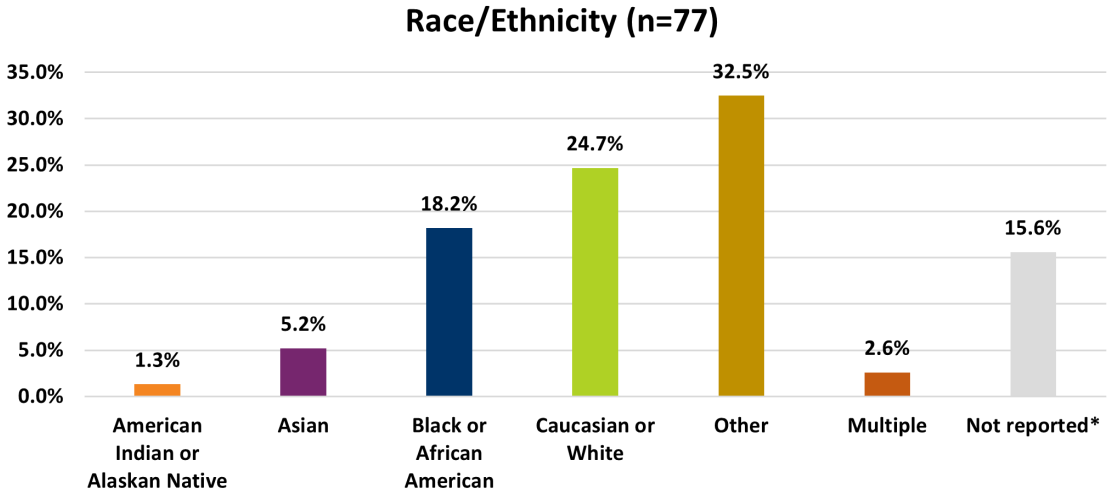
Most Adult MHFA participants identified their gender as **female (59.7%)** and half of the participants reported **female as their sex assigned at birth (61.0%)**. The majority of Adult MHFA participants were in the **26 to 59 years old age group (77.9%)**. Additionally, most participants identified as **Other (32.5%)** followed by White (24.7%), Black/African American (18.2%), Asian (5.2%), Multiple (2.6%) and American Indian or Alaskan Native (1.3%). More than half of participants identified as **Hispanic/Latinx (58.4%).**











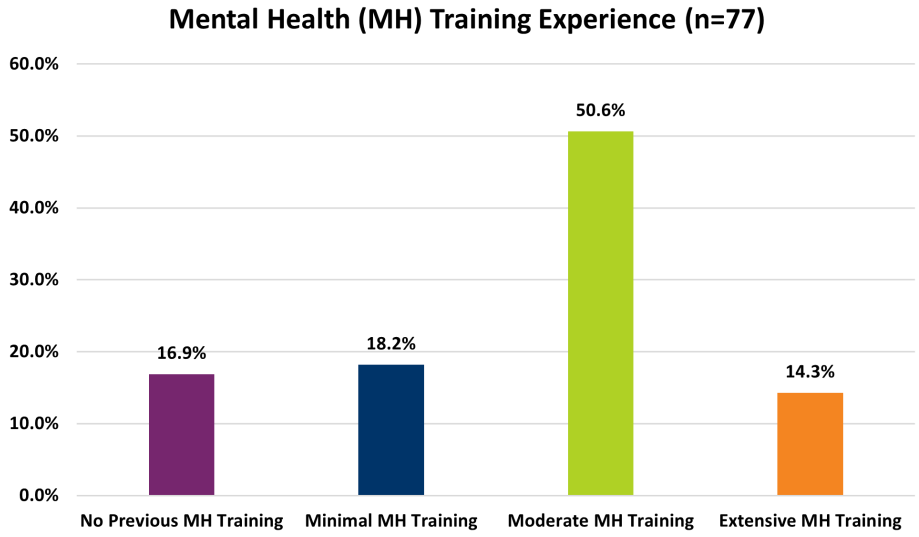
**Note:* "Not reported" includes individuals who chose not to answer.*

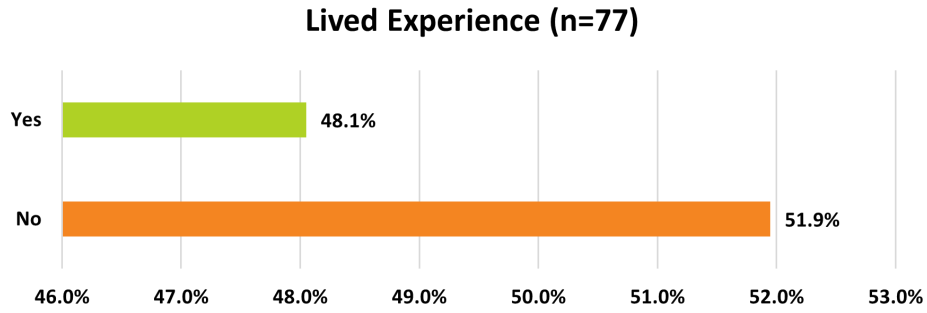
MENTAL HEALTH FIRST AID (MHFA)

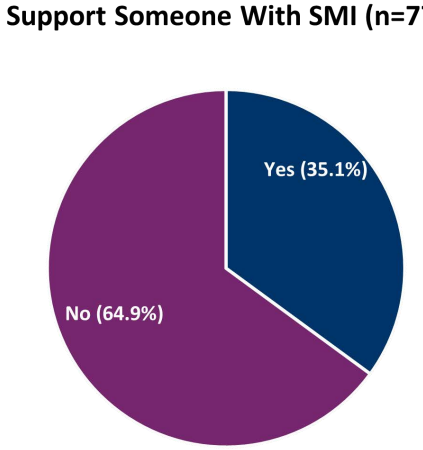
ADULT MHFA DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **50.6% of participants had reported that they had moderate mental health training**, which includes several workshops, trainings, or classes about mental health. In addition, about 51.9% of the participants reported that they do not identify as a person with lived experience or a person in long-term recovery. And lastly, over one-third of participants (35.1%) reported that they support a family member with lived experience, serious mental illness, or in long-term recovery.







**Note:* *"Not reported" includes individuals who chose not to answer.*

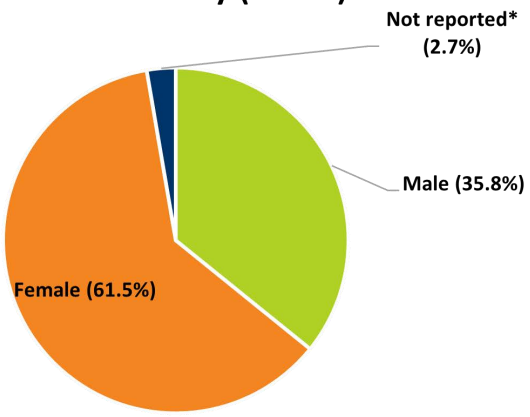
MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA DEMOGRAPHICS

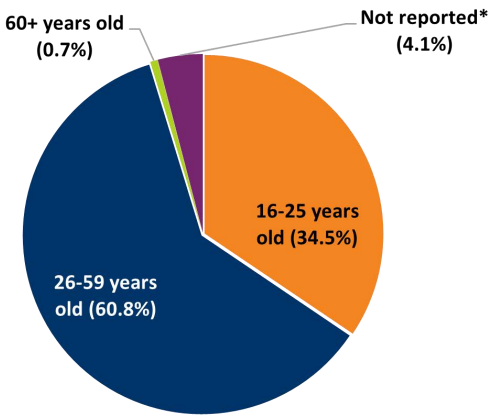
Demographics Summary

Most Youth MHFA participants identified their gender as **female (61.5%)** and half of the participants reported **female as their sex assigned at birth (61.5%)**. The majority of Youth MHFA participants were in the **26 to 59 years old age group (60.8%)**. Additionally, most participants identified as **White (40.5%)** followed by Other (29.1%), Black/African American (6.1%), Multiple (3.4%), American Indian or Alaskan Native (3.4%), Asian (2.0%), and Native Hawaiian or Other Pacific Islander (0.7%). More than half of participants identified as **Hispanic/Latinx (67.6%).**

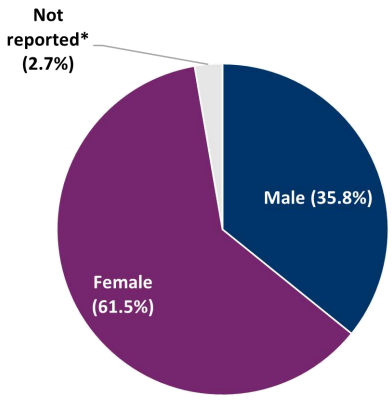
Gender Identity (n=148)



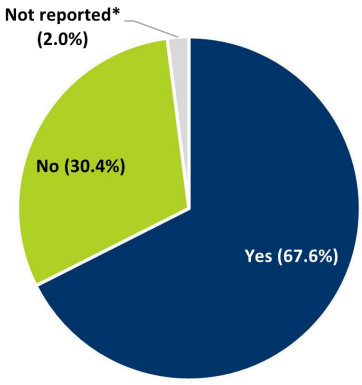
Age Groups (n=148)



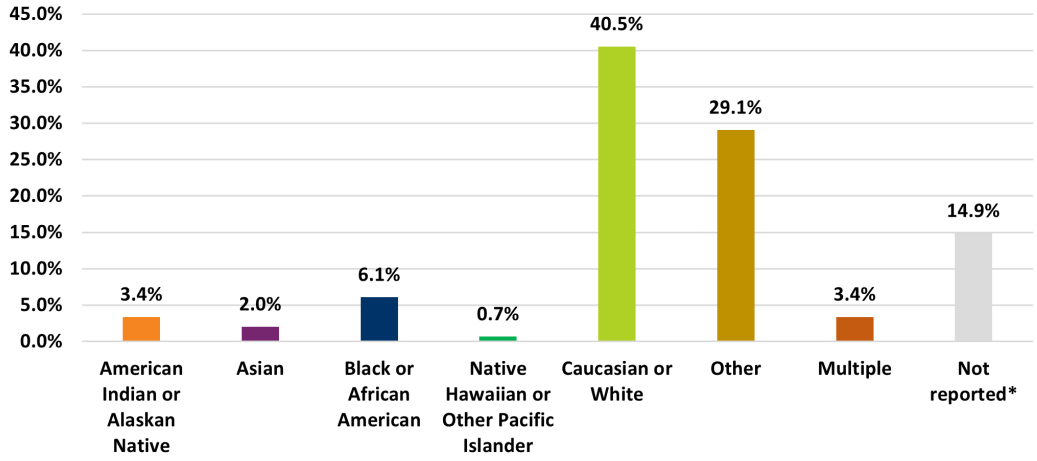
Sex Assigned at Birth (n=148)



Identify as Hispanic/Latinx (n=148)



Race/Ethnicity (n=148)



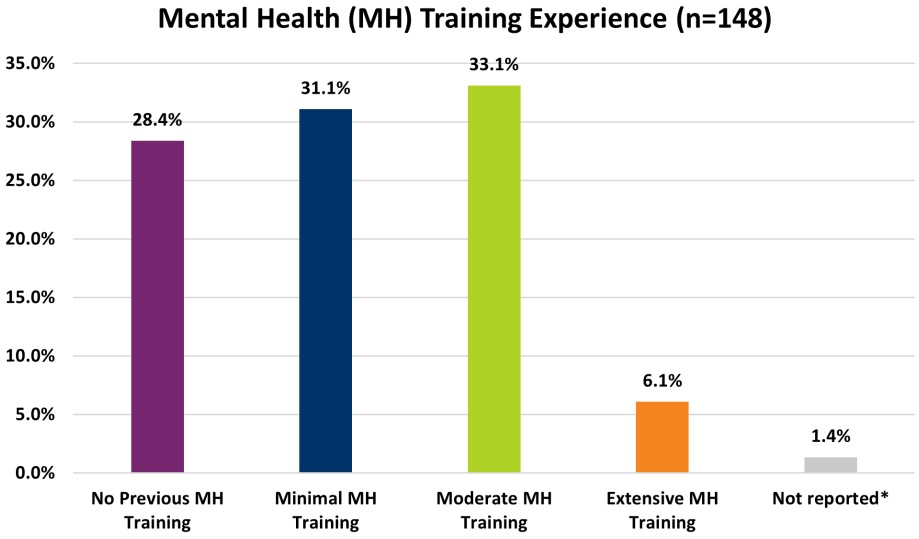
**Note:* "Not reported" includes individuals who chose not to answer.*

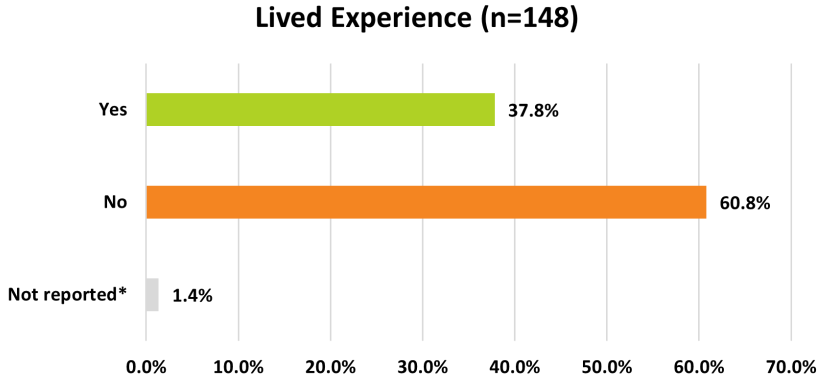
MENTAL HEALTH FIRST AID (MHFA)

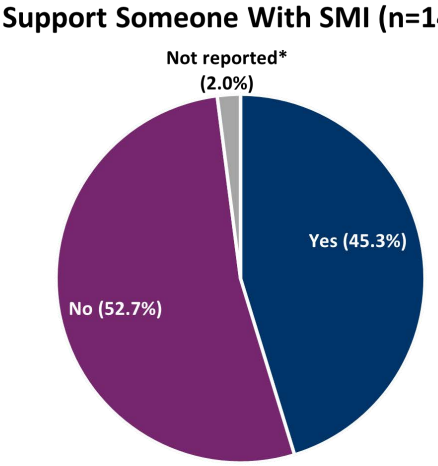
YOUTH MHFA DEMOGRAPHICS

Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **33.1% of participants had reported that they had moderate mental health training**, which includes attending several workshops, trainings, or classes about mental health. In addition, **60.8% of participants reported that they do not identify as a person with lived experience** or a person in long-term recovery. And lastly, about **45.3% of participants reported that they support a family member** with lived experience, serious mental illness, or in long-term recovery.







**Note:* "Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA PRE/POST OUTCOMES

Adult MHFA Pre/Post Outcomes Summary

As a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. There were a total of **76 individuals** who completed both the Pre and Post measures from the Adult and Youth MHFA trainings. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
4a. Have a supportive conversation with anyone about mental health or substance use challenges.
4b. Ask anyone directly whether they are considering killing themselves.
4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe.

**Note:* Pre and Post analysis was only conducted for individuals who completed both measures.*

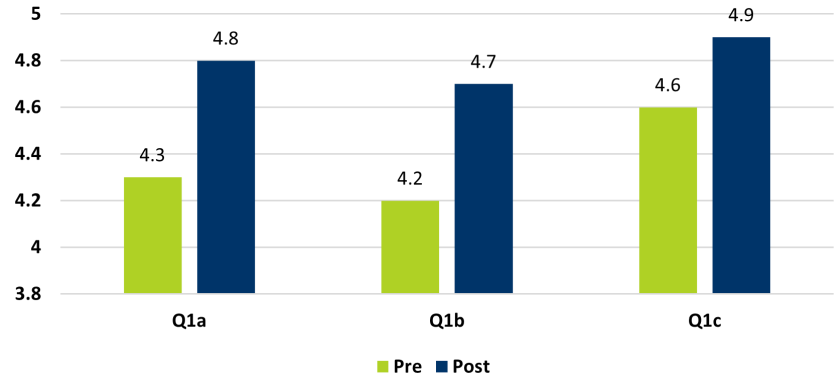
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA PRE/POST OUTCOMES

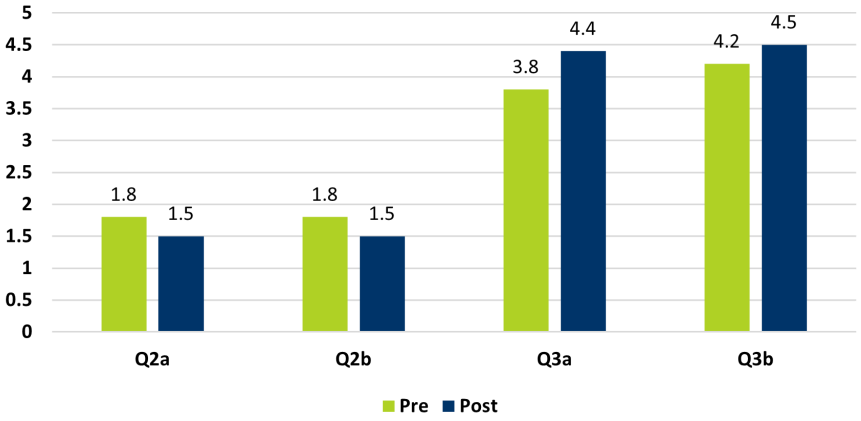
Adult MHFA Pre/Post Outcomes Summary (cont.)

Across all domains, the majority of participants had increased confidence, knowledge, and intention in helping individuals who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions. Participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.

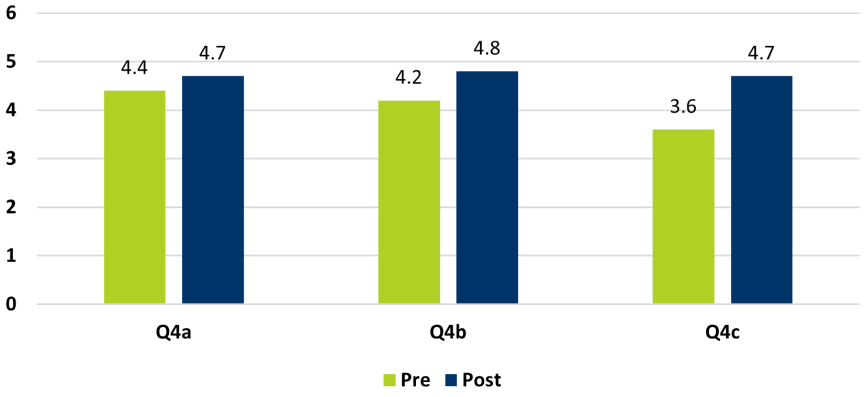
Your Beliefs About Mental Health and Substance Use (n=76)



Your Beliefs About MHFA Actions (n=76)



Your Confidence in Performing Mental Health Actions (n=76)



MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA PRE/POST OUTCOMES

Youth MHFA Pre/Post Outcomes Summary

Similar to the requirement made for Adult MHFA, as a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
4a. Have a supportive conversation with anyone about mental health or substance use challenges.
4b. Ask anyone directly whether they are considering killing themselves.
4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe.

**Note:* Pre and Post analysis was only conducted for individuals who completed both measures.*

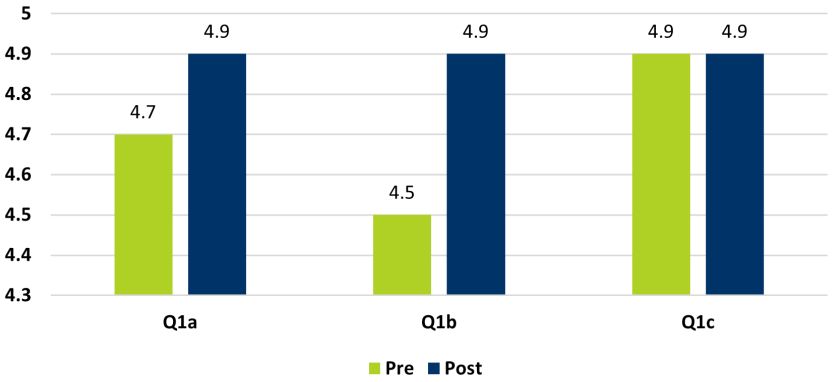
MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA PRE/POST OUTCOMES

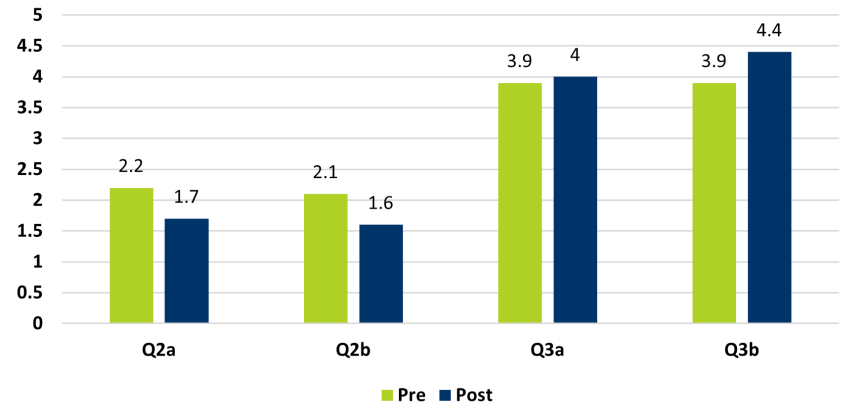
Youth MHFA Pre/Post Outcomes Summary (cont.)

Similar to the results shown in the Adult MHFA Pre/Post Outcomes, across all domains, the majority of Youth MHFA participants had increased confidence, knowledge, and intention in helping youth who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions, and participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.

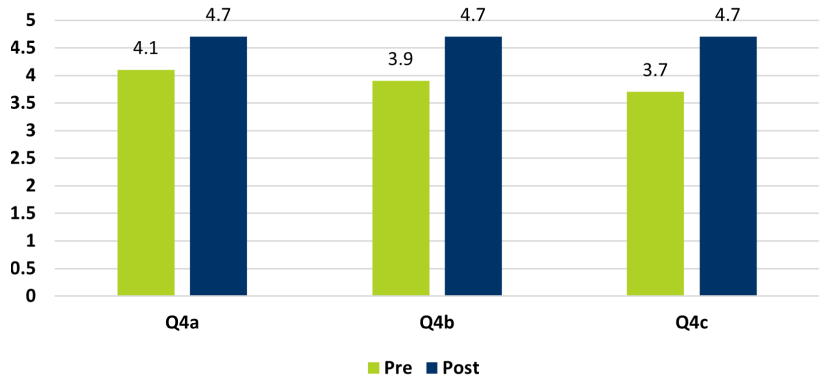
Your Beliefs About Mental Health and Substance Use (n=148)



Your Beliefs About MHFA Actions (n=148)



Your Confidence in Performing Mental Health Actions (n=148)



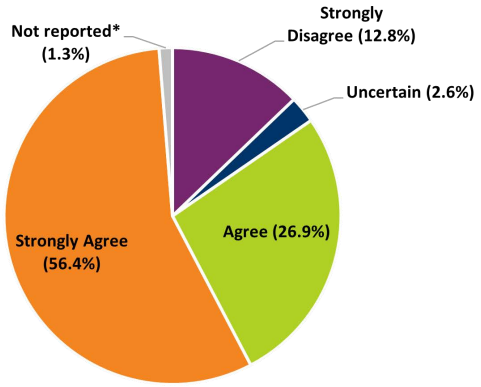
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA OVERALL SATISFACTION

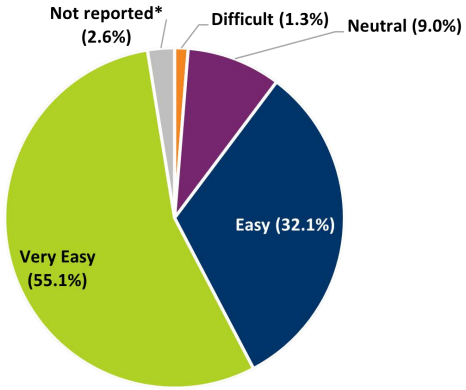
Adult MHFA Satisfaction Summary

Participants are also asked to complete a program evaluation feedback form at the end of the training. Some of the responses to the satisfaction questions are shown below. Individuals reported that they **strongly agree (54.4%)** that there was an adequate opportunity in practicing their skills that they learned from the training. More than half of the participants found that navigating the coursework was **very easy (55.1%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (76.9%)** to the populations that they primarily work with and about **67.9%** indicated that the pace of the coursework was **neutral**. Although not shown below, a great majority said yes to **taking another MHFA course (97.4%).**

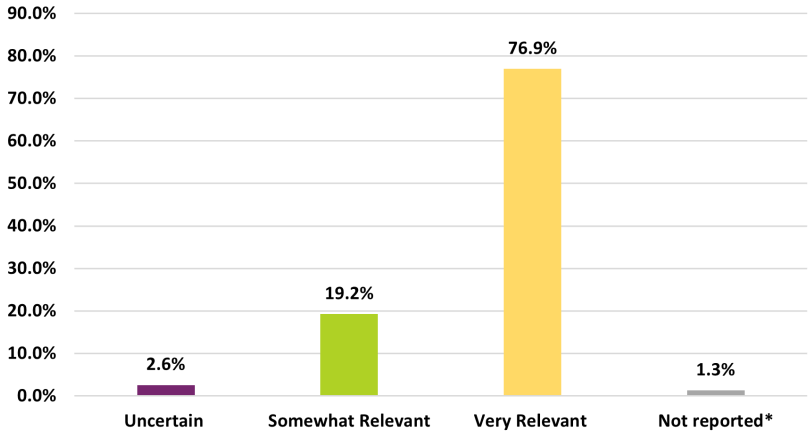
Adequate Opportunity to Practice Skills Learned (n=78)



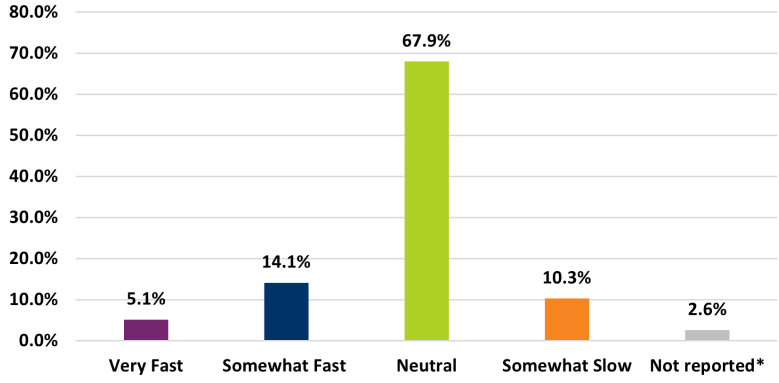
Overall Experience Navigating Coursework (n=78)



How Relevant the Existing Scenarios Are (n=78)



Pace of the Coursework (n=78)



**Note:* "Not reported" includes individuals who chose not to answer.*

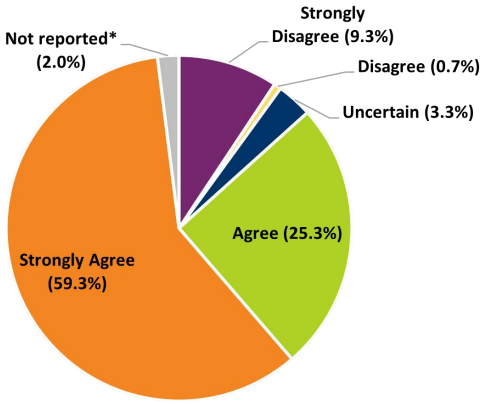
MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA OVERALL SATISFACTION

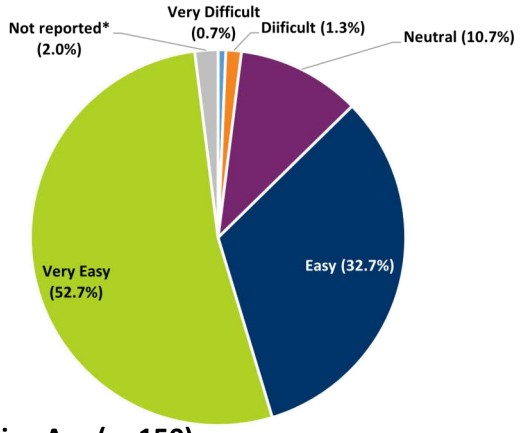
Youth MHFA Satisfaction Summary

Individuals reported that they **strongly agree (59.3%)** that there was an adequate opportunity in practicing their skills that they learned from the training. Almost half of the participants found that navigating the coursework was very **easy (52.7%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (70.7%)** to the populations that they primarily work with and about **59.3%** indicated that the pace of the coursework was **neutral**. Although not shown below, a majority said yes to **taking another MHFA course (90.7%).**

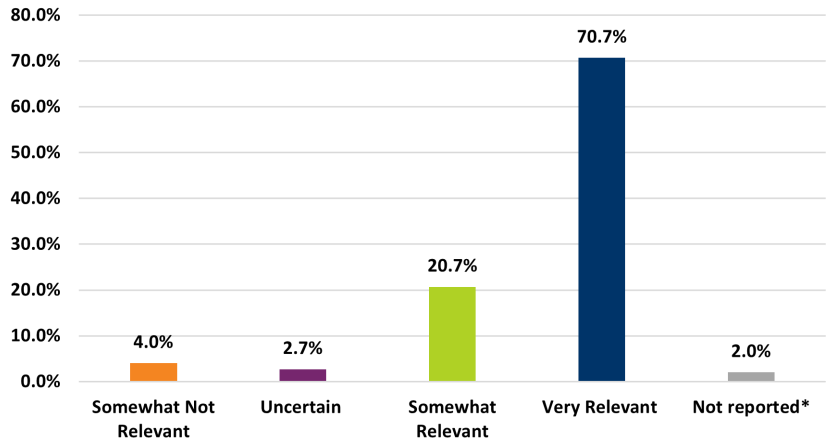
Adequate Opportunity to Practice Skills Learned (n=150)



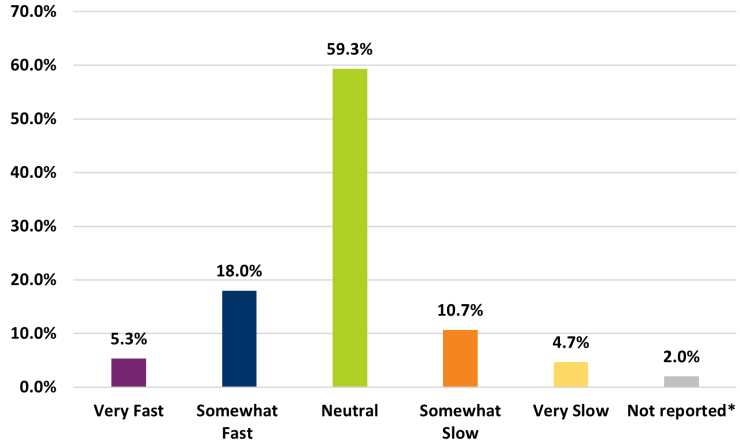
Overall Experience Navigating Coursework (n=150)



How Relevant the Existing Scenarios Are (n=150)



Pace of the Coursework (n=150)



**Note:* *"Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT & YOUTH MHFA ADDITIONAL COMMENTS

Adult MHFA and Youth MHFA Quiz Outcomes

To complete a MHFA training, participants were required to take the Adult MHFA Quiz, which evaluates participants' understanding of the MHFA program, overall knowledge, stigmatizing attitudes, and helping behaviors in assisting someone experiencing a mental health or substance use condition. The quiz is taken at the end of the training and a score of 6 out of 10 is required to pass the course. **For FY 23-24, all 225 Adult and Youth MHFA participants passed the quiz with a rate of 100%.**

Adult & Youth MHFA Additional Comments Summary

Below are the participants' comments from the program evaluation feedback forms. These comments highlight the importance of the program and other thoughts that participants had about the overall program, instructors, and training.

"I appreciated reading closely about a disorder and sharing findings with the group."

"Thank you for the examples on how we may respond to specific situations."

What Was Most Helpful About the Course?

"Knowing how to approach & speak to someone in crisis."

"Very friendly, warm, welcoming, supportive and awesome!"

"Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you."



SAFETALK

Program Description

safeTALK is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings.

This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. Additionally, 'Safe' stands for 'Suicide Alertness For Everyone' and 'TALK' stands for 'Tell, Ask, Listen, and KeepSafe'. This program helps participants practice the TALK step actions in overcoming these barriers.

Program Objective: To learn how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support.

FY 23-24 OVERVIEW

FY 23-24 safeTALK Training Overview Summary

For FY 23-24, there were a total of **503 individuals** who completed the safeTALK training. All **31 safeTALK trainings** were conducted in collaboration with **RUHS-BH PEI staff** and many other departments, such as **RUHS-Public Health, HelpLine, Loma Linda Health University, Special Service for Groups—Asian Pacific Counseling & Treatment Center (SSG-APCTC),** and **WET.** Additionally, most trainings took place in the **Western region**, while a few were conducted in **San Bernardino County**.

31
Total Number of Trainings

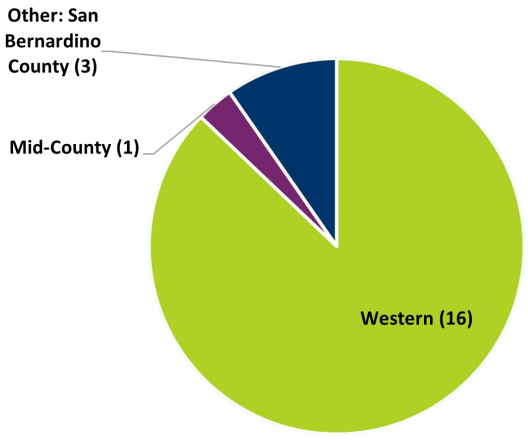
503
Total Number Reached

503
Total Number Completed Training

4
Smallest Audience Size

37
Largest Audience Size

Regions of safeTALK Trainings

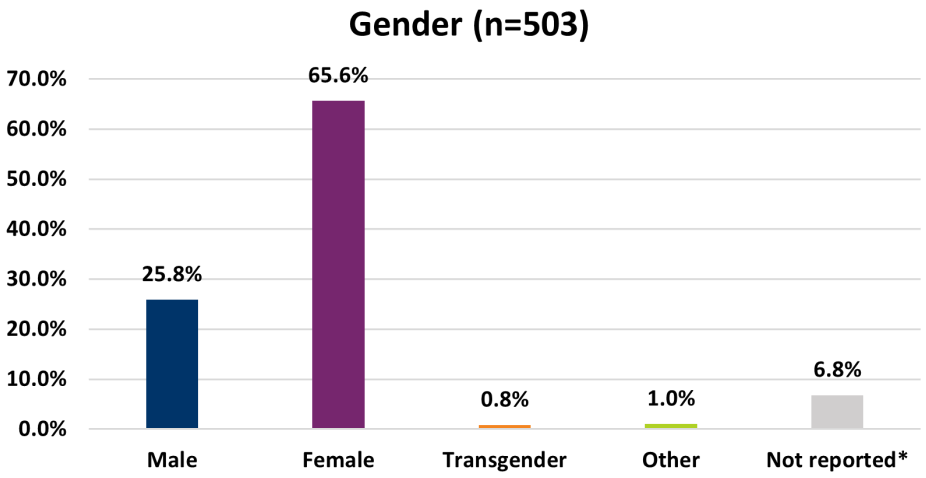


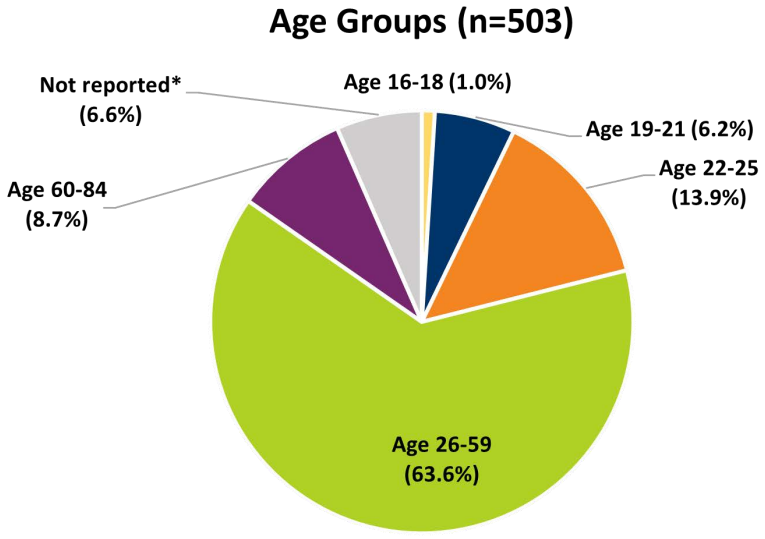
SAFETALK

DEMOGRAPHICS

Demographics Summary

More than half of the safeTALK participants identified as **female (65.6%)**, followed by male (25.8%), transgender (0.8%), and other (1.0%). In addition, most of the participants were in the **26-59 age group (63.6%)**, followed by the 22-25 age group (13.9%), 60-84 age group (8.7%), 19-21 age group (6.2%), and 16-18 age group (9.1%).





*Note: "Not reported" includes individuals who chose not to answer.

SAFETALK

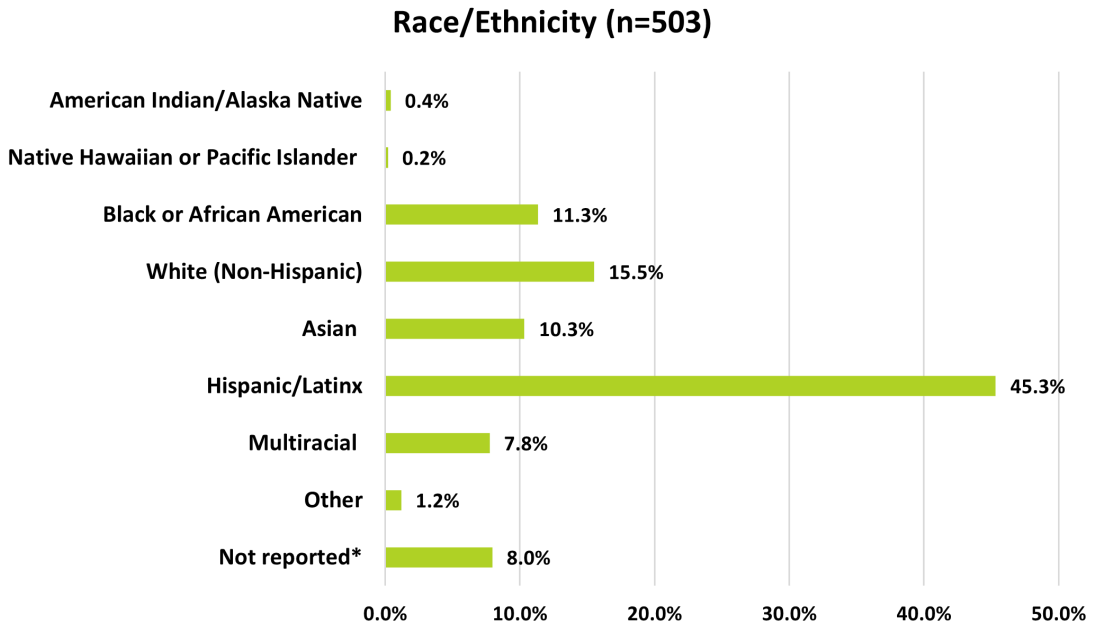
DEMOGRAPHICS

Demographics Summary

The majority of participants identified as **Hispanic/Latinx (45.5%)**, followed by White—Non Hispanic (15.5%), Black or African American (11.3%), Asian (10.3%), Multiracial (7.8%), Other (1.2%), American Indian/Alaska Native (0.4%), and Native Hawaiian or Pacific Islander (0.2%). Additionally, 8.0% of participants chose to not answer the race/ethnicity question and are included in the "not reported" category down below.

Individuals reported that they **work in a mental health care setting (22.1%),** followed by working in a school or university (16.3%), other setting (16.1%), more than one setting (11.7%), medical care setting (8.9%), and religious organization setting (2.2%).

The safeTALK trainings reached out to a diverse range of audience groups; however, the most frequent type of audience that was reported are individuals from the **community at large (35.4%)** Some examples of "other" groups include folks from nonprofit organizations, training centers, etc. Although not shown here, most participants reported that they **do not have a disabling condition (87.9%)** and that they are **not a veteran (90.5%)**. Lastly, **safeTALK participants reported that did not identify as being a part of the LGBTQ+ community (82.5%).**



Type of Work Environment	Count	Percentage
School/University	82	16.3%
Mental Health Care Setting	111	22.1%
Medical Care Setting	45	8.9%
Religious Organizations	11	2.2%
Other	81	16.1%
More than 1	59	11.7%
Not reported*	114	22.7%
Total	**503**	**100.0%**

Type of Audience Reached	Count	Percentage
An interested parent	41	8.2%
Consumer of services	47	9.3%
Community at large	178	35.4%
Other	122	24.3%
More than 1	67	13.3%
Not reported*	48	9.5%
Total	**503**	**100.0%**

**Note:* "Not reported" includes individuals who chose not to answer.*

SAFETALK

EVALUATION OUTCOMES

Evaluation Outcomes Summary

All safeTALK participants are asked to complete a feedback form at the end of the training presentation to complete their training. The feedback form includes questions about participant satisfaction of the training and any additional comments that participants would like the safeTALK program to know.

Please circle the choice that best describes your response *(1=Strongly Disagree, 2=Partly Agree, 3=Agree, 4=Strongly Agree; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
1. My trainer was prepared and familiar with the material.	**	0.4%	7.8%	91.7%
2. My trainer encouraged participation and respected all responses.	**	0.4%	4.4%	94.8%
3. I intend to tell others that they will benefit from this training:	**	1.0%	9.9%	86.9%
Please circle the choice that best describes your response *(1=Not Prepared, 2=Partly Prepared, 3=Mostly Prepared, 4=Well Prepared; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
4. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?	**	1.8%	32.6%	64.2%
On a scale of 1 *(i.e., very bad)* to 10 *(i.e., very good)*, how would you rate this training *(n=503)*?				
5. How would you rate this training?	**Average Rating (Mean)**			9.6

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*
***No responses.*

SAFETALK ADDITIONAL COMMENTS

"This training helped my school community to not be afraid and it [the training] will help them build capacity within their role."

"Going over the slides and having the videos were helpful to understand the steps. Resource are also very helpful and useful to provide to others who are in need."

"Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate."



KNOW THE SIGNS

Program Description

Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi and Russian. There are also print ads, TV and radio spots, and online ads available for the public. At the end of each presentation, everyone is encouraged to download the mobile application to help connect at -risk individuals to a supportive network.

Program Objective: Know the Signs has the overarching goal to increase Californians' capacity to prevent suicide by encouraging individuals to know the signs, find the words to talk to someone they are concerned about, and to reach out to resources.

FY 23-24 OVERVIEW

FY 23-24 Know the Signs Training Overview Summary

FY 23-24, there were a total of **17 trainings** and a total of **141 participants** who completed the training. In addition, for the type of audience reached, almost half of the Know the Signs participants identified as the **community at large (40.7%)**.



17
Total Number of Trainings

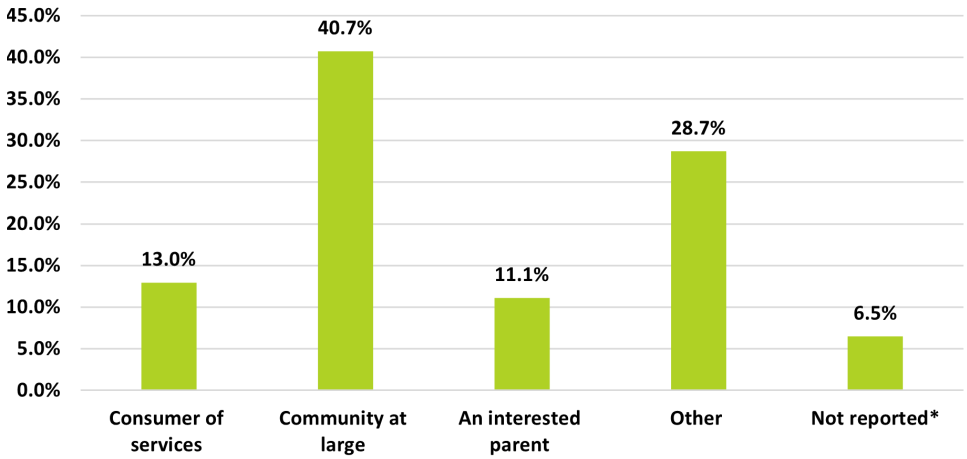


108
Total Number Reached



108
Total Number Completed Training

Type of Audience Reached (n=108)



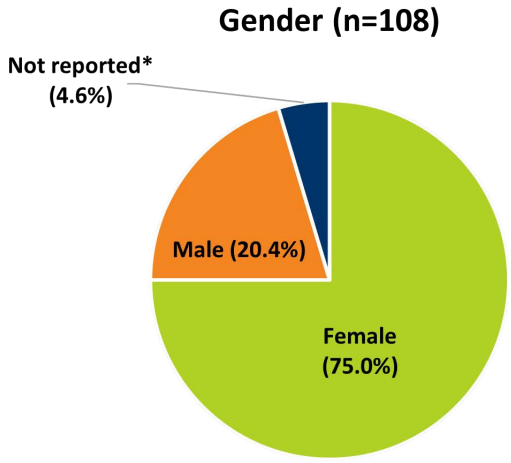
**Note:* "Not reported" includes individuals who chose not to answer.*

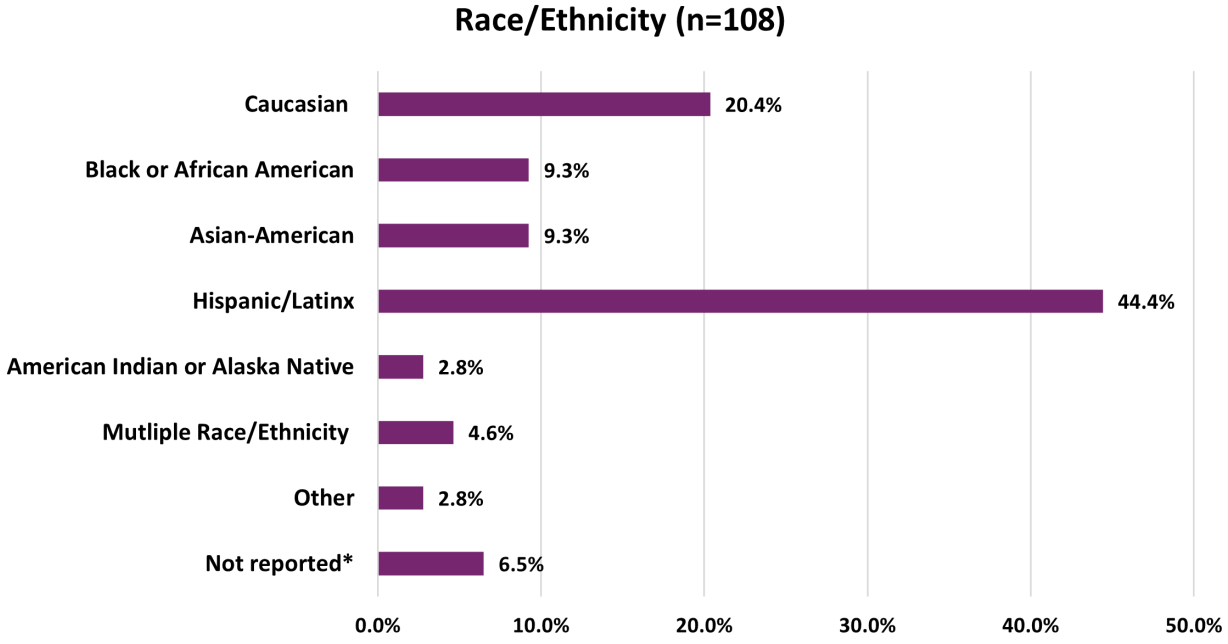
KNOW THE SIGNS

DEMOGRAPHICS

Demographics Summary

All demographic data includes participants from both the English and Spanish-speaking Know the Signs trainings. The majority of participants identified themselves as **female (75.0%)**, followed by males (20.4%). Additionally, most Know the Signs participants identified as **Hispanic/Latinx (44.4%)**, followed by Caucasian (20.4%%), Black or African American (9.3%), Asian-American (9.3%), Multiple Race/Ethnicity (4.6%), and American Indian or Alaska Native (2.8%), and Other (2.8%).





**Note:* "Not reported" includes individuals who chose not to answer.*

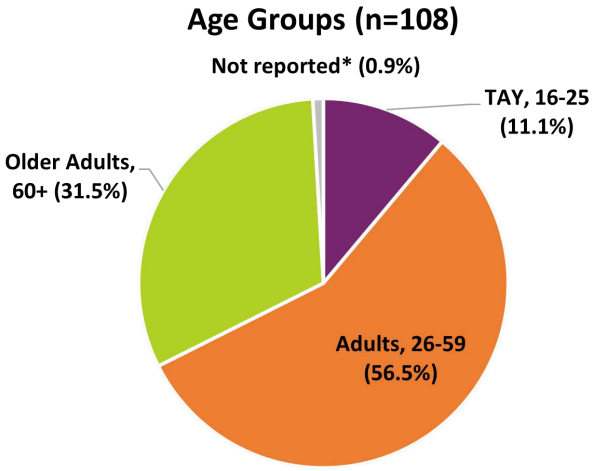
KNOW THE SIGNS

DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

Most participants from the Know the Signs training reported that they were in the **26-59 age group (56.5%)**, followed by the 60+ age group (31.5%), and the 16-25 TAY age group (11.1%). About 0.9% of participants did not report their age resulting in some unknown data.

In addition, a great majority of Know the Signs participants reported **English as their preferred language (89.8%)**. Most Know the Signs participants reported that they **did not have a disability (86.1%) nor did they identify as a veteran (88.9%)**. Lastly, a majority of respondents indicated that they **did not identify as lesbian, gay, bisexual, or queer (LGBQ) (71.3%)** as their sexual orientation status.



Demographic Characteristic	Percentage
Preferred Language (n=108)	
English	89.8%
Spanish	5.6%
*Not reported**	3.7%
Disability (n=108)	
Yes	7.4%
No	86.1%
*Not reported**	6.5%
Veteran Status (n=108)	
Yes	4.6%
No	88.9%
*Not reported**	6.5%
LGBQ Sexual Orientation Status (n=108)	
Yes	11.1%
No	71.3%
*Not reported**	14.8%

**Note:* "Not reported" includes individuals who chose not to answer.*

KNOW THE SIGNS

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of a Know the Signs training, participants are asked to complete a feedback survey via Google Forms to further understand how participants felt and thought about the training. Below are the results of the feedback survey and additional comments that participants may have provided.

As a result of this training, I feel more confident that I can… *(1=Not confident at all, 3=Somewhat confident…5=Very confident; n=108)*					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
1. Recognize the warning signs of suicide.	**	**	5.7%	22.6%	71.7%
2. Ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide.	**	0.9%	3.7%	25.2%	70.1%
3. Connect or refer someone at-risk for suicide to resources.	**	**	4.7%	21.7%	73.6%

Please circle the number that best describes your response *(1=Strongly Disagree, 3=Neutral… 5=Strongly Agree; n=108)*.					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
4. Overall, the course goals were clearly communicated.	0.9%	**	1.9%	15.9%	81.3%
5. The presenter demonstrated knowledge of the material presented.	**	0.9%	1.9%	12.1%	85.0%
6. I would recommend this training to someone else.	**	**	1.9%	19.6%	78.5%

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

KNOW THE SIGNS ADDITIONAL COMMENTS

"It was very informative and helpful. Great job! Thank you both so much!"

"This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful."

"Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support."



APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

Program Description

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed.

ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

Program Objective: To learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone safe.

FY 23-24 OVERVIEW

FY 23-24 ASIST Overview Summary

Overall, for FY 23-24, ASIST had a total of **19 trainings** with **314 participants** who completed the 2-day training. All 19 trainings for ASIST were conducted in collaboration or co-facilitation with **PEI, Helpline, Public Health, Consumer Affairs, WET, school districts,** and **Inland Empire Health Plan (IEHP)**. Additionally, most of the trainings took place at the **Rustin Conference Center** and in the **Western region** of Riverside County.

19
Total Number of Trainings

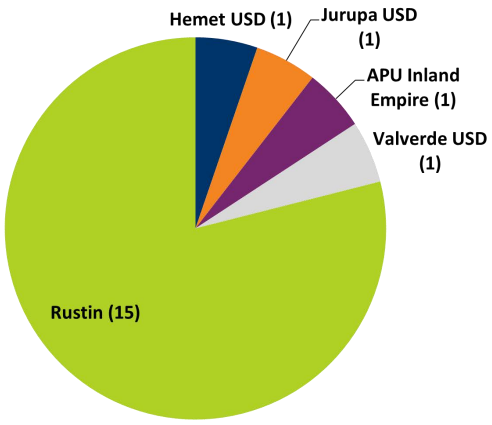
327
Total Number Reached

314
Total Number Completed Training

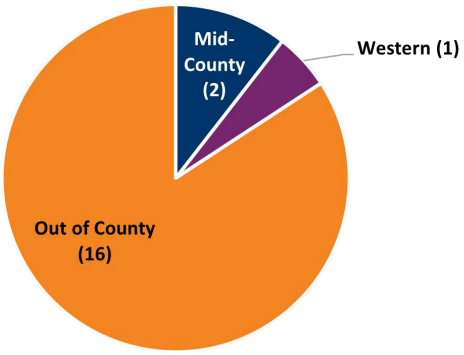
5
Smallest Audience Size

30
Largest Audience Size

Location of Training



Region of Training



**Note:* *"Not reported" includes individuals who chose not to answer.*

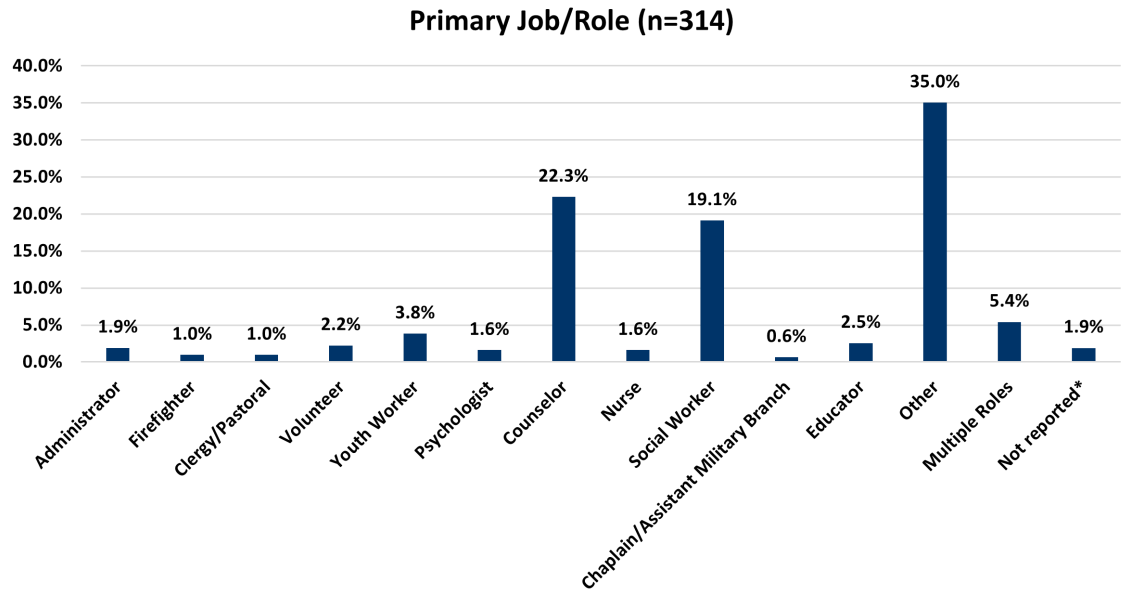
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

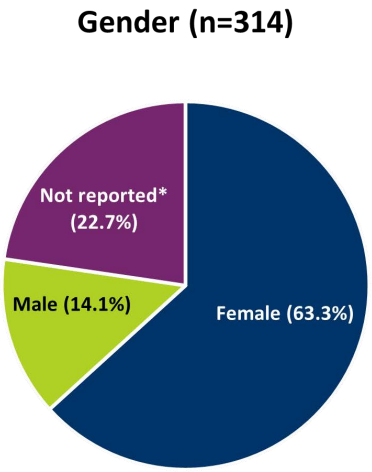
DEMOGRAPHICS

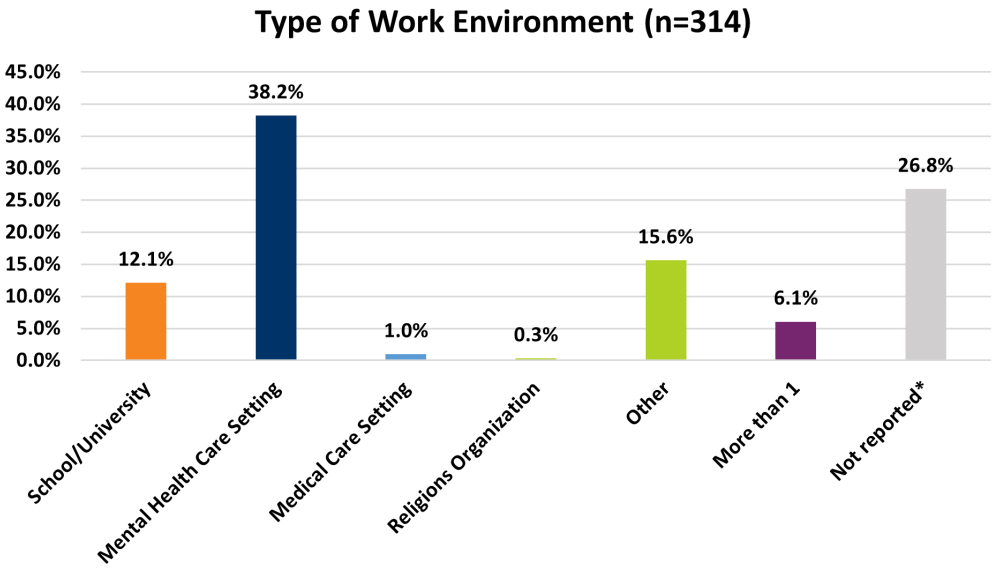
Demographics Summary

Note: There are more "Not reported" counts this fiscal year than there were last fiscal year due to a misunderstanding in providing the demographics section for two trainings for ASIST. Because of this, some demographic information may not be available throughout the demographics section of the report for ASIST.

Many of the ASIST participants come from a diverse range of occupations and primary roles. For example, **35.0% of respondents identified as 'Other'** as their primary job or role. Additionally, the next frequently chosen response was counselor (22.3%), social worker (19.1%), followed by having multiple primary roles (5.4%), youth worker (3.8%), and educator (2.5%). The most frequently chosen type of work environment was **mental health care setting (38.2%)** among ASIST participants. Additionally, the majority of ASIST participants identified themselves **as female (63.3%)**, followed by male (14.1%), and those who did not report on their gender identity (22.7%).







**Note:* "Not reported" includes individuals who chose not to answer.*

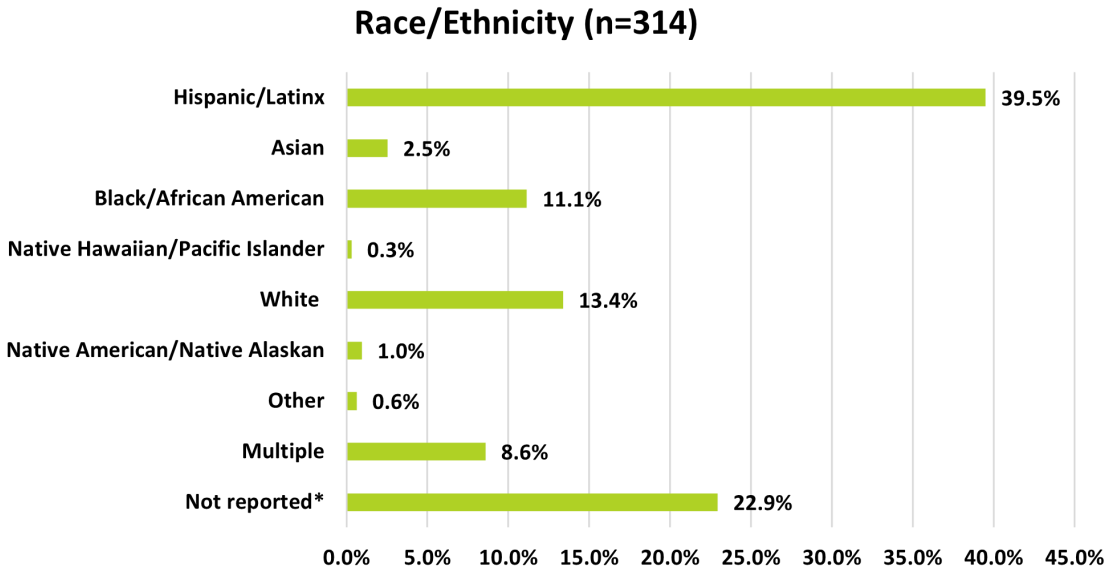
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

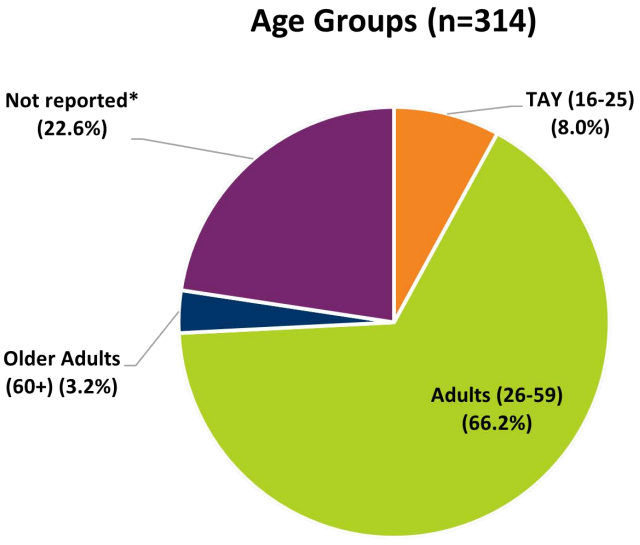
DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

More than half of the ASIST participants identified as **Hispanic/Latinx (39.5%)**, followed by White (13.4%), Black/ African American (11.1%), Multiple (8.6%), Asian (2.5%), Native American/Native Alaskan (1.0%), Other (0.6%), and Native Hawaiian/Pacific Islander (0.3%). Most of the participants reported being in the **26-59 age group (66.2%)**, followed by the Transitional Age Youth (TAY) 16-25 age group (8.0%), and the 60+ age group (3.2%).

In addition, most individuals reported **English as their preferred language (72.3%)**. A great majority of participants reported that they **did not have a disability (70.1%) nor a veteran (76.4%)**. Lastly, most participants did **not identify as LGBTQ+ (64.6%).**





Demographic Characteristic	Percentage
Preferred Language (n=314)	
English	72.3%
Spanish	0.6%
English & Another Language	3.8%
Other	0.6%
Disability (n=314)	
No	70.1%
Veteran Status (n=314)	
No	76.4%
LGBTQ+ Status (n=314)	
Yes	9.2%
No	64.6%

**Note:* *"Not reported" includes individuals who chose not to answer.*

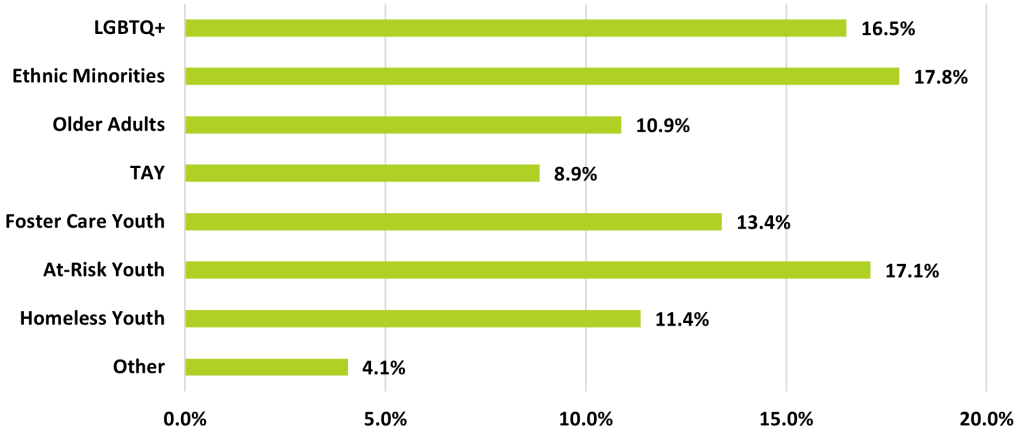
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

DEMOGRAPHICS—PEOPLE SERVED/WANT TO SERVE (cont.)

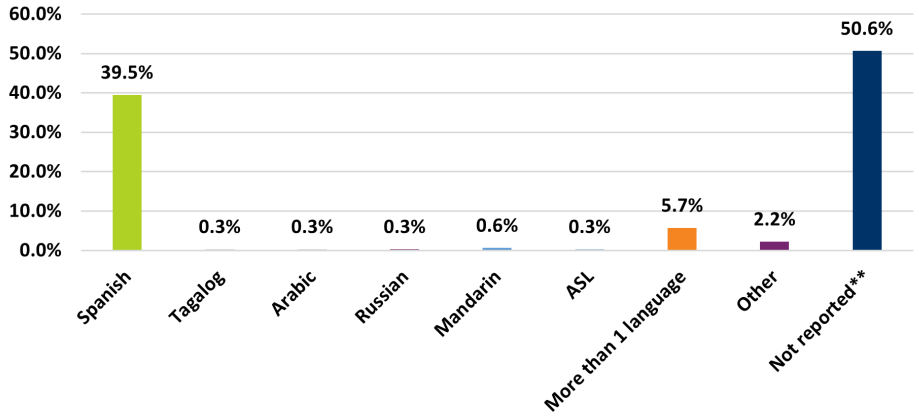
Demographics Summary (cont.)

The most frequently reported special population group that ASIST participants serve or want to serve was the **ethnic minorities group (17.8%)**, closely followed by the at-risk youth group (17.1%). Participants were able to choose multiple special population groups for this question. Additionally, participants most frequently chose **Spanish (39.5%) as another language other than English that they serve**. Lastly, participants most frequently responded that they serve or want to serve the **18-25 age group (28.7%)**.

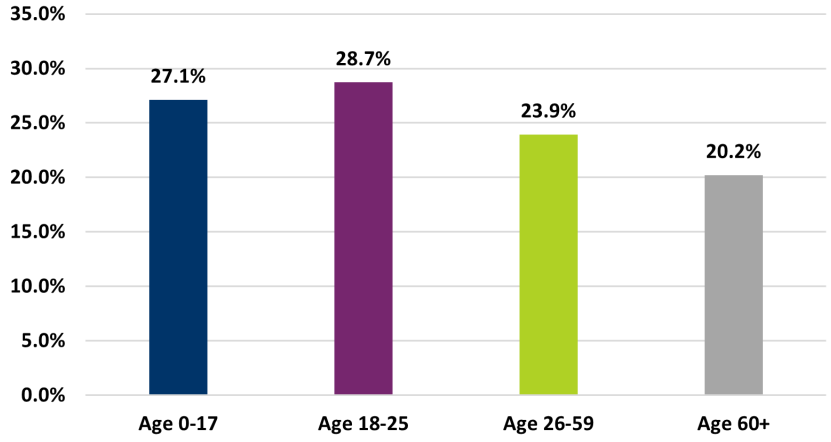
Special Populations (n=836)*



Other Than English, Another Language Served (n=314)



Age of People Served (n=564)*



**Note:* Multiple responses are reported here.*

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of ASIST, all participants are encouraged to complete a feedback survey which includes questions about the overall course, how ASIST is helpful to them or others, and a section for additional comments or thoughts about the training.

On a scale of 1 (i.e., did not like at all…) to 10 (i.e., liked a lot), please write the rating that best describes your responses.* (n=314)	Rating (Mean)
1. How would you rate the quality of the ASIST workshop	9.4
2. Would you recommend ASIST to others?	9.6
3. This workshop has practice use in my personal life.	9.2
4. This workshop has practical use in my work life.	9.6

Please circle the number that best describes your response (1=Strongly Disagree… 5=Strongly Agree).* (n=314)					
Questions	Responses				
	1	2	3	4	5
5. If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide.	1.0%	**	0.6%	10.2%	88.2%
6. Before taking the ASIST training, my answer to #5 would have been:	5.7%	12.7%	30.6%	25.2%	25.2%
7. If someone told me he or she were thinking of suicide, I would do a suicide intervention.	1.3%	**	1.3%	14.7%	82.7%
8. Before taking the ASIST training, my answer to #7 would have been:	6.7%	10.5%	23.6%	28.3%	30.9%
9. I feel prepared to help a person at risk of suicide.	60.0%	0.3%	2.2%	23.2%	73.6%
10. Before taking the ASIST training, my answer to #9 would have been:	11.5%	17.2%	24.5%	25.8%	20.7%
11. I feel confident I could help a person at-risk of suicide.	1.0%	0.3%	2.9%	23.6%	72.3%
12. Before taking the ASIST training, my answer to #11 would have been:	13.4%	15.3%	23.6%	28.3%	18.8%

Lastly, a great majority of ASIST participants (n=314) **agreed** with the following statements:

13. I attended two consecutive 8-hour days of training **(100%)**.
14. All trainers were present at the workshop for the full 2 days **(99.3%)**.
15. The "Jack" exercise was done on the afternoon of day 1 **(99.0%)**.

"The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS."

"I felt it was very beneficial for my life and future profession."

"ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally."

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

Riverside University HEALTH SYSTEM Behavioral Health

Triple P and Teen Triple P Positive Parenting Programs

FY 2023/2024

MHSA Prevention and Early Intervention

Program Overview

RUHS-BH with MHSA Prevention and Early Intervention (PEI) funding implemented Triple P Positive Parenting Program and Teen Triple P Program, which are multi-level systems of parenting and family support strategies for families with children aged 2-12, and for families with teens aged 12-16, respectively. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens, and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. The service delivery method for this implementation of Level 4 Triple P and Teen Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Triple P throughout Riverside County, and Teen Triple P in the West and Mid-County Regions of Riverside County.

Triple P Outcome Evaluation

Evaluation of Triple P parenting focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in children's disruptive behavior. The following measures are used in the evaluation of Triple P:

Alabama Parenting Questionnaire (APQ)
The APQ is a parent completed questionnaire that measures several dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. Two of six parenting dimensions are used for analysis including: positive parenting, and inconsistent discipline. Parents completed the Alabama Parenting Questionnaire (APQ) before and after completing the program.

Eyberg Child Behavior Inventory (ECBI)
The ECBI is a parent completed measure that focuses on child disruptive behaviors and the parent's perception of whether the behavior is problematic. The ECBI includes an Intensity Scale (frequency of disruptive behaviors) and a Problem Scale (parent's perception of problematic behaviors).

Depression, Anxiety and Stress Scale (DASS-21)
The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure parent's negative emotional states of depression, anxiety, and stress.

Teen Triple P Outcome Evaluation

Similar to Triple P, evaluation of Teen Triple P also focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in teens conflict behavior. The following measures are used in the evaluation of Teen Triple P:

Strength and Difficulties Questionnaire (SDQ)
Parents completed the SDQ before and after completing the program. The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these (emotional, conduct, hyperactivity and peer problems) creates a total difficulty score. The emotional and peer items together create an internalizing problems score and the conduct and hyperactivity questions together get an externalizing score.

Alabama Parenting Questionnaire (APQ)
Parents completed the APQ before and after completing the program. For the Teen Triple P program, the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Conflict Behavior Questionnaire (CBQ)
The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score.

A satisfaction survey is also used for both programs to measure the parent's satisfaction in program logistics, program leaders, and program content.

Executive Summary - Key Findings

Enrollment and Demographics

Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. Demographics information showed that most of the parents in Triple P spoke English as their preferred language (72.2%), and in Teen Triple P, 62.5% of parents identified English as their primary language. The majority of parents served in Triple P and Teen Triple P were Hispanic/Latinx, 64.6% and 71.5%, respectively. The average age of the child of focus in Triple P was 6.3 years, and 13.5 years for Teen Triple P. The majority of parents/caregivers enrolled in both Triple P and Teen Triple P programs were female.

Service data showed that Countywide 80.8% of parents completed the Triple P Program, and 84% of parents completed the Teen Triple P program. Across both programs, parents had a 81.5% program completion rate. Parents were overall highly satisfied with both programs.

Triple P: Positive Parenting Practices Improved

Analysis of the APQ measure indicated that overall, by the end of the program, participants had shown increases in positive parenting practices, and decreases in inconsistent discipline practices. Analysis of the DASS-21 also showed that parents experienced a decrease in their depression, anxiety, and stress levels.

Triple P: Child Disruptive Behavior Decreased

Outcomes from ECBI measures showed overall decreases in the frequency of children's disruptive behaviors. ECBI Intensity Scale scores decreased significantly from pre to post measure. ECBI Problem Scale scores also decreased significantly indicating that parents reported fewer behaviors as problematic.

Teen Triple P: Teen Problem Scores Decreased, Prosocial Skills Increased

Countywide, outcomes of the SDQ indicated that teen total problems of emotional, conduct, hyperactivity, peer problems decreased significantly upon parent completion of Teen Triple P. Teen prosocial behaviors significantly increased pre to post.

Teen Triple P: Increase in Parent Involvement and Positive Parenting

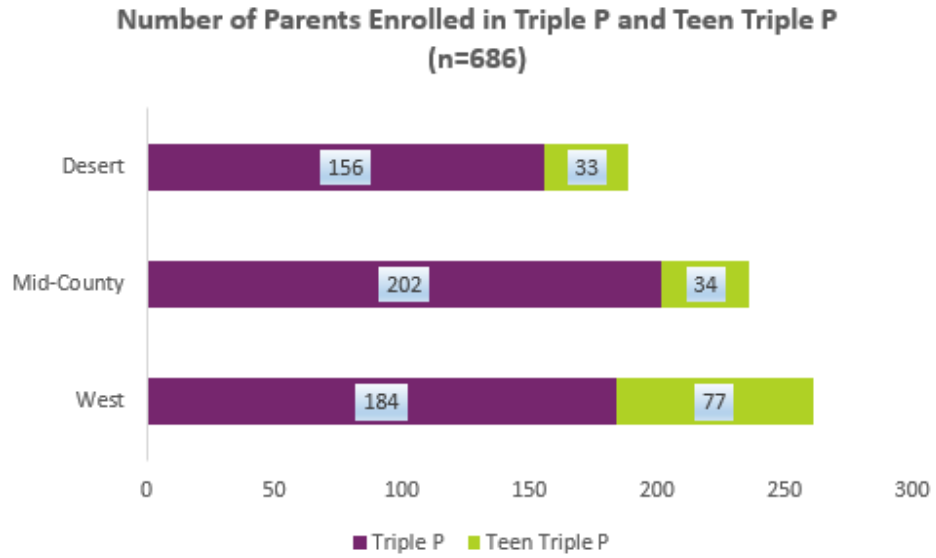
Analysis of the APQ measure indicated that countywide, parents had a significant increase in involvement with their teen and in positive parenting practices. There was a decrease in poor monitoring practices, however this decrease was not statistically significant.

Teen Triple P: Decrease in General Parent-Teen Discord

Countywide, analysis of the CBQ indicated a statistically significant decrease in parent's report of general conflict between parent and teen.

Parent Enrollment

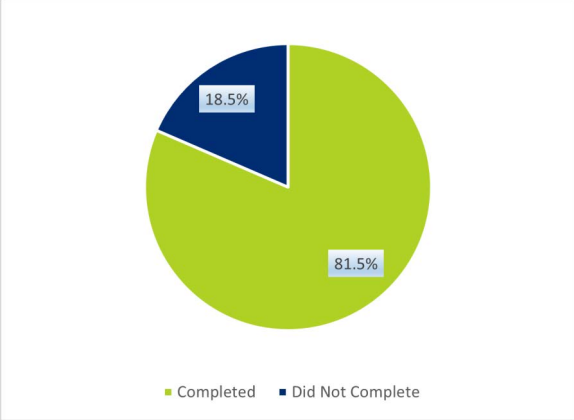
Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. **Note:** Some parents may not have reside within the County of Riverside, but had an active Child Protection Services (CPS) case within the County. In this case, the parent's region served is based on the location of the CPS case/ location of the child.



Program Completion

Countywide across both programs, parents had a 81.5% program completion rate. Program completion for both Triple P and Teen Triple P is defined as attending at least 6 out of 8 sessions, missing no more than one phone session, and not missing the first Triple P or Teen Triple P session. The table below details the completion rate regionally by program.

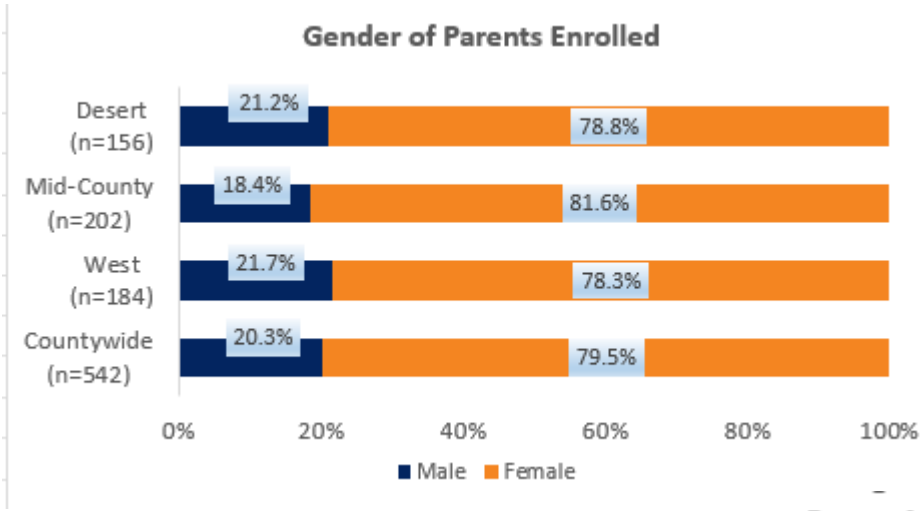
Countywide Completion Rates Triple P and Teen Triple P (Combined) n=686



Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	124 (79.5%)	165 (81.0%)	148 (81.7%)	438 (80.8%)
Did not Complete	32 (20.5%)	37 (19.0%)	35 (18.3%)	104 (19.2%)
Total Enrolled	156	202	184	542

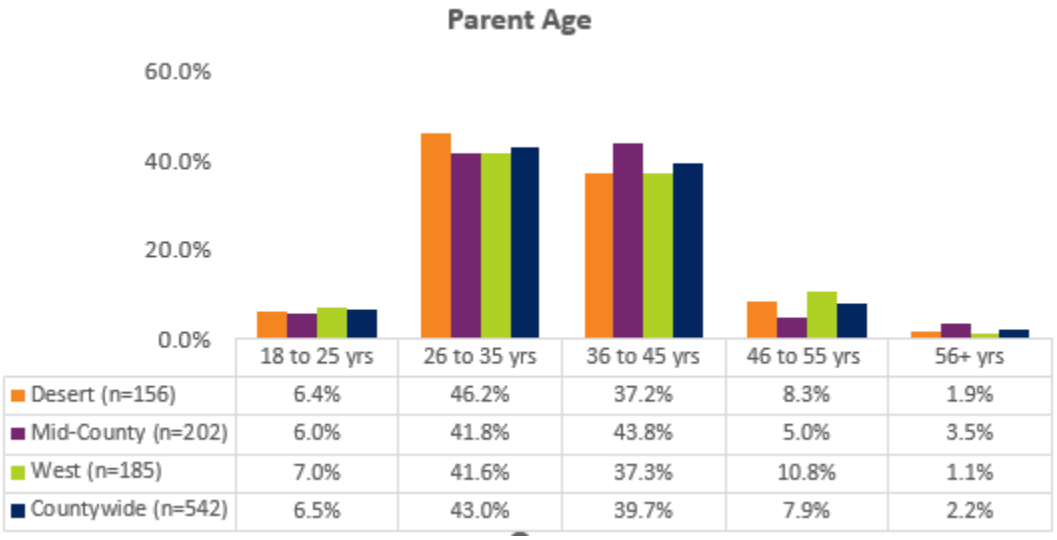
Teen Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	28 (84.8%)	28 (82.4%)	65 (84.4%)	121 (84%)
Did not Complete	5 (15.2%)	6 (17.6%)	12 (15.6%)	23 (16%)
Total Enrolled	33	34	77	144

Triple P Parent Enrollment and Demographics

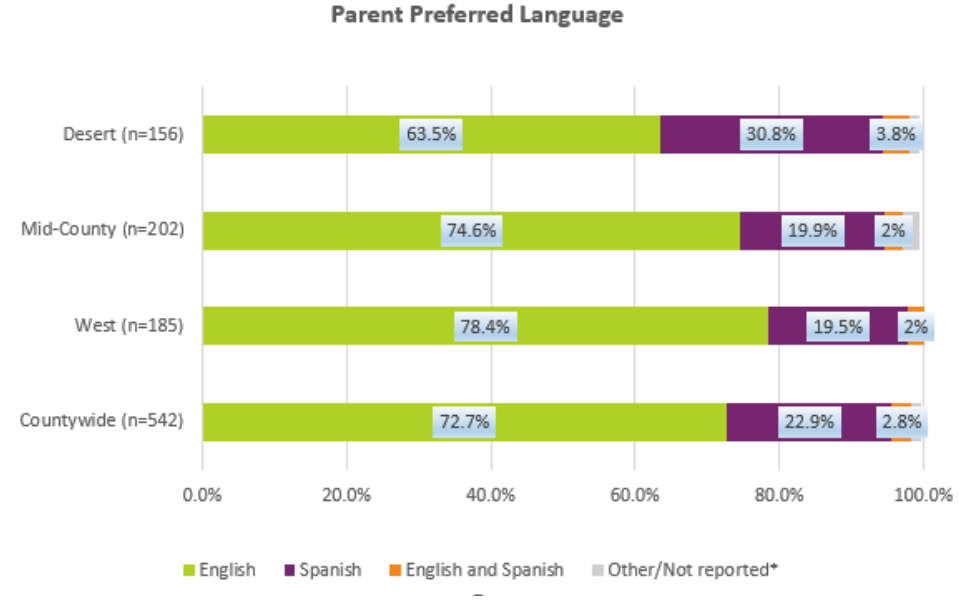


Countywide, the majority of parents/caregivers enrolled in Triple P parenting were females (79.5%).

A majority of parents/ caregivers identified as being a part of the 26 to 35 years old group (43.0%). The average parent age was 36.2 years old.

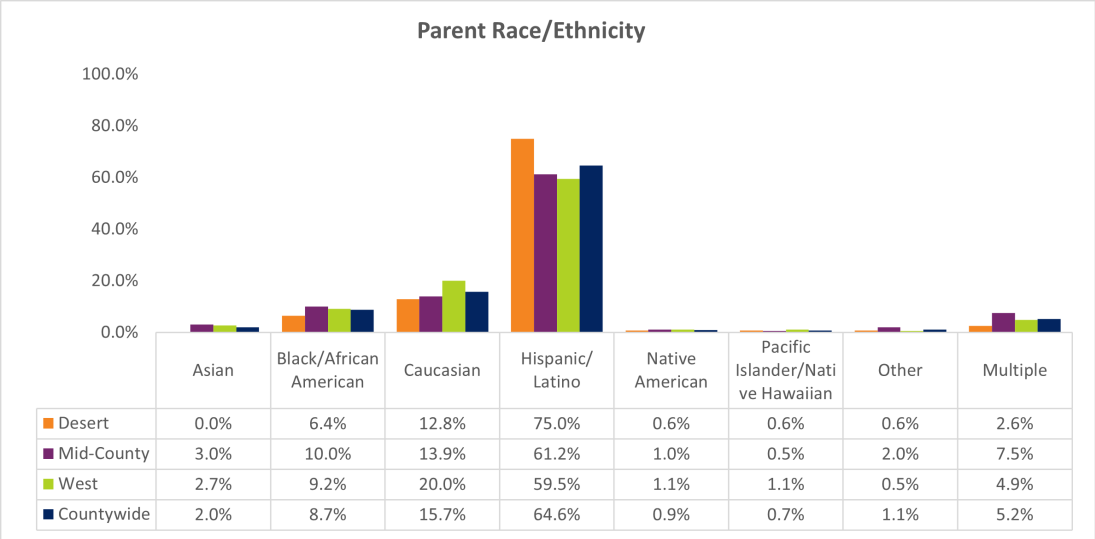


	18 to 25 yrs	26 to 35 yrs	36 to 45 yrs	46 to 55 yrs	56+ yrs
Desert (n=156)	6.4%	46.2%	37.2%	8.3%	1.9%
Mid-County (n=202)	6.0%	41.8%	43.8%	5.0%	3.5%
West (n=185)	7.0%	41.6%	37.3%	10.8%	1.1%
Countywide (n=542)	6.5%	43.0%	39.7%	7.9%	2.2%



Countywide, more than half of participants (72.2%) reported English as their preferred language. Most parents enrolled in classes of their preferred language (English or Spanish).

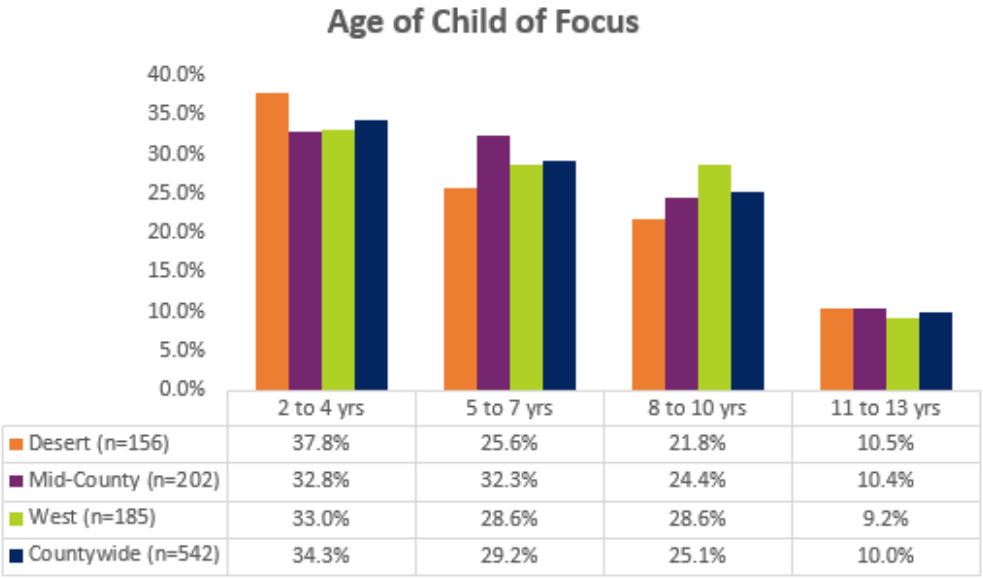
Triple P
Parent and Child Demographics



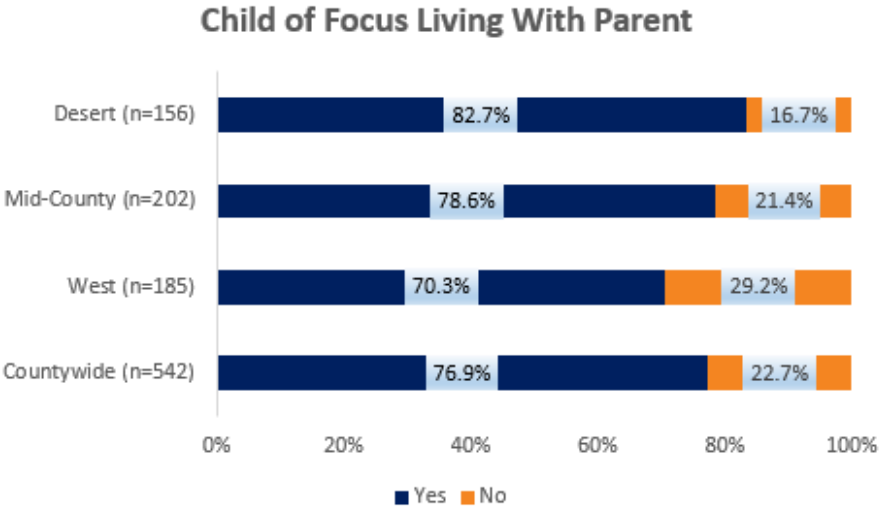
	Asian	Black/African American	Caucasian	Hispanic/ Latino	Native American	Pacific Islander/Native Hawaiian	Other	Multiple
Desert	0.0%	6.4%	12.8%	75.0%	0.6%	0.6%	0.6%	2.6%
Mid-County	3.0%	10.0%	13.9%	61.2%	1.0%	0.5%	2.0%	7.5%
West	2.7%	9.2%	20.0%	59.5%	1.1%	1.1%	0.5%	4.9%
Countywide	2.0%	8.7%	15.7%	64.6%	0.9%	0.7%	1.1%	5.2%

Countywide, the majority of Triple P participants identified as Hispanic/Latinx (64.6%), followed by Caucasian (15.7%) and Black/ African American (8.7%).

Parents/caregivers were asked to identify one of their children who posed the most parenting challenges. This child was considered the primary focus for the program. Countywide, the most reported age group for the child of focus was the 2 to 4 years old age group (34.3%). The average age of the child of focus was 6.3 years old.



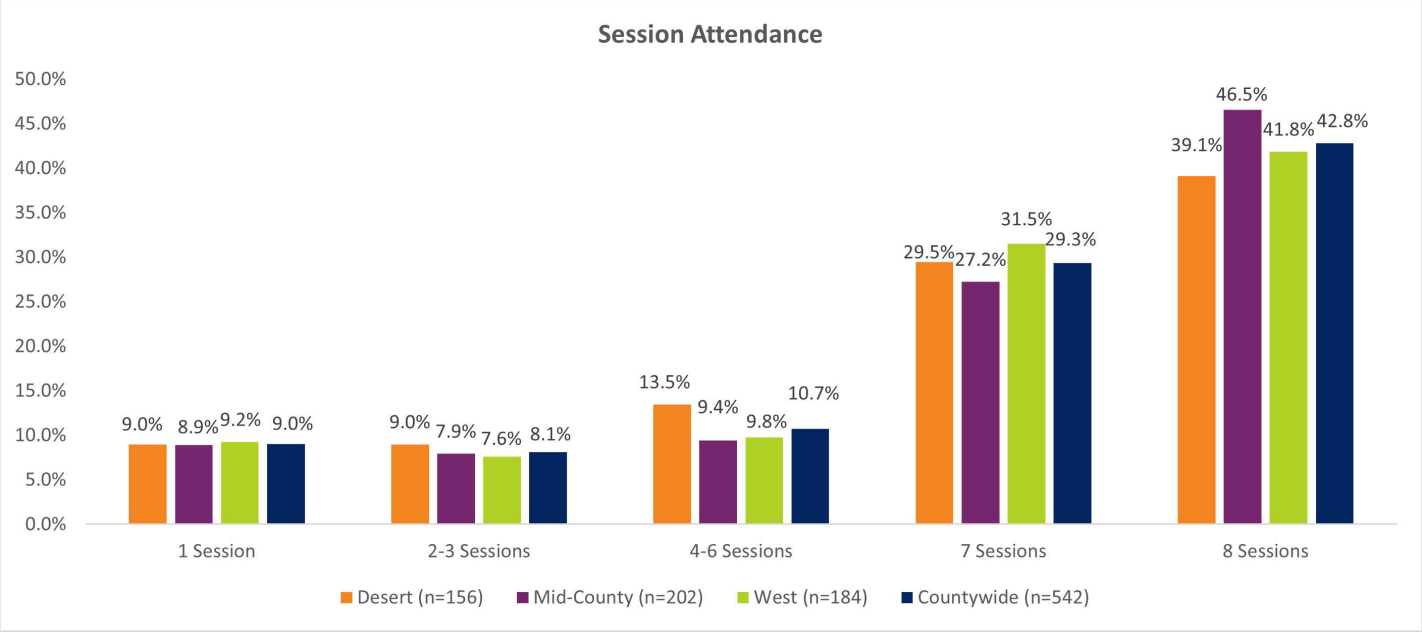
	2 to 4 yrs	5 to 7 yrs	8 to 10 yrs	11 to 13 yrs
Desert (n=156)	37.8%	25.6%	21.8%	10.5%
Mid-County (n=202)	32.8%	32.3%	24.4%	10.4%
West (n=185)	33.0%	28.6%	28.6%	9.2%
Countywide (n=542)	34.3%	29.2%	25.1%	10.0%



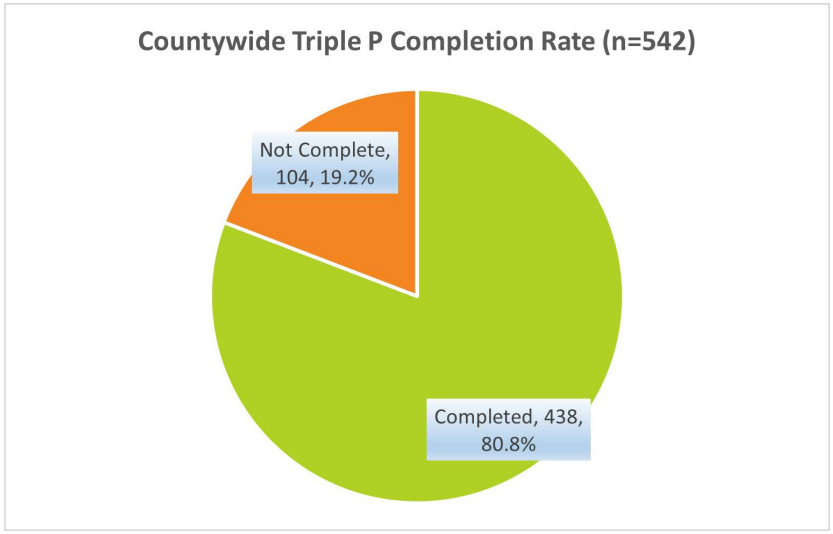
Countywide, 76.9% of parents/ caregivers served in Triple P reported that they lived with their child of focus.

Triple P Program Statistics

Countywide, session attendance showed that 82.8% of participants completed 6-8 Teen Triple P sessions, with 42.8% of participants attending all eight Teen Triple P sessions. Countywide, only 9.0% of the parents attended only one session.

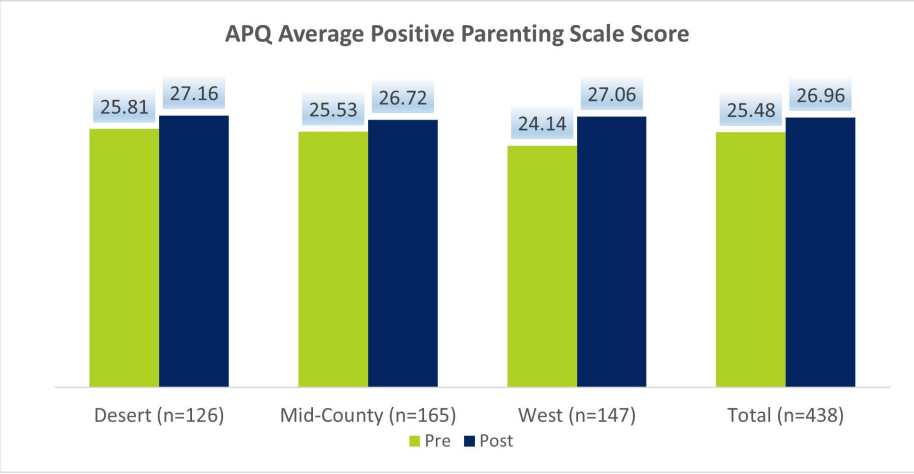


Countywide, 80.8% of parents completed the program. Page 5 of this report details the completion rate by region for the Triple P program.



Alabama Parenting Questionnaire

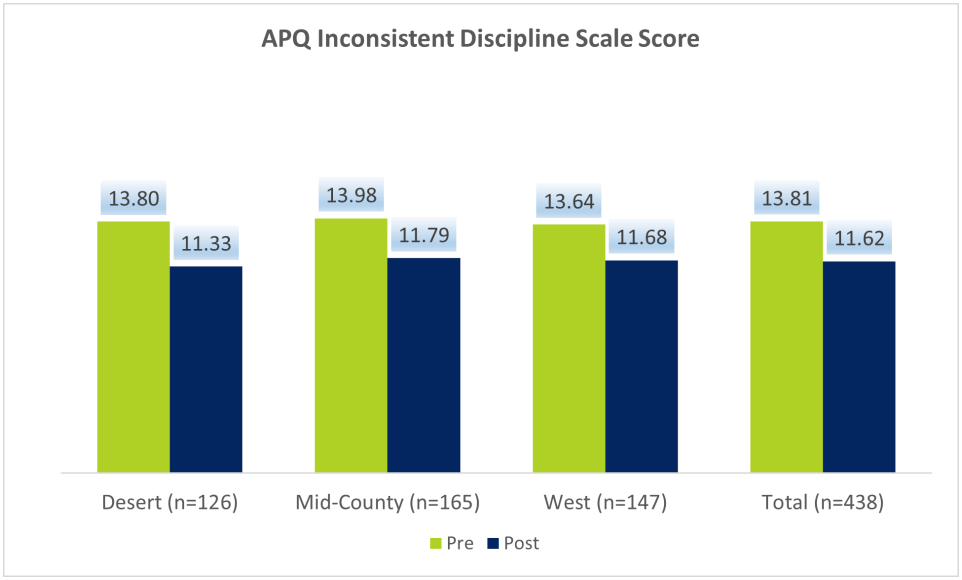
Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Triple P program, only the positive parenting (6 items) and use of inconsistent discipline scales (6 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always). The APQ was scored for parents whose children are between ages 4-17.



t=-3.71 df=125 p<0.001 | t=-4.25 df=164 p<0.001 | t=-5.60 df=146 p<0.001 | t=-7.87 df=437 p<0.001

Countywide there was a statistically significant increase for practicing positive parenting skills after parents/caregivers had completed the Triple P program. Each region also showed a statistically significant increase in positive parenting skills as well.

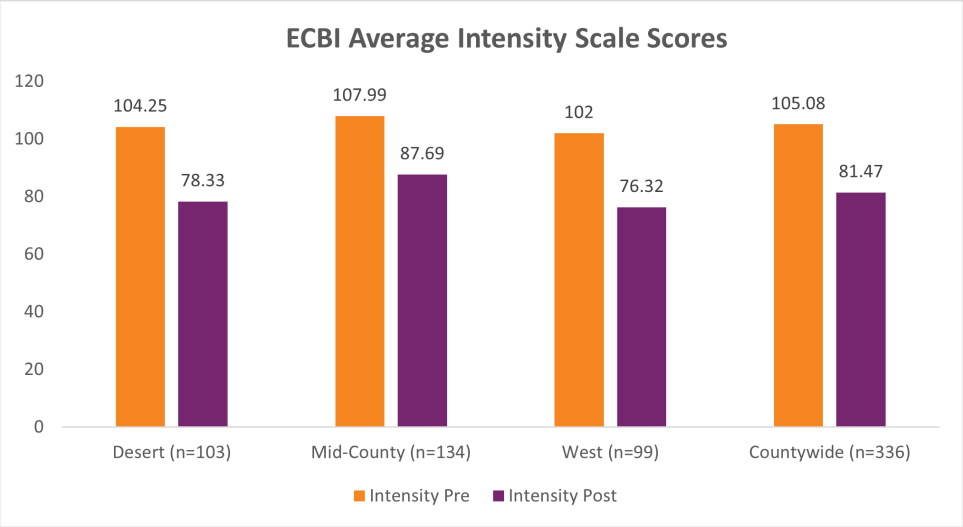
Countywide and across all three regions, there was a statistically significant decrease in the use of inconsistent disciplining practices after parents/caregivers completed the Triple P program.



t=6.29 df=125 p<0.001 | t=6.51 df=164 p<0.001 | t=5.16 df=147 p<0.001 | t=10.35 df=437 p<0.001

Eyberg Child Behavior Inventory

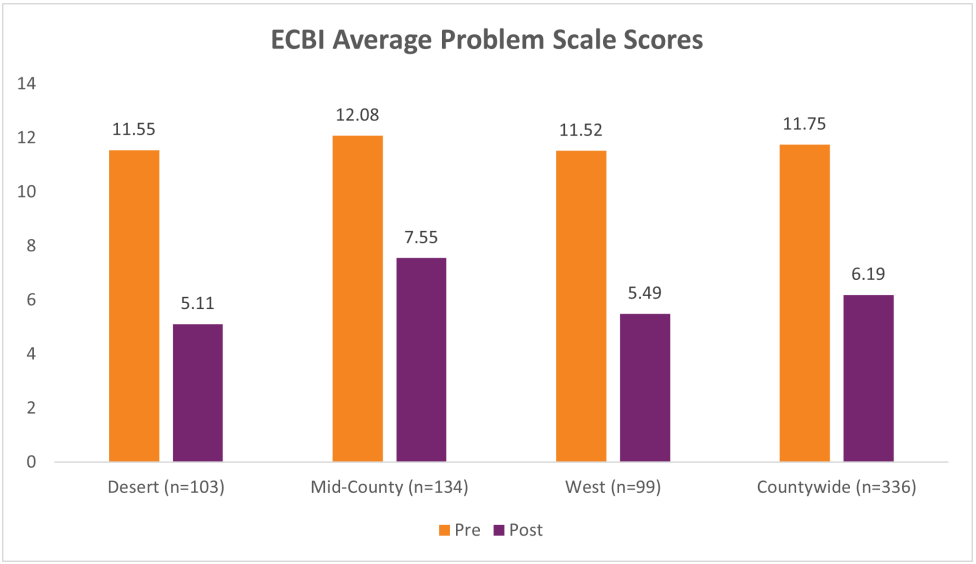
The Eyberg Child Behavior Inventory (ECBI) is a parent-completed rating scale used to measure the frequency of children's disruptive behaviors (Intensity scale) and parent's perceptions of problematic behaviors (Problem Scale). The ECBI consists of 36 items intended to assess "typical problem behaviors" reported by parents of children age 2-16 years. Each behavior is rated on a 7-point scale for intensity, as well as on a yes/ no scale to indicate whether the parent perceives the behavior to be a problem or not.



t=7.58 df=102 p<0.001 | t=7.95 df=133 p<0.001 | t=7.91 df=98 p<0.001 | t=13.51 df=335 p<0.001

Countywide and across all three regions individually, there was a statistically significant decrease in child problem behaviors from Pre to Post. For the ECBI intensity scale, the cut-off score is 130. At baseline, about 26.8% of children had a raw score above 130. By post, there was a decrease with only 9.5% of children who had a raw score of above 130.

From the ECBI Average Problem Scale, there was a statistically significant decrease in the parent's perception of their child's behavior as a problem countywide and across all three regions individually. The clinical cut-off is a score of 15. At baseline, about 33.3% of parent's ratings were above the cut-off score; however, by the end of the Triple P program, this decreased to 14.0%.



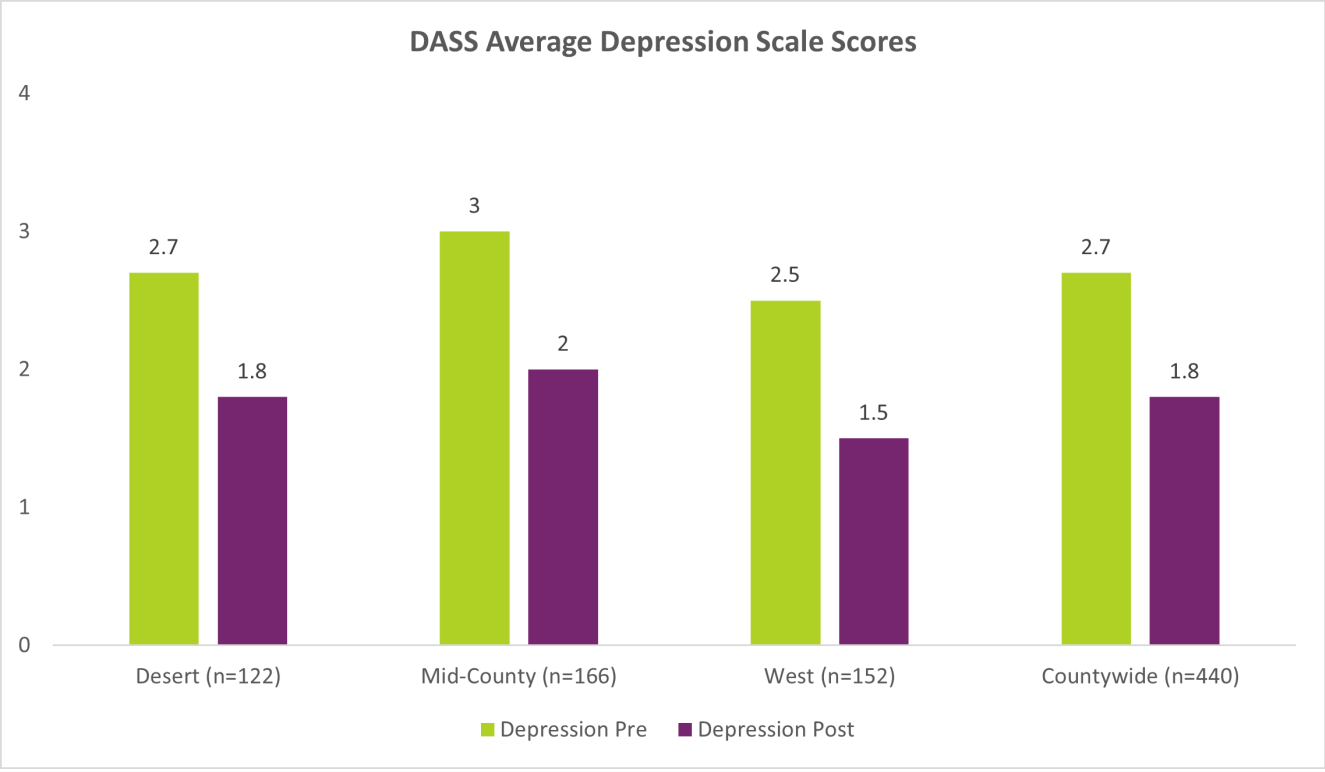
t=9.80 df=102 p<0.001 | t=7.20 df=133 p<0.001 | t=7.43 df=98 p<0.001 | t=13.81 df=335 p<0.001

Depression Anxiety and Stress Scale

The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure the negative emotional states of depression, anxiety, and stress. In completing the DASS, the individual is required to indicate the presence of a symptom in the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week). For the DASS-21 the following cut-off scores have been recommended for each subscale:

	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+

All three regions in Riverside County scored in the normal range for the DASS depression subscale in the pre-measures. There was also a statistically significant decrease in reported depression symptoms for the post-measures.

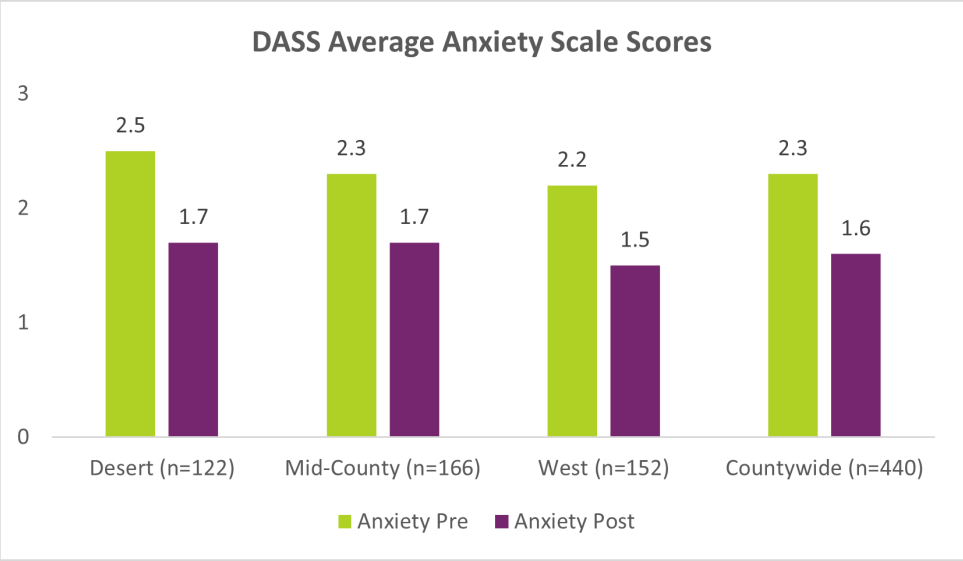


Desert (n=122)	Mid-County (n=166)	West (n=152)	Countywide (n=440)
t=2.95 df=121 p=0.004	t=4.30 df=165 p<0.001	t=3.82 df=151 p<0.001	t=6.37 df=439 p<0.001

Triple P
Depression, Anxiety, Stress Scale

Depression Anxiety and Stress Scale

	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+



t=2.62 df=121
p=0.010

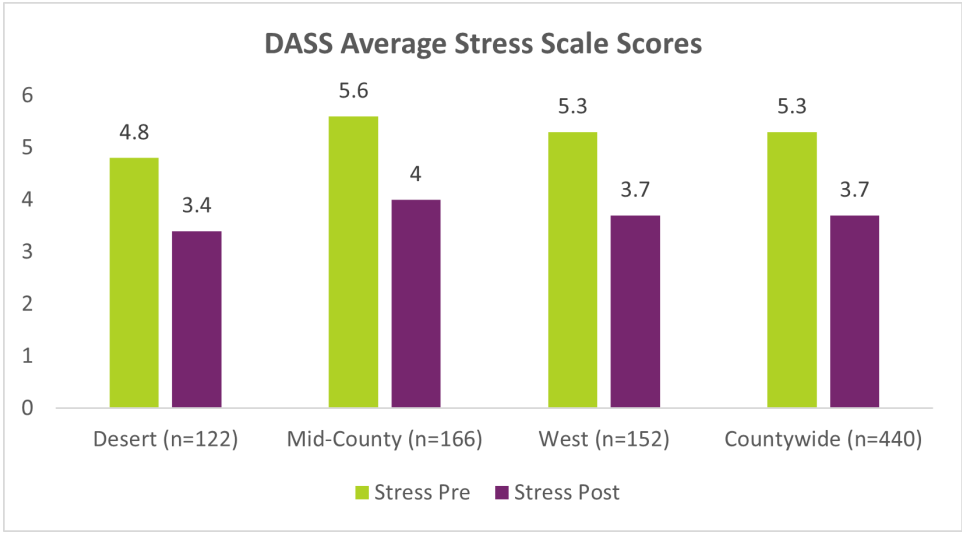
t=3.58 df=165
p<0.001

t=3.30 df=151
p=0.001

t=5.42 df=439
p<0.001

All three regions in Riverside County scored in the normal range for the DASS anxiety subscale in the pre-measures. Additionally, there was a statistically significant decrease in the DASS average anxiety subscale for the post-measure.

All three regions in Riverside County scored in the normal range for the DASS stress subscale in the pre-measures. There was a statistically significant decrease in the DASS stress subscale scores for the post-measure.



t=3.17 df=121
p=0.002

t=5.75 df=165
p<0.001

t=5.26 df=151
p<0.001

t=8.05 df=439
p<0.001

Triple P Satisfaction Survey

A total of 438 participants completed the satisfaction survey for the Triple P program. Overall, the majority of participants were highly satisfied with all aspects of the Triple P program including program logistics, quality of group leaders, and overall satisfaction of the program.

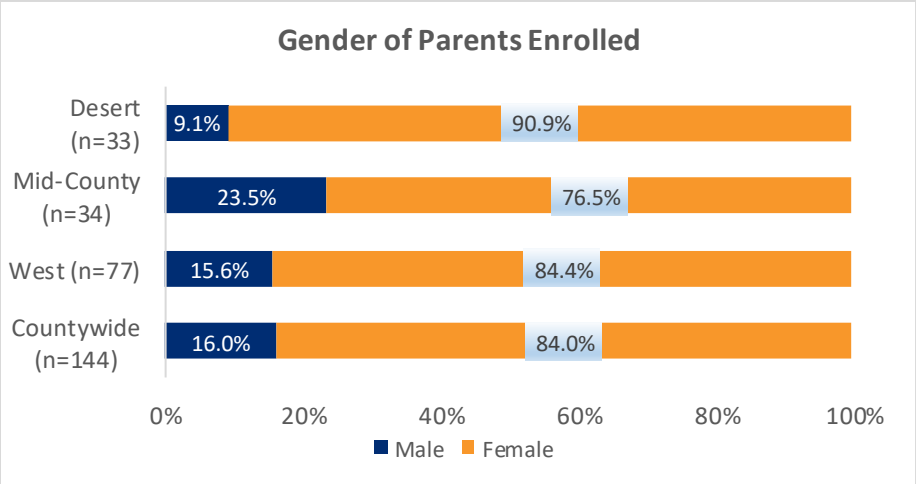
Triple P Countywide Satisfaction Survey Results (*N*=438)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.90	–	1 (0.2%)	5 (1.1%)	30 (6.8%)	402 (91.8%)
The location of the program was convenient for me and my family.	4.94	1 (0.2%)	2 (0.5%)	3 (0.7%)	9 (2.1%)	423 (96.6%)
The sessions were at a time convenient for me and my family.	4.85	1 (0.2%)	5 (1.1%)	11 (2.5%)	27 (6.2%)	394 (90.0%)
My family got the help we wanted for my child.	4.83	1 (0.2%)	6 (1.4%)	9 (2.1%)	35 (8.0%)	387 (88.4%)
Facilitators treated me with respect.	4.97	–	1 (0.2%)	2 (0.5%)	6 (1.4%)	429 (97.9%)
Facilitators spoke to me in a way that I understood.	4.97	–	–	2 (0.5%)	9 (2.1%)	427 (96.5%)
Facilitators are respectful of my cultural/ethnic background.	4.97	–	1 (0.2%)	3 (0.7%)	6 (1.4%)	428 (97.7%)
As a result of the program, I am satisfied with our family life right now.	4.80	2 (0.5%)	4 (0.9%)	12 (2.7%)	46 (10.5%)	374 (85.4%)
I felt comfortable talking about my child's problems with the staff.	4.91	2 (0.5%)	–	7 (1.6%)	17 (3.9%)	412 (94.1%)
The facilitators listened to what I had to say.	4.97	–	–	3 (0.7%)	7 (1.6%)	428 (97.7%)
The facilitators knew how to help me.	4.91	1 (0.2%)	–	8 (1.8%)	20 (4.6%)	409 (93.4%)

Triple P Satisfaction Survey

The following are comments provided by parents/caregivers from across all three regions of Riverside County about things that they learned, liked, and disliked from the Triple P program.

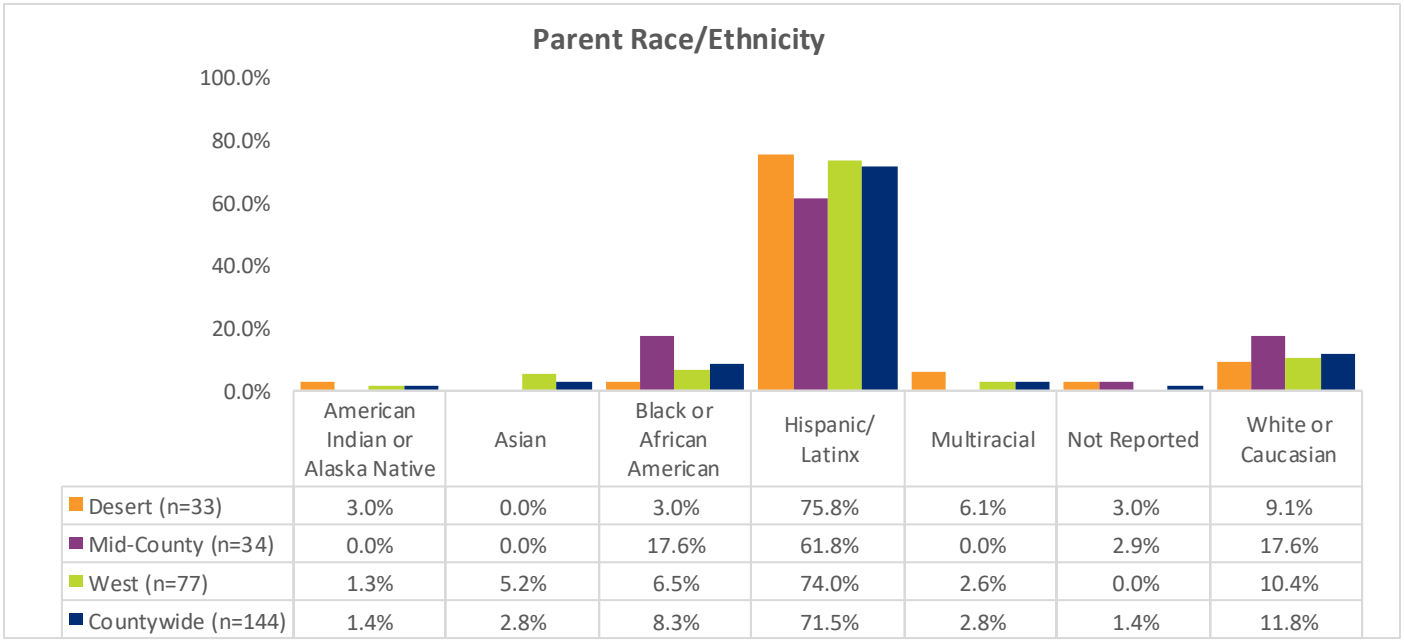
Common Things Learned……
"To praise! The power of praising is definitely a great way to be a positive parent & encourage the behavior tasks we want our children to follow."
"To see things differently with our children. And we should have more love and kindness to them because we don't know what they are going through."
"Be more assertive and to give less accidental rewards to my daughter."
"Better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
Common Things Liked…..
"I liked that everyone comes together, shares the struggles of parenting & also work together creatively to seek positive parenting strategies that help get through that rough patch/milestone."
"Meeting all of the parents in class. Sharing our experiences and helping each other through this process."
"It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
"I really enjoyed goal-setting, the videos, and the workbook. It was nice when other parents spoke with each other and offered advice, and it was great to see my husband do better because of this."
Common Things Disliked…..
"That it was only 8 wks. I would love to attend other workshops. I enjoyed learning about child development & ways to parent in a positive way."
"I wish there was more information about how to deal with siblings problems."
"I think we could have had better snacks and I would have preferred to do every session in person instead over the phone, maybe with our child present to see the behavior for feedback."
"The time constraint, it was right when I would get home from getting the kids and I had about 10 min before I had to hop on Zoom. I had to get up several time to attend to my child."

Teen Triple P Parent Enrollment and Demographics



Countywide the majority of parents/caregivers enrolled in Teen Triple P parenting were females (84%).

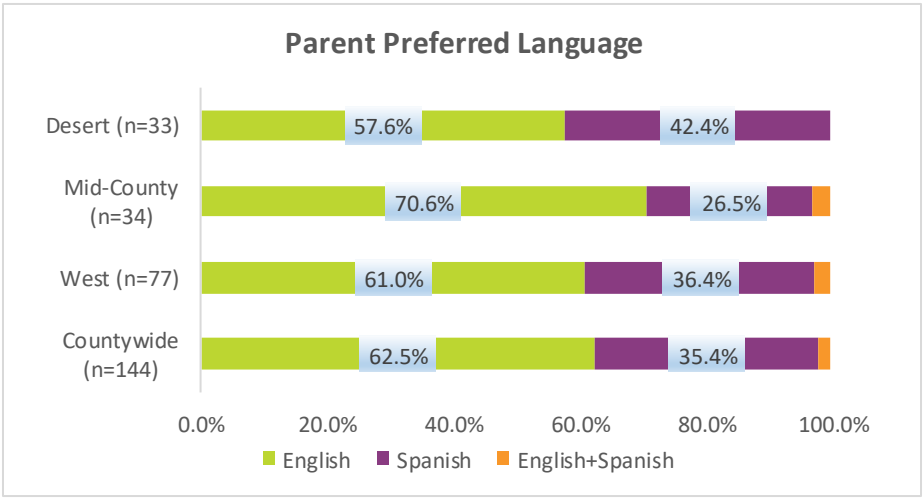
Countywide the majority of parents/caregivers served by Teen Triple P were Hispanic/Latinx (71.5%).



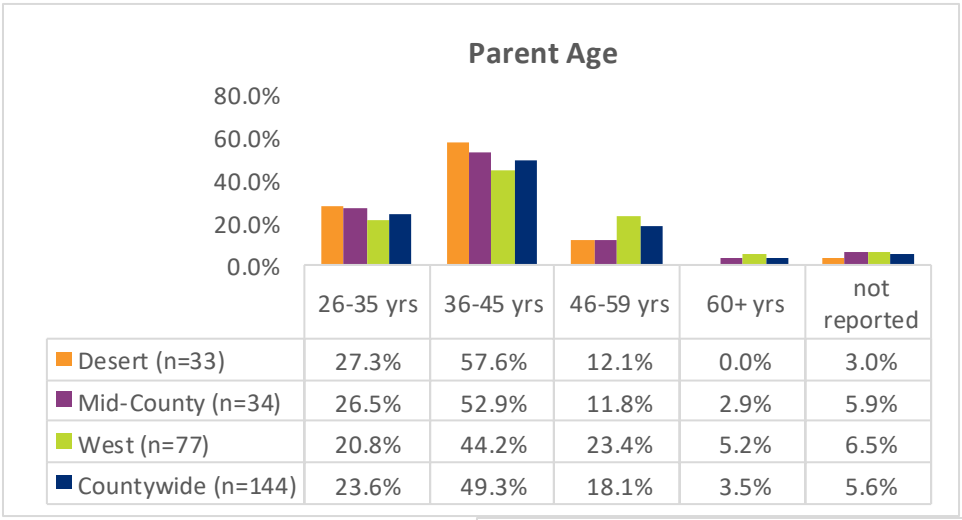
	American Indian or Alaska Native	Asian	Black or African American	Hispanic/ Latinx	Multiracial	Not Reported	White or Caucasian
Desert (n=33)	3.0%	0.0%	3.0%	75.8%	6.1%	3.0%	9.1%
Mid-County (n=34)	0.0%	0.0%	17.6%	61.8%	0.0%	2.9%	17.6%
West (n=77)	1.3%	5.2%	6.5%	74.0%	2.6%	0.0%	10.4%
Countywide (n=144)	1.4%	2.8%	8.3%	71.5%	2.8%	1.4%	11.8%

Countywide, a majority of the parents selected English as their preferred language (62.5%). Slightly over a third of parents preferred Spanish, and a small percentage of parents Countywide indicated they didn't have a preference between English or Spanish and they selected both (2.1%).

Parents were placed in classes conducted in their preferred language (English or Spanish).



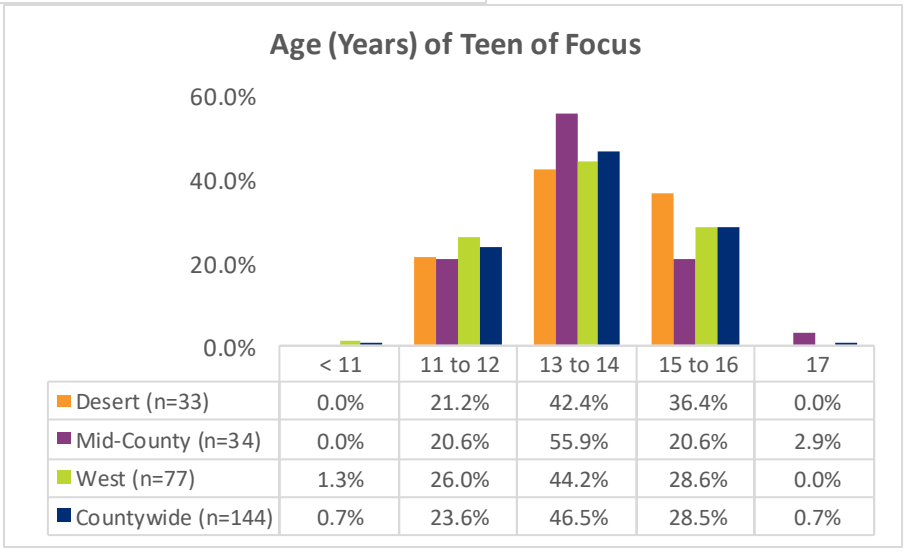
Teen Triple P
Parent and Teen Demographics



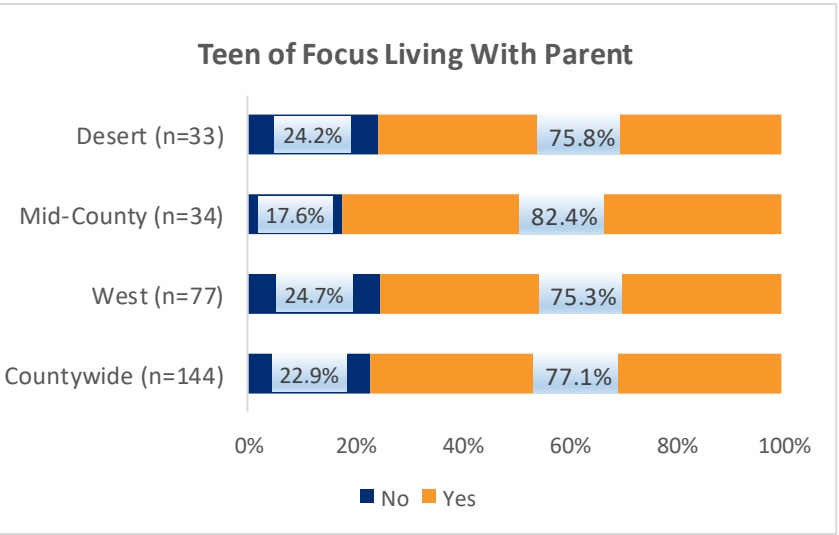
	26-35 yrs	36-45 yrs	46-59 yrs	60+ yrs	not reported
Desert (n=33)	27.3%	57.6%	12.1%	0.0%	3.0%
Mid-County (n=34)	26.5%	52.9%	11.8%	2.9%	5.9%
West (n=77)	20.8%	44.2%	23.4%	5.2%	6.5%
Countywide (n=144)	23.6%	49.3%	18.1%	3.5%	5.6%

Countywide, a majority of parents/caregivers were 36-45 years of age (49.3%). The average age was 41 years.

Parents/caregivers were asked to identify one of their teens who posed the most parenting challenges. This teen would be the primary focus in the program. Countywide, and across all regions the majority of the teens were between 13 to 14 years old (46.5%). The average age of the teen of focus was 13.5 years.



	< 11	11 to 12	13 to 14	15 to 16	17
Desert (n=33)	0.0%	21.2%	42.4%	36.4%	0.0%
Mid-County (n=34)	0.0%	20.6%	55.9%	20.6%	2.9%
West (n=77)	1.3%	26.0%	44.2%	28.6%	0.0%
Countywide (n=144)	0.7%	23.6%	46.5%	28.5%	0.7%



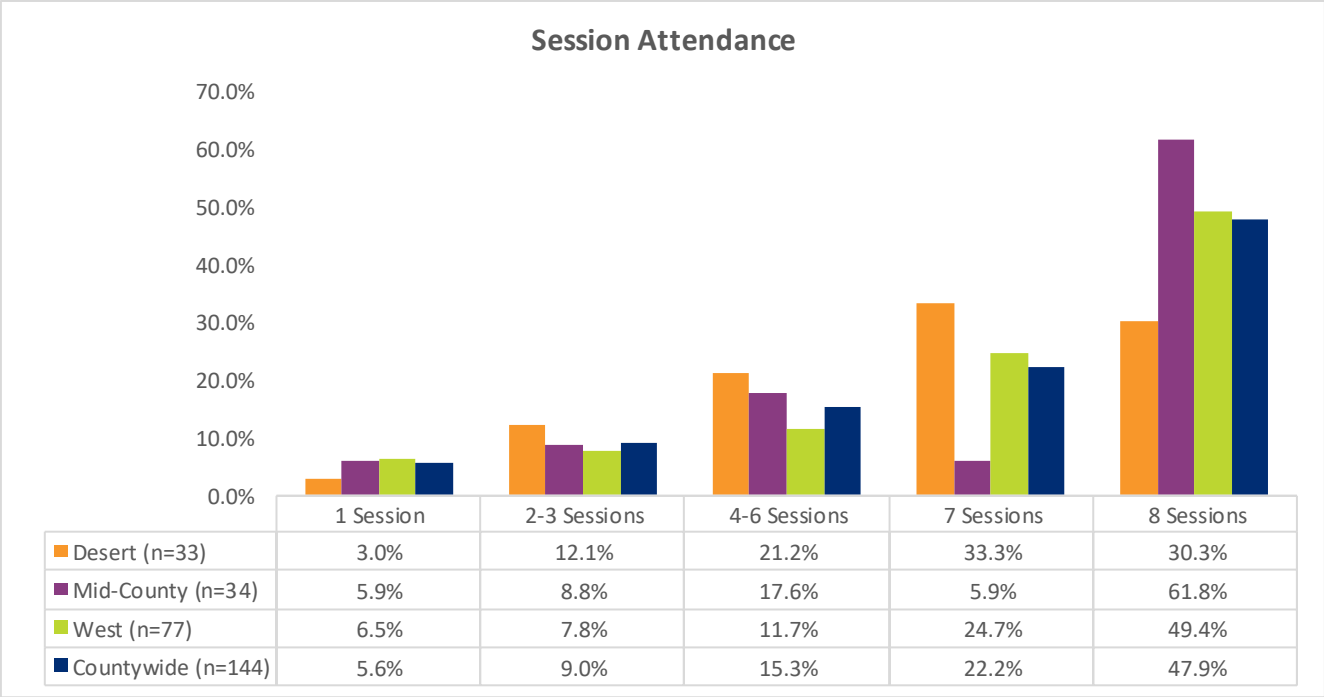
Countywide, 77.1% of parents served had their teen of focus living with them. Of the 33 parents who's teen was not living with them, about half (45.5%) of the parents were receiving services through DPSS (CPS or non-CPS related).

Impact on Other Children in the Household

- 88.2% of parents cared for a child under the age of 25 (not including the teen of focus)
- The parenting program had an impact on 434 kids under the age of 25 (including the teen of focus)

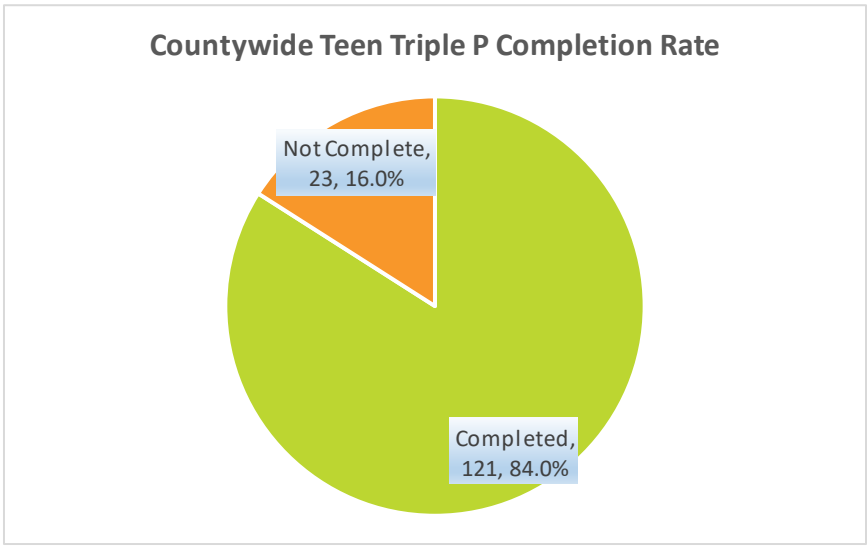
Teen Triple P Program Statistics

Countywide, session attendance showed that 84% of participants completed 6-8 Teen Triple P sessions, with 47.9% of participants attending all eight Teen Triple P sessions. Countywide, only 5.6% of the parents attended only one session.



	1 Session	2-3 Sessions	4-6 Sessions	7 Sessions	8 Sessions
Desert (n=33)	3.0%	12.1%	21.2%	33.3%	30.3%
Mid-County (n=34)	5.9%	8.8%	17.6%	5.9%	61.8%
West (n=77)	6.5%	7.8%	11.7%	24.7%	49.4%
Countywide (n=144)	5.6%	9.0%	15.3%	22.2%	47.9%

Countywide 84% of parents completed the program. Further detail on completion rate by region for the Teen Triple P program is shown on page 5 of the report.

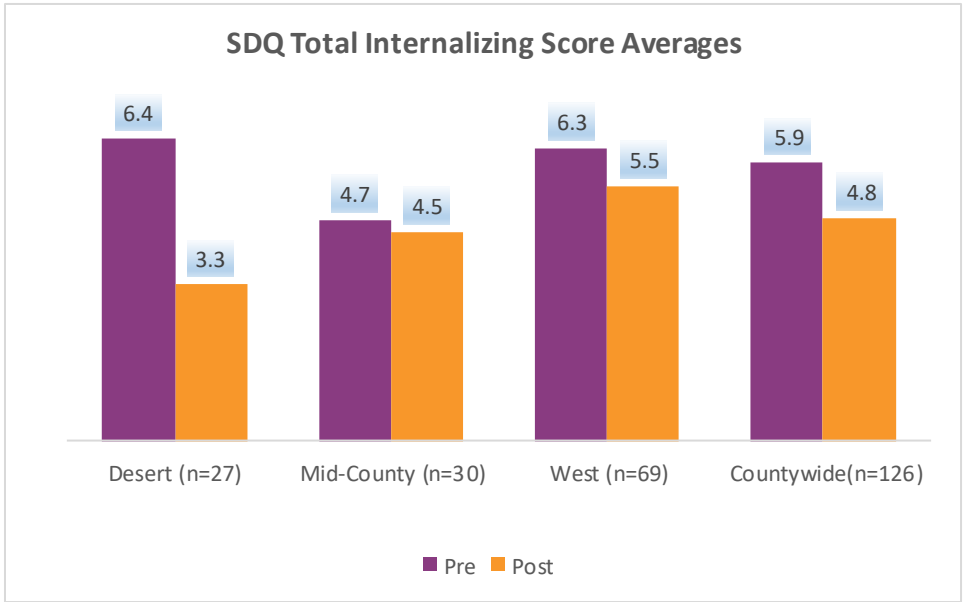


Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these scales (emotional, conduct, hyperactivity and peer problems) create a **total difficulty score** (range 0-40). The emotional and peer items together create an **internalizing problems score** (range 0-20) and the conduct and hyperactivity questions together get an **externalizing score** (range 0-20). Normal, borderline, and abnormal scores are shown below.

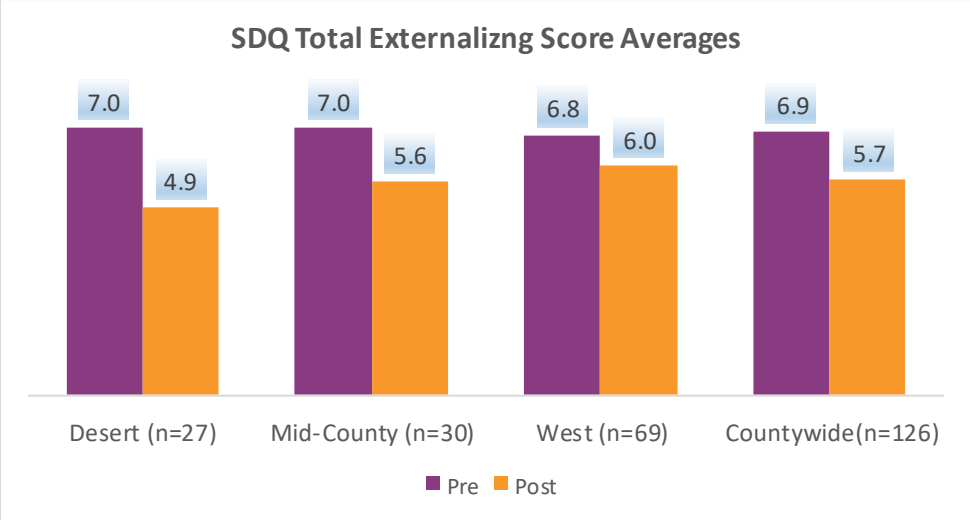
Scale	Normal	Borderline	Abnormal
Total Difficulty	**0-15**	**16-19**	**20-40**
Emotional Symptoms	**0-5**	**6**	**7-10**
Peer Problem	**0-3**	**4-5**	**6-10**
Conduct Problem	**0-3**	**4**	**5-10**
Hyperactivity	**0-5**	**6**	**7-10**
Prosocial	**6-10**	**5**	**0-4**

Key findings from the analysis of the pre-post SDQ data indicated a statistically significant decrease countywide in internalizing and externalizing problem scores, as well as in total difficulties ($p<0.001$). Data also showed a statistically significant improvement countywide in prosocial scores ($p<0.005$). Statistical significance by specific regions are shown in the accompanying tables.



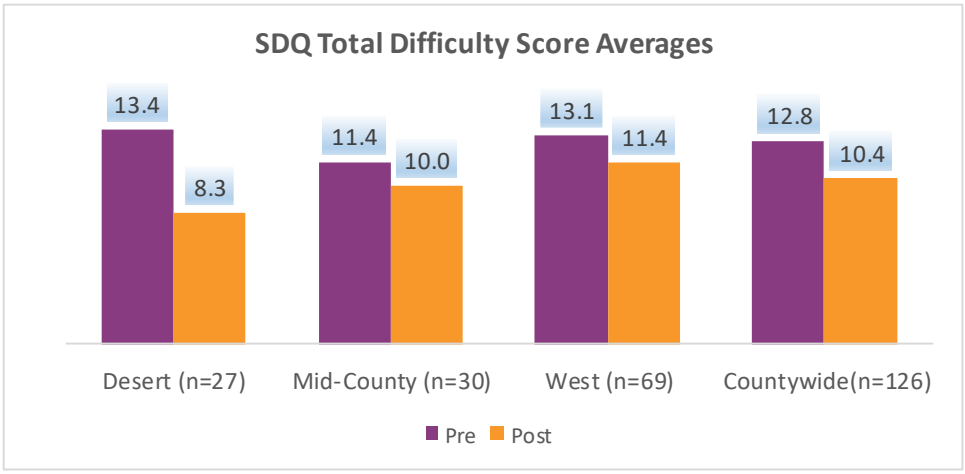
Desert	**Df**	**26**
	t-value	3.82
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	0.643
	p-value	0.526
West	**Df**	**68**
	t-value	1.86
	p-value	0.48
Countywide	**Df**	**126**
	t-value	**3.65**
	p-value	**<0.001**

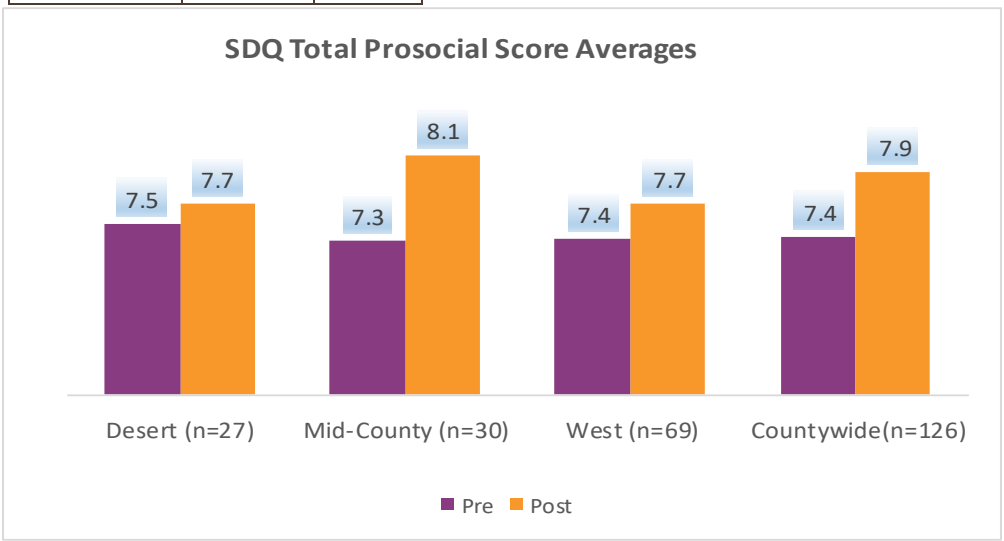
Strengths and Difficulties Questionnaire (SDQ)



Desert	Df	26
	t-value	3.23
	p-value	0.003
Mid-County	**Df**	**29**
	t-value	3.14
	p-value	0.004
West	**Df**	**68**
	t-value	1.94
	p-value	0.06
Countywide	**Df**	**126**
	t-value	**4.20**
	p-value	**<0.001**

Desert	Df	26
	t-value	3.91
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	2.13
	p-value	0.04
West	**Df**	**68**
	t-value	2.34
	p-value	0.02
Countywide	**Df**	**126**
	t-value	**4.53**
	p-value	**<0.001**



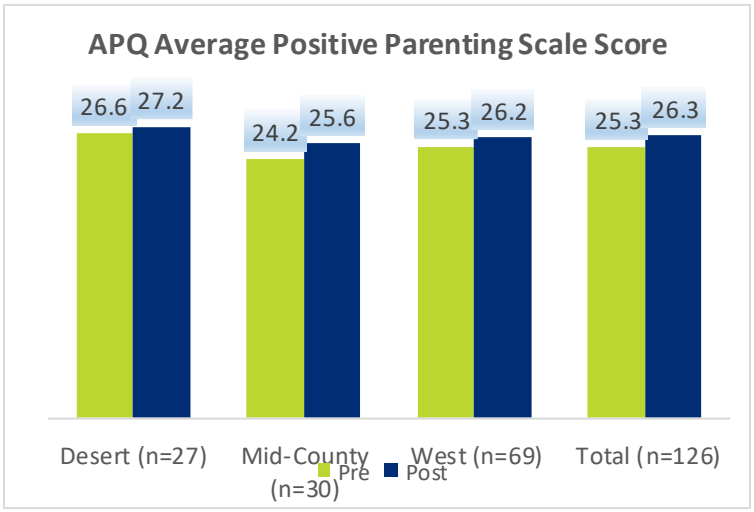


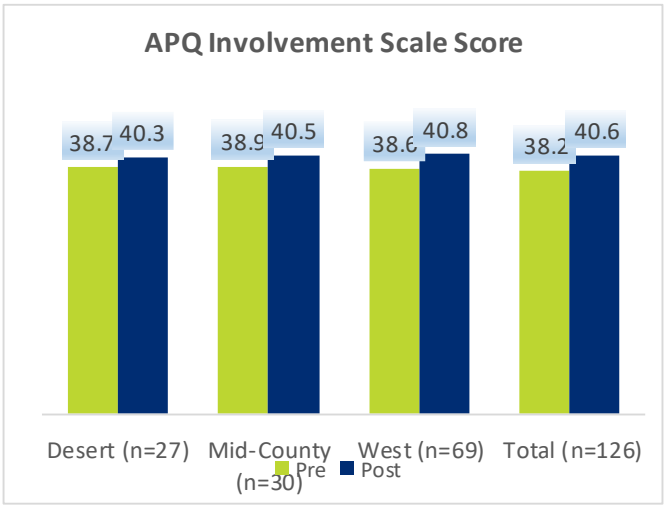
Desert	Df	26
	t-value	-2.89
	p-value	0.008
Mid-County	**Df**	**29**
	t-value	-2.06
	p-value	0.05
West	**Df**	**68**
	t-value	0.24
	p-value	0.27
Countywide	**Df**	**126**
	t-value	**-2.98**
	p-value	**0.004**

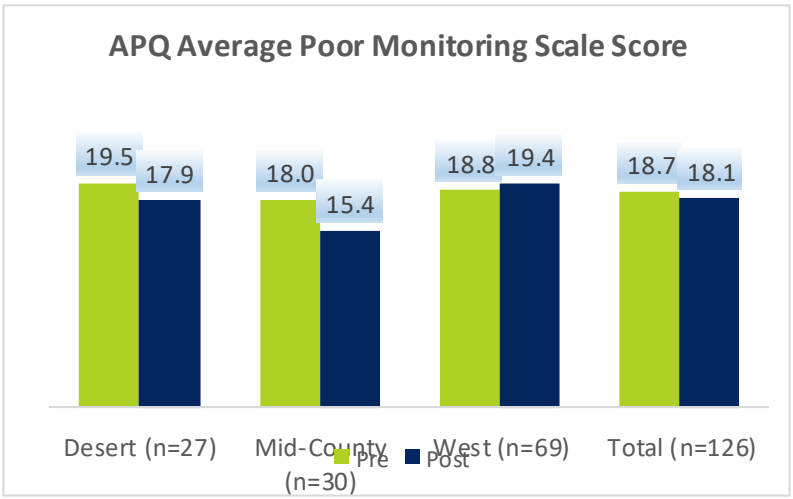
Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Teen Triple P program, only the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Key findings from the analysis of the pre-post APQ data indicated a statistically significant increase ($p<0.05$) countywide in parental involvement and positive parenting, and a slight decrease (not statistically significant) countywide in poor monitoring.



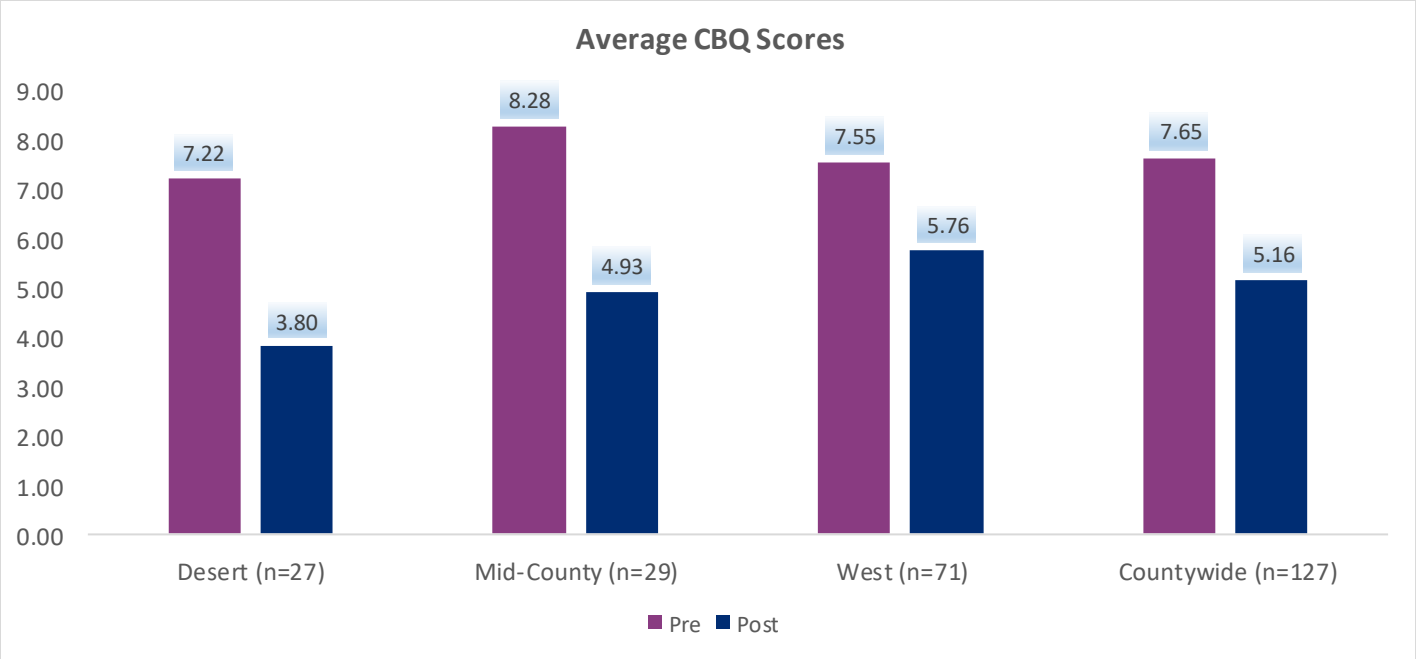




Scale	Region	T-Score	Df	P-Value
Involvement	Desert	-.751	26	0.460
	Mid-County	-3.58	29	0.001
	West	-2.63	68	0.011
	Countywide	**-3.51**	**126**	**<0.001**
Positive Parenting	Desert	-0.92	26	0.364
	Mid-County	-2.52	29	0.018
	West	-1.87	68	0.07
	Countywide	**-2.94**	**126**	**0.004**
Poor Monitoring	Desert	1.55	26	0.134
	Mid-County	1.89	29	0.068
	West	-0.75	68	0.453
	Countywide	1.03	126	0.307

Conflict Behavior Questionnaire

The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score; 126 parents completed the CBQ.



Desert (n=27)	Mid-County (n=29)	West (n=71)	Countywide (n=127)
t=3.39 df=26 p=0.002	t=3.39 df=28 p=0.002	t=3.16 df=70 p=0.002	t= 5.59 df=126 p<0.001

Results showed a statistically significant decrease (improvement) across all regions and Countywide in the parent's rating of general discord between parent and teen youth.

Teen Triple P Satisfaction Survey

A total of 122 participants completed the satisfaction survey. Overall, the majority of participants were highly satisfied with all aspects of the Teen Triple P program including program logistics, quality of group leaders, and overall satisfaction.

Teen Triple P Countywide Satisfaction Survey Results (*N*=122)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.76	–	1 (0.8%)	2 (1.6%)	22 (18%)	97 (79.5%)
The location of the program was convenient for me and my family.	4.89	–	1 (0.8%)	1 (0.8%)	9 (7.4%)	111 (91.0%)
The sessions were at a time convenient for me and my family.	4.75	–	3 (2.5%)	4 (3.3%)	13 (10.7%)	102 (83.6%)
My family got the help we wanted for my teen.	4.71	–	3 (2.5%)	4 (3.3%)	18 (14.8%)	97 (79.5%)
Facilitators treated me with respect.	4.96	–	–	1 (0.8%)	3 (2.5%)	118 (96.7%)
Facilitators spoke to me in a way that I understood.	4.93	–	–	–	8 (6.6%)	114 (93.4%)
Facilitators are respectful of my cultural/ethnic background.	4.93	–	–	–	9 (7.4%)	113 (92.6%)
As a result of the program, I am satisfied with our family life right now.	4.68	–	3 (2.5%)	6 (4.9%)	18 (14.8%)	95 (77.9%)
I felt comfortable talking about my teen's problems with the staff.	4.82	–	–	4 (3.3%)	14 (11.5%)	104 (85.2%)
The facilitators listened to what I had to say.	4.89	–	–	–	13 (10.7%)	109 (89.3%)
The facilitators knew how to help me.	4.81	–	–	6 (4.9%)	11 (9.0%)	105 (86.1%)

Teen Triple P Satisfaction Survey

Across all sites, the following are comments provided by parents about things they learned, liked, and disliked.

Common Things Learned……
"That we are working as a team and that we can improve our relationship and communication with our child."
"Be more patient and listen to my daughter before making any comments that might make her feel bad."
"The behavior contract. How to validate my teens emotion & what to do; praising the good behavior."
"Maintain consistency in rules, listen more to my teenager without interrupting."
"To allow my teenager to calm down before talking to her. Make sure to praise her when she doing good."
Common Things Liked…..
"I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."
"It is very important for families to be able to guide our adolescents to be better people in their future."
"I got to hear from other parents and saw that I wasn't alone in my struggles. They also had good advice and techniques for me to try within my home."
"The convenience (zoom) was very helpful."
"What I liked is that the instructor was really nice & understanding."
Common Things Disliked…..
"The fact that my children are not with me at the moment, and only see them once a month so it's hard to apply what I learned."
"There wasn't anything I didn't like the program was very enjoyable and informative."
"The only thing was that you can't get too deep into each subject due to the time, 2 hrs."

Preschool 0-5 Programs

Prevention and Early Intervention

Mobile Services

Fiscal Year 2023-2024

Program Overview

The RUHS-BH Prevention and Early Intervention (PEI) preschool 0-5 programs, which includes the Mobile Services has overall goals of:

- Helping reduce young children's challenging behaviors, while increasing emotional control; promoting social competence
- Reducing stigma associated with receiving mental health services
- Reducing or eliminating geographical isolation and transportation barriers to services
- Connecting with families with children than might not otherwise qualify for mental health services
- Offering young children the opportunity to develop skills and abilities that will prepare the for school and life

The Preschool 0-5 Clinic offers mental health services which include PCIT, an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the ear through which the therapist provides in the moment coaching skills. The clinic also offers parenting groups and child prosocial skills groups.

The clinic also harbors three sprinter vans which are used for providing services at the client's home, school sites, or anywhere that is needed in identified underserved areas as defined by the Prevention and Early Intervention plan. The vans are built with the capacity to hold PCIT sessions, child prosocial sessions and more. For FY 23-24 the vans were not in use as the program was working out the logistics and administrative tasks associated with deploying the vans. Details on the activities of staff dedicated to the mobile unit are discussed further in this report.

Data Collection and Outcome Evaluation for FY 23-24

- Mental Health service enrollment and utilization provided is recorded in the RUHS-BH electronic health record for those children that require clinical mental health services.
- A PCIT enrollment form within the Electronic Medical Health Record captures the progress of PCIT for those receiving that service.
- Data for PCIT and other mental health services is evaluated by examining changes in children's behavior and parents stress as it relates to their parental role. Outcome measures include:

    1. The **Eyberg Child Behavior Inventory (ECBI)** is a 36 item parent report scale that measures the frequency of a child's disruptive behavior and if that behavior is a problem for the parent. Measures are collected pre, post, and sometimes mid treatment. The pre and post measures are used for analysis.
    2. The **Parental Stress Index Short Form (PSI-4-SF)** is a self report 36 item questionnaire that assesses the level of stress experienced by parents as a function of their role as a parent and as a function of their child's behavior. The measure is completed pre and post treatment.
    3. The **Therapy Attitude Inventory (TAI)** is a fifteen question satisfaction survey for the parent/primary caregiver to complete at the conclusion of services.

Data Collection and Outcome Evaluation *Continued*

Parent Consultations (PEI Mobile Services RUs Only)

A parent may be on the phone, or walk in to the mobile unit, request information on a concern for their child and/or information on specific parenting skills. Demographic data, as well as data on the details of the consultation (services, referrals) are tracked using a one page parent consultation form.

Provider Consultations (PEI Mobile Services RUs Only)

Provider consultations are also a part of the mobile unit's service and is primarily done at school sites for school personnel. The provider consultation may take the form of general or clinical classroom consultations with optional classroom observation. Details of the consultation was recorded on a provider consultation form, and any referrals made for children during the process were tracked. No provider consultations were recorded for FY 23-24.

Outreach Events (*PEI Mobile Services RUs Only*)

Details of any community outreach events at which the sprinter vans are present are recorded on a one page outreach activities form which gives details of the event type as well as the audience.

Key Findings

MH Services and PCIT

- A total of 300 children (families) received PCIT/MH services in the West, Desert, and Mid-County Regions.
- A total of 11,408 mental health related services totaling to 9,276.2 service hours
- Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively.

MH Services/PCIT Demographics

- Countywide, two thirds of the participants were male (66.3%).
- Countywide, a majority of participants served were Hispanic/Latinx (44%).
- A majority of children served were 4 years of age (32.7%).

PCIT Specific Outcomes

- 203 families were enrolled in PCIT (or Toddler PCIT or Trauma Directed Interaction).
- Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment.
- A majority of children served were 4 years of age (32.7%).
- 88% of families had a good or fair prognosis after attending PCIT.
- 57.4% of families met all or some of the goals set by the family and the therapist.

MH Services/PCIT Outcomes

- Countywide there was a statistically significant decrease in the frequency of child problem behaviors and in the extent to which caregivers perceived their child's behavior to be a problem.
- Pre and Post PSI scores showed a statistically significant decrease countywide in parent's stress levels.
- Overall parents felt more confident in their parenting skills and ability to discipline their child. Parents felt their relationship with their child and their child's behavior improved.
- A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children.
- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received.

PEI Mobile Services Parent Consultations

- In the 23-24 fiscal year, 23 parent consultations served 22 parents.
- Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.
- Tantrums and child not listening to parent were the two frequently discussed concerns during parent consultations.
- Parent tip sheets and referral to child pro-social groups constituted a majority of the referrals.

PEI Mobile Services Outreach Events

- PEI Mobile Services recorded a total of 4 outreach events provided to 52 people

Administrative Data and Billing

There were a total of **300 families** served by the Pre-School 0-5 clinic which includes the clinic as well as PEI Mobile Services). A total of **11,408 PCIT/MH services** were provided. For administrative purposes this section analyses the number of families (participants) served by each RU in FY 23-24.

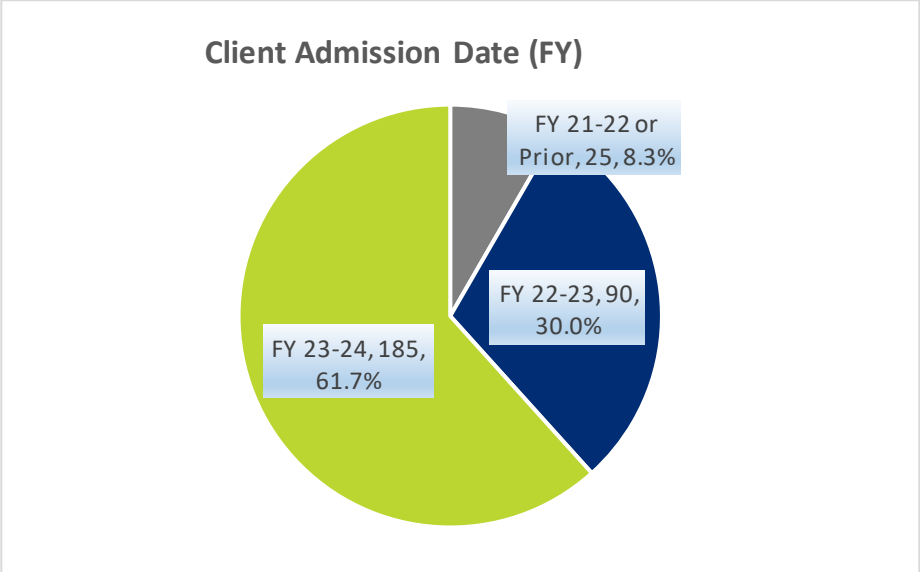
As shown in the table below, a majority of participants served were billed under 33ET01 RU. A total of 5,972 services were billed. Service details are provided in a different section of this report.

For services billed under the PEI Mobile Services RUs (33ETPC, 33HUPC, 33G8PC), services were given to families who resided in the underserved areas of Riverside as defined by the PEI plan. Staff who billed these RUs provided services at the client's home, the closest school site where Preschool 0-5 has a location, or at the nearest outlining clinic. Services for families who were non-Medi-Cal or IEHP were also captured with the PEI Mobile Services RUs.

Given that the team was short staffed, all staff helped with all RUs, and were billing all four RUs based on the population they were serving.

RU	Program Name	# of Participants Served	# of Services
33ET01	Preschool 0-5 Clinic Services	175 (58.3%)	5,972 (52.3%)
33ETPC	PEI Mobile Services-West	67 (22.3%)	3,257 (28.6%)
33HUPC	PEI Mobile Services-Mid-County	43 (14.3%)	1,598 (14%)
33G8PC	PEI Mobile Services-Desert	15 (5%)	581 (5.1%)

Client Admission Date

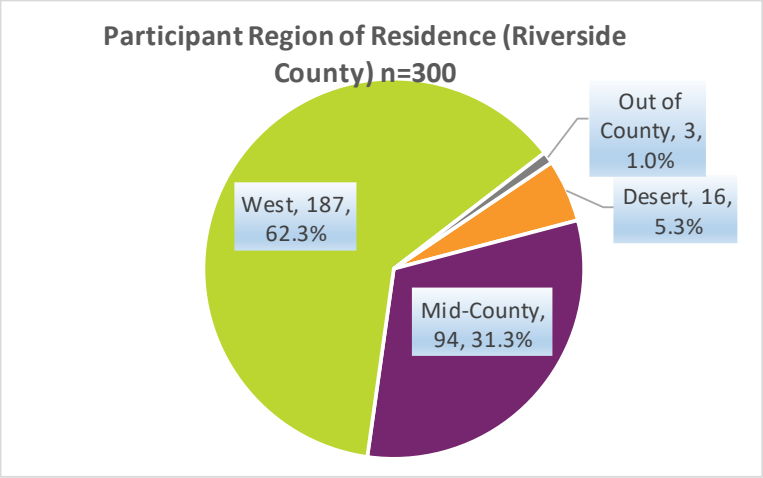


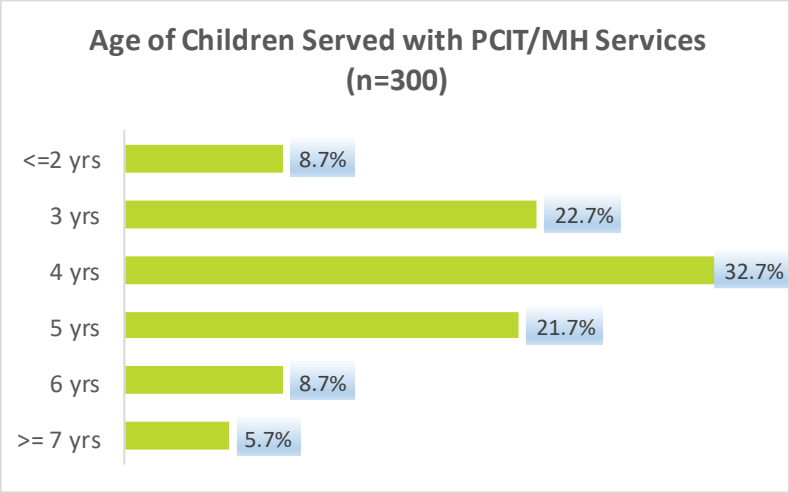
Of the 300 families served, 62% were new in the 23-24 FY. 30% were carry overs from 22-23 FY and 8.3% were open to the program 21-22 FY or prior.

Preschool 0-5 Programs
All MH Services Data

Participant Demographics

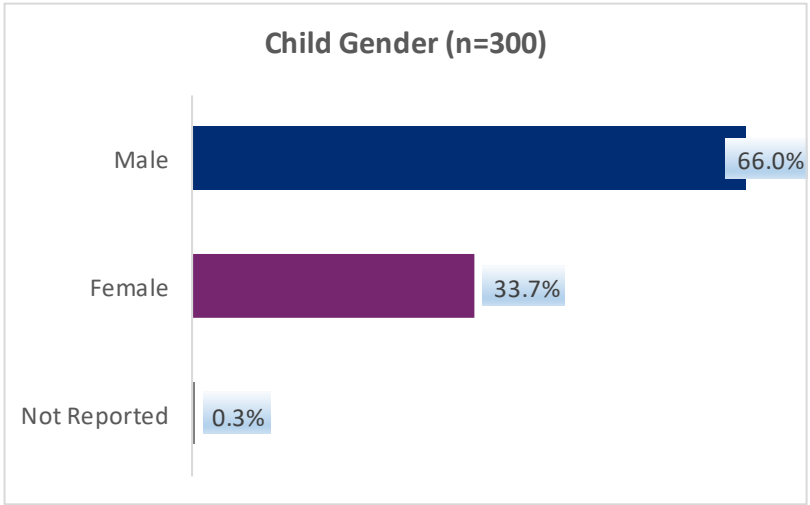
Of the clients served with mental health services, a majority resided in the Western region of Riverside County (62.3%), as determined by their reported residential zip code.

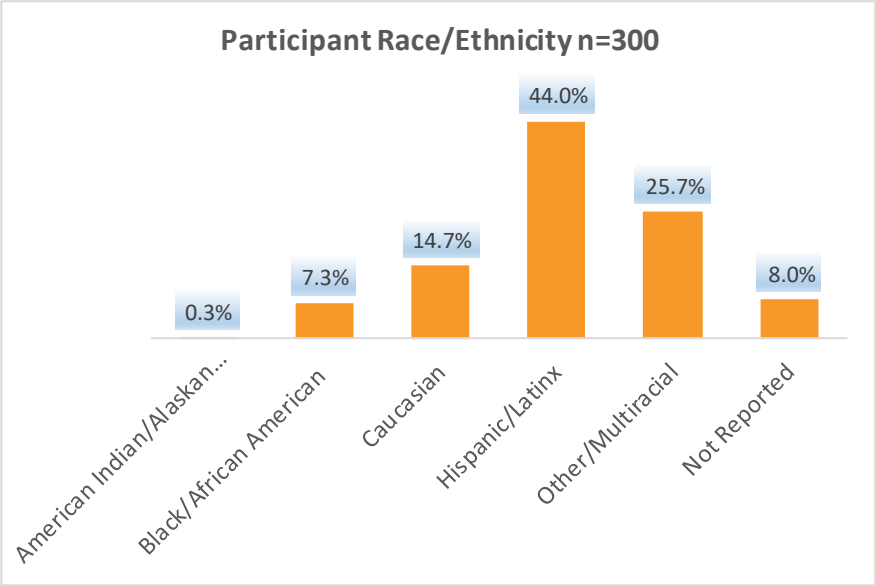




A majority of children served were 4 years of age (32.7%). The age of the oldest children served was 13 years. These children were primarily receiving Trauma Focused CBT Therapy. Children who were under two years of age were primarily receiving toddler PCIT services.

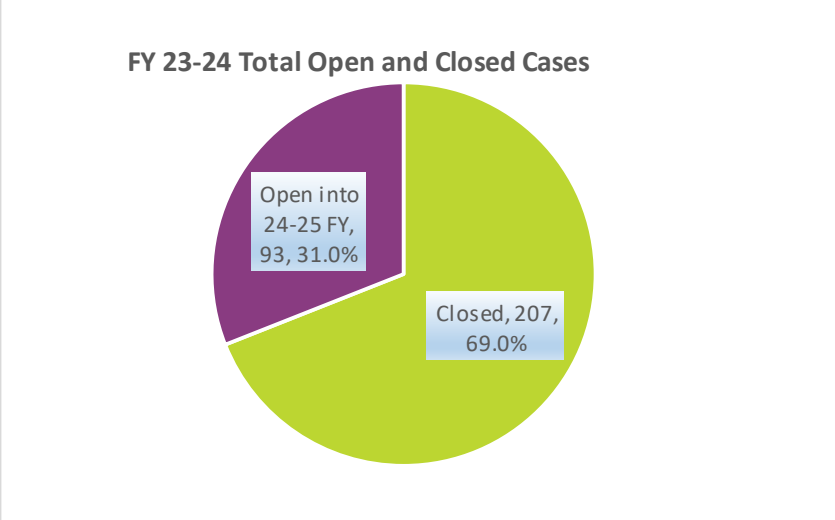
Two-thirds of the children served with mental health /PCIT services were male.





Countywide, a majority of participants served were Hispanic/Latinx (44%).

Participant Program Completion Data



In the 23-24 FY, 69% of the clients closed to the program. 31% will continue to receive services into the 24-25 FY.

The table below summarizes the reason for close for the 207 clients who closed to the program.

As shown on the table to the right, 30 percent of the reasons for close included completed (further tx. or no further tx. recommended), Mutual agreement (goals reached or partially reached) and transfer to another provider.

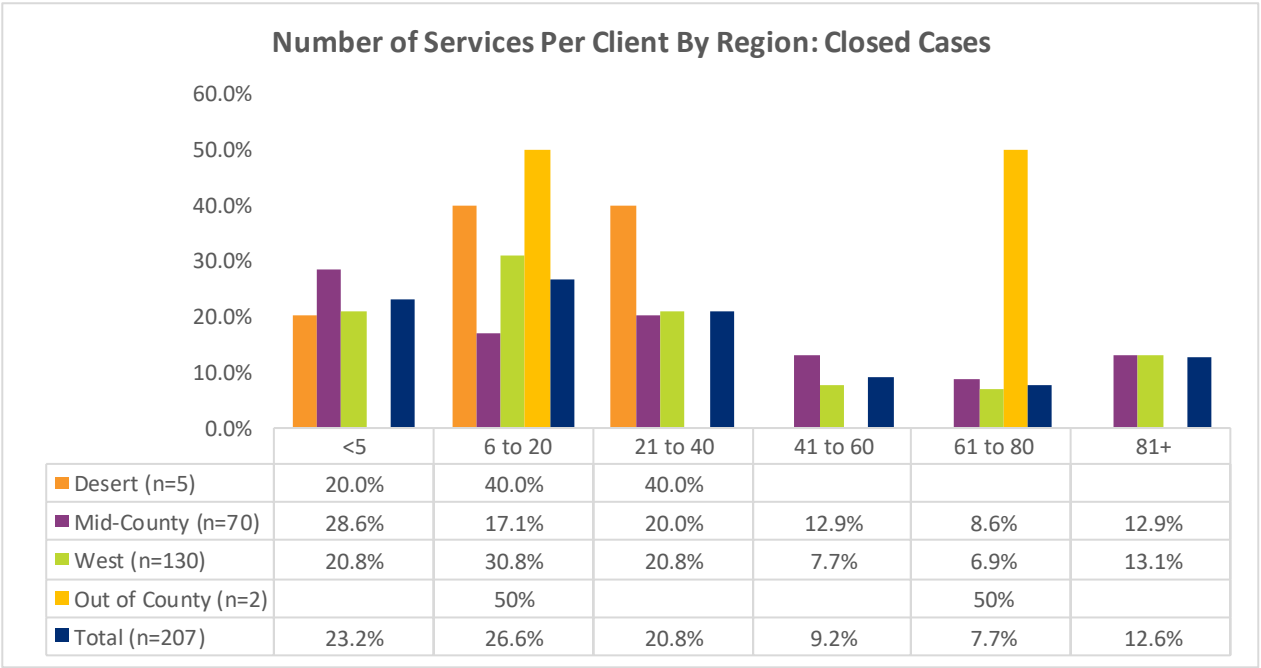
Close Reason	#, %
Client Withdrew	45 (21.7%)
Closed/No Show/No Contact	68 (32.9%)
Completed-No Further Tx Recommended	**23 (11.1%)**
Completed-Referred for Further Tx	**4 (1.9%)**
Did Not Need Service	5 (2.4%)
Moved Out of Area	5 (2.4%)
Mutual Agreement/Goals Not Reached	11 (5.3%)
Mutual Agreement/Goals Reached	**26 (12.6%)**
Mutual Agreement/Partial Completion	**8 (3.9%)**
Transfer to Another Provider	**3 (1.4%)**
Other/Reason Not Available	9 (4.4%)

Preschool 0-5 Programs
All MH Services Data

A total of 11,408 mental health related services totaling to 9,276.2 service hours were provided to 300 clients and their families in FY 23-24. Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively. Note, if an activity required two therapists and they each billed for the hours, that was counted as two services and the hours billed were also counted for each therapist.

Service	Count of Service	% of Svcs.	Service Hours	Clients Receiving Service
Assessment	283	2.5%	505	156
Case Management Brokerage	**4411**	**38.7%**	**2,017.8**	**278**
Case Management Family	195	1.7%	96.3	89
Family/Non Family Collateral	1	0.01%	1	2
Family Therapy With Client	**3620**	**31.7%**	**4180.7**	**223**
Group MH Service	177	1.6%	279.8	16
Individual Therapy	172	1.5%	178.5	32
Intensive Care Coordination	7	0.1%	1.9	7
Intensive Care Coordination Review	8	0.1%	6.7	7
Intensive Care Coordination with Family	63	0.6%	52.8	18
Intensive Care Coordination Without Family	258	2.3%	130.0	29
Medication Services	28	0.2%	15.3	6
Mental Health Service	1937	17.0%	1592.0	234
Non Family Collateral	1	0.0%	0.3	1
Peer Mental Health Engagement/Activity	247	2.2%	218.1	33
Total	**11,408**	**100%**	**9276.2**	

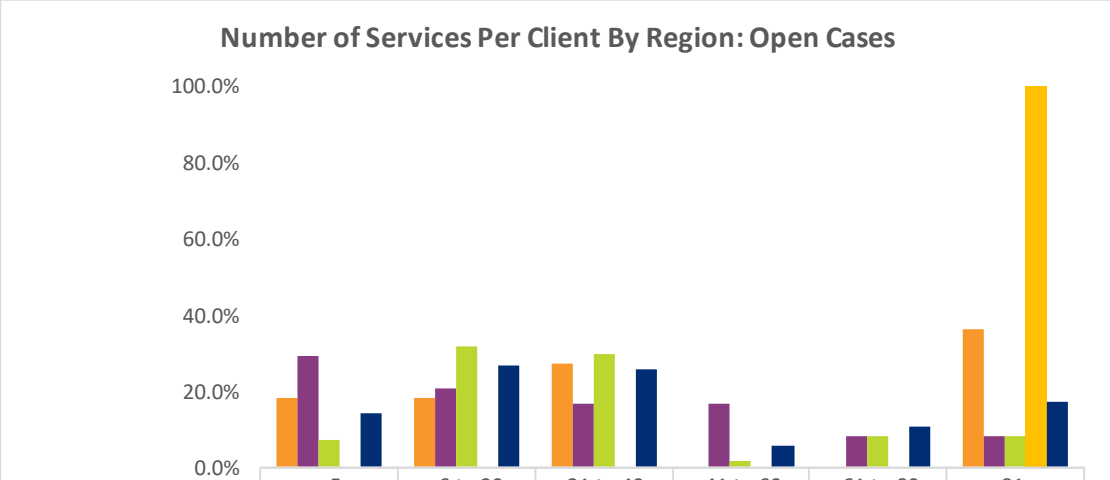
Service data for the 207 children who completed or were discharged from the program showed a total of 7,460 PCIT services in FY 23-24. Countywide, 23.2% of clients had 5 or fewer services, 26.6% received 6 to 20 services, 20.8% received 21-40 services, 9.2% received 41 to 60 services, 7.7% received 61 to 80 services and 12.6% received 61 or more services. The regions indicated on the graph correspond to the participant's region of residence.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=5)	20.0%	40.0%	40.0%			
Mid-County (n=70)	28.6%	17.1%	20.0%	12.9%	8.6%	12.9%
West (n=130)	20.8%	30.8%	20.8%	7.7%	6.9%	13.1%
Out of County (n=2)		50%			50%	
Total (n=207)	23.2%	26.6%	20.8%	9.2%	7.7%	12.6%

Preschool 0-5 Programs
All MH Services Data

The graph below shows the number of services provided in the 23-24 FY for the 93 children who are still continuing the program into the 24-25 FY. In total there were 3,948 services provided to these clients. A majority of these children have received 6 to 20 services (26.9%) or 21 to 40 services (25.8%). There were children who received less than 5 services, but these were newer clients served towards the end of the fiscal year and who are continuing into the new fiscal year.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=11)	18.2%	18.2%	27.3%			36.4%
Mid-County (n=24)	29.2%	20.8%	16.7%	16.7%	8.3%	8.3%
West (n=57)	7.0%	31.6%	29.8%	1.8%	8.3%	8.3%
Out of County (n=1)						100.0%
Total (n=93)	14.0%	26.9%	25.8%	5.4%	10.8%	17.2%

Preschool 0-5 Programs
PCIT Service Data

This section takes a closer look at the PCIT (and related) services, primarily using data collected from ELMR's PCIT Enrollment Form. For reference:

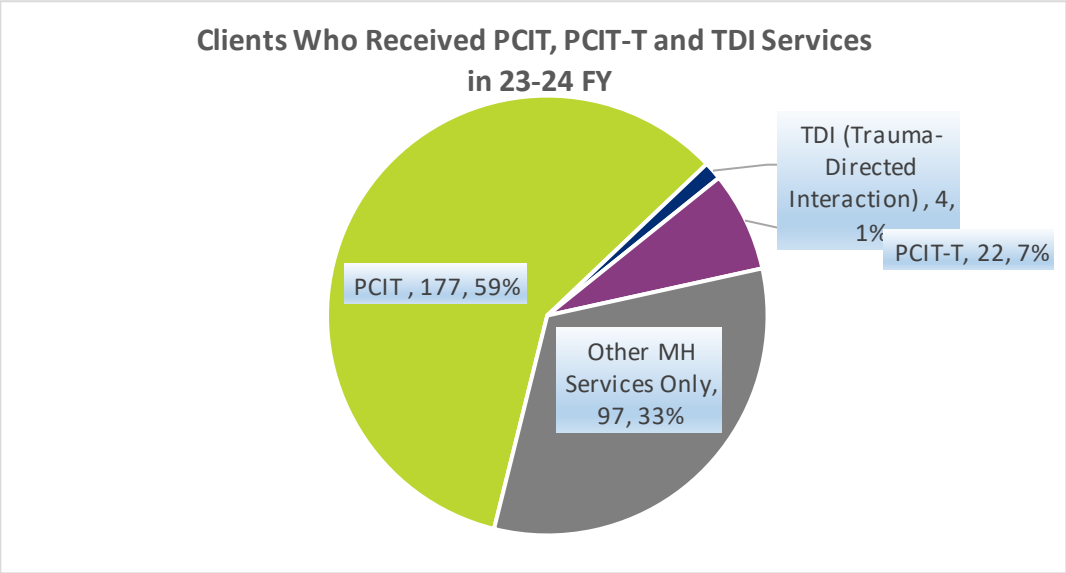
- PCIT is an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the hear through which the therapist provides in the moment coaching skills. The treatment consists of two phases—the child directed phase (CDI) and the parent directed phase (PDI). The CDI Phase encourages warm, secure caregiver-child relationships. The PDI increases child compliance and decreases child disruptive behaviors.

- Trauma Directed Interaction, or TDI is an adaptation of PCIT therapy for families with a history of trauma. TDI maintains the key elements and theoretical aspects of PCIT and adds sessions to cover psychoeducation about trauma, coping skills to aid child and caregiver of trauma reactions, and caregiver responses to child trauma reactions.

- PCIT toddlers, or PCIT-T is an early intervention program that involves coaching parents while they interact with their 12-24 month old children. Goals include decreasing problematic behaviors, improve attachment, increase children's language and encourage toddlers to follow directions. It also addresses parent stress (anxiety, dissatisfaction, difficulty coping, lack of confidence).

Preschool 0-5 Programs
PCIT Service Data

Of the 300 families receiving mental health services from the Preschool 0-5 programs, **a total of 203 families (67.6%) received PCIT (or related models of PCIT) services.** The graph below shows the distribution of clients receiving each type of service. 177 families received PCIT, 4 families received TDI therapy, and 22 clients received PCIT-Toddler.



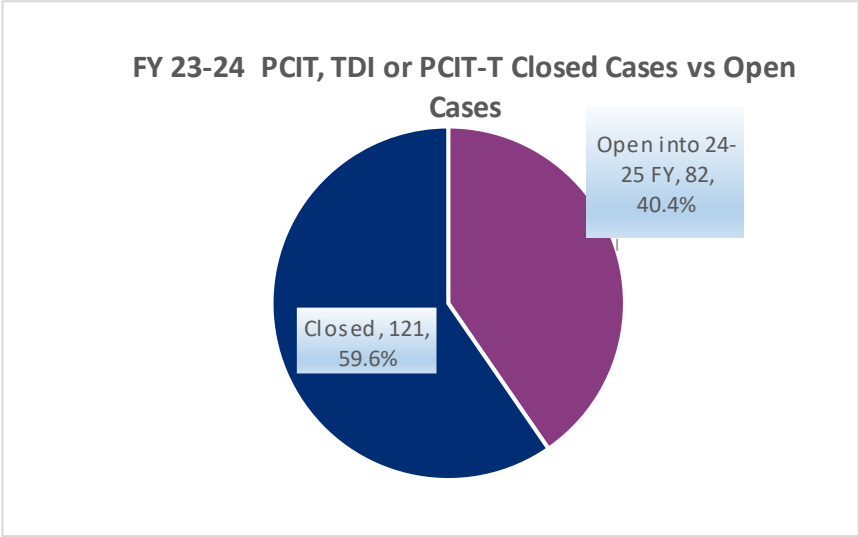
PCIT, TDI or PCIT-T Enrollment By Program (Out of a Total of 203 Clients)

A majority of participants served with PCIT, TDI, or PCIT-T were served by the Preschool 0-5 Clinic, followed by staff using the Western PEI Mobile Services RU.

RU	Program Name	# of Participants
33ET01	Preschool 0-5 Clinic Services	111 (54.7%)
33ETPC	PEI Mobile Services-West	50 (24.6%)
33HUPC	PEI Mobile Services-Mid-County	9 (4.4%)
33G8PC	PEI Mobile Services-Desert	33 (16.3%)

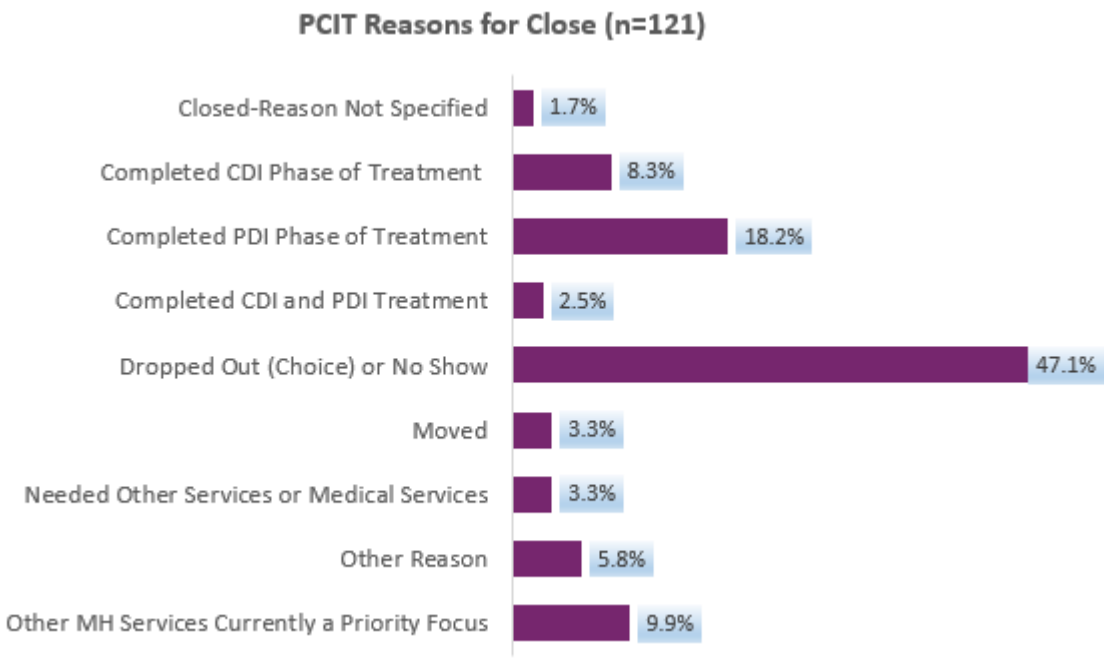
PCIT, TDI or PCIT-T Open Vs. Closed Cases (Out of a Total of 203 Clients)

Nearly 60% of families closed out of PCIT (or related) treatment in the 23-24 FY. Reasons for closed are analyzed on the next page. 40% of families will continue receiving the service into the 24-25 FY.

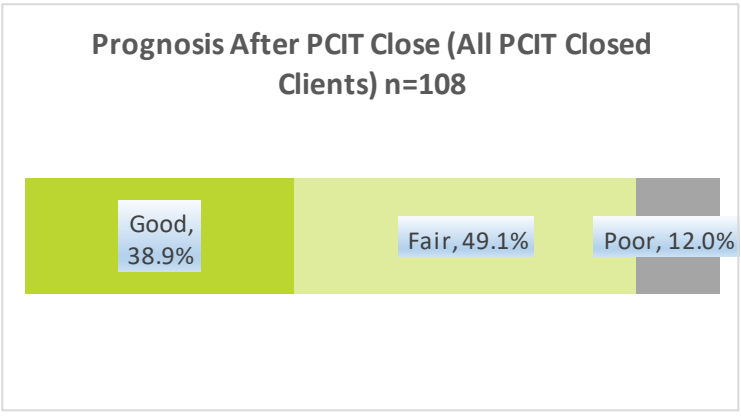


Reasons for Close

Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment. A little less than half dropped out due to personal choice, or were closed out due to multiple no show appointments after attempts to contact were made. Reasons marked as "Other" included lack of perceived effectiveness, transportation issue or conflict with caregiver's work schedule.



Closed PCIT Cases Only (n=108) Goals met and Prognosis

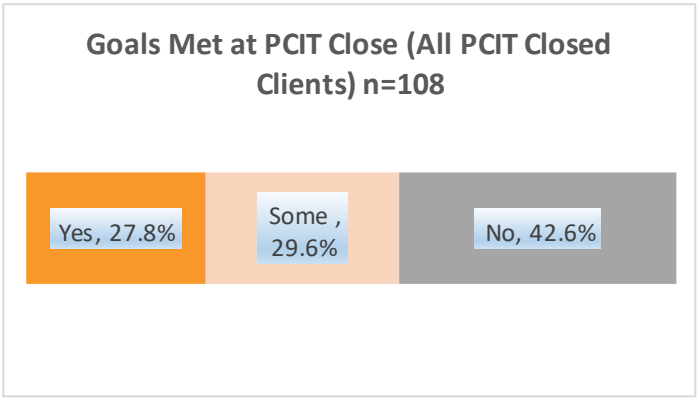


Upon closing a PCIT case, therapists complete a PCIT close form in ELMR. They record the prognosis after treatment for each client.

As shown in the figure to the left, 88% of families had a good or fair prognosis after attending PCIT.

Upon closing therapists noted if the families met goals set at treatment.

As shown in the figure to the right 57.4% of families met all or some of the goals set by the family and the therapist.



Dinosaur School and IY Parenting Classes



Of the 300 families served, A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children. Classes range from 6-8 weeks, and are usually once per week. Parents are attending the parenting group while their child is being provided the dinosaur school session.

- In total, the sixteen children served with Dinosaur school received 24 hours of service
- In total, the sixteen parents served with IY Parenting classes received 27 hours of service
- 3 Cycles consisting of 6-8 sessions were conducted in July, September and February.
- Sessions were provided by staff from the clinic RU (33ET01) or the Western Mobile RU (33ETPC).
- Services were billed as Group MH Service, and is included in the service analysis on page 8 of the report

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a evidenced based practice to help children affected by trauma. TF-CBT helps to resolve behavioral and emotional difficulties that occur with single, multiple, or complex trauma experiences.

- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received
- Children ranged from 4-10 years old
- 5 of the 6 children resided in the Western region of Riverside and were served by the 33ET01 clinic RU; 1 child resided in the Mid-County region of Riverside and was served by the Western Mobile RU (33ETPC).
- Details of TF-CBT outcomes and program statistics are shared in a separate county report.

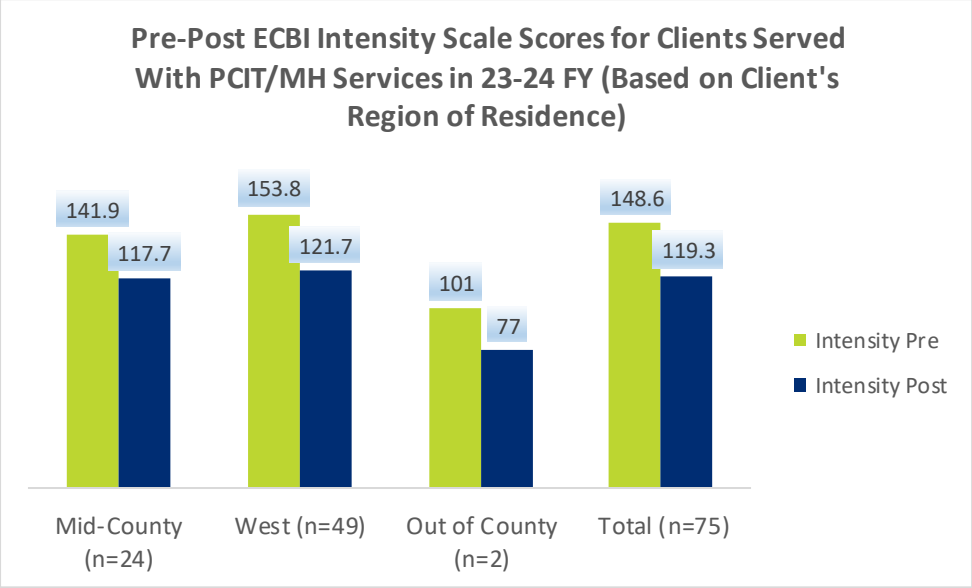
The next section will highlight the outcomes of families receiving all MH services as a whole.

PCIT/MH Services Outcomes ECBI

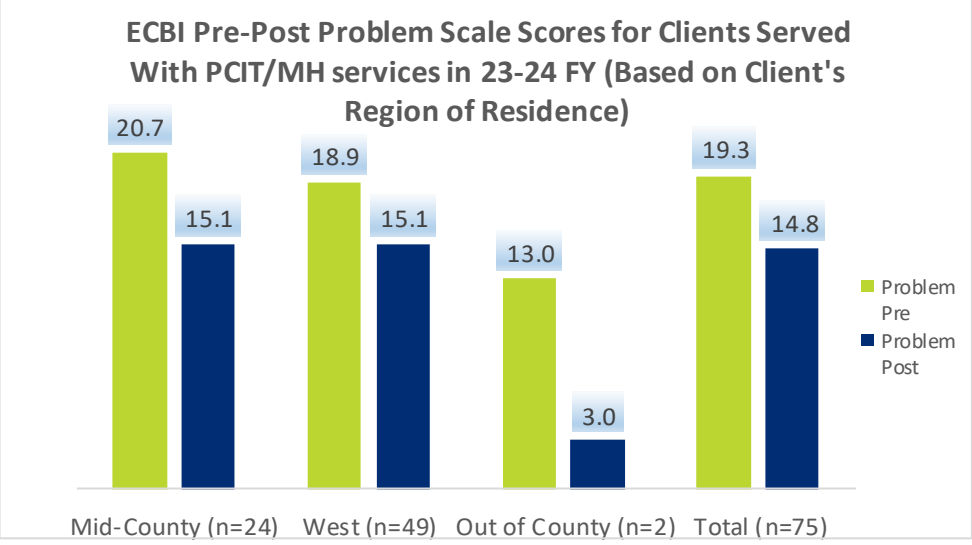
The ECBI rating scale measures the frequency and severity of children's problem behaviors at home and school settings (Intensity Score) as well as the extent to which the parents and teachers find the child's behavior troublesome (Problem Score). A child rated at or above an Intensity raw score of 131 on the ECBI and/or 15 or higher on the Problem raw score is in the clinical range.

There were a total of 75 parents who completed the ECBI measure pre to post (mid-score is considered a post score for clients who haven't closed out of the program). In total, there was a statistically significant decrease in the frequency of child problem behaviors (Intensity scale) as well as a statistically significant decrease in the extent to which caregivers perceived their child's behavior to be a problem (Problem Scale). Statistical significance was not measured for clients who lived Out of County due to the small sample size.

Of the 75 parents who completed the ECBI pre and post, 70 parents (93.3%) received PCIT services.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	3.29	0.003
West	48	5.56	<0.001
Out of County	1	*	*
Total	**74**	**6.46**	**<0.001**



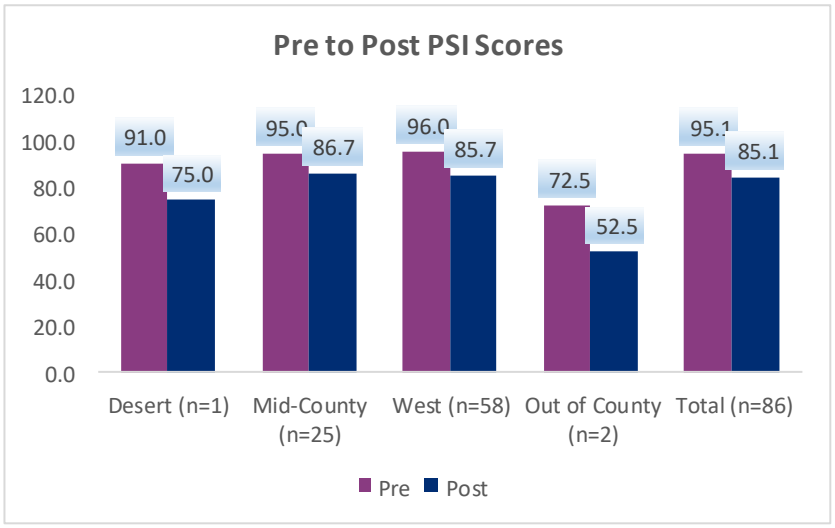
ECBI Problem Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	2.77	0.011
West	48	2.17	0.035
Out of County	1	*	*
County-wide	**74**	**3.39**	**0.001**

PCIT/MH Services Outcomes PSI-4-SF

The Parental Stress Index Version 4 Short Form (PSI-4-SF) is a 36 item questionnaire used to measure the overall level of parental stress experienced by parents of children 12 years of age or younger. The PSI-4-SF yields a total stress score that is a combined score of three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child.

There were a total of 86 parents (91% of whom received PCIT) who completed the PSI pre to post (mid-score is considered a post score for clients who haven't closed out of the program). As shown in the graph below, in total and regionally these parents experienced a decrease in the level of stress pre to post PCIT intervention. Statistical significance was not measured for the desert region and out of county cases due to the small sample size.

The clinical cutoff for the PSI-4-SF is 85. Post scores show that these parents were at the clinical cutoff of 85 post intervention.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	n/a	*	*
Mid-County	24	2.60	0.016
West	57	4.36	<0.001
Out of County	1	*	*
County-wide	**85**	**5.40**	**<0.001**

Satisfaction

Satisfaction of services is measured by a survey called Therapy Attitude Inventory (TAI). Answers are based on a scale from 1-5.

A total of **28 parents** completed the TAI in FY 23-24. (64.8% of those parents received PCIT services). On average, the parents felt more confident in their parenting skills and ability to discipline their child and felt their relationship with their child and their child's behavior improved. The parents felt the techniques learned were accepted by their family, community and religious beliefs.

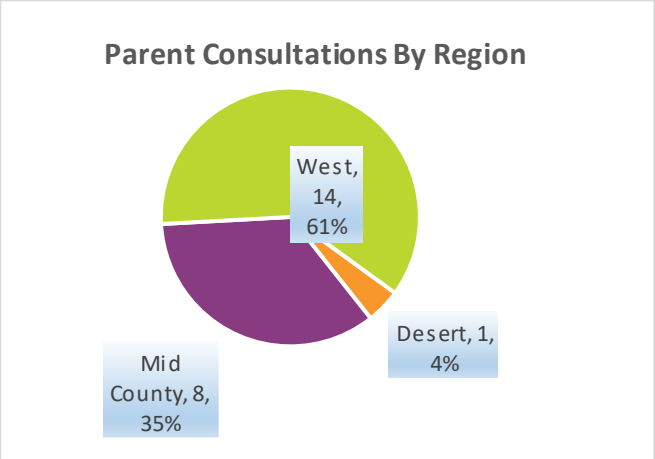
The specific TAI questions, as well as the average scores given to each item by the 28 parents are shown on the following page.

Preschool 0-5 Programs
All MH Services Data

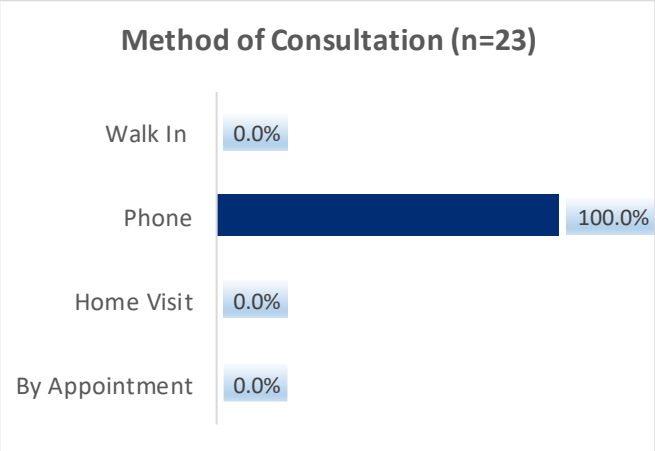
Question	Average Score (n=28)	1	2	3	4	5
Regarding techniques of disciplining, I feel I have learned:	**4.68**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding techniques for teaching my child new skills I feel like I have learned:	**4.75**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding the relationship between myself and my child, I feel we get along:	**4.68**	Much worse than before	Somewhat worse than before	The same as before	Somewhat better than before	Very much better than before
Regarding confidence in my ability to discipline my child I feel:	**4.75**	Much less confident	Somewhat less confident	The same	Somewhat more confident	Much more confident
The major behavior problems that my child presented at home before the program started are at this time:	**4.82**	Considerably worse	Somewhat worse	The same	Somewhat improved	Greatly Improved
I feel that my child's compliance to my commands or requests is at this time:	**4.86**	Considerably worse	Somewhat worse	The same	Somewhat Improved	Greatly Improved
Regarding the progress my child has made in his/her general behavior I am:	**4.89**	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
To what degree has the treatment program helped with other general, personal, or family problems not directly related to your child in the program?	**4.64**	Hindered much more than helped	Hindered slightly	Neither helped or hindered	Helped somewhat	Helped very much
I feel the type of program that was used to help me improve the behaviors of my child was:	**4.82**	Very poor	Poor	Adequate	Good	Very good
My general feeling about the program I participated in is:	**4.89**	I disliked it very much	I disliked it somewhat	I feel neutral	I liked it somewhat	I liked it very much
Level of comfort with the ethnicity of your therapist/coach:	**5.00**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
Level of comfort with the ethnicity of the assessment staff:	**4.89**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
To what degree have the skills you learned in this treatment program been accepted by the people in your family (e.g., mother/father, adult siblings, other extended relatives)?	**4.32**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree have the skills you learned in this treatment program been accepted by the people in your community (e.g., neighbors, other school/Head Start parents, friends)?	**4.36**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree do you feel that the skills you have learned in this program are consistent with your religious or spiritual upbringing and values?	**4.36**	Not consistent	Somewhat not consistent	Neutral	Somewhat consistent	Very consistent

PEI Mobile Staff—Parent Consultations

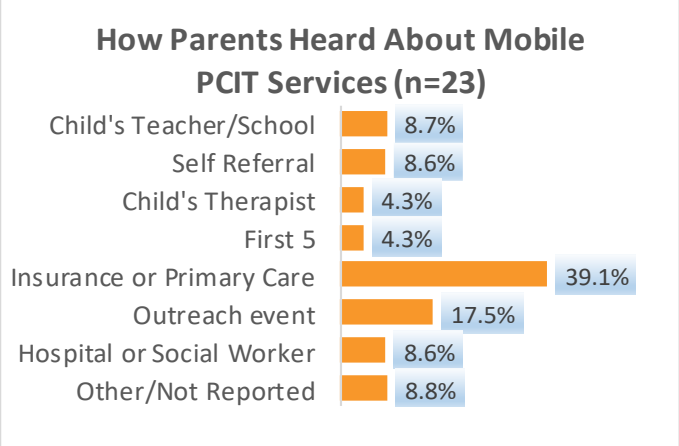
Parent consultations are provided by PEI Mobile staff as a light touch service where parents can, by walk-in or appointment, talk about raising their children, and discuss the social, emotional, and learning issues that they are facing. Clinicians can enroll the child/parent in supportive services that will help foster the child's academic and personal growth, and can refer out to other services when necessary. Consultations are also available by phone.

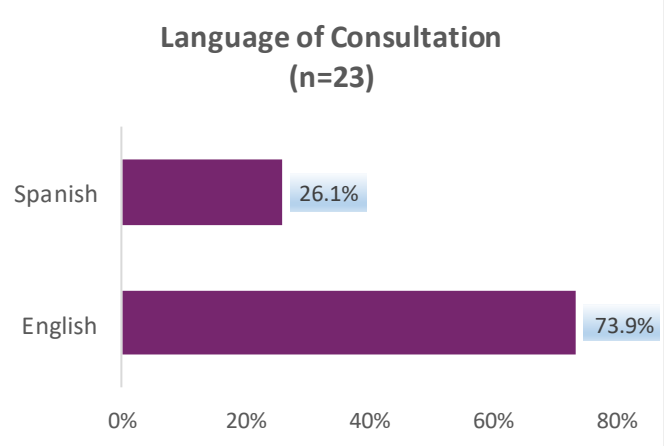


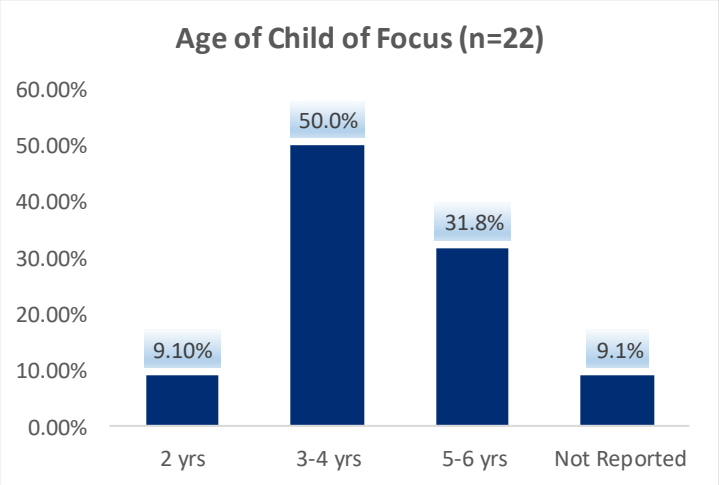
A majority of parent consultations (61%) were provided to parents in the Western region.



In the 23-24 fiscal year, 23 parent consultations served **22 parents**. All parent consultations were provided on the phone (100%).





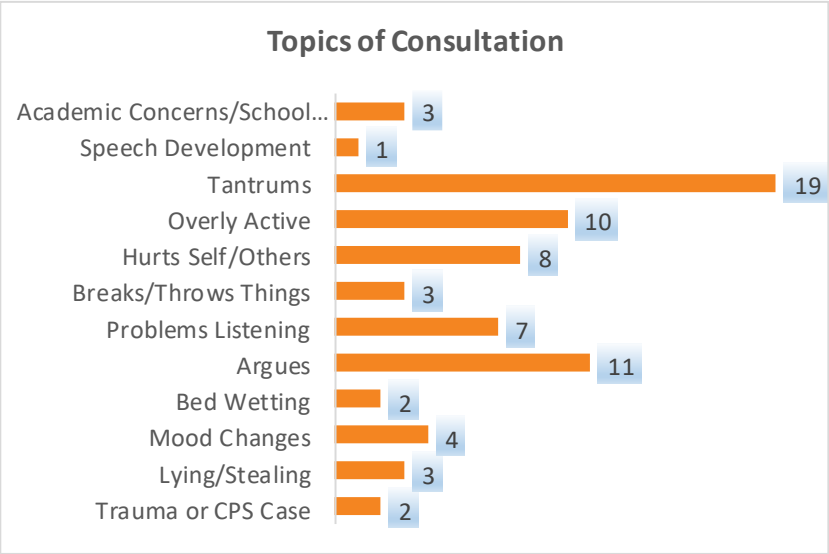


A majority of consultations (73.9%) were provided in English.

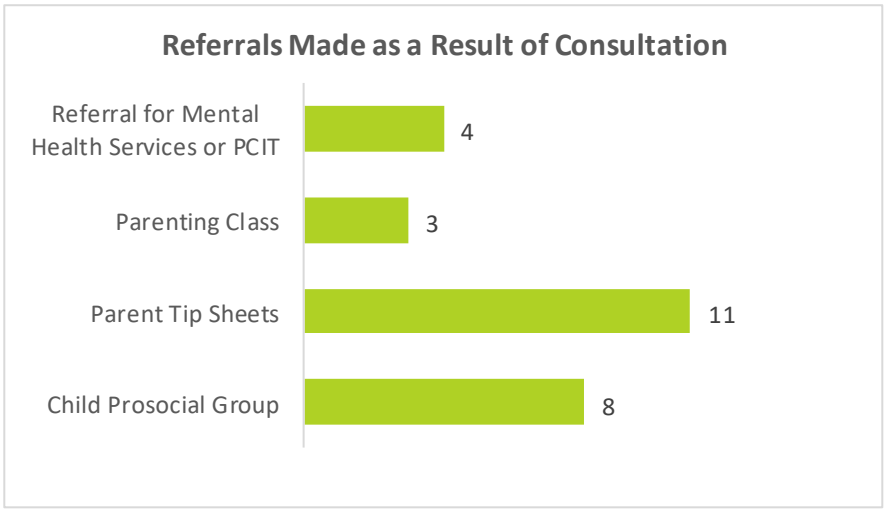
A majority of parents learned of the consultation and other services through their insurance or primary care doctor, or through an outreach event.

Half of the children of focus (50%) were 3-4 years of age. Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.

PEI Mobile Staff
Additional Light Touch Services Data



Tantrums and arguing were the two frequently discussed concerns during parent consultations, followed by being overly active. *(Each parent consultation could focus on multiple topics, so counts are depicted in the graph).*





23 parent consultations resulted in a total of 26 referrals (including tip-sheets/ behavioral charts.). Parent tip sheets and referral to child pro -social groups constituted a majority of the referrals.

PEI Mobile Staff— Outreach Events

- PEI Mobile staff recorded a total of 4 outreach events which included providing an informational presentation to the Comprehensive Autism Center, participating at health and wellness fair, and provided resources and service information at an elementary school
- Outreach was provided to 52 people
- The events were virtual or in the Western region of Riverside County.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Strengthening Families Program (SFP)
Annual Report FY 2023-2024

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Program Overview

Overview

Strengthening Families Program (SFP) is a prevention program for children ages 6-11 and their families. SFP's goals include strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional, and social problems in high-risk children (those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses). The program consists of 14 sessions. The program completion standard is defined as at least one caregiver per family having attended ten or more sessions. Participants are also given the opportunity to attend a booster session 3 or 6 months after completing the program.

Outcomes Evaluation

Program outcome is evaluated based three measures: the Alabama Parenting Questionnaire (APQ), the Strength and Difficulties Questionnaire (SDQ), and the Family Relationship Index (FRI). The APQ measures three dimensions of parenting: parental involvement, positive parenting, and inconsistent discipline. The SDQ measures both positive and negative psychological attributes among children, including emotional problems, conduct problems, hyperactivity, peer problems, pro-social skills, and total difficulties. The third measure, FRI, measures family cohesion, expressiveness, and family conflict.

Providers

Community-Based Organizations (CBOs) are contracted to provide SFP services. For FY 2023-2024 the providers were: My Family, Inc. (MFI) in the Western region; California Family Life Center (CFLC) in the Mid-County region, and Riverside Latino Commission in the Desert region.

Executive Summary

Enrollment

- Countywide, Strengthening Families enrolled 117 families made up of 144 individual parents/caregivers.
- 99 of the 117 enrolled families (85%) met the program-completion standard by attending 10 or more sessions.
- Each provider is contractually required to have 40 families complete the program. Latino Commission (Desert) and MFI (Western) each achieved 39 families completed. CFLC (Mid-County) started late in the fiscal year, but was still able to achieve 21 families completed.

Demographics

- Of the 144 enrolled parents/caregivers, the majority (64%) were 26 through 39 years of age.
- The majority (80%) of enrolled parents/caregivers reported being Hispanic/Latinx. 59% selected Spanish as their primary language.
- The majority of enrolled parents/caregivers reported their relationship to the SFP child as “mother” (70%) followed by “father” (18%).
- The majority of enrolled SFP children were 6-7 years old (50%). The median age was 7 years.
- Enrolled SFP children were 52% female and 48% male.
- The majority (85%) of SFP children were identified as Hispanic/Latinx. Their predominant primary language was English (78%).

Family and Child Risk Factors Identified During Screening

- The Family Risk Factors most frequently identified were *Poor Communication* (79%), *Underserved Community* (25%), and *Family Conflict or Neglect* (23%).
- The Child Risk Factors most frequently identified were *Behavior Problems* (58%), *Low Self Esteem* (36%), *Low Academic Motivation* (24%), and *Skill Deficits* (16%).

Outcomes

- Countywide, improvement in all dimensions of the APQ was statistically significant ($p \leq 0.05$). Improvement in the APQ’s *Parental Involvement* dimension, for example, was 15%.
- Countywide, improvement in child behavior as measured by the SDQ was statistically significant ($p \leq 0.05$). The SDQ’s *Total Difficulty* score improved (decreased) 11%.
- Countywide, improvement in all FRI subscales (*Family Cohesion*, *Expressiveness*, and *Conflict)* was statistically significant ($p \leq 0.05$)—evidence that families were strengthened through participation in SFP.

Satisfaction

103 participants completed the satisfaction survey. All reported being either *very satisfied* (92%) or *satisfied* (8%) with the program. All reported being either *very satisfied* (93%) or *satisfied* (7%) with their group leaders. 95% indicated the course helped their family very much. 100% would recommend the course to other families.

Enrollment and Completion

Countywide in FY 2023-2024 the Strengthening Families Program enrolled 117 families made up of 144 individual parents/caregivers. Of the 117 families, 99 (85%) completed the program by attending at least ten of the fourteen sessions. This represents an increase from the FY 2022-2023 values of 92 completed families and 72% completion. Table 1.1 summarizes enrollment and completion countywide and by region. Figure 1.1 shows the distribution of the number of sessions attended for the 117 enrolled families.

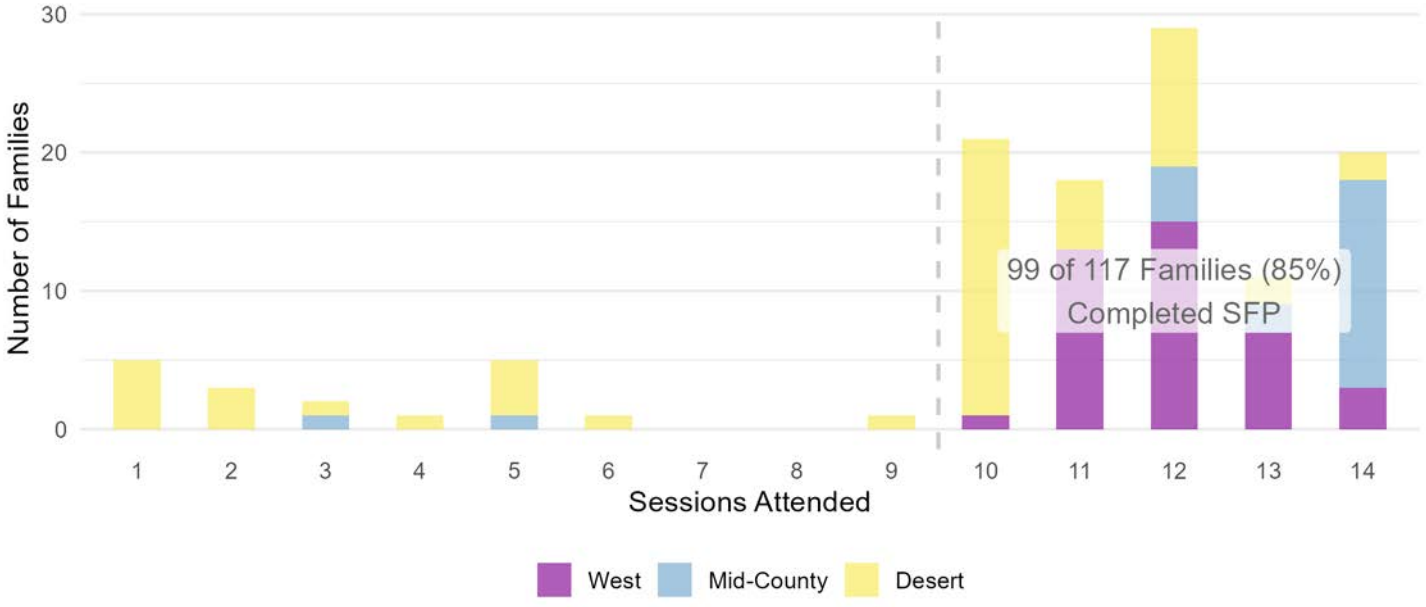
Contract Expectation

SFP's defined standard of completion is attendance of at least ten sessions by at least one enrolled parent/guardian. Each regional provider has a contractual expectation of 40 completed families. Table 1.1 summarizes attendance and completion, including the percentage of contract completion for each provider. Note that Mid-County started late in the fiscal year, thus limiting their available time for outreach and registering groups. Mid-County's enrollment and completion rates, however, demonstrate their capacity to meet the standard of completion given a full year.

Table 1.1: Family Enrollment and Completion by Region

Description	Desert	Mid County	Western	COUNTYWIDE
Family Enrollment	55	23	39	**117**
Family Completion	39	21	39	**99**
Family Completion Contract Expectation	40	40	40	**120**
Percent of Contract Completion	98%	52%	98%	**82%**

Figure 1.1: Family Attendance and Completion



Parent/Caregiver Demographics

Parent/caregiver demographic information is collected as part of SFP screening. Figure 2.1 shows the age distribution for the 144 enrolled parents/caregivers. Countywide, the majority (64%) of parents/caregivers were 26 through 39 years of age. Note that we exclude 3 *not reported.*

Figure 2.2 shows gender for the 144 enrolled caregivers. Countywide, 111 (78%) were female. Note that we exclude 2 *not reported.*

In FY 2023-2024, 2 female parents/caregivers identified as LGB, none as transgender.

Figure 2.1: Age of Enrolled Parents/Caregivers

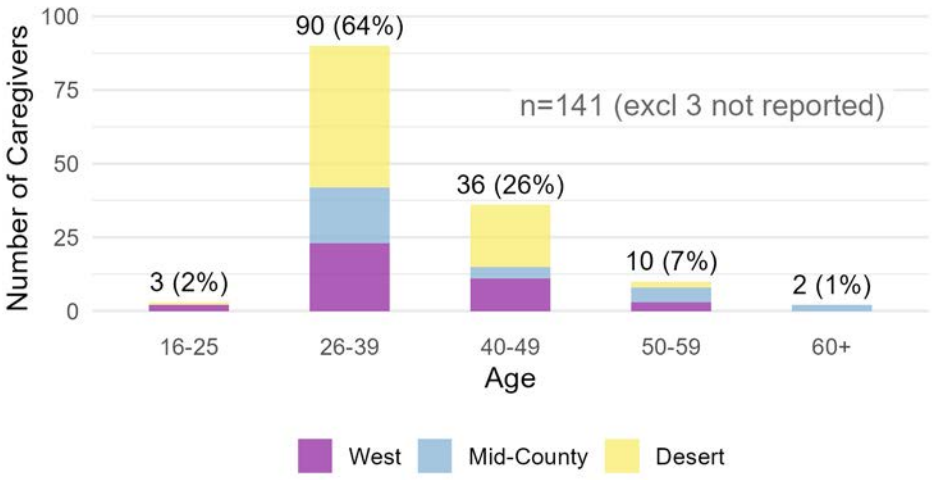
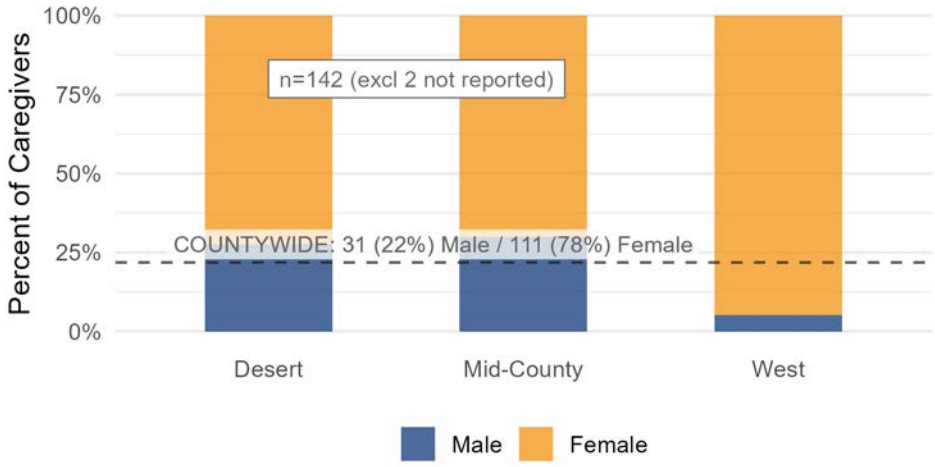


Figure 2.2: Gender of Enrolled Parents/Caregivers



Parent/Caregiver Demographics (continued)

The SFP Demographics and Screening Form lists common race and ethnicity categories. Prospective participants can make multiple selections or fill-in a race and/or ethnicity not listed.

Figure 2.3 summarizes the *unduplicated* races reported by the 144 enrolled parents/caregivers. Note the category *Multiple,* which captures parents/caregivers specifying multiple races. Multiple races counted in this category are not re-counted (duplicated) in specific race categories. Two parents/caregivers specified multiple races as: (1) Native American and Hispanic/Latinx; and (2) Native American and Black/African American.

In FY 2023-2024, parents/caregivers were predominantly Hispanic/Latinx, with 115 (80%) identifying as such, followed by White with 15 (10%), and Black/African American with 7 (5%).

There were two parents/caregivers identifying as Native American, both subsumed by the *Multiple*-race category as noted in Figure 2.3.

Table 2.1 lists the ethnicity specified by the n= 116 Hispanic/Latinx parents/caregivers. Note we include the one Hispanic/Latinx subsumed by the *Multiple*-race category. The majority, 77 (66%), of Hispanic/Latinx parents/caregivers further identified as Mexican.

Figure 2.3: Ethnicity of Enrolled Parents/Caregivers (Unduplicated)

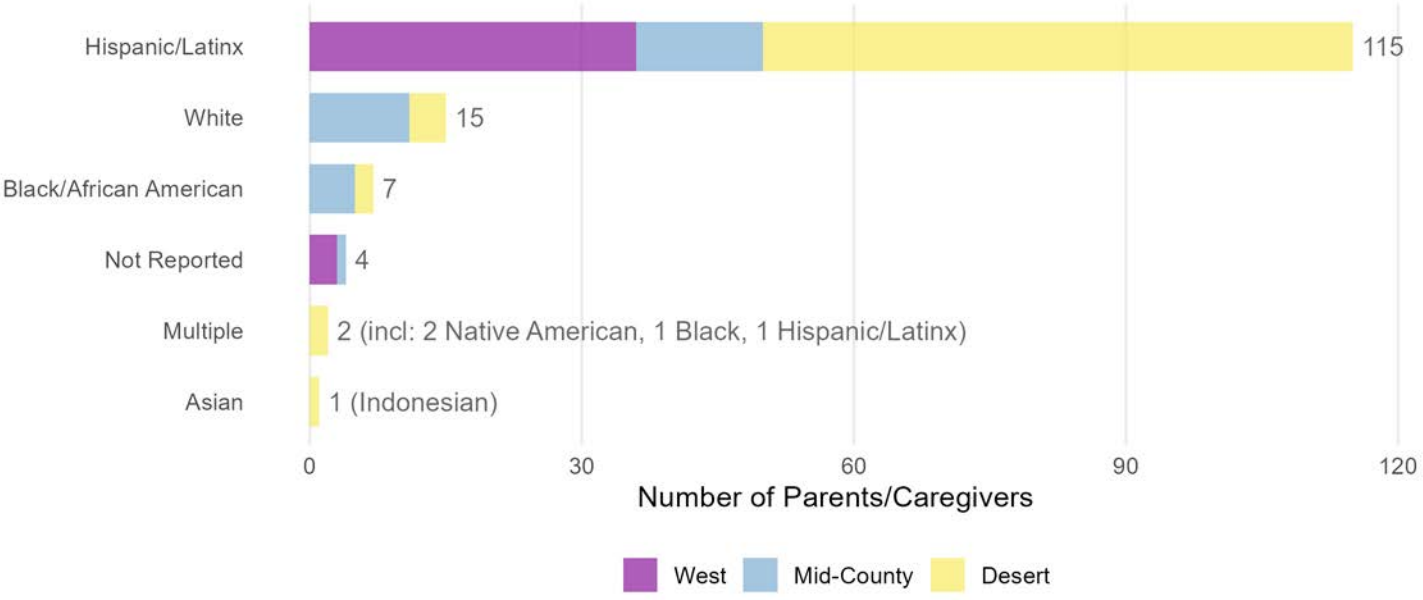


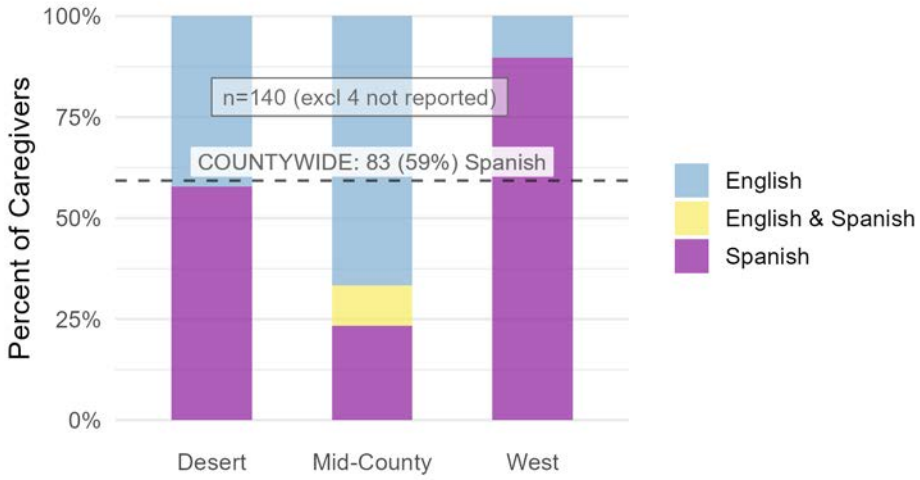
Table 2.1: Hispanic/Latinx Ethnicity of Enrolled Parents/Caregivers

Mexican	77	66%
Central American	3	3%
Venezuelan	1	1%
Not Reported	35	30%

Parent/Caregiver Demographics (continued)

Figure 2.4 summarizes the primary language specified by the 144 enrolled parents/caregivers . Spanish was predominant with 83 (59%) parents/caregivers specifying it as their preferred language.

Figure 2.4: Language of Enrolled Parents/Caregivers



Disability Specification

Countywide, 3 enrolled parents/caregivers (2%) identified as disabled.

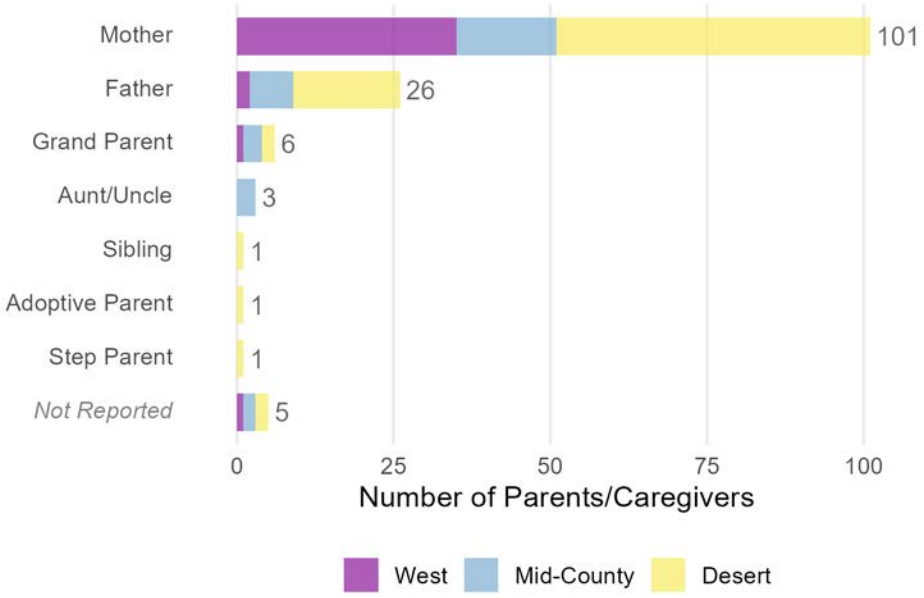
Veteran Status

Countywide, 1 enrolled parent/caregiver claimed veteran status.

Parent/Caregiver Relationship to SFP Child

Figure 3.1 shows relationship to SFP child as reported by the 144 enrolled parents/caregivers. Countywide, the 101 (70%) reporting as “mother” represents a majority, and is a greater percentage than the 66% reported in FY 2022-2023. 26 parents/caregivers (18%) reported as “father”, also greater than the 13% reporting as such in FY 2022-2023.

Figure 3.1: Relationship to SFP Child for Enrolled Parents/Caregivers



Child Demographics

SFP is intended for children ages 6-11. Parents/caregivers are asked to identify one child in the family within this age range, and to focus on this child for the program. This child is referred to as the SFP child. Results below are for the 117 SFP children of the 117 enrolled families.

Figure 4.1 summarizes the age distribution for the SFP children. The majority at 50% were between 6 and 7. In the last fiscal year, this group constituted only 37%. Also in that year, more children occupied higher age categories. Overall, FY 2023-2024 children were younger than in the previous year. The median FY 2023-2024 child age was 7 years, a one-year decrease from last year's median.

Figure 4.2 shows the gender breakdown for the117 SFP children of the enrolled families. 52% were male and 48% female.

Figure 4.1: Age of SFP Child

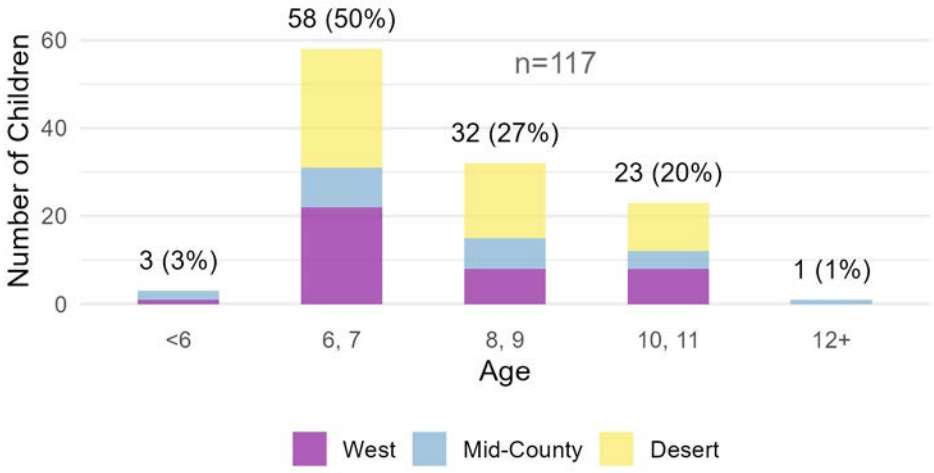
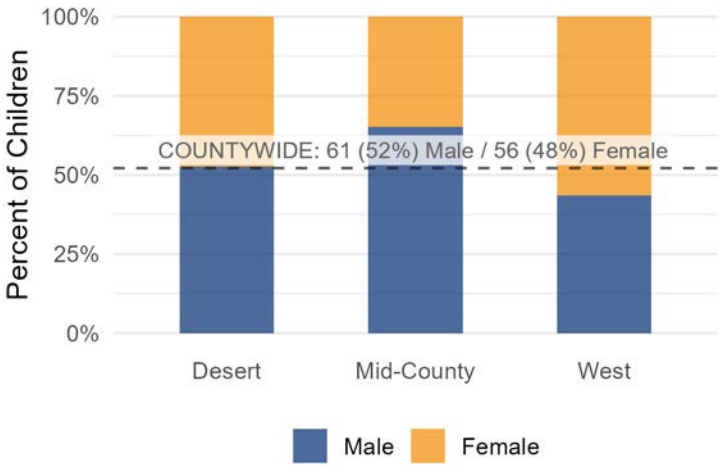


Figure 4.2: Gender of SFP Child



Child Demographics (continued)

Figure 4.3 summarizes the reported race of the 117 enrolled SFP children. Countywide, the children were predominantly Hispanic/Latinx, with 100 (85%) reported as such, and one more subsumed by the multiple-race category (n=101 Hispanic/Latinx total).

For children reported as Hispanic/Latinx, further ethnic specificity may be provided. Table 4.1 summarizes the specification for these 101 Hispanic/Latinx children. Among them, 64 (63%) were further identified as Mexican.

Figure 4.3: Race of SFP Child (Unduplicated)

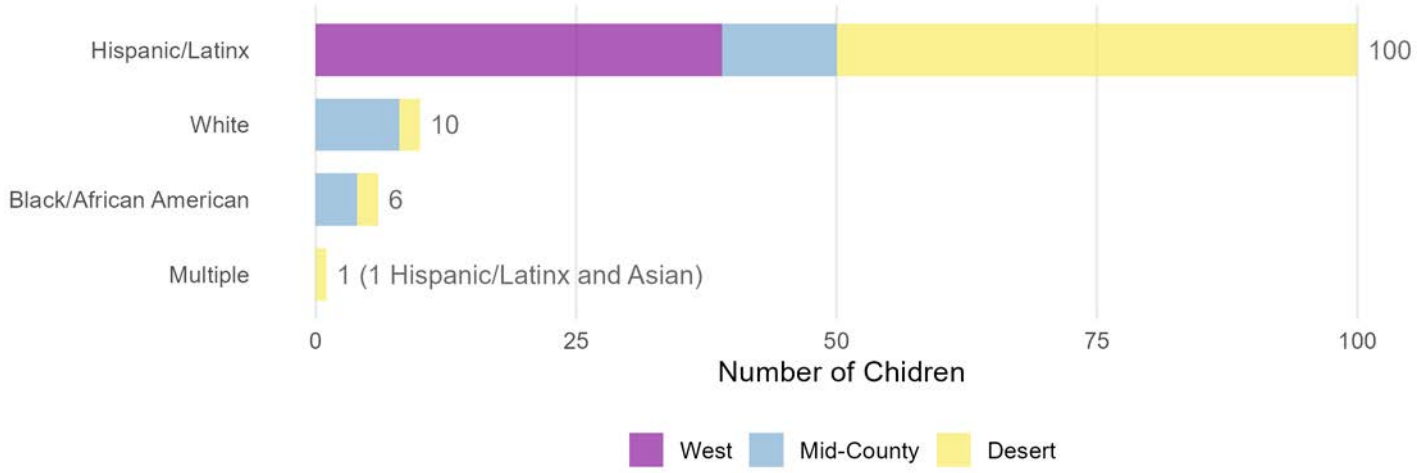


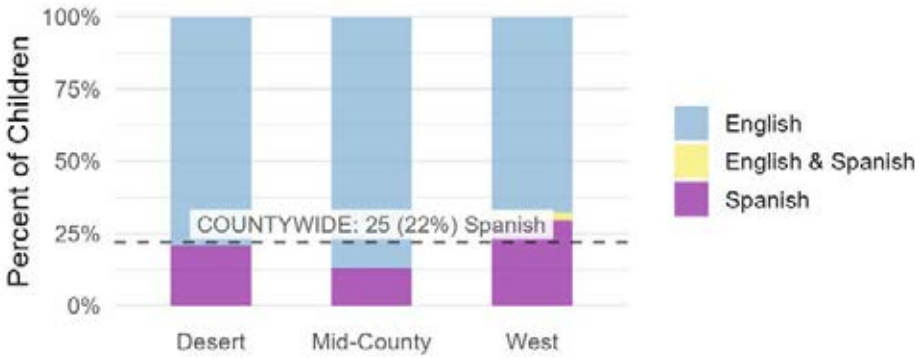
Table 4.1: Hispanic/Latinx Ethnicity of SFP Child

Mexican	64	63%
Central American	5	5%
Venezuelan	1	1%
Not Specified	31	31%

Child Demographics (continued)

Figure 4.4 summarizes the primary language specified for the 117 SFP children. English was predominant at 77% (22% Spanish, 1% both).

Figure 4.4: SFP Child Language



Disability Specification

Countywide, of the 117 enrolled SFP children, 2 were reported as disabled. One included a specification, which was autism. For comparison, in FY 2022-2023, 9 children were reported as disabled, 4 specified as autism.

Risk Factors

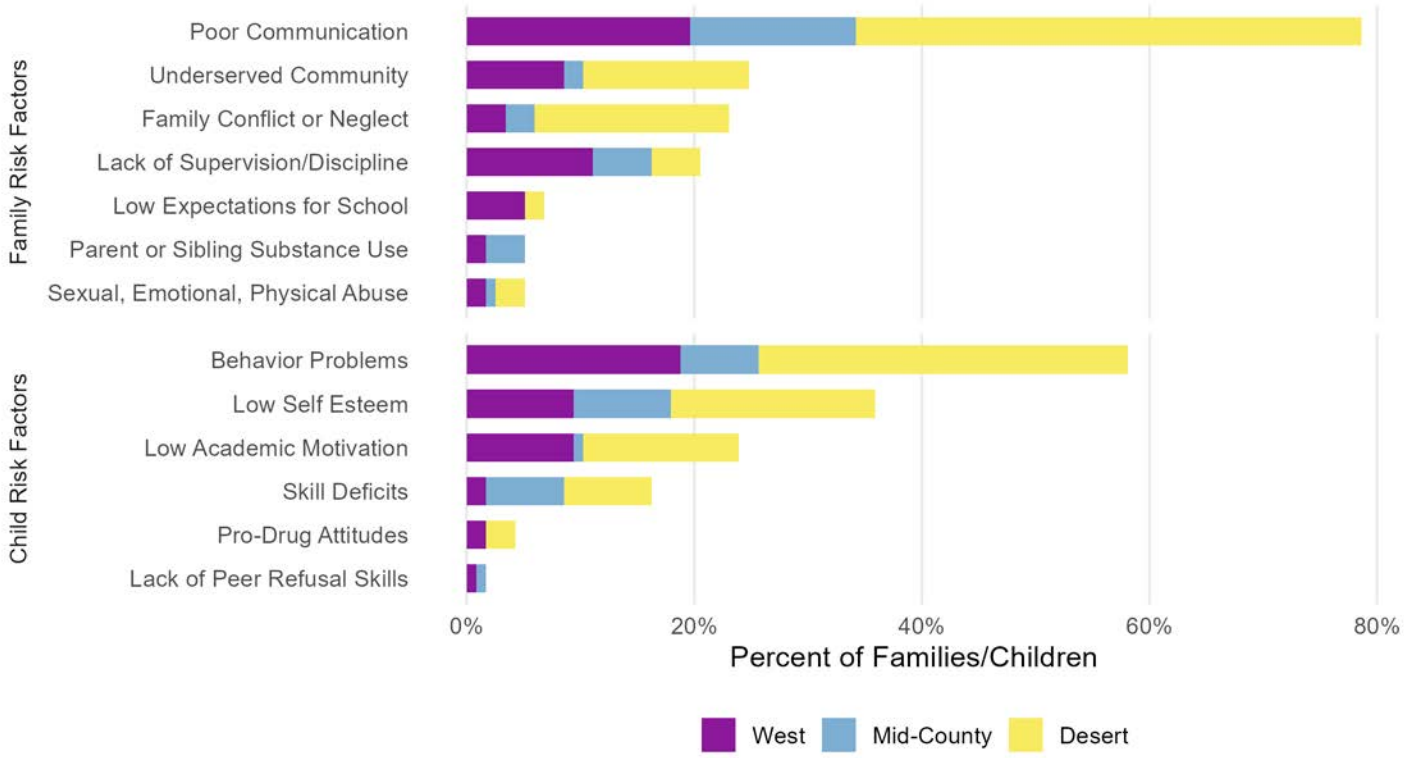
The SFP screening form includes a *Risk Factors* section listing seven possible *Family Risk Factors* and six possible *Child Risk Factors*. During screening, site coordinators have a conversation with prospective SFP parents/caregivers both to determine eligibility as well as to identify likely risk factors.

The identification of risk factors is useful during the program; the knowledge can help providers better connect with participants based on individual needs. The identification of risk factors also helps reveal prevailing issues in the community.

Figure 5.1 summarizes the frequency of occurrence of each risk factor among the 117 enrolled families during FY 2023-2024.

The Family Risk Factor most frequently cited was *Poor Communication* at 79%. The Child Risk Factor most frequently cited was *Behavior Problems* (58%).

Figure 5.1: Risk Factors



Program Outcomes

For the outcomes analysis, we include only parents/caregivers in families meeting the criteria of completion (attendance of ten or more sessions and completion of both pre and post inventories by at least one enrolled parent/caregiver in the family). For FY 2023-2024, 99 families met the criteria of completion. These families consisted of n=107 individual parents/caregivers. Unanswered questions, however, result in loss of data points. FY 2023-2024 completion rates were very good as revealed by the COUNTYWIDE n values included in the figures below.

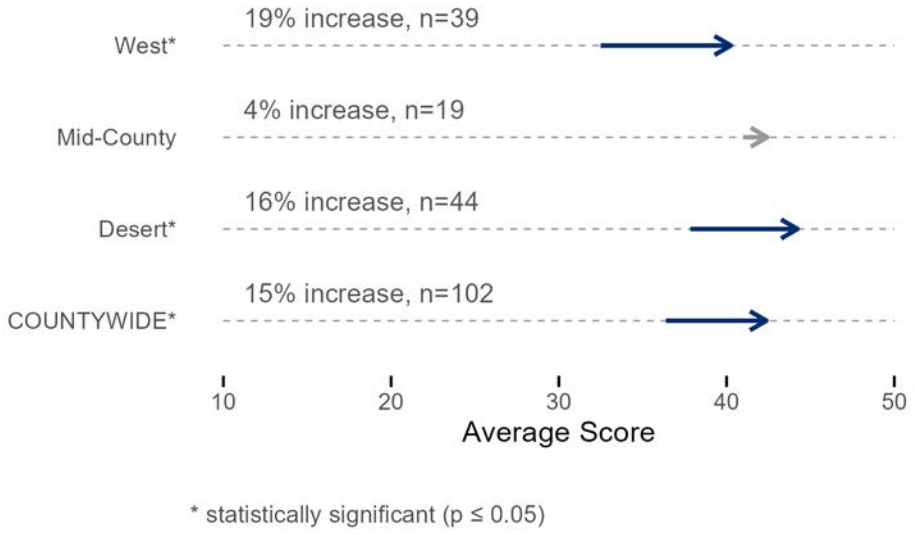
Program Outcomes: APQ

The Alabama Parenting Questionnaire (APQ) consists of 22 questions covering three distinct parenting dimensions summarized below.

1. The *Parental Involvement* dimension includes items such as, “you play games or do other fun things with your child” and “you ask your child about his/or day in school”.
2. The *Positive Parenting* dimension includes items such as, “you praise your child when he/she is doing a good job with something”.
3. The *Inconsistent Discipline* dimension represents negative aspects of parenting. Improvement thus corresponds to a decline in the score. This scale includes items such as “you threaten to punish your child and then do not actually punish her/him” and “you feel that getting your child to obey you is more trouble than it’s worth”.

Figures 6.1 through 6.3 show the outcomes for each of the three dimensions. Arrows point from the average pre to the average post score.

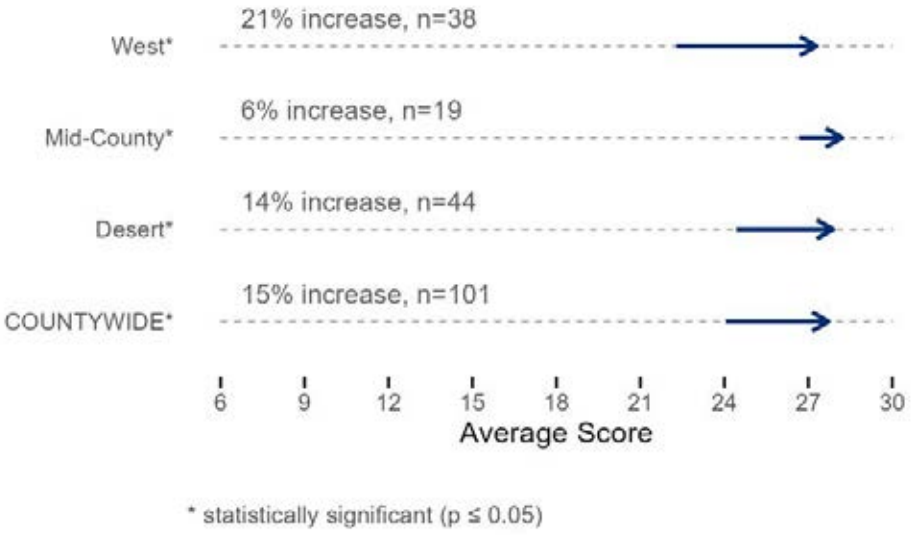
Figure 6.1: APQ Parental Involvement



The *Parental Involvement* dimension is scored from 10 to 50 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, parental involvement as measured by the APQ improved 15%.

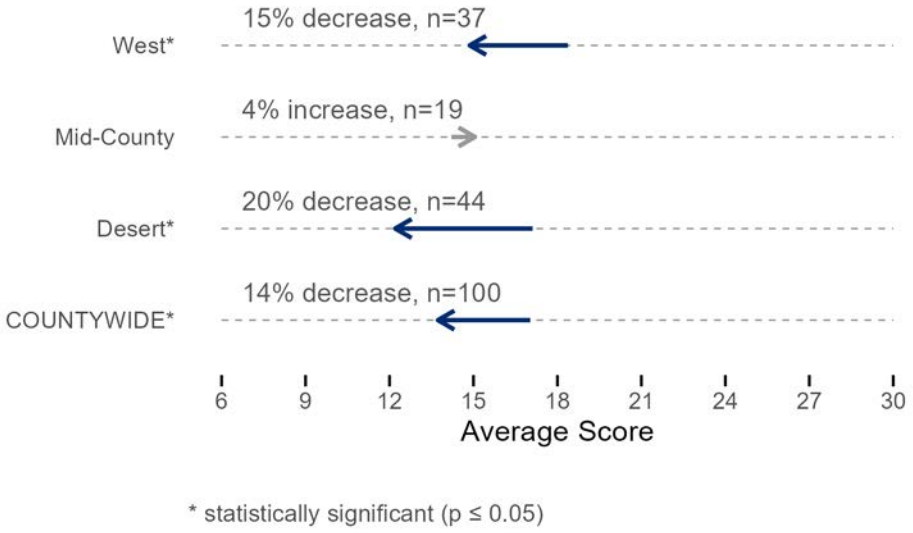
Program Outcomes: APQ (continued)

Figure 6.2: APQ Positive Parenting



The *Positive Parenting* dimension is scored from 6 to 30 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for all regions. Countywide, positive parenting as measured by the APQ improved 15%.

Figure 6.3: APQ Inconsistent Discipline



The *Inconsistent Discipline* dimension is scored from 6 to 30 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, inconsistent discipline as measured by the APQ improved 14%.

Program Outcomes: SDQ

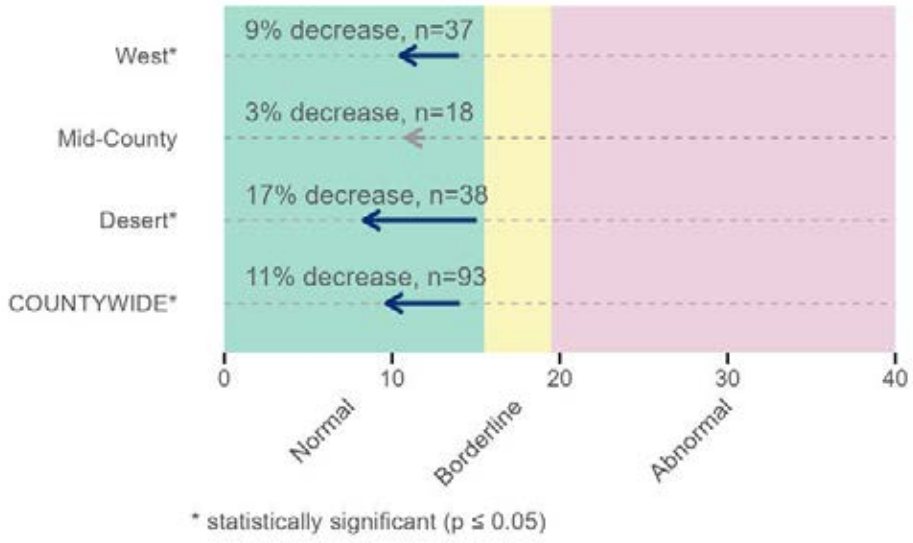
The Strength and Difficulties Questionnaire (SDQ) is used to quantify both positive psychological attributes (strengths) and negative ones (difficulties). SFP uses the Parent Version of the SDQ.

Scoring for the 25 questions includes a total score (total difficulty) and four subscale scores consisting of (1) emotional symptoms, (2) conduct problems, (3) hyperactivity, and (4) peer-relationship problems. Higher scores on these behavioral-difficulty subscales suggest greater negative psychological attributes. Decreases represent improvement in these subscales.

There is also an independent pro-social scale not used in the total score. For the pro-social scale, higher scores suggest greater positive social behaviors (increases represent improvement).

Figure 7.1 shows the pre/post change in the overall *Total Difficulty* score. Figures 7.2 through 7.5 show the changes in the four subscale scores. Finally, Figure 7.6 shows the change in the *Pro-Social* score. Arrows point from the average pre to the average post score.

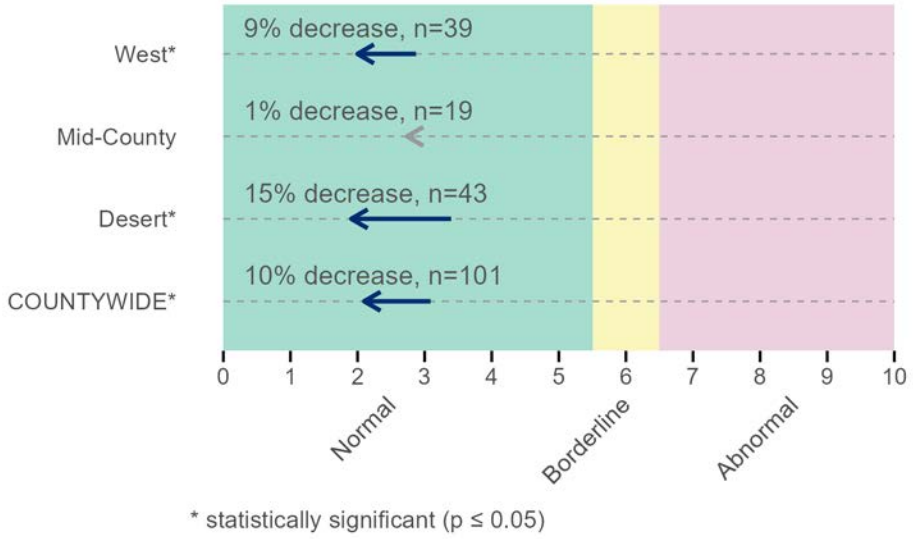
Figure 7.1: SDQ Total Difficulty



The *Total Difficulty* score ranges from 0 to 40 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, total difficulty as measured by the SDQ improved by 11%.

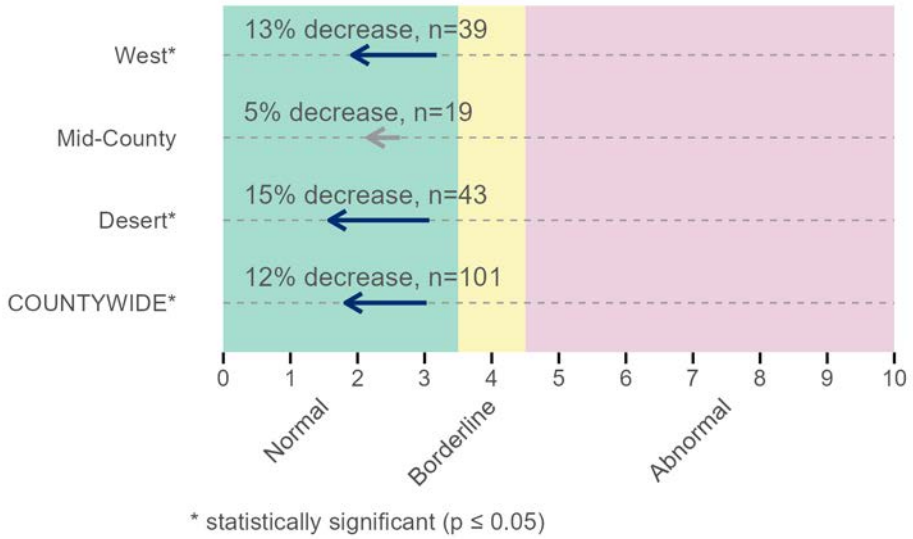
Program Outcomes: SDQ (continued)

Figure 7.2: SDQ Emotional Symptoms



The *Emotional Symptoms* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and the West and Desert regions. Countywide, emotional symptoms as measured by the SDQ improved by 10%.

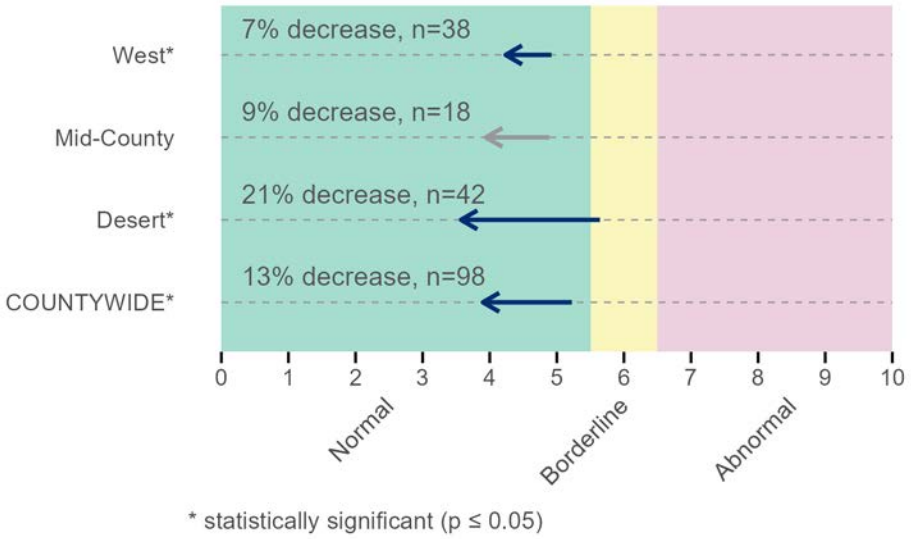
Figure 7.3: SDQ Conduct Problems



The *Conduct Problems* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, conduct problems as measured by the SDQ improved by 12%.

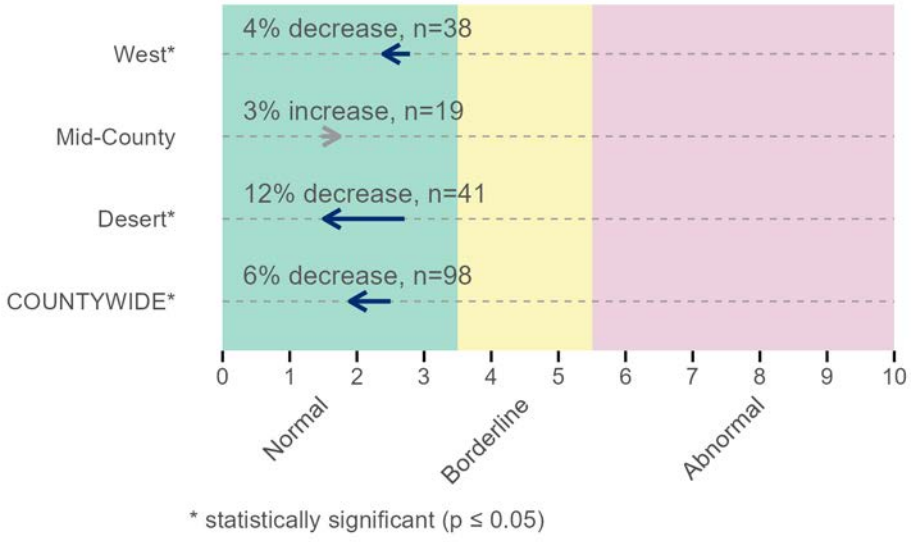
Program Outcomes: SDQ (continued)

Figure 7.4: SDQ Hyperactivity



The *Hyperactivity* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and the West and Desert regions. Countywide, hyperactivity as measured by the SDQ improved by 13%.

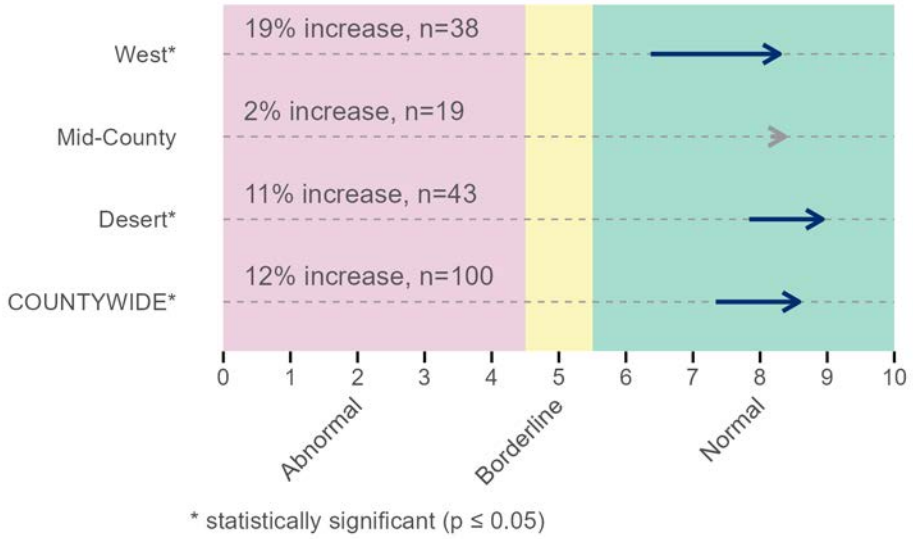
Figure 7.5: SDQ Peer Problems



The *Peer Problems* score ranges from 0 to 10 with a **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, peer problems as measured by the SDQ improved by 6%.

Program Outcomes: SDQ (continued)

Figure 7.6: SDQ Pro Social



The *Pro-Social* score ranges from 0 to 10 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, pro-social behavior as measured by the SDQ improved by 12%.

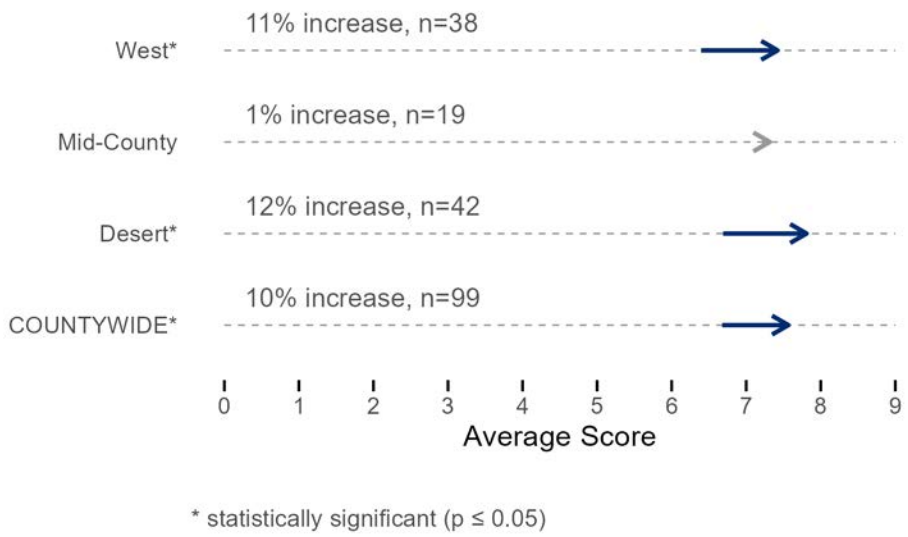
Program Outcomes: FRI

The Family Relationship Index (FRI) uses true/false questions (scored 1 or 0) to measure the quality of the family environment. There are three subscales: (1) family cohesion, (2) expressiveness, and (3) conflict. The three scales are summarized below.

1. The *Family Cohesion* scale includes items such as, “family members really back each other up” and “there is a feeling of togetherness in our family”.
2. The *Expressiveness* scale includes items such as, “we tell each other about our personal problems” and “there are a lot of spontaneous discussions in our family”.
3. The *Conflict* scale represents negative aspects of family relationships. Improvement thus corresponds to a decline in the score. This scale includes items such as “we fight a lot in our family” and “family members often criticize each other”.

Figure 8.1 through 8.3 show the outcomes for each of the three scales. Arrows point from the average pre to the average post score.

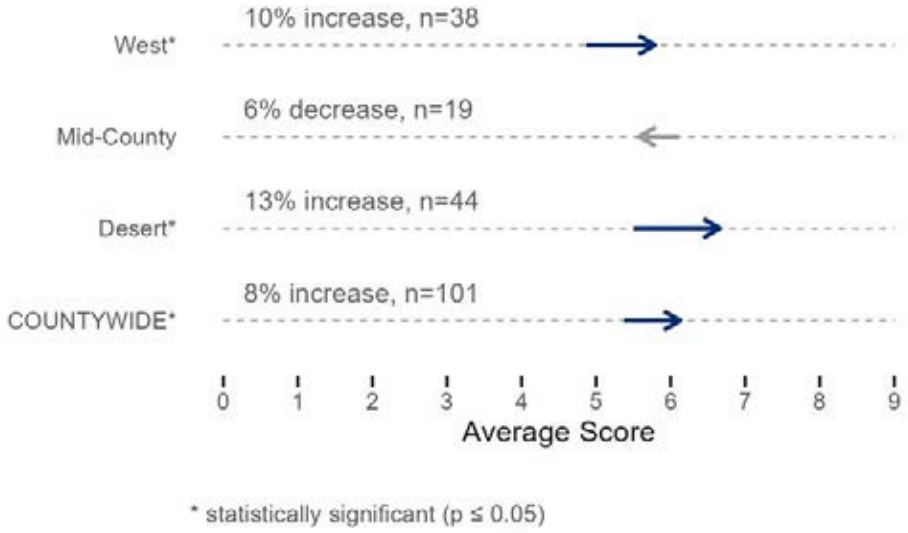
Figure 8.1: FRI Family Cohesion



Family Cohesion is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, family cohesion as measured by the FRI improved 10%.

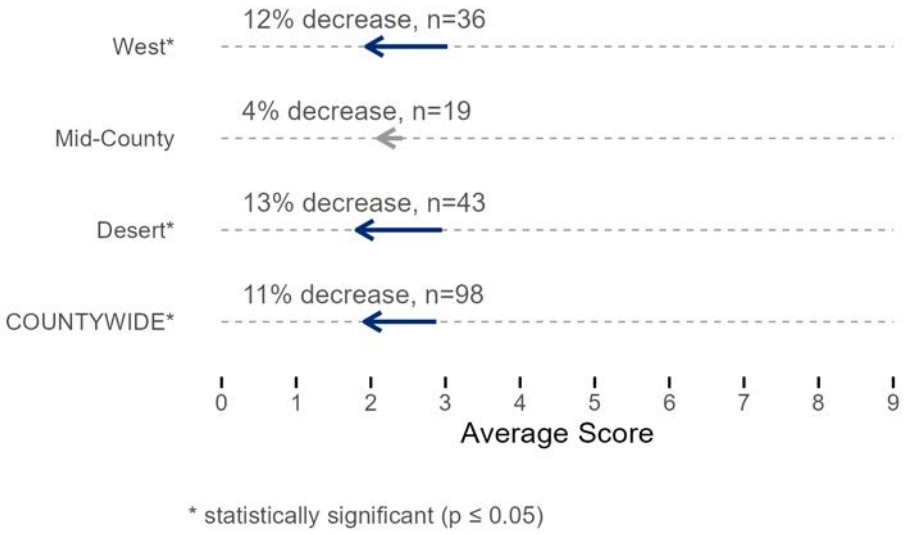
Program Outcomes: FRI (continued)

Figure 8.2: FRI Expressiveness



Expressiveness is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, expressiveness as measured by the FRI improved 8%.

Figure 8.3: FRI Conflict



Conflict is scored from 0 to 9 with **decreases** corresponding to **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, conflict as measured by the FRI improved 11%.

Post Program Satisfaction Survey Results

The inventory questionnaires given at the conclusion of the program includes a satisfaction survey. 110 parents/caregivers completed this survey.

Figures 9.1 through 9.3 summarize the results of the multiple choice questions. The results are favorable. Additionally, in response to the question “Would you recommend this course to other families?”, 100% responded in the affirmative.

Figure 9.1: How Satisfied Were You With This Program?

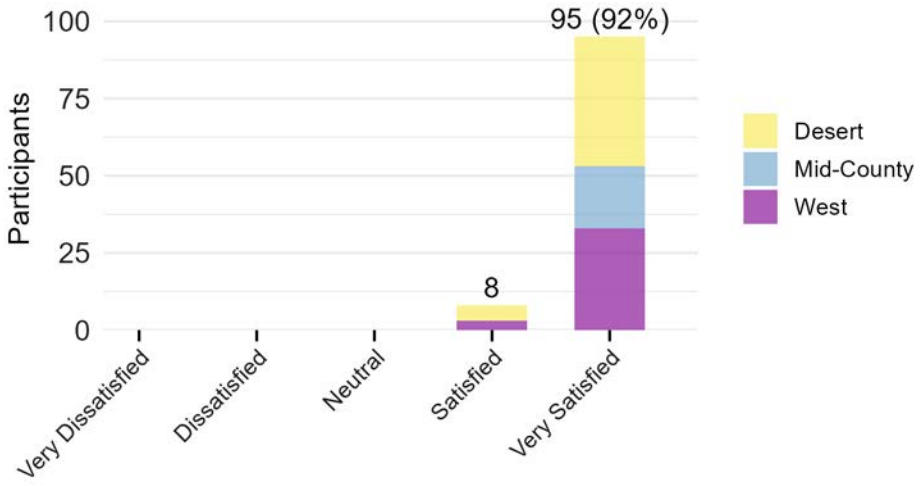
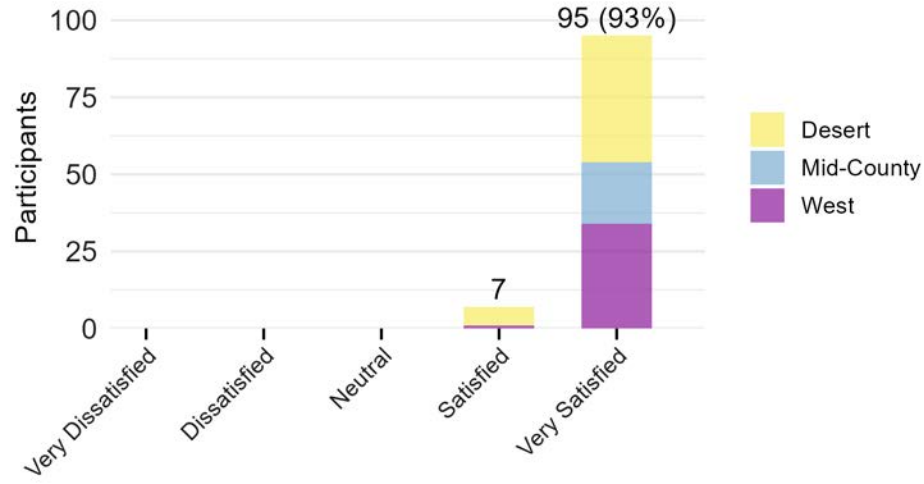
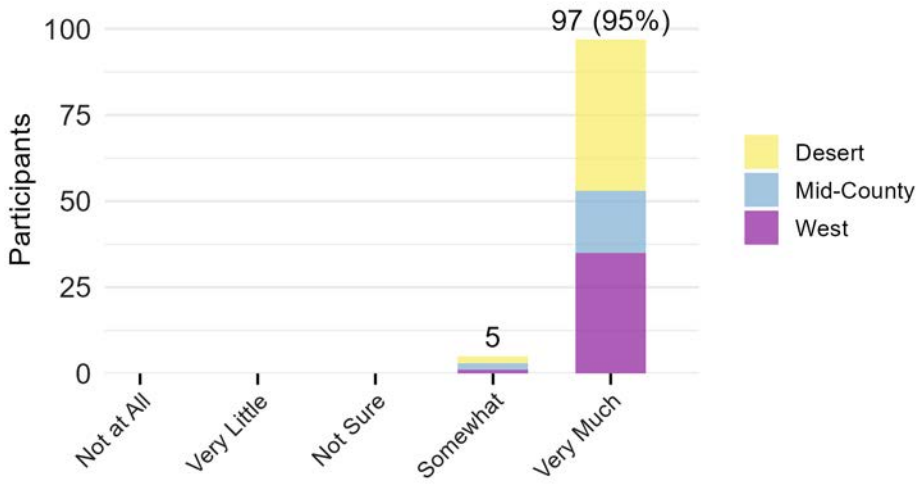


Figure 9.2: How Satisfied Were You With Your Group Leaders?



Post Program Satisfaction Survey Results (continued)

Figure 9.3: How Much Has This Course Helped Your Family?



Post Program Comments

Selected Comments

- I loved this program and would love to do another booster class. My daughter has also loved this program and doesn't want it to end.
- All the kids grew a strong bond together.
- (The program) helped me a lot with communication with the family, and to have greater communication with everyone.
- SFP helped a lot and opened my eyes on how to identify problems and how to solve them. Thanks from my entire family to the SFP team.
- The group leaders are very good at their jobs. They are very nice people, professional and kind not only with parents but with children. I am very grateful for the patience with my 6-year-old. May God always bless you so that you can continue helping more families with this program.
- Loved this class. It has helped out more than I expected.
- I enjoyed learning coping skills and how to manage behaviors with appraisals and nice compliments when children are on task.
- This program was very encouraging and very helpful with all the adults we had. They gave a lot of advice and a lot of tips to help with our children.
- I loved the program and I believe these programs are important and great for parents. With parents, there can never be too much learning. This class has helped me better understand my kids and become a better parent. The group leaders were awesome!
- I wanted to thank you for these programs that help us improve as people and that integrate children, it is very good, thank you very much!
- Thanks for everything. For helping us to be better in the family, and giving us different ways to help our children.
- My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them.
- This class has been very helpful to me and my son. We have a better relationship now than when we first started the class.
- So beneficial. This group was really amazing and might I say it turned my whole life around. I will never forget y'all.
- This program helped us a lot. We never got along well and now we do. Very grateful for everything. The children were very happy with the teachers.

Booster Attendance and Satisfaction

Booster sessions for FY 2023-2024 families could not be scheduled in time for this report. Results will therefore be included in the FY 2024-2025 report.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Stress and Your Mood (SAYM)

Annual Outcomes Report FY 2023-2024

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Program Overview

Stress and Your Mood (SAYM) is an early intervention for depression based on a Cognitive Behavioral Therapy (CBT) Model, with modifications for adolescent-age youths. SAYM was developed to improve access to evidence-based treatment for youth with depressive disorders and sub-clinical depressive symptoms. Specifically, this program targets transition age youth (TAY), or those between the ages of 16-25 years old.

SAYM services have three phases: "***Conceptualization***," "***Skills and Application Training***," and "***Relapse Prevention***." SAYM services are low-intensity and time limited, in accordance with the CBT model, and can either be provided in a group, individual sessions, or combination of both. Consistent with the CBT model, providers will refer to TAY as appropriate for medication-related evaluation and work closely with the prescribing psychiatrist to ensure continuity of care.

Program Provider Overview

Operation Safehouse, a community-based organization, was awarded prevention and early intervention funds to implement Stress and Your Mood (SAYM) Program. Operation Safehouse provides services in the Western, Desert, and Mid-County regions of Riverside County.

Evaluation Overview

A summary of SAYM Program's demographics, service data, and outcomes measurement is included in this report. This page describes the general methodology of the program's data collection methods.

Process Evaluation

A process evaluation includes collecting descriptive information related to the program, which describes what the program provided, how many people were served, the amount of service time provided, and basic demographic characteristics of the program. The process evaluation data is assessed using electronic health records and the group sign-in sheets, which record basic information on the SAYM topic and the number of participants in attendance. This data is collected by the Operation Safehouse staff at each session.

Outcome Evaluation

The outcomes evaluation measured a reduction in depressive symptomatology and improvements in general mental health function. Embedded in the program design, is also a measurement instrument that apprehends the assessment of each participant by the clinician. Satisfaction surveys included items on overall helpfulness of the SAYM program and overall helpfulness on specific components of the SAYM program. Evaluation measures are summarized below:

- **Centers for Epidemiological Studies Depression Scale (CES-D):** this measure utilizes to measure changes in depressive symptoms. Previous studies used the CES-D as a baseline and follow-up measure to examine outcomes. Intake and final CES-D measures were collected to examine changes in depressive symptoms following participation in the intervention.
- **Clinical Global Impression Improvement Scale (CGI-I):** this measure represents the clinician's assessment of how much the participant's symptoms have improved or worsened relative to a baseline state at the beginning of the intervention. The CGI-I is embedded in service delivery and is completed at the conclusion of each module. Intake and final CGI-I ratings are used for outcomes evaluation.
- **Youth Outcome Questionnaire-Self Report (Y-OQ®-SR):** this is a youth measure of global mental health functioning. Y-OQ®-SR measures were collected from youth under the age of eighteen at intake and at the conclusion of services to evaluate improvements in overall emotional well-being.
- **Behavior and Symptom Identification Scale (BASIS-24®):** this is an adult measure of global mental health functioning. BASIS-24® measures were collected for TAY age eighteen and older at intake and at the conclusion of services to evaluate any changes in emotional well-being.

Executive Summary

Enrollment/Demographics

Demographics information showed that the SAYM program served the intended target population of Transition Age Youth (TAY). A total of 244 participants enrolled in the SAYM program in FY 2023-2024, and 100% of the participants were TAY. The majority of those enrolled in the SAYM program were Female (66.7%), chose English as their preferred language (93.9%), and were predominantly Hispanic/Latino (63.1%). Of the youths served, the majority of participants were 16-17 years of age (83.3%), and 25% identified as LGBTQIA+.

Service Information

SAYM services were provided in both group and individual formats. There were a total of 1,448.27 hours provided to participants, and the most widely used SAYM services were for Individual Therapy Sessions (806.02 hours, or 42% of total services), and 28.2% of the participants received between 4.01 to 8 hours of service. Overall, SAYM Program met 79% of contract expectations. The program completion rate was 68% with 166 out of 244 youths completing the program, and 2 participants continuing their SAYM services in the fiscal year 2024-2025. The Mid-County region had the highest enrollment (39.8%) in FY 2023-2024, followed closely by the Western region (39.3%).

Depression Symptoms

Centers for Epidemiological Studies Depression Scale (CES-D)

Participants in the SAYM program showed decreases in the frequency of depression symptoms. Overall, the CES-D scores decreased from pre-test (30.77) to post-test (23.35), an improvement of 7.42 points. These changes were statistically significant (t = 9.511, df = 172, p = .000).

Clinical Global Impression Improvement Scale (CGI-I)

Clinicians' ratings also showed that the youth psychiatric status improved following the SAYM Program. The CGI-I was completed by clinicians after each module (1 and 2) and at conclusion of the SAYM services. The rating is based on the level of improvement compared to the youth's status at enrollment. By the conclusion of SAYM Program, 87.7% of participants improved in some capacity. The majority of youths (a total of 59.8%) were noted as "Much Improved" (33.2%) and "Very Much Improved" (26.6%). Across modules, there seems to be a cumulative affect where clients' level of improvement kept increasing they continued in the program. This illustrates the importance of clients completing the SAYM program.

Overall Functioning Improved

Youth Outcome Questionnaire (Y-OQ-SR®)

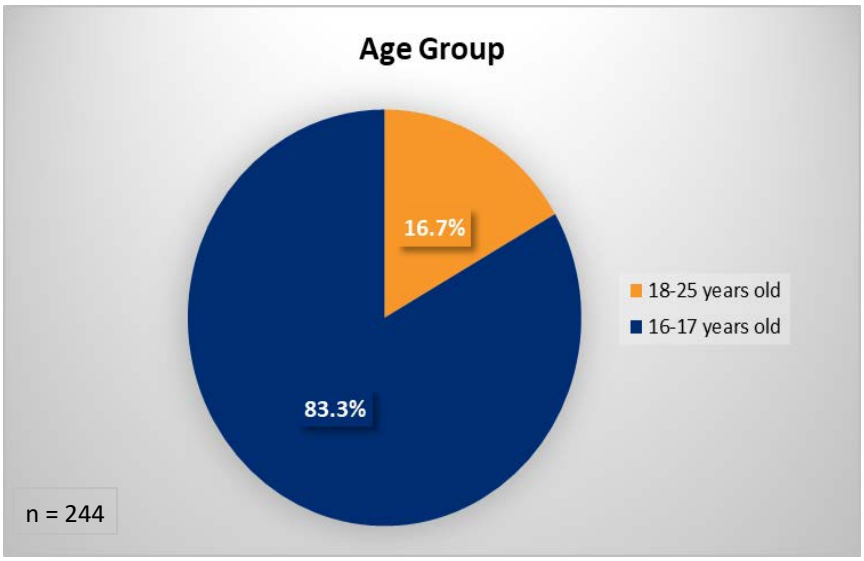
Youth global functioning also improved following SAYM intervention. Since the SAYM Program serves TAY (Youths ages 16-25), two measures of general mental health were used: one for adults–the *Behavior and Symptom Identification Scale* (BASIS-24®), and one for youth–the *Youth Outcome Questionnaire Self-Report* (Y-OQ®-SR). On the Y-OQ®-SR, higher scores indicate more impairment. Pre- to post-comparisons on Y-OQ®-SR total scores showed statistically significant decreases on the majority of subscales. On average, the decrease on the Y-OQ®-SR Total Score was 12.87 points. Although this change was not considered notable enough for showing clinical improvement (i.e. more than 13 points), it still showed a statistically significant change (t = 7.028, df = 134, p = .000). All the subscales, except for *Social Problems*, also showed statistically significant decreases.

Behavior and Symptom Identification Scale (BASIS-24®)

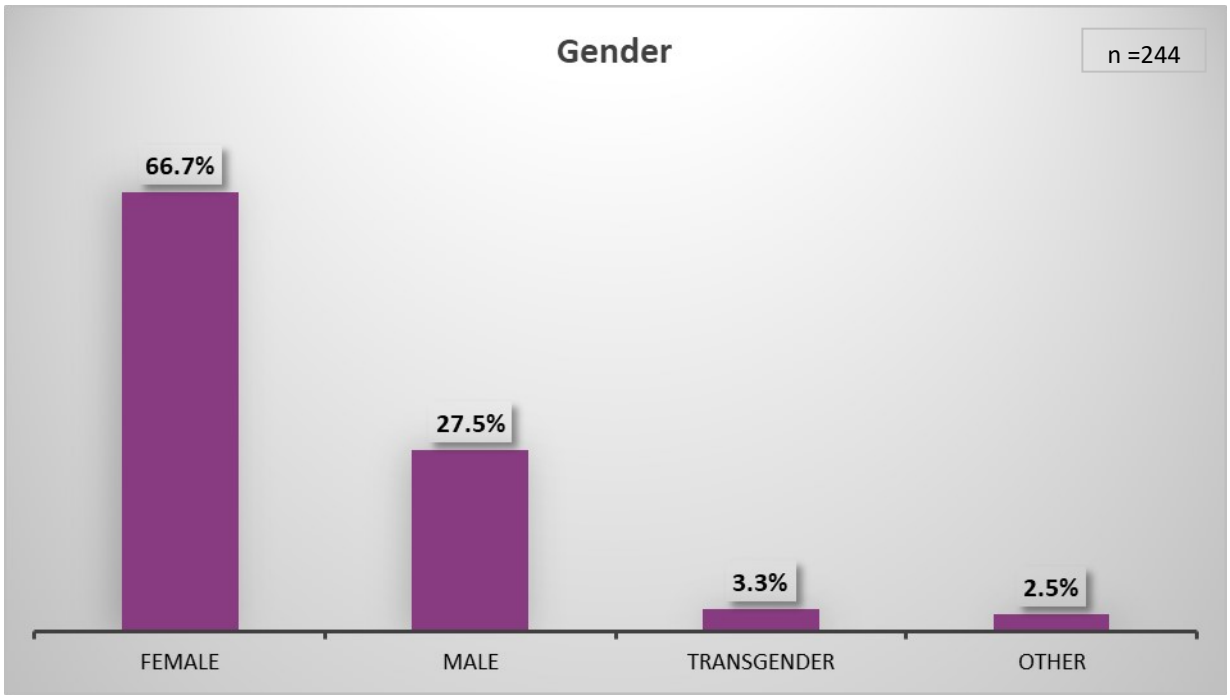
Using BASIS-24® scale, baseline measurement scores showed heightened spectrum of difficulty with the *Emotionally Labile Scale* (2.52 points) and *Depression and Functioning Scale* (2.1 points) . Overall, the sub-scales were shown to decrease (0.86 points or less), although it is noted that the 2 scales with the highest scores at intake have shown the most decrease at post measures.

Demographics: Age Groups, TAY and Gender

During the fiscal year 2023-2024, there were a total of 244 participants who enrolled in the Stress and Your Mood (SAYM) program, which includes 2 rollover participants from FY 2022-2023. Basic demographic information was collected for enrolled participants during the screening process and is summarized on the figures below.

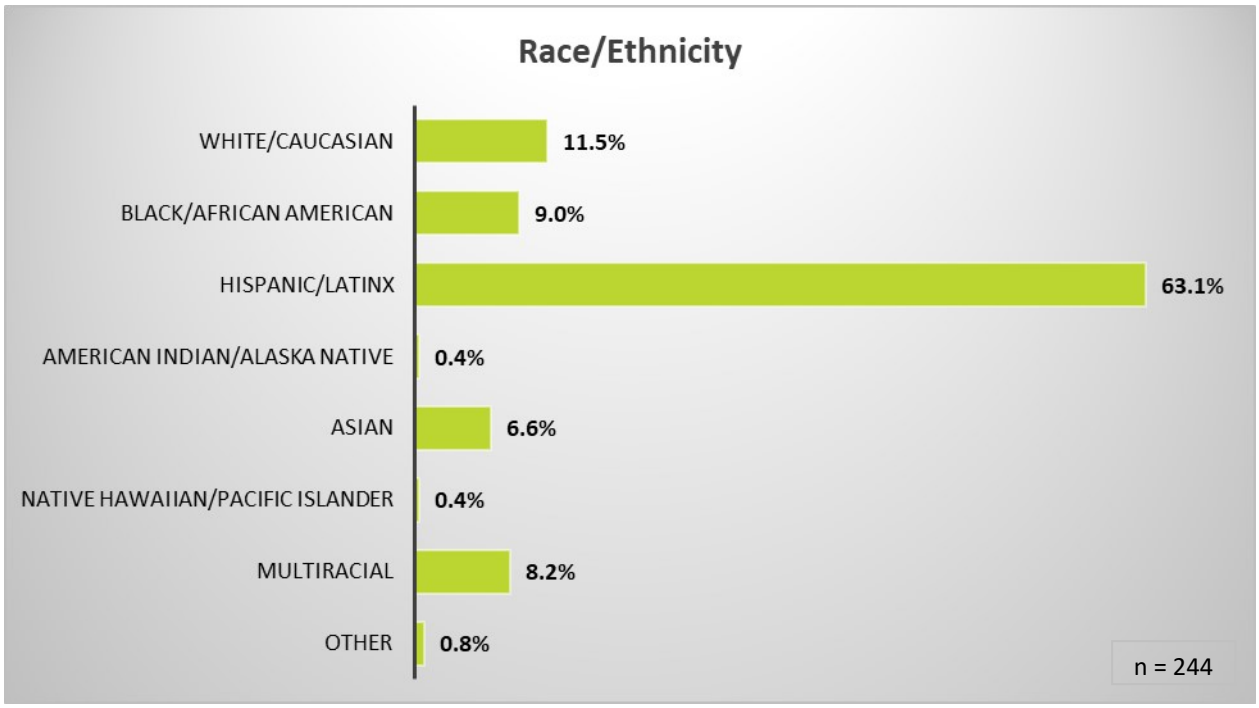


Enrollment data shows that the majority of SAYM participants were between 16-17 years old (83.3%, n = 203). A Few youth were between the ages of 18 and 25 years old (16.7%, n = 41). Additionally, when categorizing between Non-TAY and TAY population, all FY 2023-2024 SAYM participants were within the TAY category (100%).

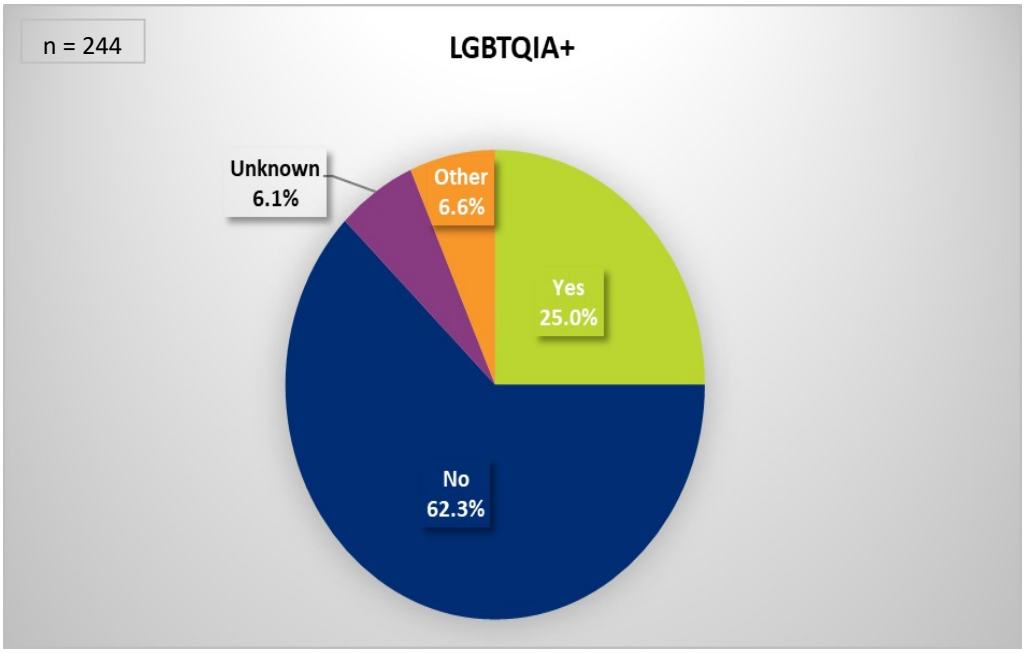


The majority of SAYM participants were Female (66.7%, n = 163), followed by Male (27.5%, n = 67). There were also smaller percentages of participants who identified as Transgender (3.3%, n = 8), and Other (2.2%, n = 6). Of those who categorized as Transgender, 6 specified as Transfeminine, 1 specified as Gender Fluid, and 1 participant chose not to respond.

Demographics: Race/Ethnicity and LGBTQI Category



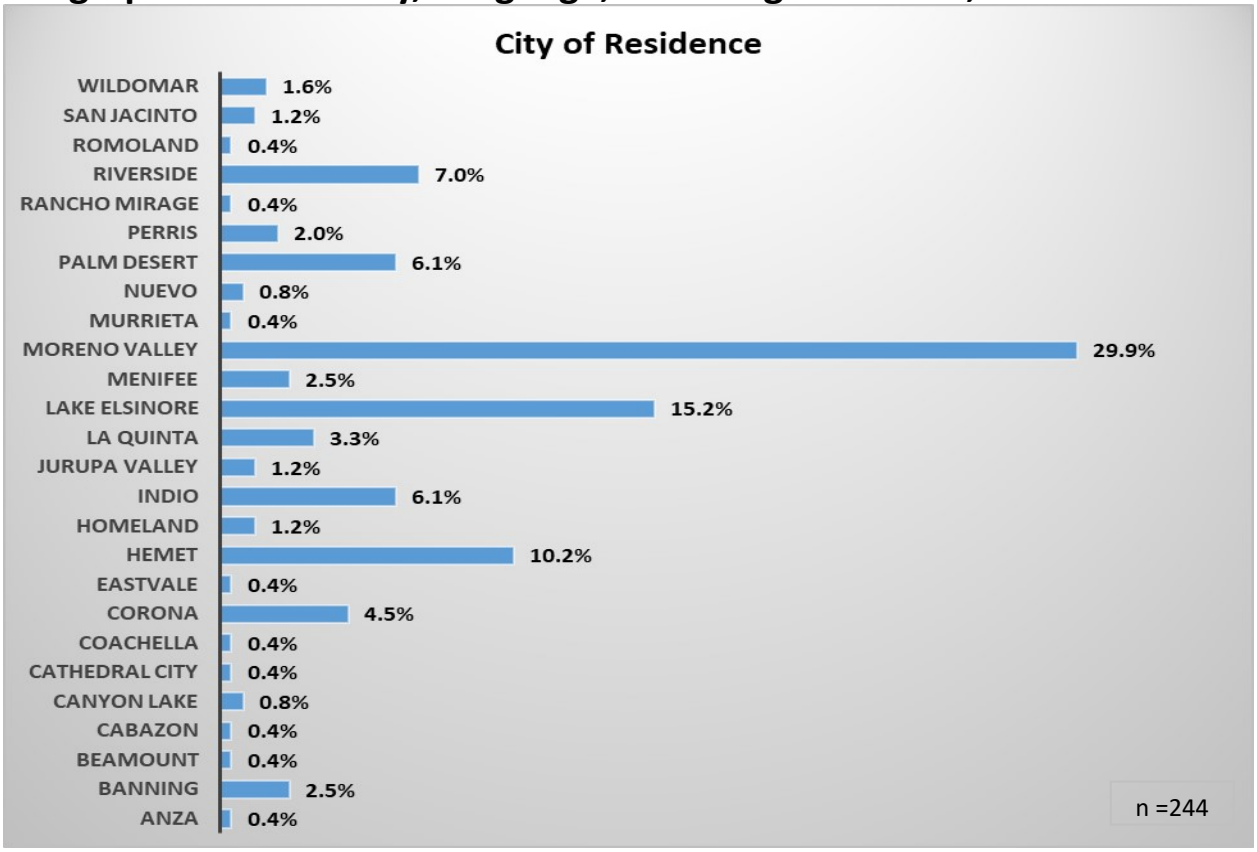
During the fiscal year 2023-2024, the majority of SAYM participants categorized as Hispanic/Latinx (63.1%, n = 154), followed by White/Caucasian (11.5%, n = 28), Black/African American (9%, n = 22), Multiracial (8.2%, n = 20), and Asian (6.6%, n = 16), respectively. There were also smaller percentages of participants who categorized as Other (0.8%, n = 2), Native Hawaiian/Pacific Islander (0.4%, n = 1), and American Indian/ Alaska Native (0.4%, n = 1).



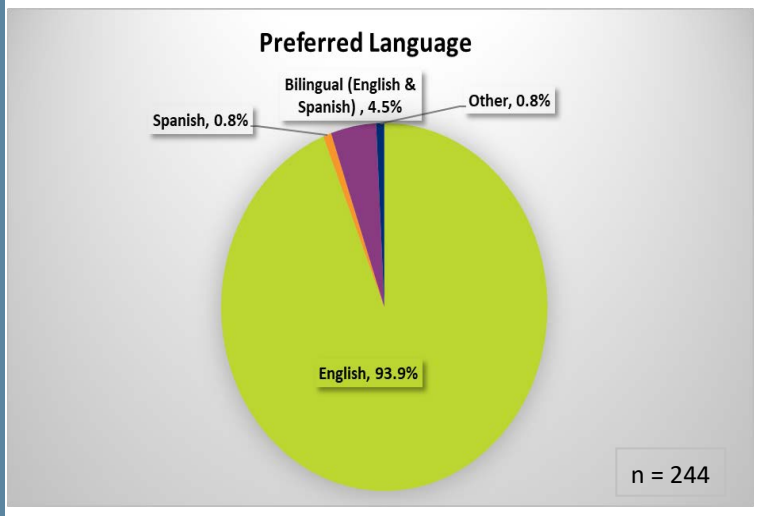
LGBTQI Categories	Percentage
Asexual	0.9%
Bisexual	14.3%
Gay	1.6%
Lesbian	2.5%
Omnisexual	1.2%
Pansexual	4.5%
Total (n = 61):	**25.0%**

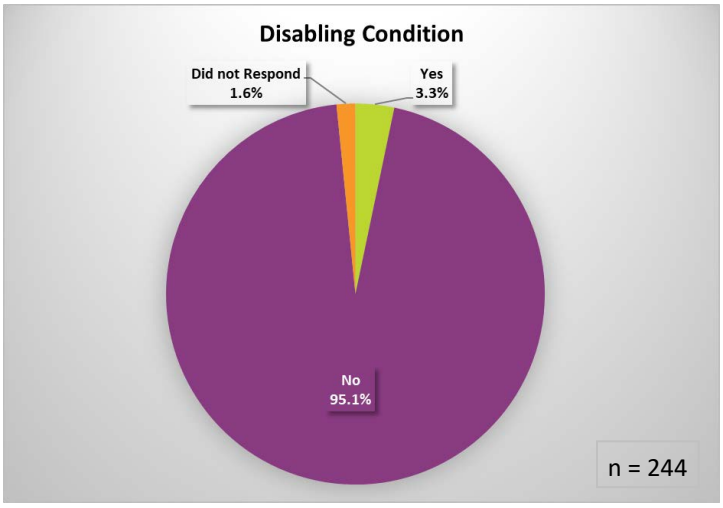
Participants were also asked if any of them identified themselves as LGBTQIA+. Results showed that the majority of participants responded "No" (62.3%, n = 152), while the remaining participants identified themselves as LGBTQIA+ (25%, n = 61), Other (6.6%, n = 16), and Unknown (6.1%, n = 15). Of those who did identify themselves as LGBTQIA+ (n = 61), the majority categorized themselves as Bisexual (14.3%, n = 35), as shown on table above.

Demographics: Residency, Language, Disabling Condition, and Veteran Status



During the fiscal year 2023-2024, the majority of SAYM participants lived in Moreno Valley (29.9%, n = 73), Lake Elsinore (15.2%, n = 37), and Hemet (10.2%, n = 25).

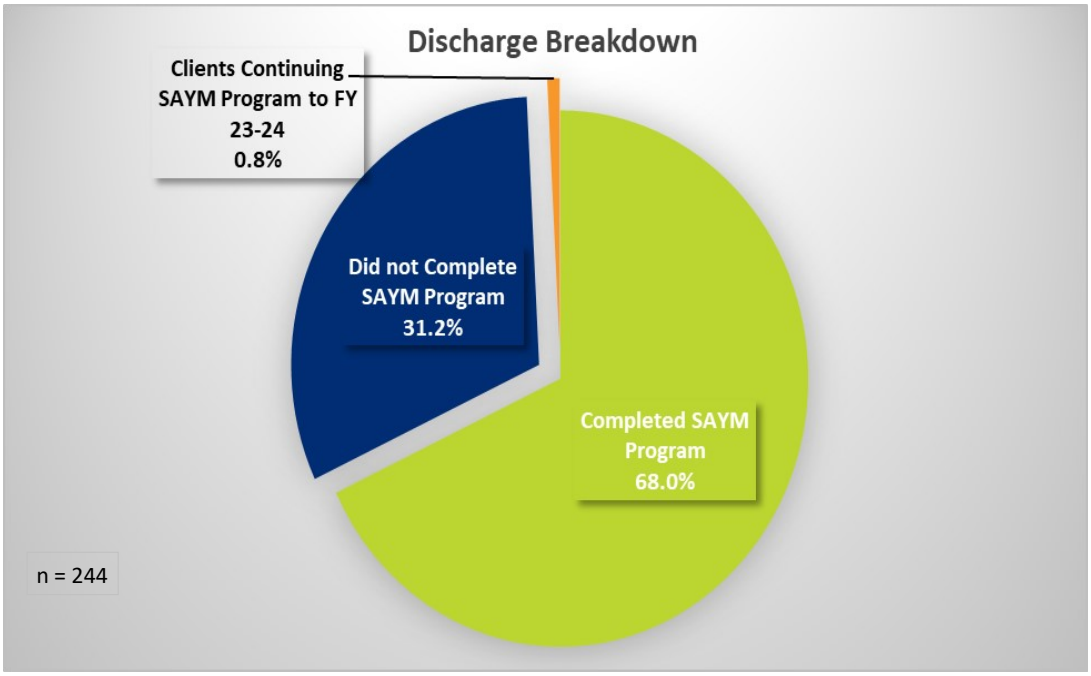




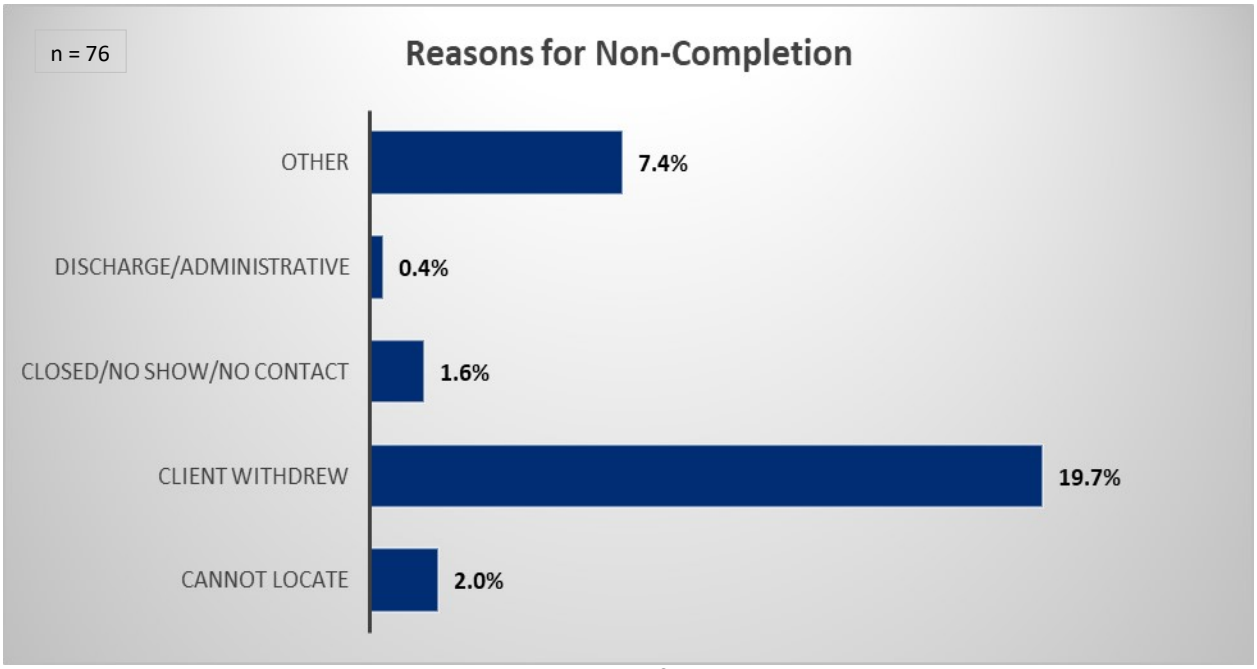
- The majority of SAYM participants responded that their preferred language is English (93.9%, n = 229), followed by Bilingual-English and Spanish (4.5%, n = 11), Spanish (0.8%, n = 2), and Other (0.8%, n = 2) respectively.
- The majority of SAYM participants indicated that they did not have any disabling condition (95.1%, n = 232), while a small percentage of participants responded as having a disabling condition (3.3%, n = 8), and 4 participants (1.6%) chose not to respond. Of the 8 participants who responded as having a disabling condition, 4 specified "ADHD" as the type of disability, while the remaining participants indicated as having Bad Vision, Dyslexia, Learning Disability, and Speech Impairment.
- In regards to veteran status, all SAYM participants (100%) indicated that they were not Veterans.

Service Information: Discharge & Non-Completion

The figure below pertains to the closed cases of SAYM Program in the fiscal year 2023-2024. There were two possible values: (1) *Did Not Complete*, and (2) *Completed*. A total of 166 participants (68%) completed the SAYM Program, while 76 participants (31.2%) did not. Of the total SAYM participants who completed, the majority (66.4%, n = 162) *completed with no further treatment required*, and 4 participants (1.6%) *completed with referral for further treatment*. Additionally, there are also 2 participants (0.8%) who are currently continuing in the FY 2024-2025 SAYM Program.

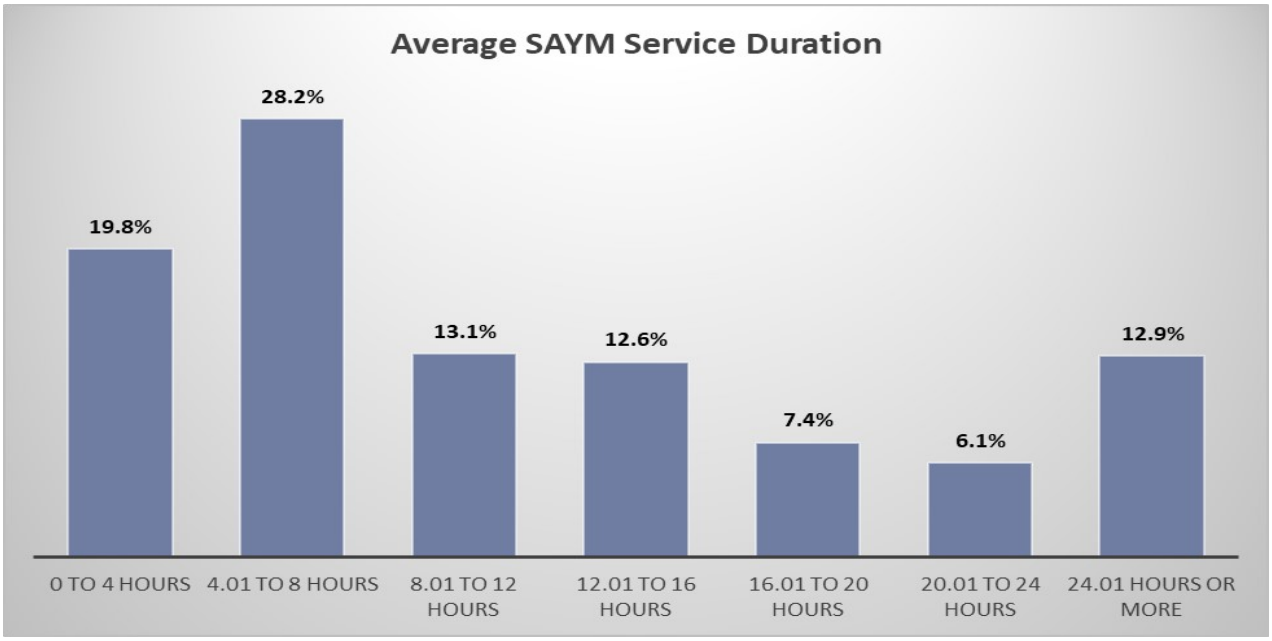


The discharge data on reasons for non-completion are shown in graph below. Overall, there were a total of 76 SAYM participants who did not complete the program during the fiscal year 2023-2024. The majority of participants *chose to withdraw from program* (19.7%, n = 48). There were also smaller percentages of participants who did not complete due to *unable to locate* (2%, n = 5), *no show/no contact* (1.6%, n = 4), or *administrative discharge* (0.4%, n = 1).

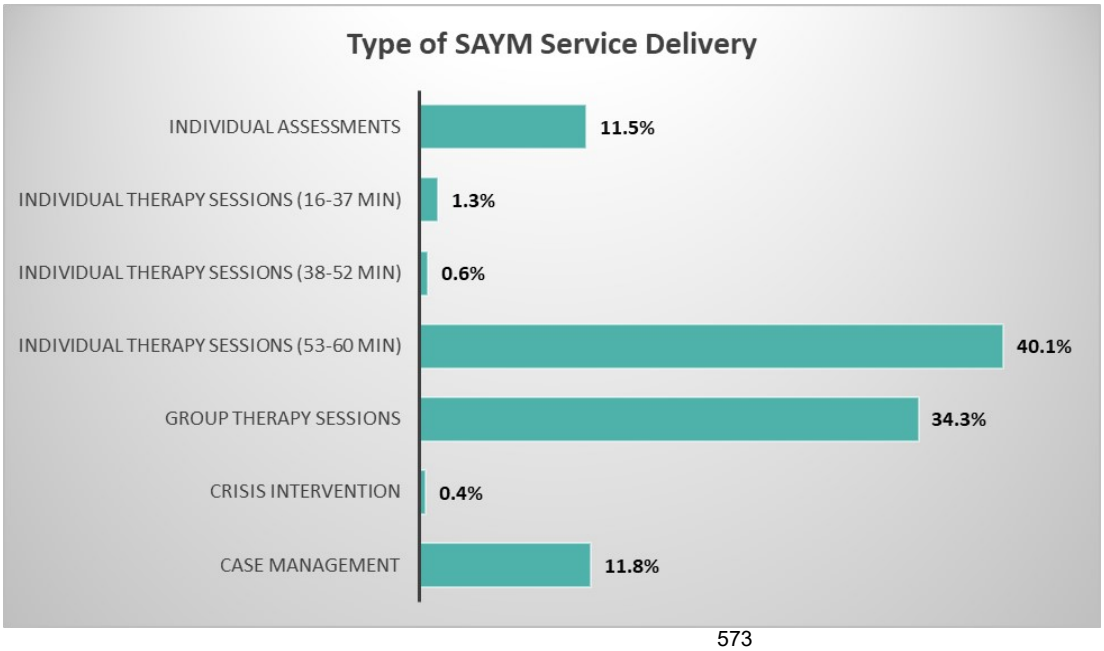


Service Information: Duration and Type of Delivery

Stress and Your Mood Program services can be provided as follows: group sessions, individual sessions, or a combination of both group and individual sessions. The graph below represents the average length of service hours provided for all SAYM participants during fiscal year 2023-2024. The majority of participants received between 4.01 to 8.0 hours of service (28.2%) and between 0 to 4.0 hours of service (19.8%), while the smallest percentage is for 20.01 to 24 hours of service (6.1%).



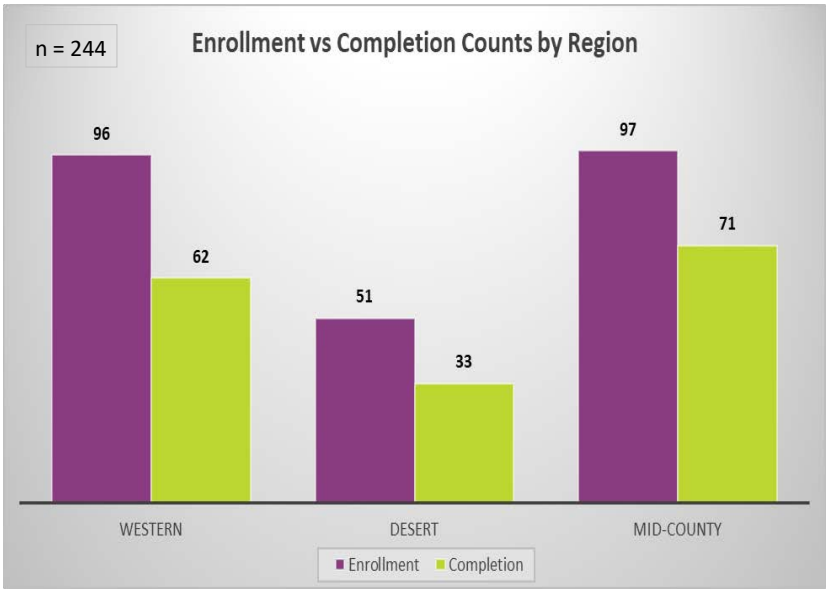
The graph and table below represent the type of SAYM services delivered: Individual Assessments, Individual Therapy Sessions (which have been categorized into different lengths: *16-37 minutes*, *38-52 minutes*, and *53-60 minutes*), Group Therapy Sessions, Crisis Intervention, and Case Management. Overall, the total service time provided during SAYM Program in FY 2023-2024 was **1,448.27** hours. Of these, the majority of service time provided was in *Individual Therapy Sessions* (a combined total of 806.02 hours), followed by *Group Therapy Sessions* (252.50 hours), *Individual Assessments* (203.58 hours), *Case Management* (180.42 hours) and *Crisis Intervention* (5.75 hours), respectively.

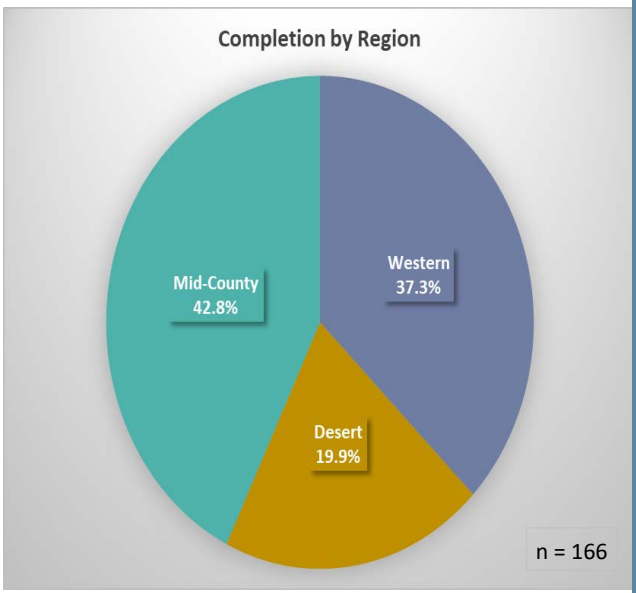


Type of Service Delivery	Total Hours Provided
Individual Assessment	203.58
Group Therapy	252.50
Individual Therapy (16-37 min)	12.27
Individual Therapy (38-52 min)	8.25
Individual Therapy (53-60 min)	785.50
Case Management	180.42
Crisis Intervention	5.75
Total Hours of Service Delivery	1,448.27

Program Completion

The figures below pertain to the total number of participants who completed the SAYM Program during the fiscal year by region.





There were a total of 244 participants enrolled in the Stress and Your Mood Program during the fiscal year 2023-2024. Of these, 166 participants completed the program, and 2 participants are continuing into the fiscal year 2024-2025. The majority of SAYM participants enrolled in the fiscal year 2023-2024 were from the Mid-County region (39.8%, n = 97), followed by the Western region (39.3%, n = 96), and the Desert region (20.9%, n = 51), respectively.

Overall, the completion rate of SAYM Program in FY 2023-2024 is 68% (166 out of 244 enrolled participants). The enrollment and completion counts by regions are summarized below:

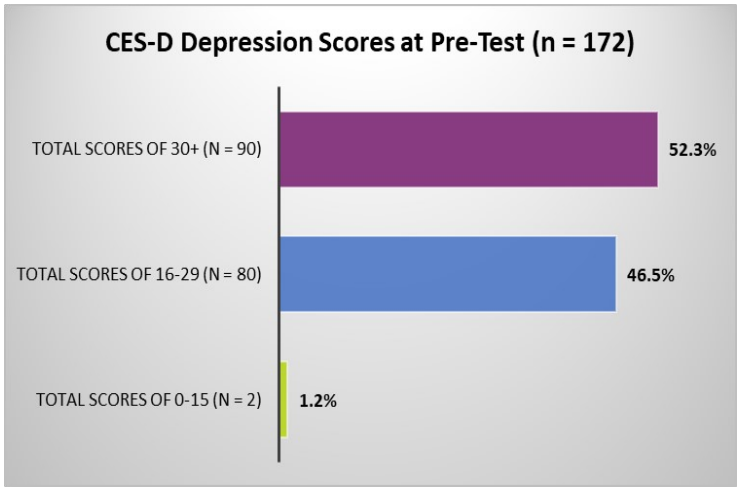
- In Mid-County region, 71 out of 97 participants completed the SAYM Program (42.8%)
- In Western region, 62 out of 96 participants completed SAYM Program (37.3%)
- In Desert region, 33 out of 51 participants completed SAYM Program (19.9%)

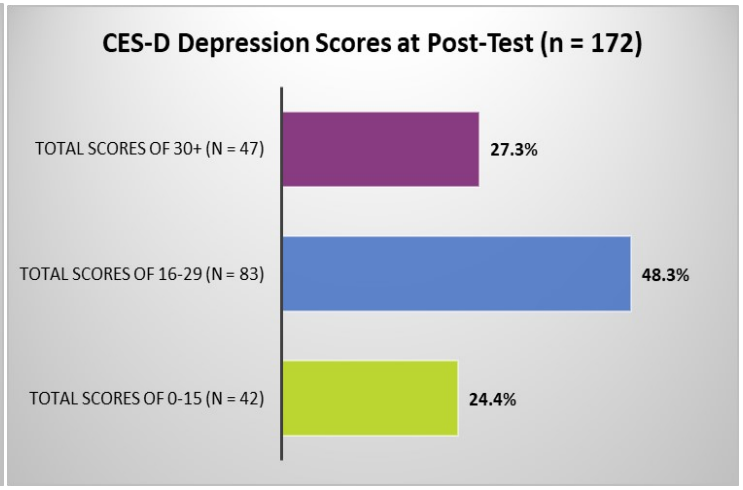
The table below displays the SAYM Program contract expectations, as well as the completion results (n = 166) during the fiscal year. Overall, there was a decrease in the enrollment of SAYM Program in comparison to FY 2022-2023 (from 274 enrolled participants enrolled in FY 22-23 to 244 enrolled participants in FY 23-24). In terms of contract expectation and percent completion, only Mid-County region exceeded the contract expectation in FY 2023-2024 (101.4%). Both Western region (88.6%) and Desert region (47.1%) did not meet their contract expectations in FY 2023-2024. Cumulatively within all regions of Riverside County, SAYM Program had an overall 79% contract completion rate.

SAYM Program Completions (N = 166)			
Source:	**Completed**	**Contract Expectations**	**Percent Completed**
Mid-County	**71**	**70**	**101.4%**
Western	**62**	**70**	**88.6%**
Desert	**33**	**70**	**47.1%**
Countywide	**166**	**210**	**79%**

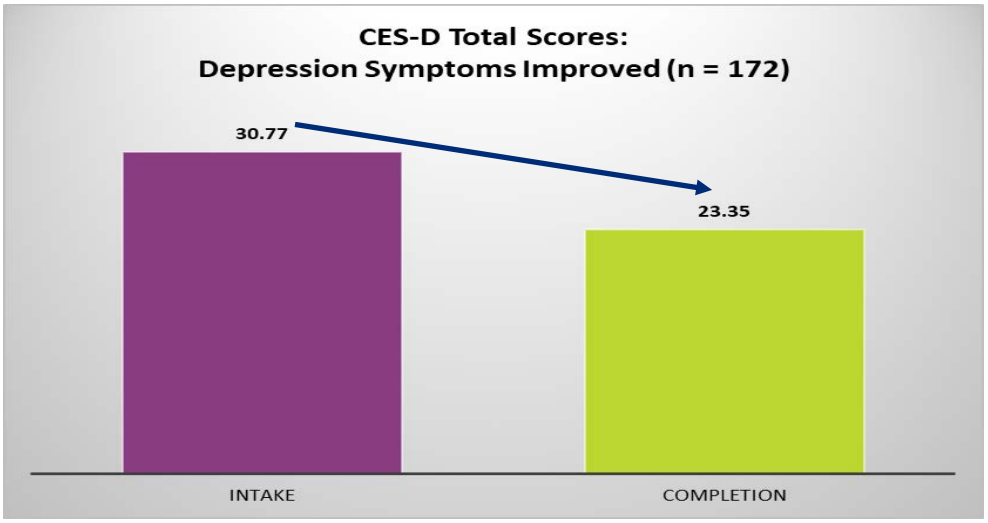
CES-D Scale: Pre to Post Analysis

The **Centers for Epidemiological Studies Depression (CES-D) Scale** is a measure of depression that assesses various depression symptoms experienced by participants during the SAYM Program. Responses are organized in a Likert-scale, where participants were asked to report a typical frequency in which a particular symptom occurs throughout the duration of the SAYM Program. Higher total scores could indicate a higher level of distress. Additionally, a score of 16 or more suggests a clinically significant level of psychological distress, although it does not necessarily mean that the participant has a clinical diagnosis of depression. The total of CES-D scores can range from 0 to 60, with higher scores indicating higher level of distress on the participants.





The graphs above represent the CES-D scores comparison from pre– to post-intervention, and only included participants who had completed both pre-tests and post-tests. A total of 172 participants had matched CES-D pre-and post-measures. Results from pre-tests indicated that there were 2 participants (1.2%) who had scored below 16 points, while the majority scored above 30 points (52.3%, n = 90), followed by those with scores between 16 and 29 points (46.5%). Results from post-tests showed improvements in CES-D scores. Participants who scored below 16 points had increased to 42 participants (24.4%), participants who scored between 16 and 29 points had increased to 83 (48.3%), and participants who scored 30 points or more de-creased to 47 (27.3%). These results suggest that overall, the SAYM Program had greatly helped participants to decrease their depression symptoms.



Further analysis using paired samples t-test is reflected on the graph above. Overall, results showed that on average, participants' depression symptoms improved after participating in the SAYM Program. The decrease in average CES-D scores at post-tests are also shown to be 7.42 points lower than the pre-tests, and based on the analysis, this change was shown to be statistically significant, $t = 9.511$, df = 171, p = .000.

CES-D Scale: Item-by-Item Analysis

The CES-D is a robust test that measures many aspects related to depression, and the table below shows an item-by-item analysis of the CES-D measures. The matched pairs t-test results indicated the improvements on every facet of CES-D criteria, and except for 1 item ("You felt that everything you did was an effort"), all other items showed to be statistically significant ($p < .05$). CES-D results on table below also illustrates the success ***and*** the improvements of the SAYM program across all depression statements, which suggest that the SAYM program has helped participants to significantly decrease their symptoms of depressions.

CES-D Item	Average Decrease	*t*	df	p
You were bothered by things that usually don't bother you	-0.33	4.235	171	.000
You did not feel like eating; your appetite was poor	-0.27	2.963	171	.003
You felt that you could not shake off the blues even with help from your family or friends	-0.43	4.761	171	.000
You felt that you were just as good as other people	-0.41	4.410	171	.000
You had trouble keeping your mind on what you were doing	-0.48	6.113	171	.000
You felt depressed	-0.46	5.892	171	.000
You felt that everything you did was an effort	-0.12	1.358	171	.176
You felt hopeful about the future	-0.27	3.173	171	.002
You thought your life had been a failure	-0.57	6.133	171	.000
You felt fearful	-0.39	4.690	171	.000
Your sleep was restless	-0.28	3.063	171	.003
You were happy	-0.27	3.245	171	.001
You talked less than usual	-0.40	4.485	171	.000
You felt lonely	-0.55	6.279	171	.000
People were unfriendly	-0.19	2.549	171	.012
You enjoyed life	-0.15	2.137	171	.034
You had crying spells	-0.28	3.379	171	.001
You felt sad	-0.53	6.823	171	.000
You felt that people disliked you	-0.45	4.812	171	.000
You could not "get going"	-0.59	7.091	171	.000

Clinical Global Impression—Improvement Scale

The Clinical Global Impression Improvement (CGI-I) Scale measures the clinician's assessment of how much the participant's symptoms have improved or worsened compared to the baseline measurement at the beginning of the intervention.

The CGI-I scale is used to track the progress of participants across three periods of the SAYM intervention:
1. Module 1 Intervention
2. Module 2 Intervention
3. Post Intervention

Clinicians rate total improvement in overall depressive symptomatology since initial enrollment. Total scores ranging from **1** (***very much improved***) to **7** (***very much worse***) measure the participants' improvement or de-crease in their overall depressive symptomatology since enrollment.

The following are descriptions of the scores participants can receive on the CGI-I scale.
CGI-I Rating Levels:

1) *Very Much Improved* - All or most of the target symptoms have been improved to a significant degree. Changes have a major and discernible impact on functioning, both subjectively and as observed by others. Clinicians are comfortable administering a simple maintenance treatment regiment, where there is little or no room for further improvement. Does not meet criteria for psychiatric disorder.

2) *Much Improved* - Several symptoms have improved to a degree that the participant feels an important change has occurred. The change is large enough that it's distinctly noticeable by others; however, there is still some room for improvement. Does not meet criteria for psychiatric disorder.

3) *Minimally Improved* - Only 1 or 2 symptoms (at most) show improvement, and the degree of change is not sufficient. Improvements may not be consistent across informants or domains of functioning. Thus, there is considerable room for improvement, clearly requiring further therapeutic adjustments. Possibly meets criteria for psychiatric disorder.

4) *No Change* - No symptoms are showing improvement compared to the baseline state, or changes are so minimal as to be completely inconsequential. Meets criteria for psychiatric disorder.

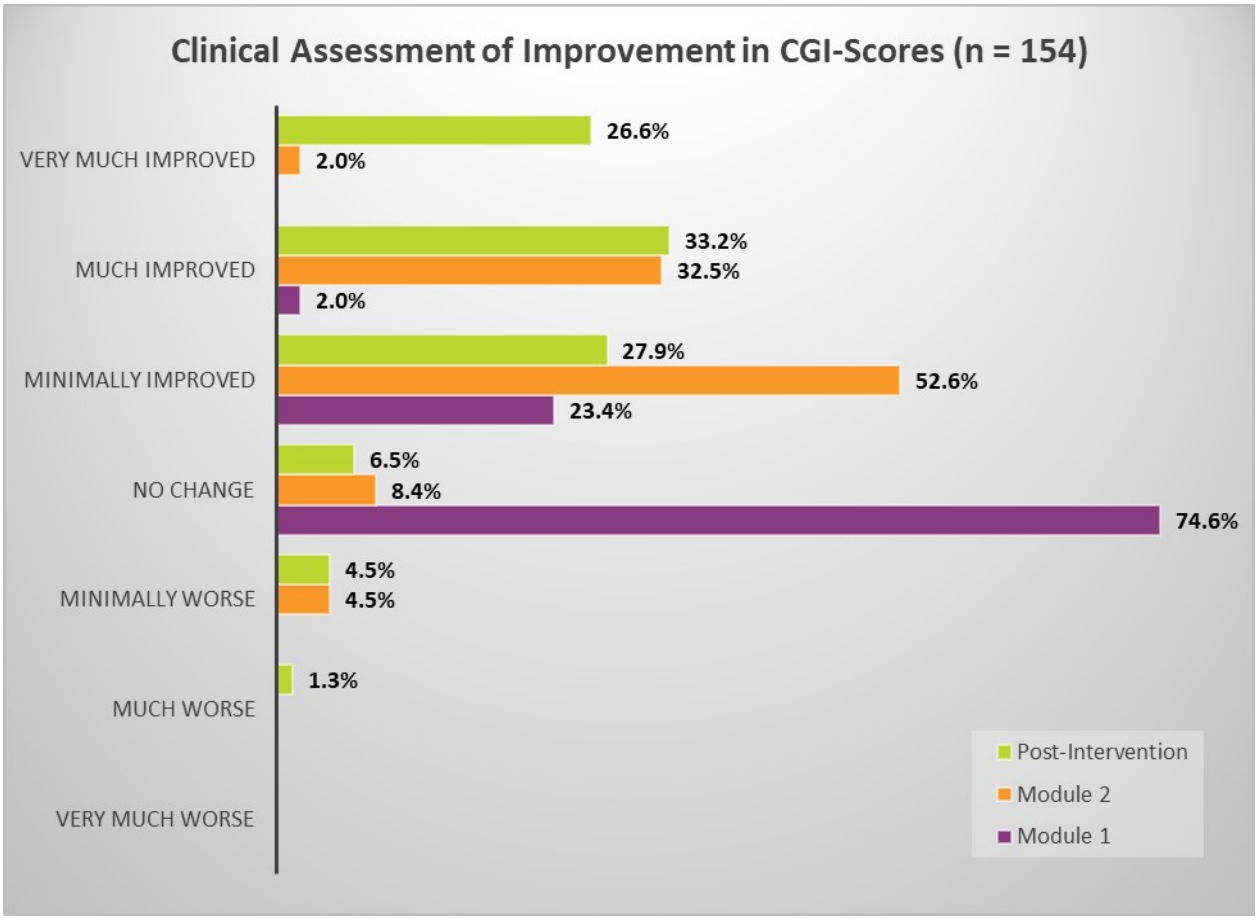
5) *Minimally Worse* - There is some worsening over the baseline state in the target symptoms, though not to a degree that one would wish to completely stop treatment. Nevertheless, changes in treatments need to be considered. Meets criteria for psychiatric disorder.

6) *Much Worse* - Participants condition is worse enough that stopping or changing treatment should be heavily considered, even though not all target symptoms are worse. Worsened condition is clearly discernible by the youth and other observers. Meets criteria for psychiatric disorder.

7) ***Very Much Worse*** - Most target symptoms are worse, where stopping, changing and/or adding new treatments is clearly apparent. Meets criteria for psychiatric disorder.

CGI-I Clinical Assessments: Pre to Post Intervention

Clinician ratings across each of the three time periods (i.e. *Pre-Intervention or Module 1*, *Module 2*, and *Post-Intervention*) are shown on the graph below. CGI-I scores were provided for the 154 participants who had a rating for all three time periods. Overall, there are notable improvements from Pre-Intervention/Module 1 to Post-Intervention. The graph below is structured so that the top bar represents positive outcomes and the bottom portions represent negative outcomes, showing 3 different modules: Pre-Intervention/Module 1, Module 2, and Post-Intervention.



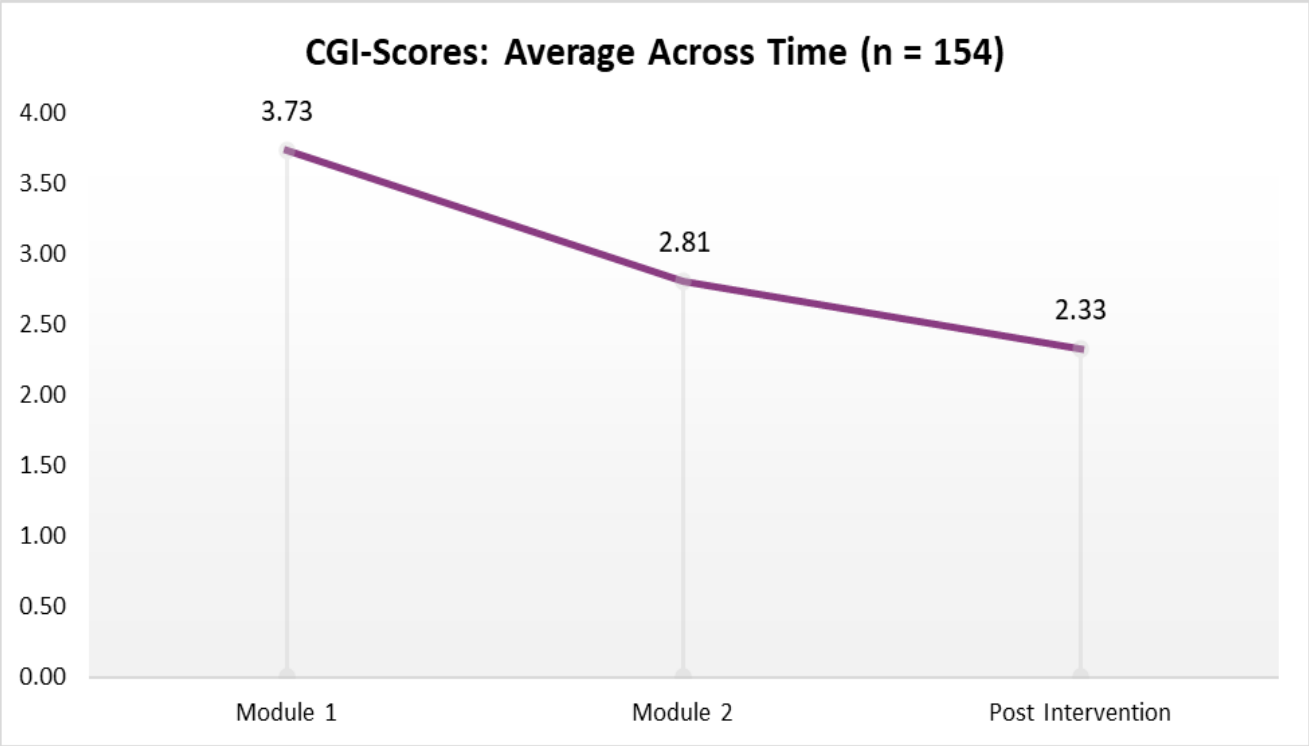
At the conclusion of Module 1, a total of 23.4% of SAYM participants were recorded as "Minimally Improved" and 1.9% of participants were recorded as "Much Improved"(25.3% combined), while 74.7% showed "No Change" on their symptoms.

After Module 2 completion, the improvements were much higher, where a total of 52.6% of SAYM participants were "Minimally Improved", 32.5% "Much Improved", and 1.9% "Very Much Improved" (87% combined). Additionally, there were only 8.4% of participants recorded as"No Change" and 4.5% recorded as "Minimally Worse" on their symptoms.

After SAYM completion, at the conclusion of Module 3, participants showed significant improvements. There were a total of 87.7% participants with improved symptoms in some capacity, in which a large portion of 33.1% were "Much Improved", 26.6% "Very Much Improved", and 27.9% "Minimally Improved". There were only 6.5% participants with "No Change", 4.5% participants were"Minimally Worse", and a small percentage 1.3% were" Much Worse" symptoms. Further analysis on the CGI-I scores are shown on the following page.

CGI-I Results: Pre to Post Analysis

The following graph reflects the change in scores from Pre-Intervention (Module 1) to Post-Intervention (Module 3). Lower scores represent lower Depression Symptomology in 183 participants who completed all three modules. These scores significantly improved as recorded by clinicians, from pre-intervention (3.44) to post-intervention (2.07).



CGI-I Scores Measurement: T-Test Pre to Post					
Interval	**Pairs**	**1st Level**	**2nd Level**	**Difference**	**Significance**
Module 1 (Pre) to Module 2 (Mid)	**154**	**3.73**	**2.81**	**-0.92**	**.000**
Module 2 (Mid) to Module 3 (Post)	**154**	**2.81**	**2.33**	**-0.48**	**.000**
Module 1 (Pre) to Module 3 (Post)	**154**	**3.73**	**2.33**	**-1.4**	**.000**

Further comparison analysis using the paired-samples t-tests indicated that there were more improvement in participants' psychiatric symptoms from Module 1- to Module 2-Interventions with a difference of 0.92 points (t = 16.132, df = 153, p = .000), compared to Module 2 to Post-Interventions with a difference of 0.48 points (t = 0.661, df = 153, p = .000), with a difference of 0.44 point.

Both results also showed statistical significance across all modules, which suggests that the SAYM Program did help to reduce participants' depression symptoms to "Much Improved" (based on the clinicians' assessments across all modules shown on previous page). Additionally, the highest significant improvements were shown from Module 1 to Post-Interventions, with a difference of 1.4 points (t = 15.198, df = 153, p = .000), which suggests that participants would benefit the most significant decrease in their symptoms if they were to complete the entire SAYM Program, as noted on table above.

Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR)

The Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR) is a measure of a wide range of behaviors, situations, and moods which commonly apply to youth. Five sub-scales analysis are included in the Y-OQ®-SR that were used in the SAYM Program, which measures behavioral problems as well as elements of healthy behaviors:

- ***Intrapersonal Distress***
- ***Somatic***
- ***Interpersonal Relations***
- ***Social Problems***
- ***Behavioral Dysfunction***

Each subscale on the Y-OQ®-SR questionnaire is a summation of selected items as shown on table below, and the total score reflected on the Y-OQ®-SR questionnaire is the summation of items from each sub-scale and is designed to reflect the total amount of distress a child or adolescent is experiencing.

Y-OQ®-SR Scales and Item Numbers

Scales Measured in Y-OQ®-SR Questionnaire	Item Numbers
Interpersonal Distress	1,3,5,9,15,17,25,32,33,34,41,49,53,57,61,62,63,64
Somatic	2,10,18,26,35,42,50,54
Interpersonal Relations	4,7,11,16,20,24,27,36,37,43
Social Problems	6,13,22,29,31,39,47,55
Behavioral Dysfunctions	8,14,23,30,40,45,48,52,56,59,60

General Uses/Advantages-YOQ

- Risk assessment. High scores on critical items scales indicate those who may need an immediate intervention beyond standard outpatient treatment.
- Subscale scores can be used to identify and target particularly problematic areas such as a focus of treatment and cues on treatment planning.
- Overall change can be tracked from total scores, and specific symptoms or behaviors can be tracked using subscale scores.
- The Self Report Youth-Outcome Questionnaire (Y-OQ®-SR) can be used to track participant's therapeutic progress.

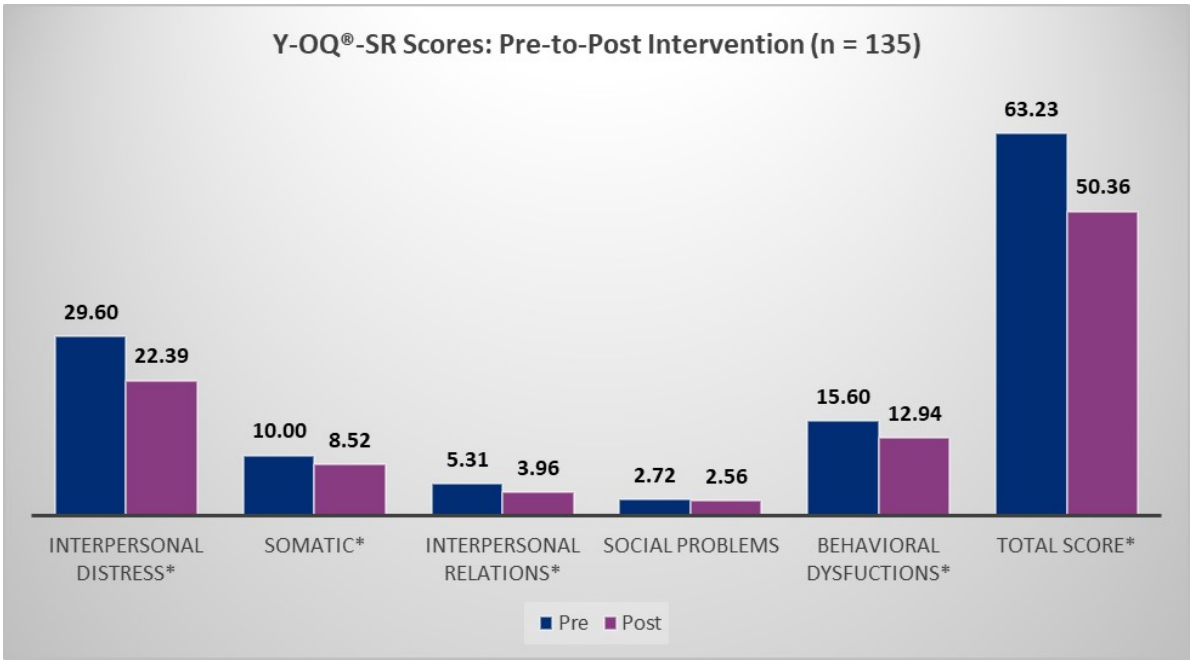
Guidelines for Clinical Interpretation

The Y-OQ®-SR total score quantifies overall level of disturbance. A total score of 46 or higher is considered within the clinical or dysfunctional range, while a total score under 46 is considered to be normal or within the non-clinical range. The satisfactory change index for the Y-OQ®-SR is 13 points, which means that the participants must report a minimum change of 13 points in their ***total score*** from pre- to post- measures in order for that change to be considered clinically significant.

Y-OQ®-SR: Pre to Post Analysis

The table below shows the average decrease on all subscales measured in the Y-OQ®-SR analysis from pre– to post intervention. There were a total of 135 participants between the ages of 15 to 17 years of age, who completed both pre and post measures. Overall, participants' average scores showed statistically significant decreases across all subscales. The average total scores also decreased significantly by 12.87 points, which is slightly less than the YOQ satisfactory change index of 13 points. This indicates that the average improvements were slightly below clinically significant. In the table, an asterisk indicates significant changes within that particular scale. All scales except "Social Problems" scale, were shown to be statistically significant.

Y-OQ®-SR Scales	Average Score Decrease	*t*	df	p
Interpersonal Distress*	-7.21	7.732	134	.000
Somatic*	-1.48	4.032	134	.000
Interpersonal Relations*	-1.36	3.336	134	.001
Social Problems	-0.16	0.594	134	.553
Behavioral Dysfuctions*	-2.66	5.315	134	.000
Total Score*	**-12.87**	**7.028**	**134**	**.000**



Average pre to post Y-OQ®-SR scores for the SAYM Program were analyzed with paired samples t-tests from 135 participants. Based on the statistical analysis, all post-test scales showed statistically significant changes from pre-test scores (p = .000), except for "Social Problems" scale. The total scores represent the summation of all items in the survey, and the rest of the sub-scales are sums of selected questions within the survey. Overall, the decreases in the total score signifies that there were reductions in the general level of distress. The total scores also showed a statistically significant decrease from pre-test (63.23) to post-tests (50.36), *t* = 7.028, df = 134, p = .000. Although all the scores showed statistically significant decreases from pre– to post measures, participants on average are still considered within the clinical or dysfunctional range after the SAYM Program completion (i.e. the average total scores are still shown as higher than 46 points). This result is consistent with the result of CES-D analysis on page 10, which suggests that participants were significantly depressed prior to starting the SAYM Program, and also suggests that by completing the SAYM program, participants have actually shown improvement in their depression symptoms and general mental health functioning.

BASIS-24® Scale

The BASIS-24® scale is a twenty-four item self-report questionnaire designed to assess treatment outcomes by measuring symptoms and functional difficulties. Scores can be computed for the overall BASIS-24®, as well as for the following six scales:

- ***Depression and Functioning***
- ***Interpersonal Relationships***
- ***Psychosis***
- ***Substance Abuse***
- ***Emotionally Labile***
- ***Self-Harm***

BASIS-24® Scales and Item Numbers

Scales Measured in BASIS-24® Questionnaire	Item Numbers
Depression and Functioning	1,2,3,9,10,12
Interpersonal Relationships	4,5,6,7,8
Psychosis	14,15,16,17
Substance Abuse	21,22,23,24
Emotionally Labile	13,18,19
Self-Harm	11,20

Outcomes evaluation of SAYM Program included a general measure of functioning for Adults 18 to 25 years of age. Participants were asked to take the BASIS-24® tests before starting the SAYM Program and after program completion (i.e. pre- and post-interventions).

BASIS-24® questions are scored on a 5-point Likert scale (i.e. score values from 0 to 4) reflecting either a spectrum of difficulty with the behavior in question or the frequency with which someone engages in a particular behavior.

Difficulty spectrum of responses: (*e.g. difficulty sleeping, coping with life problems*)
0 = “no difficulty”
1 = “a little difficulty”
2 = “moderate difficulty”
3 = “quite a bit of difficulty”
4 = “extreme difficulty”

Frequency spectrum of responses: (*e.g. feeling confident in yourself, feeling sad/depressed*)
0 = “none of the time”
1 = “a little of the time”
2 = “half of the time”
3 = “most of the time”
4 = “all of the time”

Lower scores indicate more normative, non-clinical aspects of general mental health functioning, while higher scores indicate greater symptomatology. The average intake scores for all SAYM participants on the BASIS-24® tests on both the subscales and total scores are shown on the table and graph on the following two pages.

BASIS-24® Subscales and Results

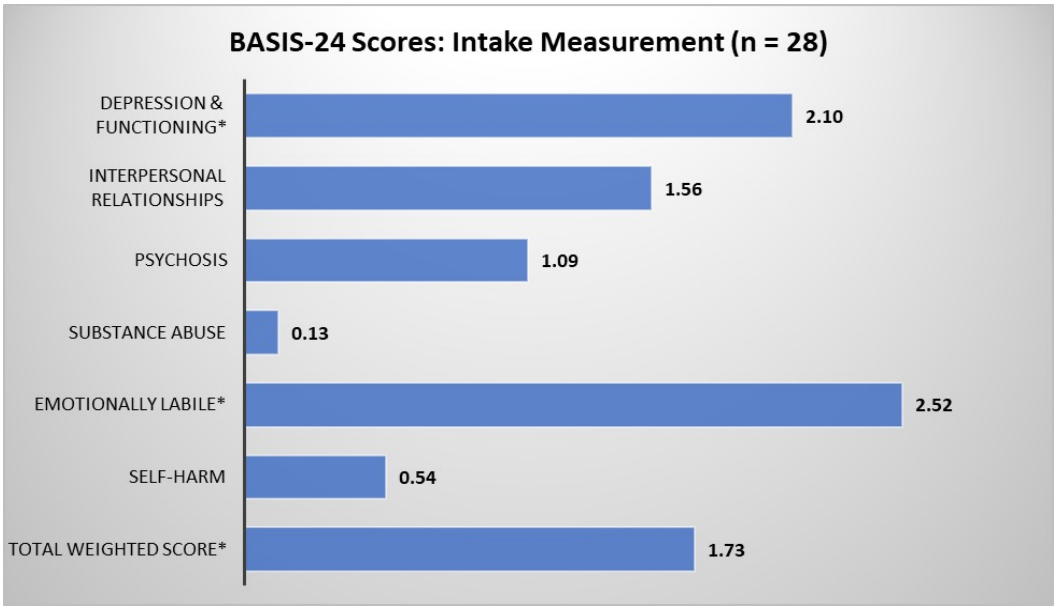
There are a total of 28 participants between the ages of 18 to 25 years old who completed the BASIS-24® during intake. Overall, participants showed low scores for "Psychosis", "Substance Abuse", and "Self-Harm" subscales. Given that SAYM is designed for Early Intervention for depression, the low scores in these subscales showed that the population served matches the intended target population. Based on analysis at intake, the following subscales presented difficulties to participants:

Depression and Functioning Scale: 2.10

Participants are experiencing some difficulty in their functioning due to depressive symptomatology.

Emotionally Labile: 2.52

The average participant is experiencing excessive emotional reactions and frequent mood changes on a periodical basis, indicating that participants are experiencing some debilitation by not being able to control their emotions.



The table below shows the results of only the participants ages 18 to 25 years of age who had matched pre– and post measures. There were a total of 12 participants who completed and were included in the analysis. Since the sample size is relatively small, it may be challenging to make a solid conclusion based on these results. With a low number of participants for this analysis, it is not typical to do statistical tests. Generally, the differences in the average scores on all subscales and total weighted score from pre-tests to post-tests showed decreases. The most decreases were shown on the *Depression and Functioning Scale* (0.86 points) and *Emotionally Labile Scale* (0.56 points). Despite the low sample size, considering these 2 sales were shown to have the highest scores at intake, it is still worthwhile to note that the improvements at post-measures are also shown on these 2 scales, which suggests that SAYM Program helped participants to decrease their Depression and Emotional Distress.

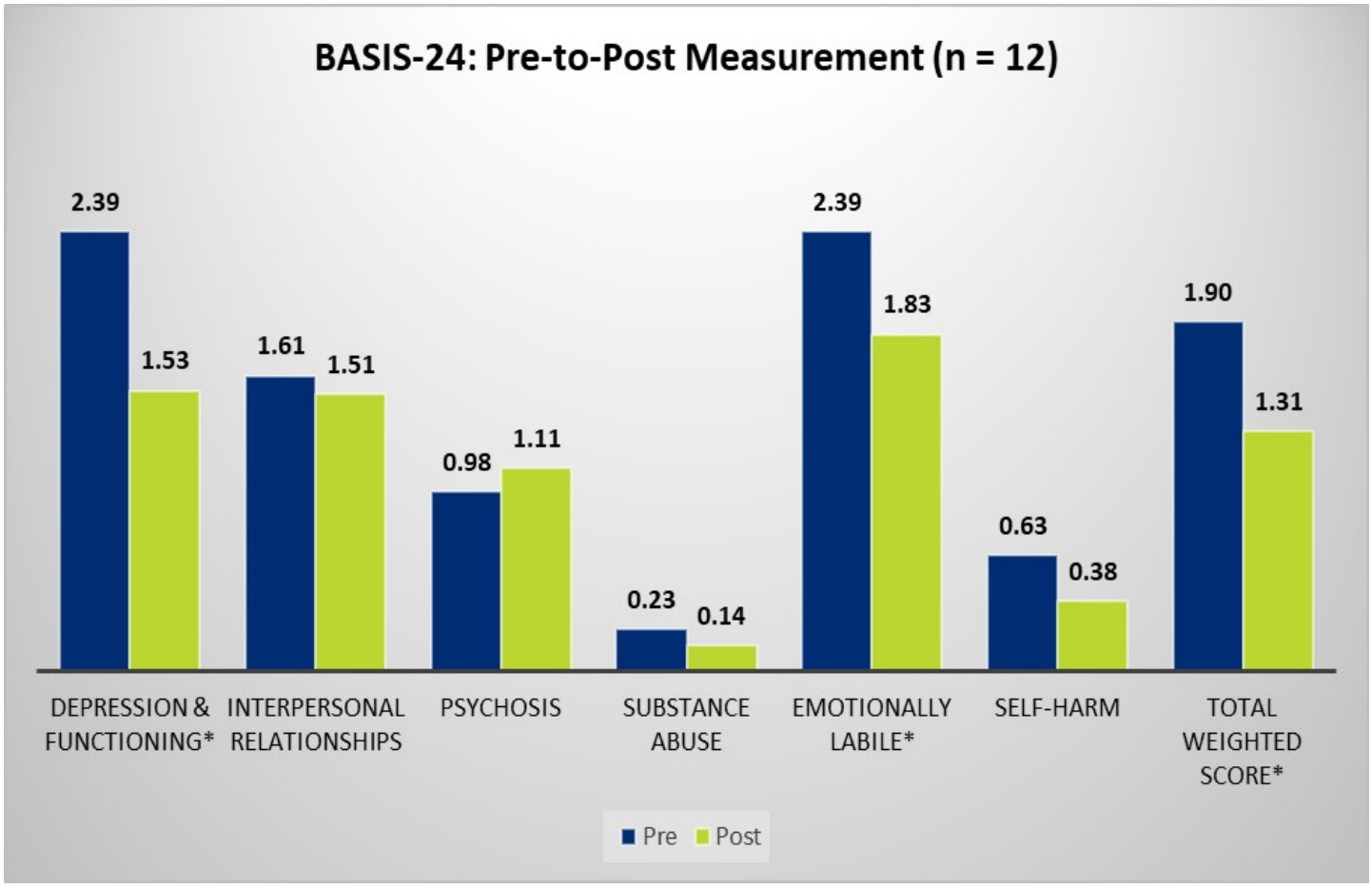
BASIS-24 Scales	Pre-Post Score Difference
Depression & Functioning*	-0.86
Interpersonal Relationships	-0.10
Psychosis	0.13
Substance Abuse	-0.09
Emotionally Labile*	-0.56
Self-Harm	-0.25
Total Weighted Score*	-0.59

BASIS-24® Pre-to Post– Analysis

The graph below shows how SAYM participants who are over 18 years of age before and after the SAYM Program. There were a total of 12 SAYM participants between the ages of 18 to 25 years old who completed both pre– and post-BASIS-24® measures. Overall, there are decreases across all subscales except Psychosis which was very low at intake. Furthermore, participants had relatively low or zero scores for the following subscales: "Substance Abuse" and "Self-Harm" at intake. These symptoms were not reported to be a significant issue for those served.

Since there were only 12 participants who completed and had matched pairs of BASIS-24® measures, the statistical significance test was not possible. Overall, results showed decreases across all subscales, although they were only 0.9 points or lower. However, this does not mean that the SAYM Program did not help the participants, and conclusions should not be made based on the results due to the small sample size. It should also be noted that the analysis was only based on the participants who are over 18 years of age. The overall "Total Weighted Scores" across subscales are also low at intake, and shown as deceased at post-measures (0.59 points).

In sum, these subscales are useful in understanding SAYM participants' other areas of mental functioning. decreases are seen across most subscales and the total score.



Post-Satisfaction Surveys

The Post-Satisfaction Surveys for the Stress and Your Mood Program were collected from participants at the conclusion of the program's services. Participants were asked to rate nine satisfaction survey items on a five-point Likert scale, where: ***1*** *= Strongly Disagree,* ***2*** *= Disagree,* ***3*** *= Neutral,* ***4*** *= Agree, and* ***5*** *= Strongly Agree*. A total of 169 SAYM participants completed the post-satisfaction surveys during the fiscal year 2023-2024, The post-satisfaction survey results are shown on table below, with a corresponding graph that illustrated the survey results shown on the next page.

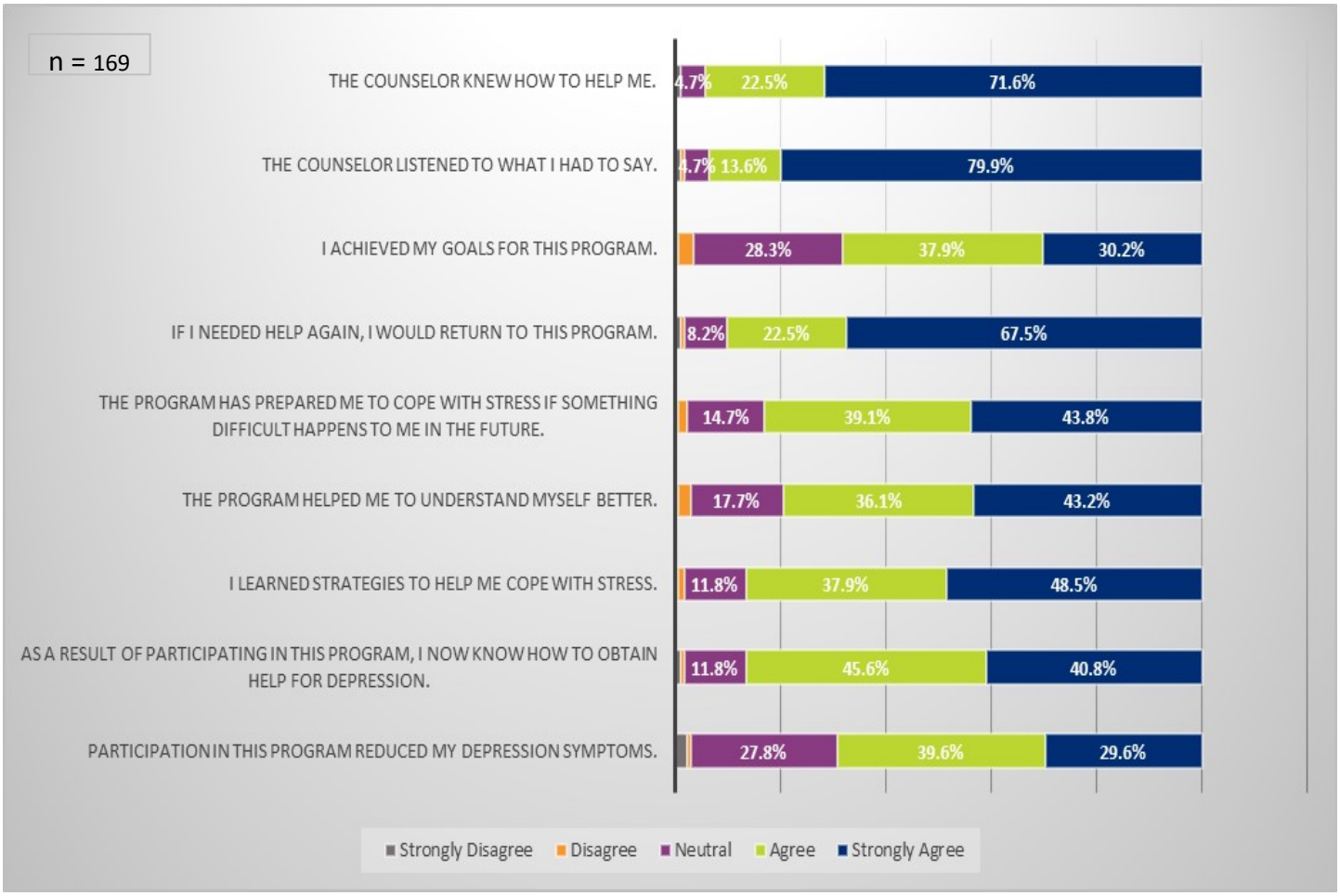
Post-Satisfaction Survey Results

Item No.	Countywide (n = 169)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Participation in this program reduced my depression symptoms.	2.4%	0.6%	27.8%	**39.6%**	**29.6%**
2	As a result of participating in this program, I now know how to obtain help for depression.	1.2%	0.6%	11.8%	**45.6%**	**40.8%**
3	I learned strategies to help me cope with stress.	0.6%	1.2%	11.8%	**37.9%**	**48.5%**
4	The program helped me to understand myself better.	0.6%	2.4%	17.7%	**36.1%**	**43.2%**
5	The program has prepared me to cope with stress if something difficult happens to me in the future.	0.6%	1.8%	14.7%	**39.1%**	**43.8%**
6	If I needed help again, I would return to this program.	1.2%	0.6%	8.2%	**22.5%**	**67.5%**
7	I achieved my goals for this program.	0.6%	3.0%	28.3%	**37.9%**	**30.2%**
8	The counselor listened to what I had to say.	1.2%	0.6%	4.7%	**13.6%**	**79.9%**
9	The counselor knew how to help me.	1.2%		4.7%	**22.5%**	**71.6%**

The SAYM post-satisfaction survey results are summarized below:

- **69.2%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program reduced their depression symptoms, while **27.8%** of participants felt "Neutral" about this statement.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they know how to obtain help after completing the SAYM Program.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they learned strategies in the SAYM Program to help them with coping with stress.
- **79.3%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program has helped to understand themselves better.
- **82.9%** of participants "Agreed" or "Strongly Agreed" that the SAYM program helped them to cope with stress if something difficult happens in the future.
- **90%** of participants "Agreed" or "Strongly Agreed" that they would return to the SAYM Program if they felt that they needed help.
- **68.1%** of participants "Agreed" or "Strongly Agreed" that they achieved their goals after participating in the SAYM Program, while **28.3%** of participants felt "Neutral" about this statement.
- **93.5%** of participants "Agreed" or "Strongly Agreed" that the counselors listened to what they had to say.
- **94.1%** of participants "Agreed" or "Strongly Agreed" that the counselors knew how to help them.

Post-Satisfaction Survey Results



As illustrated on the previous table, the general responses to the SAYM Program are overwhelmingly positive, with more than 79% of participants either "*Agreed*" or "*Strongly Agreed*" to most of the statements on the post-satisfaction surveys, except for the following:

- "Participation in this program reduced my depression symptoms" (where 69.2% responded *Agreed or Strongly Agreed,* and 27.8% still felt *Neutral* about this statement).
- "I achieved my goals for this program" (where 68.1% responded *Agree or Strongly Agreed*, and 28.3% still felt *Neutral* about this statement).

Additionally, more than 93% of participants responded that they either "*Agreed*" or "*Strongly Agreed*" in regards to statements about their counselors:

- "The counselor listened to what I had to say."
- "The counselor knew how to help me."

Post-Satisfaction Survey Comments

Youth satisfaction surveys included additional spaces for write-in comments. SAYM Participants were asked to comment on aspects of the program they liked, did not like, and what they learned from the program. Most of their comments are detailed below and on the next three pages.

1. Things I learned in the program are...

"Attending this group I've learned many things. Having self love, focusing on my mental health, being open minded, and keeping in mind that it's okay to cry and bounce back."
"How to communicate my emotions cope with situation."
"New ways to cope with anger towards someone."
"Want to cope with stress and want to stop having negative thoughts."
"Something I learned from this program is what causes my moods and how to cope with stress."
"I learned if my mind is racing to write my thoughts down."
"How to get help if I think about hurting myself or others."
"To not be afraid to reach out for guidance for mental health."
"I learned how to not to self sabotage."
"I learned many ways to cope with stress, how to help others, and really just understand myself better."
"How to cope with my feelings as well as understanding myself."
"That I'm not alone and I can always talk about my problems with someone."
"How to help myself get through life easier."
"That I'm not alone and I can do this."
"How to identify and manage positive self-disclosures or negative ones, and stopping cognitive disclosures."
"I learned to finally speak about my feelings and to not bottle everything up."
"How to cope with my emotion."
"How to cope with stress and ways to be more confident."
"I learned how to cope with my emotions and learned about ones people experiences."
"Healthy coping skill for careful situations, how/who to reach out If I need help with mental issues."
"I learned ways to cope with sad emotions I also learned different ways people's mind works."
"Exercise on how to control yourself methods on mental health."
"How to ask for help, cope with stress, way to distress myself."
"How to cope with negative and positive thoughts breathing techniques."
"How to deal with my stress and any irrational thoughts."
"How to communicate better, be more understanding with how others feel."
"I learned how to focus on myself, and how to distress."
"I learned I'm not alone and always have someone."
"How to understand myself and others when going through situations."
"I learned about mental illness and staying in a moment to calm down. Using coping skills I learned in the program."
"How to communicate not to depend on people to change, how to cope, spend time with friends."
"I learned ways to control my anger on the spot."
"Ways to cope with negative thoughts as well as doing activities to improve myself."
"Thinking more positively, social speaking/sharing and coping strategies."
"The point of realization about my problems, ways to know what the problem is and some how reflect on it."
"Thanks to the counselor I was able to relax and be able to control my emotions, actions, and feeling."
"How to deal with thoughts how actions can change my thoughts and emotion; and that it's okay to reach out for help."
"Finding ways to cope with myself, reflect on my actions, helped me set a goal for myself."

1. Things I learned in the program are… (continued)

"I learned how to be more aware of my emotions and to deal with them more."
"How to deal with negative thoughts and how to get over them."
"How to love myself and appreciate life."
"How to cope with boredom, stress and feeling alone"
"How to manage my thoughts and knowing it's okay to feel a certain way that it's not always wrong to say or do."
"What I learned in the program is how to take care of ourselves physically and mentally. Breathing techniques, exercises, and how to relax our mind."
"Learning how to start putting myself first."
"Coping with anxiety and coping with emotions."
"Learned how to cope with activating events and resolve problems in life."
"How to handle my emotions and dealing with my problems with others."
"How to manage stress, different kinds of research spiraling and learning to second things in a positive way. I also learned to deal with depression, and how to respond quickly to certain situation, in order for me to communicate."
"I learned that it is okay to talk to someone abut how you are feeling or what your going through."
"That feelings should be managed and not disregarded no matter how insignificant it may seem."
"Ways to manage my emotions and how to communicate them to others effectively."
"How to communicate better with both adults and people my age. How to manage my thoughts and outlook. Feeling more comfortable being myself."
"How to view criticism from certain family members/people and not internalize it."
"I learned how I was feeling when I didn't know what it was."
"How to cope with stress and anxiety through coping mechanisms such as meditation."
"How to set small realistic goals that helps you keep going everyday."
"How to manage stress and alleviate negative feelings."
"I learned physical ways to calm down by feeling and thinking about my surroundings/mediation skills."
"Different ways to calm down and cope with stress like thinking of a good place, tightening and releasing muscles and breathing exercises."
"I learned how to cope and how to recognize my flaw and where I need room to improve."
"How to cope with stress and depression."
"How to manage stress and anxiety while in difficult situations."
"I learned how to communicate and I learned that I and control how I think and therefore control how I feel."
"List of things on how to cope with things and not worry about anything and just enjoy life."
"How to not be so fearful of change and appreciate it. Learned how to deal with losing people. How to not let others worry about me."
"Positive counter thoughts; breathing techniques to help my anxiety and thinking with the logical mind, and identifying emotion and separating school work from my own time outside of school."
"How to talk with someone who's having a bad day and be the person to talk to."
"Participating in this program reduced negative thoughts."
"How to stay calm and positive."
"How to think and control my anger"
"Ways to think positively, how to relax and destress, and journaling my feelings/thoughts."
"I learned to deal with my stress and worrying what I have, and that's it's okay to talk about my feelings and how to calm myself down."
"I learned how to recognize my feelings, negative thoughts into positive ones, etc."
"I learned how identify my tell-tale signs. Once I learned them, then I learned how to cope."
"I learned ways to communicate with those around me so that relationships are stronger and filled with trust. I also learned how to know when my thoughts were irrational and how to change them to be more positive."

2. What I liked about the program is…

"Our counselor is Awesome! She's so caring, and gives the best advice. She's never made me feel uneasy or anything I felt so safe and cared for when expressing myself to her."
"Our counselor! He is super sweet and coping and listens to what we say."
"Having a calm space to be able to talk."
"What I liked about this program was the methods. They wasn't boring but simple enough to understand."
"I liked the group because it's very welcoming."
"I was comfortable with everyone in the group."
"I felt heard, the program made me feel like I had voice."
"Love the snacks, activities, and people in here were all so great. I also love my counselor, overall he's a good listener and knows what to say, and he's also funny."
"Hearing what others say when they go through their problems."
"How fun and honest it is. I can be very honest."
"I liked that I got to met new people and I learned a lot more about my friends."
"Being able to talk about our weeks with no judgement."
"I loved the program it was such an amazing stress reliever, I felt safe."
"I like the counselor, she listened to me and made me feel comfortable. I like how I'm not alone, knowing others shared and I can relate."
"How I got to meet new people from my school I didn't know before."
"Being able to talk with and relate with others."
"It was a safe place, everyone was understanding."
"I liked that I can relate to the people's problems."
"That I felt comfortable and it was welcoming."
"I liked how it was very active and everyone participated."
"Being able to be comfortable around others. Not being shy feeling safe around others."
"My counselor, made me very comfortable to talk to."
"It was welcoming. I felt like I was able to open up about my issues."
"I liked that it was a group and I had people in here that I knew which they helped us along the way."
"My counselor very understanding and 10/10 person."
"I was able to engage with someone and not feel like I was able to be confident."
"How kind our counselor is."
"How my counselor was able to respond and help me when I was down at night and I felt heard."
"I like how it was able to work out with my schedule and if I could not make it to the session there was no trouble."
"I got to see the others improve with me."
"I liked that I got to hear about other people's problem and how to deal with it."
"It felt like a safe space where I was able to be myself."
"I made new friends and had amazing time here."
"How nice and caring the counselor was. I always had the best day."
"You get to talk about your feelings you get helped if needed."
"Everyone was open with what they were feeling and it was a very comfortable experience."
"The energy and good vibe I got every time I walked in."
"My counselor was a really good presenter."
"Being able to have a safe space as well as someone who understood me, and being vulnerable without judgment."
"I felt supported when people listen to me."
"I learned how to confront my issues with others rather than let my emotions build up."

2. What I liked about the program is… (continued)

"I loved how my counselor took time to get to know each one of us. It made me feel more comfortable talking about my problems to her. She was always so welcoming. Loved the snacks, and I learned so much."
"How it let me to allowed me to express my feelings and to get them off my chest."
"It was a really friendly environment despite whatever was going on."
"That the counselor listened to everything we had to say."
"I had a safe space to talk to someone and it helped me very much."
"How understanding and comfortable I felt while talking."
"I didn't feel forced to share my past traumas, I could be myself. I felt listened to and my counselor really, really is sweet. I was able to put my coping skills to use."
"I don't feel alone because hearing everyone also go through similar things that I go through is comforting."
"How I always felt listened to and what I said and thought was valid."
"It was all very personal and suited for what I needed."
"My counselor really understood me and let me be heard."
"My counselor, being able to talk about issues or feelings being able to view things differently."
"I like that I finally felt like someone was listening to me and actually cared for me and what I had to say. I liked feeling wanted and I got to have someone hear me out."
"That my counselor cared about me and listened while still helping me."
"I liked that I was able to express how I feel without being judged."
"I liked that I can talk about anything without judgment and that really helps me."
"It helped me feel comfortable with myself and helped me come out a little more."
"Liked that I could talk about whatever without being judged."
"That there are no wrong answers."
"I liked was I met wonderful people who matched the same vibe as me and it was very fun."
"I was able to talk abut my feelings and not feel judged."
"I like how comfortable we got and I made so many good friends here. It helped me get closure and help me understand myself better."
"I liked being able to talk about my feelings, finding a way to speak up for myself and voice my boundaries. Being able to notice my emotions also feeling them and finding solutions to the things they may have cause them. Understanding how my mind works and that some of the things I'm thinking are normal amongst people."
"I liked that I didn't feel judged when speaking about my personal life."
"I feel very safe and speak freely and not be judged."
"I liked how they taught me how to relax during stressful times."
"I liked everything I liked the people the counselor the activities and everything we learned."
"The closeness/felt with the group sessions and the new people I have met."
"It's a great way to be social and connect with people my age going through the same things."
"I liked how open people are and some understand what you are going through."
"Everyone was really nice and helpful."
"That the counselor listened to me and gave me advice on how to cope."
"The counselor made me feel validated and important. She listened to what I had to say and provided me with comfort whenever I was having a hard time."
"Everyone was very nice and listened to everything I had to say."
"I always felt like it was a safe space."
"The counselor cared for all group members equally."
"I liked that it's a small group and confidential."
"I liked how the counselor interacted with the group. It helped us open up more and felt like a welcoming environment."

3. What I didn't like about the program is...

"Nothing, it was super helpful actually!"
"Nothing, This program made me get out of my comfort zone but it felt comfortable."
"Absolutely nothing this class helped me so much and was so much fun."
"What some people had to say about conversation topics I disagree on."
"The schedule being once per week."
"Sometimes it felt we where going to slow."
"How it felt a bit uncomfortable for random student at the same school to hear my issues. I have nothing against them but it feels awkward when some of us have mutual friends."
"Not enough time."
"Sometimes I forget about my objective because I forget to write in my notebook."
"That time went by fast."
"Sometimes I wish the things I share are a little personal and the only reason I don't say to much is because I want someone to listen to me."
"Nothing, maybe it could be longer."
"It ended so soon."
"The check in."
"Missing some assignments in class time."
"I wish it was longer."
"It wasn't often."
"Missing class."
"It's only every other Thursday."
"How infrequent the meeting were."
"A lot of paperwork."
"Being in 2 groups makes it difficult to really open up or say anything."
"Our group is big so we had to split it up and I couldn't see my counselor every week. Also, I should be longer than 10 weeks because 2nd semester is always the worst."
"The county not letting us have the program longer. I will miss my counselor."
"Sometimes I got called out of important periods."
"The time limit."
"I wish we had more time."
"That it's ending."
"That there was not a lot of meetings."
"I still feel depressed (getting progressively worse). Though I thing its my own issue and not the fault of the program."
"Just how short it felt, finally finishing all my sessions with the person assigned to help me."
"I need longer sessions."
"A lot of sitting."
"I don't like that it's over and that it's not a permanent thing."
"That more people don't know about it. I have a couple friends I've referred the program too."
"That it took me out of class at some new environment."
"Sometimes I get nervous talking in front of other people."
"I can't really think of a negative thing about it. It helped me a lot."
"How it is very structural. Rather than just talking about ourselves we had to follow a bunch of guidelines."
"I didn't enjoy the amount of time limit."
"I didn't like that sometimes certain people didn't get their pass on time."

Riverside University HEALTH SYSTEM Behavioral Health

Peer-to-Peer

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

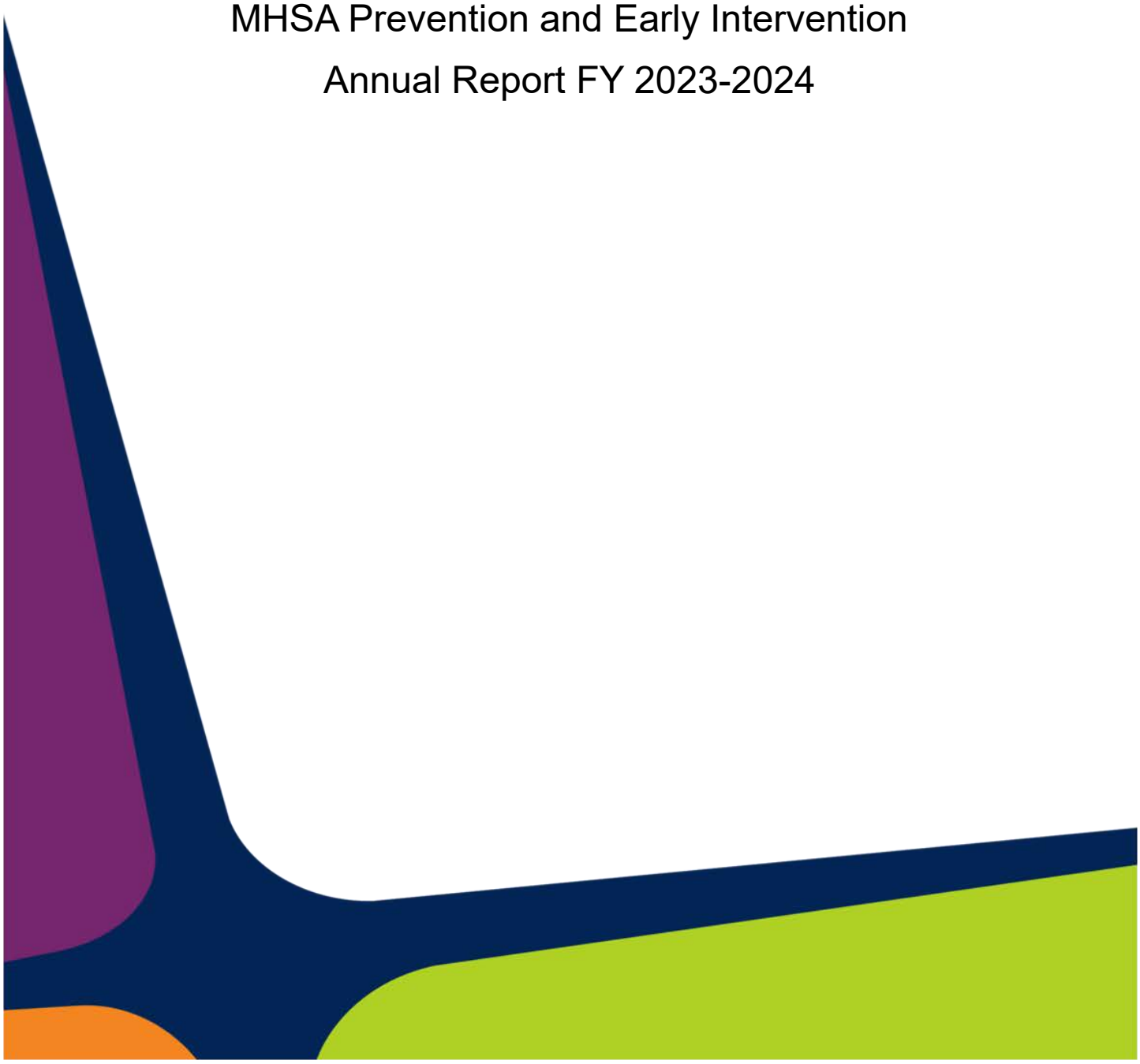


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Program Overview and Provider

Program Overview:

Riverside University Health System - Behavioral Health (RUHS-BH) is contracted with Operation SafeHouse to provide specific activities designed to reach transition age youth (TAY) - defined as youth between the ages of 16 and 25 years old. Specific target populations within TAY include homeless, foster or former foster, transitioning to college, and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals. The Peer-to-Peer program is designed to provide formal outreach, informal counseling, and support/informational groups to at-risk youth and families. Additionally, the program is designed to educate the public about mental health, depression, and suicide, while also working to reduce stigma towards mental illness among TAY individuals who are considered to be at high-risk. The program outreaches to Gay/Straight Alliances, social services agencies, and the community-at-large, in order to organize and facilitate small and large TAY group presentations and discussions to local community-based locations, school districts, and college campuses, with activities that include Directing Change outreach and workshops, Speaker's Bureau presentations, LGBTQ+ support groups, Peer Mentoring program, and Coping and Support Training (CAST).

- Directing Change workshops are aimed to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and developing a story in a digital public service announcement (PSA) format to promote that understanding and participation in submitting PSAs to the state Directing Change program.
- Speaker's Bureau presentations are utilized to educate and outreach to at-risk TAY, caregivers, educators, and TAY service providers on the unique issues that at-risk TAY experience as it relates to mental health and interpersonal issues, with the aim of reducing stigmatizing attitudes.
- LGBTQ+ support groups are provided by trained peers based on the My Identity My Self (MIMS) curriculum.
- The Peer Mentoring program is utilized to encourage and monitor progress with individualized goal setting through one-on-one interactions with a peer mentor.
- Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts. Each CAST group consists of an initial screening session followed by nine (9) sessions facilitated by TAY Peer Youth Specialists.

Provider:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse in the Riverside area will be noted as *Western*, whereas Operation SafeHouse in the Coachella Valley will be noted as *Desert*.

Executive Summary: Key Findings

There was a total of 86 Directing Change outreach presentations in the Desert, Mid-County, and Western regions. Additionally, there were 13 Directing Change workshops with five held in the Desert region, one in the Mid-County region, and seven in the Western region.

- A total of 229 participants attended a Directing Change workshop; 82 of whom were TAY in the Desert region, 5 we TAY in the Mid-County region, and 124 were TAY in the Western region, with the average age being 16.5 years old.
- Countywide, the majority of workshop participants identified as a girl/woman (52%), Hispanic/ Latinx (78%), and that their preferred language is English (80%).
- Satisfaction surveys were collected from 226 participants. Participants felt the workshops were a good use of their time and that they would recommend this workshop to a friend. Below are some youth comments:
  - ⇒ "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
  - ⇒ "Thank you for coming! This made me realize so much."

There was a total of 25 Speaker's Bureau presentations in the Desert, Mid-County, and Western regions of Riverside County.

- A total of 420 individuals attended a Speakers Bureau event; 80.2% of whom were TAY, with the average age being 16.9 years old.
- The most frequently reported race/ethnicity for each region was Hispanic/Latinx.
- The highest reported zip codes for Desert, Mid-County, and Western regions were for the cities of Indio 92201 (n=2), Hemet 92544 (n=5), Riverside 92506 (n=4) and Corona 92882 (n=4), respectively.
- Pre- and post-tests were collected from 392 individuals. Pre- and post-tests included a compilation of four different questionnaires to measure stigmatizing (AQ-9), recovery (RS-3), empowerment (ES-3), and care-seeking attitudes (CS-6). Sample sizes for each questionnaire varied due to incomplete items between the pre- and post-tests. Meaningful improvements were found for stigmatizing, recovery, and empowerment attitudes. In other words, stigmatizing attitudes significantly decreased from pre- to post-tests whereas recovery and empowerment attitudes increased from pre- to post-tests thus suggesting participants' attitudes towards people with mental illnesses improved from the presentation. Care-seeking attitudes slightly increased but were not statistically significant.

There were 10 LGBTQ+ support groups utilizing the "My Identity My Self" curriculum to support TAY youth.

- There were a total of 78 attendees of which 71 were TAY. The majority were in the 16 to 17 age group (72%).
- Transgender, nonbinary, and gender fluid youth accounted for 38% of those attending (11.5% transgender, 12.8% nonbinary, and 14.1% gender fluid).
- Over half of the youth attending were Hispanic/Latinx (64.1%).
- Satisfaction surveys were collected for these support groups (n=42). Approximately 93% of participants reported that they would participate in this program again; and 95% of participants reported that participating in the support group has been an affirming experience for them.

Executive Summary: Key Findings (cont.)

There were 51 youth screened, 45 youth enrolled in, and 26 who completed the Peer Mentoring program.

- Session attendance varied: 58% attended all 12 sessions, 2% attended between 9 to 11 sessions, 18% attended between 5 and 8 sessions, 13% attended between 2 and 4 sessions, and 9% attended one session.
- The majority of mentees identified as a girl/woman (64%, n=29), were Hispanic/Latino (60%, n=27), and the preferred language for almost all of the mentees was English (91%, n=41). Additionally, 15 mentees (33%) identified as LGB+. Lastly, most were TAY (96%, n=43) where the average age was 17 years old.
- Improvements were found in mentees ratings of goal achievement with 81% reporting improvements in relationships/support, 88% in school/work activities, and 77% in coping/ mood.
- The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. There are a total of 18 questions, related to: Social Support (how they feel about the presence of social supports in their lives), Self (how they feel about themselves in different scenarios), Goal Setting (how they view and act upon their own life goals), and Coping (how they cope with different life situations presented to them). Overall, increases in average scores can be seen across all four domains, with the highest increases in the area of Self (23%) followed by Coping (21%), Social Support (16%), and Goal Setting (14%). All four areas showed a statistically significant increase after completing the program.
- 100% of mentees reported that the mentoring program has helped them define their current goals. 92% of mentees have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future. 85% of mentees reported that the program has allowed them to build stronger relationships with those whom they depend on. 100% of mentees were satisfied with the Peer Mentoring program.

There were 11 CAST groups where 95 youth were screened with a total of 87 enrolled participants; 83 of whom attended at least one session. Of those 83 participants, 62 completed CAST, representing a 75% completion rate.

- Countywide, the majority of participants were Hispanic/Latinx (71%, n=59), female (58%, n=48), and the average age of entry into CAST was 17 years old.
- Monitoring Group Goals consist of survey items regarding participants' management of their feelings of depression and anger, school smarts, and drug use. Countywide, participants' average post-test scores significantly increased from their pre-test scores for mood, school behaviors, and drug use suggesting meaningful improvement from the start of participation in the program to the end.
- For How Are We Doing in Group surveys, the largest increase was in participants' sense of "belonging" from the pre (Session 2) to post (Session 9) with a mean difference score of 0.63.
- There were statistically significant increases in the Recognition of Progress items from pre to post for the self esteem item specifically "being positive with myself, recognizing my strengths", for the personal control item on depression specifically "getting 'unstuck' from negative moods", and for the personal control item on anger specifically "controlling my thoughts, feelings, and actions."

Event Statistics

Type of Events by Region

Each event was categorized into one of the following five activities: Directing Change outreach or workshop, Speaker's Bureau presentation, LGBTQ+ support group, Peer Mentoring, and Coping and Support Training (CAST). A total of 536 various Peer-to-Peer events and activities were held throughout the County during FY 2023-2024.

Activity:	Desert (n=166)	Mid-County (n=274)	Western (n=96)	Countywide (n=536)
Directing Change Outreach Events	43	20	23	86
Directing Change Workshops	5	1	7	13
Speaker's Bureau Presentations	4	7	14	25
LGBTQ+ Support Groups	5	2	3	10
Peer Mentoring Sessions	108	240	43	391
CAST Groups	1	4	6	11

Participants by Region

Countywide, a total of 3,637 individuals participated in Peer-to-Peer activities. Of the total participants:

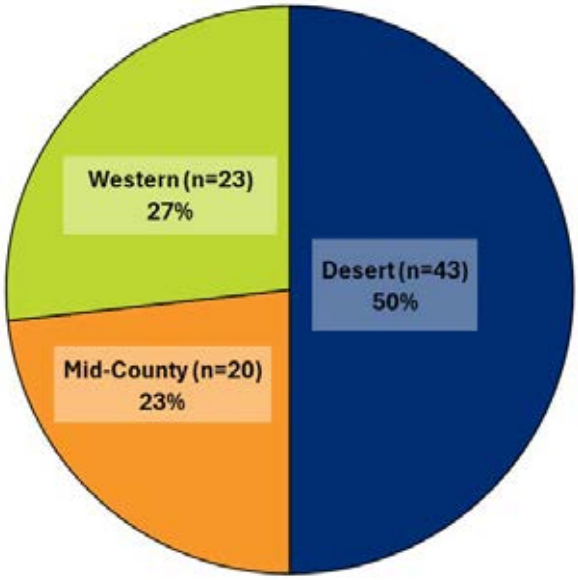
- 1,706 (46.9%) were in the Desert region
- 747 (20.5%) were in the Mid-County region
- 1,184 (32.6%) were in the Western region

Participants by Activity	Desert (n=1,706)	Mid-County (n=747)	Western (n=1,184)	Countywide (n=3,637)
Directing Change Outreach Participants	1,483	566	733	2,782
Directing Change Workshop Participants	100	5	124	229
Speaker's Bureau Participants	58	117	245	420
LGBTQ+ Support Group Participants	39	12	27	78
Peer Mentoring - Mentees	17	24	4	45
CAST Group Participants	9	23	51	83

Directing Change Outreach Event Statistics

During FY 2023-2024, a total of 86 Directing Change Outreach (DCO) events were held throughout Riverside County reaching 2,782 participants. The majority of Directing Change Outreach events occurred in the Desert region (50%, n=43) followed by the Western (27%, n=23) and Mid-County (23%, n=20) regions.

Directing Change Outreach Events by Region (n=86)



Region	Participants	Percentage
Desert (n=43)	1,483	53.3%
Mid-County (n=20)	566	20.3%
Western (n=23)	733	26.3%
Countywide (n=86)	**2,782**	

Directing Change Outreach Event Locations: Cities and Zip Codes

Of the 86 Directing Change Outreach events countywide, 43 were in the Desert region within 11 zip codes, 20 were in the Mid-County region within nine zip codes, and 23 were in the Western region within eight zip codes. The zip codes and cities for each event by region are listed below.

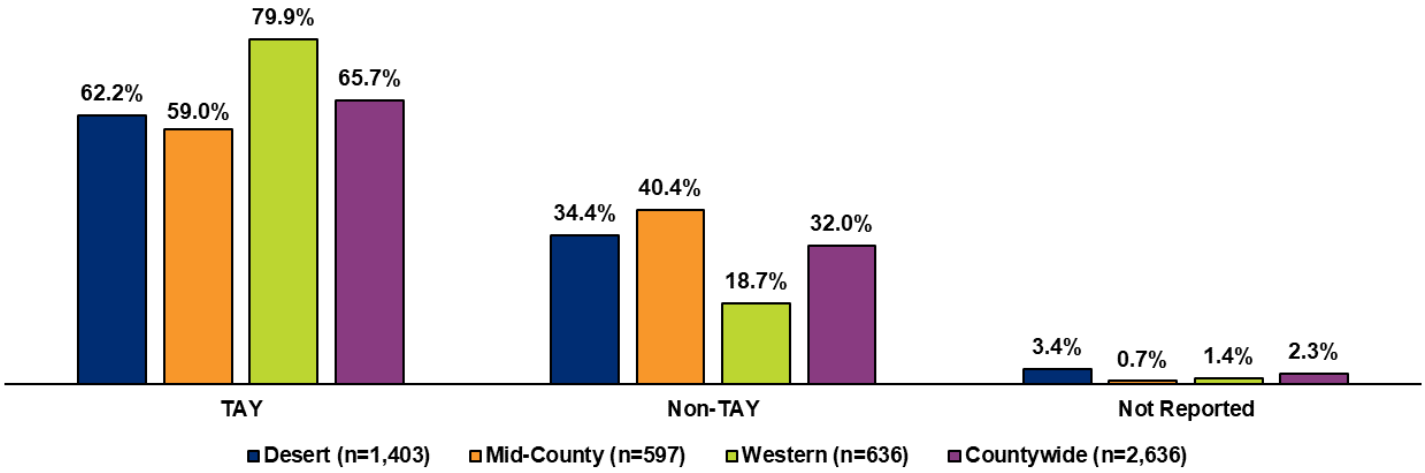
Desert (n=43)		Mid-County (n=20)		Western (n=23)	
92201 Indio	23 (26.7%)	92530 Lake Elsinore	1 (1.2%)	92501 Riverside	3 (3.5%)
92211 Indio	1 (1.2%)	92532 Lake Elsinore	1 (1.2%)	92503 Riverside	1 (1.2%)
92220 Banning	7 (8.1%)	92543 Hemet	3 (3.5%)	92504 Riverside	1 (1.2%)
92225 Blythe	1 (1.2%)	92544 Hemet	3 (3.5%)	92506 Riverside	11 (12.8%)
92234 Cathedral City	1 (1.2%)	92545 Hemet	4 (4.7%)	92507 Riverside	2 (2.3%)
92253 La Quinta	2 (2.3%)	92562 Murrieta	4 (4.7%)	92551 Moreno Valley	3 (3.5%)
92254 Mecca	1 (1.2%)	92570 Perris	1 (1.2%)	92553 Moreno Valley	1 (1.2%)
92260 Palm Desert	2 (2.3%)	92583 San Jacinto	2 (2.3%)	92860 Norco	1 (1.2%)
92270 Rancho Mirage	1 (1.2%)	92585 Menifee	1 (1.2%)		
92274 Thermal	1 (1.2%)				
92276 Thousand Palms	3 (3.5%)				

Directing Change Outreach: Demographics

Attendance

Countywide, 2,636 unduplicated individuals signed-in to a Directing Change outreach (DCO) event attendance sheet. There were 1,403 individuals (53.2%) from the Desert region, 597 individuals (22.6%) from the Mid-County region, and 636 individuals (24.1%) from the Western region who were reached through a DCO event. Countywide, 65.7% (n=1,732) of participants reported as TAY and 32% (n=843) were Non-TAY with 2.3% (n=61) unknown.

TAY and Non-TAY Attendance



Countywide, 2,575 participants reported their age. Participants were between the ages of 11 and 65, with the average age being 16.5 years old. From the TAY Age Breakdown table below, most TAY participants reported being in the 16 and 17 age groups (81.5%).

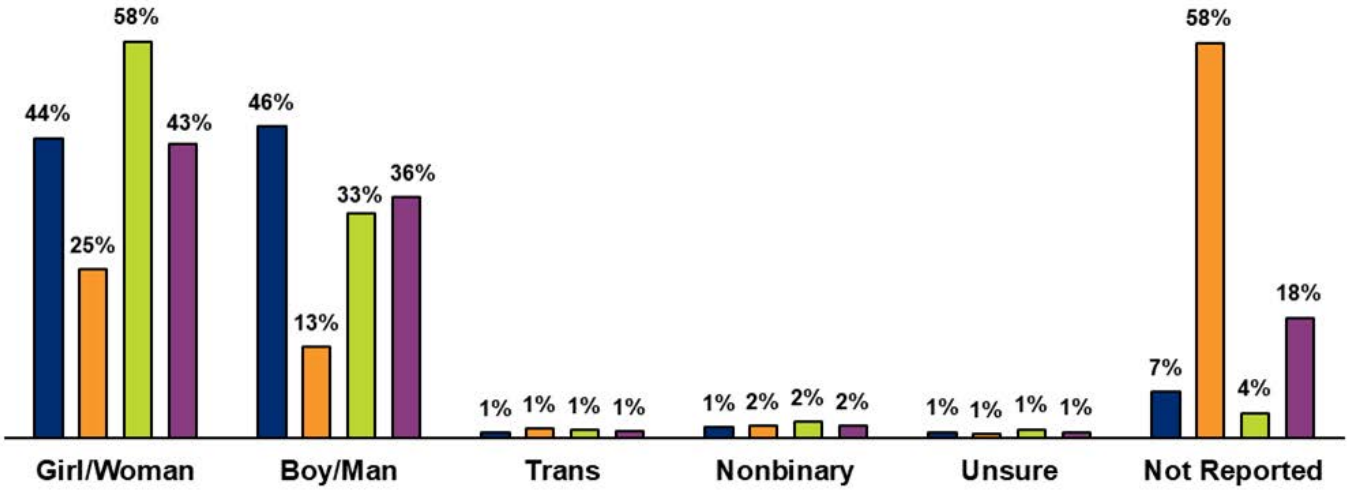
Age	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
11-15	473 (33.7%)	239 (40.0%)	99 (15.6%)	811 (30.8%)
16-25 (TAY)	**872 (62.2%)**	**352 (59.0%)**	**508 (79.9%)**	**1732 (65.7%)**
26 and Older	10 (0.7%)	2 (0.3%)	20 (3.1%)	32 (1.2%)
Not Reported	48 (3.4%)	4 (0.7%)	9 (1.4%)	61 (2.3%)

TAY Age Breakdown	Desert (n=872)	Mid-County (n=352)	Western (n=508)	Countywide (n=1,732)
16	444 (50.9%)	179 (50.9%)	128 (25.2%)	751 (43.4%)
17	345 (39.6%)	128 (36.4%)	187 (36.8%)	660 (38.1%)
18-21	78 (8.9%)	45 (12.8%)	169 (33.3%)	292 (16.9%)
22-25	5 (0.6%)	0 (0%)	24 (4.7%)	29 (1.7%)

Directing Change Outreach: Demographics cont.

Gender

Countywide, 43% (n=1,141) of the participants identified as a girl/woman, and 36% (n=936) identified as a boy/man. The remaining participants reported identifying as transgender (0.9%, n=25), nonbinary (1.7%, n=46), or were unsure (0.8%, n=22). Additionally, 18% (n=466) had no response.



Sexual Orientation

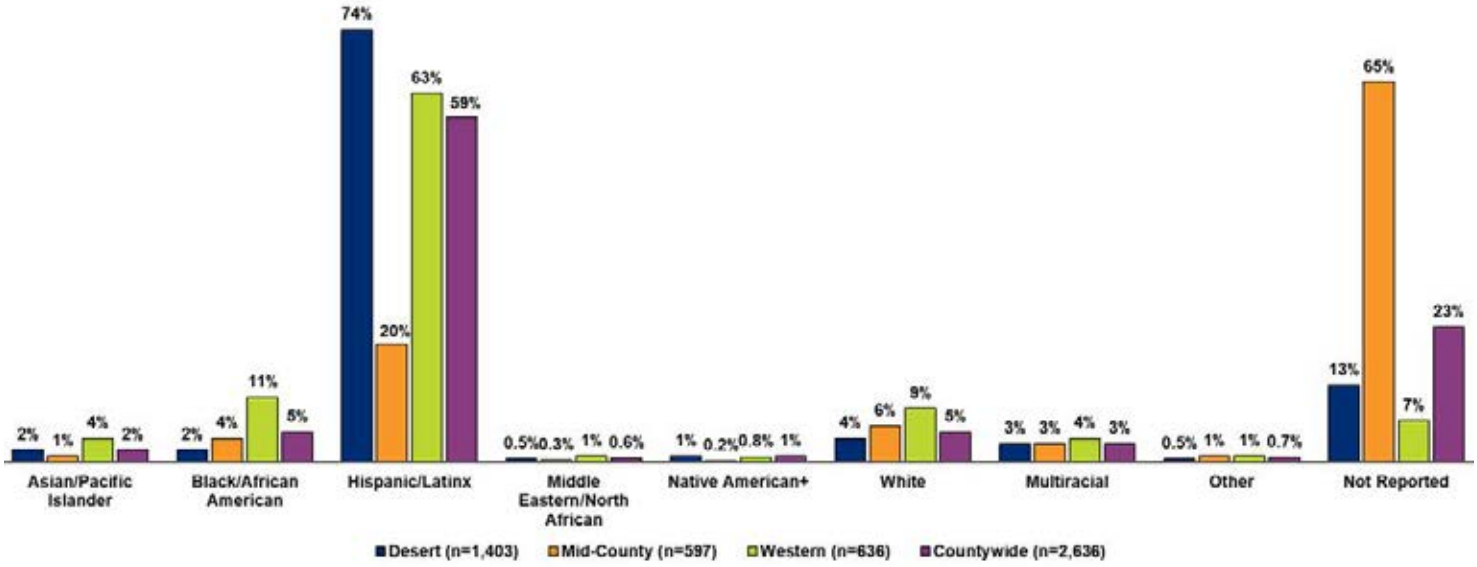
Countywide, among the total of 2,636 individuals, 11% of participants identified as lesbian, gay, or bisexual (Desert: n=132; Mid-County n=56; Western: n=110).

Sexual Orientation	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
Straight	855 (60.9%)	120 (20.1%)	399 (62.7%)	1374 (52.1%)
Lesbian	22 (1.6%)	12 (2.0%)	13 (2.0%)	47 (1.8%)
Gay	33 (2.4%)	4 (0.7%)	9 (1.4%)	46 (1.7%)
Bisexual	77 (5.5%)	40 (6.7%)	88 (13.8%)	205 (7.8%)
Unsure	41 (2.9%)	15 (2.5%)	32 (5.0%)	88 (3.3%)
Not Reported	375 (26.7%)	406 (68.0%)	95 (14.9%)	876 (33.2%)

Directing Change Outreach: Demographics cont.

Race and Ethnicity

Countywide, 58.8% (n=1,551) of participants identified as Hispanic/Latinx, 5.2% (n=138) as White, 4.6% (n=122) as Black/African American, 3.4% (n=90) as Multi-racial, 2.4% (n=63) as Asian/Pacific Islander, 0.9% (n=24) as Native American (and one other race), 0.6% (n=17) as Middle Eastern/ North African, 0.7% (n=19) as Other, and 23.2% (n=612) was not reported.



Language

Countywide, English (60%) was the most frequently reported primary language.

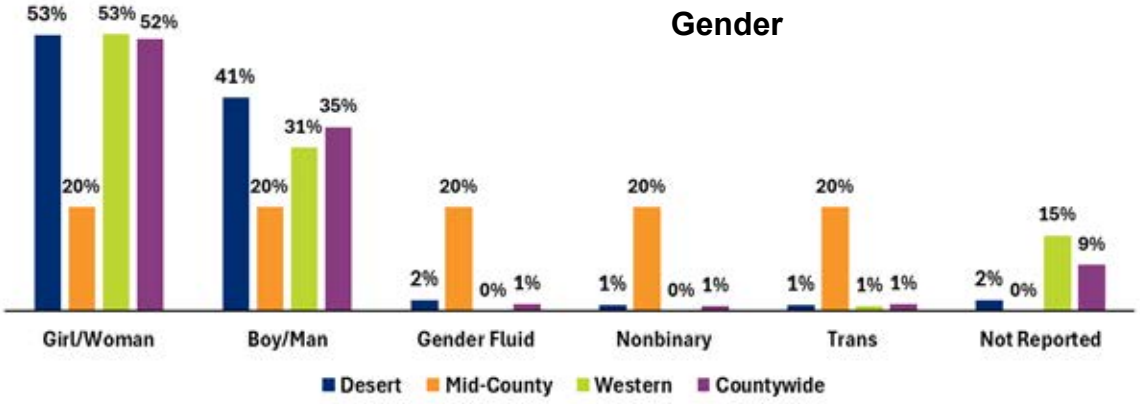
Language	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
English	884 (63.0%)	200 (33.5%)	484 (76.1%)	1568 (59.5%)
Spanish	60 (4.3%)	4 (0.7%)	26 (4.1%)	90 (3.4%)
English and Spanish	256 (18.2%)	7 (1.2%)	75 (11.8%)	338 (12.8%)
Other or Multiple	11 (0.8%)	0 (0%)	9 (1.4%)	20 (0.8%)
Not reported	192 (13.7%)	386 (64.7%)	42 (6.6%)	620 (23.5%)

Directing Change Workshop Demographics

The Directing Change workshops are intended to encourage and equip TAY with the technical skills to prepare a personalized or informative public service announcement (PSA) for submission in the annual Directing Change Student Film Contest. The workshops aim to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and to assist in the development of a digital PSA to promote that understanding. The workshops focus on providing TAY with technical assistance in producing a digital film as a means of increasing mental health and suicide awareness.

During FY 2023-2024, a total of 13 Directing Change workshops were held countywide where five (5) were held in the Desert region, seven (7) in the Western region, and one (1) in the Mid-County region. The Desert region had 100 participants in attendance of whom 82 were TAY, the Western region had 124 participants, of whom 72 were TAY, and Mid County had five (5) participants all of which were TAY.

Gender

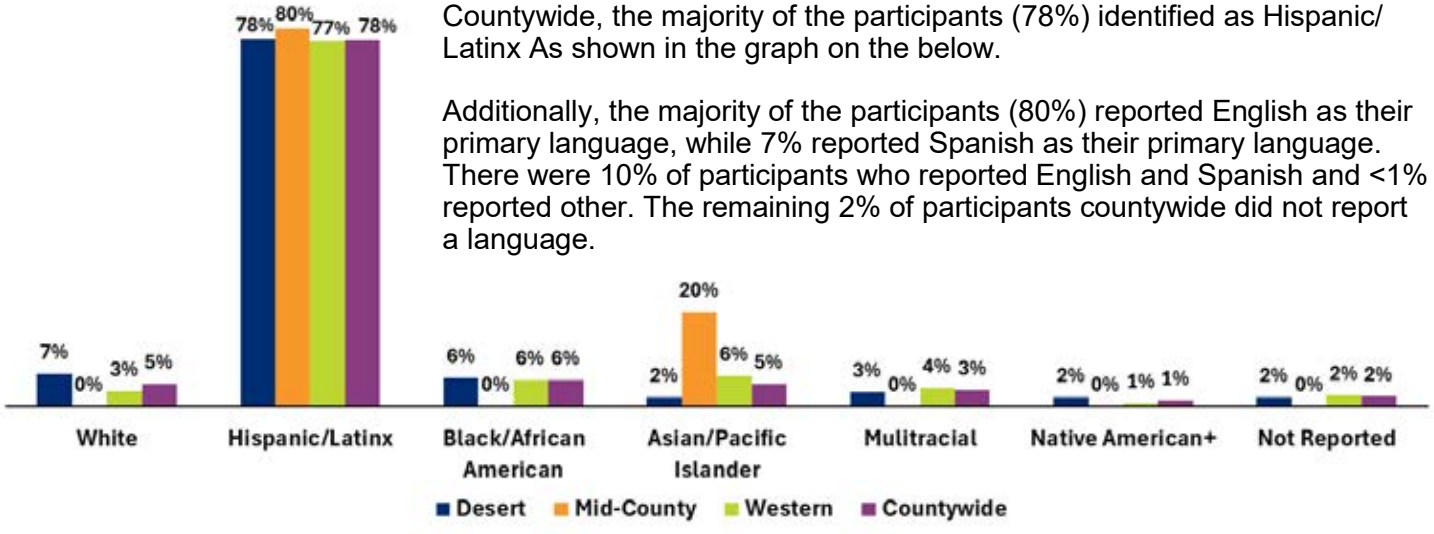


A majority of participants identified as a girl/woman (52%, n=120). Not shown on the graph, 13% of participants reported they were LGB.

Age and Race/Ethnicity

Age	Desert	Mid-County	Western	Countywide
13-15	17 (17.0%)	0 (0.0%)	48 (38.7%)	65 (28.4%)
16	24 (24.0%)	1 (20.0%)	20 (16.1%)	45 (19.7%)
17	40 (40.0%)	3 (60.0%)	38 (30.6%)	81 (35.4%)
18-25	18 (18.0%)	1 (20.0%)	14 (11.3%)	33 (14.4%)
26+	0 (0.0%)	0 (0.0%)	1 (0.8%)	1 (0.4%)
Not Reported	1 (1.0%)	0 (0.0%)	3 (2.4%)	4 (1.7%)

As shown to the left, approximately 69.4%% of the participants were within the TAY age range, with the average age being 16.5 years old.



Countywide, the majority of the participants (78%) identified as Hispanic/ Latinx As shown in the graph on the below.

Additionally, the majority of the participants (80%) reported English as their primary language, while 7% reported Spanish as their primary language. There were 10% of participants who reported English and Spanish and <1% reported other. The remaining 2% of participants countywide did not report a language.

Directing Change Workshops: Satisfaction Survey

Satisfaction surveys were collected at the end of Directing Change Workshops. Participants were asked to rate their experiences with the workshop using a 5-point Likert Scale, where **1=*Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree*,** and ***5=Strongly Agree***. The satisfaction surveys consist of 7 questions, which include 4 rating questions and 3 open-ended questions to gather participants' feedbacks regarding the Directing Change Workshop. Overall, there were a total of 226 participants completed the satisfaction survey, and the results are summarized below:

- 71% of participants felt that the workshop was a good use of their time.
- 55% of participants felt connected and involved in the workshop.
- 50% of participants would participate in the workshop again.
- 70% of participants would recommend this workshop to a friend

It is also noted that about 33% and 32% of participants chose to rate "Neutral" for question #2 (*I felt connected and involved in the workshop*) and question #3 (*I would participate in this workshop again*), respectively.

Countywide (n=226)	Avg.	(1) Strongly Disagree	(2) Disagree	(3) Neutral	(4) Agree	(5) Strongly Agree	No Response
1. The workshop was a good use of my time.	**4.03**	1.3%	4.0%	23.0%	34.1%	37.6%	0.0%
2. I felt connected and involved in the workshop.	**3.63**	4.4%	7.5%	32.7%	31.4%	23.9%	0.0%
3. I would participate in this workshop again.	**3.60**	4.4%	12.4%	32.3%	19.9%	30.5%	0.4%
4. I would recommend this workshop to a friend.	**3.98**	2.2%	7.1%	20.8%	30.1%	39.8%	0.0%

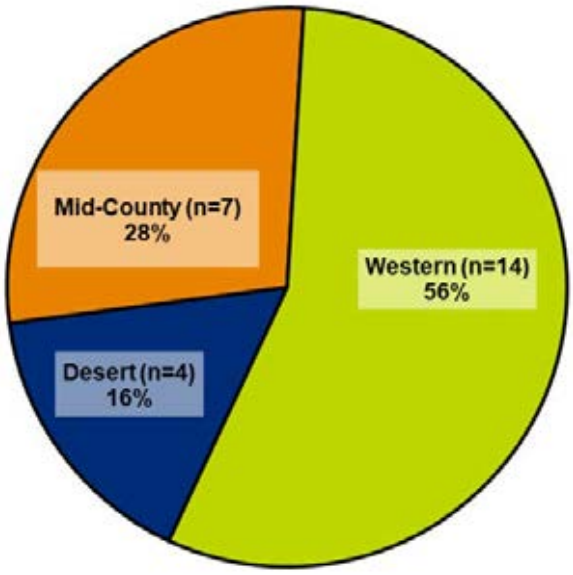
Some of the participants' responses on the additional feedback questions are listed below:

5. What did you like about your workshop experience?
   - "I enjoyed learning about the many different ways to cope with our mental health"
   - "I liked that there was good examples and to show how to handle suicide even if it's not for you and for a friend."
   - "Something I liked about the workshop is how positive everyone is and bringing good energy to a negative topic."
   - "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
   - "I liked how engaged everyone was and the fact the presenters had experiences that related to us."
6. What could have made your workshop experience better?
   - "I personally have been in desperate need before, and there workshops tend to isolate people - maybe the kids could have interacted w/ each other & the staff to establish trust"
   - "If we had some type of icebreaker to feel less awkward"
   - "Something that could have made the workshop experience better would have been on class engaging in it a bit more"
   - "People asking questions and sharing their own experiences would have made it better since it would have made me feel connected."
   - "It could have been better if it was more interactive."
7. Any additional comments?
   - "I really liked all the speakers and how they all shared their personal experiences"
   - "You guys did amazing. Thank you. I appreciate you"
   - "Thank you for coming! This made me realize so much."

Speaker's Bureau Event Statistics

Each year, Peer-to-Peer contractors are expected to hold 35 Speaker's Bureau presentations reaching 525 participants, per region for a total of 105 presentations and 1,575 unduplicated TAY. During FY 2023-2024, a total of 25 events, reaching 420 unduplicated individuals, were held throughout the County. No region reached contract expectations.

Speaker's Bureau Events by Region (n=25)



Region	Participants	Percentage
Desert (n=4)	58	13.8%
Mid-County (n=7)	117	27.9%
Western (n=14)	245	58.3%
Countywide (n=25)	**420**	

City/Zip Code Locations

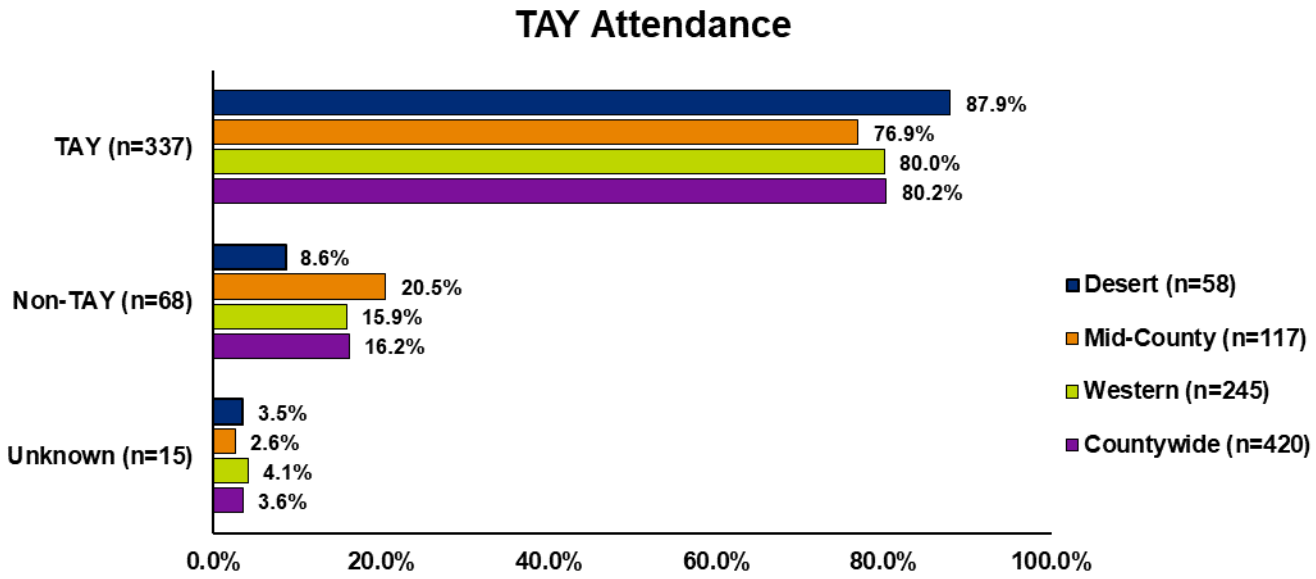
Of the 25 Speaker's Bureau presentations countywide, 4 were in the Desert region within three zip codes; 7 were in the Mid-County region within two zip codes, and 14 were in the Western region within seven zip codes. The zip codes and cities for each region are listed below.

Region	Zip Code and City	Countywide (n=25)
Desert (n=4)	92201 Indio	**2 (8%)**
	92260 Palm Desert	**1 (4%)**
	92276 Thousand Palms	**1 (4%)**
Mid-County (n=7)	92532 Lake Elsinore	**2 (8%)**
	92544 Hemet	**5 (20%)**
Western (n=14)	92501 Riverside	**2 (8%)**
	92503 Riverside	**1 (4%)**
	92506 Riverside	**4 (16%)**
	92507 Riverside	**1 (4%)**
	92509 Riverside	**1 (4%)**
	92551 Moreno Valley	**1 (4%)**
	92882 Corona	**4 (16%)**

Speaker's Bureau: Demographics

Attendance

Countywide, there were a total of 420 unduplicated individuals that attended a Speaker's Bureau event where 58 (13.8%) were in the Desert region, 117 (27.9%) were in the Mid-County region, and 245 (58.3%) were in the Western region. Countywide, the majority (80.2%, n=337) of the participants were TAY. TAY attendance was higher than non-TAY attendance in all regions. These participants' attendance and information were



Countywide, 405 participants who attended Speaker's Bureau events reported their age which ranged from 10 to 60+ years old, with the average age being 17 years old. Among the TAY individuals, most participants reported their age as 16-17 within the Desert (70.6%, n=36), Mid-County (62.2%, n=56), and Western (78.1%, n=153) regions. The second largest group of TAY individuals was 18-19 within the Desert (25.5%, n=13), Mid-County (37.8%, n=34), and Western (19.9%, n=39) regions. Less than 2% of the Countywide TAY population fell between 20 to 25 years of age.

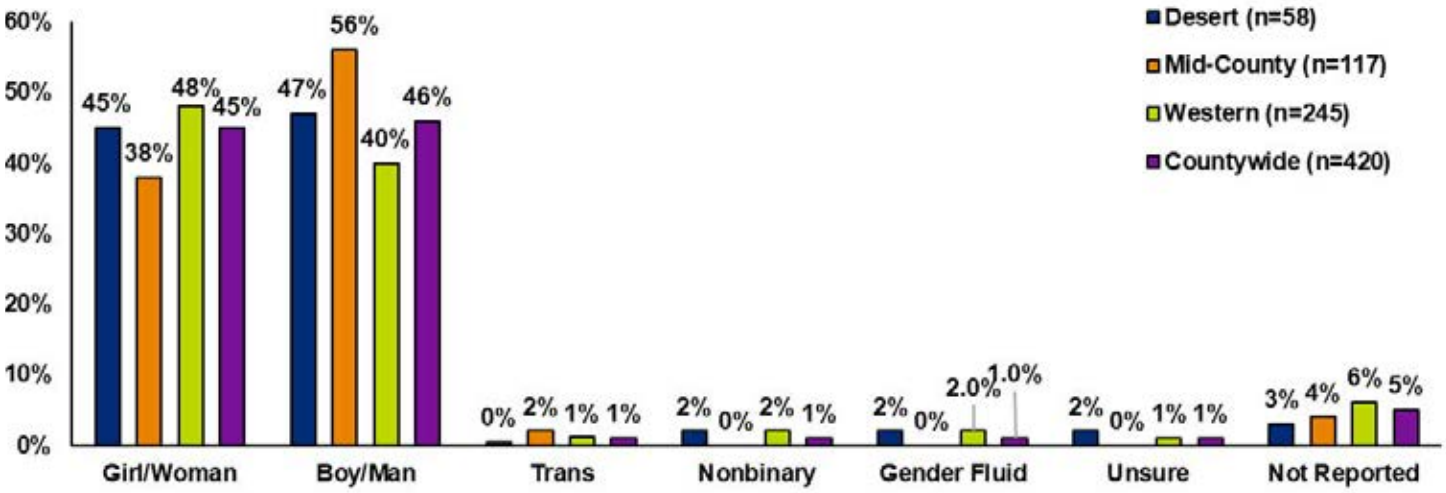
Age	Desert (n=56)	Mid-County (n=114)	Western (n=235)	Countywide (n=405)
12-15	5 (8.9%)	24 (21.1%)	37 (15.7%)	66 (16.3%)
TAY 16-25	**51 (91.1%)**	**90 (78.9%)**	**196 (83.4%)**	**337 (83.2%)**
26 and Older	0 (0%)	0 (0%)	2 (0.9%)	2 (0.5%)

TAY Age Breakdown	Desert (n=51)	Mid-County (n=90)	Western (n=196)	Countywide (n=337)
16-17	36 (70.6%)	56 (62.2%)	153 (78.1%)	245 (72.7%)
18-19	13 (25.5%)	34 (37.8%)	39 (19.9%)	86 (25.5%)
20-21	1 (2.0%)	0 (0%)	3 (1.5%)	4 (1.2%)
22-25	1 (2.0%)	0 (0%)	1 (0.5%)	2 (0.6%)

Speaker's Bureau: Demographics cont.

Countywide, 45% (n=188) of participants identified as a girl/woman, and 46% (n=192) identified as boy/man. The remaining participants identified as transgender (1.0%, n=4), as nonbinary (1.2%, n=5), as gender fluid (1.4%, n=6), were unsure (0.7%, n=3), or did not respond (5%, n=22).

Gender



Sexual Orientation	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Straight	42 (72.4%)	96 (82.1%)	154 (62.9%)	292 (69.5%)
Lesbian	2 (3.4%)	1 (0.9%)	8 (3.3%)	11 (2.6%)
Gay	0 (0.0%)	0 (0.0%)	8 (3.3%)	8 (1.9%)
Bisexual	3 (5.2%)	6 (5.1%)	20 (8.2%)	29 (6.9%)
Pansexual	1 (1.7%)	1 (0.9%)	5 (2.0%)	7 (1.7%)
Other	1 (1.7%)	0 (0.0%)	2 (0.8%)	3 (0.7%)
Unsure	1 (1.7%)	1 (0.9%)	7 (2.9%)	9 (2.1%)
Declined	4 (6.9%)	4 (3.4%)	19 (7.8%)	27 (6.4%)
Not Reported	4 (6.9%)	8 (6.8%)	22 (9.0%)	34 (8.1%)

Countywide, 29 participants reported having a disabling condition and one participant reported being a veteran.

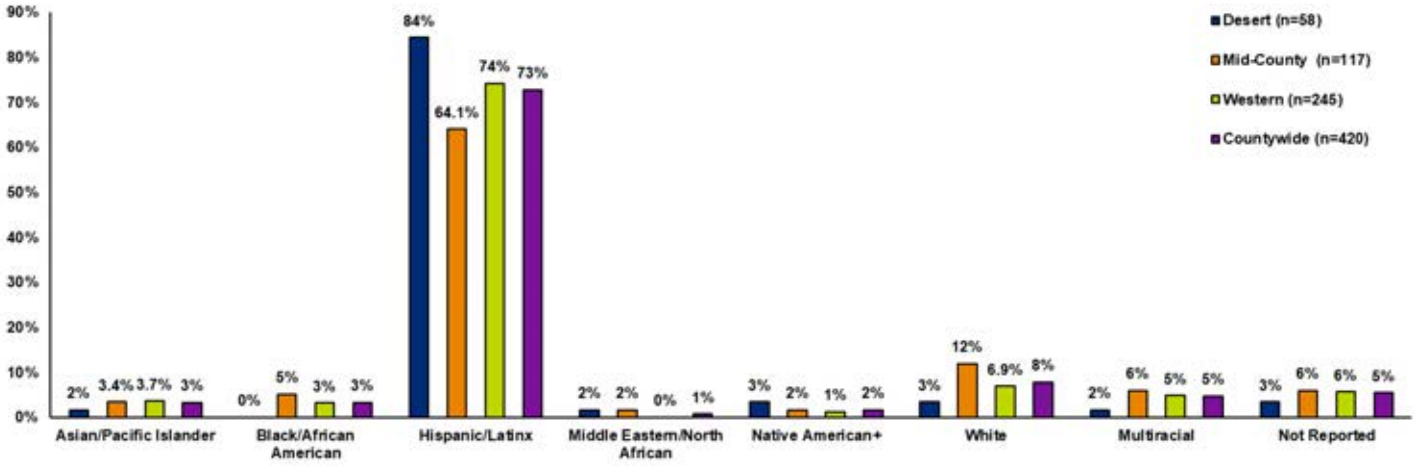
	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Disabled	3 (5.2%)	4 (3.4%)	22 (9.0%)	29 (6.9%)
Veteran	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)

Speaker's Bureau: Demographics

Race/Ethnicity

Countywide, 72.9% (n=306) of participants identified as Hispanic/Latinx, 7.9% (n=33) White, 4.8% (n=20) Multiracial/ethnic, 3.3% (n=14) Asian/Pacific Islander, 3.3% (n=14) Black/African American, 1.7% (n=7) Native American (and one other race), 0.7% (n=3) Middle Eastern/North African, and 5.5% (n=23) was not reported.

Countywide, there were 225 (53.6%) participants who reported their specific ethnicity as Mexican, followed by 15 (3.6%) Central American, 6 (1.4%) Guatemalan, 2 (0.5%) Salvadoran, 1 (0.2%) Cuban, 1 (0.2%) Puerto Rican, 5 (1.2%) Filipino, 2 (0.5%) Vietnamese, 1 (0.2%) Cambodian, 2 (0.5%) South Asian, 2 (0.5%) Irish, 1 (0.2%) Arab, and 9 (2.1%) Multi-ethnic. Lastly, 35.2% (n=148) of participants did not report a specific ethnicity.



Language

Countywide, as well as in all regions, English (79.5%) was the most frequently reported primary language, with Spanish at 6.2%, English and Spanish at 8.3%, multiple languages 1.0%, and <1% of other languages. A total of 4.8% of the participants countywide did not report a primary language.

Language	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
English	41 (70.7%)	98 (83.8%)	195 (79.6%)	334 (79.5%)
Spanish	6 (10.3%)	5 (4.3%)	15 (6.1%)	26 (6.2%)
English and Spanish	8 (13.8%)	9 (7.7%)	18 (7.3%)	35 (8.3%)
Multiple Languages	1 (1.7%)	0 (0.0%)	3 (1.2%)	4 (1.0%)
Other	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)
Not Reported	2 (3.4%)	5 (4.3%)	13 (5.3%)	20 (4.8%)

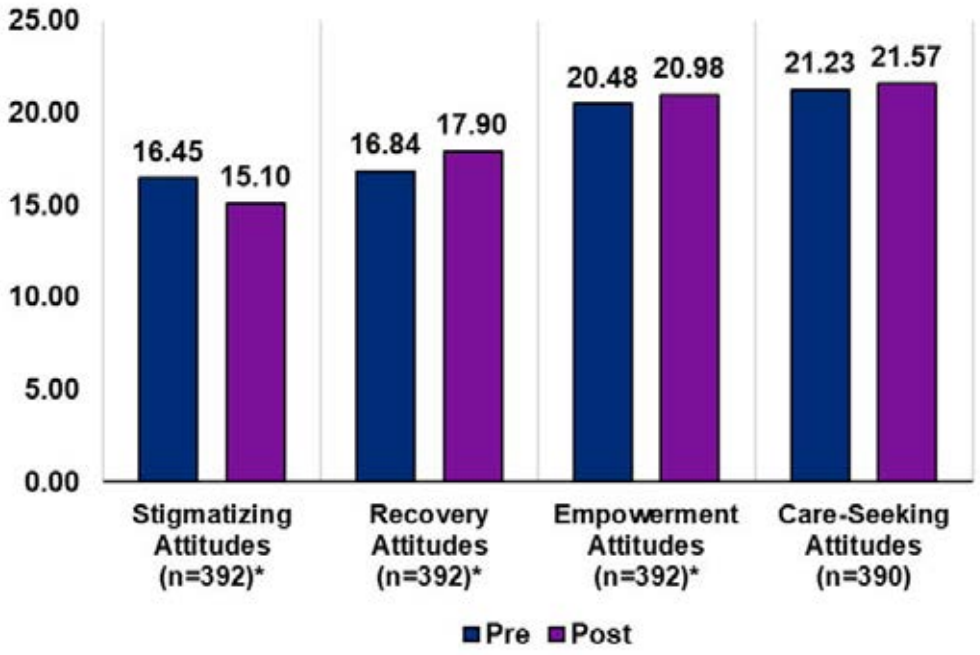
Speaker's Bureau Pre/Post Test Questionnaire

A total of 392 individuals who attended a Speaker's Bureau presentation completed pre- and post-test outcomes measures. Pre and post-tests were administered immediately before and after each presentation in order to assess their impact on the attendees. The questionnaire consists of four measures of stigma: Stigmatizing Attitudes (AQ-5), Recovery Attitudes (RS-3), Empowerment Attitudes (ES-3), and Care-Seeking Attitudes (CS-4).

Measures of Stigma	Questionnaire	9-Point Rating Scale
Stigmatizing Attitudes (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to a person with schizophrenia. *Example:* "I think that most people with mental illness are to blame for their problems"	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "If I were significantly anxious or depressed, I would speak to a mental health professional."*	Score range: 4-36 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

An average score for all questions within each of the four questionnaires were computed for pre/post-test comparisons. Higher average scores for the AQ-5 represent greater stigmatizing attitudes, whereas higher average scores on the RS-3, ES-3, and CS-4 represent positive attitudes toward the described constructs. The graph below depicts the means and paired t-test results for participants who completed pre- and post-test measures. However, not all individuals completed all of the items within the pre-test and/or post-test, thus accounting for less total outcomes within each of the four measures of stigma questionnaire sections. Meaningful improvements were found for Stigmatizing, Recovery, and Empowerment Attitudes. In other words, Stigmatizing Attitudes significantly decreased from pre to post whereas Recovery and Empowerment Attitudes increased from pre to post thus suggesting participants' attitudes improved from the presentation. Care-Seeking Attitudes slightly increased but were not statistically significant.

Speaker's Bureau Average Pre vs Post Results



Speaker's Bureau Presentations: Comments

Additional Comments…

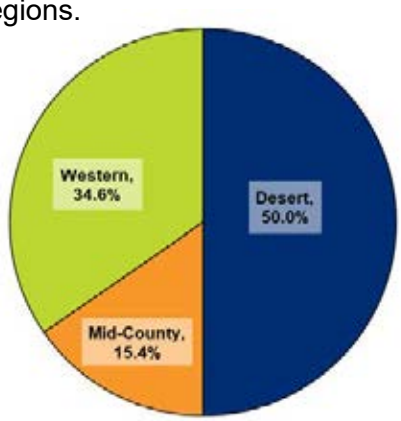
- "A lot of these questions are to vague or general, not one answer fits all mental illnesses."
- "Good presentation"
- "Great job on the performance, even if you feel rusty it sounded amazing. Keep it up."
- "I believe that a person with mental problems cannot take care of themselves because they need someone's help to be able to do the necessary things by themselves."
- "I feel like people with mental illness can do just as much as we do I had a homie with one leg went down and came back up."
- "I hope everyone finds happiness and find their true selves."
- "I loved the presentation. (heart symbol)"
- "I personally like the lady and Her story, it is inspiring and gives me Hope in myself."
- "I really liked the first story that was shared. I also liked how open the second story was."
- "I really liked the presentations, they were informative (two heart symbols)"
- "I really loved the Presentation and how open they were that takes alot."
- "I think it was nice how she shared her story with the class to help us understand."
- "I think that many can't or wouldn't get professional help because of financial problems, sense of hurting their pride, family members not believing in professional help."
- "I think you guys should speak to younger teens more often. Kids can experience mental illness at any age and they may benefit from some of the advice you're giving. Thanks for sharing (smiley face and heart symbol)"
- "I'm really happy you guys talk about this! It's so important and I'm really glad and proud of you guys."
- "It was a nice and enlightening presentation, I hope everything works out in your future."
- "I've been dating a mentally ill person for 7 months. The experience recount I just heard reminded me slightly of my partner's past with her almost 20 ex's."
- "Loved the presentation!"
- "Lovely Presentation!"
- "My point of view on this has changed now that I've heard an impackedful story first hand and how people can grow and better themselves."
- "No just thank you for sharing the storys with us and everything."
- "People can get better if they seek help. Also to manage how to cope."
- "People with mental illness are very special people who need to be cared for in the best possible way, whether by family members, relatives or doctors." [Translated from Spanish]
- "People with mental problem cannot help themselves that is to say they do not know what they are doing whether it is correct or not and that is why they cannot have a determined future or help other people."
- "Personal recognition from me, I also resignated with your speech, me myself dealt with problems as said from this story, I had a bad past partner that made me have to do some deep healing to move on from what I was forced in."
- "Thank you for presenting to us!"
- "Thank you for sharing your story I admire being able to be vulnerable and public speaking."
- "Thank you guys for coming especially since you don't do freshmen but thank you a lot I've learned a ton and you all are amazing."
- "Thanks for sharing your personal story [facilitator]."
- "Thanks for todays presentation"
- "The beginning of the presentation made it hard to focus a bit. Because it was quiet & low energy."
- "The Cup of Happy team is doing an AMAZING job!"
- "The only thing I gotta say is that like since were heath academy we already learned this. But I feel like other Freshmen to should know about this. I know a lot of Freshmen who don't have resources."
- "The woman in the green romper is very strong!"
- "This helped"
- "We love you [facilitator] & [facilitator] thank you for sharing your stories"
- "You guys are so strong! (heart symbol)"

LGBTQ+ Support Groups

Attendance by Region

In FY2023-2024, there were a total of **10** LGBTQ+ support groups held within Riverside County. From these groups, a total of **78** youth attended, with a majority of attendees from the Desert region (50.0%, n=39), followed by the Western (34.6%, n=27) and Mid-County (15.4%, n=12) regions.

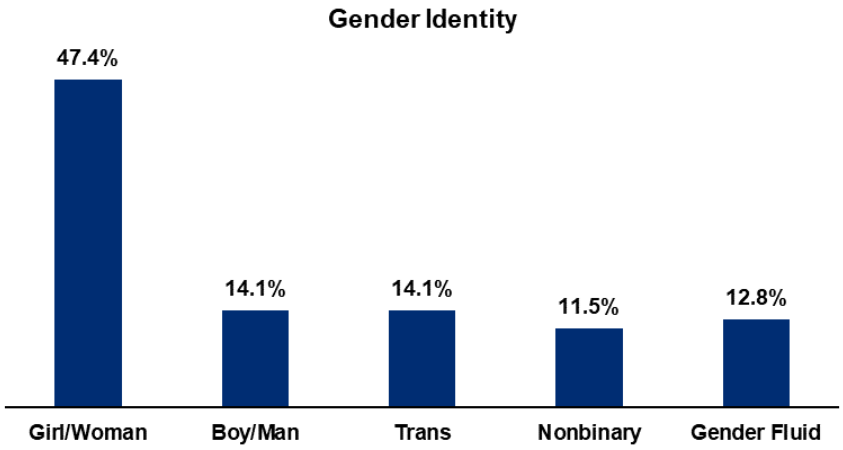
Region	Number of Groups	Number of Attendees
Desert	5	39
Mid-County	2	12
Western	3	27
Countywide	**10**	**78**

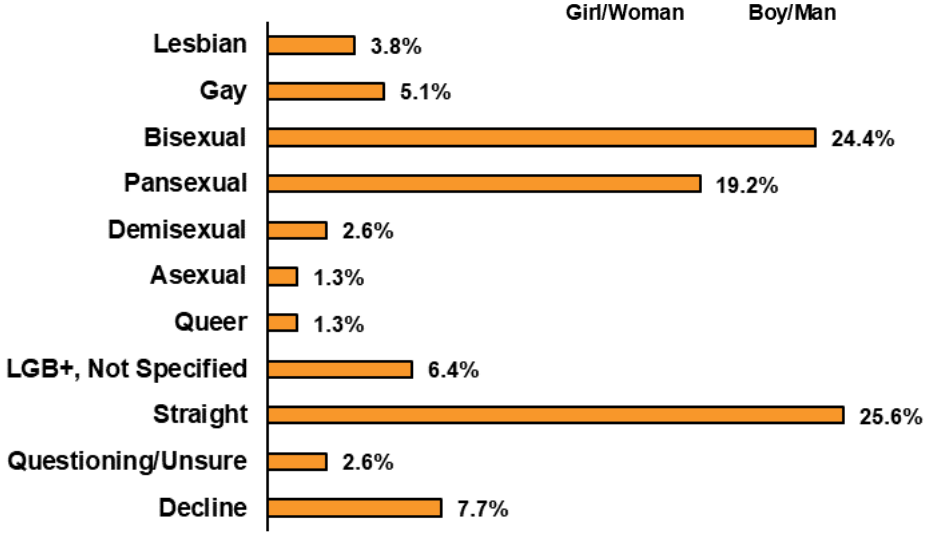


LGBTQ+ Support Groups: Demographics

Gender and Sexual Orientation

The 47.4% (n=37) of attendees identified as a girl/woman, 14.1% (n=11) as a boy/man, 14.1% (n=11) as transgender, 12.8% (n=10) as gender fluid, and 11.5% (n=9) as nonbinary.



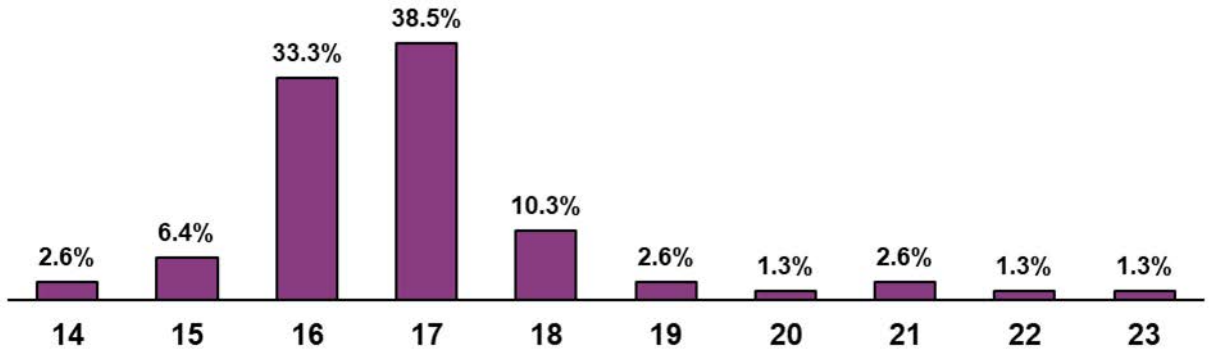


Countywide, most of the LGBTQ+ Support Groups' attendees identified as LGBTQ+ (64.1%, n=50), while 25.6% (n=20) participants identified as straight, 7.7% (n=6) declined to answer, and 2.6% (n=2) were unsure.

LGBTQ+ Support Groups: Demographics cont.

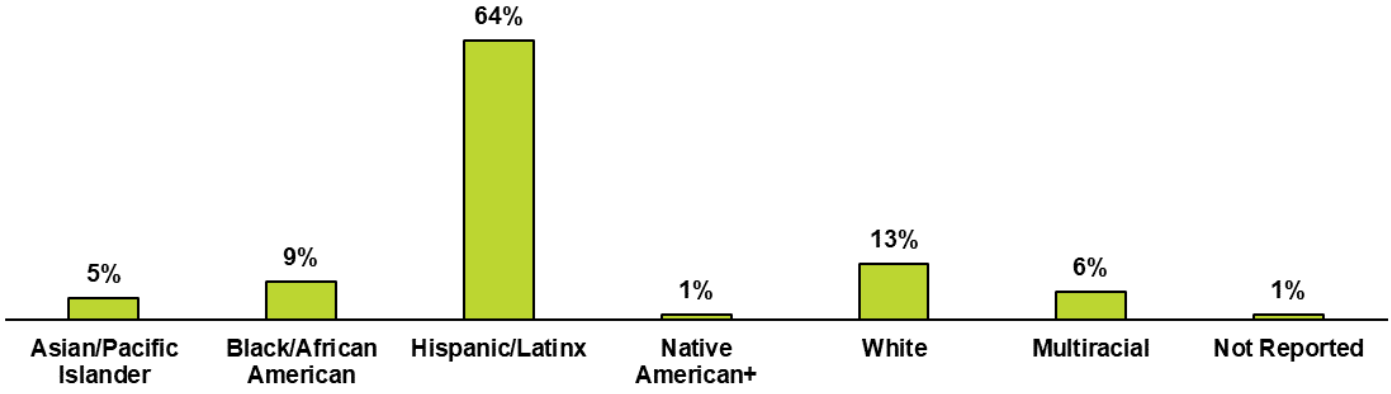
Age of Attendees

Countywide, the ages of attendees in the LGBTQ+ Support Groups were between 14 to 23 years old, with the majority being 17 years old (38.5%, n=30). From the figure below, most TAY participants Countywide reported being in the 16 to 17 age groups (71.8%, n=56). Overall, 91.2% (n=71) of the attendees were TAY.



Race/Ethnicity

Countywide, 64.1% (n=50) of participants identified as Hispanic/Latinx, 12.8% (n=10) as White, 9.0% (n=7) as Black/African American, 6.4% (n=5) as Multiracial, 5.1% (n=4) as Asian/Pacific Islander, 1.3% (n=1) as Native American (and one other race), and 1.3% (n=1) was not reported.



Language

The majority of attendees reported English as their preferred language (91.0%, n=71), followed by 6.4% (n=5) reporting both English and Spanish, 1.3% (n=1) Spanish, and 1.3% (n=1) was not reported.

Language	n	%
English	71	91.0%
Spanish	1	1.3%
English and Spanish	5	6.4%
Not Reported	1	1.3%

LGBTQ+ Support Groups: Satisfaction Surveys

At the end of each group, attendees were asked to fill out satisfaction surveys to gather feedback on their experience. Each survey consists of **11** satisfaction items, rated on a 5-point Likert scale, where ***1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree***, and ***5=Strongly Agree***. There were a total of **42** attendees who completed the satisfaction surveys, and the results are summarized below:

- **74%** of participants Agreed or Strongly Agreed that the support group changed how they think about themselves in a positive way
- **83%** of participants Agreed or Strongly Agreed that learning "SELF" skills was helpful to them
  - ◊ **76%** are more aware of their emotional and physical safety
  - ◊ **60%** experienced emotional growth
  - ◊ **62%** feel more comfortable discussing loss
  - ◊ **79%** developed a healthy self-identity that will be useful in the future
- **95%** of participants Agreed or Strongly Agreed that participating in this group has been an affirming experience for them
- **88%** of participants Agreed or Strongly Agreed that group topics were engaging and **83%** felt that the facilitator helped them feel safe in a group environment
- **93%** of participants Agreed or Strongly Agreed they would participate in this program again and **95%** would recommend this program to a friend who relates to them

Countywide (n=42)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Reported
1. This group has changed how I think about myself in a positive way	2.4%	2.4%	21.4%	42.9%	31.0%	-
2. Learning "SELF" skills has been helpful to me	4.8%	-	9.5%	35.7%	47.6%	2.4%
3. I am more aware of my emotional and physical safety	-	-	9.5%	35.7%	40.5%	14.3%
4. I experienced emotional growth	-	2.4%	23.8%	40.5%	19.0%	14.3%
5. I feel more comfortable discussing loss	-	7.1%	16.7%	21.4%	40.5%	14.3%
6. I developed a healthy self-identity that will be useful in the future	4.8%	-	16.7%	33.3%	45.2%	-
7. Participating in this group has been an affirming experience for me	4.8%	-	-	35.7%	59.5%	-
8. Group topics were engaging	2.4%	2.4%	4.8%	21.4%	66.7%	2.4%
9. Facilitator helped me feel safe in this group environment	-	-	2.4%	4.8%	78.6%	14.3%
10. I would participate in this program again	2.4%	2.4%	2.4%	4.8%	88.1%	-
11. I would recommend this group to a friend who can relate to me	2.4%	2.4%	-	9.5%	85.7%	-

Note: Some participants completed an older version of the survey which did not have all the same questions on the satisfaction survey so those responses were excluded for items 3, 4, 5, and 9 (n=6).

LGBTQ+ Support Groups: Satisfaction Survey Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- “Although I haven't been here I learned not to judge others.”
- “Being able to talk about more sensitive topics. To come out of my shell.”
- “By thinking more positive than negative”
- “Helped me talk to people more about my problems and helped me be in group settings.”
- “I feel more inspired to help younger people with the same issues that I had felt before.”
- “I felt seen”
- “I has helped with my self confidence and well being.”
- “I know a few more people who are similar to me and feel a bit more comfortable talking about my experience in the LGBTQ community”
- “I talked to more people”
- “I'm more social and more aware of my emotions.”
- “It has brought helpful change in me by making me more appreciative of others experiences.”
- “It has given me a place to be myself and a place to stay. It has also given me a great community.”
- “It has helped me have a better understanding of my self and others. I am more comfortable in talking about sensitive topics.”
- “It has helped me understand things and be more confident/meet new people.”
- “It helped me be way more social”
- “It helped me grow confidence in myself. I also look at life differently.”
- “It helped me open up and be more comfortable talking about issues”
- “It helped me understand my friend's experiences.”
- “It made me think more about my identity and how to accept myself.”
- “It made me understand what other people are going through and helped me to learn to comfort people”
- “It showed me not to feel bad about who I am”
- “It taught me to be more open and how to help a friend through any identity crisis.”
- “It's helped me talk to people and helped me engage as my true self at times.”
- “Made me realize other's emotions”
- “Stable medication, better mental health, community”
- “The people were fun to be around.”
- “The program has helped me open up and talk about some of my issues.”
- “They made me feel more seen!”
- “This program brought me a lot of comfort and safety that I don't usually experience during class.”
- “This program has been a very safe environment that I look forward to coming to because I feel like I can just be myself.”
- “This program has made me more confident to speak in a room full of people”
- “This program has made me realize that people have different struggles and made me change my perspective on certain topics.”
- “This program really helped me understand that I wasn't the only one who felt bad emotions.”

LGBTQ+ Support Groups: Satisfaction Survey Comments (cont.)

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants Disliked…

- "Besides the changes, no."
- "I had no problems with the program."
- "I know a lot of this stuff already."
- "I like everything!!"
- "I really enjoyed this program."
- "I'm quite anti-social and I guess talking but I could always get past it."
- "t was fine the way it was."
- "No I think everything was fair and a good opportunity."
- "No, I did not see anything that would make me feel like I did not like the program."
- "No, I liked everything."
- "Not much the program is great"
- "That the times to come were midday it would be better near last period."
- "There could be more people here, but it did as much as it could."
- "There wasn't anything I particularly didn't like. I really enjoyed the entire group! It was really fun."
- "We got off task a lot other then that it was a good group."

Additional Comments…

- "Best group ever. Everyone was nice and they are the best (smiley face)"
- "Everything was so fun and engaging, Thank You for doing this for us and making a safe environment."
- "Give [facilitator 1] and [facilitator 2] a raise"
- "I enjoyed listening to everyone's expirances"
- "I enjoyed this program."
- "I really loved this group and I hope it comes back next year!!! (heart symbol)"
- "I will miss you guys! (lmk when the next meeting/program for this will be!)"
- "I would love to join this group again for my next two years of high school"
- "I'm greatful I got this experience (smiley face) I love everyone here (heart symbol)"
- "It was very fun, the facilitators made the experiences very enjoyable."
- "Love their dynamic, they're really nice and make me feel safe"
- "[Facilitator 1, facilitator 2, and facilitator 3] were super sweet, and I hope to see them again"
- "Much Love"
- "Our instructors were amazing (smiley face)"
- "They are so nice (smiley face)"
- "This group is extremely helpful to me!"
- "This is a very safe environment that I personally believe a lot of people would enjoy!"

Mentoring: Eligibility Screening and Enrollment

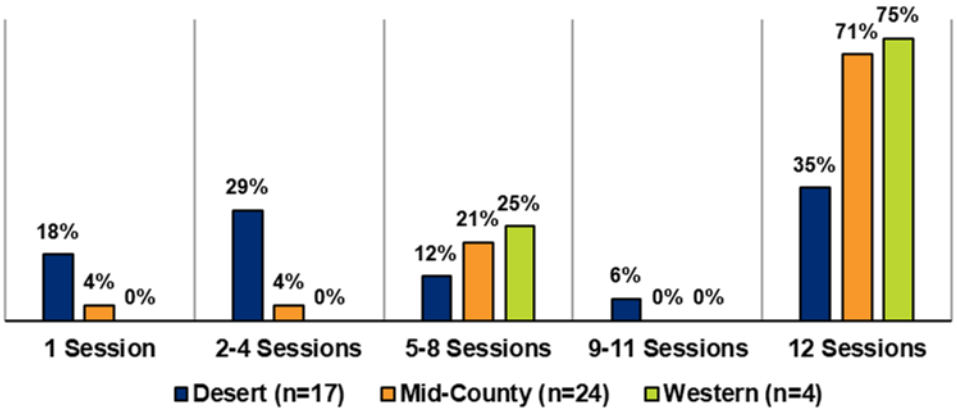
Mentoring is an individualized weekly activity provided by TAY Peer Youth Specialists. Mentors meet with youth once a week for three months and it is expected that mentor and mentees will have 12 contacts. An integral part of the mentoring program is goal setting with mentoring activities focused on supporting each mentees individualized goals. A goal setting action plan is used to set individualized goals and to monitor progress. Measurement of the participants perceptions of progress in the goal areas is assessed at the beginning, middle, and end of the mentoring period. Evaluation involves a pre and post survey that measures TAY mentees experiences with goal setting and goal obtainment during their participation in mentoring. In FY 2023-2024, TAY Peer Youth Specialists were to provide TAY peer mentoring to at least 20 youths per region for a total of 60 youths countywide. TAY youth are screened for eligibility into the program. In total, **51 youths were screened** for the mentoring program, of which **45 were enrolled** and **26 completed** the mentoring program.

Peer-to-Peer Mentoring Program				
	Desert	Mid-County	Western	Countywide
Screened	23	24	4	51
Enrolled	17	24	4	45
Completed	6 (35%)	17 (71%)	3 (75%)	26 (58%)

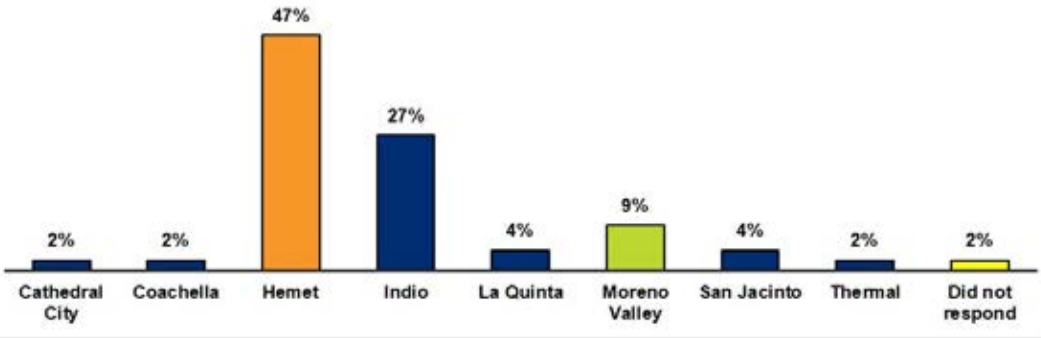
Session Attendance

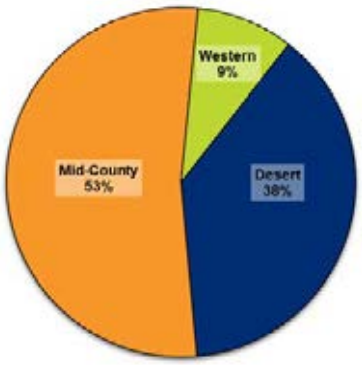
The session attendance in the Mentoring program varied. The goal is for youths to receive mentoring for 12 weekly sessions. The number of sessions per participant are shown in the following table and figure. A total of 391 sessions were provided during the 2023-2024 FY. The majority of the participants completed all 12 sessions (58%).

Number of Sessions	Number of Youths	%
1	4	9%
2 to 4	6	13%
5 to 8	8	18%
9 to 11	1	2%
12	26	58%



Mentees' City and Region



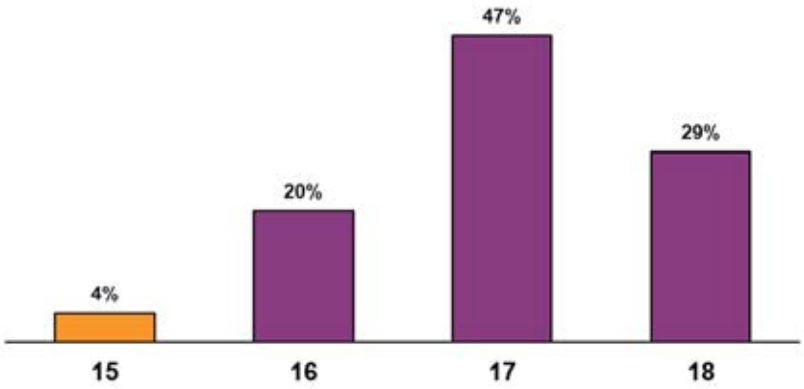


The majority of the mentees were from Hemet (47%, n=21) and Indio (27%, n=12).

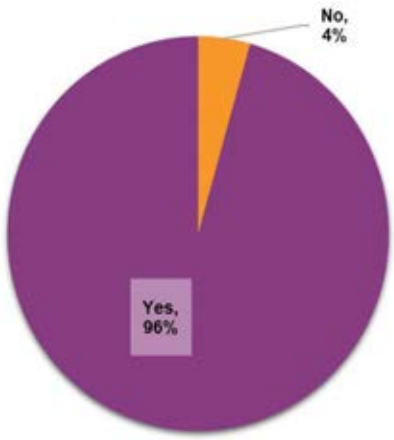
Mentoring: Demographics

The demographics for the enrolled youth are shown below. The majority of the mentees were TAY (96%, n=43) where the average age was 17 years old.

Age



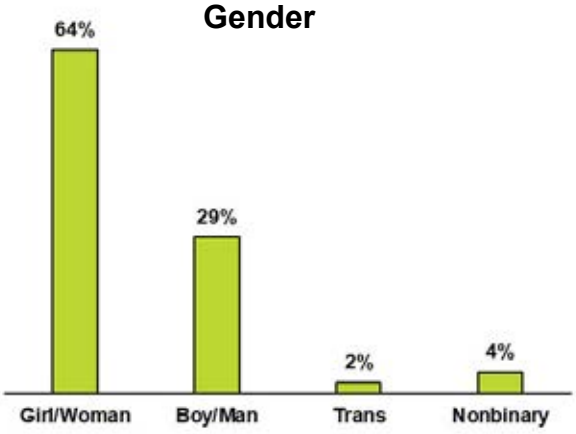
TAY/Non-TAY



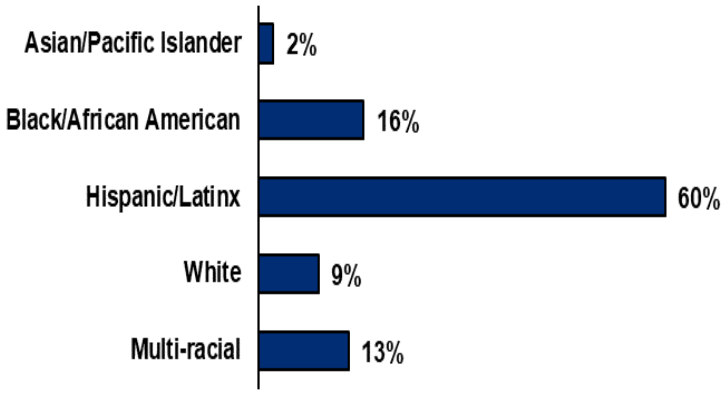
The majority of mentees identified as a girl/woman (64%, n=29), followed by 29% (n=13) as a boy/man, 4% (n=2) as nonbinary, and 2% (n=1) as transgender. Additionally, 15 mentees (33%) identified as LGB+.

The majority of the mentees were Hispanic/Latino (60%, n=27) and the preferred language for almost all of the mentees was English (91%, n=41).

Gender



Race/Ethnicity



Sexual Orientation	n	%
Straight	24	53.3%
Gay	3	6.7%
Bisexual	10	22.2%
Demisexual	1	2.2%
Omnisexual	1	2.2%
Unsure	2	4.4%
Decline	4	8.9%

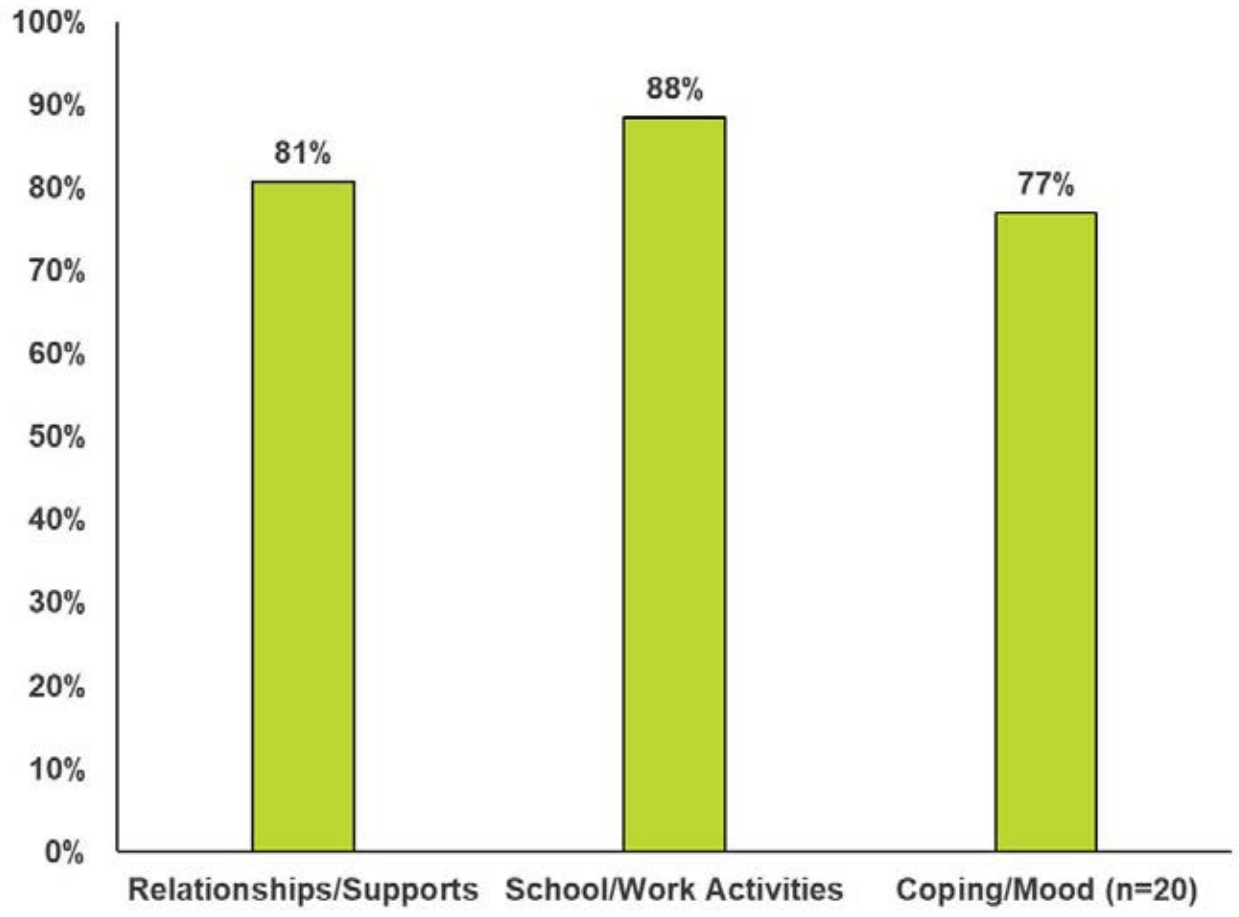
Language	n	%
English	41	91.1%
Spanish	3	6.7%
English and Spanish	1	2.2%

Mentoring: Goal Action Plan

Mentees were asked to complete a Goal Action Plan at the start, mid-way, and at the conclusion of mentoring sessions. At the beginning of the program, each mentee works with their mentor to complete the first Goal Action Plan. The participant sets three goals to work on during the mentoring time. While the goals are individualized, they define a goal for each of the following domains: **Relationships and Supports**, **Improvement in School/Work Activities**, and **Coping and Mood**. After creating the goals, the mentee then rates their feelings about each goal. There ratings are on a Likert scale of 1 to 4, where **1=Very Disappointed, 2=Somewhat Disappointed, 3=Somewhat Pleased**, and **4=Very Pleased**. During the program, once a mentee was pleased with the progress of a goal, it was replaced with a new goal.

Countywide, there were 26 mentees with pre- and post-goal ratings. The following figure represents the percentage of youth with improvement in goal ratings. In comparing goal achievements from pre to post of the 26 youth with data submitted, 16 mentees showed improvements for all three goal areas (61%). The domain with the most improvement was in **School/Work Activities** (88%), followed by **Relationships/Supports** (81%), and **Coping/Mood** (77%), respectively. Overall, mentees showed improvements and felt that they were very pleased with their own progress on their goals at the conclusion of the mentoring program, in comparison to how they felt about their goals at the beginning of the program.

Percentage of Youth with Improvements Pre to Post (n=26)

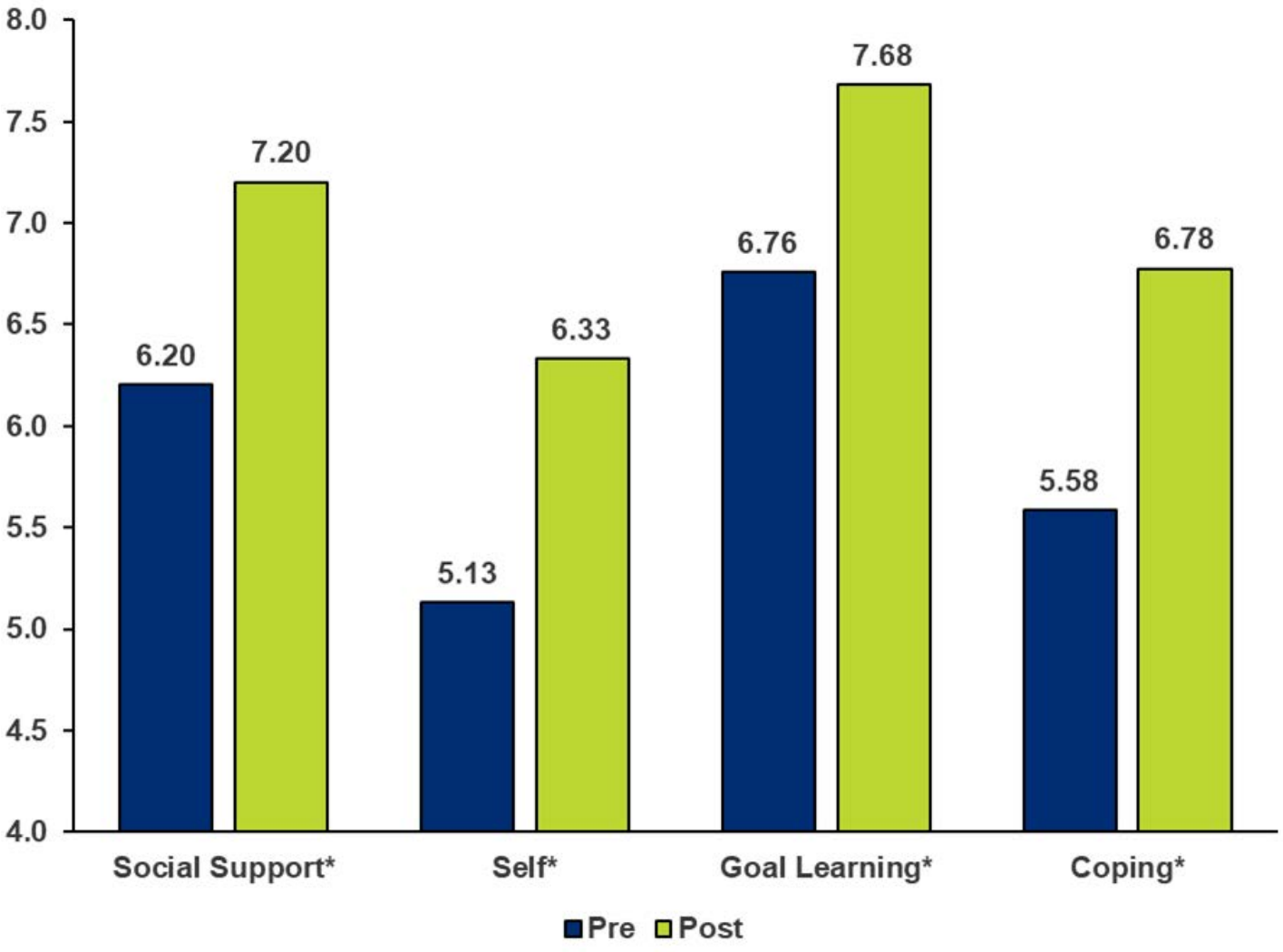


Mentoring: Pre/Post Surveys

The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. Each mentee was asked to fill out a pre-survey during the first session, and then a post-survey at the last session. There are a total of 18 questions, related to: **Social Support** (how they feel about the presence of social supports in their lives), **Self** (how they feel about themselves in different scenarios), **Goal Setting** (how they view and act upon their own life goals), and **Coping** (how they cope with different life situations presented to them). Mentees rated themselves on a Likert scale of 1 to 9, where **1**=**Strongly Disagree** to **9**=**Strongly Agree.**

There were a total of 26 matched pairs of pre- and post-surveys. The majority of mentees with pre- and post-surveys completed were from the Mid-County region (65%, n=17). Overall, increases in average scores can be seen across all domains, with the highest increases in the areas of **Self** and **Coping**. The increases across all domains are statistically significant (p< .05).

Mentoring Program Average Scores Pre to Post (n=26)



Note: * indicates statistical significance

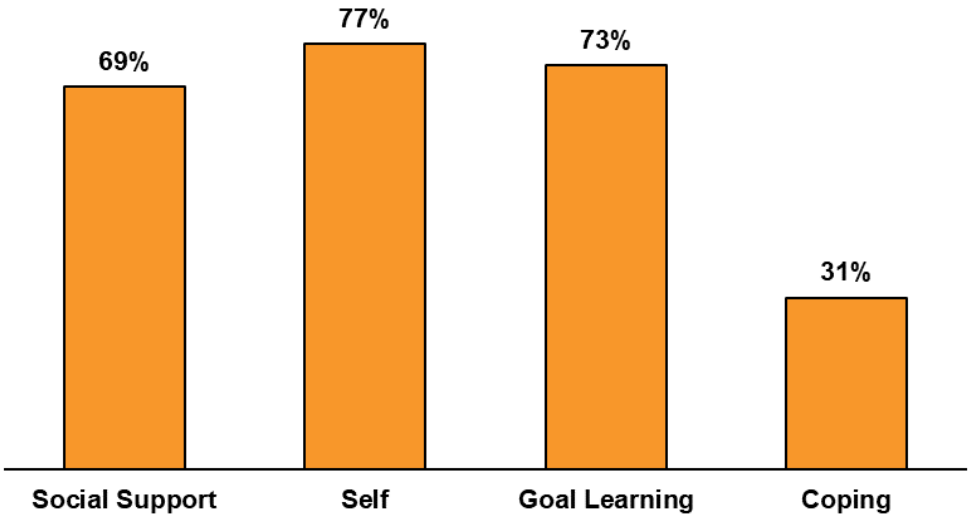
Mentoring: Pre/Post Questionnaire cont.

The following table shows the percent increase on mentees' average scores where all four domains increased. The "Self" domain increased the most (23%) on average scores in comparison to the other three domains.

Countywide (n=26)	% Increase on Average Scores
Social Support Having family members to rely on Having a friend to rely on Having someone to share most private worries and fear Knowing someone to turn to when dealing with personal problems	**16%**
Self Getting emotional support from friends or relatives Talking to someone about feelings Being optimistic in spite of what happened Refusing to let negative emotions drag them down Staying positive even when things look bad	**23%**
Goal Setting Having goals they want to reach Seeking something else to strive for after completing a goal Succeeding in reaching goals in school and/or work Succeeding in reaching goals in extracurricular activities	**14%**
Coping Concentrating efforts in reaching goals Taking action to get around problems when they arise Doing what has to be done when facing an issue, one step at a time Coming up with strategies when planning Thinking hard about what steps to take when planning	**21%**

The following chart shows the percentage of mentees who have shown improvement from pre- to post-measures in all four areas. "Self" had the largest proportion of mentees' who improved (77%, n=20), which suggest that the mentees' feeling about themselves increased by participating in the mentoring program.

Percentage of Mentees with Improvements from Pre to Post (n=26)



Mentoring: Satisfaction Surveys

The satisfaction survey is used to gather feedback from mentees on their experience in mentoring program and with their mentor. Each mentee was asked to rate 10 satisfaction items on a 5-point Likert scale, where **1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree**, and **5=Strongly Agree**. There were a total of 26 mentees who completed the satisfaction survey for the mentorship program, and their responses are summarized below.

In terms of feedback regarding the mentoring program:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentoring program has helped them define their current goals.
- **92%** of mentees "Agreed" or "Strongly Agreed" that through the program, they have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future.
- **85%** of mentees "Agreed" or "Strongly Agreed" that the program has allowed them to build stronger relationships with those whom I depend on.
- **81%** of mentees "Agreed" or "Strongly Agreed" that they felt as though this program was personalized towards reaching their specific goals.

In term of feedback regarding the mentors:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentors were knowledgeable when sharing information, their mentors met them at convenient times and locations, and their mentors kept their scheduled appointments.

Overall, **100%** of mentees reported being satisfied with the mentoring program.

Countywide (n=26)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Participation in this program has helped me define my current goals.	-	-	-	50.0%	50.0%
2. I feel as though this program was personalized towards reaching my specific goals.	-	-	19.2%	26.9%	53.8%
3. Through the program, I have come to understand the importance of self-praise throughout the goal-setting process.	-	-	7.7%	26.9%	65.4%
4. This program has allowed me to build stronger relationships with those whom I depend on.	-	-	15.4%	42.3%	42.3%
5. The program has helped me learn new ways to cope.	3.8%	-	3.8%	23.1%	69.2%
6. As a result of participating in this program, I now know how to make realistic and reachable goals in the future.	-	-	7.7%	30.8%	61.5%
7. The mentor was knowledgeable when sharing information.	-	-	-	3.8%	96.2%
8. My mentor met with me at convenient times/locations.	-	-	--	11.5%	88.5%
9. My mentor kept our scheduled appointments.	-	-	-	3.8%	96.2%
10. Overall, I am satisfied with the mentoring program.	-	-	-	-	100%

Mentoring: Comments

Mentees were also asked to comment on aspects of the mentoring program. Below are some comments from the participants.

What have been the most helpful things about the mentoring services that you've received?

- "Advise on life stuff."
- "Being able to feel heard about certain situations."
- "Being able to learn to open up and having someone to talk to and learn from."
- "Coping and how to improve."
- "Help doing things differently in my life."
- "Helping me set goals for the things I need to achieve."
- "Helping with my homework."
- "How I can be proud of myself and have realistic goals."
- "How to focus on my goals and grades."
- "How to keep my emotions in control during my activity and while at home."
- "I have learned a lot of things about myself that I would not have known without this program and my mentor. I have grown a lot from when I first started versus now. I allow myself to feel my emotions and be less damaging and harsh on myself for everything, especially the things I can't control. I feel like I have more control over my life instead of letting it pass by me and letting the things or people that happen to me choose my emotions for me. I know I care about things too much sometimes but I've come to realize that some things about me that may seem like a curse can actually be blessings."
- "I was able to build new relationships and try and get my future together."
- "It helped me be more comfortable with who I am. My mentor was the best too."
- "Just helping me realize that I have many options in life."
- "Just mainly keeping me on track and helping me improve things in my life."
- "Overall just listening to me speak and helping me through my problems also being understanding."
- "Some of the coping activities helped when I did use them, and some of the things that were meant to help me get homework done."
- "Talking really it's nice to have someone to talk to outside of home with problems."
- "Talking to them and he helped me and gave me advice and told me what to work on."
- "The coping skills being self praise."
- "The fact of talking freely with someone about the things I like to talk about." [Translated from Spanish]
- "The journaling."
- "The most helpful thing about mentoring was being able to improve myself and work towards my goals."
- "The most helpful thing is the realness and honesty of what we talked about."
- "The positive feedback from my mentor."
- "They gave me advice in situations I wasn't to sure about."

Additional comments:

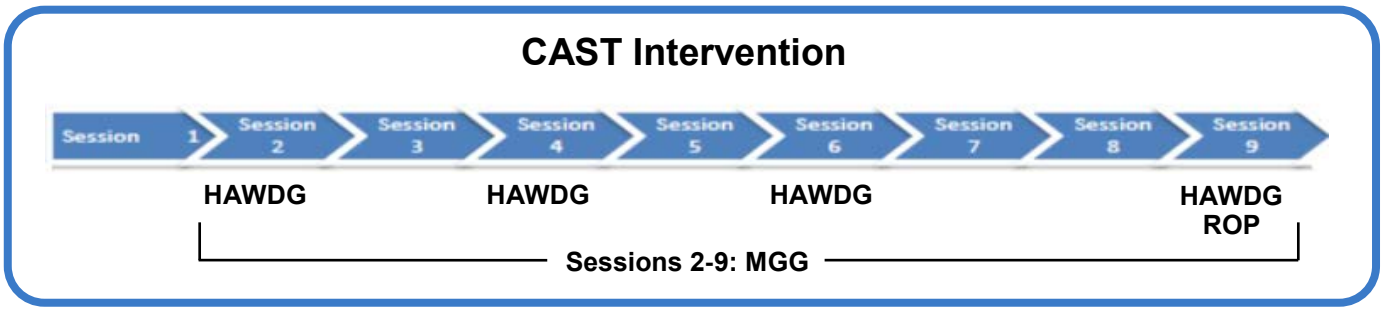
- "All in all, it helped out a lot. Most importantly it has helped me stay on track and keep up with school work."
- "Best mentor ever"
- "He was the best mentor I could ask for he was always there for me and I wish we had more time."
- "I love my mentor."
- "I'm glad I was able to participate in this program."
- "[Facilitator] was the best and helpful during the mentoring."
- "My mentor has helped me a lot with facing my problem and how to better my relationship with loved ones."
- "Overall I'm glad to have this opportunity to better myself."
- "Thank you so much, [facilitator]!! You have been a light in my life especially in the dark parts of it and I couldn't thank you more for the impact you've left on me."

Coping and Support Training (CAST)

Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and School Achievement. It was first implemented in the Peer-to-Peer program during FY 2013-2014. For FY 2023-2024, each CAST group consisted of a screening session, followed by 9 sessions facilitated by PEI TAY Peer Youth Specialists. Each year, Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region.

CAST uses three process evaluation measures to determine if the program was delivered as designed and obtained the desired outcomes. The process evaluation measures included:

- **Monitoring Group Goals (MGG)**
  - A survey rating, by session, on how well the student is doing in each of the 3 major CAST goals:
    1. Mood Management
    2. Drug Use Control
    3. School Achievement
- **How Are We Doing In Group? (HAWDG)**
  - A 12-item evaluation of CAST Leader and CAST peer group support and help, belonging, and student responsiveness.
- **Recognition of Progress (ROP)**
  - A survey where participants rate their current performance compared to when they first began CAST and identify areas in which they still need work. It measures specific acquisition related to CAST skill areas and progress goals (self-esteem, decision making, and personal control of moods, school, and drug use).



**Please Note: Since FY2015-2016, the 12-week session content was condensed into 9 weeks.*

CAST: Participation

In order to participate in the CAST program, participants first complete a "Demographic, Screening, and Enrollment Form" during a screening session. Eligibility into the program is determined by participant's reported age (must fall within TAY ages of 16-25 years), priority population (LGBTQ+, Homeless, Transitioning to college, Foster or former foster youth), and their self-rating scores in the Self-Esteem, Mood, and School sections of the Recognition of Progress (ROP) survey which are embedded into the screening form. If participants score 4 or less on the Mood section of the ROP they may not be appropriate for the CAST program since it indicates that the participant is experiencing high levels of distress. Those scoring 4 or less on the Mood section of the ROP will then be asked to complete the Center for Epidemiologic Studies Depression Scale (CES-D) to determine referral into the "Stress and Your Mood," or other appropriate programs. For FY 2023-2024, a total of 95 screenings were completed where 85 were TAY aged individuals and 10 were non-TAY aged individuals. Of those 95 screenings, 83 attended a group, 4 declined services, 0 were referred to other programs, and 8 did not meet criteria for participation.

	Desert	Mid-County	Western	Countywide
Attended	9	23	51	83
Declined	1	0	3	4
Referred	0	0	0	0
Did not meet criteria	4	0	4	8

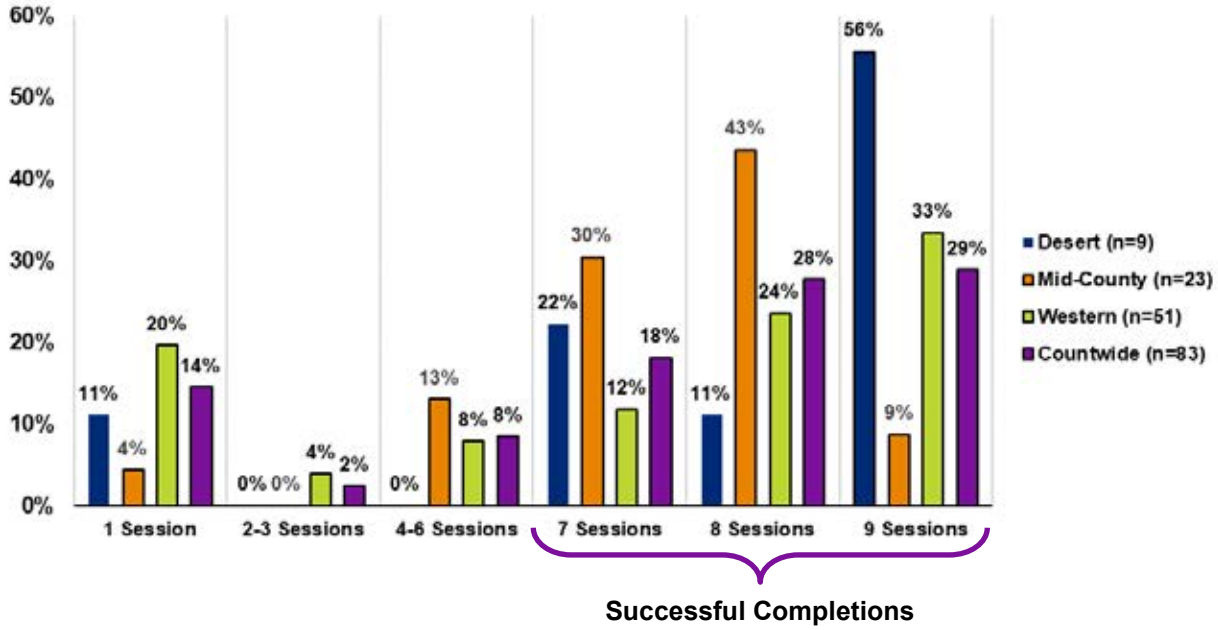
CAST: Attendance and Program Completion

Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region. During FY 2023-2024, countywide there were 95 individuals who were screened for CAST with 87 who were enrolled in CAST. Of the 87 individuals who were enrolled, 95% (n=83) attended at least one session. The Desert region held 1 group with 9 participants, the Mid-County region held 4 groups with 23 participants, and the Western region held 6 groups with 51 participants. Completion of CAST was defined as completing seven or more sessions. Of the total 83 participants who enrolled *and* attended at least one session in a CAST group offered throughout the county, 75% (n=62) completed the program.

Peer-to-Peer CAST Program				
	Desert	Mid-County	Western	Countywide
Screened	14	23	58	95
Enrolled	10	23	54	87
Attended ≥ 1 Session	9 (90%)	23 (100%)	51 (94%)	83 (95%)
Completion of ≥ 7 Sessions	8 (89%)	19 (83%)	35 (69%)	62 (75%)

In the Desert region, a total of 9 individuals enrolled and attended a CAST session with 8 (89%) attending 7 or more sessions. In the Mid-County region, a total of 23 individuals enrolled and attended a CAST session with 19 attending 7 or more sessions. In the Western region, a total of 51 individuals enrolled and attended a CAST session with 35 (69%) attending 7 or more sessions.

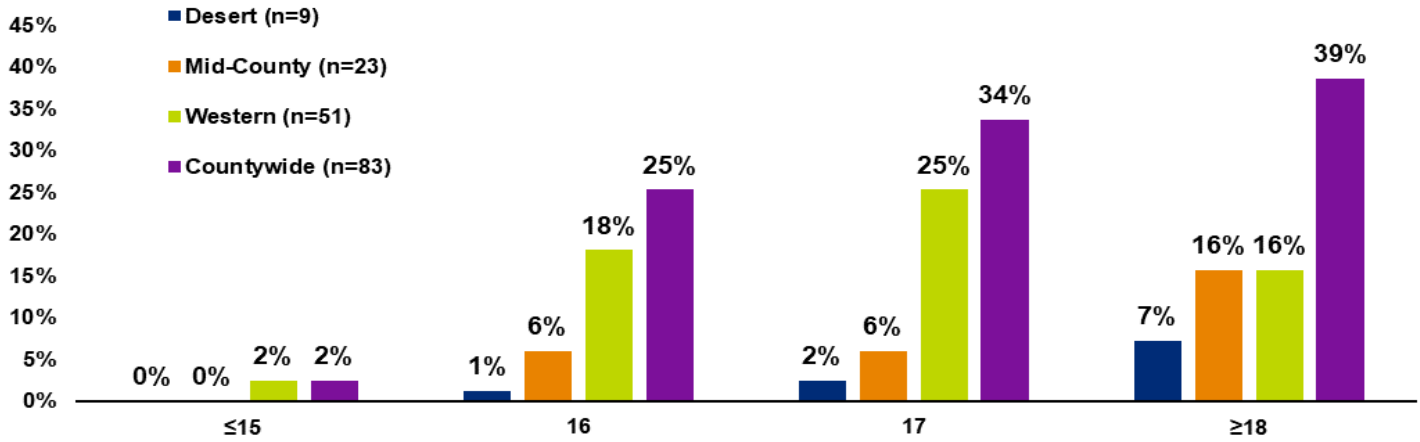
Number of CAST Sessions Attended (n=83)



Since CAST is typically held on school campuses, Peer-to-Peer staff had challenges with schools allowing access to some campuses to conduct CAST groups. Specifically, in the Desert region, two CAST group were started where 21 youth were screened and enrolled. Of those 21 enrolled, 17 attended at least one session and 4 declined services. However, after completing four of the nine sessions, the school revoked permission to conduct the program, therefore these participants were not included in the descriptive and outcome data.

CAST: Demographics

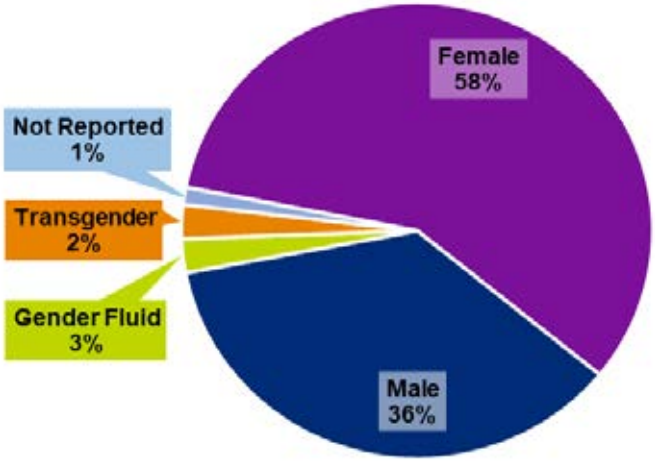
Age



Participants from the Desert region were primarily 18+ with 7% (n=6). In the Mid-County region, the largest age group was also 18+ with 16% (n=13), and Western region reported 25% (n=21) of their participants were 17. Of the 83 participants enrolled countywide, 98% (n=81) were TAY while the remaining 2% (n=2) were not TAY.

Gender and Sexual Orientation

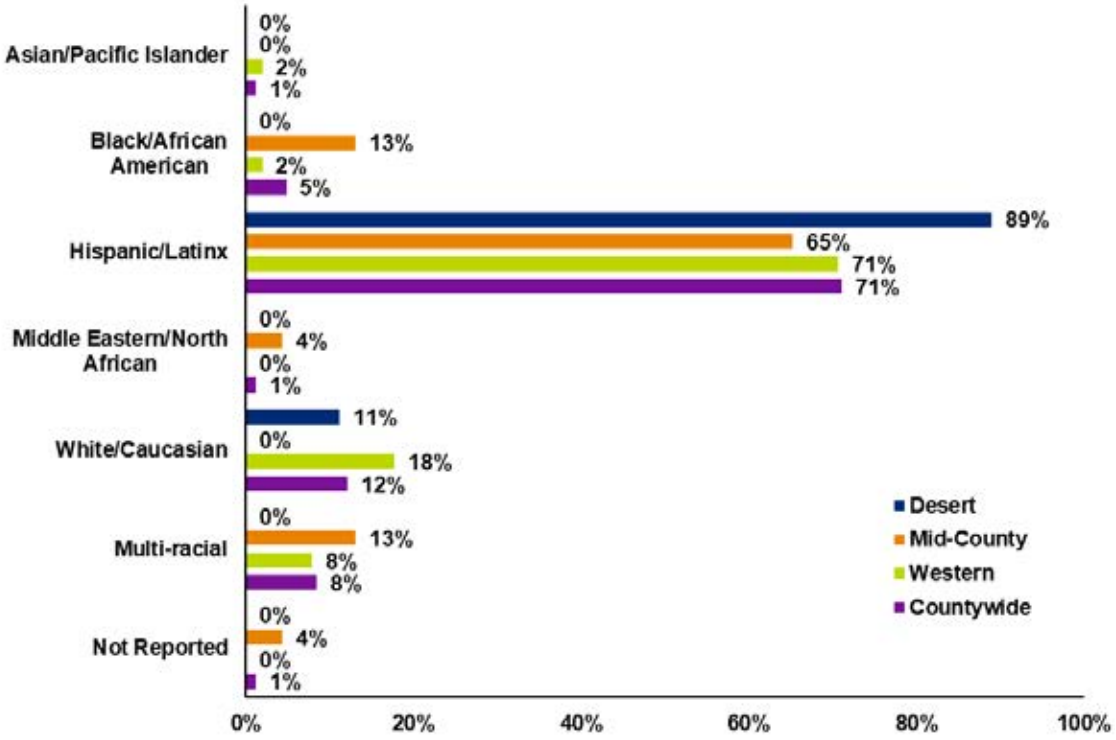
Countywide, the majority of youth enrolled in CAST were female (58%, n=48). Additionally, 36% (n=30) were male, 2% (n=2) identified as transgender, 2% (n=2) identified as gender fluid, and 1% (n=1) chose not to respond. There were 4% (n=3) of participants in Desert region who identified as LGB, 8% (n=7) in Mid-county region, and 19% (n=16) in Western region.



Countywide, most participants (96%, n=80) reported not having disabling condition, while a few participants (4%, n=3) reported having a disabling condition (these participants noted as having Asthma, Dyslexia, and Stuttering). Additionally, almost all participants (99%, n=82) indicated that they were not Veterans, while 1 participant chose not to respond to this question.

LGB	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide
Yes	3 (4%)	7 (8%)	16 (19%)	26 (31%)
No	4 (5%)	16 (19%)	26 (31%)	46 (55%)
Not Reported	0 (0%)	0 (0%)	2 (2%)	2 (2%)
Unknown	2 (2%)	0 (0%)	7 (8%)	9 (11%)

CAST: Demographics

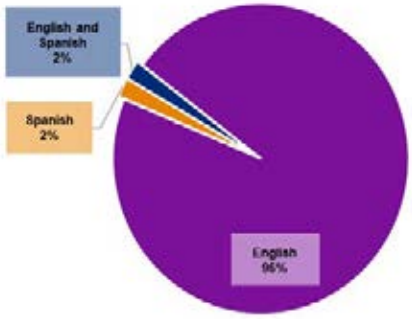


Race/Ethnicity

Countywide, the majority of youth enrolled in CAST were Hispanic/ Latinx (71%, n=59). About 12% (n=110) of youth identified as White/Caucasian, 5% (n=4) identified as Black/ African American, and 18% (n=15) identified as Multiple Races. There were 3 participants who identified as Asian/ Pacific Islander, Middle Eastern/North African, and chose not to respond (1%, n=1 in each category).

Countywide, 47% (n=39)

Language



Ninety-five percent (n=79) of participants reported English as their primary language countywide. This was followed by 2% (n=2) of participants reporting both English and Spanish as their primary language, and 2% (n=2) reported Spanish only.

Participants' City of Residence

Countywide, the majority of CAST participants reported their residences as the city of Riverside (51%,n=42), followed by Hemet (22%, n=18). For the Desert region, the reported cities were Indio (10%, n=8) and Thermal (1%, n=1). In the Mid-County region, the reported cities were Hemet (22%, n=18), San Jacinto (5%, n=4), Perris (2%, n=2), and Winchester (1%, n=1). For the Western region, the reported cities were Riverside (51%, n=42), Jurupa Valley (7%, n=6), and Rubidoux (1%, n=1).

Cities	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide (n=83)
Hemet	0 (0%)	18 (22%)	0 (0%)	18 (22%)
Indio	8 (10%)	0 (0%)	0 (0%)	8 (10%)
Jurupa Valley	0 (0%)	0 (0%)	6 (7%)	6 (7%)
Perris	0 (0%)	2 (2%)	0 (0%)	2 (2%)
Riverside	0 (0%)	0 (0%)	42 (51%)	42 (51%)
Rubidoux	0 (0%)	0 (0%)	1 (1%)	1 (1%)
San Jacinto	0 (0%)	4 (5%)	0 (0%)	4 (5%)
Thermal	1 (1%)	0 (0%)	0 (0%)	1 (1%)
Winchester	0 (0%)	1 (1%)	0 (0%)	1 (1%)

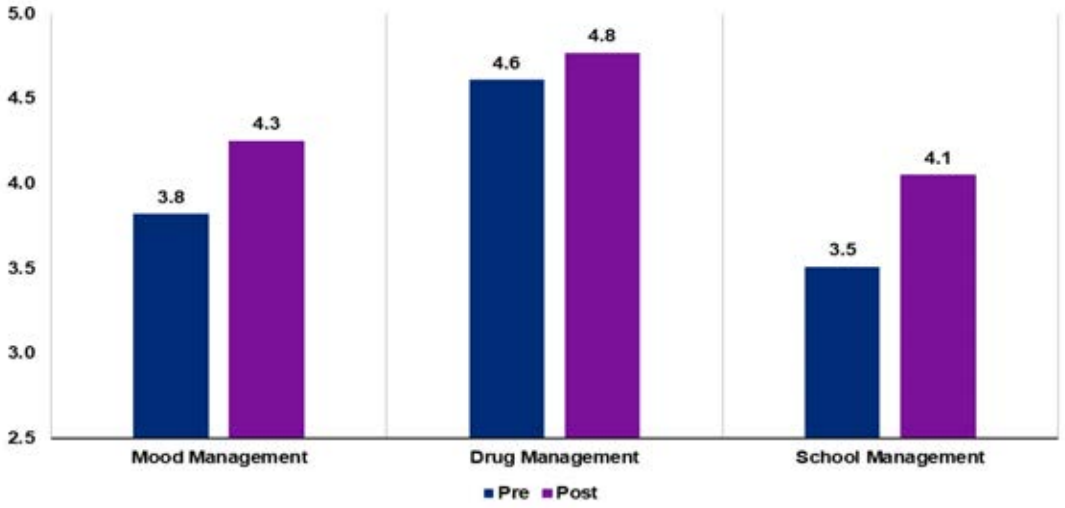
CAST Outcome Measures

Monitoring Group Goals (MGG)

MGG surveys were collected from participants at the end of sessions 2 through 9, in order to measure participants' performance in the three major CAST goal areas of mood management, drug-use control, and school achievement. Surveys collected at the end of sessions 2 and 9 were used for pre- to post-test analysis. There are some instances in which participants did not attend nor complete items for sessions 2 and/or 9, therefore means are reported for other sessions (3-8) but no other comparisons will be completed.

Of the 62 participants who completed the program, a total of 61 participants submitted MGGs for pre to post comparisons for some or all three items. Of the total 61 participants, 57.4% (n=35) attended CAST sessions in the Western region, 29.5% (n=18) attended CAST in the Mid-County region, and 13.1% (n=8) attended CAST in the Desert region, respectively.

MGG Pre/Post Results



The MGG surveys consist of survey items regarding participants' management of their feelings of depression and anger, drug use, and school smarts. All three questions are rated on a scale of 1-5; where lower ratings indicate poor management, and higher ratings indicate more positive management of the CAST goals. Countywide, participants' average post-test scores significantly increased from their pre-test scores for Mood Management, School Smarts Management and Drug Use Management suggesting meaningful improvement from the start of participation in the program to the end. High scores in Drug use management overall indicate little to no use of drugs and/or controlled substances.

Countywide Mean Differences and Percentage of Change

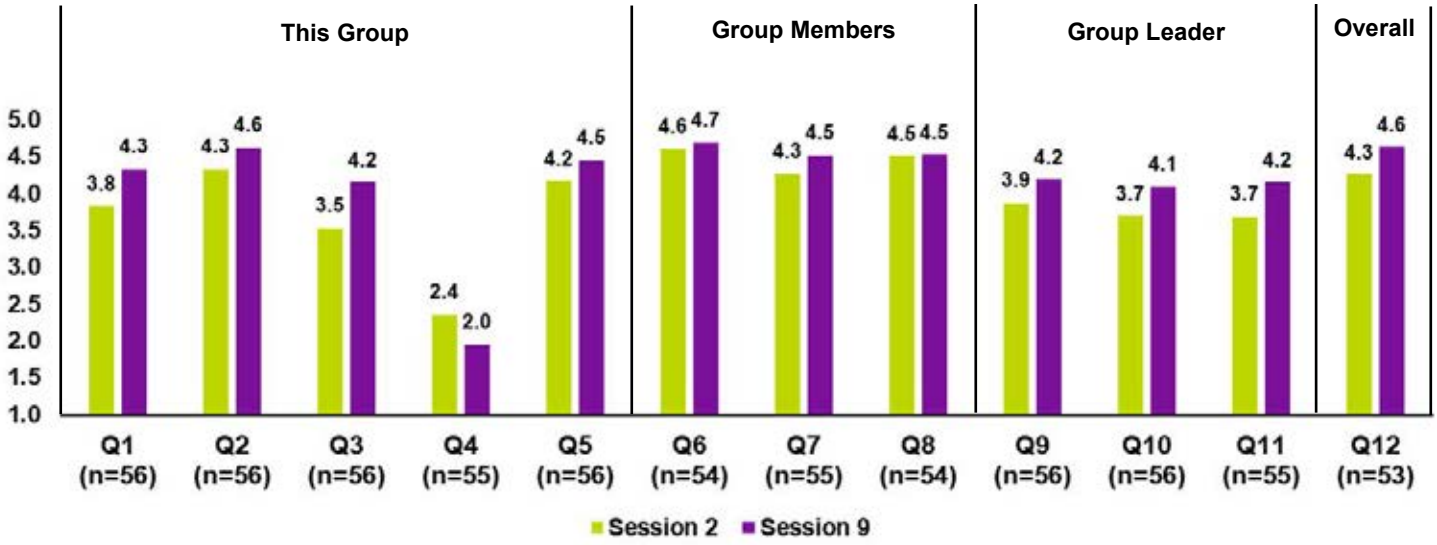
	Mean Difference	Worsened	Same	Improved
Mood (Depression/Anger) Management: (1) Feeling super depressed (or super angry), (2) Feeling depressed (or angry), (3) Feeling sort of sad (or a little angry), (4) Feeling OK, and (5) Feeling great	**0.44***	10 (16%)	22 (36%)	29 (48%)
Drug-Use Management: (1) Using way too much, out of control, (2) Using too much, (3) Using a little, (4) Not using, but tempted, and (5) Not using, in control	**0.17***	1 (2%)	51 (83%)	9 (15%)
School Smarts Management: (1) Messing up big time, (2) Just barely passing, (3) Doing fair, but could be better, (4) Doing OK, and (5) Doing great	**0.54***	8 (13%)	23 (38%)	30 (49%)

Note. * indicates significant mean difference from pre to post measure. It is important to note each management item does not contain the same participants even though the "n" is the same for each item.

CAST Outcome Measures

How Are We Doing in Group? (HAWDG)

HAWDG surveys were collected from participants at the end of sessions 2, 4, 6, and 9, in order to measure the participants' feelings of support and help in group. Of the 62 participants who completed the program, a total of 56 participants submitted at least one item pair from the HAWDG survey for sessions 2 or 9. Of the 56 participants, 60.7% (n=34) attended CAST sessions in the Western region, 30.4% (n=17) attended CAST sessions in the Mid-County region, and 8.9% (n=5) attended CAST sessions in the Desert region.



The HAWDG surveys include general items about the participant's feelings toward the group, the group leader, other group members, and the overall experience. It is rated on a scale from 1-5, with lower ratings indicating less frequency and higher ratings indicating more frequency (1-Never/Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). The mean difference scores reflect the average difference between Session 2 and Session 9. All items except Q2 and Q8 showed meaningful increases in frequency. Countywide, the largest increase was in participants' sense of "belonging" for item 3. Below is the table showing percentages of increase and decrease in frequencies for participants.

	Mean Difference	Decreased	Same	Increased	No Response
In This Group					
1. The topics we cover interest me	**0.5***	3 (5%)	28 (50%)	25 (45%)	0 (0%)
2. I really want to do my best	**0.29***	4 (7%)	35 (63%)	17 (30%)	0 (0%)
3. I have a real sense of "belonging"	**0.63***	4 (7%)	23 (41%)	29 (52%)	0 (0%)
4. We have serious conflicts and tensions	**-0.42***	17 (30%)	29 (52%)	9 (16%)	1 (2%)
5. I learn something useful each Session	**0.29***	9 (16%)	27 (48%)	20 (36%)	0 (0%)
The Group Leader (Teacher)					
6. Encourages and supports me	0.09	6 (11%)	37 (66%)	11 (20%)	2 (4%)
7. Is someone I can count on to help me	**0.26***	7 (13%)	34 (61%)	14 (25%)	1 (2%)
8. Offers useful points of view about topics we discuss	0.02	12 (21%)	32 (57%)	10 (18%)	2 (4%)
The Other Group Members					
9. Encourages and support me	**0.32***	7 (13%)	28 (50%)	21 (38%)	0 (0%)
10. Give me advice or information I need	**0.43***	11 (20%)	20 (36%)	25 (45%)	0 (0%)
11. Get support and encouragement from me	**0.47***	10 (18%)	22 (39%)	23 (41%)	1 (2%)
Overall					
12. I am satisfied with the support and encouragement I get	**0.38***	2 (4%)	33 (59%)	18 (32%)	3 (5%)

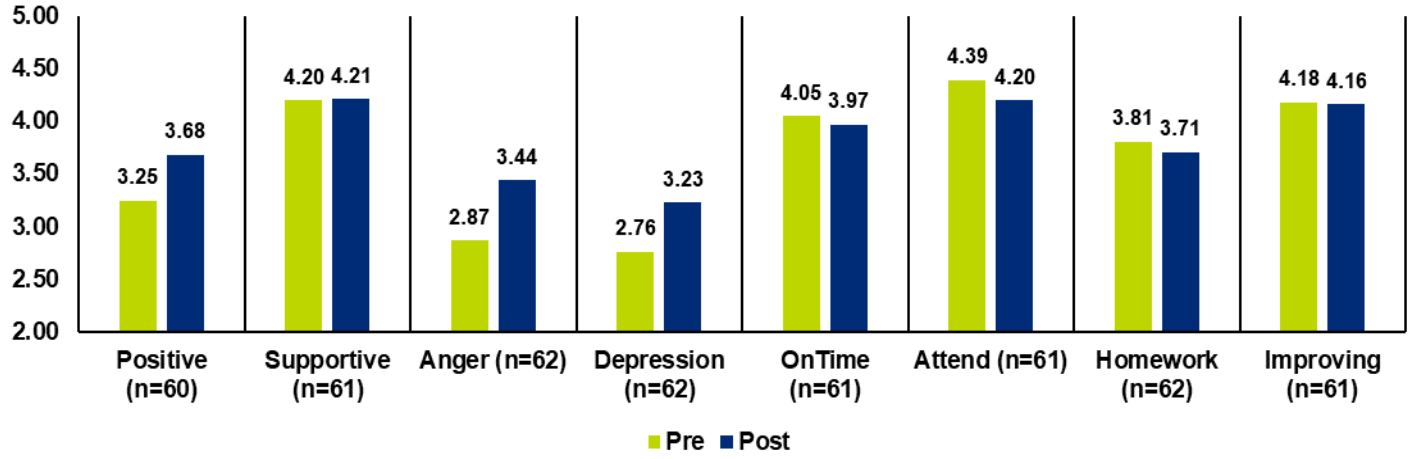
Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

CAST Outcome Measures

Recognition of Progress (ROP)

ROP surveys were collected from participants during the initial screening session and the final session, in order to measure participants self rated skills in the following areas: self-esteem and personal control with moods, school work, and drug use. A total of 62 participants completed CAST and submitted pre-and post-surveys. Of the 62 participants who submitted pre- and post-surveys, 57% (n=35) completed CAST in the Western region, 31% (n=19) completed CAST in the Mid-County region, and 13% (n=8) completed CAST in the Desert region. Please note that the graph below does not depict Personal Control or Drug Use items as they had relatively low scores. Mean differences for these items are still reported in the table below.

ROP Pre/Post Results



ROP evaluates items in the skill areas of self-esteem and personal control of moods, school, and drug use. It is rated on a scale from 1-5, with lower ratings indicating lower frequency and higher ratings indicating higher frequency (1-Never/ Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). For analysis of self-esteem and personal control of moods, school, and drug use, post-test scores completed at the end of the program were compared to pre-test scores from their ROP survey at screening. Countywide, average post-test scores showed statistically significant ($p<.05$) improvement over the average pre-test scores to post-test scores in one item of self-esteem, both items of personal control in moods, and in one item of personal control in drug use. The mean differences in these four items that showed significance are shown in bold below.

Countywide (n=62)	Mean Difference	Worse	Same	Improved	No Response
Self-Esteem:					
Being positive with myself, recognizing my strengths	**0.43***	8 (12.9%)	26 (41.9%)	26 (41.9%)	2 (3.2%)
Praising and being supportive of others	0.02	13 (21%)	34 (54.8%)	14 (22.6%)	1 (1.6%)
Personal Control - Moods:					
Anger-controlling my thoughts, feelings and actions	**0.57***	9 (14.5%)	17 (27.4%)	36 (58.1%)	0 (0.0%)
Depression-getting "unstuck" from negative moods	**0.47***	13 (21.0%)	19 (30.6%)	30 (48.4%)	0 (0.0%)
Personal Control - School:					
Being on time for class	-0.08	18 (29.0%)	25 (40.3%)	18 (29.0%)	1 (1.6%)
Attending class daily	-0.20	19 (30.6%)	31 (50.0%)	11 (17.7%)	1 (1.6%)
Doing my assignments, homework	-0.10	15 (24.2%)	35 (56.5%)	12 (19.4%)	0 (0.0%)
Working on improving my grades, school achievement	-0.02	13 (21.0%)	35 (56.5%)	13 (21.0%)	1 (1.6%)
Personal Control - Drug Use:					
Smoking (cigarettes)	0.10	1 (1.6%)	53 (85.5%)	4 (6.5%)	4 (6.5%)
Using Alcohol	0.05	4 (6.5%)	50 (80.6%)	4 (6.5%)	4 (6.5%)
Using Marijuana	**0.20***	1 (1.6%)	49 (79.0%)	9 (14.5%)	3 (4.8%)
Using other drugs	0.05	1 (1.6%)	56 (90.3%)	1 (1.6%)	4 (6.5%)

Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

Annual CAST Program Reviews

CAST Screening, Enrollment, Attendance, and Completion

A total of 95 participants were screened for enrollment into the CAST program in FY 2023-2024 as opposed to 133 and 117 who were screened in FYs 2022-2023 and 2021-2022, respectively. Additionally, of the total participants who attended a CAST group during FY2023-2024, 75% completed the program, compared to 58% and 55% in FYs 2022-2023 and 2021-2022, respectively.

FY 2023-2024 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	14	23	58	**95**
Enrolled	10 (71%)	23 (100%)	54 (93%)	**87 (92%)**
Attended ≥ 1 Session (% of Enrolled Participants)	9 (90%)	23 (100%)	51 (94%)	**83 (95%)**
*Completion of ≥ 7 (of 9) Sessions	8 (89%)	19 (83%)	35 (69%)	**62 (75%)**

FY 2022-2023 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	53	14	66	**133**
Enrolled	47 (89%)	10 (71%)	64 (97%)	**121 (91%)**
Attended ≥ 1 Session (% of Enrolled Participants)	41 (87%)	9 (90%)	62 (97%)	**112 (93%)**
*Completion of ≥ 7 (of 9) Sessions	21 (51%)	0 (0%)	44 (71%)	**65 (58%)**

FY 2021-2022 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	50	17	50	**117**
Enrolled	50 (100%)	0 (0%)	47 (94%)	**97 (83%)**
Attended ≥ 1 Session (% of Enrolled Participants)	37 (74%)	0 (0%)	36 (77%)	**73 (75%)**
*Completion of ≥ 6 (of 9) Sessions	15 (41%)	0 (0%)	25 (69%)	**40 (55%)**

MHSA
Prevention and Early Intervention
Youth Outreach Report

FY 2023-2024

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YOUTH OUTREACH PROJECT

Program Description

Through the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding, Operation Safehouse, Inc. is contracted to provide services in Riverside County to Transition Age Youth (TAY) who are homeless, a run away or at of risk of running away, through their Safe Place and Street Outreach to Youth Program. The Youth Outreach Program is dedicated to the safety and well being of youth in crisis and is committed to providing comprehensive support services for at-risk youth and those struggling with crisis situations. MHSA PEI funding is focused on two components of Operation Safehouse programming which are described below.

Operation Safehouse Safe Place Project



Operation Safehouse, Inc. was funded through MHSA-PEI to train and educate the community on the Safe Place program. This program is based on "Project Safe Place", a national program found in communities all across the United States, which creates Safe Place location designations within the local the community organizations and businesses centers, for youth to seek assistance.

Safe Place is a community prevention initiative where Safe Place trains and then designates businesses and organizations as Safe Place locations, making help readily available to youth in the community. Safe Place locations include: libraries, community centers, public buses, various businesses and social service facilities. Designated Safe Place locations display the Safe Place sign, the universal symbol of youth safety. Safe Place designated sites are trained to respond to youth that ask for assistance. Safe Place outreach, training and education are targeted to business owners, bus drivers, and other community agencies who are already a designated site or who could become a Safe Place designated site for at-risk youth in need of immediate help and safety.

In Riverside County, there are currently over 250 Safe Place locations, including all the fire stations, police stations, Riverside Transit Agency (RTA) and Sunline buses. Safe Place allows Operation Safehouse to have "virtual doors" throughout the community, by displaying the "Safe Place" symbol in various locations, their goal is to provide assistance to youth who see the sign and ask for help at any of these locations. Operation Safehouse trains staff at the designated Safe Place sites to ensure people at those locations know the resources and how to help a youth in need. Presentations on Safe Place are also provided to the community to educate community members and organizations on what Safe Place sites do.

Operation Safehouse Street Outreach

In addition some PEI funding also supports targeted street outreach to homeless and runaway youth to facilitate the reunification of the Transition Age Youth (TAY) with an identified family member or to a safe environment. Operation Safehouse staff provide youth with information on available resources and where they can seek assistance including Safe Place sites.

DATA COLLECTION

Operation Safehouse staff submitted data on a monthly basis from July 2023 to June 2024. Activities in the Western and Mid-County regions were summarized into one report, while the Desert region had its own separate monthly report. The Emergency Solutions Grant (ESG) team was the only team working with clients in both the Desert and Western/Mid-County regions, primarily focusing on youth aged 11 to 24.

In month of July 2023, for the Desert region, there was no staff to provide a monthly report for the month.

The monthly data includes the following components:

- ***Safe Place Training Information Report***
  To document the Safe Place training to Safe Place sites, including location, agency, date, and number of attendees.
- ***Safe Place Educational Presentation Report***
  To document outreach Educational presentations done to market Safe Place, at which Operation Safehouse staff present information on what Safe Place does for the community. Information recorded includes: date, location, staff presenting, number of attendance, pamphlet distribution, etc.
- ***Operation Safehouse Street Team Activities Report***
  To document street outreach activities to youth. Information recorded includes: date, type of street outreach, names of youths, race/ethnicity, age, gender, type of referrals provided, and shelter programs entered.
- ***Operation Safehouse Street Outreach Monthly Shelter Placement Report***
  To document the client name, shelter/program entered, and the total counts on the type of referrals Provided by Operation Safehouse on a monthly basis.
- ***Operation Safehouse Street Outreach Community Involvement Report***
  To document the Partnership/Community Involvement meetings attended by Operation Safehouse staff members.
- ***Operation Safehouse Staff Training Report***
  To document the RHYTTAC trainings attended by Operation Safehouse staff members.

SAFE PLACE TRAINING INFORMATION

There was no training conducted and/or no training data submitted for Safe Place Trainings between July 2023 to June 2024 for Desert region and Western/Mid-County region.

SAFE PLACE EDUCATIONAL PRESENTATIONS

Operation Safehouse conducted a total of **37** Educational Presentations, with a total attendance of **2,348** people. The table below shows the summary of all Safe Place Educational Presentations completed by Operation Safehouse staff during the fiscal year 2023-2024.

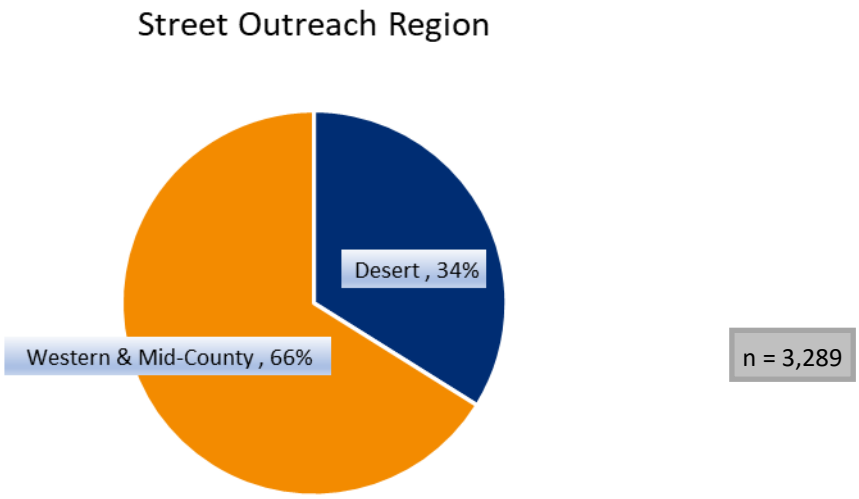
Month/ Year	Region	Team	Location of Education Presentations Conducted	Counts of Presentations	Number of Participants
Sep-23	Desert	ESG	DHS Rotary, Desert Recreation District	2	75
Oct-23	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5	360
Nov-23	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Coordinated Entry System Community Partnership, Active Shooter Training, All County Outreach Coordination Meeting	4	288
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, CES Community Partnership Meeting, YAC/YAB Meeting	3	300
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Project Bridge, County Outreach Meeting	3	169
Feb-24	Desert	ESG	Transgender Wellness Center Presentation	1	2
	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, CES Community Partnership Meeting	3	146
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5	282
Apr-24	Western & Mid-County	ESG	All County Outreach (Boots on Ground)	1	186
May-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, CES, Youth Advisory Committee & Youth Action Board	4	185
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots on the Ground, KIK Summit at YOC Rubidoux	6	355

Total Number of Educational Presentations: 37
Total Number for Attendees : 2,348

***** Several presentations were conducted more than once in a single month.

STREET OUTREACH PROGRAM: REGION AND TEAMS CATEGORIES

The graphs shown below, and on the following two pages, describe the street outreach activities/services provided by the Operation Safehouse staff members during fiscal year 2023-2024. Daily activity forms were submitted on a monthly basis to document the activities as well as the basic demographic information of the youth and adults who were provided street outreach. It is noted that the counts of youth and adults may be duplicated due to different types of services that may be provided to the same people within the same fiscal year.

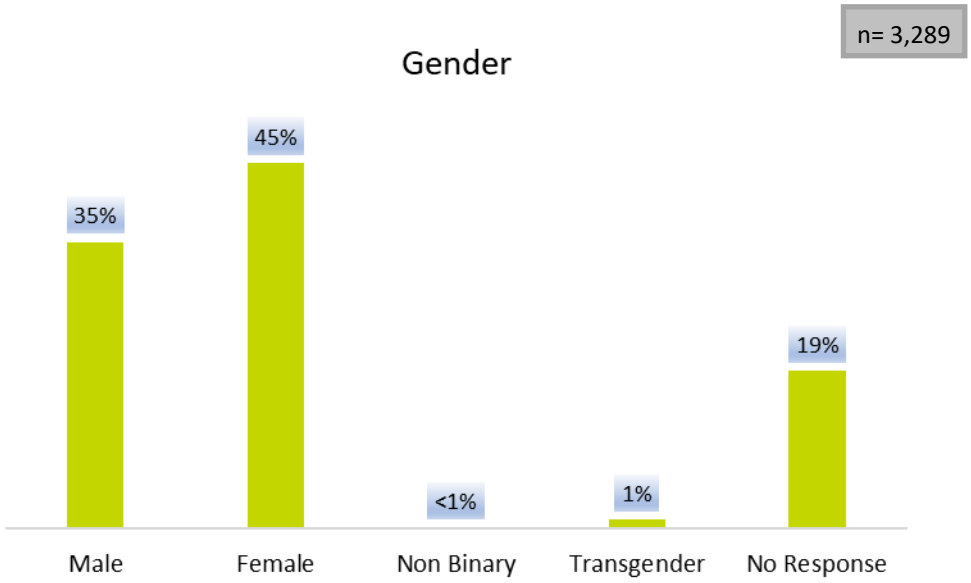


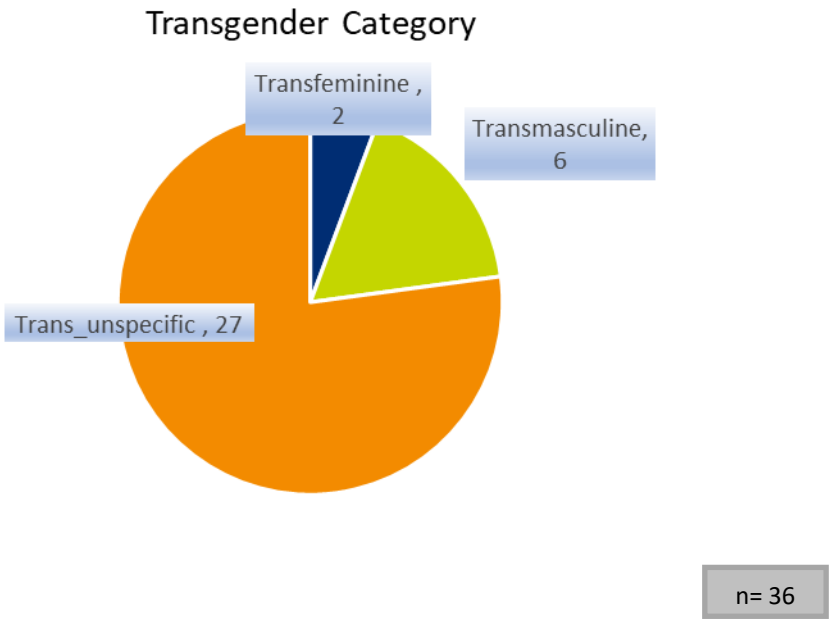
Overall, there were a total of 3,289 youth and adults who were provided street outreach services during fiscal year 2023-2024. The majority of street outreach services were provided by the Western/Mid-County Region, which served 2,174 youths and adults (66%), while the Desert Region provided services to 1,115 (34%).

This fiscal year one team provided services within Operation Safehouse, the ESG Team of the Street Outreach services between July 2023 to June 2024.

STREET OUTREACH PROGRAM: GENDER AND LGBTQI CATEGORIES

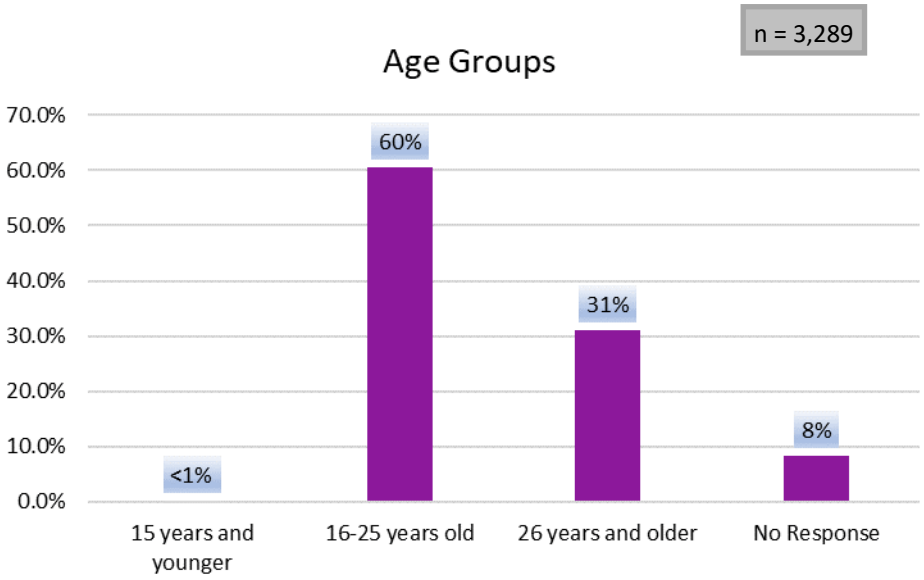
The majority of youth and adults who were provided street outreach were *Female* (45%, n = 1,465), followed by *Male* (35%, n = 1,148). There was a small percentage of youths and adults who reported themselves as *Non-Binary* (0.213%, n = 7) and *Transgender* (1%, n = 36), while 19% (n = 633) chose not to respond. Of those who indicated Transgender, 2 people reported *Transfeminine* (Male to Female), 6 people reported *Transmasculine* (Female to Male) and 28 people did not chose otherwise.



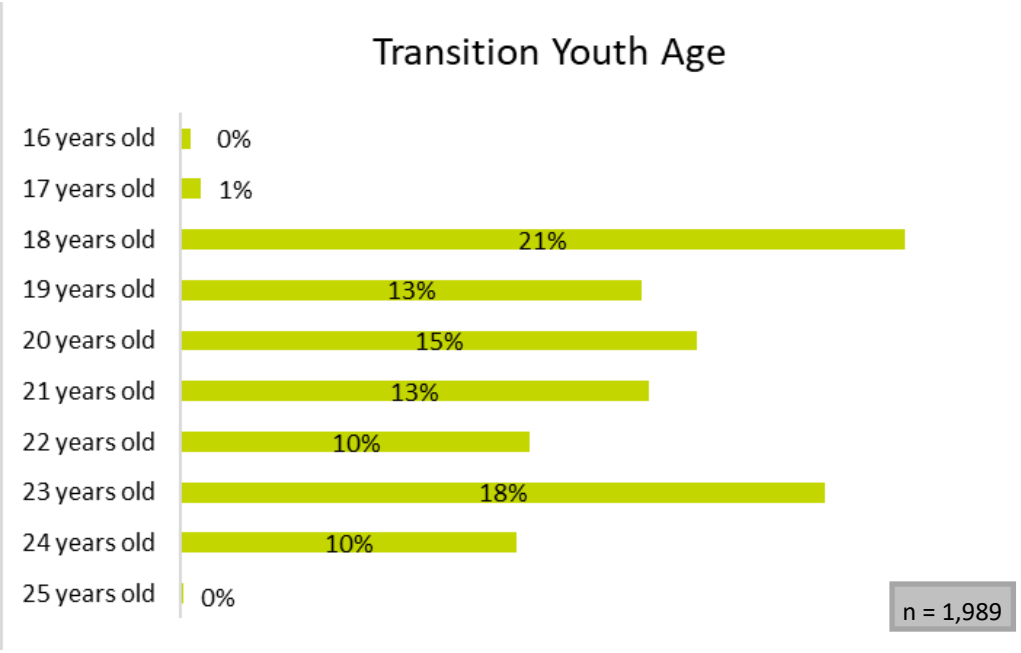


STREET OUTREACH PROGRAM: AGE GROUPS AND TRANSITION AGE YOUTH (TAY)

Categorizing into age groups, the majority of street outreach services were provided to Transition Age Youth (*16 to 25 years*) with 60% (n = 1,989), followed by, Adults (*26 years and older*) with 31% (n = 1,021), and Adolescents (*15 years and younger*) with 0.2% (n = 7). There were also 272 people (8%) who chose not to respond to the age question.



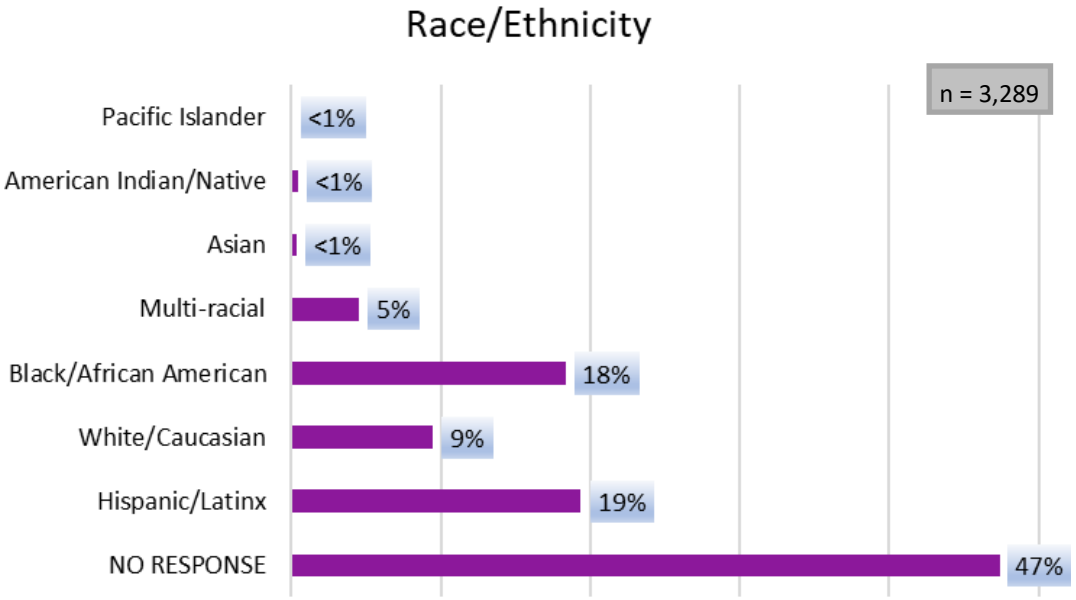
Within the Transition Age Youth (TAY) category, there were a total of 1,989 youths who were provided street outreach services. As shown on the graph and table below, the majority of these youth were 18 years old (21%, n = 264).



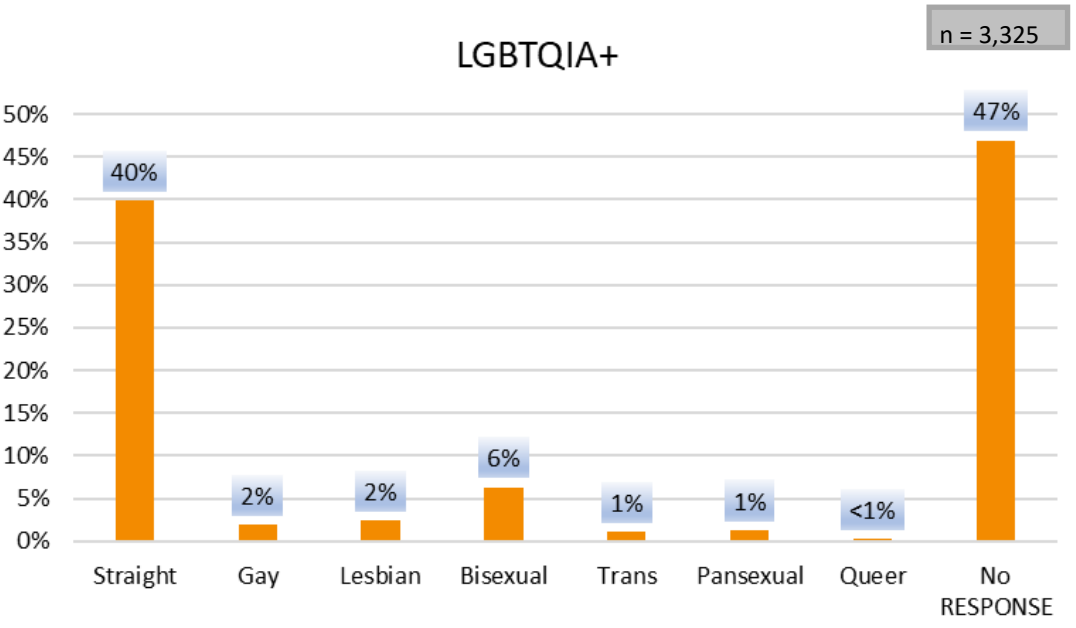
TAY Age	TAY Counts
16 years old	5
17 years old	11
18 years old	408
19 years old	260
20 years old	291
21 years old	264
22 years old	197
23 years old	363
24 years old	189
25 years old	1

STREET OUTREACH PROGRAM: RACE/ETHNICITY AND LGBTQI CATEGORY

The youth and adults who responded to the Race/Ethnicity question were mainly *Hispanic/Latino* (19%, n = 637), followed by *Black/African American* (18%, n = 603), *White/Caucasian* (9%, n = 311), and *Multiracial* (5%, n = 149). Less than 1% were *Asian* (0.36%, n = 12) and *American Indian/Native* (0.46%, n = 16).The majority of youth and adults (47%, n = 1,560) chose not to respond.



The majority of youth and adults (47%, n = 1,561) chose not to respond, while 40% (n = 1,326) categorized as *Straight*. There are also smaller percentages of youths and adults who categorized themselves as *Bisexual* (6%, n = 210), *Gay* (2%, n = 63), *Lesbian* (2%, n = 77), *Pansexual* (1%, n = 1), and *Trans* (1%, n=36) while the remaining >0.1% (n = 9) categorized as *Queer*. The total population size is higher to account for the 36 individuals identified as trans, as well as those disclosing their sexual orientation in the figure shown below.



STREET OUTREACH PROGRAM AND ACTIVITY DESCRIPTIONS

The Street Outreach program provided by Operation Safehouse staff members was developed to help homeless and runaway youth with referrals to services, hygiene products, gift cards, and transportation to homeless shelters or transitional living programs, when it is possible to these youth to move into a more safe and stable environment. The Street Outreach team is in the community seven days a week at locations where runaway and homeless youths are known to congregate.

Transitional Living Program (TLP)

The Transitional Living Program (TLP) is a transitional program for youths to provide them with a more permanent living/housing situation. Currently, there are 3 main TLP locations provided by Operation Safehouse:

- ***Main S.T.A.Y Emergency Shelter***
  This TLP is a 30-day emergency shelter program for older homeless youths between the ages of 18 and 24 years old. This program assists youths in their journey from the streets into shelter and/or housing.
- ***Main Street TLP, Riverside***
  This TLP is for older homeless youth between the ages of 18 to 22 years old, for up to 18 months. Services provided include: continuing educational assistance, individualized therapy, financial education, employment assistance, and access to medical and dental healthcare.
- ***Harrison House, Thousand Palms***
  This TLP is an 18-month program designed to support homeless young adults between 18 and 22 years old who are seeking assistance in their movement from the streets to becoming independent and self-sufficient adults.

Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool (VI-SPDAT)

The VI-SPDAT is a risk and prioritization database where an individual needing housing assistance is enrolled. It includes information on emergency shelter, homelessness, and the client's basic demographic and identifying information, and is a tool used to help with housing placements. Operation Safehouse uses this database to enroll new clients and to count total clients receiving their outreach. This tool also helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention, to who is eligible and in greatest need of that particular intervention.

Street Cards

The Street Cards is an informational tool in a form of a card/mini brochure that lists Operation Safehouse outreach program, as well as the important phone numbers and locations that are available for youth who need help.

Gateway Products

The "gateway products" refers to any services provided by Operation Safehouse staff members, which could be anything from a hygiene kit and bus passes to actual housing placements for youths.

What's Up App Cards

The "What's Up Safehouse" is a downloadable mobile phone application that provides anonymous counseling by text-communication from 7 AM to 11 PM, seven days a week, 365 days a year, with a Licensed Mental Health professionals from Operation Safehouse. This app is mainly designed to help young people ages 11 to 24 years old, but there are no actual age restrictions. It is meant to help young people who are struggling with drug/alcohol abuse, depression, difficult family situations, bullying, and other issues, while maintaining anonymity.

OPERATION SAFEHOUSE STREET OUTREACH ACTIVITIES AND REFERRALS SUMMARY

The table below shows the summary of Street Outreach activities provided to youths and adults by Operation Safehouse's staffs during the fiscal year 2023-2024. The descriptions for these activities are listed on the following page.

Operation Safehouse Street Outreach Activities	Total Counts for Western & Mid-County Regions	Total Counts for Desert Region	Total ALL Regions
Number of Intakes Completed	212	160	372
Number of TLP (Transitional Living Program) Applications Submitted	15	65	80
Number of VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool) Completed	37	27	64
Number of Clients entered Shelter/ Program *(refer to page 11 for TLP Placements table)*	72	45	117
Number of Safehouse/Street Cards Provided	1036	606	1642
Number of Gateway Products Provided	276	329	605
Number of Individuals Educated on SafePlace	1034	753	1787
Number of What's Up App Cards Provided	1034	487	1521
Youth Referrals (Ages 11-17)	26	6	32
Youth Referrals (Ages 18-21)	958	144	1102
Youth Referrals (Ages 22-25)	404	116	520
Adult Referrals (Ages 26+)	992	43	1035
Number of Families Assisted	67	9	76

OPERATION SAFEHOUSE SHELTER PROGRAM PLACEMENTS REPORT

There were a total of **117** youth (72 were in Western/Mid-County region, and 45 were in Desert region) who either entered the Operation Safehouse shelter, or were placed/referred to a safe location (TLP) during the fiscal year 2023-2024. The table below shows the summary report of outreach clients and shelter placements completed by month.

Month/Year	Region	Team	Shelter/Placement Location	Number of Placements
Jul-23	Western & Mid-County	ESG	The Main Stay, OSH Youth Shelter, Phoenix Rescue Mission	8
Aug-23	Desert	ESG	Family Assist, Harrison House	2
	Western & Mid-County	ESG	Mercy House, The Main Stay, Illumination Foundation	3
Sep-23	Desert	ESG	Martha's Village, Harrison's Village	2
	Western & Mid-County	ESG	The Main Stay, Lutheran Social Seniors, Path of Life Family Shelter, Chess Program, Path of Life	8
Oct-23	Western & Mid-County	ESG	Chess Program, The Main Stay, Path of Life	9
	Desert	ESG	The Main Stay, Family Reunification, Lagos CSU, Rapid-housing (LA)	6
Nov-23	Western & Mid-County	ESG	The Main Stay, Path of Life	4
Dec-23	Western & Mid-County	ESG	The Main Stay, Chess Program, Cherished UA	6
	Desert	ESG	CVRM, The Main Stay	2
Jan-24	Western & Mid-County	ESG	The Main Stay	7
	Desert	ESG	Project Touch, Harrison House, CVRM, Hernandez Room and Board,	6
Feb-24	Western & Mid-County	ESG	Just Us 4 Youth, CVRM, Youth Shelter, The Main Stay, Path of Life, Path of Life Family Shelter	7
	Desert	ESG	Chess Program, CVRM	2
Mar-24	Western & Mid-County	ESG	The Salvation Army, CVRM, The Main Stay	5
	Desert	ESG	Mainstreet, Martha's Village and Kitchen, The Main Stay, OVRM	6
Apr-24	Western & Mid-County	ESG	CVRM	2
	Desert	ESG	Path of Life, Main Stay, Navigation Center/Access Center	5
May-24	Western & Mid-County	ESG	The Main Stay, Youth Hope Foundation, Project Touch, Path of Life, TLP, CVRM	8
	Desert	ESG	CVRM, RUHS Behavioral Health, The Stay, PS Navigation Center, CEDR	7
Jun-24	Western & Mid-County	ESG	The Main Stay, Path of Life	5
	Desert	ESG	Martha Village, CVRM, Path of Life, The Stay, Main Stay, Lages	7

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS

There were a total of **96** partnership/collaborative meetings attended by Operation Safehouse staff during the fiscal year 2023-2024. The table below shows the summary of Outreach Community Involvement/ Meetings attended by Operation Safehouse staff members, which include the regions, teams, and locations.

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Aug-24	Western & Mid-County	ESG	CES Community Partnership Meeting, Back to School Resource Fair, Uplift Riverside Conference, Mayor's Initiative To End Homelessness, Youth Advisory Committee & Youth Action Board, City of Riverside Case Conferencing, GCCA	8
	Desert	ESG	DHS Rotary, Back to School Resource Fair, Bobby Bonds YOC Resource Fair, Rubidoux YOC Table, CES, Rotary	6
Jul-23	Western & Mid-County	ESG	CES Community Partnership Meeting, Youth Advisory Committee & Youth Action Board	2
Sep-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness Conferencing, Waiden Rapid Re-housing Collaboration, CES Community Partnership Meeting, City of Riverside	4
	Desert	ESG	WIN Center, DHS Rotary, Desert Recreation District Mtg	4
Oct-24	Western & Mid-County	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
Nov-22	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Coordinated Entry Services Community Partnership, Active Shooter Training, All County Outreach	4
	Desert	ESG	All County Outreach Meeting, Rotary DHS, RISE, SAP	4
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, YAC/YAB Meeting, CES Community Partnership Meeting	3
	Desert	ESG	City of Riverside Snow Day Event, Rotary, Saturation Day and Tabling City of Riverside, Ribbon Cutting - Coachella Valley BH, YAC/YAB Meeting, Riverside	6
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Project Bridge, County Outreach Meeting	4
	Desert	ESG	City Of Riverside Snow Day Event, Community Resource Fair, Rotary Meeting	3
Feb-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES Community Partnership Meeting	3
	Desert	ESG	DHS Rotary, Transgender Wellness Center Presentation, Desert Hot Springs Recreation Center, CES Meeting, All County Outreach Meeting	5

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS *(continued)*

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5
	Desert	ESG	RISE, Homelessness and Foster Youth Services Summit, YAC/YAB Meeting, DGS Rotary	4
Apr-24	Western & Mid-County	ESG	All County Outreach Meeting (Boots on the Ground)	1
	Desert	ESG	Mayor's Initiative to End Homelessness, CES Meeting, RISE Meeting, Desert Hot Springs Meeting, COD Foster Youth Presentation, All County Outreach Meeting	6
May-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES (Coordinated Entry System), Youth Advisory Committee & Youth Action Board	4
	Desert	ESG	District 5 Homeless Symposium, DHS Rotary, YAC/YAB Meeting, CES Meeting	4
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots On The Ground, KIK Summit at YOC Rubidoux	6

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE STAFF TRAININGS REPORT

During the fiscal year 2023-2024, Operation Safehouse staff members also attended a total of **10** staff trainings at the Operation Safehouse Technical Assistance Center. The tables below and on the next page show the summary of monthly RHYTTAC trainings attended by Operation Safehouse staff members.

Month/ Year	Region	Team	Monthly Runaway & Homeless Youth Training & Technical Assistance Center (RHYTTAC) eLearning/Trainings Competed by Operation Safehouse Staff Members
Jul-23	Western & Mid-County	ESG Team	SAMHSA Efforts to Support Youth Experiencing Homelessness, What Can RHY Programs Do To Identify & Prevent Labor Trafficking, Harassing Data & The Power or Youth to
Mar-24	Western & Mid-County	ESG Team	Identifying and Responding to Sexually Exploited Children, A Participatory Approach to Make Movement Meaningful, 2022 RHY Program Specific Training: Street Outreach Program, 2023 Runaway and Homelessness Youth, Presentation, Demonstration
Apr-24	Western & Mid-County	ESG Team	Transforming Trauma into Trust

* Several trainings were conducted more than once in a single month.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Cognitive Behavioral Therapy (CBT) for Late Life Depression

FY 2023-2024 Annual Report





CBT-LLD FY 2023-2024

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Provider & Program Overview

Program Overview

CBT for Late Life Depression is an active, directive, time-limited, and structured problem-solving program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with structure in modeling behavior. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions, following a structured manual.

Community-based organizations were contracted to provide Cognitive Behavioral Therapy (CBT) for Late Life Depression services to older adults experiencing symptoms of major depression:

The Center (TC) is a community-based organization that offers a safe and supportive environment for its members. Their mission is to enrich the lives of the LGBTQI community. They advance this mission by providing senior-specific programming, clinical counseling, social offerings, and much more.

Inland Caregiver Resource Center (ICRC) helps families and communities cope with and manage the challenges of aging and caregiving. Their mission is to respect the dignity of all people [including LGBTQI community] and provide assistance so clients and family members can continue to live productive, active, and enriched lives.

Provider & Program Overview

Outcomes Evaluation

CBT for Late Life Depression uses the Patient Health Questionnaire-9 (PHQ-9) as the depression screening tool and the Quality of Life (QOL) Survey to assess participants perception of the lives quality. These measures are described below. Measures are administered at the beginning of program services (Pre) and at the conclusion of services (Post).

- **Patient Health Questionnaire-9 (PHQ-9)**
  PHQ-9 is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 can function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of:
  - 0-4 is considered as having minimal levels of depression and is described as 'non-depressed'
  - 5-9 indicates symptoms of mild depression
  - 10-14 indicates symptoms of moderate depression
  - 15-19 indicates symptoms of moderately severe depression
  - 20-27 indicates symptoms of severe depression

- **Quality of Life (QOL) Survey**
  The QOL survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes, as it specifically collects feedback from participants on social behavior, relationships, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

Executive Summary: Key Findings

The Center (TC) located within the Desert region and Inland Caregiver Resource Center (ICRC) located within the Western region, provide services to older adults experiencing depression. A total of 120 participants were provided CBT for Late Life Depression (CBT- LLD) within Fiscal Year (FY) 2023-2024. The CBT for Late Life Depression program serves participants for a number of weeks throughout the year; thus, some participants who start the program later in the fiscal year will continue services into the next fiscal year (FY 2024/2025). Therefore, not all of the cases will be, or are expected to be, closed by the end of the fiscal year. *Pre to post outcomes data reflects those cases that not only received service within the fiscal year, but were also closed within the fiscal year. Enrollment and demographic data reflect a higher number served as it includes all clients enrolled in the fiscal year.*

The Center (*n*=22) and Inland Caregiver Resource Center (*n*=98) provided CBT for Late Life Depression to a total of **120** participants within FY 23/24.

∴ Overall, there were more female (*n*=84) participants than male (*n*=36) participants. Most participants were between the ages of 65 and 70. For the Center this was 37% of their participants and 34% for ICRC. Participants were mostly English-speaking (59%) with some Spanish-speaking (40%). Race/ethnicity was mostly Caucasian (95%) at The Center and (58%) Hispanic/Latino at ICRC. At The Center, a majority of participants identified as LGBTQI and 'Gay' sexual orientation (82%) whereas a majority of participants at ICRC identified as 'Straight' (92%).

∴ Seventy-three percent (*n*=87) of the clients served were closed during the fiscal year; 56% of whom, successfully completed the program (*n*=49). The remaining 28% will carry into the FY 24/25.

∴ Statistically significant ($p < 0.001$) change was observed between the pre-test and post-test PHQ -9 measures. Depression scores decreased from moderate to minimal levels overall (pre *M*=14; post *M*=4).

∴ All of the items on the Quality of Life survey showed improvement, with most (85%, *n*=11) of the total 13 items showing statistically significant ($p<.01$) positive change, indicating that participants were engaging in more social behavior and pleasurable activities.

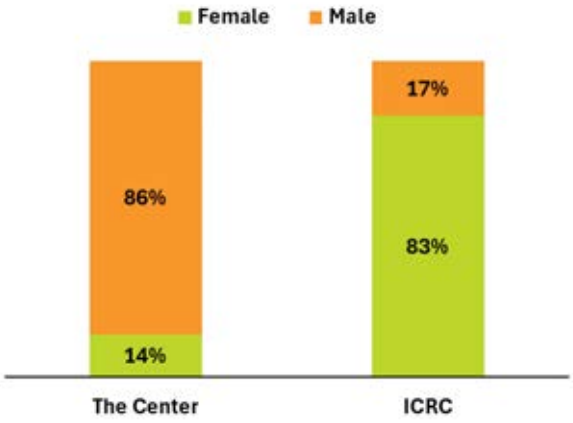
∴ The satisfaction surveys that were administered show positive ratings across all items— the highest ratings being that they would return to the program if they needed help again, the quality of service they received from their practitioner, and how satisfied they were with the program.

PROGRAM ENROLLMENT

The Center provided CBT for Late Life Depression to a total of 22 participants, whereas The Inland Caregiver Resource Center (ICRC) served 98 individuals within FY 23/24.

DEMOGRAPHICS

Participant Gender



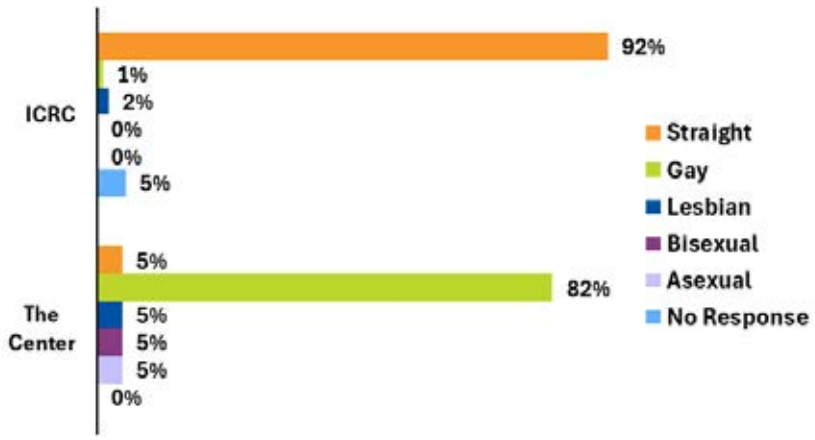
Overall, there were more female (*n*=84) participants than male (*n*=36) participants in FY 23/24. ICRC served the majority of the females, making up 83% (*n*=81) of their participants compared to males (*n*=17). Whereas, The Center served 86% males (*n*=19, 14% females (*n*=3).

Participant Age

Age	The Center (n=22)	ICRC (n=98)
59-64	5 (23%)	10 (11%)
65-70	8 (37%)	33 (34%)
71-74	5 (23%)	20 (21%)
75-79	3 (14%)	20 (21%)
>80	1 (5%)	15 (16%)

Participants ranged between the ages of 57 to 94. The majority of participants (34%) overall were within the ages of 65 and 70 (*n*=41).

Sexual Orientation



Most participants served by The Center (*n*=21) identified as part of the Lesbian, Gay, Bisexual (LGB) community—which is consistent with the agency's target population. Specifically, consumers identified as Gay (*n*=18, 82%), Lesbian (*n*=1, 5%), Bisexual (*n*=1, 5%), or Asexual (*n*=1, 5%). Whereas, the ICRC predominantly reported 'Straight' (*n*=90, 92%), Gay (*n*=1, 1%), and Lesbian (n=2, 2%). Five participants did not disclose their sexual orientation (5%). All consumers are welcomed to join program regardless of disclosing sexual orientation status.

Demographics

Frequently Reported Cities

City	Frequency (count, %)
Riverside	28 (23%)
Palm Springs	13 (11%)
Moreno Valley	9 (8%)
Corona	8 (7%)
Banning	6 (5%)
Hemet	6 (5%)
No Response	5 (4%)
Other	45 (38%)

The table above indicates the top six residential cities. Many of the participants resided in Riverside 23% (*n*=28). 'Other' specifies smaller samples among nineteen cities that are spread (range: 1-5) out in Riverside County (e.g. Indio, Coachella, Mira Loma, Perris, etc.).

Language

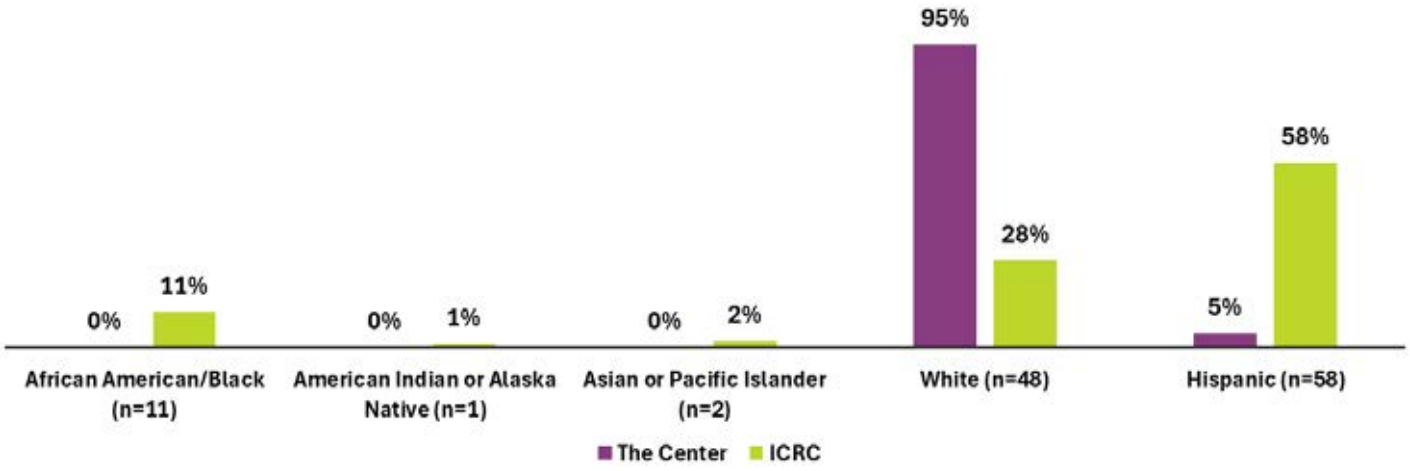
59% of participants (71) indicated primary language as English, whereas the remaining 40% (48) spoke Spanish.



The majority of the participants reported English (*n*=71) as their primary language and 48 participants noted Spanish as their primary language. There was one participant who did not indicate their primary language.

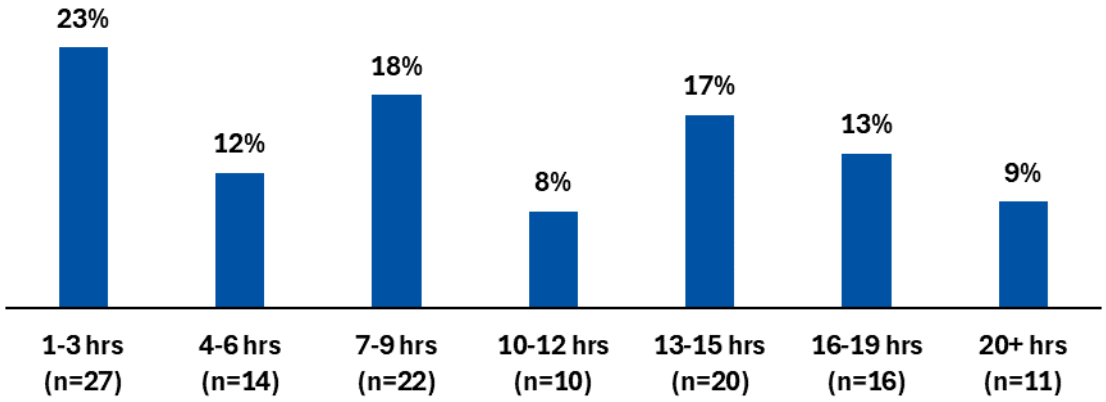
Participant Race/Ethnicity

The participants primarily identified as White at The Center (*n*=21) and there was one participant who identified as Hispanic. At ICRC the majority of participants identified as Hispanic (*n*=57) following were participants who identified as White (*n*=27). Finally, at ICRC eleven participants identified as African American/Black, one identified as American Indian or Alaska Native, and two identified as Asian or Pacific Islander.



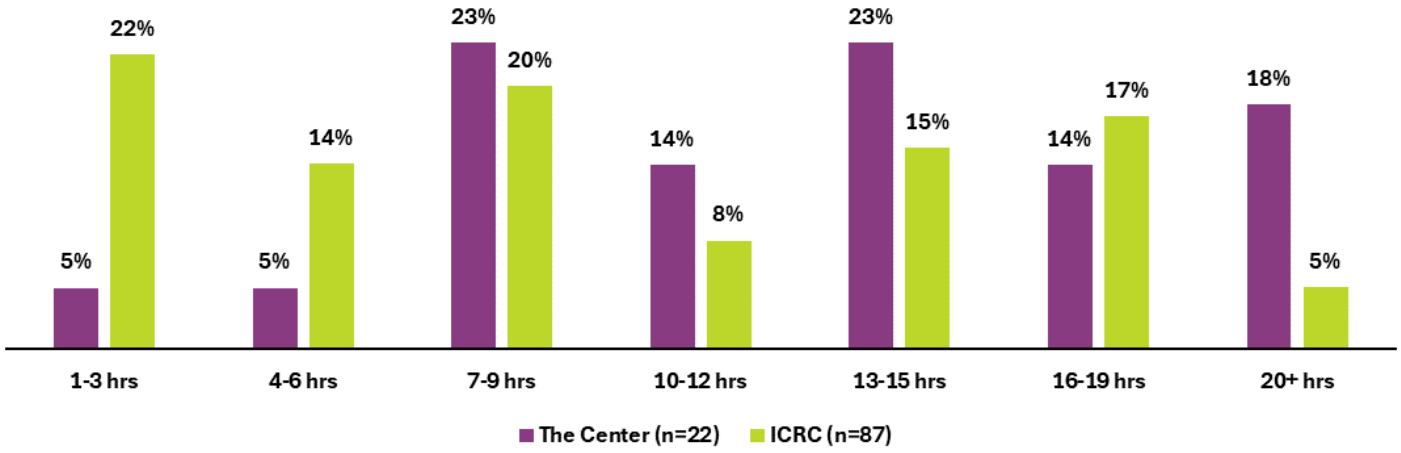
Service Data

A total of **1189.75** hours of service was reported for the **120** participants. Nearly 70% of the participants received over 6 total hours of service. Over a third of participants received 7 -15 hours of service (*n*=52, 43%); whereas nearly a quarter received 1-3 hours of service (*n*=27, 23%). Of the 42 participants who received 6 hours or less of total service, 29% were clients who carried over from the previous 22/23 FY (*n*=12) and 36% are carrying over into the next 24/25 FY (*n*=15) which can account for some of the low service hours. *Since some cases may not open and close within the same fiscal year, the total number of service hours recorded for the 23/24FY does not include services that the client may have received in previous or subsequent fiscal years.*



Service Data by Service Type

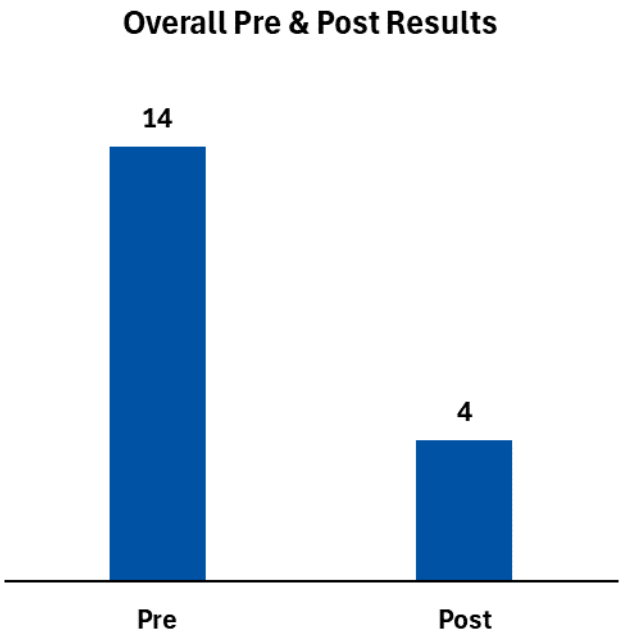
The Center provided CBT therapy sessions to all of their 22 participants totaling 299 services, amounting to 299 hours, while ICRC provided therapy services to 87 of the 98 total participants served. Furthermore, ICRC had a total of 884 services, totaling 891 hours. Of the total 884 services provided by ICRC, 62 were assessments which summed to 59 hours. The remaining 822 services were CBT therapy sessions equaling 832 hours. The graph below depicts only CBT therapy session services. This year's services were neither submitted nor compiled in the same manner as in previous years, so they will be organized by total hours per client by program, as shown in the figure below. *The current fiscal year's service hours do not include the services clients received from previous or subsequent fiscal years, this data only reflects participants services in the FY23/24.*

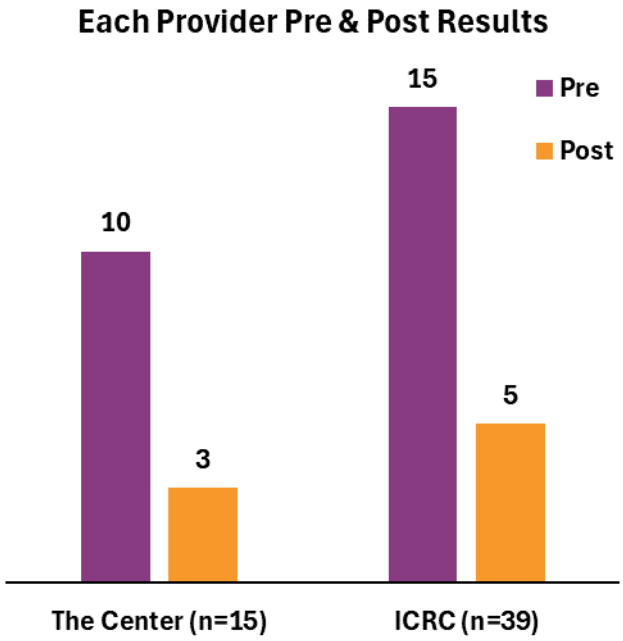


Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.





The Center (n=15) and ICRC (n=39) showed a significant decrease ($p < 0.001$) in depression symptoms from the beginning (M=14) to the end of the program (M=4). Sometimes post measures could not be collected due to participants leaving the program without completing the accompanying post measures.

Score Interpretation for PHQ-9:

- 0-4 is considered as having *minimal* levels of depression
- 5-9 indicates symptoms of *mild* depression
- 10-14 indicates symptoms of *moderate* depression
- 15-19 indicates symptoms of *moderately severe* depression
- 20-27 indicates symptoms of *severe* depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. It is rated on a scale from 1-7, with higher ratings indicating more positive results. The QOL survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc. all relevant aspects of outcome information that CBT for Late Life Depression is directed at increasing.

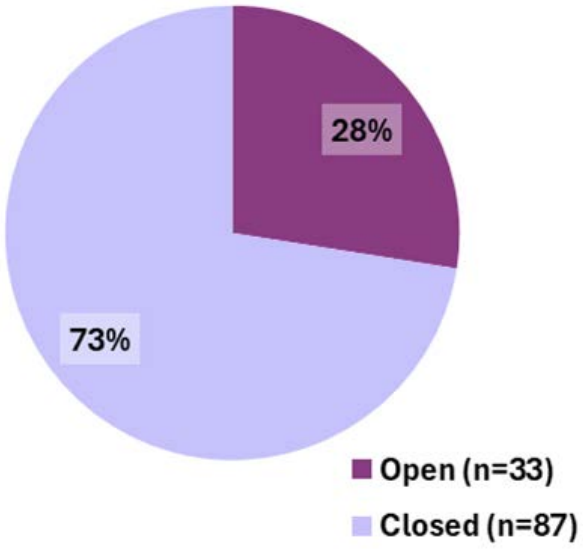
Participants reported an improvement in quality of life from pre- to post-test, as can be seen in the statistically significant (p<.05) changes found for each item as indicated in bold. All the QOL items showed improvement. However, participants experienced statistically significant (p<.05) improvements for most items such as how they felt about the things they do socially with others; life in general, and emotional well-being. Since the Quality of Life survey is not evaluated based on the total sum of participants' scores, it is shown below as individual items.

	QOL Items	Pre	Post
1	How do feel about your life in general? (1=Terrible 2=Unhappy 3=Mostly Dis-satisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.72	**4.96**
2	How do you feel about the amount of relaxation in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.64	**4.96**
3	How do you feel about the things you do with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.77	**5.85**
4	How do you feel about the amount of time you spend with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.26	**5.11**
5	How do you feel about the people you see socially? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	5.34	**5.77**
6	How do you feel about the amount of friendship in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.65	**4.96**
7	How socially active would you say you have been in the past month? (1=None 2=A little 3=Fairly Active 4=Quite Active 5=Very Active 6=Extremely Active)	2.58	**3.51**
8	In general how would you say your health is? (1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent)	2.47	**2.72**
9	How do you feel about your health in general? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.68	4.51
10	How do you feel about your physical condition? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.60	**4.25**
11	How do you feel about your emotional well-being? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	2.96	**4.77**
12	How much bodily pain have you had during the past month? (1=Very Severe 2=Severe 3=Moderate 4=Mild 5=Very Mild 6=None)	3.06	3.70
13	In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely 2=Quite a bit 3=Moderately 4=Slightly 5=Not at all)	2.60	**3.68**

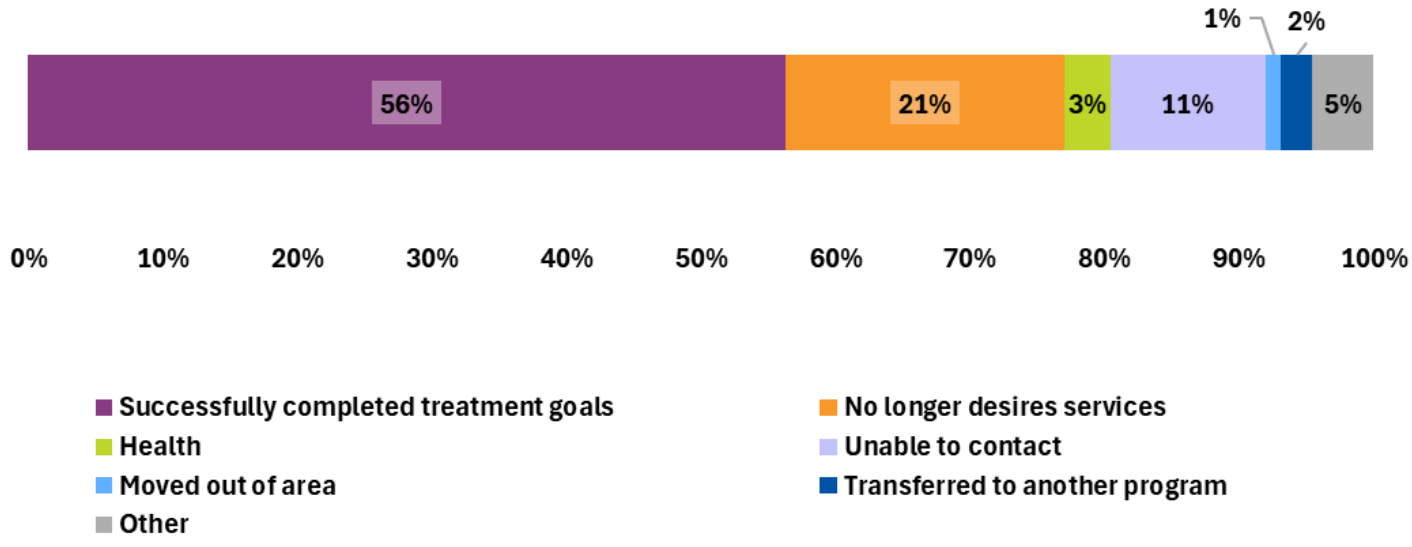
BOLD Numbers indicate statistically significant (p < 0.05) change Pre to Post

Discontinuance Summary

Of the 120 participants served, 87 closed during this 23/24 FY. At closing, Discontinuance Summary forms were completed, listing the reason for discontinuance of service, as shown below. Of the total closed participants, over half (56%, *n*=49) were reported as having successfully completed their treatment goals. The remaining 33 participants will carry over into the next 23/24 FY.



Reason	(*n=87*)
Successfully completed treatment goals	49 (56%)
No longer desires services	18 (21%)
No show	-
Health	3 (3%)
Unable to contact	10 (11%)
Moved out of area	1 (1%)
Transferred to another program	2 (2%)
Death	-
Other	4 (5%)



Satisfaction Surveys

Of the 87 participants who closed from the program, 57 (66%) completed Satisfaction Surveys, as sometimes participants may leave the program without completing the Satisfaction Survey or other post-program measures.

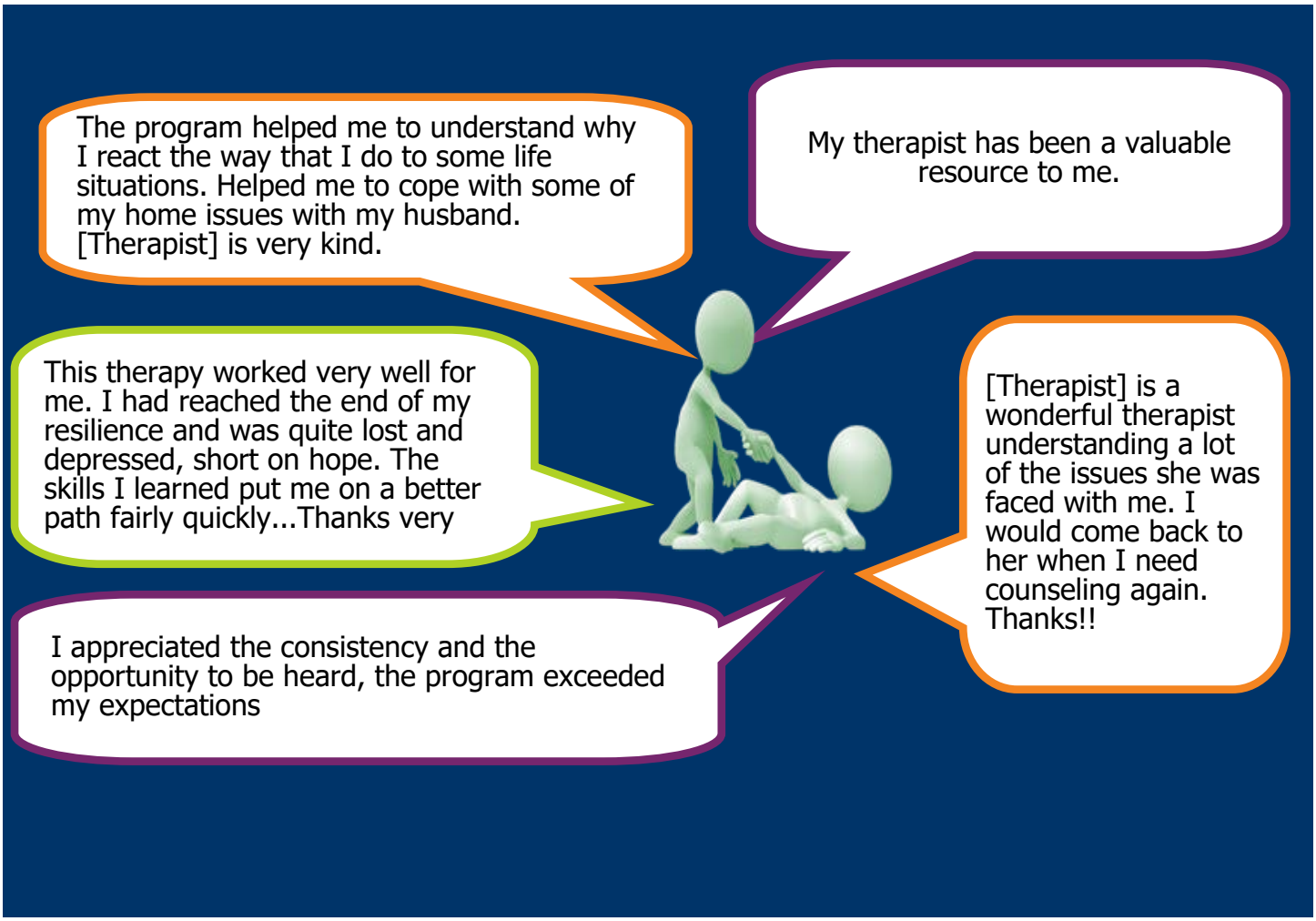
Participants gave the highest ratings to the quality of the service they received from their practitioner, their likelihood to return to the program if they were to seek help again, and the satisfaction they felt in the support they received from the program. The lowest rated item was for "Did this program help you to cope better?" (*M* =3.39). Other items relating to whether the participants felt that the program helped them improve their quality of life were among the lower ratings that were given but all questions were still in the Good/Satisfied range. Overall, the satisfaction surveys show positive feedback from participating in the CBT for Late Life Depression program.

Survey Items & Results (n=57)

Question	Average	1	2	3	4	5	*M
How would you rate the quality of service you have received from your practitioner? (Excellent=4, Good=3, Fair=2, Poor=1)	**3.84**	-	-	16%	84%	-	-
In a general sense, how satisfied are you with the support you have received from this program? (Very Satisfied=4, Mostly Satisfied=3, Mildly Dissatisfied=2, Quite Dissatisfied=1)	**3.82**	-	4%	18%	82%	-	-
Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.39**	-	-	54%	42%	-	-
Did you gain strategies to help you cope? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.77**	-	-	23%	77%	-	-
Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
Has participation in the program reduced your depression symptoms? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
**Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5, Yes, I think so=4, Not Sure=3 No, I don't think so=2, No, Definitely not=1)	**4.70**	-	-		30%	70%	-
If you were to seek help again, would you return to this program? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.93**	-	-	7%	93%	-	-

**M represents missing values*
***Questions on a scale of 1-5*

Satisfaction Surveys– Comments



APPENDIX: Annual Program Reviews

Participant Service and Completion Rates				
Program Service	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	21	50	128	120
Total # Hours Served	256.42	814.66	2484.27	1189.75
Average Hours per Participant	12.21	16.29	19.41	
# of Participants CLOSED (% of Total Served)	17 (81%)	19 (34%)	71 (55%)	87 (73%)
Successfully Completed Treatment Goals	*10 (59%)*	*9 (47%)*	*41 (58%)*	*49 (56%)*

Outcomes Evaluation				
Percentage of Participants Improved	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY23/24**
BDI-II (%)	100%	100%	—	—
PHQ-9 (%)	—	—	93%	99%
QOL (%)	100%	95%	91%	85%

**Service was provided by one contractor.*

A total of 120 participants were served with CBT for Late Life Depression during FY 23/24. The CBT-LLD program has two community-based organizations, which expanded enrollment this year. Additionally, FY 23/24 had a 73% close rate for participants who closed within the fiscal year, which increased from 55% in the previous fiscal year. Of the participants who were closed, 56% successfully completed their treatment goals, which is lower than last fiscal year 22/23.

As can be seen in the Outcomes Evaluation table, the majority (85%) of participants reported improvements within their pre to post QOL measures which is lower than fiscal year 22/23 (93%). For PHQ-9, 99% of participants showed improvement from their pre to post measure which is higher than fiscal year 22/23 in which 91% showed improvement.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Program to Encourage Active and Rewarding Lives (PEARLS) Annual Report FY 2023-2024

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Provider and Program Overview

Program Overview

The **P**rogram to **E**ncourage **A**ctive and **R**ewarding **L**ive**S** (**PEARLS**) is an evidence-based program designed for people aged 60 years or older who are experiencing minor depression or dysthymia (an ongoing, low-grade level of depression lasting two or more years). PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: (1) problem solving treatment (PST); (2) social and physical activation; and (3) pleasant-activity scheduling. These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals.

The PEARLS intervention is time limited and ideally distributed over a 19-week period. Each session is structured and designed to assist participants in defining and solving their problems, becoming more socially and physically active, and experiencing more pleasant activities. PEARLS provides a substantial, straightforward, and empowering approach to solving problems and reducing depression. Participants are encouraged to continue with the approach after the sessions have ended. PEARLS facilitators make brief follow-up calls to support and encourage participants in this transition.

PEARLS participants are recruited through outreach. Several screening tools are used to help determine eligibility and whether a client would benefit from the program. The screening tools include the nine-item Patient Health Questionnaire (PHQ-9), a set of questions to identify dysthymia, and a set of exclusion-criteria questions to screen out clients who'd be better served by other programs. An attempt is made to refer clients to such programs.

Outcomes Evaluation

The Patient Health Questionnaire (PHQ-9) is embedded in PEARLS program sessions to determine if an individual's depression symptoms are improving. Changes between the baseline intake score (pre) and final score (post) are used in evaluating the program outcomes. Similar evaluations in (1) generalized anxiety; (2) participation in social and pleasant activities; (3) physical activities; and (4) quality of life are also included in the outcomes evaluation. The measures used are summarized below:

- The PHQ-9 (Patient Health Questionnaire) is administered at each session. Changes in scores over the sessions gauge whether session activities are reducing depression symptoms. The difference between intake and final PHQ-9 scores are used to determine success in the reduction of depression symptoms.
- The GAD-7 (Generalized Anxiety Disorder) is administered at the beginning and conclusion of program services to gauge reduction in generalized anxiety.
- RAPA (Physical Activity Survey) is administered at the beginning and conclusion of program services, to gauge the increase in frequency of physical activitie.
- A pre/post program survey is administered at the beginning and conclusion of program services. It covers general quality of life, including participation in pleasant and social activities. The post questionnaire includes additional items related to satisfaction with the PEARLS program.

Executive Summary

Enrollment/Demographics

1. 133 prospective participants were screened in FY 2023-2024.
2. 109 participants were served (received one or more program services) in FY 2023-2024. This represents a 36% increase from the FY 2022-2023 total of 80.
3. All 109 served participants were of the target 60-and-over demographic.
4. Gender for the 109 served participants remained predominantly female (76%).
5. The predominant race percentages for served participants were 49% White, 33% Hispanic/Latinx, 14% Black/African-American. There was one Asian participant. There were two Native Americans, one specifying multiple races.

Services

1. The 109 served participants received an average of 5.9 total hours of service.
2. In FY 2023-2024, no participant received more than 8 PEARLS program services.
3. Of the 109 FY 2023-2024 served participants, 95 closed from the program (the remaining 14 were still active in the program). 53 of the 95 closing participants (56%) successfully completed the program. This represents an improvement over last year's 46% completion rate.

Outcomes

1. Countywide, the reduction in depression symptoms as measured by the PHQ-9 was statistically significant ($p \leq 0.05$) for PEARLS participants completing the program. Furthermore, average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.
2. Countywide, the reduction in anxiety symptoms as measured by the GAD-7 was statistically significant for PEARLS participants completing the program. Furthermore, average anxiety as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.
3. Countywide, the increase in physical activity as measured by the RAPA was not statistically significant for PEARLS participants completing the program.
4. The Quality-of-Life survey showed statistically-significant improvement for participants in eight of the nine questions: "health", "life in general", "emotional well-being", "spare time", "time with others", "friendship", "social activity", and "pleasant activities". Changes in "family" were not significant.

Selected Participant Comments

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.

Screening and Service Overview

Individuals interested in participating in PEARLS are screened to determine if they are eligible for the program. The screening consist of: (1) a PHQ-9 to determine the participant's level of depression; (2) a dysthymia screen, which may establish eligibility if the PHQ-9 fails to indicate depression; (3) an additional exclusionary screen for the presence of psychosis, bipolar disorder, drug addiction, or alcoholism; (4) a brief six-item memory cognition screen to indicate possible memory or cognitive impairment. Individuals presenting with exclusionary conditions, including **major** depression, are instead referred to treatment services appropriate for those conditions. As shown in Table 1.1, a total of 133 individuals were screened in FY 2023-2024 countywide.

Screened individuals who meet the criteria outlined above may go on to participate in PEARLS. After receiving their first PEARLS program service, individuals are referred to as *participants* and considered *served*. By continuing to receive the prescribed number of services, participants complete the program.

As shown in Table 1.1, of the 133 screened individuals, 88 both met criteria for participation, and received at least one program service. Thus 66% of screenings resulted in participation.

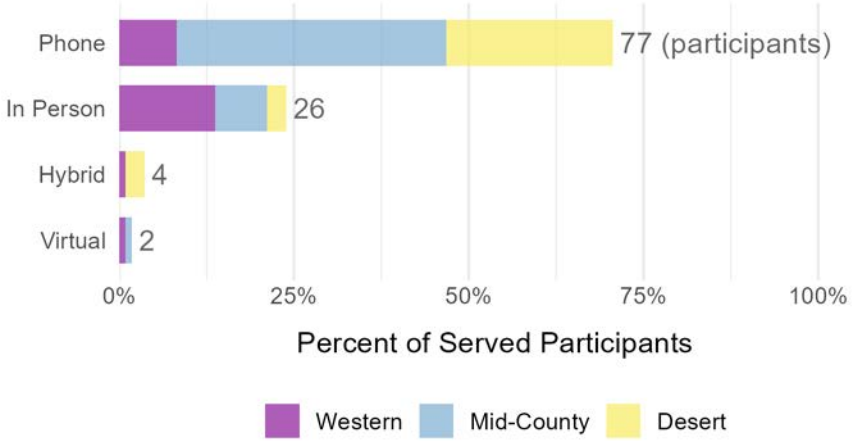
During FY 2023-2024, active participants from the previous fiscal year also received services. These participants are referred to as *carryovers* and totaled 21. Thus, the total number of participants served in FY 2023-2024 was 109, a 36% increase from the FY 2022-2023 total of 80.

Figure 1.1 shows the mode of service for the 109 participants served in FY 2023-2024.

Table 1.1: Participant Summary

Description	Desert	Mid-County	Western	COUNTYWIDE
Individuals Screened FY 2023-2024	46	54	33	**133**
Participants Screened/Served FY 2023-2024	26	44	18	**88**
Participants Active from FY 2022-2023 (Carryovers)	6	7	8	**21**
TOTAL Participants Served	32	51	26	**109**

Figure 1.1: Mode of Service



Countywide, the majority of participants 77 (71%) received service by phone, followed by in person with 26 (24%).

Service Summary

During FY 2023-2024, PEARLS delivered a total of 585 services consisting of 135 screening and 450 program services. Screenings for all individuals were completed in a single service. Two participants, however, were re-screened after leaving the program but later requesting to return. 133 distinct individuals were therefore screened in FY 2023-2024.

Figure 2.1 shows the service-duration breakdown for the 135 screening services. Figure 2.2 shows the service-duration breakdown for the 450 program services.

Figure 2.3 shows the number of program services received by a typical PEARLS participant. We exclude 34 active participants who have not yet completed their ultimate number of services. The 96 closed PEARLS participants received 406 program services distributed as shown in Figure 2.3.

Figure 2.1: Distribution of Screening Service Duration

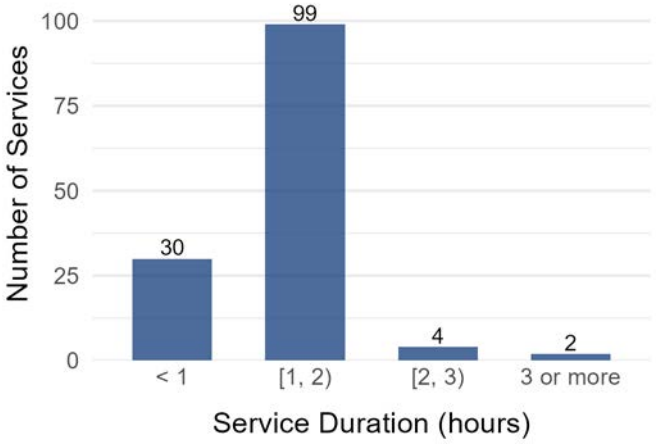


Figure 2.1 shows that the majority (73%) of the 135 screening services were between 1 and 2 hours in duration.

Figure 2.2: Distribution of Program Service Duration

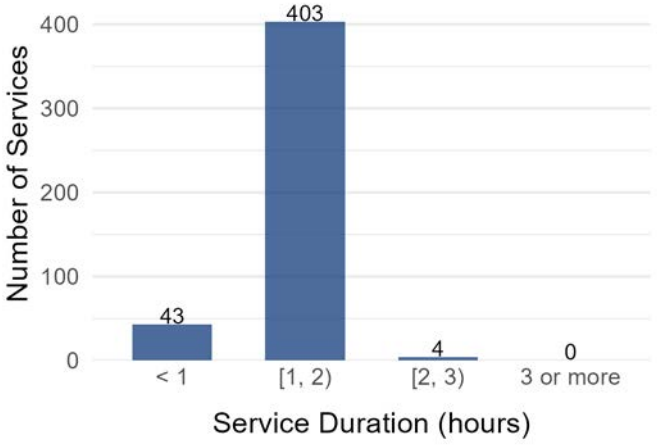


Figure 2.2 shows that the majority (90%) of the 450 program services were between 1 and 2 hours in duration.

Figure 2.3: Number of Program Services

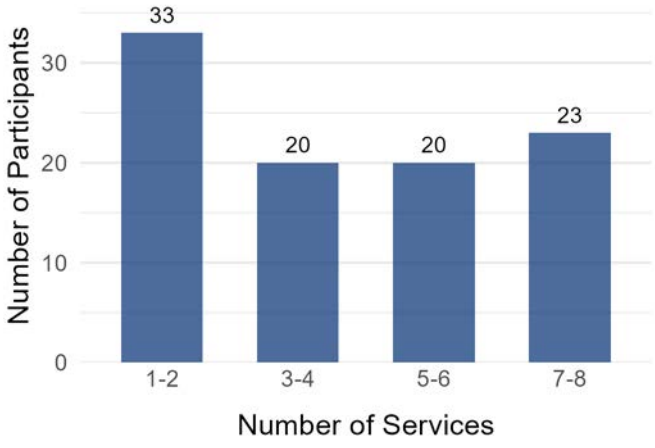


Figure 2.3 shows the distribution of 406 program services among the 96 closed (completed or terminated) participants.

Demographics

The average age of the 109 distinct PEARLS participants served in FY 2023-2024 was 74.5, an increase from the FY 2022-2023 average of 69.5.

Figure 3.1 shows age distribution. Countywide the distribution shifted to older participants compared to FY 2022-2023.

Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of PEARLS participants.

Figure 3.1: Age of PEARLS Participants

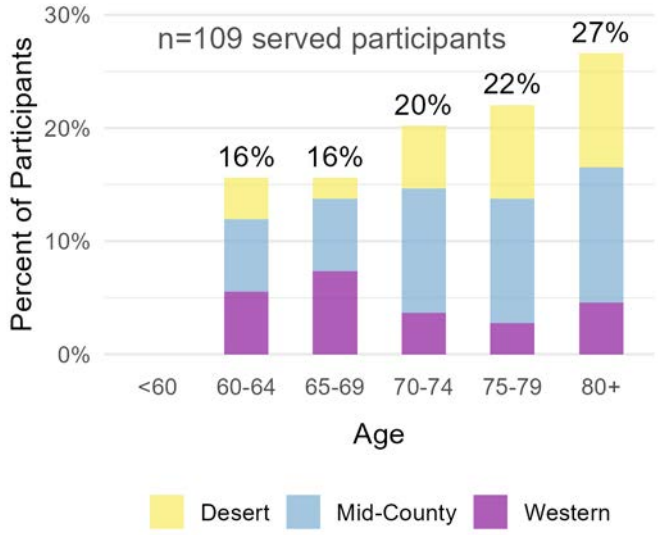


Figure 3.1 shows the age distribution of PEARLS participants by region. Countywide the distribution shifted to older participants compared to FY 2022-2023. Participants in the 75-79 cohort increased from 19% to 22%. Participants in the 80+ cohort increased from 19% to 27%. The Desert and Mid-County regions were mostly responsible for this shift.

Figure 3.2: Gender of PEARLS Participants

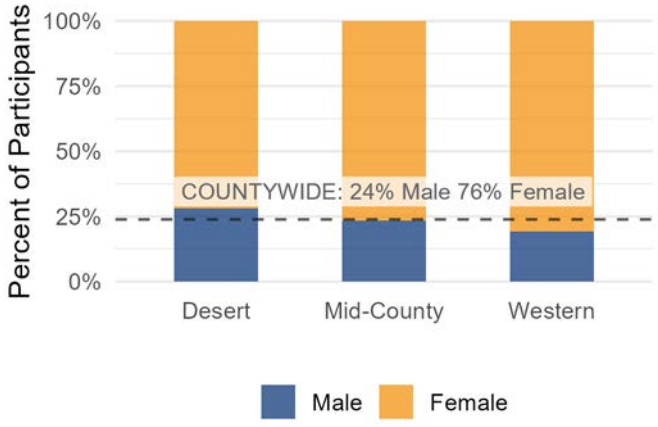


Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of the PEARLS participants. This represents an increase from the FY 2022-2023 value of 19%. Prior research has shown that older male adults are at greater risk of suicide, underscoring the need to promote intervention-type programs in this population.

Demographics (continued)

The PEARLS *Demographics and Screening Form* lists common race and ethnicity categories. Prospective participants can make one or more selections from the list or choose "Other" and provide one.

Figure 3.3 shows the breakdown of race as specified by the 109 PEARLS participants. Two FY 2023-2024 participants identified as *Native American*, with one subsumed by the *Multi-Racial* category (additionally identifying as *Hispanic/Latinx*). 49% of participants identified as *White/Caucasian*, followed by 33% *Hispanic/Latinx*, followed by 14% *Black/African American*.

Of the 109 served participants, 36 (33%) identified as *Hispanic/Latinx*. This total includes one participant also identifying as Native American, and thus subsumed by the *Multi-Racial* category in Figure 3.3. Table 3.1 lists the ethnicity specified by the 36 participants identifying as *Hispanic/Latinx*.

Figure 3.3: Race of PEARLS Participants

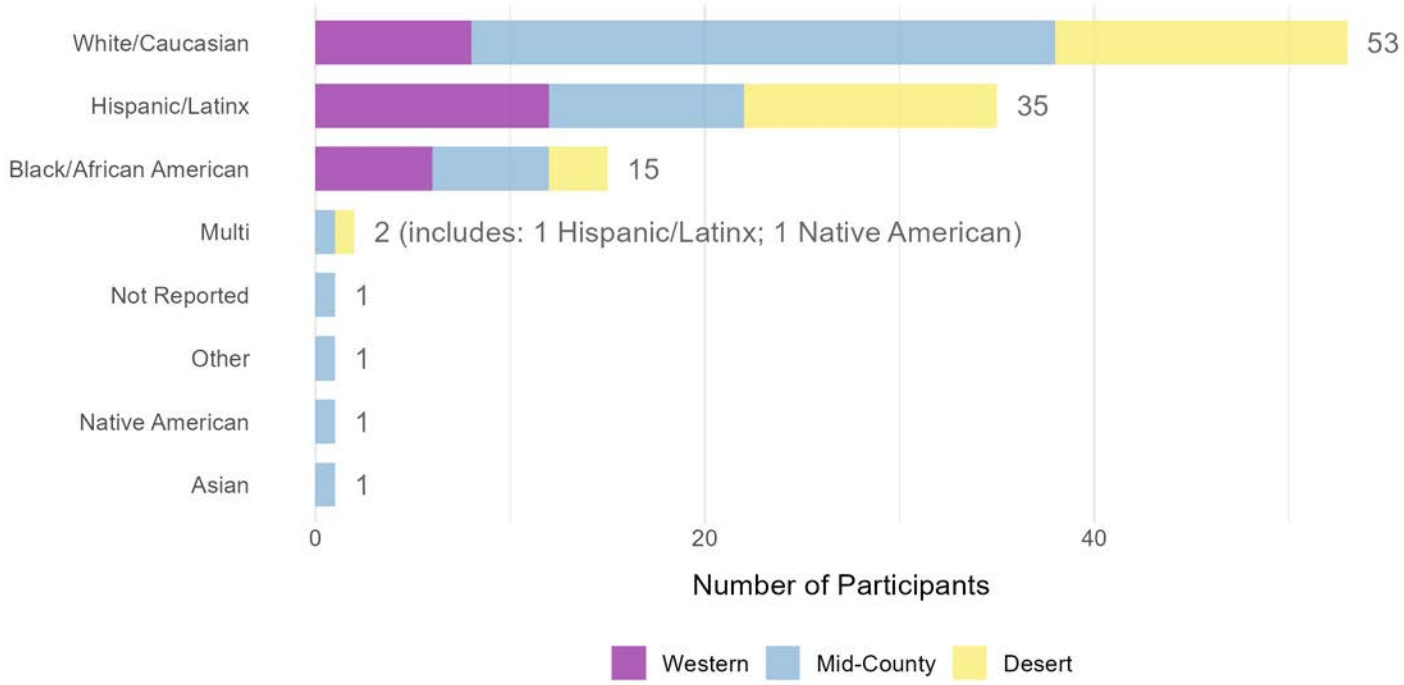


Table 3.1: Ethnicity Specified by Hispanic/Latinx PEARLS Participants

Mexican	23 (64%)
Colombian	2
Peruvian	2
Honduran	1
Salvadorean	1
Venezuelan	1
Not Specified	6

Closing of Participants

A closing disposition is documented when a participant: (1) completes the PEARLS program, (2) explicitly discontinues service, or (3) can no longer be contacted. Of the 109 participants served during FY 2023-2024, 95 had a closing disposition (the remaining 14 were still receiving services). Of the 95 closings, 53 completed the program, and 42 either explicitly discontinued or could no longer be contacted.

Figure 4.1: Completion Rates

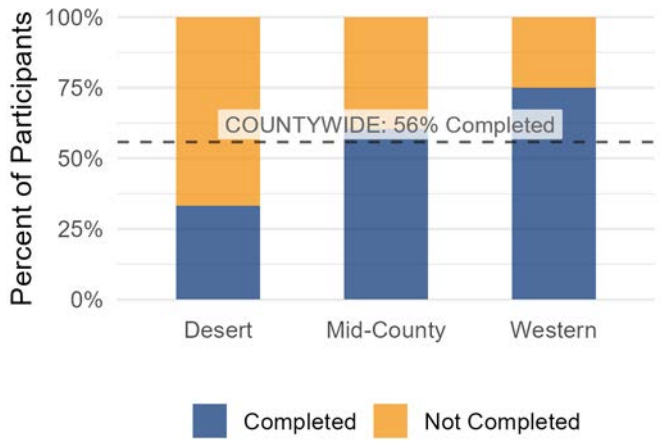
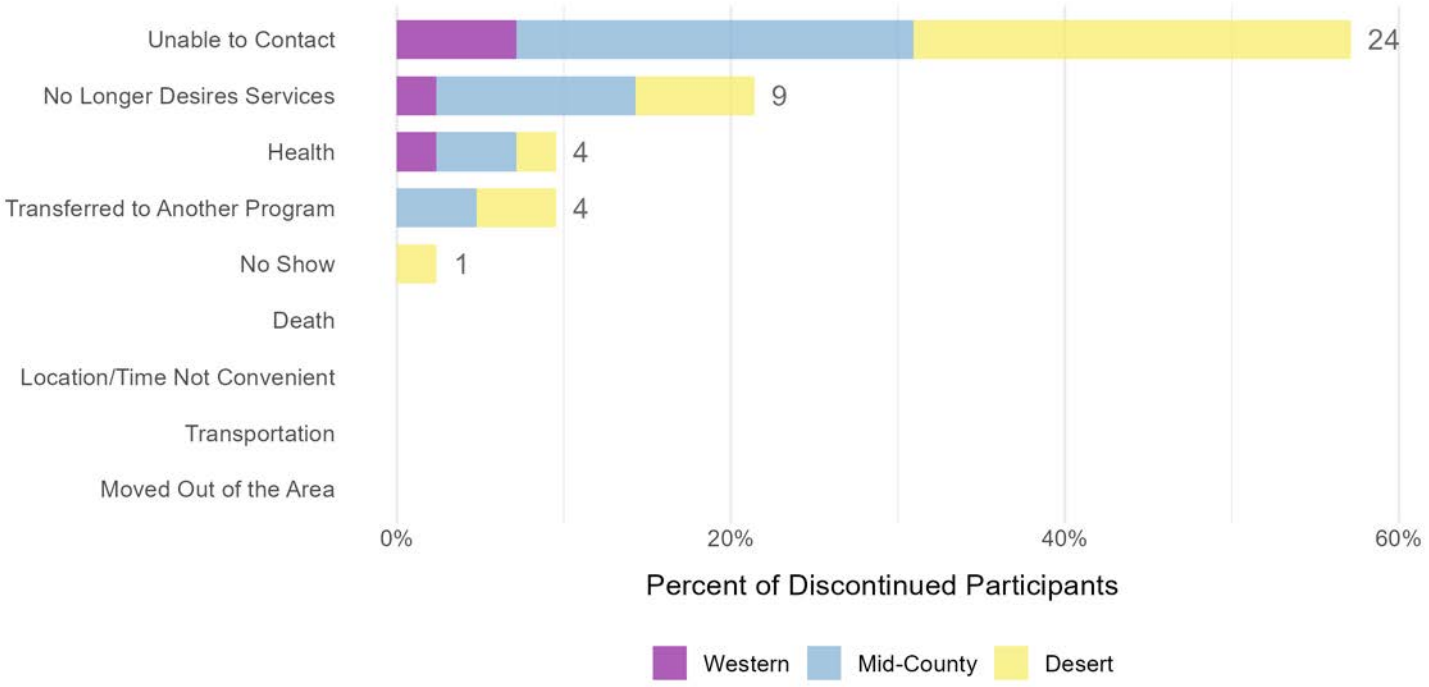


Figure 4.1 shows the completion rates for the 95 participants closed during FY 2023-2024. Countywide, 53 or 56%, completed the PEARLS program. This represents an improvement over the FY 2022-2023 completion rate of 46% .

For clients discontinuing service, an attempt is made to determine the reason. Figure 4.2 shows the reason breakdown for the 42 participants not completing the program. The majority (57%) simply could not be contacted. Reasons related to inconvenience (transportation and location/time) were not cited at all.

Figure 4.2: Reason for Not Completing



Program Outcomes: PHQ-9

The PHQ-9 measures symptoms of depression using nine questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to depression. The issues include (1) loss of interest or pleasure in doing things; (2) feeling down, tired, or bad about oneself; (3) trouble concentrating, sleeping, or speaking; (4) loss of appetite; and (5) thoughts of hurting oneself.

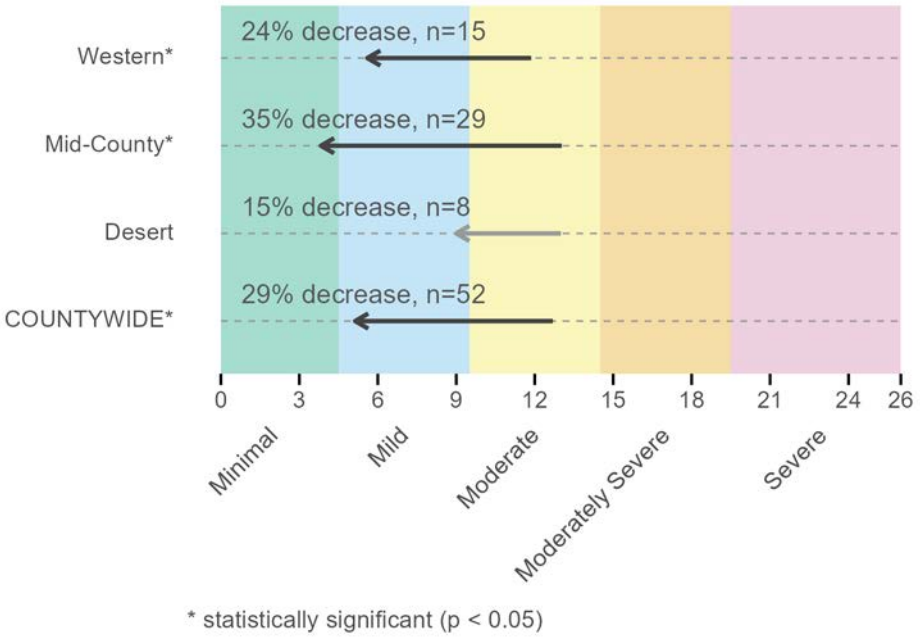
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program. We use these participants for the analysis. One participant didn't fully complete both the pre and post PHQ-9, leaving n = 52 participants for the analysis. There were no outliers.

Figure 5.1 displays the PHQ-9 results using arrows to point from the average-pre to average post-score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for all regions except Desert.

Furthermore, Figure 5.1 shows that average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.

Figure 5.1: PHQ-9 Mean Pre to Post Score Outcomes



Program Outcomes: GAD-7

The GAD-7 measures symptoms of anxiety using seven questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to anxiety. The issues include (1) feelings of nervousness, irritability, fear, and restlessness; (2) not being able to control worrying; and (3) trouble relaxing. Scores are calculated by adding the rank (0-3) selected for each question.

Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 32 fully completed both the pre and post GAD-7. There were no outliers.

Figure 6.1 displays the GAD-7 results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for Desert and Mid County regions.

An additional question following the GAD-7 is presented to quantify the impact of anxiety on the participant's life. Figure 6.2 shows the pre-to-post results. These were not statistically significant.

Figure 6.1: GAD-7 Mean Pre to Post Score Outcomes

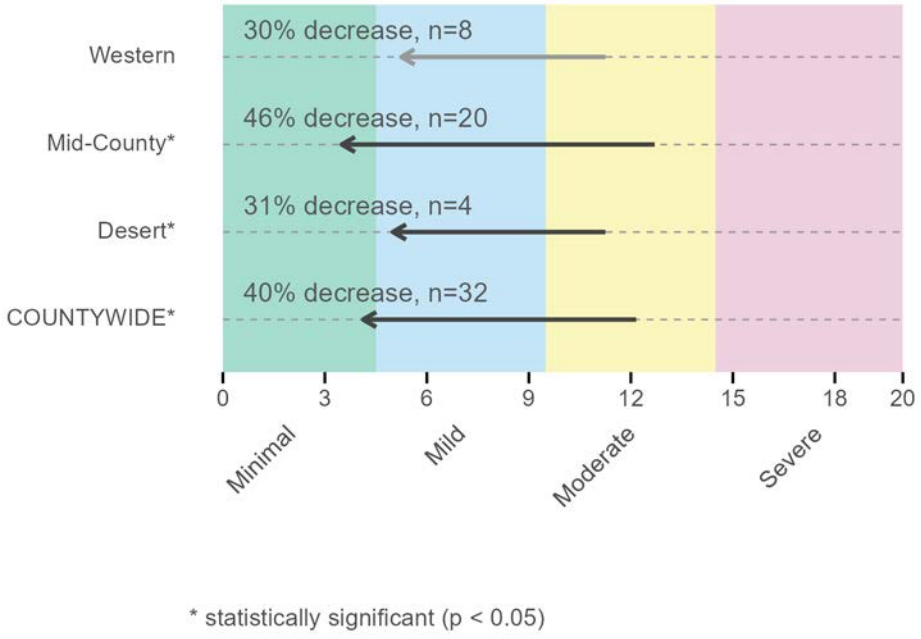


Figure 6.1 shows that average anxiety as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.

Figure 6.2: GAD-7 Extra Question

How difficult have these made it for you to do your work, take care of things at home, or get along with other people?



Program Outcomes: Physical Activity (RAPA-I)

PEARLS participant physical activity is assessed using the Rapid Assessment of Physical Activity (RAPA) questionnaire, which consists of nine yes/no questions depicting differing levels and intensity of activity. The participants check off whether or not each question is representative of their usual activity. Questions 1-7, the RAPA I, or "aerobic" section, describe aerobic activities of progressively greater duration and intensity. In contrast, the last two questions, the RAPA II or "strength and flexibility" section, simply indicate the inclusion of strength and flexibility in the participant's normal routine. RAPA II (Strength and Flexibility) outcomes are not currently analyzed.

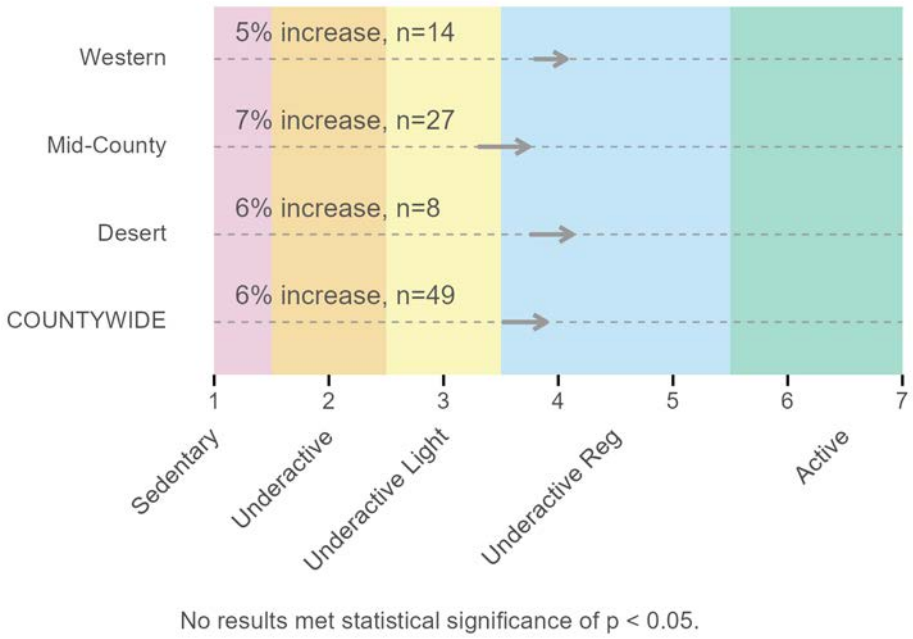
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 49 fully completed both the pre and post RAPA. There were no outliers.

Figure 7.1 displays the RAPA-I results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was not achieved for any region or countywide.

Figure 7.1 displays the progression of average pre to post scores using arrows. Improvement in physical activity as measured by the RAPA-1 was minimal for FY 2023-2024.

Figure 7.1: RAPA-I Mean Pre to Post Score Outcomes



No results met statistical significance of $p < 0.05$.

Program Outcomes: Quality of Life Survey

A nine-question quality of life survey is given to PEARLS participants at the beginning of the program and upon completion. Table 8.1 shows the average pre/post survey results for the 53 participants completing the program. Each arrow points from the average pre to the average post score. For each question, the number of participants completing both a pre and post survey is designated by *n*. Results were statistically significant ($p \leq 0.05$) for all questions except question 5, *How do you feel about the way things are in general between you and your family?*

Figure 8.1: Survey Outcomes

1. In general, would you say your health is:



2. How do you feel about your life in general?



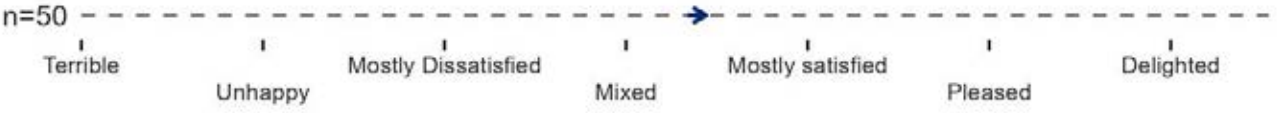
3. How do you feel about your emotional well being?



4. How do you feel about the way you spend your spare time?



5. How do you feel about the way things are in general between you and your family?



6. How do you feel about the amount of time you spend with other people?

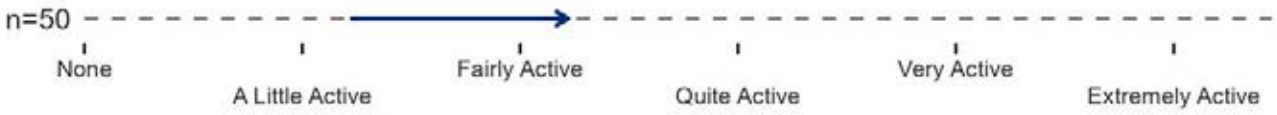


Program Outcomes: Quality of Life Survey (continued)

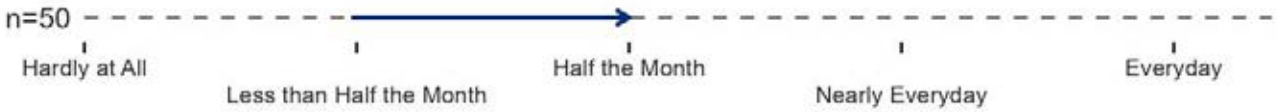
7. How do you feel about the amount of friendship in your life?



8. During the past month, which statement describes how socially active you have been?



9. During the past month, how often have you participated in pleasant activities?



Post Program Satisfaction Survey Results

Five questions related to satisfaction with the PEARLS program and practitioners are included only in the post survey. The first four questions are specific to (1) quality of service, (2) knowing how to get help, (3) likelihood to return to the program, and (4) reduction in depression. Responses to these four questions are summarized in Figures 9.1 through 9.4 below.

Figure 9.1: How Would You Rate the Quality of Service You Have Received From Your Practitioner?

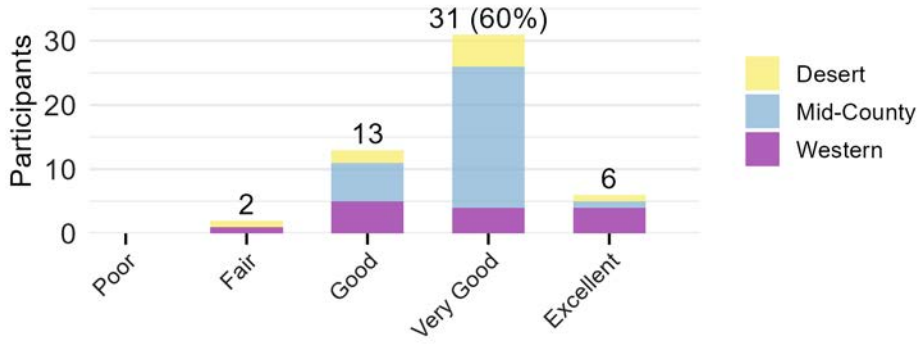


Figure 9.2: In a General Sense, How Satisfied Are You With the Support You Have Received From This Program?

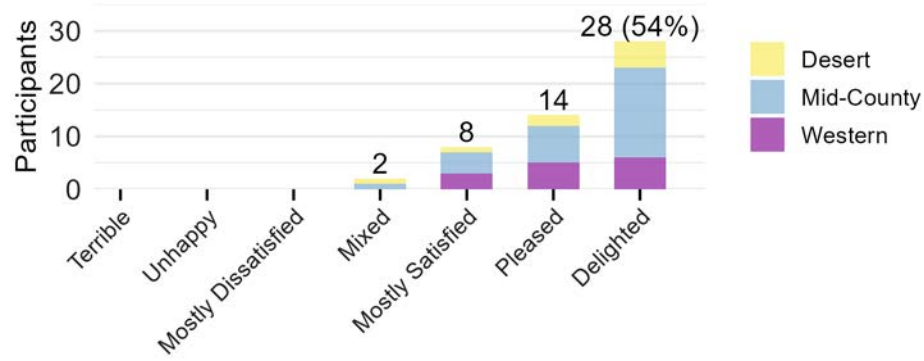
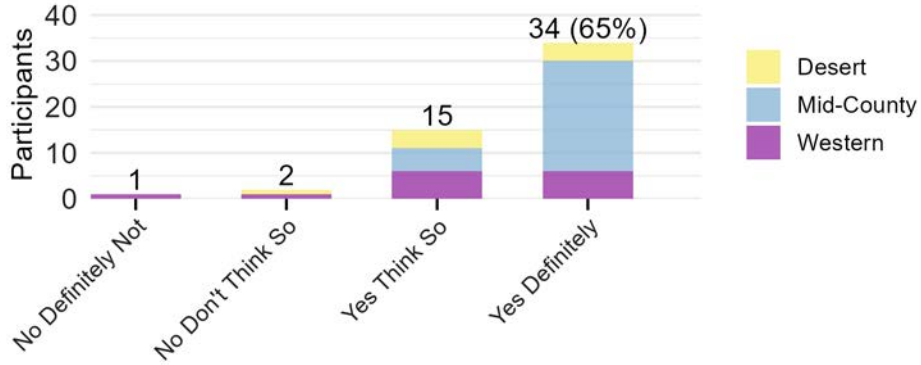


Figure 9.3: Would You Say as a Result of the Program You Now Know How to Get Help for Depression?



Post Program Survey Questions (continued)

Figure 9.4: If You Were to Seek Help Again, Would You Return to This Program?

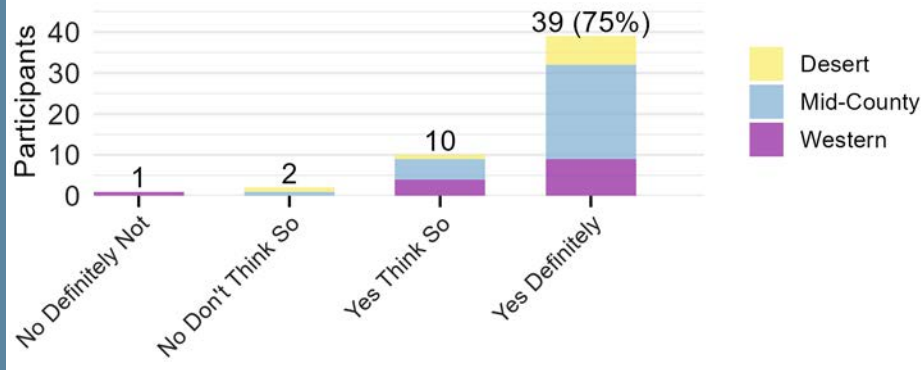
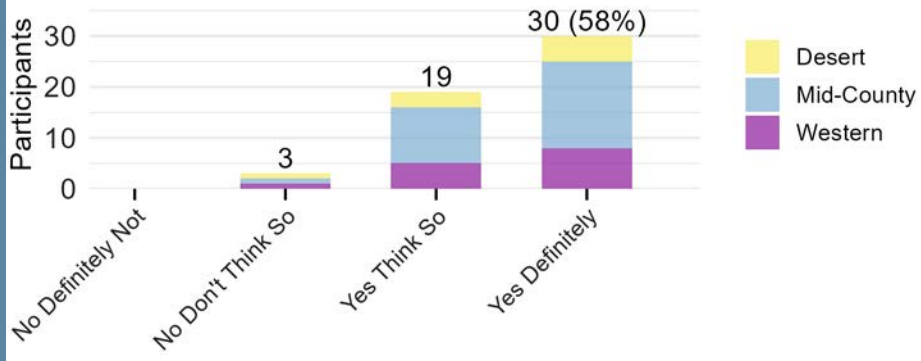


Figure 9.5: Has Participation in This Program Reduced Your Depression Symptoms?



Post Program Comments

The post-program survey includes two fill-in question. Selected responses are reproduced below with minimal edits.

"**If you did benefit from the PEARLS sessions, please describe why."**

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- I have been able to make some decisions that I was not able to make before as a result of this program.
- I was able to talk to someone with knowledge in guiding me through different scenarios.
- It gave me options that I never thought about before I started the program.
- (My practitioner) was there for me and my husband. I have learned so much that I can use in my day to day life. I really appreciate PEARLS.
- This program helped me learn about my feelings. I learned to find solutions to help me feel better when stressed.
- PEARLS helped me step back and think.
- (My practitioner) motivated me to do the things I wanted to do and now I'm doing them
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It really benefited me and I have made life changes that have made my day to day better
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.
- It re-enforced ability to redefine problems and how to solve them

"Do you have any additional comments you would like to share regarding your experience with the PEARLS program."

- I am absolutely so satisfied and happy to have had an avenue to speak openly about my feelings and emotions as I age.
- It has been a blessing that this program exists.
- I was pleasantly surprised how well it works. It wasn't easy at first but through the process it got easier and I got more comfortable.
- Your support is very valuable to improve our quality of life and you all have a gift in the way you provide support.
- I want to thank you for helping me to get out and make friends.

Historical Service and Completion

Figure 11.1: Participants Served

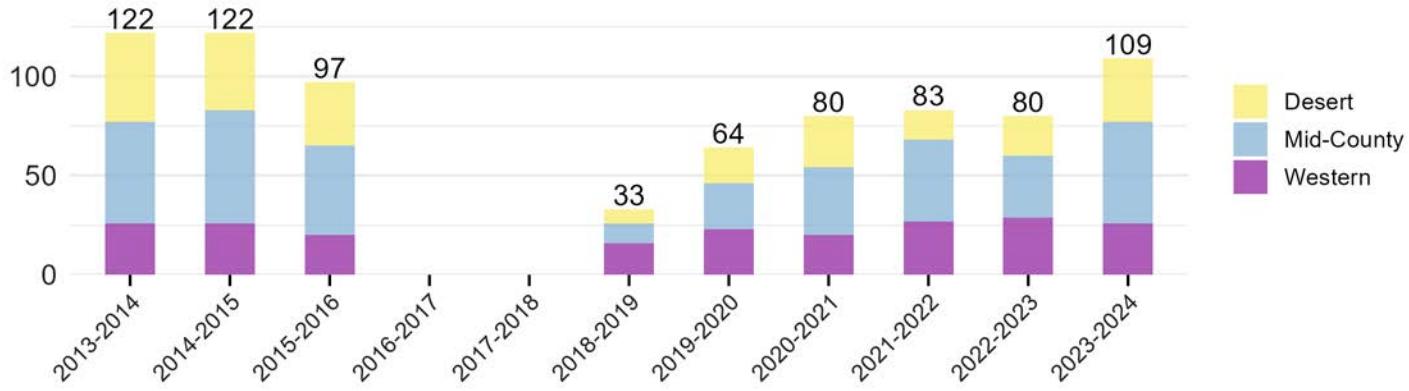
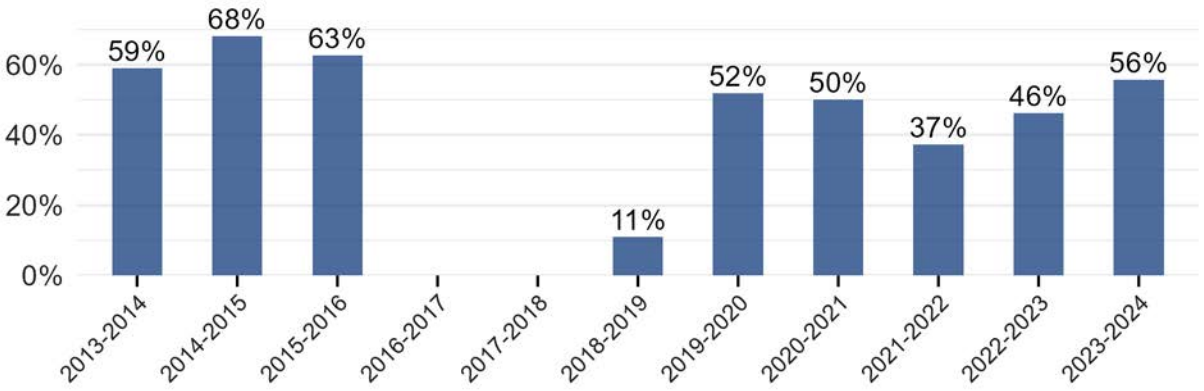


Figure 11.2: Completion Rates



Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Care Pathways (Caregiver Support Groups) Annual Report FY 2023-2024

Program Overview

The Riverside County Office on Aging (OoA) serves as the main gateway for information and referral assistance to seniors countywide, as well as to family caregivers. The OoA provides supportive services through its Family Caregiver Support Program (FCSP). OoA fully implemented the Care Pathways program, with MHSA Prevention and Early Intervention (PEI) funding, in June 2011. Care Pathways is a 12 week, two-hour class offering education and group support to caregivers of a friend or loved one, 60 years of age or older. The program holds scheduled meetings in the targeted areas of Western region (Rubidoux, East-Side Riverside, Casa Blanca, and Moreno Valley); Mid-County region (San Jacinto, Lake Elsinore, Perris, Romoland, and Winchester) and Desert region (Thermal, Mecca, Coachella, Palm Springs, Indio) of Riverside County. The classes are provided in English and in Spanish.

There is a maximum capacity of 15 participants per class. The program is structured to accommodate caregivers throughout the workshop series. If a participant misses a class within a 12 week session, the facilitator of the group will follow-up to encourage attendance and document any challenges he or she may be experiencing. Workshop Support Group Topics include: Living with Dementia; Signs of Stress & Stress Reduction Techniques; Communicating in Challenging Situations; Legal Issues Related to Challenging Situations; Managing Medications; How to Talk to the Doctor; Learning From Our Emotions; Taking Charge of Your Health; Grieving—Natural Reaction to Loss; Health Lifestyles; and Preventing Caregiver Burnout.

Outcomes Evaluation

The Care Pathways program's main goals are to reduce the risk for depression and to impact the caregivers' sense of well-being by reducing the emotional distress of caregivers. This is accomplished by providing useful information and providing the opportunity to share and bond with others. Two measures are used to evaluate program outcomes.

- Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) — a 20-item scale developed by the National Institute of Mental Health. The CES--D 20 is designed to measure current levels of depressive symptomology with emphasis on the affective component. The measure is administered at the start of participation in Care Pathways and at the conclusion of the program.

- American Medical Association's (AMA) Caregiver Self-Assessment Questionnaire — is designed to measure indices of emotional and physical distress. This measure is completed at the beginning of the program and at the conclusion of the program.

Executive Summary

Enrollment

During the 2023-2024 fiscal year, 133 individuals participated in the Care Pathways program support groups. Care Pathways enrollment showed 29% of participants were from the West, 23% from Mid-County, and 35% from the Desert region. Seven of the participants were from out of the County (5%) and ten participants (8%) were missing data on location and have not be included in this report. Of those residing in the three county regions, 116 caregivers participated in the Care Pathways program with a majority (75%) of participants enrolled completing the program. The majority (78%) of participants were female and 43% were age 60 or older. Most participants were either Caucasian (41%) and Hispanic/Latino (40%). Half (50%) of the support group participants had been providing care for 2 years or less. The caregiver's relationship to the person being cared for was often a parent (51%) or a spouse (28%).

Depression Decreased

Countywide and in the Mid-County region, there was a statistically significant decrease in Care Pathways participants' average CES-D 20 depression scores from intake to follow-up. Depression scores in the Mid-County region decreased from a mean score of 20.3 to 13.3, a decrease of 34%. Countywide depression scores decreased from 17.0 to 14.1, a 17% decrease.

Feelings of Distress Decreased

Caregivers' average AMA-Caregiver Self-Assessment Questionnaire scores showed a statistically significant decrease from pre to post Countywide and in the Mid-County region. The Mid-County region showed a 26% decrease in scores while Countywide, scores decreased 11%. In the Western region, caregivers reported a non-statistically significant decrease in current levels of stress from pre to post as measured by question 17 of the AMA-Caregiver Self-Assessment Questionnaire.

Caregiver Satisfaction was High

Caregivers reported high levels of satisfaction with 76.5% of participants who completed a satisfaction survey reporting that the support groups helped them in reducing the stress associated with being a caregiver and 96.1% of participants reporting that they would recommend the support group to friends in need of similar help.

The Care Pathways program enrolled 116 participants during the 2023-2024 fiscal year across the county's three regions. The Desert region enrolled the most caregivers. See Figure 1.

Figure 1. Enrollment by Region

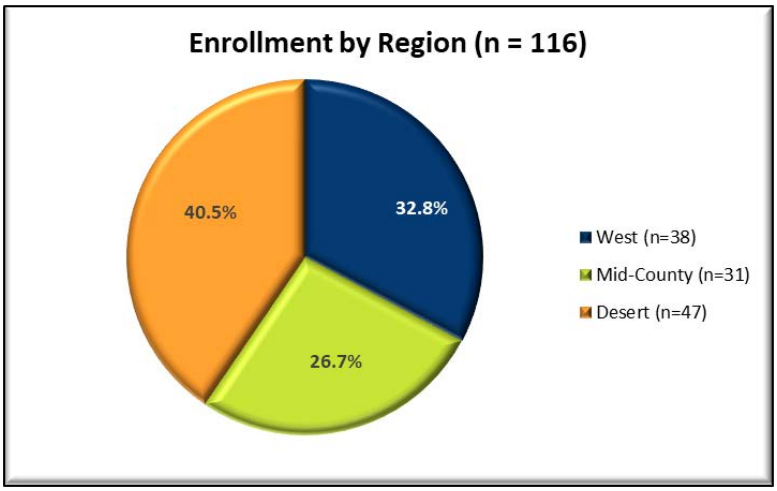
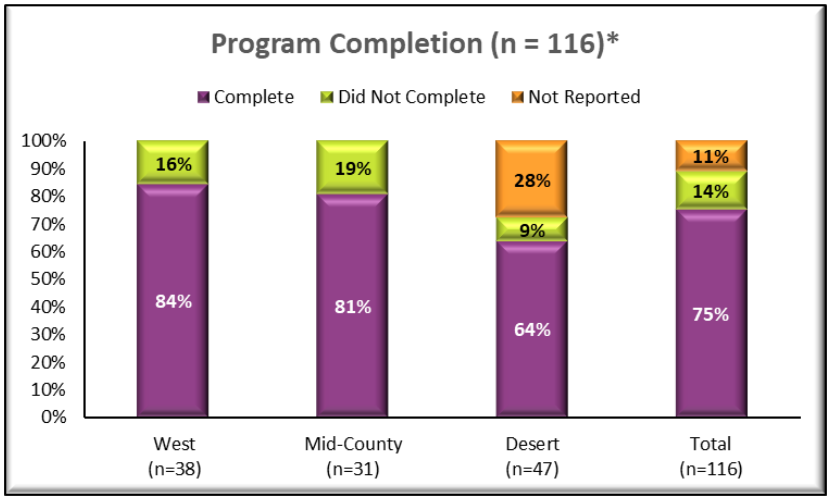


Figure 2. Program Completion



Countywide, 75% of participants completed the program. The Western region had the highest rate of completion 84%, while the Desert region had the lowest rate of completion 64%, see Figure 2.

Table 1. Contract Completion

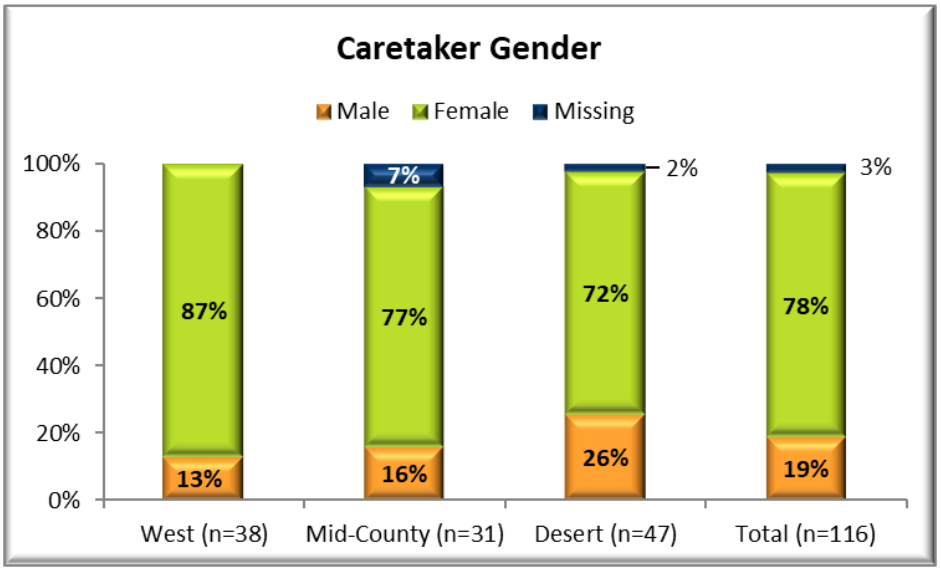
Actual Total Completed	Contract Expectations	Contract Completion
87	144	60%

Table 2: Program Completion History

Fiscal Year	Enrolled	Completed	Percent Completed
2018-2019	250	203	81%
2019-2020	183	142	78%
2020-2021	92	80	87%
2021-2022	117	88	75%
2022-2023	97	77	79%
2023-2024	116	87	60%

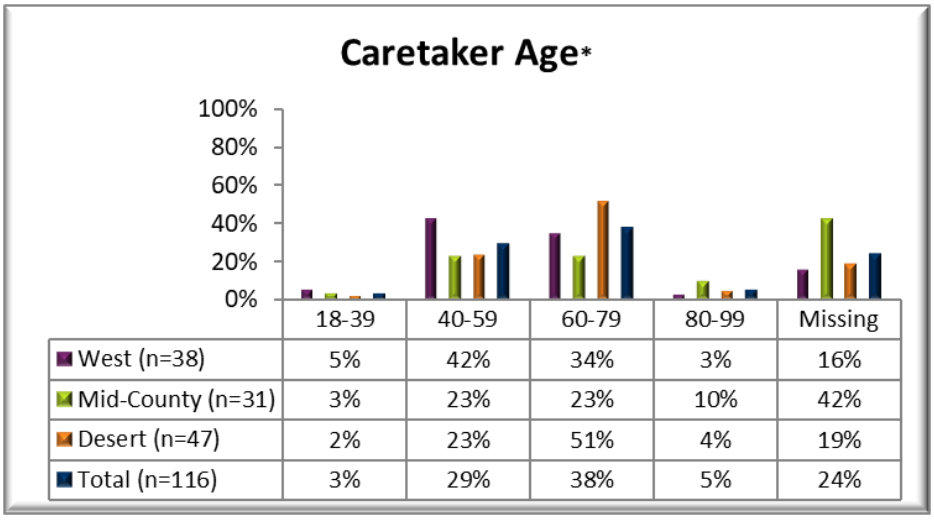
Countywide, the Office on Aging was contractually obligated to have 144 participants complete the program. Across all three regions, 87 participants completed the program, which accounts for 60% of the contract expectation. Contract expectations and completion can be seen in Table 1. Table 2 provides enrollment, completion, and the completion rate for several fiscal years.

Figure 3. Caretaker Gender



Countywide, the majority of caregiver participants reported being female (78%). The Western region served the highest percentage of females (87%).

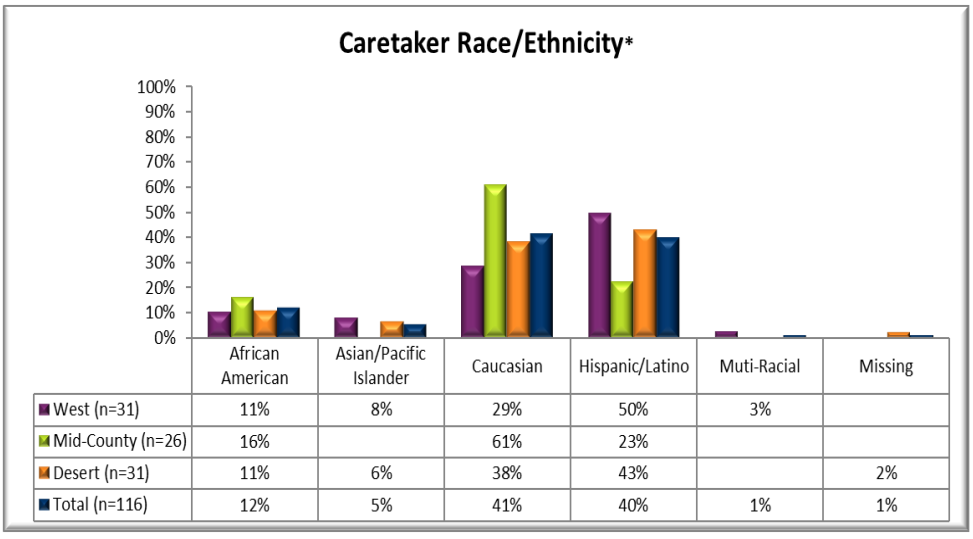
Figure 4. Caretaker Age



	18-39	40-59	60-79	80-99	Missing
West (n=38)	5%	42%	34%	3%	16%
Mid-County (n=31)	3%	23%	23%	10%	42%
Desert (n=47)	2%	23%	51%	4%	19%
Total (n=116)	3%	29%	38%	5%	24%

The majority (67%) of the caregivers participating in support groups were between the ages of 40 and 79. The average age of participants was 61 years old. Age was missing for 28 individuals.

Figure 5. Caretaker Race/Ethnicity

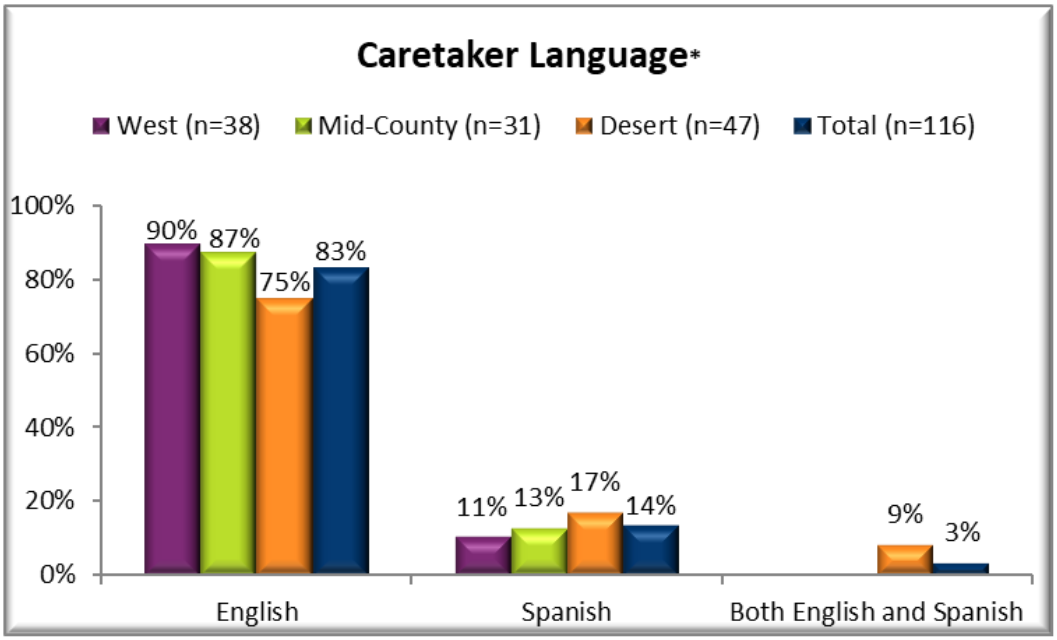


	African American	Asian/Pacific Islander	Caucasian	Hispanic/Latino	Muti-Racial	Missing
West (n=31)	11%	8%	29%	50%	3%	
Mid-County (n=26)	16%		61%	23%		
Desert (n=31)	11%	6%	38%	43%		2%
Total (n=116)	12%	5%	41%	40%	1%	1%

Overall, 41% of caregivers were Caucasian and 40% were Hispanic/Latino. One of the participants who identified as Hispanic/Latino specified being Mexican-American.

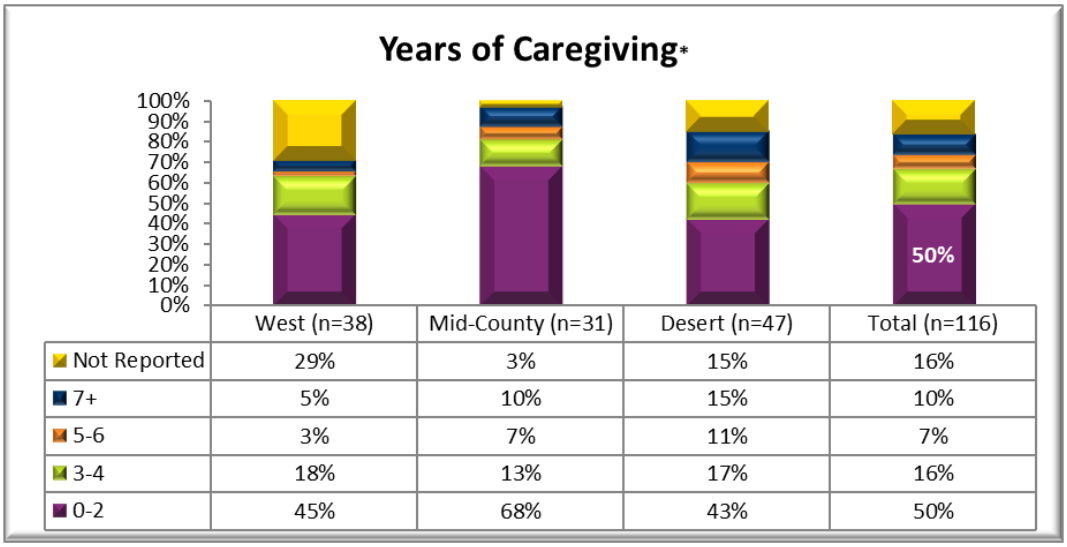
*percentages might not add to 100% due to rounding

Figure 6. Caretaker Language



The majority of participants spoke English as their primary language (83%). Classes were provided in both English and Spanish as needed.

Figure 7. Years of Caretaking



	West (n=38)	Mid-County (n=31)	Desert (n=47)	Total (n=116)
Not Reported	29%	3%	15%	16%
7+	5%	10%	15%	10%
5-6	3%	7%	11%	7%
3-4	18%	13%	17%	16%
0-2	45%	68%	43%	50%

Half (50%) of all caregivers had spent 2 years or less providing care at the time of enrollment. The average time spent providing care was 3.2 years.

Table 3 details the relationship of the Caregivers and Loved Ones. The relationship of the Caregivers and Loved Ones was not reported for four participants. The most common Loved Ones cared for were parents and spouses, respectively.

Table 3. Love One Cared for by Caretaker

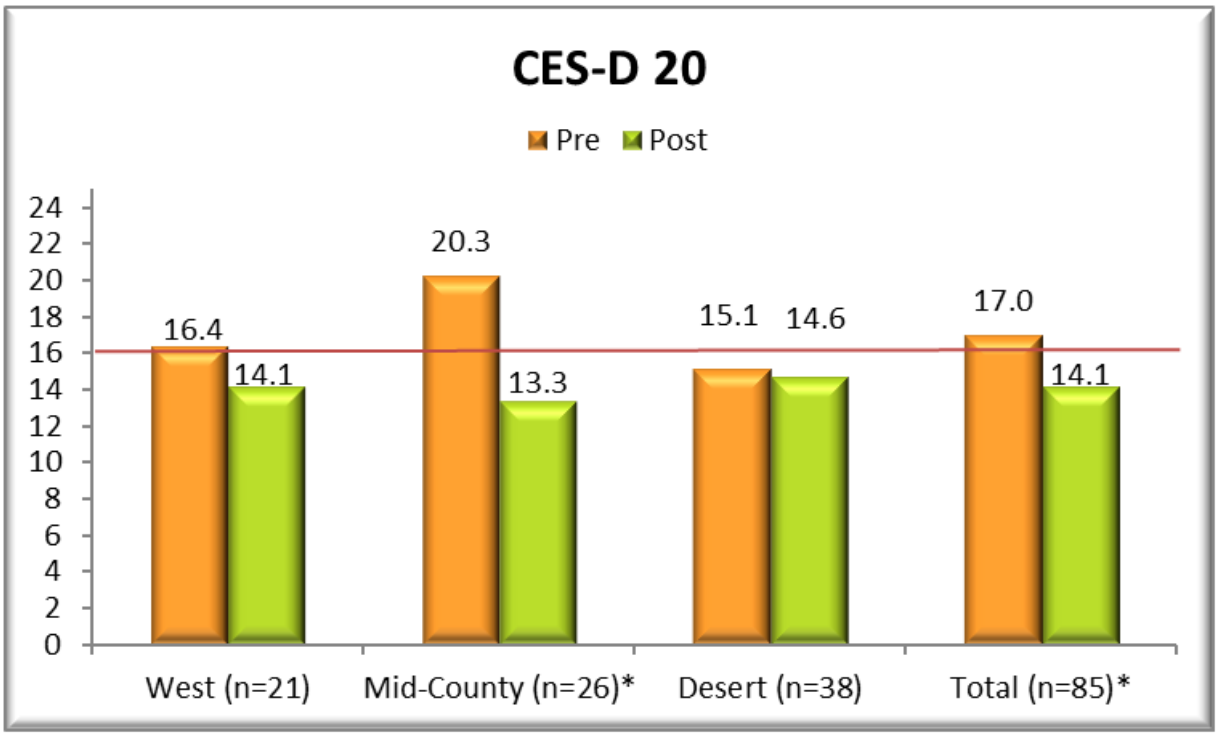
	Loved One Cared For							
	Sibling	Spouse/Partner	Parent	Parent-in-law	Family Member	Friend	Multiple	Missing
West (n=38)	-	16%	55%	11%	11%	-	-	8%
Mid-County (n=31)	-	29%	52%	3%	10%	-	7%	-
Desert (n=47)	2%	36%	47%	2%	6%	4%	-	2%
Total (n=116)	1%	28%	51%	5%	9%	2%	2%	3%

*percentages might not add to 100% due to rounding

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by The National Institute of Mental Health. Respondents are asked to choose from four possible responses in a Likert scale format, where "0" is "rarely or none of the time (less than 1 day)" and "4" is "almost or all of the time (5-7 days)." Scores range from 0 to 60. Higher scores reflect greater levels of depressive symptoms while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a clinically significant level of psychological distress. However, it does not necessarily mean that the participant has a clinical diagnosis of depression. In the general population, about 20% would be expected to score in this range.

There were a total of 85 matched pairs of pre to post measures. Countywide and in the Mid-County region, there was a statistically significant decrease in depression scores from intake to follow-up. Countywide, average CES-D 20 scores decreased by 17% from 17.0 to 14.1. In the Mid-County region scores decreased 34% from 16.4 to 14.1.

Figure 8. CES-D 20



*Significance <.05

The Caregiver Self-Assessment Questionnaire is an 18-item, caregiver self-report measure that was created by the American Medical Association (AMA) to aid physicians in the assessment of stress-levels of family caregivers who accompany chronically ill older adult patients to medical visits. The Office on Aging adopted the measure to assist in assessing caregivers perceptions of stress and emotional well-being. Caregivers are asked to respond either "Yes" or "No" to a series of statements, such as "During the past week or so, I have felt completely overwhelmed" and "During the past week or so, I have felt strained between work and family responsibilities." In addition, for questions 17 and 18, family caregivers are asked to rate their level of stress, and perception of their current health on a 1-10 scale, respectively.

Countywide and in the Mid-county region, self-assessment scores showed a statistically significant decrease from intake to follow-up. Countywide, self-assessment scores decreased 11%, while in the Mid-County region, scores decreased 26% from intake to follow-up. Figure 9 shows pre to post means for question items 1-16.

Figure 9. Total Self-Assessment

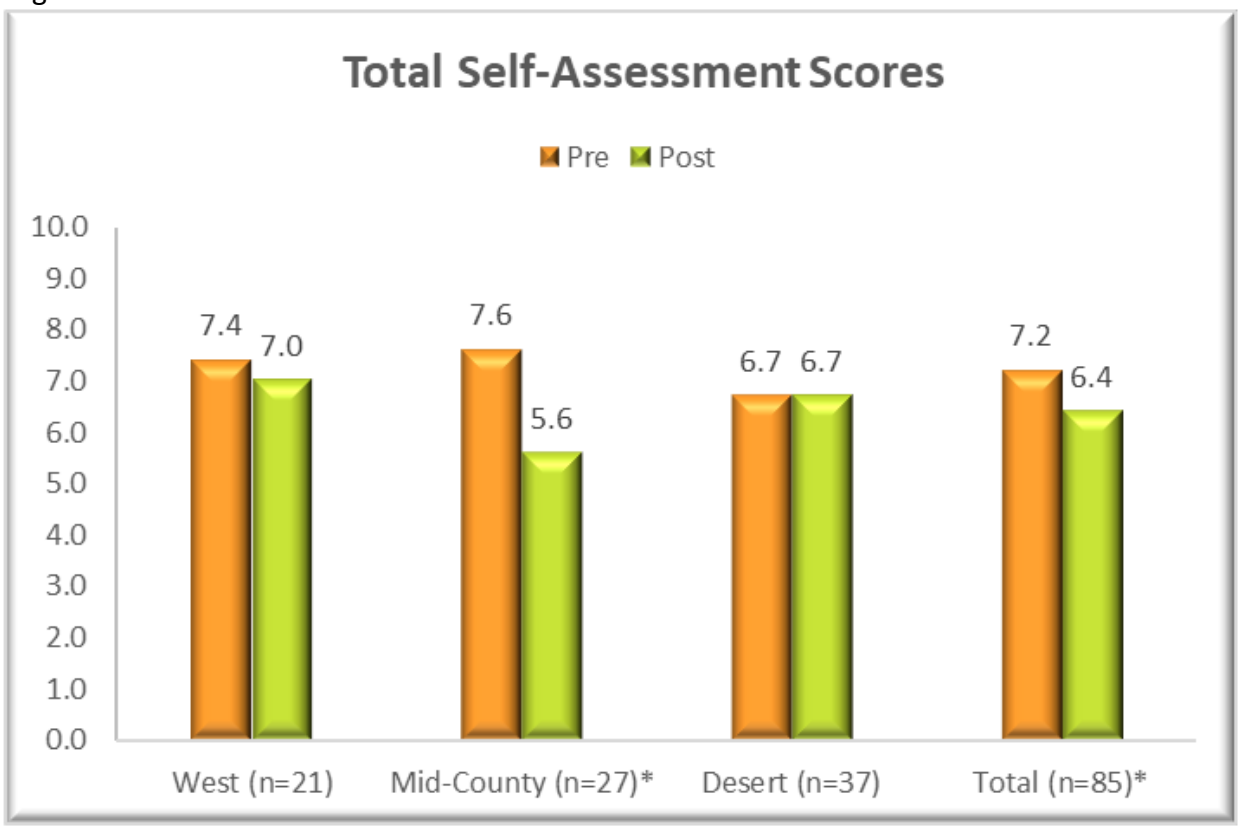
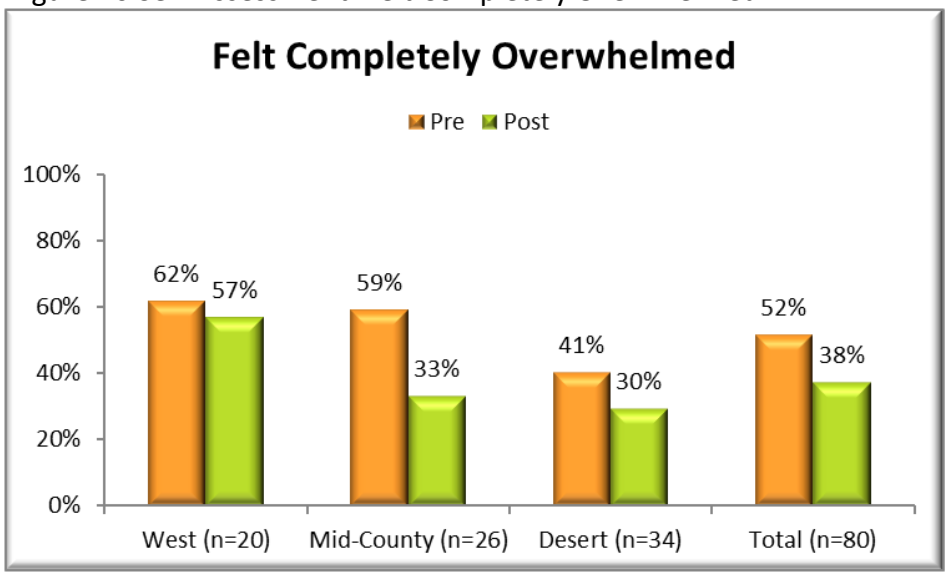


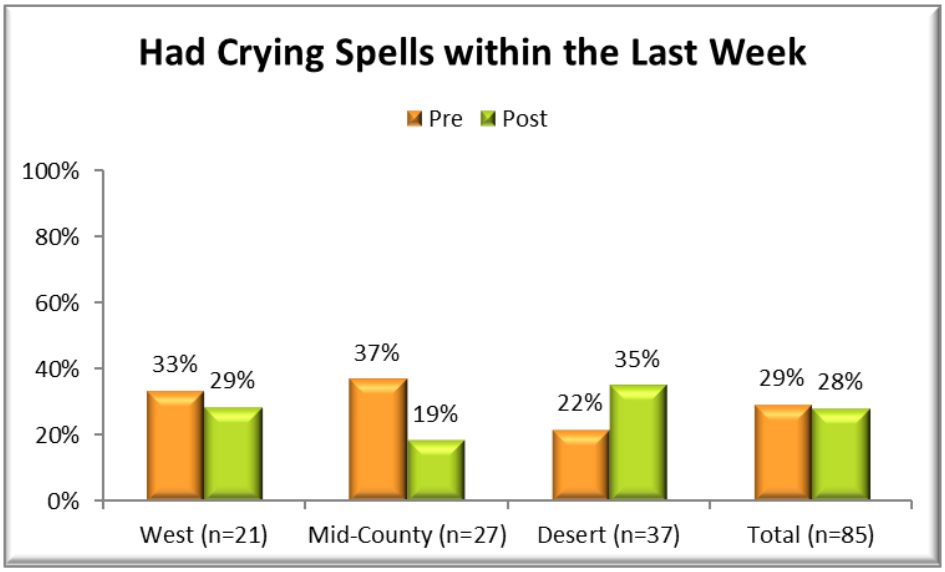
Figure 10 Self-Assessment: Felt Completely Overwhelmed



Caregivers' distress could also be indicated from answering yes to question #4 "Felt completely overwhelmed," or question #11 "Had crying spells" within the past week.

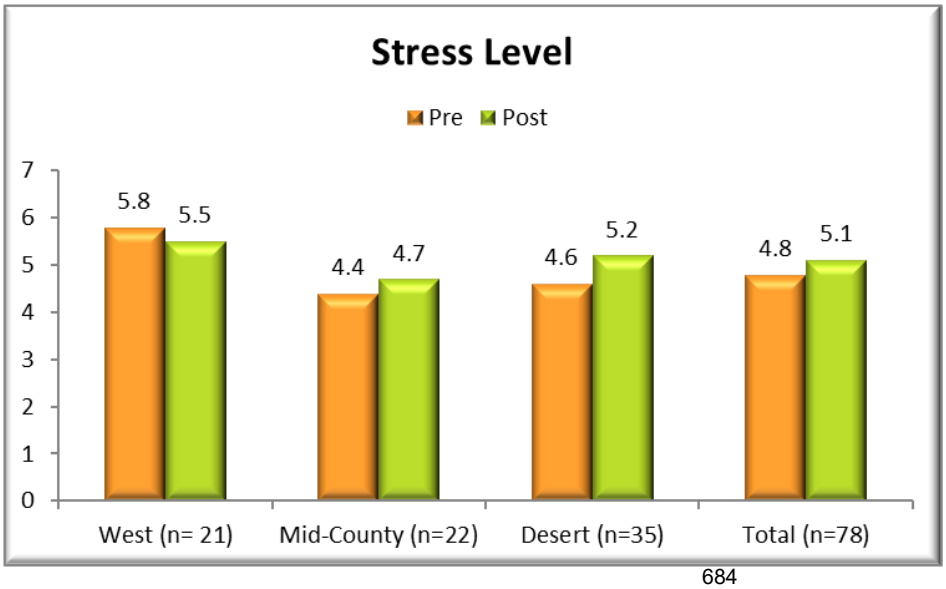
Countywide and within regions, participants reported feeling less overwhelmed at the end of the program (See Figure 10).

Figure 11. Self-Assessment: Had crying spells within the last week



Countywide, and in the Western and Mid-County regions, participants reported a decrease in crying spells (See Figure 11).

Figure 12. Self-Assessment: Stress Level



Question #17 asks caregivers to rate their current level of stress "On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful." Figure 12 provides the mean Caregiver scores for question #17. Although not statistically significant, stress levels in the Western region decreased 5% from pre to post.

Satisfaction

A total of 104 caregivers completed a satisfaction survey at the conclusion of the caregiver support groups. Results are shown in Table 4 below. Overall, caregivers were highly satisfied with the support received from the program. Caregivers also reported having reduced levels of stress and being able to cope more effectively in their caregiver role as a result of the program. Participants would recommend the program to a friend.

Table 4. Satisfaction

	Poor	Fair	Good	Excellent
1. How would you rate the quality of service you have received from the support group leader?	-	-	6.8%	93.2%
	No, definitely not	No, generally not	Yes, generally	Yes, definitely
2. Has the support group helped to reduce some of the stress associated with being a caregiver?	-	2.0%	21.6%	76.5%
	None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met
3. To what extent has the support group met your needs?	-	4.9%	32.0%	63.1%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
4. If a friend were in need of similar help, would you recommend this support group to him or her?	-	1.0%	2.9%	96.1%
	No, definitely not	No, not really	Yes, generally	Yes, definitely
5. Has attending the support group given you methods to solve problems in your role as caregiver?	-	-	17.8%	82.2%
	No, this seemed to make things worse	No, this really didn't help	Yes, this helped	Yes, this helped a great deal
6. Has attending the support group with other caregivers been helpful?	-	1.0%	12.4%	86.6%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
7. If you were to seek help again, would you return to this support group?	-	3.1%	6.2%	90.7%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
8. Has attending the support group helped you to cope more effectively in your role as caregiver?	1.0%	1.0%	17.3%	80.6%
	Quite dissatisfied	Mildly dissatisfied	Mostly satisfied	Very satisfied
9. In an overall, general sense, how satisfied are you with the support you have received from this group?	5.1%	2.0%	6.1%	86.9%

Comments
"Thank you for this resource and the presenters were wonderful. This program came at the right time for me. I had so many unanswered questions and they helped fill in the gaps. Many thanks!"
"I needed this to help me with my coping skills. I'm so grateful for all of the help I have gotten."
"Relief of my stress level and depression of my dad getting old and losing his ability of hearing, sight and mobility. Glad to talk to others in my same situation."
"Excellent instructor great selection of topics: ELDER Law, Death, Stress Management Etc…"
"The class has been very helpful to me to helping me identify some of the emotions that I've felt with being a caregiver."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Office on Aging Liaisons

FY 2023-2024 Annual Report





Office on Aging Liaisons FY 2023-2024

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Program Overview

Office on Aging Liaisons

The primary goal of this program is for the Riverside University Health System-Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging to:

1) work collaboratively to identify older adults who are either at risk of depression or are experiencing the first onset of depression.
2) ink these older adults with early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD).

In addition to referring older adults to early intervention programs, the Mental Health Liaisons are trained to provide CBT and CBT-LLD. MH Liaisons also link older adults with other resources and services, as needed, to reduce depression and suicide risk.

CBT for Late Life Depression

CBT for Late Life Depression is an active, directive, time-limited problem-solving program that follows the structure of the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults who are experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as slower rates of, or repeated, presentation of information using different modalities; greater use of practice; greater use of structure; and behavior modeling. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and shift them to being more adaptive and flexible. Emphasis is placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions following a structured manual.

Outcomes Evaluation

Referrals and Outreach

A significant amount of the Mental Health Liaisons' time is expected to be focused on completing referrals and participating in outreach events. Data collected for these activities includes referral forms with a final disposition and information on the types of outreach events that the staff participated in.

'CBT for Late Life Depression' Outcomes Evaluation

Each year, Mental Health Liaisons are expected to provide CBT for Late Life Depression to some people who are not referred out to Community-Based Providers of CBT.

1. **Patient Health Questionnaire (PHQ-9)** is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents ages 12 years and older. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and ≥ 20 indicates severe symptoms of depression.

2. **Quality of Life (QOL)** survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

3. **General Anxiety Disorder-7 (GAD-7)** is a 7-item questionnaire that measures generalized anxiety disorders and assesses its severity. Each item is scored on a scale of 0-3, ranging from no frequency to high frequency. The GAD-7 is scored by summing the ratings for the 7 questions. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and 15-21 indicates severe symptoms of anxiety.

Executive Summary: Key Findings

Referrals and Outreach

Within the fiscal year (FY) 2023-2024, Embedded Staff held 111 outreach events for a total of 160.5 hours. The majority of the events took place at community meetings (64.9%) and at public events (11.7%).

The Mental Health Liaisons processed 422 referrals in FY 23/24; where approximately 2.8% led to CBT-LLD (n=12) enrollment. Nearly 96% of the total referrals were to 'Other' (e.g. private insurance).

Cognitive Behavioral Therapy for Late Life Depression

Office on Aging liaisons provided CBT-LLD services to a total of 18 participants. The majority of the CBT-LLD participants were female (78%), and between the ages of 75-79 (27.8%). Sixty seven percent (n=12) of the participants closed from the program within FY 23/24. Since some participants start the program services later in the fiscal year, not all cases close by the end of the fiscal year. Enrollment and demographic data reflects a higher number of participants, as it includes all clients who were served in the fiscal year; whereas pre to post outcomes data only reflect those cases that were closed with post measures completed within the fiscal year. From the 12 closed cases, 50% reported successfully completing their treatment goals (n=6) while the remainder did not complete. The remaining participants discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially completed their goals.

Decrease in Depression Symptoms

- PHQ-9 pre to post scores showed a statistically significant improvement in symptoms of depression. Based on the average pre to post PHQ-9 scores, symptoms of depression decreased from moderate (m=12) to minimal (m=4) after completing the program.

Improved Quality of Life

- QOL survey results showed that participants felt significantly ($p<.05$) better in most (n=10) QOL items. In these items, participants reported improvements in how they felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being.

Decrease in Anxiety Symptoms

- GAD-7 pre to post scores showed a statistically significant decrease in anxiety symptoms. Based on the average pre (m=11) to post (m=4) GAD-7 scores, symptoms of anxiety decreased from moderate to minimal levels.

OUTREACH

Embedded Staff participated in a total of 111 outreach events. *Table 1* provides the number of outreach events that were held in each region. The majority of outreach events took place in the Desert region (78.4%), followed by Western (15.3%) and Mid-County (0.9%). A small amount of outreach events took place across all regions (5.4%; see Table 1).

Table 1: Regional Outreach Percentages

Agency	All	Mid-County	Desert	Western
Embedded Staff OOA (N= 111)	5.4% (n= 6)	0.9% (n=1)	78.4% (n=87)	15.3% (n=17)

Between all 111 events, Embedded Staff spent a total of 160.5 hours on outreach, averaging approximately 1.46 hour per event, reaching a total audience of 2,697 people (see *Table 2)*.

Table 2: *Outreach Totals*

Agency	Total # of Outreach Events	Total Time (Hrs)	Average Time (Hrs)	Total People in Attendance
Embedded Staff OOA	111	160.5	1.46	2,697

Table 3: *Types of Outreach Events*

Type of Outreach Events (N=111)	(n)	(%)
Community Meeting	72	64.9%
Public Event	13	11.7%
Phone	3	2.7%
Presentation	7	6.3%
Other	9	8.1%
Unknown	7	6.3%

As shown in *Table 3*, the majority of outreach events were identified as either Community Meetings (64.9%, n=72) or Public Events (11.7%, n=13).

Table 4: *Outreach Venues*

Type of Outreach Venues (N= 111)	(n)	(%)
C.A.R.E	16	14.4%
Community Health/ Resource Center	77	69.4%
Faith-based Organization	2	1.8%
One-On-One Outreach	1	0.9%
Senior Center/ Collaborative Meetings	13	11.7%
Senior Housing Complex	2	1.8%

Of the 111 Outreach Events, Embedded Staff completed the most outreach events through Community Health/ Resource Centers (69.4%, n=77; *See Table 4).*

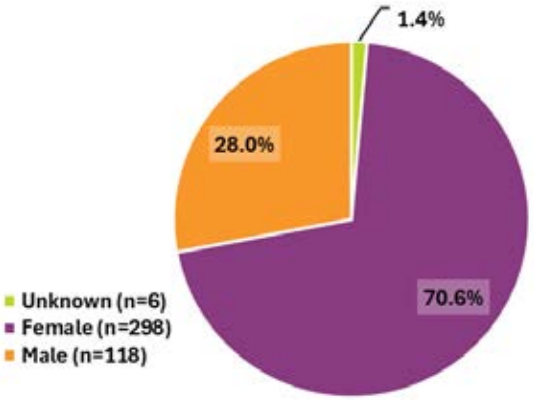
Other popular outreach venues included C.A.R.E. (14.4%) and Senior Center/ Collaborative Meetings (11.7%).

REFERALS

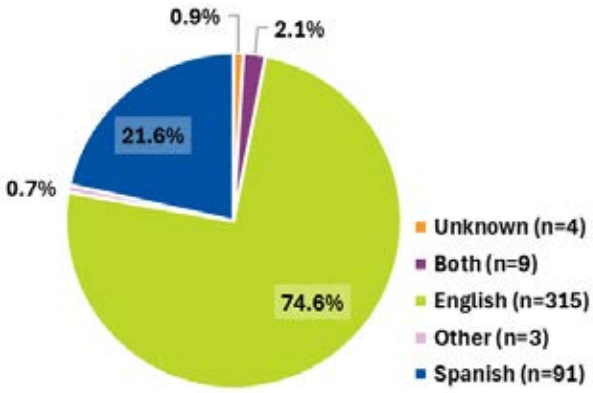
Mental Health Liaisons processed a total of 422 referrals within FY 23/24. All of the referrals were internally from the Office on Aging— such as the InfoVan, Adult Protective Services, In-Home Support Services (IHSS), Senior Centers (Coachella, Mecca, Mizell), Catholic Charities, and Sunny Adult Day Health Care. Additionally, Case Consultations were made for 159 people, which may or may not have resulted in a referral.

Characteristics of Referred Persons

Gender



Primary Language



The majority of the referrals were provided to females (n=298, 70.6%), while 118 identified as male (28.0%). A smaller amount did not report on gender (n=6).

The primary languages reported were English (n=315, 74.6%), and Spanish (n=91, 21.6%). Less than 1% did not report language whereas nine reported both English and Spanish as their primary language.

Referral Final Disposition

Among the 422 referrals that were made- some clients were referred to more than one program *(please note that the percentages in Table 5 do not sum to 100% due to stated multiple referrals)*, while others were not referred to any programs, as some referrals were unable to be completed (see Table 5.2). A total of 10 referrals were to CBT-LLD, all of which led to enrollment into the CBT-LLD program within the 23/24 fiscal year. Two additional participants were enrolled who did not come in through the referral process. *A majority of referrals had the final disposition of "Other" indicated (n=406) which was* 96.2% of total referrals. These primarily consisted of clients being referred back to their existing Primary Care Physicians and insurance (17.2%) , or the participant decided to delay referrals for the time being (22.9%).

Table 5: *Referral Dispositions*

Referral Disposition (N= 422)	n	%
Referred to a Non-PEI Program	16	3.8%
Referred to CBT-LLD	10	2.4%
Enrolled	*12*	2.8%
Did Not Meet Criteria	0	0.0%
Referred to Another PEI Program	6	1.4%
Referred to PEARLS	4	0.9%
Enrolled	*2*	0.5%
No Disposition Recorded	3	0.7%
Other (see Table 5.2 for break-down)	*406*	*96.2%*

Table 5.2: *Referral Dispositions "Other"*

Referral Disposition "Other" (N= 406)	n	%
Already receiving BH	25	6.2%
Declined Services	93	22.9%
Given/Mailed Resources	*44*	10.8%
Insights	51	12.6%
Other	28	6.9%
PEARLS	1	0.2%
Private Insurance/Referred to PCP	*70*	17.2%
Referred to RUHS	11	2.7%
Thrive	7	1.7%
Unable to Complete	76	18.7%

CBT Demographics

During FY 23/24, a total of 18 participants were enrolled and 17 received services from the Embedded Staff Office on Aging (ES-OOA) CBT program. The majority of the clients who received services were female (78%, n=14) and between the ages of 75-79 (27.8%).

Gender

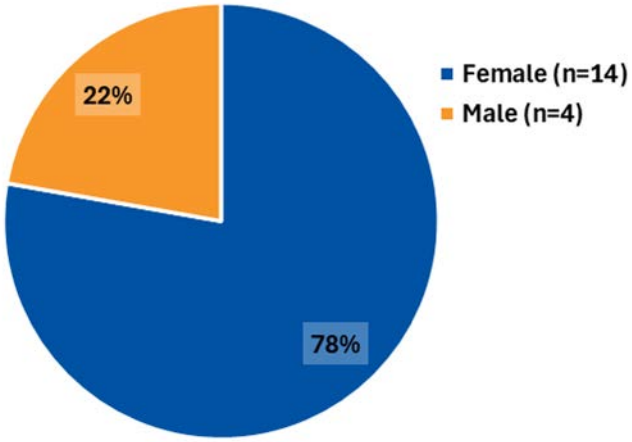
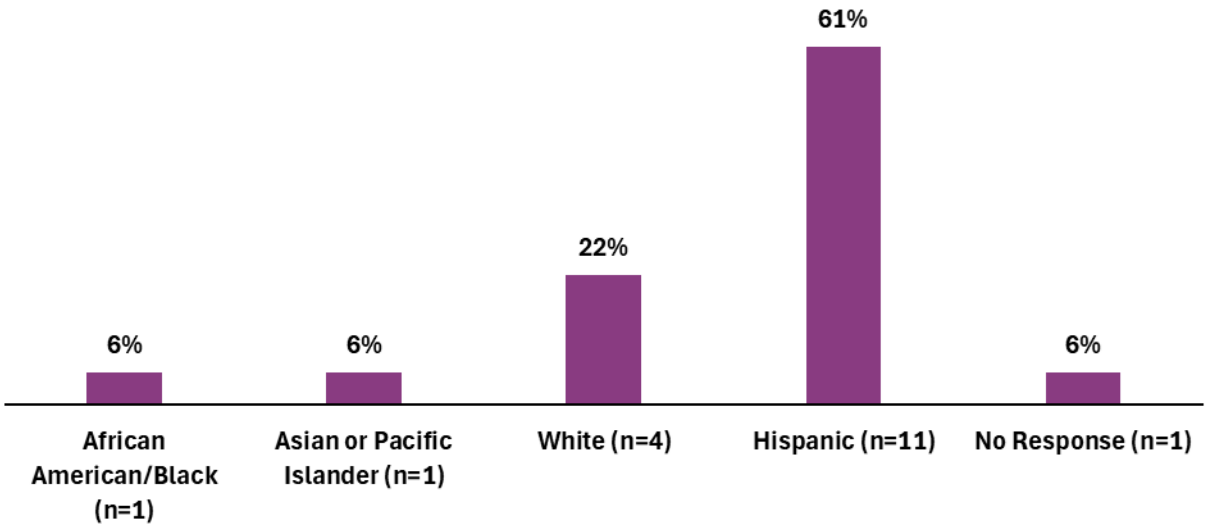


Table 6: CBT–LLD Age

Participant Age Range (*n= 18)*	n	%
59-64	4	22.2%
65-69	2	11.1%
70-74	4	22.2%
75-79	5	27.8%
>80	3	16.7%

Participant Race/Ethnicity

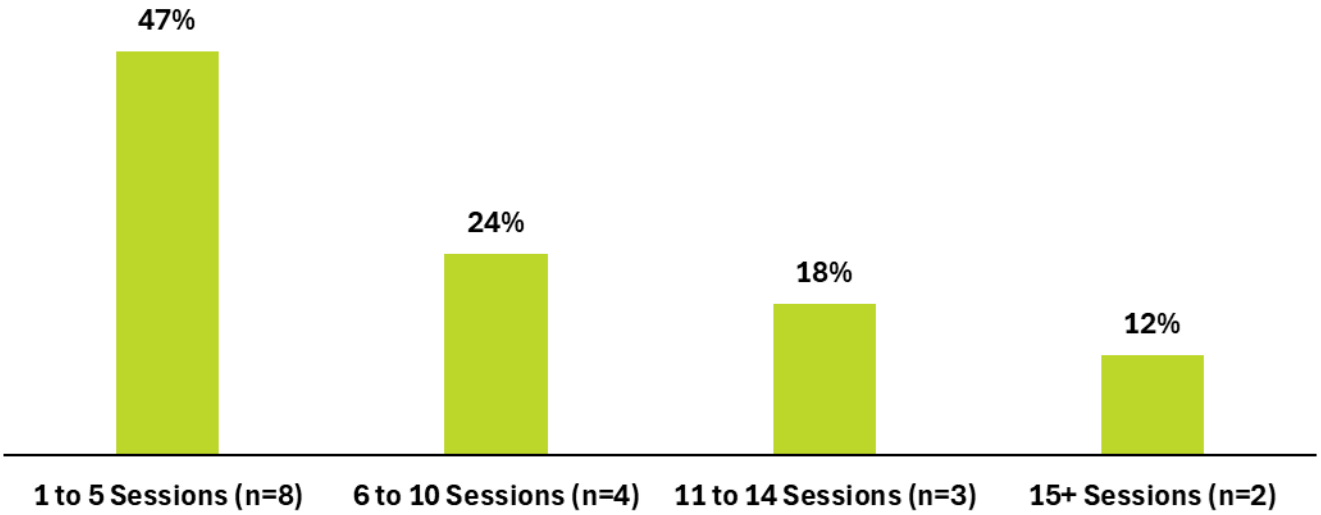


The majority participants identified as Hispanic (61%) followed by White (22%). Whereas, the remaining two participants identified themselves as and African American (6%) and Asian (6%). One participant did not disclose their Ethnicity.

CBT Program Participation

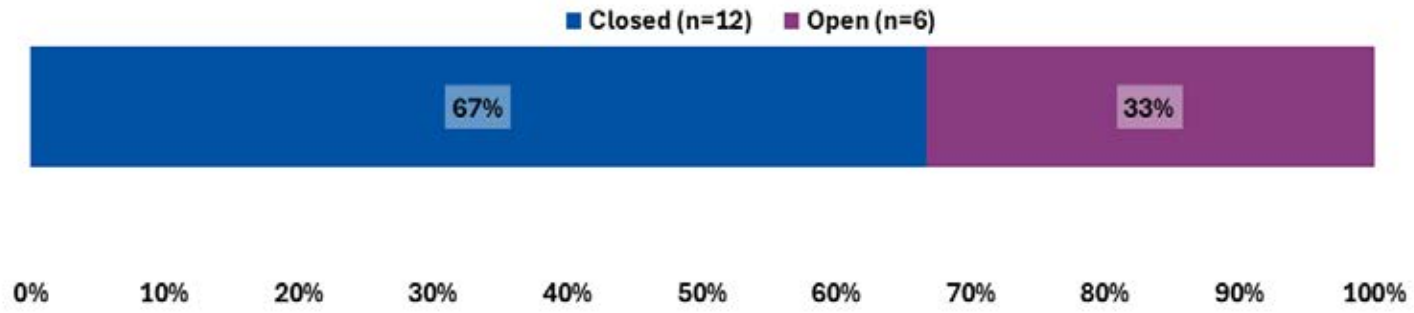
Number of Sessions Provided

Of the 18 participants who were open in FY 23/24, 17 received services. The graph depicts the number of CBT sessions that each participant (n=17) received. The range of session attendance was between 1 and 18 sessions.



Program Completion

Of the 18 participants enrolled, 67% (n=12) of the cases closed within the fiscal year, while the rest (n=6) carried into FY 24/25.

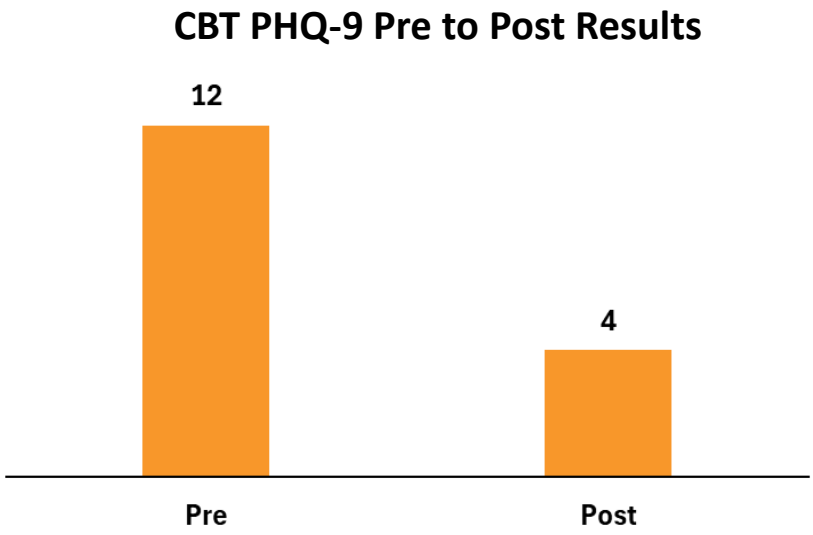


Outcomes CBT for Late Life Depression

Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.



Of the 12 participants with closing dates in FY 23/24, 75% (n=9) completed pre and post PHQ-9 measures. The pre and post PHQ-9 scores among participants showed on average a statistically significant (p <0.05) decrease in depression symptoms from the beginning to the end of the program. On average, participants reported experiencing moderate symptoms of depression at the beginning of the program (pre PHQ-9 score of 12), to experiencing minimal symptoms of depression by the end of the program (post PHQ-9 score of 4).

Table 7: ***Score Interpretation for PHQ-9***

Score Range	Depression Symptoms
0-4	Minimal symptoms of depression
5-9	Mild symptoms of depression
10-14	Moderate symptoms of depression
15-19	Moderately Severe symptoms of depression
20-27	Severe symptoms of depression

Outcomes CBT for Late Life Depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on their social behavior, activities, physical/emotional health, etc.—all aspects that CBT for Late Life Depression is directed at improving. Thus, this survey provides very relevant information on outcomes considering the goals of the program. The QOL Survey is rated on a scale of 1-7, with higher ratings indicating more positive results.

A total of 8 participants who had enrolled in the Embedded Staff's CBT-LLD program, completed both pre and post QOL surveys. For 76.9% of items (n=10), participants' scores significantly increased in the QOL survey items. There were significant improvements reported in how participants felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being (*See Table 8*). For items four and six, there was noticeable improvement from pre to post however it did not reach statistical significance.

Table 8: ***ESOOA & PE/CBT Quality of Life Results***

Quality of Life Survey Items (n=8)	Pre	Post
1. How do you feel about your life in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.125**	**5.125**
2. How do you feel about the amount of relaxation in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.375**	**5.375**
3. How do you feel about the things you do with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.5**	**6**
4. How do you feel about the amount of time you spend with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	3.75	5.125
5. How do you feel about the people you see socially? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4**	**6**
6. How do you feel about the amount of friendship in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	5.25	5.875
7. How socially active would you say you have been in the past month? (1=None; 2=A little; 3=Fairly Active; 4=Quite Active; 5=Very Active; 6=Extremely Active)	**2.375**	**3.875**
8. In general how would you say your health is? (1=Poor; 2=Fair; 3=Good; 4=Very Good; 5=Excellent)	2.875	3.25
9. How do you feel about your health in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.375**	**5.25**
10. How do you feel about your physical condition? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.75**	**5**
11. How do you feel about your emotional well-being? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.125**	**5.125**
12. How much bodily pain have you had during the past month? (1=Very Severe; 2=Severe; 3=Moderate; 4=Mild; 5=Very Mild; 6=None)	**2.625**	**4**
13. In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely; 2=Quite a bit; 3=Moderately; 4=Slightly; 5=Not at all)	**2.75**	**3.875**

BOLD Numbers indicate statistically significant ($p < 0.05$) change Pre to Post.

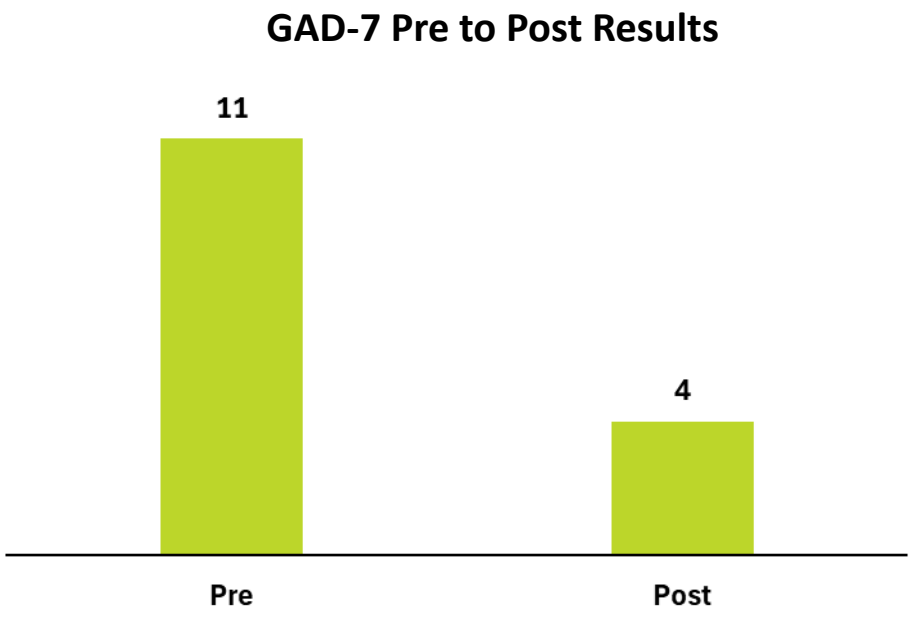
Outcomes CBT for Late Life Depression

GAD-7 Measure

The General Anxiety Disorder-7 (GAD-7) measures generalized anxiety disorders and assesses its severity. The GAD-7 measures participants' symptoms of anxiety with seven questions that ask participants to rank the degree to which, over the last two weeks, they had been bothered by: feelings of nervousness, irritability, fear, and restlessness; not being able to control worrying; and trouble relaxing.

The questions are ranked on a 0 to 3 point scale:

"0" = not at all, "1" = several days, "2" = more than half the days, "3" = nearly every day



A total of 8 participants completed both a pre-test GAD-7 survey at the beginning of the program and a post-test GAD-7 survey at the end. Countywide, participants experienced a statistically significant reduction in anxiety symptoms, with their average pre-test GAD-7 score of 11 (indicating moderate anxiety) decreasing to an average post-test score of 4 (within the minimal anxiety range).

Table 9: ***Score Interpretation for GAD-7***

Score Range	Level of Anxiety Severity
0-4	Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

Discontinuance Summary

Out of the 12 cases closed within the fiscal year, there was a total of 10 participants for which MH liaisons submitted a discontinuance form. For the remaining 2 participants it was necessary to use the electronic health record to determine discontinuance reasons. The primary cited reason for discontinuance was 'Successfully completed treatment goals' (n=6, 50%). The remaining participants (50%) discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially referred for further treatment.

Table 10: *ESOOA CBT Discontinuance*

Reason For Discontinuance (N=12)	n	%
Successfully Completed Treatment Goals	6	50%
Referred for further Tx	2	17%
Unable to Contact	1	8%
Client Withdrew	2	17%
Moved out of Area	1	8%

Satisfaction Survey

A total of 8 participants completed satisfaction surveys with Embedded Staff. Participants gave positive ratings to all items of the survey, with 'good' ratings given to their feelings of satisfaction and support received from the program and gaining coping strategies.

Embedded Staff Satisfaction Items & Results (N=8)	Avg	1	2	3	4	5	*m
1. How would you rate the quality of service you have received from your practitioner? (Excellent=4; Good=3; Fair=2; Poor=1)	**4.00**	-	-	-	100%	-	-
2. How satisfied are you with the support you have received from this program? (Very Satisfied=4; Mostly Satisfied=3; Mildly Dissatisfied=2; Quite Dissatisfied=1)	**3.88**	-	-	13%	88%	-	-
3. Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.50**	-	-	50%	50%	-	-
4. Did you gain strategies to help you cope? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-		100%	-	-
5. Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.88**	-	-	13%	88%	-	-
6. Has participation in the program reduced your depression symptoms? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.63**	-	-	38%	63%	-	-
7. Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5; Yes, I think so=4; Not sure=3; No, I don't think so=2; No, Definitely not=1)	**4.38**	-	-	-	63%	38%	-
8. If you were to seek help again, would you return to this program? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-	-	63%	-	38%
***missing data**							

Participant Comments:

- *It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much. [Translated from Spanish]*
- *The program is good, I would recommend it [Translated from Spanish]*
- *The program helped me. I liked that [Therapist] understood me and helped me to cope with my problems. I am grateful for the program*
- *[Therapist] has been a great help for me. A am very comfortable with her & opening up to her*
- *I like the support and will continue to look for BH as needed*
- *I was satisfied with this program, it helped me a lot. [Translated from Spanish]*

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors)
Annual Report FY 2023-2024

Program Overview

The Riverside County Office of Aging (OOA) with MHSA Prevention and Early Intervention (PEI) funding, implemented an evidenced-based practice to reduce the risk of depression and suicide among older adults throughout Riverside County. Under a Memorandum of Understanding (MOU) with the Riverside University Health System—Behavioral Health (RUHS--BH), the OOA integrated the Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors) program into their existing CareLink case management program. The intent of the CareLink Prevention and Early Intervention Initiative was to embed the Healthy IDEAS program into the existing CareLink case management program with the goal of preventing premature institutionalization of functionally impaired adults and the frail at risk elderly. CareLink provides care management as well as comprehensive information and assistance services. The Office on Aging trained their staff to implement the Healthy IDEAS model intervention to clients receiving case management services. State funding supporting the original CareLink program was withdrawn; and with the inclusion of PEI, the primary focus shifted to individuals at risk for mental health concerns such as depression and anxiety. Literature supports that adults dealing with functional loss, chronic illness, grief and loss issues, or psycho/social stressors, if not already in the early stages of depression, are at greater risk for depression. Frail older adults and disabled adults are screened through the OOA Information and Assistance Intake Center for Care Management. In addition, individuals referred to the CareLink program receive screening for depression. Those individuals that qualify for CareLink and meet screening criteria for depression receive the additional Healthy IDEAS program services.

***Outcomes Evaluation* Measures**

Outcomes evaluation measures for Healthy IDEAS included the use of tools provided by the developers of the evidenced based practice. The CES-D 20 depression measure and a quality of life survey were used to measure outcomes.

The Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) measures depression symptoms. The measure is administered at the beginning and at the conclusion of program services.

The Healthy IDEAS Quality of Life Survey measures quality of life and participation in social activities. The survey is administered at the beginning and at the end of the program. The post questionnaire includes additional items on satisfaction with the Healthy IDEAS program.

Executive Summary

Demographics

One hundred fifty-one participants were enrolled in CareLinks during 2023-2024 Fiscal Year. Twenty-three CareLink participants were identified as being at risk for depression and were enrolled into the Healthy IDEAS program. The majority (65%) of Healthy IDEAS participants were between the ages of 50 and 79. Healthy IDEAS participants were mostly White (48%) and Hispanic/Latino (39%).

Services

Healthy IDEAS participants had an average of 4.8 sessions and received an average 8.6 hours of service. A little over a quarter (26%) of clients completed the program in FY2023-2024. Some participants (n = 7, 30%) were not closed during the 2023-2024 fiscal year, and will carry over into FY2024-2025.

Healthy IDEAS Outcomes

Depression symptoms for Healthy IDEAS participants showed a statistically significant decrease. In addition, participants' satisfaction with their emotional well-being increased.

Care Link Satisfaction

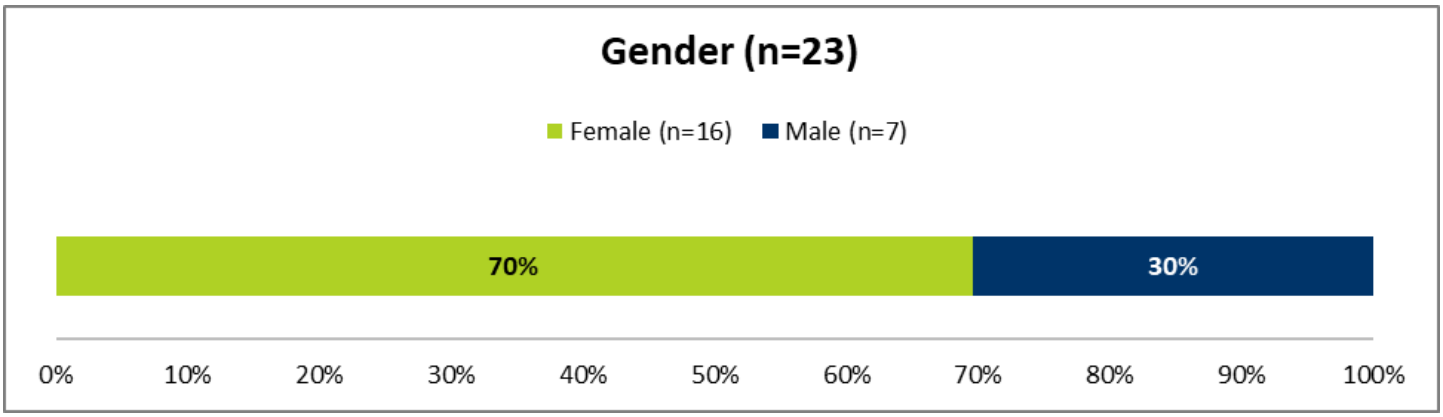
CareLink participants reported they were satisfied with many aspects of the program. Participants reported home visits and telephone contacts as being the most helpful features of the program. CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful.

Healthy IDEAS

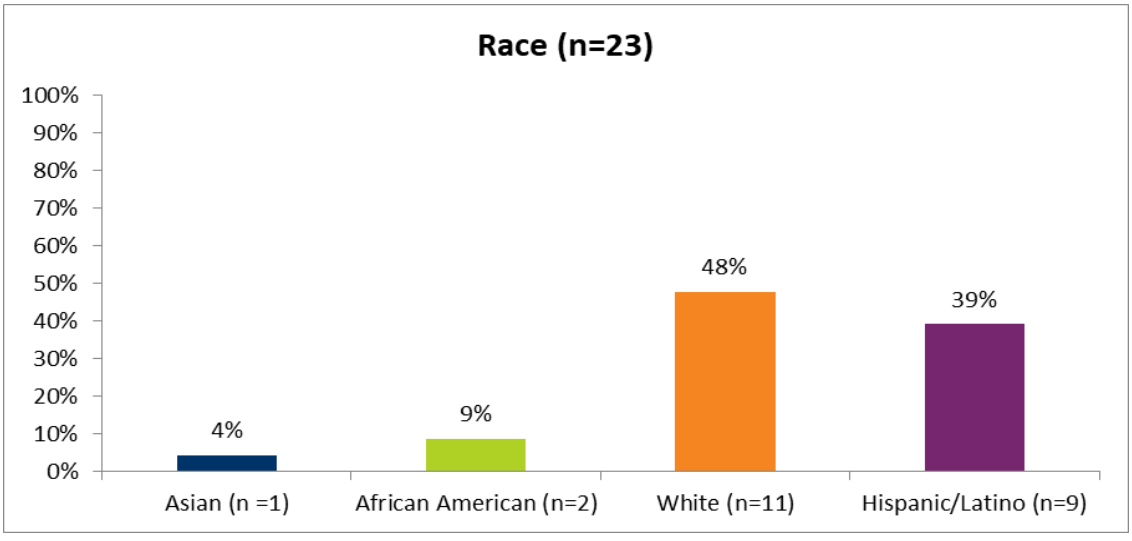
Healthy IDEAS (**I**dentifying **D**epression, **E**mpowering **A**ctivities for **S**eniors) is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives.

Demographics

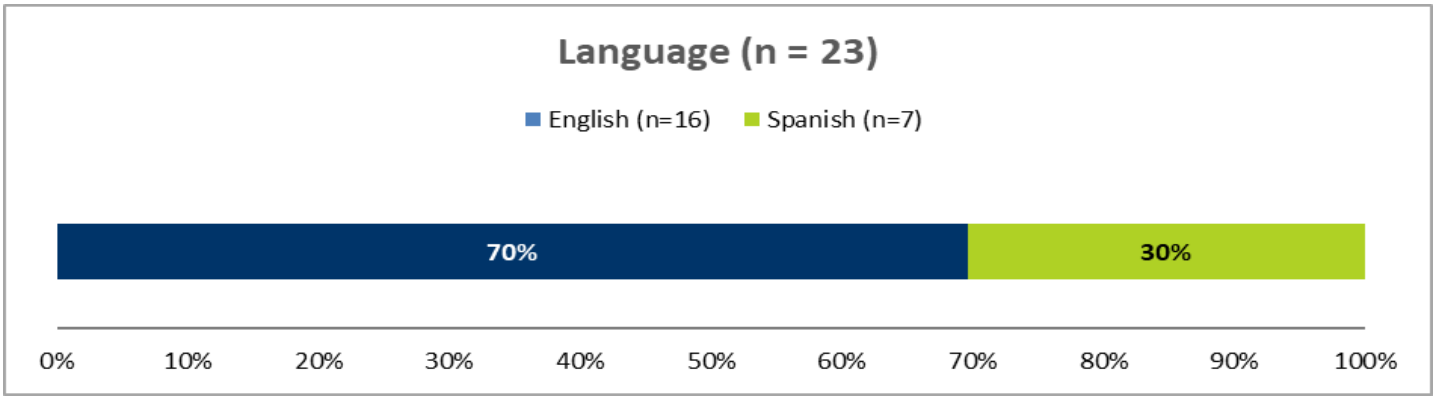
There were 151 Carelink clients during the 2023-2024 fiscal year. Twenty-three (23) Carelink clients met the screening criteria for depression and were enrolled into Healthy IDEAS program. More females than males participated in the Healthy IDEAS program.



The majority of Healthy IDEAS participants (48%) were either White or Hispanic/Latino (39%).

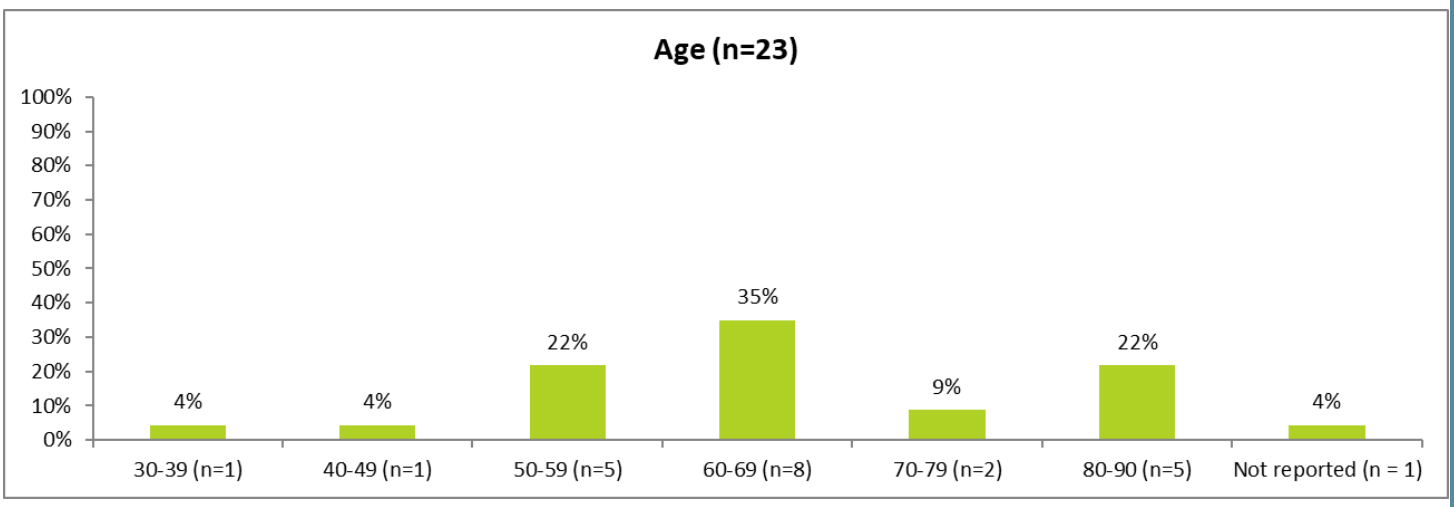


A large percentage of participants (70%) reported English as their primary language.



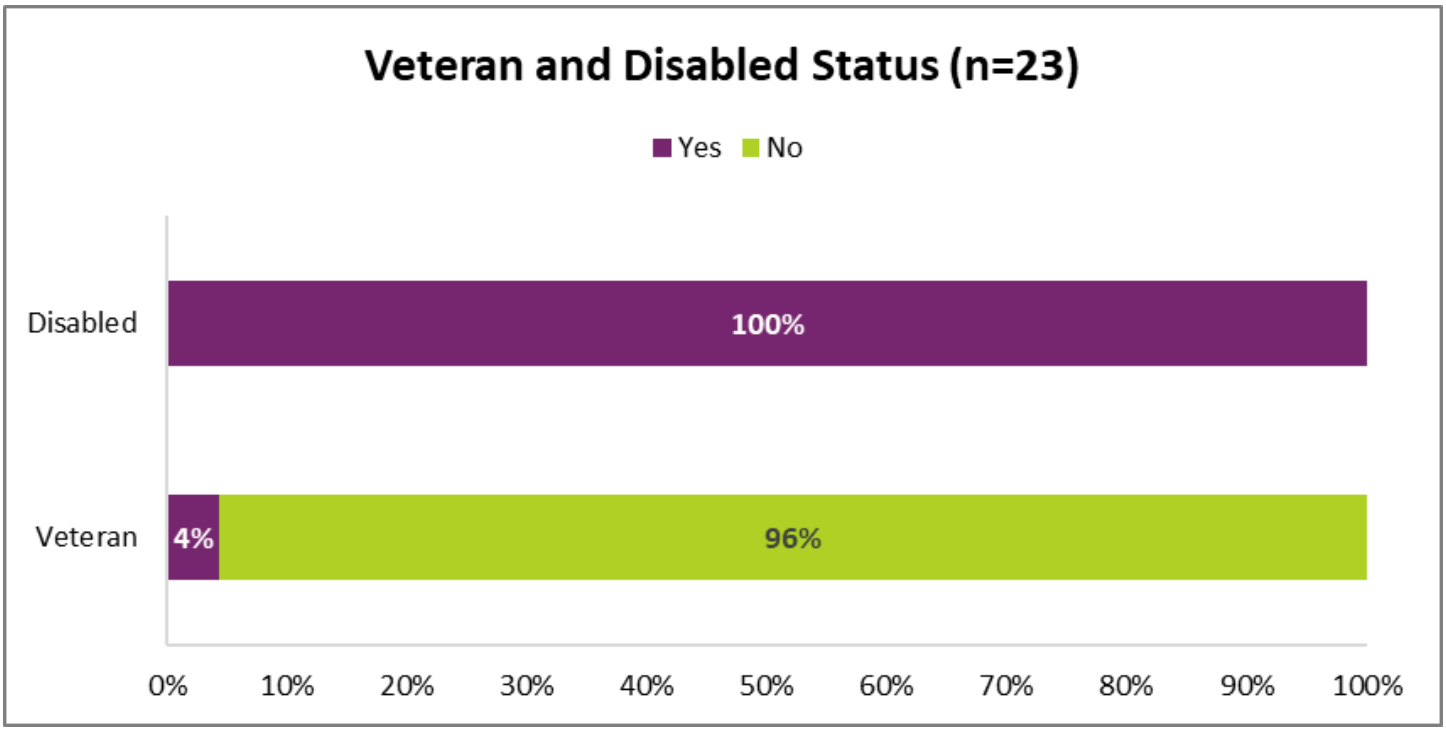
Demographics (cont.)

The majority of participants (83%) were between the age of 50 and 89 at the time of program entry. The average age of participants was 68.

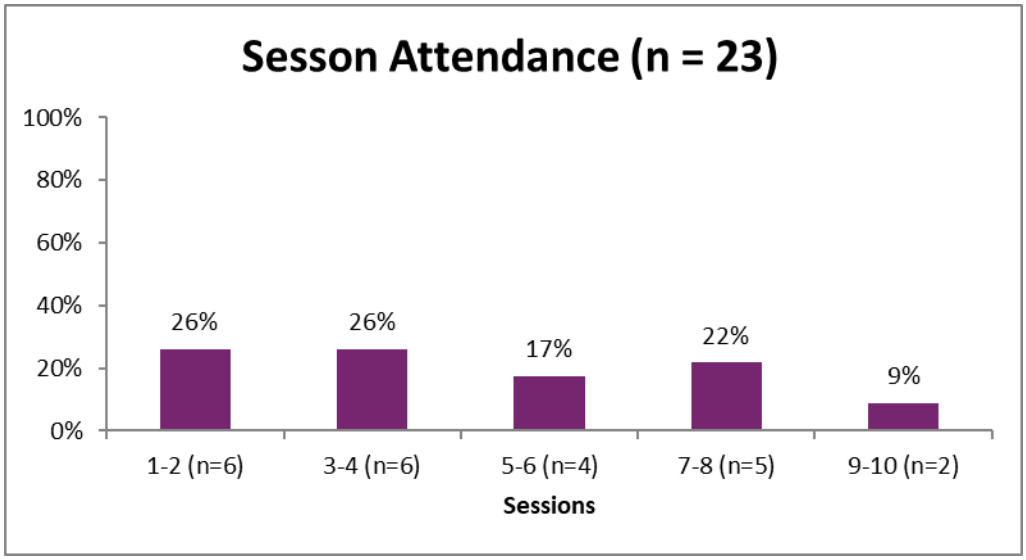


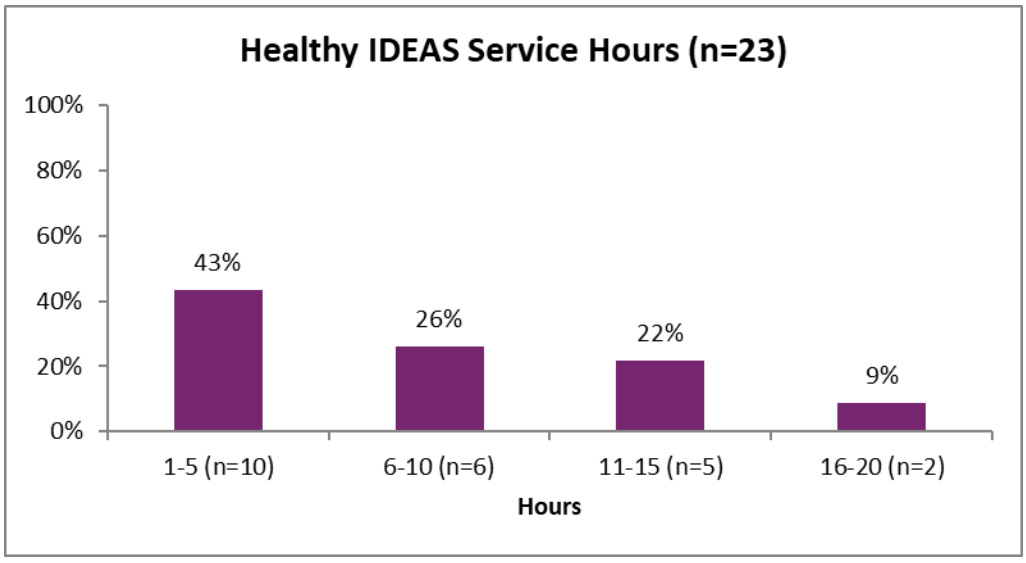
Participants were asked to report if they had a disabling condition. All participants reported having a disabling condition.

Participants were also asked to report their status as a veteran. Four (4%) percent of the participants in the 2023-2024 fiscal year reported being a veteran.



Clients attended an average 4.8 Healthy IDEAS sessions and received an average of 8.6 service hours.





Program Completions

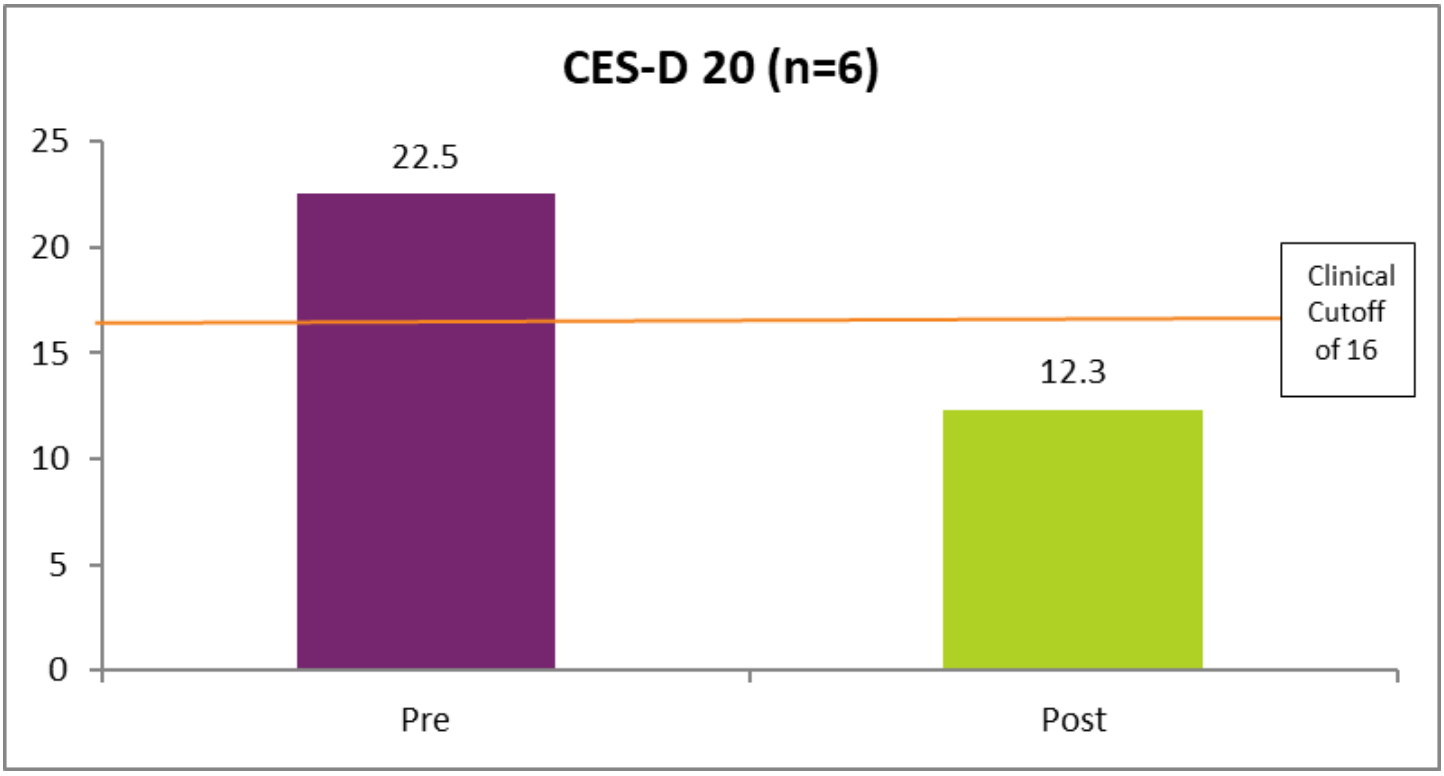
Of the 23 participants enrolled in Healthy IDEAS, 6 (28%) completed the program and 10 closed without completing. Some participants were still open at the end of the fiscal year (n = 7, 30%) and will carry over into the next fiscal year.

Disposition (n=23)		
Completed	Closed	Open
6 (26%)	10 (43%)	7 (30%)

CES-D 20

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by the National Institute of Mental Health. Respondents select from four possible responses in a Likert format, where “0” is “rarely or none of the time (less than 1 day)”, and “4” is “almost or all of the time (5-7 days)”. Scores range from 0 to 60 with higher scores reflecting greater levels of depressive symptoms, while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a significant level of psychological distress. However, It does not necessarily mean that the participant has a clinical diagnosis of depression. In a general population, about 20% would be expected to score in this range.

There was a 45% decrease in depression scores from pre to post.



Quality of Life Survey

The Healthy IDEAS survey is administered at the beginning of and at the conclusion of program. The survey includes general quality of life items, knowledge concerning accessing resources for depression, and questions on participation in social activities. The table below shows the average pre to post ratings on the Healthy IDEAS survey.

1-No,definitely not; 2-No, I don't think so; 3-Not Sure; 4-Yes, I think so; 5-Yes,definitely	Average Rating	
	Pre	Post
1. Would you say you know how to get help for depression? (n=5)	2.6	4.6

1-Poor; 2-Fair; 3-Good; 4-Very Good; 5-Excellent	Average Rating	
	Pre	Post
2. In general, how would you say your health is? (n=5)	4.6	5.0

1-None; 2-A little; 3-Fairly Active; 4-Quite Active; 5-Very Active; 6-Extremelly Active	Average Rating	
	Pre	Post
3. During the past month which statement describes how socially active you have been? (n=5)	4.8	5.0

1-Terrible; 2-Unhappy; 3-Mostly Dissatisfied; 4-Mixed; 5-Mostly Satisfied; 6-Pleased; 7-Delighted	Average Rating	
	Pre	Post
4. How do you feel about your life in general? (n=5)	3.6	5.4
5. How do you feel about the amount of relaxation you have? (n=5)	4.2	5.8
6. How do you feel about the way you spend your spare time? (n=5)	5.8	6.0
7. How do you feel about the way things are in general between you and your family? (n=5)	5.6	6.0
8. How do you feel about the amount of time you spend with other people? (n=5)	2.0	2.8
9. How do you feel about the amount of friendship in your life? (n=5)	3.6	4.6
10. How do you feel about your emotional well-being? (n=5)	2.6	3.8
11. How do you feel about your health in general? (n=5)	4.0	4.6

Participants' satisfaction with the amount of time they spent with other people and how they feel about their health in general increased. The greatest improvement was seen in the participants' knowledge of how to get help for depression, how they felt about their life in general, and the amount of relaxation time they had.

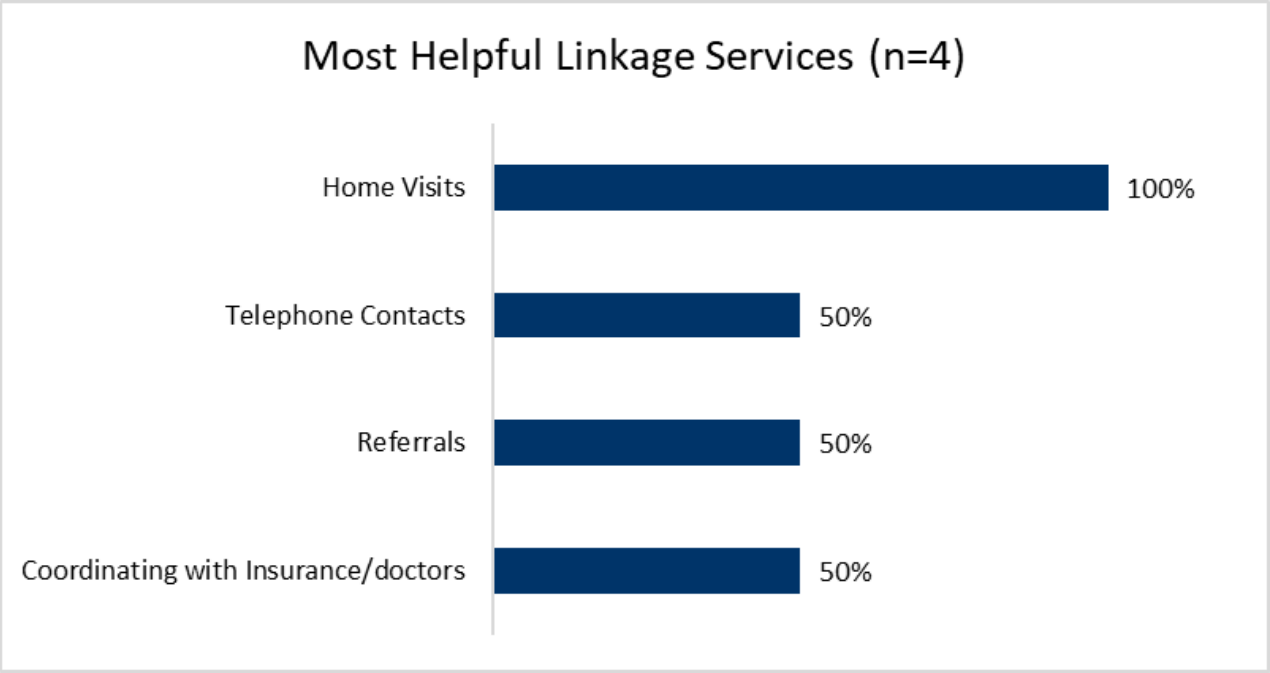
Healthy IDEAS Satisfaction Survey

Satisfaction items were collected for those participants enrolled in Healthy IDEAS and closed from the program. Participants reported that the most helpful aspects of the program were the home visits, phone contacts, and coordinating with insurance or doctors. The majority of those participating in the CareLink/Health IDEAS program reported that the program helped to reduce their depression symptoms and helped them to function better. All of the participants said they would recommend Healthy IDEAS to friends.

n = 6	No, Definitely Not (1)	No, I don't think so (2)	Not Sure (3)	Yes, I Think so (4)	Yes, definitely (5)
Has participating in the care link program helped you	-	-	-	1 (17%)	5 (83%)
Would you say the program activities in which you participated helped to reduce your depression symptoms?	-	-	-	2 (33%)	4 (67%)

CareLink Satisfaction

CareLink participants reported they were satisfied with many aspects of the program. All of the participants reported home visits to be the most helpful part of the program. Other helpful services included: telephone contacts, referrals, and coordinating with insurance companies or doctors.



CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful. Participants were pleased with the quality of service that they received from the program and would recommend the program to a friend.

Please grade the CareLink staff on the following items:	A	B	C	D
Courteous	100%	-	-	-
Efficient	100%	-	-	-
Caring	100%	-	-	-
Knowledgeable	100%	-	-	-
Respectful	100%	-	-	-
Accessible	100%	-	-	-
Helpful	100%	-	-	-

n = 4	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
Recommend CareLink to friend?	-	-	-	100%

n = 4	Poor	Fair	Good	Excellent
Quality of service received	-	-	33%	67%

n = 4	Quite Dissatisfied	Mildly Dissatisfied	Mostly Satisfied	Very Satisfied
Satisfaction with CareLink	25%	-	-	75%

Riverside University HEALTH SYSTEM Behavioral Health

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview and Providers

Program Overview and Providers

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce the duration and harmful effects of trauma for youth (ages 10-15 years) most at risk of developing mental health problems as a result of direct and/or indirect traumatic experiences. CBITS aims to increase resiliency and the development of coping strategies for program participants, reduce symptoms resulting from exposure to traumatic experiences, and reduce the need for ongoing services within the mental health system. Four providers were contracted to provide CBITS services:

- **Operation Safehouse (OSH)** was contracted to deliver the program in Western, Mid-County, and Desert regions of Riverside County. OS worked collaboratively with school districts and individual schools to identify and engage youth that would benefit from CBITS services.
- **Jurupa Unified School District - Behavioral Health (JUSD-BH)** was contracted to deliver the program in the Western region of Riverside County. JUSD-BH delivered the program to schools within the Jurupa Unified School District.
- **Special Services for Groups (SSG)** was contracted to deliver the program in the Western region of Riverside County. SSG delivered the program to schools within the Moreno Valley Unified School District.
- **Riverside County Latino Commission (RCLC)** was contracted to deliver the program in the Desert region of Riverside County. RCLC delivered the program to schools within the Coachella Valley Unified School District.

Prior to receiving services, participants are screened for trauma symptoms. Youth with a trauma symptom severity falling below the criteria threshold become ineligible for CBITS, where they are then referred to other services that better suit their needs. Eligible youth who decide to enroll in the program receive ten group sessions and one to three individual sessions in the school setting. For the purposes of Prevention and Early Intervention (PEI), completion of the program was defined as attending 8 or more sessions. In addition, parents and guardians participate in two educational sessions with the clinician. CBITS uses cognitive-behavioral techniques, including: psycho-education, relaxation, social problem solving, cognitive restructuring, and exposure to help children reduce symptoms related to traumatic experiences and depression.

Evaluation

Evaluation of program outcomes include measuring decreases in the frequency of trauma symptoms experienced by youth and decreases in depression symptomology. The following outcome measures were collected prior to the start and at the conclusion of group sessions (i.e. pre to post).

- Child Post-Traumatic Stress Disorder (PTSD) Symptom Checklist - This is the initial measure administered for determining eligibility into CBITS. It is a two part self-report assessment that identifies exposure to traumatic events and then measures the severity and frequency of the PTSD symptoms arising from those events. Scores are aggregated to yield a PTSD score, as well as scores on the re-experiencing, avoidance, and hyperarousal subscales.
- Children's Depression Inventory (CDI-II) - A self-report assessment that measures the severity of depression symptoms among youth. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems.

Executive Summary: Key Findings

Enrollment and Completion

A total of 313 youth participated in CBITS during the 2023-2024 FY with 84% completing the CBITS program. 50 participants did not complete the program. Of those who did not complete, eleven attended 5-7 sessions.

Demographics

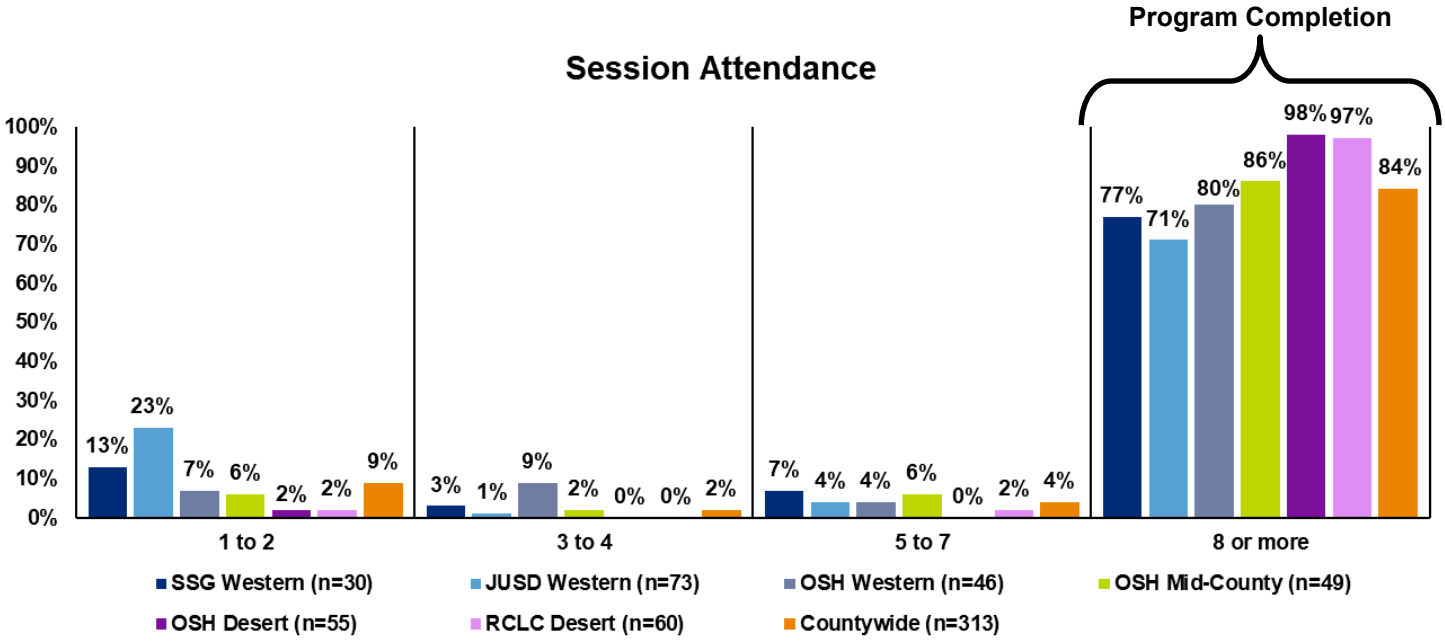
- Over half of participants were female (59%).
- Over two-thirds of the participants were Hispanic/Latinx (77%).
- English was the preferred language for 83% of participants.

Outcomes

- **Traumatic Symptoms Improved -** Intake data showed that 62% of participants had witnessed physical trauma and 79% had someone close to them die. Most youth reported multiple types of trauma. Baseline PTSD symptom scores indicated that all participants were at or beyond the 14-point threshold exhibiting moderate to severe PTSD at the beginning of the program. This percentage decreased to 64% by the end of the program. While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.
- **Depression Improved** - CDI-II average scores showed that depression symptoms improved with total CDI-II scores countywide decreasing. Additionally, CDI-II average scale scores for Emotional Problems and Functional Problems decreased. Countywide, the total score and each CDI-II scale score showed statistically significant decreases in symptoms.
- **Participants were satisfied with CBITS** - 72% of youth agreed or strongly agreed that the program taught them how to better cope with stress. 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future. Below are some participant comments on what they learned in the program:
    - “Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture.”
    - “How to stay calm during a scary situation. Or how to think twice before reacting to something.”
    - “How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident.”
    - “I learned that I’m not always alone in difficult situations and there is always someone that is here for me no matter what.”
    - “I learned that pushing away my problems will just make them harder to get through later.”
    - “I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need.”
    - “That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone.”

Enrollment and Completions

Enrolled was defined as having experienced a traumatic event, having a qualifying PTSD symptoms score of 14 or higher, and having attended at least 1 session. For FY2023-2024, countywide a total of 313 attended at least one group session in the CBITS program. Overall, 263 (84%) completed the program, defined as attending 8 or more sessions with completed outcome measures



Special Services for Groups (SSG) was contractually obligated to complete 48 participants within the Moreno Valley Unified School District. Jurupa Unified School District-Behavioral Health (JUSD-BH) was contractually obligated to complete 48 participants within the Jurupa Unified School District. Operation Safehouse (OSH) was contractually obligated to complete 48 participants in the Western region, 48 participants in the Mid-County region, and 48 participants in the Desert region from multiple school districts. Riverside County Latino Commission (RCLC) was contractually obligated to complete 48 participants within the Coachella Valley Unified School District. The table below details to what extent the providers met contract expectations for program completion based on how many participants completed the program.

Agency	Contract Expectations	Enrolled	Completed Program	% Contract Expectations
SSG Western	48	30	23	48%
JUSD-BH Western	48	73	50	104%
OSH Western	48	46	37	77%
OSH Mid-County	48	49	42	88%
OSH Desert	48	55	54	113%
RCLC Desert	48	60	57	119%
Countywide	288	313	263	91%

Meetings

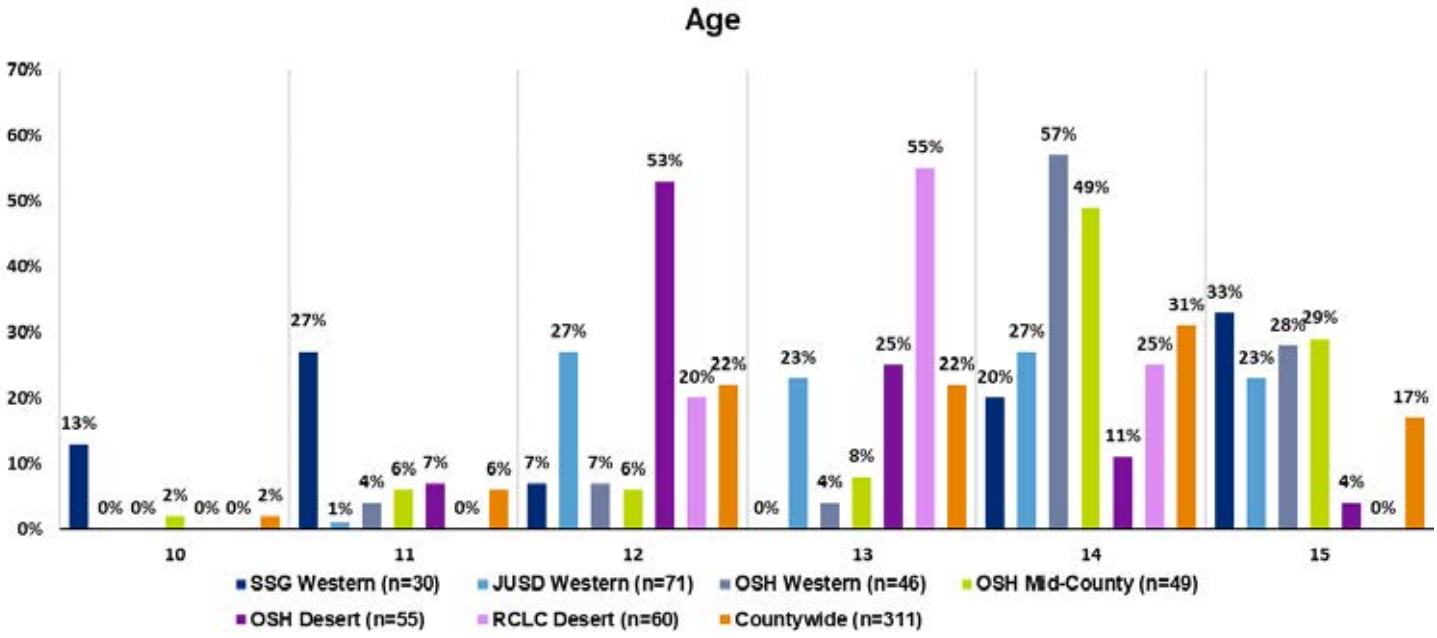
The program is designed to provide participants 1-3 individual sessions with a clinician. Additionally, parents/guardians and teachers are also given the opportunity to meet with the clinician for educational sessions. The parents/guardians are provided up to two meetings with the clinician, while teachers are provided one. The tables below show the documented student, parent/guardian, and teacher meetings with the clinicians.

Meetings	Individual Youth Meetings			
Agency	1 Meeting	2 Meetings	3 Meetings	No Meetings
SSG Western (n=30)	26	5	2	4
JUSD-BH Western (n=73)	55	28	2	18
OSH Western (n=46)	42	0	0	4
OSH Mid-County (n=49)	43	13	0	6
OSH Desert (n=55)	54	0	0	1
RCLC Desert (n=60)	58	7	0	2
Countywide (n=313)	278	53	4	35

Meetings	Parent Meetings			Teacher Meetings	
Agency	1 Meeting	2 Meetings	No Meetings	1 Meeting	No Meetings
SSG Western (n=30)	28	18	2	24	6
JUSD-BH Western (n=73)	57	0	16	68	5
OSH Western (n=46)	0	0	46	0	46
OSH Mid-County (n=49)	46	14	3	42	7
OSH Desert (n=55)	0	0	55	0	55
RCLC Desert (n=60)	60	20	0	60	0
Countywide (n=313)	191	52	122	194	119

Demographics

During the screening process or at the first class session, the participants are asked to complete a demographic questionnaire. This section will highlight the basic demographics of 311 participants since two participants did not share their demographics. The age distribution is shown below where the average age of participants was 13 years old.

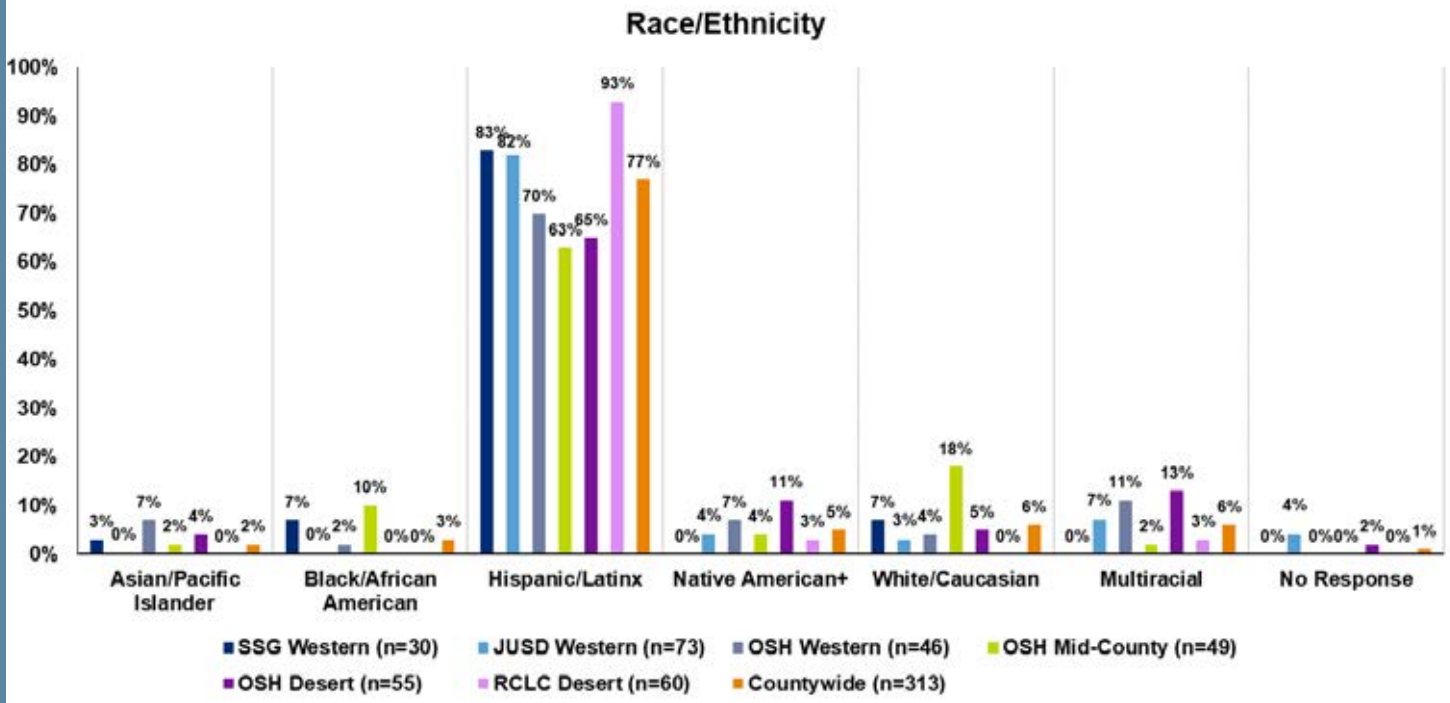


Grade level of participants was collected on the CDI-II measure. This measure is administered to youth when they enrolled in the program and at the end of the program. The participants were from 5th through 10th grade. The table below shows the grade level of the participants.

Grade Level							
Agency	**5th**	**6th**	**7th**	**8th**	**9th**	**10th**	**Not Reported**
SSG Western (n=30)	10	4	0	0	15	1	0
JUSD-BH Western (n=73)	0	0	36	2	33	0	2
OSH Western (n=46)	0	2	5	2	37	0	0
OSH Mid-County (n=49)	1	4	4	3	34	3	0
OSH Desert (n=55)	0	10	32	13	0	0	0
RCLC Desert (n=60)	0	0	21	39	0	0	0
Countywide (n=313)	11	20	98	59	119	4	2

Demographics cont.

Countywide, 77% of the program participants identified as Hispanic/Latinx, 6% White/Caucasian, 6% Multiracial/ethnic, 5% Native American (and one other race), 3% Black/African American, 2% Asian/Pacific Islander, and 1% was not reported.



Most participants reported their preferred language was English (83%), while 13% reported both English and Spanish, and six reported Spanish alone (2%).

Preferred Language				
Agency	**English**	**Spanish**	**English and Spanish**	**No Response**
SSG Western (n=30)	25	0	5	0
JUSD-BH Western (n=73)	54	0	15	4
OSH Western (n=46)	42	1	1	2
OSH Mid-County (n=49)	46	1	1	1
OSH Desert (n=55)	45	1	7	2
RCLC Desert (n=60)	47	3	10	0
Countywide (n=313)	259	6	39	9

Demographics cont.

Countywide, of the 313 participants in the CBITS program, 59% identified as female, 35% identified as male, eight identified as transgender, eleven identified as nonbinary, one as gender fluid, and two were not reported.

Gender						
Agency	**Female**	**Male**	**Trans**	**Nonbinary**	**Gender Fluid**	**No Response**
SSG Western (n=30)	16	9	2	3	0	0
JUSD-BH Western (n=73)	44	22	2	3	0	2
OSH Western (n=46)	29	17	0	0	0	0
OSH Mid-County (n=49)	37	9	2	1	0	0
OSH Desert (n=55)	29	22	1	3	0	0
RCLC Desert (n=60)	28	29	1	1	1	0
Countywide (n=313)	183	108	8	11	1	2

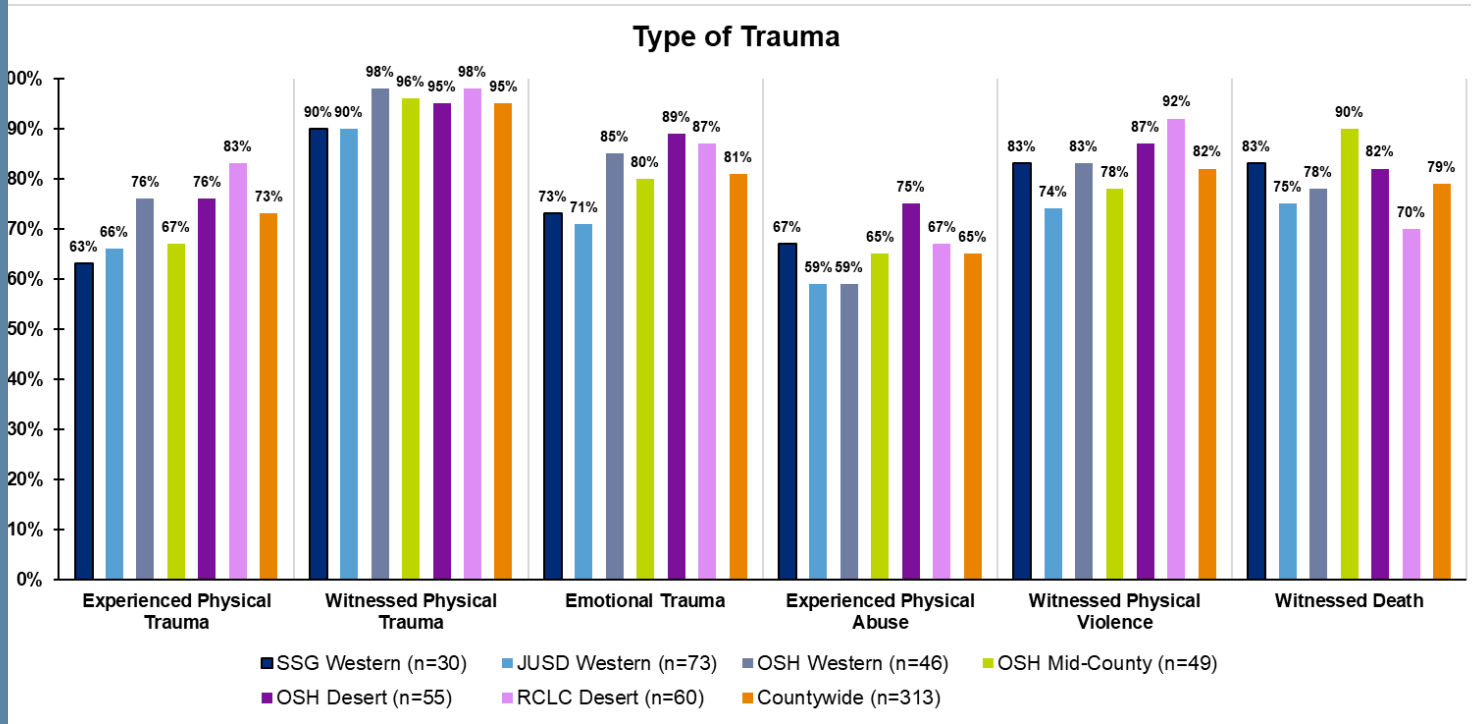
Countywide, 16% of youth indicated they were LGBTQ+ (n=51), while most of the participants (74%, n=231) reported they did not identify as LGBTQ+.

LGBTQ+								
Agency	**Lesbian**	**Gay**	**Bisexual**	**Pansexual**	**Yes**	**Asexual**	**Unsure**	**No Response**
SSG Western (n=30)	1	0	5	1	1	0	6	1
JUSD-BH Western (n=73)	0	1	4	2	4	0	3	7
OSH Western (n=46)	0	0	3	1	1	0	5	1
OSH Mid-County (n=49)	1	1	6	3	0	1	2	1
OSH Desert (n=55)	2	0	3	0	3	0	2	0
RCLC Desert (n=60)	0	0	4	0	3	0	2	1
Countywide (n=313)	4	2	25	7	12	1	20	11

Outcomes: Child Post Traumatic Stress Disorder (PTSD)

The Child Post Traumatic Stress Disorder (PTSD) Screener is used to assess exposure to traumatic experiences, as well as measure the severity of PTSD symptoms in participants exposed to trauma. The measure was used at the beginning and conclusion of the program to evaluate reductions in PTSD symptoms. The traumatic experience screener has 17 questions with a Yes/No format. If a youth answers 'Yes' to any one of these questions, this indicates exposure to a traumatic event and the youth then completes the second section. The second section measures the frequency and severity of PTSD symptoms the youth is experiencing and includes 17 questions. Higher scores indicate increased frequency and greater severity of post traumatic symptoms. The graph below displays the frequencies of trauma exposures, and the following page shows the severity of PTSD symptoms.

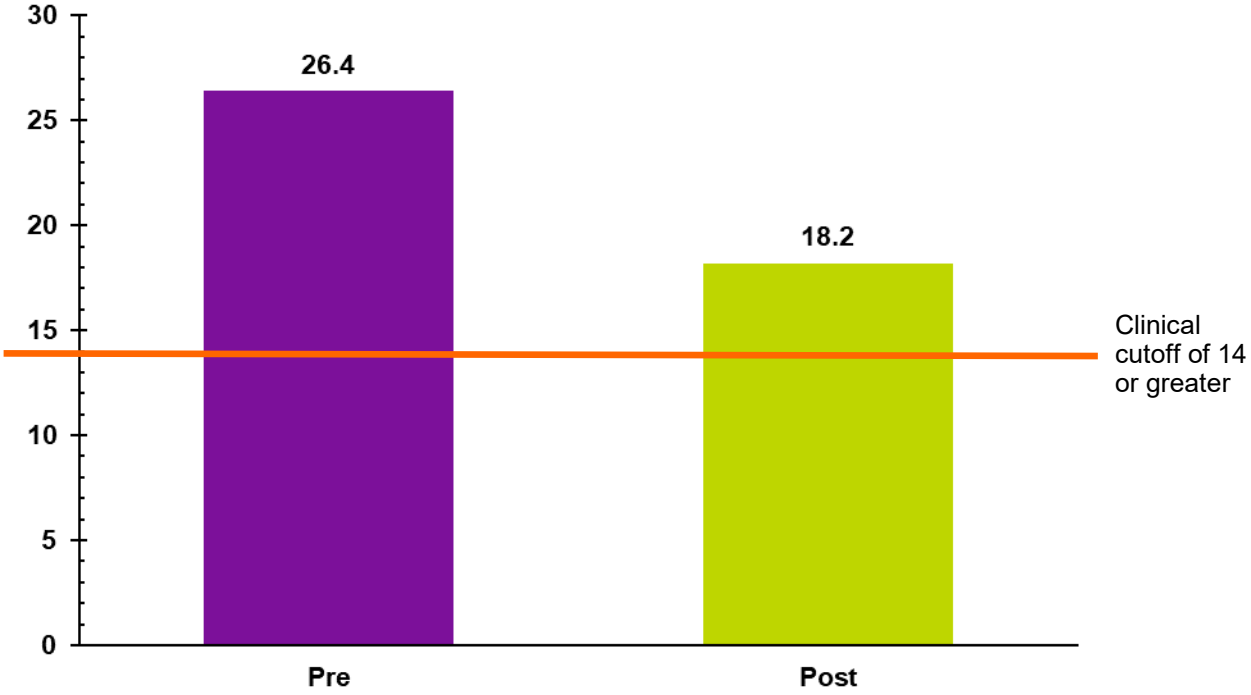
Out of the total 313 participants countywide, almost all of the participants witnessed physical trauma (95%, n=296), followed by witnessed physical abuse (82%, n=258), emotional trauma (81%, n=253), witnessed death (79%, n=247), experienced physical trauma (73%, n=227), and experienced physical abuse (65%, n=203).



Outcomes: Child Post Traumatic Stress Disorder (PTSD) cont.

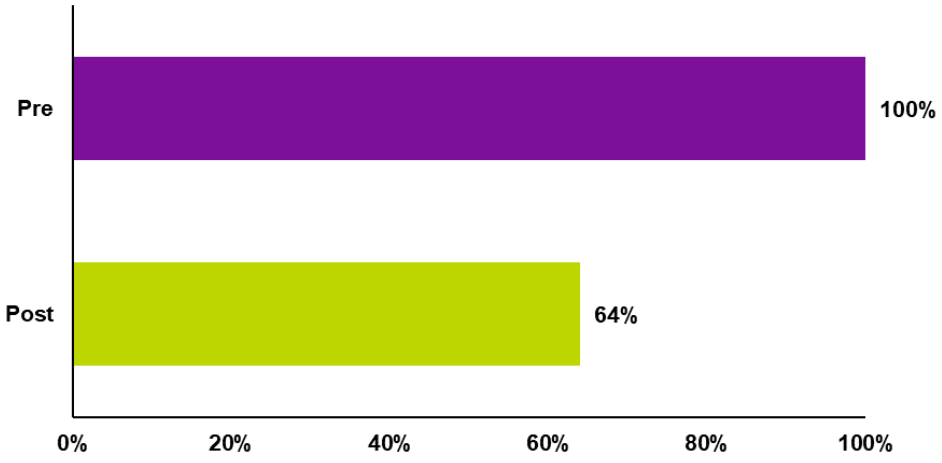
Analysis of the countywide PTSD symptom measure scores was performed on youth having both a pre and post measures, and at least 8 CBITS sessions. Scoring a 14 or higher on the Child PTSD Symptom Checklist indicates moderate to severe PTSD symptoms in the clinical range, represented by the red line in the figure below. Youth at the beginning of the CBITS program had, on average, high PTSD symptom scores above 14 points. After completing the program, youth average PTSD symptom scores showed a statistically significant decrease.

PTSD Symptoms Countywide (n=263)



Upon entering the program, 100% of youth countywide were at or above the 14 point clinical cutoff indicating moderate to severe PTSD. This percentage decreased to 64% by the end of the program (see below). While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.

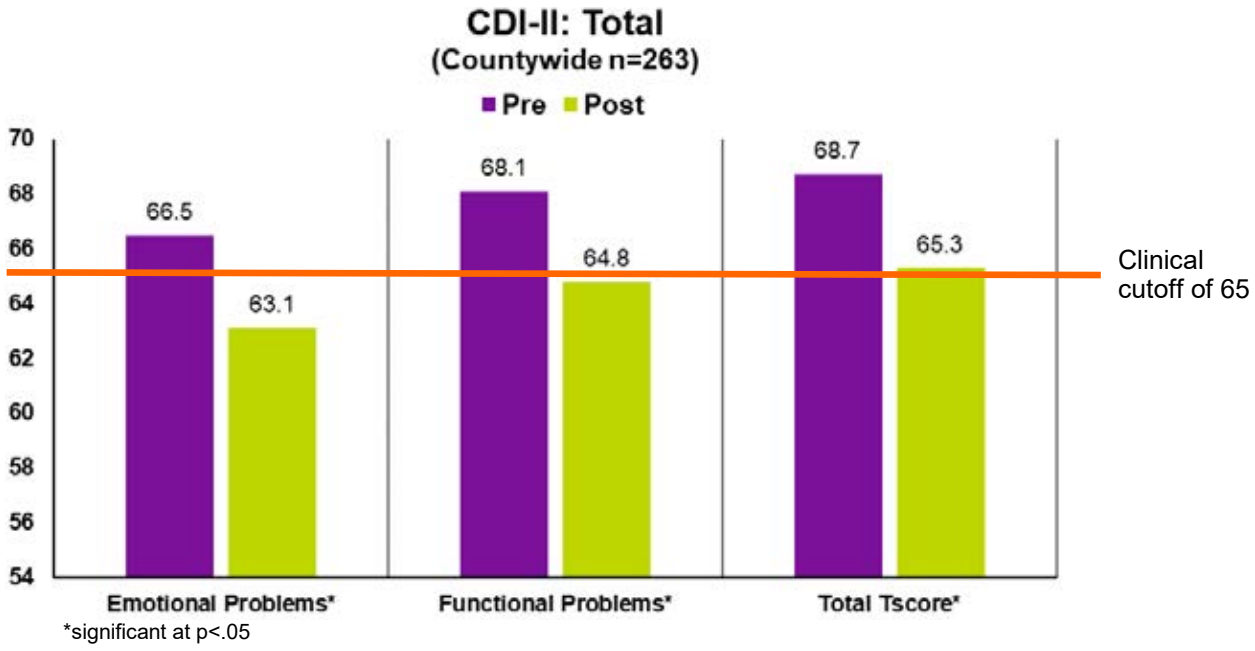
Participants with PTSD Countywide (n=263)



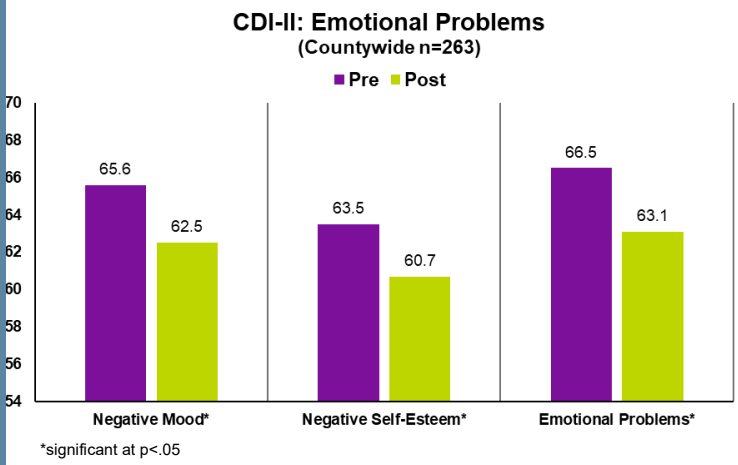
Outcomes: Children's Depression Inventory (CDI-II)

The Children's Depression Inventory 2nd edition (CDI-II) is used to measure the severity of depression symptoms in children. It is a self-reported assessment that program participants complete, both at the beginning and at the conclusion of the program. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems. Each question or 'item' has three different sentence descriptions. The participant marks which of the 3 sentences best describes them. Higher scores suggest higher depression symptomology. The raw scores for each child's CDI-II is plotted on a scoring grid and converted to a T-score. The T-score reflects how a child's score compares to other children of similar age and gender. T-scores greater than 65 are clinically significant (represented by the line on the graph below), meaning the youth meets criteria for clinical intervention.

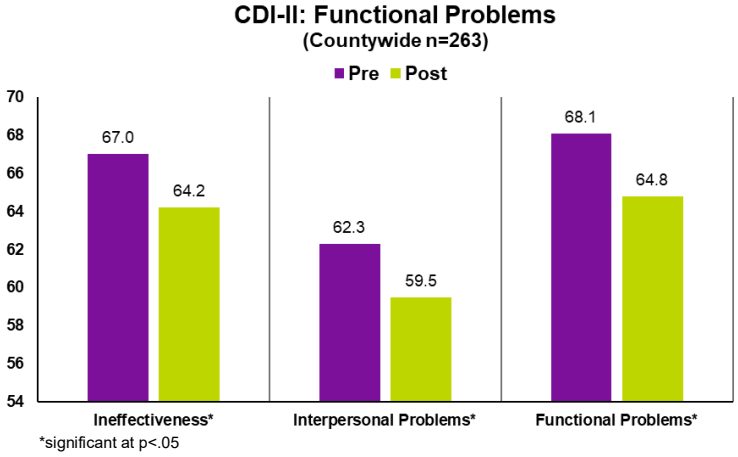
Analysis was based on participants who completed both a pre and post CDI-II measure and attended at least 8 CBITS sessions. On average, CBITS participants' total scores were above the clinical cutoff of 65 at intake (68.7) and decreased at post (65.3). Scores decreased across all scales and subscales, where paired-samples t-tests revealed statistically significant changes in average scores from pre- to post-test. Additionally, the total score demonstrated a statistically significant decrease.



*significant at p<.05



*significant at p<.05



*significant at p<.05

Outcomes: Children's Depression Inventory (CDI-II) cont.

CDI-II Total scores, Emotional Problems and Functional Problems scales, and their respective subscales scores varied by region and provider. Below are tables showing the scores from pre- to post-tests for each region by provider.

CDI-II Scores by Provider in the Western Region of Riverside County									
	SSG Western			JUSD-BH Western			OSH Western		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	23	70.4	65.6	50	68.9	65.8*	37	66.6	64.0
Emotional Problems	23	67.1	64.2	50	64.1	60.6*	37	65.9	62.7
Negative Mood	23	66.7	63.7	50	66.7	62.1*	37	65.5	62.3
Negative Self-Esteem	23	63.1	62.0	50	64.0	60.8	37	61.7	60.0
Functional Problems	23	70.0	63.7	50	67.3	65.7	37	66.5	63.1
Ineffectiveness	23	67.6	62.3	50	66.6	65.1	37	64.4	61.5*
Interpersonal Problems	23	68.0	61.4	50	61.3	60.0	37	62.3	60.0

*Significant at p<.05

CDI-II Scores by Provider in the Mid-County and Desert Regions of Riverside County									
	OSH Mid-County			OSH Desert			RCLC Desert		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	42	67.8	63.4*	54	71.3	70.2	57	67.5	62.5*
Emotional Problems	42	64.9	61.3	54	69.4	67.9	57	64.5	59.6*
Negative Mood	42	63.7	60.4	54	68.4	67.4	57	63.2	59.5*
Negative Self-Esteem	42	62.5	59.9	54	66.1	65.1	57	62.9	56.9*
Functional Problems	42	67.9	63.0*	54	69.8	68.7	57	67.5	63.2*
Ineffectiveness	42	66.3	62.8	54	68.7	67.6	57	67.4	63.7*
Interpersonal Problems	42	62.9	58.2*	54	63.4	62.9	57	59.5	55.8*

*Significant at p<.05

Satisfaction Surveys

Countywide, 260 participants completed the satisfaction survey. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

Coping with Stress

- 72% of youth agreed or strongly agreed that the program taught them how to cope with stress.
- 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future.

Personal

- 64% of youth agreed/strongly agreed that the program helped them to understand themselves better.
- 55% of youth agreed/strongly agreed that they achieved their goals for the group.
- 69% of youth agreed/strongly agreed that they will use what they learned in the program in their life.

Group Leaders

- 90% of youth agreed or strongly agreed that the leaders listened to what they had to say.
- 82% of youth agreed or strongly agreed that the leaders knew how to help them.

Question	Avg.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Response
The program taught me how to cope with stress. (n=258)	3.94	4 (1.5%)	4 (1.5%)	64 (24.6%)	**118 (45.4%)**	68 (26.2%)	2 (0.8%)
The program helped me to understand myself better. (n=257)	3.82	7 (2.7%)	14 (5.4%)	69 (26.5%)	**95 (36.5%)**	72 (27.7%)	3 (1.2%)
The program has prepared me to cope with stress if something difficult happens to me in the future. (n=259)	4.07	2 (0.8%)	10 (3.8%)	46 (17.7%)	**110 (42.3%)**	91 (35.0%)	1 (0.4%)
I achieved my goals for the group. (n=254)	3.73	4 (1.5%)	15 (5.8%)	**91 (35.0%)**	80 (30.8%)	64 (24.6%)	6 (2.3%)
The group leaders listened to what I had to say. (n=257)	4.58	1 (0.4%)	4 (1.5%)	17 (6.5%)	59 (22.7%)	**176 (67.7%)**	3 (1.2%)
The group leaders knew how to help me. (n=258)	4.32	2 (0.8%)	8 (3.1%)	34 (13.1%)	76 (29.2%)	**138 (53.1%)**	2 (0.8%)
I will use what I learned in the program in my life. (n=257)	4.00	3 (1.2%)	12 (4.6%)	62 (23.8%)	85 (32.7%)	**95 (36.5%)**	3 (1.2%)
I would recommend the program to a classmate. (n=255)	4.26	4 (1.5%)	11 (4.2%)	35 (13.5%)	70 (26.9%)	**135 (51.9%)**	5 (1.9%)

Note: Some participants completed an older version of the survey which had only the first six questions on the satisfaction survey (n=3).

Satisfaction Survey: Comments

Participants were also asked what they learned from the program, what they liked about the program, as well as what they disliked about the program. Below are some comments from the participants.

What Participants Learned…

- "#1: How to deal with Stress #2: How to talk with People #3: Calming down an angered Person."
- "A small game for to relax/distraction or whenever not in a good mindset (name colors, characters, shows, etc) they were simple and not to hard to remember."
- "Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture."
- "Finding someone to talk to if I need someone to hear me out, dealing with stress, and not overthinking."
- "Hot Seat - helpful other thoughts; Feelings Thermometer; Breathing Exercises; Thoughts, Actions, and Emotions Triangle."
- "How to calm myself down and how to deal with tough situations I may have in the future."
- "How to calm myself down when needed and become more social. I also learned how to understand myself better."
- "How to comfort others, make solutions to my problems, and how to be respectful when someone is sharing trauma."
- "How to communicate how you feel and not bottle it up."
- "How to control myself in hard situations."
- "How to cope with stress and express myself to people."
- "How to cope with stress, how to use different strategies to calm down and just how to have a better mindset in general."
- "How to cope, and think before I do anything dumb."
- "How to focus during a stressful time like breathing."
- "How to stay calm during a scary situation. Or how to think twice before reacting to something."
- "How to take bad thoughts and make them into helpful thoughts."
- "How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
- "How to understand myself, how to cope with stress. (I learned how to understand myself, how to handle my stress, and how to react in a difficult situation.)"
- "I didn't really learn anything I just talked about stuff that happened in the past."
- "I learned how to handle stress and how to solve it in the future."
- "I learned how to tell people how I feel."
- "I learned how to think more logically about my bad thoughts. Finally talking about what's been going on has made me feel better. I've met people that made me feel safe when I speak about my problems."
- "I learned that even though people look happy they have a hard past."
- "I learned that I could control how I feel."
- "I learned that if you are having a stress full time to talk to people and using strategies to help you"
- "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."
- "I learned that pushing away my problems will just make them harder to get through later."
- "I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need."
- "I learned way of coping which was really good. I learned what to do when I don't feel good and very thankful for it."
- "I'm not alone in my experiences. That there's people like me going through similar things."
- "Nothing really helped me."
- "That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone."
- "The steps of thinking something out before resorting to a negative thought/finding the positive in things."
- "To always deal with problems and not to avoid them"
- "To focus on yourself and that you yourself matter and ways to not think bad all the time and ways to calm yourself down if you ever feel scared or stressed."

Satisfaction Survey: Comments

What Participants Learned…cont.

- "To not kill myself"
- "To talk out my problems with a person that is trust worthy."
- "To think positive, facing my fears, and trying to solve the problems without fighting."
- "Ways to calm myself, Think and Question my thoughts."
- "We all have the same problems and we learned how it comes out in us."
- "We aren't the same all around."
- "We have to deal with trauma now."
- "What to do when I feel bad or stressed."
- "When there is a fight Leave from it"
- "You cant be afraid about everything and you can over come it."

What Participants Liked…

- "100% of it"
- "A break from some classes that stress me."
- "Being able to see how I can control myself and my emotions."
- "Being with a friend and food."
- "Every body was nice and so hope-full and helpful. Every one was patient with me."
- "Every one shared stories, We laughed and shared"
- "Everybody was very welcoming and they were very positive and wanted to hear what we had to say."
- "Everyone listened to what I had to say, everyone was so kind and funny, and helped me understand others go through things too."
- "Everything, This group was awesome."
- "Having the chance to meet everyone here and learning about them."
- "Hot seat-change way of thinking, Food, Other Students
- "How I could be comfortable with telling people about my problems, how you can feel safe talking about stuff."
- "How it was fun and relatable."
- "How it was very easy to become friends with the others and that the leaders always had time for us to speak."
- "How kind and understanding the leaders are. I really liked the group because my leaders made it fun and not scary."
- "How the group leaders listen people in the group give good compliments /or responses to your incident."
- "How to calm down and breath in and out"
- "How understanding they are being patient and be considerate towards the situations and advice (helpful majorly)"
- "I could share what Ive been through and no one can Judge because we've all been through the same situations."
- "I felt connected with everyone in a way"
- "I felt like I matter"
- "I got to be heard and understood by people who went through similar situation."
- "I got to have a laugh with everyone, and had a great time. Learned things to help me."
- "I learned how to deal with my stress."
- "I like how everyone was under standing and open minded."
- "I like that we learned how to deal with stressful situations."
- "I like the teachers and how I made friends"
- "I liked about the program is the copius amount of candy and hearing about how other people felt."
- "I liked how I feel like I can talk about anything and they listen and give great advice about what I can work on to become better."
- "I liked how I was able to help my stress go away."

Satisfaction Survey: Comments cont.

What Participants Liked…cont.

- "I liked how nice the teachers were and how I learned many things."
- "I liked it I was kinda glad in a way that I'm not the only one that goes threw bad stuff and it was helpful"
- "I liked that I didn't feel like I was judged and that I could actually talk without worrying as much."
- "I liked that it was a nice break from school."
- "I liked that it was like a period where we were able to talk about our problems."
- "I liked that nobody judges you."
- "I liked that the group leaders were understanding they let every voice be heard. They were super nice and caring."
- "I understood that other students were kind of in the same situation as I was."
- "It was a big stress reliever."
- "If your upset they won't talk to you they will give you a sticky note asking if your okay and if you wanna talk."
- "It is good to talk out what you dont want anyone to know"
- "It teaches you how to cope with your trauma as well as see other peoples view of things that happen."
- "It was fun I got to eat donuts and enjoy Thursdays now."
- "Just talking about stuff that we don't normally talk about in school or class."
- "Showing us many skill we can use for the future."
- "That everybody listened, nobody judged me, or spread my info around school."
- "That the ladies are super nice and chill, the music is very relaxing, they let us use figet toys during a session. I feel safe."
- "That they helped me through tough places"
- "That when you were down they will bring you up."
- "That you don't feel alone and feel like there is someone there for you when you really need it."
- "The group leaders being Amazing & Awesome. I will always remember how great & Amazing they are. The solutions are helpful! makes me feel less alone."
- "The group leaders cared about us and listened to our feelings. I was able to learn multiple new ways to cope."
- "The snacks in all honestly but I liked getting to hear other experiences close to mine."
- "What I like about the Program is that they are nice, caring, very calm, and of course the snacks. I also love the stuff we do. Sometimes it helps just being in there and away from a class."
- "What I like about the program is that they give you confidence in yourself."
- "What I like was how we learned coping strategies but in a fun way."

What Participants Disliked…

- "At first I didn't like that I had to share about my life but I'm glad I did. Thank you."
- "Facing my problems."
- "Feeling like there just here for the money"
- "Forgot drinks twice"
- "Having to makeup the work that I missed because of the group."
- "Having to share thing that you don't want to."
- "Homework"
- "How long and what period it takes place in."
- "How quiet it is in each session."
- "I did not like how it was an 1hrs long."
- "I didn't get along/talk to anyone really."
- "I didn't like that I only really knew 1 person to hangout."
- "I didn't like that it was the same period, I don't like missing work."

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- “I didn't really get to speak with the other students.”
- “I didn't really have icks about it so I don't know.”
- “I didn't really like that people would hear about my situation, other than that I actually really liked it.”
- “I don’t have anything to say I liked everything from the program and it helped me.”
- “I don't like leaving class when I have to do something important.”
- “I don't like sharing about what happen.”
- “I felt different like my own opinion was not good.”
- “I got a little bored but the program is great.”
- “I honestly liked everything about the program.”
- “I honestly loved the program.”
- “I liked alot of things about this program I can't think of something that I didn't like about this program.”
- “I love this program their nothing to hate about it”
- “I loved everything there wasnt a single thing I didnt like.”
- “I Loved The Program.”
- “I was still scared I would get judged.”
- “It felt too long”
- “It requires me to come to school.”
- “It takes me out of class.”
- “It was a little silent through out the class.”
- “It was boring at points”
- “It was kind of short.”
- “It was my fault but being marked absent because I would forget to show my teachers my passes.”
- “Missing the same class period every week.”
- “Most of the people didn't take the program seriously. Felt like I was judged a bit.”
- “Not enough time”
- “Nothing I loved this group.”
- “Nothing I'm a miss this program for real”
- “Nothing its fun! & great for one of my friends.”
- “Nothing really. I just depends if it works for you or not.”
- “Nothing was bad about the program I would recommend.”
- “Nothing you guys were awesome.”
- “Probs the socializing but I got used to it.”
- “Sharing personal information.”
- “Some of the coping skills didn't really work for me.”
- “Sometimes it was in a class period I liked.”
- “Talking about most things that remind me of stress.”
- “Talking in front people.”
- “That I don't really feel comfortable and I don't really feel sure about telling them personal things.”
- “That it is not longer.”
- “That they reminded me about stressful things.”
- “The people don’t talk that much.”
- “The teacher would side eye me a lot.”

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- “There is nothing wrong about this program it is a group to help you get throw the things are scared of or what happened to you.”
- “There isn't a thing I can say I hated because I honestly did enjoy the group.”
- “There was nothing I didn't like I think it would also help other people out.”
- “There's nothing I didnt like about the program except the asking question the personal question to much.”
- “There was a big gap that we didn't go.”
- “To be honest, I didn't dislike anything, everyone is so kind.”
- “To much writing.”
- “We didn't get to meet very often.”
- “What I didn't like about the program is the insermountable ways of trying to cope with stress that didn't work for me.”
- “What I didn't like about the program was that it's only for a short time.”
- “What I don’t really like is how we had to share. Yes I do understand why but I was very nervous.”
- “When People would laugh about something that wasn't funny.”
- “When we had to talk about our trauma but it wasn’t that bad.”
- “You had to talk about past events.”
- “We only get 30 minutes to stay.”

Riverside University HEALTH SYSTEM Behavioral Health

Seeking Safety and Seeking Strength

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview

Program Overview:

Seeking Safety focuses on improving the lives of people who have experienced a traumatic event. One of the goals of RUHS-Behavioral Health Prevention and Early Intervention plan is to reduce the detrimental effects of trauma for individuals at risk of developing mental health problems as a result of experiencing a traumatic event. Trauma is defined by the DSM-5 as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event (s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013, p. 271).

This harm includes events such combat, childhood physical or sexual abuse, serious car accident, life-threatening illness, natural disaster, or terrorist attack. Approximately 20-30% of people who experience such trauma go on to develop Post Traumatic Stress Disorder (PTSD; Adshead, 2000). In the United States, among men who develop PTSD, 52% develop alcohol use disorder and 35% develop a drug use disorder; among women these rates are 28% and 27% (Kessler et al., 1995). According to The National Child Traumatic Stress Network's Making the Connection: Trauma and Substance Abuse report (2008), studies indicate that up to 55% of young people with PTSD also subsequently develop substance abuse problems. Unfortunately, people with a dual diagnosis of PTSD and SUD, compared to those with either disorder alone, have more legal and medical problems, greater risk of suicidality, and increased rates of future trauma (Najavits, 2007).

Seeking Safety is an evidenced-based practice, identified by the PEI Steering Committee, that aims to help participants avoid or interrupt that cycle. Seeking Safety is an integrated therapy treating both PTSD and substance use disorders. This program is based on the cognitive-behavioral model of relapse prevention. It teaches present-focused coping skills designed to simultaneously help people with a history of trauma and substance abuse. It has been conducted in group or individual format; for people with both substance abuse and dependence issues; for people with PTSD; and for those with a trauma history that do not meet criteria for PTSD. The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e., peers) can conduct the sessions.

Seeking Safety focuses on coping skills and psycho-education with the following key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on PTSD and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; and (4) four content areas: cognitive, behavioral; interpersonal, and case management. The intervention consists of 25 treatment topics that cover cognitive, behavioral, and interpersonal domains. Session topics include: Introduction to Treatment/Case Management, Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You, Asking for Help, Taking Good Care of Yourself, Compassion, Red and Green Flags, Honesty, Recovery Thinking, Integrating the Split Self, Commitment, Creating Meaning, Community Resources, Setting Boundaries in Relationships, Discovery, Getting Others to Support Your Recovery, Coping with Triggers, Respecting Your Time, Healthy Relationships, Self-Nurturing, Healing from Anger, The Life Choices Game, and Termination. Successful program completion does not require completing all topics—program completion for PEI is defined as 6 or more topic sessions.

Program Providers

Providers:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse was contracted to serve TAY youth (ages 16-25) in the Seeking Safety program.

RUHS-Behavioral Health PEI Peers is a division of Prevention and Early Intervention (PEI) that aims to reach out to the community with mental health needs, by facilitating access to services and supports. RUHS-BH PEI Peers Support Specialists serve Adults (ages 26+) in the Seeking Strength program.

Evaluation Overview

Screening Method

Potential participants in the Seeking Safety program are asked about whether they have recently experienced a traumatic event. Additionally, they are asked if they have been diagnosed with PTSD and if they are actively in therapy. For those individuals who have recently experienced a traumatic event and have not been diagnosed, they are asked to complete a PTSD checklist (PCL-5).

PTSD Checklist (PCL-5): a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal. The Seeking Safety program used this screening to qualify participants into the program, utilizing a scoring criteria. The PCL-5 is scored by summing the scores for each of the 20 items to get a total symptom severity score (range—0-80). A PCL-5 score of 20 and above is the criterion for admission into the program.

Process Evaluation

The process evaluation collected descriptive information related to the program, which describes what the program provided, how many people were served, and basic demographic characteristics. Process evaluation data is assessed using group sign-in sheets, individual attendance logs, and demographic forms.

Outcomes

The outcome evaluation included measures of PTSD symptoms and coping mechanisms. Satisfaction surveys included items on overall helpfulness of the program and satisfaction with specific components of the program. Outcome evaluation measures are summarized below.

- **PTSD Checklist (PCL-5):** a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal.
- **Coping Skills Inventory (CSI):** a 38-item self report measure of coping mechanisms developed to assess a range of positive and negative coping responses to life stressors. The CSI was adapted from the Revised COPE Scale (Zuckerman & Gagne, 2003) and Coping Strategy Inventory (Reid, 2007).
- **Satisfaction Survey:** a 17-item questionnaire was given to participants to complete once they had attended six or more sessions. Responses to this Conclusion of Services questionnaire were rated on a Likert scale. Items included “Overall, how helpful was Seeking Safety to you?” and “Staff treated me with respect.” Additionally, feedback was elicited by asking participants what they liked and disliked about the program.

Executive Summary: Key Findings

Screening

Enrollment in the Seeking Safety program requires a screening process to determine program eligibility. A total of 249 individuals were screened for the Seeking Safety program by asking questions related to their experiences with traumatic events and using the PTSD Checklist (PCL-5). Participants with a score of 20 or above on the PCL-5 were eligible for the program. Of all the individuals screened, 97.2% (n=242) scored at or above a 20 on the PCL-5.

Process Evaluation

Enrolled and served individuals were derived from the receipt of demographic information, questions related to their experiences with traumatic events, PCL-5 scores, and attendance data. A total of 154 participants attended at least one Seeking Safety session. Of those 154 participants, 79.2% (n=122) met the completion criteria of attending six or more sessions which include the five core program sessions of Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), Asking for Help and either When Substances Control You, Setting Boundaries in a Relationship, or Healthy Relationships.

Demographic information is reported for those who attended at least one session (n=154). Countywide:

- Most participants were transition age youths between the ages of 16-25 years old (n= 124, 80.5%).
- A majority of participants identified as Hispanic/Latino (n= 114, 74%).
- The majority of participants identified as female (n= 101, 65.6%).
- A quarter of the participants identified as LGBTQ+ (n= 47, 30.5%).

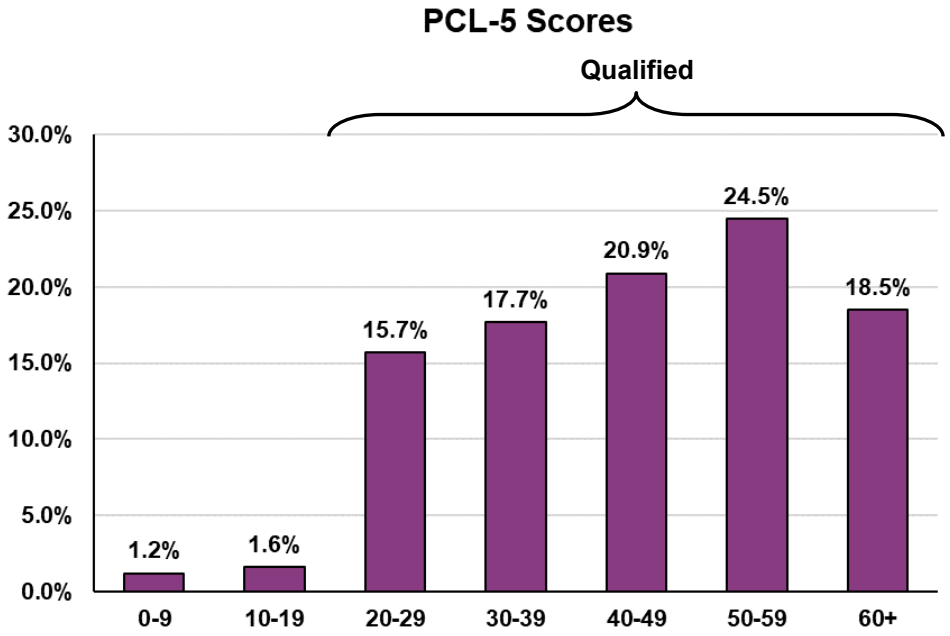
Outcomes

- **PTSD Symptoms Decreased:** Comparison of pre to post scores showed a decrease in PTSD symptoms following participation in the program. Participants' scores showed a statistically significant decrease in the total average score.
- **Coping Skills Improved:** Comparison of pre to post scores showed an improvement in positive coping response subscales (expressing emotion, understanding emotion, maintaining optimism, and goal replacement) and a decrease in negative coping responses (self blame, other blame, self-punishment, self harm, and aggressive behavior) to life stressors.
- **Participants were satisfied with the program:** Overall responses to the satisfaction survey, given upon completion of the program, were positive. Participants found the program to be helpful and would recommend the Seeking Safety program to others.

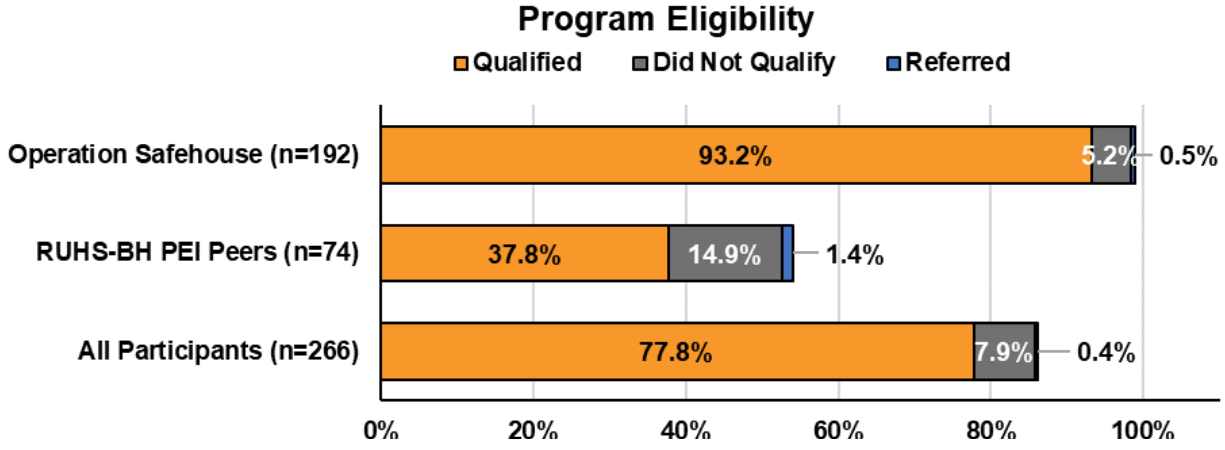
Screening

Countywide, 249 Transition Age Youths and Adults were screened for enrollment into the Seeking Safety program. To determine eligibility, participants were asked two questions: (1) if they have ever experienced a traumatic event and (2) if they have been diagnosed/received treatment for PTSD. Though there were some exceptions, participants were given a PTSD Checklist (PCL-5) screening tool if they answered yes to the first question and no to the second question about their trauma experience.

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80). A score of 20 or more on the PCL-5 determined if that participant was eligible to enroll in the Seeking Safety program. A total of 249 people (93.6% of those who were screened) completed the PCL-5. Of the 249 people, 97.2% (n=242) scored a 20 or above. **The average score on the PCL-5 was 45**.

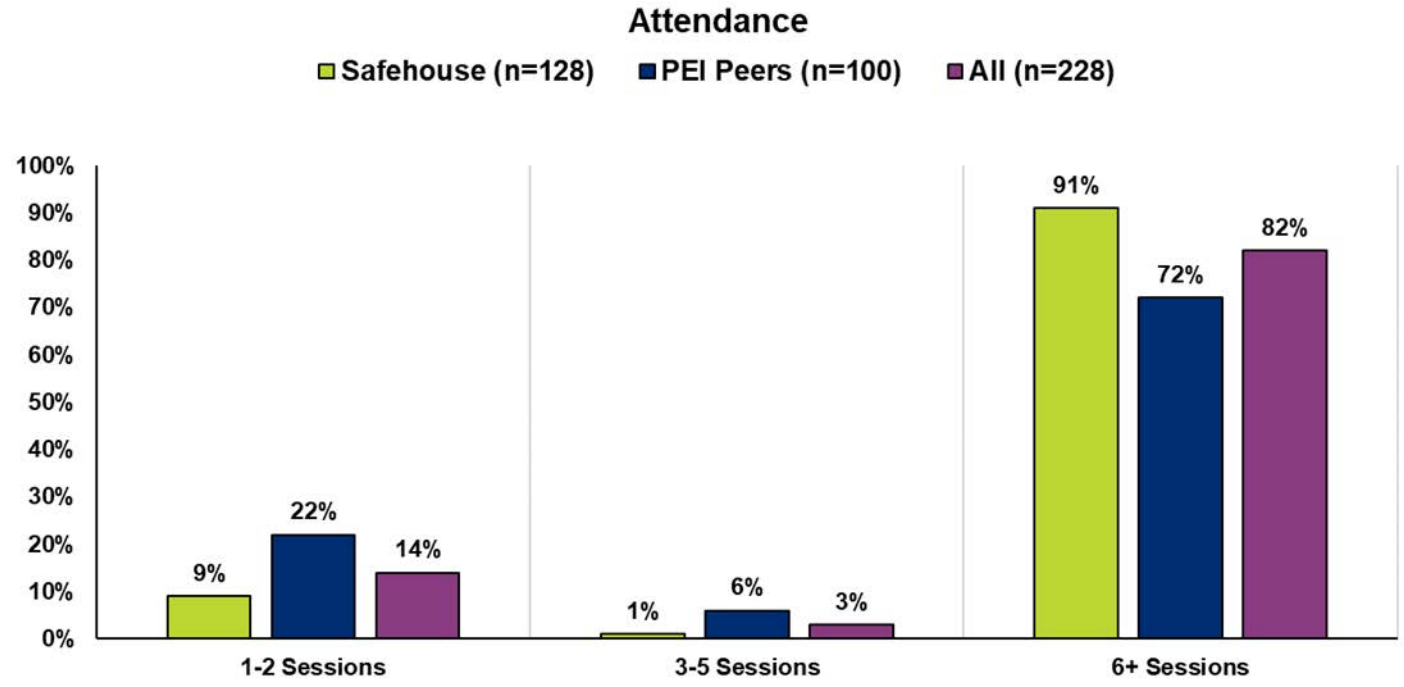


Countywide, 77.8% (n= 207) of those screened were eligible, 7.9% (n=21) were not eligible, and 0.8% (n=2) were referred to another program by request or because it was better suited to their needs.



Enrollment and Completions

Enrolled was defined as having collected demographic information, having a qualifying PCL-5 score of 20 or higher, and having attended at least 1 session. For FY2023-2024, a total of 154 participants were enrolled into the Seeking Safety program where 126 were served by Operation Safehouse and 28 were served by RUHS-BH PEI Peers. Of the 126 participants served by Operation Safehouse, 105 (83.3%) completed the program. Of the 28 participants served by RUHS-BH PEI Peers, 17 (60.7%) completed the program. Overall, of the 154 participants that were enrolled countywide, 122 (79.2%) completed the program, where completion was defined as attending 6 or more sessions (including 5 core program sessions). The figure below shows the frequency of attendance of Seeking Safety sessions.



Contract Expectations and Completions

Operation Safehouse was expected to have 180 Transition Age Youth (TAY) that are 16-25 years old complete the program and RUHS-BH PEI Peers was expected to have 180 Adults that are 26-59 years old complete the program throughout Riverside County. Overall, neither provider met the contract expectations. The table below shows the number of TAY and Adults for each provider that had completed the program compared to the number they were contracted to complete.

		Western	Mid-County	Desert	Countywide
Expected	Transition Age Youth 16-25	60	60	60	180
Completed	**Operation Safehouse**	**34 (56.7%)**	**56 (93.3%)**	**36 (60.0%)**	**126 (70.0%)**
Expected	Adults 26+	60	60	60	180
Completed	**PEI Peers**	**17 (28.3%)**	**6 (10.0%)**	**5 (8.3%)**	**28 (15.6%)**
Expected	Total	120	120	120	360
Completed	**Total**	**51 (42.5%)**	**62 (51.6%)**	**41 (34.2%)**	**154 (42.8%)**

Attendance

The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e. peers) can conduct the sessions. The program provider decides which topic to cover at each group or individual session. Successful program completion does not require completing all of the topics. However, the program model does recommend that each participant attend the Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You or Setting Boundaries in a Relationship, and Asking for Help. In order for participants and program providers to keep track of session topic attendance, there are group sign-in sheets and each participant has an individual attendance log. The table below details the frequency of attendance by topic.

Attendance by Topic

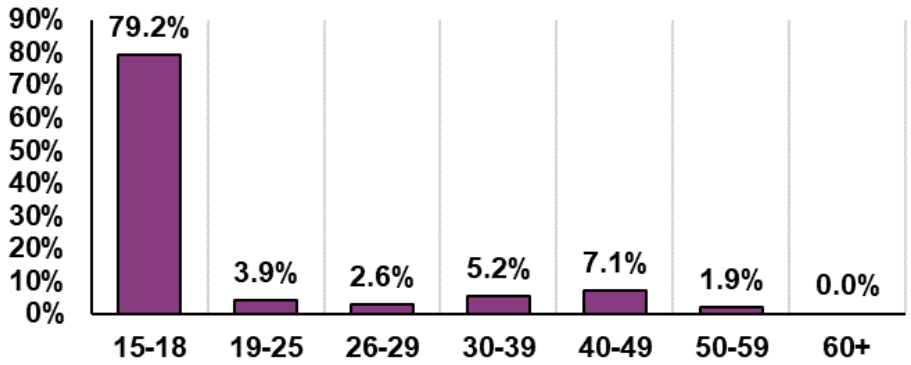
Topic	Op Safehouse (n=126)	PEI Peers (n=28)	All Ages (n=154)
***Safety**	**123 (97.6%)**	**27 (96.4%)**	**150 (97.4%)**
***PTSD: Taking Back Your Power**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Detaching from Emotional Pain (Grounding)**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Asking for Help**	**108 (85.7%)**	**18 (64.3%)**	**126 (81.8%)**
***When Substances Control You** or	**34 (27.0%)**	**1 (3.6%)**	**35 (22.7%)**
***Healthy Relationships** or	**89 (70.6%)**	**21 (75%)**	**110 (71.4%)**
***Setting Boundaries in a Relationship**	**8 (6.3%)**	**13 (46.4%)**	**21 (13.6%)**
Taking Good Care of Yourself	21 (16.7%)	-	21 (13.6%)
Compassion	76 (60.3%)	8 (28.6%)	84 (54.5%)
Red and Green Flags	23 (18.3%)	-	23 (14.9%)
Honesty	3 (2.4%)	8 (28.6%)	11 (7.1%)
Recovery Thinking	-	-	-
Integrating the Split Self	-	-	-
Commitment	1 (0.8%)	-	1 (0.6%)
Creating Meaning	6 (4.7%)	1(3.6%)	7 (4.5%)
Community Resources	-	-	-
Discovery	-	-	-
Getting Others to Support Your Recovery	-	-	-
Coping with Triggers	36 (28.6%)	-	36 (23.4%)
Respecting Your Time	-	-	-
Self Nurturing	13 (10.3%)	13 (46.4%)	26 (16.9%)
Healing from Anger	18 (14.2%)	-	18 (11.7%)
Life Choices Game	17 (13.5%)	11 (39.3%)	28 (18.2%)
Termination	59 (46.8%)	-	59 (38.3%)

Note: * denotes core program session

Demographics

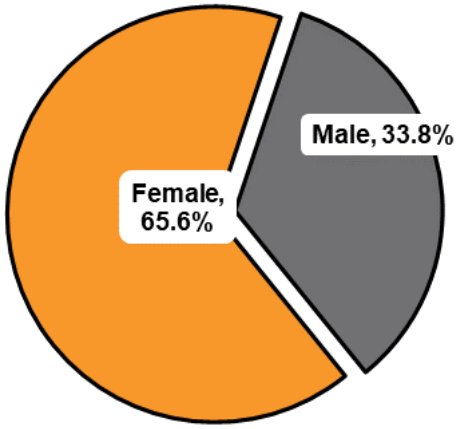
For FY2023-2024, 154 participants countywide received services in the Seeking Safety program, where 126 participants (81.8%) were served by Operation Safehouse and 28 participants (18.2%) were served by PEI Peers. This section will highlight the basic demographics of all the participants.

Age of All Participants (n=154)



The majority of participants were 15-25 years old (83.1%, n=128) and 16.9% were 26-63 (n=26).

Gender



Overall, 101 participants identified as female, 52 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure.

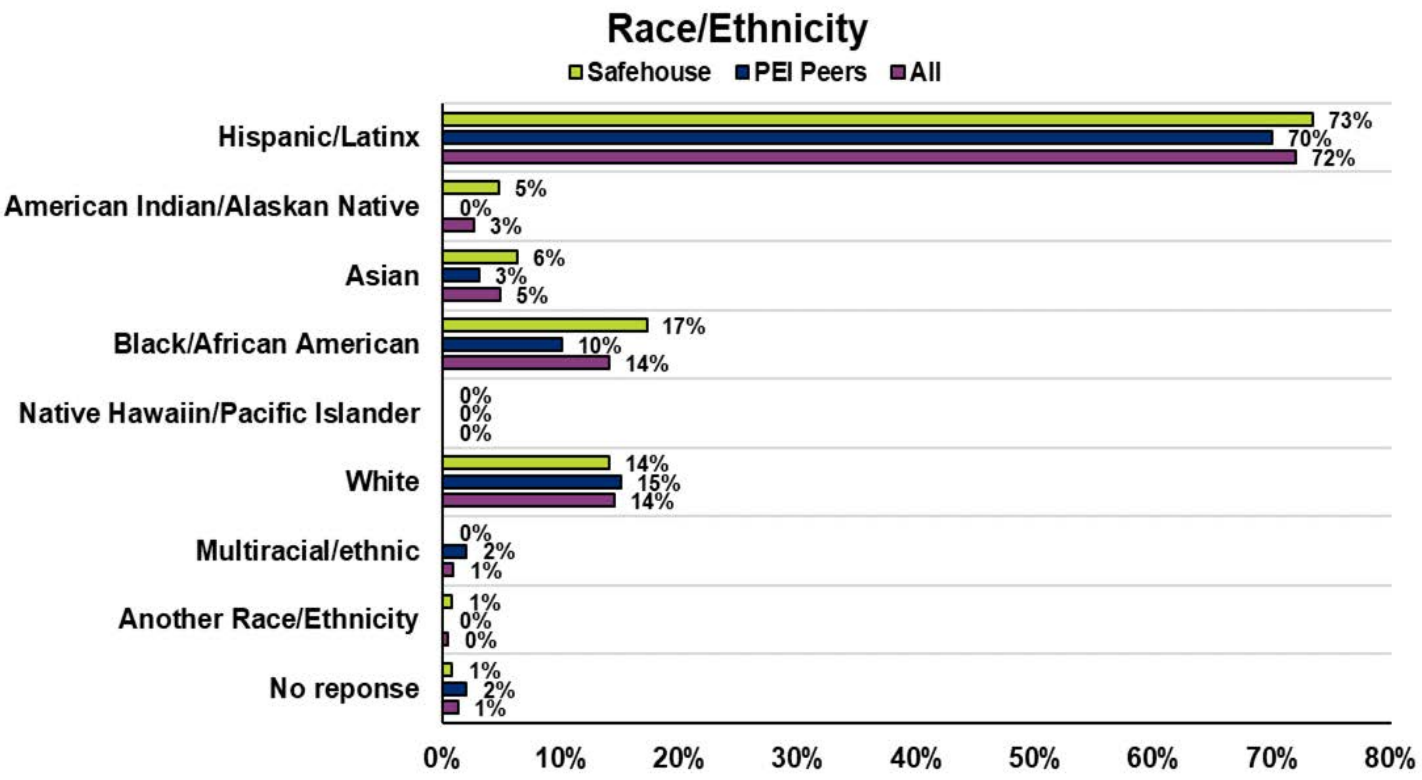
Specifically, among those served by Operation Safehouse, 79 identified as female, 46 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure. Additionally, among those served by PEI Peers, 22 identified as female, 6 identified as male.

37% of participants (57) reported identifying as LGBTQ, 8 reported having a disabling condition, and 3 participants reported being veterans.

Disabled and Veteran Status	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Disabled	5	3	8
Veteran	0	3	3

LGBTQ+	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Lesbian	5	1	6
Gay	5	1	6
Bisexual	19	1	20
Pansexual	-	-	-
Asexual	-	-	-
Unsure	2	-	2
Self-Describe	15	-	15
Declined to answer	6	2	8

Demographics cont.



Overall, 74% of the program participants identified as Hispanic/Latinx, 6.5% White, 8.4% Black/African American, 2.6% Asian, 1.3% American Indian/Alaskan Native, 5.8% Multiracial/ethnic, 0.6% Native American or Pacific Islander, and 0.6% did not provide a response. Please note, some participants chose more than one response. Additionally, of all the participants who shared their specific ethnicity, 61.7% identified as Mexican/Mexican American and 5.8% as Central American with the remaining each being less than 1%.

Specific Ethnicity

	Mexican American	Central American	Vietnamese	Chinese	Filipino	Thai
Safehouse (n=126)	76	6	1	1	1	0
PEI Peers (n=28)	19	3	0	0	0	1
All (n=154)	95	9	1	1	1	1

Preferred Language

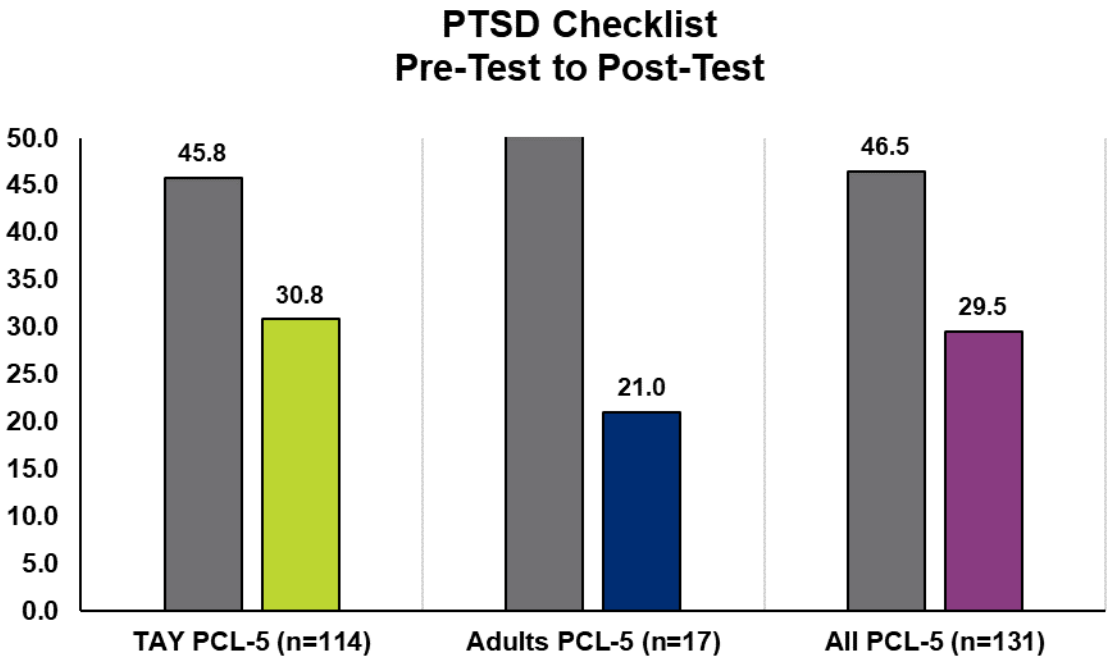
	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
English	117	20	137
Spanish	8	8	16
Declined to Answer	1	-	1

The majority of program participants (75.9%, n=117) reported a preference for English as their primary language, while 24.1% (n=16) indicated a preference for Spanish. One participant opted not to provide a response.

PTSD Checklist (PCL-5)

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program and to measure symptom change after completing the Seeking Safety program. Each checklist consists of **20** symptoms, rated on a 5-point scale, where ***0=Not at all, 1=A little bit, 2=Moderately, 3=Quite a bit***, and ***4=Extremely***. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80).

For all program participants throughout the county, a total of 131 matched pairs were used in the analysis. The difference in average scores for the PTSD Checklist showed a statistically significant decrease from pre- to post-test for all participants. Overall, PTSD symptomatology improved after program completion.



	Difference in Average Scores	*t*	df	p
Safehouse (n=110)	15.0	8.8	113	.000
PEI Peers (n=52)	29.8	8.3	16	.000
All Participants (n=162)	16.9	10.5	130	.000

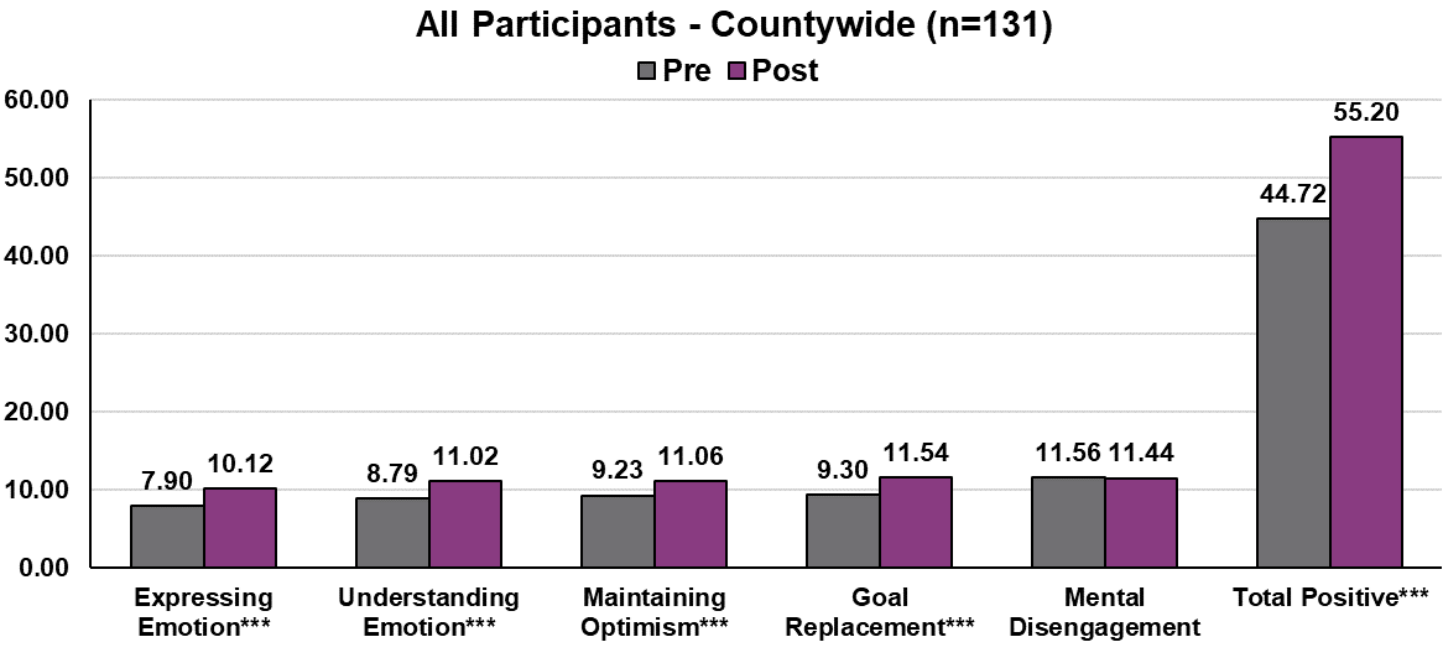
Coping Inventory: Positive Coping Skills

The Coping Inventory was used to measure positive and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that positive coping mechanisms/ responses will increase. Specifically, the positive coping skills are measured in total and using the following subscales:

Positive Coping Styles

- **Expressing Emotion**: display of feelings; none of the items refer to the experience and/or expression of negative affect.
- **Understanding Emotion**: attending to and clarifying feelings.
- **Maintaining Optimism**: represents mood regulation when facing a negative event. It describes attempts to maintain a positive attitude and optimism under adverse conditions.
- **Goal Replacement**: an acceptance of a loss and a search for some alternative source of satisfaction.
- **Mental Disengagement**: related to the person being able to distract from thinking about the behavioral dimension or goal with which the stressor is interfering.

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

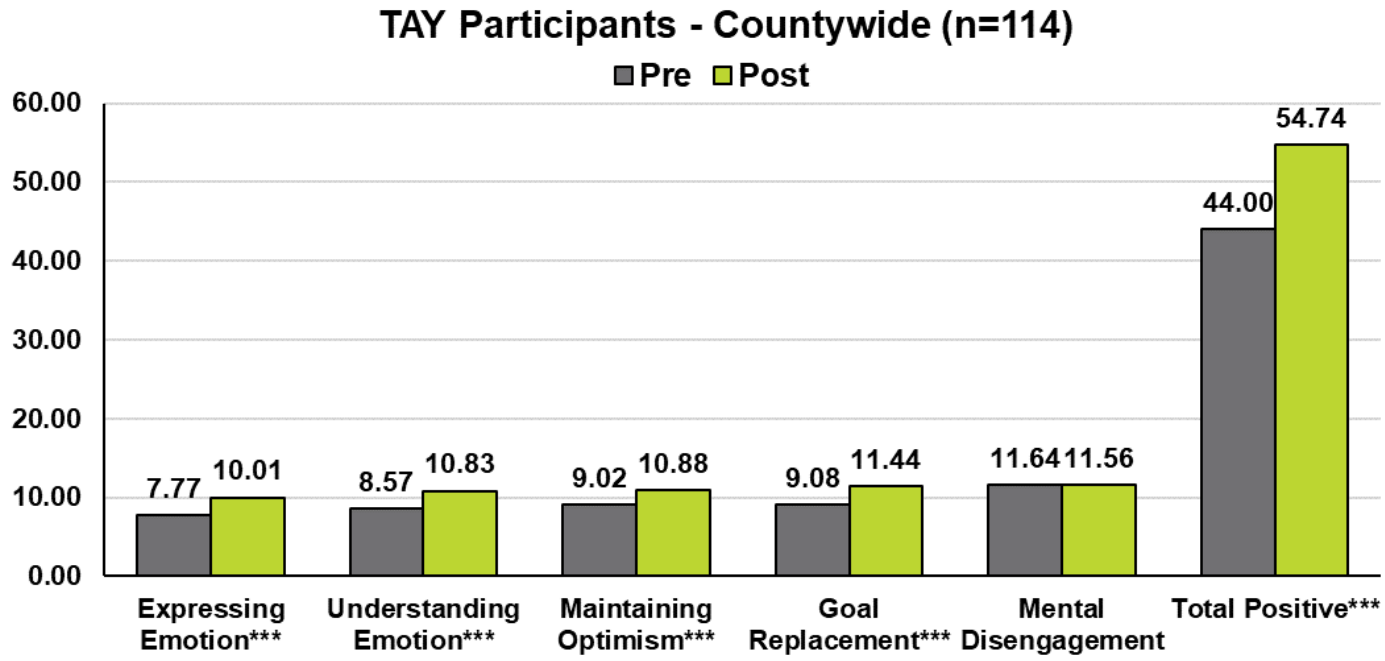


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.16	-7.10	130	.000
Understanding Emotion	-2.23	-8.29	130	.000
Maintaining Optimism	-1.83	-6.09	130	.000
Goal Replacement	-2.23	-6.71	130	.000
Mental Disengagement	0.12	0.45	130	.652
Positive Coping Skills Total	-10.48	-10.20	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Positive Coping Skills

For TAY participants throughout the county, a total of 114 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

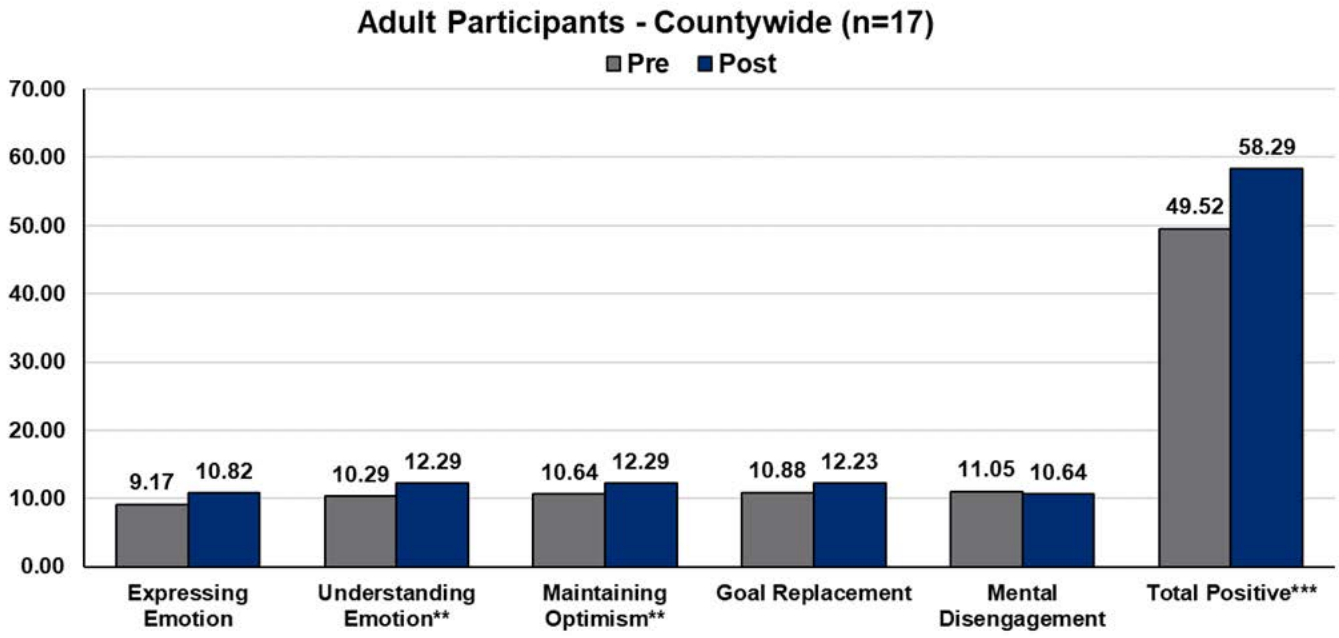


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.24	-6.83	113	.000
Understanding Emotion	-2.26	-7.90	113	.000
Maintaining Optimism	-1.85	-5.59	113	.000
Goal Replacement	-2.35	-6.47	113	.000
Mental Disengagement	0.08	0.27	113	.783
Positive Coping Skills Total	-10.73	-9.55	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Positive Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was minimal change in mental disengagement.



Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-1.64	-1.97	16	.066
Understanding Emotion	-2.00	-2.50	16	.024
Maintaining Optimism	-1.64	-2.54	16	.022
Goal Replacement	-1.35	-1.81	16	.089
Mental Disengagement	0.41	0.49	16	.629
Positive Coping Skills Total	-8.76	-3.57	16	.003

Note: Each * denotes higher significance from pre– to post–

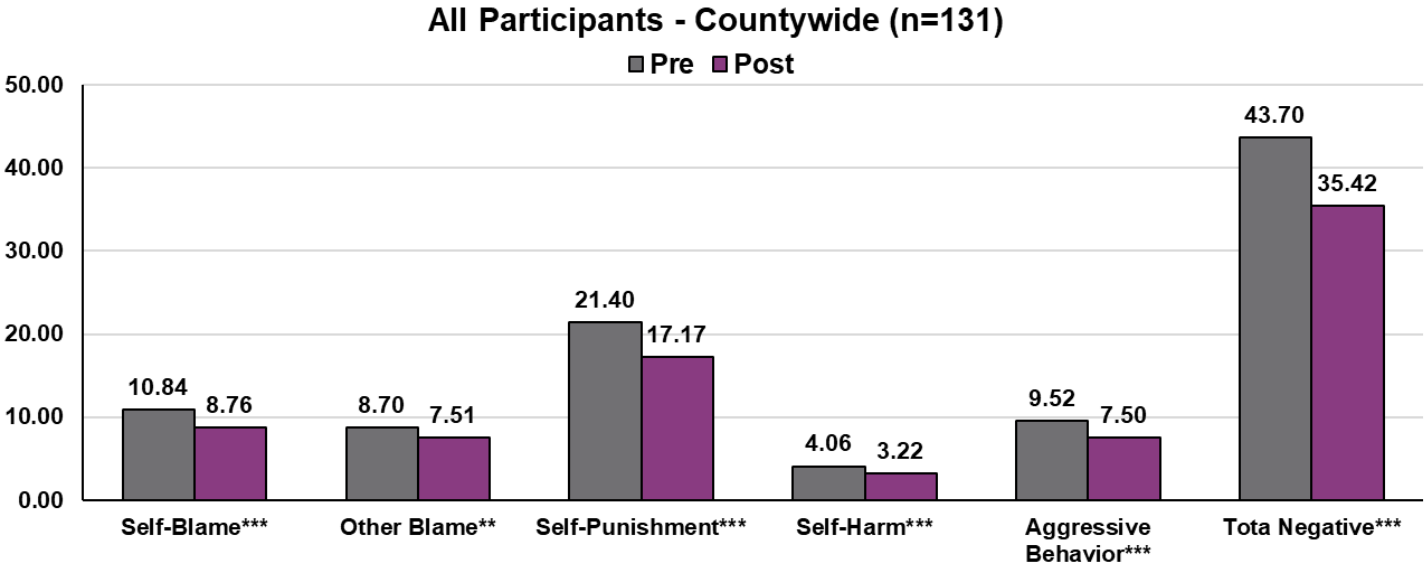
Coping Inventory: Negative Coping Skills

The Coping Inventory was used to measure positive coping skills and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that negative mechanisms/ responses will decrease. Specifically, the negative coping skills are measured in total and using the following subscales:

Negative Coping Styles

- **Self-Blame**: a tendency to criticize the self for negative events.
- **Other Blame**: includes items about causality, responsibility, and blameworthiness.
- **Self-Punishment**: tendency to inflict punishment on oneself.
- **Self-Harm**: the practice of injuring yourself in order to relieve emotional distress.
- **Aggressive Behavior:** tendency to inflict harm onto others

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.

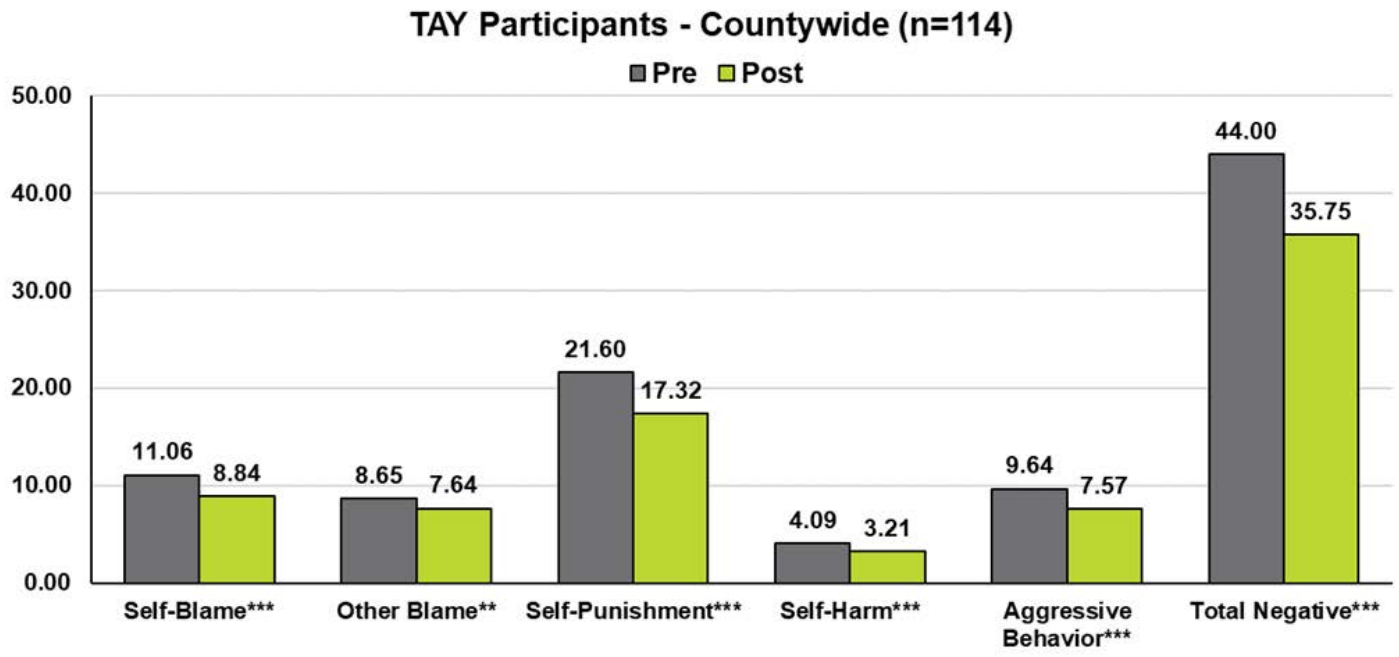


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.08	6.58	130	.000
Other Blame	1.19	4.09	130	.000
Self-Punishment	4.22	7.33	130	.000
Self-Harm	0.83	5.45	130	.000
Aggressive Behavior	2.02	6.79	130	.000
Negative Coping Skills Total	8.28	8.06	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Negative Coping Skills

For TAY participants throughout the county, a total of 110 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, self-punishment, self-harm, and aggressive behavior.

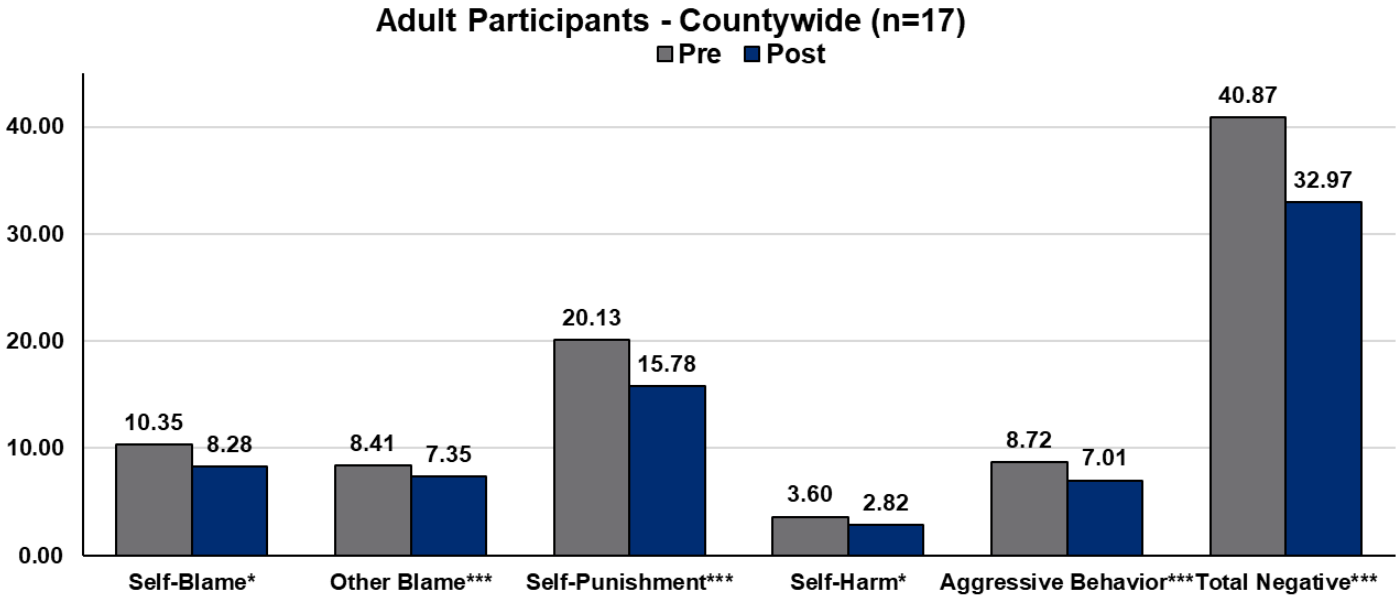


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.21	6.26	113	.000
Other Blame	1.01	3.17	113	.002
Self-Punishment	4.28	6.65	113	.000
Self-Harm	0.88	5.14	113	.000
Aggressive Behavior	2.06	6.17	113	.000
Negative Coping Skills Total	8.24	7.12	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Negative Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.



Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	1.17	2.21	16	.041
Other Blame	2.41	3.93	16	.001
Self-Punishment	3.88	3.54	16	.003
Self-Harm	0.47	2.21	16	.041
Aggressive Behavior	1.76	3.40	16	.004
Negative Coping Skills Total	8.52	5.27	16	.000

Note: Each * denotes higher significance from pre– to post–

Conclusion of Service Questionnaire: Satisfaction Surveys

A total of 126 participants completed the satisfaction survey. Most participants agreed or strongly agreed that Seeking Safety reduced their trauma symptoms and was helpful. Most participants agreed that the components of Seeking Safety were helpful such as learning new skills to help function better, the amount and type of written material provided, and the structure of the program. Nearly every participant agreed that they would recommend Seeking Safety to others.

Question (n=126)	Avg.	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree	N/A	No Response
Overall, the Seeking Safety program was helpful for me	4.51	1 (0.8%)	1 (0.8%)	10 (7.9)%	35 (27.8%)	79 (62.7%)	-	-
The Seeking Safety program helped reduce my trauma symptoms	4.07	1 (0.8%)	5 (4.0%)	28 (22.2%)	42 (33.3%)	50 (39.7%)	-	-
The Seeking Safety program helped reduce my substance use	4.00	3 (2.4%)	3 (2.4%)	10 (7.9%)	17 (13.5%)	25 (19.8%)	68 (54.0%)	-
The Seeking Safety program helped in managing my stress	4.25	1 (0.8%)	1 (0.8%)	21 (16.7%)	45 (35.7%)	58 (46.0%)	-	-
Staff treated me with respect	4.86	-	-	5 (4.0%)	7 (5.6%)	113 (89.7%)	-	1 (0.8%)
Staff spoke to me in a way that I understood	4.77	1 (0.8%)	2 (1.6%)	2 (1.6%)	14 (11.1%)	106 (84.1%)	-	1 (0.8%)
I liked the variety of topics offered	4.63	-	2 (1.6%)	8 (6.3%)	24 (19.0%)	92 (73.0%%)	-	-
The sessions were well organized	4.63	1 (0.8%)	2 (1.6%)	4 (3.2%)	28 (22.2%)	91 (72.2%)	-	-
I found the written material provided helpful	4.42	-	3 (2.4%)	16 (12.7%)	32 (25.4%)	75 (59.5%)	-	-
I found the Safe Coping Skills helpful	4.48	1 (0.8%)	2 (1.6%)	12 (9.5%)	31 (24.6%)	80 (63.5%)	-	-
I found the focus on abstinence from all substances helpful	4.06	2 (1.6%)	3 (2.4%)	12 (9.5%)	17 (13.5%)	28 (22.2%)	63 (50.0%)	1 (0.8%)
I learned new coping skills that help me to function better	4.40	-	5 (4.0%)	11 (8.7%)	38 (30.2%)	72 (57.1%)	-	-
The location of the Seeking Safety program was convenient for me	4.61	-	2 (1.6%)	8 (6.3%)	27 (21.4%)	89 (70.6%)	-	-
The time of the Seeking Safety program was convenient for me	4.51	-	5 (4.0%)	9 (7.1%)	29 (23.0%)	83 (65.9%)	-	-
I will use what I learned in the Seeking Safety program in my life	4.59	-	1 (0.8%)	7 (5.6%)	34 (27.0%)	83 (65.9%)	-	1 (0.8%)
					No	Yes	N/A	No Resp.
Would you recommend Seeking Safety to a friend?		-	-	-	-	125 (99.2%)	-	1 (0.8%)

Satisfaction Survey: Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- "It helped me find other ways to deal with stress and talk with someone trusted."
- "Every session taught gave me at least one meaningful coping skill and I often learned surprising insights about myself and my situation."
- "I came in broken and leaving more confident. [Facilitator] was amazing. I am grateful for this program"
- "The program helped me understand that it's ok to feel a certain type of way but you have to know how to safely cope with it"
- "Helping me connect with others, develop better coping skills, have more patience with myself"
- "Bringing a positive change in how I deal with stress and how I cope"
- "Taught me methods to find better approaches with my anger causing less conflict to me"
- "This program helped me break down conflicting feelings and learned to work through them in a healthy way"
- "It helped me understand more about trauma and allowed me to realize that I was not alone"
- "The program opened my perspective that talking your problems out loud doesn't make you "weak" or perceived bad. I also really like the drug abuse advice, I'm trying to help myself more."
- "The program brought a helpful change in me."
- "This program helped me by opening up to my emotions and how to cope with the topics in my life that are hard to face"
- "It helped me understand that I shouldn't overthink things people say to me and try to be more open to others"
- "It helped me more positive of myself and not be to negative and it helped me ease my stress at home"
- "It helped me realize that I should stop focusing on the bad stuffs"
- "It helped me stop smoking and be a better person overall"
- "It was a safe space for me to express my emotions"
- "The program helped express my feels and set boundaries for myself"
- "The program gave me a safe place to express myself and helped me with how I cope"
- "The program helped with teaching me ways to cope with my problems. Helped me to realize that everyone goes through similar issues and there are ways around these issues. "
- "It let me realize things about myself that I never did"
- "The program brought a helpful change in me because before I felt as if I didn't really have anyone to talk to but when I'm with my friends in session, it is okay to talk"
- It was helped me realize everyone goes through a trauma in their lifetime and it is okay to not be okay. It changed the way I view my own trauma and the way that I deal with my trauma"
- "When I get really stressed, I realize what I'm doing, take a breath, and identify some colors, textures and sounds to keep me calm"
- "Helped me calm down when I am angry or sad"
- "It helped give my brain a break"

Satisfaction Survey: Comments cont.

What Participants Disliked…

- "Just the time, I would like the session to last longer than an hour"
- "One day in the program was rough, the day we discussed PTSD and so I felt like I was dealing with panic attack symptoms during that session and I was relieved when it was over but I still got good insights when I looked at the material later on."
- "Limited time"
- "Too short of a time"
- "It was out of control of the staff, but the atmosphere was a bit awkward"
- "How short it was"
- "Sometimes it was uncomfortable to be vulnerable"
- "I didn't like some of the other people or maybe I'm just mean"
- "Maybe the class period was inconvenient"
- "There wasn't enough sessions"
- "Sometimes it's too long"
- "In the beginning, I didn't really think it was going to work for me and I didn't want to give it a shot but I'm glad I did"

Additional Comments…

- "The instructors were kind and helped a lot."
- "We need more programs that help us"
- "I am very thankful for this program and for the information. I'm thankful for [facilitator] for easily explaining to be able to understand. Thank you."
- "Thank you for offering this. I am glad that I participated."
- "Thank you [facilitator] for your patience and allowing for me to be myself. For this to be a class on zoom, you were able to make me feel like you were in the room with me with your energy"
- "Thank you for your time and being flexible with the time."
- "It made me change for the better and i am thankful for it"
- "Awesome people"
- "[Facilitator] was great when talked about my problems. She didn't write it down or make me feel uncomfortable."
- "My mentor [facilitator] was great."
- "I think it's a very fun group. You learn a lot but the vibe is also very welcoming"
- "I really enjoyed the program, thank you"
- "I appreciate the staffs time really nice person"
- "Nothing much. Thank you for being a root to helping me be a better person with better ways"
- "No critically bad things to say and I do think even mentally healthy people can learn something here"
- "My staff was very helpful and kind. She kept it real"
- "very sweet. I enjoyed my time here"
- "It's a good program and it also helps with the stress at high school"
- "Would 100% do this again"
- "I wish it lasted longer, will be coming back when it's available."
- "10/10 recommended"

Riverside University HEALTH SYSTEM Behavioral Health

Mamás y Bebés

MHSA Prevention and Early Intervention

Report 2023/2024 FY

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Program Overview

Mamás y Bebés (MyB) is a prenatal intervention program, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants.

Three community-based organization (CBO) were funded by the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) to implement the program. Reach Out is a local non-profit CBO serving underserved communities; Riverside Community Health Foundation which is a nonprofit organization supporting health and well-being in Riverside communities through a variety of programs; and California Health Collaborative which is a non-profit organization supporting and enhancing the quality of life and health for people of California particularly the underserved and underrepresented.

As we navigate the complexities of the post-COVID-19 environment, MHSA PEI programs continue to adapt as they shift toward more in-person services. A steadfast commitment to community well-being has consistently prompted modifications to the approach, opting for virtual services when necessary. While the crisis initially reduced the range of planned group classes, there has been a successful increase in the number of these classes available via Zoom. To ensure both accessibility and convenience, phone call services are also maintained as an option for those who find this method more suitable. Additionally, the program now offers both Zoom and in-person classes to cater to diverse needs, providing flexibility and support for all community members.

Evaluation Overview

Process Evaluation

The process evaluation included descriptive information related to the program, provided services, number of people served, and basic demographics.

The process evaluation data is collected using the group sign-in sheets, which records basic information on the topic and the number of participants in attendance. This data is collected by the community health workers at each session.

Outcome Evaluation

The outcome evaluation included a pre to post measure on depression symptoms. In addition, satisfaction surveys were given to participants that included items on overall helpfulness of the program, as well as overall program satisfaction.

The outcome measures included:

Major Depressive Episode Status (MDE): also known as the Mood Screener, is administered at intake and is used to determine if the potential participant is experiencing a major depressive episode.

Center for Epidemiologic Studies Depression Scale (CES-D): the CES-D is a 20-item measure that measures depression by assessing various depression symptoms that participants were experiencing in the past week.

Executive Summary

Program Enrollment & Completion Rate:

A total of 329 women were screened by the program in FY 23-24. Of the 329 screened, 255 were enrolled and 231 fully graduated from the program. Most of the women (83.1%) identified as Hispanic/Latinx, followed by those identifying as White (6.7%), African American (3.5%), Multiple (2.7%) and Asian American (2.0%); 51.4% reported English as their primary language, while 41.6% reported Spanish and 6.7% reported bilingual with both English and Spanish.



91%
(n=231)
Graduated from the program

Of the participants who enrolled in the program: 91% (n=231) completed the program. Western Region graduated 105 women, Mid-County region graduated 74 women, and Desert region graduated 52 women. To graduate and complete the program, pregnant or postpartum moms were expected to attend 6+ sessions. From the graduates, 166 completed all 8 sessions.

Outcome Evaluation:

Major Depressive Episode Status (MDE)



Since Mamás y Bebés is a prevention program, screening at intake is used to rule out symptoms consistent with a major depressive episode. The participants scoring below a 5 were eligible to enroll in this preventive program. Screening data showed 78% (n=255) of the women who were screened and enrolled into the program were experiencing symptoms consistent with having mild depression. Note: In January 2020, RUHS-PEI changed the eligibility criteria to screen for mild depression and not enroll moderate to major depression to follow the PEI model.

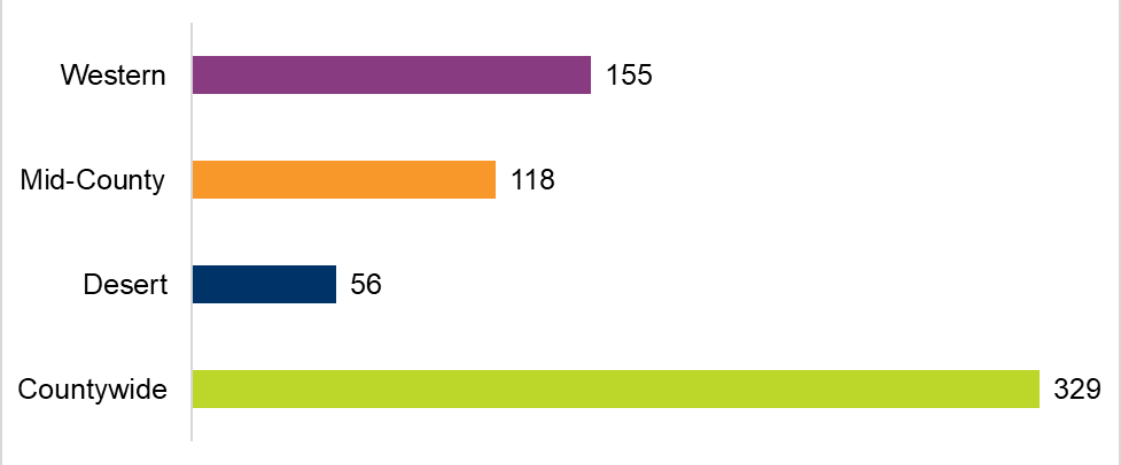
Center for Epidemiologic Studies Depression Scale (CES-D)



Pre and post scores were available for 231 women. 26% (n=60) scored between 16 and 24 at intake, which indicates clinically meaningful depression symptoms; 24.7% (n=57) scored above 24, which may be an indicator of major depression. From pre-test to post-test, outcomes data indicated that depression symptoms decreased and it was a statistically significantly decrease, p-value >0.001. At intake, the average CES-D score was 13 and after completing Mamás y Bebés the score decreased to 8.43.

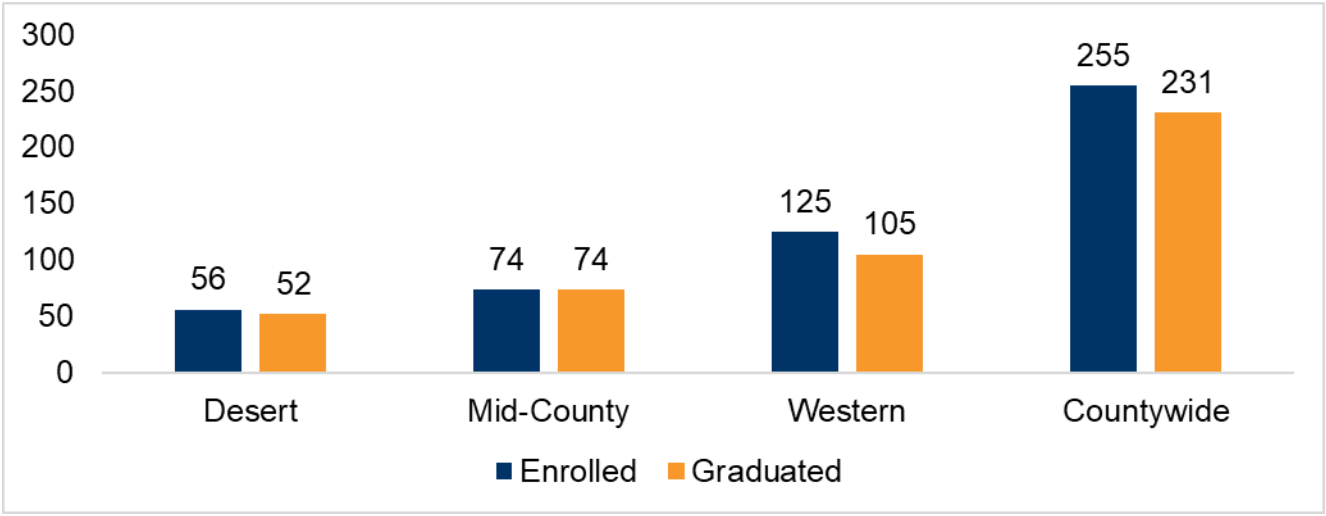
Program Enrollment and Completion

Total Screened (n=329)



Together Reach Out, Riverside Community Health Foundation and California Health Collaborative screened 329 pregnant or post-partum women to enroll in the Mamás y Bebés program. After using the mood screener questionnaire to determine eligibility, 255 women were eligible, enrolled and attended at least one group session. To be eligible for this prevention and early intervention program, women would need to complete the Mood Screener and score lower than a 5 in their current state score or a minimum of 1 in lifetime score and a 0 in current state.

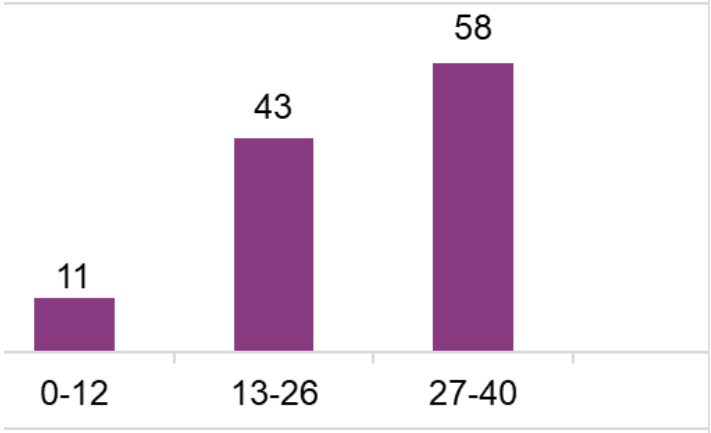
Program Completion (enrolled n=255, completed n=231)



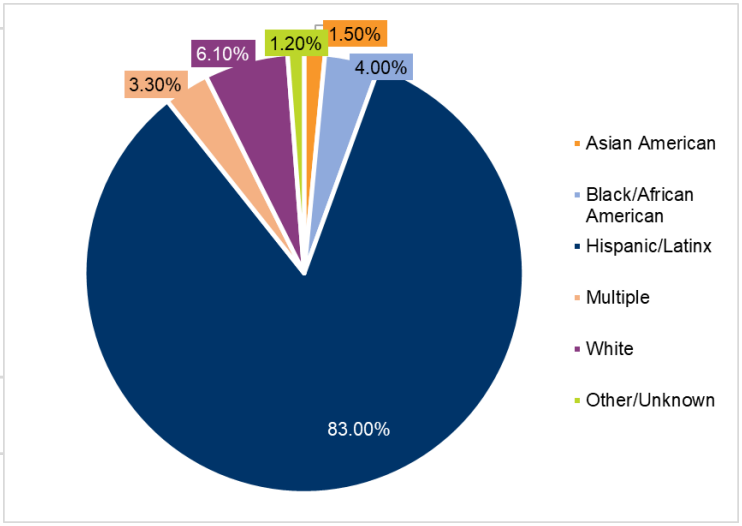
From the 255 women enrolled and served in the program, 231 successfully graduated by completing more than 6 sessions. There were eight that enrolled but never attended. The Desert region, California Health Collaborative, served 56 women while 6 dropped out of the program and one enrolled but never attended. Reasons for dropping range from conflict with time, did not feel fit for the group, and transportation. Mid-county region, Riverside Community Health Foundation, enrolled and served 74 women, 9 enrolled but never attended and only 17 dropped out of the program. Western region, enrolled and served 123 women, 4 enrolled but never attended and 22 dropped out of the program. Not all women screened and enrolled in the program attend, therefore data is based on those that attend at least one session.

Screening Demographics

Number of Weeks Pregnant n=112



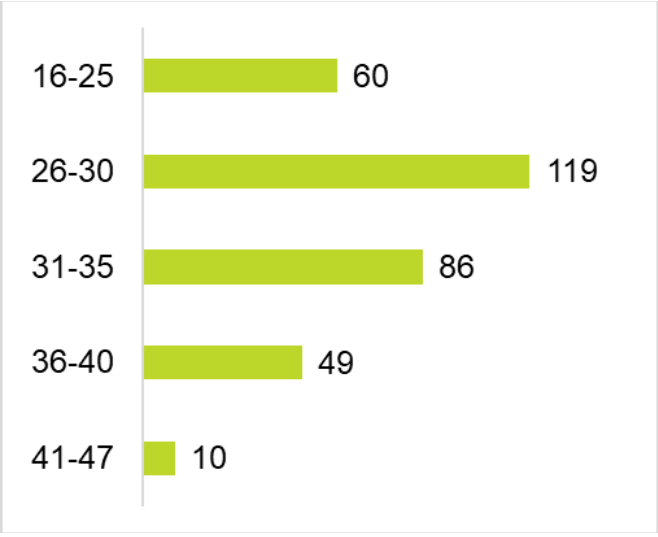
Race/Ethnicity n=329



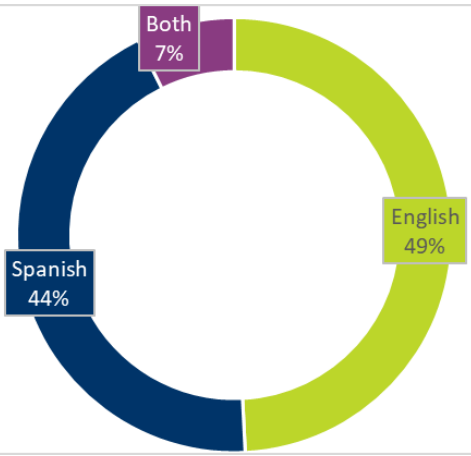
MyB is offered to women who are pregnant or going through post-partum. 112 of the 329 screened women were pregnant. Eleven were in their first trimester, forty-three in their second trimester, and fifty-eight in their third trimester. The majority of women 21 had a child under one.

83% of the women screened were Hispanic, 6.1% White, 4% African American, 3.3% Multiple and 1.5% Asian American.

Participant's Age n=329

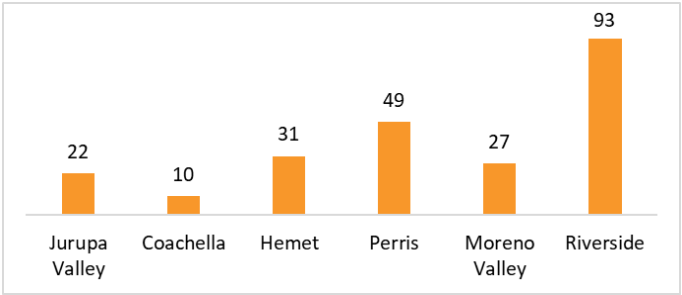


Primary Language n=329



The primary language spoken by most women was English, followed by Spanish as the second most common language. All material was available in Spanish to eliminate a language barrier

City of Residency n=329

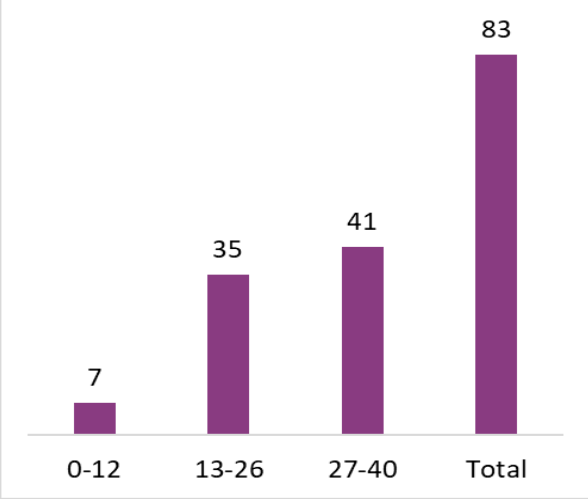


The majority of the women were under 35 years old. The youngest screened was 15 years of age, and the oldest was 43 years of age.

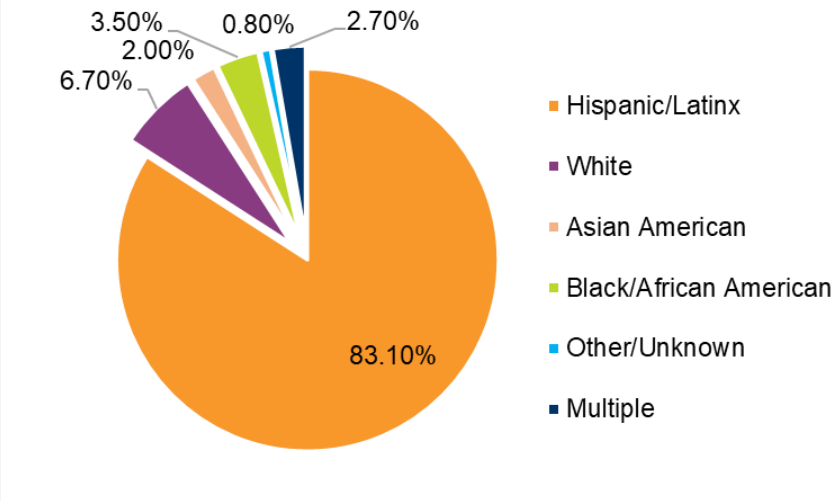
28.3% of the women screened were Riverside City residents.

Enrolled Demographics

Number of Weeks Pregnant



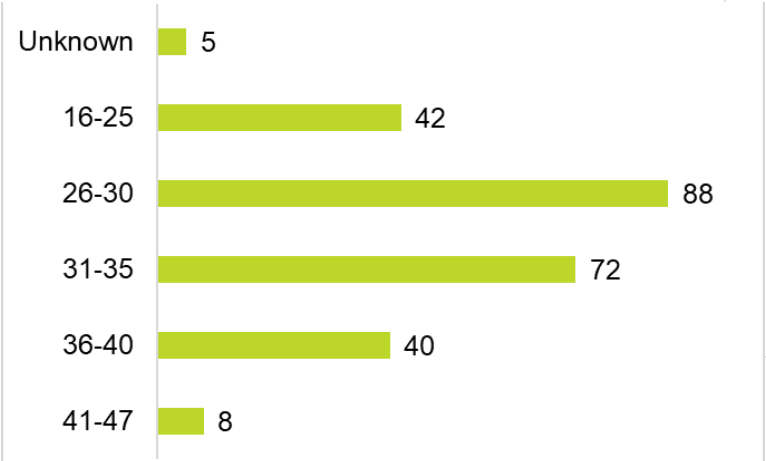
Race/Ethnicity
n=255



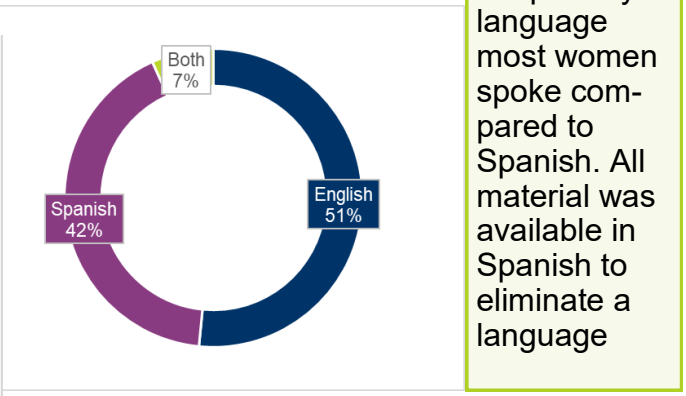
MyB is offered to women who are pregnant or going through post-partum. 83 of the 255 enrolled women were pregnant. Seven were in their first trimester, 35 in their second trimester, and 41 in their third trimester. The majority of post-partum women 172 had a child under one

83.1% of the women enrolled were Hispanic/Latinx, 6.7% White, 3.5% African American, 2.7% Multiple and 2% Asian American

Participant's Age
n=255

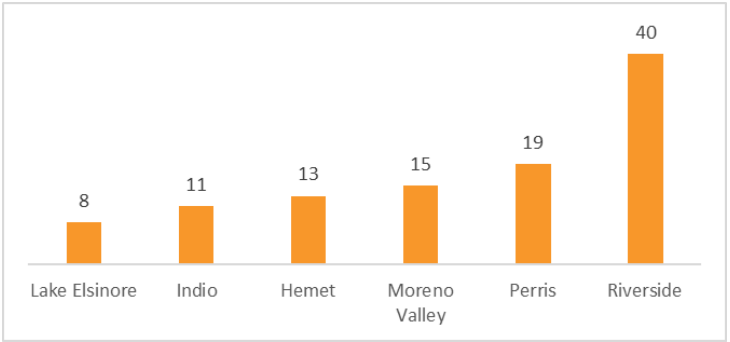


Primary Language
n=255



English was the primary language most women spoke compared to Spanish. All material was available in Spanish to eliminate a language

City of Residency
n=255



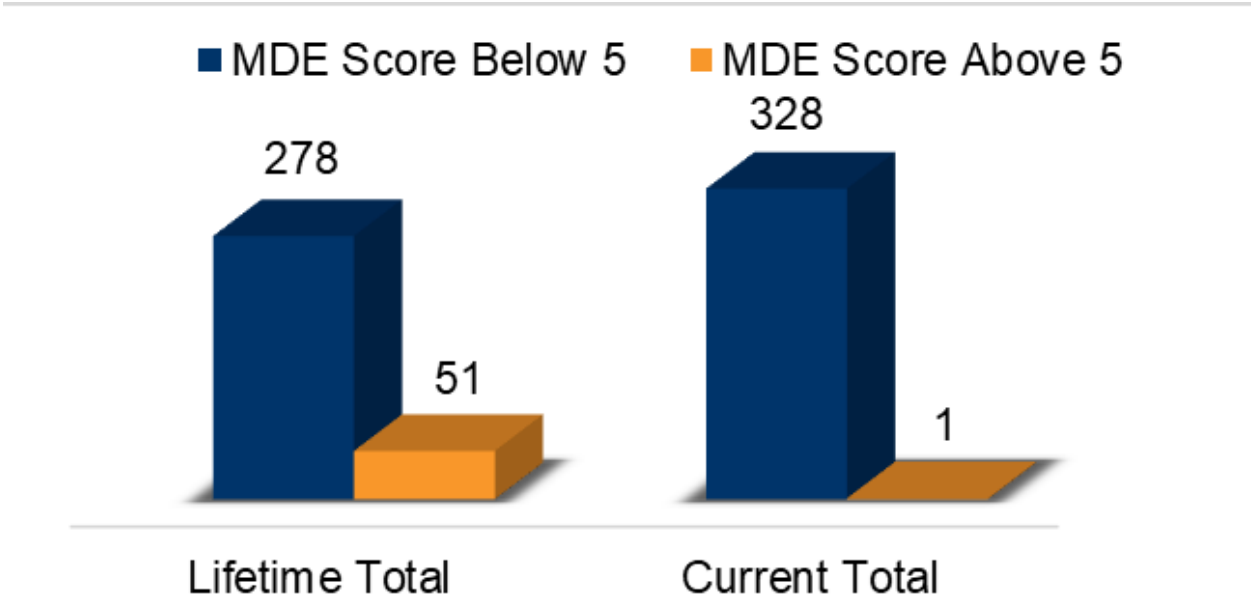
The majority of the women were under 35 years old. The youngest enrolled was 15 years of age, and the oldest was 43 years of age. Age was missing for 5 participants.

28.2% of women enrolled were Riverside City residents.

Mood Screener

The Mood Screener for major depressive episodes (MDE) is a self administered questionnaire that helps identify symptoms that may indicate whether a person is currently or in their lifetime suffered from major depression. A score of 5 of more in either the current or lifetime category, along with answering “yes” to “Did these problems interfere with your life or activities a lot?”, may be indicative of a person who is currently experiencing, or has in the past, experienced major depression. Women scoring under a 5 but answering yes to the question quoted above fit the eligibility criteria for this prevention program and a referral to seek further help is provided along with enrollment into the program.

Major Depressive Episode Score (n=329)



Did these problems interfere with your life or activities a lot?

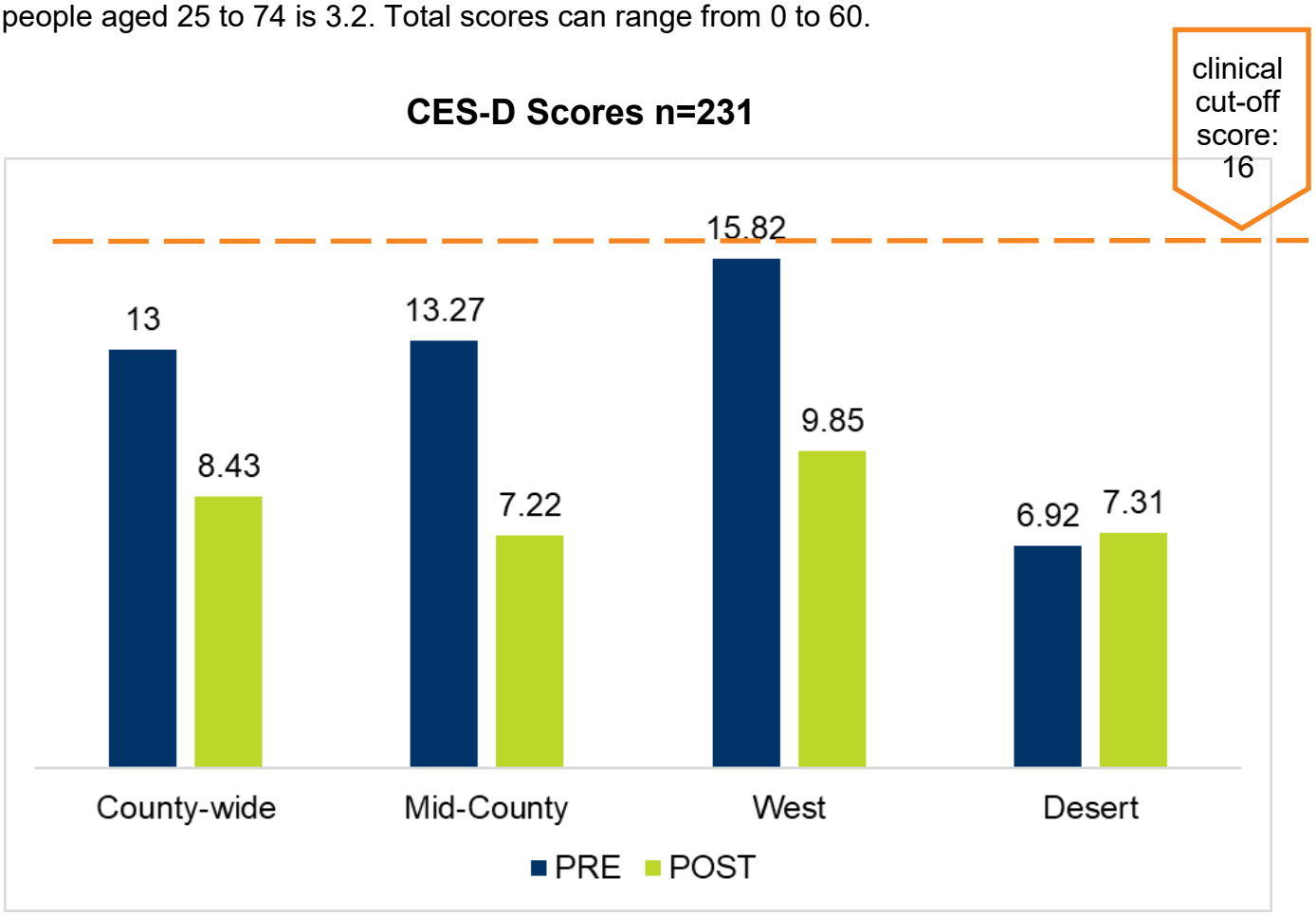
75%

Of the women who scored above a 5 on the MDE answered yes

For a women to be eligible to receive services, they must score below a 5 on the MDE screener in the “current” subscales. 328 of the screened women did score below a 5. From the 40 women scoring a zero in the “current” subscale, 37 women scored under a 5 and three scored above a 5. The total number of women enrolled in the MyB program for this 2023-2024 fiscal year was 255. There were n=329 Mood Screeners analyzed, and 38 of the 51 who scored above a 5 (75%) answered yes to the question “did these problems interfere with your life or activities a lot?”.

CES-D

The CES-D looks at a range of depressed mood that is measured by assessing various depression symptoms that participants were experiencing in the past week. Responses are organized in a Likert scale, where respondents are asked to report the typical frequency in which a particular symptom occurs. A total score is calculated, where higher scores indicate high levels of distress. A score ≥ 16 suggests a clinically significant level of depressive symptoms. It does not necessarily mean that the participant has a clinical diagnosis of depression, but that the person has an elevated level of depression symptoms, compared to other adults. The average score in the overall population for people aged 25 to 74 is 3.2. Total scores can range from 0 to 60.



CES-D scores for those who completed both a pre and a post measure indicated that depression symptoms significantly decreased among the women who participated in the program (t=6.793, df=230, p-value < 0.001). Average scores at intake (pre) indicated that women were within clinically meaningful levels of depression with an average score of 13.0. The post measure provides evidence of a significant decrease in depression levels as the score reduced to an average of 8.43, which has both clinical and statistical significance.

When comparing CES-D scores across regions, the Mid-County region showed a statistically significant improvement from pre- to post-scores (t = 6.722, df = 73, p < 0.001). The Desert region, however, did not demonstrate a significant change between pre- and post-scores (t = -0.346, df = 51, p = 0.730). In contrast, the Western region also exhibited a significant improvement (t = 5.143, df = 104, p < 0.001). Despite these findings, all three regions had post-test scores below the clinical cut-off score, indicating overall improvement. However, only the Mid-County and Western regions had statistically significant results (p < 0.05), while the Desert region did not.

Satisfaction Survey

Item Description (n=227)	1	2	3	4	5	Mean
1. The materials I received from the instructor were easy to understand.	-	-	-	9.7%	90.3%	4.90
2. I am satisfied with the information I received from this program.	-	-	-	7.9%	92.1%	4.92
3. I will use the information I learned during the program in my daily life.	-	-	-	10.1%	89.4%	4.90
4. This program helped me to cope with the moods I have experienced during pregnancy.	-	-	1.8%	17.2%	80.2%	4.79
5. I learned new methods to help me cope with feelings of sadness.	-	-	-	15.0%	85.0%	4.85
6. This program taught me how to get help for depression while I am pregnant and after the birth of my baby.	-	-	0.9%	15.9%	83.3%	4.82
7. I would recommend this program to someone else who is pregnant.	-	-	-	5.3%	94.7%	4.95
					Overall Average	4.87

**Scored on a 5-point Likert scale, where 1 represents strongly disagree and 5 is strongly agree.*

Comments:

"This program has helped me in multitude of ways. I looked forward to coming to the meetings/ classes. The only suggestion I have is to host the classes in a bigger space to allow ample space for the mamas and babies. Thank you ! ."

"I liked all the topics and conversations with the teacher. The reflections were always good. I really liked taking the class. ."

"This class helped my mental health so strong that I can manage to do a little beautiful things every-day. Thank you !"

"This program has helped me feel like I am not alone. It made me feel like a part of a community and has taught me new methods to help me cope with sadness, over whelming feeling and stress. Thank you."

"Motherhood is hard, full of challenges and it was nice to hear that other moms have same challeng-es as me. I learned new ways to cope with situations. Thank you for this program."

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. Boys Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is B.R.A.A.F.?

Building Resilience in African American Families project (B.R.A.A.F.) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American male youth and their parents/guardians that live in communities with high rates of poverty and community violence. The B.R.A.A.F. Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American males between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Executive Summary: Key Findings

Rites of Passage (ROP): In the 2023-2024 fiscal year, 24 participants enrolled in the Rites of Passage Program, with 71% (17 youth) completing the 9-month program, the completion goal was 30 youth. Across Riverside County, serving only the Desert and Western regions, approximately 192 sessions were conducted, with the majority of attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that 88% of participants maintained high academic performance, with only 12% exhibiting below-average grades by the program's conclusion. Notably, the percentage of parents indicating a need for emotional support decreased from 35% to 0% post-assessment.

Resilience measures were completed by 16 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 2.56, $p = 0.486$) or "sense of relatedness" (mean difference of 2.12, $p = 0.580$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight decrease; however, participants ($n = 17$) continued to demonstrate high levels of identity centrality. Importantly, the Cohesion subscale ($n = 16$) exhibited a statistically significant improvement ($t(15) = -2.101$, $p = 0.053$), indicating enhanced familial connections as a result of program participation.

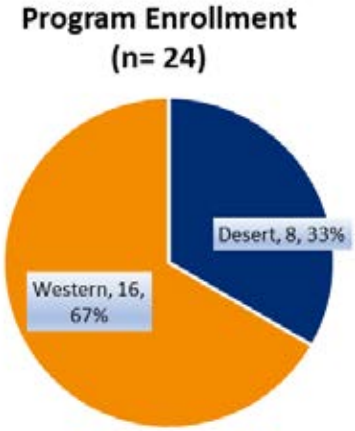
Guiding Good Choices (GGC): A total of 19 parents participated in the GGC program, with a graduation rate of 90% (17 parents). Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The results indicated significant improvements in parental involvement ($t(20) = -3.250$, $p < .05$) and reductions in inconsistent discipline ($t(20) = -3.485$, $p < .05$) and corporal punishment ($t(20) = -3.068$, $p < .05$). Furthermore, parents reported a notable 67% increase in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Overall satisfaction averaged 4.9 on a scale of 5 countywide.

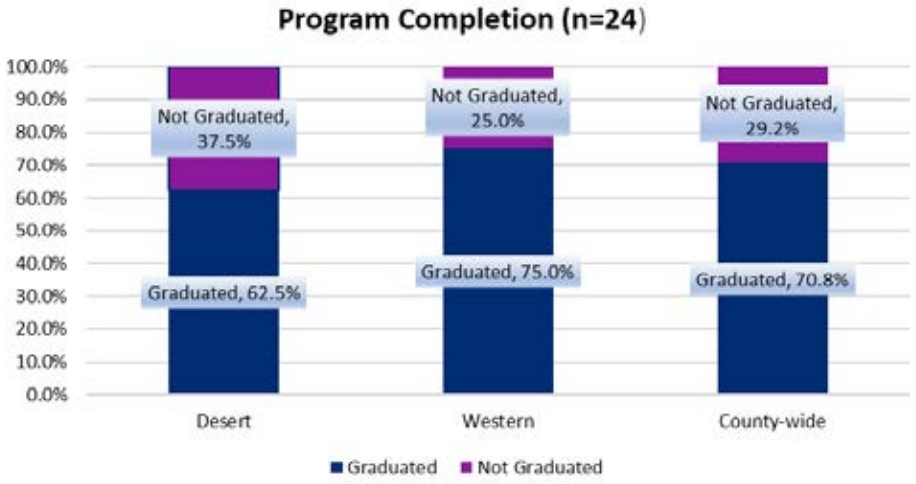
Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents.

Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted four dinners, while the Western region organized seven.

Cognitive Behavioral Therapy (CBT): Sixteen youth participated in CBT, delivered either in-person or via video conferencing. The effectiveness of CBT was evaluated using the Strengths and Difficulties Questionnaire (SDQ) and the Children's Depression Inventory-II (CDI-II). Fourteen parents completed pre- and post-SDQ surveys for their children, indicating significant decreases in emotional symptoms ($p < 0.05$) and overall difficulties, suggesting positive trends in mental health outcomes. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

Program Enrollment





A total of 24 participants were enrolled in the Rites of Passage Program; eight in the Desert, and eighteen in the Western region. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.

Most participants (71%) completed the 9 month program, while 29% were discontinued and/or did not graduate from the program. Of the completed participants, 5 were from the Desert region and 12 were from the Western region. A total of 17 youth graduated from ROP. Some of the reasons participants discontinued the B.R.A.A.F. program were relocation or being withdrawn by their parent(s).

ROP Attendance Distribution:
Number of Sessions Attended by Youths per Region

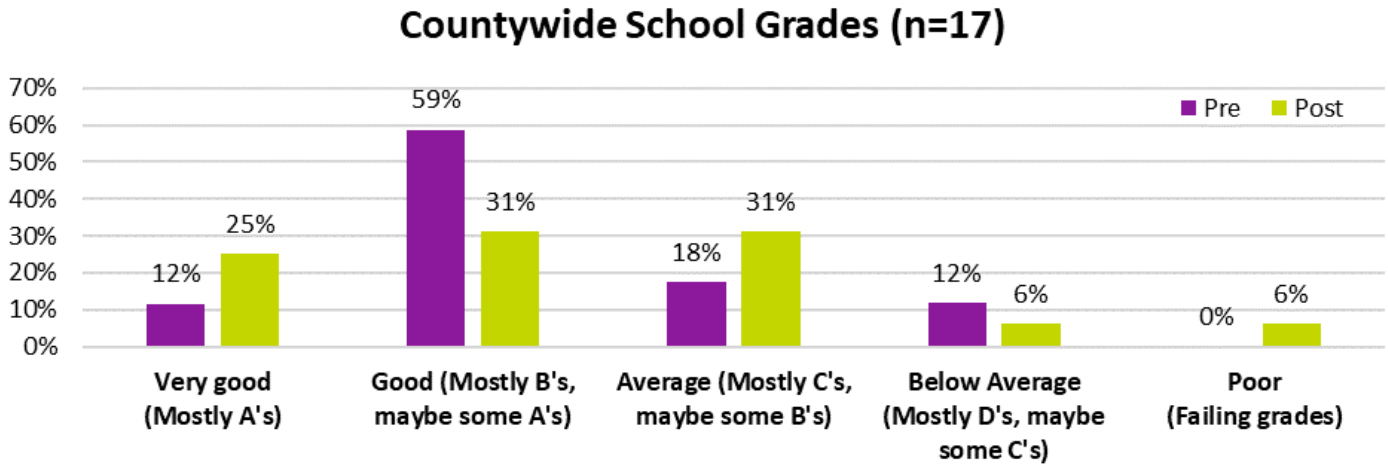
Sessions	Desert	Western	County
0-20	3	3	6
21-40	1	0	1
41-60	0	1	1
61-80	9	2	11
81-100+	3	2	5
Youths per Region	16	8	24

ROP is a 9-month program that is offered 3 times a week, with a target of 108 sessions per year/per program/per region. Approximately, 96 sessions were offered depending on each region's start date. Together, all two regions hosted approximately 192 ROP sessions throughout Riverside County.
Due to attrition the majority of participants dropped during the first half of the B.R.A.A.F. program.

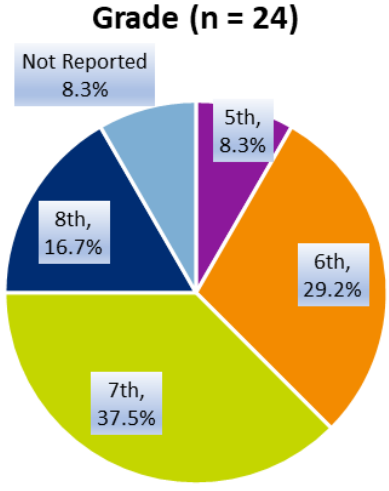
School Information

Countywide Results	*Pre		*Post	
	Yes	No	Yes	No
In the last 3 months, has the youth had a sudden drop in school performance?	29%	71%	13%	88%
Has the youth ever been suspended?	0%	100%	6%	94%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	100%
In the past year, has the youth been: arrested?	0%	100%	0%	100%
In the past year, has the youth been: on probation?	0%	100%	0%	100%
In the past year, has the youth been in any programs to help them with emotional problems?	35%	65%	0%	100%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	12%	88%	18%	82%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	100%	13%	88%
Is the youth affiliated with a gang?	0%	100%	6%	94%

*Some items for some youth are missing. Only averages across each questions were calculated from 17 participants that completed the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post).

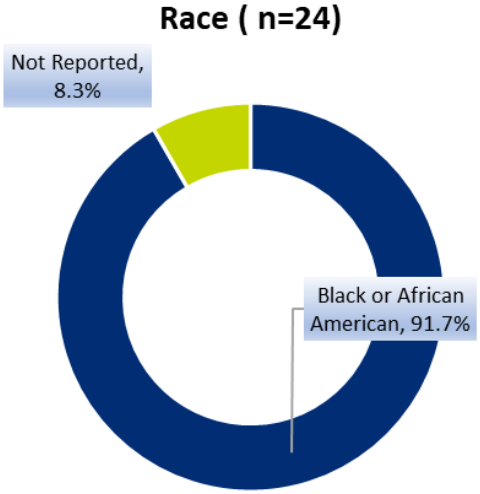


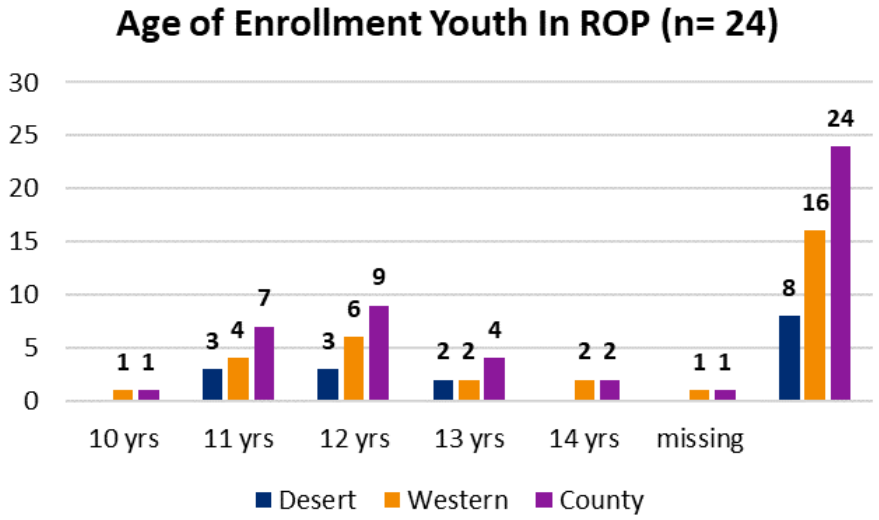
*Some items for some of the youth are missing for the School Performance. Only the 17 participants completing the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post) were used to calculate the School Performance Chart.



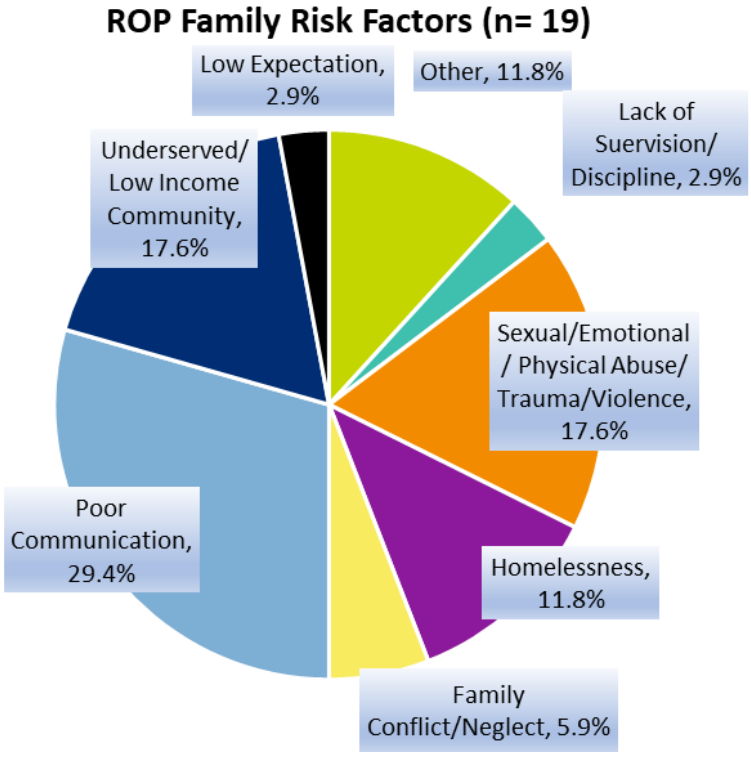
The majority of the boys in R.O.P. were in 6th, 7th, or 8th grade. Before R.O.P. began, parents were asked to complete a questionnaire regarding their youth's school performance. Once R.O.P. ended, the parents completed the same questionnaire to analyze whether being in B.R.A.A.F. had an impact on school performance. Most youth had high grades prior to the program, and this trend remained consistent by the end, with only 12% having below average to poor grades. Additionally, there was a slight decrease in support programs for emotional problems. Before R.O.P., 35% of the parents answered "yes," but after the program ended, all parents answered "no" regarding behavioral support programs for youth.

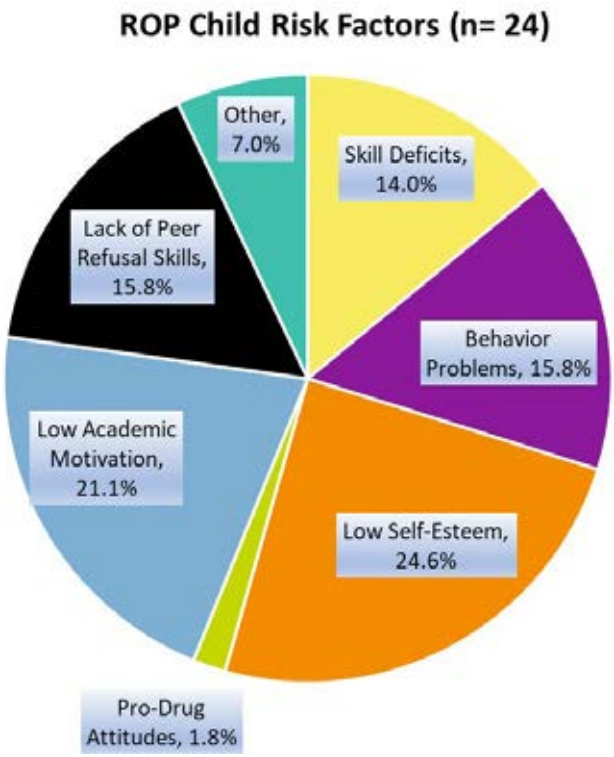
Demographics





It is important to note that 24 youth enrolled and have attended at least one session. The target enrollment for both regions was 40-50.

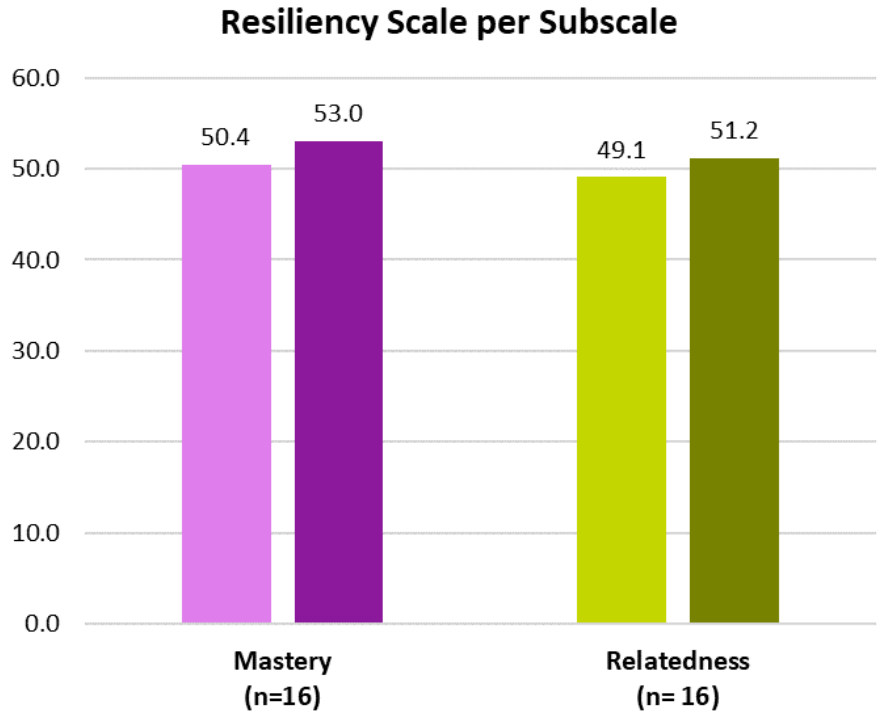




Risk Factors are based on participants that have provided at least one or more responses on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.

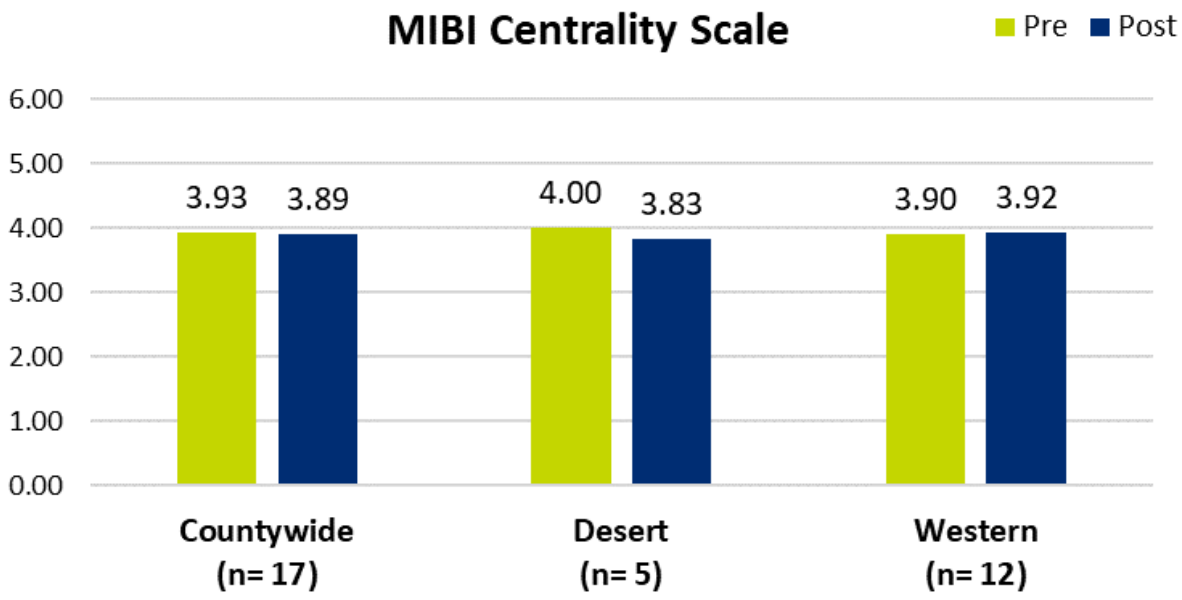


There were 16 participants from the Desert and Western regions who completed both pre- and post-measures for the chart above. Countywide, the scores for "sense of mastery," which reflects an individual's belief in their ability to manage challenges and achieve goals, slightly increased, with a mean difference of 2.56 ($t(15) = -0.715$, $p = 0.486$), indicating no statistically significant change ($p > 0.05$). The total scores suggest that youth reported an "Average" sense of mastery at both intake and follow-up, according to the Resiliency Scale scoring categories.

Similarly, there were also 16 participants with completed pre- and post-measures for the Sense of Relatedness scale, which involves feelings of connection and belonging to others. The scores on the relatedness subscale increased slightly, with a mean difference of 2.12, but there was no statistically significant change from pre- to post-measure ($t(15) = -0.565$, $p = 0.580$, $p > 0.05$). Both at intake and follow-up, youth reported an "Average" sense of relatedness, according to the Resiliency Scale scoring categories.

The Multidimensional Inventory of Black Identity

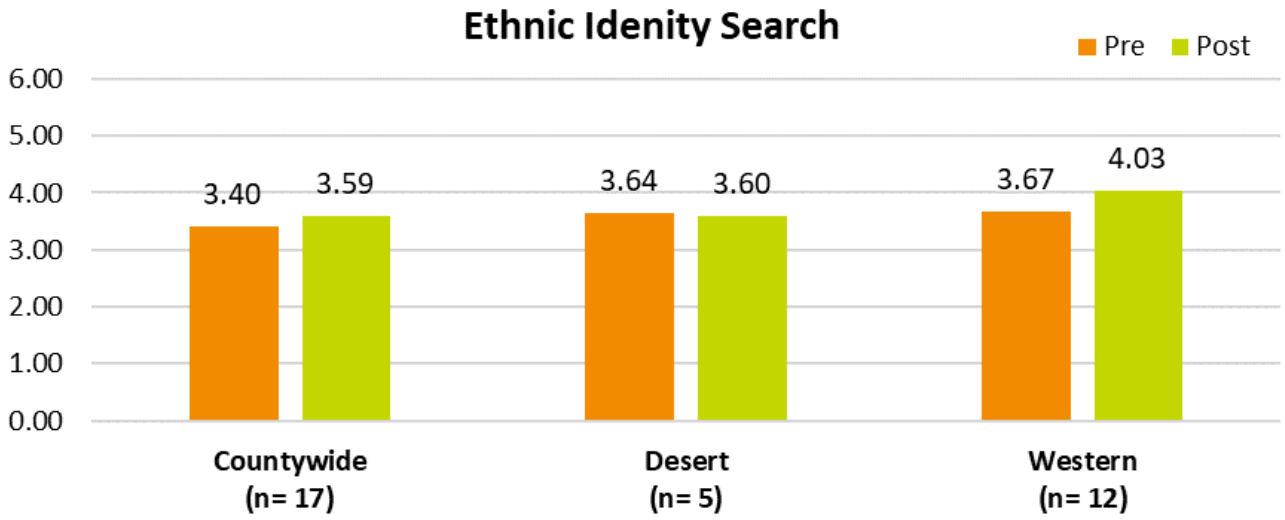
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of himself. The highest possible average one can score on Centrality is 5.

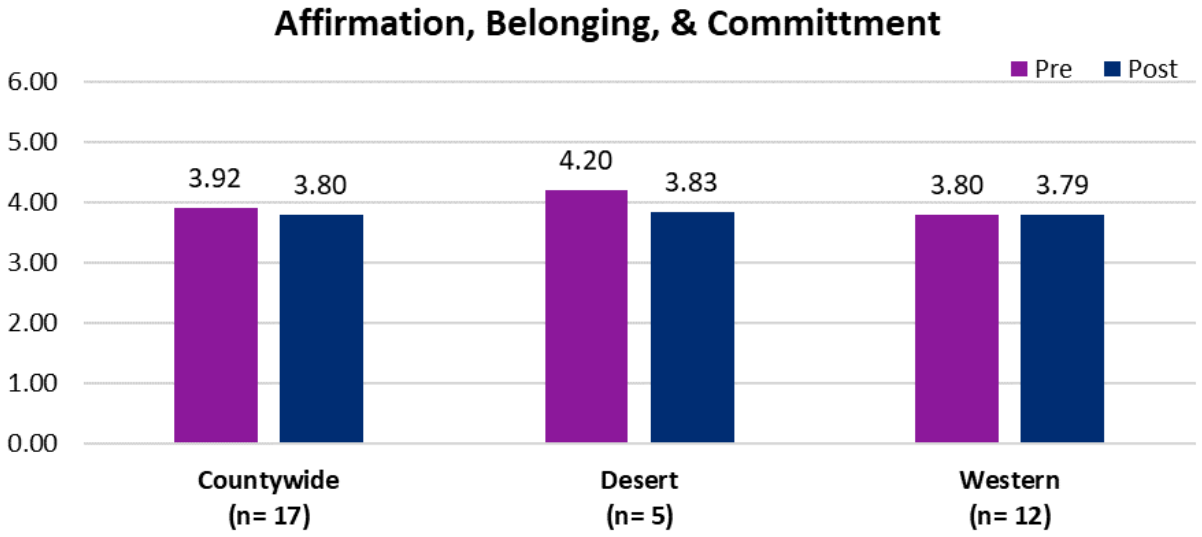


All regions were required to use the Teen MIBI measure, which consists of 9 items. Countywide, participants (n = 17) scored an average of 3.93 at the pre-assessment, and post-ROP, their average score was 3.89. This change was not statistically significant ($p = 0.913$, $p > 0.05$). Overall, the participants' scores remained around 4, indicating a strong sense of centrality regarding the importance of their Black/African American identity. In the Desert region, there was a slight decrease from pre to post, but the small sample size (n = 5) limits the reliability of any statistical comparison. Consequently, both the Desert and Western regions had small sample sizes, making it difficult to compare regional differences in racial identity. However, the average pre- and post-scores across both regions suggest that participants continued to maintain a high level of self-esteem associated with their Black/African American identity, as reflected in the MIBI Centrality Scale.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.

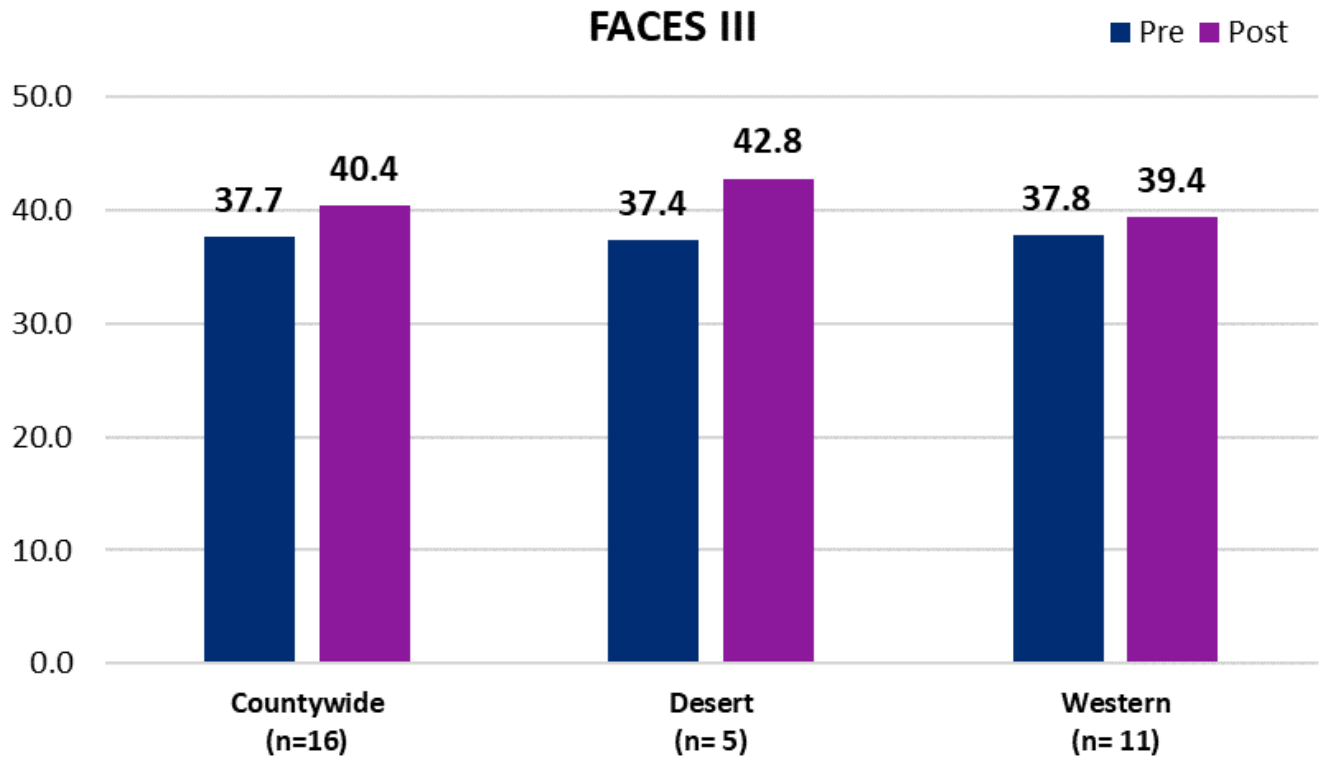




Overall, countywide, there was no change in the Multigroup Ethnic Identity Measure (pre-test = 3.40 and post-test = 3.59). In Affirmation, Belonging, and Commitment; countywide, there was no significant change with a mean difference of 0.12 (pre-test = 3.92 and post-test = 3.80). Though, there was no statistically significant change in either subscale, average scores across regions illude positive ethnic identity development in the R.O.P. youth.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



The results indicate that countywide scores on the Cohesion subscale showed a statistically significant improvement from pre to post-assessment (t(15) = -2.101, p = 0.053). This suggests that families experienced a shift in their sense of connection over the course of the program.

Initially, families reported feeling somewhat separated, with a pre-score of 37.70. However, after participating in the R.O.P., their post-score increased to 40.4, indicating a stronger sense of cohesion and connection among family members.

Although the sample sizes for each region were small, the average scores reflect a positive trend, demonstrating that families felt more united and engaged after the program. This improvement in cohesion suggests that the R.O.P. effectively fostered family bonds and enhanced the sense of togetherness within families.

Overall, these findings suggest the potential impact of the program on family dynamics, emphasizing the importance of fostering connections for overall family well-being.

Youth Satisfaction

Towards the end of the program, the majority (n= 17) of youths who graduated from ROP completed a satisfaction survey. Overall, the majority of youth who completed the satisfaction survey agreed that participating in the program was a positive experience. Also, respondents reported "good" with regard to staff treatment towards the youth.

Item Description (Score range: 1—5)	County-Wide n= 17	Desert n= 5	Western n=12
1. Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	3.82	4.00	3.75
2. Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.59	4.00	3.42
3. Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.29	3.60	3.17
4. Participating in this program has been a positive experience for me.	3.82	4.40	3.58
5. Participating in this program has changed how I think about myself in a positive way.	4.06	4.40	3.92
6. Please rate your satisfaction with how staff, in the Rites of Passage program, treated you.	4.12	4.20	4.08
7. Rites of Passage staff presented the program information in a way I understood.	4.19	4.25	4.17
8. Rites of Passage staff presented the program information in a fun way.	3.59	3.80	3.50

How this program may have affected participants
"It helped me be accountable for my actions."
"Program has changed me in a positive way by teaching me how to manage my emotions."
"This program changed me mentally and helped me deal with suicide."
What participants liked about the program
"Learning about my culture."
"The things we talked about and to trip fields."
"Good things to learn and food and activities."
What participants did not like about the program
"Having to memorize the *Nguzo Sabas* was something I didn't enjoy."

Parent/Caregiver Satisfaction

Overall, 100% of parents were satisfied with the program. Furthermore, 100% of parents indicated that they would recommend the program to a friend or relative.

Item Description (Score range: 1 - 4)	County-Wide n =15	Desert n= 5	Western n= 10
1. The program's ability to assist your child.	3.7	3.6	3.8
2. Your child's progress/accomplishments/achievements. while in the program.	3.9	4.0	3.8
3. The philosophy and approach of the program.	3.9	3.8	4.0
4. Opportunities for parents to meet together for support and share information.	3.9	3.8	4.0
5. Overall Satisfaction.	3.8	3.4	4.0

What has been most helpful to you and your child?
"My sons learned more about their African roots, and has empathy for others."
"What I loved the most was learning our African Culture. Teachings/lessons of our great pioneers and inventors that contributed to society globally. Being proud of our African Heritage and knowing our origin. Teaching cooking lessons, learning effective communication, build strong bonds with parent and son. Very enriched principles and values."
"Parent module sessions which helped support our family with ways to communicate and approach different situation with our son."
What changes can you suggest?
"Transportation needs to be upgraded for safety reasons."
"I would suggest more men mentors leading the lessons, also add a physical activity such as baking that helps with developing discipline. Build self-confidence. More outings such as hiking, camp-learn nature."
"More parent participation and more outings."
Is there anything else you want us to know?
"This program is effective in its lesson taught by the coordinators/staff. [Staff members] did a fantastic job. Continue program."
"My sons were pleased with the respect and concern they received from the staff members. My sons seemed to have enjoyed the retreats and outings."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

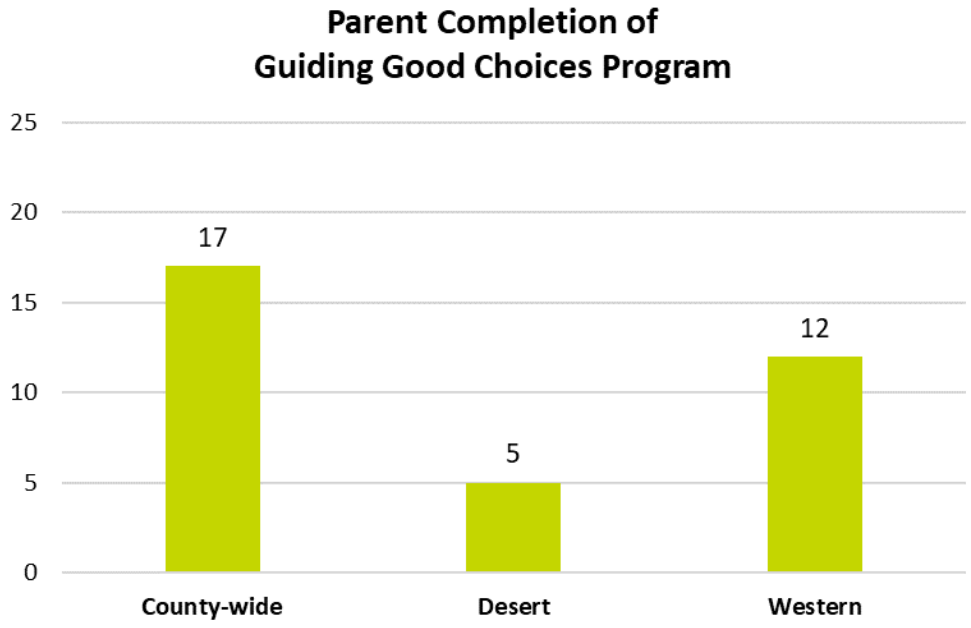
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks at the start of the program. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: how to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

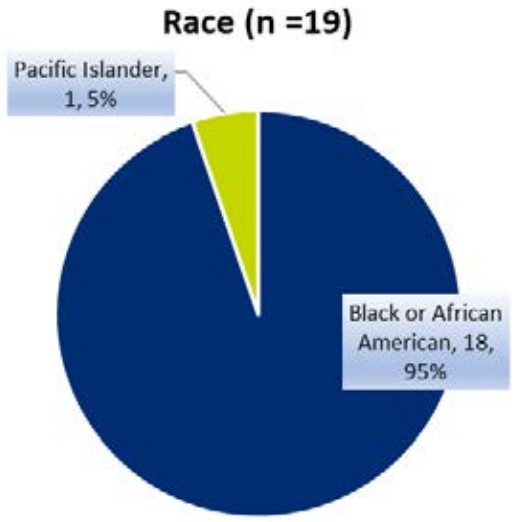
GGC Program Completion

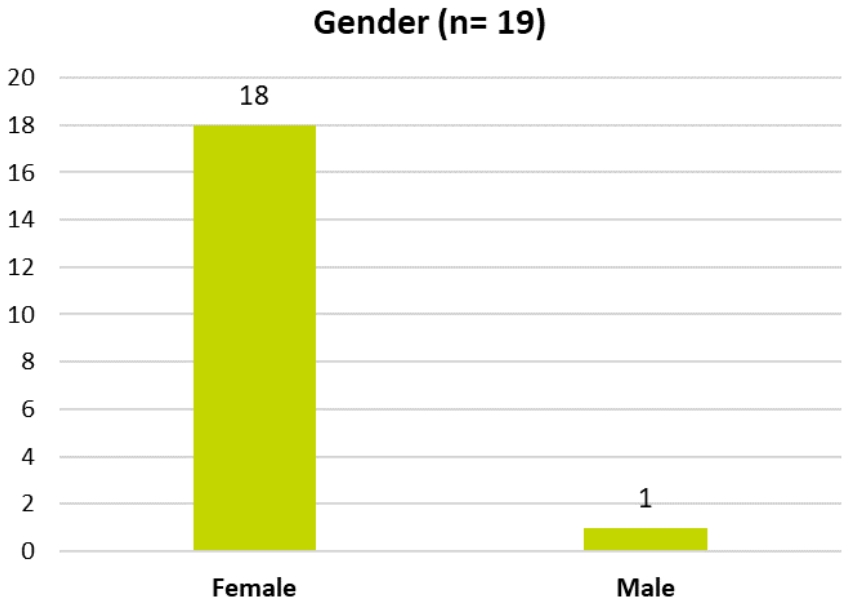
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

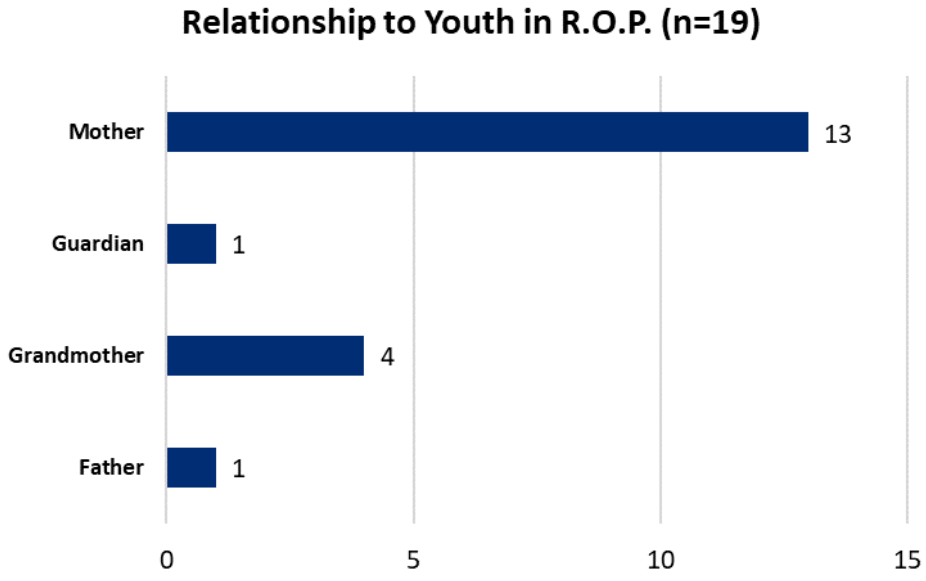


19 parents attended at least one session of GGC and 17 parents (90 % of the cohort) completed the program in 2023-2024 FY.

Demographics



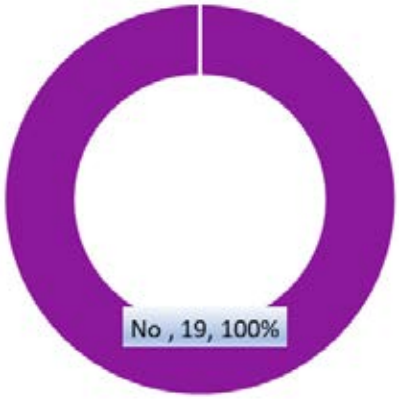




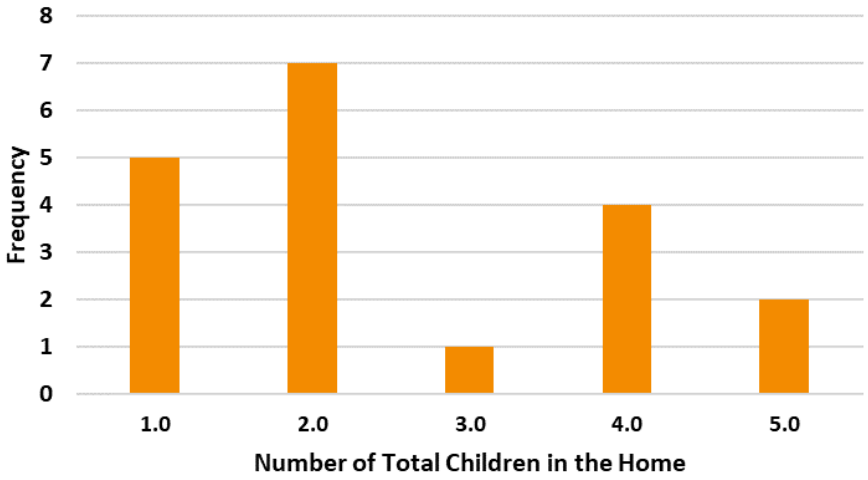
Of the self-reported data collected from GGC, 95% of the participants were African American, and 5% were Pacific Islander regarding race on the demographic form. The male-to-female ratio was, approximately, 1 to 18, respectively. Mothers (n= 13) were the primary participants, followed by grandmothers (n= 4), one father (n =1), and one guardian (n= 1).

Demographics cont.

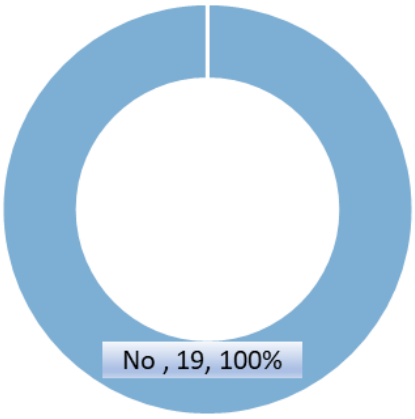
Disabling Condition? (n=19)



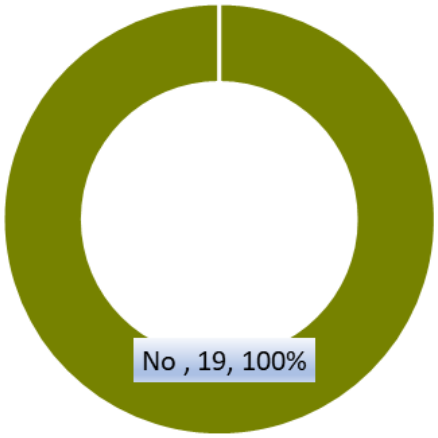
# of Children per Household (n= 19)



Child Actively Uses Drugs/Substances? (n=19)



Veteran? (n=19)

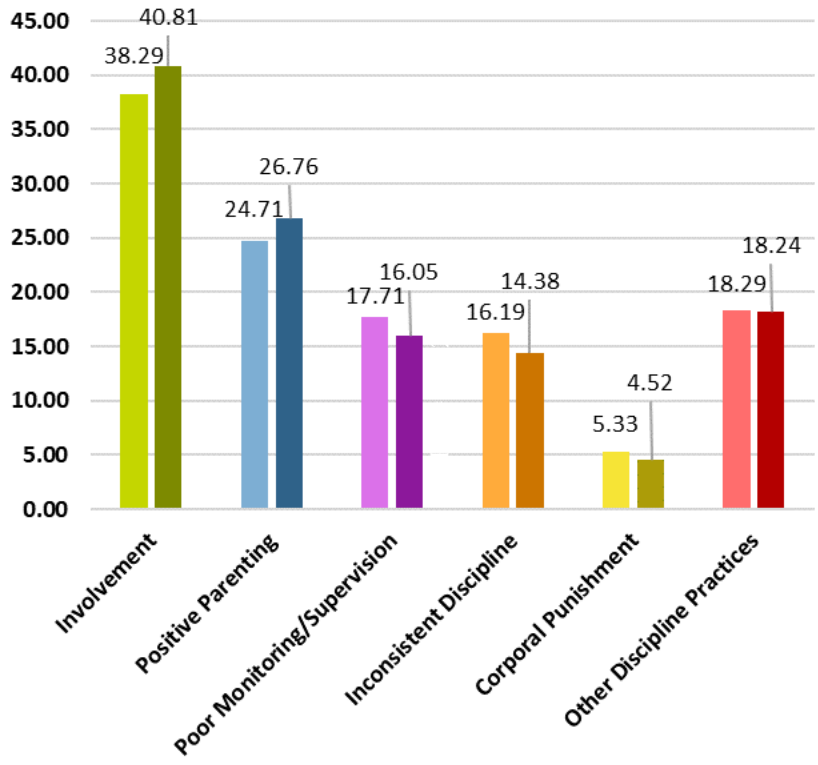


Overall, 19 parents were served in GGC and 17 parents completed the program. Of the 19 who enrolled, approximately, parents reported none of their children actively use substances (n =19). Most parents had two children in their homes.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=21)



Nineteen parents/caregivers had a pre and post APQ measure. Two parents had two siblings in the program (n =21).

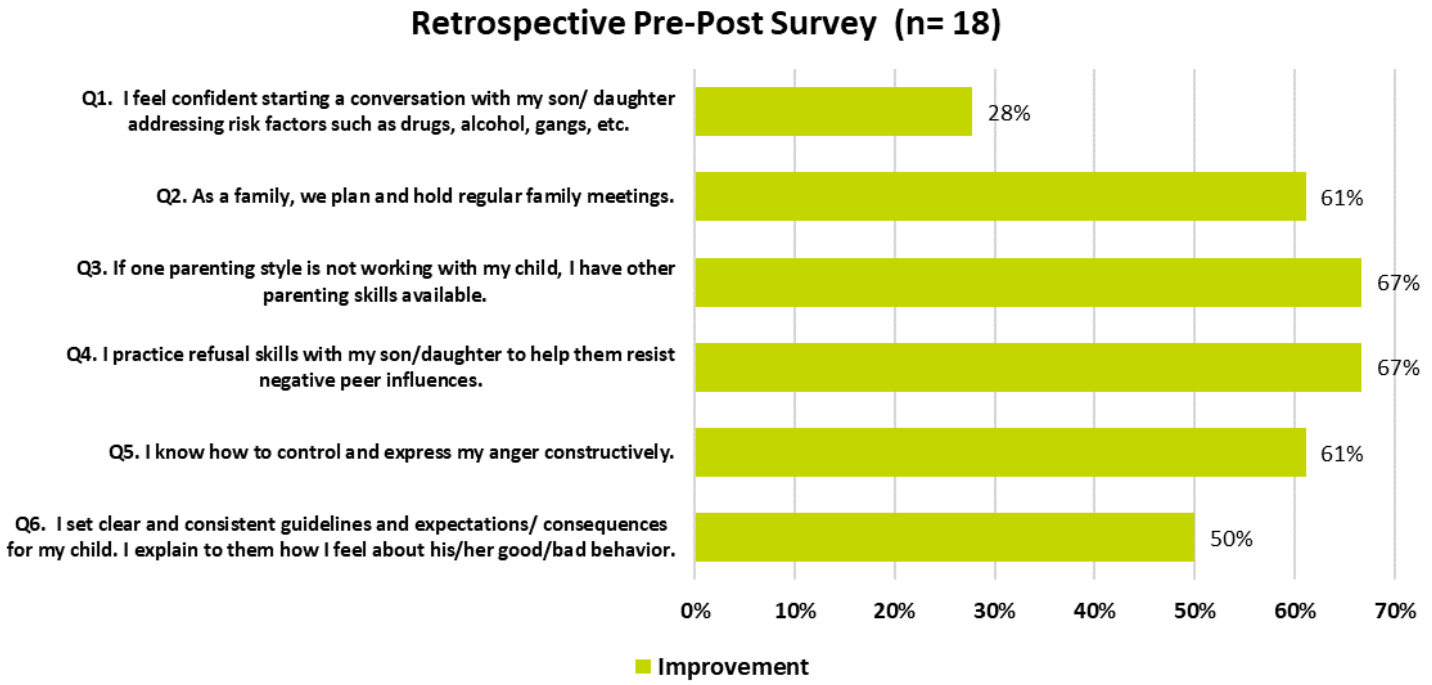
To demonstrate improvement in the six scales, the post means should be greater than the pre means for involvement, positive parenting, and other discipline practices. However, poor monitoring/supervision, inconsistent discipline, and corporal punishment, should exhibit lower post means than pre means to indicate that the parents do not agree with the "poor parenting" item questions from the APQ.

Overall, county results exhibited statistically significant differences in the following areas: parental involvement scale significantly improved, (t (20)= -3.250 , p< .05), inconsistent discipline significantly decreased, (t(20) = -3.485, p< 0.05) and corporal punishment significantly decreased, (t (20)= 3.068, p < 0.05).

		Involve-ment	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	36.38	21.75	22.13	14.38	5.75	16.75
	Post	38.63	25.38	18.13	13.88	5.25	16.75
Western	Pre	39.46	26.54	15.00	17.31	5.08	19.23
	Post	42.15	27.62	14.77	14.69	4.08	19.15

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.44	4.94	.058	Q4	3.33	4.50	<0.001
Q2	3.00	4.33	<0.001	Q5	3.28	4.17	<0.001
Q3	3.50	4.56	.002	Q6	3.83	4.44	.045

For the retrospective pre to post-survey, the parents in GGC answered six questions after the completion of the five-session program. Eighteen parents answered the questions by comparing their parenting skills at the end of the program to their parenting skills before GGC. Based on the results, parents increased the most (67% increase) in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Parents showed significant overall improvement (p <.05) after GGC regarding the following items: meeting regularly as a family, increasing parenting skills, practicing refusal skills, regulating emotions and setting clear/consistent expectations and consequences. To note, those parents that did not show improvement had scores that were high in the pre-assessment.

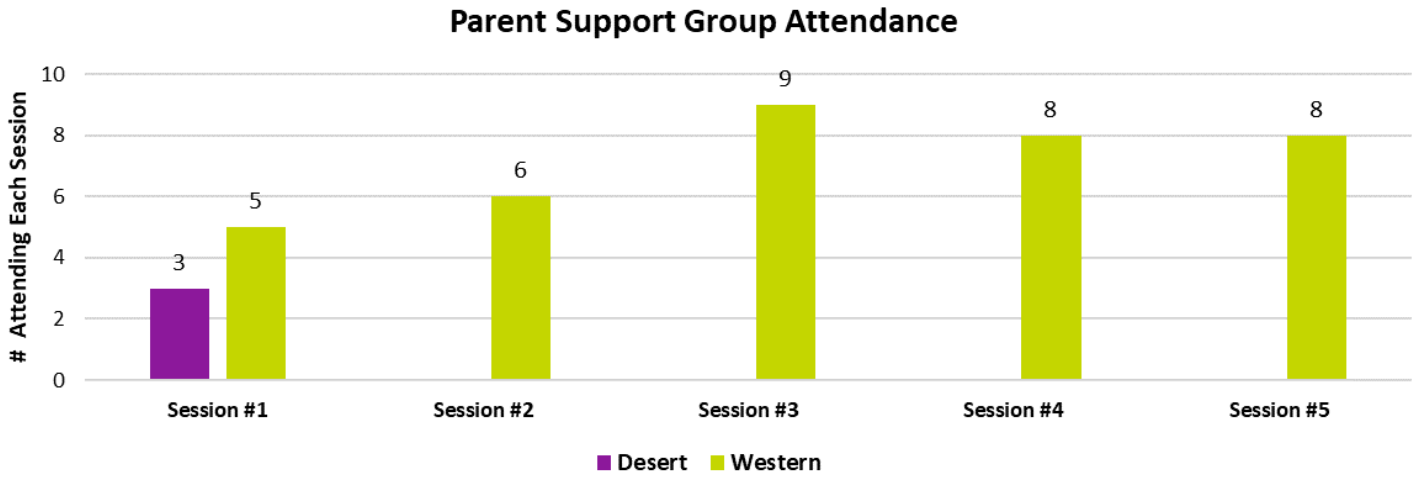
Satisfaction Survey

Item Description (Score range: 1– 5)	County-wide n= 19	Desert n=8	Western n=11
1. Overall, I am satisfied with the program.	4.9	4.9	4.9
2. The location of the program was convenient for me.	4.2	5.0	3.6
3. The sessions were at a time convenient for me and my family.	4.7	4.8	4.6
4. My family got the help we wanted for my child.	4.6	4.5	4.7
5. As a result of the program, I am satisfied with our family life right now.	4.7	4.6	4.8
6. I felt comfortable talking about my child's problems with the staff.	4.5	4.8	4.3
7. The facilitators listened to what I had to say.	4.9	4.9	4.9
8. Facilitators spoke to me in a way that I understood.	4.9	5.0	4.9
9. Facilitators are respectful of my cultural/ethnic background.	5.0	5.0	5.0

Things I learned in the GGC program are:
"Too much for these 2 lines! The importance of family meetings, involving my child in decisions, expressing my feelings about his behavior in a healthy manner, etc."
"How to set boundaries, also to stick to my guns, say what I mean and mean what I say."
"It's a program that has helped me to understand my sons on a different level of trying to understand them."
"How to communicate better with my child."
What I liked about the GGC program is:
"Hearing the experiences of other parents and how different topics and challenges can be addressed constructively."
"I was given tools to deal and take my child in different situations."
"The help and info from the other parents."
"The positive change with my child."
What I didn't like about the GGC program is:
"At times, there were hot topics where time did not allow a full conversation, though it was still a discussion."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a young teenage child. Topics discussed were about drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of B.R.A.A.F., parents were committed to keeping in touch with each other, and continue to provide support to each other when needed as they really felt like the additional support meetings have helped them become better parents overtime.

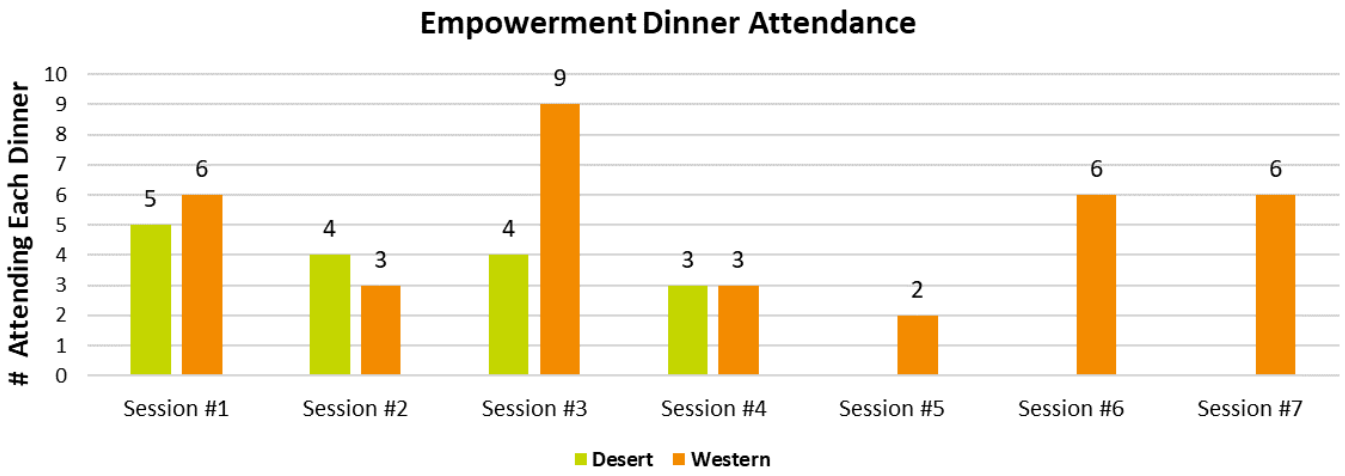


	Total Number of Sessions Hosted	Group Size Range
Desert	1 Session	1—3 People
Western	5 Sessions	1—9 People

No Parent Support Group Satisfaction Survey was conduct for Desert and Western regions at the end of the program. Refer to Parent Focus Group section for responses regarding PSG feedback.

Empowerment Dinner

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.



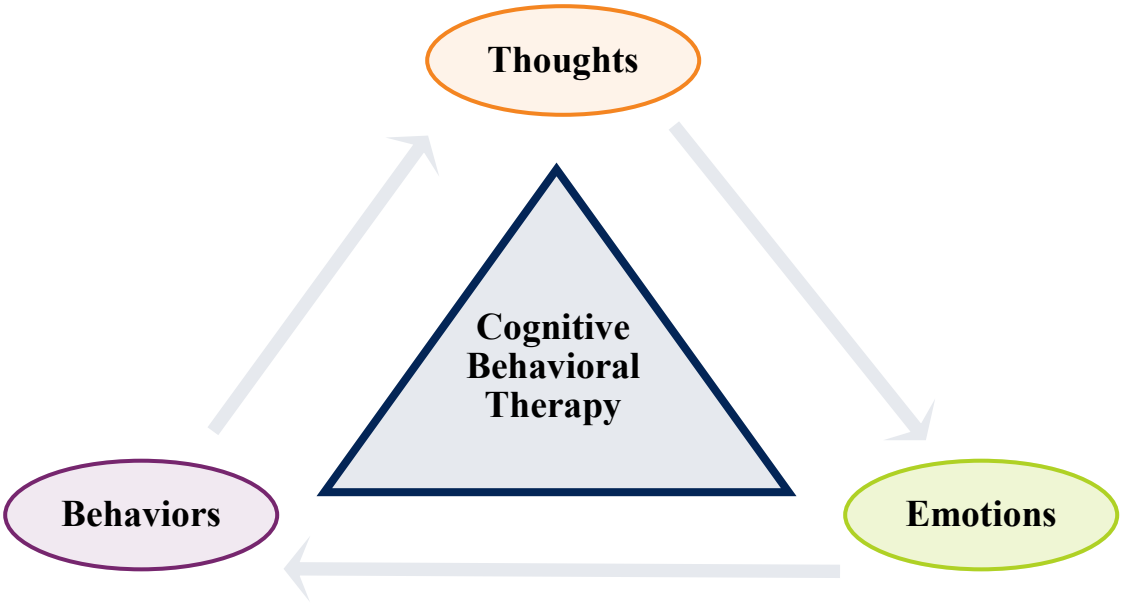
	Total Number of Sessions Hosted	Group Size Range
Desert	4 Session	1—5 People
Western	7 Sessions	1—9 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences. The youth may feel emotionally uncomfortable at times. The youth may cry, get upset, or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

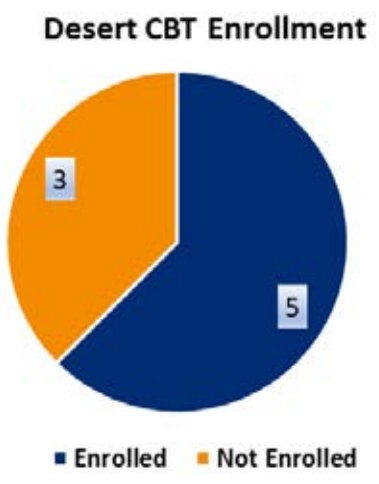
www.mayoclinic.com/cbt



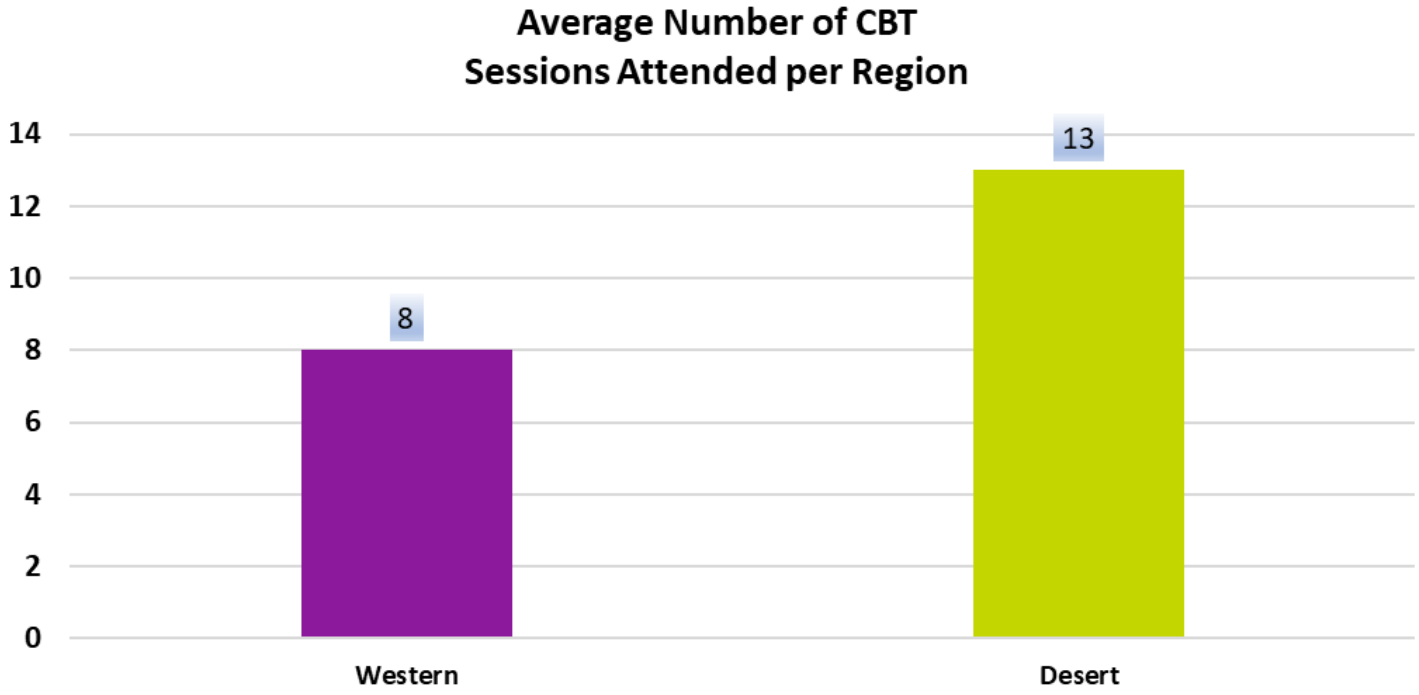
Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

CBT Enrollment



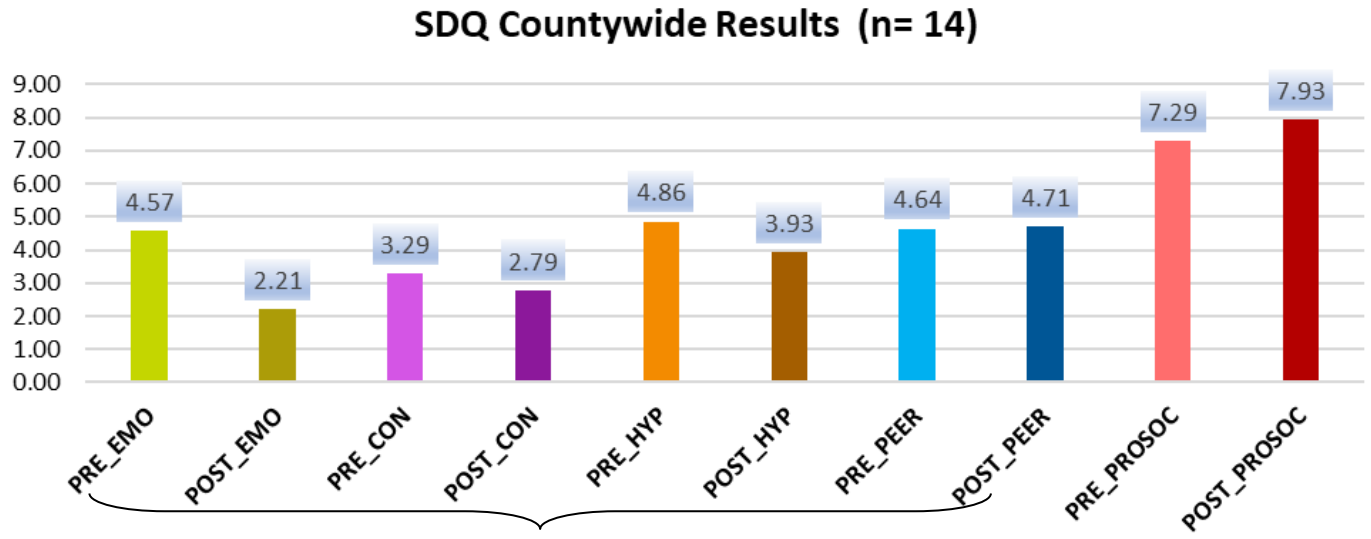




This fiscal year, CBT was offered as part of the B.R.A.A.F. program, and 16 youth received at least one session in CBT. The Desert region had 5 youth and Western region had 11 youth who received CBT sessions during the 22-23 fiscal year. On average, participants from Desert region attended 13 CBT therapy sessions and those from Western region attended 8 CBT sessions. These sessions were conducted in-person and via video-conferencing depending on the region and flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=17.36 , Post=13.64

The four behavioral subscales were expected to decrease in average sub-scores; whereas, the prosocial subscale was expected to increase. The total score slightly increased, this change from pre– to post– score was statistically significant, ($t(13)= 2.460$, $p > 0.05$), and can suggest the youth faced less difficulties after completing one-on-one CBT sessions. The participants exhibited a significant decrease in the following subscales: **emotional symptoms**, $t(13) = 0.002$, $p <0.05$).

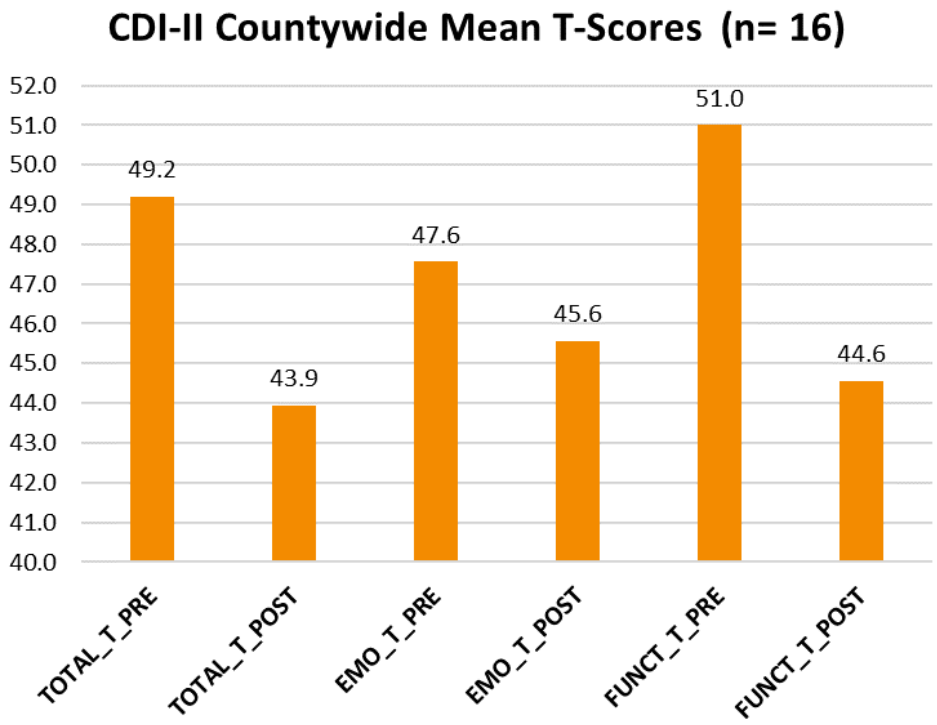
Although the results showed no statistically significant change from pre to post-measure, the decreases in conduct issues, hyperactivity/inattention, and peer relationship problems suggest a trend that could indicate the program's potential effectiveness and highlights the need for further exploration.

Children's Depression Inventory II

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches his personality. Higher scores (70 and above) suggest very elevated levels of depression for all subscales and the total score. Whereas, scores 65-69 are elevated, 60-64 are high average, 60- 64 are average, scores 59-40 are considered average and <40 are low. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



All participants were required to complete both pre and post-CDI-II. When comparing the pre and post-test total scores, there was a statistically significant decrease in Total Score and Emotional Problems (p<.05). The youth displayed a decrease in depressive symptoms; youth remained at the average range of severity of depression, according to the Children Depression Inventory (2nd edition) assessment.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	County-Wide n= 16	Desert n= 5	Western n= 11
1 The program taught me how to cope with stress.	3.31	4.00	3.00
2 The program helped me to understand myself better.	3.38	4.40	2.91
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	3.44	4.60	2.91
4 I achieved my goals for the group.	3.44	4.20	3.09
5 The facilitator listened to what I had to say.	4.38	4.80	4.18
6 The facilitator knew how to help me.	3.69	4.60	3.27

Things I learned in the program are:
"How to react in touch situations, how to talk to people and code switching."
"I learned about my ancestors and how some of them helped us and rest wasn't beneficial because I already knew most of it."
"To turn a negative to positive."
What I liked about the program is:
"Getting to tell my thoughts and feelings."
"How to facilitator took care of me."
"That someone other than my family would check up on me."
What I didn't like about the program is:
"I had to write a lot."

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last one to two hours and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in B.R.A.A.F., as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and a scribe recording comments.

The following youth focus groups were conducted from Western and Desert regions. The parent focus groups were conducted from Desert region. The focus groups were conducted in-person.

Youth Focus Groups

Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has helped you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in B.R.A.A.F. that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions.



Youth expressed positive changes in themselves and their family:

- The program helped with "my uncles death, and they got me to talked the *Mamas* and *Babas*, it helped me with it. The principle that helped me was Imani [one of the seven principles of Kwanzaa]."
- "I'm more confident in myself."
- The program helped me "be more concentrated and motivated."
- "...being more respectful"
- "One thing that was difficult for me was with my parents. *Mama* [staff] helped me with what I need to do."
- "A difficulty that I have is anger issues, but during the program, the staff helped me maintain my composure."
- "A difficult in school was learning, during the program, I talked to [staff] about it and they helped me try new stuff."
- "I used self-determination to help me reach confidence"
- " It taught me how to do it and without being told, so I started to do chores at home without being told."
- "I have stress about home, so [staff] helped me with tools to help with that."
- "My parents don't yell all the time as much."
- "My parents are more calm and start asking things in a different way."
- … "to cherish my parents."
- … "being more calm and not acting all the time."

Youth explained changes and additional comment about the BRAAF program:

- "Code-switching, means to act different around different people, doing things that would follow certain types of people."
- I liked "the retreat, everything, the activities, the ridings,"
- I liked "how we act in the program and in the retreats."
- "*Momma* [staff], she's nice."
- I disliked "the trust, they don't leave us alone, there's always some one watching the room."
- "First day of program, I did not like it, now I am excited to come to program."
- "The start of program, I looked at things at a different perspective then now."
- I dislike the program because "it felt like doing a 7th class."
- I disliked the program because "it was a lot of work."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this B.R.A.A.F. program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *What did you gain from Unity Day? Are there any areas we need improvement to meet your expectations for Unity Day?*

6. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

The youth and parent questions did not have correct and incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions by the same facilitator to reduce moderator bias.



Changes parents saw in their children after going through the program:

Many parents noted their sons changed their behavior and self-expression.

- "I've see changing with myself and my son, better communication, my boys are more out spoken, the things that they say to me, they say in a more respectful matter. Throughout the program, they've learned to speak to someone that is older than them. And little more teamwork with themselves."
- Last year was very tough, now I have seen a growth… he explains to me about what he needs from me to be more social. I've notice he has boundaries and respecting those. After identifying what we need from each other, it turned out pretty ok so far. Definitely communication has improved from since we've started the program."
- .."confidence, before he would hate people looking at him, public speaking during activities, proud to see him in front of stranger."
- "[Youth] surprised me, he got on a horse. At camp, he was able explore something new with positive peer pressure with the *Bobbas* and *Mommas* and other kids but he did it. I was proud of him for doing that."
- "My son enjoyed the program, had a good time, enjoyed the staff and enjoyed his peers, glad he was able to attend this year."

Value and benefit from parent support groups and GGC:

Parents report a sense of camaraderie and mutual benefit from the support groups.

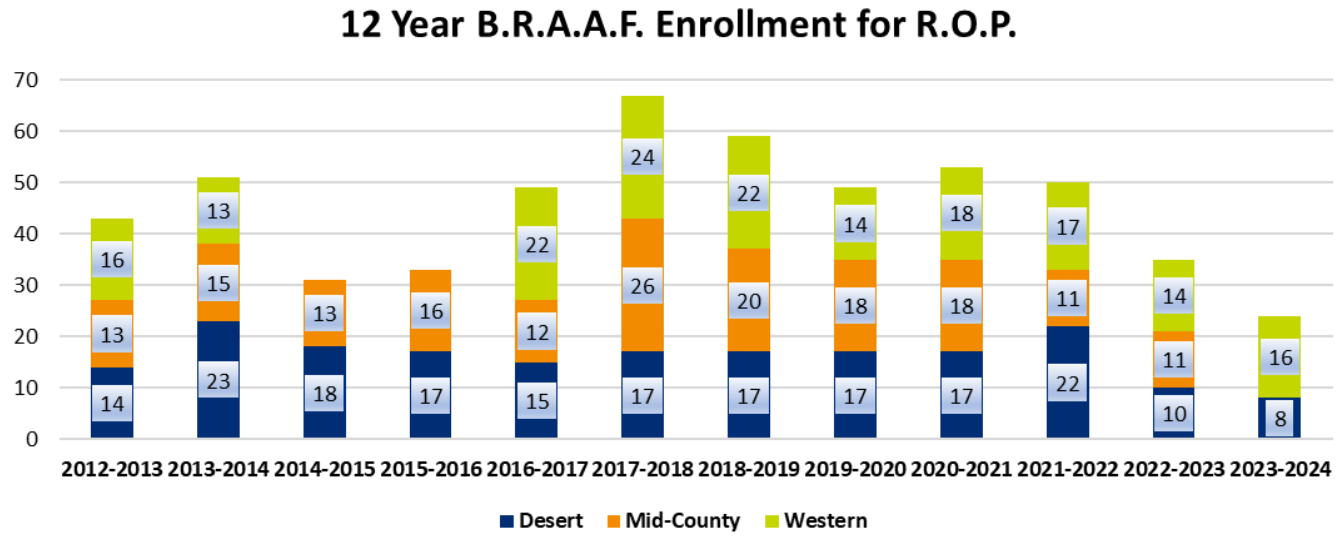
- I learned with the classes and clinicians and learned to set expectations with the boys, I know now that I need to teach them how to do things. This is what I want you to do, this is how I want you to do it, this is the time frame that I want you to do it. Also learned how to set them."
- "I have more patience, when I listen to him, and getting him to understand my point of view. We are getting better."
- Aware in how I react with my son, and better communicate with how things can go differently.
- "How to communicate with my grandson more and not to be judgmental."

Other feedback parents shared either negative or positive:

- "I wanted to see that I could get order in the house and set rules/consequences and how talk to my son better, and control myself and how I treat my son and see his perspective."
- I loved it and that we celebrate these children [on Unity Day] and how we can get together and not have any issues and have a good time. And that's what we need more in the community and wish it was long-er and more activities going on.
- During Unity Day, "I liked the games they had for the boys and it was really nice, would like to see more activities for the parents.
- I "would like parents to show up to support groups."
- "The driving hours to the program was an issue."
- " I was told that it was going to be more of a male presence, like a father-brother type, there was really no males in the program, mostly women who still did great though."
- "Be more aware of dates, and schooling different school districts."
- "The communication was off and in the beginning it was not explained much so in the beginning. No list of what is going on through the year."

Conclusion

RUHS-BH PEI is funded through the Mental Health Services Act (MHSA) to provide B.R.A.A.F. throughout Riverside County. B.R.A.A.F. was offered in the Desert and Western region during FY23/24. Sigma Beta Xi was the Western region organization and Family Health & Support Network was the Desert region organization. Program target is 3 boys programs (one per region) with 45 youth completing per year countywide. Below is the enrollment of African American youth who have enrolled and completed B.R.A.A.F. Rites of Passage program over multiple fiscal years:



B.R.A.A.F. changed parenting program curriculum over the course of several fiscal years shifting from Effective Black Parenting (EBP) to Guiding Good Choices (GGC). The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. A total of 19 parents were served in GGC this fiscal year. Below is the enrollment break-down of previous fiscal years for parenting classes:

Parenting Program											
EBP	EBP	EBP	EBP	GGC	GGC	GGC	GGC	GGC	GGC	GGC	GGC
2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
N = 52	N = 41	N = 31	N = 28	N = 66	N = 47	N = 58	N = 45	N = 44	N =55	N= 32	N= 19

B.R.A.A.F. included Parent Support Groups following GGC. Parents had the opportunity to continue meeting with a clinician and other parents from B.R.A.A.F. to talk about parenting styles and general support. All parents were encouraged to attend and share their questions and concerns.

Cognitive Behavioral Therapy has always been a component of B.R.A.A.F. Below is the distribution of enrollment from previous years:

CBT Enrollment											
2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
N = 19	N = 19	N = 0	N = 0	N = 13	N = 23	N = 17	N = 26	N = 28	N= 36	N= 11	N= 16

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. GIRLS Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is BRAAF?

Building Resilience in African American Families project (BRAAF) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American female youth and their parents/guardians that live in communities with high rates of poverty and community violence. The BRAAF Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American females between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Executive Summary: Key Findings

Rites of Passage (ROP): Sixteen youth between the ages of 11 and 14 enrolled in the B.R.A.A.F. program during the 2023-2024 fiscal year. Of the 16 youth, 12 completed the B.R.A.A.F. program. The completion goal was 15. Program target is 3 girls programs (one per region) with 45 youth completing per year countywide. This fiscal year the girls program was only available in the Desert region, approximately 96 sessions were conducted, with most attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that youth had average to very good grades before the program, and these positive academic results were maintained by the program's conclusion.

Resilience measures were completed by 12 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 1.2, $p = 0.758$) or "sense of relatedness" (mean difference of 1.0, $p = 0.779$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight increase, indicating that participants ($n = 12$) continued to demonstrate high levels of identity centrality. Additionally, there was no statistically significant difference in scores on the Cohesion subscale from pre- to post-assessment ($t(11) = -1.960$, $p = 0.076$), with scores consistently remaining within the 'separated to connected' range on the subscale. Overall, the average satisfaction score for the youth was 4.2, indicating they were satisfied at the conclusion of the program.

Guiding Good Choices (GGC): A total of 19 parents participated in at least one session of GGC, and 7 parents (37%) completed the five-session parenting course during the 2023-2024 fiscal year. The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The APQ is a 42-item self-reported measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The results showed a statistically significant decrease in *corporal punishment* and in *other disciplinary practices*, suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre- to post-assessment. Overall, the parents reported high satisfaction, with an average score of 4.71 after GGC.

Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents from support group sessions.

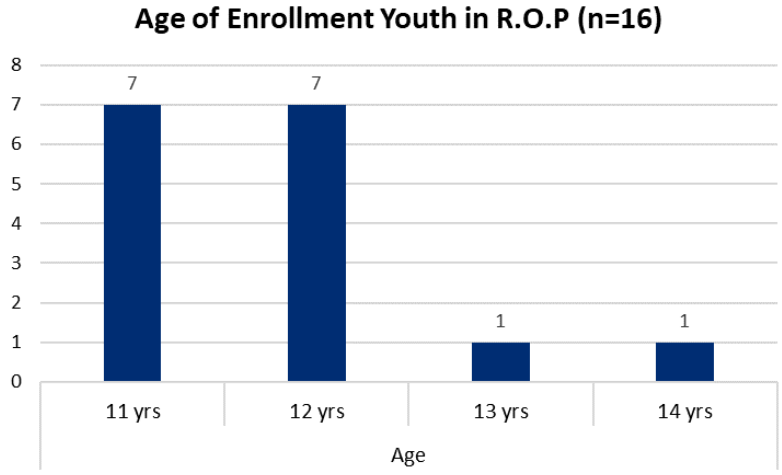
Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted five dinners throughout the program.

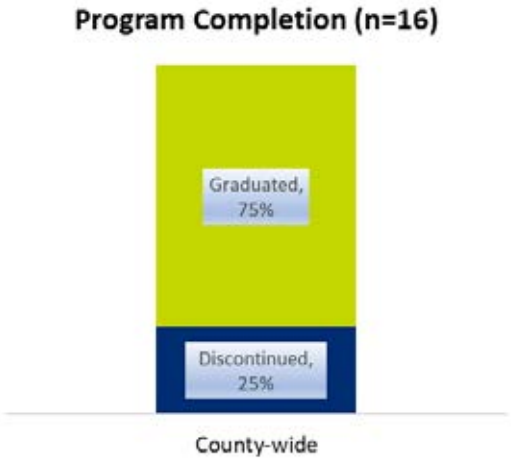
Cognitive Behavioral Therapy (CBT): This fiscal year, CBT was offered as part of B.R.A.A.F., serving 12 youth. These sessions were conducted in person and via video conferencing, depending on the flexibility of the clinician and youth. CBT effectiveness was measured with the Strengths and Difficulties Questionnaire (SDQ) and Children's Depression Inventory-II (CDI-II). Higher scores in the SDQ's four behavioral subscales and total score suggest higher risks of mental health disorders.

Twelve parents of youth served in CBT completed the pre- and post-SDQ survey for their youth. The results indicate a statistically significant change in emotional symptoms, suggesting that the youth improved their behavior even after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in peer relationships. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

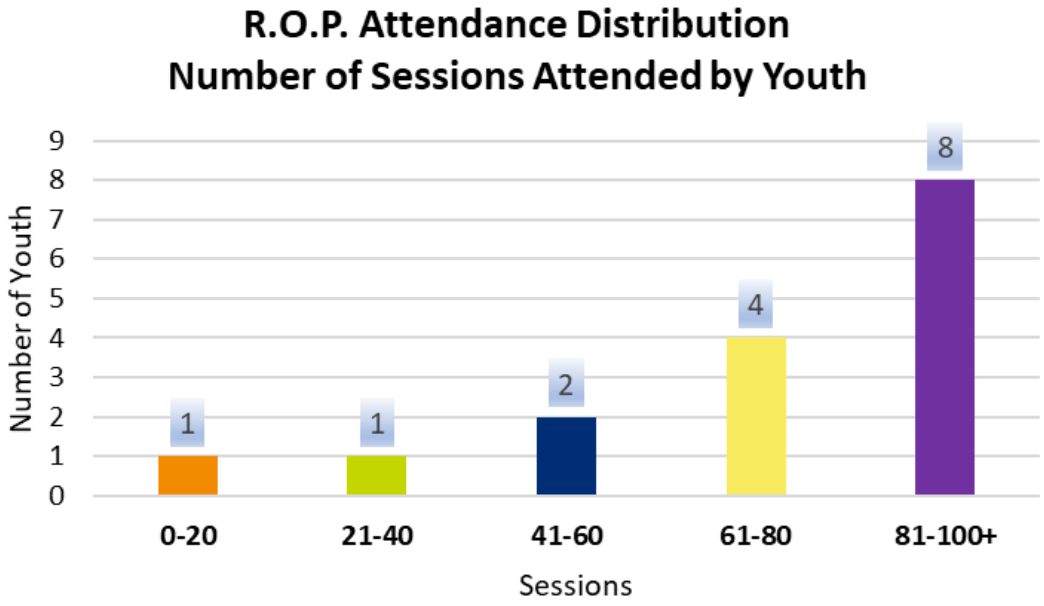
Overall, the average satisfaction score for the youth was 4.25, indicating they were satisfied at the conclusion of CBT.

Program Enrollment





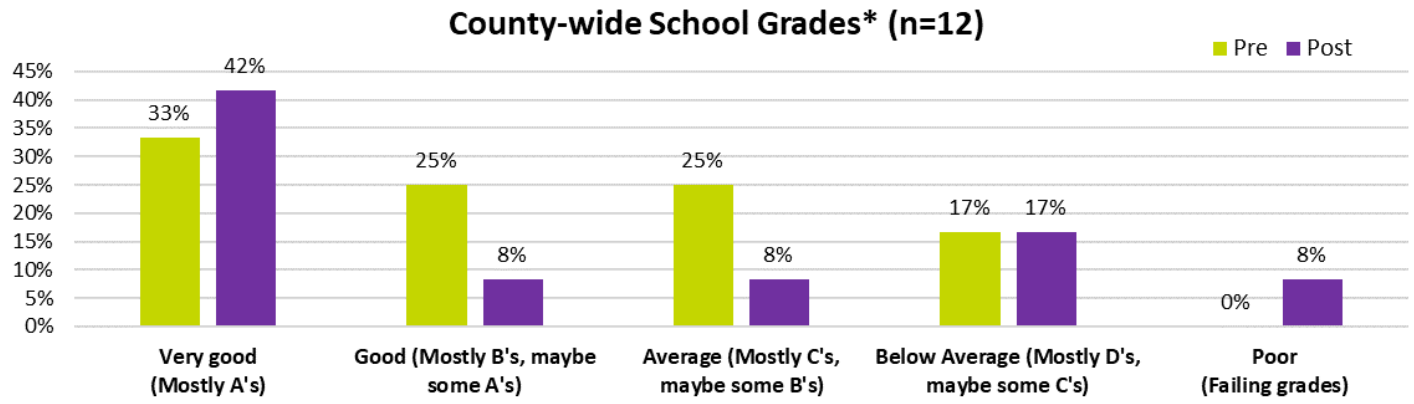
During the 2023-2024 fiscal year, a total of 16 participants aged 11 to 14 engaged in at least one session of the program. Of this group, 12 successfully completed the program. Unfortunately, the reasons for the non-completion were not provided. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.



The chart above illustrates the distribution of youth participants who attended various sessions throughout the 9-month program. The target number of session is 108 per year/per program/per region. To note, those who dropped out attended fewer than half of the total sessions offered.

School Information

Countywide Results*	Pre			Post		
	Yes	No	Not Provided	Yes	No	Not Provided
In the last 3 months, has the youth had a sudden drop in school performance?	33%	50%	17%	17%	75%	8%
Has the youth ever been suspended?	0%	100%	0%	3%	75%	0%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	0%	100%	0%
In the past year, has the youth been: on probation?	0%	100%	0%	0%	92%	8%
In the past year, has the youth been in any programs to help them with emotional problems?	8%	92%	0%	8%	92%	0%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	0%	100%	0%	8%	92%	0%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	92%	8%	8%	83%	8%
Is the youth affiliated with a gang?	0%	100%	0%	0%	100%	0%

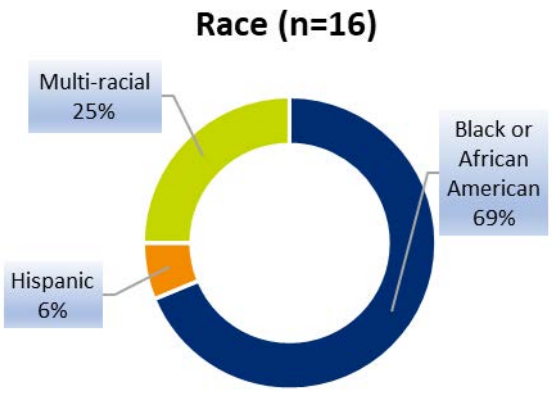


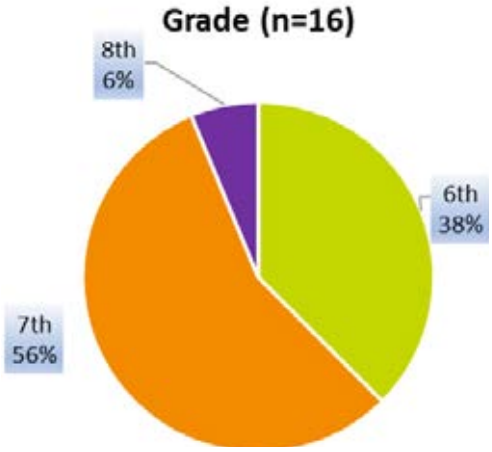
**Regarding school performance, it's important to mention that some items from the youth forms were missing. As a result, the averages calculated for each question were based on data from 12 participants who completed both the ROP Intake Form (pre) and the Program Completion/Discontinued Form (post) for school information.*

Questionnaire Results:
Before the B.R.A.A.F. program (ROP), 33% of parents reported a sudden decline in their daughters' school performance. After the program, this figure decreased to 17%, indicating a positive change. Most responses were consistently "no" to questions regarding suspension, arrest, probation, drug use, and gang affiliation throughout the program.

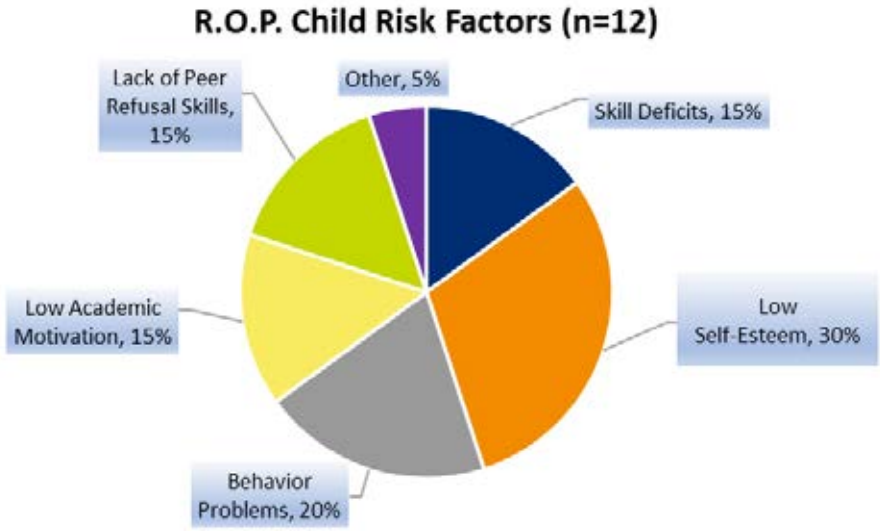
Academic Performance:
The School Performance Chart indicates that youth had average to very good grades before the program, and these positive academic results were maintained throughout the 23-24 fiscal year.

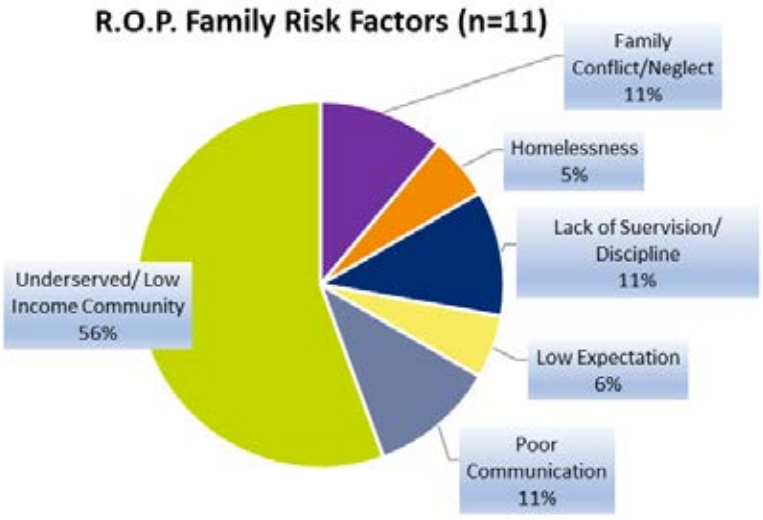
Demographics





It is important to note that 16 youth enrolled, and have attended at least one session. The target enrollment was 25-30 youth.

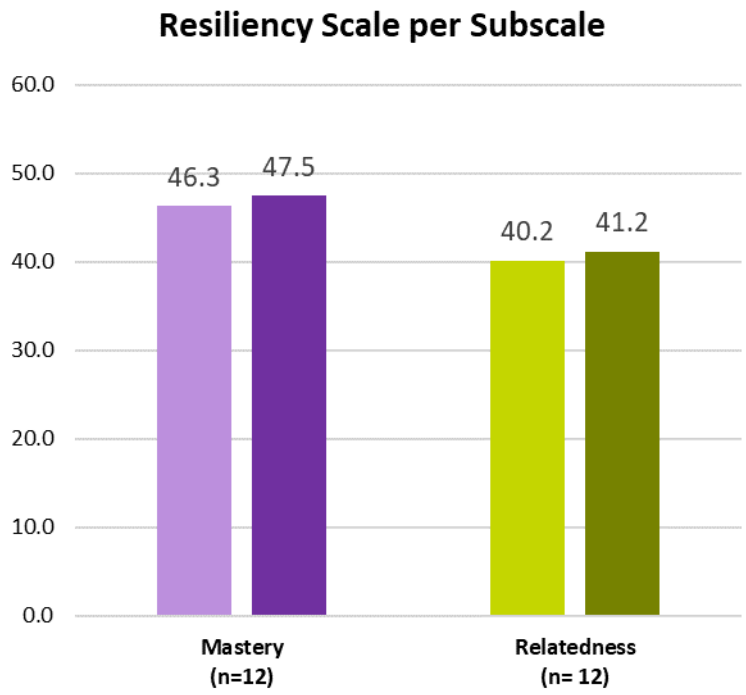




Risk factors are based upon parents/ caretakers that have provided at least one or more responses on the *Family and Child Risk Factors* on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.



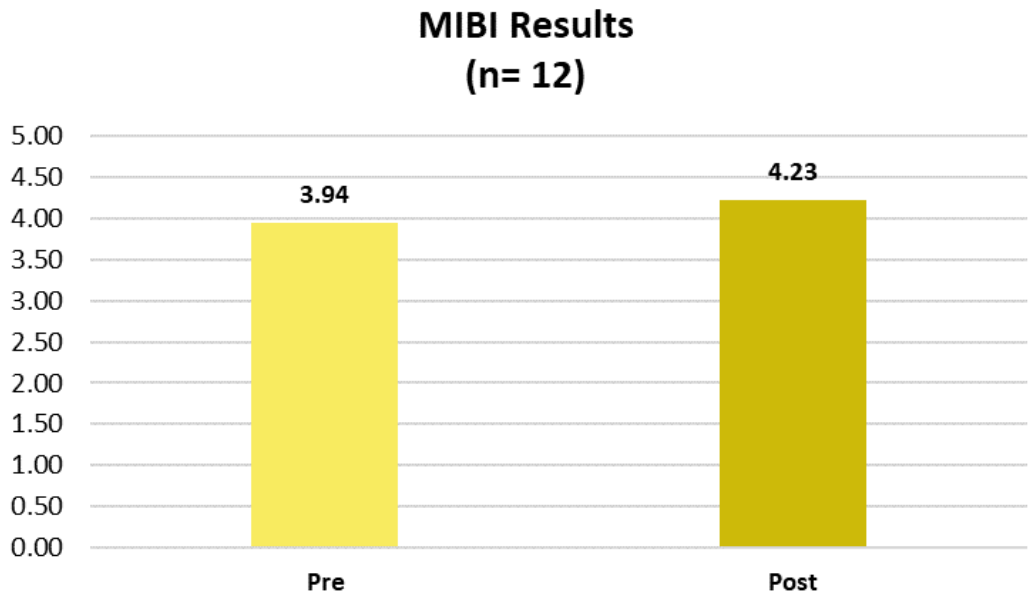
The analysis included 12 participants from the Desert region who completed both the pre- and post-measures of the Resiliency Survey.

Sense of Mastery Scale: The scores on the Sense of Mastery scale increased with a mean difference of 1.2 points. However, this increase was not found to be statistically significant based on the t-test ($t(11) = -0.316$) with a p-value of 0.758. This suggests that there was no significant improvement in participants' Sense of Mastery from pre-measure to post-measure; rather, participants maintained an average ability to cope with adverse circumstances.

Sense of Relatedness Subscale: The Sense of Relatedness subscale showed an increase of 1.0 point, but this change was also not found to be statistically significant ($t(11) = -0.288$, p-value = 0.779, $p < 0.05$). This indicates that there was no statistically significant change in participants' sense of relatedness from pre-measure to post-measure. The scores suggest that participants have a below-average sense of relatedness with others.

The Multidimensional Inventory of Black Identity

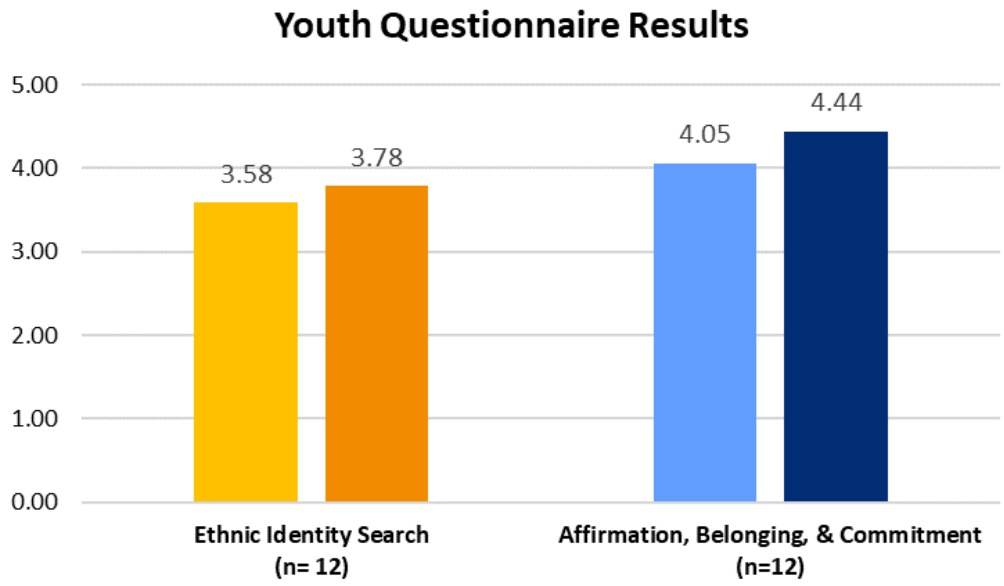
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of herself. The highest possible average one can score on Centrality is 5.



The Desert region administered the Teen MIBI measure, consisting of 9 items. The total scores averaged 3.94 at the pre-program assessment and 4.23 post-program. However, this change was not found to be statistically significant ($t(10) = -1.738$, $p = 0.113$, $p > 0.05$). In general, participants' scores hovered around 4, indicating a relatively high level of centrality placed on their Black/African American identity.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.



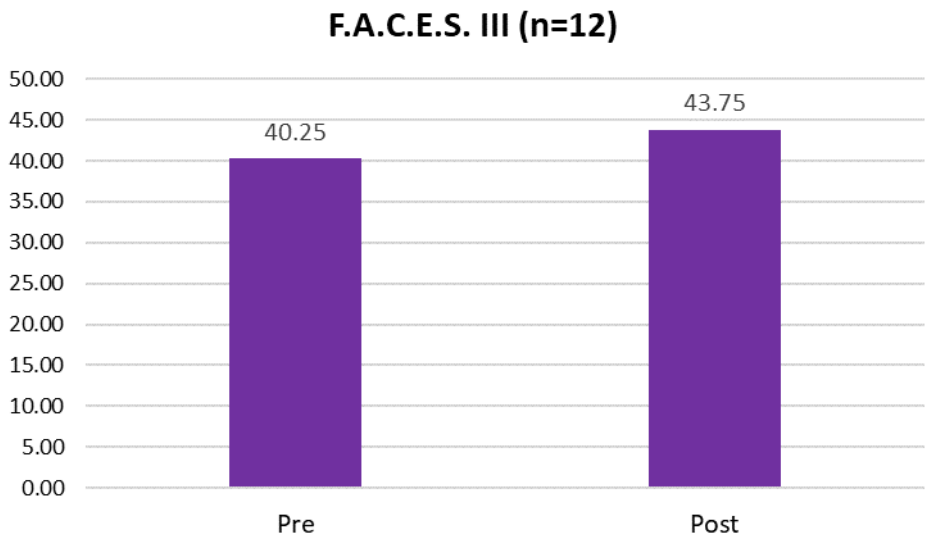
The Desert region showed a slight increase in the Ethnic Identity Search scale of the MEIM measure, with scores rising from 3.58 in the pre-test to 3.78 in the post-test. However, this change did not reach statistical significance ($t(11) = -0.957$, $p = 0.359$).

In contrast, there was an improvement in Affirmation, Belonging, and Commitment. Countywide, participants' scores increased from 4.05 in the pre-test to 4.44 in the post-test ($t(11) = -2.146$, $p = 0.055$). It's worth noting that scores in this subscale were already relatively high at the beginning of the program and remained positive at the conclusion. These findings suggest that youth continued to hold a strong view of their ethnic identity throughout their participation in ROP.

It's important to acknowledge that the sample sizes were limited to participants from the Desert region.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



There was no statistically significant difference in scores on the Cohesion subscale from pre to post (t(11) = -1.960, p = 0.076). Nonetheless, it's worth noting that there was a modest increase in scores from the pre-assessment (40.25) to the post-assessment (43.75).

On average, the scores consistently stayed within the 'separated to connected' range on the subscale, showing slight improvements with no statistical significance.

Youth Satisfaction

Towards the end of the program, 12 youth who completed ROP submitted a satisfaction survey. Overall, youth who completed the satisfaction survey agreed or strongly agreed that participating in the program was a positive experience.

Item Description (Score range: 1—5)	Countywide (N=12)
1 Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	4.33
2 Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.92
3 Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.50
4 Participating in this program has been a positive experience for me.	4.25
5 Participating in this program has changed how I think about myself in a positive way.	4.50
6 Please rate your satisfaction with how staff, presented the program information in a way I understood.	4.25
7 Rites of Passage staff presented the program information in a way I understood.	4.50
8 Rites of Passage staff presented the program information in a fun way.	4.42
How this program may have affected participants:	
"It made me more confident in myself and my race."	
"I changed me because I used to hate being black and now I'm not."	
"I used to think negative of myself, now I think positive."	
What participants liked about the program:	
"What I did like about the program was the bonding having fun."	
"Everything activities, spending time with different people."	
"When I learned how to set boundaries."	
What participants did not like about the program:	
"Really nothing because the program was great."	

Parent/Caregiver Satisfaction

Overall, 96% of parents were satisfied with the program. Moreover, every single parent indicated their satisfaction with the program's philosophy and approach

	Item Description (Score range:1 - 4)	Desert N=11
1	The program's ability to assist your child with eliminating the problems that prompted enrollment into the program...	3.82
2	Your child's progress/accomplishments/achievements while in the program...	3.82
3	The philosophy and approach of the program...	3.91
4	Opportunities for parents to meet together for support and share information...	4.00
5	Overall Satisfaction...	3.82

What has been most helpful to you and your child?
"The parts of the program that have been most helpful is interactions with my child and communication. We have learned to better communicate and articulate our thoughts and feelings openly without misunderstanding."
"The family group sessions together. I can see that my daughter like/enjoyed the time we spent together while at BRAAF wit the other families."
"Learning about our black history. Gaining confidence and better communication skills. Also new experiences."
What changes can you suggest?
"More counselors."
"To keep the program, families need it parent, and need to know truth about their kids' feelings."
Is there anything else you want us to know?
"Very satisfied with program and all in charge running it. No issues."
"I'm so grateful to have been apart of the BRAAF family. Thankful for how much help I've been giving and proud of the work yall have done and on my daughter. I am very appreciative."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

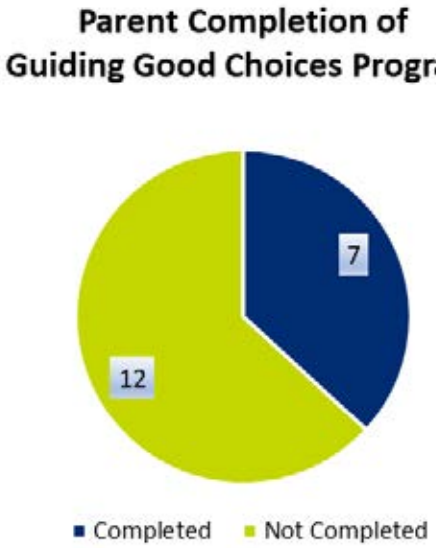
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks in the month of September. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: How to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

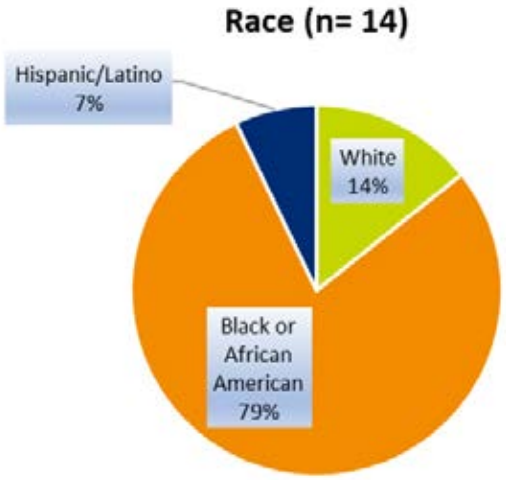
GGC Program Completion

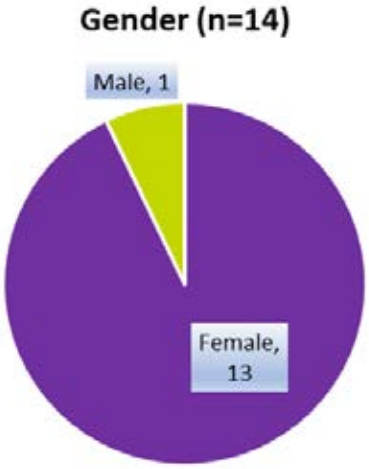
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

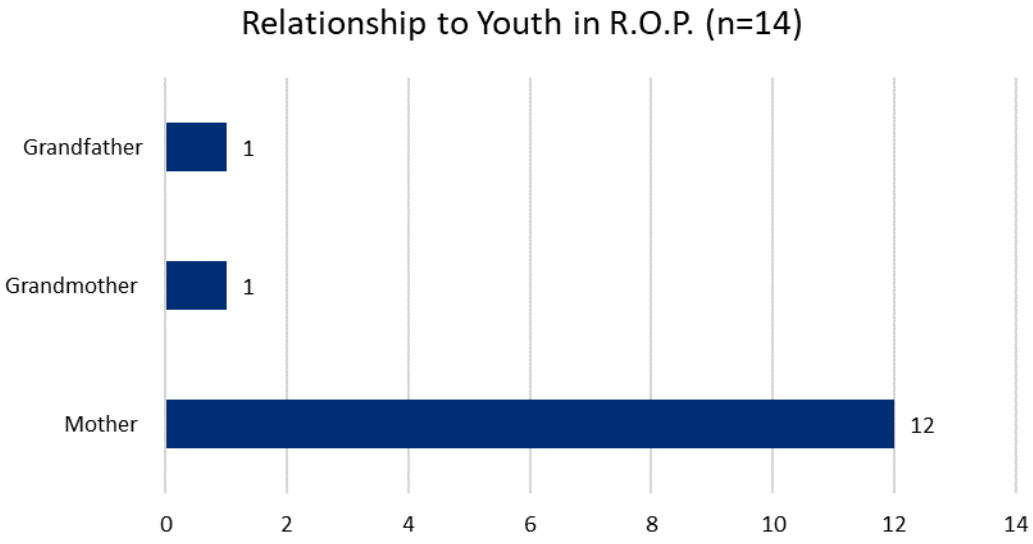


19 parents attended at least one session of GGC and 7 parents (37% of the cohort) completed the program in 2023-2024 FY.

GGC Demographics

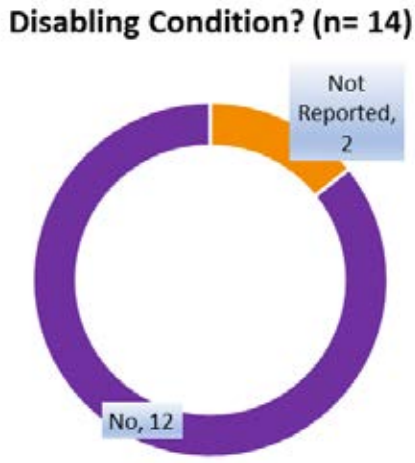


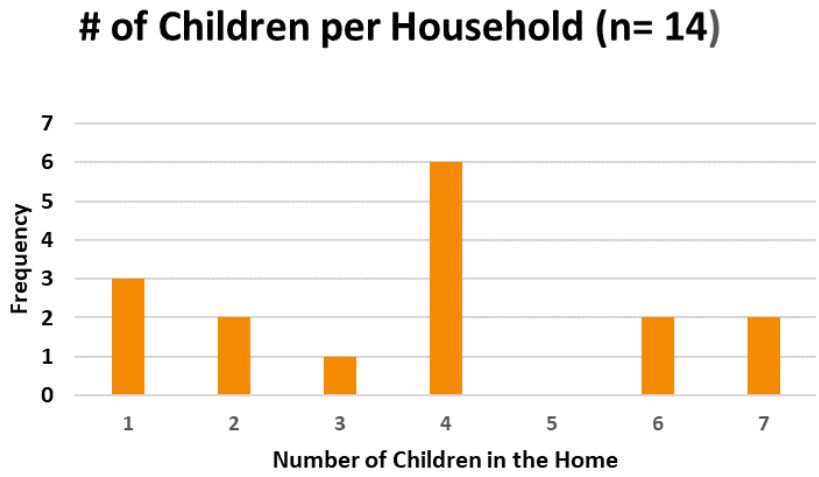


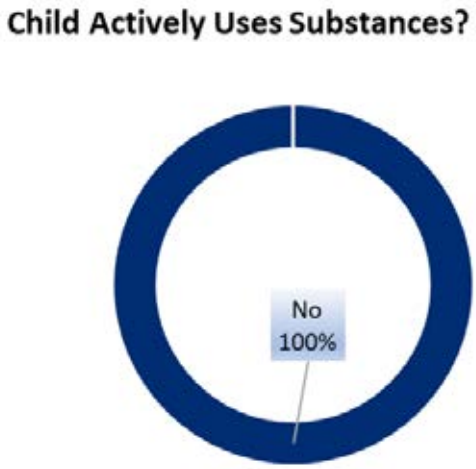


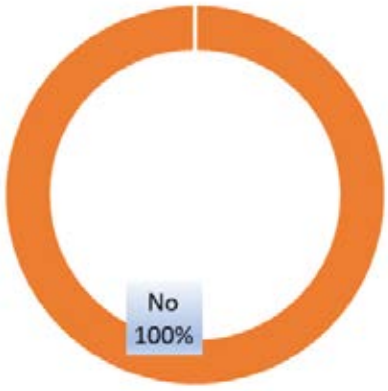
The charts above are representative of 14 parents who completed GGC Demographic form prior to the 5-week program. Based on the self-reported data, 79% of the participants identified as African American, 7% as Hispanic, and 14% as White . The gender distribution showed a ratio of approximately 1 male to 13 female. Among the GGC cohort, mothers constituted the largest group (n=12), followed by grandparents (n=2).

GGC Demographics Cont.







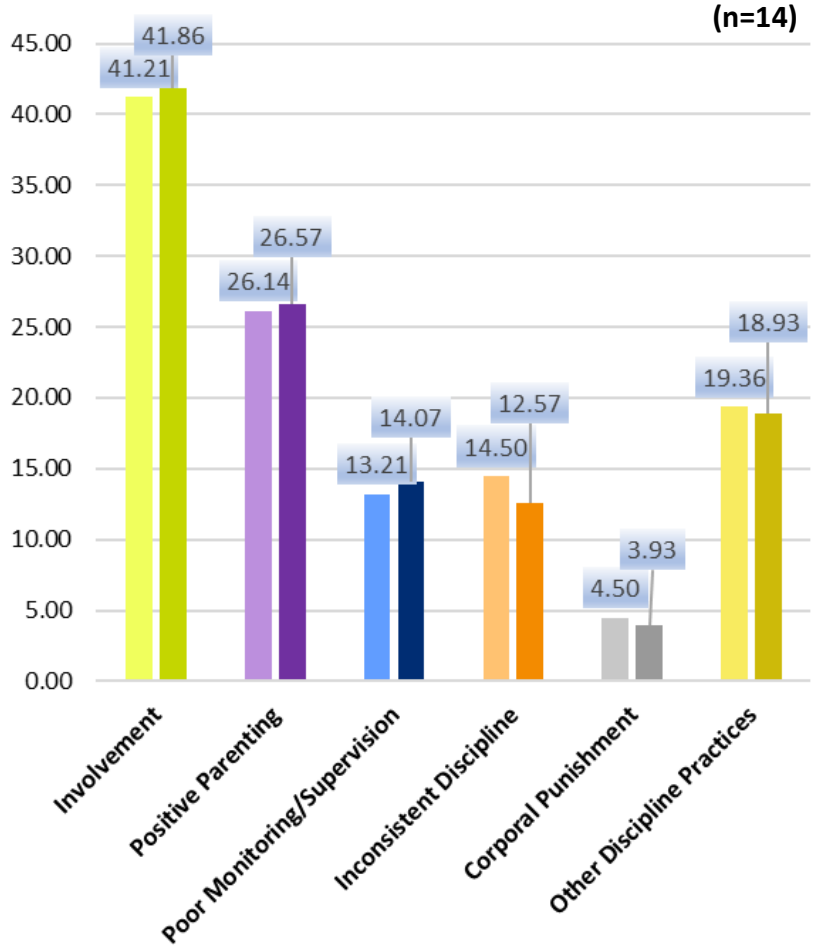


The majority of respondents answered 'no' (85%), while 15% did not provide a response. Notably, all children were reported by their parents as not actively using substances. Among the 14 enrolled parents who shared the number of children in their households, the average reported was four children per household.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=14)



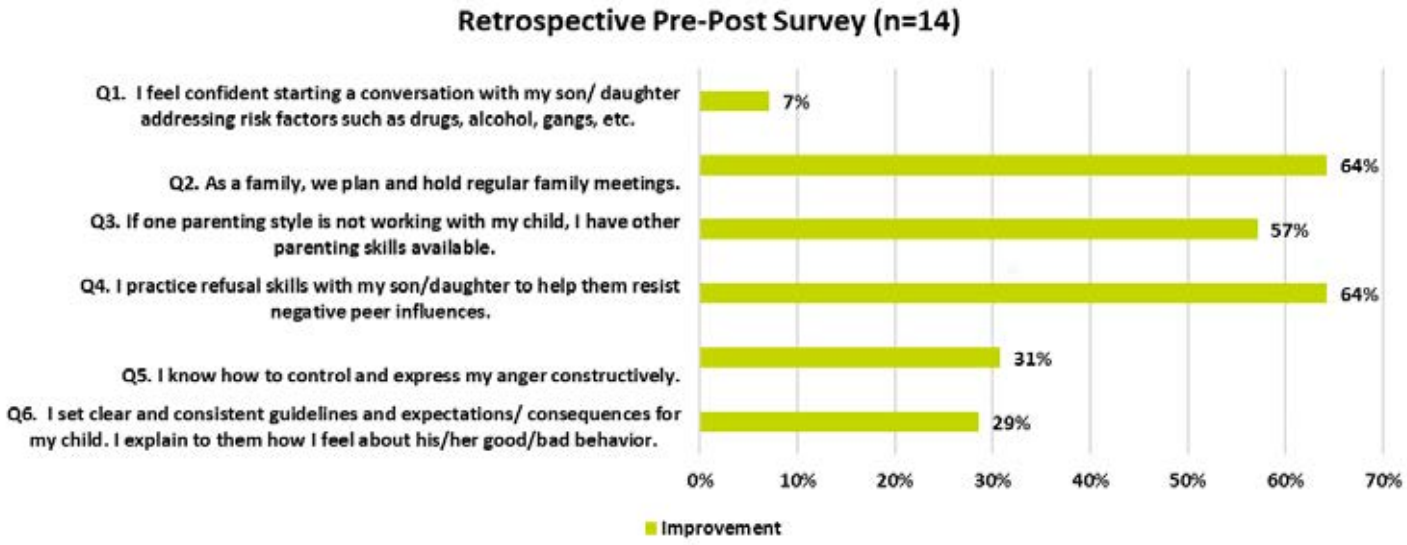
Fourteen parents/caregivers completed a pre and post APQ. To demonstrate improvement across the six scales, post-assessment scores for **involvement, positive parenting, and other discipline practices** should be higher than the pre-assessment scores, indicating improvements in these positive parenting behaviors. However, **poor monitoring/supervision, inconsistent discipline, and corporal punishment**, would reflect a decrease in agreement with the "poor parenting" items, signaling better parenting practices.

The results showed a **statistically significant decrease** in corporal punishment (t(14) =.591, p= .026) and in other **discipline practices** (t(14) =.607, p=0.021), suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre– to post-assessment. These findings suggest that parents have altered their disciplinary methods, as reflected in the decrease in corporal punishment.

		Involvement	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	41.21	26.14	13.21	14.50	4.50	19.36
	Post	41.86	26.57	14.07	12.57	3.93	18.93

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.86	4.79	p>0.05	Q4	3.00	4.36	p<0.05
Q2	3.07	4.21	p<0.05	Q5	3.46	3.69	p>0.05
Q3	3.64	4.36	p>0.05	Q6	3.93	4.43	p>0.05

For the retrospective pre-to-post survey, parents in the GGC responded to a series of six questions following the completion of the five-session program. Fourteen parents assessed the changes in their parenting skills, comparing their abilities at the program's conclusion to those before joining GGC.

Based on the results, parents increased the most (64% increase) in the adjustments towards parenting practices. Parents showed significant overall improvement after GGC regarding the following items: meeting regularly as a family and setting refusal skills with their child. It's worth noting that parents who did not experience improvement initially had high scores in the pre-assessment.

Satisfaction Survey

Item Description (Score range:1 - 5)	Countywide N=14
1. Overall, I am satisfied with the program.	4.71
2. The location of the program was convenient for me.	4.79
3. The sessions were at a time convenient for me and my family.	4.79
4. My family got the help we wanted for my child.	4.43
5. As a result of the program, I am satisfied with our family life right now.	4.50
6. I felt comfortable talking about my child's program with the staff.	4.86
7. The facilitators listened to what I had to say.	4.92
8. The facilitators spoke to me in a way that I understood.	5.00
9. The facilitators are respectful of me and my cultural/ethnic background	4.94

Things I learned in the GGC program are:
"To let her have more of a voice."
"How to better open/start conversations in different ways."
"How to communicate, efficiently with children."
What I liked about the GGC program is:
"Being able to come together as adults and learning new skills. See different perspective."
"The community coming together to help raise our children in a better manner and on to the right path."
"Opened eyes to more parenting styles, more family meeting ideas."
What I didn't like about the GGC program is:
"The drive, transportation difficulties."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a teenage child. Topics discussed included drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of BRAAF, parents had a strong bond together and many plan to continue meeting with their support group.

	Total Number of Sessions Hosted	Group Size Range
Desert	3 Sessions	6-8 People

Empowerment Dinners

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.

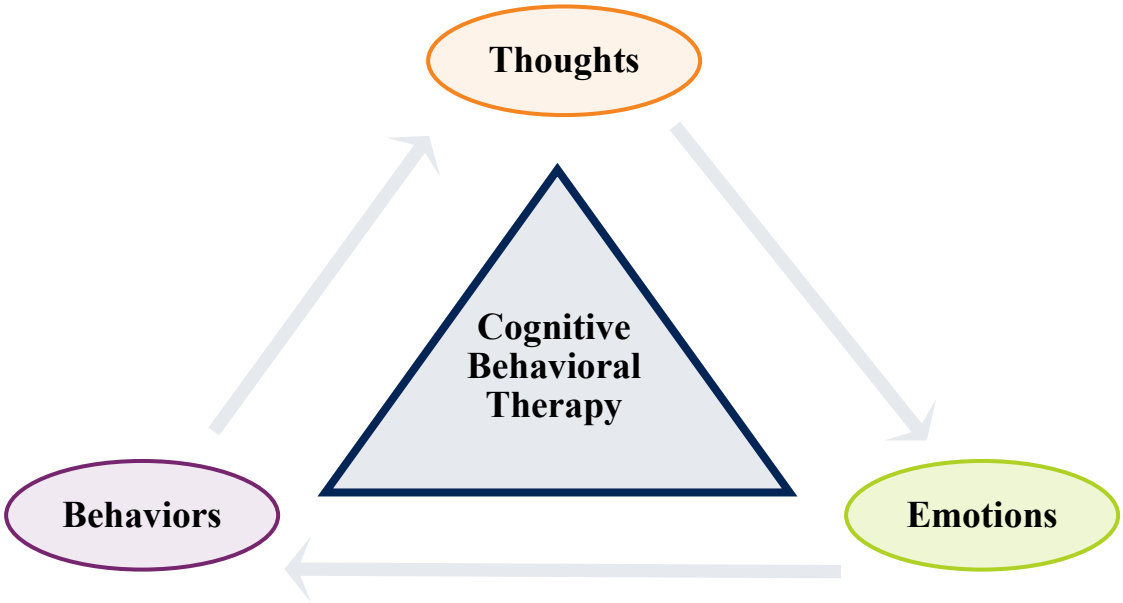
	Total Number of Sessions Hosted	Group Size Range
Desert	5 Session	1—10 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences, where the youth may feel emotionally uncomfortable at times. The youth may cry, get upset or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

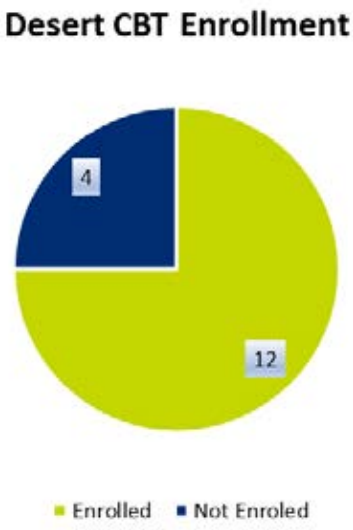
www.mayoclinic.com/cbt



Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children/students enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

Number of Youth Enrolled in CBT

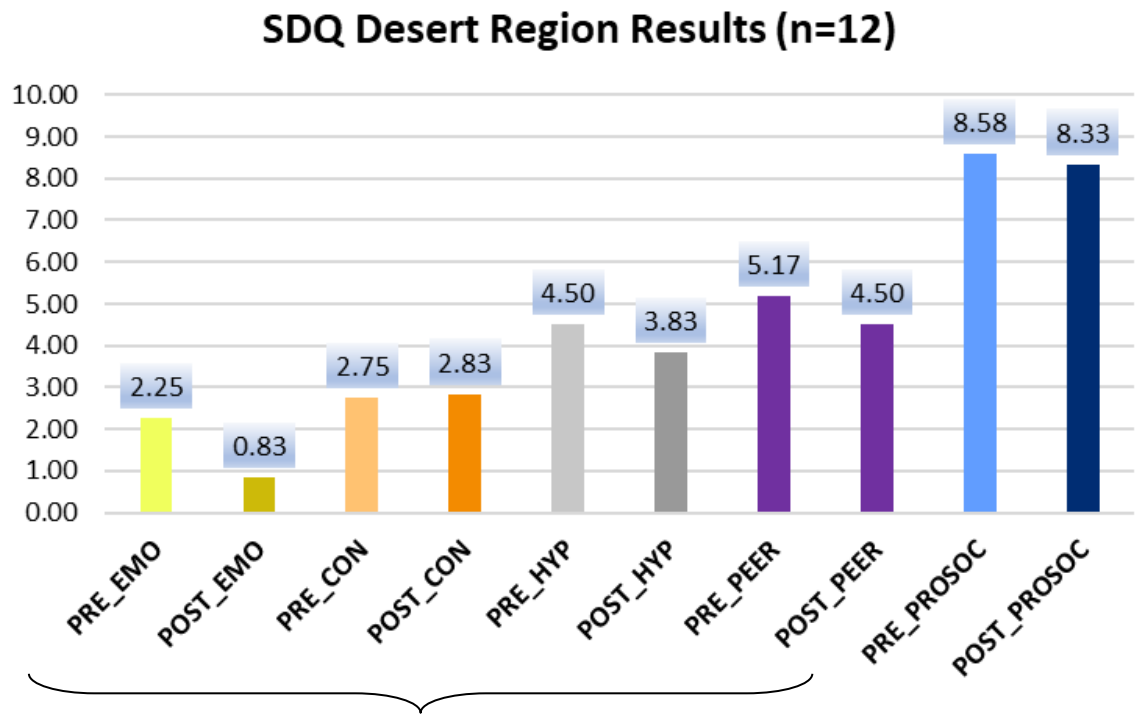


	Average CBT Sessions per Region
Desert	8 Sessions

This fiscal year, CBT was offered as part of B.R.A.A.F., benefiting 12 participants in the Desert region who each received at least one CBT therapy service. On average, participants from the Desert region attended 8 CBT therapy sessions. These sessions were conducted in-person and via video-conferencing, depending on the flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, and higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=14.67, Post=12.00

A total of twelve youth who completed both pre and post assessments were included in the analysis. The primary expectation was a decrease in average scores across the four behavioral subscales (emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems) from their intake assessment to their post-CBT assessment, with an anticipated increase in the pro-social subscale.

The results indicate a statistically significant change in **emotional symptoms** ($t(11) = 3.742$, $p = 0.003$, $p < 0.05$), suggesting that the youth improved their behavior after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in **peer relationships** ($t(11) = .442$, $p=.005$, $p<0.05$).

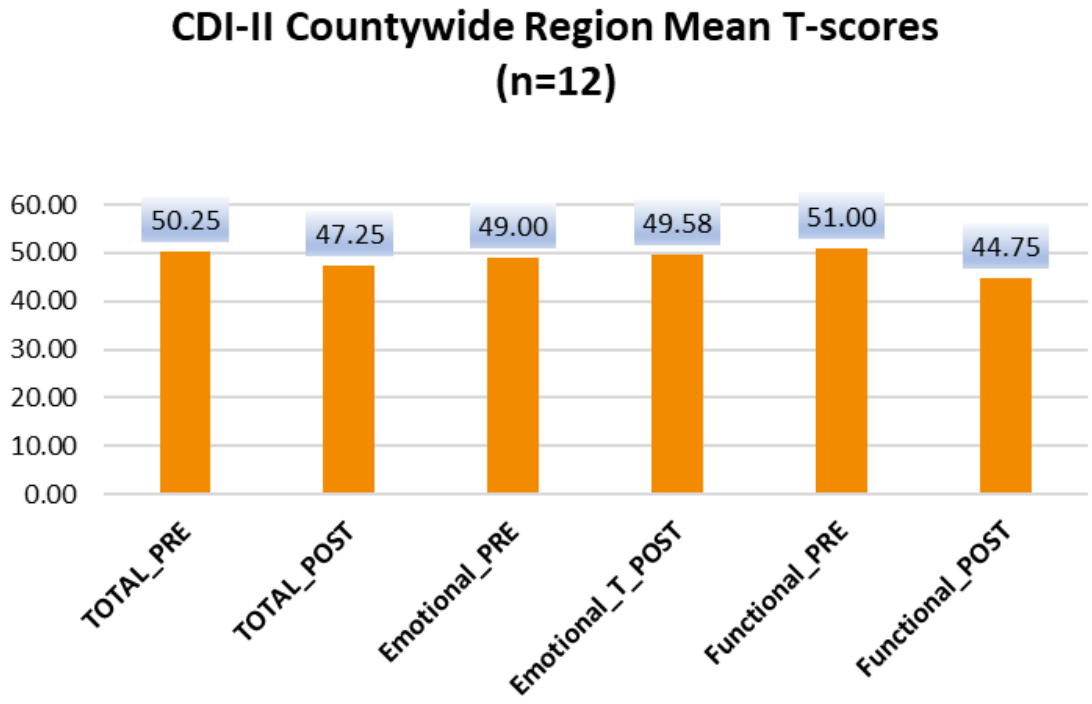
Although there were observed changes in other areas, these changes were not significant. Overall, the program had a notable impact on the participants' emotional well-being and peer interactions.

Children Depression Inventory II (CDI II)

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches their feelings. Higher scores (70 and above) suggest higher levels of depression for all subscales and the total score. Whereas, scores 59 and lower are considered average or below average. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



Out of the 12 youth who received CBT services, they were asked to complete both the pre and post CDI-II assessments. For this fiscal year, when comparing the scores from CDI-II, there was no statistically significant change in Emotional behavior. On the another hand, there was a significant decrease in Functional Problems area (p<.05). It's important to note that the small sample size may have limited our ability to detect significant improvements resulting from the CBT sessions.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	Desert Region N= 13
1 The program taught me how to cope with stress.	4.1
2 The program helped me to understand myself better.	4.5
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	4.0
4 I achieved my goals for the group.	4.3
5 The facilitator listened to what I had to say.	4.3
6 The facilitator knew how to help me.	4.3
Things I learned in the program are:	
"What I learned was how to calm down."	
"I learned how to set boundaries and how to pick the right group of people."	
"That to talk it out with them and that I could do better and I am enough."	
What I liked about the program is:	
"That it cheers me how to be and how I am changing myself and that when I save something it will be funny or that it will be just to talk it out."	
"What I liked was we would always take a minute to breath and relax."	
"I can state how I felt in that moment and how I feel now."	
What I didn't like about the program is:	
"Sometimes it was a short session."	

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last 30 minutes to an hour and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in BRAAF, as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately, and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and one scribe recording comments.

The following focus groups were conducted for Desert region. The focus groups were conducted in-person.

Youth Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has help you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in BRAAF that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants.



Youth Focus Groups

The girls' responses to the focus group questions are loosely organized in the following themes and include some quotes of the girls responses.

Youth expressed positive changes in themselves:

- "A difficulty in school, in volleyball, it helped be more mindful of my teammates."
- "BRAAF taught me to stop before responding to other people."
- "I had problems with boundaries and BRAAF helped me with that."
- "BRAAF helped me with my grades, in school, [staff] helped me figure that out."
- "BRAAF helped me to let things go and not care about it."
- "I used to let people define me, now I don't let that be the case."
- "I learn to take responsibility and to work with others in a team."
- One of the seven principles of Kwanzaa that helped me was "Imani because I believe more in myself, and I feel more accomplished."

Changes in how youth felt about their culture:

- "The program has helped me feel more confident in myself and that we are all Kings and Queens."
- "The program has helped me change the way I feel about culture, we didn't just come from slavery. We were Kings and Queens."
- "People don't know about African American culture, we are inventors."
- "They taught us about code-switching during one of the sessions."

Youth explained changes and additional comment about the BRAAF program:

- "I think that my attitude and my way of thinking changed."
- "To stand up for myself and to communicate what I need."
- " I did not like the lessons."
- "I will remember the most is the [staff]."
- "I liked the outings and the games we played."
- "I will remember the sisters in the program."
- "I will remember the trips."
- "I will remember how we can be friends and respect others."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this BRAAF program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Groups shared different experiences but all participants were asked the exact same questions by the same facilitator to reduce moderator bias.



Comments/Feedback made by Parents during Focus Groups:

Parents noted that their daughter became more confident and communicative. Many parents noted their daughters grew to be more mature and changed their behavior:

- "This program, instilled confidence in her, she has learned how to make friends and more confidence in socializing and communication in how she feels. BRAAF helped her focus on specific things, BRAAF help her achieve more and seek more. It helped her influence on the world and mindfulness. The meetings and parent support groups, BRAAF is a great program for us."
- This program helped my daughter to be "aware of their feelings and what's going on and a open line of communication."
- "The BRAAF staff did their best in teaching our children, and their availability."
- "The scheduling is hard, more parent involvement, help with staff more so that the staff continue doing most of the work."
- "My daughter's confidence, I see it more with people, outcoming of her shell more, doing a lot better. She is more confidence, speaking up for her beliefs and her opinions of things and dealing with others."
- "Two children did BRAAF, did a great job at engaging and accommodate for each cluster of children. Each of boys and girls, matched the program to the child. The topic definitely fit for my daughters each time. I think they did a great job with that."
- "I valued other parents in the same schools and grade , going to the same things, hearing others ideas and other ways to solve problems. Cause I'm working I am not around other parents so now in the groups- I learned from others.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Celebrating Families: Strengthening the Circle

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Wellbriety Celebrating Families (WCF)

During the fiscal year 2023-2024, there were a total of 37 eligible parent participants enrolled in the WCF program. A total of 7 WCF class cycles were completed Countywide: Mid-County (21 families enrolled), Western (8 families enrolled), and Desert (8 families enrolled). Of these, 23 participants completed the WCF Program (62.2% completion rate); however, only 12 matched/completed pre-post measures were submitted and analyzed. In this outcomes report, the demographic data analysis is based on the 37 enrolled participants, while the measures analysis is based on the 12 completed pre-post data.

The majority of parent participants were Female (73%), between 30 years old and 39 years old (32.4%), and did not identify as LGBTQI (81.1%). Most enrolled participants (81.1%) identified themselves as American Indian/Alaskan Native with 13 different tribes represented in the WCF program, while the remaining participants (18.9%) reported Multiracial with American Indian/Alaskan Native. All participants (100%) indicated that their preferred language is English, and that they were not Veterans. The majority of parent participants indicated that they did not have any disabling condition (83.8%). Most of the parent participants also indicated that they have at least 1 child in the "0 to 15 years" age range, as well as 1 child in the "16 to 25 years" age range.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the Alabama Parenting Questionnaire (APQ) measure. The **Parenting Involvement** scale showed a 6.6% increase, and the **Positive Parenting** scale showed a 5.4% increase. On the Guiding Good Choices Total Scores, it was shown that there was an increase of 2.58 points (a 3.3% increase) in the average scores from pre-to post-measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Guiding Good Choices** (GGC) and **Family Strength/Resilience Scale** (FSRS) measure. For the GGC measure, there was a minor increase of 1.8% on the average Total Scores from 49.67 to 50.58 (0.92 points), from pre-to-post measures. For the FSRS measure, the average Total Scores increased 7.5% from 47 to 50.83 (3.83 points), from pre-to-post measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Opinions Survey**, where increases are expected across all items except for Item# 9 (which explored Alcohol/Chemical Dependency topic). Overall, analysis from pre-to-post measures showed increases (i.e. more parent participants chose "Yes", "Always", or "Agreed/Strongly Agreed" to the statements) across all items.

Overall, the **Post-Satisfaction Survey** analysis from 12 participants showed high satisfaction (i.e. responded to either "Satisfied" or "Very Satisfied") with the WCF program (91.7%) and the group leaders (91.7%). The majority also responded that they thought the WCF program has "Somewhat" or "Very Much" helped their families, and 100% responded "Yes", that they would recommend the WCF program to other families.

Cognitive-Based Therapy (CBT)

There was no CBT activity completed for the fiscal year 2023-2024, due to less interest from clients, employee turnover, as well as the lack of a clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A total of 1 GONA event was completed for the fiscal year 2023-2024, with a total of 89 attendees conducted at Noli Indian High School on May 13th, 2024. From this event, a total of 64 post-GONA satisfaction surveys were submitted by attendees. Overall, the survey analysis showed highly positive results from all parent participants. Additionally, a total of 21 Facilitator Debrief Surveys were collected from the GONA event, and those surveys also showed positive feedback from the facilitators about the events.

Program Goals

The primary goals of the "Celebrating Families: Strengthening the Circle" program are to increase positive family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk. The setting for service delivery would not be traditional mental health settings, and would assist participants in feeling comfortable seeking services from staff that are knowledgeable and capable of identifying needs and solutions for Native American/American Indian families. The contractor for this program is Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), which is expected to utilize targeted outreach to engage the Native American/American Indian community by working within the community and collaborating with the Tribal Temporary Assistance for Needy Families (TANFs), tribal organizations, tribal leaders, tribal elders, schools, community organizations, non-profit organizations, faith-based organizations, and other individuals, groups, and/or services that have the trust of and connection with this population.

RSBCIHI is contracted to provide two (2) evidence-based practices, and one (1) culturally-based intervention which are briefly described below:

1. **Wellbriety Celebrating Families!™**
   This is a cognitive behavioral, support group model written for families in which there are risks for alcohol/substance use, domestics violence, child abuse, or neglect. RSBCIHI is expected to provide the following level of service to each of the geographic regions of Riverside County:
   - At least 2 cycles of group, per region, per year.
   - A cycle will consist of 11 weeks, and each cycle shall serve a minimum of 6 families, and shall not exceed 15 families.
   - A family shall consist of parent(s)/caregiver(s) and at least one child age 3 to 17 years of age.
   - The total number of families expected to complete the Wellbriety Celebrating Families curriculum are at least 20 per year, per region.
   - Completion is defined as a family completing 7 out of 11 sessions.

2. **Cognitive-Behavioral Therapy (CBT)**
   This is a time-sensitive, structured, present-oriented form of psychotherapy that has demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol, and drug use problems, and other behavioral health challenges. RSBCIHI is contracted to provide CBT to an individual, family, and/or group interventions as determined by screening as well as clinical assessment. A Mental Health Clinician shall provide CBT interventions for 6 to 8 sessions, and/or on as needed basis.

3. **Gathering of Native Americans (GONA)**
   This is a culture-based intervention and planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports the Native American/American Indian tribes with traditional songs, drumming, prayers and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity. RSBCIHI is expected to plan 1 GONA event per year. The GONA event will be conducted over 2 days, at a safe, non-stigmatizing location, which will be rotated among the 3 regions on an annual basis.

Wellbriety Celebrating Families!™

The Wellbriety Celebrating Families!™ (WCF) program is based on the Wellbriety Movement and Celebrating Families curriculum, which is listed on the federal Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs and Practices (NREPP) since 2008. It integrates traditional Native teachings and cultural practices, including the Healing Forest Model, as a framework allowing each community to include traditional practices. It also emphasizes the importance of a community service and individual spirituality, and integrates parenting skills with strategies to break the cycle of addiction.

The WCF program fosters the development of safe, healthy, fulfilled, and addiction-free individuals and families by increasing resiliency factors and decreasing risk factors while incorporating addiction recovery concepts with healthy family living skills. It listed works with every member of the family, from ages 3 years of age through adult, to strengthen recovery from alcohol and/or other drugs, break the cycle of addiction and increase successful family reunification.

The WCF curriculum was originally designed for 16 weeks, that addresses the needs of children and parents in families that have serious problems with alcohol and other drugs, and to serve 6 to 15 families depending on the site's physical facilities, referral process and intake of eligible families. It was later expressed by RSBCIHI as well as the feedback from previous participants that the 16 weeks was lengthy and it was harder to gain interests from ongoing participations. Similar to the previous fiscal year, for the fiscal year 2023-2024, the WCF program was also condensed to a 11-week program, by combining 2 sessions into the weeks of 2, 3, 8, 9, and 10. A full attendance of at least 7 sessions is required to complete the WCF program. Each session of the program begins with a family meal. Afterwards, family members break into age group for developmentally appropriate activities led by the group facilitators. At the end of each session, all family members reconnect in activities to learn how to apply these new skills and interact in healthy ways.

Class Curriculum

The curriculum for WCF program is listed below, which was originally designed for 16 weeks, and then later condensed into 11 weeks by combining 2 sessions into Weeks 2, 3, 8, 9, and 10:

Week 1: Orientation and Getting Started
Week 2: Healthy Living
Week 3: Nutrition
Week 4: Communication
Week 5: Feeling and Defenses
Week 6: Anger Management
Week 7: Facts about Alcohol, Tobacco, and Other Drugs (ATOD)
Week 8: Chemical Dependency is a Disease
Week 9: Chemical Dependency Affects the Whole Family
Week 10: Goal Setting
Week 11: Making Healthy Choices
Week 12: Healthy Boundaries
Week 13: Healthy Friendships and Relationships
Week 14: How We Learn
Week 15: Our Uniqueness
Week 16: Celebration

Data Collection and Outcome Measures

The following forms and measures are to be completed by parent participants, in order to gather basic demographic information, as well as how they view their parenting skills and their relationship with their child. Additionally, a post-survey will be collected to gather participants' feedback on their perception of the WCF program.

- **Demographic Screening Form** (at the beginning of each WCF program)
- **Alabama Parenting Questionnaire** (at the beginning and at the completion of WCF program)
- **Guiding Good Choices and Family Strength/Resilience Scale** (at the beginning and at the completion of WCF program)
- **Opinions (Focus Questions) Survey** (at the beginning and at the completion of WCF program)
- **Post-Satisfaction Survey** (at the completion of the WCF program)

Alabama Parenting Questionnaire (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. There were 42 items on the original version of APQ measure; however, for the purpose of WCF program, a modified format of the APQ measure was adopted for the WCF Program, with 22 items that would measure the following scales:

- **Parental Involvement** (Items No. 1, 4, 6, 8, 9, 12, 13, 16, 18, and 20)
- **Positive Parenting** (Items No. 2, 5, 11, 14, 15, and 21)
- **Inconsistent Discipline** (Items No. 3, 7, 10, 17, 19, and 22)

The **Guiding Good Choices (GGC) Scale** is taken from the GGC Program that aims to prevent teen substance use and risky behaviors by training parents to develop parenting and family management skills. Additionally, the **Family Strength/Resilience Scale** is taken from the Strengthening Families Program, an evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. The combined measure has 22 questions, which consist of Guiding Good Choices (10-questions) and Family Strength/Resilience Scale (12 questions) which were taken from these two separate programs and have been modified to fit the WCF program.

WCF Class Cycles, Class Enrollment and Completion

There were a total of 7 WCF class cycles completed Countywide during the fiscal year 2023-2024. The total number of parent participants who qualified to enroll in the WCF program was 37. Of these, 23 participants completed the program (62.2% completion rate). All enrolled participants were asked to complete pre packets at intake, and post packets at completion; however, only 12 matched pre-post measures could be used for comparison of pre to post scores. Some of the measures were either missing from the packets, or were not completed entirely. For this outcomes report, only 12 matched pre-post measures were analyzed. A list of all WCF class cycles that were completed during the fiscal year 2023-2024 is shown on table below:

Class Cycle#	Start Date	End Date	Class Name/Location
1	8/22/23	11/14/23	Tuesday PM Virtual #1
2	9/6/23	11/22/23	Soboba Virtual
3	9/6/23	12/5/23	Pechanga #1
4	1/19/24	3/19/24	Tuesday Zoom Group
5	1/17/24	3/24/24	TM TANF San Jacinto
6	10/31/23	2/6/24	Pechanga #2/#3
7	4/23/24	7/2/24	Tuesday PM Virtual #2

WCF Class Cycles, Class Enrollment and Completion (*continued*)

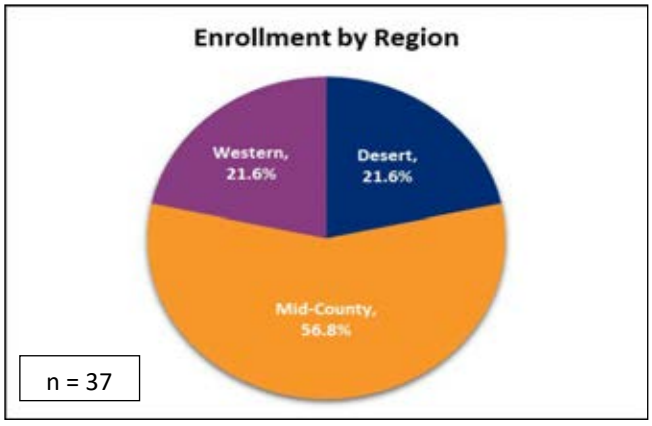
A summary of all WCF class cycles and enrollment counts for fiscal year 2023-2024 by Region, as well as Countywide are shown on the table below:

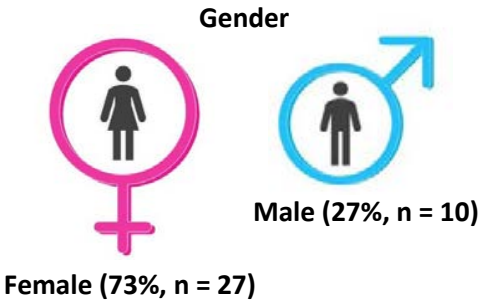
Region	Number of Families Enrolled	Number of Completion	Matched Pre-Post Data Sets Submitted	Contract Expectation	Percentage of Contract Expectation	Participants Completion Rate
Western	8	6	4	20	30%	75%
Mid-County	25	14	5	20	70%	56%
Desert	4	4	3	20	20%	100%
Countywide	37	23	12	60	38.3%	62.2%

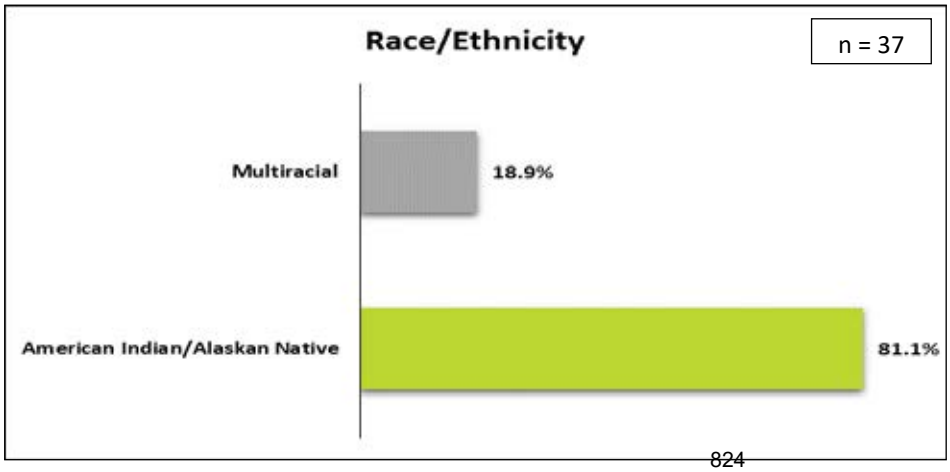
Demographics

During the fiscal year 2023-2024, a total of 7 WCF cycles were completed Countywide. The total number of participants who enrolled were 37, and the demographics data collected and analyzed were based on the total enrollments of 37 participants. The demographics data for *Enrollment by Region*, *Gender*, *Race/ Ethnicity*, and Preferred Language are summarized and shown below:

- 21 families enrolled in the Mid-County region (56.8%), 8 families enrolled in the Western County region (21.6%), and 8 families enrolled in the Desert region (21.6%)
- The majority of parent participants were Female (73%, n = 27), while the remaining participants were Male (27%, n = 10).
- 30 participants (81.1%) categorized themselves as American Indian/Alaskan Native, while 7 participants (18.9%) responded as being Multiracial.
- A total of 13 different tribes were represented across all the class cycles (as indicated by participants).
- All participants (100%) indicated that their preferred language is English.





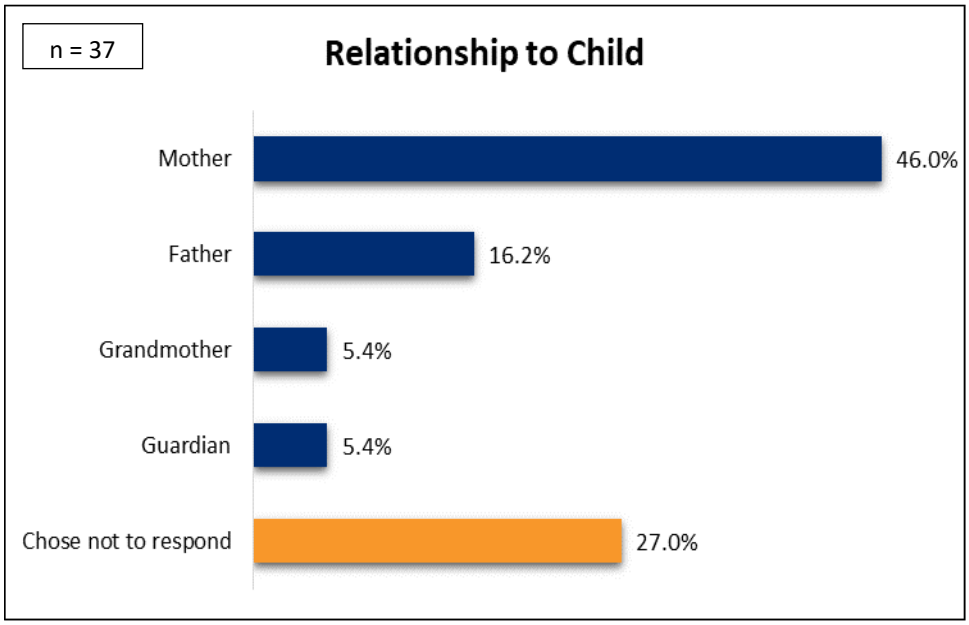


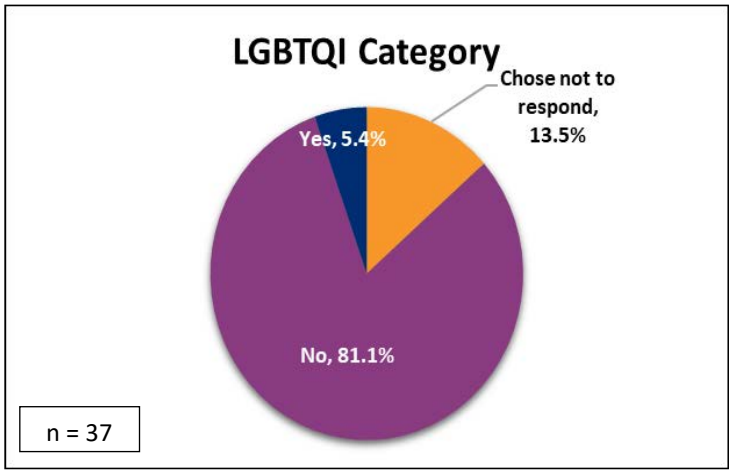
Specification of American Indian/Alaska Native Tribes
Cahuilla
Choctaw
Ely Shoshone
Hualapai
Hoopa
La Jolla
Navajo Nation
Oneida
Quechan
San Luis Rey
San Pasqual
Santa Rosa Band of Cahuilla
Torres Martinez

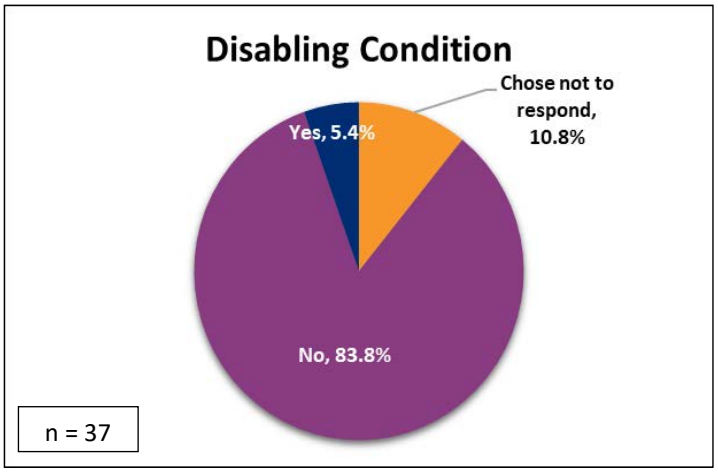
Demographics (*continued*)

The demographics data showing *Relationship of Participants to Children*, *LGBTQI Category*, *Veteran Status*, and *Disabling Condition* are summarized and shown on graphs below:

- The majority of parent participants indicated that their relationships to their children were as their "Mother" (46%, n = 17), "Father" (16.2%, n = 6), "Grandmother" (5.4%, n = 2), and "Guardian" (5.4%, n = 2), respectively. It is also noted that 10 participants (27%) chose not to respond to this question.
- Within the LGBTQI category, the majority of participants indicated "No" (81.1%, n = 30) on their responses, while 2 participants (5.4) indicated "Yes", and noted Bisexual as the category. It is also noted that the remaining 5 participants (13.5%) chose not to respond to this question.
- All participants (100%) indicated that they were not Veterans.
- A total of 31 parent participants (83.8%) indicated that they did not have any Disabling Condition, while 2 participants (5.4%) indicated that they have a Disabling Condition, and 4 participants (10.8%) chose not to respond to this question. Of those who responded "Yes", Fibromyalgia was noted as the specification of disability.



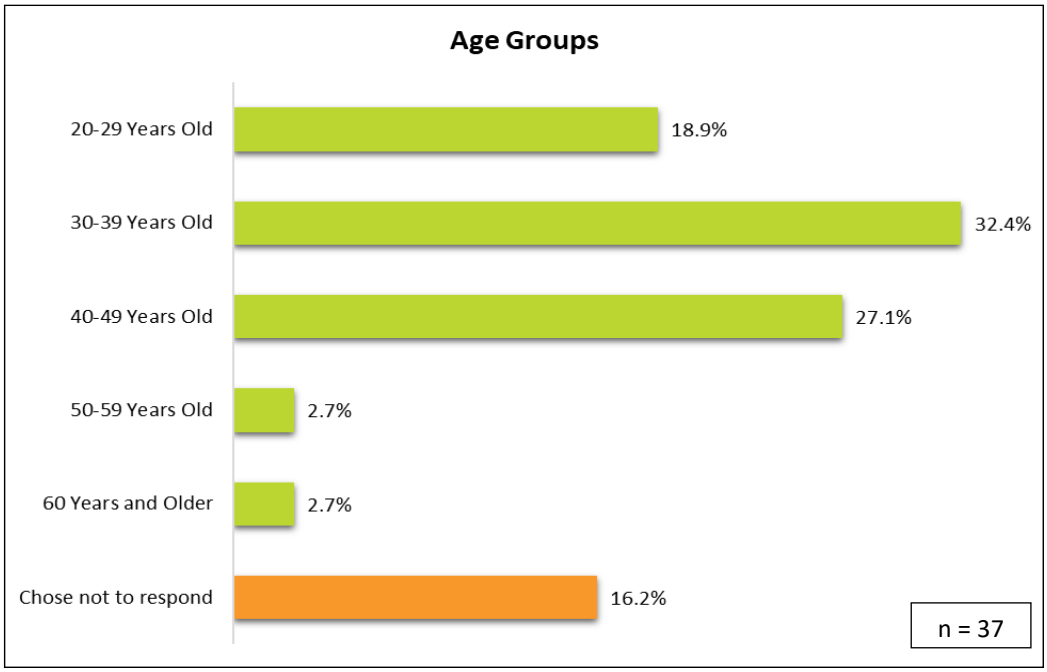




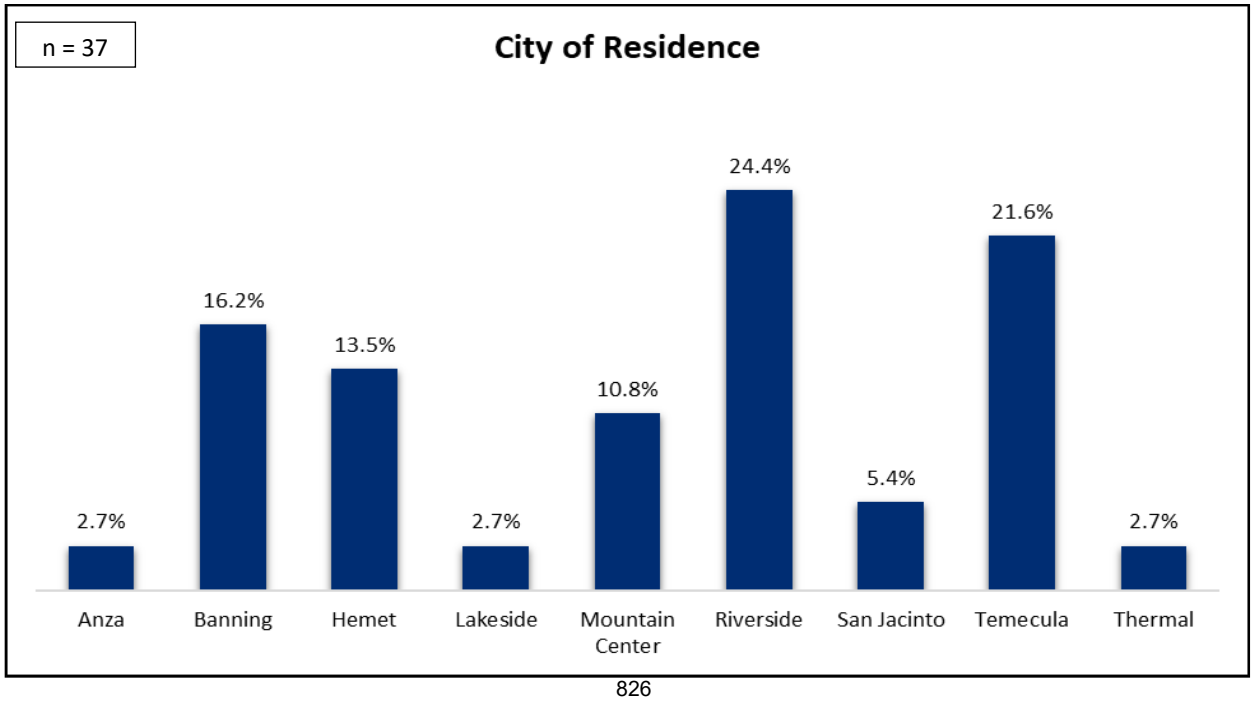
Demographics (*continued*)

The demographics data showing parent participants' Age Group and City of Residence are summarized and shown on graphs below:

- The majority of parent participants (32.4%, n = 12) were between 30 to 39 years of age. It is also noted that 6 participants (16.2%) chose not to respond. The number of participants in each age group is shown on the table below.
- Parent participants indicated that they had at least 1 child between 0 to 15 years old, and 1 child between 16 to 25 years old.
- The majority of parent participants indicated that they lived in Riverside (24.4%, n = 9), followed by Temecula (21.6%, n = 8), and Banning (16.2%, n = 6). Other cities noted were as follows: Anza, Hemet, Lakeside, Mountain Center, San Jacinto, and Thermal.



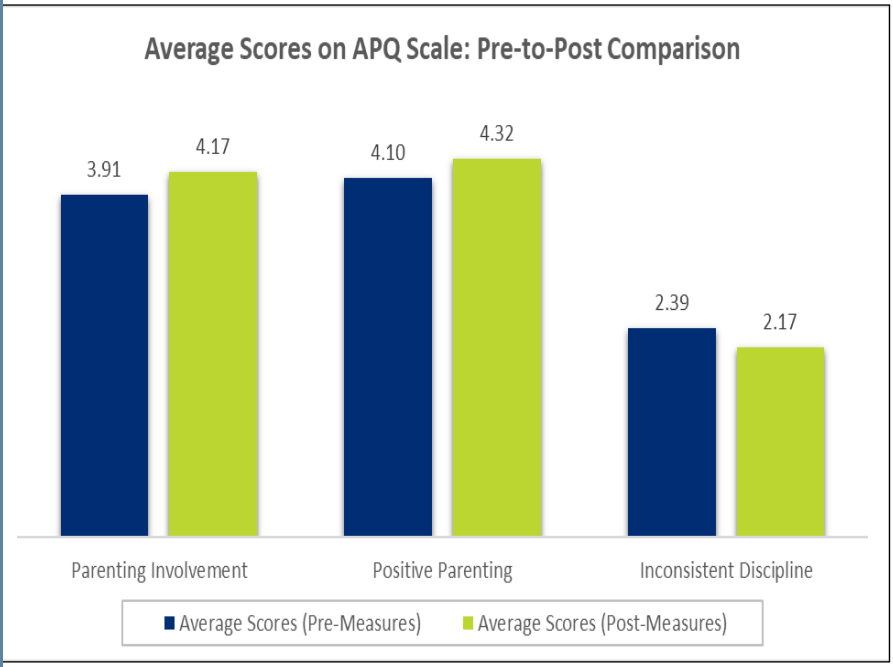
Age Groups	Counts
20-29 years old	7
30-39 years old	12
40-49 years old	10
50-59 years old	1
60 years and older	1
Chose not to respond	*6*



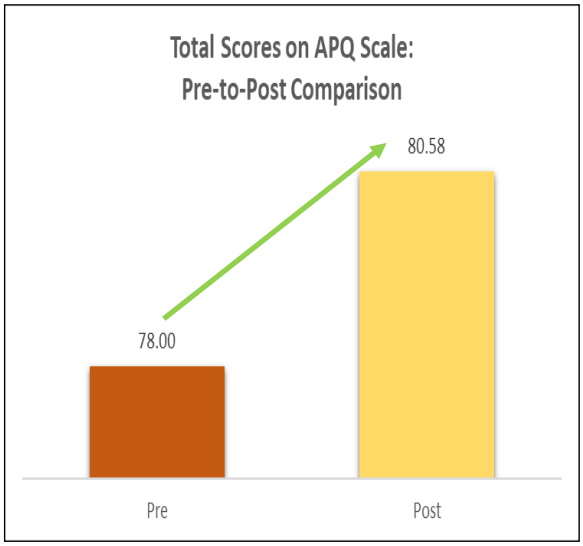
Alabama Parenting Questionnaire

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1="Never", 2="Almost Never", 3="Sometimes", 4="Often", and 5="Always". Each parent participant is asked to complete the APQ measure at the start of the WCF program, and at the end of the program. Each question on the APQ measure is a different statement about parenting practices, and each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see *increases* in the average scores for both "Parenting Involvement" and "Positive Parenting" scales, and *decreases* in the average scores of "Inconsistent Discipline" scale from pre-to-post.

A total of 12 pre-post matched pairs were completed by parent participants for the APQ measure. The graph below shows the APQ Scale results. The **Parenting Involvement** scale showed a 6.6% increase (0.26 points) from 3.91 to 4.17, and **Positive Parenting** scale showed a 5.4% increase (0.22 points) from 4.10 to 4.32. Conversely, **Inconsistent Discipline** scale showed a decrease of 9.3% (-0.22 points) from 2.39 to 2.17). All scales showed positive results from pre-post; however, due to the insufficient sample size, analysis using Paired Samples T-Tests was not possible. Overall, the average Total Scores showed an increase of 2.58 points (3.3% change) from 78 to 80.58.



n = 12



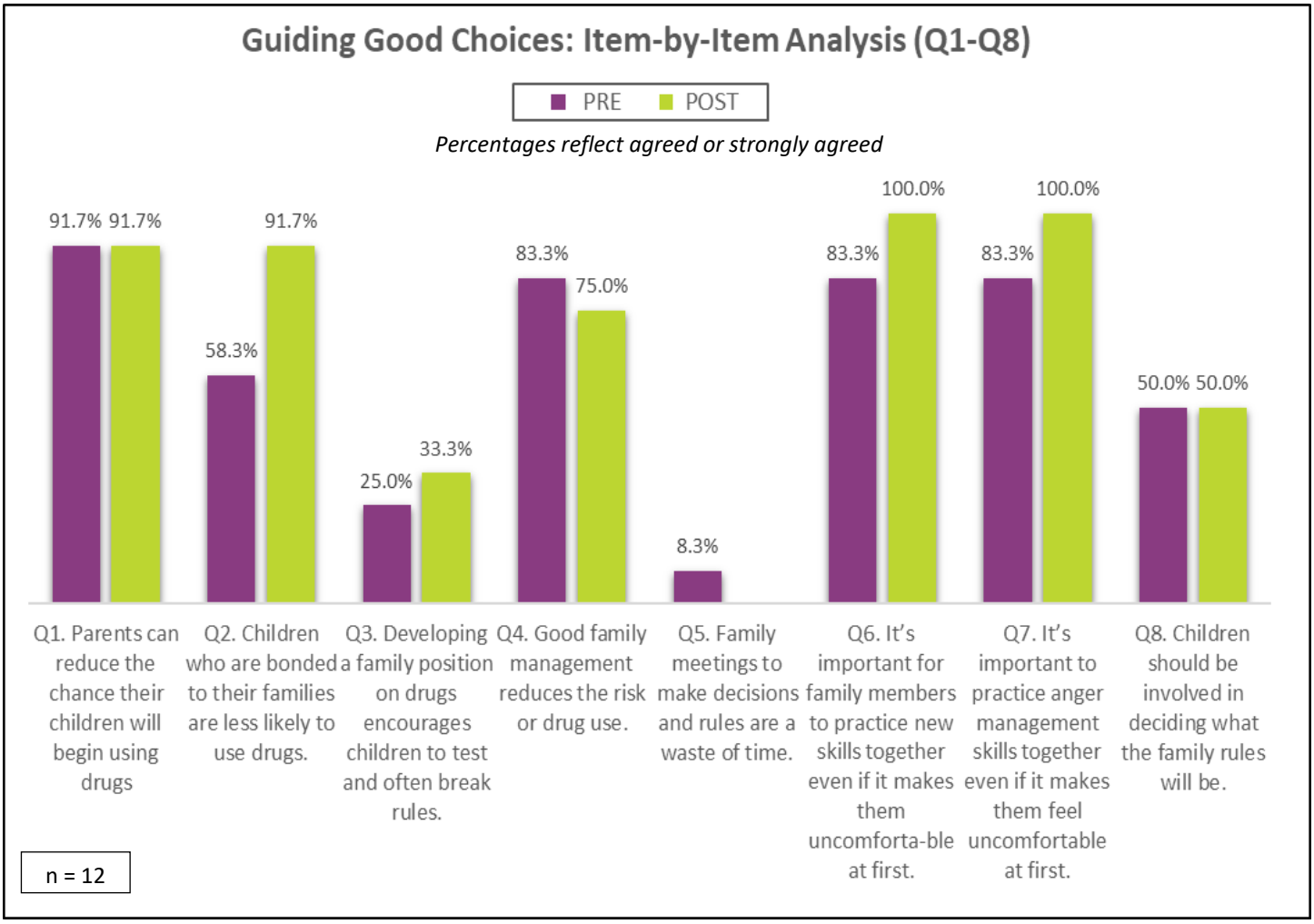
APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.6%	-1.015	11	.332
Positive Parenting	5.4%	-0.818	11	.431
Inconsistent Discipline	-9.3%	1.310	11	.217
Total Scores	**3.3%**	**-0.681**	**11**	**.510**

Guiding Good Choices and Family Strength/Resilience Scale

On the Guiding Good Choices and Family Strength/Resilience Scale measure, parent participants were asked their opinions about how often the statements would best describes their families. Ideally, we would like to see an increase in all items from pre-to post-measures, except for Item# 5 (*Family meetings to make decisions and rules are a waste of time*), on parent participants' who selected Options 5, 6, and 7 ("Tend to Agree", "Agree", and "Strongly Agree"). For the Guiding Good Choices measure (Questions 1 to 10), the questions are structured on two types of Likert Scales, and results are shown below:

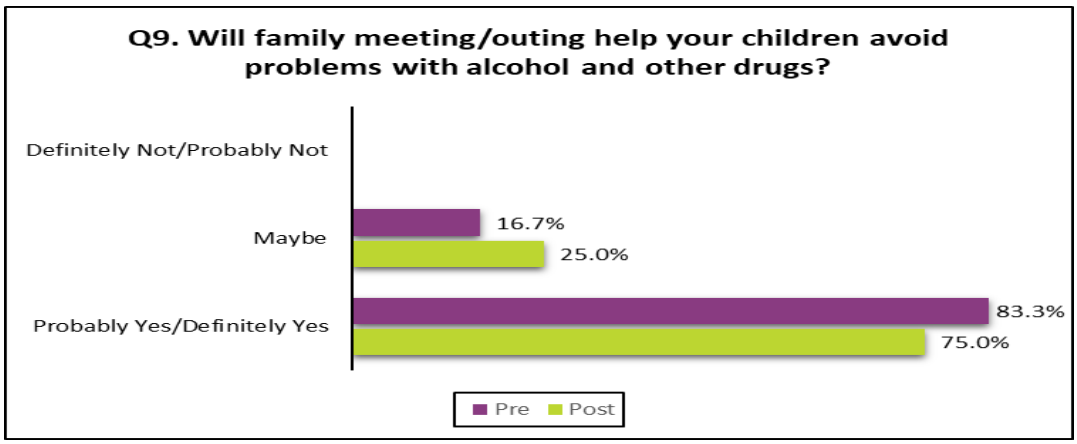
- On **Questions 1 to 8**, parents are asked to choose between 7 options, where: 1="Strongly Disagree", 2="Disagree", 3="Tend to Disagree", 4="Neutral", 5="Tend to Agree", 6="Agree" and 7="Strongly Agree".
- On **Questions 9 and 10**, parents are asked to choose between 5 options, where 1="Definitely Not", 2="Probably Not", 3="Maybe", 4="Probably Yes", and 5="Definitely Yes."

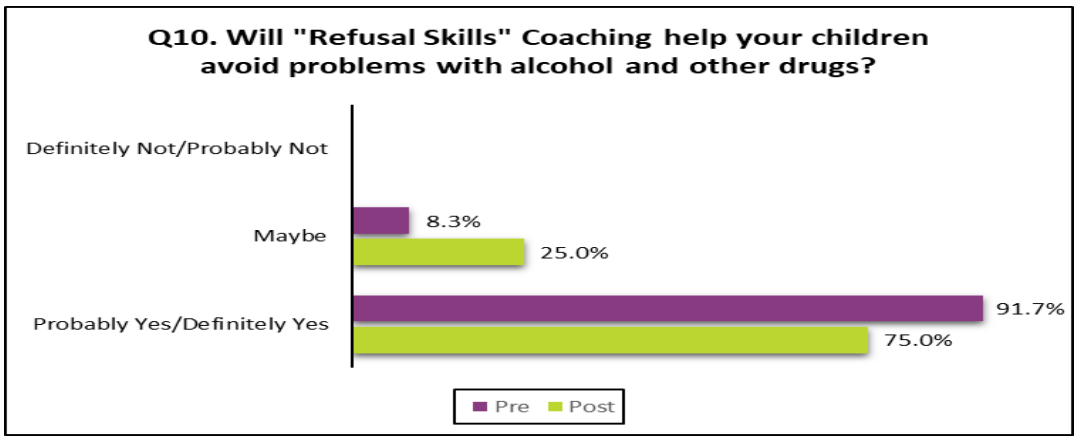
There were a total of 12 pre-to-post surveys submitted for the Guiding Good Choices measure. Overall, there are increases on parents' choices from pre– to post-measures, with the highest percent increase of 57.3% is shown on Item# 2 (*Children who are bonded to their families are less likely to use drugs*). Item#5 (*Family meetings to make decisions and rules are a waste of time*) is shown as the highest percent decrease of 100%, which is considered as ideal. Item-by-item analysis from Questions 1 to 8 on the GGC scale is shown below, while the analysis for Questions 9-10 as well as the average on Total Scores are shown on the following page.

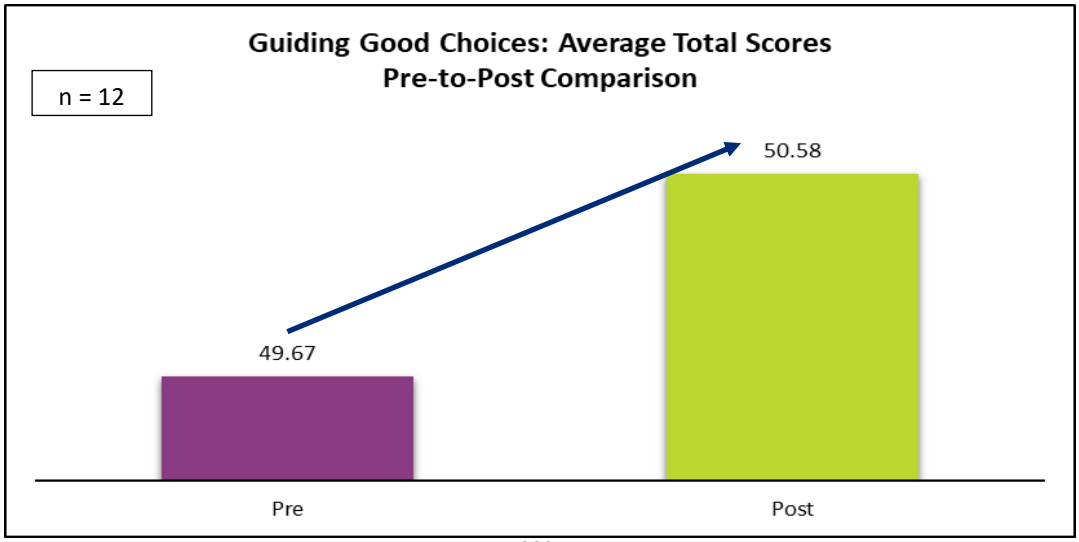


Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

From 12 pre-to-post measures submitted, analysis for questions 9 and 10 showed increases in parent participants' who selected "Maybe" from pre measures to post measures. For both Questions 9 and 10, none of the parent participants selected Options 1 and 2 ("Definitely Not" or "Probably Not"). On Question# 9, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) decreased from 83.3% to 75%. On Question# 10, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) also decreased from 91.7% to 75%. Overall, the average Total Scores on Guiding Good Choices measure also showed an increase of 0.92 points from 49.67 to 50.58 (a 1.8% increase). However, due to the small sample size, this result is not shown to be statistically significant.

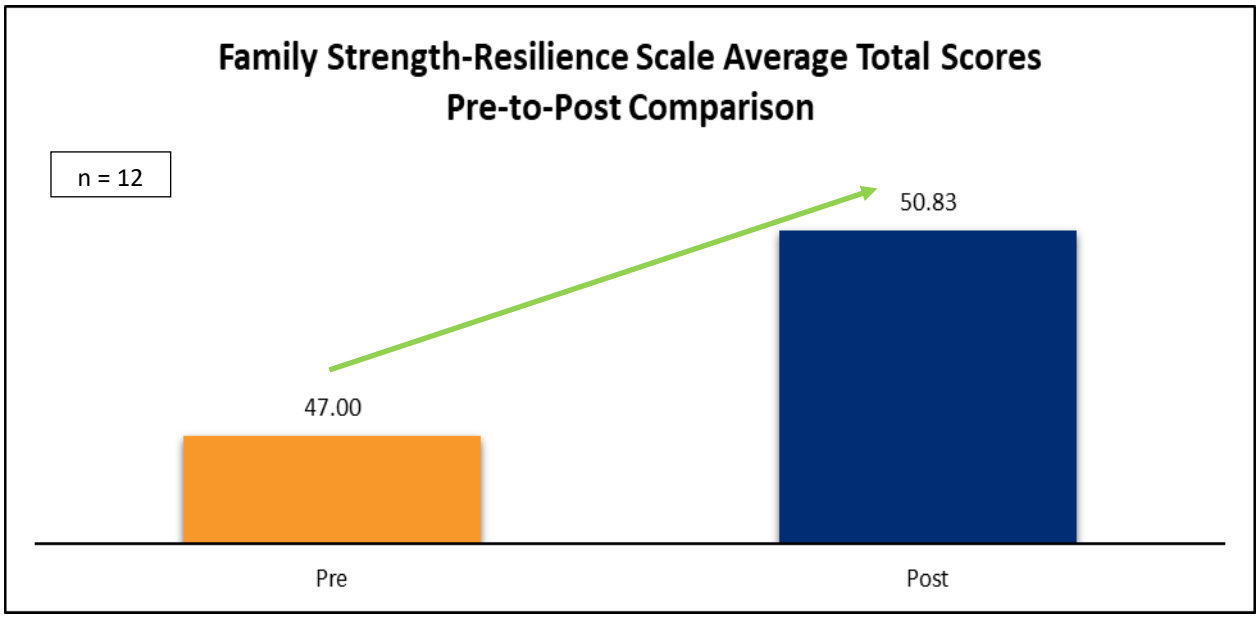






Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

On the Family Strength/Resilience Scale Questions 11 to 22, parent participants were asked to select from 5 Likert Scale options, where 1="Very Little Strength", 2="Some Strength", 3="Neutral", 4="Good Strength", and 5="Very Strong". Ideally, we would like to see increases across all items (i.e. from participants selecting options 1 or 2 on pre-measures, to selecting 4 or 5 on post-measures). Based on the analysis from 12 paired pre-post measures submitted at the completion of WCF program, the average Total Scores showed an increase of 3.83 points from 47 points to 50.83, which is a 7.5% increase from pre-to post-measure. However, due to the small sample size, this result is not shown to be statistically significant. An item-by-item analysis of Item numbers 11 to 22 are shown on table the below. Item numbers 12, 14, 15, 16, 17, and 21 showed percent increases of 25% or more (i.e. percent increases in parent participants selecting "Good Strength" and "Very Strong" from pre-measures to post-measures).



Family Strength and Resilience Scale Items	*Very Little Strength-Some Strength PRE*	*Very Little Strength-Some Strength POST*	*Good Strength-Very Strong PRE*	*Good Strength-Very Strong POST*	*Good Strength-Very Strong %DIFFERENCE*
11. Family Supportiveness, love and care	0.0%	8.3%	91.7%	91.7%	0.0%
12. Positive Family Communication (clear directions, rules, praise)	16.7%	8.3%	66.7%	91.7%	**37.5%**
13. Effective Parenting Skills (reading to child, rewarding)	16.7%	8.3%	75.0%	83.3%	11.1%
14. Effective Discipline Style that is consistent with love and respect	8.3%	8.3%	66.6%	83.3%	**25.1%**
15. Family Organization (rules, chores, self responsibility)	8.3%	16.6%	41.7%	66.6%	**59.7%**
16. Family Unity (togetherness, cohesion)	8.3%	8.3%	66.7%	91.6%	**37.3%**
17. Positive Mental Health (generally good feeling about own self)	25.0%	16.6%	66.6%	83.3%	**25.1%**
18. Physical Health	8.3%	8.3%	66.7%	75.0%	12.4%
19. Emotional Strength	25.0%	0.0%	58.3%	66.7%	14.4%
20. Knowledge and Education	8.3%	8.3%	75.0%	83.4%	11.2%
21. Social Networking (making or talking with friends, building community)	25.0%	16.7%	58.4%	75.0%	**28.4%**
22. Spiritual Strength	0.0%	8.3%	83.3%	75.0%	-10.0%

WCF Pre-Post Opinions Survey

In the Wellbriety Celebrating Families™ (WCF) program curriculum, there is one question named as "Focus Question" for each week or each different topic that is selected to be discussed with parent participants. There are a total of 10 questions selected and condensed into an "Opinions Survey", which participants are asked to complete at both at intake and at the completion of the WCF program. Generally, we would like to see if there is any change (either an increase or a decrease) in the participants' opinions from pre– to-post-measures, in regards to the topic and/or selected focus questions. More specifically, the goal is for participants' opinions to increase to a higher percentage of "Yes" (i.e. more people selecting "Yes" as an option, instead of selecting "Don't Know" or "No") at the completion of the WCF program in comparison to at intake, *except* on Question 9 when the alcohol/chemical dependency topic is introduced. Increases indicate an improvement in knowledge after program completion. Overall, there are a total of 12 pre-post measures that were analyzed and the results are shown below and on the following page.

WCF Opinions Survey Q1-Q6	Don't Know		No		Yes	
	PRE	POST	PRE	POST	PRE	POST
1. What I eat and drink changes the way my brain works.	8.3%	0%	0%	0.0%	91.7%	100%
2. A can of beer, a bottle/can of flavored alcoholic beverage, a glass of wine, and a shot of hard liquor all contain the same amount of alcohol.	50%	33.3%	16.7%	16.7%	33.3%	50%
3. People with blood relatives who have the disease of "Chemical Dependency" are at High Risk to become addicted themselves if they drink or use.	8.4%	8.4%	33.3%	8.3%	58.3%	83.3%
4. If one member of a family is chemically dependent, all other family members are affected.	0%	0%	41.7%	16.7%	58.3%	83.3%
5. If my children talk to other adults, they are less likely to become addicted.	50%	50%	16.7%	16.7%	33.3%	33.3%
6. I have a safe person who will listen when I need to talk about my problems.	8.3%	8.3%	0%	8.4%	91.7%	83.3%

For questions 1 to 6, participants are asked to select either "Don't Know", "No", or "Yes" for the selected Focus Questions as listed on table above, which can be summarized below:

- Participants' opinions changed from 91.7% to 100% on those who selected "Yes" (9.1% increase) on Question #1.
- Participant's opinions changed from 33.3% to 50% on those who selected "Yes" (50.2% increase) on Question #2.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #3.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #4.
- Participants' opinions remained the same (33.3%) on those who selected "Yes" (0.1% decrease) on Question #5.
- Participants' opinions changed from 91.7% to 83.3% on those who selected "Yes" (9.2% decrease) on Question #6.

WCF Pre-Post Opinions Survey (*continued*)

On Questions 7 and 8, participants are asked to select between "Never", "Sometimes", "About half the time", "A lot of the time", or "Always" on the selected Focus Questions as listed on table below, and the summary is as follows:

- On Question 7, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 75% at completion (50% increase in opinions).
- On Question 8, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 66.7% at completion (33.4% increase in opinions).

WCF Opinions Survey Q7-Q8	Never		Sometimes		About half the time		A lot of the time		Always	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
7. I am able to talk about my feelings.	8.3%	0.0%	0.0%	8.3%	41.7%	16.7%	33.3%	41.7%	16.7%	33.3%
8. I express my anger safely.	8.3%	0.0%	0.0%	0.0%	41.7%	33.3%	33.3%	41.7%	16.7%	25.0%

On Question 9, participants are asked to select between "25%", "40%", "50%", "60%", or "More Than 60%" on the selected Focus Question as listed on table below. Overall, there are slight increases across all options in parents' opinions in regards to alcohol/chemical dependency.

WCF Opinions Survey Q9	25%		40%		50%		60%		More than 60%	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
9. What percentage (%) of children live in a home with a parent who drinks heavily or has a problem with alcohol or other drugs?	33.3%	16.7%			33.3%	16.7%	8.4%	24.9%	25.0%	41.7%

On Question 10, participants are asked to select between "Strongly Disagree", "Disagree", "Neutral", "Agree", or "Strongly Agree" on the selected Focus Question as listed on table below. Overall, there was no participant who selected either "Strongly Disagree" or "Disagree" at both intake and completion, and 91.6% of participants selected either "Agree" or "Strongly Agree" at intake, and this has increased to 100% at completion (9.2% increase in opinions). This indicates that there are more parent participants who Agreed or Strongly Agreed at completion that "*Providing Rules and Limits help their children to build their self-esteem*."

WCF Opinions Survey Q10	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
10. Providing Rules and Limits help my children build their self-esteem.					8.4%	0.0%	58.3%	66.7%	33.3%	33.3%

WCF Post-Satisfaction Survey

A post-satisfaction survey was created to evaluate the Wellbriety Celebrating Families™ (WCF) program effectiveness and to gather attendees' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to all attendees and collected at the end of the WCF program. There are a total of 8 questions on the post-satisfaction surveys:

- The first two questions use Likert scale ranging from 1 to 5, where: 1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, and 5 = Very Satisfied
- The third question also uses Likert scale ranging from 1 to 5, where: 1 = Not At All, 2 = Very Little, 3 = Not Sure, 4 = Somewhat, and 5 = Very Much
- The fourth question provides two options, "Yes" or "No"
- Questions 5 to 8 are open ended questions, which are meant to gather participants' opinions on their thoughts about the WCF program, whether they did or did not like the WCF program, and if they had any additional comments.

At the completion of WCF Program, there are a total of 12 post-satisfaction surveys submitted by attendees, and the results are shown below.

Post-Satisfaction Survey Results

In regards to the satisfaction with both the program and the group leaders, the majority of participants (83.4%, n = 10) responded that they were "Very Satisfied". Additionally, 10 participants (83.4%) felt that the WCF program has helped their families. In regards to participants' feedback on whether they would recommend the WCF program to other families, all participants (100%) responded "Yes". A summary of their responses is shown below, and their survey comments are shown on the following three pages.

	 Neutral	 Satisfied	 Very Satisfied
Q1. How satisfied were you with this program?	**8.3%**	**8.3%**	**83.4%**
Q2. How satisfied were you with your group leaders?	**8.3%**	**8.3%**	**83.4%**
	 Not Sure	 Somewhat	 Very Much
Q3. How much has this class helped your family?	**0%**	**16.7%**	**83.3%**

Q4. Would you recommend this program to other families? 

100%

Post-Satisfaction Survey Comments

The remaining 4 questions of the post-satisfaction surveys (Questions 5 to 8) were related to participants' opinions regarding the WCF program. The participants' feedback are summarized below:

Q5. Things I learned in the Wellbriety Celebrating Families™ program are:

"I learned that disciplining while angry is inappropriate. It's best to calm down first."
"Mental health is important."
"Family boundaries and the importance of teaching kids values and morals, taking care of physical, mental, spiritual, and emotional well-being."
"Do not turn to substances for coping mechanisms."
"Managing my emotions, family connections tips, and that I am an amazing parent."
"That our group are handling the sane things in life that are positive,"
"How to work on stress and historical trauma."
"How to have a healthier family living and to be stronger in my society."
"HALT, prayer."
"To open up."
"How much what I do have a say on the next generation, healthy boundaries, and living skills on family and community."

Q6. What I liked about the Wellbriety Celebrating Families™ program was:

"I liked the Zoom class but also enjoyed getting to see everyone in person."
"Learning about how to recognize growing up in unhealthy forest."
"That there was no judgment."
"Attending with my kids."
"Being able to be open and honest and receiving thoughtful feedback on issues I'm dealing with."
"Everything! Sharing and hearing others' experiences."
"That our counselors, also group, understood each other."
"The staff really connected with you and really heartfelt."
"Openness, great leaders."
"The group."
"Variety and openness of topic."

Q7. What I didn't like about the Wellbriety Celebrating Families™ program was:

"That I struggled with Zoom sometimes."
"Nothing, it was very convenient."
"It was on Zoom."
"Mainly centered around substance abuse issues rather than co-parenting."
"It was on a work day."

Q8. Any additional comments?

"This is my first time in a group program. The Zoom was great! But I prefer in person. I believe that these program should be consistent for all other reasons."
"Instructors were amazing!"
"The leaders are very open, considerate, patient, knowledgeable, respectful, and understanding."
"Thank you!"

Cognitive-Behavioral Therapy

The Cognitive-Behavioral Therapy (CBT) is directed toward solving current problems and teaching clients skills to modify maladaptive thinking and behavior. It is included as an element of the Celebrating Families: Strengthening the Circle Project, in order to provide individual, family, and/or group interventions to participants who are identified through clinical assessment as having emerging symptoms of depression or anxiety, present for less than one (1) year. Generally, the CBT interventions will be determined by a Mental Health clinician, which may vary from participant to participant. Generally, it will be offered from 6 to 8 sessions, and/or on as needed basis.

Data Collection and Outcome Measures

Both adults and children can participate in the CBT program, and the following data collection and outcome measures are to be completed by each participant:

For each adult participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **OQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

For each child participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **YOQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

The clinician assigned to each participant is also expected to complete a Participant Log and Program Completion Summary Form, which will be submitted to RUHS-BH along with each participants' pre and post packets.

The **PHQ-9**, or **Patient Health Questionnaire-Nine**, is a self-reported depression scale that's used to screen clients for major depressive disorder. This measure consists of nine questions that ask about the frequency of symptoms over the past two weeks. Each question is rated on a scale from 0 to 27, with higher scores indicating more severe symptoms:

- 0-13: indicates *mild depression*
- 14-19: indicates *moderate depression*
- 20-27: indicates *severe depression*

The **OQ**, or the **Outcome Questionnaire**, is a 45-item multiple-choice self-report inventory used to measure psychotherapy progress in adult clients (ages 18 and older). It provides a quick by comprehensive snapshot of the client's current functioning across a wide variety of disorders, and it measures three subscales:

1. **Symptom Distress (SD)**, or subjective discomfort: intrapsychic functioning with an emphasis on client's depression and anxiety.
2. **Interpersonal Relations (IR)**: loneliness, conflict with others, and marriage and family difficulties.
3. **Social Role (SR)**: difficulties in the workplace, school, or home duties.

The Total Score for OQ ranges from 0 to 180, with a clinical cutoff of 64 points.

Data Collection and Outcome Measures *(continued)*

The **Y-OQ**, or the **Youth Outcome Questionnaire**, is a 64-item self-report completed by the parent/guardian that measures the treatment progress for children and adolescents (ages 4 to 17 years old) receiving mental health intervention. It is designed to reflect the total amount of stress a child or adolescent is experiencing, and its utility across many populations, treatment types, and modalities allows for non-invasive clinical application in nearly all settings of care. The total score of Y-OQ ranges from –16 to 240 with a clinical cut off of 47 points. There are six subscales in the YOQ measure:

1. **Intrapersonal Distress** (emotional distress).
2. **Somatic Distress** (distress presenting physically).
3. **Interpersonal Relations** (relationship with parents, other adults, and peers).
4. **Critical Items** (flags need for those requiring immediate intervention beyond standard outpatient treatment)
5. **Social Problems** (socially-related problematic behaviors)
6. **Behavioral Dysfunction** (unhealthy behaviors)

Enrollment

During the fiscal year 2023-2024, there were no participants enrolled in the CBT Program, due to less interest from clients, employee turnover, as well as unavailability of clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A Gathering of Native Americans (GONA) is a culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports Native American/American Indian tribes with traditional songs, drumming, prayers, and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity.

The overall goals of the GONA process are to:

- Provide Native communities with a framework to examine the effects of historical trauma.
- Provide an integrative experience that offers hope, encouragement, and a positive foundation for Native community action and healing.
- Provide an experience that emphasizes skill transfer and supports Native community empowerment.
- Reinforce cultural continuity with families living on tribal reservations and in urban or rural areas.
- Increase protective factors linked to healthy and safe development of Native children and their families.
- Offer Native communities a strategic framework and planning process that supports the values of *Belonging*, *Mastery*, *Interdependence*, and *Generosity*, which are inherent in Native cultures and lead to the reduction of risk behaviors contributing to mental and substance use disorders and suicide.

By utilizing SAMHSA Tribal training and Technical Assistance Center's GONA Curriculum and Facilitator Guide and Toolkit, RSBCIHI is contracted to plan one (1) GONA event per year. The identified program leadership will participate in a trans-regional GONA planning process, and the regions shall work collaboratively to plan, host and hold the event. The GONA event will be conducted over 1 –2 days, at a safe, non-stigmatizing location, which will be rotated among the three regions on an annual basis. The GONA will occur at the conclusion of the year and include Wellbriety Celebrating Families!™ program graduates, as well as the larger Native American/American Indian community in order to address the community-identified issues.

As part of data collection procedure, the following are to be collected from the GONA event:

- **Participant Sign-In Form**
- **GONA Post-Satisfaction Survey**
- **GONA Facilitator Debrief Form**

Event Sign-Ins

During the fiscal year 2023-2024, there was one GONA events completed, with a total attendance of **89** people, which was completed at Noli High School.

Date	Location	Total Attendance
5/13/2024	Noli Indian School	89

GONA Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate the Gathering of Native American (GONA) event for its effectiveness, and to gather attendees' feedback on how the program has impacted their relationship with their children, family, as well as their community. The post-satisfaction surveys were distributed to all attendees and collected at the end of the GONA event. There are a total of 12 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. At the completion of the GONA event, there were a total of 64 post-satisfaction surveys submitted by attendees. The survey results and summary of attendees' comments are shown on the following two pages.

GONA Post-Satisfaction Survey Results

	Satisfaction Survey Items (n = 64)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I received a positive portrayal of Native American culture.	3.1%	1.6%	14.1%	35.9%	45.3%
2	Gathering of Native Americans encouraged us to draw closer as a community.	1.6%	1.6%	19.0%	30.2%	47.6%
3	I learned about Native American values and culture in each of the activities.	1.6%	3.1%	26.6%	32.8%	35.9%
4	I learned about how historical trauma impacts my community.	4.8%	3.2%	23.8%	44.4%	23.8%
5	The gathering gave me a sense of belonging.	1.6%	6.3%	25.4%	31.8%	34.9%
6	An event like this one brings hope in our community.	1.6%	1.6%	31.7%	27.0%	38.1%
7	I learned about substance use disorders.	3.2%	6.3%	30.2%	38.1%	22.2%
8	I learned about mental health issues (e.g. suicide prevention, mental health disorders).	3.3%	1.6%	18.0%	42.7%	34.4%
9	I learned how to promote mental wellness.	1.6%	4.8%	28.5%	41.3%	23.8%
10	I had fun participating in Gathering of Native Americans.	3.2%	4.8%	17.4%	22.2%	52.4%
11	The event was well organized.	1.6%	6.3%	31.7%	23.8%	36.6%
12	Staff members were knowledgeable.	3.2%	4.8%	15.8%	36.5%	39.7%

Overall, the analysis from post-satisfaction surveys showed positive results from all participants. For the following survey statements, attendees showed positive results of about *75% or higher* on the combined "Agree" and "Strongly Agree" responses:

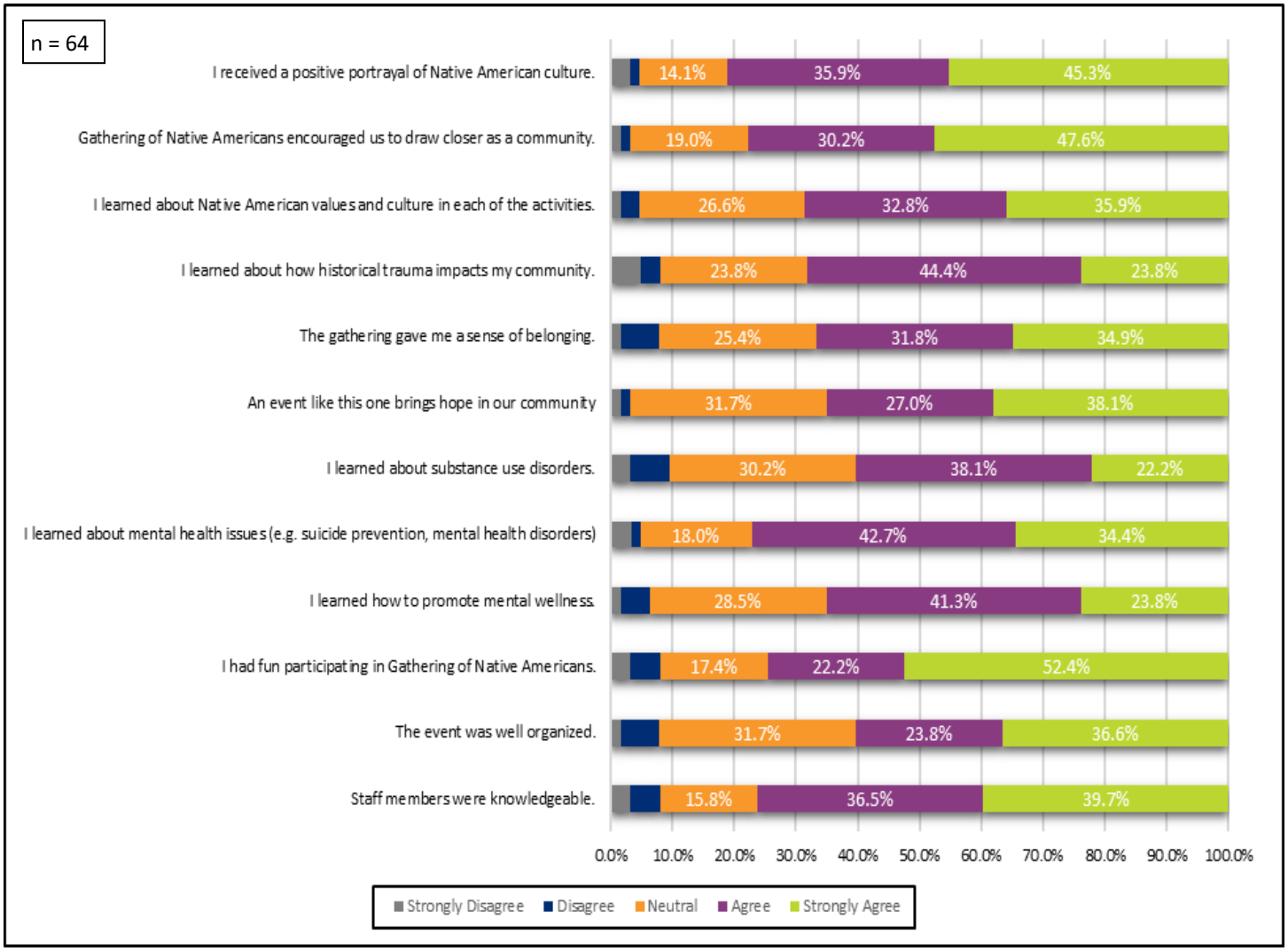
- **81.2%** responded "Strongly Agree" or "Agree" that they received positive portrayals of Native American culture from the GONA event.
- **77.8%** responded "Strongly Agree" or "Agree" that the GONA event encouraged them to draw closer as a community.
- **77.1%** responded "Strongly Agree" or "Agree" that they learned about mental health issues from the GONA event.
- **76.2%** responded "Strongly Agree" or "Agree" that the staff members were knowledgeable.
- **74.6%** responded "Strongly Agree" or "Agree" that they had fun participating at the GONA event.

For the following survey statements, attendees showed positive results of about *60% or higher* on the combined "Agree" and "Strongly Agree" responses, while some also responded "Neutral":

- **68.7%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about Native American values and culture from the GONA activities, while **26.6%** felt "Neutral".
- **68.2%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about how historical trauma impacts their community, while **23.8%** felt "Neutral".
- **66.7%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event gave them a sense of belonging, while **25.4%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event brings hope in their community, while **31.7%** felt "Neutral".
- **60.3%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about substance abuse disorders from the GONA event, while **30.2%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that they learned how to promote mental wellness from the GONA event, while **28.5%** felt "Neutral".
- **60.4%** of attendees reported "Strongly Agreed" or "Agreed" that the event was well organized, while **31.7%** felt "Neutral".

GONA Post-Satisfaction Survey Graph

The graph below shows the GONA post-satisfaction survey results in a graph format:



GONA Post-Satisfaction Survey Comments

A few of the attendees also wrote their comments in regards to the GONA event, as shown below:

"Good talk about mental health."
"It was really fun!"
"I like how much information there was. I feel like I learned a lot."
"It was nice."
"Felt like I could share without getting judged."

GONA Facilitator Debrief Surveys and Comments

Additional post-GONA evaluation tool was collected so that the GONA committee can use it to debrief the facilitators and staff. There were a total of 21 Facilitator Debrief Surveys collected from the GONA event. Their comments are listed below and on the next three pages.

Q1. What worked well about the preparation for the GONA?

"Speakers knew their topics and how they would present it."
"All of it."
"Teacher and session timing. The break also worked well to keep students calm."
"The communication."
"The organization went well as I knew where I was supposed to be and what was expected of me."
"What worked was that the presenters were engaging with the students. They would give students the chance to speak and participate."
"Agenda and planning."
"Prayers."
"The open space to be free to conduct the class; however, we deemed appropriately and concisely."
"That we had a meeting a week before the event to know what was being asked of us."
"Teamwork and people helping out."
"Being able to choose classroom."
"Close teacher-student ratio in class."
"I love the separate moms session and the outside activity, as well as the raffle."
"Having opportunity for the student to talk and answer questions."
"The overall structure was good."
"The topics chosen were appropriate for the students."

Q2. What, if anything, would you suggest to improve preparation for the GONA?

"Plan more hands-on or interactive activities."
"Timing. Plan for longer session so that students stay engaged if time is running longer that expected."
"Maybe have a presentation slide or give out information and give some student the chance to engage not all presenter did."
"Having more things to talk about."
"Maybe a little more communication through circles to how the event is going to be structured so that we can specialize the class more."
"More meetings to communicate."
"More interactions with students."
"Sending out topics in more advanced notice, discuss and prepare students."
"Maybe prep the students on the topic/content ahead of time so they would be more interactive."
"More engagement activities during the preparations, be more warm and inviting."
"Having a better setting for each workshops, like more chairs, etc."
"They needed to plan debrief for suicide session."
"Use skits, for example, how does one respond when receiving 988 call."

GONA Facilitator Debrief Survey Comments *(continued)*

Q3. What worked well about the content and format of the GONA?

"Topics were relevant to students."
"It was perfect."
"Very informative."
"Good content."
"I like how much cultural was incorporated."
"It was well presented, love the information!"
"It worked well."
"That we had enough time with each class for a back-and-forth discussion."
"Presenters were well informed and ready to present."
"The content is appropriate. I would suggest less lecture and more interaction or student engagement."
"Easy to follow and understand."
"The outdoor part got the kids excited."

Q4. What, if anything, would you suggest to improve content and format of the GONA?

"It was great the way it was."
"No lecture but have more interactions."
"It went very smoothy."
"Slide presentation, maybe do things to bring students to engage in games."
"No improvement needed."
"Less talking by presenter, more student engagement."
"I would suggest more time for the student to speak or share out. Encourage them to participate and interact more."
"Having speakers that were advocating for their culture."
"Have a debrief and more heartwarming."

Q5. What activities seemed to impact GONA participants toward healing?

"Prayer ties, talking about grief, conversation."
"Culture, prayer ties."
"Most went well."
"Connecting with everyone."
"Encouraging more self-care allowed more participants to focus on prevention."
"Opening up and talking about our problems. Doing certain exercises."
"Talking circles and prayer ties."
"Adventure involving group dynamics."
"Hands on activities, sharing of stories."
"The prayer ties seemed impactful. I wish there was more to it or more student talk/interaction. I love the conversation; it's very healing."
"Going outside and the talking circle. A few students even asked to talk to the counselor afterwards."
"Movement and the overall body healing."
"I don't feel like there was much healing, they felt like informational clumps."
"Physical activity story telling."

GONA Facilitator Debrief Survey Comments *(continued)*

Q6. What activities seemed to impact GONA participants toward community building?

"Students sharing ideas, introducing themselves, sharing about themselves."
"Being open."
"Talking circle and the selfcare section was really good, and the power of prayer too."
"Connecting."
"Movement is medicine."
"I think the talking circle was impactful but I didn't hear much from the students talking. Encourage more student speech."
"The students seemed to like the frisbee and the talking circle."
"The talking circle was really opening to how important community is."
"Sharing stories, make more connections with students."

Q7. Do you have any suggestion for the next steps of this community?

"Incorporate my learning in hands-on activities."
"More of these."
"Continuing education and healing."
"More story-telling would be great, having elders come in and tell their stories."
"More time to plan."
"More talking about how to cope with the heavy topics and more discipline."
"Having a post discussion on how everything went."
"More hands-on and student involvement. Simplify slide show and have student read bullet points—not the presenter."
"The raffle thing is cool and exciting for the kids. Perhaps more outside activities and less lecturing and more hands-on activities or making something or cultural things."
"Everything went well."
"More culture building involving the youth."
"We should have a leadership team composed of students to speak out for these topics and advocate for mental health."

Summary Report FY 2023-2024

The Asian American Pacific Islander Mental Health Resource Center (*formerly known as Perris Valley Filipino-American Mental Health Resource Center*) began their MHSA PEI funded activities in the fiscal year of 2017-2018. The resource center provides mental health resources to the Asian American and Pacific Islander populations in Riverside, Perris, Moreno Valley, Menifee, and other surrounding cities with a high density of the target community. Additionally, the resource center was funded to educate, support, and link Filipino-American families and other Asian American and Pacific Islander individuals who reside in Riverside County experiencing emotional and mental health crises with the Riverside University Health Systems-Behavioral Health (RUHS-BH) mental health services. The resource center is located in Moreno Valley and is run by the Perris Valley Filipino-American Association (PVFAA). In 2022, in response to the COVID-19 Pandemic, PVFAA partnered with a local organization, Asian Pacific Counseling and Treatment Center (APCTC) to establish a COVID-19 Awareness Program to support the community through the pandemic.

The type of services that Resource Center staff provide may include but are not limited to:

1. Community Outreach
2. Recruitment and communicating activities and available services, through combinations of:
   Ads in Filipino-American generated newspapers, E-mail blast announcements, E-mail articles reflecting issues that concern the Filipino/Asian American community, Text Messages, Social Media, Phone Campaigns, Handing out Flyers and Postcards, and Distribution of Annual Newsletter by mail/e-mail
3. Information and Referral
4. Quarterly mental health community seminars, symposia, and workshops on mental health awareness and stigma
5. Monthly Mental Health Support Groups

For the fiscal year 2023-2024, the data collection tool used includes:

- Walk-In Sign-In Sheet
- Initial Contact and Referral Form
- Offsite Outreach Activities Form
- Quarterly Seminar or Mental Health Support Group Sign-In
- Presentation Post-Satisfaction Surveys

This report summarizes the counts of activities provided by AAPI MHRC staff, which include submissions of online and paper forms from the data collection tools listed above. The data from walk-in sign-ins, offsite outreach activities form and the list of Mental Health events and presentations are summarized on pages 2 to 4 of this report. It is noted that there may be missing data from either the following: data not being collected for a particular event/activity, data not submitted to RUHS-BH staff, or missing data from attendees who chose not to sign-in for an event and/or chose not to respond to a demographic question on the form provided. For the Mental Health Events/Presentations provided in the fiscal year 2023-2024, attendees were encouraged to fill out the post-satisfaction surveys at the end of each event. The analysis of the surveys, as well as the comments from attendees, are summarized on pages 5 to 7 of this report.

AAPI MHRC Information of Walk-In Clients

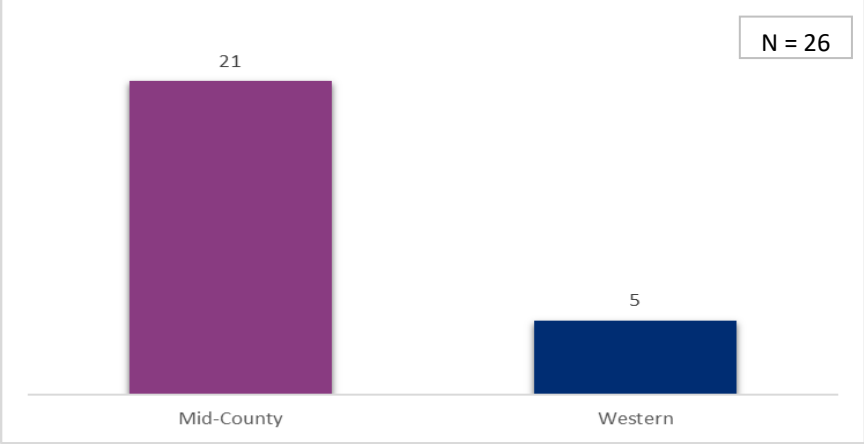
Based on the AAPI MHRC Contact List for those individuals who requested further support in Mental Health, there were a total of 2 people who were referred to RUHS-Behavioral Health. AAPI MHRC staff indicated that they received other requests for help or assistance for various needs, such as housing, employment, and social security concerns, which were not documented for this program.

AAPI MHRC Events and Presentations

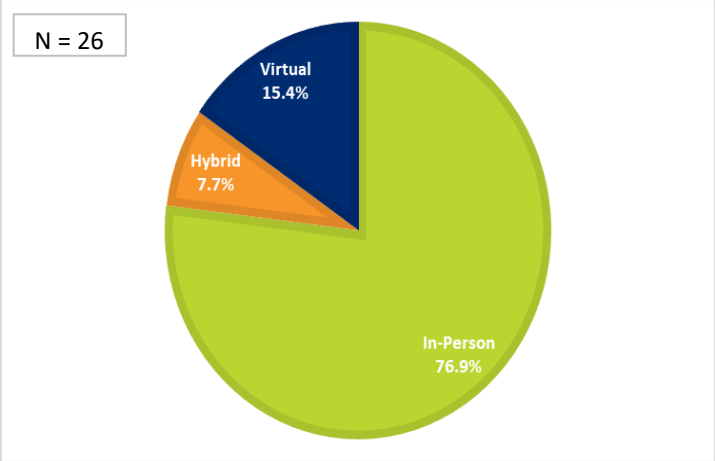
During the fiscal year 2023-2024, there were a total of 26 events conducted by AAPI MHRC. The activity forms were submitted by e-mail or online using Google forms. All of these events were conducted either In-Person, Virtual, or Hybrid, with the majority of the events being conducted In Person (76.9%, n = 20), mostly at the AAPI MHRC main office in Perris. A total of 21 events were completed in the Mid-County region (80.8%), while the remaining 5 events were completed in the Western region (19.2%). The majority of the events were completed in English (80.8%, n = 21), while the remaining 5 events were completed in combination of English and Tagalog. It is also noted that there may be other events that were held by AAPI MHRC but the information was not submitted via online or paper forms.

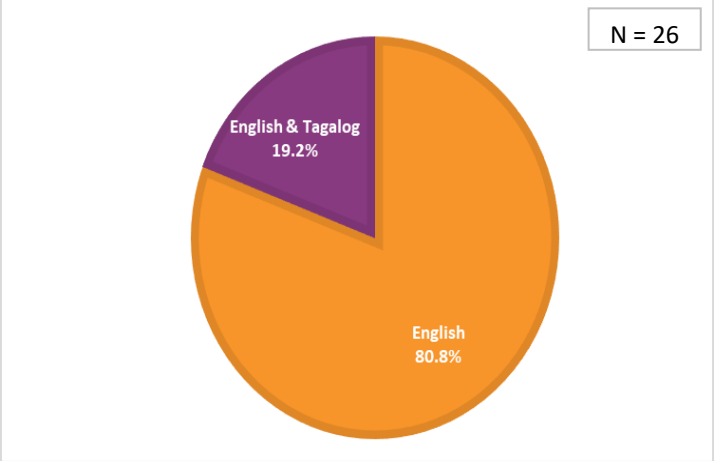
Sign-in sheets from AAPI MHRC events were submitted by either using an online forms or paper forms, by AAPI MHRC staff, and the total number of attendees for each event are listed on the table on the following page. It is also noted that some of the AAPI MHRC presentations were collaborative efforts, with AAPI MHRC staff hosting the events and other RUHS-BH and/or AAPI providers contributed to the events.

Regions of AAPI MHRC Events



Type and Language of AAPI MHRC Events





AAPI MHRC Events and Presentations

Event Date	Event Name/Title/Topic	Event Type/Description	#People in Attendance
07/28/23	Self-Care In Community: Movie Screening "Turning Red"	AAPI Community Movie Screening Series "Turning Red" (geared towards AAPI Teens)	9
07/29/23	AAPI Luau Picnic Event at Lake Perris	AAPI Marketing Presentation & PVFAA Annual Picnic Celebration	43
08/26/23	Self-Care in Community: Movie Screening "A Man Called Otto"	AAPI Community Movie Screening Series "A Man Called Otto" (for Suicide Prevention Month)	3
08/30/23	AAPI MHRC Marketing Presentation	AAPI Marketing Presentation via Zoom	24
09/09/23	Self Care in Community: AAPI Karaoke Night	AAPI Marketing Presentation and Self-Care Activity in honor of Suicide Prevention Awareness Month	18
09/30/23	Film Screening and Talk on Asian Family Mental Health with Dr. Ma	AAPI Marketing Presentation in honor of Suicide Prevention Awareness Month	25
10/21/23	Self-Care in Community: Self-Affirmations in Baybayin	AAPI Marketing Presentation	69
10/25/23	Annual Harvest Festival by Avalon Elementary School	AAPI Health Fair/Community Wellness Event	137
11/18/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	32
11/18/23	AAPI Workshop on “Making Gender-ational Mosaics” (MH Workshops on Gender Euphoria Intergenerational Queer Community and Digital Collage)	AAPI Educational Workshop	*Not listed*
12/02/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	18
12/03/23	AAPI Parol (Lantern) Festival	AAPI Marketing Presentation	200
01/13/24	AAPI Educational Workshop on MH Wellness and Challenges that AAPI young adults face today	AAPI Educational Workshop	29
02/03/24	AAPI Educational Workshop on MH Awareness and Self-Concept through community storytelling and Asian Diasporic Futurist Framework	AAPI Educational Workshop	21
03/23/24	AAPI Educational Workshop - All the Feels: Unlocking Emotions through K-Dramas	AAPI Educational Workshop	17
04/13/24	AAPI Community Wellness & Yard Sale Event at Faith Community Church-Perris	AAPI Health Fair/Community Wellness Event	35
04/13/24	AAPI Educational Workshop - Mindful Melodies: Nurturing Community Wellness through Music	AAPI Educational Workshop	27
04/25/24	Let's Get Together, Mental Health Matters: Introduction to Chika Chika Connection	AAPI Educational Workshop	8
05/04/24	AAPI Community MH Wellness Event: Daisy Walk a Sysco Riverside	AAPI Health Fair/Community Wellness Event	27
05/09/24	Let's Get Together, Mental Health Matters: 2nd Chika Chika Connection	AAPI Educational Workshop	12
05/13/24	AAPI Film Screening: Nurse Unseen (Honoring Filipino Heroes that served on the front lines of the COVID-19 Pandemic	AAPI Marketing Presentation	30
05/17/24	AAPI Luau Event at Val Verde High School-Perris	AAPI Health Fair/Community Wellness Event	48
05/27/24	Let's Get Together, Mental Health Matters: 3rd Chika Chika Connection	AAPI Educational Workshop	12
06/01/24	AAPI Community Garden Event	AAPI Health Fair/Community Wellness Event	15
06/10/24	Let's Get Together, Mental Health Matters: 4th Chika Chika Connection	AAPI Educational Workshop	10
06/24/24	Let's Get Together, Mental Health Matters: 5th Chika Chika Connection on "The 10 Guideposts to Wholehearted Living"	AAPI Educational Workshop	10

Total Number of Mental Health Events: 26

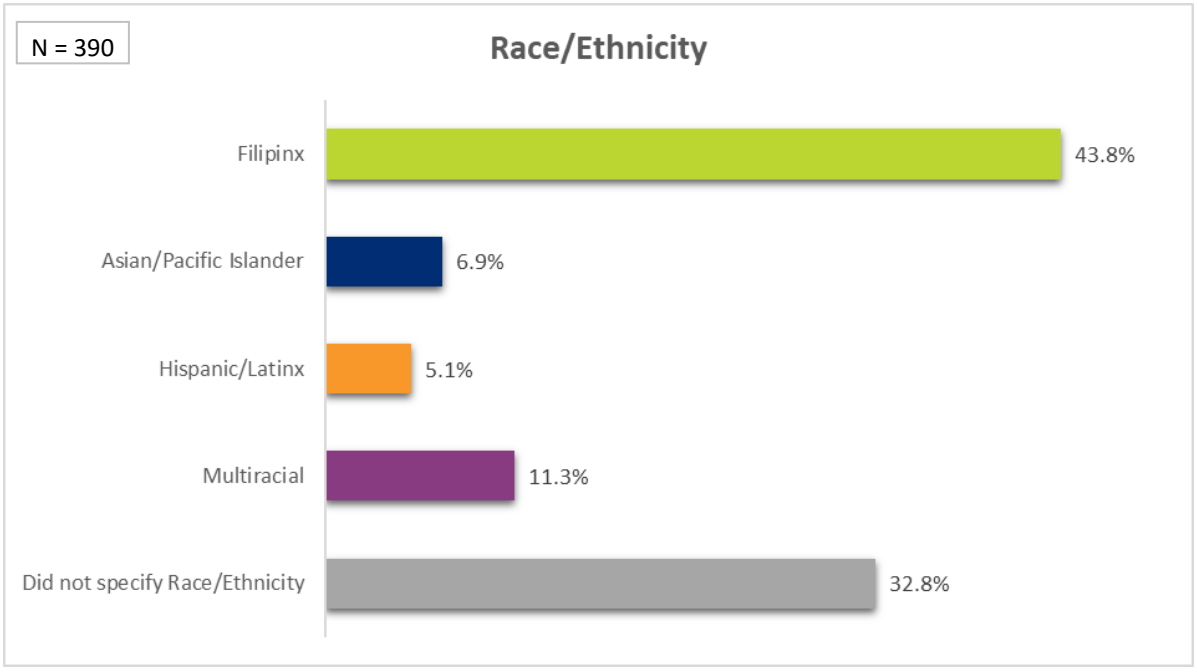
Total Counts of Event Attendees: 390 *(based on sign-in sheets submitted)*

AAPI MHRC Demographic Information of Event Attendees

Based on the online and paper sign-in sheets and demographic forms submitted, there were a total of 390 people who attended the AAPI MHRC mental health events during the fiscal year 2023-2024. It is noted that on some of the events, some attendees may chose not to fill out the sign-in forms, or there may be missing data from forms not being submitted. The event sign-in form provides a section where attendees can choose to respond to the basic demographic questions. The graphs below summarized the *Age Group*, and *Race/ Ethnicity* of the AAPI MHRC events' attendees, based on the data submitted.

The majority of the events' attendees left the *Gender* question unanswered, therefore, there was not enough data to count. When categorizing attendees into different *Age* groups, the majority of the attendees also chose "not to respond" (64.9%, n = 253). Of those who did respond to the *Age* question, the majority "60 years or older" (12.3%, n = 48). In regards to the *Race/Ethnicity* question, the majority indicated that they were "Filipinx" (43.8%, n = 171), followed by "Multiracial" (11.3%, n = 44), "Asian/Pacific Islander" (6.9%, n = 27), and "Hispanic/Latinx" (5.1%, n = 20), respectively. It is also noted that 32.8% of the attendees (n = 128) chose not to respond to this question.

Age Category (n = 390)	Number of People/Percentage
17 years old or younger	**22 (5.6%)**
18 to 29 years old	**23 (5.9%)**
30 to 39 years old	**10 (2.6%)**
40 to 49 years old	**17 (4.4%)**
50 to 59 years old	**17 (4.4%)**
60 years or older	**48 (12.3%)**
Chose not to respond	**253 (64.9%)**
Total	**390**



AAPI MHRC Events: Post-Satisfaction Survey Results

After each AAPI MHRC presentation, attendees were asked to complete the post-satisfaction surveys. For the FY 2023-2024, a total of 58 satisfaction surveys were completed and submitted using both online and paper formats.

Satisfaction Survey Items (n = 58)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The information presented was easy to understand.				6.9%	93.1%
2. The presenter was engaging when presenting the information.				6.9%	93.1%
3. I would recommend to my friend and family members that they attend a presentation like this.	1.7%			5.2%	93.1%
4. As a result of this presentation I feel I am better able to talk about mental health issues with my family and friends.			5.1%	19.0%	75.9%
5. I view mental illness as something to be ashamed off.	51.7%	10.3%	6.9%	12.1%	19.0%
6. Mental illness can be managed and treated.			3.5%	24.1%	72.4%
7. I would feel comfortable seeking help for myself or a family member regarding mental health issues.		1.7%	6.9%	22.4%	69.0%

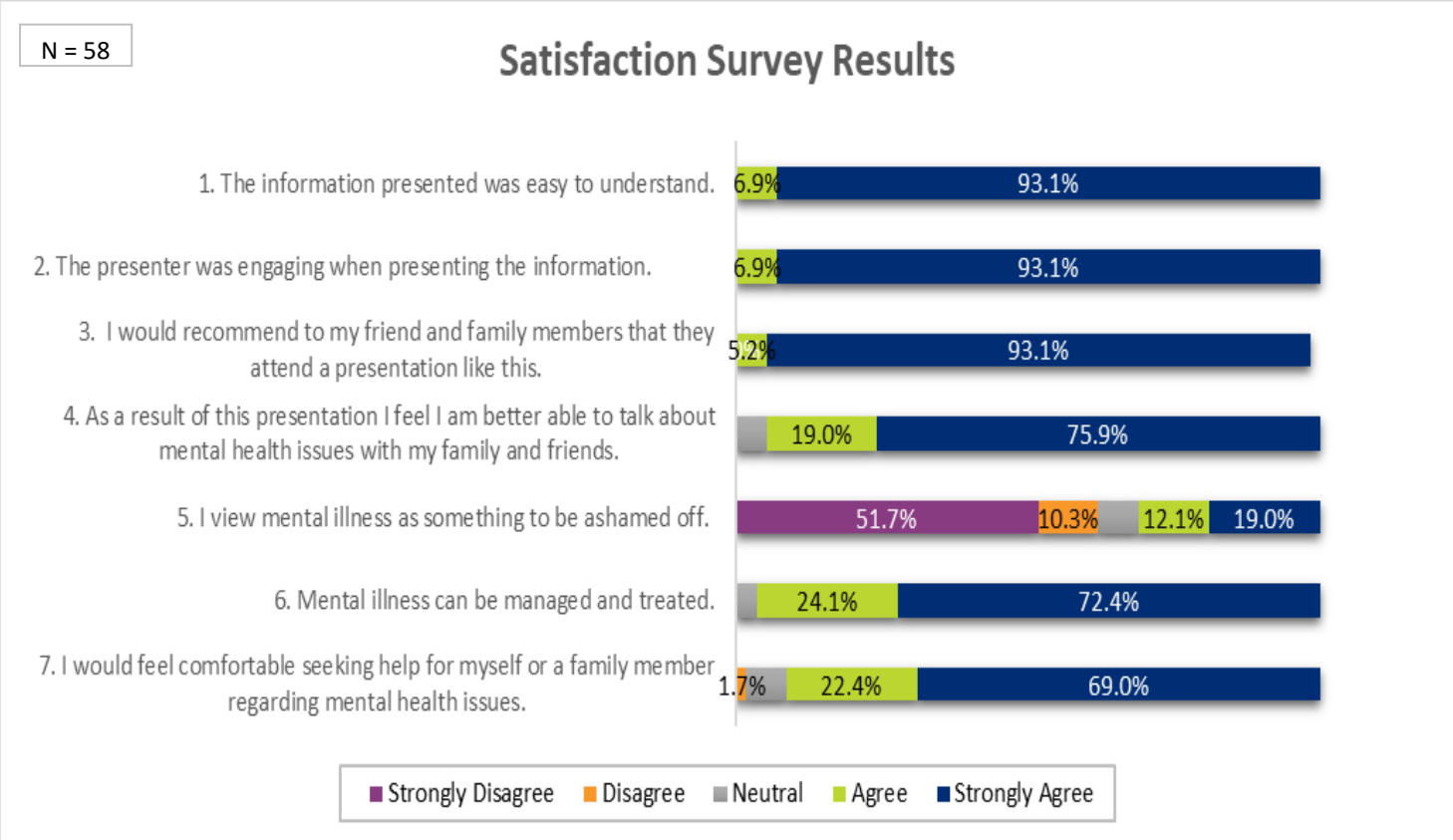
Summary of Survey Results:

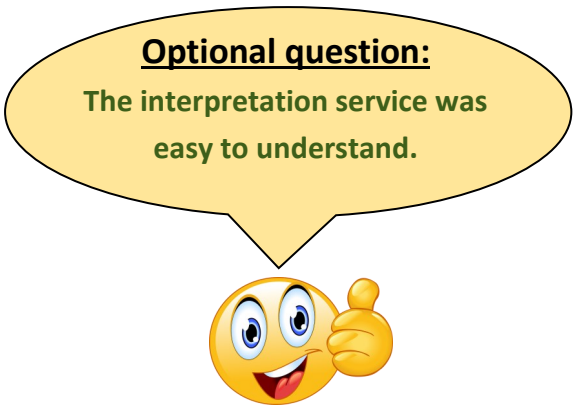
The results of post-satisfaction surveys collected from AAPI MHRC event attendees can be summarized below:

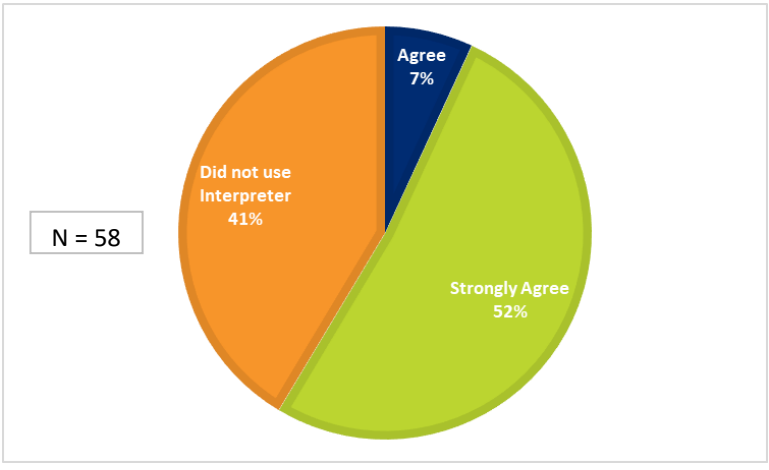
- **100%** attendees responded "Strongly Agreed" or "Agreed" that ***the information presented during the presentation was easy to understand***, and that ***the presenter was engaging when he/she presented the information***.
- **98.3%** of the attendees "Strongly Agreed" or "Agreed" that *they* ***would recommend their friends and family members to attend a similar presentation***.
- After the presentation, **94.9%** of the attendees felt "Strongly Agreed" or "Agreed" that ***they were better able to talk about mental health issues with their family and friends***.
- After the presentation, **51.7%** of attendees "Strongly Agreed" that ***they did not view mental illness as something to be ashamed of***, while **19%** "Strongly Agreed" that ***they viewed mental illness as otherwise***.
- After the presentation, **96.5%** of attendees felt "Strongly Agreed" or "Agreed" that ***mental illness can be managed and treated***.
- **91.4%** of attendees felt "Strongly Agreed" or "Agreed" that ***they would feel comfortable seeking help for themselves or their family members regarding mental health issues after the presentation***.

AAPI MHRC Events: Post Satisfaction Survey Results (*continued*)

The figure below shows the post-satisfaction survey results in a graph format to better illustrate the attendees' responses after the AAPI MHRC events/presentations.







The last question on the satisfaction survey was for attendees to indicate whether or not they used the interpretation service while attending AAPI MHRC events, and if so, whether or not the interpretation service was easy to understand. This was an optional question since not all attendees needed the interpretation service, although it was still offered during the events. Based on survey data collected from 58 attendees, **34** (**58.6%**) responded that they were either "Strongly Agreed" or "Agreed" that ***the interpretation service was easy to understand***, while 41.4% (n = 24) indicated that they did not use the interpretation service.

AAPI MHRC Events: Post-Satisfaction Survey Comments

The post satisfaction survey also has a section where participants could write comments on whether or not "***the presentation was helpful***", as well if to comment if they had any other feedback regarding the program. Below are the comments from participants that were gathered from the satisfaction surveys:

"Great Event! Made mental health a more "family-friendly "topic for something that is usually so taboo. Very impactful!"
"Liked the open communication across generations."
"The material presented was relevant and good information to be heard and learned."
"Liked the group interaction, and the support group to look forward."
"Good reminder to find your support and do self-care."
"I liked everything that was discussed during the event."
"The presenter was understandable, did a great job and helpful!"
"I really appreciate the open and supportive atmosphere. Thank you for making through the mental health awakening management in a very clear and supportive way."
"I liked how they tried to get through the mental wellness plan together and the collaborative nature in multiple AAPI community organization."
"I learned a lot from this event."
"All of the topics are very helpful. Dr. Navarro is very knowledgeable."
"Now I understand the meaning of othering, how that affects me and others without knowing it."
"Very Satisfied! Learned a lot of great ideas and principles. Applicable to daily life."
"Movie and captivity were great demonstration on identifying signs of mental health challenges, how to offer help and how to develop skills and relationships to improve outlook."
"They made the environment very comfortable to talk & interact both very welcoming new talks."
"The physical resources are helpful. I'll definitely take them hoe to share with my family."
"I liked the Chika Chika connection with other Filipina women."
"Good event and set-up. Very well coordinated and planned out."
"There is a solution of everything, and acceptance is very important, being honest of oneself."
"I liked the breathing exercise, affirmations, using digital collage to explore feelings and expressions."
"I felt like it gave me a space to deep-dive and reflect on some buried thoughts. It was comforting to share it with a community of people with similarities."
"A lot of opportunities to share, spotlight on how Asian culture adds additional layers of complexity to the conversation, very validating and real stance of presenter/well researched current events examples, actionable takeaways of what to try and what to avoid."
"It was really nice to be in a community of people with similar experiences."
"I liked the activities as well as learning about the connection of art, narratives, and mental health."
"I had so much fun today. It was a stress reliever, I laughed a lot, and what a great way to connect! Would love another session to join anytime soon."
"The interaction and activities were really good. I was a little shy at first, but the facilitators were welcoming and broke the ice for participants to jump in and participate."
"I liked being in community and listening to healing music"
"It was very affirming to connect with others regarding the connect we all share with music, and connecting it to how we cope, express, create, and live. Thank you very much!"
"I liked using music as a way to cope with mental health was a very creative concept! Thanks!"
"The connection between music and mental health."
"This presentation was so warm and welcoming, I had fun making a playlist :) Thank you so much!"

MHSA Prevention and Early Intervention
Keeping Intergenerational Ties in Ethnic Families (KITE)

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Intergenerational/Intercultural conflict is a significant stressor in immigrant families that occurs because of differential acculturation between migrant parents and their children (Ying, 2007). More specifically, Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) is a community-based educational intervention that aims to strengthen the intergenerational relationship between immigrant parents and their school-age children and adolescents. Parents are introduced to methods that may be used to cope with the stresses of parenting and migration, that are adapted from a course on the prevention of depression (Munoz & Ying, 2002).

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI that started in the fiscal year 2019-2020, and is currently in its fifth year of funding. The KITE program was built to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community, and was awarded to Asian Pacific Counseling and Treatment Center (APCTC) to begin in July 2019. More specifically, the KITE program was designed to offer Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school aged children and adolescents (ages 6 to 17 years old).

During the fiscal year 2023-2024, there were a total of 67 parent participants within Riverside County enrolled in a total of 5 KITE parenting program series (2 class series were offered in Chinese, and 2 class series were offered in combination of Tagalog and English, and 1 class series was offered in Korean). Of these, a total of 54 parent participants successfully completed the program. For FY 2023-2024, KITE parenting classes were completed using a combination of virtual via Zoom, as well as in-person (offered at churches or local schools), depending on participants' schedules and preferences. Despite the fact that some of the parent participants were unable to complete the program due to scheduling conflict or other personal reasons, the total completion percentage for the KITE program during the fiscal year 2023-2024 was still relatively high at 80.6%.

Additionally, during the fiscal year 2023-2024, KITE program workshops were offered to the Asian-American Pacific Islander (AAPI) communities, and KITE program outreach activities were also conducted. Similar to the KITE parenting program, these workshops were offered in combination of virtual and in-person methods, depending on parents' and/or coordinators' schedules. KITE outreach activities were also in combination of in-person as well as virtually via Facebook groups and WeChat. In fiscal year 2023-2024, there were a total of 21 KITE workshops offered with a total of 273 AAPI attendees.

Executive Summary

Based on the demographic data submitted from 67 enrolled parent participants for the fiscal year 2023-2024, the demographic data shows that the majority of participants for the KITE Program were Female (64.8%, n = 35), who mostly resided in the city of Eastvale (40.7%, n = 22). The KITE parent participants were predominantly Chinese (61.1%, n = 33), who preferred to use Mandarin/Chinese as their primary language. Additionally, there were 39 participants (72.2%) who responded that they were the "First-Generation Americans," and 50% of the total participants (n = 27) responded "Yes," that they do have conflicts with their children due to different cultural beliefs. Based on responses on their children's ages, parent participants indicated that their children were between the ages of 6 and 11 years old (48.2%, n = 26) and between the ages of 11 and 17 years old (46%, n = 25), while the remaining 3 participants indicated that their children were under the age of 6 (3.8%), and over the age of 17 (1.9%).

There were three survey measures collected at the beginning and at the end of the KITE Program, as well as post–satisfaction surveys collected at the completion of the program. The pre-post *Strength and Difficulties Questionnaire (SDQ)* analysis showed that there were decreases on the average scores in **Hyperactivity Scale** (11.3% change from 1.93 to 1.71), **Emotional Symptom Scale** (11.1% change from 1.57 to 1.39), **Peer Problems Scale** (8.9% change from 1.53 to 1.40), and **Conduct Problems Scale** (7.5% change from 1.43 to 1.33). Additionally, there was an increase on the **Prosocial Scale** (9.6% change from 2.34 to 2.57). Overall, average scores on the SDQ pre-measures were within the normal range across all SDQ scales, which suggest that parent participants did not view their children's strength and difficulties as an issue, at enrollment into the KITE program. The pre to post analysis using a paired samples T-Test showed statistically significant results ($p < .05$) on all items on the of the SDQ scale, as well as the **Total Difficulties** scale.

Additionally, the pre-post *Alabama Parenting Questionnaire (APQ)* analysis showed a 6.7% increase on the **Parenting Involvement Scale** (from 3.50 to 3.74) and a 5.1% increase on the **Positive Parenting Scale** (from 4.06 to 4.27), while **Inconsistent Discipline Scale** showed a 7.5% decrease (from 2.74 to 2.514, and **Other Discipline Practices Scale** showed a 2.9% decrease (from 2.61 to 2.53). Furthermore, both **Parenting Involvement** and **Positive Parenting** scales showed statistically significant results ($p < .05$).

The pre-post *Relationship* analysis showed that the total scores increased 2.52 points from pre-to-post measures, from 32.39 to 34.91, and a paired samples T-Test showed that this result is statistically significant ($p < .05$). An item-by-item analysis showed the highest percent differences was shown on items number 9 (**I am satisfied with our relationship**), with a 18.5% increase from pre-to-post measures, followed by item number 3 (**My child obeys me**), with 14.8% increase from pre-to-post measures. Further analysis using paired samples T-tests also showed that 7 out of 9 APQ scale items showed statistically significant results at or below $p < .05$.

Overall, analysis on the post-satisfaction surveys showed highly positive results, that the majority of parent participants (92% or more) responded to either "Strongly Agree" or "Agree" to all of the survey statements. The majority of parent participants also provided very positive feedback regarding the KITE parenting programs, with many commenting that they understood their children more, that their relationships with their children were much closer, that they communicated better, and that they were able to bridge the cross-cultural gaps with their children.

Program Description

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community. This program first started in the fiscal year 2019-2020, and currently in its third year of funding. KITE Program offers Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school-aged children and adolescents (ages 6 to 17 years old). Furthermore, the KITE program is built as a community-based educational intervention that aims to strengthen the inter-generational relationship between Asian-American Pacific Islander (AAPI) immigrant parents and their school-aged children and adolescents.

The KITE program is designed to target on the parents' affection, cognition, and behaviors. Through KITE program, parents are expected to learn to effectively empathize with their child's perspective, to cognitively understand variations in the ethnic and American Cultures and its impact on their child's development, values and their intergenerational relationship, as well as to develop effective behavioral parenting skills. Parents are introduced to methods that may be used to cope with stresses of parenting and migration. The KITE program also incorporates cultural competency principles, including but not limited to, awareness of cultural differences, knowledge of cultural contents (i.e. norms, customs, language, lifestyle, etc.), accurate assessment and differentiation of culture and pathology, and use of culturally competent interventions.

The community based organization assigned for this program is Asian Pacific Counseling and Treatment Center (APCTC), which is contracted to provide education and skill development for parents by conducting parent education workshops to Asian-American Pacific Islander parents within community organizations, such as schools, churches, homes, and other natural settings that are non-threatening/non-stigmatizing locations for participants. KITE is an 8-session program, with 2-hour sessions usually held weekly in the evening, and offered in the parents' preferred language. Currently, they are offered in Simplified Chinese, Korean, and combination of English/Tagalog languages. It is an intensive program where detailed curriculum is followed, in which parents need to complete weekly homework assignments, and are individually reviewed by the trained instructors.

The KITE program goals include: strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional and social problems in children and adolescents; i.e. those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses. Currently the services are provided in the Western and Mid-County Regions of Riverside County, in the target communities identified below:

- **Western Region**: Riverside, Jurupa, Moreno Valley, Norco, Rubidoux, Pedley, Sunnyslope, Mira Loma, Glen Avon and other surrounding unincorporated areas.
- **Mid-County Region**: Hemet, San Jacinto, Lake Elsinore, Perris, and other surrounding unincorporated areas.

APCTC is contracted to provide parenting educational group series, for a combined minimum of 40 parents per region, per year. Each group will have a minimum of 6 parents enrolled and a maximum of 20 parents enrolled (Ratio: 1 Facilitator to 10 Parents). The KITE program completion is defined as completing 6 out of 8 sessions. Additionally, APCTC is expected to implement at least 10 "Community Education/Outreach Workshops" per region, per year, with each specific Asian immigrant parent group (i.e., Chinese, Korean, or Filipino).

Class Curriculum

The KITE class curriculum is based on the SITIF program, which was developed and validated by Dr. Yu-Wen Ying of UC Berkeley, and has been translated in Chinese, Korean, Vietnamese, and Spanish. In KITE program curriculum, different skills have different objectives, and parents are invited to employ the skills that are most likely to yield the desired outcome, so all of the methods covered in KITE program focus on parenting process of "how-to" and not specific parenting content of "what-to." For example, while immigrant parents may prefer a hierarchical unidirectional method of communication that is sanctioned by their ethnic culture, their children may prefer a more interactive style that involved less lecturing and more active listening (Ying, 2007). Generally, the KITE program is designed to bring parents' awareness, promoting greater cross-cultural competence, to improve their sense of control in parenting and developing effective parenting skills, particularly in the area of communication, and to help them cope better with the stresses of cross-cultural parenting.

The KITE class curriculum developed by Dr. Ying was originally designed to be a 10-session curriculum for first -generation immigrant parents, and it is a culturally sensitive, community-based intervention. For the KITE program, the curriculum has been modified and condensed into an 8-session program, where parent participants are expected to complete 6 out of 8 sessions in order to complete the parenting series. The aim of KITE class curriculum is to improve the intergenerational relationship, and discusses the following:

- Parents sense of self-efficacy (i.e. emotional awareness and empathy for their children's experiences)
- Knowledge and understanding of differences between the native and American cultures
- Teaches behavioral parenting skills, including self-care

The KITE program's 8-session class schedule and topics are as follows:

- *1st Session: Introduction & Learning about Cultural Differences*
- *2nd Session: Understanding Your Child*
- *3rd Session: Promoting Parent-Child Understanding*
- *4th Session: The Use of Structuring and Reinforcement*
- *5th Session: The Use of Rules, Limits, Consequences, and Punishment*
- *6th Session: The Use of Special Time*
- *7th Session: Review of Parenting Skills*
- *8th Session: Coping with Stress & Strengthening the Intergenerational Relationship-Conclusion*

After each KITE class session, parent participants are required to do the assigned homework related to the current week's topic, which is then discussed together as a group on the following class session. Overall, the KITE class curriculum highly encourages parent participants to be actively involved in the following, but not limited to, sharing their cultural background, family background, opinions about raising their child in a different culture than the one the parents were raised in, experiences in communicating with their child, and any challenges they may encounter when trying to strengthen their relationship with their child.

Data Collection

The RUHS-BH Demographic form is to be collected at the beginning of each KITE parenting class series (1st session/Week 1), as well as the Pre-Measures. Additionally, Post-Measures and Post-Satisfaction Surveys are to be collected at the end of each class series (8th session/Week 8). Other forms such as, Weekly Sign-In Form, Master Attendance Roster Form, Data Submission Checklist Form, and Justification for Missing Performance Measures Form are additional documents to be collected and submitted to RUHS-BH at the completion of each KITE parenting class series.

There are three different measures used for the KITE program that are collected at the beginning of the KITE program, and at the completion of KITE program:

- ***Strength and Difficulties Questionnaire (SDQ)***
- ***Alabama Parenting Questionnaire (APQ)***
- ***Relationship Questionnaire***

These three measures are used to document participant's thoughts and challenges prior to and after the KITE program has been completed, and will be analyzed to measure and compare the changes in participants' thoughts and relationships with their children before and after completing the KITE program. The post-satisfaction surveys are also distributed and collected at the end of the KITE program, with the purpose of documenting the participants' feedbacks on their perception of the KITE Program.

On all of the measures, we asked each parent participant to list the child name and age, and to focus on their current relationship with that particular child. When parents have more than one child, we asked the parent to list the child's name and age on which the parents would like to focus their current relationship on. The child's age must be between the ages of 6 and 17 years old. Generally, the oldest child is used as the "target child", on whom parent participants would practice their parenting skills as part of their weekly homework assignments. For families with more than one child, the target child can also be the child with whom the parent participant has the most relationship challenges.

There were a total of 5 KITE parenting class series completed during the fiscal year 2023-2024, and a total of 67 parent participants enrolled in the KITE program. Of these enrolled participants, a total of 54 completed the KITE program, a completion rate of 80.6%. The classes were offered in the following groups, using the group's native language:

- Chinese (2 class series were completed, offered in Chinese Simplified/Mandarin)
- Filipino (2 class series was completed, offered in combination of English and Tagalog)
- Korean (1 class series were completed, offered in Korean)

In addition to the KITE parenting class series, KITE workshops were also offered to AAPI parents who were interested to participate prior to joining the KITE parenting program. The KITE workshops are generally shorter, consist of 1 session or more, depending on the type of workshop, and last approximately one hour. There were a total of 21 KITE workshops completed during the fiscal year 2023-2024, where 13 workshops were offered in the Western region, and 8 workshops were completed in the Mid-County region, with a total of 273 attendees:

- 12 workshops were completed in Mandarin/Simplified Chinese for Chinese groups
- 6 workshops were completed in combination of English and Tagalog for Filipino groups
- 3 workshops were completed in Korean for Korean groups

The detailed description for KITE Program Completion, as well as the lists for KITE Parenting Class Series and KITE Workshops are shown on pages 7 to 10.

KITE Parenting Class Series and Workshop Completions

The contract expectations for the KITE program were to complete the following: 10 "Community Education/ Outreach Workshops", 3 "Bicultural Parenting Class Series", as well as a combined minimum of 40 parents completed per region, per year, with each specific Asian immigrant parent group (i.e. Chinese, Korean, or Filipino). Tables below describe the total completion and contract expectations from KITE Program during the fiscal year 2023-2024.

Due to the widespread of COVID-19 pandemic since early 2020, all outreach activities, workshops and parenting class series were conducted entirely online for the fiscal years 2020-2021 and 2021-2022. For the fiscal years 2022-2023 and 2023-2024, a combination of virtual and in-person outreach activities, workshops, and parenting class series were conducted. There were a total of 21 KITE workshops completed (a 105% completion rate), in which 13 workshops were completed in the Western region and 8 workshops were completed in the Mid-County region. Overall, the total workshops completion for fiscal year 2023-2024 exceeded the contract expectation of completing 20 workshops in the fiscal year. Additionally, there were a total of 5 KITE parenting class series completed (a 83.3% completion rate) during the fiscal year 2023-2024, in which 3 of the parenting class series were completed in the Western region, and 2 parenting class series were completed in the Mid-County region.

It is also expected that the assigned contractor would provide a KITE parenting class series to a minimum of 40 parents per region, per year. During the fiscal year 2023-2024, a total of 54 parent participants completed the KITE parenting class series, out of 67 parent participants within Riverside county regions (a 80.6% completion rate). Based on the total counts of class completion, the Western region met 66.7% of the contract expectation (40 parents completed), while the Mid-County region met 23.3% of the contract expectation (14 parents completed). Overall, the Countywide percent completion for KITE parenting program is 45% in regards to the contract expectation.

KITE Workshop Completion (n = 21)			
Source:	**Number of Workshops Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**13**	**10**	**130%**
Mid-County	**8**	**10**	**80%**
Countywide	**21**	**20**	**105%**

KITE Parenting Class Series Completion (n = 5)			
Source:	**Number of Parenting Classes Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**3 series**	**3 cycles**	**100%**
Mid-County	**2 series**	**3 cycles**	**66.7%**
Countywide	**5 series**	**6 cycles**	**83.3%**

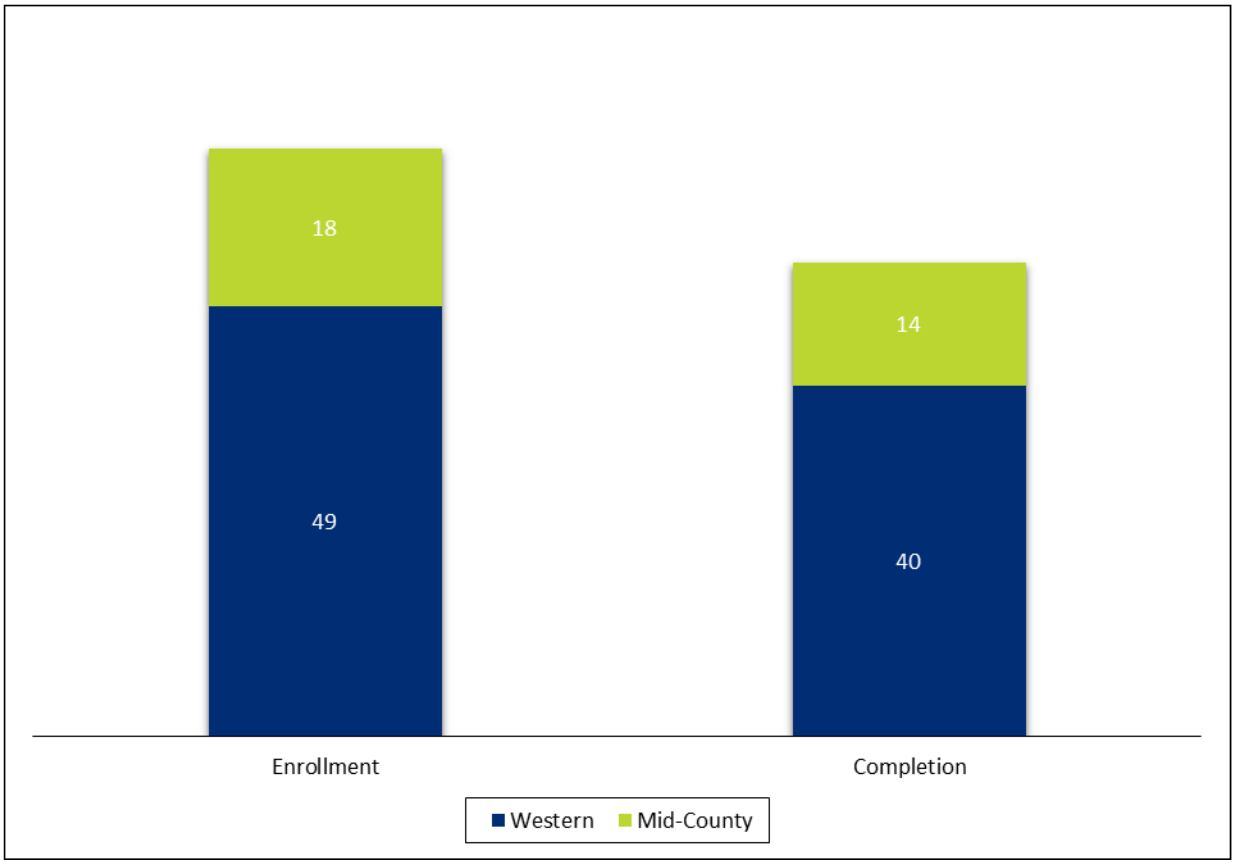
KITE Parenting Class Participants Completion (n = 54)			
Source:	**Number of Parent Participants Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**40**	**40**	**100%**
Mid-County	**14**	**40**	**35%**
Countywide	**54**	**80**	**67.5%**

KITE Parenting Classes—FY 2023-2024

Language	Location/Group Site	Number of Cycles	Region		Start Date	End Date	Number of Enrollment	Number of Completion
			Mid-County	Western				
Chinese	Eastvale Elementary School	2	0	2	07/20/23	09/28/23	11	9
	Riverside Unified School District (Zoom)				01/31/24	03/27/24	30	26
Korean	Riverside Korean Baptist Church	1	0	1	10/18/23	12/20/23	8	5
Filipino	New Hope Community Church	2	1	0	10/14/23	01/13/24	10	8
	New Hope Community Church		1	0	03/27/24	05/15/24	8	6
Total:		**5**	**2**	**3**	**Total:**		**67**	**54**

Completion Rate: 80.6%

KITE Parenting Class Enrollments by Region—FY 2023-2024



KITE Workshops—FY 2023-2024

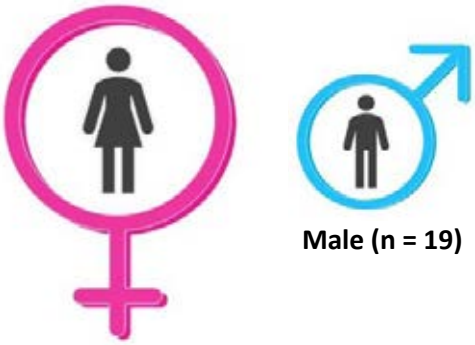
Language/ Ethnicity	Number of Workshops	Region		Date	Location	Topic	Attendees
		Mid-County	Western				
Korean	3	2	1	4/10/2024	Calvary Church Murrieta (Zoom)	5 Love Languages of Children	6
				5/19/2024	Riverside Korean Baptist Church	5 Love Languages of Children	41
				5/30/2024	Calvary Church Murrieta	Bicultural Identity	3
Filipino	6	6		09/30/23	New Hope Community Church Temecula	Family Ties	27
				11/18/23	San Manual Filipino Association	Showing Understanding	7
				01/23/24	Liberty High School	Showing Understanding	4
				02/23/24	Crown Hills School	Bicultural Identity	4
				05/18/24	Bataan Association	5 Love Languages of Children	9
				06/22/24	Onward Zion	KITE Parent Class Preview	13
Chinese	12		12	07/27/23	Eastvale Elementary School	Bicultural Identity	11
				08/03/23	Eastvale Elementary School	Understanding Your Teens	13
				09/14/23	Eastvale Elementary School	5 Love Languages of Children	8
				09/21/23	Eastvale Elementary School	Self-Care: Mindfulness	7
				09/27/23	Roosevelt High School	Understanding Your Teens	9
				10/12/23	Riverside Unified School District (Zoom)	5 Love Languages of Children	2
				02/07/24	Riverside Unified School District (Zoom)	Understanding Your Teens	25
				03/13/24	Zoom	Self-Care: Mindfulness	22
				03/20/24	Zoom	5 Love Languages of Children	20
				05/19/24	Norco Community Christian Church	Cross-Cultural Identity of Chinese American	20
				05/23/24	Norco Community Christian Church (Zoom)	Cross-Cultural Identity of Chinese American	19
				06/04/24	Eastvale Library	KITE Parent Class Preview	3
Total Number of Workshops: 21		**8**	**13**				**Total Workshop Attendees: 273**

Demographics

There were a total of 67 parent participants who enrolled in the KITE program in Riverside County for the fiscal year 2023-2024. Of these, 54 participants completed the parenting class series and submitted the complete demographic forms, pre measures, post measures, as well as satisfaction surveys. The remaining 13 participants did not complete the program due to scheduling conflicts or personal reasons. The overall completion rate for the KITE parenting program in FY 2023-2024 was 80.6%.

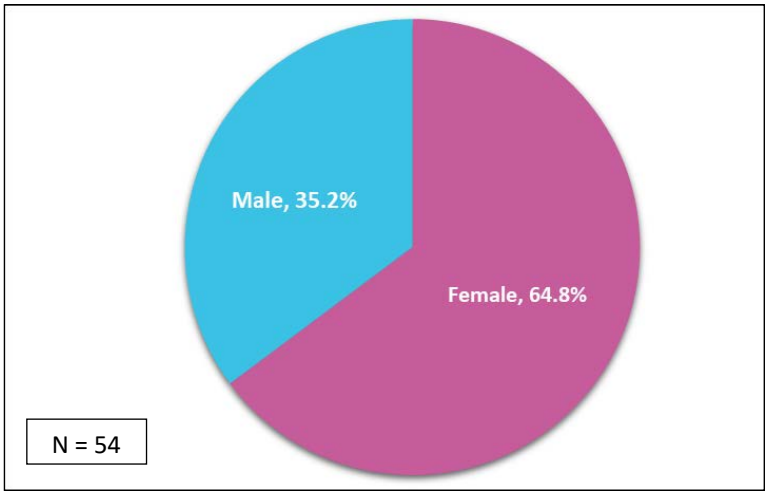
Gender

The majority of KITE parent participants were Female (64.8%, n = 35), while the remaining participants were Male (35.2%, n = 19).



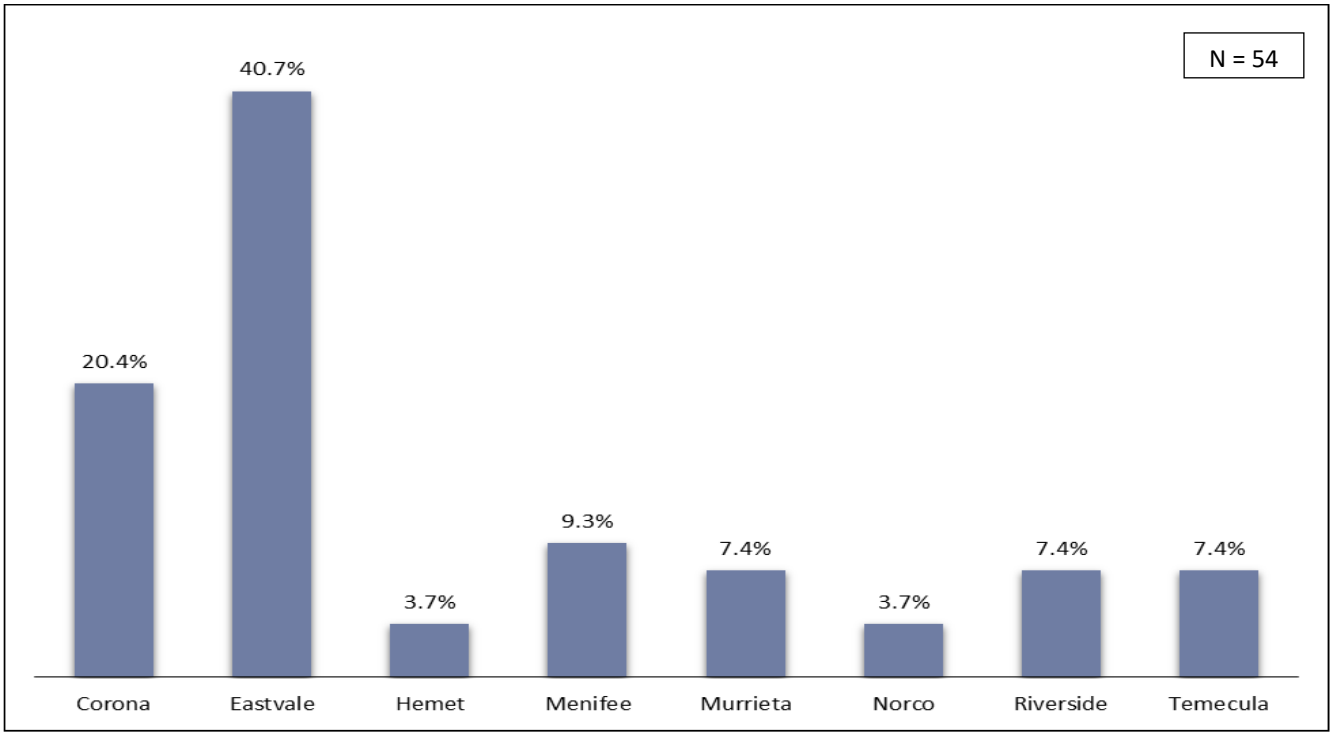
Male (n = 19)

Female (n = 35)



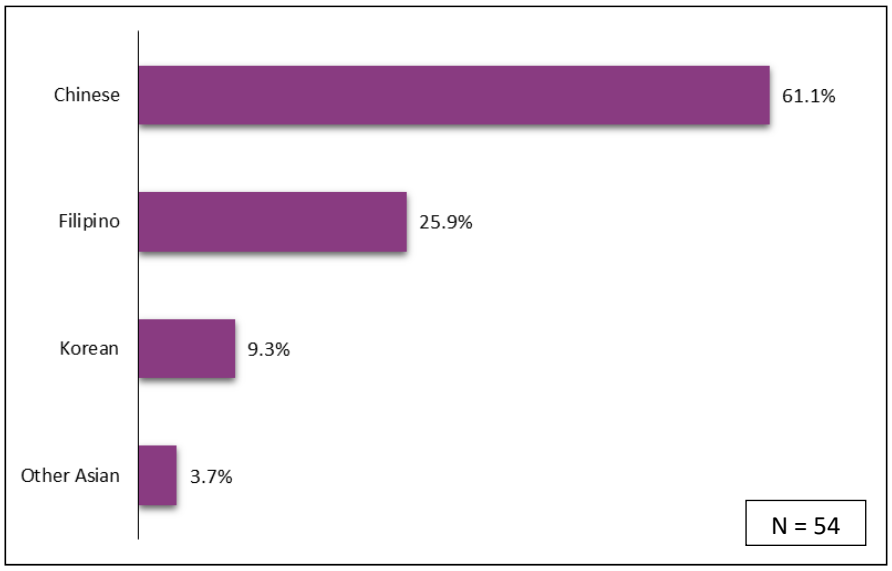
City of Residence

The majority of KITE parent participants indicated that they reside in Eastvale (40.7%, n = 22). Smaller percentages of parent participants resided in Corona (20.4%, n = 11) and Menifee (9.3%, n = 5), while the remaining participants indicated that they resided in Murrieta, Riverside, Temecula, Hemet, and Norco.



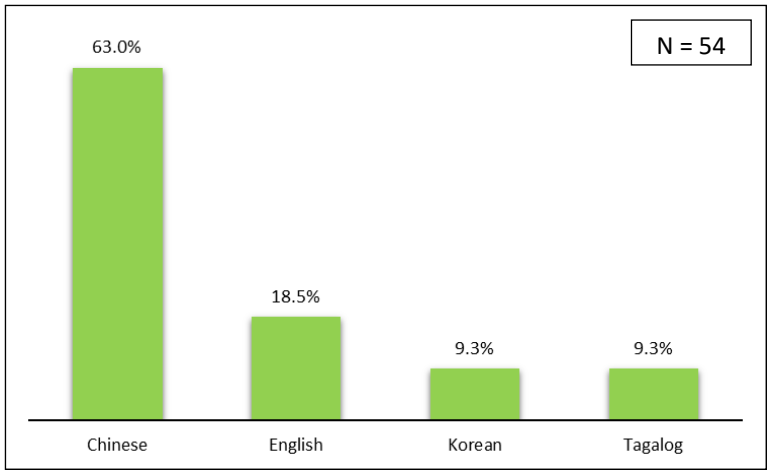
Race/Ethnicity

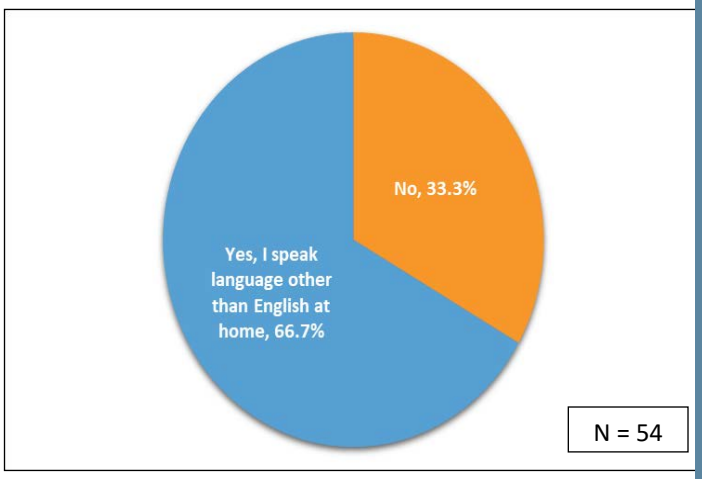
The majority of parent participants enrolled in the KITE Program were Chinese (61.1%, n = 33), while the remaining participants reported they were Filipino (25.9%, n = 14), Korean (9.3%, n = 5), and Other Asian (3.7%, n = 2).



Preferred Language and Language Spoken at Home

The majority of parent participants indicated that their preferred language was Chinese (63%, n = 37), while other languages spoken were English (18.5), Korean (9.3%), and Tagalog (9.3%). We also asked participants if they speak a non-English Language at home, and 66.7% (n = 36) responded "Yes". Participants listed the languages used at home as follows: Chinese, Korean, and Tagalog.





Disabling Condition, LGBTQI, and Veteran Status

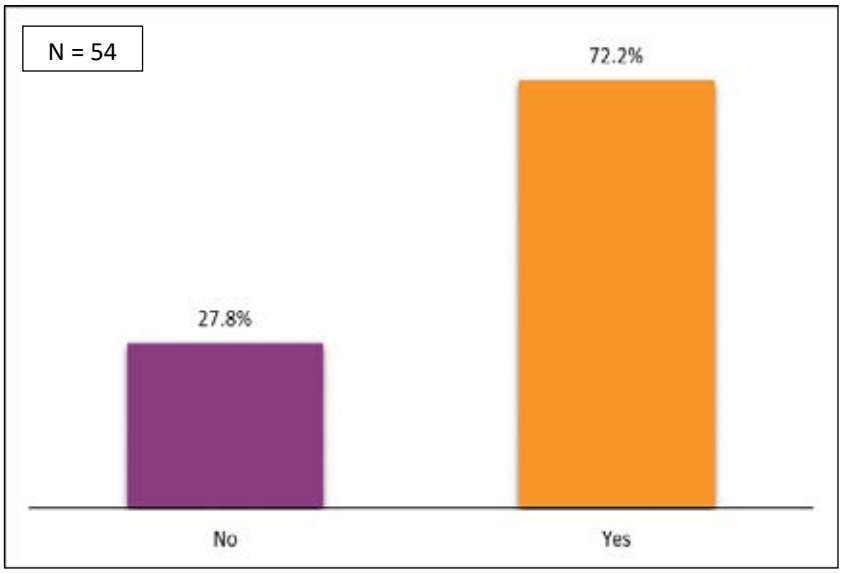
In response to demographic questions related to whether or not they have identified themselves as having Disabling Condition, identified as LGBTQI, and identified as Veterans, the results can be summarized as follows:

- 92.6% participants (n = 50) responded "No", in regards to whether or not they have any disabling condition. The remaining 4 participants who responded "Yes", noted that they have the following conditions: PTSD, Aneurysm, Psoriatic Arthritis, and Hearing Loss.
- 100% participants responded that they did not identify themselves as LGBTQI.
- 94.4% participants (n = 51) responded that they were not Veterans.

First Generation Americans and Conflicts due to Cultural Beliefs

One of the demographic question was for parent participants to indicate whether they were either "First Generation" or "Second Generation" Americans. First-generation Americans are defined as being born outside of the United States, while second-generation Americans are born in the United States but have parents who are born abroad. In response to this question, the majority (72.2%, n = 39) responded "Yes", that they are First-Generation Americans. Parent participants were also asked whether they had conflicts with their children due to different cultural beliefs, and 50% responded "Yes".

Are you 1st Generation Americans?

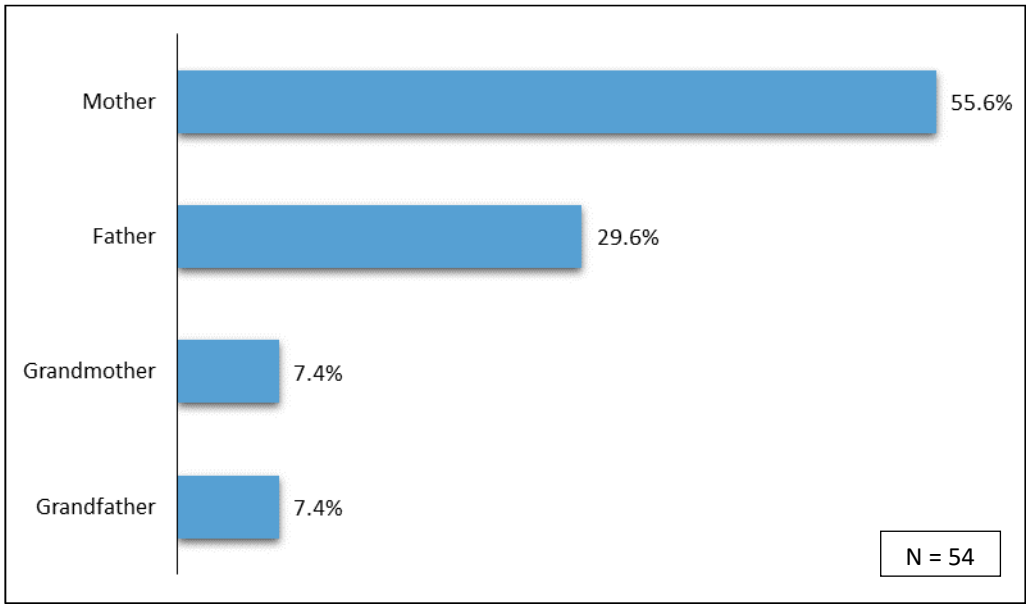


Do you have conflicts with your children because of different cultural beliefs?



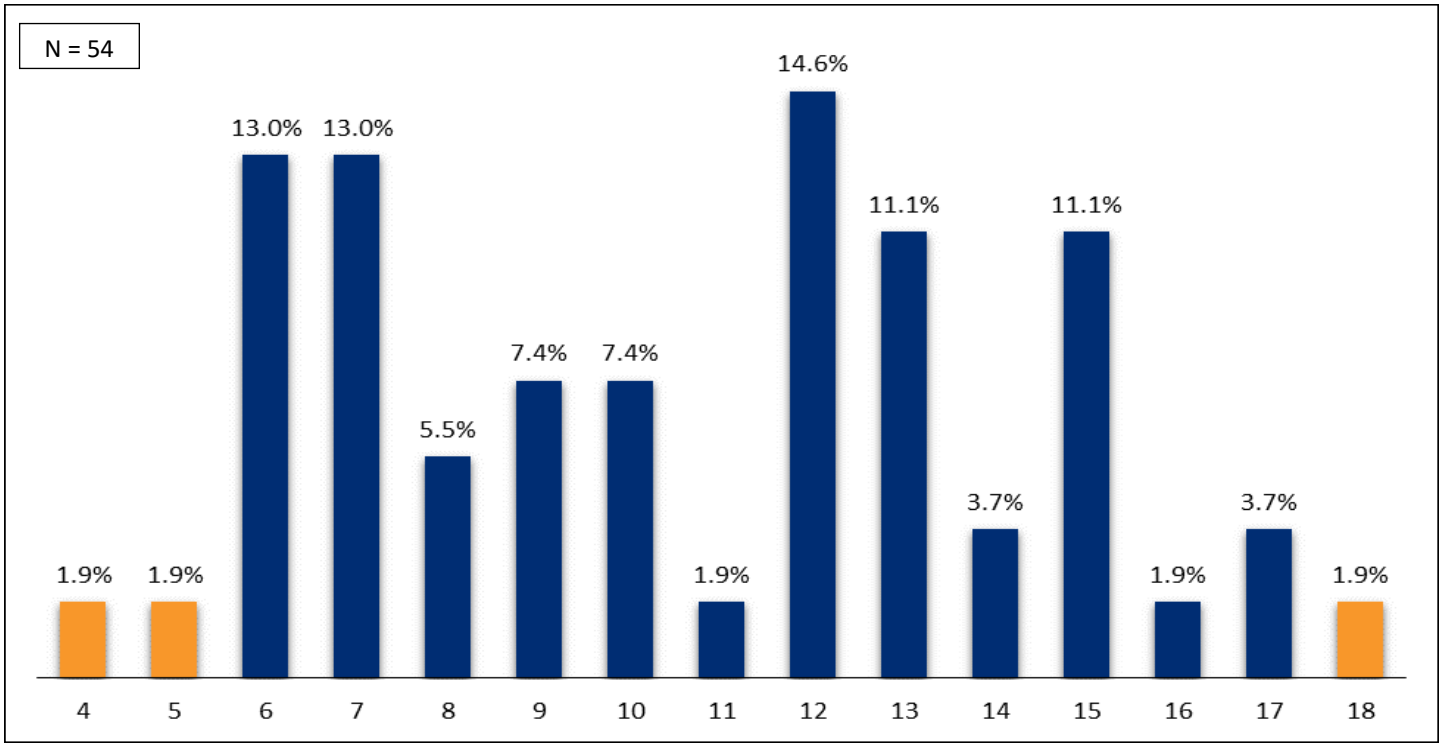
50% **50%**

Role of Parents Completing KITE Program



Parent participants were also asked the type of role/relationship they had with their children, and the results are as follows: 30 participants (55.6%) indicated their roles as the child's "Mother", 16 participants (29.6%) indicated their roles as the child's "Father", and the remaining 8 participants indicated as the child's "Grandmother" (7.4%), and the child's "Grandfather" (7.4%), respectively.

Ages of Participants' Children



We were also interested in knowing the ages of the participants' children, to confirm that they were indeed between the ages of 6 and 17 years old, and whether there was any correlation between the ages of their children and the level of intergenerational conflicts due to cultural beliefs between the two generations, which was shown on the previous page.

We asked parent participants to list the name and age of children of whom they would like to focus their relationship on. This question is listed on all of the KITE's pre- and post- measures. When parents have more than 1 child, they are asked to list the oldest child, or the child with whom they view as having the most challenges, as the "target child". The graph above only shows the total number of participants who completed the pre-and post-questionnaires and included in the analysis. Based on the current ages of children that parent participants have listed on their measures, the results are divided almost equally, where 26 participants (48.2%) responded that their children were between the ages of 6 and 11 years old, and 25 participants (46%) responded that their children were between the ages of 12 and 17 years old. It is also noted that 3 participants indicated that their children were under 6 years old (3.8%, n = 2) and older than 17 years old (1.9%, n = 1).

On page 13, it is shown that 50% of parent participants had indicated "Yes", that they do have conflicts with their children due to different cultural beliefs, and the majority of parent participants indicated that their children are indeed between the ages of 6 and 17 years old (94.3%, n = 51), which shows that the KITE program did meet the goal to provide services to the target audience of AAPI parents with school-aged children and adolescents within the ages of 6 to 17 years old. Furthermore, it is hoped that the KITE program would help to address the parents' needs in bridging the intergenerational gap due to different cultural beliefs, which then aims to strengthen biculturality and intergenerational relationship between the AAPI Parents and their children.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaires (SDQ) are used to measure the degree of strengths and difficulties that the child has, as viewed by their parents. On the SDQ form, we asked each parent participant to list the child name and age, and to focus on their child's strengths and the difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the strengths and difficulties questionnaires on. The SDQ measure has a total of 25 questions, which comprises 5 scales of 5 items each. The scales measured in SDQ are as follows:

- **Emotional Symptoms**
- **Conduct Problems**
- **Hyperactivity**
- **Peer Problems**
- **Prosocial Scales**

Detailed explanation of the scales, average scores, and the item numbers which correspond to each scale are shown on tables below. Moreover, the SDQ measure is structured on a 3-point a Likert Scale, where parents choose between three choices, where: 1 = "Not True", 2 = "Somewhat True", and 3 = "Certainly True".

Each question on the SDQ measure is a different statement/questionnaire that we asked each parent to choose the option that represents their child the most. The higher the score, the more likely parents viewed their child as having strengths or difficulties towards the statements. Each parent participant is asked to fill out SDQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

SDQ Scales and Item Numbers

Scales Measured in Strength and Difficulties Questionnaire	Item Numbers
Emotional Symptoms	3, 8, 13, 16, 24
Conduct Problems	5, 7, 12, 18, 22
Hyperactivity Scale	2, 10, 15, 21, 25
Peer Problems Scale	6, 11, 14, 19, 23
Prosocial Scale	1, 4, 9, 17, 20

SDQ Scales and Average Scores Interpretation

SDQ Scales	Normal	Borderline	Abnormal
Emotional Symptoms Scale	0-3	4	5-10
Conduct Problems Scale	0-2	3	4-10
Hyperactivity Scale	0-5	6	7-10
Peer Problems Scale	0-2	3	4-10
Prosocial Scale	6-10	5	0-4
Total Difficulties	0-13	14-16	17-40

***Possible score: 0 to 10 for each scale, or up to 40 for total scores*

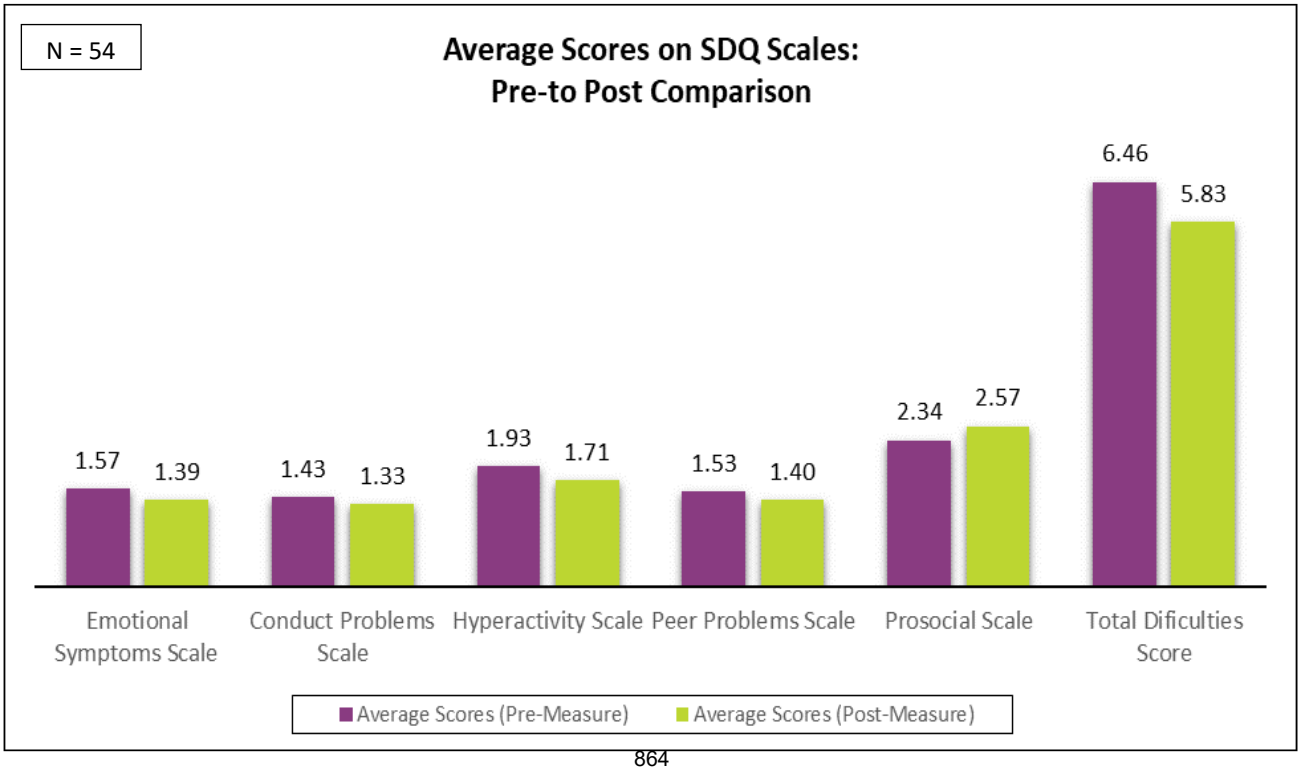
Strengths and Difficulties Questionnaire (SDQ) Scale Analysis and Results

There were a total of 54 pre-post matched pairs completed for the SDQ measure. Overall, changes were shown on the average scores across all scales, scores were found to be in the "normal range" at pre and post. Ideally, we would want to see a ***decrease*** in the Emotional Symptoms Scale, Conduct Problems Scale, Hyperactivity Scale, and Peer Problems Scale, and an ***increase*** in the Prosocial Scale.

The pre-post analysis showed that there were decreases on the average scores on the **Emotional Symptoms Scale** (11.1% decrease from 1.57 to 1.39), **Conduct Problems Scale** (7.5% decrease from 1.43 to 1.33), **Hyperactivity Scale** (11.3 % decrease from 1.93 to 1.71), as well as on **Peer Problems Scale** (8.9% decrease from 1.53 to 1.40). Overall, pre-scores fell within the normal range across all scales measured, which suggest that parent participants did not view their children's strength and difficulties as issues to them. The analysis also showed the ideal decreases on the 4 scales, and an increase on 1 scale listed above, as we would have expected. The pre-post analysis using paired samples T-Test showed that all changes in SDQ scales were *statistically significant* ($p < .05$).

In addition to the 5 scales measured in SDQ measure, we also compared the **Total Difficulties' Average Scores** from pre-to-post. The Total Difficulties Score is generated by adding the scores from all scales, *except* for **Prosocial Scale**, and this score can range from 0 to 40. Based on the pre-to post analysis, the Total Difficulties' average scores for all participants decreased from 6.46 to 5.83 (a change of 9.9%), and analysis using paired samples T-Test showed this decrease to be statistically significant ($t = 4.733$, $p < .05$), highlighted in green on table below. All pre– and post–scores on all scales are also shown within the normal range.

APQ Scales	Percent Change	*t*	df	p
Emotional Symptoms Scale	-11.1%	3.168	53	.003
Conduct Problems Scale	-7.5%	4.087	53	.000
Hyperactivity Scale	-11.3%	3.884	53	.000
Peer Problems Scale	-8.9%	2.750	53	.008
Prosocial Scale	9.6%	-3.984	53	.000
Total Dificulties Score	**-9.9%**	**4.733**	**53**	**.000**



Alabama Parenting Questionnaire (APQ)

The second measure collected during the KITE Program, Alabama Parenting Questionnaires (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth.

There were 42 items on the original version of APQ measure; however, for the purpose of KITE program, a modified format of the APQ measure was adopted for the KITE Program, with 29 items that would measure the following scales:

- **Parental Involvement**
- **Positive Parenting**
- **Inconsistent Discipline**
- **Other Discipline Practices (Harsh Discipline)**

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Never", 2 = "Almost Never", 3 = "Sometimes", 4 = "Often", and 5 = "Always". Each parent participant is asked to fill out APQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

Similar to the SDQ measure, each parent was asked to list the child name and age on the APQ measure, and to focus on their child's strengths and difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the parenting practices on.

Each question on the APQ measure is a different statement about parenting practices. For the KITE Program, each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. The scales measured on the modified APQ measure and the corresponding item numbers that belong to each score are shown on table below.

APQ Scales and Item Numbers

Scales Measured in Alabama Parenting Questionnaire	Item Numbers
Parenting Involvement	1 to 10
Positive Parenting	11 to 16
Inconsistent Discipline	17 to 22
Other Discipline Practices (Harsh Discipline)	23 to 29

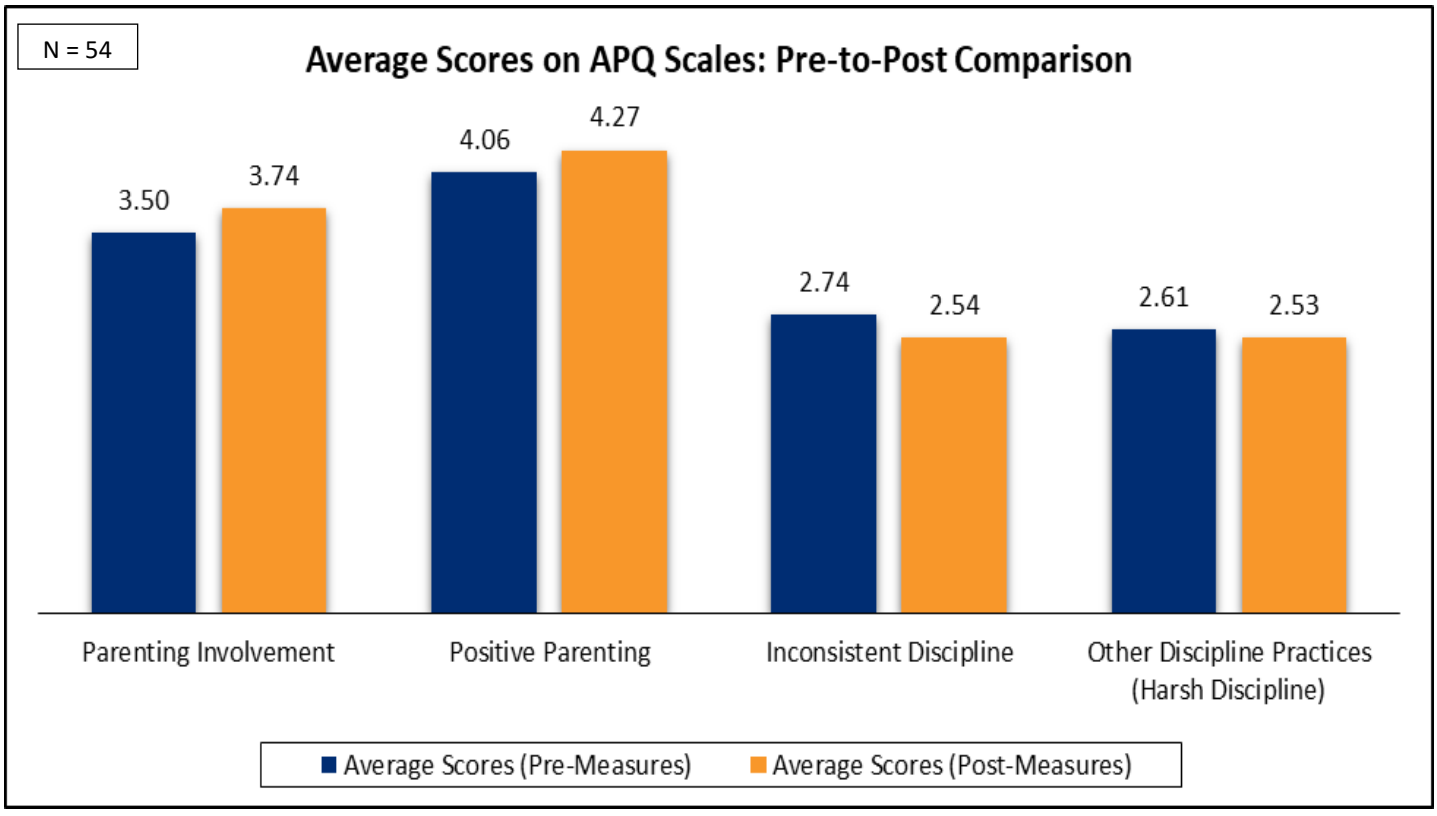
For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see that the average scores in "Parenting Involvement" and "Positive Parenting" scales to increase, and for the average scores in "Inconsistent Discipline" and "Other Discipline Practices (Harsh Discipline)" scales to decrease from pre-to-post.

Alabama Parenting Questionnaire (APQ) Scale Analysis and Results

A total of 54 pre-post matched pairs were completed by parent participants for the APQ measure. The table and graph below show the APQ Scale analysis and results. Based on the paired-samples T-Test analysis, the results showed improvements in the expected directions. The **Parenting Involvement** scale showed a 6.7% *increase* from 3.5 to 3.74 (which was a slight increase of parents' choices from "*Sometimes",* that changed towards "*Often"*) and a 5.1% *increase* on **Positive Parenting** scale from 4.06 to 4.27 (which was a slight *increase* of parents' choices from "*Often"*, that changed towards "*Always"*).

Additionally, **Inconsistent Discipline** scale showed the largest change, which is a *decrease* of 7.5% from 2.74 to 2.54), and **Other Discipline Practices** scale also showed a *decrease* of 2.9% from 2.61 to 2.53). Further analysis using paired samples T-tests for each of the APQ scale items are shown on the table below. Both **Parenting Involvement** and **Positive Parenting** scales, which showed increases from pre-to-post, also showed statistically significant results at or below $p < .05$, as shown on table below (highlighted in green). In sum, these overall results from APQ Scales showed positive improvements in parenting practices, from pre-measures to post-measures.

APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.7%	-2.280	53	.027
Positive Parenting	5.1%	-2.020	53	.048
Inconsistent Discipline	-7.5%	1.944	53	.057
Other Discipline Practices (Harsh Discipline)	-2.9%	0.966	53	.339

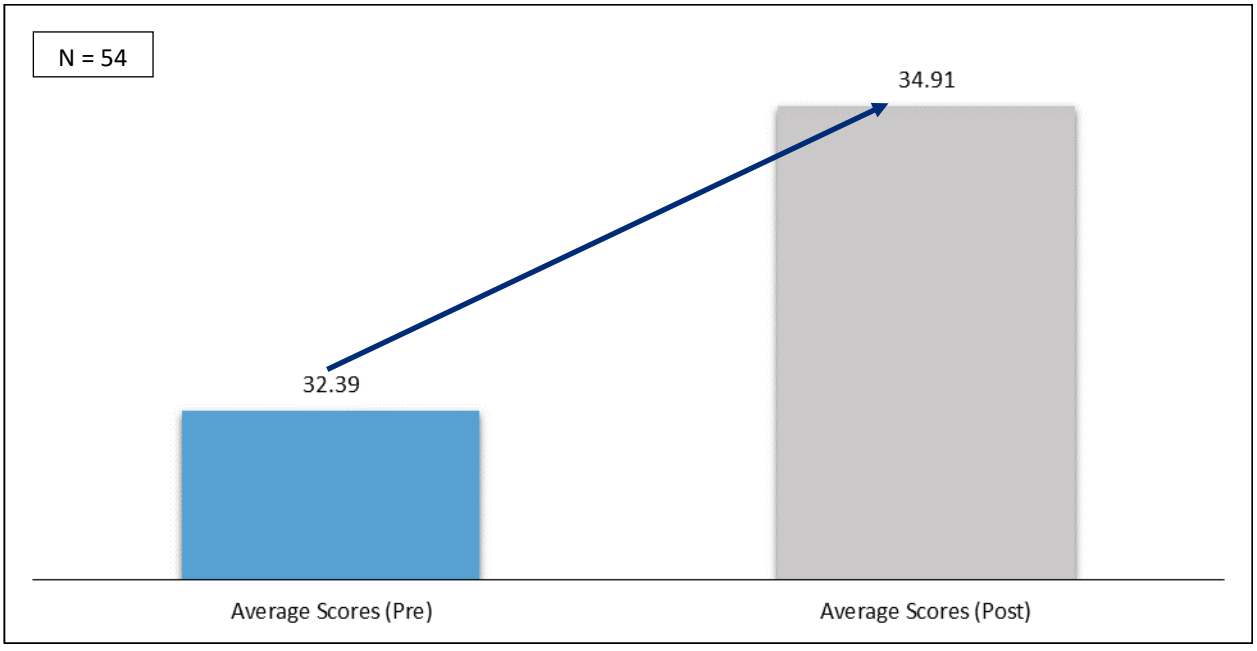


Relationship Scale

The Relationship Scale, the third measure used in the KITE program, is used to measure the degree of positive relationship that parent participants have with their children. Similar to APQ and SDQ measures, all parent participants were asked to list the child's name and age on the Relationship measure, and to focus on their relationship with their "target child" when responding to the questions. When parents have more than one child, we asked the parent participants to list the child's name and age with whom their current relationship is the most challenging, and to focus on the target child when responding to the relationship questions. The Relationship Scale was also collected at the beginning of the KITE parenting class series, and at the end of the KITE parenting class series.

The Relationship Scale has a total of 9 questions, structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Strongly Disagree", 2 = "Disagree", 3 = "Neutral", 4 = "Agree", and 5 = "Strongly Agree". For this Relationship measure, higher scores indicate a more positive relationship between the parent participants and their children.

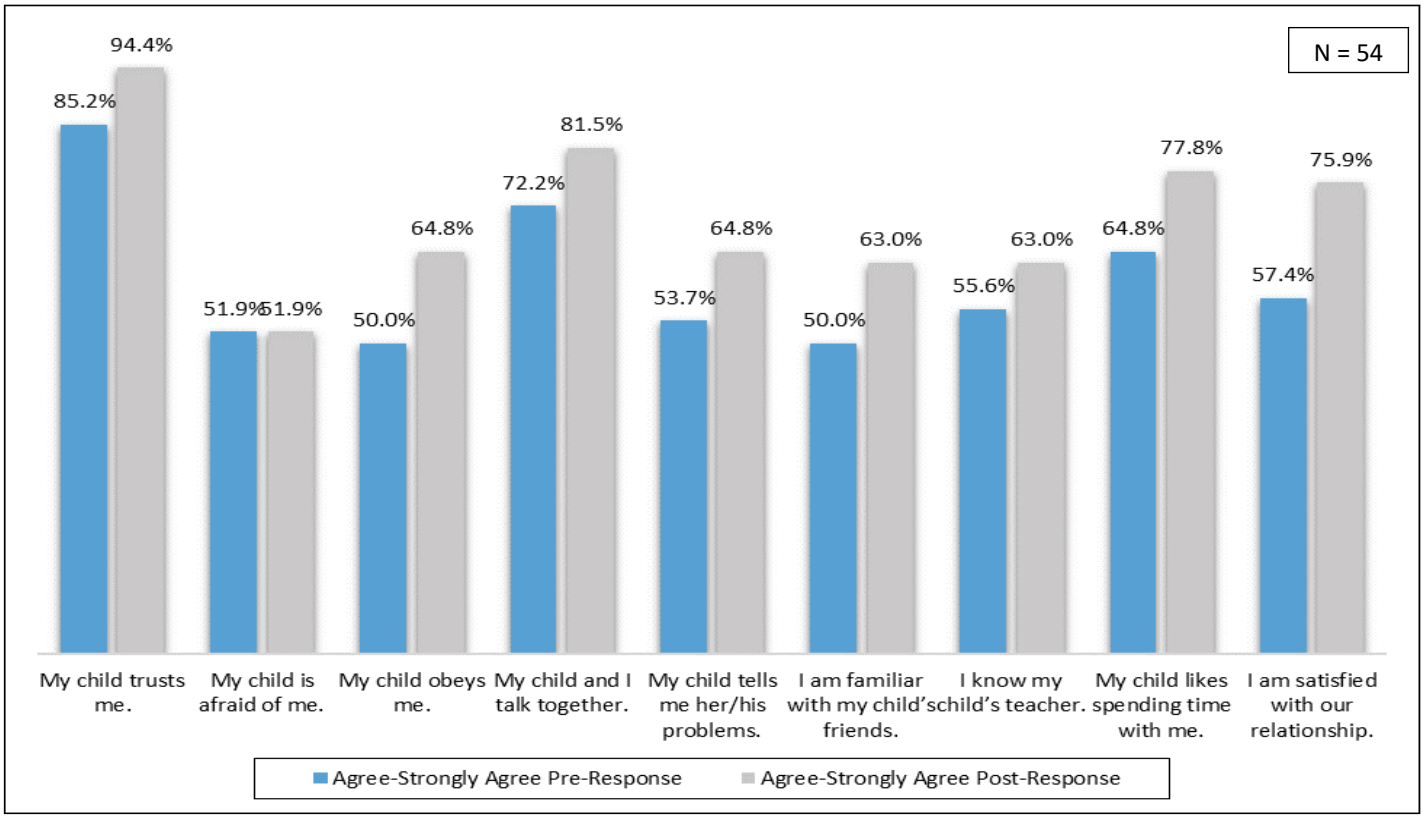
Relationship Scale
Average Total Scores: Pre-to-Post Comparison



Overall, the average total scores on Relationship Scale increased 2.52 points from pre-to post-measure, from 32.39 to 34.91. The pre survey total scores were already relatively high at the beginning of the KITE Program, which showed that parent participants already had a positive relationship with their children. Further analysis using paired samples T-Test also showed a *statistically significant* result, $t(53) = -3.529$, $p = < .05$. An item-by-item analysis on the Relationship Scale will be shown on the following page.

Average Total Scores on Relationship Scale—Pre to Post Analysis	Percent Increase	*t*	df	p
	7.8%	-3.529	59	0.001

Relationship Scale Analysis: Pre-to-Post Comparison



Relationship Scale—Survey Items (n = 54)	Percent Change	*t*	df	p
1. My child trusts me.	9.2%	-2.281	53	.027
2. My child is afraid of me.**	0.0%	-0.327	53	.745
3. My child obeys me.	14.8%	-2.131	53	.038
4. My child and I talk together.	9.3%	-2.530	53	.014
5. My child tells me her/his problems.	11.1%	-2.700	53	.009
6. I am familiar with my child's friends.	13.0%	-2.745	53	.008
7. I know my child's teacher.	7.4%	-1.237	53	.222
8. My child likes spending time with me.	13.0%	-3.792	53	.000
9. I am satisfied with our relationship.	18.5%	-3.041	53	.004

***** = Item #2 has a reversed scale***

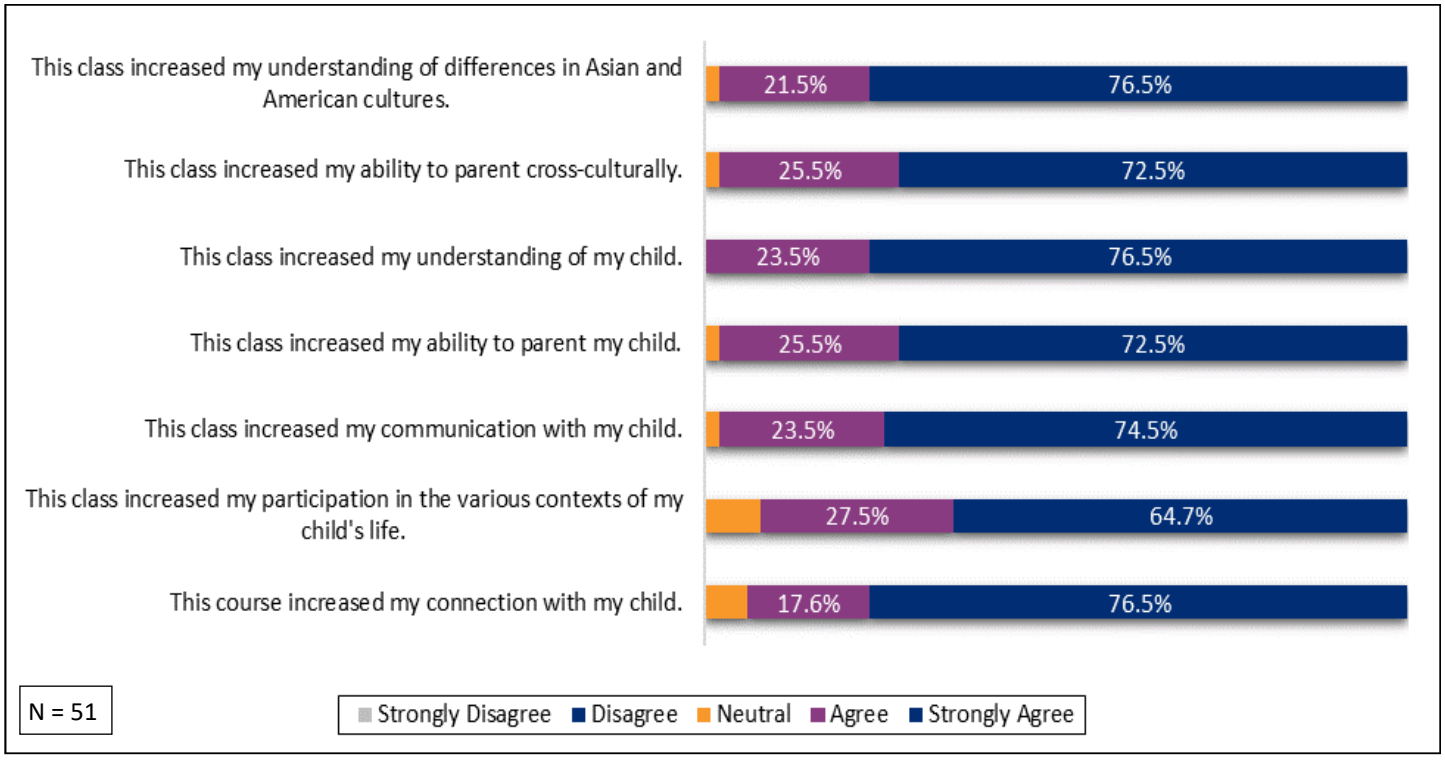
Similar to SDQ and APQ measures, there were a total of 54 pre-post matched pairs completed for the Relationship Scale. Figures above showed the Relationship Scale Analysis from pre-to-post measures, and ideally, we would like to see increases across all questionnaire items, except for number 2 (**My child is afraid of me**). This item has a reverse scale, and ideally, we would like to see a decrease, although a pre-post analysis on this scale item showed that the percentages from pre-to-post remained the same. Overall, based on the pre-post analysis, all scale items have shown increases from pre-to post-measures, which suggests that parents' views on their relationships with their children have generally increased at the conclusion of the KITE parenting program, in comparison to the beginning of the program.

The highest percent difference was shown on item number 9 (**I am satisfied with our relationship**), which showed an increase of 18.5% from pre-to-post measures. Item number 3 (**My child obeys me**) also showed a increase of 14.8%, and both item number 6 (**I am familiar with my child's friends**) and item number 8 (**My child likes spending time with me**) showed an equal increase of 13.0% from pre-to-post measures. Further analysis using paired samples T-tests are shown on the table above. Overall, 7 out of 9 items on the Relationship Scale (highlighted in green on table above) showed *statistically significant* results at ($p < .05$).

Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate KITE program effectiveness and to gather participants' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to participants and collected at the end of each KITE parenting class series. There are 7 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. There were a total of 51 post-satisfaction surveys completed at the end of all KITE parenting class series, and the results are shown below.

Survey Results



Overall, the analysis from post-satisfaction surveys showed highly positive results from all parent participants who responded "Strongly Agree" or "Agree" to all of the survey statements, as summarized below:

- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of differences in Asian and American cultures.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent cross-culturally.***
- 100% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their communication with their children.***
- 92.2% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their participation in the various contexts of their children's lives.***
- 94.1% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their connection with their children.***

Post-Satisfaction Survey Comments for Question #1

There were a total of five follow-up questions on the KITE post-satisfaction surveys, which were created to measure the effectiveness of the KITE program. Selected responses from participants for each question are shown below and on pages 23-26.

1. ***How did you change personally?***

"I put my child's feelings first and empathize according to the content of the courses."
"The way of communicating with my children has changed."
"Standing in my child's perspective to view issue."
"Through the study of the course, I am no longer anxious. If I change my mood as a parent, everything will change."
"Through communication with teacher and parents in class, I identify the differences of Chinese culture."
"I improved my tone and patience when talking to my child."
"Use the time during school pick up/drop to communicate more with my child, and talk about what happened in the day."
"I became a little more patient with my child."
"A chance to take a moment in a situation where you're angry or about to be angry."
"I try not to immediately get mad and making an effort to be more patient."
"I became more attentive to my child."
"I will look at things from my child's perspective"
"Have confidence in educating my children."
"Through the study in the parent-child class, I learned that the needs of children and the responsibilities of parents in raising children are actually unified. If you think about the demands and demands behind the behaviors of the children from another angle, you can better understand the children and form a good parent-child relationship with them.
At the same time, I also learned a lot of parenting skills, encourage and praise children more, and interact with children with high-quality companionship. Don't always use punishment to make children obedient. Properly letting children bear natural consequences is a required course for their growth!"
"In the end, the parent-child relationship is more important than academic performance, always remember this and raise our children from there."
"Be more understandable to kids."
"I began to care about her feelings and try my best to help her within my ability."
"Pay more attention to your approach when talking to your children."
"Begin to learn to praise children."
"Recognize cultural differences and psychological changes in children."
"I tried to use the method taught by the teacher, and it was very pleasant to get along with the children several times."
"In the past, I would get very angry when my child did something wrong and would yell at him. After class, I would change. When he did something wrong, I would express my understanding of his feelings and then make an evaluation."
"I've learned to think about things from my child's perspective when we have disagreements."
"Learn to take deep breaths. Only by adjusting your mentality can you deal with children happily."
"Suitable for another way to communicate with children."
"Do special time as much as possible."
"When there is a conflict, try your best to calm down first and then deal with it."
"Put yourself more from the child's perspective and consider his situation at that time."
"Understand the child's difficulties."
"Talk to your child calmly."
"More aware of my interaction to my kids, be more present to them."
"I became more aware of how to parent cross culturally."
"I became more aware of the way I parent, spoke and interacted with my grandchild. "
"Learned to be more understanding and use parental message better."
"I became more understanding and accepting of the situation."

Post-Satisfaction Survey Comments for Question #2

2. How did you change in the way you parent?

"Through the scientific parenting method in the curriculum, if my children have behavioral problems, as parents should reflect on changing the bad parts of traditional Chinese education methods if they want to have a healthy parenting relationship and physical and mental health."
"After learning the courses, I learned how to use the right communication method to communicate with children. I try to express my understanding first, and then express my needs, so my children will be more acceptable."
"Listen to my children's thoughts first, and then consider their views as parents."
"Parenting knowledge and workshops learned in class."
"I don't know how to praise my daughter before studying the courses. After studying, I often praise her, and the effect is very good."
"When I find that my child has done something wrong. I will calm down and communicate with the child."
"I became a better listener."
"I have gained more patience when communicating with my child."
"I became a parent who waits."
"Will change the way of educating children, insist on praising, discover strengths and actively communicate."
"Will see things from the child's perspective and understand and help them."
"Everything starts from the child's feelings and is educated based on the content learned."
"Learn to listen, encourage and praise more."
"I began to want to know her perspective on everything."
"Start learning to make friends with your children."
"Change by learning to understand the child's growth process."
"How to get along and communicate with children."
"After taking the class, I feel that as a parent, we should focus on encouragement and try to impose as few punishments as possible."
"Learn to communicate with children in short words."
"Listen more and start with "I." Special time effectively improves quality sharing time."
"See things from a child's perspective."
"Treat children more calmly."
"Need to be more concerned with children's psychology"
"Read a lot of books about children's education through continuous exploration."
"Understand the reasons for her rebellious period."
"Praise a lot."
"Better interaction with children."
"Understanding more and listening."
"Listen, pause, look at them more, less yelling."
"I am more patient and understanding."
"I became a better listener."
"Be more friendly to my children."
"I'm more conscious in how I parent my children."
"More understanding."
"I begin to think of his feeling instead of mine."
"Just being aware not all about me, but my child has the say as well."
"Better in understating of the situation."
"More communication and interaction between us."

Post-Satisfaction Survey Comments for Question #3

3. What was the most helpful topic we covered?

"Emotions, discipline methods, parenting communication methods."
"Use structure and encouragement, rules, limits, consequences and punishments, special time."
"Structuring intervention."
"Understand the cultural differences."
"How parents cope with stress."
"Parenting communication methods and coping with stress."
"Understand the importance of the tone and attitude of parents in the communication process between their children."
"Understanding between parents and children."
"Conversations with my child have become smoother."
"How to communicate with my children."
"We became more understanding of each other."
"Build a structure express understanding."
"Use expressive understanding and parent messages and teach children rules, limits and consequences."
"Practical and effective communication skills."
"Parent-child relationship, natural consequences, multi-cultural conflict."
"Quality time with kid."
"Structure makes me feel like I can relax occasionally in life."
"Ways to encourage children."
"I think what was helpful for me was learning about how to express love to my children."
"Cross-cultural differences and how to integrate into mainstream culture."
"Empathy and Understanding Asian Children."
"The "I message" I find most useful."
"Learn to use the word you as little as possible when speaking."
"Understand cultural differences. Introduce different effective ways to deal with various situations encountered in life."
"Build a bridge of communication between children and parents."
"Special time and love languages."
"Less punishment, and as many natural consequences as possible."
"Methods of educating children and their five languages."
"If you want to communicate more deeply with your children, it's not through the surface."
"Understand children's thoughts."
"Communicating with children."
"Showing understanding."
"Bonding each of my kids, self-care."
"How to use punishment correctly."
"Special time with my child."
"The one where I can see her, and I understand her."
"Special Time."
"All of the topics."
"Talking to my child more and get care for his feeling."
"Understanding and Communication."
"Understanding the differences in culture and generation."
"Understanding and Acceptance."

Post-Satisfaction Survey Comments for Question #4

4. What was the least helpful topic we covered?

"It is very suitable."
"None. All are useful."
"How to use special time to build a good relationship with children."
"Coping with stress."
"I don't have any."
"None. All very good and useful."
"Understand the self-identity of children and second-generation Chinese."
"Homework."
"Punishment. Because I started letting my child know when she would be punished when she was young."
"Most of them are useful, but we are new immigrants, so the temporary cross-cultural differences do not apply to us."
"Communication skills with children are difficult to achieve."
"The content of the class is very useful."
"All very effective."
"All practical."
"No, they are all quite useful."
"All topics were helpful."
"Nothing! All are very important."

Post-Satisfaction Survey Comments for Question #5

5. How did your relationship with your child change?

"Increased intimacy and trust with my children."
"My children are more willing to communicate with me, and I am more patient with them."
"Through me changing, my child has slowly positively change. We respect each other more and have a closer relationship."
"The relationship with my children becomes more understandable and will consider problems from each other's perspective."
"The relationship with my children is getting better and better."
"Become more patient. When I found the child's needs, the child trusted me even more."
"I give my child a hug every day."
"We have come to understand each other."
"I am trying as of right now."
"There isn't a huge change right now."
"We have more personal time for ourselves now."
"Through my changes, my children have also gradually changed. Our relationship has become closer and we respect each other."
"My children trust me more and our relationship becomes closer."
"Through learning, we can better communicate with children and better understand their needs and feelings."
"More harmonious, less anxious."
"More talkative."
"She is more willing to express herself. We developed some rapport, and maybe she's grown up a little and knows how to express her thoughts."
"I communicate a little more than before."
"She started talking to me about her relationships with her friends."
"I become more friendly and equal."
"I think my children are more willing to take the initiative to communicate with me."
"The child seems much happier."
"It still takes time and practice, but the change in mentality and attitude is relatively big."
"Easier to communicate than before."
"It becomes more harmonious."
"Unite knowledge and action, act immediately, correct mistakes when they are known."
"Give each other more respect and understanding."
"Know each other more."
"There are a lot less conflicts."
"She would be more patient and talk to me about the details of class and classmates."
"More harmonious."
"More in tune."
"We gotten more closer."
"My relationship was already strong. This class just allowed me to be more aware."
"Strengthened my communication skills with her. I became more aware of her emotions."
"It's still in progress."
"We have better communication with my sons."
"More communicative."
"We are working on a good relationship of talking each night."
"Great outcome. Conversing more with enthusiasm."
"It has changed for the best communication."

References

Ying, Y. (2007). *Strengthening intergenerational/intercultural ties in immigrant families (SITIF): Testing a culturally-sensitive, community-based intervention with Chinese American parents*. Journal of Immigrant and Refugee Studies, Vol. 5(2) 2007, The Haworth Press.

Munoz, R.F. & Ying, Y. (2002). *The prevention of depression: Research and practice.* Baltimore, MD: Johns Hopkins University Press.

PEI Overview

Prevention and Early Intervention (PEI) aims to prevent the development of mental illness or intervene early when symptoms first appear. Our goals are to:

- Increase community outreach and awareness regarding mental health within unserved and underserved populations.
- Increase awareness of mental health topics and reduce discrimination.
- Prevent the development of mental health issues by building protective factors and skills, increasing support, and reducing risk factors or stressors.
- Address a condition early in its manifestation that is of relatively low intensity and is of relatively short duration (less than one year).
- Increase education and awareness of Suicide Prevention; implement strategies to eliminate suicide in Riverside County; train helpers for a suicide-safer community.

Programs need to be provided in places where mental health services are not traditionally given, such as schools, community centers, faith-based organizations, etc. PEI programs intend to engage individuals before the development of serious mental illness or serious emotional disturbance or to alleviate the need for additional or extended mental health treatment The PEI unit includes an Administrative Services Manager, five Staff Development Officers (SDOs), one Clinical Therapists (CT), two Social Service Planners (SSPs), one Behavioral Health Specialist (BHS), five Peer Support Specialists



(PSS), one Executive Assistant, and two Office Assistants (OA). The SDOs have completed the process of becoming trained trainers in many of the funded programs, which allows for local expertise as well as cost savings. Each SDO works with their assigned PEI providers to offer training and any needed problem solving and technical assistance, as well as monitoring of model fidelity. The SSP/CTs also offer ongoing support to the PEI providers through technical assistance including, but not limited to, support surrounding outcome measures. The PEI unit was built into the overall PEI implementation plan to ensure that model fidelity remains a priority as well as to support providers in the ongoing implementation of new programs within the community. In FY23/24 two Requests for Proposals (RFP) were released and one new contract was awarded for PEI programs.

In addition to training and technical assistance to PEI providers, the PEI unit coordinates and implements a variety of community-wide activities. Activities include suicide prevention training and coordination including co-leadership of the Riverside County Suicide Prevention Coalition, education, and awareness events such as the local Directing Change Screening and Recognition ceremony, the Dare to be Aware Youth Conference, Send Silence Packing exhibits and community presentations, May is Mental Health month activities, Suicide Prevention Awareness week activities including an awareness walk and more. PEI staff carry out outreach activities focusing on mental health awareness and suicide prevention. Additionally, PEI staff educate the community about mental health and reduce stigma while encouraging help-seeking behavior throughout the year. The PEI team attended 53 outreach events reaching 11,810 community members.



In Riverside County, PEI programs have been in place since September of 2009. The annual update and community planning process has allowed for ongoing community and stakeholder input regarding the programs that have been implemented, an opportunity to evaluate programs and look at new and expanded programs and services. Stakeholder feedback is a critical element in the success of PEI programming. We take the voice of the community seriously and look for ways to improve our communication. To this end, quarterly PEI Collaborative meetings are held to share program highlights and outcomes, current and upcoming PEI activities, receive feedback from the community, and provide a space for provider networking and partnership development to improve the delivery of services. Additionally, a quarterly newsletter, the PEI Pulse, is disseminated electronically and available on our website.

Each year MHSA Administration, including PEI, meets with many stakeholder groups, RUHS-BH committees, and the community to share the MHSA plan, mental health outcomes, and plans for the upcoming year during the community planning process. These diverse groups review the outcomes of programs currently being implemented to make informed decisions about programs and services for the upcoming fiscal year. This input is then shared with the Prevention and Early Intervention Steering Committee. The PEI Steering Committee is made up of subject matter experts who utilize their knowledge to provide feedback, oversight, and recommendation for the

PEI plan The PEI Steering Committee provides recommendation and feedback on the plan for the final draft. The PEI Steering Committee supports the plan as described below.

PEI is largely outreach-based. Programs and providers are typically in the community at natural gathering spaces. Post-COVID, contract providers continue to struggle with recruitment and enrollment across programs. Virtual options are offered, when appropriate. Outcome data demonstrates positive impacts in the lives of participants. This will be further detailed below in each work plan and can also be found in the PEI program and evaluation report in the PEI Appendix to this document.

In Fiscal Year 23/24, program implementation continued serving many communities throughout Riverside County. The PEI Unit continues its commitment to providing training and technical assistance for the evidence-based and evidence-informed models that are being implemented as well as booster trainings related to those models and other PEI topic-specific trainings. In FY23/24, there were 138 training days with 1,767 people trained. Staff Development Officers continued to work closely with PEI contract providers to maintain fidelity to evidence-based/informed models while offering both virtual and in-person services to the community. Our virtual training menu continued into FY23/24 available to anyone who lives and/or works in Riverside County at no cost. The trainings were created and facilitated by PEI Admin staff. Trainings have been available since the fall 2020 and include: Mental Health 101, Self-Care and Wellness, Know the Signs, and Building Resiliency and Understanding Trauma.



The PEI website, https://www.ruhealth.org/behavioral-health/prevention-early- intervention, includes comprehensive information about prevention and early intervention and the variety of services available to the community. This information is easy to find and community friendly. This site serves as the PEI Directory of Services, ensuring contact and program information is up-to-date and readily accessible to the community. The community can also access our training calendar and can easily register for training with the click of a button making it easier to access and benefit from our free community education, both virtually and in-person.

The Annual Prevention and Early Intervention Summit is also provided. The overall purpose of the Summit is to (1) address any challenges PEI providers have been facing in the past year and provide skills they can directly apply to their work in PEI, (2) educate providers about all PEI programs and increase their understanding



of how their program fits into the PEI plan, (3) to increase collaboration, partnership, and referrals between PEI providers, and (4) recognize the contributions of PEI providers in Riverside County and motivate providers to continue the work in the year to come. The Summit was held in the Desert region at the Hilton in Palm Springs. The Summit's theme was "Working Together", with keynote presentations from Mary Obideyi on "Reigniting Connections – Innovative Outreach Strategies for Community Mental Health Services" and Dr. Yvonne Ator on "How to Serve Sustainably and Thrive as A Mission-Driven Professional in a Chaotic Burnout Inducing World." We also had a panel discussion with our Cultural Community Liaisons to discuss helpful and effective engagement strategies for our underserved communities.

Prevention and Early Intervention Statewide Activities – Joint Powers Authority
Program Type: Prevention Program



California counties collectively pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project at a statewide level. The PEI Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. These campaigns are: Know the Signs, Directing Change, and Take Action for Mental Health. The Take Action for Mental Health campaign helps individuals learn how to take action for the mental health of themselves and those around them through three pillars: Check In, Learn More, and Get Support. In FY23/24, CalMHSA did not renew their contract with Youth Creating Change for the Directing Change Program and Film Contest. CalMHSA has since stated that they do not intend to contract with or provide funds to support Directing Change in the future. Riverside County plans to continue to support this program directly, separate from the JPA.

In 2010, Riverside County Department of Mental Health committed local PEI dollars to the statewide effort. This commitment has continued through the years of PEI program implementation. The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of *Take Action for Mental Health* is critical for creating a culture of mental wellness and wellbeing regardless of where individuals live, work, or play. Riverside County stakeholders agreed to maintain this commitment for the current 3-Year plan. Stakeholders see the benefit of supporting the statewide efforts and explore ways the statewide campaigns can make the biggest impact at a local level as a way of leveraging on messaging and materials that have already been developed. In FY23/24, the statewide project focused on diversity, equity and inclusion, with a particular emphasis on supporting marginalized communities. Key initiatives included:

- Juneteenth micro-campaign - The Juneteenth Digital Toolkit promotes mental wellness and raises awareness about the significance of Juneteenth, which

celebrates the emancipation of enslaved African Americans. The toolkit includes social media content, activity ideas, and educational resources. These materials encourage conversations, foster unity, and support mental health in Black communities, emphasizing both historical reflection and contemporary issues.

- Collaborations with streetwear designer and influencer Khano Ngo for the AAPI community

- Pride Month (July) - The Pride Digital Toolkit provides resources to support mental health and well-being within the LGBTQIA+ community during Pride Month and beyond. The toolkit includes social media content, educational materials, and activity ideas. These resources promote inclusivity, reduce stigma, and celebrate LGBTQIA+ identities. The goal is to create supportive environments, raise awareness about mental health challenges, and crucial resources. And support for Transgender day of Remembrance.

- Suicide Prevention Week and Month (September) - The Suicide Prevention Activation Kit (digital and physical) provides a range of resources to support individuals and organizations in raising awareness during National Suicide Prevention Awareness Week and throughout the year. Key materials in the kit include guides for creating social media posts, Infographics for awareness campaigns, activity Tip Sheets for community engagement, and downloadable posters tailored for diverse communities. These resources aim to help individuals recognize warning signs, initiate meaningful conversations, and connect with local suicide prevention resources. The goal of the kit is to empower everyone to take action and promote the importance of suicide prevention.

- Winter Wellness (December-January) - The Winter Wellness Digital Toolkit (digital and physical) offers resources designed to help individuals maintain their mental well-being during the colder months. This toolkit addresses the unique challenges of winter, including seasonal affective disorder (SAD) and isolation. It includes practical materials such as wellness tips for managing winter-related stress, activity guides to promote engagement and connection, social media content to raise awareness and encourage self-care. These resources support individuals in prioritizing self-care, staying connected, and engaging in positive activities that promote mental health during the winter season.

- May is Mental Health Matters Month (May) - The May is Mental Health Matters Month 2024 Toolkit (digital and physical) includes essential resources to raise awareness and promote mental health during Mental Health Matters Month in May. The toolkit contains social media content, educational resources, and activity ideas. These resources are designed to reduce stigma, increase

understanding, and encourage open conversations about mental health. They equip individuals and organizations with the tools to engage communities, raise awareness, and create a supportive environment for mental well-being, with a focus on inspiring action year-round.

- Take Action 4 Mental Health also disseminated physical and digital materials for National Rural Health Day and Student Athlete Suicide Prevention.

The PEI Project continues to prioritize outreach to younger populations, with approximately 61.67% of support provided to individuals under 25 years old. Below are the estimates for outreach and program evaluation within this demographic:

- Outreach: 55% of participants are under 25 years old (social media); 55% toolkits and collateral

- Evaluation: 65% of individuals served are under 25

The Take Action for Mental Health website has become a key resource for individuals seeking mental health information and tools with 105,558 sessions and 9,133 resources downloaded.

Funding to the PEI Project supported programs such as:

- Continued production, promotion, and dissemination of the Take Action for Mental Health campaign's materials and messages, providing technical assistance and outreach to members contributing to the PEI Program.

- Providing mental health and suicide prevention trainings to diverse audiences.

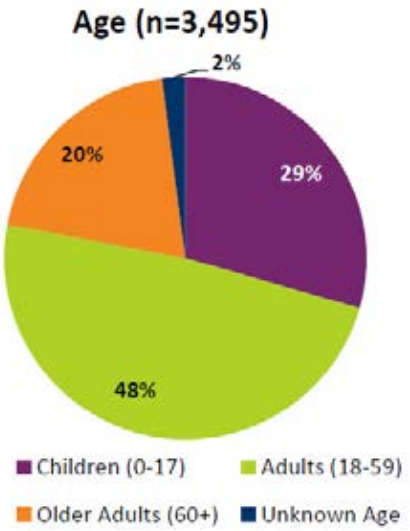
In FY23/24, Riverside County concluded participation in the Suicide Prevention Learning Collaborative through CalMHSA, Striving for Zero. This opportunity provided subject matter experts in the area of suicide prevention to give guidance and support to our local efforts in the implementation of our local suicide prevention strategic plan and assisting with the ongoing work of our local Suicide Prevention Coalition. RUHS-BH continues to leverage the resources provided at the state level and enhance local efforts with these activities.

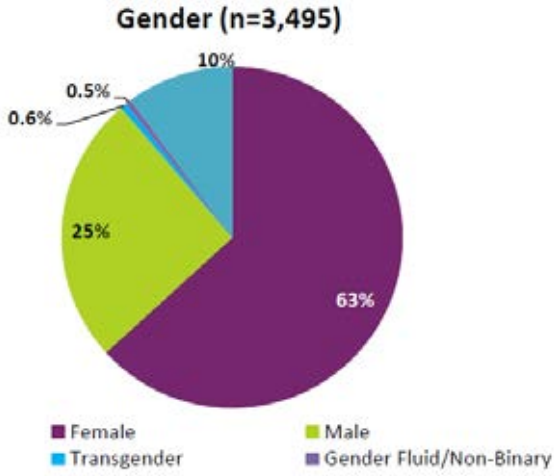


Who We Serve – Prevention and Early Intervention

In FY23/24 121,438 individuals were reached by PEI from a variety of Outreach activities including, depression screening at Community Health Centers. Riverside County residents were engaged by Prevention and Early Intervention outreach and service programs. Of those, A total of 3,495 individuals and families participated in PEI programs (excluding outreach) and an additional 2,878 middle school and high school age youth and 374 school staff, parents and community members participated in suicide prevention training on school sites. This resulted in a total of 6,747 served (not including outreach).

The following details the demographics of the PEI program participants.





Race/Ethnicity	PEI Participants (n=3,495)	County Census (n=2,458,774)
Caucasian	11.9%	32.2%
Hispanic/Latinx	47.0%	51.4%
Black/African American	7.1%	6.3%
Asian/Pacific Islander	3.5%	7.2%
American Indian	1.7%	0.46%
Other/Unk/ Multi-Racial	28.7%	2.5%

PEI programs are intended to engage underserved cultural populations. In Riverside County, the target ethnic groups are Hispanic/Latinx, Black/African American, Asian/Pacific Islander, and American Indian/Native American. The table above lists each of the groups and the percentage of PEI participants from each in comparison to the County census for Riverside. The table demonstrates that PEI services are reaching the intended un/underserved ethnic groups at appropriate rates.

Each PEI program has an annual outcome report with detailed data outcomes that are available upon request. Specific demographic information, by program, can be found in the PEI Appendix to this document.

PEI-01 Mental Health Outreach, Awareness, and Stigma Reduction

The programs that are included in this Work Plan are wide reaching and include activities that engage unserved and underserved individuals in their communities to increase awareness about mental health with an overarching goal to reduce stigma related to mental health challenges.

Cultural Competency Program - Outreach and Engagement Activities
Program Type: Prevention Program
The Cultural Competency Program (CCP) is dedicated to eliminating barriers and increasing access for underserved and underrepresented populations through the MHSA values of:

1. Equal access for diverse populations
2. Wellness, Recovery & Resilience
3. Client/Consumer and family-driven
4. Strength-Based and Evidence-Based Practices
5. Community-Driven Based Practices
6. Innovative and Outcome-Driven
7. Cultural Humility and Inclusivity

Research indicates that culturally informed care works. The more people are reached and connected to needed care, the less likely they are to experience the consequences of untreated mental health needs, such as repeated hospitalizations, the use of expensive emergency services, incarceration, school failure, and homelessness. Service delivery would be easier if we were all exactly alike and had the same experiences, but meeting people where they are increasing the likelihood of opening the door to healthier and more productive lives. Some folks do better when matched with a provider who shares or understands their worldview. This can be based on a shared perspective like religion or spirituality, a shared experience like being a military veteran, or a shared cultural history such as being an ethnic minority.

Some of the highlights from this year's Cultural Competency Plan include:
We hired a full-time Veteran Services Liaison or VSL. Our long-standing VSL resigned almost 2 years ago, leaving a vacancy that was difficult to recruit. The VSL is a therapist who not only provides therapeutic and case management services to Riverside County Vets but also promotes behavioral health awareness and stigma reduction to seek care for our military veterans and their families. The incumbent holds a degree to provide psychotherapy and has their own lived experience in the military. In August 2024, we re-filled the position with a veteran Navy corpsman and have begun the process of rebuilding the infrastructure of his role.
We also improved crisis engagement for the Deaf and Hard-of-Hearing Community. In partnership with Hanna Interpreting Services, our program developed remote video American Sign Language interpretation for our 24/7 mobile crisis teams. This allows quality ASL interpretation at any time of day or night when dispatched to assist an ASL speaker in a behavioral health crisis.

We ensured the voices of our 10 identified communities were part of MHSA plan development. Our Cultural Community Liaisons (CCLs) are people from these 10 communities who are

contracted to reduce access barriers to behavioral health care. The CCLs actively provide community education, build care bridges, and make referrals to support and services. They host their own community advisory committees, serve on the steering committee of this PEI plan, and on the steering committee for the MHSA Innovation plan serving people with eating disorders.

We refined and standardized the Cultural Competency Program evaluation protocols. Collaborating with the Department's Evaluation unit, we developed standardized data protocols to create consistent measurements of program outcomes. We measure audiences' responses to training and presentations and the number of direct referrals our program makes to service providers.

We sustained and developed a 10-month cross-county collaboration with San Bernardino County's Department of Behavioral Health. The collaboration focused on capacity building of Black-owned community-based organizations to help fill the gaps in behavioral health care program options. This collaborative continues by looking at capacity building for Asian/Pacific Islander and LGBTQ communities.

We look forward to partnering even more with the community to ensure every Riverside has the opportunity to thrive and contribute to building Riverside County's future.

The collective efforts of the CCP Staff, cultural community liaisons (CCLs), and cultural advisory committees bring a breadth of knowledge and expertise, strengthening our capacity to reduce disparities throughout our behavioral health system of care and barriers to accessing services.

Cultural Competency Reducing Disparities Advisory Committee

The Cultural Competency Reducing Disparities (CCRD) Advisory Committee is a committee including RUHS-BH staff, members of the cultural subcommittees, community-based organizations, community leaders, and consumers. CCRD works to identify cultural barriers and unmet needs with underrepresented populations. Partnering with Workforce Education and Training, CCRD promotes and hosts workforce training.

The CCRD committee prioritized the recommendations as follows:

1. Hiring bilingual staff
2. Cultural Competence Staff Training
3. Sustainability
4. Dissemination of information
5. Availability of Resources

CCRD reviews the updated Cultural Competency Plan on an annual basis. The plan addresses adherence to CLAS Standards, commitment to cultural competence, strategies, and efforts to reduce racial-ethnic, cultural, and linguistic mental health disparities, assessment of service

needs and adaptation of services, culturally competent training activities, hiring and retaining culturally and linguistically competent staff, and language capacity.

The subcommittees for cultural communities have been established and convene regularly, with the active participation of community members.
Through their collaboration with the CCLs, these subcommittees have secured sponsorships worth approximately $160,000 to support community service providers in delivering culturally appropriate mental health workshops and outreach events in the identified communities:

- **Asian Pacific Islander Desi American & Native Hawaiian (APIDANH) –** Dr. Ernelyn Navarro
- **African American Family Wellness Advisory Group (AAFWAG)** – Hazel Lambert
- **Middle Eastern and North African (MENA) –** [currently vacant, managed by CCP team]
- **Native American Council –** Dr. Sean Milanovich
- **Wellness and Disability Equity Alliance (WADE) –** Dakota Brown
- **Hispanic/Latinx (HISLA) –** Shirley Guzman
- **Deaf Collaborative Advisory Network (DCAN) –** [currently vacant, managed by CCP team]
- **Community Advisory on Gender and Sexuality Inclusion (CAGSI) –** [currently vacant, managed by CCP team]
- **Spirituality & Faith-Based –** Rev. Benita Ramsey
- **Veterans (hosted by the Behavioral Health Commission) –** Felix Gbagbo, MSW, Navy Corpsman

Inland SoCal Crisis and Suicide Helpline and 211
Program Type: Suicide Prevention Program

A program of Inland SoCal United Way & 211+, the Inland SoCal Crisis and Suicide Helpline is available 24/7 by calling 951-686-HELP (4357). The service is a bilingual hotline staffed by highly trained and compassionate Crisis Counselors who are as diverse and representative as the Inland SoCal Region. They assist with emotional support, suicidality assessment and prevention, coping skills, resource referrals and warm hand-off for mental health services, and help for a range of other mental health related crises and experiences such as suicide loss grief, abuse, domestic violence, struggles with aspects such as identity and relationships, and other sensitive topics. The Helpline also conducts trainings across the region to teach and support residents in identifying and responding to mental health needs in their communities. Mental health services are essential to healthy communities. Everyone deserves access to respect, dignity, and wellbeing – especially in moments of crisis. Understanding the nature of that kind of intervention – who calls and why – informs better response systems.

The Inland SoCal Crisis Helpline has achieved significant success in responding to mental health crises through the implementation of a community point of access (aka front door) to the RUHS-BH 24/7 mobile crisis response. This initiative enhances immediate access to crisis stabilization services and supports community resilience. Key achievements include:



- Enhanced Crisis Response: The 24/7 mobile crisis team provides timely, on-site intervention, reducing the need for emergency department visits and law enforcement involvement. This aligns with best practices in crisis care, prioritizing de-escalation and connection to appropriate community-based services.

- Trauma-Informed and Evidence-Based Training: Comprehensive training for crisis responders emphasizes de-escalation techniques, trauma-informed care, and culturally competent practices. This specialized training has contributed to a reduction in the need for law enforcement intervention, promoting a person-centered approach.

- Increased Community Awareness and Utilization: Community outreach efforts have significantly increased awareness of helpline services, resulting in a substantial increase in call volume. This demonstrates the effectiveness of proactive communication in promoting help-seeking behaviors. Data collected also showed a significant reduction in 911 call rates, emphasizing the effectiveness of preventative care and proactive intervention in addressing mental health crises before they escalate.

- Data-Driven Outcomes: Data indicates a positive impact on crisis system utilization, with a significant increase in calls to the helpline and requests for mobile crisis services and Mental Health Urgent Care. Critically, the data also shows a low percentage of calls involving active rescues for imminent risk to life, suggesting that the mobile crisis services are effectively de-escalating situations and providing appropriate support.

Despite these successes, several challenges must be addressed to ensure the long-term sustainability and effectiveness of the crisis helpline:

- Funding Instability: Consistent and adequate funding is essential for maintaining service quality and meeting increasing demand. The transition from MHSA to BHSA requires careful navigation to ensure continued support for essential crisis services.

- Workforce Development and Retention: As call volumes rise, ensuring sufficient staffing levels with qualified and well-trained responders is crucial. Ongoing training in evidence-based practices, such as crisis intervention, trauma-informed care, and culturally competent care, is essential. Addressing staff burnout through robust support systems, including supervision, debriefing, and self-care resources, is also a priority.

- Data Collection and Outcome Measurement: Strengthening data collection and outcome measurement processes will allow for more robust evaluation of program effectiveness and identification of areas for improvement.

A key lesson learned is the critical importance of ongoing training and support for crisis responders. While initial training is essential, continuous professional development is necessary to keep staff up to date with evolving best practices and address the diverse needs of individuals experiencing mental health crises. Furthermore, prioritizing staff well-being through robust support systems is crucial for mitigating burnout and maintaining team effectiveness.
A total of 8,312 calls were made to 951-686-HELP for FY23/24. The number of calls went up by 128% from July 2023 (407 calls) to June 2024 (928 crisis calls). Active rescues have decreased by 16% since the prior year (from 62 in 2022-2023 to 52 in 2023-2024). This decrease from all prior years demonstrates that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations. In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to Riverside County Crisis Mobile Units for in-person support. The number of BIPOC callers has increased by 20% in the last 12 months (although there was no proportional increase in crisis callers).

Inland SoCal Crisis Helpline Annual Report 2023-2024

EXECUTIVE SUMMARY

The Inland SoCal Crisis Helpline (951-686-HELP) is a project of Inland SoCal United Way and Inland SoCal United 211+. Services include 24/7 someone to call, routing to somewhere to go (Mental Health Urgent Care) or warm hand-off to someone to come to you (Riverside County Crisis Mobile). The Inland SoCal Crisis Helpline also provides a statistical dashboard, evidence-based training, such as Mental Health First Aid, and social work field placements through six universities.

The goal of this annual report is to increase access to local data and evidence about community mental health trends and to enhance dialogues for suicide prevention regional planning.

To illustrate the types of situations that require support, this report also includes real stories.

KEY FINDINGS:

- The number of calls to 686-HELP went up by 128% from July 2023 (407 calls) to June 2024 (928 Crisis Calls).

Calls for Crisis Mobile services increased by 444.2% within two fiscal quarters, from December 2023 (43 calls) to June 2024 (234 calls).

• Calls for Mental Health Urgent Care grew by 351% over two fiscal quarters, from December 2023 (51 calls) to June 2024 (230 calls).

• Overall, we had 53% more calls this year than last year and 67% more calls compared to two years ago. Most of these new calls came after we launched the 24/7 mobile service.

• Active rescues for imminent risk to life made up only 0.63% of total calls, despite the increase in call volume. This marks a decline from all previous years, showing that the launch of 24/7 crisis mobile services provided a less intrusive intervention in most situations.

• The number of BIPOC callers in the past 12 months increased by 20% compared to the previous year, although there was no proportional increase in crisis callers.

• Crisis Helpline internships support the next generation of behavioral health professionals. In the 2023/2024 school year, 26 social work students completed a suicide prevention internship, and 100% of recent graduates expressed a desire to continue working in crisis care.





PEI

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COMMUNITY CRISIS CARE

The Inland SoCal Crisis Helpline (951-686-HELP) is one of the longest running suicide hotlines in California. Our Crisis Workers answer over 8,000 calls and train over 500 residents a year in courses like Mental Health First Aid. Our service is free, confidential, and can be anonymous. Bilingual counselors are available.

Serving Inland Southern California since 1968



TELEPHONIC EMOTIONAL SUPPORT

24/7 Crisis Counseling with highly trained, compassionate Crisis Workers. We make mental health crises and suicide prevention easily accessible through locally operated tele-help. 951-686-HELP offers active listening, emotional support, suicide prevention, collaborative problem solving, and a connection to in-person support via the verified 211 database.

CRISIS CONTINUUM OF CARE

On January 1, 2024, Riverside County launched a new 24/7 Crisis Mobile Unit, accessible through our Inland SoCal Crisis Helpline, 951-686-HELP. The expanded service, provided by our primary funder, the Riverside University Health System, also offers telephonic crisis intervention and connects callers to three 24/7 Mental Health Urgent Care Centers. Aligned with SAMHSA's Crisis Continuum of Care, Inland SoCal United Way ensures individuals in crisis have someone to call, somewhere to go, and someone to come to them around the clock and for free.

PREVENTION & POSTVENTION

The Inland SoCal Crisis Helpline also trains 500 people a year to help prevent suicide via Mental Health First Aid (8 hours), safeTALK (4 hours), ASIST (16 hours), and QPR (60 minutes). In addition, we partner on postvention services with the Trauma Intervention Team to respond to suicide deaths.

SOCIAL WORK FIELD PLACEMENTS

Social work internships are an invaluable part of practical training and supervised experience to deliver mental health and social services. Since starting the internship program in 2020, the Inland SoCal Crisis Helpline has trained more than 100 graduate and undergraduate students from 6 universities.

What's next?

With 56 years of local crisis care service, the AAS and Inform USA Accredited Inland SoCal Crisis Helpline seeks to expand our reach by joining the 988 network. We also seek to expand our service area to the entire Inland Southern California region.

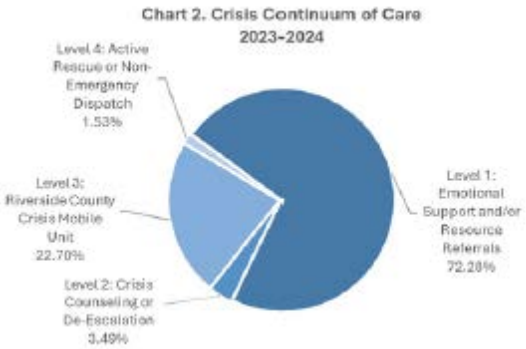
CRISIS CONTINUUM OF CARE

17.81% of calls were referred to Mental Health Urgent Care

The Inland SoCal Crisis Helpline and the Riverside County (RUHS) Crisis Mobile Unit expanded the continuum of crisis care in 2024. In this first partnership year, the Crisis Helpline assessed and warm transferred 174 calls to RCCMU for in-person support.

The Substance Abuse and Mental Health Services Administration (SAMHSA), a Crisis Continuum of Care, consists of three core components: 1) Regional Crisis Call Centers, 2) Local Mobile Crisis Response Teams, and 3) Local Crisis Stabilization Centers. This creates a Continuum of Care, providing community members with Someone to Call, Someone to Come, and Somewhere to Go during a mental health crisis. The model decouples mental health crisis response from law enforcement. In Riverside County, the Inland SoCal Crisis Helpline (951-686-HELP) serves as the front door phone number for community members and helping professionals to request screening and prospective dispatch of the Mobile Crisis Unit or referral to a Mental Health Urgent Care Center.





IMPACT

Topics of Crisis/Importance

The following are real-life issues of diverse needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Economic Despair
- Personal Relationship Conflict
- Substance Misuse Disorder
- Isolation/Loneliness
- Elder/Child Care Stress
- Major Life Events
- Grief/Loss
- Chronic Mental Illness
- Physical Illness/Pain
- Work/School Stress

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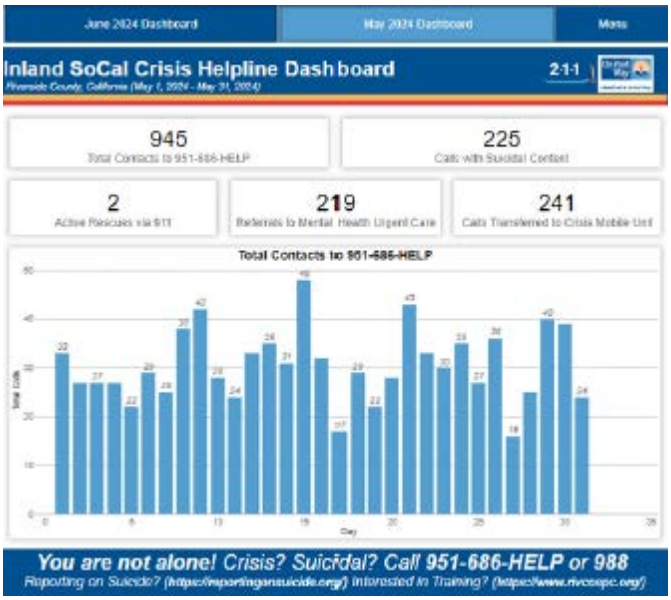
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RAPID REPORTING

Crisis Helpline Annual Report 2023-2024

As part of the Youth Suicide Rapid Reporting and Response Pilot via the California Department of Public Health and Riverside UHS Public Health, Inland SoCal Crisis Helpline launched a dashboard to share with the public data on:

- Total Calls to 951-686-HELP
- Calls with Suicidal Content Active Rescues via 911 Referrals to Mental Health Urgent Care
- Calls Transferred to Crisis Mobile Unit
- Total Calls to 951-686-HELP by Date



EMERGENCIES

Emergencies are about 5% of call volume. These are the most intense, unpredictable calls, ranging from active suicide attempts, child and elder abuse, homicidal intent and other forms of imminent danger.

- Active rescues have decreased by 16.13% since the prior year. In 2023-2024, there were 52 active rescues via 911 dispatch for calls involving imminent or active harm to self or others (2022-2023: 62 active rescues).
- In the role of caring for vulnerable populations, the Crisis Helpline is a mandated reporter of suspected abuse and neglect. There were 8 reports of child abuse and 19 reports of elder or dependent abuse.

DEMOGRAPHICS

Riverside County is one of the largest counties in the country, the size of Oklahoma. It is also one of the most diverse communities in the country, and our callers reflect this.

- Gender Identity: 59.67% Female (4084); 40.08% Male (2743); 0.25% LGBTQIA+ (17)
- Race/Ethnicity: 74.66% BIPOC (772); 25.34% White (Non-Hispanic) (262)
- Age: 11.47% Youth 0-17 (265); 13.24% Transition Aged Youth 18-25 (306); 32.93% Adults 26-49 (761); 31.33% Older Adults 50-64 (724); 11.03% Older Adults 65+ (255)

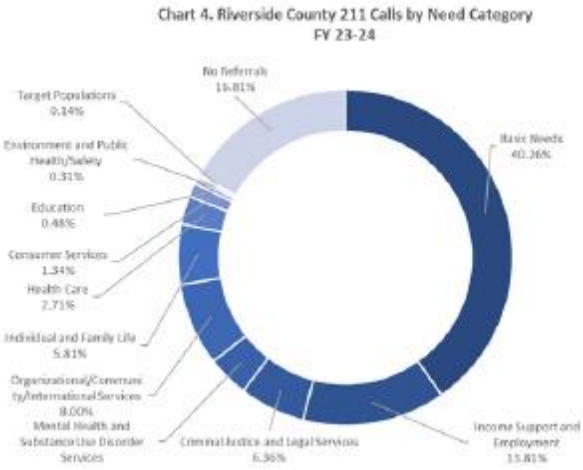
ECONOMIC INSECURITY

Crisis Helpline Annual Report 2023-2024

Economic security and mobility are protective factors for mental health. Inland SoCal 211+ callers frequently discuss stressors associated with meeting basic needs, including needing services for food, housing, clothes, and other essentials. Inland SoCal Crisis Helpline (951-686-HELP), a program of Inland SoCal 211+, provides specialized behavioral health crisis support. Callers to this line are primarily individuals experiencing mental health or substance use crises. For callers requiring additional social services, such as food, housing, or utility assistance, 686-HELP Crisis Counselors transfer them to 211 Referral Specialists for appropriate support. Conversely, 211 Referral Specialists transfer individuals presenting with immediate behavioral health crises to 686-HELP. During the last fiscal year, Riverside County residents placed 48,111 calls to 211 seeking social services. Among these, 40.26% expressed urgent needs related to necessities like food, utilities, and housing. The United Way of California Real Cost Measure finds that 1/3 of residents in Riverside and San Bernardino Counties do not have enough income for daily living needs, like food, housing, utilities, and other essentials.

Despair is a feeling of hopelessness, in this case resulting from an external factor over which callers have very little control—their economic position:

- Older adults express that housing unaffordability and homelessness cause suicidal thoughts.
- Parents express that they cannot make ends meet and provide for their children, causing emotional distress.
- Children and teens feel distraught due to financial stress that puts added pressure on families.
- Unhoused crisis calls show that extreme chronic stress damages mental health and causes depression, anxiety, and emotional distress.



IMPACT

Topics of Crisis/Importance

The following are real examples of economic despair issues needs that were addressed in the last year that illustrate the type of calls needing in-person crisis support:

- Housing (Lack of stable housing or lack of shelter or living with unsafe individuals)
- Employment (unemployment, underemployment, or holding multiple jobs)
- Basic Needs (lack of food, utilities, elder care, child care, or medical care)
- Transportation (lack of transportation to work or medical appointments)

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PREVENTION & POSTVENTION
Crisis Helpline Annual Report 2023-2024

In addition to responding to active crises, the Inland SoCal Crisis & Suicide Helpl ine provides trainings, courses, and workshops to prepare the general publ ic, schools, businesses, and other providers to identify and respond to mental health needs and suicide signs. In the 2023-2024 program year, Inland SoCal Crisis Trainers conducted 320 hours of training across 39 days to 29 cohorts.

> *"I couldn't prevent the suicide of my family member many years ago, but I feel blessed to have new tools from this safeTALK workshop. I now know what to do if someone tells me they have suicidal thoughts."*

Training Courses:

Question Persuade Respond (QPR) is a 90 minute evidence based workshop with three steps anyone can learn to help prevent suicide.

Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive workshop and suicide first aid course. Ages 16+. Available in English.

Mental Health First Aid is an 8-hour course that teaches the public to help someone with mental health needs. Ages 18+. Available in English.

Suicide Alertness/safeTALK is a 4-hour course that helps the public recognize a person with thoughts of suicide and connect life-affirming help. Ages 15+. English and Spanish.

In 2023-2024, we also continued to support postvention services to help individuals heal from suicide loss and other situations. We are proud to partner with the Trauma Intervention Program (TIP) Riverside Chapter. TIP is a dedicated group of everyday people helping everyday people in traumatic crises. Their group of helpful, supportive volunteers is here to serve the needs of anyone when requested by a first responder, hospital personnel, paramedic, or coroner's office to bring emotional first aid to survivors, friends, and family in crisis.

Inland SoCal United Way

Inland SoCal 211+

FIELD PLACEMENTS
Crisis Helpline Annual Report 2023-2024



Interns and Staff represent Crisis Helpline at the Out of Darkness Suicide Prevention Walk at Fairmont Park, September 2023.

Mental health services are essential for community wellness. However, the number of licensed therapists in California declined by 20% from 2016 to 2020 (CalHHS). This puts additional pressure on mental health care systems that are already overwhelmed by increased demands caused by the pandemic, inflation, wildfires, gun violence, racism, the housing crisis, and other stressors. In 2020, to address the need for more mental health workers, the Inland SoCal Crisis & Suicide Helpline launched a workforce development initiative. The program provides mental health career students with a fieldwork site and behavioral health work experience while focusing on developing their own protective factors to remain in the field.

Participating Universities:

- California Baptist University
- La Sierra University
- Grand Canyon University
- Chamberlain University
- Western New Mexico University
- University of Louisville

Preparing the Next Generation:

- More than 100 students have completed the program since its launch.
- 26 students completed a behavioral health internship with Crisis Helpline in 2023-2024.
- 24 of the 26 students were Masters of Social Work graduate student interns. The remaining 2 were undergraduate students completing a bachelor's degree in social work.
- 100% completed over 60 hours of suicide prevention and crisis intervention training and assisted thousands of community members in crisis.
- 100% of program graduates report having a long-term goal to remain in the behavioral health profession, and many report wanting to work long-term in crisis care.

United Way
Inland SoCal United Way

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Inland SoCal 211+

PEI

ACKNOWLEDGEMENTS
Crisis Helpline Annual Report 2023-2024

In recognition of their contributions, the Inland SoCal Crisis & Suicide Helpline acknowledges and is grateful for support from all community partners in the 2023-2024 program year.

With special thanks to:

Riverside County Behavioral Health (RUHS) for their 56 years of funding and partnership support to the Crisis Helpline services in Riverside County.

Kristin Miller of the Riverside County Crisis Mobile Unit for developing and launching our joint effort to make mobile crisis accessible to the public through the Crisis Helpline.

Riverside County Public Health (RUHS) for their 2023-2025 grant focused on expanding Crisis Helpline awareness and suicide prevention training in Eastern Riverside County.

Dr. Charles Lee-Johnson, Froylana Miller, and Judy Latham of California Baptist University's Department of Social Work for our 6th year anniversary of partnership with their department. Approximately 75% of the Crisis Helpline's social work interns each year join us from their respective programs. With training and supervision by Crisis Helpline staff, their interns answer roughly half of all calls.

Prof. Daphne Thomas and Dr. Marni Straine of La Sierra University's Department of Social Work for supporting our team with additional training and development opportunities.

Riverside County Suicide Prevention Co-Chairs, Diana Gutierrez (RUHS-BH) and Rebecca Antillon (RUHS-PH), for their ongoing collaboration and support of regional suicide prevention.

Magda Stewart of the Riverside Trauma Intervention Program (TIP) for partnering on postvention services to survivors of suicide loss.

United Way
Inland SoCal United Way

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Inland SoCal 211+

Take My Hand Peer Chat

Program Type: Suicide Prevention

TakemyHand™ is a peer-to-peer live chat interface operated by RUHS-Behavioral Health Certified Medi-Cal Peer Support Specialists, providing anonymous live chat support using real-time conversations for people 16 years of age or older who are seeking non-crisis emotional support in Riverside County. TakemyHand™ website also offers resources and promotional materials (https://helpathand.info) to the Riverside County community. Access to the LiveChat is available Monday-Thursday 8:00-5:00 and Fridays 8:00-4:00. LiveChat is accessed through the TakemyHand™ website. Website visitors can respond to the LiveChat invitation or utilize the resources available on the website. The program was developed under MHSA Innovations funding. The Tech Suite Innovations project has come to an end. Due to the success of Take My Hand, and in order to keep these services in our County, Take My Hand will be supported, in part, through PEI funding which will cover the chat service technology component only. Details of this service are shared in the Innovation section of the MHSA plan.



Network of Care

Program Type: Stigma and Discrimination Reduction Program

Network of Care is a user-friendly website that is a highly interactive, single information place where consumers, community members, community-based organizations, and providers can easily access a wide variety of important information. The Network of Care is designed so there is "No Wrong Door" for those who need services. In FY23/24 the website had an average of 611 Website visits per day and a total of 428,238 page views. Visitors viewed approximately 1,170 pages daily on average. Each visitor viewed nearly 2 pages per visit. Visitors spent an average of over 9 minutes on the site per session, reflecting strong user engagement.



May is Mental Health Matters Month

Program Type: PEI Stigma and Discrimination Reduction Program

The 2024 May is Mental Health Events were held in all three





regions of Riverside County. "The Art of Wellness" themed events took place at Fairmount Park in Western Riverside, the Coachella Valley History Museum in the Desert Region, and Valley Wide Regional Park in Mid-County. The events featured free food, culturally diverse music, art and activities to engage roughly 3800 community members in mental health wellness education and resources. Also included in this year's events were screening areas for Directing Change, highlighting video submissions from Riverside County youth that address stigma reduction for mental health, help seeking, and suicide prevention.
Roughly 300 partner agencies across the County shared their services and resources to community members of all ages and walks of life.

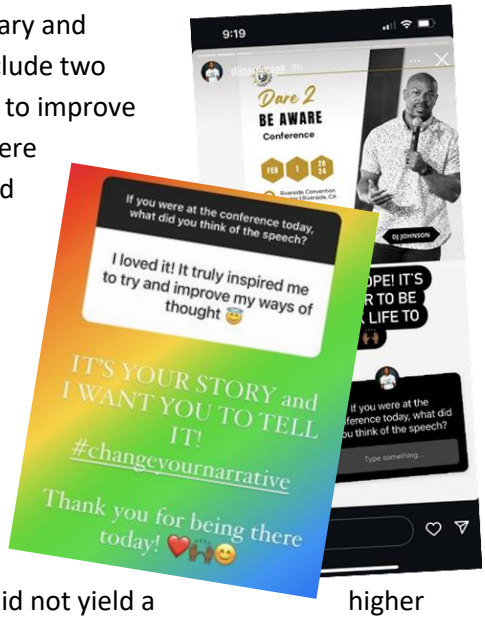


To help increase the reach into the Desert and Mid-County regions, contract providers that have strong ties to their local communities were contracted to organize outreach and help coordinate volunteer efforts. Riverside County Latino Commission covered the Desert region, and California Family Life Center covered the Mid-County region.

"Dare to Be Aware" Youth Conference
Program Type: PEI Stigma and Discrimination Reduction Program



This is a full-day conference for high school and middle school students. The day includes presentations on mental health-related topics along with activities. The 2024 Dare to be Aware youth conference was hosted in February and expanded to include two events this year to improve access. There were conferences held in Riverside and Palm Springs. There was a total of 23 schools countywide that attended the events and a total of 500 youth and advisors in attendance. Both events featured two keynote speakers (DJ Johnson and Gentre Adkins) that shared messages of hope and resilience, giving attendees tools to use in their lives to help bolster their own innate resilience. Students and advisors also received an inspirational activity of chair yoga by Dat Yoga Dude, James Woods, to also add mindfulness, movement, and breathing to their toolbox. Two events did not yield a higher than typical attendance and with the high costs associated with two event venues, the 2025 event will return to one location.



Stand Against Stigma:

Program Type: PEI Stigma and Discrimination Reduction Program

The program goals of this project are to reduce stigma regarding mental illness and to increase community awareness within target populations regarding mental health information and resources. This is an interactive public education program in which consumer speakers share their personal stories about living with mental illness and achieving recovery. The target audiences and goals are:

- Employers: to increase hiring and reasonable accommodations
- Landlords/Housing officials: to increase rentals and reasonable accommodations
- Health care providers: for provision of the full range of health services
- Legislators and other government-related individuals: for support of greater resources for mental health
- Faith-based communities: for greater inclusion in all aspects of the community
- Media: to promote positive images and to stop negative portrayals
- Community (e.g., students, older adults, service clubs, etc.): to increase social acceptance of mental illness
- Ethnic/Cultural groups: to promote access to mental health services



The program consists of a small team of presenters who share their lived experience with mental illness and their recovery journey to reduce stigma and spread messages of hope. Overall, the Stand Against Stigma program saw an increase in their presentations by 24% compared to last fiscal year. This included reaching a total of 248 community members. The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (59.6%), which is one of our underserved communities. Furthermore, most of the presentations and attendance were from the Desert region (65.1%), which is a region in the County that has a high need for support and services. Program outcomes showed a statistically significant increase in participants' affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Attendees reported strong satisfaction with the enthusiasm and knowledge of the presenters, and a high likelihood of recommending the program to others. To help increase community access to presentations, the provider worked on promoting open, virtual presentations for community members to attend. Efforts were made to advertise and promote those regional, virtual presentations; however, it proved to be a challenge to have people attend these events. Oftentimes no one would show to these open, virtual presentations. Furthermore,

when virtual presentations were held, the program did not see high completion rates of outcome measures. Additionally, the program saw a lot of staff turnover, resulting in an even smaller pool of presenters that were able and available to share their lived experience. The biggest lesson learned from FY23/24 was that the open, virtual community presentations were not successful in generating attendance from community members, and that a better, more strategic approach would be to decrease these offerings, and focus on approaching other organizations to host for their members. Additionally, due to the small presenter pool, it is important for the team to communicate and coordinate upcoming presentations to help avoid presenter burnout and to properly care for their own mental health and wellbeing.

One of our presenters shared the following experience from one of their presentations in the Desert region: "During one of our presentations for the Desert community, a listener shared that although her experiences were different, my story helped her understand why some people struggle to open up to therapists or other trained professionals. She mentioned that she had previously believed people who didn't seek help were sometimes responsible for staying in unsafe situations; however, after hearing about my negative experience with a therapist, she said she became more empathetic toward those who have difficulty going to or returning to therapy. I believe this example is significant because I felt like I was able to help reduce stigma and offer a new perspective to this community member."

Feedback from community members who attended the presentation:

- "I love that the presenters shared true life stories. It was a heartfelt presentation."
- "Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful."
- "Great job! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone."
- "Your honesty and vulnerability are appreciated. Thank you for your time."
- "Thank you! This was wonderful to see and hear that there are people fighting the good fight."
- "Life is a miracle if we can experience it."

Riverside University HEALTH SYSTEM Behavioral Health

Stand Against Stigma

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

PEI

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Program Overview and Provider

Program Overview and Provider*:*

MHSA Prevention and Early Intervention has funded stigma reduction programing focused on specific presentations that are aimed at: (1) reducing stigma regarding mental illness, and (2) increasing community awareness within target populations regarding mental health information and resources. “Stand Against Stigma” is an anti-stigma program based on leading researchers’ previous studies about the importance of increasing community awareness about mental health information and resources, that suggests five principles that effectively decrease the consequences of public stigma, referred to as TLC3 (Targeted, Local, Credible, Continuous, Contact). This program is provided by RUHS-Behavioral Health Prevention and Early Intervention Peer Support Specialists known as PEI Peers. They provide services throughout the three regions of Riverside County: Desert, Mid-County, and Western.

Peer Support Specialists promote the consumer perspective in all their presentations. Stand Against Stigma is designed to provide anti-stigma presentations to individuals and organizations by specifically outreaching and collaborating with schools, businesses, community organizations, and faith-based organizations throughout the county to bring presentations to as many people as possible.

“Stand Against Stigma” presentations are utilized to educate and outreach to target audiences to share the unique stories of those with mental illness with the aim of reducing stigmatizing attitudes. Presentations are evidence-supported and structured to discuss mental health through presenters sharing their lived experience with mental health challenges and including an ‘on-the-way-up’ message to discuss strengths and recovery because of services, supports, and/or treatment. Presentations are aimed at reaching the following target audiences: community members, employers, landlords/housing officials, health care providers, other government-related entities, faith -based communities, and media.

Executive Summary: Key Findings

During the fiscal year 2023-2024, there were a total of 14 “Stand Against Stigma” presentations held by RUHS-Behavioral Health PEI Peers in the Desert (n=8), Mid-County (n=1), and Western (n=5) regions, for a total service of 14 hours. The majority of events targeted the general community.

- There were a total of 248 people who attended “Stand Against Stigma” presentations. The presentations were held either in-person or virtually via Zoom (n=14), the total number includes attendees from outside Riverside County regions. Due to the Stand Against Stigma program being provided to people who reside, work, or study in Riverside County, one (1) individuals who resided outside of Riverside County was excluded for analysis purposes. Additionally, one (1) individual who did not provide information regarding their residence was excluded as well. Moreover, 139 attendees did not complete the demographic and pre/post questionnaires. This resulted in only 109 attendees who were included in the analysis for this report.
- Most attendees resided in the Desert region (n=71, 65.1%).
- The attendees’ ages ranged from 19 to 68 years old, with an average age of 40 years old.
- The most frequently reported race/ethnicity for all regions was Hispanic/Latinx (n=65, 59.6%).
- The majority of attendees were female (n=72, 66.1%).
- Post-test results revealed a statistically significant increase in participants’ affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Paired samples T-test showed statistically significant results for Stigmatizing Attitudes and Care-Seeking Attitudes scales ($p<=0.001$).
- Speaker’s Bureau attendees reported strong satisfaction with the enthusiasm and knowledge of the Speaker’s Bureau presenters, and a high likelihood to recommend the program to others.

Event Statistics

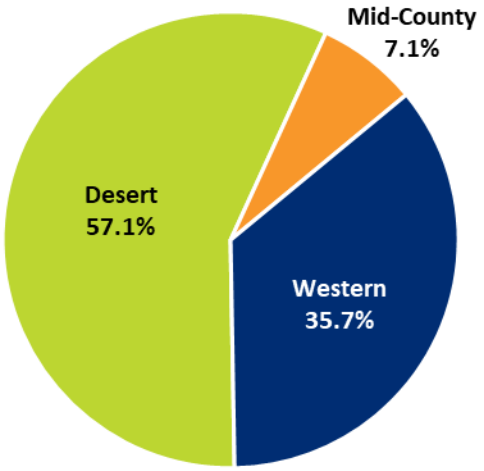
RUHS-Behavioral Health PEI Peers are expected to hold 40 “Stand Against Stigma” presentations per region each year. During FY 2023-2024, a total of 14 presentations were held throughout the County and no region met expectations.

RUHS-BH PEI Peers FY 2023-2024 Speaker’s Bureau Events Countywide			
Presentation Format	**Contract Expectation**	**Current Total**	**Percent Completion**
Speaker’s Bureau	**120**	**14**	**11.7%**

Out of the 14 total "Stand Against Stigma" presentations conducted by RUHS-BH PEI Peers, the majority took place in the Desert region (n=8), followed by the Western region (n=5), and the Mid-County region (n=1).

The presentations were evenly split between virtual and in-person formats, with 7 of each. The PEI Peers collaborated with a variety of community venues, including libraries, family engagement centers, colleges, social services organizations, and other community locations.

Event Statistics by Region



Event Duration by Region

Region	Total Time
Countywide	**14 Hours**
Desert	**8 (57.1%)**
Mid-County	**1 Hour (7.1%)**
Western	**5 Hours (35.7%)**

The total presentation time that was spent on Speaker’s Bureau events across all regions was 14 hours, with the Desert, Western, and Mid-County regions making up 57.1%, 35.7%, and 7.1% of the total time, respectively. The average time was 1 hour for presentations. Most of the presentations were conducted only in English (n=12, 85.7%), while an additional one presentation were conducted in American Sign Language (7.1%), and one more presentations were conducted in Spanish (7.1%).

Event Statistics cont.

City/Zip Code Locations

Region	City and Zip Code	Countywide
Desert		**8 (57.1%)**
	Indio, Palm Desert, Thermal	5 (62.5%)
	Virtual	3 (37.5%)
Mid-County		**1 (7.1%)**
	Virtual	1 (100%)
Western		**5 (35.7%)**
	Riverside, 92507	2 (40.0%)
	Virtual	3 (60.0%)

In FY 2023-2024, a total of 14 “Stand Against Stigma” presentations were delivered by providers, either virtually via Zoom or in-person. Of the seven in-person presentations, five took place in the Desert region and two in the Western region, with one event occurring in the Mid-County region.

Target Population

Target Population	Countywide (n=14)
Community	12 (85.7%)
Peers	1 (7.1%)
Other	1 (7.1%)

Speaker’s Bureau presentations were intended to target particular populations in non-traditional settings. The largest target population reached by the program was to the “Community” (n=12, 85.7%), followed by “Peers” (n=1, 7.1%) and “Other” (n=1, 7.1%). The community was reached through libraries, community organizations, and colleges.

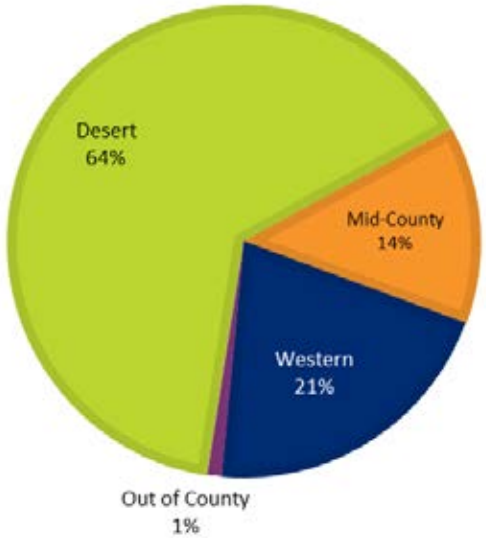
Participant Demographics

Attendance

A total of 248 individuals participated in the 14 “Stand Against Stigma” presentations during the fiscal year 2023-2024. Attendees were asked to complete demographic forms and pre/post surveys at each event. In total, 111 demographic forms and surveys were submitted, including responses from non-Riverside County residents, employees, or students (n=1) and individuals with unknown residency (n=1). Since the program is exclusively available to Riverside County residents, employees, and students, the analysis was based on 109 valid responses. Countywide analysis revealed a small percentage of attendees who identified as LGBTQ+ (n=14, 12.8%) or as having a disability (n=9, 8.3%), with no attendees identifying as veterans.

Residence by Region

Of the 109 total attendees who live, work, or study within Riverside County, most were from the Desert region (n=71, 64.5%), followed by the Western (n=23, 20.9%), and Mid-County regions (n=15, 13.6%) of Riverside County with the remaining living outside of the county (n=1, 1.0%). The figure below shows the total attendance by region of residence.



Language

Language	Countywide (n=109)
English	97 (89.0%)
Spanish	9 (8.3%)
Both	2 (1.8%)
Not Reported	1 (1.0%)

Age

Age Range	Countywide (n=109)
18 to 29 years old	16 (14.7%)
30 to 39 years old	34 (31.2%)
40 to 49 years old	38 (34.9%)
50 to 59 years old	16 (14.7%)
60 to 69 years old	3 (2.8)
70 years or older	0 (0%)
Not Reported	2 (1.8%)

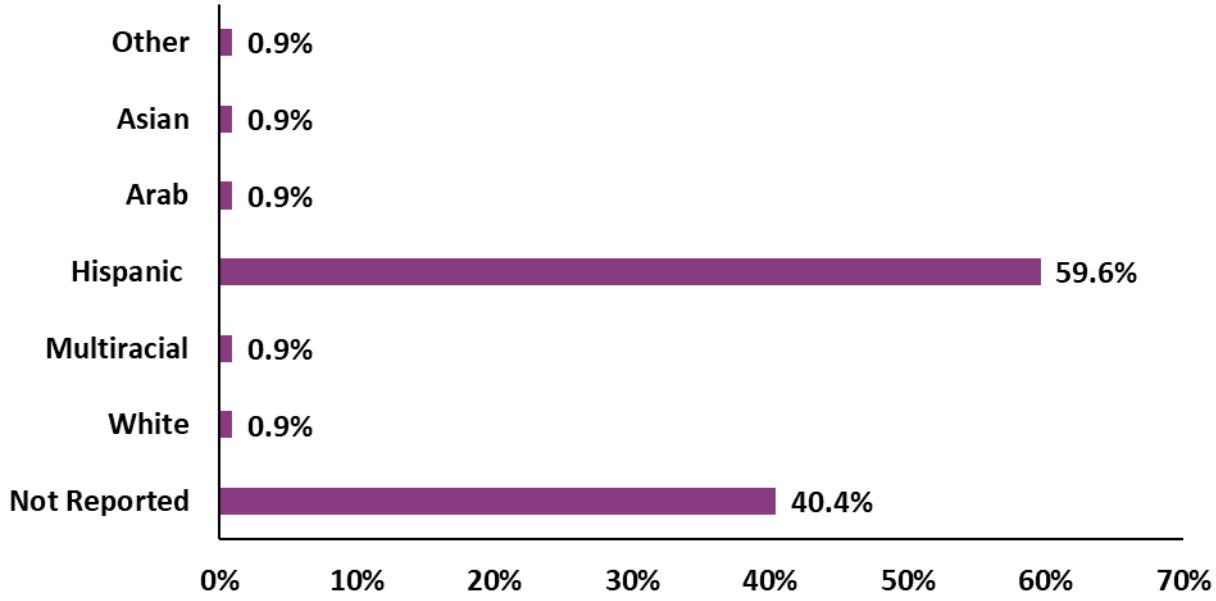
The table above presents the distribution of reported ages. Among the 109 attendees residing, working, or studying within Riverside County, the average age was 40 years, the median age was also 40 years, and the most frequently reported age was 39 years.

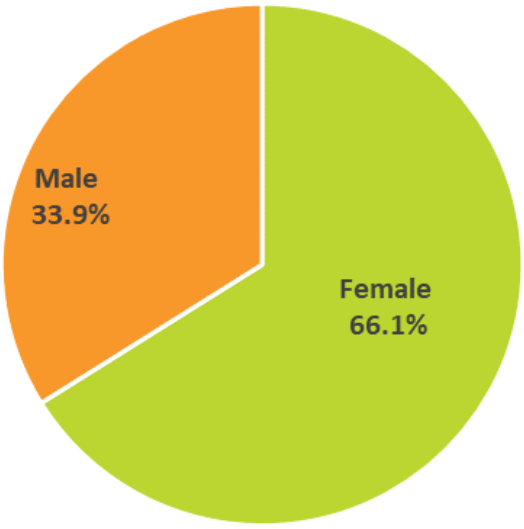
Among the 109 attendees residing, working, or studying in Riverside County, the majority (n=97, 89.0%) indicated that English was their preferred language, while 8.3% (n=9) preferred Spanish. One attendee selected both English and Spanish as their preferred languages, and another declined to respond.

Participant Demographics cont.

Race/Ethnicity

Of the 109 total attendees who live, work, or study within Riverside County, the majority of attendees identified as Hispanic or Latino/Latina (n=65, 59.6%). A small fraction of attendees identified as White (n=1, 1.0%), Asian American (n=1, 1.0%) and Multiracial (n=1, 1.0%). The rest of the attendees declined to report (n=44, 40.4%)





Gender

The majority of attendees identified as female (n=72, 66.1%), followed by male (n=37, 33.9%).

"Stand Against Stigma" Pre/Post Test Questionnaire

Pre-tests and post-tests were administered immediately before and after each "Stand Against Stigma" presentations in order to assess its impact on the attendees. The pre and post questionnaires were designed using a Likert Scale of 1 to 9, where 1 represents "Strongly Disagree" and 9 represents "Strongly Agree". There are a total of 15 questions in the pre and post questionnaires, in which four stigma sections were measured:

- 5 Questions on Stigmatizing Attitudes (AQ-5)
- 3 Questions on Recovery Attitudes (RS-3)
- 3 Questions on Empowerment Attitudes (ES-3)
- 4 Questions Care-Seeking Attitudes (CS-4)

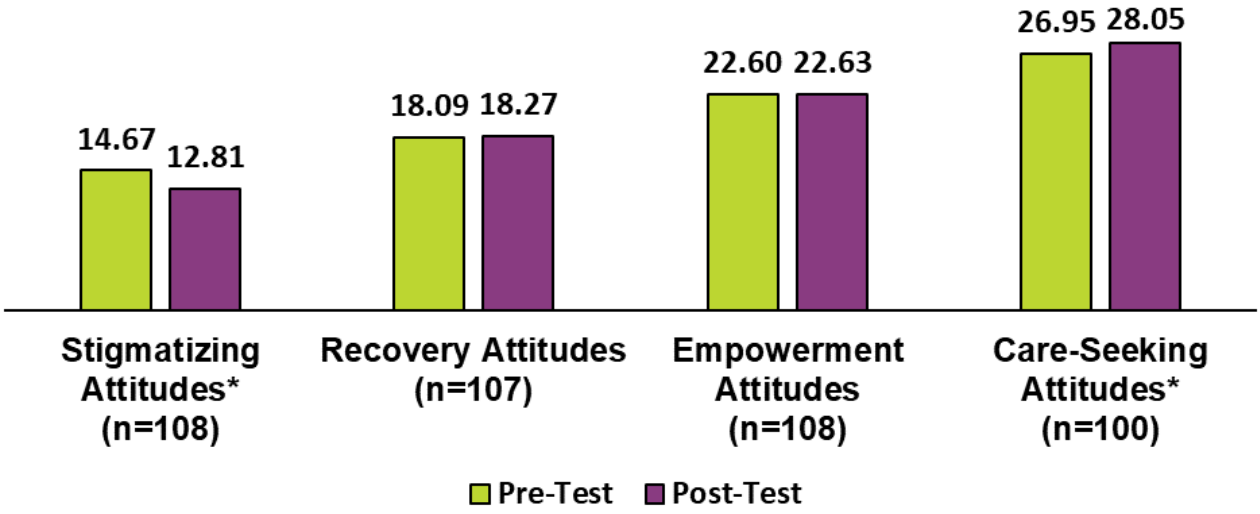
Measures of Stigma	Questionnaire	Rating Scale
Stigma Change (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to people with mental illnesses. *Example: "I think that most people with mental illness are to blame for their problems."*	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "I would speak to a counselor if I were significantly anxious or depressed."*	Score range: 6-54 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

A total of 109 attendees participated in a "Stand Against Stigma" presentation and completed pre- and post-test outcome measures. However, one attendee did not complete all items in the Stigmatizing Attitudes scale (n=108), two attendees did not complete all questions related to Recovery Attitudes (n=107), one attendee did not fully complete the Empowerment Attitudes scale (n=108), and nine attendees did not complete all items on the Care-Seeking Attitudes scale (n=100).

Scores for all items within each of the four questionnaire sections were summed, with pre/post-test comparisons based on the cumulative scores. Higher cumulative scores for the AQ-5 represent greater stigmatizing attitudes and higher cumulative scores on the RS-3, ES-3, and CS-4 represent more positive attitudes toward the described constructs.

"Stand Against Stigma" Average Scores: Pre-Tests vs. Post-Tests

In order to measure the effectiveness of the presentations, ideally there would be a decrease in the average scores of the Stigmatizing Attitudes scale from pre- to post-measures and an increase in the average scores of the Recovery Attitudes, Empowerment Attitudes, and Care-Seeking Attitudes from pre- to post-measures. Overall, the average scores across all scales showed improvements from pre -tests to post-tests. Further analysis using paired samples t-tests shows the improvements were statistically significant (p<=.001) for two scales as shown on graph and table below.



Note: Significance levels * = Numbers indicate statistically significant (p<=.001) change from Pre to Post

Measured Scales	Difference in Average Scores	*t*	df	p
Stigmatizing Attitudes (AQ-5)	1.86	4.200	105	.000
Recovery Attitudes (RS-3)	-0.18	-0.406	105	.685
Empowerment Attitudes (ES-3)	-0.03	-0.080	105	.936
Care-Seeking Attitudes (CS-4)	-1.10	-2.699	99	.008

When comparing the pre- and post-test results across the scales, the Care-Seeking Attitudes scale demonstrated the most significant increase, with an average score change of 1.10 points, followed by a 0.18-point change in the Recovery Attitudes scale. However, the small increase in Recovery Attitudes was not statistically significant. Additionally, the minimal change in scores on the Empowerment Attitudes scale may be attributed to the relatively high baseline scores of attendees (average of 22.60 points, with a range of 3-27), and this change was also not statistically significant.

Overall, statistically significant improvements were observed in both the Stigmatizing Attitudes and Care-Seeking Attitudes scales. These findings suggest that the "Stand Against Stigma" presentations were effective in positively shifting attendees' perceptions of individuals with mental health conditions, increasing their belief in recovery and empowerment, and enhancing the likelihood of attendees seeking help when facing anxiety and/or depression.

Satisfaction Surveys

Additional satisfaction questions were included at the end of the "Stand Against Stigma" post-test questionnaire. Using a scale of 1-9, with 1 representing the poorest satisfaction and 9 representing the greatest positive satisfaction, participants were asked to rate the presenters' level of enthusiasm and knowledge (n=109), and their likelihood to recommend others to participate in a similar "Stand Against Stigma" presentation (n=109). Their responses are summarized below:

- With an average score of 8.25, 72.5% of attendees strongly agreed that the presenters were enthusiastic and knowledgeable when sharing the information
- With an average score of 8.17, 70.6% of attendees strongly agreed that they would recommend others to participate in similar activities

The table below shows the percentages of attendees' responses to each satisfaction survey question. On average, all participants who completed the satisfaction questions reported positive feedback (over 87.6% of attendees chose "6" or higher). Additionally, their comments about the events are shown below and continue on the next page.

		1=Strongly Disagree								9=Strongly Agree	
Countywide (n=103)	**Average**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**No Response**
1. The presenters were enthusiastic and knowledgeable when sharing the information.	8.25	3.7%	-	-	0.9%	4.6%	1.8%	1.8%	11.9%	72.5%	2.8%
2. I would recommend an activity like this to my friends, family members, and colleagues.	8.17	3.7%	-	-	0.9%	6.4%	0.9%	3.7%	11.9%	70.6%	1.8%

Comments

Additional Comments

- I love that the presenters shared true life stories. It was a heartfelt presentation.
- Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful .
- Thank you for sharing. You are so brave and strong.
- Great job ! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone.
- Your honesty and vulnerability are appreciated. Thank you for your time.
- Thank you! This was wonderful to see and hear that there are people fighting the good fight.
- Brave speakers !
- Thank you for sharing.
- Thank you to [facilitator] and [facilitator] for sharing your stories. Thank you for still being here, and congrats on the work you have done so far. I hope the best for the work ahead.
- Presenters were very brave.
- Very touchful stories.
- Each of their stories was very touching and overall highly recommended.
- Life is a miracle if we can experience it.
- Able to change the cycle, learn from it and grow. Be the best person, sibling, parent, wife.
- The experiences with life were very valuable.
- I would love to see PowerPoint from families.
- Thank you for sharing your stories.

Up2Riverside Media Campaign
Program Type: PEI Stigma and Discrimination Reduction Program



RUHS - BH continued to contract with a marketing firm, Civilian, to maintain and expand Up2Riverside.org, a paid media campaign for mental health awareness, stigma reduction, and suicide prevention (as well as substance use and prevention) in Riverside County. The campaign included television and radio ads and print materials reflective of Riverside County and included materials reflecting various cultural populations and ages as well as individuals, couples, and families. Up2Riverside.org includes social media in its overall digital presence. This website has many resources for community members to access. There are downloadable mental wellness kits, the Mental Health Back to School Toolkit, and information about important campaigns such as May is Mental Health Month and Suicide Prevention Awareness Month.

In FY23/24, Civilian designed a new website for a more modern/current look and feel, and refreshed/reworked content throughout the site, creating an overall better user experience for website viewers. The campaign would benefit from updating the commercial ads, but production (video shoot) was not able to move forward.



Emails continued to be responsible for the largest volume of site sessions (38% of total paid sessions), with the lowest Cost Per Click ($0.45) and cost per session ($0.52), making this channel a very cost-effective manner to share a longer form message and entice users to learn more on the website. The campaign introduced Spotify as a new tactic and while the primary Key Performance Indicators for Spotify is awareness (impressions), it is worth noting that the Spotify companion banner outperformed the industry benchmark of 0.05% and generated a total of 853 site sessions, proving the success of this tactic and need to include it in future plans to test further. In doubling Paid Search's budget Year-Over-Year this campaign saw a 2.36x increase in site sessions while maintaining the overall Cost Per Click benchmark of $1.35 (Paid Search was responsible for generating 13.51% of all paid sessions). Success of this tactic was due to both the increase in budget, as well as optimizations throughout the campaign.
The FY 23/24 paid media campaign delivered a total of 61M+ impressions and 344K+ clicks and was responsible for 81% of all website sessions. The campaign also sustained 242 total display points at 113 venues in Hemet and San Jacinto through narrowcasting efforts to share educational and resource information for the campaign with the general public.

Promotores de Salud Mental y Bienestar Program and Community Mental Health Promotion Program (CMHPP)

Program Type: Outreach for Increasing Recognition of Early Signs of Mental Illness Program



The Promotores(as) de Salud Mental y Bienestar program is an outreach and education approach to build a relationship with the Latinx community and increase access to mental health services while reducing the stigma associated with mental illness. Because Promotores(as) come from the communities they serve, they can address access barriers that arise from cultural and linguistic differences, stigma, and mistrust of the system. Furthermore, since they usually provide services in the community when and where it is convenient to community members, they help decrease barriers due to limited resources, lack of transportation, and limited availability. In addition to coming from the communities they serve, Promotores(as) can be characterized by three Ps: Presence in the community, Persistence, and Patience – these build trust in the community. Relationships with the community is one of the key factors that distinguish Promotores(as) from other health workers. The program includes a series of 10 mental health topics that are offered to the Latinx community in 1-hour presentations. The topics include anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, bipolar disorder, and grief & loss. The schizophrenia presentation has been replaced with the culturally specific La Clave curriculum. Resources are also provided.

The Community Mental Health Promotion Program (CMHPP) is an ethnically and culturally specific mental health promotion program that targets: Native Americans, Asian Americans/Pacific Islanders, and Middle Eastern/North African (MENA). A similar approach to the Promotores model, the program focuses on reaching un/underserved cultural groups who would not have received mental health information and access to support and services. The promotors received a 40-hour training in which they are educated on topics in mental health, given a list of culturally competent local resources, and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide 1-hour presentations on 10 different mental health topics in non-stigmatizing community locations such as local churches, community centers, schools, and parks. The topics include anxiety, depression, mental health, schizophrenia, self-care, substance abuse, suicide prevention, trauma, bipolar disorder, and grief & loss. Resources are also provided.

In fiscal year 2023/2024, the following agencies provided the CMHP Program to each of their respective underserved populations: Visíon y Compromiso (Hispanic/Latiné); Riverside-San Bernardino County Indian Health, Inc. (Native American); Special Services for Groups (Asian American/Pacific Islander); Sahaba Initiative (Middle Eastern/North African). Each of our providers worked to utilize community engagement effectively by continuing to cultivate and strengthen relationships with important stakeholders and key leaders, ensuring that their goals were aligned with the community's needs and priorities to foster interest and investment. Many of our providers were able to make inroads with different faith-based organizations, workplaces,

and community organizations and collaborated with them to tailor their presentations to best meet the needs of the culture and social context of their communities.

Visíon y Compromiso established a new MOU with Jurupa Valley Unified School District and began partnering with the goal of supporting the district's parents, increasing their awareness and education around the different mental health topics. Throughout the County, the majority of those in attendance indicated Spanish as their primary language (85%). Furthermore, the program expanded to include service to the Mid-County region in FY23/24, and the provider was able to provide a total of 3,476 presentations with a total of 11,862 people in attendance.

Visión y Compromiso

Promotores
3,476 Presentations
11,862 Attended

Riverside-San Bernardino Indian Health, Inc. continued to collaborate with community organizations and found new resources to share with their Native American community members. A strong partnership continued during FY23/24 with the University of California, Riverside and their Native American Student Programs. Other relationships with local colleges were developed during this fiscal year as well. The provider held a total of 143 presentations countywide with 1,083 in attendance, 85.6% of whom identified as American Indian or Alaskan Native.

Native American
143 Presentations
1,083 Attended

Special Services for Groups found innovative ways to make their presentations appealing for their diverse AA/PI community. They found much success with infusing culturally relevant activities with their presentations to draw in more AA/PI community members. They centered their presentations around culturally tailored workshops, such as traditional dance, traditional crafting, and healthy living clubs. Community members were attracted by the different cultural activities and attended the mental health presentations that were related to those different activities (e.g., choreography and self-care and wellness, candle making and suicide prevention, etc.). In FY23/24 the provider held a total of 47 presentations in English, Korean, and Chinese with 1,028 in attendance. immerse

ssg
Special Service for Groups

Asian American/
Pacific Islander
47 Presentations
1,028 Attended

Sahaba Initiative started their contract approximately halfway through FY23/24 and were able to establish an office location in the Riverside area and hire two full-time staff to serve in Western and Mid-County regions of the county. During their first 6-months they were able to have both staff complete their 40-hour promoter training to be able to provide culturally tailored presentations to the Middle Eastern/North African community.

Sahaba Initiative

Middle
Eastern/North
African
Completed Training

Some of the challenges that the providers faced during FY23/24 included finding key organizational leaders that they could connect with to champion their programs and bring them to the community members for presentations. Other providers faced staffing challenges and had pauses in service delivery to hold interviews, find the right fit for the team and community, undergo the onboarding requirements (e.g., DOJ background checks), and to conduct the extensive 40-hour training. Whether starting these services brand new in the County (e.g.,

Sahaba Initiative for the MENA community), or expanding services to new regions (e.g., Visíon y Compromiso 's expansion into Mid-County), the providers faced challenges with sharing their program in areas that were not familiar with the services provided. It took time to establish a presence and build relationships in the different communities. Additionally, some communities are more conservative than others, making it difficult to overcome the stigma associated with mental health and discussions around mental illness and suicide prevention. The providers encountered challenges with gathering community specific resources for their different underserved cultural groups, particularly for underserved groups with a lot of intragroup diversity (e.g., the many different tribes in Native American, the different cultures that make up Asian American/Pacific Islander, etc.). At times providers faced challenges with locating community spaces in which to host presentations. An alternative was to provide virtual presentations via Zoom when it was found to meet community need; however, this was often found to not be a lucrative option for many community members, who were fatigued of virtual services since the pandemic, and often yielded in low attendance and low completion of demographic forms and satisfaction surveys.

The providers in the CMHP program learned the importance of persevering with their efforts to identify the leaders of each community to assist them in collaborative efforts to deliver the needed presentations to the underserved populations. They also found value in their continued work with churches and temples where audiences are already mobilized to raise awareness about their CMHP programs and other available resources. Overall, the providers learned how to establish credibility by being transparent, consistent, and respectful. They involved diverse stakeholders, ensuring all community groups were represented, especially marginalized voices. This led to them being able to more effectively utilize culturally appropriate approaches to remove barriers to participation.

The outreach efforts have been a great success in leading workshops and building relationships within the different communities.

Feedback from participants includes:

- "It helps me understand more about my sister and to know how to help her."
- "It is very useful to know the symptoms so we can help someone or detect the disease early."
- "Making me more comfortable to talk about depression with my friends and family."
- "It brings awareness and helps people understand where others are coming from."
- "The mindset to think about things again and make an effort to put into practice."
- "Learned different ways to cope with stress."
- "The information shared in the training series were useful."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention (PEI)

Community Mental Health Promotion Program

FY 2023-24 Annual Report



Introduction

The ethnically and culturally specific Community Mental Health Promotion Program (CMHPP) trains lay workers in the community (promoters) to outreach to their communities, bring awareness to mental health topics, reduce stigma and provide resources and/or referrals to prevention and early intervention services.

The selected promoters go through a 40-hour training in which they are educated on various mental health topics, given a list of culturally competent local resources and are empowered to create a plan of action as a group to address the unique mental health needs of their community. They provide services in non-stigmatizing community locations such as local churches, community centers, schools and other community locations. The promoters reach out to the Desert, Mid-County, and Western regions of Riverside County, and are especially focused on neighborhoods and communities identified by the MHSA Prevention and Early Intervention (PEI) planning committee as areas of high need. Outreach and education is provided to a range of age groups from middle/high school students, transitional age youth (TAY), adults, and older adults.

Contracted Partner Agencies

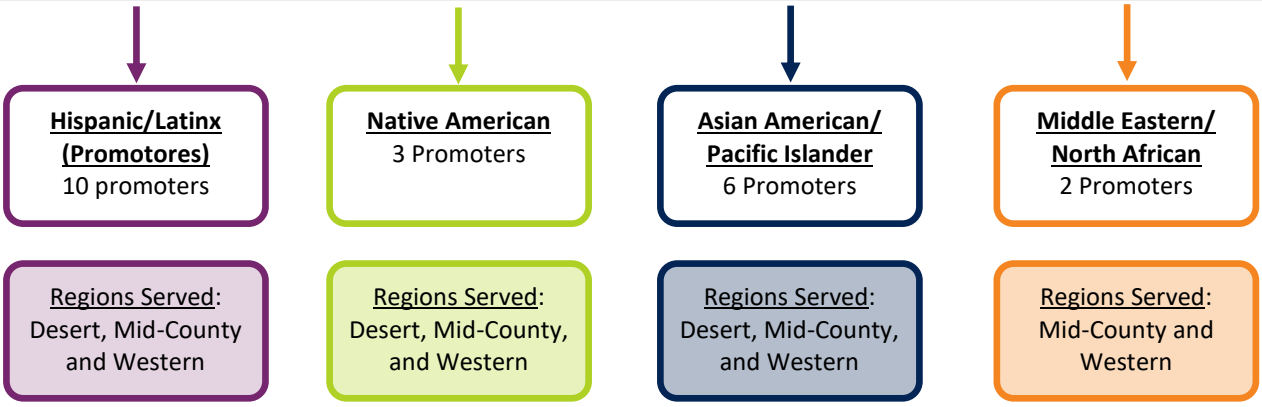
MHSA PEI formed partnerships and contracted with key community agencies. The agencies were responsible for selecting culturally competent promoters who have an understanding of the values, beliefs and language of the community, ensuring that all staffing needs were met and ensuring that the promoters received training as required by MHSA-PEI. They were responsible for program implementation and documentation.

Promotores Latinx/Latino	MHSA-PEI partnered with Visión y Compromiso, who's committed to community well being by supporting Promotores and Community Health Workers. Visión y Compromiso also have a vision towards a healthy and dignified life.
Native American RSBCIHI	MHSA-PEI partnered with Riverside/San Bernardino County Indian Health Inc. The organization advocates on behalf of American Indians through the delivery of quality health care services, which honor spiritual and cultural values.
Asian American/Pacific Islander Asian Pacific Counseling & Treatment Centers is a division of ssg Special Service for Groups	MHSA-PEI partnered with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), specializing in culturally sensitive approaches to address the social and psychological needs of Asian and Pacific Islander communities.
Middle Eastern/North African SAHABA INITIATIVE Sahaba Initiative nurturing healthy families	MHSA-PEI partnered with Sahaba Initiative who outlines a vision for the Middle Eastern/North African (MENA) communities where mental health is valued and acknowledged with an emphasis on the importance of mental health education and ensuring everyone has access to necessary resources.

Other contracted agencies have provided Outreach in the past to the Black African American community and LGBTQI community, these contractors were unable to continue so this report includes the current contracts.

Staffing By Program and Region

Overall in FY 2023-24, **21** promoters provided outreach and presentations across the CMHP programs in the Desert, Mid-County, and Western regions of Riverside County.



Promoter Training Requirements

As mentioned in the introduction, per contract guidelines, all new promoters are required to complete a 40-hour training which includes topics of safety, community outreach, PEI and community resources, the role of a promoter, mental health topics review, promoter presentations review and data collection. Upon completion of the trainings, program directors complete and submit a performance review of the promoter including strengths and areas of improvement. The promoters also complete an evaluation scoring on a scale of 1-5, if the trainings were effective and helpful in their development as a promoter and if they were confident in their ability to provide community resources and answer questions on mental health issues in a culturally competent way.

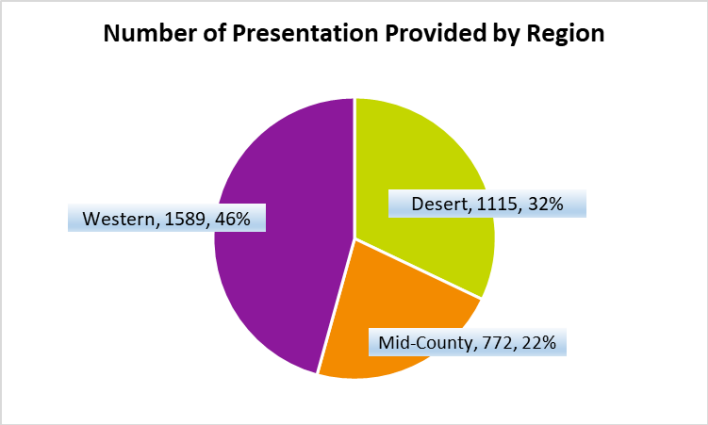
Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Promotores Hispanic/Latinx CMHP program provided a total of **3,476** 1-hour mental health presentations across the Desert, Western and Mid-County regions of Riverside County.

A majority of presentations were provided in the Western region of Riverside County **(46%).** Presentations were available in Spanish and English.

Most presentations were in-person (96%), while presentations were also provided virtually (4%). In-person presentations included residential homes or at public locations such as churches, clinics, community centers, libraries, parks, schools, and shopping centers.



Participants were welcomed to attend more than one presentation. A total of **11,862** people were recorded as attending, which includes those who attended multiple times. Among them, **9,658** reported that attending one of the nine presentation topics was their first time, while **1,879** indicated that they had attended more than one topic, while **325** participants did not response.

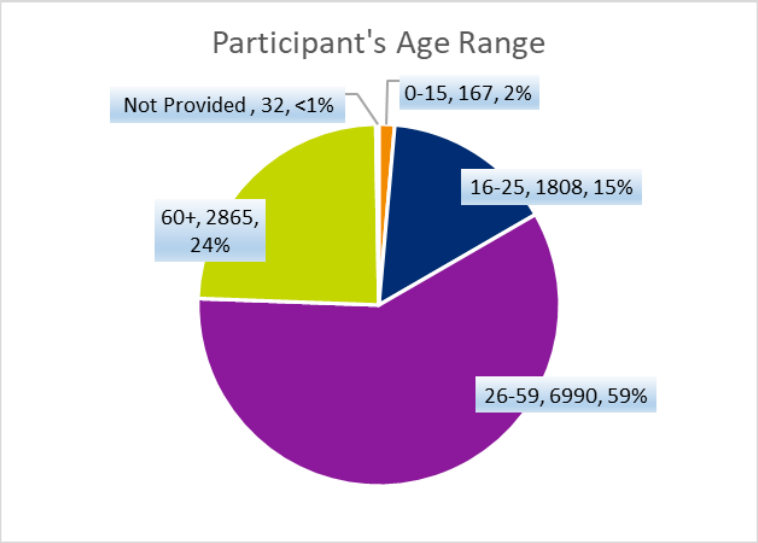
Half of the presentations **(54%)** provided by Promotores CMHPP were on Mental Health, Anxiety, and Depression. The remainder of topics **(46%)** discussed were Trauma, Effects of Drugs and Alcohol, Bipolar Disorder, Suicide Prevention, Grief & Loss and Schizophrenia, collectively.

Topic	n (%)
Anxiety	**577 (16.6%)**
Bipolar Disorder	311 (8.9%)
Depression	**581 (16.7%)**
Effects of Drugs and Alcohol	215 (6.2%)
Grief and Loss	159 (4.6%)
Mental Health	**735 (21.1%)**
Schizophrenia	301 (8.7%)
Suicide Prevention	215 (6.2%)
Trauma	382 (11.0%)



Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All data is based on the total number of participants who have attended presentations, including duplicated counts since participants can attend more than one presentation. The graphs below display totals for those participants that provided a response in the presentation sign-in demographic form.



59% of the participants who attended the presentations reported being adults aged 26 to 59 years old. 15% were youth aged 16 to 25, and 24% were 60 and older, while 2% were 15 years old or younger.

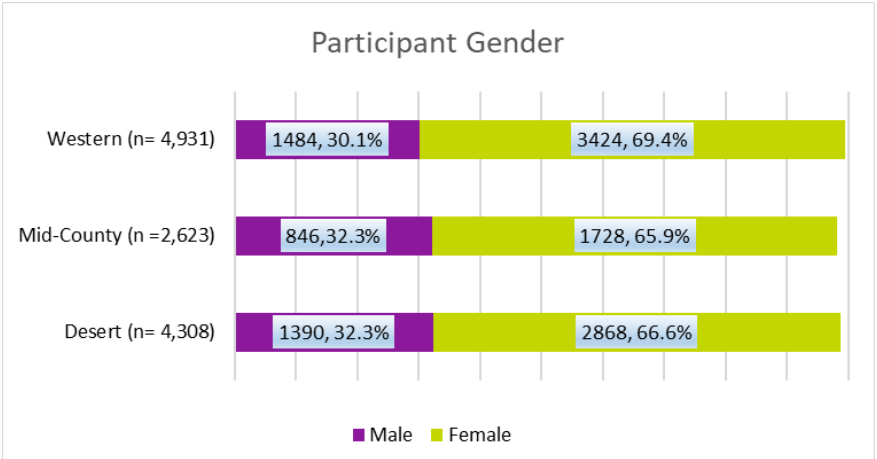
Most participants indicated Spanish as their primary language (85%), 5% selected being fluent in both English and Spanish and 9% of participants spoke only English, while <1% did not provide a response.







Regardless of region, the proportion of females reached was greater than the proportion of males. This occurrence could be by chance or influenced by stigma. Hispanic/Latinx male individuals may be less inclined to talk publicly about challenges at home compared to the female member(s) of the household. Overall (not shown in this graph), across all regions, 115 individuals did not self– identify, 6 participants identified as trans, and 1 participant identified as non-binary. Additionally, a very small percentage of participants identified as Lesbian, Gay, or Bisexual (n=37).

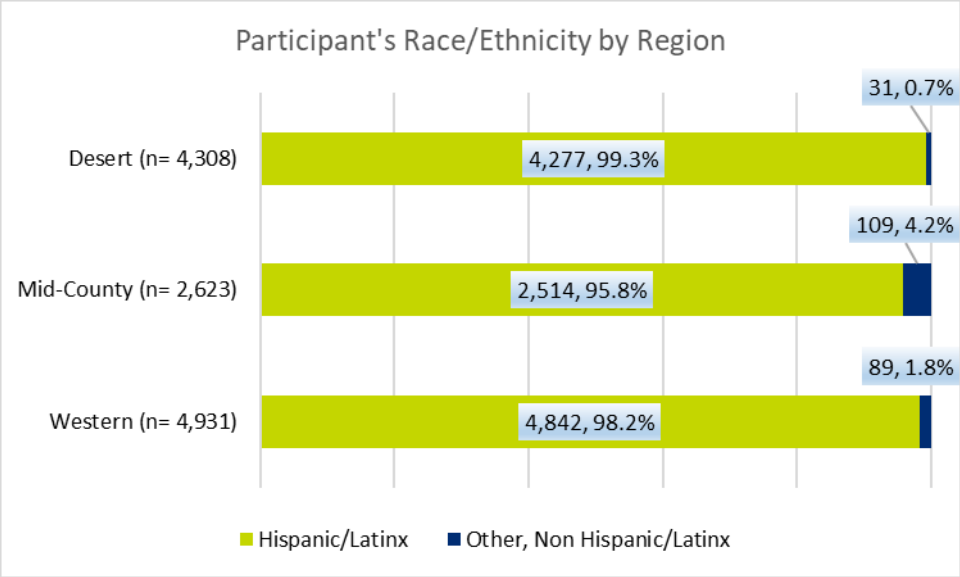


**This data does not include individuals that have self-identified as non-binary, trans, or those who have not provided a gender identity, due to the small number breakdowns. Please refer to text for additional information. Note that totals do not add to 100%.*

Mental Health Presentations: Demographics (cont.)

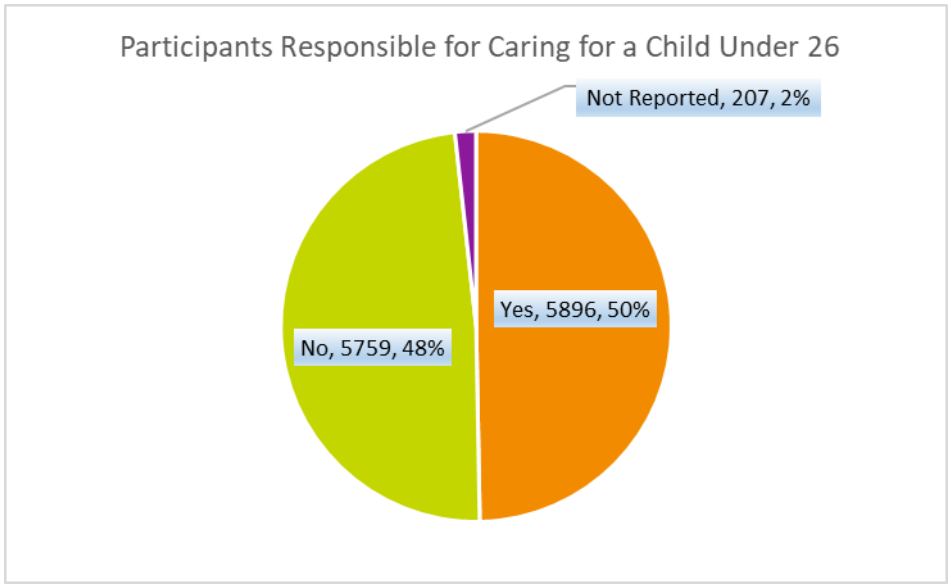
In the Desert, Mid-County, and Western regions, participants in the Promotores CMHP program identified as Hispanic/Latinx (**n=11,633**). Across all regions, 84 self-identified as Caucasian, 23 as Black/African American, 7 as Asian/Pacific Islander, 3 as Native/Indigenous, 48 as Other/Non-Specific, and 48 chose not to self-identify.

While the CMHP program focused on Hispanic/Latinx individuals, it welcomed anyone who felt they would benefit. The graphs below display totals for participants who provided a response on the presentation sign-in demographic form.



**Individuals that did not self-identify as Hispanic/Latinx were categorized as Other, Non Hispanic/Latinx. Please refer to text for additional information regarding racial breakdowns.*

A total of **11,862** responses were submitted regarding caring for a child under 26 years old. Approximately 1 in 2 participants reported having a child under 26. The graph below provides a detailed breakdown of responses across all regions.



Promotores Hispanic/Latinx CMHPP

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

A randomized sample of 500 participants from the 8,527 who completed the satisfaction survey was used to evaluate satisfaction. Surveys from individuals who attended multiple presentations were included, as their experiences may have varied between sessions.

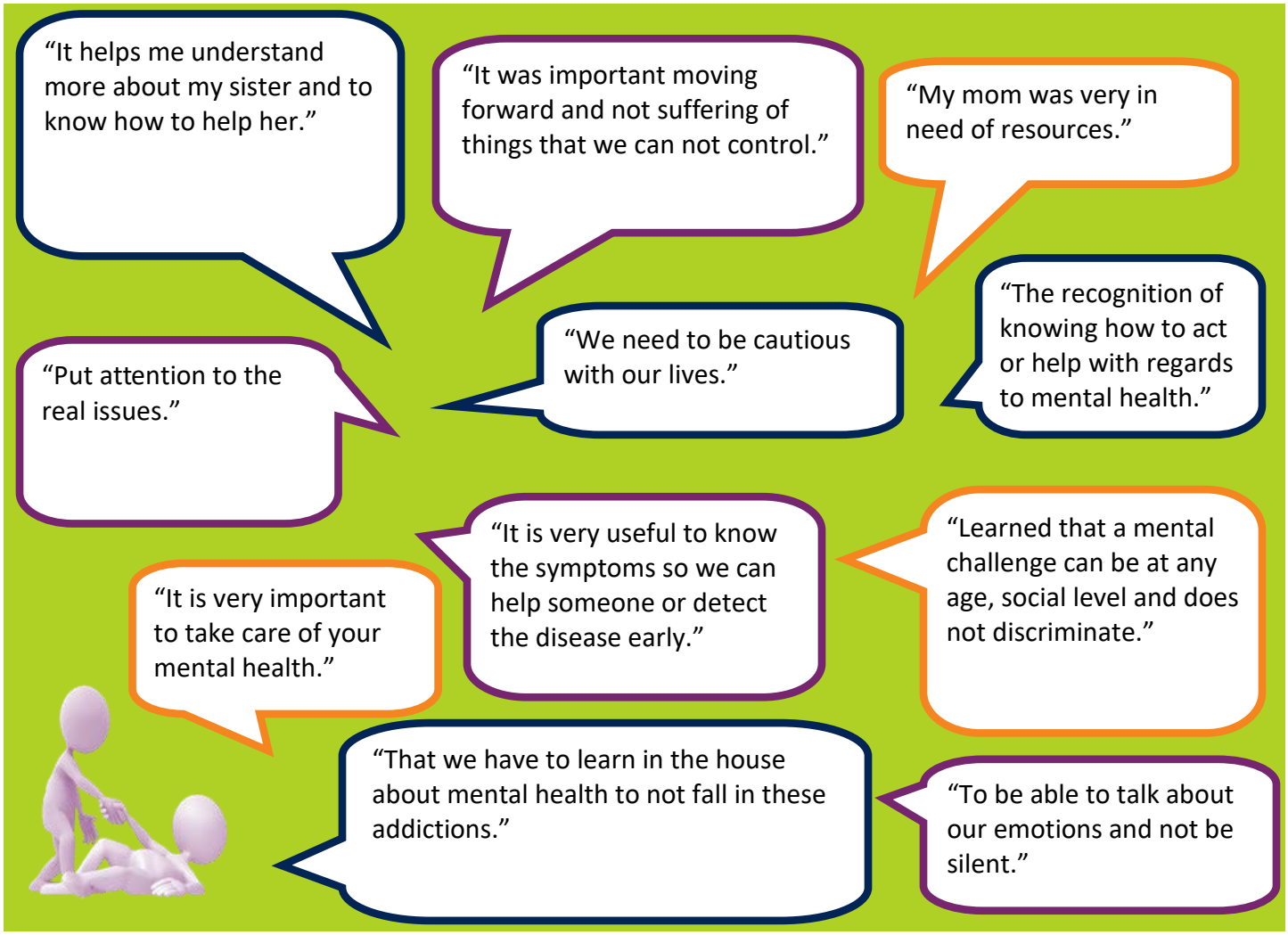
As shown below, a majority of participants strongly agreed with all statements in the survey, indicating they felt confident in seeking help and finding resources, and that they could share the information with family and friends, that they got a better understanding of mental health issues, and that they had a great experience with the promoter.

Questions (n= 500)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
The presenter understands the needs of my community	**4.93**	–	1 (0.2%)	4 (0.8%)	26 (5.2%)	**467 (93.4%)**	2 (0.4%)
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.92**	–	1 (0.2%)	5 (1.0%)	29 (5.8%)	**461 (92.2%)**	4 (0.8%)
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.92**	–	1 (0.2%)	4 (0.8%)	27 (5.4%)	**466 (93.2%)**	2 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.85**	–	1 (0.2%)	9 (1.8%)	54 (10.8%)	**433 (86.6%)**	3 (0.6%)
I know mental illness can me managed and treated	**4.87**	–	1 (0.2%)	7 (1.4%)	49 (9.8%)	**440 (88.0%)**	3 (0.6%)
I feel comfortable seeking help for a family member, friend, or myself	**4.87**	–	2 (0.4%)	6 (1.2%)	48 (9.6%)	**442 (88.4%)**	2 (0.4%)
I know where to seek resources for a family member, friend, or myself	**4.90**	1 (0.2%)	1 (0.2%)	4 (0.8%)	37 (7.4%)	**455 (91.0%)**	2 (0.4%)

Promotores Hispanic/Latinx CMHPP

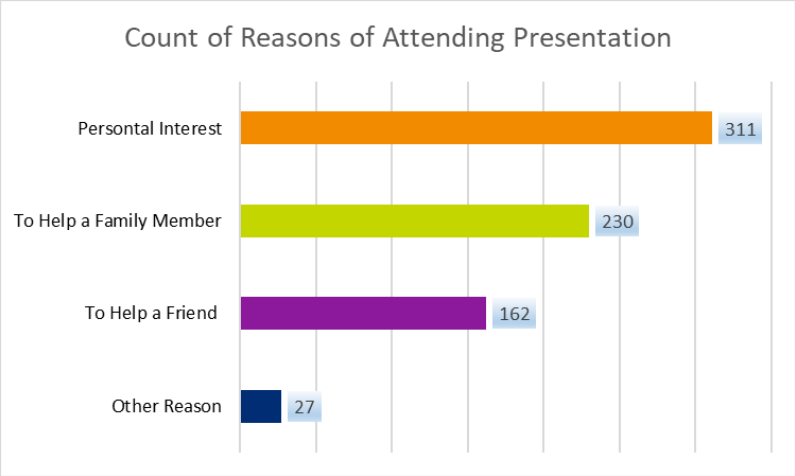
Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Feedback (cont.)

Reasons for Attending



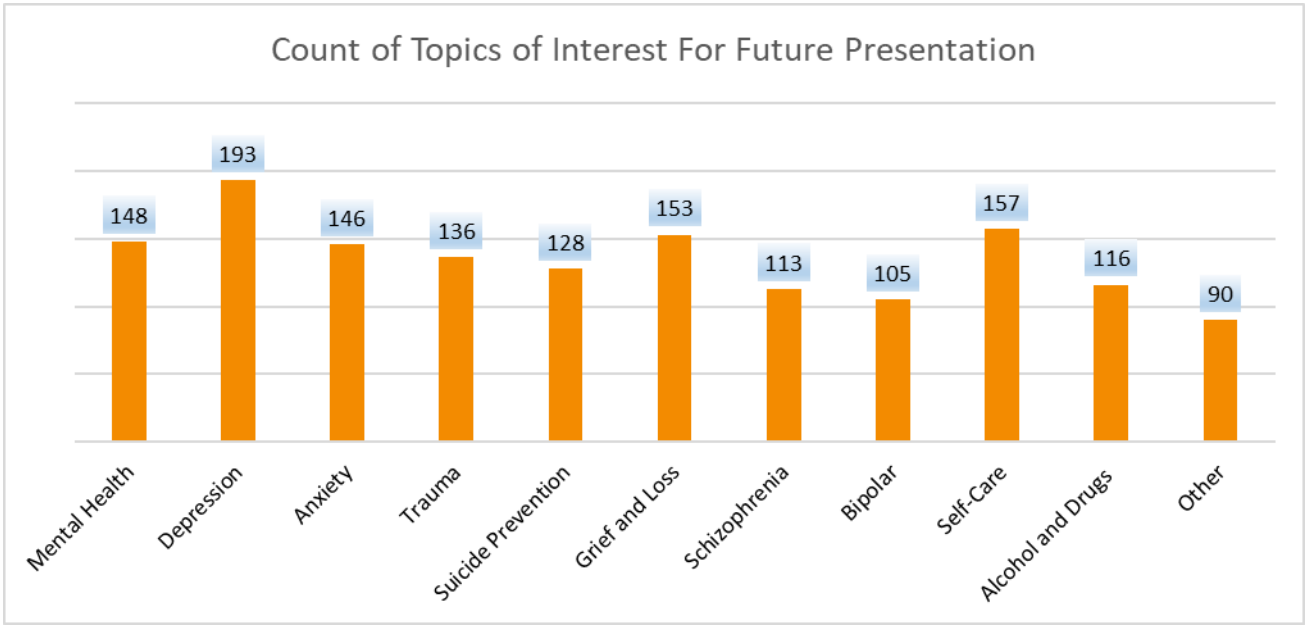
Out of 8,527 participants who completed the satisfaction survey, a randomized sample of 500 provided their reasons for attending the presentation. Participants could select more than one response.

The majority indicated that personal interest was their primary reason for attending, followed by a desire to help a family member. Among those who selected "other reason," the most common response was receiving an invitation from a friend or family member.

Topics for Future Presentations

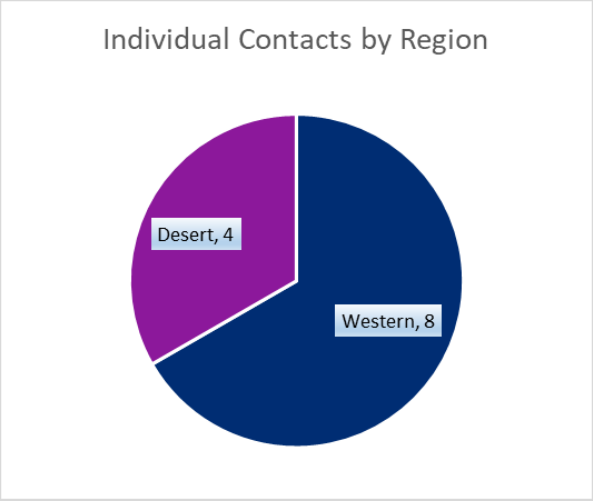
Among sample size of participants who completed the satisfaction survey, a majority expressed interest in learning about Depression, followed by Self-Care, and then Grief & Loss. Additional topics of interest not listed included Autism, Self-Esteem, and Obsessive-Compulsive Disorder. Participants were allowed to select more than one topic.

Feedback from these surveys will be considered by promoters when planning presentations on these topics for the 2024-2025 fiscal year.

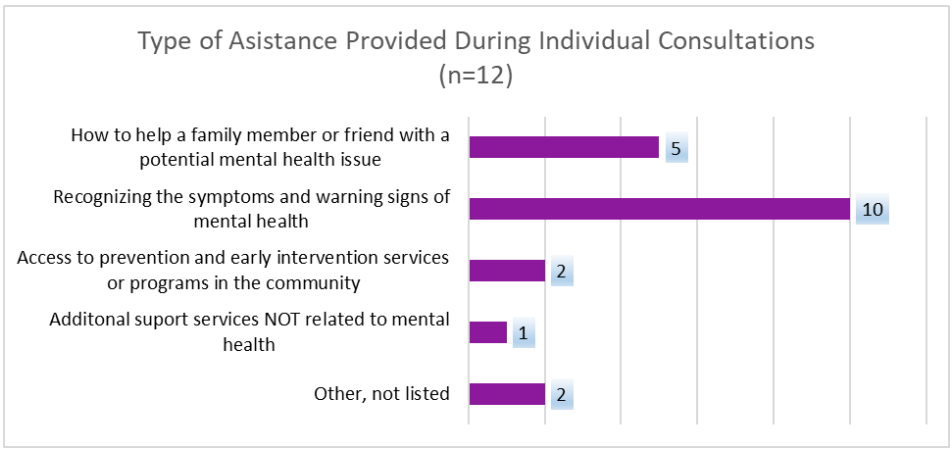


Promotores Hispanic/Latinx CMHPP

Individual Contacts: Type of Assistance



Individual contacts for the CMHP program are defined as when a promoter provides more in-depth one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Promotores Hispanic/Latinx CMHP program completed **12** individual consultations. Although not shown, all twelve individuals contacts were in-person and occurred as a result of presentations.



The chart above summarizes the types of consultation that were provided. A majority of mental health-related consultations involved recognizing the symptoms/warning signs of mental health issues and providing services to help a family member or friend with a potential mental health issue. Additionally, many participants asked for access to prevention and early intervention services or programs in the community. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.

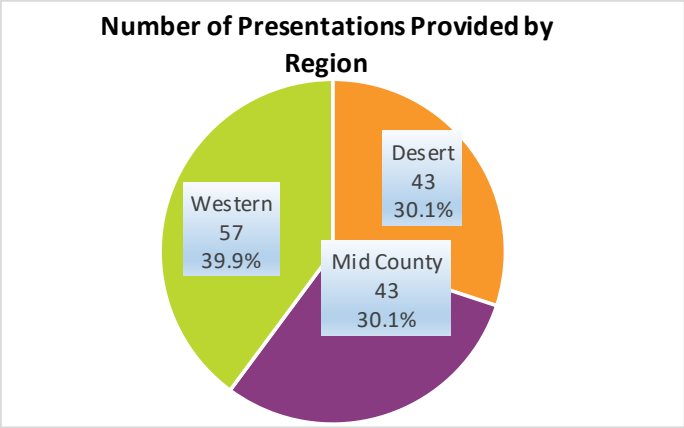
Resources and Referrals Type	Count
Mental Health Education Material	5
Medical Resources	1
Support Groups	1
Housing/Shelter/Homeless Shelter	1
Other Resources *(2-1-1 Connect IE, CARES Line, Take-My-Hand)*	24

The table to the left indicates the frequency of the types of referrals and resources provided as a result of the individual consultations. A total of **32** different resources and referrals were provided during the consultations. Participants requested information on mental health education materials, support groups, housing assistance, and other resources.

Native American CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Native American CMHP program provided a total of **143** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. Most presentations were provided in person (78%) at schools/universities, libraries, coffee shops, recreation centers and tribal offices, with 21% conducted virtually through Zoom. Participants were informed about these presentations through various community outreach methods which included tabling, social media, putting fliers in community areas and reaching out to key community leaders at planning meetings.



A majority of presentations were provided in the Western region (39.9%), followed by the Desert (30.1%) and Mid-County (30.1%) regions. All presentations were provided in English.

Presentations were provided to **1,083** participants. Of these participants, 930 participants attended the presentation for the first time, 122 participants attended presentations two or more times (different presentation topics), and 31 participants did not report how many times they attended the presentation. The majority of participants attended presentations conducted by the Desert region (35.9%, n=389), followed by Mid-County (33.3%, n=361) and Western (30.7%, n=333) regions. While most of the participants were from the target region of the presentations, there were a small number of participants from out of county as well as some participants who attended presentations of a targeted region different than their region of residence. For these reasons, we have included an analysis of the cities of residence of the people (duplicated) that attended the presentations in each region below.

# of people who attended presentations in Desert: 389 Cites of Residence	
Banning	208 (53.5%)
Beaumont	84 (21.6%)
Cathedral City	8 (2.1%)
Palm Springs	8 (2.1%)
Thermal	26 (6.7%)
Other Desert	3 (0.7%)
Mid/West Riv.	12 (3.1%)
Out of County	7 (1.8%)
Not Reported	33 (8.5%)

# of people who attended presentations in Mid-County: 361 Cites of Residence	
Anza	25 (6.9%)
Hemet	28 (7.8%)
Lake Elsinore	8 (2.2%)
Menifee	7 (1.9%)
San Jacinto	217 (60.1%)
Temecula	31 (8.6%)
Other Mid Cty.	15 (4.2%)
Out of County	2 (0.6%)
Not Reported	28 (7.8%)

# of people who attended presentations in Western: 333 Cites of Residence	
Corona	3 (0.9%)
Jurupa Valley	1 (0.3%)
Moreno Valley	41 (12.3%)
Riverside	263 (79%)
Other Desert	1(0.3%)
Other Mid Cty.	1(0.3%)
Out of County	19 (5.7%)
Not Reported	4 (1.2%)

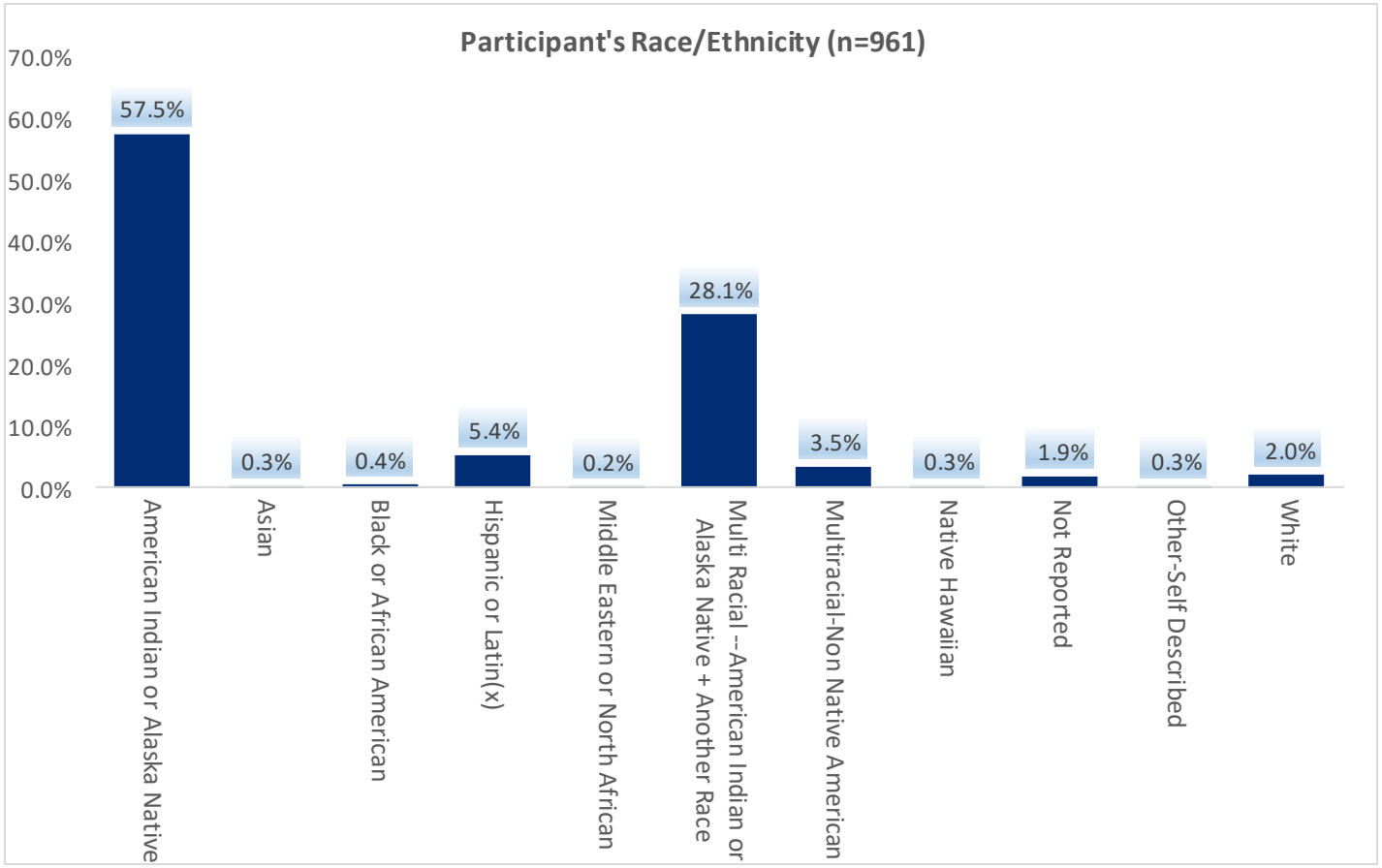
Mental Health Presentations: Topics

Countywide, a majority of the presentations provided by promoters in Native American CMHPP was on General Mental Health (48.3%) followed by Self Care (17%) of presentations.

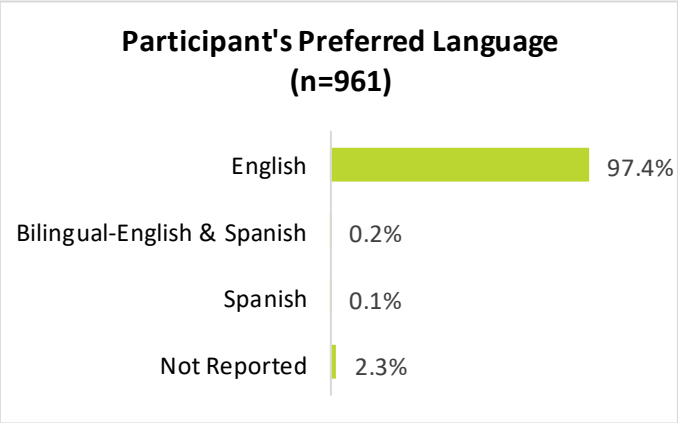
Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	13 (9.1%)	Mental Health and Stigma	7 (4.9%)
Bullying	2 (1.4%)	Self Care	24 (16.8%)
Depression	14 (9.8%)	Substance Use and Abuse	2 (1.4%)
Grief and Loss	7 (4.9%)	Suicide Prevention	2 (1.4%)
Mental Health 101	**69 (48.3%)**	Trauma	3 (2.1%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. All numbers are based on the unduplicated count of **961** participants (including participants who did not report the number of times they attended a presentation - Desert n=323, Mid-County n=312, and Western n=326). Countywide 85.6% of the participants served were American Indian or Alaskan Native (or American Indian or Alaskan Native + Another Race). While the program was focused towards individuals from the Native American community, the program welcomed anyone who felt they would benefit.

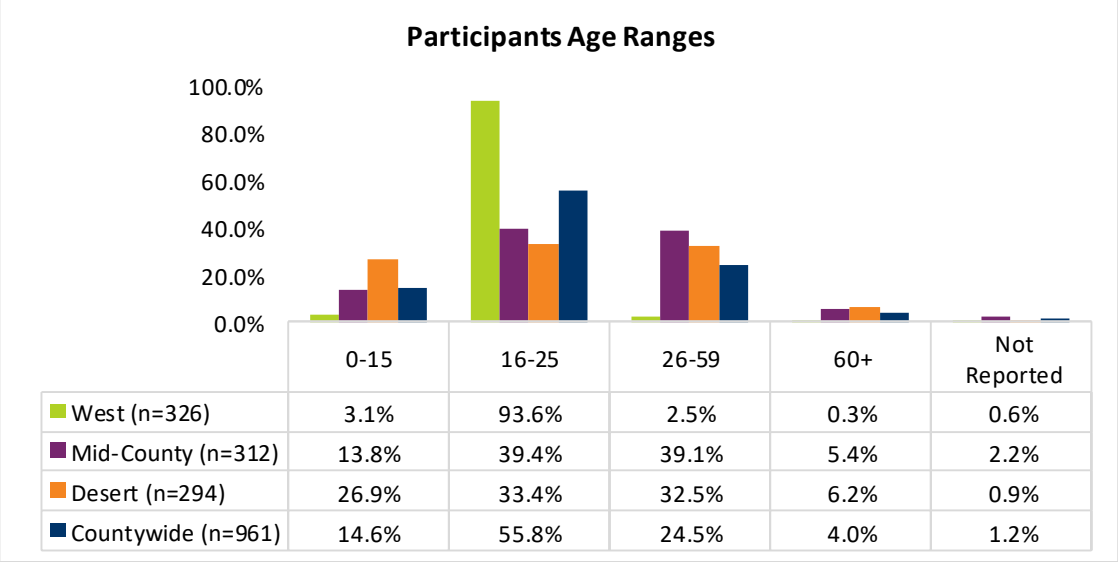


Mental Health Presentations: Demographics cont.



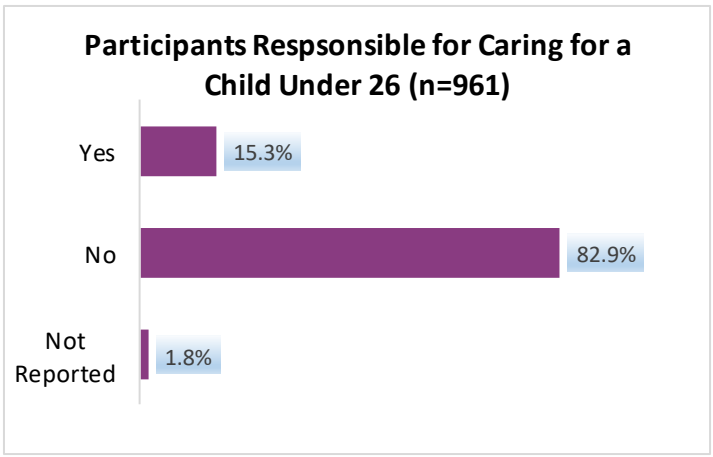
Countywide, a majority of participants indicated English as their primary language (97%).

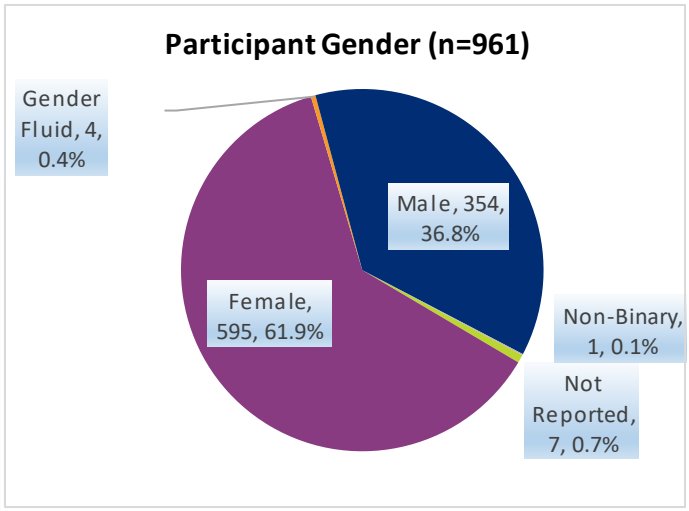
Since there were differences in age demographics by region, the graph below shows participant age by region. Countywide, a majority of participants reported they were 16-25 years old (56%).



	0-15	16-25	26-59	60+	Not Reported
West (n=326)	3.1%	93.6%	2.5%	0.3%	0.6%
Mid-County (n=312)	13.8%	39.4%	39.1%	5.4%	2.2%
Desert (n=294)	26.9%	33.4%	32.5%	6.2%	0.9%
Countywide (n=961)	14.6%	55.8%	24.5%	4.0%	1.2%

Countywide, 15% of participants reported they were responsible for caring for at least one child aged 25 and younger.





Countywide, a majority of participants reached by presentations were female (62%).

Countywide (not shown in this graph) 2.5% of participants identified as LGBTQ.

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the presentation delivery/cultural sensitivity, class content, and their confidence in talking about and seeking help for their mental health or the mental health of family members/friends. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey. 1,080 participants completed the survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time.

As shown below, a majority of participants agreed or strongly agreed with all statements in the survey—that they felt able to find help and get resources, that they could share the information with family and friends, that they got a better understanding of mental health issues in a culturally relevant way.

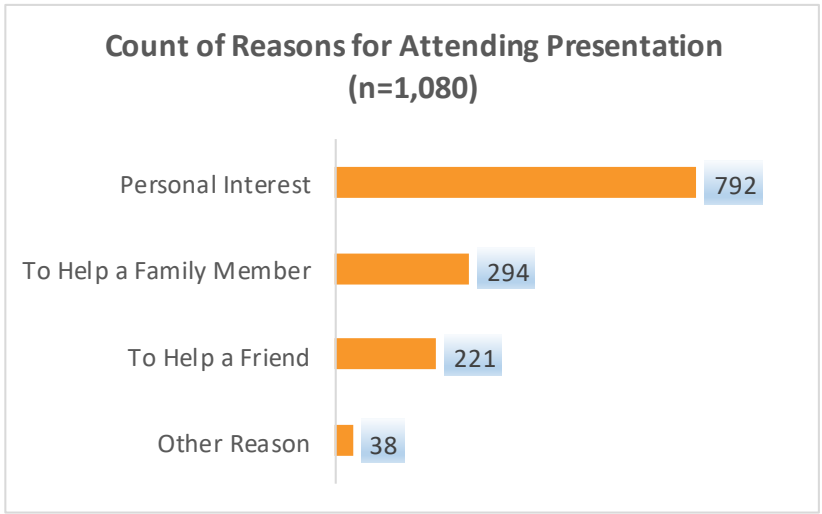
Question (n=1,080)	Avg Score	1	2	3	4	5	No resp.
The information presented was easy to understand	**4.66**	—	1 (0.1%)	42 (3.9%)	283 (26.2%)	**754 (69.8%)**	—
The presenter understands the needs of my community	**4.58**	—	2 (0.2%)	51 (4.7%)	343 (31.8%)	**684 (63.3%)**	—
I would recommend to my friends and family members that they attend a presentation like this in the future	**4.55**	—	2 (0.4%)	57 (5.3%)	364 (33.7%)	**655 (60.6%)**	—
The material in this presentation gave me a better understanding of the early signs of mental health issues within my culture	**4.60**	—	1 (0.1%)	71 (6.6%)	287 (26.7%)	**717 (66.4%)**	4 (0.4%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.45**	4 (0.4%)	8 (0.7%)	101 (9.4%)	355 (32.9%)	**608 (56.3%)**	4 (0.4%)
I know mental illness can be managed and treated	**4.53**	—	3 (0.3%)	69 (6.4%)	358 (33.1%)	**648 (60.0%)**	2 (0.2%)
I feel comfortable seeking help for a family member, friend, or myself	**4.49**	3 (0.3%)	4 (0.4%)	86 (8.0%)	349 (32.3%)	**633 (58.6%)**	5 (0.5%)
I know where to seek resources for a family member, friend, or myself	**4.63**	1 (0.1%)	—	61 (5.6%)	277 (25.6%)	**737 (68.2%)**	5 (0.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well CMHPP was in the community. Below are some of the comments made by participants when asked what was helpful and if they had any other comments.



Mental Health Presentations: Reasons for Attending

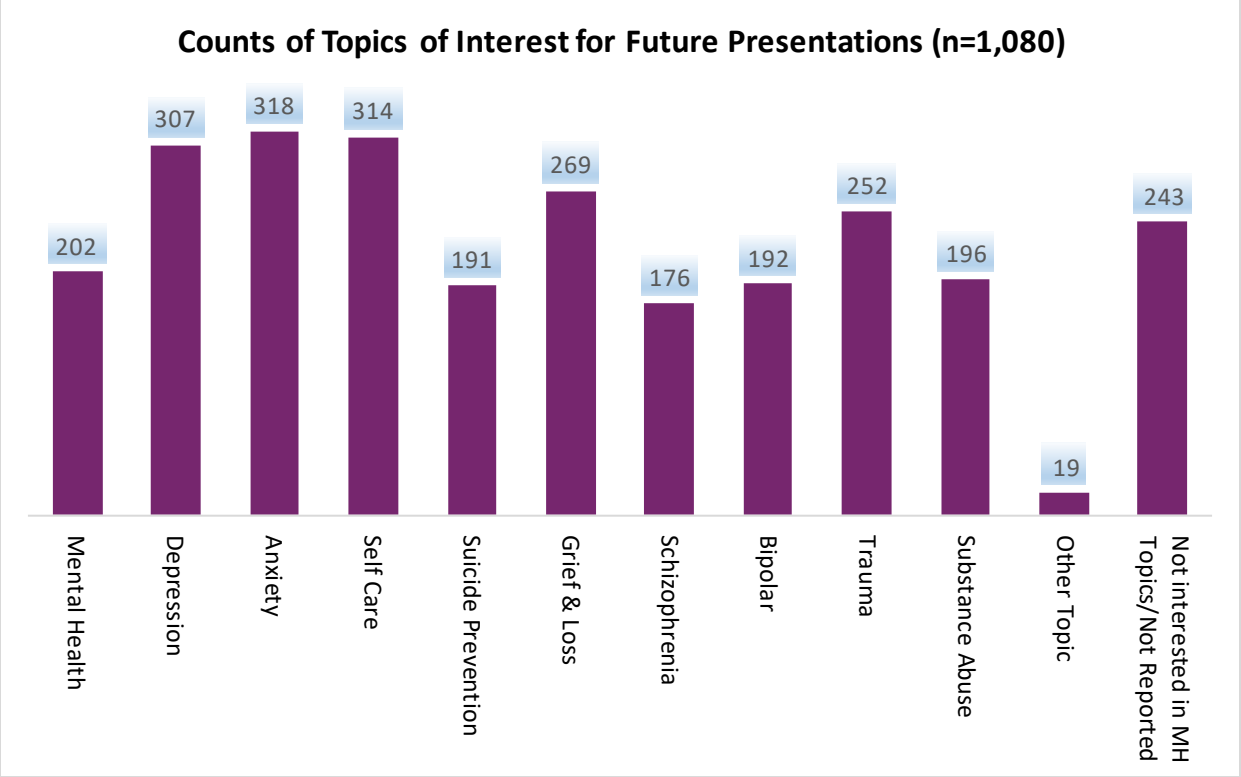


Of the 1,080 people completing the survey, a majority of the people indicated personal interest as a reason for attending the presentation. People were allowed to select more than one response.

For participants that marked "other reason," the most common reasons were that it was required by their school, that they attended with their friend or that they were interested in helping the community.

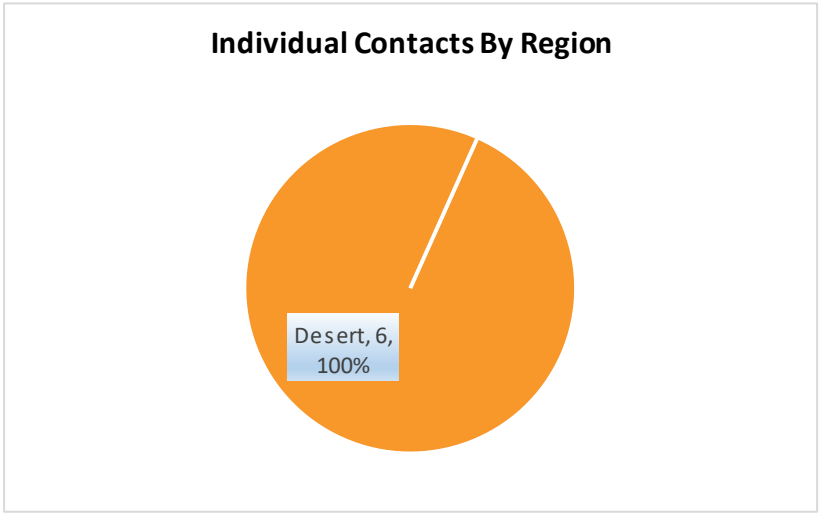
Mental Health Presentations: Topics for Future Presentations

A majority of participants expressed interest in learning about anxiety followed by self care, depression and grief/loss.



Individual Contacts

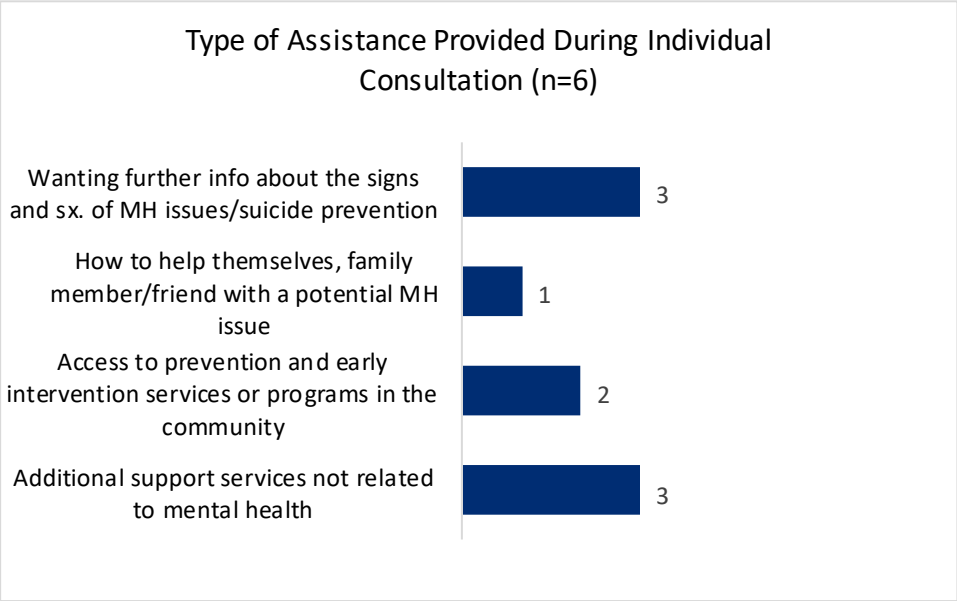
Individual contacts for the CMHP program are defined as when a promoter provides more in depth one-on-one assistance upon outreach or after a presentation to help an individual or family with specific needs and provides referrals to help meet those needs. For FY 2023-24, the Native American CMHP program completed **6** individual consultations. All individual contacts took place face-to-face in person, following the presentations.



The majority of the individual contacts took place in the Desert region of Riverside County (100%).

Individual Contacts cont.

The chart below summarizes the types of assistance that were provided. A majority of mental health related consultations involved wanting further information about the signs and symptoms of mental health issues and suicide prevention. Only frequencies are displayed here, as there could have been multiple reasons for a consultation.



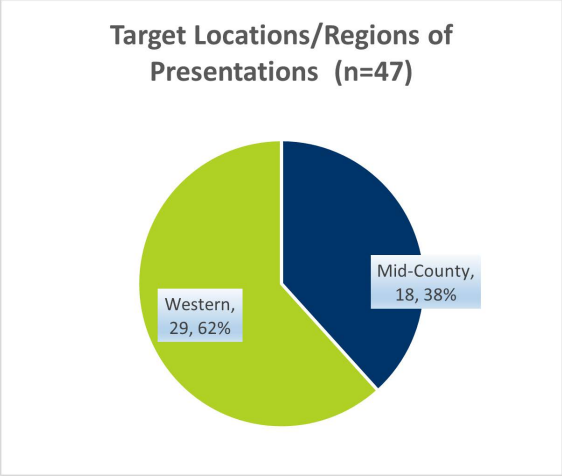
The table below shows the frequency of the type of referrals and resources provided as a result of the individual consultation. A total of **8** different resources and referrals were provided as a result of the consultations.

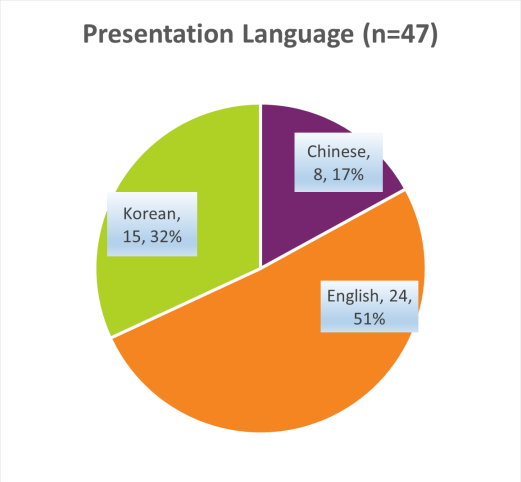
Resources and Referrals Type	Count
Food (*HELP Inc, WIC)*	3
Support Group (*Soboba talking circles*)	1
Cares Line	1
Behavioral Health Specialist (RSBCIHI)	1
Native Challenge	1
PEI Program *(Celebrating Families)*	1

Asian American/Pacific Islander CMHPP

Mental Health Presentations: Service Delivery and Attendance

From July 1st, 2023 to June 30, 2024 promoters for the Asian American/Pacific Islander CMHP program provided a total of **47** 1-hour mental health presentations across the Desert, Mid-County, and Western regions of Riverside County. The majority of presentations targeted the Western region of Riverside County (61.7%). Additionally, a little over half (51%) of the 47 presentations were targeted for the English-speaking community, followed by the Korean-speaking community (32%), and the Chinese-speaking community (17%).





For FY 2023-24, there was a total of **1,028** attendees for the presentations. Out of the 1,028 attendees, 915 attendees had completed a demographic form with 144 people who had attended more than one presentation. As a result, **771** unique individuals are included within the unduplicated count for the demographics portion of the report.

City of Residence

As some presentations were available virtually, it was possible that participants could have joined from outside of Riverside County. The table below reports on the zip codes of the 771 participants who provided demographic information. Of the people who provided their zip code information, the majority of participants reside in the cities of Corona and Riverside. The Asian American/Pacific Islander CMHP program also reached individuals outside of Riverside County, such as San Bernardino, Los Angeles, Orange and many other counties.

City of Residence Riverside County	n, (%)	City of Residence Outside of Riverside County	n, (%)
Riverside	**188 (24.4%)**	San Bernardino County	28 (3.6%)
Corona	**86 (11.2%)**	Los Angeles County	38 (4.9%)
Murrieta	59 (7.7%)	Orange County	20 (2.6%)
Temecula	40 (5.2%)	Other/Not Reported*	231 (30.0%)
Moreno Valley	20 (2.6%)		
Winchester	15 (1.9%)		
Other Cities in Riverside County	76 (9.9%)		

**Includes participants who did not respond to this question and those who lived outside of the cities/counties of interest above (e.g., Santa Barbara County, etc.).*

Mental Health Presentations: Service Delivery and Attendance cont.

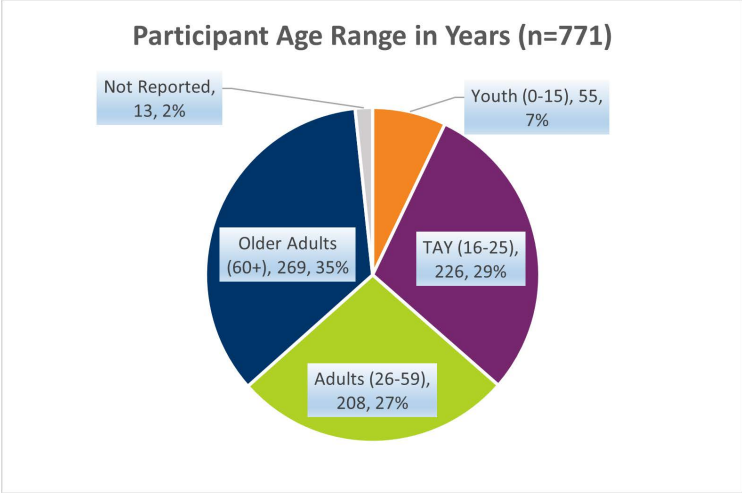
Countywide, most of the presentations that were done by promoters from the Asian American/Pacific Islander CMHP program were on the topic of Mental Health (40.4%), followed by Self-Care (21.3%). Some presentations were tailored to specific audiences. For example, for the Mental Health topic, promoters presented on material for Children's Mental Health.

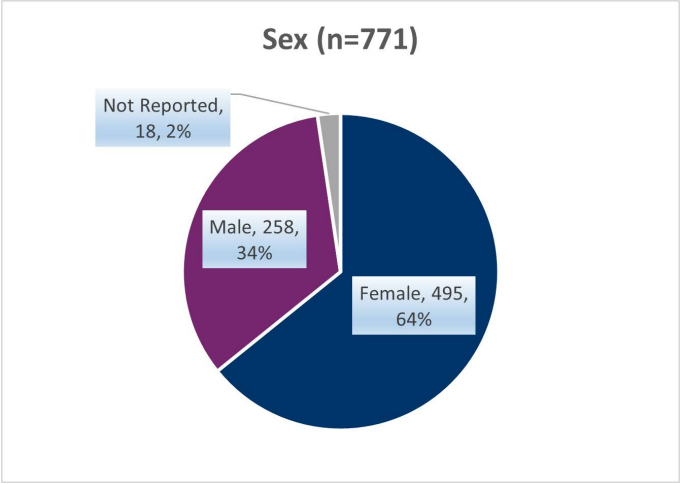


Topic	# and % of Presentations	Topic	# and % of Presentations
Anxiety	2 (4.3%)	Self-Care	10 (21.3%)
Depression	2 (4.3%)	Stress Management	5 (10.6%)
Mental Health	19 (40.4%)	Suicide Prevention	3 (6.4%)
Psychosis	1 (2.1%)	Trauma	5 (10.6%)

Mental Health Presentations: Demographics

This section highlights the basic demographics of participants provided for FY 2023-24. There was a total of 915 individuals who provided demographic information; however, the following demographic data is based on the unduplicated count of participants (**n=771)**. Additionally, all of the demographic data is analyzed on a countywide level.

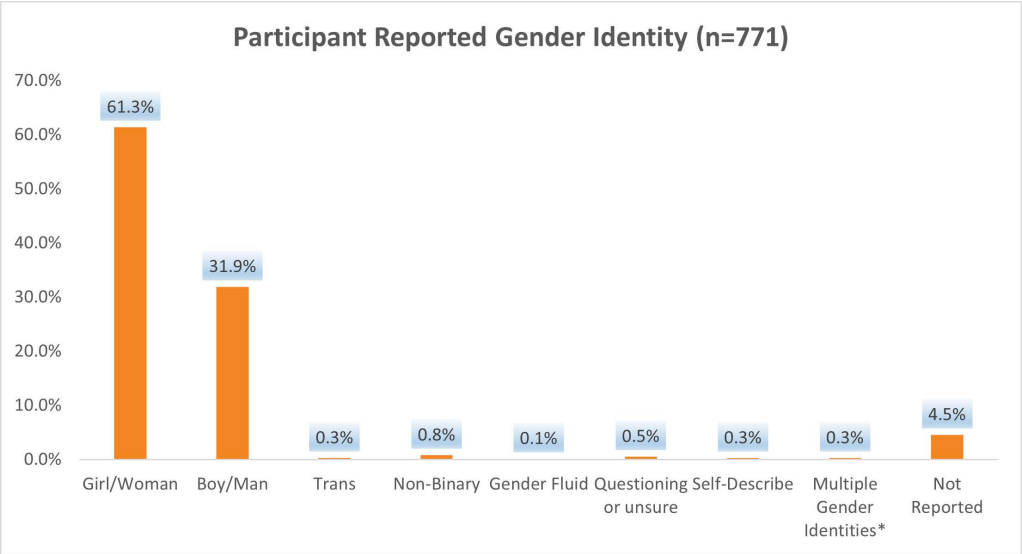


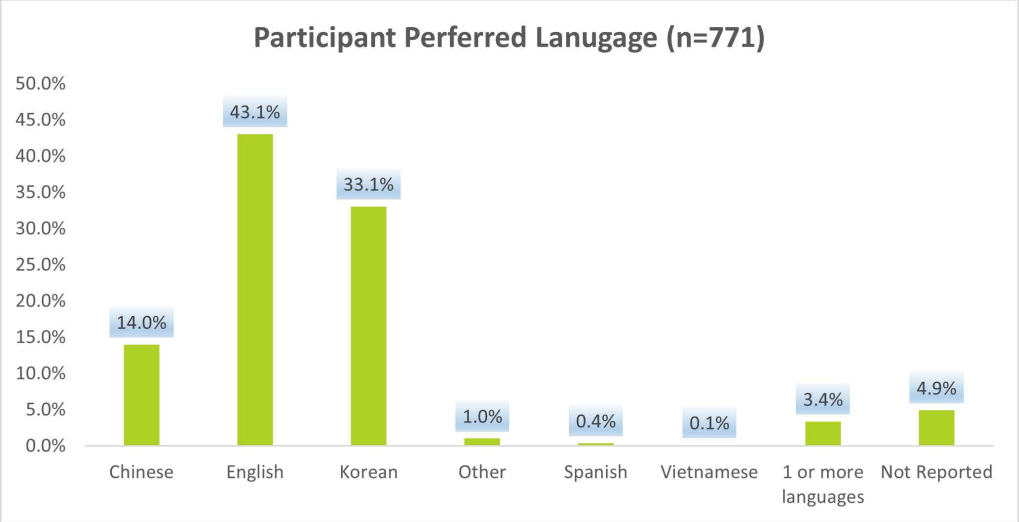


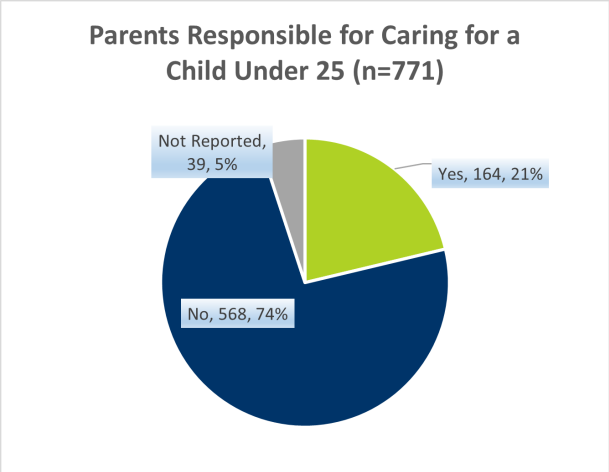
There was a wide variety of ages of those who attended the CMHP Asian American/Pacific Islander presentations. A little over one-third of participants reported being in the 60+ age group (35%), closely followed by the Transitional Age Youth (TAY) age group of 16-25 years old (29%). Almost one-third of participants identified being in the 26-59 age group (27%) and lastly, participants identified being in the 0-15 age group (7%). In addition, the majority of participants who attended the presentations reported their sex as female (64%), followed by male (34%).

Mental Health Presentations: Demographics cont.

Countywide, most participants identified their gender as Girl/Woman (61.3%), followed by Boy/Man (31.9%). In addition, there was variation in participants' preferred languages with about 43.1% of participants having a preference for English, followed by Korean (33.1%), Chinese (14.0%), and more than one language as their preferred language (3.4%). Notably, a majority of participants said that they are not responsible for caring for a child who is 25 years old and under (74%).

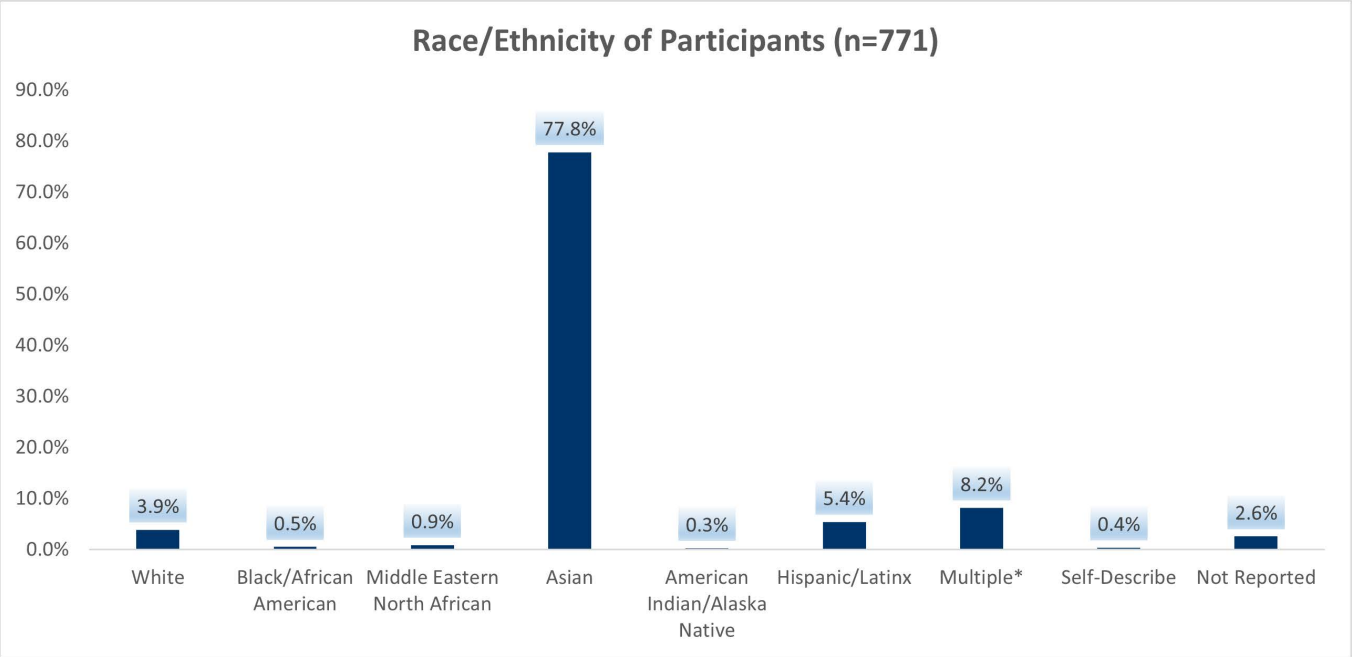




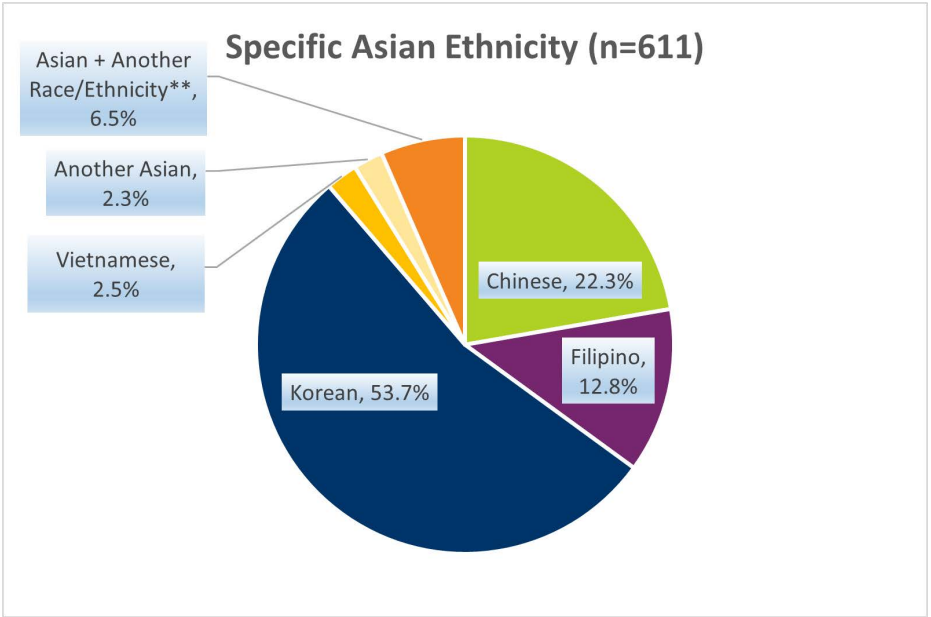


Mental Health Presentations: Demographics cont.

Most respondents identified their race/ethnicity as Asian (77.8%), followed by Multiple Race/Ethnicities (8.2%). Within the breakdown of the categories for the Asian race/ethnicity group, most individuals identified as Korean (53.7%), followed by Chinese (22.3%), Filipino (12.8%), Asian + Another Race/Ethnicity (6.5%), Vietnamese (2.5%), and Another Asian ethnicity (2.3%). Although not shown here, the majority of participants identified as Heterosexual or Straight (70.9%). Lastly, the majority of participants indicated that they did not have a disabling condition (88.2%) nor a veteran (90.8%).



**Includes individuals who identify with multiple race/ethnicities.*



***Includes individuals who identified generally as Asian or a specific Asian identity + another race/ethnicity.*

Mental Health Presentations: Satisfaction and Feedback

After the presentation, participants were encouraged to complete a satisfaction survey which asked about their satisfaction with the promoter, class content, and their confidence in talking about and seeking help for their mental health. They were asked on a scale of 1-5 *(1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree*) about how much they agreed with the statements in the survey. There was a total of **913** participants who completed the satisfaction survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time they attended a new presentation.

The average rating scores for all statements in the survey were above a score of 4, indicating that most participants agreed with the statements on seeking help and finding resources, being able to talk about the presentation topic with friends and family, and having a better understanding of mental health issues.

Question (n=913)	Avg Score	1	2	3	4	5	No Resp.
The information presented was easy to understand	**4.44**	11 (1.2%)	5 (0.5%)	27 (3.0%)	158 (17.3%)	**695 (76.1%)**	17 (1.9%)
The presenter was enthusiastic when presenting the information	**4.58**	11 (1.2%)	7 (0.8%)	55 (6.0%)	199 (22.8%)	**629 (68.9%)**	12 (1.3%)
I would recommend to my friends and family members that they attend a presentation like this	**4.58**	9 (1.0%)	7 (0.8%)	67 (7.3%)	184 (20.2%)	**635 (69.6%)**	11 (1.2%)
The material in the presentation gave me a better understanding of the early signs of mental health issues	**4.59**	9 (1.0%)	11 (1.2%)	50 (5.5%)	197 (21.6%)	**631 (69.1%)**	15 (1.6%)
As a result of this presentation							
I feel I am better able to talk about this topic with my family and friends	**4.46**	10 (1.1%)	10 (1.1%)	86 (9.4%)	238 (26.1%)	**550 (60.2%)**	19 (2.1%)
I know mental illness can me managed and treated	**4.60**	7 (0.8%)	5 (0.5%)	46 (5.0%)	223 (24.4%)	**612 (67.0%)**	20 (2.2%)
I feel comfortable seeking help for a family member or myself	**4.47**	8 (0.9%)	17 (1.9%)	87 (9.5%)	213 (23.3%)	**569 (62.3%)**	19 (2.1%)
I know where to seek resources for a family member or myself	**4.54**	11 (1.2%)	8 (0.9%)	55 (6.0%)	232 (25.4%)	**584 (64.0%)**	23 (2.5%)

Mental Health Presentations: Comments

The participants' comments on the satisfaction survey also highlight how well received the CMHP program was in the community. Below are some of the comments made by participants when asked what was helpful about the presentation and if they had any other comments about the presentations.

"I think that it was very helpful to hear terms such as 'kapwa' and to hear mental health described as affected by the collective history of my community."

"Looking forward to attending many more mental health related seminars in the future. Much appreciated!"

"Learned different ways to cope with stress."

"Learning about how different Asian communities handle trauma and mental health issues."

"The mindset to think about things again and make an effort to put into practice."

"Made easy for children to understand and kept them engaged with game."

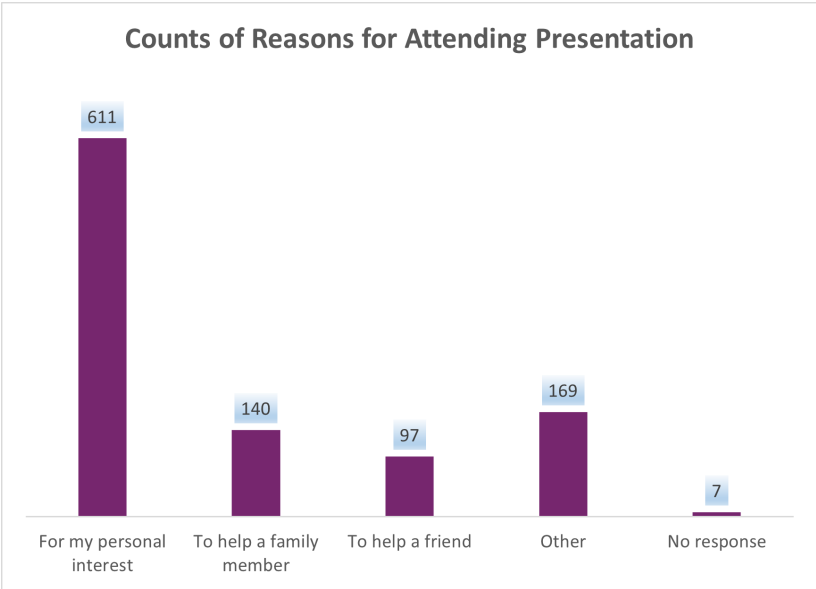
"A warm and welcoming space was created to allow us to be vulnerable and open."

"The presentation was good at bridging some gaps and making the intersectionality between mental health, trauma, and layers of colonization + systemic violence."



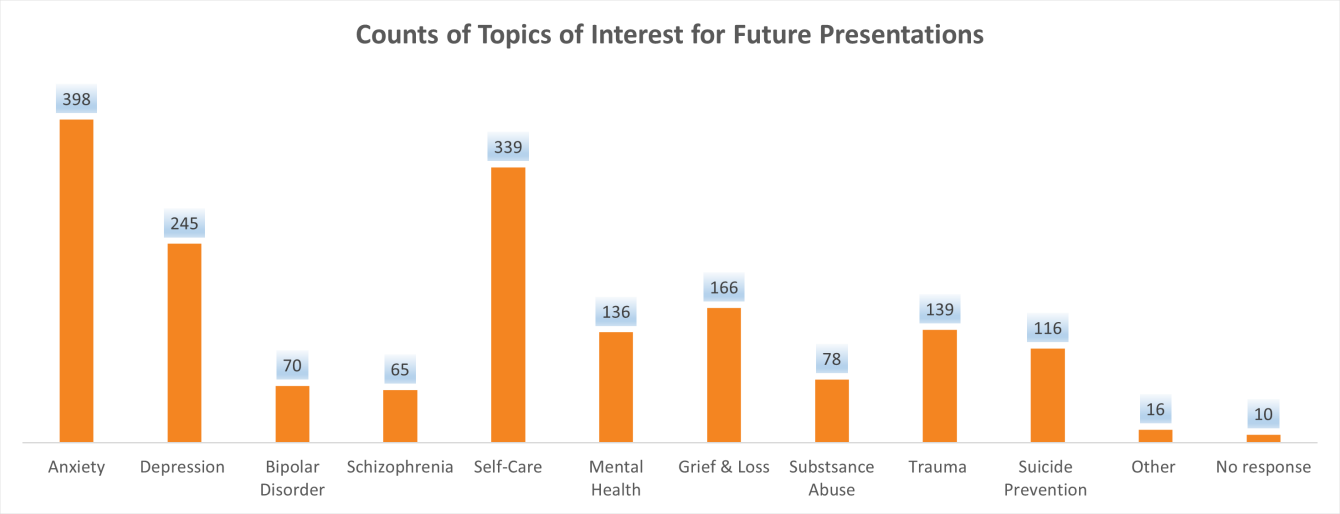
Mental Health Presentations: Reasons for Attending

Of the 913 people who completed the satisfaction survey, **906** participants provided reasons as to why they attended a CMHP AAPI presentation. The most frequently chosen response among participants was "for my personal interest".



Mental Health Presentations: Topics for Future Presentations

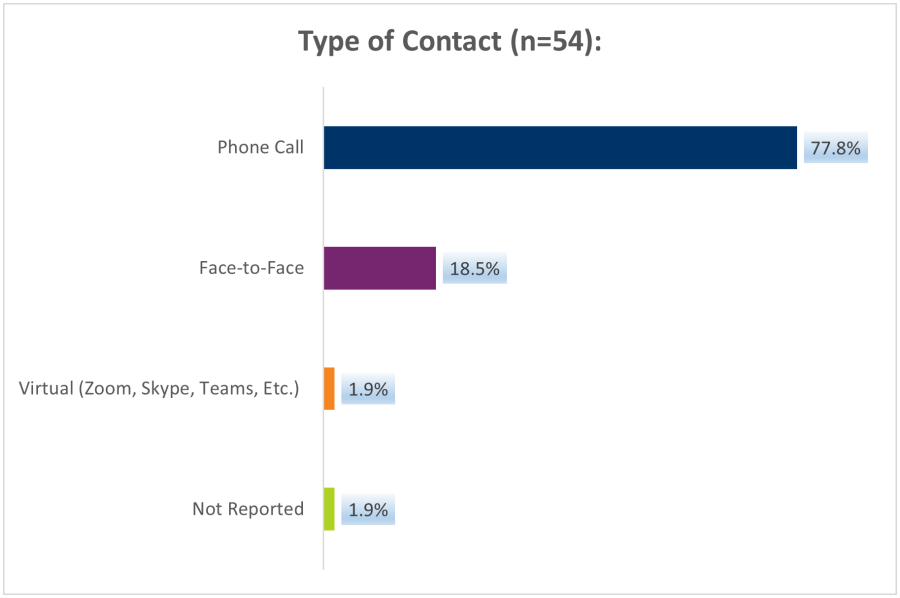
Of the 913 people who completed the satisfaction survey, **903** participants expressed interest in learning about different topics in future presentations. The most frequently chosen response for a topic of interest for future presentations was anxiety, closely followed by self-care.



Individual Contacts

Individual contacts for the CMHP program are defined as when a promoter provides more in-depth, one-on-one assistance upon outreach or after presentations to help an individual or family with specific needs and provide referrals to help meet those needs. For FY 2023-24, the Asian American/Pacific Islander CMHP program completed **54** individual consultations.

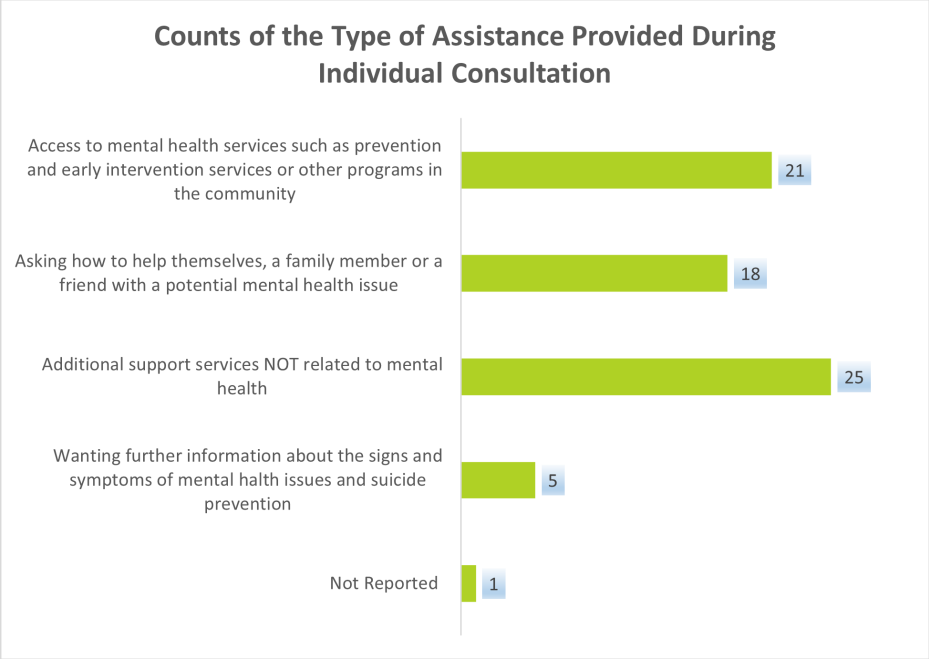
The most frequent type of contact that a promoter made with CMHP participants was through phone call (77.8%), followed by face-to-face interaction (18.5%), and then through virtual platforms such as Zoom, Skype, Teams, etc. (1.9%).





Individual Contacts cont.

Most participants indicated that they received more than one type of assistance during an individual consultation. This means that an individual had assistance with any of the types of assistance listed down below. In addition, the most frequent type of resource/referral that participants received was mental health education material, followed by individuals who were referred to a private mental health service, such as the SSG-APCTC's Riverside Counseling Center.



Resources and Referrals Type	Count
Mental Health Education Material	17
Prevention and Early Intervention Program(s)	9
Housing/Utilities Assistance	3
Food/Clothing Assistance	3
Employment/Education Services	1
Transportation Services	2
Medical Resources	6
Support Groups	3
Referral to Private Mental Health Services *(SSG-APCTC's Riverside Counseling Center)*	16
211	2
CARES	1
988/Helpline	1
Other Resources *(SSDI resources, disability services, legal inquiries, etc.)*	25

Middle Eastern/North African CMHPP

Promoter Training

For FY 2023-24, there were two promoters from Sahaba Initiative's MENA CMHP program who completed all 40 hours of required training as required by RUHS-BH MHSA PEI.

Topics included:

- CMHPP overview
- Community Outreach Strategies
- Presentation Tips
- Mental Health Basics
- Mental Health Needs of MENA
- Suicide Prevention, Anxiety
- Trauma
- Grief and Loss
- Psychosis/Schizophrenia
- Bipolar Disorder
- Depression
- Substance Misuse
- Self-Care and Wellness



Director's Feedback

The program director had a very positive experience training the community mental health promoters and preparing them for program implementation in the community. The promoters were highly engaged throughout the training days and asked thoughtful questions to help deepen their understanding of the material.

One promoter had a reaction of discomfort to the psychosis and bipolar disorder presentations, and shared that the reaction was largely due to learning about more severe case examples of psychosis and bipolar disorder during the discussion portion of the training. The director provided support by welcoming discussion about their reactions, checking in with them on the day of and afterwards, and responding to any questions that came up.

Additionally, the promoters demonstrated great skill when presenting the material back during practice presentations, not only when it came to presentation style and presence, but also in conveying the relevant information appropriately and accurately. The promoters found the training beneficial and they demonstrated great enthusiasm for bringing the presentations to the community. Overall, the director felt the training went well.

Promoter Training cont.

Promoter's Feedback

After completion of their 40 hour training, promoters participated in a survey in which they rated their agreement with statements on a scale from 1-5 (1-strongly disagree to 5-strongly agree). Their responses are shown in the table below. The promoters strongly agreed that the trainings were effective and helpful in their development as a promoter. They are confident in their knowledge of mental health, their ability to work with the community, and answer questions on mental health issues in a culturally competent way. In addition, the promotor provided comments based on the trainings.

Question	Avg. Score
I felt like an active participant in my development as a Promotor.	5
The training will help me to be an effective Promotor.	5
I feel able to utilize the materials presented in the training.	5
The trainers were knowledgeable and communicated clearly and effectively.	5
How would you rate your ability to do community mental health presentations?	5
How would you rate your ability to talk to people and answer questions about mental health issues?	5
How would you rate your knowledge of community resources and your ability to provide these resources to the community?	5
How would you rate your overall knowledge of mental health and about being a Promotor?	5
How would you rate your ability to understand cultural and linguistic diversity issues?	5



PEI

Suicide Prevention Activities

Program Type: Suicide Prevention Program

The past several years has included a larger focus on suicide prevention in Riverside County. A local strategic plan was developed, and the goals/objectives of the plan are being addressed through the Riverside County Suicide Prevention Coalition. Our local efforts are designed to align with and enhance the statewide goals for suicide prevention.

Building Hope and Resiliency: A Collaborative Approach to Suicide Prevention in Riverside County is the Riverside County suicide prevention strategic plan. As part of our statewide partnership, PEI participated in a suicide prevention learning collaborative. The plan was created through a data-driven process with community stakeholder feedback. In June 2020, the strategic plan was released. The plan identifies specific goals and objectives to address suicide in Riverside County and is in line with the California statewide strategic plan, *Striving for Zero.* In September 2020, the Riverside County Board of Supervisors passed a resolution adopting this strategic plan as a countywide initiative.

Riverside County Suicide Prevention Coalition: To bring the strategic plan to life, a Suicide Prevention Coalition was established. The Coalition kicked off in October 2020. Currently, the Coalition is led in partnership by RUHS Behavioral Health (PEI) and Public Health (Injury Prevention) and includes eight (8) sub-committees: Measuring & Sharing Outcomes, Effective Messaging & Communications, Upstream, Prevention-Trainings, Prevention-Engaging Schools, Prevention-Higher Education, Intervention, and Postvention. The Coalition meets quarterly and offers learning opportunities in suicide prevention best practices and is where sub-committees share ongoing progress.

Riverside County is one of 10 counties selected by the California Department of Public Health (CDPH) for a grant: The Youth Suicide Prevention and Response Network (YSPRN) pilot focused on developing a system flow map for supporting youth in suicidal crisis with the goals of filling any gaps in support identified in Riverside County. It is a partnership with RUHS-PH, RUHS-BH, RCOE, and United Way (Helpline). This funding supported the development of the Suicide Fatality Review Team, rapid surveillance data collection, suicide risk screening training for schools, development of a crisis call dashboard for our local Helpline, development of a system flow map to improve understanding and services for youth in suicidal crisis, and a portion of the annual SPC conference in October 2024.

Sub-committees meet monthly. Below is an update on the activities of each sub-committee for this reporting period.

Measuring & Sharing Outcomes (Data) sub-committee

- Data Brief: Suicides in Riverside County 2018-2022
    - RUHS-PH and BH worked together to develop this brief and it can be found by scanning the QR code

- CDPH grant: Monthly Rapid Surveillance of youth suicides and attempts shared with county partners to better inform our work.

- CDPH grant: Suicide Fatality Review Team

    - The review team is currently focused on youth 25 years old and younger. This multi-disciplinary team works together to review 2-3 suicide deaths per meeting looking for opportunities to prevent future suicides. Shared data from involved partners is used to identify risk and protective factors for suicide that are unique to Riverside County with the goal of making recommendations for local policy and practice changes to help reduce suicide risk and promote safety.

Effective Messaging sub-committee

- Supported sub-committees with ensuring work product utilized best practices for messaging safety, coordinated press releases for the annual SPC conference and local Directing Change event resulting in local media coverage of both events. Hosted a Safe and Effective Messaging and Communication Workshop in January 2025 for Public Information Officers and individuals that interact with the media and public to report out after a suicide loss.

Upstream sub-committee

- Concluded the Kindness Kit initiative with older adults focused on reducing social isolation and worked with local social work students at La Sierra University to develop a social media campaign for youth.

Prevention: Trainings sub-committee

- Developed and released a Public Service Announcement commercial for the gatekeeper trainings that are offered at no cost to anyone who lives or works in Riverside County. Facilitated 84 suicide prevention gatekeeper trainings throughout the year, training a total of 1,150 new helpers.

    - Know the Signs – 17

    - Mental Health First Aid (Youth & Adult) – 17

    - ASIST – 19

    - safeTALK - 31

- CDPH grant funding will allow RUHS-BH to bring Collaborative Assessment and Management of Suicidality (CAMS) training to our staff. CAMS is an evidence-based approach to treating people suffering from serious thoughts of self-harm. The goal is to have 140 RUHS-BH clinicians and RUHS-BH contracted clinicians certified in this model by June 2025.

Prevention: Engaging Schools sub-committee

- Increased school district participation in the sub-committee
- Co-chairs completed the school-based Suicide Risk Screening T4T making this training available to school districts throughout Riverside County, through a grant with CDPH.
    - The goal of the training is to provide educators and other adults with the confidence and tools to assess suicide risk in youth.
    - The training prepares educators and outreach staff how to effectively identify and respond to suicide risk. School staff are trained how to use the Columbia-Suicide Severity Rating Scale to determine the risk of suicide and how to deliver assistance to the youth once assessing their risk.
    - Partnership between RCOE, PH, and BH with trained facilitators to provide this to school districts throughout Riverside County.

Prevention Higher Education sub-committee

- Created a series of videos for students and staff including "How to Help a Student in Distress" and "Employee Self-Care."
- Hosted Art with Impact workshops which aim to promote mental wellness by creating space for young people to learn and connect through art and media.
- The Active Minds Send Silence Packing traveling exhibit is an immersive experience utilizing mixed mediums to guide the visitor through the mental health journey of several American youth and young adults in an effort to increase awareness and reduce stigma associated with mental health concerns and suicide. In October 2023 PEI funded an exhibit at University of California, Riverside and Mt. San Jacinto College. The exhibits were well received by students and faculty.



Intervention sub-committee

- Continued distribution and advertisement of the Care Transitions Flyer as well as the launch of the Firearm Lock Distribution project distributing nearly 1,000 gun locks and attending approximately 10 community events this fiscal year.

Postvention sub-committee

- Active Postvention response continued with on-scene support from the Trauma Intervention Program (TIP) volunteers following a loss to suicide. Volunteers provide resource kits to loss survivors. For FY23/24 TIP received a total of 649 calls to their dispatch center. Of those 55 were suicide deaths. 62 LOSS kits were distributed.

- Clinical Bereavement Counseling for Suicide Loss, launched in November 2024, is short-term grief counseling for survivors of suicide loss provided at no cost to residents of Riverside County. This pilot project will offer 6-8 free sessions to suicide loss survivors through community-based clinicians who are trained in a specific approach to support suicide bereavement. The manual was developed specifically for Riverside County by Dr. Sally Spencer-Thomas, a leader in the field of suicide prevention and bereavement. This is the first program of its kind in the country. PEI partnered with IEHP to train several of their providers to offer this as a benefit to their members. Suicide Loss survivors can request this service by visiting the TIP website at: https://tiprivco.org/bereavement-counseling/. Applications for clinicians who would like to get trained to provide this service for PEI are being accepted on an ongoing basis, until the County determines it has obtained enough providers to adequately address the needs of the County, issues a new procurement for this program, or funding is no longer available. You can find the application at www.rivcospc.org.

- Peer Support Groups for Suicide Loss launched in January 2025. The SPC and PEI partnered with the American Foundation for Suicide Prevention (AFSP) to train community members/volunteers to facilitate support groups for suicide loss survivors. This support was nearly non-existent in Riverside County up to this point. PEI will provide ongoing support for facilitators, in partnership with AFSP, to ensure groups are available to community members in need.

- **Out of Darkness Walks** - For the second year the Suicide Prevention Coalition was a Regional Lifesaver Sponsor for the American Foundation for Suicide Prevention's (AFSP) three Out of Darkness Walks, the events were in Riverside, Coachella Valley, and Inland Empire (Rancho Cucamonga). There was great community participation in the walks and resulted in raising a substantial amount of funds for AFSP research. The coalition hosted an outreach table at each event to spread awareness about our current efforts. Through our outreach, several individuals expressed interest in becoming facilitators for Peer Support Groups for survivors of suicide loss here in our county.





The SPC offers quarterly virtual presentations to build awareness, knowledge, and increase best practices regarding suicide prevention in Riverside County. The quarterly webinars are free, offered virtually, and recordings remain available on our website (www.rivcospc.org). This fiscal year, the following topics were offered:

- July 2023 – Workplace Suicide Prevention

- The October quarterly presentation is our full-day in-person conference. In October 2023, the conference theme was "Creating Hope Through Action: Bridging the Gap Between Spirituality and Suicide Prevention." The event hosted over 350 attendees. The conference included one keynote presentation focused on the essentials of suicide prevention in faith communities and two panels with 11 local faith leaders to discuss the role that faith communities can play in stigma reduction and suicide prevention efforts.



- January 2024 - #safesocial: Social Media's Impact on Mental Health
- April 2024 – Suicide Prevention for Children and Pre-Teens: Why is it necessary and what can we do?

Man Therapy - The SPC/PEI continued to support Mantherapy.org with local advertisement and resources. Man Therapy is a web-based campaign focused on men that uses humor and male stereotypes to start the conversation and get men to think differently about their mental health. Man Therapy aims include helping men to explore how gender socialization influences their relationships and mental health, to reduce stigma about mental health and suicide, to empower men to seek help, and to reduce suicide risk. Its approach is around hope and resilience, while integrating humor throughout the website. Nearly 5,000 head inspections (online risk screening) were completed this fiscal year.



Suicide Prevention and Mental Health Awareness Trainings

The PEI Administration team coordinates and facilitates the following trainings for individuals who live and/or work in Riverside County. You can find out more and register for free for any of these trainings here: https://www.ruhealth.org/behavioral-health/prevention-early-intervention. In FY23/24, the training team delivered the following trainings:

safeTALK

- In-person 3-hour suicide alertness training
- **31 trainings; 503 participants for FY23-24**

Applied Suicide Intervention Skills Training (ASIST)

- In-person 2-day suicide intervention skills training
- **19 trainings; 327 participants for FY23-24**



Mental Health First Aid

- Offered with Youth and Adult focus
- In-person 8-hour mental health awareness and crisis support training
- **17 trainings; 231 participants for FY23-24**



Mental Health 101

- Mental Health vs. Mental Illness
- 90-minutes
- **7 trainings; 77 participants for FY23-24**



Self-Care and Wellness

- Interactive activities to promote self-care and wellness
- 2-hours
- **5 trainings; 79 participants for FY23-24**



Building Resiliency and Understanding Trauma

- Understanding Adverse Childhood Experience; Impact of trauma on well-being and health; building resiliency
- 2-hours
- **8 trainings; 185 participants for FY23-24**



Know the Signs

- Suicide prevention training – learn the signs, find the words, reach out to resources to support someone.
- 2-hours
- **17 trainings; 108 participants for FY23-24**

Some comments from participants include:

- “Knowing how to approach & speak to someone in crisis.”
- “Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you.”
- “This training helped my school community to not be afraid and it [the training] will help them build capacity within their role.”
- “Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate.”
- “Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support.”
- “This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful.”
- “The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS.”
- “ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally.”

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention (PEI)

PEI Suicide Prevention Trainings

Mental Health First Aid (MHFA)

safeTALK

Know the Signs

Applied Suicide Intervention Skills Training (ASIST)

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Evaluation Outcomes and Additional Comments 30

OVERVIEW DESCRIPTION OF TRAININGS

Riverside County currently offers four suicide prevention trainings through the help of the Mental Health Service Act Prevention and Early Intervention (MHSA PEI) Department.

- **Applied Suicide Intervention Skills Training (ASIST)** is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed. ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

- **The Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care. Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA. Each certification must be renewed every three years.

- **safeTALK** is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings. This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. safeTALK also helps participants practice the TALK step actions in overcoming these barriers.

- **Know the Signs** is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The goal for MHSA PEI is to have various Riverside County department employees and community-based organizations trained in these suicide prevention courses so that each department or organization has the ability to host the trainings for communities at large.

EXECUTIVE SUMMARY

FY 2023-2024 TOTAL NUMBER OF SUICIDE PREVENTION TRAININGS: 84

Pain Isn't Always Obvious
KNOW THE SIGNS
Suicide Is Preventable.org

17
Total Number of Trainings

Mental Health FIRST AID
from NATIONAL COUNCIL FOR MENTAL WELLBEING

17
Total Number of Trainings

ASIST

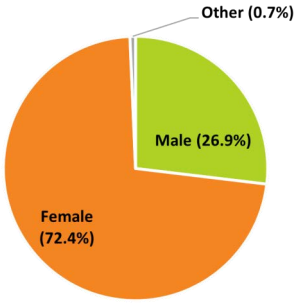
19
Total Number of Trainings

SUICIDE safeTALK

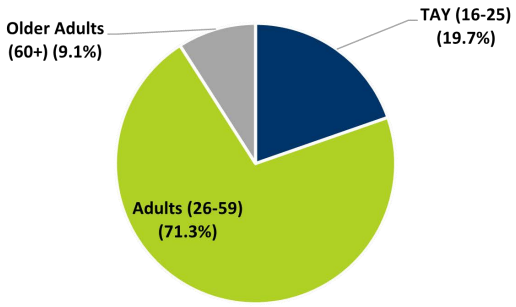
31
Total Number of Trainings

FY 2023-2024 TOTAL NUMBER OF PARTICIPANTS TRAINED: 1,150

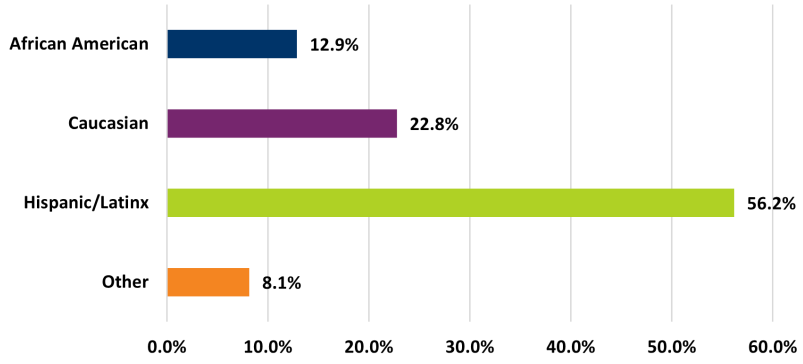
Gender (n=1,030)*



Age Groups (n=1,037)*



Race/Ethnicity (n=970)*



**Note:* Some categories are not shown here, including not reported/unknown.*

EXECUTIVE SUMMARY (cont.)

FY 23-24 PEI SUICIDE PREVENTION TRAININGS OVERVIEW

Mental Health FIRST AID from NATIONAL COUNCIL FOR MENTAL WELLBEING

- Total of 17 trainings for FY 23-24
- Audience reached was 231 participants with 225 participants (97.4%) who completed the training
- The smallest audience size for a training was 6 people while the largest audience size for a training was 28 people

- Total of 31 trainings for FY 23-24
- Total audience reached was 503 with *all* participants completing the training (100%)
- On a scale of 1 (i.e., very bad) to 10 (i.e., very good), the average rating for this training was 9.6

SUICIDE safeTALK

Pain Isn't Always Obvious KNOW THE SIGNS Suicide Is Preventable.org

- Total of 17 trainings for FY 23-24
- Total audience reached was 108 with *all* participants completing the training (100%)
- About 98.1% of Know the Signs participants would agree or strongly agree that they would recommend this training to someone else

- Total of 19 trainings for FY 23-24
- Total audience reached was 327 participants with 314 participants completing the training (96.0%)
- On a scale of 1 (i.e., did not like) to 10 (i.e., liked a lot), participants (n=314) rated the quality of ASIST as 9.4 out of 10

ASIST

MENTAL HEALTH FIRST AID (MHFA)

Program Description

The **Mental Health First Aid (MHFA)** program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care.

Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA (YMHFA). Each certification must be renewed every three years.

Program Objective: MHFA teaches about *recovery* and *resiliency*—the belief that individuals experiencing these challenges can and do get better because they utilize their strengths to stay well.

FY 23-24 OVERVIEW

FY 23-24 MHFA Training Overview Summary

All **17 Adult MHFA and Youth MHFA trainings** were conducted in collaboration with **PEI, WET, Public Health, HelpLine, RUHS-BH Crisis, Moreno Valley College** and **other organizations**. Additionally, all trainings took place in either the **Western or Mid-County** regions. Specific audiences/groups that were targeted were the MHSA provider groups, law enforcement, as well as WET interns.



17
Total Number of Trainings



231
Total Number Reached



225
Total Number Completed Training



6
Smallest Audience Size



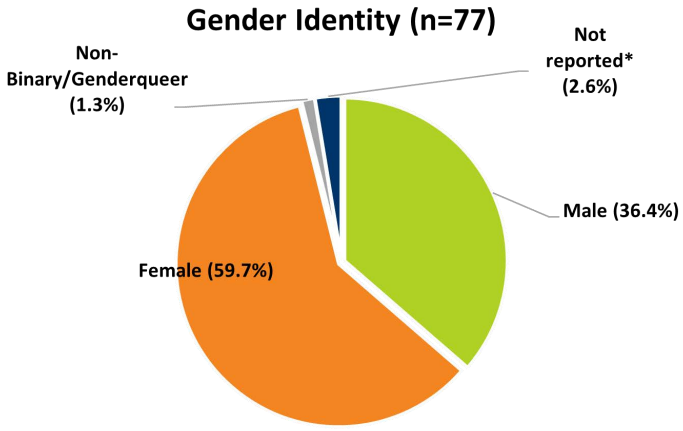
28
Largest Audience Size

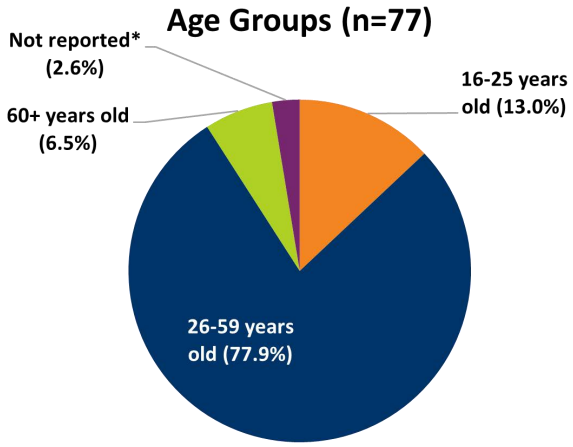
MENTAL HEALTH FIRST AID (MHFA)

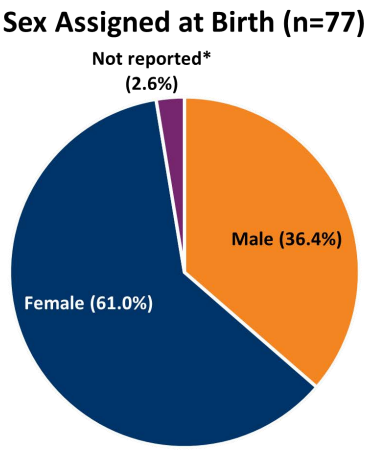
ADULT MHFA DEMOGRAPHICS

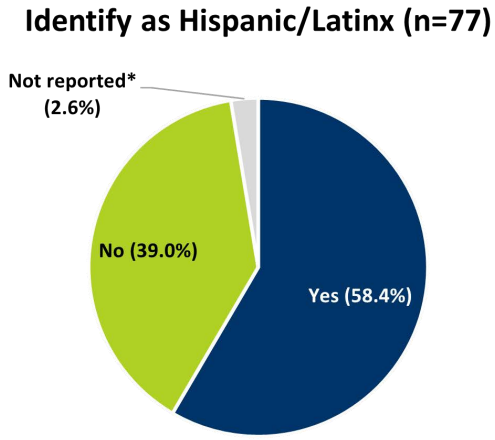
Demographics Summary

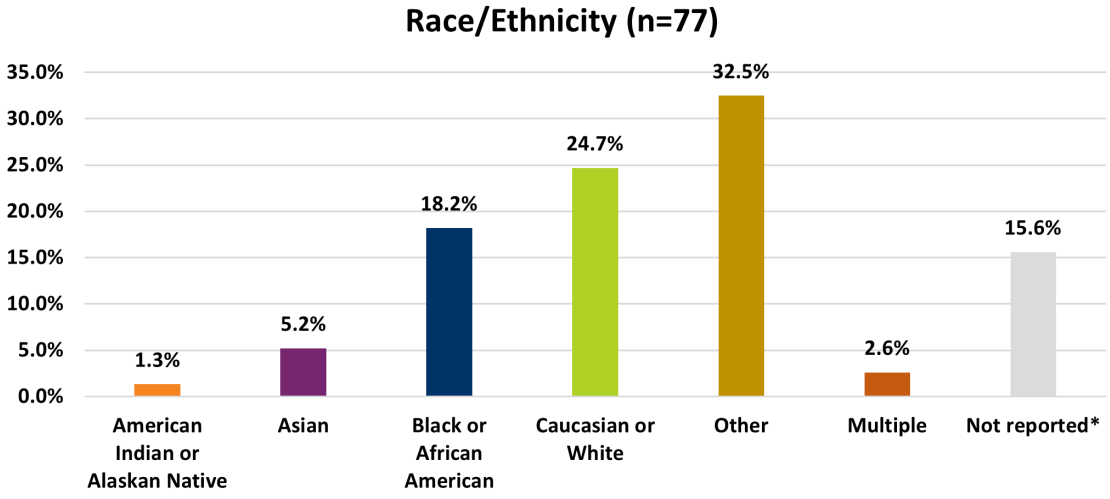
Most Adult MHFA participants identified their gender as **female (59.7%)** and half of the participants reported **female as their sex assigned at birth (61.0%)**. The majority of Adult MHFA participants were in the **26 to 59 years old age group (77.9%)**. Additionally, most participants identified as **Other (32.5%)** followed by White (24.7%), Black/African American (18.2%), Asian (5.2%), Multiple (2.6%) and American Indian or Alaskan Native (1.3%). More than half of participants identified as **Hispanic/Latinx (58.4%).**











**Note:* "Not reported" includes individuals who chose not to answer.*

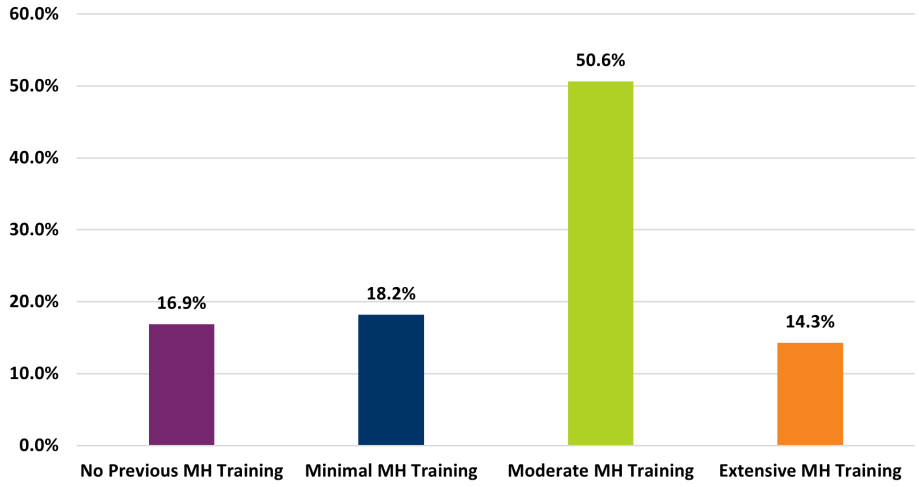
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA DEMOGRAPHICS (cont.)

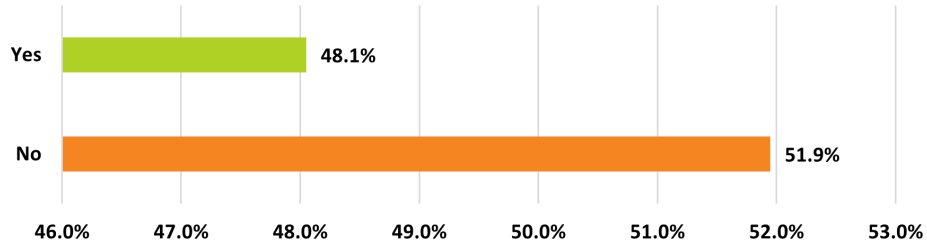
Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **50.6% of participants had reported that they had moderate mental health training**, which includes several workshops, trainings, or classes about mental health. In addition, about 51.9% of the participants reported that they do not identify as a person with lived experience or a person in long-term recovery. And lastly, over one-third of participants (35.1%) reported that they support a family member with lived experience, serious mental illness, or in long-term recovery.

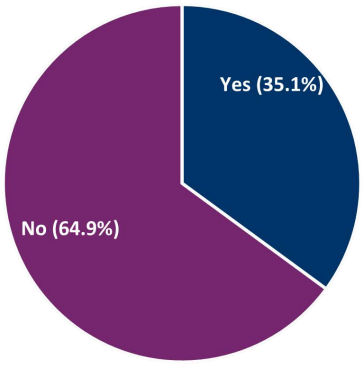
Mental Health (MH) Training Experience (n=77)



Lived Experience (n=77)



Support Someone With SMI (n=77)



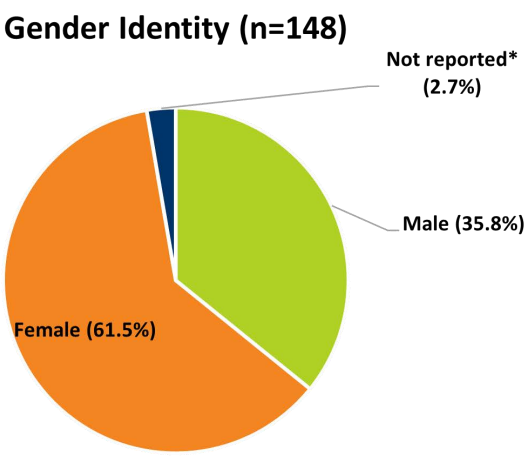
**Note:* *"Not reported" includes individuals who chose not to answer.*

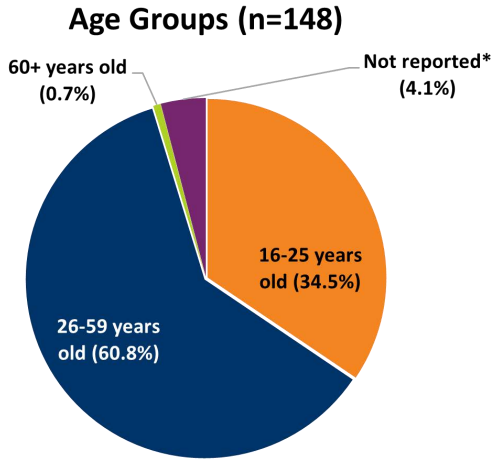
MENTAL HEALTH FIRST AID (MHFA)

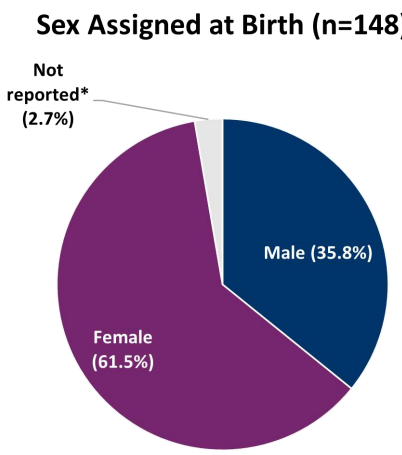
YOUTH MHFA DEMOGRAPHICS

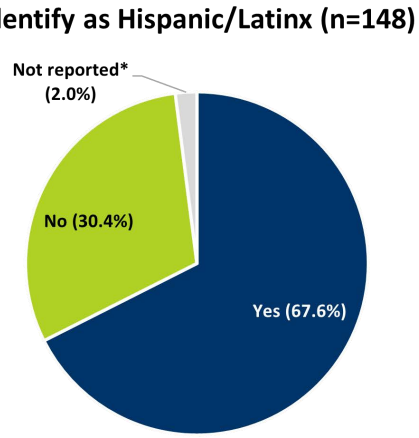
Demographics Summary

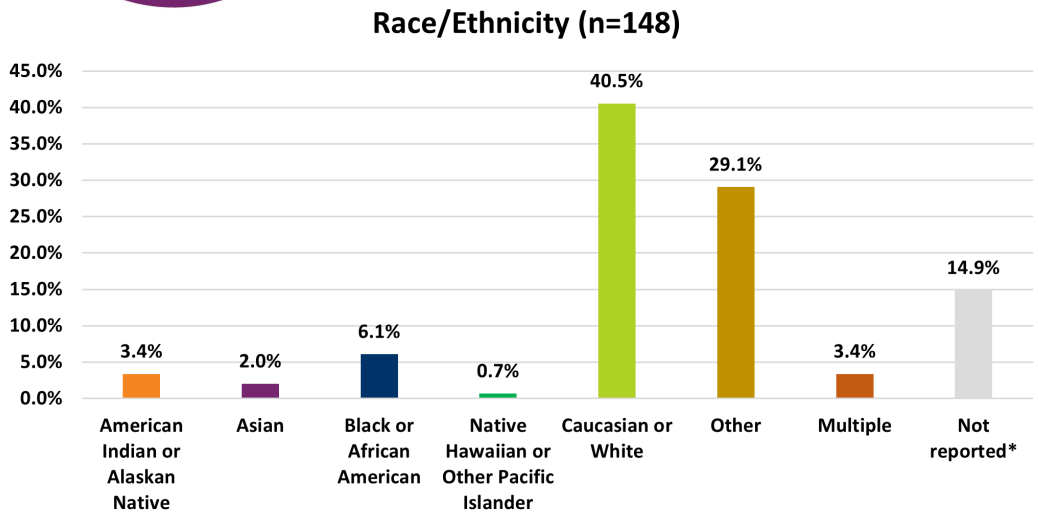
Most Youth MHFA participants identified their gender as **female (61.5%)** and half of the participants reported **female as their sex assigned at birth (61.5%)**. The majority of Youth MHFA participants were in the **26 to 59 years old age group (60.8%)**. Additionally, most participants identified as **White (40.5%)** followed by Other (29.1%), Black/African American (6.1%), Multiple (3.4%), American Indian or Alaskan Native (3.4%), Asian (2.0%), and Native Hawaiian or Other Pacific Islander (0.7%). More than half of participants identified as **Hispanic/Latinx (67.6%).**











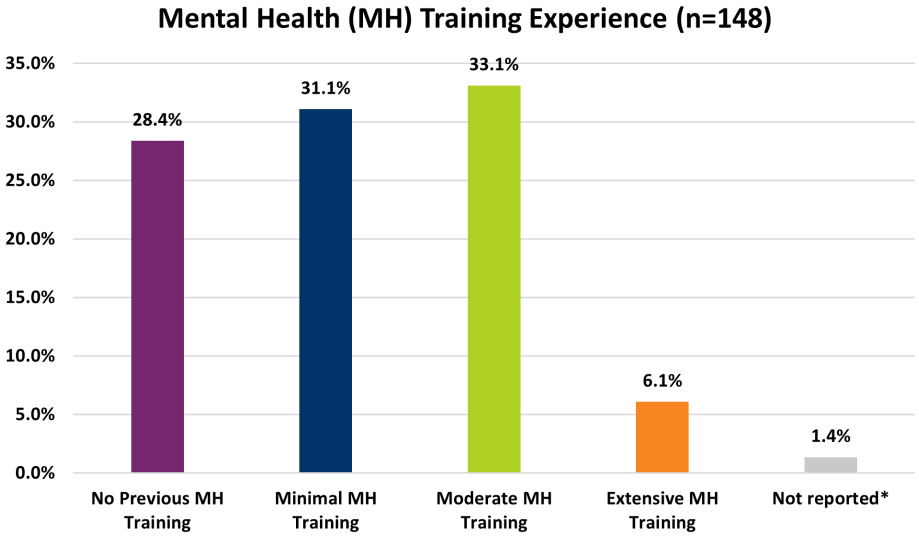
**Note:* *"Not reported" includes individuals who chose not to answer.*

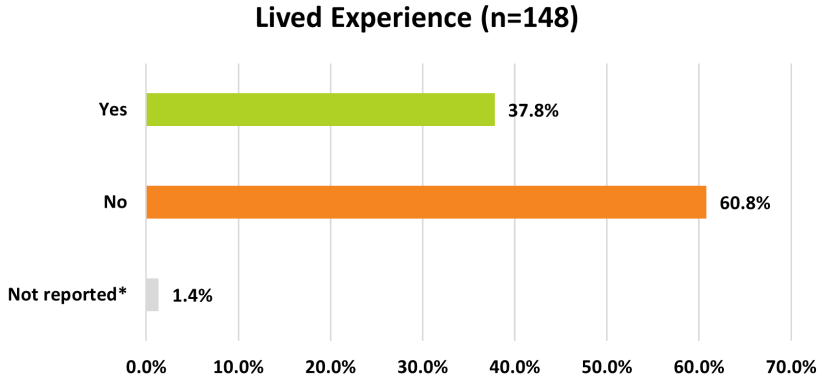
MENTAL HEALTH FIRST AID (MHFA)

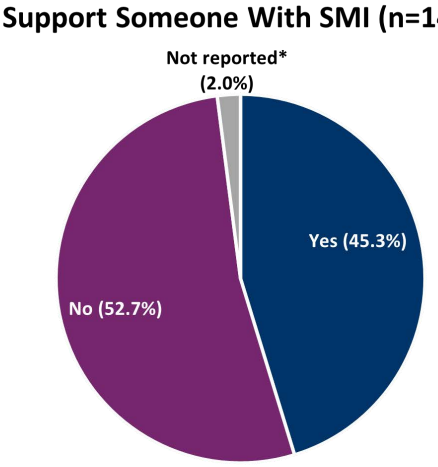
YOUTH MHFA DEMOGRAPHICS

Demographics Summary (cont.)

Of the participants that reported their mental health level experience, about **33.1% of participants had reported that they had moderate mental health training**, which includes attending several workshops, trainings, or classes about mental health. In addition, **60.8% of participants reported that they do not identify as a person with lived experience** or a person in long-term recovery. And lastly, about **45.3% of participants reported that they support a family member** with lived experience, serious mental illness, or in long-term recovery.







**Note:* "Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA PRE/POST OUTCOMES

Adult MHFA Pre/Post Outcomes Summary

As a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. There were a total of **76 individuals** who completed both the Pre and Post measures from the Adult and Youth MHFA trainings. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
4a. Have a supportive conversation with anyone about mental health or substance use challenges.
4b. Ask anyone directly whether they are considering killing themselves.
4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe.

**Note:* Pre and Post analysis was only conducted for individuals who completed both measures.*

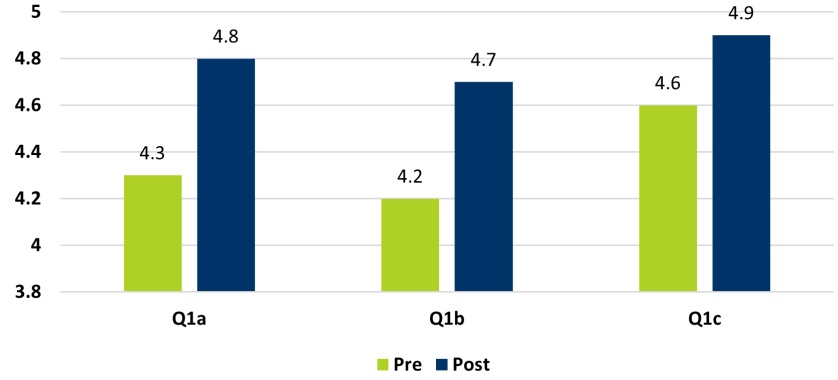
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA PRE/POST OUTCOMES

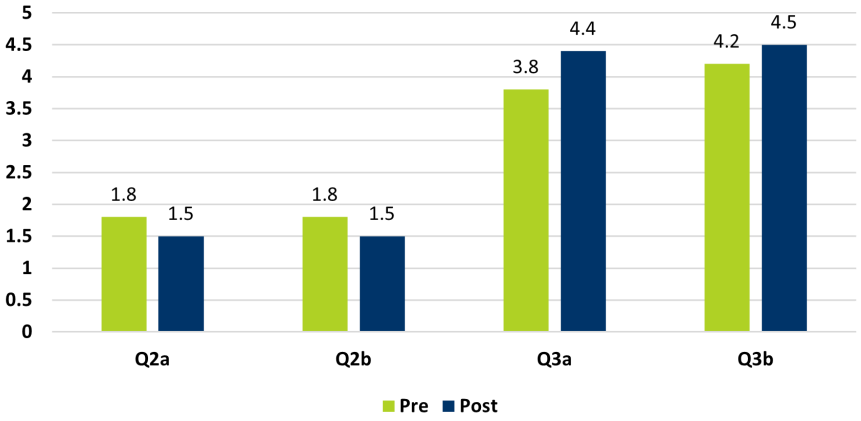
Adult MHFA Pre/Post Outcomes Summary (cont.)

Across all domains, the majority of participants had increased confidence, knowledge, and intention in helping individuals who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions. Participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.

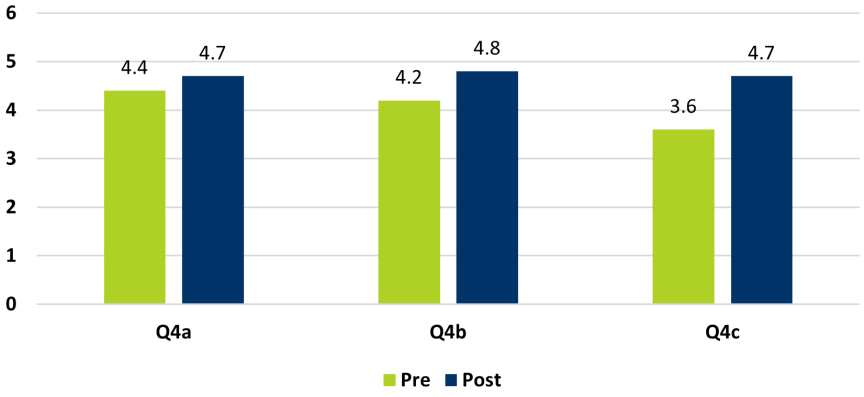
Your Beliefs About Mental Health and Substance Use (n=76)



Your Beliefs About MHFA Actions (n=76)



Your Confidence in Performing Mental Health Actions (n=76)



MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA PRE/POST OUTCOMES

Youth MHFA Pre/Post Outcomes Summary

Similar to the requirement made for Adult MHFA, as a part of the outcomes evaluation, the MHFA training requires individuals to complete a Mental Health First Aid Pre-Evaluation and Post-Evaluation form before and after the training.

Within the Pre and Post Evaluation forms, participants indicated to what extent they agree or disagree with specific statements regarding various mental health concepts. The Pre and Post scores from the evaluation forms are shown on the next page with their respective questions shown down below.

Your Beliefs About Mental Health and Substance Use (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
1. In general, I believe that…
1a. I intend to take action to help anyone I work with to address their mental health or substance use challenge(s).
1b. I intend to reach out and express my concerns to anyone I work with that might be experiencing mental health or substance use challenge(s).
1c. I intend to listen without expressing my judgement to anyone I suspect of experiencing a mental health or substance use challenge(s).
Your Beliefs About Mental Health First Aid Actions (1=Not Difficult At All; 2=Somewhat Not difficult; 3=Unsure; 4=Somewhat Difficult; 5=Extremely Difficult)
2. Currently I believe that for me…
2a. Giving practical resources (e.g., self-help information, crisis hotline number) to anyone showing signs and symptoms of a mental health or substance use challenge(s) is:
2b. Referring anyone experiencing a mental health or substance use challenge(s) to a health professional is:
Your Beliefs About Mental Health First Aid Actions (1=Extremely Unlikely; 2=Somewhat Unlikely; 3=Neither Likely Nor Unlikely; 4=Somewhat Likely; 5=Extremely Likely)
3. For each statement below, please circle the response that best describes your opinion.
3a. If I express my concerns to any person about the mental health signs and symptoms that they are experiencing, it will help that person to seek timely support.
3b. If I give information about mental health professionals in the community to any person experiencing mental health or substance use challenge(s), it will assist that person to get help.
Your Confidence in Performing Mental Health Actions (1=Strongly Disagree; 2=Somewhat Disagree; 3=Neither Agree nor Disagree; 4=Somewhat Agree; 5=Strongly Agree)
4. Currently, I am confident that I can…
4a. Have a supportive conversation with anyone about mental health or substance use challenges.
4b. Ask anyone directly whether they are considering killing themselves.
4c. Respond to a substance use crisis including an overdose and know what to do keep an individual safe.

**Note:* Pre and Post analysis was only conducted for individuals who completed both measures.*

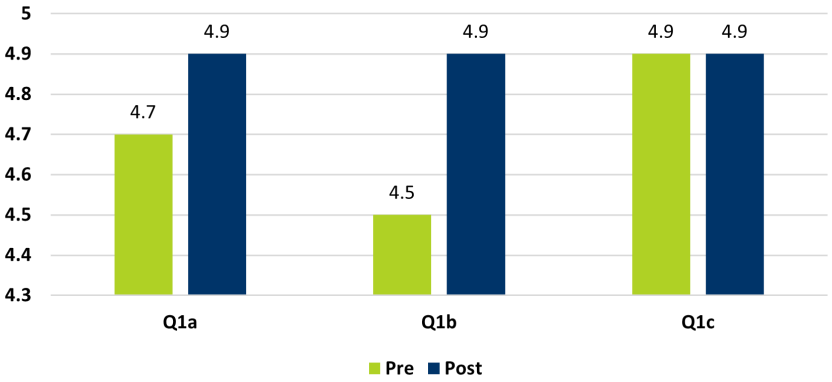
MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA PRE/POST OUTCOMES

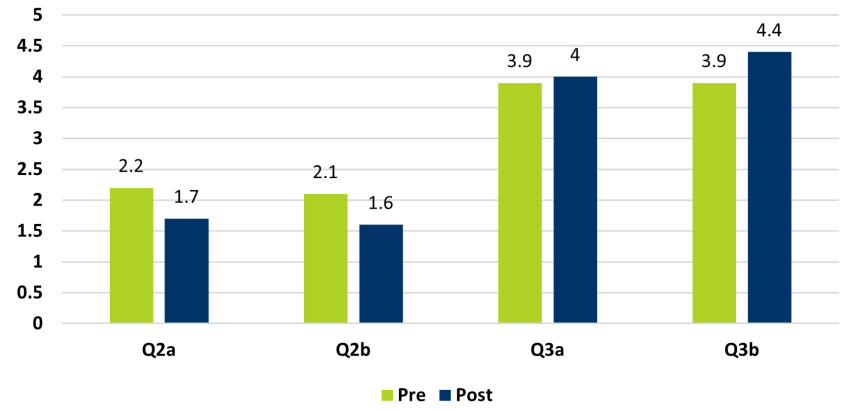
Youth MHFA Pre/Post Outcomes Summary (cont.)

Similar to the results shown in the Adult MHFA Pre/Post Outcomes, across all domains, the majority of Youth MHFA participants had increased confidence, knowledge, and intention in helping youth who may be experiencing a mental health crisis. It should be noted that questions 2a and 2b asked individuals how *difficult* it might be to perform MHFA actions, and participants responded that there was an overall decrease in difficulty in conducting those actions after completing the training.

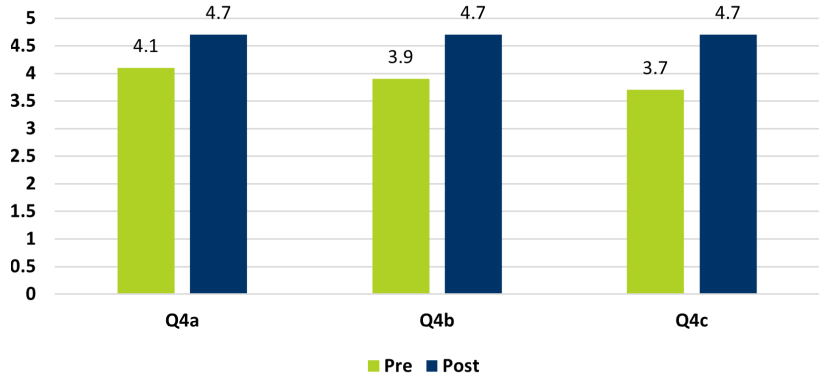
Your Beliefs About Mental Health and Substance Use (n=148)



Your Beliefs About MHFA Actions (n=148)



Your Confidence in Performing Mental Health Actions (n=148)



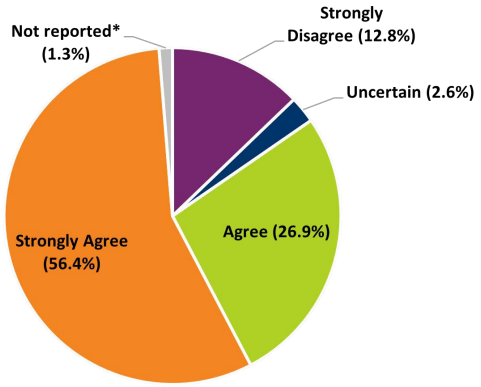
MENTAL HEALTH FIRST AID (MHFA)

ADULT MHFA OVERALL SATISFACTION

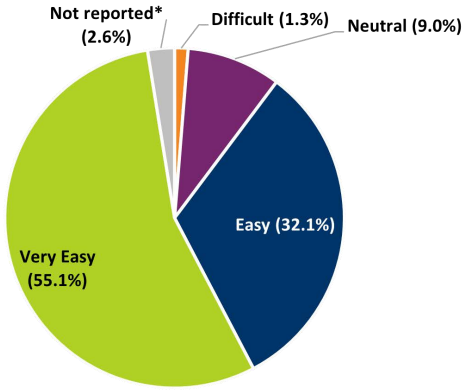
Adult MHFA Satisfaction Summary

Participants are also asked to complete a program evaluation feedback form at the end of the training. Some of the responses to the satisfaction questions are shown below. Individuals reported that they **strongly agree (54.4%)** that there was an adequate opportunity in practicing their skills that they learned from the training. More than half of the participants found that navigating the coursework was **very easy (55.1%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (76.9%)** to the populations that they primarily work with and about **67.9%** indicated that the pace of the coursework was **neutral**. Although not shown below, a great majority said yes to **taking another MHFA course (97.4%).**

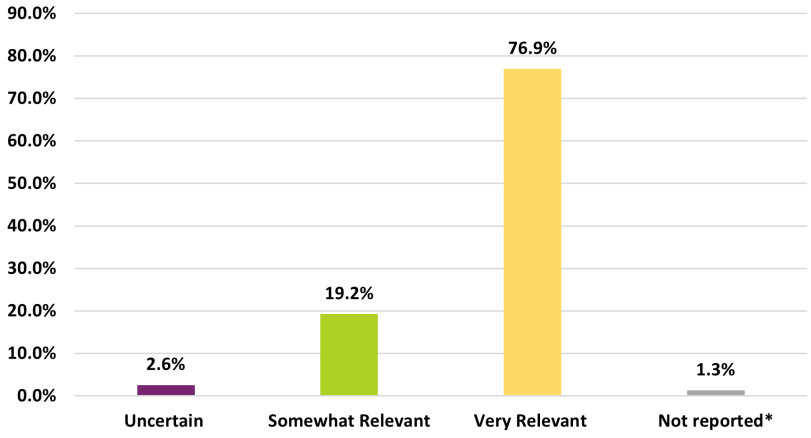
Adequate Opportunity to Practice Skills Learned (n=78)



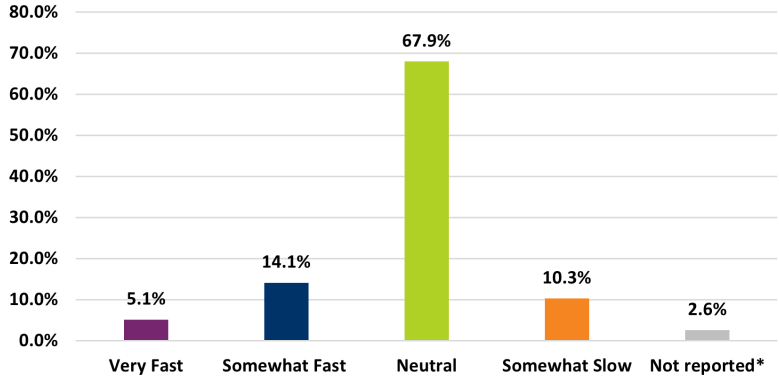
Overall Experience Navigating Coursework (n=78)



How Relevant the Existing Scenarios Are (n=78)



Pace of the Coursework (n=78)



**Note:* "Not reported" includes individuals who chose not to answer.*

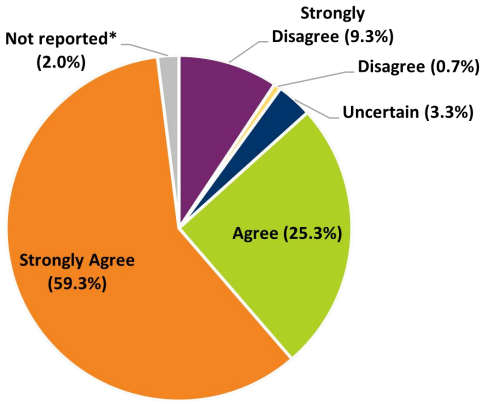
MENTAL HEALTH FIRST AID (MHFA)

YOUTH MHFA OVERALL SATISFACTION

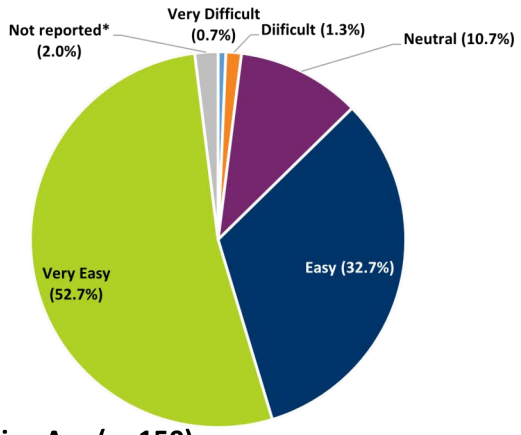
Youth MHFA Satisfaction Summary

Individuals reported that they **strongly agree (59.3%)** that there was an adequate opportunity in practicing their skills that they learned from the training. Almost half of the participants found that navigating the coursework was very **easy (52.7%)**. Additionally, more than half of the respondents found that the existing scenarios from the training were **very relevant (70.7%)** to the populations that they primarily work with and about **59.3%** indicated that the pace of the coursework was **neutral**. Although not shown below, a majority said yes to **taking another MHFA course (90.7%).**

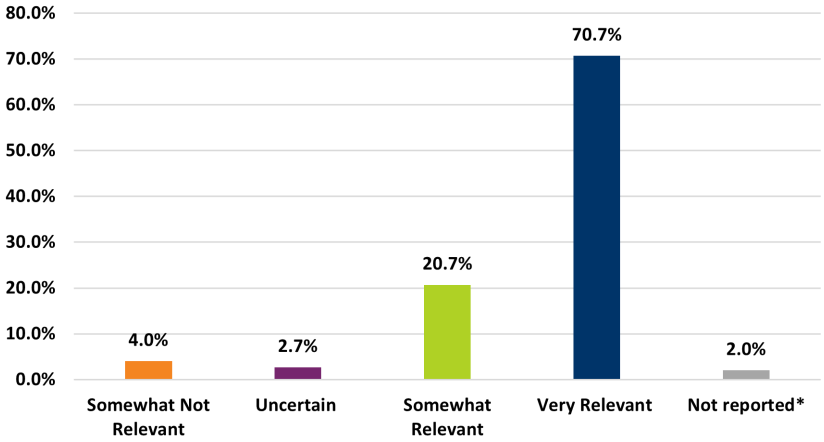
Adequate Opportunity to Practice Skills Learned (n=150)



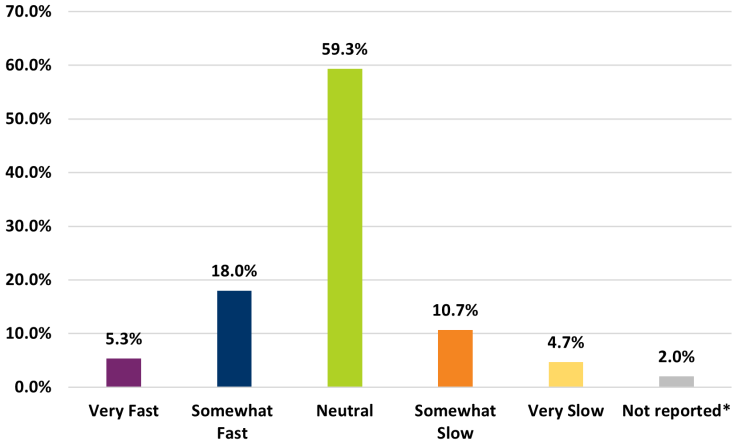
Overall Experience Navigating Coursework (n=150)



How Relevant the Existing Scenarios Are (n=150)



Pace of the Coursework (n=150)



**Note:* *"Not reported" includes individuals who chose not to answer.*

MENTAL HEALTH FIRST AID (MHFA)

ADULT & YOUTH MHFA ADDITIONAL COMMENTS

Adult MHFA and Youth MHFA Quiz Outcomes

To complete a MHFA training, participants were required to take the Adult MHFA Quiz, which evaluates participants' understanding of the MHFA program, overall knowledge, stigmatizing attitudes, and helping behaviors in assisting someone experiencing a mental health or substance use condition. The quiz is taken at the end of the training and a score of 6 out of 10 is required to pass the course. **For FY 23-24, all 225 Adult and Youth MHFA participants passed the quiz with a rate of 100%.**

Adult & Youth MHFA Additional Comments Summary

Below are the participants' comments from the program evaluation feedback forms. These comments highlight the importance of the program and other thoughts that participants had about the overall program, instructors, and training.

"I appreciated reading closely about a disorder and sharing findings with the group."

"Thank you for the examples on how we may respond to specific situations."

What Was Most Helpful About the Course?

"Knowing how to approach & speak to someone in crisis."

"Very friendly, warm, welcoming, supportive and awesome!"



"Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you."

SAFETALK

Program Description

safeTALK is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings.

This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. Additionally, 'Safe' stands for 'Suicide Alertness For Everyone' and 'TALK' stands for 'Tell, Ask, Listen, and KeepSafe'. This program helps participants practice the TALK step actions in overcoming these barriers.

Program Objective: To learn how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support.

FY 23-24 OVERVIEW

FY 23-24 safeTALK Training Overview Summary

For FY 23-24, there were a total of **503 individuals** who completed the safeTALK training. All **31 safeTALK trainings** were conducted in collaboration with **RUHS-BH PEI staff** and many other departments, such as **RUHS-Public Health, HelpLine, Loma Linda Health University, Special Service for Groups—Asian Pacific Counseling & Treatment Center (SSG-APCTC),** and **WET.** Additionally, most trainings took place in the **Western region**, while a few were conducted in **San Bernardino County**.

31
Total Number of Trainings

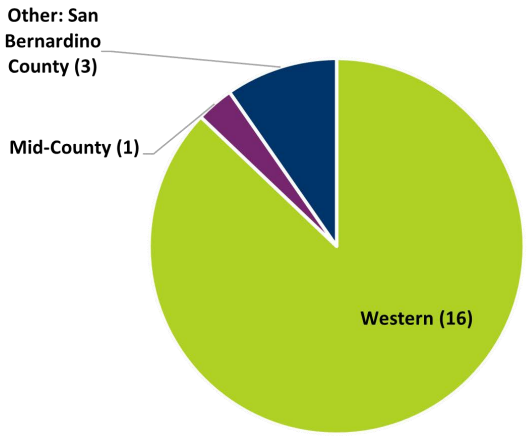
503
Total Number Reached

503
Total Number Completed Training

4
Smallest Audience Size

37
Largest Audience Size

Regions of safeTALK Trainings

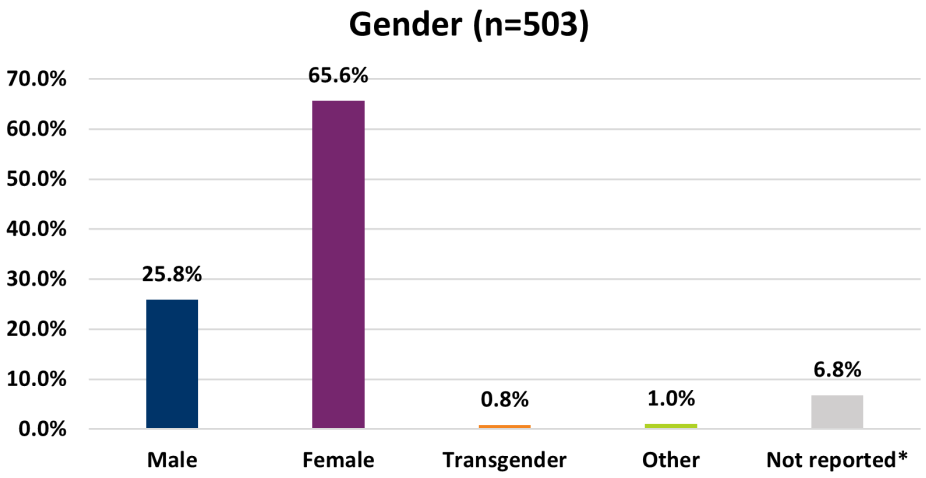


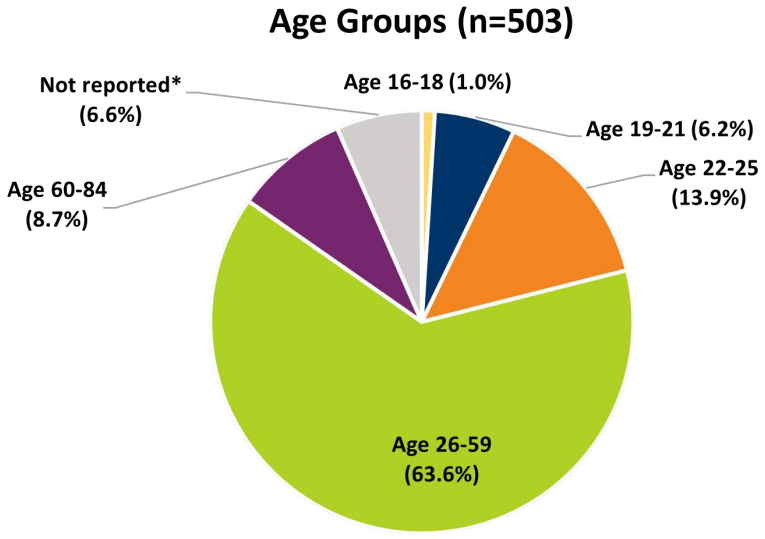
SAFETALK

DEMOGRAPHICS

Demographics Summary

More than half of the safeTALK participants identified as **female (65.6%)**, followed by male (25.8%), transgender (0.8%), and other (1.0%). In addition, most of the participants were in the **26-59 age group (63.6%)**, followed by the 22-25 age group (13.9%), 60-84 age group (8.7%), 19-21 age group (6.2%), and 16-18 age group (9.1%).





*Note: "Not reported" includes individuals who chose not to answer.

SAFETALK

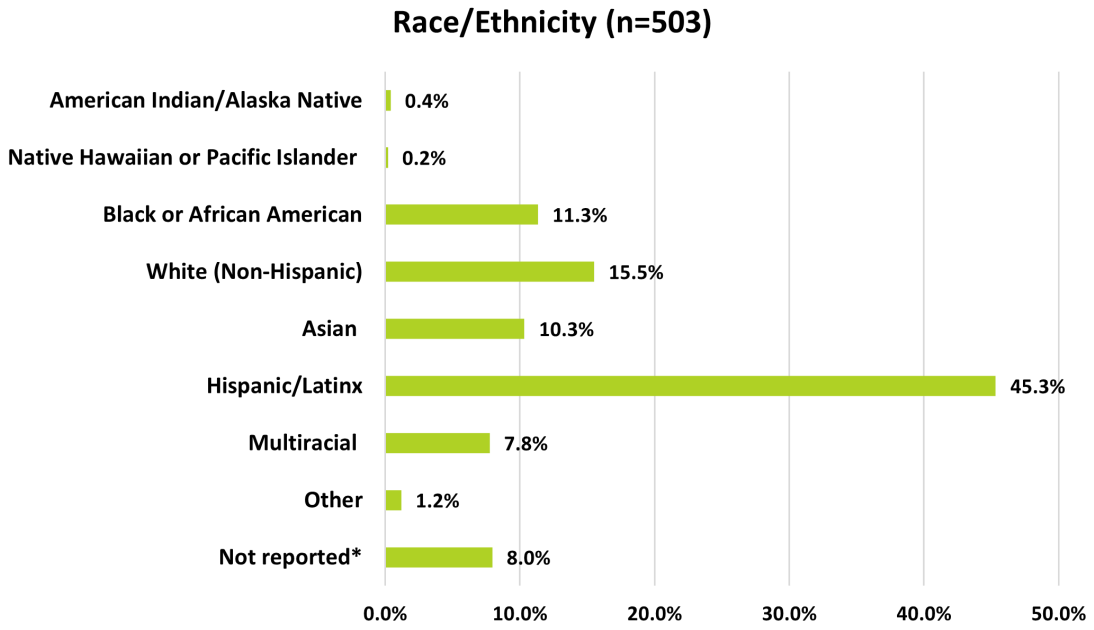
DEMOGRAPHICS

Demographics Summary

The majority of participants identified as **Hispanic/Latinx (45.5%)**, followed by White—Non Hispanic (15.5%), Black or African American (11.3%), Asian (10.3%), Multiracial (7.8%), Other (1.2%), American Indian/Alaska Native (0.4%), and Native Hawaiian or Pacific Islander (0.2%). Additionally, 8.0% of participants chose to not answer the race/ethnicity question and are included in the "not reported" category down below.

Individuals reported that they **work in a mental health care setting (22.1%),** followed by working in a school or university (16.3%), other setting (16.1%), more than one setting (11.7%), medical care setting (8.9%), and religious organization setting (2.2%).

The safeTALK trainings reached out to a diverse range of audience groups; however, the most frequent type of audience that was reported are individuals from the **community at large (35.4%)** Some examples of "other" groups include folks from nonprofit organizations, training centers, etc. Although not shown here, most participants reported that they **do not have a disabling condition (87.9%)** and that they are **not a veteran (90.5%)**. Lastly, **safeTALK participants reported that did not identify as being a part of the LGBTQ+ community (82.5%).**



Type of Work Environment	Count	Percentage
School/University	82	16.3%
Mental Health Care Setting	111	22.1%
Medical Care Setting	45	8.9%
Religious Organizations	11	2.2%
Other	81	16.1%
More than 1	59	11.7%
Not reported*	114	22.7%
Total	**503**	**100.0%**

Type of Audience Reached	Count	Percentage
An interested parent	41	8.2%
Consumer of services	47	9.3%
Community at large	178	35.4%
Other	122	24.3%
More than 1	67	13.3%
Not reported*	48	9.5%
Total	**503**	**100.0%**

**Note:* "Not reported" includes individuals who chose not to answer.*

SAFETALK

EVALUATION OUTCOMES

Evaluation Outcomes Summary

All safeTALK participants are asked to complete a feedback form at the end of the training presentation to complete their training. The feedback form includes questions about participant satisfaction of the training and any additional comments that participants would like the safeTALK program to know.

Please circle the choice that best describes your response *(1=Strongly Disagree, 2=Partly Agree, 3=Agree, 4=Strongly Agree; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
1. My trainer was prepared and familiar with the material.	**	0.4%	7.8%	91.7%
2. My trainer encouraged participation and respected all responses.	**	0.4%	4.4%	94.8%
3. I intend to tell others that they will benefit from this training:	**	1.0%	9.9%	86.9%
Please circle the choice that best describes your response *(1=Not Prepared, 2=Partly Prepared, 3=Mostly Prepared, 4=Well Prepared; n=503).**				
Questions	**Responses**			
	1	**2**	**3**	**4**
4. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?	**	1.8%	32.6%	64.2%
On a scale of 1 *(i.e., very bad)* to 10 *(i.e., very good)*, how would you rate this training *(n=503)*?				
5. How would you rate this training?	**Average Rating (Mean)**			9.6

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*
***No responses.*

SAFETALK ADDITIONAL COMMENTS

"This training helped my school community to not be afraid and it [the training] will help them build capacity within their role."

"Going over the slides and having the videos were helpful to understand the steps. Resource are also very helpful and useful to provide to others who are in need."

"Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate."



KNOW THE SIGNS

Program Description

Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: *"Know the signs. Find the words. Reach out."* This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources.

The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi and Russian. There are also print ads, TV and radio spots, and online ads available for the public. At the end of each presentation, everyone is encouraged to download the mobile application to help connect at -risk individuals to a supportive network.

Program Objective: Know the Signs has the overarching goal to increase Californians' capacity to prevent suicide by encouraging individuals to know the signs, find the words to talk to someone they are concerned about, and to reach out to resources.

FY 23-24 OVERVIEW

FY 23-24 Know the Signs Training Overview Summary

FY 23-24, there were a total of **17 trainings** and a total of **141 participants** who completed the training. In addition, for the type of audience reached, almost half of the Know the Signs participants identified as the **community at large (40.7%)**.



17
Total Number of Trainings

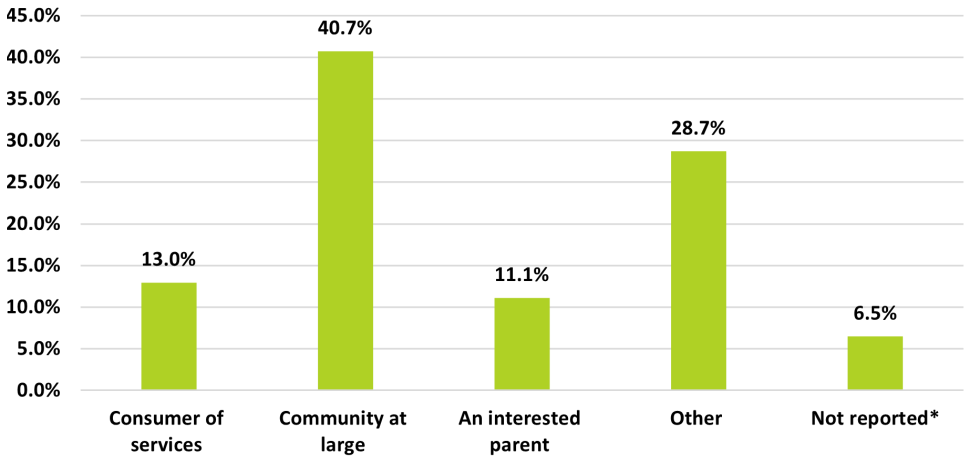


108
Total Number Reached



108
Total Number Completed Training

Type of Audience Reached (n=108)



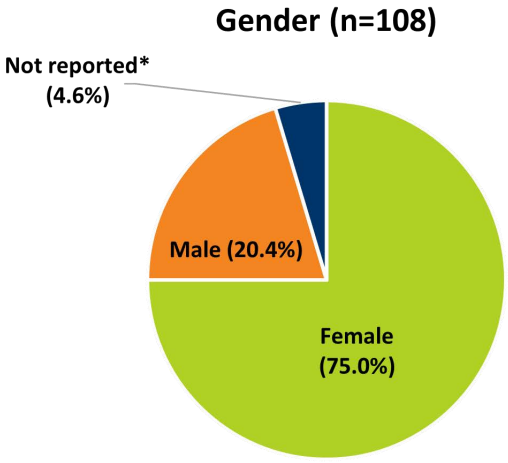
**Note:* "Not reported" includes individuals who chose not to answer.*

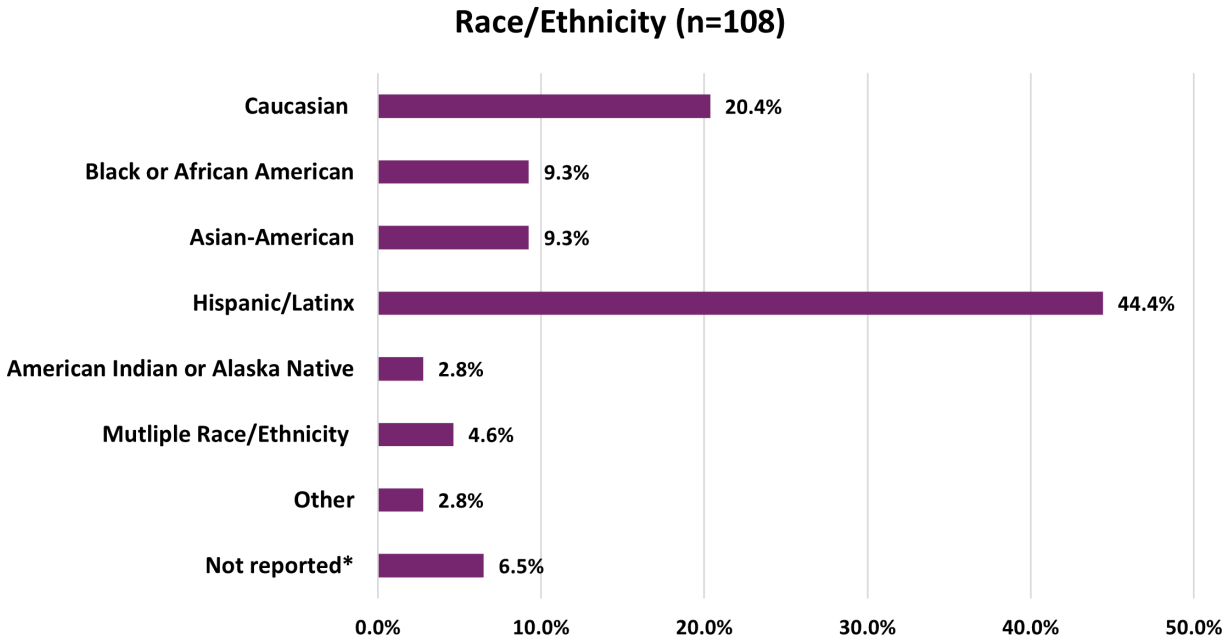
KNOW THE SIGNS

DEMOGRAPHICS

Demographics Summary

All demographic data includes participants from both the English and Spanish-speaking Know the Signs trainings. The majority of participants identified themselves as **female (75.0%)**, followed by males (20.4%). Additionally, most Know the Signs participants identified as **Hispanic/Latinx (44.4%)**, followed by Caucasian (20.4%%), Black or African American (9.3%), Asian-American (9.3%), Multiple Race/Ethnicity (4.6%), and American Indian or Alaska Native (2.8%), and Other (2.8%).





**Note:* "Not reported" includes individuals who chose not to answer.*

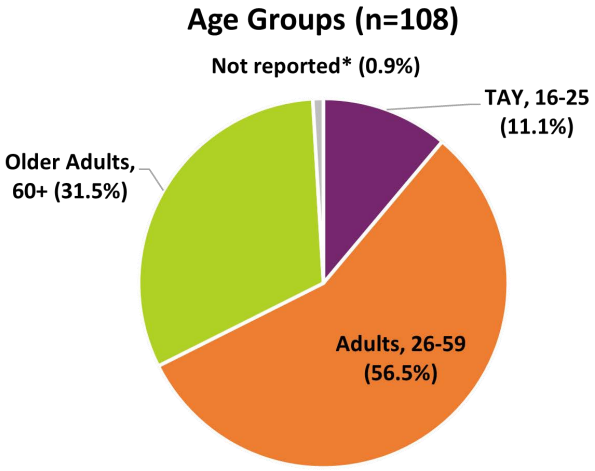
KNOW THE SIGNS

DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

Most participants from the Know the Signs training reported that they were in the **26-59 age group (56.5%)**, followed by the 60+ age group (31.5%), and the 16-25 TAY age group (11.1%). About 0.9% of participants did not report their age resulting in some unknown data.

In addition, a great majority of Know the Signs participants reported **English as their preferred language (89.8%)**. Most Know the Signs participants reported that they **did not have a disability (86.1%) nor did they identify as a veteran (88.9%)**. Lastly, a majority of respondents indicated that they **did not identify as lesbian, gay, bisexual, or queer (LGBQ) (71.3%)** as their sexual orientation status.



Demographic Characteristic	Percentage
Preferred Language (n=108)	
English	89.8%
Spanish	5.6%
*Not reported**	3.7%
Disability (n=108)	
Yes	7.4%
No	86.1%
*Not reported**	6.5%
Veteran Status (n=108)	
Yes	4.6%
No	88.9%
*Not reported**	6.5%
LGBQ Sexual Orientation Status (n=108)	
Yes	11.1%
No	71.3%
*Not reported**	14.8%

**Note:* "Not reported" includes individuals who chose not to answer.*

KNOW THE SIGNS

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of a Know the Signs training, participants are asked to complete a feedback survey via Google Forms to further understand how participants felt and thought about the training. Below are the results of the feedback survey and additional comments that participants may have provided.

As a result of this training, I feel more confident that I can… *(1=Not confident at all, 3=Somewhat confident…5=Very confident; n=108)*					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
1. Recognize the warning signs of suicide.	**	**	5.7%	22.6%	71.7%
2. Ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide.	**	0.9%	3.7%	25.2%	70.1%
3. Connect or refer someone at-risk for suicide to resources.	**	**	4.7%	21.7%	73.6%

Please circle the number that best describes your response *(1=Strongly Disagree, 3=Neutral… 5=Strongly Agree; n=108)*.					
Questions	**Responses***				
	1	**2**	**3**	**4**	**5**
4. Overall, the course goals were clearly communicated.	0.9%	**	1.9%	15.9%	81.3%
5. The presenter demonstrated knowledge of the material presented.	**	0.9%	1.9%	12.1%	85.0%
6. I would recommend this training to someone else.	**	**	1.9%	19.6%	78.5%

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*

***No responses.*

KNOW THE SIGNS ADDITIONAL COMMENTS

"It was very informative and helpful. Great job! Thank you both so much!"

"This training was extremely helpful. The trainers are very knowledgeable, welcoming, and helpful."

"Thank you for sharing this valuable information. I fully support all efforts to stop the stigma of needing mental health support."



APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

Program Description

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed.

ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

Program Objective: To learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone safe.

FY 23-24 OVERVIEW

FY 23-24 ASIST Overview Summary

Overall, for FY 23-24, ASIST had a total of **19 trainings** with **314 participants** who completed the 2-day training. All 19 trainings for ASIST were conducted in collaboration or co-facilitation with **PEI, Helpline, Public Health, Consumer Affairs, WET, school districts,** and **Inland Empire Health Plan (IEHP)**. Additionally, most of the trainings took place at the **Rustin Conference Center** and in the **Western region** of Riverside County.

19
Total Number of Trainings

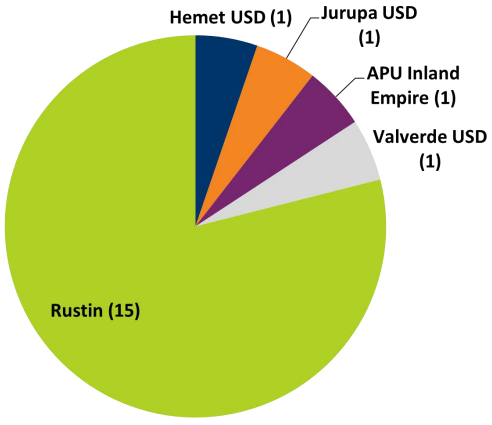
327
Total Number Reached

314
Total Number Completed Training

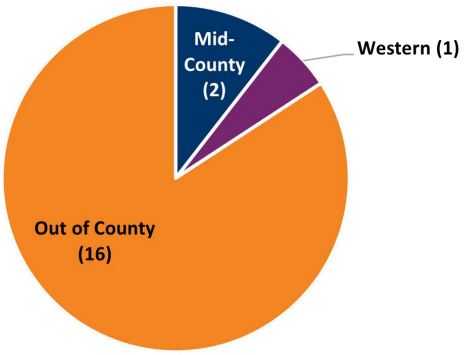
5
Smallest Audience Size

30
Largest Audience Size

Location of Training



Region of Training



**Note:* *"Not reported" includes individuals who chose not to answer.*

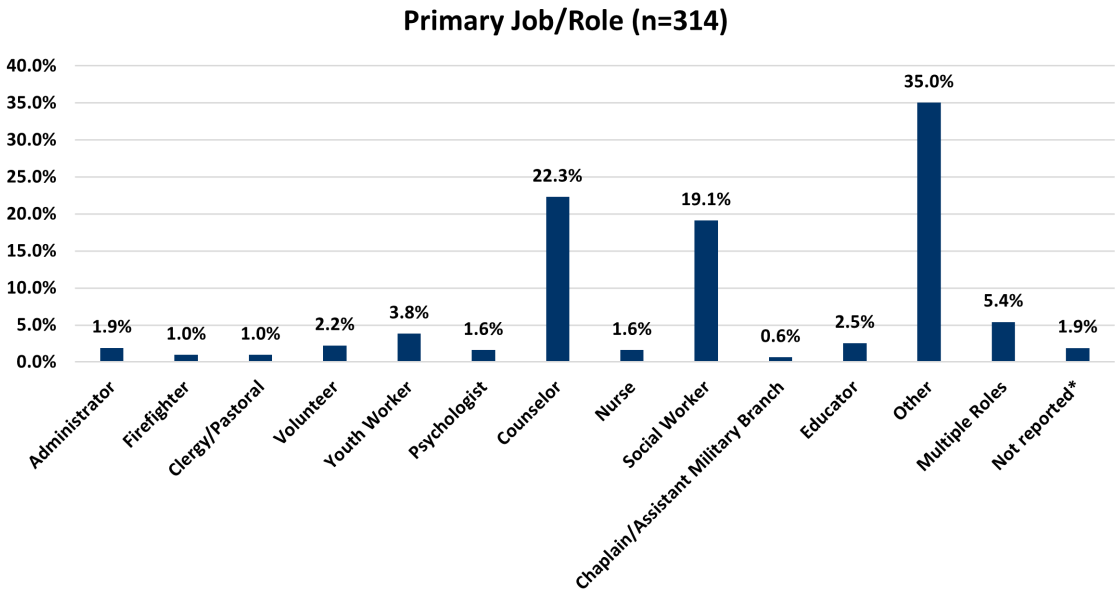
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

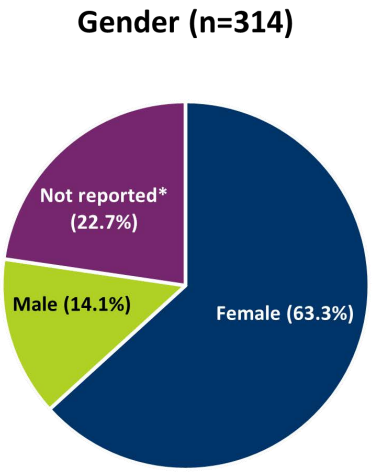
DEMOGRAPHICS

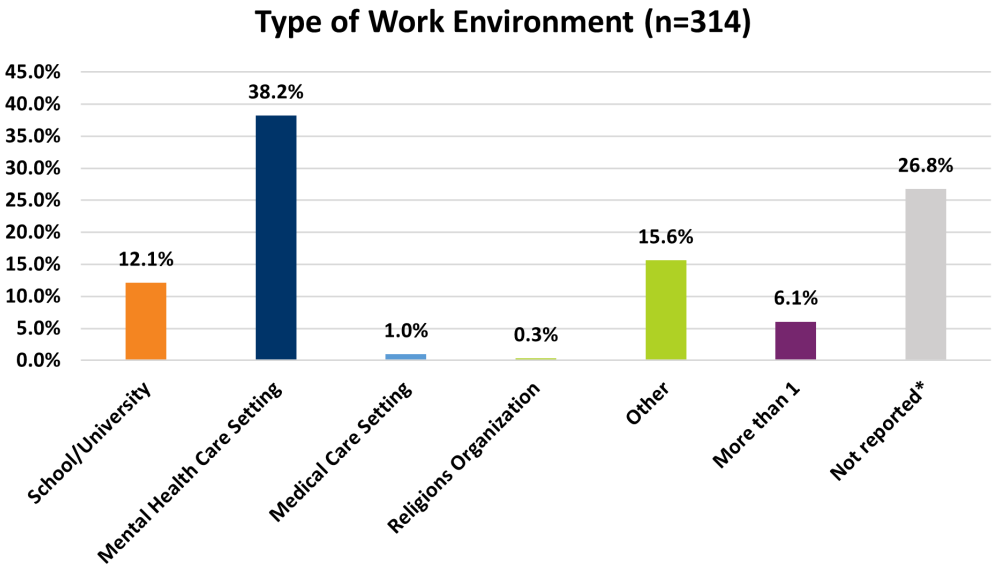
Demographics Summary

Note: There are more "Not reported" counts this fiscal year than there were last fiscal year due to a misunderstanding in providing the demographics section for two trainings for ASIST. Because of this, some demographic information may not be available throughout the demographics section of the report for ASIST.

Many of the ASIST participants come from a diverse range of occupations and primary roles. For example, **35.0% of respondents identified as 'Other'** as their primary job or role. Additionally, the next frequently chosen response was counselor (22.3%), social worker (19.1%), followed by having multiple primary roles (5.4%), youth worker (3.8%), and educator (2.5%). The most frequently chosen type of work environment was **mental health care setting (38.2%)** among ASIST participants. Additionally, the majority of ASIST participants identified themselves **as female (63.3%)**, followed by male (14.1%), and those who did not report on their gender identity (22.7%).







**Note:* "Not reported" includes individuals who chose not to answer.*

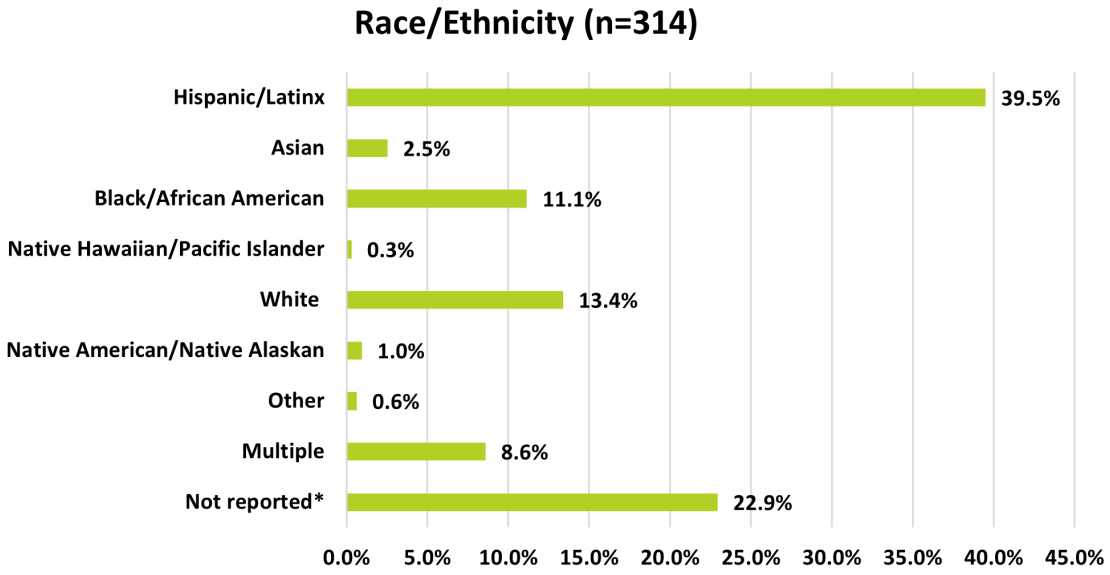
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

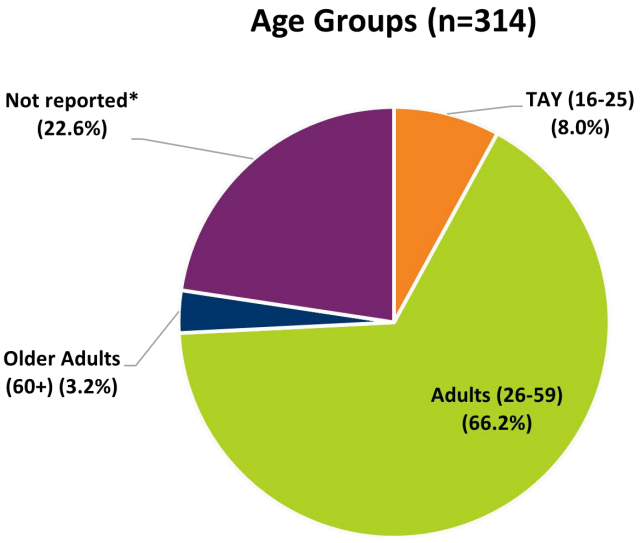
DEMOGRAPHICS (cont.)

Demographics Summary (cont.)

More than half of the ASIST participants identified as **Hispanic/Latinx (39.5%)**, followed by White (13.4%), Black/ African American (11.1%), Multiple (8.6%), Asian (2.5%), Native American/Native Alaskan (1.0%), Other (0.6%), and Native Hawaiian/Pacific Islander (0.3%). Most of the participants reported being in the **26-59 age group (66.2%)**, followed by the Transitional Age Youth (TAY) 16-25 age group (8.0%), and the 60+ age group (3.2%).

In addition, most individuals reported **English as their preferred language (72.3%)**. A great majority of participants reported that they **did not have a disability (70.1%) nor a veteran (76.4%)**. Lastly, most participants did **not identify as LGBTQ+ (64.6%).**





Demographic Characteristic	Percentage
Preferred Language (n=314)	
English	72.3%
Spanish	0.6%
English & Another Language	3.8%
Other	0.6%
Disability (n=314)	
No	70.1%
Veteran Status (n=314)	
No	76.4%
LGBTQ+ Status (n=314)	
Yes	9.2%
No	64.6%

**Note:* *"Not reported" includes individuals who chose not to answer.*

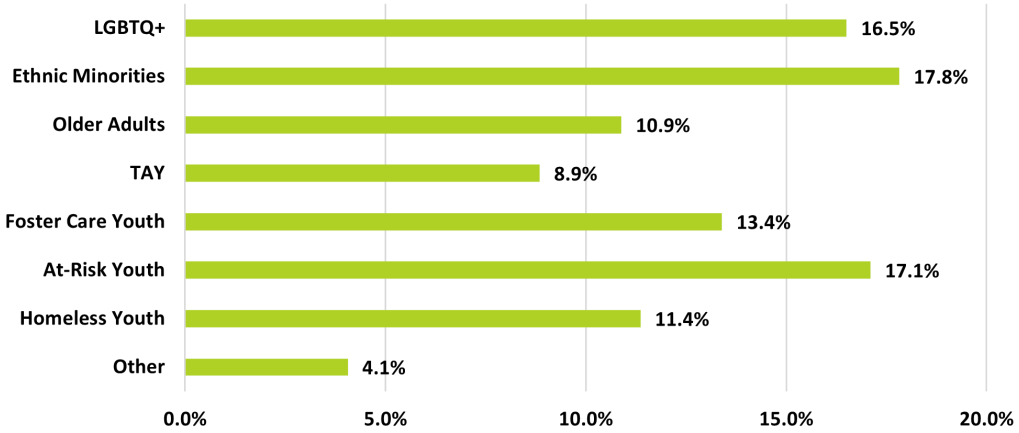
APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

DEMOGRAPHICS—PEOPLE SERVED/WANT TO SERVE (cont.)

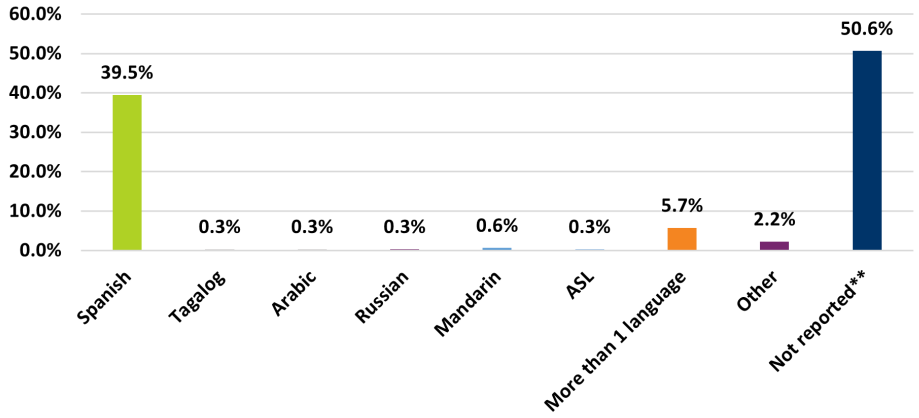
Demographics Summary (cont.)

The most frequently reported special population group that ASIST participants serve or want to serve was the **ethnic minorities group (17.8%)**, closely followed by the at-risk youth group (17.1%). Participants were able to choose multiple special population groups for this question. Additionally, participants most frequently chose **Spanish (39.5%) as another language other than English that they serve**. Lastly, participants most frequently responded that they serve or want to serve the **18-25 age group (28.7%)**.

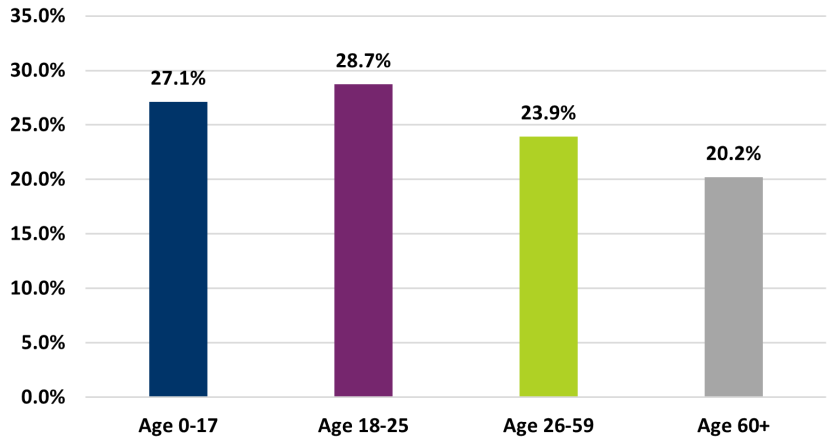
Special Populations (n=836)*



Other Than English, Another Language Served (n=314)



Age of People Served (n=564)*



**Note:* Multiple responses are reported here.*

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

EVALUATION OUTCOMES

Evaluation Outcomes Summary

At the end of ASIST, all participants are encouraged to complete a feedback survey which includes questions about the overall course, how ASIST is helpful to them or others, and a section for additional comments or thoughts about the training.

On a scale of 1 (i.e., did not like at all…) to 10 (i.e., liked a lot), please write the rating that best describes your responses.* (n=314)	Rating (Mean)
1. How would you rate the quality of the ASIST workshop	9.4
2. Would you recommend ASIST to others?	9.6
3. This workshop has practice use in my personal life.	9.2
4. This workshop has practical use in my work life.	9.6

Please circle the number that best describes your response (1=Strongly Disagree… 5=Strongly Agree).* (n=314)					
Questions	Responses				
	1	2	3	4	5
5. If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide.	1.0%	**	0.6%	10.2%	88.2%
6. Before taking the ASIST training, my answer to #5 would have been:	5.7%	12.7%	30.6%	25.2%	25.2%
7. If someone told me he or she were thinking of suicide, I would do a suicide intervention.	1.3%	**	1.3%	14.7%	82.7%
8. Before taking the ASIST training, my answer to #7 would have been:	6.7%	10.5%	23.6%	28.3%	30.9%
9. I feel prepared to help a person at risk of suicide.	60.0%	0.3%	2.2%	23.2%	73.6%
10. Before taking the ASIST training, my answer to #9 would have been:	11.5%	17.2%	24.5%	25.8%	20.7%
11. I feel confident I could help a person at-risk of suicide.	1.0%	0.3%	2.9%	23.6%	72.3%
12. Before taking the ASIST training, my answer to #11 would have been:	13.4%	15.3%	23.6%	28.3%	18.8%

Lastly, a great majority of ASIST participants (n=314) **agreed** with the following statements:

13. I attended two consecutive 8-hour days of training **(100%)**.
14. All trainers were present at the workshop for the full 2 days **(99.3%)**.
15. The "Jack" exercise was done on the afternoon of day 1 **(99.0%)**.

"The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS."

"I felt it was very beneficial for my life and future profession."

"ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally."

**Total percentage may not equal to 100% due to "not reported" data which is not shown here.*
***No responses.*

PEI-02 Parent Education and Support

Triple P (Positive Parenting Program)

Program Type: Prevention Program

The Triple P Parenting Program is a multi-level system of parenting and family support strategies for families with children from birth to age 12. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. In FY23/24 RUHS - BH continued to contract with one well-established provider to deliver the Level 4 parenting program for both parents of children 2-12 as well as parents of teens 12-17 in targeted communities in the West, Mid- County, and Desert regions of Riverside County. The service delivery method of Level 4 Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put skills into practice. The group then reconvenes for the eighth and final session where graduation occurs.

For FY23/24 the provider's contract deliverables were doubled (from 360 parents countywide to 720 parents countywide). The program's outreach efforts also expanded to recruit more parents into the service. In total, the provider was able to provide service to 686 parents, coming very close to the goal of 720. Across both programs, parents had an 81.5% program completion rate and parents were overall highly satisfied with both programs (Triple P and Teen Triple P). Program outcomes indicated that participants increased in their positive parenting practices, decreased in inconsistent discipline practices, decreased experiences of depression, anxiety and stress levels, increased the level of involvement with their child/teen, reported decreases in the frequency of disruptive behaviors, and increases in prosocial behaviors.

Positive Parenting Practices Improved

Recruitment into the Spanish and Teen classes remained a significant challenge for FY23/24. Additionally, some school districts had lengthy and complex MOU requirements, delaying approvals and complicating the process with extensive demands to promote and provide services to school parents. With the expansion of contract deliverables, the team needed to increase staffing for the program. This took some time for new team members to be hired and complete the Triple P training and accreditation requirements to be able to facilitate classes. Additionally, staff turnover further impacted program implementation as new staff had to be recruited and trained in the Triple P model. This created delays in being able to start more classes through the County.

Behavior Problems Decreased

With the expansion of contract deliverables, the provider learned new ways to increase outreach and gained valuable insights on how to effectively connect with and relate to diverse communities. They were able to expand outreach efforts by collaborating with new organizations and spaces; for example, creating social media presence in different locations throughout the County (e.g., "Mom Walk" in the mid-county region), partnering with recovery centers for referrals, and focusing on private schools to help with recruitment. The provider learned more about the importance of understanding the unique needs and dynamics of each group they provide services for and worked on tailoring the different classes offered to best meet those needs.

Feedback from participants included:

- "[I learned] better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
- "It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
- "I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."

Riverside University HEALTH SYSTEM Behavioral Health

Triple P and Teen Triple P Positive Parenting Programs

FY 2023/2024

MHSA Prevention and Early Intervention

Program Overview

RUHS-BH with MHSA Prevention and Early Intervention (PEI) funding implemented Triple P Positive Parenting Program and Teen Triple P Program, which are multi-level systems of parenting and family support strategies for families with children aged 2-12, and for families with teens aged 12-16, respectively. Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. Teen Triple P aims to promote positive, caring relationships between parents and their teens, and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. The service delivery method for this implementation of Level 4 Triple P and Teen Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Triple P throughout Riverside County, and Teen Triple P in the West and Mid-County Regions of Riverside County.

Triple P Outcome Evaluation

Evaluation of Triple P parenting focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in children's disruptive behavior. The following measures are used in the evaluation of Triple P:

- ***Alabama Parenting Questionnaire (APQ)***
  The APQ is a parent completed questionnaire that measures several dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. Two of six parenting dimensions are used for analysis including: positive parenting, and inconsistent discipline. Parents completed the Alabama Parenting Questionnaire (APQ) before and after completing the program.

- ***Eyberg Child Behavior Inventory (ECBI)***
  The ECBI is a parent completed measure that focuses on child disruptive behaviors and the parent's perception of whether the behavior is problematic. The ECBI includes an Intensity Scale (frequency of disruptive behaviors) and a Problem Scale (parent's perception of problematic behaviors).

- ***Depression, Anxiety and Stress Scale (DASS-21)***
  The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure parent's negative emotional states of depression, anxiety, and stress.

Teen Triple P Outcome Evaluation

Similar to Triple P, evaluation of Teen Triple P also focuses on the development and use of positive parenting practices and decreases in the use of negative parenting practices. Evaluation also includes measuring changes in teens conflict behavior. The following measures are used in the evaluation of Teen Triple P:

Strength and Difficulties Questionnaire (SDQ)
Parents completed the SDQ before and after completing the program. The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these (emotional, conduct, hyperactivity and peer problems) creates a total difficulty score. The emotional and peer items together create an internalizing problems score and the conduct and hyperactivity questions together get an externalizing score.

Alabama Parenting Questionnaire (APQ)
Parents completed the APQ before and after completing the program. For the Teen Triple P program, the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Conflict Behavior Questionnaire (CBQ)
The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score.

A satisfaction survey is also used for both programs to measure the parent's satisfaction in program logistics, program leaders, and program content.

Executive Summary - Key Findings

Enrollment and Demographics

Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. Demographics information showed that most of the parents in Triple P spoke English as their preferred language (72.2%), and in Teen Triple P, 62.5% of parents identified English as their primary language. The majority of parents served in Triple P and Teen Triple P were Hispanic/Latinx, 64.6% and 71.5%, respectively. The average age of the child of focus in Triple P was 6.3 years, and 13.5 years for Teen Triple P. The majority of parents/caregivers enrolled in both Triple P and Teen Triple P programs were female.

Service data showed that Countywide 80.8% of parents completed the Triple P Program, and 84% of parents completed the Teen Triple P program. Across both programs, parents had a 81.5% program completion rate. Parents were overall highly satisfied with both programs.

Triple P: Positive Parenting Practices Improved

Analysis of the APQ measure indicated that overall, by the end of the program, participants had shown increases in positive parenting practices, and decreases in inconsistent discipline practices. Analysis of the DASS-21 also showed that parents experienced a decrease in their depression, anxiety, and stress levels.

Triple P: Child Disruptive Behavior Decreased

Outcomes from ECBI measures showed overall decreases in the frequency of children's disruptive behaviors. ECBI Intensity Scale scores decreased significantly from pre to post measure. ECBI Problem Scale scores also decreased significantly indicating that parents reported fewer behaviors as problematic.

Teen Triple P: Teen Problem Scores Decreased, Prosocial Skills Increased

Countywide, outcomes of the SDQ indicated that teen total problems of emotional, conduct, hyperactivity, peer problems decreased significantly upon parent completion of Teen Triple P. Teen prosocial behaviors significantly increased pre to post.

Teen Triple P: Increase in Parent Involvement and Positive Parenting

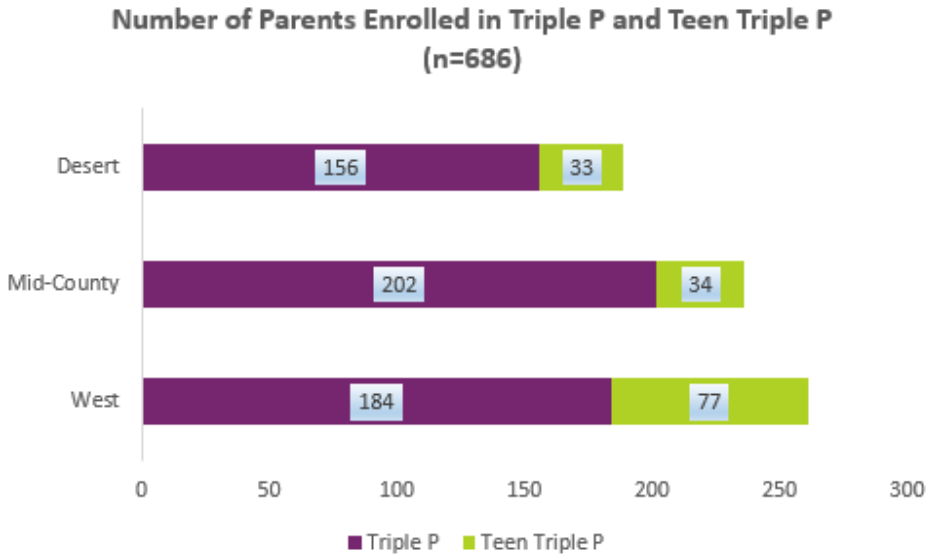
Analysis of the APQ measure indicated that countywide, parents had a significant increase in involvement with their teen and in positive parenting practices. There was a decrease in poor monitoring practices, however this decrease was not statistically significant.

Teen Triple P: Decrease in General Parent-Teen Discord

Countywide, analysis of the CBQ indicated a statistically significant decrease in parent's report of general conflict between parent and teen.

Parent Enrollment

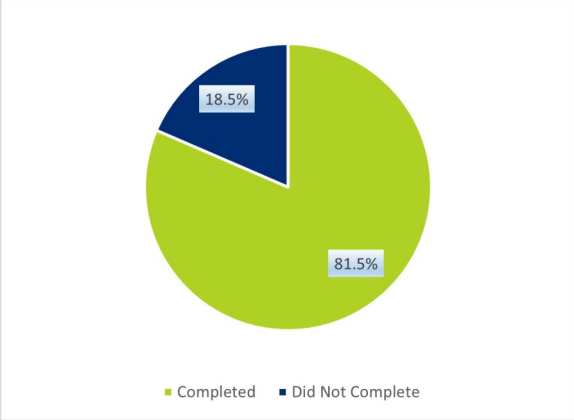
Countywide, Triple P and Teen Triple P combined served 686 parents in FY 23-24. A total of 261 parents were served in the Western region, 236 parents in the Mid-County Region, and 189 parents in the Desert region. By program, Triple P served 542 parents and Teen Triple P served 144 parents Countywide. **Note:** Some parents may not have reside within the County of Riverside, but had an active Child Protection Services (CPS) case within the County. In this case, the parent's region served is based on the location of the CPS case/ location of the child.



Program Completion

Countywide across both programs, parents had a 81.5% program completion rate. Program completion for both Triple P and Teen Triple P is defined as attending at least 6 out of 8 sessions, missing no more than one phone session, and not missing the first Triple P or Teen Triple P session. The table below details the completion rate regionally by program.

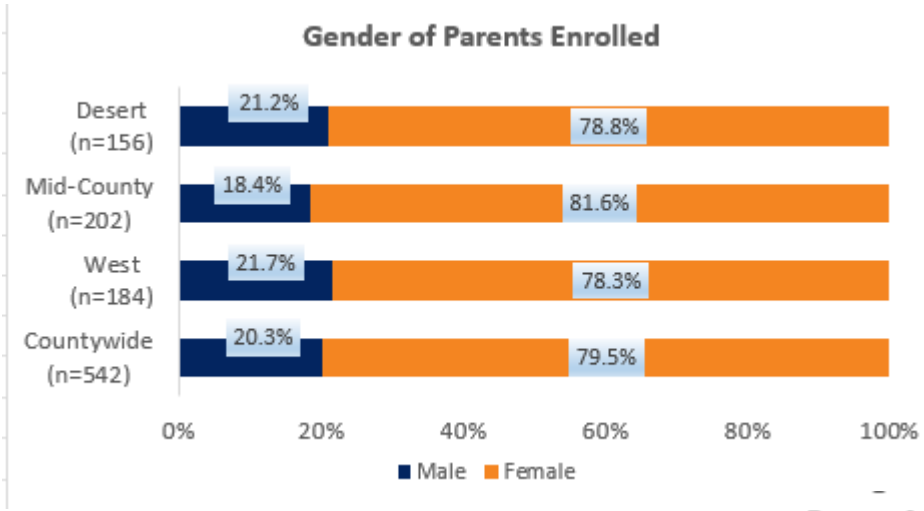
Countywide Completion Rates Triple P and Teen Triple P (Combined) n=686



Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	124 (79.5%)	165 (81.0%)	148 (81.7%)	438 (80.8%)
Did not Complete	32 (20.5%)	37 (19.0%)	35 (18.3%)	104 (19.2%)
Total Enrolled	156	202	184	542

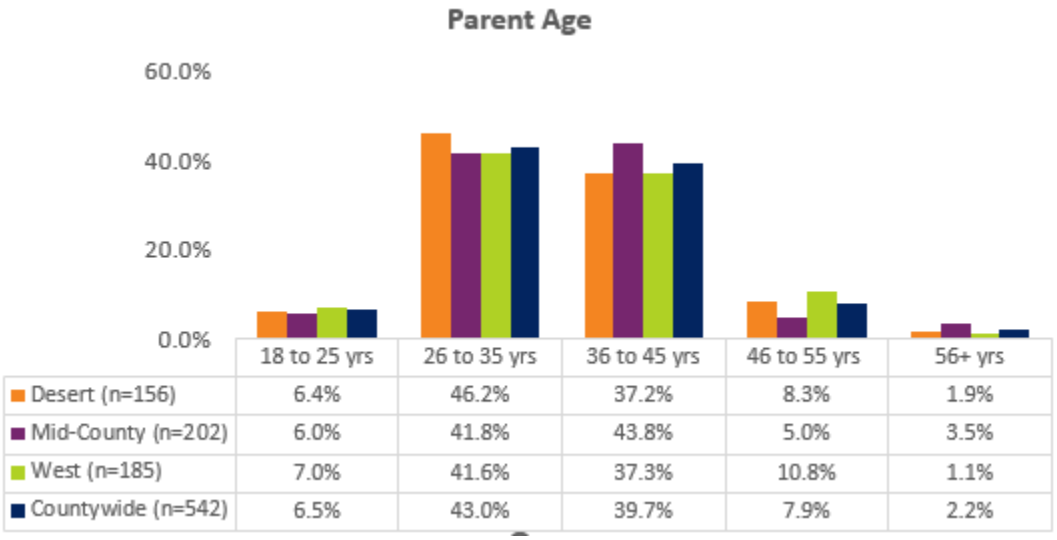
Teen Triple P Parenting Program Completion				
	Desert	**Mid-County**	**West**	**Countywide**
Completed	28 (84.8%)	28 (82.4%)	65 (84.4%)	121 (84%)
Did not Complete	5 (15.2%)	6 (17.6%)	12 (15.6%)	23 (16%)
Total Enrolled	33	34	77	144

Triple P Parent Enrollment and Demographics

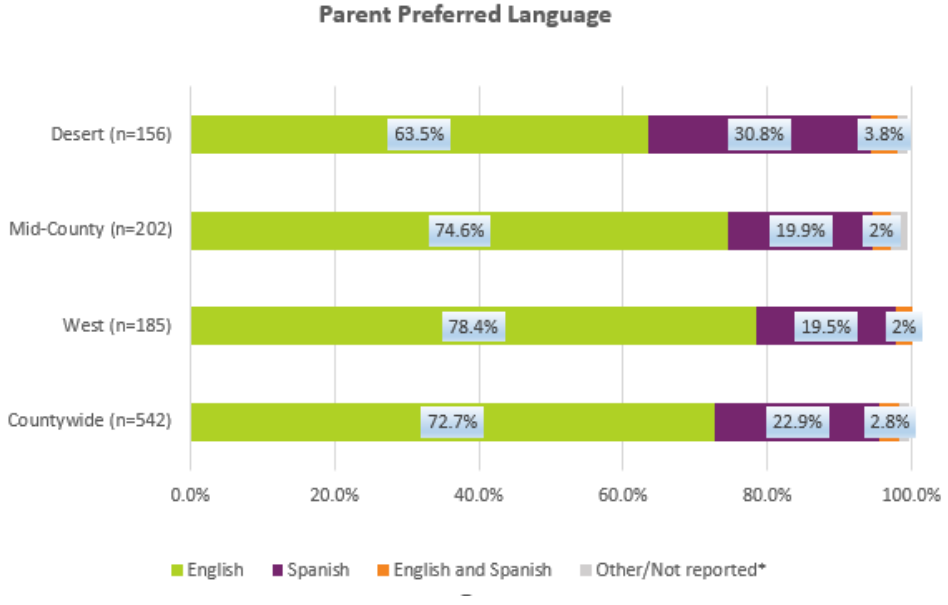


Countywide, the majority of parents/caregivers enrolled in Triple P parenting were females (79.5%).

A majority of parents/ caregivers identified as being a part of the 26 to 35 years old group (43.0%). The average parent age was 36.2 years old.

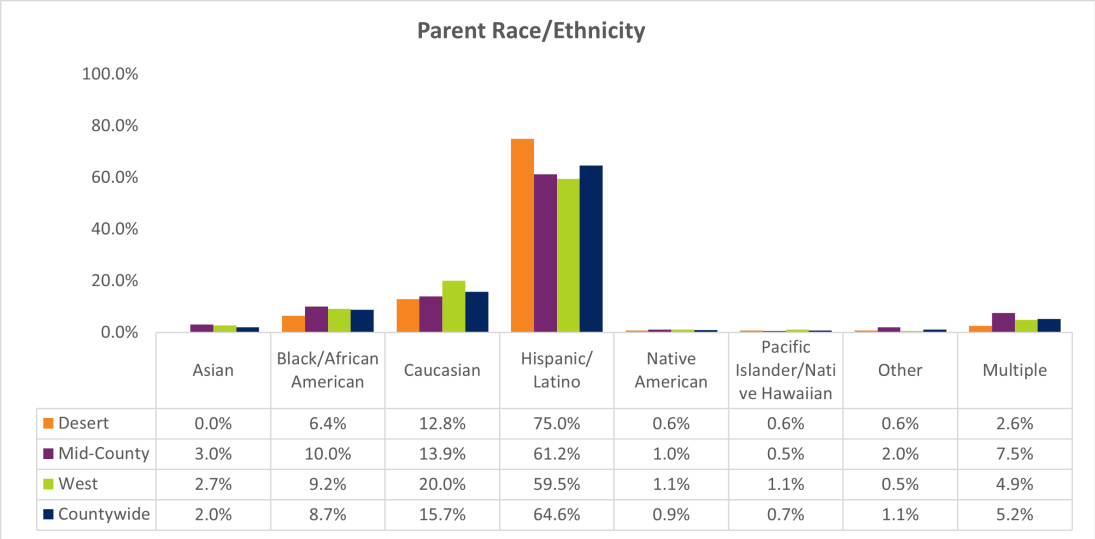


	18 to 25 yrs	26 to 35 yrs	36 to 45 yrs	46 to 55 yrs	56+ yrs
Desert (n=156)	6.4%	46.2%	37.2%	8.3%	1.9%
Mid-County (n=202)	6.0%	41.8%	43.8%	5.0%	3.5%
West (n=185)	7.0%	41.6%	37.3%	10.8%	1.1%
Countywide (n=542)	6.5%	43.0%	39.7%	7.9%	2.2%



Countywide, more than half of participants (72.2%) reported English as their preferred language. Most parents enrolled in classes of their preferred language (English or Spanish).

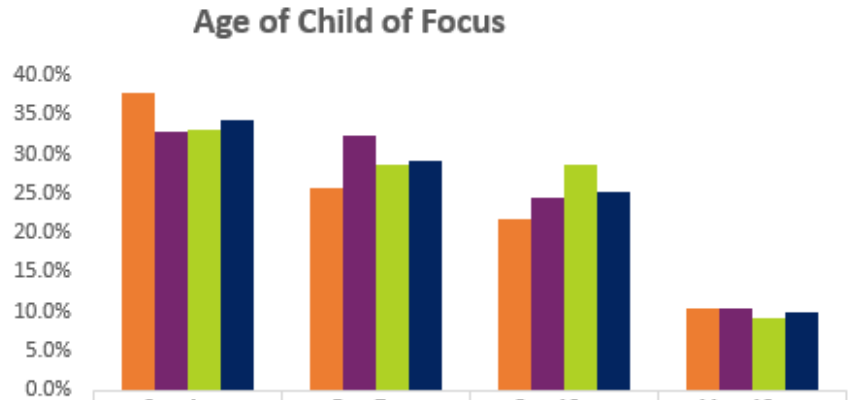
Triple P
Parent and Child Demographics



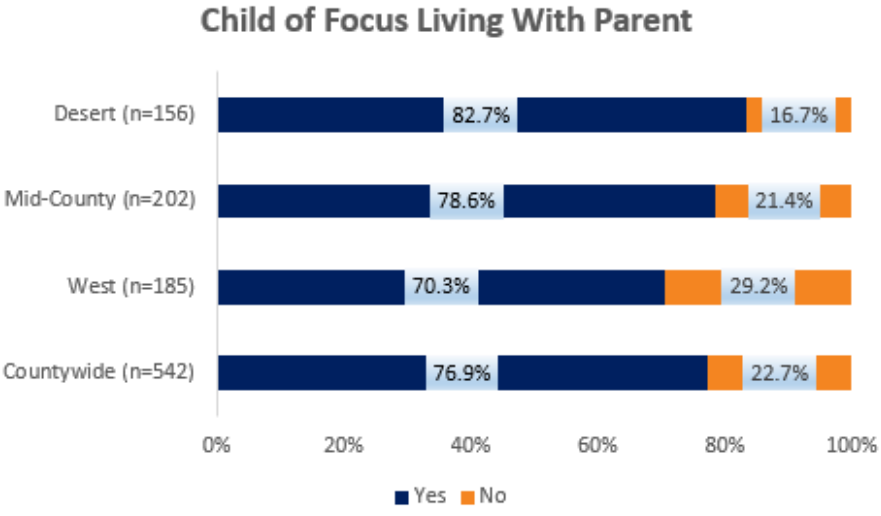
	Asian	Black/African American	Caucasian	Hispanic/ Latino	Native American	Pacific Islander/Native Hawaiian	Other	Multiple
Desert	0.0%	6.4%	12.8%	75.0%	0.6%	0.6%	0.6%	2.6%
Mid-County	3.0%	10.0%	13.9%	61.2%	1.0%	0.5%	2.0%	7.5%
West	2.7%	9.2%	20.0%	59.5%	1.1%	1.1%	0.5%	4.9%
Countywide	2.0%	8.7%	15.7%	64.6%	0.9%	0.7%	1.1%	5.2%

Countywide, the majority of Triple P participants identified as Hispanic/Latinx (64.6%), followed by Caucasian (15.7%) and Black/ African American (8.7%).

Parents/caregivers were asked to identify one of their children who posed the most parenting challenges. This child was considered the primary focus for the program. Countywide, the most reported age group for the child of focus was the 2 to 4 years old age group (34.3%). The average age of the child of focus was 6.3 years old.



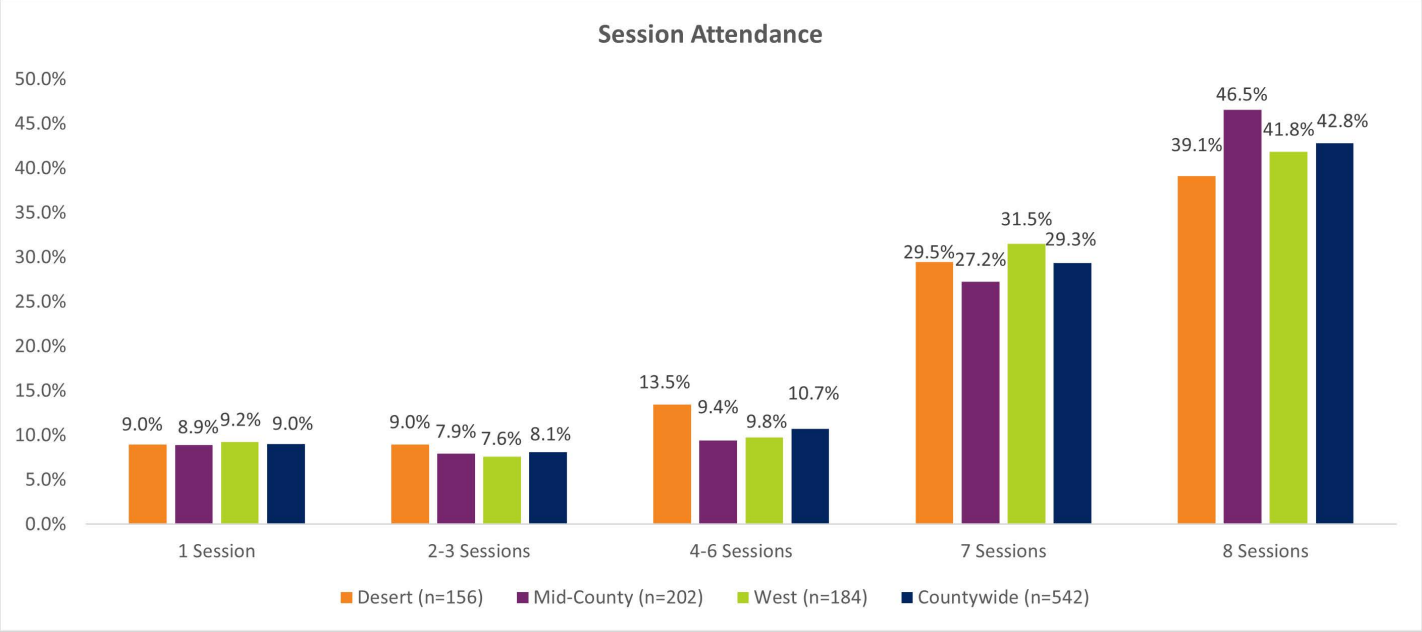
	2 to 4 yrs	5 to 7 yrs	8 to 10 yrs	11 to 13 yrs
Desert (n=156)	37.8%	25.6%	21.8%	10.5%
Mid-County (n=202)	32.8%	32.3%	24.4%	10.4%
West (n=185)	33.0%	28.6%	28.6%	9.2%
Countywide (n=542)	34.3%	29.2%	25.1%	10.0%



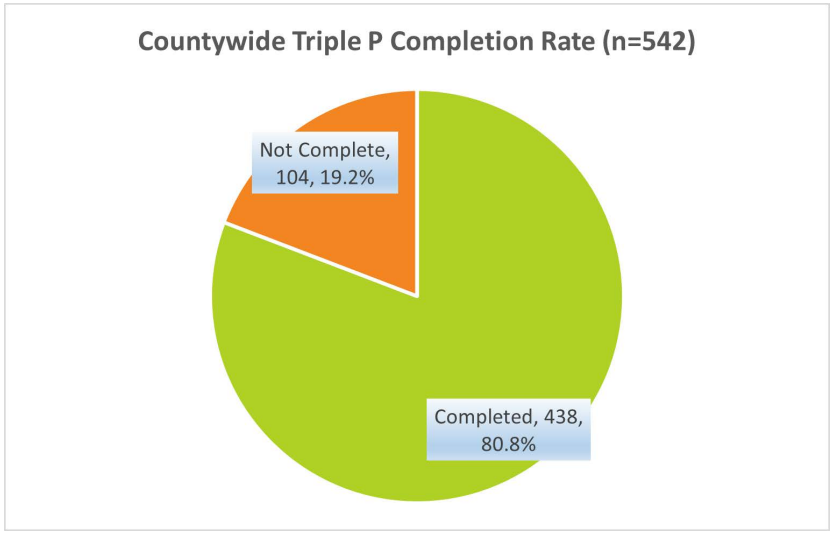
Countywide, 76.9% of parents/ caregivers served in Triple P reported that they lived with their child of focus.

Triple P Program Statistics

Countywide, session attendance showed that 82.8% of participants completed 6-8 Teen Triple P sessions, with 42.8% of participants attending all eight Teen Triple P sessions. Countywide, only 9.0% of the parents attended only one session.

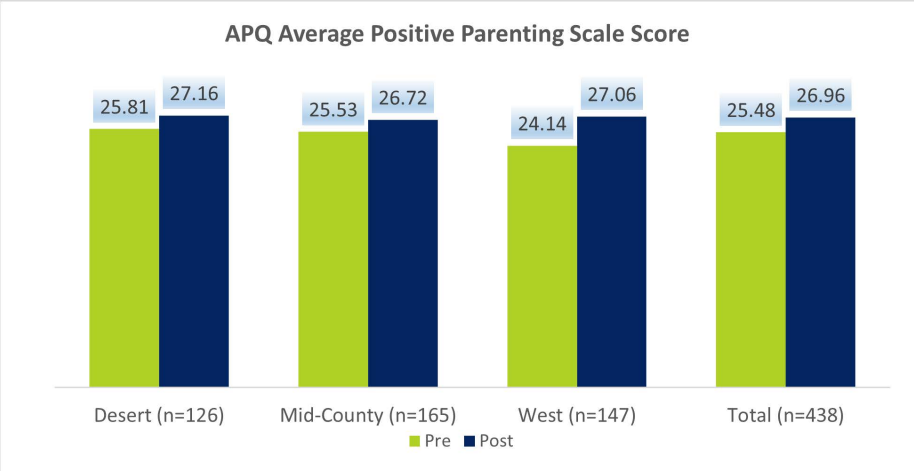


Countywide, 80.8% of parents completed the program. Page 5 of this report details the completion rate by region for the Triple P program.



Alabama Parenting Questionnaire

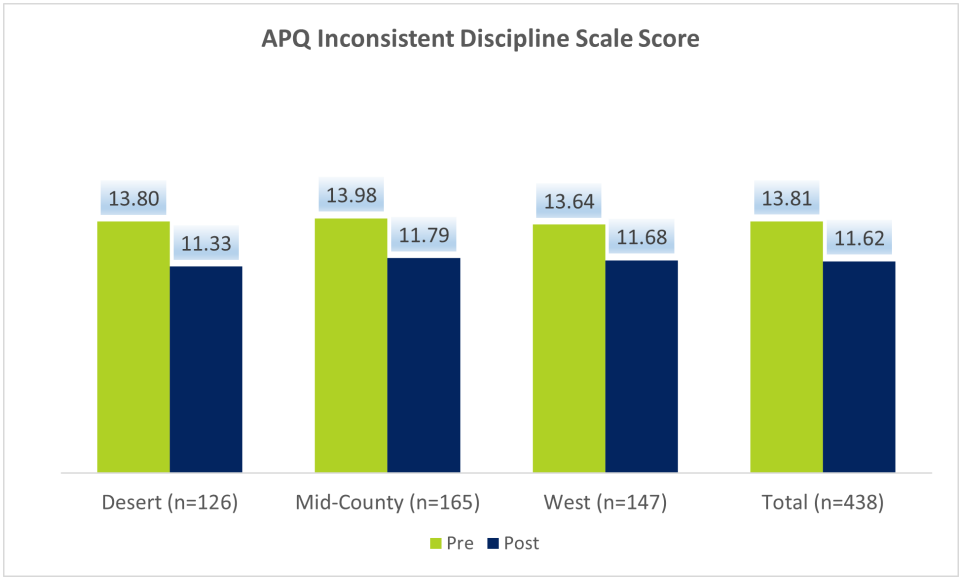
Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Triple P program, only the positive parenting (6 items) and use of inconsistent discipline scales (6 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always). The APQ was scored for parents whose children are between ages 4-17.



t=-3.71 df=125 p<0.001 | t=-4.25 df=164 p<0.001 | t=-5.60 df=146 p<0.001 | t=-7.87 df=437 p<0.001

Countywide there was a statistically significant increase for practicing positive parenting skills after parents/caregivers had completed the Triple P program. Each region also showed a statistically significant increase in positive parenting skills as well.

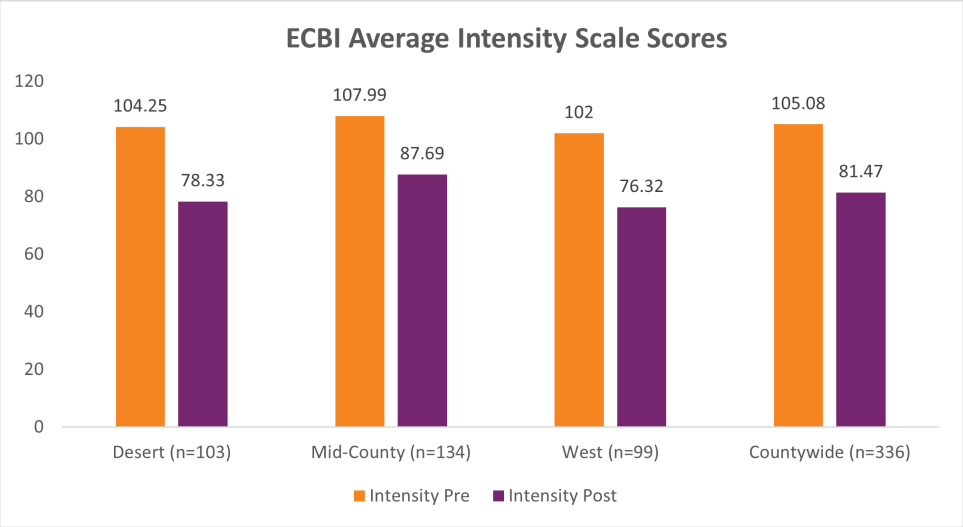
Countywide and across all three regions, there was a statistically significant decrease in the use of inconsistent disciplining practices after parents/caregivers completed the Triple P program.



t=6.29 df=125 p<0.001 | t=6.51 df=164 p<0.001 | t=5.16 df=147 p<0.001 | t=10.35 df=437 p<0.001

Eyberg Child Behavior Inventory

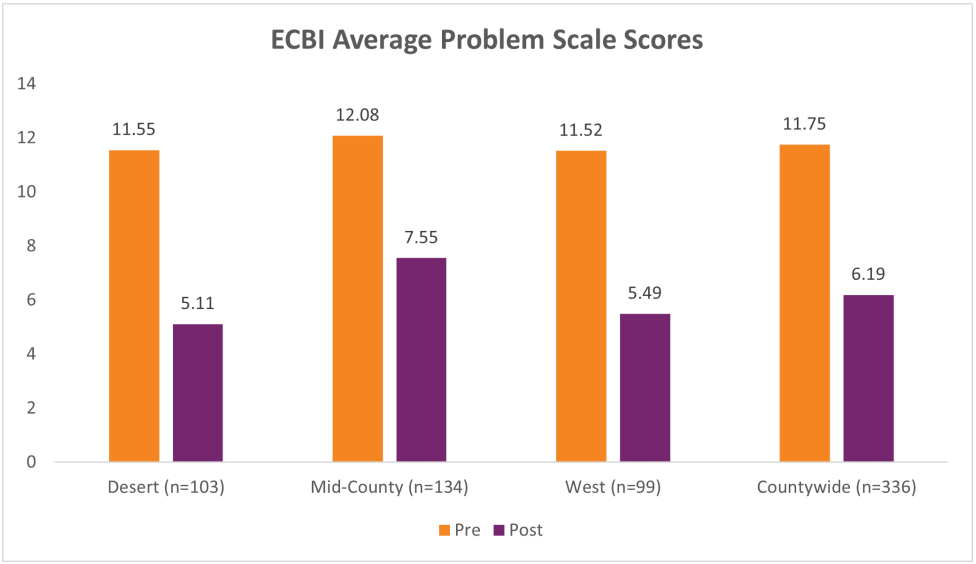
The Eyberg Child Behavior Inventory (ECBI) is a parent-completed rating scale used to measure the frequency of children's disruptive behaviors (Intensity scale) and parent's perceptions of problematic behaviors (Problem Scale). The ECBI consists of 36 items intended to assess "typical problem behaviors" reported by parents of children age 2-16 years. Each behavior is rated on a 7-point scale for intensity, as well as on a yes/ no scale to indicate whether the parent perceives the behavior to be a problem or not.



t=7.58 df=102 p<0.001 | t=7.95 df=133 p<0.001 | t=7.91 df=98 p<0.001 | t=13.51 df=335 p<0.001

Countywide and across all three regions individually, there was a statistically significant decrease in child problem behaviors from Pre to Post. For the ECBI intensity scale, the cut-off score is 130. At baseline, about 26.8% of children had a raw score above 130. By post, there was a decrease with only 9.5% of children who had a raw score of above 130.

From the ECBI Average Problem Scale, there was a statistically significant decrease in the parent's perception of their child's behavior as a problem countywide and across all three regions individually. The clinical cut-off is a score of 15. At baseline, about 33.3% of parent's ratings were above the cut-off score; however, by the end of the Triple P program, this decreased to 14.0%.



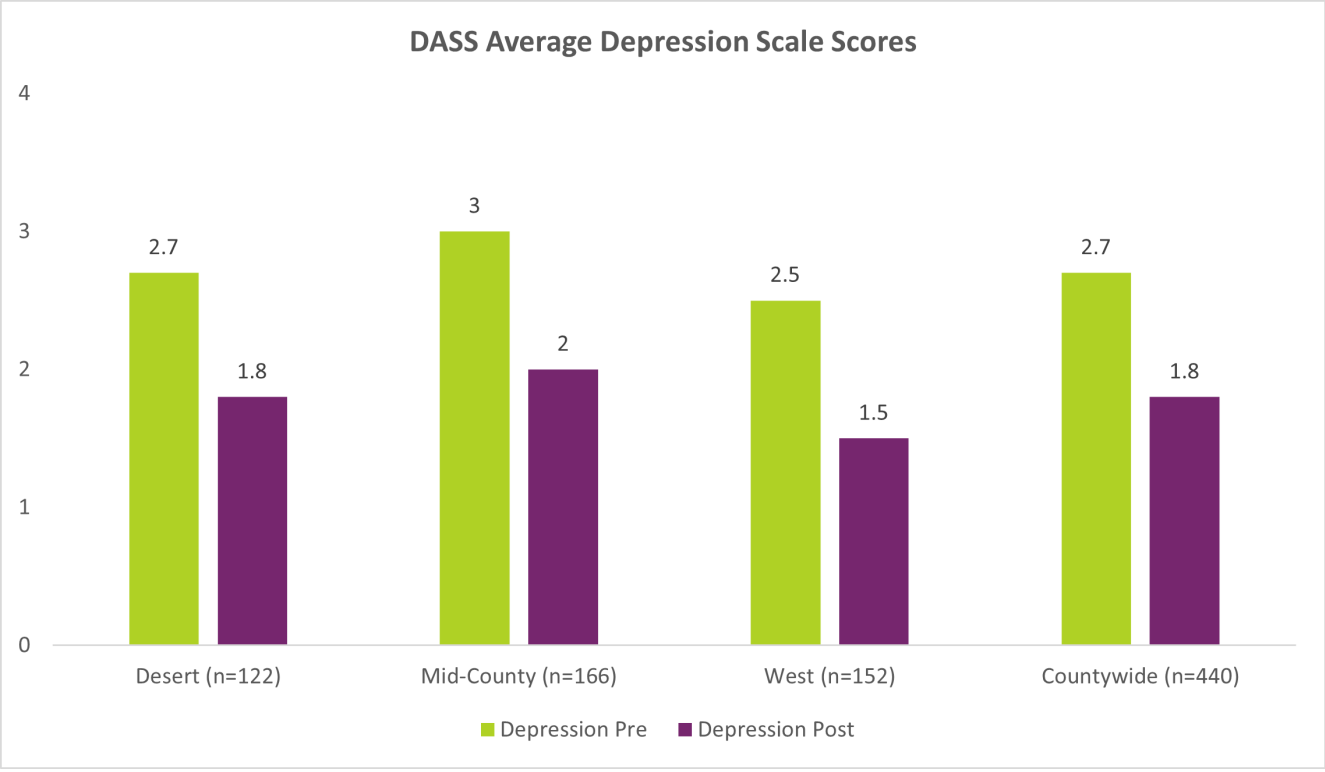
t=9.80 df=102 p<0.001 | t=7.20 df=133 p<0.001 | t=7.43 df=98 p<0.001 | t=13.81 df=335 p<0.001

Depression Anxiety and Stress Scale

The Depression Anxiety and Stress Scale (DASS) is a 21-item questionnaire which includes three self-report scales designed to measure the negative emotional states of depression, anxiety, and stress. In completing the DASS, the individual is required to indicate the presence of a symptom in the previous week. Each item is scored from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week). For the DASS-21 the following cut-off scores have been recommended for each subscale:

	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+

All three regions in Riverside County scored in the normal range for the DASS depression subscale in the pre-measures. There was also a statistically significant decrease in reported depression symptoms for the post-measures.

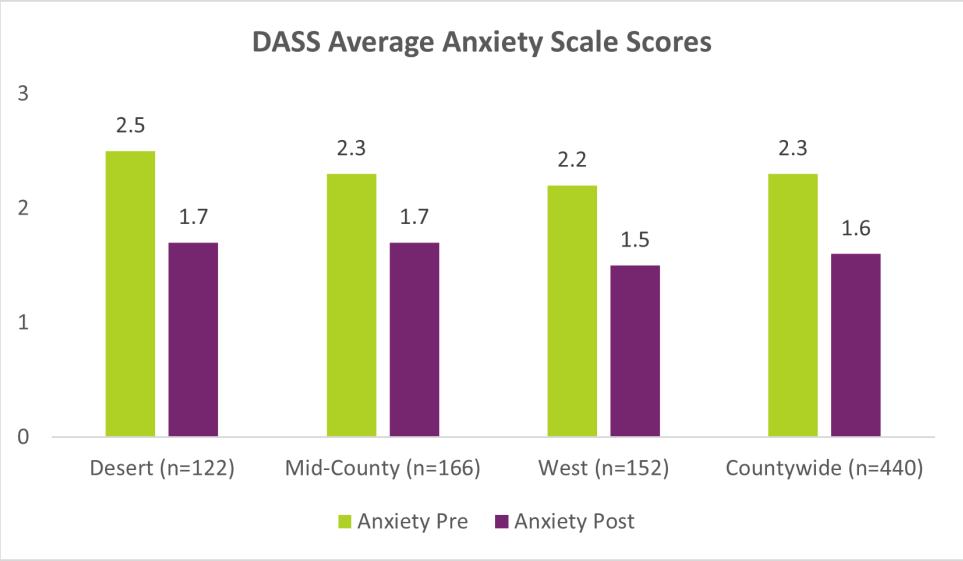


Desert (n=122)	Mid-County (n=166)	West (n=152)	Countywide (n=440)
t=2.95 df=121 p=0.004	t=4.30 df=165 p<0.001	t=3.82 df=151 p<0.001	t=6.37 df=439 p<0.001

Triple P
Depression, Anxiety, Stress Scale

Depression Anxiety and Stress Scale

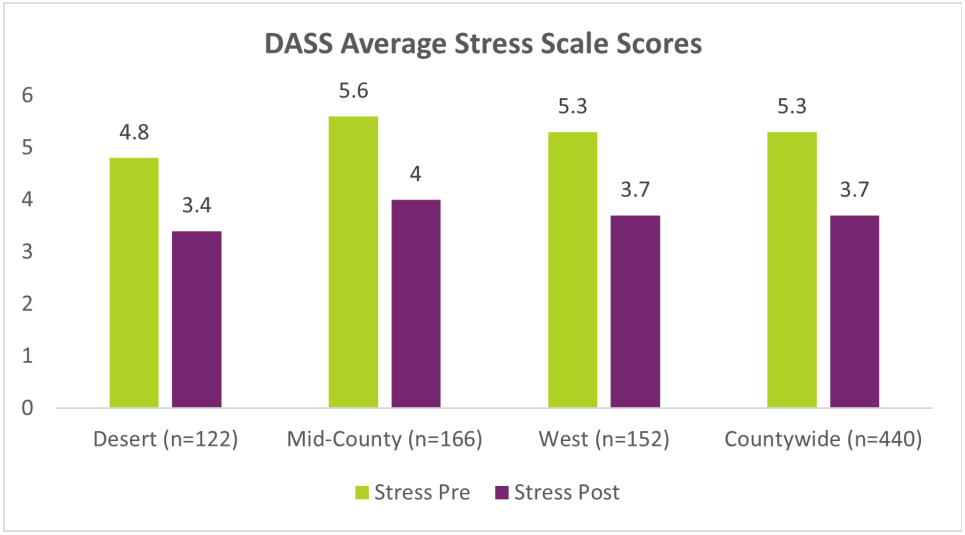
	Normal	Mild	Moderate	Severe	Extreme
Depression	0-4	5-6	7-10	11-13	14+
Anxiety	0-3	4-5	6-7	8-9	10+
Stress	0-7	8-9	10-12	13-16	17+



t=2.62 df=121 p=0.010 | t=3.58 df=165 p<0.001 | t=3.30 df=151 p=0.001 | t=5.42 df=439 p<0.001

All three regions in Riverside County scored in the normal range for the DASS anxiety subscale in the pre-measures. Additionally, there was a statistically significant decrease in the DASS average anxiety subscale for the post-measure.

All three regions in Riverside County scored in the normal range for the DASS stress subscale in the pre-measures. There was a statistically significant decrease in the DASS stress subscale scores for the post-measure.



t=3.17 df=121 p=0.002 | t=5.75 df=165 p<0.001 | t=5.26 df=151 p<0.001 | t=8.05 df=439 p<0.001

Triple P Satisfaction Survey

A total of 438 participants completed the satisfaction survey for the Triple P program. Overall, the majority of participants were highly satisfied with all aspects of the Triple P program including program logistics, quality of group leaders, and overall satisfaction of the program.

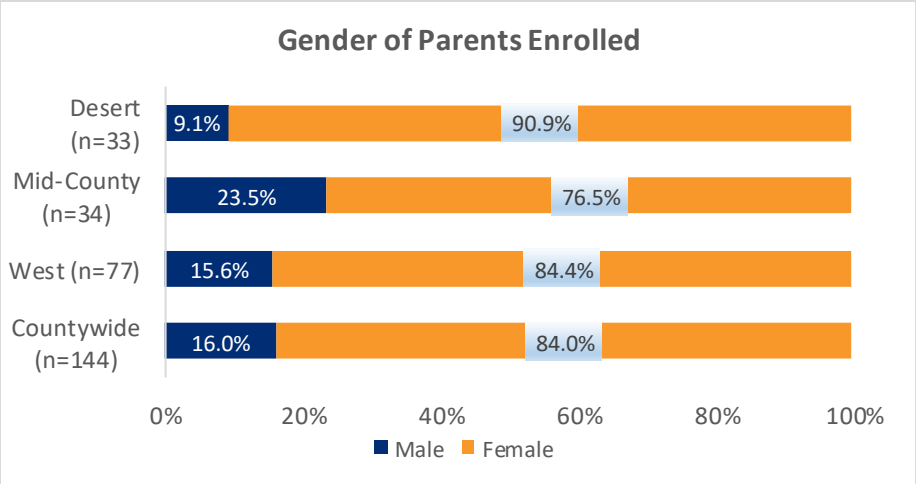
Triple P Countywide Satisfaction Survey Results (*N*=438)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.90	–	1 (0.2%)	5 (1.1%)	30 (6.8%)	402 (91.8%)
The location of the program was convenient for me and my family.	4.94	1 (0.2%)	2 (0.5%)	3 (0.7%)	9 (2.1%)	423 (96.6%)
The sessions were at a time convenient for me and my family.	4.85	1 (0.2%)	5 (1.1%)	11 (2.5%)	27 (6.2%)	394 (90.0%)
My family got the help we wanted for my child.	4.83	1 (0.2%)	6 (1.4%)	9 (2.1%)	35 (8.0%)	387 (88.4%)
Facilitators treated me with respect.	4.97	–	1 (0.2%)	2 (0.5%)	6 (1.4%)	429 (97.9%)
Facilitators spoke to me in a way that I understood.	4.97	–	–	2 (0.5%)	9 (2.1%)	427 (96.5%)
Facilitators are respectful of my cultural/ethnic background.	4.97	–	1 (0.2%)	3 (0.7%)	6 (1.4%)	428 (97.7%)
As a result of the program, I am satisfied with our family life right now.	4.80	2 (0.5%)	4 (0.9%)	12 (2.7%)	46 (10.5%)	374 (85.4%)
I felt comfortable talking about my child's problems with the staff.	4.91	2 (0.5%)	–	7 (1.6%)	17 (3.9%)	412 (94.1%)
The facilitators listened to what I had to say.	4.97	–	–	3 (0.7%)	7 (1.6%)	428 (97.7%)
The facilitators knew how to help me.	4.91	1 (0.2%)	–	8 (1.8%)	20 (4.6%)	409 (93.4%)

Triple P Satisfaction Survey

The following are comments provided by parents/caregivers from across all three regions of Riverside County about things that they learned, liked, and disliked from the Triple P program.

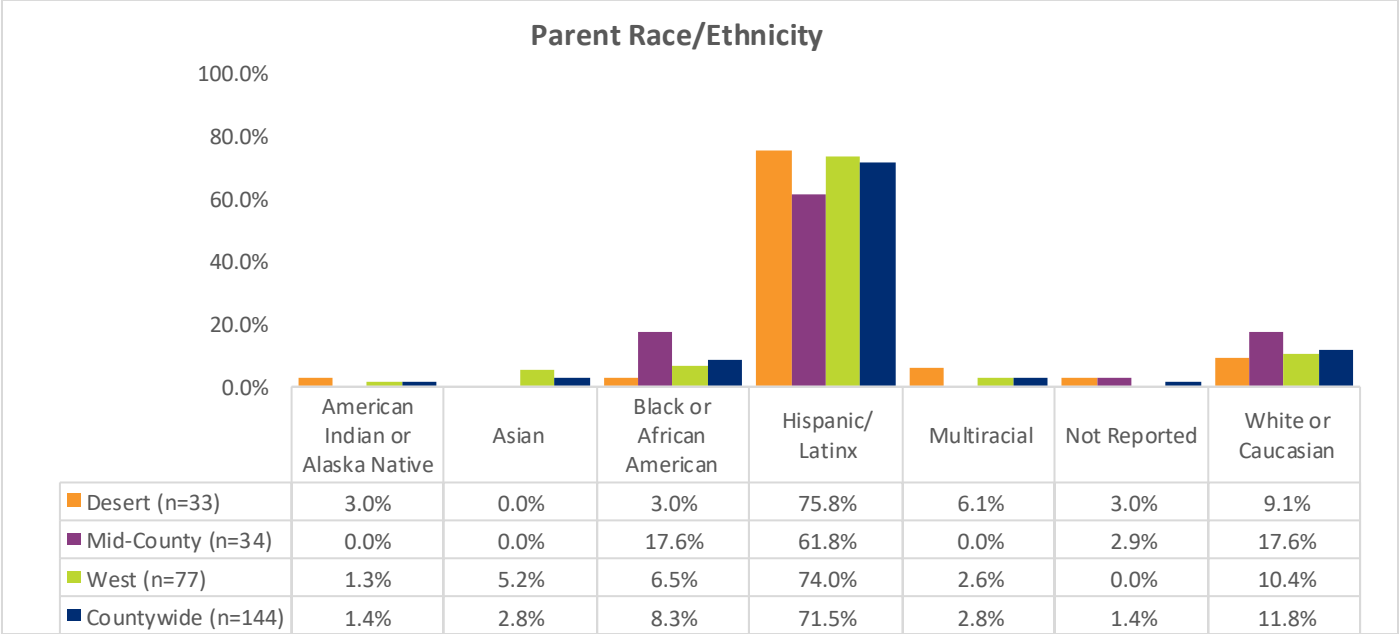
Common Things Learned……
"To praise! The power of praising is definitely a great way to be a positive parent & encourage the behavior tasks we want our children to follow."
"To see things differently with our children. And we should have more love and kindness to them because we don't know what they are going through."
"Be more assertive and to give less accidental rewards to my daughter."
"Better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
Common Things Liked…..
"I liked that everyone comes together, shares the struggles of parenting & also work together creatively to seek positive parenting strategies that help get through that rough patch/milestone."
"Meeting all of the parents in class. Sharing our experiences and helping each other through this process."
"It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
"I really enjoyed goal-setting, the videos, and the workbook. It was nice when other parents spoke with each other and offered advice, and it was great to see my husband do better because of this."
Common Things Disliked…..
"That it was only 8 wks. I would love to attend other workshops. I enjoyed learning about child development & ways to parent in a positive way."
"I wish there was more information about how to deal with siblings problems."
"I think we could have had better snacks and I would have preferred to do every session in person instead over the phone, maybe with our child present to see the behavior for feedback."
"The time constraint, it was right when I would get home from getting the kids and I had about 10 min before I had to hop on Zoom. I had to get up several time to attend to my child."

Teen Triple P Parent Enrollment and Demographics



Countywide the majority of parents/caregivers enrolled in Teen Triple P parenting were females (84%).

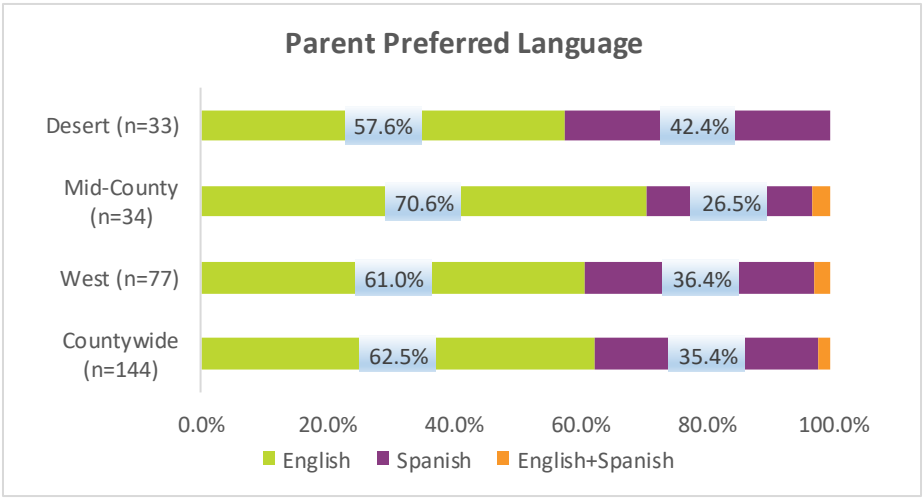
Countywide the majority of parents/caregivers served by Teen Triple P were Hispanic/Latinx (71.5%).



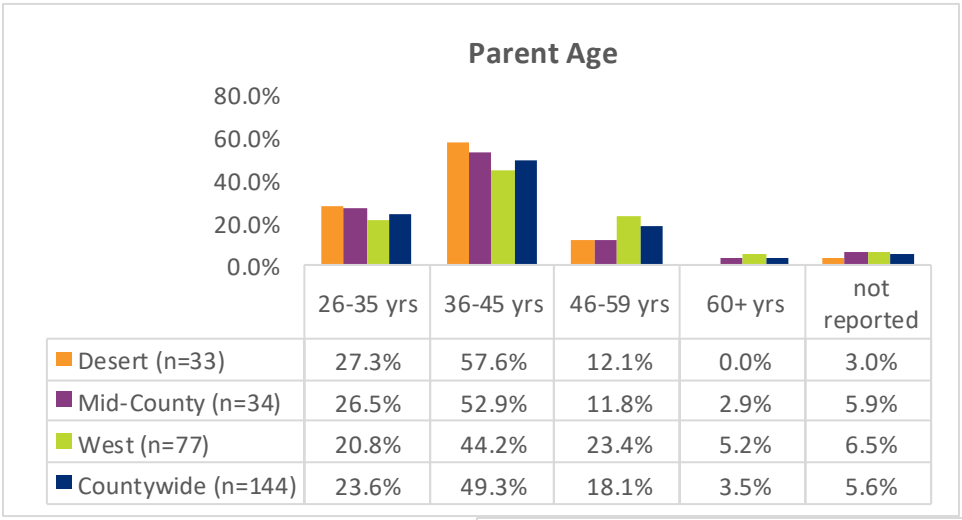
	American Indian or Alaska Native	Asian	Black or African American	Hispanic/ Latinx	Multiracial	Not Reported	White or Caucasian
Desert (n=33)	3.0%	0.0%	3.0%	75.8%	6.1%	3.0%	9.1%
Mid-County (n=34)	0.0%	0.0%	17.6%	61.8%	0.0%	2.9%	17.6%
West (n=77)	1.3%	5.2%	6.5%	74.0%	2.6%	0.0%	10.4%
Countywide (n=144)	1.4%	2.8%	8.3%	71.5%	2.8%	1.4%	11.8%

Countywide, a majority of the parents selected English as their preferred language (62.5%). Slightly over a third of parents preferred Spanish, and a small percentage of parents Countywide indicated they didn't have a preference between English or Spanish and they selected both (2.1%).

Parents were placed in classes conducted in their preferred language (English or Spanish).



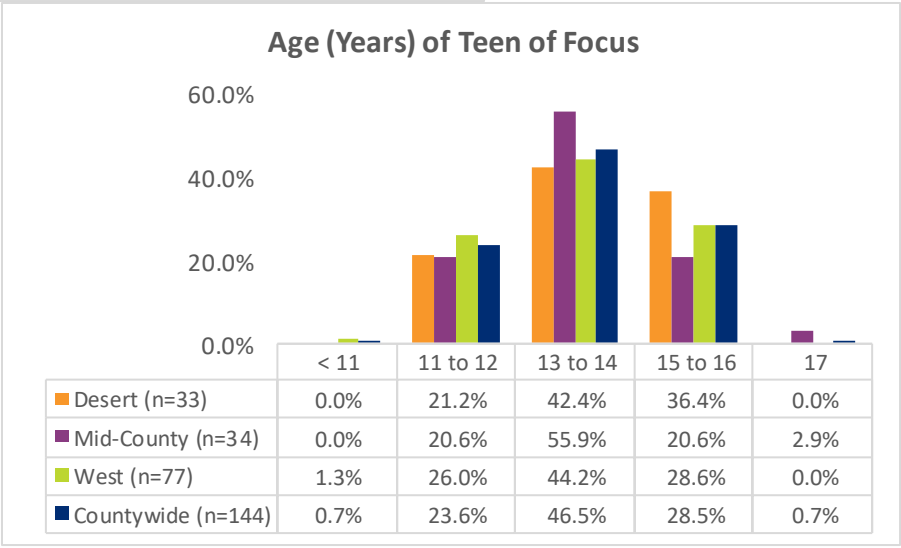
Teen Triple P
Parent and Teen Demographics



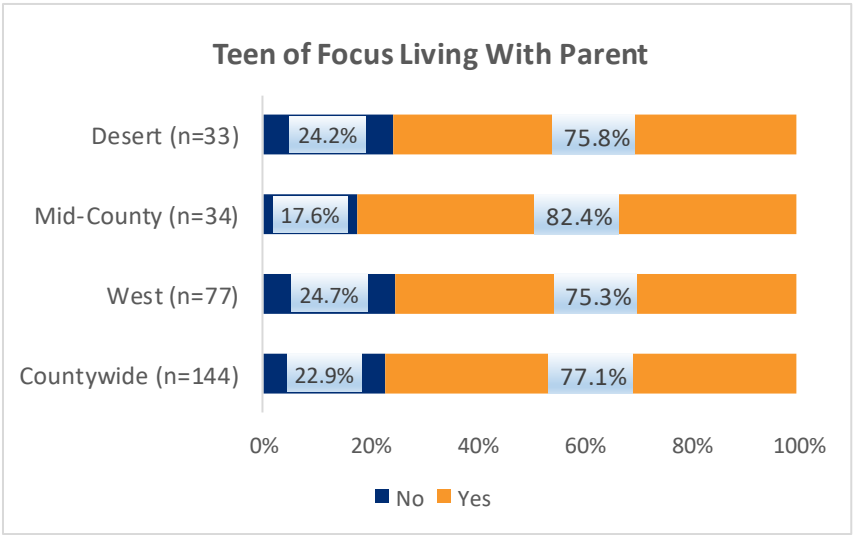
	26-35 yrs	36-45 yrs	46-59 yrs	60+ yrs	not reported
Desert (n=33)	27.3%	57.6%	12.1%	0.0%	3.0%
Mid-County (n=34)	26.5%	52.9%	11.8%	2.9%	5.9%
West (n=77)	20.8%	44.2%	23.4%	5.2%	6.5%
Countywide (n=144)	23.6%	49.3%	18.1%	3.5%	5.6%

Countywide, a majority of parents/caregivers were 36-45 years of age (49.3%). The average age was 41 years.

Parents/caregivers were asked to identify one of their teens who posed the most parenting challenges. This teen would be the primary focus in the program. Countywide, and across all regions the majority of the teens were between 13 to 14 years old (46.5%). The average age of the teen of focus was 13.5 years.



	< 11	11 to 12	13 to 14	15 to 16	17
Desert (n=33)	0.0%	21.2%	42.4%	36.4%	0.0%
Mid-County (n=34)	0.0%	20.6%	55.9%	20.6%	2.9%
West (n=77)	1.3%	26.0%	44.2%	28.6%	0.0%
Countywide (n=144)	0.7%	23.6%	46.5%	28.5%	0.7%



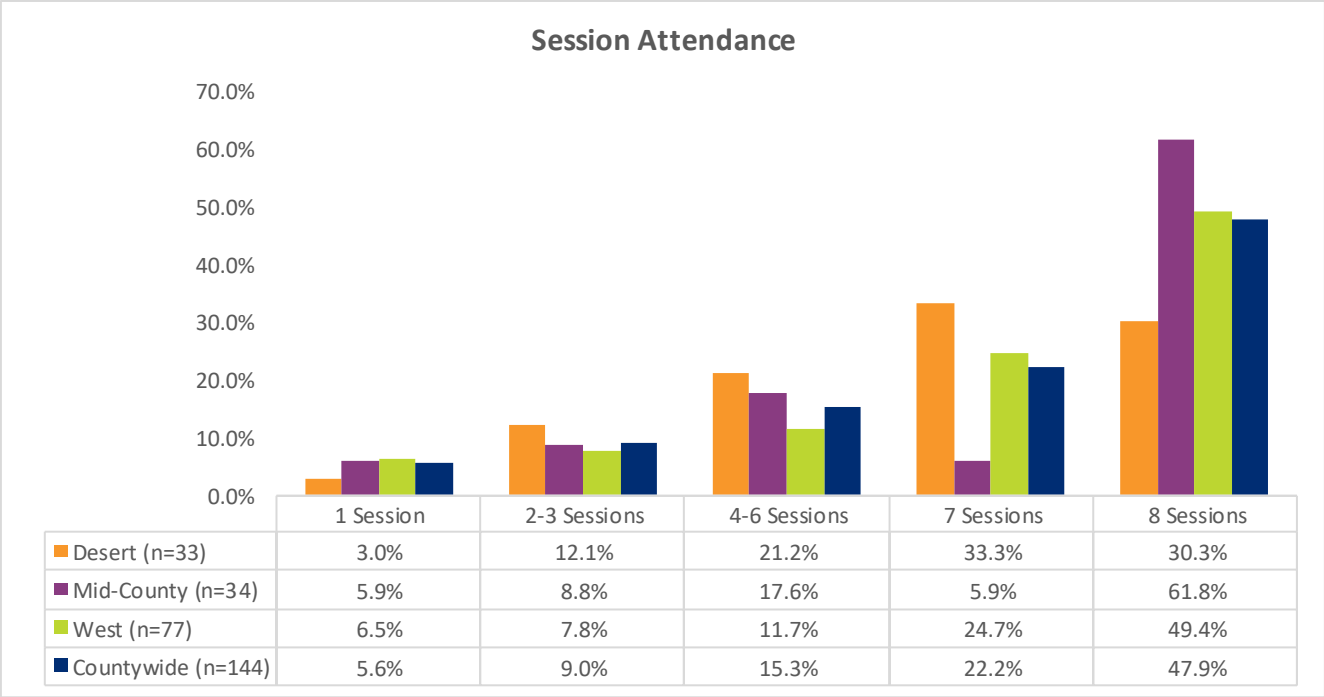
Countywide, 77.1% of parents served had their teen of focus living with them. Of the 33 parents who's teen was not living with them, about half (45.5%) of the parents were receiving services through DPSS (CPS or non-CPS related).

Impact on Other Children in the Household

- 88.2% of parents cared for a child under the age of 25 (not including the teen of focus)
- The parenting program had an impact on 434 kids under the age of 25 (including the teen of focus)

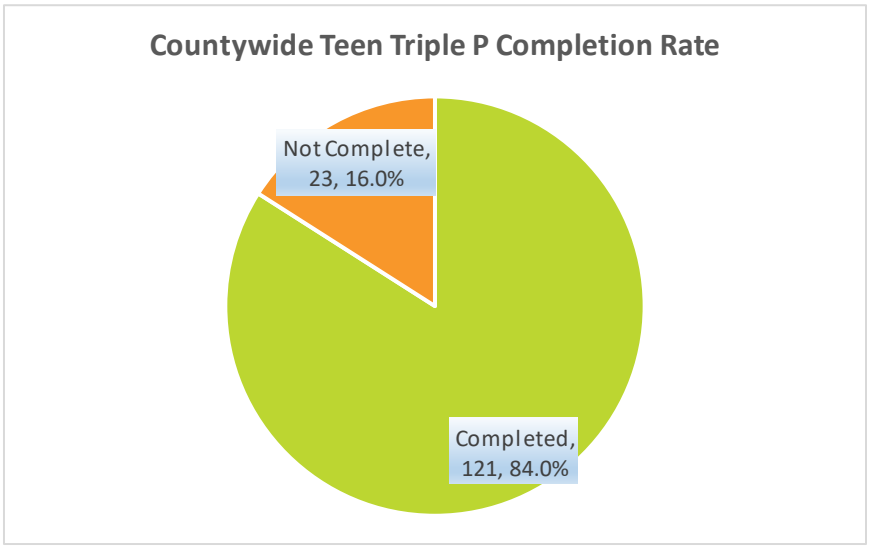
Teen Triple P Program Statistics

Countywide, session attendance showed that 84% of participants completed 6-8 Teen Triple P sessions, with 47.9% of participants attending all eight Teen Triple P sessions. Countywide, only 5.6% of the parents attended only one session.



	1 Session	2-3 Sessions	4-6 Sessions	7 Sessions	8 Sessions
Desert (n=33)	3.0%	12.1%	21.2%	33.3%	30.3%
Mid-County (n=34)	5.9%	8.8%	17.6%	5.9%	61.8%
West (n=77)	6.5%	7.8%	11.7%	24.7%	49.4%
Countywide (n=144)	5.6%	9.0%	15.3%	22.2%	47.9%

Countywide 84% of parents completed the program. Further detail on completion rate by region for the Teen Triple P program is shown on page 5 of the report.

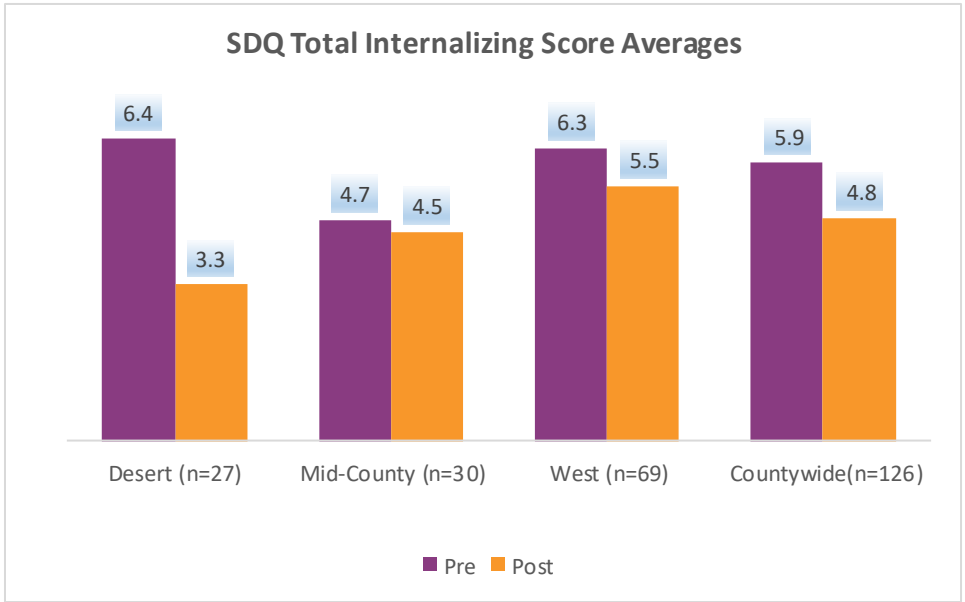


Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a behavioral screening questionnaire designed for children and adolescents aged 4-17 years. Each of the five scales of the SDQ (emotional, conduct, hyperactivity, peer problems, prosocial) are scored from 0-10. Four of these scales (emotional, conduct, hyperactivity and peer problems) create a **total difficulty score** (range 0-40). The emotional and peer items together create an **internalizing problems score** (range 0-20) and the conduct and hyperactivity questions together get an **externalizing score** (range 0-20). Normal, borderline, and abnormal scores are shown below.

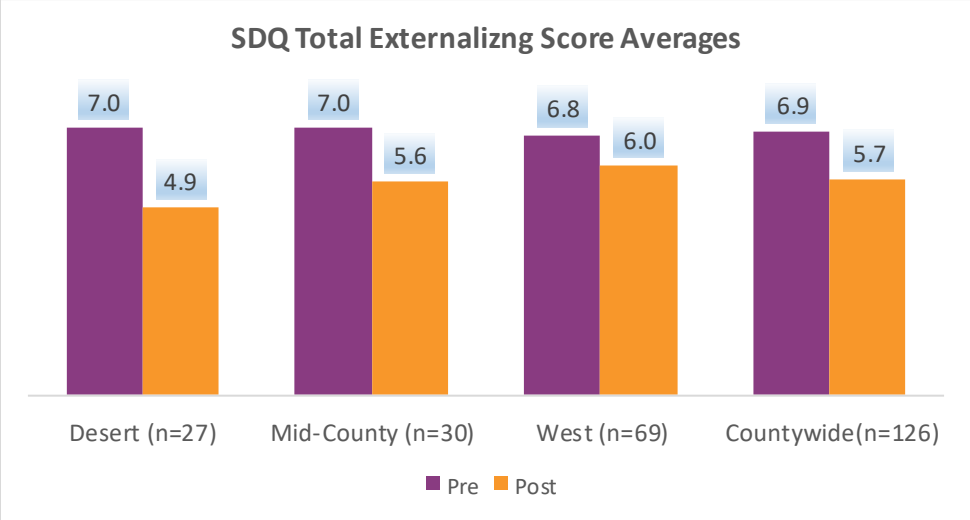
Scale	Normal	Borderline	Abnormal
Total Difficulty	**0-15**	**16-19**	**20-40**
Emotional Symptoms	**0-5**	**6**	**7-10**
Peer Problem	**0-3**	**4-5**	**6-10**
Conduct Problem	**0-3**	**4**	**5-10**
Hyperactivity	**0-5**	**6**	**7-10**
Prosocial	**6-10**	**5**	**0-4**

Key findings from the analysis of the pre-post SDQ data indicated a statistically significant decrease countywide in internalizing and externalizing problem scores, as well as in total difficulties ($p<0.001$). Data also showed a statistically significant improvement countywide in prosocial scores ($p<0.005$). Statistical significance by specific regions are shown in the accompanying tables.



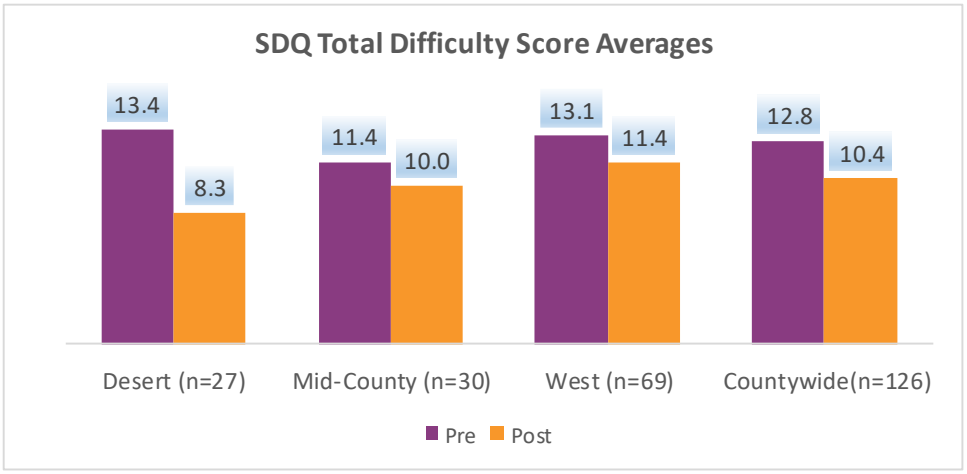
Desert	**Df**	**26**
	t-value	3.82
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	0.643
	p-value	0.526
West	**Df**	**68**
	t-value	1.86
	p-value	0.48
Countywide	**Df**	**126**
	t-value	**3.65**
	p-value	**<0.001**

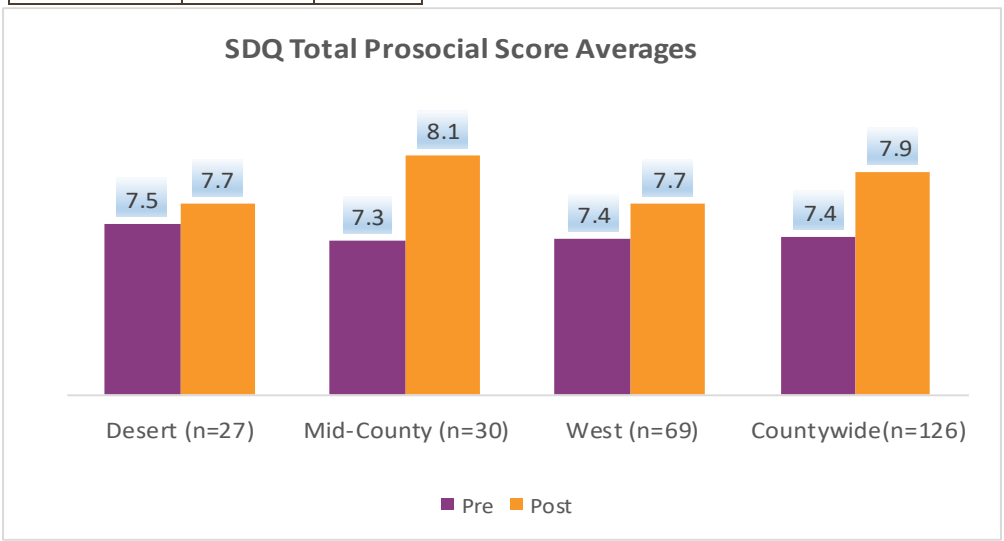
Strengths and Difficulties Questionnaire (SDQ)



Desert	Df	26
	t-value	3.23
	p-value	0.003
Mid-County	**Df**	**29**
	t-value	3.14
	p-value	0.004
West	**Df**	**68**
	t-value	1.94
	p-value	0.06
Countywide	**Df**	**126**
	t-value	**4.20**
	p-value	**<0.001**

Desert	Df	26
	t-value	3.91
	p-value	0.001
Mid-County	**Df**	**29**
	t-value	2.13
	p-value	0.04
West	**Df**	**68**
	t-value	2.34
	p-value	0.02
Countywide	**Df**	**126**
	t-value	**4.53**
	p-value	**<0.001**



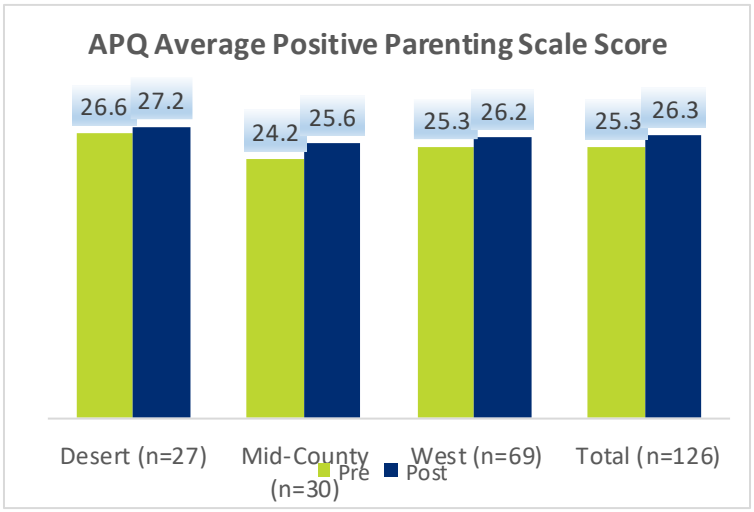


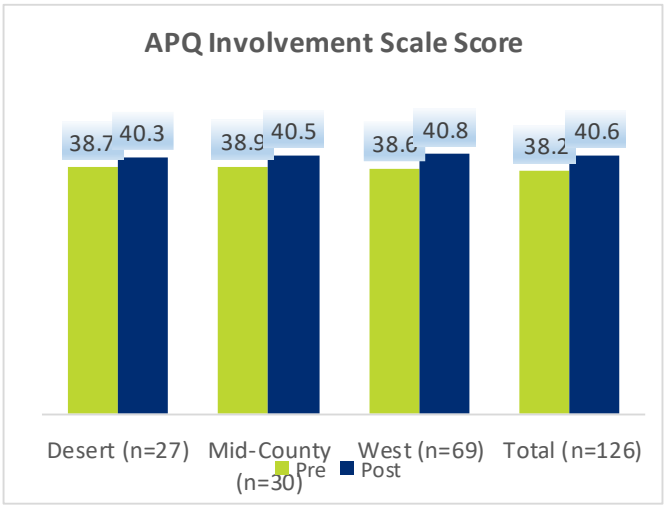
Desert	Df	26
	t-value	-2.89
	p-value	0.008
Mid-County	**Df**	**29**
	t-value	-2.06
	p-value	0.05
West	**Df**	**68**
	t-value	0.24
	p-value	0.27
Countywide	**Df**	**126**
	t-value	**-2.98**
	p-value	**0.004**

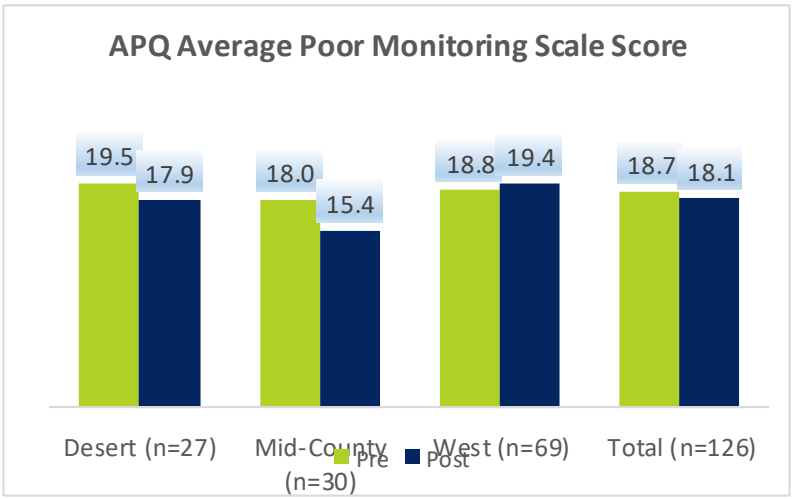
Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices and decreasing negative practices have been effective in reducing problem behaviors in children. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. It is a 42-item self-report measure filled out by parents assessing six parenting constructs. For the Teen Triple P program, only the involvement scale score (10 items), positive parenting scale score (6 items), and poor monitoring and supervision scale score (10 items) are used. The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale (1—never, 2—almost never, 3—sometimes, 4—often, 5—always).

Key findings from the analysis of the pre-post APQ data indicated a statistically significant increase ($p<0.05$) countywide in parental involvement and positive parenting, and a slight decrease (not statistically significant) countywide in poor monitoring.



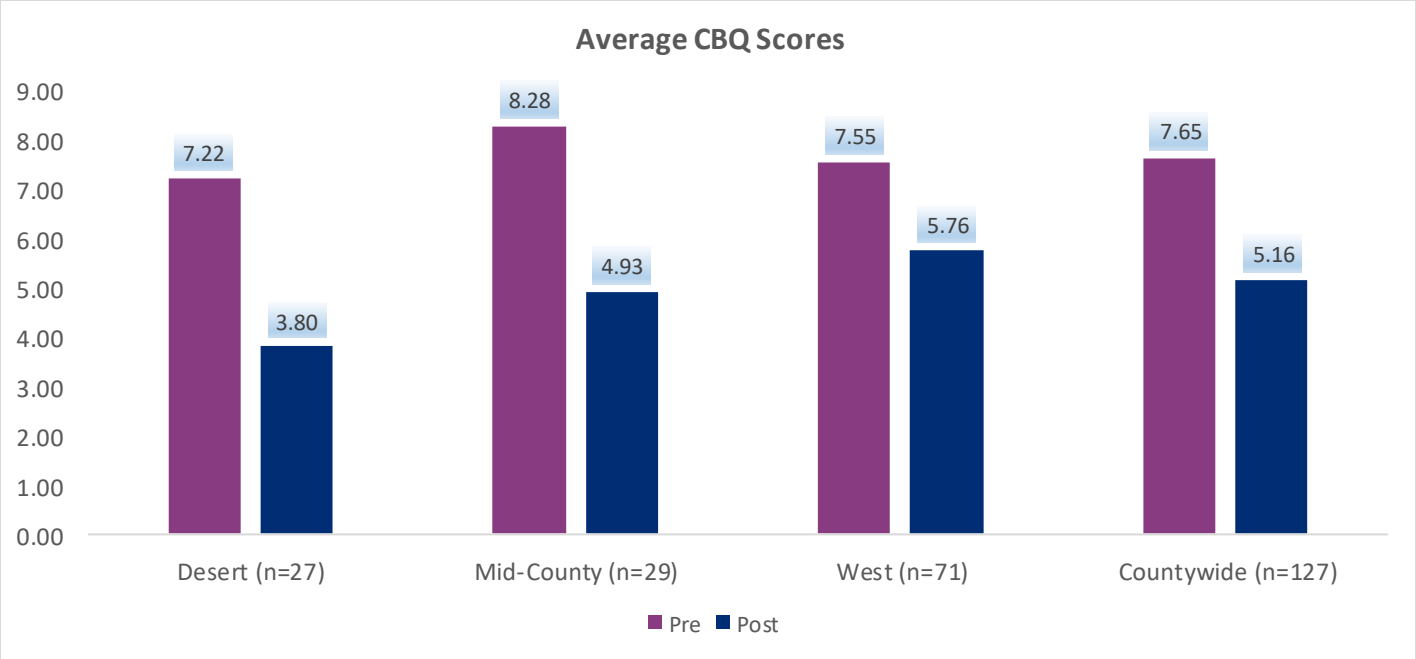




Scale	Region	T-Score	Df	P-Value
Involvement	Desert	-.751	26	0.460
	Mid-County	-3.58	29	0.001
	West	-2.63	68	0.011
	Countywide	**-3.51**	**126**	**<0.001**
Positive Parenting	Desert	-0.92	26	0.364
	Mid-County	-2.52	29	0.018
	West	-1.87	68	0.07
	Countywide	**-2.94**	**126**	**0.004**
Poor Monitoring	Desert	1.55	26	0.134
	Mid-County	1.89	29	0.068
	West	-0.75	68	0.453
	Countywide	1.03	126	0.307

Conflict Behavior Questionnaire

The Conflict Behavior Questionnaire (CBQ) is a 20 item questionnaire that uses a true false scale to assess general conflict between parents and their children. The responses are then scored (and some items reverse scored) to obtain a total score; 126 parents completed the CBQ.



Desert (n=27)	Mid-County (n=29)	West (n=71)	Countywide (n=127)
t=3.39 df=26 p=0.002	t=3.39 df=28 p=0.002	t=3.16 df=70 p=0.002	t= 5.59 df=126 p<0.001

Results showed a statistically significant decrease (improvement) across all regions and Countywide in the parent's rating of general discord between parent and teen youth.

Teen Triple P Satisfaction Survey

A total of 122 participants completed the satisfaction survey. Overall, the majority of participants were highly satisfied with all aspects of the Teen Triple P program including program logistics, quality of group leaders, and overall satisfaction.

Teen Triple P Countywide Satisfaction Survey Results (*N*=122)	Mean	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
Overall, I am satisfied with the program.	4.76	–	1 (0.8%)	2 (1.6%)	22 (18%)	97 (79.5%)
The location of the program was convenient for me and my family.	4.89	–	1 (0.8%)	1 (0.8%)	9 (7.4%)	111 (91.0%)
The sessions were at a time convenient for me and my family.	4.75	–	3 (2.5%)	4 (3.3%)	13 (10.7%)	102 (83.6%)
My family got the help we wanted for my teen.	4.71	–	3 (2.5%)	4 (3.3%)	18 (14.8%)	97 (79.5%)
Facilitators treated me with respect.	4.96	–	–	1 (0.8%)	3 (2.5%)	118 (96.7%)
Facilitators spoke to me in a way that I understood.	4.93	–	–	–	8 (6.6%)	114 (93.4%)
Facilitators are respectful of my cultural/ethnic background.	4.93	–	–	–	9 (7.4%)	113 (92.6%)
As a result of the program, I am satisfied with our family life right now.	4.68	–	3 (2.5%)	6 (4.9%)	18 (14.8%)	95 (77.9%)
I felt comfortable talking about my teen's problems with the staff.	4.82	–	–	4 (3.3%)	14 (11.5%)	104 (85.2%)
The facilitators listened to what I had to say.	4.89	–	–	–	13 (10.7%)	109 (89.3%)
The facilitators knew how to help me.	4.81	–	–	6 (4.9%)	11 (9.0%)	105 (86.1%)

Teen Triple P Satisfaction Survey

Across all sites, the following are comments provided by parents about things they learned, liked, and disliked.

Common Things Learned……
"That we are working as a team and that we can improve our relationship and communication with our child."
"Be more patient and listen to my daughter before making any comments that might make her feel bad."
"The behavior contract. How to validate my teens emotion & what to do; praising the good behavior."
"Maintain consistency in rules, listen more to my teenager without interrupting."
"To allow my teenager to calm down before talking to her. Make sure to praise her when she doing good."
Common Things Liked…..
"I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."
"It is very important for families to be able to guide our adolescents to be better people in their future."
"I got to hear from other parents and saw that I wasn't alone in my struggles. They also had good advice and techniques for me to try within my home."
"The convenience (zoom) was very helpful."
"What I liked is that the instructor was really nice & understanding."
Common Things Disliked…..
"The fact that my children are not with me at the moment, and only see them once a month so it's hard to apply what I learned."
"There wasn't anything I didn't like the program was very enjoyable and informative."
"The only thing was that you can't get too deep into each subject due to the time, 2 hrs."

PEI

Mobile Mental Health Clinics and Preschool 0-5 Program

Program Type: Prevention Program

The Preschool 0-5 Program is made up of multiple components including SET-4-School, Prevention and Early Intervention Mobile Services (PEIMS), and the Growing Healthy Minds Initiative. The program is operated using leveraged funds including Medi-Cal, MHSA/PEI, and First 5. All program components are implemented through relationships with selected school districts and community-based organization partners. Evidence based and evidence informed services are accessible at clinic sites, on mobile units out in the community, and at school sites across Riverside County. Services include a comprehensive continuum of early identification (screening), early intervention, and treatment services designed to promote social competence and decrease the development of disruptive behavior disorders among children 0 through 6 years of age. Services offered within the program are time-limited and include the following: Parent- Child Interaction Therapy (PCIT); Parent Child Interaction Therapy with Toddlers (PCIT- T); Trauma Focused Cognitive Behavioral Therapy (TF-CBT); Incredible Years (IY); Positive Parenting Program (Triple P); Nurturing Parenting; Education Equip and Support (EES); psychiatric consultation and medication evaluation; classroom support for early care providers and educators; community presentations; and participation in outreach events.

Growing Healthy Minds is the newest component of Preschool 0-5 Programs. The mission of the Growing Healthy Minds Initiative is to work in partnership with the community to increase opportunities for young children across Riverside County to develop skills and abilities that will prepare them for school and life.



The mobile units were in need of much repair and ongoing maintenance. The Department made the decision to downsize the mobile units to sprinter vans and with limited to no access available on school campuses during the COVID pandemic, it seemed a good time to make this transition. The new vans were delivered early in 2024, however, there were delays related to manufacturing issues that impacted their use within the community. We anticipate roll-out of the vans in March 2025.

The Preschool 0-5 Program under RUHS Prevention and Early Intervention (PEI) remains dedicated to raising awareness, providing education, and offering comprehensive mental health services to families, children, and the community. The program addresses social-emotional challenges, enhances school readiness, and, in the past year, has intensified efforts to support children impacted by trauma. Mental health services continue to make a significant impact, with most being provided at school sites to reduce stigma and improve accessibility. This is especially important while awaiting the operation of mobile vans for more outreach. Key outcomes for FY23/24 include:

Mental health services:

- A total of 11,408 mental health-related services were provided during this fiscal year, amounting to 9,276.2 service hours.
- 300 children (and their families) received PCIT/MH services in the West, Desert, and Mid-County regions.
- Case management and family therapy accounted for most services—38.7% and 31.7%, respectively.
- 16 children and 16 caregivers participated in the Incredible Years Program, which offers therapeutic groups for parents and children. This program focuses on addressing challenging behaviors, enhancing social skills, and promoting school-related expectations.

Parent's stress levels decreased

Treatment outcomes:

- Countywide, there was a statistically significant decrease in the frequency of child problem behaviors, as well as in caregivers' perceptions of their child's behavior as problematic.
- 88% of families reported a good or fair prognosis after attending PCIT.
- Pre- and post-PSI scores showed a statistically significant decrease in parent stress levels countywide.
- Parents reported feeling more confident in their parenting skills and their ability to discipline their children. They also felt their relationship with their child and their child's behavior improved.
- 57.4% of families met all or some of the goals set by the family and the therapist.

Parents relationship with child improved

Outreach:

- Four outreach events—including a mental health fair, a back-to-school event, and a school administration orientation—engaged 52 parents, teachers, and community providers.
- 23 parent consultations provided awareness and education to caregivers seeking guidance on managing behavioral concerns and enhancing their child's social skills, with tip sheets and handouts for additional support.

Behavior problems decreased

Implementation Challenges:

During FY23/24, the Preschool 0-5 Program (PEI) experienced increased collaboration with school districts, with many becoming more receptive to services. While previous barriers, such as the pandemic and concerns about school violence, have posed challenges, the program has made

significant progress. The number of children served rose from 101 in FY22/23 to 300 in FY23/24, a 197% increase. However, some school districts continue to face challenges aligning educational and behavioral health priorities and policies. The program is actively addressing these challenges to ensure consistent support for children and families. Key issues include:

- Ensuring students requiring assistance are correctly recognized, referred to, and connected to the necessary services.
- Guaranteeing students in need of mental health services can be excused from class without repercussions.
- Securing access to school campuses, providing designated parking spaces for mobile therapy units (up to 6 feet and a half in length), and ensuring accessible restroom and breakroom facilities.
- Maintaining HIPAA privacy for students receiving services.
- Streamlining the process for initiating behavioral services, including parenting groups, within schools and the community.

Enhancing teacher awareness and improving understanding of social-emotional and early intervention treatments.

Additionally, reduced visibility on school campuses, challenges in community outreach, and travel to remote locations have impacted the number of services provided. However, this is expected to improve in 2025 with the arrival of mobile units and the planned rollout of services.

Another challenge influencing the program's impact was the shift in staffing preferences. In 2024, Riverside County administration made changes to enhance salaries, differential pay, and benefits, making in-person roles more competitive than remote work options. As a result, three of four vacancies have been filled, with the onboarding of a fourth clinician scheduled for 2025.

The Preschool 0-5 Program (PEI) has learned the critical importance of sustaining strong connections and maintaining constant communication with school districts to address administrative changes that may hinder success. These include:

- Evolving school staff awareness or the need for reorientation regarding services and the referral process.
- Coordinating our presence at school events, such as back-to-school nights or staff development meetings, to maintain awareness and support, whether in person or virtually.
- Maintaining awareness of Memoranda of Understanding (MOUs) between RUHS-BH and partner school districts and ensuring continued service provision and health screenings in the absence of mobile units.
- Coordinating arrangements regarding staff access to campus restrooms and breakrooms, especially with the reduction in mobile space now utilizing sprinter vans.

- Balancing school safety protocols due to increasing societal concerns while navigating classroom consultations, observations, and services for children.
- Staying informed about safety protocols from both RUHS-BH and school districts to ensure the well-being of children, families, and staff.

Despite facing challenges such as limited collaboration with certain school districts, staffing shortages, and the continued absence of mobile clinics, the PEI team has demonstrated resilience and adaptability in delivering critical services. To address geographical barriers, three school sites were strategically utilized, increasing accessibility for families across the region. The use of telehealth also played a key role in accessibility for those families in isolated areas. Additionally, the program has successfully secured partnerships with six school districts, ensuring continuity of services and collaboration. Strong administrative support has been instrumental in addressing staffing shortages, prioritizing hiring efforts, and implementing improvements to strengthen the program's capacity. These actions have enabled the program to maintain its commitment to serving the community, despite ongoing challenges.

A family testimonial below highlights how these efforts make a meaningful impact on the lives of families, showcasing the true purpose of our work at Preschool 0-5 (PEI). Please note that the family providing the testimonial has authorized us to share their story.

I just wanted to take the time to tell you how appreciative I am of not only this program, but the individuals tasked with facilitating it. I began my journey with Ms. Jamie, and shortly after transitioned to Ms. Kaira and Ms. Rocio. I cannot recommend or speak more highly of these individuals or this program. They have accommodated my schedule, when sick or training has come up have rescheduled me with ease or done a check in to ensure the week was smooth. Provided multiple resources and ideas to implement at home. When weeks were more challenging than others offered words of reassurance and encouragement. Throughout this whole process I can say I was excited to come, to show my skills as well as mine and my daughters' improvements. Our relationship, while not perfect (though can it really ever be?) has improved significantly. We are bummed to have completed but have both come out stronger more confident individuals and I have no one but these women and your program to thank. I can take my daughter to places without having to worry about outbursts or feel embarrassed and it is thanks to these skills and the consistency. I'm sure you know how positively impactful your program is, but I wanted to give thanks the only way I know how. Your program is one I will continue to recommend to anyone and everyone who is experiencing similar challenges to those I had once experienced. I cannot say it enough but thank you so much to Kaira and Rocio for the support, continued support, words of encouragement and especially the support during those challenging sessions. I will forever be grateful to all of you, and I know my little one is just as grateful. With many thanks.

Preschool 0-5 Programs

Prevention and Early Intervention

Mobile Services

Fiscal Year 2023-2024

Program Overview

The RUHS-BH Prevention and Early Intervention (PEI) preschool 0-5 programs, which includes the Mobile Services has overall goals of:

- Helping reduce young children's challenging behaviors, while increasing emotional control; promoting social competence
- Reducing stigma associated with receiving mental health services
- Reducing or eliminating geographical isolation and transportation barriers to services
- Connecting with families with children than might not otherwise qualify for mental health services
- Offering young children the opportunity to develop skills and abilities that will prepare the for school and life

The Preschool 0-5 Clinic offers mental health services which include PCIT, an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the ear through which the therapist provides in the moment coaching skills. The clinic also offers parenting groups and child prosocial skills groups.

The clinic also harbors three sprinter vans which are used for providing services at the client's home, school sites, or anywhere that is needed in identified underserved areas as defined by the Prevention and Early Intervention plan. The vans are built with the capacity to hold PCIT sessions, child prosocial sessions and more. For FY 23-24 the vans were not in use as the program was working out the logistics and administrative tasks associated with deploying the vans. Details on the activities of staff dedicated to the mobile unit are discussed further in this report.

Data Collection and Outcome Evaluation for FY 23-24

- Mental Health service enrollment and utilization provided is recorded in the RUHS-BH electronic health record for those children that require clinical mental health services.
- A PCIT enrollment form within the Electronic Medical Health Record captures the progress of PCIT for those receiving that service.
- Data for PCIT and other mental health services is evaluated by examining changes in children's behavior and parents stress as it relates to their parental role. Outcome measures include:

    1. The **Eyberg Child Behavior Inventory (ECBI)** is a 36 item parent report scale that measures the frequency of a child's disruptive behavior and if that behavior is a problem for the parent. Measures are collected pre, post, and sometimes mid treatment. The pre and post measures are used for analysis.
    2. The **Parental Stress Index Short Form (PSI-4-SF)** is a self report 36 item questionnaire that assesses the level of stress experienced by parents as a function of their role as a parent and as a function of their child's behavior. The measure is completed pre and post treatment.
    3. The **Therapy Attitude Inventory (TAI)** is a fifteen question satisfaction survey for the parent/primary caregiver to complete at the conclusion of services.

Data Collection and Outcome Evaluation *Continued*

Parent Consultations (PEI Mobile Services RUs Only)

A parent may be on the phone, or walk in to the mobile unit, request information on a concern for their child and/or information on specific parenting skills. Demographic data, as well as data on the details of the consultation (services, referrals) are tracked using a one page parent consultation form.

Provider Consultations (PEI Mobile Services RUs Only)

Provider consultations are also a part of the mobile unit's service and is primarily done at school sites for school personnel. The provider consultation may take the form of general or clinical classroom consultations with optional classroom observation. Details of the consultation was recorded on a provider consultation form, and any referrals made for children during the process were tracked. No provider consultations were recorded for FY 23-24.

Outreach Events (*PEI Mobile Services RUs Only*)

Details of any community outreach events at which the sprinter vans are present are recorded on a one page outreach activities form which gives details of the event type as well as the audience.

Key Findings

MH Services and PCIT

- A total of 300 children (families) received PCIT/MH services in the West, Desert, and Mid-County Regions.
- A total of 11,408 mental health related services totaling to 9,276.2 service hours
- Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively.

MH Services/PCIT Demographics

- Countywide, two thirds of the participants were male (66.3%).
- Countywide, a majority of participants served were Hispanic/Latinx (44%).
- A majority of children served were 4 years of age (32.7%).

PCIT Specific Outcomes

- 203 families were enrolled in PCIT (or Toddler PCIT or Trauma Directed Interaction).
- Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment.
- A majority of children served were 4 years of age (32.7%).
- 88% of families had a good or fair prognosis after attending PCIT.
- 57.4% of families met all or some of the goals set by the family and the therapist.

MH Services/PCIT Outcomes

- Countywide there was a statistically significant decrease in the frequency of child problem behaviors and in the extent to which caregivers perceived their child's behavior to be a problem.
- Pre and Post PSI scores showed a statistically significant decrease countywide in parent's stress levels.
- Overall parents felt more confident in their parenting skills and ability to discipline their child. Parents felt their relationship with their child and their child's behavior improved.
- A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children.
- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received.

PEI Mobile Services Parent Consultations

- In the 23-24 fiscal year, 23 parent consultations served 22 parents.
- Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.
- Tantrums and child not listening to parent were the two frequently discussed concerns during parent consultations.
- Parent tip sheets and referral to child pro-social groups constituted a majority of the referrals.

PEI Mobile Services Outreach Events

- PEI Mobile Services recorded a total of 4 outreach events provided to 52 people

Preschool 0-5 Programs
All MH Services Data

Administrative Data and Billing

There were a total of **300 families** served by the Pre-School 0-5 clinic which includes the clinic as well as PEI Mobile Services). A total of **11,408 PCIT/MH services** were provided. For administrative purposes this section analyses the number of families (participants) served by each RU in FY 23-24.

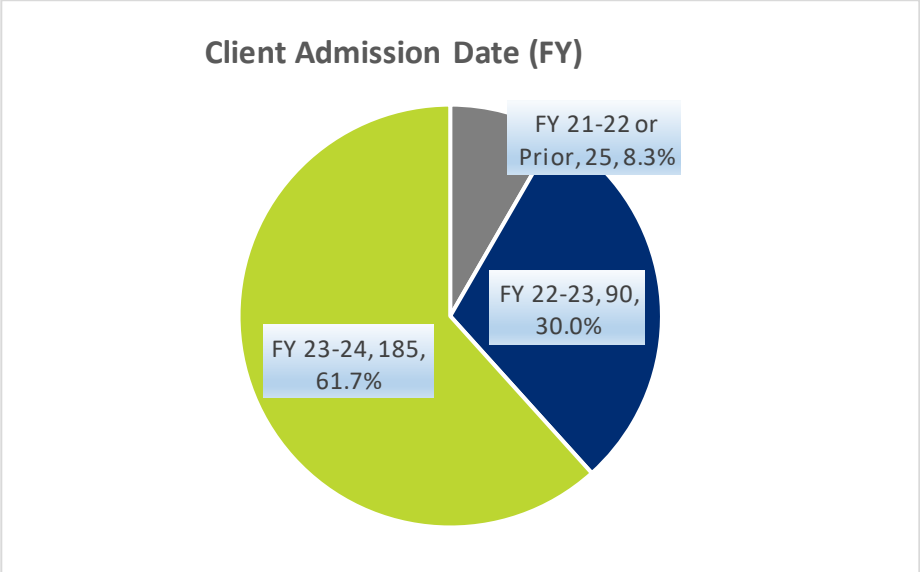
As shown in the table below, a majority of participants served were billed under 33ET01 RU. A total of 5,972 services were billed. Service details are provided in a different section of this report.

For services billed under the PEI Mobile Services RUs (33ETPC, 33HUPC, 33G8PC), services were given to families who resided in the underserved areas of Riverside as defined by the PEI plan. Staff who billed these RUs provided services at the client's home, the closest school site where Preschool 0-5 has a location, or at the nearest outlining clinic. Services for families who were non-Medi-Cal or IEHP were also captured with the PEI Mobile Services RUs.

Given that the team was short staffed, all staff helped with all RUs, and were billing all four RUs based on the population they were serving.

RU	Program Name	# of Participants Served	# of Services
33ET01	Preschool 0-5 Clinic Services	175 (58.3%)	5,972 (52.3%)
33ETPC	PEI Mobile Services-West	67 (22.3%)	3,257 (28.6%)
33HUPC	PEI Mobile Services-Mid-County	43 (14.3%)	1,598 (14%)
33G8PC	PEI Mobile Services-Desert	15 (5%)	581 (5.1%)

Client Admission Date

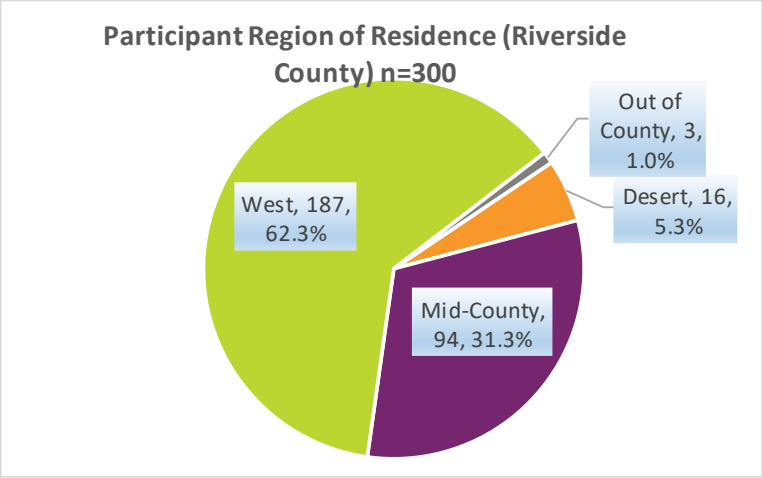


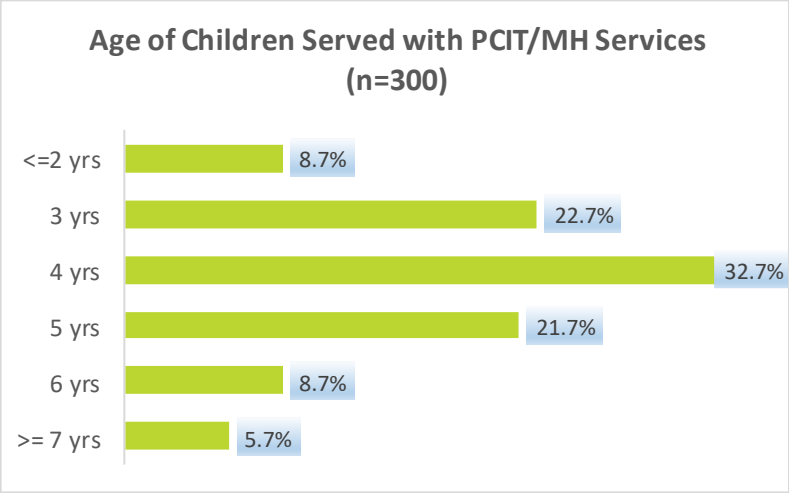
Of the 300 families served, 62% were new in the 23-24 FY. 30% were carry overs from 22-23 FY and 8.3% were open to the program 21-22 FY or prior.

Preschool 0-5 Programs
All MH Services Data

Participant Demographics

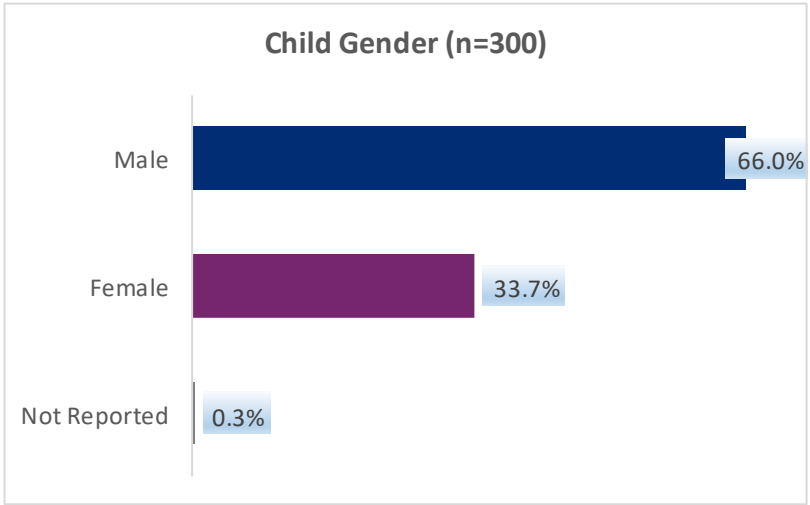
Of the clients served with mental health services, a majority resided in the Western region of Riverside County (62.3%), as determined by their reported residential zip code.



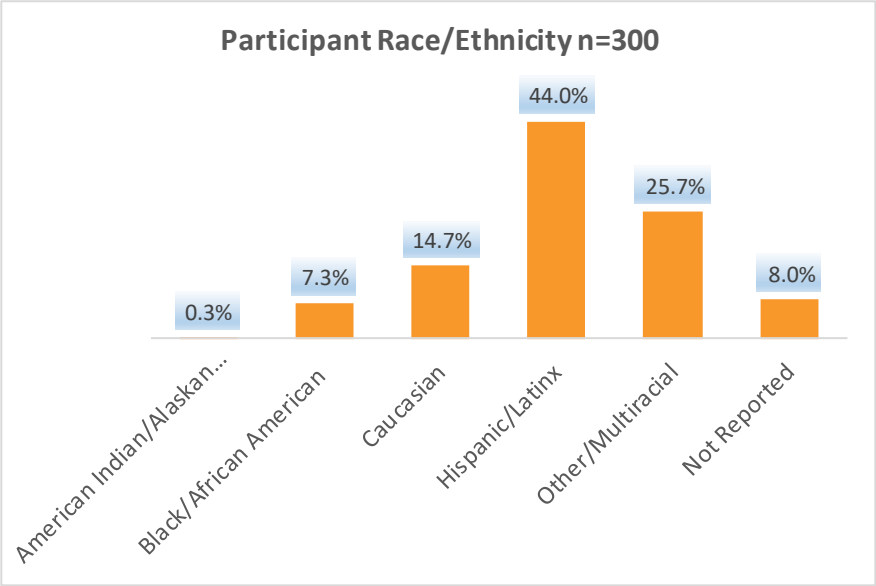


A majority of children served were 4 years of age (32.7%). The age of the oldest children served was 13 years. These children were primarily receiving Trauma Focused CBT Therapy. Children who were under two years of age were primarily receiving toddler PCIT services.

Two-thirds of the children served with mental health /PCIT services were male.

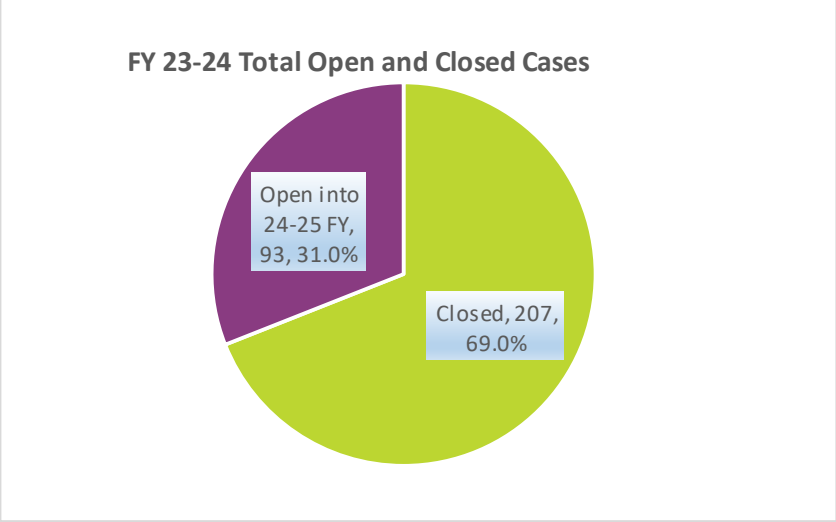


Preschool 0-5 Programs
All MH Services Data



Countywide, a majority of participants served were Hispanic/Latinx (44%).

Participant Program Completion Data



In the 23-24 FY, 69% of the clients closed to the program. 31% will continue to receive services into the 24-25 FY.

The table below summarizes the reason for close for the 207 clients who closed to the program.

As shown on the table to the right, 30 percent of the reasons for close included completed (further tx. or no further tx. recommended), Mutual agreement (goals reached or partially reached) and transfer to another provider.

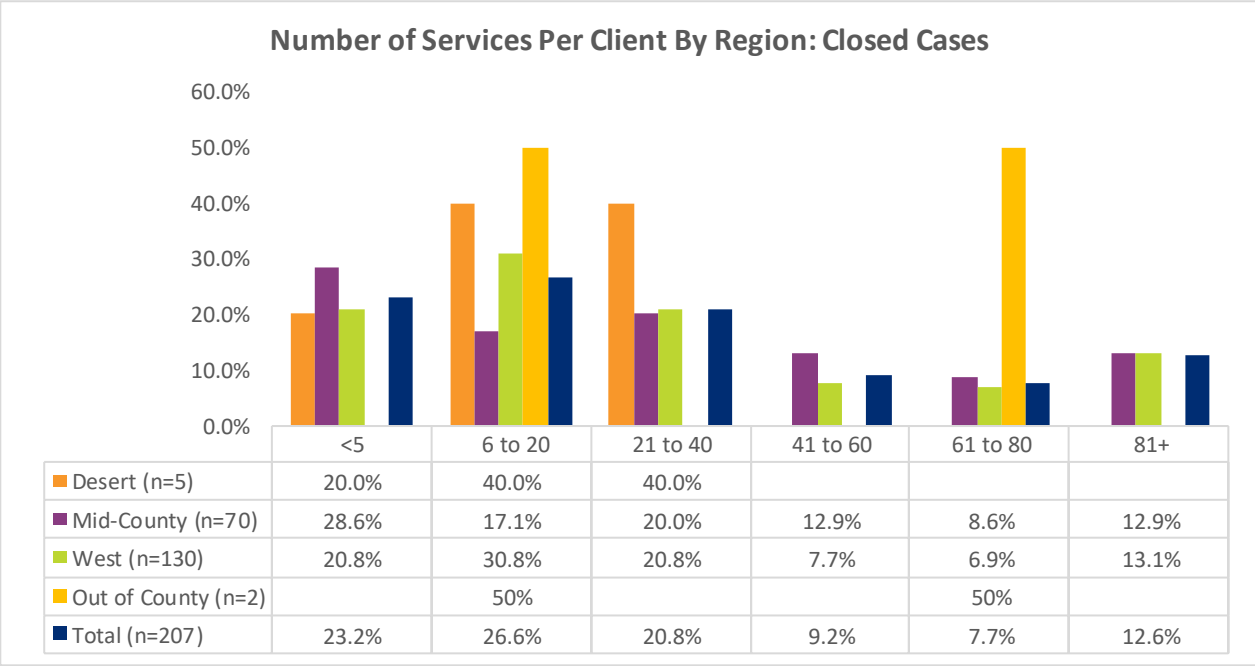
Close Reason	#, %
Client Withdrew	45 (21.7%)
Closed/No Show/No Contact	68 (32.9%)
Completed-No Further Tx Recommended	**23 (11.1%)**
Completed-Referred for Further Tx	**4 (1.9%)**
Did Not Need Service	5 (2.4%)
Moved Out of Area	5 (2.4%)
Mutual Agreement/Goals Not Reached	11 (5.3%)
Mutual Agreement/Goals Reached	**26 (12.6%)**
Mutual Agreement/Partial Completion	**8 (3.9%)**
Transfer to Another Provider	**3 (1.4%)**
Other/Reason Not Available	9 (4.4%)

Preschool 0-5 Programs
All MH Services Data

A total of 11,408 mental health related services totaling to 9,276.2 service hours were provided to 300 clients and their families in FY 23-24. Case management services as well as family therapy with client accounted for the majority of services—38.7% and 31.7%, respectively. Note, if an activity required two therapists and they each billed for the hours, that was counted as two services and the hours billed were also counted for each therapist.

Service	Count of Service	% of Svcs.	Service Hours	Clients Receiving Service
Assessment	283	2.5%	505	156
Case Management Brokerage	**4411**	**38.7%**	**2,017.8**	**278**
Case Management Family	195	1.7%	96.3	89
Family/Non Family Collateral	1	0.01%	1	2
Family Therapy With Client	**3620**	**31.7%**	**4180.7**	**223**
Group MH Service	177	1.6%	279.8	16
Individual Therapy	172	1.5%	178.5	32
Intensive Care Coordination	7	0.1%	1.9	7
Intensive Care Coordination Review	8	0.1%	6.7	7
Intensive Care Coordination with Family	63	0.6%	52.8	18
Intensive Care Coordination Without Family	258	2.3%	130.0	29
Medication Services	28	0.2%	15.3	6
Mental Health Service	1937	17.0%	1592.0	234
Non Family Collateral	1	0.0%	0.3	1
Peer Mental Health Engagement/Activity	247	2.2%	218.1	33
Total	**11,408**	**100%**	**9276.2**	

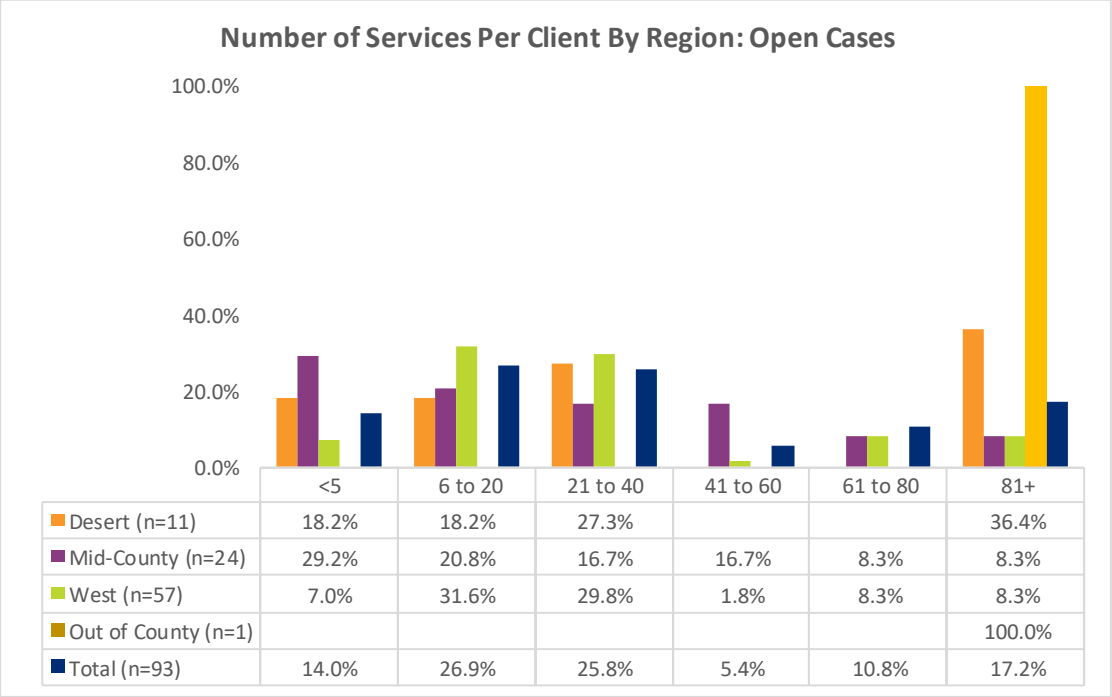
Service data for the 207 children who completed or were discharged from the program showed a total of 7,460 PCIT services in FY 23-24. Countywide, 23.2% of clients had 5 or fewer services, 26.6% received 6 to 20 services, 20.8% received 21-40 services, 9.2% received 41 to 60 services, 7.7% received 61 to 80 services and 12.6% received 61 or more services. The regions indicated on the graph correspond to the participant's region of residence.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=5)	20.0%	40.0%	40.0%			
Mid-County (n=70)	28.6%	17.1%	20.0%	12.9%	8.6%	12.9%
West (n=130)	20.8%	30.8%	20.8%	7.7%	6.9%	13.1%
Out of County (n=2)		50%			50%	
Total (n=207)	23.2%	26.6%	20.8%	9.2%	7.7%	12.6%

Preschool 0-5 Programs
All MH Services Data

The graph below shows the number of services provided in the 23-24 FY for the 93 children who are still continuing the program into the 24-25 FY. In total there were 3,948 services provided to these clients. A majority of these children have received 6 to 20 services (26.9%) or 21 to 40 services (25.8%). There were children who received less than 5 services, but these were newer clients served towards the end of the fiscal year and who are continuing into the new fiscal year.



	<5	6 to 20	21 to 40	41 to 60	61 to 80	81+
Desert (n=11)	18.2%	18.2%	27.3%			36.4%
Mid-County (n=24)	29.2%	20.8%	16.7%	16.7%	8.3%	8.3%
West (n=57)	7.0%	31.6%	29.8%	1.8%	8.3%	8.3%
Out of County (n=1)						100.0%
Total (n=93)	14.0%	26.9%	25.8%	5.4%	10.8%	17.2%

Preschool 0-5 Programs
PCIT Service Data

This section takes a closer look at the PCIT (and related) services, primarily using data collected from ELMR's PCIT Enrollment Form. For reference:

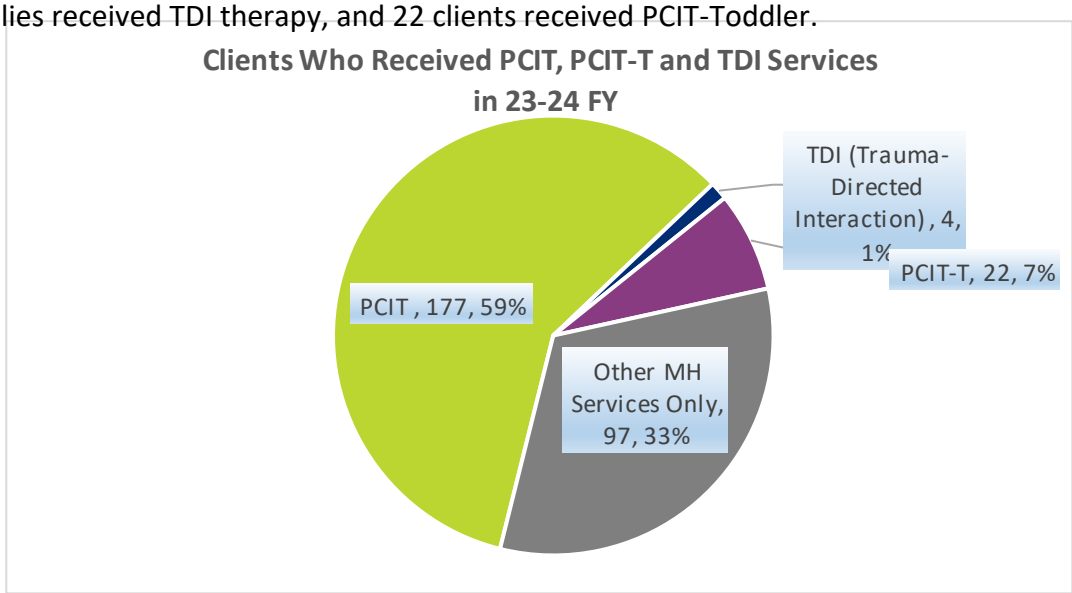
- PCIT is an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. the caregiver wears a device in the hear through which the therapist provides in the moment coaching skills. The treatment consists of two phases—the child directed phase (CDI) and the parent directed phase (PDI). The CDI Phase encourages warm, secure caregiver-child relationships. The PDI increases child compliance and decreases child disruptive behaviors.

- Trauma Directed Interaction, or TDI is an adaptation of PCIT therapy for families with a history of trauma. TDI maintains the key elements and theoretical aspects of PCIT and adds sessions to cover psychoeducation about trauma, coping skills to aid child and caregiver of trauma reactions, and caregiver responses to child trauma reactions.

- PCIT toddlers, or PCIT-T is an early intervention program that involves coaching parents while they interact with their 12-24 month old children. Goals include decreasing problematic behaviors, improve attachment, increase children's language and encourage toddlers to follow directions. It also addresses parent stress (anxiety, dissatisfaction, difficulty coping, lack of confidence).

Preschool 0-5 Programs
PCIT Service Data

Of the 300 families receiving mental health services from the Preschool 0-5 programs, **a total of 203 families (67.6%) received PCIT (or related models of PCIT) services.** The graph below shows the distribution of clients receiving each type of service. 177 families received PCIT, 4 families received TDI therapy, and 22 clients received PCIT-Toddler.



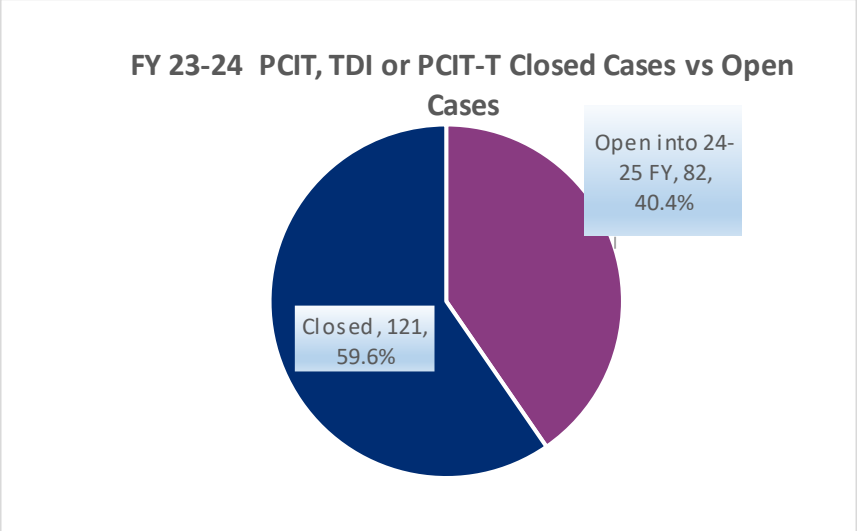
PCIT, TDI or PCIT-T Enrollment By Program (Out of a Total of 203 Clients)

A majority of participants served with PCIT, TDI, or PCIT-T were served by the Preschool 0-5 Clinic, followed by staff using the Western PEI Mobile Services RU.

RU	Program Name	# of Participants
33ET01	Preschool 0-5 Clinic Services	111 (54.7%)
33ETPC	PEI Mobile Services-West	50 (24.6%)
33HUPC	PEI Mobile Services-Mid-County	9 (4.4%)
33G8PC	PEI Mobile Services-Desert	33 (16.3%)

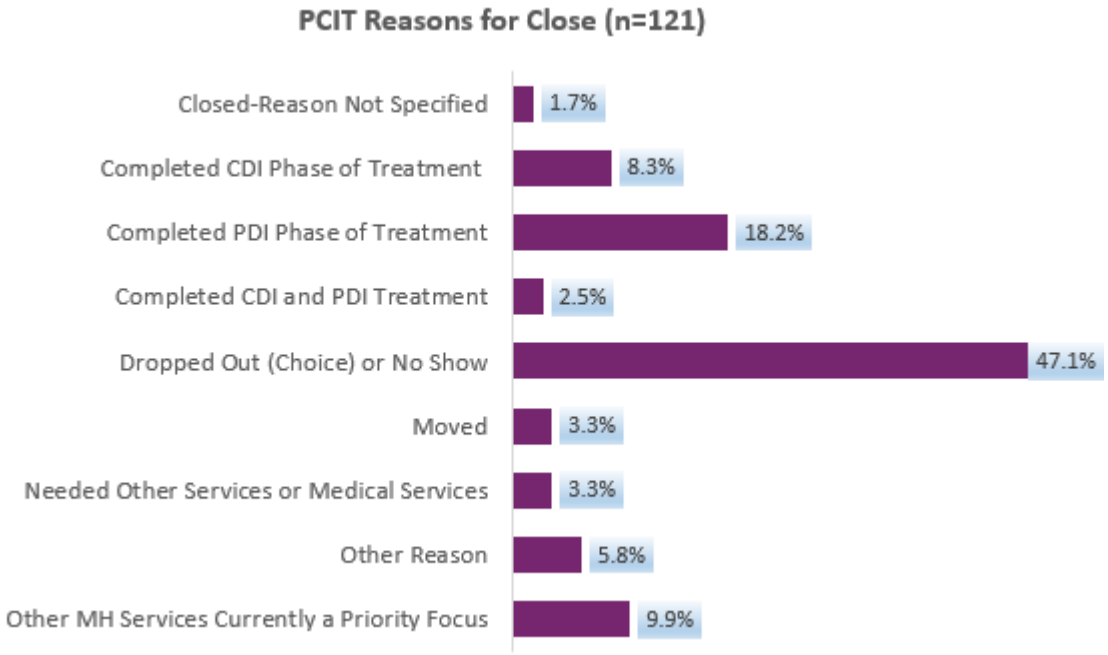
PCIT, TDI or PCIT-T Open Vs. Closed Cases (Out of a Total of 203 Clients)

Nearly 60% of families closed out of PCIT (or related) treatment in the 23-24 FY. Reasons for closed are analyzed on the next page. 40% of families will continue receiving the service into the 24-25 FY.

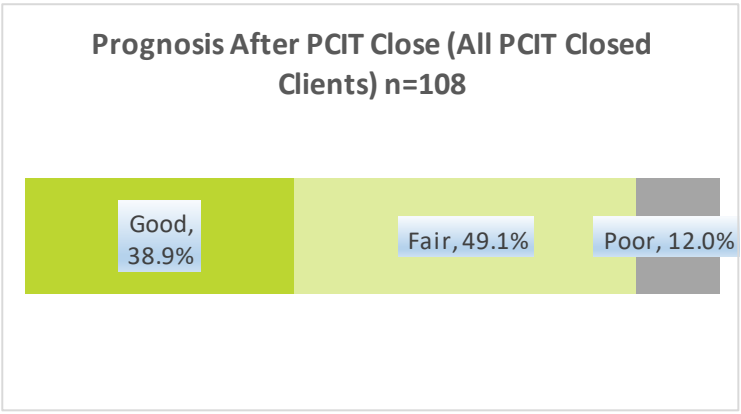


Reasons for Close

Of the 121 clients that closed to PCIT (or PCIT-T, TDI), 29% closed due to completion of one or more phases of the treatment. A little less than half dropped out due to personal choice, or were closed out due to multiple no show appointments after attempts to contact were made. Reasons marked as "Other" included lack of perceived effectiveness, transportation issue or conflict with caregiver's work schedule.



Closed PCIT Cases Only (n=108) Goals met and Prognosis

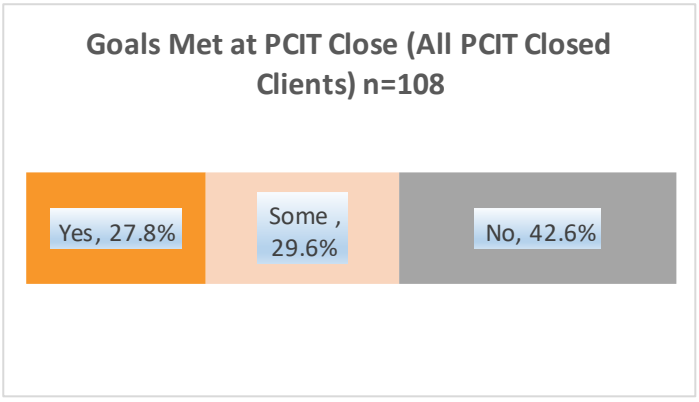


Upon closing a PCIT case, therapists complete a PCIT close form in ELMR. They record the prognosis after treatment for each client.

As shown in the figure to the left, 88% of families had a good or fair prognosis after attending PCIT.

Upon closing therapists noted if the families met goals set at treatment.

As shown in the figure to the right 57.4% of families met all or some of the goals set by the family and the therapist.



Dinosaur School and IY Parenting Classes



Of the 300 families served, A total of sixteen children and sixteen caregivers (16 families) were served with the Incredible Years Parenting Program and Dinosaur School, a prosocial skills group for children. Classes range from 6-8 weeks, and are usually once per week. Parents are attending the parenting group while their child is being provided the dinosaur school session.

- In total, the sixteen children served with Dinosaur school received 24 hours of service
- In total, the sixteen parents served with IY Parenting classes received 27 hours of service
- 3 Cycles consisting of 6-8 sessions were conducted in July, September and February.
- Sessions were provided by staff from the clinic RU (33ET01) or the Western Mobile RU (33ETPC).
- Services were billed as Group MH Service, and is included in the service analysis on page 8 of the report

Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a evidenced based practice to help children affected by trauma. TF-CBT helps to resolve behavioral and emotional difficulties that occur with single, multiple, or complex trauma experiences.

- A total of 6 children, (out of 300 served with MH services) were served with TF-CBT as part of the therapy they received
- Children ranged from 4-10 years old
- 5 of the 6 children resided in the Western region of Riverside and were served by the 33ET01 clinic RU; 1 child resided in the Mid-County region of Riverside and was served by the Western Mobile RU (33ETPC).
- Details of TF-CBT outcomes and program statistics are shared in a separate county report.

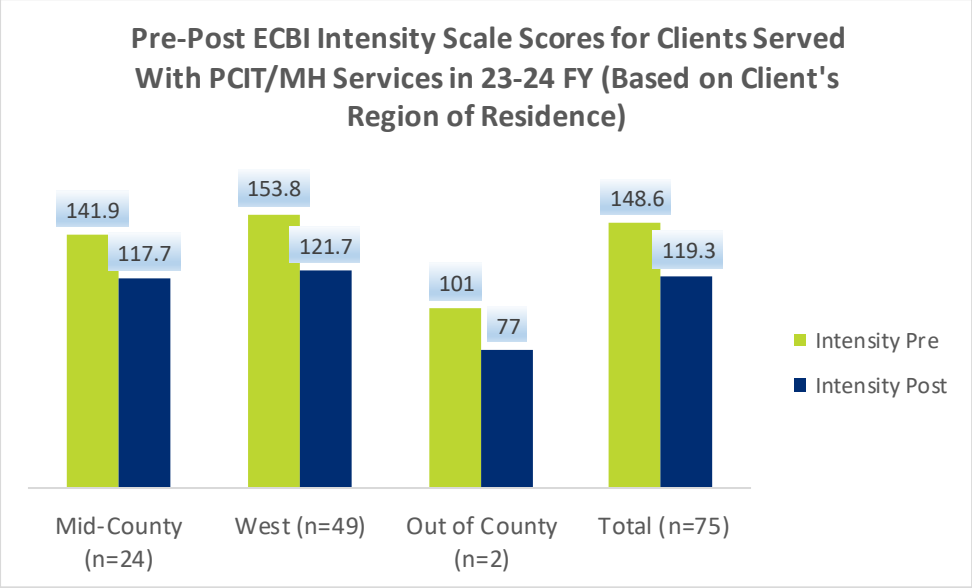
The next section will highlight the outcomes of families receiving all MH services as a whole.

PCIT/MH Services Outcomes ECBI

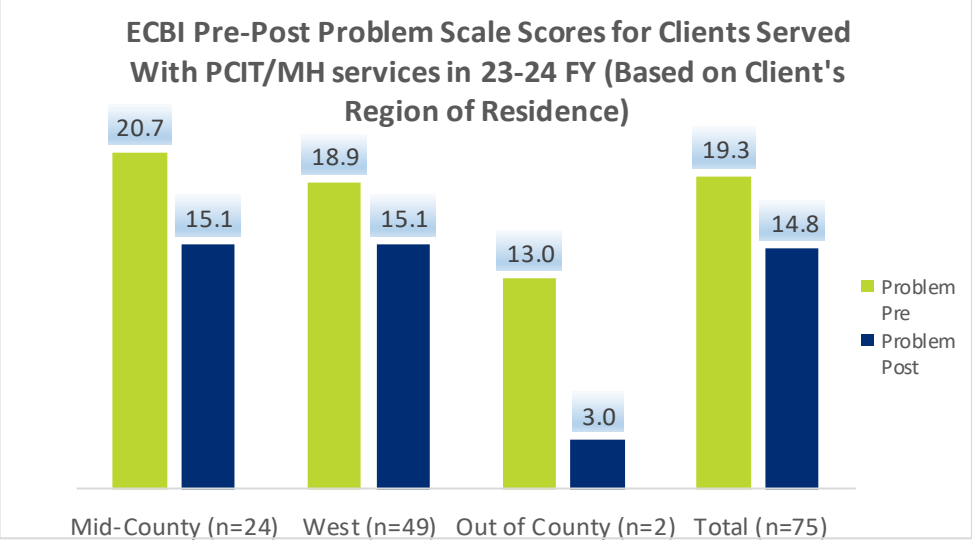
The ECBI rating scale measures the frequency and severity of children's problem behaviors at home and school settings (Intensity Score) as well as the extent to which the parents and teachers find the child's behavior troublesome (Problem Score). A child rated at or above an Intensity raw score of 131 on the ECBI and/or 15 or higher on the Problem raw score is in the clinical range.

There were a total of 75 parents who completed the ECBI measure pre to post (mid-score is considered a post score for clients who haven't closed out of the program). In total, there was a statistically significant decrease in the frequency of child problem behaviors (Intensity scale) as well as a statistically significant decrease in the extent to which caregivers perceived their child's behavior to be a problem (Problem Scale). Statistical significance was not measured for clients who lived Out of County due to the small sample size.

Of the 75 parents who completed the ECBI pre and post, 70 parents (93.3%) received PCIT services.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	3.29	0.003
West	48	5.56	<0.001
Out of County	1	*	*
Total	**74**	**6.46**	**<0.001**



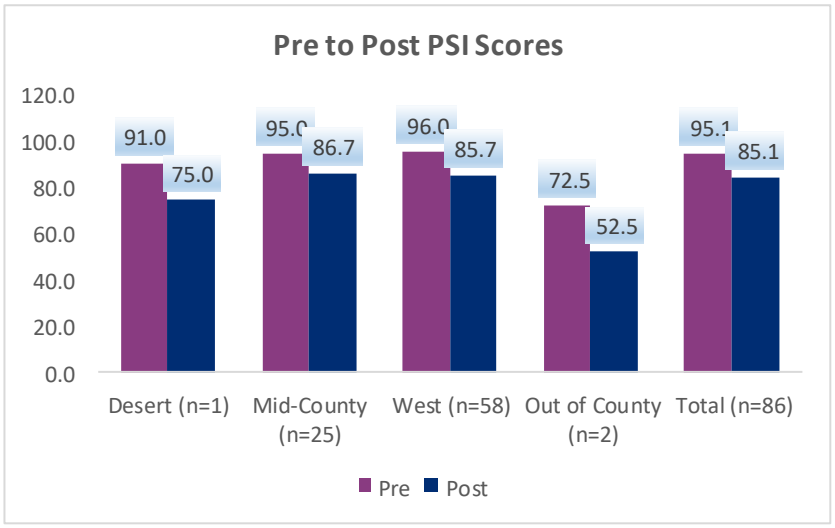
ECBI Problem Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	-	-	-
Mid-County	23	2.77	0.011
West	48	2.17	0.035
Out of County	1	*	*
County-wide	**74**	**3.39**	**0.001**

PCIT/MH Services Outcomes PSI-4-SF

The Parental Stress Index Version 4 Short Form (PSI-4-SF) is a 36 item questionnaire used to measure the overall level of parental stress experienced by parents of children 12 years of age or younger. The PSI-4-SF yields a total stress score that is a combined score of three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child.

There were a total of 86 parents (91% of whom received PCIT) who completed the PSI pre to post (mid-score is considered a post score for clients who haven't closed out of the program). As shown in the graph below, in total and regionally these parents experienced a decrease in the level of stress pre to post PCIT intervention. Statistical significance was not measured for the desert region and out of county cases due to the small sample size.

The clinical cutoff for the PSI-4-SF is 85. Post scores show that these parents were at the clinical cutoff of 85 post intervention.



ECBI Intensity Score (Pre-Post): Statistical Significance			
Region	Df	T-Score	P-Value
Desert	n/a	*	*
Mid-County	24	2.60	0.016
West	57	4.36	<0.001
Out of County	1	*	*
County-wide	**85**	**5.40**	**<0.001**

Satisfaction

Satisfaction of services is measured by a survey called Therapy Attitude Inventory (TAI). Answers are based on a scale from 1-5.

A total of **28 parents** completed the TAI in FY 23-24. (64.8% of those parents received PCIT services). On average, the parents felt more confident in their parenting skills and ability to discipline their child and felt their relationship with their child and their child's behavior improved. The parents felt the techniques learned were accepted by their family, community and religious beliefs.

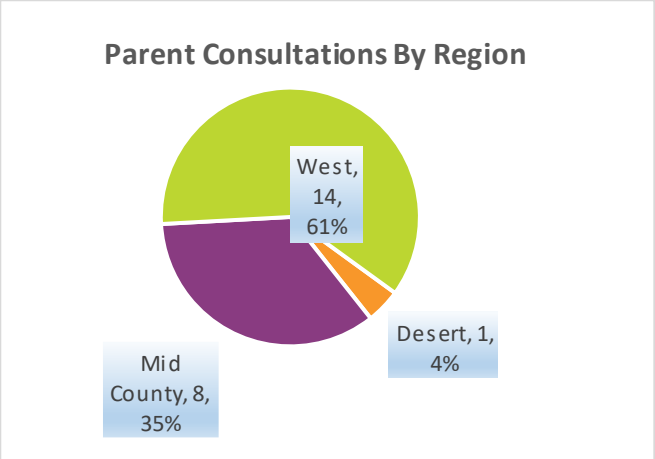
The specific TAI questions, as well as the average scores given to each item by the 28 parents are shown on the following page.

Preschool 0-5 Programs
All MH Services Data

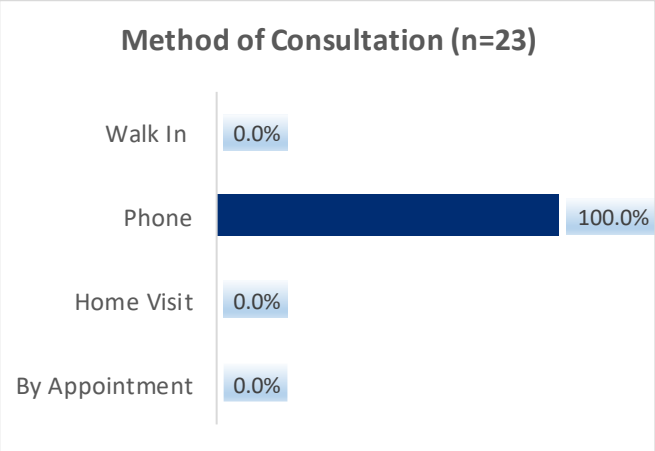
Question	Average Score (n=28)	1	2	3	4	5
Regarding techniques of disciplining, I feel I have learned:	**4.68**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding techniques for teaching my child new skills I feel like I have learned:	**4.75**	Nothing	Very little	A few new techniques	Several useful techniques	Very many useful techniques
Regarding the relationship between myself and my child, I feel we get along:	**4.68**	Much worse than before	Somewhat worse than before	The same as before	Somewhat better than before	Very much better than before
Regarding confidence in my ability to discipline my child I feel:	**4.75**	Much less confident	Somewhat less confident	The same	Somewhat more confident	Much more confident
The major behavior problems that my child presented at home before the program started are at this time:	**4.82**	Considerably worse	Somewhat worse	The same	Somewhat improved	Greatly Improved
I feel that my child's compliance to my commands or requests is at this time:	**4.86**	Considerably worse	Somewhat worse	The same	Somewhat Improved	Greatly Improved
Regarding the progress my child has made in his/her general behavior I am:	**4.89**	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
To what degree has the treatment program helped with other general, personal, or family problems not directly related to your child in the program?	**4.64**	Hindered much more than helped	Hindered slightly	Neither helped or hindered	Helped somewhat	Helped very much
I feel the type of program that was used to help me improve the behaviors of my child was:	**4.82**	Very poor	Poor	Adequate	Good	Very good
My general feeling about the program I participated in is:	**4.89**	I disliked it very much	I disliked it somewhat	I feel neutral	I liked it somewhat	I liked it very much
Level of comfort with the ethnicity of your therapist/coach:	**5.00**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
Level of comfort with the ethnicity of the assessment staff:	**4.89**	Not comfortable	Somewhat comfortable	Neutral	Somewhat Comfortable	Very Comfortable
To what degree have the skills you learned in this treatment program been accepted by the people in your family (e.g., mother/father, adult siblings, other extended relatives)?	**4.32**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree have the skills you learned in this treatment program been accepted by the people in your community (e.g., neighbors, other school/Head Start parents, friends)?	**4.36**	Not accepted	Somewhat not accepted	Neutral	Somewhat accepted	Very accepted
To what degree do you feel that the skills you have learned in this program are consistent with your religious or spiritual upbringing and values?	**4.36**	Not consistent	Somewhat not consistent	Neutral	Somewhat consistent	Very consistent

PEI Mobile Staff—Parent Consultations

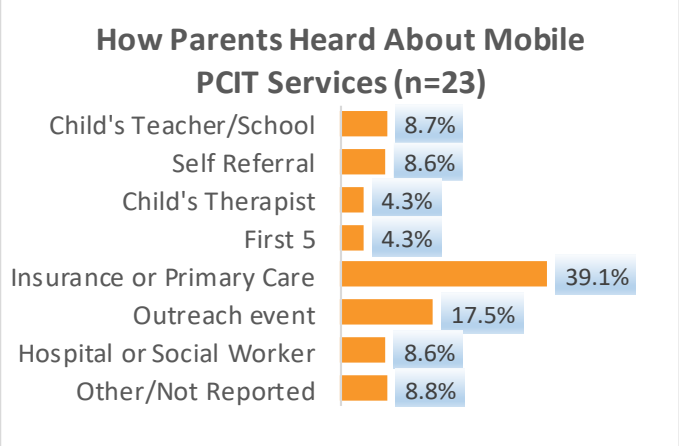
Parent consultations are provided by PEI Mobile staff as a light touch service where parents can, by walk-in or appointment, talk about raising their children, and discuss the social, emotional, and learning issues that they are facing. Clinicians can enroll the child/parent in supportive services that will help foster the child's academic and personal growth, and can refer out to other services when necessary. Consultations are also available by phone.

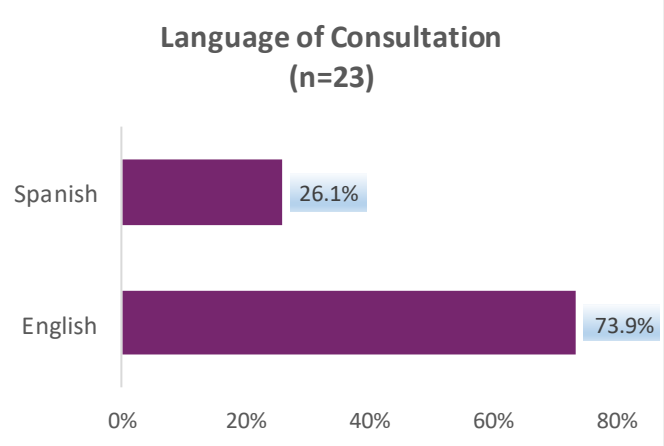


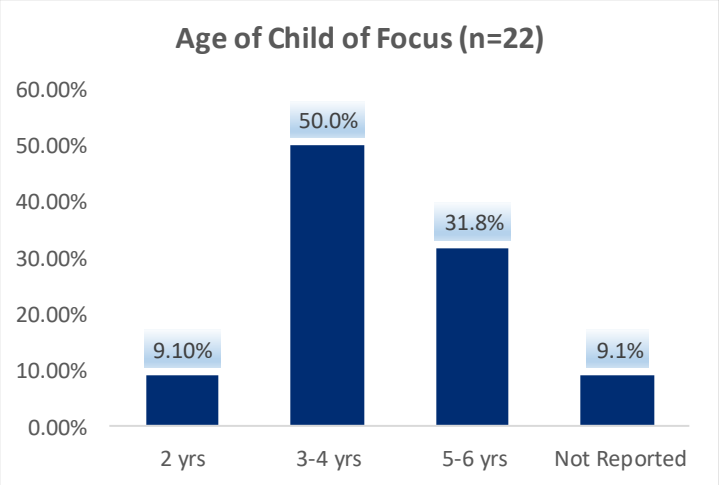
A majority of parent consultations (61%) were provided to parents in the Western region.



In the 23-24 fiscal year, 23 parent consultations served **22 parents**. All parent consultations were provided on the phone (100%).





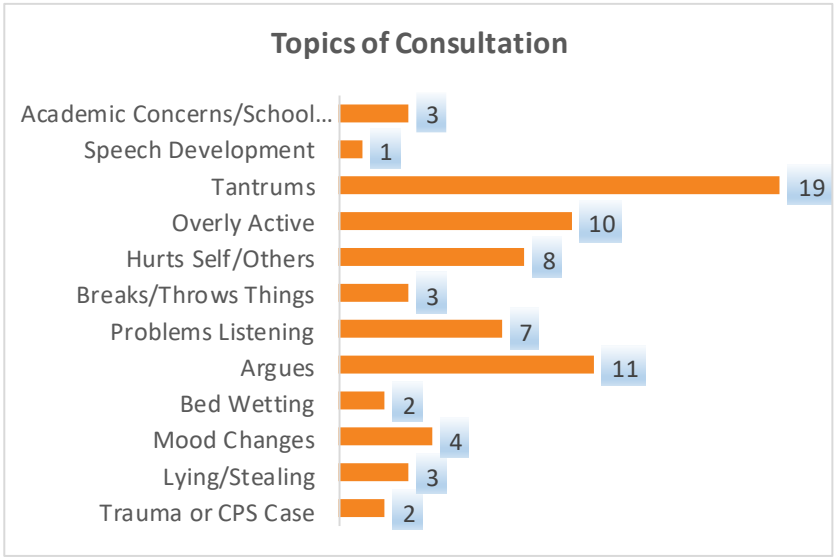


A majority of consultations (73.9%) were provided in English.

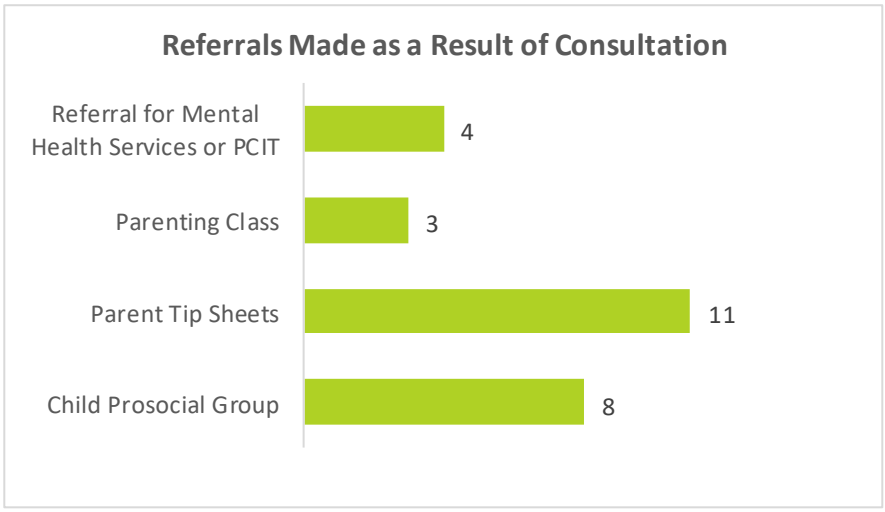
A majority of parents learned of the consultation and other services through their insurance or primary care doctor, or through an outreach event.

Half of the children of focus (50%) were 3-4 years of age. Average age of the child was 4.1 years with 64% of the parents also reporting they have another child between the ages of 0-18 at home.

PEI Mobile Staff— Parent Consultations *Continued*



Tantrums and arguing were the two frequently discussed concerns during parent consultations, followed by being overly active. *(Each parent consultation could focus on multiple topics, so counts are depicted in the graph).*





23 parent consultations resulted in a total of 26 referrals (including tip-sheets/ behavioral charts.). Parent tip sheets and referral to child pro -social groups constituted a majority of the referrals.

PEI Mobile Staff— Outreach Events

- PEI Mobile staff recorded a total of 4 outreach events which included providing an informational presentation to the Comprehensive Autism Center, participating at health and wellness fair, and provided resources and service information at an elementary school
- Outreach was provided to 52 people
- The events were virtual or in the Western region of Riverside County.

Strengthening Families Program (6-11) (SFP)



Program Type: Prevention Program

SFP is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children. This program brings together families for 14 weeks, for 2 ½ hours each week.

Across all providers, the program was delivered with high fidelity and compliance to the evidence-based practice to the families served. Countywide, the Strengthening Families Program enrolled 117 families made up of 144 individual parents/caregivers. Of those enrolled in the program 85% met the program completion standards. Most parents/caregivers enrolled identified as Hispanic/Latinx (80%) and 59% selected Spanish as their primary language.

Children's conduct and emotional problems improved. Parental involvement improved and families were strengthened.

Statistically significant improvements were seen in parental involvement, child behavior, and family cohesion. The providers in both Western and Desert region achieved completing 39 families – coming very close to reaching the contract goals of 40 families. The provider in Mid-County was able to complete 21 families, despite experiencing staffing challenges and a delayed start-up of services until mid-fiscal year.

All programs faced staffing changes and challenges in FY23/24. A new Mid-County provider was added this year and experienced delays in service start time because of challenges with staffing the program. The provider received the SFP training when the program was fully staffed, but shortly after training experienced staff turnover. Program implementation was delayed as they had to hire, onboard, and train new staff. Western region experienced staff shortages due to their organization shifting staff from this contract to work other jobs within the organization. The Desert region also brought on new staff, as long-time staff on the contract left for other opportunities. Several of the providers also reported increased challenges with families this fiscal year in regard to children's developmental delays that made it challenging to manage some of the group sessions and may have resulted in other families dropping out of the program due to the experience of "chaos" in those groups.

Due to staffing changes and time in between SFP trainings, providers had to learn to work with new co-facilitators by pairing up a trained staff with a new staff to remain in compliance with fidelity to the program.

After experiences of some behavioral challenges in some of the groups, the providers learned how to improve their screening process and how to share program criteria with referring parties to better match the families to the program. As a result, providers learned about additional community resources that they could share with those families that needed additional support with managing their children's behaviors and development.

Our newest SFP provider in Mid-County stated that they learned how important it is for the SFP team to make the connection during the first few weeks with all the families. It's paramount that the SFP team makes the families feel as welcomed and nurtured as possible to help increase retention. They learned the value of spending time getting to know the parents and children, eating with them, serving them, etc. and how that added to the bond that they were hoping to make. They observed that the families didn't really start connecting with each other until about week 4, so it is the responsibility of the SFP team to make the families want to keep coming until they eventually build those dynamic relationships with the other families. Once that happened, they found that it was much easier to have the families return each week.

They also learned how important it was to make each session fun. They realized that a lot of the families were not used to doing things or having fun together as a family, and the sessions provided the opportunity for them to do so, and they got better at it as each week passed. They found that the best way to get the parents to come each week was to make sure the children were having a great time. On numerous occasions the parents have told the Site Coordinator that the children are always reminding them when the SFP class is scheduled or telling them they want to be sure to go to class and not miss it. If the children are having fun and continuing to remind their parents of the weekly sessions, that increases the likelihood that the parents will be there too.

SFP Enrolled 117 families made up of 144 individual parents/guardians. 85% completed the program.

Community feedback on program impact and success:

- "The group leaders are very good at their jobs. They are very nice people, professional and kind, not only with parents but with children. I am very grateful for the patience with my 6-year-old. May God always bless you so that you can continue helping more families with this program."
- "I loved the program and I believe these programs are important and great for parents. With parents, there can never be too much learning. This class has helped me better understand my kids and become a better parent. The group leaders were awesome!"
- "My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them."
- "This class has been very helpful to me and my son. We have a better relationship now than when we first started the class."
- "So beneficial. This group was really amazing and might I say it turned my whole life around. I will never forget y'all."

- “This program helped us a lot. We never got along well and now we do. Very grateful for everything. The children were very happy with the teachers.”

Guiding Good Choices

Program Type: Prevention Program

Community feedback regarding the ongoing need for parent support as well as impacts to children over the past several years indicate the need and desire for more prevention options. Guiding Good Choices has been in the PEI plan as a component of work plan 7. In the coming 3-year plan, PEI will expand this model and select providers to deliver this service through the competitive bid process.

Guiding Good Choices is an evidence-based practice that focuses on the prevention of substance use and other problem behaviors. The group targets parents of children ages 9-14, who DO NOT have a substance abuse issue—this is a prevention program. It is a 5- week, 2-hour, group for 10-12 parents. The program consists of five 2-hour workshops, usually held one time per week for five consecutive weeks. Workshop topics are appropriate for a wide and diverse audience. Here's what each workshop covers:

- Getting Started: How to Prevent Drug Use in Your Family
- Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
- Managing Conflict: How to Control and Express Your Anger Constructively
- Avoiding Trouble: How to Say No to Drugs & Other Problem Behaviors (Children are invited this session)
- Involving Everyone: How to Strengthen Family Bonds

Due to staffing shortages, the RFP has been delayed. This program is on hold as we navigate the changes related to the Behavioral Health Services Act.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Strengthening Families Program (SFP)
Annual Report FY 2023-2024

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Program Overview

Overview

Strengthening Families Program (SFP) is a prevention program for children ages 6-11 and their families. SFP's goals include strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional, and social problems in high-risk children (those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses). The program consists of 14 sessions. The program completion standard is defined as at least one caregiver per family having attended ten or more sessions. Participants are also given the opportunity to attend a booster session 3 or 6 months after completing the program.

Outcomes Evaluation

Program outcome is evaluated based three measures: the Alabama Parenting Questionnaire (APQ), the Strength and Difficulties Questionnaire (SDQ), and the Family Relationship Index (FRI). The APQ measures three dimensions of parenting: parental involvement, positive parenting, and inconsistent discipline. The SDQ measures both positive and negative psychological attributes among children, including emotional problems, conduct problems, hyperactivity, peer problems, pro-social skills, and total difficulties. The third measure, FRI, measures family cohesion, expressiveness, and family conflict.

Providers

Community-Based Organizations (CBOs) are contracted to provide SFP services. For FY 2023-2024 the providers were: My Family, Inc. (MFI) in the Western region; California Family Life Center (CFLC) in the Mid-County region, and Riverside Latino Commission in the Desert region.

Executive Summary

Enrollment

- Countywide, Strengthening Families enrolled 117 families made up of 144 individual parents/ caregivers.
- 99 of the 117 enrolled families (85%) met the program-completion standard by attending 10 or more sessions.
- Each provider is contractually required to have 40 families complete the program. Latino Commission (Desert) and MFI (Western) each achieved 39 families completed. CFLC (Mid-County) started late in the fiscal year, but was still able to achieve 21 families completed.

Demographics

- Of the 144 enrolled parents/caregivers, the majority (64%) were 26 through 39 years of age.
- The majority (80%) of enrolled parents/caregivers reported being Hispanic/Latinx. 59% selected Spanish as their primary language.
- The majority of enrolled parents/caregivers reported their relationship to the SFP child as “mother” (70%) followed by “father” (18%).
- The majority of enrolled SFP children were 6-7 years old (50%). The median age was 7 years.
- Enrolled SFP children were 52% female and 48% male.
- The majority (85%) of SFP children were identified as Hispanic/Latinx. Their predominant primary language was English (78%).

Family and Child Risk Factors Identified During Screening

- The Family Risk Factors most frequently identified were *Poor Communication* (79%), *Underserved Community* (25%), and *Family Conflict or Neglect* (23%).
- The Child Risk Factors most frequently identified were *Behavior Problems* (58%), *Low Self Esteem* (36%), *Low Academic Motivation* (24%), and *Skill Deficits* (16%).

Outcomes

- Countywide, improvement in all dimensions of the APQ was statistically significant ($p \leq 0.05$). Improvement in the APQ’s *Parental Involvement* dimension, for example, was 15%.
- Countywide, improvement in child behavior as measured by the SDQ was statistically significant ($p \leq 0.05$). The SDQ’s *Total Difficulty* score improved (decreased) 11%.
- Countywide, improvement in all FRI subscales (*Family Cohesion*, *Expressiveness*, and *Conflict)* was statistically significant ($p \leq 0.05$)—evidence that families were strengthened through participation in SFP.

Satisfaction

103 participants completed the satisfaction survey. All reported being either *very satisfied* (92%) or *satisfied* (8%) with the program. All reported being either *very satisfied* (93%) or *satisfied* (7%) with their group leaders. 95% indicated the course helped their family very much. 100% would recommend the course to other families.

Enrollment and Completion

Countywide in FY 2023-2024 the Strengthening Families Program enrolled 117 families made up of 144 individual parents/caregivers. Of the 117 families, 99 (85%) completed the program by attending at least ten of the fourteen sessions. This represents an increase from the FY 2022-2023 values of 92 completed families and 72% completion. Table 1.1 summarizes enrollment and completion countywide and by region. Figure 1.1 shows the distribution of the number of sessions attended for the 117 enrolled families.

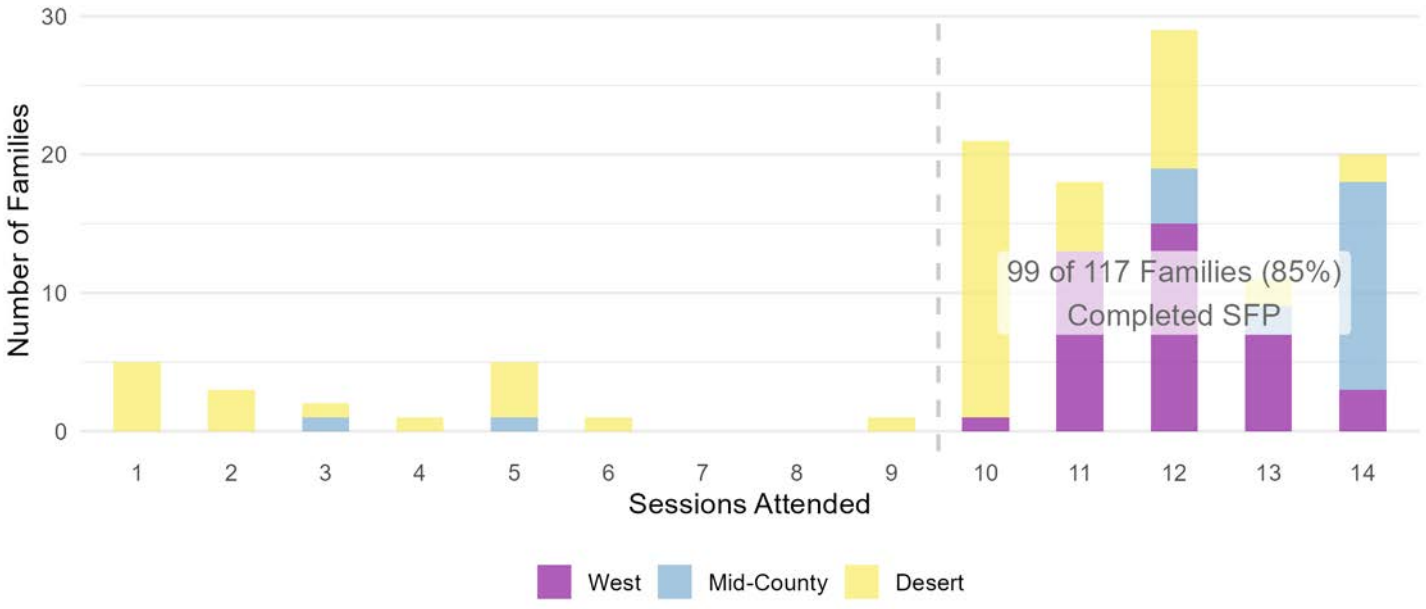
Contract Expectation

SFP's defined standard of completion is attendance of at least ten sessions by at least one enrolled parent/guardian. Each regional provider has a contractual expectation of 40 completed families. Table 1.1 summarizes attendance and completion, including the percentage of contract completion for each provider. Note that Mid-County started late in the fiscal year, thus limiting their available time for outreach and registering groups. Mid-County's enrollment and completion rates, however, demonstrate their capacity to meet the standard of completion given a full year.

Table 1.1: Family Enrollment and Completion by Region

Description	Desert	Mid County	Western	COUNTYWIDE
Family Enrollment	55	23	39	**117**
Family Completion	39	21	39	**99**
Family Completion Contract Expectation	40	40	40	**120**
Percent of Contract Completion	98%	52%	98%	**82%**

Figure 1.1: Family Attendance and Completion



Parent/Caregiver Demographics

Parent/caregiver demographic information is collected as part of SFP screening. Figure 2.1 shows the age distribution for the 144 enrolled parents/caregivers. Countywide, the majority (64%) of parents/caregivers were 26 through 39 years of age. Note that we exclude 3 *not reported.*

Figure 2.2 shows gender for the 144 enrolled caregivers. Countywide, 111 (78%) were female. Note that we exclude 2 *not reported.*

In FY 2023-2024, 2 female parents/caregivers identified as LGB, none as transgender.

Figure 2.1: Age of Enrolled Parents/Caregivers

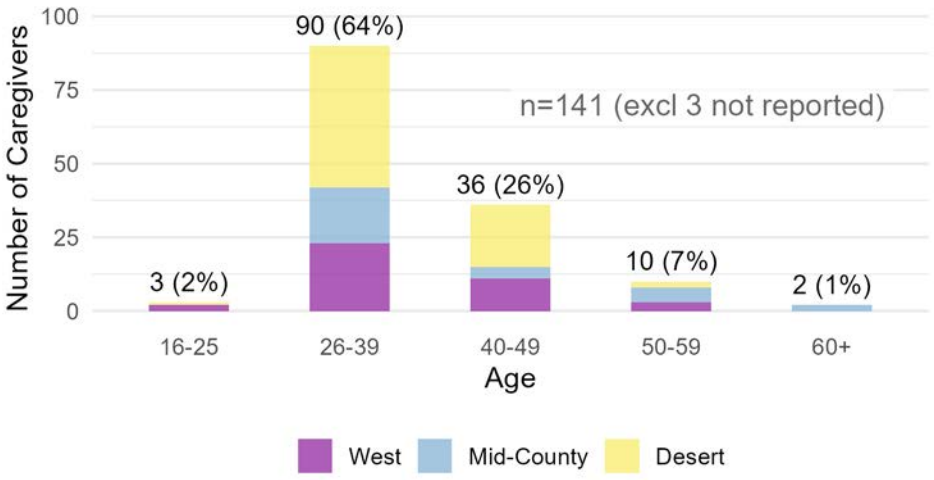
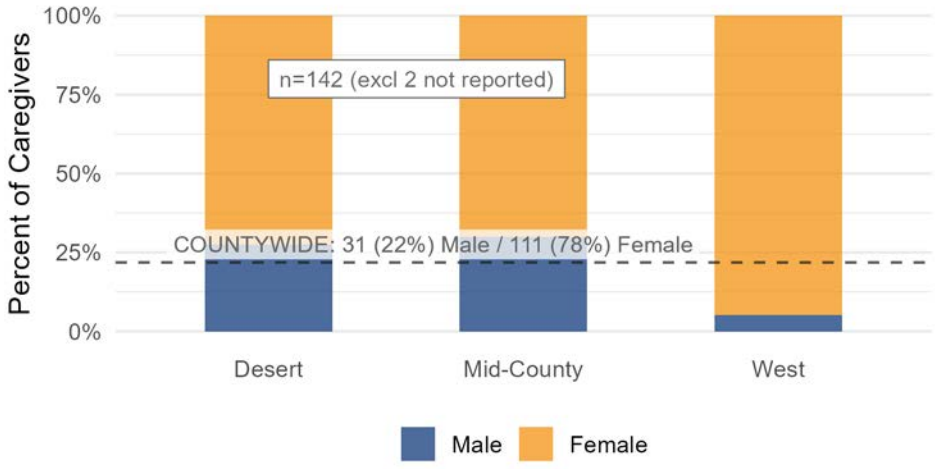


Figure 2.2: Gender of Enrolled Parents/Caregivers



Parent/Caregiver Demographics (continued)

The SFP Demographics and Screening Form lists common race and ethnicity categories. Prospective participants can make multiple selections or fill-in a race and/or ethnicity not listed.

Figure 2.3 summarizes the *unduplicated* races reported by the 144 enrolled parents/caregivers. Note the category *Multiple,* which captures parents/caregivers specifying multiple races. Multiple races counted in this category are not re-counted (duplicated) in specific race categories. Two parents/ caregivers specified multiple races as: (1) Native American and Hispanic/Latinx; and (2) Native American and Black/African American.

In FY 2023-2024, parents/caregivers were predominantly Hispanic/Latinx, with 115 (80%) identifying as such, followed by White with 15 (10%), and Black/African American with 7 (5%).

There were two parents/caregivers identifying as Native American, both subsumed by the *Multiple*-race category as noted in Figure 2.3.

Table 2.1 lists the ethnicity specified by the n= 116 Hispanic/Latinx parents/caregivers. Note we include the one Hispanic/Latinx subsumed by the *Multiple*-race category. The majority, 77 (66%), of Hispanic/Latinx parents/caregivers further identified as Mexican.

Figure 2.3: Ethnicity of Enrolled Parents/Caregivers (Unduplicated)

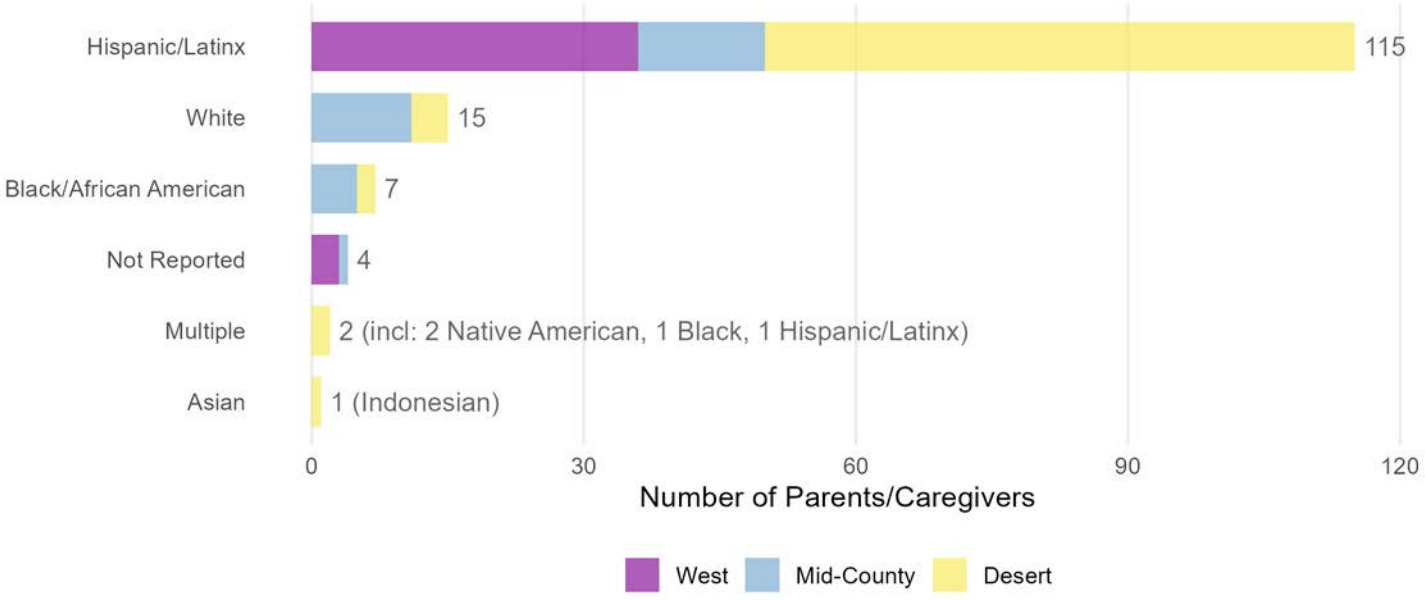


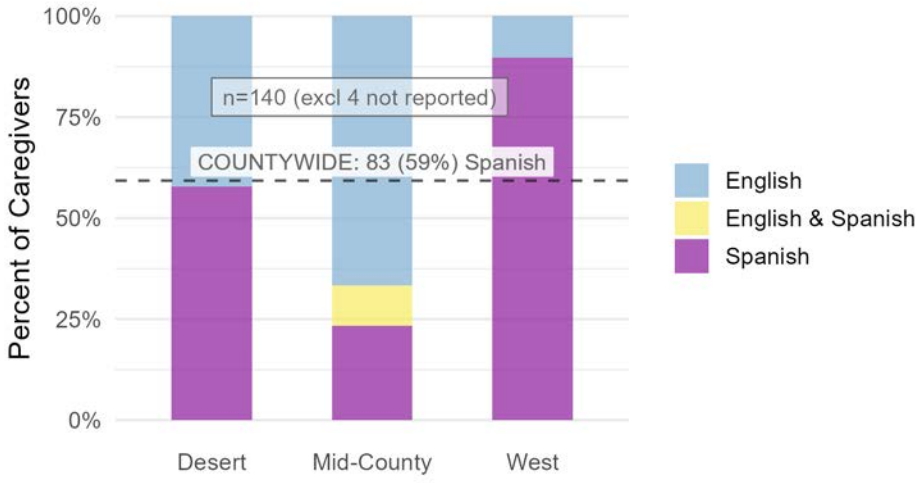
Table 2.1: Hispanic/Latinx Ethnicity of Enrolled Parents/Caregivers

Mexican	77	66%
Central American	3	3%
Venezuelan	1	1%
Not Reported	35	30%

Parent/Caregiver Demographics (continued)

Figure 2.4 summarizes the primary language specified by the 144 enrolled parents/caregivers . Spanish was predominant with 83 (59%) parents/caregivers specifying it as their preferred language.

Figure 2.4: Language of Enrolled Parents/Caregivers



Disability Specification

Countywide, 3 enrolled parents/caregivers (2%) identified as disabled.

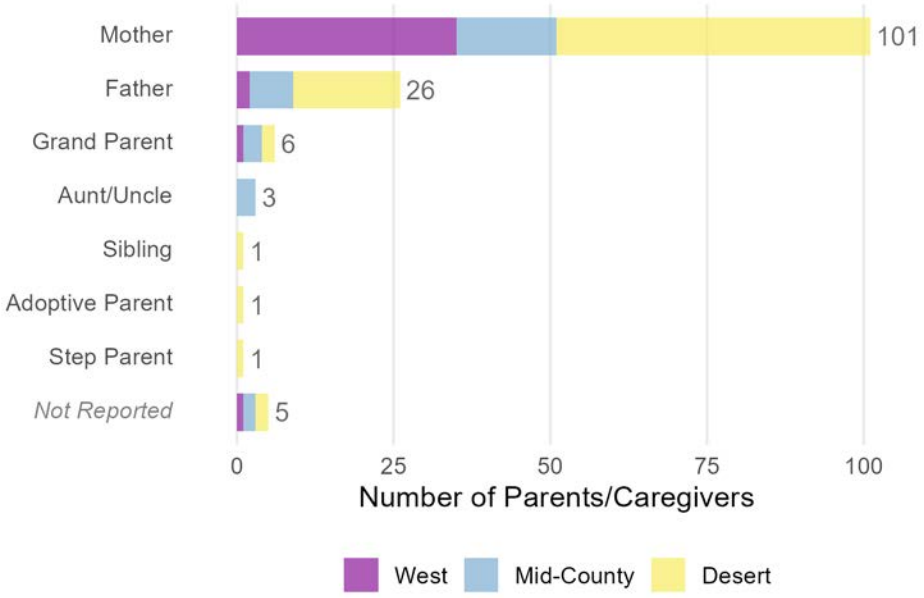
Veteran Status

Countywide, 1 enrolled parent/caregiver claimed veteran status.

Parent/Caregiver Relationship to SFP Child

Figure 3.1 shows relationship to SFP child as reported by the 144 enrolled parents/caregivers. Countywide, the 101 (70%) reporting as “mother” represents a majority, and is a greater percentage than the 66% reported in FY 2022-2023. 26 parents/caregivers (18%) reported as “father”, also greater than the 13% reporting as such in FY 2022-2023.

Figure 3.1: Relationship to SFP Child for Enrolled Parents/Caregivers



Child Demographics

SFP is intended for children ages 6-11. Parents/caregivers are asked to identify one child in the family within this age range, and to focus on this child for the program. This child is referred to as the SFP child. Results below are for the 117 SFP children of the 117 enrolled families.

Figure 4.1 summarizes the age distribution for the SFP children. The majority at 50% were between 6 and 7. In the last fiscal year, this group constituted only 37%. Also in that year, more children occupied higher age categories. Overall, FY 2023-2024 children were younger than in the previous year. The median FY 2023-2024 child age was 7 years, a one-year decrease from last year's median.

Figure 4.2 shows the gender breakdown for the117 SFP children of the enrolled families. 52% were male and 48% female.

Figure 4.1: Age of SFP Child

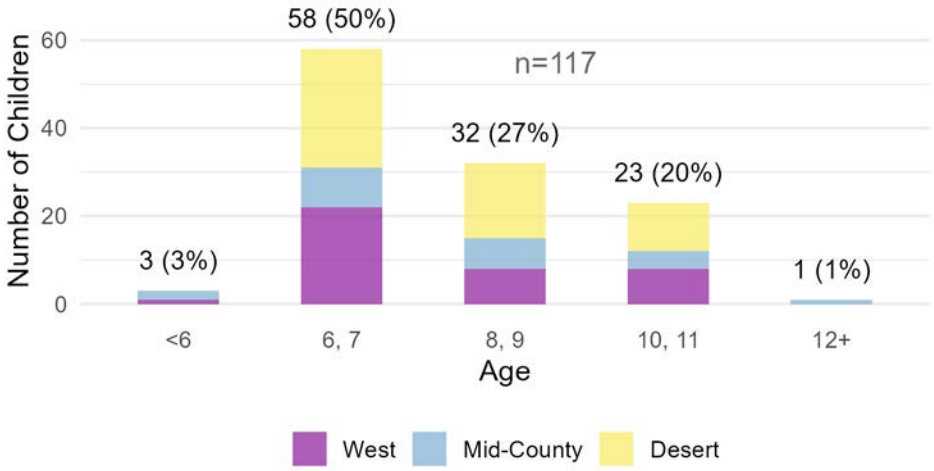
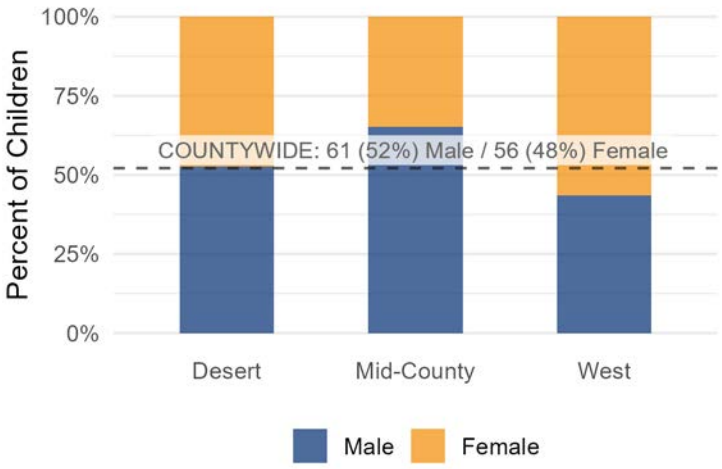


Figure 4.2: Gender of SFP Child



Child Demographics (continued)

Figure 4.3 summarizes the reported race of the 117 enrolled SFP children. Countywide, the children were predominantly Hispanic/Latinx, with 100 (85%) reported as such, and one more subsumed by the multiple-race category (n=101 Hispanic/Latinx total).

For children reported as Hispanic/Latinx, further ethnic specificity may be provided. Table 4.1 summarizes the specification for these 101 Hispanic/Latinx children. Among them, 64 (63%) were further identified as Mexican.

Figure 4.3: Race of SFP Child (Unduplicated)

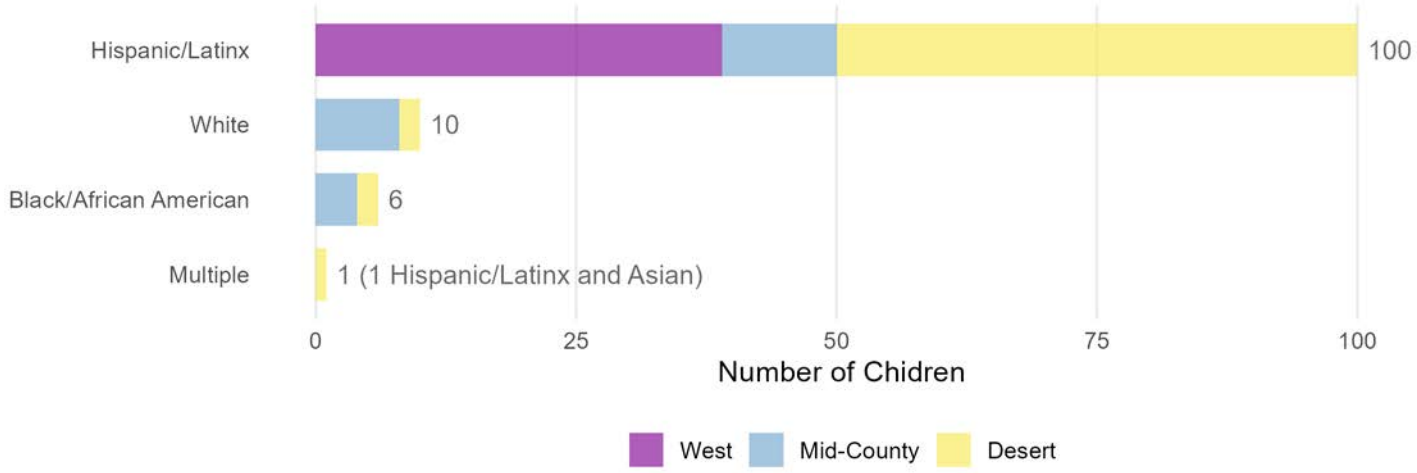


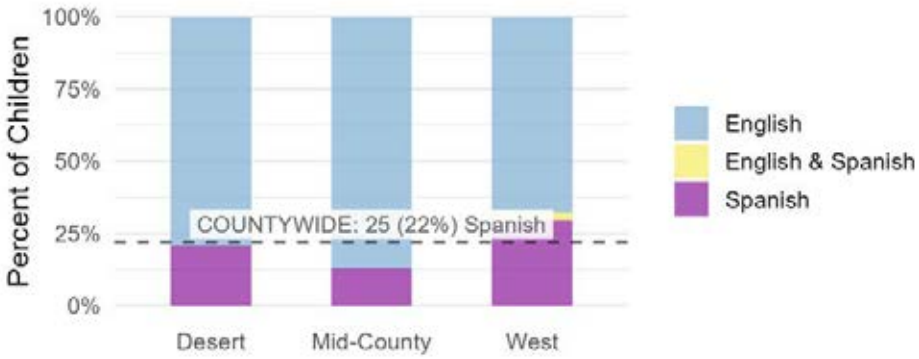
Table 4.1: Hispanic/Latinx Ethnicity of SFP Child

Mexican	64	63%
Central American	5	5%
Venezuelan	1	1%
Not Specified	31	31%

Child Demographics (continued)

Figure 4.4 summarizes the primary language specified for the 117 SFP children. English was predominant at 77% (22% Spanish, 1% both).

Figure 4.4: SFP Child Language



Disability Specification

Countywide, of the 117 enrolled SFP children, 2 were reported as disabled. One included a specification, which was autism. For comparison, in FY 2022-2023, 9 children were reported as disabled, 4 specified as autism.

Risk Factors

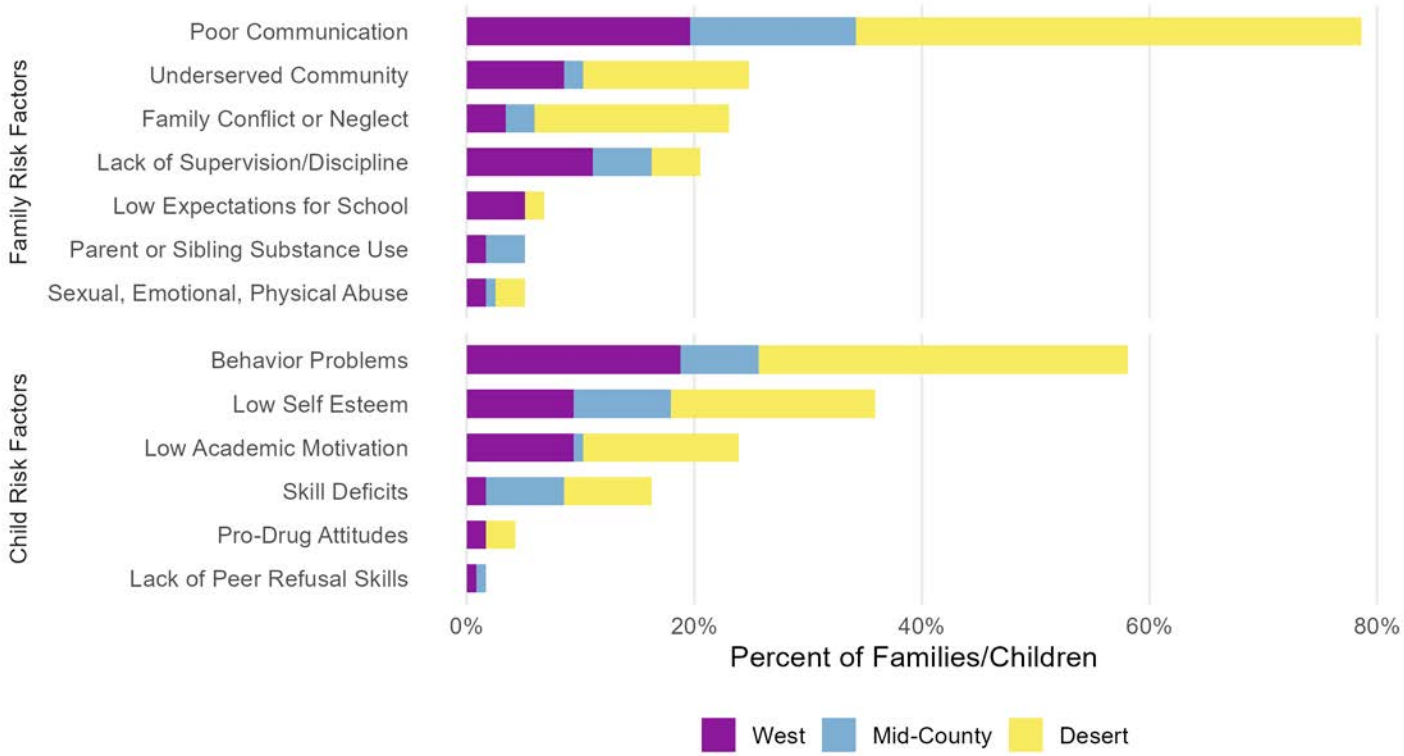
The SFP screening form includes a *Risk Factors* section listing seven possible *Family Risk Factors* and six possible *Child Risk Factors*. During screening, site coordinators have a conversation with prospective SFP parents/caregivers both to determine eligibility as well as to identify likely risk factors.

The identification of risk factors is useful during the program; the knowledge can help providers better connect with participants based on individual needs. The identification of risk factors also helps reveal prevailing issues in the community.

Figure 5.1 summarizes the frequency of occurrence of each risk factor among the 117 enrolled families during FY 2023-2024.

The Family Risk Factor most frequently cited was *Poor Communication* at 79%. The Child Risk Factor most frequently cited was *Behavior Problems* (58%).

Figure 5.1: Risk Factors



Program Outcomes

For the outcomes analysis, we include only parents/caregivers in families meeting the criteria of completion (attendance of ten or more sessions and completion of both pre and post inventories by at least one enrolled parent/caregiver in the family). For FY 2023-2024, 99 families met the criteria of completion. These families consisted of n=107 individual parents/caregivers. Unanswered questions, however, result in loss of data points. FY 2023-2024 completion rates were very good as revealed by the COUNTYWIDE n values included in the figures below.

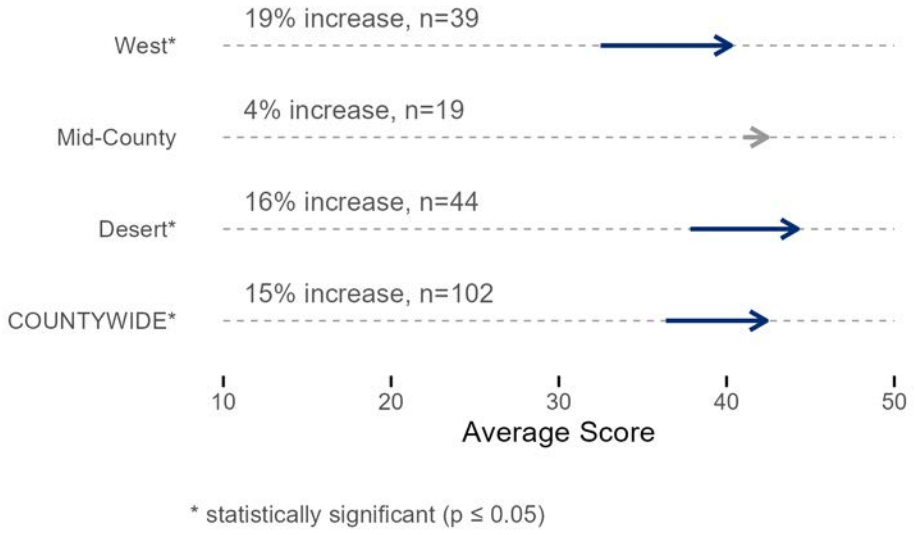
Program Outcomes: APQ

The Alabama Parenting Questionnaire (APQ) consists of 22 questions covering three distinct parenting dimensions summarized below.

1. The *Parental Involvement* dimension includes items such as, “you play games or do other fun things with your child” and “you ask your child about his/or day in school”.
2. The *Positive Parenting* dimension includes items such as, “you praise your child when he/she is doing a good job with something”.
3. The *Inconsistent Discipline* dimension represents negative aspects of parenting. Improvement thus corresponds to a decline in the score. This scale includes items such as “you threaten to punish your child and then do not actually punish her/him” and “you feel that getting your child to obey you is more trouble than it’s worth”.

Figures 6.1 through 6.3 show the outcomes for each of the three dimensions. Arrows point from the average pre to the average post score.

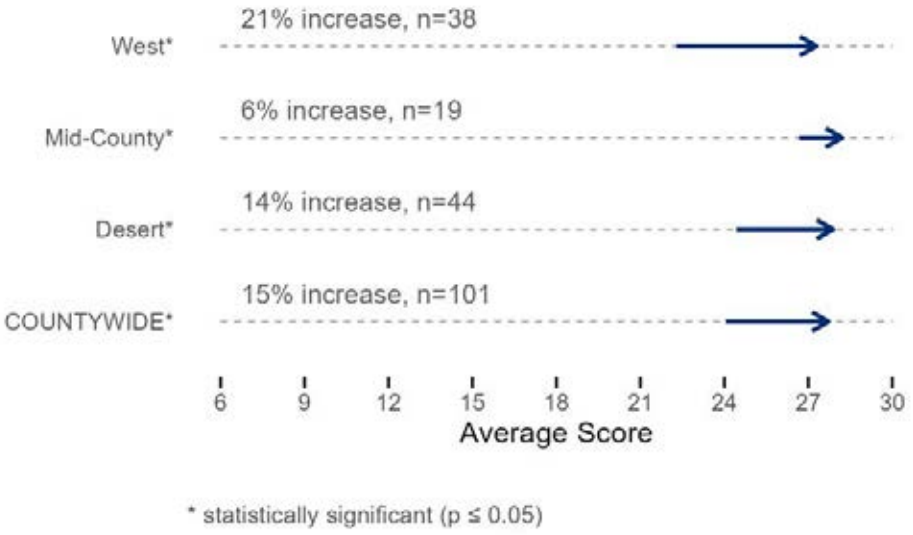
Figure 6.1: APQ Parental Involvement



The *Parental Involvement* dimension is scored from 10 to 50 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, parental involvement as measured by the APQ improved 15%.

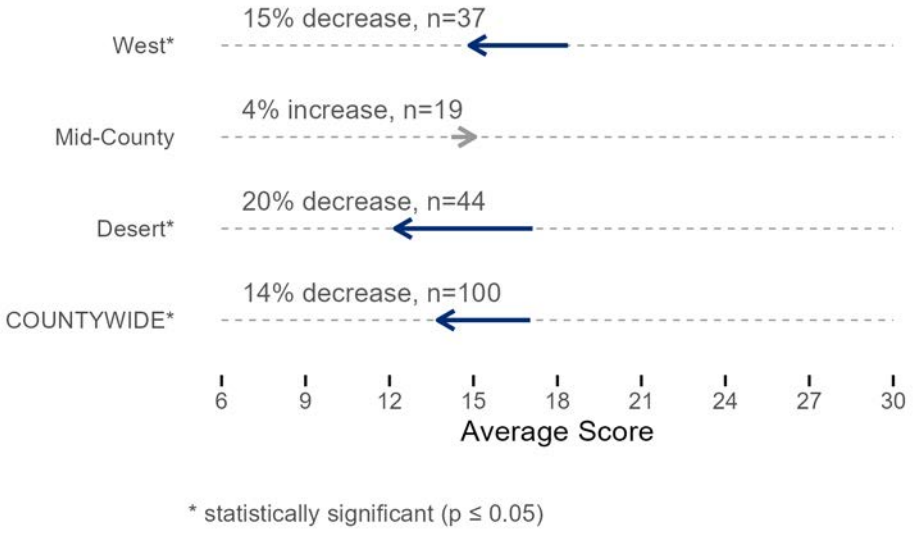
Program Outcomes: APQ (continued)

Figure 6.2: APQ Positive Parenting



The *Positive Parenting* dimension is scored from 6 to 30 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for all regions. Countywide, positive parenting as measured by the APQ improved 15%.

Figure 6.3: APQ Inconsistent Discipline



The *Inconsistent Discipline* dimension is scored from 6 to 30 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, inconsistent discipline as measured by the APQ improved 14%.

Program Outcomes: SDQ

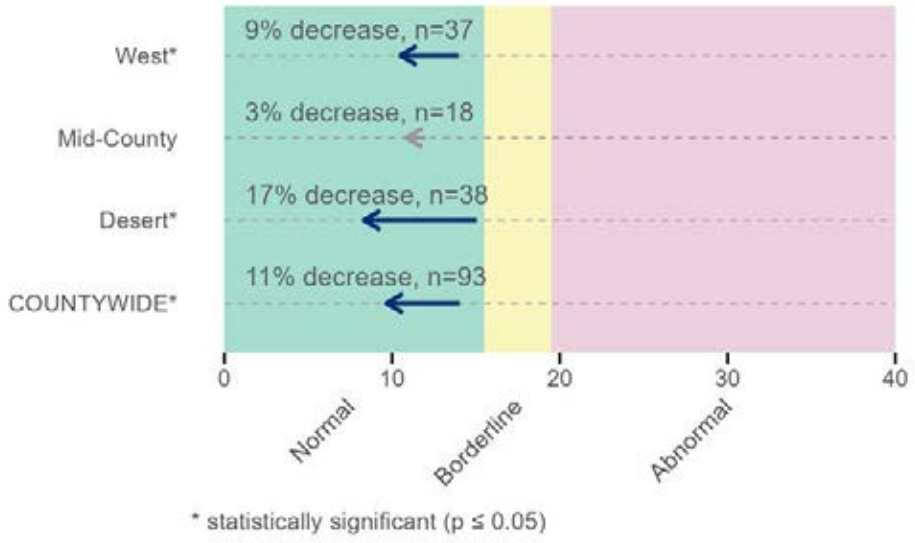
The Strength and Difficulties Questionnaire (SDQ) is used to quantify both positive psychological attributes (strengths) and negative ones (difficulties). SFP uses the Parent Version of the SDQ.

Scoring for the 25 questions includes a total score (total difficulty) and four subscale scores consisting of (1) emotional symptoms, (2) conduct problems, (3) hyperactivity, and (4) peer-relationship problems. Higher scores on these behavioral-difficulty subscales suggest greater negative psychological attributes. Decreases represent improvement in these subscales.

There is also an independent pro-social scale not used in the total score. For the pro-social scale, higher scores suggest greater positive social behaviors (increases represent improvement).

Figure 7.1 shows the pre/post change in the overall *Total Difficulty* score. Figures 7.2 through 7.5 show the changes in the four subscale scores. Finally, Figure 7.6 shows the change in the *Pro-Social* score. Arrows point from the average pre to the average post score.

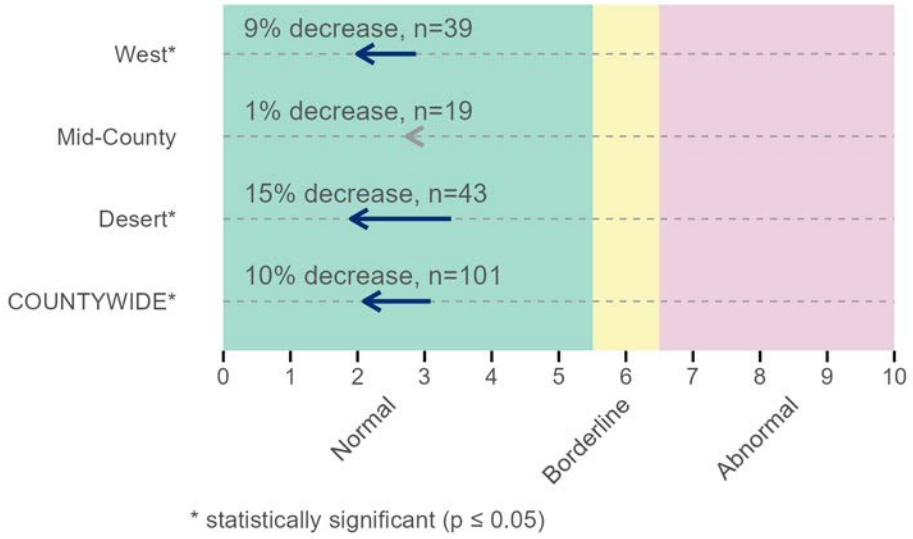
Figure 7.1: SDQ Total Difficulty



The *Total Difficulty* score ranges from 0 to 40 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, total difficulty as measured by the SDQ improved by 11%.

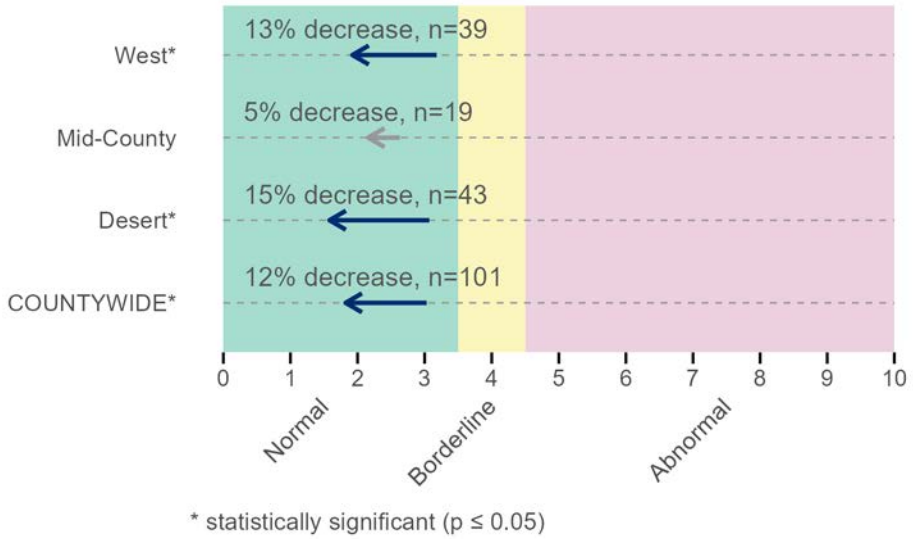
Program Outcomes: SDQ (continued)

Figure 7.2: SDQ Emotional Symptoms



The *Emotional Symptoms* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and the West and Desert regions. Countywide, emotional symptoms as measured by the SDQ improved by 10%.

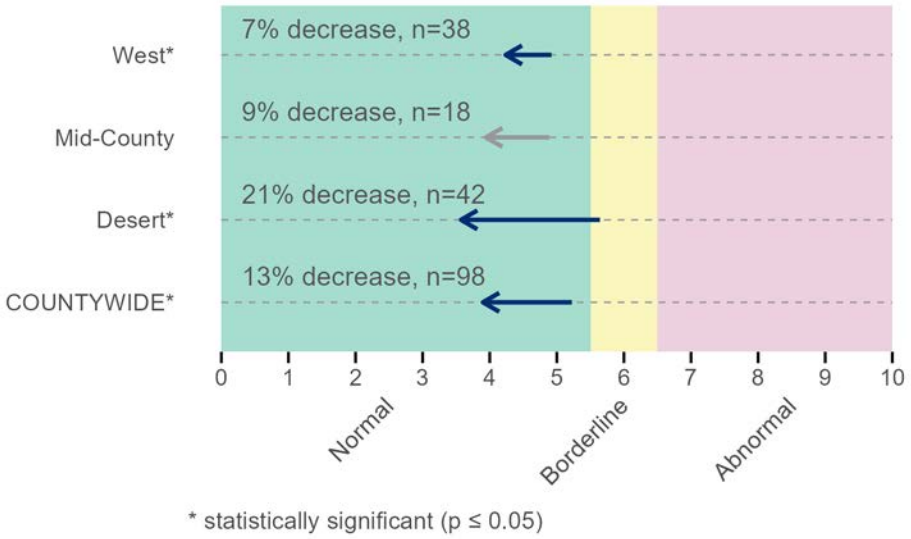
Figure 7.3: SDQ Conduct Problems



The *Conduct Problems* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, conduct problems as measured by the SDQ improved by 12%.

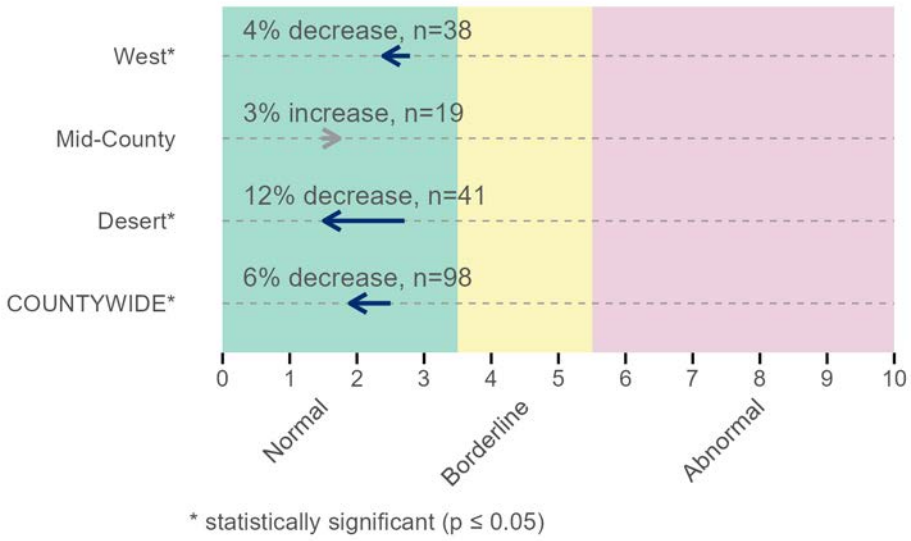
Program Outcomes: SDQ (continued)

Figure 7.4: SDQ Hyperactivity



The *Hyperactivity* score ranges from 0 to 10 with **decreases** representing **improvement**. Results were statistically significant (p ≤ 0.05) countywide and the West and Desert regions. Countywide, hyperactivity as measured by the SDQ improved by 13%.

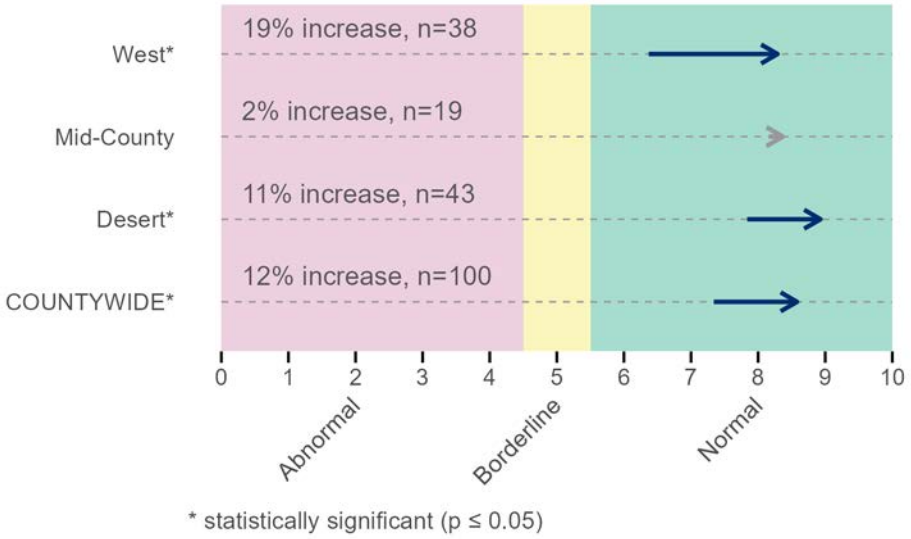
Figure 7.5: SDQ Peer Problems



The *Peer Problems* score ranges from 0 to 10 with a **decreases** representing **improvement**. Results were statistically significant (p ≤ 0.05) countywide and for the West and Desert regions. Countywide, peer problems as measured by the SDQ improved by 6%.

Program Outcomes: SDQ (continued)

Figure 7.6: SDQ Pro Social



The *Pro-Social* score ranges from 0 to 10 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, pro-social behavior as measured by the SDQ improved by 12%.

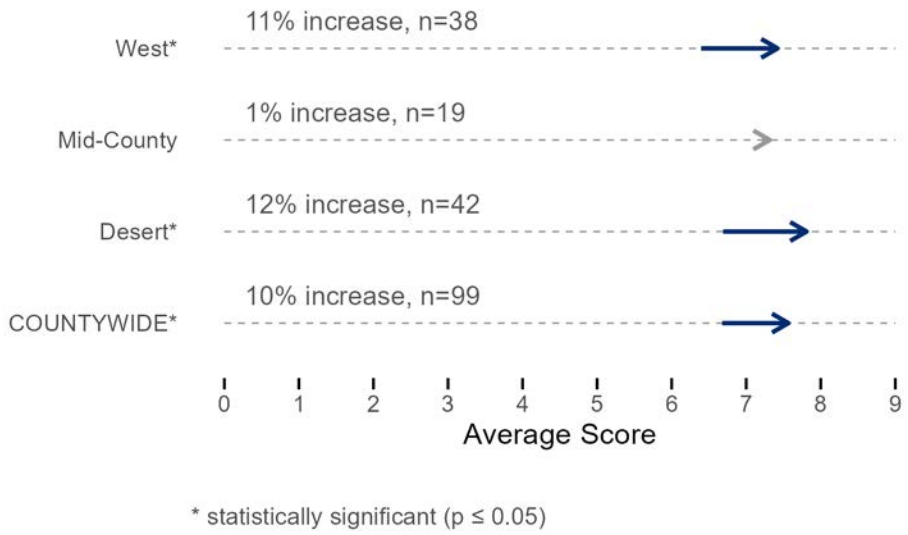
Program Outcomes: FRI

The Family Relationship Index (FRI) uses true/false questions (scored 1 or 0) to measure the quality of the family environment. There are three subscales: (1) family cohesion, (2) expressiveness, and (3) conflict. The three scales are summarized below.

1. The *Family Cohesion* scale includes items such as, “family members really back each other up” and “there is a feeling of togetherness in our family”.
2. The *Expressiveness* scale includes items such as, “we tell each other about our personal problems” and “there are a lot of spontaneous discussions in our family”.
3. The *Conflict* scale represents negative aspects of family relationships. Improvement thus corresponds to a decline in the score. This scale includes items such as “we fight a lot in our family” and “family members often criticize each other”.

Figure 8.1 through 8.3 show the outcomes for each of the three scales. Arrows point from the average pre to the average post score.

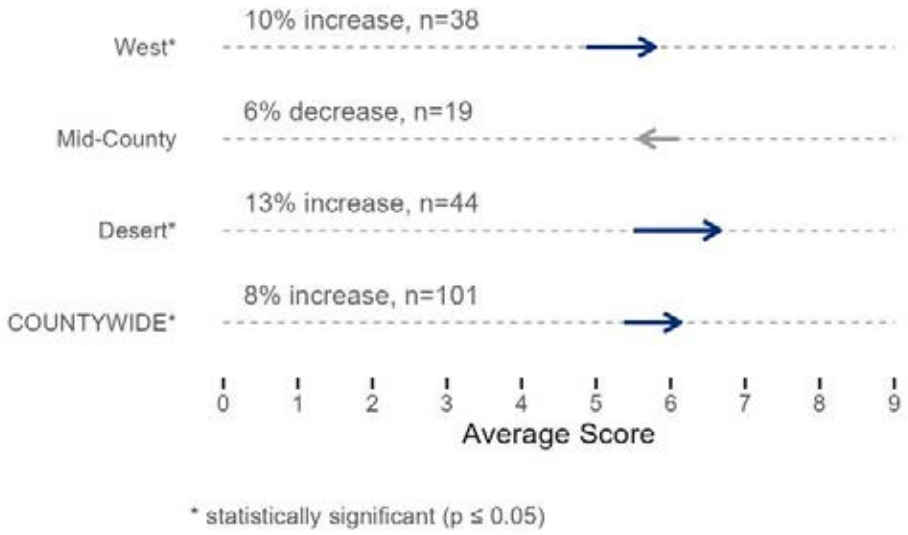
Figure 8.1: FRI Family Cohesion



Family Cohesion is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, family cohesion as measured by the FRI improved 10%.

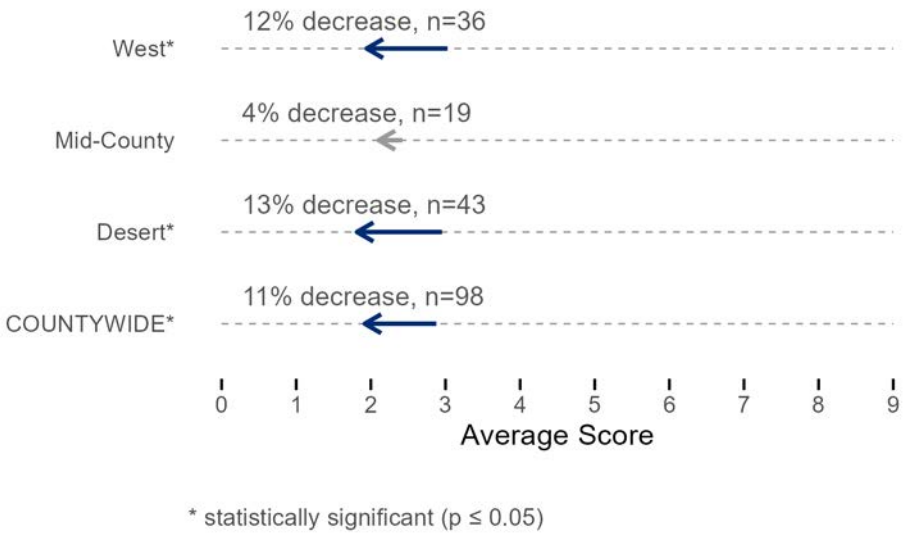
Program Outcomes: FRI (continued)

Figure 8.2: FRI Expressiveness



Expressiveness is scored from 0 to 9 with **increases** representing **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, expressiveness as measured by the FRI improved 8%.

Figure 8.3: FRI Conflict



Conflict is scored from 0 to 9 with **decreases** corresponding to **improvement**. Results were statistically significant ($p \leq 0.05$) countywide and for the West and Desert regions. Countywide, conflict as measured by the FRI improved 11%.

Post Program Satisfaction Survey Results

The inventory questionnaires given at the conclusion of the program includes a satisfaction survey. 110 parents/caregivers completed this survey.

Figures 9.1 through 9.3 summarize the results of the multiple choice questions. The results are favorable. Additionally, in response to the question “Would you recommend this course to other families?”, 100% responded in the affirmative.

Figure 9.1: How Satisfied Were You With This Program?

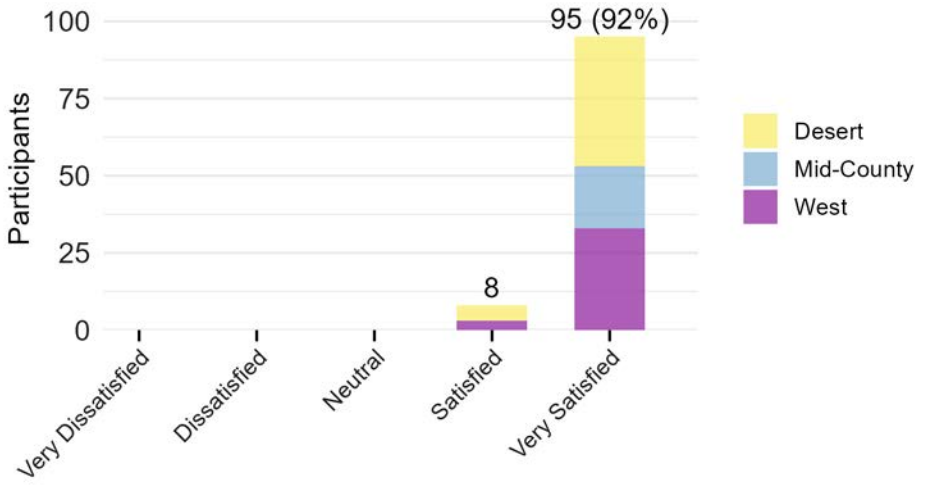
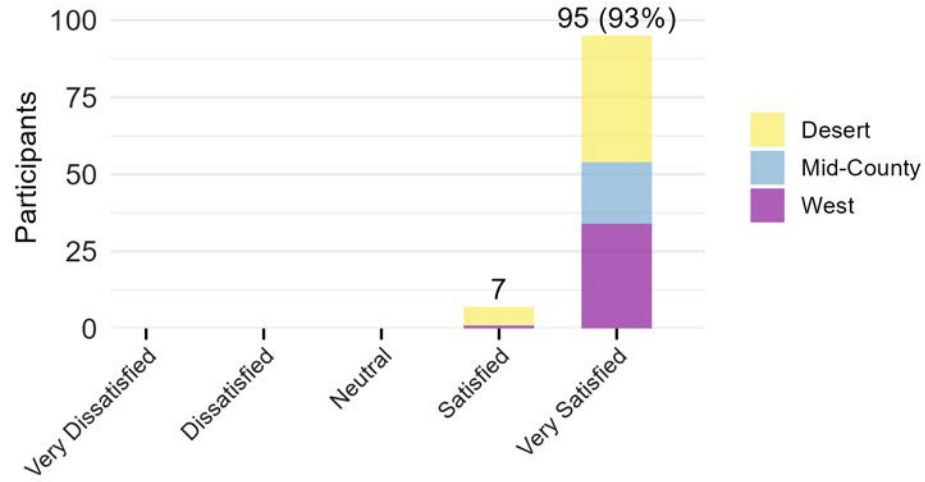
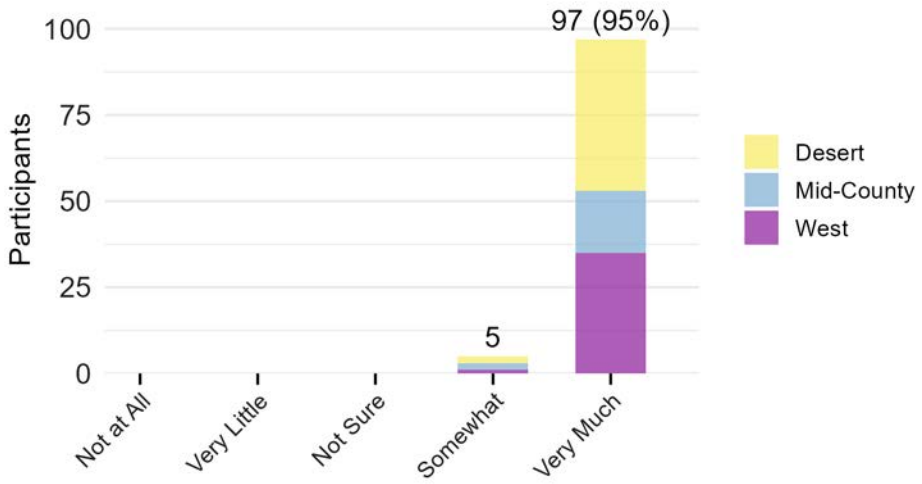


Figure 9.2: How Satisfied Were You With Your Group Leaders?



Post Program Satisfaction Survey Results (continued)

Figure 9.3: How Much Has This Course Helped Your Family?



Post Program Comments

Selected Comments

- I loved this program and would love to do another booster class. My daughter has also loved this program and doesn't want it to end.
- All the kids grew a strong bond together.
- (The program) helped me a lot with communication with the family, and to have greater communication with everyone.
- SFP helped a lot and opened my eyes on how to identify problems and how to solve them. Thanks from my entire family to the SFP team.
- The group leaders are very good at their jobs. They are very nice people, professional and kind not only with parents but with children. I am very grateful for the patience with my 6-year-old. May God always bless you so that you can continue helping more families with this program.
- Loved this class. It has helped out more than I expected.
- I enjoyed learning coping skills and how to manage behaviors with appraisals and nice compliments when children are on task.
- This program was very encouraging and very helpful with all the adults we had. They gave a lot of advice and a lot of tips to help with our children.
- I loved the program and I believe these programs are important and great for parents. With parents, there can never be too much learning. This class has helped me better understand my kids and become a better parent. The group leaders were awesome!
- I wanted to thank you for these programs that help us improve as people and that integrate children, it is very good, thank you very much!
- Thanks for everything. For helping us to be better in the family, and giving us different ways to help our children.
- My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them.
- This class has been very helpful to me and my son. We have a better relationship now than when we first started the class.
- So beneficial. This group was really amazing and might I say it turned my whole life around. I will never forget y'all.
- This program helped us a lot. We never got along well and now we do. Very grateful for everything. The children were very happy with the teachers.

Booster Attendance and Satisfaction

Booster sessions for FY 2023-2024 families could not be scheduled in time for this report. Results will therefore be included in the FY 2024-2025 report.

PEI-03 Early Intervention for Families in Schools

Peace4Kids

Program Type: Prevention Program

Peace 4 Kids is based on five (5) components (Moral Reasoning, Empathy, Anger Management, Character Education, and Essential Social Skills). The program goals include: helping students master social skills, improving school performance, controlling anger, decreasing the frequency of acting out behaviors, and increasing the frequency of constructive behaviors. There is also a parent component, which strives to create social bonding among families and within families while teaching social skills within the family unit.

Peace4Kids is a school based program that is designed to improve protective factors for children, teach parents effective communication skills, build social support networks, and empower parents to be the primary prevention advocates in their children's life in a setting that is de-stigmatizing to a lot of families, which is school. As was shared in our previous update, the PEACE4Kids program was released for competitive bid for school districts in May 2022. The goal is to have PEACE4Kids programs in at least one school district per region. Unfortunately, no bids were received. Due to staffing shortages, the re-release of this RFP has been delayed. This program is on hold as we navigate the changes related to the Behavioral Health Services Act.

PEI-04 Transition Age Youth (TAY) Project

This project includes multiple activities and programs to address the unique needs of TAY in Riverside County. As identified in the PEI Work Plan this project focuses on specific outreach, stigma reduction, and suicide prevention activities. Targeted outreach for each activity focused on TAY in the foster care system, entering college, homeless or runaway, and those who are Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ).

TAY Resiliency Project: Stress and Your Mood (SAYM)/Peer-to-Peer

Program Type: Early Intervention Program/Prevention (respectively)

The **TAY Resiliency Project** includes the delivery of Stress and Your Mood as well as Peer- to-Peer services. These two programs have been in the PEI plan since implementation began. These two plans have been packaged into one contract for a service provider to deliver the full scope of both programs. Connecting the programs into one contract did not result in higher levels of inter-program referrals. In last year's report we noted the intent to re-release for competitive bid and separate the programs into two distinct contracts, one for Stress and Your Mood and one for Peer-to-Peer. This will allow for a greater range of service providers to bid for contract. This plan is on hold as we navigate the changes related to the Behavioral Health Services Act.

The **Stress and Your Mood (SAYM)** program is an evidence-based early intervention used to treat Transition Age Youth who are experiencing depression. Demographics information showed that the SAYM program served the intended target population of Transition Age Youth (TAY). A total of 244 participants were enrolled in the SAYM program during FY23/24, and 100% of the participants were TAY.

SAYM services were provided in both group and individual formats. Overall, the SAYM program met 79% of contract expectations. The program completion rate was 68% with 166 out of 244 youths completing the program, and 2 participants continuing their SAYM services in the FY24/25. Participants in the SAYM program showed decreases in the frequency of depression symptoms. Overall, the CES-D scores decreased from pre-test to post-test. These changes were statistically significant. Clinicians' ratings on the Clinical Global Impression Improvement Scale (CGI-I) also showed that the youth psychiatric status improved following the SAYM Program. The majority of youths (a total of 59.8%) were noted as "Much Improved" and "Very Much Improved". Across modules, there seems to be a cumulative effect where clients' level of improvement kept increasing as they continued in the program. This illustrates the importance of clients completing the SAYM program. Pre- to post-comparisons on Y-OQ®-SR total scores showed statistically significant decreases on most subscales.



PEI

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Stress and Your Mood (SAYM)

Annual Outcomes Report FY 2023-2024

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Program Overview

Stress and Your Mood (SAYM) is an early intervention for depression based on a Cognitive Behavioral Therapy (CBT) Model, with modifications for adolescent-age youths. SAYM was developed to improve access to evidence-based treatment for youth with depressive disorders and sub-clinical depressive symptoms. Specifically, this program targets transition age youth (TAY), or those between the ages of 16-25 years old.

SAYM services have three phases: "***Conceptualization***," "***Skills and Application Training***," and "***Relapse Prevention***." SAYM services are low-intensity and time limited, in accordance with the CBT model, and can either be provided in a group, individual sessions, or combination of both. Consistent with the CBT model, providers will refer to TAY as appropriate for medication-related evaluation and work closely with the prescribing psychiatrist to ensure continuity of care.

Program Provider Overview

Operation Safehouse, a community-based organization, was awarded prevention and early intervention funds to implement Stress and Your Mood (SAYM) Program. Operation Safehouse provides services in the Western, Desert, and Mid-County regions of Riverside County.

Evaluation Overview

A summary of SAYM Program's demographics, service data, and outcomes measurement is included in this report. This page describes the general methodology of the program's data collection methods.

Process Evaluation

A process evaluation includes collecting descriptive information related to the program, which describes what the program provided, how many people were served, the amount of service time provided, and basic demographic characteristics of the program. The process evaluation data is assessed using electronic health records and the group sign-in sheets, which record basic information on the SAYM topic and the number of participants in attendance. This data is collected by the Operation Safehouse staff at each session.

Outcome Evaluation

The outcomes evaluation measured a reduction in depressive symptomatology and improvements in general mental health function. Embedded in the program design, is also a measurement instrument that apprehends the assessment of each participant by the clinician. Satisfaction surveys included items on overall helpfulness of the SAYM program and overall helpfulness on specific components of the SAYM program. Evaluation measures are summarized below:

- **Centers for Epidemiological Studies Depression Scale (CES-D):** this measure utilizes to measure changes in depressive symptoms. Previous studies used the CES-D as a baseline and follow-up measure to examine outcomes. Intake and final CES-D measures were collected to examine changes in depressive symptoms following participation in the intervention.
- **Clinical Global Impression Improvement Scale (CGI-I):** this measure represents the clinician's assessment of how much the participant's symptoms have improved or worsened relative to a baseline state at the beginning of the intervention. The CGI-I is embedded in service delivery and is completed at the conclusion of each module. Intake and final CGI-I ratings are used for outcomes evaluation.
- **Youth Outcome Questionnaire-Self Report (Y-OQ®-SR):** this is a youth measure of global mental health functioning. Y-OQ®-SR measures were collected from youth under the age of eighteen at intake and at the conclusion of services to evaluate improvements in overall emotional well-being.
- **Behavior and Symptom Identification Scale (BASIS-24®):** this is an adult measure of global mental health functioning. BASIS-24® measures were collected for TAY age eighteen and older at intake and at the conclusion of services to evaluate any changes in emotional well-being.

Executive Summary

Enrollment/Demographics

Demographics information showed that the SAYM program served the intended target population of Transition Age Youth (TAY). A total of 244 participants enrolled in the SAYM program in FY 2023-2024, and 100% of the participants were TAY. The majority of those enrolled in the SAYM program were Female (66.7%), chose English as their preferred language (93.9%), and were predominantly Hispanic/Latino (63.1%). Of the youths served, the majority of participants were 16-17 years of age (83.3%), and 25% identified as LGBTQIA+.

Service Information

SAYM services were provided in both group and individual formats. There were a total of 1,448.27 hours provided to participants, and the most widely used SAYM services were for Individual Therapy Sessions (806.02 hours, or 42% of total services), and 28.2% of the participants received between 4.01 to 8 hours of service. Overall, SAYM Program met 79% of contract expectations. The program completion rate was 68% with 166 out of 244 youths completing the program, and 2 participants continuing their SAYM services in the fiscal year 2024-2025. The Mid-County region had the highest enrollment (39.8%) in FY 2023-2024, followed closely by the Western region (39.3%).

Depression Symptoms

Centers for Epidemiological Studies Depression Scale (CES-D)

Participants in the SAYM program showed decreases in the frequency of depression symptoms. Overall, the CES-D scores decreased from pre-test (30.77) to post-test (23.35), an improvement of 7.42 points. These changes were statistically significant (t = 9.511, df = 172, p = .000).

Clinical Global Impression Improvement Scale (CGI-I)

Clinicians' ratings also showed that the youth psychiatric status improved following the SAYM Program. The CGI-I was completed by clinicians after each module (1 and 2) and at conclusion of the SAYM services. The rating is based on the level of improvement compared to the youth's status at enrollment. By the conclusion of SAYM Program, 87.7% of participants improved in some capacity. The majority of youths (a total of 59.8%) were noted as "Much Improved" (33.2%) and "Very Much Improved" (26.6%). Across modules, there seems to be a cumulative affect where clients' level of improvement kept increasing they continued in the program. This illustrates the importance of clients completing the SAYM program.

Overall Functioning Improved

Youth Outcome Questionnaire (Y-OQ-SR®)

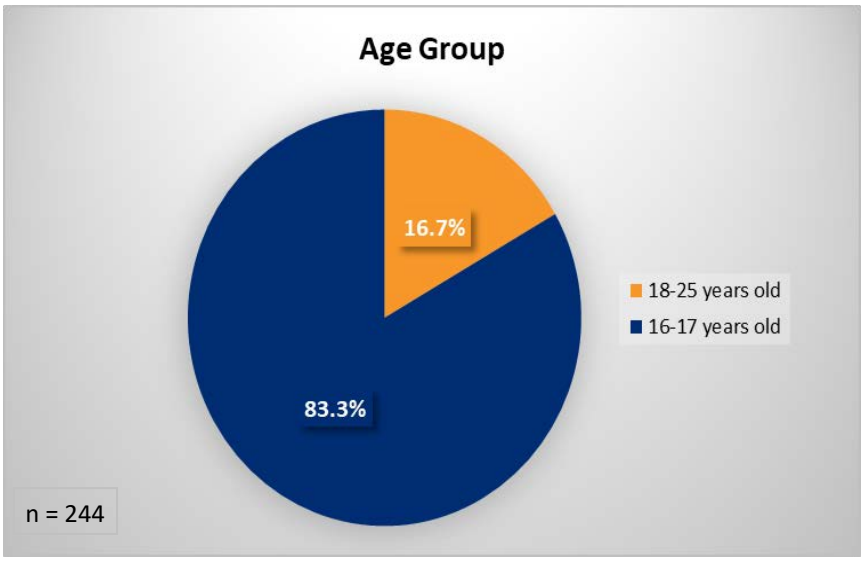
Youth global functioning also improved following SAYM intervention. Since the SAYM Program serves TAY (Youths ages 16-25), two measures of general mental health were used: one for adults–the *Behavior and Symptom Identification Scale* (BASIS-24®), and one for youth–the *Youth Outcome Questionnaire Self-Report* (Y-OQ®-SR). On the Y-OQ®-SR, higher scores indicate more impairment. Pre- to post-comparisons on Y-OQ®-SR total scores showed statistically significant decreases on the majority of subscales. On average, the decrease on the Y-OQ®-SR Total Score was 12.87 points. Although this change was not considered notable enough for showing clinical improvement (i.e. more than 13 points), it still showed a statistically significant change (t = 7.028, df = 134, p = .000). All the subscales, except for *Social Problems*, also showed statistically significant decreases.

Behavior and Symptom Identification Scale (BASIS-24®)

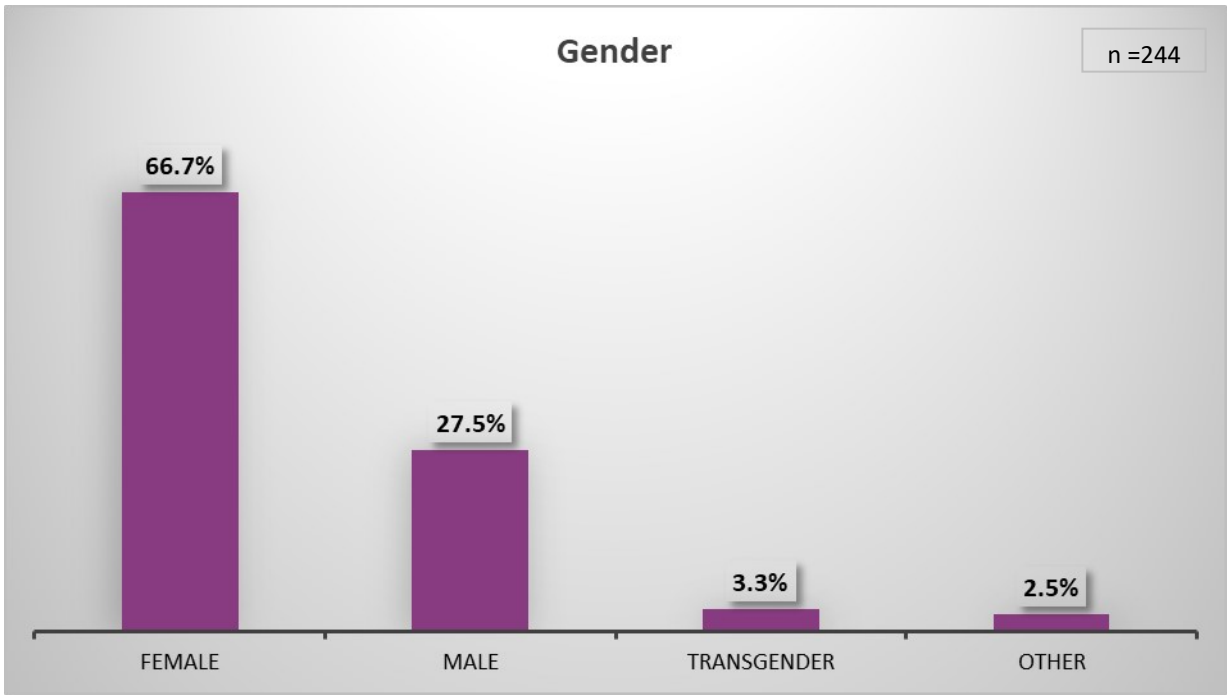
Using BASIS-24® scale, baseline measurement scores showed heightened spectrum of difficulty with the *Emotionally Labile Scale* (2.52 points) and *Depression and Functioning Scale* (2.1 points) . Overall, the sub-scales were shown to decrease (0.86 points or less), although it is noted that the 2 scales with the highest scores at intake have shown the most decrease at post measures.

Demographics: Age Groups, TAY and Gender

During the fiscal year 2023-2024, there were a total of 244 participants who enrolled in the Stress and Your Mood (SAYM) program, which includes 2 rollover participants from FY 2022-2023. Basic demographic information was collected for enrolled participants during the screening process and is summarized on the figures below.

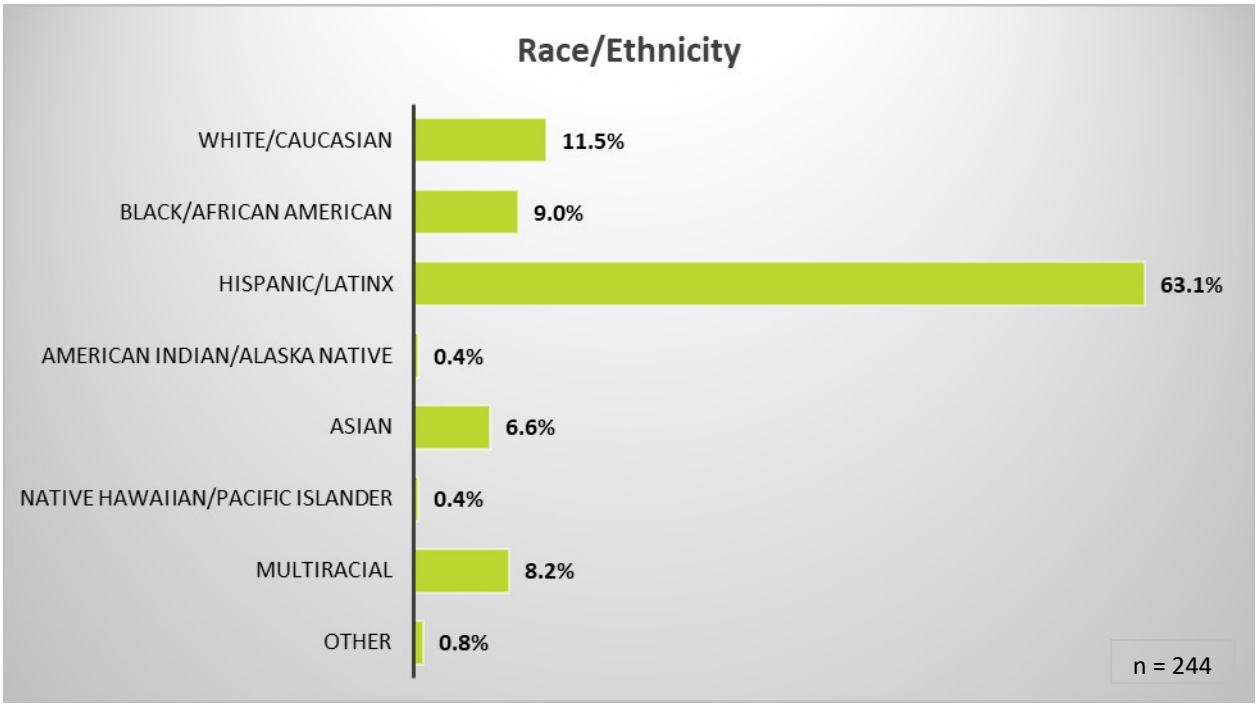


Enrollment data shows that the majority of SAYM participants were between 16-17 years old (83.3%, n = 203). A Few youth were between the ages of 18 and 25 years old (16.7%, n = 41). Additionally, when categorizing between Non-TAY and TAY population, all FY 2023-2024 SAYM participants were within the TAY category (100%).

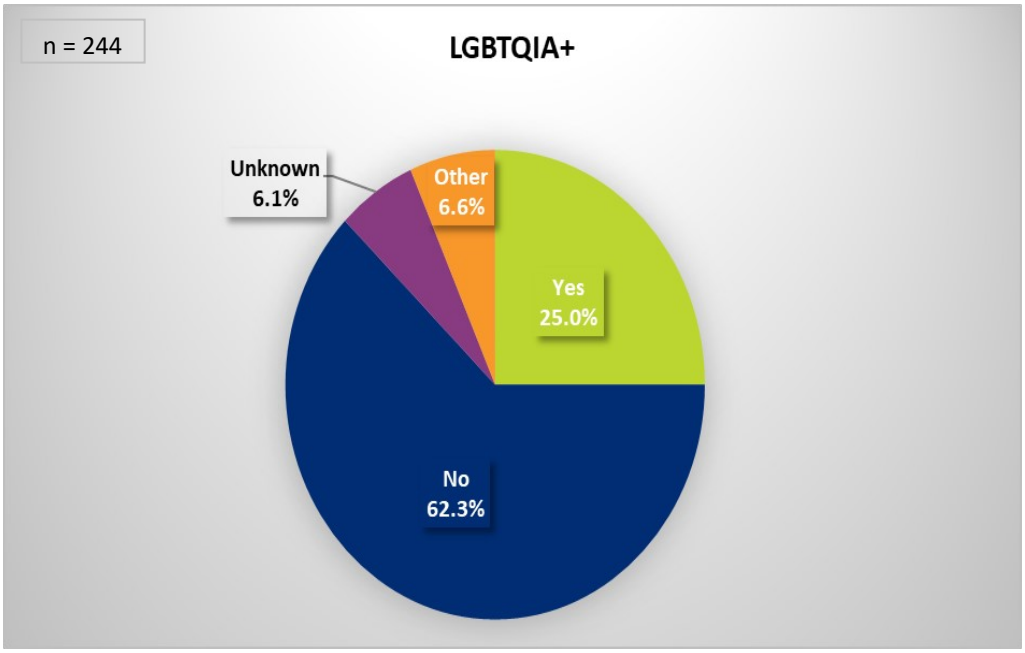


The majority of SAYM participants were Female (66.7%, n = 163), followed by Male (27.5%, n = 67). There were also smaller percentages of participants who identified as Transgender (3.3%, n = 8), and Other (2.2%, n = 6). Of those who categorized as Transgender, 6 specified as Transfeminine, 1 specified as Gender Fluid, and 1 participant chose not to respond.

Demographics: Race/Ethnicity and LGBTQI Category



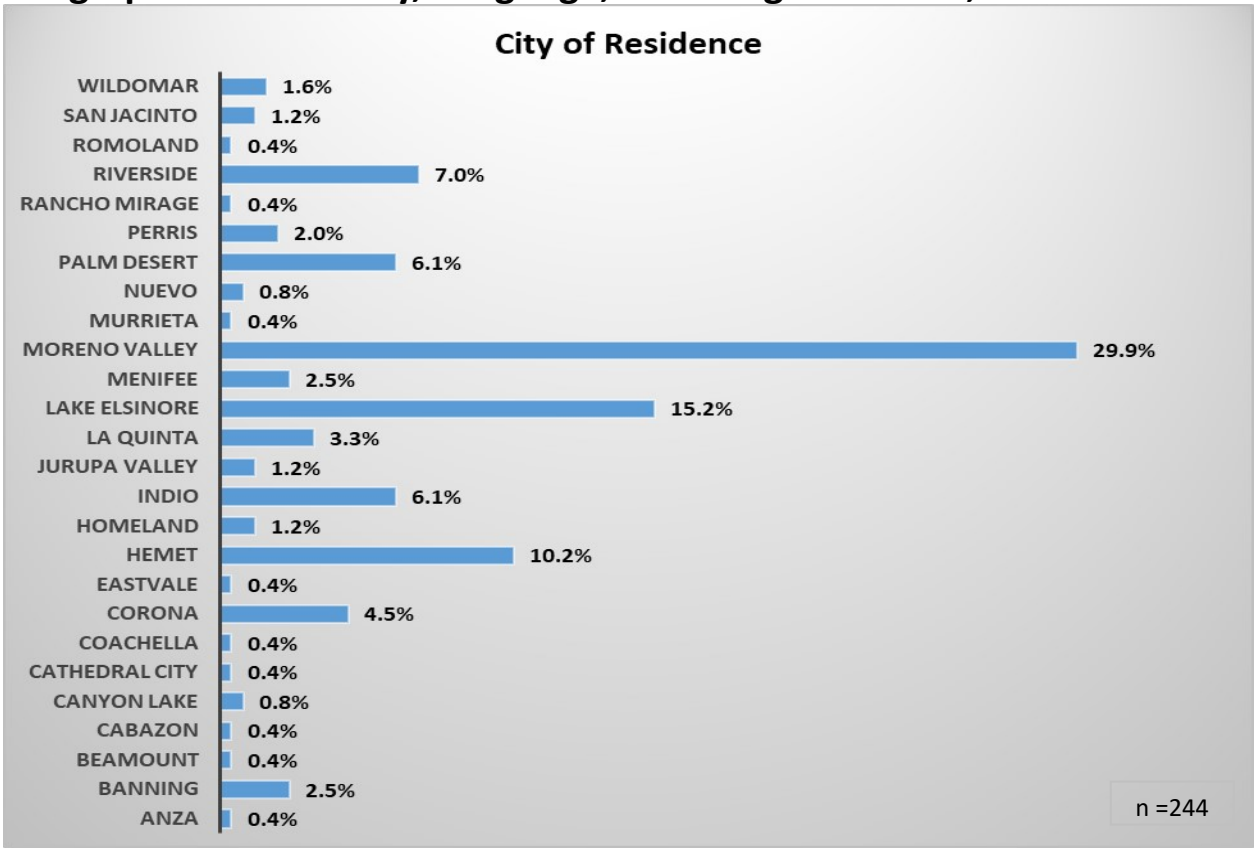
During the fiscal year 2023-2024, the majority of SAYM participants categorized as Hispanic/Latinx (63.1%, n = 154), followed by White/Caucasian (11.5%, n = 28), Black/African American (9%, n = 22), Multiracial (8.2%, n = 20), and Asian (6.6%, n = 16), respectively. There were also smaller percentages of participants who categorized as Other (0.8%, n = 2), Native Hawaiian/Pacific Islander (0.4%, n = 1), and American Indian/ Alaska Native (0.4%, n = 1).



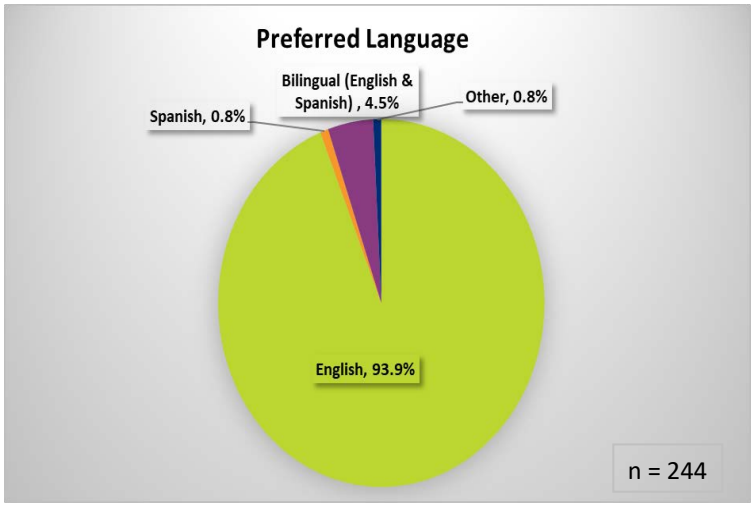
LGBTQI Categories	Percentage
Asexual	0.9%
Bisexual	14.3%
Gay	1.6%
Lesbian	2.5%
Omnisexual	1.2%
Pansexual	4.5%
Total (n = 61):	**25.0%**

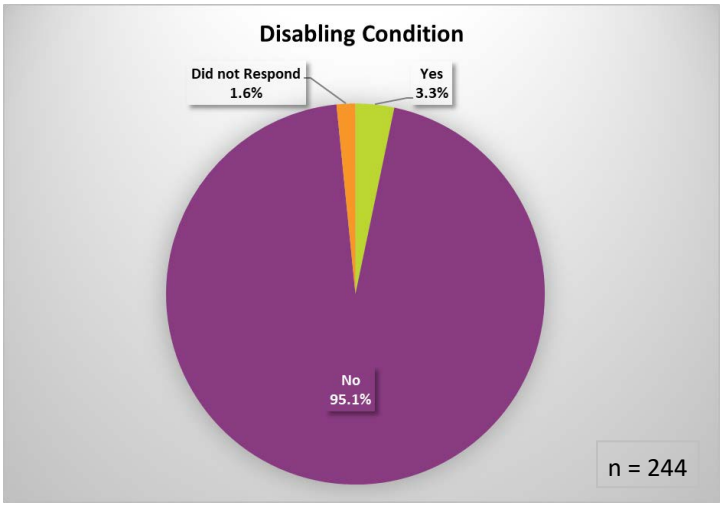
Participants were also asked if any of them identified themselves as LGBTQIA+. Results showed that the majority of participants responded "No" (62.3%, n = 152), while the remaining participants identified themselves as LGBTQIA+ (25%, n = 61), Other (6.6%, n = 16), and Unknown (6.1%, n = 15). Of those who did identify themselves as LGBTQIA+ (n = 61), the majority categorized themselves as Bisexual (14.3%, n = 35), as shown on table above.

Demographics: Residency, Language, Disabling Condition, and Veteran Status



During the fiscal year 2023-2024, the majority of SAYM participants lived in Moreno Valley (29.9%, n = 73), Lake Elsinore (15.2%, n = 37), and Hemet (10.2%, n = 25).

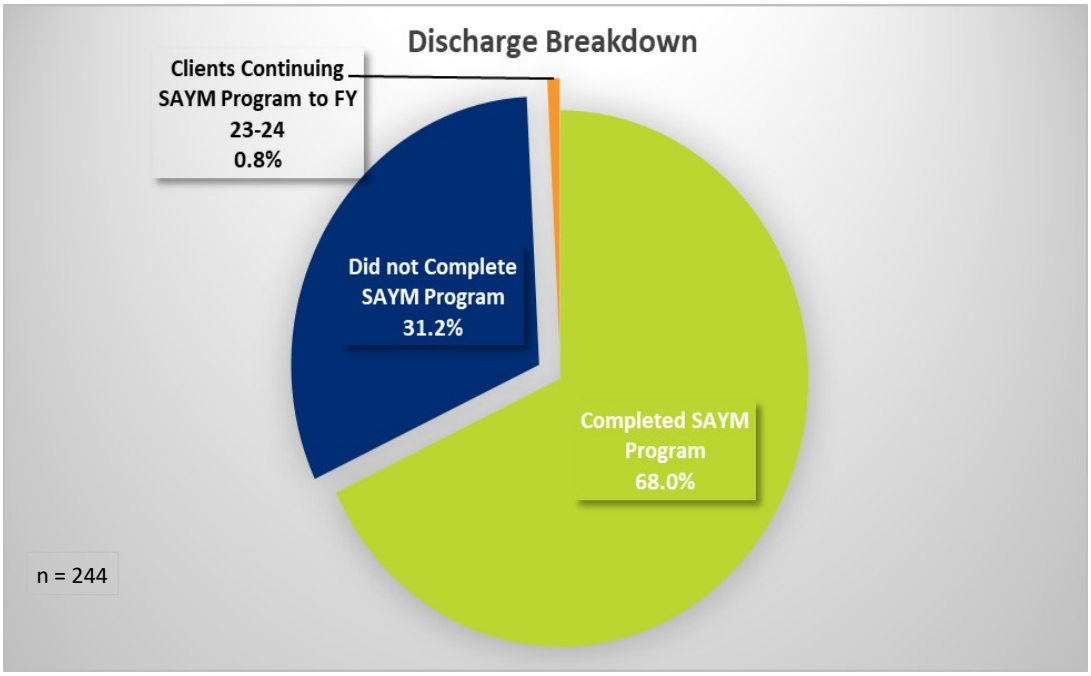




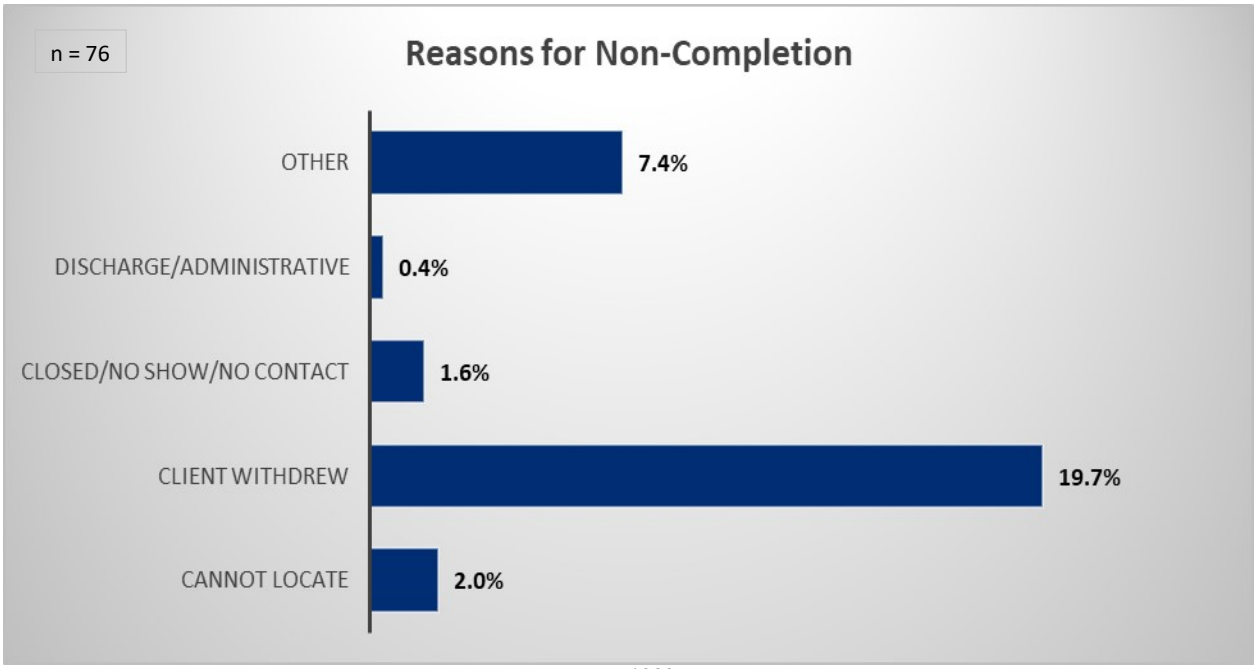
- The majority of SAYM participants responded that their preferred language is English (93.9%, n = 229), followed by Bilingual-English and Spanish (4.5%, n = 11), Spanish (0.8%, n = 2), and Other (0.8%, n = 2) respectively.
- The majority of SAYM participants indicated that they did not have any disabling condition (95.1%, n = 232), while a small percentage of participants responded as having a disabling condition (3.3%, n = 8), and 4 participants (1.6%) chose not to respond. Of the 8 participants who responded as having a disabling condition, 4 specified "ADHD" as the type of disability, while the remaining participants indicated as having Bad Vision, Dyslexia, Learning Disability, and Speech Impairment.
- In regards to veteran status, all SAYM participants (100%) indicated that they were not Veterans.

Service Information: Discharge & Non-Completion

The figure below pertains to the closed cases of SAYM Program in the fiscal year 2023-2024. There were two possible values: (1) *Did Not Complete*, and (2) *Completed*. A total of 166 participants (68%) completed the SAYM Program, while 76 participants (31.2%) did not. Of the total SAYM participants who completed, the majority (66.4%, n = 162) *completed with no further treatment required*, and 4 participants (1.6%) *completed with referral for further treatment*. Additionally, there are also 2 participants (0.8%) who are currently continuing in the FY 2024-2025 SAYM Program.

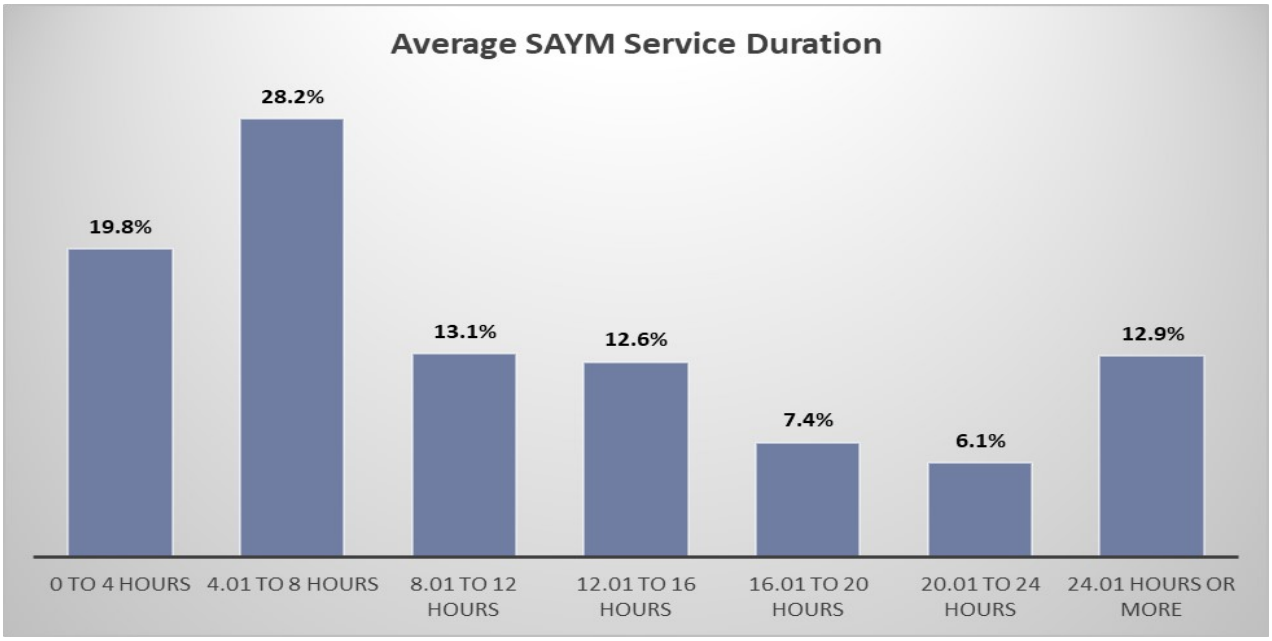


The discharge data on reasons for non-completion are shown in graph below. Overall, there were a total of 76 SAYM participants who did not complete the program during the fiscal year 2023-2024. The majority of participants *chose to withdraw from program* (19.7%, n = 48). There were also smaller percentages of participants who did not complete due to *unable to locate* (2%, n = 5), *no show/no contact* (1.6%, n = 4), or *administrative discharge* (0.4%, n = 1).

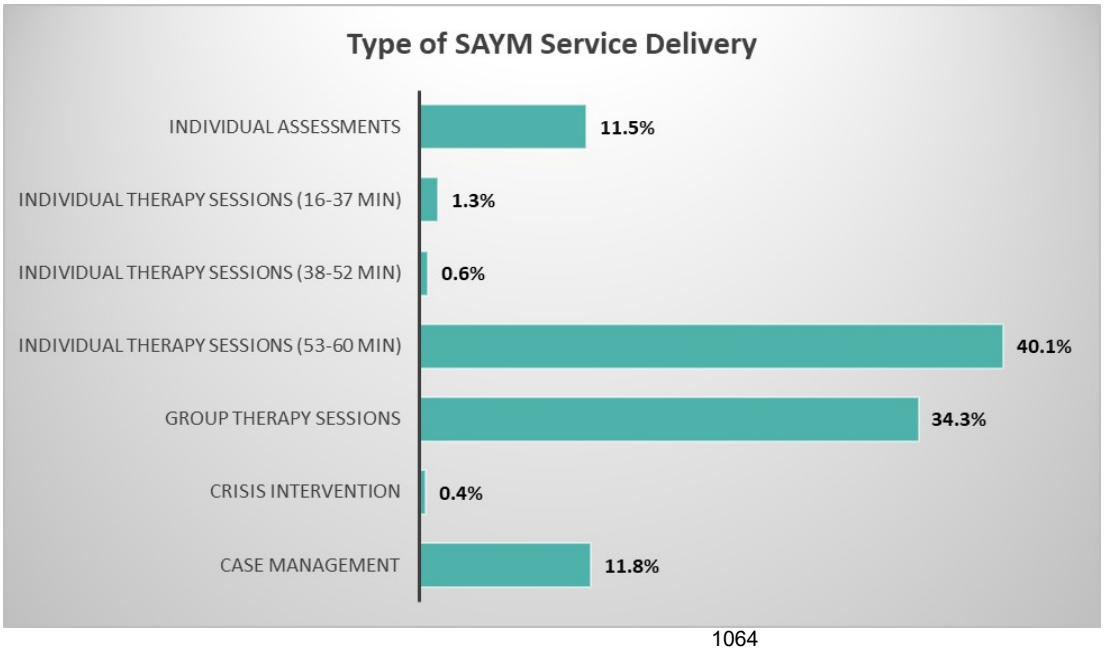


Service Information: Duration and Type of Delivery

Stress and Your Mood Program services can be provided as follows: group sessions, individual sessions, or a combination of both group and individual sessions. The graph below represents the average length of service hours provided for all SAYM participants during fiscal year 2023-2024. The majority of participants received between 4.01 to 8.0 hours of service (28.2%) and between 0 to 4.0 hours of service (19.8%), while the smallest percentage is for 20.01 to 24 hours of service (6.1%).



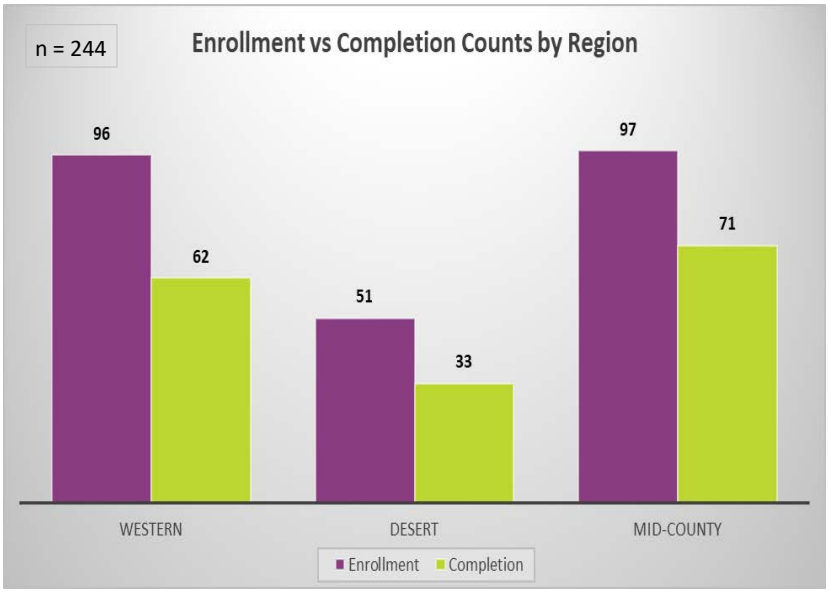
The graph and table below represent the type of SAYM services delivered: Individual Assessments, Individual Therapy Sessions (which have been categorized into different lengths: *16-37 minutes*, *38-52 minutes*, and *53-60 minutes*), Group Therapy Sessions, Crisis Intervention, and Case Management. Overall, the total service time provided during SAYM Program in FY 2023-2024 was **1,448.27** hours. Of these, the majority of service time provided was in *Individual Therapy Sessions* (a combined total of 806.02 hours), followed by *Group Therapy Sessions* (252.50 hours), *Individual Assessments* (203.58 hours), *Case Management* (180.42 hours) and *Crisis Intervention* (5.75 hours), respectively.

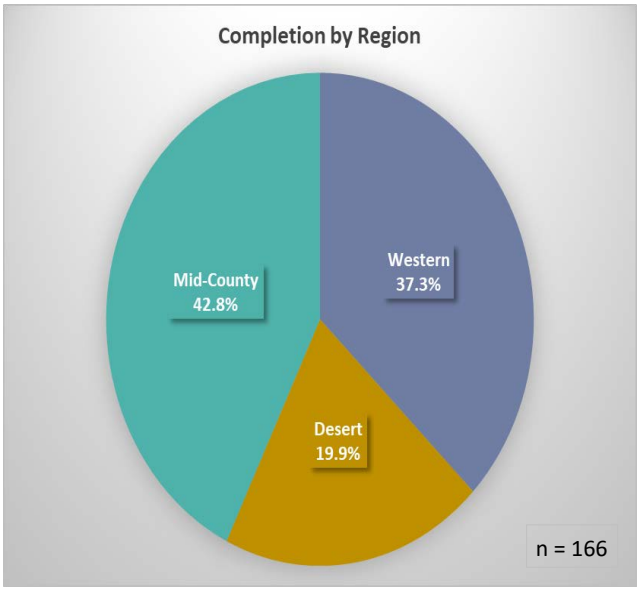


Type of Service Delivery	Total Hours Provided
Individual Assessment	203.58
Group Therapy	252.50
Individual Therapy (16-37 min)	12.27
Individual Therapy (38-52 min)	8.25
Individual Therapy (53-60 min)	785.50
Case Management	180.42
Crisis Intervention	5.75
Total Hours of Service Delivery	1,448.27

Program Completion

The figures below pertain to the total number of participants who completed the SAYM Program during the fiscal year by region.





There were a total of 244 participants enrolled in the Stress and Your Mood Program during the fiscal year 2023-2024. Of these, 166 participants completed the program, and 2 participants are continuing into the fiscal year 2024-2025. The majority of SAYM participants enrolled in the fiscal year 2023-2024 were from the Mid-County region (39.8%, n = 97), followed by the Western region (39.3%, n = 96), and the Desert region (20.9%, n = 51), respectively.

Overall, the completion rate of SAYM Program in FY 2023-2024 is 68% (166 out of 244 enrolled participants). The enrollment and completion counts by regions are summarized below:

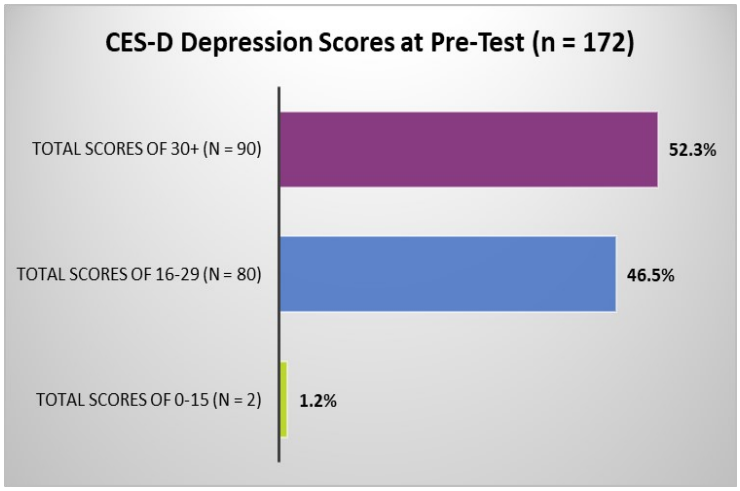
- In Mid-County region, 71 out of 97 participants completed the SAYM Program (42.8%)
- In Western region, 62 out of 96 participants completed SAYM Program (37.3%)
- In Desert region, 33 out of 51 participants completed SAYM Program (19.9%)

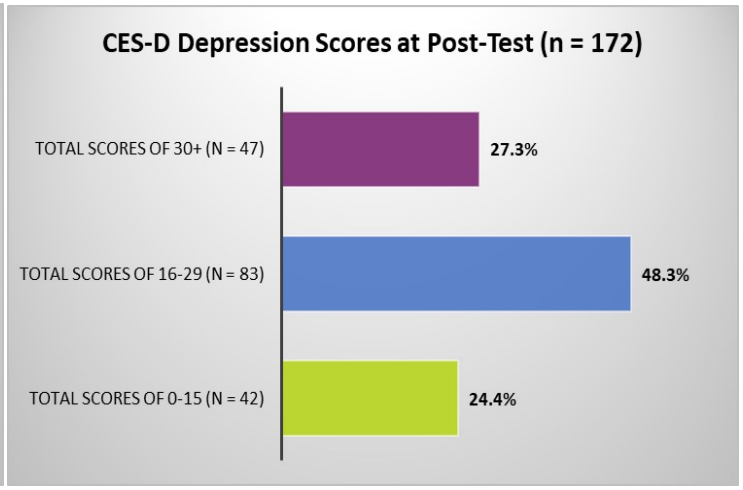
The table below displays the SAYM Program contract expectations, as well as the completion results (n = 166) during the fiscal year. Overall, there was a decrease in the enrollment of SAYM Program in comparison to FY 2022-2023 (from 274 enrolled participants enrolled in FY 22-23 to 244 enrolled participants in FY 23-24). In terms of contract expectation and percent completion, only Mid-County region exceeded the contract expectation in FY 2023-2024 (101.4%). Both Western region (88.6%) and Desert region (47.1%) did not meet their contract expectations in FY 2023-2024. Cumulatively within all regions of Riverside County, SAYM Program had an overall 79% contract completion rate.

SAYM Program Completions (N = 166)			
Source:	**Completed**	**Contract Expectations**	**Percent Completed**
Mid-County	**71**	**70**	**101.4%**
Western	**62**	**70**	**88.6%**
Desert	**33**	**70**	**47.1%**
Countywide	**166**	**210**	**79%**

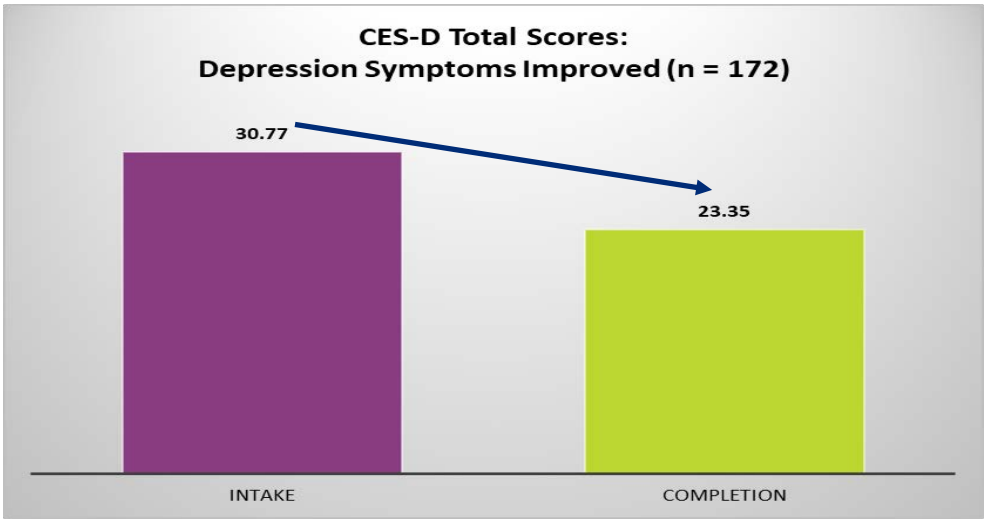
CES-D Scale: Pre to Post Analysis

The **Centers for Epidemiological Studies Depression (CES-D) Scale** is a measure of depression that assesses various depression symptoms experienced by participants during the SAYM Program. Responses are organized in a Likert-scale, where participants were asked to report a typical frequency in which a particular symptom occurs throughout the duration of the SAYM Program. Higher total scores could indicate a higher level of distress. Additionally, a score of 16 or more suggests a clinically significant level of psychological distress, although it does not necessarily mean that the participant has a clinical diagnosis of depression. The total of CES-D scores can range from 0 to 60, with higher scores indicating higher level of distress on the participants.





The graphs above represent the CES-D scores comparison from pre– to post-intervention, and only included participants who had completed both pre-tests and post-tests. A total of 172 participants had matched CES-D pre-and post-measures. Results from pre-tests indicated that there were 2 participants (1.2%) who had scored below 16 points, while the majority scored above 30 points (52.3%, n = 90), followed by those with scores between 16 and 29 points (46.5%). Results from post-tests showed improvements in CES-D scores. Participants who scored below 16 points had increased to 42 participants (24.4%), participants who scored between 16 and 29 points had increased to 83 (48.3%), and participants who scored 30 points or more de-creased to 47 (27.3%). These results suggest that overall, the SAYM Program had greatly helped participants to decrease their depression symptoms.



Further analysis using paired samples t-test is reflected on the graph above. Overall, results showed that on average, participants' depression symptoms improved after participating in the SAYM Program. The decrease in average CES-D scores at post-tests are also shown to be 7.42 points lower than the pre-tests, and based on the analysis, this change was shown to be statistically significant, $t = 9.511$, df = 171, p = .000.

CES-D Scale: Item-by-Item Analysis

The CES-D is a robust test that measures many aspects related to depression, and the table below shows an item-by-item analysis of the CES-D measures. The matched pairs t-test results indicated the improvements on every facet of CES-D criteria, and except for 1 item ("You felt that everything you did was an effort"), all other items showed to be statistically significant ($p < .05$). CES-D results on table below also illustrates the success ***and*** the improvements of the SAYM program across all depression statements, which suggest that the SAYM program has helped participants to significantly decrease their symptoms of depressions.

CES-D Item	Average Decrease	*t*	df	p
You were bothered by things that usually don't bother you	-0.33	4.235	171	.000
You did not feel like eating; your appetite was poor	-0.27	2.963	171	.003
You felt that you could not shake off the blues even with help from your family or friends	-0.43	4.761	171	.000
You felt that you were just as good as other people	-0.41	4.410	171	.000
You had trouble keeping your mind on what you were doing	-0.48	6.113	171	.000
You felt depressed	-0.46	5.892	171	.000
You felt that everything you did was an effort	-0.12	1.358	171	.176
You felt hopeful about the future	-0.27	3.173	171	.002
You thought your life had been a failure	-0.57	6.133	171	.000
You felt fearful	-0.39	4.690	171	.000
Your sleep was restless	-0.28	3.063	171	.003
You were happy	-0.27	3.245	171	.001
You talked less than usual	-0.40	4.485	171	.000
You felt lonely	-0.55	6.279	171	.000
People were unfriendly	-0.19	2.549	171	.012
You enjoyed life	-0.15	2.137	171	.034
You had crying spells	-0.28	3.379	171	.001
You felt sad	-0.53	6.823	171	.000
You felt that people disliked you	-0.45	4.812	171	.000
You could not "get going"	-0.59	7.091	171	.000

Clinical Global Impression—Improvement Scale

The Clinical Global Impression Improvement (CGI-I) Scale measures the clinician's assessment of how much the participant's symptoms have improved or worsened compared to the baseline measurement at the beginning of the intervention.

The CGI-I scale is used to track the progress of participants across three periods of the SAYM intervention:
1. Module 1 Intervention
2. Module 2 Intervention
3. Post Intervention

Clinicians rate total improvement in overall depressive symptomatology since initial enrollment. Total scores ranging from **1** (***very much improved***) to **7** (***very much worse***) measure the participants' improvement or de-crease in their overall depressive symptomatology since enrollment.

The following are descriptions of the scores participants can receive on the CGI-I scale.
CGI-I Rating Levels:

1) ***Very Much Improved*** - All or most of the target symptoms have been improved to a significant degree. Changes have a major and discernible impact on functioning, both subjectively and as observed by others. Clinicians are comfortable administering a simple maintenance treatment regiment, where there is little or no room for further improvement. Does not meet criteria for psychiatric disorder.

2) ***Much Improved*** - Several symptoms have improved to a degree that the participant feels an important change has occurred. The change is large enough that it's distinctly noticeable by others; however, there is still some room for improvement. Does not meet criteria for psychiatric disorder.

3) ***Minimally Improved*** - Only 1 or 2 symptoms (at most) show improvement, and the degree of change is not sufficient. Improvements may not be consistent across informants or domains of functioning. Thus, there is considerable room for improvement, clearly requiring further therapeutic adjustments. Possibly meets criteria for psychiatric disorder.

4) ***No Change*** - No symptoms are showing improvement compared to the baseline state, or changes are so minimal as to be completely inconsequential. Meets criteria for psychiatric disorder.

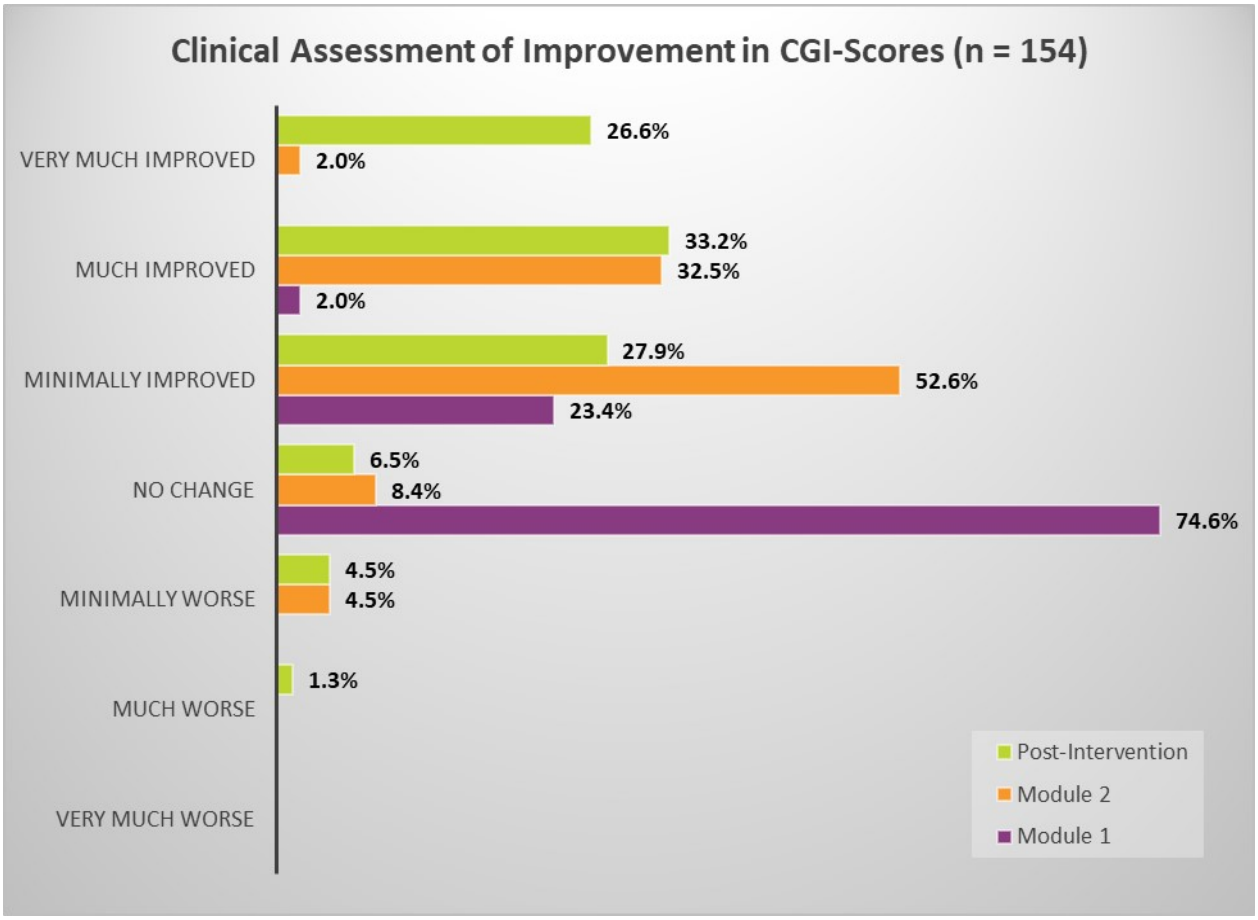
5) ***Minimally Worse*** - There is some worsening over the baseline state in the target symptoms, though not to a degree that one would wish to completely stop treatment. Nevertheless, changes in treatments need to be considered. Meets criteria for psychiatric disorder.

6) ***Much Worse*** - Participants condition is worse enough that stopping or changing treatment should be heavily considered, even though not all target symptoms are worse. Worsened condition is clearly discernible by the youth and other observers. Meets criteria for psychiatric disorder.

7) ***Very Much Worse*** - Most target symptoms are worse, where stopping, changing and/or adding new treatments is clearly apparent. Meets criteria for psychiatric disorder.

CGI-I Clinical Assessments: Pre to Post Intervention

Clinician ratings across each of the three time periods (i.e. *Pre-Intervention or Module 1*, *Module 2*, and *Post-Intervention*) are shown on the graph below. CGI-I scores were provided for the 154 participants who had a rating for all three time periods. Overall, there are notable improvements from Pre-Intervention/Module 1 to Post-Intervention. The graph below is structured so that the top bar represents positive outcomes and the bottom portions represent negative outcomes, showing 3 different modules: Pre-Intervention/Module 1, Module 2, and Post-Intervention.



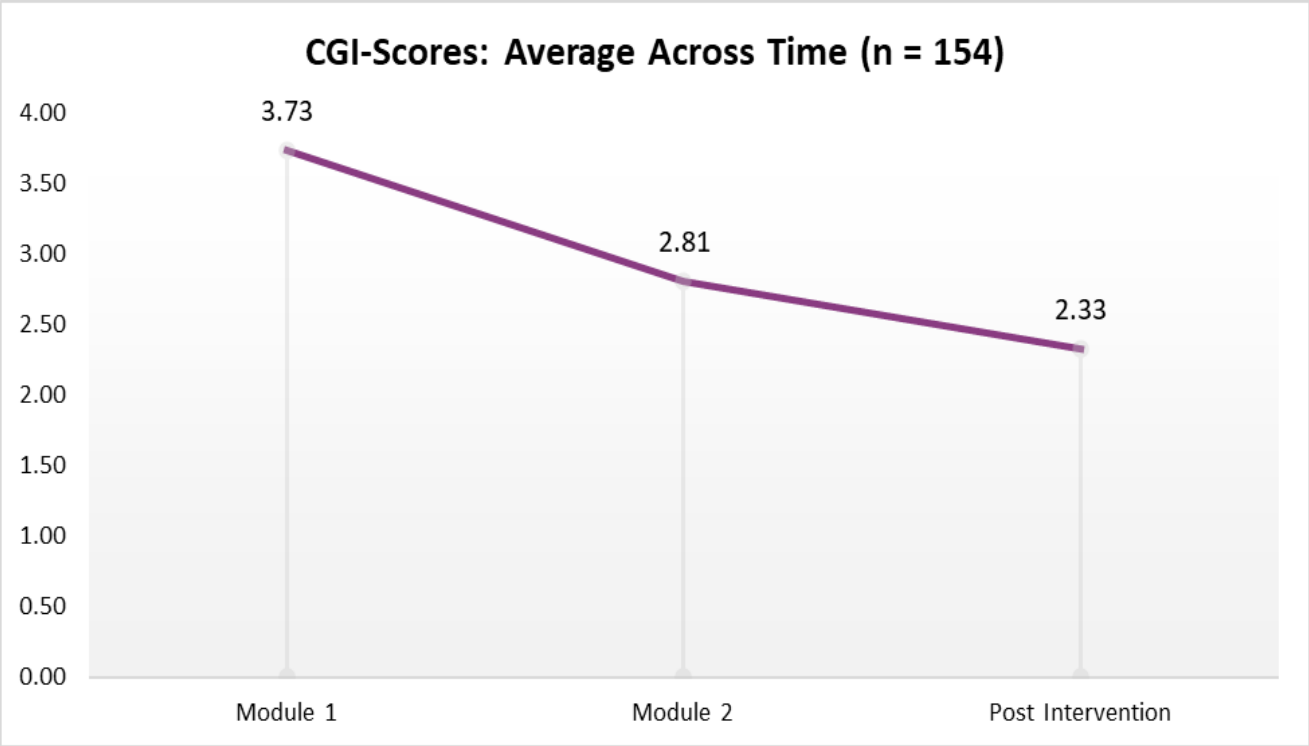
At the conclusion of Module 1, a total of 23.4% of SAYM participants were recorded as "Minimally Improved" and 1.9% of participants were recorded as "Much Improved"(25.3% combined), while 74.7% showed "No Change" on their symptoms.

After Module 2 completion, the improvements were much higher, where a total of 52.6% of SAYM participants were "Minimally Improved", 32.5% "Much Improved", and 1.9% "Very Much Improved" (87% combined). Additionally, there were only 8.4% of participants recorded as"No Change" and 4.5% recorded as "Minimally Worse" on their symptoms.

After SAYM completion, at the conclusion of Module 3, participants showed significant improvements. There were a total of 87.7% participants with improved symptoms in some capacity, in which a large portion of 33.1% were "Much Improved", 26.6% "Very Much Improved", and 27.9% "Minimally Improved". There were only 6.5% participants with "No Change", 4.5% participants were"Minimally Worse", and a small percentage 1.3% were" Much Worse" symptoms. Further analysis on the CGI-I scores are shown on the following page.

CGI-I Results: Pre to Post Analysis

The following graph reflects the change in scores from Pre-Intervention (Module 1) to Post-Intervention (Module 3). Lower scores represent lower Depression Symptomology in 183 participants who completed all three modules. These scores significantly improved as recorded by clinicians, from pre-intervention (3.44) to post-intervention (2.07).



CGI-I Scores Measurement: T-Test Pre to Post					
Interval	**Pairs**	**1st Level**	**2nd Level**	**Difference**	**Significance**
Module 1 (Pre) to Module 2 (Mid)	**154**	**3.73**	**2.81**	**-0.92**	**.000**
Module 2 (Mid) to Module 3 (Post)	**154**	**2.81**	**2.33**	**-0.48**	**.000**
Module 1 (Pre) to Module 3 (Post)	**154**	**3.73**	**2.33**	**-1.4**	**.000**

Further comparison analysis using the paired-samples t-tests indicated that there were more improvement in participants' psychiatric symptoms from Module 1- to Module 2-Interventions with a difference of 0.92 points (t = 16.132, df = 153, p = .000), compared to Module 2 to Post-Interventions with a difference of 0.48 points (t = 0.661, df = 153, p = .000), with a difference of 0.44 point.

Both results also showed statistical significance across all modules, which suggests that the SAYM Program did help to reduce participants' depression symptoms to "Much Improved" (based on the clinicians' assessments across all modules shown on previous page). Additionally, the highest significant improvements were shown from Module 1 to Post-Interventions, with a difference of 1.4 points (t = 15.198, df = 153, p = .000), which suggests that participants would benefit the most significant decrease in their symptoms if they were to complete the entire SAYM Program, as noted on table above.

Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR)

The Youth-Outcome Questionnaire Self-Report (Y-OQ®-SR) is a measure of a wide range of behaviors, situations, and moods which commonly apply to youth. Five sub-scales analysis are included in the Y-OQ®-SR that were used in the SAYM Program, which measures behavioral problems as well as elements of healthy behaviors:

- ***Intrapersonal Distress***
- ***Somatic***
- ***Interpersonal Relations***
- ***Social Problems***
- ***Behavioral Dysfunction***

Each subscale on the Y-OQ®-SR questionnaire is a summation of selected items as shown on table below, and the total score reflected on the Y-OQ®-SR questionnaire is the summation of items from each sub-scale and is designed to reflect the total amount of distress a child or adolescent is experiencing.

Y-OQ®-SR Scales and Item Numbers

Scales Measured in Y-OQ®-SR Questionnaire	Item Numbers
Interpersonal Distress	1,3,5,9,15,17,25,32,33,34,41,49,53,57,61,62,63,64
Somatic	2,10,18,26,35,42,50,54
Interpersonal Relations	4,7,11,16,20,24,27,36,37,43
Social Problems	6,13,22,29,31,39,47,55
Behavioral Dysfunctions	8,14,23,30,40,45,48,52,56,59,60

General Uses/Advantages-YOQ

- Risk assessment. High scores on critical items scales indicate those who may need an immediate intervention beyond standard outpatient treatment.
- Subscale scores can be used to identify and target particularly problematic areas such as a focus of treatment and cues on treatment planning.
- Overall change can be tracked from total scores, and specific symptoms or behaviors can be tracked using subscale scores.
- The Self Report Youth-Outcome Questionnaire (Y-OQ®-SR) can be used to track participant's therapeutic progress.

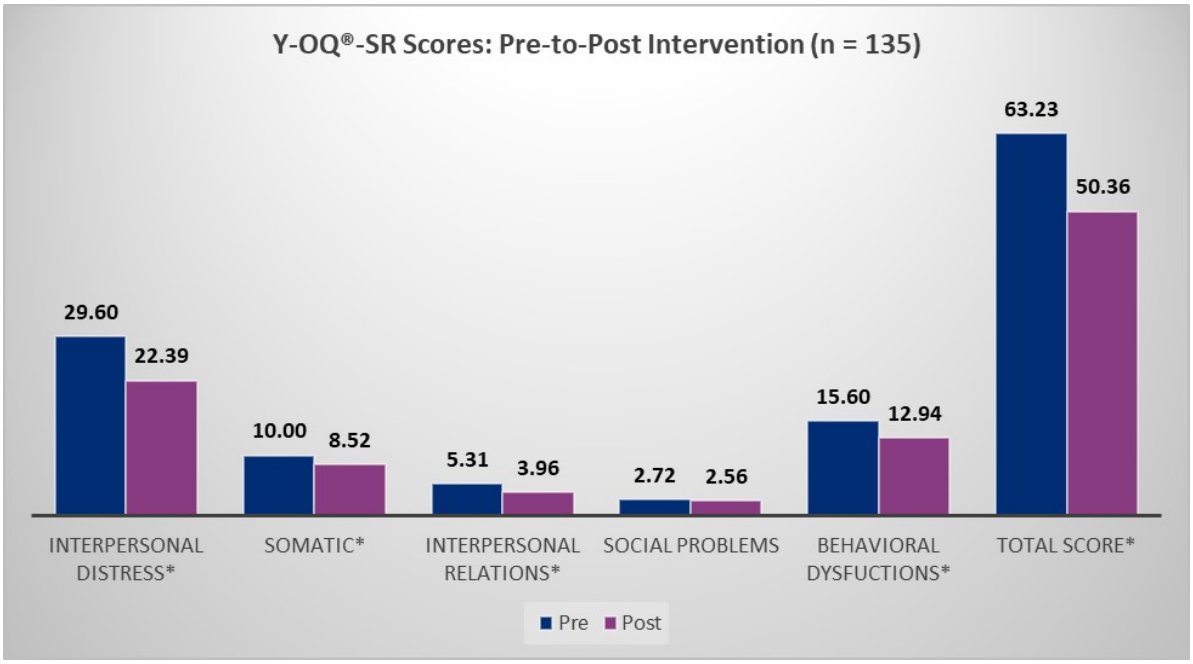
Guidelines for Clinical Interpretation

The Y-OQ®-SR total score quantifies overall level of disturbance. A total score of 46 or higher is considered within the clinical or dysfunctional range, while a total score under 46 is considered to be normal or within the non-clinical range. The satisfactory change index for the Y-OQ®-SR is 13 points, which means that the participants must report a minimum change of 13 points in their ***total score*** from pre- to post- measures in order for that change to be considered clinically significant.

Y-OQ®-SR: Pre to Post Analysis

The table below shows the average decrease on all subscales measured in the Y-OQ®-SR analysis from pre– to post intervention. There were a total of 135 participants between the ages of 15 to 17 years of age, who completed both pre and post measures. Overall, participants' average scores showed statistically significant decreases across all subscales. The average total scores also decreased significantly by 12.87 points, which is slightly less than the YOQ satisfactory change index of 13 points. This indicates that the average improvements were slightly below clinically significant. In the table, an asterisk indicates significant changes within that particular scale. All scales except "Social Problems" scale, were shown to be statistically significant.

Y-OQ®-SR Scales	Average Score Decrease	*t*	df	p
Interpersonal Distress*	-7.21	7.732	134	.000
Somatic*	-1.48	4.032	134	.000
Interpersonal Relations*	-1.36	3.336	134	.001
Social Problems	-0.16	0.594	134	.553
Behavioral Dysfuctions*	-2.66	5.315	134	.000
Total Score*	**-12.87**	**7.028**	**134**	**.000**



Average pre to post Y-OQ®-SR scores for the SAYM Program were analyzed with paired samples t-tests from 135 participants. Based on the statistical analysis, all post-test scales showed statistically significant changes from pre-test scores (p = .000), except for "Social Problems" scale. The total scores represent the summation of all items in the survey, and the rest of the sub-scales are sums of selected questions within the survey. Overall, the decreases in the total score signifies that there were reductions in the general level of distress. The total scores also showed a statistically significant decrease from pre-test (63.23) to post-tests (50.36), *t* = 7.028, df = 134, p = .000. Although all the scores showed statistically significant decreases from pre– to post measures, participants on average are still considered within the clinical or dysfunctional range after the SAYM Program completion (i.e. the average total scores are still shown as higher than 46 points). This result is consistent with the result of CES-D analysis on page 10, which suggests that participants were significantly depressed prior to starting the SAYM Program, and also suggests that by completing the SAYM program, participants have actually shown improvement in their depression symptoms and general mental health functioning.

BASIS-24® Scale

The BASIS-24® scale is a twenty-four item self-report questionnaire designed to assess treatment outcomes by measuring symptoms and functional difficulties. Scores can be computed for the overall BASIS-24®, as well as for the following six scales:

- ***Depression and Functioning***
- ***Interpersonal Relationships***
- ***Psychosis***
- ***Substance Abuse***
- ***Emotionally Labile***
- ***Self-Harm***

BASIS-24® Scales and Item Numbers

Scales Measured in BASIS-24® Questionnaire	Item Numbers
Depression and Functioning	1,2,3,9,10,12
Interpersonal Relationships	4,5,6,7,8
Psychosis	14,15,16,17
Substance Abuse	21,22,23,24
Emotionally Labile	13,18,19
Self-Harm	11,20

Outcomes evaluation of SAYM Program included a general measure of functioning for Adults 18 to 25 years of age. Participants were asked to take the BASIS-24® tests before starting the SAYM Program and after program completion (i.e. pre- and post-interventions).

BASIS-24® questions are scored on a 5-point Likert scale (i.e. score values from 0 to 4) reflecting either a spectrum of difficulty with the behavior in question or the frequency with which someone engages in a particular behavior.

Difficulty spectrum of responses: (*e.g. difficulty sleeping, coping with life problems*)
0 = “no difficulty”
1 = “a little difficulty”
2 = “moderate difficulty”
3 = “quite a bit of difficulty”
4 = “extreme difficulty”

Frequency spectrum of responses: (*e.g. feeling confident in yourself, feeling sad/depressed*)
0 = “none of the time”
1 = “a little of the time”
2 = “half of the time”
3 = “most of the time”
4 = “all of the time”

Lower scores indicate more normative, non-clinical aspects of general mental health functioning, while higher scores indicate greater symptomatology. The average intake scores for all SAYM participants on the BASIS-24® tests on both the subscales and total scores are shown on the table and graph on the following two pages.

BASIS-24® Subscales and Results

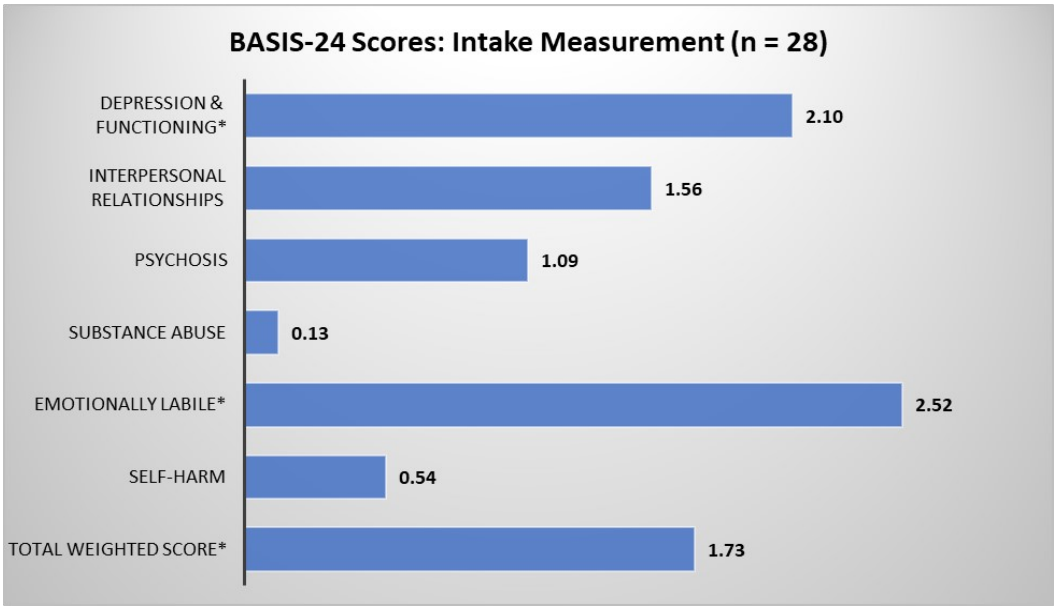
There are a total of 28 participants between the ages of 18 to 25 years old who completed the BASIS-24® during intake. Overall, participants showed low scores for "Psychosis", "Substance Abuse", and "Self-Harm" subscales. Given that SAYM is designed for Early Intervention for depression, the low scores in these subscales showed that the population served matches the intended target population. Based on analysis at intake, the following subscales presented difficulties to participants:

Depression and Functioning Scale: 2.10

Participants are experiencing some difficulty in their functioning due to depressive symptomatology.

Emotionally Labile: 2.52

The average participant is experiencing excessive emotional reactions and frequent mood changes on a periodical basis, indicating that participants are experiencing some debilitation by not being able to control their emotions.



The table below shows the results of only the participants ages 18 to 25 years of age who had matched pre– and post measures. There were a total of 12 participants who completed and were included in the analysis. Since the sample size is relatively small, it may be challenging to make a solid conclusion based on these results. With a low number of participants for this analysis, it is not typical to do statistical tests. Generally, the differences in the average scores on all subscales and total weighted score from pre-tests to post-tests showed decreases. The most decreases were shown on the *Depression and Functioning Scale* (0.86 points) and *Emotionally Labile Scale* (0.56 points). Despite the low sample size, considering these 2 sales were shown to have the highest scores at intake, it is still worthwhile to note that the improvements at post-measures are also shown on these 2 scales, which suggests that SAYM Program helped participants to decrease their Depression and Emotional Distress.

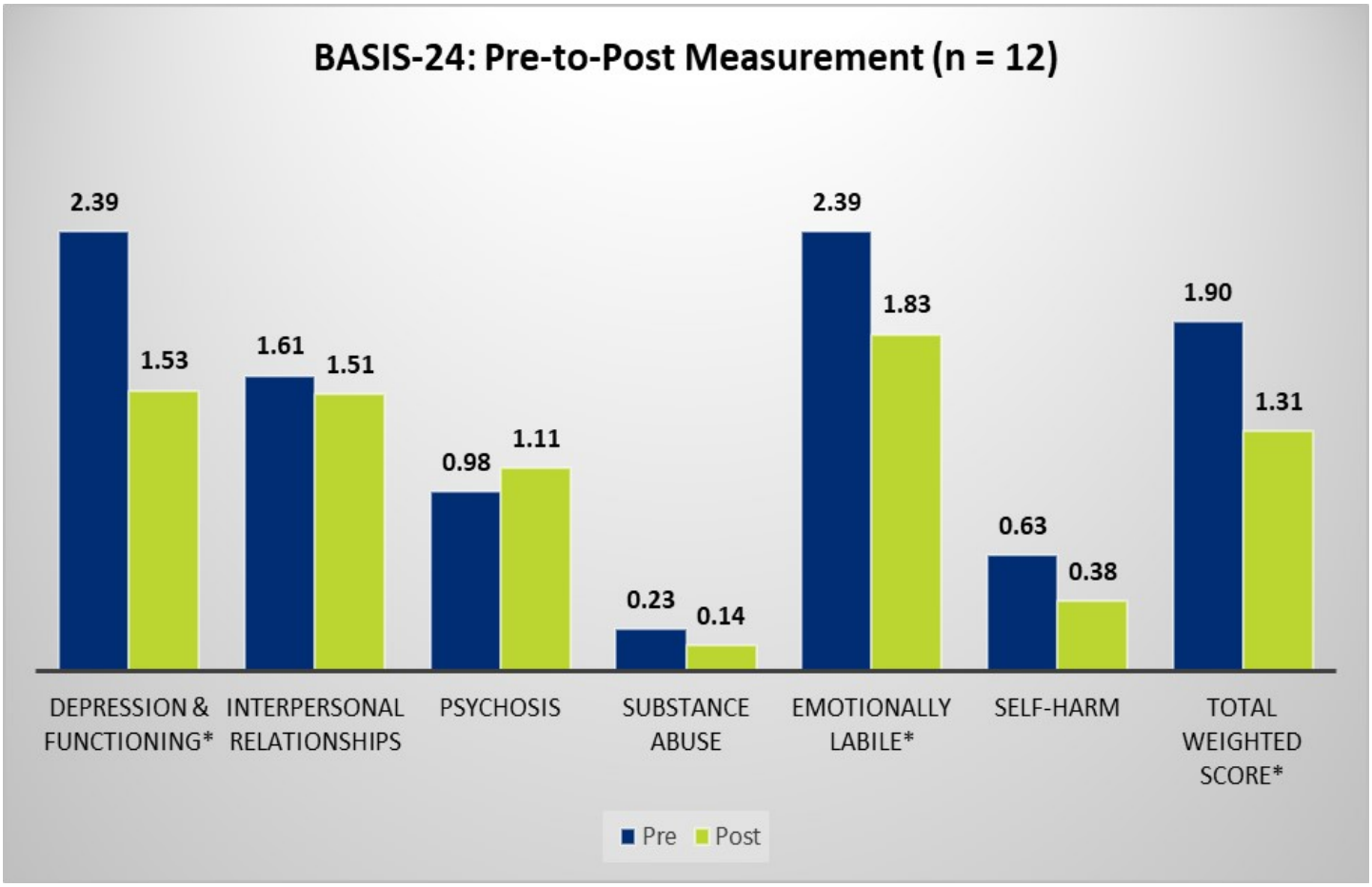
BASIS-24 Scales	Pre-Post Score Difference
Depression & Functioning*	-0.86
Interpersonal Relationships	-0.10
Psychosis	0.13
Substance Abuse	-0.09
Emotionally Labile*	-0.56
Self-Harm	-0.25
Total Weighted Score*	-0.59

BASIS-24® Pre-to Post– Analysis

The graph below shows how SAYM participants who are over 18 years of age before and after the SAYM Program. There were a total of 12 SAYM participants between the ages of 18 to 25 years old who completed both pre– and post-BASIS-24® measures. Overall, there are decreases across all subscales except Psychosis which was very low at intake. Furthermore, participants had relatively low or zero scores for the following subscales: "Substance Abuse" and "Self-Harm" at intake. These symptoms were not reported to be a significant issue for those served.

Since there were only 12 participants who completed and had matched pairs of BASIS-24® measures, the statistical significance test was not possible. Overall, results showed decreases across all subscales, although they were only 0.9 points or lower. However, this does not mean that the SAYM Program did not help the participants, and conclusions should not be made based on the results due to the small sample size. It should also be noted that the analysis was only based on the participants who are over 18 years of age. The overall "Total Weighted Scores" across subscales are also low at intake, and shown as deceased at post-measures (0.59 points).

In sum, these subscales are useful in understanding SAYM participants' other areas of mental functioning. decreases are seen across most subscales and the total score.



Post-Satisfaction Surveys

The Post-Satisfaction Surveys for the Stress and Your Mood Program were collected from participants at the conclusion of the program's services. Participants were asked to rate nine satisfaction survey items on a five-point Likert scale, where: ***1*** *= Strongly Disagree,* ***2*** *= Disagree,* ***3*** *= Neutral,* ***4*** *= Agree, and* ***5*** *= Strongly Agree*. A total of 169 SAYM participants completed the post-satisfaction surveys during the fiscal year 2023-2024, The post-satisfaction survey results are shown on table below, with a corresponding graph that illustrated the survey results shown on the next page.

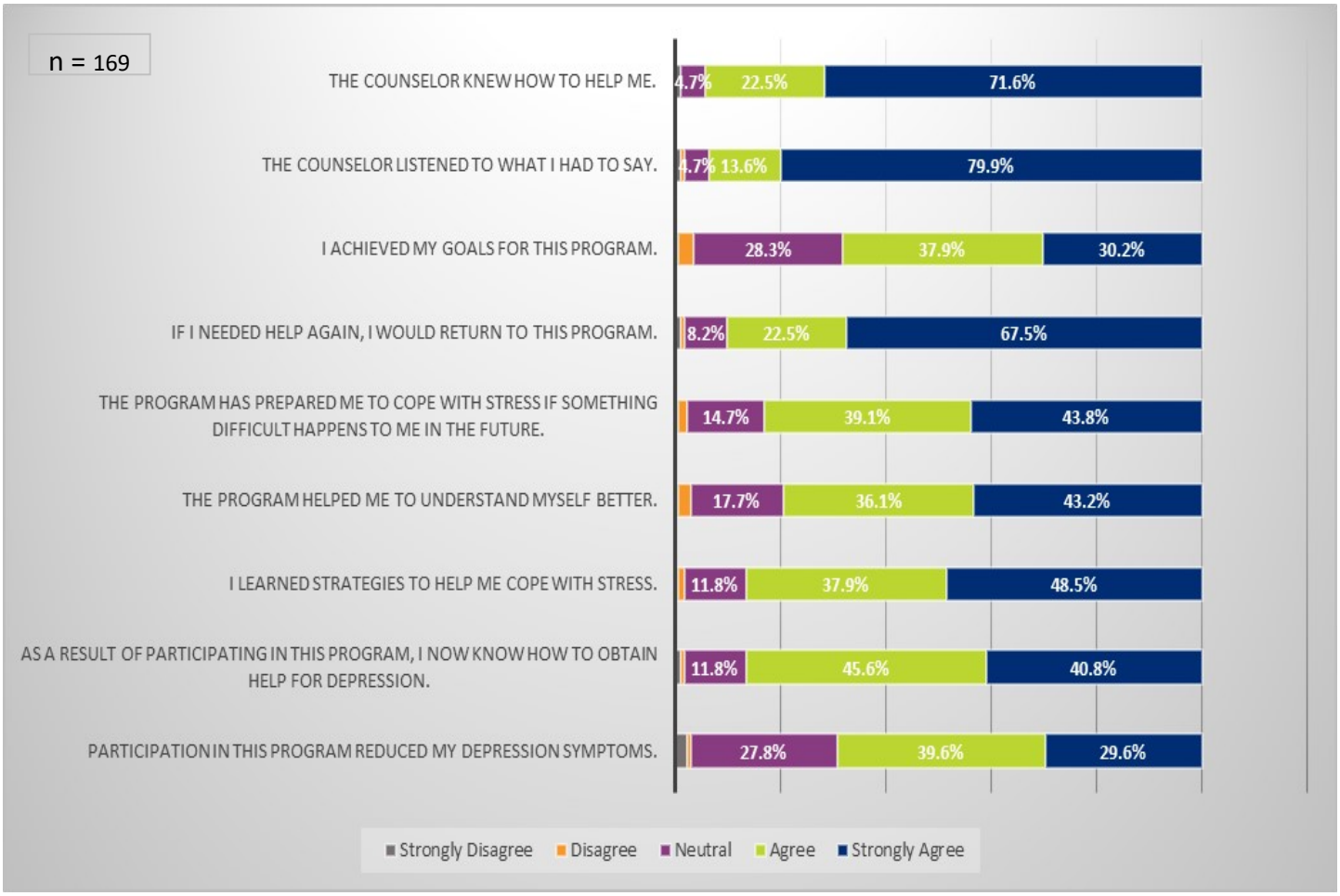
Post-Satisfaction Survey Results

Item No.	Countywide (n = 169)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	Participation in this program reduced my depression symptoms.	2.4%	0.6%	27.8%	**39.6%**	**29.6%**
2	As a result of participating in this program, I now know how to obtain help for depression.	1.2%	0.6%	11.8%	**45.6%**	**40.8%**
3	I learned strategies to help me cope with stress.	0.6%	1.2%	11.8%	**37.9%**	**48.5%**
4	The program helped me to understand myself better.	0.6%	2.4%	17.7%	**36.1%**	**43.2%**
5	The program has prepared me to cope with stress if something difficult happens to me in the future.	0.6%	1.8%	14.7%	**39.1%**	**43.8%**
6	If I needed help again, I would return to this program.	1.2%	0.6%	8.2%	**22.5%**	**67.5%**
7	I achieved my goals for this program.	0.6%	3.0%	28.3%	**37.9%**	**30.2%**
8	The counselor listened to what I had to say.	1.2%	0.6%	4.7%	**13.6%**	**79.9%**
9	The counselor knew how to help me.	1.2%		4.7%	**22.5%**	**71.6%**

The SAYM post-satisfaction survey results are summarized below:

- **69.2%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program reduced their depression symptoms, while **27.8%** of participants felt "Neutral" about this statement.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they know how to obtain help after completing the SAYM Program.
- **86.4%** of participants "Agreed" or "Strongly Agreed" that they learned strategies in the SAYM Program to help them with coping with stress.
- **79.3%** of participants "Agreed" or "Strongly Agreed" that the SAYM Program has helped to understand themselves better.
- **82.9%** of participants "Agreed" or "Strongly Agreed" that the SAYM program helped them to cope with stress if something difficult happens in the future.
- **90%** of participants "Agreed" or "Strongly Agreed" that they would return to the SAYM Program if they felt that they needed help.
- **68.1%** of participants "Agreed" or "Strongly Agreed" that they achieved their goals after participating in the SAYM Program, while **28.3%** of participants felt "Neutral" about this statement.
- **93.5%** of participants "Agreed" or "Strongly Agreed" that the counselors listened to what they had to say.
- **94.1%** of participants "Agreed" or "Strongly Agreed" that the counselors knew how to help them.

Post-Satisfaction Survey Results



As illustrated on the previous table, the general responses to the SAYM Program are overwhelmingly positive, with more than 79% of participants either "*Agreed*" or "*Strongly Agreed*" to most of the statements on the post-satisfaction surveys, except for the following:

- "Participation in this program reduced my depression symptoms" (where 69.2% responded *Agreed or Strongly Agreed,* and 27.8% still felt *Neutral* about this statement).
- "I achieved my goals for this program" (where 68.1% responded *Agree or Strongly Agreed*, and 28.3% still felt *Neutral* about this statement).

Additionally, more than 93% of participants responded that they either "*Agreed*" or "*Strongly Agreed*" in regards to statements about their counselors:

- "The counselor listened to what I had to say."
- "The counselor knew how to help me."

Post-Satisfaction Survey Comments

Youth satisfaction surveys included additional spaces for write-in comments. SAYM Participants were asked to comment on aspects of the program they liked, did not like, and what they learned from the program. Most of their comments are detailed below and on the next three pages.

1. Things I learned in the program are...

"Attending this group I've learned many things. Having self love, focusing on my mental health, being open minded, and keeping in mind that it's okay to cry and bounce back."
"How to communicate my emotions cope with situation."
"New ways to cope with anger towards someone."
"Want to cope with stress and want to stop having negative thoughts."
"Something I learned from this program is what causes my moods and how to cope with stress."
"I learned if my mind is racing to write my thoughts down."
"How to get help if I think about hurting myself or others."
"To not be afraid to reach out for guidance for mental health."
"I learned how to not to self sabotage."
"I learned many ways to cope with stress, how to help others, and really just understand myself better."
"How to cope with my feelings as well as understanding myself."
"That I'm not alone and I can always talk about my problems with someone."
"How to help myself get through life easier."
"That I'm not alone and I can do this."
"How to identify and manage positive self-disclosures or negative ones, and stopping cognitive disclosures."
"I learned to finally speak about my feelings and to not bottle everything up."
"How to cope with my emotion."
"How to cope with stress and ways to be more confident."
"I learned how to cope with my emotions and learned about ones people experiences."
"Healthy coping skill for careful situations, how/who to reach out If I need help with mental issues."
"I learned ways to cope with sad emotions I also learned different ways people's mind works."
"Exercise on how to control yourself methods on mental health."
"How to ask for help, cope with stress, way to distress myself."
"How to cope with negative and positive thoughts breathing techniques."
"How to deal with my stress and any irrational thoughts."
"How to communicate better, be more understanding with how others feel."
"I learned how to focus on myself, and how to distress."
"I learned I'm not alone and always have someone."
"How to understand myself and others when going through situations."
"I learned about mental illness and staying in a moment to calm down. Using coping skills I learned in the program."
"How to communicate not to depend on people to change, how to cope, spend time with friends."
"I learned ways to control my anger on the spot."
"Ways to cope with negative thoughts as well as doing activities to improve myself."
"Thinking more positively, social speaking/sharing and coping strategies."
"The point of realization about my problems, ways to know what the problem is and some how reflect on it."
"Thanks to the counselor I was able to relax and be able to control my emotions, actions, and feeling."
"How to deal with thoughts how actions can change my thoughts and emotion; and that it's okay to reach out for help."
"Finding ways to cope with myself, reflect on my actions, helped me set a goal for myself."

1. Things I learned in the program are… (continued)

"I learned how to be more aware of my emotions and to deal with them more."
"How to deal with negative thoughts and how to get over them."
"How to love myself and appreciate life."
"How to cope with boredom, stress and feeling alone"
"How to manage my thoughts and knowing it's okay to feel a certain way that it's not always wrong to say or do."
"What I learned in the program is how to take care of ourselves physically and mentally. Breathing techniques, exercises, and how to relax our mind."
"Learning how to start putting myself first."
"Coping with anxiety and coping with emotions."
"Learned how to cope with activating events and resolve problems in life."
"How to handle my emotions and dealing with my problems with others."
"How to manage stress, different kinds of research spiraling and learning to second things in a positive way. I also learned to deal with depression, and how to respond quickly to certain situation, in order for me to communicate."
"I learned that it is okay to talk to someone abut how you are feeling or what your going through."
"That feelings should be managed and not disregarded no matter how insignificant it may seem."
"Ways to manage my emotions and how to communicate them to others effectively."
"How to communicate better with both adults and people my age. How to manage my thoughts and outlook. Feeling more comfortable being myself."
"How to view criticism from certain family members/people and not internalize it."
"I learned how I was feeling when I didn't know what it was."
"How to cope with stress and anxiety through coping mechanisms such as meditation."
"How to set small realistic goals that helps you keep going everyday."
"How to manage stress and alleviate negative feelings."
"I learned physical ways to calm down by feeling and thinking about my surroundings/mediation skills."
"Different ways to calm down and cope with stress like thinking of a good place, tightening and releasing muscles and breathing exercises."
"I learned how to cope and how to recognize my flaw and where I need room to improve."
"How to cope with stress and depression."
"How to manage stress and anxiety while in difficult situations."
"I learned how to communicate and I learned that I and control how I think and therefore control how I feel."
"List of things on how to cope with things and not worry about anything and just enjoy life."
"How to not be so fearful of change and appreciate it. Learned how to deal with losing people. How to not let others worry about me."
"Positive counter thoughts; breathing techniques to help my anxiety and thinking with the logical mind, and identifying emotion and separating school work from my own time outside of school."
"How to talk with someone who's having a bad day and be the person to talk to."
"Participating in this program reduced negative thoughts."
"How to stay calm and positive."
"How to think and control my anger"
"Ways to think positively, how to relax and destress, and journaling my feelings/thoughts."
"I learned to deal with my stress and worrying what I have, and that's it's okay to talk about my feelings and how to calm myself down."
"I learned how to recognize my feelings, negative thoughts into positive ones, etc."
"I learned how identify my tell-tale signs. Once I learned them, then I learned how to cope."
"I learned ways to communicate with those around me so that relationships are stronger and filled with trust. I also learned how to know when my thoughts were irrational and how to change them to be more positive."

2. What I liked about the program is…

"Our counselor is Awesome! She's so caring, and gives the best advice. She's never made me feel uneasy or anything I felt so safe and cared for when expressing myself to her."
"Our counselor! He is super sweet and coping and listens to what we say."
"Having a calm space to be able to talk."
"What I liked about this program was the methods. They wasn't boring but simple enough to understand."
"I liked the group because it's very welcoming."
"I was comfortable with everyone in the group."
"I felt heard, the program made me feel like I had voice."
"Love the snacks, activities, and people in here were all so great. I also love my counselor, overall he's a good listener and knows what to say, and he's also funny."
"Hearing what others say when they go through their problems."
"How fun and honest it is. I can be very honest."
"I liked that I got to met new people and I learned a lot more about my friends."
"Being able to talk about our weeks with no judgement."
"I loved the program it was such an amazing stress reliever, I felt safe."
"I like the counselor, she listened to me and made me feel comfortable. I like how I'm not alone, knowing others shared and I can relate."
"How I got to meet new people from my school I didn't know before."
"Being able to talk with and relate with others."
"It was a safe place, everyone was understanding."
"I liked that I can relate to the people's problems."
"That I felt comfortable and it was welcoming."
"I liked how it was very active and everyone participated."
"Being able to be comfortable around others. Not being shy feeling safe around others."
"My counselor, made me very comfortable to talk to."
"It was welcoming. I felt like I was able to open up about my issues."
"I liked that it was a group and I had people in here that I knew which they helped us along the way."
"My counselor very understanding and 10/10 person."
"I was able to engage with someone and not feel like I was able to be confident."
"How kind our counselor is."
"How my counselor was able to respond and help me when I was down at night and I felt heard."
"I like how it was able to work out with my schedule and if I could not make it to the session there was no trouble."
"I got to see the others improve with me."
"I liked that I got to hear about other people's problem and how to deal with it."
"It felt like a safe space where I was able to be myself."
"I made new friends and had amazing time here."
"How nice and caring the counselor was. I always had the best day."
"You get to talk about your feelings you get helped if needed."
"Everyone was open with what they were feeling and it was a very comfortable experience."
"The energy and good vibe I got every time I walked in."
"My counselor was a really good presenter."
"Being able to have a safe space as well as someone who understood me, and being vulnerable without judgment."
"I felt supported when people listen to me."
"I learned how to confront my issues with others rather than let my emotions build up."

2. What I liked about the program is… (continued)

"I loved how my counselor took time to get to know each one of us. It made me feel more comfortable talking about my problems to her. She was always so welcoming. Loved the snacks, and I learned so much."
"How it let me to allowed me to express my feelings and to get them off my chest."
"It was a really friendly environment despite whatever was going on."
"That the counselor listened to everything we had to say."
"I had a safe space to talk to someone and it helped me very much."
"How understanding and comfortable I felt while talking."
"I didn't feel forced to share my past traumas, I could be myself. I felt listened to and my counselor really, really is sweet. I was able to put my coping skills to use."
"I don't feel alone because hearing everyone also go through similar things that I go through is comforting."
"How I always felt listened to and what I said and thought was valid."
"It was all very personal and suited for what I needed."
"My counselor really understood me and let me be heard."
"My counselor, being able to talk about issues or feelings being able to view things differently."
"I like that I finally felt like someone was listening to me and actually cared for me and what I had to say. I liked feeling wanted and I got to have someone hear me out."
"That my counselor cared about me and listened while still helping me."
"I liked that I was able to express how I feel without being judged."
"I liked that I can talk about anything without judgment and that really helps me."
"It helped me feel comfortable with myself and helped me come out a little more."
"Liked that I could talk about whatever without being judged."
"That there are no wrong answers."
"I liked was I met wonderful people who matched the same vibe as me and it was very fun."
"I was able to talk abut my feelings and not feel judged."
"I like how comfortable we got and I made so many good friends here. It helped me get closure and help me understand myself better."
"I liked being able to talk about my feelings, finding a way to speak up for myself and voice my boundaries. Being able to notice my emotions also feeling them and finding solutions to the things they may have cause them. Understanding how my mind works and that some of the things I'm thinking are normal amongst people."
"I liked that I didn't feel judged when speaking about my personal life."
"I feel very safe and speak freely and not be judged."
"I liked how they taught me how to relax during stressful times."
"I liked everything I liked the people the counselor the activities and everything we learned."
"The closeness/felt with the group sessions and the new people I have met."
"It's a great way to be social and connect with people my age going through the same things."
"I liked how open people are and some understand what you are going through."
"Everyone was really nice and helpful."
"That the counselor listened to me and gave me advice on how to cope."
"The counselor made me feel validated and important. She listened to what I had to say and provided me with comfort whenever I was having a hard time."
"Everyone was very nice and listened to everything I had to say."
"I always felt like it was a safe space."
"The counselor cared for all group members equally."
"I liked that it's a small group and confidential."
"I liked how the counselor interacted with the group. It helped us open up more and felt like a welcoming environment."

3. What I didn't like about the program is...

"Nothing, it was super helpful actually!"
"Nothing, This program made me get out of my comfort zone but it felt comfortable."
"Absolutely nothing this class helped me so much and was so much fun."
"What some people had to say about conversation topics I disagree on."
"The schedule being once per week."
"Sometimes it felt we where going to slow."
"How it felt a bit uncomfortable for random student at the same school to hear my issues. I have nothing against them but it feels awkward when some of us have mutual friends."
"Not enough time."
"Sometimes I forget about my objective because I forget to write in my notebook."
"That time went by fast."
"Sometimes I wish the things I share are a little personal and the only reason I don't say to much is because I want someone to listen to me."
"Nothing, maybe it could be longer."
"It ended so soon."
"The check in."
"Missing some assignments in class time."
"I wish it was longer."
"It wasn't often."
"Missing class."
"It's only every other Thursday."
"How infrequent the meeting were."
"A lot of paperwork."
"Being in 2 groups makes it difficult to really open up or say anything."
"Our group is big so we had to split it up and I couldn't see my counselor every week. Also, I should be longer than 10 weeks because 2nd semester is always the worst."
"The county not letting us have the program longer. I will miss my counselor."
"Sometimes I got called out of important periods."
"The time limit."
"I wish we had more time."
"That it's ending."
"That there was not a lot of meetings."
"I still feel depressed (getting progressively worse). Though I thing its my own issue and not the fault of the program."
"Just how short it felt, finally finishing all my sessions with the person assigned to help me."
"I need longer sessions."
"A lot of sitting."
"I don't like that it's over and that it's not a permanent thing."
"That more people don't know about it. I have a couple friends I've referred the program too."
"That it took me out of class at some new environment."
"Sometimes I get nervous talking in front of other people."
"I can't really think of a negative thing about it. It helped me a lot."
"How it is very structural. Rather than just talking about ourselves we had to follow a bunch of guidelines."
"I didn't enjoy the amount of time limit."
"I didn't like that sometimes certain people didn't get their pass on time."

The **Peer-to-Peer program** utilizes Transition Age Youth (TAY) Peers to provide formal outreach, informal counseling, and support/informational groups to other TAY who are at high risk of developing mental health problems. Specific target populations within TAY include homeless youth, foster youth, LGBTQ youth, and youth transitioning into college. The providers also educate the public and school staff about mental health, depression, and suicide. The components of this program include Speakers' Bureau Honest, Open, Proud presentations, Coping and Support Training (CAST), Directing Change workshops, Peer Mentorship, and general outreach activities.

There was a total of 86 Directing Change outreach presentations countywide. Additionally, there were 13 Directing Change workshops with 229 participants in attendance. There was a total of 25 Speaker's Bureau presentations countywide with 420 participants in attendance. Pre- and post-tests were collected from 392 individuals. Stigmatizing attitudes significantly decreased from pre- to post-tests whereas recovery and empowerment attitudes increased from pre- to post-tests thus suggesting participants' attitudes towards people with mental illnesses improved from the presentation. Care-seeking attitudes slightly increased but were not statistically significant. There were 10 LGBTQ+ support groups utilizing the "My Identity My Self" curriculum to support TAY youth serving 78 participants. Approximately 93% of participants reported that they would participate in this program again; and 95% of participants reported that participating in the support group has been an affirming experience for them. There were 51 youth screened, 45 youth enrolled in, and 26 who completed the Peer Mentoring program. Improvements were found in mentees' ratings of goal achievement with 81% reporting improvements in relationships/support, 88% in school/work activities, and 77% in coping/mood. There were 11 CAST groups where 95 youth were screened with a total of 87 enrolled participants; 83 of whom attended at least one session. Of those 83 participants, 62 completed CAST, representing a 75% completion rate.



The provider experienced success in contacting higher education institutions. This included being invited to do outreach on campuses and increase exposure for services to the 18–25-year-old population. The provider has developed good working relationships with a variety of school districts in the county. They continue to refer students to both programs in the TAY project and are helpful in facilitating logistics around implementation on their respective campuses, when the district is receptive to mental health services. Social media outreach and engagement have increased during the program year. While contact at higher education institutions and organizations has increased, the number of participants aged 18-25 did not increase. Higher education institutions often have robust services offered on campus that are free to students. There are also fewer places where this age group naturally gathers (unlike 16–17-year-olds which are easier to access on a high school campus).

Staffing challenges across the program significantly impacted service delivery and the ability to meet contract deliverables. Neither paraprofessional nor professional staff levels were maintained across regions in both program components. Turnover and difficulty in hiring were

challenges. There were also significant leadership changes that contributed to low staff morale and turnover.

Consent for participation in the program continued to be a barrier to delivering services on school campuses. There continues to be increased attention and scrutiny toward mental health topics, and anything involving LGBTQ+, in schools. Program providers were blocked from entire districts due to new policies regarding outside mental health services and services geared to LGBTQ+ youth. “Notification policies” also made some students leery of participating in services, even in non-clinical services, because of fears related to their caregivers being notified. These policies continue to be a barrier to students receiving supportive services in a safe, accessible environment. The provider will continue to expand and “think outside the box” regarding outreach and service for 18–25-year-olds. Increased partnership with non-educational institutions is necessary but challenging. Group services are much more efficient, but many students are requesting individual services in the Stress & Your Mood component. This puts extra strain on the therapist and requires that they set better expectations with the site contacts about how the services are best implemented.

Participants had the following comments after participating in the TAY Resiliency Project:

- “I personally struggle with mental health and hearing it be normalized was really important.”
- “My point of view on this has changed now that I have heard this impackedful [SIC] story firsthand and how people can grow and better themselves”.
- “It has given me a place to be myself and a place to stay. It has also give me a great community”.



- “I have learned a lot of things about myself that I would not have known without this program and my mentor. I have grown a lot from when I first started versus now. I allow myself to feel my emotions and be less damaging and harsh on myself for everything, especially the things I can’t control. I feel like I have more control over my life instead of letting it pass me by and letting other people or things that happen to me choose my emotions for me. I know I care about things to much sometimes, but I’ve come to realize that some things about that may seem like a curse can actually be blessings.”
- “I learned how to deal with thoughts, how actions can change my thoughts and emotions; and that its ok to reach out for help.”
- “I learned how to communicate better with both adults and people my age. How to manage my thoughts and outlook. Feeling more comfortable being myself.”
- "What I learned in the program is how to take care of ourselves physically and mentally. Breathing techniques, exercises, and how to relax our mind."

- "Positive counter thoughts; breathing techniques to help my anxiety and thinking with the logical mind, and identifying emotion and separating school work from my own time outside of school."

Riverside University HEALTH SYSTEM Behavioral Health

Peer-to-Peer

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview and Provider

Program Overview:

Riverside University Health System - Behavioral Health (RUHS-BH) is contracted with Operation SafeHouse to provide specific activities designed to reach transition age youth (TAY) - defined as youth between the ages of 16 and 25 years old. Specific target populations within TAY include homeless, foster or former foster, transitioning to college, and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals. The Peer-to-Peer program is designed to provide formal outreach, informal counseling, and support/informational groups to at-risk youth and families. Additionally, the program is designed to educate the public about mental health, depression, and suicide, while also working to reduce stigma towards mental illness among TAY individuals who are considered to be at high-risk. The program outreaches to Gay/Straight Alliances, social services agencies, and the community-at-large, in order to organize and facilitate small and large TAY group presentations and discussions to local community-based locations, school districts, and college campuses, with activities that include Directing Change outreach and workshops, Speaker's Bureau presentations, LGBTQ+ support groups, Peer Mentoring program, and Coping and Support Training (CAST).

- Directing Change workshops are aimed to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and developing a story in a digital public service announcement (PSA) format to promote that understanding and participation in submitting PSAs to the state Directing Change program.
- Speaker's Bureau presentations are utilized to educate and outreach to at-risk TAY, caregivers, educators, and TAY service providers on the unique issues that at-risk TAY experience as it relates to mental health and interpersonal issues, with the aim of reducing stigmatizing attitudes.
- LGBTQ+ support groups are provided by trained peers based on the My Identity My Self (MIMS) curriculum.
- The Peer Mentoring program is utilized to encourage and monitor progress with individualized goal setting through one-on-one interactions with a peer mentor.
- Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts. Each CAST group consists of an initial screening session followed by nine (9) sessions facilitated by TAY Peer Youth Specialists.

Provider:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse in the Riverside area will be noted as *Western*, whereas Operation SafeHouse in the Coachella Valley will be noted as *Desert*.

Executive Summary: Key Findings

There was a total of 86 Directing Change outreach presentations in the Desert, Mid-County, and Western regions. Additionally, there were 13 Directing Change workshops with five held in the Desert region, one in the Mid-County region, and seven in the Western region.

- A total of 229 participants attended a Directing Change workshop; 82 of whom were TAY in the Desert region, 5 we TAY in the Mid-County region, and 124 were TAY in the Western region, with the average age being 16.5 years old.
- Countywide, the majority of workshop participants identified as a girl/woman (52%), Hispanic/ Latinx (78%), and that their preferred language is English (80%).
- Satisfaction surveys were collected from 226 participants. Participants felt the workshops were a good use of their time and that they would recommend this workshop to a friend. Below are some youth comments:
  - ⇒ "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
  - ⇒ "Thank you for coming! This made me realize so much."

There was a total of 25 Speaker's Bureau presentations in the Desert, Mid-County, and Western regions of Riverside County.

- A total of 420 individuals attended a Speakers Bureau event; 80.2% of whom were TAY, with the average age being 16.9 years old.
- The most frequently reported race/ethnicity for each region was Hispanic/Latinx.
- The highest reported zip codes for Desert, Mid-County, and Western regions were for the cities of Indio 92201 (n=2), Hemet 92544 (n=5), Riverside 92506 (n=4) and Corona 92882 (n=4), respectively.
- Pre- and post-tests were collected from 392 individuals. Pre- and post-tests included a compilation of four different questionnaires to measure stigmatizing (AQ-9), recovery (RS-3), empowerment (ES-3), and care-seeking attitudes (CS-6). Sample sizes for each questionnaire varied due to incomplete items between the pre- and post-tests. Meaningful improvements were found for stigmatizing, recovery, and empowerment attitudes. In other words, stigmatizing attitudes significantly decreased from pre- to post-tests whereas recovery and empowerment attitudes increased from pre- to post-tests thus suggesting participants' attitudes towards people with mental illnesses improved from the presentation. Care-seeking attitudes slightly increased but were not statistically significant.

There were 10 LGBTQ+ support groups utilizing the "My Identity My Self" curriculum to support TAY youth.

- There were a total of 78 attendees of which 71 were TAY. The majority were in the 16 to 17 age group (72%).
- Transgender, nonbinary, and gender fluid youth accounted for 38% of those attending (11.5% transgender, 12.8% nonbinary, and 14.1% gender fluid).
- Over half of the youth attending were Hispanic/Latinx (64.1%).
- Satisfaction surveys were collected for these support groups (n=42). Approximately 93% of participants reported that they would participate in this program again; and 95% of participants reported that participating in the support group has been an affirming experience for them.

Executive Summary: Key Findings (cont.)

There were 51 youth screened, 45 youth enrolled in, and 26 who completed the Peer Mentoring program.

- Session attendance varied: 58% attended all 12 sessions, 2% attended between 9 to 11 sessions, 18% attended between 5 and 8 sessions, 13% attended between 2 and 4 sessions, and 9% attended one session.
- The majority of mentees identified as a girl/woman (64%, n=29), were Hispanic/Latino (60%, n=27), and the preferred language for almost all of the mentees was English (91%, n=41). Additionally, 15 mentees (33%) identified as LGB+. Lastly, most were TAY (96%, n=43) where the average age was 17 years old.
- Improvements were found in mentees ratings of goal achievement with 81% reporting improvements in relationships/support, 88% in school/work activities, and 77% in coping/ mood.
- The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. There are a total of 18 questions, related to: Social Support (how they feel about the presence of social supports in their lives), Self (how they feel about themselves in different scenarios), Goal Setting (how they view and act upon their own life goals), and Coping (how they cope with different life situations presented to them). Overall, increases in average scores can be seen across all four domains, with the highest increases in the area of Self (23%) followed by Coping (21%), Social Support (16%), and Goal Setting (14%). All four areas showed a statistically significant increase after completing the program.
- 100% of mentees reported that the mentoring program has helped them define their current goals. 92% of mentees have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future. 85% of mentees reported that the program has allowed them to build stronger relationships with those whom they depend on. 100% of mentees were satisfied with the Peer Mentoring program.

There were 11 CAST groups where 95 youth were screened with a total of 87 enrolled participants; 83 of whom attended at least one session. Of those 83 participants, 62 completed CAST, representing a 75% completion rate.

- Countywide, the majority of participants were Hispanic/Latinx (71%, n=59), female (58%, n=48), and the average age of entry into CAST was 17 years old.
- Monitoring Group Goals consist of survey items regarding participants' management of their feelings of depression and anger, school smarts, and drug use. Countywide, participants' average post-test scores significantly increased from their pre-test scores for mood, school behaviors, and drug use suggesting meaningful improvement from the start of participation in the program to the end.
- For How Are We Doing in Group surveys, the largest increase was in participants' sense of "belonging" from the pre (Session 2) to post (Session 9) with a mean difference score of 0.63.
- There were statistically significant increases in the Recognition of Progress items from pre to post for the self esteem item specifically "being positive with myself, recognizing my strengths", for the personal control item on depression specifically "getting 'unstuck' from negative moods", and for the personal control item on anger specifically "controlling my thoughts, feelings, and actions."

Event Statistics

Type of Events by Region

Each event was categorized into one of the following five activities: Directing Change outreach or workshop, Speaker's Bureau presentation, LGBTQ+ support group, Peer Mentoring, and Coping and Support Training (CAST). A total of 536 various Peer-to-Peer events and activities were held throughout the County during FY 2023-2024.

Activity:	Desert (n=166)	Mid-County (n=274)	Western (n=96)	Countywide (n=536)
Directing Change Outreach Events	43	20	23	86
Directing Change Workshops	5	1	7	13
Speaker's Bureau Presentations	4	7	14	25
LGBTQ+ Support Groups	5	2	3	10
Peer Mentoring Sessions	108	240	43	391
CAST Groups	1	4	6	11

Participants by Region

Countywide, a total of 3,637 individuals participated in Peer-to-Peer activities. Of the total participants:

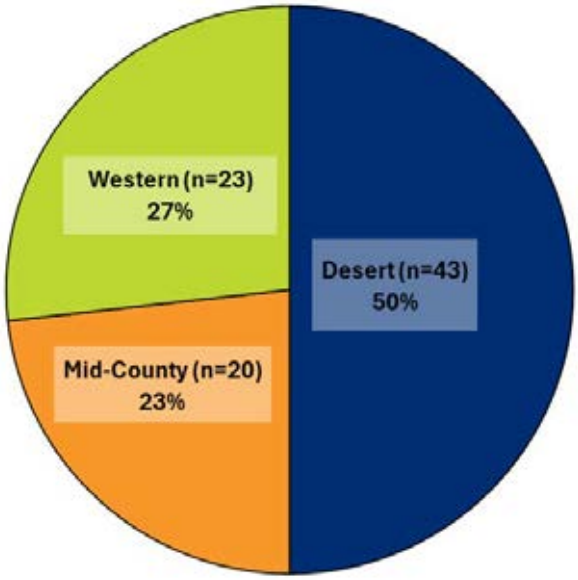
- 1,706 (46.9%) were in the Desert region
- 747 (20.5%) were in the Mid-County region
- 1,184 (32.6%) were in the Western region

Participants by Activity	Desert (n=1,706)	Mid-County (n=747)	Western (n=1,184)	Countywide (n=3,637)
Directing Change Outreach Participants	1,483	566	733	2,782
Directing Change Workshop Participants	100	5	124	229
Speaker's Bureau Participants	58	117	245	420
LGBTQ+ Support Group Participants	39	12	27	78
Peer Mentoring - Mentees	17	24	4	45
CAST Group Participants	9	23	51	83

Directing Change Outreach Event Statistics

During FY 2023-2024, a total of 86 Directing Change Outreach (DCO) events were held throughout Riverside County reaching 2,782 participants. The majority of Directing Change Outreach events occurred in the Desert region (50%, n=43) followed by the Western (27%, n=23) and Mid-County (23%, n=20) regions.

Directing Change Outreach Events by Region (n=86)



Region	Participants	Percentage
Desert (n=43)	1,483	53.3%
Mid-County (n=20)	566	20.3%
Western (n=23)	733	26.3%
Countywide (n=86)	**2,782**	

Directing Change Outreach Event Locations: Cities and Zip Codes

Of the 86 Directing Change Outreach events countywide, 43 were in the Desert region within 11 zip codes, 20 were in the Mid-County region within nine zip codes, and 23 were in the Western region within eight zip codes. The zip codes and cities for each event by region are listed below.

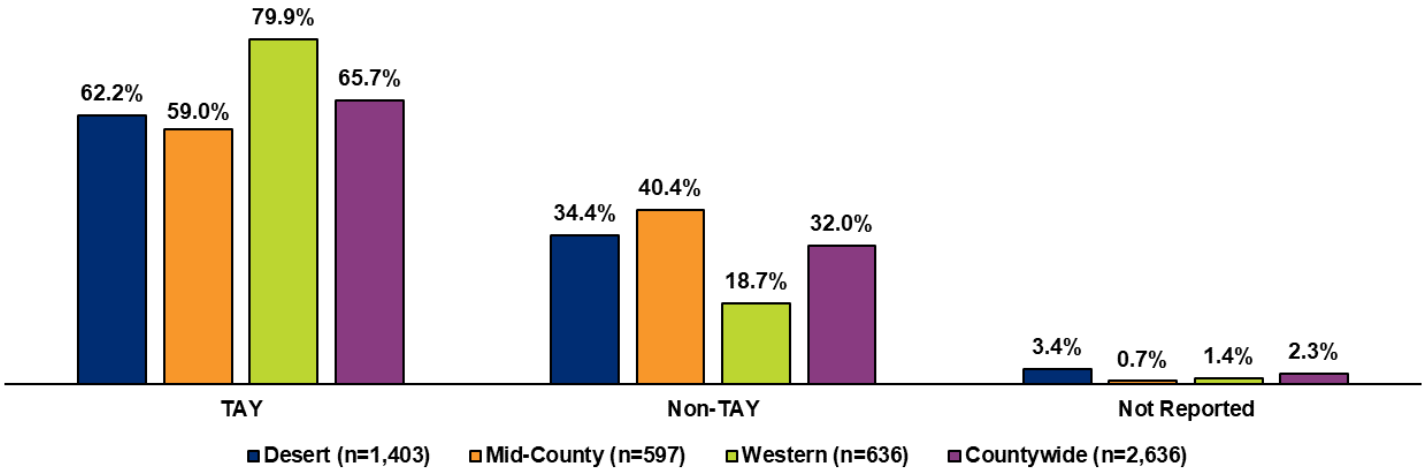
Desert (n=43)		Mid-County (n=20)		Western (n=23)	
92201 Indio	23 (26.7%)	92530 Lake Elsinore	1 (1.2%)	92501 Riverside	3 (3.5%)
92211 Indio	1 (1.2%)	92532 Lake Elsinore	1 (1.2%)	92503 Riverside	1 (1.2%)
92220 Banning	7 (8.1%)	92543 Hemet	3 (3.5%)	92504 Riverside	1 (1.2%)
92225 Blythe	1 (1.2%)	92544 Hemet	3 (3.5%)	92506 Riverside	11 (12.8%)
92234 Cathedral City	1 (1.2%)	92545 Hemet	4 (4.7%)	92507 Riverside	2 (2.3%)
92253 La Quinta	2 (2.3%)	92562 Murrieta	4 (4.7%)	92551 Moreno Valley	3 (3.5%)
92254 Mecca	1 (1.2%)	92570 Perris	1 (1.2%)	92553 Moreno Valley	1 (1.2%)
92260 Palm Desert	2 (2.3%)	92583 San Jacinto	2 (2.3%)	92860 Norco	1 (1.2%)
92270 Rancho Mirage	1 (1.2%)	92585 Menifee	1 (1.2%)		
92274 Thermal	1 (1.2%)				
92276 Thousand Palms	3 (3.5%)				

Directing Change Outreach: Demographics

Attendance

Countywide, 2,636 unduplicated individuals signed-in to a Directing Change outreach (DCO) event attendance sheet. There were 1,403 individuals (53.2%) from the Desert region, 597 individuals (22.6%) from the Mid-County region, and 636 individuals (24.1%) from the Western region who were reached through a DCO event. Countywide, 65.7% (n=1,732) of participants reported as TAY and 32% (n=843) were Non-TAY with 2.3% (n=61) unknown.

TAY and Non-TAY Attendance



Countywide, 2,575 participants reported their age. Participants were between the ages of 11 and 65, with the average age being 16.5 years old. From the TAY Age Breakdown table below, most TAY participants reported being in the 16 and 17 age groups (81.5%).

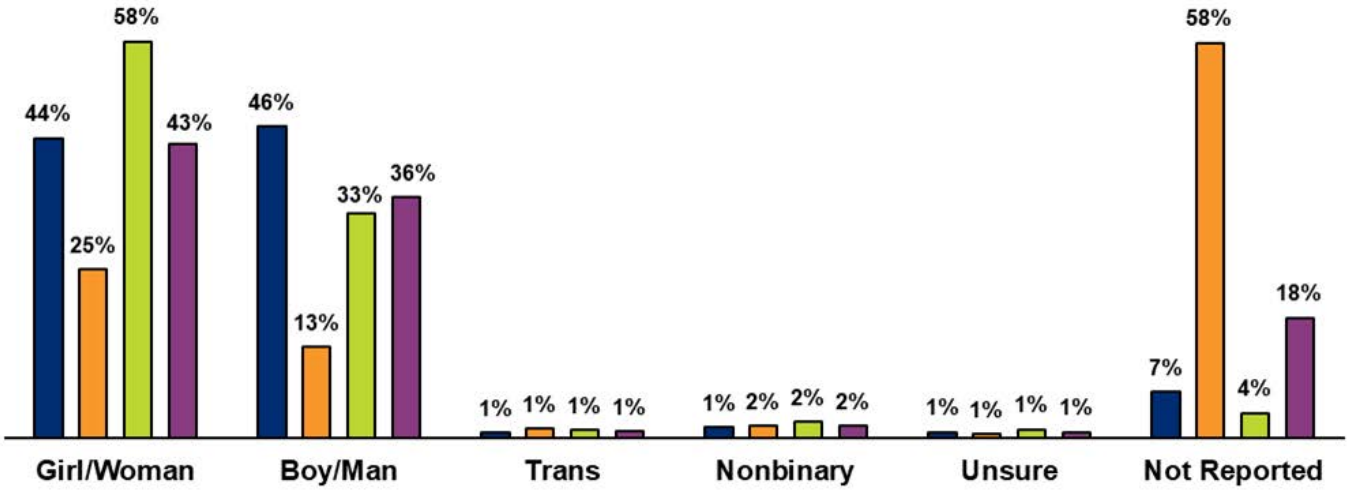
Age	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
11-15	473 (33.7%)	239 (40.0%)	99 (15.6%)	811 (30.8%)
16-25 (TAY)	**872 (62.2%)**	**352 (59.0%)**	**508 (79.9%)**	**1732 (65.7%)**
26 and Older	10 (0.7%)	2 (0.3%)	20 (3.1%)	32 (1.2%)
Not Reported	48 (3.4%)	4 (0.7%)	9 (1.4%)	61 (2.3%)

TAY Age Breakdown	Desert (n=872)	Mid-County (n=352)	Western (n=508)	Countywide (n=1,732)
16	444 (50.9%)	179 (50.9%)	128 (25.2%)	751 (43.4%)
17	345 (39.6%)	128 (36.4%)	187 (36.8%)	660 (38.1%)
18-21	78 (8.9%)	45 (12.8%)	169 (33.3%)	292 (16.9%)
22-25	5 (0.6%)	0 (0%)	24 (4.7%)	29 (1.7%)

Directing Change Outreach: Demographics cont.

Gender

Countywide, 43% (n=1,141) of the participants identified as a girl/woman, and 36% (n=936) identified as a boy/man. The remaining participants reported identifying as transgender (0.9%, n=25), nonbinary (1.7%, n=46), or were unsure (0.8%, n=22). Additionally, 18% (n=466) had no response.



Sexual Orientation

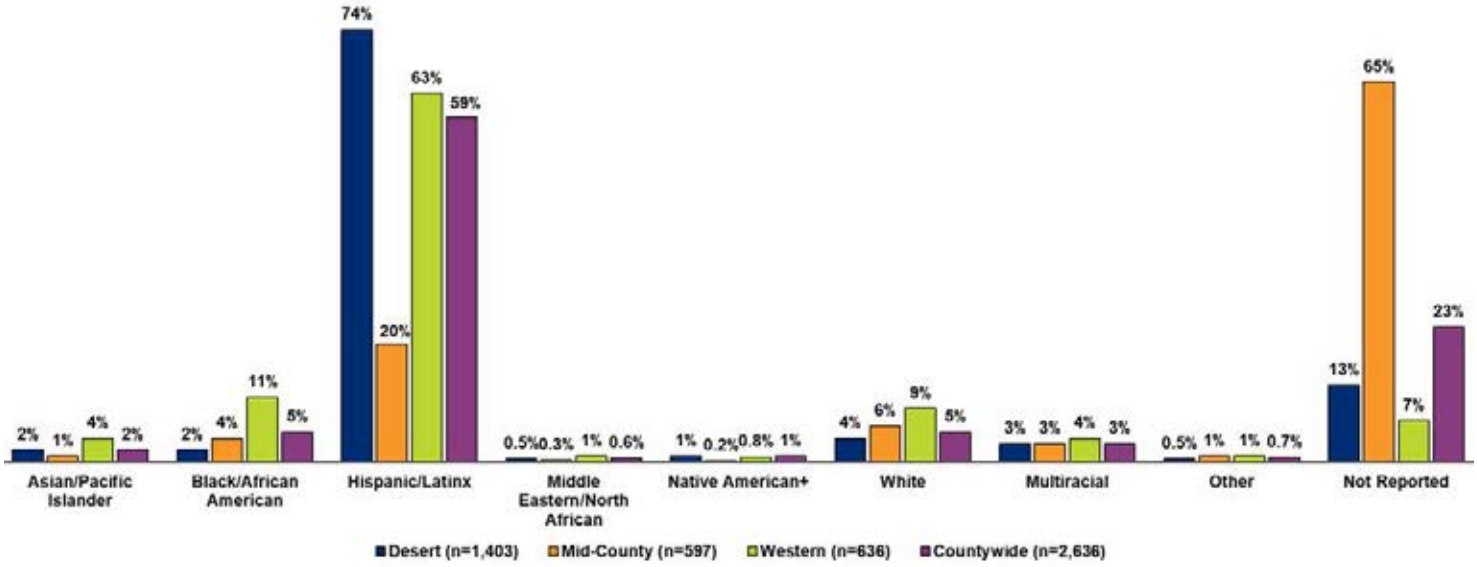
Countywide, among the total of 2,636 individuals, 11% of participants identified as lesbian, gay, or bisexual (Desert: n=132; Mid-County n=56; Western: n=110).

Sexual Orientation	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
Straight	855 (60.9%)	120 (20.1%)	399 (62.7%)	1374 (52.1%)
Lesbian	22 (1.6%)	12 (2.0%)	13 (2.0%)	47 (1.8%)
Gay	33 (2.4%)	4 (0.7%)	9 (1.4%)	46 (1.7%)
Bisexual	77 (5.5%)	40 (6.7%)	88 (13.8%)	205 (7.8%)
Unsure	41 (2.9%)	15 (2.5%)	32 (5.0%)	88 (3.3%)
Not Reported	375 (26.7%)	406 (68.0%)	95 (14.9%)	876 (33.2%)

Directing Change Outreach: Demographics cont.

Race and Ethnicity

Countywide, 58.8% (n=1,551) of participants identified as Hispanic/Latinx, 5.2% (n=138) as White, 4.6% (n=122) as Black/African American, 3.4% (n=90) as Multi-racial, 2.4% (n=63) as Asian/Pacific Islander, 0.9% (n=24) as Native American (and one other race), 0.6% (n=17) as Middle Eastern/ North African, 0.7% (n=19) as Other, and 23.2% (n=612) was not reported.



Language

Countywide, English (60%) was the most frequently reported primary language.

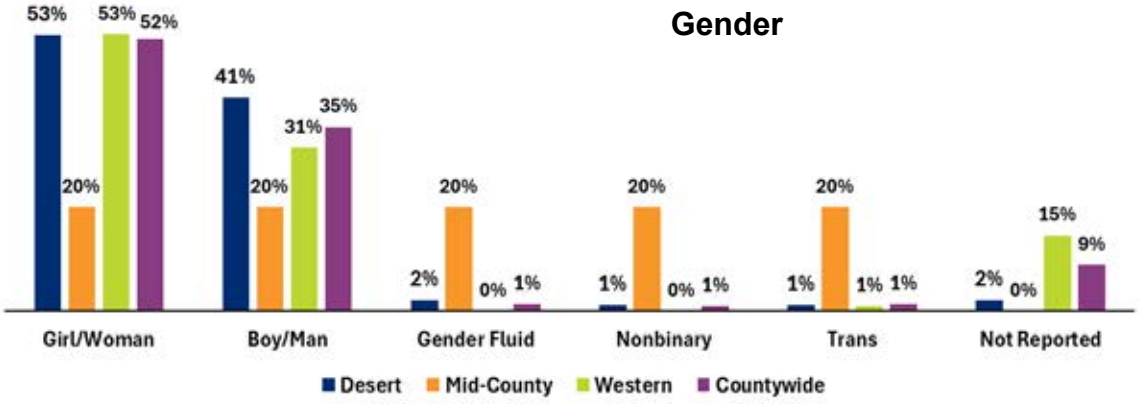
Language	Desert (n=1,403)	Mid-County (n=597)	Western (n=636)	Countywide (n=2,636)
English	884 (63.0%)	200 (33.5%)	484 (76.1%)	1568 (59.5%)
Spanish	60 (4.3%)	4 (0.7%)	26 (4.1%)	90 (3.4%)
English and Spanish	256 (18.2%)	7 (1.2%)	75 (11.8%)	338 (12.8%)
Other or Multiple	11 (0.8%)	0 (0%)	9 (1.4%)	20 (0.8%)
Not reported	192 (13.7%)	386 (64.7%)	42 (6.6%)	620 (23.5%)

Directing Change Workshop Demographics

The Directing Change workshops are intended to encourage and equip TAY with the technical skills to prepare a personalized or informative public service announcement (PSA) for submission in the annual Directing Change Student Film Contest. The workshops aim to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and to assist in the development of a digital PSA to promote that understanding. The workshops focus on providing TAY with technical assistance in producing a digital film as a means of increasing mental health and suicide awareness.

During FY 2023-2024, a total of 13 Directing Change workshops were held countywide where five (5) were held in the Desert region, seven (7) in the Western region, and one (1) in the Mid-County region. The Desert region had 100 participants in attendance of whom 82 were TAY, the Western region had 124 participants, of whom 72 were TAY, and Mid County had five (5) participants all of which were TAY.

Gender

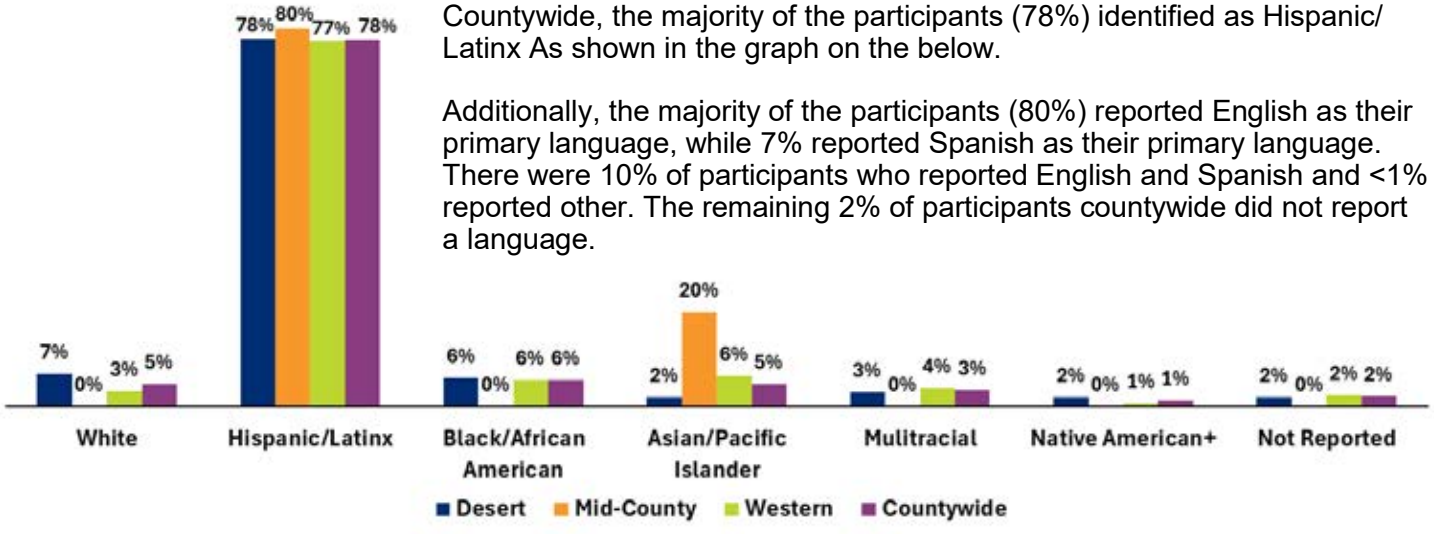


A majority of participants identified as a girl/woman (52%, n=120). Not shown on the graph, 13% of participants reported they were LGB.

Age and Race/Ethnicity

Age	Desert	Mid-County	Western	Countywide
13-15	17 (17.0%)	0 (0.0%)	48 (38.7%)	65 (28.4%)
16	24 (24.0%)	1 (20.0%)	20 (16.1%)	45 (19.7%)
17	40 (40.0%)	3 (60.0%)	38 (30.6%)	81 (35.4%)
18-25	18 (18.0%)	1 (20.0%)	14 (11.3%)	33 (14.4%)
26+	0 (0.0%)	0 (0.0%)	1 (0.8%)	1 (0.4%)
Not Reported	1 (1.0%)	0 (0.0%)	3 (2.4%)	4 (1.7%)

As shown to the left, approximately 69.4%% of the participants were within the TAY age range, with the average age being 16.5 years old.



Countywide, the majority of the participants (78%) identified as Hispanic/ Latinx As shown in the graph on the below.

Additionally, the majority of the participants (80%) reported English as their primary language, while 7% reported Spanish as their primary language. There were 10% of participants who reported English and Spanish and <1% reported other. The remaining 2% of participants countywide did not report a language.

Directing Change Workshops: Satisfaction Survey

Satisfaction surveys were collected at the end of Directing Change Workshops. Participants were asked to rate their experiences with the workshop using a 5-point Likert Scale, where ***1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree,*** and ***5=Strongly Agree***. The satisfaction surveys consist of 7 questions, which include 4 rating questions and 3 open-ended questions to gather participants' feedbacks regarding the Directing Change Workshop. Overall, there were a total of 226 participants completed the satisfaction survey, and the results are summarized below:

- 71% of participants felt that the workshop was a good use of their time.
- 55% of participants felt connected and involved in the workshop.
- 50% of participants would participate in the workshop again.
- 70% of participants would recommend this workshop to a friend

It is also noted that about 33% and 32% of participants chose to rate "Neutral" for question #2 (*I felt connected and involved in the workshop*) and question #3 (*I would participate in this workshop again*), respectively.

Countywide (n=226)	**Avg.**	**(1) Strongly Disagree**	**(2) Disagree**	**(3) Neutral**	**(4) Agree**	**(5) Strongly Agree**	**No Response**
1. The workshop was a good use of my time.	**4.03**	1.3%	4.0%	23.0%	34.1%	37.6%	0.0%
2. I felt connected and involved in the workshop.	**3.63**	4.4%	7.5%	32.7%	31.4%	23.9%	0.0%
3. I would participate in this workshop again.	**3.60**	4.4%	12.4%	32.3%	19.9%	30.5%	0.4%
4. I would recommend this workshop to a friend.	**3.98**	2.2%	7.1%	20.8%	30.1%	39.8%	0.0%

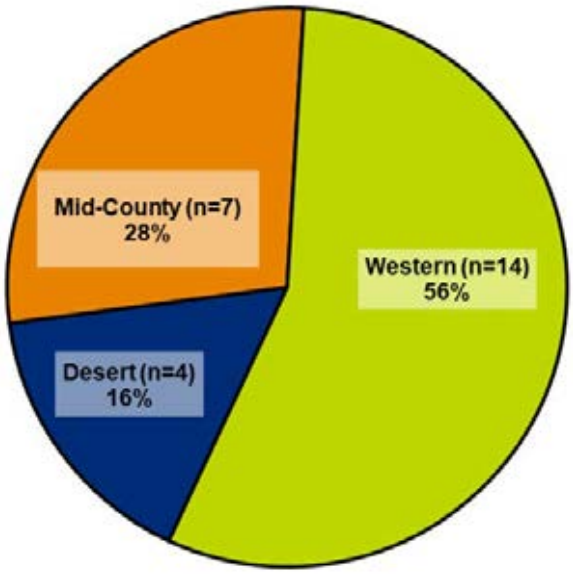
Some of the participants' responses on the additional feedback questions are listed below:

5. What did you like about your workshop experience?
   - "I enjoyed learning about the many different ways to cope with our mental health"
   - "I liked that there was good examples and to show how to handle suicide even if it's not for you and for a friend."
   - "Something I liked about the workshop is how positive everyone is and bringing good energy to a negative topic."
   - "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
   - "I liked how engaged everyone was and the fact the presenters had experiences that related to us."
6. What could have made your workshop experience better?
   - "I personally have been in desperate need before, and there workshops tend to isolate people - maybe the kids could have interacted w/ each other & the staff to establish trust"
   - "If we had some type of icebreaker to feel less awkward"
   - "Something that could have made the workshop experience better would have been on class engaging in it a bit more"
   - "People asking questions and sharing their own experiences would have made it better since it would have made me feel connected."
   - "It could have been better if it was more interactive."
7. Any additional comments?
   - "I really liked all the speakers and how they all shared their personal experiences"
   - "You guys did amazing. Thank you. I appreciate you"
   - "Thank you for coming! This made me realize so much."

Speaker's Bureau Event Statistics

Each year, Peer-to-Peer contractors are expected to hold 35 Speaker's Bureau presentations reaching 525 participants, per region for a total of 105 presentations and 1,575 unduplicated TAY. During FY 2023-2024, a total of 25 events, reaching 420 unduplicated individuals, were held throughout the County. No region reached contract expectations.

Speaker's Bureau Events by Region (n=25)



Region	Participants	Percentage
Desert (n=4)	58	13.8%
Mid-County (n=7)	117	27.9%
Western (n=14)	245	58.3%
Countywide (n=25)	**420**	

City/Zip Code Locations

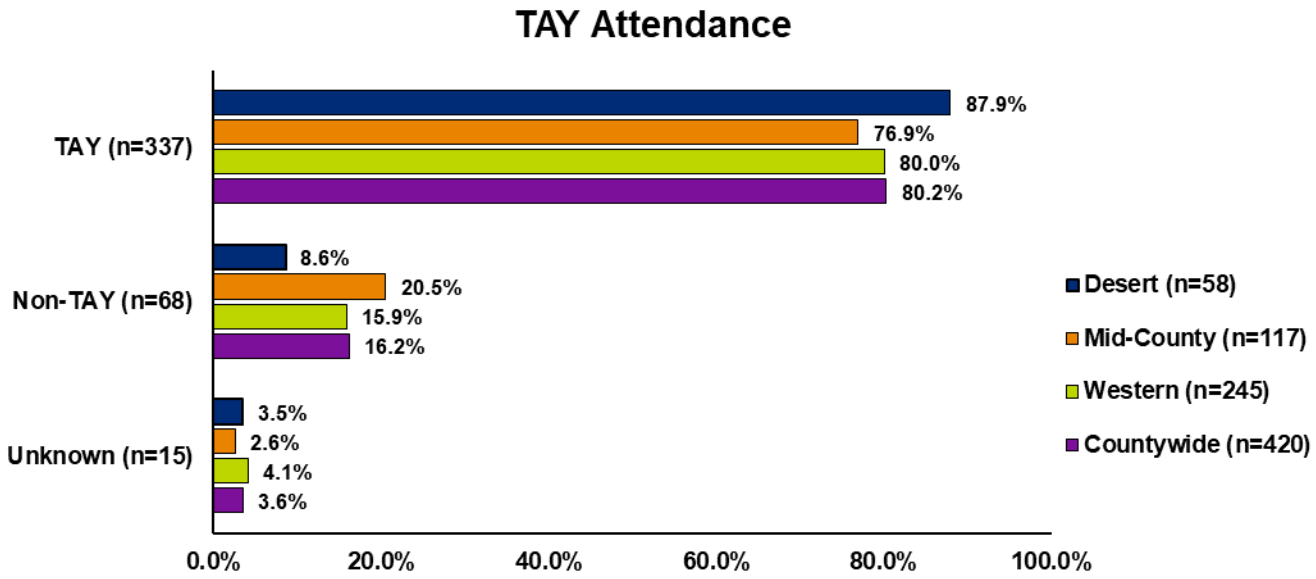
Of the 25 Speaker's Bureau presentations countywide, 4 were in the Desert region within three zip codes; 7 were in the Mid-County region within two zip codes, and 14 were in the Western region within seven zip codes. The zip codes and cities for each region are listed below.

Region	Zip Code and City	Countywide (n=25)
Desert (n=4)	92201 Indio	**2 (8%)**
	92260 Palm Desert	**1 (4%)**
	92276 Thousand Palms	**1 (4%)**
Mid-County (n=7)	92532 Lake Elsinore	**2 (8%)**
	92544 Hemet	**5 (20%)**
Western (n=14)	92501 Riverside	**2 (8%)**
	92503 Riverside	**1 (4%)**
	92506 Riverside	**4 (16%)**
	92507 Riverside	**1 (4%)**
	92509 Riverside	**1 (4%)**
	92551 Moreno Valley	**1 (4%)**
	92882 Corona	**4 (16%)**

Speaker's Bureau: Demographics

Attendance

Countywide, there were a total of 420 unduplicated individuals that attended a Speaker's Bureau event where 58 (13.8%) were in the Desert region, 117 (27.9%) were in the Mid-County region, and 245 (58.3%) were in the Western region. Countywide, the majority (80.2%, n=337) of the participants were TAY. TAY attendance was higher than non-TAY attendance in all regions. These participants' attendance and information were



Countywide, 405 participants who attended Speaker's Bureau events reported their age which ranged from 10 to 60+ years old, with the average age being 17 years old. Among the TAY individuals, most participants reported their age as 16-17 within the Desert (70.6%, n=36), Mid-County (62.2%, n=56), and Western (78.1%, n=153) regions. The second largest group of TAY individuals was 18-19 within the Desert (25.5%, n=13), Mid-County (37.8%, n=34), and Western (19.9%, n=39) regions. Less than 2% of the Countywide TAY population fell between 20 to 25 years of age.

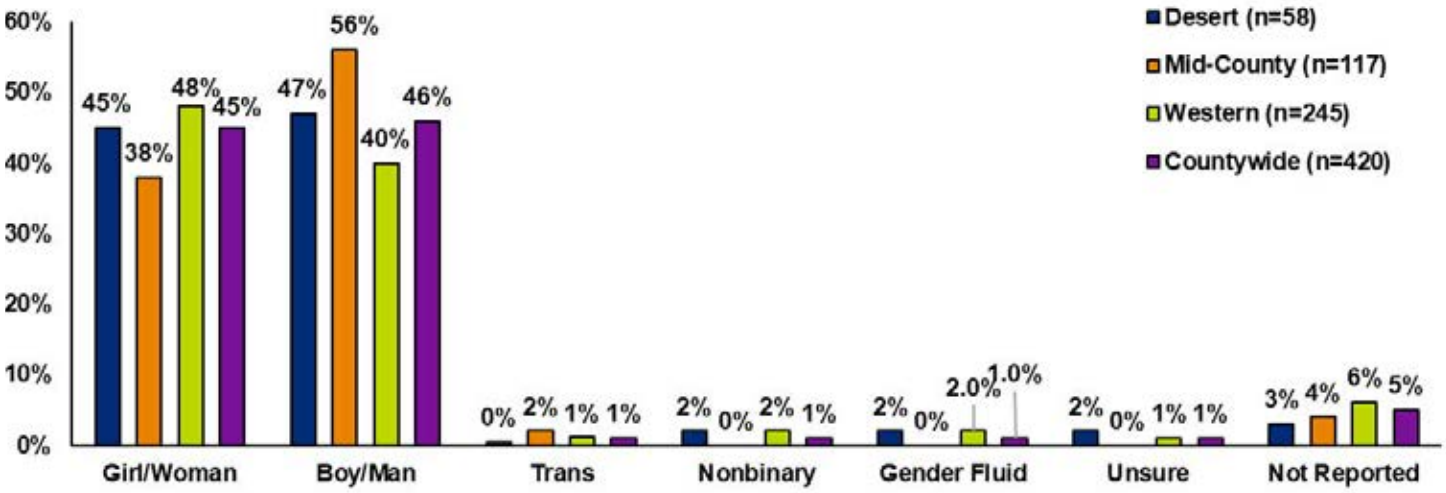
Age	Desert (n=56)	Mid-County (n=114)	Western (n=235)	Countywide (n=405)
12-15	5 (8.9%)	24 (21.1%)	37 (15.7%)	66 (16.3%)
TAY 16-25	**51 (91.1%)**	**90 (78.9%)**	**196 (83.4%)**	**337 (83.2%)**
26 and Older	0 (0%)	0 (0%)	2 (0.9%)	2 (0.5%)

TAY Age Breakdown	Desert (n=51)	Mid-County (n=90)	Western (n=196)	Countywide (n=337)
16-17	36 (70.6%)	56 (62.2%)	153 (78.1%)	245 (72.7%)
18-19	13 (25.5%)	34 (37.8%)	39 (19.9%)	86 (25.5%)
20-21	1 (2.0%)	0 (0%)	3 (1.5%)	4 (1.2%)
22-25	1 (2.0%)	0 (0%)	1 (0.5%)	2 (0.6%)

Speaker's Bureau: Demographics cont.

Countywide, 45% (n=188) of participants identified as a girl/woman, and 46% (n=192) identified as boy/man. The remaining participants identified as transgender (1.0%, n=4), as nonbinary (1.2%, n=5), as gender fluid (1.4%, n=6), were unsure (0.7%, n=3), or did not respond (5%, n=22).

Gender



Sexual Orientation	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Straight	42 (72.4%)	96 (82.1%)	154 (62.9%)	292 (69.5%)
Lesbian	2 (3.4%)	1 (0.9%)	8 (3.3%)	11 (2.6%)
Gay	0 (0.0%)	0 (0.0%)	8 (3.3%)	8 (1.9%)
Bisexual	3 (5.2%)	6 (5.1%)	20 (8.2%)	29 (6.9%)
Pansexual	1 (1.7%)	1 (0.9%)	5 (2.0%)	7 (1.7%)
Other	1 (1.7%)	0 (0.0%)	2 (0.8%)	3 (0.7%)
Unsure	1 (1.7%)	1 (0.9%)	7 (2.9%)	9 (2.1%)
Declined	4 (6.9%)	4 (3.4%)	19 (7.8%)	27 (6.4%)
Not Reported	4 (6.9%)	8 (6.8%)	22 (9.0%)	34 (8.1%)

Countywide, 29 participants reported having a disabling condition and one participant reported being a veteran.

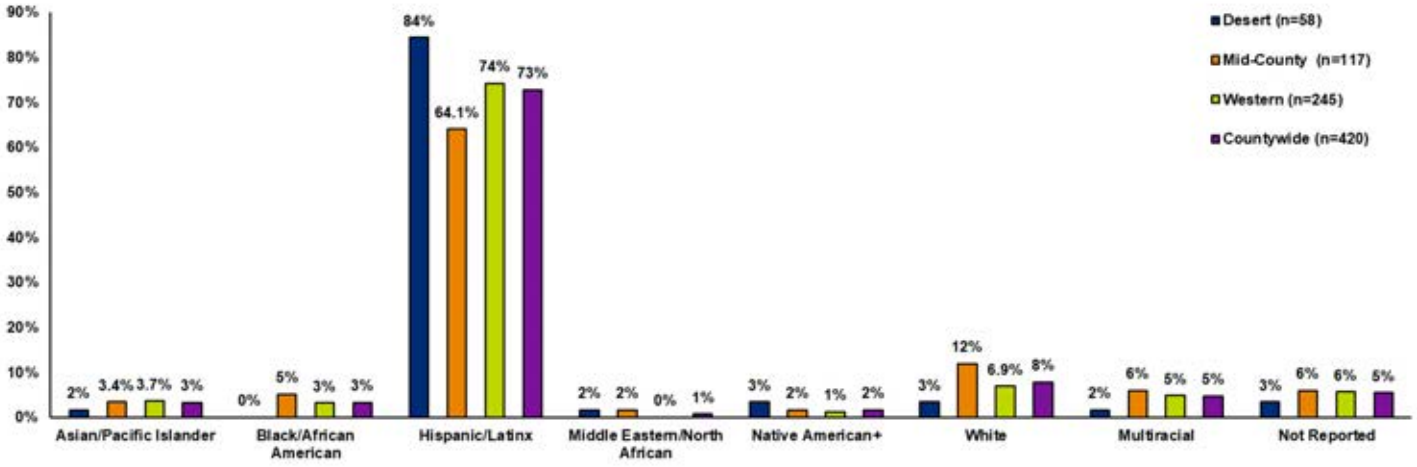
	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
Disabled	3 (5.2%)	4 (3.4%)	22 (9.0%)	29 (6.9%)
Veteran	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)

Speaker's Bureau: Demographics

Race/Ethnicity

Countywide, 72.9% (n=306) of participants identified as Hispanic/Latinx, 7.9% (n=33) White, 4.8% (n=20) Multiracial/ethnic, 3.3% (n=14) Asian/Pacific Islander, 3.3% (n=14) Black/African American, 1.7% (n=7) Native American (and one other race), 0.7% (n=3) Middle Eastern/North African, and 5.5% (n=23) was not reported.

Countywide, there were 225 (53.6%) participants who reported their specific ethnicity as Mexican, followed by 15 (3.6%) Central American, 6 (1.4%) Guatemalan, 2 (0.5%) Salvadoran, 1 (0.2%) Cuban, 1 (0.2%) Puerto Rican, 5 (1.2%) Filipino, 2 (0.5%) Vietnamese, 1 (0.2%) Cambodian, 2 (0.5%) South Asian, 2 (0.5%) Irish, 1 (0.2%) Arab, and 9 (2.1%) Multi-ethnic. Lastly, 35.2% (n=148) of participants did not report a specific ethnicity.



Language

Countywide, as well as in all regions, English (79.5%) was the most frequently reported primary language, with Spanish at 6.2%, English and Spanish at 8.3%, multiple languages 1.0%, and <1% of other languages. A total of 4.8% of the participants countywide did not report a primary language.

Language	Desert (n=58)	Mid-County (n=117)	Western (n=245)	Countywide (n=420)
English	41 (70.7%)	98 (83.8%)	195 (79.6%)	334 (79.5%)
Spanish	6 (10.3%)	5 (4.3%)	15 (6.1%)	26 (6.2%)
English and Spanish	8 (13.8%)	9 (7.7%)	18 (7.3%)	35 (8.3%)
Multiple Languages	1 (1.7%)	0 (0.0%)	3 (1.2%)	4 (1.0%)
Other	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.2%)
Not Reported	2 (3.4%)	5 (4.3%)	13 (5.3%)	20 (4.8%)

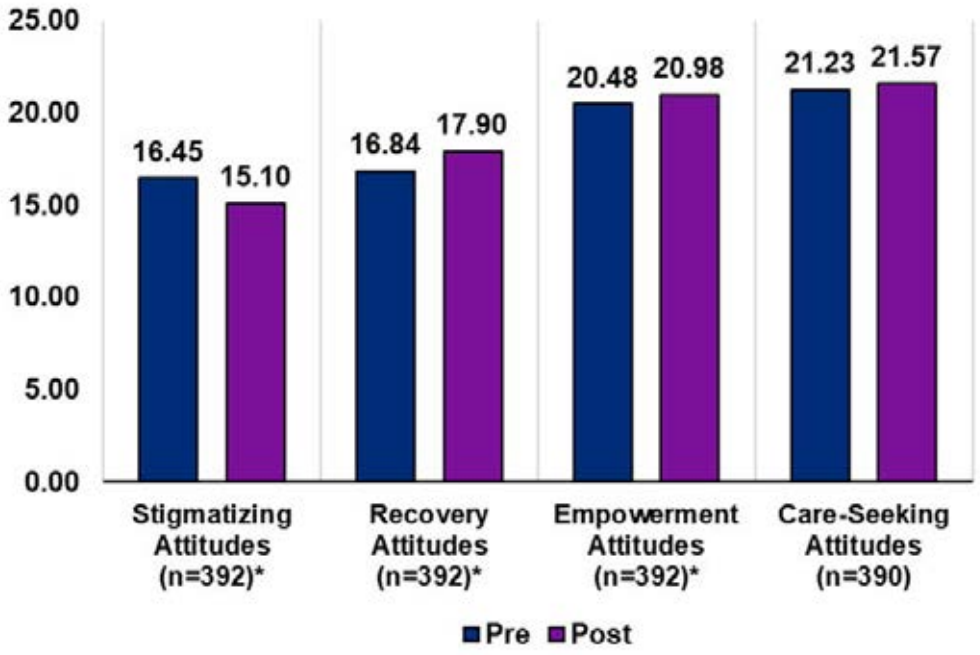
Speaker's Bureau Pre/Post Test Questionnaire

A total of 392 individuals who attended a Speaker's Bureau presentation completed pre- and post-test outcomes measures. Pre and post-tests were administered immediately before and after each presentation in order to assess their impact on the attendees. The questionnaire consists of four measures of stigma: Stigmatizing Attitudes (AQ-5), Recovery Attitudes (RS-3), Empowerment Attitudes (ES-3), and Care-Seeking Attitudes (CS-4).

Measures of Stigma	Questionnaire	9-Point Rating Scale
Stigmatizing Attitudes (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to a person with schizophrenia. *Example:* "I think that most people with mental illness are to blame for their problems"	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "If I were significantly anxious or depressed, I would speak to a mental health professional."*	Score range: 4-36 1 = 'Strongly Disagree' 9 = 'Strongly Agree'

An average score for all questions within each of the four questionnaires were computed for pre/post-test comparisons. Higher average scores for the AQ-5 represent greater stigmatizing attitudes, whereas higher average scores on the RS-3, ES-3, and CS-4 represent positive attitudes toward the described constructs. The graph below depicts the means and paired t-test results for participants who completed pre- and post-test measures. However, not all individuals completed all of the items within the pre-test and/or post-test, thus accounting for less total outcomes within each of the four measures of stigma questionnaire sections. Meaningful improvements were found for Stigmatizing, Recovery, and Empowerment Attitudes. In other words, Stigmatizing Attitudes significantly decreased from pre to post whereas Recovery and Empowerment Attitudes increased from pre to post thus suggesting participants' attitudes improved from the presentation. Care-Seeking Attitudes slightly increased but were not statistically significant.

Speaker's Bureau Average Pre vs Post Results



Speaker's Bureau Presentations: Comments

Additional Comments…

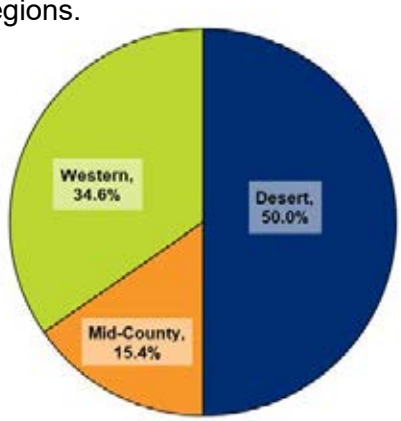
- "A lot of these questions are to vague or general, not one answer fits all mental illnesses."
- "Good presentation"
- "Great job on the performance, even if you feel rusty it sounded amazing. Keep it up."
- "I believe that a person with mental problems cannot take care of themselves because they need someone's help to be able to do the necessary things by themselves."
- "I feel like people with mental illness can do just as much as we do I had a homie with one leg went down and came back up."
- "I hope everyone finds happiness and find their true selves."
- "I loved the presentation. (heart symbol)"
- "I personally like the lady and Her story, it is inspiring and gives me Hope in myself."
- "I really liked the first story that was shared. I also liked how open the second story was."
- "I really liked the presentations, they were informative (two heart symbols)"
- "I really loved the Presentation and how open they were that takes alot."
- "I think it was nice how she shared her story with the class to help us understand."
- "I think that many can't or wouldn't get professional help because of financial problems, sense of hurting their pride, family members not believing in professional help."
- "I think you guys should speak to younger teens more often. Kids can experience mental illness at any age and they may benefit from some of the advice you're giving. Thanks for sharing (smiley face and heart symbol)"
- "I'm really happy you guys talk about this! It's so important and I'm really glad and proud of you guys."
- "It was a nice and enlightening presentation, I hope everything works out in your future."
- "I've been dating a mentally ill person for 7 months. The experience recount I just heard reminded me slightly of my partner's past with her almost 20 ex's."
- "Loved the presentation!"
- "Lovely Presentation!"
- "My point of view on this has changed now that I've heard an impackedful story first hand and how people can grow and better themselves."
- "No just thank you for sharing the storys with us and everything."
- "People can get better if they seek help. Also to manage how to cope."
- "People with mental illness are very special people who need to be cared for in the best possible way, whether by family members, relatives or doctors." [Translated from Spanish]
- "People with mental problem cannot help themselves that is to say they do not know what they are doing whether it is correct or not and that is why they cannot have a determined future or help other people."
- "Personal recognition from me, I also resignated with your speech, me myself dealt with problems as said from this story, I had a bad past partner that made me have to do some deep healing to move on from what I was forced in."
- "Thank you for presenting to us!"
- "Thank you for sharing your story I admire being able to be vulnerable and public speaking."
- "Thank you guys for coming especially since you don't do freshmen but thank you a lot I've learned a ton and you all are amazing."
- "Thanks for sharing your personal story [facilitator]."
- "Thanks for todays presentation"
- "The beginning of the presentation made it hard to focus a bit. Because it was quiet & low energy."
- "The Cup of Happy team is doing an AMAZING job!"
- "The only thing I gotta say is that like since were heath academy we already learned this. But I feel like other Freshmen to should know about this. I know a lot of Freshmen who don't have resources."
- "The woman in the green romper is very strong!"
- "This helped"
- "We love you [facilitator] & [facilitator] thank you for sharing your stories"
- "You guys are so strong! (heart symbol)"

LGBTQ+ Support Groups

Attendance by Region

In FY2023-2024, there were a total of **10** LGBTQ+ support groups held within Riverside County. From these groups, a total of **78** youth attended, with a majority of attendees from the Desert region (50.0%, n=39), followed by the Western (34.6%, n=27) and Mid-County (15.4%, n=12) regions.

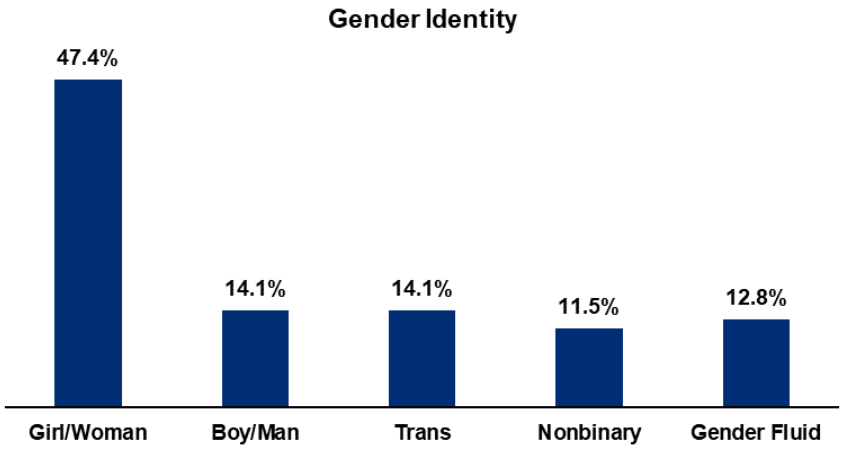
Region	Number of Groups	Number of Attendees
Desert	5	39
Mid-County	2	12
Western	3	27
Countywide	**10**	**78**

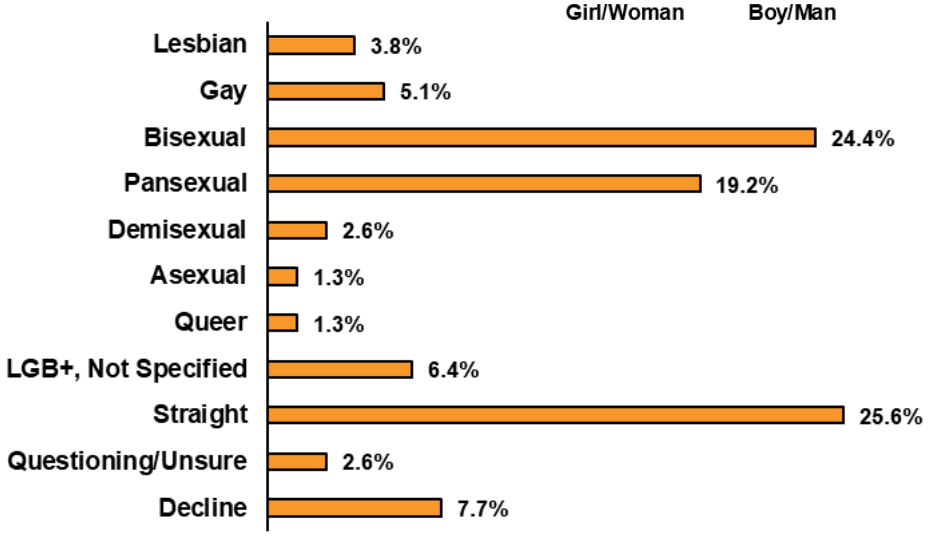


LGBTQ+ Support Groups: Demographics

Gender and Sexual Orientation

The 47.4% (n=37) of attendees identified as a girl/woman, 14.1% (n=11) as a boy/man, 14.1% (n=11) as transgender, 12.8% (n=10) as gender fluid, and 11.5% (n=9) as nonbinary.



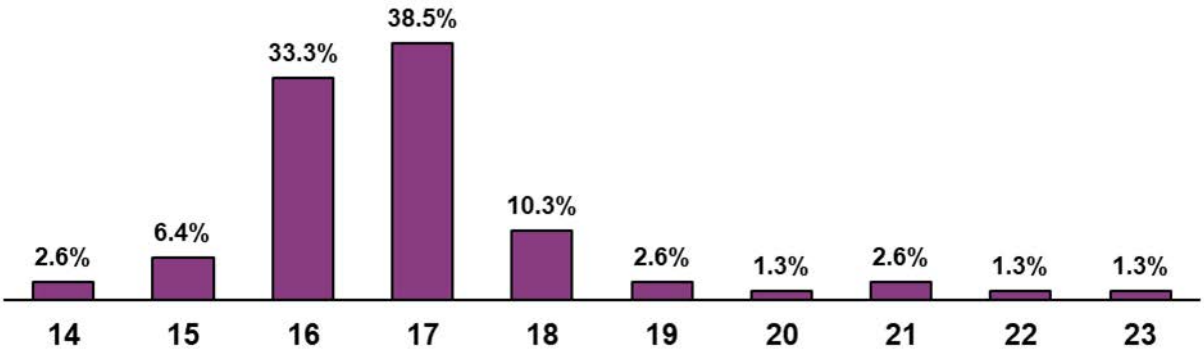


Countywide, most of the LGBTQ+ Support Groups' attendees identified as LGBTQ+ (64.1%, n=50), while 25.6% (n=20) participants identified as straight, 7.7% (n=6) declined to answer, and 2.6% (n=2) were unsure.

LGBTQ+ Support Groups: Demographics cont.

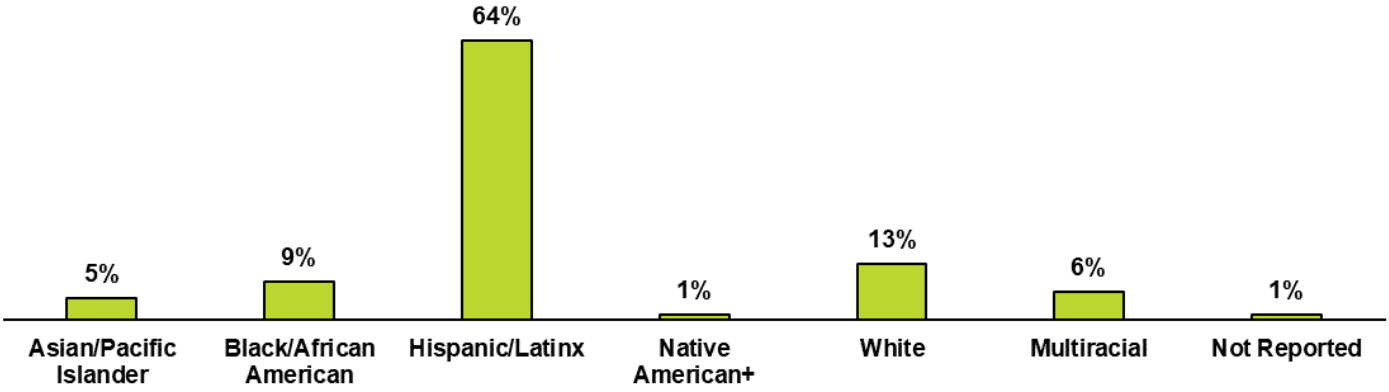
Age of Attendees

Countywide, the ages of attendees in the LGBTQ+ Support Groups were between 14 to 23 years old, with the majority being 17 years old (38.5%, n=30). From the figure below, most TAY participants Countywide reported being in the 16 to 17 age groups (71.8%, n=56). Overall, 91.2% (n=71) of the attendees were TAY.



Race/Ethnicity

Countywide, 64.1% (n=50) of participants identified as Hispanic/Latinx, 12.8% (n=10) as White, 9.0% (n=7) as Black/African American, 6.4% (n=5) as Multiracial, 5.1% (n=4) as Asian/Pacific Islander, 1.3% (n=1) as Native American (and one other race), and 1.3% (n=1) was not reported.



Language

The majority of attendees reported English as their preferred language (91.0%, n=71), followed by 6.4% (n=5) reporting both English and Spanish, 1.3% (n=1) Spanish, and 1.3% (n=1) was not reported.

Language	n	%
English	71	91.0%
Spanish	1	1.3%
English and Spanish	5	6.4%
Not Reported	1	1.3%

LGBTQ+ Support Groups: Satisfaction Surveys

At the end of each group, attendees were asked to fill out satisfaction surveys to gather feedback on their experience. Each survey consists of **11** satisfaction items, rated on a 5-point Likert scale, where ***1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree***, and ***5=Strongly Agree***. There were a total of **42** attendees who completed the satisfaction surveys, and the results are summarized below:

- **74%** of participants Agreed or Strongly Agreed that the support group changed how they think about themselves in a positive way
- **83%** of participants Agreed or Strongly Agreed that learning "SELF" skills was helpful to them
  - ◊ **76%** are more aware of their emotional and physical safety
  - ◊ **60%** experienced emotional growth
  - ◊ **62%** feel more comfortable discussing loss
  - ◊ **79%** developed a healthy self-identity that will be useful in the future
- **95%** of participants Agreed or Strongly Agreed that participating in this group has been an affirming experience for them
- **88%** of participants Agreed or Strongly Agreed that group topics were engaging and **83%** felt that the facilitator helped them feel safe in a group environment
- **93%** of participants Agreed or Strongly Agreed they would participate in this program again and **95%** would recommend this program to a friend who relates to them

Countywide (n=42)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Reported
1. This group has changed how I think about myself in a positive way	2.4%	2.4%	21.4%	42.9%	31.0%	-
2. Learning "SELF" skills has been helpful to me	4.8%	-	9.5%	35.7%	47.6%	2.4%
3. I am more aware of my emotional and physical safety	-	-	9.5%	35.7%	40.5%	14.3%
4. I experienced emotional growth	-	2.4%	23.8%	40.5%	19.0%	14.3%
5. I feel more comfortable discussing loss	-	7.1%	16.7%	21.4%	40.5%	14.3%
6. I developed a healthy self-identity that will be useful in the future	4.8%	-	16.7%	33.3%	45.2%	-
7. Participating in this group has been an affirming experience for me	4.8%	-	-	35.7%	59.5%	-
8. Group topics were engaging	2.4%	2.4%	4.8%	21.4%	66.7%	2.4%
9. Facilitator helped me feel safe in this group environment	-	-	2.4%	4.8%	78.6%	14.3%
10. I would participate in this program again	2.4%	2.4%	2.4%	4.8%	88.1%	-
11. I would recommend this group to a friend who can relate to me	2.4%	2.4%	-	9.5%	85.7%	-

Note: Some participants completed an older version of the survey which did not have all the same questions on the satisfaction survey so those responses were excluded for items 3, 4, 5, and 9 (n=6).

LGBTQ+ Support Groups: Satisfaction Survey Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- “Although I haven't been here I learned not to judge others.”
- “Being able to talk about more sensitive topics. To come out of my shell.”
- “By thinking more positive than negative”
- “Helped me talk to people more about my problems and helped me be in group settings.”
- “I feel more inspired to help younger people with the same issues that I had felt before.”
- “I felt seen”
- “I has helped with my self confidence and well being.”
- “I know a few more people who are similar to me and feel a bit more comfortable talking about my experience in the LGBTQ community”
- “I talked to more people”
- “I'm more social and more aware of my emotions.”
- “It has brought helpful change in me by making me more appreciative of others experiences.”
- “It has given me a place to be myself and a place to stay. It has also given me a great community.”
- “It has helped me have a better understanding of my self and others. I am more comfortable in talking about sensitive topics.”
- “It has helped me understand things and be more confident/meet new people.”
- “It helped me be way more social”
- “It helped me grow confidence in myself. I also look at life differently.”
- “It helped me open up and be more comfortable talking about issues”
- “It helped me understand my friend's experiences.”
- “It made me think more about my identity and how to accept myself.”
- “It made me understand what other people are going through and helped me to learn to comfort people”
- “It showed me not to feel bad about who I am”
- “It taught me to be more open and how to help a friend through any identity crisis.”
- “It's helped me talk to people and helped me engage as my true self at times.”
- “Made me realize other's emotions”
- “Stable medication, better mental health, community”
- “The people were fun to be around.”
- “The program has helped me open up and talk about some of my issues.”
- “They made me feel more seen!”
- “This program brought me a lot of comfort and safety that I don't usually experience during class.”
- “This program has been a very safe environment that I look forward to coming to because I feel like I can just be myself.”
- “This program has made me more confident to speak in a room full of people”
- “This program has made me realize that people have different struggles and made me change my perspective on certain topics.”
- “This program really helped me understand that I wasn't the only one who felt bad emotions.”

LGBTQ+ Support Groups: Satisfaction Survey Comments (cont.)

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants Disliked…

- "Besides the changes, no."
- "I had no problems with the program."
- "I know a lot of this stuff already."
- "I like everything!!"
- "I really enjoyed this program."
- "I'm quite anti-social and I guess talking but I could always get past it."
- "t was fine the way it was."
- "No I think everything was fair and a good opportunity."
- "No, I did not see anything that would make me feel like I did not like the program."
- "No, I liked everything."
- "Not much the program is great"
- "That the times to come were midday it would be better near last period."
- "There could be more people here, but it did as much as it could."
- "There wasn't anything I particularly didn't like. I really enjoyed the entire group! It was really fun."
- "We got off task a lot other then that it was a good group."

Additional Comments…

- "Best group ever. Everyone was nice and they are the best (smiley face)"
- "Everything was so fun and engaging, Thank You for doing this for us and making a safe environment."
- "Give [facilitator 1] and [facilitator 2] a raise"
- "I enjoyed listening to everyone's expirances"
- "I enjoyed this program."
- "I really loved this group and I hope it comes back next year!!! (heart symbol)"
- "I will miss you guys! (lmk when the next meeting/program for this will be!)"
- "I would love to join this group again for my next two years of high school"
- "I'm greatful I got this experience (smiley face) I love everyone here (heart symbol)"
- "It was very fun, the facilitators made the experiences very enjoyable."
- "Love their dynamic, they're really nice and make me feel safe"
- "[Facilitator 1, facilitator 2, and facilitator 3] were super sweet, and I hope to see them again"
- "Much Love"
- "Our instructors were amazing (smiley face)"
- "They are so nice (smiley face)"
- "This group is extremely helpful to me!"
- "This is a very safe environment that I personally believe a lot of people would enjoy!"

Mentoring: Eligibility Screening and Enrollment

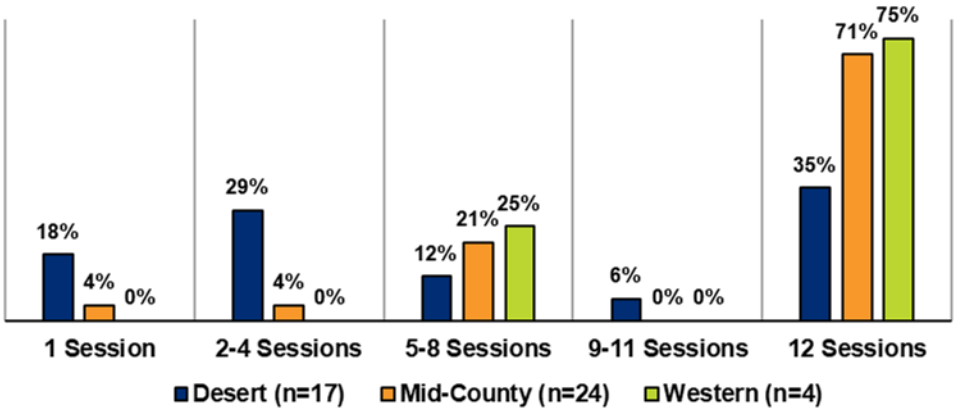
Mentoring is an individualized weekly activity provided by TAY Peer Youth Specialists. Mentors meet with youth once a week for three months and it is expected that mentor and mentees will have 12 contacts. An integral part of the mentoring program is goal setting with mentoring activities focused on supporting each mentees individualized goals. A goal setting action plan is used to set individualized goals and to monitor progress. Measurement of the participants perceptions of progress in the goal areas is assessed at the beginning, middle, and end of the mentoring period. Evaluation involves a pre and post survey that measures TAY mentees experiences with goal setting and goal obtainment during their participation in mentoring. In FY 2023-2024, TAY Peer Youth Specialists were to provide TAY peer mentoring to at least 20 youths per region for a total of 60 youths countywide. TAY youth are screened for eligibility into the program. In total, **51 youths were screened** for the mentoring program, of which **45 were enrolled** and **26 completed** the mentoring program.

Peer-to-Peer Mentoring Program				
	Desert	Mid-County	Western	Countywide
Screened	23	24	4	51
Enrolled	17	24	4	45
Completed	6 (35%)	17 (71%)	3 (75%)	26 (58%)

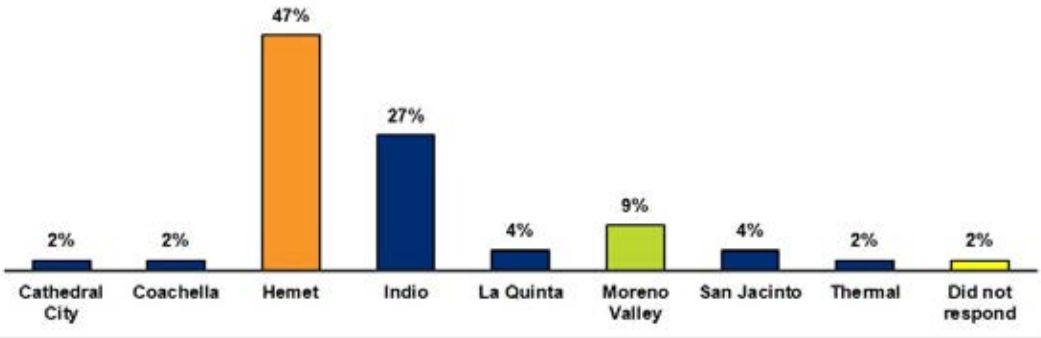
Session Attendance

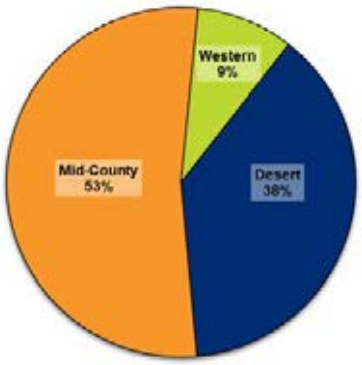
The session attendance in the Mentoring program varied. The goal is for youths to receive mentoring for 12 weekly sessions. The number of sessions per participant are shown in the following table and figure. A total of 391 sessions were provided during the 2023-2024 FY. The majority of the participants completed all 12 sessions (58%).

Number of Sessions	Number of Youths	%
1	4	9%
2 to 4	6	13%
5 to 8	8	18%
9 to 11	1	2%
12	26	58%



Mentees' City and Region



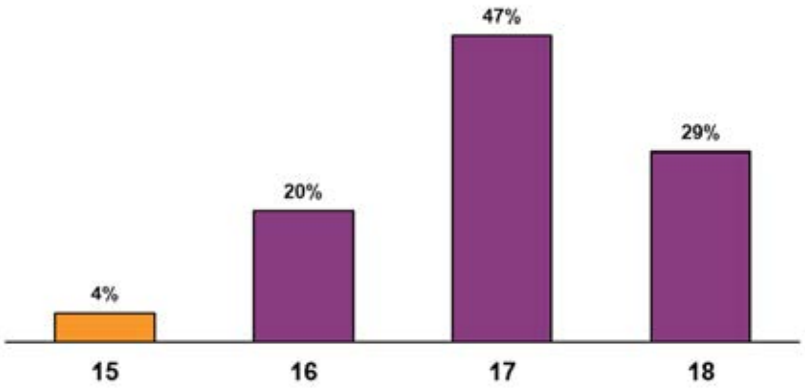


The majority of the mentees were from Hemet (47%, n=21) and Indio (27%, n=12).

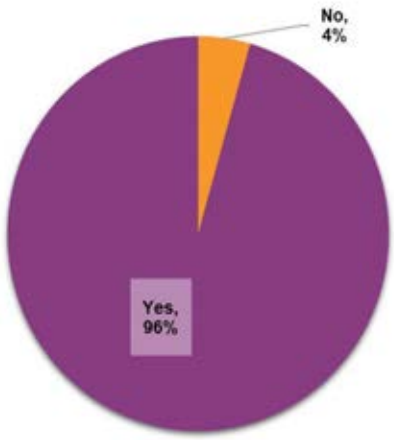
Mentoring: Demographics

The demographics for the enrolled youth are shown below. The majority of the mentees were TAY (96%, n=43) where the average age was 17 years old.

Age



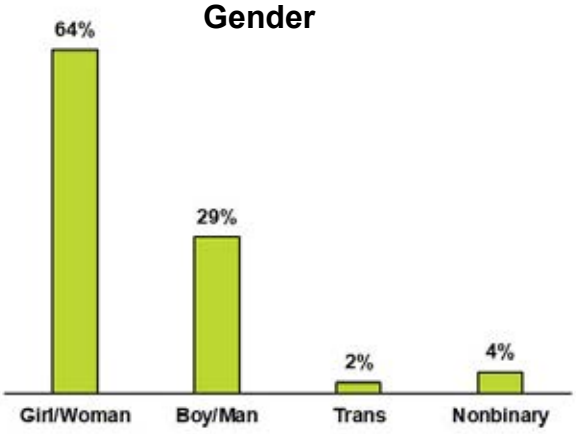
TAY/Non-TAY



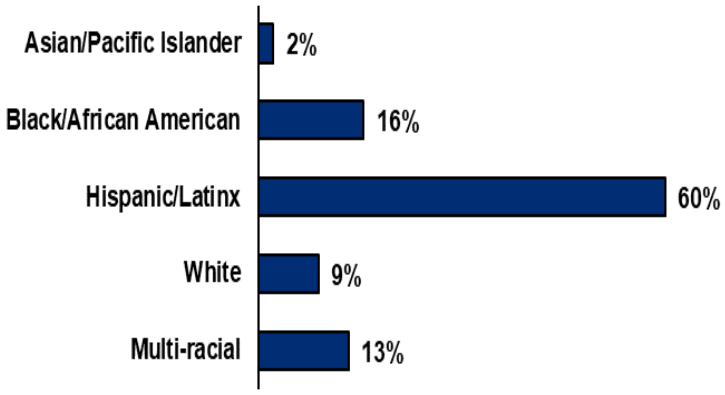
The majority of mentees identified as a girl/woman (64%, n=29), followed by 29% (n=13) as a boy/man, 4% (n=2) as nonbinary, and 2% (n=1) as transgender. Additionally, 15 mentees (33%) identified as LGB+.

The majority of the mentees were Hispanic/Latino (60%, n=27) and the preferred language for almost all of the mentees was English (91%, n=41).

Gender



Race/Ethnicity



Sexual Orientation	n	%
Straight	24	53.3%
Gay	3	6.7%
Bisexual	10	22.2%
Demisexual	1	2.2%
Omnisexual	1	2.2%
Unsure	2	4.4%
Decline	4	8.9%

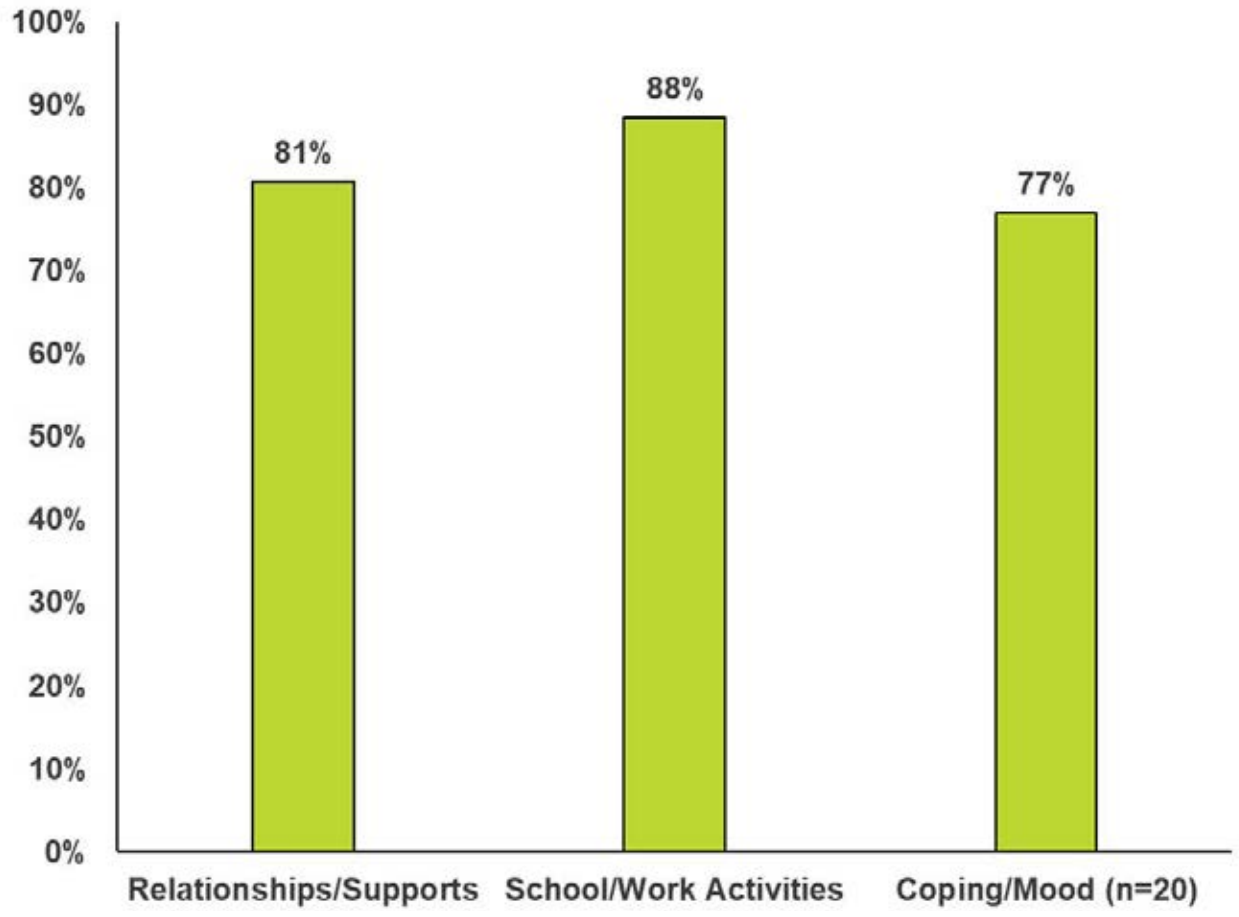
Language	n	%
English	41	91.1%
Spanish	3	6.7%
English and Spanish	1	2.2%

Mentoring: Goal Action Plan

Mentees were asked to complete a Goal Action Plan at the start, mid-way, and at the conclusion of mentoring sessions. At the beginning of the program, each mentee works with their mentor to complete the first Goal Action Plan. The participant sets three goals to work on during the mentoring time. While the goals are individualized, they define a goal for each of the following domains: **Relationships and Supports**, **Improvement in School/Work Activities**, and **Coping and Mood**. After creating the goals, the mentee then rates their feelings about each goal. There ratings are on a Likert scale of 1 to 4, where **1=Very Disappointed, 2=Somewhat Disappointed, 3=Somewhat Pleased**, and **4=Very Pleased**. During the program, once a mentee was pleased with the progress of a goal, it was replaced with a new goal.

Countywide, there were 26 mentees with pre- and post-goal ratings. The following figure represents the percentage of youth with improvement in goal ratings. In comparing goal achievements from pre to post of the 26 youth with data submitted, 16 mentees showed improvements for all three goal areas (61%). The domain with the most improvement was in **School/Work Activities** (88%), followed by **Relationships/Supports** (81%), and **Coping/Mood** (77%), respectively. Overall, mentees showed improvements and felt that they were very pleased with their own progress on their goals at the conclusion of the mentoring program, in comparison to how they felt about their goals at the beginning of the program.

Percentage of Youth with Improvements Pre to Post (n=26)

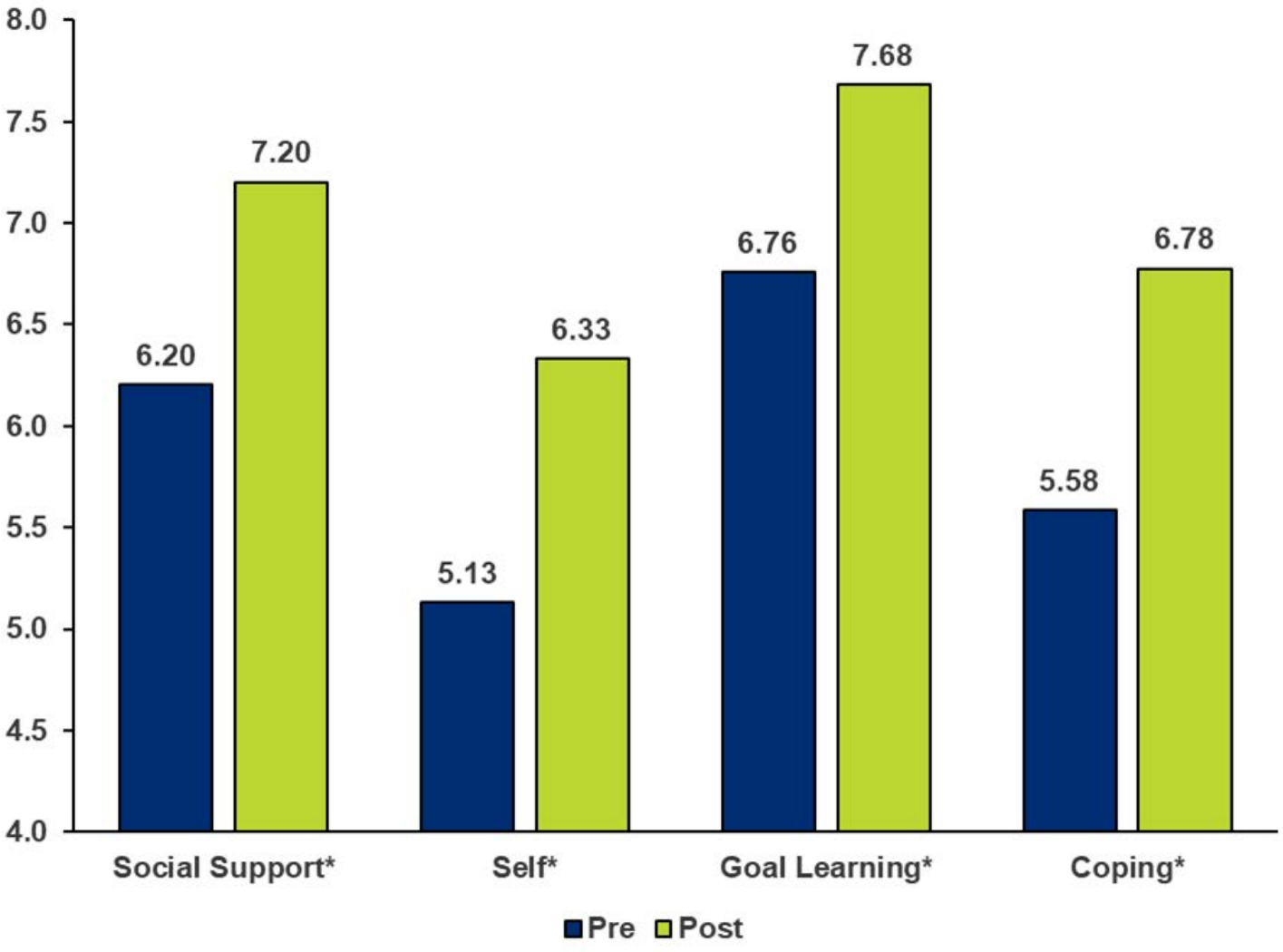


Mentoring: Pre/Post Surveys

The pre-and post-surveys are used to document the mentees' experiences and feelings for goal settings and accomplishment behaviors. Each mentee was asked to fill out a pre-survey during the first session, and then a post-survey at the last session. There are a total of 18 questions, related to: **Social Support** (how they feel about the presence of social supports in their lives), **Self** (how they feel about themselves in different scenarios), **Goal Setting** (how they view and act upon their own life goals), and **Coping** (how they cope with different life situations presented to them). Mentees rated themselves on a Likert scale of 1 to 9, where **1**=**Strongly Disagree** to **9**=**Strongly Agree.**

There were a total of 26 matched pairs of pre- and post-surveys. The majority of mentees with pre- and post-surveys completed were from the Mid-County region (65%, n=17). Overall, increases in average scores can be seen across all domains, with the highest increases in the areas of **Self** and **Coping**. The increases across all domains are statistically significant (p< .05).

Mentoring Program Average Scores
Pre to Post (n=26)



Note: * indicates statistical significance

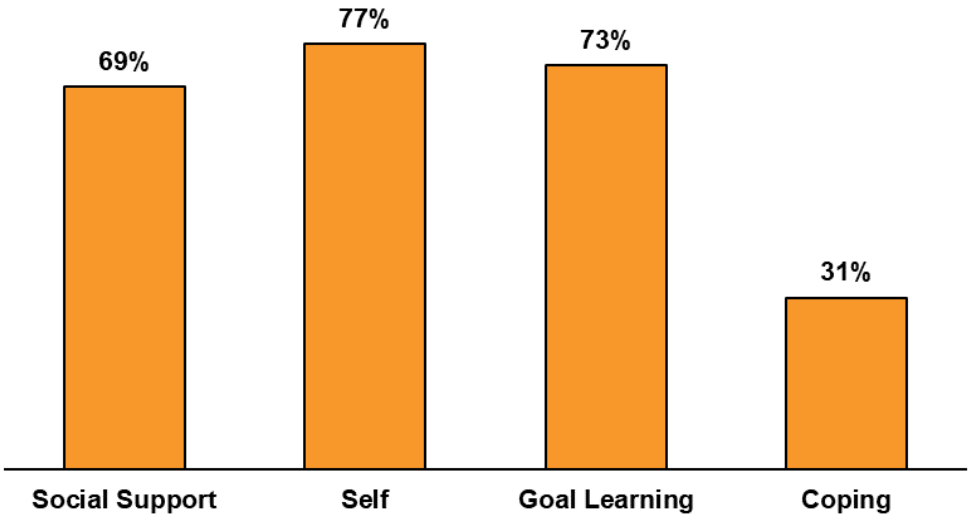
Mentoring: Pre/Post Questionnaire cont.

The following table shows the percent increase on mentees' average scores where all four domains increased. The "Self" domain increased the most (23%) on average scores in comparison to the other three domains.

Countywide (n=26)	% Increase on Average Scores
Social Support Having family members to rely on Having a friend to rely on Having someone to share most private worries and fear Knowing someone to turn to when dealing with personal problems	**16%**
Self Getting emotional support from friends or relatives Talking to someone about feelings Being optimistic in spite of what happened Refusing to let negative emotions drag them down Staying positive even when things look bad	**23%**
Goal Setting Having goals they want to reach Seeking something else to strive for after completing a goal Succeeding in reaching goals in school and/or work Succeeding in reaching goals in extracurricular activities	**14%**
Coping Concentrating efforts in reaching goals Taking action to get around problems when they arise Doing what has to be done when facing an issue, one step at a time Coming up with strategies when planning Thinking hard about what steps to take when planning	**21%**

The following chart shows the percentage of mentees who have shown improvement from pre- to post-measures in all four areas. "Self" had the largest proportion of mentees' who improved (77%, n=20), which suggest that the mentees' feeling about themselves increased by participating in the mentoring program.

Percentage of Mentees with Improvements from Pre to Post (n=26)



Mentoring: Satisfaction Surveys

The satisfaction survey is used to gather feedback from mentees on their experience in mentoring program and with their mentor. Each mentee was asked to rate 10 satisfaction items on a 5-point Likert scale, where **1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree**, and **5=Strongly Agree**. There were a total of 26 mentees who completed the satisfaction survey for the mentorship program, and their responses are summarized below.

In terms of feedback regarding the mentoring program:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentoring program has helped them define their current goals.
- **92%** of mentees "Agreed" or "Strongly Agreed" that through the program, they have come to understand the importance of self-praise throughout the goal-setting process, that the program has helped them learn new ways to cope, and that as a result of participating in this program, they now know how to make realistic and reachable goals in the future.
- **85%** of mentees "Agreed" or "Strongly Agreed" that the program has allowed them to build stronger relationships with those whom I depend on.
- **81%** of mentees "Agreed" or "Strongly Agreed" that they felt as though this program was personalized towards reaching their specific goals.

In term of feedback regarding the mentors:

- **100%** of mentees "Agreed" or "Strongly Agreed" that the mentors were knowledgeable when sharing information, their mentors met them at convenient times and locations, and their mentors kept their scheduled appointments.

Overall, **100%** of mentees reported being satisfied with the mentoring program.

Countywide (n=26)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Participation in this program has helped me define my current goals.	-	-	-	50.0%	50.0%
2. I feel as though this program was personalized towards reaching my specific goals.	-	-	19.2%	26.9%	53.8%
3. Through the program, I have come to understand the importance of self-praise throughout the goal-setting process.	-	-	7.7%	26.9%	65.4%
4. This program has allowed me to build stronger relationships with those whom I depend on.	-	-	15.4%	42.3%	42.3%
5. The program has helped me learn new ways to cope.	3.8%	-	3.8%	23.1%	69.2%
6. As a result of participating in this program, I now know how to make realistic and reachable goals in the future.	-	-	7.7%	30.8%	61.5%
7. The mentor was knowledgeable when sharing information.	-	-	-	3.8%	96.2%
8. My mentor met with me at convenient times/locations.	-	-	--	11.5%	88.5%
9. My mentor kept our scheduled appointments.	-	-	-	3.8%	96.2%
10. Overall, I am satisfied with the mentoring program.	-	-	-	-	100%

Mentoring: Comments

Mentees were also asked to comment on aspects of the mentoring program. Below are some comments from the participants.

What have been the most helpful things about the mentoring services that you've received?

- "Advise on life stuff."
- "Being able to feel heard about certain situations."
- "Being able to learn to open up and having someone to talk to and learn from."
- "Coping and how to improve."
- "Help doing things differently in my life."
- "Helping me set goals for the things I need to achieve."
- "Helping with my homework."
- "How I can be proud of myself and have realistic goals."
- "How to focus on my goals and grades."
- "How to keep my emotions in control during my activity and while at home."
- "I have learned a lot of things about myself that I would not have known without this program and my mentor. I have grown a lot from when I first started versus now. I allow myself to feel my emotions and be less damaging and harsh on myself for everything, especially the things I can't control. I feel like I have more control over my life instead of letting it pass by me and letting the things or people that happen to me choose my emotions for me. I know I care about things too much sometimes but I've come to realize that some things about me that may seem like a curse can actually be blessings."
- "I was able to build new relationships and try and get my future together."
- "It helped me be more comfortable with who I am. My mentor was the best too."
- "Just helping me realize that I have many options in life."
- "Just mainly keeping me on track and helping me improve things in my life."
- "Overall just listening to me speak and helping me through my problems also being understanding."
- "Some of the coping activities helped when I did use them, and some of the things that were meant to help me get homework done."
- "Talking really it's nice to have someone to talk to outside of home with problems."
- "Talking to them and he helped me and gave me advice and told me what to work on."
- "The coping skills being self praise."
- "The fact of talking freely with someone about the things I like to talk about." [Translated from Spanish]
- "The journaling."
- "The most helpful thing about mentoring was being able to improve myself and work towards my goals."
- "The most helpful thing is the realness and honesty of what we talked about."
- "The positive feedback from my mentor."
- "They gave me advice in situations I wasn't to sure about."

Additional comments:

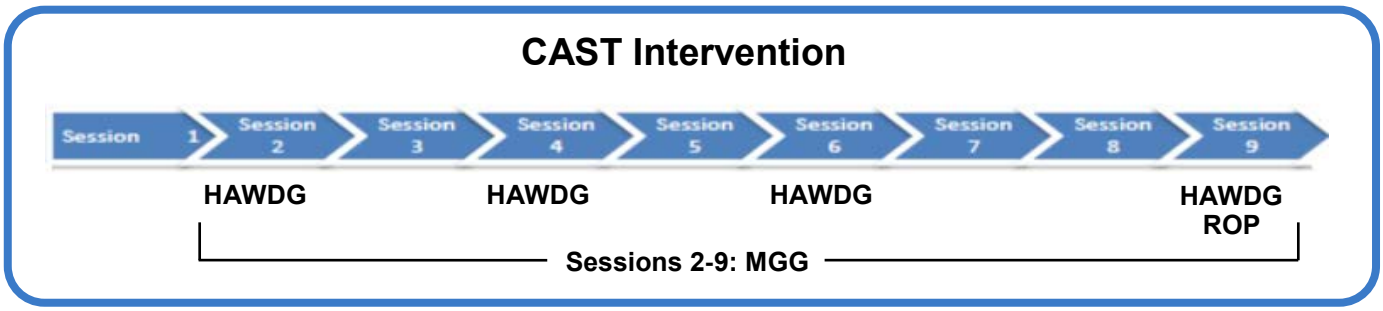
- "All in all, it helped out a lot. Most importantly it has helped me stay on track and keep up with school work."
- "Best mentor ever"
- "He was the best mentor I could ask for he was always there for me and I wish we had more time."
- "I love my mentor."
- "I'm glad I was able to participate in this program."
- "[Facilitator] was the best and helpful during the mentoring."
- "My mentor has helped me a lot with facing my problem and how to better my relationship with loved ones."
- "Overall I'm glad to have this opportunity to better myself."
- "Thank you so much, [facilitator]!! You have been a light in my life especially in the dark parts of it and I couldn't thank you more for the impact you've left on me."

Coping and Support Training (CAST)

Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and School Achievement. It was first implemented in the Peer-to-Peer program during FY 2013-2014. For FY 2023-2024, each CAST group consisted of a screening session, followed by 9 sessions facilitated by PEI TAY Peer Youth Specialists. Each year, Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region.

CAST uses three process evaluation measures to determine if the program was delivered as designed and obtained the desired outcomes. The process evaluation measures included:

- **Monitoring Group Goals (MGG)**
  - A survey rating, by session, on how well the student is doing in each of the 3 major CAST goals:
    1. Mood Management
    2. Drug Use Control
    3. School Achievement
- **How Are We Doing In Group? (HAWDG)**
  - A 12-item evaluation of CAST Leader and CAST peer group support and help, belonging, and student responsiveness.
- **Recognition of Progress (ROP)**
  - A survey where participants rate their current performance compared to when they first began CAST and identify areas in which they still need work. It measures specific acquisition related to CAST skill areas and progress goals (self-esteem, decision making, and personal control of moods, school, and drug use).



**Please Note: Since FY2015-2016, the 12-week session content was condensed into 9 weeks.*

CAST: Participation

In order to participate in the CAST program, participants first complete a "Demographic, Screening, and Enrollment Form" during a screening session. Eligibility into the program is determined by participant's reported age (must fall within TAY ages of 16-25 years), priority population (LGBTQ+, Homeless, Transitioning to college, Foster or former foster youth), and their self-rating scores in the Self-Esteem, Mood, and School sections of the Recognition of Progress (ROP) survey which are embedded into the screening form. If participants score 4 or less on the Mood section of the ROP they may not be appropriate for the CAST program since it indicates that the participant is experiencing high levels of distress. Those scoring 4 or less on the Mood section of the ROP will then be asked to complete the Center for Epidemiologic Studies Depression Scale (CES-D) to determine referral into the "Stress and Your Mood," or other appropriate programs. For FY 2023-2024, a total of 95 screenings were completed where 85 were TAY aged individuals and 10 were non-TAY aged individuals. Of those 95 screenings, 83 attended a group, 4 declined services, 0 were referred to other programs, and 8 did not meet criteria for participation.

	Desert	Mid-County	Western	Countywide
Attended	9	23	51	83
Declined	1	0	3	4
Referred	0	0	0	0
Did not meet criteria	4	0	4	8

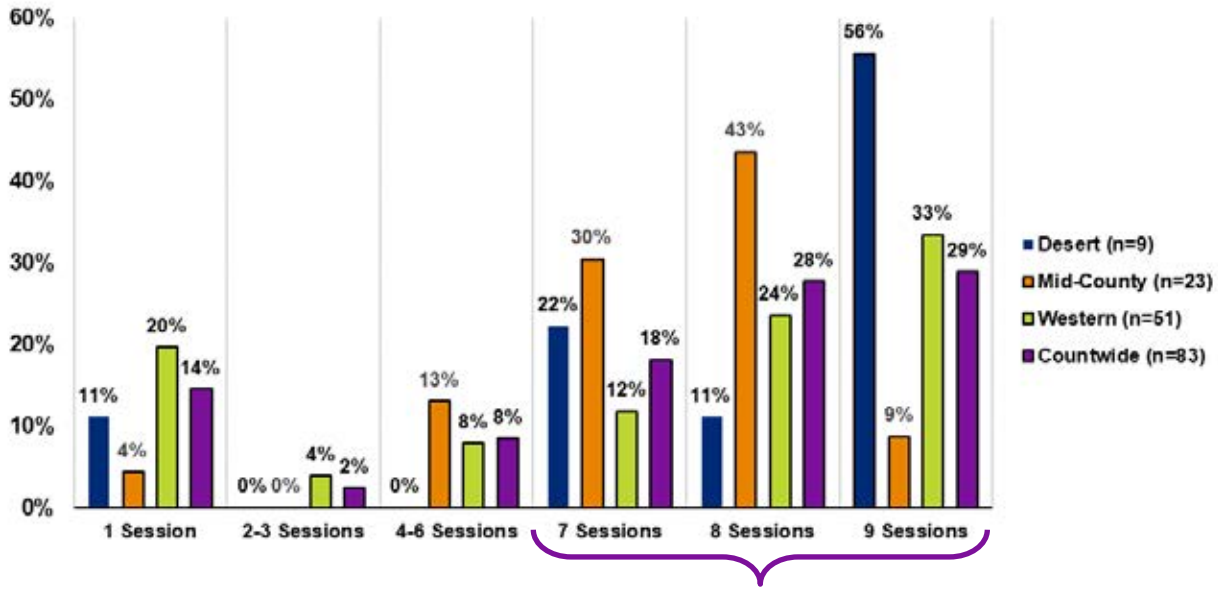
CAST: Attendance and Program Completion

Peer-to-Peer contractors are expected to hold a minimum of 6 groups, with at least 60 participants meeting completion standards, per region. During FY 2023-2024, countywide there were 95 individuals who were screened for CAST with 87 who were enrolled in CAST. Of the 87 individuals who were enrolled, 95% (n=83) attended at least one session. The Desert region held 1 group with 9 participants, the Mid-County region held 4 groups with 23 participants, and the Western region held 6 groups with 51 participants. Completion of CAST was defined as completing seven or more sessions. Of the total 83 participants who enrolled *and* attended at least one session in a CAST group offered throughout the county, 75% (n=62) completed the program.

Peer-to-Peer CAST Program				
	Desert	Mid-County	Western	Countywide
Screened	14	23	58	95
Enrolled	10	23	54	87
Attended ≥ 1 Session	9 (90%)	23 (100%)	51 (94%)	83 (95%)
Completion of ≥ 7 Sessions	8 (89%)	19 (83%)	35 (69%)	62 (75%)

In the Desert region, a total of 9 individuals enrolled and attended a CAST session with 8 (89%) attending 7 or more sessions. In the Mid-County region, a total of 23 individuals enrolled and attended a CAST session with 19 attending 7 or more sessions. In the Western region, a total of 51 individuals enrolled and attended a CAST session with 35 (69%) attending 7 or more sessions.

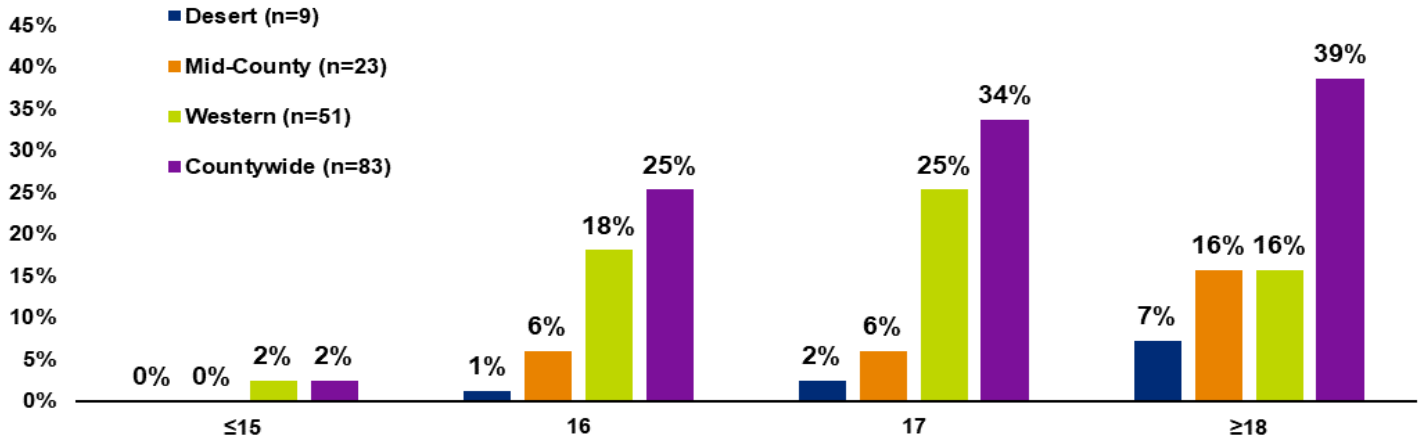
Number of CAST Sessions Attended (n=83)



Since CAST is typically held on school campuses, Peer-to-Peer staff had challenges with schools allowing access to some campuses to conduct CAST groups. Specifically, in the Desert region, two CAST group were started where 21 youth were screened and enrolled. Of those 21 enrolled, 17 attended at least one session and 4 declined services. However, after completing four of the nine sessions, the school revoked permission to conduct the program, therefore these participants were not included in the descriptive and outcome data.

CAST: Demographics

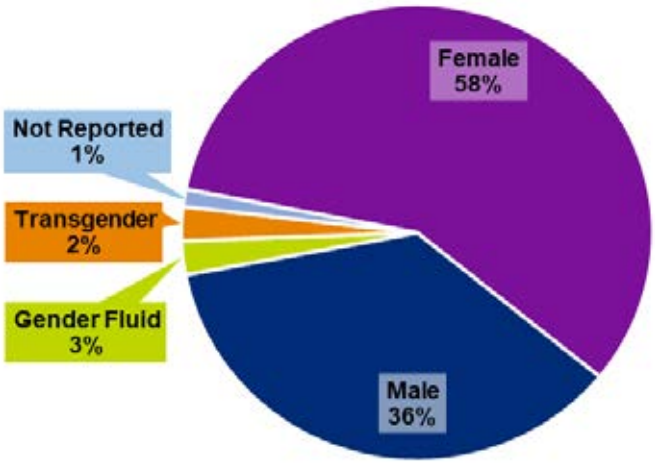
Age



Participants from the Desert region were primarily 18+ with 7% (n=6). In the Mid-County region, the largest age group was also 18+ with 16% (n=13), and Western region reported 25% (n=21) of their participants were 17. Of the 83 participants enrolled countywide, 98% (n=81) were TAY while the remaining 2% (n=2) were not TAY.

Gender and Sexual Orientation

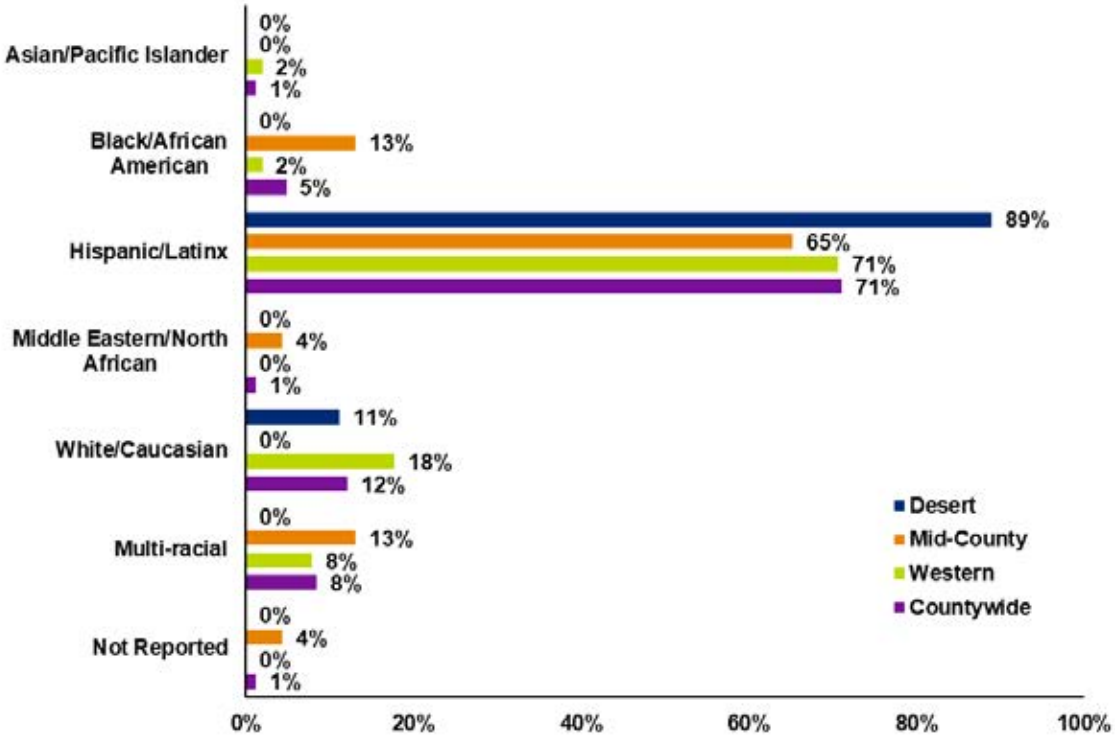
Countywide, the majority of youth enrolled in CAST were female (58%, n=48). Additionally, 36% (n=30) were male, 2% (n=2) identified as transgender, 2% (n=2) identified as gender fluid, and 1% (n=1) chose not to respond. There were 4% (n=3) of participants in Desert region who identified as LGB, 8% (n=7) in Mid-county region, and 19% (n=16) in Western region.



Countywide, most participants (96%, n=80) reported not having disabling condition, while a few participants (4%, n=3) reported having a disabling condition (these participants noted as having Asthma, Dyslexia, and Stuttering). Additionally, almost all participants (99%, n=82) indicated that they were not Veterans, while 1 participant chose not to respond to this question.

LGB	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide
Yes	3 (4%)	7 (8%)	16 (19%)	26 (31%)
No	4 (5%)	16 (19%)	26 (31%)	46 (55%)
Not Reported	0 (0%)	0 (0%)	2 (2%)	2 (2%)
Unknown	2 (2%)	0 (0%)	7 (8%)	9 (11%)

CAST: Demographics

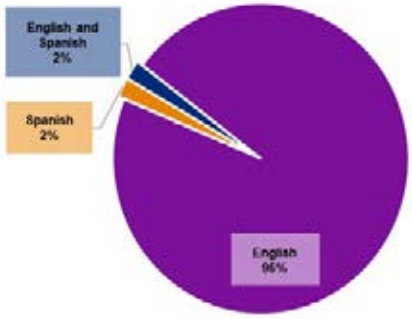


Race/Ethnicity

Countywide, the majority of youth enrolled in CAST were Hispanic/ Latinx (71%, n=59). About 12% (n=110) of youth identified as White/Caucasian, 5% (n=4) identified as Black/ African American, and 18% (n=15) identified as Multiple Races. There were 3 participants who identified as Asian/ Pacific Islander, Middle Eastern/North African, and chose not to respond (1%, n=1 in each category).

Countywide, 47% (n=39)

Language



Ninety-five percent (n=79) of participants reported English as their primary language countywide. This was followed by 2% (n=2) of participants reporting both English and Spanish as their primary language, and 2% (n=2) reported Spanish only.

Participants' City of Residence

Countywide, the majority of CAST participants reported their residences as the city of Riverside (51%,n=42), followed by Hemet (22%, n=18). For the Desert region, the reported cities were Indio (10%, n=8) and Thermal (1%, n=1). In the Mid-County region, the reported cities were Hemet (22%, n=18), San Jacinto (5%, n=4), Perris (2%, n=2), and Winchester (1%, n=1). For the Western region, the reported cities were Riverside (51%, n=42), Jurupa Valley (7%, n=6), and Rubidoux (1%, n=1).

Cities	Desert (n=9)	Mid-County (n=23)	Western (n=51)	Countywide (n=83)
Hemet	0 (0%)	18 (22%)	0 (0%)	18 (22%)
Indio	8 (10%)	0 (0%)	0 (0%)	8 (10%)
Jurupa Valley	0 (0%)	0 (0%)	6 (7%)	6 (7%)
Perris	0 (0%)	2 (2%)	0 (0%)	2 (2%)
Riverside	0 (0%)	0 (0%)	42 (51%)	42 (51%)
Rubidoux	0 (0%)	0 (0%)	1 (1%)	1 (1%)
San Jacinto	0 (0%)	4 (5%)	0 (0%)	4 (5%)
Thermal	1 (1%)	0 (0%)	0 (0%)	1 (1%)
Winchester	0 (0%)	1 (1%)	0 (0%)	1 (1%)

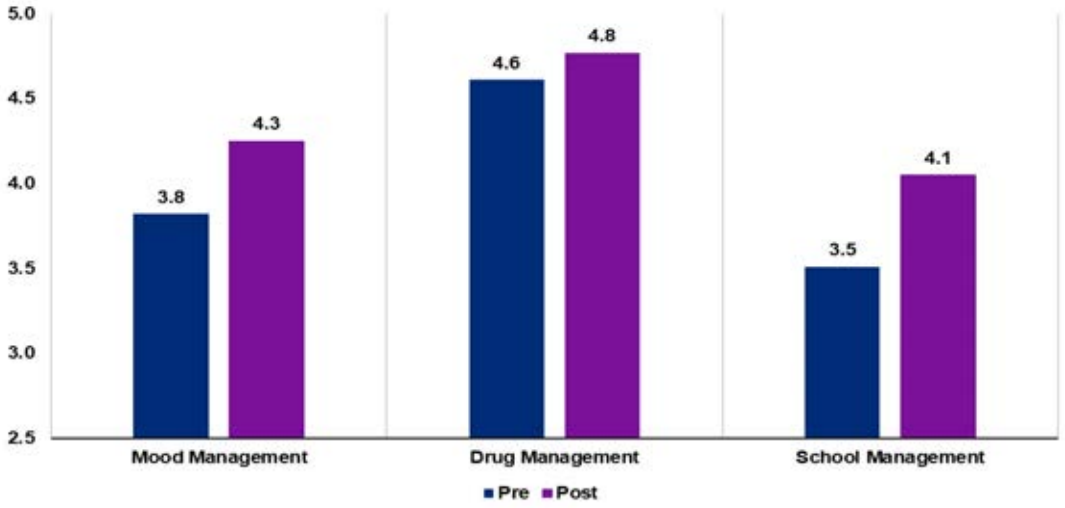
CAST Outcome Measures

Monitoring Group Goals (MGG)

MGG surveys were collected from participants at the end of sessions 2 through 9, in order to measure participants' performance in the three major CAST goal areas of mood management, drug-use control, and school achievement. Surveys collected at the end of sessions 2 and 9 were used for pre- to post-test analysis. There are some instances in which participants did not attend nor complete items for sessions 2 and/or 9, therefore means are reported for other sessions (3-8) but no other comparisons will be completed.

Of the 62 participants who completed the program, a total of 61 participants submitted MGGs for pre to post comparisons for some or all three items. Of the total 61 participants, 57.4% (n=35) attended CAST sessions in the Western region, 29.5% (n=18) attended CAST in the Mid-County region, and 13.1% (n=8) attended CAST in the Desert region, respectively.

MGG Pre/Post Results



The MGG surveys consist of survey items regarding participants' management of their feelings of depression and anger, drug use, and school smarts. All three questions are rated on a scale of 1-5; where lower ratings indicate poor management, and higher ratings indicate more positive management of the CAST goals. Countywide, participants' average post-test scores significantly increased from their pre-test scores for Mood Management, School Smarts Management and Drug Use Management suggesting meaningful improvement from the start of participation in the program to the end. High scores in Drug use management overall indicate little to no use of drugs and/or controlled substances.

Countywide Mean Differences and Percentage of Change

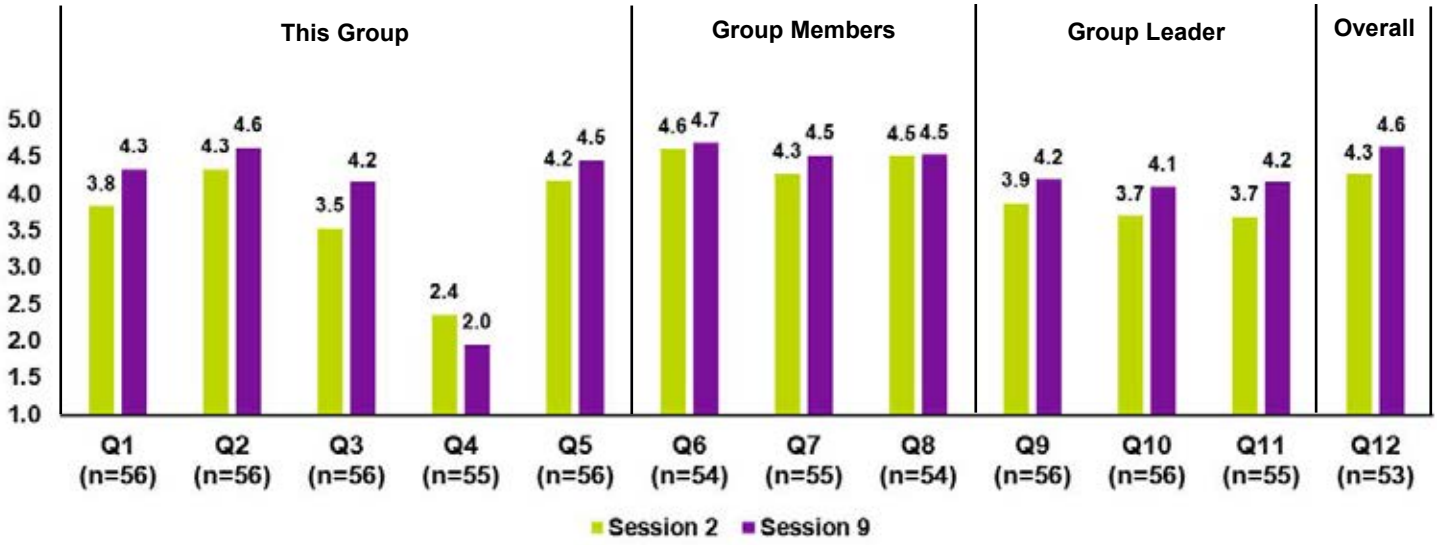
	Mean Difference	Worsened	Same	Improved
Mood (Depression/Anger) Management: (1) Feeling super depressed (or super angry), (2) Feeling depressed (or angry), (3) Feeling sort of sad (or a little angry), (4) Feeling OK, and (5) Feeling great	**0.44***	10 (16%)	22 (36%)	29 (48%)
Drug-Use Management: (1) Using way too much, out of control, (2) Using too much, (3) Using a little, (4) Not using, but tempted, and (5) Not using, in control	**0.17***	1 (2%)	51 (83%)	9 (15%)
School Smarts Management: (1) Messing up big time, (2) Just barely passing, (3) Doing fair, but could be better, (4) Doing OK, and (5) Doing great	**0.54***	8 (13%)	23 (38%)	30 (49%)

Note. * indicates significant mean difference from pre to post measure. It is important to note each management item does not contain the same participants even though the "n" is the same for each item.

CAST Outcome Measures

How Are We Doing in Group? (HAWDG)

HAWDG surveys were collected from participants at the end of sessions 2, 4, 6, and 9, in order to measure the participants' feelings of support and help in group. Of the 62 participants who completed the program, a total of 56 participants submitted at least one item pair from the HAWDG survey for sessions 2 or 9. Of the 56 participants, 60.7% (n=34) attended CAST sessions in the Western region, 30.4% (n=17) attended CAST sessions in the Mid-County region, and 8.9% (n=5) attended CAST sessions in the Desert region.



The HAWDG surveys include general items about the participant's feelings toward the group, the group leader, other group members, and the overall experience. It is rated on a scale from 1-5, with lower ratings indicating less frequency and higher ratings indicating more frequency (1-Never/Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). The mean difference scores reflect the average difference between Session 2 and Session 9. All items except Q2 and Q8 showed meaningful increases in frequency. Countywide, the largest increase was in participants' sense of "belonging" for item 3. Below is the table showing percentages of increase and decrease in frequencies for participants.

	Mean Difference	Decreased	Same	Increased	No Response
In This Group					
1. The topics we cover interest me	**0.5***	3 (5%)	28 (50%)	25 (45%)	0 (0%)
2. I really want to do my best	**0.29***	4 (7%)	35 (63%)	17 (30%)	0 (0%)
3. I have a real sense of "belonging"	**0.63***	4 (7%)	23 (41%)	29 (52%)	0 (0%)
4. We have serious conflicts and tensions	**-0.42***	17 (30%)	29 (52%)	9 (16%)	1 (2%)
5. I learn something useful each Session	**0.29***	9 (16%)	27 (48%)	20 (36%)	0 (0%)
The Group Leader (Teacher)					
6. Encourages and supports me	0.09	6 (11%)	37 (66%)	11 (20%)	2 (4%)
7. Is someone I can count on to help me	**0.26***	7 (13%)	34 (61%)	14 (25%)	1 (2%)
8. Offers useful points of view about topics we discuss	0.02	12 (21%)	32 (57%)	10 (18%)	2 (4%)
The Other Group Members					
9. Encourages and support me	**0.32***	7 (13%)	28 (50%)	21 (38%)	0 (0%)
10. Give me advice or information I need	**0.43***	11 (20%)	20 (36%)	25 (45%)	0 (0%)
11. Get support and encouragement from me	**0.47***	10 (18%)	22 (39%)	23 (41%)	1 (2%)
Overall					
12. I am satisfied with the support and encouragement I get	**0.38***	2 (4%)	33 (59%)	18 (32%)	3 (5%)

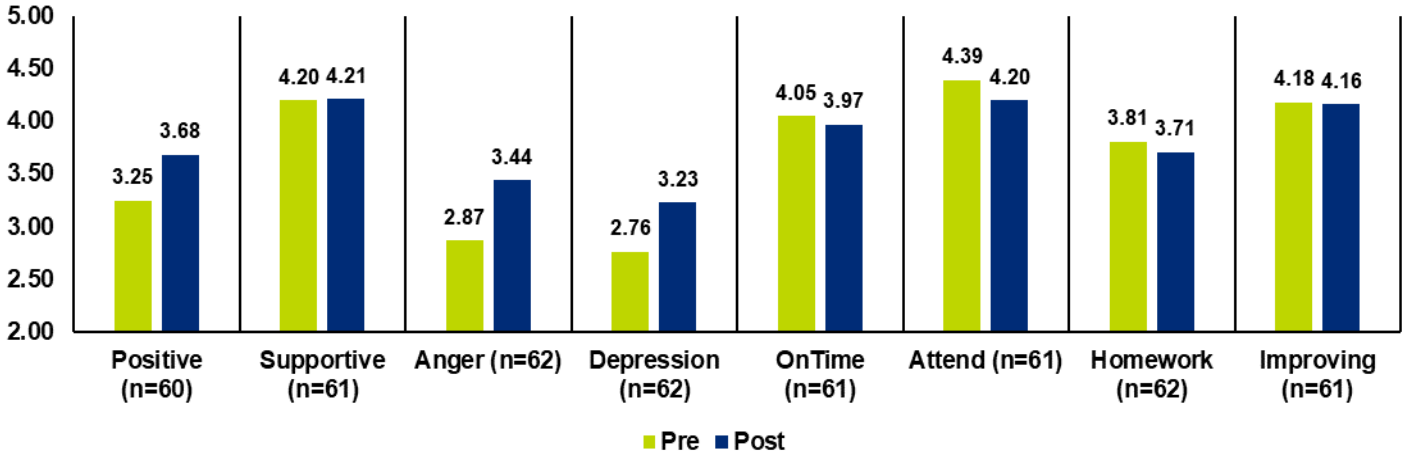
Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

CAST Outcome Measures

Recognition of Progress (ROP)

ROP surveys were collected from participants during the initial screening session and the final session, in order to measure participants self rated skills in the following areas: self-esteem and personal control with moods, school work, and drug use. A total of 62 participants completed CAST and submitted pre-and post-surveys. Of the 62 participants who submitted pre- and post-surveys, 57% (n=35) completed CAST in the Western region, 31% (n=19) completed CAST in the Mid-County region, and 13% (n=8) completed CAST in the Desert region. Please note that the graph below does not depict Personal Control or Drug Use items as they had relatively low scores. Mean differences for these items are still reported in the table below.

ROP Pre/Post Results



ROP evaluates items in the skill areas of self-esteem and personal control of moods, school, and drug use. It is rated on a scale from 1-5, with lower ratings indicating lower frequency and higher ratings indicating higher frequency (1-Never/ Very Rarely, 2-Seldom/Sometimes, 3-About 1/2 the Time, 4-Often/Typically, and 5-A Lot/Always). For analysis of self-esteem and personal control of moods, school, and drug use, post-test scores completed at the end of the program were compared to pre-test scores from their ROP survey at screening. Countywide, average post-test scores showed statistically significant ($p<.05$) improvement over the average pre-test scores to post-test scores in one item of self-esteem, both items of personal control in moods, and in one item of personal control in drug use. The mean differences in these four items that showed significance are shown in bold below.

Countywide (n=62)	Mean Difference	Worse	Same	Improved	No Response
Self-Esteem:					
Being positive with myself, recognizing my strengths	**0.43***	8 (12.9%)	26 (41.9%)	26 (41.9%)	2 (3.2%)
Praising and being supportive of others	0.02	13 (21%)	34 (54.8%)	14 (22.6%)	1 (1.6%)
Personal Control - Moods:					
Anger-controlling my thoughts, feelings and actions	**0.57***	9 (14.5%)	17 (27.4%)	36 (58.1%)	0 (0.0%)
Depression-getting "unstuck" from negative moods	**0.47***	13 (21.0%)	19 (30.6%)	30 (48.4%)	0 (0.0%)
Personal Control - School:					
Being on time for class	-0.08	18 (29.0%)	25 (40.3%)	18 (29.0%)	1 (1.6%)
Attending class daily	-0.20	19 (30.6%)	31 (50.0%)	11 (17.7%)	1 (1.6%)
Doing my assignments, homework	-0.10	15 (24.2%)	35 (56.5%)	12 (19.4%)	0 (0.0%)
Working on improving my grades, school achievement	-0.02	13 (21.0%)	35 (56.5%)	13 (21.0%)	1 (1.6%)
Personal Control - Drug Use:					
Smoking (cigarettes)	0.10	1 (1.6%)	53 (85.5%)	4 (6.5%)	4 (6.5%)
Using Alcohol	0.05	4 (6.5%)	50 (80.6%)	4 (6.5%)	4 (6.5%)
Using Marijuana	**0.20***	1 (1.6%)	49 (79.0%)	9 (14.5%)	3 (4.8%)
Using other drugs	0.05	1 (1.6%)	56 (90.3%)	1 (1.6%)	4 (6.5%)

Note. Mean Difference items that are in bold and have asterisks (*) are statistically significant.

Annual CAST Program Reviews

CAST Screening, Enrollment, Attendance, and Completion

A total of 95 participants were screened for enrollment into the CAST program in FY 2023-2024 as opposed to 133 and 117 who were screened in FYs 2022-2023 and 2021-2022, respectively. Additionally, of the total participants who attended a CAST group during FY2023-2024, 75% completed the program, compared to 58% and 55% in FYs 2022-2023 and 2021-2022, respectively.

FY 2023-2024 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	14	23	58	**95**
Enrolled	10 (71%)	23 (100%)	54 (93%)	**87 (92%)**
Attended ≥ 1 Session (% of Enrolled Participants)	9 (90%)	23 (100%)	51 (94%)	**83 (95%)**
*Completion of ≥ 7 (of 9) Sessions	8 (89%)	19 (83%)	35 (69%)	**62 (75%)**

FY 2022-2023 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	53	14	66	**133**
Enrolled	47 (89%)	10 (71%)	64 (97%)	**121 (91%)**
Attended ≥ 1 Session (% of Enrolled Participants)	41 (87%)	9 (90%)	62 (97%)	**112 (93%)**
*Completion of ≥ 7 (of 9) Sessions	21 (51%)	0 (0%)	44 (71%)	**65 (58%)**

FY 2021-2022 CAST Program				
	Desert	Mid-County	Western	**Countywide**
Screened	50	17	50	**117**
Enrolled	50 (100%)	0 (0%)	47 (94%)	**97 (83%)**
Attended ≥ 1 Session (% of Enrolled Participants)	37 (74%)	0 (0%)	36 (77%)	**73 (75%)**
*Completion of ≥ 6 (of 9) Sessions	15 (41%)	0 (0%)	25 (69%)	**40 (55%)**

Outreach and Reunification Services to Runaway Youth (Safe Place)

Program Type: Outreach for Increasing Recognition of Early Signs of Mental Illness Program



In Riverside County, there are currently over 250 Safe Place locations, including all the fire stations, police stations, Riverside Transit Agency (RTA) and Sunline buses. Safe Place allows Operation Safehouse to have "virtual doors" throughout the community; by displaying the "Safe Place" symbol in various locations, their goal is to provide assistance to youth who see the sign and ask for help at any of these locations. Operation Safehouse trains staff at the designated Safe Place sites to ensure people at those locations know the resources and how to help a youth in need. Presentations on Safe Place are also provided to the community to educate community members and organizations on what Safe Place sites do. This program includes targeted street outreach and engagement to the TAY population to provide needed services to return them to a home environment. Outreach includes training and education for business owners, bus drivers, and other community agencies to become aware of at-risk youth who may be homeless or runaway and seeking support. Trained individuals assist youth in connecting them to safety and additional resources. Outreach includes going to schools to provide students with information on available resources, including crisis shelters; going to places where youth naturally congregate, such as malls; and working with organizations most likely to encounter the youth. Crisis intervention and counseling strategies are used to facilitate the reunification of the youth with an identified family member.

- **A total of 3,289 individuals were provided services by Operation Safehouse**
- **A total of 117 youth entered or were placed/referred to a Safe Place location (TLP).**

Due to staffing shortages, there was no training conducted and/or no training data submitted for Safe Place Trainings between July 2023 to June 2024 for Desert region and Western/Mid-County region. The provider conducted a total of 37 Educational Presentations, with a total attendance of 2,348 people. The provider has continued helping youth in finding suitable housing by getting them into shelters, transitional programs, and treatment centers. We have continued partnering with other departments throughout the agency to reach schools, law enforcement, transit agencies, and other community entities that would benefit from our services. Due to these efforts, we continue to see an uptick in referrals and youth coming forward. The Street Outreach Team is having trouble meeting its targeted goals. Staffing has been an issue in the last several months. Staff retention rates have been low, and we are working on hiring more staff currently.

The objective of the Outreach program through Operation SafeHouse, is to increase youth safety, well-being, and self-sufficiency, so that they build permanent connections with caring adults and community members. Through our efforts, we have encountered and assisted youth who have run away or have been asked to leave their homes. Some of these youths have experienced physical, sexual, or emotional abuse; neglect; rejection; or parental substance abuse. Once on the

streets, they can become victim to sexual exploitation, physical or sexual assault, weapons assault, robbery, and gang activity. The longer they are exposed to the streets, the more likely they are to fall victim to these crimes and victimization. Additionally, these youth are sleeping in places that are not safe or appropriate. They have become acculturated to street life and turn to drugs and alcohol as a means of coping. They often suffer from serious physical health, behavioral, and emotional problems, including depression and anxiety. Others can become victims of labor trafficking and other types of sexual exploitation.

A success story:

A 24-year-old male who has been homeless for a couple of weeks was in a room for rent but could not afford it after his seasonal job ended. He had been couch-surfing and sleeping on the streets since then. He did not have regular access to food and water since he slept outside. He spent the night at the Path of Life but was only able to stay one night. He was sleeping at La Sierra Park when the street outreach team contacted him. The outreach team was able to connect him with MainSTAY shelter and secure him a bed.

The street outreach team was also able to connect him with several longer-term housing options, including Starting Over Inc., the Ranch, and Coachella Valley Rescue Mission. He was accepted to Coachella Valley Rescue Mission residential program. On December 30th, the street outreach team assisted and transported him to Coachella Valley Rescue Mission for his intake. The client left the program with connection to resources and safe and stable housing.

MHSA
Prevention and Early Intervention
Youth Outreach Report

FY 2023-2024

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YOUTH OUTREACH PROJECT

Program Description

Through the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding, Operation Safehouse, Inc. is contracted to provide services in Riverside County to Transition Age Youth (TAY) who are homeless, a run away or at of risk of running away, through their Safe Place and Street Outreach to Youth Program. The Youth Outreach Program is dedicated to the safety and well being of youth in crisis and is committed to providing comprehensive support services for at-risk youth and those struggling with crisis situations. MHSA PEI funding is focused on two components of Operation Safehouse programming which are described below.

Operation Safehouse Safe Place Project



Operation Safehouse, Inc. was funded through MHSA-PEI to train and educate the community on the Safe Place program. This program is based on "Project Safe Place", a national program found in communities all across the United States, which creates Safe Place location designations within the local the community organizations and businesses centers, for youth to seek assistance.

Safe Place is a community prevention initiative where Safe Place trains and then designates businesses and organizations as Safe Place locations, making help readily available to youth in the community. Safe Place locations include: libraries, community centers, public buses, various businesses and social service facilities. Designated Safe Place locations display the Safe Place sign, the universal symbol of youth safety. Safe Place designated sites are trained to respond to youth that ask for assistance. Safe Place outreach, training and education are targeted to business owners, bus drivers, and other community agencies who are already a designated site or who could become a Safe Place designated site for at-risk youth in need of immediate help and safety.

In Riverside County, there are currently over 250 Safe Place locations, including all the fire stations, police stations, Riverside Transit Agency (RTA) and Sunline buses. Safe Place allows Operation Safehouse to have "virtual doors" throughout the community, by displaying the "Safe Place" symbol in various locations, their goal is to provide assistance to youth who see the sign and ask for help at any of these locations. Operation Safehouse trains staff at the designated Safe Place sites to ensure people at those locations know the resources and how to help a youth in need. Presentations on Safe Place are also provided to the community to educate community members and organizations on what Safe Place sites do.

Operation Safehouse Street Outreach

In addition some PEI funding also supports targeted street outreach to homeless and runaway youth to facilitate the reunification of the Transition Age Youth (TAY) with an identified family member or to a safe environment. Operation Safehouse staff provide youth with information on available resources and where they can seek assistance including Safe Place sites.

DATA COLLECTION

Operation Safehouse staff submitted data on a monthly basis from July 2023 to June 2024. Activities in the Western and Mid-County regions were summarized into one report, while the Desert region had its own separate monthly report. The Emergency Solutions Grant (ESG) team was the only team working with clients in both the Desert and Western/Mid-County regions, primarily focusing on youth aged 11 to 24.

In month of July 2023, for the Desert region, there was no staff to provide a monthly report for the month.

The monthly data includes the following components:

- ***Safe Place Training Information Report***
  To document the Safe Place training to Safe Place sites, including location, agency, date, and number of attendees.
- ***Safe Place Educational Presentation Report***
  To document outreach Educational presentations done to market Safe Place, at which Operation Safehouse staff present information on what Safe Place does for the community. Information recorded includes: date, location, staff presenting, number of attendance, pamphlet distribution, etc.
- ***Operation Safehouse Street Team Activities Report***
  To document street outreach activities to youth. Information recorded includes: date, type of street outreach, names of youths, race/ethnicity, age, gender, type of referrals provided, and shelter programs entered.
- ***Operation Safehouse Street Outreach Monthly Shelter Placement Report***
  To document the client name, shelter/program entered, and the total counts on the type of referrals Provided by Operation Safehouse on a monthly basis.
- ***Operation Safehouse Street Outreach Community Involvement Report***
  To document the Partnership/Community Involvement meetings attended by Operation Safehouse staff members.
- ***Operation Safehouse Staff Training Report***
  To document the RHYTTAC trainings attended by Operation Safehouse staff members.

SAFE PLACE TRAINING INFORMATION

There was no training conducted and/or no training data submitted for Safe Place Trainings between July 2023 to June 2024 for Desert region and Western/Mid-County region.

SAFE PLACE EDUCATIONAL PRESENTATIONS

Operation Safehouse conducted a total of **37** Educational Presentations, with a total attendance of **2,348** people. The table below shows the summary of all Safe Place Educational Presentations completed by Operation Safehouse staff during the fiscal year 2023-2024.

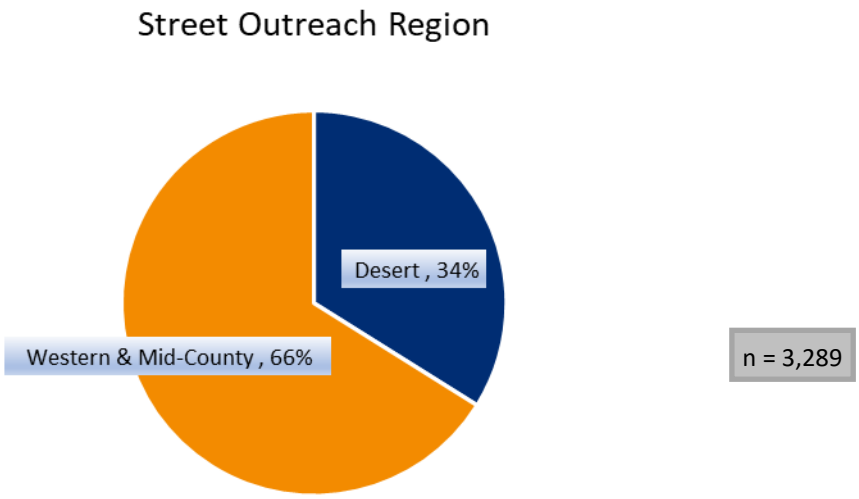
Month/ Year	Region	Team	Location of Education Presentations Conducted	Counts of Presentations	Number of Participants
Sep-23	Desert	ESG	DHS Rotary, Desert Recreation District	2	75
Oct-23	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5	360
Nov-23	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Coordinated Entry System Community Partnership, Active Shooter Training, All County Outreach Coordination Meeting	4	288
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, CES Community Partnership Meeting, YAC/YAB Meeting	3	300
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, Project Bridge, County Outreach Meeting	3	169
Feb-24	Desert	ESG	Transgender Wellness Center Presentation	1	2
	Western & Mid-County	ESG	Mayor's Initiative To End Youth Homelessness, CES Community Partnership Meeting	3	146
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5	282
Apr-24	Western & Mid-County	ESG	All County Outreach (Boots on Ground)	1	186
May-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, CES, Youth Advisory Committee & Youth Action Board	4	185
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots on the Ground, KIK Summit at YOC Rubidoux	6	355

Total Number of Educational Presentations: **37**
Total Number for Attendees : **2,348**

***** Several presentations were conducted more than once in a single month.

STREET OUTREACH PROGRAM: REGION AND TEAMS CATEGORIES

The graphs shown below, and on the following two pages, describe the street outreach activities/services provided by the Operation Safehouse staff members during fiscal year 2023-2024. Daily activity forms were submitted on a monthly basis to document the activities as well as the basic demographic information of the youth and adults who were provided street outreach. It is noted that the counts of youth and adults may be duplicated due to different types of services that may be provided to the same people within the same fiscal year.

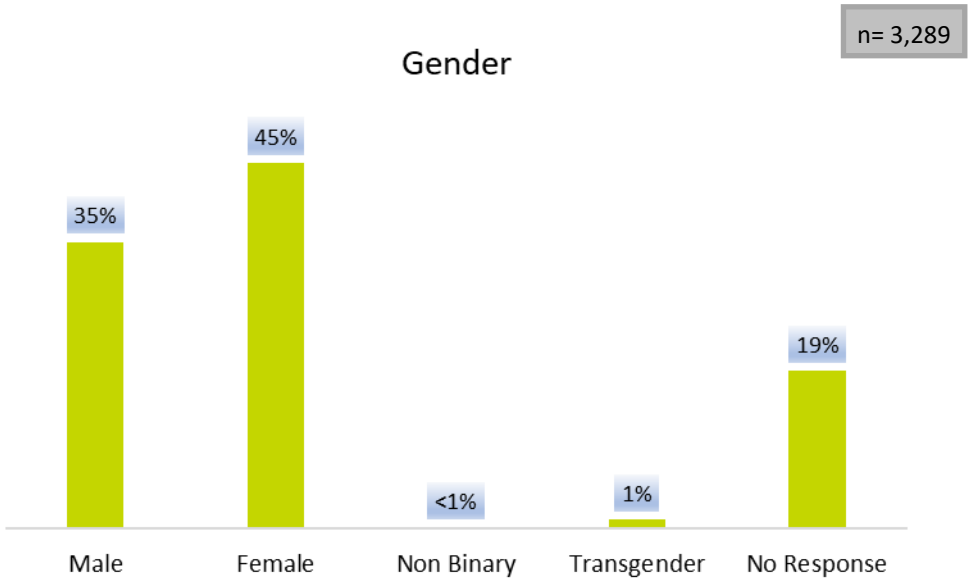


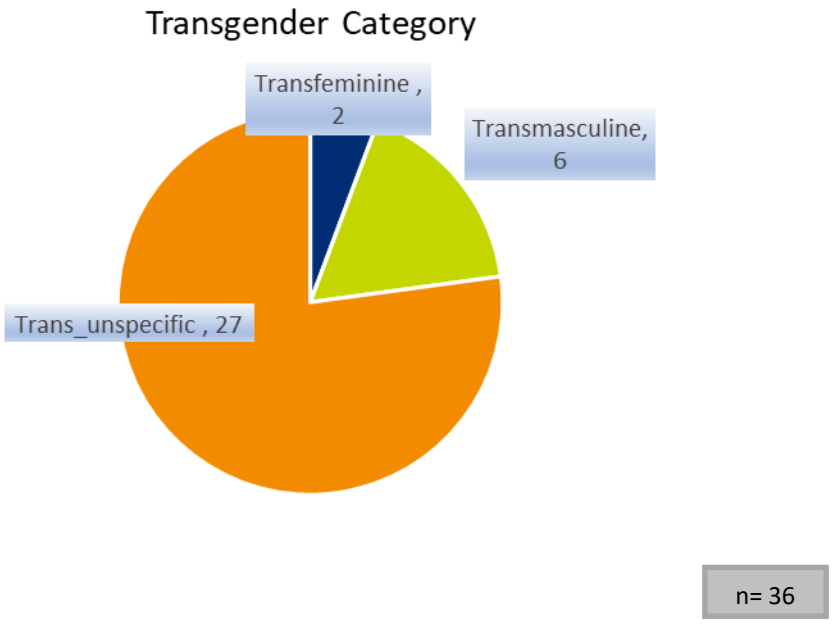
Overall, there were a total of 3,289 youth and adults who were provided street outreach services during fiscal year 2023-2024. The majority of street outreach services were provided by the Western/Mid-County Region, which served 2,174 youths and adults (66%), while the Desert Region provided services to 1,115 (34%).

This fiscal year one team provided services within Operation Safehouse, the ESG Team of the Street Outreach services between July 2023 to June 2024.

STREET OUTREACH PROGRAM: GENDER AND LGBTQI CATEGORIES

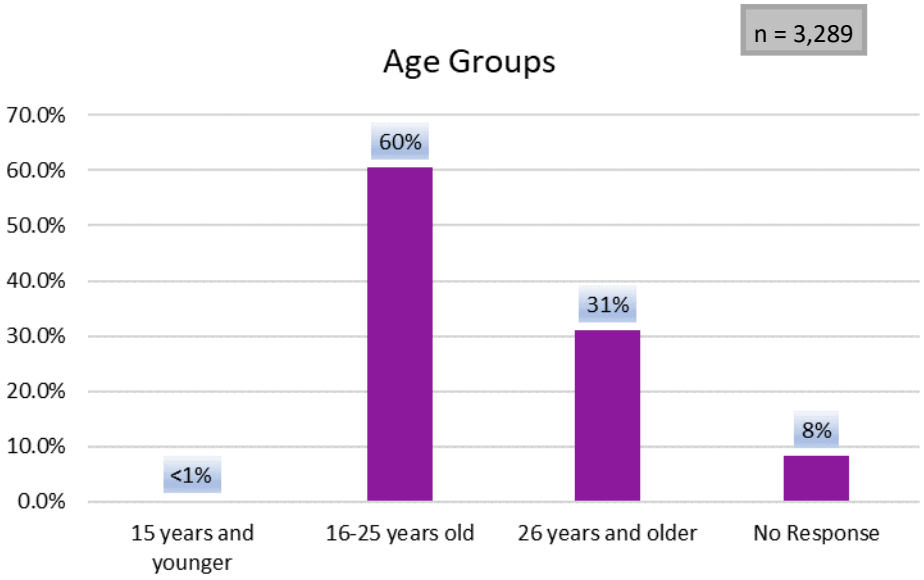
The majority of youth and adults who were provided street outreach were *Female* (45%, n = 1,465), followed by *Male* (35%, n = 1,148). There was a small percentage of youths and adults who reported themselves as *Non-Binary* (0.213%, n = 7) and *Transgender* (1%, n = 36), while 19% (n = 633) chose not to respond. Of those who indicated Transgender, 2 people reported *Transfeminine* (Male to Female), 6 people reported *Transmasculine* (Female to Male) and 28 people did not chose otherwise.



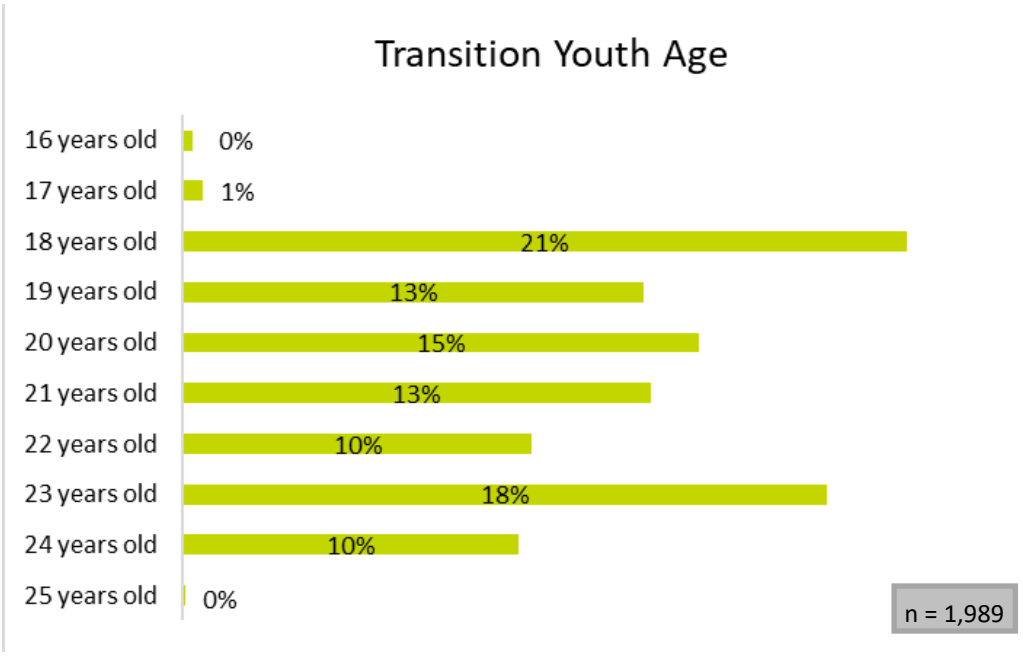


STREET OUTREACH PROGRAM: AGE GROUPS AND TRANSITION AGE YOUTH (TAY)

Categorizing into age groups, the majority of street outreach services were provided to Transition Age Youth (*16 to 25 years*) with 60% (n = 1,989), followed by, Adults (*26 years and older*) with 31% (n = 1,021), and Adolescents (*15 years and younger*) with 0.2% (n = 7). There were also 272 people (8%) who chose not to respond to the age question.



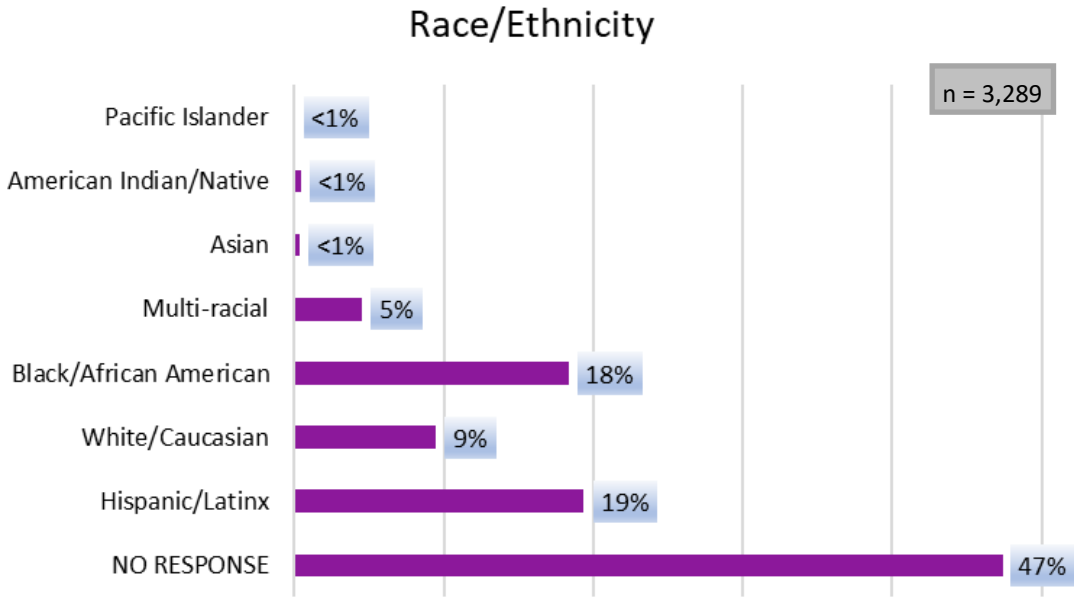
Within the Transition Age Youth (TAY) category, there were a total of 1,989 youths who were provided street outreach services. As shown on the graph and table below, the majority of these youth were 18 years old (21%, n = 264).



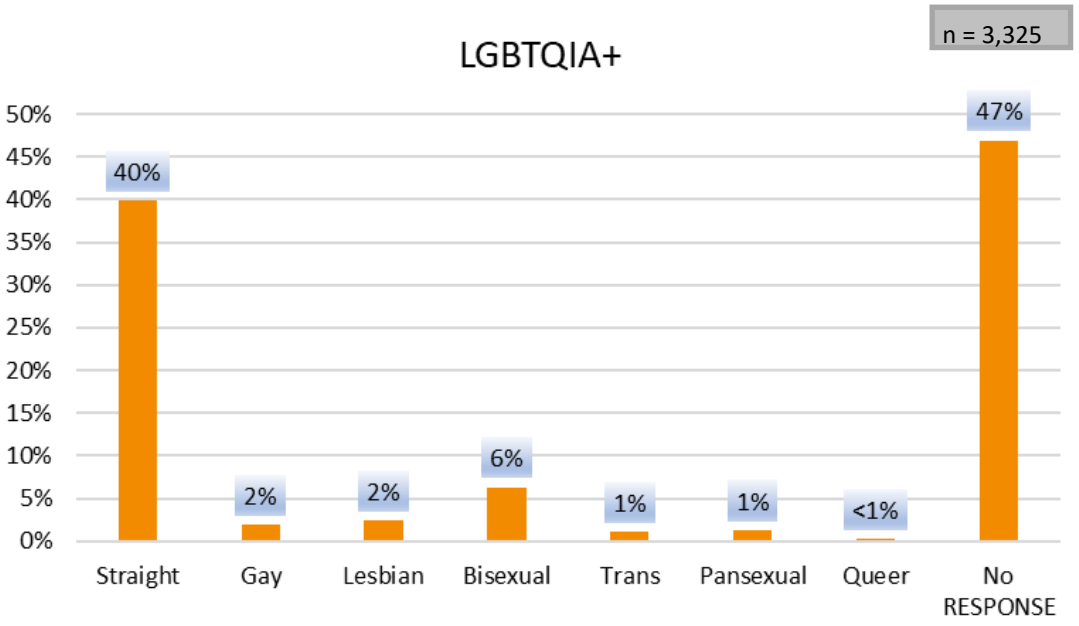
TAY Age	TAY Counts
16 years old	5
17 years old	11
18 years old	408
19 years old	260
20 years old	291
21 years old	264
22 years old	197
23 years old	363
24 years old	189
25 years old	1

STREET OUTREACH PROGRAM: RACE/ETHNICITY AND LGBTQI CATEGORY

The youth and adults who responded to the Race/Ethnicity question were mainly *Hispanic/Latino* (19%, n = 637), followed by *Black/African American* (18%, n = 603), *White/Caucasian* (9%, n = 311), and *Multiracial* (5%, n = 149). Less than 1% were *Asian* (0.36%, n = 12) and *American Indian/Native* (0.46%, n = 16).The majority of youth and adults (47%, n = 1,560) chose not to respond.



The majority of youth and adults (47%, n = 1,561) chose not to respond, while 40% (n = 1,326) categorized as *Straight*. There are also smaller percentages of youths and adults who categorized themselves as *Bisexual* (6%, n = 210), *Gay* (2%, n = 63), *Lesbian* (2%, n = 77), *Pansexual* (1%, n = 1), and *Trans* (1%, n=36) while the remaining >0.1% (n = 9) categorized as *Queer*. The total population size is higher to account for the 36 individuals identified as trans, as well as those disclosing their sexual orientation in the figure shown below.



STREET OUTREACH PROGRAM AND ACTIVITY DESCRIPTIONS

The Street Outreach program provided by Operation Safehouse staff members was developed to help homeless and runaway youth with referrals to services, hygiene products, gift cards, and transportation to homeless shelters or transitional living programs, when it is possible to these youth to move into a more safe and stable environment. The Street Outreach team is in the community seven days a week at locations where runaway and homeless youths are known to congregate.

Transitional Living Program (TLP)

The Transitional Living Program (TLP) is a transitional program for youths to provide them with a more permanent living/housing situation. Currently, there are 3 main TLP locations provided by Operation Safehouse:

- ***Main S.T.A.Y Emergency Shelter***
  This TLP is a 30-day emergency shelter program for older homeless youths between the ages of 18 and 24 years old. This program assists youths in their journey from the streets into shelter and/or housing.
- ***Main Street TLP, Riverside***
  This TLP is for older homeless youth between the ages of 18 to 22 years old, for up to 18 months. Services provided include: continuing educational assistance, individualized therapy, financial education, employment assistance, and access to medical and dental healthcare.
- ***Harrison House, Thousand Palms***
  This TLP is an 18-month program designed to support homeless young adults between 18 and 22 years old who are seeking assistance in their movement from the streets to becoming independent and self-sufficient adults.

Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool (VI-SPDAT)

The VI-SPDAT is a risk and prioritization database where an individual needing housing assistance is enrolled. It includes information on emergency shelter, homelessness, and the client's basic demographic and identifying information, and is a tool used to help with housing placements. Operation Safehouse uses this database to enroll new clients and to count total clients receiving their outreach. This tool also helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention, to who is eligible and in greatest need of that particular intervention.

Street Cards

The Street Cards is an informational tool in a form of a card/mini brochure that lists Operation Safehouse outreach program, as well as the important phone numbers and locations that are available for youth who need help.

Gateway Products

The "gateway products" refers to any services provided by Operation Safehouse staff members, which could be anything from a hygiene kit and bus passes to actual housing placements for youths.

What's Up App Cards

The "What's Up Safehouse" is a downloadable mobile phone application that provides anonymous counseling by text-communication from 7 AM to 11 PM, seven days a week, 365 days a year, with a Licensed Mental Health professionals from Operation Safehouse. This app is mainly designed to help young people ages 11 to 24 years old, but there are no actual age restrictions. It is meant to help young people who are struggling with drug/alcohol abuse, depression, difficult family situations, bullying, and other issues, while maintaining anonymity.

OPERATION SAFEHOUSE STREET OUTREACH ACTIVITIES AND REFERRALS SUMMARY

The table below shows the summary of Street Outreach activities provided to youths and adults by Operation Safehouse's staffs during the fiscal year 2023-2024. The descriptions for these activities are listed on the following page.

Operation Safehouse Street Outreach Activities	Total Counts for Western & Mid-County Regions	Total Counts for Desert Region	Total ALL Regions
Number of Intakes Completed	212	160	372
Number of TLP (Transitional Living Program) Applications Submitted	15	65	80
Number of VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance pre-screening Tool) Completed	37	27	64
Number of Clients entered Shelter/ Program *(refer to page 11 for TLP Placements table)*	72	45	117
Number of Safehouse/Street Cards Provided	1036	606	1642
Number of Gateway Products Provided	276	329	605
Number of Individuals Educated on SafePlace	1034	753	1787
Number of What's Up App Cards Provided	1034	487	1521
Youth Referrals (Ages 11-17)	26	6	32
Youth Referrals (Ages 18-21)	958	144	1102
Youth Referrals (Ages 22-25)	404	116	520
Adult Referrals (Ages 26+)	992	43	1035
Number of Families Assisted	67	9	76

OPERATION SAFEHOUSE SHELTER PROGRAM PLACEMENTS REPORT

There were a total of **117** youth (72 were in Western/Mid-County region, and 45 were in Desert region) who either entered the Operation Safehouse shelter, or were placed/referred to a safe location (TLP) during the fiscal year 2023-2024. The table below shows the summary report of outreach clients and shelter placements completed by month.

Month/Year	Region	Team	Shelter/Placement Location	Number of Placements
Jul-23	Western & Mid-County	ESG	The Main Stay, OSH Youth Shelter, Phoenix Rescue Mission	8
Aug-23	Desert	ESG	Family Assist, Harrison House	2
	Western & Mid-County	ESG	Mercy House, The Main Stay, Illumination Foundation	3
Sep-23	Desert	ESG	Martha's Village, Harrison's Village	2
	Western & Mid-County	ESG	The Main Stay, Lutheran Social Seniors, Path of Life Family Shelter, Chess Program, Path of Life	8
Oct-23	Western & Mid-County	ESG	Chess Program, The Main Stay, Path of Life	9
	Desert	ESG	The Main Stay, Family Reunification, Lagos CSU, Rapid-housing (LA)	6
Nov-23	Western & Mid-County	ESG	The Main Stay, Path of Life	4
Dec-23	Western & Mid-County	ESG	The Main Stay, Chess Program, Cherished UA	6
	Desert	ESG	CVRM, The Main Stay	2
Jan-24	Western & Mid-County	ESG	The Main Stay	7
	Desert	ESG	Project Touch, Harrison House, CVRM, Hernandez Room and Board,	6
Feb-24	Western & Mid-County	ESG	Just Us 4 Youth, CVRM, Youth Shelter, The Main Stay, Path of Life, Path of Life Family Shelter	7
	Desert	ESG	Chess Program, CVRM	2
Mar-24	Western & Mid-County	ESG	The Salvation Army, CVRM, The Main Stay	5
	Desert	ESG	Mainstreet, Martha's Village and Kitchen, The Main Stay, OVRM	6
Apr-24	Western & Mid-County	ESG	CVRM	2
	Desert	ESG	Path of Life, Main Stay, Navigation Center/Access Center	5
May-24	Western & Mid-County	ESG	The Main Stay, Youth Hope Foundation, Project Touch, Path of Life, TLP, CVRM	8
	Desert	ESG	CVRM, RUHS Behavioral Health, The Stay, PS Navigation Center, CEDR	7
Jun-24	Western & Mid-County	ESG	The Main Stay, Path of Life	5
	Desert	ESG	Martha Village, CVRM, Path of Life, The Stay, Main Stay, Lages	7

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS

There were a total of **96** partnership/collaborative meetings attended by Operation Safehouse staff during the fiscal year 2023-2024. The table below shows the summary of Outreach Community Involvement/ Meetings attended by Operation Safehouse staff members, which include the regions, teams, and locations.

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Aug-24	Western & Mid-County	ESG	CES Community Partnership Meeting, Back to School Resource Fair, Uplift Riverside Conference, Mayor's Initiative To End Homelessness, Youth Advisory Committee & Youth Action Board, City of Riverside Case Conferencing, GCCA	8
	Desert	ESG	DHS Rotary, Back to School Resource Fair, Bobby Bonds YOC Resource Fair, Rubidoux YOC Table, CES, Rotary	6
Jul-23	Western & Mid-County	ESG	CES Community Partnership Meeting, Youth Advisory Committee & Youth Action Board	2
Sep-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness Conferencing, Waiden Rapid Re-housing Collaboration, CES Community Partnership Meeting, City of Riverside	4
	Desert	ESG	WIN Center, DHS Rotary, Desert Recreation District Mtg	4
Oct-24	Western & Mid-County	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
	Desert	ESG	Eastside Fall Festival at Bobby Bonds, Expanding Horizons Youth Summit, Mayor's Initiative, CES Meeting	5
Nov-22	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Coordinated Entry Services Community Partnership, Active Shooter Training, All County Outreach	4
	Desert	ESG	All County Outreach Meeting, Rotary DHS, RISE, SAP	4
Dec-23	Western & Mid-County	ESG	PRCSD Snow Day, YAC/YAB Meeting, CES Community Partnership Meeting	3
	Desert	ESG	City of Riverside Snow Day Event, Rotary, Saturation Day and Tabling City of Riverside, Ribbon Cutting - Coachella Valley BH, YAC/YAB Meeting, Riverside	6
Jan-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, Project Bridge, County Outreach Meeting	4
	Desert	ESG	City Of Riverside Snow Day Event, Community Resource Fair, Rotary Meeting	3
Feb-23	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES Community Partnership Meeting	3
	Desert	ESG	DHS Rotary, Transgender Wellness Center Presentation, Desert Hot Springs Recreation Center, CES Meeting, All County Outreach Meeting	5

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE PARTNERSHIP/COLLABORATIVE MEETINGS *(continued)*

Month/ Year	Region	Team	Partnership/Collaborative Meetings Attended*	Number of Meetings Attended
Mar-24	Western & Mid-County	ESG	Mayor's Initiative, Community Partnership (Fair), Spark Meeting, Project Bridge Meeting, Community Initiative Partnership (CES)	5
	Desert	ESG	RISE, Homelessness and Foster Youth Services Summit, YAC/YAB Meeting, DGS Rotary	4
Apr-24	Western & Mid-County	ESG	All County Outreach Meeting (Boots on the Ground)	1
	Desert	ESG	Mayor's Initiative to End Homelessness, CES Meeting, RISE Meeting, Desert Hot Springs Meeting, COD Foster Youth Presentation, All County Outreach Meeting	6
May-24	Western & Mid-County	ESG	Mayor's Initiative To End Homelessness, CES (Coordinated Entry System), Youth Advisory Committee & Youth Action Board	4
	Desert	ESG	District 5 Homeless Symposium, DHS Rotary, YAC/YAB Meeting, CES Meeting	4
Jun-24	Western & Mid-County	ESG	Mayor's Initiative to End Youth Homelessness, Community Partnership, Lutheran Social Services Meeting, Roots On The Ground, KIK Summit at YOC Rubidoux	6

* Several partnerships/collaborative meetings were conducted more than once in a single month.

OPERATION SAFEHOUSE STAFF TRAININGS REPORT

During the fiscal year 2023-2024, Operation Safehouse staff members also attended a total of **10** staff trainings at the Operation Safehouse Technical Assistance Center. The tables below and on the next page show the summary of monthly RHYTTAC trainings attended by Operation Safehouse staff members.

Month/ Year	Region	Team	Monthly Runaway & Homeless Youth Training & Technical Assistance Center (RHYTTAC) eLearning/Trainings Competed by Operation Safehouse Staff Members
Jul-23	Western & Mid-County	ESG Team	SAMHSA Efforts to Support Youth Experiencing Homelessness, What Can RHY Programs Do To Identify & Prevent Labor Trafficking, Harassing Data & The Power or Youth to
Mar-24	Western & Mid-County	ESG Team	Identifying and Responding to Sexually Exploited Children, A Participatory Approach to Make Movement Meaningful, 2022 RHY Program Specific Training: Street Outreach Program, 2023 Runaway and Homelessness Youth, Presentation, Demonstration
Apr-24	Western & Mid-County	ESG Team	Transforming Trauma into Trust

* Several trainings were conducted more than once in a single month.

Active Minds/Send Silence Packing

Program Type: Suicide Prevention Program



Active Minds is a student-run club on college and university campuses to promote conversation among students, staff, and faculty about mental health. In FY10/11, FY11/12, and FY13/14 RUHS - BH provided seed funding for four campuses in Riverside County to start up chapters on campus. The college and university campuses that now continue to have Active Minds chapters are the University of California Riverside, College of the Desert, Riverside City College, Mount San Jacinto College, and Moreno Valley College. Student activities include providing information to students and faculty regarding mental health topics and promoting self-care. The development of the chapters and the positive working relationships between county mental health and the local college campuses continued to be of interest both at the local and state level. Maintaining student participation in the club, particularly at the community college level, has been a challenge. The RUHS-BH PEI team has worked with advisors and club presidents to provide technical assistance, outreach materials, and ongoing support to assist them with club activities and planning for the future. Additionally, suicide prevention training has been offered on their campuses for both faculty and students. Since 2011, RUHS-BH has partnered with Active Minds and local college and university campuses to bring the Send Silence Packing exhibit to Riverside County with the goal of inspiring and empowering a new generation to change the conversation about mental health. The exhibit has been updated. The Send Silence Packing traveling exhibit is an immersive experience utilizing mixed mediums to guide the visitor through the mental health journey of several American youth and young adults to increase awareness and reduce stigma associated with mental health concerns and suicide. Send Silence Packing is a full-day exhibit that includes personal stories from individuals impacted by suicide, an interactive wall display, as well as local and national resources to connect visitors to. All personal stories have been revised to meet safe messaging best practices when sharing suicide attempts or losses. Participants are encouraged to read and/or watch videos of these personal stories to end the silence around mental illness and suicide. The exhibit also encourages visitors to connect with local and national support resources for themselves and others in need. After attending, most visitors tell three or more people about what they learned, and many reach out to a friend in need or seek their own support services because of the information they received. The Active Minds Send Silence Packing traveling exhibit is an immersive experience utilizing mixed mediums to guide the visitor through the mental health journey of several American youth and young adults in an effort to increase



awareness and reduce stigma associated with mental health concerns and suicide. In October 2023 PEI funded an exhibit at University of California, Riverside and Mt. San Jacinto College. The exhibits were well received by students and faculty.

Directing Change Program and Film Contest

Program Type: Suicide Prevention Program

The statewide Directing Change Program and Student Film Contest offers young people the exciting opportunity to participate by creating 60-second films about suicide prevention and mental health, which are used to support awareness, education, and advocacy efforts on these topics. Learning objectives surrounding mental health and suicide prevention are integrated into the submission categories of the film contest, giving young people the opportunity to critically explore these topics. To support the contest and to acknowledge those local students who submitted videos, RUHS – BH has partnered with RUHS-Public Health and Riverside County Office of Education to co-host a local event to recognize Riverside County youth who enter the statewide contest.



In FY23/24 203 Riverside County films were submitted from 26 schools and CBOs with 580 participants. Riverside County's Eleanor Roosevelt High School won 1st place in the Suicide Prevention Category titled "Speaking Up" for both our local recognition ceremony as well as the statewide contest. You can view it here: https://vimeo.com/916108816. The Riverside County recognition ceremony also featured an Art Gallery Walk, recognizing the youth who submitted and won the state's monthly Hope & Justice contests throughout the academic year. The monthly contest throughout the year offers the opportunity for youth to submit a variety of media entries. Riverside County youth won 1st place in September 2023, November 2023, January 2024, and February 2024. In addition, Riverside youth received 3rd place in September 2023 and January 2024.



On May 16, 2024, Riverside County hosted the 8th local recognition and screening ceremony in partnership with RUHS-Public Health and Riverside County Office of Education (RCOE). Nearly 300 students, advisors, families, and other community members were in attendance. We celebrated the inspirational and thought-provoking artwork created by Riverside County youth this academic year and honored the art of mental health storytelling through film, music,



and art. This year, we introduced a couple of new elements such as the Hope & Justice Art Gallery to honor monthly contest winners and a musical performance by the November Hope & Justice first place winners! Riverside County also has its own landing page on the Directing Change website where you can find winning films from every year of the contest: https://directingchangeca.org/riversidecounty/.

RUHS-BH, PH, and RCOE will co-host again the Riverside County Screening and Recognition Ceremony on May 15, 2025 at the Fox Theater in Riverside. As mentioned earlier in this document, CalMHSA will no longer provide funding support for this statewide program. Riverside County youth and schools have participated robustly in the statewide program and film contest and local support and recognition of these students has been a key element in our local PEI plan. Therefore, RUHS-BH PEI will continue to provide funding support directly to Youth Creating Change, the creator of the Directing Change Program and Film Contest. This funding provides local dollars to support the statewide program while ensuring we get local benefits that include monthly technical assistance with the Youth Creating Change team, subject matter experts for local presentations, mini-grant awards to local youth and schools, targeted outreach to Riverside County schools and students, and support for our local youth to attend the statewide ceremony. In addition, this includes maintenance of Riverside County's local landing page on the Directing Change statewide website, promotion of the program with Riverside County youth, schools, and organizations, and consultation regarding general local suicide prevention efforts.

Teen Suicide Awareness and Prevention Program (TSAPP)

Program Type: Suicide Prevention Program

Riverside University Health System – Public Health, Injury Prevention Services (IPS) continued to implement the teen suicide prevention and awareness program in sixteen school districts throughout Riverside County in FY23/24. The 16 districts served were Alvord USD, Banning USD, Beaumont USD, Corona- Norco USD, Desert Sands USD, Hemet USD, Lake Elsinore USD, Menifee USD, Moreno Valley USD, Murrieta USD, Nuview USD, Riverside USD, San Jacinto USD, Palm Springs USD, Temecula USD, Val Verde USD.

Through the coordinated effort of our school sites, student groups and community partners, the provider successfully accomplished the following this school year:

- Conducted eighty-nine (89) Teen Suicide Prevention trainings to over (2,878) high/middle school students.
- Conducted one (1) ASIST training, impacting (32) staff members
- Conducted four (4) SafeTALK trainings, impacting (102) staff/community personnel
- Conducted one (1) MHFA training, impacting (6) community RUHS personnel
- Conducted one (1) Youth MHFA training, impacting (31) school staff personnel
- Conducted thirty (30) Parent/Community workshops, reaching approximately (203) members

- Distributed a total of (29,129) resources and incentives.
- Coordinated (144) Suicide Prevention campaigns, impacting (114,509) students across Riverside County
- Cost ratio average of approximately $4.54 was spent on each student impacted by the program

Additional risk behaviors will be addressed this year, focusing on the dangers of underage alcohol use, harm reduction strategies for alcohol consumption, and connecting students to resources. Community trainings on substance use and overdose prevention, including updated information on underage alcohol and cannabis use, will also be offered, with an emphasis on the LGBTQ community. A comprehensive School-Based Substance Use Prevention Toolkit will be developed and distributed to local schools, and a youth-driven cultural competency committee will meet up to four times a year to guide substance use prevention efforts for youth.

The provider developed a post survey and retrospective evaluation to be distributed to the student body at participating school sites. The purpose of the post survey process was to determine how successful TSAPP has been in reaching the goal of raising awareness around the issue of teen suicide and promoting the resources available to youth. The purpose of the retrospective evaluation was to see the effectiveness of the program and to analyze how students benefited from the TSAPP program. We received a total and 2,463 post-surveys from the middle and high school sites. Once the program was concluded for the school year, 631 retrospective surveys were completed by middle and high school students. All the students who









completed the retrospective evaluation participated in the training and campaigns.

Student Training Results

Based on the goals of the program, an evaluation process was established that was conducted for the students that participated in the training component. A total of 2,463 evaluations were returned to IPS after the student's trainings were completed. The results were as follows:

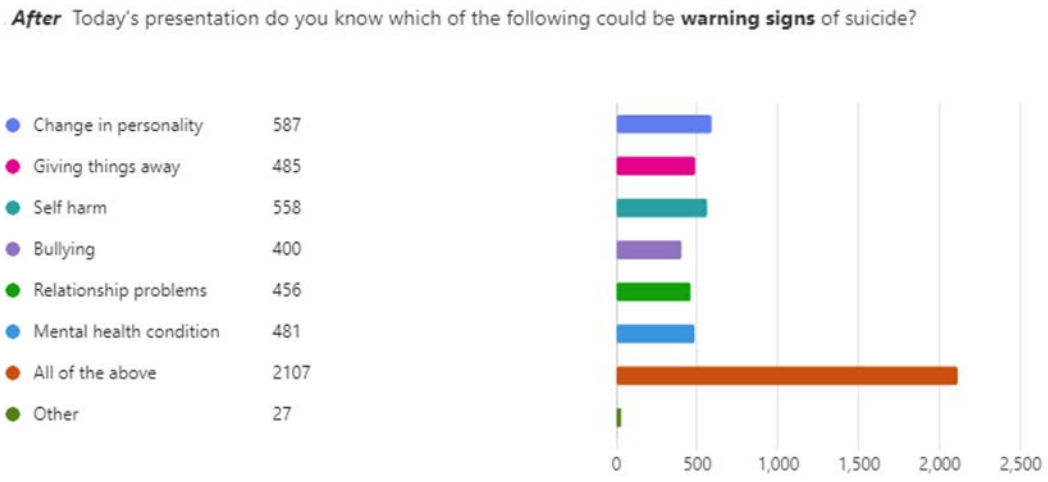
- 90% felt that after the presentation, they were more knowledgeable about the resources available to someone who may be in crisis.
- 90% correctly identified risk factors presented in the post survey.
- 85% correctly identified potential warning sides of suicide.
- 89% correctly answered the next step to take if they were concerned about a friend who thinks they are depressed or thinking about suicide.

- 90% felt more knowledgeable about the resources available to someone who may be in crisis.

Student Retrospective Results

Upon completion of the program, a retrospective evaluation was conducted that was disseminated to the students who were trained and participated in the campaigns. The survey was disseminated virtually and received a total of 631 responses. The results were as follows:

- 76% can correctly identify all warning signs of suicide.
    - "The most memorable moment for me is learning about mental health and if anyone is having any suicidal thoughts I know where to go or where to call."
    - "My most memorable moment participating in the Teen Suicide Awareness Prevention Program was figuring out how to help care for someone with depression or suicidal thoughts/ feelings and know what procedures to take."



- 84% of students can correctly identify all risk factors of suicide.
    - "My most memorable moment was when me and other students made posters for suicide awareness month."
    - "Focusing on suicide prevention becomes especially important to build social connections, raise awareness, and provide hope. Reaching out to loved ones for their mental health and wellbeing could be lifesaving."
- 84% of students correctly answered the next step to take if they were concerned about a friend who thinks they are depressed or thinking about suicide.
    - "The most memorable moment in the TSAPP program was when I got to learn exactly what to do in this situation if I hadn't gone through this training, I wouldn't have any idea what to do or what the signs are if someone were thinking about suicide."

- "A memorable moment about participating in Teen Suicide Awareness Prevention Program was the way we went into depth and all the information about a way to communication."

- 86% felt more knowledgeable about the resources available to someone who may be in crisis.

  - "My favorite memorable moment participating in the TSAPP was learning all of the resources that were actually available for everyone and getting to discuss it."

  - "My most memorable moment while participating in the Teen Suicide Awareness Prevention Program was seeing the stats about how common suicide was, because it put a real-life perspective on it."

Some difficulties did come up this school year, despite ongoing collaborations with local districts and attempts to offer resources and training to the student body. The biggest problem was fulfilling the requests for training from every school, which ranged from training the entire school assembly style to training several classes simultaneously. We also encountered difficulties in communicating with school advisers at times, and it became difficult for program staff to obtain all necessary documentation from the school sites. Program employees achieved the necessary goals despite these obstacles.

As we engaged with school sites and provided training to students, we learned that school site personnel and parents/caregivers were also interested in suicide prevention education. As a result, we offered training for staff on how to identify warning signs of suicide, strategies for asking the direct question of suicide and tips on how to provide a warm handoff to the next level of care. This really helped staff feel more comfortable in dealing with suicide. Parents and caregivers were also offered similar training with extensive community resources shared during these presentations. The feedback was positive from participants, and we learned that addressing youth suicide needs to encompass training and resources for everyone involved in a youth's life.

Students were asked, "What was your most memorable moment participating in the Teen Suicide Awareness Prevention Program?" Below are some examples of responses received:

- "My favorite memorable moment participating in the TSAPP was learning all of the resources that were actually available for everyone and getting to discuss it."

- "The most memorable moment in the TSAP program was when I got to learn exactly what to do in this situation if I hadn't gone through this training, I wouldn't have any idea what to do or what the signs are if someone were thinking about suicide."

- "Listening and understanding about what to do when someone comes to me with suicidal thoughts."

- "My most memorable moment was when me and other students made posters for suicide awareness month."

- “My most memorable moment while participating in the Teen Suicide Awareness Prevention Program was seeing the stats about how common suicide was, because it put a real-life perspective on it.”
- ” Focusing on suicide prevention becomes especially important to build social connections, raise awareness, and provide hope. Reaching out to loved ones for their mental health and wellbeing could be lifesaving.”

PEI-05 First Onset for Older Adults

There are currently five programs in this Work Plan and each of them focuses on the reduction of depression to reduce the risk of suicide.

Cognitive-Behavioral Therapy for Late-Life Depression



Program Type: Early Intervention Program

This program focuses on early intervention services that reduce suicide risk and depression. Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program. It includes specific modifications for older adults experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with structure in modeling behavior. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60-minute) sessions, following a structured manual.

120 participants were served by the CBTLLD program

Client PHQ-9 scores decreased throughout treatment. The average PHQ-9 score at intake was 14 (indicating moderate depression) and at discharge was 4 (indicating minimal levels of depression). The Quality of Life Questionnaire overall showed improvements in all 13 items that it measures. The most notable improvements were in items that measured their social functioning, emotional well-being and life in general. 72% of clients enrolled during FY 23/24 completed the entirety of the program. 33 clients continued services into FY 24/25. At closing, clients are given the opportunity to provide comments on their services. Participants gave the highest ratings to the quality of services received from their therapist, their likelihood to return to the program if they were to seek help again, and the support they received from the program.

Depression significantly decreased after program participation

Some successes in implementation this year include sustainable training practices. As new staff are onboarding into agencies, they are trained quickly by a PEI Admin staff that is a certified trainer in this model, which allows providers to begin to see clients using the LLD model quickly. Supervision and the consultation/certification process is smooth and allows therapists using the model to get hands on support with implementation and fidelity. Word-of-mouth referrals have been one of the best outreach tools. Former clients often refer friends and neighbors. There has

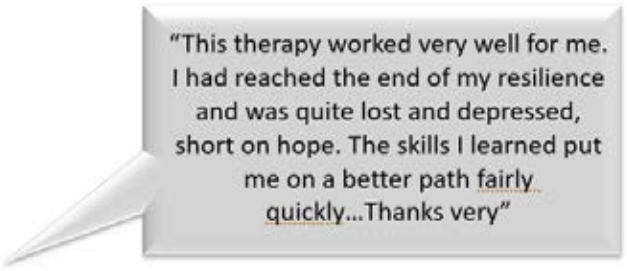
been an increase in visits and requests for program presentations from senior living facilities, primarily in the Desert region. There was an increase in Spanish-speaking and in-person services countywide.

The number of enrolled clients has been hard to increase and maintain. The Center has significantly struggled with getting LLD clients. Many of the clients seeking services there are significantly younger than they have been in previous years. Outreach in the Mid-County and Desert regions has been more difficult. There was continued effort to increase program visibility and networking/partnership with other community-based organizations, however that did not ultimately result in increased or on-going program referrals.

Providers are continuing to see that "one size fits all" does not work for outreach—each region is more responsive to different kinds of outreach. ICRC has found that the Western Region clients really want to have in-person sessions while their Desert Region clients request telehealth services.

Clients that completed the program had the following to say about their participation in the CBT-LLD program:

- "I appreciated the consistency and the opportunity to be heard, the program exceeded my expectations."
- "I appreciate the assistance I received. The tools given to put into practice are extremely helpful and {Therapist's} guidance has been excellent."



- "[Therapist] is a wonderful therapist understanding a lot of the issues she was faced with me. I would come back to her when I need counseling again. Thanks!!"
- "The program helped me to understand why I react the way that I do to some life situations. Helped me to cope with some of my home issues with my husband. [Therapist] is very kind."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Cognitive Behavioral Therapy (CBT) for Late Life Depression

FY 2023-2024 Annual Report





CBT-LLD FY 2023-2024

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Provider & Program Overview

Program Overview

CBT for Late Life Depression is an active, directive, time-limited, and structured problem-solving program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with structure in modeling behavior. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions, following a structured manual.

Community-based organizations were contracted to provide Cognitive Behavioral Therapy (CBT) for Late Life Depression services to older adults experiencing symptoms of major depression:

The Center (TC) is a community-based organization that offers a safe and supportive environment for its members. Their mission is to enrich the lives of the LGBTQI community. They advance this mission by providing senior-specific programming, clinical counseling, social offerings, and much more.

Inland Caregiver Resource Center (ICRC) helps families and communities cope with and manage the challenges of aging and caregiving. Their mission is to respect the dignity of all people [including LGBTQI community] and provide assistance so clients and family members can continue to live productive, active, and enriched lives.

Provider & Program Overview

Outcomes Evaluation

CBT for Late Life Depression uses the Patient Health Questionnaire-9 (PHQ-9) as the depression screening tool and the Quality of Life (QOL) Survey to assess participants perception of the lives quality. These measures are described below. Measures are administered at the beginning of program services (Pre) and at the conclusion of services (Post).

- **Patient Health Questionnaire-9 (PHQ-9)**
  PHQ-9 is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 can function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of:
  - 0-4 is considered as having minimal levels of depression and is described as 'non-depressed'
  - 5-9 indicates symptoms of mild depression
  - 10-14 indicates symptoms of moderate depression
  - 15-19 indicates symptoms of moderately severe depression
  - 20-27 indicates symptoms of severe depression

- **Quality of Life (QOL) Survey**
  The QOL survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes, as it specifically collects feedback from participants on social behavior, relationships, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

Executive Summary: Key Findings

The Center (TC) located within the Desert region and Inland Caregiver Resource Center (ICRC) located within the Western region, provide services to older adults experiencing depression. A total of 120 participants were provided CBT for Late Life Depression (CBT- LLD) within Fiscal Year (FY) 2023-2024. The CBT for Late Life Depression program serves participants for a number of weeks throughout the year; thus, some participants who start the program later in the fiscal year will continue services into the next fiscal year (FY 2024/2025). Therefore, not all of the cases will be, or are expected to be, closed by the end of the fiscal year. *Pre to post outcomes data reflects those cases that not only received service within the fiscal year, but were also closed within the fiscal year. Enrollment and demographic data reflect a higher number served as it includes all clients enrolled in the fiscal year.*

The Center (*n*=22) and Inland Caregiver Resource Center (*n*=98) provided CBT for Late Life Depression to a total of **120** participants within FY 23/24.

∴ Overall, there were more female (*n*=84) participants than male (*n*=36) participants. Most participants were between the ages of 65 and 70. For the Center this was 37% of their participants and 34% for ICRC. Participants were mostly English-speaking (59%) with some Spanish-speaking (40%). Race/ethnicity was mostly Caucasian (95%) at The Center and (58%) Hispanic/Latino at ICRC. At The Center, a majority of participants identified as LGBTQI and 'Gay' sexual orientation (82%) whereas a majority of participants at ICRC identified as 'Straight' (92%).

∴ Seventy-three percent (*n*=87) of the clients served were closed during the fiscal year; 56% of whom, successfully completed the program (*n*=49). The remaining 28% will carry into the FY 24/25.

∴ Statistically significant ($p < 0.001$) change was observed between the pre-test and post-test PHQ -9 measures. Depression scores decreased from moderate to minimal levels overall (pre *M*=14; post *M*=4).

∴ All of the items on the Quality of Life survey showed improvement, with most (85%, *n*=11) of the total 13 items showing statistically significant ($p<.01$) positive change, indicating that participants were engaging in more social behavior and pleasurable activities.

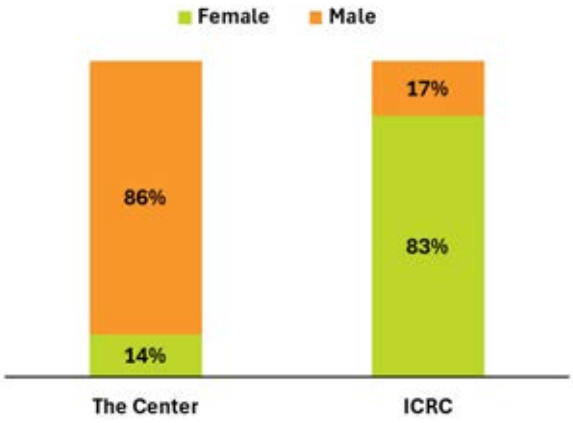
∴ The satisfaction surveys that were administered show positive ratings across all items— the highest ratings being that they would return to the program if they needed help again, the quality of service they received from their practitioner, and how satisfied they were with the program.

PROGRAM ENROLLMENT

The Center provided CBT for Late Life Depression to a total of 22 participants, whereas The Inland Caregiver Resource Center (ICRC) served 98 individuals within FY 23/24.

DEMOGRAPHICS

Participant Gender



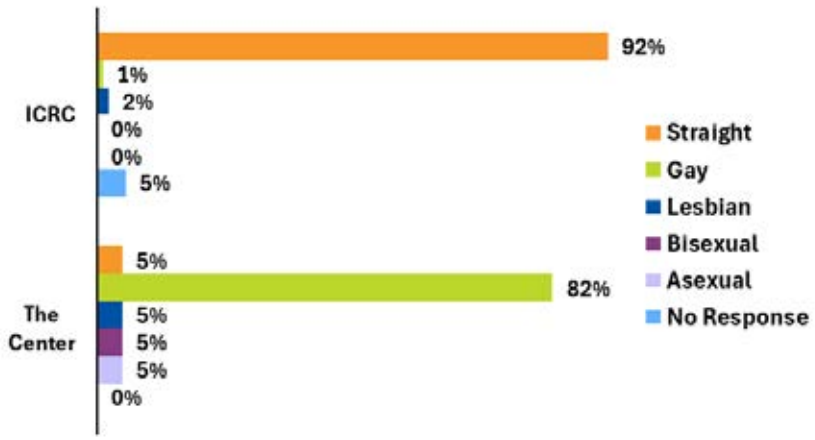
Overall, there were more female (*n*=84) participants than male (*n*=36) participants in FY 23/24. ICRC served the majority of the females, making up 83% (*n*=81) of their participants compared to males (*n*=17). Whereas, The Center served 86% males (*n*=19, 14% females (*n*=3).

Participant Age

Age	The Center (n=22)	ICRC (n=98)
59-64	5 (23%)	10 (11%)
65-70	8 (37%)	33 (34%)
71-74	5 (23%)	20 (21%)
75-79	3 (14%)	20 (21%)
>80	1 (5%)	15 (16%)

Participants ranged between the ages of 57 to 94. The majority of participants (34%) overall were within the ages of 65 and 70 (*n*=41).

Sexual Orientation



Most participants served by The Center (*n*=21) identified as part of the Lesbian, Gay, Bisexual (LGB) community—which is consistent with the agency's target population. Specifically, consumers identified as Gay (*n*=18, 82%), Lesbian (*n*=1, 5%), Bisexual (*n*=1, 5%), or Asexual (*n*=1, 5%). Whereas, the ICRC predominantly reported 'Straight' (*n*=90, 92%), Gay (*n*=1, 1%), and Lesbian (n=2, 2%). Five participants did not disclose their sexual orientation (5%). All consumers are welcomed to join program regardless of disclosing sexual orientation status.

Demographics

Frequently Reported Cities

City	Frequency (count, %)
Riverside	28 (23%)
Palm Springs	13 (11%)
Moreno Valley	9 (8%)
Corona	8 (7%)
Banning	6 (5%)
Hemet	6 (5%)
No Response	5 (4%)
Other	45 (38%)

The table above indicates the top six residential cities. Many of the participants resided in Riverside 23% (*n*=28). 'Other' specifies smaller samples among nineteen cities that are spread (range: 1-5) out in Riverside County (e.g. Indio, Coachella, Mira Loma, Perris, etc.).

Language

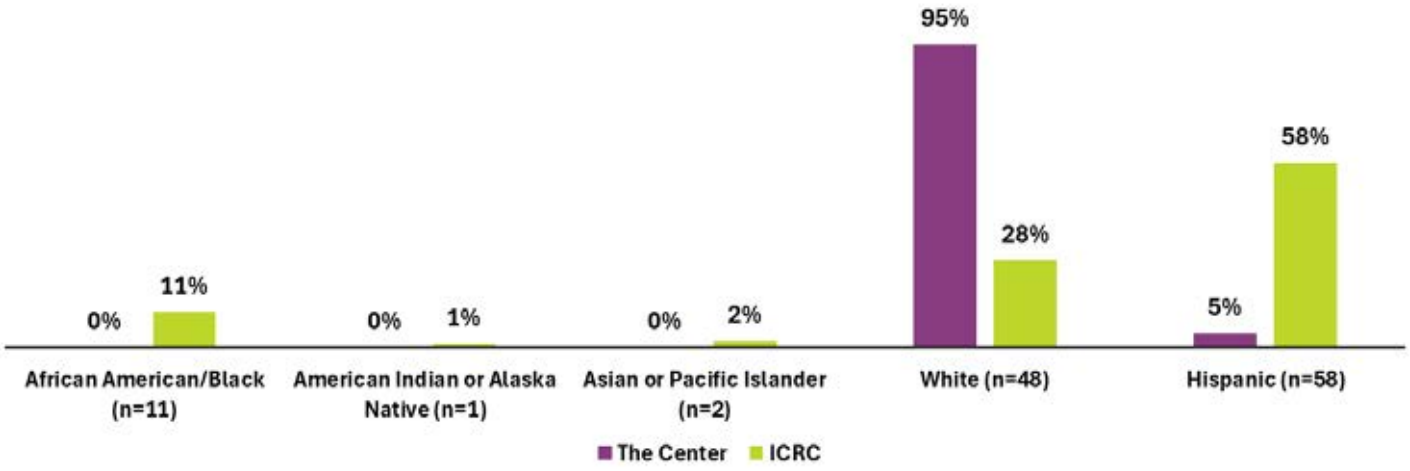
59% of participants (71) indicated primary language as English, whereas the remaining 40% (48) spoke Spanish.



The majority of the participants reported English (*n*=71) as their primary language and 48 participants noted Spanish as their primary language. There was one participant who did not indicate their primary language.

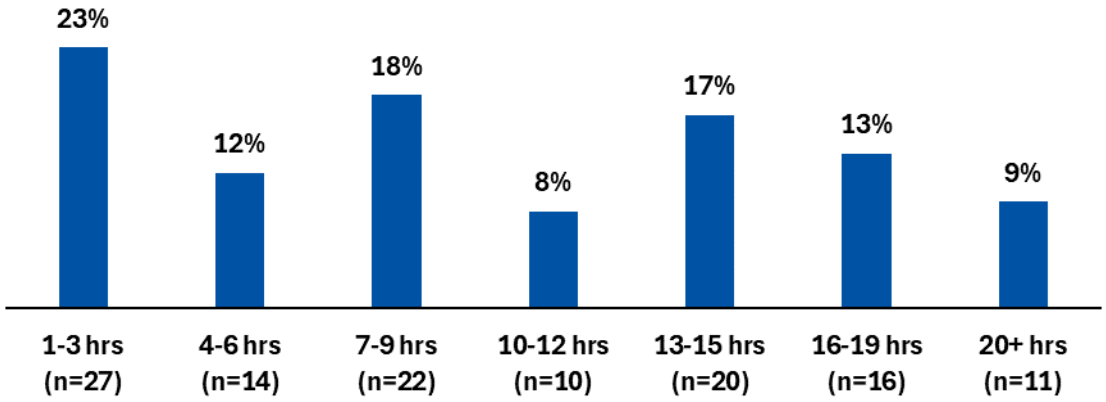
Participant Race/Ethnicity

The participants primarily identified as White at The Center (*n*=21) and there was one participant who identified as Hispanic. At ICRC the majority of participants identified as Hispanic (*n*=57) following were participants who identified as White (*n*=27). Finally, at ICRC eleven participants identified as African American/Black, one identified as American Indian or Alaska Native, and two identified as Asian or Pacific Islander.



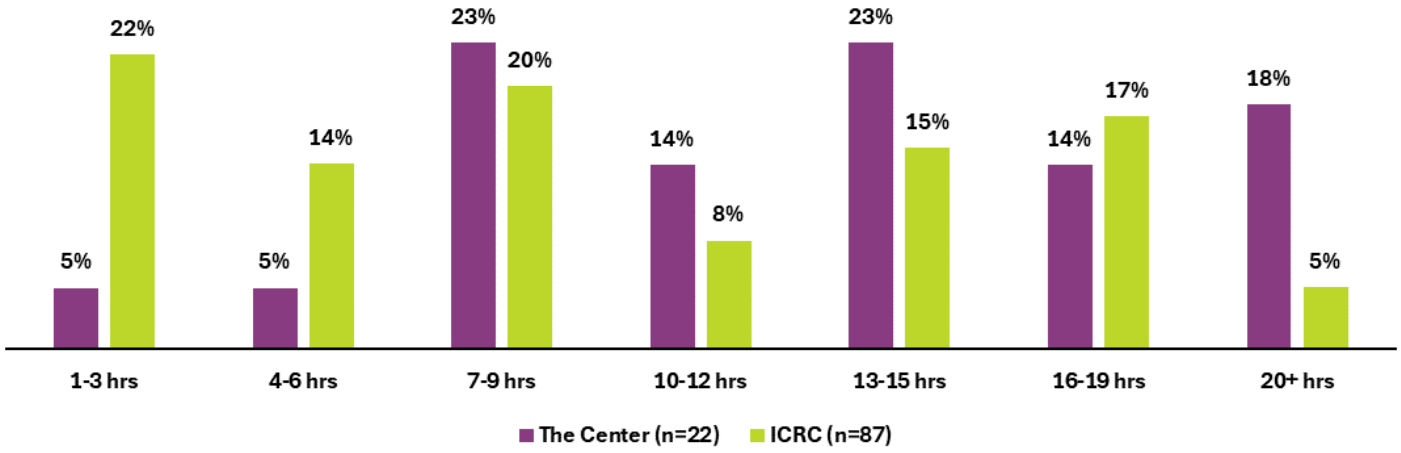
Service Data

A total of **1189.75** hours of service was reported for the **120** participants. Nearly 70% of the participants received over 6 total hours of service. Over a third of participants received 7 -15 hours of service (*n*=52, 43%); whereas nearly a quarter received 1-3 hours of service (*n*=27, 23%). Of the 42 participants who received 6 hours or less of total service, 29% were clients who carried over from the previous 22/23 FY (*n*=12) and 36% are carrying over into the next 24/25 FY (*n*=15) which can account for some of the low service hours. *Since some cases may not open and close within the same fiscal year, the total number of service hours recorded for the 23/24FY does not include services that the client may have received in previous or subsequent fiscal years.*



Service Data by Service Type

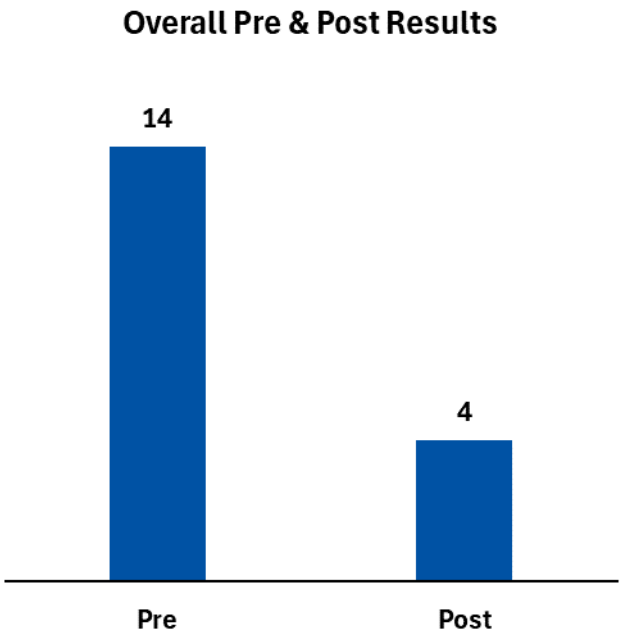
The Center provided CBT therapy sessions to all of their 22 participants totaling 299 services, amounting to 299 hours, while ICRC provided therapy services to 87 of the 98 total participants served. Furthermore, ICRC had a total of 884 services, totaling 891 hours. Of the total 884 services provided by ICRC, 62 were assessments which summed to 59 hours. The remaining 822 services were CBT therapy sessions equaling 832 hours. The graph below depicts only CBT therapy session services. This year's services were neither submitted nor compiled in the same manner as in previous years, so they will be organized by total hours per client by program, as shown in the figure below. *The current fiscal year's service hours do not include the services clients received from previous or subsequent fiscal years, this data only reflects participants services in the FY23/24.*

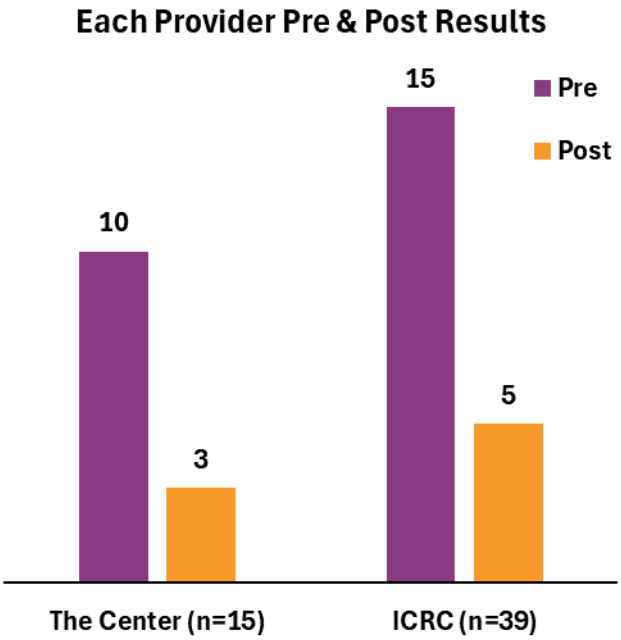


Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.





The Center (n=15) and ICRC (n=39) showed a significant decrease ($p < 0.001$) in depression symptoms from the beginning (M=14) to the end of the program (M=4). Sometimes post measures could not be collected due to participants leaving the program without completing the accompanying post measures.

Score Interpretation for PHQ-9:

- 0-4 is considered as having *minimal* levels of depression
- 5-9 indicates symptoms of *mild* depression
- 10-14 indicates symptoms of *moderate* depression
- 15-19 indicates symptoms of *moderately severe* depression
- 20-27 indicates symptoms of *severe* depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. It is rated on a scale from 1-7, with higher ratings indicating more positive results. The QOL survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc. all relevant aspects of outcome information that CBT for Late Life Depression is directed at increasing.

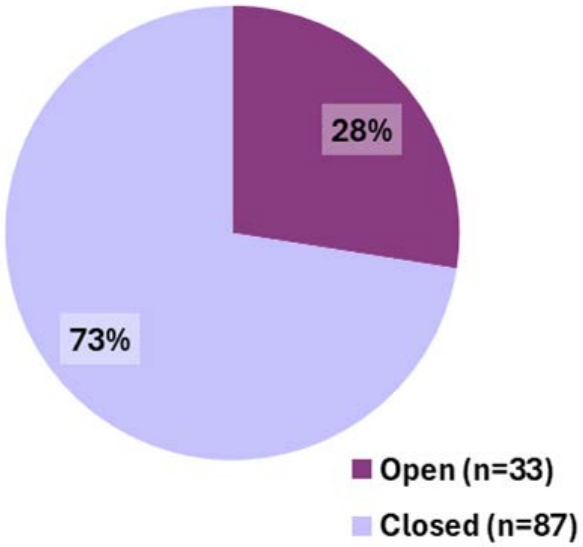
Participants reported an improvement in quality of life from pre- to post-test, as can be seen in the statistically significant (p<.05) changes found for each item as indicated in bold. All the QOL items showed improvement. However, participants experienced statistically significant (p<.05) improvements for most items such as how they felt about the things they do socially with others; life in general, and emotional well-being. Since the Quality of Life survey is not evaluated based on the total sum of participants' scores, it is shown below as individual items.

	QOL Items	Pre	Post
1	How do feel about your life in general? (1=Terrible 2=Unhappy 3=Mostly Dis-satisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.72	**4.96**
2	How do you feel about the amount of relaxation in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.64	**4.96**
3	How do you feel about the things you do with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.77	**5.85**
4	How do you feel about the amount of time you spend with other people? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.26	**5.11**
5	How do you feel about the people you see socially? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	5.34	**5.77**
6	How do you feel about the amount of friendship in your life? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	4.65	**4.96**
7	How socially active would you say you have been in the past month? (1=None 2=A little 3=Fairly Active 4=Quite Active 5=Very Active 6=Extremely Active)	2.58	**3.51**
8	In general how would you say your health is? (1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent)	2.47	**2.72**
9	How do you feel about your health in general? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.68	4.51
10	How do you feel about your physical condition? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	3.60	**4.25**
11	How do you feel about your emotional well-being? (1=Terrible 2=Unhappy 3=Mostly Dissatisfied 4=Mixed 5=Mostly Satisfied 6=Pleased 7=Delighted)	2.96	**4.77**
12	How much bodily pain have you had during the past month? (1=Very Severe 2=Severe 3=Moderate 4=Mild 5=Very Mild 6=None)	3.06	3.70
13	In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely 2=Quite a bit 3=Moderately 4=Slightly 5=Not at all)	2.60	**3.68**

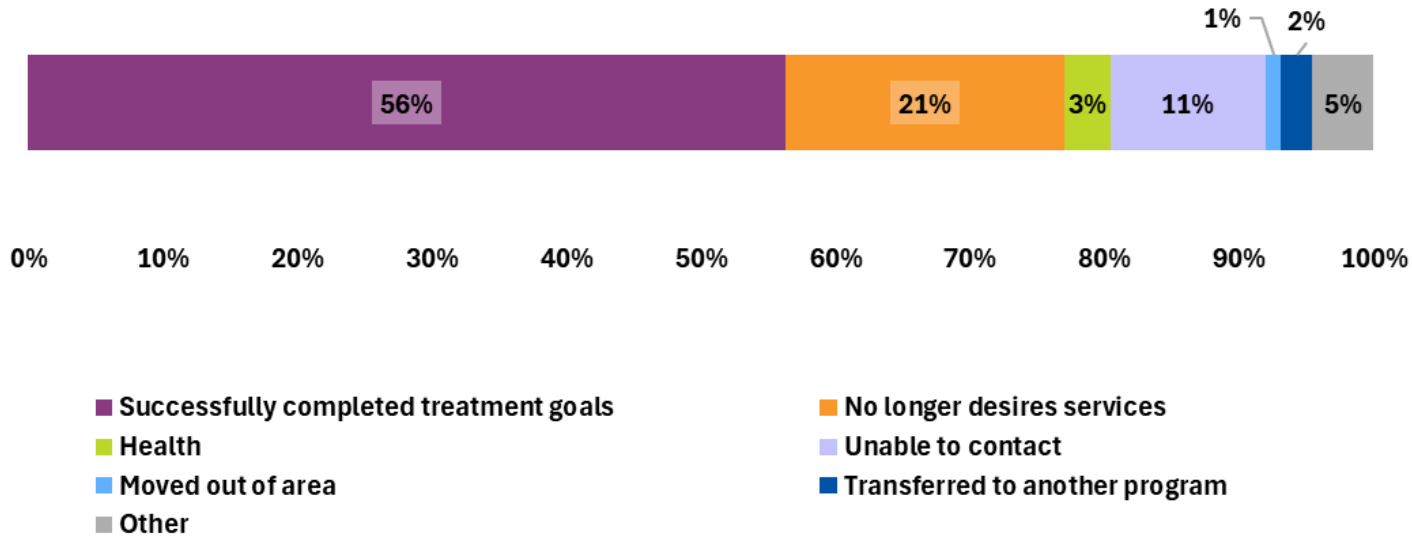
BOLD Numbers indicate statistically significant (p < 0.05) change Pre to Post

Discontinuance Summary

Of the 120 participants served, 87 closed during this 23/24 FY. At closing, Discontinuance Summary forms were completed, listing the reason for discontinuance of service, as shown below. Of the total closed participants, over half (56%, *n*=49) were reported as having successfully completed their treatment goals. The remaining 33 participants will carry over into the next 23/24 FY.



Reason	(*n=87*)
Successfully completed treatment goals	49 (56%)
No longer desires services	18 (21%)
No show	-
Health	3 (3%)
Unable to contact	10 (11%)
Moved out of area	1 (1%)
Transferred to another program	2 (2%)
Death	-
Other	4 (5%)



Satisfaction Surveys

Of the 87 participants who closed from the program, 57 (66%) completed Satisfaction Surveys, as sometimes participants may leave the program without completing the Satisfaction Survey or other post-program measures.

Participants gave the highest ratings to the quality of the service they received from their practitioner, their likelihood to return to the program if they were to seek help again, and the satisfaction they felt in the support they received from the program. The lowest rated item was for "Did this program help you to cope better?" (*M* =3.39). Other items relating to whether the participants felt that the program helped them improve their quality of life were among the lower ratings that were given but all questions were still in the Good/Satisfied range. Overall, the satisfaction surveys show positive feedback from participating in the CBT for Late Life Depression program.

Survey Items & Results (n=57)

Question	Average	1	2	3	4	5	*M
How would you rate the quality of service you have received from your practitioner? (Excellent=4, Good=3, Fair=2, Poor=1)	**3.84**	-	-	16%	84%	-	-
In a general sense, how satisfied are you with the support you have received from this program? (Very Satisfied=4, Mostly Satisfied=3, Mildly Dissatisfied=2, Quite Dissatisfied=1)	**3.82**	-	4%	18%	82%	-	-
Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.39**	-	-	54%	42%	-	-
Did you gain strategies to help you cope? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.77**	-	-	23%	77%	-	-
Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
Has participation in the program reduced your depression symptoms? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.75**	-	-	25%	75%	-	-
**Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5, Yes, I think so=4, Not Sure=3 No, I don't think so=2, No, Definitely not=1)	**4.70**	-	-		30%	70%	-
If you were to seek help again, would you return to this program? (Yes, Definitely=4, Yes, I think so=3, No, I don't think so=2, No, Definitely not=1)	**3.93**	-	-	7%	93%	-	-

**M represents missing values*
***Questions on a scale of 1-5*

Satisfaction Surveys– Comments

The program helped me to understand why I react the way that I do to some life situations. Helped me to cope with some of my home issues with my husband. [Therapist] is very kind.

My therapist has been a valuable resource to me.



This therapy worked very well for me. I had reached the end of my resilience and was quite lost and depressed, short on hope. The skills I learned put me on a better path fairly quickly...Thanks very

[Therapist] is a wonderful therapist understanding a lot of the issues she was faced with me. I would come back to her when I need counseling again. Thanks!!

I appreciated the consistency and the opportunity to be heard, the program exceeded my expectations

APPENDIX: Annual Program Reviews

Participant Service and Completion Rates				
Program Service	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	21	50	128	120
Total # Hours Served	256.42	814.66	2484.27	1189.75
Average Hours per Participant	12.21	16.29	19.41	
# of Participants CLOSED (% of Total Served)	17 (81%)	19 (34%)	71 (55%)	87 (73%)
Successfully Completed Treatment Goals	*10 (59%)*	*9 (47%)*	*41 (58%)*	*49 (56%)*

Outcomes Evaluation				
Percentage of Participants Improved	***FY 20/21**	**FY 21/22**	**FY 22/23**	**FY23/24**
BDI-II (%)	100%	100%	—	—
PHQ-9 (%)	—	—	93%	99%
QOL (%)	100%	95%	91%	85%

**Service was provided by one contractor.*

A total of 120 participants were served with CBT for Late Life Depression during FY 23/24. The CBT-LLD program has two community-based organizations, which expanded enrollment this year. Additionally, FY 23/24 had a 73% close rate for participants who closed within the fiscal year, which increased from 55% in the previous fiscal year. Of the participants who were closed, 56% successfully completed their treatment goals, which is lower than last fiscal year 22/23.

As can be seen in the Outcomes Evaluation table, the majority (85%) of participants reported improvements within their pre to post QOL measures which is lower than fiscal year 22/23 (93%). For PHQ-9, 99% of participants showed improvement from their pre to post measure which is higher than fiscal year 22/23 in which 91% showed improvement.

PEI

Program to Encourage Active, Rewarding LiveS (PEARLS)

Program Type: Prevention Program



PEARLS is an evidence-based program designed for people aged 60 years or older who are experiencing minor depression or dysthymia. PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: program solving treatment (PST), social and physical activation, and pleasant activity scheduling.

These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals. The PEARLS intervention is time limited and, ideally, distributed over a period of 19 weeks. Each session is structured and designed to assist participants in defining and solving their problems, becoming more socially and physically active, and experiencing more pleasant activities. This program is provided by one contract provider countywide.

109 participants were served within the PEARLS program

The provider worked to increase their connection with community professionals through drop-in visits and by offering means of social and emotional support as well as resource information, which resulted in cross networking and presentations. In the Western region, "word of mouth" increased referrals from Community Champions (PEARLS graduates) as they shared information about their experiences with this program. To increase accessibility, the provider purchased and used audio amplifier devices to work with participants with hearing impairments, which successfully resulted in serving five individuals. 133 prospective participants were screened, and 109 participants were served (received one or more program services) in FY23/24. This represents a 36% increase from the FY22/23 total of 80.

Countywide, the reduction in depression symptoms as measured by the PHQ-9 was statistically significant for PEARLS participants completing the program. Furthermore, average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide. Countywide, the reduction in anxiety symptoms as measured by the GAD-7 was statistically significant for PEARLS participants completing the program which reduced 40% from "moderate" to "minimal" countywide. The Quality-of-Life survey showed statistically significant improvement for participants in eight of the nine questions: "health", "life in general", "emotional well-being", "spare time", "time with others", "friendship", "social activity", and "pleasant activities".

56% of the participants successfully completed the program.

Depression and anxiety symptoms significantly decreased.

The provider struggled with getting consistent referral sources in the Desert and Mid-County. Efforts to increase program visibility did not result in continued on-going referrals. The provider worked with senior centers and community centers, however, many of the seniors were resistant to enroll in the program. Mantaining engagement for the duration of the PEARLS program was also a challenge, specifically with individuals 70+ years old with identified hearing impairment, particularly when the provider was unable to meet by phone or in-person (to screen, make appointments, or even just connect). A "one size fits all" approach for outreach does not work. Each of the three regions in our county are unique and require different approaches. Each region and target population requires a unique approach and effort for visibility and engagement both with the community and seniors. In addition, stigma related to mental illness and fear of judgment plays a role in community members' hesitation to engage in the program and/or tell others about their own experience in the program.

The post-program survey includes two fill-in questions: "If you did benefit from the PEARLS sessions, please describe why" and "Do you have any additional comments you would like to share regarding your experience with the PEARLS program?" Some responses are shared here:

- "PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work."
- "I have been able to make some decisions that I was not able to make before as a result of this program."
- "This program helped me learn about my feelings. I learned to find solutions to help me feel better when stressed."
- "It helped improve my quality of life and my self-esteem and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself."
- "I was pleasantly surprised how well it works. It wasn't easy at first but through the process it got easier and I got more comfortable."
- "Your support is very valuable to improve our quality of life and you all have a gift in the way you provide support."
- "I want to thank you for helping me to get out and make friends."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Program to Encourage Active and Rewarding Lives (PEARLS) Annual Report FY 2023-2024

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Provider and Program Overview

Program Overview

The **P**rogram to **E**ncourage **A**ctive and **R**ewarding **L**ive**S** (**PEARLS**) is an evidence-based program designed for people aged 60 years or older who are experiencing minor depression or dysthymia (an ongoing, low-grade level of depression lasting two or more years). PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: (1) problem solving treatment (PST); (2) social and physical activation; and (3) pleasant-activity scheduling. These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals.

The PEARLS intervention is time limited and ideally distributed over a 19-week period. Each session is structured and designed to assist participants in defining and solving their problems, becoming more socially and physically active, and experiencing more pleasant activities. PEARLS provides a substantial, straightforward, and empowering approach to solving problems and reducing depression. Participants are encouraged to continue with the approach after the sessions have ended. PEARLS facilitators make brief follow-up calls to support and encourage participants in this transition.

PEARLS participants are recruited through outreach. Several screening tools are used to help determine eligibility and whether a client would benefit from the program. The screening tools include the nine-item Patient Health Questionnaire (PHQ-9), a set of questions to identify dysthymia, and a set of exclusion-criteria questions to screen out clients who'd be better served by other programs. An attempt is made to refer clients to such programs.

Outcomes Evaluation

The Patient Health Questionnaire (PHQ-9) is embedded in PEARLS program sessions to determine if an individual's depression symptoms are improving. Changes between the baseline intake score (pre) and final score (post) are used in evaluating the program outcomes. Similar evaluations in (1) generalized anxiety; (2) participation in social and pleasant activities; (3) physical activities; and (4) quality of life are also included in the outcomes evaluation. The measures used are summarized below:

- The PHQ-9 (Patient Health Questionnaire) is administered at each session. Changes in scores over the sessions gauge whether session activities are reducing depression symptoms. The difference between intake and final PHQ-9 scores are used to determine success in the reduction of depression symptoms.
- The GAD-7 (Generalized Anxiety Disorder) is administered at the beginning and conclusion of program services to gauge reduction in generalized anxiety.
- RAPA (Physical Activity Survey) is administered at the beginning and conclusion of program services, to gauge the increase in frequency of physical activitie.
- A pre/post program survey is administered at the beginning and conclusion of program services. It covers general quality of life, including participation in pleasant and social activities. The post questionnaire includes additional items related to satisfaction with the PEARLS program.

Executive Summary

Enrollment/Demographics

1. 133 prospective participants were screened in FY 2023-2024.
2. 109 participants were served (received one or more program services) in FY 2023-2024. This represents a 36% increase from the FY 2022-2023 total of 80.
3. All 109 served participants were of the target 60-and-over demographic.
4. Gender for the 109 served participants remained predominantly female (76%).
5. The predominant race percentages for served participants were 49% White, 33% Hispanic/Latinx, 14% Black/African-American. There was one Asian participant. There were two Native Americans, one specifying multiple races.

Services

1. The 109 served participants received an average of 5.9 total hours of service.
2. In FY 2023-2024, no participant received more than 8 PEARLS program services.
3. Of the 109 FY 2023-2024 served participants, 95 closed from the program (the remaining 14 were still active in the program). 53 of the 95 closing participants (56%) successfully completed the program. This represents an improvement over last year's 46% completion rate.

Outcomes

1. Countywide, the reduction in depression symptoms as measured by the PHQ-9 was statistically significant ($p \leq 0.05$) for PEARLS participants completing the program. Furthermore, average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.
2. Countywide, the reduction in anxiety symptoms as measured by the GAD-7 was statistically significant for PEARLS participants completing the program. Furthermore, average anxiety as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.
3. Countywide, the increase in physical activity as measured by the RAPA was not statistically significant for PEARLS participants completing the program.
4. The Quality-of-Life survey showed statistically-significant improvement for participants in eight of the nine questions: "health", "life in general", "emotional well-being", "spare time", "time with others", "friendship", "social activity", and "pleasant activities". Changes in "family" were not significant.

Selected Participant Comments

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.

Screening and Service Overview

Individuals interested in participating in PEARLS are screened to determine if they are eligible for the program. The screening consist of: (1) a PHQ-9 to determine the participant's level of depression; (2) a dysthymia screen, which may establish eligibility if the PHQ-9 fails to indicate depression; (3) an additional exclusionary screen for the presence of psychosis, bipolar disorder, drug addiction, or alcoholism; (4) a brief six-item memory cognition screen to indicate possible memory or cognitive impairment. Individuals presenting with exclusionary conditions, including **major** depression, are instead referred to treatment services appropriate for those conditions. As shown in Table 1.1, a total of 133 individuals were screened in FY 2023-2024 countywide.

Screened individuals who meet the criteria outlined above may go on to participate in PEARLS. After receiving their first PEARLS program service, individuals are referred to as *participants* and considered *served*. By continuing to receive the prescribed number of services, participants complete the program.

As shown in Table 1.1, of the 133 screened individuals, 88 both met criteria for participation, and received at least one program service. Thus 66% of screenings resulted in participation.

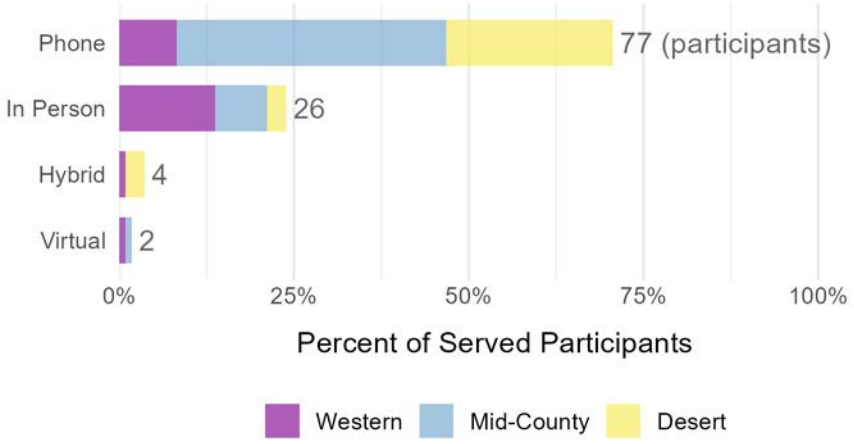
During FY 2023-2024, active participants from the previous fiscal year also received services. These participants are referred to as *carryovers* and totaled 21. Thus, the total number of participants served in FY 2023-2024 was 109, a 36% increase from the FY 2022-2023 total of 80.

Figure 1.1 shows the mode of service for the 109 participants served in FY 2023-2024.

Table 1.1: Participant Summary

Description	Desert	Mid-County	Western	COUNTYWIDE
Individuals Screened FY 2023-2024	46	54	33	**133**
Participants Screened/Served FY 2023-2024	26	44	18	**88**
Participants Active from FY 2022-2023 (Carryovers)	6	7	8	**21**
TOTAL Participants Served	32	51	26	**109**

Figure 1.1: Mode of Service



Countywide, the majority of participants 77 (71%) received service by phone, followed by in person with 26 (24%).

Service Summary

During FY 2023-2024, PEARLS delivered a total of 585 services consisting of 135 screening and 450 program services. Screenings for all individuals were completed in a single service. Two participants, however, were re-screened after leaving the program but later requesting to return. 133 distinct individuals were therefore screened in FY 2023-2024.

Figure 2.1 shows the service-duration breakdown for the 135 screening services. Figure 2.2 shows the service-duration breakdown for the 450 program services.

Figure 2.3 shows the number of program services received by a typical PEARLS participant. We exclude 34 active participants who have not yet completed their ultimate number of services. The 96 closed PEARLS participants received 406 program services distributed as shown in Figure 2.3.

Figure 2.1: Distribution of Screening Service Duration

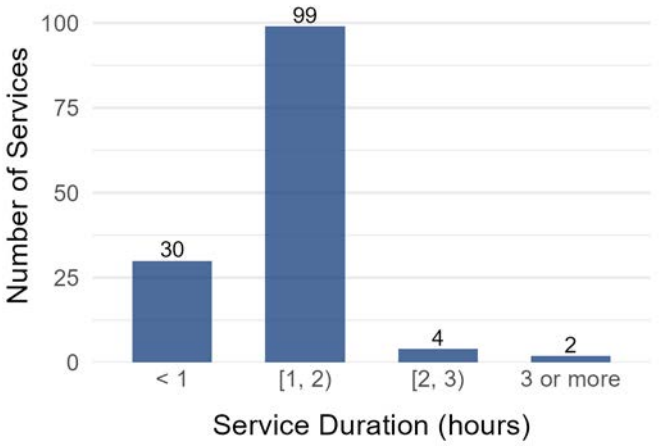


Figure 2.1 shows that the majority (73%) of the 135 screening services were between 1 and 2 hours in duration.

Figure 2.2: Distribution of Program Service Duration

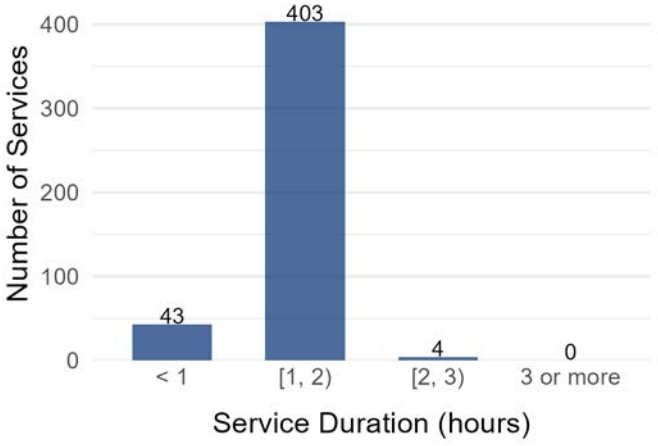


Figure 2.2 shows that the majority (90%) of the 450 program services were between 1 and 2 hours in duration.

Figure 2.3: Number of Program Services

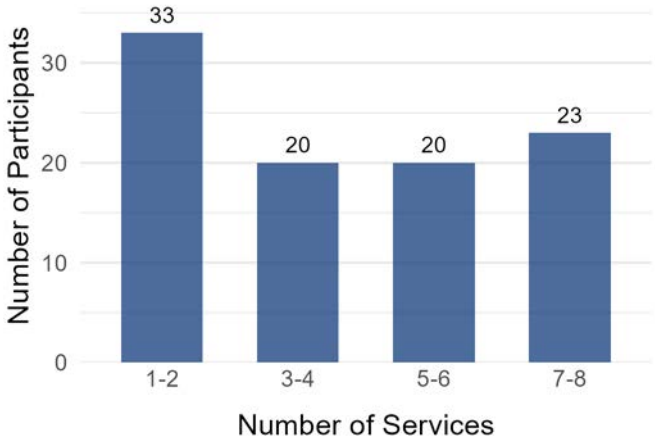


Figure 2.3 shows the distribution of 406 program services among the 96 closed (completed or terminated) participants.

Demographics

The average age of the 109 distinct PEARLS participants served in FY 2023-2024 was 74.5, an increase from the FY 2022-2023 average of 69.5.

Figure 3.1 shows age distribution. Countywide the distribution shifted to older participants compared to FY 2022-2023.

Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of PEARLS participants.

Figure 3.1: Age of PEARLS Participants

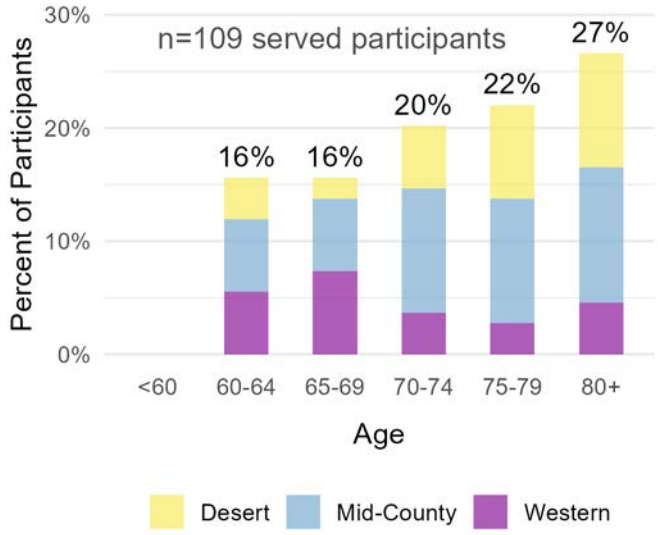


Figure 3.1 shows the age distribution of PEARLS participants by region. Countywide the distribution shifted to older participants compared to FY 2022-2023. Participants in the 75-79 cohort increased from 19% to 22%. Participants in the 80+ cohort increased from 19% to 27%. The Desert and Mid-County regions were mostly responsible for this shift.

Figure 3.2: Gender of PEARLS Participants

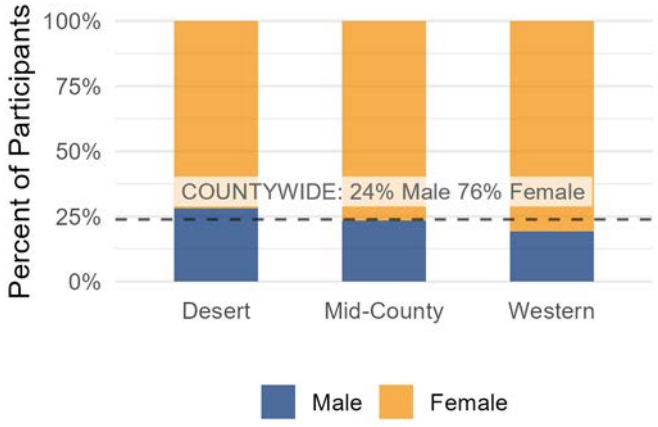


Figure 3.2 shows the gender ratios of the n = 109 served participants by region. Countywide, males constituted 24% of the PEARLS participants. This represents an increase from the FY 2022-2023 value of 19%. Prior research has shown that older male adults are at greater risk of suicide, underscoring the need to promote intervention-type programs in this population.

Demographics (continued)

The PEARLS *Demographics and Screening Form* lists common race and ethnicity categories. Prospective participants can make one or more selections from the list or choose "Other" and provide one.

Figure 3.3 shows the breakdown of race as specified by the 109 PEARLS participants. Two FY 2023-2024 participants identified as *Native American*, with one subsumed by the *Multi-Racial* category (additionally identifying as *Hispanic/Latinx*). 49% of participants identified as *White/Caucasian*, followed by 33% *Hispanic/Latinx*, followed by 14% *Black/African American*.

Of the 109 served participants, 36 (33%) identified as *Hispanic/Latinx*. This total includes one participant also identifying as Native American, and thus subsumed by the *Multi-Racial* category in Figure 3.3. Table 3.1 lists the ethnicity specified by the 36 participants identifying as *Hispanic/Latinx*.

Figure 3.3: Race of PEARLS Participants

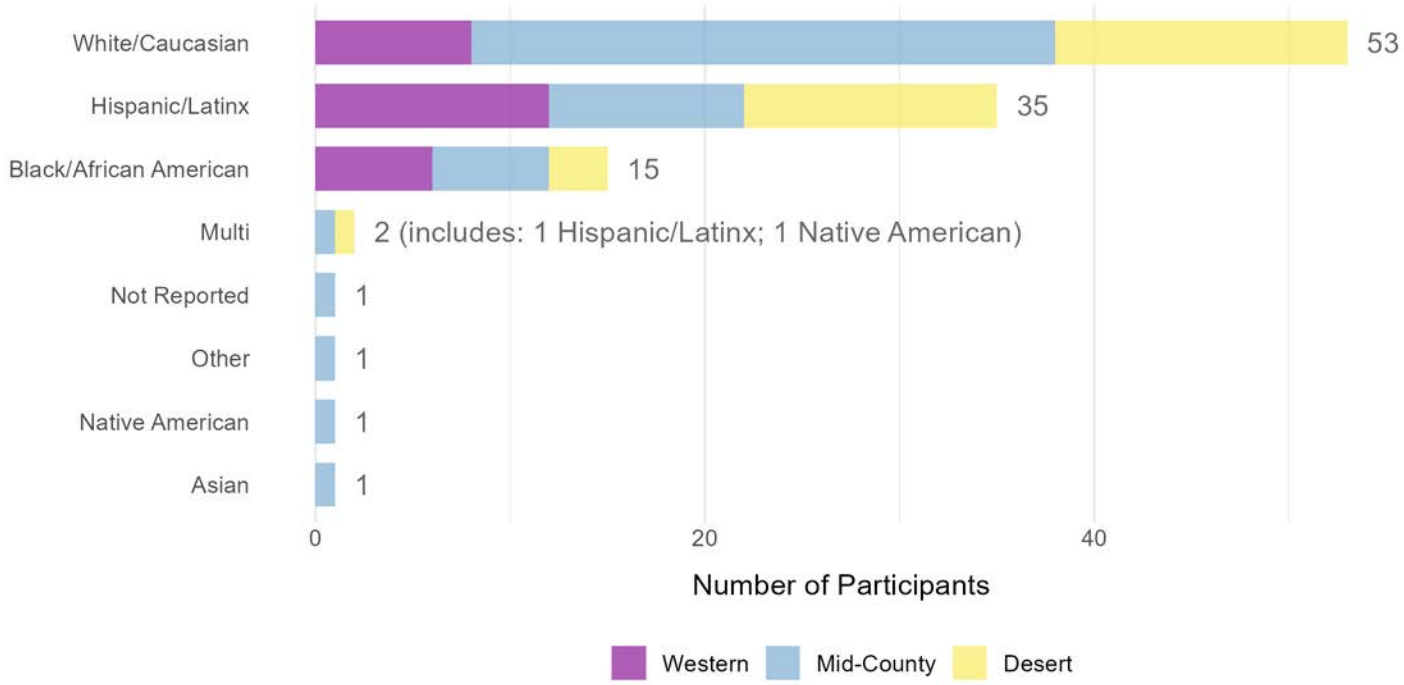


Table 3.1: Ethnicity Specified by Hispanic/Latinx PEARLS Participants

Mexican	23 (64%)
Colombian	2
Peruvian	2
Honduran	1
Salvadorean	1
Venezuelan	1
Not Specified	6

Closing of Participants

A closing disposition is documented when a participant: (1) completes the PEARLS program, (2) explicitly discontinues service, or (3) can no longer be contacted. Of the 109 participants served during FY 2023-2024, 95 had a closing disposition (the remaining 14 were still receiving services). Of the 95 closings, 53 completed the program, and 42 either explicitly discontinued or could no longer be contacted.

Figure 4.1: Completion Rates

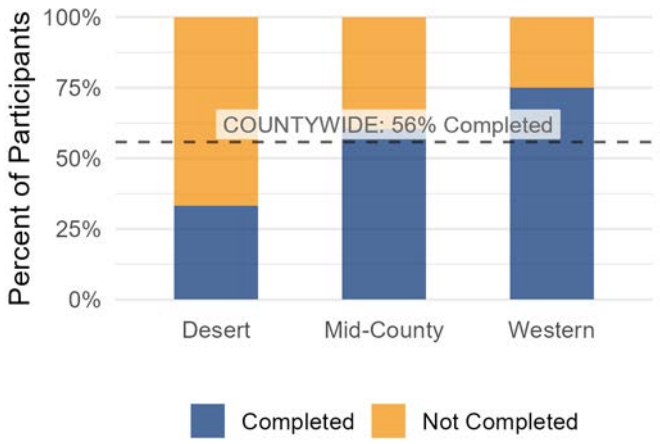
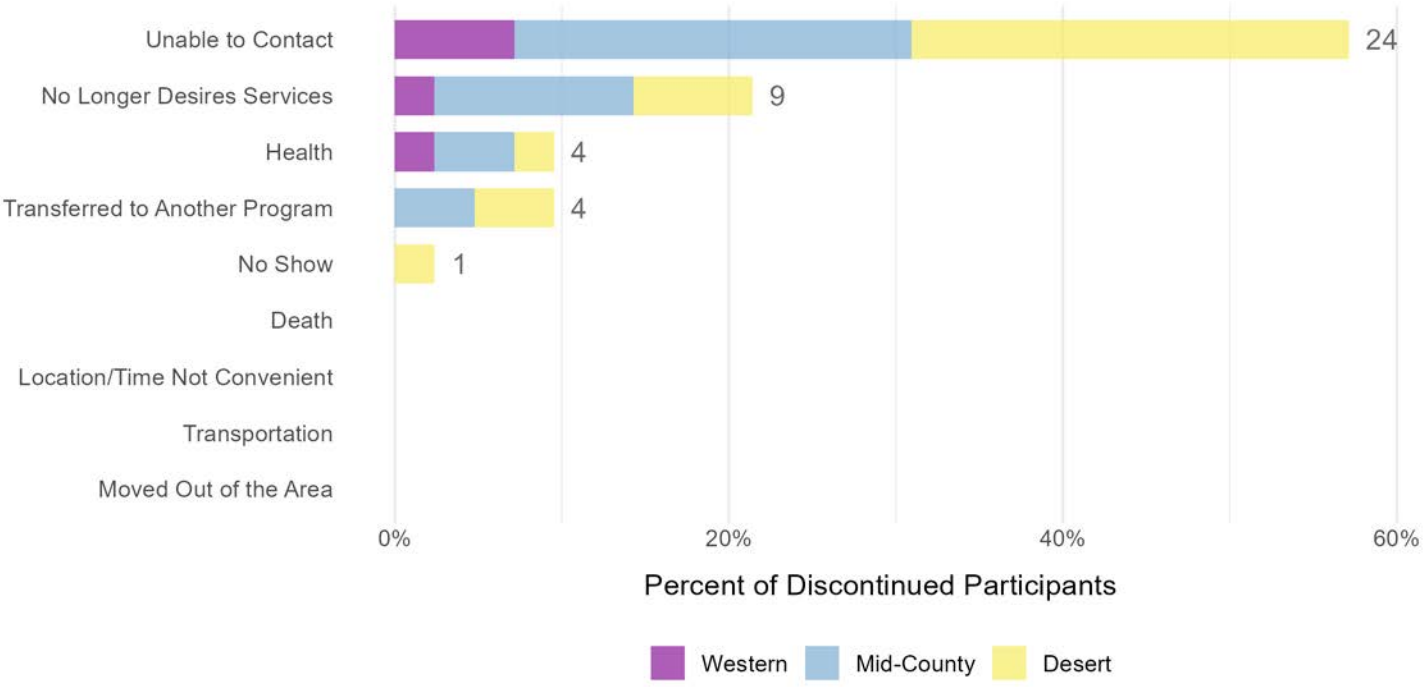


Figure 4.1 shows the completion rates for the 95 participants closed during FY 2023-2024. Countywide, 53 or 56%, completed the PEARLS program. This represents an improvement over the FY 2022-2023 completion rate of 46% .

For clients discontinuing service, an attempt is made to determine the reason. Figure 4.2 shows the reason breakdown for the 42 participants not completing the program. The majority (57%) simply could not be contacted. Reasons related to inconvenience (transportation and location/time) were not cited at all.

Figure 4.2: Reason for Not Completing



Program Outcomes: PHQ-9

The PHQ-9 measures symptoms of depression using nine questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to depression. The issues include (1) loss of interest or pleasure in doing things; (2) feeling down, tired, or bad about oneself; (3) trouble concentrating, sleeping, or speaking; (4) loss of appetite; and (5) thoughts of hurting oneself.

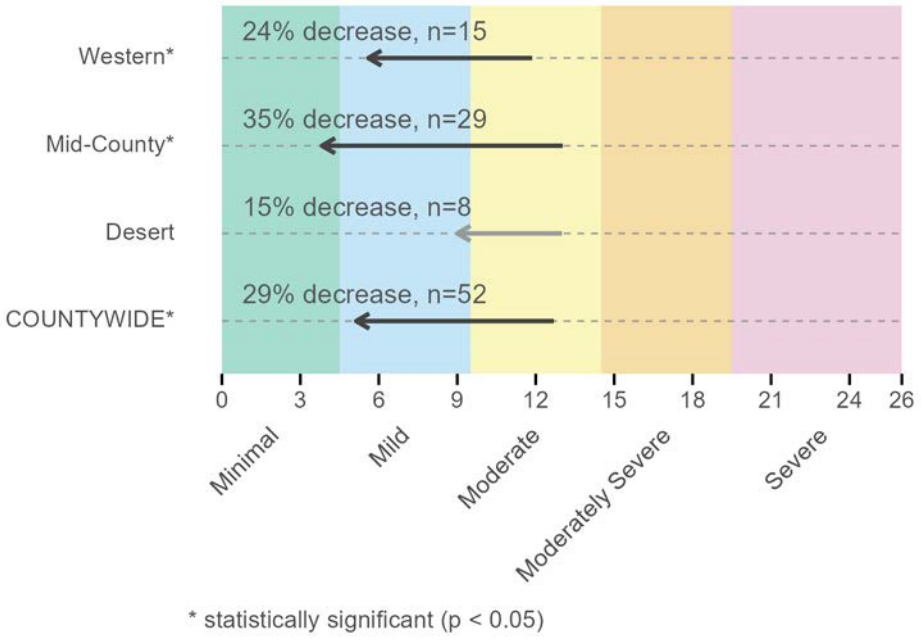
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program. We use these participants for the analysis. One participant didn't fully complete both the pre and post PHQ-9, leaving n = 52 participants for the analysis. There were no outliers.

Figure 5.1 displays the PHQ-9 results using arrows to point from the average-pre to average post-score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for all regions except Desert.

Furthermore, Figure 5.1 shows that average depression as measured by the PHQ-9 was reduced 29% from "moderate" to "mild" countywide.

Figure 5.1: PHQ-9 Mean Pre to Post Score Outcomes



Program Outcomes: GAD-7

The GAD-7 measures symptoms of anxiety using seven questions in which participants rank on a 0-3 point scale the degree to which they've been bothered by issues related to anxiety. The issues include (1) feelings of nervousness, irritability, fear, and restlessness; (2) not being able to control worrying; and (3) trouble relaxing. Scores are calculated by adding the rank (0-3) selected for each question.

Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 32 fully completed both the pre and post GAD-7. There were no outliers.

Figure 6.1 displays the GAD-7 results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was achieved countywide and for Desert and Mid County regions.

An additional question following the GAD-7 is presented to quantify the impact of anxiety on the participant's life. Figure 6.2 shows the pre-to-post results. These were not statistically significant.

Figure 6.1: GAD-7 Mean Pre to Post Score Outcomes

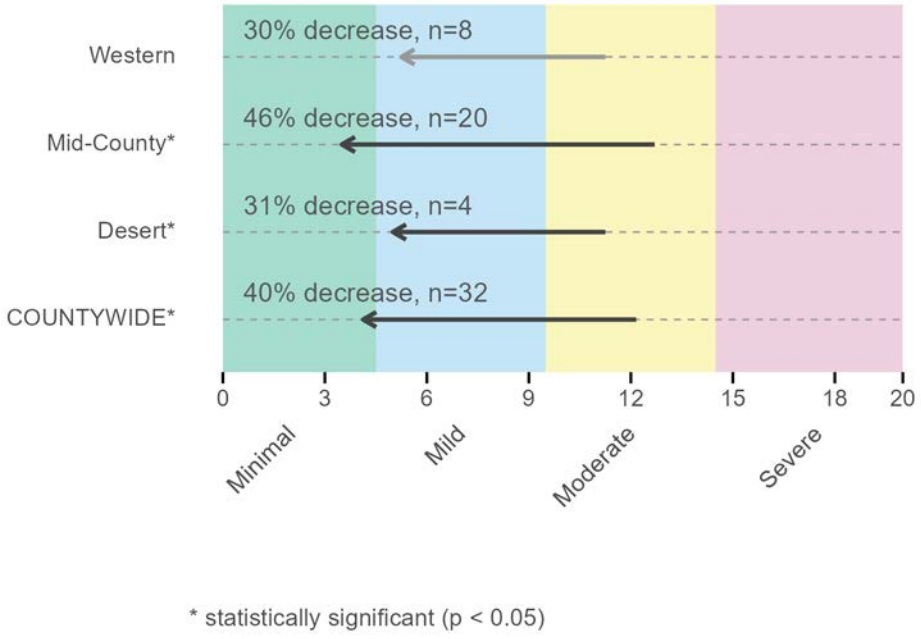


Figure 6.1 shows that average anxiety as measured by the GAD-7 was reduced 40% from "moderate" to "minimal" countywide.

Figure 6.2: GAD-7 Extra Question

How difficult have these made it for you to do your work, take care of things at home, or get along with other people?



Program Outcomes: Physical Activity (RAPA-I)

PEARLS participant physical activity is assessed using the Rapid Assessment of Physical Activity (RAPA) questionnaire, which consists of nine yes/no questions depicting differing levels and intensity of activity. The participants check off whether or not each question is representative of their usual activity. Questions 1-7, the RAPA I, or "aerobic" section, describe aerobic activities of progressively greater duration and intensity. In contrast, the last two questions, the RAPA II or "strength and flexibility" section, simply indicate the inclusion of strength and flexibility in the participant's normal routine. RAPA II (Strength and Flexibility) outcomes are not currently analyzed.

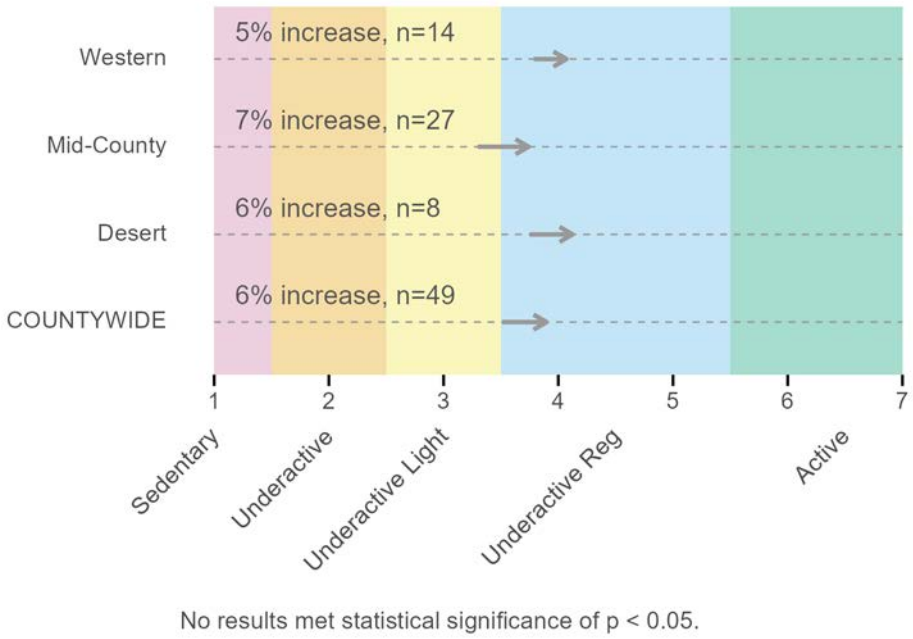
Of the 109 FY 2023-2024 PEARLS participants, 53 completed the program, and n = 49 fully completed both the pre and post RAPA. There were no outliers.

Figure 7.1 displays the RAPA-I results using arrows to point from the average-pre to average-post score.

The one-sided paired T test provides an indication of whether or not the change in average pre to post score is sufficiently significant to be attributable to the program. Statistical significance ($p \leq 0.05$) was not achieved for any region or countywide.

Figure 7.1 displays the progression of average pre to post scores using arrows. Improvement in physical activity as measured by the RAPA-1 was minimal for FY 2023-2024.

Figure 7.1: RAPA-I Mean Pre to Post Score Outcomes



No results met statistical significance of $p < 0.05$.

Program Outcomes: Quality of Life Survey

A nine-question quality of life survey is given to PEARLS participants at the beginning of the program and upon completion. Table 8.1 shows the average pre/post survey results for the 53 participants completing the program. Each arrow points from the average pre to the average post score. For each question, the number of participants completing both a pre and post survey is designated by *n*. Results were statistically significant ($p \leq 0.05$) for all questions except question 5, *How do you feel about the way things are in general between you and your family?*

Figure 8.1: Survey Outcomes

1. In general, would you say your health is:



2. How do you feel about your life in general?



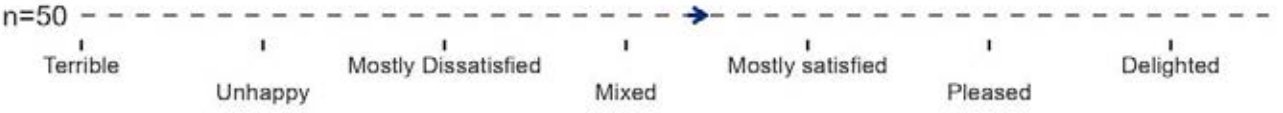
3. How do you feel about your emotional well being?



4. How do you feel about the way you spend your spare time?



5. How do you feel about the way things are in general between you and your family?



6. How do you feel about the amount of time you spend with other people?



Program Outcomes: Quality of Life Survey (continued)

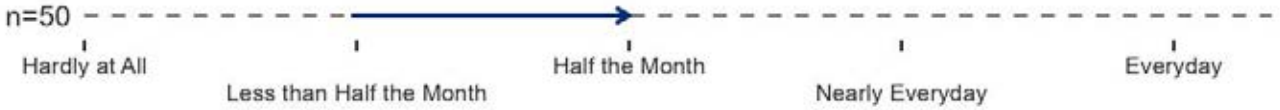
7. How do you feel about the amount of friendship in your life?



8. During the past month, which statement describes how socially active you have been?



9. During the past month, how often have you participated in pleasant activities?



Post Program Satisfaction Survey Results

Five questions related to satisfaction with the PEARLS program and practitioners are included only in the post survey. The first four questions are specific to (1) quality of service, (2) knowing how to get help, (3) likelihood to return to the program, and (4) reduction in depression. Responses to these four questions are summarized in Figures 9.1 through 9.4 below.

Figure 9.1: How Would You Rate the Quality of Service You Have Received From Your Practitioner?

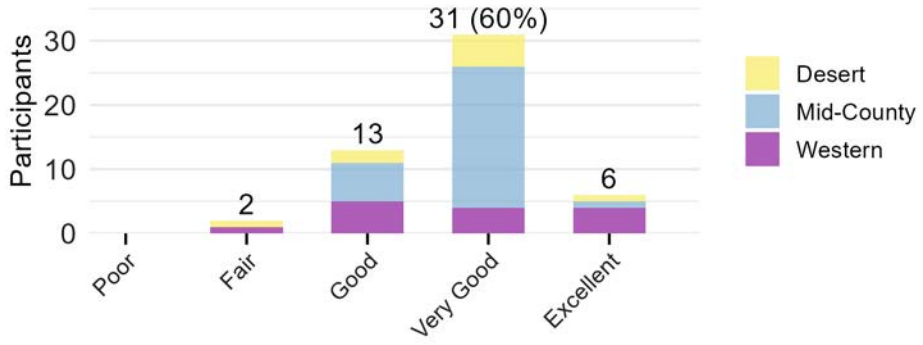


Figure 9.2: In a General Sense, How Satisfied Are You With the Support You Have Received From This Program?

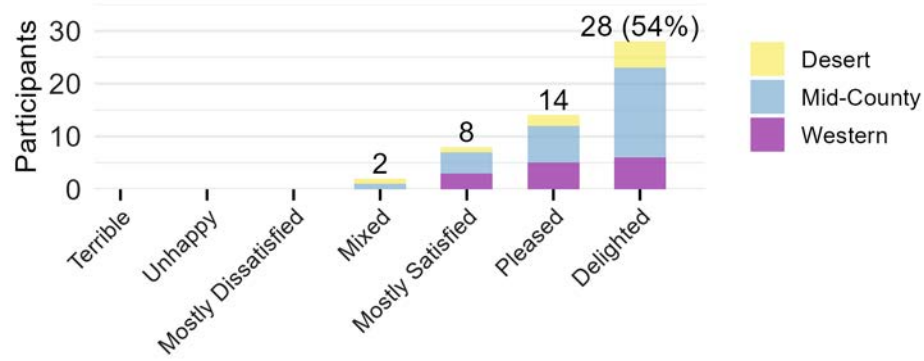
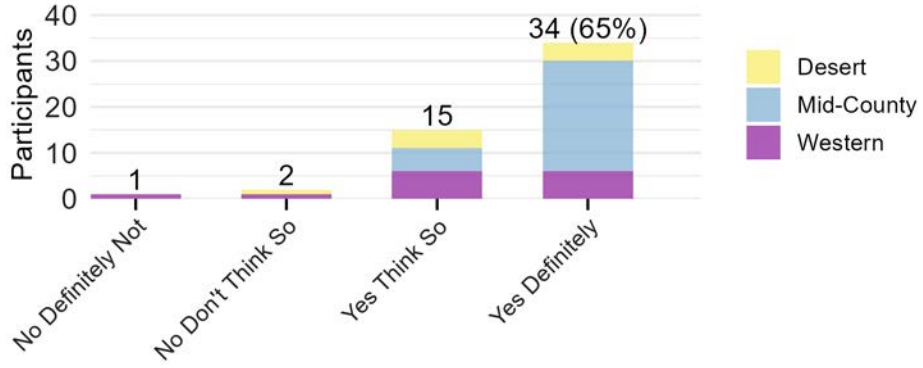


Figure 9.3: Would You Say as a Result of the Program You Now Know How to Get Help for Depression?



Post Program Survey Questions (continued)

Figure 9.4: If You Were to Seek Help Again, Would You Return to This Program?

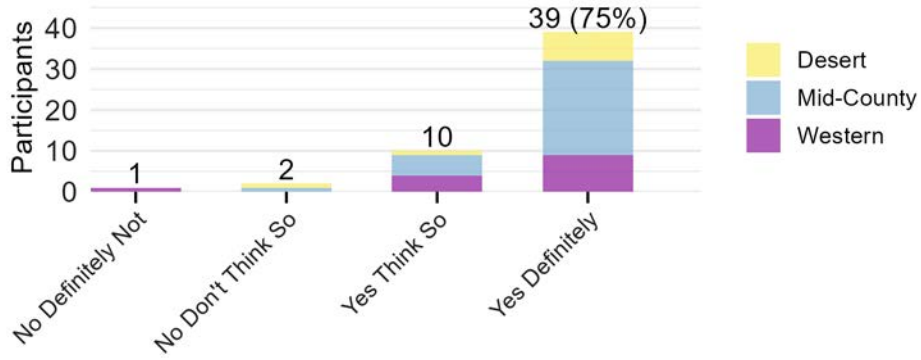
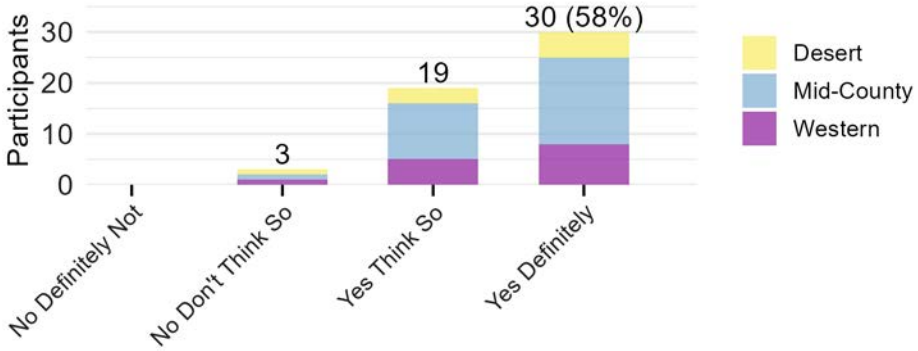


Figure 9.5: Has Participation in This Program Reduced Your Depression Symptoms?



Post Program Comments

The post-program survey includes two fill-in question. Selected responses are reproduced below with minimal edits.

"**If you did benefit from the PEARLS sessions, please describe why."**

- PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.
- I have been able to make some decisions that I was not able to make before as a result of this program.
- I was able to talk to someone with knowledge in guiding me through different scenarios.
- It gave me options that I never thought about before I started the program.
- (My practitioner) was there for me and my husband. I have learned so much that I can use in my day to day life. I really appreciate PEARLS.
- This program helped me learn about my feelings. I learned to find solutions to help me feel better when stressed.
- PEARLS helped me step back and think.
- (My practitioner) motivated me to do the things I wanted to do and now I'm doing them
- (My practitioner's) calm and friendly approach has helped me as a caregiver to not see things in an awful way. It has helped me focus on things I have control over.
- It really benefited me and I have made life changes that have made my day to day better
- It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.
- It re-enforced ability to redefine problems and how to solve them

"Do you have any additional comments you would like to share regarding your experience with the PEARLS program."

- I am absolutely so satisfied and happy to have had an avenue to speak openly about my feelings and emotions as I age.
- It has been a blessing that this program exists.
- I was pleasantly surprised how well it works. It wasn't easy at first but through the process it got easier and I got more comfortable.
- Your support is very valuable to improve our quality of life and you all have a gift in the way you provide support.
- I want to thank you for helping me to get out and make friends.

Historical Service and Completion

Figure 11.1: Participants Served

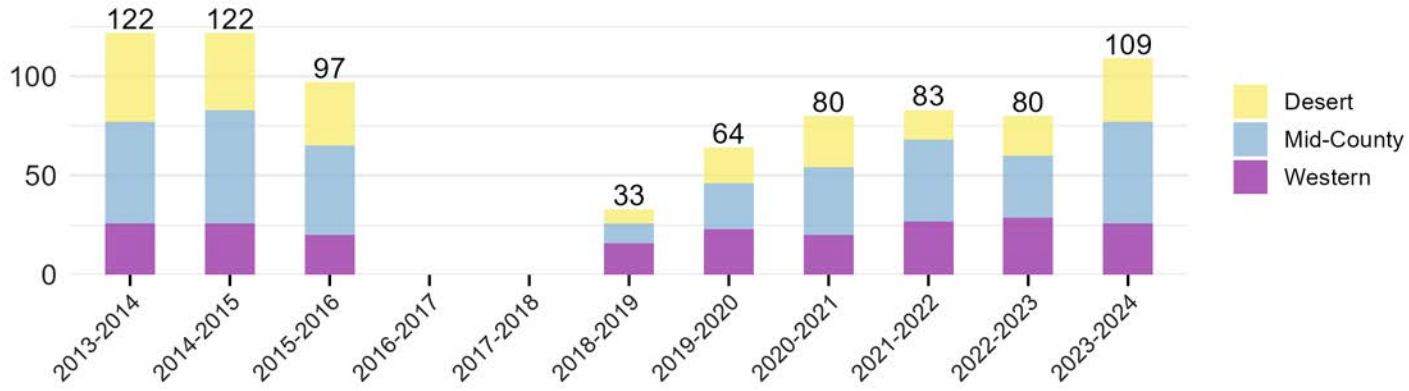
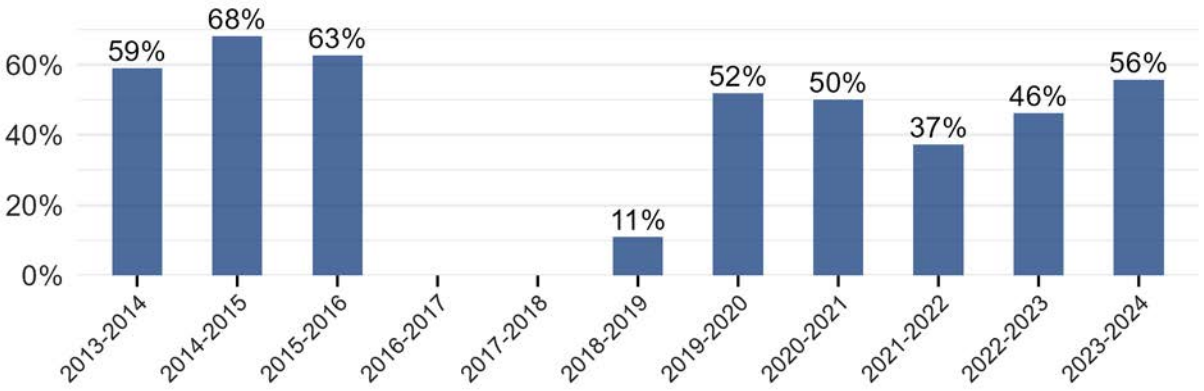


Figure 11.2: Completion Rates



PEI

Care Pathways - Caregiver Support Groups

Program Type: Prevention Program



A Memorandum of Understanding (MOU) was continued with the area Office on Aging (OoA) to provide the Caregiver Support Groups in all three regions of the county. The support groups target individuals who are caring for older adults who are receiving prevention and early intervention services, have a mental illness, or have dementia. Their program, called "Care Pathways", consists of a 12-week cycle that provides education and support on a variety of topics that caregivers face. Support Group topics include: Living with Dementia; Signs of Stress & Stress Reduction Techniques; Communicating in Challenging Situations; Legal Issues Related to Challenging Situations; Managing Medications; How to Talk to the Doctor; Learning From Our Emotions; Taking Charge of Your Health; Grieving—Natural Reaction to Loss; Health Lifestyles; and Preventing Caregiver Burnout. The Care Pathways program's main goals are to reduce the risk for depression and to impact the caregivers' sense of well-being by reducing the emotional distress of caregivers. This is accomplished by providing useful information and providing the opportunity to share and bond with others.

During FY23/24, 116 individuals participated in the Care Pathways program support groups. The majority (78%) of participants were female and 43% were age 60 or older. Half (50%) of the support group participants had been providing care for 2 years or less. The caregiver's relationship to the person being cared for was often a parent (51%) or a spouse (28%). A highlight for this year is participant outcomes which demonstrate decreases in depression scores and feelings of distress, as well as self-reports of high caregiver satisfaction. For example, in the Mid-County region, CES-D 20 mean scores from intake to follow up showed a decrease in depression of 34%, and countywide the decrease was 17%. Caregivers' self-assessment questionnaire scores for feelings of distress also showed statistically significant decreases from pre-to-post completion, with a decrease of 26% for the Mid-County region and 11% decrease countywide. Furthermore, satisfaction surveys completed by 90% of participants at the conclusion of support groups indicated they were highly satisfied with various aspects of the program. They reported having reduced stress levels and learning new ways to cope effectively with their caregiving role because of the program. Graduates were also given the opportunity to attend a virtual Dementia Tour to add to their knowledge and experience of the realities of those living with dementia to further their understanding and coping skills.

116 people enrolled
75% completed program

These positive results for numerous caregivers participating in Care Pathways are not only a source of pride for Office on Aging implementation, but also a source of inspiration. We aim to increase our reach to enroll, educate and support many more caregivers that can benefit from participation and graduation. To

Depression scores and Feelings of distress decreased

support that goal, in Q4 of FY23/24, we developed a relationship with Public Authority to assist us in our outreach efforts by requesting a list of caregivers in Riverside County. We capitalized on this rich population of caregivers to implement targeted robotexts to potential caregivers to inform them of the Care Pathways offerings. In turn, class facilitators contacted all interested parties who responded to the robotexts to enroll them in classes. Furthermore, the reopening of the senior center in Desert Hot Springs afforded the opportunity to hold class there to serve more caregivers in the desert location that has proven to be successful on many fronts.

Outreach and enrollment proved to be a significant challenge to implementing Care Pathways for FY23/24. This challenge is evident in reflecting on the number enrollees at 116, falling short of the goal of 144 participants per contract expectation. Concerted efforts were made throughout the year to conduct outreach, inform and educate partner agencies, community-based organizations alike, including at various hospitals, churches, and libraries. However, while a few potential participants expressed interest from those efforts, none of those sites proved fruitful in ultimately enrolling participants. An additional challenge with enrollment was limited staffing with a facilitator vacancy that existed for half of the year resulting in less class offerings. Once an additional facilitator was hired, time invested for onboarding further limited the ability to provide classes for more participants, as the new facilitator was only able to teach one session in Q4.

There were multiple lessons learned as an agency for FY 23/24 Care Pathways implementation. First, the provider recognized the need to have a centralized and streamlined method for tracking interested caregivers for follow-up and enrollment. Secondly, they plan to not only expand their outreach efforts across multiple locations and modalities but also keep track of those that prove to be most successful in garnering interest and enrollments for the classes. Thirdly, they recognized the challenges that caregivers face in being able to attend a series of classes over 12 weeks in person. To that end, they are planning an experiment for the next fiscal year to offer a mid-quarter class that condenses all the course material into 8 weeks to encourage more participation and more graduates. In short, they learned a shorter class series can improve enrollment. Moreover, they added an incentive for participants to receive at graduation to increase completion rates. Lastly, the facilitators also learned to become more comfortable utilizing Zoom for both online classes and support groups. With so many lessons learned during this fiscal year, the provider aims to make steady strides and improvements over the next fiscal year toward positive impacts for participants across the county and those they care for.

A success story:

Spousal caregiver (81) cares for his wife (78) with Alzheimer's. He was referred by the Office on Aging case manager to an in-person class. The caregiver decided to join and was one of only two males in the class. He spoke in the class about how his adult children did not know much about what was going on with their mom and how quickly her condition was declining. He said that he kept it to himself. One of the class members suggested having a weekly Sunday dinner so that the caregiver could give an update and so that the children could spend time with their mother. He said he would try it and the following week in class he let everyone know that his children had come to the home and made dinner and helped him around the home. As the class continued, he was happy to report that his children were continuing to come home, and that the relationship

had strengthened because of the family dinners. He no longer felt alone in the caregiving journey because he now had the support of his adult children and the others in class. He also said he would be joining the after-care support group because he wanted to continue his relationship with those he met in class.

Feedback from participants included:

- "Thank you for this resource and the presenters were wonderful. This program came at the right time for me. I had so many unanswered questions and they helped fill in the gaps. Many thanks!"
- "I needed this to help me with my coping skills. I'm so grateful for all of the help I have gotten."
- "Relief of my stress level and depression of my dad getting old and losing his ability of hearing, sight and mobility. Glad to talk to others in my same situation."
- "Excellent instructor great selection of topics: ELDER Law, Death, Stress Management Etc…"
- "The class has been very helpful to me to helping me identify some of the emotions that I've felt with being a caregiver."

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention Care Pathways (Caregiver Support Groups) Annual Report FY 2023-2024

Program Overview

The Riverside County Office on Aging (OoA) serves as the main gateway for information and referral assistance to seniors countywide, as well as to family caregivers. The OoA provides supportive services through its Family Caregiver Support Program (FCSP). OoA fully implemented the Care Pathways program, with MHSA Prevention and Early Intervention (PEI) funding, in June 2011. Care Pathways is a 12 week, two-hour class offering education and group support to caregivers of a friend or loved one, 60 years of age or older. The program holds scheduled meetings in the targeted areas of Western region (Rubidoux, East-Side Riverside, Casa Blanca, and Moreno Valley); Mid-County region (San Jacinto, Lake Elsinore, Perris, Romoland, and Winchester) and Desert region (Thermal, Mecca, Coachella, Palm Springs, Indio) of Riverside County. The classes are provided in English and in Spanish.

There is a maximum capacity of 15 participants per class. The program is structured to accommodate caregivers throughout the workshop series. If a participant misses a class within a 12 week session, the facilitator of the group will follow-up to encourage attendance and document any challenges he or she may be experiencing. Workshop Support Group Topics include: Living with Dementia; Signs of Stress & Stress Reduction Techniques; Communicating in Challenging Situations; Legal Issues Related to Challenging Situations; Managing Medications; How to Talk to the Doctor; Learning From Our Emotions; Taking Charge of Your Health; Grieving—Natural Reaction to Loss; Health Lifestyles; and Preventing Caregiver Burnout.

Outcomes Evaluation

The Care Pathways program's main goals are to reduce the risk for depression and to impact the caregivers' sense of well-being by reducing the emotional distress of caregivers. This is accomplished by providing useful information and providing the opportunity to share and bond with others. Two measures are used to evaluate program outcomes.

- Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) — a 20-item scale developed by the National Institute of Mental Health. The CES--D 20 is designed to measure current levels of depressive symptomology with emphasis on the affective component. The measure is administered at the start of participation in Care Pathways and at the conclusion of the program.

- American Medical Association's (AMA) Caregiver Self-Assessment Questionnaire — is designed to measure indices of emotional and physical distress. This measure is completed at the beginning of the program and at the conclusion of the program.

Executive Summary

Enrollment

During the 2023-2024 fiscal year, 133 individuals participated in the Care Pathways program support groups. Care Pathways enrollment showed 29% of participants were from the West, 23% from Mid-County, and 35% from the Desert region. Seven of the participants were from out of the County (5%) and ten participants (8%) were missing data on location and have not be included in this report. Of those residing in the three county regions, 116 caregivers participated in the Care Pathways program with a majority (75%) of participants enrolled completing the program. The majority (78%) of participants were female and 43% were age 60 or older. Most participants were either Caucasian (41%) and Hispanic/Latino (40%). Half (50%) of the support group participants had been providing care for 2 years or less. The caregiver's relationship to the person being cared for was often a parent (51%) or a spouse (28%).

Depression Decreased

Countywide and in the Mid-County region, there was a statistically significant decrease in Care Pathways participants' average CES-D 20 depression scores from intake to follow-up. Depression scores in the Mid-County region decreased from a mean score of 20.3 to 13.3, a decrease of 34%. Countywide depression scores decreased from 17.0 to 14.1, a 17% decrease.

Feelings of Distress Decreased

Caregivers' average AMA-Caregiver Self-Assessment Questionnaire scores showed a statistically significant decrease from pre to post Countywide and in the Mid-County region. The Mid-County region showed a 26% decrease in scores while Countywide, scores decreased 11%. In the Western region, caregivers reported a non-statistically significant decrease in current levels of stress from pre to post as measured by question 17 of the AMA-Caregiver Self-Assessment Questionnaire.

Caregiver Satisfaction was High

Caregivers reported high levels of satisfaction with 76.5% of participants who completed a satisfaction survey reporting that the support groups helped them in reducing the stress associated with being a caregiver and 96.1% of participants reporting that they would recommend the support group to friends in need of similar help.

The Care Pathways program enrolled 116 participants during the 2023-2024 fiscal year across the county's three regions. The Desert region enrolled the most caregivers. See Figure 1.

Figure 1. Enrollment by Region

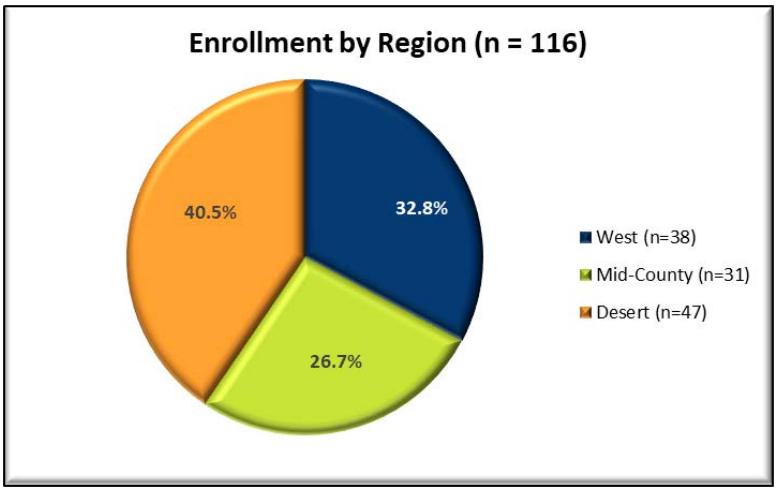
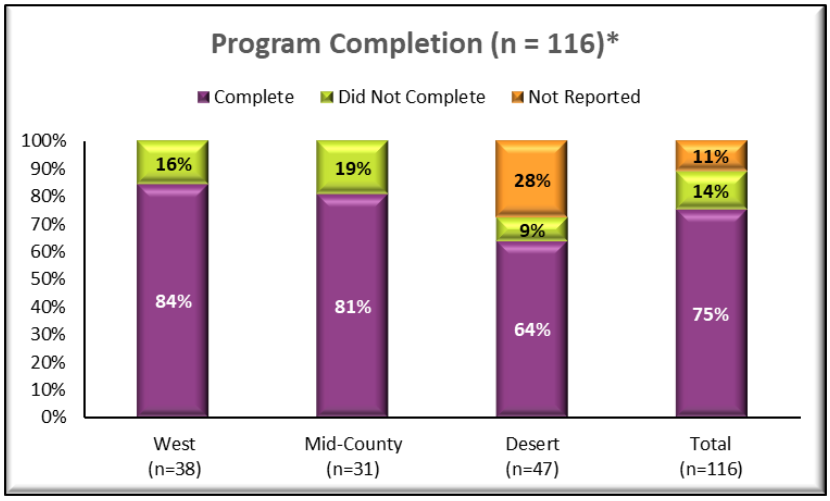


Figure 2. Program Completion



Countywide, 75% of participants completed the program. The Western region had the highest rate of completion 84%, while the Desert region had the lowest rate of completion 64%, see Figure 2.

Table 1. Contract Completion

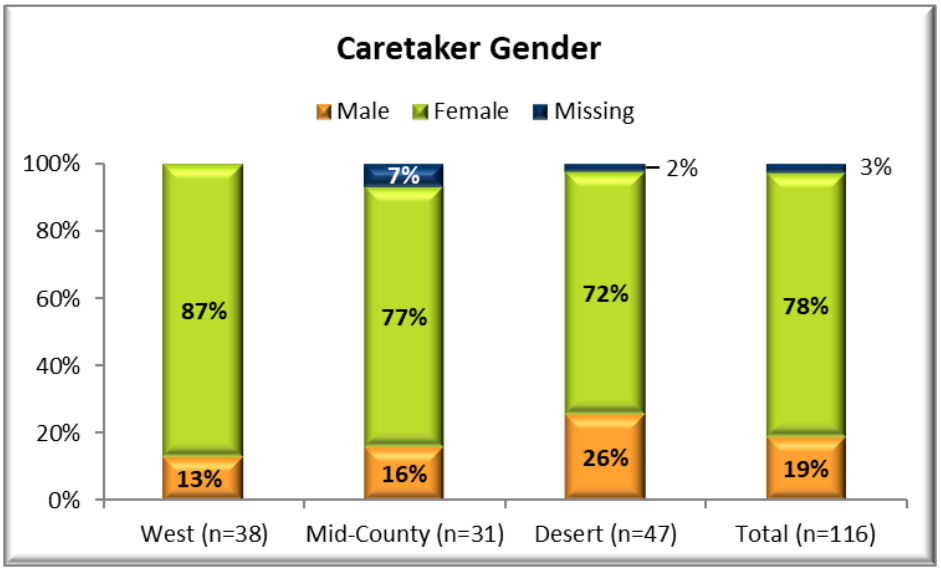
Actual Total Completed	Contract Expectations	Contract Completion
87	144	60%

Table 2: Program Completion History

Fiscal Year	Enrolled	Completed	Percent Completed
2018-2019	250	203	81%
2019-2020	183	142	78%
2020-2021	92	80	87%
2021-2022	117	88	75%
2022-2023	97	77	79%
2023-2024	116	87	60%

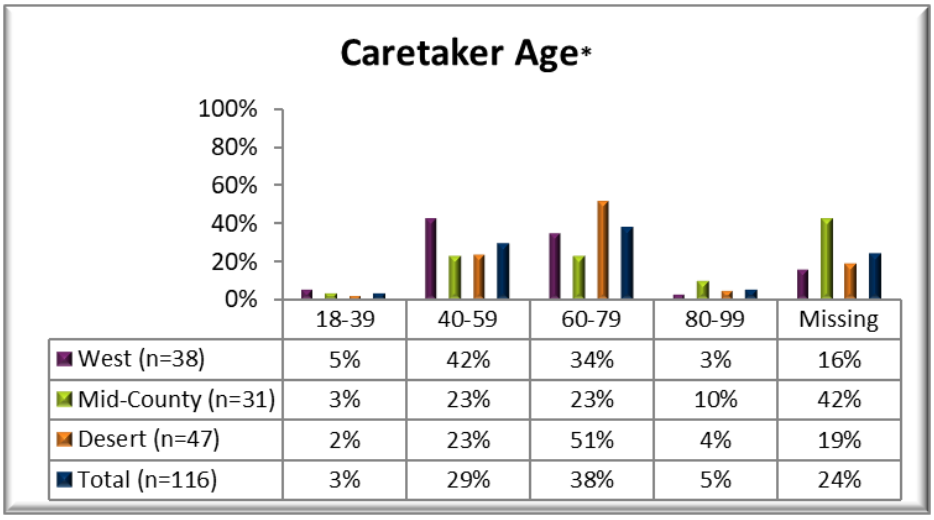
Countywide, the Office on Aging was contractually obligated to have 144 participants complete the program. Across all three regions, 87 participants completed the program, which accounts for 60% of the contract expectation. Contract expectations and completion can be seen in Table 1. Table 2 provides enrollment, completion, and the completion rate for several fiscal years.

Figure 3. Caretaker Gender



Countywide, the majority of caregiver participants reported being female (78%). The Western region served the highest percentage of females (87%).

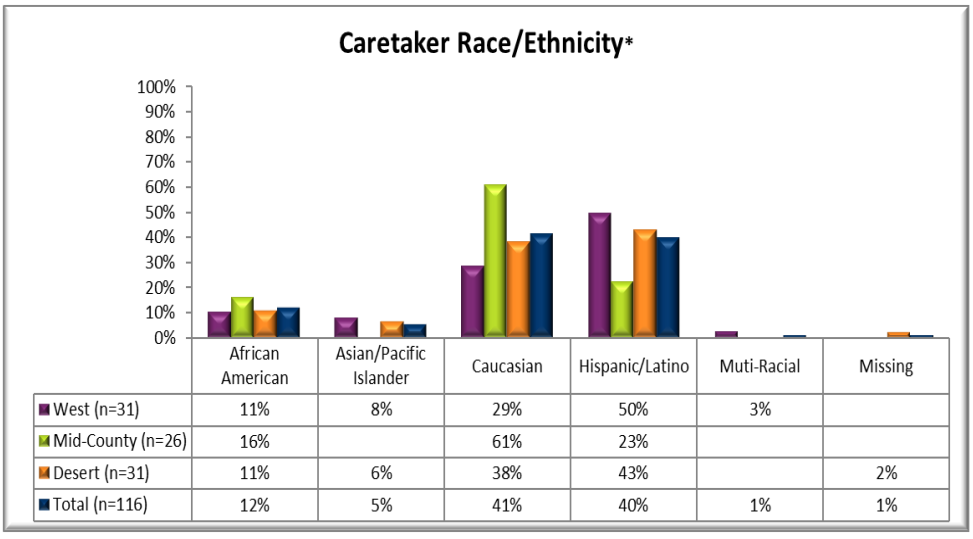
Figure 4. Caretaker Age



	18-39	40-59	60-79	80-99	Missing
West (n=38)	5%	42%	34%	3%	16%
Mid-County (n=31)	3%	23%	23%	10%	42%
Desert (n=47)	2%	23%	51%	4%	19%
Total (n=116)	3%	29%	38%	5%	24%

The majority (67%) of the caregivers participating in support groups were between the ages of 40 and 79. The average age of participants was 61 years old. Age was missing for 28 individuals.

Figure 5. Caretaker Race/Ethnicity

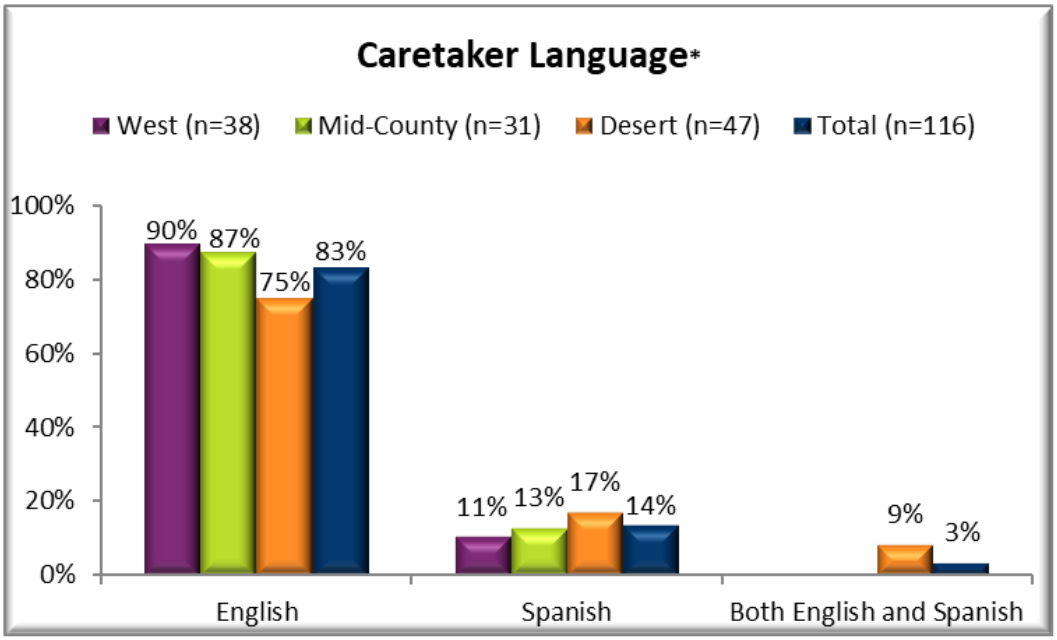


	African American	Asian/Pacific Islander	Caucasian	Hispanic/Latino	Muti-Racial	Missing
West (n=31)	11%	8%	29%	50%	3%	
Mid-County (n=26)	16%		61%	23%		
Desert (n=31)	11%	6%	38%	43%		2%
Total (n=116)	12%	5%	41%	40%	1%	1%

Overall, 41% of caregivers were Caucasian and 40% were Hispanic/Latino. One of the participants who identified as Hispanic/Latino specified being Mexican-American.

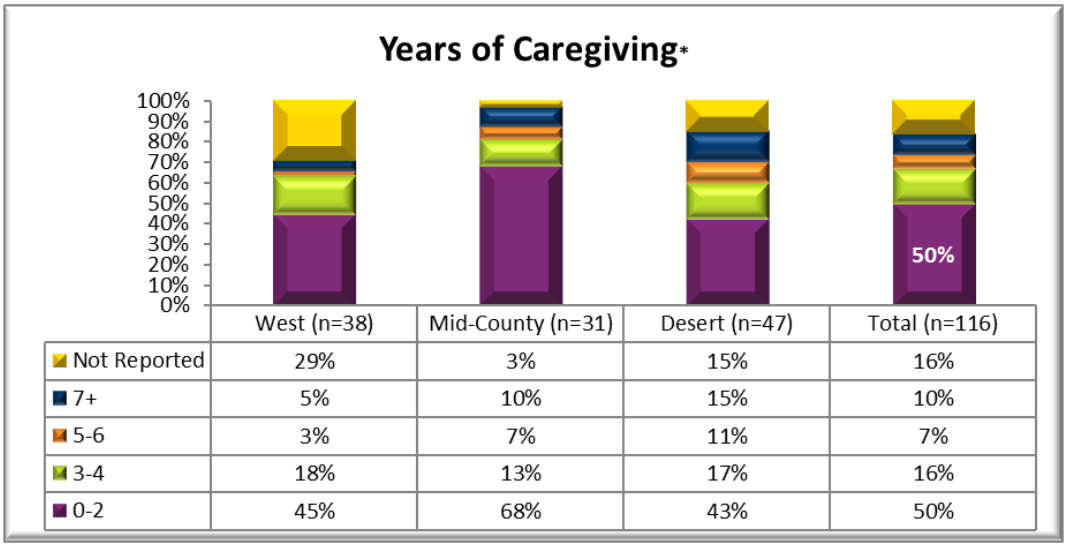
*percentages might not add to 100% due to rounding

Figure 6. Caretaker Language



The majority of participants spoke English as their primary language (83%). Classes were provided in both English and Spanish as needed.

Figure 7. Years of Caretaking



	West (n=38)	Mid-County (n=31)	Desert (n=47)	Total (n=116)
Not Reported	29%	3%	15%	16%
7+	5%	10%	15%	10%
5-6	3%	7%	11%	7%
3-4	18%	13%	17%	16%
0-2	45%	68%	43%	50%

Half (50%) of all caregivers had spent 2 years or less providing care at the time of enrollment. The average time spent providing care was 3.2 years.

Table 3 details the relationship of the Caregivers and Loved Ones. The relationship of the Caregivers and Loved Ones was not reported for four participants. The most common Loved Ones cared for were parents and spouses, respectively.

Table 3. Love One Cared for by Caretaker

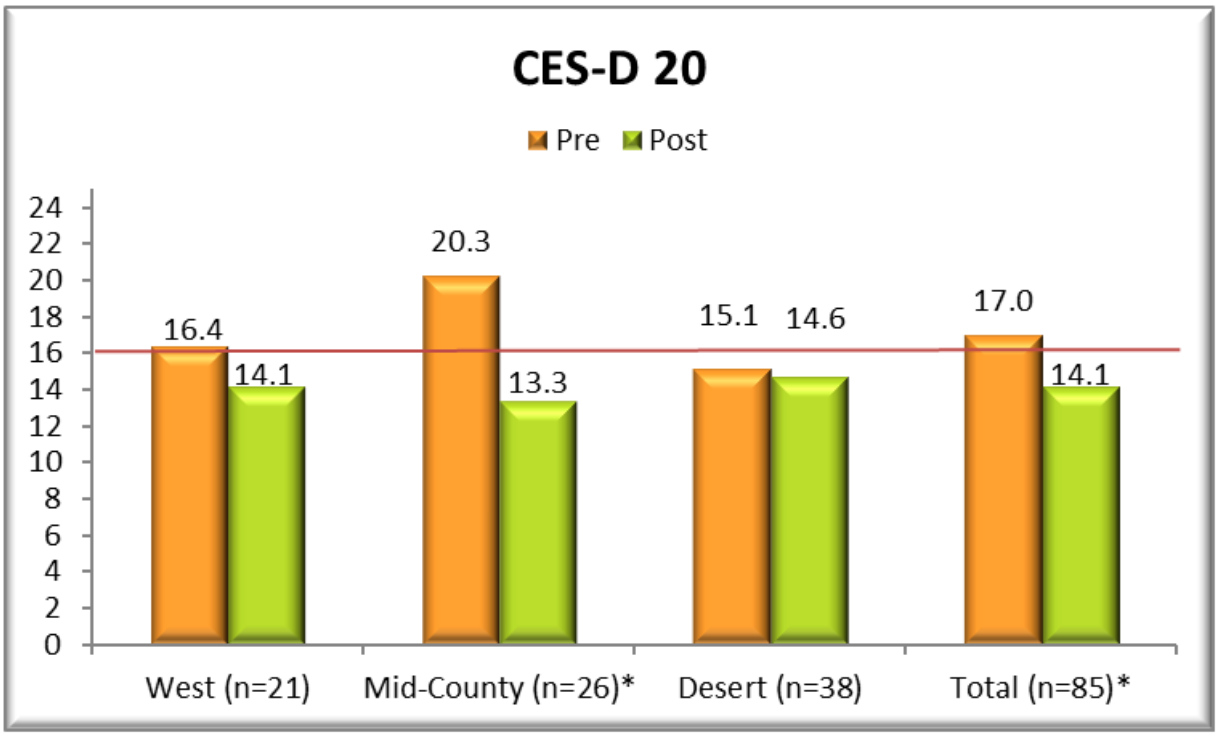
	Loved One Cared For							
	Sibling	Spouse/Partner	Parent	Parent-in-law	Family Member	Friend	Multiple	Missing
West (n=38)	-	16%	55%	11%	11%	-	-	8%
Mid-County (n=31)	-	29%	52%	3%	10%	-	7%	-
Desert (n=47)	2%	36%	47%	2%	6%	4%	-	2%
Total (n=116)	1%	28%	51%	5%	9%	2%	2%	3%

*percentages might not add to 100% due to rounding

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by The National Institute of Mental Health. Respondents are asked to choose from four possible responses in a Likert scale format, where "0" is "rarely or none of the time (less than 1 day)" and "4" is "almost or all of the time (5-7 days)." Scores range from 0 to 60. Higher scores reflect greater levels of depressive symptoms while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a clinically significant level of psychological distress. However, it does not necessarily mean that the participant has a clinical diagnosis of depression. In the general population, about 20% would be expected to score in this range.

There were a total of 85 matched pairs of pre to post measures. Countywide and in the Mid-County region, there was a statistically significant decrease in depression scores from intake to follow-up. Countywide, average CES-D 20 scores decreased by 17% from 17.0 to 14.1. In the Mid-County region scores decreased 34% from 16.4 to 14.1.

Figure 8. CES-D 20



*Significance <.05

The Caregiver Self-Assessment Questionnaire is an 18-item, caregiver self-report measure that was created by the American Medical Association (AMA) to aid physicians in the assessment of stress-levels of family caregivers who accompany chronically ill older adult patients to medical visits. The Office on Aging adopted the measure to assist in assessing caregivers perceptions of stress and emotional well-being. Caregivers are asked to respond either "Yes" or "No" to a series of statements, such as "During the past week or so, I have felt completely overwhelmed" and "During the past week or so, I have felt strained between work and family responsibilities." In addition, for questions 17 and 18, family caregivers are asked to rate their level of stress, and perception of their current health on a 1-10 scale, respectively.

Countywide and in the Mid-county region, self-assessment scores showed a statistically significant decrease from intake to follow-up. Countywide, self-assessment scores decreased 11%, while in the Mid-County region, scores decreased 26% from intake to follow-up. Figure 9 shows pre to post means for question items 1-16.

Figure 9. Total Self-Assessment

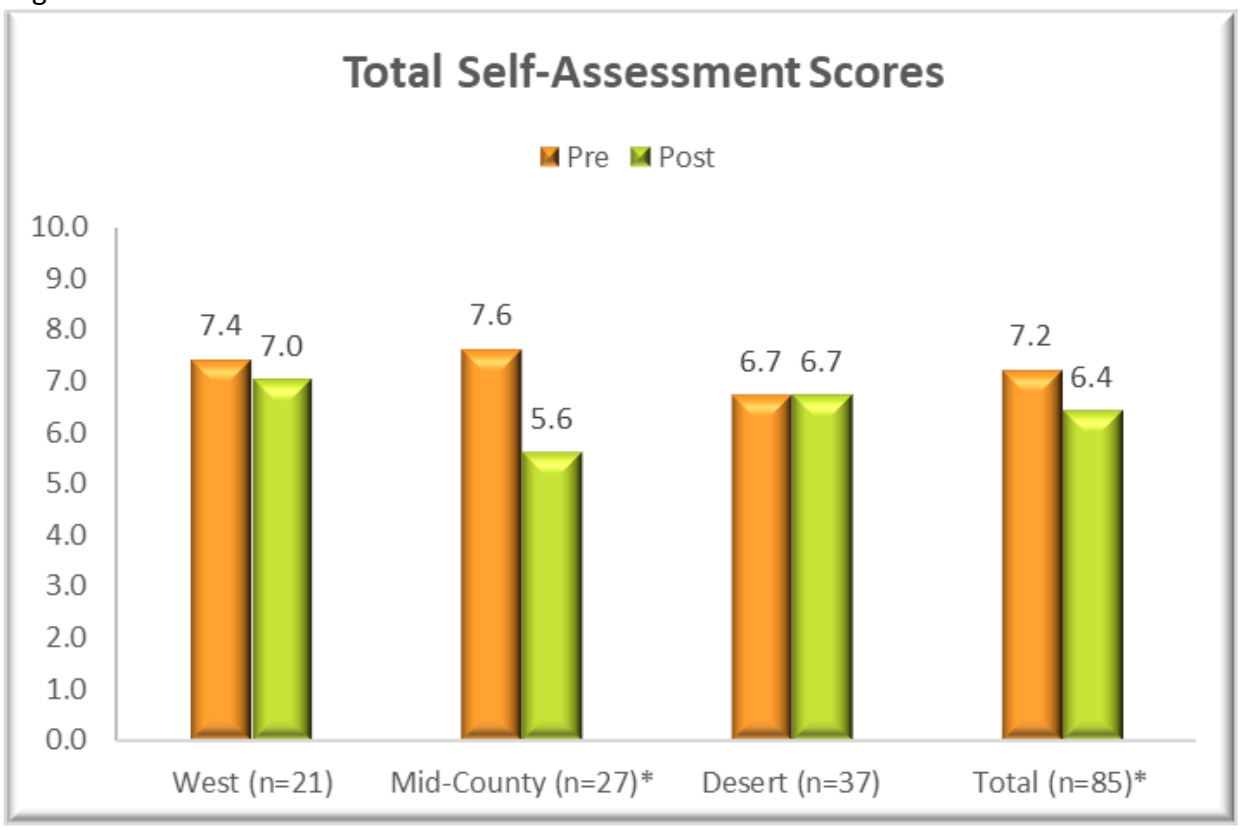
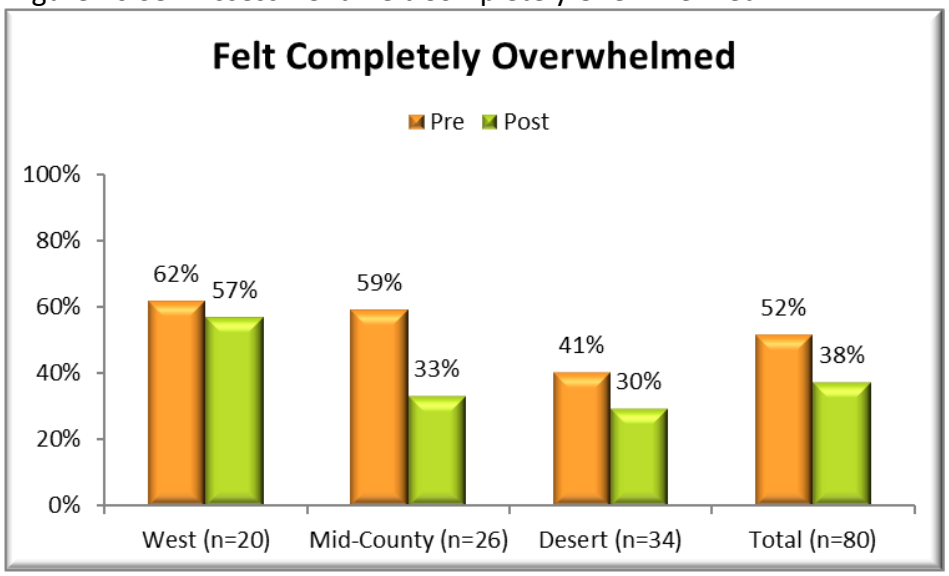


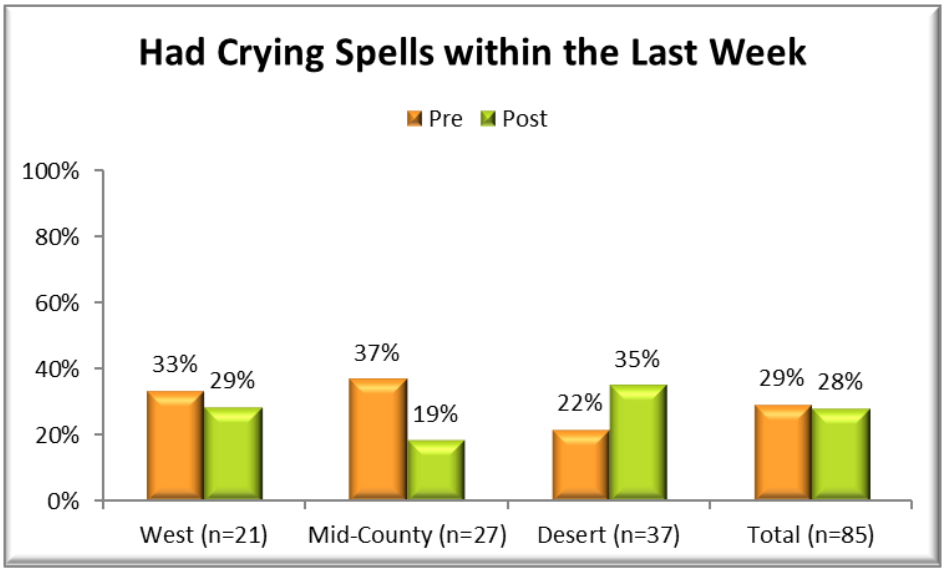
Figure 10 Self-Assessment: Felt Completely Overwhelmed



Caregivers' distress could also be indicated from answering yes to question #4 "Felt completely overwhelmed," or question #11 "Had crying spells" within the past week.

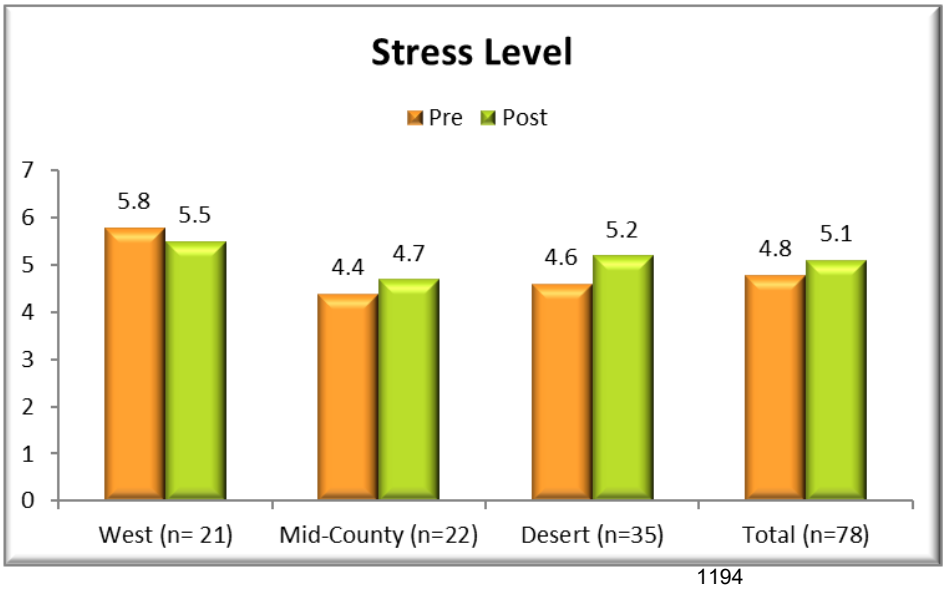
Countywide and within regions, participants reported feeling less overwhelmed at the end of the program (See Figure 10).

Figure 11. Self-Assessment: Had crying spells within the last week



Countywide, and in the Western and Mid-County regions, participants reported a decrease in crying spells (See Figure 11).

Figure 12. Self-Assessment: Stress Level



Question #17 asks caregivers to rate their current level of stress "On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful." Figure 12 provides the mean Caregiver scores for question #17. Although not statistically significant, stress levels in the Western region decreased 5% from pre to post.

Satisfaction

A total of 104 caregivers completed a satisfaction survey at the conclusion of the caregiver support groups. Results are shown in Table 4 below. Overall, caregivers were highly satisfied with the support received from the program. Caregivers also reported having reduced levels of stress and being able to cope more effectively in their caregiver role as a result of the program. Participants would recommend the program to a friend.

Table 4. Satisfaction

	Poor	Fair	Good	Excellent
1. How would you rate the quality of service you have received from the support group leader?	-	-	6.8%	93.2%
	No, definitely not	No, generally not	Yes, generally	Yes, definitely
2. Has the support group helped to reduce some of the stress associated with being a caregiver?	-	2.0%	21.6%	76.5%
	None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met
3. To what extent has the support group met your needs?	-	4.9%	32.0%	63.1%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
4. If a friend were in need of similar help, would you recommend this support group to him or her?	-	1.0%	2.9%	96.1%
	No, definitely not	No, not really	Yes, generally	Yes, definitely
5. Has attending the support group given you methods to solve problems in your role as caregiver?	-	-	17.8%	82.2%
	No, this seemed to make things worse	No, this really didn't help	Yes, this helped	Yes, this helped a great deal
6. Has attending the support group with other caregivers been helpful?	-	1.0%	12.4%	86.6%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
7. If you were to seek help again, would you return to this support group?	-	3.1%	6.2%	90.7%
	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
8. Has attending the support group helped you to cope more effectively in your role as caregiver?	1.0%	1.0%	17.3%	80.6%
	Quite dissatisfied	Mildly dissatisfied	Mostly satisfied	Very satisfied
9. In an overall, general sense, how satisfied are you with the support you have received from this group?	5.1%	2.0%	6.1%	86.9%

Comments
"Thank you for this resource and the presenters were wonderful. This program came at the right time for me. I had so many unanswered questions and they helped fill in the gaps. Many thanks!"
"I needed this to help me with my coping skills. I'm so grateful for all of the help I have gotten."
"Relief of my stress level and depression of my dad getting old and losing his ability of hearing, sight and mobility. Glad to talk to others in my same situation."
"Excellent instructor great selection of topics: ELDER Law, Death, Stress Management Etc…"
"The class has been very helpful to me to helping me identify some of the emotions that I've felt with being a caregiver."

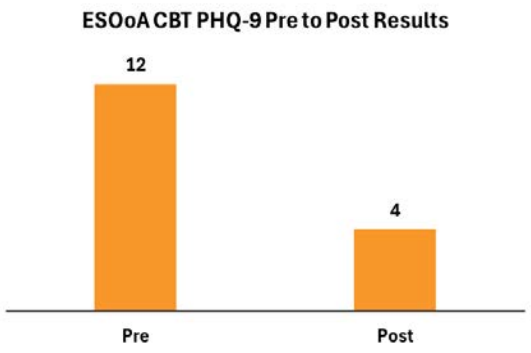
Mental Health Liaisons to the Office on Aging

Program Type: Outreach for Increasing Recognition of Early Signs of Mental Illness, Prevention, and Access and Linkage to Treatment

There are RUHS - BH Clinical Therapists embedded at the two Riverside County Office on Aging locations (Riverside and La Quinta). They provide a variety of services and activities including screening for depression, providing the CBT for Late-Life Depression program, providing referrals and resources to individuals referred for screening, educating Office on Aging staff and other organizations serving older adults about mental health-related topics, as well as providing mental health consultations for Office on Aging participants. In FY23/24, two Clinical Therapists staffed this program.

The primary goals of this program are for the Riverside University Health System - Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging to work collaboratively to identify older adults who are either at risk of depression or are experiencing the first onset of depression and to link these older adults to early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD). In addition to referring older adults to early intervention programs, the Mental Health Liaisons are trained to provide CBT and CBT-LLD. MH Liaisons also link older adults with other resources and services, as needed, to reduce depression and suicide risk.

In FY23/24, the Mental Health Liaisons held 111 outreach events for a total of 160.5 hours. The majority of the events took place at community meetings (64.9%) and at public events (11.7%). The Mental Health Liaisons processed 422 referrals in FY23/24; where approximately 2.8% led to CBT-LLD enrollment. Nearly 96% of the total referrals were to 'Other' (e.g. private insurance). Office on Aging liaisons provided CBT-LLD services to a total of 18 participants. The majority of the CBT-LLD participants were female (78%), and between the ages of 75-79 (27.8%). Of the 12 closed cases, 50% reported successfully completing their treatment goals. The remaining participants discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially completed their goals. PHQ-9 pre to post scores showed a statistically significant improvement in symptoms of depression. The Quality of Life (QOL) survey results showed that participants felt significantly better in most QOL items. GAD-7 pre-to-post scores showed a statistically significant decrease in anxiety symptoms.



Staff were able to serve two homebound clients in Blythe. Blythe has been a longstanding challenge due to the community being very remote compared to the rest of the County. It's also a very small community, requiring a lot of extra work around trust and rapport-building. Completing two clients in this community is a big accomplishment. Staff worked to find ways to make required paperwork easier for clients to access and aid in getting to session agenda items in a timelier manner. Clients have been receptive to having copies of the PHQ-9 left with them to allow them to complete them before their session time. Sending follow-up letters with resources after being unable to reach clients by

phone, including crisis support and CARES Line information, has been useful. Clients have responded that they were able to get connected to ongoing support and services.

Privacy when providing services in a client's home has been more of a challenge recently. It has led to working with clients on setting healthy boundaries. Helping homebound clients identify pleasant activities in rural communities is hard. Working with clients with increasing cognitive decline is challenging. The change in cognition also exacerbated symptoms of depression and anxiety. Despite agreeing to be referred to therapy services, potential clients are not always ready to engage in the process. They want someone to validate their concerns and listen. Many are also not aware that the 24/7 warmlines exist and those end up being a good outlet for them.

Participants of CBTLLD are asked to complete a post-survey. Below are some of the responses received:

- "It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much." [Translated from Spanish]
- "The program is good, I would recommend it" [Translated from Spanish]
- "The program helped me. I liked that [Therapist] understood me and helped me to cope with my problems. I am grateful for the program"
- "[Therapist] has been a great help for me. A am very comfortable with her & opening up to her"
- "I like the support and will continue to look for BH as needed"
- "I was satisfied with this program, it helped me a lot." [Translated from Spanish]

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention

Office on Aging Liaisons

FY 2023-2024 Annual Report





Office on Aging Liaisons FY 2023-2024

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Program Overview

Office on Aging Liaisons

The primary goal of this program is for the Riverside University Health System-Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging to:

1) work collaboratively to identify older adults who are either at risk of depression or are experiencing the first onset of depression.
2) ink these older adults with early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD).

In addition to referring older adults to early intervention programs, the Mental Health Liaisons are trained to provide CBT and CBT-LLD. MH Liaisons also link older adults with other resources and services, as needed, to reduce depression and suicide risk.

CBT for Late Life Depression

CBT for Late Life Depression is an active, directive, time-limited problem-solving program that follows the structure of the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults who are experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as slower rates of, or repeated, presentation of information using different modalities; greater use of practice; greater use of structure; and behavior modeling. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and shift them to being more adaptive and flexible. Emphasis is placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions following a structured manual.

Outcomes Evaluation

Referrals and Outreach

A significant amount of the Mental Health Liaisons' time is expected to be focused on completing referrals and participating in outreach events. Data collected for these activities includes referral forms with a final disposition and information on the types of outreach events that the staff participated in.

'CBT for Late Life Depression' Outcomes Evaluation

Each year, Mental Health Liaisons are expected to provide CBT for Late Life Depression to some people who are not referred out to Community-Based Providers of CBT.

1. **Patient Health Questionnaire (PHQ-9)** is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents ages 12 years and older. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response. The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and ≥ 20 indicates severe symptoms of depression.

2. **Quality of Life (QOL)** survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

3. **General Anxiety Disorder-7 (GAD-7)** is a 7-item questionnaire that measures generalized anxiety disorders and assesses its severity. Each item is scored on a scale of 0-3, ranging from no frequency to high frequency. The GAD-7 is scored by summing the ratings for the 7 questions. A total score of 0-4 indicates minimal; 5-9 indicates mild; 10-14 indicates moderate; and 15-21 indicates severe symptoms of anxiety.

Executive Summary: Key Findings

Referrals and Outreach

Within the fiscal year (FY) 2023-2024, Embedded Staff held 111 outreach events for a total of 160.5 hours. The majority of the events took place at community meetings (64.9%) and at public events (11.7%).

The Mental Health Liaisons processed 422 referrals in FY 23/24; where approximately 2.8% led to CBT-LLD (n=12) enrollment. Nearly 96% of the total referrals were to 'Other' (e.g. private insurance).

Cognitive Behavioral Therapy for Late Life Depression

Office on Aging liaisons provided CBT-LLD services to a total of 18 participants. The majority of the CBT-LLD participants were female (78%), and between the ages of 75-79 (27.8%). Sixty seven percent (n=12) of the participants closed from the program within FY 23/24. Since some participants start the program services later in the fiscal year, not all cases close by the end of the fiscal year. Enrollment and demographic data reflects a higher number of participants, as it includes all clients who were served in the fiscal year; whereas pre to post outcomes data only reflect those cases that were closed with post measures completed within the fiscal year. From the 12 closed cases, 50% reported successfully completing their treatment goals (n=6) while the remainder did not complete. The remaining participants discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially completed their goals.

Decrease in Depression Symptoms

- PHQ-9 pre to post scores showed a statistically significant improvement in symptoms of depression. Based on the average pre to post PHQ-9 scores, symptoms of depression decreased from moderate (m=12) to minimal (m=4) after completing the program.

Improved Quality of Life

- QOL survey results showed that participants felt significantly ($p<.05$) better in most (n=10) QOL items. In these items, participants reported improvements in how they felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being.

Decrease in Anxiety Symptoms

- GAD-7 pre to post scores showed a statistically significant decrease in anxiety symptoms. Based on the average pre (m=11) to post (m=4) GAD-7 scores, symptoms of anxiety decreased from moderate to minimal levels.

OUTREACH

Embedded Staff participated in a total of 111 outreach events. *Table 1* provides the number of outreach events that were held in each region. The majority of outreach events took place in the Desert region (78.4%), followed by Western (15.3%) and Mid-County (0.9%). A small amount of outreach events took place across all regions (5.4%; see Table 1).

Table 1: Regional Outreach Percentages

Agency	All	Mid-County	Desert	Western
Embedded Staff OOA (N= 111)	5.4% (n= 6)	0.9% (n=1)	78.4% (n=87)	15.3% (n=17)

Between all 111 events, Embedded Staff spent a total of 160.5 hours on outreach, averaging approximately 1.46 hour per event, reaching a total audience of 2,697 people (see *Table 2)*.

Table 2: *Outreach Totals*

Agency	Total # of Outreach Events	Total Time (Hrs)	Average Time (Hrs)	Total People in Attendance
Embedded Staff OOA	111	160.5	1.46	2,697

Table 3: *Types of Outreach Events*

Type of Outreach Events (N=111)	(n)	(%)
Community Meeting	72	64.9%
Public Event	13	11.7%
Phone	3	2.7%
Presentation	7	6.3%
Other	9	8.1%
Unknown	7	6.3%

As shown in *Table 3*, the majority of outreach events were identified as either Community Meetings (64.9%, n=72) or Public Events (11.7%, n=13).

Table 4: *Outreach Venues*

Type of Outreach Venues (N= 111)	(n)	(%)
C.A.R.E	16	14.4%
Community Health/ Resource Center	77	69.4%
Faith-based Organization	2	1.8%
One-On-One Outreach	1	0.9%
Senior Center/ Collaborative Meetings	13	11.7%
Senior Housing Complex	2	1.8%

Of the 111 Outreach Events, Embedded Staff completed the most outreach events through Community Health/ Resource Centers (69.4%, n=77; *See Table 4).*

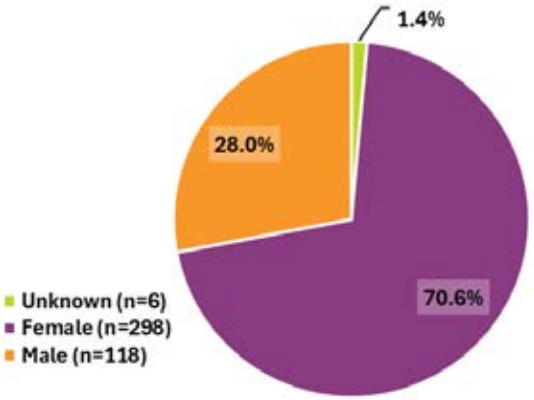
Other popular outreach venues included C.A.R.E. (14.4%) and Senior Center/ Collaborative Meetings (11.7%).

REFERALS

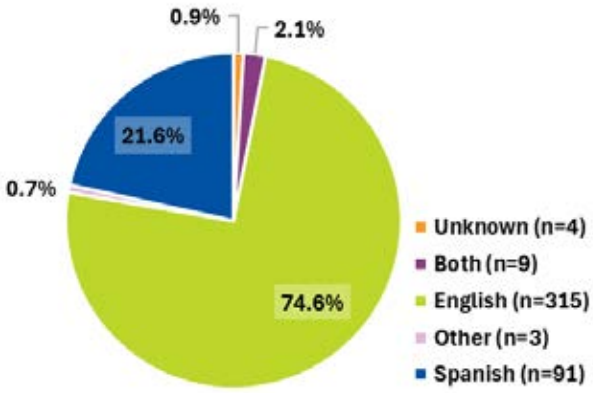
Mental Health Liaisons processed a total of 422 referrals within FY 23/24. All of the referrals were internally from the Office on Aging— such as the InfoVan, Adult Protective Services, In-Home Support Services (IHSS), Senior Centers (Coachella, Mecca, Mizell), Catholic Charities, and Sunny Adult Day Health Care. Additionally, Case Consultations were made for 159 people, which may or may not have resulted in a referral.

Characteristics of Referred Persons

Gender



Primary Language



The majority of the referrals were provided to females (n=298, 70.6%), while 118 identified as male (28.0%). A smaller amount did not report on gender (n=6).

The primary languages reported were English (n=315, 74.6%), and Spanish (n=91, 21.6%). Less than 1% did not report language whereas nine reported both English and Spanish as their primary language.

Referral Final Disposition

Among the 422 referrals that were made- some clients were referred to more than one program *(please note that the percentages in Table 5 do not sum to 100% due to stated multiple referrals)*, while others were not referred to any programs, as some referrals were unable to be completed (see Table 5.2). A total of 10 referrals were to CBT-LLD, all of which led to enrollment into the CBT-LLD program within the 23/24 fiscal year. Two additional participants were enrolled who did not come in through the referral process. *A majority of referrals had the final disposition of "Other" indicated (n=406) which was* 96.2% of total referrals. These primarily consisted of clients being referred back to their existing Primary Care Physicians and insurance (17.2%) , or the participant decided to delay referrals for the time being (22.9%).

Table 5: ***Referral Dispositions***

Referral Disposition (N= 422)	n	%
Referred to a Non-PEI Program	16	3.8%
Referred to CBT-LLD	10	2.4%
Enrolled	*12*	2.8%
Did Not Meet Criteria	0	0.0%
Referred to Another PEI Program	6	1.4%
Referred to PEARLS	4	0.9%
Enrolled	*2*	0.5%
No Disposition Recorded	3	0.7%
Other (see Table 5.2 for break-down)	*406*	*96.2%*

Table 5.2: ***Referral Dispositions "Other"***

Referral Disposition "Other" (N= 406)	n	%
Already receiving BH	25	6.2%
Declined Services	93	22.9%
Given/Mailed Resources	*44*	10.8%
Insights	51	12.6%
Other	28	6.9%
PEARLS	1	0.2%
Private Insurance/Referred to PCP	*70*	17.2%
Referred to RUHS	11	2.7%
Thrive	7	1.7%
Unable to Complete	76	18.7%

CBT Demographics

During FY 23/24, a total of 18 participants were enrolled and 17 received services from the Embedded Staff Office on Aging (ES-OOA) CBT program. The majority of the clients who received services were female (78%, n=14) and between the ages of 75-79 (27.8%).

Gender

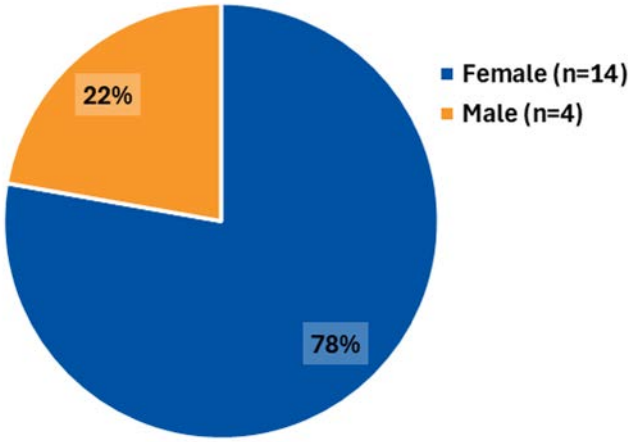
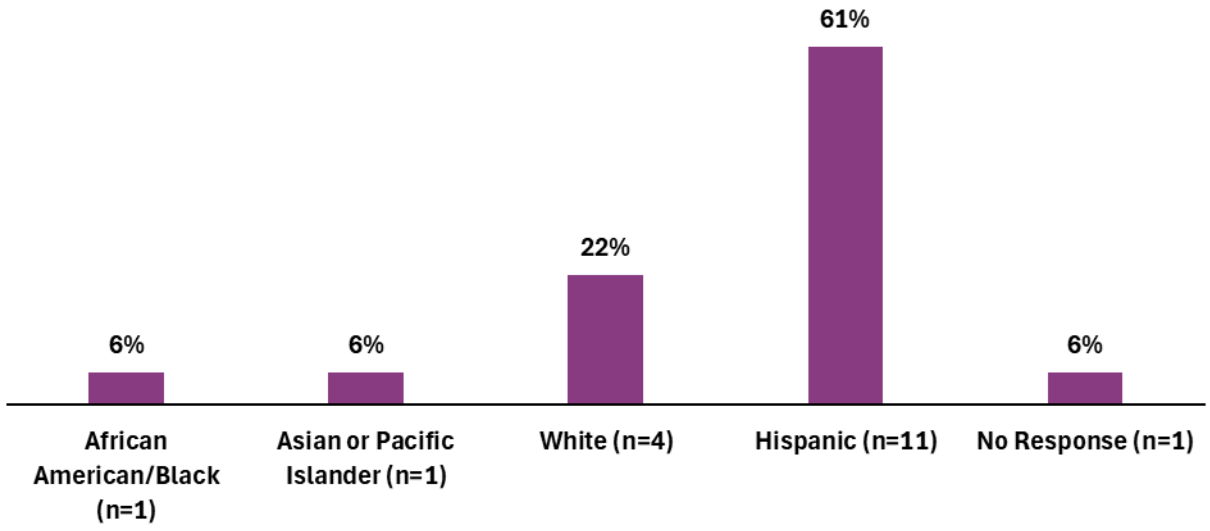


Table 6: CBT–LLD Age

Participant Age Range (*n= 18*)	n	%
59-64	4	22.2%
65-69	2	11.1%
70-74	4	22.2%
75-79	5	27.8%
>80	3	16.7%

Participant Race/Ethnicity

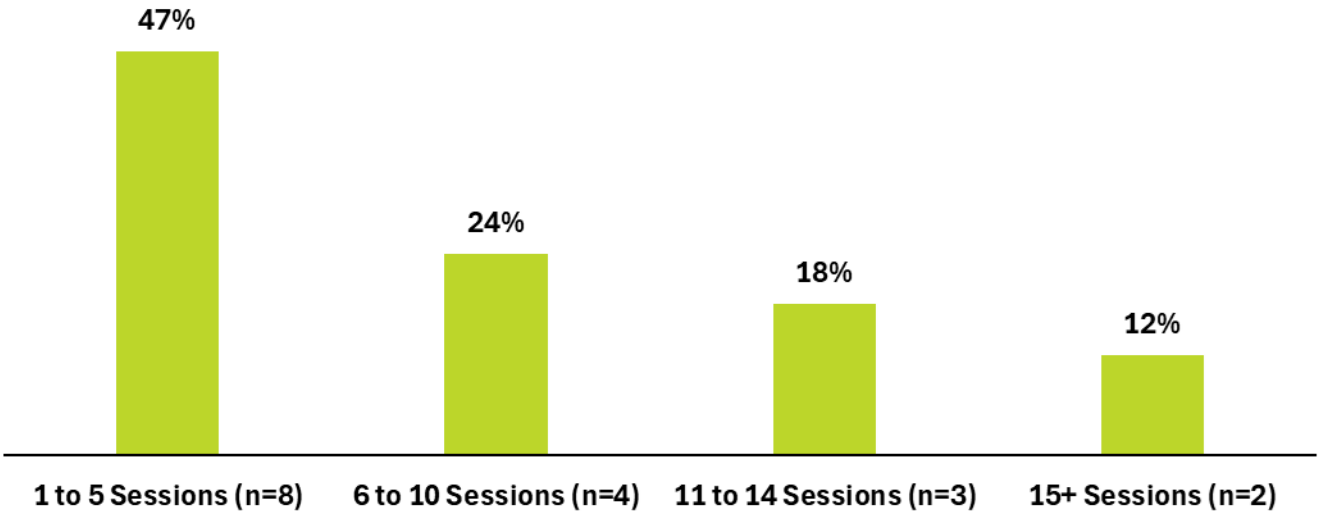


The majority participants identified as Hispanic (61%) followed by White (22%). Whereas, the remaining two participants identified themselves as and African American (6%) and Asian (6%). One participant did not disclose their Ethnicity.

CBT Program Participation

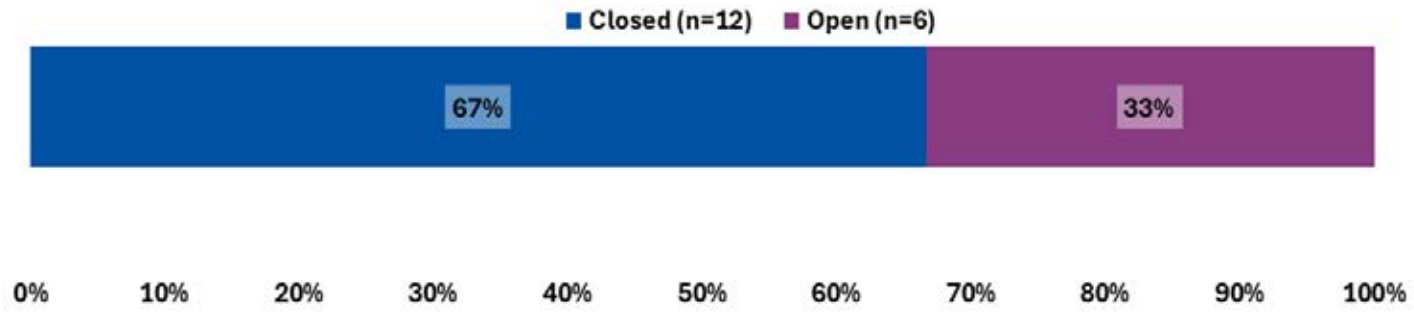
Number of Sessions Provided

Of the 18 participants who were open in FY 23/24, 17 received services. The graph depicts the number of CBT sessions that each participant (n=17) received. The range of session attendance was between 1 and 18 sessions.



Program Completion

Of the 18 participants enrolled, 67% (n=12) of the cases closed within the fiscal year, while the rest (n=6) carried into FY 24/25.

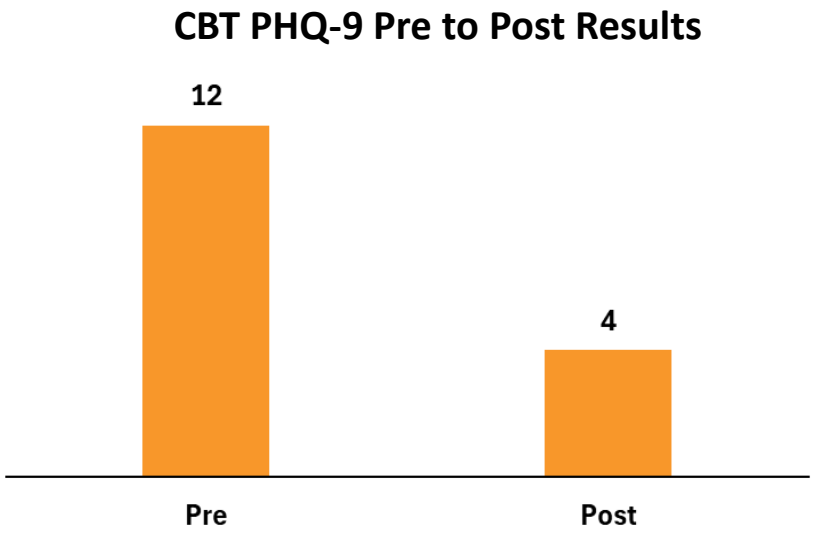


Outcomes CBT for Late Life Depression

Patient Health Questionnaire-9 (PHQ-9) Pre & Post Results

Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. This shorter test is derived from the original and longer PHQ assessment that addresses multiple mental health concerns including depression, panic disorder, anxiety, sleep disorders, and others. Each item is scored on a scale of 0-3, ranging from the least severe clinical response to the most severe clinical response.

The PHQ-9 is scored by summing the ratings for the 9 items. A total score of 0-4 is considered as having minimal levels of depression—generally describing those, whose scores fall within the range, as 'non-depressed.' A total score of 5-9 indicates symptoms of mild depression; a total score of 10-14 indicates symptoms of moderate depression; a total score of 15-19 indicates symptoms of moderately serve depression; and a total score of 20-27 indicates symptoms of severe depression.



Of the 12 participants with closing dates in FY 23/24, 75% (n=9) completed pre and post PHQ-9 measures. The pre and post PHQ-9 scores among participants showed on average a statistically significant (p <0.05) decrease in depression symptoms from the beginning to the end of the program. On average, participants reported experiencing moderate symptoms of depression at the beginning of the program (pre PHQ-9 score of 12), to experiencing minimal symptoms of depression by the end of the program (post PHQ-9 score of 4).

Table 7: ***Score Interpretation for PHQ-9***

Score Range	Depression Symptoms
0-4	Minimal symptoms of depression
5-9	Mild symptoms of depression
10-14	Moderate symptoms of depression
15-19	Moderately Severe symptoms of depression
20-27	Severe symptoms of depression

Outcomes CBT for Late Life Depression

Quality of Life Survey

The Quality of Life (QOL) survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on their social behavior, activities, physical/emotional health, etc.—all aspects that CBT for Late Life Depression is directed at improving. Thus, this survey provides very relevant information on outcomes considering the goals of the program. The QOL Survey is rated on a scale of 1-7, with higher ratings indicating more positive results.

A total of 8 participants who had enrolled in the Embedded Staff's CBT-LLD program, completed both pre and post QOL surveys. For 76.9% of items (n=10), participants' scores significantly increased in the QOL survey items. There were significant improvements reported in how participants felt about the amount of time they spend with other people, the amount of friendship in their lives, and about their emotional well being (*See Table 8*). For items four and six, there was noticeable improvement from pre to post however it did not reach statistical significance.

Table 8: ***ESOOA & PE/CBT Quality of Life Results***

Quality of Life Survey Items (n=8)	Pre	Post
1. How do you feel about your life in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.125**	**5.125**
2. How do you feel about the amount of relaxation in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.375**	**5.375**
3. How do you feel about the things you do with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.5**	**6**
4. How do you feel about the amount of time you spend with other people? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	3.75	5.125
5. How do you feel about the people you see socially? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4**	**6**
6. How do you feel about the amount of friendship in your life? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	5.25	5.875
7. How socially active would you say you have been in the past month? (1=None; 2=A little; 3=Fairly Active; 4=Quite Active; 5=Very Active; 6=Extremely Active)	**2.375**	**3.875**
8. In general how would you say your health is? (1=Poor; 2=Fair; 3=Good; 4=Very Good; 5=Excellent)	2.875	3.25
9. How do you feel about your health in general? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**4.375**	**5.25**
10. How do you feel about your physical condition? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.75**	**5**
11. How do you feel about your emotional well-being? (1=Terrible; 2=Unhappy; 3=Mostly Dissatisfied; 4=Mixed; 5=Mostly Satisfied; 6=Pleased; 7=Delighted)	**3.125**	**5.125**
12. How much bodily pain have you had during the past month? (1=Very Severe; 2=Severe; 3=Moderate; 4=Mild; 5=Very Mild; 6=None)	**2.625**	**4**
13. In the past month, how much has your physical/emotional health interfered with your normal social activities with family, friends, neighbors or groups? (1=Extremely; 2=Quite a bit; 3=Moderately; 4=Slightly; 5=Not at all)	**2.75**	**3.875**

BOLD Numbers indicate statistically significant ($p < 0.05$) change Pre to Post.

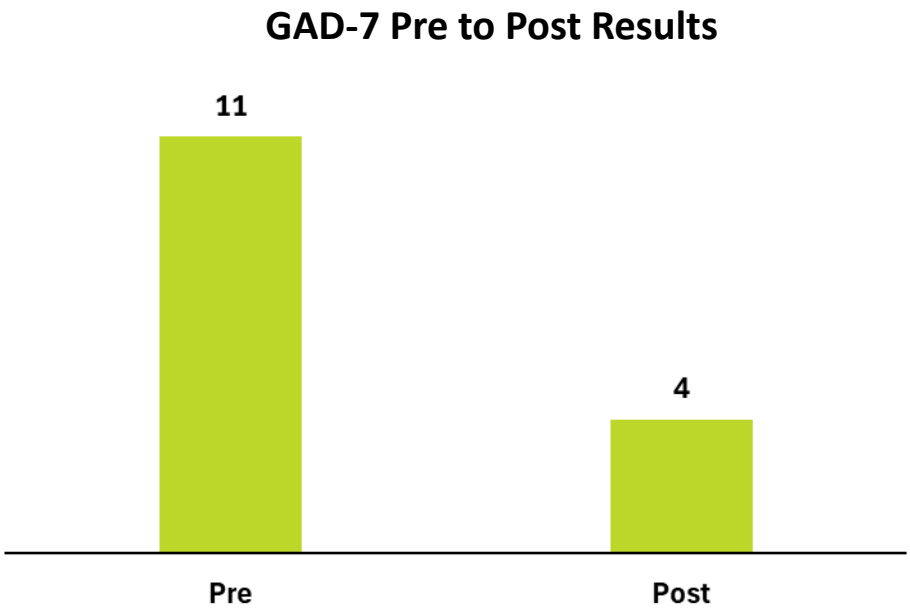
Outcomes CBT for Late Life Depression

GAD-7 Measure

The General Anxiety Disorder-7 (GAD-7) measures generalized anxiety disorders and assesses its severity. The GAD-7 measures participants' symptoms of anxiety with seven questions that ask participants to rank the degree to which, over the last two weeks, they had been bothered by: feelings of nervousness, irritability, fear, and restlessness; not being able to control worrying; and trouble relaxing.

The questions are ranked on a 0 to 3 point scale:

"0" = not at all, "1" = several days, "2" = more than half the days, "3" = nearly every day



A total of 8 participants completed both a pre-test GAD-7 survey at the beginning of the program and a post-test GAD-7 survey at the end. Countywide, participants experienced a statistically significant reduction in anxiety symptoms, with their average pre-test GAD-7 score of 11 (indicating moderate anxiety) decreasing to an average post-test score of 4 (within the minimal anxiety range).

Table 9: ***Score Interpretation for GAD-7***

Score Range	Level of Anxiety Severity
0-4	Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

Discontinuance Summary

Out of the 12 cases closed within the fiscal year, there was a total of 10 participants for which MH liaisons submitted a discontinuance form. For the remaining 2 participants it was necessary to use the electronic health record to determine discontinuance reasons. The primary cited reason for discontinuance was 'Successfully completed treatment goals' (n=6, 50%). The remaining participants (50%) discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially referred for further treatment.

Table 10: *ESOOA CBT Discontinuance*

Reason For Discontinuance (N=12)	n	%
Successfully Completed Treatment Goals	6	50%
Referred for further Tx	2	17%
Unable to Contact	1	8%
Client Withdrew	2	17%
Moved out of Area	1	8%

Satisfaction Survey

A total of 8 participants completed satisfaction surveys with Embedded Staff. Participants gave positive ratings to all items of the survey, with 'good' ratings given to their feelings of satisfaction and support received from the program and gaining coping strategies.

Embedded Staff Satisfaction Items & Results (N=8)	Avg	1	2	3	4	5	*m
1. How would you rate the quality of service you have received from your practitioner? (Excellent=4; Good=3; Fair=2; Poor=1)	**4.00**	-	-	-	100%	-	-
2. How satisfied are you with the support you have received from this program? (Very Satisfied=4; Mostly Satisfied=3; Mildly Dissatisfied=2; Quite Dissatisfied=1)	**3.88**	-	-	13%	88%	-	-
3. Did this program help you to cope better? (Almost all of my needs have been met=4, Most=3, Only a few=2, None=1)	**3.50**	-	-	50%	50%	-	-
4. Did you gain strategies to help you cope? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-		100%	-	-
5. Did you gain strategies to help you improve your quality of life? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.88**	-	-	13%	88%	-	-
6. Has participation in the program reduced your depression symptoms? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**3.63**	-	-	38%	63%	-	-
7. Would you say, as a result of the program, you now know how to get help for depression? (Yes, Definitely=5; Yes, I think so=4; Not sure=3; No, I don't think so=2; No, Definitely not=1)	**4.38**	-	-	-	63%	38%	-
8. If you were to seek help again, would you return to this program? (Yes, Definitely=4; Yes, I think so=3; No, I don't think so=2; No, Definitely not=1)	**4.00**	-	-	-	63%	-	38%
***missing data**							

Participant Comments:

- *It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much. [Translated from Spanish]*
- *The program is good, I would recommend it [Translated from Spanish]*
- *The program helped me. I liked that [Therapist] understood me and helped me to cope with my problems. I am grateful for the program*
- *[Therapist] has been a great help for me. A am very comfortable with her & opening up to her*
- *I like the support and will continue to look for BH as needed*
- *I was satisfied with this program, it helped me a lot. [Translated from Spanish]*

CareLink/Healthy IDEAS Program

Program Type: Prevention Program

CareLink is a care management program for older adults who are at risk of losing placement in their homes due to a variety of factors. This program includes the implementation of the Healthy IDEAS (Identifying Depression Empowering Activities for Seniors) model. Healthy IDEAS is a depression self-management program that includes screening and assessment, education for clients and family caregivers, referral and linkages to appropriate health professionals, and behavioral activation and is most often provided in the home.

One hundred fifty-one participants were enrolled in CareLink during FY23/24 Fiscal Year. Twenty-three CareLink participants were identified as being at risk for depression and were enrolled into the Healthy IDEAS program. The majority (65%) of Healthy IDEAS participants were between the ages of 50 and 79. Depression symptoms for Healthy IDEAS participants showed a statistically significant decrease. In addition, participants' satisfaction with their emotional well-being increased. Most of the participants of HealthyIDEAS report a lower CES-D score upon completion and have an overall improved outlook on life with effective coping skills learned and reinforced during the program. CareLink participants reported they were satisfied with many aspects of the program. Participants reported home visits and telephone contacts as being the most helpful features of the program. CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful.

23 Older Adults enrolled in Healthy Ideas

Participants' depression symptoms significantly decreased.

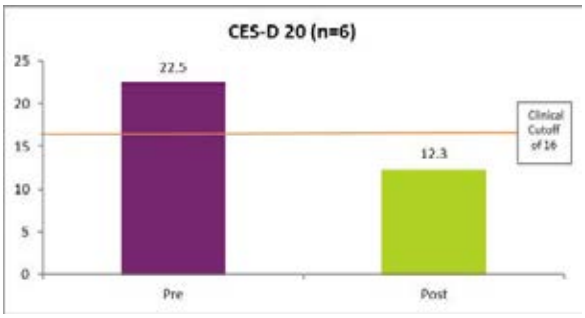
Implementation challenges continue with finding appropriate clients for the intervention that meet prevention requirements of new onset of depression/anxiety, a score 16 or above on the CES-D, are not currently receiving treatment i.e. therapy or meds, have no recent history of treatment, are willing to participate when they do score 16+ on the CES-D, and are cognitively able to participate.

We have learned that giving presentations to induction classes for new social workers at the Department of Social Services (DPSS) is not fruitful in obtaining referrals as the new employees are overwhelmed with all the new information they are receiving and are a month or so away from seeing clients to refer. We are now scheduling periodic check-ins with DPSS units to remind them of Office on Aging programs, highlighting and emphasizing HealthyIDEAS. Another lesson learned this year is homelessness does not preclude participation in HealthyIDEAS. In the past, when someone was homeless, they would not even be considered for enrollment in case management or HealthyIDEAS. Having an existing client become homeless while in service gave us an opportunity to try the program and it was successful.

Results from satisfaction surveys indicate participants' satisfaction with the amount of time they spend with other people and how they feel about their health in general increased. The greatest improvement was seen in the participants' knowledge of how to get help for depression, how

they felt about their life in general, and the amount of relaxation time they had. A couple of success stories are shared here:

One client, a newly widowed 85-year-old female who was the primary caregiver for her husband until he died, had an initial score of 30. She was grieving and had withdrawn from many of the activities she was formerly involved in, including Bible study at her church. Her goal was to address her grief. The HealthyIDEAS practitioner found a grief support group that the client began attending. The client had previously attended Care Pathways as a caregiver and had some follow-up after-care group sessions. She incorporated what she learned in Care Pathways regarding self-care and continued to build upon those skills to cope with her grief. She stated that Care Pathways had "saved her life." Toward the end of the HealthyIDEAS sessions, she had resumed attending Bible Study at her church and had a post CES-D score of 12. She looked forward to spending time with her son and grandchildren over the holidays and is planning to tackle a kitchen remodel that she has been wanting to do for several years.



A second client is a 60-year-old male, who became homeless shortly after enrolling in Carelink case management. His goal was to obtain permanent housing. He worked closely with the HealthyIDEAS practitioner and the homeless shelter staff at Path of Life to follow through with the application process and things he needed to do to get housed. When discouraged, he was reminded of how much he had accomplished with the social worker. He obtained permanent housing in mid-December. He expressed appreciation for the HealthyIDEAS intervention, as well as the Path of Life shelter staff, and now feels comfortable reaching out for help when he needs it, something he would never have done in the past.

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors)
Annual Report FY 2023-2024

Program Overview

The Riverside County Office of Aging (OOA) with MHSA Prevention and Early Intervention (PEI) funding, implemented an evidenced-based practice to reduce the risk of depression and suicide among older adults throughout Riverside County. Under a Memorandum of Understanding (MOU) with the Riverside University Health System—Behavioral Health (RUHS--BH), the OOA integrated the Healthy IDEAS (**I**dentifying, **E**mpowering, **A**ctivities for **S**eniors) program into their existing CareLink case management program. The intent of the CareLink Prevention and Early Intervention Initiative was to embed the Healthy IDEAS program into the existing CareLink case management program with the goal of preventing premature institutionalization of functionally impaired adults and the frail at risk elderly. CareLink provides care management as well as comprehensive information and assistance services. The Office on Aging trained their staff to implement the Healthy IDEAS model intervention to clients receiving case management services. State funding supporting the original CareLink program was withdrawn; and with the inclusion of PEI, the primary focus shifted to individuals at risk for mental health concerns such as depression and anxiety. Literature supports that adults dealing with functional loss, chronic illness, grief and loss issues, or psycho/social stressors, if not already in the early stages of depression, are at greater risk for depression. Frail older adults and disabled adults are screened through the OOA Information and Assistance Intake Center for Care Management. In addition, individuals referred to the CareLink program receive screening for depression. Those individuals that qualify for CareLink and meet screening criteria for depression receive the additional Healthy IDEAS program services.

***Outcomes Evaluation* Measures**

Outcomes evaluation measures for Healthy IDEAS included the use of tools provided by the developers of the evidenced based practice. The CES-D 20 depression measure and a quality of life survey were used to measure outcomes.

The Centers for Epidemiological Studies-Depression Scale-20 (CES-D 20) measures depression symptoms. The measure is administered at the beginning and at the conclusion of program services.

The Healthy IDEAS Quality of Life Survey measures quality of life and participation in social activities. The survey is administered at the beginning and at the end of the program. The post questionnaire includes additional items on satisfaction with the Healthy IDEAS program.

Executive Summary

Demographics

One hundred fifty-one participants were enrolled in CareLinks during 2023-2024 Fiscal Year. Twenty-three CareLink participants were identified as being at risk for depression and were enrolled into the Healthy IDEAS program. The majority (65%) of Healthy IDEAS participants were between the ages of 50 and 79. Healthy IDEAS participants were mostly White (48%) and Hispanic/Latino (39%).

Services

Healthy IDEAS participants had an average of 4.8 sessions and received an average 8.6 hours of service. A little over a quarter (26%) of clients completed the program in FY2023-2024. Some participants (n = 7, 30%) were not closed during the 2023-2024 fiscal year, and will carry over into FY2024-2025.

Healthy IDEAS Outcomes

Depression symptoms for Healthy IDEAS participants showed a statistically significant decrease. In addition, participants' satisfaction with their emotional well-being increased.

Care Link Satisfaction

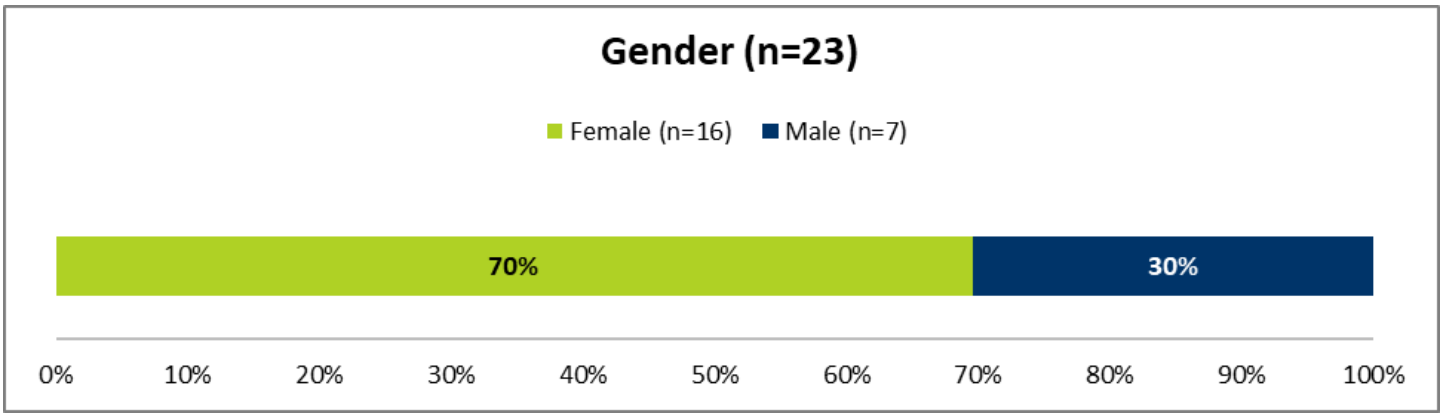
CareLink participants reported they were satisfied with many aspects of the program. Participants reported home visits and telephone contacts as being the most helpful features of the program. CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful.

Healthy IDEAS

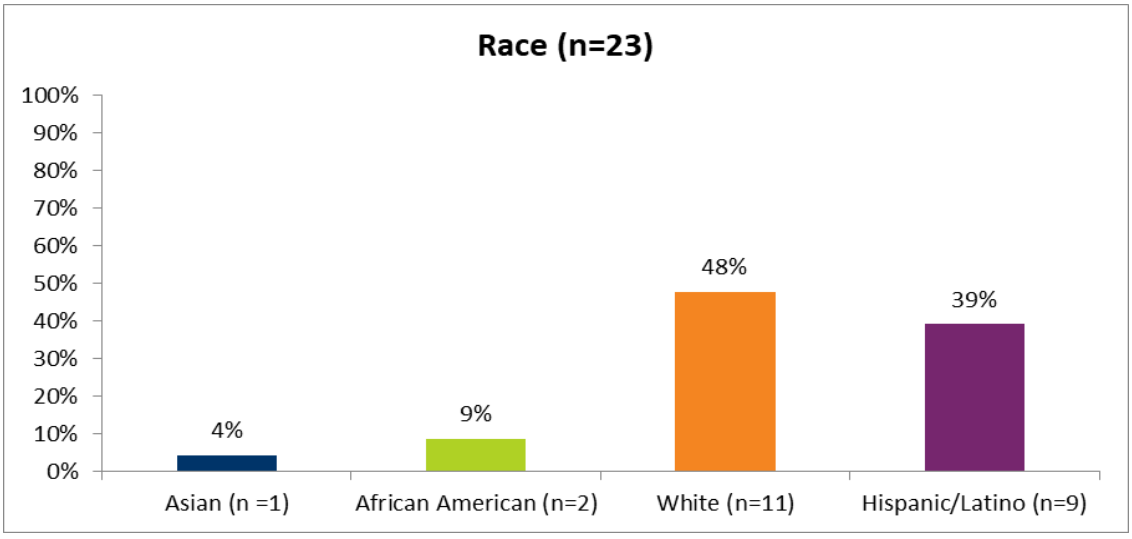
Healthy IDEAS (**I**dentifying **D**epression, **E**mpowering **A**ctivities for **S**eniors) is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives.

Demographics

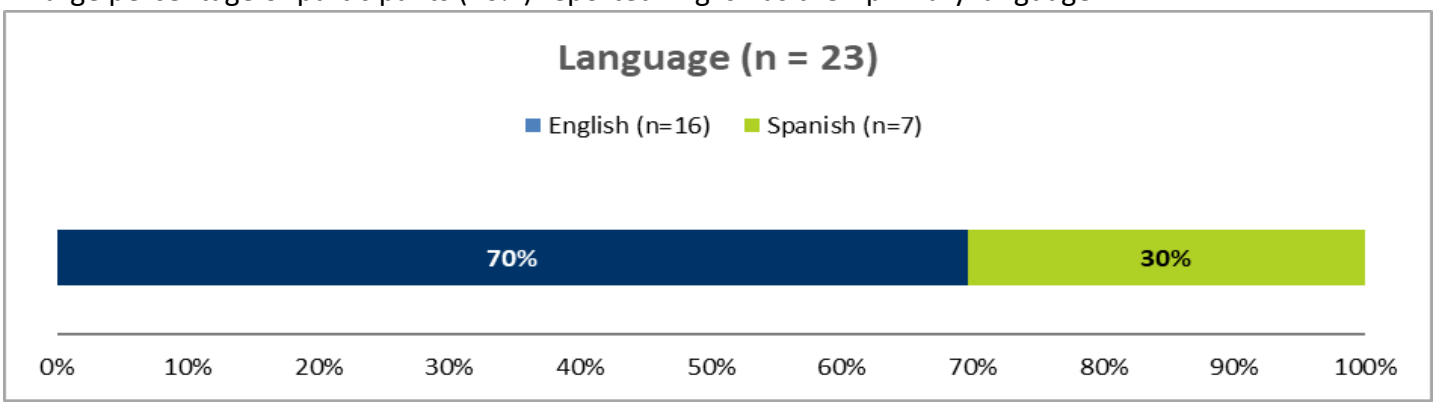
There were 151 Carelink clients during the 2023-2024 fiscal year. Twenty-three (23) Carelink clients met the screening criteria for depression and were enrolled into Healthy IDEAS program. More females than males participated in the Healthy IDEAS program.



The majority of Healthy IDEAS participants (48%) were either White or Hispanic/Latino (39%).

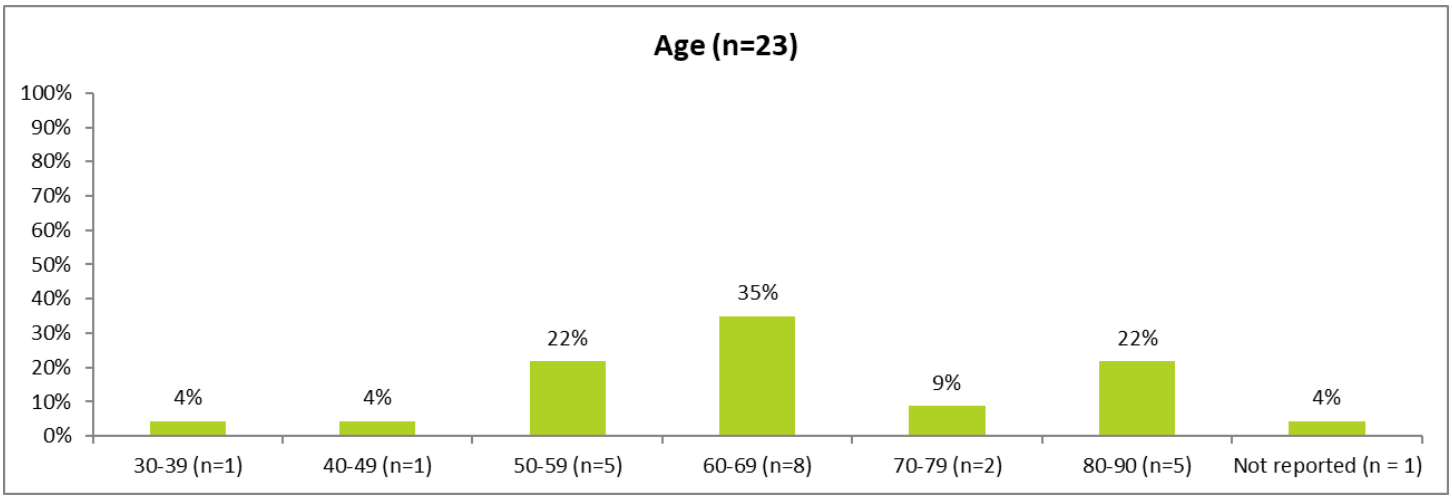


A large percentage of participants (70%) reported English as their primary language.



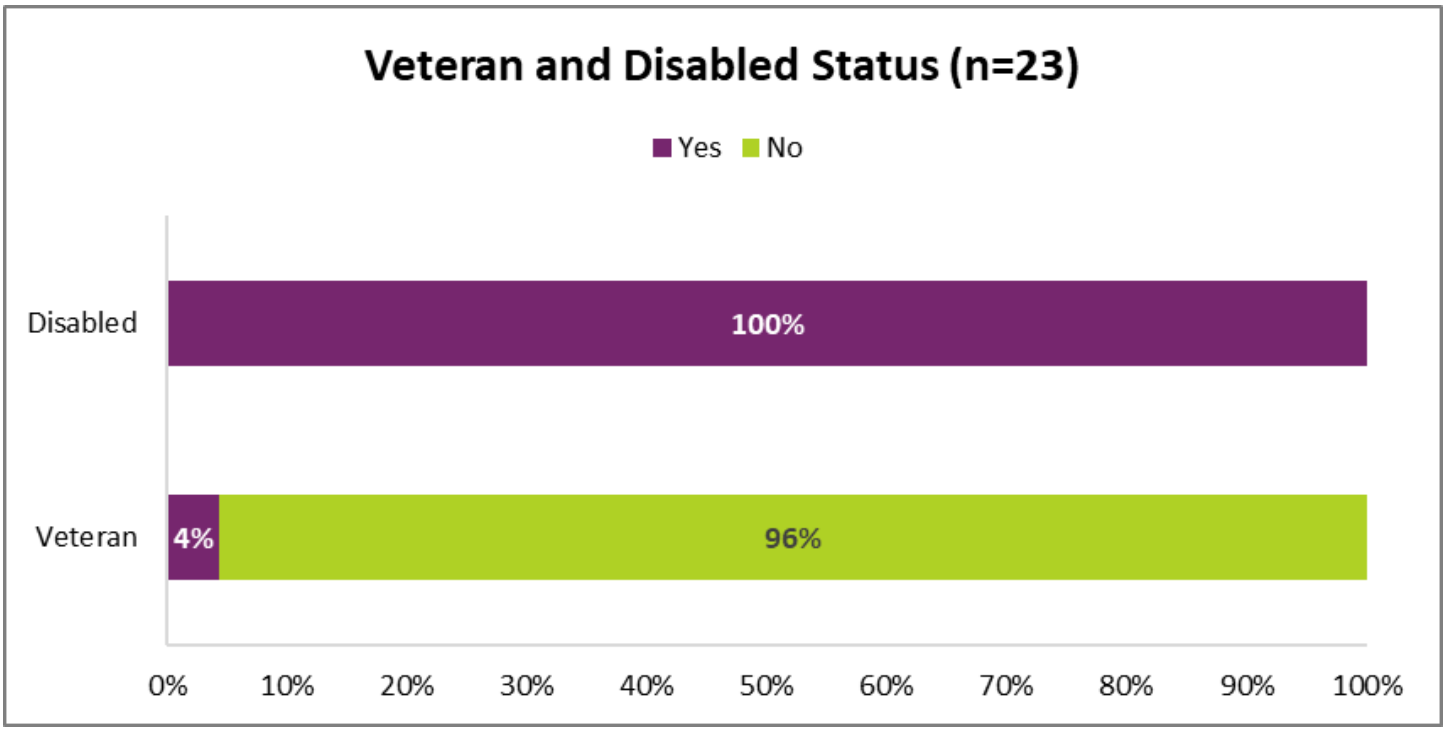
Demographics (cont.)

The majority of participants (83%) were between the age of 50 and 89 at the time of program entry. The average age of participants was 68.

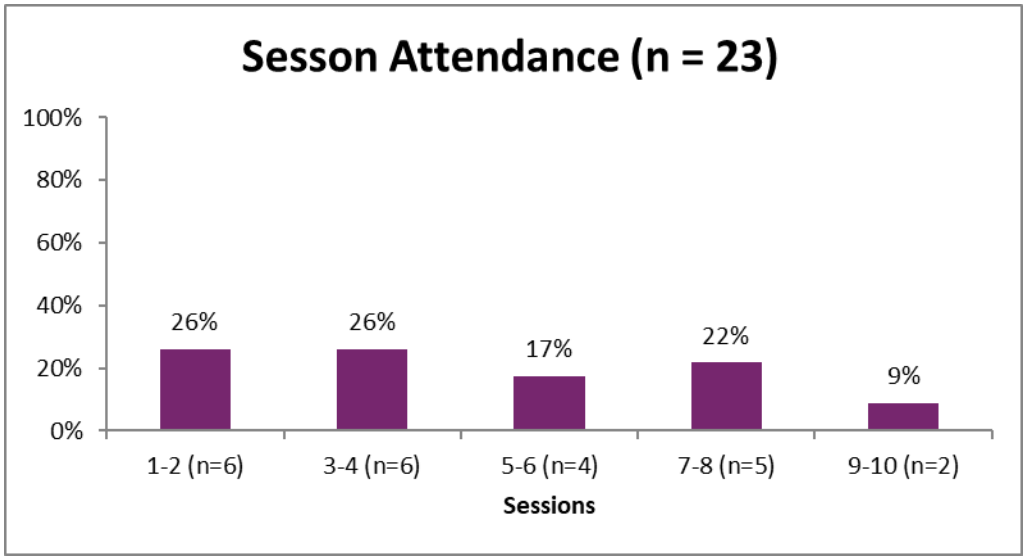


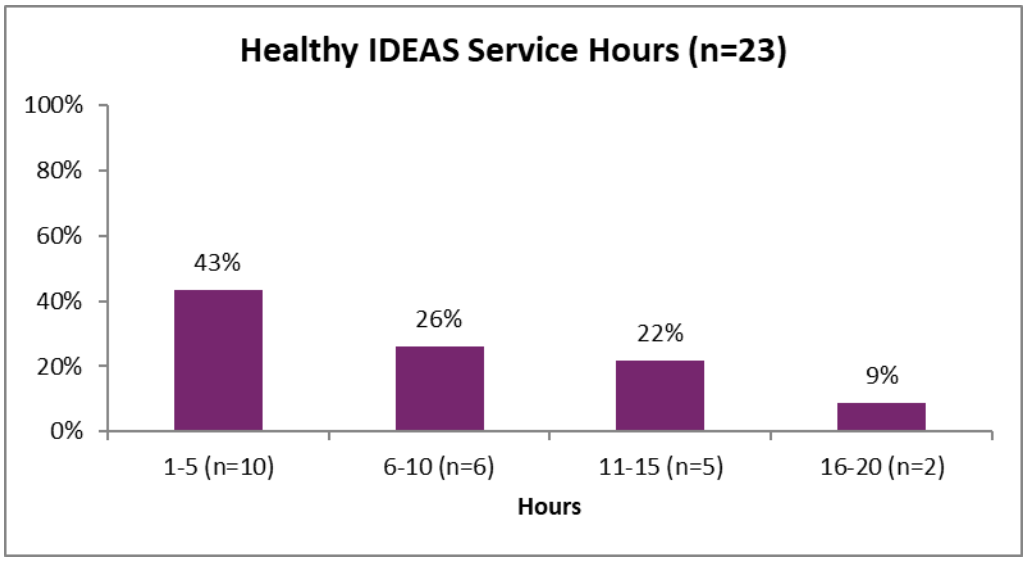
Participants were asked to report if they had a disabling condition. All participants reported having a disabling condition.

Participants were also asked to report their status as a veteran. Four (4%) percent of the participants in the 2023-2024 fiscal year reported being a veteran.



Clients attended an average 4.8 Healthy IDEAS sessions and received an average of 8.6 service hours.





Program Completions

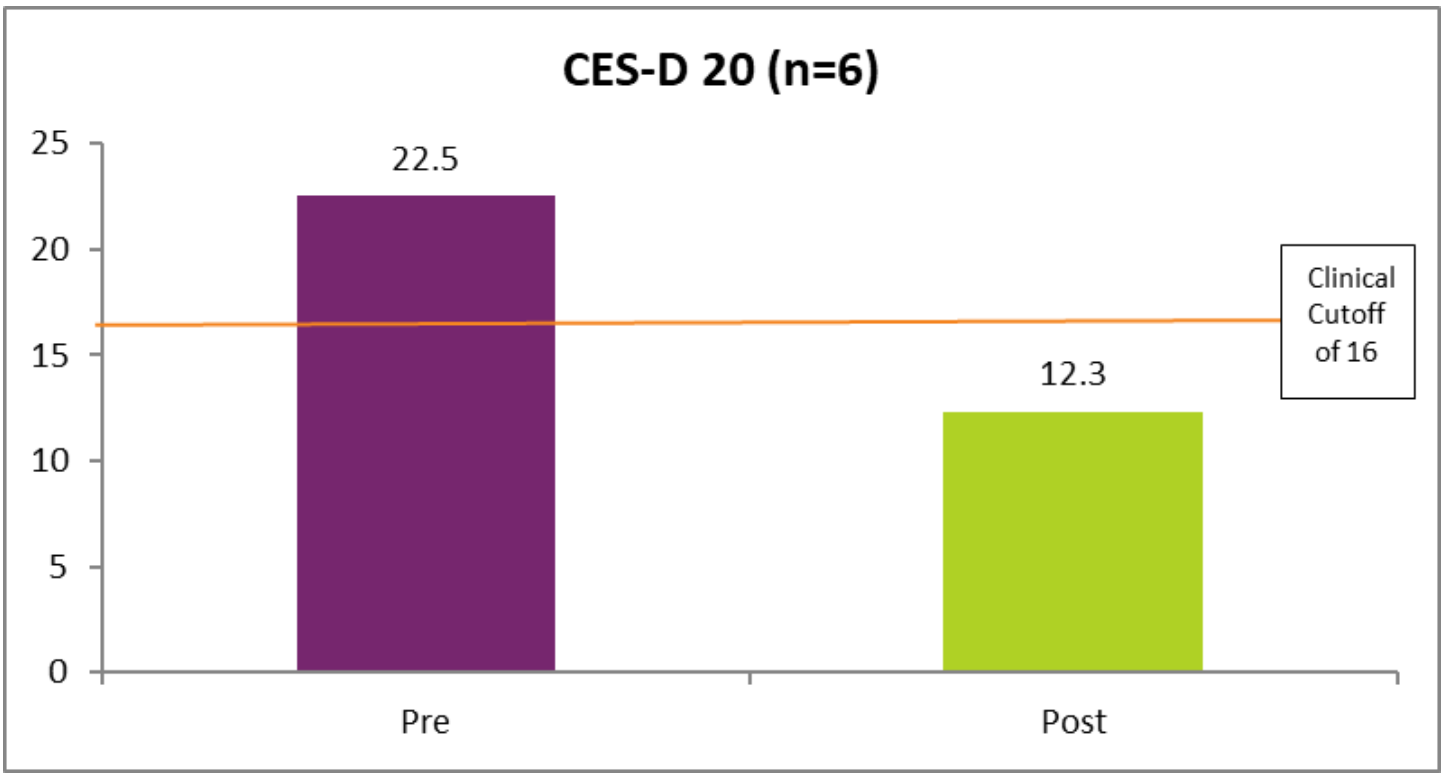
Of the 23 participants enrolled in Healthy IDEAS, 6 (28%) completed the program and 10 closed without completing. Some participants were still open at the end of the fiscal year (n = 7, 30%) and will carry over into the next fiscal year.

Disposition (n=23)		
Completed	Closed	Open
6 (26%)	10 (43%)	7 (30%)

CES-D 20

The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item scale that was developed by the National Institute of Mental Health. Respondents select from four possible responses in a Likert format, where “0” is “rarely or none of the time (less than 1 day)”, and “4” is “almost or all of the time (5-7 days)”. Scores range from 0 to 60 with higher scores reflecting greater levels of depressive symptoms, while lower scores reflect lower levels of symptoms. A score of 16 or greater suggests a significant level of psychological distress. However, It does not necessarily mean that the participant has a clinical diagnosis of depression. In a general population, about 20% would be expected to score in this range.

There was a 45% decrease in depression scores from pre to post.



Quality of Life Survey

The Healthy IDEAS survey is administered at the beginning of and at the conclusion of program. The survey includes general quality of life items, knowledge concerning accessing resources for depression, and questions on participation in social activities. The table below shows the average pre to post ratings on the Healthy IDEAS survey.

1-No,definitely not; 2-No, I don't think so; 3-Not Sure; 4-Yes, I think so; 5-Yes,definitely	Average Rating	
	Pre	Post
1. Would you say you know how to get help for depression? (n=5)	2.6	4.6

1-Poor; 2-Fair; 3-Good; 4-Very Good; 5-Excellent	Average Rating	
	Pre	Post
2. In general, how would you say your health is? (n=5)	4.6	5.0

1-None; 2-A little; 3-Fairly Active; 4-Quite Active; 5-Very Active; 6-Extremelly Active	Average Rating	
	Pre	Post
3. During the past month which statement describes how socially active you have been? (n=5)	4.8	5.0

1-Terrible; 2-Unhappy; 3-Mostly Dissatisfied; 4-Mixed; 5-Mostly Satisfied; 6-Pleased; 7-Delighted	Average Rating	
	Pre	Post
4. How do you feel about your life in general? (n=5)	3.6	5.4
5. How do you feel about the amount of relaxation you have? (n=5)	4.2	5.8
6. How do you feel about the way you spend your spare time? (n=5)	5.8	6.0
7. How do you feel about the way things are in general between you and your family? (n=5)	5.6	6.0
8. How do you feel about the amount of time you spend with other people? (n=5)	2.0	2.8
9. How do you feel about the amount of friendship in your life? (n=5)	3.6	4.6
10. How do you feel about your emotional well-being? (n=5)	2.6	3.8
11. How do you feel about your health in general? (n=5)	4.0	4.6

Participants' satisfaction with the amount of time they spent with other people and how they feel about their health in general increased. The greatest improvement was seen in the participants' knowledge of how to get help for depression, how they felt about their life in general, and the amount of relaxation time they had.

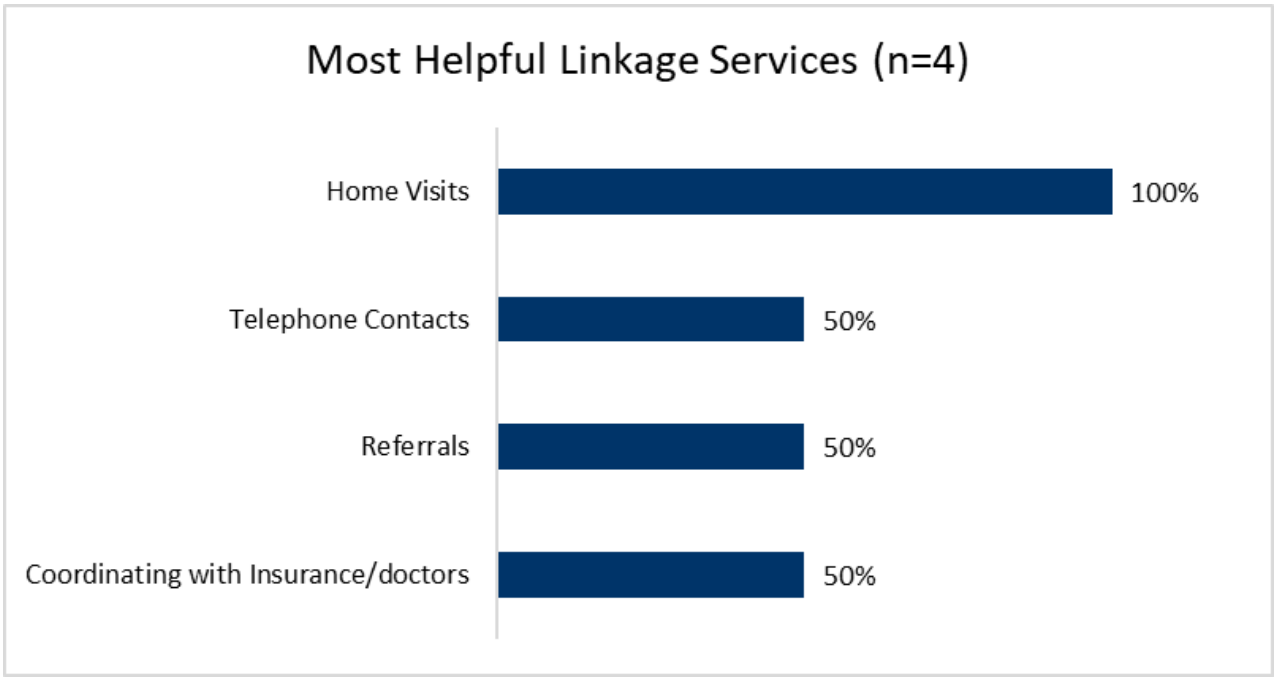
Healthy IDEAS Satisfaction Survey

Satisfaction items were collected for those participants enrolled in Healthy IDEAS and closed from the program. Participants reported that the most helpful aspects of the program were the home visits, phone contacts, and coordinating with insurance or doctors. The majority of those participating in the CareLink/Health IDEAS program reported that the program helped to reduce their depression symptoms and helped them to function better. All of the participants said they would recommend Healthy IDEAS to friends.

n = 6	No, Definitely Not (1)	No, I don't think so (2)	Not Sure (3)	Yes, I Think so (4)	Yes, definitely (5)
Has participating in the care link program helped you	-	-	-	1 (17%)	5 (83%)
Would you say the program activities in which you participated helped to reduce your depression symptoms?	-	-	-	2 (33%)	4 (67%)

CareLink Satisfaction

CareLink participants reported they were satisfied with many aspects of the program. All of the participants reported home visits to be the most helpful part of the program. Other helpful services included: telephone contacts, referrals, and coordinating with insurance companies or doctors.



CareLink participants reported that the CareLink staff were courteous, efficient, caring, knowledgeable, respectful, accessible, and helpful. Participants were pleased with the quality of service that they received from the program and would recommend the program to a friend.

Please grade the CareLink staff on the following items:	A	B	C	D
Courteous	100%	-	-	-
Efficient	100%	-	-	-
Caring	100%	-	-	-
Knowledgeable	100%	-	-	-
Respectful	100%	-	-	-
Accessible	100%	-	-	-
Helpful	100%	-	-	-

n = 4	No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
Recommend CareLink to friend?	-	-	-	100%

n = 4	Poor	Fair	Good	Excellent
Quality of service received	-	-	33%	67%

n = 4	Quite Dissatisfied	Mildly Dissatisfied	Mostly Satisfied	Very Satisfied
Satisfaction with CareLink	25%	-	-	75%

PEI-06 Trauma-Exposed Services

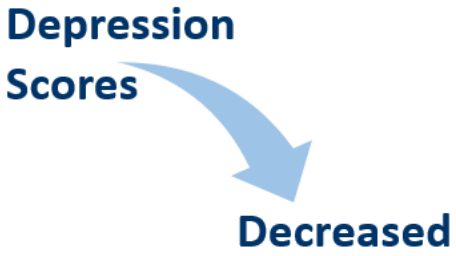
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Program Type: Prevention Program

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce the duration and harmful effects of trauma for youth (ages 10-15 years) most at risk of developing mental health problems as a result of direct and/or indirect traumatic experiences. CBITS aims to increase resiliency and the development of coping strategies for program participants, reduce symptoms resulting from exposure to traumatic experiences, and reduce the need for ongoing services within the mental health system. Four providers were contracted to provide CBITS services. Eligible youth who decide to enroll in the program receive ten group sessions and one to three individual sessions in the school setting. For the purposes of Prevention and Early Intervention (PEI), completion of the program was defined as attending 8 or more sessions. In addition, parents and guardians participate in two educational sessions with the clinician. CBITS uses cognitive-behavioral techniques, including psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure to help children reduce symptoms related to traumatic experiences and depression.

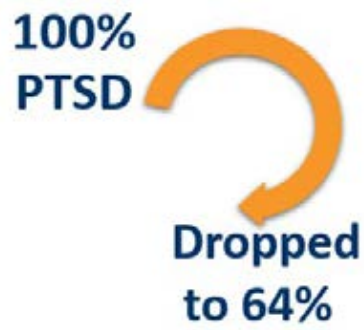
Grades 5-10th 313 students enrolled in CBITS, 84% completed

CBITS had a high program completion rate during FY 23/24. Countywide, there were 313 students enrolled in the program. 263 students completed at least 8 sessions, for a completion rate of 84%! Intake data showed that 62% of participants had witnessed physical trauma and 79% had someone close to them die. Most youth reported multiple types of traumas. Baseline PTSD symptom scores indicated that all participants were at or beyond the 14-point threshold exhibiting moderate to severe PTSD at the beginning of the program. This percentage decreased to 64% by the end of the program. While only 36% of youth showed a decrease to below the cutoff score of 14, overall, 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score. Students are reporting experiencing additional trauma exposures/stressful events during the course of the program, which might explain why PTSD symptoms do not decrease as much as would be expected. CDI-II average scores showed that depression symptoms improved with total CDI-II scores countywide decreasing. Additionally, CDI-II average scale scores for Emotional Problems and Functional Problems decreased. Countywide, the total score and each CDI-II scale score showed statistically significant decreases in symptoms.



PEI

Partnerships with individual school sites across districts served allowed the processes for screening and implementation to be improved. There were fewer hiccups with scheduling space at schools, getting consents back from families, and having passes sent for students to attend group. As new staff are onboarded into agencies, they are trained quickly by a PEI Admin staff that is a certified trainer in this model, which ensured there was no disruption to service delivery. Overall, staffing was stable across all providers during the program year. Providers were able to deliver service at new school sites during the program year, broadening the reach of the program across districts. Caregiver engagement continues to be a challenge across regions and providers. Providers have offered Caregiver Education Sessions in a variety of modalities, languages, locations, and times. Incentives have been offered as another means to increase attendance/participation but did not yield increased participation as hoped. There was an increase in the severity of trauma exposure and PTSD symptoms. There were many more students that needed additional support for crisis assessments and CPS reports throughout the course of the program year. These all added to increased feelings of stress and compassion fatigue for program facilitators.



Continuing to nurture relationships with school partners, whether services are facilitated year-round or only part of the school year, is critical to program success. It helps with making sure all the processes from confirming space, pulling students, screening, and getting consent move smoothly and do not cause delay/disruption in the timeline. When planning the calendar for the group schedule, advanced preparation for combining sessions when there isn't enough time for all 10 weeks of program, it is best to combine sessions at the end of group. Providers were able to increase the number of schools that are receiving the CBITS program. Schools have been more receptive to mental health services overall, helping to destigmatize help-seeking behaviors.

72% of youth agreed or strongly agreed that the program taught them how to better cope with stress. 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future. Participants are given the opportunity to provide feedback at the completion of the program.

Students had the following to say about participating in the program:

- "I learned how to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
- "I learned how to think more logically about my bad thoughts. Finally talking about what's been going on has made me feel better. I've met people that made me feel safe when I speak about my problems."
- "The group leaders cared about us and listened to our feelings. I was able to learn multiple new ways to cope."
- "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."

Bounce Back

Program Type: Prevention Program

Bounce Back is an adaptation of the CBITS model for elementary school students (grades K-5). Community feedback and impacts from the pandemic highlight the need for trauma support to the elementary school population. The expansion of CBITS to include this adaptation in school settings increases access for youth where they are, improves their social-emotional development, and supports the school environment.

Bounce Back is a cognitive-behavioral, skills-based group intervention aimed at relieving symptoms of child posttraumatic stress disorder (PTSD), anxiety, depression, and functional impairment among elementary school children (ages 5-11) who have been exposed to traumatic events. It is used most for children who experienced or witnessed community, family, or school violence, or who have been involved in natural disasters, or traumatic separation from a loved one due to death, incarceration, deportation, or child welfare detainment. It includes 10 group sessions where children learn and practice feelings identification, relaxation, courage thoughts, problem solving and conflict resolution, and build positive activities and social support. It is designed to be used in schools with children from a variety of ethnic and socio-economic backgrounds and acculturation levels. It also includes 2-3 individual sessions in which children complete a trauma narrative to process their traumatic memory and share it with a parent/caregiver. Bounce Back also includes materials for parent education sessions.

This program was released through a competitive bid process in FY24/25. Once the program is implemented, outcomes will be included in the annual report.

Riverside University HEALTH SYSTEM Behavioral Health

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview and Providers

Program Overview and Providers

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce the duration and harmful effects of trauma for youth (ages 10-15 years) most at risk of developing mental health problems as a result of direct and/or indirect traumatic experiences. CBITS aims to increase resiliency and the development of coping strategies for program participants, reduce symptoms resulting from exposure to traumatic experiences, and reduce the need for ongoing services within the mental health system. Four providers were contracted to provide CBITS services:

- **Operation Safehouse (OSH)** was contracted to deliver the program in Western, Mid-County, and Desert regions of Riverside County. OS worked collaboratively with school districts and individual schools to identify and engage youth that would benefit from CBITS services.
- **Jurupa Unified School District - Behavioral Health (JUSD-BH)** was contracted to deliver the program in the Western region of Riverside County. JUSD-BH delivered the program to schools within the Jurupa Unified School District.
- **Special Services for Groups (SSG)** was contracted to deliver the program in the Western region of Riverside County. SSG delivered the program to schools within the Moreno Valley Unified School District.
- **Riverside County Latino Commission (RCLC)** was contracted to deliver the program in the Desert region of Riverside County. RCLC delivered the program to schools within the Coachella Valley Unified School District.

Prior to receiving services, participants are screened for trauma symptoms. Youth with a trauma symptom severity falling below the criteria threshold become ineligible for CBITS, where they are then referred to other services that better suit their needs. Eligible youth who decide to enroll in the program receive ten group sessions and one to three individual sessions in the school setting. For the purposes of Prevention and Early Intervention (PEI), completion of the program was defined as attending 8 or more sessions. In addition, parents and guardians participate in two educational sessions with the clinician. CBITS uses cognitive-behavioral techniques, including: psycho-education, relaxation, social problem solving, cognitive restructuring, and exposure to help children reduce symptoms related to traumatic experiences and depression.

Evaluation

Evaluation of program outcomes include measuring decreases in the frequency of trauma symptoms experienced by youth and decreases in depression symptomology. The following outcome measures were collected prior to the start and at the conclusion of group sessions (i.e. pre to post).

- Child Post-Traumatic Stress Disorder (PTSD) Symptom Checklist - This is the initial measure administered for determining eligibility into CBITS. It is a two part self-report assessment that identifies exposure to traumatic events and then measures the severity and frequency of the PTSD symptoms arising from those events. Scores are aggregated to yield a PTSD score, as well as scores on the re-experiencing, avoidance, and hyperarousal subscales.
- Children's Depression Inventory (CDI-II) - A self-report assessment that measures the severity of depression symptoms among youth. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems.

Executive Summary: Key Findings

Enrollment and Completion

A total of 313 youth participated in CBITS during the 2023-2024 FY with 84% completing the CBITS program. 50 participants did not complete the program. Of those who did not complete, eleven attended 5-7 sessions.

Demographics

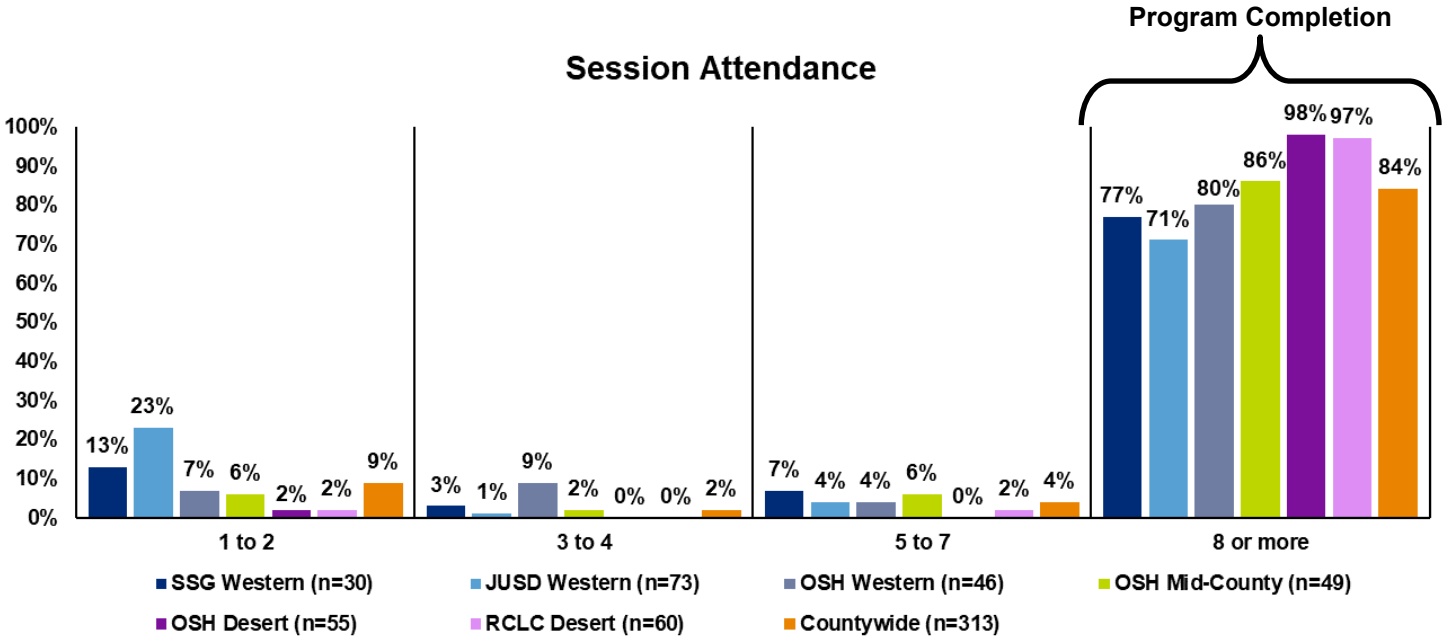
- Over half of participants were female (59%).
- Over two-thirds of the participants were Hispanic/Latinx (77%).
- English was the preferred language for 83% of participants.

Outcomes

- **Traumatic Symptoms Improved -** Intake data showed that 62% of participants had witnessed physical trauma and 79% had someone close to them die. Most youth reported multiple types of trauma. Baseline PTSD symptom scores indicated that all participants were at or beyond the 14-point threshold exhibiting moderate to severe PTSD at the beginning of the program. This percentage decreased to 64% by the end of the program. While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.
- **Depression Improved** - CDI-II average scores showed that depression symptoms improved with total CDI-II scores countywide decreasing. Additionally, CDI-II average scale scores for Emotional Problems and Functional Problems decreased. Countywide, the total score and each CDI-II scale score showed statistically significant decreases in symptoms.
- **Participants were satisfied with CBITS** - 72% of youth agreed or strongly agreed that the program taught them how to better cope with stress. 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future. Below are some participant comments on what they learned in the program:
    - “Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture.”
    - “How to stay calm during a scary situation. Or how to think twice before reacting to something.”
    - “How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident.”
    - “I learned that I’m not always alone in difficult situations and there is always someone that is here for me no matter what.”
    - “I learned that pushing away my problems will just make them harder to get through later.”
    - “I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need.”
    - “That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone.”

Enrollment and Completions

Enrolled was defined as having experienced a traumatic event, having a qualifying PTSD symptoms score of 14 or higher, and having attended at least 1 session. For FY2023-2024, countywide a total of 313 attended at least one group session in the CBITS program. Overall, 263 (84%) completed the program, defined as attending 8 or more sessions with completed outcome measures



Special Services for Groups (SSG) was contractually obligated to complete 48 participants within the Moreno Valley Unified School District. Jurupa Unified School District-Behavioral Health (JUSD-BH) was contractually obligated to complete 48 participants within the Jurupa Unified School District. Operation Safehouse (OSH) was contractually obligated to complete 48 participants in the Western region, 48 participants in the Mid-County region, and 48 participants in the Desert region from multiple school districts. Riverside County Latino Commission (RCLC) was contractually obligated to complete 48 participants within the Coachella Valley Unified School District. The table below details to what extent the providers met contract expectations for program completion based on how many participants completed the program.

Agency	Contract Expectations	Enrolled	Completed Program	% Contract Expectations
SSG Western	48	30	23	48%
JUSD-BH Western	48	73	50	104%
OSH Western	48	46	37	77%
OSH Mid-County	48	49	42	88%
OSH Desert	48	55	54	113%
RCLC Desert	48	60	57	119%
Countywide	288	313	263	91%

Meetings

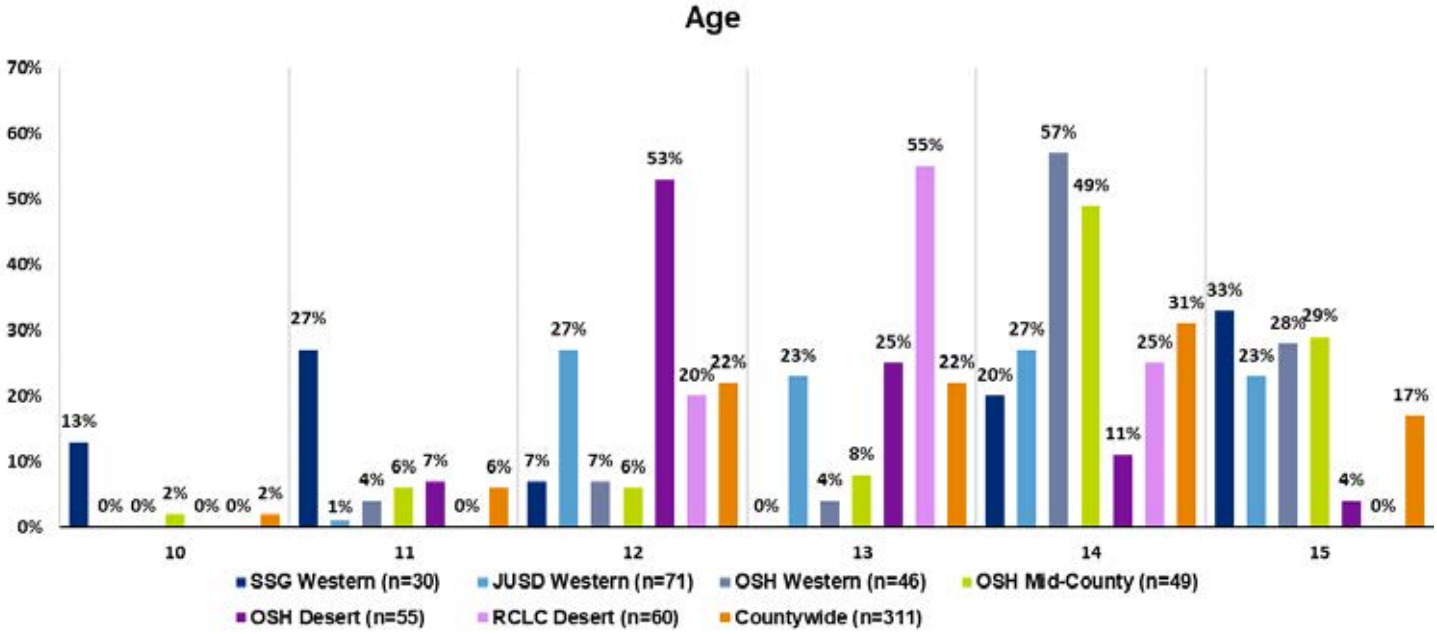
The program is designed to provide participants 1-3 individual sessions with a clinician. Additionally, parents/guardians and teachers are also given the opportunity to meet with the clinician for educational sessions. The parents/guardians are provided up to two meetings with the clinician, while teachers are provided one. The tables below show the documented student, parent/guardian, and teacher meetings with the clinicians.

Meetings	Individual Youth Meetings			
Agency	1 Meeting	2 Meetings	3 Meetings	No Meetings
SSG Western (n=30)	26	5	2	4
JUSD-BH Western (n=73)	55	28	2	18
OSH Western (n=46)	42	0	0	4
OSH Mid-County (n=49)	43	13	0	6
OSH Desert (n=55)	54	0	0	1
RCLC Desert (n=60)	58	7	0	2
Countywide (n=313)	278	53	4	35

Meetings	Parent Meetings			Teacher Meetings	
Agency	1 Meeting	2 Meetings	No Meetings	1 Meeting	No Meetings
SSG Western (n=30)	28	18	2	24	6
JUSD-BH Western (n=73)	57	0	16	68	5
OSH Western (n=46)	0	0	46	0	46
OSH Mid-County (n=49)	46	14	3	42	7
OSH Desert (n=55)	0	0	55	0	55
RCLC Desert (n=60)	60	20	0	60	0
Countywide (n=313)	191	52	122	194	119

Demographics

During the screening process or at the first class session, the participants are asked to complete a demographic questionnaire. This section will highlight the basic demographics of 311 participants since two participants did not share their demographics. The age distribution is shown below where the average age of participants was 13 years old.

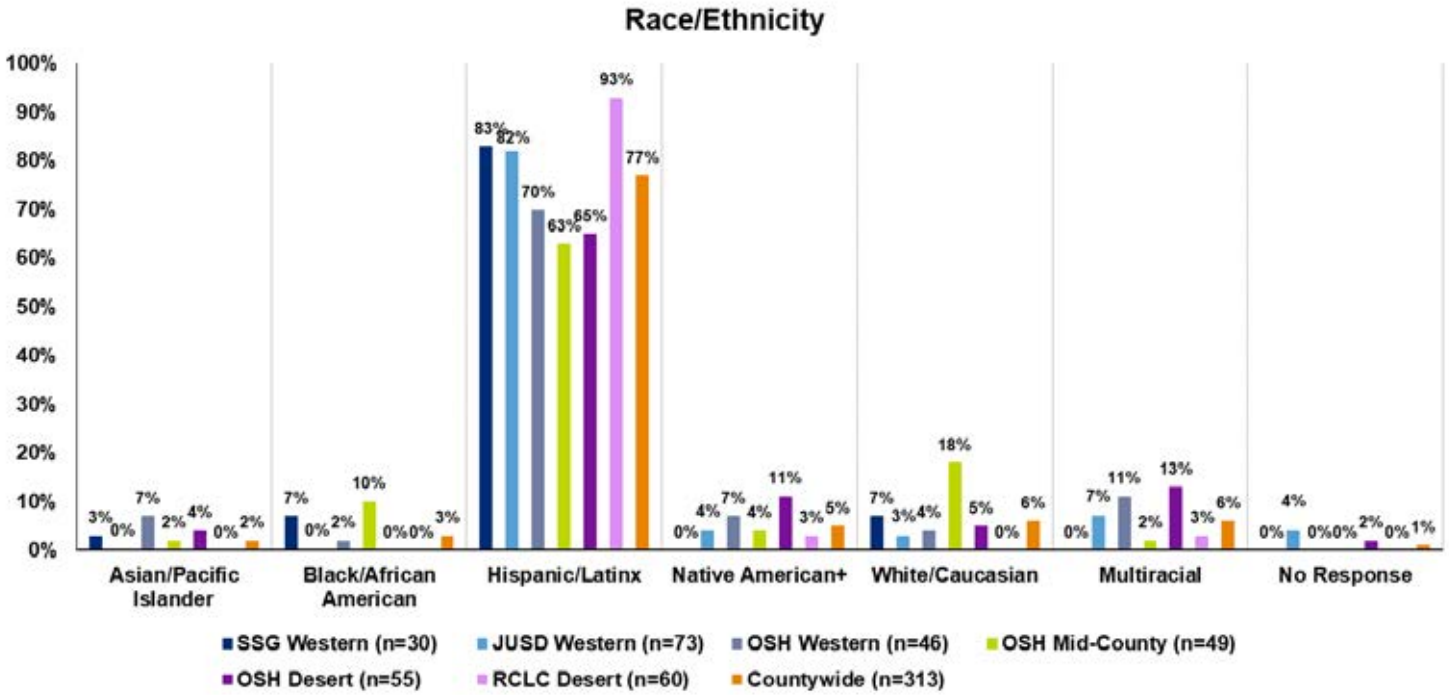


Grade level of participants was collected on the CDI-II measure. This measure is administered to youth when they enrolled in the program and at the end of the program. The participants were from 5th through 10th grade. The table below shows the grade level of the participants.

Grade Level							
Agency	**5th**	**6th**	**7th**	**8th**	**9th**	**10th**	**Not Reported**
SSG Western (n=30)	10	4	0	0	15	1	0
JUSD-BH Western (n=73)	0	0	36	2	33	0	2
OSH Western (n=46)	0	2	5	2	37	0	0
OSH Mid-County (n=49)	1	4	4	3	34	3	0
OSH Desert (n=55)	0	10	32	13	0	0	0
RCLC Desert (n=60)	0	0	21	39	0	0	0
Countywide (n=313)	11	20	98	59	119	4	2

Demographics cont.

Countywide, 77% of the program participants identified as Hispanic/Latinx, 6% White/Caucasian, 6% Multiracial/ethnic, 5% Native American (and one other race), 3% Black/African American, 2% Asian/Pacific Islander, and 1% was not reported.



Most participants reported their preferred language was English (83%), while 13% reported both English and Spanish, and six reported Spanish alone (2%).

Preferred Language				
Agency	**English**	**Spanish**	**English and Spanish**	**No Response**
SSG Western (n=30)	25	0	5	0
JUSD-BH Western (n=73)	54	0	15	4
OSH Western (n=46)	42	1	1	2
OSH Mid-County (n=49)	46	1	1	1
OSH Desert (n=55)	45	1	7	2
RCLC Desert (n=60)	47	3	10	0
Countywide (n=313)	259	6	39	9

Demographics cont.

Countywide, of the 313 participants in the CBITS program, 59% identified as female, 35% identified as male, eight identified as transgender, eleven identified as nonbinary, one as gender fluid, and two were not reported.

Gender						
Agency	**Female**	**Male**	**Trans**	**Nonbinary**	**Gender Fluid**	**No Response**
SSG Western (n=30)	16	9	2	3	0	0
JUSD-BH Western (n=73)	44	22	2	3	0	2
OSH Western (n=46)	29	17	0	0	0	0
OSH Mid-County (n=49)	37	9	2	1	0	0
OSH Desert (n=55)	29	22	1	3	0	0
RCLC Desert (n=60)	28	29	1	1	1	0
Countywide (n=313)	183	108	8	11	1	2

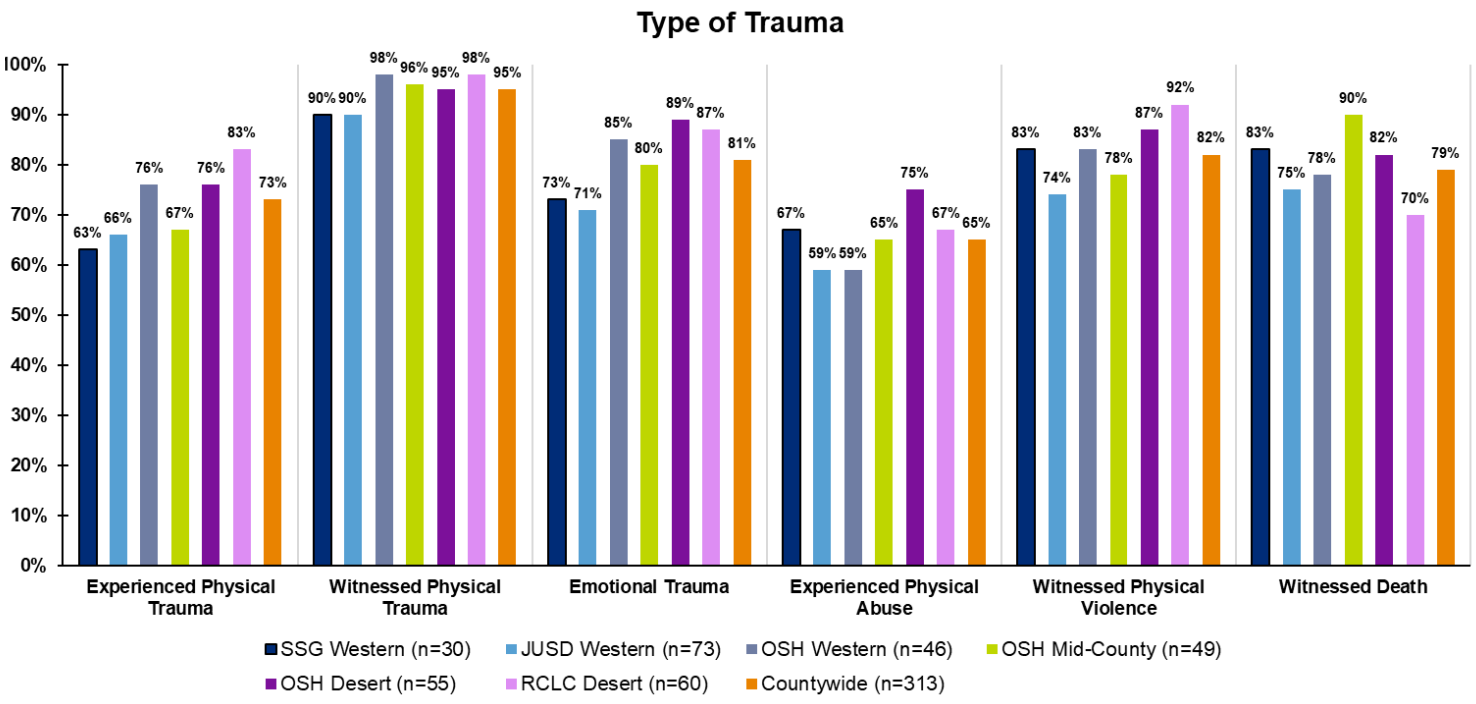
Countywide, 16% of youth indicated they were LGBTQ+ (n=51), while most of the participants (74%, n=231) reported they did not identify as LGBTQ+.

LGBTQ+								
Agency	**Lesbian**	**Gay**	**Bisexual**	**Pansexual**	**Yes**	**Asexual**	**Unsure**	**No Response**
SSG Western (n=30)	1	0	5	1	1	0	6	1
JUSD-BH Western (n=73)	0	1	4	2	4	0	3	7
OSH Western (n=46)	0	0	3	1	1	0	5	1
OSH Mid-County (n=49)	1	1	6	3	0	1	2	1
OSH Desert (n=55)	2	0	3	0	3	0	2	0
RCLC Desert (n=60)	0	0	4	0	3	0	2	1
Countywide (n=313)	4	2	25	7	12	1	20	11

Outcomes: Child Post Traumatic Stress Disorder (PTSD)

The Child Post Traumatic Stress Disorder (PTSD) Screener is used to assess exposure to traumatic experiences, as well as measure the severity of PTSD symptoms in participants exposed to trauma. The measure was used at the beginning and conclusion of the program to evaluate reductions in PTSD symptoms. The traumatic experience screener has 17 questions with a Yes/No format. If a youth answers 'Yes' to any one of these questions, this indicates exposure to a traumatic event and the youth then completes the second section. The second section measures the frequency and severity of PTSD symptoms the youth is experiencing and includes 17 questions. Higher scores indicate increased frequency and greater severity of post traumatic symptoms. The graph below displays the frequencies of trauma exposures, and the following page shows the severity of PTSD symptoms.

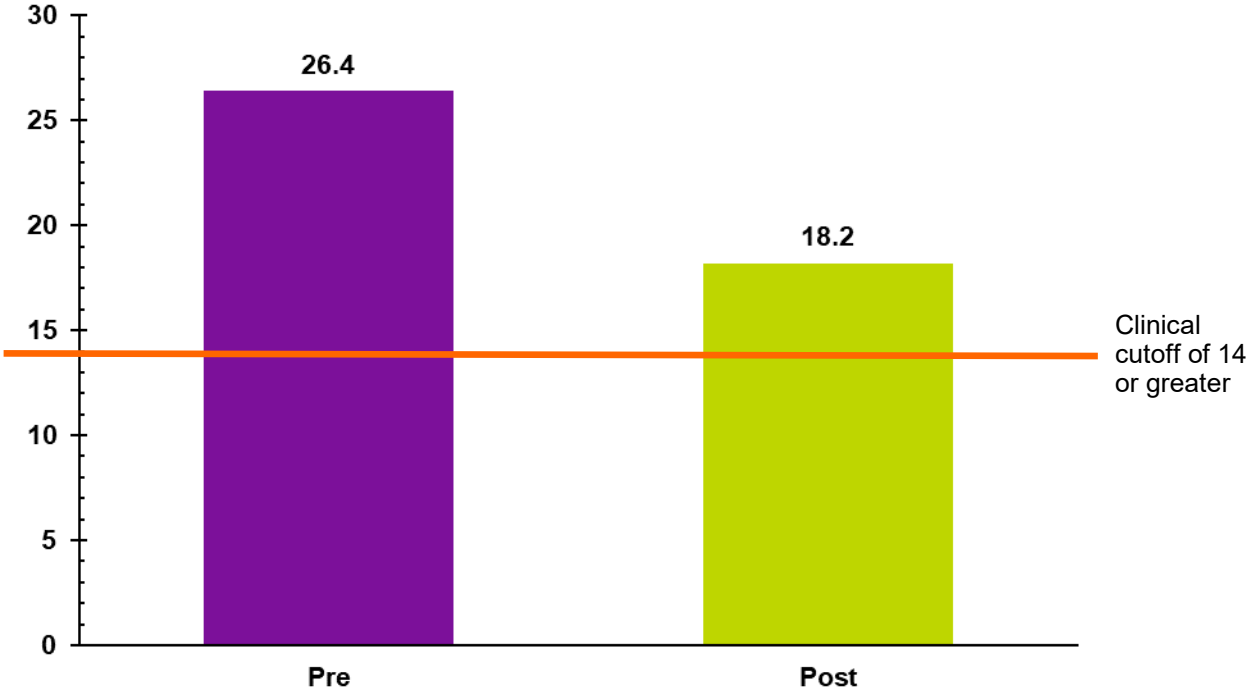
Out of the total 313 participants countywide, almost all of the participants witnessed physical trauma (95%, n=296), followed by witnessed physical abuse (82%, n=258), emotional trauma (81%, n=253), witnessed death (79%, n=247), experienced physical trauma (73%, n=227), and experienced physical abuse (65%, n=203).



Outcomes: Child Post Traumatic Stress Disorder (PTSD) cont.

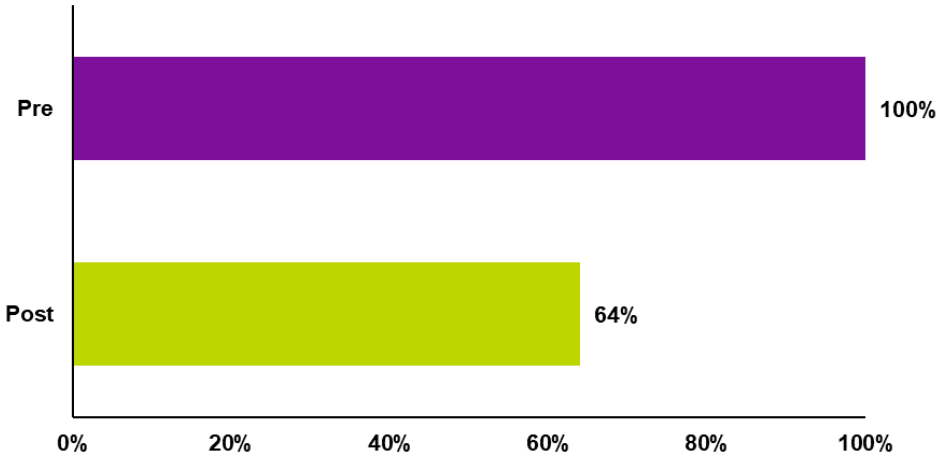
Analysis of the countywide PTSD symptom measure scores was performed on youth having both a pre and post measures, and at least 8 CBITS sessions. Scoring a 14 or higher on the Child PTSD Symptom Checklist indicates moderate to severe PTSD symptoms in the clinical range, represented by the red line in the figure below. Youth at the beginning of the CBITS program had, on average, high PTSD symptom scores above 14 points. After completing the program, youth average PTSD symptom scores showed a statistically significant decrease.

PTSD Symptoms Countywide (n=263)



Upon entering the program, 100% of youth countywide were at or above the 14 point clinical cutoff indicating moderate to severe PTSD. This percentage decreased to 64% by the end of the program (see below). While only 36% of youth showed a decrease to below the cutoff score of 14, overall 78% of youth who completed the program showed a decrease in their total Child PTSD Symptom Checklist score.

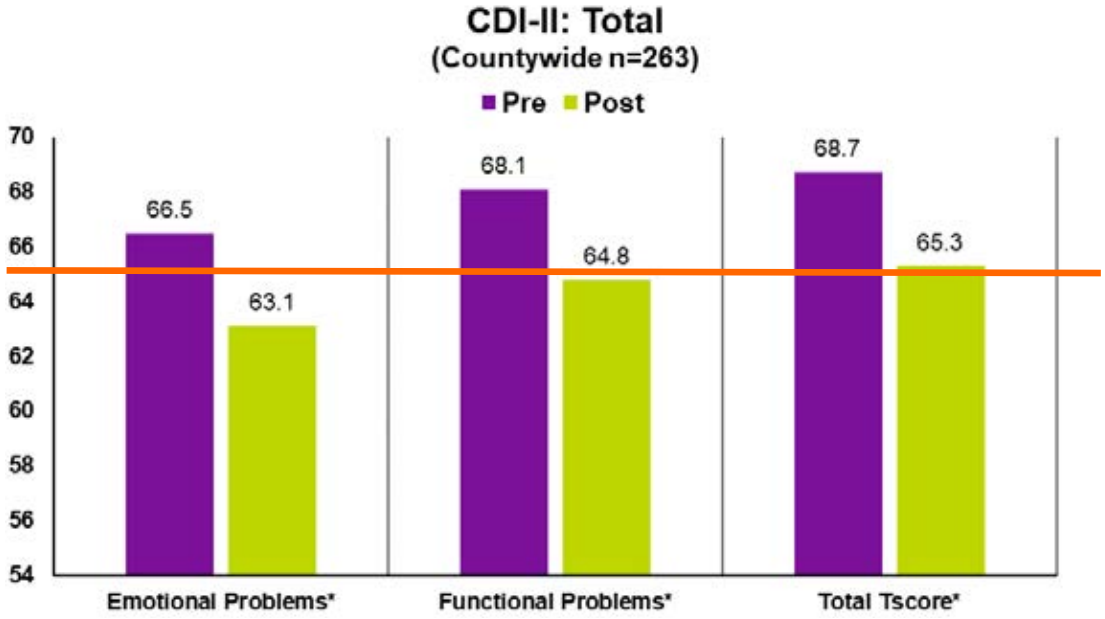
Participants with PTSD Countywide (n=263)



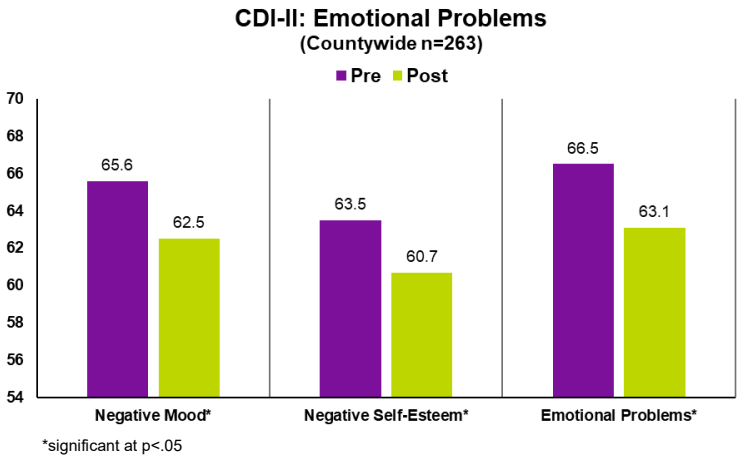
Outcomes: Children's Depression Inventory (CDI-II)

The Children's Depression Inventory 2nd edition (CDI-II) is used to measure the severity of depression symptoms in children. It is a self-reported assessment that program participants complete, both at the beginning and at the conclusion of the program. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems. Each question or 'item' has three different sentence descriptions. The participant marks which of the 3 sentences best describes them. Higher scores suggest higher depression symptomology. The raw scores for each child's CDI-II is plotted on a scoring grid and converted to a T-score. The T-score reflects how a child's score compares to other children of similar age and gender. T-scores greater than 65 are clinically significant (represented by the line on the graph below), meaning the youth meets criteria for clinical intervention.

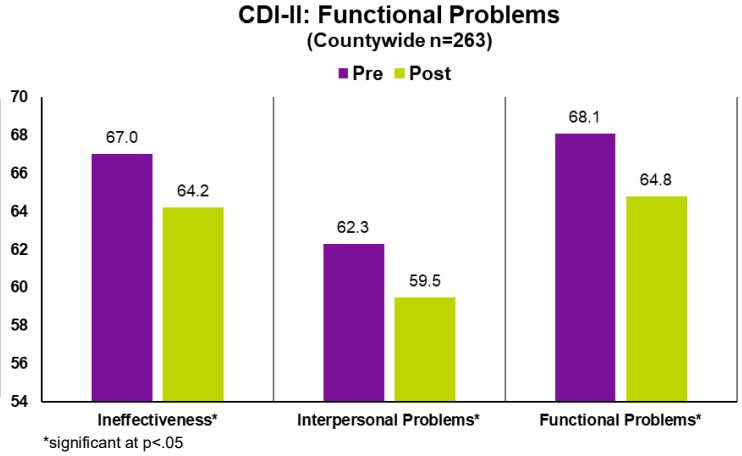
Analysis was based on participants who completed both a pre and post CDI-II measure and attended at least 8 CBITS sessions. On average, CBITS participants' total scores were above the clinical cutoff of 65 at intake (68.7) and decreased at post (65.3). Scores decreased across all scales and subscales, where paired-samples t-tests revealed statistically significant changes in average scores from pre- to post-test. Additionally, the total score demonstrated a statistically significant decrease.



*significant at p<.05



*significant at p<.05



*significant at p<.05

Outcomes: Children's Depression Inventory (CDI-II) cont.

CDI-II Total scores, Emotional Problems and Functional Problems scales, and their respective subscales scores varied by region and provider. Below are tables showing the scores from pre- to post-tests for each region by provider.

CDI-II Scores by Provider in the Western Region of Riverside County									
	SSG Western			JUSD-BH Western			OSH Western		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	23	70.4	65.6	50	68.9	65.8*	37	66.6	64.0
Emotional Problems	23	67.1	64.2	50	64.1	60.6*	37	65.9	62.7
Negative Mood	23	66.7	63.7	50	66.7	62.1*	37	65.5	62.3
Negative Self-Esteem	23	63.1	62.0	50	64.0	60.8	37	61.7	60.0
Functional Problems	23	70.0	63.7	50	67.3	65.7	37	66.5	63.1
Ineffectiveness	23	67.6	62.3	50	66.6	65.1	37	64.4	61.5*
Interpersonal Problems	23	68.0	61.4	50	61.3	60.0	37	62.3	60.0

*Significant at p<.05

CDI-II Scores by Provider in the Mid-County and Desert Regions of Riverside County									
	OSH Mid-County			OSH Desert			RCLC Desert		
Scales and Subscales	n	Pre	Post	n	Pre	Post	n	Pre	Post
Total	42	67.8	63.4*	54	71.3	70.2	57	67.5	62.5*
Emotional Problems	42	64.9	61.3	54	69.4	67.9	57	64.5	59.6*
Negative Mood	42	63.7	60.4	54	68.4	67.4	57	63.2	59.5*
Negative Self-Esteem	42	62.5	59.9	54	66.1	65.1	57	62.9	56.9*
Functional Problems	42	67.9	63.0*	54	69.8	68.7	57	67.5	63.2*
Ineffectiveness	42	66.3	62.8	54	68.7	67.6	57	67.4	63.7*
Interpersonal Problems	42	62.9	58.2*	54	63.4	62.9	57	59.5	55.8*

*Significant at p<.05

Satisfaction Surveys

Countywide, 260 participants completed the satisfaction survey. They were asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey.

Coping with Stress

- 72% of youth agreed or strongly agreed that the program taught them how to cope with stress.
- 77% of youth agreed or strongly agreed that the program has prepared them to cope with stress if something difficult happens in the future.

Personal

- 64% of youth agreed/strongly agreed that the program helped them to understand themselves better.
- 55% of youth agreed/strongly agreed that they achieved their goals for the group.
- 69% of youth agreed/strongly agreed that they will use what they learned in the program in their life.

Group Leaders

- 90% of youth agreed or strongly agreed that the leaders listened to what they had to say.
- 82% of youth agreed or strongly agreed that the leaders knew how to help them.

Question	Avg.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Response
The program taught me how to cope with stress. (n=258)	3.94	4 (1.5%)	4 (1.5%)	64 (24.6%)	**118 (45.4%)**	68 (26.2%)	2 (0.8%)
The program helped me to understand myself better. (n=257)	3.82	7 (2.7%)	14 (5.4%)	69 (26.5%)	**95 (36.5%)**	72 (27.7%)	3 (1.2%)
The program has prepared me to cope with stress if something difficult happens to me in the future. (n=259)	4.07	2 (0.8%)	10 (3.8%)	46 (17.7%)	**110 (42.3%)**	91 (35.0%)	1 (0.4%)
I achieved my goals for the group. (n=254)	3.73	4 (1.5%)	15 (5.8%)	**91 (35.0%)**	80 (30.8%)	64 (24.6%)	6 (2.3%)
The group leaders listened to what I had to say. (n=257)	4.58	1 (0.4%)	4 (1.5%)	17 (6.5%)	59 (22.7%)	**176 (67.7%)**	3 (1.2%)
The group leaders knew how to help me. (n=258)	4.32	2 (0.8%)	8 (3.1%)	34 (13.1%)	76 (29.2%)	**138 (53.1%)**	2 (0.8%)
I will use what I learned in the program in my life. (n=257)	4.00	3 (1.2%)	12 (4.6%)	62 (23.8%)	85 (32.7%)	**95 (36.5%)**	3 (1.2%)
I would recommend the program to a classmate. (n=255)	4.26	4 (1.5%)	11 (4.2%)	35 (13.5%)	70 (26.9%)	**135 (51.9%)**	5 (1.9%)

Note: Some participants completed an older version of the survey which had only the first six questions on the satisfaction survey (n=3).

Satisfaction Survey: Comments

Participants were also asked what they learned from the program, what they liked about the program, as well as what they disliked about the program. Below are some comments from the participants.

What Participants Learned…

- "#1: How to deal with Stress #2: How to talk with People #3: Calming down an angered Person."
- "A small game for to relax/distraction or whenever not in a good mindset (name colors, characters, shows, etc) they were simple and not to hard to remember."
- "Coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture."
- "Finding someone to talk to if I need someone to hear me out, dealing with stress, and not overthinking."
- "Hot Seat - helpful other thoughts; Feelings Thermometer; Breathing Exercises; Thoughts, Actions, and Emotions Triangle."
- "How to calm myself down and how to deal with tough situations I may have in the future."
- "How to calm myself down when needed and become more social. I also learned how to understand myself better."
- "How to comfort others, make solutions to my problems, and how to be respectful when someone is sharing trauma."
- "How to communicate how you feel and not bottle it up."
- "How to control myself in hard situations."
- "How to cope with stress and express myself to people."
- "How to cope with stress, how to use different strategies to calm down and just how to have a better mindset in general."
- "How to cope, and think before I do anything dumb."
- "How to focus during a stressful time like breathing."
- "How to stay calm during a scary situation. Or how to think twice before reacting to something."
- "How to take bad thoughts and make them into helpful thoughts."
- "How to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
- "How to understand myself, how to cope with stress. (I learned how to understand myself, how to handle my stress, and how to react in a difficult situation.)"
- "I didn't really learn anything I just talked about stuff that happened in the past."
- "I learned how to handle stress and how to solve it in the future."
- "I learned how to tell people how I feel."
- "I learned how to think more logically about my bad thoughts. Finally talking about what's been going on has made me feel better. I've met people that made me feel safe when I speak about my problems."
- "I learned that even though people look happy they have a hard past."
- "I learned that I could control how I feel."
- "I learned that if you are having a stress full time to talk to people and using strategies to help you"
- "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."
- "I learned that pushing away my problems will just make them harder to get through later."
- "I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need."
- "I learned way of coping which was really good. I learned what to do when I don't feel good and very thankful for it."
- "I'm not alone in my experiences. That there's people like me going through similar things."
- "Nothing really helped me."
- "That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone."
- "The steps of thinking something out before resorting to a negative thought/finding the positive in things."
- "To always deal with problems and not to avoid them"
- "To focus on yourself and that you yourself matter and ways to not think bad all the time and ways to calm yourself down if you ever feel scared or stressed."

Satisfaction Survey: Comments

What Participants Learned…cont.

- "To not kill myself"
- "To talk out my problems with a person that is trust worthy."
- "To think positive, facing my fears, and trying to solve the problems without fighting."
- "Ways to calm myself, Think and Question my thoughts."
- "We all have the same problems and we learned how it comes out in us."
- "We aren't the same all around."
- "We have to deal with trauma now."
- "What to do when I feel bad or stressed."
- "When there is a fight Leave from it"
- "You cant be afraid about everything and you can over come it."

What Participants Liked…

- "100% of it"
- "A break from some classes that stress me."
- "Being able to see how I can control myself and my emotions."
- "Being with a friend and food."
- "Every body was nice and so hope-full and helpful. Every one was patient with me."
- "Every one shared stories, We laughed and shared"
- "Everybody was very welcoming and they were very positive and wanted to hear what we had to say."
- "Everyone listened to what I had to say, everyone was so kind and funny, and helped me understand others go through things too."
- "Everything, This group was awesome."
- "Having the chance to meet everyone here and learning about them."
- "Hot seat-change way of thinking, Food, Other Students
- "How I could be comfortable with telling people about my problems, how you can feel safe talking about stuff."
- "How it was fun and relatable."
- "How it was very easy to become friends with the others and that the leaders always had time for us to speak."
- "How kind and understanding the leaders are. I really liked the group because my leaders made it fun and not scary."
- "How the group leaders listen people in the group give good compliments /or responses to your incident."
- "How to calm down and breath in and out"
- "How understanding they are being patient and be considerate towards the situations and advice (helpful majorly)"
- "I could share what Ive been through and no one can Judge because we've all been through the same situations."
- "I felt connected with everyone in a way"
- "I felt like I matter"
- "I got to be heard and understood by people who went through similar situation."
- "I got to have a laugh with everyone, and had a great time. Learned things to help me."
- "I learned how to deal with my stress."
- "I like how everyone was under standing and open minded."
- "I like that we learned how to deal with stressful situations."
- "I like the teachers and how I made friends"
- "I liked about the program is the copius amount of candy and hearing about how other people felt."
- "I liked how I feel like I can talk about anything and they listen and give great advice about what I can work on to become better."
- "I liked how I was able to help my stress go away."

Satisfaction Survey: Comments cont.

What Participants Liked…cont.

- "I liked how nice the teachers were and how I learned many things."
- "I liked it I was kinda glad in a way that I'm not the only one that goes threw bad stuff and it was helpful"
- "I liked that I didn't feel like I was judged and that I could actually talk without worrying as much."
- "I liked that it was a nice break from school."
- "I liked that it was like a period where we were able to talk about our problems."
- "I liked that nobody judges you."
- "I liked that the group leaders were understanding they let every voice be heard. They were super nice and caring."
- "I understood that other students were kind of in the same situation as I was."
- "It was a big stress reliever."
- "If your upset they won't talk to you they will give you a sticky note asking if your okay and if you wanna talk."
- "It is good to talk out what you dont want anyone to know"
- "It teaches you how to cope with your trauma as well as see other peoples view of things that happen."
- "It was fun I got to eat donuts and enjoy Thursdays now."
- "Just talking about stuff that we don't normally talk about in school or class."
- "Showing us many skill we can use for the future."
- "That everybody listened, nobody judged me, or spread my info around school."
- "That the ladies are super nice and chill, the music is very relaxing, they let us use figet toys during a session. I feel safe."
- "That they helped me through tough places"
- "That when you were down they will bring you up."
- "That you don't feel alone and feel like there is someone there for you when you really need it."
- "The group leaders being Amazing & Awesome. I will always remember how great & Amazing they are. The solutions are helpful! makes me feel less alone."
- "The group leaders cared about us and listened to our feelings. I was able to learn multiple new ways to cope."
- "The snacks in all honestly but I liked getting to hear other experiences close to mine."
- "What I like about the Program is that they are nice, caring, very calm, and of course the snacks. I also love the stuff we do. Sometimes it helps just being in there and away from a class."
- "What I like about the program is that they give you confidence in yourself."
- "What I like was how we learned coping strategies but in a fun way."

What Participants Disliked…

- "At first I didn't like that I had to share about my life but I'm glad I did. Thank you."
- "Facing my problems."
- "Feeling like there just here for the money"
- "Forgot drinks twice"
- "Having to makeup the work that I missed because of the group."
- "Having to share thing that you don't want to."
- "Homework"
- "How long and what period it takes place in."
- "How quiet it is in each session."
- "I did not like how it was an 1hrs long."
- "I didn't get along/talk to anyone really."
- "I didn't like that I only really knew 1 person to hangout."
- "I didn't like that it was the same period, I don't like missing work."

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- “I didn't really get to speak with the other students.”
- “I didn't really have icks about it so I don't know.”
- “I didn't really like that people would hear about my situation, other than that I actually really liked it.”
- “I don’t have anything to say I liked everything from the program and it helped me.”
- “I don't like leaving class when I have to do something important.”
- “I don't like sharing about what happen.”
- “I felt different like my own opinion was not good.”
- “I got a little bored but the program is great.”
- “I honestly liked everything about the program.”
- “I honestly loved the program.”
- “I liked alot of things about this program I can't think of something that I didn't like about this program.”
- “I love this program their nothing to hate about it”
- “I loved everything there wasnt a single thing I didnt like.”
- “I Loved The Program.”
- “I was still scared I would get judged.”
- “It felt too long”
- “It requires me to come to school.”
- “It takes me out of class.”
- “It was a little silent through out the class.”
- “It was boring at points”
- “It was kind of short.”
- “It was my fault but being marked absent because I would forget to show my teachers my passes.”
- “Missing the same class period every week.”
- “Most of the people didn't take the program seriously. Felt like I was judged a bit.”
- “Not enough time”
- “Nothing I loved this group.”
- “Nothing I'm a miss this program for real”
- “Nothing its fun! & great for one of my friends.”
- “Nothing really. I just depends if it works for you or not.”
- “Nothing was bad about the program I would recommend.”
- “Nothing you guys were awesome.”
- “Probs the socializing but I got used to it.”
- “Sharing personal information.”
- “Some of the coping skills didn't really work for me.”
- “Sometimes it was in a class period I liked.”
- “Talking about most things that remind me of stress.”
- “Talking in front people.”
- “That I don't really feel comfortable and I don't really feel sure about telling them personal things.”
- “That it is not longer.”
- “That they reminded me about stressful things.”
- “The people don’t talk that much.”
- “The teacher would side eye me a lot.”

Satisfaction Survey: Comments cont.

What Participants Disliked…cont.

- “There is nothing wrong about this program it is a group to help you get throw the things are scared of or what happened to you.”
- “There isn't a thing I can say I hated because I honestly did enjoy the group.”
- “There was nothing I didn't like I think it would also help other people out.”
- “There's nothing I didnt like about the program except the asking question the personal question to much.”
- “There was a big gap that we didn't go.”
- “To be honest, I didn't dislike anything, everyone is so kind.”
- “To much writing.”
- “We didn't get to meet very often.”
- “What I didn't like about the program is the insermountable ways of trying to cope with stress that didn't work for me.”
- “What I didn't like about the program was that it's only for a short time.”
- “What I don’t really like is how we had to share. Yes I do understand why but I was very nervous.”
- “When People would laugh about something that wasn't funny.”
- “When we had to talk about our trauma but it wasn’t that bad.”
- “You had to talk about past events.”
- “We only get 30 minutes to stay.”

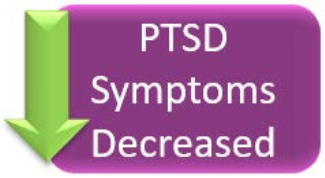
Seeking Safety

Program Type: Prevention Program

This is an evidence-based present-focused coping skills program designed for individuals with a history of trauma and substance abuse. It can be conducted in group or individual format, for female, male or mixed-gender groups, for people with both substance abuse and dependence issues, for people with PTSD, and for individuals with a history of trauma but do not meet the criteria for PTSD. The program addresses both the TAY and adult populations in Riverside County.

Seeking Safety served **154** participants with **79%** completed

In FY23/24, the program saw success in the continued partnerships and relationships that they have managed to build over the years. Operation Safehouse saw this with some school sites by being invited back by school counselors and receiving referrals. They were able to table and outreach at different school sites to cast a wide net for students to voluntarily sign-up. Additionally, they were able to partner with other programs within their organization to help increase referrals to the Seeking Safety program. The RUHS-BH PEI Peers also saw continuity of partnerships and expanding processes to be able to receive referrals. One of these partnerships is with the Sexual Assault and Forensic Evaluation (SAFE) Clinic. The provider was able to set up a referral system with this clinic and follow-up with victims of assault to screen and be able to provide this early intervention program for trauma.



There was a total of 249 individuals screened for this service. Of those, 154 participants went on to attend at least one session, and 79.2% (n=122) of those met the completion criteria by attending six or more sessions. Most participants were transition age youths between the ages of 16-25 (80.5%). Of all program participants, most of them identified as Hispanic/Latinx (74%), and a quarter of participants identified as LGBTQ+ (30.5%). After completion of the program, participants demonstrated decreases in PTSD symptoms and increases in positive coping skills. A challenge that was experienced by both providers was getting people enrolled in the program, particularly those that were in the older TAY demographic (ages 19-25) and adults (ages 26-59). When the use of an interest form was utilized, oftentimes team members were not able to contact those who filled out the form – being met with unresponsiveness to their follow-up calls/texts/emails. Across both programs, staffing was also a challenge. One of the providers underwent significant leadership changes, which contributed to staff in this program leaving for other opportunities. Onboarding and training new staff took additional time and took away from time spent on actual service delivery.

For services being provided on school campuses, the providers were met with unique challenges

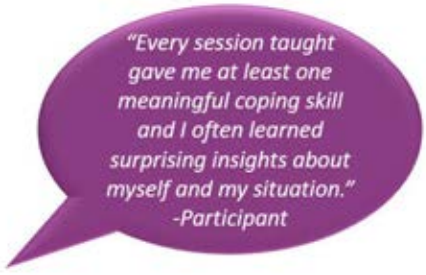


to those locations such as working around school schedules and testing, scarcity of physical space on campus to hold groups, denials of MOUs, and requirements to get parental consent before being able to screen for services. Some school sites and districts expressed their preference to provide their own mental health services and have restricted access for outside service providers to be on campus. The contracted TAY provider has focused largely on the 16–18-year-old population through school partnerships. When the academic year ended, this resulted in a disruption to service delivery as

community-based contacts/outreach was minimal. It also resulted in very low participation from 19–25-year-olds. Technical support to the provider has focused on expanding outreach efforts to include partnerships with other organizations for year-round services, and to increase program schedule flexibility to be able to meet the needs of an older TAY population. Additionally, outreach efforts and a focus on making new contacts in the community were emphasized with the adult service provider.

Feedback and comments from conclusion of service questionnaires:

- "I came in broken and am leaving more confident. [Facilitator] was amazing. I'm grateful for this program."
- "Thank you [facilitator] for your patience and allowing for me to be myself. For this to be a class on zoom, you were able to make me feel like you were in the room with me with your energy."
- "I am very thankful for this program and for the information. I'm thankful for [facilitator] for easily explaining to be able to understand. Thank you."
- "The program brought a helpful change in me because before I felt as if I didn't really have anyone to talk to but when I'm with my friends in session, it is okay to talk."
- "The program opened my perspective that talking your problems out loud doesn't make you "weak" or perceived bad. I also really like the drug abuse advice, I'm trying to help myself more."
- "The program helped me understand that it's ok to feel a certain type of way but you have to know how to safely cope with it."



Riverside University HEALTH SYSTEM Behavioral Health

Seeking Safety and Seeking Strength

Riverside University Health System - Behavioral Health

MHSA Prevention and Early Intervention

Annual Report FY 2023-2024

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Program Overview

Program Overview:

Seeking Safety focuses on improving the lives of people who have experienced a traumatic event. One of the goals of RUHS-Behavioral Health Prevention and Early Intervention plan is to reduce the detrimental effects of trauma for individuals at risk of developing mental health problems as a result of experiencing a traumatic event. Trauma is defined by the DSM-5 as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event (s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013, p. 271).

This harm includes events such combat, childhood physical or sexual abuse, serious car accident, life-threatening illness, natural disaster, or terrorist attack. Approximately 20-30% of people who experience such trauma go on to develop Post Traumatic Stress Disorder (PTSD; Adshead, 2000). In the United States, among men who develop PTSD, 52% develop alcohol use disorder and 35% develop a drug use disorder; among women these rates are 28% and 27% (Kessler et al., 1995). According to The National Child Traumatic Stress Network's Making the Connection: Trauma and Substance Abuse report (2008), studies indicate that up to 55% of young people with PTSD also subsequently develop substance abuse problems. Unfortunately, people with a dual diagnosis of PTSD and SUD, compared to those with either disorder alone, have more legal and medical problems, greater risk of suicidality, and increased rates of future trauma (Najavits, 2007).

Seeking Safety is an evidenced-based practice, identified by the PEI Steering Committee, that aims to help participants avoid or interrupt that cycle. Seeking Safety is an integrated therapy treating both PTSD and substance use disorders. This program is based on the cognitive-behavioral model of relapse prevention. It teaches present-focused coping skills designed to simultaneously help people with a history of trauma and substance abuse. It has been conducted in group or individual format; for people with both substance abuse and dependence issues; for people with PTSD; and for those with a trauma history that do not meet criteria for PTSD. The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e., peers) can conduct the sessions.

Seeking Safety focuses on coping skills and psycho-education with the following key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on PTSD and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; and (4) four content areas: cognitive, behavioral; interpersonal, and case management. The intervention consists of 25 treatment topics that cover cognitive, behavioral, and interpersonal domains. Session topics include: Introduction to Treatment/Case Management, Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You, Asking for Help, Taking Good Care of Yourself, Compassion, Red and Green Flags, Honesty, Recovery Thinking, Integrating the Split Self, Commitment, Creating Meaning, Community Resources, Setting Boundaries in Relationships, Discovery, Getting Others to Support Your Recovery, Coping with Triggers, Respecting Your Time, Healthy Relationships, Self-Nurturing, Healing from Anger, The Life Choices Game, and Termination. Successful program completion does not require completing all topics—program completion for PEI is defined as 6 or more topic sessions.

Program Providers

Providers:

Operation SafeHouse has been providing emergency shelter, intervention, and outreach services to youth and families in crisis for over 20 years through its established locations in Riverside and the Coachella Valley. It has served as a haven for runaway and homeless youth, and more recently has expanded to include a counseling center. Operation SafeHouse works within the community, offering their resources with the goal of supporting positive shifts in the lives of at-risk youth and families in the area. Operation SafeHouse was contracted to serve TAY youth (ages 16-25) in the Seeking Safety program.

RUHS-Behavioral Health PEI Peers is a division of Prevention and Early Intervention (PEI) that aims to reach out to the community with mental health needs, by facilitating access to services and supports. RUHS-BH PEI Peers Support Specialists serve Adults (ages 26+) in the Seeking Strength program.

Evaluation Overview

Screening Method

Potential participants in the Seeking Safety program are asked about whether they have recently experienced a traumatic event. Additionally, they are asked if they have been diagnosed with PTSD and if they are actively in therapy. For those individuals who have recently experienced a traumatic event and have not been diagnosed, they are asked to complete a PTSD checklist (PCL-5).

PTSD Checklist (PCL-5): a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal. The Seeking Safety program used this screening to qualify participants into the program, utilizing a scoring criteria. The PCL-5 is scored by summing the scores for each of the 20 items to get a total symptom severity score (range—0-80). A PCL-5 score of 20 and above is the criterion for admission into the program.

Process Evaluation

The process evaluation collected descriptive information related to the program, which describes what the program provided, how many people were served, and basic demographic characteristics. Process evaluation data is assessed using group sign-in sheets, individual attendance logs, and demographic forms.

Outcomes

The outcome evaluation included measures of PTSD symptoms and coping mechanisms. Satisfaction surveys included items on overall helpfulness of the program and satisfaction with specific components of the program. Outcome evaluation measures are summarized below.

- **PTSD Checklist (PCL-5):** a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). Research has demonstrated the PCL-5 exhibits strong internal consistency, test-retest reliability, and convergent and discriminant validity (Blevins et al., 2015). In addition, confirmatory factor analyses indicated adequate fit for the final 20-item scale with the DSM-5 4-factor model: re-experiencing; avoidance; negative alterations in cognitions and mood; hyper-arousal.
- **Coping Skills Inventory (CSI):** a 38-item self report measure of coping mechanisms developed to assess a range of positive and negative coping responses to life stressors. The CSI was adapted from the Revised COPE Scale (Zuckerman & Gagne, 2003) and Coping Strategy Inventory (Reid, 2007).
- **Satisfaction Survey:** a 17-item questionnaire was given to participants to complete once they had attended six or more sessions. Responses to this Conclusion of Services questionnaire were rated on a Likert scale. Items included “Overall, how helpful was Seeking Safety to you?” and “Staff treated me with respect.” Additionally, feedback was elicited by asking participants what they liked and disliked about the program.

Executive Summary: Key Findings

Screening

Enrollment in the Seeking Safety program requires a screening process to determine program eligibility. A total of 249 individuals were screened for the Seeking Safety program by asking questions related to their experiences with traumatic events and using the PTSD Checklist (PCL-5). Participants with a score of 20 or above on the PCL-5 were eligible for the program. Of all the individuals screened, 97.2% (n=242) scored at or above a 20 on the PCL-5.

Process Evaluation

Enrolled and served individuals were derived from the receipt of demographic information, questions related to their experiences with traumatic events, PCL-5 scores, and attendance data. A total of 154 participants attended at least one Seeking Safety session. Of those 154 participants, 79.2% (n=122) met the completion criteria of attending six or more sessions which include the five core program sessions of Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), Asking for Help and either When Substances Control You, Setting Boundaries in a Relationship, or Healthy Relationships.

Demographic information is reported for those who attended at least one session (n=154). Countywide:

- Most participants were transition age youths between the ages of 16-25 years old (n= 124, 80.5%).
- A majority of participants identified as Hispanic/Latino (n= 114, 74%).
- The majority of participants identified as female (n= 101, 65.6%).
- A quarter of the participants identified as LGBTQ+ (n= 47, 30.5%).

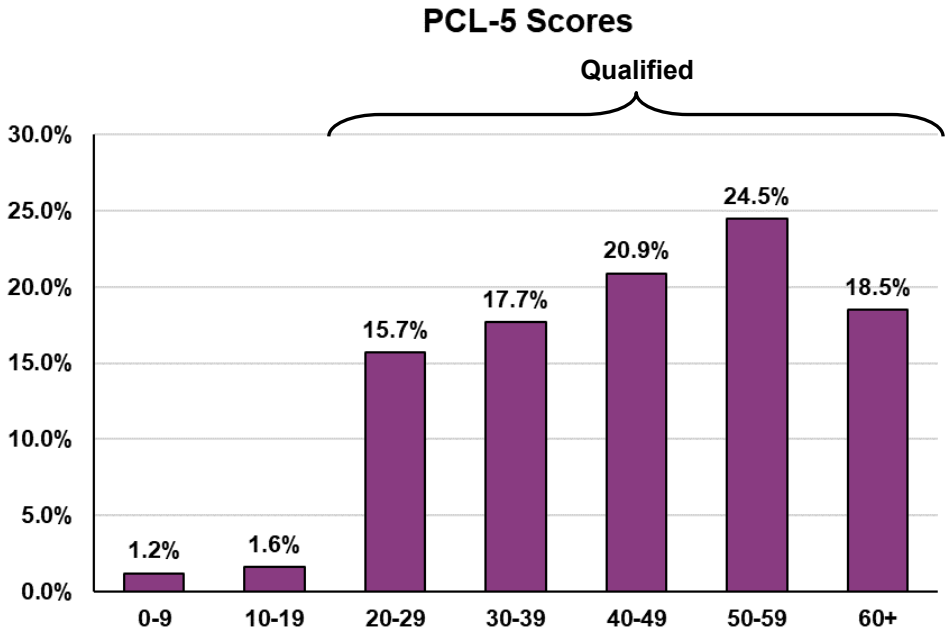
Outcomes

- **PTSD Symptoms Decreased:** Comparison of pre to post scores showed a decrease in PTSD symptoms following participation in the program. Participants' scores showed a statistically significant decrease in the total average score.
- **Coping Skills Improved:** Comparison of pre to post scores showed an improvement in positive coping response subscales (expressing emotion, understanding emotion, maintaining optimism, and goal replacement) and a decrease in negative coping responses (self blame, other blame, self-punishment, self harm, and aggressive behavior) to life stressors.
- **Participants were satisfied with the program:** Overall responses to the satisfaction survey, given upon completion of the program, were positive. Participants found the program to be helpful and would recommend the Seeking Safety program to others.

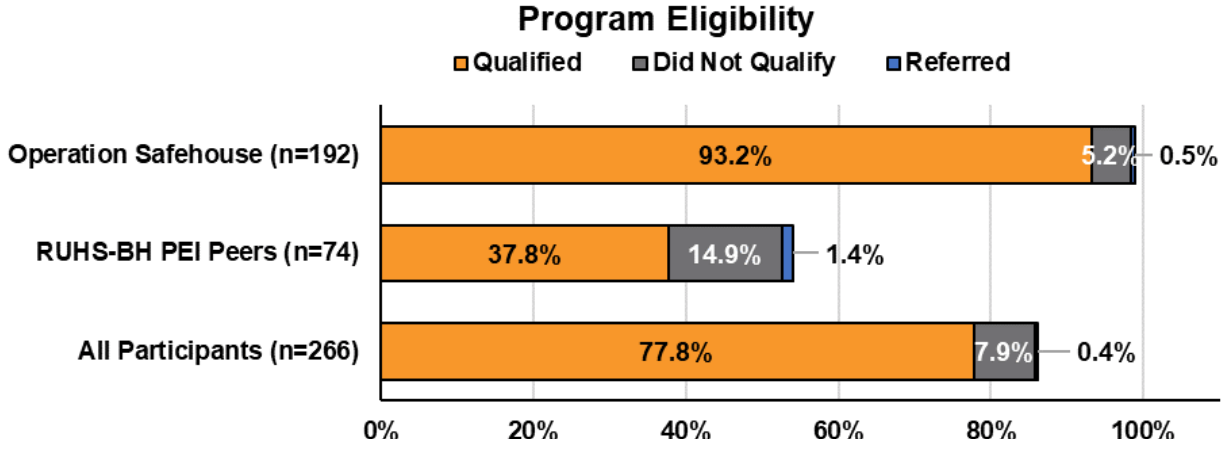
Screening

Countywide, 249 Transition Age Youths and Adults were screened for enrollment into the Seeking Safety program. To determine eligibility, participants were asked two questions: (1) if they have ever experienced a traumatic event and (2) if they have been diagnosed/received treatment for PTSD. Though there were some exceptions, participants were given a PTSD Checklist (PCL-5) screening tool if they answered yes to the first question and no to the second question about their trauma experience.

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80). A score of 20 or more on the PCL-5 determined if that participant was eligible to enroll in the Seeking Safety program. A total of 249 people (93.6% of those who were screened) completed the PCL-5. Of the 249 people, 97.2% (n=242) scored a 20 or above. **The average score on the PCL-5 was 45**.

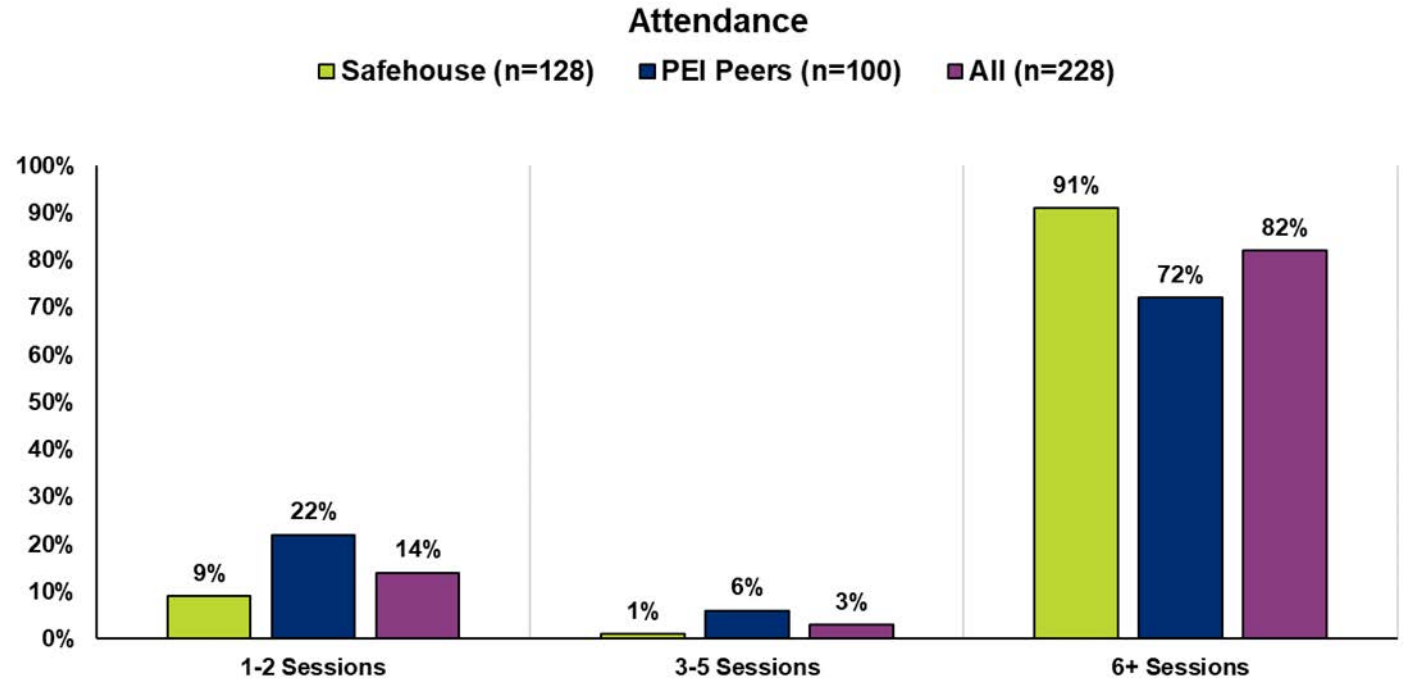


Countywide, 77.8% (n= 207) of those screened were eligible, 7.9% (n=21) were not eligible, and 0.8% (n=2) were referred to another program by request or because it was better suited to their needs.



Enrollment and Completions

Enrolled was defined as having collected demographic information, having a qualifying PCL-5 score of 20 or higher, and having attended at least 1 session. For FY2023-2024, a total of 154 participants were enrolled into the Seeking Safety program where 126 were served by Operation Safehouse and 28 were served by RUHS-BH PEI Peers. Of the 126 participants served by Operation Safehouse, 105 (83.3%) completed the program. Of the 28 participants served by RUHS-BH PEI Peers, 17 (60.7%) completed the program. Overall, of the 154 participants that were enrolled countywide, 122 (79.2%) completed the program, where completion was defined as attending 6 or more sessions (including 5 core program sessions). The figure below shows the frequency of attendance of Seeking Safety sessions.



Contract Expectations and Completions

Operation Safehouse was expected to have 180 Transition Age Youth (TAY) that are 16-25 years old complete the program and RUHS-BH PEI Peers was expected to have 180 Adults that are 26-59 years old complete the program throughout Riverside County. Overall, neither provider met the contract expectations. The table below shows the number of TAY and Adults for each provider that had completed the program compared to the number they were contracted to complete.

		Western	Mid-County	Desert	Countywide
Expected	Transition Age Youth 16-25	60	60	60	180
Completed	**Operation Safehouse**	**34 (56.7%)**	**56 (93.3%)**	**36 (60.0%)**	**126 (70.0%)**
Expected	Adults 26+	60	60	60	180
Completed	**PEI Peers**	**17 (28.3%)**	**6 (10.0%)**	**5 (8.3%)**	**28 (15.6%)**
Expected	Total	120	120	120	360
Completed	**Total**	**51 (42.5%)**	**62 (51.6%)**	**41 (34.2%)**	**154 (42.8%)**

Attendance

The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e. peers) can conduct the sessions. The program provider decides which topic to cover at each group or individual session. Successful program completion does not require completing all of the topics. However, the program model does recommend that each participant attend the Safety, PTSD: Taking Back Your Power, Detaching from Emotional Pain (Grounding), When Substances Control You or Setting Boundaries in a Relationship, and Asking for Help. In order for participants and program providers to keep track of session topic attendance, there are group sign-in sheets and each participant has an individual attendance log. The table below details the frequency of attendance by topic.

Attendance by Topic

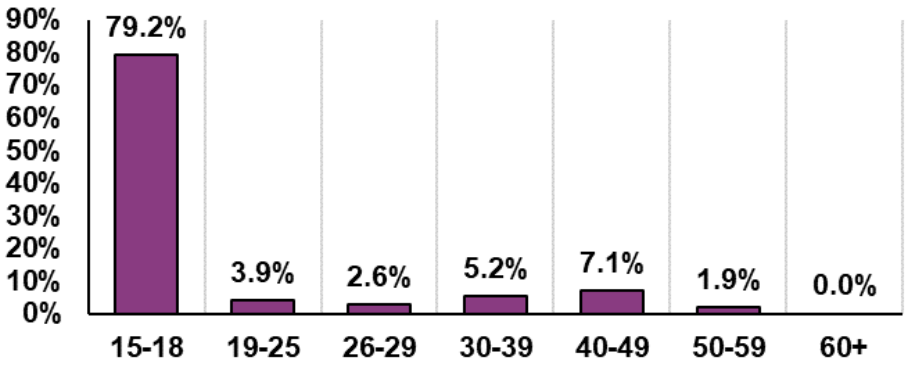
Topic	Op Safehouse (n=126)	PEI Peers (n=28)	All Ages (n=154)
***Safety**	**123 (97.6%)**	**27 (96.4%)**	**150 (97.4%)**
***PTSD: Taking Back Your Power**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Detaching from Emotional Pain (Grounding)**	**126 (100%)**	**28 (100%)**	**154 (100%)**
***Asking for Help**	**108 (85.7%)**	**18 (64.3%)**	**126 (81.8%)**
***When Substances Control You** or	**34 (27.0%)**	**1 (3.6%)**	**35 (22.7%)**
***Healthy Relationships** or	**89 (70.6%)**	**21 (75%)**	**110 (71.4%)**
***Setting Boundaries in a Relationship**	**8 (6.3%)**	**13 (46.4%)**	**21 (13.6%)**
Taking Good Care of Yourself	21 (16.7%)	-	21 (13.6%)
Compassion	76 (60.3%)	8 (28.6%)	84 (54.5%)
Red and Green Flags	23 (18.3%)	-	23 (14.9%)
Honesty	3 (2.4%)	8 (28.6%)	11 (7.1%)
Recovery Thinking	-	-	-
Integrating the Split Self	-	-	-
Commitment	1 (0.8%)	-	1 (0.6%)
Creating Meaning	6 (4.7%)	1(3.6%)	7 (4.5%)
Community Resources	-	-	-
Discovery	-	-	-
Getting Others to Support Your Recovery	-	-	-
Coping with Triggers	36 (28.6%)	-	36 (23.4%)
Respecting Your Time	-	-	-
Self Nurturing	13 (10.3%)	13 (46.4%)	26 (16.9%)
Healing from Anger	18 (14.2%)	-	18 (11.7%)
Life Choices Game	17 (13.5%)	11 (39.3%)	28 (18.2%)
Termination	59 (46.8%)	-	59 (38.3%)

Note: * denotes core program session

Demographics

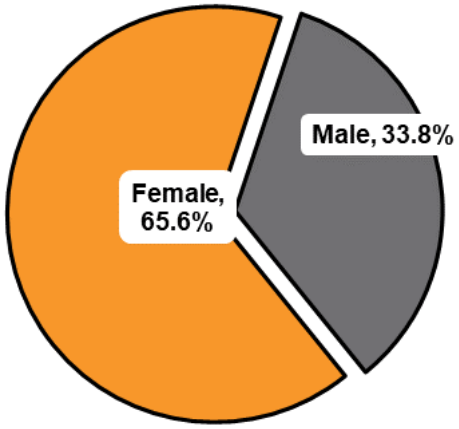
For FY2023-2024, 154 participants countywide received services in the Seeking Safety program, where 126 participants (81.8%) were served by Operation Safehouse and 28 participants (18.2%) were served by PEI Peers. This section will highlight the basic demographics of all the participants.

Age of All Participants (n=154)



The majority of participants were 15-25 years old (83.1%, n=128) and 16.9% were 26-63 (n=26).

Gender



Overall, 101 participants identified as female, 52 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure.

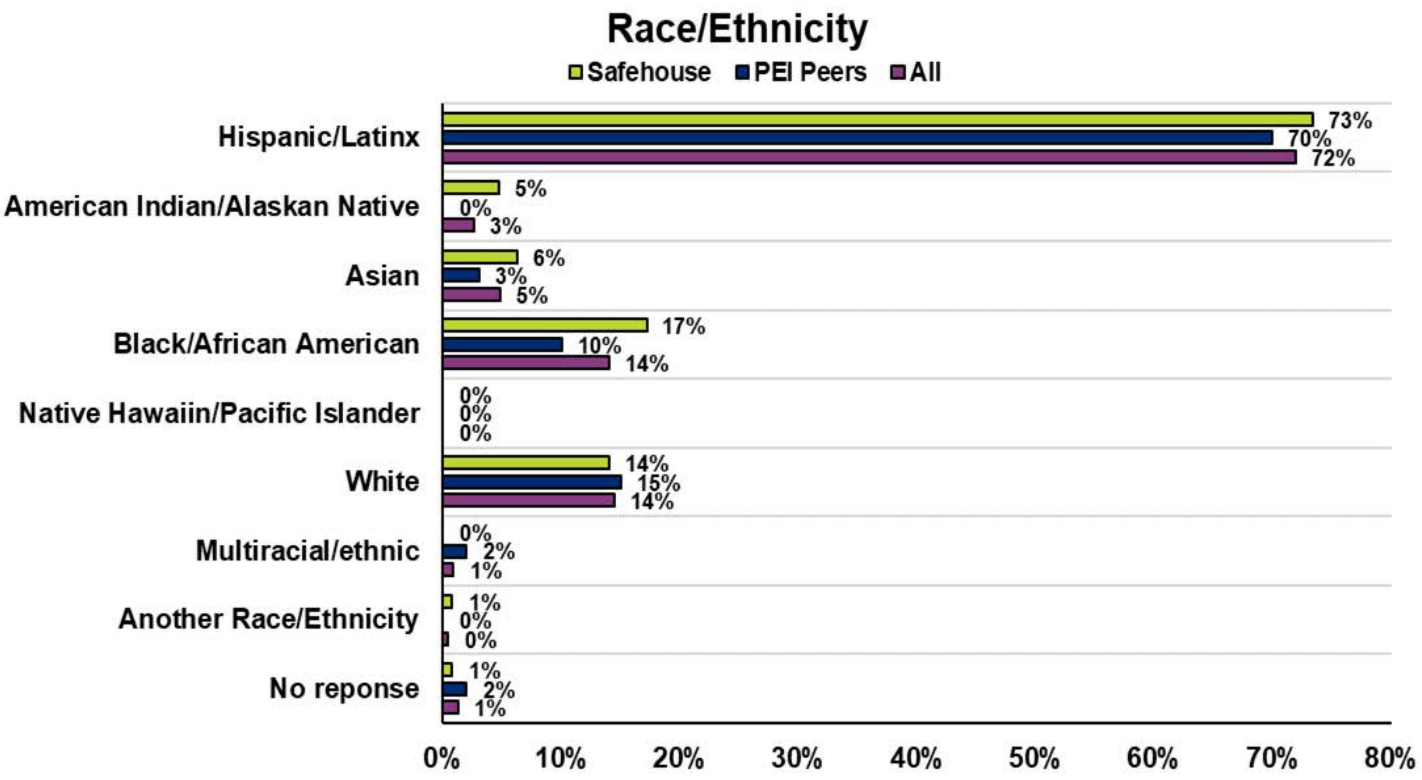
Specifically, among those served by Operation Safehouse, 79 identified as female, 46 identified as male, six identified as gender fluid, six identified as nonbinary, three identified as transgender, and two was unsure. Additionally, among those served by PEI Peers, 22 identified as female, 6 identified as male.

37% of participants (57) reported identifying as LGBTQ, 8 reported having a disabling condition, and 3 participants reported being veterans.

Disabled and Veteran Status	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Disabled	5	3	8
Veteran	0	3	3

LGBTQ+	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
Lesbian	5	1	6
Gay	5	1	6
Bisexual	19	1	20
Pansexual	-	-	-
Asexual	-	-	-
Unsure	2	-	2
Self-Describe	15	-	15
Declined to answer	6	2	8

Demographics cont.



Overall, 74% of the program participants identified as Hispanic/Latinx, 6.5% White, 8.4% Black/African American, 2.6% Asian, 1.3% American Indian/Alaskan Native, 5.8% Multiracial/ethnic, 0.6% Native American or Pacific Islander, and 0.6% did not provide a response. Please note, some participants chose more than one response. Additionally, of all the participants who shared their specific ethnicity, 61.7% identified as Mexican/Mexican American and 5.8% as Central American with the remaining each being less than 1%.

Specific Ethnicity

	Mexican American	Central American	Vietnamese	Chinese	Filipino	Thai
Safehouse (n=126)	76	6	1	1	1	0
PEI Peers (n=28)	19	3	0	0	0	1
All (n=154)	95	9	1	1	1	1

Preferred Language

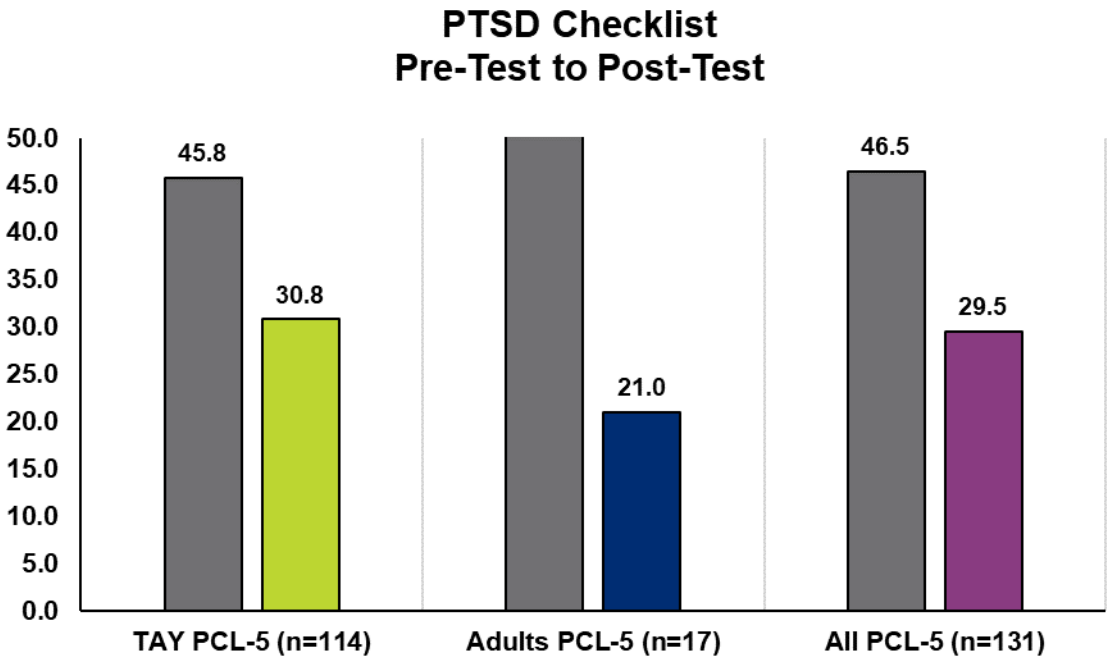
	Safehouse (n=126)	PEI Peers (n=28)	All (n=154)
English	117	20	137
Spanish	8	8	16
Declined to Answer	1	-	1

The majority of program participants (75.9%, n=117) reported a preference for English as their primary language, while 24.1% (n=16) indicated a preference for Spanish. One participant opted not to provide a response.

PTSD Checklist (PCL-5)

The PCL-5 is a 20-item self-reported measure that assesses DSM-5 symptoms of PTSD. It can be used to: (1) monitor symptoms change during and after treatment; (2) screen individuals for PTSD; or (3) make a provisional PTSD diagnosis (Weathers et.al., 2013, para 1). The measure was used as part of the criteria to qualify participants into the program and to measure symptom change after completing the Seeking Safety program. Each checklist consists of **20** symptoms, rated on a 5-point scale, where ***0=Not at all, 1=A little bit, 2=Moderately, 3=Quite a bit***, and ***4=Extremely***. The PCL-5 is scored by summing the responses of the 20 items to get a total symptom severity score (range of 0-80).

For all program participants throughout the county, a total of 131 matched pairs were used in the analysis. The difference in average scores for the PTSD Checklist showed a statistically significant decrease from pre- to post-test for all participants. Overall, PTSD symptomatology improved after program completion.



	Difference in Average Scores	*t*	df	p
Safehouse (n=110)	15.0	8.8	113	.000
PEI Peers (n=52)	29.8	8.3	16	.000
All Participants (n=162)	16.9	10.5	130	.000

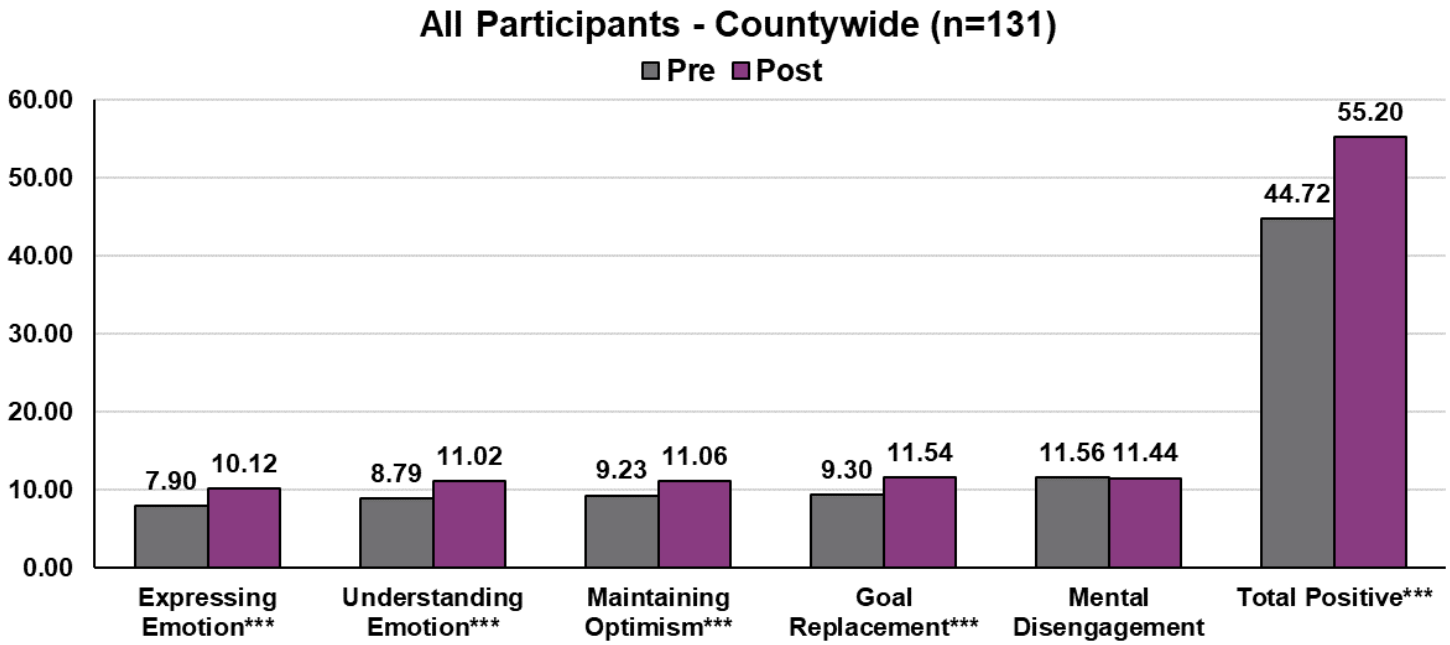
Coping Inventory: Positive Coping Skills

The Coping Inventory was used to measure positive and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that positive coping mechanisms/ responses will increase. Specifically, the positive coping skills are measured in total and using the following subscales:

Positive Coping Styles

- **Expressing Emotion**: display of feelings; none of the items refer to the experience and/or expression of negative affect.
- **Understanding Emotion**: attending to and clarifying feelings.
- **Maintaining Optimism**: represents mood regulation when facing a negative event. It describes attempts to maintain a positive attitude and optimism under adverse conditions.
- **Goal Replacement**: an acceptance of a loss and a search for some alternative source of satisfaction.
- **Mental Disengagement**: related to the person being able to distract from thinking about the behavioral dimension or goal with which the stressor is interfering.

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

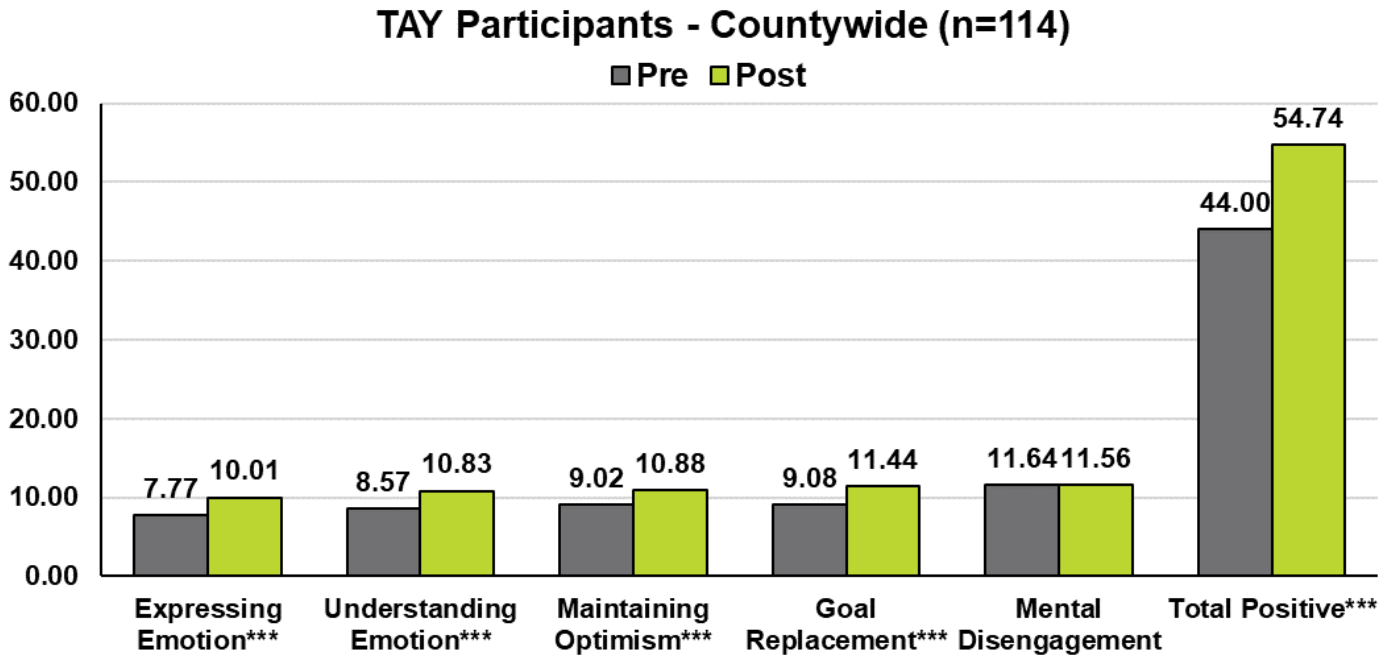


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.16	-7.10	130	.000
Understanding Emotion	-2.23	-8.29	130	.000
Maintaining Optimism	-1.83	-6.09	130	.000
Goal Replacement	-2.23	-6.71	130	.000
Mental Disengagement	0.12	0.45	130	.652
Positive Coping Skills Total	-10.48	-10.20	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Positive Coping Skills

For TAY participants throughout the county, a total of 114 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was no significant change in mental disengagement.

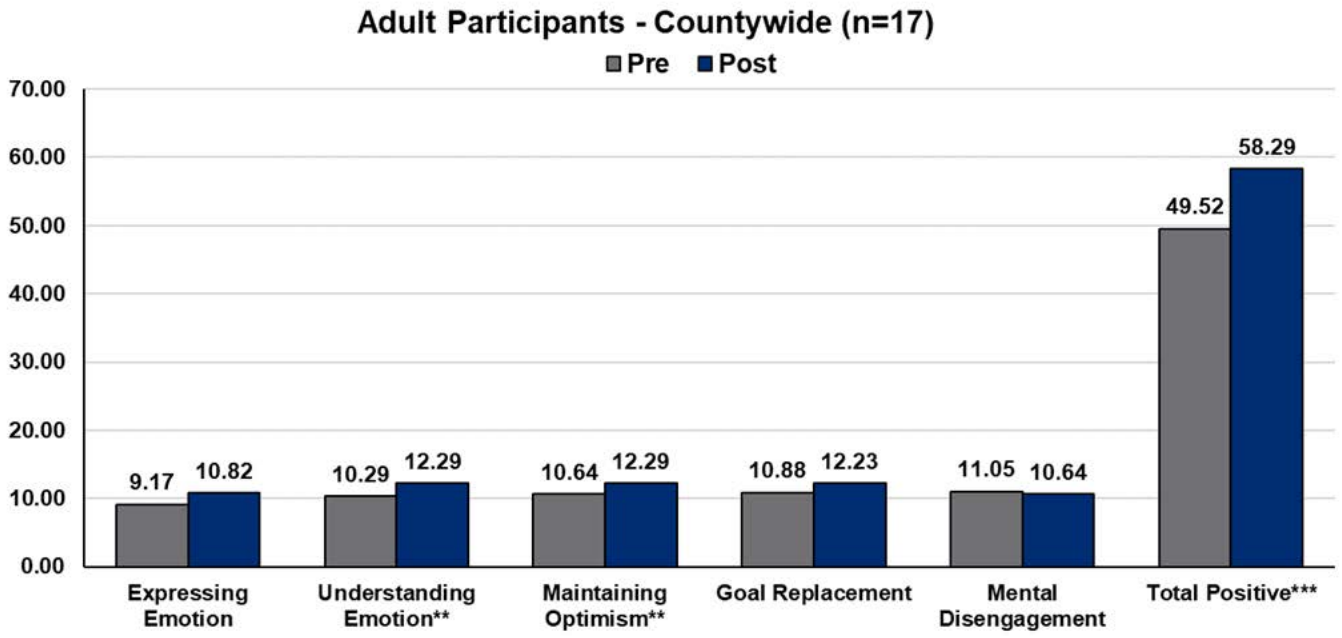


Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-2.24	-6.83	113	.000
Understanding Emotion	-2.26	-7.90	113	.000
Maintaining Optimism	-1.85	-5.59	113	.000
Goal Replacement	-2.35	-6.47	113	.000
Mental Disengagement	0.08	0.27	113	.783
Positive Coping Skills Total	-10.73	-9.55	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Positive Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant increases in total positive coping skills, specifically in the areas of expressing emotion, understanding emotion, maintaining optimism, and goal replacement. There was minimal change in mental disengagement.



Measured Scales	Difference in Average Scores	*t*	df	p
Expressing Emotion	-1.64	-1.97	16	.066
Understanding Emotion	-2.00	-2.50	16	.024
Maintaining Optimism	-1.64	-2.54	16	.022
Goal Replacement	-1.35	-1.81	16	.089
Mental Disengagement	0.41	0.49	16	.629
Positive Coping Skills Total	-8.76	-3.57	16	.003

Note: Each * denotes higher significance from pre– to post–

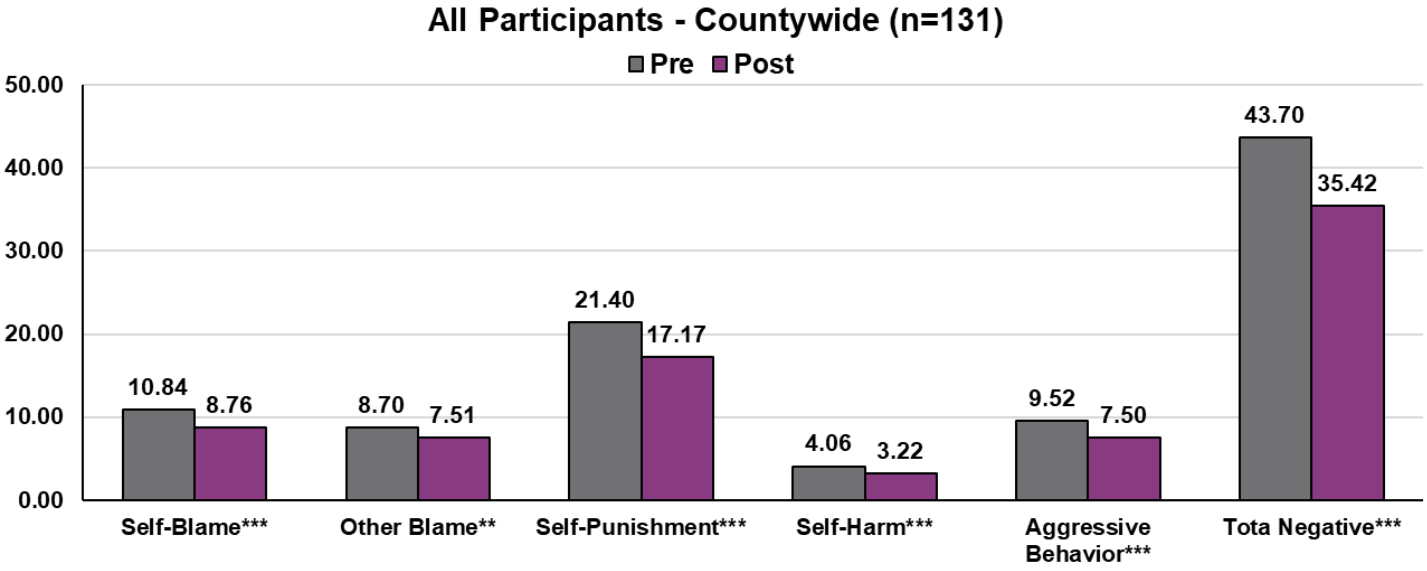
Coping Inventory: Negative Coping Skills

The Coping Inventory was used to measure positive coping skills and negative coping skills at two time-points (pre to post-test). After participating in the Seeking Safety program, it is expected that negative mechanisms/ responses will decrease. Specifically, the negative coping skills are measured in total and using the following subscales:

Negative Coping Styles

- **Self-Blame**: a tendency to criticize the self for negative events.
- **Other Blame**: includes items about causality, responsibility, and blameworthiness.
- **Self-Punishment**: tendency to inflict punishment on oneself.
- **Self-Harm**: the practice of injuring yourself in order to relieve emotional distress.
- **Aggressive Behavior:** tendency to inflict harm onto others

For all program participants throughout the county, a total of 131 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.

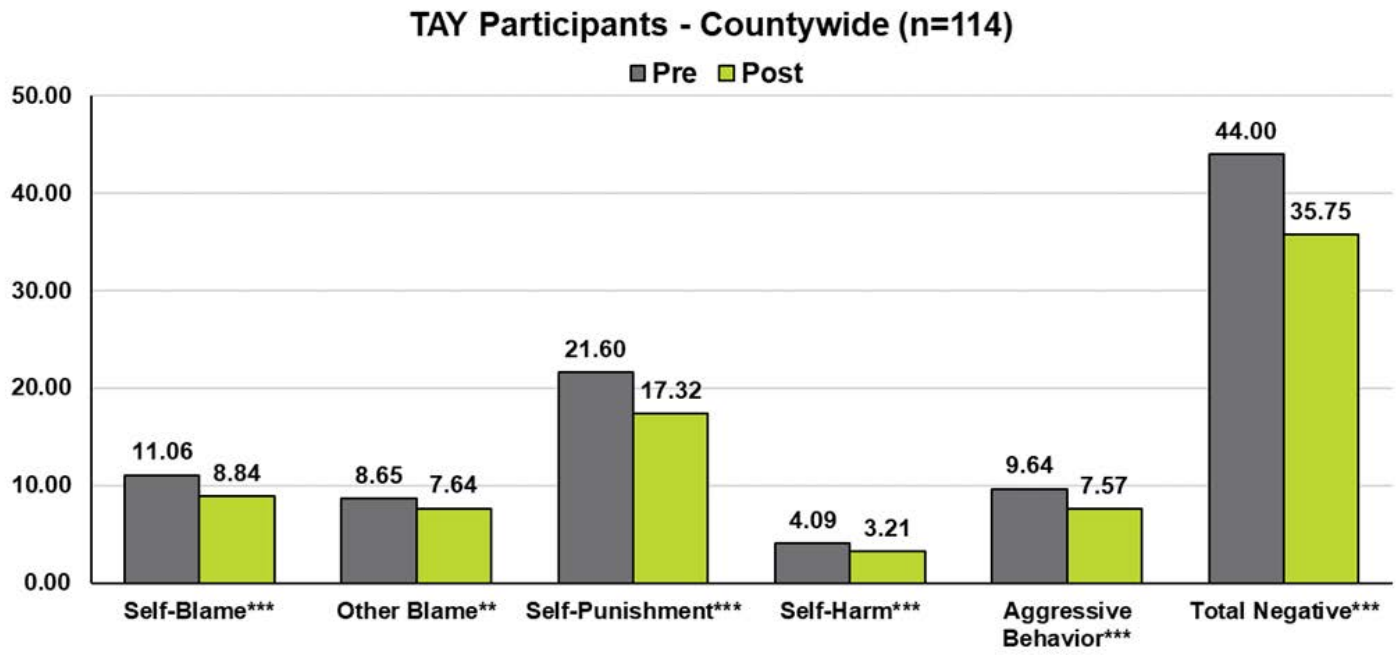


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.08	6.58	130	.000
Other Blame	1.19	4.09	130	.000
Self-Punishment	4.22	7.33	130	.000
Self-Harm	0.83	5.45	130	.000
Aggressive Behavior	2.02	6.79	130	.000
Negative Coping Skills Total	8.28	8.06	130	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: TAY Negative Coping Skills

For TAY participants throughout the county, a total of 110 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, self-punishment, self-harm, and aggressive behavior.

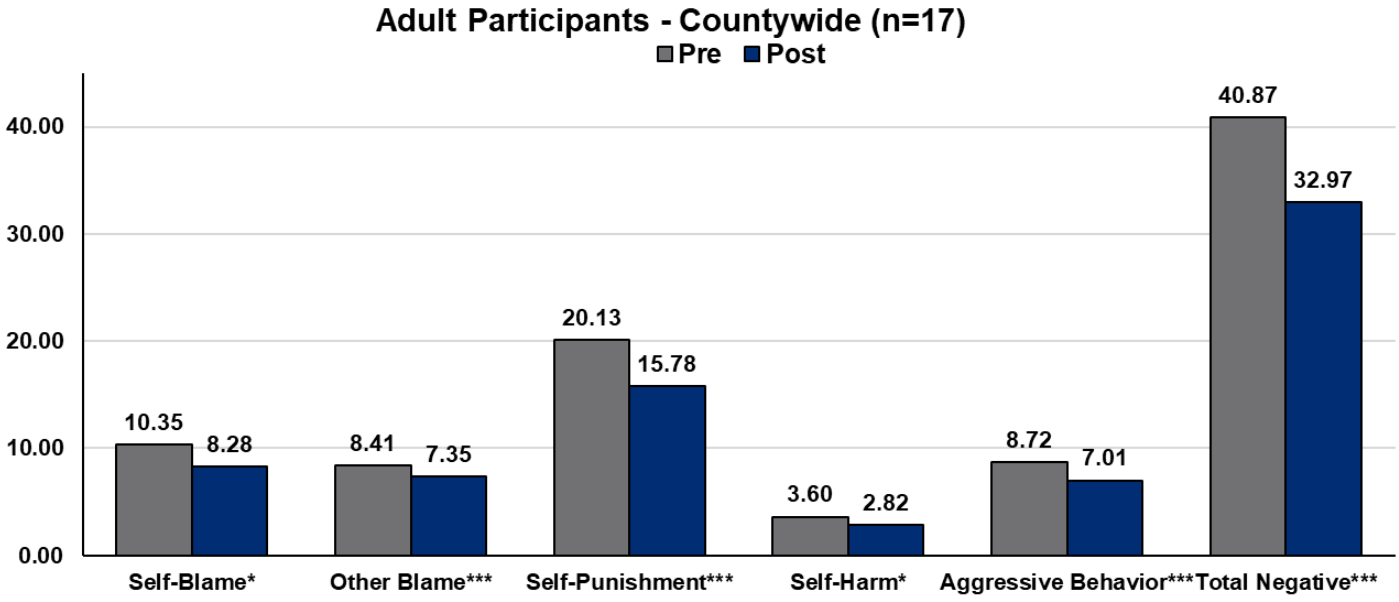


Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	2.21	6.26	113	.000
Other Blame	1.01	3.17	113	.002
Self-Punishment	4.28	6.65	113	.000
Self-Harm	0.88	5.14	113	.000
Aggressive Behavior	2.06	6.17	113	.000
Negative Coping Skills Total	8.24	7.12	113	.000

Note: Each * denotes higher significance from pre– to post–

Coping Inventory: Adults Negative Coping Skills

For adult participants throughout the county, a total of 17 pre- to post-test matched pairs were used in the analysis. Participants reported significant decreases in total negative coping skills specifically in the areas of self-blame, other blame, self-punishment, self-harm, and aggressive behavior.



Measured Scales	Difference in Average Scores	*t*	df	p
Self -Blame	1.17	2.21	16	.041
Other Blame	2.41	3.93	16	.001
Self-Punishment	3.88	3.54	16	.003
Self-Harm	0.47	2.21	16	.041
Aggressive Behavior	1.76	3.40	16	.004
Negative Coping Skills Total	8.52	5.27	16	.000

Note: Each * denotes higher significance from pre– to post–

Conclusion of Service Questionnaire: Satisfaction Surveys

A total of 126 participants completed the satisfaction survey. Most participants agreed or strongly agreed that Seeking Safety reduced their trauma symptoms and was helpful. Most participants agreed that the components of Seeking Safety were helpful such as learning new skills to help function better, the amount and type of written material provided, and the structure of the program. Nearly every participant agreed that they would recommend Seeking Safety to others.

Question (n=126)	Avg.	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree	N/A	No Response
Overall, the Seeking Safety program was helpful for me	4.51	1 (0.8%)	1 (0.8%)	10 (7.9)%	35 (27.8%)	79 (62.7%)	-	-
The Seeking Safety program helped reduce my trauma symptoms	4.07	1 (0.8%)	5 (4.0%)	28 (22.2%)	42 (33.3%)	50 (39.7%)	-	-
The Seeking Safety program helped reduce my substance use	4.00	3 (2.4%)	3 (2.4%)	10 (7.9%)	17 (13.5%)	25 (19.8%)	68 (54.0%)	-
The Seeking Safety program helped in managing my stress	4.25	1 (0.8%)	1 (0.8%)	21 (16.7%)	45 (35.7%)	58 (46.0%)	-	-
Staff treated me with respect	4.86	-	-	5 (4.0%)	7 (5.6%)	113 (89.7%)	-	1 (0.8%)
Staff spoke to me in a way that I understood	4.77	1 (0.8%)	2 (1.6%)	2 (1.6%)	14 (11.1%)	106 (84.1%)	-	1 (0.8%)
I liked the variety of topics offered	4.63	-	2 (1.6%)	8 (6.3%)	24 (19.0%)	92 (73.0%%)	-	-
The sessions were well organized	4.63	1 (0.8%)	2 (1.6%)	4 (3.2%)	28 (22.2%)	91 (72.2%)	-	-
I found the written material provided helpful	4.42	-	3 (2.4%)	16 (12.7%)	32 (25.4%)	75 (59.5%)	-	-
I found the Safe Coping Skills helpful	4.48	1 (0.8%)	2 (1.6%)	12 (9.5%)	31 (24.6%)	80 (63.5%)	-	-
I found the focus on abstinence from all substances helpful	4.06	2 (1.6%)	3 (2.4%)	12 (9.5%)	17 (13.5%)	28 (22.2%)	63 (50.0%)	1 (0.8%)
I learned new coping skills that help me to function better	4.40	-	5 (4.0%)	11 (8.7%)	38 (30.2%)	72 (57.1%)	-	-
The location of the Seeking Safety program was convenient for me	4.61	-	2 (1.6%)	8 (6.3%)	27 (21.4%)	89 (70.6%)	-	-
The time of the Seeking Safety program was convenient for me	4.51	-	5 (4.0%)	9 (7.1%)	29 (23.0%)	83 (65.9%)	-	-
I will use what I learned in the Seeking Safety program in my life	4.59	-	1 (0.8%)	7 (5.6%)	34 (27.0%)	83 (65.9%)	-	1 (0.8%)
					No	Yes	N/A	No Resp.
Would you recommend Seeking Safety to a friend?		-	-	-	-	125 (99.2%)	-	1 (0.8%)

Satisfaction Survey: Comments

Participants were also asked in what way has the program brought a helpful change in them, if there was anything they did not like about the program, and any additional comments. Below are some comments from the participants.

What Participants found helpful…

- "It helped me find other ways to deal with stress and talk with someone trusted."
- "Every session taught gave me at least one meaningful coping skill and I often learned surprising insights about myself and my situation."
- "I came in broken and leaving more confident. [Facilitator] was amazing. I am grateful for this program"
- "The program helped me understand that it's ok to feel a certain type of way but you have to know how to safely cope with it"
- "Helping me connect with others, develop better coping skills, have more patience with myself"
- "Bringing a positive change in how I deal with stress and how I cope"
- "Taught me methods to find better approaches with my anger causing less conflict to me"
- "This program helped me break down conflicting feelings and learned to work through them in a healthy way"
- "It helped me understand more about trauma and allowed me to realize that I was not alone"
- "The program opened my perspective that talking your problems out loud doesn't make you "weak" or perceived bad. I also really like the drug abuse advice, I'm trying to help myself more."
- "The program brought a helpful change in me."
- "This program helped me by opening up to my emotions and how to cope with the topics in my life that are hard to face"
- "It helped me understand that I shouldn't overthink things people say to me and try to be more open to others"
- "It helped me more positive of myself and not be to negative and it helped me ease my stress at home"
- "It helped me realize that I should stop focusing on the bad stuffs"
- "It helped me stop smoking and be a better person overall"
- "It was a safe space for me to express my emotions"
- "The program helped express my feels and set boundaries for myself"
- "The program gave me a safe place to express myself and helped me with how I cope"
- "The program helped with teaching me ways to cope with my problems. Helped me to realize that everyone goes through similar issues and there are ways around these issues. "
- "It let me realize things about myself that I never did"
- "The program brought a helpful change in me because before I felt as if I didn't really have anyone to talk to but when I'm with my friends in session, it is okay to talk"
- It was helped me realize everyone goes through a trauma in their lifetime and it is okay to not be okay. It changed the way I view my own trauma and the way that I deal with my trauma"
- "When I get really stressed, I realize what I'm doing, take a breath, and identify some colors, textures and sounds to keep me calm"
- "Helped me calm down when I am angry or sad"
- "It helped give my brain a break"

Satisfaction Survey: Comments cont.

What Participants Disliked…

- "Just the time, I would like the session to last longer than an hour"
- "One day in the program was rough, the day we discussed PTSD and so I felt like I was dealing with panic attack symptoms during that session and I was relieved when it was over but I still got good insights when I looked at the material later on."
- "Limited time"
- "Too short of a time"
- "It was out of control of the staff, but the atmosphere was a bit awkward"
- "How short it was"
- "Sometimes it was uncomfortable to be vulnerable"
- "I didn't like some of the other people or maybe I'm just mean"
- "Maybe the class period was inconvenient"
- "There wasn't enough sessions"
- "Sometimes it's too long"
- "In the beginning, I didn't really think it was going to work for me and I didn't want to give it a shot but I'm glad I did"

Additional Comments…

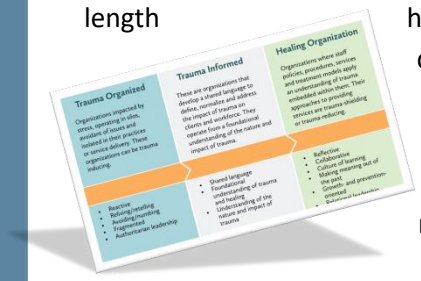
- "The instructors were kind and helped a lot."
- "We need more programs that help us"
- "I am very thankful for this program and for the information. I'm thankful for [facilitator] for easily explaining to be able to understand. Thank you."
- "Thank you for offering this. I am glad that I participated."
- "Thank you [facilitator] for your patience and allowing for me to be myself. For this to be a class on zoom, you were able to make me feel like you were in the room with me with your energy"
- "Thank you for your time and being flexible with the time."
- "It made me change for the better and i am thankful for it"
- "Awesome people"
- "[Facilitator] was great when talked about my problems. She didn't write it down or make me feel uncomfortable."
- "My mentor [facilitator] was great."
- "I think it's a very fun group. You learn a lot but the vibe is also very welcoming"
- "I really enjoyed the program, thank you"
- "I appreciate the staffs time really nice person"
- "Nothing much. Thank you for being a root to helping me be a better person with better ways"
- "No critically bad things to say and I do think even mentally healthy people can learn something here"
- "My staff was very helpful and kind. She kept it real"
- "very sweet. I enjoyed my time here"
- "It's a good program and it also helps with the stress at high school"
- "Would 100% do this again"
- "I wish it lasted longer, will be coming back when it's available."
- "10/10 recommended"

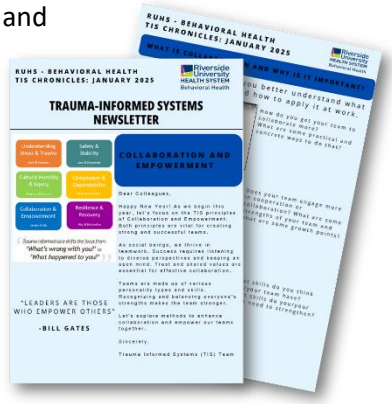
PEI

Trauma-Informed Systems

Program Type: Prevention Program

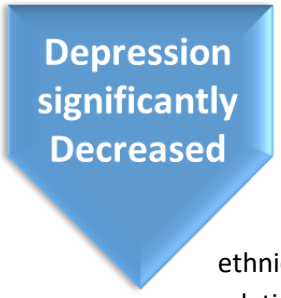
The Community Planning Process continues to identify trauma as an area of high need in Riverside County. In January 2014 the members of the PEI Steering Committee discussed in length how to best address this need through PEI efforts. The discussion centered on focusing efforts to develop a trauma-informed system and communities in addition to services for TAY and adults who have experienced trauma. There is currently a countywide effort focusing on trauma and resiliency now known as Resilience Initiative through Support and Empowerment (RISE) under the leadership of RUHS-Public Health. RUHS-BH continues to partner in these efforts to maximize benefits to the community. RUHS-BH received training and consultation in Trauma-Informed Systems. This effort is implemented and supported in partnership between the PEI and WET Administration teams. Implementation kicked off in April 2019 with leadership training in Trauma 101. Recently we added additional trainers to our team and currently have 22 trainers. Trauma Informed Systems (TIS)101 training is offered eight times per year and is a mandatory training for all Behavioral Health staff.





In FY 23/24 we trained 228 staff. The Champions group has grown to include representation from across the county and service system. PEI Admin staff review the TIS principles of the month at every fidelity meeting with PEI contract providers to encourage them to incorporate these principles into their organizations and the PEI work they are contracted to do. A monthly TIS Newsletter is created by the Champions group and distributed to all RHS-BH staff.

PEI-07 Underserved Cultural Populations



This Work Plan includes programming for underserved ethnic populations within Riverside County. The programs include evidence-based and evidence-informed practices that are effective with the populations identified for implementation. In addition to the programs identified below it is important to note that each of the populations were identified as priority populations in all the PEI programs being implemented. Demographic information, including ethnicity and culture, is gathered for PEI programs to ensure that the priority populations are receiving the programs. The mental health awareness and stigma reduction activities also include a focus on the unserved and underserved populations throughout the county.

Hispanic/Latinx & African American/Black Communities:

Mamás y Bebés (Mothers and Babies)

Program Type: Prevention Program



Mamás y Bebés (MyB) is a perinatal intervention program, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants. With increased awareness of the persistent and dire maternal health needs of African American women, this program was expanded to include African American women as a target group to serve. The program is offered in all three regions of the county by three different community-based organizations.

A total of 329 women were screened by the program in FY23/24. Of the 329 screened, 255 were enrolled and 231 fully graduated from the program. Most of the women (83.1%) identified as Hispanic/Latinx, followed by those identifying as White (6.7%), African American (3.5%), Multiple (2.7%) and Asian American (2.0%); 51.4% reported English as their primary language, while 41.6% reported Spanish and 6.7% reported bilingual with both English and Spanish. Of the participants who enrolled in the program: 91% (n=231) completed the program.

Since MyB is a prevention program, screening at intake is used to rule out symptoms consistent with a major depressive episode. The participants scoring below a 5 were eligible to enroll in this preventive program. Screening data showed 78% (n=255) of the women who were screened and enrolled into the program were experiencing symptoms consistent with having mild depression. Note: In January 2020, RUHS-PEI changed the eligibility criteria to screen for mild depression and not enroll moderate to major depression to follow the PEI model. Pre and post scores were available for 231 women. 26% (n=60) scored between 16 and 24 at intake, which indicates

clinically meaningful depression symptoms; 24.7% (n=57) scored above 24, which may be an indicator of major depression. From pre-test to post-test, outcomes data indicated that depression symptoms decreased, and it was a statistically significant decrease. At intake, the average CES-D score was 13 and after completing MyB the score decreased to 8.43.

In-person classes were offered this year by one provider due to a strategic partnership with a community women's clinic. Social media outreach has been impactful for this program. All 3 providers get most of their participants via self-referral from seeing the flyer in a variety of social media sites/groups. Internal transitions reduced the availability of staff to do in-person outreach events, forcing staff to rely heavily on social media and email outreach efforts.

There were several moms that experienced pregnancy loss or death of their baby. There is a significant lack of culturally relevant support for grief & loss relevant to miscarriage/still birth/infant loss. Hospital systems are a difficult entity to partner with. They are typically large systems that do not have streamlined ways to get information about groups/supports to their providers to share with their patients. OB/GYN providers screen their patients, but the systems don't generally have good support for pregnancy related/postpartum mental health issues, and they are not open to advertising/promoting outside resources.

School districts have been difficult to partner with this program year. There seems to be such an influx of resources and referrals offered to schools for their families that the districts are at capacity with what they can offer and promote. Some districts also have a difficult time seeing how this program can impact student success and attendance—even when explained during meetings/presentations. Providers need new strategies to engage our common-sense partners (like physicians and schools) to help meet the needs of the community and program.

African American/Black women are still hard to reach and significantly underrepresented in program participation. 3.5% of program participants identified as African American/Black. Providers worked through the year to change outreach strategies, including updating flyers and language around the program. But it did not yield the increased enrollment from the African American/Black community that was hoped for. The program material requires some adjustment to be more culturally relevant to the African American/Black community. This will be further explored in the year to come.

Despite being "post-COVID" most participants are opting to participate in group virtually rather than in-person. Many moms cite that flexibility and no need for transportation or childcare as benefits. The program does provide childcare, but many moms have children of a variety of ages and being able to participate from home removes significant challenges for them. The likelihood of this program only being offered in-person (as was the case pre-2020) does not seem realistic.

At the completion of the program, participants are offered an opportunity to provide feedback:

- "This program helped me in a multitude of ways. I looked forward to coming to class. Thank you!"
- "This class helped my mental health to be strong. I can manage to do small beautiful things everyday. Thank you!"

- “This program helped me feel like I am not alone. It made me feel like part of a community and has taught me new methods to help me cope with sadness, overwhelming feelings, and stress. Thank you.”
- “Motherhood is hard, full of challenges, and it was nice to hear that other moms have the same challenges as me. I learned new ways to cope with situations. Thank you for this program.”

Program Overview

Mamás y Bebés (MyB) is a prenatal intervention program, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants.

Three community-based organization (CBO) were funded by the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) to implement the program. Reach Out is a local non-profit CBO serving underserved communities; Riverside Community Health Foundation which is a nonprofit organization supporting health and well-being in Riverside communities through a variety of programs; and California Health Collaborative which is a non-profit organization supporting and enhancing the quality of life and health for people of California particularly the underserved and underrepresented.

As we navigate the complexities of the post-COVID-19 environment, MHSA PEI programs continue to adapt as they shift toward more in-person services. A steadfast commitment to community well-being has consistently prompted modifications to the approach, opting for virtual services when necessary. While the crisis initially reduced the range of planned group classes, there has been a successful increase in the number of these classes available via Zoom. To ensure both accessibility and convenience, phone call services are also maintained as an option for those who find this method more suitable. Additionally, the program now offers both Zoom and in-person classes to cater to diverse needs, providing flexibility and support for all community members.

Evaluation Overview

Process Evaluation
The process evaluation included descriptive information related to the program, provided services, number of people served, and basic demographics.

The process evaluation data is collected using the group sign-in sheets, which records basic information on the topic and the number of participants in attendance. This data is collected by the community health workers at each session.

Outcome Evaluation
The outcome evaluation included a pre to post measure on depression symptoms. In addition, satisfaction surveys were given to participants that included items on overall helpfulness of the program, as well as overall program satisfaction.

The outcome measures included:

Major Depressive Episode Status (MDE): also known as the Mood Screener, is administered at intake and is used to determine if the potential participant is experiencing a major depressive episode.

Center for Epidemiologic Studies Depression Scale (CES-D): the CES-D is a 20-item measure that measures depression by assessing various depression symptoms that participants were experiencing in the past week.

Executive Summary

Program Enrollment & Completion Rate:

A total of 329 women were screened by the program in FY 23-24. Of the 329 screened, 255 were enrolled and 231 fully graduated from the program. Most of the women (83.1%) identified as Hispanic/Latinx, followed by those identifying as White (6.7%), African American (3.5%), Multiple (2.7%) and Asian American (2.0%); 51.4% reported English as their primary language, while 41.6% reported Spanish and 6.7% reported bilingual with both English and Spanish.



91%
(n=231)
Graduated from the program

Of the participants who enrolled in the program: 91% (n=231) completed the program. Western Region graduated 105 women, Mid-County region graduated 74 women, and Desert region graduated 52 women. To graduate and complete the program, pregnant or postpartum moms were expected to attend 6+ sessions. From the graduates, 166 completed all 8 sessions.

Outcome Evaluation:

Major Depressive Episode Status (MDE)



Since Mamás y Bebés is a prevention program, screening at intake is used to rule out symptoms consistent with a major depressive episode. The participants scoring below a 5 were eligible to enroll in this preventive program. Screening data showed 78% (n=255) of the women who were screened and enrolled into the program were experiencing symptoms consistent with having mild depression. Note: In January 2020, RUHS-PEI changed the eligibility criteria to screen for mild depression and not enroll moderate to major depression to follow the PEI model.

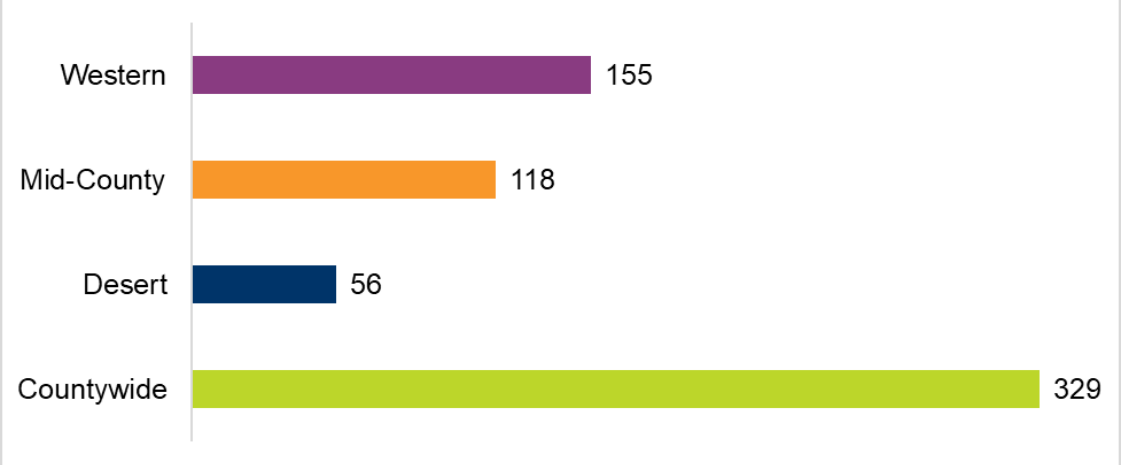
Center for Epidemiologic Studies Depression Scale (CES-D)



Pre and post scores were available for 231 women. 26% (n=60) scored between 16 and 24 at intake, which indicates clinically meaningful depression symptoms; 24.7% (n=57) scored above 24, which may be an indicator of major depression. From pre-test to post-test, outcomes data indicated that depression symptoms decreased and it was a statistically significantly decrease, p-value >0.001. At intake, the average CES-D score was 13 and after completing Mamás y Bebés the score decreased to 8.43.

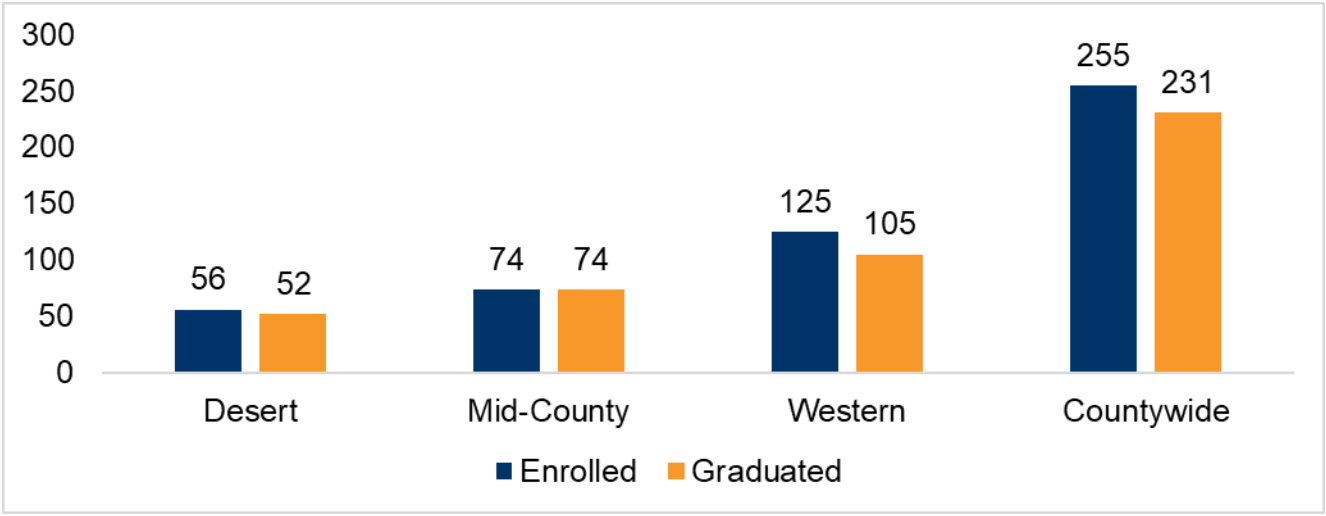
Program Enrollment and Completion

Total Screened (n=329)



Together Reach Out, Riverside Community Health Foundation and California Health Collaborative screened 329 pregnant or post-partum women to enroll in the Mamás y Bebés program. After using the mood screener questionnaire to determine eligibility, 255 women were eligible, enrolled and attended at least one group session. To be eligible for this prevention and early intervention program, women would need to complete the Mood Screener and score lower than a 5 in their current state score or a minimum of 1 in lifetime score and a 0 in current state.

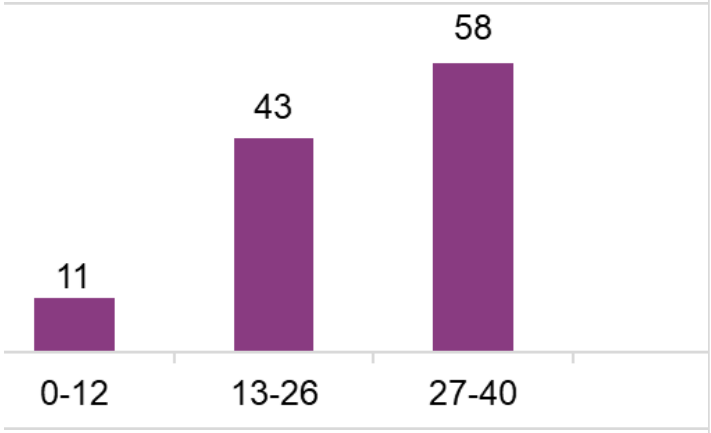
Program Completion (enrolled n=255, completed n=231)



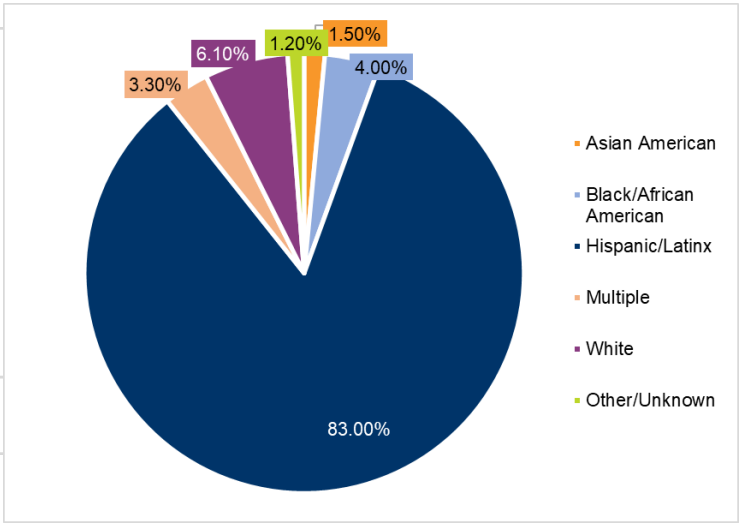
From the 255 women enrolled and served in the program, 231 successfully graduated by completing more than 6 sessions. There were eight that enrolled but never attended. The Desert region, California Health Collaborative, served 56 women while 6 dropped out of the program and one enrolled but never attended. Reasons for dropping range from conflict with time, did not feel fit for the group, and transportation. Mid-county region, Riverside Community Health Foundation, enrolled and served 74 women, 9 enrolled but never attended and only 17 dropped out of the program. Western region, enrolled and served 123 women, 4 enrolled but never attended and 22 dropped out of the program. Not all women screened and enrolled in the program attend, therefore data is based on those that attend at least one session.

Screening Demographics

Number of Weeks Pregnant n=112



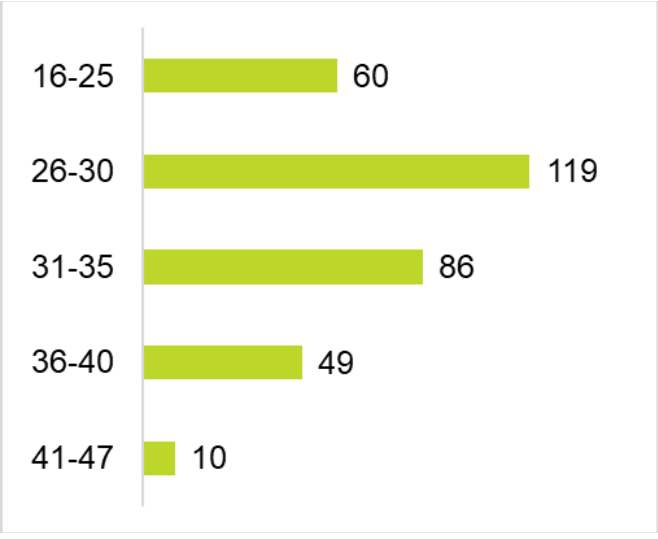
Race/Ethnicity n=329



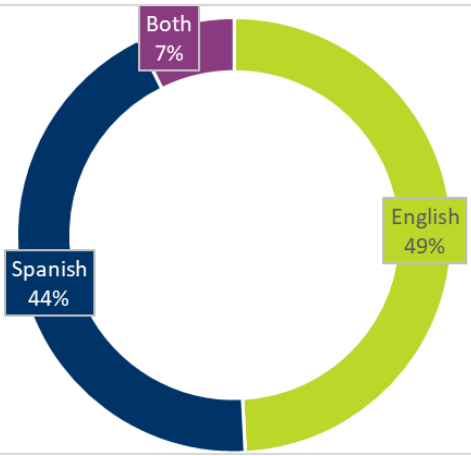
MyB is offered to women who are pregnant or going through post-partum. 112 of the 329 screened women were pregnant. Eleven were in their first trimester, forty-three in their second trimester, and fifty-eight in their third trimester. The majority of women 21 had a child under one.

83% of the women screened were Hispanic, 6.1% White, 4% African American, 3.3% Multiple and 1.5% Asian American.

Participant's Age n=329

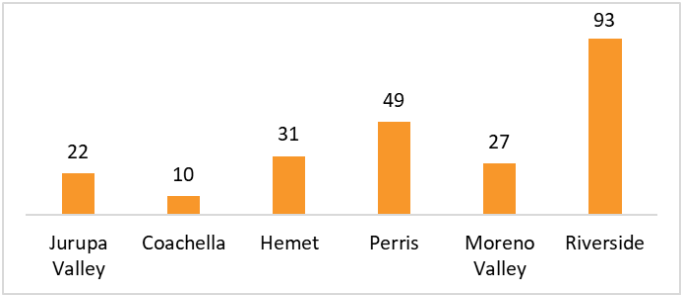


Primary Language n=329



The primary language spoken by most women was English, followed by Spanish as the second most common language. All material was available in Spanish to eliminate a language barrier

City of Residency n=329

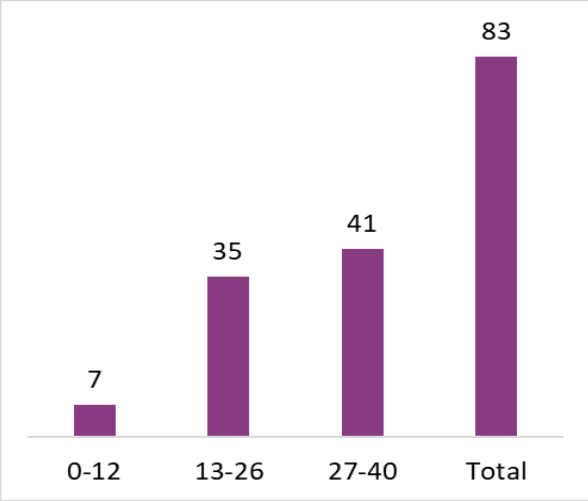


The majority of the women were under 35 years old. The youngest screened was 15 years of age, and the oldest was 43 years of age.

28.3% of the women screened were Riverside City residents.

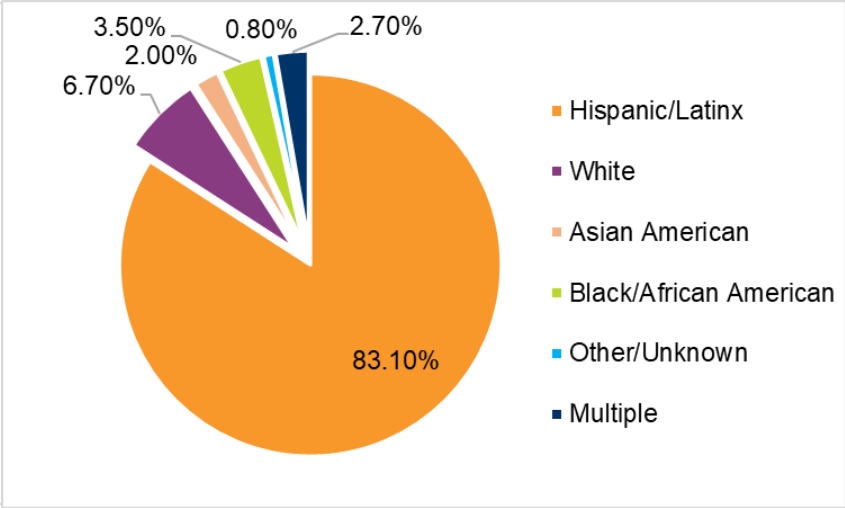
Enrolled Demographics

Number of Weeks Pregnant



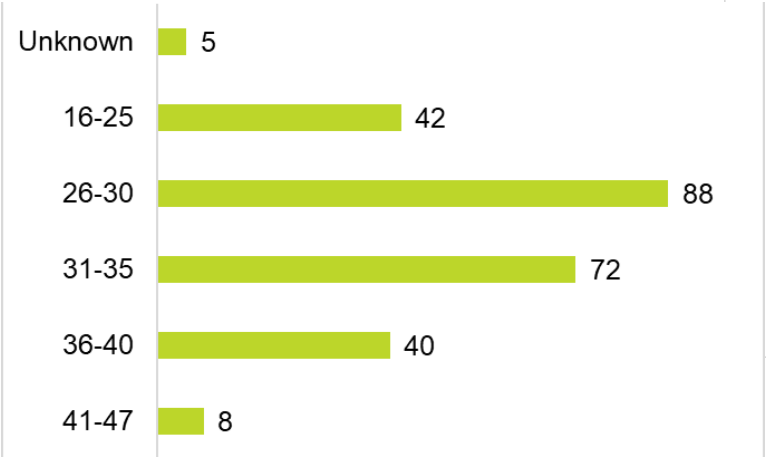
MyB is offered to women who are pregnant or going through post-partum. 83 of the 255 enrolled women were pregnant. Seven were in their first trimester, 35 in their second trimester, and 41 in their third trimester. The majority of post-partum women 172 had a child under one

Race/Ethnicity n=255



83.1% of the women enrolled were Hispanic/Latinx, 6.7% White, 3.5% African American, 2.7% Multiple and 2% Asian American

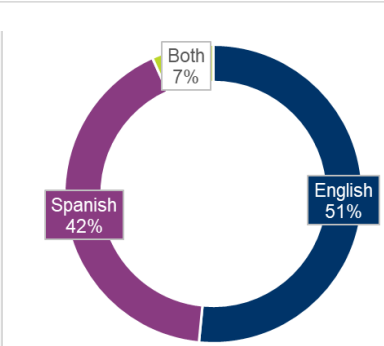
Participant's Age n=255



The majority of the women were under 35 years old. The youngest enrolled was 15 years of age, and the oldest was 43 years of age. Age was missing for 5 participants.

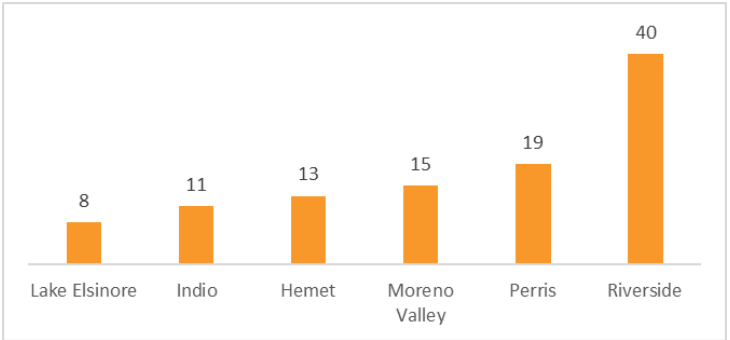
28.2% of women enrolled were Riverside City residents.

Primary Language n=255



English was the primary language most women spoke compared to Spanish. All material was available in Spanish to eliminate a language

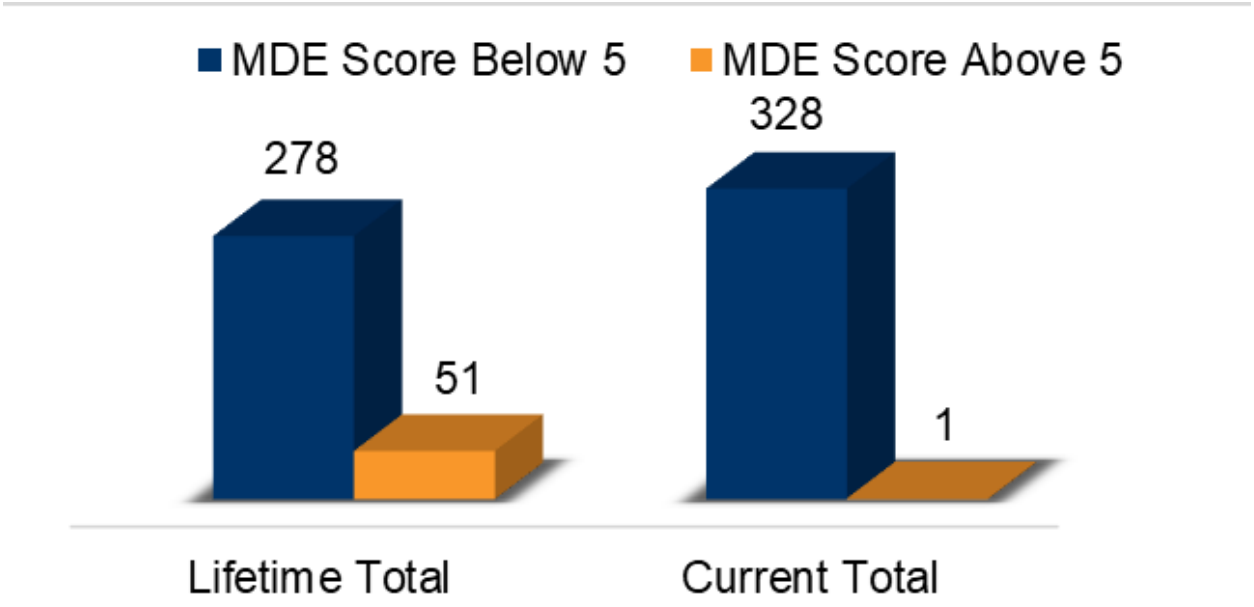
City of Residency n=255



Mood Screener

The Mood Screener for major depressive episodes (MDE) is a self administered questionnaire that helps identify symptoms that may indicate whether a person is currently or in their lifetime suffered from major depression. A score of 5 of more in either the current or lifetime category, along with answering “yes” to “Did these problems interfere with your life or activities a lot?”, may be indicative of a person who is currently experiencing, or has in the past, experienced major depression. Women scoring under a 5 but answering yes to the question quoted above fit the eligibility criteria for this prevention program and a referral to seek further help is provided along with enrollment into the program.

Major Depressive Episode Score (n=329)



Did these problems interfere with your life or activities a lot?

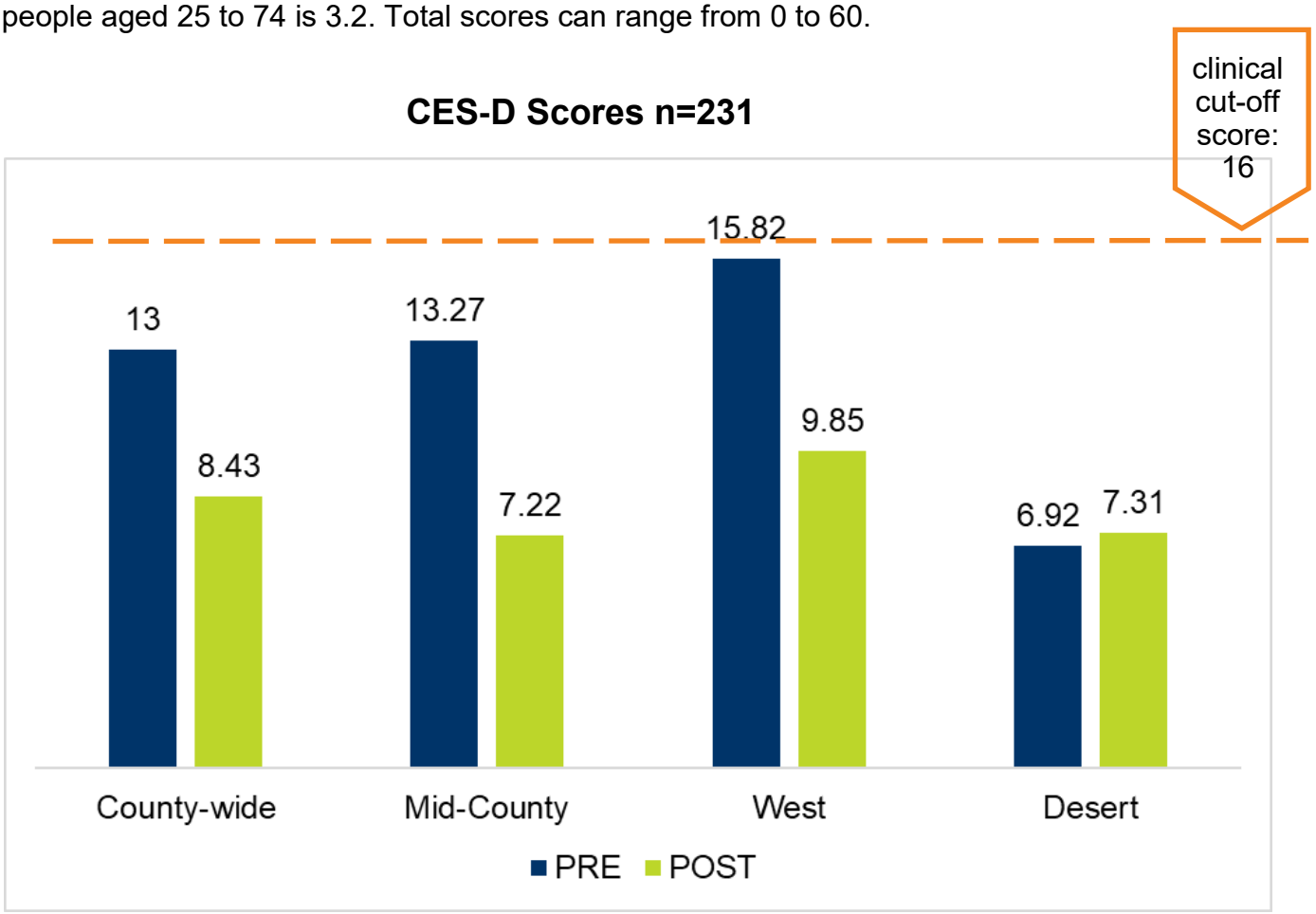
75%

Of the women who scored above a 5 on the MDE answered yes

For a women to be eligible to receive services, they must score below a 5 on the MDE screener in the “current” subscales. 328 of the screened women did score below a 5. From the 40 women scoring a zero in the “current” subscale, 37 women scored under a 5 and three scored above a 5. The total number of women enrolled in the MyB program for this 2023-2024 fiscal year was 255. There were n=329 Mood Screeners analyzed, and 38 of the 51 who scored above a 5 (75%) answered yes to the question “did these problems interfere with your life or activities a lot?”.

CES-D

The CES-D looks at a range of depressed mood that is measured by assessing various depression symptoms that participants were experiencing in the past week. Responses are organized in a Likert scale, where respondents are asked to report the typical frequency in which a particular symptom occurs. A total score is calculated, where higher scores indicate high levels of distress. A score ≥ 16 suggests a clinically significant level of depressive symptoms. It does not necessarily mean that the participant has a clinical diagnosis of depression, but that the person has an elevated level of depression symptoms, compared to other adults. The average score in the overall population for people aged 25 to 74 is 3.2. Total scores can range from 0 to 60.



CES-D scores for those who completed both a pre and a post measure indicated that depression symptoms significantly decreased among the women who participated in the program (t=6.793, df=230, p-value < 0.001). Average scores at intake (pre) indicated that women were within clinically meaningful levels of depression with an average score of 13.0. The post measure provides evidence of a significant decrease in depression levels as the score reduced to an average of 8.43, which has both clinical and statistical significance.

When comparing CES-D scores across regions, the Mid-County region showed a statistically significant improvement from pre- to post-scores (t = 6.722, df = 73, p < 0.001). The Desert region, however, did not demonstrate a significant change between pre- and post-scores (t = -0.346, df = 51, p = 0.730). In contrast, the Western region also exhibited a significant improvement (t = 5.143, df = 104, p < 0.001). Despite these findings, all three regions had post-test scores below the clinical cut-off score, indicating overall improvement. However, only the Mid-County and Western regions had statistically significant results (p < 0.05), while the Desert region did not.

Satisfaction Survey

Item Description (n=227)	1	2	3	4	5	Mean
1. The materials I received from the instructor were easy to understand.	-	-	-	9.7%	90.3%	4.90
2. I am satisfied with the information I received from this program.	-	-	-	7.9%	92.1%	4.92
3. I will use the information I learned during the program in my daily life.	-	-	-	10.1%	89.4%	4.90
4. This program helped me to cope with the moods I have experienced during pregnancy.	-	-	1.8%	17.2%	80.2%	4.79
5. I learned new methods to help me cope with feelings of sadness.	-	-	-	15.0%	85.0%	4.85
6. This program taught me how to get help for depression while I am pregnant and after the birth of my baby.	-	-	0.9%	15.9%	83.3%	4.82
7. I would recommend this program to someone else who is pregnant.	-	-	-	5.3%	94.7%	4.95
					Overall Average	4.87

**Scored on a 5-point Likert scale, where 1 represents strongly disagree and 5 is strongly agree.*

Comments:

"This program has helped me in multitude of ways. I looked forward to coming to the meetings/ classes. The only suggestion I have is to host the classes in a bigger space to allow ample space for the mamas and babies. Thank you ! ."

"I liked all the topics and conversations with the teacher. The reflections were always good. I really liked taking the class. ."

"This class helped my mental health so strong that I can manage to do a little beautiful things every-day. Thank you !"

"This program has helped me feel like I am not alone. It made me feel like a part of a community and has taught me new methods to help me cope with sadness, over whelming feeling and stress. Thank you."

"Motherhood is hard, full of challenges and it was nice to hear that other moms have same challeng-es as me. I learned new ways to cope with situations. Thank you for this program."

African American/Black Communities:

Building Resilience in African American Families (BRAAF) Program

Program Type: Prevention Program



BRAAF is a 9-month program for middle school Black youth that includes three components: the Africentric Youth and Family Rites of Passage program, developed by Dr. Aminifu Harvey (RoP), Guiding Good Choices (a 5-week parent workshop), and Cognitive-Behavioral Therapy (CBT) based clinical intervention, as needed. The RoP component runs throughout the academic year and youth meet at the contract providers location 3 days per week for 3 hours per day. Nguzo Saba and RIPSO principles are foundational elements to each lesson and interaction with youth and their families.

BRAAF was one of the first prevention programs to be implemented in Riverside County starting in 2010. Over the past 14 years of implementation, there were several rounds of Request for Proposals (RFP), the competitive bid process, and changes in providers. PEI support for this program includes monthly fidelity meetings with PEI staff, quarterly BRAAF leadership meetings, monthly BRAAF Clinician support meetings, and annual training. Data collection is a requirement to track enrollment and mental health outcomes for both youth and parents. Consistently, data collection has had challenges, and many adjustments have been made to address them. Despite this, outcomes have been static and continue to demonstrate little to no change in participants. The past several years has also shown a sharp decline in enrollment and program completions. The project target is 3 girls' programs and 3 boys' programs per fiscal year, completing a minimum of 90 youth per year. The last several years have fallen well below that target.

FY22/23 focused on a return to project intent as it was designed by the African American Family and Wellness Advisory Group (AAFWAG) as well as re-establishing fidelity to the Rites of Passage and Guiding Good Choices programs. To support a return to program fidelity and contract compliance several resources/actions were put in place. This included:

- Increased program structure and focus on program fidelity – clarification of program components.
- A comprehensive training plan was put in place.
- A contract between RUHS-BH PEI and a BRAAF consultant was put in place for the development of Master BRAAF training and includes the following:
    - The development of a comprehensive Rites of Passage manual based upon the research and teachings of Dr. Aminifu Harvey (developer of this program).
    - The development of a 3-day Foundational BRAAF training for all staff.
    - The development of a full program module curriculum.

- On-site technical assistance, training, and program support by the BRAAF Master Trainer/Consultant for all contractors that included assistance with lesson planning and contractor orientation for new staff.

- Guiding Good Choices – development of local trainers (RUHS-BH PEI staff) to ensure quality training that adheres to model fidelity and supports sustainability.

After receiving a full year of this high-level of support and technical assistance, FY23/24 has not shown sufficient progress. Feedback from providers and the community provide additional context. First, parents have expressed a concern that the length of the program impacts school performance negatively, e.g., no time for tutoring if needed. Second, families reported conflicting sports schedules, academic, or familial needs. Parents report to staff that their child is too tired to do their homework, chores, or other responsibilities after a full day of school and extra hours of program. This has resulted in parents having pulled youth from the program. Third, there is a desire for more college readiness programming versus a Rites of Passage program. Furthermore, program staff reported challenges with local churches, schools, and elder communities when attempting to advertise/recruit for the program. Local outreach tabling has not yielded enrollments as expected. Providers have reported faith communities (churches) state that they already have after school programming they would prefer their youth to participate in. Additionally, providers have stated local Black owned businesses are not willing to display BRAAF program flyers. Nguzo Saba principles and Africentric verbiage may present a barrier to African Americans participating in the program.

The BRAAF project was initially designed 15 years ago and much has changed in that time. The needs of the community have changed, and this is reflected in the community feedback highlighting that the program interferes with other needs/activities of families and youth. In addition, the past several years has shown a sharp decline in enrollment and program completions, another indicator that this program does not reflect the needs/desires of the community it aims to serve. Program outcomes demonstrate little to no change in participants. Program fidelity and contract compliance challenges continued despite the resources/actions that were put in place. The current structure and poor participation in BRAAF demonstrate that it is not meeting the needs of the community in its current design. This project ended in June 2024 and will be removed from the PEI plan.

PEI Administration will be working with the African American Family Wellness Advisory Group (AAFWAG) and the RUHS-BH Cultural Liaison to gather qualitative community-based data. The goal is to better understand the current needs of the African American/Black community in Riverside County and use this data to inform the service delivery system on how to meet these needs.

FY23/24 Data outcomes for the BRAAF Boys Program:

Africentric Youth and Family Rites of Passage Program (ROP)

This is a nine-month after-school program for African American males in middle school (11-13 years old) and their caregivers/families. The program focuses on empowerment and cultural connectedness. The youth meet three times per week and focus on knowledge development and

skill building. The program includes caregivers and family members who participate in Family Empowerment dinners. Family enhancement and empowerment dinners are held monthly for a minimum of 2 hours each meeting, over 9 months of the program. The objectives of the dinners are to empower adults to advocate on behalf of their families and to work toward community improvement. Community guest speakers/experts are included in the monthly presentations.

In FY23/24, 24 participants enrolled in the Boys Rites of Passage Program, with 71% (17 youth) completing the 9-month program, the completion goal was 30 youth. The program target is 3 boys' programs (one per region) with 45 youth completing per year countywide. This fiscal year the boys' program was only available in the Western and Desert regions. Resilience measures were completed by 16 participants, demonstrating no statistically significant changes in "sense of mastery" or "sense of relatedness", both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight decrease; however, participants continued to demonstrate high levels of identity centrality. Importantly, the Cohesion subscale exhibited a statistically significant improvement, indicating enhanced familial connections as a result of program participation.

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. Boys Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is B.R.A.A.F.?

Building Resilience in African American Families project (B.R.A.A.F.) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American male youth and their parents/guardians that live in communities with high rates of poverty and community violence. The B.R.A.A.F. Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American males between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Executive Summary: Key Findings

Rites of Passage (ROP): In the 2023-2024 fiscal year, 24 participants enrolled in the Rites of Passage Program, with 71% (17 youth) completing the 9-month program, the completion goal was 30 youth. Across Riverside County, serving only the Desert and Western regions, approximately 192 sessions were conducted, with the majority of attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that 88% of participants maintained high academic performance, with only 12% exhibiting below-average grades by the program's conclusion. Notably, the percentage of parents indicating a need for emotional support decreased from 35% to 0% post-assessment.

Resilience measures were completed by 16 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 2.56, $p = 0.486$) or "sense of relatedness" (mean difference of 2.12, $p = 0.580$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight decrease; however, participants ($n = 17$) continued to demonstrate high levels of identity centrality. Importantly, the Cohesion subscale ($n = 16$) exhibited a statistically significant improvement ($t(15) = -2.101$, $p = 0.053$), indicating enhanced familial connections as a result of program participation.

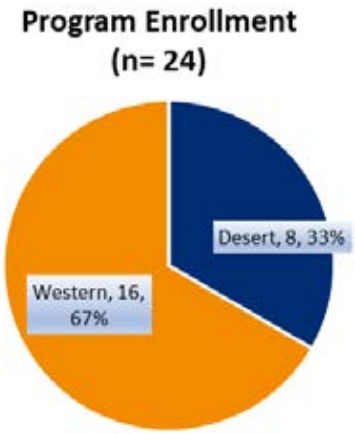
Guiding Good Choices (GGC): A total of 19 parents participated in the GGC program, with a graduation rate of 90% (17 parents). Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The results indicated significant improvements in parental involvement ($t(20) = -3.250$, $p < .05$) and reductions in inconsistent discipline ($t(20) = -3.485$, $p < .05$) and corporal punishment ($t(20) = -3.068$, $p < .05$). Furthermore, parents reported a notable 67% increase in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Overall satisfaction averaged 4.9 on a scale of 5 countywide.

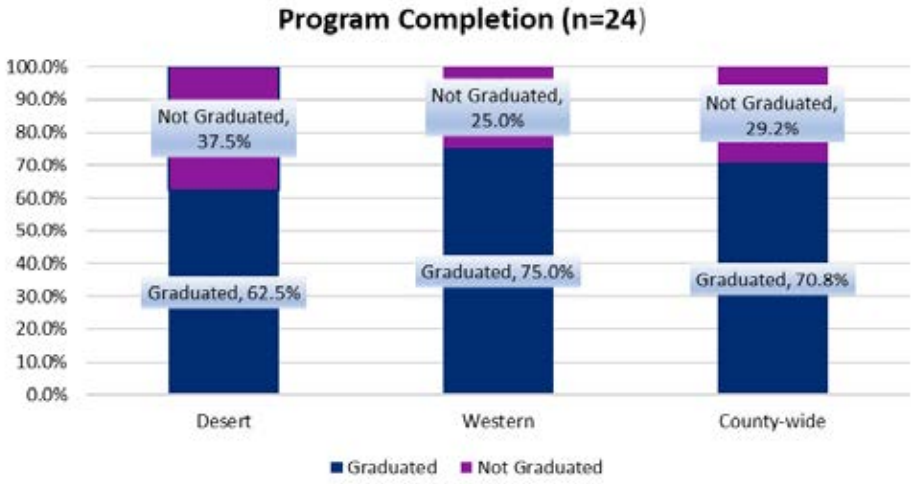
Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents.

Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted four dinners, while the Western region organized seven.

Cognitive Behavioral Therapy (CBT): Sixteen youth participated in CBT, delivered either in-person or via video conferencing. The effectiveness of CBT was evaluated using the Strengths and Difficulties Questionnaire (SDQ) and the Children's Depression Inventory-II (CDI-II). Fourteen parents completed pre- and post-SDQ surveys for their children, indicating significant decreases in emotional symptoms ($p < 0.05$) and overall difficulties, suggesting positive trends in mental health outcomes. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

Program Enrollment





A total of 24 participants were enrolled in the Rites of Passage Program; eight in the Desert, and eighteen in the Western region. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.

Most participants (71%) completed the 9 month program, while 29% were discontinued and/or did not graduate from the program. Of the completed participants, 5 were from the Desert region and 12 were from the Western region. A total of 17 youth graduated from ROP. Some of the reasons participants discontinued the B.R.A.A.F. program were relocation or being withdrawn by their parent(s).

ROP Attendance Distribution:
Number of Sessions Attended by Youths per Region

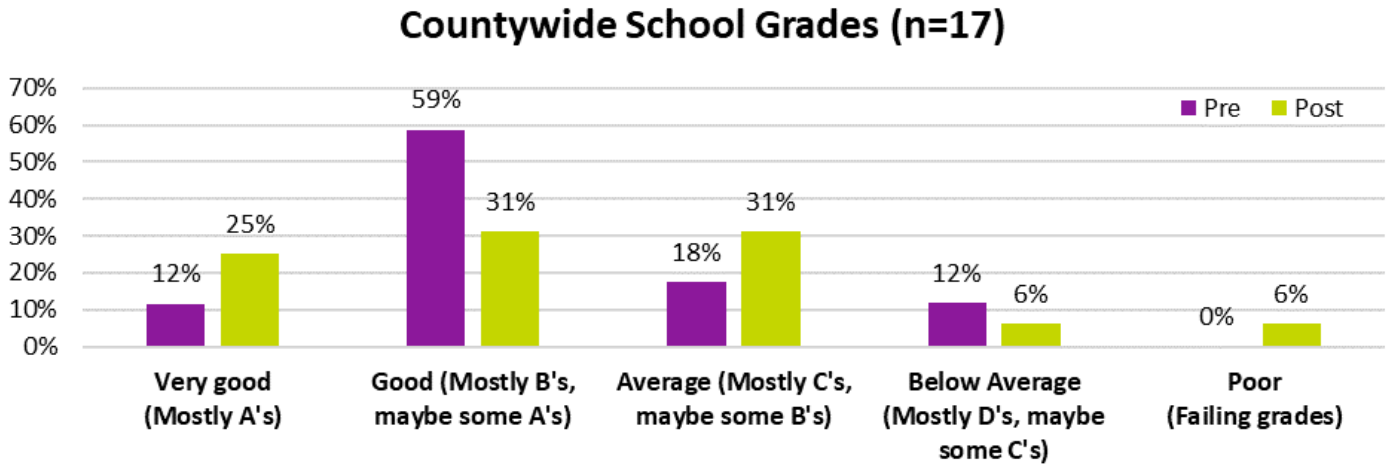
Sessions	Desert	Western	County
0-20	3	3	6
21-40	1	0	1
41-60	0	1	1
61-80	9	2	11
81-100+	3	2	5
Youths per Region	16	8	24

ROP is a 9-month program that is offered 3 times a week, with a target of 108 sessions per year/per program/per region. Approximately, 96 sessions were offered depending on each region's start date. Together, all two regions hosted approximately 192 ROP sessions throughout Riverside County.
Due to attrition the majority of participants dropped during the first half of the B.R.A.A.F. program.

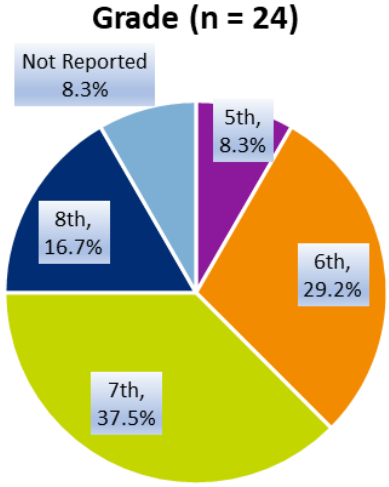
School Information

Countywide Results	*Pre		*Post	
	Yes	No	Yes	No
In the last 3 months, has the youth had a sudden drop in school performance?	29%	71%	13%	88%
Has the youth ever been suspended?	0%	100%	6%	94%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	100%
In the past year, has the youth been: arrested?	0%	100%	0%	100%
In the past year, has the youth been: on probation?	0%	100%	0%	100%
In the past year, has the youth been in any programs to help them with emotional problems?	35%	65%	0%	100%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	12%	88%	18%	82%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	100%	13%	88%
Is the youth affiliated with a gang?	0%	100%	6%	94%

*Some items for some youth are missing. Only averages across each questions were calculated from 17 participants that completed the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post).

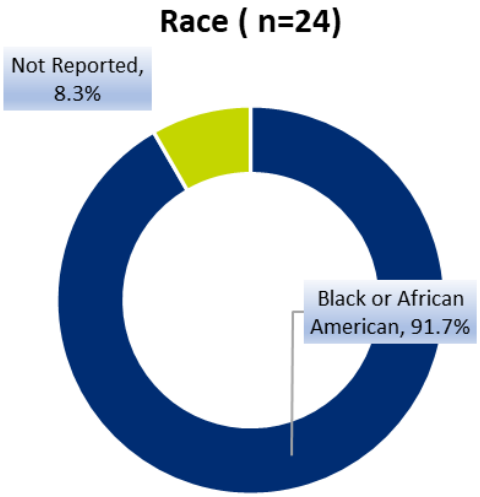


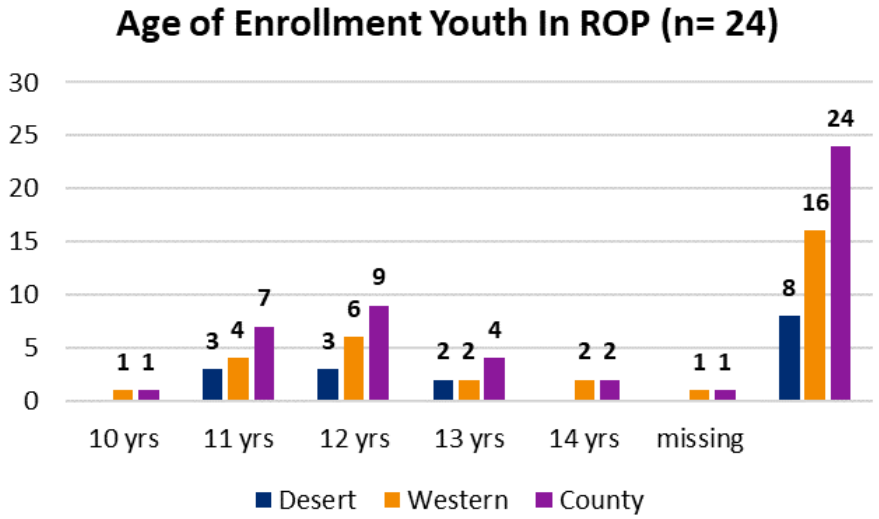
*Some items for some of the youth are missing for the School Performance. Only the 17 participants completing the R.O.P. Intake Form (pre) and Program Completion/Discontinued Form (post) were used to calculate the School Performance Chart.



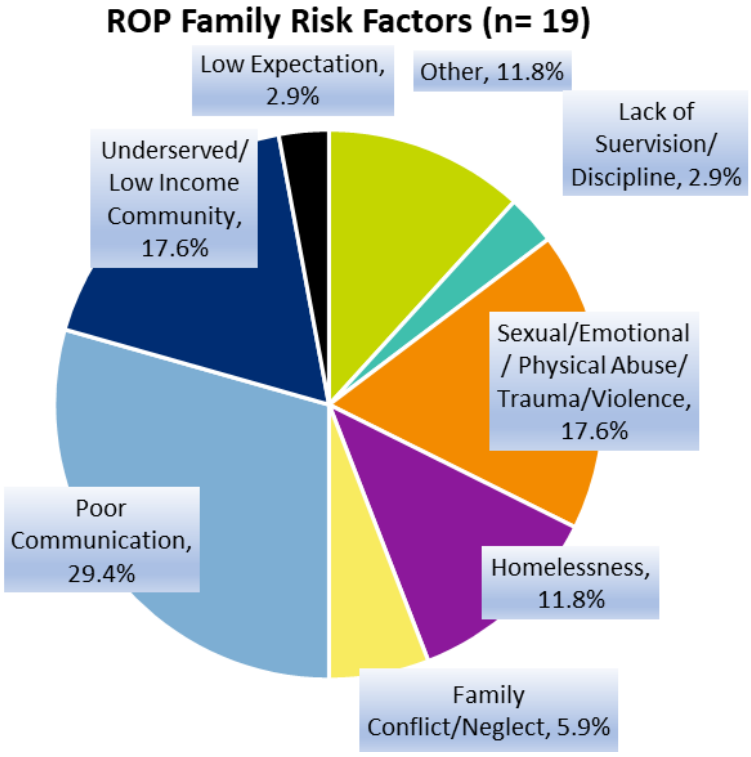
The majority of the boys in R.O.P. were in 6th, 7th, or 8th grade. Before R.O.P. began, parents were asked to complete a questionnaire regarding their youth's school performance. Once R.O.P. ended, the parents completed the same questionnaire to analyze whether being in B.R.A.A.F. had an impact on school performance. Most youth had high grades prior to the program, and this trend remained consistent by the end, with only 12% having below average to poor grades. Additionally, there was a slight decrease in support programs for emotional problems. Before R.O.P., 35% of the parents answered "yes," but after the program ended, all parents answered "no" regarding behavioral support programs for youth.

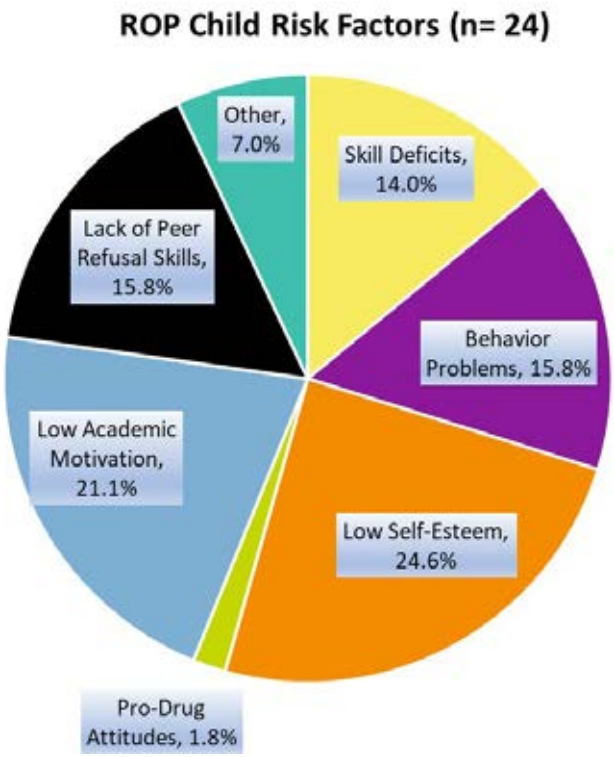
Demographics





It is important to note that 24 youth enrolled and have attended at least one session. The target enrollment for both regions was 40-50.

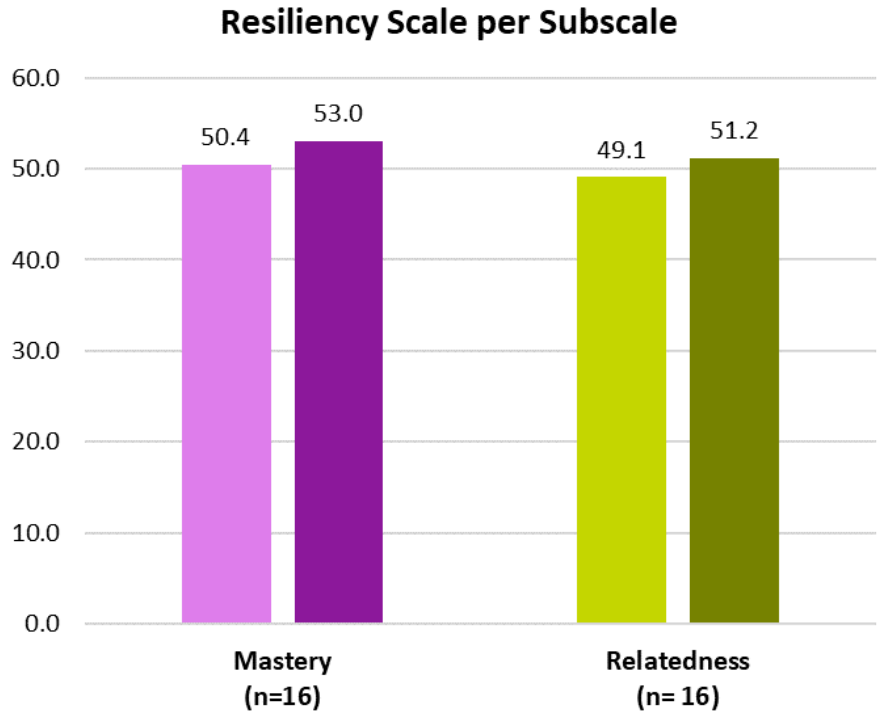




Risk Factors are based on participants that have provided at least one or more responses on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.

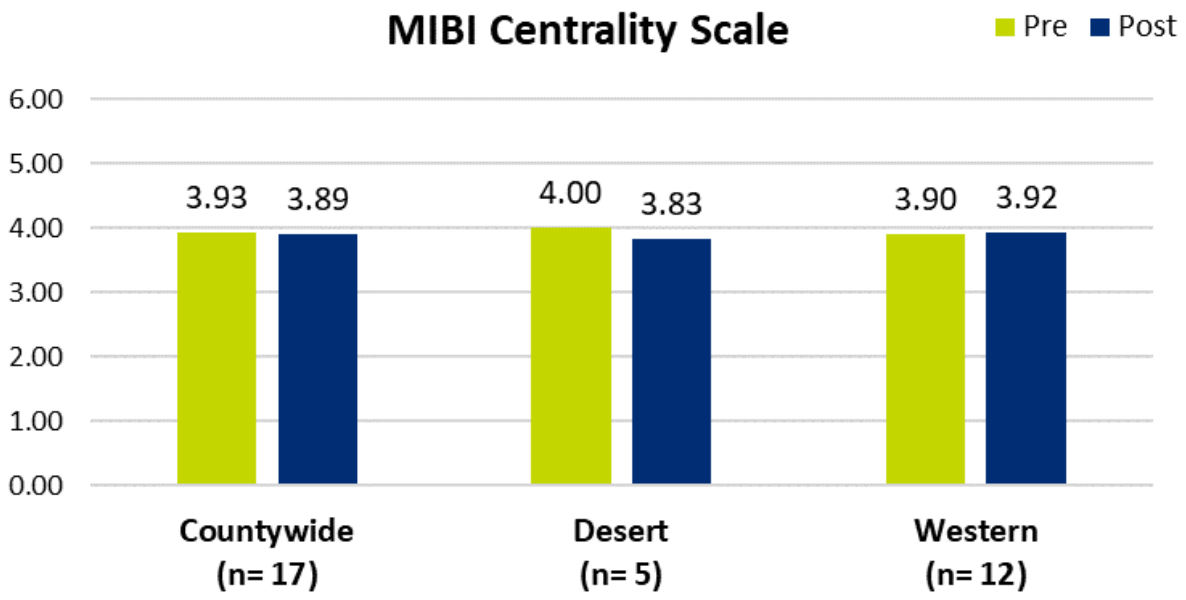


There were 16 participants from the Desert and Western regions who completed both pre- and post-measures for the chart above. Countywide, the scores for "sense of mastery," which reflects an individual's belief in their ability to manage challenges and achieve goals, slightly increased, with a mean difference of 2.56 ($t(15) = -0.715$, $p = 0.486$), indicating no statistically significant change ($p > 0.05$). The total scores suggest that youth reported an "Average" sense of mastery at both intake and follow-up, according to the Resiliency Scale scoring categories.

Similarly, there were also 16 participants with completed pre- and post-measures for the Sense of Relatedness scale, which involves feelings of connection and belonging to others. The scores on the relatedness subscale increased slightly, with a mean difference of 2.12, but there was no statistically significant change from pre- to post-measure ($t(15) = -0.565$, $p = 0.580$, $p > 0.05$). Both at intake and follow-up, youth reported an "Average" sense of relatedness, according to the Resiliency Scale scoring categories.

The Multidimensional Inventory of Black Identity

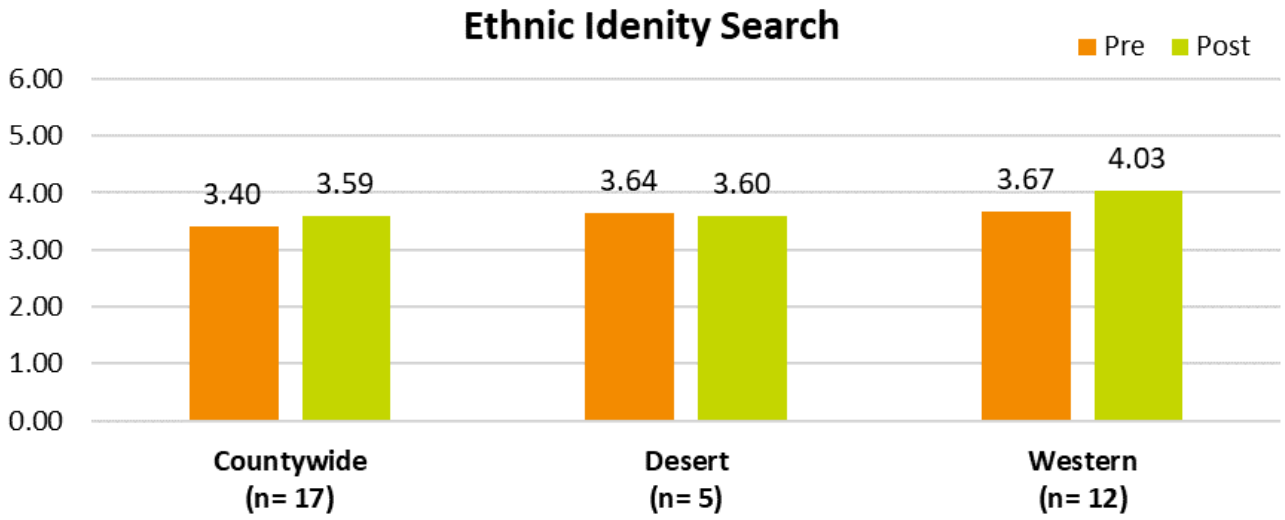
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of himself. The highest possible average one can score on Centrality is 5.

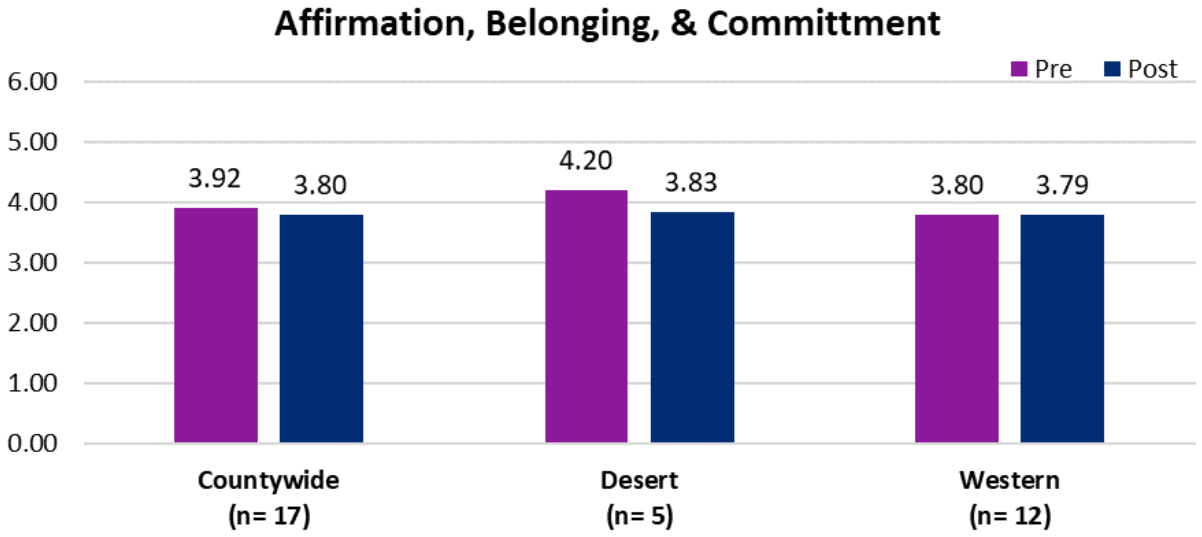


All regions were required to use the Teen MIBI measure, which consists of 9 items. Countywide, participants (n = 17) scored an average of 3.93 at the pre-assessment, and post-ROP, their average score was 3.89. This change was not statistically significant ($p = 0.913$, $p > 0.05$). Overall, the participants' scores remained around 4, indicating a strong sense of centrality regarding the importance of their Black/African American identity. In the Desert region, there was a slight decrease from pre to post, but the small sample size (n = 5) limits the reliability of any statistical comparison. Consequently, both the Desert and Western regions had small sample sizes, making it difficult to compare regional differences in racial identity. However, the average pre- and post-scores across both regions suggest that participants continued to maintain a high level of self-esteem associated with their Black/African American identity, as reflected in the MIBI Centrality Scale.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.

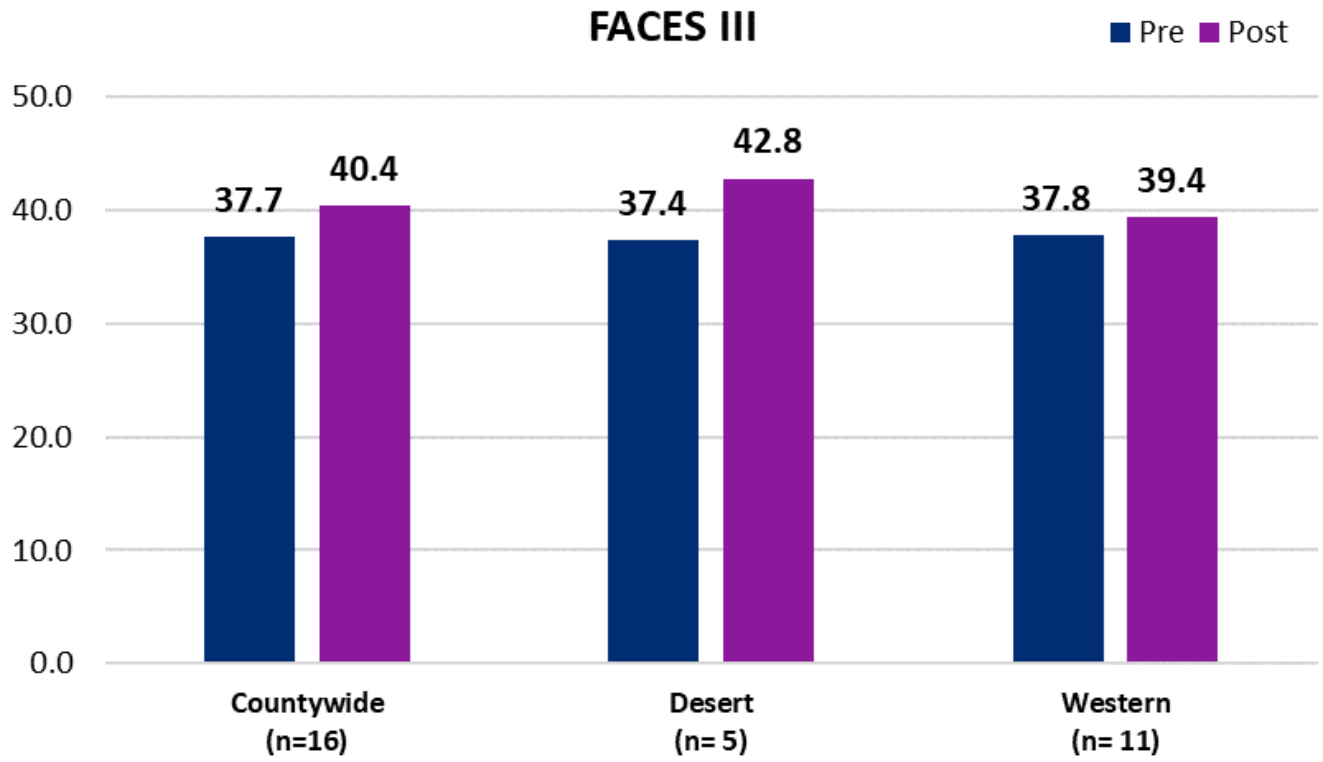




Overall, countywide, there was no change in the Multigroup Ethnic Identity Measure (pre-test = 3.40 and post-test = 3.59). In Affirmation, Belonging, and Commitment; countywide, there was no significant change with a mean difference of 0.12 (pre-test = 3.92 and post-test = 3.80). Though, there was no statistically significant change in either subscale, average scores across regions illude positive ethnic identity development in the R.O.P. youth.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



The results indicate that countywide scores on the Cohesion subscale showed a statistically significant improvement from pre to post-assessment ($t(15) = -2.101$, $p = 0.053$). This suggests that families experienced a shift in their sense of connection over the course of the program.

Initially, families reported feeling somewhat separated, with a pre-score of 37.70. However, after participating in the R.O.P., their post-score increased to 40.4, indicating a stronger sense of cohesion and connection among family members.

Although the sample sizes for each region were small, the average scores reflect a positive trend, demonstrating that families felt more united and engaged after the program. This improvement in cohesion suggests that the R.O.P. effectively fostered family bonds and enhanced the sense of togetherness within families.

Overall, these findings suggest the potential impact of the program on family dynamics, emphasizing the importance of fostering connections for overall family well-being.

Youth Satisfaction

Towards the end of the program, the majority (n= 17) of youths who graduated from ROP completed a satisfaction survey. Overall, the majority of youth who completed the satisfaction survey agreed that participating in the program was a positive experience. Also, respondents reported "good" with regard to staff treatment towards the youth.

Item Description (Score range: 1—5)	County-Wide n= 17	Desert n= 5	Western n=12
1. Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	3.82	4.00	3.75
2. Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.59	4.00	3.42
3. Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.29	3.60	3.17
4. Participating in this program has been a positive experience for me.	3.82	4.40	3.58
5. Participating in this program has changed how I think about myself in a positive way.	4.06	4.40	3.92
6. Please rate your satisfaction with how staff, in the Rites of Passage program, treated you.	4.12	4.20	4.08
7. Rites of Passage staff presented the program information in a way I understood.	4.19	4.25	4.17
8. Rites of Passage staff presented the program information in a fun way.	3.59	3.80	3.50

How this program may have affected participants
"It helped me be accountable for my actions."
"Program has changed me in a positive way by teaching me how to manage my emotions."
"This program changed me mentally and helped me deal with suicide."
What participants liked about the program
"Learning about my culture."
"The things we talked about and to trip fields."
"Good things to learn and food and activities."
What participants did not like about the program
"Having to memorize the *Nguzo Sabas* was something I didn't enjoy."

Parent/Caregiver Satisfaction

Overall, 100% of parents were satisfied with the program. Furthermore, 100% of parents indicated that they would recommend the program to a friend or relative.

Item Description (Score range: 1 - 4)	County-Wide n =15	Desert n= 5	Western n= 10
1. The program's ability to assist your child.	3.7	3.6	3.8
2. Your child's progress/accomplishments/achievements. while in the program.	3.9	4.0	3.8
3. The philosophy and approach of the program.	3.9	3.8	4.0
4. Opportunities for parents to meet together for support and share information.	3.9	3.8	4.0
5. Overall Satisfaction.	3.8	3.4	4.0

What has been most helpful to you and your child?
"My sons learned more about their African roots, and has empathy for others."
"What I loved the most was learning our African Culture. Teachings/lessons of our great pioneers and inventors that contributed to society globally. Being proud of our African Heritage and knowing our origin. Teaching cooking lessons, learning effective communication, build strong bonds with parent and son. Very enriched principles and values."
"Parent module sessions which helped support our family with ways to communicate and approach different situation with our son."
What changes can you suggest?
"Transportation needs to be upgraded for safety reasons."
"I would suggest more men mentors leading the lessons, also add a physical activity such as baking that helps with developing discipline. Build self-confidence. More outings such as hiking, camp-learn nature."
"More parent participation and more outings."
Is there anything else you want us to know?
"This program is effective in its lesson taught by the coordinators/staff. [Staff members] did a fantastic job. Continue program."
"My sons were pleased with the respect and concern they received from the staff members. My sons seemed to have enjoyed the retreats and outings."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

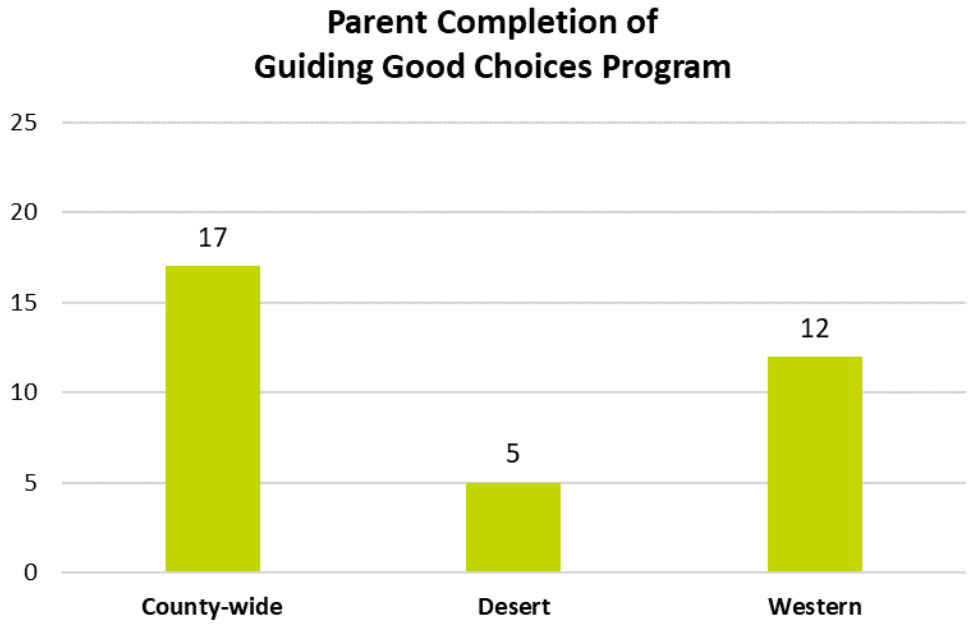
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks at the start of the program. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: how to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

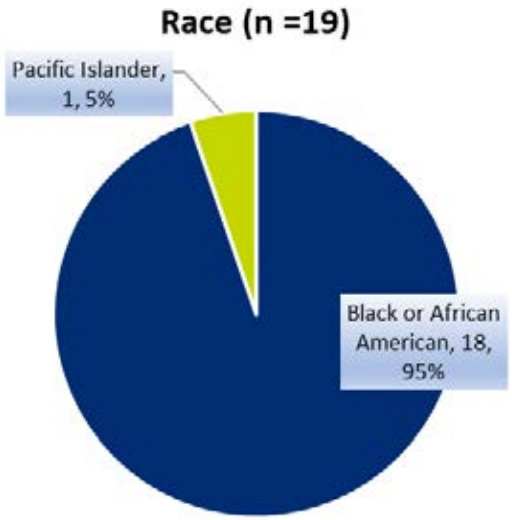
GGC Program Completion

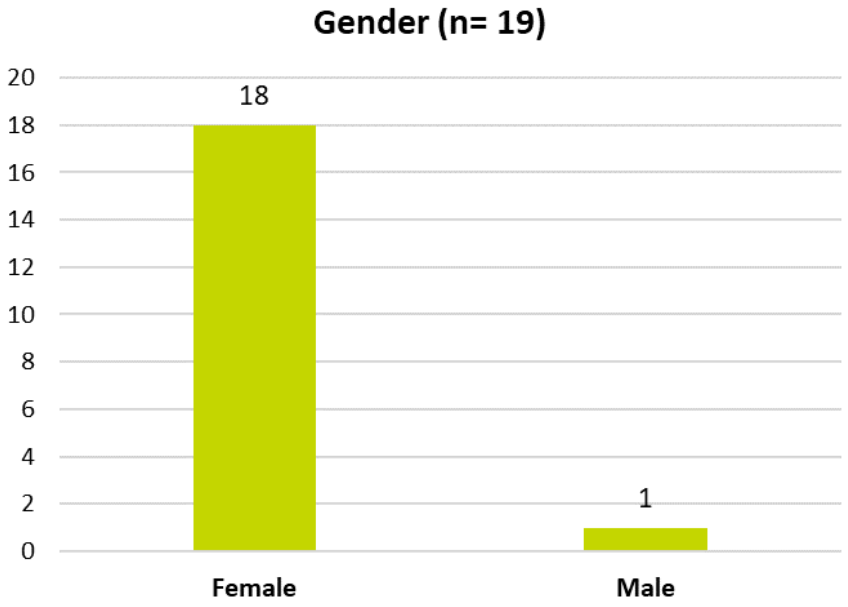
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

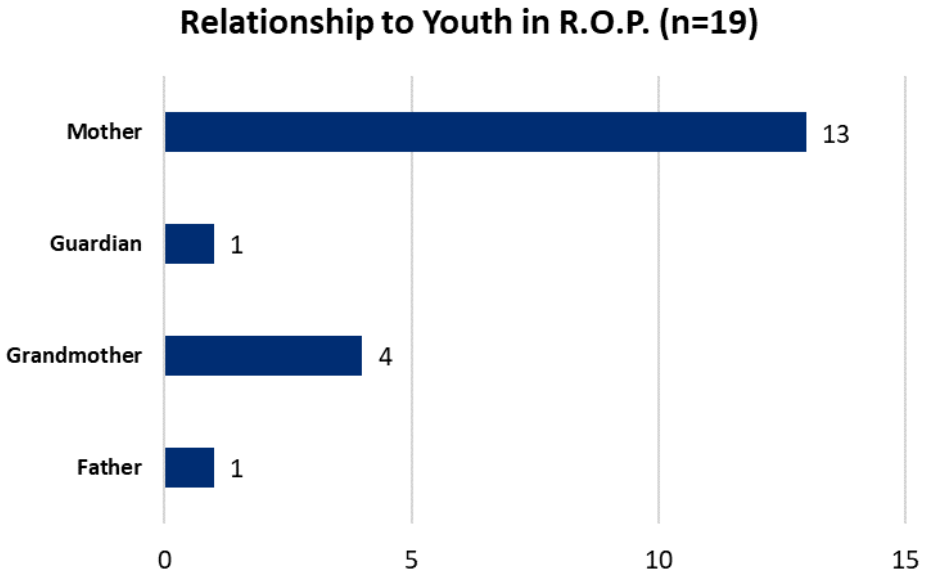


19 parents attended at least one session of GGC and 17 parents (90 % of the cohort) completed the program in 2023-2024 FY.

Demographics



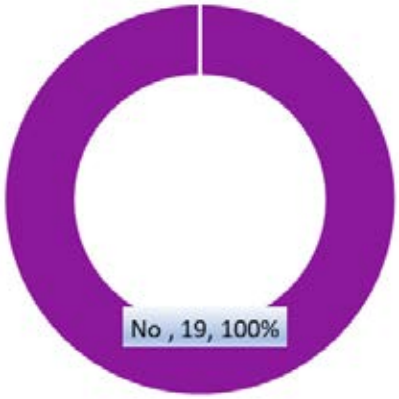




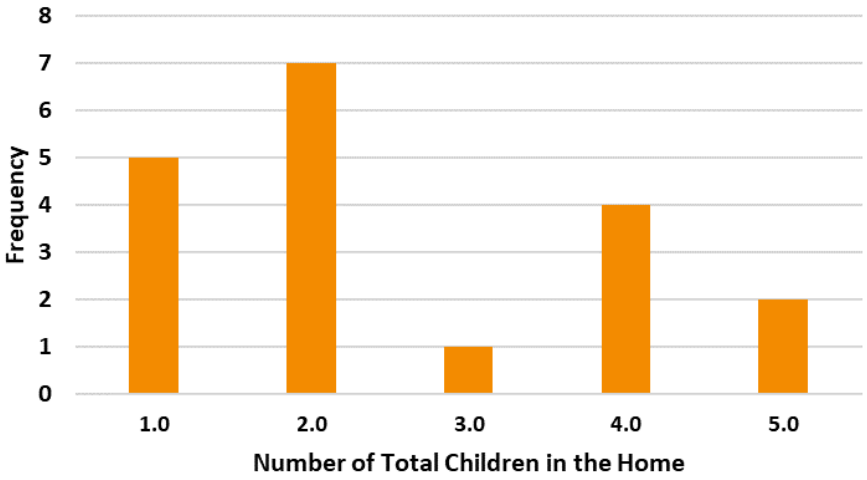
Of the self-reported data collected from GGC, 95% of the participants were African American, and 5% were Pacific Islander regarding race on the demographic form. The male-to-female ratio was, approximately, 1 to 18, respectively. Mothers (n= 13) were the primary participants, followed by grandmothers (n= 4), one father (n =1), and one guardian (n= 1).

Demographics cont.

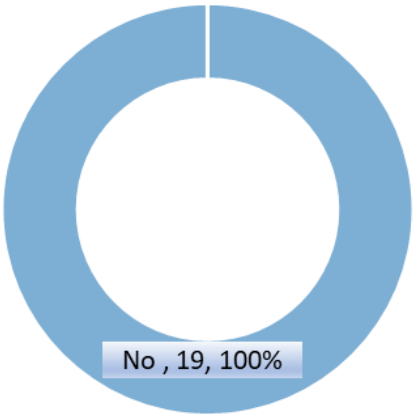
Disabling Condition? (n=19)



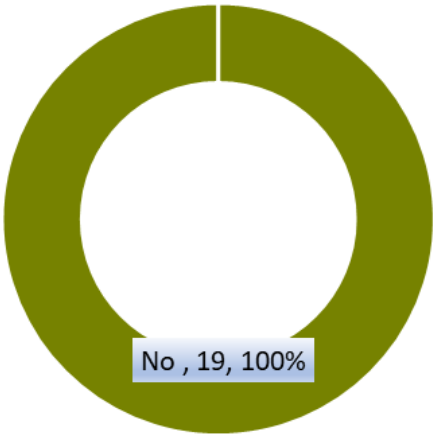
# of Children per Household (n= 19)



Child Actively Uses Drugs/Substances? (n=19)



Veteran? (n=19)

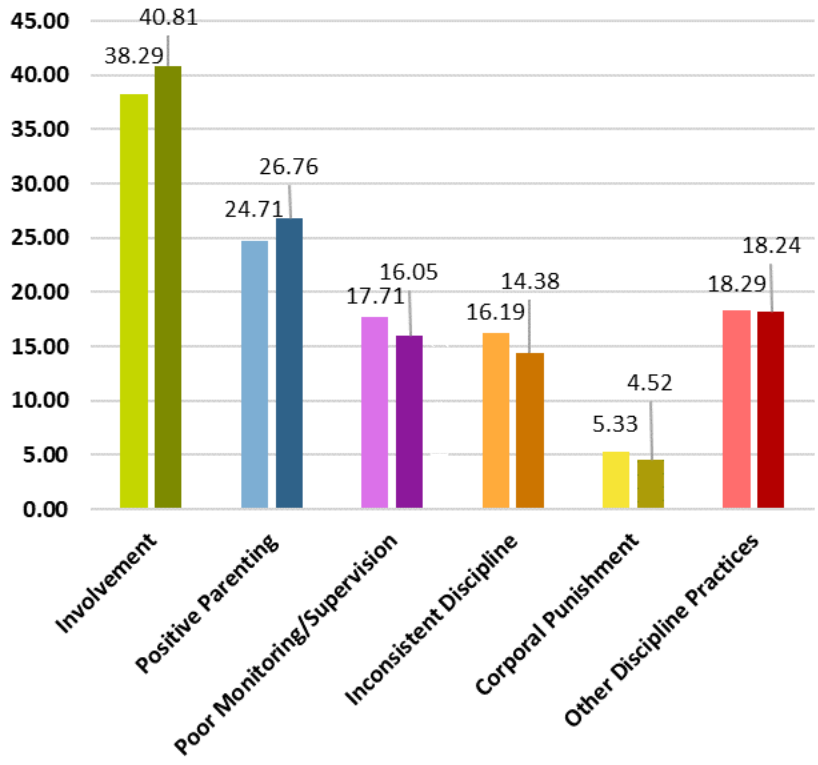


Overall, 19 parents were served in GGC and 17 parents completed the program. Of the 19 who enrolled, approximately, parents reported none of their children actively use substances (n =19). Most parents had two children in their homes.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=21)



Nineteen parents/caregivers had a pre and post APQ measure. Two parents had two siblings in the program (n =21).

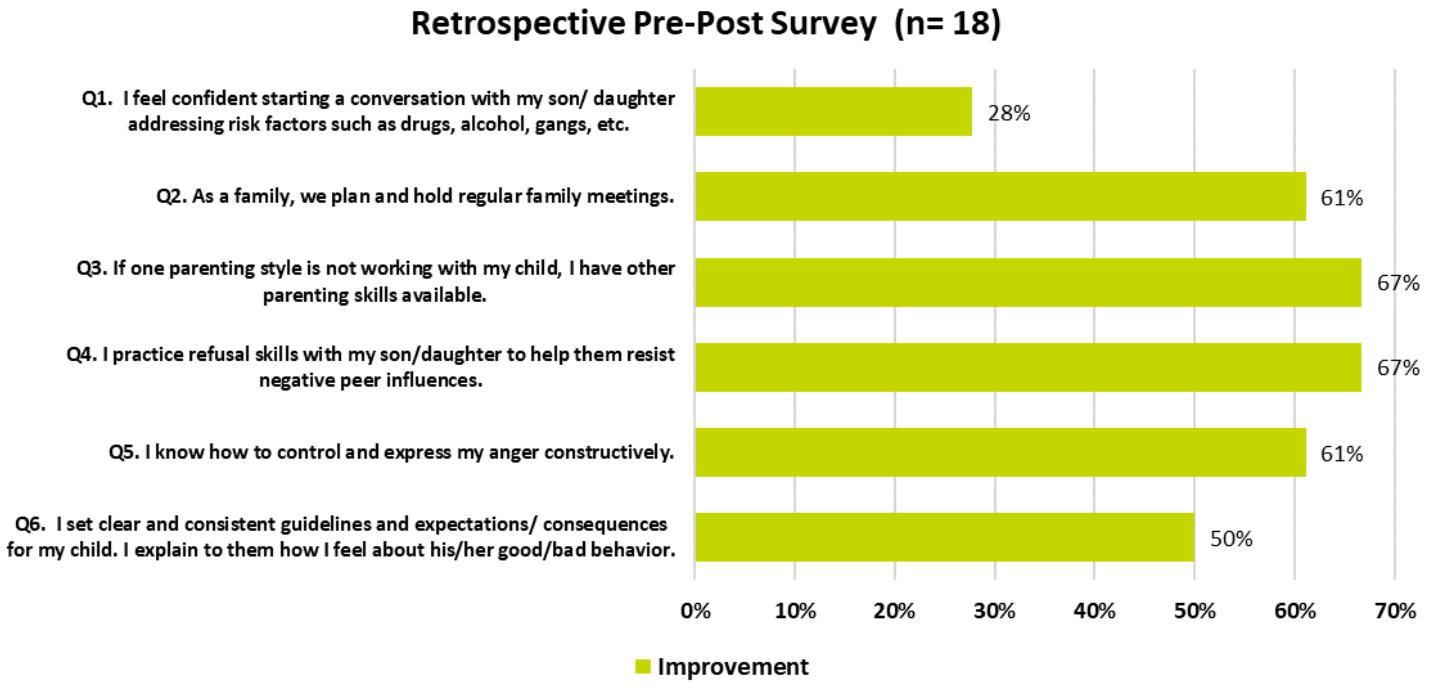
To demonstrate improvement in the six scales, the post means should be greater than the pre means for involvement, positive parenting, and other discipline practices. However, poor monitoring/supervision, inconsistent discipline, and corporal punishment, should exhibit lower post means than pre means to indicate that the parents do not agree with the "poor parenting" item questions from the APQ.

Overall, county results exhibited statistically significant differences in the following areas: parental involvement scale significantly improved, (t (20)= -3.250 , p< .05), inconsistent discipline significantly decreased, (t(20) = -3.485, p< 0.05) and corporal punishment significantly decreased, (t (20)= 3.068, p < 0.05).

		Involve-ment	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	36.38	21.75	22.13	14.38	5.75	16.75
	Post	38.63	25.38	18.13	13.88	5.25	16.75
Western	Pre	39.46	26.54	15.00	17.31	5.08	19.23
	Post	42.15	27.62	14.77	14.69	4.08	19.15

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.44	4.94	.058	Q4	3.33	4.50	<0.001
Q2	3.00	4.33	<0.001	Q5	3.28	4.17	<0.001
Q3	3.50	4.56	.002	Q6	3.83	4.44	.045

For the retrospective pre to post-survey, the parents in GGC answered six questions after the completion of the five-session program. Eighteen parents answered the questions by comparing their parenting skills at the end of the program to their parenting skills before GGC. Based on the results, parents increased the most (67% increase) in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children. Parents showed significant overall improvement (p <.05) after GGC regarding the following items: meeting regularly as a family, increasing parenting skills, practicing refusal skills, regulating emotions and setting clear/consistent expectations and consequences. To note, those parents that did not show improvement had scores that were high in the pre-assessment.

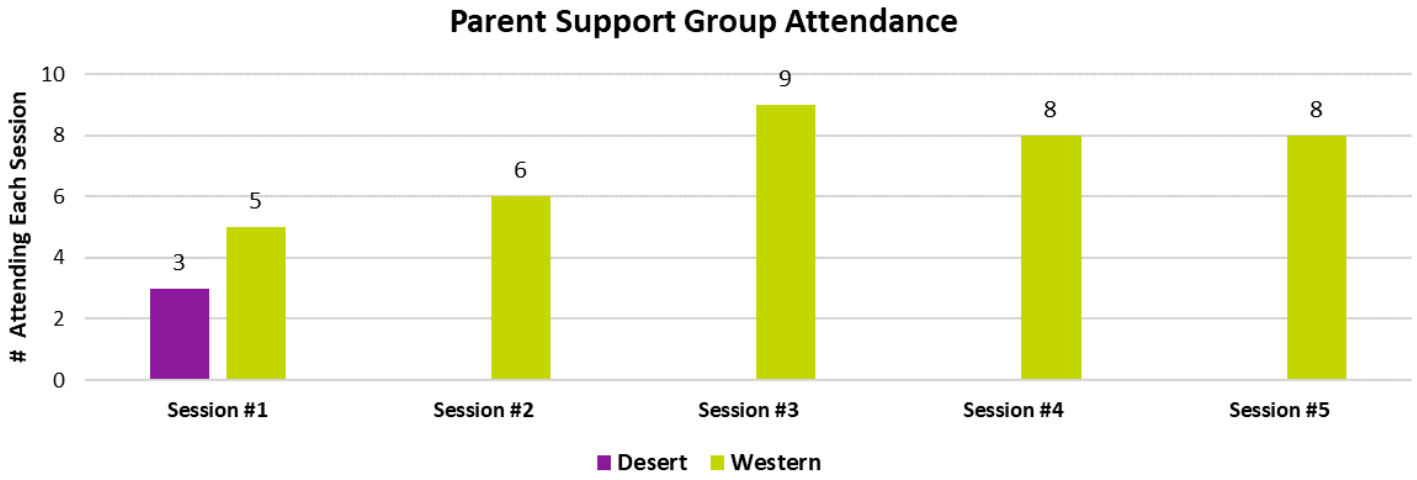
Satisfaction Survey

Item Description (Score range: 1– 5)	County-wide n= 19	Desert n=8	Western n=11
1. Overall, I am satisfied with the program.	4.9	4.9	4.9
2. The location of the program was convenient for me.	4.2	5.0	3.6
3. The sessions were at a time convenient for me and my family.	4.7	4.8	4.6
4. My family got the help we wanted for my child.	4.6	4.5	4.7
5. As a result of the program, I am satisfied with our family life right now.	4.7	4.6	4.8
6. I felt comfortable talking about my child's problems with the staff.	4.5	4.8	4.3
7. The facilitators listened to what I had to say.	4.9	4.9	4.9
8. Facilitators spoke to me in a way that I understood.	4.9	5.0	4.9
9. Facilitators are respectful of my cultural/ethnic background.	5.0	5.0	5.0

Things I learned in the GGC program are:
"Too much for these 2 lines! The importance of family meetings, involving my child in decisions, expressing my feelings about his behavior in a healthy manner, etc."
"How to set boundaries, also to stick to my guns, say what I mean and mean what I say."
"It's a program that has helped me to understand my sons on a different level of trying to understand them."
"How to communicate better with my child."
What I liked about the GGC program is:
"Hearing the experiences of other parents and how different topics and challenges can be addressed constructively."
"I was given tools to deal and take my child in different situations."
"The help and info from the other parents."
"The positive change with my child."
What I didn't like about the GGC program is:
"At times, there were hot topics where time did not allow a full conversation, though it was still a discussion."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a young teenage child. Topics discussed were about drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of B.R.A.A.F., parents were committed to keeping in touch with each other, and continue to provide support to each other when needed as they really felt like the additional support meetings have helped them become better parents overtime.

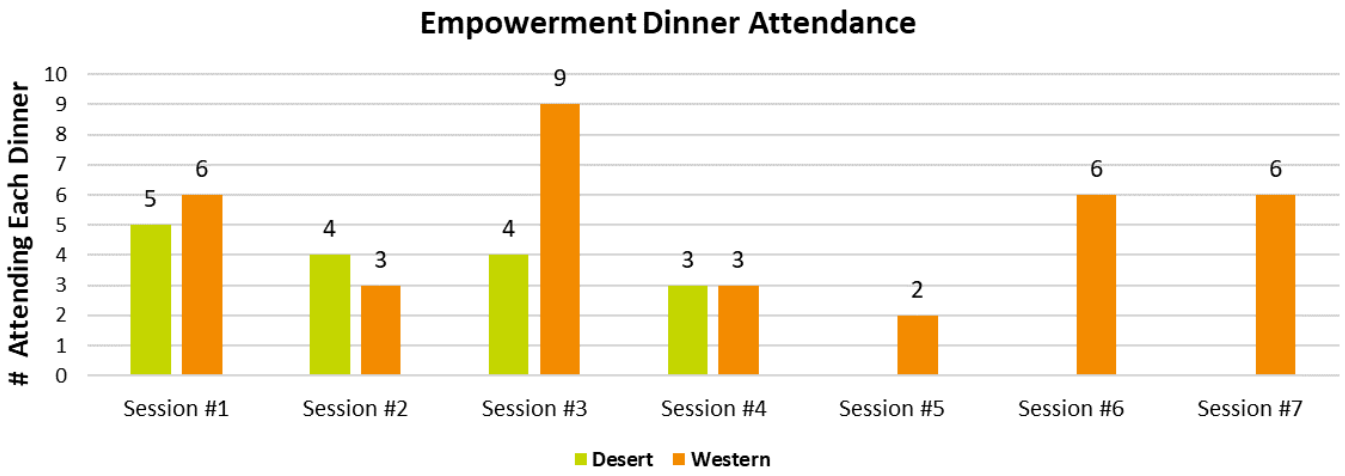


	Total Number of Sessions Hosted	Group Size Range
Desert	1 Session	1—3 People
Western	5 Sessions	1—9 People

No Parent Support Group Satisfaction Survey was conduct for Desert and Western regions at the end of the program. Refer to Parent Focus Group section for responses regarding PSG feedback.

Empowerment Dinner

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.



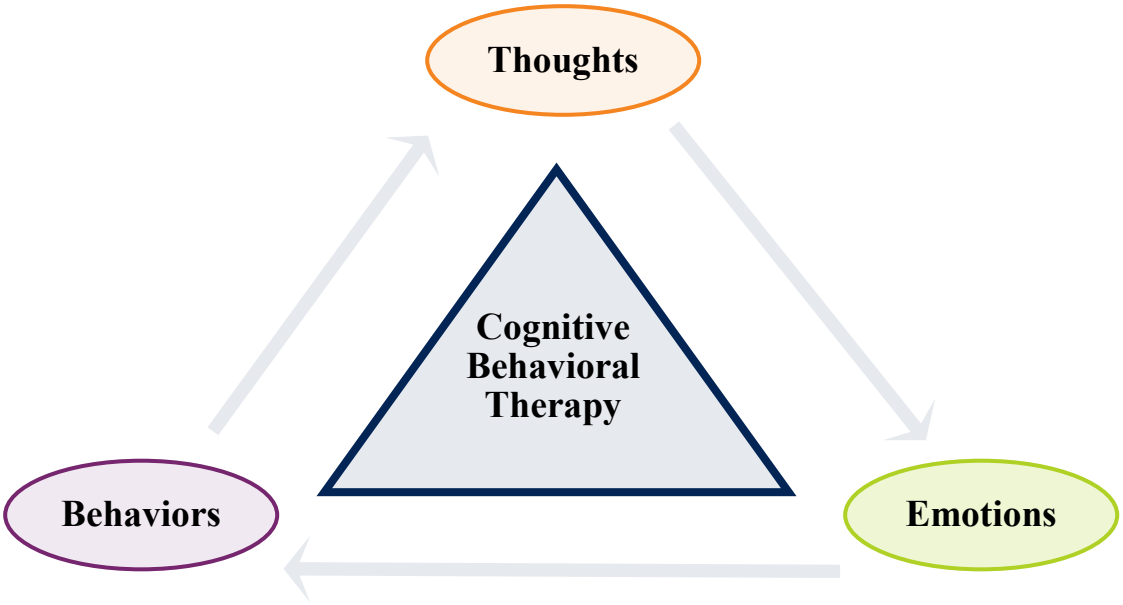
	Total Number of Sessions Hosted	Group Size Range
Desert	4 Session	1—5 People
Western	7 Sessions	1—9 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences. The youth may feel emotionally uncomfortable at times. The youth may cry, get upset, or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

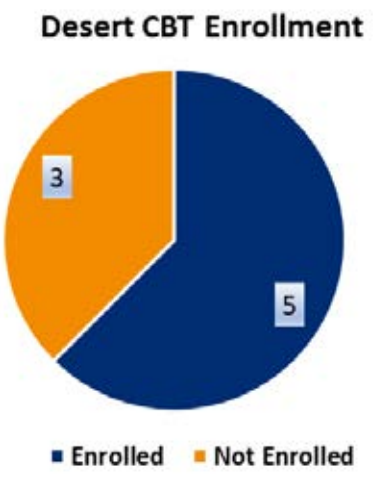
www.mayoclinic.com/cbt



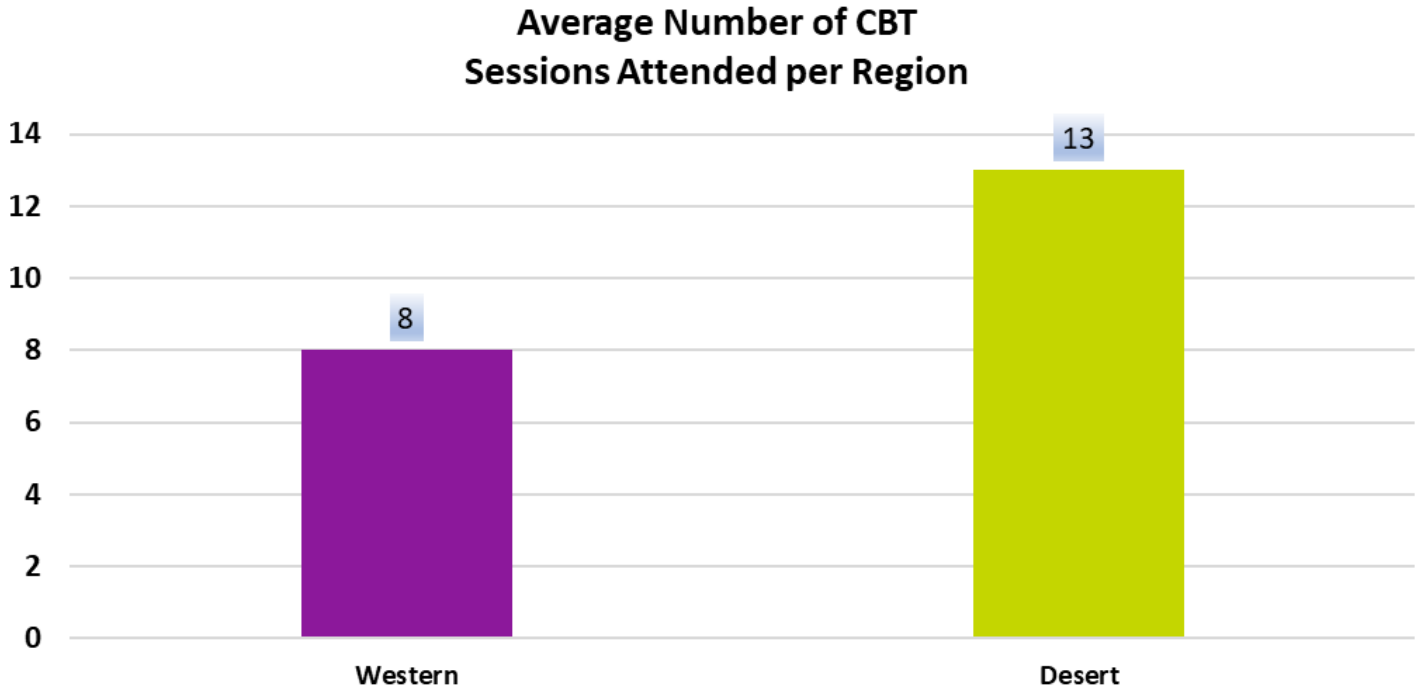
Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

CBT Enrollment



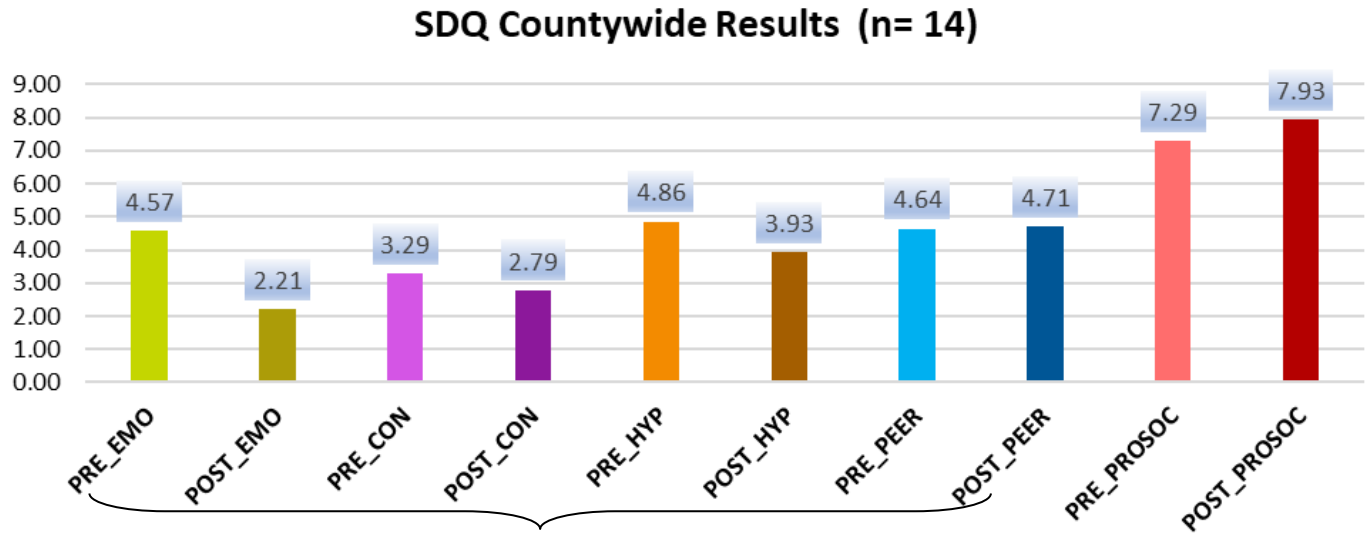




This fiscal year, CBT was offered as part of the B.R.A.A.F. program, and 16 youth received at least one session in CBT. The Desert region had 5 youth and Western region had 11 youth who received CBT sessions during the 22-23 fiscal year. On average, participants from Desert region attended 13 CBT therapy sessions and those from Western region attended 8 CBT sessions. These sessions were conducted in-person and via video-conferencing depending on the region and flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=17.36 , Post=13.64

The four behavioral subscales were expected to decrease in average sub-scores; whereas, the prosocial subscale was expected to increase. The total score slightly increased, this change from pre– to post– score was statistically significant, ($t(13)= 2.460$, $p > 0.05$), and can suggest the youth faced less difficulties after completing one-on-one CBT sessions. The participants exhibited a significant decrease in the following subscales: **emotional symptoms**, $t(13) = 0.002$, $p <0.05$).

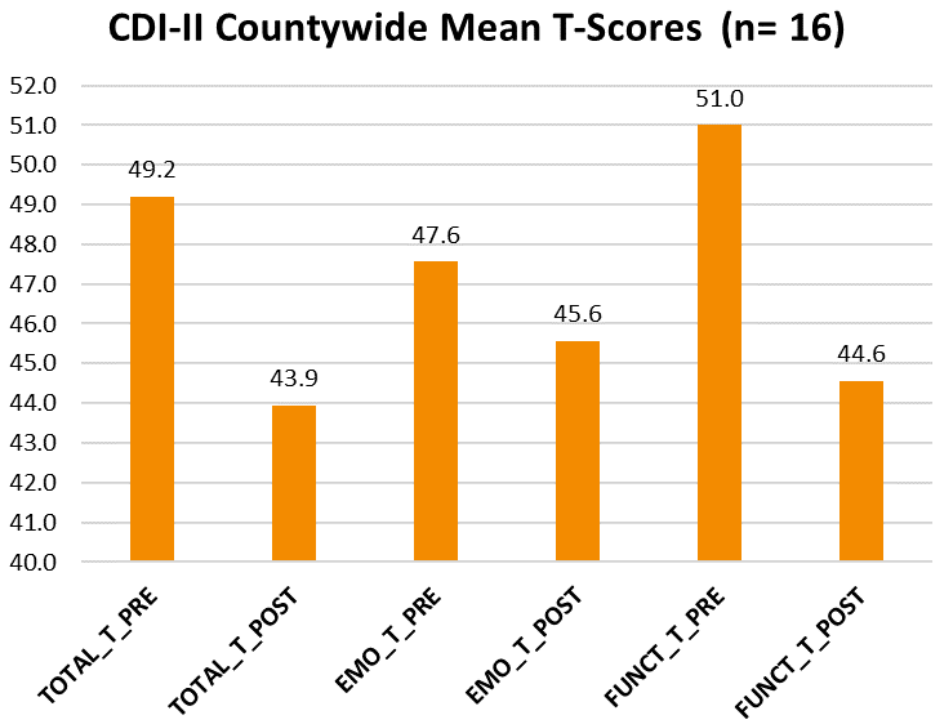
Although the results showed no statistically significant change from pre to post-measure, the decreases in conduct issues, hyperactivity/inattention, and peer relationship problems suggest a trend that could indicate the program's potential effectiveness and highlights the need for further exploration.

Children's Depression Inventory II

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches his personality. Higher scores (70 and above) suggest very elevated levels of depression for all subscales and the total score. Whereas, scores 65-69 are elevated, 60-64 are high average, 60- 64 are average, scores 59-40 are considered average and <40 are low. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



All participants were required to complete both pre and post-CDI-II. When comparing the pre and post-test total scores, there was a statistically significant decrease in Total Score and Emotional Problems (p<.05). The youth displayed a decrease in depressive symptoms; youth remained at the average range of severity of depression, according to the Children Depression Inventory (2nd edition) assessment.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	County-Wide n= 16	Desert n= 5	Western n= 11
1 The program taught me how to cope with stress.	3.31	4.00	3.00
2 The program helped me to understand myself better.	3.38	4.40	2.91
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	3.44	4.60	2.91
4 I achieved my goals for the group.	3.44	4.20	3.09
5 The facilitator listened to what I had to say.	4.38	4.80	4.18
6 The facilitator knew how to help me.	3.69	4.60	3.27

Things I learned in the program are:
"How to react in touch situations, how to talk to people and code switching."
"I learned about my ancestors and how some of them helped us and rest wasn't beneficial because I already knew most of it."
"To turn a negative to positive."
What I liked about the program is:
"Getting to tell my thoughts and feelings."
"How to facilitator took care of me."
"That someone other than my family would check up on me."
What I didn't like about the program is:
"I had to write a lot."

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last one to two hours and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in B.R.A.A.F., as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and a scribe recording comments.

The following youth focus groups were conducted from Western and Desert regions. The parent focus groups were conducted from Desert region. The focus groups were conducted in-person.

Youth Focus Groups

Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has helped you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in B.R.A.A.F. that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions.



Youth expressed positive changes in themselves and their family:

- The program helped with "my uncles death, and they got me to talked the *Mamas* and *Babas*, it helped me with it. The principle that helped me was Imani [one of the seven principles of Kwanzaa]."
- "I'm more confident in myself."
- The program helped me "be more concentrated and motivated."
- "...being more respectful"
- "One thing that was difficult for me was with my parents. *Mama* [staff] helped me with what I need to do."
- "A difficulty that I have is anger issues, but during the program, the staff helped me maintain my composure."
- "A difficult in school was learning, during the program, I talked to [staff] about it and they helped me try new stuff."
- "I used self-determination to help me reach confidence"
- " It taught me how to do it and without being told, so I started to do chores at home without being told."
- "I have stress about home, so [staff] helped me with tools to help with that."
- "My parents don't yell all the time as much."
- "My parents are more calm and start asking things in a different way."
- … "to cherish my parents."
- … "being more calm and not acting all the time."

Youth explained changes and additional comment about the BRAAF program:

- "Code-switching, means to act different around different people, doing things that would follow certain types of people."
- I liked "the retreat, everything, the activities, the ridings,"
- I liked "how we act in the program and in the retreats."
- "*Momma* [staff], she's nice."
- I disliked "the trust, they don't leave us alone, there's always some one watching the room."
- "First day of program, I did not like it, now I am excited to come to program."
- "The start of program, I looked at things at a different perspective then now."
- I dislike the program because "it felt like doing a 7th class."
- I disliked the program because "it was a lot of work."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this B.R.A.A.F. program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *What did you gain from Unity Day? Are there any areas we need improvement to meet your expectations for Unity Day?*

6. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

The youth and parent questions did not have correct and incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Each region shared different experiences but all were asked the exact same questions by the same facilitator to reduce moderator bias.



Changes parents saw in their children after going through the program:

Many parents noted their sons changed their behavior and self-expression.

- "I've see changing with myself and my son, better communication, my boys are more out spoken, the things that they say to me, they say in a more respectful matter. Throughout the program, they've learned to speak to someone that is older than them. And little more teamwork with themselves."
- Last year was very tough, now I have seen a growth… he explains to me about what he needs from me to be more social. I've notice he has boundaries and respecting those. After identifying what we need from each other, it turned out pretty ok so far. Definitely communication has improved from since we've started the program."
- .."confidence, before he would hate people looking at him, public speaking during activities, proud to see him in front of stranger."
- "[Youth] surprised me, he got on a horse. At camp, he was able explore something new with positive peer pressure with the *Bobbas* and *Mommas* and other kids but he did it. I was proud of him for doing that."
- "My son enjoyed the program, had a good time, enjoyed the staff and enjoyed his peers, glad he was able to attend this year."

Value and benefit from parent support groups and GGC:

Parents report a sense of camaraderie and mutual benefit from the support groups.

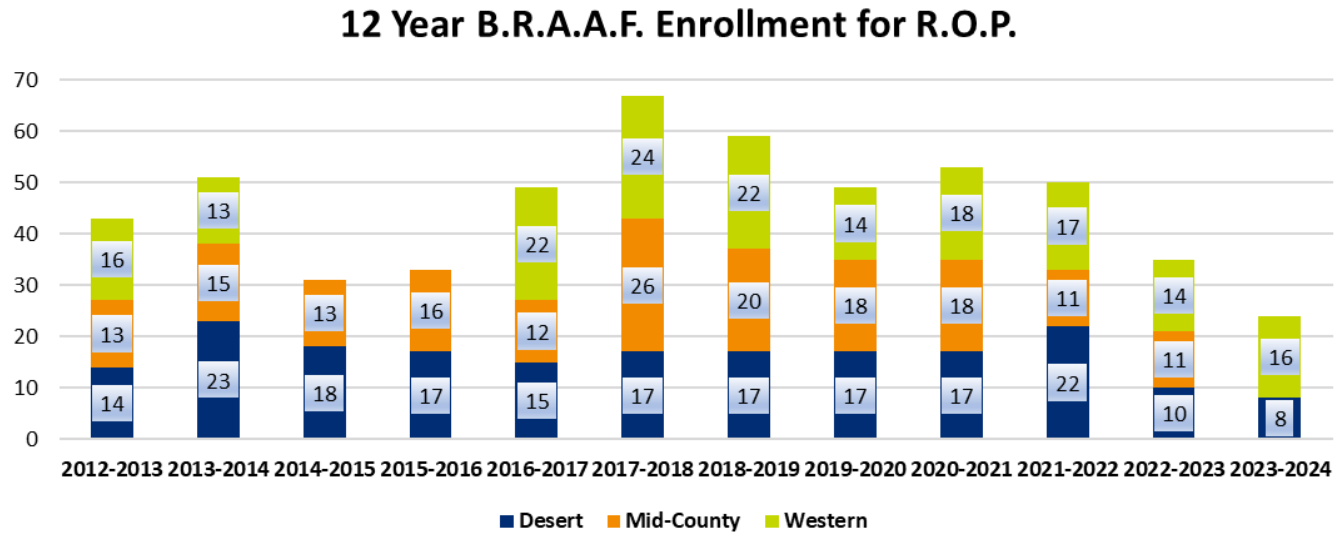
- I learned with the classes and clinicians and learned to set expectations with the boys, I know now that I need to teach them how to do things. This is what I want you to do, this is how I want you to do it, this is the time frame that I want you to do it. Also learned how to set them."
- "I have more patience, when I listen to him, and getting him to understand my point of view. We are getting better."
- Aware in how I react with my son, and better communicate with how things can go differently.
- "How to communicate with my grandson more and not to be judgmental."

Other feedback parents shared either negative or positive:

- "I wanted to see that I could get order in the house and set rules/consequences and how talk to my son better, and control myself and how I treat my son and see his perspective."
- I loved it and that we celebrate these children [on Unity Day] and how we can get together and not have any issues and have a good time. And that's what we need more in the community and wish it was longer and more activities going on.
- During Unity Day, "I liked the games they had for the boys and it was really nice, would like to see more activities for the parents.
- I "would like parents to show up to support groups."
- "The driving hours to the program was an issue."
- " I was told that it was going to be more of a male presence, like a father-brother type, there was really no males in the program, mostly women who still did great though."
- "Be more aware of dates, and schooling different school districts."
- "The communication was off and in the beginning it was not explained much so in the beginning. No list of what is going on through the year."

Conclusion

RUHS-BH PEI is funded through the Mental Health Services Act (MHSA) to provide B.R.A.A.F. throughout Riverside County. B.R.A.A.F. was offered in the Desert and Western region during FY23/24. Sigma Beta Xi was the Western region organization and Family Health & Support Network was the Desert region organization. Program target is 3 boys programs (one per region) with 45 youth completing per year countywide. Below is the enrollment of African American youth who have enrolled and completed B.R.A.A.F. Rites of Passage program over multiple fiscal years:



B.R.A.A.F. changed parenting program curriculum over the course of several fiscal years shifting from Effective Black Parenting (EBP) to Guiding Good Choices (GGC). The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. A total of 19 parents were served in GGC this fiscal year. Below is the enrollment break-down of previous fiscal years for parenting classes:

Parenting Program											
EBP	EBP	EBP	EBP	GGC	GGC	GGC	GGC	GGC	GGC	GGC	GGC
2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
N = 52	N = 41	N = 31	N = 28	N = 66	N = 47	N = 58	N = 45	N = 44	N =55	N= 32	N= 19

B.R.A.A.F. included Parent Support Groups following GGC. Parents had the opportunity to continue meeting with a clinician and other parents from B.R.A.A.F. to talk about parenting styles and general support. All parents were encouraged to attend and share their questions and concerns.

Cognitive Behavioral Therapy has always been a component of B.R.A.A.F. Below is the distribution of enrollment from previous years:

CBT Enrollment											
2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
N = 19	N = 19	N = 0	N = 0	N = 13	N = 23	N = 17	N = 26	N = 28	N= 36	N= 11	N= 16

PEI

FY23/24 Data outcomes for the BRAAF Girls Program:

Africentric Youth and Family Rites of Passage Program (ROP)

This is nine-month after-school program for African American girls in middle school (11-13 years old) and their caregivers/families. The program focuses on empowerment and cultural connectedness. The youth meet three times per week and focus on knowledge development and skill building. The program includes caregivers and family members who participate in Family Empowerment dinners. Family enhancement and empowerment dinners are held monthly for a minimum of 2 hours each meeting, over 9 months of the program. The objectives of the dinners are to empower adults to advocate on behalf of their families and to work toward community improvement. Community guest speakers/experts are included in the monthly presentations.

Sixteen participants between the ages of 11 and 14 enrolled in the program during the FY23/24. Of the 16 youth, 12 completed the program. The completion goal was 15. The program target is 3 girls' programs (one per region) with 45 youth completing per year countywide. This fiscal year the girls' program was only available in the Desert region. Resilience measures were completed by 12 participants, demonstrating no statistically significant changes in "sense of mastery" or "sense of relatedness", both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight increase, indicating that participants (n = 12) continued to demonstrate high levels of identity centrality. Additionally, there was no statistically significant difference in scores on the Cohesion subscale from pre- to post-assessment, with scores consistently remaining within the 'separated to connected' range on the subscale.

Riverside University HEALTH SYSTEM Behavioral Health

Building Resilience in African American Families

B.R.A.A.F. GIRLS Program

2023/2024 FY

MHSA Prevention and Early Intervention

Project Overview

What is BRAAF?

Building Resilience in African American Families project (BRAAF) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American female youth and their parents/guardians that live in communities with high rates of poverty and community violence. The BRAAF Project utilizes three evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive-Behavioral Therapy (CBT), and Guiding Good Choices (GGC) in three different Riverside County regions.

Rites of Passage

The Africentric Youth and Family Rites of Passage Program is designed for African American females between ages 11 and 13. The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week.

Outcome Evaluation

The **Africentric Youth and Family Rites of Passage Program** is a program developed by the MAAT (an ancient Egyptian word meaning an ethical way of life) Center for Human and Organizational Enhancement, Inc. of Washington, D.C. In ROP, data was collected before intervention and 9 months after the intervention was implemented. Topics such as African culture, African proverbs, etiquette, hygiene, and family togetherness were practiced for 9 months and evaluated using the outcome measures below.

Objective	Measures	Measure Targets
Outcomes evaluation focused on resiliency, positive identification with culture, and family Cohesion, as well as peer relations and school climate.	Resiliency Scale for Children and Adolescents	Three scale tool that measures the personal attributes of the child that are critical for resiliency. ROP will focus on Sense of Mastery and Sense of Relatedness.
	The Multidimensional Inventory of Black Identity	Assesses the dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). In this program, only the Centrality subscale was used.
	Multigroup Ethnic Identity Measure	Responses to this instrument reveal the extent to which an individual feels connected to his or her ethnic group
	Family Adaptation and Cohesion Scales III	Measures perceptions of cohesion and flexibility within the participant's family unit.
	Social, Emotional, and Bullying Behavior Survey	This measure covers social and emotional skills, peer relations/bullying behaviors, school climate, and substance abuse.

Executive Summary: Key Findings

Rites of Passage (ROP): Sixteen youth between the ages of 11 and 14 enrolled in the B.R.A.A.F. program during the 2023-2024 fiscal year. Of the 16 youth, 12 completed the B.R.A.A.F. program. The completion goal was 15. Program target is 3 girls programs (one per region) with 45 youth completing per year countywide. This fiscal year the girls program was only available in the Desert region, approximately 96 sessions were conducted, with most attrition occurring in the initial months of the program. Pre-program and post-program assessments indicated that youth had average to very good grades before the program, and these positive academic results were maintained by the program's conclusion.

Resilience measures were completed by 12 participants, demonstrating no statistically significant changes in "sense of mastery" (mean difference of 1.2, $p = 0.758$) or "sense of relatedness" (mean difference of 1.0, $p = 0.779$), both remaining within the "Average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight increase, indicating that participants ($n = 12$) continued to demonstrate high levels of identity centrality. Additionally, there was no statistically significant difference in scores on the Cohesion subscale from pre- to post-assessment ($t(11) = -1.960$, $p = 0.076$), with scores consistently remaining within the 'separated to connected' range on the subscale. Overall, the average satisfaction score for the youth was 4.2, indicating they were satisfied at the conclusion of the program.

Guiding Good Choices (GGC): A total of 19 parents participated in at least one session of GGC, and 7 parents (37%) completed the five-session parenting course during the 2023-2024 fiscal year. The goal is for every enrolled family (minimum 45) to complete all 5 sessions of GGC. Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The APQ is a 42-item self-reported measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The results showed a statistically significant decrease in *corporal punishment* and in *other disciplinary practices*, suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre- to post-assessment. Overall, the parents reported high satisfaction, with an average score of 4.71 after GGC.

Parent Support Groups (PSG): While no satisfaction survey was conducted, qualitative feedback collected from focus groups highlighted a sense of community and support among participating parents from support group sessions.

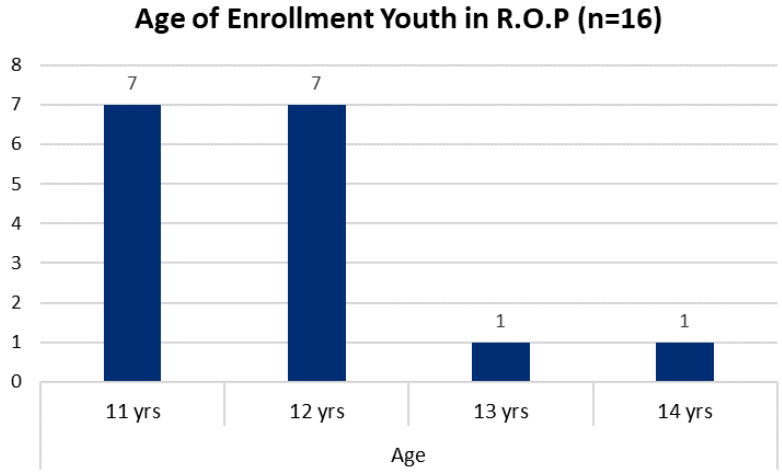
Parent Empowerment Dinner: This monthly meeting focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. The Desert region hosted five dinners throughout the program.

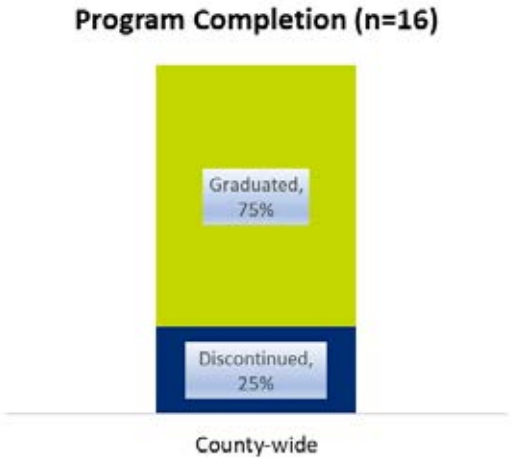
Cognitive Behavioral Therapy (CBT): This fiscal year, CBT was offered as part of B.R.A.A.F., serving 12 youth. These sessions were conducted in person and via video conferencing, depending on the flexibility of the clinician and youth. CBT effectiveness was measured with the Strengths and Difficulties Questionnaire (SDQ) and Children's Depression Inventory-II (CDI-II). Higher scores in the SDQ's four behavioral subscales and total score suggest higher risks of mental health disorders.

Twelve parents of youth served in CBT completed the pre- and post-SDQ survey for their youth. The results indicate a statistically significant change in emotional symptoms, suggesting that the youth improved their behavior even after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in peer relationships. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

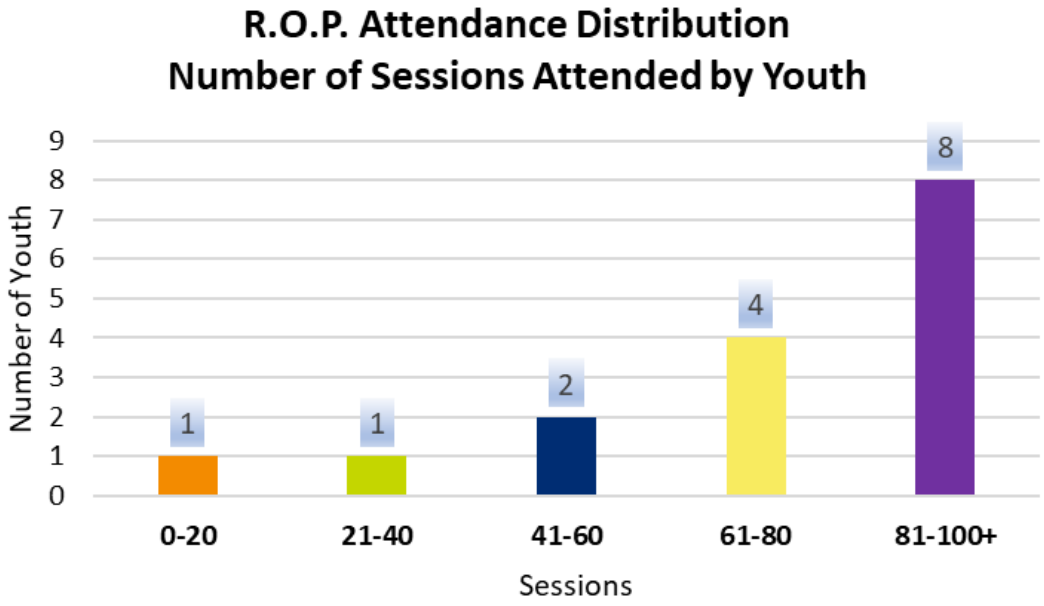
Overall, the average satisfaction score for the youth was 4.25, indicating they were satisfied at the conclusion of CBT.

Program Enrollment





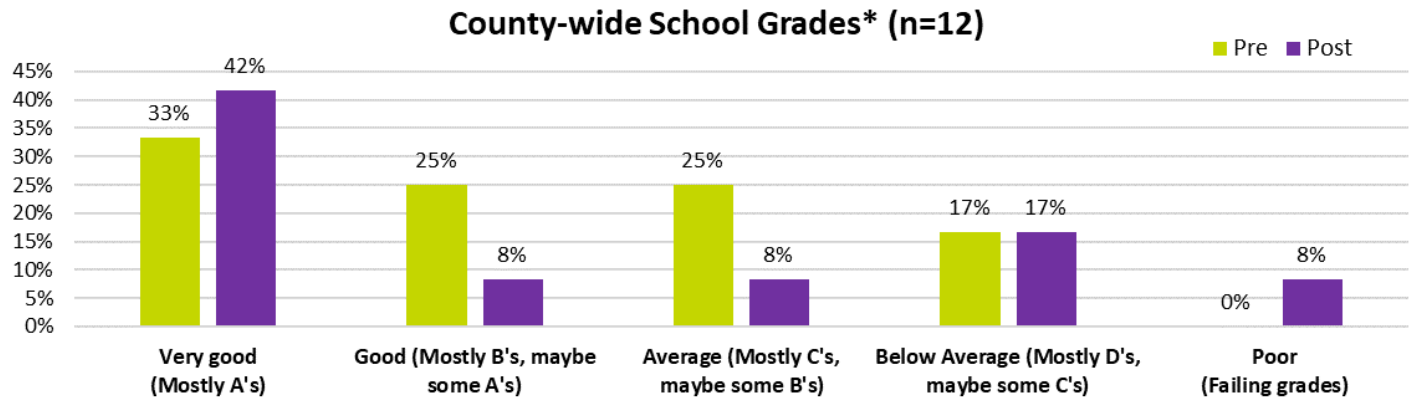
During the 2023-2024 fiscal year, a total of 16 participants aged 11 to 14 engaged in at least one session of the program. Of this group, 12 successfully completed the program. Unfortunately, the reasons for the non-completion were not provided. The goal is to enroll 20-25 youth each year to account for attrition with the goal of graduating a minimum of 15 youth per program/region.



The chart above illustrates the distribution of youth participants who attended various sessions throughout the 9-month program. The target number of session is 108 per year/per program/per region. To note, those who dropped out attended fewer than half of the total sessions offered.

School Information

Countywide Results*	Pre			Post		
	Yes	No	Not Provided	Yes	No	Not Provided
In the last 3 months, has the youth had a sudden drop in school performance?	33%	50%	17%	17%	75%	8%
Has the youth ever been suspended?	0%	100%	0%	3%	75%	0%
In the past year, has the youth been: in contact with law enforcement?	0%	100%	0%	0%	100%	0%
In the past year, has the youth been: on probation?	0%	100%	0%	0%	92%	8%
In the past year, has the youth been in any programs to help them with emotional problems?	8%	92%	0%	8%	92%	0%
In the last year, has the youth exhibited any violent or aggressive behaviors with which their parent or guardian was concerned?	0%	100%	0%	8%	92%	0%
In the last 3 months, has the youth used/experimented with drugs and/or alcohol?	0%	92%	8%	8%	83%	8%
Is the youth affiliated with a gang?	0%	100%	0%	0%	100%	0%

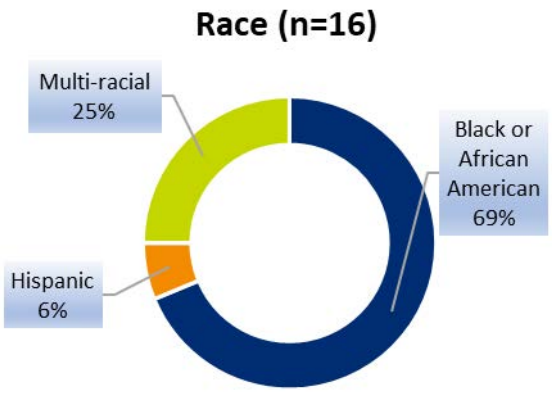


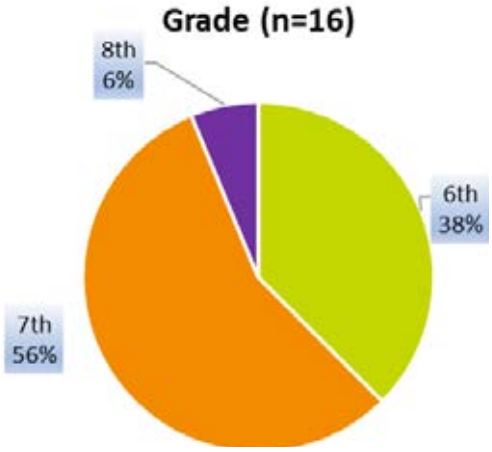
**Regarding school performance, it's important to mention that some items from the youth forms were missing. As a result, the averages calculated for each question were based on data from 12 participants who completed both the ROP Intake Form (pre) and the Program Completion/Discontinued Form (post) for school information.*

Questionnaire Results:
Before the B.R.A.A.F. program (ROP), 33% of parents reported a sudden decline in their daughters' school performance. After the program, this figure decreased to 17%, indicating a positive change. Most responses were consistently "no" to questions regarding suspension, arrest, probation, drug use, and gang affiliation throughout the program.

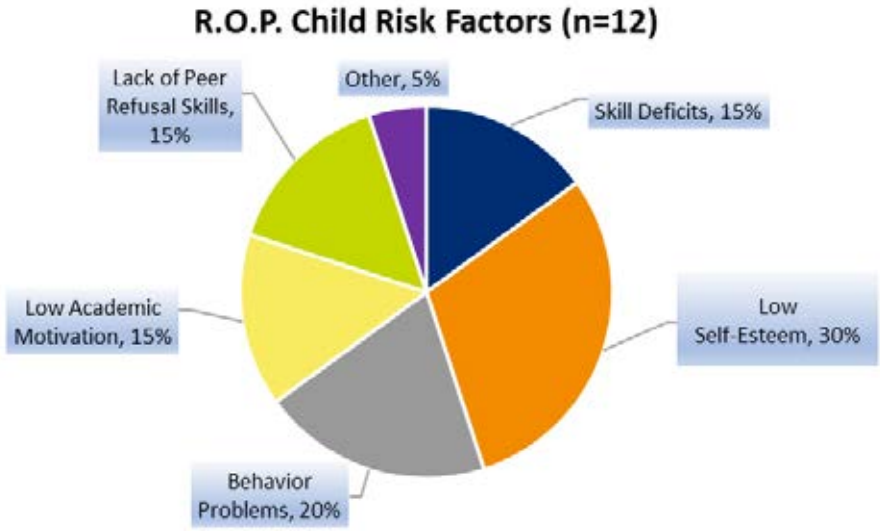
Academic Performance:
The School Performance Chart indicates that youth had average to very good grades before the program, and these positive academic results were maintained throughout the 23-24 fiscal year.

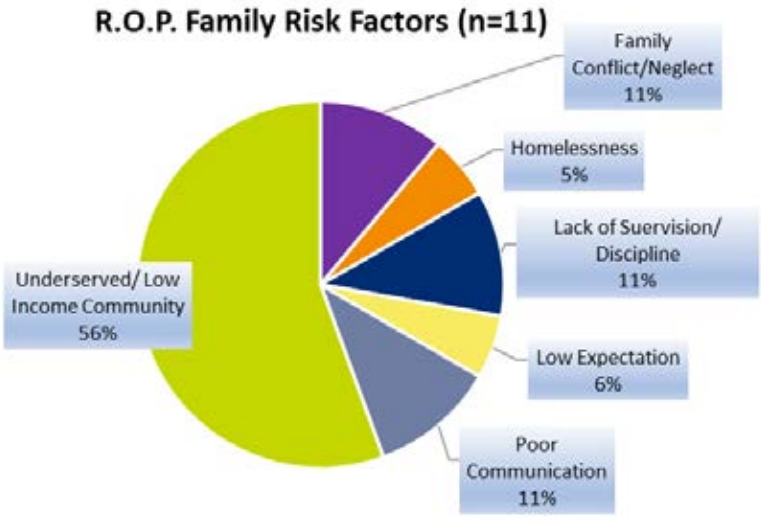
Demographics





It is important to note that 16 youth enrolled, and have attended at least one session. The target enrollment was 25-30 youth.

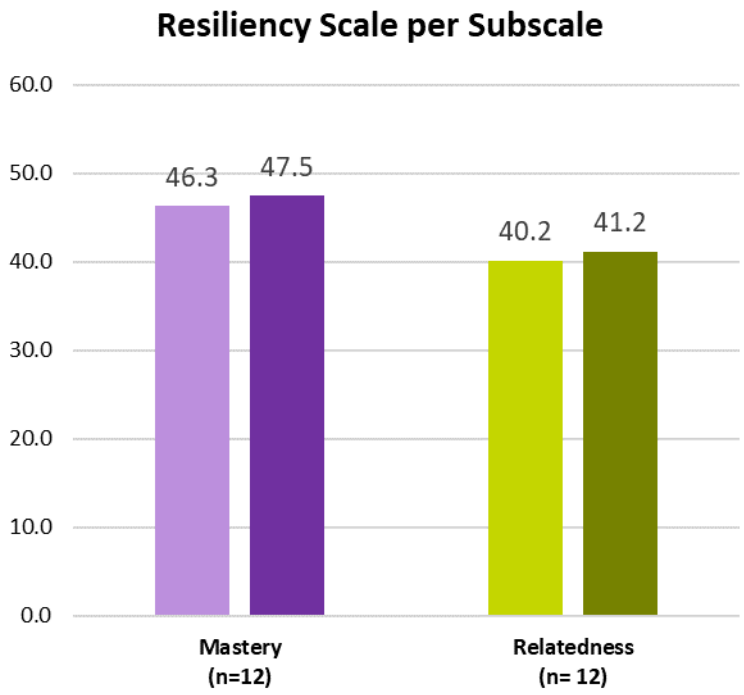




Risk factors are based upon parents/ caretakers that have provided at least one or more responses on the *Family and Child Risk Factors* on the ROP Demographic Form.

Resiliency Scale for Children and Adolescents

The Resiliency Scales for Children and Adolescents is a tool that measures the personal attributes of the child that are critical for resiliency. The measure is composed of two stand-alone global scales, Sense of Mastery having 20 questions and Sense of Relatedness having 24 questions. The Sense of Mastery scale measures the likelihood that the individual will be able to cope with adverse circumstances. The Sense of Relatedness scale measures relationships with others that serve as a buffer against stress. Participants' self reported answers are summed and converted into normalized T-scores. Scores are categorized as 60+ is High; Above average 56-59 ; Average 46-55; Below Average 41-45; and less than 40 is Low.



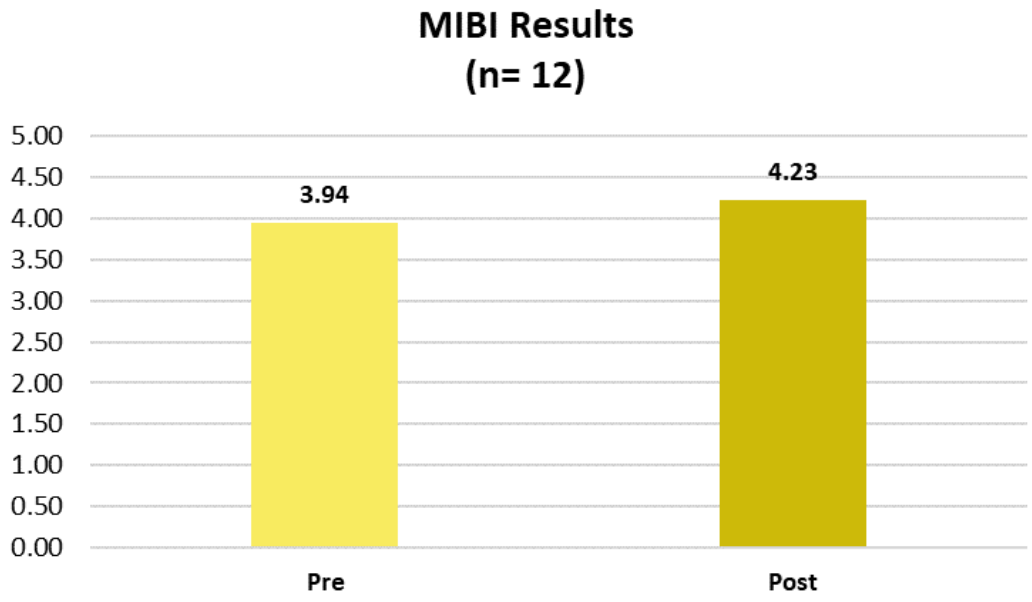
The analysis included 12 participants from the Desert region who completed both the pre- and post-measures of the Resiliency Survey.

Sense of Mastery Scale: The scores on the Sense of Mastery scale increased with a mean difference of 1.2 points. However, this increase was not found to be statistically significant based on the t-test ($t(11) = -0.316$) with a p-value of 0.758. This suggests that there was no significant improvement in participants' Sense of Mastery from pre-measure to post-measure; rather, participants maintained an average ability to cope with adverse circumstances.

Sense of Relatedness Subscale: The Sense of Relatedness subscale showed an increase of 1.0 point, but this change was also not found to be statistically significant ($t(11) = -0.288$, p-value = 0.779, $p < 0.05$). This indicates that there was no statistically significant change in participants' sense of relatedness from pre-measure to post-measure. The scores suggest that participants have a below-average sense of relatedness with others.

The Multidimensional Inventory of Black Identity

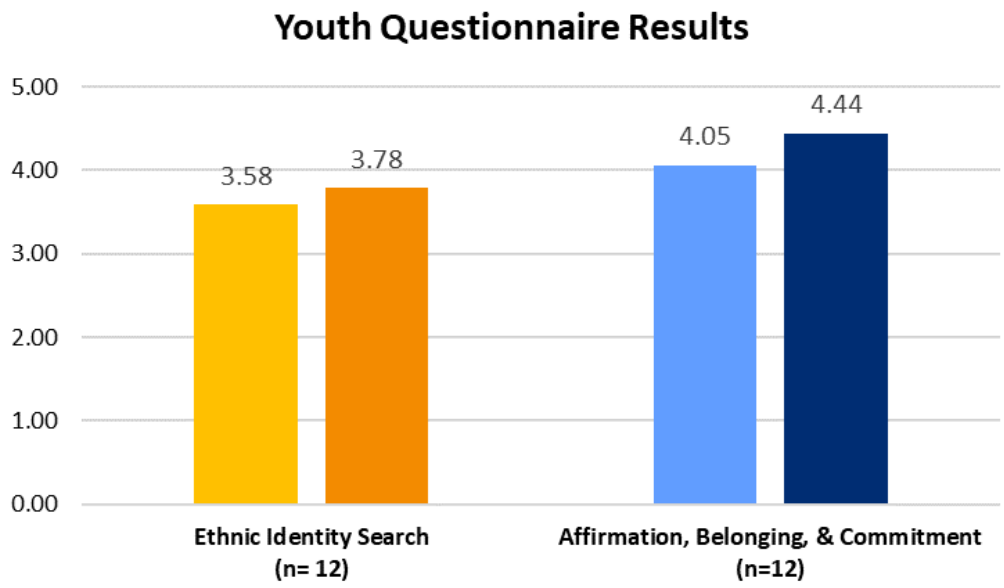
The Multidimensional Inventory of Black Identity (MIBI) measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). For the Rites of Passage program only the Centrality subscale was used. The Centrality scale consists of items measuring the extent to which being African American is central to the respondents definition of himself/ herself. The higher the scores on Centrality, the more the respondent views being African American as a central definition of herself. The highest possible average one can score on Centrality is 5.



The Desert region administered the Teen MIBI measure, consisting of 9 items. The total scores averaged 3.94 at the pre-program assessment and 4.23 post-program. However, this change was not found to be statistically significant ($t(10) = -1.738$, $p = 0.113$, $p > 0.05$). In general, participants' scores hovered around 4, indicating a relatively high level of centrality placed on their Black/African American identity.

The Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) was developed to measure the process of ethnic identity development among adolescents and young adults. It is a valid and reliable survey instrument that is one of the most common measures of ethnic identity. It has two subscales: ethnic identity search and affirming, belonging, and commitment. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of ethnic identity.



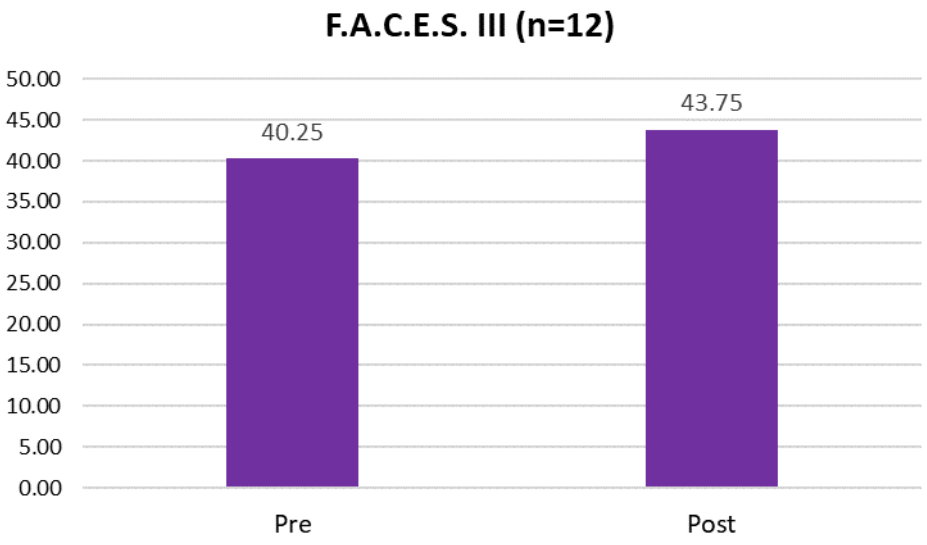
The Desert region showed a slight increase in the Ethnic Identity Search scale of the MEIM measure, with scores rising from 3.58 in the pre-test to 3.78 in the post-test. However, this change did not reach statistical significance ($t(11) = -0.957$, $p = 0.359$).

In contrast, there was an improvement in Affirmation, Belonging, and Commitment. Countywide, participants' scores increased from 4.05 in the pre-test to 4.44 in the post-test ($t(11) = -2.146$, $p = 0.055$). It's worth noting that scores in this subscale were already relatively high at the beginning of the program and remained positive at the conclusion. These findings suggest that youth continued to hold a strong view of their ethnic identity throughout their participation in ROP.

It's important to acknowledge that the sample sizes were limited to participants from the Desert region.

Family Adaptation and Cohesion Scale III

The Family Adaptation and Cohesion Scale III (FACES III) is a self-reported 10 item scale that measures perceptions of cohesion within the family unit. The *Cohesion* subscale measures the strength of family members attachment to one another. The FACES III is completed by a parent, relative, or caregiver. Participants respond via 5 point Likert scale (1 = Almost Never; 5 = Almost Always). Scores are summed for the cohesion subscale. Interpretation of the *Cohesion* subscale is as follows: 10-34, disengaged; 35-40 separated; 41-45 connected; 46-50 involved.



There was no statistically significant difference in scores on the Cohesion subscale from pre to post (t(11) = -1.960, p = 0.076). Nonetheless, it's worth noting that there was a modest increase in scores from the pre-assessment (40.25) to the post-assessment (43.75).

On average, the scores consistently stayed within the 'separated to connected' range on the subscale, showing slight improvements with no statistical significance.

Youth Satisfaction

Towards the end of the program, 12 youth who completed ROP submitted a satisfaction survey. Overall, youth who completed the satisfaction survey agreed or strongly agreed that participating in the program was a positive experience.

Item Description (Score range: 1—5)	Countywide (N=12)
1 Overall, how satisfied were you with the type of activities in the Africentric Rites of Passage Program?	4.33
2 Since attending the Africentric Rites of Passage program, I feel more involved in school.	3.92
3 Since attending the Africentric Rites of Passage program, I feel I get along better with my teachers	3.50
4 Participating in this program has been a positive experience for me.	4.25
5 Participating in this program has changed how I think about myself in a positive way.	4.50
6 Please rate your satisfaction with how staff, presented the program information in a way I understood.	4.25
7 Rites of Passage staff presented the program information in a way I understood.	4.50
8 Rites of Passage staff presented the program information in a fun way.	4.42

How this program may have affected participants:
"It made me more confident in myself and my race."
"I changed me because I used to hate being black and now I'm not."
"I used to think negative of myself, now I think positive."

What participants liked about the program:
"What I did like about the program was the bonding having fun."
"Everything activities, spending time with different people."
"When I learned how to set boundaries."

What participants did not like about the program:
"Really nothing because the program was great."

Parent/Caregiver Satisfaction

Overall, 96% of parents were satisfied with the program. Moreover, every single parent indicated their satisfaction with the program's philosophy and approach

Item Description (Score range:1 - 4)	Desert N=11
1 The program's ability to assist your child with eliminating the problems that prompted enrollment into the program...	3.82
2 Your child's progress/accomplishments/achievements while in the program...	3.82
3 The philosophy and approach of the program...	3.91
4 Opportunities for parents to meet together for support and share information...	4.00
5 Overall Satisfaction...	3.82

What has been most helpful to you and your child?
"The parts of the program that have been most helpful is interactions with my child and communication. We have learned to better communicate and articulate our thoughts and feelings openly without misunderstanding."
"The family group sessions together. I can see that my daughter like/enjoyed the time we spent together while at BRAAF wit the other families."
"Learning about our black history. Gaining confidence and better communication skills. Also new experiences."
What changes can you suggest?
"More counselors."
"To keep the program, families need it parent, and need to know truth about their kids' feelings."
Is there anything else you want us to know?
"Very satisfied with program and all in charge running it. No issues."
"I'm so grateful to have been apart of the BRAAF family. Thankful for how much help I've been giving and proud of the work yall have done and on my daughter. I am very appreciative."

Program Information

What is Guiding Good Choices (GGC)?

The GGC curriculum was developed under the name *Preparing for the Drug-Free Years®* by Dr. David Hawkins and Dr. Richard Catalano of the University of Washington for parents of children in grades four through eight. With GGC, parents learn specific strategies for promoting healthy behaviors in children and reducing risks that predict adolescent health and behavior problems.

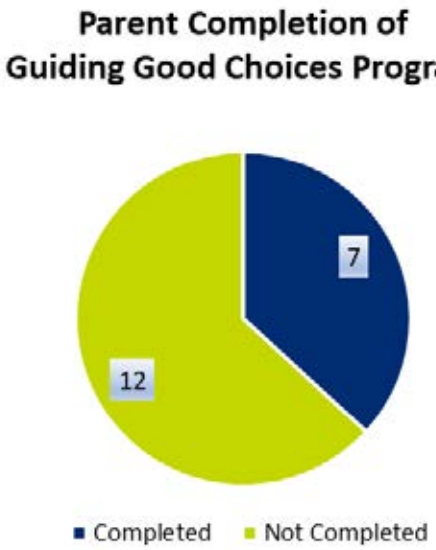
Children are exposed to risks in their schools and communities, and sometimes in their families and with peers. Some children start using alcohol, tobacco or other drugs. Some drop out of school, have sex (and risk pregnancy), or become involved in delinquency or violence. Others, while exposed to similar risks, do not develop these adolescent heath and behavior problems because they are protected by factors like strong family bonds and healthy beliefs and clear standards for behavior.

In GGC, parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks in the month of September. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. The five sessions are as following:

1. Getting Started: How to Prevent Drug Use in Your Family
2. Setting Guidelines: How to Develop Healthy Beliefs and Clear Standards
3. Avoiding Trouble: How to Say No to Drugs
4. Managing Conflict: How to Control and Express Your Anger Constructively
5. Involving Everyone: How to Strengthen Family Bonds

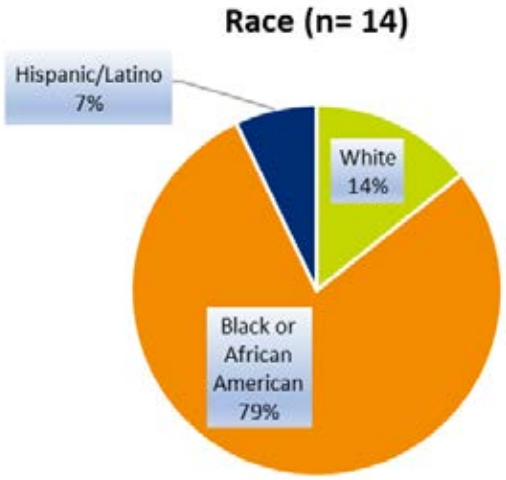
GGC Program Completion

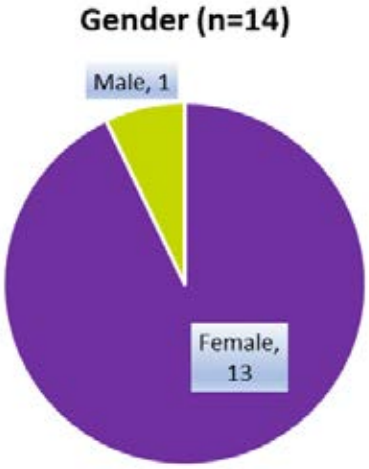
At least one parent of the child enrolled in ROP was required to complete all five sessions of GGC.

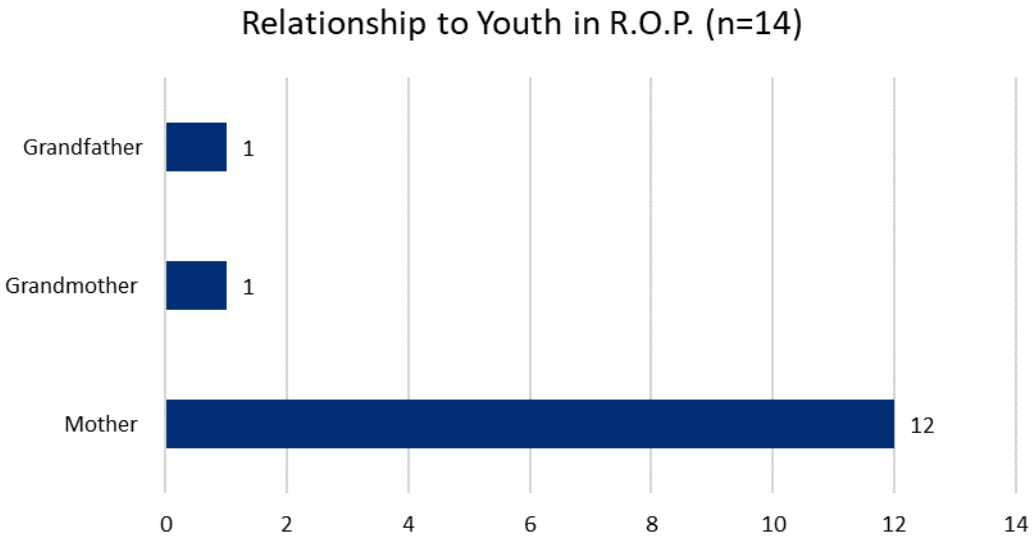


19 parents attended at least one session of GGC and 7 parents (37% of the cohort) completed the program in 2023-2024 FY.

GGC Demographics

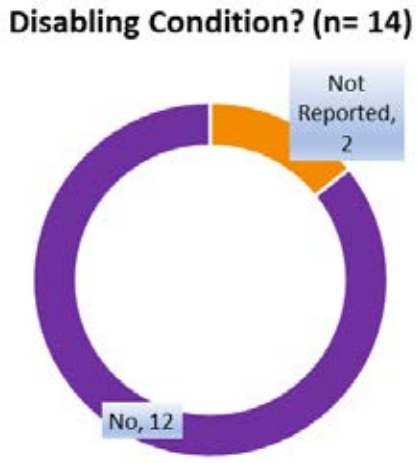


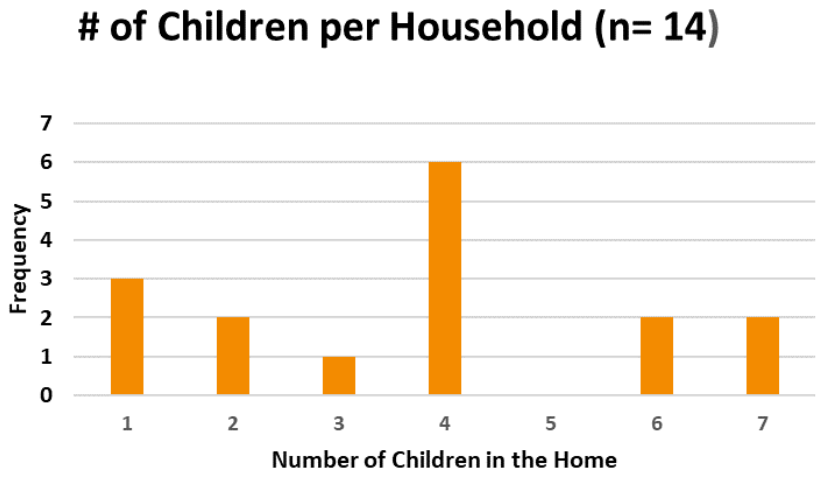


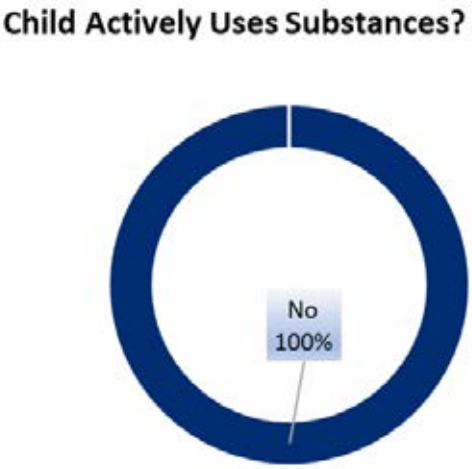


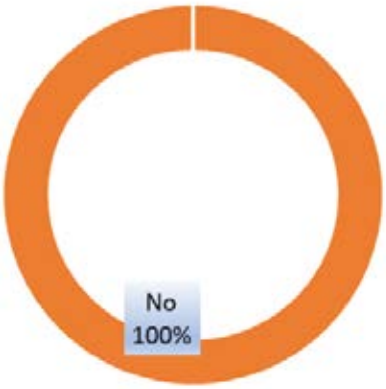
The charts above are representative of 14 parents who completed GGC Demographic form prior to the 5-week program. Based on the self-reported data, 79% of the participants identified as African American, 7% as Hispanic, and 14% as White . The gender distribution showed a ratio of approximately 1 male to 13 female. Among the GGC cohort, mothers constituted the largest group (n=12), followed by grandparents (n=2).

GGC Demographics Cont.







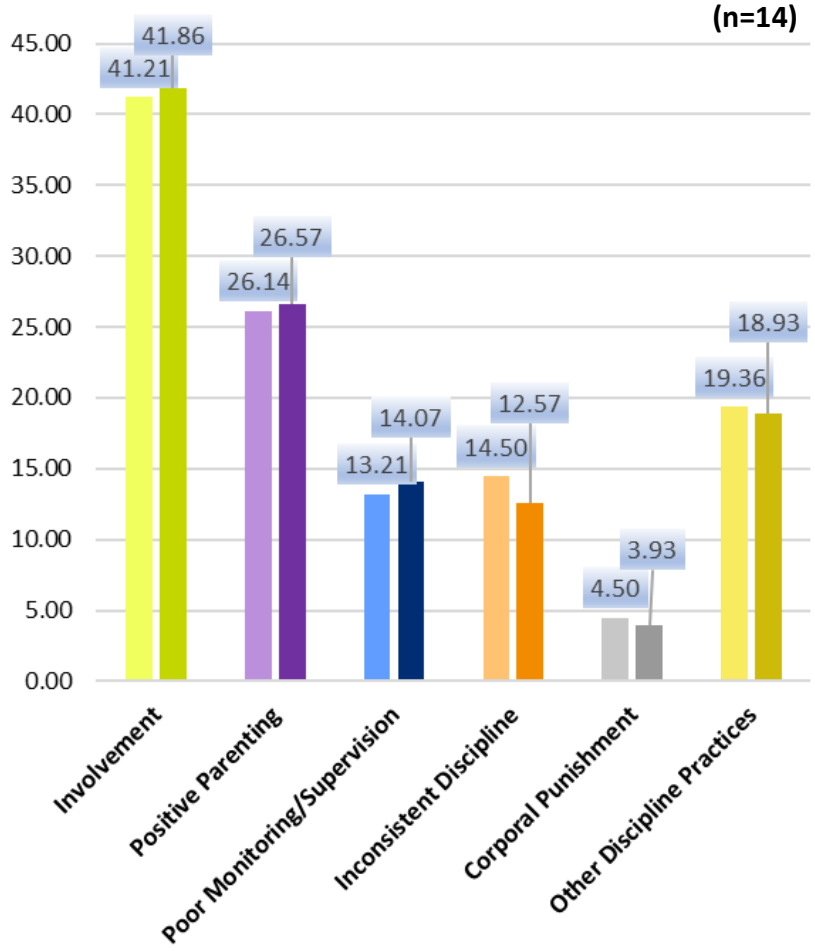


The majority of respondents answered 'no' (85%), while 15% did not provide a response. Notably, all children were reported by their parents as not actively using substances. Among the 14 enrolled parents who shared the number of children in their households, the average reported was four children per household.

Alabama Parenting Questionnaire

Past research has shown that increasing positive parenting practices while decreasing negative parenting practices have been effective in reducing problem behaviors in children at least 4 years old. The Alabama Parenting Questionnaire (APQ) assesses several dimensions of parenting—positive and negative parenting practices—that are the target of many parent management interventions. The APQ is a 42-item parent self-report measure assessing five parenting constructs: parental involvement (10 items), use of positive reinforcement (6 items), poor parental monitoring and supervision (10 items), use of inconsistent discipline (6 items), and corporal punishment (3 items). The APQ measures the frequency in which parents engage in particular parenting practices; items are rated by parents on a 5-point scale from 1 (*never*) to 5 (*always*).

Alabama Parenting Questionnaire Countywide Results (n=14)



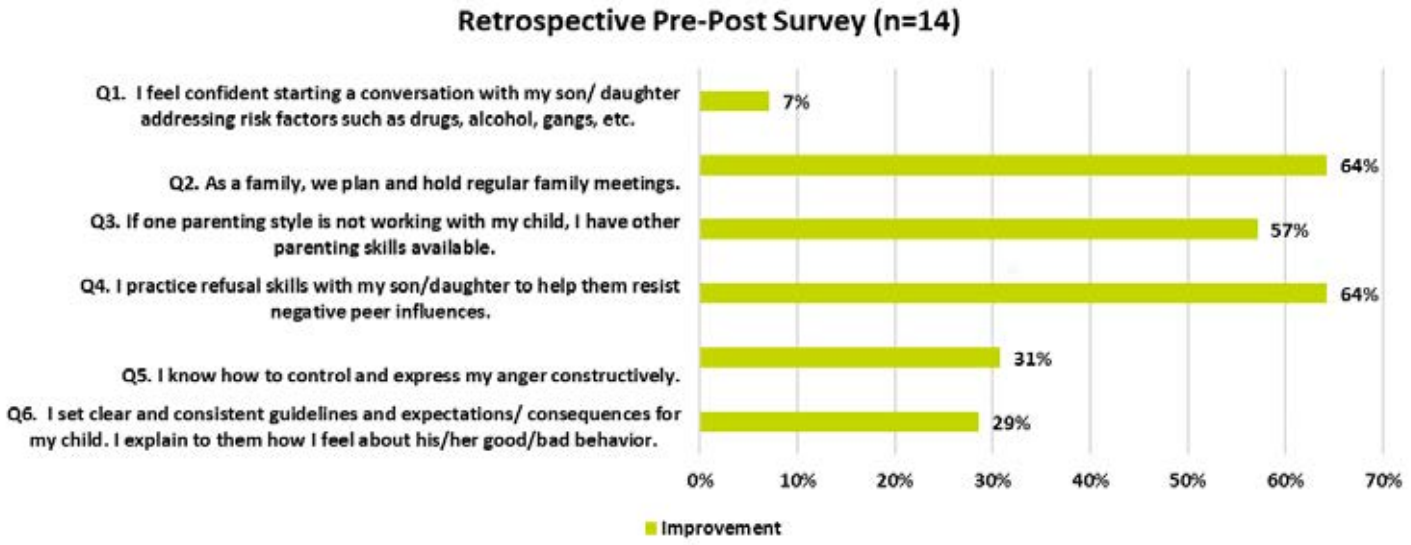
Fourteen parents/caregivers completed a pre and post APQ. To demonstrate improvement across the six scales, post-assessment scores for **involvement, positive parenting, and other discipline practices** should be higher than the pre-assessment scores, indicating improvements in these positive parenting behaviors. However, **poor monitoring/supervision, inconsistent discipline, and corporal punishment**, would reflect a decrease in agreement with the "poor parenting" items, signaling better parenting practices.

The results showed a **statistically significant decrease** in corporal punishment (t(14) =.591, p= .026) and in other **discipline practices** (t(14) =.607, p=0.021), suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre– to post-assessment. These findings suggest that parents have altered their disciplinary methods, as reflected in the decrease in corporal punishment.

		Involvement	Positive Parenting	Poor Monitoring/ Supervision	Inconsistent Discipline	Corporal Punishment	Other Discipline Practices
		Mean	Mean	Mean	Mean	Mean	Mean
Desert	Pre	41.21	26.14	13.21	14.50	4.50	19.36
	Post	41.86	26.57	14.07	12.57	3.93	18.93

Satisfaction Survey

A satisfaction survey is administered at the conclusion of the GGC program. The first six questions are retrospective pre and post, and the following 12 (on the next page) are post scores only. Results are provided in the following tables. Participants' comments are also included on the satisfaction survey. Overall, participants indicated that they were satisfied with course instructors and the effectiveness of GGC classes.



Likert scale breakdown: 1=strongly disagree, 2=disagree 3=neutral, 4=agree, 5=strongly agree

Question	Retro-Pre	Post	P-value	Question	Retro-Pre	Post	P-value
Q1	4.86	4.79	p>0.05	Q4	3.00	4.36	p<0.05
Q2	3.07	4.21	p<0.05	Q5	3.46	3.69	p>0.05
Q3	3.64	4.36	p>0.05	Q6	3.93	4.43	p>0.05

For the retrospective pre-to-post survey, parents in the GGC responded to a series of six questions following the completion of the five-session program. Fourteen parents assessed the changes in their parenting skills, comparing their abilities at the program's conclusion to those before joining GGC.

Based on the results, parents increased the most (64% increase) in the adjustments towards parenting practices. Parents showed significant overall improvement after GGC regarding the following items: meeting regularly as a family and setting refusal skills with their child. It's worth noting that parents who did not experience improvement initially had high scores in the pre-assessment.

Satisfaction Survey

Item Description (Score range:1 - 5)	Countywide N=14
1. Overall, I am satisfied with the program.	4.71
2. The location of the program was convenient for me.	4.79
3. The sessions were at a time convenient for me and my family.	4.79
4. My family got the help we wanted for my child.	4.43
5. As a result of the program, I am satisfied with our family life right now.	4.50
6. I felt comfortable talking about my child's program with the staff.	4.86
7. The facilitators listened to what I had to say.	4.92
8. The facilitators spoke to me in a way that I understood.	5.00
9. The facilitators are respectful of me and my cultural/ethnic background	4.94

Things I learned in the GGC program are:
"To let her have more of a voice."
"How to better open/start conversations in different ways."
"How to communicate, efficiently with children."
What I liked about the GGC program is:
"Being able to come together as adults and learning new skills. See different perspective."
"The community coming together to help raise our children in a better manner and on to the right path."
"Opened eyes to more parenting styles, more family meeting ideas."
What I didn't like about the GGC program is:
"The drive, transportation difficulties."

Parent Support Groups

Once Guiding Good Choices parenting classes ended, the parents were encouraged to attend weekly parent support groups. These groups were designed to be an open space where the parents can share parenting skills and seek advice on how to overcome family difficulties in raising a teenage child. Topics discussed included drugs, lying, bullying, weapons, etc. Every week the parents were called and invited to attend the support group. By the end of BRAAF, parents had a strong bond together and many plan to continue meeting with their support group.

	Total Number of Sessions Hosted	Group Size Range
Desert	3 Sessions	6-8 People

Empowerment Dinners

The B.R.A.A.F. program's Parent Empowerment Dinner is a monthly meeting that focuses on a theme/topic for discussion to enhance the parents' ability to advocate for themselves and their youth. It facilitates opportunities for families to connect, share experiences, and discuss strategies for supporting their children's development. Discussions on resources, strategies for empowerment, and ways to enhance the parent-child relationship further enrich the experience. Overall, these gatherings are essential for building a supportive community and maximizing the program's impact. Each program/region should host 9 empowerment dinners per year.

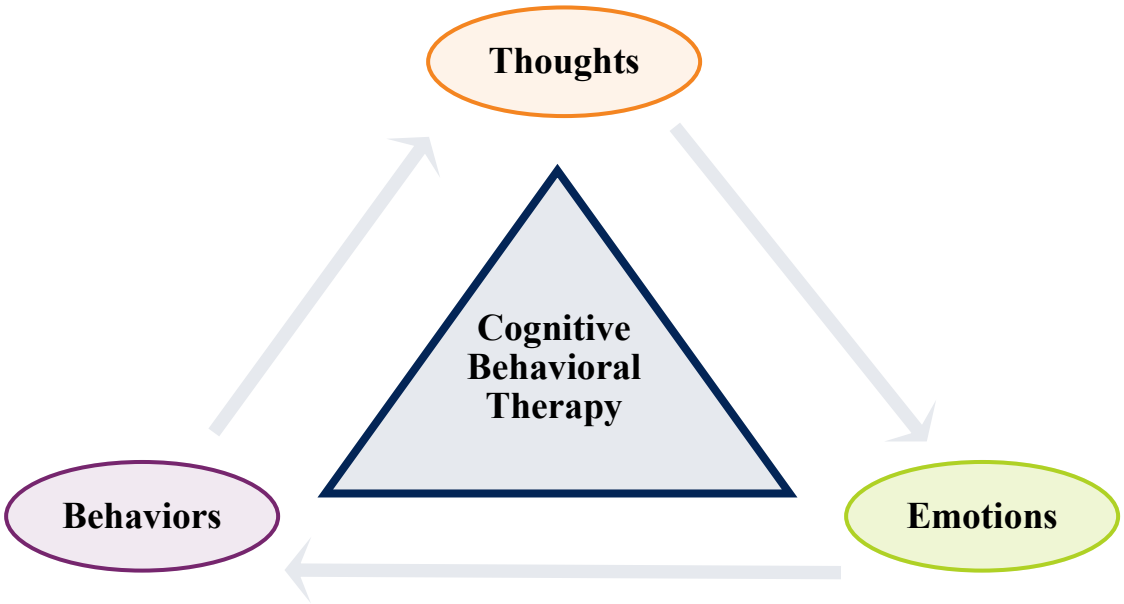
	Total Number of Sessions Hosted	Group Size Range
Desert	5 Session	1—10 People

Cognitive Behavioral Therapy

Cognitive –Behavioral therapy is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. It can be an effective tool to help those youth with behavioral concerns learn how to better manage their behavior and stressful life situations.

CBT can explore painful feelings, emotions, and experiences, where the youth may feel emotionally uncomfortable at times. The youth may cry, get upset or feel angry during a challenging session. Some forms of CBT, such as exposure therapy, may require the youth to confront situations they'd rather avoid. This can lead to temporary stress or anxiety. However, working with a skilled therapist minimizes any risks. The coping skills the youth learns in CBT will help them to manage and conquer negative feelings and fears.

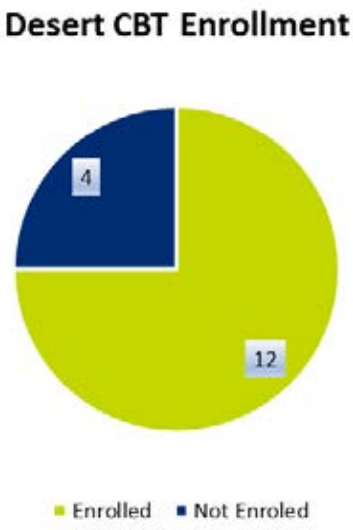
www.mayoclinic.com/cbt



Outcome Evaluation

Children's Depression Inventory (CDI-II)	A self-report assessment that measures the severity of depression symptoms among youth. The measure includes five components of depression: Negative Self Esteem, Negative Mood, Anhedonia, Ineffectiveness, and Interpersonal Problems.
Strength and Difficulties Questionnaire (SDQ)	A parent completed measure, where they are asked to assess the positive and negative psychological attributes about their children/students enrolled in the program. Consisting of 25 Likert Scale items assessing the client's behavior over the previous month.

Number of Youth Enrolled in CBT

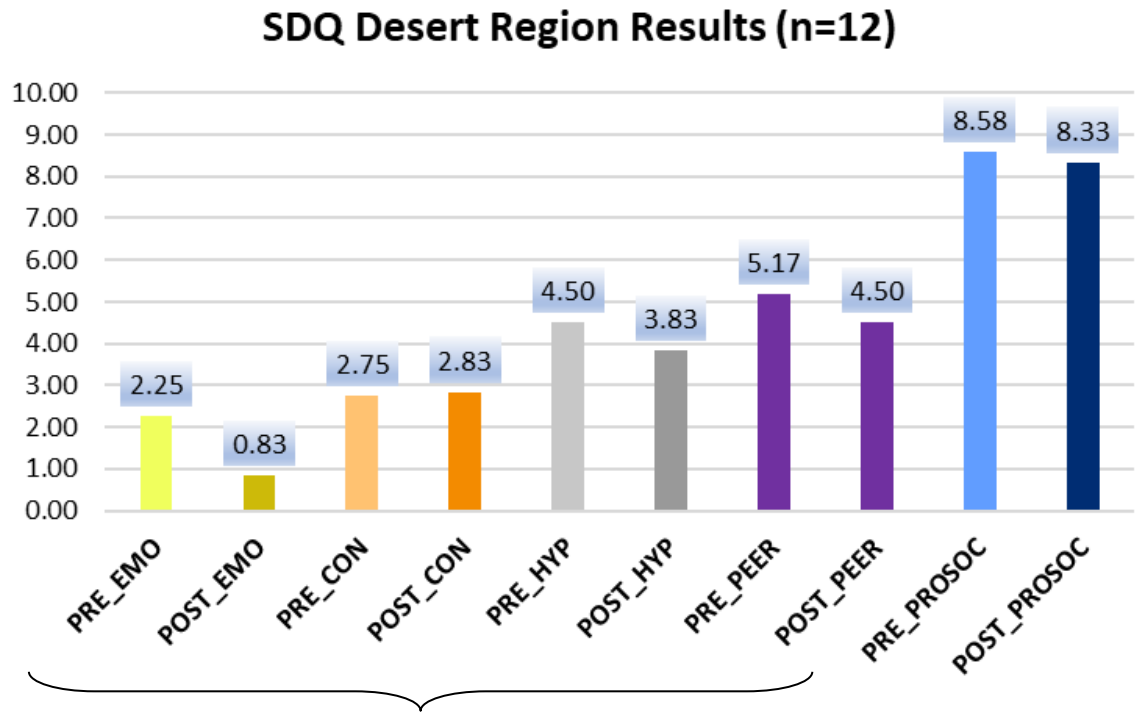


	Average CBT Sessions per Region
Desert	8 Sessions

This fiscal year, CBT was offered as part of B.R.A.A.F., benefiting 12 participants in the Desert region who each received at least one CBT therapy service. On average, participants from the Desert region attended 8 CBT therapy sessions. These sessions were conducted in-person and via video-conferencing, depending on the flexibility of the clinician and youth.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is used to screen for both positive and negative psychological attributes among program participants. There are multiple versions of the SDQ measure. This program used the SDQ Parent Version, for adolescents between 11 and 17 years of age. The SDQ emphasizes both strengths (pro-social behavior) as well as behavioral difficulties, and it can be used both as an assessment and as a program evaluation tool. The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes. There is also a Pro-Social scale which is an independent scale from the other four, and higher scores suggest greater pro-social behaviors. The total score was calculated by summing the averages of the emotion, conduct, hyperactivity, and peer problems subscales.



Total Score: Pre=14.67, Post=12.00

A total of twelve youth who completed both pre and post assessments were included in the analysis. The primary expectation was a decrease in average scores across the four behavioral subscales (emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems) from their intake assessment to their post-CBT assessment, with an anticipated increase in the pro-social subscale.

The results indicate a statistically significant change in **emotional symptoms** ($t(11) = 3.742$, $p = 0.003$, $p < 0.05$), suggesting that the youth improved their behavior after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in **peer relationships** ($t(11) = .442$, $p=.005$, $p<0.05$).

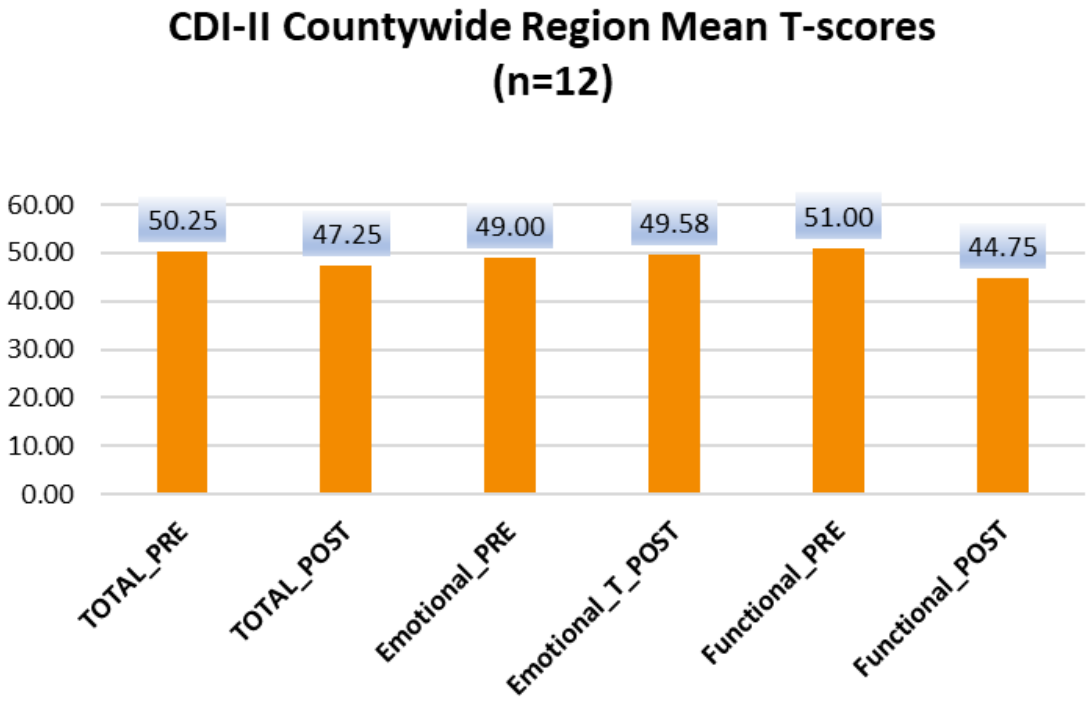
Although there were observed changes in other areas, these changes were not significant. Overall, the program had a notable impact on the participants' emotional well-being and peer interactions.

Children Depression Inventory II (CDI II)

The Children's Depression Inventory (CDI-II) is used to measure the severity of depressive symptoms in children. The participants complete this self-reported survey before and after CBT. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems. During scoring, subscales are combined to create two additional subscales using the following steps:

- Negative Mood + Negative Self-Esteem = Emotional Problems
- Ineffectiveness + Interpersonal Problems = Functional Problems
- Emotional Problem + Functional Problems = Total Score

Each item in the survey has three different descriptors in which the participants select the description that best matches their feelings. Higher scores (70 and above) suggest higher levels of depression for all subscales and the total score. Whereas, scores 59 and lower are considered average or below average. A paired-samples t-test is utilized to assess the significant differences between the pre and post test scores.



Out of the 12 youth who received CBT services, they were asked to complete both the pre and post CDI-II assessments. For this fiscal year, when comparing the scores from CDI-II, there was no statistically significant change in Emotional behavior. On the another hand, there was a significant decrease in Functional Problems area (p<.05). It's important to note that the small sample size may have limited our ability to detect significant improvements resulting from the CBT sessions.

Satisfaction Survey

Satisfaction surveys data of individuals who completed at least 1 sessions were utilized for the following table.

Item Description (Score range: 1—5)	Desert Region N= 13
1 The program taught me how to cope with stress.	4.1
2 The program helped me to understand myself better.	4.5
3 The program has prepared me to cope with stress if something difficult happens to me in the future.	4.0
4 I achieved my goals for the group.	4.3
5 The facilitator listened to what I had to say.	4.3
6 The facilitator knew how to help me.	4.3
Things I learned in the program are:	
"What I learned was how to calm down."	
"I learned how to set boundaries and how to pick the right group of people."	
"That to talk it out with them and that I could do better and I am enough."	
What I liked about the program is:	
"That it cheers me how to be and how I am changing myself and that when I save something it will be funny or that it will be just to talk it out."	
"What I liked was we would always take a minute to breath and relax."	
"I can state how I felt in that moment and how I feel now."	
What I didn't like about the program is:	
"Sometimes it was a short session."	

Focus Groups

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the more shy members to open up. The focus group session may last 30 minutes to an hour and consist of a RUHS-BH program staff to help lead the discussion and multiple evaluation staff as note takers.

Purpose and Objectives:

The Prevention and Early Intervention team evaluated the Africentric Rites of Passage programs throughout Riverside County. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Data Collection:

Qualitative data was collected from the youth participants who had completed the 9 month ROP program in BRAAF, as well as the parents who actively attended empowerment dinners and parenting classes. The youth and parent focus groups were conducted at the site where their weekly sessions took place.

The youth focus groups and parent focus groups were conducted separately, and were designed to last approximately 30 minutes each. There were seven predetermined questions youth were asked to answer and seven predetermined questions for the parents to answer. There was one group facilitator and one scribe recording comments.

The following focus groups were conducted for Desert region. The focus groups were conducted in-person.

Youth Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **youth** focus group:

1. *Think about something difficult that you have had to deal with in the past year. (Pause to think). How has the program helped you with that difficulty? If you have used any of the program's principles, could you explain that?*

2. *What did you learn in this ROP program that has help you get along better with your family at home? Did you notice a change in your parents?*

3. *How has the program changed how you feel about yourself and your own culture?*

4. *Do you think you have changed in any way after going through this program? In what way (s)?*

5. *What about this program will you remember the most? Was there anything in BRAAF that you disliked or did not meet expectations?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants.



Youth Focus Groups

The girls' responses to the focus group questions are loosely organized in the following themes and include some quotes of the girls responses.

Youth expressed positive changes in themselves:

- "A difficulty in school, in volleyball, it helped be more mindful of my teammates."
- "BRAAF taught me to stop before responding to other people."
- "I had problems with boundaries and BRAAF helped me with that."
- "BRAAF helped me with my grades, in school, [staff] helped me figure that out."
- "BRAAF helped me to let things go and not care about it."
- "I used to let people define me, now I don't let that be the case."
- "I learn to take responsibility and to work with others in a team."
- One of the seven principles of Kwanzaa that helped me was "Imani because I believe more in myself, and I feel more accomplished."

Changes in how youth felt about their culture:

- "The program has helped me feel more confident in myself and that we are all Kings and Queens."
- "The program has helped me change the way I feel about culture, we didn't just come from slavery. We were Kings and Queens."
- "People don't know about African American culture, we are inventors."
- "They taught us about code-switching during one of the sessions."

Youth explained changes and additional comment about the BRAAF program:

- "I think that my attitude and my way of thinking changed."
- "To stand up for myself and to communicate what I need."
- " I did not like the lessons."
- "I will remember the most is the [staff]."
- "I liked the outings and the games we played."
- "I will remember the sisters in the program."
- "I will remember the trips."
- "I will remember how we can be friends and respect others."

Parent Focus Groups
Questions and Analysis

Focus Group Questions:

The following questions were asked during each **parent** focus group:

1. *Can you tell us your favorite activity to do as a family?*

2. *Based on what you learned and practiced during the five Guiding Good Choices classes: How has your relationship with your son in ROP changed?*

3. *Do you think your child has changed in any way by going through this BRAAF program? If yes, in what way?*

4. *For those who attended the parent support groups, what did you value and benefit from the group?*

5. *Is there any other feedback you would like to share, both positive and negative?*

Focus Group Analysis:

Both youth and parent questions did not have correct or incorrect answers. The responses were analyzed to find themes that were reoccurring across participants. Groups shared different experiences but all participants were asked the exact same questions by the same facilitator to reduce moderator bias.



Comments/Feedback made by Parents during Focus Groups:

Parents noted that their daughter became more confident and communicative. Many parents noted their daughters grew to be more mature and changed their behavior:

- "This program, instilled confidence in her, she has learned how to make friends and more confidence in socializing and communication in how she feels. BRAAF helped her focus on specific things, BRAAF help her achieve more and seek more. It helped her influence on the world and mindfulness. The meetings and parent support groups, BRAAF is a great program for us."
- This program helped my daughter to be "aware of their feelings and what's going on and a open line of communication."
- "The BRAAF staff did their best in teaching our children, and their availability."
- "The scheduling is hard, more parent involvement, help with staff more so that the staff continue doing most of the work."
- "My daughter's confidence, I see it more with people, outcoming of her shell more, doing a lot better. She is more confidence, speaking up for her beliefs and her opinions of things and dealing with others."
- "Two children did BRAAF, did a great job at engaging and accommodate for each cluster of children. Each of boys and girls, matched the program to the child. The topic definitely fit for my daughters each time. I think they did a great job with that."
- "I valued other parents in the same schools and grade , going to the same things, hearing others ideas and other ways to solve problems. Cause I'm working I am not around other parents so now in the groups- I learned from others.

Guiding Good Choices (GGC)

This prevention program provides parents of children in grades 4 through 8 (9-14 years old) with the knowledge and skills needed to guide their children through early adolescence. It seeks to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding within the family and teach skills that allow children to resist drug use successfully.

A total of 19 parents participated in at least one session of GGC, and 7 parents (37%) completed the five-session parenting course during the 2023-2024 fiscal year. The results of the Alabama Parenting Questionnaire (APQ) showed a statistically significant decrease in corporal punishment and in other disciplinary practices, suggesting that parents shifted towards less harsh disciplinary methods. However, no significant changes were observed across the remaining subscales from pre- to post-assessment.

Cognitive Behavioral Therapy (CBT) CBT is tailored to include individual, family, and/or group intervention to reduce symptoms of anxiety, depression, address emotional crisis, family intervention, and provide coping skills. CBT intervention is implemented under the guidance/consultation of the RUHS - BH Staff Development Officer.

Twelve youth participated in CBT. The results indicate a statistically significant change in emotional symptoms, suggesting that the youth improved their behavior after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in peer relationships. For this fiscal year, when comparing the scores from the CDI-II, there was no statistically significant change evident in either emotional behavior or functional problems.



Qualitative Feedback

Quantitative data outcomes do not tell the full story of the impacts of the BRAAF program. To address concerns that have arisen over the years regarding initial distrust as well as capturing impacts that are difficult to assess via pre/post measurement tools, we have added qualitative evaluation to this project. This is done through focus groups at the program end with youth from both the boys' and girls' programs as well as their parents. Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. Through analyzing responses, evaluations staff can identify shared and common knowledge, which allows culturally sensitive topics to be discussed in a safe environment. Participants often provide mutual support in expressing feelings and help the shyer members to open up. The focus group session may last

one to two hours and consist of a Staff Development Officer to help lead the discussion and multiple evaluation staff as note takers.

Some comments received in focus groups and satisfaction surveys include:

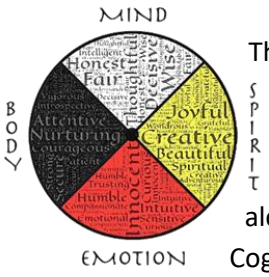
- "I'm more confident in myself."
- "The program helped me "be more concentrated and motivated."
- "...being more respectful"
- "It taught me how to do it and without being told, so I started to do chores at home without being told."
- "I have stress about home, so [staff] helped me with tools to help with that."
- "The start of program, I looked at things at a different perspective then now."
- I dislike the program because "it felt like doing a 7th class."
- I disliked the program because "it was a lot of work."
- "I've see changing with myself and my son, better communication, my boys are more out spoken, the things that they say to me, they say in a more respectful matter. Throughout the program, they've learned to speak to someone that is older than them. And little more teamwork with themselves."
- Last year was very tough, now I have seen a growth… he explains to me about what he needs from me to be more social. I've notice he has boundaries and respecting those. After identifying what we need from each other, it turned out pretty ok so far. Definitely communication has improved from since we've started the program."
- Aware in how I react with my son and better communicate with how things can go differently.
- "How to communicate with my grandson more and not to be judgmental."
- "I would like parents to show up to support groups."
- "The driving hours to the program was an issue."
- "I was told that it was going to be more of a male presence, like a father-brother type, there was really no males in the program, mostly women who still did great though."
- "Be more aware of dates and schooling different school districts."
- "The communication was off and in the beginning it was not explained much so in the beginning. No list of what is going on through the year."
- "BRAAF taught me to stop before responding to other people."
- "I had problems with boundaries and BRAAF helped me with that."

- “I used to let people define me, now I don’t let that be the case.”
- “The program has helped me change the way I feel about culture, we didn’t just come from slavery. We were Kings and Queens.”
- “People don’t know about African American culture, we are inventors.”
- “I think that my attitude and my way of thinking changed.”
- “To stand up for myself and to communicate what I need.”
- “I did not like the lessons.”
- “This program helped my daughter to be “aware of their feelings and what’s going on and a open line of communication.”
- “The scheduling is hard, more parent involvement, help with staff more so that the staff continue doing most of the work.”

Native American Communities:

Celebrating Families! Strengthening the Circle

Program Type: Prevention Program



The "Celebrating Families: Strengthening the Circle" program includes two (2) evidence-based practices and one (1) culturally based intervention. Wellbriety Celebrating Families (WCF) is a cognitive behavioral, support group model written for families in which there are risks for alcohol/substance use, domestic violence, child abuse, or neglect. Cognitive-Behavioral Therapy is a time-sensitive, structured, present-oriented form of psychotherapy that has demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol, and drug use problems, and other behavioral health challenges. Gathering of Native Americans (GONA) is a culture-based intervention and planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports the Native American/American Indian tribes with traditional songs, drumming, prayers and stories.



The primary goals of the "Celebrating Families: Strengthening the Circle" program are to increase positive family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk. The setting for service delivery is not traditional mental health settings and assist participants in feeling comfortable seeking services from staff that are knowledgeable and capable of identifying needs and solutions for Native American/American Indian families. The contracted provider is expected to provide the following level of service to each of the geographic regions of Riverside County: at least two group cycles, per region, per year; a cycle will consist of 11 weeks and each cycle shall serve a minimum of 6 families and maximum of 15 families. A family shall consist of parent(s)/caregiver(s) and at least one child aged 3 to 17 years. The total number of families expected to complete the Wellbriety Celebrating Families curriculum is at least 20 per year, per region. Completion is defined as a family completing 7 out of 11 sessions. The contract deliverable is to provide services to 60 families that meet graduation requirements countywide.

There was a total of seven WCF class cycles completed countywide during the FY23/24. The total number of parent participants who qualified to enroll in the WCF program was 37. Of these, 23 participants completed the program (62.2% completion rate). All enrolled participants were asked to complete pre packets at intake, and post packets at completion; however, only 12 matched pre-post measures could be used for comparison of pre to post scores.

A total of **126** Native American/American Indian individuals were served during the FY 2023-2024, through the combined GONA events and Celebrating Families program.

Some of the measures were either missing from the packets or were not completed entirely. For this outcomes report, only 12 matched pre-post measures were analyzed. Most enrolled participants (81.1%) identified themselves as American Indian/Alaskan Native with 13 different tribes represented in the WCF program, while the remaining participants (18.9%) reported Multiracial with American Indian/Alaskan Native. Overall parenting measures showed positive results from pre-post; however, due to the insufficient sample size, analysis using paired samples T-Tests was not possible.

The Wellbriety Celebrating Families program was able to provide services to families throughout each region. Additionally, the provider was able to engage the local schools in their GONA planning process to meet the needs of the community and have the event focus on important community concerns through a cultural lens.

The provider was able to reach out to new organizations within the community to help increase outreach efforts, including Olive Crest's monthly Community Days, Betty Ford Native American Families program in the Desert region, and The Happier Life Project in the Mid- County region.

The program struggled with staff retention and challenges with recruitment and hiring of a clinician. The program's Program Coordinator is a Licensed Clinical Social Worker, but the program did not provide any Cognitive-Behavioral Therapy (CBT) services to any community members during FY23/24. Furthermore, there were challenges in recruiting and retaining families in the Wellbriety Celebrating Families program. Families cited competing priorities for their family, such as afterschool sports or extracurricular activities for their children. This led to not being able to serve all the children in a family; parents at times preferred to participate in the program and have their children engaged in other after school activities.

The provider had challenges in locating central and easily accessible locations for families to participate in the program, leading to the offering of mostly virtual classes. Internet connectivity and having enough devices for all family members to have access to utilize the different breakout groups became a challenge and led to families becoming disengaged. When the provider partnered with one organization to provide services, all communication with parents and families enrolled in the program had to go through the other organization first, leaving them to rely on the partner organization to make contact, keep up with engagement, and following up about completion of program outcome measures, which resulted in a lot of missing data. The partnering organizations did not always understand the program components or requirements, which led to the provider accepting people into the Wellbriety Celebrating Families program that were not eligible for that service (e.g., they did not have any children in their care), and therefore their outcome measures were excluded and not valid. The provider learned the importance of having direct communication and engagement with families, and the challenges that can arise when having to rely on partner organizations that lack an understanding of the program.

During FY23/24, there were no participants enrolled in the CBT program, due to less interest from clients, employee turnover, as well as unavailability of clinician who could be solely assigned for this program from the contracted organization.

Program participants shared what they had learned after participating in the Wellbriety Celebrating Families program:

- “I learned that disciplining while angry is inappropriate. It’s best to calm down first.”
- “Mental health is important.”
- “Family boundaries and the importance of teaching kids values and morals, taking care of physical, mental, spiritual, and emotional well-being.”
- “Do not turn to substances for coping mechanisms.”
- “How much what I do have a say on the next generation, healthy boundaries, and living skills on family and community.”

Feedback from community members who participated in the GONA event:

- “I like how much information there was. I feel like I learned a lot.”
- “It was nice.”
- “Felt like I could share without getting judged.”

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Celebrating Families: Strengthening the Circle

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Wellbriety Celebrating Families (WCF)

During the fiscal year 2023-2024, there were a total of 37 eligible parent participants enrolled in the WCF program. A total of 7 WCF class cycles were completed Countywide: Mid-County (21 families enrolled), Western (8 families enrolled), and Desert (8 families enrolled). Of these, 23 participants completed the WCF Program (62.2% completion rate); however, only 12 matched/completed pre-post measures were submitted and analyzed. In this outcomes report, the demographic data analysis is based on the 37 enrolled participants, while the measures analysis is based on the 12 completed pre-post data.

The majority of parent participants were Female (73%), between 30 years old and 39 years old (32.4%), and did not identify as LGBTQI (81.1%). Most enrolled participants (81.1%) identified themselves as American Indian/Alaskan Native with 13 different tribes represented in the WCF program, while the remaining participants (18.9%) reported Multiracial with American Indian/Alaskan Native. All participants (100%) indicated that their preferred language is English, and that they were not Veterans. The majority of parent participants indicated that they did not have any disabling condition (83.8%). Most of the parent participants also indicated that they have at least 1 child in the "0 to 15 years" age range, as well as 1 child in the "16 to 25 years" age range.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the Alabama Parenting Questionnaire (APQ) measure. The **Parenting Involvement** scale showed a 6.6% increase, and the **Positive Parenting** scale showed a 5.4% increase. On the Guiding Good Choices Total Scores, it was shown that there was an increase of 2.58 points (a 3.3% increase) in the average scores from pre-to post-measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Guiding Good Choices** (GGC) and **Family Strength/Resilience Scale** (FSRS) measure. For the GGC measure, there was a minor increase of 1.8% on the average Total Scores from 49.67 to 50.58 (0.92 points), from pre-to-post measures. For the FSRS measure, the average Total Scores increased 7.5% from 47 to 50.83 (3.83 points), from pre-to-post measures. However, due to the small sample size, these results could not be analyzed for statistical significance.

A total of 12 pre-post matched pairs were completed by WCF parent participants for the **Opinions Survey**, where increases are expected across all items except for Item# 9 (which explored Alcohol/Chemical Dependency topic). Overall, analysis from pre-to-post measures showed increases (i.e. more parent participants chose "Yes", "Always", or "Agreed/Strongly Agreed" to the statements) across all items.

Overall, the **Post-Satisfaction Survey** analysis from 12 participants showed high satisfaction (i.e. responded to either "Satisfied" or "Very Satisfied") with the WCF program (91.7%) and the group leaders (91.7%). The majority also responded that they thought the WCF program has "Somewhat" or "Very Much" helped their families, and 100% responded "Yes", that they would recommend the WCF program to other families.

Cognitive-Based Therapy (CBT)

There was no CBT activity completed for the fiscal year 2023-2024, due to less interest from clients, employee turnover, as well as the lack of a clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A total of 1 GONA event was completed for the fiscal year 2023-2024, with a total of 89 attendees conducted at Noli Indian High School on May 13th, 2024. From this event, a total of 64 post-GONA satisfaction surveys were submitted by attendees. Overall, the survey analysis showed highly positive results from all parent participants. Additionally, a total of 21 Facilitator Debrief Surveys were collected from the GONA event, and those surveys also showed positive feedback from the facilitators about the events.

Program Goals

The primary goals of the "Celebrating Families: Strengthening the Circle" program are to increase positive family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk. The setting for service delivery would not be traditional mental health settings, and would assist participants in feeling comfortable seeking services from staff that are knowledgeable and capable of identifying needs and solutions for Native American/American Indian families. The contractor for this program is Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), which is expected to utilize targeted outreach to engage the Native American/American Indian community by working within the community and collaborating with the Tribal Temporary Assistance for Needy Families (TANFs), tribal organizations, tribal leaders, tribal elders, schools, community organizations, non-profit organizations, faith-based organizations, and other individuals, groups, and/or services that have the trust of and connection with this population.

RSBCIHI is contracted to provide two (2) evidence-based practices, and one (1) culturally-based intervention which are briefly described below:

1. **Wellbriety Celebrating Families!™**
   This is a cognitive behavioral, support group model written for families in which there are risks for alcohol/substance use, domestics violence, child abuse, or neglect. RSBCIHI is expected to provide the following level of service to each of the geographic regions of Riverside County:
   - At least 2 cycles of group, per region, per year.
   - A cycle will consist of 11 weeks, and each cycle shall serve a minimum of 6 families, and shall not exceed 15 families.
   - A family shall consist of parent(s)/caregiver(s) and at least one child age 3 to 17 years of age.
   - The total number of families expected to complete the Wellbriety Celebrating Families curriculum are at least 20 per year, per region.
   - Completion is defined as a family completing 7 out of 11 sessions.

2. **Cognitive-Behavioral Therapy (CBT)**
   This is a time-sensitive, structured, present-oriented form of psychotherapy that has demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol, and drug use problems, and other behavioral health challenges. RSBCIHI is contracted to provide CBT to an individual, family, and/or group interventions as determined by screening as well as clinical assessment. A Mental Health Clinician shall provide CBT interventions for 6 to 8 sessions, and/or on as needed basis.

3. **Gathering of Native Americans (GONA)**
   This is a culture-based intervention and planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports the Native American/American Indian tribes with traditional songs, drumming, prayers and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity. RSBCIHI is expected to plan 1 GONA event per year. The GONA event will be conducted over 2 days, at a safe, non-stigmatizing location, which will be rotated among the 3 regions on an annual basis.

Wellbriety Celebrating Families!™

The Wellbriety Celebrating Families!™ (WCF) program is based on the Wellbriety Movement and Celebrating Families curriculum, which is listed on the federal Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs and Practices (NREPP) since 2008. It integrates traditional Native teachings and cultural practices, including the Healing Forest Model, as a framework allowing each community to include traditional practices. It also emphasizes the importance of a community service and individual spirituality, and integrates parenting skills with strategies to break the cycle of addiction.

The WCF program fosters the development of safe, healthy, fulfilled, and addiction-free individuals and families by increasing resiliency factors and decreasing risk factors while incorporating addiction recovery concepts with healthy family living skills. It listed works with every member of the family, from ages 3 years of age through adult, to strengthen recovery from alcohol and/or other drugs, break the cycle of addiction and increase successful family reunification.

The WCF curriculum was originally designed for 16 weeks, that addresses the needs of children and parents in families that have serious problems with alcohol and other drugs, and to serve 6 to 15 families depending on the site's physical facilities, referral process and intake of eligible families. It was later expressed by RSBCIHI as well as the feedback from previous participants that the 16 weeks was lengthy and it was harder to gain interests from ongoing participations. Similar to the previous fiscal year, for the fiscal year 2023-2024, the WCF program was also condensed to a 11-week program, by combining 2 sessions into the weeks of 2, 3, 8, 9, and 10. A full attendance of at least 7 sessions is required to complete the WCF program. Each session of the program begins with a family meal. Afterwards, family members break into age group for developmentally appropriate activities led by the group facilitators. At the end of each session, all family members reconnect in activities to learn how to apply these new skills and interact in healthy ways.

Class Curriculum

The curriculum for WCF program is listed below, which was originally designed for 16 weeks, and then later condensed into 11 weeks by combining 2 sessions into Weeks 2, 3, 8, 9, and 10:

Week 1: Orientation and Getting Started
Week 2: Healthy Living
Week 3: Nutrition
Week 4: Communication
Week 5: Feeling and Defenses
Week 6: Anger Management
Week 7: Facts about Alcohol, Tobacco, and Other Drugs (ATOD)
Week 8: Chemical Dependency is a Disease
Week 9: Chemical Dependency Affects the Whole Family
Week 10: Goal Setting
Week 11: Making Healthy Choices
Week 12: Healthy Boundaries
Week 13: Healthy Friendships and Relationships
Week 14: How We Learn
Week 15: Our Uniqueness
Week 16: Celebration

Data Collection and Outcome Measures

The following forms and measures are to be completed by parent participants, in order to gather basic demographic information, as well as how they view their parenting skills and their relationship with their child. Additionally, a post-survey will be collected to gather participants' feedback on their perception of the WCF program.

- **Demographic Screening Form** (at the beginning of each WCF program)
- **Alabama Parenting Questionnaire** (at the beginning and at the completion of WCF program)
- **Guiding Good Choices and Family Strength/Resilience Scale** (at the beginning and at the completion of WCF program)
- **Opinions (Focus Questions) Survey** (at the beginning and at the completion of WCF program)
- **Post-Satisfaction Survey** (at the completion of the WCF program)

Alabama Parenting Questionnaire (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth. There were 42 items on the original version of APQ measure; however, for the purpose of WCF program, a modified format of the APQ measure was adopted for the WCF Program, with 22 items that would measure the following scales:

- **Parental Involvement** (Items No. 1, 4, 6, 8, 9, 12, 13, 16, 18, and 20)
- **Positive Parenting** (Items No. 2, 5, 11, 14, 15, and 21)
- **Inconsistent Discipline** (Items No. 3, 7, 10, 17, 19, and 22)

The **Guiding Good Choices (GGC) Scale** is taken from the GGC Program that aims to prevent teen substance use and risky behaviors by training parents to develop parenting and family management skills. Additionally, the **Family Strength/Resilience Scale** is taken from the Strengthening Families Program, an evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. The combined measure has 22 questions, which consist of Guiding Good Choices (10-questions) and Family Strength/Resilience Scale (12 questions) which were taken from these two separate programs and have been modified to fit the WCF program.

WCF Class Cycles, Class Enrollment and Completion

There were a total of 7 WCF class cycles completed Countywide during the fiscal year 2023-2024. The total number of parent participants who qualified to enroll in the WCF program was 37. Of these, 23 participants completed the program (62.2% completion rate). All enrolled participants were asked to complete pre packets at intake, and post packets at completion; however, only 12 matched pre-post measures could be used for comparison of pre to post scores. Some of the measures were either missing from the packets, or were not completed entirely. For this outcomes report, only 12 matched pre-post measures were analyzed. A list of all WCF class cycles that were completed during the fiscal year 2023-2024 is shown on table below:

Class Cycle#	Start Date	End Date	Class Name/Location
1	8/22/23	11/14/23	Tuesday PM Virtual #1
2	9/6/23	11/22/23	Soboba Virtual
3	9/6/23	12/5/23	Pechanga #1
4	1/19/24	3/19/24	Tuesday Zoom Group
5	1/17/24	3/24/24	TM TANF San Jacinto
6	10/31/23	2/6/24	Pechanga #2/#3
7	4/23/24	7/2/24	Tuesday PM Virtual #2

WCF Class Cycles, Class Enrollment and Completion (*continued*)

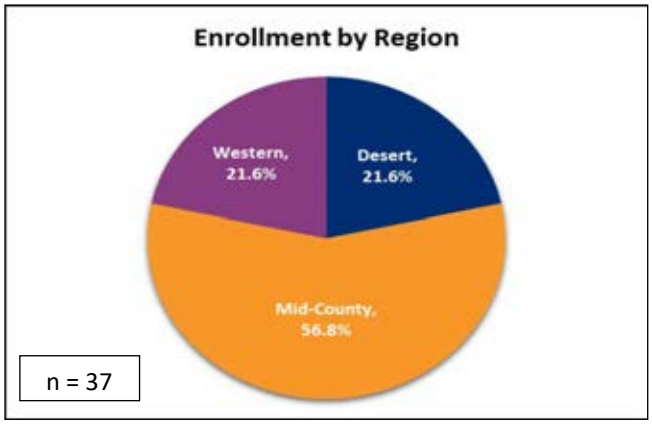
A summary of all WCF class cycles and enrollment counts for fiscal year 2023-2024 by Region, as well as Countywide are shown on the table below:

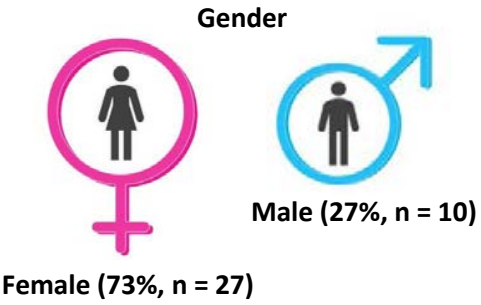
Region	Number of Families Enrolled	Number of Completion	Matched Pre-Post Data Sets Submitted	Contract Expectation	Percentage of Contract Expectation	Participants Completion Rate
Western	8	6	4	20	30%	75%
Mid-County	25	14	5	20	70%	56%
Desert	4	4	3	20	20%	100%
Countywide	37	23	12	60	38.3%	62.2%

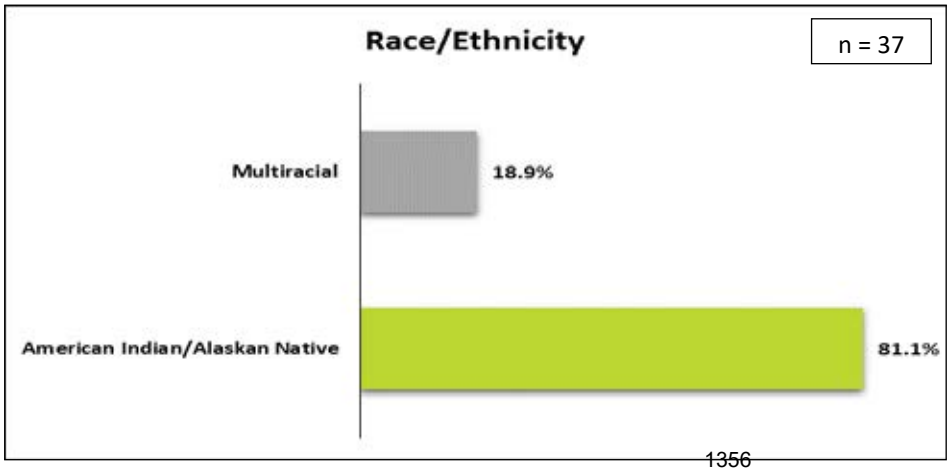
Demographics

During the fiscal year 2023-2024, a total of 7 WCF cycles were completed Countywide. The total number of participants who enrolled were 37, and the demographics data collected and analyzed were based on the total enrollments of 37 participants. The demographics data for *Enrollment by Region*, *Gender*, *Race/ Ethnicity*, and Preferred Language are summarized and shown below:

- 21 families enrolled in the Mid-County region (56.8%), 8 families enrolled in the Western County region (21.6%), and 8 families enrolled in the Desert region (21.6%)
- The majority of parent participants were Female (73%, n = 27), while the remaining participants were Male (27%, n = 10).
- 30 participants (81.1%) categorized themselves as American Indian/Alaskan Native, while 7 participants (18.9%) responded as being Multiracial.
- A total of 13 different tribes were represented across all the class cycles (as indicated by participants).
- All participants (100%) indicated that their preferred language is English.





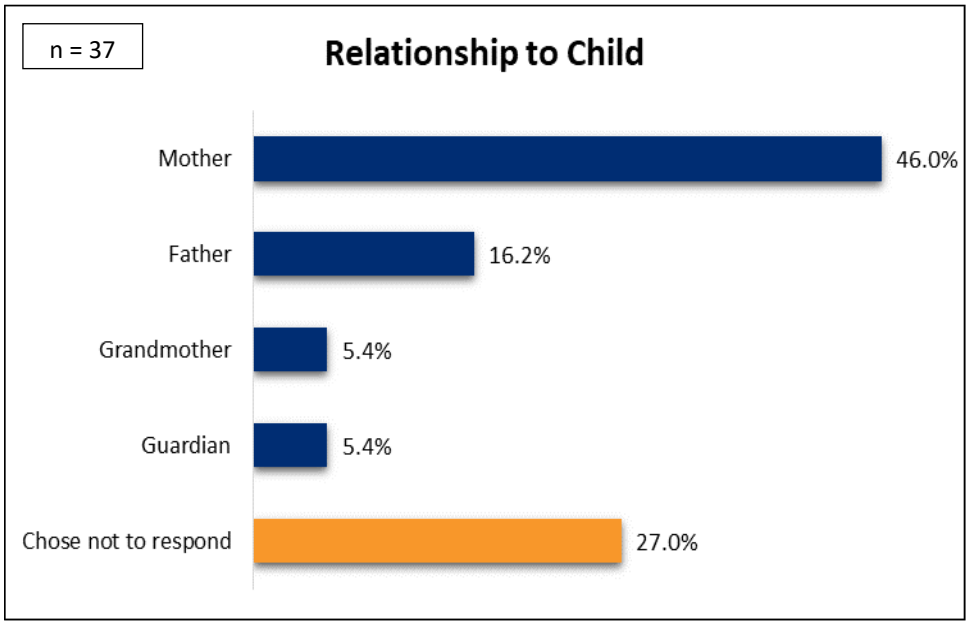


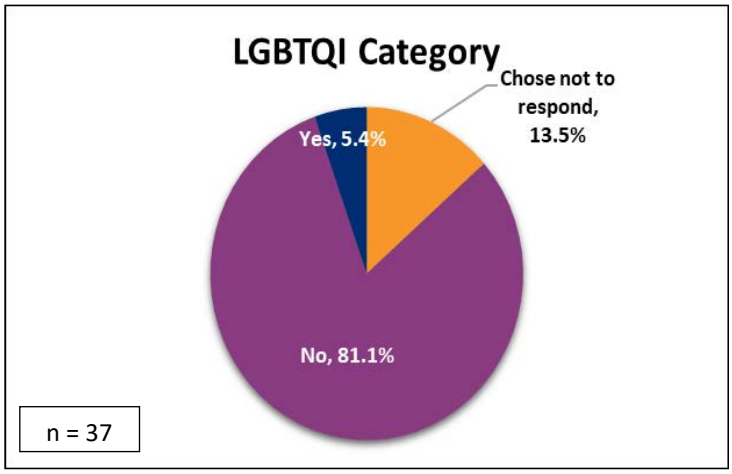
Specification of American Indian/Alaska Native Tribes
Cahuilla
Choctaw
Ely Shoshone
Hualapai
Hoopa
La Jolla
Navajo Nation
Oneida
Quechan
San Luis Rey
San Pasqual
Santa Rosa Band of Cahuilla
Torres Martinez

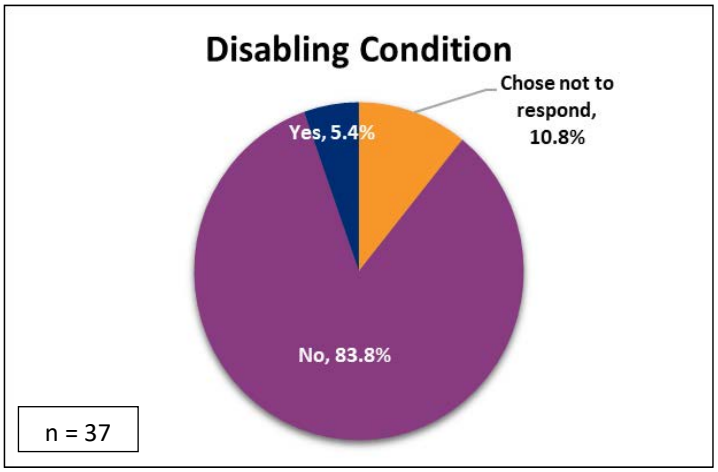
Demographics (*continued*)

The demographics data showing *Relationship of Participants to Children*, *LGBTQI Category*, *Veteran Status*, and *Disabling Condition* are summarized and shown on graphs below:

- The majority of parent participants indicated that their relationships to their children were as their "Mother" (46%, n = 17), "Father" (16.2%, n = 6), "Grandmother" (5.4%, n = 2), and "Guardian" (5.4%, n = 2), respectively. It is also noted that 10 participants (27%) chose not to respond to this question.
- Within the LGBTQI category, the majority of participants indicated "No" (81.1%, n = 30) on their responses, while 2 participants (5.4) indicated "Yes", and noted Bisexual as the category. It is also noted that the remaining 5 participants (13.5%) chose not to respond to this question.
- All participants (100%) indicated that they were not Veterans.
- A total of 31 parent participants (83.8%) indicated that they did not have any Disabling Condition, while 2 participants (5.4%) indicated that they have a Disabling Condition, and 4 participants (10.8%) chose not to respond to this question. Of those who responded "Yes", Fibromyalgia was noted as the specification of disability.



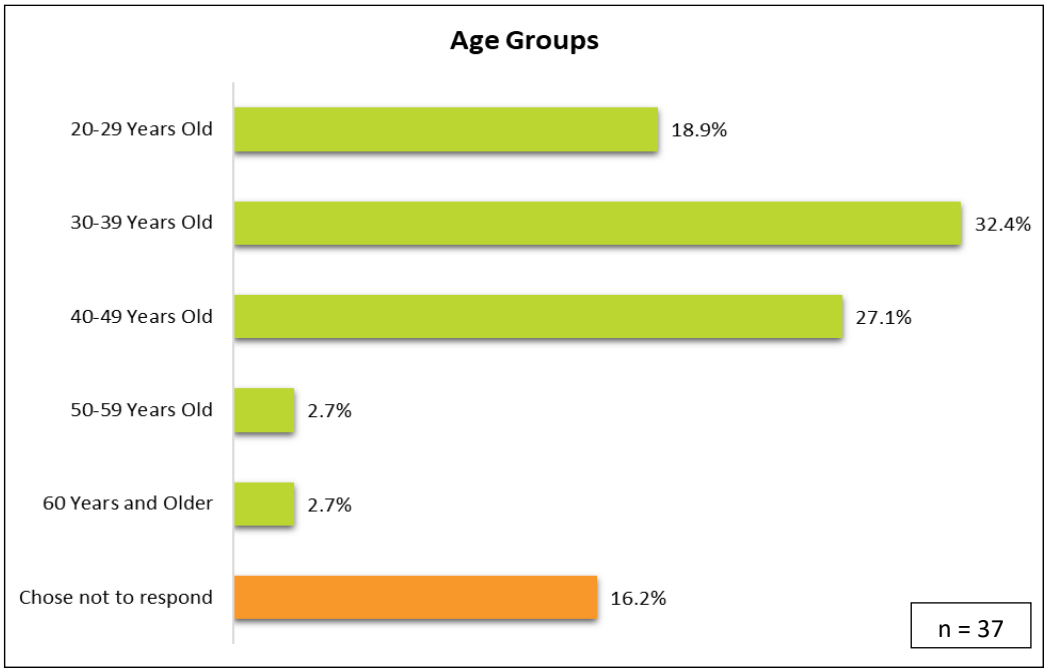




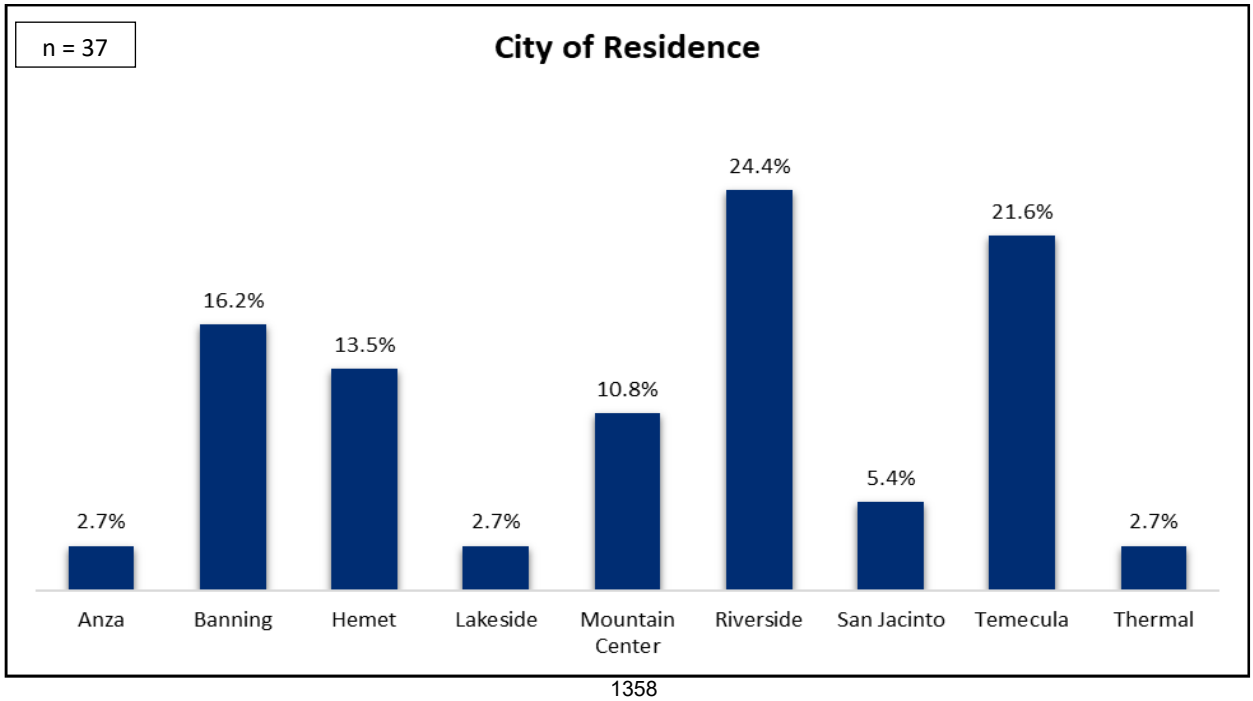
Demographics (*continued*)

The demographics data showing parent participants' Age Group and City of Residence are summarized and shown on graphs below:

- The majority of parent participants (32.4%, n = 12) were between 30 to 39 years of age. It is also noted that 6 participants (16.2%) chose not to respond. The number of participants in each age group is shown on the table below.
- Parent participants indicated that they had at least 1 child between 0 to 15 years old, and 1 child between 16 to 25 years old.
- The majority of parent participants indicated that they lived in Riverside (24.4%, n = 9), followed by Temecula (21.6%, n = 8), and Banning (16.2%, n = 6). Other cities noted were as follows: Anza, Hemet, Lakeside, Mountain Center, San Jacinto, and Thermal.



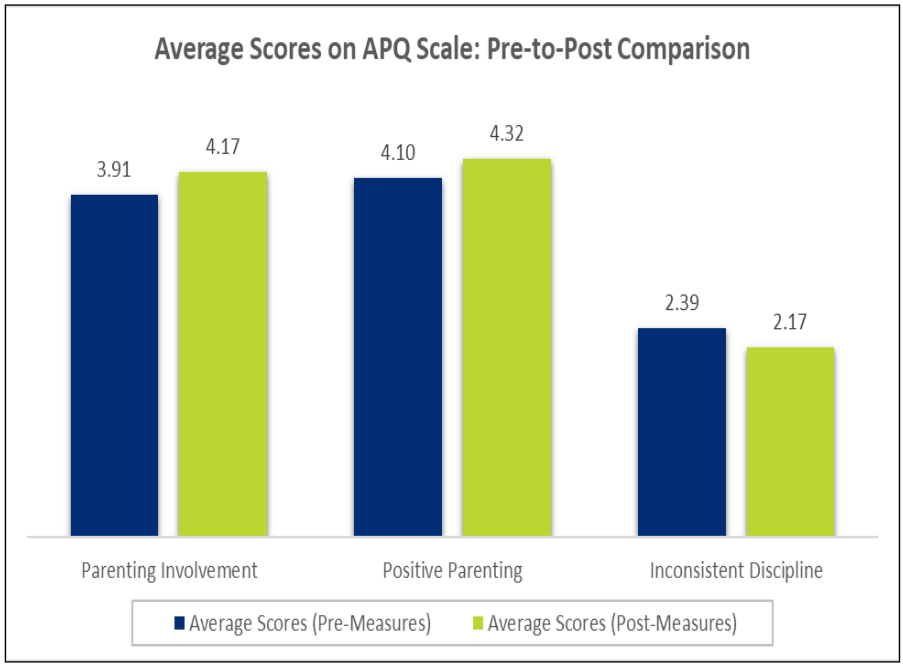
Age Groups	Counts
20-29 years old	7
30-39 years old	12
40-49 years old	10
50-59 years old	1
60 years and older	1
Chose not to respond	*6*



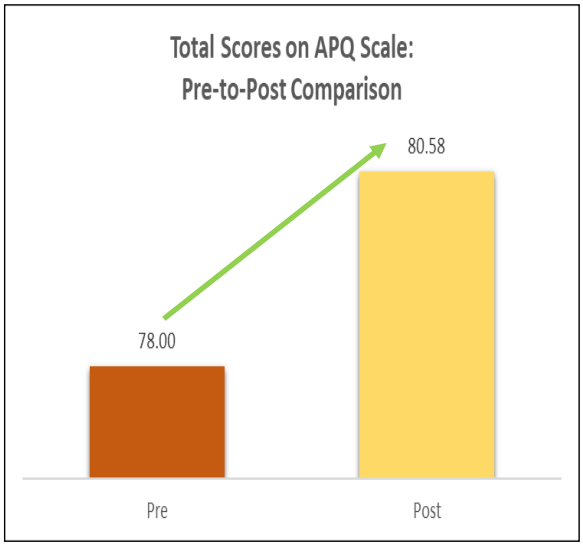
Alabama Parenting Questionnaire

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1="Never", 2="Almost Never", 3="Sometimes", 4="Often", and 5="Always". Each parent participant is asked to complete the APQ measure at the start of the WCF program, and at the end of the program. Each question on the APQ measure is a different statement about parenting practices, and each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see *increases* in the average scores for both "Parenting Involvement" and "Positive Parenting" scales, and *decreases* in the average scores of "Inconsistent Discipline" scale from pre-to-post.

A total of 12 pre-post matched pairs were completed by parent participants for the APQ measure. The graph below shows the APQ Scale results. The **Parenting Involvement** scale showed a 6.6% increase (0.26 points) from 3.91 to 4.17, and **Positive Parenting** scale showed a 5.4% increase (0.22 points) from 4.10 to 4.32. Conversely, **Inconsistent Discipline** scale showed a decrease of 9.3% (-0.22 points) from 2.39 to 2.17). All scales showed positive results from pre-post; however, due to the insufficient sample size, analysis using Paired Samples T-Tests was not possible. Overall, the average Total Scores showed an increase of 2.58 points (3.3% change) from 78 to 80.58.



n = 12



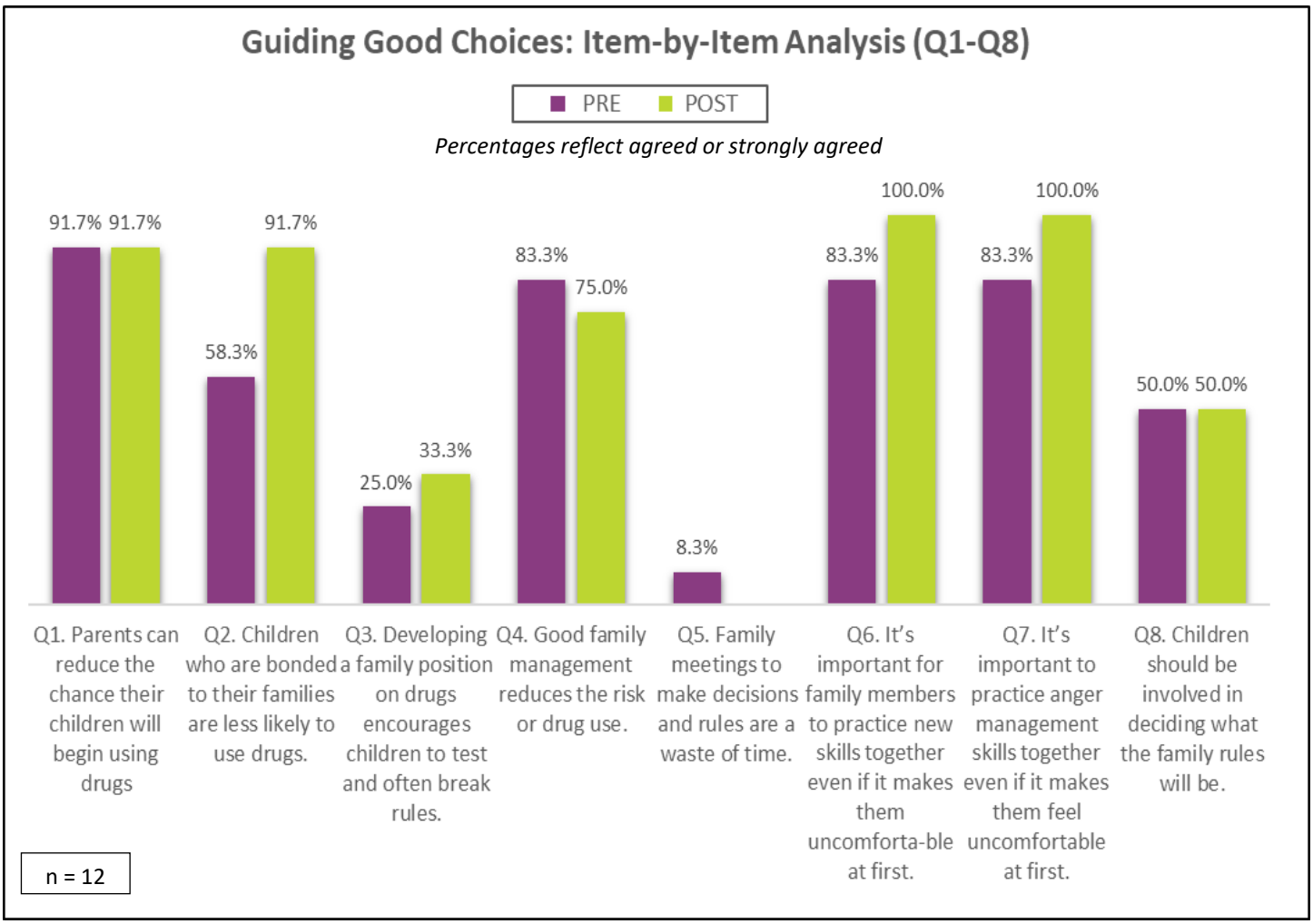
APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.6%	-1.015	11	.332
Positive Parenting	5.4%	-0.818	11	.431
Inconsistent Discipline	-9.3%	1.310	11	.217
Total Scores	**3.3%**	**-0.681**	**11**	**.510**

Guiding Good Choices and Family Strength/Resilience Scale

On the Guiding Good Choices and Family Strength/Resilience Scale measure, parent participants were asked their opinions about how often the statements would best describes their families. Ideally, we would like to see an increase in all items from pre-to post-measures, except for Item# 5 (*Family meetings to make decisions and rules are a waste of time*), on parent participants' who selected Options 5, 6, and 7 ("Tend to Agree", "Agree", and "Strongly Agree"). For the Guiding Good Choices measure (Questions 1 to 10), the questions are structured on two types of Likert Scales, and results are shown below:

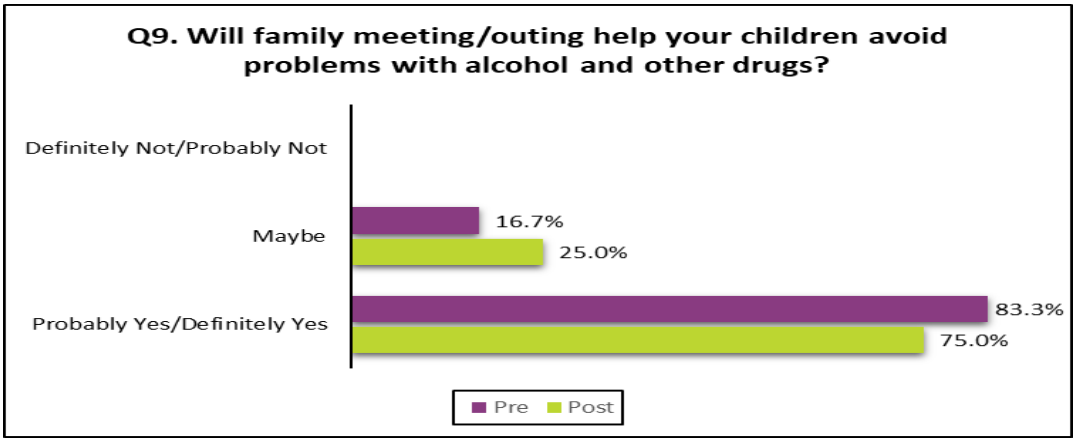
- On **Questions 1 to 8**, parents are asked to choose between 7 options, where: 1="Strongly Disagree", 2="Disagree", 3="Tend to Disagree", 4="Neutral", 5="Tend to Agree", 6="Agree" and 7="Strongly Agree".
- On **Questions 9 and 10**, parents are asked to choose between 5 options, where 1="Definitely Not", 2="Probably Not", 3="Maybe", 4="Probably Yes", and 5="Definitely Yes."

There were a total of 12 pre-to-post surveys submitted for the Guiding Good Choices measure. Overall, there are increases on parents' choices from pre– to post-measures, with the highest percent increase of 57.3% is shown on Item# 2 (*Children who are bonded to their families are less likely to use drugs*). Item#5 (*Family meetings to make decisions and rules are a waste of time*) is shown as the highest percent decrease of 100%, which is considered as ideal. Item-by-item analysis from Questions 1 to 8 on the GGC scale is shown below, while the analysis for Questions 9-10 as well as the average on Total Scores are shown on the following page.

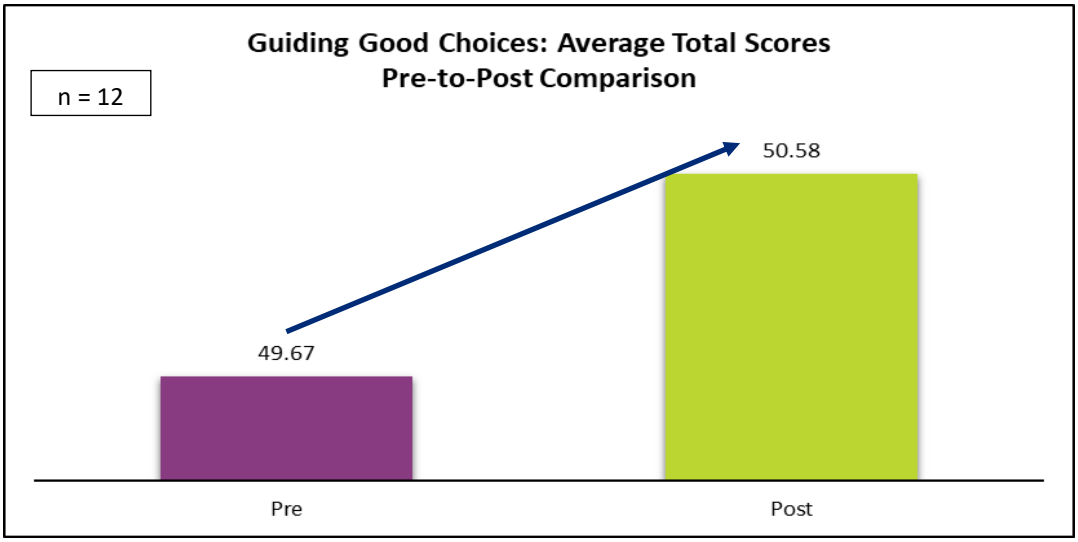


Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

From 12 pre-to-post measures submitted, analysis for questions 9 and 10 showed increases in parent participants' who selected "Maybe" from pre measures to post measures. For both Questions 9 and 10, none of the parent participants selected Options 1 and 2 ("Definitely Not" or "Probably Not"). On Question# 9, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) decreased from 83.3% to 75%. On Question# 10, the percentage of "Probably Yes" or "Definitely Yes" responses (i.e. those who chose Options 4 and 5) also decreased from 91.7% to 75%. Overall, the average Total Scores on Guiding Good Choices measure also showed an increase of 0.92 points from 49.67 to 50.58 (a 1.8% increase). However, due to the small sample size, this result is not shown to be statistically significant.

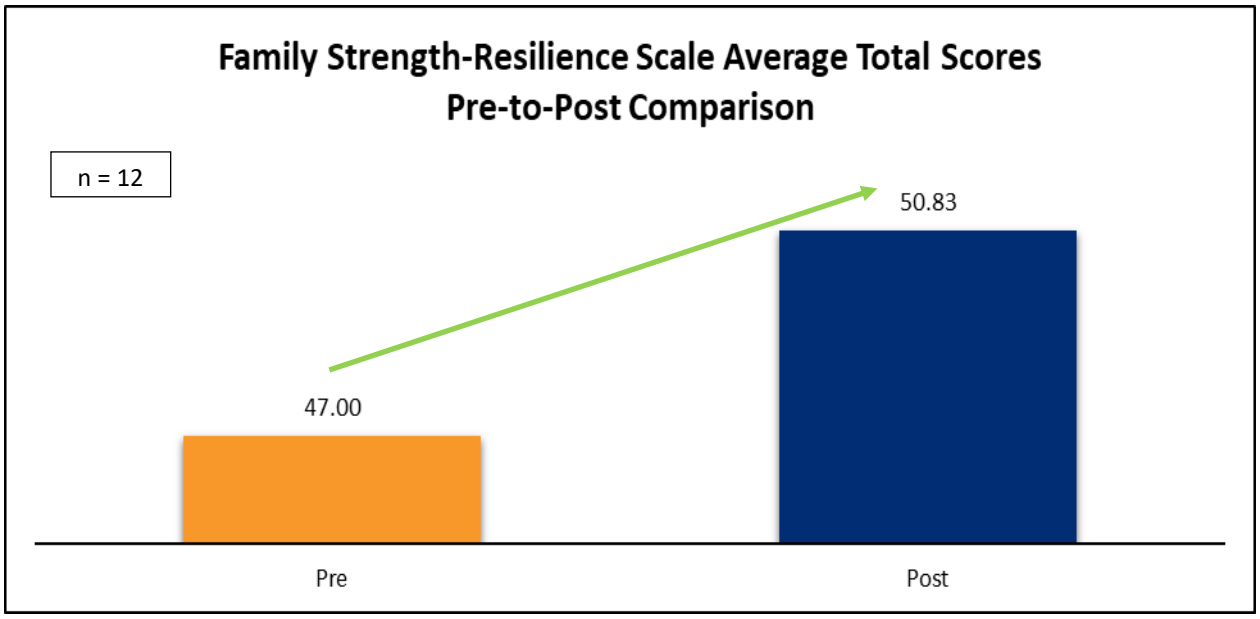






Guiding Good Choices and Family Strength/Resilience Scale (*continued*)

On the Family Strength/Resilience Scale Questions 11 to 22, parent participants were asked to select from 5 Likert Scale options, where 1="Very Little Strength", 2="Some Strength", 3="Neutral", 4="Good Strength", and 5="Very Strong". Ideally, we would like to see increases across all items (i.e. from participants selecting options 1 or 2 on pre-measures, to selecting 4 or 5 on post-measures). Based on the analysis from 12 paired pre-post measures submitted at the completion of WCF program, the average Total Scores showed an increase of 3.83 points from 47 points to 50.83, which is a 7.5% increase from pre-to post-measure. However, due to the small sample size, this result is not shown to be statistically significant. An item-by-item analysis of Item numbers 11 to 22 are shown on table the below. Item numbers 12, 14, 15, 16, 17, and 21 showed percent increases of 25% or more (i.e. percent increases in parent participants selecting "Good Strength" and "Very Strong" from pre-measures to post-measures).



Family Strength and Resilience Scale Items	*Very Little Strength-Some Strength PRE*	*Very Little Strength-Some Strength POST*	*Good Strength-Very Strong PRE*	*Good Strength-Very Strong POST*	*Good Strength-Very Strong %DIFFERENCE*
11. Family Supportiveness, love and care	0.0%	8.3%	91.7%	91.7%	0.0%
12. Positive Family Communication (clear directions, rules, praise)	16.7%	8.3%	66.7%	91.7%	**37.5%**
13. Effective Parenting Skills (reading to child, rewarding)	16.7%	8.3%	75.0%	83.3%	11.1%
14. Effective Discipline Style that is consistent with love and respect	8.3%	8.3%	66.6%	83.3%	**25.1%**
15. Family Organization (rules, chores, self responsibility)	8.3%	16.6%	41.7%	66.6%	**59.7%**
16. Family Unity (togetherness, cohesion)	8.3%	8.3%	66.7%	91.6%	**37.3%**
17. Positive Mental Health (generally good feeling about own self)	25.0%	16.6%	66.6%	83.3%	**25.1%**
18. Physical Health	8.3%	8.3%	66.7%	75.0%	12.4%
19. Emotional Strength	25.0%	0.0%	58.3%	66.7%	14.4%
20. Knowledge and Education	8.3%	8.3%	75.0%	83.4%	11.2%
21. Social Networking (making or talking with friends, building community)	25.0%	16.7%	58.4%	75.0%	**28.4%**
22. Spiritual Strength	0.0%	8.3%	83.3%	75.0%	-10.0%

WCF Pre-Post Opinions Survey

In the Wellbriety Celebrating Families™ (WCF) program curriculum, there is one question named as "Focus Question" for each week or each different topic that is selected to be discussed with parent participants. There are a total of 10 questions selected and condensed into an "Opinions Survey", which participants are asked to complete at both at intake and at the completion of the WCF program. Generally, we would like to see if there is any change (either an increase or a decrease) in the participants' opinions from pre– to-post-measures, in regards to the topic and/or selected focus questions. More specifically, the goal is for participants' opinions to increase to a higher percentage of "Yes" (i.e. more people selecting "Yes" as an option, instead of selecting "Don't Know" or "No") at the completion of the WCF program in comparison to at intake, *except* on Question 9 when the alcohol/chemical dependency topic is introduced. Increases indicate an improvement in knowledge after program completion. Overall, there are a total of 12 pre-post measures that were analyzed and the results are shown below and on the following page.

WCF Opinions Survey Q1-Q6	Don't Know		No		Yes	
	PRE	POST	PRE	POST	PRE	POST
1. What I eat and drink changes the way my brain works.	8.3%	0%	0%	0.0%	91.7%	100%
2. A can of beer, a bottle/can of flavored alcoholic beverage, a glass of wine, and a shot of hard liquor all contain the same amount of alcohol.	50%	33.3%	16.7%	16.7%	33.3%	50%
3. People with blood relatives who have the disease of "Chemical Dependency" are at High Risk to become addicted themselves if they drink or use.	8.4%	8.4%	33.3%	8.3%	58.3%	83.3%
4. If one member of a family is chemically dependent, all other family members are affected.	0%	0%	41.7%	16.7%	58.3%	83.3%
5. If my children talk to other adults, they are less likely to become addicted.	50%	50%	16.7%	16.7%	33.3%	33.3%
6. I have a safe person who will listen when I need to talk about my problems.	8.3%	8.3%	0%	8.4%	91.7%	83.3%

For questions 1 to 6, participants are asked to select either "Don't Know", "No", or "Yes" for the selected Focus Questions as listed on table above, which can be summarized below:

- Participants' opinions changed from 91.7% to 100% on those who selected "Yes" (9.1% increase) on Question #1.
- Participant's opinions changed from 33.3% to 50% on those who selected "Yes" (50.2% increase) on Question #2.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #3.
- Participants' opinions changed from 58.3% to 83.3% on those who selected "Yes" (42.9% increase) on Question #4.
- Participants' opinions remained the same (33.3%) on those who selected "Yes" (0.1% decrease) on Question #5.
- Participants' opinions changed from 91.7% to 83.3% on those who selected "Yes" (9.2% decrease) on Question #6.

WCF Pre-Post Opinions Survey (*continued*)

On Questions 7 and 8, participants are asked to select between "Never", "Sometimes", "About half the time", "A lot of the time", or "Always" on the selected Focus Questions as listed on table below, and the summary is as follows:

- On Question 7, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 75% at completion (50% increase in opinions).
- On Question 8, 50% of participants selected "A lot of the time" or "Always" at intake, and this has increased to 66.7% at completion (33.4% increase in opinions).

WCF Opinions Survey Q7-Q8	Never		Sometimes		About half the time		A lot of the time		Always	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
7. I am able to talk about my feelings.	8.3%	0.0%	0.0%	8.3%	41.7%	16.7%	33.3%	41.7%	16.7%	33.3%
8. I express my anger safely.	8.3%	0.0%	0.0%	0.0%	41.7%	33.3%	33.3%	41.7%	16.7%	25.0%

On Question 9, participants are asked to select between "25%", "40%", "50%", "60%", or "More Than 60%" on the selected Focus Question as listed on table below. Overall, there are slight increases across all options in parents' opinions in regards to alcohol/chemical dependency.

WCF Opinions Survey Q9	25%		40%		50%		60%		More than 60%	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
9. What percentage (%) of children live in a home with a parent who drinks heavily or has a problem with alcohol or other drugs?	33.3%	16.7%			33.3%	16.7%	8.4%	24.9%	25.0%	41.7%

On Question 10, participants are asked to select between "Strongly Disagree", "Disagree", "Neutral", "Agree", or "Strongly Agree" on the selected Focus Question as listed on table below. Overall, there was no participant who selected either "Strongly Disagree" or "Disagree" at both intake and completion, and 91.6% of participants selected either "Agree" or "Strongly Agree" at intake, and this has increased to 100% at completion (9.2% increase in opinions). This indicates that there are more parent participants who Agreed or Strongly Agreed at completion that "*Providing Rules and Limits help their children to build their self-esteem*."

WCF Opinions Survey Q10	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
10. Providing Rules and Limits help my children build their self-esteem.					8.4%	0.0%	58.3%	66.7%	33.3%	33.3%

WCF Post-Satisfaction Survey

A post-satisfaction survey was created to evaluate the Wellbriety Celebrating Families™ (WCF) program effectiveness and to gather attendees' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to all attendees and collected at the end of the WCF program. There are a total of 8 questions on the post-satisfaction surveys:

- The first two questions use Likert scale ranging from 1 to 5, where: 1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, and 5 = Very Satisfied
- The third question also uses Likert scale ranging from 1 to 5, where: 1 = Not At All, 2 = Very Little, 3 = Not Sure, 4 = Somewhat, and 5 = Very Much
- The fourth question provides two options, "Yes" or "No"
- Questions 5 to 8 are open ended questions, which are meant to gather participants' opinions on their thoughts about the WCF program, whether they did or did not like the WCF program, and if they had any additional comments.

At the completion of WCF Program, there are a total of 12 post-satisfaction surveys submitted by attendees, and the results are shown below.

Post-Satisfaction Survey Results

In regards to the satisfaction with both the program and the group leaders, the majority of participants (83.4%, n = 10) responded that they were "Very Satisfied". Additionally, 10 participants (83.4%) felt that the WCF program has helped their families. In regards to participants' feedback on whether they would recommend the WCF program to other families, all participants (100%) responded "Yes". A summary of their responses is shown below, and their survey comments are shown on the following three pages.

	 Neutral	 Satisfied	 Very Satisfied
Q1. How satisfied were you with this program?	**8.3%**	**8.3%**	**83.4%**
Q2. How satisfied were you with your group leaders?	**8.3%**	**8.3%**	**83.4%**
	 Not Sure	 Somewhat	 Very Much
Q3. How much has this class helped your family?	**0%**	**16.7%**	**83.3%**
Q4. Would you recommend this program to other families?		**100%**	

Post-Satisfaction Survey Comments

The remaining 4 questions of the post-satisfaction surveys (Questions 5 to 8) were related to participants' opinions regarding the WCF program. The participants' feedback are summarized below:

Q5. Things I learned in the Wellbriety Celebrating Families™ program are:

"I learned that disciplining while angry is inappropriate. It's best to calm down first."
"Mental health is important."
"Family boundaries and the importance of teaching kids values and morals, taking care of physical, mental, spiritual, and emotional well-being."
"Do not turn to substances for coping mechanisms."
"Managing my emotions, family connections tips, and that I am an amazing parent."
"That our group are handling the sane things in life that are positive,"
"How to work on stress and historical trauma."
"How to have a healthier family living and to be stronger in my society."
"HALT, prayer."
"To open up."
"How much what I do have a say on the next generation, healthy boundaries, and living skills on family and community."

Q6. What I liked about the Wellbriety Celebrating Families™ program was:

"I liked the Zoom class but also enjoyed getting to see everyone in person."
"Learning about how to recognize growing up in unhealthy forest."
"That there was no judgment."
"Attending with my kids."
"Being able to be open and honest and receiving thoughtful feedback on issues I'm dealing with."
"Everything! Sharing and hearing others' experiences."
"That our counselors, also group, understood each other."
"The staff really connected with you and really heartfelt."
"Openness, great leaders."
"The group."
"Variety and openness of topic."

Q7. What I didn't like about the Wellbriety Celebrating Families™ program was:

"That I struggled with Zoom sometimes."
"Nothing, it was very convenient."
"It was on Zoom."
"Mainly centered around substance abuse issues rather than co-parenting."
"It was on a work day."

Q8. Any additional comments?

"This is my first time in a group program. The Zoom was great! But I prefer in person. I believe that these program should be consistent for all other reasons."
"Instructors were amazing!"
"The leaders are very open, considerate, patient, knowledgeable, respectful, and understanding."
"Thank you!"

Cognitive-Behavioral Therapy

The Cognitive-Behavioral Therapy (CBT) is directed toward solving current problems and teaching clients skills to modify maladaptive thinking and behavior. It is included as an element of the Celebrating Families: Strengthening the Circle Project, in order to provide individual, family, and/or group interventions to participants who are identified through clinical assessment as having emerging symptoms of depression or anxiety, present for less than one (1) year. Generally, the CBT interventions will be determined by a Mental Health clinician, which may vary from participant to participant. Generally, it will be offered from 6 to 8 sessions, and/or on as needed basis.

Data Collection and Outcome Measures

Both adults and children can participate in the CBT program, and the following data collection and outcome measures are to be completed by each participant:

For each adult participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **OQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

For each child participant:

- **Demographic Screening Form** (at the beginning of each program)
- **PHQ-9 Questionnaire** (at the beginning and at the completion of each program)
- **YOQ Form** (at the beginning and at the completion of each program)
- **Post-Satisfaction Survey** (at the completion of each program)

The clinician assigned to each participant is also expected to complete a Participant Log and Program Completion Summary Form, which will be submitted to RUHS-BH along with each participants' pre and post packets.

The **PHQ-9**, or **Patient Health Questionnaire-Nine**, is a self-reported depression scale that's used to screen clients for major depressive disorder. This measure consists of nine questions that ask about the frequency of symptoms over the past two weeks. Each question is rated on a scale from 0 to 27, with higher scores indicating more severe symptoms:

- 0-13: indicates *mild depression*
- 14-19: indicates *moderate depression*
- 20-27: indicates *severe depression*

The **OQ**, or the **Outcome Questionnaire**, is a 45-item multiple-choice self-report inventory used to measure psychotherapy progress in adult clients (ages 18 and older). It provides a quick by comprehensive snapshot of the client's current functioning across a wide variety of disorders, and it measures three subscales:

1. **Symptom Distress (SD)**, or subjective discomfort: intrapsychic functioning with an emphasis on client's depression and anxiety.
2. **Interpersonal Relations (IR)**: loneliness, conflict with others, and marriage and family difficulties.
3. **Social Role (SR)**: difficulties in the workplace, school, or home duties.

The Total Score for OQ ranges from 0 to 180, with a clinical cutoff of 64 points.

Data Collection and Outcome Measures *(continued)*

The **Y-OQ**, or the **Youth Outcome Questionnaire**, is a 64-item self-report completed by the parent/guardian that measures the treatment progress for children and adolescents (ages 4 to 17 years old) receiving mental health intervention. It is designed to reflect the total amount of stress a child or adolescent is experiencing, and its utility across many populations, treatment types, and modalities allows for non-invasive clinical application in nearly all settings of care. The total score of Y-OQ ranges from –16 to 240 with a clinical cut off of 47 points. There are six subscales in the YOQ measure:

1. **Intrapersonal Distress** (emotional distress).
2. **Somatic Distress** (distress presenting physically).
3. **Interpersonal Relations** (relationship with parents, other adults, and peers).
4. **Critical Items** (flags need for those requiring immediate intervention beyond standard outpatient treatment)
5. **Social Problems** (socially-related problematic behaviors)
6. **Behavioral Dysfunction** (unhealthy behaviors)

Enrollment

During the fiscal year 2023-2024, there were no participants enrolled in the CBT Program, due to less interest from clients, employee turnover, as well as unavailability of clinician who could be solely assigned for this program from the contracted organization.

Gathering of Native Americans (GONA)

A Gathering of Native Americans (GONA) is a culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports Native American/American Indian tribes with traditional songs, drumming, prayers, and stories. There are four elements of the GONA curriculum that incorporate the values of human growth and responsibility that are found in Native cultures: Belonging, Mastery, Interdependence, and Generosity.

The overall goals of the GONA process are to:

- Provide Native communities with a framework to examine the effects of historical trauma.
- Provide an integrative experience that offers hope, encouragement, and a positive foundation for Native community action and healing.
- Provide an experience that emphasizes skill transfer and supports Native community empowerment.
- Reinforce cultural continuity with families living on tribal reservations and in urban or rural areas.
- Increase protective factors linked to healthy and safe development of Native children and their families.
- Offer Native communities a strategic framework and planning process that supports the values of *Belonging*, *Mastery*, *Interdependence*, and *Generosity*, which are inherent in Native cultures and lead to the reduction of risk behaviors contributing to mental and substance use disorders and suicide.

By utilizing SAMHSA Tribal training and Technical Assistance Center's GONA Curriculum and Facilitator Guide and Toolkit, RSBCIHI is contracted to plan one (1) GONA event per year. The identified program leadership will participate in a trans-regional GONA planning process, and the regions shall work collaboratively to plan, host and hold the event. The GONA event will be conducted over 1 –2 days, at a safe, non-stigmatizing location, which will be rotated among the three regions on an annual basis. The GONA will occur at the conclusion of the year and include Wellbriety Celebrating Families!™ program graduates, as well as the larger Native American/American Indian community in order to address the community-identified issues.

As part of data collection procedure, the following are to be collected from the GONA event:

- **Participant Sign-In Form**
- **GONA Post-Satisfaction Survey**
- **GONA Facilitator Debrief Form**

Event Sign-Ins

During the fiscal year 2023-2024, there was one GONA events completed, with a total attendance of **89** people, which was completed at Noli High School.

Date	Location	Total Attendance
5/13/2024	Noli Indian School	89

GONA Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate the Gathering of Native American (GONA) event for its effectiveness, and to gather attendees' feedback on how the program has impacted their relationship with their children, family, as well as their community. The post-satisfaction surveys were distributed to all attendees and collected at the end of the GONA event. There are a total of 12 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. At the completion of the GONA event, there were a total of 64 post-satisfaction surveys submitted by attendees. The survey results and summary of attendees' comments are shown on the following two pages.

GONA Post-Satisfaction Survey Results

	Satisfaction Survey Items (n = 64)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I received a positive portrayal of Native American culture.	3.1%	1.6%	14.1%	35.9%	45.3%
2	Gathering of Native Americans encouraged us to draw closer as a community.	1.6%	1.6%	19.0%	30.2%	47.6%
3	I learned about Native American values and culture in each of the activities.	1.6%	3.1%	26.6%	32.8%	35.9%
4	I learned about how historical trauma impacts my community.	4.8%	3.2%	23.8%	44.4%	23.8%
5	The gathering gave me a sense of belonging.	1.6%	6.3%	25.4%	31.8%	34.9%
6	An event like this one brings hope in our community.	1.6%	1.6%	31.7%	27.0%	38.1%
7	I learned about substance use disorders.	3.2%	6.3%	30.2%	38.1%	22.2%
8	I learned about mental health issues (e.g. suicide prevention, mental health disorders).	3.3%	1.6%	18.0%	42.7%	34.4%
9	I learned how to promote mental wellness.	1.6%	4.8%	28.5%	41.3%	23.8%
10	I had fun participating in Gathering of Native Americans.	3.2%	4.8%	17.4%	22.2%	52.4%
11	The event was well organized.	1.6%	6.3%	31.7%	23.8%	36.6%
12	Staff members were knowledgeable.	3.2%	4.8%	15.8%	36.5%	39.7%

Overall, the analysis from post-satisfaction surveys showed positive results from all participants. For the following survey statements, attendees showed positive results of about *75% or higher* on the combined "Agree" and "Strongly Agree" responses:

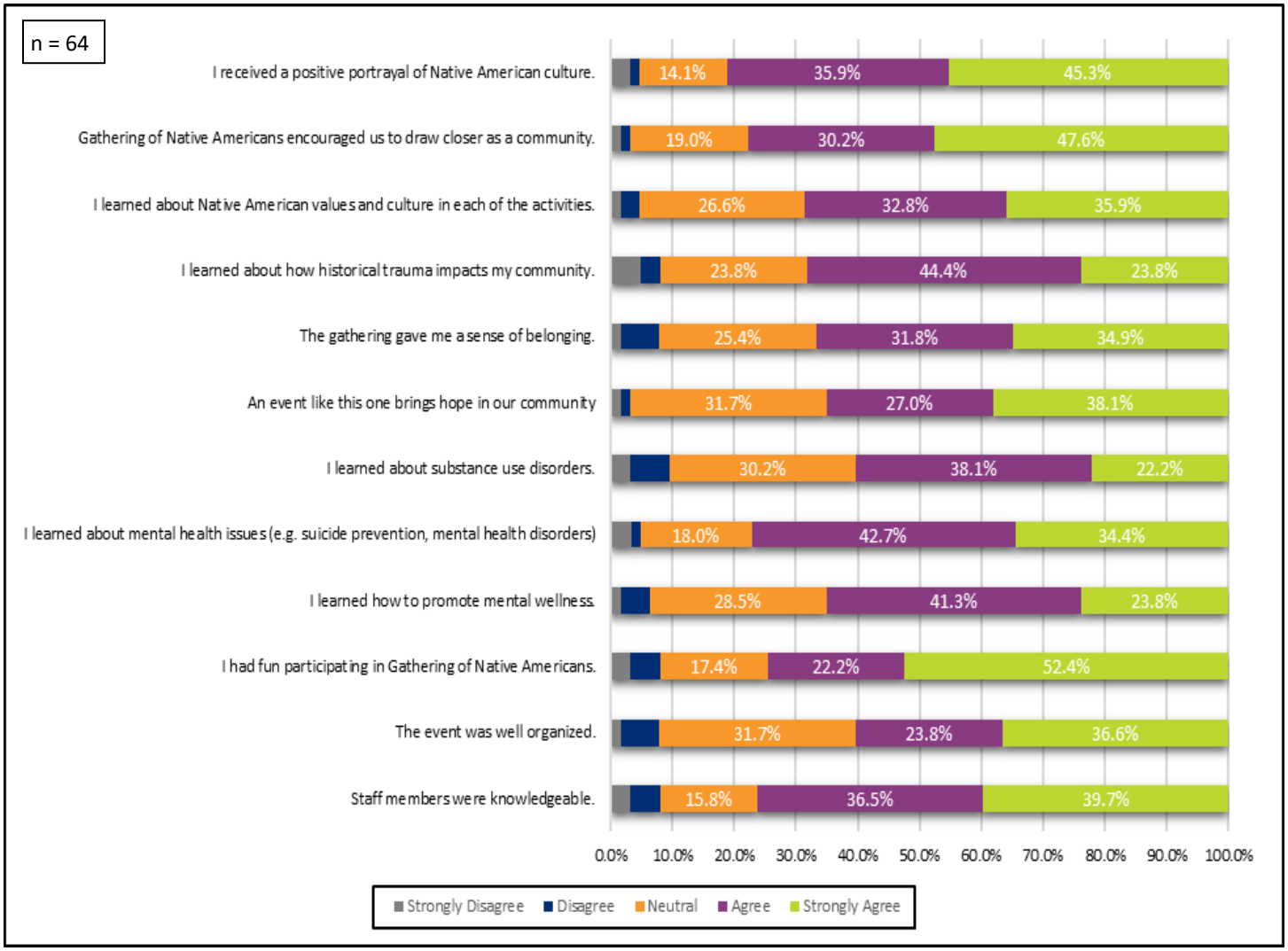
- **81.2%** responded "Strongly Agree" or "Agree" that they received positive portrayals of Native American culture from the GONA event.
- **77.8%** responded "Strongly Agree" or "Agree" that the GONA event encouraged them to draw closer as a community.
- **77.1%** responded "Strongly Agree" or "Agree" that they learned about mental health issues from the GONA event.
- **76.2%** responded "Strongly Agree" or "Agree" that the staff members were knowledgeable.
- **74.6%** responded "Strongly Agree" or "Agree" that they had fun participating at the GONA event.

For the following survey statements, attendees showed positive results of about *60% or higher* on the combined "Agree" and "Strongly Agree" responses, while some also responded "Neutral":

- **68.7%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about Native American values and culture from the GONA activities, while **26.6%** felt "Neutral".
- **68.2%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about how historical trauma impacts their community, while **23.8%** felt "Neutral".
- **66.7%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event gave them a sense of belonging, while **25.4%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that the GONA event brings hope in their community, while **31.7%** felt "Neutral".
- **60.3%** of attendees reported "Strongly Agreed" or "Agreed" that they learned about substance abuse disorders from the GONA event, while **30.2%** felt "Neutral".
- **65.1%** of attendees reported "Strongly Agreed" or "Agreed" that they learned how to promote mental wellness from the GONA event, while **28.5%** felt "Neutral".
- **60.4%** of attendees reported "Strongly Agreed" or "Agreed" that the event was well organized, while **31.7%** felt "Neutral".

GONA Post-Satisfaction Survey Graph

The graph below shows the GONA post-satisfaction survey results in a graph format:



GONA Post-Satisfaction Survey Comments

A few of the attendees also wrote their comments in regards to the GONA event, as shown below:

"Good talk about mental health."
"It was really fun!"
"I like how much information there was. I feel like I learned a lot."
"It was nice."
"Felt like I could share without getting judged."

GONA Facilitator Debrief Surveys and Comments

Additional post-GONA evaluation tool was collected so that the GONA committee can use it to debrief the facilitators and staff. There were a total of 21 Facilitator Debrief Surveys collected from the GONA event. Their comments are listed below and on the next three pages.

Q1. What worked well about the preparation for the GONA?

"Speakers knew their topics and how they would present it."
"All of it."
"Teacher and session timing. The break also worked well to keep students calm."
"The communication."
"The organization went well as I knew where I was supposed to be and what was expected of me."
"What worked was that the presenters were engaging with the students. They would give students the chance to speak and participate."
"Agenda and planning."
"Prayers."
"The open space to be free to conduct the class; however, we deemed appropriately and concisely."
"That we had a meeting a week before the event to know what was being asked of us."
"Teamwork and people helping out."
"Being able to choose classroom."
"Close teacher-student ratio in class."
"I love the separate moms session and the outside activity, as well as the raffle."
"Having opportunity for the student to talk and answer questions."
"The overall structure was good."
"The topics chosen were appropriate for the students."

Q2. What, if anything, would you suggest to improve preparation for the GONA?

"Plan more hands-on or interactive activities."
"Timing. Plan for longer session so that students stay engaged if time is running longer that expected."
"Maybe have a presentation slide or give out information and give some student the chance to engage not all presenter did."
"Having more things to talk about."
"Maybe a little more communication through circles to how the event is going to be structured so that we can specialize the class more."
"More meetings to communicate."
"More interactions with students."
"Sending out topics in more advanced notice, discuss and prepare students."
"Maybe prep the students on the topic/content ahead of time so they would be more interactive."
"More engagement activities during the preparations, be more warm and inviting."
"Having a better setting for each workshops, like more chairs, etc."
"They needed to plan debrief for suicide session."
"Use skits, for example, how does one respond when receiving 988 call."

GONA Facilitator Debrief Survey Comments *(continued)*

Q3. What worked well about the content and format of the GONA?

"Topics were relevant to students."
"It was perfect."
"Very informative."
"Good content."
"I like how much cultural was incorporated."
"It was well presented, love the information!"
"It worked well."
"That we had enough time with each class for a back-and-forth discussion."
"Presenters were well informed and ready to present."
"The content is appropriate. I would suggest less lecture and more interaction or student engagement."
"Easy to follow and understand."
"The outdoor part got the kids excited."

Q4. What, if anything, would you suggest to improve content and format of the GONA?

"It was great the way it was."
"No lecture but have more interactions."
"It went very smoothy."
"Slide presentation, maybe do things to bring students to engage in games."
"No improvement needed."
"Less talking by presenter, more student engagement."
"I would suggest more time for the student to speak or share out. Encourage them to participate and interact more."
"Having speakers that were advocating for their culture."
"Have a debrief and more heartwarming."

Q5. What activities seemed to impact GONA participants toward healing?

"Prayer ties, talking about grief, conversation."
"Culture, prayer ties."
"Most went well."
"Connecting with everyone."
"Encouraging more self-care allowed more participants to focus on prevention."
"Opening up and talking about our problems. Doing certain exercises."
"Talking circles and prayer ties."
"Adventure involving group dynamics."
"Hands on activities, sharing of stories."
"The prayer ties seemed impactful. I wish there was more to it or more student talk/interaction. I love the conversation; it's very healing."
"Going outside and the talking circle. A few students even asked to talk to the counselor afterwards."
"Movement and the overall body healing."
"I don't feel like there was much healing, they felt like informational clumps."
"Physical activity story telling."

GONA Facilitator Debrief Survey Comments *(continued)*

Q6. What activities seemed to impact GONA participants toward community building?

"Students sharing ideas, introducing themselves, sharing about themselves."
"Being open."
"Talking circle and the selfcare section was really good, and the power of prayer too."
"Connecting."
"Movement is medicine."
"I think the talking circle was impactful but I didn't hear much from the students talking. Encourage more student speech."
"The students seemed to like the frisbee and the talking circle."
"The talking circle was really opening to how important community is."
"Sharing stories, make more connections with students."

Q7. Do you have any suggestion for the next steps of this community?

"Incorporate my learning in hands-on activities."
"More of these."
"Continuing education and healing."
"More story-telling would be great, having elders come in and tell their stories."
"More time to plan."
"More talking about how to cope with the heavy topics and more discipline."
"Having a post discussion on how everything went."
"More hands-on and student involvement. Simplify slide show and have student read bullet points—not the presenter."
"The raffle thing is cool and exciting for the kids. Perhaps more outside activities and less lecturing and more hands-on activities or making something or cultural things."
"Everything went well."
"More culture building involving the youth."
"We should have a leadership team composed of students to speak out for these topics and advocate for mental health."

Asian American/Pacific Islander Communities:

Keeping Intergenerational Ties in Ethnic Families (KITE)

Program Type: Prevention Program

Intergenerational/Intercultural conflict is a significant stressor in immigrant families that occurs because of differential acculturation between migrant parents and their children (Ying, 2007). Formerly known as Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF): A Curriculum for Immigrant Families, the name of the program was changed to a more culturally appealing name by the community-based provider, KITE. More specifically, Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) is a community-based educational intervention that aims to strengthen the intergenerational relationship between immigrant parents and their school-age children and adolescents. Parents are introduced to methods that may be used to cope with the stresses of parenting and migration, that are adapted from a course on the prevention of depression (Munoz & Ying, 2002). The KITE program was designed to offer Prevention and Early Intervention services for Asian American Pacific Islander (AAPI) parents with school aged children and adolescents (ages 6 to 17 years old). The KITE program is designed to target parents' affection, cognition, and behaviors. Through the KITE program, parents are expected to learn to effectively empathize with their child's perspective, to cognitively understand variations in the ethnic and American Cultures and its impact on their child's development, values and their intergenerational relationship, as well as to develop effective behavioral parenting skills. Parents are introduced to methods that may be used to cope with stresses of parenting and migration. The KITE program also incorporates cultural competency principles, including but not limited to, awareness of cultural differences, knowledge of cultural contents (i.e. norms, customs, language, lifestyle, etc.), accurate assessment and differentiation of culture and pathology, and use of culturally competent interventions. KITE is an 8-session program, with 2-hour sessions held weekly and offered in the parents' preferred language. Currently, they are offered in Simplified Chinese, Korean, and combination of English/Tagalog languages. It is an intensive program where detailed curriculum is followed, in which parents need to complete weekly homework assignments, and are individually reviewed by the trained instructors. The provider is contracted to deliver the parenting educational group series to a minimum of 40 parents per region, per year. Each group will have a minimum of 6 and a maximum of 20 parents enrolled. Program completion is defined as completing 6 out of 8 sessions. Additionally, the provider is expected to implement at least 10 "Community Education/Outreach Workshops" per region, per year, with each specific Asian immigrant parent group (i.e., Chinese, Korean, or Filipino).

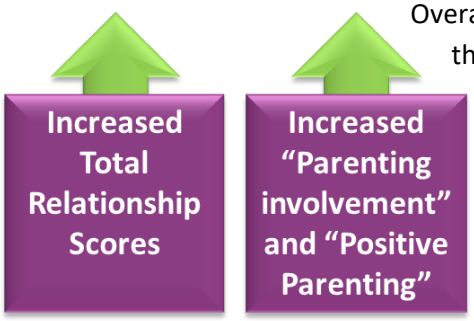


For FY23/24, KITE parenting classes were completed using a combination of virtual (via Zoom), as well as in-person (offered at churches or local schools) options, depending on participants' schedules and preferences. The provider conducted a total of 21 parent workshops in the Western and Mid-County regions combined, surpassing the target goal. The workshop topics continue to be pertinent to AAPI families, including: Five Love Languages of Children, Parent Self-Care, Bicultural Parenting, Navigating School Systems, etc.



The provider conducted 5 parenting class cycles in Chinese, Korean, and Filipino (Tagalog/English), with 67 parents enrolled and 54 parents graduated, which is an 80.6% completion rate. Over the course of the parenting classes, the parent specialists were able to build trusting relationships with the parents, enabling open discussions about the challenges they or their children face. This rapport helped reduce mental health stigma and facilitated linkages to mental health services and other valuable school and community resources.

The pre-post Strength and Difficulties Questionnaire (SDQ) analysis showed that there were decreases in the average scores in Hyperactivity Scale, Emotional Symptom Scale, Peer Problems Scale, and Conduct Problems Scale. Additionally, there was an increase in the Prosocial Scale. Overall, average scores on the SDQ pre-measures were within the normal range across all SDQ scales, which suggest that parent participants did not view their children's strength and difficulties as an issue, at enrollment into the KITE program. The pre-to-post analysis using a paired samples T-Test showed statistically significant results on all items of the SDQ scale, as well as the Total Difficulties scale. Additionally, the pre-post Alabama Parenting Questionnaire (APQ) analysis showed a 6.7% increase on the Parenting Involvement Scale and a 5.1% increase on the Positive Parenting Scale, while Inconsistent Discipline Scale showed a 7.5% decrease, and Other Discipline Practices Scale showed a 2.9% decrease. Both Parenting Involvement and Positive Parenting scales showed statistically significant results. The pre-post Relationship analysis showed that the total scores increased from pre-to-post measures, which was statistically significant. Overall, analysis of the post-satisfaction surveys showed highly positive results.



API bias-motivated incidents and hate crimes remain prevalent, increasing public unease ahead of the presidential election. Consequently, AAPI communities have been reluctant to attend non-mandatory in-person events, hindering efforts to recruit families for KITE workshops and parent groups. API parents who have expressed interest in or enrolled in the KITE parenting class did not meet fidelity requirements (e.g., children were outside the target age group, or parents withdrew due to formal transition back to in-person workplace). As a result, the KITE program fell short of its target of 80 combined participants from Western and Mid-County parenting courses.

The provider has promoted their workshops and parenting classes through mass emails and social media, but these efforts have been insufficient for participant recruitment. To address this, they are employing more traditional methods, including visiting and posting flyers at locations

frequented by AAPIs, such as schools, churches, restaurants, healthcare providers, markets, and after school tutoring centers. Additionally, one-on-one outreach, engagement with community leaders, and word-of-mouth promotion have proven effective and will continue to be prioritized in FY24/25.

While participant recruitment remains a challenge, the provider will actively encourage in-person participation in workshops and parenting groups in FY24/25. However, they are remaining responsive to community needs by offering limited virtual and hybrid sessions for parents facing accessibility challenges. They will also continue to develop relevant workshop topics, such as fostering healthy digital media habits for children, to better engage parents and caregivers. The implementation of incentives for workshop and parenting classes has proven successful in increasing interest, and the provider intends to maintain this approach.



In FY23/24, the provider continued collaborating with the Corona-Norco Unified School District, offering an in-person course at an elementary school with high API enrollment. Looking ahead to FY24/25, they anticipate offering more workshops and parenting classes, driven by growing interest from the historically hard-to-engage Filipino community in Mid-County.

Parents completed a post-survey at the conclusion of the program and below are examples of comments received:

- "The way of communicating with my children has changed."
- "Standing in my child's perspective to view issue."
- "Through the study of the course, I am no longer anxious. If I change my mood as a parent, everything will change."
- "I try not to immediately get mad and making an effort to be more patient."
- "I became more attentive to my child."
- "I became more aware of how to parent cross culturally."
- "I don't know how to praise my daughter before studying the courses. After studying, I often praise her, and the effect is very good."
- "Will change the way of educating children, insist on praising, discover strengths and actively communicate."
- "Will see things from the child's perspective and understand and help them."
- "Through me changing, my child has slowly positively change. We respect each other more and have a closer relationship."
- "Know each other more."
- "There are a lot less conflicts."

- “She would be more patient and talk to me about the details of class and classmates.”
- “We have better communication with my sons.”

Summary Report FY 2023-2024

The Asian American Pacific Islander Mental Health Resource Center (*formerly known as Perris Valley Filipino-American Mental Health Resource Center*) began their MHSA PEI funded activities in the fiscal year of 2017-2018. The resource center provides mental health resources to the Asian American and Pacific Islander populations in Riverside, Perris, Moreno Valley, Menifee, and other surrounding cities with a high density of the target community. Additionally, the resource center was funded to educate, support, and link Filipino-American families and other Asian American and Pacific Islander individuals who reside in Riverside County experiencing emotional and mental health crises with the Riverside University Health Systems-Behavioral Health (RUHS-BH) mental health services. The resource center is located in Moreno Valley and is run by the Perris Valley Filipino-American Association (PVFAA). In 2022, in response to the COVID-19 Pandemic, PVFAA partnered with a local organization, Asian Pacific Counseling and Treatment Center (APCTC) to establish a COVID-19 Awareness Program to support the community through the pandemic.

The type of services that Resource Center staff provide may include but are not limited to:

1. Community Outreach
2. Recruitment and communicating activities and available services, through combinations of:
   Ads in Filipino-American generated newspapers, E-mail blast announcements, E-mail articles reflecting issues that concern the Filipino/Asian American community, Text Messages, Social Media, Phone Campaigns, Handing out Flyers and Postcards, and Distribution of Annual Newsletter by mail/e-mail
3. Information and Referral
4. Quarterly mental health community seminars, symposia, and workshops on mental health awareness and stigma
5. Monthly Mental Health Support Groups

For the fiscal year 2023-2024, the data collection tool used includes:

- Walk-In Sign-In Sheet
- Initial Contact and Referral Form
- Offsite Outreach Activities Form
- Quarterly Seminar or Mental Health Support Group Sign-In
- Presentation Post-Satisfaction Surveys

This report summarizes the counts of activities provided by AAPI MHRC staff, which include submissions of online and paper forms from the data collection tools listed above. The data from walk-in sign-ins, offsite outreach activities form and the list of Mental Health events and presentations are summarized on pages 2 to 4 of this report. It is noted that there may be missing data from either the following: data not being collected for a particular event/activity, data not submitted to RUHS-BH staff, or missing data from attendees who chose not to sign-in for an event and/or chose not to respond to a demographic question on the form provided. For the Mental Health Events/Presentations provided in the fiscal year 2023-2024, attendees were encouraged to fill out the post-satisfaction surveys at the end of each event. The analysis of the surveys, as well as the comments from attendees, are summarized on pages 5 to 7 of this report.

AAPI MHRC Information of Walk-In Clients

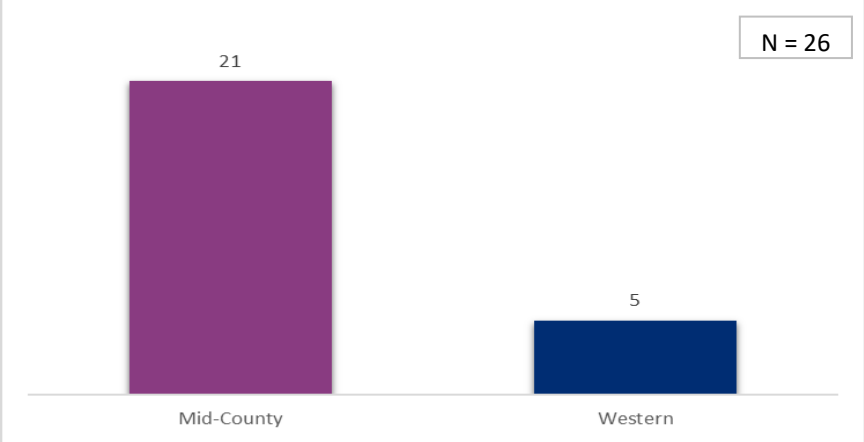
Based on the AAPI MHRC Contact List for those individuals who requested further support in Mental Health, there were a total of 2 people who were referred to RUHS-Behavioral Health. AAPI MHRC staff indicated that they received other requests for help or assistance for various needs, such as housing, employment, and social security concerns, which were not documented for this program.

AAPI MHRC Events and Presentations

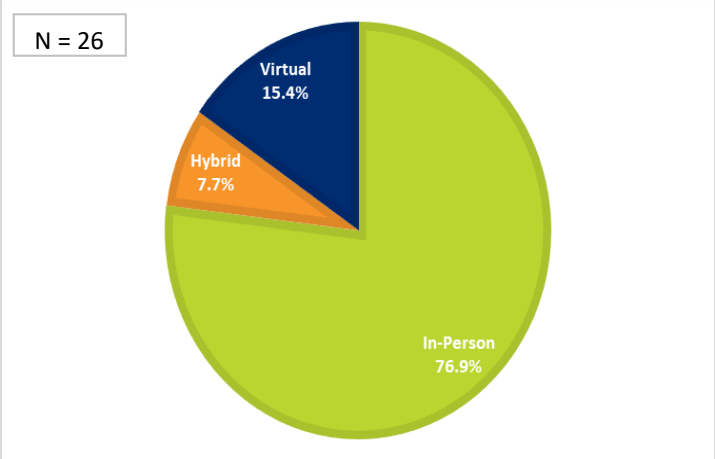
During the fiscal year 2023-2024, there were a total of 26 events conducted by AAPI MHRC. The activity forms were submitted by e-mail or online using Google forms. All of these events were conducted either In-Person, Virtual, or Hybrid, with the majority of the events being conducted In Person (76.9%, n = 20), mostly at the AAPI MHRC main office in Perris. A total of 21 events were completed in the Mid-County region (80.8%), while the remaining 5 events were completed in the Western region (19.2%). The majority of the events were completed in English (80.8%, n = 21), while the remaining 5 events were completed in combination of English and Tagalog. It is also noted that there may be other events that were held by AAPI MHRC but the information was not submitted via online or paper forms.

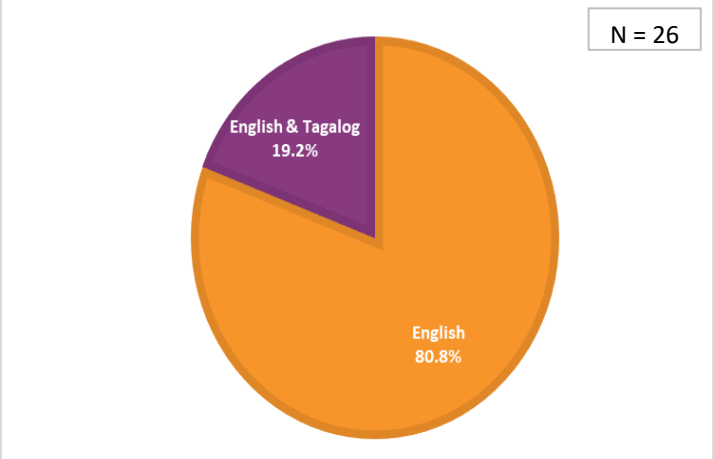
Sign-in sheets from AAPI MHRC events were submitted by either using an online forms or paper forms, by AAPI MHRC staff, and the total number of attendees for each event are listed on the table on the following page. It is also noted that some of the AAPI MHRC presentations were collaborative efforts, with AAPI MHRC staff hosting the events and other RUHS-BH and/or AAPI providers contributed to the events.

Regions of AAPI MHRC Events



Type and Language of AAPI MHRC Events





AAPI MHRC Events and Presentations

Event Date	Event Name/Title/Topic	Event Type/Description	#People in Attendance
07/28/23	Self-Care In Community: Movie Screening "Turning Red"	AAPI Community Movie Screening Series "Turning Red" (geared towards AAPI Teens)	9
07/29/23	AAPI Luau Picnic Event at Lake Perris	AAPI Marketing Presentation & PVFAA Annual Picnic Celebration	43
08/26/23	Self-Care in Community: Movie Screening "A Man Called Otto"	AAPI Community Movie Screening Series "A Man Called Otto" (for Suicide Prevention Month)	3
08/30/23	AAPI MHRC Marketing Presentation	AAPI Marketing Presentation via Zoom	24
09/09/23	Self Care in Community: AAPI Karaoke Night	AAPI Marketing Presentation and Self-Care Activity in honor of Suicide Prevention Awareness Month	18
09/30/23	Film Screening and Talk on Asian Family Mental Health with Dr. Ma	AAPI Marketing Presentation in honor of Suicide Prevention Awareness Month	25
10/21/23	Self-Care in Community: Self-Affirmations in Baybayin	AAPI Marketing Presentation	69
10/25/23	Annual Harvest Festival by Avalon Elementary School	AAPI Health Fair/Community Wellness Event	137
11/18/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	32
11/18/23	AAPI Workshop on “Making Gender-ational Mosaics” (MH Workshops on Gender Euphoria Intergenerational Queer Community and Digital Collage)	AAPI Educational Workshop	*Not listed*
12/02/23	Hands-On Parol (Lantern) Making for the Holidays - Connecting Tradition and Culture and Managing Stress during the Holidays	AAPI Marketing Presentation	18
12/03/23	AAPI Parol (Lantern) Festival	AAPI Marketing Presentation	200
01/13/24	AAPI Educational Workshop on MH Wellness and Challenges that AAPI young adults face today	AAPI Educational Workshop	29
02/03/24	AAPI Educational Workshop on MH Awareness and Self-Concept through community storytelling and Asian Diasporic Futurist Framework	AAPI Educational Workshop	21
03/23/24	AAPI Educational Workshop - All the Feels: Unlocking Emotions through K-Dramas	AAPI Educational Workshop	17
04/13/24	AAPI Community Wellness & Yard Sale Event at Faith Community Church-Perris	AAPI Health Fair/Community Wellness Event	35
04/13/24	AAPI Educational Workshop - Mindful Melodies: Nurturing Community Wellness through Music	AAPI Educational Workshop	27
04/25/24	Let's Get Together, Mental Health Matters: Introduction to Chika Chika Connection	AAPI Educational Workshop	8
05/04/24	AAPI Community MH Wellness Event: Daisy Walk a Sysco Riverside	AAPI Health Fair/Community Wellness Event	27
05/09/24	Let's Get Together, Mental Health Matters: 2nd Chika Chika Connection	AAPI Educational Workshop	12
05/13/24	AAPI Film Screening: Nurse Unseen (Honoring Filipino Heroes that served on the front lines of the COVID-19 Pandemic	AAPI Marketing Presentation	30
05/17/24	AAPI Luau Event at Val Verde High School-Perris	AAPI Health Fair/Community Wellness Event	48
05/27/24	Let's Get Together, Mental Health Matters: 3rd Chika Chika Connection	AAPI Educational Workshop	12
06/01/24	AAPI Community Garden Event	AAPI Health Fair/Community Wellness Event	15
06/10/24	Let's Get Together, Mental Health Matters: 4th Chika Chika Connection	AAPI Educational Workshop	10
06/24/24	Let's Get Together, Mental Health Matters: 5th Chika Chika Connection on "The 10 Guideposts to Wholehearted Living"	AAPI Educational Workshop	10

Total Number of Mental Health Events: 26

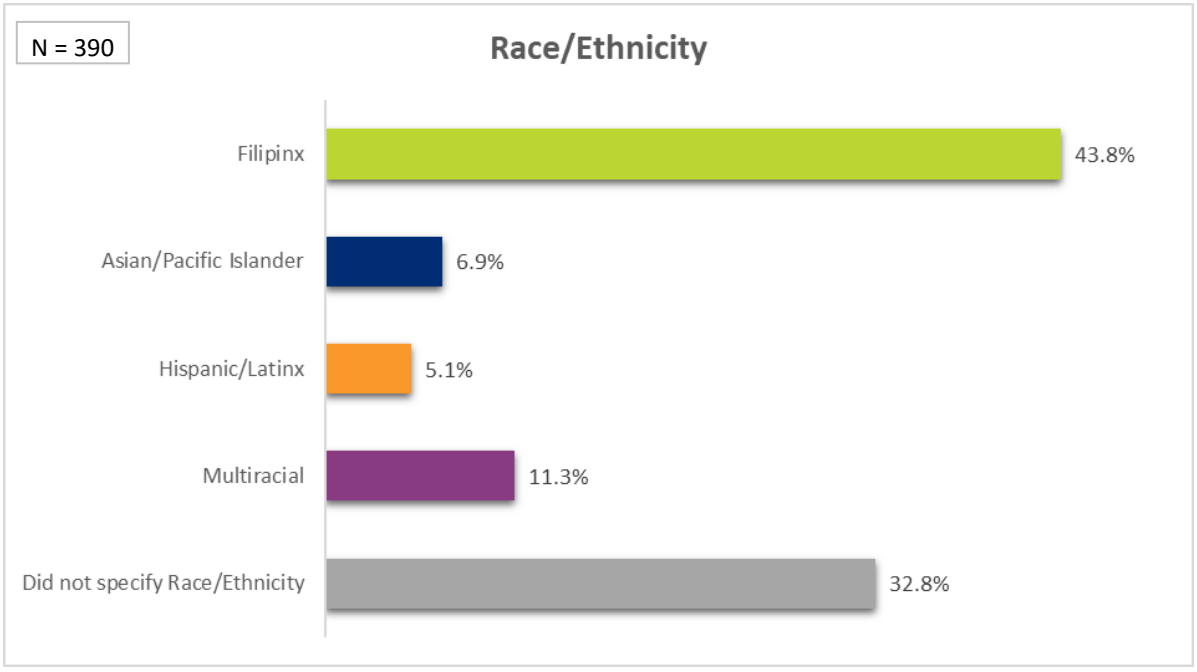
Total Counts of Event Attendees: 390 *(based on sign-in sheets submitted)*

AAPI MHRC Demographic Information of Event Attendees

Based on the online and paper sign-in sheets and demographic forms submitted, there were a total of 390 people who attended the AAPI MHRC mental health events during the fiscal year 2023-2024. It is noted that on some of the events, some attendees may chose not to fill out the sign-in forms, or there may be missing data from forms not being submitted. The event sign-in form provides a section where attendees can choose to respond to the basic demographic questions. The graphs below summarized the *Age Group*, and *Race/ Ethnicity* of the AAPI MHRC events' attendees, based on the data submitted.

The majority of the events' attendees left the *Gender* question unanswered, therefore, there was not enough data to count. When categorizing attendees into different *Age* groups, the majority of the attendees also chose "not to respond" (64.9%, n = 253). Of those who did respond to the *Age* question, the majority "60 years or older" (12.3%, n = 48). In regards to the *Race/Ethnicity* question, the majority indicated that they were "Filipinx" (43.8%, n = 171), followed by "Multiracial" (11.3%, n = 44), "Asian/Pacific Islander" (6.9%, n = 27), and "Hispanic/Latinx" (5.1%, n = 20), respectively. It is also noted that 32.8% of the attendees (n = 128) chose not to respond to this question.

Age Category (n = 390)	Number of People/Percentage
17 years old or younger	**22 (5.6%)**
18 to 29 years old	**23 (5.9%)**
30 to 39 years old	**10 (2.6%)**
40 to 49 years old	**17 (4.4%)**
50 to 59 years old	**17 (4.4%)**
60 years or older	**48 (12.3%)**
Chose not to respond	**253 (64.9%)**
Total	**390**



AAPI MHRC Events: Post-Satisfaction Survey Results

After each AAPI MHRC presentation, attendees were asked to complete the post-satisfaction surveys. For the FY 2023-2024, a total of 58 satisfaction surveys were completed and submitted using both online and paper formats.

Satisfaction Survey Items (n = 58)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. **The information presented was easy to understand.**				6.9%	93.1%
2. **The presenter was engaging when presenting the information.**				6.9%	93.1%
3. **I would recommend to my friend and family members that they attend a presentation like this.**	1.7%			5.2%	93.1%
4. **As a result of this presentation I feel I am better able to talk about mental health issues with my family and friends.**			5.1%	19.0%	75.9%
5. **I view mental illness as something to be ashamed off.**	51.7%	10.3%	6.9%	12.1%	19.0%
6. **Mental illness can be managed and treated.**			3.5%	24.1%	72.4%
7. **I would feel comfortable seeking help for myself or a family member regarding mental health issues.**		1.7%	6.9%	22.4%	69.0%

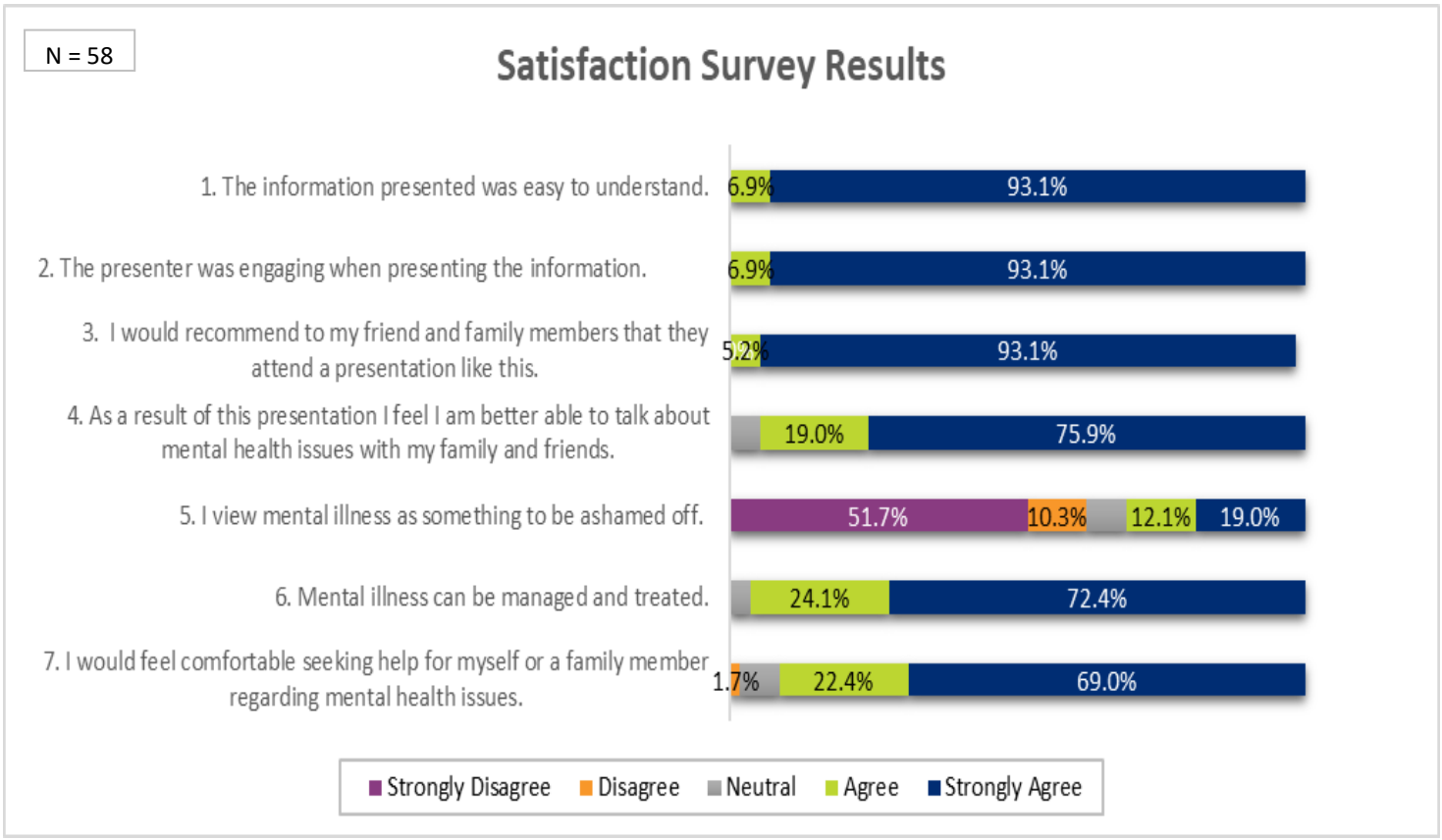
Summary of Survey Results:

The results of post-satisfaction surveys collected from AAPI MHRC event attendees can be summarized below:

- **100%** attendees responded "Strongly Agreed" or "Agreed" that ***the information presented during the presentation was easy to understand***, and that ***the presenter was engaging when he/she presented the information***.
- **98.3%** of the attendees "Strongly Agreed" or "Agreed" that *they* ***would recommend their friends and family members to attend a similar presentation***.
- After the presentation, **94.9%** of the attendees felt "Strongly Agreed" or "Agreed" that ***they were better able to talk about mental health issues with their family and friends***.
- After the presentation, **51.7%** of attendees "Strongly Agreed" that ***they did not view mental illness as something to be ashamed of***, while **19%** "Strongly Agreed" that ***they viewed mental illness as otherwise***.
- After the presentation, **96.5%** of attendees felt "Strongly Agreed" or "Agreed" that ***mental illness can be managed and treated***.
- **91.4%** of attendees felt "Strongly Agreed" or "Agreed" that ***they would feel comfortable seeking help for themselves or their family members regarding mental health issues after the presentation***.

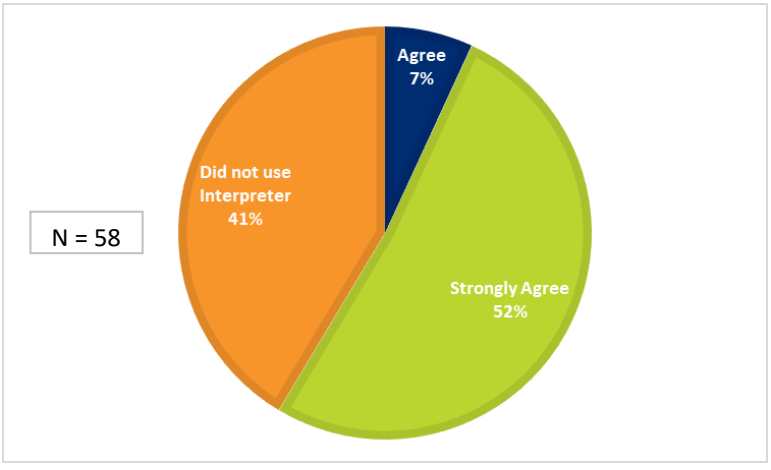
AAPI MHRC Events: Post Satisfaction Survey Results (*continued*)

The figure below shows the post-satisfaction survey results in a graph format to better illustrate the attendees' responses after the AAPI MHRC events/presentations.



Optional question:
The interpretation service was easy to understand.





The last question on the satisfaction survey was for attendees to indicate whether or not they used the interpretation service while attending AAPI MHRC events, and if so, whether or not the interpretation service was easy to understand. This was an optional question since not all attendees needed the interpretation service, although it was still offered during the events. Based on survey data collected from 58 attendees, **34** (**58.6%**) responded that they were either "Strongly Agreed" or "Agreed" that ***the interpretation service was easy to understand***, while 41.4% (n = 24) indicated that they did not use the interpretation service.

AAPI MHRC Events: Post-Satisfaction Survey Comments

The post satisfaction survey also has a section where participants could write comments on whether or not "***the presentation was helpful***", as well if to comment if they had any other feedback regarding the program. Below are the comments from participants that were gathered from the satisfaction surveys:

"Great Event! Made mental health a more "family-friendly "topic for something that is usually so taboo. Very impactful!"
"Liked the open communication across generations."
"The material presented was relevant and good information to be heard and learned."
"Liked the group interaction, and the support group to look forward."
"Good reminder to find your support and do self-care."
"I liked everything that was discussed during the event."
"The presenter was understandable, did a great job and helpful!"
"I really appreciate the open and supportive atmosphere. Thank you for making through the mental health awakening management in a very clear and supportive way."
"I liked how they tried to get through the mental wellness plan together and the collaborative nature in multiple AAPI community organization."
"I learned a lot from this event."
"All of the topics are very helpful. Dr. Navarro is very knowledgeable."
"Now I understand the meaning of othering, how that affects me and others without knowing it."
"Very Satisfied! Learned a lot of great ideas and principles. Applicable to daily life."
"Movie and captivity were great demonstration on identifying signs of mental health challenges, how to offer help and how to develop skills and relationships to improve outlook."
"They made the environment very comfortable to talk & interact both very welcoming new talks."
"The physical resources are helpful. I'll definitely take them hoe to share with my family."
"I liked the Chika Chika connection with other Filipina women."
"Good event and set-up. Very well coordinated and planned out."
"There is a solution of everything, and acceptance is very important, being honest of oneself."
"I liked the breathing exercise, affirmations, using digital collage to explore feelings and expressions."
"I felt like it gave me a space to deep-dive and reflect on some buried thoughts. It was comforting to share it with a community of people with similarities."
"A lot of opportunities to share, spotlight on how Asian culture adds additional layers of complexity to the conversation, very validating and real stance of presenter/well researched current events examples, actionable takeaways of what to try and what to avoid."
"It was really nice to be in a community of people with similar experiences."
"I liked the activities as well as learning about the connection of art, narratives, and mental health."
"I had so much fun today. It was a stress reliever, I laughed a lot, and what a great way to connect! Would love another session to join anytime soon."
"The interaction and activities were really good. I was a little shy at first, but the facilitators were welcoming and broke the ice for participants to jump in and participate."
"I liked being in community and listening to healing music"
"It was very affirming to connect with others regarding the connect we all share with music, and connecting it to how we cope, express, create, and live. Thank you very much!"
"I liked using music as a way to cope with mental health was a very creative concept! Thanks!"
"The connection between music and mental health."
"This presentation was so warm and welcoming, I had fun making a playlist :) Thank you so much!"

Riverside University HEALTH SYSTEM Behavioral Health

MHSA Prevention and Early Intervention
Keeping Intergenerational Ties in Ethnic Families (KITE)

Annual Outcomes Report
FY 2023-2024

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Executive Summary

Intergenerational/Intercultural conflict is a significant stressor in immigrant families that occurs because of differential acculturation between migrant parents and their children (Ying, 2007). More specifically, Strengthening Intergenerational/Intercultural Ties in Immigrant Families (SITIF) is a community-based educational intervention that aims to strengthen the intergenerational relationship between immigrant parents and their school-age children and adolescents. Parents are introduced to methods that may be used to cope with the stresses of parenting and migration, that are adapted from a course on the prevention of depression (Munoz & Ying, 2002).

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI that started in the fiscal year 2019-2020, and is currently in its fifth year of funding. The KITE program was built to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community, and was awarded to Asian Pacific Counseling and Treatment Center (APCTC) to begin in July 2019. More specifically, the KITE program was designed to offer Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school aged children and adolescents (ages 6 to 17 years old).

During the fiscal year 2023-2024, there were a total of 67 parent participants within Riverside County enrolled in a total of 5 KITE parenting program series (2 class series were offered in Chinese, and 2 class series were offered in combination of Tagalog and English, and 1 class series was offered in Korean). Of these, a total of 54 parent participants successfully completed the program. For FY 2023-2024, KITE parenting classes were completed using a combination of virtual via Zoom, as well as in-person (offered at churches or local schools), depending on participants' schedules and preferences. Despite the fact that some of the parent participants were unable to complete the program due to scheduling conflict or other personal reasons, the total completion percentage for the KITE program during the fiscal year 2023-2024 was still relatively high at 80.6%.

Additionally, during the fiscal year 2023-2024, KITE program workshops were offered to the Asian-American Pacific Islander (AAPI) communities, and KITE program outreach activities were also conducted. Similar to the KITE parenting program, these workshops were offered in combination of virtual and in-person methods, depending on parents' and/or coordinators' schedules. KITE outreach activities were also in combination of in-person as well as virtually via Facebook groups and WeChat. In fiscal year 2023-2024, there were a total of 21 KITE workshops offered with a total of 273 AAPI attendees.

Executive Summary

Based on the demographic data submitted from 67 enrolled parent participants for the fiscal year 2023-2024, the demographic data shows that the majority of participants for the KITE Program were Female (64.8%, n = 35), who mostly resided in the city of Eastvale (40.7%, n = 22). The KITE parent participants were predominantly Chinese (61.1%, n = 33), who preferred to use Mandarin/Chinese as their primary language. Additionally, there were 39 participants (72.2%) who responded that they were the "First-Generation Americans," and 50% of the total participants (n = 27) responded "Yes," that they do have conflicts with their children due to different cultural beliefs. Based on responses on their children's ages, parent participants indicated that their children were between the ages of 6 and 11 years old (48.2%, n = 26) and between the ages of 11 and 17 years old (46%, n = 25), while the remaining 3 participants indicated that their children were under the age of 6 (3.8%), and over the age of 17 (1.9%).

There were three survey measures collected at the beginning and at the end of the KITE Program, as well as post–satisfaction surveys collected at the completion of the program. The pre-post *Strength and Difficulties Questionnaire (SDQ)* analysis showed that there were decreases on the average scores in **Hyperactivity Scale** (11.3% change from 1.93 to 1.71), **Emotional Symptom Scale** (11.1% change from 1.57 to 1.39), **Peer Problems Scale** (8.9% change from 1.53 to 1.40), and **Conduct Problems Scale** (7.5% change from 1.43 to 1.33). Additionally, there was an increase on the **Prosocial Scale** (9.6% change from 2.34 to 2.57). Overall, average scores on the SDQ pre-measures were within the normal range across all SDQ scales, which suggest that parent participants did not view their children's strength and difficulties as an issue, at enrollment into the KITE program. The pre to post analysis using a paired samples T-Test showed statistically significant results ($p < .05$) on all items on the of the SDQ scale, as well as the **Total Difficulties** scale.

Additionally, the pre-post *Alabama Parenting Questionnaire (APQ)* analysis showed a 6.7% increase on the **Parenting Involvement Scale** (from 3.50 to 3.74) and a 5.1% increase on the **Positive Parenting Scale** (from 4.06 to 4.27), while **Inconsistent Discipline Scale** showed a 7.5% decrease (from 2.74 to 2.514, and **Other Discipline Practices Scale** showed a 2.9% decrease (from 2.61 to 2.53). Furthermore, both **Parenting Involvement** and **Positive Parenting** scales showed statistically significant results ($p < .05$).

The pre-post *Relationship* analysis showed that the total scores increased 2.52 points from pre-to-post measures, from 32.39 to 34.91, and a paired samples T-Test showed that this result is statistically significant ($p < .05$). An item-by-item analysis showed the highest percent differences was shown on items number 9 (**I am satisfied with our relationship**), with a 18.5% increase from pre-to-post measures, followed by item number 3 (**My child obeys me**), with 14.8% increase from pre-to-post measures. Further analysis using paired samples T-tests also showed that 7 out of 9 APQ scale items showed statistically significant results at or below $p < .05$.

Overall, analysis on the post-satisfaction surveys showed highly positive results, that the majority of parent participants (92% or more) responded to either "Strongly Agree" or "Agree" to all of the survey statements. The majority of parent participants also provided very positive feedback regarding the KITE parenting programs, with many commenting that they understood their children more, that their relationships with their children were much closer, that they communicated better, and that they were able to bridge the cross-cultural gaps with their children.

Program Description

Keeping Intergenerational Ties in Ethnic Families (KITE) Program, formerly known as SITIF, is funded by RUHS Behavioral Health MHSA-PEI to address the needs of our culturally diverse Asian-American Pacific Islander (AAPI) community. This program first started in the fiscal year 2019-2020, and currently in its third year of funding. KITE Program offers Prevention and Early Intervention services for Asian-American Pacific Islander (AAPI) parents with school-aged children and adolescents (ages 6 to 17 years old). Furthermore, the KITE program is built as a community-based educational intervention that aims to strengthen the inter-generational relationship between Asian-American Pacific Islander (AAPI) immigrant parents and their school-aged children and adolescents.

The KITE program is designed to target on the parents' affection, cognition, and behaviors. Through KITE program, parents are expected to learn to effectively empathize with their child's perspective, to cognitively understand variations in the ethnic and American Cultures and its impact on their child's development, values and their intergenerational relationship, as well as to develop effective behavioral parenting skills. Parents are introduced to methods that may be used to cope with stresses of parenting and migration. The KITE program also incorporates cultural competency principles, including but not limited to, awareness of cultural differences, knowledge of cultural contents (i.e. norms, customs, language, lifestyle, etc.), accurate assessment and differentiation of culture and pathology, and use of culturally competent interventions.

The community based organization assigned for this program is Asian Pacific Counseling and Treatment Center (APCTC), which is contracted to provide education and skill development for parents by conducting parent education workshops to Asian-American Pacific Islander parents within community organizations, such as schools, churches, homes, and other natural settings that are non-threatening/non-stigmatizing locations for participants. KITE is an 8-session program, with 2-hour sessions usually held weekly in the evening, and offered in the parents' preferred language. Currently, they are offered in Simplified Chinese, Korean, and combination of English/Tagalog languages. It is an intensive program where detailed curriculum is followed, in which parents need to complete weekly homework assignments, and are individually reviewed by the trained instructors.

The KITE program goals include: strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional and social problems in children and adolescents; i.e. those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses. Currently the services are provided in the Western and Mid-County Regions of Riverside County, in the target communities identified below:

- **Western Region**: Riverside, Jurupa, Moreno Valley, Norco, Rubidoux, Pedley, Sunnyslope, Mira Loma, Glen Avon and other surrounding unincorporated areas.
- **Mid-County Region**: Hemet, San Jacinto, Lake Elsinore, Perris, and other surrounding unincorporated areas.

APCTC is contracted to provide parenting educational group series, for a combined minimum of 40 parents per region, per year. Each group will have a minimum of 6 parents enrolled and a maximum of 20 parents enrolled (Ratio: 1 Facilitator to 10 Parents). The KITE program completion is defined as completing 6 out of 8 sessions. Additionally, APCTC is expected to implement at least 10 "Community Education/Outreach Workshops" per region, per year, with each specific Asian immigrant parent group (i.e., Chinese, Korean, or Filipino).

Class Curriculum

The KITE class curriculum is based on the SITIF program, which was developed and validated by Dr. Yu-Wen Ying of UC Berkeley, and has been translated in Chinese, Korean, Vietnamese, and Spanish. In KITE program curriculum, different skills have different objectives, and parents are invited to employ the skills that are most likely to yield the desired outcome, so all of the methods covered in KITE program focus on parenting process of "how-to" and not specific parenting content of "what-to." For example, while immigrant parents may prefer a hierarchical unidirectional method of communication that is sanctioned by their ethnic culture, their children may prefer a more interactive style that involved less lecturing and more active listening (Ying, 2007). Generally, the KITE program is designed to bring parents' awareness, promoting greater cross-cultural competence, to improve their sense of control in parenting and developing effective parenting skills, particularly in the area of communication, and to help them cope better with the stresses of cross-cultural parenting.

The KITE class curriculum developed by Dr. Ying was originally designed to be a 10-session curriculum for first -generation immigrant parents, and it is a culturally sensitive, community-based intervention. For the KITE program, the curriculum has been modified and condensed into an 8-session program, where parent participants are expected to complete 6 out of 8 sessions in order to complete the parenting series. The aim of KITE class curriculum is to improve the intergenerational relationship, and discusses the following:

- Parents sense of self-efficacy (i.e. emotional awareness and empathy for their children's experiences)
- Knowledge and understanding of differences between the native and American cultures
- Teaches behavioral parenting skills, including self-care

The KITE program's 8-session class schedule and topics are as follows:

- *1st Session: Introduction & Learning about Cultural Differences*
- *2nd Session: Understanding Your Child*
- *3rd Session: Promoting Parent-Child Understanding*
- *4th Session: The Use of Structuring and Reinforcement*
- *5th Session: The Use of Rules, Limits, Consequences, and Punishment*
- *6th Session: The Use of Special Time*
- *7th Session: Review of Parenting Skills*
- *8th Session: Coping with Stress & Strengthening the Intergenerational Relationship-Conclusion*

After each KITE class session, parent participants are required to do the assigned homework related to the current week's topic, which is then discussed together as a group on the following class session. Overall, the KITE class curriculum highly encourages parent participants to be actively involved in the following, but not limited to, sharing their cultural background, family background, opinions about raising their child in a different culture than the one the parents were raised in, experiences in communicating with their child, and any challenges they may encounter when trying to strengthen their relationship with their child.

Data Collection

The RUHS-BH Demographic form is to be collected at the beginning of each KITE parenting class series (1st session/Week 1), as well as the Pre-Measures. Additionally, Post-Measures and Post-Satisfaction Surveys are to be collected at the end of each class series (8th session/Week 8). Other forms such as, Weekly Sign-In Form, Master Attendance Roster Form, Data Submission Checklist Form, and Justification for Missing Performance Measures Form are additional documents to be collected and submitted to RUHS-BH at the completion of each KITE parenting class series.

There are three different measures used for the KITE program that are collected at the beginning of the KITE program, and at the completion of KITE program:

- ***Strength and Difficulties Questionnaire (SDQ)***
- ***Alabama Parenting Questionnaire (APQ)***
- ***Relationship Questionnaire***

These three measures are used to document participant's thoughts and challenges prior to and after the KITE program has been completed, and will be analyzed to measure and compare the changes in participants' thoughts and relationships with their children before and after completing the KITE program. The post-satisfaction surveys are also distributed and collected at the end of the KITE program, with the purpose of documenting the participants' feedbacks on their perception of the KITE Program.

On all of the measures, we asked each parent participant to list the child name and age, and to focus on their current relationship with that particular child. When parents have more than one child, we asked the parent to list the child's name and age on which the parents would like to focus their current relationship on. The child's age must be between the ages of 6 and 17 years old. Generally, the oldest child is used as the "target child", on whom parent participants would practice their parenting skills as part of their weekly homework assignments. For families with more than one child, the target child can also be the child with whom the parent participant has the most relationship challenges.

There were a total of 5 KITE parenting class series completed during the fiscal year 2023-2024, and a total of 67 parent participants enrolled in the KITE program. Of these enrolled participants, a total of 54 completed the KITE program, a completion rate of 80.6%. The classes were offered in the following groups, using the group's native language:

- Chinese (2 class series were completed, offered in Chinese Simplified/Mandarin)
- Filipino (2 class series was completed, offered in combination of English and Tagalog)
- Korean (1 class series were completed, offered in Korean)

In addition to the KITE parenting class series, KITE workshops were also offered to AAPI parents who were interested to participate prior to joining the KITE parenting program. The KITE workshops are generally shorter, consist of 1 session or more, depending on the type of workshop, and last approximately one hour. There were a total of 21 KITE workshops completed during the fiscal year 2023-2024, where 13 workshops were offered in the Western region, and 8 workshops were completed in the Mid-County region, with a total of 273 attendees:

- 12 workshops were completed in Mandarin/Simplified Chinese for Chinese groups
- 6 workshops were completed in combination of English and Tagalog for Filipino groups
- 3 workshops were completed in Korean for Korean groups

The detailed description for KITE Program Completion, as well as the lists for KITE Parenting Class Series and KITE Workshops are shown on pages 7 to 10.

KITE Parenting Class Series and Workshop Completions

The contract expectations for the KITE program were to complete the following: 10 "Community Education/ Outreach Workshops", 3 "Bicultural Parenting Class Series", as well as a combined minimum of 40 parents completed per region, per year, with each specific Asian immigrant parent group (i.e. Chinese, Korean, or Filipino). Tables below describe the total completion and contract expectations from KITE Program during the fiscal year 2023-2024.

Due to the widespread of COVID-19 pandemic since early 2020, all outreach activities, workshops and parenting class series were conducted entirely online for the fiscal years 2020-2021 and 2021-2022. For the fiscal years 2022-2023 and 2023-2024, a combination of virtual and in-person outreach activities, workshops, and parenting class series were conducted. There were a total of 21 KITE workshops completed (a 105% completion rate), in which 13 workshops were completed in the Western region and 8 workshops were completed in the Mid-County region. Overall, the total workshops completion for fiscal year 2023-2024 exceeded the contract expectation of completing 20 workshops in the fiscal year. Additionally, there were a total of 5 KITE parenting class series completed (a 83.3% completion rate) during the fiscal year 2023-2024, in which 3 of the parenting class series were completed in the Western region, and 2 parenting class series were completed in the Mid-County region.

It is also expected that the assigned contractor would provide a KITE parenting class series to a minimum of 40 parents per region, per year. During the fiscal year 2023-2024, a total of 54 parent participants completed the KITE parenting class series, out of 67 parent participants within Riverside county regions (a 80.6% completion rate). Based on the total counts of class completion, the Western region met 66.7% of the contract expectation (40 parents completed), while the Mid-County region met 23.3% of the contract expectation (14 parents completed). Overall, the Countywide percent completion for KITE parenting program is 45% in regards to the contract expectation.

KITE Workshop Completion (n = 21)			
Source:	**Number of Workshops Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**13**	**10**	**130%**
Mid-County	**8**	**10**	**80%**
Countywide	**21**	**20**	**105%**

KITE Parenting Class Series Completion (n = 5)			
Source:	**Number of Parenting Classes Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**3 series**	**3 cycles**	**100%**
Mid-County	**2 series**	**3 cycles**	**66.7%**
Countywide	**5 series**	**6 cycles**	**83.3%**

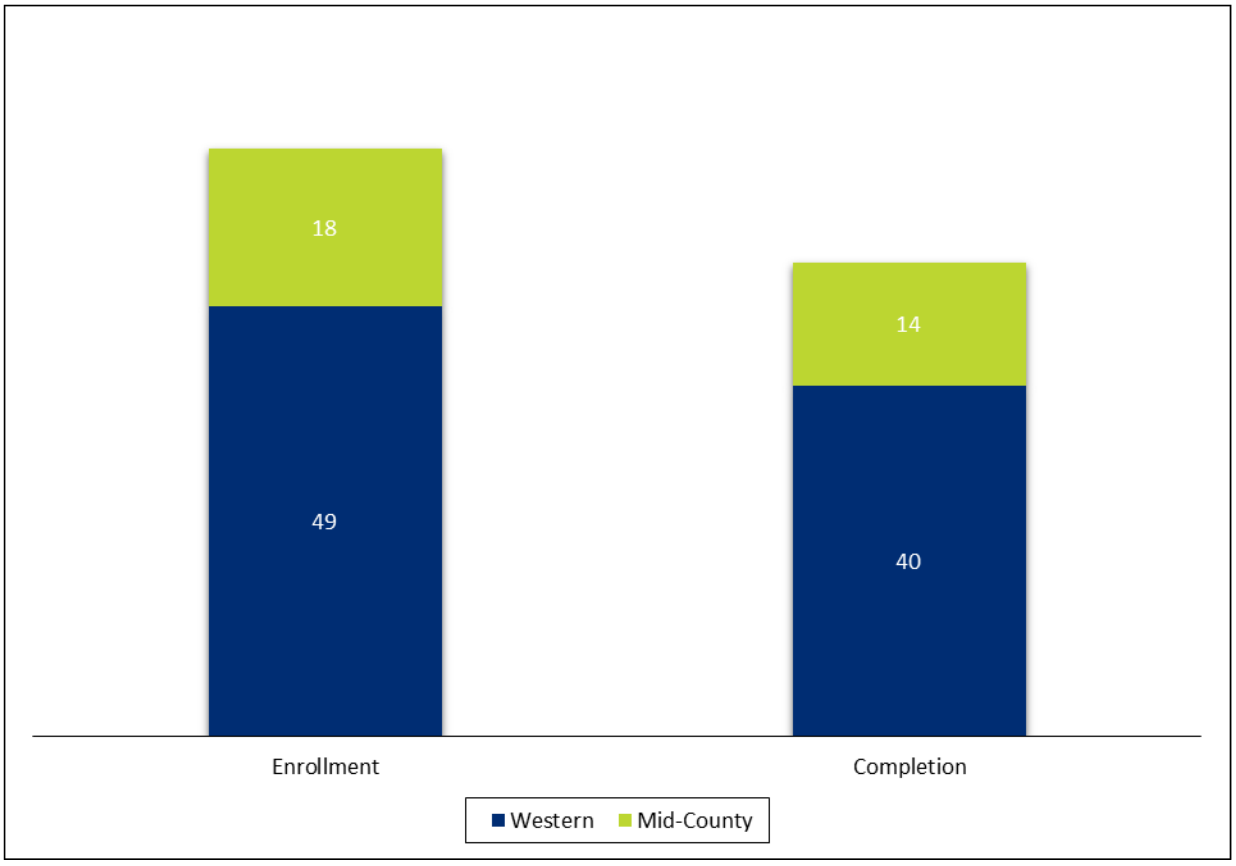
KITE Parenting Class Participants Completion (n = 54)			
Source:	**Number of Parent Participants Completed**	**Contract Expectations**	**Percent Completed**
Western/Riverside	**40**	**40**	**100%**
Mid-County	**14**	**40**	**35%**
Countywide	**54**	**80**	**67.5%**

KITE Parenting Classes—FY 2023-2024

Language	Location/Group Site	Number of Cycles	Region		Start Date	End Date	Number of Enrollment	Number of Completion
			Mid-County	Western				
Chinese	Eastvale Elementary School	2	0	2	07/20/23	09/28/23	11	9
	Riverside Unified School District (Zoom)				01/31/24	03/27/24	30	26
Korean	Riverside Korean Baptist Church	1	0	1	10/18/23	12/20/23	8	5
Filipino	New Hope Community Church	2	1	0	10/14/23	01/13/24	10	8
	New Hope Community Church		1	0	03/27/24	05/15/24	8	6
Total:		**5**	**2**	**3**	**Total:**		**67**	**54**

Completion Rate: 80.6%

KITE Parenting Class Enrollments by Region—FY 2023-2024



KITE Workshops—FY 2023-2024

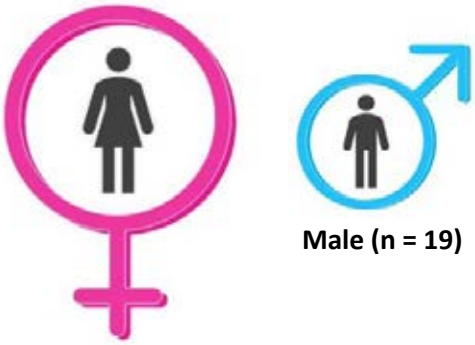
Language/ Ethnicity	Number of Workshops	Region		Date	Location	Topic	Attendees
		Mid-County	Western				
Korean	3	2	1	4/10/2024	Calvary Church Murrieta (Zoom)	5 Love Languages of Children	6
				5/19/2024	Riverside Korean Baptist Church	5 Love Languages of Children	41
				5/30/2024	Calvary Church Murrieta	Bicultural Identity	3
Filipino	6	6		09/30/23	New Hope Community Church Temecula	Family Ties	27
				11/18/23	San Manual Filipino Association	Showing Understanding	7
				01/23/24	Liberty High School	Showing Understanding	4
				02/23/24	Crown Hills School	Bicultural Identity	4
				05/18/24	Bataan Association	5 Love Languages of Children	9
				06/22/24	Onward Zion	KITE Parent Class Preview	13
Chinese	12		12	07/27/23	Eastvale Elementary School	Bicultural Identity	11
				08/03/23	Eastvale Elementary School	Understanding Your Teens	13
				09/14/23	Eastvale Elementary School	5 Love Languages of Children	8
				09/21/23	Eastvale Elementary School	Self-Care: Mindfulness	7
				09/27/23	Roosevelt High School	Understanding Your Teens	9
				10/12/23	Riverside Unified School District (Zoom)	5 Love Languages of Children	2
				02/07/24	Riverside Unified School District (Zoom)	Understanding Your Teens	25
				03/13/24	Zoom	Self-Care: Mindfulness	22
				03/20/24	Zoom	5 Love Languages of Children	20
				05/19/24	Norco Community Christian Church	Cross-Cultural Identity of Chinese American	20
				05/23/24	Norco Community Christian Church (Zoom)	Cross-Cultural Identity of Chinese American	19
				06/04/24	Eastvale Library	KITE Parent Class Preview	3
Total Number of Workshops: 21		**8**	**13**				**Total Workshop Attendees: 273**

Demographics

There were a total of 67 parent participants who enrolled in the KITE program in Riverside County for the fiscal year 2023-2024. Of these, 54 participants completed the parenting class series and submitted the complete demographic forms, pre measures, post measures, as well as satisfaction surveys. The remaining 13 participants did not complete the program due to scheduling conflicts or personal reasons. The overall completion rate for the KITE parenting program in FY 2023-2024 was 80.6%.

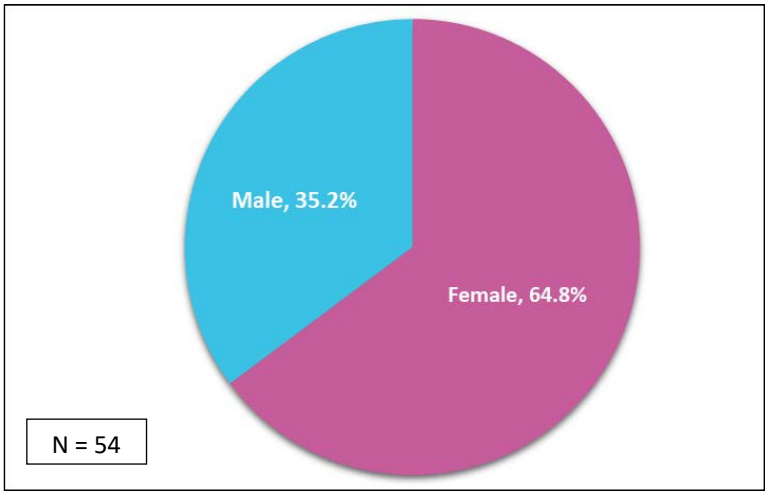
Gender

The majority of KITE parent participants were Female (64.8%, n = 35), while the remaining participants were Male (35.2%, n = 19).



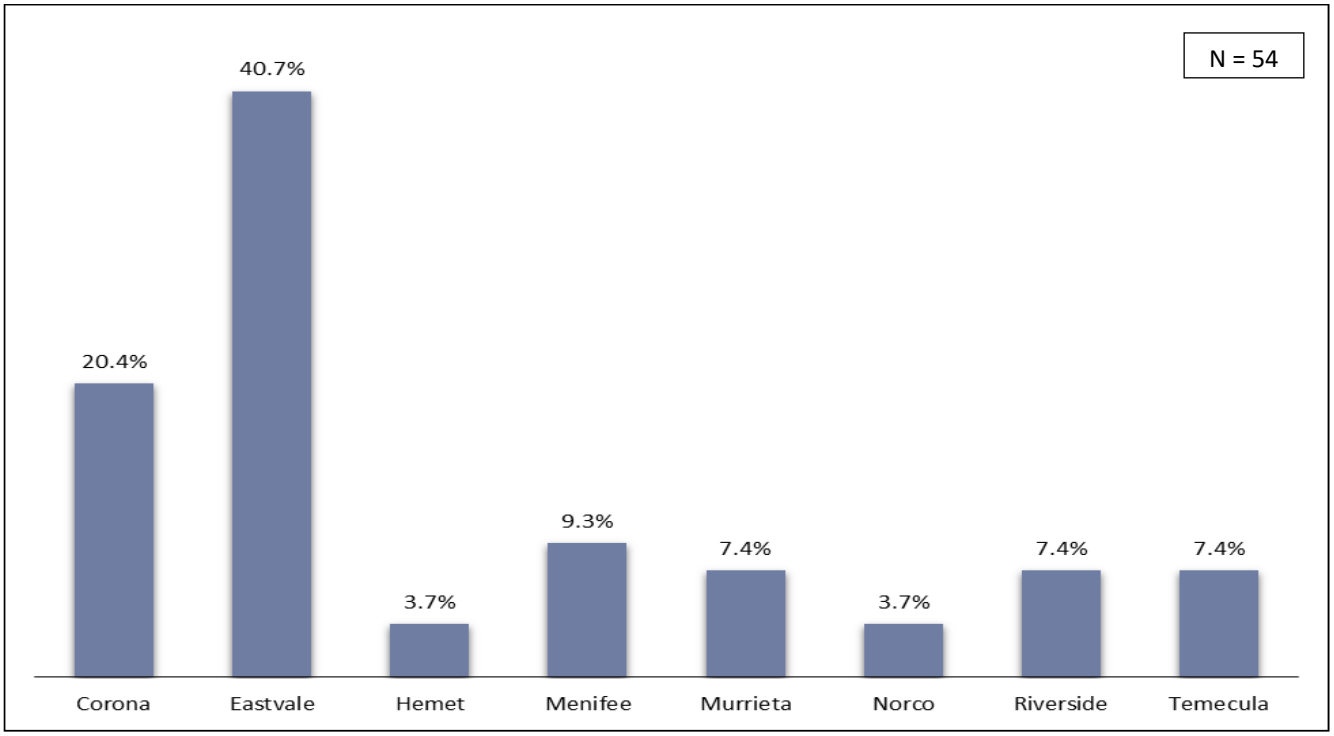
Male (n = 19)

Female (n = 35)



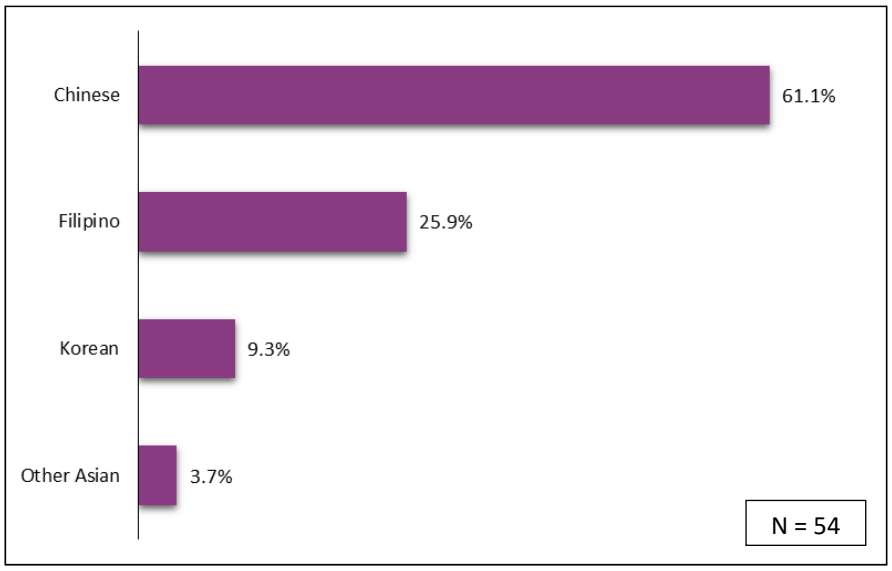
City of Residence

The majority of KITE parent participants indicated that they reside in Eastvale (40.7%, n = 22). Smaller percentages of parent participants resided in Corona (20.4%, n = 11) and Menifee (9.3%, n = 5), while the remaining participants indicated that they resided in Murrieta, Riverside, Temecula, Hemet, and Norco.



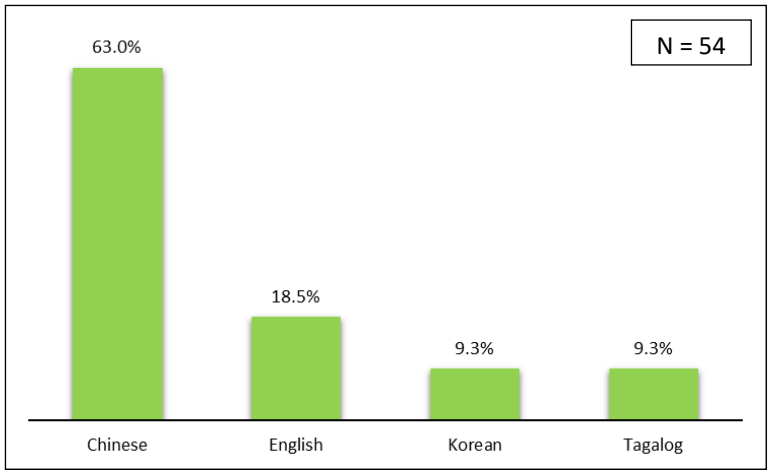
Race/Ethnicity

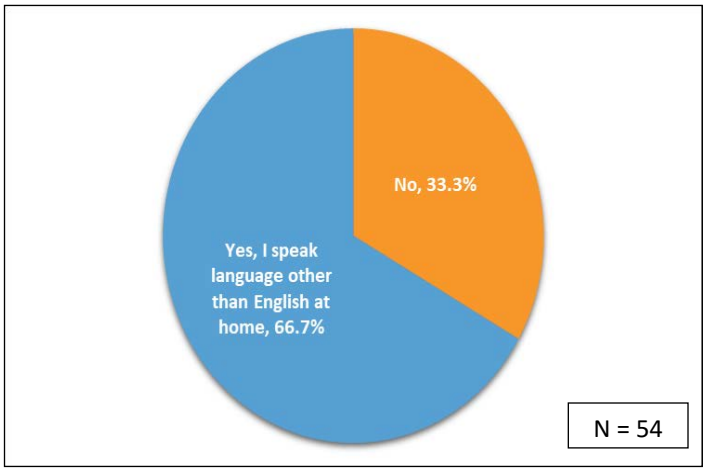
The majority of parent participants enrolled in the KITE Program were Chinese (61.1%, n = 33), while the remaining participants reported they were Filipino (25.9%, n = 14), Korean (9.3%, n = 5), and Other Asian (3.7%, n = 2).



Preferred Language and Language Spoken at Home

The majority of parent participants indicated that their preferred language was Chinese (63%, n = 37), while other languages spoken were English (18.5), Korean (9.3%), and Tagalog (9.3%). We also asked participants if they speak a non-English Language at home, and 66.7% (n = 36) responded "Yes". Participants listed the languages used at home as follows: Chinese, Korean, and Tagalog.





Disabling Condition, LGBTQI, and Veteran Status

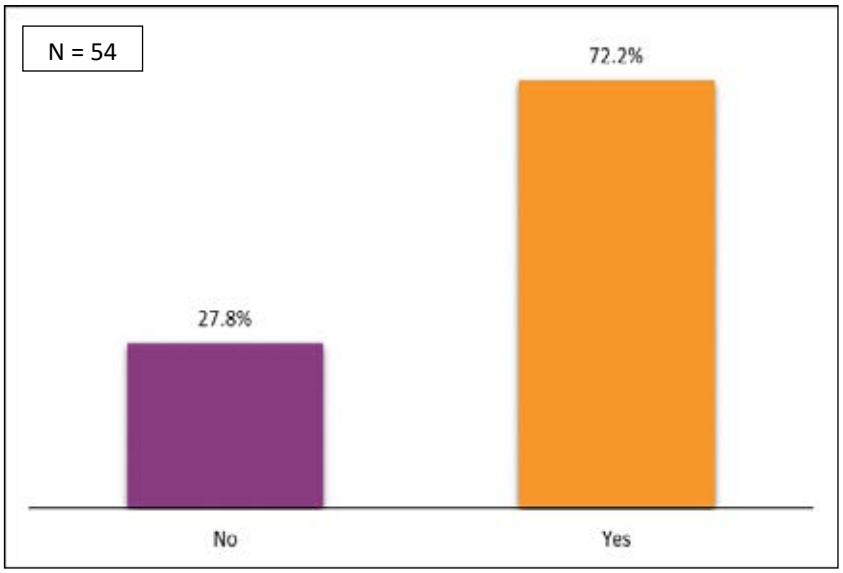
In response to demographic questions related to whether or not they have identified themselves as having Disabling Condition, identified as LGBTQI, and identified as Veterans, the results can be summarized as follows:

- 92.6% participants (n = 50) responded "No", in regards to whether or not they have any disabling condition. The remaining 4 participants who responded "Yes", noted that they have the following conditions: PTSD, Aneurysm, Psoriatic Arthritis, and Hearing Loss.
- 100% participants responded that they did not identify themselves as LGBTQI.
- 94.4% participants (n = 51) responded that they were not Veterans.

First Generation Americans and Conflicts due to Cultural Beliefs

One of the demographic question was for parent participants to indicate whether they were either "First Generation" or "Second Generation" Americans. First-generation Americans are defined as being born outside of the United States, while second-generation Americans are born in the United States but have parents who are born abroad. In response to this question, the majority (72.2%, n = 39) responded "Yes", that they are First-Generation Americans. Parent participants were also asked whether they had conflicts with their children due to different cultural beliefs, and 50% responded "Yes".

Are you 1st Generation Americans?

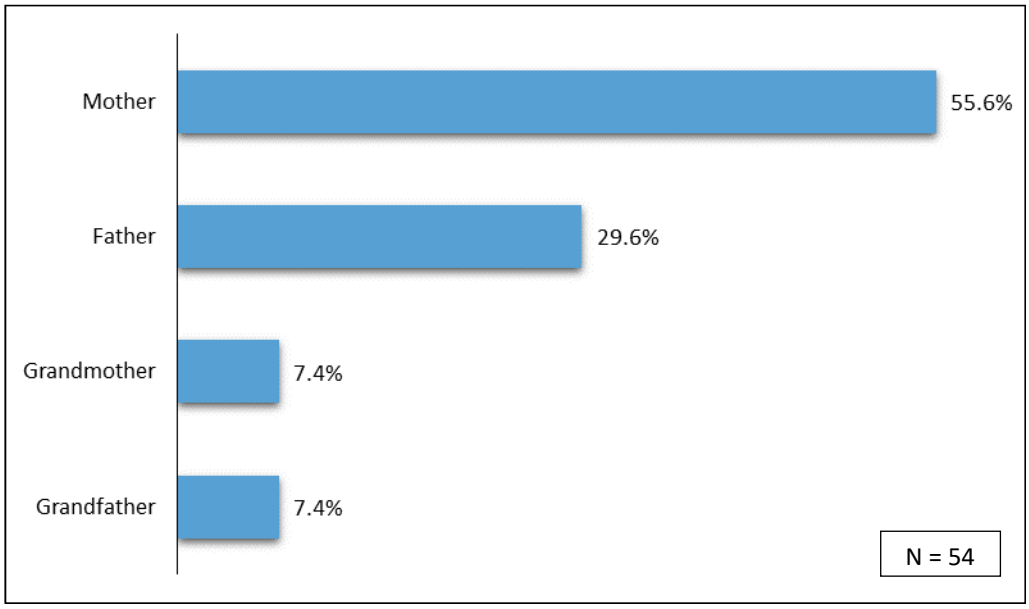


Do you have conflicts with your children because of different cultural beliefs?



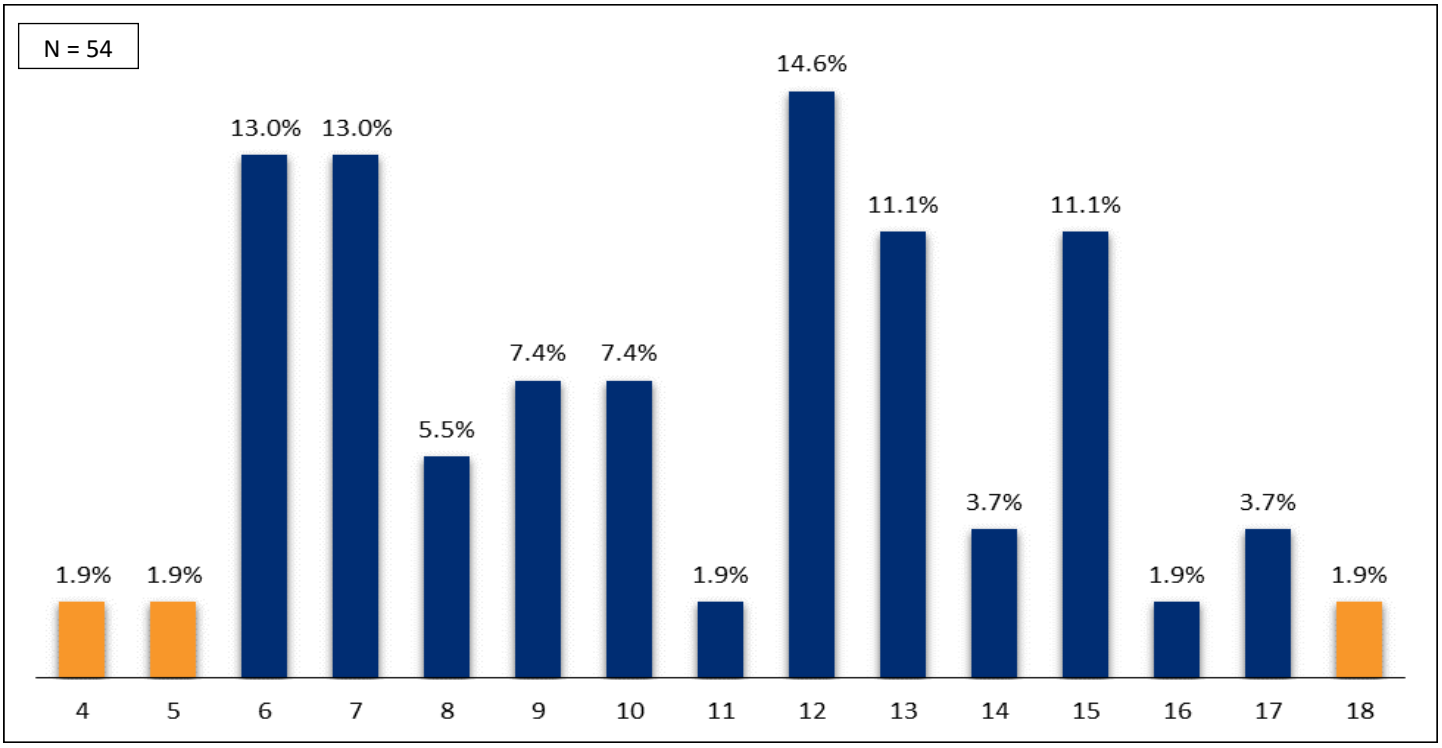
50% **50%**

Role of Parents Completing KITE Program



Parent participants were also asked the type of role/relationship they had with their children, and the results are as follows: 30 participants (55.6%) indicated their roles as the child's "Mother", 16 participants (29.6%) indicated their roles as the child's "Father", and the remaining 8 participants indicated as the child's "Grandmother" (7.4%), and the child's "Grandfather" (7.4%), respectively.

Ages of Participants' Children



We were also interested in knowing the ages of the participants' children, to confirm that they were indeed between the ages of 6 and 17 years old, and whether there was any correlation between the ages of their children and the level of intergenerational conflicts due to cultural beliefs between the two generations, which was shown on the previous page.

We asked parent participants to list the name and age of children of whom they would like to focus their relationship on. This question is listed on all of the KITE's pre- and post- measures. When parents have more than 1 child, they are asked to list the oldest child, or the child with whom they view as having the most challenges, as the "target child". The graph above only shows the total number of participants who completed the pre-and post-questionnaires and included in the analysis. Based on the current ages of children that parent participants have listed on their measures, the results are divided almost equally, where 26 participants (48.2%) responded that their children were between the ages of 6 and 11 years old, and 25 participants (46%) responded that their children were between the ages of 12 and 17 years old. It is also noted that 3 participants indicated that their children were under 6 years old (3.8%, n = 2) and older than 17 years old (1.9%, n = 1).

On page 13, it is shown that 50% of parent participants had indicated "Yes", that they do have conflicts with their children due to different cultural beliefs, and the majority of parent participants indicated that their children are indeed between the ages of 6 and 17 years old (94.3%, n = 51), which shows that the KITE program did meet the goal to provide services to the target audience of AAPI parents with school-aged children and adolescents within the ages of 6 to 17 years old. Furthermore, it is hoped that the KITE program would help to address the parents' needs in bridging the intergenerational gap due to different cultural beliefs, which then aims to strengthen biculturality and intergenerational relationship between the AAPI Parents and their children.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaires (SDQ) are used to measure the degree of strengths and difficulties that the child has, as viewed by their parents. On the SDQ form, we asked each parent participant to list the child name and age, and to focus on their child's strengths and the difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the strengths and difficulties questionnaires on. The SDQ measure has a total of 25 questions, which comprises 5 scales of 5 items each. The scales measured in SDQ are as follows:

- **Emotional Symptoms**
- **Conduct Problems**
- **Hyperactivity**
- **Peer Problems**
- **Prosocial Scales**

Detailed explanation of the scales, average scores, and the item numbers which correspond to each scale are shown on tables below. Moreover, the SDQ measure is structured on a 3-point a Likert Scale, where parents choose between three choices, where: 1 = "Not True", 2 = "Somewhat True", and 3 = "Certainly True".

Each question on the SDQ measure is a different statement/questionnaire that we asked each parent to choose the option that represents their child the most. The higher the score, the more likely parents viewed their child as having strengths or difficulties towards the statements. Each parent participant is asked to fill out SDQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

SDQ Scales and Item Numbers

Scales Measured in Strength and Difficulties Questionnaire	Item Numbers
Emotional Symptoms	3, 8, 13, 16, 24
Conduct Problems	5, 7, 12, 18, 22
Hyperactivity Scale	2, 10, 15, 21, 25
Peer Problems Scale	6, 11, 14, 19, 23
Prosocial Scale	1, 4, 9, 17, 20

SDQ Scales and Average Scores Interpretation

SDQ Scales	Normal	Borderline	Abnormal
Emotional Symptoms Scale	0-3	4	5-10
Conduct Problems Scale	0-2	3	4-10
Hyperactivity Scale	0-5	6	7-10
Peer Problems Scale	0-2	3	4-10
Prosocial Scale	6-10	5	0-4
Total Difficulties	0-13	14-16	17-40

***Possible score: 0 to 10 for each scale, or up to 40 for total scores*

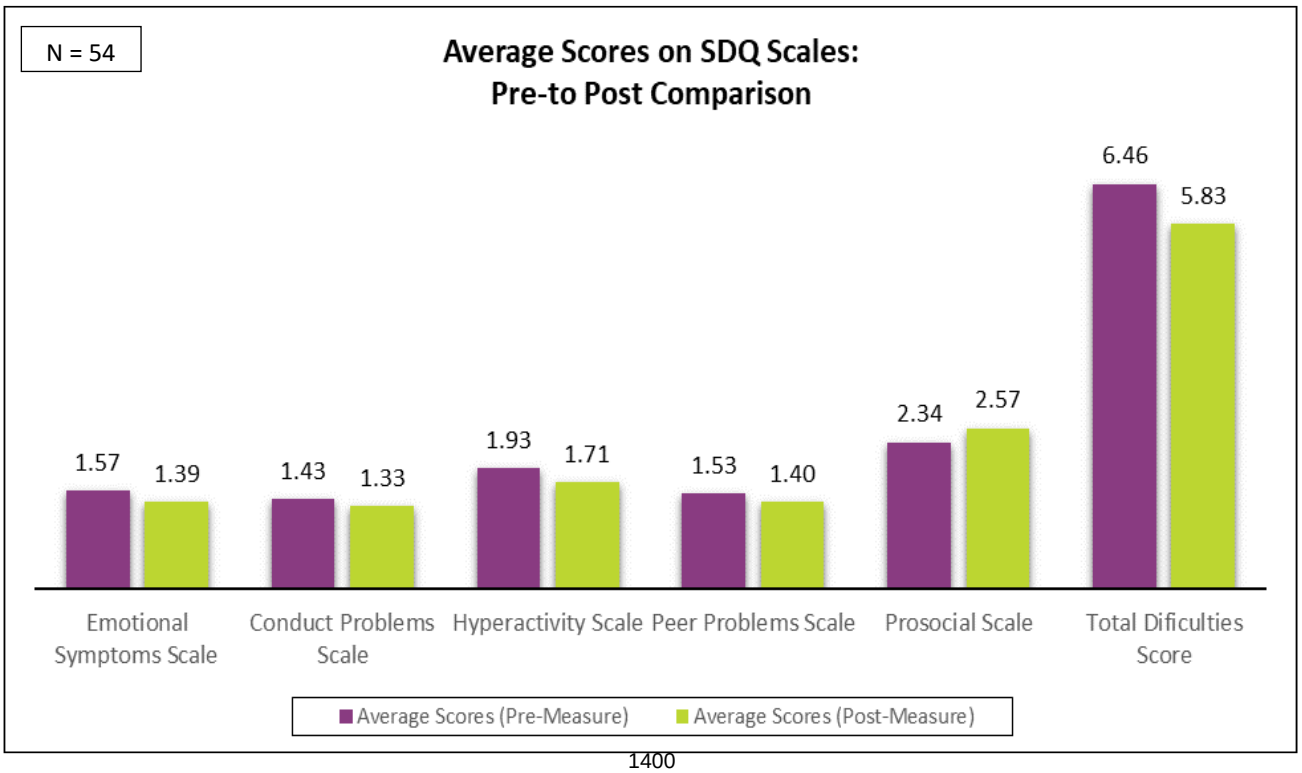
Strengths and Difficulties Questionnaire (SDQ) Scale Analysis and Results

There were a total of 54 pre-post matched pairs completed for the SDQ measure. Overall, changes were shown on the average scores across all scales, scores were found to be in the "normal range" at pre and post. Ideally, we would want to see a ***decrease*** in the Emotional Symptoms Scale, Conduct Problems Scale, Hyperactivity Scale, and Peer Problems Scale, and an ***increase*** in the Prosocial Scale.

The pre-post analysis showed that there were decreases on the average scores on the **Emotional Symptoms Scale** (11.1% decrease from 1.57 to 1.39), **Conduct Problems Scale** (7.5% decrease from 1.43 to 1.33), **Hyperactivity Scale** (11.3 % decrease from 1.93 to 1.71), as well as on **Peer Problems Scale** (8.9% decrease from 1.53 to 1.40). Overall, pre-scores fell within the normal range across all scales measured, which suggest that parent participants did not view their children's strength and difficulties as issues to them. The analysis also showed the ideal decreases on the 4 scales, and an increase on 1 scale listed above, as we would have expected. The pre-post analysis using paired samples T-Test showed that all changes in SDQ scales were *statistically significant* ($p < .05$).

In addition to the 5 scales measured in SDQ measure, we also compared the **Total Difficulties' Average Scores** from pre-to-post. The Total Difficulties Score is generated by adding the scores from all scales, *except* for **Prosocial Scale**, and this score can range from 0 to 40. Based on the pre-to post analysis, the Total Difficulties' average scores for all participants decreased from 6.46 to 5.83 (a change of 9.9%), and analysis using paired samples T-Test showed this decrease to be statistically significant ($t = 4.733$, $p < .05$), highlighted in green on table below. All pre– and post–scores on all scales are also shown within the normal range.

APQ Scales	Percent Change	*t*	df	p
Emotional Symptoms Scale	-11.1%	3.168	53	.003
Conduct Problems Scale	-7.5%	4.087	53	.000
Hyperactivity Scale	-11.3%	3.884	53	.000
Peer Problems Scale	-8.9%	2.750	53	.008
Prosocial Scale	9.6%	-3.984	53	.000
Total Dificulties Score	**-9.9%**	**4.733**	**53**	**.000**



Alabama Parenting Questionnaire (APQ)

The second measure collected during the KITE Program, Alabama Parenting Questionnaires (APQ), is used to measure positive and negative parenting practices. More specifically, it is meant to measure several different dimensions of parenting that have proven to be important for understanding the causes of conduct problems and delinquency in youth.

There were 42 items on the original version of APQ measure; however, for the purpose of KITE program, a modified format of the APQ measure was adopted for the KITE Program, with 29 items that would measure the following scales:

- **Parental Involvement**
- **Positive Parenting**
- **Inconsistent Discipline**
- **Other Discipline Practices (Harsh Discipline)**

The questions on APQ measure are structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Never", 2 = "Almost Never", 3 = "Sometimes", 4 = "Often", and 5 = "Always". Each parent participant is asked to fill out APQ form on the first day of KITE parenting class series (pre-measure) and on the last day of the KITE parenting class series (post-measure).

Similar to the SDQ measure, each parent was asked to list the child name and age on the APQ measure, and to focus on their child's strengths and difficulties that parents are experiencing with the child, if any. When parents have more than one child, we asked the parent to list the child's name and age with whom the parent participants would like to focus the parenting practices on.

Each question on the APQ measure is a different statement about parenting practices. For the KITE Program, each parent participant is asked to choose the option that best represents his/her parenting practices. The higher the score, the more likely parents viewed themselves as having positive parenting practices with their children. The scales measured on the modified APQ measure and the corresponding item numbers that belong to each score are shown on table below.

APQ Scales and Item Numbers

Scales Measured in Alabama Parenting Questionnaire	Item Numbers
Parenting Involvement	1 to 10
Positive Parenting	11 to 16
Inconsistent Discipline	17 to 22
Other Discipline Practices (Harsh Discipline)	23 to 29

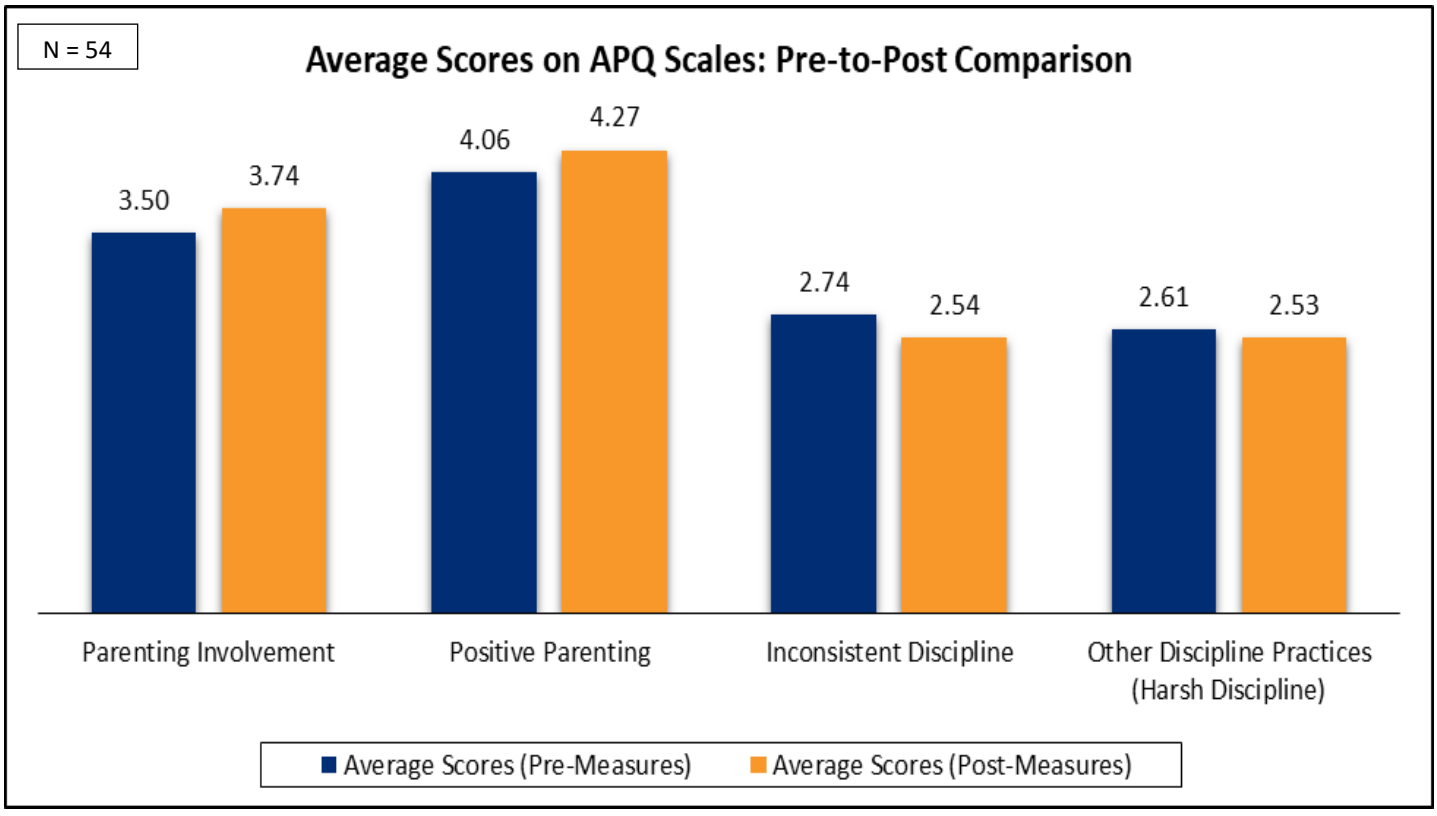
For analysis purpose, the average scores of these above scales on the modified APQ measures were then compared from pre-to-post measure. Ideally, we would like to see that the average scores in "Parenting Involvement" and "Positive Parenting" scales to increase, and for the average scores in "Inconsistent Discipline" and "Other Discipline Practices (Harsh Discipline)" scales to decrease from pre-to-post.

Alabama Parenting Questionnaire (APQ) Scale Analysis and Results

A total of 54 pre-post matched pairs were completed by parent participants for the APQ measure. The table and graph below show the APQ Scale analysis and results. Based on the paired-samples T-Test analysis, the results showed improvements in the expected directions. The **Parenting Involvement** scale showed a 6.7% *increase* from 3.5 to 3.74 (which was a slight increase of parents' choices from "*Sometimes",* that changed towards "*Often"*) and a 5.1% *increase* on **Positive Parenting** scale from 4.06 to 4.27 (which was a slight *increase* of parents' choices from "*Often"*, that changed towards "*Always"*).

Additionally, **Inconsistent Discipline** scale showed the largest change, which is a *decrease* of 7.5% from 2.74 to 2.54), and **Other Discipline Practices** scale also showed a *decrease* of 2.9% from 2.61 to 2.53). Further analysis using paired samples T-tests for each of the APQ scale items are shown on the table below. Both **Parenting Involvement** and **Positive Parenting** scales, which showed increases from pre-to-post, also showed statistically significant results at or below $p < .05$, as shown on table below (highlighted in green). In sum, these overall results from APQ Scales showed positive improvements in parenting practices, from pre-measures to post-measures.

APQ Scales	Percent Change	*t*	df	p
Parenting Involvement	6.7%	-2.280	53	.027
Positive Parenting	5.1%	-2.020	53	.048
Inconsistent Discipline	-7.5%	1.944	53	.057
Other Discipline Practices (Harsh Discipline)	-2.9%	0.966	53	.339

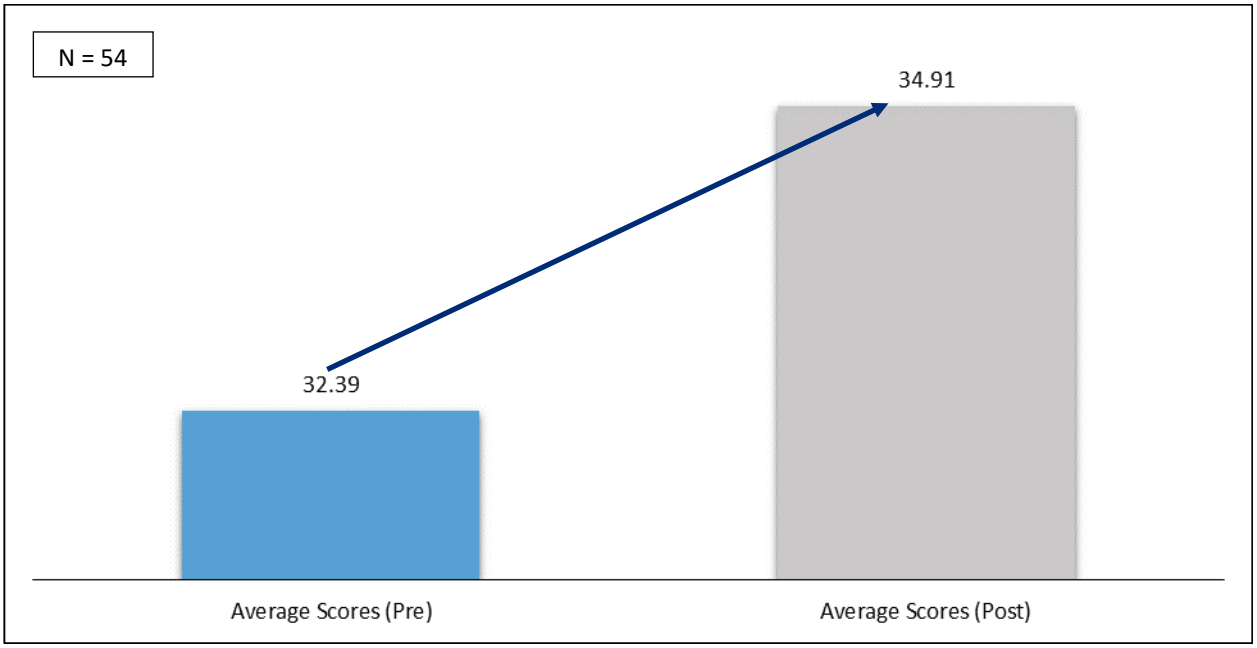


Relationship Scale

The Relationship Scale, the third measure used in the KITE program, is used to measure the degree of positive relationship that parent participants have with their children. Similar to APQ and SDQ measures, all parent participants were asked to list the child's name and age on the Relationship measure, and to focus on their relationship with their "target child" when responding to the questions. When parents have more than one child, we asked the parent participants to list the child's name and age with whom their current relationship is the most challenging, and to focus on the target child when responding to the relationship questions. The Relationship Scale was also collected at the beginning of the KITE parenting class series, and at the end of the KITE parenting class series.

The Relationship Scale has a total of 9 questions, structured on a 5-point Likert Scale, where parents choose between 5 options, where: 1 = "Strongly Disagree", 2 = "Disagree", 3 = "Neutral", 4 = "Agree", and 5 = "Strongly Agree". For this Relationship measure, higher scores indicate a more positive relationship between the parent participants and their children.

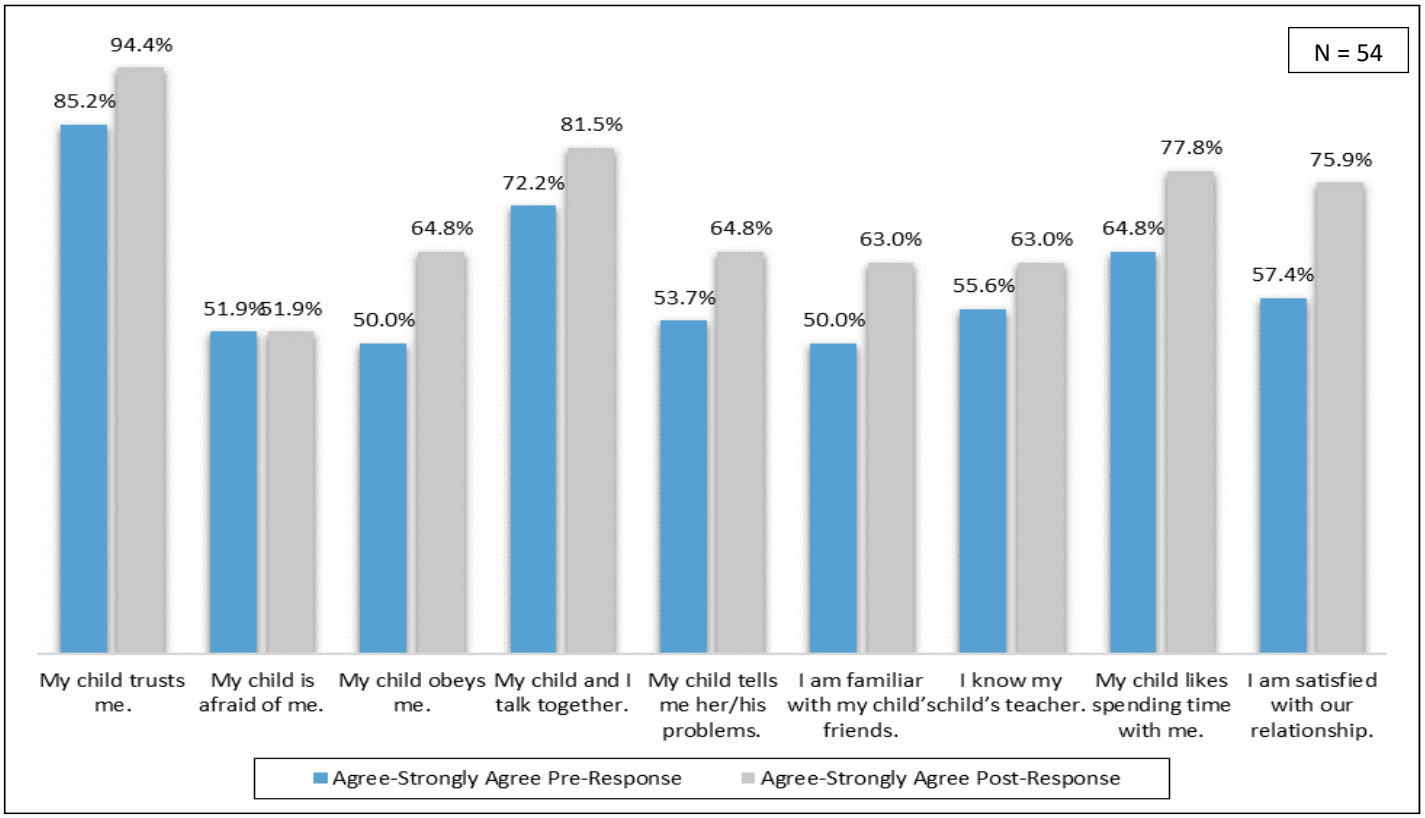
Relationship Scale
Average Total Scores: Pre-to-Post Comparison



Overall, the average total scores on Relationship Scale increased 2.52 points from pre-to post-measure, from 32.39 to 34.91. The pre survey total scores were already relatively high at the beginning of the KITE Program, which showed that parent participants already had a positive relationship with their children. Further analysis using paired samples T-Test also showed a *statistically significant* result, $t(53) = -3.529$, $p = < .05$. An item-by-item analysis on the Relationship Scale will be shown on the following page.

Average Total Scores on Relationship Scale—Pre to Post Analysis	Percent Increase	*t*	df	p
	7.8%	-3.529	59	0.001

Relationship Scale Analysis: Pre-to-Post Comparison



Relationship Scale—Survey Items (n = 54)	Percent Change	*t*	df	p
1. My child trusts me.	9.2%	-2.281	53	.027
2. My child is afraid of me.**	0.0%	-0.327	53	.745
3. My child obeys me.	14.8%	-2.131	53	.038
4. My child and I talk together.	9.3%	-2.530	53	.014
5. My child tells me her/his problems.	11.1%	-2.700	53	.009
6. I am familiar with my child's friends.	13.0%	-2.745	53	.008
7. I know my child's teacher.	7.4%	-1.237	53	.222
8. My child likes spending time with me.	13.0%	-3.792	53	.000
9. I am satisfied with our relationship.	18.5%	-3.041	53	.004

***** = Item #2 has a reversed scale***

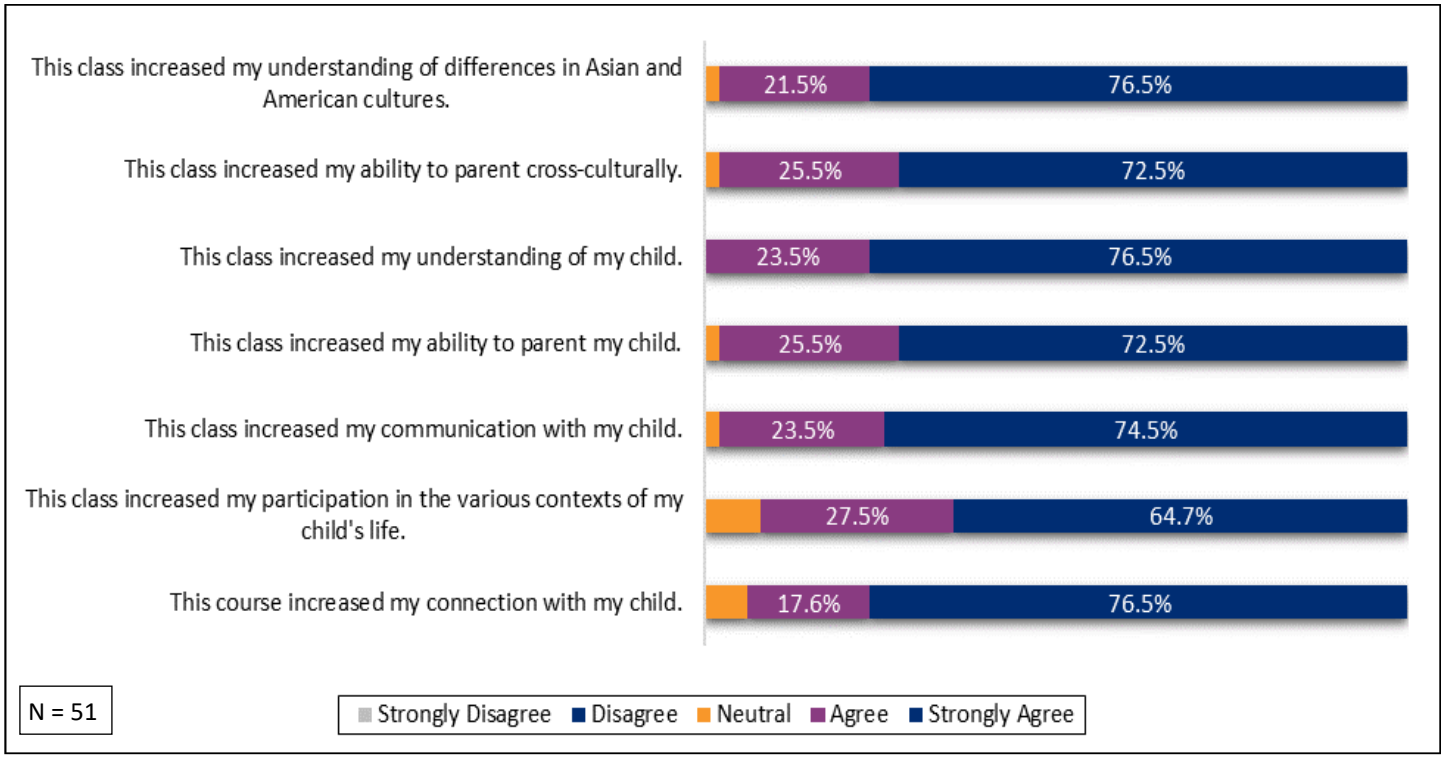
Similar to SDQ and APQ measures, there were a total of 54 pre-post matched pairs completed for the Relationship Scale. Figures above showed the Relationship Scale Analysis from pre-to-post measures, and ideally, we would like to see increases across all questionnaire items, except for number 2 (**My child is afraid of me**). This item has a reverse scale, and ideally, we would like to see a decrease, although a pre-post analysis on this scale item showed that the percentages from pre-to-post remained the same. Overall, based on the pre-post analysis, all scale items have shown increases from pre-to post-measures, which suggests that parents' views on their relationships with their children have generally increased at the conclusion of the KITE parenting program, in comparison to the beginning of the program.

The highest percent difference was shown on item number 9 (**I am satisfied with our relationship**), which showed an increase of 18.5% from pre-to-post measures. Item number 3 (**My child obeys me**) also showed a increase of 14.8%, and both item number 6 (**I am familiar with my child's friends**) and item number 8 (**My child likes spending time with me**) showed an equal increase of 13.0% from pre-to-post measures. Further analysis using paired samples T-tests are shown on the table above. Overall, 7 out of 9 items on the Relationship Scale (highlighted in green on table above) showed *statistically significant* results at ($p < .05$).

Post-Satisfaction Surveys

A post-satisfaction survey was created to evaluate KITE program effectiveness and to gather participants' feedback on how the program has impacted their relationship with their children. The post-satisfaction surveys were distributed to participants and collected at the end of each KITE parenting class series. There are 7 questions on the post-satisfaction surveys, using a Likert scale ranging from 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. There were a total of 51 post-satisfaction surveys completed at the end of all KITE parenting class series, and the results are shown below.

Survey Results



Overall, the analysis from post-satisfaction surveys showed highly positive results from all parent participants who responded "Strongly Agree" or "Agree" to all of the survey statements, as summarized below:

- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of differences in Asian and American cultures.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent cross-culturally.***
- 100% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their understanding of their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their ability to parent their children.***
- 98% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their communication with their children.***
- 92.2% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their participation in the various contexts of their children's lives.***
- 94.1% of participants responded they either "Strongly Agreed" or "Agreed" that the ***KITE parenting classes had increased their connection with their children.***

Post-Satisfaction Survey Comments for Question #1

There were a total of five follow-up questions on the KITE post-satisfaction surveys, which were created to measure the effectiveness of the KITE program. Selected responses from participants for each question are shown below and on pages 23-26.

1. ***How did you change personally?***

"I put my child's feelings first and empathize according to the content of the courses."
"The way of communicating with my children has changed."
"Standing in my child's perspective to view issue."
"Through the study of the course, I am no longer anxious. If I change my mood as a parent, everything will change."
"Through communication with teacher and parents in class, I identify the differences of Chinese culture."
"I improved my tone and patience when talking to my child."
"Use the time during school pick up/drop to communicate more with my child, and talk about what happened in the day."
"I became a little more patient with my child."
"A chance to take a moment in a situation where you're angry or about to be angry."
"I try not to immediately get mad and making an effort to be more patient."
"I became more attentive to my child."
"I will look at things from my child's perspective"
"Have confidence in educating my children."
"Through the study in the parent-child class, I learned that the needs of children and the responsibilities of parents in raising children are actually unified. If you think about the demands and demands behind the behaviors of the children from another angle, you can better understand the children and form a good parent-child relationship with them.
At the same time, I also learned a lot of parenting skills, encourage and praise children more, and interact with children with high-quality companionship. Don't always use punishment to make children obedient. Properly letting children bear natural consequences is a required course for their growth!"
"In the end, the parent-child relationship is more important than academic performance, always remember this and raise our children from there."
"Be more understandable to kids."
"I began to care about her feelings and try my best to help her within my ability."
"Pay more attention to your approach when talking to your children."
"Begin to learn to praise children."
"Recognize cultural differences and psychological changes in children."
"I tried to use the method taught by the teacher, and it was very pleasant to get along with the children several times."
"In the past, I would get very angry when my child did something wrong and would yell at him. After class, I would change. When he did something wrong, I would express my understanding of his feelings and then make an evaluation."
"I've learned to think about things from my child's perspective when we have disagreements."
"Learn to take deep breaths. Only by adjusting your mentality can you deal with children happily."
"Suitable for another way to communicate with children."
"Do special time as much as possible."
"When there is a conflict, try your best to calm down first and then deal with it."
"Put yourself more from the child's perspective and consider his situation at that time."
"Understand the child's difficulties."
"Talk to your child calmly."
"More aware of my interaction to my kids, be more present to them."
"I became more aware of how to parent cross culturally."
"I became more aware of the way I parent, spoke and interacted with my grandchild. "
"Learned to be more understanding and use parental message better."
"I became more understanding and accepting of the situation."

Post-Satisfaction Survey Comments for Question #2

2. How did you change in the way you parent?

"Through the scientific parenting method in the curriculum, if my children have behavioral problems, as parents should reflect on changing the bad parts of traditional Chinese education methods if they want to have a healthy parenting relationship and physical and mental health."
"After learning the courses, I learned how to use the right communication method to communicate with children. I try to express my understanding first, and then express my needs, so my children will be more acceptable."
"Listen to my children's thoughts first, and then consider their views as parents."
"Parenting knowledge and workshops learned in class."
"I don't know how to praise my daughter before studying the courses. After studying, I often praise her, and the effect is very good."
"When I find that my child has done something wrong. I will calm down and communicate with the child."
"I became a better listener."
"I have gained more patience when communicating with my child."
"I became a parent who waits."
"Will change the way of educating children, insist on praising, discover strengths and actively communicate."
"Will see things from the child's perspective and understand and help them."
"Everything starts from the child's feelings and is educated based on the content learned."
"Learn to listen, encourage and praise more."
"I began to want to know her perspective on everything."
"Start learning to make friends with your children."
"Change by learning to understand the child's growth process."
"How to get along and communicate with children."
"After taking the class, I feel that as a parent, we should focus on encouragement and try to impose as few punishments as possible."
"Learn to communicate with children in short words."
"Listen more and start with "I." Special time effectively improves quality sharing time."
"See things from a child's perspective."
"Treat children more calmly."
"Need to be more concerned with children's psychology"
"Read a lot of books about children's education through continuous exploration."
"Understand the reasons for her rebellious period."
"Praise a lot."
"Better interaction with children."
"Understanding more and listening."
"Listen, pause, look at them more, less yelling."
"I am more patient and understanding."
"I became a better listener."
"Be more friendly to my children."
"I'm more conscious in how I parent my children."
"More understanding."
"I begin to think of his feeling instead of mine."
"Just being aware not all about me, but my child has the say as well."
"Better in understating of the situation."
"More communication and interaction between us."

Post-Satisfaction Survey Comments for Question #3

3. What was the most helpful topic we covered?

"Emotions, discipline methods, parenting communication methods."
"Use structure and encouragement, rules, limits, consequences and punishments, special time."
"Structuring intervention."
"Understand the cultural differences."
"How parents cope with stress."
"Parenting communication methods and coping with stress."
"Understand the importance of the tone and attitude of parents in the communication process between their children."
"Understanding between parents and children."
"Conversations with my child have become smoother."
"How to communicate with my children."
"We became more understanding of each other."
"Build a structure express understanding."
"Use expressive understanding and parent messages and teach children rules, limits and consequences."
"Practical and effective communication skills."
"Parent-child relationship, natural consequences, multi-cultural conflict."
"Quality time with kid."
"Structure makes me feel like I can relax occasionally in life."
"Ways to encourage children."
"I think what was helpful for me was learning about how to express love to my children."
"Cross-cultural differences and how to integrate into mainstream culture."
"Empathy and Understanding Asian Children."
"The "I message" I find most useful."
"Learn to use the word you as little as possible when speaking."
"Understand cultural differences. Introduce different effective ways to deal with various situations encountered in life."
"Build a bridge of communication between children and parents."
"Special time and love languages."
"Less punishment, and as many natural consequences as possible."
"Methods of educating children and their five languages."
"If you want to communicate more deeply with your children, it's not through the surface."
"Understand children's thoughts."
"Communicating with children."
"Showing understanding."
"Bonding each of my kids, self-care."
"How to use punishment correctly."
"Special time with my child."
"The one where I can see her, and I understand her."
"Special Time."
"All of the topics."
"Talking to my child more and get care for his feeling."
"Understanding and Communication."
"Understanding the differences in culture and generation."
"Understanding and Acceptance."

Post-Satisfaction Survey Comments for Question #4

4. What was the least helpful topic we covered?

"It is very suitable."
"None. All are useful."
"How to use special time to build a good relationship with children."
"Coping with stress."
"I don't have any."
"None. All very good and useful."
"Understand the self-identity of children and second-generation Chinese."
"Homework."
"Punishment. Because I started letting my child know when she would be punished when she was young."
"Most of them are useful, but we are new immigrants, so the temporary cross-cultural differences do not apply to us."
"Communication skills with children are difficult to achieve."
"The content of the class is very useful."
"All very effective."
"All practical."
"No, they are all quite useful."
"All topics were helpful."
"Nothing! All are very important."

Post-Satisfaction Survey Comments for Question #5

5. How did your relationship with your child change?

"Increased intimacy and trust with my children."
"My children are more willing to communicate with me, and I am more patient with them."
"Through me changing, my child has slowly positively change. We respect each other more and have a closer relationship."
"The relationship with my children becomes more understandable and will consider problems from each other's perspective."
"The relationship with my children is getting better and better."
"Become more patient. When I found the child's needs, the child trusted me even more."
"I give my child a hug every day."
"We have come to understand each other."
"I am trying as of right now."
"There isn't a huge change right now."
"We have more personal time for ourselves now."
"Through my changes, my children have also gradually changed. Our relationship has become closer and we respect each other."
"My children trust me more and our relationship becomes closer."
"Through learning, we can better communicate with children and better understand their needs and feelings."
"More harmonious, less anxious."
"More talkative."
"She is more willing to express herself. We developed some rapport, and maybe she's grown up a little and knows how to express her thoughts."
"I communicate a little more than before."
"She started talking to me about her relationships with her friends."
"I become more friendly and equal."
"I think my children are more willing to take the initiative to communicate with me."
"The child seems much happier."
"It still takes time and practice, but the change in mentality and attitude is relatively big."
"Easier to communicate than before."
"It becomes more harmonious."
"Unite knowledge and action, act immediately, correct mistakes when they are known."
"Give each other more respect and understanding."
"Know each other more."
"There are a lot less conflicts."
"She would be more patient and talk to me about the details of class and classmates."
"More harmonious."
"More in tune."
"We gotten more closer."
"My relationship was already strong. This class just allowed me to be more aware."
"Strengthened my communication skills with her. I became more aware of her emotions."
"It's still in progress."
"We have better communication with my sons."
"More communicative."
"We are working on a good relationship of talking each night."
"Great outcome. Conversing more with enthusiasm."
"It has changed for the best communication."

References

Ying, Y. (2007). *Strengthening intergenerational/intercultural ties in immigrant families (SITIF): Testing a culturally-sensitive, community-based intervention with Chinese American parents*. Journal of Immigrant and Refugee Studies, Vol. 5(2) 2007, The Haworth Press.

Munoz, R.F. & Ying, Y. (2002). *The prevention of depression: Research and practice.* Baltimore, MD: Johns Hopkins University Press.

Section IV

Inn

Innovation

MHSA Annual Updates 25/26

Innovation

The Riverside County Innovation Component projects of the Mental Health Services Act were designed to increase the quality of and access to mental health services for all members of the County through interagency and community collaboration. The projects provide a mechanism to affect change in the mental health field through the examination of a challenging problem via creative and evolving solutions.



Our current plan was approved by the MHSOAC on February 22, 2024, followed by approval by our Riverside Board of Supervisors on July 9, 2024. Project implementation began in August 2024. Over the past year, we have actively shaped a new Riverside County Innovation plan, an Eating Disorder Intensive Outpatient and Training Program, entitled The Mindful Body and Recovery Program. This Five-Year, $29 Million plan was approved by the State in February 2024. Designed to address the challenges of treating eating disorders, this project is creating an Eating Disorder Hub where we can examine how to best treat, train, and educate our Riverside County Community through an integrated care approach.

The Intensive Outpatient Program (IOP) will serve adolescents ages 12 to 18 years old who require this higher level of care. This project aims to address the critical need for improved treatment and care for individuals with eating disorders, which have the second-highest mortality rate among mental health conditions. By focusing on enhancing treatment practices, increasing access for underserved populations, and raising community awareness, we aim to improve both the quality and availability of care. This approach includes training practitioners and providing a level of care previously non-existent in public behavioral health.

In addition to the IOP, we will implement targeted education and outreach programs to promote early diagnosis and intervention, which are key to preventing the escalation of eating disorders and ensuring individuals receive timely treatment. Through these efforts, we aim to foster a deeper understanding of eating disorders and make a lasting impact on treatment outcomes and access to care for vulnerable populations.

Early implementation of the project started in August of 2024. Since then, The Mindful Body and Recovery Program has hired, trained, and onboarded staff, developed a strategic plan, and begun building its operational infrastructure. Moving forward, our next steps include welcoming members, creating, collecting, and distributing informational materials, and collaborating with plan partners to educate the community. Currently housed at the Perris Valley CHC, The Mindful Body and Recovery Project is set to relocate by the end of 2026 to the Mead Valley Wellness Village as part of the Capital Facilities project.

Our previous 5-year Innovation Plan, Help@Hand (Help at Hand), ended on February 26, 2024. The Help at Hand Innovation Plan explored the best ways to bring technology-based mental health tools into the public mental health service system. Riverside County planned and implemented nine (9) projects, all in alignment with the initial goals and objectives. Eight of the nine projects have been transitioned into our standard system of care to continue to serve the Riverside County community, with the ninth one continuing to inform our work with the Deaf and Hard-of-Hearing Community (DHoH). Information on the Help at Hand project can be accessed at https://HelpatHand.info.

The 722-page Help@Hand Statewide Evaluation Final Report compiled by the University of California, Irvine Help@Hand Evaluation Team can be found in the reports section of our Riverside County Website at https://HelpatHand.info. This research & evaluation outcomes report highlights the innovative research learnings and accomplishments of the (12) California counties and (2) cities that participated in the Five-Year Help@Hand California Statewide Collaborative of Digital Health Solutions Program. Take the opportunity to explore the full report which contains valuable research insights, lessons learned, and key takeaways beneficial to transform the Digital Health Arena.

Following, please find the Riverside County Final Report supplemented by two Whole Person Health Score reports on the digitization of the tool by the University of California, Irvine Help@Hand evaluation team and validation of the tool by the Patient-Reported Outcomes, Value, & Experience (PROVE) Center at Brigham and Women's Hospital, affiliated with Harvard Medical School.

NNI

Riverside University HEALTH SYSTEM Behavioral Health

Help@Hand Innovation Project Evaluation Report 2021-2024

Riverside University Health System— Behavioral Health- Evaluations Unit

help @ hand™

CONNECTING PEOPLE WITH CARE

RIVERSIDE

Authors: Suzanna Juarez-Williamson and Yuniar Praheswari– RUHS-BH Research and Technology Evaluations Unit

RUHS-BH Help@Hand Innovation Program

Riverside University Health System-Behavioral Health (RUHS-BH) joined the Hep@Hand Statewide Innovation Collaborative after putting forward a Mental Health Services Act (MHSA) plan to use innovation funds to bring technology based mental health solutions to the public mental health system in Riverside County. The Help@Hand collaborative was designed to provide opportunities for counties and cities to implement highly innovative technology solutions from a suite of applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional behavioral destabilization, connects individuals seeking help, and increase user access to mental health services when needed. The five-year RUHS-BH Innovation project focused on a set technology based mental services and solutions to increase access to unserved and underserved communities.

Target Populations

Hearing and Visually Impaired Communities Higher Risk Populations:

First Onset Re-entry

FSP Consumers Eating Disorders Suicide Prevention

Traditionally Underserved Communities:

Hispanic/Latino American Indian African American

Asian-Pacific Islander LGBTQ

Deaf and Hard of Hearing

5-Year
Retrospective
Help@Hand Innovation Meeting

Celebrating Five Years of Innovation
Changing Lives Through Technology



Project Evaluation

TakemyHand™



TakemyHand™

TakemyHand™ is a peer-to-peer live chat interface operated by RUHS-Behavioral Health Certified Medi-Cal Peer Support Specialists, providing anonymous live chat support using real-time conversations for people 16 years of age or older who are seeking non-crisis emotional support in Riverside County. TakemyHand™ website also offers resources and promotional materials (https://helpathand.info) to the Riverside County community. Access to the LiveChat is available Monday-Thursday 8:-5:00 and Fridays 8:00-4:00. LiveChat is accessed through the TakemyHand™ website. Website visitors can respond to the LiveChat invitation or utilize the resources available on the website.

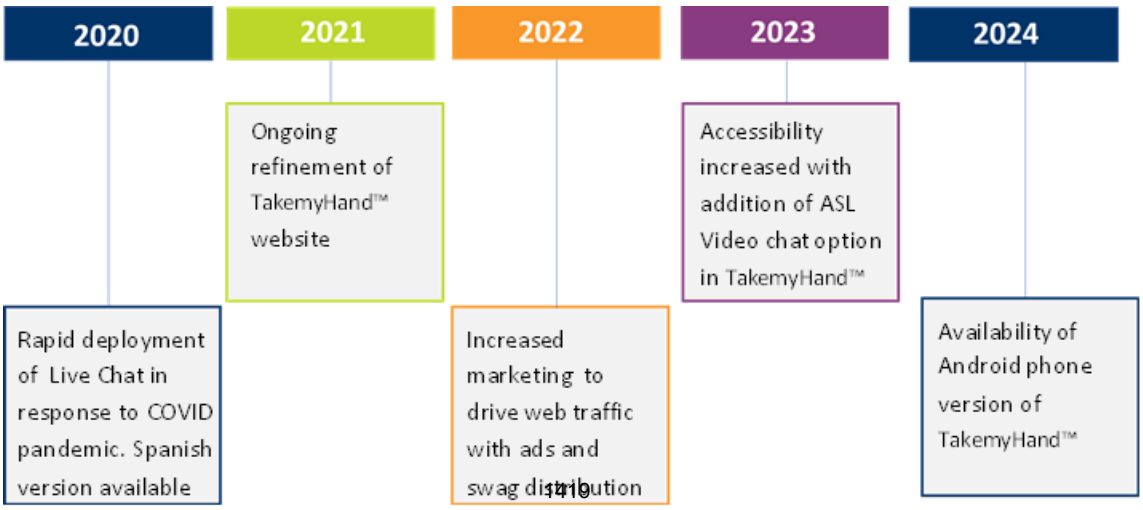
Implementation and Functionality Highlights:

TakemyHand™ was developed in response to RUHS-BH Peer workforce stakeholder input. Peer Support Specialist with lived experience developed the idea for a digital tool with an anonymous live chat, after reviewing the array of other digital tools available for piloting in the Help@Hand project. RUHS-BH Peer Support Specialist input was integral to the development and implementation of this product.

The TakemyHand™ framework developed is a website that uses the LiveChat Inc chat engine within the website. Training of Peer Support Chat operators was an important component of the product deployment.

The RUHS-BH Consumer Affairs Manager of the Peer Support specialist program established the expectations for the Peer Chat operators and developed a document for Peer Support Specialist to sign in as acknowledgement for their duties on the peer chat. In addition, the Senior Peer Support Specialist worked collaboratively with other staff to write a training manual on the functions of the LiveChat and how to operate accepting LiveChats. The training manual also covered goals and parameters of interactions and how to handle inappropriate response from people using the chat. Training occurred as new Peer Chat operators joined the team. Marketing strategies were implemented to inform the community including, billboards, bus shelters ads, bus wraps, radio (rural city), Google Ads, Department Facebook, Instagram, NAMI San Jacinto Facebook, LinkedIn.

Key Implementation Milestones



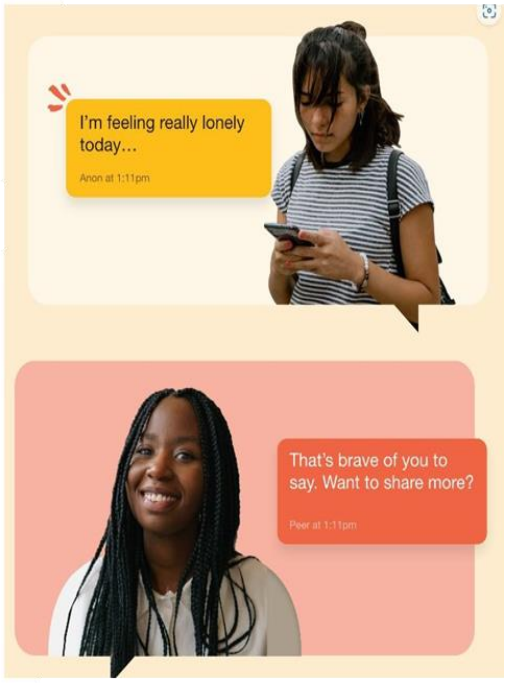
TakemyHand™

Welcome to TakeMyHand Peer Chat! A new resource brought to you by Riverside University Health System-Behavioral Health Help@Hand. Peer Chat Operators can provide emotional support to anyone experiencing feelings concerning behaviors or situations that may cause distress. TakeMyHand Peer Chat is an effort to provide support to our community. We are currently in an evaluation phase.

Please Note: TakeMyHand Peer Chat is not an emergency service. If you think you have a psychiatric or medical emergency, call 911 and request a Mobile Crisis Response Team. If you are an immediate danger to yourself or others please request the Community Behavioral Assessment Team.

CHAT NOW!

Anonymous. Safe. Always Free.



- Safe and anonymous
- Always free
- Data is never stored or shared
- Designed to help you feel better

This Is Your Opportunity To Be Heard, Validated And Empowered.

Like us, you most likely learned that you aren't supposed to talk about your struggles or challenges. Which can often leave you feeling more alone. Why not partner with TakemyHand Live Peer Chat to arrive at new solutions to a challenge?

Our peers can help. We are here to listen and support. We care for you.

We Offer:

1. Coping skills and resources
2. Safe space that's judgment free
3. A sounding board and good ear to listen

Hey there, need support? Tap here to start a live Peer support chat...

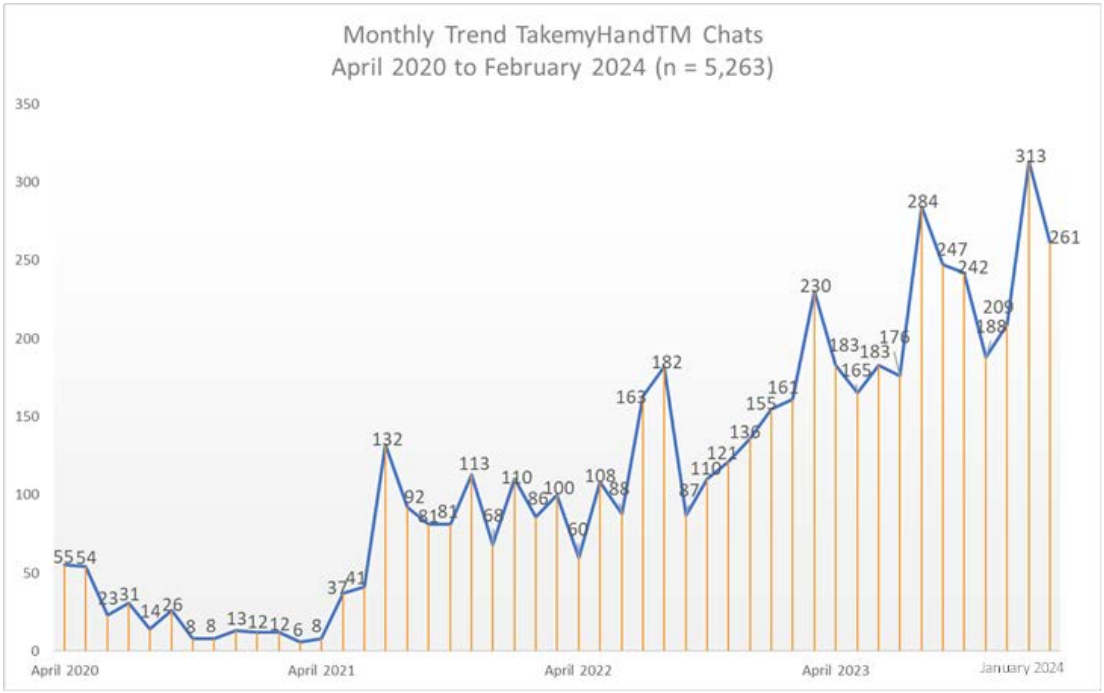


TakemyHand™

Evaluation Summary:

- Evaluate the overall use of TakemyHand™ Live Peer Chat
- Examine any feedback from chat users willing to complete the post chat survey

Between April 2020 to February 2024, the TakemyHand™ had a total of 5,263 chats. The total chats count by month varied, but has generally increased as the years of implementation progressed, with early 2024 having the most frequent chats. Over the most recent 6 months the average number of chats daily was 7 chats and the monthly average was 202 chats.



Total Live Chats: 5,263

Total Number of 1st Time Visitors: 3,772 (71.7%)

Average Chat Duration: 17:12

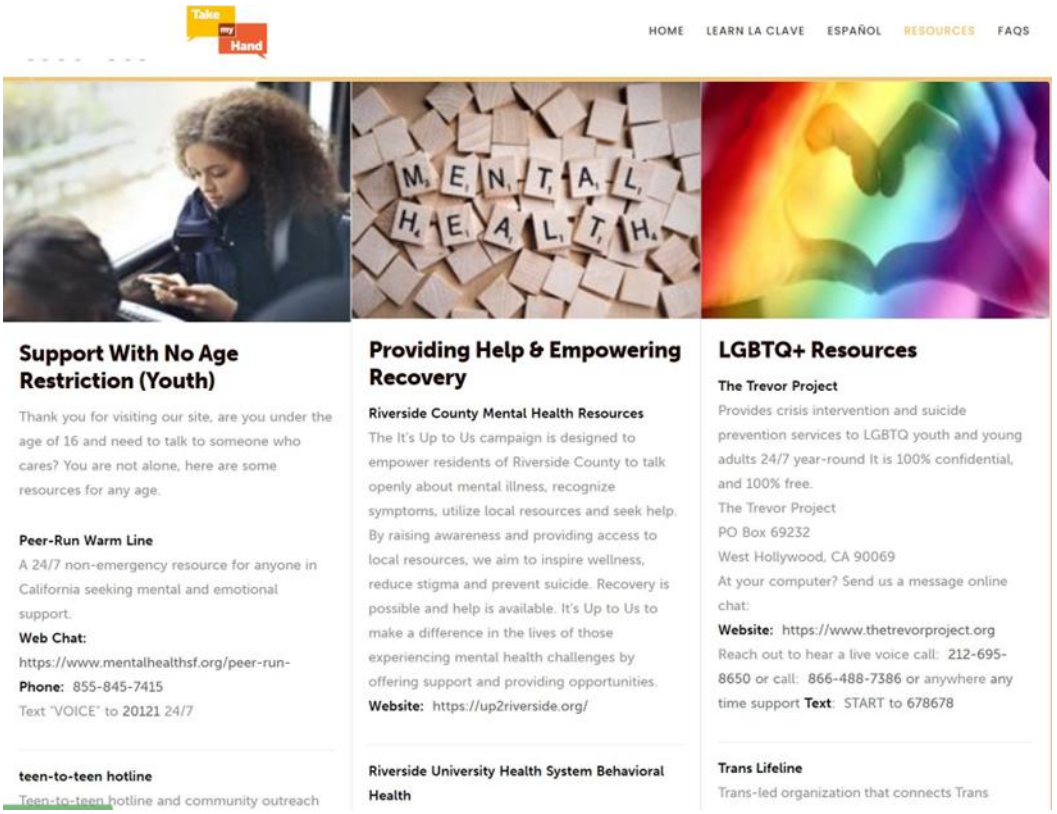
Average Response Time Answering Chat: 1:06

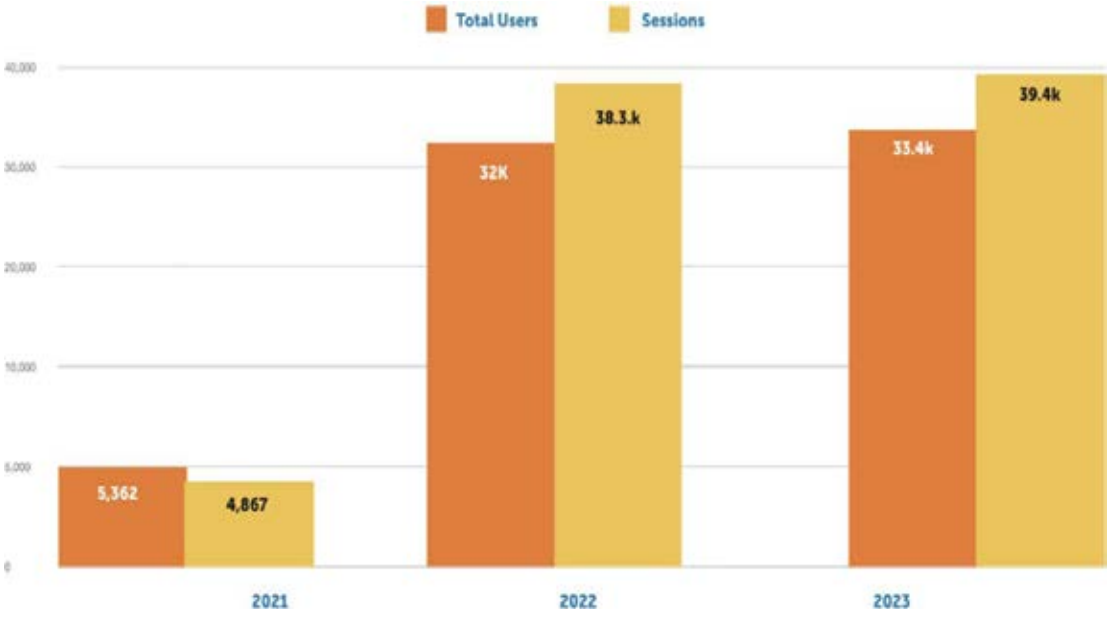
Most recent 6 months data:

- **Average Chats per month: 202**
- **Average Chats per day: 7**

TakemyHand™

The TakemyHand™ website provides resource in addition to the opportunity for Live Chat





TakemyHand™

Feedback from chat participants was solicited at the completion of TakemyHand™ chats with a built in prompt: *We want you to have a voice in how this chat service takes shape. Take a few seconds to answer questions that will make TakemyHand™ as peer-to-peer focused and responsive as possible*. Items focused on:

- **What was your experience using TakemyHand™ chats?**
- **Was the TakemyHand™ chat experience what you expected?**
- **Would you participate in TakemyHand™ chat again?**

The response rate to the survey questions was relatively low given the number of chats, however slightly more than 300 survey responses were collected. Chat participants chose to respond to some questions and not others so the sample size varied. Most survey items were in the form of a statement and participants were asked to rate the item according to ta Likert scale. Space for comments were available. Some demographic information was also requested.

Post-LiveChat Survey Items

Overall this chat was helpful

Strongly Agree-Agree-Neither Agree or Disagree-Disagree—Strongly Disagree

My overall experience using TakemyHand™ chat was...

Very Positive –Positive-Somewhat-Positive-Neutral Somewhat Negative-Negative-Very negative

This chat experience was what I expected

Strongly Disagree-Disagree-Neither Agree or Disagree-Agree-Strongly Agree

The support provided in this chat fit my needs

Strongly Disagree-Disagree-Neither Agree or Disagree-Agree-Strongly Agree

I am likely to participate in the TakemyHand™ chat again.

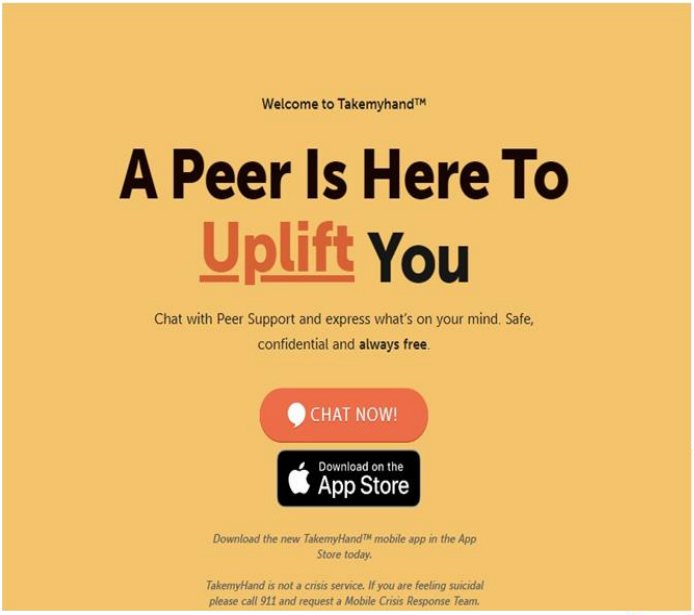
Yes–No

There were Technical problems during the chat Yes–

No

Overall, the TakemyHand™ chat participants responded that their experience was positive, helpful, what they expected, fit their needs, and the Chat was something they were likely to participate in again.

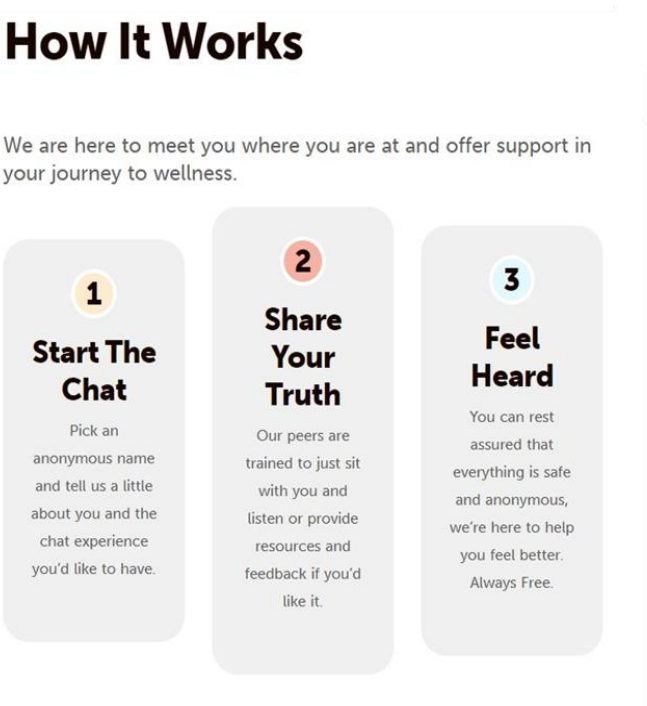




A Spanish version of the TakemyHand™ website was implemented in May 2020. Website visitors can choose the Spanish icon on the TakemyHand™ website to use a Spanish version. Spanish speaking Chat operators were also available.



Were there technical problems during this



I am likely to participate in the TakemyHand™ Chat again

YES

95% (n=300)

CHAT NOW!

Chat Participants comments:

Most of the comments were related to appreciation for the chat and the Peer Support Specialist.

"Thanks for helping me realize what to do."
"Thanks for what you do you seem amazing by the way."
"Very kind and helpful will make you feel better at the end of the day."
"I enjoyed our conversations, she is friendly, caring and wonderful peer, friend."
"Thank you for your help and the great resources Christopher. You went above and beyond!"
"Thank you (PSS) for being here for me today."
"Always an excellent supportive listener. Thank you!"
"The Chat was Fantastic!"
"(PSS) is awesome! He is very helpful, friendly, and empathetic! I appreciated him so much for his kind
words and wisdom. Thank you!"
"Thank you for being here for me today!"
"Third time speaking with Christopher and I am so thankful for him and his words of encouragement. You are
having a huge (positive) impact in my life and I hope you know that you're a very special person. Thank you!"
"(PSS) is a wonderful coach and very attentive, resourceful. love talking to her. Thank you!"
"Thanks (PSS) for helping me get my resources today."
"The chat was very nice, helpful!"
"(PSS) was nice and understands how I feel."
"(PSS) was so deeply empathetic and helpful. I am so grateful for the support. Thank you!"
"(PSS) is a super peer support specialist. Thank you!"
"Our chat was a Great Help!"
"Thank you for being here for me today!"
"(PSS) is a caring peer support specialist. Thank you!"
"Thank you! Theresa is excellent at listening and cares."
"Very helpful, patient, and a good listener."
"You're awesome!"
"(PSS) is a great listener and super helpful. Thank you."
"(PSS) is excellent! Thanks!"
"You are good."
"It prevented hospitalization and gave us new coping skills and knowledge that I do have someone to reach
out to in crisis right now."

TakemyHand™

Testimonials collected from participants

Caring testimonials from our Chat Patrons

"I just want to say that I spent about an hour talking with Christopher and I have not left feeling a conversation in my entire life with so much growth as I did with him. Christopher listens, is empathetic and just very mature. I give him 100 stars out of 10—he was that great to me! Thank you so much and I hope to talk with you soon!" 5/23/2023

I've been wanting to write you an email and introduce myself. And tell you what I think and feel about the Take My Hand App on my phone that I currently use a lot to chat with real Peer Supports. I can even name a few of them so I will, Ilene, Lisa, and Juan have been super mental health peer support specialist.

They deserve a raise too. All that they have heard from me has been possibly hard to hear, and I want them to know that I really appreciate them! This is one of those many moments when you hope you meet them one day. They have said I am very resilient and that I would be a great mental health peer support.

"My point in writing this email has been because I want to you to know that the peer supports on the Platform Take my Hand need and should be recognized for their hard work. That they do to support us all on a daily. They have said they are not AI bots. I hope they really aren't also." *12/28/2023*

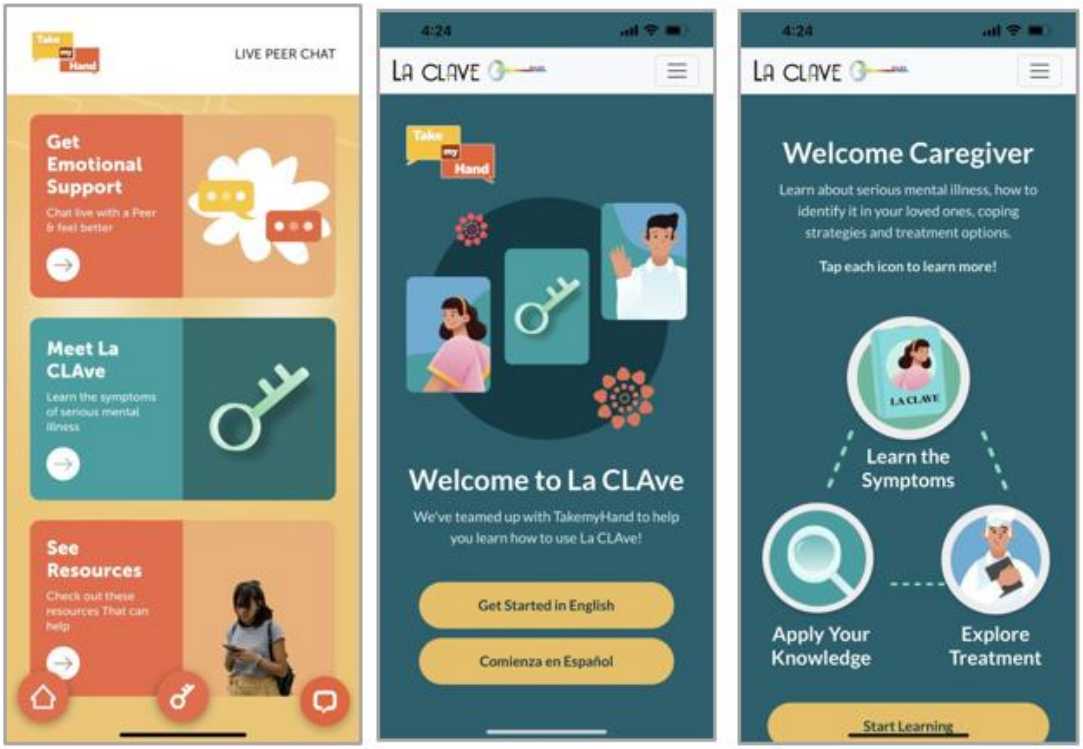
TakemyHand™

Future Directions:

TakemyHand™ has transitioned beyond the implementation during the Help@Hand project. The website and LiveChat is locally maintained and operated by RUHS-BH. Certified Peer Support Specialists manage the LiveChat during business hours. The ChatBot is available during non-business hours to respond to chat requests and steer chat visitors to the resources page on TakemyHand™ . The volume of chats per day is relatively low at about 7 per day, and is manageable for the staff that complete other duties in addition to the chat. Outreach to drive traffic to the site will continue.

Future plans for enhancement for TakemyHand™ is to include a Wellness check-in survey that could be used to encourage and support help seeking through the resource page, and also could increase use of the LiveChat.

The addition of La CLAve as a tool to increase mental health literacy and to increase access to resources will continue. This component could be developed further to support the implementation of the RUHS-BH First Episode Psychosis program.



Project Evaluation

APP for INDEPENDENCE A4i



App for Independence (A4i)

RUHS-BH piloted the App for Independence (A4i) a digital technology for individuals with schizophrenia spectrum diagnoses. A4i is a phone app designed for those with schizophrenia symptoms and is built to engage both the consumer and the mental health providers serving that consumer. The app features include: Notes sent by the consumer to their mental health provider, a Newsfeed that supports connection to a community of people with similar challenges, Check-Ins to track mood, sleep, and goals, medication reminders, and an ambient sound detector to aid those with auditory hallucinations to differentiate environmental sounds from hallucinations. A4i features also include a clinical dashboard for providers to view client Notes sent, and client responses to A4i mood, sleep, goals and medication Check-Ins. The provider dashboard is meant to accessed by the clinic "Care Team" who provide services at the County clinic.

Implementation Highlights:

The process for selecting A4i as a pilot app was a collaborative process involving the RUHS-BH Peer Support Specialists (PSS) staff assigned to the Help@Hand project. PSS staff reviewed multiple digital apps to make recommendations on potential apps for RUHS-BH to pilot. The criteria included reviewing apps that could support the high-risk population of focus. After reviewing multiple digital apps, the PSS staff recommended A4i or Focus as potential apps to test in a pilot for high risk populations. A series of focus groups with RUHS -BH consumers were conducted to gather feedback on which app the consumers preferred for the pilot. Due to the COVID pandemic in 2020 the focus groups were conducted on Zoom. During the focus groups the functions of each app were shared with app screen shots or with actual sharing of the app in Zoom screen share. A4i was preferred by consumers slightly more than the Focus app because of the additional features available in A4i.

The A4i pilot implementation required managing multiple project components including: training staff in the use of the A4i, managing smart phone devices distributed to consumers for use during the pilot, and development of training materials, welcome packets for consumers, and protocols. Initially the team of Peer Support Specialist staff for the Help@Hand project used the A4i app to become familiar with the features and functionality.

Pilot participant recruitment began by marketing the pilot to County clinic supervisors through a series of emails and presentations. Recruitment initially focused on the adult Full Service Partnership programs with expansion to additional populations in Older Adult clinics and TAY Drop-in centers. Clinic staff referred consumers they believed fit the criteria of Schizophrenia Spectrum diagnosis, and who would be interested in participating, and could benefit from using the A4i app. The piloting of the A4i app was designed to occur over a six-month. Period. However, the recruitment was targeting at least 90 consumers which occurred over a period of months. Since recruitment was occurring in a rolling process, consumers enrolled over he course of the pilot. Consumers graduating from the pilot completed 6 months using the A4i.

A4i Pilot

A4i Participant On-Boarding & Features and Functionality

RUHS-BH Help@Hand Peer Support Specialist contacted referred participants to engage the consumer and further describe the expectations and benefits of participating in the pilot. If the consumer agreed an orientation appointment was set with a Peer at a location convenient to the consumer. Sometimes the orientations were done in the clinic sometimes at a home visit or other community location. The orientation appointment was designed to be a welcoming and engaging process. The RUHS-BH Peer Support staff designed a Welcome Packet to use during the orientation. The Welcoming packet included a consent to participate in the pilot, which outlined the benefits and responsibilities of being in the A4i pilot, and the incentives consumers would receive for participation. The consumers were given a Smartphone with a phone plan including data. Participants were asked to sign a Device Agreement and Waiver for the Smartphone. The phone was preloaded with the A4i App and several other mental health digital tools. The Welcome packet also included content on the other digital mental health apps loaded on the phone.

The RUHS-BH Help@Hand Peer Support Specialist also created workflow documents for the Help@Hand Peer team and the County clinic staff with enrolled participants outlining the process steps for entire pilot. In addition, a manual with screen shots was created for the County clinic to use as a reference guide on the use of the A4i and how to view the dashboard.

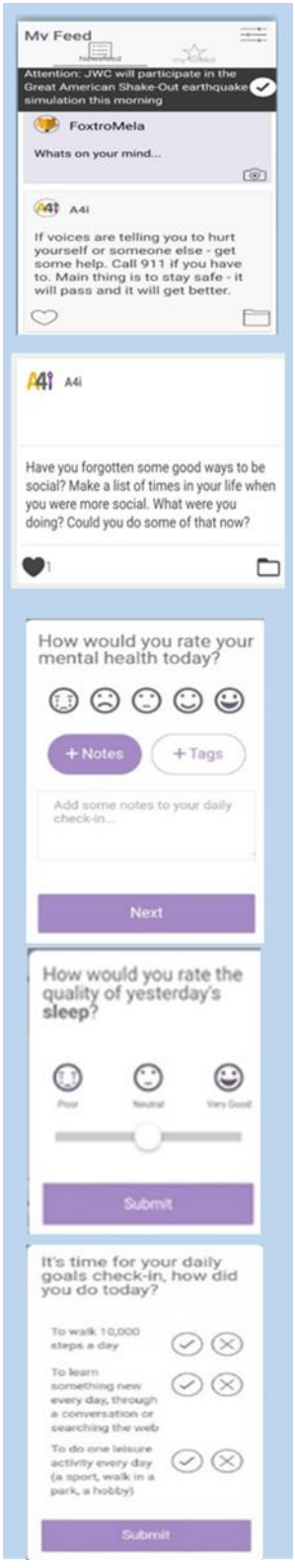
Early in the pilot it was clear the Help@Hand Peer Support Specialist would need to support the County clinics with the functions that would typically be completed by the County Clinic “Care Team”. The County clinics varied with regards to their need for this type of support. Help@Hand Peer Support Specialist moderated the post to the feed to ensure the A4i consumers’ post could be put on the Newsfeed, and created and posted their own content to the Newsfeed to support consumers with recovery focused messages.

Peer Support Specialist also supported consumers with any technology issues with the County issued phone, and with challenges navigating the A4i App. The communication between the Peer Support Specialist and the A4i consumer proved invaluable in finding challenges with how the A4i app functioned. This communication combined with information from the one month interviews was relayed to the A4i developers, MemoText, during weekly meetings. MemoText was very responsive and creative in upgrading making adjustments and upgrading the A4i app features based on the feedback form users. These were rolled out as quickly as possible to support A4i consumers as they used the app through out the pilot.

A4i Pilot

A4i Features and Functionality

Newsfeed



A4i has developed a "newsfeed" similar to a social media platform that allows user and providers to post content to a community of A4i users providing a safe space for support. Newsfeed content is reviewed by staff before it is posted including consumers posts. A4i directly delivers content to the Newsfeed. A4i created posts and prompts can be uniquely designed for each user's need. These posts make suggestions and provide support and resources relevant to coping with symptoms of schizophrenia, psychosis, thought process challenges, motivation and anxiety. Each user's posts can be tailored to their needs based on a short questionnaire.

Content on the Newsfeed was also generated by the Peer Support Specialist or Care team members. The newsfeed platform was interactive as the community of A4i consumers can also post to the feed. This provides additional content for support.

Anonymous A4i users can support each other and react to post. A4i users can interact with posts on the news feed in two ways: by liking a post which will show for all the users, or by selecting the heart icon. User could save posts to a folder in the app tool kit for later use.

Daily Mental Wellness Check-In

This feature is especially important for an A4i user and the care team to track the users mood. This check-in appears in the clinical dashboard for providers to follow-up with their consumer based on their self-report of mood. A4i prompts automatically when the app is opened by asking, "How would you rate your mental health today?" User can rate themselves from sad to happy.

Daily Sleep Check-In

The feature functions similar to mental Wellness check in each day the user is prompted to rate their sleep quality. A4i also monitors mental health and sleep quality trends that can alert the care team members for negative trends, which will also trigger email notifications to the clinical staff.

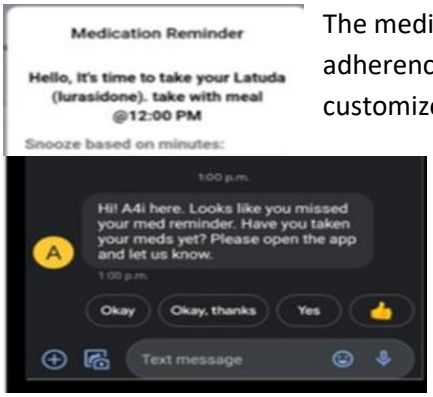
Goal Achievement Check-In

The A4i app has a Goal-Setting tool to aid users on their journey to wellness. After

setting up their goals the app will track goal achievements through check-ins. The daily prompt and data from responses provides the opportunity for the consumer to monitor their success. A4i will send support in the form of coping skills and suggestions to assist in their success as well as alert the care team when there are patterns of challenges. This feature is built in the A4i app to aid in the users' success , and can be customized with the user's care team during registration. Setting and meeting personal goals no matter how small is an important element to supporting the consumer on their journey to wellness.

A4i Features

The medication reminder



The medication reminder feature is used to help support medication adherence and improve successful outcomes, and it can be customized for each medication name, time it should be taken, and any special instructions. Setting up medication reminders is simple and can be done through either the A4i app or the care team portal. Each reminder can be snoozed for 15, 30, or 60 minutes if it is not convenient to take the medication at the set time. Users are able to indicate when they have taken a medication ahead of time, if they have already marked the medication as taken the reminders for that medication and time is turned off. (Note: only for medication reminders that are under the TODAY section set time).

A4i also tracks medication adherence based on interactions and responses from the user over time to track adherence patterns and
escalate notifications to clinical staff for "low medication adherence

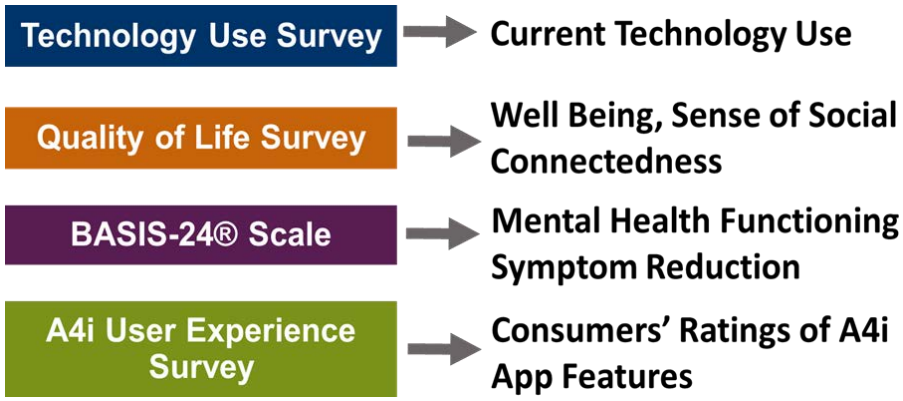
A4i Pilot

Evaluation Summary

The main goal of this pilot implementation is to test the impacts of using the A4i application in a real-world community outpatient setting to support consumers with schizophrenia spectrum disorders. This pilot will seek to understand if the A4i application is feasible to deploy in a community mental health clinic with the intended target populations. Program evaluation will examine the extent to which individuals with
schizophrenia spectrum or other psychoses are able to efficiently utilize and benefit from the features of A4i. Key Evaluation Questions:

- Evaluate pilot participants experience with A4i regarding acceptability, likeability, usability, usefulness of features, successful adoption (frequency of use, retention rate); and any variations in these factors
  among different target populations.
- Evaluate pilot participants reported increases in social connectedness; well-being; sense of connection to care team; and symptom reduction.
- Evaluate the impact of using A4i on consumers setting goals and goal attainment.
- Evaluate the extent to which the A4i technology can be used by the clinical care team to detect changes in mental health status that would prompt care team staff to initiate an intervention.

A4i Evaluation Survey Measures



Data collection for the pilot used an engagement approach . Since the Help@ Hand Peer Support Specialist (PSSS) were completing welcoming and orientations with consumers, they incorporated intake data collection into their welcoming and orientation process. The consumers received incentives for the completion of measures and qualitative interviews. The PSS maintained a tracking sheet to ensure they collected 3-month and 6-month follow-up data. The PSS also assisted with scheduling qualitative interviews with a graduate student from Claremont Graduate University to independently collect the interview data from consumers. PSS staff ensured consumers received their incentives for completing the intake, and follow-up survey packets.

A4i Pilot

A4i Pilot Measures

The figure below shows the A4i Data Collection interval schedule and the measures collected as pre-to post and those that were collected only once.

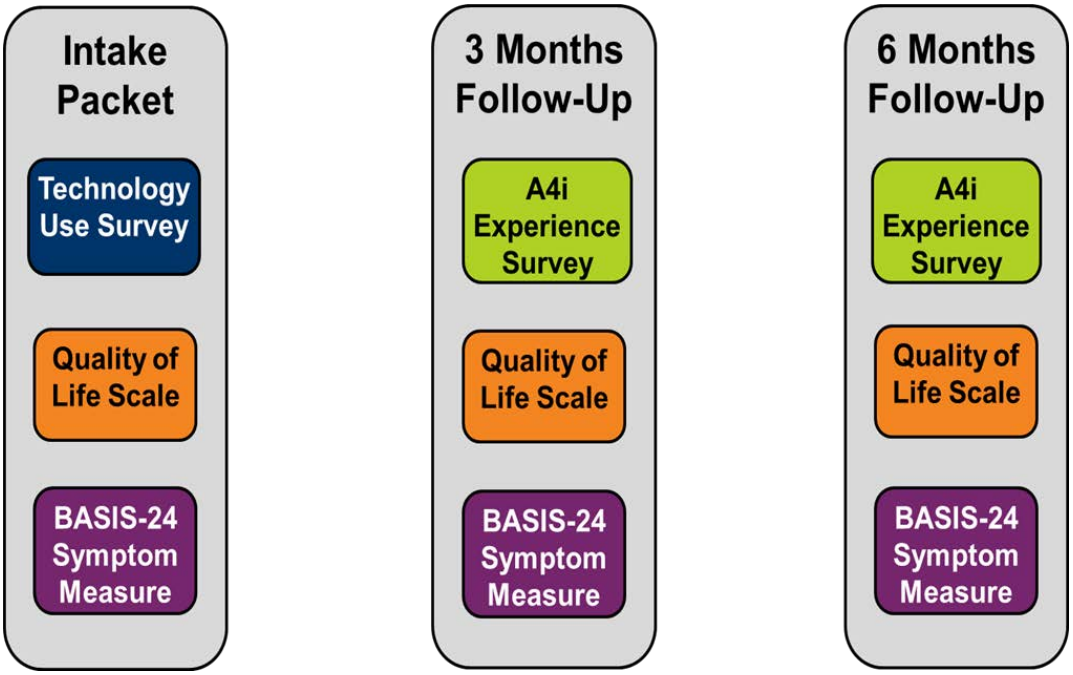
Technology Use Survey-This survey was used specifically to gather information on the participant's current use of technology including devices they use, any experience with technology, and experience with mental wellness applications. Participants were asked to complete this survey at intake. The survey consisted of 12 questions, and the questions focused on the use of phones, computers, and internet use (e.g. do you use any smartphone application, total number of hours/week of using computer/phone, what do you usually use your computer/phone for, etc.).

Quality of Life and BASIS-24:

Quality of Life and the BASIS-24 were collected 3 times to obtain pre, mid, and post data (a 3-month data collection was included in the event consumers left the pilot prior to the 6-month end of the pilot).

A4i Experience Survey:

This survey was used specifically to gather participants' experience with the A4i app and was also administered at 3 months and at 6 months.



A4i Pilot

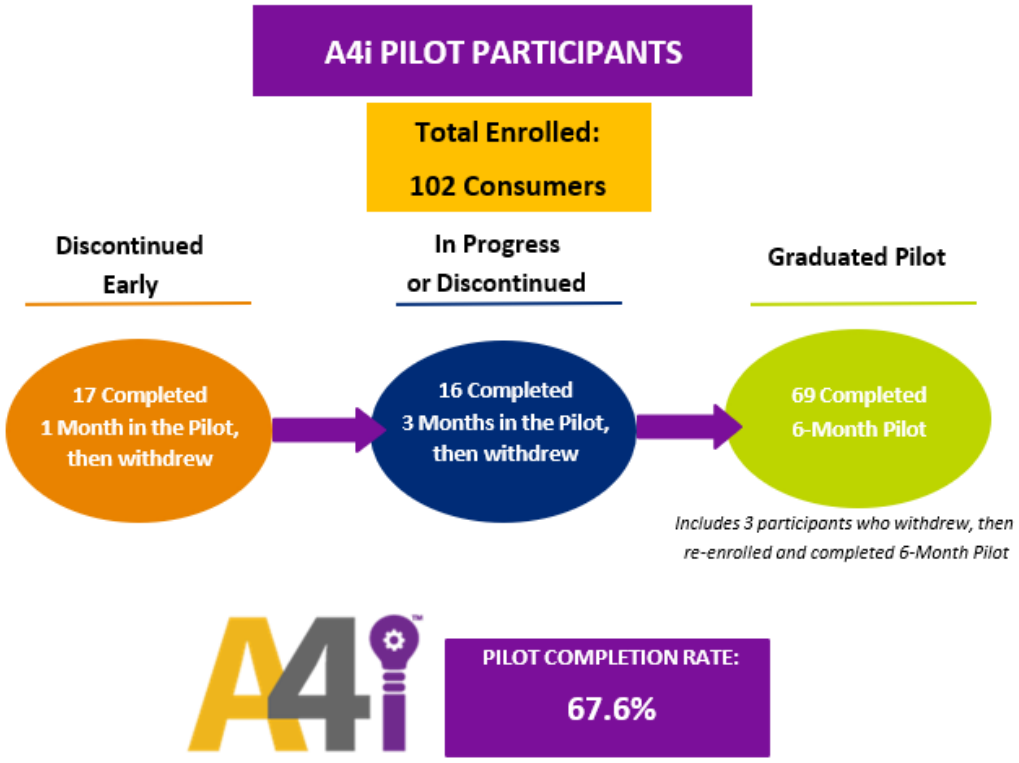
A4i Pilot Participants

A total of 102 consumers enrolled in the A4i pilot. Enrollment occurred between 2021 and 2023. The data below shows the pilot completion rate for the A4i enrolled consumers.

A4i Summary of Completion

Total counts of participants who completed 1 Month in the A4i Pilot (*completed Intake Form, received A4i Phone, and registered as a user for the A4i Application*) then withdrew from the program:	**17**
Total counts of participants who completed 3 Months in the A4i Pilot (*completed Intake Form & 3-Month Outcomes*) then withdrew from the program:	**16**
Total counts of participants who completed 6 Months in the A4i Pilot (*including 3 participants who withdrew then re-enrolled and completed the program*):	**69**

Total counts of enrolled participants: 102



A4i Pilot

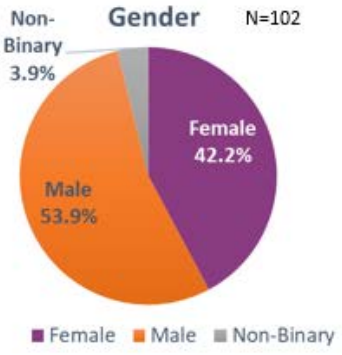
A4i Pilot Demographics

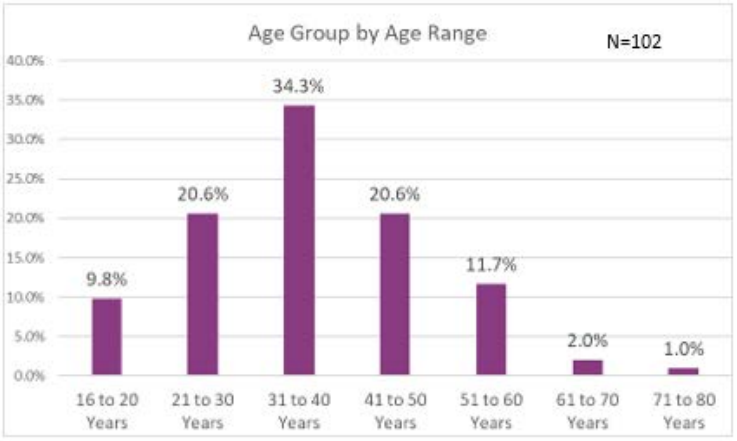
The following figures provide the demographics of the A4i pilot participants (n = 102).

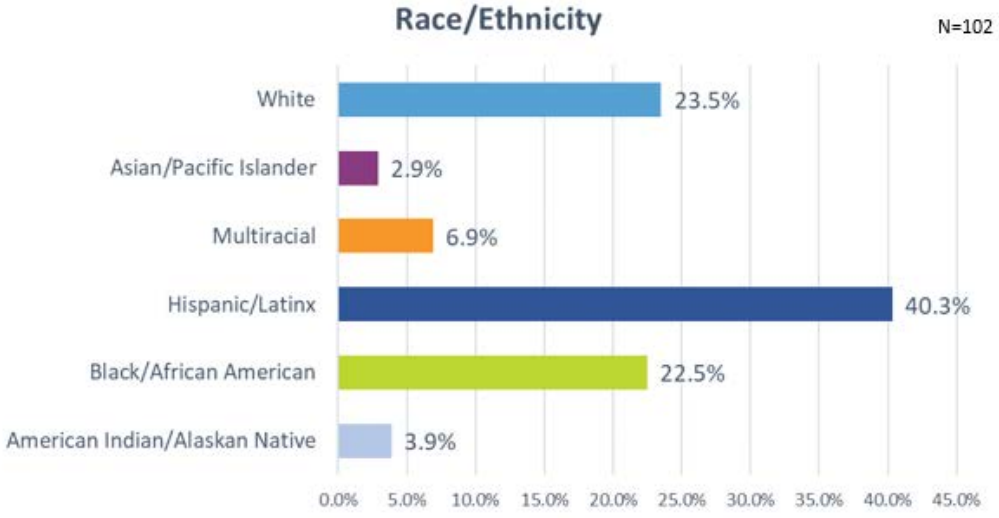
- More than half the A4i participants were Male (53.9%, n = 55), followed by Female (42.2%, n = 43), while 3.9% (n = 4) reported they were Non-Binary.

- Most A4i consumers were Adults (78.4% ,n = 80) between the ages of 26 to 59 years old, with many (34%)reported an age between 31 to 40 years old.

- The majority of A4i participants were Hispanic/Latinx (40.3%, n = 41), followed by White(23.35%, n = 24) and Black/African American (22.5%, n = 23). The remaining participants reported they were Multiracial (6.9%, n = 7), or American Indian/Alaskan Native (3.9%, n = 4), or Asian/Pacific Islander (2.9%, n = 3).





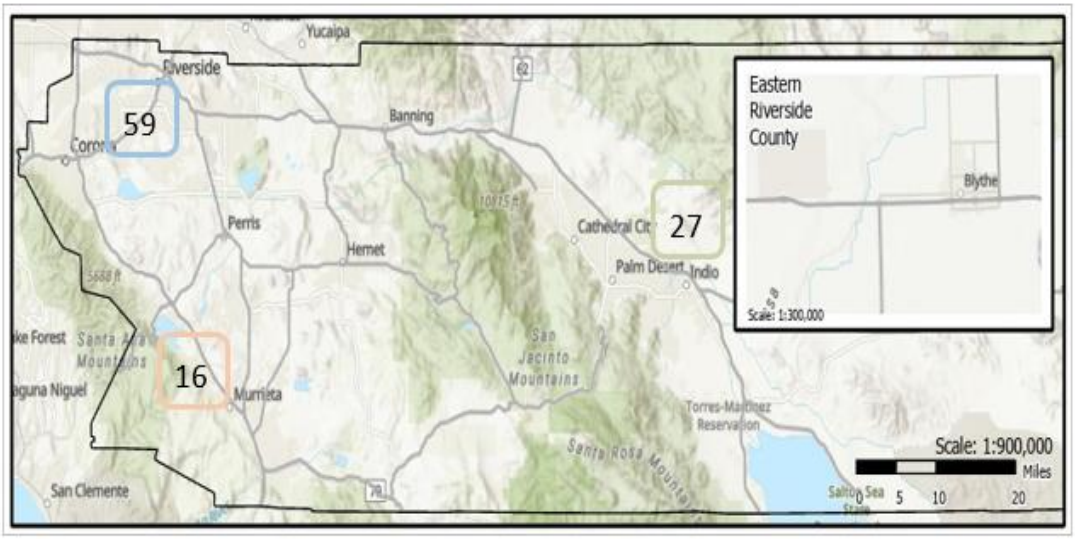


A4i Pilot

A4i Pilot Demographics

Additional demographics for A4i pilot participants (n = 102).

- 20% of A4i consumers reported they identify as LGBTQI
- 92% reported their preferred language as English.
- 59% reported that and a disabling condition and a few indicated they were Hard of hearing.
- The majority of enrollments in A4i: 52% occurred in 2023, and nearly a third (32%) occurred in 2022.



Western Region

West Adults FSP-27
Re-Entry Adult FSP-12
West Adult Clinic-9
Peer Support
Recovery Center -6
West TAY –1
West Older Adults-4

Mid-County Region

Lake Elsinore Adult Clinic-9
Temecula Peer Support Recovery Center-7

Desert Region

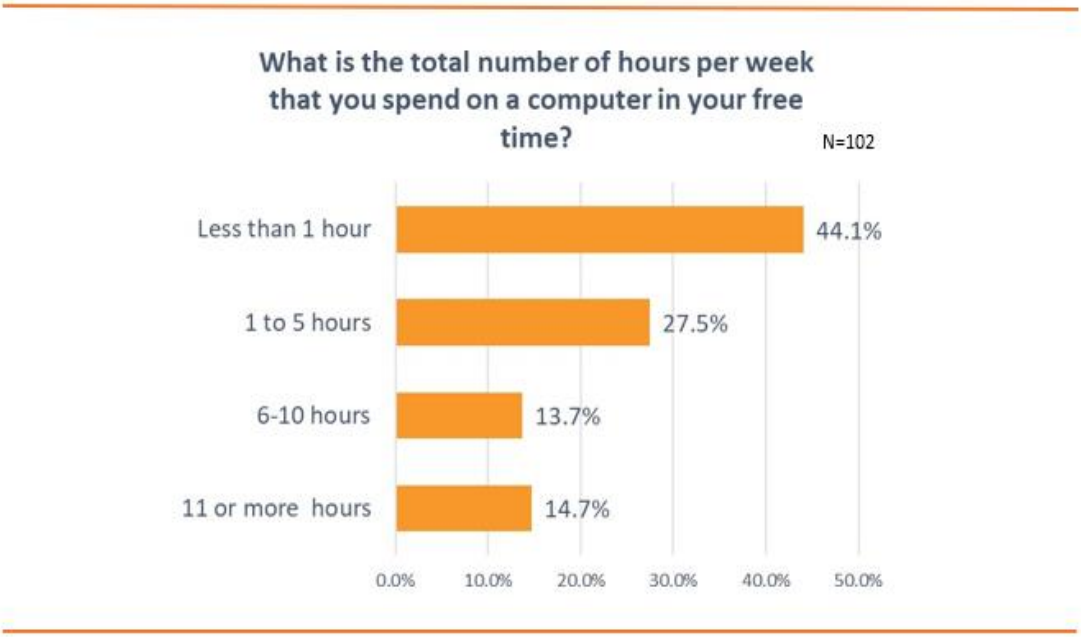
Windy Springs FSP-2
Indio Peer Support Recovery Center-13
Desert TAY-12

A4i Pilot

A4i Pilot Enrollment Technology Use Survey

Technology Use survey results showed:

- A4i consumers used technology devices, including Smart phones (88%), and more than half 58% use a laptop/desktop, a slightly less than a third used a tablet, 24% used a basic phone. Only 2% reported not using one of these technology devices.
- A4i consumers frequently used computers and their phone to access the internet.



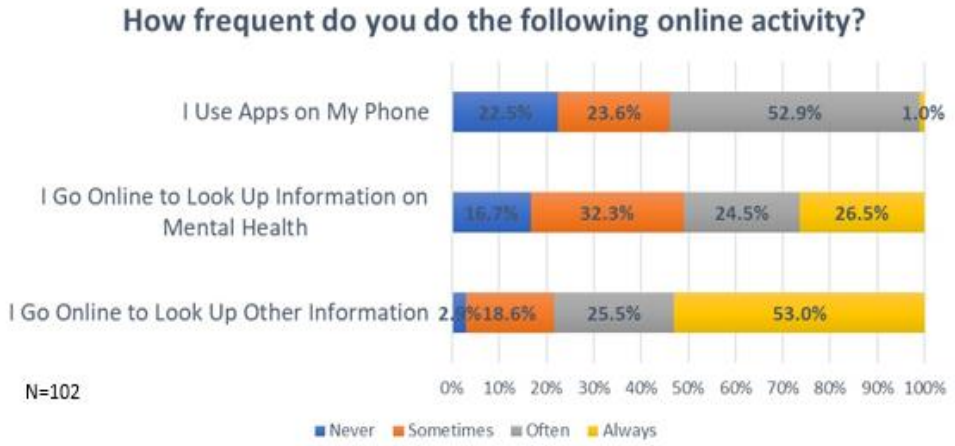


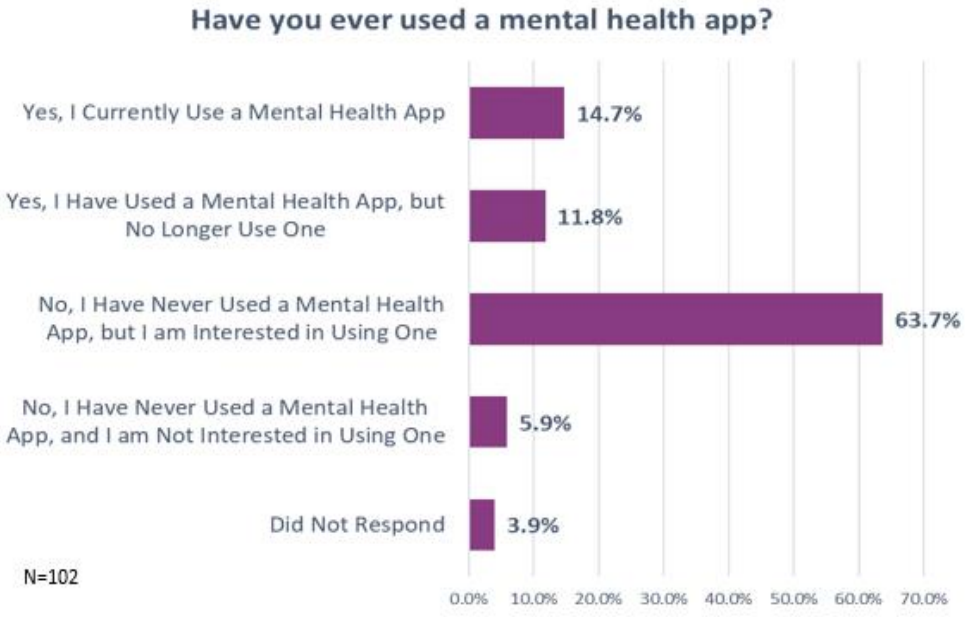
A4i Pilot

A4i Pilot Enrollment Technology Use Survey

Technology Use survey results showed:

- More than half of A4i consumers (54%) reported they use phone apps.
- Half of A4i consumers (51%) reported they go online to look up information on mental health.
- More than three quarters reported they go online to look up other information.
- Nearly two-thirds (64%) reported they have never used a mental health app but were interested in using one.





A4i Pilot

A4i Pilot Enrollment Technology Use Survey

Technology Use survey results showed:

- Most of A4i consumers (83%) felt confident "*Using their Phone or Computer/Tablet to Get Information"*
- Many (80%)reported they felt confident using phone apps

Comments and the types of apps A4i consumers have used were also collected. Below are a list of phone applications consumers reported using, and comments collected on the technology use survey.

Phone Apps Used
"I used A4i previously."
"Calm, Calm Music."
"Calm, Relax Melodies, Head Space."
"Daily Journal, Wobot, Breathe, Fabulous."
"DBSA App."
"You Tube."
"Finch, I am Sober."
"Fixer App (IEHP)."
"I am Sober app."
"Journaling app."
"Meditation app."
"Meditopia."
"Web-Care."
"WRAP."
Internet Use
"I have never used a mental health app, but I looked up online for tips and advice to be a better healthier individual."
"I never used one but I'm interested so I can be in tune with my emotions and find a healthy way to help myself cope with what I'm going through."
"I tried using the phone app once. I don't remember what happened. I returned the phone and said I wasn't interested and would be going back to school. I would like to try again. My communication is just okay for me."
"Nami Forum Board & YouTube."
"Researched to learn more about apps."
"Telehealth app for doctor appointments."

A4i Pilot

A4i Pilot Enrollment Technology Use Survey

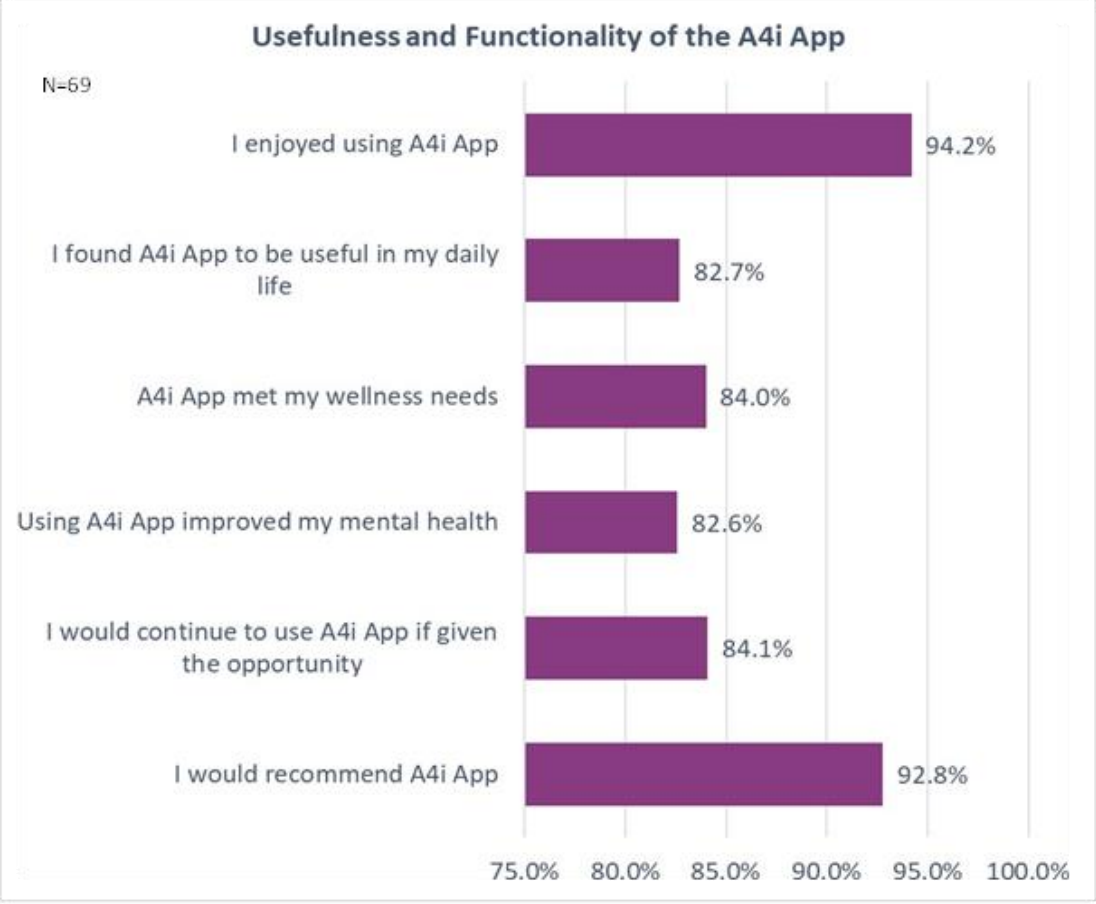
After participating in using the A4i app for at least 6–months consumers were asked to complete the A4i User Experience survey. Only data for those completing 6-months in A4i was used for analysis. The User Experience Survey had 38 questions focusing on the functionality of the app and any benefits the consumers believed they gained from using the app. The results of 69 consumers who completed the A4i pilot are included in the following data. Percentages below reflect "Agreed" or "Strongly Agreed" responses to the survey item statements.

Usefulness of A4i and Functionality

Most responses were positive with regards to usefulness and functionality. The top 4 were as follows:

- 94.2% enjoyed using the A4i App.
- 92.8% would recommend the A4i app.
- 89.8% thought A4i was easy to use.
- 86.9% thought the information on A4i is credible and trustworthy.

The figure below reflects items related to benefits of the A4i app and continued use of A4i.



A4i Pilot

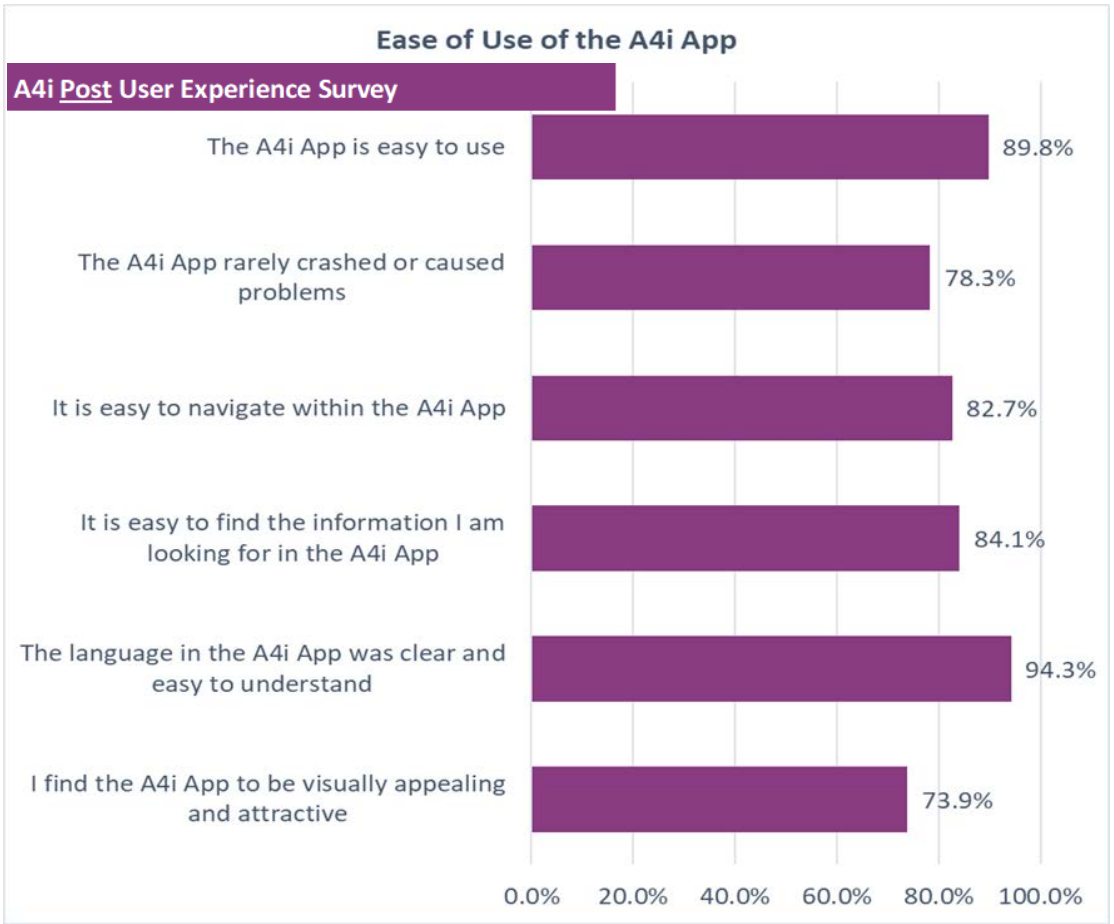
Most responses on ease of use were positive . However two aspects of the app had lower ratings on the survey;1). “I find the A4i app visually appealing” and ,2). “The A4i app rarely crashed or caused problems”. For these two items ratings were slightly more than 70 % were rated at agreed or strongly agreed. Early in the deployment of A4i, several features mostly the Check-Ins for medication, mood, sleep and goals were challenging due to the timing of when the check-in appeared in the app. It was early feedback from consumers that contributed to A4i developer upgrades during the pilot. This feedback was gathered in 1 month interviews and from PSS as they provided tech support for A4i users.

A4i Ease of Use

Most responses were positive with regards to ease of use. Percentages are agreed or strongly agreed with the item statement. The top 4 were as follows:

- 94.3% the language was easy to understand.
- 89.8% the A4i app was easy to use.
- 84.1% easy to find information looking for in app.
- 82.7% easy to navigate within the app.

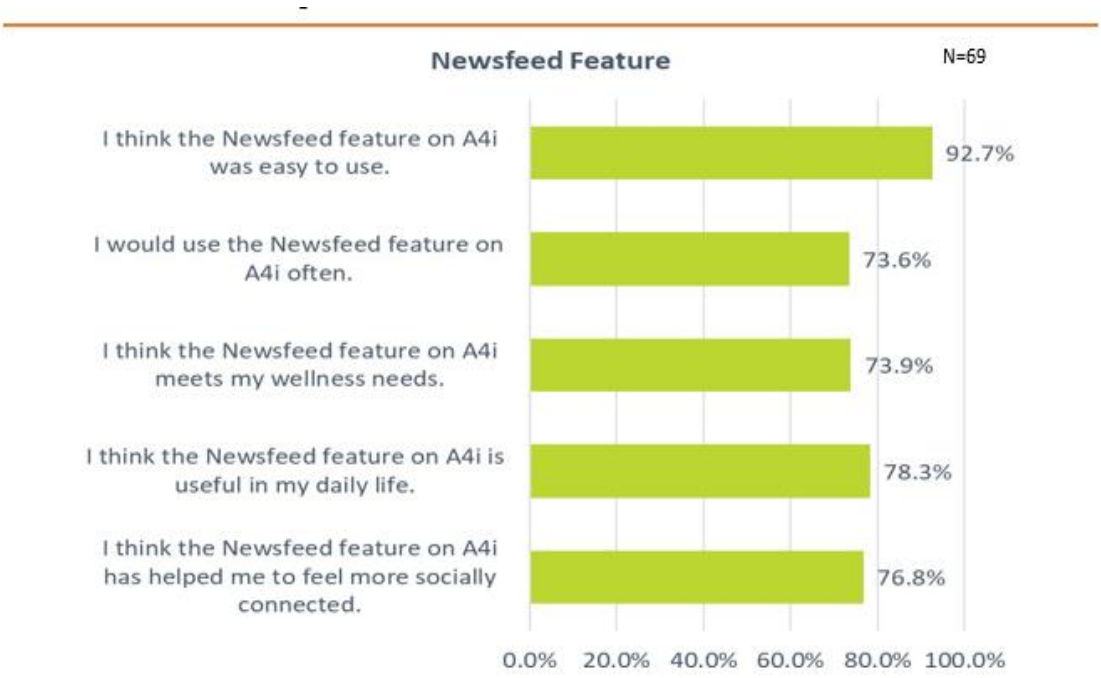
The figure below reflects items related to benefits of the app and continued use of A4i.



A4i Pilot

A4i Post User Experience Survey

User experience with specific features in the A4i app also showed positive experiences. In particular, the Newsfeed feature. The Goal tracking feature showed some positive responses as well. A4i app utilization data showed the Goal tracking feature was used far less often than the Newsfeed.





A4i Pilot

A4i Post User Experience Survey

Below are other items analyzed from the A4i User Experience surveys of graduated participants (n = 69). Percentages below reflect “Agreed” and “Strongly Agreed” responses to other A4i app features.

Content and Security

- ⇒ 75% of participants trust A4i with their personal information.
- ⇒ 87% of participants felt that the information on A4i is credible and trustworthy.
- ⇒ 96% of participants felt that the content in A4i is appropriate for them.

Costs of Using A4i

- ⇒ 93% felt they have the resources necessary to use A4i app.
- ⇒ Only 13% felt concerned about the costs associated with using A4i app.

Culture and Values

- ⇒ 89% felt A4i values and respects cultural differences
- ⇒ Only 46% felt that A4i demonstrates knowledge about their culture, while 23.5% felt neutral.

Notes Feature

- ⇒ 81.2% felt the Notes feature on the A4i app was easy to use
- ⇒ Only 50.0% used the Notes feature often, while 23.5% felt neutral about using the Notes feature

A4i Pilot

A4i Utilization Data

Utilization data was available directly from the A4i app. Files of user activity in A4i were provided on a monthly basis. In examining the consumers' use of the A4i features, the data was analyzed based on the number of times consumers engaged in the activity in the app. User data directly available from the app is recorded as an activity logged. Using this data is was possible to determine how frequently a feature was used.

User Engagement Data by Activity Type

Posting to Feed

- 91% of consumers used Newsfeed feature.
- 28,290 "Post to Feed" were recorded.
- 92% of consumers used the feature at least 10 times.

Medication Reminder

- 50% of consumers used the "Medication Reminder.
- A total of 13,082 "Medication Reminder" logs were recorded.
- 86% used the "Medication Reminder" feature at least 10 times.
- 94.2% confirmed in the app whether Medication was taken.

Goals Check In

- 82% used the "Goals Check In" feature.
- A total of 5,461 "Goals Check In" logs were recorded.
- 78.6% used the "Goals Check In" feature at least 10 times.

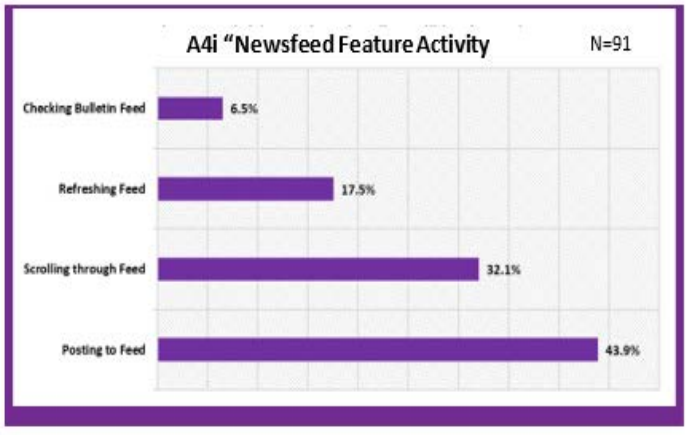
Notes to Care Team

- 65% of consumers used "Notes to my Care Team" feature. At least once.
- 266 "Notes to my Care Team" were recorded.

Sound Detector

- 66% of consumers used the "Sound Detector" feature.
- A total of 1,003 "Sound Detector" logs were recorded, 46% were identified as "Correct Sound Detection".

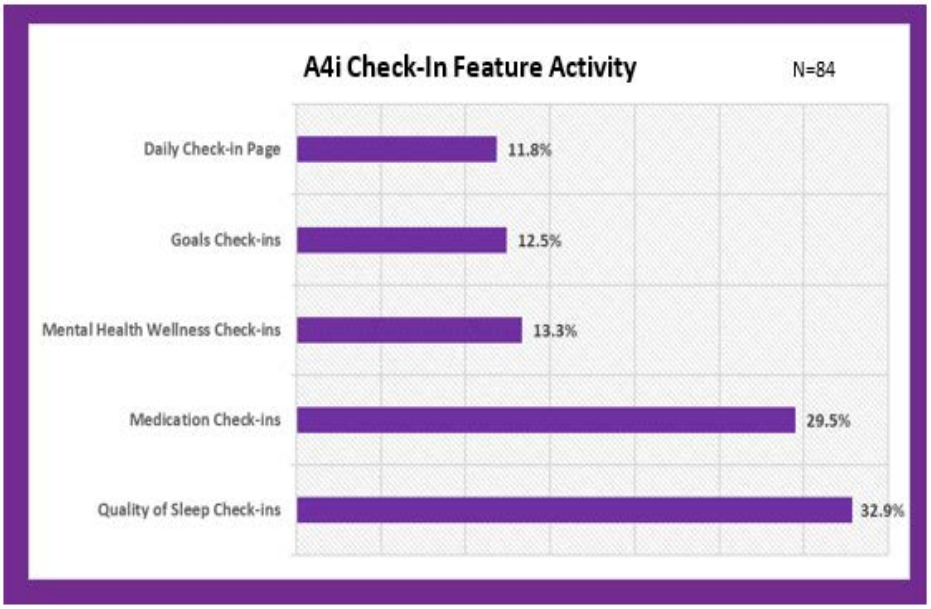
The Newsfeed feature was the most frequently used feature. Activity in this feature showed, consumers more frequently posted to the feed when they used this feature.



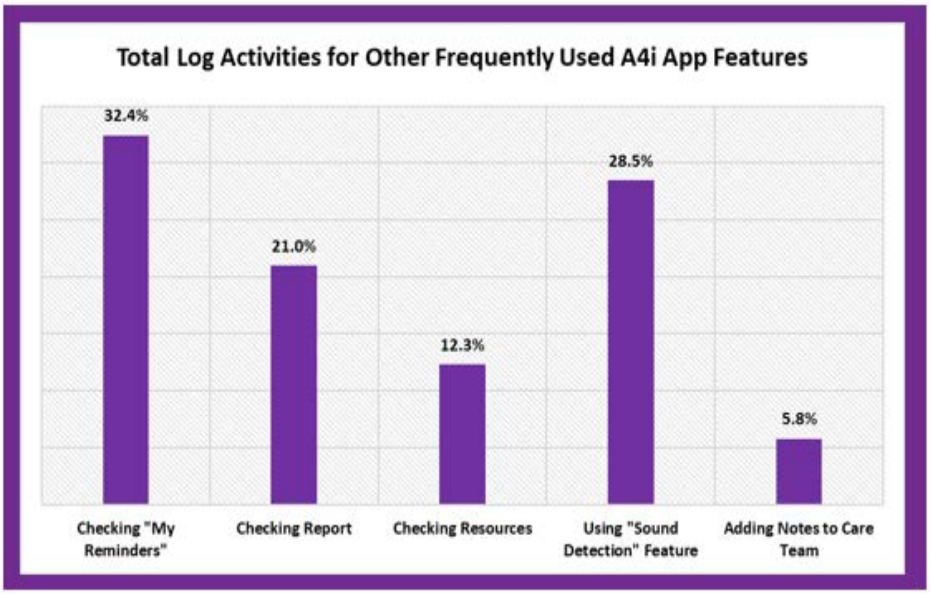
A4i Pilot

A4i Utilization Data

The second highest most frequently used feature was the A4i app Check-Ins feature. The total combined activity logs for Check-Ins was 44,046. Check-in activities were more frequent for Sleep Quality Check-ins (33%) and Medication Check-ins (30%).



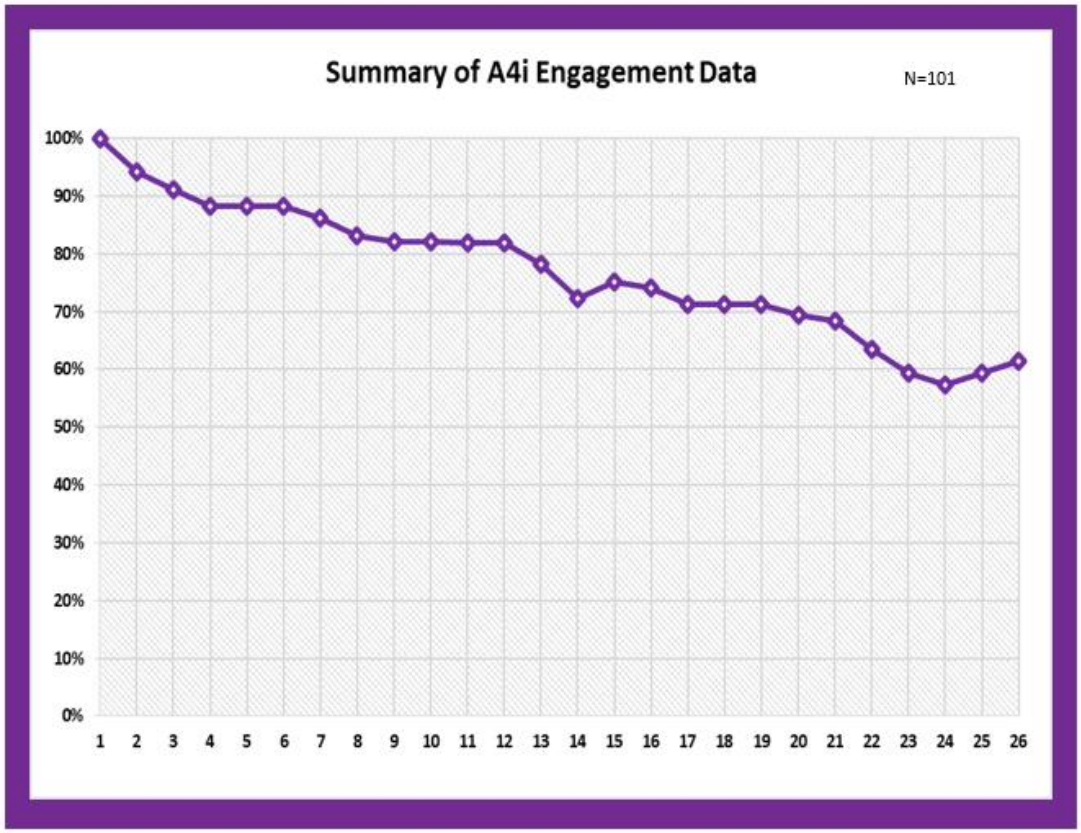
Other activities available in A4i included; **My Reminder**, **Report**, **Resources**, **Sound Detector**, and **Notes** features. The total count of activities for these 5 features was **4,625**. Of these, the most frequently used were *"My Reminder"* feature (32.4%), and *"Sound Detection"* feature (28.5%).



A4i Pilot

A4i Utilization Data

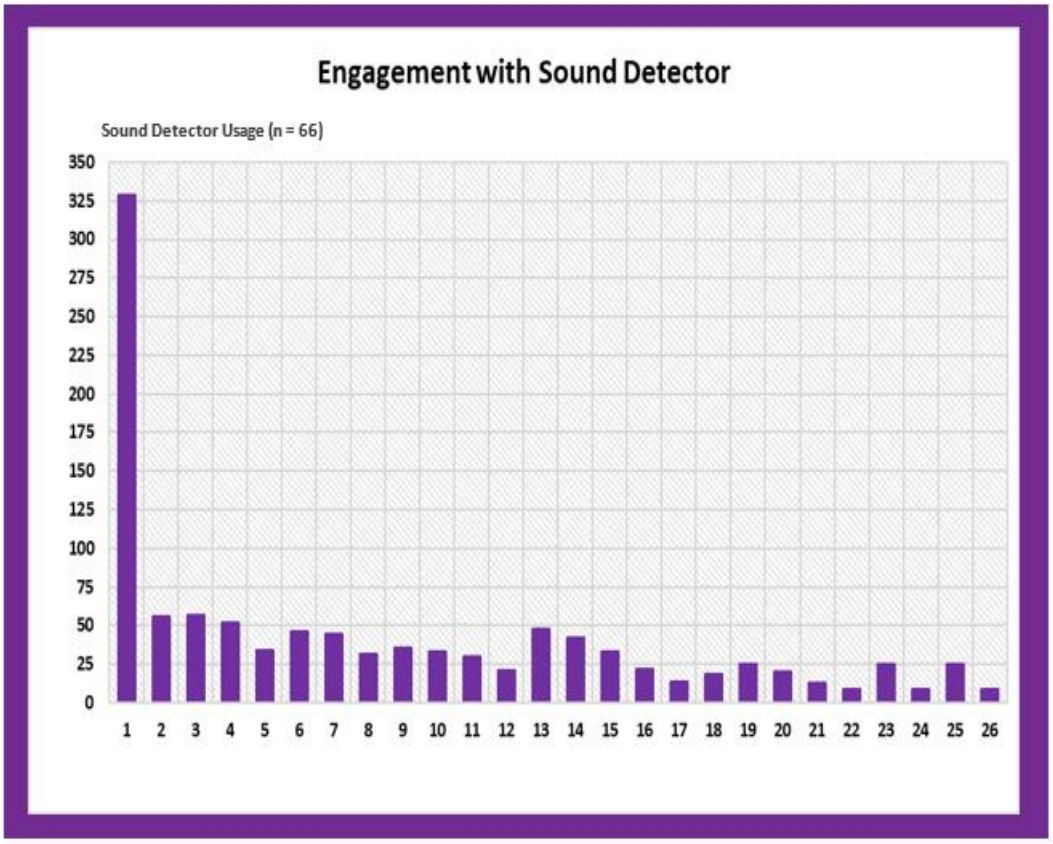
A4i engagement data from 102 participants who enrolled, installed, registered, and engaged in the app showed fairly consistent use across the 6-month pilot. Of 102 participants who enrolled in the A4i pilot, 1 never installed the app, therefore the data is only based on 101 participants. Observed weekly, the following plot provides a summary of the proportion of consumers engaged in the A4i app each week of the pilot. There was some decline in use over time, however the rate of participation remained relatively high by the end of the pilot. The average engagement in the app each week was **76.9%**. The weeks are each consumers first week and so on, rather then just a representation of a six- month period.



A4i Pilot

A4i Utilization Data

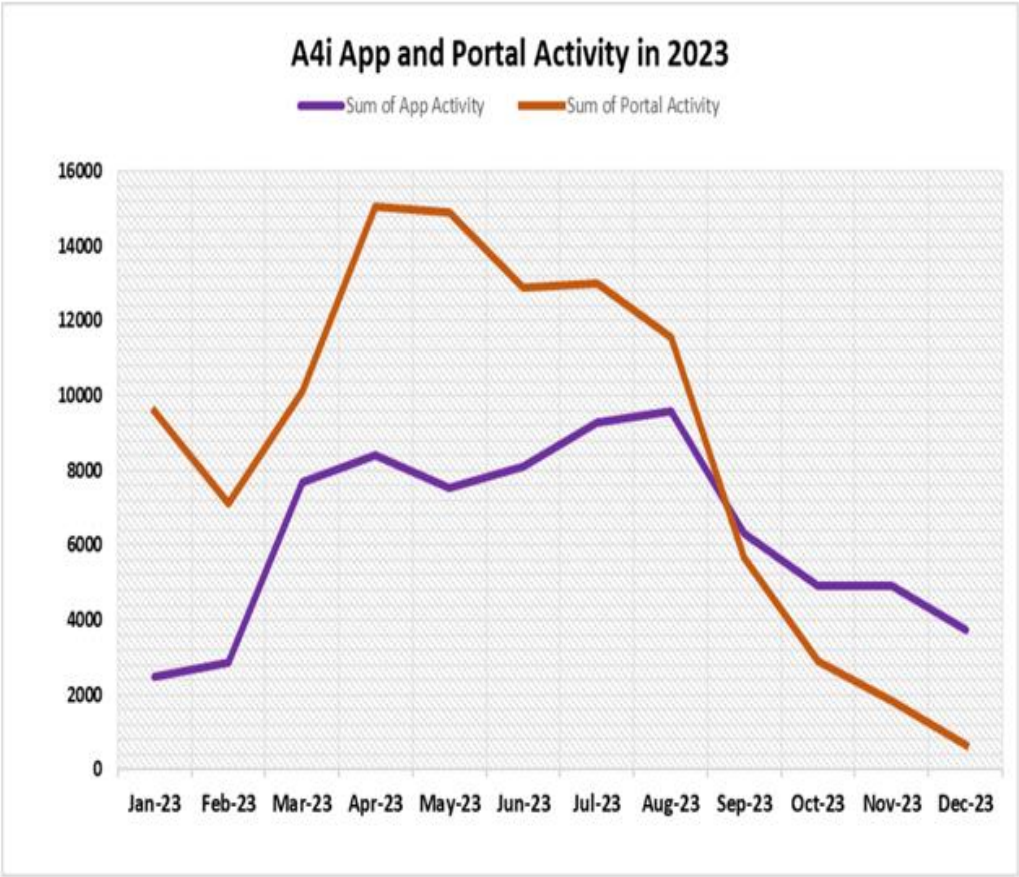
Engagement in the sound detector feature across the 26 weeks varied with 66 of the consumers using the sound detector at least once. There was some decline in use over time. Observed weekly, the following plot shows the number of times the sound detector was utilized each week. The weeks are each consumers first week and so on, rather then just a representation of a six-month period. The initial spike in the first week could have been those testing out this feature. More consistent use was found among a smaller number of consumers. In qualitative interviews when asked about this feature some consumers indicated they did not have the auditory hallucinations symptom, while others relied on the sound detector and reported it was quite helpful for managing auditory hallucinations. Fewer consumers used the sound detector after the first month; approximately 20 consumers accounted for the activity on sound detector after the first month, and closer to the end of the pilot approximately 11 to 15 consumers were using the sound detector feature.



A4i Pilot

A4i Utilization Data

There was some evidence of parallels in A4i app portal use by clinicians and the use of the A4i app by consumers. This figure below shows the monthly activities of consumer app users plotted with the Peer Support Specialists/Care team activity on the portal. The relationship between staff activity in the A4i app and the engagement of consumers became apparent in the qualitative interviews, where it was found that the consumers reporting high A4i use also reported the most communication and engagement with their mental health provider, and had discussed the use of the app with their Care team.



A4i Pilot

A4i Consumers Outcomes Evaluations

A4i consumers outcomes evaluation included measuring changes in quality of life, in particular increases in social connectedness, and well-being. Outcomes evaluation also included measuring symptom reduction and a sense of connection to clinic care team. A quasi-experimental pre-to-post data collection was implemented.

Pre-to-post outcome survey measures included:

- **Quality of Life Scale**—A 9-item questionnaire used to collect general quality of life, well being, and sense of social connectedness.
- **BASIS-24 Symptom Measure**—The Behavior and Symptom Identification Scale (BASIS) has 24 items measuring degree or frequency of difficulty/distress across serval symptom domains (depression/ functioning, relationships, self-harm, emotional lability, psychosis, substance abuse).

Quality of Life Survey Results

The Quality of Life (QOL) measure was administered at enrollment into the pilot (pre-measure) and at three and six months. Since 50% of those that dropped out of the pilot dropped in the first month, post data analysis only included those that completed the six month pilot (N=69). Pre to post measures were compared for improvements in quality of life. The following table shows the percentage of consumers rating high satisfaction between 4-6 at pre measure and post and the percentage of increase. The increase is percentage of consumers that rated their QOL higher on the post measure. Overall, some improvements were found in participants self-ratings of QOL. Emotional well-being and feelings about meaningful activity in their lives showed the most improvement.

Quality of Life - Items (Meaningful Activity and Relationships) (n = 69)	Satisfaction Increased—*Ratings 4-6*		
Scale of 1 (Unhappy/Terrible) to 6-(Delighted)	Pre	Post	% Increase
1. How do you feel about your life in general?	47.8%	63.8%	**33.5%**
2. How do you feel about your emotional well-being?	43.5%	71.0%	**63.2%**
3. How do you feel about the way you spend your spare time?	52.2%	58.0%	11.1%
4. How do you feel about the amount of meaningful activity (e.g. work, school, volunteer, leisure) in your life ?	47.8%	65.2%	**36.4%**
5. How do you feel about the amount of time you spend with other	43.5%	65.2%	**49.9%**
6. How do you feel about the amount of friendship in your life?	53.6%	62.3%	16.2%

A4i Pilot

A4i Consumers Outcomes Evaluations

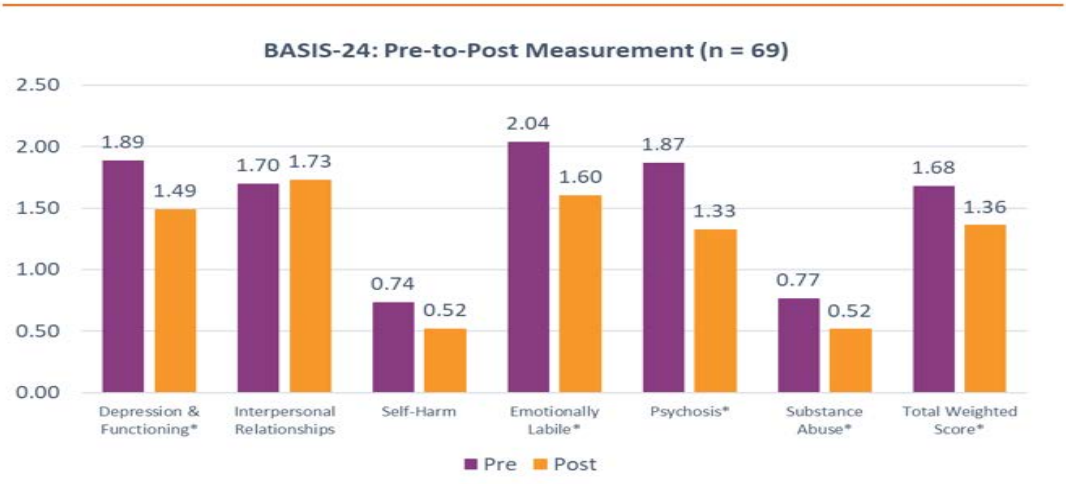
Quality of Life Survey Results

The Quality of Life (QOL) measure ratings on satisfaction with life and a sense of belonging are shown in the table below. Overall, dis-satisfaction decreased and satisfaction increased. The highest rating increase was in the feeling of satisfaction with feeling a part of their community at 81.8%.

Quality of Life - Survey Items (n = 69) (Satisfaction with Life and Sense of Belonging)	Dis-Satisfaction Decreased *Ratings 1-4*			Satisfaction Increased *Ratings 7-10*		
Scale of 1 (Not Satisfied) to 10 (Completely Satisfied)	Pre	Post	% Decrease	Pre	Post	% Increase
7. How satisfied are you with your life as a whole?	26.1%	17.4%	**-33.3%**	42.0%	66.7%	**58.8%**
8. How satisfied are you with feeling part of your community?	29.0%	24.6%	**-15.2%**	31.9%	58.0%	**81.8%**
9. How satisfied are you with your personal relationships?	30.4%	13.0%	**-57.2%**	43.8%	68.1%	**55.5%**

BASIS-24– Survey Results

The 24-item Behavior and Symptom Identification Scale (BASIS-24) measures six major areas of difficulty and/ or distress including: Depression, Functioning, Relationships, Self-Harm, Emotional Lability, Psychosis, and Substance Abuse. Similar to Quality of Life Scale, the BASIS-24 measure was administered at enrollment and at 3-months and 6 months. Only data for consumers that completed 6-months of the pilot was included in the analysis. The responses from 69 A4i participants who completed the Pilot were analyzed using paired samples T-Tests. Overall, participants' scores on BASIS-24 improved with statistically significant decreases ($p < .05$) [6]from baseline to post-measures in the following 4 areas: Depression and Functioning (-21.0%), Emotionally Labile (-21.4%), Psychosis (-29.0%), Substance Abuse (-32.4%), as well as on the Overall Total Weighted Scores (-19.1%).



[6] *Statistically significant results (p<=.05)*

A4i Pilot

A4i Consumers Structured Interviews

Qualitative Analysis

As part of the evaluation process, interviews were conducted with A4i enrolled participants to gather their feedback on A4i, including features they used, challenges, and any perceived benefits of using A4i. Interviews scheduled at 1 month were done to determine if their were any technological issues or challenges the consumers were experience. This section includes data from the initial interviews, as well as final interviews.



Initial Interview—1 month after consumer enrolled in A4i and used the A4i app. 75 interviews were completed (88% of consumers enrolled).



Final Interview—6 months after consumer enrolled in A4i and completed the A4i pilot. 67 of the 69 graduates of the pilot participated in the final interview.

Key Findings from 6-Month Interviews

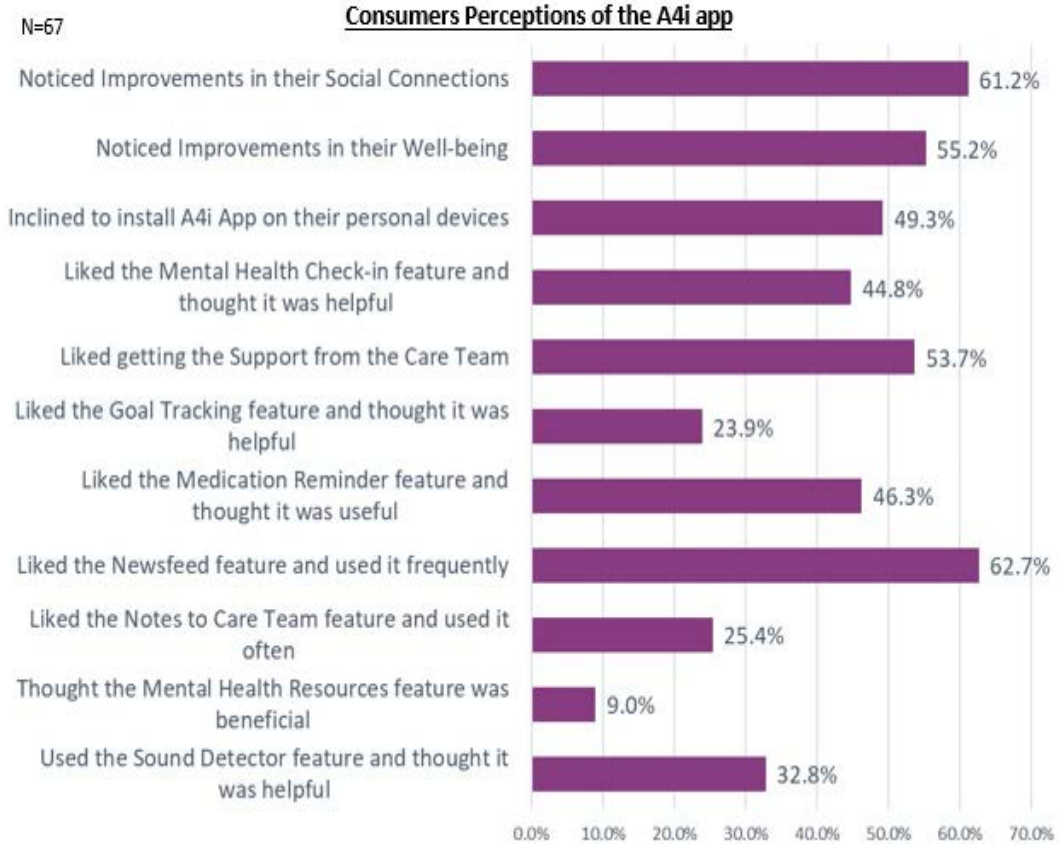
- **Increased Social Connections**-Most participants reported that A4i helped then improve their social connections. Several consumers expressed a heightened sense of belonging within a community that shares similar personal struggles after engaging with the app. One participant articulated that "*Knowing that there are people on the app, sharing their experiences and posting mental health quotes, allowed me to feel connected, knowing that others have shared experiences and I don't feel alone.*"
- **Increased engagement**-Most participants mentioned that they liked the "Newsfeed" feature because it helped them to engage with other participants anonymously. Consumers enjoyed the Newsfeed commenting that it was similar to Facebook but aimed towards Mental Health. One participant noted, "*I liked it that when I go there I can post and also see other people's posts. It keeps me in touch with people and I don't ever feel so alone. I also get to share things that are going on in my life and it just makes me feel better.*"
- **Connection to Care Team**-Participants also liked the "Notes to my care team" feature because it helped them connect with their care team members, and they generally got responses right away. One participant expressed, "*I liked how I can just message my care team and I would get a response so I always felt connected like my problems were being taken care of.*"
- **Increased Support**-Participants also reported receiving valuable support from their care team via the app. Most participants expressed that the app facilitated easier and more accessible communication with their care support person when needed. Furthermore, they received significant emotional support from members of their care team. One participant articulated, "*I think it helped me a lot because there is someone I can reach out to if I'm feeling some type of way because there is no judgment. I feel like they actually genuinely care.*"

A4i Pilot

A4i Consumers Structured Interviews

- **Improved Well-Being**-Most participants mentioned that A4i ***improved their well-being***. Enhanced well-being was expressed as a reduction in feelings of isolation and loneliness, increased self-awareness regarding mental and physical health, and a decrease in the impact of daily stress and anxiety. For instance, one of the participants highlighted how the app aided in medication management: *"The app helped me with my timing, particularly my medication intake. Using the reminders feature, I set reminders for 11 am and 11 pm. If I miss a dose, I see the reminder in the morning and take it then. It prevents me from accidentally double-dosing because I forget whether I've taken it or not."* Another participant shared, *"The app helps because when I check in, it keeps me calm. It's a significant support."*
- **Resources**-Participants also expressed positive sentiments on the resources that were provided in the app, as well as other Mental Health apps that had been pre-installed on the County phones. The following apps were frequently mentioned as being useful to them: *TakemyHand, Sleep App, PTSD Coach, Mind Shift, YouTube, Wiser, Super Better, My Healthpointe, Happy Color,* and *Don't Panic.*
- Most participants indicated they were inclined to ***install A4i on their personal device*** and would like to ***continue using the A4i app*** after completing the Pilot.

The following graph is based on the 6-month qualitative interviews and reflects the frequently of expressed experiences/perceptions of A4i from the consumers comments coded for themes.



A4i Pilot

A4i Consumers Structured Interviews Features Comments

Participants' Comments, Feedback and Experience from A4i Pilot and Reception to A4i App

22 participants (32.8%) stated that they liked the ***Sound detector*** feature, although some noted that they did not use this feature often. Those who used this feature also noted that they liked how this feature provided tips on how to cope with hallucinations.



Sound Detector and Sound Analysis

Comments from participants:

- ⇒ *"I liked knowing that I could use this as a reality check, like I was hearing voices and I could test this to see if I really was hearing voices or if it was just a background noise. So that was good."*
- ⇒ *"I've used it but don't use it often. Sometimes just to check if I'm really hearing things."*
- ⇒ *"Well, I have schizophrenia. So every time I hear a sound, I use that because it helps a lot. Helps me knowing what sounds are only my hallucination or not."*
- ⇒ *"This tool has helped me with identifying noises. I liked it."*
- ⇒ *"I like this tool. It's helpful to go with paranoia. To see if I hear natural sounds, or if that's not real, you know? So I've used that like, a few times when absolutely needed and I thought it was great."*

N=67

Notes for My Care Team

17 participants (25.4%) mentioned that they used the ***Notes to my care team*** feature in the A4i app and liked that they would get direct responses from their care team.



Comments from participants:

- ⇒ *"I liked having a place like a journal where I can put notes to my care team."*
- ⇒ *"I liked having this because I can tell my care team when I needed space and they wouldn't bombard me either. She would still check in on me but kind of understood that, okay, I understand you're tired."*
- ⇒ *"I liked how my care team helped me realize that mental health issue is real, like really real and also helped me that I wasn't alone in this. I didn't even realize how much support I got and how much they were supporting me. Even the posts helped."*
- ⇒ *"I liked how I can just message my team and I would get a response, so I always felt connected like my problems were being taken care of."*

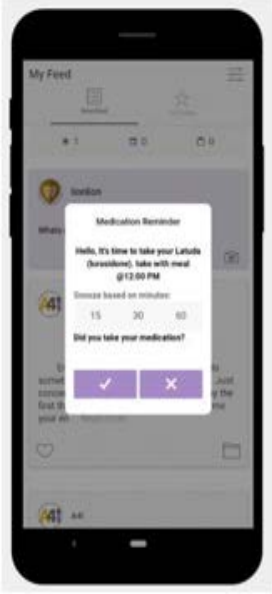
A4i Pilot

A4i Consumers Structured Interviews Features Comments

Participants' Comments, Feedback and Experience from A4i Pilot and Reception to A4i App

31 participants (46.2%) noted that they used the ***Medication reminder*** frequently, and liked how it helps them with their regimen of taking medications.

Medication Reminders

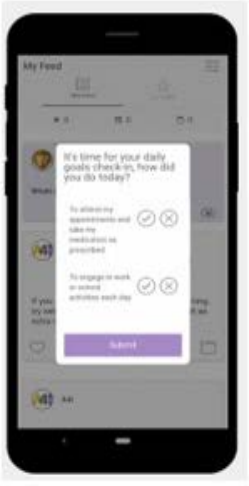


Comments from participants:

- ⇒ *"Once they fixed it and I found a nice rhythm of using it, I really liked using it."*
- ⇒ *"I think it helps more to be more consistent with my regimen of taking medications."*
- ⇒ *"I like it because I can logged my meds and that helps. I felt great."*
- ⇒ *"The medication one was a big reminder because at first I'd forget to take it and was confused, but now that I've been using that for a little over six or seven months, I just naturally take my medication before the alarm goes off. That was helpful."*
- ⇒ *"I've been up and down on everything, so for me to be reminded to take my meds through the app helps me a lot."*

16 participants (23.9%) mentioned that they liked the ***Goal tracking*** feature.

Goal Tracking



Comments from participants:

- ⇒ *"I'm bipolar so I'm like everywhere. Using goals tacking helped me to stay focused on my goals aspect on completing them and building up my confidence in the fact that I completed a goal to help me articulate better."*
- ⇒ *"The goal tracking helped me with staying consistent with my schedules and to actually follow through."*
- ⇒ *"I like to be able to track on the goals and things like that. It just feels like I'm on point with it or know where I'm at."*
- ⇒ *"I liked the goal tracking thing, it was helpful for me."*

A4i Pilot

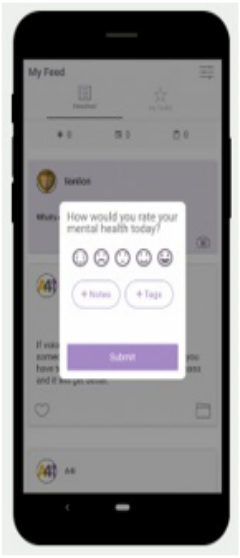
A4i Consumers Structured Interviews Features Comments

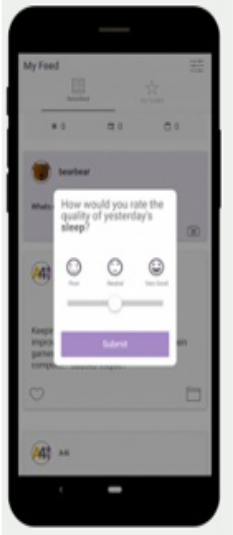
Participants' Comments, Feedback and Experience from A4i Pilot and Reception to A4i App



30 participants (44.7%) mentioned that they used the ***mental health wellness check-ins*** feature frequently.

Wellness Check-Ins





Comments from participants:

⇒ *"I like how the app is asking how I was feeling for the day. I also like knowing that there were other people that were going through same things that I'm going through."*

⇒ *"The app gives me a social outlet when I check in. I like how it asks me if I took my meds, checking my mental state, and kind of gives me a reminder where I need to be and how I need to adjust so I can focus on myself."*

⇒ *"I feel like I'm being productive because I'm recording everything I'm doing. So it's like I'm more accountable for my actions, and that's helpful."*

⇒ *"I liked how let's say I have a bad day or bad mood or something, then I would get a call from my support person and she checked on me. Like how I'm feeling in the day, is everything okay? I thought things like that were great."*

⇒ *"I liked the daily check-ins, and that helped me set my day. I would plug in the responses and then it was kind of like, okay, a promise to myself that I was going to achieve those goals for that day."*

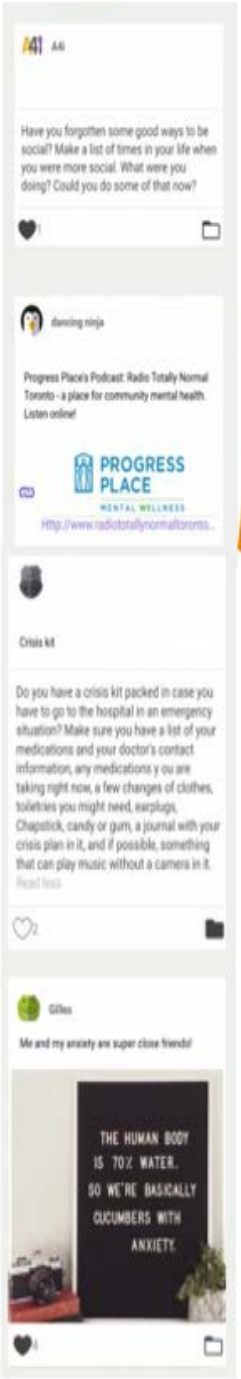
⇒ *"I think the check in allows you to keep awareness, like how you're doing, like your mental state. That allows you to be up to date and it puts it on the puts it on your, your radar, something that you start to think through because I think when you know, you know that you're just living life but you don't necessarily partake in realizing, how was yesterday, how was today. Tomorrow might be better but how would you know, it's like everyday is just everyday. But I think the check in is trying to tell you that you could kind of gauge life, like when you're upset or what's going on. So if I didn't get rest today, and then I don't feel good or anything like that. Then I can check in and kind of like, you know what, I didn't get much sleep yesterday so okay I'm going to try to do better, I'm going to try to get better. And honestly say like, using the check in, I started to manage my sleep more. I started to take note to learn something new does make my day a little bit better. So it's like I try to learn something new every day. I try to apply it for next time, and tell myself that it's not just all bad, like I can set a goal to myself to be better tomorrow, and I want to mark the smiley face all the way from now on."*

A4i Pilot

A4i Consumers Structured Interviews Features Comments

Participants' Comments, Feedback and Experience from A4i Pilot and Reception to A4i App

Most participants expressed positive sentiments toward the ***Newsfeed*** feature of the A4i app, and 42 participants (62.7%) mentioned that they used it frequently.



Newsfeed

Comments from participants:

⇒ *"I liked it a lot. It reminds me of a mental health Facebook, kind of. It's cool because everybody who's on this app has some mental health challenges, and we're here to see that people are doing good. It makes me feel better about myself knowing that if they can get through it, I can too."*

⇒ *"I liked posting and reading other people's posts because it reminds me to hang in there, or something like that. Sometimes when I post I know I won't get a response, but I already felt better by just getting it off your chest."*

⇒ *"I like knowing that there other people sharing their experiences with others and posting stuff like mental health quotes, and I like that. It allows me to also feel connected and don't feel alone."*

⇒ *"The newsfeed was really helpful for me because I felt like I wasn't alone. It felt like there were people who talk to you and people who know and understand that they had health issues too. So for me that was good. That was comforting."*

⇒ *"I like reading other's people comments on how the cope with their schizophrenia. And saying to continue moving forward with their lives so I felt better. Also I like being able to talk to someone at any given time and calling my support specialist and even telling them whatever it is. It's good to know."*

⇒ *"I've done, okay, I don't really have too many bad days, but there's times where moments start going sideways and so I go on and log into it and start reading other people's stuff. It makes me feel better. It takes me out of my head. Any kind of distraction you take me out of my head is a good thing."*

⇒ *"I like submitting my post on the newsfeed. And then the peer support team could read them and stuff, and then they get back to me. I liked that."*

⇒ *"I like seeing updates and everybody else' posts. You can like kind of see everybody else's words like, Have fun today, or Have a good day, or Happy Monday. Things like that, but it's been helpful, and I can honestly say it's really helpful when, when things are slow, or things are hard, because then it kind of keeps us focused because it's like a constant positive. You know, like, it's just you're reading like mostly positive things about other people. So it's kind of like, okay I also need to stay positive."*

A4i Pilot

A4i Consumers Structured Interviews Features Comments

Participants' Comments, Feedback and Experience from A4i Pilot and Reception to A4i App



36 participants (53.7%) stated that they liked the Support from Care team throughout the Pilot and that the Care team gave them the motivation to continue.

Support from Care Team



Comments from participants:

- ⇒ *"If they weren't there, I probably could have done it on my own but probably would not do anything. But knowing that they look at my progress and then check on me and leave notes for me, it was like a natural light and a small Facebook for me. I also like how it tells us everyday, like good morning, to check messages and stuff like that. So for me that helps a lot."*
- ⇒ *"I liked the support and knowledge from the peer team like coaching and having someone there to talk to you about things."*
- ⇒ *"I really like how I can reach out if I'm feeling some type of way and there's no judgement. I feel like they actually genuinely care, you know. I was going through a little rough patch, and she was like, we haven't heard from you. How are you doing? It was consistent, you know. She didn't just text me one time. She texted me multiple times, just to make sure I was doing okay. And that's good. Because a lot of people in this day and age, they're not really worried about anybody else except for themselves. And I didn't feel that from the care team. They genuinely cared about me."*
- ⇒ *"At one point, I almost stopped eating. My peer support was with me every step of the way. It's like she knows exactly what I was going through and everything. Like she's got it on there, you know, and she wants to know exactly what I ate and all that because she wants to make sure I'm eating and I'm doing better. And it really helps when I can tell her my story."*



A heartful note from participant from the final interview:

"I want to commend you guys, for even thinking of this app or whoever thought of this app. I want to commend you for what you're doing with mental health, because this app is very helpful. It's very intuitive; reading, grabbing grasp of thinking that there is hope that we can overcome our mental disabilities. You guys made that somewhat possible for someone like me. I will retain a lot of aspects as far as mental health even somewhat suicidal tendencies that I had. You guys helped me overcome whatever emotions that I was going through and guide me to where I'm at now. And I thank you for that."

A4i Consumers Structured Interviews continued

Key Findings from Initial 1-month Interviews

Initial interviews were conducted approximately one month after participants enrolled and engaged in the A4i app. The feedback from the initial interviews completed in late 2022 and early 2023 contributed to A4i app development. The A4i app developers took into account the Pilot Participants' feedback as well as the Care Team's feedback in modifying the app features to be more user friendly. Overall, 31 participants expressed that there were issues with the app in the beginning of the pilot, but after getting help from the Care Team and after the issues had been fixed by the A4i team, most A4i consumers reported they liked the app. One of the most frequently mentioned issues was related to the medication reminder feature. Most expressed that the original earlier version in the app did not really function as a reminder, rather it was more of a check at a certain time of day to record if they had taken their medication. If they missed the check-in there was no way to go back and updated it which resulted in inaccurate results on the clinical dashboard. This feature of the app was updated to allow consumers to record their medication check in for the previous day. Check-in features had the times for notifications updated to be more in line with consumers activity which was also based on consumers feedback.

Challenges in Using A4i App

A small number of participants expressed that they encountered some challenges with A4i while partici- pating in the Pilot, and some of their comments are noted below:

- 8 participants (11.9%) ***did not find the app helpful*** or felt that the ***app made no difference*** to them. Some also mentioned that they did not like having separate phones to carry.
- 4 participants (5.9%) noted they ***did not get the support they needed*** while they were in the Pilot. Some also felt that the app did not provide enough support for what they personally need.
- 7 participants (10.4%) noted that ***the app was confusing***. One participant expressed, "*Maybe the daily goals are kind of hard for me because I work all the time and I just don't have time to do some of the goals that I have*." Another expressed that "*using the app was a headache*," while the rest mentioned that "*the medication reminders really confused them*" or "*did not help much*". One participant men- tioned, "*I marked the medication on the bubble and when I check in in the morning and evening it just constantly says that I did not take medication so I'm not going to lie, I got frustrated and just stopped using the app*." A few of the participants also expressed that the sound detector feature was on the difficult side for them and it was hard to comprehend what it was and/or how to use it.

One participant expressed that the ***A4i Pilot should have been made more extensive*** and ***longer than six months***: "*I feel like haven't really gotten the chance to dig into it and to really evaluate how each aspect of the app works in my daily living as a mental health patient and also as an employed person with a job. So I was saying maybe after 6 months is a good way to check in, but maybe the program should be like a year, you know, or 12 months before it actually concluded. Because in my situation, it would be so much more effective. Because I know that some people periodically get off the beaten path and you know, they're just at the wrong side of the trail. They can't keep up or they can't follow along anymore. And the program is built to be totally extensive, you know, a very careful, thoughtful way to introduce yourself and you're in the program to use the app and it's for people who really needs them. So I feel like for that reason, it should have been longer, like extended to 12 months*."

A4i Pilot

Future Directions

The collaboration with A4i continued after the conclusion of the Help@Hand Innovation. The partnership with Memo Text has resulted in upgrades to the app and has provided opportunities for RUHS-BH to
continue the availability of the app to RUHS-BH consumers. A number of consumers chose to continue using the A4i app and when needed were allowed to keep the phone provided in the pilot.

Project Evaluation

Deaf and Hard of Hearing Mental Health Needs Survey

CODiE
CENTER ON DEAFNESS - INLAND EMPIRE

Deaf and Hard of Hearing MH Needs

RUHS-BH started the Deaf and/or Hard of Hearing Needs Assessment project in order to improve services for the Deaf and/or Hard of Hearing (DHoH) community in Riverside County. The city of Riverside has a California School for the Deaf, which is one of only two such schools in the state. The school has been in operation for 70 years and serves deaf children and youth age 3-21 years old. Riverside also has a California Home for the Deaf Adult. This history has contributed to a large deaf and hard of hearing community in Riverside County. This community is one of the largest in the United States and it has been thriving and growing since 1953.

People who are deaf experience the typical mental health issues of the general population. However, deaf people are subject to a significantly greater number of mental health risks than their hearing counterparts. Access to necessary mental health treatment services is lacking. It has been estimated that less than 2% of deaf individuals in need of mental health treatment receive it. It is speculated that an even smaller proportion of deaf individuals from ethnic minority groups receive appropriate services[7]. Studies on deaf mental health concerns are limited.[1] Given the DHoH community is an underserved cultural group in Riverside county, initial plans to develop digital tools started with a needs assessment survey to better understand the DHoH perspective on mental health needs.

Implementation Highlights:

RUHS-BH leveraged the existing relationship between the Center on Deafness Inland Empire known as CODIE and the RUHS-BH Cultural Competency program. CODIE has been a key RUHS-BH stakeholder for a number of years. CODIE was asked to assist with the review of the survey items and the dissemination of the survey to the DHoH community. CODIE contributed suggestions for modifications on language and urged RUHS-BH to consider the use of ASL videos to collect the survey. It would not have been possible to create and distribute the survey without the assistance CODIE provided. The following are the key implementation steps taken to conduct the survey

- Creation of the survey draft which was then reviewed by CODIE for suggestions and edits. The initial survey had too many items, so a shorter survey was created and language was edited.
- Qualtrics was used as the platform to build the survey for distribution. A contract with Red Pepper, a Qualtrics implementation consulting firm, was established to assist with the survey build and survey security.
- CODIE suggested using the services of Sorenson Communications, an industry leader in providing communication tools for DHoH, to produce ASL videos of the survey items. RUHS-BH then contracted with Sorenson communications to create ASL videos of each survey item.

[7] Mental health care for DHH individuals: Needs, risk factors, and access to treatment. Retrieved from https:// www.nationaldeafcenter.org/mental-health-research

- Once the ASL videos were completed, 81 videos were embedded in the Qualtrics survey. RUHS-BH evaluations staff learned the process for embedding the videos with guidance from Red Pepper.
- Distribution began with the creation of links to the survey for email distribution by CODIE to their contacts in the DHoH community. RUHS-BH collaborated with CODIE to create a script for the email describing the purpose for the survey and the availability of an incentive for completing the survey.
    - The email distribution process was laborious for CODIE staff, and the survey response rate was low. Additional methods to distribute the survey were developed including posting the survey link on the CODIE website with an ASL video and a text description for access to the survey. A pre-survey was developed to try and limit the survey respondents to members of the DHoH community. The pre-survey included an introduction and a series of questions about the potential respondents language and association with DHoH community. A CODIE employee created an ASL video to post on the CODIE website using the following script.

Riverside University Health Systems-Behavioral Health wants to improve services for Deaf and Hard of Hearing people. Would you like to help us learn about the mental health needs of Deaf and Hard of Hearing people by completing a survey? Please answer a few short questions in the link below and a second link to the full survey will be emailed to you. We would really like to know what you think. Your thoughts matter!

- If the potential survey respondent completed the Pre-survey on the CODIE website, met the criteria, and provided their email, a link to the full survey was sent with the following message.

Email Message

Hi Name, (name was auto-filled from Pre-Survey completed)

You recently provided your email after completing a survey invite on the CODIE website. Thank you for providing your email so you could receive the Survey link below. There will be an incentive provided for completing this survey.

Riverside University Health Systems-Behavioral Health wants to improve services for Deaf and Hard of Hearing people. By completing this survey you will help us learn about the mental health needs of Deaf and Hard of Hearing people.

- Pre-Survey Items:

Only those indicating yes to at least the first question were provided the following prompt to receive and email response with a link to the survey.

Deaf and Hard of Hearing MH Needs

Are you Deaf or Hard of Hearing (Deaf, Late Deafness, DeafBlind, Hard of Hearing)?

Do you use an assisted hearing device?

Are you fluent in American Sign Language (ASL)?

If you are interested in completing this survey, please enter your contact information below to receive a link to the survey. Those providing an email and completing the survey will receive a gift. First name, Last name , Zip code and email were required to receive an emailed link.

- An informed consent was presented electronically when the respondent clicked on the survey link . The respondent was required to acknowledge consent prior to the full survey opening. Participants also had the option to download a copy of the consent form.

Please review and sign the following consent to participate form. You will also be able to download a copy to keep for your records.

- Respondents completing the full survey received a $25.00 gift card for their participation. Incentive gift cards were not distributed automatically after completing the survey. Instead a list of survey completers were regularly provided to CODIE to confirm if the gift card should be provided. The incentive was later increased to $100 to encourage more responses.
- In order to qualify for the incentive, respondents had to be 18 years of age, reside in Riverside County and had to identify as being part of the DHoH community.
- Additional security measures were embedded within the Qualtrics survey to avoid bot attacks. Despite these efforts after collecting 46 surveys, a cyber bot attack in January 2023 on a single day resulted in a closing of the web survey on the CODIE site and a new survey link being created with additional security embedded in the survey. Also a QR code for the survey was generated for CODIE to provide to potential survey respondents.
- CODIE offered to solicit survey respondents at various CODIE events using the QR code. They also held an event at their office to bring in people to complete the survey using the QR code link.

DHoH Survey Content

The survey was focused on understanding DHoH mental health needs, and the strategies used to manage their mental health needs. The survey was constructed to cover four broad areas:

- General technology use including the use of mental health apps.
- Mental health needs
- Use and interest in mental health resources
- Important considerations for mental health apps

At the beginning and at the conclusion of the survey a list of resources were provided:
***24/7* The Peer-Run Warm Line**

Deaf and Hard of Hearing MH Needs

Mental Health Association of San Francisco

https://www.mentalhealthsf.org/peer-run-warmline/ 855-845-7415

Riverside University Health System – Behavioral Health

Providing Help Empowering Recovery

https://www.rcdmh.org/

To access Riverside County Behavioral Health services call the central access phone line at

CARES Line

Community Access, Referral, Evaluation and Support

800-499-3008

For TTY Users: Use your preferred relay service or dial **711** then **1-800-499-3008**.

24/7 Mental Health Urgent Care Riverside: (951) 509-2499

Palm Springs: (442) 268-7000

Perris: (951) 349-4195

HELPLine

Providing Help / Empowering Recovery Free, confidential crisis/suicide intervention service 24/7

951-686-HELP or 951-686-4351

Crisis Text Line

Text **HOME** to **741741**

24/7

Teen Text Line

Text **TEEN** to **839863** Anonymous line staffed by Peers 6-9pm Daily

Take my Hand Live Peer Chat

Partner with a Peer Support Specialist who has walked through their own struggles and is here to listen to you, just a few keystrokes away.

https://takemyhand.co

Please know resources are available to you.

National Suicide Prevention Lifeline

You can chat with a Lifeline counselor 24/7 by:

Online chat – Click the Chat button at

https://suicidepreventionlifeline.org/help-yourself/for-deaf-hard-of-hearing/

For TTY Users: Use your preferred relay service or dial 711 then 1-800-273-8255.

TTY: (800) 799-4TTY (4889)

Deaf and Hard of Hearing MH Needs

DHoH Survey Results

The DHoH survey data was collected between August 2022 though February 2024, a total of 73 people completed the survey. The QR code was used the most to complete the survey.

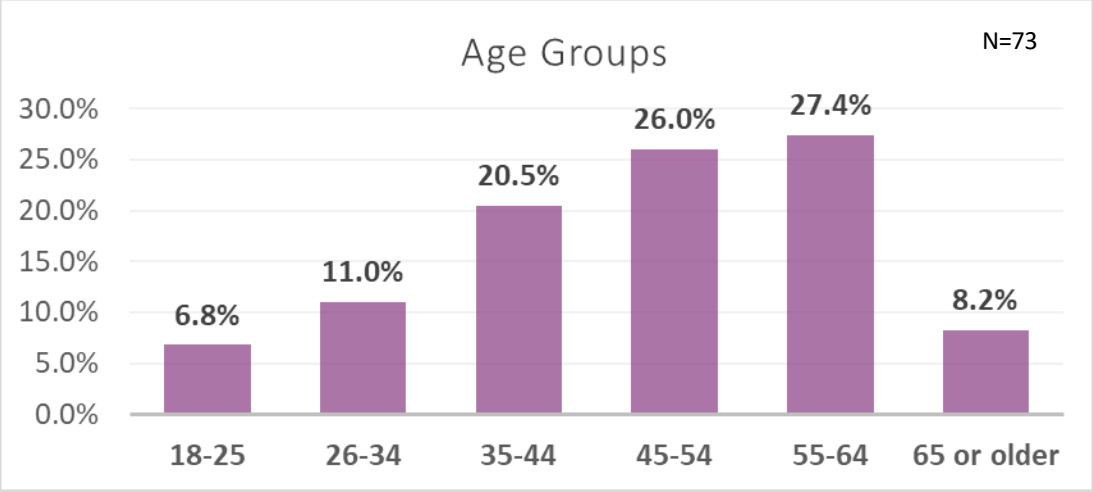


A set of eligibility questions were embedded at the beginning of the full survey to further determine eligibility to participate in the survey. Respondents were asked: age, identifications with DHoH community, and residing in Riverside County. All respondents indicated they were part of the DHoH community.

Do you identify as part of the Deaf and/or Hard of Hearing Community? Yes, 100%

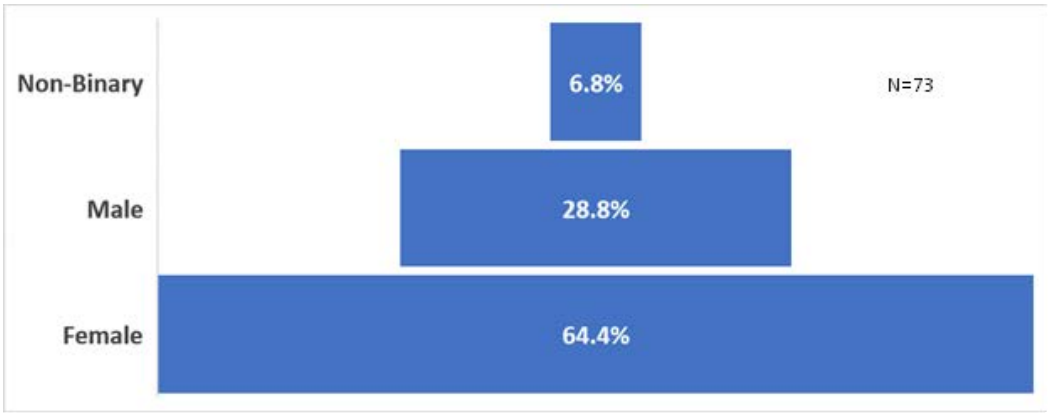
Nearly one half of the respondents (46%) were between 35 and 54 years of age.

How old are you? (Select one answer.)



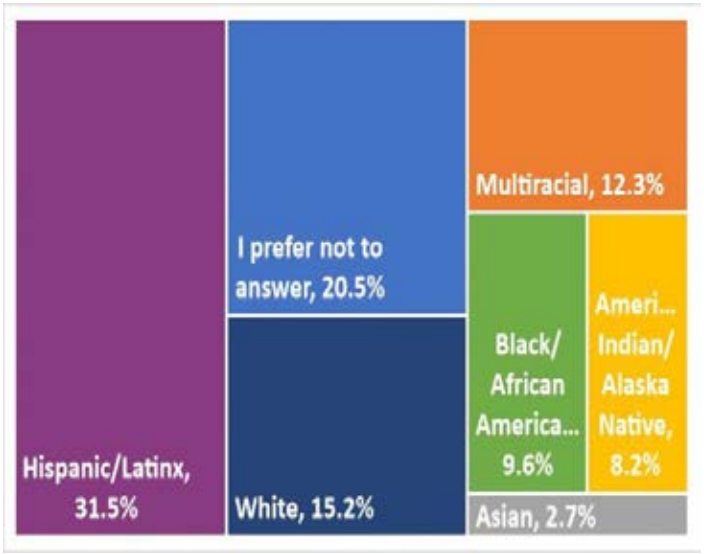
Deaf and Hard of Hearing MH Needs

DHoH Survey Results Demographics



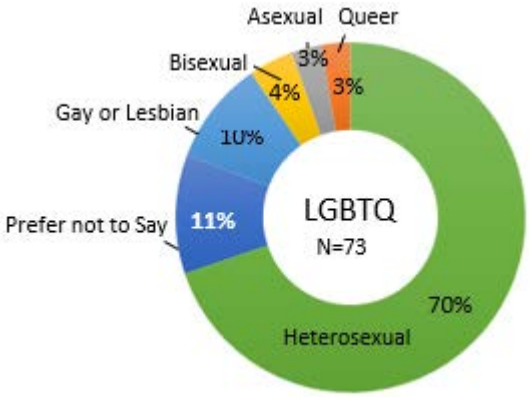
The majority of survey respondents reported as female (64%) . Also a small proportion indicated they were Non-Binary. Identification as transgender was asked as a separate survey item. A small proportion 2.7% reported they identified as Transgender.

Race/Ethnicity N=73



The majority of DHoH survey respondents reported their race/ethnicity as Hispanic/ Latinx (31.5%, n = 23), although it is also noted that 20.5% of the participants (n = 15) chose not to answer this question. White and Multi-racial, respectively. were the second and third most frequently reported race/ethnic group.

Demographic data collected for LGBTQ showed that 20% of respondents were a member of the LGBTQ population.

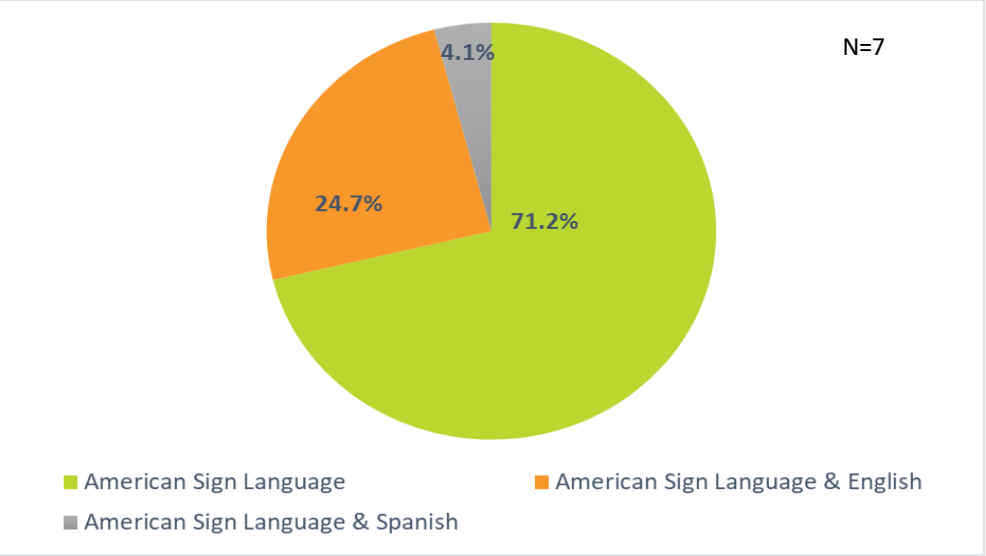


Deaf and Hard of Hearing MH Needs

DHoH Survey Results Demographics

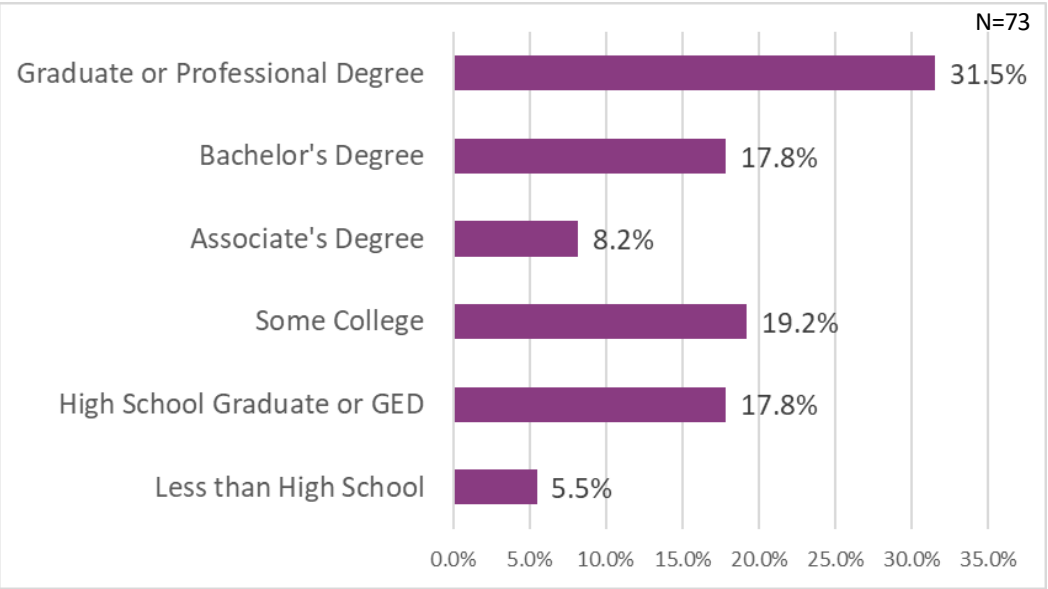
The majority of survey respondents reported American Sign Language (ASL) as their preferred method of communication (71%). Nearly a quarter indicated English and ASL (24.7%). A smaller proportion indicated ASL and Spanish was their preferred communication method

Preferred Method of Communication



A third of the respondents indicated they had a graduate or professional degree. Slightly more than a quarter had an Associates or Bachelors degree, and only a small proportion had less than a high school education.

Highest Level of Education



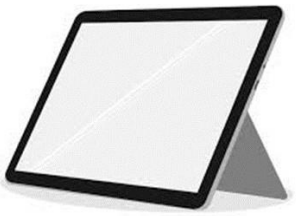
Deaf and Hard of Hearing MH Needs

Survey Responses:

General Technology Use

The first component of the Survey had questions on "General Technology Use." Respondents were asked about their use of smartphones/tablets, and laptops/desktops, availability of a mobile plan, and consistent and reliable access to Wi-Fi .

Use of Smartphones, tablets, laptops/desktops


- 67% reported using both smartphone and a computer laptop or tablet
- 26% reported using a Smartphone or tablet only

N=7

Reliable Access to Wi-Fi



- 92%
- 4%
- 3% Not

Have a Mobile Phone Plan



- 85%
- 3% No
- 8% Prefer not

N=73

Note if the respondent indicated they used a Smartphone they were asked if they had a mobile plan

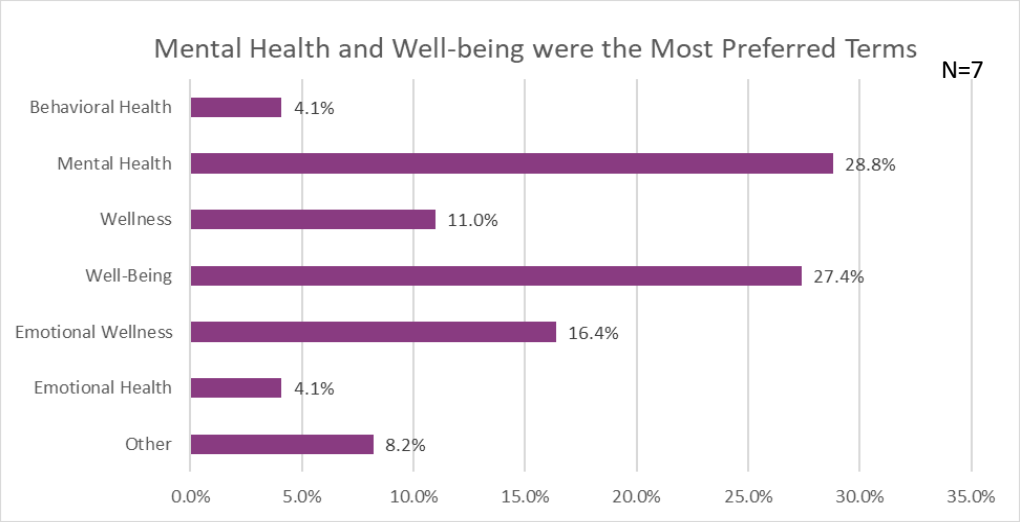
Deaf and Hard of Hearing MH Needs

Survey Responses:

Mental Health Needs

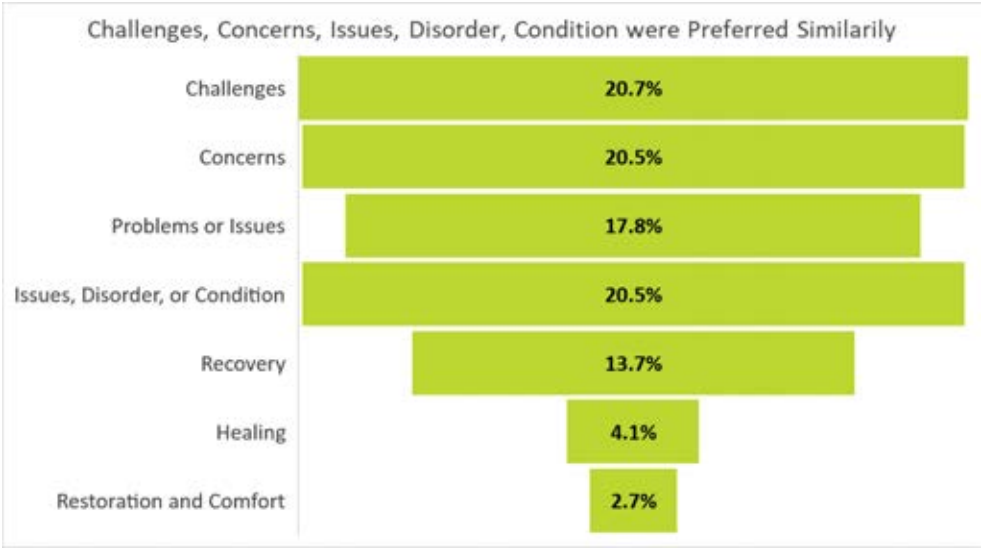
Survey items for mental health needs included items related to the language used to describe mental health, any needs the respondent has experienced, help seeking, and stigma.

Which of the following terms about your emotional, mental, or psychological health do you prefer the most?



How do you rank the following terms generally used to refer to challenges related to your mental, emotional, or psychological health?

N=73



Deaf and Hard of Hearing MH Needs

Survey Responses:

Mental Health Needs

A series of statements were used to inquire about the respondents mental health. How they have been feeling during the past 30 days. For each statement, respondents were asked to indicate how often they experienced common mental health needs. Items were rated on a Likert Scale where 1 = None of the time, and 5 = All of the Time. The table below represents the responses. An additional survey any previous or current history of a mental health challenge.

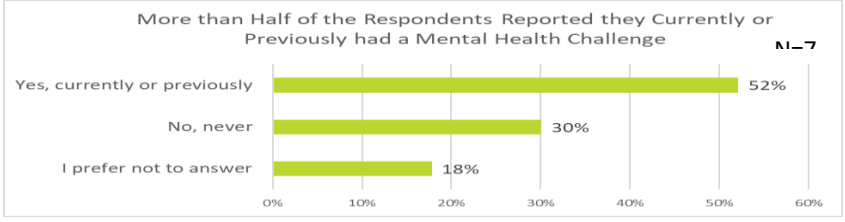
How have you been feeling during the past 30 days?

Survey Items N=73	*None of*	*A little of*	*Some of*	*Most of*	*All of*
Are you tired out for no good reason?	*0.0%*	*43.8%*	*45.2%*	*11.0%*	*0.0%*
Are you nervous?	*0.0%*	*65.8%*	*30.1%*	*4.1%*	*0.0%*
Are you so nervous that nothing could calm you down?	*0.0%*	*80.8%*	*17.8%*	*1.4%*	*0.0%*
Are you hopeless?	*0.0%*	*79.5%*	*17.8%*	*2.7%*	*0.0%*
Are you restless or fidgety?	*0.0%*	*65.8%*	*28.8%*	*5.5%*	*0.0%*
Are you so restless that you could not sit still?	*0.0%*	*75.4%*	*16.4%*	*8.2%*	*0.0%*
Are you depressed?	*0.0%*	*67.1%*	*24.7%*	*6.8%*	*1.4%*
Do you think everything was an effort?	*0.0%*	*52.1%*	*34.2%*	*9.6%*	*4.1%*
Are you so sad that nothing could cheer you up?	*0.0%*	*79.5%*	*17.8%*	*1.4%*	*1.4%*
Do you feel worthless?	*0.0%*	*83.6%*	*15.1%*	*1.4%*	*0.0%*

Overall, respondents showed positive feelings in their mental health needs in the past 30 days (mostly selecting "*a little of the time*" and "*some of the time*" on almost all of the statement items), with only 2 items showing a rating higher than 10% for "Most of the time" and "All of the time":

- **Feeling tired out for no good reason (11.0%)**
- **Thinking that everything was an effort (13.7%)**

Have you ever experienced a mental health challenge ?



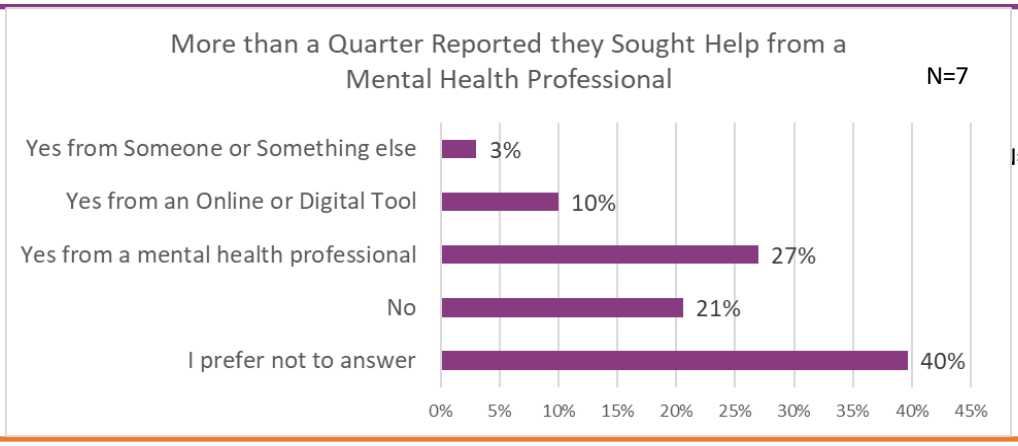
Deaf and Hard of Hearing MH Needs

Survey Responses:

Mental Health Help Seeking and Stigma

Several items were focused on help seeking, and several focused on stigmatizing beliefs about mental illness.[8]

Did you seek help for your mental or

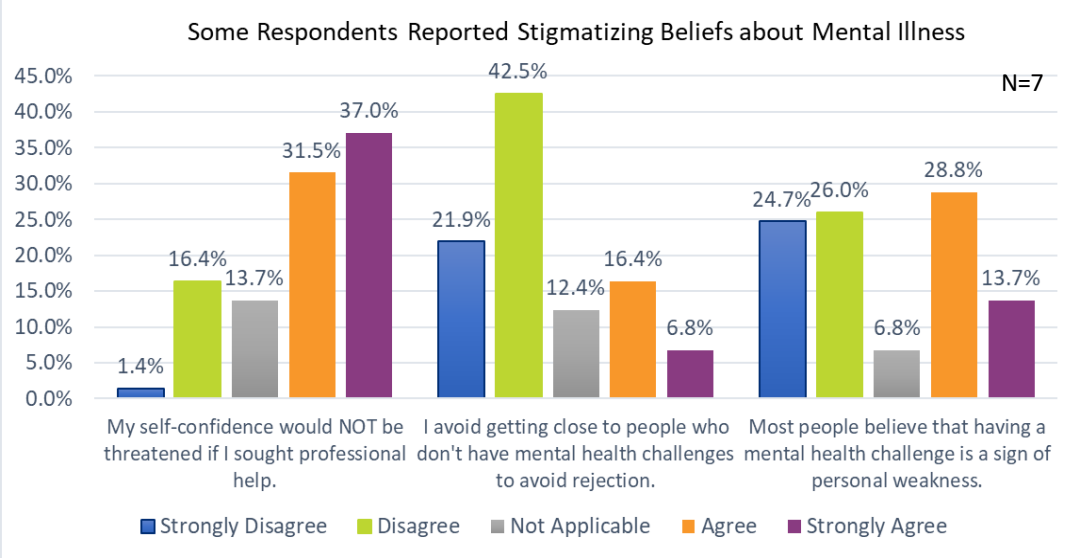


N=73

I=73

What are your thoughts about mental health challenges and getting mental

More than 40% of respondents had the perception that most people thought having a mental health challenge was a personal weakness. This finding indicates the many respondents had a perception that mental illness is stigmatized in the community. Nearly a quarter (23%) reported they avoid getting close to people who do not have a mental health challenge to avoid rejection. This finding seems to indicate that those with a mental health challenge have some fear of personally experiencing stigma for their mental challenges.



[8] For those that indicated someone or something else (n=2) one response was an ASL Counselor, another was Close friends.

Deaf and Hard of Hearing MH Needs

Survey Responses:

Use and Interest in Mental Health Resources

A series of survey items focused on the resources and strategies respondents would use, or would like to use to managing their mental health. The items were in the form of a statement and for each of the survey items, respondents were asked to select one of the following choices:

- *I currently use this resource*
- *I don't use the resources and I don't want to use it.*
- *I would like to use this resource*
- *I do not use this resources and do not want to use it*

Survey Items N=73	*I currently use this resource*	*I would like to use this resource*	*I do not use this resource and do not want to use it*
Informal Support (e.g. Talking or Spending Time with Family or Friends)	**60.3%**	31.5%	8.2%
Professional Mental Health Services (e.g. counseling with psychologist, clinical social worker, etc.)	17.8%	**49.3%**	32.9%
Mental Health Hotlines, Warm Lines, or Peer Chats (e.g. National Suicide Prevention Line)	5.5%	41.1%	**53.4%**
Riverside's TakemyHand™ Live Peer Chat	5.5%	**54.8%**	39.7%
Social Media (e.g. Facebook, Twitter, Tik Tok)	**39.8%**	26.0%	34.2%
Online Forums or Communities (e.g. Mental Health Forum, BeyondBlue)	11.0%	42.5%	**46.5%**
Mental Health Websites (e.g. Moodygm, Psychology Today)	15.0%	**42.5%**	**42.5%**
Mental Health Mobile Apps (e.g. 7 Cups, Headspace, Moodpath)	6.9%	**43.8%**	**49.3%**
Exercise Program or Physical Activities	35.6%	**43.9%**	20.5%
Art Activities (e.g. Painting, Writing, Listening to or Creating Music)	38.4%	**45.2%**	16.4%

Do you currently use or do the following?

Overall, "*Informal Support*" (60.3%) and "*Social Media"* (39.8%) were selected most frequently as a support the respondents currently used. Interestingly, nearly half (49%) indicated they would like to use mental health services, and more than half would like to use the TakemyHand™ LiveChat/website. In addition, more than 40% reported they would like to use mental health websites, open forums or communities, mental health hotlines, or mental health mobile apps. In terms of resources the respondents did not use and did not want to use, 53% reported mental health hotlines was not a resource they wanted. While many were interested in using mental health mobile apps, 49% indicated they do not use them and would not want to use them. About a third reported they do not use mental health services and would not want to use that resource.

Deaf and Hard of Hearing MH Needs

Survey Responses:

Challenges Accessing Mental Health Resources

Participants were asked another set of question about the type of challenges they have experienced while accessing Mental Health-related resources, and the majority responded "Yes" to the following statements:

- **There is limited support for American Sign Language (89%)**
- **The waiting time to access resources is too long (75%)**
- **I question whether the resources are helpful (73%)**
- **I prefer to deal with issues of my own (55%)**
- **I question how serious my needs are (67%)**
- **I question whether the resources are helpful (72.6%)**

What challenges do you experience when accessing Mental Health related resources?

Survey Items	*Yes* N= 73	*No*
There is limited support for American Sign Language (ASL)	89.0%	11.0%
The waiting time to access resources is too long	75.3%	24.7%
I prefer to deal with issues on my own	54.8%	45.2%
I question how serious my needs are	67.1%	32.9%
I don't think anyone can understand my problems	46.6%	53.4%
I question whether the resources are helpful	72.6%	27.4%
I don't have time	30.1%	69.9%
I worry about what others will think of me	39.7%	60.3%
I have a bad experience with mental health resources in the past	46.6%	53.4%
I am not comfortable using technology nor have the resources to use technology	23.3%	76.7%

Overall, limited support for ASL was the most frequently report challenge (89%) along with long wait times for access (75%). Some survey free response comments also touched on the need for ASL counselors. One respondent indicated, "I prefer anonymity, so if in ASL then live person can see me. Deaf community is too small and familiar with each other. Live text-based chat would work."; another respondent noted, "The counselors in California are limited, I either know them or they are helping my friend (conflict of interest)." Interestingly, nearly three quarters (73%) indicated they question whether the resources are helpful, and more then two thirds (67%) questioned the seriousness of their needs. A fairly large proportion indicated they had a bad experience with mental health resources in the past . More than half reported they prefer to deal with issues on their own. Not having enough time, and comfort with technology were not reported challenges for more than two-thirds of respondents.

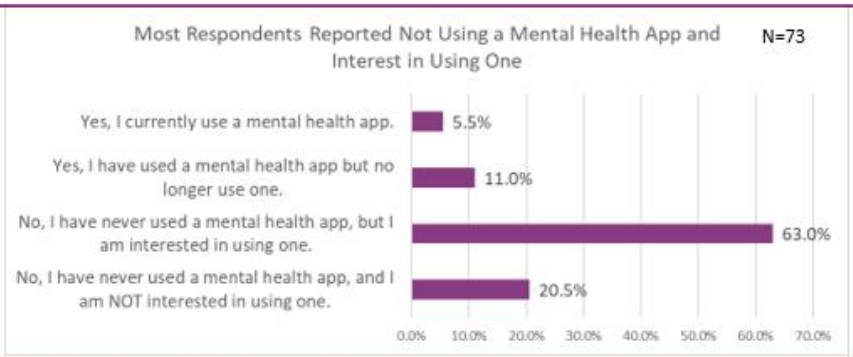
Deaf and Hard of Hearing MH Needs

Survey Responses:

Important Considerations for a Mental Health App

The survey also included a set of questions about the use of mental health apps ,and what would be important considerations for mental health apps. Items were rated on a scale from Not At All Important (1) to Extremely Important. Responses to mental health app use indicated 63% had not used an app before but were interested in using one.

Have you ever used a mental health app?



The majority of respondents indicated that all of the app considerations were either "Very Important" or "Extremely Important", except for Artificial Intelligence or Chatbot (41.1% responded "*Not At All Important*"). The following is a summary of responses rated as either "Very Important" or " Extremely Important":

- **Referral to Clinical Mental Health Services Outside of the App (67.1%)**
- **Education or Information on Signs and Symptoms of Mental Health Illness, Causes, and Treatments (78.1%)**
- **Self-Tracking Mental Health Symptoms (74%)**
- **Telehealth (69.8%)**
- **Peer Support and Chat (67.1%)**
- **Crisis or Emergency Support (79.4%)**
- **Suicide Prevention (83.5%)**
- **Mental Health Screening (79.5%)**

What do you think of the importance of the	*Not At All Important*	*Slightly Important*	*Moderately Important*	*Very Important*	*Extremely Important*
Referral to Clinical Mental Health Services Outside of the App	4.1%	15.1%	13.7%	**37.0%**	**30.1%**
Telehealth (Direct Connection to Clinical Mental Health Services	5.5%	9.6%	15.1%	**35.6%**	**34.2%**
Peer Support and Chat (with a Certified Peer Support Specialist)	4.1%	12.4%	16.4%	**32.9%**	**34.2%**
Education or Information on How to Spot the Signs and Symptoms of Mental Illness, Causes, and Treatments	1.4%	4.1%	16.4%	**37.0%**	**41.1%**
Self-Tracking Mental Health Symptoms (e.g. Mood and	5.5%	6.8%	13.7%	**43.9%**	**30.1%**
Crisis or Emergency Support	2.7%	8.2%	9.7%	**30.1%**	**49.3%**
Mental Health Screening	4.1%	8.2%	8.2%	**41.1%**	**38.4%**
Suicide Prevention	6.8%	4.1%	5.6%	**30.1%**	**53.4%**
Artificial Intelligence or Chatbot	**41.1%**	13.7%	13.7%	15.1%	16.4%

Deaf and Hard of Hearing MH Needs

Survey Responses:

Important Considerations for a Mental Health App

The survey also included a set of questions about the what would be important for a mental health app specifically for a person who is deaf or hard of hearing. Items were rated on a scale from **Not At All Important**
(1) to **Extremely Important (5)**.

When thinking about using an app to support mental health what aspects are important to you ?

Survey Items N=73	***Important***	***Not Important***
The app supports American Sign Language (ASL)	98.6%	1.4%
The app connects me directly with a person who knows American Sign Language (ASL)	94.5%	5.5%
The app contains a lot of visuals and images	97.3%	2.7%
The app has video with captions	97.3%	2.7%
The app is available in languages other than English	87.7%	12.3%
The app is free	95.9%	4.1%
The app is sensitive to my culture, race, ethnicity, gender, and/or sexuality	84.9%	15.1%
People I interact with on the app are similar to me	84.9%	15.1%
My personal information will be kept private	98.6%	1.4%
The app will not have a negative effect on my device (e.g. app will not drain my phone battery, take up too much memory, or use up my data plan)	90.4%	9.6%
Parts of the app can be used offline	87.7%	12.3%

Overall, the respondents endorsed all of the app considerations as important. The top four items are listed below:

- **My personal information will be kept private (98.6%)**
- **The app supports American Sign Language (98.6%)**
- **The app has video with captions (97.3%)**
- **The app contains a lot of visuals and images (97.3%)**

Deaf and Hard of Hearing MH Needs

Survey Responses:

Respondent Comments for a Mental Health App

The survey also included a section for respondents to type in comments about the symptoms or issues they felt were important for a mental health app to cover.

What symptoms or mental health concerns would you like an app for mental health to cover? (Example: depression, loneliness, anxiety, eating disorders, etc.)

Free responses general themes

- **Depression and Anxiety**

"Depression, loneliness, anxiety, social skills."
"Depression with ASL direct service."
"Depression, anxiety, feelings of disconnect." "Anxiety, suicidal thoughts, and depression."
"Suicide."
"Loneliness and feeling like no one really gets it. My hearing makes me feel limited."

- **General Emotional Wellness or All Aspects of Mental Health** *"Emotional health and wellness, and physical health and wellness." "Health in general."*

"Everything, really. It's important to give 100% access to everything for Deaf people."
"All common issues."
"Any emotions , Any trauma , Any frustrations , struggles , hardship . Anything a person feels and needs support. It shouldn't have limit."
"All mental health should be covered. We should be able to access the resources at all times."
"All aspects of mental health."
"Stress, health issues."

- **Relationships**

"Grieving and understanding the stages of losing someone."
"How to get out from unhealthy relationship. How to identify toxic (gaslighting, metal/verbal abuse, etc.)."
"Talk about loss in family. Talk about breaking ups from a long relationship."

- **Specific Mental Health Concerns** *"Insomnia from anxiety" "Eating disorders" "Emergency panic attacks" "Trauma and PTSD."*

- **Access**

"Helping and feedback with videophone and important have ASL providers for deaf/hard of hearing." "Symptoms or mental health concerns based on deaf community experience - how symptoms might impact ASL, visual, and etc."

Deaf and Hard of Hearing MH Needs

Survey Responses:

Important Considerations for a Mental Health App

What else would you like to share with us?

(This could include but is not limited to: sharing more about the types of technologies you use, resources you use to support your mental health and well-being, and Deaf and Hard of Hearing culture)

Free responses in general themes

Most additional comments focused on various ways to increase access.

- **Access**

“24/7 access regardless of location” "Caption phone apps are helpful."

"Even though the mental app don't specifically provide service for the deaf community. It would be lovely if there is development to support ASL on the app."

"I use yoga and meditation app, also strength your mind and spiritually those app are amazing but unfortunately most don't have captions."

"Need options available in both ASL, visuals, and English. If in ASL, have available in written form (as captions, or transcript)."

"Highly recommend to improve with the direct service in ASL."

“Everything seems to be for kids and as an adult your just out of luck." "No AI. Very difficult to use non-human aspects of an app."

"Spread more awareness."

"This research is a very helpful concept to identify and work on improving deaf community. Thank you."

Deaf and Hard of Hearing MH Needs

Future Directions:

RUHS-BH will utilize the survey results to continue efforts to better serve the Deaf and Hard of Hearing community of Riverside County. The findings from this survey provided some important information about the needs of the DHoH community including; access to services are a challenge, mental health stigma is an issue, appropriate forms of communication is a pressing need, greater awareness and education on mental health topics are needed.

Key findings:

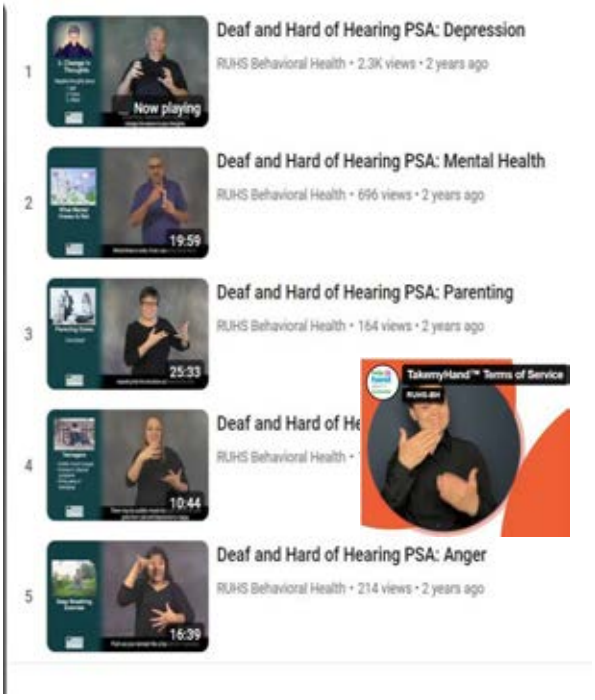
- 89% indicated there is limited support for American Sign Language
- 75% indicated the waiting time to access services is too long.
- 67% questioned the seriousness of their needs.
- 73% indicated they question whether the resources are helpful.
- 40% had the perception that most people thought having a mental illness was a personal weakness.

Initial Actions to Address Needs:

A series of mental health educational videos were produced using ASL. Links to those videos were posted on the TakemyHand™ website. The videos play on the RUHS-BH You Tube channel. There are five videos
covering the following topics: Depression, Mental Health, Parenting, Suicide, Anger.

In addition a trial of providing ASL LiveChat on the TakemyHand™ website was initiated in December of 2023 and functioned through February 26th 2024. One part-time and one full time Deaf certified Peer Support Specialist staff were trained in providing support via the LiveChat. A real time video capability for the LiveChat was installed on the TakemyHand™ website.

Approximately 2 to 5 DHoH people engaged with the LiveChat per week during the trail period offering valuable feedback. Collaborations with CODIE facilitated community involvement, with in-person events to demonstrate the LiveChat service and gather feedback. Feedback included common themes involving technical challenges, direct services for DHoH community, and communication access concerns.



Deaf and Hard of Hearing MH Needs

Future Directions:

Recommendations from the trial period of LiveChat using ASL are summarized below:

- Implement a feature to adjust the video chat screen size for better visual accessibility.
- Increase the availability of ASL Peer Counseling to meet the demand within the community.
- Extend service hours, especially in the evenings, to provide emotional support and accommodate community schedules.
- Provide Deaf-Sensitive Training for TMH Peer Support Specialists to enhance cultural competence and

communication skills.

- Ensure mobile apps are fully functional and accessible for video chat sessions. Recommendations for next steps included:
- Continuously upgrade training curriculum and hiring processes based on community feedback.
- Explore additional features and improvements to enhance visual accessibility and user experience.
- Expand outreach efforts to increase awareness and participation within the target communities.

The goal is to pursue expanding the TakemyHand™ LiveChat service to continue serving the needs of the DHoH community.

Deaf and Hard of Hearing MH Needs

Initial Actions to Address Needs:

Digital Literacy Videos were also produced using ASL and closed captioning to inform the community about safe practices when using technology and online resources. The 10 videos were made available on 77 of the Kiosks deployed in the community. In addition, links to the videos were posted to the TakemyHand™ website resources page.

ASL Digital Literacy

Welcome to the Help@Hand Digital Mental Health ASL Literacy Video Page

Help@Hand is a California multi-city and county Collaboration created to help shape the future of technology-based mental health solutions and connect people to care across the state. These brief, basic skills video tutorials are intended to empower California communities to make informed decisions about how they engage with technology. Please check out our page for new content. Don't forget to take the survey at the end of each video to let us know if the information was valuable.

"Tips for Staying Safe Online" Video Series

Part 1



"Important Terms" Video Transcription



"Safer Website Browsing" Video Transcription (PDF)



"Phishing" Video Transcription (PDF)



"Scam Malware" Video Transcription (PDF)

Deaf and Hard of Hearing MH Needs

Initial Actions to Address Needs:

Help @ Hand ASL Digital Literacy Videos (continued)

Part 2



"Downloading Anti-Virus and Anti-Malware Software" Video Transcription (PDF)



"Creating and Managing Passwords" Video Transcription (PDF)



"Using Public Wi-Fi" Video Transcription (PDF)



"Adjusting Browser Settings for Internet Explorer" Video Transcription (PDF) – Coming Soon



"Adjusting Browser Settings for Safari" Video Transcription (PDF) –



"Adjusting Browser Settings for Google Chrome" Video Transcription (PDF)

Project Evaluation

Recovery Record



Recovery Record Pilot

Implementation Highlights

RUHS-Behavioral Health Help@Hand Project piloted the Recovery Record mobile application that serves as digital support tool for individuals with an eating disorder diagnosis. Recovery Record is a mobile platform built on decades of Cognitive Behavioral Therapy and self-monitoring research. The utilization of the mobile app was also embedded within the Riverside County Eating Disorder (ED) Program. The Recovery Record App has daily logs for self-ratings which include: Client daily *Meals*, *Feelings*, *Photos*, *Urges*, *Disordered Behavior*, as well as *Interactions with (to and from) their Clinicians*. Recovery Record features also include a clinical dashboard for providers to view client activity in the Recovery Record App. For this pilot, RUHS-BH recruited County clinic clients and contracted providers' clients as Recovery Record pilot participants. At the completion of Help@Hand in February, 2024, a total of 37 Pilot Participants were enrolled and linked in the Recovery Record App, and 50 Care Team Providers were onboarded. Based on engagement data, 21 Clinicians were linked to RR Clients during Pilot.



Recovery Record Pilot

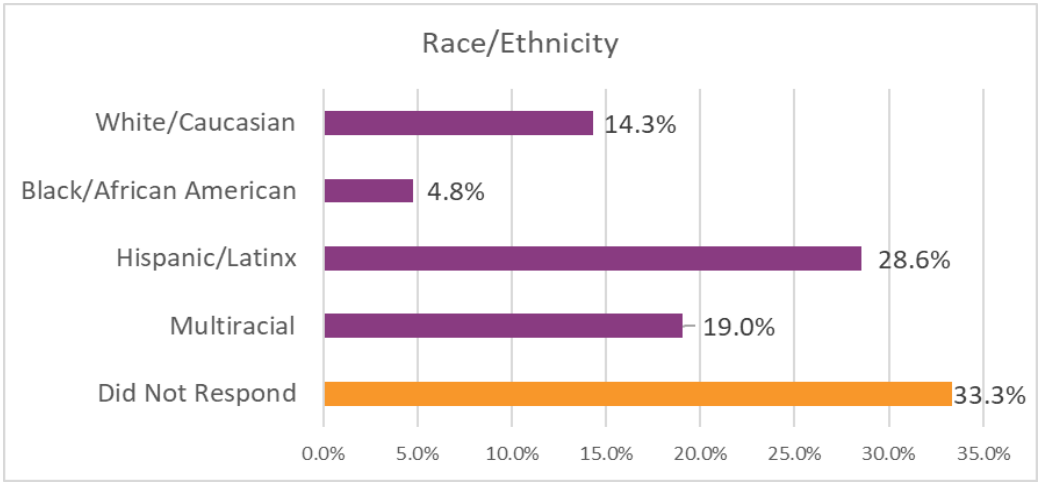
Demographics RR Pilot Participants

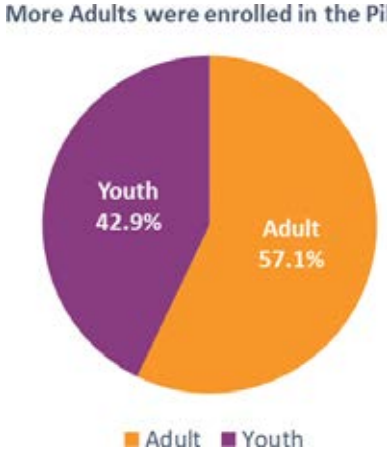
Recruitment of consumers to pilot the Recovery Record (RR) app resulted in 26 total participants that were enrolled and linked to RUHS-BH staff, and 21 clinicians were linked to these RR consumers during the pilot.

Demographic data was available for 21 consumers in the pilot, collected from evaluation forms and the electronic health record.

Summary of Demographics for Recovery Record Pilot consumers (n = 21):

- 57% Adult clients (18 years or older).
- 90% Female, 5% Male and 5% Transgender.
- 19% Multiracial, 14% White/Caucasian, 27% Hispanic/Latinx, 5% Black/African American, 33% chose not to respond

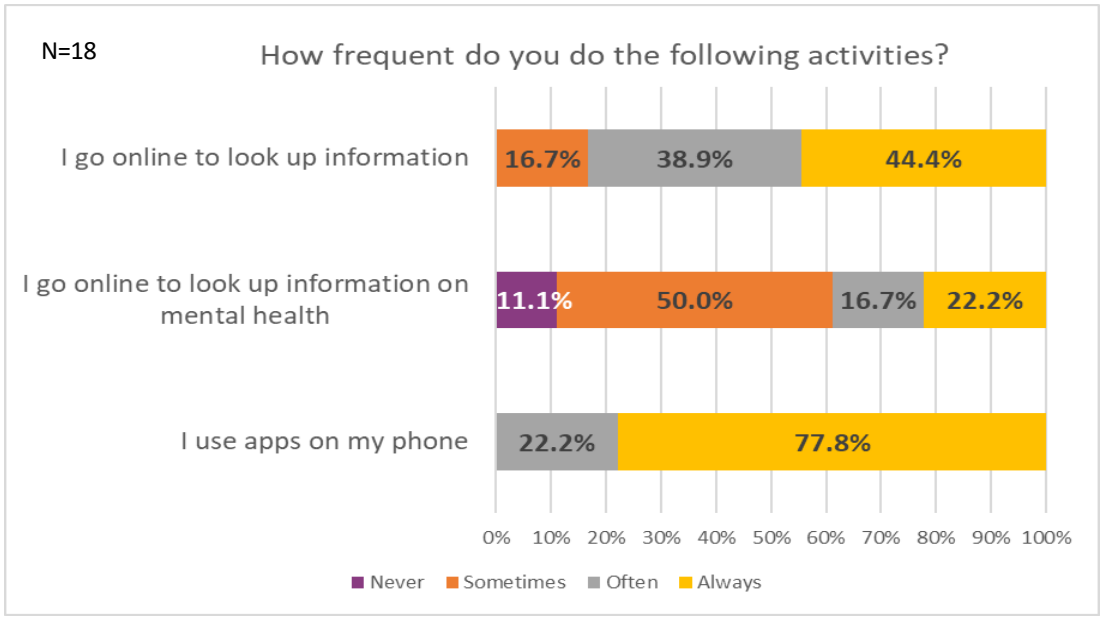


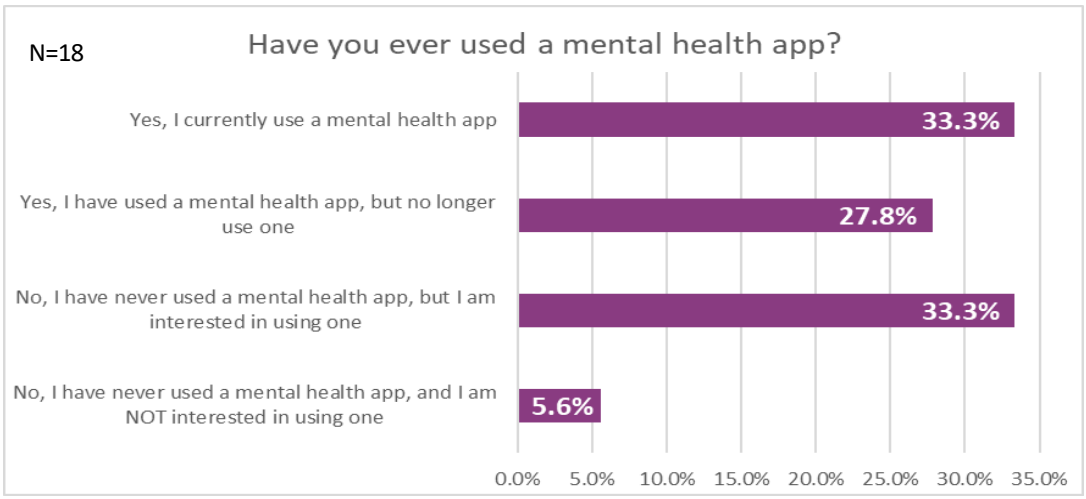


Recovery Record Pilot

Technology Use RR Pilot Participants

Technology use surveys were distributed to consumer who enrolled in the RR pilot. A total of 18 Technology Use surveys were collected. Based on the responses, 89% currently use Smartphones, and over 80% currently use their smartphones, tablets, or computers to browse on Social Network Sites (88.9%), Listen to Music (8.3.%), and for Online Shopping (83.3%). Also, 94% reported they feel *Confident* or *Very Confident* in using Phone applications, and 100% responded that they either *Often* or *Always* use apps on their phones. The survey also included items on seeking information about mental health online, and the use of phone or online mental health applications. The results are shown in the following figures. A large proportion of





respondents reported having used a mental health app (61%), and a third had not used a mental health app but would like to use one.

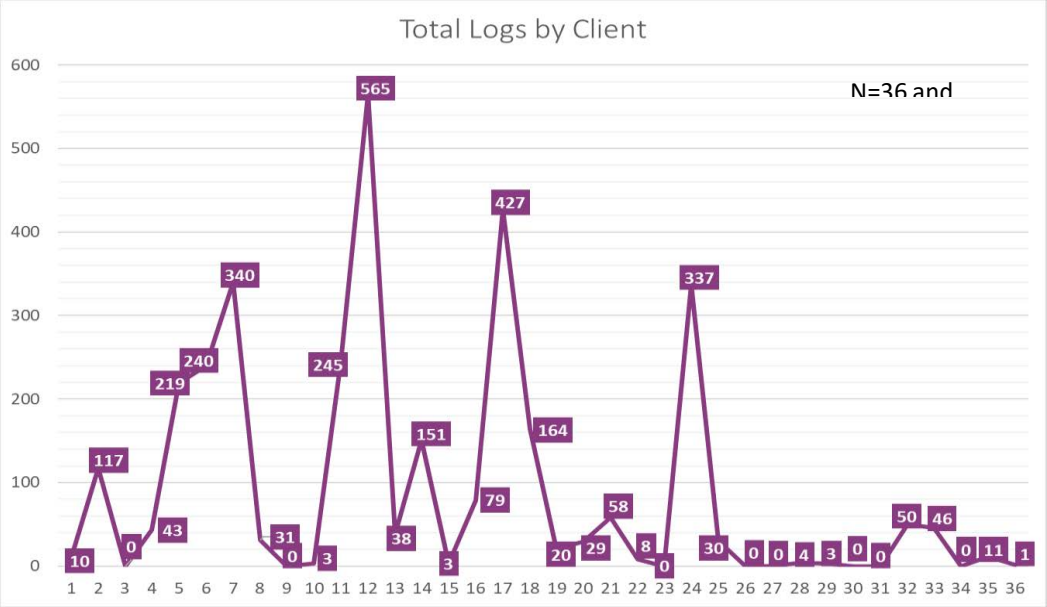
Recovery Record Pilot

Evaluation Summary:

- Evaluate the overall use of Recovery Record app
- Examine any feedback from pilot participants on their experiences with the app

Data collection put in place for depression measures and an Eating Disorder measure did not result in sufficient pre to post measure collection to generate meaningful analysis.

Use of the Recovery Record app was examined using data provided by the Recovery Record developers. Data on app use included the number of times pilot consumers engaged in the logging activity features of the app. Data was available for the 27 RR pilot participants and 9 people that onboarded clinicians linked with in the app but did not formally enroll in the pilot. Data on usage is reported for all 36 consumers.

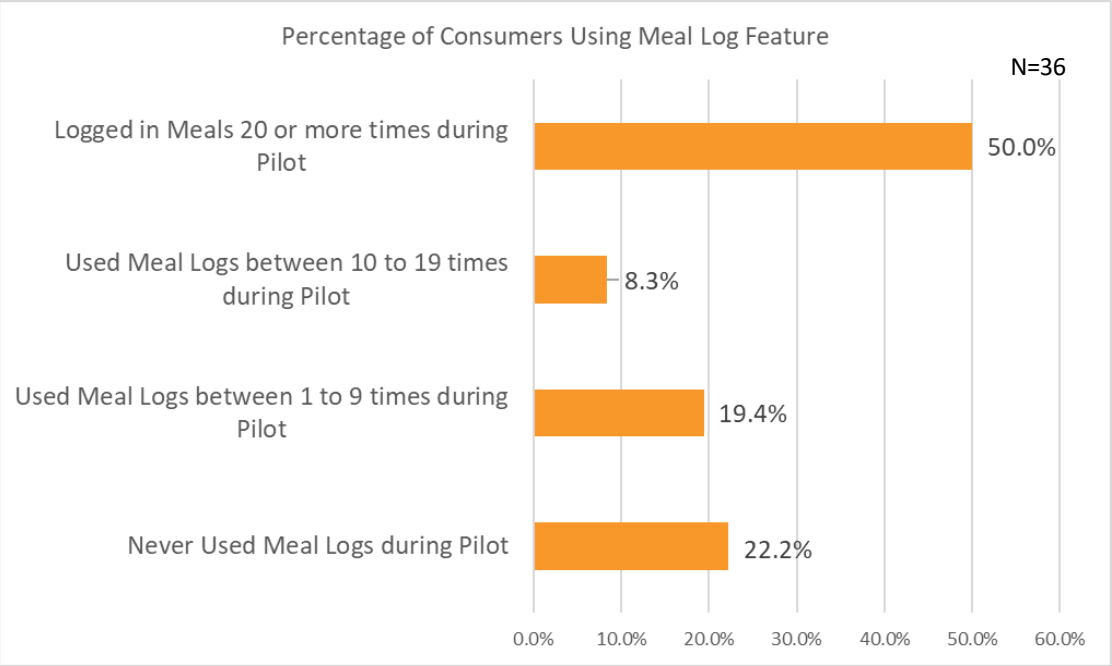


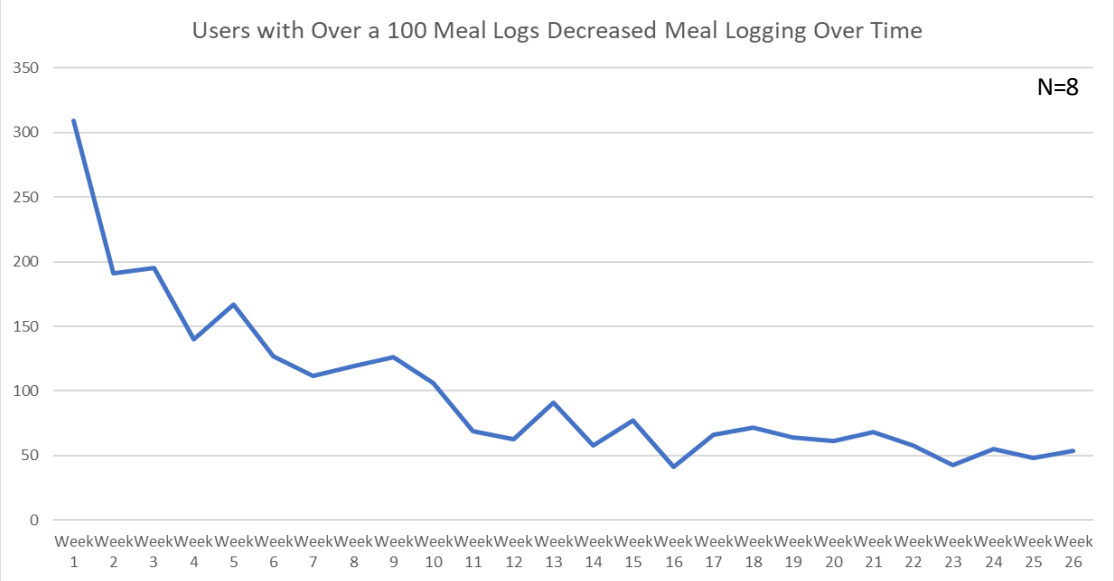
There was wide variation in logging in the RR app with 76% of the clients logging in the app at least once. Nine consumers had 0 log entries and did not use the app. More than a third (36% ,n=13) only logged from 0- 3 times, and 33% logged greater then 3 times but less than 51, and 31% logged between 53 and more than 100 times. This total log count (3,272) includes logging the daily 3 meal and 2 snacks and any logging of feelings or disordered thoughts. For a small proportion of consumers using the app, logging was more regular, while for others they were not as engaged in logging in the app or were not using it.

Recovery Record Pilot

Use of the Recovery Record app was examined using data provided by the Recovery Record developers. The following figures are specific to the Meal Logging feature in the app.

- Out of the total 36 consumers 71.1% logged in meals within the 6-months pilot.
- A few (21%, n=8) consumers did more meal logging with at least a 100+ meal logs.

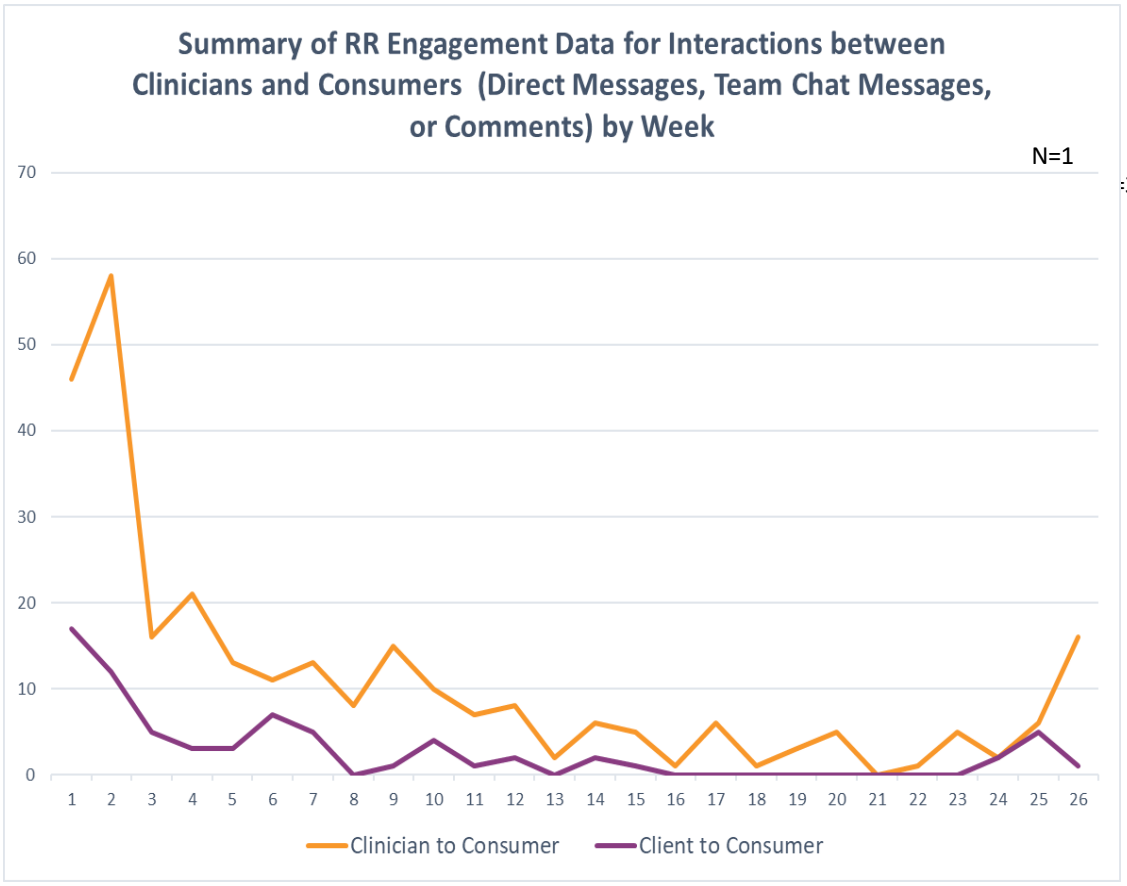




Recovery Record Pilot

Use of the Recovery Record app was examined using data provided by the Recovery Record developers. The following figure is specific to the messaging feature in the app.

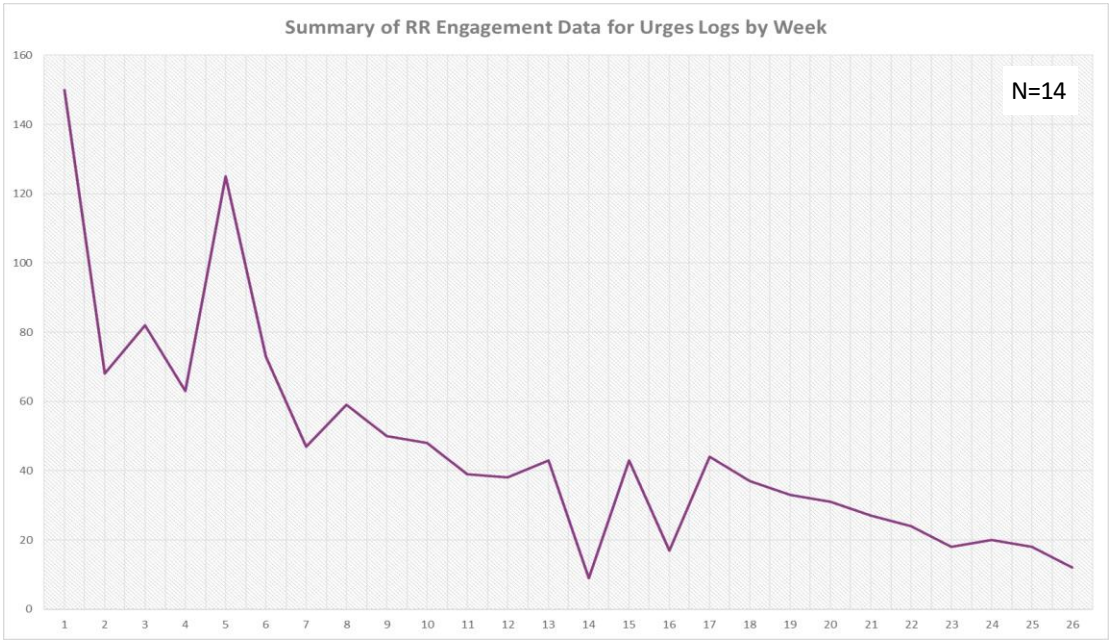
- Use of the messaging feature was low overall and declined over time.



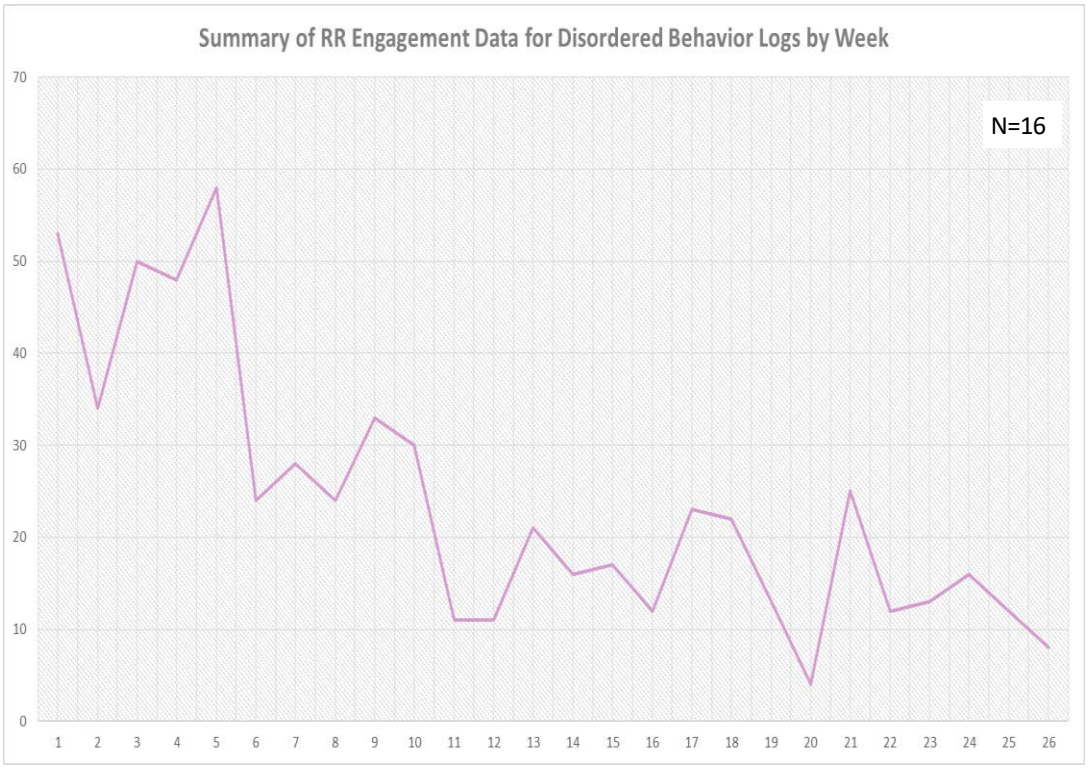
- 16 out of 37 clients (43.3%) used the messaging feature to interact with their Clinicians during the Pilot (i.e. through Direct Messages, Team Chat Messages, or Comments).

Recovery Record Pilot

Use of the Recovery Record app was examined using data provided by the Recovery Record developers. The following figure is specific to recording of urges and disordered thinking.



- 38% of consumers recorded urges at least once and 43% recorded disordered thoughts at least once.
- Logging of urges and disordered thoughts decreased over time.



Recovery Record Pilot

Very little post User Experience surveys were submitted for analysis.

Summary of User Experience Survey after 6-Months Pilot

Analysis of the **5** participant's data from the Recovery Record User Experience Survey post results on select items are shown below. Percentages reflect "*Agreed*" or "*Strongly Agreed*" responses to survey item
statements.

- 83.3% enjoyed using Recovery Record
- 66.7% found Recovery Record useful in their daily lives
- 66.7% thought Recovery Record met their wellness needs
- 50.0% thought using Recovery Record improved their mental health
- 66.7% would continue to use Recovery Record if given the opportunity
- 66.7% would recommend Recovery Record
- 83.3% thought Recovery Record is easy to use
- 100.0% thought Recovery Record rarely crashed or caused problems
- 100.0% thought it is easy to navigate within Recovery Record
- 100.0% thought it is easy to find the information they need in Recovery Record
- 100.0% found Recovery Record to be visually appealing and attractive
- 83.3% thought the content in Recovery Record is appropriate for them
- 83.3% trust Recovery Record with their personal information
- 83.3% felt the information in Recovery Record is credible and trustworthy
- 100.0% felt they could get help from others if they had difficulties while using Recovery Record
- 83.3% thought the "Messages from Clinicians" Feature helped them to feel connected to their service providers and services at the clinic they attended.

Weekly Skills and Goals

- 50% felt it helped them to achieve their goals
- 50% felt it was useful in their daily life
- 66.7% felt it met their wellness needs
- 33.4% used this feature
- 66.7% felt it was easy to use

Community Coping Skills

- 33.3% felt it helped them to feel more socially connected
- 66.7% felt it was useful in their daily life
- 66.7% felt it met their wellness needs
- 33.4% used this feature
- 66.7% felt it was easy to use

Meal Planner

- 66.7% felt it was easy to use
- 66.7% used this feature often
- 66.7% felt it helped them to remember information they wanted to communicate to their clinician

Recovery Record Pilot

Recovery Record Future Direction

Challenges with Recovery Record were related to the spread of clinicians across many clinics which made it difficult to coordinate and support clinicians in utilizing the app.

- RHUS-BH has reviewed the benefits of Recovery Record noted in some literature for people with eating disorders.
- Given the promise of using Recovery Record app with a population that has high risks, RUHS-BH decided to relaunch implementing Recovery Record in a more structured setting to try the app in one context at the new Eating Disorder Intensive Outpatient Treatment clinic. The will provide the opportunity to have more training for staff and consumers using the app, and will also provide the opportunity for more hands on support for staff.
- Evaluation on the use of the app will also continue in this new Eating Disorder clinic.

Project Evaluation

Digital Mental Health Literacy



Digital Mental Health Literacy

Early in the implementation of Help@Hand, CalMHSA identified the opportunity to empower staff members with digital literacy trainings to support the implementation of digital therapeutics. The Digital Mental Health Literacy Project (DMHL) was designed to enhance access to digital therapeutic tools for underserved communities (FSP, TAY, Adults and Mature Adults), through digital literacy trainings. RUHS-BH contracted with Painted Brain, to provide train-the-trainer workshops and "Appy Hour" training sessions to consumers and staff. The goal was to increase staff confidence and knowledge to encourage the use of digital therapeutic tools. The Appy Hour component focused on introducing clinic consumers and staff to mental health apps and assisting them with how to use the apps. RUHS-Behavioral Health Peer Support Specialists were tasked with providing Digital Literacy workshops. These workshops provided by RUHS-BH Peer supports were provided to encourage and support consumers' use of digital tools safely, and to use the tools to support their emotional wellness. Peer supports also conducted assisted consumers with accessing their behavioral health records through the County EHR ***myHealthPointe*** portal.

Implementation Highlights:

Providing **Digital Mental Health Literacy** (DMHL) began with training RUHS-BH Help@Hand Peer support Specialist and Peer Support Specialist working in the clinics. A series of Train the Trainer sessions were conducted with Painted Brain facilitating those trainings. During those sessions, Painted Brain focused on informing staff about Anti-Phishing /Anti Scamming, and Online Safety and Privacy.

RUHS-BH Peer Supports collaborated with Painted Brain to provide the **"Appy Hour"** sessions. Peer Support Specialist reviewed and selected the Apps offered at the sessions. Presentations were conducted with clinic supervisors to market the availability of Appy Hours for the clinic consumers, and to schedule Appy Hours sessions. Outreach and recruitment efforts were used to encourage consumers to attend the scheduled Appy Hour workshops. Additional workshops were provided focused solely on using Internet safely for privacy and avoidance of scams.

Consumer received an incentive in the form of a gift card for attending Appy Hour workshops. RUHS-BH Help@Hand Peer Support Specialists also provided "**Learn and Earn**" workshops to support consumers with accessing their behavioral health records through the County EHR ***myHealthPointe*** portal. Consumers received assistance in enrolling in the ***myHealthPointe*** portal, and received a gift card incentive for setting up their account. Learn and Earn workshops also introduced consumers to the **RUHS Whole Person Health Score** (WPHS). The WPHS is a tool to assess social determinants of health which includes an easy to read score report for the consumer to understand areas where additional resources may be needed. Learn and Earn sessions were advertised to County clinics with emails and flyers.

Digital Mental Health Literacy

Train the Trainer DMHL

There were a total of 6 workshops completed Countywide, from April 18th, 2023 to May 9th 2023, with 45 staff attending. The majority of participants were from the Western region (42.2%, n = 19), followed by Desert region (31.1%, n = 14), and Mid-County region (26.7%, n = 12), respectively. There were 2 workshop topics offered by Painted Brain, based on the results from an online poll sent to RUHS-BH Staff in March 2023 prior to starting the Train the Trainer workshops. The topics selected by staff were "Online Safety and Privacy" and "Anti-Phishing and Anti-Scamming", and the majority of staff chose to attend the "Anti- Phishing and Anti-Scamming" (62.2%, n = 28) training. A total of 21 post-satisfaction surveys were submitted via online survey at the conclusion of the training.

Staff response to Training

- 80.9% participants (n = 17) responded that they "Agreed" or "Strongly Agreed" that the ***Workshop helped them in understanding the topic better.***
- 71.4% participants (n = 15) responded that they "Agreed" or "Strongly Agreed" that the ***Workshop presentation was clear and organized***.
- 61.9% participants (n = 13) responded that they "Agreed" or "Strongly Agreed" that the ***Workshop that they attended was useful to them***.
- 47.6% participants (n = 10) responded that they "Agreed" or "Strongly Agreed" that the ***Workshop provided enough information for them to present the information to their clients***.



Participant Comments

Things I learned in the Train the Trainer Workshop were:

"Types of bad actors, types of scams, how to avoid scams, things we can do to increase privacy while browsing online."

"I learned more about the help at hand program and the anti-phishing and anti-scamming issues."

"Why it's so important to be aware."

What I liked about the Train the Trainer Workshop was:

"I liked that the trainers where on top of everyone's questions and encouraged sharing." "Learning more about App permissions."

"I liked the topic and I did learn more about the types of scams and bad actors."

"Learning some of the new terms for scamming."

Digital Mental Health Literacy

DMHL Appy Hour Workshops

Appy Hours were held at County clinic locations and County Peer Support and Recovery Centers. The goal was to increase consumers knowledge, confidence and skills when using online or phone Apps focused on mental wellness.

Each workshop was designed to engage consumers and encourage them to:

- Be Empowered through the use of digital wellness applications.
- Gain hands-on learning on how to best use these digital wellness tools.
- Learn how the app can be integrated into their daily lives.
- Learn how to protect themselves while browsing online and avoid digital phishing and scams.
- Experience a fun and collaborative learning environment.

Additionally, from each wellness app, the goals were for consumers to learn about:

- What a Wellness App is
- What the benefits of a Wellness App are
- Why should consumers use a Wellness App
- What are the user tools within the Wellness App

Painted Brain was contracted by the Help@Hand Innovation to provide a total of 39 Appy Hour workshops Countywide. At the end of each workshop, incentives were also given to all of the consumers who attended, participated, and completed the workshops. Each clinic that participated had the options to choose the workshop and following topics to be offered for their consumers:

- **Don't Panic Wellness App**
- **PTSD Wellness App**
- **Super Better Wellness App**
- **Anti Phishing and Anti Scamming (*Internet Safety*)**
- **Online Safety and Privacy (*Internet Safety*)**

Appy Hour workshops were conducted, from August 22nd, 2023 to November 1st, 2023.



Digital Mental Health Literacy

DMHL Appy Hour Workshops

Appy Hour Workshops Mental Wellness Apps

Appy Hour Workshops Summary:

- **39** Appy Hour Workshops completed Countywide (***24*** *App Workshops and* ***15*** *Internet Safety Workshops*)
- **447** Consumers attended Appy Hour Workshops

  443 Post Satisfaction Surveys submitted

Don't Panic

Offered in English/Spanish

This app includes a number of tools that assist in connecting with one's thoughts and feelings, managing mood swings, and recognize indicators of sadness and anxiety. Tools also include coping with extreme emotions and ways to manage suicidal thoughts.

PTSD Coach

Offered in English/Spanish

This app offers knowledge about PTSD, details on professional care, a PTSD self-assessment tool, opportunities to connect with support, and tools that can help to cope with the demands of daily life.

SuperBetter

Offered in English

This app incorporates gaming to overcome hurdles in many aspects of life. As they strive for epic victories, players can adopt a secret identity, activate power-ups, battle opponents, accomplish objectives, and check-in with allies.

Additional Workshops

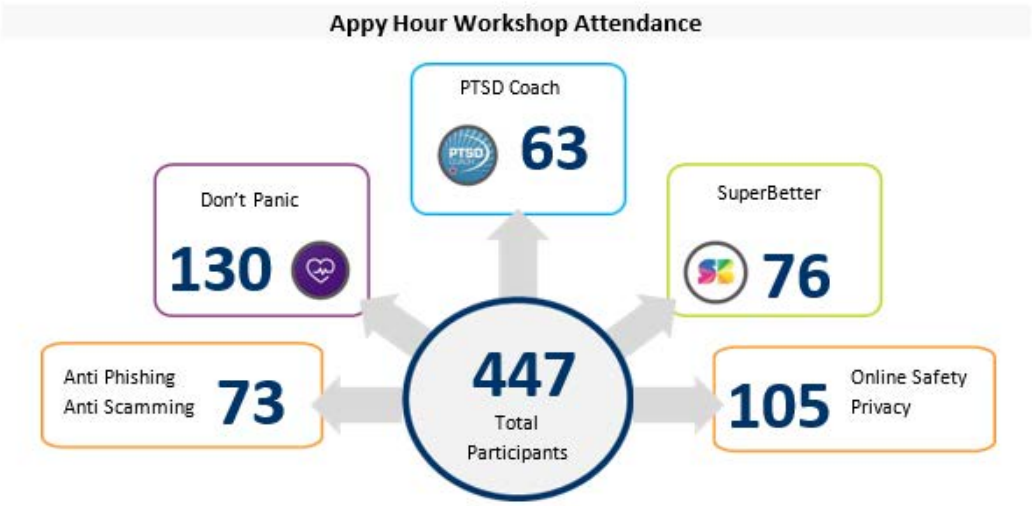
- **Anti Phishing and Anti Scamming**, Focused on learning about phishing and scamming, different types of electronic scams, types of phishing attacks, and how to avoid them.

Online Safety and Privacy, Focused on online safety, privacy and privacy settings, enabling authentication



Digital Mental Health Literacy

DMHL Appy Hour Workshops



Digital Mental Health Literacy

DMHL Appy Hour Workshops Satisfaction

At the end of each Appy Hour workshop, staff asked all consumers to complete post-satisfaction surveys. The post-satisfaction survey is meant to gather participants' feedback on their overall satisfaction with the Appy Hour workshops, the workshops' contents, the engagement with workshop trainers, and whether the consumers would recommend workshops to other people. On the post-satisfaction survey form, consumers comments were also solicited on the things they liked or learned from the Appy Hour workshops, as well as to provide any feedback on things they did not like about the workshops.

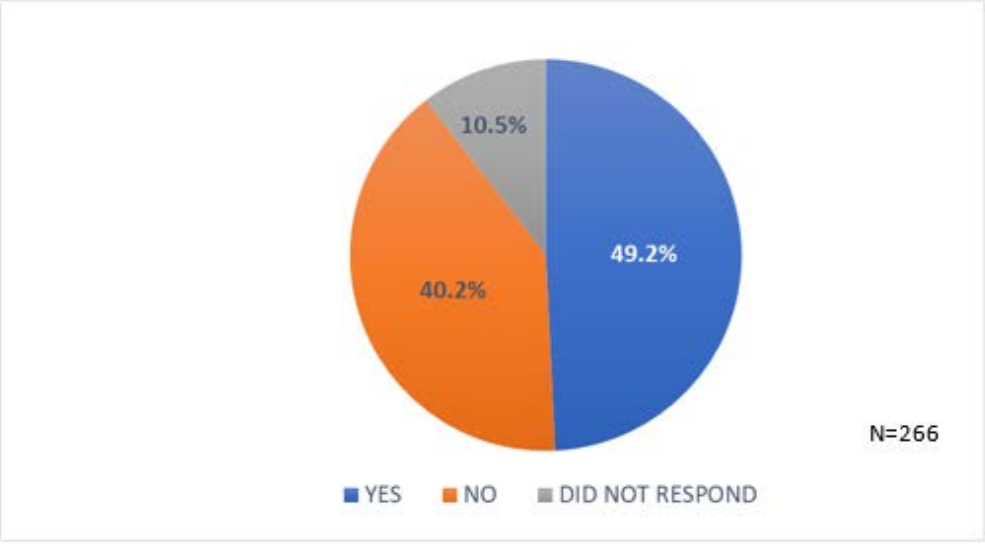
There are two different types of post-satisfaction surveys distributed at the end of the workshops, based on the type of topic attended by consumers: Wellness App surveys and Internet Safety surveys. Each type of survey was analyzed separately.

Appy Hour Satisfaction Survey Summary: Wellness App Series

Don't Panic PTSD Coach SuperBetter

Consumers' experience with using a Mental Health/Wellness App prior to attending the Appy Hour work- shop was gathered on the post-satisfaction survey.

Have you ever used a Mental Health application prior to this workshop?

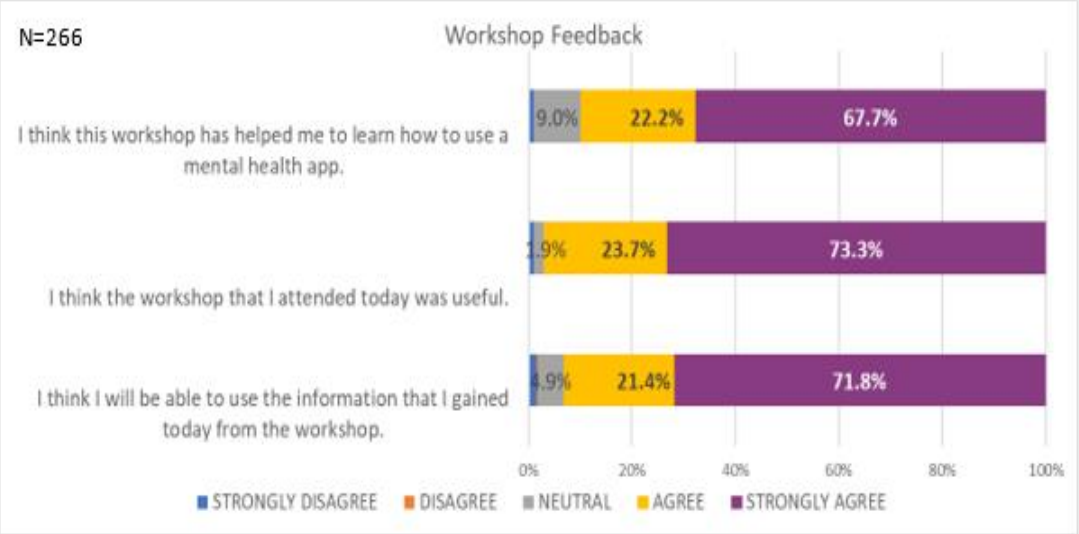


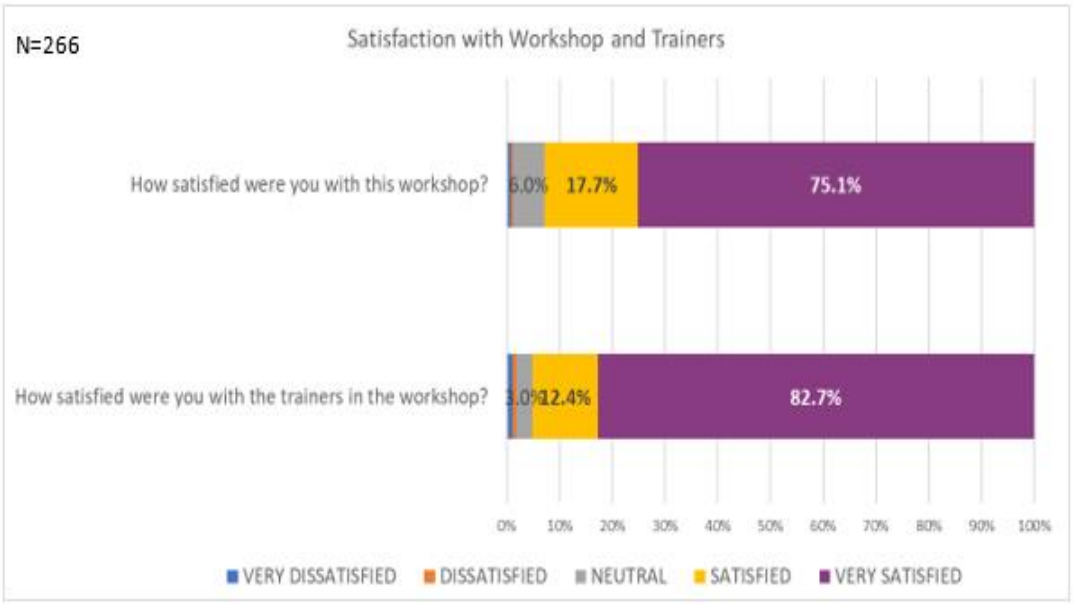
Digital Mental Health Literacy

DMHL Appy Hour Workshops Satisfaction

Appy Hour Satisfaction Survey Summary: Wellness App Series

Don't Panic PTSD Coach SuperBetter





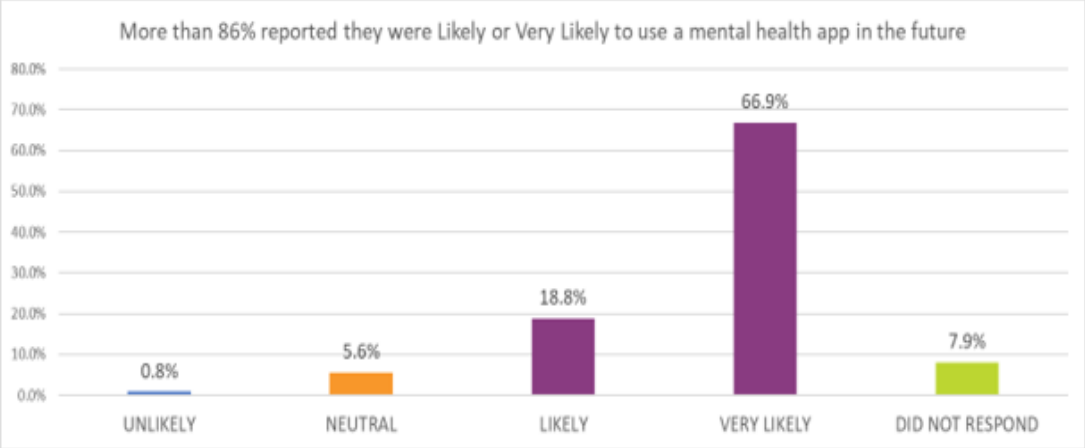
Digital Mental Health Literacy

DMHL Appy Hour Workshops Satisfaction

Appy Hour Satisfaction Survey Summary: Wellness App Series

Don't Panic PTSD Coach SuperBetter

How likely are you to use a Mental Health app similar to the one you learned today?



Appy Hour Participant Comments

What Participants Liked

I have help for my anxiety at my finger tips.

This application has many benefits and I am going to share it with friends and family.

That I can work on my mental health in a fun way and at my comfort of my own home.

I can use this app to help with my wellness, and I learned how to use the app I never knew how to use.

I liked that we have options to help us heal.

Learned there is extra help online by coming and being informed.

I now have an application that can help support my struggles.

Digital Mental Health Literacy

DMHL Appy Hour Workshops Satisfaction

Online Safety & Privacy and Anti Phishing & Anti Scamming Workshops

Online Safety

Workshops focused on how consumers can keep themselves safe online. Content included online safety tips; including how to use privacy setting, how to enable multi-factor authentication and how to identify potential scammers.

Anti-Phishing/Scamming

Workshops included information on how phishing can be used to steal sensitive personal and financial information. Information was provided on the different types of scams that can occur on line and ways to avoid them.





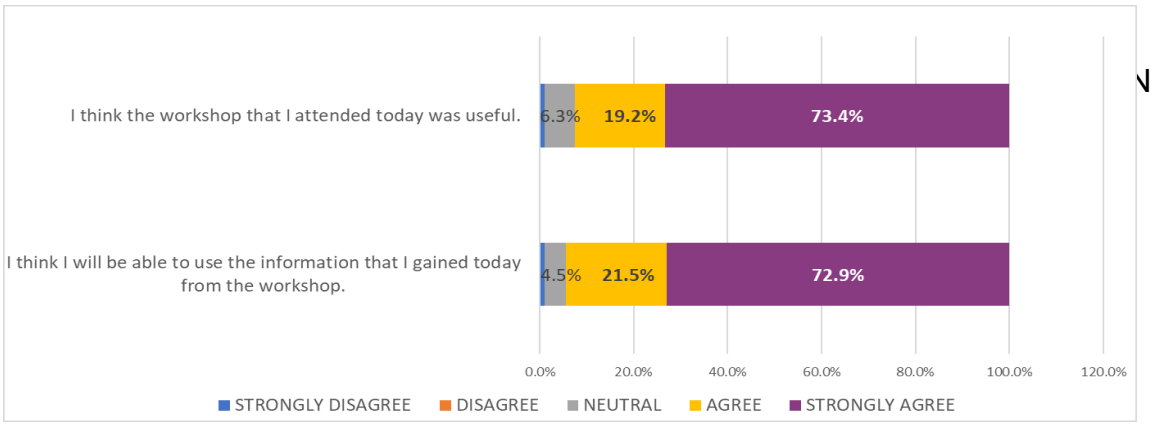
Satisfaction Survey Summary: Online Safety and Anti-Phishing/Scamming

Consumers were asked their opinions about the usefulness of the workshops and whether they gained any useful information from the workshops, the results are summarized below:

- **92.6%** (n = 164) consumers "Agreed" or "Strongly Agreed" that *the non-app series workshops that they attended today was useful.*
- **92.4%** (n = 167) consumers "Agreed" or "Strongly Agreed" that *they would be able to use the information that they gained today from the non-app series workshops.*
- Consumers were also asked if they would recommend the Internet Safety workshops to other people, and **96.6%**

(n = 171) responded "Yes", that they would recommend this type of workshops to other people.

Usefulness of Workshops and Information Gained from Workshops



Overall, consumers' satisfaction with the Appy Hour Internet Safety Workshops positive:

- **93.8%** of the consumers felt "Satisfied" or "Very Satisfied" with the Appy Hour (Internet Safety series)

workshops that they attended today.

- **97.2%** of the consumers felt "Satisfied" or "Very Satisfied" with the App Hour (Internet Safety series) workshops Trainers.

Consumer Comments:

What Participants Liked



I learned about the types of scams.

I liked learning about the general awareness of scammers methods.

I learned about my need to take care of my information

A sense of empowerment.

Useful ways to protect your information on-line

That I wasn't alone in my feeling on scams.

I liked the trainer patience

Today's class made me more aware of online scams and how to stop them

I learn how to use my phone better and erase some apps that I don't need and avoid giving personal information to anyone, avoid being scammed.

The warmness in the room. People shared and respected everyone.

Very organized content, presenter was professional and gave us opportunity to share. The videos were good.

DMHL Learn and Earn Workshops

Learn and Earn Workshops

The "Learn and Earn" Workshops are part of the Digital Mental Health Literacy Activities that were completed by RUHS-Behavioral Health Peer Support Staff, between December 2023 and February 2024. The length of each workshop was 1.5 hours, and consisted of training consumers to learn more about the following applications:

- **Whole PERSON Health Score**
- **MyHealthPointe**

The workshops were focused on assisting consumers with registering, downloading and navigating myHealthPointe which is the application for consumers to have access to the behavioral health medical record. The workshop also trained consumers in how to access the Whole Person Health Score application. Consumers were offered an incentive after downloading and registering for myHealthPointe and completing the Whole Person Health Score.

myHealthPointe workshops were conducted to assist consumers with setting up access to their behavioral health medical records through the RUHS -BH electronic health record ***myHealthPointe*** application. Consumers were assisted with setting a login and pin and how to navigate the application.

Netsmart myHealthPointe

Whole Person Health Score developed by RUHS assess social determinants of health across six domains (Physical Health, Emotional Health, Resource Utilization, Socio-Economics, Ownership, Nutrition, and Lifestyle)



For the Learn and Earn Workshops, the RUHS-Behavioral Health Peer Support Specialists completed:

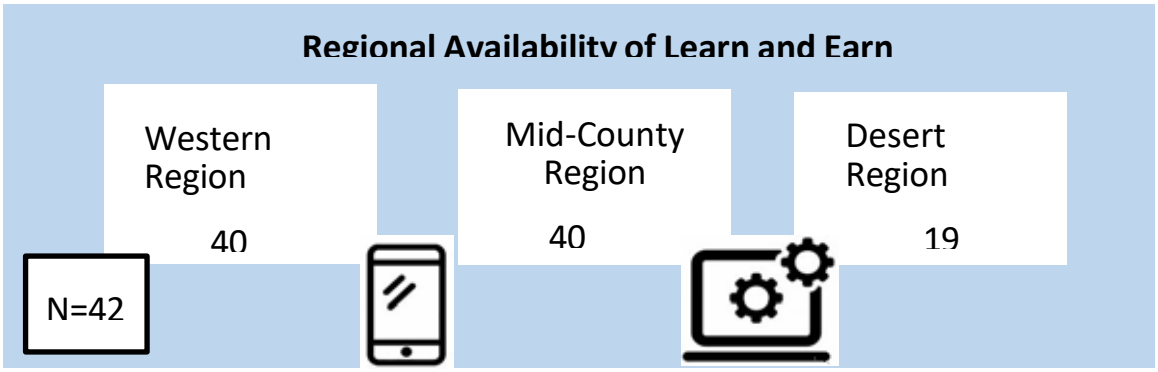
- Creation of user guides and presentations to consumers
- Trained consumers on how to use the ***myHealthPointe*** application
- Trained consumers on completing the Whole Person Health Score online by scanning QR codes
- Translated training materials in Spanish and facilitated Spanish trainings when needed
- Reached out to A4i participants to invite them to participate in the Learn and Earn training activities
- Support othered planning activities of the Learn and Earn training sessions

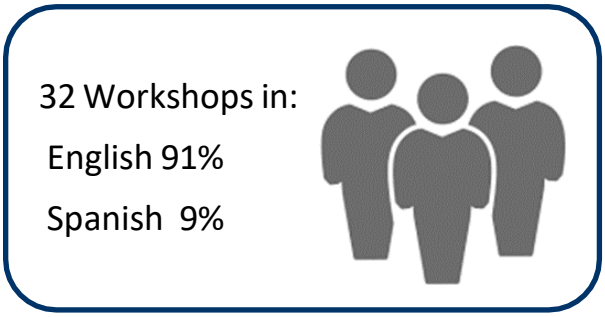
Evaluation Summary:

- Evaluate consumers feedback on the workshops
- Summarize the process data on consumers participation in the workshops

Learn and Earn Workshops Summary

Between December 2023 and February 2024, a total of 32 Learn and Earn Workshops were completed Countywide. A total of 426 participants completed the Learn & Earn Workshops, and 423 post-satisfaction surveys were submitted.





What I liked about the Workshop	What I liked about the Workshop	What I liked about the Workshop
"Access to my medical records." -Consumer Participant comment	"Access to behavioral health infor- mation made easy" -Consumer Participant comment	"Bringing me more into the 21st century." -Consumer Participant comment

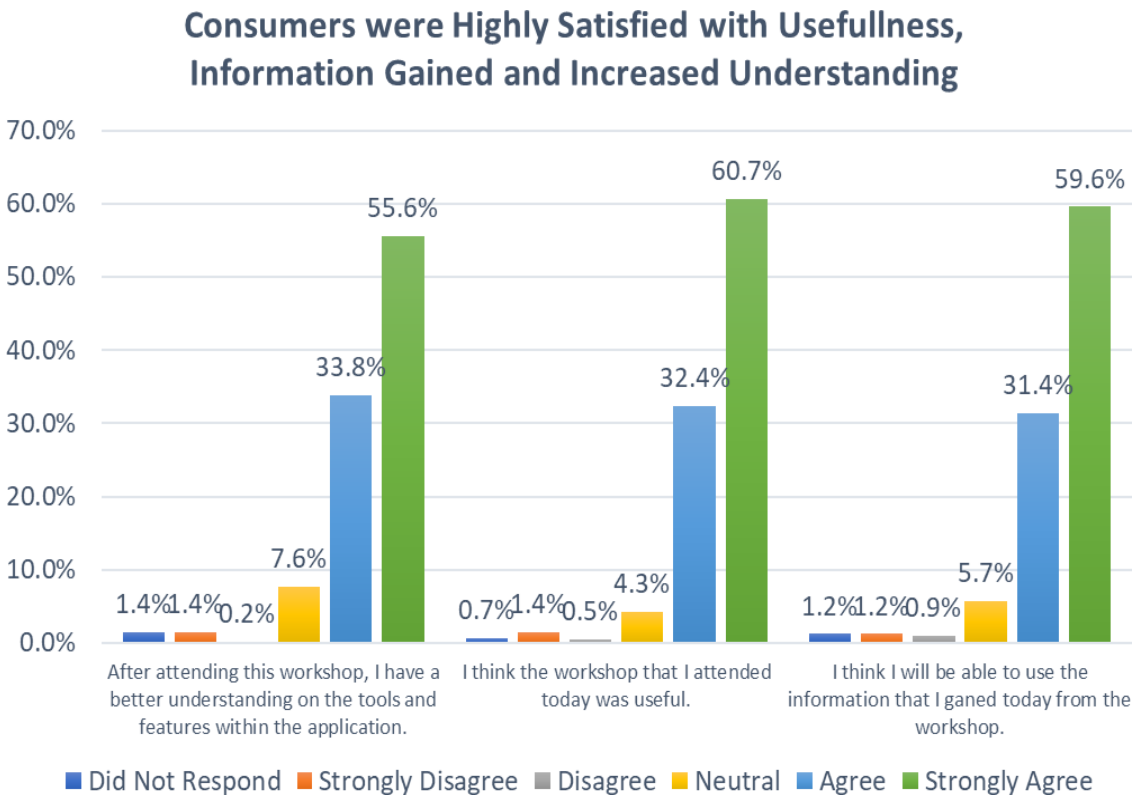
Consumers were asked to complete a learn and earn post survey at the completion of the workshop. Three items focused on benefits gained from the workshop were rated on a scale of 1 to 5 with 1 corresponding to *"Strongly Disagree"* and 5 corresponding to *"Strongly Agree".*

Learn and Earn Feedback Survey Summary

- **89.4%** of the participants "*Agreed*" or "*Strongly Agreed*" that **after attending this workshops, they have a better understanding on the tools and features within the application.**
- **93.1%** of the participants "*Agreed*" or "*Strongly Agreed*" that **the workshop that they attended today**

was useful.

- **89.4%** of the participants "*Agreed*" or "*Strongly Agreed*" that **they would be able to use the information that they gained today from the workshop.**



Several items on the survey focused on general satisfaction with the trainers and the workshop format. Item ratings were on a scale of 1 to 5 with 1 corresponding to *"Very Dissatisfied"* and 5 corresponding *to "Very Satisfied"* .

Learn and Earn Feedback Survey Summary

- **93.9%** of the participants were "*Satisfied*" or "*Very Satisfied*" with the Learn and Earn Workshops.
- **93.2%** of the participants were "*Satisfied*" or "*Very Satisfied*" with the Learn and Earn Workshop Trainers.

Comments were also collected from workshop participants on the satisfaction survey. The survey had a comment prompt for things participants liked or disliked about the workshops.
Key take-aways on what participants liked about Learn and Earn Workshops*:*

- **Learning how to use the technology and the Apps** "Learning about the app to track your medications." "A walk through of the app."

"How to see all my medical history."

- **Benefits of my health and behavioral health**

"I can learn more about myself."
"Learn how to take care of my physical and mental health."
"How to communicate with my doctor."
"Learning new ways to stay updated to my health and mental health while in recovery." "The helpful tools to better understand my conditions."
"How attentive they were."

- **Workshop trainer and format was good**

"How clear the staff explained the workshop." "Information presented was easy to understand."
"How clear the staff explained the workshop." "How friendly and informative staff was!"
"How helpful and explained step by step how to put my information down."

- **Increased Access**

"How to see all my medical history."
"How we can access our health records through this app."
"I now have access to a helpful/useful app that tracks my health."
"Knowing how the app works, and having information at my fingertips I can use." "Obtaining direct access to my mental health records."
"Be able to access my appointments and medication."

Challenges in Workshops

- Complicated information
- Size of room and crowded
- Struggles with general use of phone technology

Additional Recommendations on improving the myHealthPointe or WPHS app.



96% of Participants

Would recommend others attend

Workshops like this

Comments were also collected from workshop participants on the satisfaction survey. The survey had a comment prompt for things participants liked or disliked about the workshops.
Key take-aways on what participants liked about Learn and Earn Workshops*:*

- **More training in App use**
- **More features like being able to view past appointments**
- **More resources in the WPHS app**
- **More Languages available**
- **Benefits of my health and behavioral health**

Digital Mental Health Literacy Future Directions

Future Directions:

- Continue to support the implementation on myHealthpointe and engaging consumers in registering and access this free source to their electronic health records.
- Continued implementation of Whole Person Health Score (WPHS). The WPHS as an assessment of Social Determinants of Health has been implemented in a County clinic for screening all new consumers in the clinic with connection to resources. This work will continue to be implemented across eventually all County clinics in the community.

Project Evaluation

MAN THERAPY



Man Therapy

The RUHS-BH Help@Hand project invested Innovation funding into marketing the MAN THERAPY website at mantherapy.org. The goal in this investment was to implement a strategy to prevent suicide, since 75% of the suicides in Riverside County are men. MAN THERAPY began as a suicide prevention campaign that evolved into a man's mental health campaign to support all men before they are ever in crisis.

The goals of MAN THERAPY include:

- Shrink Stigma
- Increase help seeking behavior
- Reduce depression and suicidal ideation for men in Riverside County, particularly the high risk group of men over 45 years of age.

Man Therapy campaign started in January 2023. As an effort to increase the help-seeking behaviors, Man Therapy offers and 18-point Head Inspection (assessment) local resources and a crisis link are available on the website. The Head Inspection was promoted in community outreach activities Countywide.

The MAN THERAPY Website (http://www.mantherapy.org) was initially available in English. Feedback from the RUHS-BH Help at Hand's Peer Support Team led to the implementation of a MAN THERAPY website in Spanish which officially launched in February 2024.

The marketing campaign utilized a muti-media approach (offered in English and Spanish) countywide:

- Billboards (includes Veteran's billboards)
- Sunline Bus Ads
- Radio Spots and Digital Displays
- Collateral and Swags (Business Cards, Posters, T-shirts, Stickers, and Koozies)
- Paid Social Media (Facebook)
- Paid Search Engine (Google)

MAN THERAPY uses an impact model approach to drive traffic to the website content.



Strategy: Drive community awareness, action and outreach with branded marketing assets.

Strategy: Mental health screening, access to psycho-educational tools, connection to national and local resources, and navigation to care.

Strategy: Provide confidential, aggregate user engagement data at the state and community level

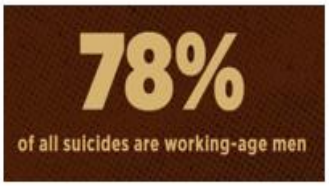
Man Therapy Website (http://www.mantherapy.org)



MAN THERAPY Website Topics









Between January 2023 to February 2024, a total of **12,840** Man Therapy Head Inspection screenings were completed.

Man Therapy Messaging and Creative Highlights





Billboards

Digital Ads



Posters and T-Shirts









Sunline Bus Ads

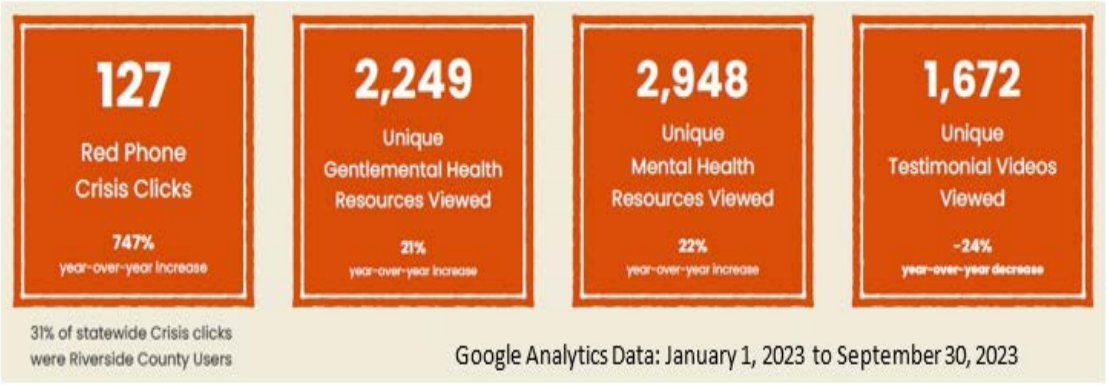
Man Therapy Basic Engagement Data (January 1st to September 30th, 2023) - Google Data

Region	Sessions	Users	New Users	Pageviews	Average Session Duration	Head Inspection Completed	Crisis Action (Red Phone Click, Chat Click, and Vets
Western	3,781	3,035	2,963	6927	1:52	775	17
Mid County	5,387	4,882	4,796	9057	1:28	1311	14
Desert	5,012	4,451	4,374	8155	1:27	1161	9
Countywide	14,180	12,368	12,133	24139	1:34	3247	40

Man Therapy Basic Engagement Data (October 1st, 2023 to February 29th, 2024) - GA4 and Mixpanel Data

Region	Sessions	Users	New Users	Pageviews	Average Session Duration	Head Inspection Completed	Crisis Action- Red Phone Click
Western	1,0478	9,709	9,499	1,0478	1:43	3,972	*Data only available from December 15th for Total Countywide*
Mid County	9,051	8,406	8,255	9,051	1:44	3,421	
Desert	8,949	8,253	8,080	8,949	1:32	3,055	
Countywide	28,478	26,368	2,5834	28,478	1:40	9,593	105

Man Therapy Mental Health Resources Views and Crisis Actions





MAN THERAPY Website Future Direction

- Support to continue the RUHS-BH collaboration with MAN THERAPY was approved using MHSA funding from Prevention and Early Intervention as part of the County Suicide Prevention Coalition work.
- Peer Support Specialist trained as MAN THERAPY Ambassadors will continue community outreach, as well as other avenues within the department to market the mantherapy.org website.
- The Spanish version of MAN THERAPY will continue.
- Swag and marketing materials not distributed will be utilized as well.
- Links to the MAN THERAPY site will be available on the County Suicide Prevention Coalition Website.



National Suicide Prevention Lifeline

Call 988-or *(800)273-8255

Local Inland Empire Resource

Inland SoCal Crisis Suicide Helpline: (English/Español) **(951)686-HELP (4357)**



Project Evaluation

La CLAve



INNI

La CLAve

La CLAve is a guide to the key symptoms of serious mental illness. In Spanish 'la clave' refers to clue or key. The La CLAve guide was originally developed for a Spanish speaking audience. The program began as an initiative to help families identify the symptoms of serious mental illness in their loved ones, and empower them to seek early treatment. This effort started in Puebla, Mexico, and in the San Fernando Valley area within Los Angeles County, and primarily targeted the Spanish-speaking Latinx community. More recently, it has extended to Kern, Ventura, and Riverside Counties, as well as to Mexico City. The two primary goals of the La CLAve project are:

(a) to initiate conversations about serious mental illness within communities, and

(b) To reduce treatment delay for those early in the illness course

Embedded in stories and popular culture, the La CLAve program uses a mnemonic device in Spanish to aid the retention of the following symptoms of psychosis:



C - Creencias falsas o ideas delirantes (**false beliefs or delusions**)



L - Lenguaje desorganizado (**disorganized speech**)



A - Alucinaciones (**hallucinations**) of which there are two prominent types:



V - Ver cosas que otros no ven (**seeing things that others do not see**)



E - Escuchar sonidos o voces que otros no escuchan (**hearing sounds or voices**

The program draws on multiple evidence-based resources (film, flip chart, and recorded expert) in conjunction with group based discussions to teach the community about psychosis. In fact, the short dramatic film with versions in Spanish and English has won awards for promoting health and social justice. The current focus of the La CLAve team is to establish partnerships with community organizations and mental health service providers to train their staff and partners to implement the La CLAve program as an important part of their outreach services.

LA CLAve Implementation

RUHS-Behavioral Health and La CLAve Collaboration Timeline



La CLAve Milestones

- In December 2023, La CLAve and RUHS-BH were featured in interview segments by Univision for TV, Radio, and online advertising and feature presentations. La CLAve's 30-second commercial stories were produced and went live on December 25th, 2023.
- Between November and December 2023, La CLAve was promoted on an ongoing basis at community outreach events. Billboards, kiosk ads and Google ads invited users to visit UseLaCLAve.com to learn the signs of serious mental illness.
- In 2023, there were a total of 17,074 UseLaClave.com website visitors and 52,953 website visits. This was a 27% and 30% increase in website traffic in comparison to 2022.
- RUHS-BH collaborated with Dreamsyte to integrate La CLAve content within TakemyHand™ app, and it was completed in December 2023.
- In December 2023, Google ads were also run to direct users to **Tomamimano.co** and **TakemyHand.co** to learn La CLAve. There were a total of 636 visits on the "Learn La CLAve" page and 1,519 visits on the "Aprende La CLAve" page.
- Four in-person Facilitator Trainings completed between June and December 2023, and 1 Hybrid Facilitator Training was completed in January 2024. Overall, a total of Five Facilitator Trainings were completed for this project, and the summary will be included in this report.
- La CLAve DVDs movies were distributed to the RUHS-BH clinics and community organizations who participated in the Facilitator Training.

La CLAve Integration with TakemyHand™ App



La CLAve Kick-Off Event

In May 2023, RUHS-BH held a hybrid (In-Person and Teams Virtual) kick-off event open to service provers and interested community members. Dr. Stephen Lopez the researcher who developed La CLAve presented on the concepts and research behind LA CLAve. Information was collected from people attending the event on a survey collected at the conclusion of the event.

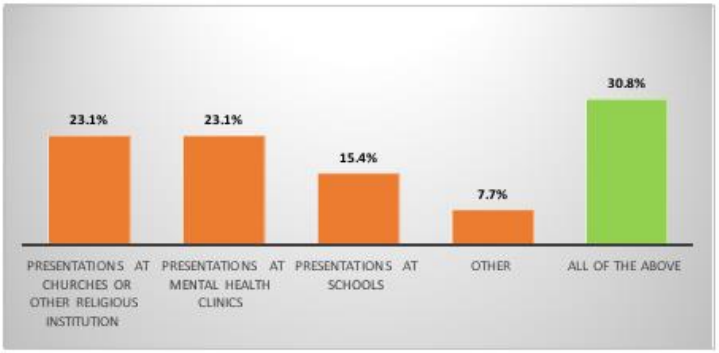




58% of Kick-Off Attendees reported they were Hispanic/Latinx.

Most (85%) reported they came to learn about how they could use this information in their work, at clinics, or in the community

What do you think are the best ways for other Hispanic/LatinX people to hear about La CLAve?



In June and August of 2023, RUHS-BH Help@Hand project hosted four in-person facilitator trainings and one hybrid training. At the conclusion of the training a feedback survey was distributed to evaluate attendees satisfaction with the training, trainers, and content. More than a third of those trained were Peer Support Specialists.





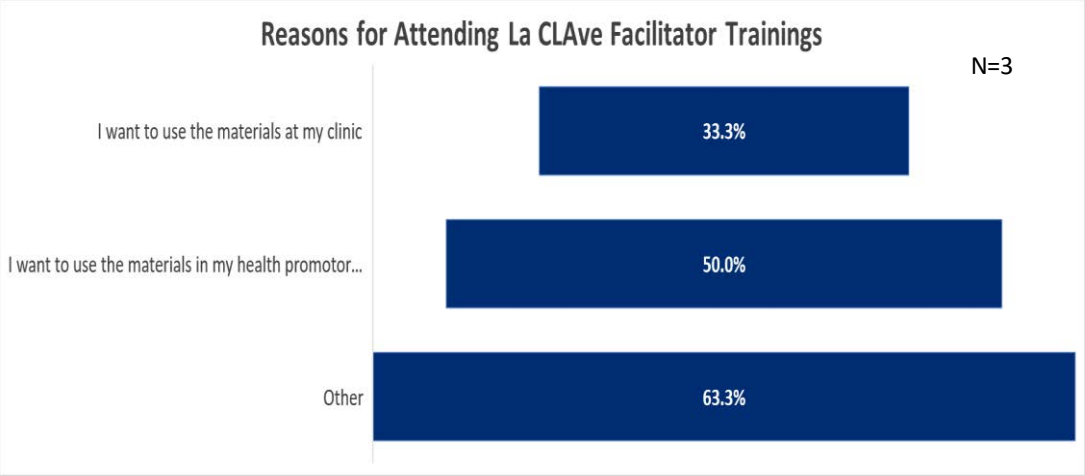


33 Facilitators Trained

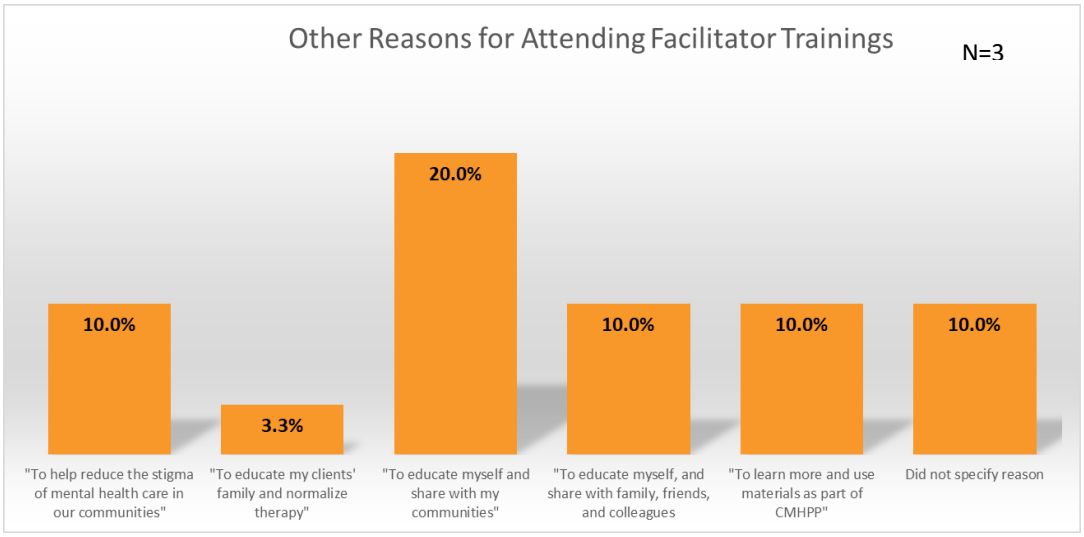
73% of Attendees reported that were Hispanic/Latinx

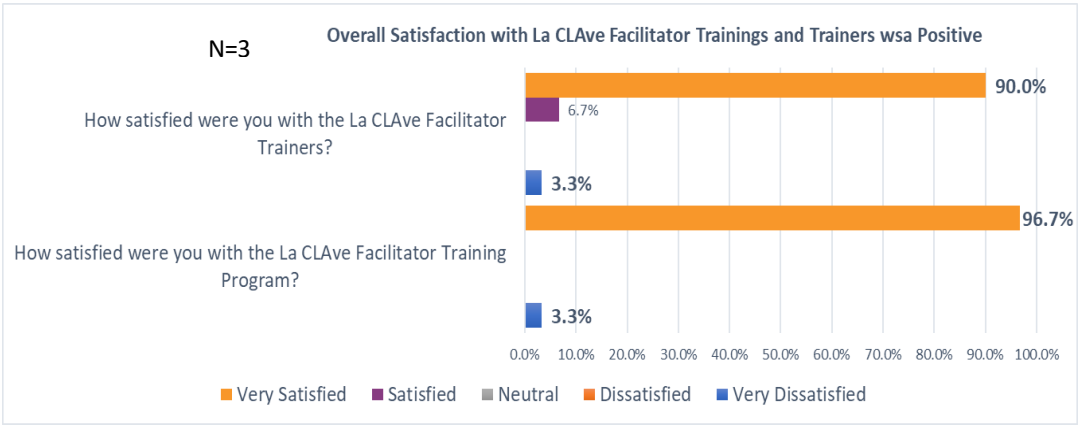


Attendees were asked to share their reason for attending the La CLAve facilitator training. The following figure show attendee responses on the 30 surveys collected.



Attendees satisfaction with the facilitator training was overwhelmingly high.





Facilitator Training Attendee Comments

What I Liked—Attendees Comments



"The trainers answered all our questions and kept me engaged. They were patient, encouraging and well informed."

"It was very interactive, loved the rehearsing part."

"The different perspectives and multimedia ways to help people understand psychosis and approach resources."

"The practice, the ability to learn from Dr. Lopez himself, and Dr. Lopez sharing the history of La CLAve."

"I really appreciate the mission behind La CLAve."

"Easy for community to understand the signs of SMI."

"We need to be creative to reach our communities from different cultures."

"Grateful to have been a part of this training."

"The curriculum is well written easy to follow, learner friendly!"

"The tools provided. Easy to follow manual."



100% of the training attendees indicated they would recommend the training to others

La CLAve Marketing





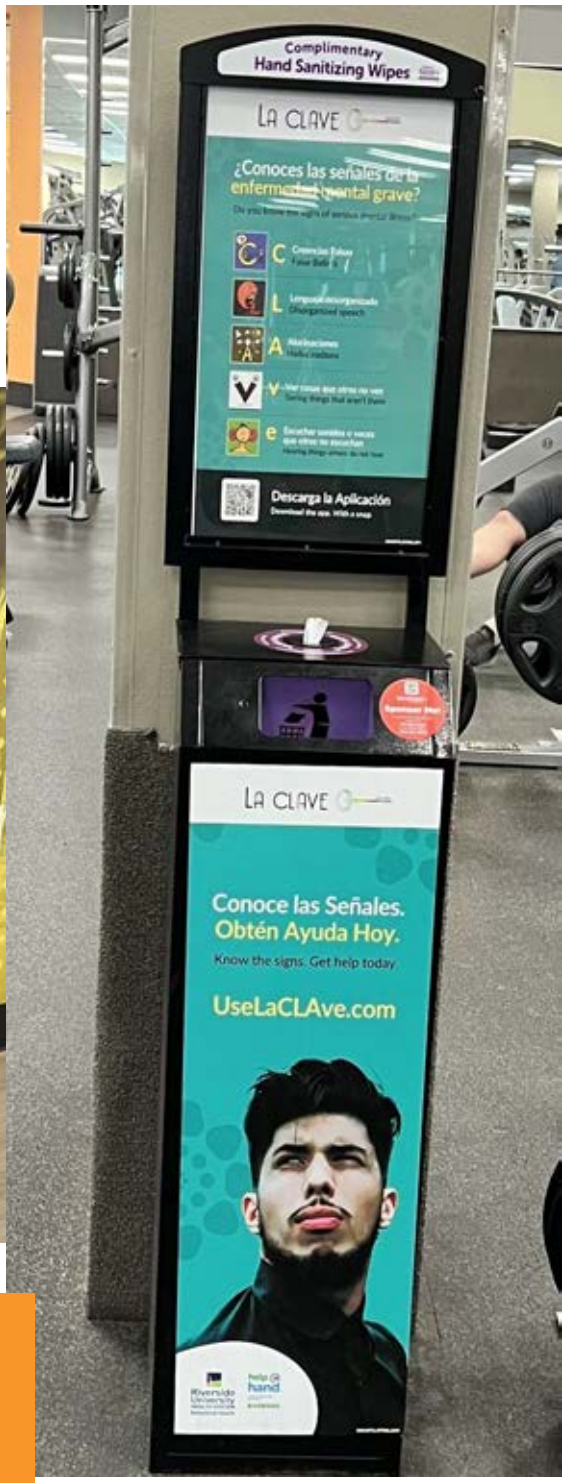
Billboards & Posters



La CLAve Marketing Campaign







Marketing is placed in multiple community settings. Branded Swag distributed.

La CLAve Future Directions

La CLAve Marketing

RUHS-BH applied the La CLAve marketing strategies across multiple other initiatives. This application of La CLAve into other department projects included :

- Embedding the La CLAve tools and content into the RUHS-BH Prevention and Early Intervention Community Mental Health Promotors Program (CMHPP) will provide La CLAve content throughout the community during in person presentation. This program trains promotors to provide mental health education presentations in the Latinx community in a variety of locations (schools, churches, community centers, libraries). The Latinx CMHPP program completes outreach presentations to more than 7,000 people per year. This ensures the messaging will continue in the community.
- La CLAve content was embedded into the TakemyHand™ website to provide virtual access to La CLAve content at anytime. The website addition is offered in English and Spanish and is tailored for caregiver, persons experiencing symptoms and providers seeking information. The content is user friendly and includes educational content, videos, a self-assessment, and resources to gain access to treatment.
- TakemyHand™ links are embedded across other websites and RUH-BH social media increasing the opportunity for the community to link to La CLAve

TakemyHand™ Addition of La CLAve



Project Evaluation

Kiosks Terminals



Kiosks Terminals

Kiosks are interactive computer terminals that provides access to information and digital applications.

RUHS-BH deployed Kiosks for public access in multiple community locations. These are self-service terminals designed to be used by anyone in the locations they were deployed. The content is interactive providing information to educate on mental illness and symptoms as well as reduce stigma by promoting mental wellness.

Implementation Highlights:

The Kiosks content is designed to connect consumers to wellness tools, digital resources and RUHS-BH services.

The idea for the deployment of Kiosks originated from our Peer Support workforce. The Deputy Director of Consumer Affairs brought forward the idea after seeing the Kiosks in other health systems outside of Riverside County. The content to add to the Kiosks was developed in unison with the TakemyHand™ website content so that the interface on the Kiosks was the TakemyHand™ website.

The installation began in 2021 and was accomplished by utilizing contracts with two vendors, Jaguar and G/ M Business Interiors. The Kiosks were installed in two phases across Riverside County Departments and partner locations.

Phase I of the implementation occurred between 2021-2022. This phase included the installation of 32 iPad Pro Kiosks and 8 large 55" Kiosks in public behavioral health outpatient clinic facilities. In phase II during 2022-2023, an additional 37 Kiosks were deployed at new sites some of which were the 55" and some were iPad Pro units.

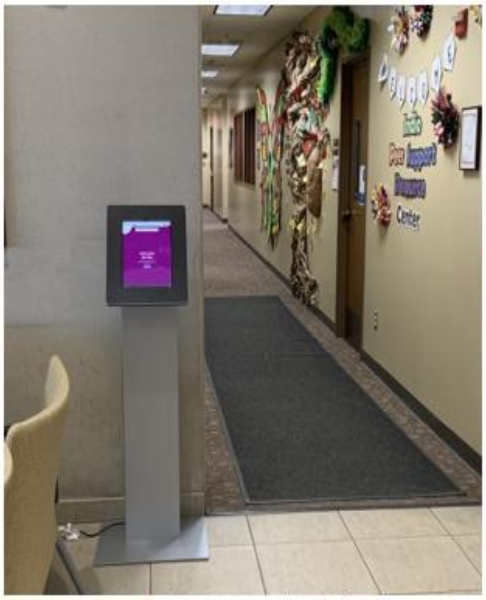
Overall, in Phase I and Phase II RUHS-BH deployed 77 Kiosks: 62 iPad Pro style and 15 larger 55" Kiosks. Additionally, RUHS-BH purchased 10 iPad Pro size Kiosks bolted on tabletops to fulfill requests from other community organizations.

Kiosks Locations

Outpatient Mental Clinics 41 Kiosks at 32 facilities across the County	Substance Abuse Clinics 6 Kiosks at 6 sites across the County	Mental Urgent Care facilities 3 Kiosks one in each region of the County	Peer Support and Recovery Centers 5 Kiosks at 3 Regional facilities
Residential Facilities 7 Kiosks at 6 sites Adult residential and Crisis residential	Adult and Youth Probation facilities 2 Kiosks at 2 sites	Medical Facilities 7 Kiosks at 4 primary care clinics and 2 hospitals	Community Organizations 7 Kiosks at y sites including 2 College campuses

An interactive map showing the locations of the Kiosks can be accessed at: https://arcg.is/bmLmv





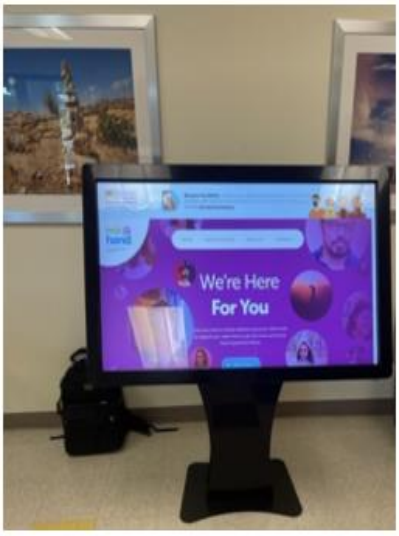
Kiosks were located in general areas in the lobby or open public spaces.





Charging Stations were installed to support the ability to charge devices while been exposed to content. The charging stations have a QR code to download the TakemyHand™ app.





Dual branding to support La CLAve dissemination was rolled out on Kiosks in 2023.



Future Directions: RUHS-BH will continue to maintain Kiosks installed at County sites. The IT support for Kiosks transitioned to RUHS IT team. Kiosks installed at Community locations will be maintained by the organization itself. County leader hip approved the installation of more Kiosks at two more college campuses. RUHS-BH has begun discussions on installing Kiosks in detention settings to serve as a resource for inmates to facilitate enrollment in Medi-Cal and behavioral health services upon release.

Riverside County Whole Person Health Score Evaluation



INTRODUCTION

The Whole Person Health Score (WPHS) tool is a 28-question assessment that provides a "snapshot" of an individual's health across six domains: physical health, emotional health, resource utilization, socioeconomics, ownership, and nutrition and lifestyle.[53]

In January 2023, RUHS and RUHS-BH began distributing the digital version of the adult WPHS assessment tool to patients, clients, and consumers. The tool was distributed by three differe departments:

- **Medical Center/Community Clinics:** RUHS medical clinici and patient navigators emailed and texted unique links to patients seen at RUHS and Riverside Community Health Clinics. Patients also had the option to complete the assessment on iPads and kiosks located at County locations.
- **Behavioral Health:** At first, RUHS-BH selected the Corona clinic to automatically distribute texts and emails to their 70 consumers in their current caseload. Consumers received a unique link of the WPHS assessment survey. This approach was not successful; only three consumers completed the assessment. The team decided to introduce the WPHS during their "Learn and Earn" digital literacy workshops. In addition, all RUHS-BH Staff members were invited to have their consumers take the WPHS survey. Staff was provided with a "WPHS Overview and Guide – A Clinical Perspective" and consumers were offered an incentive for taking the WPHS. Consumers could access the assessment on County iPads and kiosks, through a text or email link, and by a QR code located on flyers, banners, and promotional materials.
- **RivCoONE:** RivCoONE is an integrated services delivery initiative in Riverside County. Through RivCoONE, RUHS distributed WPHS tools to community members who access various County services, such as Riverside County Department of Public School Services, Riverside County Probation, Riverside County Veterans Services, and Riverside County Office on Aging.

This section includes findings from the WPHS assessment tool and is organized by departments that distributed the survey (e.g., Medical Center/Community Clinics, Behavioral Health, and RivCoONE). The information was shared by RUHS and represents WPHS response data collected from January 2023-January 2024.[54]

[53] More information on the Whole Person Health Score can be found at: https://www.ruhealth.org/news/whole-person-health-score. An assessment can be completed at: https://www.riversidehel-pathand.org/.

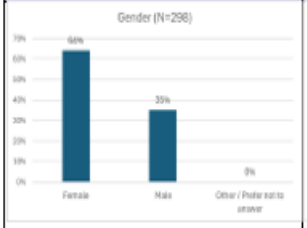
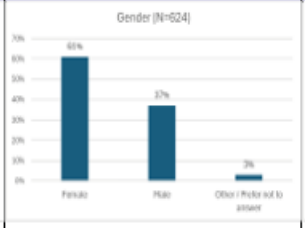
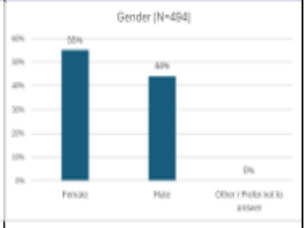
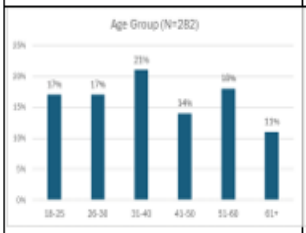
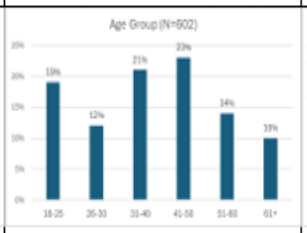
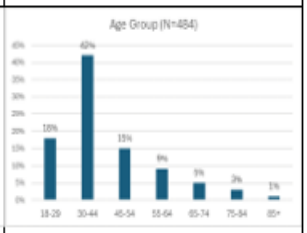
[54] RUHS published preliminary findings from the implementation of the WPHS assessment (Khura, 2022). The WPHS assessment tool has not yet been validated and discussions are underway with an external agency to validate the tool in the future.

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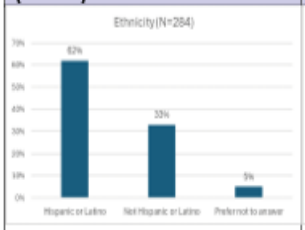
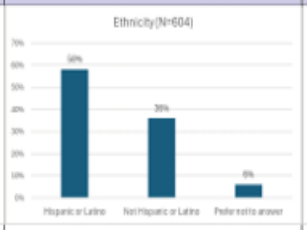
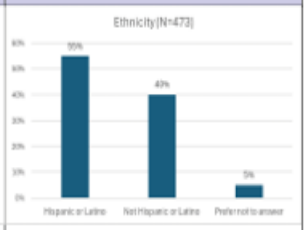
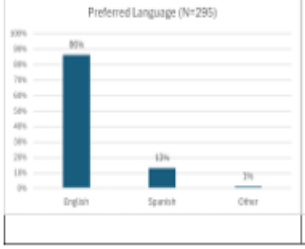
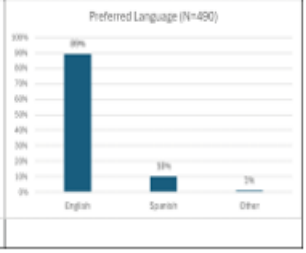
DEMOGRAPHICS

This section presents a summary of the demographics of individuals who completed the WPHS assessment through the Medical Center/Community Clinics, Behavioral Health, and RivCoONE.

More people who completed the WPHS self-identified as females than males. Age varied across cohorts.[55]

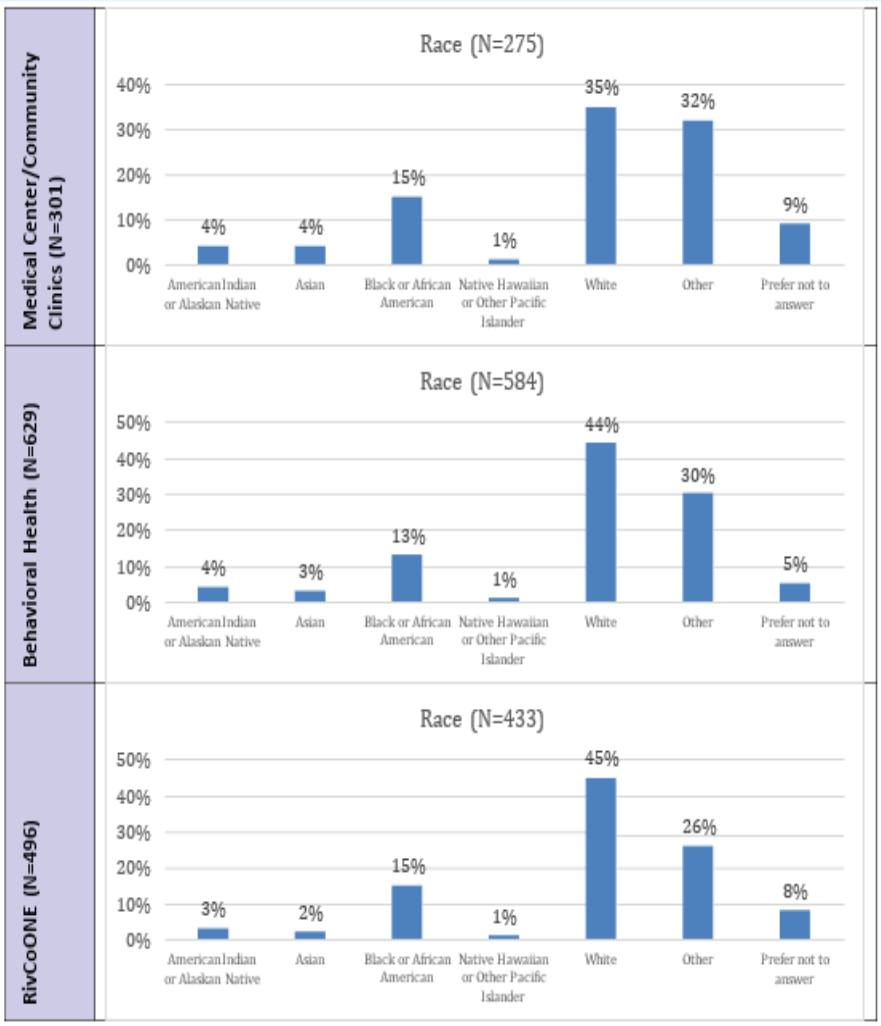
Medical Center/Community Clinics (N=301)	Behavioral Health (N=629)	RivCoONE (N=496)
		
		

The most commonly reported ethnicity was Hispanic or Latino and the most commonly reported race was White. The most commonly reported preferred language was English.

Medical Center/Community Clinics (N=301)	Behavioral Health (N=629)	RivCoONE (N=496)
		
		

[55] The RivCoONE cohort used different categories for age than the medical center/community clinics and behavioral health cohorts.

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DISTRIBUTION OF WPHS ASSESSMENT SCORES BY DOMAIN

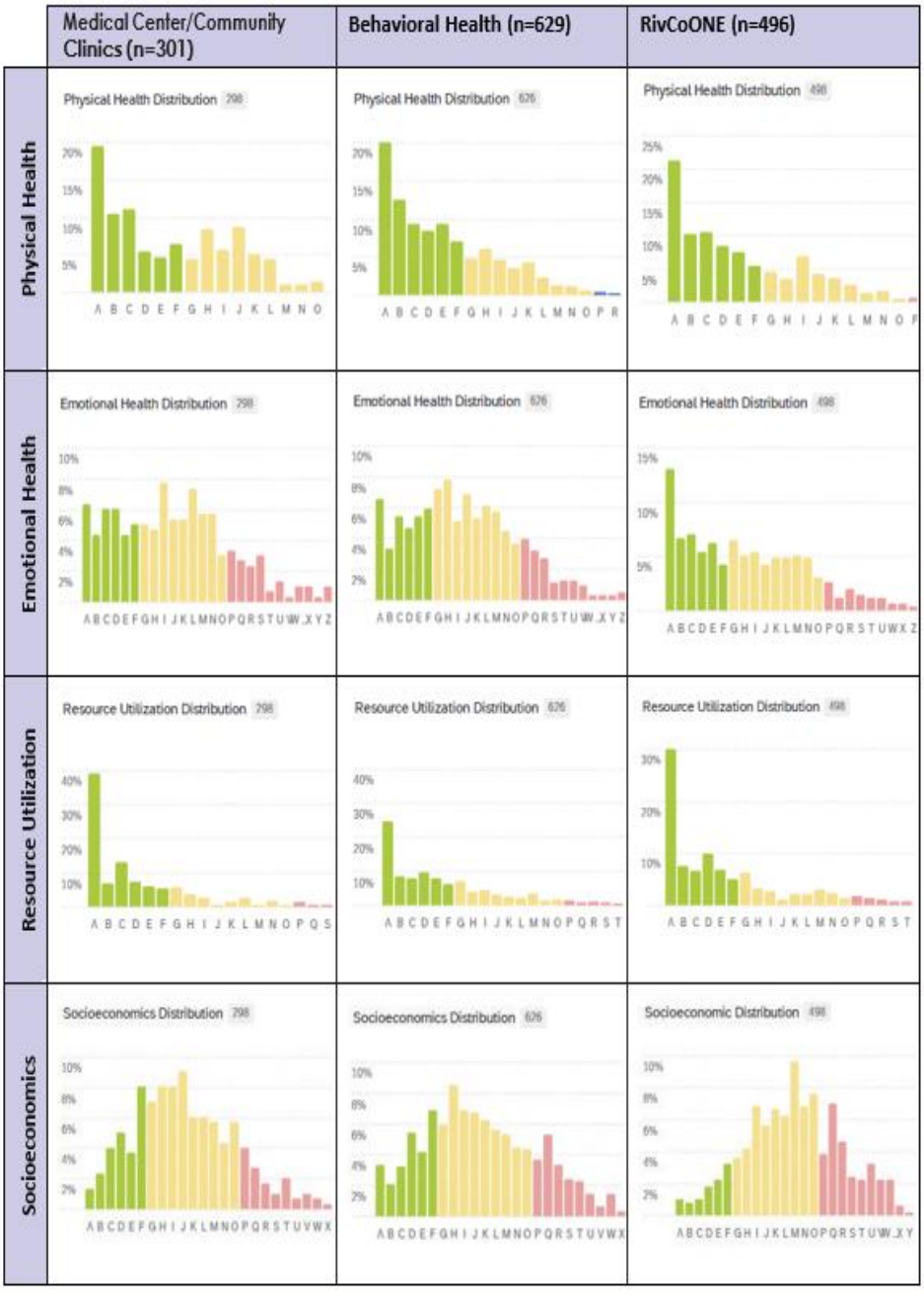
The WPHS assessment tool includes a rating across each of six domains: 1) physical health; 2) emotional health; 3) resource utilization; 4) socioeconomic; 5) ownership; and 6) nutrition and lifestyle.

Overall scores for each domain were assigned a color (green, yellow, red, or grey) and letter designation ("A" being best and "Z" being worst) to represent a holistic snapshot of the individual's health status.

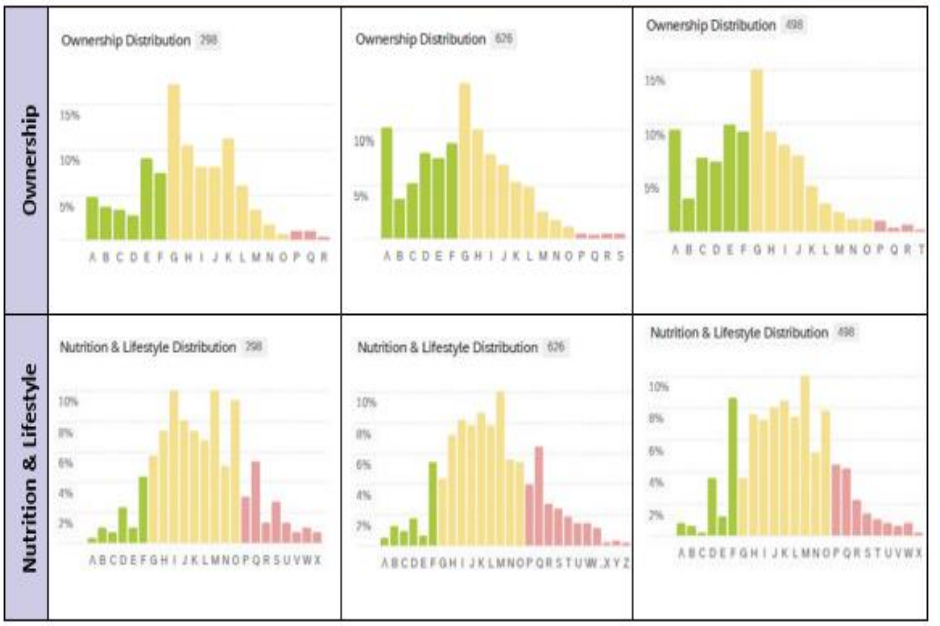
A-F	**Good:** You are doing well in this area of health.
G-O	**Fair:** This area of health is likely impacting your overall well-being. Consider seeking additional support or help.
P-Z	**Needs Improvement:** This area of health is already impacting your overall well-being and needs immediate or continued attention.
NS	**Not Scored:** A question went unanswered. As a result, a score could not be calculated.

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A summary of the distribution of scores by domain is below. The distributions below indicate those completing the tool needed more support in the domains of emotional health, socioeconomics, and nutrition and lifestyle than the other domains (physical health, resource utilization, and ownership).



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POTENTIAL AREAS FOR INTERVENTION

Emotional Health: Trust primarily affected lower emotional health scores across all three departments. Individuals who did not have someone that they can talk to about their problems, worries, or themselves were more likely to have their emotional health impact their overall wellbeing.

Potential areas for intervention could include connecting individuals to a social worker or therapist to allow for space to talk about their problems and worries.

Socioeconomics: Many variables affected lower socioeconomic scores (e.g., lack of transportation, living situation, lack of money, finances, education, job status). The primary variable affecting the score varied across the three departments.

- **Medical Center and Community Clinics:** Finance primarily affected lower socioeconomic scores. Those rating poorer overall household finances were more likely to have their socioeconomics impact their overall wellbeing.
- **Behavioral Health:** Education primarily affected lower socioeconomic scores. Those with lower levels of education were more likely to have their socioeconomics impact their overall wellbeing.
- **RivCoONE:** Lack of transportation primarily affected lower socioeconomics scores. Those experiencing transportation issues were more likely to have their socioeconomics impact their overall wellbeing.

Potential areas of intervention include connecting individuals to accessible General Education Development (GED) resources and social service programs that can assist with financial support and transportation options.

Nutrition and Lifestyle: Many variables affected lower nutrition and lifestyle scores (e.g., smoking, alcohol and drugs, and eating habits). Smoking and alcohol and drugs primarily affected scores across all three departments. Those who smoked more frequently and/or reported using alcohol or drugs in a way that affected their life or someone else's life negatively were more likely to have their nutrition and lifestyle score impact their overall wellbeing.

Potential areas of intervention include connecting individuals with a medical provider to support smoking cessation and supporting individuals with substance use and addiction services.

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Whole Person Health Score Overview and Guide For the Clinical Perspective



A participant takes the Whole Person Health Score, which is a **6-letter score** that provides a **snapshot of health** (each letter representing a different dimension):

Physical Health: looks at your current physical and medical conditions

Emotional Health: looks at your emotional, mental, and spiritual well-being

Resource Utilization: looks at how you use health care services

Socioeconomics: looks at your living situation, finances, and resources

Ownership: looks at how you view your own health and ability to make change

Nutrition and Lifestyle: looks at your health habits

4 ranges are identified: Green, Yellow, Red, Grey.

Letters range from A to Z for each dimension ("A" being the best and "Z" being the worst)

Based on a **28-question assessment**

- Each question represents an element that affects **longevity and lifespan**

A-F	**Good:** You are doing well in this area of health.	**P-Z**	**Needs Improvement:** This area of health is already impacting your overall well-being and needs immediate or continued attention.
G-O	**Fair:** This area of health is likely impacting your overall well-being. Consider seeking additional support or help.	**NS**	**Not Scored:** A question went unanswered. As a result, a score could not be calculated.

Whole Person Health Score
Guide For the Clinical Perspective

A consumer may approach you to share their score with you. You may be asked for support in shifting their score to reflect a healthier overall wellbeing.



For Example:



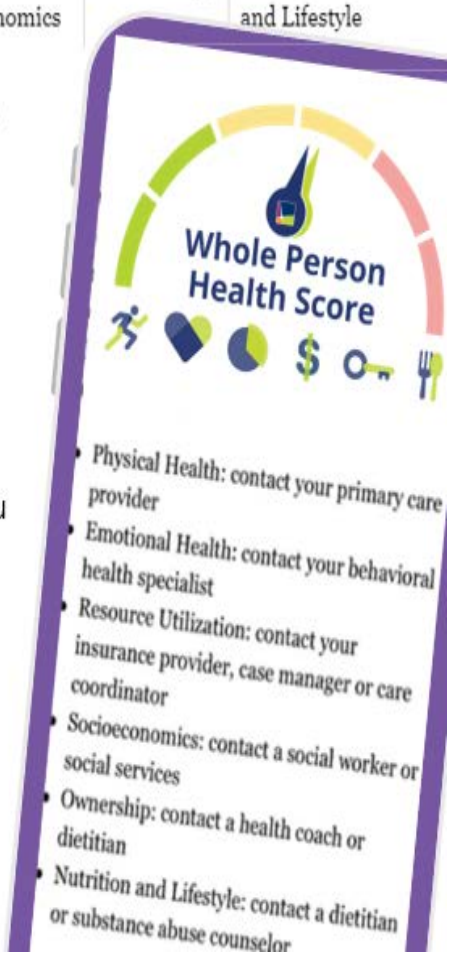
Let's say someone comes in with a score which has a yellow score in the ownership domain. Good health in this domain could be considered as a mindset.

C	F	A	F	N	Q
Physical Health	**E**motional Health	**R**esource Utilization	**S**ocio-economics	**O**wnership	**N**utrition and Lifestyle

You may be able to support in ways which enrich the person's felt sense of control in their experiences. Perhaps this support looks like linkage to a useful service.



After some time implementing changes brought on through this new awareness, the consumer may come to you with a new Whole Person Health Score reflecting a positive change in their domains!



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February 3, 2025

Executive Summary

The Riverside University Health System (RUHS) contracted with the Patient- Reported Outcomes, Value, & Experience (PROVE) Center at Brigham and Women's Hospital, affiliated with Harvard Medical School, to conduct an independent validation of the Whole PERSON Health Score (WPHS). The WPHS is a holistic, patient-centered tool developed by RUHS to assess health across six domains: physical health, emotional health, resource utilization, socioeconomics, ownership, and nutrition and lifestyle. The WPHS was designed as a practical tool to measure determinants of health that influence life expectancy and well-being, as well as to identify strengths and opportunities for intervention at both the individual and population levels. Previously, the RUHS team had validated the WPHS for content and reliability and had demonstrated the tool's usability, feasibility, and acceptability among patients and providers. However, as interest in the WPHS tool grew beyond the local RUHS service area, RUHS sought a more rigorous and independent validation, which led to this project. The overarching goal of this evaluation is to evaluate the measurement performance of WPHS domain and composite scores and provide actionable recommendations for further refinement and implementation.

In collaboration with the RUHS team, the PROVE Center conducted a comprehensive evaluation of the WPHS domain and composite scores, using data provided by RUHS from electronic health records. The analytic sample included 58,055 patients who completed at least one WPHS survey between August 2019 and February 2024. The dataset included demographic and clinical characteristics, WPHS responses and scores, types of clinical visits, and diagnosis indicators of chronic health conditions.

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

The PROVE team first assessed the data quality of the WPHS survey, identifying potential issues related to questions and workflows of data collection. Following this, the team evaluated its measurement properties across three key areas: measurement type, reliability, and validity.

Quality of data was found to be generally good. Identified data entry and system algorithm errors were corrected and resolved before analysis was conducted. In the psychometric evaluation, the PROVE team determined that four domains (physical health, resource utilization, socioeconomics, and nutrition and lifestyle) function as indices, while two domains (emotional health and ownership) function as scales. The WPHS composite score was also found to function as a scale. The PROVE team's analysis provided evidence supporting the reliability and validity of the six domain scores, including known-group validity, floor and ceiling effects, convergent validity, structural validity (where applicable), and predictive validity.

Analysis of the physical health domain score demonstrated, for example, known- group validity in its ability to differentiate patients based on age groups, number of pre- survey clinical visits, and presence of chronic health conditions. As another example, analysis of the emotional health domain score demonstrated convergent validity with the Patient Health Questionnaire – 2 score. All six domain scores showed acceptable floor effects and trivial ceiling effects and were predictive of three-month post-survey clinical visits. Similarly, the WPHS composite score, constructed using the six domains, showed acceptable measurement properties.

The evaluation also identified areas for further improvement. First, additional validity analyses using external variables would strengthen the conclusions. Second, adjustments to the implementation and data collection processes would improve data quality and enhance the reliability and validity of WPHS domain and composite scores. Finally, instrument refinements based on this evaluation report could further optimize the performance of the WPHS.

In conclusion, this one-year evaluation provides preliminary evidence supporting the validity and reliability of the WPHS to measure determinants of health. Moving
From now on, the PROVE team recommends addressing identified issues related to data quality and measurement to optimize performance. Further evaluation is encouraged to ensure the WPHS continues to evolve as a valuable tool for patient-centered care and quality improvement within and beyond RUHS.

Section V

WET

Workforce Education and Training

MHSA Annual Update FY 25/26

Workforce Education and Trainings

WET



01 Workforce Staffing Support

Training & Tech Assist

02

03

Financial Incentives

Career Pathway

04

05

Residency / Internship





Workforce Education and Training

WET

What is WET?

"Education. Vocation. Transformation."

The Workforce Education and Training (WET) component of the Mental Health Services Act (MHSA) was established to address the ongoing workforce development needs for public behavioral health departments. This includes a specific focus on the recruitment, training and retention of a qualified workforce that is culturally competent and recovery-oriented, that incorporates those with lived-experience, and includes those with language and cultural capacities that help meet the needs of the communities we serve. To achieve these goals, WET established five individual work plans with corresponding strategies/actions.

1. Workforce Staffing Support
2. Training and Technical Assistance
3. Career Pathways
4. Internship and Residency
5. Financial Incentives

The workforce is the heart of any public service agency. Workforce development focuses on employees for long-term success. It involves training, upskilling, and continuous education opportunities to enhance job performance and career trajectory. Staff development is a commitment to quality care. It helps an agency improve customer care, meet critical agency goals, and improve staff retention. Most of the success of any agency can be tied back directly to the exceptional work being done by front line staff day in and day out. For this reason, workforce development for all positions, must remain an ongoing focus for public service agencies to meet the current and future needs of an evolving communities. WET was designed to develop people that serve in the public, behavioral health workforce. WET's mission is to promote the recruitment, retention, and to advance the recovery-oriented practice skills of those who serve our consumers and families. WET continues to value a diverse workforce that reflects the membership of our unique communities. We strive to reduce service disparities by improving cultural and linguistic competency and by encouraging and supporting members of our diverse communities to pursue public, behavioral health careers. WET also values the meaningful inclusion of people with lived experience – as consumer, parent, or family member – into all levels and programs of public behavioral health service.

WET understands that people with mental illnesses and those dealing with substance use concerns deserve the best of public service, not just when seeking mental health and substance related care, but also when needing allied services such as law enforcement, academics, housing, social services, and primary health care. WET continues to value educating other service providers on acknowledging and understanding the impact of stigma,

learning how to effectively engage someone experiencing distress, and connecting people to resources that benefit their recovery.

WET actions/strategies in the RUHS-BH WET Plan are divided by the funding categories originally designed by MHSA regulations. Each funding category represents a strategic theme to address WET's mission. The actions/strategies developed within each category were developed and informed by our stakeholders. WET's stakeholders, are an important part of our plan and action development, the feedback comes from job classifications throughout the department, academic institutions, cultural competency, and lived experience practitioners. WET's goal to resume the Stakeholder Steering committee, is going to be directly connected to the Behavioral Health Transformation, so that we can ensure that the appropriate individuals are included to help with future recommendations. The executive assistant has that was assigned to this task has done early research to determine the past committee make up. This includes contacting previous members to identify their continued interest, recruiting new members in order to maintain the representation of the original make up of the committee, in addition scheduling and communicate meetings.

WET continues to ensure that the 5 established plans are a part of our day-to-day work. In the past year, WET has expanding the team to include an additional Clinical Therapist II position and an Administrative Services Assistant. Both positions were added because of the expansion of efforts to support the department overall. We continue to maintain good relationships with our community and partner agencies to increase outreach. WET maintains the focus of building and educating the future clinical and substance use staff by offering our internship and residency programs. Also, while continuing to support staff obtain training so that they are well versed so in order to provide service in our Public Health system. We continue to support with informing and offering loan repayments programs to reduce staff debt. WET continues to rely on the voice of those we serve, by getting feedback from department staff and community. We also take into account the learning from past experiences so that we can ensure that we are meeting the goals of the plan.

WET-01 Workforce Staffing Support

This work plan is desig ffing necessary to manage and implement Riverside County's WET plan. In the past year, WET and the Lehman center have had consistent staff and all positions were filled, until the later part of the year. The staff that were hired in the last year to fill our vacant positions were either veteran staff or new to our systems. In the later case, staff were supported with training so that they can provide efficient and effective services. Closer to the end of the year, 1 staff from Lehman and 1 from WET had other job opportunities, thus leaving a vacancy in both units.

Maintaining long term staff remains to be the continued challenge year after year.

It is importance to maintain a fully staffed team not only because workforce staffing and supports is our first workplan but because we continue to take pride in overseeing the operations of our department's conference center, trainings, financial assistance program, internship programs and more.

WET-02 Training and Technical Assistance

This work plan is designed to provide the training and technical assistance needed to meet the centralized and customized training needs of Riverside County's public behavioral health workforce. Annual, global training goals include ensuring that our behavioral health workforce is prepared to serve the consumers of today and the consumers of the future.

To meet those global training goals, the past few years, we focused our strategies on the following:

- Trainings
- Evidence-Based Practices, Advanced Treatment, and Recovery Skills Development Program
- Cultural Competency and Diversity Education Development Program
- Professional Development for Clinical and Administrative Supervisors
- Community Resource Education
- Lehman Center Support
- Collaborative Involvement
- Social Media Communication and Interaction

Trainings

Workforce Education & Training (WET) strives to educate, innovate, empower, and transform the learning and lives of our Riverside University Health System – Department of Behavioral Health (RUHS-BH) workforce. A main purpose of our work is to provide necessary training to all staff within our service system. Well also offer trainings to other community agencies, our contract providers and community organizations that we collaborate with. This training plan component is intended to increase the mental health services workforce by providing necessary and desired trainings with the ultimate goal of offer services that benefit the consumers we service. WET continues to effectively offer hybrid model of trainings by providing virtual live trainings, virtual self-paced trainings as well as In Person trainings. All trainings are provided by subject matter experts who are either certificated/certified county staff, individual contracts, or contracted agencies.

Our training audiences continue to include Department employees, employees of partner agencies, partner academic institutions and the community. All instructors, whether contracted or Department staff, include in their training, the 5 Essential Elements of the MHSA to ensure training content is relevant:

Community Collaboration
Cultural Competency
Client and Family-Driven
Wellness Focus which includes Recovery and Resilience

Integrated Services

WET continues to offer the well-received and attended trainings, as well as continue to do the research for new training opportunities for our audiences.

Program improvements, changes, updates, growth

WET continues to renew agreements with three Continuing Education (CE) providers to support Certified Alcohol and Drug Counselors, Registered Nurses, and Behavioral Health Licensed Professionals in meeting their CE requirements. Committed to addressing community needs, we regularly assess our consumer population profile and workforce demands. To enhance virtual learning, we utilize Articulate 360, an advanced training platform that enriches the e-learning experience with interactive and customized curriculums. Additionally, we leverage virtual platforms such as ZOOM and Microsoft Teams to ensure trainers have seamless access to conduct remote courses efficiently.

During this last year WET offered a variety of advanced training topics in meeting the needs of our workforce. W.E.T. Offered 468 education units and 24 were advanced topics. Some of the advanced topics included:

Disability Awareness - Stronger Together
Solution Focus Brief Therapy
Integrated Model of Genogram, Ecomap, and Timeline
Square Model
Co-Occurring Disorders
CBT for PTSD
Seeking Safety
Non-Violent Crisis Intervention (NCI)
Motivational Interviewing
LGBTQ Series: Transgender Foundations
Dialectical behavior therapy (DBT)

Earlier in the year we were still short staffed and living with the issues of Covid. We are pleased to share that these challenges have now been resolved. Not only have we returned to full capacity, but we have also been able to add several new trainers to our team, further strengthening our department. Our training content has been optimized for both in-person and virtual formats, our learning management system is fully functional, and our trainers are now fully available to meet the needs of our workforce. We are proud to have bounced back from the setbacks caused by COVID-19 and are well-positioned to continue supporting our workforce with high-quality training and resources.

Evidence-Based Practices (EBP)

WET continues to be dedicated to supporting evidence-based advanced treatment practices to effectively cater to the needs of our consumers. Noteworthy evidence-based practices endorsed by the department encompass Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Family-Based Therapy, Eating Disorder Practices, Cognitive Behavioral Therapy, Motivational Interviewing, and Eye Movement Desensitization and

Reprocessing, among others. In response to the escalating demand for trauma-informed practices, WET continues to provide Trauma-Informed Systems 101, enhancing our ability to serve consumers better and to have self-awareness about how we as providers and our co-worker also need support and resources as we serve. The commitment of having well trained staff aligns with our ongoing mission to educate our entire workforce under the TIS model. Staff members receive ongoing support through various evidence-based practice (EBP) training sessions, boosters, and regular practitioner meetings. These supportive initiatives continue to contribute to the successful implementation of the EBP programs and the continued focus on fidelity of the endorsed practices. Furthermore, the research and evaluation team actively participate in training efforts, ensuring that consumer data is systematically captured to better address the evolving needs of the community and to ensure that our trained department staff are providing these models throughout our service system.

Eating Disorder Practice

Eating disorders have the second highest mortality rate of all mental health disorders, only after opioid addiction. Our county largely serves those from racial and ethnic minorities, many from low socioeconomic backgrounds. This demographic has experienced disparities in the diagnosis and treatment of eating disorders. The Eating Disorder program continues to grow and evolve in its ability to meet the need to serve our consumers affected by this disorder.

The internal infrastructure that was established five years ago continues to provide a solid foundation for our Eating Disorders (ED) Program, which is built on the principle of a team approach to provide intensive treatment. This infrastructure is lead by our Eating Disorder Administrator and consists of our Eating Disorder Champions, expert practitioners in eating disorders, who provide consultation and guidance to our ED Practitioners. We continue to provide bi-monthly micro trainings to the department's ED practitioners with our subject matter expert, who also provides bi-monthly consultations with our ED Champions. The ED Champions provide consultations to ED practitioners twice a month and as needed. The success of this foundation of this structure is evident in our ability to continue to provide quality services for this serious diagnosis throughout the department despite the turnover of our practitioners. Further, this program structure has served as a model for other counties in the state.

There are currently over 200 Eating Disorder practitioners who are RUHS staff and contract providers. The main treatment models our department practices to treat Eating Disorders are the evidence based treatments of Family Based Treatment (FBT) and Dialectical Behavioral Therapy (DBT). We continue to provide annual trainings on these models for new practitioners. In November 2023, we provided a 2-day FBT Training, and a 2-day DBT Training in December 2023. Bi-monthly, our subject matter expert provides a 90-minute refresher training on these topics or other models that enhance the skills of our practitioners. This past fiscal year, the micro - training topics included FBT Refresher for ED, Cognitive Behavioral Therapy for ED, Exposure Therapy, Motivational Interviewing and ED Assessment and Medical Complications. We have an average of 50 practitioners attending these bi-monthly micro-trainings.

An established solid infrastructure for Eating Disorders has allowed our department to be innovative in creating new projects to expand meeting the needs of our consumers. As technology evolves, our program last year piloted with Help@Hand to pilot the Recovery Record App to use as a tool for our ED practitioners to help support eating disorder treatment. The success of the pilot lead to the continued use of this app. This past year, Eating Disorders worked to collaborated with Innovations to create our own Intensive Outpatient Program to meet the high need of these services. This collaboration with WET and Innovations will allow Eating Disorders training to increase the number of trainings offered and train more professional staff and community members.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) is an Evidenced Based Practice (EBP) focused on helping people heal from various symptoms and emotional distress that is associated with traumatic memories and/or life experiences. Research has indicated that this EBP has shown to alleviate symptoms of distress, increase cognitive insight and functioning (EMDR Institute Inc.) This worldwide used EBP has been effective with a range of symptoms, behaviors, and diagnoses; with the ability to be used on children, teens and adults alike.

In 2022/2023, EMDR was implemented within RUHS-BH by training 30 clinicians in this valuable treatment modality. This cohort serviced to be the original group of clinicians who were recognized by the department as EMDR provider. To date WET continues to support the EMDR clinicians, so that they can continue to provide this treatment modality efficiently and effectively to our consumers. Since training the original cohort of 30 staff, other previously trained staff were added to the list of recognized EMDR clinicians, which brought the total to 35 trained staff. Due to several reasons, such as staff transitioning to other roles or other opportunities, there was a decrease in the number of EMDR clinicians in our department. It shifted from 35 to 23 staff who currently providing the service. The EMDR leadership team is aware of the need for more trained clinician, thus they recommend that staff use the resource of “Textbook & Tuition Reimbursement” to reimburse the cost of EMDR training if they desire to provide the service for consumers.

The leadership team was developed as a part of the infrastructure for EMDR. It was put in place to ensure that staff needs were heard and addressed, to develop process and procedures, to develop a feedback loop and to have centralized oversight as it relates to EMDR. The infrastructure also included 2-hour, bimonthly (twice a month) study groups, facilitated by the trainers. Once those offerings ended, the department continued to have internal groups without the EMDR trainers in order to continue to provide the needed support to EMDR clinicians. Although those original expert lead support groups stopped, the leadership team continues until today. The team was able to understand that the clinicians needed additional support thus, re-entered into contract with the original trainers to restart the study groups. In addition to restarting the groups, the team worked on finalizing the referral process in order to meet the growing need of the provision of EMDR services. The goal for next fiscal year is to monitor the efficiency of that process.

The contract with EMDR Professionals came after a request from clinicians, for more direction and support from the experts, as well as more advance training. Several EMDR clinicians have taken avantage of getting the advance trainings. The title of the trainings staff have selected are listed in the table below*. The WET coordinator negotiated the contract to include:

Study Groups

- Study groups to focus on ongoing support in administering EMDR to clients
- Study groups will touch base on questions/concerns/barriers to treatment and direct professional feedback from trainers.

1 EMDR Advanced Trainings for each trained clinician

- Addictions
- Somatic Approaches
- EMDR and Dissociative Disorders
- Psychosis and EMDR
- EMDR and children
- And more…

ADVANCED TRAINING NAME
• A relational model for Parts/Ego State work in EMDR Therapy • EMDR and the Art of Psychotherapy w/Children • EMDR Bootcamp: Basik Skill Refresher, Study Group 2 hrs • The Power of the Pain: EMDR Therapy, Addiction, and Recovery, Study Group 2 hrs • DeTUR October 2024: Urge Reduction Protocol for Addictions and dysfunctional behaviors • RTEP-GTEP Sept/Oct 2024 • DeTUR October 2024: Urge Reduction Protocol for Addictions and dysfunctional behaviors • OnDemand* Introduction to Using EMDR with Kids with Ease • OnDemand*At War with Food Full, Course: Trauma-Informed Clinical Skills for Treating the Spectrum of Eating Disorders, Study Group 2 hrs

During the next fiscal year, the leadership team will be focused on getting staff to accurately enter information in the system in order to track how many clinicians are providing EMDR services and how many consumers are receiving the treatment modality. Once both processes are effectively implemented, the leadership team would be able to pull data and reference tracking systems, to be able to develop a report. The report would provide quantitative feedback regarding EMDR services across the department in order to see who provides that service, how many consumers were referred and how many received services.

Seeking Safety EBP:

Seeking Safety is an evidence-based practice designed to improve the lives of individuals with a history of trauma and co-occurring substance use disorders (SUD). Trauma, as defined by the DSM-5 (American Psychiatric Association, 1994), refers to the experience, threat, or witnessing of physical harm. This harm includes events such as combat, childhood physical or sexual abuse, serious car accidents, life-threatening illnesses, natural disasters, and terrorist attacks. Approximately 20-30% of individuals who experience such trauma go on to develop Post-Traumatic Stress Disorder (PTSD; Adshead, 2000). In the United States, among men who develop PTSD, 52% also develop alcohol use disorder, and 35% develop a drug use disorder. Among women, these rates are 28% and 27%, respectively (Kessler et al., 1995). According to The National Child Traumatic Stress Network's Making the Connection: Trauma and Substance Abuse, studies indicate that up to 59% of young people with PTSD also develop substance use issues.

Individuals with a dual diagnosis of PTSD and SUD face more significant challenges than those with either disorder alone, including increased legal and medical problems, a higher risk of suicidality, and greater vulnerability to future trauma (Najavits, 2007). The Seeking Safety program is based on the cognitive-behavioral model of relapse prevention. It teaches present-focused coping skills aimed at simultaneously addressing both trauma history and substance use. The program can be delivered in group or individual formats.

In Fiscal Year 2023-2024, six meetings were held for department staff. These meetings provided various learning opportunities on the 25 topics, assistance with fidelity measures and data collection, and support for staff in implementing the evidence-based practice in both individual and group settings. Through the Southern Counties Regional Partnership (SCRP) funding, a total of 79 staff members who are now trained within the department.

The benefits for our Seeking Safety practitioners were directly supported through our involvement in the Southern California Regional Partnership (SCRP). SCRP consists of the WET (Workforce Education and Training) coordinators from the 10 southernmost counties in California. This partnership receives a small allocation of funds intended for public behavioral health workforce development projects that benefit the region. A portion of these SCRP funds was allocated to support staff development by contracting with Gabriella Grant, director of the California Center of Excellence for Trauma-Informed Care. Ms. Grant provided Seeking Safety consultations for staff already trained in the program, as well as introductory training sessions for new staff members. These consultations and training sessions were held throughout 2023-2024.

This collaborative effort has strengthened the implementation of Seeking Safety across our department, ensuring better outcomes for those we serve.

Non-Violent Crisis Intervention (NCI) EBP:

The Crisis Prevention Institute's (CPI) Non-Violent Crisis Intervention (NCI) program is an evidence-based, fully accredited training designed to equip human service professionals with the decision-making skills necessary to appropriately respond to crisis situations. The program

includes de-escalation techniques as well as restrictive and nonrestrictive interventions. NCI has been shown to improve safety, reduce workplace risk, mitigate staff burnout, and enhance the well-being of those we serve.

The NCI program is a mandatory training for approximately 2,110 staff members in Behavioral Health. From July 2021 to June 2022, 17 NCI trainings were conducted, training 247 staff members. From July 2022 to June 2023, 16 trainings were held, reaching 267 staff members. From July 1, 2023, to June 30, 2024, 16 trainings were again conducted, training 322 staff members.

The Workforce Education and Training (WET) team worked closely with Riverside County's Learning Management System and CPI to implement a hybrid NCI training model. In this model, direct service staff participate in an in-person, one-day training that covers verbal de-escalation techniques, personal safety skills, and holding skills (also referred to as restraints in other programs). Administrative staff, on the other hand, participate in a virtual, four-hour training that includes verbal and personal safety skills, but not holding skills. Direct service staff, for training purposes, includes any staff members who work in settings where consumers are directly served, excluding psychiatrists. This category also includes clerical and other administrative staff who have regular consumer contact within clinics.

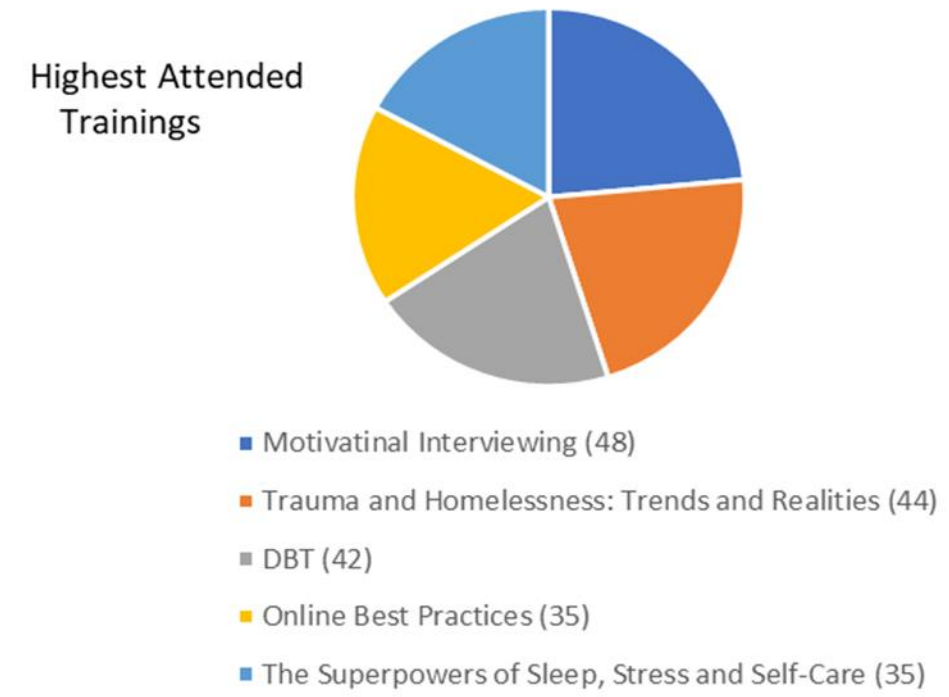
The WET team added five new trainers to the NCI training team, although two trainers left the department, resulting in a total of seven NCI trainers. In May 2023, the NCI hybrid model was rolled out department-wide, further expanding the program's reach and ensuring that staff are well-equipped to handle crisis situations effectively and safely.

This ongoing training initiative continues to enhance the skills and safety of our staff while improving the care and support provided to the individuals we serve.

Training Data

WET for fiscal year 23/24 was able to offer Trainings that were offered included Suicide Harm and Trauma, Domestic Violence, and CBT for PTSD. Culturally specific trainings offered included Disability Training and Gender Affirming Care to better serve our LGBTQ community. Advancing more services for our LGBTQ population is priority at they are at higher risks for suicide.

The target audiences for these trainings included RUHS–Behavioral Health clinical and administrative staff, contract providers, community members, and retirees. A total of 137 trainings were held where 468 continuing education (CE) credits were offered. There were 24-advanced topics. Across all trainings, WET hosted a total of 3057 attendees.



All WET sponsored trainings were assessed via a standard evaluation. Attendees evaluated the overall content of the training, instructor methods, how well the training was delivered, and the training facility. On average, using a standard 5 point scale where 5 indicates strong agreement, our trainings have produced the following evaluation trends and outcomes:

Testimonials from those who have benefitted from your program(s):

Content learned can be applied to my work and professional contexts.	5
This course enhanced my professional expertise.	5
This course was relevant to my professional expertise	5
There was a good balance between theoretical and practical concepts.	5
Diversity/Multi-cultural/Language concepts were addressed.	4
The instructor demonstrated substantial knowledge and expertise of the topic.	5
The instructor kept me engaged.	4
The instructor was responsive to questions, comments, and opinions.	3
The instructor presented course materials in a coherent and logical manner.	5
The instructional materials were well organized.	5
Visual aids, handouts, and oral presentations clarified content.	4
Teaching methods and tools focused on how to apply course content to my work environment.	4
The amount of material presented was appropriate for the amount of time provided.	4
The materials provided are likely to be used as a future reference.	3

Facility was comfortable and adequate for training.	5
All facility needs were met.	5
Facility was accessible.	5

Our workforce shared the benefits of the various advanced trainings offered during the fiscal year 23/24. Some of the highlight trainings include DSM – 5-TR, Substance Use Disorders; and Suicide Assessment Intervention training.

Training Comments:

3/14/2024 DMS – 5-TR – Matthew Rensi

The best part of this course was:

- Learning how to use the DMS correctly
- Understanding what was removed and added
- Interactive discussions and an open environment

1/11/2024 Substance Use Disorders – Gabby Grant

- The videos helped bring it all together
- The instructor was very engaging and knowledgeable which made me feel comfortable asking questions
- The materials provided were amazing and I will use them with clients

1/24/24 Suicide Assessment and Intervention-Deborah Silveria, PhD

- The resources presented, answered my questions and the examples provided were extremely helpful
- Learning about the different safety plans and interventions to utilize with clients.
- Presentation of material in various modes such as PowerPoint, videos, and techniques used were helpful

Crisis Intervention Training (CIT)

Program Narrative

The Crisis Intervention Training (CIT) program and curriculum "has become a globally recognized model for safely and effectively assisting people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, behavioral health providers, people with mental and substance use disorders, along with their families and others. While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is part of the model. These other community services (e.g., mobile crisis teams, crisis phone lines) are essential for avoiding criminal justice system involvement for those with behavioral health challenges – a goal of CIT programs. CIT is just one part of a robust continuum of behavioral

health services for the whole community" (Substance Abuse and Mental Health Services Administration, 2018).

The CIT program is performed by Riverside University Health System – Behavioral Health (RUHS-BH) staff and Riverside County Sheriff. Both organizations provide trainers to educate law enforcement and other first responders such as paramedics and emergency medical technicians on how to recognize the signs and symptoms of mental disorders and learn effective ways to safely de-escalate crisis situations involving individuals with a mental illness. In addition, recognizing that this population of emergency service workers are at higher risk of behavioral health concerns, the training includes how to identify their own symptoms of mental distress including anxiety, depression, and post-traumatic stress. Lastly, in the training participants learn about the community resources available for individuals experiencing distress and symptoms of mental illness including how to access treatment.

Crisis Intervention Training (CIT) Program Design/Model

Riverside University Health System- Behavioral Health (RUHS-BH) focuses on training emergency services personnel including law enforcement, firefighters, paramedics and emergency medical technicians (EMTs) to recognize the signs and symptoms of mental disorders and how to safely de-escalate crisis situations involving individuals with a mental illness and provide education on resources available in the community for individuals with a mental illness and other relevant resources.

Training material consists of national-approved and evidence-based crisis intervention training (CIT) curriculum. Crisis Intervention Team (CIT) training is a specialized law enforcement curriculum, that can be adapted to the whole community, that aims to reduce the risk of serious injury or death during an emergency interaction between persons with mental illness and police officers. CIT has been implemented widely both nationally and internationally.

In FY 23/24: RUHS-BH expanded from law enforcement agencies to also include in-person, virtual and hybrid trainings for other first responders such as firefighters, paramedics and emergency medical technicians (EMTs). A specialized training was developed where 40-hour CIT curriculum will be reduced in 2-8 hours of course material.

Lessons Learned: The lessons learned include the need for the CIT program to expand to firefighters, paramedics, and EMTs. There are approximately 1,067 firefighters as well as 1,311 paramedics and 4,000 EMTs in Riverside County. Emergency personnel such as firefighters, paramedics and EMTs encounter individuals with mental illness, often in crisis, and in need of de-escalation. Between July 2021 and June 2022, Riverside County EMTs responded to 12,785 calls for 5150s and 5585s due to individuals experiencing a mental health crisis such as suicidal or homicidal thoughts and behaviors.

Unfortunately, most firefighters, paramedics and EMTs lack the mental health awareness training or expertise needed to provide effective intervention. Without understanding mental illness and trauma, these front-line workers attempt to help the community as best they can; however, lacking specific training, they are unable to provide adequate services, consequently, individuals with mental illness do not get the assistance needed. Identifying signs, symptoms,

and behaviors as well as learning de-escalation techniques, has the potential to reduce harm to both the community and the responders. These first responders also lack knowledge of appropriate supportive resources to help their community.

Firefighters and EMTs tend to develop their own mental health challenges such as depression, anxiety, and post-traumatic stress disorder (PTSD) as they often lack the psychological support needed. According to the Firefighter Behavioral Health Alliance, more firefighters die from suicide each year than in the line of duty, and many additional suicides are likely unreported. Public safety personnel are 5 times more likely to suffer symptoms of post-traumatic stress disorder (PTSD) and depression than their civilian counterparts, leading to higher rates of suicide. In fact, over 1,000 U.S. firefighters were surveyed in 2015 and found that at some point in their careers:

47% experienced suicidal thoughts;

19% established plans to complete suicide; and

16% made a suicide attempt.

One of the primary barriers to firefighters, paramedics and EMTs getting the psychological help that they need to address behavioral health symptoms is stigma related to mental health. “For many responders, there is a stigma associated with seeking help for mental illness, which is perceived by some as a sign of weakness. Studies have shown that up to 92% of surveyed firefighters indicate this stigma as a reason for their unwillingness to get help.”

Firefighters and EMTs frequently encounter individuals with mental illness despite lacking mental health awareness training, knowledge and effective de-escalations skills. As a result, many firefighters, paramedics and EMTs often witness horrific traumatic events such as suicide attempts, homicidal behaviors, psychotic episodes, manic episodes, and other mental health symptoms.

Riverside University Health System - Behavioral Health (RUHS-BH) will address the lack of mental health awareness training and support for firefighters, paramedics and EMT personnel in Riverside County using national-approved and evidence-based crisis intervention training (CIT) curriculum.

Progress Data: From July 1, 2023 to June 30, 2024, the Crisis Intervention Training program trained over 300 number of staff on Crisis Intervention and on average the trainees rated the training at a number 5 which indicates that it was an excellent training and stated that it meet their learning objective expectations. Below is an example of a completed course evaluation indicating “5- Excellent scoring.”



RIVERSIDE COUNTY SHERIFF'S DEPARTMENT
Ben Clark Public Safety Training Center
Course Evaluation

Name/Agency (optional): RSO Rank/Position: Deputy

Contact info/Email (optional):

Course: Crisis Intervention Date: August 17-18, 2023

Instructor: Behavioral Health Services Supervisor Tiffany Ross

Please circle the response option that best reflects your evaluation of the training provided:

	Excellent	Good	Fair	Poor	N/A
1. The instructor's knowledge/expertise was:	(5)	4	3	2	1
2. The instructor's effectiveness in teaching was:	(5)	4	3	2	1
3. The instructor's professionalism was:	(5)	4	3	2	1
4. The instructor's use of class time was:	(5)	4	3	2	1
5. The course/skills presented were:	(5)	4	3	2	1
6. The pace of the instructor was:	(5)	4	3	2	1
7. Class participation/interaction encouraged was:	(5)	4	3	2	1
8. The time allotted for the course was:	(5)	4	3	2	1
9. How would you rate the manual/handouts:	(5)	4	3	2	1
10. Overall, how would you rate this training class:	(5)	4	3	2	1

*Use the back of the page if needed.

11. What are the most important things, (skills or topics) you learned during this training? Patience, De-escalation and Tactics when dealing with mentally ill people
12. What teaching/instructor method was most effective? Why? All. Instructor and Bringing in People who suffer from mental illness
13. In your opinion, what changes in training or instruction would improve this course? NONE, MADE EACH DAY
14. Did this course meet your expectations? Why? YES, VERY INFORMATIVE
15. Would you recommend this training to others? Why? YES, NEEDED FOR ALL LAW ENFORCEMENT
16. What additional courses would you like to see offered at Ben Clark Training Center?

Additional comments:

CIT and MHAT Trainings for FY 23-24 included as follows:

CIT Trainings					
Course Title	**Date(s)**	**Multi-Day Training**	**Location**	**Attended**	**Instructor(s)**
Corrections Crisis Intervention Training [In-Service]	1/8/2024	1 day	Larry D. Smith Correctional Facility	8	Lydia Session, Robin Smith
Corrections Crisis Intervention Training [In-Service]	1/11/2024	1 day	Larry D. Smith Correctional Facility	5	Lydia Session, Robin Smith
Corrections Crisis Intervention Training [In-Service]	1/15/2024	1 day	Larry D. Smith Correctional Facility	9	Lydia Session, Robin Smith
Crisis Intervention Training	2/14/2024	2 day	Ben Clark Training Center	29	Lydia Session, Robin Smith
Adult Corrections Officer Core Course *(4-Day)**	2/21/2024	4 day	ECTC College of The Desert	4	Lydia Session, Robin Smith
Probation DPO Academy	2/26/2024	2 day	Research Park	26	Lydia Session, Robin Smith
Adult Corrections Officer Supplemental Course (2-day)*	3/13/2024	2 day	Ben Clark Training Center	18	Lydia Session, Robin Smith
Crisis Intervention Training	3/18/2024	2 day	Ben Clark Training Center	29	Lydia Session, Robin Smith
Adult Corrections Officer Core Course *(4-Day)**	4/10/2024	4 day	Ben Clark Training Center	50	Lydia Session, Robin Smith
Crisis Intervention Training	4/17/2024	2 day	Ben Clark Training Center	32	Lydia Session, Robin Smith
Crisis Intervention Training	5/29/2024	2 day	Ben Clark Training Center	33	Lydia Session, Robin Smith
Probation JCO Academy	7/15/2024	4 day	Research Park	24	Lydia Session, Robin Smith
Crisis Intervention Training	8/13/2024	3 day	Ben Clark Training Center	18	Lydia Session, Robin Smith
Corrections Crisis Intervention Training	8/19/2024	2 day	Ben Clark Training Center	28	Lydia Session, Robin Smith
FBI Crisis Negotiation Training	8/26/2024	1 day	OC Sheriff Training Facility	30	Lydia Session, Robin Smith
Adult Corrections Officer Core Course *(4-Day)**	8/28/2024	4 day	Ben Clark Training Center	51	Lydia Session, Robin Smith
Crisis Intervention Training	9/17/2024	3 day	Ben Clark Training Center	26	Lydia Session, Robin Smith
Inmate classification	10/8/2024	1 day training	BCTC	27	Lydia Session
CIT	10/22/2024	3 day training	BCTC	27	Robin Smith, Crisitina Zamora

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Total Persons Trained				**720**	
Total Number on Trainings = 29					
Non-Law Enforcement Courses:	**Date(s)**	**Multi-Day Training**	**Location**	**Attended**	**Instructor(s)**
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Total Trained				**185**	
Total Number on Trainings = 5					

MHAT Trainings					
Fire/EMT/Paramedic Courses:	**Date(s)**	**Multi-Day Training**	**Location**	**Attended**	**Instructor(s)**
Mental Health Awareness Training [MHAT]	5/7/2024	3 day	Pechanga Fire	16	Lydia Session, Robin Smith
Mental Health Awareness Training [MHAT]	8/9/2024	1 day	NCTI Riverside	10	Lydia Session, Robin Smith
MHAT	10/25/2024	1 day training	BCTC	6	Robin Smith
MHAT	11/19/2024	1 day training	BCTC	19	Robin Smith
Total Trained				**51**	
Total Number on Trainings = 4					

3-Year Plans & Goals: Program learning objections of the CIT program are:

• Increase awareness of the most common mental illnesses, symptoms and behaviors

• Understand the dynamics of dealing with an individual with a mental illness

• Identify specific community resources

• Identify de-escalation skills to reduce potential crisis situations

The CIT program has the following 3-year plans and goals:

• Expand CIT Training Program and curriculum to also include in-person, virtual and hybrid trainings for other first responders such as firefighters, paramedics and emergency medical technicians (EMTs). A specialized training will be developed where 40-hour CIT curriculum will be reduced in 8 hours of course material. In addition, the virtual self-paced training that will be developed will allow law enforcement, firefighters, paramedics and EMTs to complete training within 2-4 hours. Further, peer trainers will also expand to include firefighters, paramedics and EMTs, similar to how law enforcement officers are peer trainings for the traditional CIT curriculum.

• Develop new pre and post evaluation tools to better capture the program goals and objectives mentioned below. Post surveys will capture utilization of course material and community resources provided.

• Additional goals and objectives of the CIT program are:

Goal	Objective
1. Increase the number of emergency personnel in	By the end of year three, 300 law enforcement, firefighters, paramedics and/or EMTs will have participated in the CIT training conducted by a team of

WET

Riverside County that have received training in mental health awareness.	RUHS-BH clinical therapist and emergency personnel peer trainers.
2. Increase training participants' knowledge in recognizing the signs and/or symptoms of mental disorders, and/or de-escalation strategies.	By the end of the training, 60% of the Riverside County law enforcement, firefighters, paramedics and EMTs CIT-trained will indicate in post-test evaluation tools they increased knowledge in recognizing the signs and/or symptoms of mental disorders and/or learned additional effective ways to safely de-escalate crisis situations involving individuals with a mental illness compared to their pretest scores.
3. Increase mental health awareness training of emergency personnel to recognize their own psychological exposure and trauma.	By the end of year three, 100% of the law enforcement firefighters, paramedics and/or EMTs CIT-trained will have access to available resources to deal with personal mental health issues.
4. Track referrals and linkages of culturally and linguistically appropriate behavioral health resources.	4.a. By the end of year three, 100% of the law enforcement, firefighters, paramedics and/or EMTs who participated in the CIT training will receive community behavioral resources. 4.b. Six months after training, 100% of the firefighters, paramedics and/or EMTs who participated in the CIT training will receive a survey tracking their referrals and linkages provided to community behavioral health resources.

Riverside County that have received training in mental health awareness.	RUHS-BH clinical therapist and emergency personnel peer trainers.
2. Increase training participants' knowledge in recognizing the signs and/or symptoms of mental disorders, and/or de-escalation strategies.	By the end of the training, 60% of the Riverside County law enforcement, firefighters, paramedics and EMTs CIT-trained will indicate in post-test evaluation tools they increased knowledge in recognizing the signs and/or symptoms of mental disorders and/or learned additional effective ways to safely de-escalate crisis situations involving individuals with a mental illness compared to their pretest scores.
3. Increase mental health awareness training of emergency personnel to recognize their own psychological exposure and trauma.	By the end of year three, 100% of the law enforcement firefighters, paramedics and/or EMTs CIT-trained will have access to available resources to deal with personal mental health issues.
4. Track referrals and linkages of culturally and linguistically appropriate behavioral health resources.	4.a. By the end of year three, 100% of the law enforcement, firefighters, paramedics and/or EMTs who participated in the CIT training will receive community behavioral resources. 4.b. Six months after training, 100% of the firefighters, paramedics and/or EMTs who participated in the CIT training will receive a survey tracking their referrals and linkages provided to community behavioral health resources.

Annual Update: Progress Report on 3-Year Plan

Here is CIT program's progress report on the 3-year plans and goals:

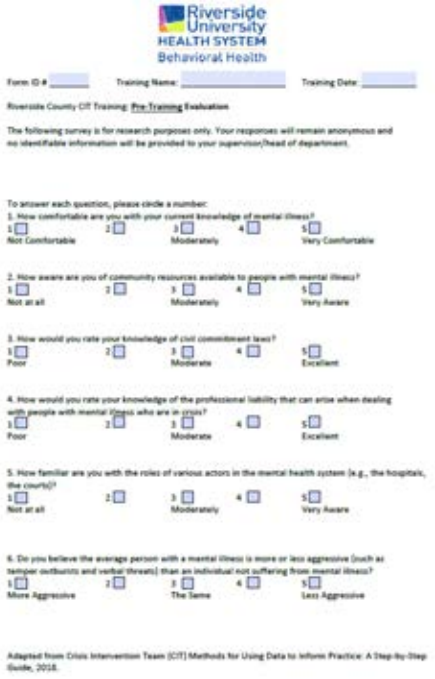
• Goal: Expand CIT Training Program and curriculum to also include in-person, virtual and hybrid trainings for other first responders such as firefighters, paramedics and emergency medical technicians (EMTs). A specialized training will be developed where 40-hour CIT curriculum will be reduced in 8 hours of course material. In addition, the virtual self-paced

training that will be developed will allow law enforcement, firefighters, paramedics and EMTs to complete training within 2-4 hours. Further, peer trainers will also expand to include firefighters, paramedics and EMTs, similar to how law enforcement officers are peer trainings for the traditional CIT curriculum. Progress Update: The CIT program has developed new curriculum for other first responders such as firefighters, paramedics and emergency medical technicians (EMTs). The curriculum consists of 8 hours of course material as planned. Currently, we are rolling out the first phase of trainings that are 8 hours in-person. We are coordinating training dates with emergency contractors to hopefully begin training implementation by end of March 2024. The second phase will include virtual training options. We are working to expand training offered to students training to be firefighters, paramedics and emergency medical technicians (EMTs).

Progress Update: Goal partially obtained. We complete the in-person version of the curriculum with variations of training length as requested from 2-8 hours training. It was later determined that a self-paced online training was not ideal for this population as the experiential learning via in-person training is essential.

• Goal: Develop new pre and post evaluation tools to better capture the program goals and objectives mentioned below. Post surveys will capture utilization of course material and community resources provided.

Progress Update: Goal attained as we developed new CIT training pre/post evaluation tools to evaluate attendees' knowledge, attitudes and beliefs regarding mental health, crisis de-escalation techniques, and utilization of community resources available. See below for newly developed CIT pre/post evaluation tools:


Riverside University HEALTH SYSTEM Behavioral Health

Form ID # _____ Training Name: _____ Training Date: _____

Riverside County CIT Training: Pre-Training Evaluation

The following survey is for research purposes only. Your responses will remain anonymous and no identifiable information will be provided to your supervisor/head of department.

To answer each question, please circle a number:

1. How comfortable are you with your current knowledge of mental illness?
1 Not Comfortable 2 3 Moderately 4 5 Very Comfortable

2. How aware are you of community resources available to people with mental illness?
1 Not at all 2 3 Moderately 4 5 Very Aware

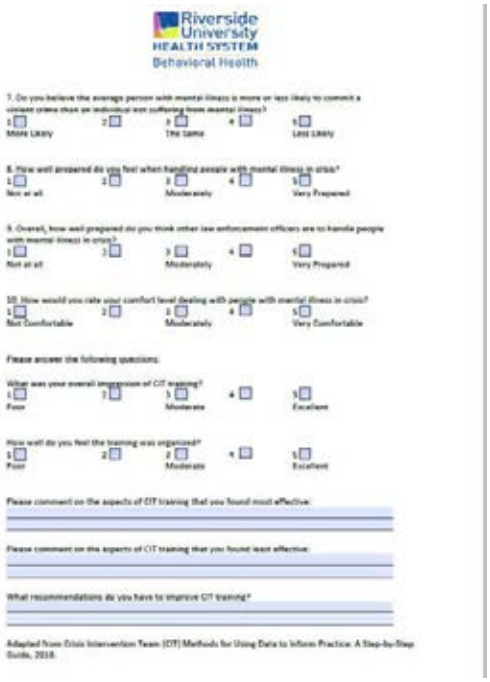
3. How would you rate your knowledge of civil commitment laws?
1 Poor 2 3 Moderate 4 5 Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?
1 Poor 2 3 Moderate 4 5 Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., the hospitals, the courts)?
1 Not at all 2 3 Moderately 4 5 Very Aware

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?
1 More Aggressive 2 3 The Same 4 5 Less Aggressive

Adapted from Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide, 2018.


Riverside University HEALTH SYSTEM Behavioral Health

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?
1 More Likely 2 3 The Same 4 5 Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?
1 Not at all 2 3 Moderately 4 5 Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to handle people with mental illness in crisis?
1 Not at all 2 3 Moderately 4 5 Very Prepared

10. How would you rate your comfort level dealing with people with mental illness in crisis?
1 Not Comfortable 2 3 Moderately 4 5 Very Comfortable

Please answer the following questions:

What was your overall impression of CIT training?
1 Poor 2 3 Moderate 4 5 Excellent

How well do you feel the training was organized?
1 Poor 2 3 Moderate 4 5 Excellent

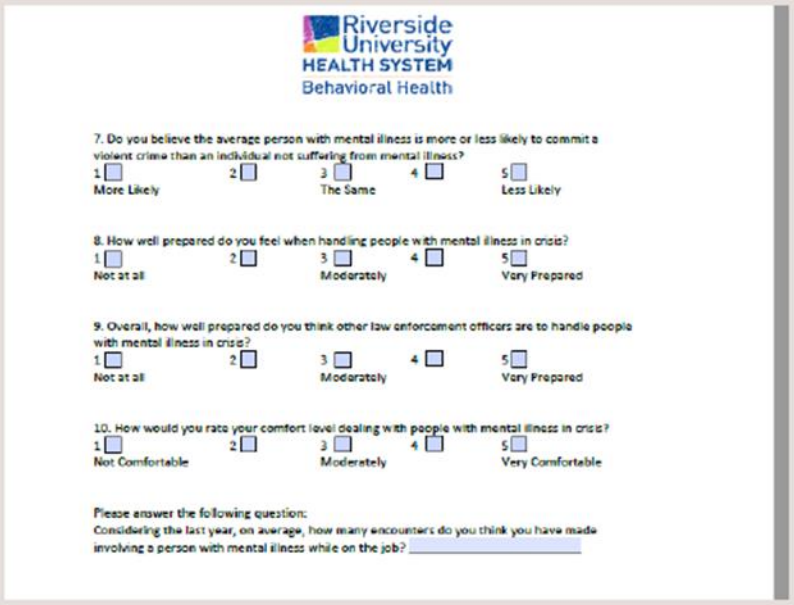
Please comment on the aspects of CIT training that you found most effective:

Please comment on the aspects of CIT training that you found least effective:

What recommendations do you have to improve CIT training?

Adapted from Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide, 2018.

- Additional goals and objectives of the CIT program will be:



Riverside University HEALTH SYSTEM Behavioral Health

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1 ☐ More Likely 2 ☐ 3 ☐ The Same 4 ☐ 5 ☐ Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?

1 ☐ Not at all 2 ☐ 3 ☐ Moderately 4 ☐ 5 ☐ Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to handle people with mental illness in crisis?

1 ☐ Not at all 2 ☐ 3 ☐ Moderately 4 ☐ 5 ☐ Very Prepared

10. How would you rate your comfort level dealing with people with mental illness in crisis?

1 ☐ Not Comfortable 2 ☐ 3 ☐ Moderately 4 ☐ 5 ☐ Very Comfortable

Please answer the following question:
Considering the last year, on average, how many encounters do you think you have made involving a person with mental illness while on the job? _____

WET

WET

Goal	Objective
1. Increase the number of emergency personnel in Riverside County that have received training in mental health awareness.	By the end of year three, 300 law enforcement, firefighters, paramedics and/or EMTs will have participated in the CIT training conducted by a team of RUHS-BH clinical therapist and emergency personnel peer trainers. **Progress Update:** We provided our Overview Presentation of this new CIT training to emergency contractors. We are in the process of coordinating training dates.
2. Increase training participants' knowledge in recognizing the signs and/or symptoms of mental disorders, and/or de-escalation strategies.	By the end of the training, 60% of the Riverside County law enforcement, firefighters, paramedics and EMTs CIT-trained will indicate in post-test evaluation tools they increased knowledge in recognizing the signs and/or symptoms of mental disorders and/or learned additional effective ways to safely de-escalate crisis situations involving individuals with a mental illness compared to their pretest scores. **Progress Update:** Pending training rollout.
3. Increase mental health awareness training of emergency personnel to recognize their own psychological exposure and trauma.	By the end of year three, 100% of the law enforcement firefighters, paramedics and/or EMTs CIT-trained will have access to available resources to deal with personal mental health issues. **Progress Update:** Pending training rollout.
4. Track referrals and linkages of culturally and linguistically appropriate behavioral health resources.	4.a. By the end of year three, 100% of the law enforcement, firefighters, paramedics and/or EMTs who participated in the CIT training will receive community behavioral resources. 4.b. Six months after training, 100% of the firefighters, paramedics and/or EMTs who participated in the CIT training will receive a survey tracking their referrals and linkages provided to community behavioral health resources. **Progress Update:** Pending training rollout. Resources have been developed by CIT staff. Resources include resources for consumers as well as first responders such as firefighters, paramedics and EMTs.

Here is a training evaluation provided positive reviews:

HEALTH SYSTEM
Behavioral Health

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to handle people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

10. How would you rate your comfort level dealing with people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

Please answer the following questions:

11. What was your overall impression of CIT training?

1	2	3	4	5
Poor		Moderate		Excellent

12. How well do you feel the training was organized?

1	2	3	4	5
Poor		Moderate		Excellent

13. Please comment on the aspects of CIT training that you found most effective:

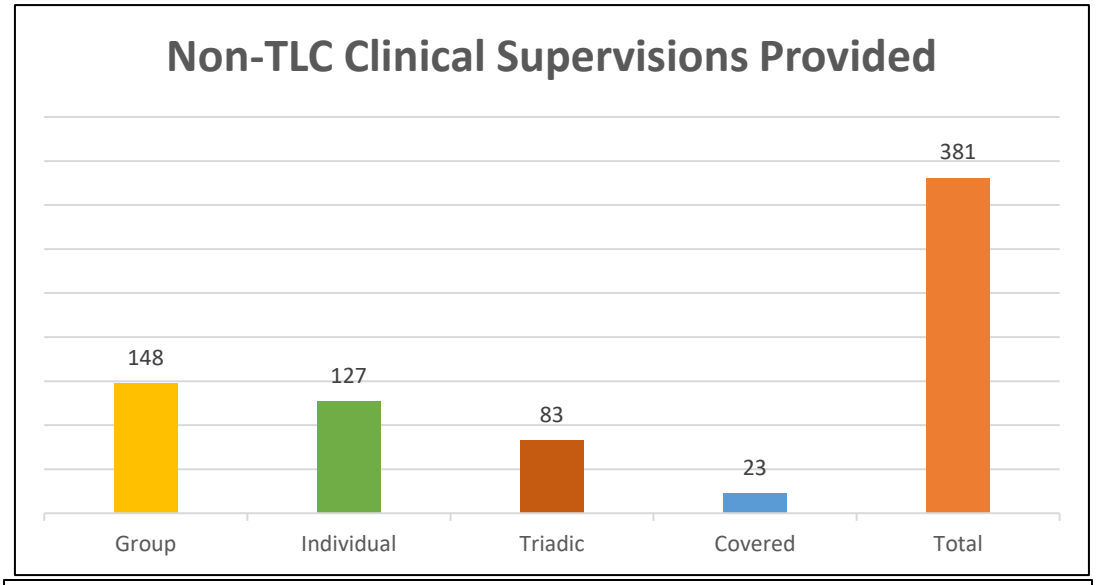
It was very valuable to get to hear what we are supposed to be doing with these patients. Also, the numbers of who to call for help with mental patients

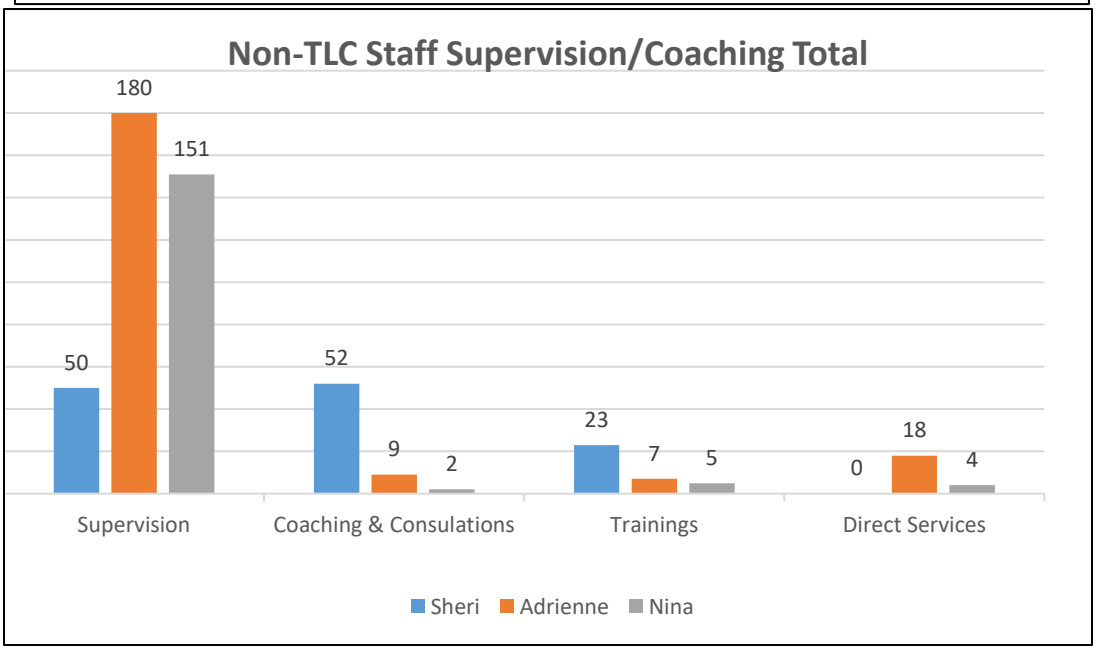
Post-Test 2

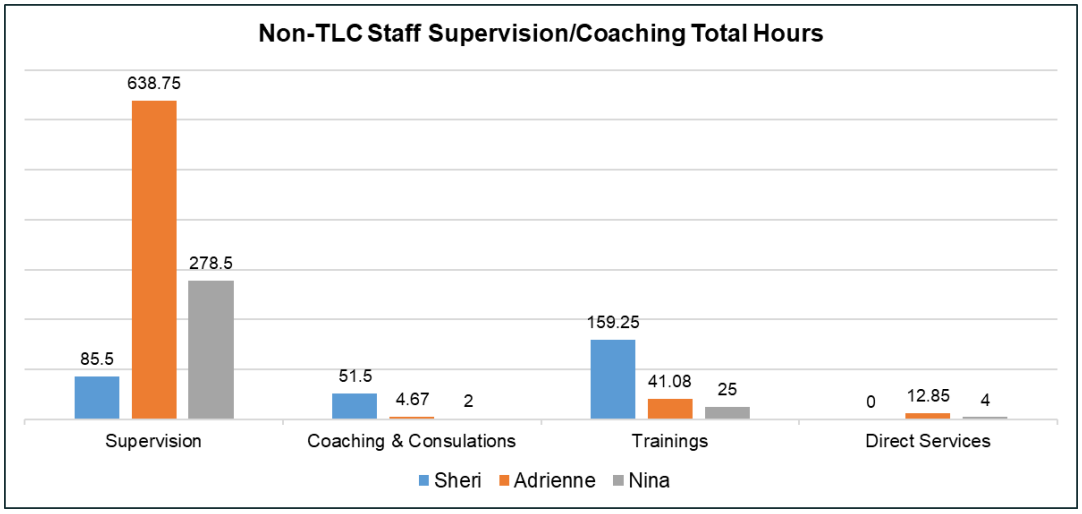
WET

LEHMAN TLC

student interns provided clinical services in our adult and children's clinics. TLC staff provided clinical supervision and specialized training for TLC interns as well as other GIFT students. TLC provided multiple individual and group clinical supervisions for clinical therapists in Behavioral Health and Public Health. TLC continued conducting an ongoing group for 23 Senior Clinical Therapists in Behavioral Health. This group provided information on BBS regulations and emerging legal mandates. The Clinical Supervisor Workgroup created and provided 3 trainings based on SCRP competencies for supervision, working with therapists effectively, and has become a significant support to that group. TLC continued to assist with facilitating the Clinical Supervision in Public Behavioral Health SCRP meetings. TLC has developed and provided CE approved trainings for Behavioral Health and county providers. TLC provided consultations, coaching, and mentoring for Behavioral Health and Public Health staff as referred by supervisors. TLC provided leadership and/ or support for Administrative Supervisor group, Trauma Informed Services champions, All County Supervisors, and All County Supervisors professional hour.







Collaborative Involvement

Collaboration Programs

Ongoing collaboration persists between Prevention and Early Intervention (PEI) and WET, focusing on diverse trainings designed for our workforce and community partners. Both units share common objectives, including the reduction of stigma and the promotion of mental health awareness. Sustaining this collaborative spirit involves organizing diverse training sessions, including safeTALK, Applied Suicide Intervention Training (ASIST), and Mental Health First Aid (Adults & Youth Curriculum). Notably, these training opportunities are provided to attendees at no cost.

Cultural Competency and Diversity Education Development Program

The WET Coordinator and the Cultural Competency Coordinator meet regularly to review the status of RUHS-BH's training to assist staff with developing culturally informed practice and service, as well as, the identification and necessity of trainings addressing the unique needs of each cultural community. As recommended WET has prioritized by our internal Cultural Competency and Reducing Disparities (CCRD) workgroup. Cultural Community Liaisons include the following populations: Wellness & Disability Equity Alliance, Middle Eastern & North African, Hispanic/Latinx, African American, Asian American, LGBTQ, Spiritualty, Deaf & Hard of hearing, and Veterans. WET attends various workgroups to gather information on needs of community and utilizes information to better inform training plans for the department. The plan is to continue to build the collaboration among cultural competency to best serve the needs of the community.

Social Media Communication and Interaction

Community Resource Educator (CRE) and Marketing Integration

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Key Achievements & Advancements

ω **Enhanced Collaboration:** LyűŜ∃NIˑűλyƎ űKŜ /w9 LJ2ăλűλ2y λyű2 űKŜ ϒIˑN]ŜűλyƎ űŜIˑϒ KIˑă ăúNŜIˑϒfλyŜŘ Ö2ϒϒdzyλÖIˑűλ2yãΣ ŜyãdzNλyƎ Ö2yãλăúŜyű ϒŜăăIˑƎλyƎ Iˑō2dzű ōŜKIˑØλ2NIˑf KŜIˑfűK ăŜNØλÖŜăφ

ω **Broadened Community Connections**ϒ {úN2y∃ŜN NŜfIˑűλ2yãKλLJă ǿλűK f2ÖIˑf NŜă2dzNÖŜ 2N∃Iˑyλî Iˑűλ2yã KIˑØŜ λϒLJN2ØŜŘ NŜŦŜNNIˑf LJIˑúKǿIˑèăΣ KŜfLJλyƎ Ö2ϒϒdzyλűè ϒŜϒōŜNă IˑÖÖŜăă ÖNdzÖλIˑf ăŜNØλÖŜă ϒ2NŜ ŜŦŦλÖλŜyűfèφ

ω **Resource Sharing & Education**ϒ ² λűK ϒIˑN]ŜűλyƎ ŜÈLJŜNúλăŜ y2ǿ ŜϒōŜŘŘŜŘ λyúKŜ /w9Ωă ǿ2N]Σ w¦ I{π. I KIˑă LJN2ŘdzÖŜŘ ϒ2NŜ λϒLJIˑÖűŦdzf ŜŘdzÖIˑűλ2yIˑf ϒIˑűŜNλIˑfăΣ IˑÖűλØŜfè úNIˑλyλyƎ ō2űK ăúIˑŦŦ IˑyŘ Ö2ϒϒdzyλűè LJIˑNűyŜNă 2yˑIˑØIˑλfIˑōfŜ ōŜKIˑØλ2NIˑf KŜIˑfűK NŜă2dzNÖŜăφ

ω **Staff Engagement Initiatives**ϒ .è Ö2yúNλōdzűλyƎ ű2 λ/2yyŜÖű IˑyŘ Iˑy ŜϒLJf2èŜŜ NŜÖ2∃yλúλ2y LJN2∃NIˑϒΣ űKŜ /w9 N2fŜ KIˑă ŦdzNűKŜN LJN2ϒ2űŜŘ ăúIˑŦŦ ŘŜØŜf2LJϒŜyű IˑyŘ NŜÖ2∃yλúλ2yΣ Ŧ2ăúŜNλyƎ Iˑ Ödzfűdz NŜ 2Ŧ Ö2ffIˑō2NIˑűλ2yˑűKIˑű dzfűλϒIˑűŜfè ŜyKIˑyÖŜă ăŜNØλÖŜ ŘŜfλØŜNè ű2 úKŜ Ö2ϒϒdzyλűè φ

Community Impact

ω **Improved Service Visibility**ϒ CIˑϒλfλŜă IˑyŘ λyŘλØλŘdzIˑfă λyˑySŜŘ y2ǿ KIˑØŜ ÖfŜIˑNŜNΣ ŜIˑăλŜNπ ú2πŦλyŘ λyŦ2NϒIˑűλ2yˑ2yˑōŜKIˑØλ2NIˑf KŜIˑfűK ăŜNØλÖŜăφ

ω **Stronger Outreach & Impact**ϒ /22NŘλyIˑűŜŘ ϒIˑN]ŜűλyƎ ŜŦŦ2Núă Ŝyãdz NŜ Iˑ ϒ2NŜ dzyλŦλŜŘ LJNŜăŜyÖŜ λyˑűKŜ Ö2ϒϒdzyλűèΣ IˑffǿλyƎ Ŧ2N ŘŜŜLJŜN ŜyƎIˑ∃ŜϒŜyű IˑyŘ λϒLJN2ØŜŘ IˑǿIˑNŜyŜää 2Ŧ ÖNλűλÖIˑf LJN2∃NIˑϒă IˑyŘ NŜă2dzNÖŜăφ

Social Media's Role in Enhancing Behavioral Health Resources

Lyˑ Iˑyˑ ŜNIˑ ǿKŜNŜ Řλ∃λúIˑf Ö2ϒϒdzyλÖIˑűλ2yˑλă ŜăăŜyűλIˑfΣ w¦ I{π. I KIˑă fŜØŜNIˑ∃ŜŘ ă2ÖλIˑf ϒŜŘλIˑ LJfIˑűŦ2NϒăúŸ2 IˑÖűλØŜfè ŜyƎIˑ∃ŜΣ λyŦ2NϒΣ IˑyŘ ădzLJLJ2Nű wλØŜNăλŘŜ /2dzyűè NŜăλŘŜyűăφ ¢KN2dz∃K .dzăλySăă ű2 IdzϒIˑyˑó.HIú IˑyŘ IdzϒIˑyˑű2 IdzϒIˑyˑóIHIú ϒIˑN]ŜűλyƎ ăúNIˑűŜ∃λŜăΣ w¦ I{π. I Ŧ2ăűŜNă ϒŜIˑyλy∃Ŧdzf Ö2yyŜÖűλ2yã űKIˑű ăLJ2ŭfλ∃Kű úKŜ NŜIˑf ŜŦŦ2Núă IˑyŘ λϒLJIˑÖűă 2Ŧ ŘŜŘλÖIˑúŜŘ ŜϒLJf2èŜŜăφ

Latest Social Media Performance Metrics

Instagram

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- Reach: 15K (↑115.7%)

Facebook

- Reach: 48.4K
- Content Interactions: 5.2K (↑85.2%)
- Page Visits: 17.9K (↑127.7%)

LinkedIn

- Reactions: 638
- Impressions: 14,118

These metrics indicate increased community engagement across multiple platforms. Even where certain metrics have dipped, overall interactions and reach have grown substantially, signaling strong public interest in behavioral health resources and services.

YouTube's Impact on Behavioral Health Awareness

RUHS-BH's YouTube channel remains a vital platform for distributing educational videos, service updates, and awareness campaigns. During the most recent reporting period, the channel demonstrated significant audience engagement and growth:

- **Total Views**: 11,405
- **Watch Time**: 583 hours
- **New Subscribers**: +102

Viewer Demographics

- **Female (**51.1%): Average watch time of 3:01 minutes
- **Male** (48.9%): Average watch time of 4:15 minutes

Age Distribution

- **25–34 years**: 53.3% of viewers
- **55–64 years**: 46.7% of viewers, exhibiting notably higher watch time

These figures highlight the channel's effectiveness in reaching diverse age groups and maintaining viewer attention—crucial for disseminating critical information about behavioral health.

By integrating the CRE role into the broader RUHS-BH marketing framework, the department has achieved stronger collaboration, improved social media outreach, and enhanced

community engagement. The addition of a second Marketing Media Communications Coordinator has further empowered these initiatives, resulting in:

- Greater Community Awareness: More people now have the information and resources they need to seek assistance.
- Increased Digital Engagement: Social media platforms and YouTube content continue to expand the reach and impact of behavioral health messaging.
- Ongoing Innovation & Support: Unified marketing strategies ensure sustainability and adaptability, allowing RUHS-BH to remain a leading provider and advocate for behavioral health services.

Moving forward, RUHS-BH will continue leveraging data-driven insights to optimize outreach, refine strategic marketing efforts, and maintain a high level of engagement with the community. These efforts ensure that individuals and families in need can access vital behavioral health support, underscoring RUHS-BH's ongoing commitment to promoting wellness and recovery throughout Riverside County.

WET-03 Mental Health Career Pathways

This work plan is designed to provide community members with the information and supports necessary to identify educational or professional career pathways into the public behavioral health service system. These actions/strategies help create accessible career pipelines aimed at expanding and diversifying our workforce in ways that better meet our communities' needs. It promotes the mental health careers through outreach and activities geared toward junior high, high school and community college students. In addition in this work plan there is an action to support and assist pre-licensed clinical therapist in developing their professional identity and clinical skills in order to pass State Licensure exams.

To meet the outreach and education goals in this work plan, we focused our strategies on the following:

- Pipeline and Outreach Efforts
- Volunteer Services Program
- Clinical Licensure Advancement Support
- Clinical Supervision Supports

<u>Pipeline and Outreach Efforts</u>

Behavioral Health Career Pathways and Outreach Report

This initiative is designed to employ various strategies to promote careers in behavioral health, support local career pipeline efforts, provide accurate information about mental health, and work to reduce stigma in the communities we serve. During this reporting period, significant efforts were made to collaborate with Cultural Competency program liaisons to

share information about educational and career pathways into behavioral health with underserved communities.

In partnership with Cultural Competency's Asian American Task Force (AATF) and the Middle Eastern North African (MENA)/MECCA, presentations on educational and career pathways were provided to college students in the Asian Pacific Island Social Work Club (APISWC) and the Middle Eastern Student Center (MESC) and Middle Eastern Student Assembly (MESA) at the University of California, Riverside campus.

Support for local high schools and health academies continued, further increasing our presence in the community. The Workforce Education and Training (WET) team participated in advisory committees and career and wellness fairs and provided both virtual and in-person classroom presentations. We continued our collaboration with Reach Out's Moving in New Directions (MIND) club, offering psychoeducational presentations to junior and senior students at Corona-Norco High School. This program targets at-risk students with an interest in behavioral health. During this reporting period, we also provided training on "Introduction to Psychosis" for Health Academy students at Eleanor Roosevelt High School. Additionally, WET delivered a presentation on "Careers in Behavioral Health" to students in the MSW program at California State University, San Bernardino, highlighting the Clinical Therapist I position.

Our partnerships grew this reporting period, with WET participating in the following outreach events to promote educational and career pathways into the public behavioral health service system. These events reached approximately 2,205 students and community members throughout the year:

- Val Verde Unified School District Wellness Fair
- CCHS Health Academy Professional Interview Day
- Emerging Professionals Event, California State University, San Bernardino
- Riverside Unified School District Educational Options Center Career Fair
- Norco College Safety and Wellness Expo
- Moreno Valley College Emerging Career Spotlight Guest Speaker – Social Work
- Riverside City College Health and Wellness Fair
- Pinacante Middle School Wellness Fair
- Moreno Valley College Spring Career Fair
- RUHS-BH May is Mental Health Month events in Palm Desert, Mid-County, and Western Regions

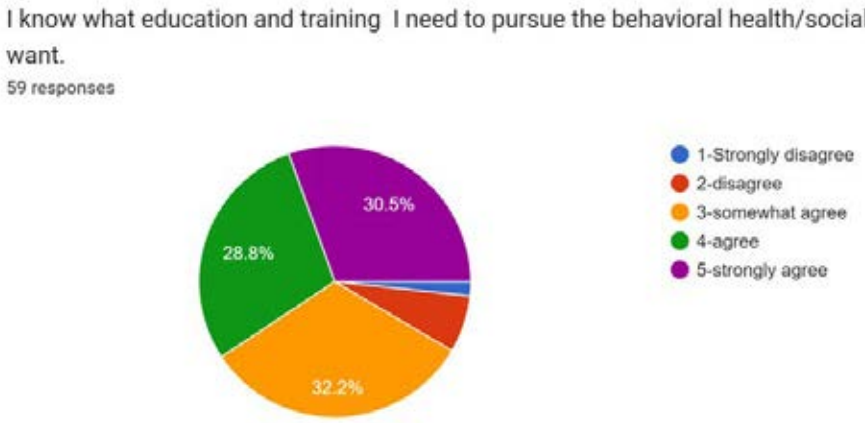
In November 2022, in partnership with Vista Del Lago High School's Community Health Worker Academy, WET hosted the first-ever virtual Get Psyched event. Over 100 students participated in the virtual workshop, which provided them an opportunity to explore various

careers in behavioral health, learn about the desirable characteristics of a provider working with consumers, and understand the importance of the field in our community. During this reporting period, efforts were made to expand the Get Psyched event to an in-person format, targeting both high school and community college students. In collaboration with Vista Del Lago High School and Moreno Valley College (MVC), the Get Psyched conference was held at MVC on October 10, 2023. The conference was attended by over 100 students from both high school and community college levels.

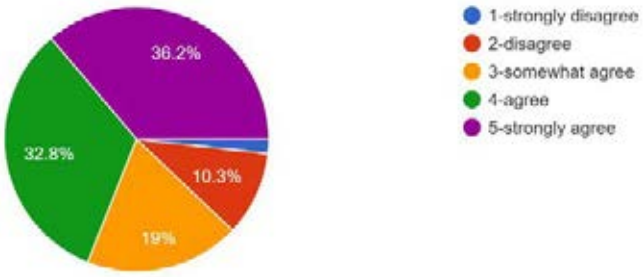
Students attended presentations from MVC counselors on mental health and wellness resources available on campus, as well as instructors from the Social Work, Human Services, and Counseling programs. RUHS-BH Cultural Competency Liaisons from AAFWAG and HISLA spoke about the importance of workforce representation, and a panel of current MVC Social Work students and RUHS-BH staff shared their experiences navigating the career pipeline. WET also presented on the educational and career pathways into the public behavioral health service system. Additionally, local social work bachelor's-level programs and community resources set up informational tables throughout the event, offering students an opportunity to learn about available programs and services to support their educational journey. Post-event measures indicated positive feedback and strong engagement from participants.

These outreach efforts continue to effectively raise awareness about career opportunities in behavioral health, reduce stigma, and foster the development of a diverse and qualified workforce within the public behavioral health system. Post-event measures indicated positive feedback and engagement from participants.

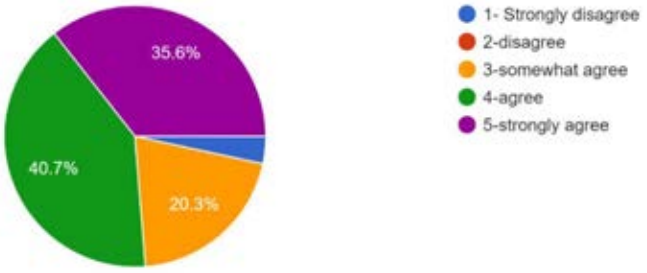
Pre-Test Results-



I am interested in pursing a career in behavioral health.
58 responses

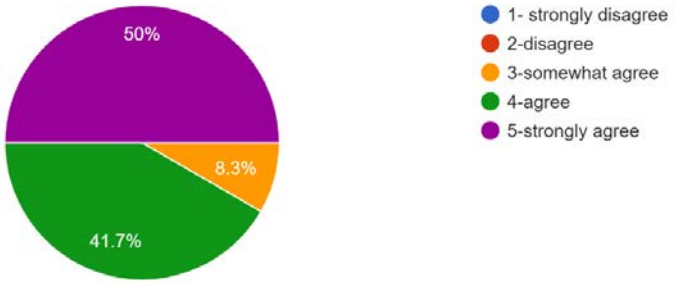


I know about different types of careers that I can pursue in the behavioral health field.
59 responses



Post Test Results-

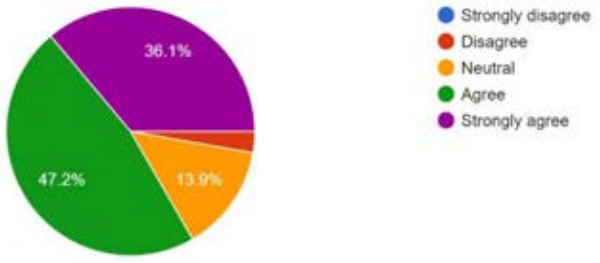
I know about different types of careers that I can pursue in the behavioral health field.
36 responses



WET

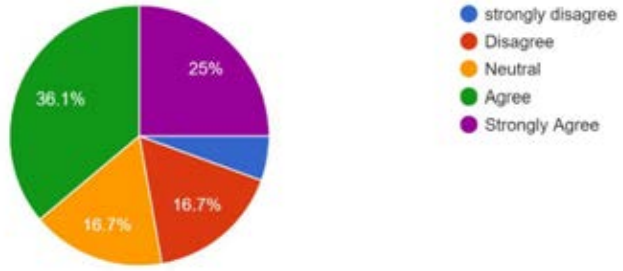
I know what education and training I need to pursue the behavioral health workforce.

36 responses



I am interested in pursuing a career in behavioral health

36 responses



Statements from participant surveys of the Get Psyched 2023 Event:

What is needed to go into the behavioral health career ie requirement. The current program and services that Moreno Valley College offer far as willingness and everyday life.
The speeches of mental health awareness. It motivates me to keep moving forward.
Th Get Psyched event opened my mind on struggles in the community and helped me know its not just me. I like the opportunities this event has gave me as someone that needs help.
talk about my mental health and exercises and different careers of social work
the student panel section
learning about how to care for yourself and how its needed.
the breathing exercises
the environment as it made the topic less heavy.
i loved the student and professional panels.
I like hearing people's backgrounds and raising awareness towards the stigma of mental health because its never really talked about
How well they outlined the education soft skills needed for the careers

SCRP funds were allocated to support two key outreach events in October and November 2024: the second annual Get Psyched MVC event, which reached 200 high school and community college students, and the inaugural Palm Desert Get Psyched event, which engaged approximately 230 high school students. Both events focused on education and career pathways into the public behavioral health service system.

During this period, virtual engagement with community partners, such as OneFuture Coachella, continued to support connections with teachers and community leaders to explore opportunities for program development. WET participated in OneFuture Coachella's Mental Health Matters Webinar Series on YouTube, presenting on careers in behavioral health. The webinar has received 83 views to date. Additionally, WET continued its involvement in the Behavioral Health A-Team (Desert) monthly virtual outreach meetings to support their efforts in creating employment opportunities and programs for students interested in the behavioral health field.

These ongoing outreach and partnership efforts have significantly contributed to raising awareness of career opportunities in behavioral health, combating stigma, and fostering the development of a diverse and well-trained workforce in public behavioral health services.

Volunteer Services Program

Volunteering with Riverside University Health System-Behavioral Health (RUHS-BH) is an opportunity to explore different career pipeline activities. It offers volunteers great opportunities for education growth, network building, improving customer service skills and hands-on training. RUHS-BH encourages volunteerism to support the departments' mission to help clients achieve and maintain their greatest wellness and recovery. Some of the benefits of volunteering in the Volunteer Services Program are the ability to give back to the community, improve professional skills, and provides an opportunity to learn about recovery-oriented care.

The Volunteer Service Program has been undergoing changes in an attempt to streamline and facilitate the process.

In 2022-23, we have begun to rebuild the program and are continued the rebuilding process in 2023-2024. The growth has been slow, due in part to the continued concerns regarding the public health crisis and staffing changes that occurred. Six individuals were placed in programs throughout the County in the 2023-2024 year while others started the process but did not finish it due to many different reasons.



WET's future aim is to continue to re-build the Volunteer Service Program in an effort to create strong partnerships with RUHS-BH teams for placement and to increase the Volunteers in support of those programs while also providing growth and opportunity for learning and experience for those interested in future careers with RUHS-BH.

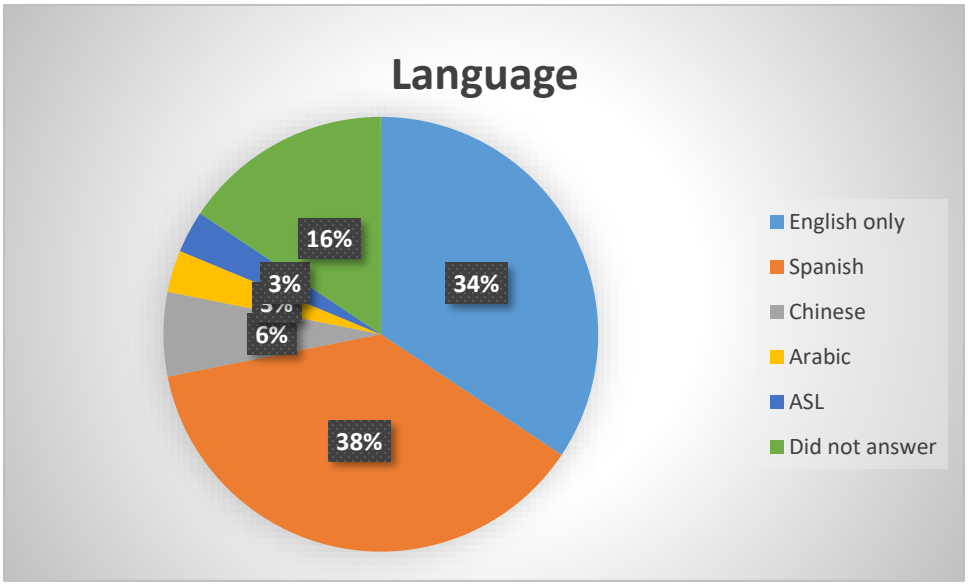
CLAS Program, Clinical Supervision Workgroup and Clinical Supervision Supports

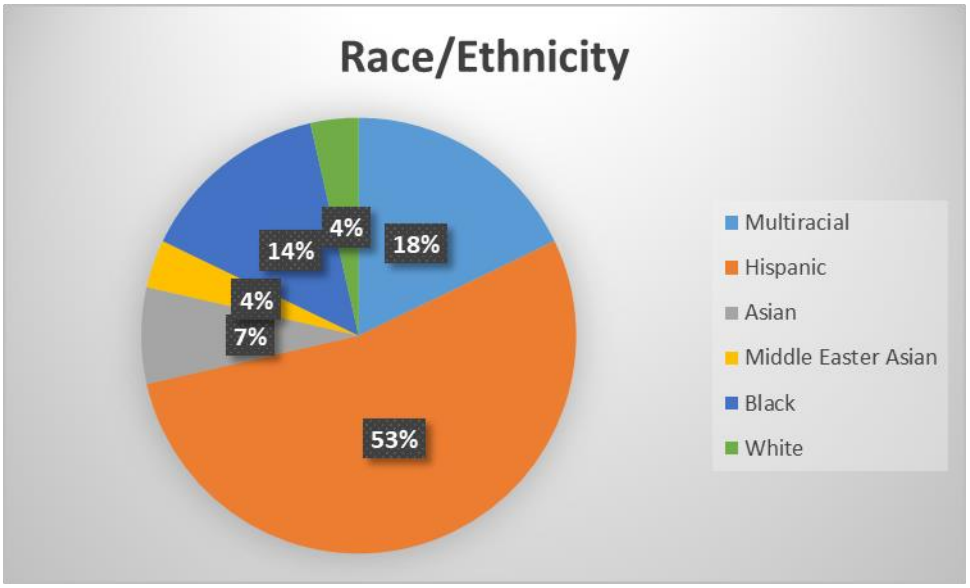
Clinical Licensure Advancement Support (CLAS) Program

The Clinical Licensure Advancement and Support (CLAS) Program was designed to support the Department's journey level clinical therapist in their professional development and preparation for state licensing. Participants are offered one online study program material specific to their licensure, one hour weekly study group, individual coaching, and customized mini lessons on critical areas of skill development.

There are two primary reasons that WET focuses specific resources and attention on this part of our workforce. First, this strategy promotes retention of a critical section of our workforce. Nearly 50% of our clinical workforce is comprised of pre-licensed clinical therapists and these employees must complete the licensing process within a certain amount of time in order to remain employed with the agency. This program is also highly desired and well-received by the workforce, which means helping to increase retention through increased employee satisfaction and loyalty. Second, this program helps us diversify our workforce and helps to increase competency of our clinicians.

The new applications for the program increased to 33 applicants from 30 applicants the previous year. The CLAS program continues to be diverse. For new applicants, approximately 50% are bilingual in Spanish, Chinese, Arabic or American Sign Language. Ninety-six percent of new applicants identify as non-white. This past year, 24 CLAS participants passed their clinical exam, another increase from last year's 16.





To be able to serve clinicians throughout the county, CLAS activities occur on our virtual platform. The virtual platform established in 2020 in response to the COVID pandemic has become the standard practice for CLAS activities. Because virtual meetings eliminate travel time, it has allowed more participants to participate in virtual mini lessons, individual coaching/mentorship, and study groups. Mini lessons are offered every other month. This past year, the mini lesson topics were on Clinical Assessments, Theories, Treatment Planning, Crisis Management, and Diagnosis. Many CLAS participants have shared that they find these mini lessons, which target specific topics from the test and applying test strategies to practice questions, the most helpful in preparation for their exams. This year, we continue to look forward to adding new mini lessons, targeting the highest utilizers to get them to licensure quicker, reduce participant's time in time in the program, and providing study group and individual coaching curriculums. Also, based on participant feedback, we now offer an additional test preparation program for CLAS participants as many have requested.

The goal last year was to target those who failed to help them pass their exams. Five of the six people who requested individual coaching had failed their exam multiple times (at least two) prior to joining CLAS. One person requested individual coaching had not yet taken their exam.

We had 32 CLAS participants report attempting their exam this past fiscal year. 24 passed their exam, while 8 failed their exam. Of the 8, there were two that failed their exam twice. Another previous goal was to improve data collection to improve CLAS services. The increased data examined the number of participants seeking which licensure, the services CLAS participants participated in, and the breakdown of passing and failing in each category. This data will help CLAS improve its goal of providing services to increase the number of therapists pass their licensure exam.

LPCC		
Passed	3	1st attempt
	3	***Total Passed***
Failed	1	2nd attempt
	1	***Total Failed***

LMFT		
Passed	2	4th attempt
	4	1st attempt
	6	***Total Passed***
Failed	1	1st attempt
	1	4th attempt
	2	5th attempt
	4	***Total (One person failed twice)***

LCSW		
Passed	11	1st attempt
	1	2nd attempt
	1	3rd attempt
	1	4th attempt
	1	5th attempt
	15	***Total Passed***
Failed	1	1st attempt
	2	3rd attempt
	3	***Total Failed***

**Some participants joined CLAS after failing their exam one or more times. Attempts prior to joining CLAS are included.*

Participation of CLAS Services of those who Attempted their Exam

Study Program

Program	Passed	Failed
AATBS/Grossman	11	4
TDC	12	2
Did not request	1	
Total	24	6

Study Group

Program	Passed	Failed
Study group	13	2
No Study group	11	4
Total	24	6

Individual Coaching

Program	Passed	Failed
Individual coaching	4	2
No individual coaching	20	4
Total	24	6

Mini Lessons

Program	Passed	Failed
Attended at least one	14	4
Did not attend any	10	2
Total	24	6

Clinical Supervision Supports

Our agency recognizes the value of strong clinical supervision in order to increase the quality of consumer services. We continue to build from the collaboration with the Southern California Regional Partnership on its efforts to improve clinical supervision in our region. Our county has continued to strengthen our clinical supervision program, building off the Competency-Based Clinical Supervision training and Train the Trainers Initiative to strengthen and improve clinical supervision in the region that began in 2019. In 2021, Riverside County created a clinical supervision workgroup and lead in creating a collaborative on clinical supervision with our SCRP partners. This past year, we continued to build on this knowledge

with our clinical supervision workgroup, clinical supervisor consultation groups and County Collaborative with other SCRP members focusing on clinical supervision.

One way the WET team has aided both our RUHS-BH program supervisors and our pre-licensed clinical staff is that WET staff have begun assisting in providing clinical supervision to help fill in the gap when the supervisor is unable to do so. An example of this is when a Clinical Therapist I (CT I) is unable to receive their supervision hours from their direct supervisor due to licensure requirements. The supervisor contacts the WET team and if available, we provide group or triadic supervision or add the staff member to our waitlist to help the CT I meet the pre-licensed staff's requirements of the Board of Behavioral Sciences towards licensure, which assists RUHS-BH in keeping the staff member eligible to work. The WET teams' clinical staff (including those from the Lehman's Center clinics) assist in providing clinical supervision for these pre-licensed staff members.

Clinical Supervision Workgroup

Those who participated in the initial competency-based training on clinical supervision, formed a Clinical Supervisor workgroup in 2020, which continues to meet monthly. The workgroup was established to be an advisory board for clinical supervisors in the county, with the goal to standardize clinical supervision, make recommendations to the department, recommend best practices, and advise new and current clinical supervisors. The challenges experience with the workgroup continues to be a decrease in members and/or inconsistent participation. While most of the members remained within our department, many of the members were required to take on additional responsibilities or were promoted, which impacted their ability to participate in and/ or attend these meetings consistently. This has also caused delays in the achievement of some of the workgroup goals.



Another challenge the group incurred is the change in the CEU reference requirements. Currently, the group is working on updating the references for all developed "mini-lessons" on advanced clinical supervision topics based on the nine-month curriculum of the Competency-Based Clinical Supervision training course in order to apply for CEU approval. The goal is to offer these lessons every other month for one CE credit each, so that supervisors can accrue the necessary six CEs required by the BSS for every licensure renewal. The workgroup is also continuing to work on standardizing clinical supervision forms for use in RUHS-BH. The workgroup also ensured that all new supervision laws and regulations that took effect with BBS were communicated regularly with clinical supervisors across the department to prepare for the changes in advance.

Clinical Supervisor Consultation Groups

The clinical supervision consult groups were created to provide support and training to clinical supervisors in the department based on the supervisor training program. Clinical supervisors continue to express need for more training in clinical supervision, as well as consulting about supervisees and sharing knowledge with each other. We continued the Senior CT Clinical Consultation Group started in 2022 to provide information, tips, review RUHS-BH policies, review QI feedback, and support new clinical supervisors. We also expanded the group to include Senior CTs from SAPT and other licensed clinical staff. This group meets monthly, which includes didactic teachings on clinical supervision topics, problem solving clinical supervision challenges, and providing updates on Board of Behavioral Science regulations and department policies.

County Collaborative on Clinical Supervision

Riverside County continues to lead the clinical supervision collaborative with the SCRP counties. This collaborative began in November 2021 when our county reached out to other members of the SCRP, who also completed the Competency-Based Supervision Training, to ask if there was interest in meeting to share ideas and problem solve similar clinical supervision challenges in our region. There was such a desire among the group members to continue, that the collaborative continues to meet every two months, to discuss best practices in public behavioral health and problem solve together on challenges relating to clinical supervision. As a group, we have experienced similar challenges and have discussed ways to address issues such as; staff retention concerns, lack of LCSW clinical supervision coverage and had conversations about how each county is navigating challenges with the implementation of Cal-Aim. We also continued to share ideas and resources from each of our counties, such as sharing training curricula, strategies, and forms with each other to improve each of our processes. We also discuss ways to improve support to clinical supervisors and improve trainings. Due to our efforts, the group was highlighted in SCRP clinical supervision conference in October 2023 as a model of intercountry collaboration. We are excited to continue this county collaborative with other Southern California Counties to improve and strengthen clinical supervision practices, identify general best practices, review ideas for staff retention, and to share resources and ideas.

WET-04 Residency and Internship

This work plan is designed to create opportunities for new professionals in our communities to learn and train with local public behavioral health and substance use programs. Well-structured and organized residency and internship programs also serve as effective recruitment and retention strategies which eventually improves loyalty, retention and workplace productivity. Residency and Internship programs have long been the heart of practitioner development. These programs are structured learning experiences that allow participants to provide service to our consumers and community while also meeting academic or professional development goals. It is important to note that WET centrally coordinates one of the largest BH internship programs in the IE.

To meet the Residency and Internship goals in this work plan, we focused our strategies on the following:

- The Graduate Internship Field & Traineeship Program
- Alcohol and Other Drugs (AOD) Program and Mentored Internship Program(MIP)
- Psychiatric Residency Program Supports

Graduate Internship, Field, and Traineeship (GIFT) Program

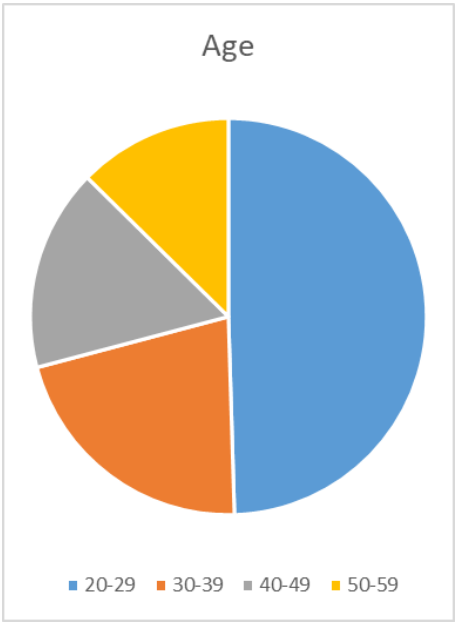
The Graduate Intern, Field, and Traineeship (GIFT) Program, as part of Workforce Education and Training, is a highly competitive and sought-after program in the region and continues to remain one of the largest internship programs in the Inland Empire. The Staff Development Officer of Education (SDO), who oversees this program, interviewed over 85 applicants, and in so, screened students to identify those who met the values of the Department workforce development needs, MHSA values, and who demonstrated a passion for public, recovery-oriented services. We are always looking for students with a passion for learning, a passion for service and those who may be interested in having a career in the public mental health system. The individuals chosen through the interview process exhibited a commitment to the underserved, those with lived experience as a consumer or family member or had cultural and linguistic knowledge required to serve the consumers of the County of Riverside. The picture below is WET's Staff Development Officer of Education, Sherie Park, LMFT, and Office Assistant III, Maryse Saba at a student recruitment fair at one of our supporting universities for new GIFT Program student interns.

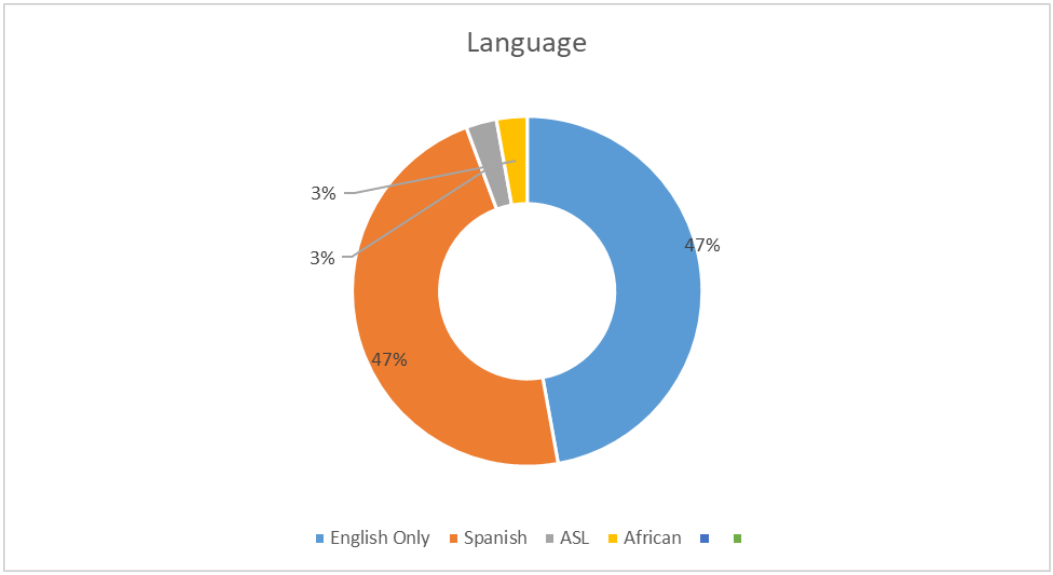


The 2023-2024 cohort, which consists of both GIFT and 20/20 Program students, consisted of 37 students, and represented 10 university programs, all of which have RUHS-BH completed Affiliation Agreements. In 2023-2024, the GIFT Program received 120 applications and coordinated internships for 37 master or bachelor level students in the GIFT Program. Forty-two percent of the students in the cohort were multi-lingual with over 50% of those being Spanish speakers, which is the threshold language for Riverside County. Many of the students in the cohort had previous lived experience (as a consumer or family member). Demographically, 51% identified as Hispanic or Hispanic mixed with another race, 21%

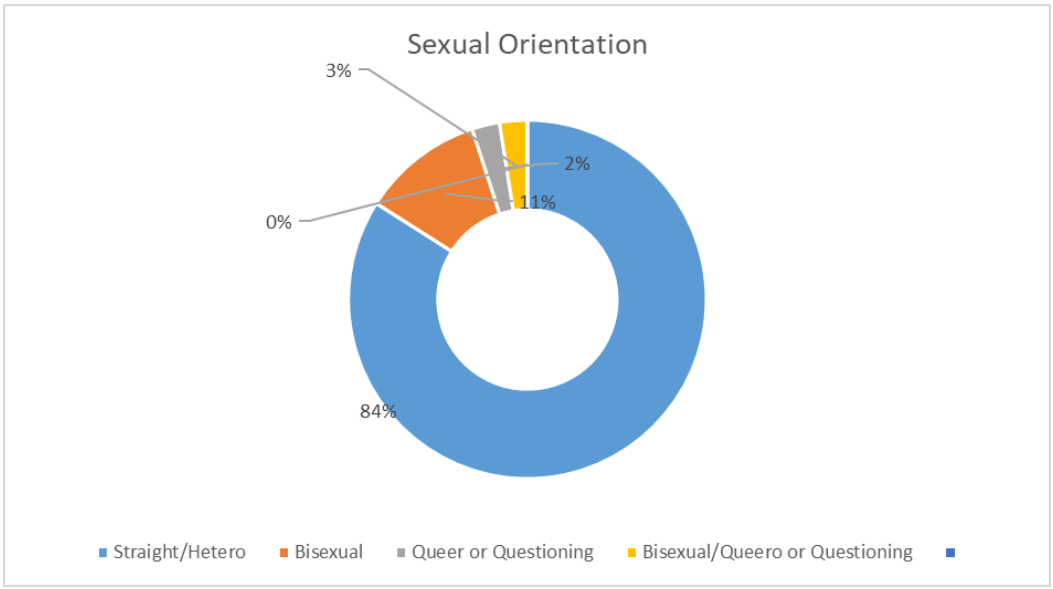
Caucasian or white, 11% as African American, and 3% identified as other races (Asian or Multiple Mixed Races). Note: the pie charts below represent the 2023-2024 GIFT & 20/20 Program Demographics.

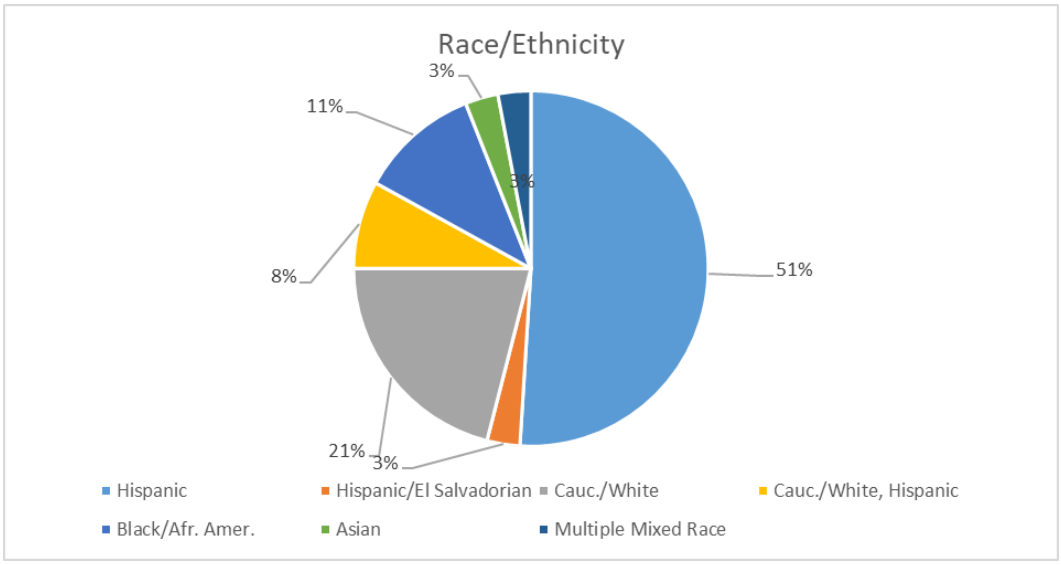






WET





Each student in the program received a two-week pre-placement Student Orientation to enhance their field/practicum learning in behavioral health. These trainings were conducted by WET and other staff members and included the following topics: A Program Overview, Therapeutic Boundaries, Differential Diagnosis, Mental Health First Aid, Cultural Competency, RUHS-BH Support Services, Co-Occurring Disorders, Risk Assessment, Thriving in Public Service, GET's (Genogram, Ecomap, and Timelines), SAFE TALK, and Trauma Informed Services 101. In addition to the Student Orientation, students received three other trainings (Square Model, Solution Focused Brief Therapy, and the Student Spring Meeting) designed specifically for the cohort, which provided hands-on practical learning experiences for them to implement with their clients. Students can also attend most other trainings offered for our staff with supervisor permissions.

All students in our GIFT Program received weekly individual supervision and for those desiring additional supervision, group supervision was made available by our WET team. WET also

serves as a support and backing for all members of the learning team: the clinical field site, the student, and the university. This allowed for standardized support, monitoring, and oversight.

In order to become a part of the GIFT Program, our graduate student interns must go through the same competitive hiring process as any applicant in order to become a Clinical Therapist in the Department. The Department continues to hire many of the graduating student cohort each year. This enables us to not only meet the workforce development needs for this hard-to-fill job classification but confirms that the GIFT Program prepares our students to succeed in public mental health services. In an effort to assist with the transition from student to professional, our SDO assists in collaboration with our Human Resources team to help facilitate the interview process for the graduates of the GIFT Program for the position of CT I with RUHS-BH supervisors.

Each of our GIFT Program students were placed in clinics or programs in RUHS-BH throughout the County; the three regions represented 11 placements in the Western region, 7 placement sites in Mid-County and 4 in the Desert region. We extend a debt of gratitude to the 25 supervisors who extended themselves to provide countless hours of supervision to our students; our program would not be successful without them.

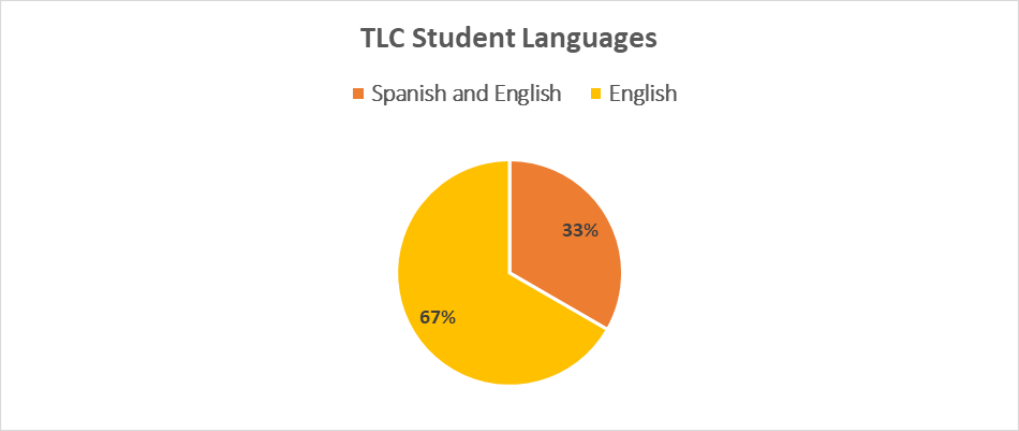
GIFT & The Lehman Center (TLC)

The Lehman Center (TLC) recruits student interns from the GIFT program. One out of six TLC interns continued on to their second year of their MSW Program and accepted a GIFT position with RUHS-BH's crisis system of care. One out of six was admitted to an advanced standing MSW Program to continue their education. One out of six did not apply to RUHS due to moving out of the area post-graduation. One out of six did not apply to RUHS_BH due to accepting a private practice position. One out of six applied to RUHS-BH. However, they were ultimately hired by San Bernadino County. One out of the six student's post-graduation status is unknown. Students reported they wanted to be at the TLC placement due to the advanced training, excellent quality supervision and treatment opportunities. TLC was able to recruit and hire a bilingual OA III. TLC recruited student interns who represent the community and clients served. TLC trained the Spanish speaking students how to use the Spanish DSM-V and provide services in Spanish.

TLC assisted with the WET booth in May is Mental Health Month Fair at Fairmount Park in Riverside and at Valley Wide Park in Hemet. Adrienne Jordan-Delgado, of TLC, assisted with holding the Public Forum for the MHSA plan community feedback in Hemet. TLC students did community outreach through the Thanksgiving Food Basket Drive at both sites, Halloween Drive Thru Event at Myers, and The Longest Night. TLC continued to utilize telehealth to serve clients and families of clients when they tested positive or were ill to avoid gaps in services. TLC coordinated with Blaine Clinic to complete assessments, openings, and treatment for their clients.

Sheri Marquez, of TLC, expanded trainings in a collaboration with Behavioral Health TOPPS program and Hemet Unified School District. She increased the CEU trainings provided by Behavioral Health. She provided training exchange for San Bernardino County Mental Health.

She provided support to managers and supervisors through referrals to her coaching/mentoring program.



TLC provided trainings for the GIFT students, TLC students, and for the Behavioral Health Clinics throughout the county. These trainings included, but were not limited to, The Square Model, GET, Solution Focus Brief Therapy, PAIR, Crisis, Equine Therapy, Narrative Therapy, Substance Abuse 101. Mindfulness, and Legal Ethical Issues. TLC staff provided training for GIFT students as part of the 2-week orientation including Differential Diagnosis. TLC staff participated in GIFT end of the year mock interviews. TLC Senior Clinicians also facilitated a SCRP Clinical Supervision Workgroup. The TLC staff renewed their own CANS certifications and assisted student interns with their CANS certification. TLC provided individual and small group coaching, consultation, and large group trainings. Senior CTs continued group supervisions for ASWs due to the lack of LCSWs available to provide clinical supervision as required by BBS. Senior CTs also provided individual supervision to seven CT1s across various programs to address need for LCSW supervision. Adrienne provided individual coaching with Senior CTs who were struggling in their role based on BHSS requests for extra support.

Sheri expanded trainings and provided CE's for the Integrated Model of Genogram, Ecomap and Timeline, Solution Focus Brief Therapy, and The Square Model. She continued to provide group supervision for CT 1s in Behavioral and Public Health.

TLC Student Intern Trainings (18)

TLC Student Intern Trainings (18)

Question	Average Score
This training increased my understanding of the subject matter	4.93
Did the instructor(s) present the training materials in a clear and cohesive way?	4.93
Was the instructor attentive to questions?	4.99

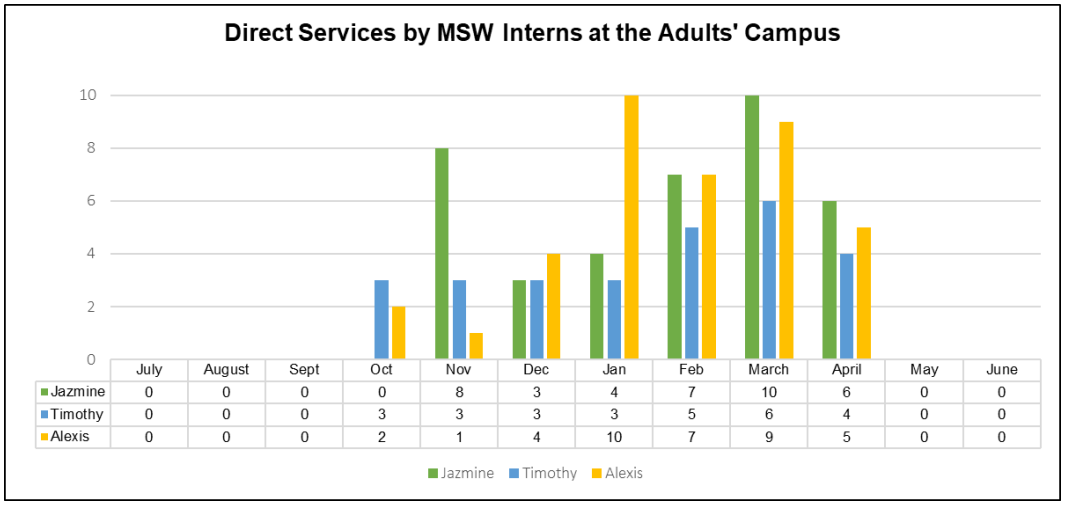
Non-TLC Trainings (19)

	Average Score
This training increased my understanding of the subject matter	4.90
Did the instructor(s) present the training materials in a clear and cohesive way?	4.95
Was the instructor attentive to questions?	4.94

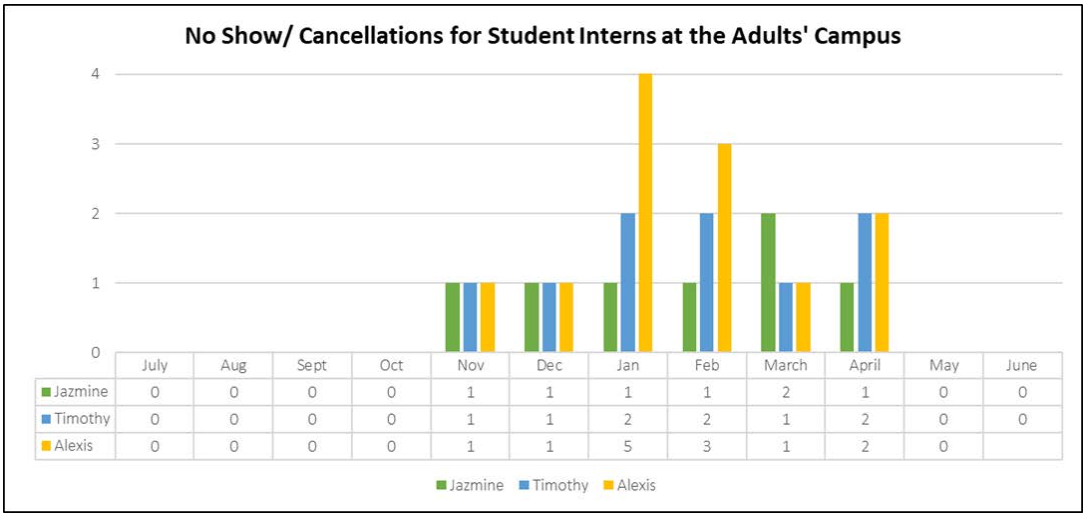
One of the biggest challenges was the continuing challenges made to CalAims. Due to the Cal-Aim shifts, we had to make and adjust changes to trainings, our training binder, processes/procedures, documentation, etc. The process from the county and the state was slow and affected the development of our binder and policies in the clinic. Another challenge was gaining access to ELMR and the completion of background checks which severely delayed and decreased the students' time to provide services to clients. The absences of Sheri Marquez, TLC BHSS, also created significant challenges with regard to coverage, training, and our adult site move to Corona. Due to changes in supervisory staff at Blaine, it was difficult to maintain consistent processes, procedures, and plans to assist Blaine with client services. Other challenges were assessment no show rates and having pending referrals already being linked with other clinics due to delayed ELMR access/start time for students.

The TLC staff reviewed student feedback for student Binders and revised according to Cal AIM (revised policy, procedures, documentation examples, workflow charts). The TLC staff continue to update the Square Model training to be consistent with Cal AIMS changes. Senior CTs assisted with retaining clinical staff in department through supervision. Nina Le and Adrienne Jordan-Delgado, of TLC, continued group supervision for ASWs due to the need for required LCSW supervision. Adrienne continued the Senior CT Group. Senior CTs continued the Clinical Supervision Workgroup and presenting trainings to disseminate information on SCRP competencies for clinical supervision developed by the Clinical Supervision Workgroup for feedback and in preparation for request of CEUs in the Senior CT Group.

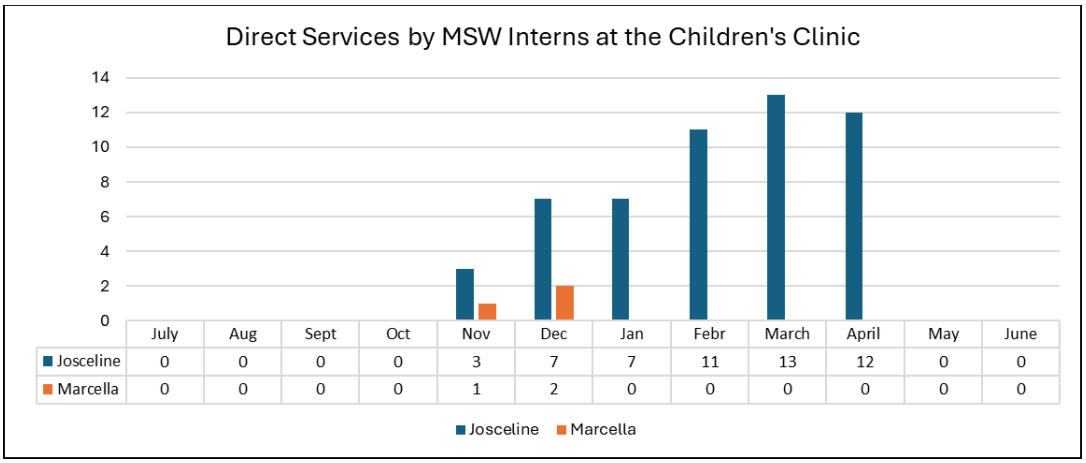
See below, the last graph for this section demonstrates overall services for both the Children's and Adult Campuses.



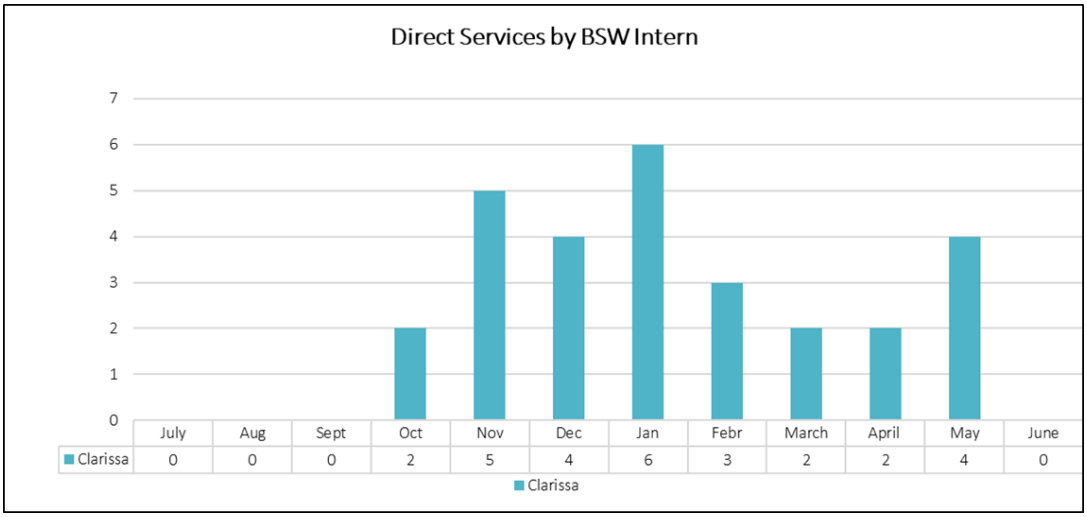
	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Jazmine	0	0	0	0	8	3	4	7	10	6	0	0
Timothy	0	0	0	3	3	3	3	5	6	4	0	0
Alexis	0	0	0	2	1	4	10	7	9	5	0	0



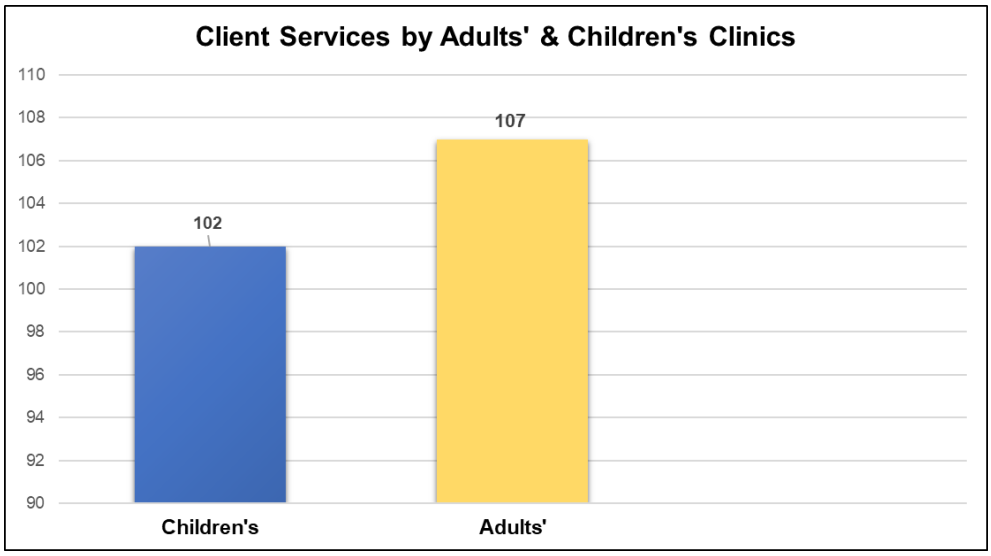
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Jazmine	0	0	0	0	1	1	1	1	2	1	0	0
Timothy	0	0	0	0	1	1	2	2	1	2	0	0
Alexis	0	0	0	0	1	1	5	3	1	2	0	



	July	Aug	Sept	Oct	Nov	Dec	Jan	Febr	March	April	May	June
Josceline	0	0	0	0	3	7	7	11	13	12	0	0
Marcella	0	0	0	0	1	2	0	0	0	0	0	0



	July	Aug	Sept	Oct	Nov	Dec	Jan	Febr	March	April	May	June
Clarissa	0	0	0	2	5	4	6	3	2	2	4	0



Alcohol & Other Drugs (AOD) Program and MIP

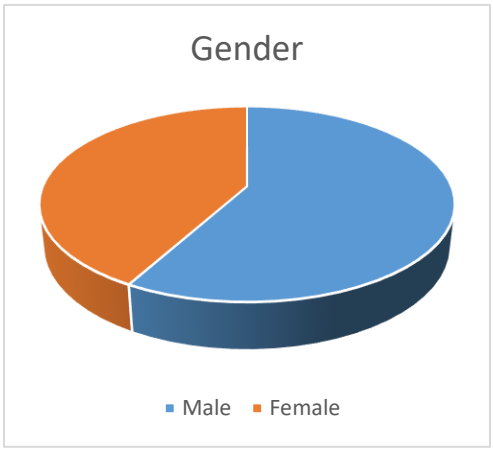
Alcohol & Other Drugs Internship Program

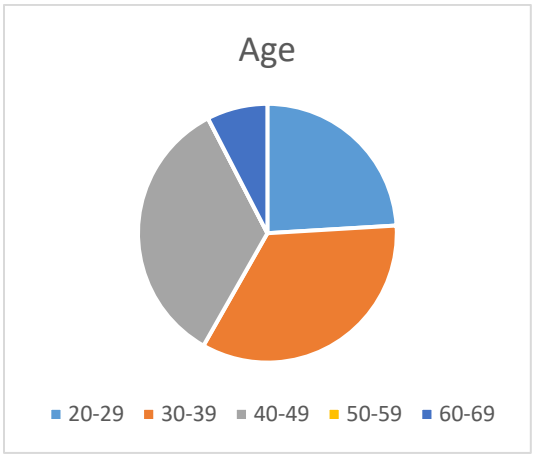
Much like our GIFT Program, the Alcohol and Other Drugs student internship provides a way to combine academic learning with hands-on clinical and treatment skills. This combination of learning with application allows them to develop the confidence and competence of basic skills and the values and ethics that help grow them as a professional in the field. WET assists these students in becoming not only employable recruits but allows them to become recovery-oriented, well-rounded, and successful professionals in their field of study.

In 2023-2024, the AOD Student Internship Program placed 11 students in the Substance Abuse, Prevention and Treatment (SAPT) clinics for internship. During this process, WET was able to update and establish new affiliation agreements with substance abuse counselor programs at various universities/schools to build the AOD Student Internship Program. Students who were placed with RUHS-BH SAPT clinics for internships came from a variety of programs. In addition, WET has also collaborated in a working partnership with SAPT clinics for placement and supervision of these students.

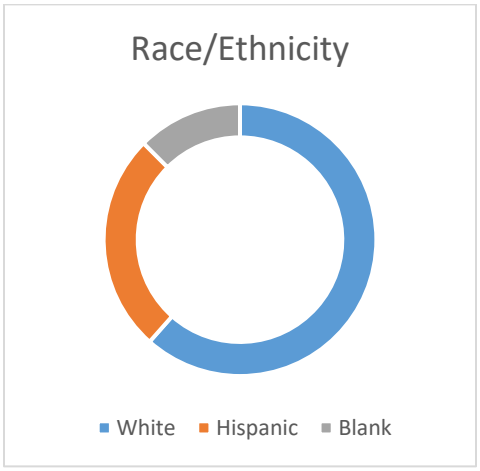
Of the 11 students placed, the primary gender was female, with the majority ranging from ages 30 to 59, and one-quarter being fluent Spanish speakers. Our goal in the AOD Program for the future is to continue to support and build this program and strengthen the working relationships with our partners in SAPT. Below are charts depicting the demographics of the AOD and MIP internships.

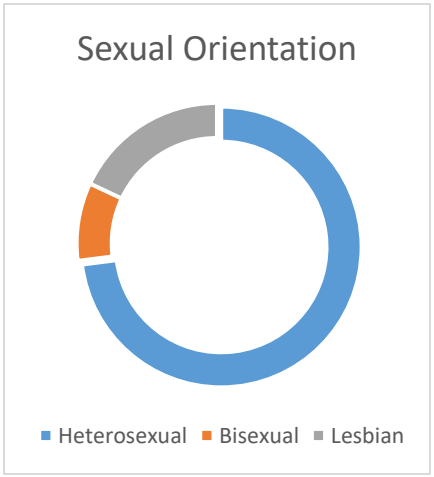
WET


Gender
Male
Female


Age
20-29
30-39
40-49
50-59
60-69


Language
English
Spanish


Race/Ethnicity
White
Hispanic
Blank


Sexual Orientation
Heterosexual
Bisexual
Lesbian

MIP

In FY 2023-24, WET was able to continue with the Mentored Internship Program (MIP) grant in partnership with the SAPT Programs. The California Department of Health Care Services (DHCS) funds the MIP grant. The MIP Program grants goals are to develop and implement an in-house MIP to assist in the treatment of recovery of clients with co-occurring disorders. The students in this program were screened to determine that each has had a co-occurring disorder or has a family member who has had a co-occurring disorder. The aim is to assist those individuals, already in an academic drug and alcohol counselor program to obtain the clinical experience needed to effectively gain employment, specifically in the area of co-occurring disorders. To make this program successful, both WET and SAPT worked together to develop a separate curriculum, an extensive training program, and a supervisory plan with an additional focus on co-occurring disorders. Since the implementation of the program, we have seen great success, and WET aims to have this program continue this program in future years if available.

In the fall of 2022, we were able to fully implement the program with four mentees for internships at two Substance Abuse Prevention and Treatment Program sites in the Western and Desert regions. In the fall of 2023, we were able to secure an additional year of continuance of the grant.

Psychiatric Residency Program Support

The Residency Program in psychiatry is fully accredited and has partnerships with the UCR School of Medicine and RUHS-BH. It is administered through the office of the Medical Director and financially supported by WET funding. Though WET does not directly manage this program, our team provides a range of professional support to the Residency Program to improve the development of psychiatrists dedicated to public service. Residency programs provide the post-M.D. Training is required for physicians to become fully independent and board-certified in their specialties. Psychiatry training programs are four years long, and during that time, residents provide patient care under the supervision of attending physicians who are faculty of the residency program. In 2023-24, the WET team assisted in onboarding nine UCR Residents.

In addition to the UCR School of Medicine residents, residents from the Desert Regional Medical Center also completed rotations with our Behavioral Health physicians in the Desert Region of Riverside County. WET, in collaboration with the Desert Region managers and supervisors, assisted with ensuring that these residents successfully completed their rotations in Behavioral Health by providing the necessary scheduling and onboarding of the residents. In FY 2023-2024, WET assisted in successfully onboarding and securing rotations for eight DRMC residents to complete their rotation with RUHS-BH.

WET-05 Financial Incentives for Workforce Development

This work plan offers financial and academic incentives to support workforce development efforts. The purpose in offering financial and academic incentives for workforce development is twofold; the long term retention of quality employees and fostering a qualified workforce

that is committed and prepared to serve in public behavioral health. WET approaches financial and academic incentives strategically; we focus on filling unmet workforce needs specific to our agency as well as maximizing workforce development funding investment

To meet the Financial Incentives goals in this work plan, we focused our strategies on the following:

- The Paid Academic Support Hours (PASH) and 20/20 Program
- Textbook and Tuition Reimbursement
- Loan Repayment Program

PASH & 20/20 PROGRAM

The 20/20 and PASH Program was developed as a staff incentive program to encourage and support staff with bachelor's degrees to pursue graduate study in preparation for Clinical Therapist I (a hard-to-fil position) job openings within RUHS-BH. WET began overseeing the program in 2007; program records indicate that the program originally started in 1992. Due to fiscal constraints, the program was suspended in 2008-2010. The program reopened in the fall of 2011.

With WET's recommendation, the Department expanded the targeted areas of workforce development beyond bilingual/bicultural skills to include certified skills in treating chemical dependence, developmental disabilities, or acute physical health. Additionally, applicants scored higher if they demonstrated a commitment to work in the hard-to-recruit geographical area of Blythe. WET also developed the Paid Academic Support Hours (PASH) phase of the 20/20 Program to support employees accepted into a graduate program completing only their academic portion (before the internship phase).

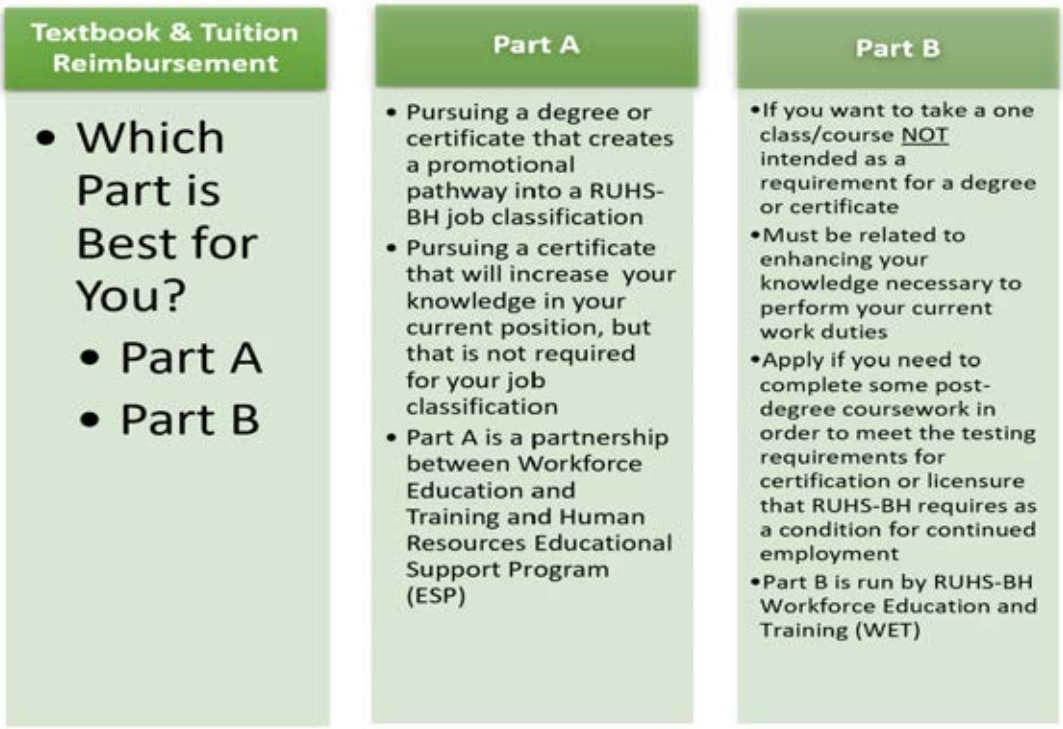
The program parameters were revised in 2013, 2016, and 2019 to strengthen the program, streamline the application process, and enhance quality selection. In addition, significant changes were made to the selection process, the number of candidates to be accepted, and the commitment agreement. In 2022, the program was granted an additional student from the previous cap of three students. In 2022-2023, four candidates were newly accepted into the program, with one student continuing in their 20/20 Program. In the 2023-2024 Program year, the program again increased the number of students accepted from four to seven new students. The payback commitment remains at a period of 5 years working in RUHS-BH.

From 2012 to the present, the department has enjoyed an increase in both interest in the program and the number of applicants. Generally, employees who complete the 20/20 Program remain employed with the department for some time. From 2012 to 2023, 67 employees were accepted into the program (*5 of those were dismissed from the program for various reasons), and 28 continue to serve RUHS-BH. Most former 20/20 students who have left RUHS-BH have left for relocation purposes and other opportunities outside of the County.

Year	Accepted into the Program	Currently working for RUHS-BH
2012/2013	3	1
2013/2014	5, *1 dismissed from program and didn't complete	0
2014/2015	6	1
2015/2016	6, *2 dismissed from program and didn't complete	1
2016/2017	10	2
2017/2018	7	3
2018/2019	7	2
2019/2020	3	1
2020/2021	3	1
2021/2022	3, *1 dismissed from program and didn't complete	2
2022/2023	4	4
2023/2024	7 new (*1 PASH student withdrew)	10

TEXTBOOK & TUITION REIMBURSEMENT

Riverside County encourages the development of a department-sponsored tuition reimbursement program to support employee skill development and create pathways to career advancement, which is an incentive program for our staff. WET proposed and developed an infrastructure to manage the Textbook & Tuition Reimbursement Program. In doing so, a partnership with the Human Resources' Educational Support Program (ESP), WET implemented the Textbook and Tuition Reimbursement Program at the start of 2013. Below is a description of the two parts (A & B) in the program:



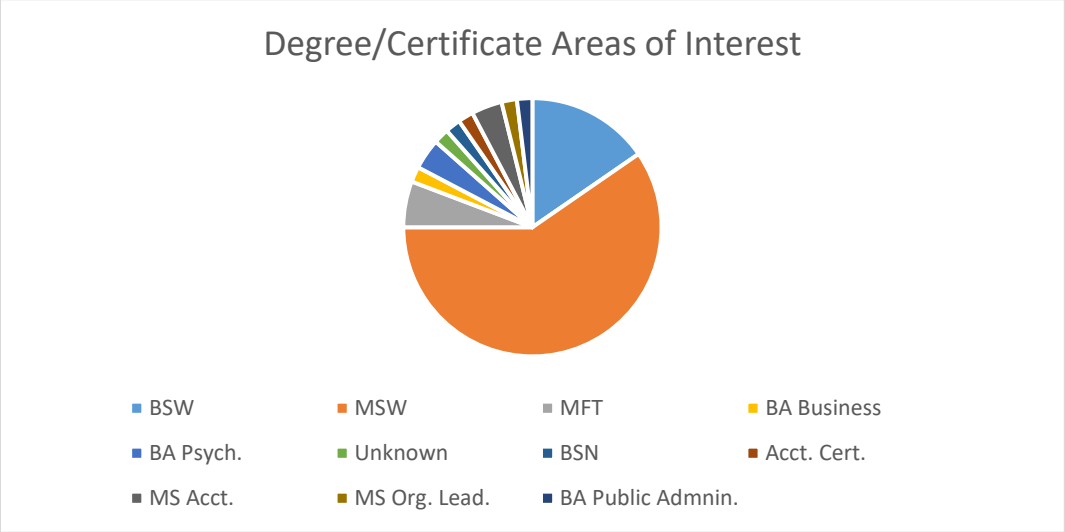
Since its inception in 2013 to FY 2023-2024, there have been over 176 employees who have accessed or benefitted from Textbook & Tuition Reimbursement. Employees have benefited from this incentive program, earning degrees, certificates, or credentials with their Career Development Plans supporting the advancement of the following RUHS-BH job classifications: Accountant II or above, Analyst II or above, Clinical Therapist I or above, Behavioral Health Specialist III or above, Licensed Vocational Nurse or Licensed Psychiatric Technician. Each of these job classifications is a hard-to-fill position within RUHS-BH.

The table below demonstrates the number of awards for the Textbook & Tuition Reimbursement Program from its inception in 2013:

Year	Number of Staff Awarded	Awarded
FY 2013-14	07	$47,418.47
FY 2014-15	03	$49,389.36
FY 2015-16	04	$42, 059.91
FY 2016-17	13	$65, 187.05
FY 2017-18	15	$70,197.22
FY 2018-19	30	$113,827.77
FY 2019-20	20	$125,846.60
FY 2020-21	13	$131,797.90
FY 2021-22	26	$112,008.73
FY 2022-23	16	$32,732.65
FY 2023-24	29	$84,693.25

In the 2023-2024 year, there were 30 applications received, with 29 of those being approved for the Textbook & Tuition Reimbursement Program. During the 2023-2024 fiscal year, a total of $84, 693.25 was awarded to program participants.

As you will see in the pie chart below, the greatest number of staff members receiving the awards were those seeking a Master of Social Work, Bachelor of Social Work, or Master of Counseling Psychology.



The program has two components designed to address separate needs, Part A and Part B (see the breakdown below for each part). Most of the requests for participation in this program are Part A applications, as this pertains to pursuing a degree or certificate.

LOAN REPAYMENT PROGRAMS

National Health Service Corps (NHSC)

The National Health Service Corps (NHSC) is a loan repayment program (LRP) that is administered by the Health Resources and Services Administration (HRSA). To qualify for this LRP, staff must be at an approved Health Professional Shortage Area (HPSA) site. Staff who provide 32 hours of direct service out of a 40-hour day are eligible to apply for the program and, if approved, can receive up to $50,000 in LRP funds. The NHSC opens its application cycle 2x per year.

During the last fiscal year, RUHS BH had 8 active NHSC-approved sites and qualifying HRSA scores. During the last fiscal year, WET began working on getting more approved sites. Applications were submitted to HRSA for 7 sites, and the department was able to get 6 sites approved. Staff at 14 sites can now apply for the NHSC loan repayment.

Each loan repayment program is assigned a WET coordinator. During this fiscal year, the coordinator took another professional opportunity, thus leaving a vacancy. The goal is to hire for this position during the next fiscal year. In the meantime, the coverage of this LRP will be supported by other WET staff.

Health Care Access and Information (HCAI) Programs

During this reporting period, the Workforce Education and Training (WET) team actively promoted various financial loan repayment programs to department staff in need of financial assistance. These programs included the California Department of Health Care Access and Information (HCAI) Licensed Mental Health Services Provider Education Program, the Steven M. Thompson Physician Corps (STLRP), and the California State Loan Repayment Program (SLRP).

Additionally, staff members were provided with information and guidance regarding Riverside County's Education Support Program (ESP) and support in applying for the federally funded Public Service Loan Forgiveness (PSLF) program. These resources are aimed at helping staff reduce their student loan burdens and incentivize retention within the behavioral health workforce.

Physician Education Loan Repayment Program

In April 2019, the California Department of Health Care Services (DHCS) launched CalHealthCares, and DHCS has contracted with PHC to administer the statewide loan repayment program. During this reporting period, WET continued to promote the Physician Education Loan Repayment program administered through CalHealthCares which provides repayment on educational debt for California physicians who provide care to Medi-Cal patients. Eligible physicians can apply for up to $300,000 in loan repayment in exchange for a five-year service obligation. CalHealthCares commits $340 million voter-approved, state tobacco tax revenues from Proposition 56 (2016) to support and incentivize physicians to increase participation in the Medi-Cal program.

WET continues to promote state wide loan repayment programs to staff; such programs include the California Department of Health Care Access and Information (HCAI), Licensed Mental Health Services Provider Education Program, Steven M. Thompson Physician Corps (STLRP), and the California State Loan Repayment Program (SLRP).

SCRP WET Loan Repayment Program

The SCRP WET Loan repayment program is another MHSA workforce retention strategy for the public mental health service system. In collaboration with other SCRP counties, we have partnered with the California Mental Health Services Authority (CalMHSA) to make this funding available to our workforce for the past four years. It has awarded up to $10,000 to qualified RUHS-Behavioral Health staff to reduce student debt in exchange for a 12-month service obligation in a recognized hard-to-fill or hard-to-retain position. Through this program, the regional partnership seeks to support its qualified providers who serve the county's most underserved populations and work in the most hard-to-retain positions. WET continues to make targeted efforts to promote the program to Riverside's public behavioral health employees. For FY 23/24, 40 Riverside County workers were selected into the program, this is an increase by 10 from the previous year. During last fiscal year, there was a decision to shift the disbursement schedule from paying out the funds after staff's service agreement to CALMHSA disbursing half the funds after the application approval and half in the middle of the

service agreement. This LRP will sunset in 2026, thus all service agreements must be complete. Due to this, 23/24 fiscal year and the beginning of 25/26 fiscal year will be focused on spending down all remaining funds. This means that staff who remained with the department can get award increases if they still have loan balances to be repaid.

SCRP Award Amounts			
FY 24-25 Riverside	40	$10,000	$400,000

Section VI

CFTN

Capital Facilities and Technology

MHSA Annual Update FY 25/26

Capital Facilities and Technology

What is Capital Facilities?

Funds are utilized to enhance the infrastructure of public mental health services. Capital Facilities enable counties to acquire, develop, or renovate buildings that house and support MHSA programs. Technology assists counties in transforming and modernizing clinical and administrative information systems while also increasing access to health information and records for consumers and family members electronically in various private settings. The last CF/TN funds were allocated in 2013-2014, while a portion of CSS funds can be allocated to address new workplaces or projects.

Mead Valley Wellness Village

The Mead Valley Wellness Village represents a significant MHSA Capital Facilities investment in Riverside County to close critical gaps in behavioral health, substance use disorders, and integrated medical services. Historically, many residents—particularly children—had limited access to timely, coordinated mental health care, which often required lengthy travel or out-of-county referrals. Notably, there was no local Children's Crisis Residential Program or urgent care facility for children under 13.

In response, Riverside University Health System (RUHS) is creating an 18-acre campus that centralizes essential health and support services. Guided by a Behavioral Health Continuum of Care model, the Village will integrate and coordinate behavioral health, primary care, substance use treatment, and social supports on one campus, ensuring that patients receive seamless, wraparound services without navigating multiple providers across large distances.

Project Progress and Milestones

- **Groundbreaking (June 12, 2024):** Construction officially began with county officials, healthcare leaders, and community members in attendance, emphasizing the significance of improving local access to comprehensive healthcare.
- **Current Construction Status:** Site grading, foundation work, and initial framing are complete, keeping the project on schedule.
- **Topping-Out Ceremony (June 2025**): RUHS will commemorate the placement of the final structural beam for the campus's five main buildings, marking a significant milestone in the development process.

Facilities and Services

The Wellness Village's five core buildings and surrounding amenities will address the full spectrum of mental health needs, including prevention, early intervention, crisis response, and rehabilitative care:

1. **Youth and Family Care Center**
    - Outpatient services, a Children's Crisis Residential Program, a Short-Term Residential Therapeutic Program (STRTP), and family accommodations.

2. Wellness and Education Center
   - o Outpatient behavioral health services, primary care, perinatal and substance use prevention programs, a children's eating disorder intensive outpatient program, dental services, imaging, and a public pharmacy.
3. Recovery Center
   - o Adult and youth behavioral health urgent care, a sobering center, crisis residential treatment, and substance use disorder detox services.
4. The Residences
   - o Supportive housing and recovery residences for individuals and families needing stable housing while receiving ongoing treatment and support.
5. Restorative Care Facility
   - o An Adult Residential Facility and a Mental Health Rehabilitation Center should be established to address more intensive long-term behavioral health needs.

Beyond clinical services, the campus will include green spaces, meditation gardens, sports courts, and a public market with a café, creating a welcoming, stigma-free environment for healing, social engagement, and community support.

Economic and Social Impact

- Healthcare Disparities: By offering specialized services in-county, the project reduces the need for out-of-county referrals, ensuring timely access to mental health care for all age groups.
- Prevention of Crises: Proactive treatment and integrated care models help lower emergency room visits and inpatient hospitalizations.
- Job Creation: The Wellness Village will create hundreds of permanent positions in healthcare, behavioral health, administration, and support services.
- Local Economy: Beacon Economics projects millions in new tax revenue and boosts to local businesses, while vocational training and job placement programs on-site will address social determinants of health and support long-term recovery.

Next Steps

- **Construction Through Mid-2025**: Following the Topping-Out Ceremony, work will focus on interior construction, technology infrastructure, and equipment installation.
- **Program Implementation (Late 2025 – 2026):** RUHS will develop and finalize operational protocols, staffing, and program structures, ensuring readiness for an estimated launch by late 2026.
- **Ongoing Commitment:** RUHS is dedicated to delivering innovative, accessible, and evidence-based services aligned with the Mental Health Services Act, setting a new standard for integrated behavioral health and wellness in Riverside County.

The Mead Valley Wellness Village exemplifies Riverside County's commitment to leveraging MHSA Capital Facilities funding to expand access to comprehensive, integrated care. By centralizing mental health, medical, and social services on one campus and incorporating community-friendly environments, this project prioritizes holistic care, timely intervention, and sustainable solutions for individuals and families. Through strategic planning,

partnerships, and continued stakeholder engagement, RUHS anticipates that the Wellness Village will significantly improve the well-being of residents, reduce healthcare disparities, and strengthen the county's capacity to meet evolving mental health needs.

Franklin Residential Care Renovation

Riverside University Health System – Behavioral Health (RUHS-BH) is nearing completion of a significant renovation at Franklin Residential Care, an 84-bed Adult Residential Facility (ARF) that will provide short-term recuperative care and outpatient behavioral health services. The renovation supports RUHS-BH's mission to bridge the gap between acute psychiatric care and long-term community-based housing solutions. Franklin Residential Care will be a critical transitional facility for individuals requiring structured support before moving toward independent living.

Renovation Progress & Timeline

The Franklin Residential Care renovation is a $38 million project funded through a combination of local Behavioral Health funds and $10.2 million in state and federal grants. Approved by the Board of Supervisors on October 3, 2024, the project has been in active construction to transform the two-story, 42,000-square-foot facility into a modern, therapeutic environment. Renovation began in October 2023. The anticipated ribbon-cutting ceremony is scheduled for February 19, 2025, with client placements expected to begin in early Q2 2025.

Facility Enhancements

The renovated Franklin Residential Care facility will offer:

- **Licensed Adult Residential Services:** Housing, meals, medication management, and personal care assistance for individuals transitioning from acute care.
- **Outpatient Behavioral Health Clinic:** This clinic is accessible to residents and community members and provides comprehensive mental health treatment and case management.
- **Integrated Recovery Programs:** Supportive services, including vocational training, benefits assistance, and housing navigation.
- **Therapeutic Amenities:** Common spaces such as group therapy rooms, a commercial kitchen and dining hall, outdoor recreation areas, and a fitness space to promote holistic well-being.

Role in the Behavioral Health Continuum

Franklin Residential Care will provide structured support for individuals who have stabilized in psychiatric or medical facilities but are not yet ready for independent housing. By incorporating recuperative care, Franklin will ensure:

- **Reduced hospital readmissions** by offering post-discharge stabilization services.
- **Transitional housing options** through board and care facilities, permanent supportive housing, and other community-based solutions.
- **Comprehensive case management** to help residents achieve long-term stability.

A Step Toward Systemic Change

This project aligns with RUHS-BH's strategic plan to expand recuperative care services across Riverside County, complementing existing facilities such as Roy's Desert Springs in Palm

Springs and Desert Sage in Indio. By increasing access to structured housing and outpatient behavioral health services, Franklin Residential Care will play a key role in reducing homelessness, improving health outcomes, and supporting individuals with serious mental illness in their journey to recovery.

RUHS-BH remains committed to innovative, person-centered solutions that foster long-term independence and community reintegration. The Franklin Residential Care renovation is a testament to that vision, ensuring Riverside County residents receive the care and support they need at a critical stage in their recovery journey.

Service Program Renovations and Expansions:

- Myers Campus Roof in the City of Riverside. Myers' Campus is home to several Children's Behavioral Health Programs. The roof needed to be replaced due to severe leaks.

- Roy's Generator. Roy's Place is an augmented board care and Full-Service Partnership program in the Desert Region. The generator supports two residential facilities and an outpatient clinic. Without the generator, the clinic and residential facility would not have a backup power supply.

- San Jacinto Facility Development. This development allows New Life to grow in San Jacinto. New Life is a program that serves justice-involved consumers. This new clinic space was needed as San Jacinto had recently expanded to offer Forensic Full-Service Partnership (FFSP) services, which are field-based intensive treatment for the most vulnerable populations. In addition, San Jacinto has expanded to offer Laura's Law Assisted Outpatient Treatment, and a Justice Outreach Team in San Jacinto, which is a field-based screening, referral, and linkage team.

- Blythe Facility Development. The expansion will allow us to add treatment space to Blythe to offer the Substance Abuse treatment, "MOM's Program". The MOMS Perinatal Program is an intensive outpatient treatment program for pregnant and parenting women who want to enter substance abuse recovery. Clients may receive up to 19 hours of clinical services a week. Secondarily, this expansion allows for our Mobile Crisis Response Team to have space locally in Blythe and enable the clinic itself to allow on site crisis triage and linkage services for the community with a separate entrance, lobby, and triage rooms.

- Monroe Facility Development in the City of Indio – Substance Abuse Prevention and Treatment (SAPT) has outgrown their current space. This cost allowed the department to have an architect design the expansion at 44199 Monroe St. The building is currently not designed for an outpatient clinic. Indio SAPT is our largest Desert Clinic currently serving over 160 consumers a month in intensive treatment with a need to expand both the number of treatment staff and the number of consumers seeking services.

Section VII

FUNDING

MHSA Annual Update FY 25/26

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

County: Riverside

Date: 4/1/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	35,862,099	24,052,993	23,161,655	2,084,670	40,975,469	
2. Estimated New FY2023/24 Funding	148,607,706	37,151,926	9,776,823			
3. Transfer in FY2023/24[a/]	(7,000,000)			2,000,000	5,000,000	
4. Access Local Prudent Reserve in FY2023/24						0
5. Estimated Available Funding for FY2023/24	177,469,805	61,204,919	32,938,478	4,084,670	45,975,469	
B. Estimated FY2023/24 MHSA Expenditures	126,063,111	37,410,355	4,083,806	1,581,216	12,500,000	
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	51,406,694	23,794,564	28,854,672	2,503,454	33,475,469	
2. Estimated New FY2024/25 Funding	105,057,965	26,264,491	6,911,708			
3. Transfer in FY2024/25[a/]	(2,000,000)			2,000,000	0	
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	154,464,659	50,059,055	35,766,380	4,503,454	33,475,469	
D. Estimated FY2024/25 MHSA Expenditures	118,150,872	30,811,333	5,471,035	1,836,968	27,000,000	
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	36,313,787	19,247,722	30,295,345	2,666,486	6,475,469	
2. Estimated New FY2025/26 Funding	111,392,736	27,848,184	7,328,469			
3. Transfer in FY2025/26[a/]	(7,500,000)			2,500,000	5,000,000	
4. Access Local Prudent Reserve in FY2025/26						0
5. Estimated Available Funding for FY2025/26	140,206,523	47,095,906	37,623,814	5,166,486	11,475,469	
F. Estimated FY2025/26 MHSA Expenditures	127,780,168	33,322,457	5,944,211	1,986,681	11,000,000	
G. Estimated FY2025/26 Unspent Fund Balance	12,426,355	13,773,449	31,679,603	3,179,806	475,469	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	24,217,189
2. Contributions to the Local Prudent Reserve in FY 2023/24	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	24,217,189
5. Contributions to the Local Prudent Reserve in FY 2024/25	0
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	24,217,189
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	24,217,189

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

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

County: Riverside Date: 4/1/25

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS-01 Full Service Partnership	146,804,301	56,542,569	39,800,840	0	33,866,986	16,593,906
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
Non-FSP Programs						
1. CSS-02 General System Development	252,123,339	56,829,137	119,377,674	0	47,145,600	28,770,927
2. CSS-03 Outreach, Engagement	8,178,649	3,538,643	2,711,837	0	1,198,170	729,998
3. CSS-04 Housing	9,292,267	6,803,740	15,868	0	0	2,472,659
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CSS Administration	6,340,673	2,349,022	3,854,119	0	0	137,533
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	422,739,228	126,063,111	165,760,337	0	82,210,757	48,705,023
FSP Programs as Percent of Total	116.5%					

FUNDING

FUNDING

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS-01 Full Service Partnership	120,820,295	40,574,119	50,563,538	0	11,492,890	18,189,748
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
Non-FSP Programs						
1. CSS-02 General System Development	298,064,805	62,460,023	130,449,918	4,068,784	65,037,330	36,048,751
2. CSS-03 Outreach, Engagement	9,464,685	3,947,371	3,658,720	66,610	1,415,211	376,773
3. CSS-04 Housing	10,731,457	8,678,616	22,368	0	925	2,029,549
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CSS Administration	7,114,408	2,490,743	4,342,001	101,150	150,513	30,000
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	446,195,651	118,150,872	189,036,544	4,236,544	78,096,870	56,674,821
FSP Programs as Percent of Total	102.3%					

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS-01 Full Service Partnership	130,667,150	43,880,910	54,684,466	0	12,429,561	19,672,212
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
Non-FSP Programs						
1. CSS-02 General System Development	322,357,087	67,550,515	141,081,586	4,400,390	70,337,872	38,986,725
2. CSS-03 Outreach, Engagement	10,236,057	4,269,081	3,956,906	72,039	1,530,551	407,480
3. CSS-04 Housing	11,606,071	9,385,923	24,191	0	1,001	2,194,957
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CSS Administration	7,694,232	2,693,739	4,695,875	109,394	162,780	32,445
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	482,560,596	127,780,168	204,443,023	4,581,822	84,461,765	61,293,819
FSP Programs as Percent of Total	102.3%					

FUNDING

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

County: Riverside

Date: 4/1/25

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI-01 Mental Health Outreach, Awareness and Stigma Reduction	27,019,009	26,558,462	421,715	0	0	38,832
2. PEI-02 Parent Education and Support	7,209,784	3,071,175	1,781,228	0	1,088,410	1,268,971
3. PEI-03 Early Intervention for Families in Schools	34,377	34,377	0	0	0	0
4. PEI-04 Transitional Age Youth (TAY) Project	1,161,744	1,153,567	8,177	0	0	0
5. PEI-05 First Onset for Older Adults	924,128	924,128	0	0	0	0
6. PEI-06 Trauma Exposed Services For All Ages	1,280,139	1,280,139	0	0	0	0
7. PEI-07 Underserved Cultural Polpulations	2,022,080	2,022,080	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PEI-04 Transitional Age Youth (TAY) Project	427,450	427,450	0	0	0	0
12. PEI-05 First Onset for Older Adults	432,572	418,459	14,113	0	0	0
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,520,518	1,520,518	0	0	0	0
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	42,031,800	37,410,355	2,225,233	0	1,088,410	1,307,803

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI-01 Mental Health Outreach, Awareness and Stigma Reduction	19,086,208	18,522,347	530,276	0	0	33,585
2. PEI-02 Parent Education and Support	6,969,679	2,779,611	1,811,446	0	1,108,548	1,270,074
3. PEI-03 Early Intervention for Families in Schools	18,931	18,931	0	0	0	0
4. PEI-04 Transitional Age Youth (TAY) Project	1,732,747	1,720,268	12,479	0	0	0
5. PEI-05 First Onset for Older Adults	908,610	908,610	0	0	0	0
6. PEI-06 Trauma Exposed Services For All Ages	2,134,833	2,134,833	0	0	0	0
7. PEI-07 Underserved Cultural Polpulations	2,364,243	2,364,243	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PEI-04 Transitional Age Youth (TAY) Project	373,408	373,408	0	0	0	0
12. PEI-05 First Onset for Older Adults	463,643	448,516	15,126	0	0	0
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,540,567	1,540,567	0	0	0	0
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	35,592,868	30,811,333	2,369,327	0	1,108,548	1,303,660

FUNDING

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI-01 Mental Health Outreach, Awareness and Stigma Reduction	20,641,734	20,031,918	573,493	0	0	36,323
2. PEI-02 Parent Education and Support	7,537,707	3,006,149	1,959,079	0	1,198,894	1,373,585
3. PEI-03 Early Intervention for Families in Schools	20,474	20,474	0	0	0	0
4. PEI-04 Transitional Age Youth (TAY) Project	1,873,965	1,860,470	13,496	0	0	0
5. PEI-05 First Onset for Older Adults	982,662	982,662	0	0	0	0
6. PEI-06 Trauma Exposed Services For All Ages	2,308,822	2,308,822	0	0	0	0
7. PEI-07 Underserved Cultural Polpulations	2,556,928	2,556,928	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. PEI-04 Transitional Age Youth (TAY) Project	403,840	403,840	0	0	0	0
12. PEI-05 First Onset for Older Adults	501,430	485,070	16,359	0	0	0
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,666,123	1,666,123	0	0	0	0
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	38,493,686	33,322,457	2,562,427	0	1,198,894	1,409,908

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Riverside

Date: 4/1/25

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-07 Tech Suite	3,879,616	3,879,616	0	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	204,190	204,190	0	0	0	0
Total INN Program Estimated Expenditures	4,083,806	4,083,806	0	0	0	0

FUNDING

FUNDING

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-08 ED IOP	5,725,803	5,197,483	528,320	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	273,552	273,552				
Total INN Program Estimated Expenditures	5,999,355	5,471,035	528,320	0	0	0

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-08 ED IOP	6,219,743	5,648,365	571,378	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	295,846	295,846				
Total INN Program Estimated Expenditures	6,515,589	5,944,211	571,378	0	0	0

FUNDING

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

County: Riverside

Date: 4/1/25

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-01 Workforce Staffing Support	1,737,506	1,135,818	601,688	0	0	0
2. WET-02 Training and Technical Assistance	95,391	62,358	33,033	0	0	0
3. WET-03 Mental Health Career Pathways	36,746	36,746	0	0	0	0
4. WET-04 Residency and Internship	30,735	30,735	0	0	0	0
5. WET-05 Financial Incentives	315,559	315,559	0	0	0	0
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	2,215,937	1,581,216	634,722	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-01 Workforce Staffing Support	2,327,314	1,521,378	805,935	0	0	0
2. WET-02 Training and Technical Assistance	204,856	134,808	70,049	0	0	0
3. WET-03 Mental Health Career Pathways	10,330	10,330	0	0	0	0
4. WET-04 Residency and Internship	44,240	44,240	0	0	0	0
5. WET-05 Financial Incentives	126,211	126,211	0	0	0	0
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	2,712,952	1,836,968	875,984	0	0	0

FUNDING

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-01 Workforce Staffing Support	2,516,990	1,645,371	871,619	0	0	0
2. WET-02 Training and Technical Assistance	221,552	145,795	75,757	0	0	0
3. WET-03 Mental Health Career Pathways	11,172	11,172	0	0	0	0
4. WET-04 Residency and Internship	47,846	47,846	0	0	0	0
5. WET-05 Financial Incentives	136,498	136,498	0	0	0	0
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	2,934,057	1,986,681	947,376	0	0	0

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

County: Riverside

Date: 4/1/25

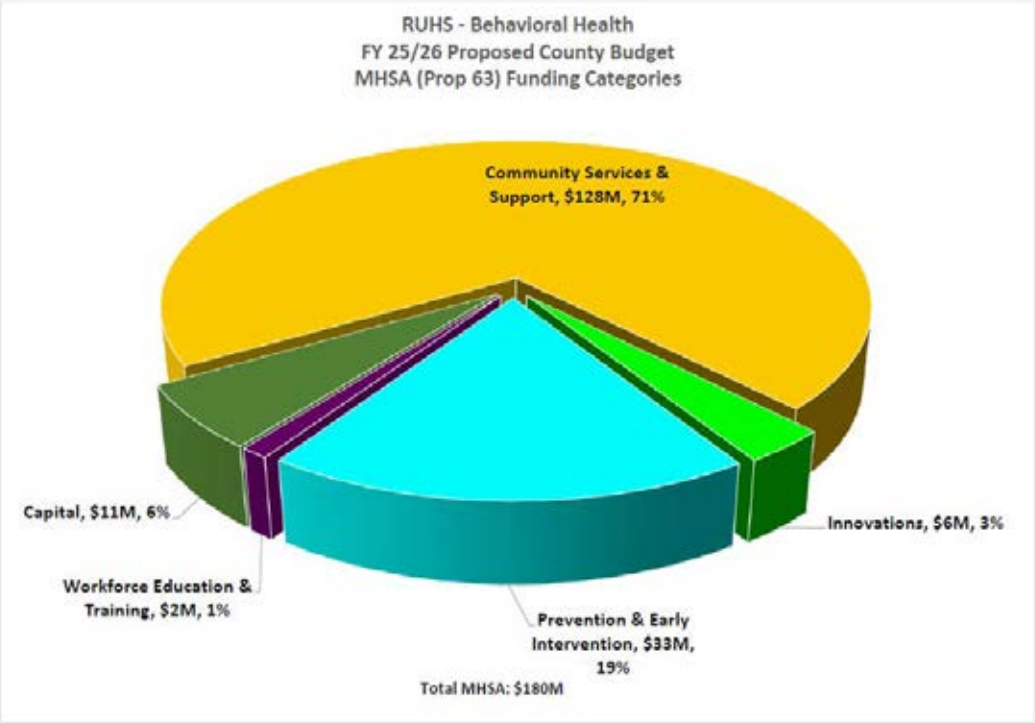
	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Monroe Capital Project	500,000	500,000	0	0	0	0
2. Franklin Adult Residential Facility and Clinic	15,500,000	12,000,000	0	0	0	3,500,000
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	16,000,000	12,500,000	0	0	0	3,500,000

FUNDING

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Franklin Adult Residential Facility and Clinic	23,000,000	18,500,000	0	0	0	4,500,000
2. Monroe Capital Project	3,000,000	3,000,000	0	0	0	0
3. Hulen Place Project	5,000,000	500,000	0	0	0	4,500,000
5. Myers Roof Renovation	2,000,000	2,000,000	0	0	0	0
6. San Jacinto New Life Project	2,000,000	2,000,000	0	0	0	0
7. Blythe Clinic Expansion	1,000,000	1,000,000	0	0	0	0
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	36,000,000	27,000,000	0	0	0	9,000,000

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Monroe Capital Project	3,000,000	3,000,000	0	0	0	0
2. Franklin Adult Residential Facility and Clinic	2,000,000	2,000,000	0	0	0	0
3. Hulen Place Project	3,000,000	3,000,000	0	0	0	0
4. San Jacinto New Life Project	2,000,000	2,000,000	0	0	0	0
5. Blythe Clinic Expansion	1,000,000	1,000,000	0	0	0	0
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	11,000,000	11,000,000				

FUNDING



Type	MHSA %	MHSA Funding
Community Services & Support	70.98%	$128M
Innovations	3.30%	$6M
Prevention & Early Intervention	18.51%	$33M
Workforce Education & Training	1.10%	$2M
Capital	6.11%	$11M
		$180M

CSS
INN
PEI
WET
CAP

Cost Per Client
MHSA Cost per Client-CSS

CSS 01

PLAN NAME:	Full Service Partnership
UNIQUE CLIENTS:	32,746
COST:	$89,151,321
AVERAGE COST:	$2,722.51

CSS 02

PLAN NAME:	General System Development
UNIQUE CLIENTS:	51,651
COST:	$48,645,979
AVERAGE COST:	$941.82

CSS 03

PLAN NAME:	Outreach, Engagement
UNIQUE CLIENTS:	575
COST:	$1,274,628
AVERAGE COST:	$2,216.74

CSS 04

PLAN NAME:	Housing
UNIQUE CLIENTS:	14,063
COST:	$6,444,922
AVERAGE COST:	$458.29

Cost Per Client

MHSA Cost Per Client-PEI
FY 2023 / 2024

PEI PROGRAMS- PREVENTION

PLAN NAME:	PEI-01 Mental Health Outreach, Awareness and Stigma Reduction
UNIQUE CLIENTS:	109,679
COST:	$15,260,781
AVERAGE COST:	$139.14

PLAN NAME:	PEI-02 Parent Education and Support
UNIQUE CLIENTS:	1,828
COST:	$3,189,718
AVERAGE COST:	$1,744.92

PLAN NAME:	PEI-04 Transitional Age Youth (TAY) Project
UNIQUE CLIENTS:	7,033
COST:	$1,291,601
AVERAGE COST:	$183.65

PLAN NAME:	PEI-05 First Onset for Older Adults
UNIQUE CLIENTS:	667
COST:	$1,610,541
AVERAGE COST:	$2,415.51

PLAN NAME:	PEI-06 Trauma Exposed Services For All Ages
UNIQUE CLIENTS:	467
COST:	$1,626,901
AVERAGE COST:	$3,483.73

PLAN NAME:	PEI-07 Underserved Cultural Polpulations
UNIQUE CLIENTS:	814
COST:	$2,002,213
AVERAGE COST:	$2,459.72

PEI PROGRAMS- EARLY INTERVENTION

PLAN NAME:	PEI-04 Transitional Age Youth (TAY) Project
UNIQUE CLIENTS:	244
COST:	$373,391
AVERAGE COST:	$1,530.29

PLAN NAME:	PEI-05 First Onset for Older Adults
UNIQUE CLIENTS:	222
COST:	$395,711
AVERAGE COST:	$1,780.48

Cost Per Client

MHSA Cost Per Client-Innovation
FY 2023 / 2024

INNOVATION PROGRAMS

PLAN NAME:	INN-07 Technology Suite (Tech Suite)
UNIQUE CLIENTS:	11,899
COST:	$6,830,863
AVERAGE COST:	$574.07

Section VIII

PUBLIC COMMENTS

MHSA Annual Updates FY25/26

Public Comments

1. Which behavioral health Programs are you aware of and would like to keep?

1. **Comment:** Hemet-Crochet Class/ Pathways to Success/Peer-to-Peer Facilitated Class

Response: Having options for treatment, recovery development, vocational and socialization supports can help each person individuate their own plan to manage their behavioral health. Pathways to Success is vocational development program. Peer-to-Peer classes utilizes the lived experienced of certified peer support specialists to assist others in developing the insight, skills, and abilities to be successful.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

2. **Comment:** Family Advocate

Response: Family Advocate is a program designed to meet the support needs of family members who have an adult loved one experiencing mental illness. Each Family Advocate has their own lived experience as a family members and use that insight to support, teach, and guide.

BHC Recommendation: The BHC recommends sustaining the Family Advocate services identified above in this MHSA Annual Update FY 25/26.

3. **Comment:** Suicide Prevention, MH Urgent Care and Crisis Team, Family Advocate, CBAT

Response: Suicide Prevention is a focal point of Prevention and Early Intervention. There is a Mental Health Urgent Care, or sometimes referred to as a Crisis Stabilization Unit (CSU, in each service region and are in the cities of Riverside, Perris, and Palm Springs. Family Advocate is a program designed to meet the support needs of family members who have an adult loved one experiencing mental illness. Each Family Advocate has their own lived experience as a family members and use that insight to support, teach, and guide. Community Behavioral Assessment Team (CBAT) is a partnership between local law enforcement agencies and RUHS-BH to provide engagement and behavioral health services in the field.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

4. **Comment:** The recovery transformation center, the center helped me in the worst years of my life from 2023 -2025 and helped me in a crisis final times of 20 years, horrible voice and signs of insanity that never ended 20 years from the age of 16 to 37

Response: Riverside Telecare Restorative Transformation Center (Mental Health Rehabilitation Center) is a 30-bed voluntary program with a multidisciplinary team of staff. They serve adult residents of Riverside County (ages 18 and older), who have been found incompetent to stand trial (IST), who are eligible for Laura's Law/Assisted Outpatient Treatment, or who have a severe

and persistent mental illness. They also serve individuals who may be on an LPS conservatorship, have been served in a locked treatment setting, or those who might otherwise progress into more restricted levels of care.
Thank you for this testimony and to the power of your partnership to transform your life.
BHC Recommendation: The BHC recommends sustaining the MHRC as identified above in this MHSA Annual Update FY 25/26.

Socialization, Movies, learning to take care of financials, etc., groups for Schizophrenia (Alternative Prescriptions)

Response: Having options for treatment, recovery development, vocational and socialization supports can help each person individuate their own plan to manage their behavioral health. Pathways to Success is vocational development program. Peer-to-Peer classes utilizes the lived experienced of certified peer support specialists to assist others in developing the insight, skills, and abilities to be successful.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

6. **Comment:** "Children's Treatment Services (CTS)
3125 Myers Street
Riverside, CA 92503
Phone: (951) 358-4840

Lake Elsinore Children's Mental Health Clinic
31946 Mission Trail, Suite B
Lake Elsinore, CA 92530
Phone: (951) 245-7663

Indio Mental Health Clinic
47-825 Oasis Street
Indio, CA 92201
Phone: (760) 863-8455

Corona Wellness & Recovery Center
2813 S. Main St.
Corona, CA 92882
Phone: (800) 720-9553

The Lehman Center - Children's Campus
3075 Myers Street
Riverside, CA
Phone: (951) 358-4625

Temecula Children's Mental Health Clinic
41002 County Center Drive,
Suite 320
Temecula, CA 92591
Phone: (951) 600-6355

Moreno Valley Children's Interagency Program (MVCIP)

ALL PROGRAMS NEEDED

Response: Thank you for being a strong advocate for Children's Mental Health Services.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

7. **Comment:** Peer Services / Behavioral Health

Response: Peer Services are behavioral health programs and providers that have been developed and implemented by people with lived experience either with their own diagnosis, with partnering with an adult loved one with behavioral health needs.

BHC Recommendation: The BHC recommends sustaining the peer services and programs in this MHSA Annual Update FY 25/26.

8. **Comment:** Peer Support and Resource Center, SAPT, Mental Health Court, Vocational Training, Day Reporting Center, HHOPE Housing, JOT, OASIS Outpatient clinic

Response: Peer Support and Resource Centers are in each region and offer peer provided recovery supports. Substance Abuse Prevention and Treatment (SAPT) is the RUHS-BH system of care focused on levels of substance abuse treatment and intervention. Mental Health Courts are collaboratives courts that combine the authority of the court with a behavioral health treatment plan and services. Vocational Training through our Pathways to Success programs offer people who have experienced mental illness an opportunity to re-enter the workforce. Day Reporting Centers are service and support centers for people who are justice involved. The Homeless Housing Opportunities, Partnership & Education (HHOPE) provides a comprehensive range of services for individuals experiencing homelessness or at risk of homelessness. The Justice Outreach Teams (JOT) are field-based screening and referral teams, which help with linkage to behavioral health programs for people who are justice involved. Oasis Community Services is a Full-Service Partnership (FSP) that provides TAY members (ages 16-25) with individual and group counseling, case management, medication management, crisis intervention, and job counseling, with the goal to break the cycle of homelessness, hospitalization, and/or incarceration.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

9. **Comment:** Outpatient clinics, and Youth Hospital Intervention program, MDFT, and wraparound

Response: RUHS-BH offers a continuum of care from Prevention to Long Term Care support, and those levels of care include outpatient services for children, transitional age youth, adults, and older adults. Youth Hospital Intervention Programs (YHIP) links families to care and supports them with services toward stabilization while a youth is in the hospital. Multidimensional Family Therapy (MDFT) is a home and community-based program serving drug-abusing or high-risk adolescents ages 12-17 with disruptive behaviors (such as running away, shoplifting, and truancy from school). Wraparound Services are a "whatever it takes" model that connects a multi-disciplinary team to youth who had consequences from unstable behavioral health disorders.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

10. **Comment:** Detention and JOT. MHUCs, County clinics, CBAT, Friday Night Live. W.E.T., Family Advocates, Inpatient Treatment Facility, PCIT, MH Court, Veterans Court, Wraparound, Vocational programs, Juvenile Justice, LPS/Conservatorship, HOPE

Response: RUHS offers a continuum of care that includes behavioral health care within Detention facilities and to people who are justice involved. The continuum of care includes prevention services (Friday Night Live), peer services (Family Advocate), outpatient services (Parent-Child Interaction Therapy, intensive outpatient care (Wraparound), crisis system programs (Mental Health Urgent Care, CBAT, Inpatient Treatment), and legal and assisted levels of care (Mental Health Court, Veteran's Court, Juvenile Justice LPS/Conservatorship). RUHS-BH includes vocational programs for clients re-entering the workforce, and also workforce development strategies (WET) to recruit and retain staff in public behavioral health.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

11. **Comment:** PEI

Response: Prevention and Early Intervention (PEI) is the second largest component of MHSA. PEI focuses on mental health awareness, stigma reduction, and reaching people earlier in the potential development of a diagnosis. There are 7 workplans in Riverside's PEI Plan. The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

12. **Comment:** The urgent care clinics are helpful for those who need walk in services. The increase in residential beds scheduled to open in March in Riverside is encouraging as well

as the Mead Valley Wellness Village which appears to offer supportive housing. Roy's in the desert is a great facility and is doing good work. TAY services and FSP clinics are helpful for families who are struggling.

Response: Thank you for your support of the RUHS continuum of care and for developing projects like the Mead Valey Wellness Village.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

13. **Comment:** PEI, TSAPP, OAPP, Peer program, Parent Support, and Training, Friday Night Live

Response: Prevention and Early Intervention, Peer/Parent Support and Training are part of the MHSA Plan. Teen Suicide Awareness and Prevention Program (TSAPP) is a RUHS Public Health program that receives some MHSA funds. Overdose Awareness and Prevention (OAPP) and Friday Night Live target substance use and are funded using other funding resources.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

14. **Comment:** Crisis System of Care, Family Advocate, Peer Support, Mental Health Resources Fairs offer a lot of information

Response: Crisis System of Care includes the crisis dispatch center, the mobile crisis teams, the mental health urgent cares and more. Family Advocate and Peer support services provide lived experience specialists to support the community navigate care and care systems. Mental health resources fairs, like May is Mental Health, offer the community and opportunity to learn about resources and behavioral health in a safe, fun environment. These outreach events are part of the Prevention and Early Intervention (PEI) plan. BHSA has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

15. **Comment:** The Strengthening Families Program

Response: Strengthening Families is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children ages 6-11. SFP is listed as a prevention program in the current MHSA plan. The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level, and wants health care prevention across specialties to be provided

by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

16. **Comment:** Service animals in the ADA likes to see more events that are wheelchair accessible

Response: Riverside has a Cultural Community Liaison specific to communities of disability. We will provide your comment to the liaison and to the teams responsible for event coordination.

BHC Recommendation: The BHC supports equal access for all community members and encourages Department planning to consider disability access when reviewing public park and convention options in each region's cities.

17. **Comment:** We appreciate the County's ongoing support for the Older Adult Integrated System Care and culturally competent services such as TakeMyHand Live Peer Chat and LGBTQ+ peer outreach initiatives. These programs help address stigma and provide trusted entry points for underserved populations. We strongly encourage continued investment in peer-led programs, crisis response teams, and housing-linked behavioral health services (e.g., HHOPE).

Response: Thank you for this thorough and thoughtful comment on programs to be sustained in MHSA planning.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

18. **Comment:** Strengthening Families Program, it is a program that has benefited many of our families here at Val Verde Unified School District

Response: Strengthening Families is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children ages 6-11. SFP is listed as a prevention program in the current MHSA plan. The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level, and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

19. **Comment:** Cultural Competence Program, P.A.I.R. Program, Equine Therapy, Musical expression of self at Stepping Stones. Love the meditations that Ashley does at the Indio Peer Support Resource Center.

Response: Cultural Competency Program works with marginalized and at-risk communities to provide culturally informed outreach, education, and linkage to behavioral health care. PAIR and Equine therapy utilized animals in the therapeutic process. Music and Meditation offer non-traditional forms of therapeutic expression that facilitate healing, inspire healing, and increase overall life satisfaction.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

20. **Comment:** The CCRD meetings involving our communities like the Wade alliance, and community liaisons allow me to communicate to our community, and to know what is available for wellness. Along with the Peer Support Resource Center, which allows for me to attend and communicate at events like the sound meditation and meditation. Events along with talks from the counselors involving community members and speakers that offer opportunities to better myself.

Response: Cultural Competency Reducing Disparities (CCRD) meeting and the Wellness and Disability Equity Alliance (WADE) subcommittee, created to outreach and better serve people with disabilities, are regularly held meeting hosted by the Cultural Competency Program. Disability access allows for all members of our community to attend and learn more about behavioral health, services, and participate in scheduled activities.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

21. **Comment**: I would like to see Creative Recovery at the Blaine Street Clinic preserved and expanded. It is a powerful, community-centered program offering art therapy activities such as beading, drawing, and coloring that help individuals heal and express themselves in safe, creative ways. This program has deeply impacted my own recovery and those around me.

Response: Your comment has been provided Western Region Adult Services Administrator that oversees programming at the Blaine Clinic.

BHC Recommendation: The BHC encourages Department services and programs to integrate art therapy and artistic expression into service choices for members who want art as part of their treatment planning.

22. **Comment:** TAY Stepping Stones

Response: Transitional Age Youth (16-15) are recognized as a distinct developmental period requiring age informed care. Stepping Stones is the TAY Center in Western Riverside and offers a variety of therapeutic interventions.

BHC Recommendation: The BHC recommends sustaining TAY programs and services identified above in this MHSA Annual Update FY 25/26.

23. **Comment:** Indio Mental Health – FSP- Windy Spring Wellness, many Riverside Treatment Centers (private), including stays and work as a peer support Specialist at Telecare INC.

Response: Thank you for your support of outpatient, Full Service Partnership, and peer support as part of the behavioral health system of care.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

2. Which behavioral health Programs are you aware of and would like to see us change?

1. **Comment:** we need more assistance on housing programs and allow our pets, and programs to keep us busy, exercise, and use games

Response: Housing development is a central issue for the State of California and is a central component of the new Behavioral Health Services Act (BHSA). You can learn more about housing developments and supports in this plan by reading the chapter "CSS-04 Housing" which includes a coordinated entry system to assess and refer those in housing crisis, street outreach, emergency housing, rental assistance, transitional housing, permanent supportive housing, augmented adult residential facilities, and enhanced case management. You can also learn more about some current developments under the "Capital Facilities and Technology" chapter which includes description of the "The Place" renovation, Franklin Avenue Augmented Adult Residential Facility, 5 new apartment communities, and the Mead Valley Wellness Village which includes a pet motel!

Each region also has a Peer Recovery and Resource Center that includes both wellness development and social programs. Additionally, working closely with a wellness coach can lead to community integration and utilizing social and recreational activities that exist for everyone in their local communities.

Housing is a new component in the Behavioral Health Services Act. The Department is currently examining how this new regulations may change our housing planning, but our housing programs remain a focal point of our commitment to supporting people with behavioral health challenges.

BHC Recommendation: The BHC recommends sustaining the housing and homeless programs in this MHSA Annual Update FY 25/26.

2. **Comment:** Weekly Peer-to-Peer Support changed to allow siblings with a diagnosis to attend together. Currently, one peer is left out as not allowed to attend together. Weekly support

group for caregivers to have a monthly information meeting, as was done before Covid, on Zoom meetings during Covid.

Response: You can read more about Peer Support Programming at the planning level in chapter CSS-03, detailing the programs and services of central peer support through Peer Services, Family Advocate, and Parent Support and Training. Your recommendation for specific program or service operation changes have been provided to the Deputy Director of Peer Support Services. Individual program rules around participation may vary. Sometimes family members sharing a same service can impact therapeutic relationships, inhibit vulnerability and sharing, impair confidentiality, or create a "dyad" in a group setting that changes group dynamics. Both family members should continue to be offered services, but with different groups and peer leaders. Treatment and recovery planning limits and possibilities can be reviewed with your treatment program.

BHC Recommendation: The BHC recommends sustaining peer programs and services in this MHSA Annual Update FY 25/26.

3. **Comment:** Vocational Training

Response: The Department's specific program designed for vocational development is called Pathways to Success. To learn more about this program, please contact staff at a TAY, Adult, or Older Adult program.

BHC Recommendation: The BHC recommends sustaining vocational supports in this MHSA Annual Update FY 25/26.

4. **Comment:** Pathway to Success process takes so long, loved one went to orientation in February and to date has not received a call back.

Response: Pathways to Success is a vocational development and support program that is part of CSS-02. Timeliness to care and support are important. Your feedback has been provider provided to the Administrator over the Pathways to Success program. Each program should have grievance forms available in lobby areas. These kind of complaints are taken seriously and investigated by the Department's Quality Improvement unit. You can also find grievance booklets on the Quality Improvement page of the Department's website: https://www.ruhealth.org/behavioral-health/quality-improvement

BHC Recommendation: The BHC recommends sustaining vocational supports in the MHSA Annual Update FY 25/26 and will monitor timely access to Department services.

5. **Comment:** I am familiar with the Strengthening Families Program and feel at this time it doesn't need to be changed. I do feel however that it should continue to be funded after the 2025-2026 fiscal year ends on June 30th, 2026. I have worked with over 60 families the past year and have seen the results first-hand on the impact it's made in the lives of the families who have gone through the program. It's truly an investment in our future and in the lives of families in our own community.

Response: Strengthening Families Program (SFP) is classified as a Prevention program in our current PEI Plan (Page 315). SFP is an evidence based program that emphasizes the importance of

strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children ages 6-11. SFP is listed as a prevention program in the current MHSA plan. The Behavioral Health Services Act (BHSA) has removed population based prevention as a funded services at the county level. The State collects some funds to address population based prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

We are currently in the process of examining all programs that might be impacted by the changed in Behavioral Health Services Act (BHSA) legislation, both looking at potential budget shortfalls and regulatory limits and possibilities.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

6. **Comment:** All the mental health services being aware of the rules I would like to see events made more wheelchair accessible

Response: Outreach and Engagement events are part of CSS-03 and PEI-01. These are opportunities for the Department to facilitate conversations about behavioral health in non-judgmental, fun, and educational environments often held at community parks or similar city recreation spaces. Inclusivity and access are valued by the Department. Though some regions may have limited options regarding where larger events can be held and defer to city compliance with access regulations, your feedback has been provided to the Deputy of Peer Support Services and the Prevention and Early Intervention Manager.

BHC Recommendation: The BHC supports equal access for all community members and encourages Department planning to consider disability access when reviewing public park and convention options in each region's cities.

7. **Comment:** While the Older Adult Integrated System of Care is vital, it lacks specificity around key subpopulations such as older adults living with HIV, LGBTQ+ elders, and those aging with chronic conditions like AIDS, diabetes, or dementia. We urge the County to update this program to include these groups explicitly and train providers accordingly. Similarly, LGBTQ+ programs largely target youth (TAY); the absence of LGBTQ+ elders and long-term survivors of HIV is a significant oversight and should be addressed.

Response: Thank you for your advocacy for mature adults, senior LGBTQ community, and people with chronic health conditions. Unfortunately, as you have stated, much of the funding and legislative regulations favor youth under the age of 25. This can pose an additional challenge when reaching older adults, and older adults from marginalized communities. Your recommendations have been reviewed with the Administrator over older adult services.

He is interested in providing more training to his staff on serving older adults who identify as LGBTQ or who are living with HIV. Prevention and Early Intervention (PEI)has an existing contractual relationship with The Center in Palm Springs to provide Cognitive Behavioral Therapy for Late Life Depression, an evidence-based model to treat the early signs of depression. The Center focuses on

the LGBTQ population. Before closing, Borrego Health contracted with PEI to provide additional outreach and support to LGBTQ and HIV communities. DAP Health (formerly Desert AIDS Project) has now assumed much of the former Borrego Health clinics, and this may provide a new contracting opportunity or at least a new referral resource.

RUHS-BH Mature Adult programs in Western and Mid-County regions provide a therapy group called "Living Healthy with Chronic Conditions." Mature Adult Desert Program has plans to invite presenters from DAP on topics of sexual health and HIV/AIDS.

BHC Recommendation: BHC recognizes the importance of culturally informed care and recommends continued outreach, engagement, and development of culturally informed services. The BHC recommends sustaining the supports provided by the Culturally Competency program in the MHSA Annual Update FY 25/26.

8. **Comment:** Youth Connect

Response: Youth Connect supports young people discharged from inpatient psychiatric care as they transition back into their everyday lives. They provide comprehensive wraparound services to help ensure stability at home and in school. It is unclear from your comment what changes you would like to see, but by mentioning the program, you underscore the importance of the service.

BHC Recommendation: The BHC recommends sustaining hospital navigation supports in the MHSA Annual Update FY 25/26.

9. **Comment:** Mobile Crisis and Peer Support (maybe on a smaller scale). Expand ETS. Increase in-home services for those who are bedridden.

Response: RUHS-BH has multiple mobile crisis teams that include Community Behavioral Assessment Teams (CBAT), which is a law enforcement and clinical therapist partnership that responds to law enforcement dispatch, crisis management, and crisis response teams that can be dispatched 24/27 into the community address behavioral health crises county-wide. Crisis Management and Crisis Response teams include Peer Support Specialists. Other in-home and field based services can depend on a program's treatment model and staffing level. Clients served in Full Service Partnership programs (FSP) frequently receive field based services.

It is important to note that "In Home Supportive Services (IHSS)" is the common named used to refer to a Department of Social Services Program that provides daily living assistants to help keep people in their homes. This is not a RUHS-BH service.

MHSA has regulatory limits on funds used for care provided in involuntary care settings. In most cases, MHSA funds cannot be used to build facilities that would receive people on a 5150. But, expanding and modernizing acute levels of care such as Emergency Treatment Services (ETS) was part of the 2024 Proposition 1. Proposition 1 included the Behavioral Health Services Act (BHSA,) but also included a $6.4 billion dollar bond measure for behavioral health residential care. RUHS-BH applied for and was awarded funds from this bond measure that includes plans to build a new psychiatric hospital with a larger capacity near the current RUHS Medical Center. RUHS-BH has already started building the Mead Valley Wellness Village, which includes crisis and residential

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levels of care. You can read more about the Wellness Village in the Capital Facilities chapter of this plan.

BHC Recommendation: The BHC recommends sustaining the crisis and FSP services identified above in this MHSA Annual Update FY 25/26.

10. **Comment:** There is still a large need for long term care for the seriously mentally ill. They continue to be released too early from ETS and other psych hospitals to the streets when they need more time to stabilize. It could take over a year for someone with serious mental illness to be in a locked hospital for them to realize they need treatment forever. The Riverside Behavioral Health Care unit provided adequate treatment for my son only after he was conserved by the county, and this was only after being jailed for years and causing much trauma and heartache in the community and to his family. If we would have had access to these services when he needed them, he would not have had to go through years of legal battles and the family would not have been harmed. Instead because of the current system process he was arrested, put-on short-term psych holds, released too early multiple times until he did something terrible while in another psychotic episode which held him for four years in jail. Although Care Court is encouraging, it is voluntary so it will not capture the sickest people.

Response: Thank you for this testimony regarding your son's and your experience with his emergency psychiatric care, California State laws for civil commitment of the mentally ill, and the justice system. The original laws written for involuntary treatment of people with mental health disorders were based on very strict risk criteria and favored individual liberties over forced treatment. These laws originated out of abuses related to civil commitment. Everyone who is hospitalized against their will has legal due process and these State laws must be followed. Changes in these laws can only happen at the State level. These laws have been recently updated for the first time since they were passed in 1972, expanding the definition of grave disability for adults, giving authorized professionals greater flexibility in determining risk due to a mental disorder. Care Court is a beginning and may be amended as the State receives county data on success rates and challenges. The Family Advocate Program is a RUHS-BH program that supports family members of adults who have mental health disorders. The program is staffed by people who have the lived experience of also having a family member with mental health needs. The program offers support, system navigation, and education on a variety of behavioral health related topics including mental health law, medications, psychiatric diagnoses, and illness management. You can learn more about the program by visiting: https://www.ruhealth.org/behavioral-health/pss/family-advocate-program The Family Advocate often works with the National Alliance on Mental Illness (NAMI), a community organization for family support. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI started as a small group of families gathered around a kitchen table in 1979 and has blossomed into an alliance of more than 600 local Affiliates and 49 State Organizations who work in the community to raise awareness and provide support and education. You can find out more about NAMI and locate a local chapter here:
https://www.nami.org/

The BHC and Department programs offer community advisory meetings that provide updates on legislation, regulations, programs, and information as they develop. You can learn more about these advisory group meetings in the directory that begins on page 33 of this plan.

BHC Recommendation: The BHC encourages people to become more involved in advocacy and advisory committees and to participate in organizations that advocate for changes in behavioral health law.

11. Comment: HHOPE, easier for access to services before homelessness

Response: Homeless Housing Opportunities, Partnerships & Education Program (HHOPE) offers a continuum of housing interventions for people who are homeless or at risk of being homeless. You can read more about HHOPE programs in CSS 04.

As affordable housing decreases, the demand for housing services increases. But the resources do not develop at the same pace. This creates regulations and policies that become more restrictive to concentrate resources for the greatest need.

A significant percentage of homeless individuals experience mental health or substance use disorders, and it's crucial to understand that these are not the primary causes of homelessness for most people. While estimates vary, studies indicate that a substantial portion of the homeless population struggles with mental illness and/or substance abuse, with some research suggesting that over half of those experiencing homelessness have a mental health condition or substance use disorder. Active participation in programs that address mental health and addiction can help prevent homelessness for some people when behavioral health is a primary variable in housing instability.

Economic factors like lack of affordable housing, unemployment, and low wages are often the root causes of homelessness, requiring multi-system changes to address housing costs and shortages.

BHC Recommendation: The BHC recommends sustaining HHOPE services identified above in this MHSA Annual Update FY 25/26 and encourages the expansion of housing supports as we transition into BHSA.

12. Comment: Expand the P.A.I. R. (Pets Assisting in Recovery) Program to include more clinicians, peers, and animals to serve more members

Response: Thank you for your support of the PAIR program. Any program expansion is dependent on related regulations, demand, and the resources. Animals in treatment can have a powerful outcome on engagement and outcome. Your recommendation has been provided to the Administrator over the PAIR program.

BHC Recommendation: The BHC agrees that animals can be an effective addition for some people in recovery and recommends sustaining related services as much as possible as we transition into BHSA.

13. Comment: Peers center less meditation. Meditation is an hour long. That is too long to sit and breathe. We should take this time and do other active activities for relaxation.

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Response: Peer Recovery and Resource Centers are included in plan CSS-03. There is one Peer Center in each service region. Your program operations recommendation has been provided to the Deputy of Peer Services.

BHC Recommendation: The BHC recommends sustaining peer support services in the MHSA Plan annual update FY 25/26.

14. **Comment:** The recording program recently implemented at Stepping Stones is a valuable step forward, but it deserves broader visibility and strategic implementation across the county. I helped conceptualize this type of creative recovery model, and while I'm grateful to see it launched, I was not included in its production despite my direct involvement in developing and promoting it.

Response: Thank you for your leadership and support of this great project at Stepping Stones, the Transitional Age Youth (TAY) center in Western Region. Though the TAY centers are partially funded using MHSA funds, the direct operation of the program is not addressed at this planning level. Concerns of this type regarding program operation or service promotion should first go to the program supervisor and then program administrator and then the program deputy.

BHC Recommendation: The BHC recommends sustaining TAY programs and services in the MHSA Plan annual update FY 25/26.

15. **Comment:** Family Advocate, CSU, ITF, ETS, TAY, PEI, FEP and Pathway to Success

Response: The Family Advocate is a peer run program focused on the support needs of family members caring for an adult loved one who had mental health needs. Crisis Stabilization Unit is an urgent care service provided to voluntary clients in behavioral health crisis. ETS and ITF are the emergency room and inpatient facility for emergency psychiatric needs. PEI or Prevention and Early Intervention is the second largest component under MHSA. FEP is First Episode Psychosis and evidence-based intervene program typically designed for transitional age youth (TAY) who had their first symptoms of psychosis. Pathways to Success is a TAY and adult system of care vocational development program.

BHC Recommendation: The BHC recommends sustaining the above identified programs in the MHSA Plan annual update FY 25/26.

16. **Comment:** Many modern Therapies are not available in Riverside County, like EMDR. There are no therapists dealing with complex PTSD caused by bullying, but this is true for all counties. Dissociative Identity Disorder, CBD, DBA magnet therapy, Etc.

Response: MHSA funds several Evidence Based Practices (EBP) including EMDR (Eye Movement Desensitization and Reprocessing) for selectively trained clinicians within our service system. Some other EBPs include: Trauma Focused Cognitive Behavioral Therapy, High Fidelity Wraparound, Multidimensional Family Therapy, Dialectical Behavioral Therapy, Eating Disorder Practices, and Motivational Interviewing. Access to other specialized care such as Electroconvulsive Therapy (ECT) is based on psychiatrist recommendation and provided by a specialized contractor.

BHSA also includes EBPs as part of the regulations, but the State may limit the EBPs that can be chosen by a county or may direct the counties to offer certain EBPs. BHSA regulations currently mandate First Episode Psychosis (FEP) as part of Early Intervention, Assertive Community Treatment/Forensic Assertive Community Treatment for adult FSP, and High Fidelity Wraparound for children and youth FSP.

BHC Recommendation: The BHC recommends sustaining the EBPs in the MHSA Plan annual update FY
25/26 and the encourages he Department to consider emerging treatments as they become approved as standards of care.

17. **Comment:** Keep adapting for treatment for community, not leaving people with disadvantages behind helps everyone, include financial guidance to keep disadvantaged from failing (Boundaries)

Response: Thank you for advocating for people with the fewest resources. County behavioral health may be their only option and we want to ensure that they are offered high quality care.

BHC Recommendation: The BHC agrees that county services are the safety net for behavioral health care and encourages continued development of high quality care for those with the fewest resources.

3. What other thoughts or comments do you have about behavioral health services or about the MHSA plan?

1. **Comment:** For what I'm hearing it I think you all are doing a great job, keep going

Response: Thank you for your support of the behavioral health system of care.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

2. **Comment:** More Housing support, Expand psychiatric Services-County wide

Response: You can read more about MHSA funded housing supports in CSS 04.
The Association of American Medical Colleges (AAMC) estimates that by 2036, the U.S. is expected to face a physician shortage of between 13,500 and 86,000 physicians. This study succeeds a previous conclusion from 2021, in which the AAMC reported a shortage of between 37,800 and 124,000 individuals within the following two decades. RUHS-BH employees more psychiatrists than any behavioral health provider in the region but recruitment remains challenging. We have developed relationship with medical schools and residency programs to encourage more psychiatrists to enter our system of care. We have also pursued alternative prescribers such as nurse practitioners and physician assistants.

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BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

3. **Comment:** Would like to have what services are offered and, if a client needs to ask for the services/ Clear advice as to where to access programs such as SSI, CARE, Conservatorship, etc.

Response: There are two great starting places to learn more about behavioral health services. The first is our website: https://www.ruhealth.org/behavioral-health
The buttons on this page are a combination of system access information and navigation.
The second is our central access number called the CARES line: 1-800-499-3008.
More direct navigation support is also available for Parents of Minor Children through Parent Support and Training by calling: 888-358-3622
More direct navigation support is also available for Family Members or Friends of Adults with mental health needs by calling the Family Advocate at: 800-330-4522.
The Family Advocate often works with the National Alliance on Mental Illness (NAMI), a community organization for family support. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI started as a small group of families gathered around a kitchen table in 1979 and has blossomed into an alliance of more than 600 local Affiliates and 49 State Organizations who work in the community to raise awareness and provide support and education. You can find out more about NAMI and locate a local chapter here:
https://www.nami.org/
The BHC and Department programs offer community advisory meetings that provide updates on legislation, regulations, programs, and information as they develop. You can learn more about these advisory group meetings in the directory that begins on page 33 of this plan.

BHC Recommendation: The BHC recommends sustaining community education and outreach in the MHSA Annual Update FY 25/26 and encourages the Department to more regularly market opportunities for the community to participate in these activities and committees.

4. **Comment**: I work in a very caring and empathetic environment. I'm so grateful every day I come into the office.

Response: Care and empathy are the start of what we do. Thank you for your support.

BHC Recommendation: The BHC acknowledges the daily work of hundreds of dedicated direct practices, technical, and support employees who make it possible to serve over 45,000 people annually.

5. **Comment:** Behavioral Health Services are just as important as housing services.

Response: We believe in the importance of the behavioral health services across the continuum of care: Prevention and Access, Early Intervention, Outpatient Care, Full-Service Partnership, Crisis Services, Residential care, Acute Hospital Care, and Long Term Care. We realize that social determinants of health, such as quality affordable housing, also impact overall wellness.

BHC Recommendation: The BHC recommends sustaining the programs and services identified above in this MHSA Annual Update FY 25/26.

6. **Comment:** People need to maintain stability in their mental health to maintain their housing.

Response: Providing supportive and integrated services into housing options maximizes success.

BHC Recommendation: The BHC recommends sustaining the supportive housing programs and services identified above in this MHSA Annual Update FY 25/26.

7. **Comment:** Some (like HHOPE) have very limiting, strict guidelines for who they can help that leave out a lot of people that need that service as well.

Response: Homeless Housing Opportunities, Partnerships & Education Program (HHOPE) services can be restricted by federal, state, and local regulations that specify how funding and resources can be used and who is edible to receive them. These rules can't be changed unless they are changed by the related governing authority. Many grants also have guidelines established by the grantor on how the funds can be used.

HHOPE offers a continuum of housing interventions for people who are homeless or at risk of being homeless. You can read more about HHOPE programs in CSS 04.

As affordable housing decreases, the demand for housing services increases. But the related resources do not develop at the same pace. This results in regulations and policies that become more restrictive to concentrate resources for the greatest need.

A significant percentage of homeless individuals experience mental health or substance use disorders, and it's crucial to understand that these are not the primary causes of homelessness for most people. While estimates vary, studies indicate that a substantial portion of the homeless population struggles with mental illness and/or substance abuse, with some research suggesting that over half of those experiencing homelessness have a mental health condition or substance use disorder. Active participation in programs that address mental health and addiction for some people can help prevent homelessness when behavioral health is a primary variable in housing instability.

Economic factors like lack of affordable housing, unemployment, and low wages are often the root causes of homelessness, requiring multi-system changes to address housing costs and shortages.

BHC Recommendation: The BHC recommends sustaining the supportive housing programs and services identified above in this MHSA Annual Update FY 25/26.

8. **Comment:** Find a way to fund adequate treatment for those with SMI: Schizoaffective, Schizophrenia and Bipolar d/o (if needed). Find a way to get around the IMD exclusion or classify these disorders differently. There is no reason someone with Alzheimer's has inpatient care and housing options for treatment immediately available to them to keep

them and their families safe, but SMI has none. Without this, we will continue to have tragedies and homeless people filling our streets and jails.

Response: The interface of mental illness, the law, treatment, funding, and access to social determinants of health is not always where each person needs it to be. Each one of those variables has an important contribution in getting care needs met. We appreciate your advocacy for people with serious mental illness and for people who are homeless. Should you want to become more involved in housing advocacy, please consider joining the Housing Committee under the Behavioral Health Commission. You can learn more about the housing committee and other community advisory meetings starting on page 33 of this plan.

BHC Recommendation: The BHC encourages people to become more involved in advocacy and advisory committees and to participate in organizations that advocate for changes in behavioral health law.

9. **Comment:** I'm not certain whether this falls under the current plan or if it pertains specifically to Behavioral Health Services within RUHS. The appointment line intended for triaging clients is extremely disorganized, and the customer service is poor.

Response: Thank you for sharing your concerns. RUHS-BH has a commitment to quality customer service. We are sorry that your access to care did not represent those ideals. Response times from request for service-to-service appointment are monitored. RUHS-BH is a system of care with multiple clinics, programs, and services across a continuum of care county-wide. It is difficult to know which program is identified in your experience, but each program should have grievance forms available in lobby areas. These kinds of complaints are taken seriously and investigated by the Department's Quality Improvement unit. You can find grievance booklets on the Quality Improvement page of the Department's website: https://www.ruhealth.org/behavioral-health/quality-improvement

BHC Recommendation: The BHC encourages all stakeholders to voice their concerns to help shape and improve service delivery and recommends utilizing the public comments agenda item to public voice their opinions at BHC meetings. You can learn more about meetings here: https://www.ruhealth.org/behavioral-health/advisory-committees

10. **Comment:** As an LMFT in the community, I have supported several clients in contacting the CARES line in hopes of obtaining FSP [Full Service Partnership] services, and the process has been consistently challenging. Callbacks from clinicians often take a long time, and the triage team has been reported as unhelpful and, at times, rude. They frequently undermine the support that clients are actively receiving during the call. At this time, it has become increasingly difficult to refer clients to RUHS for services due to these ongoing issues.

Response: RUHS-BH has a commitment to quality customer service. Response times from request for service-to-service appointment are monitored. The CARES Line is the central access line for Department services. We are sorry that your experience did not meet these ideals. Though some CARES line expenses are covered in the MHSA plan, the specific operations of the program are not typically addressed at this planning level. Operation complaints are usually address to the program supervisor or manager, or by the Department's Quality Improvement unit. Your concerns have been

provided to the CARES Line Manager. You can find grievance booklets on the Quality Improvement page of the Department's website: https://www.ruhealth.org/behavioral-health/quality-improvement

BHC Recommendation: The BHC recommends sustaining Quality Improvement oversight of Department service delivery in the MHSA Annual Update FY 25/26, and that all issues, concerns, and grievances be shared with program leadership.

11. **Comment:** Workshop on how Medicaid cuts could impact, strategies to ensure our community does not suffer

Response: The realities of funding changes are still unfolding, and some are difficult to predict. As information becomes clearer and the impact to programs more evident, the results will be shared with the greater community. In the meantime, becoming involved in community advisory committees can allow for greater discussion and having your voice heard. You can discover a list of community advisory committees under the Behavioral Health Commission (BHC)and under Cultural Competency. The BHC has a committee specifically to look at legislative changes called the Legislative Committee. You can find out more about these meetings starting on page 33 of this plan document.

BHC Recommendation: The BHC recommends regular committee advisory meeting participation to get information on changes to behavioral health related legislation, changes in service delivery, and how to provide feedback on the changes.

12. **Comment:** It's disappointing that so many wonderful programs that are associated with PEI seem to be going away with BHSA. I feel the MHSA plan is fine and should stay intact or as is. They are all preventive based and have such a large impact in the lives of the families who need this type of direct help.

Response: Prevention and Early Intervention (PEI) has been a hallmark of the MHSA legislation since inception. Though many of these programs will no longer meet legislative requirements, health care prevention will remain. Prevention will not only have a specific State level intervention, but Public Health will assume a larger role in prevention across the health care spectrum. Part of the new Behavioral Health Services Act (BHSA) legislation directs Behavioral Health and Public Health to work together with Manager Care Providers and the community to assess needs and develop related interventions. Though the change does represent a loss to our familiar prevention efforts, it may also open new possibilities. Stay informed and speak out! Please consider joining a related community advisory committee. You can find a directory of these meetings starting on page 33 of this plan document.

BHC Recommendation: The BHC recommends regular committee advisory meeting participation to get information on changes to behavioral health related legislation, changes in service delivery, and how to provide feedback on the changes.

13. **Comment**: I would like to see events that are more wheelchair accessible and autism friendly and I definitely want to see more service dog awareness and have properly interact

with them. The MHSA Plan would benefit from acknowledging the California HIV & Aging Act (SB 258, 2021), which formally recognizes older adults living with HIV as a "population of greatest social need." As the County implements Proposition 1, now is the time to integrate HIV-informed mental health services, trauma recovery models, and peer workforce development for long-term survivors. Aging and HIV Institute ("A&H," AgingandHIV.org) would welcome the opportunity to provide technical assistance and community input to ensure these priorities are incorporated. Behavioral health equity must include those aging with HIV.

Response: Outreach and Engagement events are part of CSS-03 and PEI-01. These are opportunities for the Department to facilitated conversations about behavioral health in non-judgmental, fun, and educational environments often held at community parks or similar city recreation spaces. Inclusivity and access are valued by the Department. Though some regions may have limited options regarding where larger events can be held and defer to city compliance with access regulations, your feedback has been provided to the Deputy of Peer Support Services and the Prevention and Early Intervention Manager.

As health care services become more fully integrated, and both the physical health care and behavioral health care are treated more holistically, more opportunities for comprehensive care will be available in one location. BHSA directs public health and behavioral health to work together with managed care providers and the community to ensure a comprehensive assessment of community health care needs.

The BHSA does contain a list of specific stakeholders that are regulatorily required; this includes representatives from the LGBTQ+ communities and eligible older adults but does not specifically mention people living with HIV. That does not mean that this vulnerable population should be excluded. We will include the Aging and HIV institute in our stakeholder outreach.

BHC Recommendation: BHC recommends sustaining program and services within the Older Adult System of Care, and department support of culturally informed services to the LGBTQ community in the MHSA Annual Update FY 25/26.

14. **Comment:** The behavioral health services funded through the MHSA plan- particularly programs like Strengthening Families- have had an incredible and lasting impact on the San Jacinto community. We have been able to refer numerous families to these services and the transformation we've witnessed has been truly inspiring. Families who have participated in the program have demonstrated significant improvements in areas such as chronic absenteeism, student discipline, and overall school engagement. Perhaps most importantly, we've seen powerful shifts in the relationships between parents/guardians and their children. These programs equip families with the tools and support they need to foster healthier communication, build trust, and create stronger, more stable home environments. For many of our families, this has been life changing. Maintaining and expanding behavioral health services is not just important, it's essential. Programs like these are a critical investment in the well-being of our students, families, and the long-term strength of our community.

Response: Strengthening Families is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in

children ages 6-11. SFP is listed as a prevention program in the current MHSA plan (pg. 135). The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

15. **Comment:** Our school district has greatly benefitted from these free mental health programs. Our families love them and have made a positive impact in their lives. If they were to be cut, it would be a tremendous loss. We have offered Strengthening Families at our district for many, many years and we would hate to lose such an amazing program. Please do not cut funding for it.

Response: Thank you for your advocacy for the Strengthening Families Program. Strengthening Families is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children ages 6-11. SFP is listed as a prevention program in the current MHSA plan (pg. 135). The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

16. **Comment:** People are being radicalized online through YouTube and other Social Media that operate using algorithms which continually present more of the unverified toxic material they are already consuming. Young men, especially, are going down deceptive rabbit-holes like White Nationalism, Nutrition Fads, Get Rich Quick schemes, Extremist and Conspiracy Theories, Mental Health misinformation, and content that causes distress. They need be taught (or reminded) of critical-thinking skills and empathy for "the other." They need self-soothing skills. With financial prospects for men with no college education shrinking, they should also be recognized as an at-risk group, in need of extra support. Perhaps Man Therapy can provide a page in an "Are you being lied to?" or "Risks of Social Media" option under the "Men's Health Topics" banner.

    Young men are also falling victim to addictive gambling as a result of the recent deregulation of sports betting apps. There's evidence suggesting that online sports betting, with its predatory marketing practices, can negatively impact men, particularly young men, and those in low-income areas. Outcomes are debt accumulation, bankruptcy, mental health

and relationship problems, addiction and stress.

Related to both: Accessibility and "Dark Patterns": The design and features of some betting apps and social media algorithms may exploit cognitive biases and encourage excessive. uncontrolled use.

Response: Each of our well-being is an intersection of multiple variables and influences. You have touched on three here: popular culture messaging (which certainly occurs in social media), gender, and age/generation. Man Therapy, a behavioral health outreach and education campaign designed toward men started in our Help@Hand Innovation project and is now funded under PEI. Man Therapy considers some of these variables, encouraging men to know when they need to seek help. You can explore their website here: https://mantherapy.org/

Help@Hand also focused on "digital literacy," about understanding and navigating the digital world in a healthy and informed way. With the expiration of the Help@Hand Innovation project, digital literacy has transitioned and continues in our Peer Support system of care.

It would be difficult for one system of care to be able to make inroads with all the variables that impact each life. A part of the PEI philosophy is that change needs to be pervasive across demographics, institutions, organizations, and traditions. Prevention is about changing the conditions that lead to negative health outcomes. Based on your thoughts, it appears you would agree.

We can certainly pass on your thoughts to Man Therapy and the Deputy of Peer Services.

BHC Recommendation: The BHC recommends sustaining the related programs and services as identified above in the MHSA Annual Update FY 25/26.

17. **Comment:** We need more services for people with disabilities like autism and deafness. We need to be more inviting to these individuals and offer more resources at the behavioral health departments along with training and interpreters on site, at least training to teach the employees to sign so they can communicate with the Deaf, it will expand services to our communities. We have autistic and Deaf homeless people out there who need help and services as much as the others that attend these departments. We used to have a group of special needs that came to the peers center they no longer attend. I myself have tried to seek services at the Rustin and Blaine St locations to get told they don't have anything for me. How does this make me feel like I need to become homeless and become an addict to receive services at these locations. I will not do that but I'm asking for your help including people like me and others so we are not excluded. Autism has its own behaviors outburst meltdowns anger emotional imbalance etc. We are runners if we don't get help or some not me self-harm that could lead to suicide due to lack of services. Please take this into consideration and help find a resolution and help fight this stigma. Thank you for your time

Response: Thank you for sharing your personal experience and for advocating for the Autistic and the Deaf communities. System navigation can be overwhelming at times, especially when multiple needs are presented. State regulations often identify different needs into classifications that are served by different systems of care. Autism is a developmental disability that traditionally has not been directly served in adult behavioral health care which was formed to treat serious mental illness and substance use disorders. Certainly, there are times when people have intersecting needs of both a mental illness (SMI) and/or a substance use disorder (SUD), and a developmental disability.

Professionals screening for service within behavioral health will be assessing for behavioral health disorders first to determine if a member meets the qualifications for specialty mental health. Therapist who are treating people who have both a developmental disability and a SMI/SUD need the proper training to best understand and support their client holistically.
The ability to communicate is essential in seeking care and members of the deaf community need to be welcomed and served in the language of their choice, this includes ASL. The county contracts with ASL interpretation services, and recruits ASL speakers through our student internship program. We need more qualified behavioral health professionals who speak ASL and understand the unique worldview of deaf consumers.
Your recommendations have been provided to our Disabled Communities Liaison (Cultural Competency Program, PEI 01) to help formulate planning around access barriers, and to our Workforce Education and Training manager around training needs and recruitment.

BHC Recommendation: The BHC recommends continued outreach and engagement with People with Disabilities within the MHSA Annual Update FY 25/26, and encourages expansion of training, supports, and access to ensure culturally informed care.

18. **Comment:** The community needs these community advocates to be aware of opportunities that will not only help myself but looks to improve the community. And does so through listening to the community and those individuals looking for help and are not aware of the possibilities until they are comfortable in a supportive environment so that they can communicate about strategies to achieve their goals.

Response: Agreed. Advocacy is not only about pointing out what isn't working or needs to change but also about partnering on a plan or strategy to create the change. The barriers to service access are like potholes in a road, which ones need to be filled first needs to be identified by each community and addressed together. Sometimes it isn't' about just filling in the hole but building bridges or new roads. That can be hard work, but necessary work. Advocacy ends if action fails to begin. Please consider joining a community advisory group sponsored by the BHC or Cultural Competency. You can find a directory of such meetings starting on page 33 of this plan document.

BHC Recommendation: The BHC recommends sustaining the outreach and engagement strategies as identified in the MHSA Annual Update FY 25/26, and actively partnering with the community around program changes as the result of BHSA.

19. **Comment:** RUHS has the opportunity to set a national example for how creative expression can foster mental health. I urge you to fully adopt and scale the recording program across Riverside County and formally recognize collaborators like myself who helped birth these initiatives. In addition, expanding Creative Recovery groups into other cities, with consistent structure and culturally responsive leadership, would create safe havens for healing.
I am deeply invested in seeing these programs succeed and would gladly work with the County to help formalize, expand, and promote them. Let's ensure these community-rooted efforts reach their full potential—and that those who plant the seeds are welcomed into the garden.

Response: Thank you for your contribution and support. Your recommendation has been provided to the Deputy of Children's Services who oversees the Transition Age Youth programs.

BHC Recommendation: The BHC encourages Department services and programs to integrate art therapy and artistic expression into service choices for members who want art as part of their treatment planning.

20. **Comment:** I would like to see more therapists available and more specialists

Response: Workforce shortages have also impacted behavioral health. State data reveals that the Inland Empire has a particularly difficult time retaining licensed therapists as a region. Workforce Education and Training (WET component in this plan) has several workplans that address workforce recruitment and retention that include the largest internship program in the region, licensure advancement supports, and financial incentives. You can read more about these initiatives starting on page 496 of this MHSA plan.

BHC Recommendation: The BHC recommends sustaining the WET workplans that address workforce development in the MHSA Annual Update FY 25/26.

Public Hearing Comment Summaries

Desert Region

1. **Comment:** George, representing *Peace From Chaos*, emphasized the urgent mental health challenges in Blythe, a small, underserved community in Riverside County. While he acknowledges some positive changes from previous advocacy, he highlights ongoing issues such as high rates of suicide, overdose, and systemic violence. George calls for:

    - A true 24/7 crisis response team with clinicians, not just peer support.
    - Improved dispatch awareness of local resources and geography.
    - Consistent mental health staffing (therapists and psychologists) for long-term support.
    - Travel and service accessibility adjustments for remote areas like Blythe.
    - Strengthened cultural competency, especially for the growing Latinx and LGBTQ+ populations.
    - Support and burnout prevention training for local behavioral health staff, who face isolation and fewer resources than those in other regions.
    - Equal professionalism and customer service across all county clinics.

    He offers to continue participating and supporting these efforts.

Response: Clinician recruitment into Blythe has been a challenge. A special therapist job classification was created just for Blythe to increase the salary for this regional position to enhance recruitment for prospective applicants. Blythe has also consistency been approved for National Health Service Corp loan assumption, a federal program designed to entice professionals into workforce shortage areas that provides up to $50k in student loan repayment for a 2 year service

commitment. Workforce Education and Training provides additional selection points for any employee applying to the 20/20, a workforce advancement program that enables paraprofessional employees to attend graduate clinical therapist schools. National data reveals that most clinical therapists prefer to work in metropolitan areas.

Blythe is a unique community loved by the people who live or were raised there. We know that therapists tend to stay in communities that they consider home. One strategy is to "grow your own," and look to current residents who have an interest in pursuing careers as therapists. WET partnered with the county HR Education Support Program to create a cohort for Desert region paraprofessional employees and our contractors through UMass Global University, an online university, who wanted to pursue a clinical social work degree. Cohort participants get discounted tuition and additional support.

WET is open to learning about other creative ideas that can support workforce development in Blythe.

WET training supports include cultural competency training on better service LGBTQ communities and people from ethnic cultural communities, such as Latinx. Training on compassion fatigue and trauma informed systems is also offered.

RUHS-BH has a commitment to quality customer service. We are sorry that your access to care did not represent those ideals. Each program should have grievance forms available in lobby areas. These kind of complaints are taken seriously and investigated by the Department's Quality Improvement unit. You can find grievance booklets on the Quality Improvement page of the Department's website: https://www.ruhealth.org/behavioral-health/quality-improvement

BHC Recommendation: The BHC recommends continuing outreach and service development supports to the Blythe community, and to sustain the suicide prevention activities that are identified in the PEI Plan as MHSA transitions into BHSA.

Mid-County Region

1. **Comment:** From Lake Elsinore, shared personal testimony about her experiences as a patient with autism, bipolar disorder, ADHD, and anxiety. She has visited ETS (Emergency Treatment Services) over 50 times since adolescence and expressed deep concern about the "lack of compassion and professionalism" from staff.

Key points from her statement include:

- Lack of respect and empathy from nurses and doctors, especially for vulnerable patients like those experiencing suicidal thoughts or domestic trauma.
- Poor bedside manner, including dismissive or shaming attitudes toward patients.
- A failure to provide timely or adequate care, including a specific example involving a pregnant woman.
- A sense that the facility is a "revolving door" that relies on medication without offering real help or rehabilitation.
- Mistreatment of her wheelchair-bound sister, who was threatened with forced medication.
- Overall, she describes the facility as unsafe and unwelcoming, with staff showing apathy rather than support.

PUBLIC COMMENTS

She urges for better training and accountability for ETS staff so patients can feel safe, heard, and genuinely helped—rather than retraumatized—during mental health crises.

Response: Thank you for your testimony and sharing your story. Seeking behavioral health care is a vulnerable act and should always be done in an environment of safety. We are sorry that that was not your experience.
ETS, the county psychiatric emergency department, is governed under the RUHS Medical Center and license. Though funding in involuntary settings is limited in MHSA, we want everyone to experience quality, compassionate care. Your concerns will be provided to RUHS-BH leadership to review with their Medical Center partners.
RUHS has a commitment to quality customer service. Each program should have grievance forms available in lobby areas. These kind of complaints are taken seriously and investigated by the Inpatient Quality Improvement unit. You can find grievance booklets on the Quality Improvement page of the RUHS website: https://www.ruhealth.org/behavioral-health/quality-improvement
All community stakeholders are encouraged to participate in the available community advisory meetings that start on page 33 of this plan for regular community advocacy.

BHC Recommendation: The BHC recommends utilizing the grievance procedures available and to participate in community advisory meetings that provide a collective voice of accountability and change.

2. **Comment:** Background: Has worked in various youth and family programs in California for 15 years, including group homes, job training for young adults, and currently in the *Strengthening Families Program*.

- Personal Insight: Adoptive parent to two children, one of whom has faced mental health challenges.
- Program Overview:
    - Works with families voluntarily seeking to improve their relationships.
    - Currently supports 24 families weekly, aiming to prevent negative behaviors by early intervention with children aged 6–11.
    - Emphasizes the value of building community among families, mutual support, and shared experiences.
    - Believes the program is vital and hopes to see it sustained as it provides tools and education for stronger families.

Response: Thank you for your advocacy for the Strengthening Families Program. Strengthening Families is an evidence-based program that emphasizes the importance of strong family relationships and building family resiliency. The program seeks to make family life less stressful and reduce family risk factors for behavioral, emotional, academic, and social problems in children ages 6-11. SFP is listed as a prevention program in the current MHSA plan (pg. 135). The Behavioral Health Services Act (BHSA) has removed population based prevention from a funded services at the county level. The State collects some funds to address population prevention at the State level and wants health care prevention across specialties to be provided by public health. Though Riverside's PEI plan will remain in effect through 25/26 fiscal year, there will be substantial changes to behavioral health's programming around prevention.

BHC Recommendation: The BHC encourages RUHS-BH to become an active partner with State and county public health prevention campaigns and programs to ensure behavioral health integration around health care prevention.

3. **Comment:** An individual shared lived experience as a person with treatment-resistant depression caused by trauma.

- Main Concern:
    - Cannot access effective therapies in their county, including EMDR, DBT, CBT, or magnet therapy.
    - Notes that local therapists often lack specialization in trauma or disability-related disorders.
    - While some therapies are advertised as available in the county, they have not been accessible in practice.
- Desire: Strong need for access to high-quality, specialized mental health treatments that go beyond basic talk therapy.

Overall Message: She stresses the critical importance of sustained, accessible, and specialized mental health services — both for families aiming to prevent future challenges and for individuals already navigating complex mental health needs.

Response. MHSA funds several Evidence Based Practices (EBP) including EMDR (Eye Movement Desensitization and Reprocessing) for select clinicians within our service system. Some other EBPs include: Trauma Focused Cognitive Behavioral Therapy, High Fidelity Wraparound, Multidimensional Family Therapy, Dialectical Behavioral Therapy (DBT); Eating Disorder Practices, Cognitive Behavioral Therapy (CBT) and Motivational Interviewing. Access to other specialized care such as Electroconvulsive Therapy (ECT) is based on psychiatrist recommendation and provided by a specialized contractor. All evidence models have inclusion and exclusion criteria designed to ensure that only people who will benefit from the model will received the practice.

If you have been excluded from a particular treatment modality, the rationale should be explained to you and possible alternative treatment options should have been discussed. If you are having trouble accessing care that you think would benefit you, please ask to speak to the program supervisor, or you can file a grievance with our Quality Improvement unit. You can find grievance booklets on the Quality Improvement page of the RUHS website: https://www.ruhealth.org/behavioral-health/quality-improvement

BHC Recommendation: The BHC recommends continuing the Evidence Based Practiced (EBP) supported by the MHSA Annual Update FY 25/26 and encourages the Department to examine emerging practices that become standard of care and are supported by BHSA EBP parameters.

4. **Comment**: The speaker, a non-licensed housing provider working with women in recovery, expresses deep appreciation for:
    - Dedicated Caseworkers: Acknowledges county caseworkers who go above and beyond, even working weekends to support clients.
    - California's CalAIM Initiative: Praises the initiative for pioneering work in whole-person care, especially in Riverside County, noting that while it's still developing and has growing pains, it holds significant promise.

PUBLIC COMMENTS

Despite being "just a housing provider" and not a licensed clinician, the speaker:

- Advocates for Provider Inclusion: Wants better communication and collaboration between systems and non-licensed providers who often hold valuable insights into clients' needs.
- Sees Patterns & Solutions: Observes trends (e.g., age-related needs, hormone therapy benefits) among the women she serves and feels this knowledge is underutilized.
- Urges Systemic Change: Recommends a mechanism to share this on-the-ground insight with decision-makers—ideally, making it part of the contract or funding requirement.
- Values Recovery Housing: Stresses the ongoing importance of shared, community-based housing as an alternative for clients who may not be ready for larger, more formal facilities due to stigma or preference.

Core Message: Non-licensed providers play a crucial role in the recovery ecosystem and should be better integrated into communication and planning processes to enhance care and support whole-person wellness.

Response: Though non-licensed staff do not hold the same system authority based on regulatory operations as licensed and certified staff, they make up a large portion of the behavioral health workforce. Both lived experience and seasoned paraprofessional practice provide each employee and practitioner unique insights that are valuable and informative. Care and wisdom are not limited to a license. You do not need a formal credential to have an informed opinion on services or care. Substance Use treatment providers have regular meetings coordinated through RUHS-BH Substance Abuse, Prevention, and Treatment administration. You can learn more about working collaboratively here: https://www.ruhealth.org/behavioral-health/sapt/services

BHC Recommendation: The BHC recommends continued recovery options as supported by the Substance Abuse, Prevention, and Treatment (SAPT) program, and looks to more visible opportunities of an integrated system under BHSA.

Western Region

1. **Comment:** Volunteer at Riverside University Health System and the Care Center, appreciates the services provided but suggests adding autism-related support. She notes that individuals with autism face behavioral challenges like outbursts and meltdowns, and current responses—such as offering sensory toys—are insufficient. Speaker emphasizes the need for training and resources to better understand and address these issues effectively.

Response: Autism is a developmental disability that traditionally has not been directly served in adult behavioral health care which was formed to treat serious mental illness and substance use disorders. Certainly, there are times when people have intersecting needs of both a mental illness (SMI) and/or a substance use disorder (SUD), and a developmental disability. Professionals screening for service within behavioral health will assess for behavioral health disorders first to determine if a member meets the qualifications for specialty mental health. Therapist who are treating people who have both a developmental disability and a SMI/SUD need the proper training to best understand and support their clients.

Your recommendations have been provided to our Workforce Education and Training manager around training needs.

BHC Recommendation: The BHC recommends continued training around workforce development in the MHSA Annual Update FY 25/26 that includes working with members who have developmental and physical disabilities.

2. **Comment:** Speaker shares their appreciation for the support they've received from a service center, highlighting how kind and helpful the staff are, including janitors and security. They mention starting their journey with the program at age 19 and now, at 25, they're surprised by how far they've come. They've received assistance with therapy and feel grateful for the resources provided, such as group activities and food. One of their main challenges is transportation, as they need a vehicle to access services. Despite personal struggles, including the recent loss of a friend, they express gratitude for the support and are trying to help others in return.

Response: Thank you for your personal testimony and telling your story. Lived experience is like a concentric circle that touches everyone you meet to the power of your journey, including therapy and behavioral health care. You are an inspiration even on the days when it might not feel like it.

BHC Recommendation: The BHC recommends sustaining TAY programs in the MHSA Annual Update FY 25/26.

3. **Comment**: Speaker affiliated with RUHS and H Housing, expresses gratitude for the support he has received through The Place [permanent supportive housing and homeless outreach center] and related services. He introduces himself as the founder of H Deep and shares the origins of a creative recording program developed in partnership with RUHS and local mental health clinics. This initiative, showcased at Stepping Stones TAY Center, offers a creative outlet for individuals with mental health challenges and has had a positive impact by empowering participants to express themselves. Speaker emphasizes the importance of recognizing the program's originators and advocates for its expansion across Riverside County to support more adults and children through creative expression.

Response: Thank you for your compelling testimony and your commitment to promoting artistic expression as a form of healing and empowerment. Art has long been a therapeutic tool to aid in discovery, expression, and tangible evidence of self-efficacy.
Expansion of any program is dependent on demand, availability, and costs. Your recommendation of expansion has been provided to the Deputy over Children and TAY services.

BHC Recommendation: The BHC encourages Department services and programs to integrate art therapy and artistic expression into service choices for members who want art as part of their treatment planning.

4. **Comment:** Speaker shares a personal story about growing up in Riverside County after losing her parents at a young age. Her mother's best friend, Barbara, went to school to become a massage therapist to help care for Speaker and her siblings. Speaker reflects on

the challenges of growing up without parental support and how it affected her and others in similar situations. She expresses gratitude for the support available in Riverside today, saying it's easier and safer than it was for her parents, thanks to the services provided. She believes those services help people give back and make a positive impact in the community.

Response: Thank you for your sharing your personal story of grief, challenges, discovery, and empowerment. Your gratitude is heard. You are a living example of the strength that develops from our own commitment, the right services, and unconditional support of those who believe in you. You are one of people who gives back and makes a positive impact on the community.

BHC Recommendation: The BHC recommends sustaining outreach and services to children, parents, and families in the MHSA Annual Update FY 25/26.

5. **Comment:** Speaker, who identifies as part of the Asian and Pacific Islander (API) community, thanks the group for the opportunity to speak and emphasizes the importance of early intervention for developmental concerns like autism within the API population. They highlight unique challenges such as cultural stigma, language barriers, and lack of culturally appropriate services, which can lead to underdiagnosis or misdiagnosis. They advocate for early prevention models that lead to better long-term outcomes and inclusive care, stressing the need for services that respect and reflect cultural differences. They express gratitude for the meeting and the chance to share their perspective.

Response: Thank you for sharing your story and your unique insights regarding the intersection of need, stigma, culture, language, and healing. Culturally informed care across all levels of care – Prevention and Access, Early Intervention, Outpatient, Full Service Partnership, Crisis Services, Residential, Acute Hospital Care, and Long Term Care – is essential.

BHC Recommendation: The BHC recommends sustaining cultural informed outreach and informed services in the MHSA Annual Update FY 25/26.

6. **Comment:** A representative from the Inland Chinese American Alliance speaks on behalf of their organization, which primarily serves seniors in the AAPI community, emphasizing their vulnerability and underrepresentation. They stress the importance of prevention and early intervention, particularly for seniors, noting its effectiveness before and after the pandemic. They share an inspiring story about seniors forming their own safety groups in Northern California. The speaker highlights that prevention is more cost-effective and impactful than responding to crises. Citing data showing AAPI individuals make up 1 in 10 residents in the Inland Empire, they urge policymakers to recognize and respond to the specific needs of the AAPI community. They express appreciation for Riverside University Health System's PEI program and Family Advocate

Response: Thank you for your testimony and insight into culturally informed care. Prevention and Early Intervention can be powerful tools in empowerment. The transition from the Mental Health Services Act to the Behavioral Health Services Act will pose some challenges to prevention at the county level. Population based prevention is under the authority of the State, and the State will develop the related programs and services that are offered. How that will look and be implemented remains to be seen but may bring us new opportunities to reach people. We look forward to your continued advocacy as these new programs become more known to our communities.

BHC Recommendation: The BHC recommends sustaining culturally informed outreach and informed services in the MHSA Annual Update FY 25/26.

PUBLIC COMMENTS

FEEDBACK AND PUBLIC COMMENTS

WHICH BEHAVIORAL HEALTH PROGRAMS ARE YOU AWARE OF AND WOULD LIKE TO KEEP?

Overall Message:
Stakeholders emphasize that all current programs are vital and should be maintained.

Peer Support & Family Advocate, PEI, Crisis Services, Urgent Care, Housing, Youth Services, Cultural Competence

- **Peer & Family Support:** Strong backing for peer-led services and family-focused programs.
- **Crisis Services:** Support for 24/7 urgent care, crisis beds, and suicide prevention.
- **Youth Mental Health**: Appreciation for youth programs (e.g., TAY Centers, Wraparound, YHIP, Friday Night Live).
- **Continuum of Care**: Value placed on programs supporting housing, vocational training, and addiction services.
- **Cultural Inclusion:** Endorsement of culturally competent services, LGBTQ+ outreach, AAPI, and calls for better diability accessibility.

WHICH BEHAVIORAL HEALTH PROGRAMS ARE YOU AWARE AND WOULD LIKE TO SEE US TO CHANGE?

- **Expand housing, Access, and Flexibility** with pet access and engaging activities, and improve early access to HHOPE and peer support services.
- **Improve Youth and Vocational Opportunities:** Expand youth programs, vocational training, and programs for creative expression
- **Increase accessibility and inclusion** -Welcoming customer service and timeliness to service, wheelchair access, and culturally informed care

PUBLIC HEARING AND FEEDBACK FORMS

PLAN SATISFACTION



Public Participation Process

- No comments were received during the 30-day public posting from April 1, 2025, to April 30, 2025. As a result, no substantive changes were made to the MHSA Annual Update FY 25/26 based on the 30-day posting.
- All viable comments received during both the in-person and virtual public hearings from May 01, 2025, to May 25, 2025, were reviewed by the Behavioral Health Commission. Each comment and response is documented in this chapter of the MHSA Annual Update 25/26.

RUHS-BH MHSA Annual Prevention and Early Intervention Evaluation Report for the Mental Health Services Oversight and Accountability Commission

Addendum

Riverside University HEALTH SYSTEM Behavioral Health

MHSA

Three-Year Prevention and Early Intervention Evaluation Report

FY 21/22 to FY 23/24

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Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #1
Mental Health Outreach, Awareness, and Stigma Reduction

Asian American/Pacific Islander Mental Health Resource Center (AAPI-MHRC)

Description of Program: Stigma and Discrimination Reduction

The Asian American Pacific Islander Mental Health Resource Center started in FY 2017-2018. The Resource Center provides mental health resources to the Asian American and Pacific Islander populations in Riverside, Perris, Moreno Valley, Menifee, and other surrounding cities with high density of Asian Americans/Pacific Islanders. The Resource Center engages in activities that reduces mental health stigma, increases mental health awareness, connects people with services and community mental health resources, and engages and educates about the signs and symptoms of mental illness within the Asian American community. The type of services provided may include but is not limited to: Community Outreach, Recruitment and Communicating Activities through mail and social media, Information and Referral, Quarterly Mental Health Community Seminars, and Monthly Mental Health Support Groups.

Program Outcomes

For fiscal years 2021-2024, the majority of participants showed high satisfaction (over 90% responded "agreed" or "strongly agreed") with all statements in the satisfaction survey - that the information presented was easy to understand, the presenter was engaging, felt more comfortable to talk about mental health issues with their family and friends, believed mental illness can be managed and treated, felt comfortable seeking help for themselves, and would recommend their friends and families to attend this type of presentation.

Comments from attendees:

- *"There was a lot of opportunities to share, especially the spotlight on how Asian culture adds additional layer of complexity to the conversation. It was very validating and the presenter showed real stance, researched well in current events, provided examples and actionable takeaways of what to try and what to avoid."*
- *"It was very empowering to hear from different generations and their perspectives on mental health. Mental Health is so taboo in Filipino/AAPI cultures so it is encouraging to hear other families to speak openly about it. It is also nice to see older generation of Filipinos be willing to look past cultural traditions/ beliefs/mindsets to better understand their children."*

Counts of Attendees, Presentations, and Demographic Information Completed by Fiscal Year

Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Attendees	155	108	390
# of Presentations	12	9	26
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	11	1	0
Hispanic/Latinx	8	1	20
Black/African American	0	0	0
Asian/Pacific Islander	83	72	198
Native American	0	1	0
Multiracial	5	7	44
Other/Not Reported	48	26	128
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children/Youth (0-15)	1	2	7
Transition Aged Youth (16-25)	18	18	27
Adults (26-59)	58	20	55
Older Adults (60+)	16	26	48
Not Reported	62	42	253
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	16	6	0
Female	77	9	0
Transgender	0	0	0
Other/Not Reported	62	93	390

PEI - Stand Against Stigma (SAS)

Description of Program: Stigma and Discrimination Reduction

Stand Against Stigma is designed to provide anti-stigma presentations to individuals and organizations by specifically outreaching and collaborating with schools, businesses, community organizations, and faith-based organizations throughout the county to bring presentations to as many people as possible. “Stand Against Stigma” presentations are utilized to educate and outreach to target audiences to share the unique stories of those with mental illness with the aim of reducing stigmatizing attitudes. Presentations are evidence-supported and structured to discuss mental health through presenters sharing their lived experience with mental health challenges and including an ‘on-the-way-up’ message to discuss strengths and recovery because of services, supports, and/or treatment. Presentations are aimed at reaching the following target audiences: community members, employers, landlords/housing officials, health care providers, other government-related entities, faith -based communities, and media.

Program Outcomes

For fiscal years 2021-2024, statistically significant improvements suggest that the "Stand Against Stigma" presentations were effective in positively shifting attendees' perceptions of individuals with mental health conditions, increasing their belief in recovery and empowerment, and enhancing the likelihood of attendees seeking help when facing anxiety and/or depression. Majority of participants (87.6%) reported positive feedback.

Comments from attendees:

- “Great job ! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone.”
- “Thank you to [facilitator] and [facilitator] for sharing your stories. Thank you for still being here, and congrats on the work you have done so far. I hope the best for the work ahead.”
- “Your honesty and vulnerability are appreciated. Thank you for your time. “

Counts of Attendees, Presentations, and Demographic Information Completed by Fiscal Year

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Attendees	470	200	248
# of Presentations	25	16	14
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	141	91	93
Hispanic/Latinx	82	67	74
Black/African American	24	7	9
Asian/Pacific Islander	10	1	1
Native American	2	0	0
Other/Unkn/Multi-Racial	200	101	219
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children/Youth (0-15)	0	0	0
Transition Aged Youth (16-25)	14	9	12
Adults (26-59)	147	85	93
Older Adults (60+)	23	7	3
Not Reported	194	99	140
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	28	12	37
Female	161	89	73
Transgender	0	1	0
Other/Not Reported	189	98	138

PEI – Promotores(as) de Salud Mental y Bienestar Program

Description of Program: Outreach

In partnership with the agency Vision y Compromiso, the Promotores(as) de Salud Mental y Bienestar program trained lay workers community (promotors) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early intervention services in the Hispanic/Latinx community. The selected promotors from the program go through a 40 hour training in which they are educated on topics in mental health and given a list of culturally competent local resources. Promoters then provide 1-hour presentations on mental health topics in locations such as schools/universities, libraries, coffee shops, local churches and other community locations. Participants were informed about these presentations through various community outreach methods which included tabling, social media, fliers, and reaching out to key community leaders at planning meetings.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (duplicated)	7,164	5,350	11,862
# of Presentations	1,799	1,399	3,476

Outcomes Evaluation

In all three fiscal years, the majority of participants agreed or strongly agreed with the following statements: I felt comfortable seeking help and getting resources, I could talk about the topic with family and friends, I got a better understanding of mental health issues, I they had a good experience with the promoter.

- "*The pandemic greatly impacted our mental health, it is important to talk about this.*" *(FY21/22)*
- "*There is always a light at the end of the tunnel and there is always an out and a long journey ahead." (FY22/23)*
- "*Learned that a mental challenge can be at any age, social level and does not discriminate." (FY23/24)*

Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	68	30	84
Hispanic/Latinx	6,976	5,220	11,633
Black/African American	0	0	23
Asian/Pacific Islander	0	0	7
Native American	0	0	3
Other/Unkn/Multi-Racial	121	100	112
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	0	0	167
Transition Aged Youth (16-25)	878	707	1,808
Adults (26-29)	4,742	3,113	6,990
Older Adults (60+)	1,515	1,452	2,865
Not Reported	29	78	32
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	2,012	3,758	8,020
Female	5,063	1,512	3,720
Transgender	0	0	6
Unknown/Other	89	80	116

PEI – CMHPP Native American

Description of Program: Outreach

The ethnically and culturally specific Community Mental Health Promoters Program trains lay workers in the community (promotors) to outreach to their communities, bring awareness to mental health topics, reduce stigma, and provide resource referrals to prevention and early intervention services. MHSA-PEI partnered with Riverside/San Bernardino County Indian Health Inc. The organization advocates on behalf of the Native American through the delivery of quality health care services, which honor spiritual and cultural values. The selected promotors from the program go through a 40 hour training in which they are educated on topics in mental health and given a list of culturally competent local resources. Promoters then provide 1-hour presentations on topics on mental health in locations such as schools/ universities, libraries, coffee shops, recreation centers and tribal offices. Participants were informed about these presentations through various community outreach methods which included tabling, social media, fliers, and reaching out to key community leaders at planning meetings.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	1,169	926	961
# of Presentations	125	132	143

Outcomes Evaluation

A majority of participants agreed or strongly agreed with all statements in a satisfaction survey—that they felt able to find help and get resources, that they could share the information with family and friends, and that they got a better understanding of mental health issues in a culturally relevant way.
Things participants found helpful included:

- *"Talking about types of bullying and what I can do to help".*
- *"It brings awareness and helps other people understand where others are coming from."*
- *"Making me more comfortable to talk about depression with my friends and family."*

Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	14	7	19
Hispanic/Latinx	54	17	52
Black/African American	8	3	4
Asian/Pacific Islander	1	8	6
Native American	1,054	848	553
Other/Unkn/Multi-Racial	38	43	327
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	302	194	140
Transition Aged Youth (16-25)	341	435	536
Adults (26-29)	477	224	235
Older Adults (60+)	4	31	38
Not Reported	45	42	12
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	380	329	354
Female	744	484	595
Transgender	2	2	0
Unknown/Other	43	111	12

PEI – CMHPP Black/African American

Description of Program: Outreach

The ethnically and culturally specific Community Mental Health Promoters Program trains lay workers in the community (promotors) to outreach to their communities, bring awareness to mental health topics, reduce stigma, and provide resource referrals to prevention and early intervention services. MHSA-PEI partnered with the Black/African American Health Coalition, who is a group of healthcare and mental health medical advocates passionate about serving the community with the best free and low cost quality resources. The selected promotors from the program go through a 40 hour training in which they are educated on topics in mental health and given a list of culturally competent local resources. They provide 1-hour presentations on topics on mental health in locations such as a consumer's residence, or at public locations such as parks, community centers, churches, bus stops and store fronts.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	1,235	1,073	N/A
# of Presentations	408	371	N/A

Outcomes Evaluation

Majority of participants strongly agreed with all statements in the satisfaction survey, indicating they felt confident in seeking help and finding resources, and that they can share the information with family and friends. They felt they got a better understanding of mental health issues, and had a great experience with the promoter.

- *"The promotor was very informational. She was confident in what she was teaching and gave all the proper resources."*
- *"Gave me the confidence to talk more about mental health"*
- *"It was helpful to know where I can get help"*

Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	15	11	N/A
Hispanic/Latinx	70	41	N/A
Black/African American	1099	1009	N/A
Asian/Pacific Islander	11	1	N/A
Native American	2	1	N/A
Other/Unkn/Multi-Racial	38	10	N/A
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	151	68	N/A
Transition Aged Youth (16-25)	257	169	N/A
Adults (26-29)	632	601	N/A
Older Adults (60+)	168	229	N/A
Not Reported	27	6	N/A
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	527	402	N/A
Female	639	659	N/A
Transgender	8	3	N/A
Unknown/Other	61	9	N/A

PEI – CMHPP Asian American/Pacific Islander

Description of Program: Outreach

The ethnically and culturally specific Community Mental Health Promoters Program trains lay workers in the community (promotors) to outreach to their communities, bring awareness to mental health topics, reduce stigma, and provide resource referrals to prevention and early intervention services. MHSA-PEI partnered with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), specializing in culturally sensitive approaches to address the social and psychological needs of Asian and Pacific Islander communities. The selected promotors from the program go through a 40 hour training in which they are educated on topics in mental health and given a list of culturally competent local resources. Promoters then provide 1-hour presentations on topics on mental health in locations such as schools/universities, libraries, coffee shops, local churches and other community locations. Participants were informed about these presentations through various community outreach methods which included tabling, social media, fliers, and reaching out to key community leaders at planning meetings.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	536	407	771
# of Presentations	66	61	47

Outcomes Evaluation

A majority of participants agreed or strongly agreed with all statements in a satisfaction survey - indicating that most participants agreed with the statements on seeking help and finding resources, being able to talk about the presentation topic with friends and family, and having a better understanding of mental health issues.

Things participants found helpful included:

- *"Learned different ways to cope with stress."*
- *"A warm and welcoming space was created to allow us to be vulnerable and open."*
- *"The mindset to think about things again and make an effort to put into practice."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	28	26	30
Hispanic/Latinx	24	16	42
Black/African American	2	4	4
Asian/Pacific Islander	474	314	600
Native American	1	1	2
Other/Unkn/Multi-Racial	163	62	86

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	81	67	55
Transition Aged Youth (16-25)	132	119	226
Adults (26-29)	270	110	208
Older Adults (60+)	53	109	269
Unknown	132	2	13

Gender	FY 21/22	FY 22/23	FY 23/24
Male	176	130	258
Female	349	257	495
Transgender	0	1	2
Unknown/Other	143	19	45

CMHPP Lesbian Gay Bisexual Transgender Questioning/Queer (LGBTQ+)

Description of Program: Outreach

MHSA-PEI partnering with Borrego Health, trained lay workers in the community (promoters) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early Intervention services for the Lesbian Gay Bisexual Transgender Questioning/Queer+ community. The selected promotors from the program go through a 40-hour training in which they are educated on mental health topics and provided a list of culturally competent local resources. They conduct 1-hour presentations on a variety of mental health topics in locations such as a consumer's residence, or at public locations such as community centers, bus stops, and store fronts. After a presentation, participants are encouraged to complete a satisfaction survey which asks about their satisfaction with the promoter, presentation content, and their confidence in talking about and seeking help for their mental health. They are asked on a scale of 1-5 (1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree) about how much they agreed with the statements in the survey. Surveys of people who attended more than one presentation were included as they may have had a different experience each time.

Outcomes Evaluation

For FY 21/22, 331 participants completed a survey and for FY 22/23, 348 participants completed a survey. In both fiscal years, a majority of participants agreed with the following statements in the survey: they felt comfortable seeking help and getting resources, they could talk about the topic with family and friends, they got a better understanding of mental health issues, and they had a good experience with the promoter. Unfortunately, the CMHP LGBTQ+ Program did not have a provider for FY 23/24.

Comments from attendees:

- "The way it was for LGBTQ specific resources"
- "I now know how to get treatment for my mental illness"
- "I had a hard time talking to family and friends but I know now that I shouldn't be scared or ashamed"
- "I am going to seek help for my self in order to not stay depressed. Thank you very much."
- "It's given me a truly thorough list of helpful resources in our area."

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	286	342	n/a
# of Presentations	43	34	n/a
Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	115	135	n/a
Hispanic/Latinx	116	101	n/a
Black/African American	25	23	n/a
Asian/Pacific Islander	8	17	n/a
Native American	2	1	n/a
Other/Unkn/Multi-Racial	20	65	n/a
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	47	50	n/a
Transition Aged Youth (16-25)	64	37	n/a
Adults (26-29)	61	30	n/a
Older Adults (60+)	109	174	n/a
Not Reported	5	51	n/a
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	111	87	n/a
Female	136	202	n/a
Transgender	29	2	n/a
Nonbinary	8	6	n/a
Unknown/Other	2	45	n/a
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual	105	67	n/a
Not LGB/Not Reported	181	275	n/a

CMHPP Middle Eastern/North African (MENA)

Description of Program: Outreach

MHSA-PEI partnering with Sahaba Initiative, trained lay workers in the community (promoters) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early Intervention services for the Middle Eastern/North African community. The selected promotors from the program go through a 40-hour training in which they are educated on mental health topics and provided a list of culturally competent local resources. They conduct the 1-hour presentations on a variety of mental health topics in locations such as a consumer's residence (in-person and virtually), or at public locations such as community centers, schools, colleges/ universities, and store fronts.

Program Outcomes:

Sahaba Initiative started their contract approximately halfway through FY 23/24 and were able to establish an office location in the Riverside area and hire two full-time staff to serve in the Western and Mid-County regions of the county. During their first six months, they were able to have both staff complete their 40-hour promoter training to be able to provide culturally tailored presentations to the Middle Eastern/North African community.

The program director had a very positive experience training the community mental health promoters and preparing them for program implementation in the community. The promoters were highly engaged throughout the training days and asked thoughtful questions to help deepen their understanding of the material. Additionally, the promoters demonstrated great skill when presenting the material back during practice presentations, not only when it came to presentation style and presence, but also in conveying the relevant information appropriately and accurately.

After completion of their 40 hour training, promoters participated in a survey in which they rated their agreement with statements on a scale from 1-5 (1-strongly disagree to 5-strongly agree). The promoters strongly agreed that the trainings were effective and helpful in their development as a promoter. They are confident in their knowledge of mental health, their ability to work with the community, and answer questions on mental health issues in a culturally competent way.

PEI – Applied Suicide Interventions (ASIST) Workshops

Description of Program: Suicide Prevention

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and community members may be the first to encounter an at-risk individual, but have little or no training to help. ASIST emphasizes the importance of learning suicide first-aid to keep at-risk individuals safe and to seek further help if needed. ASIST also helps individuals in formal helping roles with professional development so that they are better prepared to perform suicide first aid help when providing care to others. After completing ASIST, participants will know how to use a suicide intervention model to identify individuals with suicidal thoughts and develop a safety plan with them.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	166	279	314
# of Trainings	8	14	19

Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	134	199	42
Hispanic/Latinx	94	156	124
Black/African American	10	15	35
Asian/Pacific Islander	3	14	8
Native American	0	0	3
Other/Unkn/Multi-Racial	18	50	101

Outcomes Evaluation

At the end of ASIST, all participants are encouraged to complete a feedback survey which includes questions about the overall course, how ASIST is helpful to them or others. Things participants found helpful included:

- *"The training was very smooth and informative. Presenters engaged all and did well. I liked learning the PALS."*
- *"I felt it was very beneficial for my life and future profession."*
- *"ASIST was a fun and helpful training. The guidance and experience obtained is invaluable to me personally and professionally."*

Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	14	37	25
Adults (26-29)	144	196	208
Older Adults (60+)	4	3	10
Unknown	4	43	71

Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	22	48	44
Female	141	208	198
Transgender	0	1	1
Unknown/Other	3	22	71

PEI – SafeTALK Workshops

Description of Program: Suicide Prevention

SafeTALK is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. SafeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all SafeTALK trainings. This program provides gradual exposure to practice actions and to help participants understand how false societal beliefs can cause otherwise caring and helpful people to miss, dismiss, or avoid warning signs of suicide. Additionally, 'Safe' stands for 'Suicide Alertness For Everyone' and 'TALK' stands for 'Tell, Ask, Listen, and KeepSafe'. This program helps participants practice the TALK step actions in overcoming these barriers.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	59	341	503
# of Trainings	3	19	31

Outcomes Evaluation

All safeTALK participants are asked to complete a feedback form at the end of the training presentation to complete their training.

Things participants found helpful included:

- *"This training helped my school community to not be afraid and it [the training] will help them build capacity within their role."*
- *"Going over the slides and having the videos were helpful to understand the steps. Resource are also very helpful and useful to provide to others who are in need."*
- *"Very informative, kept my attention & was engaging which made it more comfortable to speak out & participate."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	34	226	78
Hispanic/Latinx	22	138	228
Black/African American	10	29	57
Asian/Pacific Islander	10	33	52
Native American	0	6	2
Other/Unkn/Multi-Racial	4	45	85

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	9	110	106
Adults (26-29)	41	198	320
Older Adults (60+)	9	23	44
Unknown	0	10	33

Gender	FY 21/22	FY 22/23	FY 23/24
Male	11	133	130
Female	48	192	330
Transgender	0	3	4
Unknown/Other	0	10	39

PEI – Know the Signs

Description of Program: Suicide Prevention

Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: "Know the signs. Find the words. Reach out." This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources. The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi and Russian. There are also print ads, TV and radio spots, and online ads available for the public. At the end of each presentation, everyone is encouraged to download the mobile application to help connect at -risk individuals to a supportive network.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	493	141	108
# of Trainings	37	17	17

Outcomes Evaluation

At the end of a Know the Signs training, participants are asked to complete a feedback survey via Google Forms to further understand how participants felt and thought about the training.

Things participants found helpful included:

- *"Excellent. I appreciate the language provided to direct these difficult conversations."*
- *"Wonderful training! Enjoyed the interactive nature of the training. Great resources were provided. The scenarios were a great way to have staff practice and be more comfortable with having conversations regarding suicide."*
- *"Very informative and concise information that can help empower people to intervene with appropriate resources when warning signs are presented."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	355	96	22
Hispanic/Latinx	228	71	48
Black/African American	24	10	10
Asian/Pacific Islander	19	9	10
Native American	3	0	3
Other/Unkn/Multi-Racial	91	26	15

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	28	23	12
Adults (26-29)	317	89	61
Older Adults (60+)	36	6	34
Unknown	112	23	1

Gender	FY 21/22	FY 22/23	FY 23/24
Male	93	26	22
Female	384	111	81
Transgender	2	1	0
Unknown/Other	14	3	5

PEI – Mental Health First Aid (MHFA) - Adult and Youth Courses

Description of Program: Suicide Prevention

The Mental Health First Aid (MHFA) program is an 8-hour long interactive session and can be conducted in three different ways: one-day 8-hour seminar, two-day 4-hour seminar, or a four-day 2-hour seminar. The program covers risk/protective factors, warning signs of mental health problems, prevalence data, stigma, assessment, intervention, and how to connect individuals in crisis with appropriate care. Additionally, the MHFA program provides evidence-based professional, peer, social, and self-help resources for individuals with a mental health illness. For specific target populations, there are two courses that are offered for training and certification, the Adult MHFA and the Youth MHFA (YMHFA). Each certification must be renewed every three years.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served (unduplicated)	33	217	225
# of Trainings	3	16	17

Outcomes Evaluation

Individuals reported that they strongly agree that there was an adequate opportunity in practicing their skills that they learned from the training.

Things participants found helpful included:

- *"I appreciated reading closely about a disorder and sharing findings with the group." "Thank you for the examples on how we may respond to specific situations."*
- *"Very friendly, warm, welcoming, supportive and awesome!"*
- *"Knowing how to approach & speak to someone in crisis."*
- *"Loved both instructors, both of their styles went well together. I appreciate how realistic they are too. Thank you."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	23	88	79
Hispanic/Latinx	18	96	145
Black/African American	6	23	23
Asian/Pacific Islander	0	11	7
Native American	0	5	6
Other/Unkn/Multi-Racial	4	89	109

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	0	38	61
Adults (26-29)	30	134	150
Older Adults (60+)	2	17	6
Unknown	1	28	8

Gender	FY 21/22	FY 22/23	FY 23/24
Male	8	58	81
Female	22	139	137
Transgender	0	0	0
Unknown/Other	3	20	6

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #2
Parent Education and Support

PEI – Triple P (2-12)

Description of Program: Prevention

Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The service delivery method for this implementation of Level 4 Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Triple P throughout Riverside County.

Participant Service and Completion Rates

	FY 21/22	FY 22/23	FY 23/24
Total Enrolled	324	232	542
Total Completed	263 (81.2%)	203 (87.5%)	438 (80.8%)

Note: Completion is defined as attending at least 6 out of 8 sessions, missing no more than one phone session, and not missing the first session.

Outcomes Evaluation

- Positive parenting practices increased, and inconsistent discipline practices decreased, as indicated by the APQ measure
- Parents experienced a decrease in their depression, anxiety and stress levels as indicated by the DASS-21 measure
- The ECBI measure showed decreases in frequency of children's disruptive behaviors and parents reported fewer behaviors as problematic

Satisfaction

A majority of participants were highly satisfied with all aspects of the Triple P program including program logistics, quality of group leaders and overall with the program. Below are some comments:

- *"I learned to praise! the power of praising is definitely a great way to be a positive parent & encourage the behavior we want our children to follow."*
- *"I liked meeting all of the parents in class. Sharing our experiences and helping each other through the process."*
- *"I learned new techniques to approach our problems and to give myself some grace."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	37	37	85
Hispanic/Latinx	238	158	350
Black/African American	20	12	47
Asian/Pacific Islander	10	7	15
Native American	3	2	5
Other/Unkn/Multi-Racial	16	16	40

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	19	11	35
Adults (26-29)	304	215	491
Older Adults (60+)	0	4	12
Unknown	1	2	4

Gender	FY 21/22	FY 22/23	FY 23/24
Male	42	38	110
Female	282	194	431
Transgender	0	0	0
Unknown	0	0	1

PEI – Teen Triple P

Description of Program: Prevention

Teen Triple P aims to promote positive, caring relationships between parents and their teens, and to help parents develop effective management strategies for dealing with a variety of teen behavior problems and common developmental issues. The service delivery method for this implementation of Level 4 Teen Triple P is a series of group parenting classes with active skills training focused on acquiring knowledge and skills. The program is structured to provide four initial group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group. Following the initial series of group sessions, parents receive three follow-up telephone sessions to provide additional consultation and support as parents put into practice the skills learned in group. The group then reconvenes for the eighth and final session. The Carolyn Wylie Center, a well established Community-Based Organization (CBO), was contracted to provide Level 4 Teen Triple P throughout Riverside County.

Participant Service and Completion Rates			
	FY 21/22	FY 22/23	FY 23/24
Total Enrolled	126	58	144
Total Completed	99 (78.6%)	42 (72.4%)	121 (84%)

Note: Completion is defined as attending at least 6 out of 8 sessions, missing no more than one phone session, and not missing the first session

Outcomes Evaluation

- Teen problem scores in areas of emotional, conduct, hyperactivity and peer problems decreased as indicated by the SDQ measure. Prosocial skills scored increased
- Increase in parent involvement and positive parenting and a decrease in poor monitoring practices, as indicated by the APQ
- The CBQ showed a decrease in general conflict between parent and teen

Satisfaction

A majority of participants were highly satisfied with all aspects of the Teen Triple P program including program logistics, quality of group leaders and overall with the program. Below are some comments:

- *"I liked that I got to speak about my situation and get feedback on my situation as well."*
- *"I learned how to work on a behavior contract to encourage a behavior I want to see more often. I learned how to give my daughter time to cooperate and use logical consequences when needed."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	20	12	17
Hispanic/Latinx	85	43	103
Black/African American	7	0	12
Asian/Pacific Islander	2	0	4
Native American	1	1	2
Other/Unkn/Multi-Racial	11	2	6

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	0	0	0
Adults (26-29)	123	56	131
Older Adults (60+)	2	1	5
Unknown	1	1	8

Gender	FY 21/22	FY 22/23	FY 23/24
Male	15	5	23
Female	110	53	121
Transgender	0	0	0
Unknown	1	0	0

PEI Mobile Services/Preschool 0-5 Clinic

Description of Program: Prevention

The Preschool 0-5 Clinic offers mental health services which include PCIT, an evidence-based treatment for young children with behavioral problems. It's conducted through coaching sessions during which the caregiver and child are in a playroom while the therapist is in an observation room watching the caregiver interact with the child through a one way mirror. The caregiver wears a device in the ear through which the therapist provides in the moment coaching skills. The clinic also offers parenting groups and child prosocial skills groups. The clinic also harbors three sprinter vans which are used for providing services at the client's home, school sites, or anywhere that is needed in identified underserved areas as defined by the Prevention and Early Intervention plan. The vans are built with the capacity to hold PCIT sessions, child prosocial sessions and more. For FY 23-24 the vans were not in use as the program was working out the logistics and administrative tasks associated with deploying the vans.

Participant Service and Completion Rates			
	FY 21/22	FY 22/23	FY 23/24*
Total Enrolled	150	233	622

*Note, in 23-24 we included clinic services billed to the clinic RU as well as services billed to the three mobile RUs. FY 21-23 We included only those served by the mobile RUs. This explains the increase in the number of individuals served.

Outcomes Evaluation

All Mental Health Services (including PCIT):
Across all fiscal years combined, a total of 15,145 mental health services totaling 12,686 hours were provided to families.

PCIT Specific Outcomes:
Countywide there was a statistically significant decrease in the frequency of child problem behaviors and in the extent to which caregivers perceived their child's behavior to be a problem. Pre and Post PSI scores showed a statistically significant decrease countywide in parent's stress levels. Overall parents felt more confident in their parenting skills and ability to discipline

In FY 23/24, of the 121 families (242 participants) that closed to PCIT, 29% closed due to completion of one or more phases of treatment. 88% of families had a good or fair prognosis after attending PCIT. 57.4% of families met all or some of the goals set by the family and therapist.

Parent Consultations Outcomes:
Majority of parent consultations resulted in the distribution of parent tip sheets and referrals to PCIT or to Child Pro-Social groups

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	37	20	44
Hispanic/Latinx	37	43	132
Black/African American	6	5	22
Asian/Pacific Islander	0	1	0
Native American	0	0	1
Other/Unkn/Multi-Racial	70	164	423

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	75	101	300
Transition Aged Youth (TAY) (16-25)	0	0	0
Adults (26-29)	75	132	322
Older Adults (60+)	0	0	0
Unknown	0	0	0

Gender	FY 21/22	FY 22/23	FY 23/24
Male	47	67	198
Female	28	34	101
Transgender	0	0	0
Unknown	75	132	323

PEI – Strengthening Families Program (SFP)

Description of Program: Prevention

The Strengthening Families Program (SFP) is a prevention program for families with children ages 6-11. SFP's goals include strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional, and social problems in high-risk children (those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses). The program consists of 14 sessions. Sessions 1-4 focus on parent/youth attachment and bonding; Sessions 5-9, parent/youth communication and family organization; sessions 10-13, parental supervision and building discipline. Each session includes skill-training, activities, group practice, and a meal.

Participant Service and Completion Rates	FY 21/22	FY 22/23	FY 23/24
Total Enrolled	154	127	117
Total Completed	128 (83.1%)	92 (72.4%)	99 (84.6%)

Note: Service counts represent families (not individual participants). Completion is defined as either parent/caregiver attending at least 10 out of the 14 sessions.

Outcomes Evaluation

- Consistent improvement in all dimensions of the APQ, including increases in parental involvement and positive parenting, with a concomitant reduction in inconsistent discipline.
- Consistent improvement in all dimensions of the FRI, with increases in family cohesion, expressiveness, and reduction in conflict—evidence of SFP's strengthening effect on families.

Satisfaction

95% or more of parents/caregivers indicate SFP helped their family very much. Comments often echo an appreciation for the opportunity to learn and engage with other families in a fun, friendly environment.

"My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them."

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	4	7	15
Hispanic/Latinx	169	144	115
Black/African American	4	2	8
Asian/Pacific Islander	2	3	1
Native American	1	0	2
Other/Unkn/Multi-Racial	18	11	3

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	2	2	3
Adults (26-59)	173	154	136
Older Adults (60+)	5	1	2
Unknown	18	10	3

Gender	FY 21/22	FY 22/23	FY 23/24
Male	45	33	31
Female	136	123	111
Transgender	2	0	0
Unknown	15	11	2

Note: Demographics counts represent individual parents/caregivers.

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #3
Early Intervention for Families in Schools

PEI - PEACE4Kids

Description of Program: Prevention

Peace4Kids is a school based program that is designed to improve protective factors for children, teach parents effective communication skills, build social support networks, and empower parents to be the primary prevention advocates in their children's life in a setting that is de-stigmatizing to a lot of families, which is school.

Based on Aggression Replacement Training for middle school students during school with two levels. The program goals are for students to master social skills, school success, control anger, decrease acting out behaviors, and increase constructive behaviors. A parent component is included in the program as well to create social bonding among families.

The impacts of the COVID-19 pandemic essentially de-railed this project. It became clear that the model for implementation we were using was not ideal. In May 2022, this program was released for competitive bid for school districts. Unfortunately, no bids were received. Currently this program is on hold. Peace4Kids was not implemented in fiscal years 2021-2024.

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #4
Transition Age Youth (TAY) Project

PEI – Stress and Your (SAYM)

Description of Program: Early Intervention

Stress and Your Mood (SAYM) is an early intervention for depression program based on the Cognitive Behavioral Therapy (CBT) model, with modifications for transition age youth (TAY). SAYM was developed to improve access to evidence-based treatment for TAY with depressive disorders and sub-clinical depressive symptoms, with referrals given to those in need of medication evaluation with prescribing psychiatrists to ensure continuity of care. SAYM services were provided in both group and individual formats, and were constructed to have three phases: Conceptualization; Skills and application training; and Relapse prevention. Services are low-intensity and time limited, and can be provided in either group or in individual sessions. Outcomes for Depression Symptoms were measured using the Centers for Epidemiological Studies Depression Scale (CES-D) and Clinical Global Impression Improvement Scale (CGI-I). Improvements in participant's overall functioning were measured using either Youth Outcome Questionnaire (Y-OQ-SR®) for participants who were under 18 years old, or Behavioral and Symptom Identification Scale (BASIS-24®) for participants who were at least 18 years old. Post satisfaction surveys were also collected to gather participants' feedback on program.

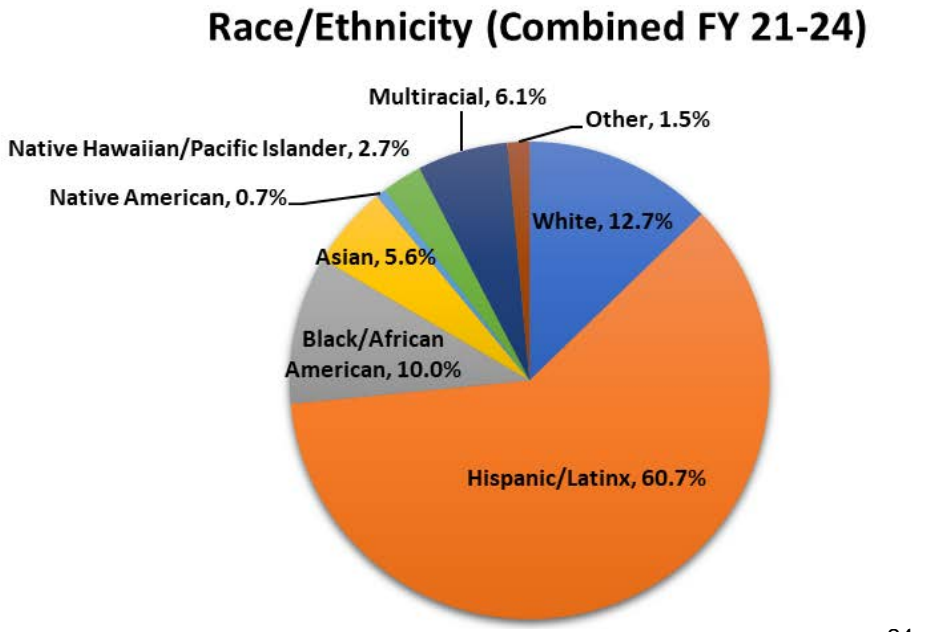
Demographic:

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	23	43	28
Hispanic/Latinx	136	158	154
Black/African American	23	29	22
Asian	13	12	16
Native American	1	3	1
Native Hawaiian/Pacific Islander	19	0	1
Multiracial	0	25	20
Other	5	4	2

Gender	FY 21/22	FY 22/23	FY 23/24
Male	62	69	67
Female	147	190	163
Transgender	10	8	8
Unknown	1	7	6

Sexual Orientation	FY 21/22	FY 22/23	FY 23/24
Lesbian	2	7	6
Gay	4	8	4
Bisexual	26	43	35
Other	31	31	16
Unknown	8	31	0
Not LGBTQI	149	154	183

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	8	31	0
Transition Age Youth (16-25)	212	243	244
Adults (26-59)	0	0	0
Older Adults (60+)	0	0	0
Unknown	0	0	0



PEI – Stress and Your (SAYM)

Completion Rates, Service Delivery, and Program Outcomes:

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	220	274	244
# of Participants Completed	157	204	166
Successfully Completed Treatment Goals	***71%***	***74%***	***68%***

SAYM Service Information			
Type of Service Delivery	**FY 21/22**	**FY 22/23**	**FY23/24**
Individual Assessments	440.25	545.25	203.58
Individual Therapy Sessions	1045.50	1,029.78	806.02
Group Therapy Sessions	974.22	1,088.27	252.50
Non-Family Therapy without Clients	75.75	183.05	0
Case Management/Crisis Intervention	0	0	186.17
Total Hours Provided	**2,535.72**	**2,846.35**	**1,448.27**

Program Outcomes			
Percent Change in Average Total Scores from Pre to Post	**FY 21/22**	**FY 22/23**	**FY23/24**
CES-D (%)	41%	31%	24%
CGI-I (%)	29%	40%	37%
Y-OQ-SR® (%)	19%	20%	20%
BASIS-24® (%)	27%	30%	31%

The Program Outcomes only show results from SAYM participants who completed the SAYM Program entirely, and have completed the Pre and Post measures.

- Overall, results from CES-D showed that on average, participants' depression symptoms improved after participating and completing the SAYM Program.
- In CGI-s, the average scores of SAYM participants were compared from Pre (Module 1) to Post (Module 3) of those who completed the program. Clinicians also rated the participants halfway through the program, and the results were compared. Overall, the results suggested that those who completed the SAYM Program entirely had showed more significant improvements compared to those who only completed the program partially.
- Y-OQ-SR® results were based on SAYM participants who were under 18 years of age, have completed the Pre and Post measures, and have completed the SAYM Program entirely. Overall, the results suggested that participants have shown reductions in the general level of distress, consistent with the results of CES-D analysis.
- BASIS-24® results were based on SAYM participants who were at least 18 years of age, have completed the Pre and Post measures, and have completed the SAYM Program entirely. Overall, the average total weighted scores were already low at intake, and although the sample size was relatively small, participants still showed improvements after completing the SAYM program.

PEI – Stress and Your (SAYM)

Satisfaction Surveys:

From Fiscal Years 2021 to 2024, the post-satisfaction survey results from SAYM participants showed generally high satisfaction, where at least two-thirds of the participants responded either "Agreed" or "Strongly Agreed" to all of the survey statements as shown on table below. It is also shown that 93% or more participants felt that the "***SAYM counselors listened to what they had to say***", and that "***The SAYM counselors knew how to help them***".

Comments from participants:

- *"I liked that this program was interactive between instructor and group. Being in a group setting helped me get more comfortable about speaking up and answering questions out loud. Knowing that others could relate was also nice. I also liked meeting new people I would not have if not for the program. The program was also very straight to the point."*
- *"I loved how the counselor made everyone feel included and listened to what everyone had to say. I liked that this program gave me different ways on how to cope with a variety of things and that all resources were provided."*
- *"I liked how every topic was relatable to my life and benefited me. I was able to apply the things I learned directly to my life which was great. My therapist was amazing and always made me feel comfortable and validated throughout the program. I also liked the flexibility of being able to schedule an appointment that accommodates my schedule.*
- *"I learned how to manage stress, different kinds of research, and learning to respond to things in a positive way. I also learned how to deal with depression, and how to respond quickly to certain situation in order for me to communicate."*
- *"I learned how important it is to take care of ourselves physically and mentally, especially the breathing techniques, exercises, and how to relax our minds.*

Stress and Your Mood (SAYM) Satisfaction Survey Results			
Survey Statements	**FY 21/22**	**FY 22/23**	**FY 23/24**
1. Participation in SAYM Program reduced my depression symptoms	73%	70%	69%
2. As a result of participating in the SAYM program, I now know how to obtain help for depression	85%	84%	86%
3. I learned strategies to help me cope with stress	91%	87%	86%
4. The SAYM program helped me to understand myself better	84%	75%	79%
5. The SAYM program has prepared me to cope with stress if something difficult happens to me in the future	92%	86%	83%
6. If I needed help again, I would return to the SAYM program	94%	92%	90%
7. I achieved my goals for the SAYM program	68%	65%	68%
8. The counselor listened to what I had to say	96%	98%	93%
9. The counselor knew how to help me	96%	96%	94%

Note: percentage results are calculated based on participants who responded "Strongly Agree" and "Agree" on survey statements above.

Peer-to-Peer

Description of Program: Prevention

Riverside University Health System - Behavioral Health (RUHS-BH) is contracted with Operation SafeHouse to provide specific activities designed to reach transition age youth (TAY) - defined as youth between the ages of 16 and 25 years old. Specific target populations within TAY include homeless, foster or former foster, transitioning to college, and LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals. The Peer-to-Peer program is designed to provide formal outreach, informal counseling, and support/informational groups to at-risk youth and families. Additionally, the program is designed to educate the public about mental health, depression, and suicide, while also working to reduce stigma towards mental illness among TAY individuals who are considered to be at high-risk. The program outreaches to Gay/Straight Alliances, social services agencies, and the community-at-large, in order to organize and facilitate small and large TAY group presentations and discussions to local community-based locations, school districts, and college campuses, with activities that include Directing Change outreach and workshops, Speaker's Bureau presentations, LGBTQ+ support groups, a Peer Mentoring program, and Coping and Support Training (CAST).

- Directing Change workshops are aimed to emphasize the importance of understanding the signs and symptoms of mental health and suicide, and developing a story in a digital public service announcement (PSA) format to promote that understanding and participation in submitting PSAs to the state Directing Change program.
- Speaker's Bureau presentations are utilized to educate and outreach to at-risk TAY, caregivers, educators, and TAY service providers on the unique issues that at-risk TAY experience as it relates to mental health and interpersonal issues, with the aim of reducing stigmatizing attitudes.
- LGBTQ+ support groups are provided by trained peers based on the My Identity My Self (MIMS) curriculum.
- The Peer Mentoring program is utilized to encourage and monitor progress with individualized goal setting through one-on-one interactions with a peer mentor.
- Coping and Support Training (CAST) is an evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts. Each CAST group consists of an initial screening session followed by nine (9) sessions facilitated by TAY Peer Youth Specialists.

Peer-to-Peer: Directing Change

Directing Change Service Information Countywide			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Outreach Events	38	42	86
# of Outreach Participants	1,388	1,312	2,782
# of Workshops	6	15	13
# of Workshop Participants	99	351	229
Demographics for Workshop Participants			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	9	13	11
Hispanic/Latinx	70	108	166
Black/African American	10	17	7
Asian/Pacific Islander	2	15	6
Native American	1	1	0
Multiracial/Other/Not Reported	6/1/0	32/2/163	34/0/5
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	65	35	65
Transition Aged Youth (16-25)	33	197	159
Adults (26-29)	0	7	1
Older Adults (60+)	0	0	0
Not Reported	1	112	4
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	40	78	93
Female	53	106	123
Transgender	3	4	3
Nonbinary/Gender Fluid	3	1/4	2/3
Not Reported	0	158	5
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	15	29	30
Not LGB+/Unknown/Not Reported	73/11/0	141/15/166	157/3/39

Outcomes Evaluation

Peer Youth Specialists conduct outreach events throughout the county to inform youth about the state Directing Change program, encourage submissions, and to recruit participants for Directing Change Workshops. The workshops assist students in developing their submissions to the statewide program. For fiscal years 2021-2024 there were 166 outreach events reaching 5,482 people and 34 workshops training 679 people.

Satisfaction surveys were collected at the end of each Directing Change workshop. The satisfaction surveys consist of seven questions, which include four rating questions and three open-ended questions to gather participants' feedback regarding the Directing Change workshop. Participants were asked to rate their experiences using a 5-point Likert Scale, where 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree.

Satisfaction Survey Results for Directing Change Workshops	FY 21/22 (n=99)	FY 22/23 (n=251)	FY 23/24 (n=226)
1. The workshop was a good use of my time.	4.03	4.15	4.03
2. I felt connected and involved in the workshop.	3.71	3.79	3.63
3. I would participate in this workshop again.	3.69	3.77	3.60
4. I would recommend this workshop to a friend.	4.16	4.17	3.98

Participant comments:

- "I liked everything about this workshop. I personally struggle with mental health and hearing it be normalized is really important."
- "I liked how engaged everyone was and the fact the presenters had experiences that related to us."
- "You do a very good job :) these topics are important and sometimes they are not talked about much."
- "I loved this presentation it made me realize that I should start checking up on my loved ones."

Peer-to-Peer: Speaker's Bureau

Program Services:

- In FY 21/22 there were 55 presentations with 1,042 attendees and 780 completed pre- and post-test outcomes measures.
- In FY 22/23 there were 55 presentations with 1,291 attendees and 1,010 completed pre- and post-test outcomes measures.
- In FY 23/24 there were 25 presentations with 429 attendees and 392 completed pre- and post-test outcomes measures.

Participant comments:

- "My point of view on this has changed now that I've heard an impactful story first hand and how people can grow and better themselves."
- "Mental illness is a real thing at times its hard to like try and find an out but no matter how hard we try or I try can't get rid of it but I'm sure it'll be better I have been talking with someone about it they are also struggling as well. We are there for each other. I'm glad you came in today, it was a remembrance to keep going that I'm able to get through it. Thank you both."
- "I admired the overall presentation, felt connected and involved even relieved to just hear the discussion. I wish we would have more presentations in the future."
- "[Presenter's] story really resonated with me. I kinda experience the same thing where I think everyone's watching, I've gotten better, but it still happens occasionally. Hearing her story really opened my eyes about it and made me realize that others perceptions don't really matter. I thank [presenter] for sharing and I plan to get better moving forward."
- "I appreciate the fact you didn't just say "suicide is bad" I like that you explained what helped you and give us the tool that helped you."
- "I always love hearing other LGBT+ stories, especially from adults. It lets me know I too will make it when I grow up, as I see myself in those currently making it."
- "I really enjoyed the presentation :) It is very helpful for teens our age especially seniors since we have a lot ahead of us the stress can be intense at times."

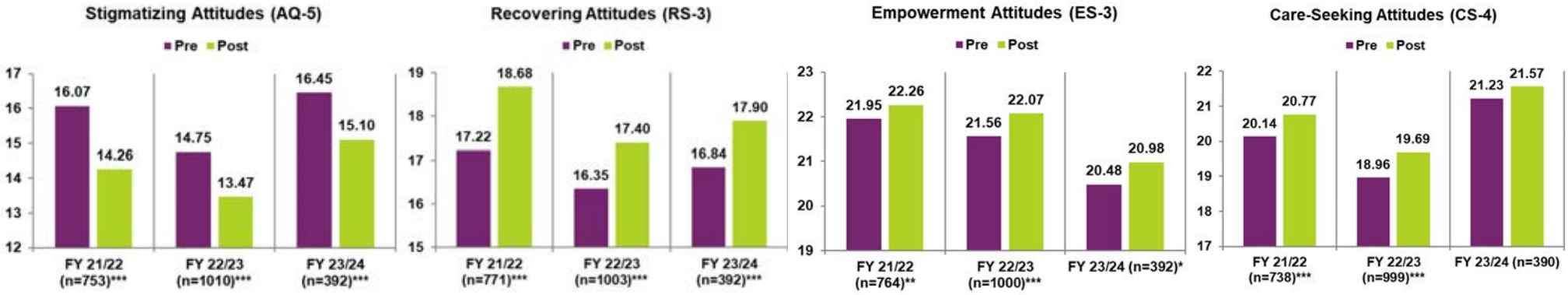
Speaker's Bureau Presentations			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Presentations	55	55	25
# of Participants (unduplicated)	990	1,175	420
Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	106	54	36
Hispanic/Latinx	575	798	306
Black/African American	58	77	14
Asian/Pacific Islander	35	22	14
Native American	9	6	7
Multiracial/Other/Not Reported	113/33/61	73/26/119	20/0/23
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	497	164	66
Transition Aged Youth (16-25)	481	988	337
Adults (26-29)	9	14	1
Older Adults (60+)	0	2	1
Not Reported	3	7	15
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	425	508	195
Female	505	565	192
Transgender	20	7	4
Nonbinary/Gender Fluid	32	27/1	5/6
Not Reported	8	67	18
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	152	69	58
Not LGB+/Unknown/Not Reported	389/47/402	1,106	292/9/61

Peer-to-Peer: Speaker's Bureau cont.

Outcomes Evaluation:

Pre- and post-tests were administered immediately before and after each presentation in order to assess their impact on the attendees. The questionnaire consists of four measures of stigma: Stigmatizing Attitudes (AQ-5), Recovery Attitudes (RS-3), Empowerment Attitudes (ES-3), and Care-Seeking Attitudes (CS-4). An average score for all questions within each of the four questionnaires were computed for pre/post-test comparisons. Higher average scores for the AQ-5 represent greater stigmatizing attitudes, whereas higher average scores on the RS-3, ES-3, and CS-4 represent positive attitudes toward the described constructs. The graphs below depicts the means and paired t-test results for participants who completed pre- and post-test measures. However, not all individuals completed all of the items within the pre-test and/or post-test, thus accounting for less total outcomes within each of the four measures of stigma questionnaire sections. Each of the fiscal years demonstrated meaningful improvements for Stigmatizing, Recovery, and Empowerment Attitudes. In other words, Stigmatizing Attitudes significantly decreased from pre to post whereas Recovery and Empowerment Attitudes increased from pre to post thus suggesting participants' attitudes improved from the presentation. Additionally, Care-Seeking Attitudes increased in all fiscal years but were not statistically significant for fiscal year 2023-2024.

Measures of Stigma	Questionnaire	9-Point Rating Scale
Stigmatizing Attitudes (AQ-5)	Five-item Attribution Questionnaire (AQ-5) assessing participants' cognitive, affective, and behavioral reactions to a person with schizophrenia. *Example:* "I think that most people with mental illness are to blame for their problems"	Score range: 5-45 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Recovery Attitudes (RS-3)	Three-item Recovery Scale (RS-3) assessing participants' attitudes toward people with mental health conditions' capabilities to overcome psychological challenges. *Example: "People with mental illness are hopeful about their future."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Empowerment Attitudes (ES-3)	Three-item Empowerment Scale (ES-3) assessing participants' attitudes about people with mental illness relative to people without. *Example: "I see people with mental illness as capable people."*	Score range: 3-27 1 = 'Strongly Disagree' 9 = 'Strongly Agree'
Care-Seeking Attitudes (CS-4)	Four-item Care Seeking Questionnaire (CS-4) assessing participants' willingness to seek out mental health services if they were experiencing impairing anxiety and/or depression. *Example: "If I were significantly anxious or depressed, I would speak to a mental health professional."*	Score range: 4-36 1 = 'Strongly Disagree' 9 = 'Strongly Agree'



Significance levels: * p ≤ .05, ** p ≤ .01, *** p ≤ .001

Peer-to-Peer: LGBTQ+ Support Groups

Support Groups Service Information Countywide			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Groups	12	11	10
# of Participants	122	95	78
Demographics for Support Group Participants			
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	5	20	11
Female	25	37	37
Transgender	10	16	11
Nonbinary/Gender Fluid	2/9	2/20	9/10
Not Reported	71	0	0
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	37	69	50
Not LGB+/Unknown/Not Reported	2/5/78	13/11/2	20/2/6

Demographics for Support Group Participants cont.			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	7	15	10
Hispanic/Latinx	27	39	50
Black/African American	5	9	7
Asian/Pacific Islander	1	4	4
Native American	0	2	1
Multiracial/Other/Not Reported	7/2/73	25/1/0	5/0/1
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	13	34	7
Transition Aged Youth (16-25)	38	61	71
Adults (26-29)	0	0	0
Older Adults (60+)	0	0	0
Not Reported	71	0	0

Outcomes Evaluation

Peer Youth Specialists facilitate a 10 session support group for LGBTQ+ youth. At the end of each group, attendees were asked to fill out a satisfaction survey to gather feedback on their experience. For fiscal years 21/22 and 22/23 each survey consisted of 10 items while fiscal year 23/24 had a new survey with 11 items, all rated on a 5-point Likert scale, where 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree. In FY 21/22 there were 37 completed surveys, where 92% of participants agreed/strongly agreed participating in the program has been a positive experience, 76% of participants agreed/strongly agreed they learned Emotional Management Skills, and 92% of participants agreed/strongly agreed learning “SELF” skills has been helpful. In FY 22/23 there were 43 completed surveys, where 100% of participants agreed/strongly agreed that participating in this program has been a positive experience, 90% or more participants agreed/ strongly agreed that, staff presentation was engaging, that they feel safe in this group, that they would participate in this workshop again, and that they would recommend this workshop to their friends, 84% of participants agreed/strongly agreed that they learned Emotional Management Skills they could apply in their lives, 81% of participants agreed/strongly agreed that learning “SELF” skills was helpful to them, 79% of participants agreed/strongly agreed that they developed a healthy self-identity that will be useful in the future, 72% of participants agreed/strongly agreed that participating in the program changed how they thought about themselves in a positive way. It is noted that only 67% of participants agreed/strongly agreed that they learned skills to help cope with a loss, while about a fourth (26%) still felt neutral about this statement. In FY 23/24 there were 42 completed surveys, where 74% of participants agreed/strongly agreed that the support group changed how they think about themselves in a positive way, 83% of participants agreed/strongly agreed that learning “SELF” skills was helpful to them, 76% are more aware of their emotional and physical safety, 60% experienced emotional growth, 62% feel more comfortable discussing loss, 79% developed a healthy self-identity that will be useful in the future, 95% of participants agreed/strongly agreed that participating in this group has been an affirming experience for them, 88% of participants agreed/strongly agreed that group topics were engaging, 83% felt that the facilitator helped them feel safe in a group environment, 93% of participants agreed/strongly agreed they would participate in this program again, and 95% would recommend this program to a friend who relates to them.

Peer-to-Peer: Peer Mentoring

Mentoring Service Information Countywide			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Individuals Screened	36	51	51
# of Participants Enrolled	20	27	45
# of Participants Completed	3 (15%)	1 (4%)	26 (58%)
# of Sessions Provided	286	277	391
Demographics			
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	3	1	4
Hispanic/Latinx	12	17	21
Black/African American	3	3	7
Asian/Pacific Islander	0	0	0
Native American	0	1	0
Multiracial/Other/Not Reported	2/0/0	5/0/0	13/0/0
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	3	1	2
Transition Aged Youth (16-25)	17	26	43
Adults (26-29)	0	0	0
Older Adults (60+)	0	0	0
Not Reported	0	0	0
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	6	5	13
Female	12	21	29
Transgender	0	1	1
Nonbinary/Gender Fluid	0/2	0/0	2/0
Not Reported	0	0	0
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	6	12	15
Not LGB+/Unknown/Not Reported	12/2/0	12/2/1	24/2/4

Outcomes Evaluation

In FY 21/22, there were 36 youth screened with 20 enrolled in the peer mentoring program where three completed 25 or more sessions. In FY 22/23, there were 51 youth screened with 27 enrolled in the peer mentoring program where one completed 25 or more sessions. Based on feedback from participants and the provider as well as the outcome measures, it was determined that the length of the program was too long and it was shortened from 32 weeks to 12 weeks. In FY 23/24, there were 51 youth screened with 45 enrolled in the peer mentoring program where 26 completed all 12 sessions. Changing the metric for completion for FY 21/22 results in 10 (50%) mentees completing 12 sessions or more and for FY 22/23 results in 12 (44%) mentees completing 12 sessions or more.

For fiscal years 2021-2024, there were 43 satisfaction surveys collected from mentees. All mentees who completed a survey agreed/ strongly agreed that participating in the program helped them define their goals, their mentor was knowledgeable when sharing information, met them at convenient times/locations, mentors kept their scheduled appointments, and mentees overall were satisfied with the mentoring program.

Participant comments:

- “The most helpful thing was having someone to talk to about stuff that stresses/upsets me and getting good advice from them.”
- “[Mentor’s name] has been an AMAZING mentor, she has always try to be flexible when I needed her to be and has always tried to be here for me. I wouldn’t have chosen any other mentor!”
- “Coping with problems in life. Working on small goals to work my way into big goals.”
- “The most helpful things about the mentoring services that I've received is healthy coping mechanism and healthy communication.”
- “This mentor helped me a lot mentally with school work or outside of school!”
- “Thank you so much, [mentor’s name]!! You have been a light in my life especially in the dark parts of it and I couldn't thank you more for the impact you've left on me :)”

Peer-to-Peer: Coping and Support Training (CAST)

Program Services:

In order to participate in the CAST program, participants first complete a "Demographic, Screening, and Enrollment Form" during a screening session. Eligibility into the program is determined by participant's reported age (fall within TAY ages of 16-25 years), priority population (LGBTQ+, Homeless, Transitioning to college, Foster or former foster youth), and their self-rating scores in the Self-Esteem, Mood, and School sections of the Recognition of Progress (ROP) survey which are embedded into the screening form. If participants score 4 or less on the Mood section of the ROP they may not be appropriate for the CAST program since it indicates that the participant is experiencing high levels of distress so they are asked to complete the Center for Epidemiologic Studies Depression Scale (CES-D) to determine referral into the "Stress and Your Mood," or other appropriate programs.

- For FY 21/22, a total of 117 screenings were completed where 82 were TAY aged individuals and 35 were non-TAY aged individuals or unknown. Of those 117 screenings, 73 attended a group, 24 declined services, one was referred, two did not meet criteria, and 17 were cancelled.
- For FY 22/23, a total of 133 screenings were completed where 120 were TAY aged individuals and 13 were non-TAY aged individuals. Of those 133 screenings, 112 attended a group, 13 declined services, three were referred, and five did not meet criteria.
- For FY 23/24, a total of 95 screenings were completed where 85 were TAY aged individuals and 10 were non-TAY aged individuals. Of those 95 screenings, 83 attended a group, four declined services, none were referred to other programs, and 8 did not meet criteria for participation.

CAST Service Information Countywide			
Type of Service Delivery	**FY 21/22**	**FY 22/23**	**FY23/24**
# of Individuals Screened	117	133	95
# of Participants Enrolled	97 (83%)	121 (91%)	87 (92%)
# of Participants Attended	73 (75%)	112 (93%)	83 (95%)
# of Participants Completed	40 (55%)	65 (58%)	62 (75%)
# of Groups	9	13	11
# of Sessions Attended	386	668	553

Demographics			
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	17	12	2
Transition Aged Youth (16-25)	53	100	81
Adults (26-29)	0	0	0
Older Adults (60+)	0	0	0
Not Reported	3	0	0
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	6	10	11
Hispanic/Latinx	47	70	59
Black/African American	6	14	4
Asian/Pacific Islander	0	4	1
Native American	1	0	0
Multiracial	9	13	7
Other	0	1	0
Not Reported	4	0	1
Language	**FY 21/22**	**FY 22/23**	**FY 23/24**
English	55	94	79
Spanish	7	8	2
Bilingual	6	9	2
Not Reported	5	1/0	0
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	14	33	30
Female	48	73	44
Transgender	1	1	2
Nonbinary/Gender Fluid	0/6	0/5	5/2
Not Reported	4	0	0
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	25	33	26
Not LGB+/Unknown/Not Reported	40/4/4	65/8/6	46/1/10

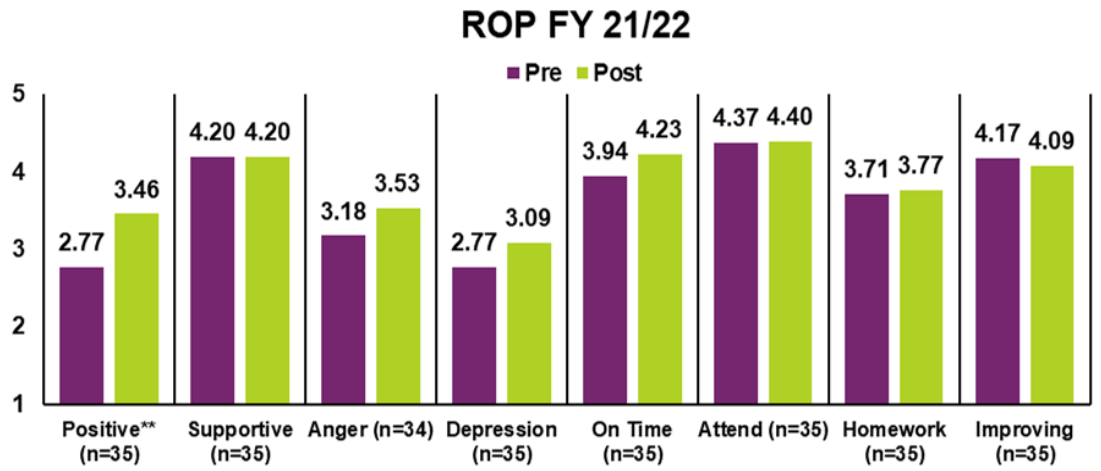
Peer-to-Peer: CAST cont.

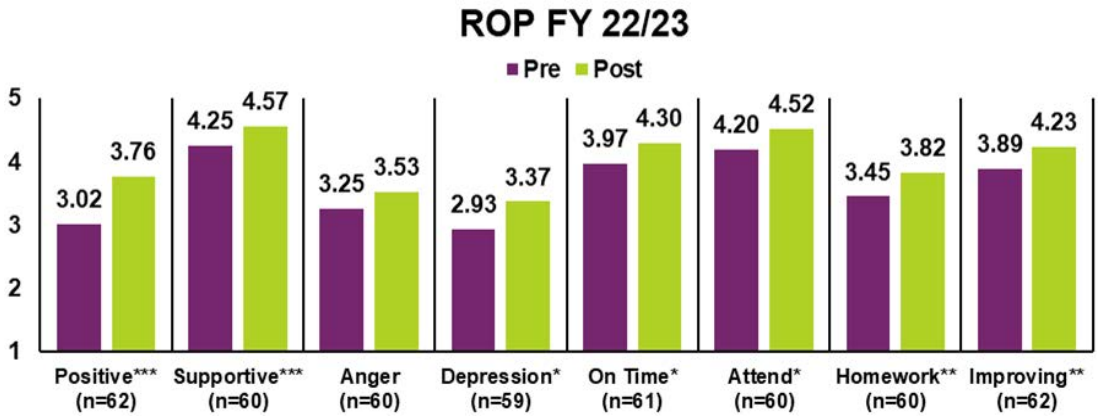
Outcomes Evaluation:
ROP surveys were collected from participants during the initial screening session and the final session, in order to measure participants self rated skills in the following areas: self-esteem, personal control with moods, personal control with school work, and personal control with drug use.

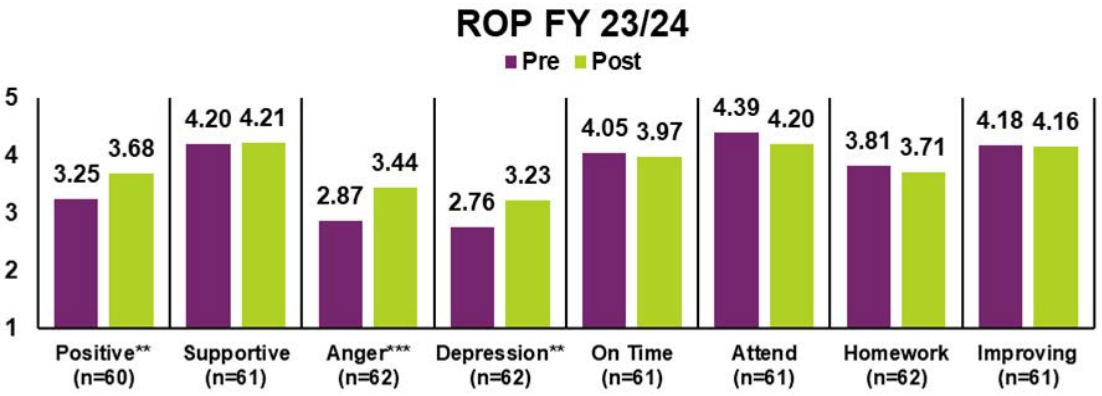
- Self-Esteem:
  - ⇒ Being **positive** with myself, recognizing my strengths
  - ⇒ Praising and being **supportive** of others
- Personal Control - Moods:
  - ⇒ **Anger** - controlling my thoughts, feelings and actions
  - ⇒ **Depression** - getting "unstuck" from negative moods
- Personal Control - School:
  - ⇒ Being **on time** for class
  - ⇒ **Attending** class daily
  - ⇒ Doing my assignments, **homework**
  - ⇒ Working on **improving** my grades, school achievement
- Personal Control - Drug Use:
  - ⇒ Smoking (cigarettes)
  - ⇒ Using Alcohol
  - ⇒ Using Marijuana
  - ⇒ Using other drugs

It is rated on a scale from 1-5, with lower ratings indicating lower frequency and higher ratings indicating higher frequency (1 = never/very rarely, 2 = seldom/sometimes, 3 = about 1/2 the time, 4 = often/typically, and 5 = a lot/always).

- In FY 21/22 there was a statistically significant improvement in participants being positive with themselves and recognizing their strengths.
- In FY 22/23 there was a statistically significant improvement in participants being positive with themselves and recognizing their strengths, praising and being supportive of others, getting “unstuck” from negative moods, being on time for class, attending class daily, doing their homework, and improving their grades.
- In FY 23/24 there was a statistically significant improvement in participants being positive with themselves and recognizing their strengths, controlling their thoughts, feelings and actions, as well as getting “unstuck” from negative moods.







Significance levels: * p ≤ .05, ** p ≤ .01, *** p ≤ .001
Please note that the graphs do not depict drug use items as they had relatively low scores.

Outreach and Reunification Services to Runaway TAY (Safe Places)

Description of Program: Outreach

Operation Safehouse, Inc. was funded through MHSA-PEI to train and educate the community on the Safe Place program. This program is based on “Project Safe Place”, a national program found in communities all across the United States, which creates Safe Place location designations within the local the community organizations and businesses centers, for youth to seek assistance. Safe Place is a community prevention initiative where Safe Place trains and then designates businesses and organizations as Safe Place locations, making help readily available to youth in the community. Safe Place locations include: libraries, community centers, public buses, various businesses and social service facilities. Designated Safe Place locations display the Safe Place sign, the universal symbol of youth safety.

Operation Safehouse trains staff at the designated Safe Place sites to ensure people at those locations know the resources and how to help a youth in need. Presentations on Safe Place are also provided to the community to educate community members and organizations on what Safe Place sites do.

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Participants Served	8,867	2,625	3,289

Gender	FY 21/22	FY 22/23	FY 23/24
Male	4,467	924	1,148
Female	4,292	1,200	1,465
Transgender	44	4	36
Nonbinary	32	28	7
Unknown/Other	32	469	633

Outcomes Evaluation

FY 2021—2024:

- There were a total of 340 youth who either entered the Operation Safehouse shelter, or we placed/referred to a Transitional Living Program (TLP).
- There were a total of 203 partnership/collaborative meetings attended by Operation Safehouse staff.
- There were a total of 233 staff trainings at the Operation Safehouse Technical Assistance Center.
- Operation Safehouse conducted 84 Educational

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	710	324	311
Hispanic/Lantinx	1,072	611	637
Black/African American	674	324	603
Asian/Pacific Islander	39	24	12
Native American	0	11	16
Other/Unkn/Multi-Racial	6,372	1,351	1,560

Sexual Orientation	FY 21/22	FY 22/23	FY 23/24
Lesbian	23	5	77
Gay	60	44	63
Bisexual	213	97	210
Yes, did not specify	0	0	0
Unknown	0	0	0
Another	45	12	52
Not LGBQ/Declined to Answer	8,526	2,487	2,887

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	1,477	115	7
Transition Aged Youth (16-25)	3,325	1,286	1,989
Adults (26-29)	4,055	1,223	1,021
Older Adults (60+)	0	0	0
Not Reported	10	21	272

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #5
First Onset for Older Adults

PEI – Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD)

Description of Program: Early Intervention

CBT for Late Life Depression is an active, directive, time-limited, and structured problem-solving program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with structure in modeling behavior. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions, following a structured manual. Outcomes were measured using the Patient Health Questionnaire (PHQ-9) and Quality of Life Survey (QOL).

Demographics:

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	32	72	48
Hispanic/Lantinx	14	47	58
Black/African American	2	9	10
Asian/Pacific Islander	2	0	2
Native American	0	0	1
Other/Unkn/Multi-Racial	0	0	1

Gender	FY 21/22	FY 22/23	FY 23/24
Male	26	37	36
Female	24	90	84
Transgender	0	1	0
Not Reported	0	0	0

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-17)	0	0	0
Adults (18-59)	1	1	2
Older Adults (60+)	49	127	118
Not Reported	0	0	0

Age Breakdown	FY 21/22	FY 22/23	FY 23/24
59-64	15	28	15
65-69	12	40	36
70-74	11	22	30
75-79	8	22	23
>80	4	16	16

Sexual Orientation	FY 21/22	FY 22/23	FY 23/24
Lesbian	5	9	1
Gay	21	24	18
Bisexual	1	1	1
Yes, did not specify	0	0	3
Unknown	8	0	0
Another	0	0	1
Not LGBQ/Not Reported	15	94	96

PEI – Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD)

Program Outcomes:

Outcomes for CBT-LLD are a depression measure (BDI-II FY21/22 and PHQ-9 FY22/23 & FY23/24) in addition to the Quality of Life Survey.

- **PHQ-9** is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents age 12 years. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 can function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment. The PHQ-9 is scored by summing the ratings for the 9 items.
- The **QOL** survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes, as it specifically collects feedback from participants on social behavior, relationships, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	50	128	120
# of Participants CLOSED (% of Total Served)	19 (38%)	71 (55%)	87 (73%)
Successfully Completed Treatment Goals	*9 (47%)*	*41 (58%)*	*49 (56%)*

Outcomes Evaluation			
Percentage of Participants Improved	**FY 21/22**	**FY 22/23**	**FY23/24**
BDI-II (%)	100%	—	—
PHQ-9 (%)	—	93%	99%
QOL (%)	95%	91%	85%

Note. The BDI-II was no longer used as the depression measure after FY21/22 and was replaced with the PHQ-9.

Comments:

- *[Therapist] is a wonderful therapist understanding a lot of the issues she was faced with me. I would come back to her when I need counseling again. Thanks!!*
- *I appreciated the consistency and the opportunity to be heard, the program exceeded my expectations*
- *This therapy worked very well for me. I had reached the end of my resilience and was quite lost and depressed, short on hope. The skills I learned put me on a better path fairly quickly...Thanks very much to the Center and the mental health program - you really helped me to get my life back on track.*
- *The program helped me to understand why I react the way that I do to some life situations. Helped me to cope with some of my home issues with my husband. [Therapist] is very kind.*
- *My therapist has been a valuable resource to me.*

PEI – Program to Encourage Active and Rewarding Lives (PEARLS)

Description of Program: Prevention

The Program to Encourage Active and Rewarding LiveS (PEARLS) is designed for adults aged 60 years or older who are experiencing minor depression. PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: (1) problem solving treatment; (2) social and physical activation; and (3) pleasant-activity scheduling. The sessions are distributed over a 19-week period, with facilitators making brief follow-up calls to support and encourage participants post program. PEARLS provides a lasting, empowering approach to solving problems and reducing depression in the 60+ population.

Participant Service and Completion Rates			
	FY 21/22	FY 22/23	FY 23/24
Total Enrolled	83	80	109
Total Completed	22 (26.5%)	30 (37.5%)	53 (48.6%)

Note: Completion is defined as attending at least 8 sessions.

Outcomes Evaluation

- Consistent reduction in depression symptoms from “moderate” to “mild” as measured by the PHQ-9
- Consistent reduction in anxiety symptoms from “moderate” to “minimal” as measured by the GAD-7
- Consistent improvement in Quality-of-Life as reflected in survey questions related to “health”, “life in general”, “emotional well-being”, and “spare time”

Satisfaction

Consistently, 80% of responses to the survey question "in a general sense, how satisfied are you with the support you have received from this program" were either "pleased" or "delighted". Comments (below) tend to reflect appreciation for the support and encouragement received during the sessions, as well as the problem-solving skills acquired long term.

- *(PEARLS) helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.*
- *I benefited by being encouraged to get things done. It helped me see what it feels like to accomplish things.*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	33	24	53
Hispanic/Latinx	31	27	35
Black/African American	11	19	15
Asian/Pacific Islander	1	3	1
Native American	3	0	1
Other/Unkn/Multi-Racial	4	7	4

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	0
Transition Aged Youth (TAY) (16-25)	0	0	0
Adults (26-59)	0	0	0
Older Adults (60+)	83	80	109
Unknown	0	0	0

Gender	FY 21/22	FY 22/23	FY 23/24
Male	21	15	26
Female	62	65	83
Transgender	0	0	0
Unknown	0	10	0

PEI – Mental Health Liaisons to Office on Aging

Overall Description of Program:

The primary goal of this program is for the Riverside University Health System-Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging to:

1. work collaboratively to identify older adults who are either at risk of depression or are experiencing the first onset of depression.

2. link these older adults with early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD).

In addition to referring older adults to early intervention programs, the Mental Health Liaisons are trained to provide CBT and CBT-LLD. MH Liaisons also link older adults with other resources and services, as needed, to reduce depression and suicide risk. Outcomes for participants enrolled in CBT-LLD through Office on Aging are the Patient Health Questionnaire (PHQ-9), Quality of Life Survey (QOL), and the Generalized Anxiety Disorder (GAD-7).

CBT for Late Life Depression is an active, directive, time-limited problem-solving program that follows the structure of the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults who are experiencing symptoms of depression. The intervention includes strategies to facilitate learning within this population; such as slower rates of, or repeated, presentation of information using different modalities; greater use of practice; greater use of structure; and behavior modeling. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and shift them to being more adaptive and flexible. Emphasis is placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 (approximately 60 minute) sessions following a structured manual.

Referrals & Outreach:

A significant amount of the Mental Health Liaisons' time is expected to be focused on completing referrals and participating in outreach events. Data collected for these activities includes referral forms with a final disposition and information on the types of outreach events that the staff participated in.

Referrals			
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	77	291	118
Female	173	212	298
Transgender	0	1	0
Unknown	3	2	6
Total	**253**	**306**	**422**

Outreach			
	FY 21/22	**FY 22/23**	**FY 23/24**
Community Meeting	47	42	72
Public Event	24	19	13
Phone	13	14	3
Presentation	5	5	7
Other	13	8	9
Unknown	0	15	7
Total	**102**	**103**	**111**

PEI – Mental Health Liaisons to Office on Aging

Office on Aging CBT-LLD:

1. **Patient Health Questionnaire (PHQ-9)** is a 9-item self-report instrument for measuring the severity of depression in adults and adolescents ages 12 years and older.
2. **Quality of Life (QOL)** survey includes general quality of life items and questions on participation in pleasant and social activities. This survey is an important and integral part of measuring outcomes as it specifically collects feedback from participants on social behavior, activities, etc.—all aspects that CBT for Late Life Depression is directed at increasing. Thus, this survey provides very relevant information on outcomes when considering the goals of the program.
3. **General Anxiety Disorder-7 (GAD-7)** is a 7-item questionnaire that measures generalized anxiety disorders and assesses its severity.

Demographics (CBT):

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	17	17	4
Hispanic/Lantinx	4	6	11
Black/African American	2	3	1
Asian/Pacific Islander	2	2	1
Native American	0	0	0
Other/Unkn/Multi-Racial	2	0	1

Gender	FY 21/22	FY 22/23	FY 23/24
Male	8	6	4
Female	19	22	14
Transgender	0	0	0
Unknown	0	0	0

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-17)	0	0	0
Adults (18-59)	3	2	2
Older Adults (60+)	24	26	16
Unknown	0	0	0

Age Breakdown	FY 21/22	FY 22/23	FY 23/24
59-64	4	5	4
65-69	6	7	2
70-74	11	10	4
75-79	2	3	5
>80	4	3	3

Outcomes (CBT):

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	27	28	18
# of Participants CLOSED (% of Total Served)	19 (70%)	19 (68%)	12 (67%)
Successfully Completed Treatment Goals	**10 (53%)**	**7 (37%)**	**6 (50%)**

Outcomes Evaluation			
Percentage of Participants Improved	**FY 21/22**	**FY 22/23**	**FY 23/24**
BDI-II (%)	100%	—	—
PHQ-9 (%)	100%	80%	89%
QOL (%)	70%	86%	89%
GAD-7 (%)	78%	88%	100%

Note. The BDI-II was no longer used as the depression measure after FY 21/22 and was replaced with the PHQ-9.

Comments:

- *The program is important for the people who help us in these situations and make our lives better. Make a better life because you can always learn!* [Translated from Spanish]
- *It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much. [Translated from Spanish]*

PEI – Care Pathways - Caregiver Support Groups

Description of Program: Prevention

A 12 session support group for caregivers of older adults. Outreach, engagement, and linkage to the support groups target caregivers of individuals receiving prevention and early intervention services, caregivers of seniors with mental illness, and caregivers of seniors with dementia. The Care Pathways program's main goals are to reduce the risk for depression and to impact the caregivers' sense of well-being by reducing the emotional distress of caregivers. This is accomplished by providing useful information and providing the opportunity to share and bond with others. Two measures are used to evaluate program outcomes.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	117	97	116
Completed Program	88	77	87

Evaluation Outcomes			
Percent Decreased pre to post (Countywide)	**FY 21/22**	**FY 22/23**	**FY23/24**
CES-D 20-Depression	21%	6%	17%
AMA Caregiver Self-Assessment-Distress	13%	5%	11%

PEI – Care Pathways - Caregiver Support Groups

Demographic:

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	46	51	48
Hispanic/Latinx	38	29	46
Black/African American	15	-	14
Asian/Pacific Islander	4	4	6
Native American	1	2	-
Other/Unkn/ Multi-Racial	2	2	2

Age	FY 21/22	FY 22/23	FY 23/24
Children/Youth (0-15)	-	-	-
Transition Aged Youth (TAY) (16-25)	-	1	2
Adults (26-59)	37	41	36
Older Adults (60+)	63	40	50
Not Reported	6	-	28

Gender	FY 21/22	FY 22/23	FY 23/24
Male	19	10	22
Female	87	78	91
Transgender	-	-	-
Not Reported	-	-	3

Highlights & Achievements

A highlight of Care Pathways implementation for FY 23-24 is found in the participant outcomes as evidenced by decreases in depression scores and feelings of distress, as well as by self-reports of high caregiver satisfaction. For example, in the Mid-County region alone, CES-D 20 mean scores from intake to follow up showed a decrease in depression by 34%, and countywide the decrease was 17%. Caregivers' self-assessment questionnaire scores for feelings of distress also showed statistically significant decreases from pre-to-post completion, with a decrease of 26% for the Mid-County region and 11% decrease countywide. Furthermore, satisfaction surveys completed by 90% of participants at the conclusion of support groups indicated they were highly satisfied with various aspects of the program.

Challenges & Barriers

Outreach and enrollment proved to be a significant challenge to implementing Care Pathways for FY 23-24. This challenge is evident in reflecting on the number enrollees at 116, falling short of the goal of 144 participants per contract expectation. Concerted efforts were made throughout the year to conduct outreach, inform and educate partner agencies, community-based organizations alike, including at various hospitals, churches, and libraries. However, while a few potential participants expressed interest from those efforts, none of those sites proved fruitful in ultimately enrolling participants. An additional challenge with enrollment was limited staffing with a facilitator vacancy that existed for half of the year resulting in less class offerings. Once an additional facilitator was hired, time invested for onboarding further limited the ability to provide classes for more participants, as the new facilitator was only able to teach one session in Q4.

PEI – CareLink Program/Healthy IDEAS

Description of Program: Prevention

Facilitated by the Riverside County Office on Aging, it is a care management program for older adults who are at high risk for developing mental health problems, primarily depression and anxiety. Healthy IDEAS intervention focuses on behavioral activation and social support and is utilized for those who are demonstrating symptoms of depression and anxiety. Outcomes evaluation measures for Healthy IDEAS included the use of tools provided by the developers of the evidenced based practice. The CES-D 20 depression measure and a quality of life survey were used to measure outcomes.

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	27	29	23
Avg. # Sessions Attended	4.3	4.2	4.8
Average Hours of Service	7.8	7.8	8.6
Percent Completed Program	10	8	6

Evaluation Outcomes			
Percent Decreased from pre to post (Countywide)	**FY 21/22**	**FY 22/23**	**FY23/24**
CES-D 20	50%	34%	45%

PEI – CareLink Program/Healthy IDEAS

Demographics

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	10	15	11
Hispanic/Latinx	15	11	9
Black/African American	2	3	2
Asian/Pacific Islander	-	-	1
Native American	-	-	-
Other/Unkn/Multi-Racial	-	-	-

Age	FY 21/22	FY 22/23	FY 23/24
Children/Youth (0-15)	-	-	-
Transition Aged Youth (16-25)	-	-	-
Adults (26-59)	11	11	6
Older Adults (60+)	16	16	16
Not Reported	-	2	1

Gender	FY 21/22	FY 22/23	FY 23/24
Male	10	10	7
Female	17	19	16
Transgender	-		-
Not Reported	-		-

Highlights & Achievements

Most of the participants of Healthy IDEAS report a lower CES-D score upon completion and have an overall improved outlook on life with effective coping skills learned and reinforced during the program. Two clients are highlighted below in the success/impact section.

Challenges & Barriers

Implementation challenges continue to be receiving appropriate clients for the intervention meeting the requirements of:

- new onset of depression/anxiety
- score 16 or above on the CES-D
- not currently receiving treatment i.e. therapy or meds
- no recent history of treatment
- willing to participate when they score 16or above on the CES-D
- cognitively able to participate

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #6
Trauma Exposed Services

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Description of Program: Prevention

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce the duration and harmful effects of trauma for youth (ages 10-15 years) most at risk of developing mental health problems as a result of direct and/or indirect traumatic experiences. CBITS aims to increase resiliency and the development of coping strategies for program participants, reduce symptoms resulting from exposure to traumatic experiences, and reduce the need for ongoing services within the mental health system.

Prior to receiving services, participants are screened for trauma symptoms. Youth with a trauma symptom severity falling below the criteria threshold become ineligible for CBITS, where they are then referred to other services that better suit their needs. Eligible youth who decide to enroll in the program receive ten group sessions and one to three individual sessions in the school setting. For the purposes of Prevention and Early Intervention (PEI), completion of the program was defined as attending 8 or more sessions. In addition, parents and guardians participate in two educational sessions with the clinician. CBITS uses cognitive-behavioral techniques, including: psycho-education, relaxation, social problem solving, cognitive restructuring, and exposure to help children reduce symptoms related to traumatic experiences and depression. Evaluation of program outcomes include measuring decreases in the frequency of trauma symptoms experienced by youth and decreases in depression symptomology.

CBITS Service Information Countywide			
Type of Service Delivery	**FY 21/22**	**FY 22/23**	**FY23/24**
# of Participants Served	118	258	313
# of Participants Completed	88 (75%)	211 (82%)	263 (84%)
# of Groups	16	32	40
# of Group Sessions Attended	941	2,199	2,695
# of Individual Youth Meetings	94	287	335
# of Parent/Guardian Meetings	25	192	243
# of Teacher Meetings	13	148	194

Demographics			
Age	**FY 21/22**	**FY 22/23**	**FY 23/24**
Children (0-15)	112	257	311
Transition Aged Youth (16-25)	2	1	0
Adults (26-29)	0	0	0
Older Adults (60+)	0	0	0
Not Reported	4	0	2
Race/Ethnicity	**FY 21/22**	**FY 22/23**	**FY 23/24**
White	11	16	18
Hispanic/Latinx	85	200	241
Black/African American	8	14	8
Asian/Pacific Islander	5	8	7
Native American+	0	4	16
Multiracial	4	15	20
Not Reported	5	1	3
Language	**FY 21/22**	**FY 22/23**	**FY 23/24**
English	96	212	259
Spanish	1	8	6
Bilingual	7	33	39
Not Reported	14	5	9
Gender	**FY 21/22**	**FY 22/23**	**FY 23/24**
Male	35	85	108
Female	73	164	183
Transgender	5	5	8
Nonbinary/Gender Fluid	0	4	12
Not Reported	5	0	2
Sexual Orientation	**FY 21/22**	**FY 22/23**	**FY 23/24**
Lesbian, Gay, Bisexual+	28	34	52
Questioning/Unsure	10	26	19
Not LGB+/Not Reported	72/8	193/5	231/11

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

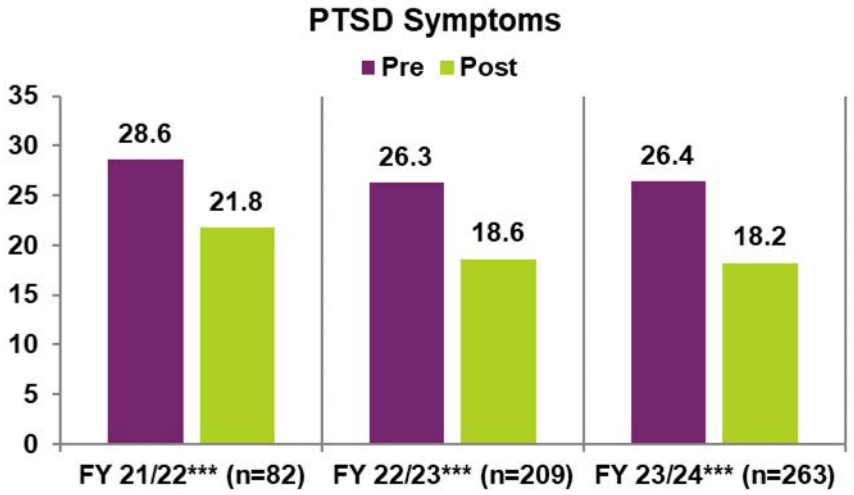
Outcomes Evaluation

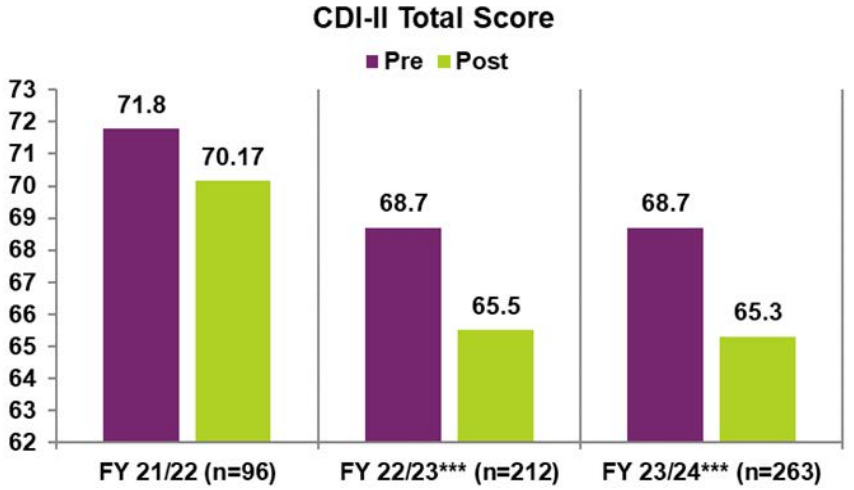
The following outcome measures were collected prior to the start and at the conclusion of group sessions (i.e. pre to post).

- **Child Post-Traumatic Stress Disorder (PTSD) Symptom Checklist** - This is the initial measure administered for determining eligibility into CBITS. It is a two part self-report assessment that identifies exposure to traumatic events and then measures the severity and frequency of the PTSD symptoms arising from those events. Scores are aggregated to yield a PTSD score.
  - ⇒ The table to the right shows all instances of trauma exposure in participants lifetime before participating in the program for each fiscal year.
  - ⇒ The graph to the right shows the analysis of the countywide PTSD symptom measure scores for participants who completed pre and post measures, and at least 8 CBITS sessions. For each fiscal year, after completing the program, youth average PTSD symptom scores showed a statistically significant decrease.
- **Children's Depression Inventory (CDI-II)** - A self-report assessment that measures the severity of depression symptoms among youth. The CDI-II has 28-items with two scales: Emotional Problems and Functional problems. Each scale has two subscales where Negative Mood and Negative Self-esteem are subscales for Emotional Problems and Interpersonal Problems and Ineffectiveness are subscales for Functional Problems.
  - ⇒ Analysis was based on participants who completed both a pre- and post-CDI-II measure and attended at least 8 CBITS sessions. For each fiscal year, on average, CBITS participants' total scores were above the clinical cutoff of 65 at intake and decreased at program completion. The total score demonstrated a statistically significant decrease in depression symptoms.

CBITS Trauma Exposure

Type of Trauma	FY 21/22	FY 22/23	FY23/24
Experienced Physical Trauma	86	194	227
Witnessed Physical Trauma	107	237	296
Emotional Trauma	101	222	253
Experienced Physical Abuse	83	174	203
Witnessed Physical Violence	91	207	258
Witnessed Death	84	197	247





Significance levels: * p ≤ .05, ** p ≤ .01, *** p ≤ .001

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Satisfaction Surveys

At the end of each group, participants were asked to fill out a satisfaction survey to gather feedback on their experience in the program. For FY 21/22 each survey consisted of 6 items while fiscal years 22/23 and 23/24 had 2 additional items for a total of 8 items, all rated on a 5-point Likert scale, where 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree. In FY 21/22 there were 78 completed surveys, in FY 22/23 there were 212 completed surveys, and in FY 23/24 there were 260 completed surveys. Below is the percentage of participants who agreed/strongly agreed to each item in the survey for each fiscal year.

Participant comments:

- Participant learned "coping mechanisms, how to manage stress better, viewing things in a calmer way, seeing the bigger picture."
- Participant learned "how to stay calm during a scary situation. Or how to think twice before reacting to something."
- Participant learned "how to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident."
- "I learned that I'm not always alone in difficult situations and there is always someone that is here for me no matter what."
- "I learned that pushing away my problems will just make them harder to get through later."
- "I learned that there are many ways to look at situation. You can make a bad one be a good problem. Knowing what helps you cope with stress can really help when in need."
- "That a lot of kids I know from school sometimes feel how I feel so it made me not feel alone."
- "Sharing your problems or talking about them can help you."
- "I don't have to be afraid to talk about how I'm feeling."
- "I learned how to deal with stress and other emotions that I may have. Learned how to act positively not in a negative way."

CBITS Satisfaction Survey Results

Survey Statements	FY 21/22 (n=78)	FY 22/23 (n=212)	FY 23/24 (n=260)
1. The program taught me how to cope with stress.	63%	73%	72%
2. The program helped me to understand myself better.	68%	60%	64%
3. The program has prepared me to cope with stress if something difficult happens to me in the future.	77%	67%	77%
4. I achieved my goals for the group.	45%	54%	55%
5. The group leaders listened to what I had to say.	97%	88%	90%
6. The group leaders knew how to help me.	79%	76%	82%
7. I will use what I learned in the program in my life.	-	51%	69%
8. I would recommend the program to a classmate.	-	60%	79%

Note: Survey was expanded in FY 22/23 to include questions seven and eight. Percentage results are calculated based on participants who responded "Strongly Agree" and "Agree" on survey statements above.

PEI - Seeking Safety and Seeking Strength

Description of Program: Prevention

Seeking Safety is an evidenced-based practice, identified by the PEI Steering Committee, that aims to help participants avoid or interrupt that cycle. Seeking Safety is an integrated therapy treating both PTSD and substance use disorders. This program is based on the cognitive-behavioral model of relapse prevention. It teaches present-focused coping skills designed to simultaneously help people with a history of trauma and substance abuse. It has been conducted in group or individual format; for people with both substance abuse and dependence issues; for people with PTSD; and for those with a trauma history that do not meet criteria for PTSD. The program has a highly flexible format: session topics can be completed in any order, clients can join in at any point, and both professionals and paraprofessionals (i.e., peers) can conduct the sessions.

Participant Service and Completion Rates			
Providers	**FY 21/22**	**FY 22/23**	**FY 23/24**
Operation SafeHouse	82%	91%	84%
RUHS-BH PEI Peers	64%	72%	61%
All Participants	73%	82%	79%

Outcomes Evaluation			
Participants Improvement	**FY 21/22**	**FY 22/23**	**FY23/24**
PTSD	29.9	31.5	29.5
CSI-Positive	54.8	57.3	55.2
CSI-Negative	31.2	35.8	35.4

Outcomes Evaluation

Most participants agreed or strongly agreed that Seeking Safety reduced their trauma symptoms and was helpful.

- *"It helped me find other ways to deal with stress and talk with someone trusted."*
- *"The program brought a helpful change in me."*
- *"The program gave me a safe place to express myself and helped me with how I cope"*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	124	179	124
Hispanic/Latinx	115	164	114
Black/African American	15	27	13
Asian/Pacific Islander	1	7	4
Native American	1	3	2
Other/Unkn/Multi-Racial	15	12	9

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	1	1	0
Transition Aged Youth (16-25)	82	129	126
Adults (26-29)	71	93	28
Older Adults (60+)	2	5	0
Unknown	0	0	0

Gender	FY 21/22	FY 22/23	FY 23/24
Male	21	49	52
Female	125	167	101
Transgender	3	2	3
Unknown	7	1	3

Riverside University HEALTH SYSTEM Behavioral Health

PEI Plan Project Area #7
Underserved Cultural Populations

PEI – Mamas y Bebes (MyB)

Description of Program: Prevention

Mamás y Bebés (MyB) is a prenatal intervention, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants. Three community-based organization (CBO) were funded by the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) to implement the program. Reach Out is a local non-profit CBO serving underserved communities; Riverside Community Health Foundation which is a nonprofit organization supporting health and well-being in Riverside communities through a variety of programs; and California Health Collaborative which is a non-profit organization supporting and enhancing the quality of life and health for people of California particularly the underserved and underrepresented.

Participant Service			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Screened	208	208	329
# of Participants Enrolled	129	171	255
# of Participants Graduated	126	162	231

Outcomes Evaluation

-Majority of participants strongly agreed with all statements in a satisfaction survey—that the presenters were enthusiastic and knowledgeable when sharing the information. They stated they would recommend others to participate in similar activities.

- *"Motherhood is hard, full of challenges and it was nice to hear that other moms have same challenges as me. I learned new ways to cope with situations. Thank you for this program."*
- *"This class helped my mental health so strong that I can manage to do a little beautiful things everyday. Thank you !"*
- *"I liked all the topics and conversations with the teacher. The reflections were always good. I really liked taking the class."*

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	117	146	229
Hispanic/Latinx	114	141	212
Black/African American	5	9	9
Asian/Pacific Islander	0	2	5
Native American	0	1	0
Other/Unkn/ Multi-Racial	7	13	9

Gender	FY 21/22	FY 22/23	FY 23/24
Male	0	0	0
Female	129	165	255
Transgender	0	0	0
Unknown	0	6	0

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-15)	0	0	1
Transition Aged Youth (TAY) (16-25)	23	33	42
Adults (26-29)	101	119	212
Older Adults (60+)	0	0	0
Unknown	5	19	0

PEI – Building Resiliency in African American Families— Boys

Description of Program: Prevention

Building Resilience in African American Families project (B.R.A.A.F.) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American male youth and their parents/guardians that live in communities with high rates of poverty and community violence. The B.R.A.A.F.

Project utilizes three evidence-based practices:

1. **Afrocentric Youth and Family Rites of Passage Program (ROP),**
2. **Cognitive-Behavioral Therapy (CBT), &**
3. **Guiding Good Choices (GGC)**

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Youth Served	50	35	24
# of Youth Completed	30	18	17
Successfully Completed Program	***60%***	***51%***	***71%***

Age	FY 21/22	FY 22/23	FY 23/24
Children/Youth (0-15)	50	35	24
Transition Age Youth (16-25)	0	0	0
Adults (26-59)	0	0	0
Older Adults (60+)	0	0	0
Unknown	0	0	0

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	0	0	0
Hispanic/Latinx	0	2	0
Black/African American	44	23	22
Asian/Pacific Islander	0	0	0
Native American	0	0	0
Multiracial	6	0	0
Other	0	4	0
Unknown	0	6	2

Gender	FY 21/22	FY 22/23	FY 23/24
Male	50	35	24
Female	0	0	0
Transgender	0	0	0
Unknown	0	0	0

PEI – Building Resiliency in African American Families— Boys

Rites of Passage: The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week. Outcomes evaluation focused on: resiliency, positive identification with culture, and family cohesion and Post– Program Satisfaction Survey.

ROP Outcomes

Resiliency Scale: The Resiliency Scales for Children and Adolescents assess key personal attributes essential for resilience, including two global scales: Sense of Mastery and Sense of Relatedness. The Sense of Mastery evaluates an individual's ability to cope with adversity, while the Sense of Relatedness gauges the strength of relationships that buffer against stress, with scores categorized as High (60+), Above Average (56-59), Average (46-55), Below Average (41-45), and Low (<40).

- From 2021– 2024, all three fiscal years, youth that participated in ROP completed the Resiliency Scale. There were no statistically significant change in neither Relatedness and Mastery. Youth's combined means total scores remained in the average 46-55 range from pre- to post-assessment.

Multi-Dimensional Inventory of Black Identity (MIBI): The MIBI measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

- From 2021– 2024, all three fiscal years, youth showed no statistically significant change in their connectedness to their Black Identity. To note, youth had high scores at pre-assessment across all fiscal years.

Family Adaptation and Cohesion Scale III (FACES III): FACES III is a

10-item self-report tool that assesses individuals' perceptions of family cohesion. The Cohesion subscale specifically evaluates the strength of emotional bonds and attachment among family members.

- Across all three fiscal years, family cohesion moved for disengaged to connected. These findings suggest the potential impact of the program on family dynamics.

Post-Program Feedback about R.O.P:

Overall, the majority of youth who completed the satisfaction survey agreed or strongly agreed that participating in the program was a positive experience. Also, participants reported very good or excellent satisfaction with regard to staff treatment.

Additional Comments from Youth:

"It helped me be accountable for my actions"

"This program changed me mentally and helped me deal with suicide."

"I feel like I am more confident in myself and I am more accepting of my heritage."

"It has changed me in multiple areas such as my anger issues, and taking responsibility."

Note: For FY21/22, the SEBBS (Social-Emotional Bullying Behavior Survey) was used to assess bullying behaviors, social-emotional skills, and victimization among students to inform interventions and enhance school environments. No significant findings were reported for FY21/22. The SEBBS was discontinued for FY22/23 and FY23/24.

PEI – Building Resiliency in African American Families— Boys

Guiding Good Choices (GGC): Parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks at the start of the program. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. Program. Outcomes were measured using Alabama Parenting Questionnaire (APQ), and Retrospective satisfaction surveys were also collected to gather program feedback from parents that participated in GGC.

Parental Participation and GGC Completion Rates

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Parents Participated	55	32	19
# of Parents Completed	28	20	17
Successfully Completed Program	***51%***	***63%***	***90%***

GGC Outcomes

Percent Change in Average Scores	FY 21/22	FY 22/23	FY 23/24
Alabama Parenting Questionnaire			
Parenting Involvement	+4.4%	+11.0%	+6.6%
Inconsistent Discipline	-11.6%	-12.3%	-11.2%
Corporal Punishment	-10.5%	+2.4%	-15.2%

Note: (-)/(+) represent decreases/increases in parenting style respected to each area in the table above.

GGC Retrospective Satisfaction Survey Percent Improved

Survey Statements:	FY 21/22	FY 22/23	FY 23/24
1. I feel confident starting a conversation with my son/daughter addressing risk factors such as drugs, alcohol, gangs, etc.	49%	52%	28%
2. As a family, we plan and hold regular family meetings.	77%	83%	61%
3. If one parenting style is not working with my child, I have other parenting skills available.	74%	70%	67%
4. I practice refusal skills with my son/daughter to help them resist negative peer influences.	74%	70%	67%
5. I know how to control and express my anger constructively.	59%	65%	61%
6. I set clear and consistent guidelines and expectations/consequences for my child. I explain to them how I feel about his/her good/bad behavior.	51%	83%	50%

Note: percentage results do not include participants with high scores on the pre-assessment form in the table above.

Satisfaction Surveys:

Parents reported high satisfaction with overall program expectations, facilitator evaluation, and acknowledgment of cultural/ethnic diversity within the program guidelines for throughout all three fiscal years. Overall satisfaction ranged from 4.6 to 4.9 on a scale of 5.

PEI – Building Resiliency in African American Families— Boys

Cognitive –Behavioral Therapy (CBT) is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. Outcomes were measured by the Children's Depression Inventory Scale (CDI-II) and the Strengthens and Difficulties Questionnaire (SDQ).

CBT Outcomes

Children's Depression Inventory—II (CDI-II): CDI-II is used to measure the severity of depressive symptoms in children. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems.

- Across all fiscal years, while decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average range of depression severity.

Strengthens and Difficulties Questionnaire (SDQ): The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes

- Emotional symptoms was the most common subscale that had a statistically significantly decrease, across the fiscal years.

Participant Service and Average CBT Sessions

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Youth Served	36	11	16
Average # of Therapy Sessions per Youth	7	8	11

CBT Satisfaction Survey:

Youth agreed or strongly agreed to the responses: the program taught me how to cope with stress, understand myself better, helped achieved my goals, facilitator knew how to help me.

Additional Comments::

When asked things that you learned in program:

"My thoughts affect my feelings and my feelings affect my behavior."

"How to make myself calm in stressful positions or how to deal with current problems."

When asked what you learned about the program is*:*

"How to facilitator took care of me."

"I had someone I could talk to."

PEI – Building Resiliency in African American Families— Boys

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Youth Focus Group Questions:

The youth focus group questions examine how the program helped with personal challenges, improved family relationships, and impacted self-perception and cultural identity. They also ask about changes the youth experienced and what they remember most, including any aspects of *B.R.A.A.F.* that didn't meet expectations.

Youth Responses about the B.R.A.A.F. program:

I learned there's "another way to live, to stay out of trouble, to learn, and how to get into college."

"The program helped me "be more concentrated and motivated."

"Taught me how to be more respectful to teachers and other people."

Response with connection to African American Culture:

"I feel better because I'm more knowledgeable about the past."

"I feel more comfortable being an African American person because I came from great people."

I learned "that no matter what you should always love your culture and yourself… no matter if people call you any names."

Parent Focus Group Questions:

The parent focus group questions give sight to key themes such as family bonding activities, the impact of the *Guiding Good Choices* and *B.R.A.A.F.* programs on parent-child relationships, and the changes observed in children. They also evaluate the value of parent support groups and seeking feedback on what worked well and areas for improvement.

Parent Responses about Change in their youth's Behavior:

My son is more nice, before he was scared to tell me things. Now I stop before I say anything."

"My son enjoyed the program, had a good time, enjoyed the staff and enjoyed his peers, glad he was able to attend this year."

Parent Feedback about the B.R.A.F.F. program:

"The group discussion was amazing, we got to feel safe, we felt safe, and bounds off each other. Our kids were going through similar things. We have lots of support."

"I have more patience, when I listen to him, and getting him to understand my point of view. We are getting better."

PEI – Building Resiliency in African American Families— Girls

Description of Program: Prevention

Building Resilience in African American Families project (B.R.A.A.F.) was implemented by Riverside University Health System Behavioral Health, Prevention and Early Intervention (PEI) through funding under the Mental Health Services Act. This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The target population served is African American male youth and their parents/guardians that live in communities with high rates of poverty and community violence. The B.R.A.A.F.

Project utilizes three evidence-based practices:

1. **Africentric Youth and Family Rites of Passage Program (ROP),**
2. **Cognitive-Behavioral Therapy (CBT), &**
3. **Guiding Good Choices (GGC)**

Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Youth Served	22	24	16
# of Youth Completed	28	15	12
Successfully Completed Program	***79%***	***63%***	***75%***

Age	FY 21/22	FY 22/23	FY 23/24
Children/Youth (0-15)	28	24	16
Transition Age Youth (16-25)	0	0	0
Adults (26-59)	0	0	0
Older Adults (60+)	0	0	0
Unknown	0	0	0

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	0	0	0
Hispanic/Latinx	0	0	1
Black/African American	24	18	11
Asian/Pacific Islander	0	0	0
Native American	0	0	0
Multiracial	4	3	4
Other	0	0	0
Unknown	0	3	0

Gender	FY 21/22	FY 22/23	FY 23/24
Male	0	0	0
Female	28	24	16
Transgender	0	0	0
Unknown	0	0	0

PEI – Building Resiliency in African American Families— Girls

Rites of Passage: The goal of the ROP program is empowerment of black adolescents through a nine-month rites of passage program. The program provides a multi-faceted, prevention based program to youth; a major component of the program is the after school program, held for three hours, three days per week. Outcomes evaluation focused on: resiliency, positive identification with culture, and family cohesion and Post– Program Satisfaction Survey.

ROP Outcomes

Resiliency Scale: The Resiliency Scales for Children and Adolescents assess key personal attributes essential for resilience, including two global scales: Sense of Mastery and Sense of Relatedness. The Sense of Mastery evaluates an individual's ability to cope with adversity, while the Sense of Relatedness gauges the strength of relationships that buffer against stress, with scores categorized as High (60+), Above Average (56-59), Average (46-55), Below Average (41-45), and Low (<40).

- Overall, the resiliency scale, across the fiscal years, showed the youth remained at the average level for sense of mastery. While participants showed a below average sense of relatedness, which demonstrated the participants continued to have a difficult ability to manage stress inducing environments.

Multi-Dimensional Inventory of Black Identity (MIBI): The MIBI measures dimensions of racial identity. Participants indicate their agreement with various statements on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

- From 2021– 2024, all three fiscal years, youth showed no statistically significant change in their connectedness to their Black Identity. To note, youth had high scores at pre-assessment across all fiscal years, total scores ranging from (3.9—4.4).

Family Adaptation and Cohesion Scale III (FACES III): FACES III is a

10-item self-report tool that assesses individuals' perceptions of family cohesion. The Cohesion subscale specifically evaluates the strength of emotional bonds and attachment among family members.

- Across all three fiscal years, family cohesion moved for disengaged to connected. These findings suggest the potential impact of the program on family dynamics.

Post-Program Feedback about R.O.P:

Overall, the majority of youth who completed the satisfaction survey agreed or strongly agreed that participating in the program was a positive experience. Also, participants reported very good or excellent satisfaction with regard the type of activities in R.O.P..

Additional Comments from Youth:

"The program helped me with my social skills and I found some new friends that changed for the better."

"The program changed me because it helped me to realize who I am."

"I liked meeting new people and making new friends."

Note: For FY21/22, the SEBBS (Social-Emotional Bullying Behavior Survey) was used to assess bullying behaviors, social-emotional skills, and victimization among students to inform interventions and enhance school environments. While in FY21/22 there was a significant improvement in the cohort's social and emotional skills, the SEBBS was discontinued for FY22/23 and FY23/24.

PEI – Building Resiliency in African American Families— Girls

Guiding Good Choices (GGC): Parents learned how to strengthen family bonds, set a clear family position on drugs, teach children skills they will need to make healthy choices, and increase children's involvement in the family. GGC was offered once a week for five weeks at the start of the program. To congratulate the parents on their accomplishments, a small ceremony and certificate is presented to acknowledge their participation. Program. Outcomes were measured using Alabama Parenting Questionnaire (APQ), and Retrospective satisfaction surveys were also collected to gather program feedback from parents that participated in GGC.

Parental Participation and GGC Completion Rates

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Parents Participated	29	20	19
# of Parents Completed	24	11	7
Successfully Completed Program	***92%***	***55%***	***37%***

GGC Outcomes

Percent Change in Average Scores	FY 21/22	FY 22/23	FY 23/24
Alabama Parenting Questionnaire			
Parenting Involvement	-4.27%	-2.7%	+1.6%
Inconsistent Discipline	-7.71%	+2.8%	-13.3%
Corporal Punishment	-15.1%	-6.0%	-12.7%

Note: (-)/(+) represent decreases/increases in parenting style respected to each area in the table above.

GGC Retrospective Satisfaction Survey Percent Improved

Survey Statements:	FY 21/22	FY 22/23	FY 23/24
1. I feel confident starting a conversation with my son/daughter addressing risk factors such as drugs, alcohol, gangs, etc.	74%	41%	7%
2. As a family, we plan and hold regular family meetings.	84%	53%	64%
3. If one parenting style is not working with my child, I have other parenting skills available.	84%	47%	57%
4. I practice refusal skills with my son/daughter to help them resist negative peer influences.	84%	41%	64%
5. I know how to control and express my anger constructively.	79%	65%	31%
6. I set clear and consistent guidelines and expectations/consequences for my child. I explain to them how I feel about his/her good/bad behavior.	89%	41%	29%

Note: percentage results do not include participants with high scores on the pre-assessment form in the table above.

Satisfaction Surveys:

Parents reported high satisfaction with overall program expectations, facilitator evaluation, and acknowledgment of cultural/ethnic diversity within the program guidelines, throughout all fiscal years. Overall satisfaction averaging a 4 on a scale of 5.

PEI – Building Resiliency in African American Families— Girls

Cognitive –Behavioral Therapy (CBT) is designed for the youth in ROP who need further assistance with behavioral issues, anger control, depression, and other behavioral management concerns. Clinical therapists structure one-on-one therapy with the youth to address their behavioral concerns. Not everyone enrolled in CBT has a behavioral health condition warranting this type of intervention. Outcomes were measured by the Children's Depression Inventory Scale (CDI-II) and the Strengthens and Difficulties Questionnaire (SDQ).

CBT Outcomes

Children's Depression Inventory—II (CDI-II): CDI-II is used to measure the severity of depressive symptoms in children. The CDI-II is a 28-item questionnaire with four initial subscales: Negative Mood, Negative Self-esteem, Ineffectiveness, and Interpersonal Problems.

- Across all fiscal years, while decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores showed participants remaining within the average– to below average range of depression severity. Sample sizes were small in across all fiscal years to proved a reliable statistically significant change.

Strengthens and Difficulties Questionnaire (SDQ): The SDQ is completed by parents at the beginning and at the conclusion of the program, in order to measure the change in participants' behavior problems over time. Higher scores on the four behavioral subscales: emotional symptoms, conduct issues, hyperactivity/ inattention, and peer relationship problems, suggest a higher incidence of negative psychological attributes

- FY21/22 showed no significant change.
- FY22/23 showed a decrease in emotional symptoms.
- FY23/24 showed a decrease in both emotional symptoms and peer relationships.

Participant Service and Average CBT Sessions

Program Service	FY 21/22	FY 22/23	FY 23/24
# of Youth Served	22	10	12
Average # of Therapy Sessions per Youth	7	5	8

CBT Satisfaction Survey:

Youth agreed or strongly agreed to the responses: the program taught me how to cope with stress, understand myself better, helped achieved my goals, facilitator knew how to help me.

Additional Comments::

When asked things that you learned in program:

"I learned how to deal with stressful situations, my parents fighting with my sister, listening, and to help my family more."

When asked what you learned about the program is*:*

"Being able to talk and she actually listened to me and hear what I'm saying."

"She taught me how to do other things to cope with sadness even when I didn't want to talk about."

PEI – Building Resiliency in African American Families— Girls

Focus groups are used in qualitative research to collect data by conducting a form of group interviews that focuses on communication from participants in the program. Focus groups can reach a depth and dimension that quantitative tools such as questionnaires or surveys can miss. The goal of the focus group was to gather participant feedback regarding the program. The feedback will be utilized to inform implementation and make adjustments where necessary and feasible for this program.

Youth Focus Group Questions:

The youth focus group questions examine how the program helped with personal challenges, improved family relationships, and impacted self-perception and cultural identity. They also ask about changes the youth experienced and what they remember most, including any aspects of *B.R.A.A.F.* that didn't meet expectations.

Youth Responses about the B.R.A.A.F. program:

"The therapy sessions, I did not like because they took me out of cool things that were going on."

"I was taught to be grateful of what you have and what your parents can give you."

Response with connection to African American Culture:

"It made me feel better about my culture, [black culture] did a lot of stuff that we don't get credit for. "

"B.R.A.A.F. helped me learn about more about my ancestors and myself."

"The program made me feel better about being African American."

Parent Focus Group Questions:

The parent focus group questions give sight to key themes such as family bonding activities, the impact of the *Guiding Good Choices* and *B.R.A.A.F.* programs on parent-child relationships, and the changes observed in children. They also evaluate the value of parent support groups and seeking feedback on what worked well and areas for improvement.

Parent Responses about Change in their youth's Behavior:

"She went from being arrogant to being open-minded. Overall, this program is very good, and more people should push their kids to go."

"This program helped my daughter to be "aware of their feelings and what's going on and a open line of communication. "

Parent Feedback about the B.R.A.F.F. program:

"During mental health topic, it made me understand and be more aware for things going on. Its fine to start at an early age to talk about issues going on and talk about sensitive topics."

"The communication and organization should be improved for next year. Also, the digital forms would be better or at least the option."

PEI – Celebrating Families: Strengthening The Circle

Description of Program: Prevention

The Celebrating Families: Strengthening the Circle Program is a new PEI program that started its service in FY 2021-2022. The primary goals are to increase family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk. Target outreach include working within the community and collaborating with the Tribal Temporary Assistance for Needy Families (TANFs), tribal organizations, tribal leaders, tribal elders, schools, community organizations, non-profit organizations, faith-based organizations, and other individuals, groups, and/or services that have the trust of and connection with this population. Program activities include evidence-based practice (Wellbriety Celebrating Families!™) and culturally-based intervention (Gathering of Native Americans/ GONA). Outcomes were measured using Alabama Parenting Questionnaire (APQ), Guiding Good Choices (GGC), and Family Strength and resilience Scale (FSRC). Post satisfaction surveys were also collected to gather program feedback from participants.

Overall Total Service Counts			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served and Attended GONA Events	113	473	126

Wellbriety Celebrating Families!™ Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	16	31	37
# of Participants Completed	12	22	23
Successfully Completed Program	***75%***	***71%***	***62%***

Wellbriety Celebrating Families!™ Program Outcomes			
Percent Change in Average Total Scores from Pre to Post	**FY 21/22**	**FY 22/23**	**FY23/24**
APQ (% increase in ***Parenting Involvement, Positive Parenting***)	5%, 3.5%	7.5%, 4.8%	6.6%, 5.4%
GGC (% increase)	7.6%	2.7%	1.8%
FSRC (% increase)	14.9%	11.7%	7.5%

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	0	0	0
Hispanic/Latinx	0	0	0
Black/African American	0	0	0
Asian/Pacific Islander	0	0	0
Native American	14	22	30
Multiracial	5	9	7
Unknown	94	442	89

Age	FY 21/22	FY 22/23	FY 23/24
Children/Youth (0-15)	0	0	0
Transition Age Youth (16-25)	2	2	5
Adults (26-59)	17	20	25
Older Adults (60+)	0	2	1
Unknown	94	449	95

Gender	FY 21/22	FY 22/23	FY 23/24
Male	1	3	10
Female	18	28	27
Transgender	0	0	0
Unknown	94	442	89

PEI – Celebrating Families: Strengthening The Circle

Satisfaction Surveys:

From Fiscal Years 2021 to 2024, the majority of participants showed high satisfaction (over 84% responded to either "satisfied" or "very satisfied") with the Wellbriety Celebrating Families!™ program and the group leaders. Over 84% of participants also responded that the program has helped their families, and all participants (100%) responded that would recommend the program to other families.

Comments from participants (Wellbriety Celebrating Families!™):

- *"I liked how we all joined together for a meal each week to sit down and eat as a family. I also like the information it provided and the insight my husband and I got out of it. I really enjoyed the counselors and their experiences that they shared with us. I also like that it helps families who come from drug addiction and past trauma."*
- *"I liked being able to express my past childhood openly without being judged and getting the help that I truly needed. Being a part of this program has changed my perspective and learning new things to become a better dad."*

Comments from participants (Gathering of Native Americans):

- *"GONA created an opportunity for generosity, demonstrated by the willingness of the staff to welcome a new resource into their class time. Students seemed to open up to our interventions best when they saw their teachers and staff respectfully and openly participate in the circle."*
- *"The prayer ties in GONA seemed impactful. I wish there was more to it or more student talk/interaction. I loved the conversation; it is very healing."*

Wellbriety Celebrating Families!™ Satisfaction Survey Results			
Survey Items	**FY 21/22**	**FY 22/23**	**FY 23/24**
Satisfaction with Program	100%	88%	92%
Satisfaction with Group Leaders	100%	84%	92%
Program has helped family	100%	88%	100%
Program recommendation to other families	100%	96%	100%

PEI – Keeping Intergenerational Ties in Ethnic Families (KITE)

Description of Program: Prevention

Keeping Intergenerational Ties in Immigrant Families (KITE) is an evidence-based parenting program based on the Strengthening Intergenerational Ties in Immigrant Families (SITIF) curriculum designed for the Asian American community that teaches behavioral parenting skills to improve intergenerational intimacy, that started in the fiscal year 2019-2020. It is a culturally-sensitive, community based intervention to strengthen the intergenerational relationship, and promotes immigrant parents' emotional awareness and empathy for their children's experiences, cognitive knowledge, understanding of differences between their native and American cultures. More specifically, the KITE program was designed to offer Prevention and Early Intervention (PEI) services for Asian American Pacific Islander (AAPI) parents with school-aged children and adolescents (ages 6 to 17 years old). Outcomes were measured using Strength and Difficulties Questionnaire (SDQ), Alabama Parenting Questionnaire (APQ), and Relationship Scale. Post satisfaction surveys were also collected to gather program feedback from participants.

KITE Participant Service and Completion Rates			
Program Service	**FY 21/22**	**FY 22/23**	**FY 23/24**
# of Participants Served	73	66	67
# of Participants Completed	61	60	54
Successfully Completed Program	***84%***	***91%***	***81%***

KITE Program Outcomes			
Percent Change in Average Scores	**FY 21/22**	**FY 22/23**	**FY 23/24**
Strength and Difficulties Scale			
Emotional Symptoms Scale decreased	-3.3%	-3.6%	-11.1%
Conduct Problems Scale decreased	-4.9%	-5.3%	-7.5%
Hyperactivity Scale decreased	-1.5%	-5.5%	-11.3%
Peer Problems Scale decreased	3.4%	-3.2%	-8.9%
Prosocial Scale increased	3.0%	4.4%	9.6%
Alabama Parenting Questionnaire			
Parenting Involvement increased	5.6%	3.2%	6.7%
Positive Parenting increased	4.8%	4.5%	5.1%
Inconsistent Discipline decreased	-0.6%	-0.3%	-7.5%
Other Discipline Practices decreased	-1.6%	-1.1%	-2.9%
Relationship Scale			
Average Total Scores increased	8.3%	13.3%	7.8%

Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
White	0	0	0
Hispanic/Latinx	0	0	0
Black/African American	0	0	0
Asian/Pacific Islander	59	58	54
Native American	0	0	0
Multiracial	2	2	0

Age	FY 21/22	FY 22/23	FY 23/24
Children (0-17)	0	0	0
Adults (18-59)	61	53	46
Older Adults (60+)	0	2	8
Unknown	0	5	0

Gender	FY 21/22	FY 22/23	FY 23/24
Male	14	10	19
Female	47	50	35
Transgender	0	0	0
Unknown	0	0	0

Language	FY 21/22	FY 22/23	FY 23/24
English	22	10	10
Spanish	0	0	0
Chinese	39	40	44
Bilingual (*English/Chinese*)	0	10	0

PEI – Keeping Intergenerational Ties in Ethnic Families (KITE)

Satisfaction Surveys:

From Fiscal Years 2021 to 2024, the majority of participants showed overwhelmingly positive responses on their satisfaction survey analysis (92% or more) on KITE program.

Comments from participants:

- *"I feel I am more willing to look and assess at situations more and taking into consideration of my child's perspectives. I feel I am able to use the different parenting techniques as a tool in successfully responding to different problems/situations. I also feel there is a positive improvement with my relationship with my child after completing this course."*
- *"I realized the importance of communicating with my child through learning from this course. I learned to build structures, rules, and I loved the children's 5 love languages and other information. It feels very practical to be able to apply it to children after learning and practice, and also getting the positive interactions."*
- *"Through the study in the parent-child class, I learned that the needs of children and the responsibilities of parents in raising children are actually unified. If you think about the demands and the demands behind the behaviors of children from another angle, you can better understand the children and form a good parent-child relationship with them. At the same time, I also learned a lot of parenting skills, encourage and praise children more, and interact with children with high quality companionship. Punishment is not always the way to make children obedient. Properly letting children bear natural consequences is a required course for the growth too."*

Keeping Intergenerational Ties in Ethnic Families (KITE) Satisfaction Survey Results			
Survey Statements	**FY 21/22**	**FY 22/23**	**FY 23/24**
1. KITE Program increased parent understanding of differences in Asian and American cultures	100%	98%	98%
2. KITE Program increased ability to parent cross-culturally	97%	93%	98%
3. KITE Program increased parent understanding of their children	100%	96%	100%
4. KITE Program increased ability to parent their children	94%	96%	98%
5. KITE Program increased parent communication with their children	97%	98%	98%
6. KITE Program increased parent participation in the various contexts of their children's lives	97%	96%	92%
7. KITE Program increased parent connection with their children	100%	93%	94%

Note: percentage results are calculated based on participants who responded "Strongly Agree" and "Agree" on survey statements above.

Riverside University Health System - Behavioral Health

MHSA
Annual Prevention and Early Intervention Program and Evaluation Report

FY 2023-2024

This report provides the data necessary to meet the Annual Prevention and Early Intervention (PEI) Program and Evaluation Report in accordance with the CCR regulations and the MHSOAC waiver enacted for PEI data collection and reporting.

The following report is structured according to the RUHS-BH, MHSA PEI Plan project areas, with a project area narrative and a data reporting table for each PEI program. Each reporting table includes the type of program, program name, project area as defined by PEI plan, program description, number of unduplicated individuals served, demographic data, implementation successes, implementation challenges, lessons learned, and relevant examples of success/impact for each program. The narrative for each project area section that precedes the data tables will address any PEI programs for which data collection and reporting was either not completed due to the nature of the program, or where data collection and reporting is evolving.

PEI Plan Project Area #1: Mental Health Outreach, Awareness, and Stigma Reduction

The goals of this PEI project area is to increase community outreach and awareness about mental health information/resources, and to reduce stigma. These activities are designed to outreach to underserved populations, increase awareness of mental health topics, and to reduce stigma and discrimination.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve. Some of these programs have limited data collection, so more narrative information is included for these programs.

Program Type: Stigma and Discrimination Reduction
Program Name: Up2Riverside.org - Media & Mental Health Promotion and Education Materials
RUHS-BH continued to contract with a marketing firm, Civilian, to continue and expand the Up2Riverside campaign for mental health awareness, stigma reduction, and suicide prevention, as well as substance use and prevention in Riverside County. Additionally, the provider began narrowcasting efforts in Hemet and San Jacinto. The campaign included television and radio ads and print materials reflective of Riverside County and included materials reflecting various cultural populations and ages as well as individuals, couples and families. The website, Up2Riverside.org, was promoted through the campaign as well as word of mouth and as a result, there was a total of 618,924 page views in fiscal year 2023-2024 with 335,816 new users. The website was developed to educate the public about the prevalence of mental illness and ways to reach out and support family and community members. Email blasts continue to be the top performing digital tactic in terms of click through rates and site duration. The average session duration on the website was 1:24. Furthermore, the website received better engagement in terms of click through rate with the Spanish campaign compared to the English campaign.

Video digital personal stories began to be added in December 2011. Digital Storytelling provides a three-day workshop for individuals during which they identify a “story” about themselves that they would like to tell and produce a 3 to 5 minute digital video to tell their story. This activity gives the individual a unique way to communicate some-thing about their life experiences, which could include trauma, loss, homelessness, etc. At the end of the workshop, the participants are then asked to invite whomever they would like to a viewing party. The digital stories are developed in conjunction with the Up2Riverside campaign and can be viewed on at www.Up2Riverside.org. There are currently 20 digital stories available for viewing on the Up2Riverside website. They include videos developed by a veteran, a Transition Age Youth, a parent, and one is in Spanish.

Program Type: Stigma and Discrimination Reduction
Program Name: Network of Care
Network of Care is a user-friendly website that is a highly interactive, single information place where consumers, community members, community-based organizations, and providers can go to easily access a wide variety of important information. The Network of Care is designed so there is "No Wrong Door" for those who need services. In fiscal year 2023-2024, the website had 223,900 visits and 428,238 page views. Data collection for this program is limited to web hits.

PEI Plan Project Area #1: Mental Health Outreach, Awareness, and Stigma Reduction

Program Type: Suicide Prevention
Program Name: Inland SoCal Crisis and Suicide Helpline (Helpline) and 211

The Inland SoCal Crisis & Suicide Helpline is a program of Inland SoCal United Way & 211+ which serves Riverside and San Bernardino counties. Services include 24/7 tele-counseling for mental health crisis and suicide prevention through 951-686-HELP (4357), community screen and referral for mental health urgent care and other resources, assessment and warm transfer to the Riverside County Crisis Mobile Unit, suicide prevention workshops and trainings for providers and the community, postvention services for suicide loss, and an evidence-based social work practicum program with field placements in the Helpline call center.

The Helpline has achieved significant success in responding to mental health crises through the implementation of a community point of access (aka front door) to the RUHS-BH 24/7 mobile crisis response. This initiative enhances immediate access to crisis stabilization services and supports community resilience. Key achievements include:

- Enhanced Crisis Response: The 24/7 mobile crisis team provides timely, on-site intervention, reducing the need for emergency department visits and law enforcement involvement. This aligns with best practices in crisis care, prioritizing de-escalation, and connection to appropriate community-based services.
- Trauma-Informed and Evidence-Based Training: Comprehensive training for crisis responders emphasizes de-escalation techniques, trauma-informed care, and culturally competent practices. This specialized training has contributed to a reduction in the need for law enforcement intervention, promoting a person-centered approach.
- Increased Community Awareness and Utilization: Community outreach efforts have significantly increased awareness of helpline services, resulting in a substantial increase in call volume. This demonstrates the effectiveness of proactive communication in promoting help-seeking behaviors. Data collected also showed a significant reduction in 911 call rates, emphasizing the effectiveness of preventative care and proactive intervention in addressing mental health crises before they escalate.
- Data-Driven Outcomes: Data indicates a positive impact on crisis system utilization, with a significant increase in calls to the helpline and requests for mobile crisis services and Mental Health Urgent Care. Critically, the data also shows a low percentage of calls involving active rescues for imminent risk to life, suggesting that the mobile crisis services are effectively de-escalating situations and providing appropriate support.

In fiscal year 2023-2024, the hotline received **8,312** calls from across the county compared to 5,331 calls in the previous fiscal year. Additionally, during FY 23/24, the crisis helpline (686-HELP) experienced a 128% increase in calls (from 407 calls in July 2023 to 928 calls in June 2024). Requests for Crisis Mobile services surged by 444% (from 43 calls in December 2023 to 234 calls in June 2024) and calls for Mental Health Urgent Care rose by 351% (from 51 calls in December 2023 to 230 calls in June 2024). Overall, the helpline received 56% more calls than the previous year and 67% more calls compared to two years ago, with most growth occurring after the 24/7 mobile service implementation. Importantly, only 0.63% of total calls involved active rescues for imminent risk to life, a decrease from previous years, indicating the effectiveness of the 24/7 mobile crisis services.

PEI Plan Project Area #1: Mental Health Outreach, Awareness, and Stigma Reduction

Inland SoCal Crisis and Suicide Helpline (Helpline) and 211 cont.

Some demographic data is collected for this program however the categories differ from those in the PEI regulations. For age, 265 were between the ages of 0-17, 306 were between the ages of 18-25, 761 were between the ages of 26-49, 724 were between the ages of 50-64, and 255 were 65 and older. For race/ethnicity, seven (7) identified as American Indian or Alaska Native, 34 identified as Asian, 68 identified as Black or African American, 631 identified as Hispanic or Latinx, two (2) identified as Native Hawaiian or other Pacific Islander, 262 identified as White, eight (8) identified as Other, and 22 identified as Multiracial. Notably, the number of BIPOC callers has increased by 20% over last year. Furthermore, 4,084 of callers identified as female, 2,743 identified as male, and 17 identified as LGBTQIA+.

Despite these successes, several challenges must be addressed to ensure the long-term sustainability and effectiveness of the crisis helpline:

- Funding Instability: Consistent and adequate funding is essential for maintaining service quality and meeting increasing demand. The transition from MHSA to BHSA requires careful navigation to ensure continued support for essential crisis services.
- Workforce Development and Retention: As call volumes rise, ensuring sufficient staffing levels with qualified and well-trained responders is crucial. Ongoing training in evidence-based practices, such as crisis intervention, trauma-informed care, and culturally competent care, is essential. Addressing staff burnout through robust support systems, including supervision, debriefing, and self-care resources, is also a priority.
- Data Collection and Outcome Measurement: Strengthening data collection and outcome measurement processes will allow for more robust evaluation of program effectiveness and identification of areas for improvement.

A key lesson learned is the critical importance of ongoing training and support for crisis responders. While initial training is essential, continuous professional development is necessary to keep staff up to date with evolving best practices and address the diverse needs of individuals experiencing mental health crises. Furthermore, prioritizing staff well-being through robust support systems is crucial for mitigating burnout and maintaining team effectiveness.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☒ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Asian American/Pacific Islander Mental Health Resource Center (AAPI-MHRC)

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: The Asian American Pacific Islander Mental Health Resource Center started in fiscal year 2017-2018. The resource center intends to provide mental health resources to the Asian American and Pacific Islander populations in Riverside, Perris, Moreno Valley, Menifee, and other surrounding cities with high density of Asian Americans/Pacific Islanders. The Resource Center engages in activities that reduces mental health stigma, increases mental health awareness, connects people with services and community mental health resources, and engages and educates about the signs and symptoms of mental illness within the Asian American community.

Number of unduplicated individual participants or audience members during FY 23/24: **390**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	7
Transition Age Youth (16-25)	27
Adult (26-59)	55
Older Adult (60+)	48
Declined to Answer	253
Race	
American Indian or Alaska Native	0
Asian	198
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	20
Other	0
More than one race	44
Declined to Answer	128
Ethnicity	
Hispanic or Latino as follows	20
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	20
Asian as follows	198
Filipino	171
Vietnamese	0
Chinese	0
Other Asian	27
Did not specify Asian group	0

Preferred Language	
English	24
Spanish	0
Bilingual	0
Another	0
Declined to Answer	366
Gender	
Male	0
Female	0
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	390
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	390
Disability	
Yes	0
No	0
Declined to Answer	390
Veteran Status	
Yes	0
No	0
Declined to Answer	390

Program Reflection: AAPI-MHRC

Implementation Successes:

During FY 23/24, there were a total of 26 events conducted by AAPI-MHRC. The activity forms were submitted by e-mail or online using Google forms. All of these events were conducted either in-person, virtual, or hybrid, with the majority of the events being conducted in-person (76.9%, n = 20), mostly at the AAPI-MHRC main office in Perris. A total of 21 events were completed in the Mid-County region (80.8%), while the remaining 5 events were completed in the Western region (19.2%). The majority of the events were completed in English (80.8%, n = 21), while the remaining 5 events were completed in combination of English and Tagalog. It is also noted that there may be other events that were held by AAPI-MHRC but the information was not submitted via online or paper forms.

Implementation Challenges:

The Asian American Pacific Islander Mental Health Resource Center (AAPI-MHRC) continued to encounter the scarcity of local AAPI bi-cultural & bi-lingual mental healthcare providers.

Staffing challenges and the loss of the resource center site location impacted the team. The contracted agency decided to not renew their contract. This service was picked up by another PEI provider focused on outreach and engagement with the AAPI community which began in FY 24/25.

Relevant Examples of Success/Impact:

The satisfaction survey has a section where participants could write comments on whether “the presentation was helpful” and add comments if they had any other feedback regarding the program. Below are some of the comments from participants that were gathered from the satisfaction surveys:

- “Great Event! Made mental health a more “family-friendly” topic for something that is usually so taboo. Very impactful!”
- “I really appreciate the open and supportive atmosphere. Thank you for making through the mental health awakening management in a very clear and supportive way.”
- “I liked how they tried to get through the mental wellness plan together and the collaborative nature in multiple AAPI community organization.”
- “I learned a lot from this event.”
- “I liked the breathing exercise, affirmations, using digital collage to explore feelings and expressions.”
- “I felt like it gave me a space to deep-dive and reflect on some buried thoughts. It was comforting to share it with a community of people with similarities.”
- “A lot of opportunities to share, spotlight on how Asian culture adds additional layers of complexity to the conversation, very validating and real stance of presenter/well researched current events examples, actionable takeaways of what to try and what to avoid.”
- “It was really nice to be in a community of people with similar experiences.”

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☒ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Stand Against Stigma (SAS)

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: The Stand Against Stigma (SAS) program outreaches to individuals and organizations, by working within the community and collaborating with schools, businesses, community organizations, and faith-based organizations, to provide activities that include Speaker's Bureau "Honest, Open, Proud" presentations. Speaker's Bureau "Honest, Open, Proud" presentations are utilized to educate and outreach to target audiences to address the unique issues that those with mental illness experience as they relate to mental health and interpersonal issues, with the aim of reducing stigmatizing attitudes.

Number of unduplicated individual participants or audience members during FY 23/24: **248**

Program Demographics:

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	12
Adult (26-59)	93
Older Adult (60+)	3
Declined to Answer	140
Race	
American Indian or Alaska Native	0
Asian	1
Black or African American	9
Native Hawaiian or other Pacific Islander	0
White	93
Other	1
More than one race	6
Declined to Answer	138
Ethnicity	
Hispanic or Latino as follows	74
Central American	1
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	1
Did not specify Hispanic/Latino group	72
Asian as follows	1
Filipino	1
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	99
Spanish	9
Bilingual	2
Another	0
Declined to Answer	138
Gender	
Male	37
Female	73
Transgender	0
Another	0
Declined to Answer	138
Sexual Orientation	
Lesbian	0
Gay	6
Bisexual	4
Yes, did not specify	0
Unknown	0
Another	1
Not LGBQ/Declined to Answer	84/153
Disability	
Yes	9
No	99
Declined to Answer	140
Veteran Status	
Yes	0
No	108
Declined to Answer	140

Program Reflection: SAS

Implementation Successes:

Overall, the Stand Against Stigma program saw an increase in their presentations by 24% compared to last fiscal year. This included reaching a total of 248 community members. The most frequently reported race/ ethnicity for all regions was Hispanic/Latinx (59.6%), which is one of our underserved communities. Furthermore, most of the presentations and attendance were from the Desert region (65.1%), which is a region in the County that has a high need for support and services.

Program outcomes showed a statistically significant increase in participants' affirming attitudes regarding recovery from mental health conditions, as well as a greater willingness to seek mental health services and support if they experience psychological challenges. Attendees reported strong satisfaction with the enthusiasm and knowledge of the presenters, and a high likelihood of recommending the program to others.

Implementation Challenges:

To help increase community access to presentations, the provider worked on promoting open, virtual presentations for community members to attend. However, it proved to be a challenge to have people attend these events. Oftentimes no one would show to these open, virtual presentations. Furthermore, when virtual presentations were held, the program did not see high completion rates of outcome measures.

Additionally, the program saw a lot of staff turnover, resulting in an even smaller pool of presenters that were able and available to share their lived experience.

Lessons Learned:

The biggest lesson learned from FY 23/24 was that the open, virtual community presentations were not successful in generating attendance from community members, and that a better, more strategic approach would be to decrease these offerings, and focus on approaching other organizations to host for their members.

Additionally, due to a small presenter pool, it is important for the team to communicate and coordinate upcoming presentations to help avoid presenter burnout and to properly care for their own mental health.

Relevant Examples of Success/Impact:

One of our presenters shared the following experience from one of their presentations in the Desert region:

"During one of our presentations for the Desert community, a listener shared that although her experiences were different, my story helped her understand why some people struggle to open up to therapists or other trained professionals. She mentioned that she had previously believed people who didn't seek help were sometimes responsible for staying in unsafe situations; however, after hearing about my negative experience with a therapist, she said she became more empathetic toward those who have difficulty going to or returning to therapy. I believe this example is significant because I felt like I was able to help reduce stigma and offer a new perspective to this community member."

Feedback from community members who attended the presentation:

- "I love that the presenters shared true life stories. It was a heartfelt presentation."
- "Thank you for sharing your life experience. I believe we are capable of things. Most people need the support to know that they can be successful."
- "Great job! Thank you for sharing your stories. They were powerful and can help so many to learn and feel less alone."
- "Your honesty and vulnerability are appreciated. Thank you for your time."
- "Thank you! This was wonderful to see and hear that there are people fighting the good fight."
- "Life is a miracle if we can experience it."

Stigma and Discrimination Reduction Activities

Type of Activity	Number of Events
Presentation	14

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☒ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Promotores(as) de Salud Mental y Bienestar Program

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: In partnership with the agency Vision y Compromiso, the Promotores(as) de Salud Mental y Bienestar program trained lay workers in the community (promotors) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early intervention services in the Hispanic/Latinx community.

Number of individual participants or audience members during FY 23/44: **11,862**

Program Demographics: The following demographic information is duplicated.

Age	
Children/Youth (0-15)	167
Transition Age Youth (16-25)	1,808
Adult (26-59)	6,990
Older Adult (60+)	2,865
Declined to Answer	32
Race	
American Indian or Alaska Native	3
Asian	7
Black or African American	23
Native Hawaiian or other Pacific Islander	0
White	11,717
Other	48
More than one race	0
Declined to Answer	64
Ethnicity	
Hispanic or Latino as follows	11,633
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	11,633
Asian as follows	7
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	7

Preferred Language	
English	534
Spanish	10,091
Bilingual	1,169
Another	0
Declined to Answer	68
Gender	
Male	3,720
Female	8,020
Transgender Male to Female	0
Transgender Female to Male	0
Another	7
Declined to Answer	115
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	37
Unknown	0
Another	0
Not LGBQ/Declined to Answer	11,825
Disability	
Yes	0
No	0
Declined to Answer	11,862
Veteran Status	
Yes	192
No	11,444
Declined to Answer	226

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☒ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Community Mental Health Promotion Program (CMHPP) - Native American

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: In partnership with the Riverside/San Bernardino County Indian Health Inc., the Native American CMHP program trained lay workers in the community (promoters) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early intervention services for the Native American community.

Number of unduplicated individual participants or audience members during FY 23/24: **961**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	140
Transition Age Youth (16-25)	536
Adult (26-59)	235
Older Adult (60+)	38
Declined to Answer	12
Race	
American Indian or Alaska Native	553
Asian	3
Black or African American	4
Native Hawaiian or other Pacific Islander	3
White	71
Other	5
More than one race	304
Declined to Answer	18
Ethnicity	
Hispanic or Latino as follows	52
Central American	4
Mexican/Mexican American/Chicano	30
South American	0
Multiple Hispanic	1
Other Hispanic	0
Did not specify Hispanic/Latino group	17
Asian as follows	3
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	3

Preferred Language	
English	936
Spanish	1
Bilingual	2
Another	0
Declined to Answer	22
Gender	
Male	354
Female	595
Transgender Male to Female	0
Transgender Female to Male	0
Another	5
Declined to Answer	7
Sexual Orientation	
Lesbian	1
Gay	1
Bisexual	17
Yes, did not specify	0
Unknown	3
Another	2
Not LGBQ/Declined to Answer	937
Disability	
Yes	12
No	914
Declined to Answer	35
Veteran Status	
Yes	5
No	939
Declined to Answer	17

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☒ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Community Mental Health Promotion Program (CMHPP) - Asian-American/Pacific Islander

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: In partnership with Asian Pacific Counseling and Treatment Centers, a division of Special Service for Groups, Inc. (SSG), the Asian-American/Pacific-Islander CMHP program trained lay workers in the community (promoters) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early intervention services for the Asian-American/Pacific Islander community.

Number of unduplicated individual participants or audience members during FY 23/24: **771**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	55
Transition Age Youth (16-25)	226
Adult (26-59)	208
Older Adult (60+)	269
Declined to Answer	13
Race	
American Indian or Alaska Native	2
Asian	600
Black or African American	4
Native Hawaiian or other Pacific Islander	0
White	72
Other	3
More than one race	63
Declined to Answer	27
Ethnicity	
Hispanic or Latino as follows	42
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	0
Asian as follows	611
Filipino	78
Vietnamese	15
Chinese	136
Korean	328
Other Asian	14
Did not specify Asian group	40

Preferred Language	
English	332
Chinese	108
Korean	255
Another	38
Declined to Answer	38
Gender	
Male	246
Female	473
Non-Binary	6
Transgender	2
Another	9
Declined to Answer	35
Sexual Orientation	
Lesbian	8
Gay	7
Bisexual	30
Yes, did not specify	8
Multiple	1
Self-Describe	16
Not LGBQ/Declined to Answer	547/154
Disability	
Yes	34
No	680
Declined to Answer	57
Veteran Status	
Yes	34
No	700
Declined to Answer	37

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☒ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Community Mental Health Promotion Program (CMHPP) - Middle Eastern/North African (MENA)

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: In partnership with Sahaba Initiative, the MENA CMHP program trained lay workers in the community (promoters) to outreach, bring awareness to topics in mental health, reduce stigma, and provide resource referrals to prevention and early Intervention services for the Middle Eastern/North African community.

Number of unduplicated individual participants or audience members during FY 23/24: **0**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0
Race	
American Indian or Alaska Native	0
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	0
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	0
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	0
Asian as follows	0
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	0
Gender	
Male	0
Female	0
Transgender	0
Nonbinary	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	0
Disability	
Yes	0
No	0
Declined to Answer	0
Veteran Status	
Yes	0
No	0
Declined to Answer	0

Program Reflection: Promotores and CMHP Programs

Implementation Successes:

Each of our providers worked to utilize community engagement effectively by continuing to cultivate and strengthen relationships with important stakeholders and key leaders, ensuring that their goals were aligned with the community's needs and priorities to foster interest and investment. Many of our providers were able to make inroads with different faith-based organizations, workplaces, and community organizations and collaborated with them to tailor their presentations to best meet the needs of the culture and social context of their communities.

Visíon y Compromiso established a new MOU with Jurupa Valley Unified School District and began partnering with the goal of supporting the district's parents, increasing their awareness and education around the different mental health topics. Additionally, the program expanded to include service to the Mid-County region in FY 23/24. Furthermore, throughout the County, the majority of those in attendance indicated Spanish as their primary language (85%). The provider held a total of 3,476 presentations with a total of 11,862 people in attendance.

Riverside-San Bernardino Indian Health, Inc. continued to collaborate with community organizations and found new resources to share with their Native American community members. A strong partnership continued during FY 23/24 with the University of California, Riverside and their Native American Student Programs. Other relationships with local colleges were developed during this fiscal year as well. The provider held a total of 143 presentations countywide with 1,083 in attendance, 85.6% of whom identified as American Indian or Alaskan Native.

Special Services for Groups found innovative ways to make their presentations appealing for their diverse AA/PI community. They found much success with infusing culturally relevant activities with their presentations to draw in more AA/PI community members. They centered their presentations around culturally tailored workshops, such as traditional dance, traditional crafting, and healthy living clubs. Community members were attracted by the different cultural activities and attended the mental health presentations that were related to those different activities (e.g., choreography and self-care and wellness, candle making and suicide prevention, etc.). In FY 23/24, the provider held a total of 47 presentations in English, Korean, and Chinese languages with 1,028 in attendance.

Sahaba Initiative started their contract approximately halfway through FY 23/24 and were able to establish an office location in the Riverside area and hire two full-time staff to serve in the Western and Mid-County regions of the county. During their first 6-months they were able to have both staff complete their 40-hour promoter training to be able to provide culturally tailored presentations to the Middle Eastern/North African community.

Implementation Challenges:

Some of the challenges that the providers faced during FY 23/24 was staffing promoters which resulted in pauses in service delivery to hold interviews, find the right fit for the team and community, undergo the onboarding requirements (e.g., DOJ background checks), and to conduct extensive 40-hour training. Whether starting these services brand new in the County (e.g., Sahaba Initiative for the MENA community), or expanding services to new regions (e.g., Visíon y Compromiso's expansion into Mid-County), the providers faced challenges with sharing their program in areas that were not familiar with the services provided. It took time to establish a presence and build relationships in the different communities.

Some communities are more conservative than others, making it difficult to overcome the stigma associated with mental health and discussions around mental illness and suicide prevention. Additionally, the providers encountered challenges with gathering community specific resources for their different underserved cultural groups, particularly for underserved groups with a lot of intragroup diversity (e.g., the many different tribes within the Native American community, the different cultures that make up Asian Americans/Pacific Islanders, etc.).

At times providers faced challenges with locating community spaces in which to host presentations. An alternative was to provide virtual presentations via Zoom when it was found to meet community need; however, this was often found to not be a worthwhile option for many community members, who were fatigued of virtual services since the pandemic, and often yielded in low attendance and low completion of demographic forms and satisfaction surveys.

Program Reflection: Promotores and CMHP Programs

Lessons Learned:

The providers in each of the CMHP programs learned the importance of persevering with their efforts to identify the leaders of each community to assist them in collaborative efforts to deliver the needed presentations to the underserved populations. They also found value in their continued work with churches and temples where audiences are already mobilized to raise awareness about their CMHP programs and other available resources. Overall, the providers learned how to establish credibility by being transparent, consistent, and respectful. They involved diverse stakeholders, ensuring all community groups were represented, especially marginalized voices. This led to them being able to more effectively utilize culturally appropriate approaches to remove barriers to participation. These outreach efforts have been a great success in leading workshops and building relationships within the different communities.

Relevant Examples of Success/Impact:

Here is a story that was shared by one of our promoters and the impact that they had on a community member:

In 2024, I began to offer Mental Health presentations at a Nutrition Center in Perris. Many ladies would attend some weeks but miss other sessions. However, there was one lady who was always there, ready to hear me talk about the topic of the day. She would be attentive, listening, and commenting. As the sessions went by, she felt more comfortable opening up and talking about her struggles so I would always point her to the resources that we had available. After each topic we would focus on self-care and putting our mental health first, so we could help others and learn to say no and set limits. The lady listened and after every class, she would remind the class about setting limits and practicing the protective factors provided in the presentations. She was even the first lady to learn what the word “stigma” meant in the class, and she was always so excited to explain to others what it meant. After some time, I no longer saw her, but one day I ran into her, and she was a different woman. She was more confident; she learned to set limits and care for herself more. She gave me the motivation to continue sharing mental health topics with the community.

Another promoter shared her experience with a community member:

On one occasion I went to reach out to some housing trailers in a parking lot in Thermal. There was an elderly woman sitting outside her trailer that caught my attention. I approached her and offered her a flyer for our program. She responded with a, “No, maybe next time.” I observed her sadness and continued to engage her in conversation. I spoke to her a little bit about depression and anxiety, and her eyes immediately filled with tears. I explained to her that we offered workshops on these different mental health topics, and that everything in this life can have a solution, and that there is always hope. I shared with her that I was going to have a presentation on depression in a local senior center, that she may feel welcomed at. I didn't think she would attend, but I was glad to see her arrive at my presentation! I introduced her to the members of the senior center, and they immediately made her feel welcomed. I was pleased to see that after each presentation she smiled and participated more until she told us about her life and experiences. In the end, we helped her find the necessary help. Not only did she succeed, but her adult daughter and her grandchildren who were going through challenges of depression and chronic alcoholism also got help. I am glad to see that she continues to participate in the senior center. She is happy with how she has been able to address her own challenges and overcome them. Now she does crafts and is in the dance group, her daughter is going to therapy, and she has been able to alleviate her symptoms of depression, which prevented her from taking care of her children and getting out of a toxic abusive relationship. Her grandchildren also found help with their drug and alcohol problems. It gave me great satisfaction to see how after a “No” that so many things could be done for this family. It gives me great pleasure to see how she greets me and thanks me every time I see her. As a promoter I feel responsible for my work and my community.

Outreach Activities

Type of Outreach	Number of Events
Presentation	3,666

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☒ Suicide Prevention	☐ Access and Linkages

Program Name: Know the Signs

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: Know the Signs is a statewide suicide prevention social marketing campaign built on three key messages: "Know the signs. Find the words. Reach out." This campaign is intended to educate on how to recognize the warning signs of suicide, how to find the words to have a direct conversation with someone in crisis, and where to find professional help and resources. The campaign has specifically designed culturally relevant posters to help communities in understanding the message. The posters and marketing materials are available in English, Spanish, Vietnamese, Korean, Hmong, Khmer, Lao, Mandarin, Tagalog, Punjabi, and Russian.

Number of unduplicated individual participants or audience members during FY 23/24: **108**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	12
Adult (26-59)	61
Older Adult (60+)	34
Declined to Answer	1
Race	
American Indian or Alaska Native	3
Asian	10
Black or African American	10
Native Hawaiian or other Pacific Islander	0
White	70
Other	3
More than one race	5
Declined to Answer	7
Ethnicity	
Hispanic or Latino as follows	48
Central American	2
Mexican/Mexican American/Chicano	41
South American	0
Multiple Hispanic	0
Other Hispanic	5
Did not specify Hispanic/Latino group	0
Asian as follows	10
Filipino	3
Vietnamese	1
Chinese	0
Other Asian	1
Did not specify Asian group	5

Preferred Language	
English	97
Spanish	6
Bilingual	0
Another	1
Declined to Answer	4
Gender	
Male	22
Female	81
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	5
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	12
Unknown	3
Another	0
Not LGBQ/Declined to Answer	79/14
Disability	
Yes	8
No	93
Declined to Answer	7
Veteran Status	
Yes	5
No	96
Declined to Answer	7

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☒ Suicide Prevention	☐ Access and Linkages

Program Name: Mental Health First Aid (MHFA) - Adult and Youth courses

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: The Mental Health First Aid program is an interactive session which runs 8 hours. It can be conducted as a one-day 9 hour seminar, two-day 4.5 hour seminar, or a four-day 2.5 hour seminar. The course covers risk/protective factors and warning signs for mental health problems, prevalence data, stigma, assessment, intervention, connecting individuals in crisis with appropriate care, as well as evidence-based professional, peer, social, and self-help resources available to help someone with a mental health problem. Separate courses are offered for adults and youth.

Number of unduplicated individual participants or audience members during FY 23/24: **225**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	61
Adult (26-59)	150
Older Adult (60+)	6
Declined to Answer	8
Race	
American Indian or Alaska Native	6
Asian	7
Black or African American	23
Native Hawaiian or other Pacific Islander	1
White	79
Other	68
More than one race	7
Declined to Answer	34
Ethnicity	
Hispanic or Latino as follows	145
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	145
Asian as follows	7
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	7

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	225
Gender	
Male	81
Female	137
Transgender Male to Female	0
Transgender Female to Male	0
Another	1
Declined to Answer	6
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	225
Disability	
Yes	0
No	0
Declined to Answer	225
Veteran Status	
Yes	0
No	0
Declined to Answer	225

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☒ Suicide Prevention	☐ Access and Linkages

Program Name: Applied Suicide Intervention (ASIST) Workshops

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: In the ASIST training, participants learn how to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. ASIST is a 2-day interactive training course.

Number of unduplicated individual participants or audience members during FY 23/24: **314**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	25
Adult (26-59)	208
Older Adult (60+)	10
Declined to Answer	71
Race	
American Indian or Alaska Native	3
Asian	8
Black or African American	35
Native Hawaiian or other Pacific Islander	1
White	166
Other	2
More than one race	27
Declined to Answer	72
Ethnicity	
Hispanic or Latino as follows	124
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	124
Asian as follows	9
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	9

Preferred Language	
English	227
Spanish	2
Bilingual	12
Another	2
Declined to Answer	71
Gender	
Male	44
Female	198
Transgender Male to Female	1
Transgender Female to Male	0
Another	0
Declined to Answer	71
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	29
Unknown	0
Another	0
Not LGBQ/Declined to Answer	203/82
Disability	
Yes	21
No	220
Declined to Answer	73
Veteran Status	
Yes	0
No	240
Declined to Answer	74

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☒ Suicide Prevention	☐ Access and Linkages

Program Name: safeTALK Workshops

Project Area as Defined by PEI Plan: PEI#1 Mental Health Outreach, Awareness, and Stigma Reduction

Program Description: It is a half-day training program that teaches participants to recognize and engage with individuals who possibly have suicidal thoughts and to connect them with community resources. safeTALK emphasizes safety while challenging the stigma in openly discussing suicide. It is recommended that individuals trained in ASIST or other suicide prevention programs to be at all safeTALK trainings.

Number of unduplicated individual participants or audience members during FY 23/24: **503**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	106
Adult (26-59)	320
Older Adult (60+)	44
Declined to Answer	33
Race	
American Indian or Alaska Native	2
Asian	52
Black or African American	57
Native Hawaiian or other Pacific Islander	1
White	306
Other	6
More than one race	39
Declined to Answer	40
Ethnicity	
Hispanic or Latino as follows	228
Central American	5
Mexican/Mexican American/Chicano	81
South American	0
Multiple Hispanic	0
Other Hispanic	3
Did not specify Hispanic/Latino group	139
Asian as follows	52
Filipino	8
Vietnamese	5
Chinese	1
Other Asian	7
Did not specify Asian group	31

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	503
Gender	
Male	130
Female	330
Transgender Male to Female	4
Transgender Female to Male	0
Another	5
Declined to Answer	34
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	3
Not LGBQ/Declined to Answer	488/12
Disability	
Yes	25
No	442
Declined to Answer	36
Veteran Status	
Yes	13
No	455
Declined to Answer	35

Program Reflection: Suicide Prevention Activities - ASIST, safeTALK, Know the Signs, MHFA

Implementation Successes:

The Riverside County Suicide Prevention Coalition (RivCo SPC) entered its fourth year during FY 23/24. Its eight (8) sub-committees continue to work towards meeting the stated goals/objectives of our local suicide prevention strategic plan, "Building Hope and Resiliency."

The SPC offers quarterly virtual presentations to build awareness, knowledge, and increase best practices regarding suicide prevention in Riverside County. The quarterly webinars are free, offered virtually, and recordings remain available on our website (www.rivcospc.org). This fiscal year, the following topics were offered:

- July 2023 - Workplace Suicide Prevention
- January 2024 - #safesocial: Social Media's Impact on Mental Health
- April 2024 - Suicide Prevention for Children and Pre-Teens: Why is it necessary and what can we do?

The October quarterly presentation is our full-day in-person conference. In October 2023, the conference theme was "Creating Hope Through Action: Bridging the Gap Between Spirituality and Suicide Prevention." The event hosted over 350 attendees. The conference included one keynote presentation focused on the essentials of suicide prevention in faith communities and two panels with 11 local faith leaders to discuss the role that faith communities can play in stigma reduction and suicide prevention efforts.

SPC sub-committees accomplished many achievements this year:

- Measuring and Sharing Outcomes - Released a data brief: Suicides in Riverside County 2018-2022.
- Effective Messaging and Communication - Supported sub-committees with ensuring work product utilized best practices for messaging safety, coordinated press releases for the annual SPC conference and local Directing Change event resulting in local media coverage of both events.
- Upstream - Concluded the Kindness Kit initiative with older adults focused on reducing social isolation and worked with local social work students at La Sierra University to develop a social media campaign for youth.
- Prevention: Trainings - Developed and released a Public Service Announcement commercial for the gatekeeper trainings that are offered at no cost to anyone who lives or works in Riverside County. Facilitated 84 suicide prevention gatekeeper trainings throughout the year, training a total of 1,150 new helpers.
    - Know the Signs - 17
    - Mental Health First Aid (Youth & Adult) - 17
    - ASIST - 19
    - safeTALK - 31
- Prevention: Engaging Schools - Increased school district participation in the sub-committee and co-chairs completed the school-based Suicide Risk Screening T4T, making this training available to school districts throughout Riverside County.
- Prevention: Higher Education - Created a series of videos for students and staff, including "How to Help a Student in Distress" and "Employee Self-Care."
- Intervention - Continued distribution and advertisement of the Care Transitions flyer as well as the launch of the Firearm Lock Distribution project distributing nearly 1,000 locks and attending approximately 10 community events this fiscal year.
- Postvention - active postvention efforts through the Trauma Intervention Program (TIP) continued. For FY 23/24, TIP received a total of 649 calls to their dispatch center where 55 were for suicide deaths. 62 LOSS kits were distributed.

Program Reflection: Suicide Prevention Activities - ASIST, safeTALK, Know the Signs, MHFA

Implementation Challenges:

The sub-committees are largely supported by volunteers and challenges continue with the recruitment and maintenance of subcommittee membership. Sub-committee co-chair vacancies and changes create more work for the remaining sub-committee members and makes it difficult to meet the objectives set forth in the strategic plan.

Lessons Learned:

Building partnerships across sectors throughout the county is critical for the sustainability of the coalition over time. This has key impacts on funding, access to a broader network of community members, and manpower to identify, develop, and implement initiatives to address the goals/objectives of the strategic plan.

Relevant Examples of Success/Impact:

Additional efforts through the SPC included:

- Youth Suicide Prevention and Response Network (YSPRN) pilot project funded and implemented by the California Department of Public Health (CDPH) – developing a system flow map for supporting youth in suicidal crisis with the goals of filling any gaps in support identified in Riverside County.
- The SPC served as a regional sponsor for the Inland Empire Out of the Darkness Walks hosted annually by the American Foundation for Suicide Prevention (AFSP). On September 30th we hosted the first Riverside Out of the Darkness Walk at Fairmount Park. We also supported the Inland Empire Walk in Rancho Cucamonga on October 21st and the Coachella Valley Walk in Palm Desert on October 28th. The coalition hosted an outreach table at each event to spread awareness about our current efforts. Through our outreach, 25 individuals expressed interest in facilitating Survivors for Suicide Loss Groups here in our county. This is just one example of the amazing connections that were made at these walks.
- This year marked the return of Send Silence Packing exhibits on our local college campuses since the pandemic began back in 2020. In October, PEI funded 2 exhibits at UCR and Mt. San Jacinto College. The Send Silence Packing traveling exhibit is an immersive experience utilizing mixed mediums to guide the visitor through the mental health journey of several American youth and young adults in an effort to increase awareness and reduce stigma associated with mental health concerns and suicide. Send Silence Packing is a full-day exhibit that includes personal stories from individuals impacted by suicide, an interactive wall display, as well as, local and national resources to connect visitors to. All personal stories have been revised to meet safe messaging best practices when sharing suicide attempts or losses. Participants are encouraged to read and/or watch videos of these personal stories to end the silence around mental illness and suicide. The exhibit also encourages visitors to connect with local and national support resources for themselves and others in need. After attending, the majority of visitors tell three or more people about what they learned and many reach out to a friend in need or seek their own support services as a result of the information they received.
- The local Directing Change Screening and Recognition Ceremony was held on May 16, 2024 at the Fox Theater. The event was attended by nearly 300 students, educators, local judges, mental health providers, families, and other community members. We celebrated the inspirational and thought-provoking artwork created by Riverside County youth this academic year and honored the art of mental health storytelling through film, music, and art. This year, we introduced the Hope & Justice Art Gallery to honor monthly contest winners and a musical performance by the November Hope & Justice first place winners. Riverside County youth submitted 203 films representing 26 schools & CBOs and 580 youth.

Suicide Prevention Activities

Type of Activity	Number of Events
Training	84 (Know the Signs, MHFA, ASIST, and safeTALK)
Conference	Second Annual Riverside County Suicide Prevention Conference

PEI Plan Project Area #2: Parent Education and Support

The goal of the project is to provide a family based intervention to teach parents effective communication skills, improve family functioning, build social support networks, and decrease children's risky social behaviors in a setting that is de-stigmatizing to a lot of families, which is school. RUHS-BH staff are co-located at two middle school campuses in one of the more resource deficient, high-risk communities in the County.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Triple P - Positive Parenting Program

Project Area as Defined by PEI Plan: PEI#2 Parent Education and Support

Program Description: Triple P is a multi-level system of parenting and family support strategies for families with children from birth to age 12. It is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program is structured to provide group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group.

Number of unduplicated individual participants or audience members during FY 23/24: **542**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	35
Adult (26-59)	491
Older Adult (60+)	12
Declined to Answer	4
Race	
American Indian or Alaska Native	5
Asian	11
Black or African American	47
Native Hawaiian or other Pacific Islander	4
White	435
Other	6
More than one race	28
Declined to Answer	6
Ethnicity	
Hispanic or Latino as follows	350
Central American	3
Mexican/Mexican American/Chicano	46
South American	2
Multiple Hispanic	0
Other Hispanic	2
Did not specify Hispanic/Latino group	297
Asian as follows	11
Filipino	3
Vietnamese	1
Chinese	0
Other Asian	3
Did not specify Asian group	4

Preferred Language	
English	394
Spanish	124
Bilingual	15
Another	2
Declined to Answer	7
Gender	
Male	110
Female	431
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	1
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	9
Unknown	0
Another	0
Not LGBQ/Declined to Answer	533
Disability	
Yes	21
No	516
Declined to Answer	5
Veteran Status	
Yes	7
No	534
Declined to Answer	1

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Teen Triple P - Positive Parenting Program

Project Area as Defined by PEI Plan: PEI#2 Parent Education and Support

Program Description: Triple P is a multi-level system of parenting and family support strategies for families with children from 12 to age 17. It is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program is structured to provide group class sessions for parents to learn through observation, discussion, and feedback. Presentations and small group practice are utilized during sessions and parents receive constructive feedback in the supportive environment of the group.

Number of unduplicated individual participants or audience members during FY 23/24: **144**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	131
Older Adult (60+)	5
Declined to Answer	8
Race	
American Indian or Alaska Native	2
Asian	4
Black or African American	12
Native Hawaiian or other Pacific Islander	0
White	120
Other	0
More than one race	4
Declined to Answer	2
Ethnicity	
Hispanic or Latino as follows	103
Central American	0
Mexican/Mexican American/Chicano	3
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	100
Asian as follows	4
Filipino	1
Vietnamese	0
Chinese	0
Other Asian	1
Did not specify Asian group	2

Preferred Language	
English	90
Spanish	51
Bilingual	3
Another	0
Declined to Answer	0
Gender	
Male	23
Female	121
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	3
Unknown	2
Another	0
Not LGBQ/Declined to Answer	139
Disability	
Yes	2
No	141
Declined to Answer	1
Veteran Status	
Yes	1
No	143
Declined to Answer	0

Program Reflection: Triple P and Teen Triple P

Implementation Successes:

For FY 23/24 the provider's contract deliverables were doubled (from 360 parents countywide to 720 parents countywide). The program's outreach efforts also expanded to recruit more parents into the service. In total, the provider was able to provide service to 686 parents, coming very close to the goal of 720.

Across both programs, parents had an 81.5% program completion rate and parents were overall highly satisfied with both programs (Triple P and Teen Triple P). Program outcomes indicated that participants increased in their positive parenting practices, decreased in inconsistent discipline practices, decreased experiences of depression, anxiety and stress levels, increased the level of involvement with their child/ teen, reported decreases in the frequency of disruptive behaviors, and increases in prosocial behaviors.

Implementation Challenges:

Recruitment into the Spanish and Teen classes remained a significant challenge for FY 23/24. Additionally, some school districts had lengthy and complex MOU requirements, delaying approvals and complicating the process with extensive demands to promote and provide services to school parents.

Additionally, with the expansion of contract deliverables, the team needed to increase staffing for the program. This took some time for new team members to be hired and complete the Triple P training and accreditation requirements to be able to facilitate classes. Additionally, staff turnover further impacted program implementation as new staff had to be recruited and trained in the Triple P model. This created delays in being able to start more classes throughout the County.

Lessons Learned:

With the expansion of contract deliverables, the provider learned new ways to increase outreach and gained valuable insights on how to effectively connect with and relate to diverse communities. They were able to expand outreach efforts by collaborating with new organizations and spaces; for example, creating social media presence in different locations throughout the County (e.g., "Mom Walk" in the mid-county region), partnering with recovery centers for referrals, and focusing on private schools to help with recruitment. The provider learned more about the importance of understanding the unique needs and dynamics of each group they provide services for and worked on tailoring the different classes offered to best meet those needs.

Relevant Examples of Success/Impact:

The provider had a parent who was taking classes in the Desert region share with them about the profound impact the program had on helping her to rebuild and strengthen her relationship with her child.

Through satisfaction surveys, other parents shared the following:

- "[I learned] better ways to discipline my child based on proper expectations of their age. I learned that my behavior is really a good way to start positivity in our household. Also, learned that slowing down translations in our household for big activities helped us all to stay calm & get ready for morning & bed routine w/ less fights."
- "It was a very safe space and I felt extremely comfortable expressing what I felt like were struggles in my household and the array of solutions and perspective I received were extremely helpful."
- "I liked that there were parents willing to discuss their troubles and offer insight into things that they do or have tried. Also liked doing the scenarios with the breakout sessions."

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Preschool 0-5 Clinic Programs

Project Area as Defined by PEI Plan: PEI#2 Parent Education and Support

Program Description: The RUHS-BH Prevention and Early Intervention preschool 0-5 programs, which includes the Mobile Services offers MH services including the evidence based practice of Parent Child Interaction Therapy (PCIT). The clinic also harbors three sprinter vans used for providing services at the client's home, school sites, or anywhere that is needed in identified underserved areas as defined by the EI Plan. Other activities include pro-social groups, parenting classes, parent consultations, provider consultations, and outreach.

Number of unduplicated individual participants or audience members during FY 23/24: **622**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	300
Transition Age Youth (16-25)	0
Adult (26-59)	322
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	1
Asian	0
Black or African American	22
Native Hawaiian or other Pacific Islander	0
White	176
Other	0
More than one race	77
Declined to Answer	346

Ethnicity	
Hispanic or Latino as follows	132
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	132
Asian as follows	0
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	622

Gender	
Male	198
Female	101
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	323

Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	622

Disability	
Yes	0
No	0
Declined to Answer	622

Veteran Status	
Yes	0
No	0
Declined to Answer	622

Program Reflection: Preschool 0-5 Clinic Programs

Implementation Successes:

The Preschool 0-5 Program under RUHS-BH Prevention and Early Intervention (PEI) remains dedicated to raising awareness, providing education, and offering comprehensive mental health services to families, children, and the community. The program addresses social-emotional challenges, enhances school readiness, and, in the past year, has intensified efforts to support children impacted by trauma. Mental health services continue to make a significant impact, with most being provided at school sites to reduce stigma and improve accessibility. This is especially important while awaiting the operation of mobile vans for more outreach. Key outcomes for FY 23/24 include:

Mental health services:

- A total of 11,408 mental health-related services were provided during this fiscal year, amounting to 9,276.2 service hours.
- 300 children (and their families) received PCIT/MH services in the Western, Mid-County, and Desert regions.
- Case management and family therapy accounted for most services - 38.7% and 31.7%, respectively.
- 16 children and 16 caregivers participated in the Incredible Years Program, which offers therapeutic groups for parents and children. This program focuses on addressing challenging behaviors, enhancing social skills, and promoting school-related expectations.

Treatment outcomes:

- Countywide, there was a statistically significant decrease in the frequency of child problem behaviors, as well as in caregivers' perceptions of their child’s behavior as problematic.
- 88% of families reported a good or fair prognosis after attending PCIT.
- Pre- and post-PSI scores showed a statistically significant decrease in parent stress levels countywide.
- Parents reported feeling more confident in their parenting skills and their ability to discipline their children. They also felt their relationship with their child and their child’s behavior improved.
- 57.4% of families met all or some of the goals set by the family and the therapist.

Outreach:

- Four outreach events - including a mental health fair, a back-to-school event, and a school administration orientation - engaged 52 parents, teachers, and community providers.
- 23 parent consultations provided awareness and education to caregivers seeking guidance on managing behavioral concerns and enhancing their child's social skills, with tip sheets and handouts for additional support.

Program Reflection: Preschool 0-5 Clinic Programs

Implementation Challenges:

During FY 23/24, the Preschool 0-5 Program (PEI) has experienced increased collaboration with school districts, with many becoming more receptive to services. While previous barriers, such as the pandemic and concerns about school violence, have posed challenges, the program has made significant progress. The number of children served rose from 101 in FY 22/23 to 300 in FY 23/24, a 197% increase. However, some school districts continue to face challenges aligning educational and behavioral health priorities and policies. The program is actively addressing these challenges to ensure consistent support for children and families. Key issues include:

- Ensuring students requiring assistance are correctly recognized, referred to, and connected to the necessary services.
- Guaranteeing students in need of mental health services can be excused from class without repercussions.
- Securing access to school campuses, providing designated parking spaces for mobile therapy units (up to 6 feet and a half in length), and ensuring accessible restroom and breakroom facilities.
- Maintaining HIPAA privacy for students receiving services.
- Streamlining the process for initiating behavioral services, including parenting groups, within schools and the community.
- Enhancing teacher awareness and improving understanding of social-emotional and early intervention treatments.

Additionally, reduced visibility on school campuses, challenges in community outreach, and travel to remote locations have impacted the number of services provided. However, this is expected to improve in 2025 with the arrival of mobile units and the planned rollout of services.

Another challenge influencing the program's impact was the shift in staffing preferences. In 2024, Riverside County administration made changes to enhance salaries, differential pay, and benefits, making in-person roles more competitive than remote work options. As a result, three of four vacancies have been filled, with the onboarding of a fourth clinician scheduled for 2025.

Lessons Learned:

The Preschool 0-5 Program (PEI) has learned the critical importance of sustaining strong connections and maintaining constant communication with school districts to address administrative changes that may hinder success. These include:

- Evolving school staff unawareness or the need for reorientation regarding services and the referral process.
- Coordinating our presence at school events, such as back-to-school nights or staff development meetings, to maintain awareness and support, whether in person or virtually.
- Maintaining awareness of Memoranda of Understanding (MOUs) between RUHS-BH and partner school districts and ensuring continued service provision and health screenings in the absence of mobile units.
- Coordinating arrangements regarding staff access to campus restrooms and breakrooms, especially with the reduction in mobile space now utilizing sprinter vans.
- Balancing school safety protocols due to increasing societal concerns while navigating classroom consultations, observations, and services for children.
- Staying informed about safety protocols from both RUHS-BH and school districts to ensure the well-being of children, families, and staff.

Program Reflection: Preschool 0-5 Clinic Programs

Relevant Examples of Success/Impact:

Despite facing challenges such as limited collaboration with certain school districts, staffing shortages, and the continued absence of mobile clinics, the PEI team has demonstrated resilience and adaptability in delivering critical services. To address geographical barriers, three school sites were strategically utilized, increasing accessibility for families across the region. The use of telehealth also played a key role in accessibility for those families in isolated areas. Additionally, the program has successfully secured partnerships with six school districts, ensuring continuity of services and collaboration. Strong administrative support has been instrumental in addressing staffing shortages, prioritizing hiring efforts, and implementing improvements to strengthen the program's capacity. These actions have enabled the program to maintain its commitment to serving the community, despite ongoing challenges.

A family testimonial below highlights how these efforts make a meaningful impact on the lives of families, showcasing the true purpose of our work at Preschool 0-5 (PEI). Please note that the family providing the testimonial has authorized us to share their story.

> "I just wanted to take the time to tell you how appreciative I am of not only this program, but the individuals tasked with facilitating it. I began my journey with Ms. Jamie, and shortly after transitioned to Ms. Kaira and Ms. Rocio. I cannot recommend or speak more highly of these individuals or this program. They have accommodated my schedule, when sick or training has come up have rescheduled me with ease or done a check in to ensure the week was smooth. Provided multiple resources and ideas to implement at home. When weeks were more challenging than others offered words of reassurance and encouragement. Throughout this whole process I can say I was excited to come, to show my skills as well as mine and my daughters' improvements. Our relationship, while not perfect (though can it really ever be?) has improved significantly. We are bummed to have completed but have both come out stronger more confident individuals and I have no one but these women and your program to thank. I can take my daughter to places without having to worry about outbursts or feel embarrassed and it is thanks to these skills and the consistency. I'm sure you know how positively impactful your program is, but I wanted to give thanks the only way I know how. Your program is one I will continue to recommend to anyone and everyone who is experiencing similar challenges to those I had once experienced. I cannot say it enough but thank you so much to Kaira and Rocio for the support, continued support, words of encouragement and especially the support during those challenging sessions. :)"

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Strengthening Families Program (SFP 6-11)

Project Area as Defined by PEI Plan: PEI#2 Parent Education and Support

Program Description: Strengthening Families Program (SFP) is a family skills training intervention designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children ages 6 to 11 years old. SFP's goals include strengthening parenting skills, building family strengths, enhancing youth's school success, and reducing risk factors for behavioral, emotional, and social problems in high-risk children (those from communities that are underserved, low-income, exposed to violence, trauma, and other stresses).

Number of unduplicated individual participants or audience members during FY23/24: **144**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	3
Adult (26-59)	136
Older Adult (60+)	2
Declined to Answer	3

Race	
American Indian or Alaska Native	0
Asian	1
Black or African American	7
Native Hawaiian or other Pacific Islander	0
White	130
Other	0
More than one race	2
Declined to Answer	4

Ethnicity	
Hispanic or Latino as follows	116
Central American	3
Mexican/Mexican American/Chicano	77
South American	1
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	35
Asian as follows	1
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	1
Did not specify Asian group	0

Preferred Language	
English	54
Spanish	83
Bilingual	3
Another	0
Declined to Answer	4

Gender	
Male	31
Female	110
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	3

Sexual Orientation	
Lesbian	2
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	142

Disability	
Yes	3
No	137
Declined to Answer	4

Veteran Status	
Yes	1
No	138
Declined to Answer	5

Program Reflection: SFP

Implementation Successes:

Across all providers, the program was delivered with high fidelity and compliance to the evidence-based practice to the families served. Countywide, the Strengthening Families Program enrolled 117 families made up of 144 individual parents/caregivers. Of those enrolled in the program 85% met the program completion standards. Most parents/caregivers enrolled identified as Hispanic/Latinx (80%) and 59% selected Spanish as their primary language. Statistically significant improvements were seen in parental involvement, child behavior, and family cohesion.

The providers in both Western and Desert region achieved completing 39 families – coming very close to reaching the contract goals of 40 families. The provider in Mid-County was able to complete 21 families, despite experiencing staffing challenges and a delayed start-up of services until mid-fiscal year.

Implementation Challenges:

All programs faced staffing changes and challenges in FY23/24. A new Mid-County provider was added this year and experienced delays in service start time because of challenges with staffing the program. The provider received the SFP training when the program was fully staffed, but shortly after training experienced staff turnover. Program implementation was delayed as they had to hire, onboard, and train new staff. Western region experienced staff shortages due to their organization shifting staff from this contract to work other jobs within the organization. The Desert region also brought on new staff, as long-time staff on the contract left for other opportunities.

Several of the providers also reported increased challenges with families this fiscal year in regard to children's developmental delays that made it challenging to manage some of the group sessions and may have resulted in other families dropping out of the program due to the experience of "chaos" in those groups.

Lessons Learned:

Due to staffing changes and time in between SFP trainings, providers had to learn to work with new co-facilitators by pairing up a trained staff with a new staff to remain in compliance with fidelity to the program.

After experiences of some behavioral challenges in some of the groups, the providers learned how to improve their screening process and how to share program criteria with referring parties to better match the families to the program. As a result, providers learned about additional community resources that they could share with those families that needed additional support with managing their children's behaviors and development.

Our newest SFP provider in Mid-County stated that they learned how important it is for the SFP team to make the connection during the first few weeks with all the families. It's paramount that the SFP team makes the families feel as welcomed and nurtured as possible to help increase retention. They learned the value of spending time getting to know the parents and children, eating with them, serving them, etc. and how that added to the bond that they were hoping to make. They observed that the families didn't really start connecting with each other until about week 4, so it is the responsibility of the SFP team to make the families want to keep coming until they eventually build those dynamic relationships with the other families. Once that happened, they found that it was much easier to have the families return each week.

They also learned how important it was to make each session fun. They realized that a lot of the families were not used to doing things or having fun together as a family, and the sessions provided that opportunity for them to do so, and they got better at it as each week passed. They found that the best way to get the parents to come each week was to make sure the children were having a great time. On numerous occasions the parents have told the Site Coordinator that the children are always reminding them when the SFP class is scheduled or telling them they want to be sure to go to class and not miss it. If the children are having fun and continuing to remind their parents of the weekly sessions, that increases the likelihood that the parents will be there too.

Program Reflection: SFP
Relevant Examples of Success/Impact:

Community feedback on program impact and success:

- “The group leaders are very good at their jobs. They are very nice people, professional and kind not only with parents but with children. I am very grateful for the patience with my 6-year-old. May God always bless you so that you can continue helping more families with this program.”
- “I loved the program and I believe these programs are important and great for parents. With parents, there can never be too much learning. This class has helped me better understand my kids and become a better parent. The group leaders were awesome!”
- “My entire family loved coming weekly to the sessions. We loved getting involved with other parents as well as the children of other kids. It really helped with our communication as a family. We always looked forward to coming to the sessions to learn more on different approaches for parenting. My girls understood their lessons equally. We'd discuss our classes at the end as a family and speak on how we could work together to implement them.”
- “This class has been very helpful to me and my son. We have a better relationship now than when we first started the class.”
- “So beneficial. This group was really amazing and might I say it turned my whole life around. I will never forget y'all.”
- “This program helped us a lot. We never got along well and now we do. Very grateful for everything. The children were very happy with the teachers.”

PEI Plan Project Area #3: Early Intervention for Families in Schools

This PEI project area works with children and families with a focus on providing services in non-traditional and natural community settings, e.g., family resource centers, faith based organizations, and child care centers. Providing services in community settings to enhance parental knowledge, skills, and confidence in managing their children's disruptive behaviors. Each component of this project focuses on children and families through a variety of interventions and strategies.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: PEACE4Kids

Project Area as Defined by PEI Plan: PEI#3 Early Intervention for Families in Schools

Program Description: Based on Aggression Replacement Training for middle school students during school with two levels. The program goals are for students to master social skills, school success, control anger, decrease acting out behaviors, and increase constructive behaviors. A parent component is included in the program as well to create social bonding among families.

Number of unduplicated individual participants or audience members during FY 23/24: **0**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	
Older Adult (60+)	
Declined to Answer	

Race	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Declined to Answer	

Ethnicity	
Hispanic or Latino as follows	
Central American	
Mexican/Mexican American/Chicano	
South American	
Multiple Hispanic	
Other Hispanic	
Did not specify Hispanic/Latino group	
Asian as follows	
Filipino	
Vietnamese	
Chinese	
Other Asian	
Did not specify Asian group	

Preferred Language	
English	
Spanish	
Bilingual	
Another	
Declined to Answer	

Gender	
Male	
Female	
Transgender Male to Female	
Transgender Female to Male	
Another	
Declined to Answer	

Sexual Orientation	
Lesbian	
Gay	
Bisexual	
Yes, did not specify	
Unknown	
Another	
Not LGBQ/Declined to Answer	

Disability	
Yes	
No	
Declined to Answer	

Veteran Status	
Yes	
No	
Declined to Answer	

Program Reflection: PEACE4Kids

Implementation Challenges:

Peace4Kids is a school based program that is designed to improve protective factors for children, teach parents effective communication skills, build social support networks, and empower parents to be the primary prevention advocates in their children's life in a setting that is de-stigmatizing to a lot of families, which is school. The impacts of the COVID-19 pandemic essentially de-railed this project. Peace4Kids was not implemented in fiscal year 2023-2024. It became clear that the model for implementation we were using was not ideal. In May 2022, this program was released for competitive bid for school districts. Unfortunately, no bids were received. Currently this program is on hold.

Lessons Learned:

School systems know their systems best. The interruption of services provided the opportunity to re-evaluate this project. The PEACE4Kids program will no longer be provided by RUHS-BH staff, instead the program will go out to competitive bid specifically for school districts so they can implement the program within their own campus communities. The goal is to have the PEACE4Kids program in at least one school district per region.

PEI Plan Project Area #4: Transition Age Youth (TAY) Project

This project area is designed to address specific outreach, stigma reduction, prevention, early intervention, and suicide prevention activities for Transition Age Youth (TAY) at highest risk of self-harm. Targeted outreach is used to identify and provide services for LGBTQ+ TAY, TAY in the foster care system and those transitioning out of the foster care system, runaway TAY, and TAY transitioning onto college campuses.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve. Some of these programs have limited data collection, so more narrative information is included for these programs.

Program Type: TAY Suicide Prevention
Program Name: Directing Change Program and Student Film Contest
The Directing Change Program and Student Film Contest is part of Take Action for Mental Health. The program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health which are used to support awareness, education, and advocacy efforts on these topics. Learning objectives surrounding mental health and suicide prevention are integrated into the submission categories of the film contest, giving young people the opportunity to critically explore these topics. In order to support the contest and to acknowledge those local students who submitted videos, RUHS-BH held a virtual awards ceremony. In fiscal year 2023-2024, **203** films were submitted by **580** Riverside County youth from **26** schools and organizations.

PEI Plan Project Area #4: Transition Age Youth (TAY) Project

Program Type: TAY Suicide Prevention
Program Name: Teen Suicide Awareness and Prevention Program (TSAPP)
Limited data is collected for this program so no data sheet is provided.
PEI funded the Riverside University Health System–Public Health (RUHS-PH), Injury Prevention Services to continue implementing the teen suicide awareness and prevention program. RUHS-PH continued their approach of contracting at the district level to serve all high schools and middle schools in each district. This ensured school district support of the program. RUHS-PH provided the Suicide Prevention (SP) curriculum training to a leadership group at each campus.

The primary goal of the SP program is to help prevent teen suicide by providing training and resources to students, teachers, counselors, and public health workers. Each high school and middle school within the selected school district are required to establish a suicide prevention club on campus or partner with an existing service group throughout the school year to train them in the Suicide Prevention curriculum. By focusing on a peer to peer approach with the SP program it helps to bridge the trust among students and utilize the program to its full potential. Individuals in each service group are identified as SP outreach providers with the ability to assist their peers in asking for help if they are in crisis. SP outreach providers have training on topics such as: leadership, identifying warning signs to suicide behavior, local resources to mental/behavioral health services, and conflict resolution.

In addition, RUHS-PH assisted each established suicide prevention club and middle school service group with a minimum of two (2) SP activities throughout the school year. One of the required high school club activities is to participate in the annual Directing Change video contest. The remaining activities include handing out SP cards at open house events, school events, and making PSA announcements. This will help to build momentum around suicide prevention and reduce the stigma associated with seeking mental health care services. Trainings are also provided that target the staff and parents of students. RUHS-PH provides Gatekeeper trainings to school staff, and SafeTALK, a 3 hour training designed to introduce the topic of suicide intervention. The goal of this training is to equip participants to respond knowledgeably and confidently to a person at risk of suicide. Just as "CPR" skills save lives, training in suicide intervention makes it possible for trained participants to be ready, willing, and able to help a person at risk. In addition, RUHS-PH works with Riverside County Helpline to provide suicide prevention and awareness trainings to parents. This will help to ensure that everyone involved with each school site has the opportunity to learn more about suicide prevention and resource awareness.

The work with schools this past year really highlighted the continued struggle school personnel and students face post pandemic. Many program advisors shared the struggle to maintain their own mental health while supporting the increased needs of their students. Due to this, program staff began offering staff training in self -care and encouraging help seeking among school personnel. Additionally, they offered increased support and resources during the year to promote help seeking for students. They also increased campaigns and encouraged students to participate in activities such as Directing Change video and film contest to support peer-to-peer education on suicide prevention and mental health awareness.

In fiscal year 2023-2024, there were **89** teen suicide prevention trainings conducted to **2,878** middle and high school students. There were **144** Suicide Prevention campaigns impacting **114,509** students across Riverside County and a total of **29,129** resources and incentives were distributed. RUHS-PH staff continued to provide parent education and staff development activities. The parent education component provided parents with a 1 to 2-hour presentation on the warning signs, risk factors, and resources available to youth in crisis. The program conducted **30** parent/community workshops reaching **203** community members. The staff development component consisted of providing **4** SafeTALK suicide awareness trainings impacting **102** student personnel **1** ASIST training with **32** school personnel, and **1** MHFA for youth training impacting **31** school personnel.

A total of 2,463 evaluations were completed after the student trainings.
- 90% felt they were more knowledgeable about resources available to someone who may be in crisis.
- 90% correctly identified all of the risk factors presented in the post survey.
- 85% correctly identified all the potential warning sides of suicide.
- 89% correctly answered the next step to take if they were concerned about a friend who thinks they are depressed or thinking about suicide.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☒ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Stress and Your Mood (SAYM)

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: Stress and Your Mood (SAYM) is an early intervention for depression program based on the Cognitive Behavioral Therapy (CBT) model, with modifications for transition age youth (TAY). SAYM was developed to improve access to evidence-based treatment for TAY with depressive disorders and sub-clinical depressive symptoms, with referrals given to those in need of medication evaluation with prescribing psychiatrists to ensure continuity of care. SAYM services have three phases: Conceptualization; Skills and application training; and Relapse prevention. Services are low-intensity and time limited, and can be provided in either group or in individual sessions.

Number of unduplicated individual participants or audience members during FY 23/24: **244**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	244
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0
Race	
American Indian or Alaska Native	1
Asian	16
Black or African American	22
Native Hawaiian or other Pacific Islander	1
White	182
Other	2
More than one race	20
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	154
Central American	3
Mexican/Mexican American/Chicano	77
South American	0
Multiple Hispanic	0
Other Hispanic	74
Did not specify Hispanic/Latino group	0
Asian as follows	17
Filipino	8
Vietnamese	3
Chinese	0
Other Asian	6
Did not specify Asian group	0

Preferred Language	
English	229
Spanish	2
Bilingual	11
Another	2
Declined to Answer	0
Gender	
Male	67
Female	163
Transgender	8
Another	6
Declined to Answer	0
Sexual Orientation	
Lesbian	6
Gay	4
Bisexual	35
Yes, did not specify	0
Unknown	0
Another	16
Not LGBQ/Declined to Answer	183
Disability	
Yes	8
No	232
Declined to Answer	4
Veteran Status	
Yes	0
No	244
Declined to Answer	0

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Peer-to-Peer - Directing Change Workshops

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: The Peer-to-Peer program is designed to provide outreach, informal counseling, and support/informational groups to at-risk youth and families. The program outreaches to the community in order to organize and facilitate TAY group presentations and discussions. Activities include CAST (evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts), Peer Mentoring, LGBTQ+ Support Groups, Speaker's Bureau presentations (utilized to focus on the unique issues that at-risk TAY experience as they relate to mental health and interpersonal issues), and Directing Change workshops.

Number of unduplicated individual participants or audience members during FY 23/24: **229**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	65
Transition Age Youth (16-25)	159
Adult (26-59)	1
Older Adult (60+)	0
Declined to Answer	4
Race	
American Indian or Alaska Native	2
Asian	7
Black or African American	13
Native Hawaiian or other Pacific Islander	4
White	189
Other	0
More than one race	9
Declined to Answer	5
Ethnicity	
Hispanic or Latino as follows	196
Central American	11
Mexican/Mexican American/Chicano	132
South American	0
Multiple Hispanic	1
Other Hispanic	1
Did not specify Hispanic/Latino group	51
Asian or Pacific Islander as follows	12
Filipino	6
Vietnamese	1
Chinese	1
Other Asian/PI	3
Did not specify Asian/PI group	1

Preferred Language	
English	183
Spanish	17
Bilingual	24
Another	0
Declined to Answer	5
Gender	
Male	93
Female	123
Transgender	3
Nonbinary	2
Gender Fluid	3
Declined to Answer	5
Sexual Orientation	
Lesbian	4
Gay	3
Bisexual	16
Yes, did not specify	0
Unsure	3
Another	7
Not LGBQ/Declined to Answer	157/39
Disability	
Yes	8
No	213
Declined to Answer	8
Veteran Status	
Yes	0
No	220
Declined to Answer	9

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Peer-to-Peer - Speaker's Bureau presentations

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: The Peer-to-Peer program is designed to provide outreach, informal counseling, and support/informational groups to at-risk youth and families. The program outreaches to the community in order to organize and facilitate TAY group presentations and discussions. Activities include CAST (evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts), Peer Mentoring, LGBTQ+ Support Groups, Speaker's Bureau presentations (utilized to focus on the unique issues that at-risk TAY experience as they relate to mental health and interpersonal issues), and Directing Change workshops.

Number of unduplicated individual participants or audience members during FY 23/24: **420**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	66
Transition Age Youth (16-25)	337
Adult (26-59)	1
Older Adult (60+)	1
Declined to Answer	15
Race	
American Indian or Alaska Native	6
Asian	11
Black or African American	21
Native Hawaiian or other Pacific Islander	3
White	342
Other	0
More than one race	14
Declined to Answer	23
Ethnicity	
Hispanic or Latino as follows	328
Central American	23
Mexican/Mexican American/Chicano	226
South American	0
Multiple Hispanic	6
Other Hispanic	2
Did not specify Hispanic/Latino group	71
Asian or Pacific Islander as follows	17
Filipino	6
Vietnamese	2
Chinese	0
Other Asian/PI	5
Did not specify Asian/PI group	4

Preferred Language	
English	334
Spanish	26
Bilingual/Multilingual	39
Another	1
Declined to Answer	20
Gender	
Male	195
Female	192
Transgender	4
Nonbinary	5
Gender Fluid	6
Declined to Answer	18
Sexual Orientation	
Lesbian	11
Gay	8
Bisexual	29
Yes, did not specify	0
Unsure	9
Another	10
Not LGBQ/Declined to Answer	292/61
Disability	
Yes	29
No	366
Declined to Answer	25
Veteran Status	
Yes	1
No	398
Declined to Answer	21

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Peer-to-Peer - LGBTQ+ Support Groups

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: The Peer-to-Peer program is designed to provide outreach, informal counseling, and support/informational groups to at-risk youth and families. The program outreaches to the community in order to organize and facilitate TAY group presentations and discussions. Activities include CAST (evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts), Peer Mentoring, LGBTQ+ Support Groups, Speaker's Bureau presentations (utilized to focus on the unique issues that at-risk TAY experience as they relate to mental health and interpersonal issues), and Directing Change workshops.

Number of unduplicated individual participants or audience members during FY 23/24: **78**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	7
Transition Age Youth (16-25)	71
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	1
Asian	4
Black or African American	11
Native Hawaiian or other Pacific Islander	0
White	60
Other	0
More than one race	1
Declined to Answer	1

Ethnicity	
Hispanic or Latino as follows	57
Central American	3
Mexican/Mexican American/Chicano	38
South American	1
Multiple Hispanic	2
Other Hispanic	1
Did not specify Hispanic/Latino group	12
Asian or Pacific Islander as follows	4
Filipino	1
Vietnamese	0
Chinese	0
Other Asian/PI	3
Did not specify Asian/PI group	0

Preferred Language	
English	71
Spanish	1
Bilingual	5
Another	0
Declined to Answer	1

Gender	
Male	11
Female	37
Transgender	11
Nonbinary	9
Gender Fluid	10
Declined to Answer	0

Sexual Orientation	
Lesbian	3
Gay	4
Bisexual	19
Yes, did not specify	5
Unsure	2
Another	19
Not LGBQ/Declined to Answer	20/6

Disability	
Yes	10
No	66
Declined to Answer	2

Veteran Status	
Yes	0
No	78
Declined to Answer	0

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Peer-to-Peer - Peer Mentoring

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: The Peer-to-Peer program is designed to provide outreach, informal counseling, and support/informational groups to at-risk youth and families. The program outreaches to the community in order to organize and facilitate TAY group presentations and discussions. Activities include CAST (evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts), Peer Mentoring, LGBTQ+ Support Groups, Speaker's Bureau presentations (utilized to focus on the unique issues that at-risk TAY experience as they relate to mental health and interpersonal issues), and Directing Change workshops.

Number of unduplicated individual participants or audience members during FY 23/24: **45**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	2
Transition Age Youth (16-25)	43
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	0
Asian	2
Black or African American	10
Native Hawaiian or other Pacific Islander	0
White	31
Other	0
More than one race	2
Declined to Answer	0

Ethnicity	
Hispanic or Latino as follows	32
Central American	1
Mexican/Mexican American/Chicano	23
South American	1
Multiple Hispanic	1
Other Hispanic	0
Did not specify Hispanic/Latino group	6
Asian or Pacific Islander as follows	4
Filipino	2
Vietnamese	0
Chinese	0
Other Asian/PI	2
Did not specify Asian/PI group	0

Preferred Language	
English	41
Spanish	3
Bilingual	1
Another	0
Declined to Answer	0

Gender	
Male	13
Female	29
Transgender	1
Nonbinary	2
Gender Fluid	0
Declined to Answer	0

Sexual Orientation	
Lesbian	0
Gay	3
Bisexual	10
Yes, did not specify	0
Unsure	2
Another	2
Not LGBQ/Declined to Answer	24/4

Disability	
Yes	4
No	40
Declined to Answer	1

Veteran Status	
Yes	0
No	45
Declined to Answer	0

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: TAY Resiliency Project: Peer-to-Peer - Coping and Support Training (CAST)

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: The Peer-to-Peer program is designed to provide outreach, informal counseling, and support/informational groups to at-risk youth and families. The program outreaches to the community in order to organize and facilitate TAY group presentations and discussions. Activities include CAST (evidenced-based curriculum with three major goals: Mood Management, Drug Use Control, and Using School Smarts), Peer Mentoring, LGBTQ+ Support Groups, Speaker's Bureau presentations (utilized to focus on the unique issues that at-risk TAY experience as they relate to mental health and interpersonal issues), and Directing Change workshops.

Number of unduplicated individual participants or audience members during FY 23/24: **83**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	2
Transition Age Youth (16-25)	81
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	0
Asian	3
Black or African American	5
Native Hawaiian or other Pacific Islander	0
White	70
Other	0
More than one race	4
Declined to Answer	1

Ethnicity	
Hispanic or Latino as follows	62
Mexican/Mexican American/Chicano	39
Central American	1
South American	2
Multiple Hispanic	0
Other Hispanic	1
Did not specify Hispanic/Latino group	19
Asian or Pacific Islander as follows	3
Filipino	1
Vietnamese	1
Chinese	0
Other Asian/PI	1
Did not specify Asian/PI group	0

Preferred Language	
English	79
Spanish	2
Bilingual	2
Another	0
Declined to Answer	0

Gender	
Male	30
Female	44
Transgender	2
Nonbinary	5
Gender Fluid	2
Declined to Answer	0

Sexual Orientation	
Lesbian	3
Gay	2
Bisexual	16
Yes, did not specify	0
Unsure	1
Another	5
Not LGBQ/Declined to Answer	46/10

Disability	
Yes	3
No	80
Declined to Answer	0

Veteran Status	
Yes	0
No	82
Declined to Answer	1

Program Reflection: TAY Resiliency Project - SAYM & Peer-to-Peer

Implementation Successes:

Stress and Your Mood (SAYM)

Demographic information showed that the SAYM program served the intended target population of Transition Age Youth (TAY). A total of 244 participants were enrolled in the SAYM program during FY 23/24, and 100% of the participants were TAY. SAYM services were provided in both group and individual formats. Overall, the SAYM program met 79% of contract expectations. The program completion rate was 68% with 166 out of 244 youths completing the program, and two (2) participants continuing their SAYM services in the FY 24/25.

Participants in the SAYM program showed decreases in the frequency of depression symptoms. Overall, the CES-D scores decreased from pre-test to post-test. These changes were statistically significant. Clinicians' ratings on the Clinical Global Impression Improvement Scale (CGI-I) also showed that the youth psychiatric status improved following the SAYM Program. The majority of youths (a total of 59.8%) were noted as "Much Improved" and "Very Much Improved." Across modules, there seems to be a cumulative effect where clients' level of improvement kept increasing as they continued in the program. This illustrates the importance of clients completing the SAYM program. Pre- to post-comparisons on Y-OQ®-SR total scores showed statistically significant decreases on most subscales.

Peer-to-Peer

There was a total of 86 Directing Change outreach presentations countywide. Additionally, there were 13 Directing Change workshops with 229 participants in attendance. There was a total of 25 Speaker's Bureau presentations countywide with 420 participants in attendance. Pre- and post-tests were collected from 392 individuals. Stigmatizing attitudes significantly decreased from pre- to post-tests whereas recovery and empowerment attitudes increased from pre- to post-tests thus suggesting participants' attitudes towards people with mental illnesses improved from the presentation. Care-seeking attitudes slightly increased but were not statistically significant. There were 10 LGBTQ+ support groups utilizing the "My Identity My Self" curriculum to support TAY youth serving 78 participants. Approximately 93% of participants reported that they would participate in this program again; and 95% of participants reported that participating in the support group has been an affirming experience for them. There were 51 youth screened, 45 youth enrolled in, and 26 who completed the Peer Mentoring program. Improvements were found in mentees' ratings of goal achievement with 81% reporting improvements in relationships/support, 88% in school/work activities, and 77% in coping/mood. There were 11 CAST groups where 95 youth were screened with a total of 87 enrolled participants; 83 of whom attended at least one session. Of those 83 participants, 62 completed CAST, representing a 75% completion rate.

Overall, the provider experienced success in contacting higher education institutions. This included being invited to do outreach on campuses and increase exposure for services to the 18–25 year-old population. The provider has developed good working relationships with a variety of school districts in the county. They continue to refer students to both programs in the TAY project and are helpful in facilitating logistics around implementation on their respective campuses, when the district is receptive to mental health services. Additionally, social media outreach and engagement have increased during the program year.

Program Reflection: TAY Resiliency Project - SAYM & Peer-to-Peer

Implementation Challenges:

While contact at higher education institutions and organizations has increased, the number of participants aged 18-25 did not increase. Higher education institutions often have robust services offered on campus that are free to students. There are also fewer places where this age group naturally gathers (unlike 16-17 year-olds which are easier to access on a high school campus).

Staffing challenges across the program significantly impacted service delivery and the ability to meet contract deliverables. Neither paraprofessional nor professional staff levels were maintained across regions in both program components. Turnover and difficulty in hiring were challenges. There were also significant leadership changes that contributed to low staff morale and turnover.

Consent for participation in the program continued to be a barrier to delivering services on school campuses. There continues to be increased attention and scrutiny toward mental health topics, and anything involving LGBTQ+, in schools. Program providers were blocked from entire districts due to new policies regarding outside mental health services and services geared to LGBTQ+ youth. “Notification policies” also made some students leery of participating in services, even in non-clinical services, because of fears related to their caregivers being notified. These policies continue to be a barrier to students receiving supportive services in a safe, accessible environment.

Lessons Learned:

The provider needs to continue to expand and “think outside the box” regarding outreach and service for 18-25 year-olds. Increased partnership with non-educational institutions is necessary but challenging.

Group services are much more efficient, but many students are requesting individual services in the Stress & Your Mood component. This puts extra strain on the therapist and requires that they set better expectations with the site contacts about how the services are best implemented.

Relevant Examples of Success/Impact:

Participants had the following comments after participating in the TAY Resiliency Project:

- “I personally struggle with mental health and hearing it be normalized was really important.”
- “My point of view on this has changed now that I have heard this impackedful [SIC] story first hand and how people can grow and better themselves.”
- “It has given me a place to be myself and a place to stay. It has also give me a great community.”
- “I have learned a lot of things about myself that I would not have known without this program and my mentor. I have grown a lot from when I first started versus now. I allow myself to feel my emotions and be less damaging and harsh on myself for everything, especially the things I can’t control. I feel like I have more control over my life instead of letting it pass me by and letting other people or things that happen to me choose my emotions for me. I know I care about things to much sometimes, but I’ve come to realize that some things about that may seem like a curse can actually be blessings.”
- “I learned how to deal with thoughts, how actions can change my thoughts and emotions; and that its ok to reach out for help.”
- “I learned how to communicate better with both adults and people my age. How to manage my thoughts and outlook. Feeling more comfortable being myself.”
- “What I learned in the program is how to take care of ourselves physically and mentally. Breathing techniques, exercises, and how to relax our mind.”
- “Positive counter thoughts; breathing techniques to help my anxiety and thinking with the logical mind, and identifying emotion and separating school work from my own time outside of school.”

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☒ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Outreach and Reunification Services to Runaway TAY (Safe Places)

Project Area as Defined by PEI Plan: PEI#4 Transition Aged Youth (TAY) Project

Program Description: Operation Safehouse, Inc. is contracted to provide services in Riverside County to Transition Age Youth (TAY) who are homeless, a run away, or at of risk of running away, through their Safe Place and Street Outreach to Youth Program. The program is dedicated to the safety and well being of youth in crisis and is committed to providing comprehensive support services for at-risk youth and those struggling with crisis situations. MHSA PEI funding is focused on two components of the programming: to train and educate the community on the Safe Place program and targeted street outreach to homeless and runaway youth to facilitate reunification with an identified family member or to a safe environment.

Number of individual participants or audience members during FY 23/24: **3,289**

Program Demographics: The following demographic information is duplicated.

Age	
Children/Youth (0-15)	7
Transition Age Youth (16-25)	1,989
Adult (26-59)	1,021
Older Adult (60+)	0
Declined to Answer	272

Race	
American Indian or Alaska Native	16
Asian	12
Black or African American	603
Native Hawaiian or other Pacific Islander	1
White	948
Other	0
More than one race	149
Declined to Answer	1,560

Ethnicity	
Hispanic or Latino as follows	637
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	637
Asian as follows	12
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	12

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	3,289

Gender	
Male	1,148
Female	1,465
Transgender Male to Female	2
Transgender Female to Male	6
Another	35
Declined to Answer	633

Sexual Orientation	
Lesbian	77
Gay	63
Bisexual	210
Yes, did not specify	0
Unknown	0
Another	10
Not LGBQ/Declined to Answer	2,929

Disability	
Yes	0
No	0
Declined to Answer	3,289

Veteran Status	
Yes	0
No	0
Declined to Answer	3,289

Program Reflection: Safe Places

Implementation Successes:

The Street Outreach Team have assisted youth in finding suitable housing by getting them into shelters, transitional programs, and treatment centers. The Team have continued partnering with other departments throughout Operation SafeHouse to reach schools, law enforcement, transit agencies, and other community entities that would benefit from their services. Due to these efforts, the program continues to see an uptick in referrals and youth coming forward.

Implementation Challenges:

The Street Outreach Team is having trouble meeting its targeted goals. Staffing has been an issue in the last several months. Staff retention rates have been low and we are working on hiring more staff currently.

Lessons Learned:

The objectives of the Outreach program through Operation SafeHouse, is to increase youth safety, well-being, and self-sufficiency, so that they build permanent connections with caring adults and community members. Through our efforts, we have encountered and assisted youth who have run away or have been asked to leave their homes. Some of these youths have experienced physical, sexual, or emotional abuse, neglect, rejection, or parental substance abuse. Once on the streets, they can become victim to sexual exploitation, physical or sexual assault, weapons assault, robbery, and gang activity. The longer they are exposed to the streets, the more likely they are to fall victim to these crimes and victimization. Additionally, these youth are sleeping in places that are not safe or appropriate. They have become acculturated to street life and turn to drugs and alcohol as a means of coping. They often suffer from serious physical health, behavioral, and emotional problems, including depression and anxiety. Others can become victims of labor trafficking and other types of sexual exploitation.

Relevant Examples of Success/Impact:

A 24-year-old male who has been homeless for a couple of weeks was in a room for rent but could not afford it after his seasonal job ended. He had been couch-surfing and sleeping on the streets since then. He did not have regular access to food and water since sleeping outside. He spent the night at Path of Life but was only able to stay one night. He was sleeping at La Sierra Park when the street outreach team contacted him. The outreach team was able to connect him with MainSTAY shelter and secure him a bed.

The street outreach team was also able to connect him with several longer-term housing options, including Starting Over Inc., the Ranch, and Coachella Valley Rescue Mission. He was accepted to Coachella Valley Rescue Mission residential program. On December 30th, the street outreach team assisted and transported him to Coachella Valley Rescue Mission for his intake. The client left the program with connection to resources and safe and stable housing.

PEI Plan Project Area #5: First Onset for Older Adults

This project area focuses on the first onset of depression in the older adult population. Programs in this project area include in home services as well as services that are portable. Collaboration includes partners that have experience and expertise with the older adult population in Riverside County, i.e.: Office on Aging. Targeted outreach is used to identify and provide services for underserved cultural populations, specifically LGBTQ+ older adults.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☐ Prevention	☒ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD)

Project Area as Defined by PEI Plan: PEI#5 First Onset for Older Adults

Program Description: CBT for Late Life Depression is a structured problem-solving program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. It includes specific modifications for older adults experiencing symptoms of depression. Clients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and redevelop them to be more adaptive and flexible thoughts. Emphasis is also placed on teaching clients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures.

Number of unduplicated individual participants or audience members during FY 23/24: **120**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	2
Older Adult (60+)	118
Declined to Answer	0
Race	
American Indian or Alaska Native	1
Asian	2
Black or African American	10
Native Hawaiian or other Pacific Islander	0
White	106
Other	1
More than one race	0
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	58
Central American	0
Mexican/Mexican American/Chicano	40
South American	9
Multiple Hispanic	0
Other Hispanic	1
Did not specify Hispanic/Latino group	8
Asian as follows	2
Filipino	1
Vietnamese	0
Chinese	1
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	71
Spanish	48
Bilingual	0
Another	0
Declined to Answer	1
Gender	
Male	36
Female	84
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	1
Gay	18
Bisexual	1
Yes, did not specify	3
Unknown	0
Another	1
Not LGBQ/Declined to Answer	96
Disability	
Yes	48
No	65
Declined to Answer	7
Veteran Status	
Yes	5
No	108
Declined to Answer	7

Program Reflection: CBT-LLD

Implementation Successes:

As new staff are onboarded into agencies, they are trained quickly and can begin to see clients using the LLD model quickly. Supervision and the consultation/certification process is smooth and allows therapists using the model to get hands on support with implementation and fidelity.

Word-of-mouth referrals have been one of the best outreach tools. Former clients often refer friends and neighbors. Additionally, there has been an increase in visits and requests for program presentations from senior living facilities, primarily in the Desert region.

Moreover, there was an increase in Spanish-speaking and in-person services Countywide.

Implementation Challenges:

The number of enrolled clients has been hard to increase and maintain. The Center has significantly struggled with getting LLD clients. Many of the clients seeking services there are significantly younger than they have been in previous years.

Outreach in the Mid-County and Desert regions has been more difficult. There was continued effort to increase program visibility and networking/partnership with other community-based organizations, however that did not ultimately result in increased or on-going program referrals.

Lessons Learned:

Providers are continuing to see that “one size fits all” does not work for outreach. It has been found that each region is more responsive to different kinds of outreach. For example, Inland Caregiver Resource Center (ICRC) has found that the Western Region clients really want to have in-person sessions while their Desert Region clients request telehealth services.

Relevant Examples of Success/Impact:

Client PHQ-9 scores decreased throughout treatment. The average PHQ-9 score at intake was 14 (indicating moderate depression) and at discharge was 4 (indicating minimal levels of depression). The Quality-of-Life Questionnaire overall showed improvements in all 13 items that it measures. The most notable improvements were in items that measured their social functioning, emotional well-being, and life in general. 72% of clients enrolled during FY 23/24 completed the entirety of the program. 33 clients continued services into FY 24/25. At closing, clients are given the opportunity to provide comments on their services. Participants gave the highest ratings to the quality of services received from their therapist, their likelihood to return to the program if they were to seek help again, and the support they received from the program.

Clients had the following comments regarding their treatment:

- “This therapy worked very well for me. I had reached the end of my resilience and was quite lost and depressed, short on hope. The skills I learned put me on a better path fairly quickly.”
- “I appreciated the consistency and the opportunity to be heard, the program exceeded my expectations.”
- “I appreciate the assistance I received. The tools given to put into practice are extremely helpful and [Therapist’s] guidance has been excellent.”

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Program to Encourage Active and Rewarding Lives (PEARLS)

Project Area as Defined by PEI Plan: PEI#5 First Onset for Older Adults

Program Description: The **P**rogram to **E**ncourage **A**ctive and **R**ewarding **L**ive**S** (PEARLS) is an evidence-based program designed for people aged 60 years or older, who are experiencing minor depression or dysthymia. PEARLS is an in-home intervention that utilizes an empowering, skill-building approach based on three core elements: program solving treatment (PST), social and physical activation, and pleasant activity scheduling. These three elements contribute to the empowerment of participants by encouraging them to engage in behaviors that will help them reach their goals.

Number of unduplicated individual participants or audience members during FY 23/24: **109**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	0
Older Adult (60+)	109
Declined to Answer	0
Race	
American Indian or Alaska Native	1
Asian	1
Black or African American	15
Native Hawaiian or other Pacific Islander	0
White	88
Other	1
More than one race	2
Declined to Answer	1
Ethnicity	
Hispanic or Latino as follows	36
Central American	2
Mexican/Mexican American/Chicano	23
South American	3
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	8
Asian as follows	1
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	1

Preferred Language	
English	80
Spanish	16
Bilingual	6
Another	1
Declined to Answer	6
Gender	
Male	26
Female	83
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	1
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	108
Disability	
Yes	84
No	22
Declined to Answer	3
Veteran Status	
Yes	11
No	98
Declined to Answer	0

Program Reflection: PEARLS

Implementation Successes:

The provider worked to increase their connection with community professionals through drop-in visits and by offering means of social and emotional support as well as resource information, which resulted in cross networking and presentations. In the Western region, “word of mouth” increased referrals from Community Champions (PEARLS graduates) as they shared information about their experiences with this program.

To increase accessibility, the provider purchased and used audio amplifier devices to work with participants with hearing impairments, which successfully resulted in serving five individuals.

133 prospective participants were screened, and 109 participants were served (received one or more program services) in FY 23/24. This represents a 36% increase from the FY 22/23 total of 80 participants.

Countywide, the reduction in depression symptoms as measured by the PHQ-9 was statistically significant for PEARLS participants completing the program. Furthermore, average depression as measured by the PHQ-9 was reduced 29% from “moderate” to “mild” countywide. Additionally, countywide, the reduction in anxiety symptoms as measured by the GAD-7 was statistically significant for PEARLS participants completing the program. Furthermore, average anxiety, as measured by the GAD-7 was reduced 40% from “moderate” to “minimal” countywide. Lastly, the Quality-of-Life questionnaire showed statistically significant improvement for participants in eight of the nine domains: “health”, “life in general”, “emotional well-being”, “spare time”, “time with others”, “friendship”, “social activity”, and “pleasant activities”.

Implementation Challenges:

The provider struggled with getting consistent referral sources in the Desert and Mid-County regions. Where efforts to increase program visibility did not result in continued on-going referrals. The provider worked with senior centers and community centers, however, many of the seniors were resistant to enroll in the program.

Maintaining engagement for the duration of the PEARLS program was also a challenge, specifically with individuals 70+ years old with identified hearing impairment, particularly when the provider was unable to meet by phone or in-person (to screen, make appointments, or even just connect).

Lessons Learned:

A “one size fits all” approach for outreach does not work. Each region and target population requires a unique approach and effort for visibility and engagement both with the community and seniors. In addition, stigma related to mental illness and fear of judgment plays a role in community members’ hesitation to engage in the program and/or tell others about their own experience in the program.

Relevant Examples of Success/Impact:

The post-program survey includes two fill-in questions: “If you did benefit from the PEARLS sessions, please describe why” and “Do you have any additional comments you would like to share regarding your experience with the PEARLS program?” Some responses are shared here:

- “PEARLS lowered my level of depression. I learned how to manage certain situations in my home and at work.”
- “I have been able to make some decisions that I was not able to make before as a result of this program.”
- “This program helped me learn about my feelings. I learned to find solutions to help me feel better when stressed.”
- “It helped improve my quality of life and my self-esteem, and helped me sleep better. I'm more social and I have faith in myself. I have courage to express myself.”
- “I was pleasantly surprised how well it works. It wasn't easy at first but through the process it got easier and I got more comfortable.”
- “Your support is very valuable to improve our quality of life and you all have a gift in the way you provide support.”
- “I want to thank you for helping me to get out and make friends.”

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Care Pathways - Caregiver Support Groups

Project Area as Defined by PEI Plan: PEI#5 First Onset for Older Adults

Program Description: A 12 session support group for caregivers of older adults. Outreach, engagement, and linkage to the support groups target caregivers of individuals receiving prevention and early intervention services, caregivers of seniors with mental illness, and caregivers of seniors with dementia.

Number of unduplicated individual participants or audience members during FY 23/24**: 116**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	2
Adult (26-59)	36
Older Adult (60+)	50
Declined to Answer	28
Race	
American Indian or Alaska Native	0
Asian	6
Black or African American	14
Native Hawaiian or other Pacific Islander	0
White	94
Other	0
More than one race	1
Declined to Answer	1
Ethnicity	
Hispanic or Latino as follows	46
Central American	0
Mexican/Mexican American/Chicano	1
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	45
Asian as follows	6
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	6

Preferred Language	
English	96
Spanish	16
Bilingual	4
Another	0
Declined to Answer	0
Gender	
Male	22
Female	91
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	3
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	116
Disability	
Yes	0
No	0
Declined to Answer	116
Veteran Status	
Yes	0
No	0
Declined to Answer	116

Program Reflection: Care Pathways

Implementation Successes:

A highlight of Care Pathways implementation for FY 23/24 is found in the participant outcomes as evidenced by decreases in depression scores and feelings of distress, as well as by self-reports of high caregiver satisfaction. For example, in the Mid-County region alone, CES-D 20 mean scores from intake to follow up showed a decrease in depression by 34%, and countywide the decrease was 17%. Caregivers' self-assessment questionnaire scores for feelings of distress also showed statistically significant decreases from pre-to-post completion, with a decrease of 26% for the Mid-County region and 11% decrease countywide. Furthermore, satisfaction surveys completed by 90% of participants at the conclusion of support groups indicated they were highly satisfied with various aspects of the program. They reported having reduced stress levels and learning new ways to cope effectively with their caregiving role because of the program. Graduates were also given the opportunity to attend a Virtual Dementia Tour to add to their knowledge and experience of the realities of those living with dementia to further inform their understanding and coping skills.

These positive results for numerous caregivers participating in the Care Pathways program is not only a source of pride for Office on Aging (OoA) implementation, but also a source of inspiration. They aim to increase their reach to enroll, educate, and support many more caregivers that can benefit from participation and graduation. To support that goal, in Q4 of fiscal year 23/24, they developed a relationship with Public Authority to assist in their outreach efforts by requesting a list of caregivers in Riverside County. They capitalized on this rich population of caregivers to implement targeted robotexts to potential caregivers to inform them of the Care Pathways offerings. In turn, class facilitators contacted all interested parties who responded to the robotexts to enroll them in classes. Furthermore, the reopening of the senior center in Desert Hot Springs afforded the opportunity to hold classes there to serve more caregivers in the desert location that has proven to be successful on many fronts.

Implementation Challenges:

Outreach and enrollment proved to be a significant challenge to implementing Care Pathways for FY 23/24. This challenge is evident in reflecting on the number enrollees at 116, falling short of the goal of 144 participants per contract expectation. Concerted efforts were made throughout the year to conduct outreach, inform and educate partner agencies, community-based organizations alike, including at various hospitals, churches, and libraries. However, while a few potential participants expressed interest from those efforts, none of those sites proved fruitful in ultimately enrolling participants. An additional challenge with enrollment was limited staffing with a facilitator vacancy that existed for half of the year resulting in less class offerings. Once an additional facilitator was hired, time invested for onboarding further limited the ability to provide classes for more participants, as the new facilitator was only able to teach one session in the fourth quarter.

Lessons Learned:

There were multiple lessons learned as an agency for FY 23/24 Care Pathways implementation. First, the provider recognized the need to have a centralized and streamlined method for tracking interested caregivers for follow-up and enrollment. Secondly, they plan to not only expand their outreach efforts across multiple locations and modalities but also keep track of those that prove to be most successful in garnering interest and enrollments for the classes. Thirdly, they recognized the challenges that caregivers face in being able to attend a series of classes over 12 weeks in person. To that end, they are planning an experiment for the next fiscal year to offer a mid-quarter class that condenses all the course material into 8 weeks to encourage more participation and more graduates. In short, they learned a shorter class series can improve enrollment. Moreover, they added an incentive for participants to receive at graduation to increase completion rates. Lastly, the facilitators also learned to become more comfortable utilizing Zoom for both online classes and support groups. With so many lessons learned during this fiscal year, the provider aims to make steady strides and improvements over the next fiscal year toward positive impacts for participants across the county and those they care for.

Program Reflection: Care Pathways
Relevant Examples of Success/Impact:
Spousal caregiver (81) cares for his wife (78) with Alzheimer's. He was referred by OoA case manager to an in-person class. The caregiver decided to join and was one of only two males in the class. He spoke in the class about how his adult children did not know much about what was going on with their mom and how quickly her condition was declining. He said that he kept it to himself. One of the class members suggested having a weekly Sunday dinner so that the caregiver could give an update and so that the children could spend time with their mother. He said he would try it and the following week in class he let everyone know that his children had come to the home and made dinner and helped him around the home. As the class continued, he was happy to report that his children were continuing to come home and that the relationship had strengthened because of the family dinners. He no longer felt alone in the caregiving journey because he now had the support of his adult children and the others in class. He also said he would be joining the after-care support group because he wanted to continue his relationship with those he met in class.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☒ Early Intervention	☒ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Mental Health Liaisons to Office on Aging

Project Area as Defined by PEI Plan: PEI#5 First Onset for Older Adults

Program Description: Mental Health Liaisons to Office on Aging is a Prevention and Early Intervention program in which Riverside University Health System-Behavioral Health (RUHS-BH) 'Mental Health Liaisons' and the Riverside County Office on Aging work collaboratively to (1) identify older adults who are either at risk of depression or are experiencing the first onset of depression and (2) link them with early intervention programs, such as Cognitive Behavioral Therapy for Late Life Depression (CBT-LLD). Additionally, the Mental Health Liaisons link older adults with other resources and services, as needed, to reduce depression and suicide risk.

Number of unduplicated individual participants or audience members during FY 23/24: **18 CBT-LLD**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	2
Older Adult (60+)	16
Declined to Answer	0
Race	
American Indian or Alaska Native	0
Asian	1
Black or African American	1
Native Hawaiian or other Pacific Islander	0
White	15
Other	0
More than one race	0
Declined to Answer	1
Ethnicity	
Hispanic or Latino as follows	11
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	11
Asian as follows	1
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	1

Preferred Language	
English	0
Spanish	0
Bilingual	0
Another	0
Declined to Answer	18
Gender	
Male	4
Female	14
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer/Unknown	18
Disability	
Yes	0
No	0
Declined to Answer	18
Veteran Status	
Yes	0
No	0
Declined to Answer	18

Program Reflection: Mental Health Liaisons to Office on Aging

Implementation Successes:

In FY 23/24, the Mental Health Liaisons held 111 outreach events for a total of 160.5 hours. The majority of the events took place at community meetings (64.9%) and at public events (11.7%).

The Mental Health Liaisons processed 422 referrals in FY 23/24; where approximately 2.8% led to CBT-LLD (n=12) enrollment. Nearly 96% of the total referrals were to 'Other' (e.g. private insurance).

Office on Aging liaisons provided CBT-LLD services to a total of 18 participants. The majority of the CBT-LLD participants were female (78%), and between the ages of 75-79 (27.8%). Of the 12 closed cases, 50% reported successfully completing their treatment goals (n=6). The remaining participants discontinued the program due to changes in personal circumstances (e.g. moved out of area) or partially completed their goals.

PHQ-9 pre- to post-scores showed a statistically significant improvement in symptoms of depression. The Quality of Life (QOL) survey results showed that participants felt significantly better in most QOL items. GAD-7 pre- to post-scores showed a statistically significant decrease in anxiety symptoms.

Staff were able to serve two homebound clients in Blythe. Blythe has been a longstanding challenge due to the community being very remote compared to the rest of the County. It's also a very small community, requiring a lot of extra work around trust and rapport-building. Completing two clients in this community is a big accomplishment. Staff worked to find ways to make required paperwork easier for clients to access and aid in getting to session agenda items in a timelier manner. Clients have been receptive to having copies of the PHQ-9 left with them to allow them to complete them before their session time. Sending follow-up letters with resources after being unable to reach clients by phone, including crisis supports and CARES Line information, has been useful. Clients have responded that they were able to get connected to ongoing supports and services.

Implementation Challenges:

Privacy when providing services in a client's home has been more of a challenge recently. It has led to working with clients on setting healthy boundaries. Helping homebound clients identify pleasant activities in rural communities is hard. Additionally, working with clients with increasing cognitive decline is challenging. The change in cognition also exacerbated symptoms of depression and anxiety.

Lessons Learned:

Despite agreeing to be referred to therapy services, potential clients are not always ready to engage in the process. However, they want someone to validate their concerns and listen. The provider found that many in the community are not aware that there are 24/7 warmlines and those end up being a good outlet for them.

Relevant Examples of Success/Impact:

Participants of CBT-LLD are asked to complete a post-survey. Below are some of the responses received:

- "It was a positive change in my life but I received many recommendations to overcome and put them into practice in my life. Thank you so much." [Translated from Spanish]
- "The program is good, I would recommend it." [Translated from Spanish]
- "The program helped me. I liked that [Therapist] understood me and helped me to cope with my problems. I am grateful for the program."
- "[Therapist] has been a great help for me. A am very comfortable with her & opening up to her."
- "I like the support and will continue to look for BH as needed."
- "I was satisfied with this program, it helped me a lot." [Translated from Spanish]

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: CareLink Program/Healthy IDEAS

Project Area as Defined by PEI Plan: PEI#5 First Onset for Older Adults

Program Description: Facilitated by the Riverside County Office on Aging, it is a care management program for older adults who are at high risk for developing mental health problems, primarily depression and anxiety. Healthy IDEAS intervention focuses on behavioral activation and social support and is utilized for those who are demonstrating symptoms of depression and anxiety.

Number of unduplicated individual participants or audience members during FY 23/24: **23**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	6
Older Adult (60+)	16
Declined to Answer	1
Race	
American Indian or Alaska Native	0
Asian	1
Black or African American	2
Native Hawaiian or other Pacific Islander	0
White	20
Other	0
More than one race	0
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	9
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	9
Asian as follows	1
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	1

Preferred Language	
English	16
Spanish	7
Bilingual	0
Another	0
Declined to Answer	0
Gender	
Male	7
Female	16
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	23
Disability	
Yes	23
No	0
Declined to Answer	23
Veteran Status	
Yes	1
No	22
Declined to Answer	0

Program Reflection: Healthy IDEAS

Implementation Successes:

Most of the participants of HealthyIDEAS report a lower CES-D score upon completion and have an overall improved outlook on life with effective coping skills learned and reinforced during the program. Two clients are highlighted below in the success/impact section.

Implementation Challenges:

Implementation challenges continue to be receiving appropriate clients for the intervention who meet the following requirements:

- new onset of depression/anxiety
- score 16 or above on the CES-D
- not currently receiving treatment i.e. therapy or meds
- no recent history of treatment
- willing to participate when they score a 16 or above on the CES-D
- cognitively able to participate

Lessons Learned:

The provider has learned that giving presentations to induction classes for new social workers at the Department of Social Services (DPSS) is not fruitful in obtaining referrals as the new employees are overwhelmed with all the new information they are receiving and are a month or so away from seeing clients to refer. They are now scheduling periodic check-ins with DPSS units to remind them of the Office on Aging programs, highlighting the Healthy IDEAS program.

Another lesson learned this year is homelessness does not preclude participation in Healthy IDEAS. In the past, when someone was homeless, they would not even be considered for enrollment in case management or Healthy IDEAS. Having an existing client become homeless while on service gave us an opportunity to try the program and it was successful.

Relevant Examples of Success/Impact:

One client, a newly widowed 85-year-old female who was the primary caregiver for her husband until he died, had an initial score of 30 on the CES-D. She was grieving and had withdrawn from many of the activities she was formerly involved in, including Bible study at her church. Her goal was to address her grief. The Healthy IDEAS practitioner found a grief support group that the client began attending. The client had previously attended Care Pathways as a caregiver and had some follow-up after-care group sessions. She incorporated what she learned in Care Pathways regarding self-care and continued to build upon those skills to cope with her grief. She stated that Care Pathways had “saved her life.” Toward the end of the Healthy IDEAS sessions, she had resumed attending Bible study at her church and had a post CES-D score of 12. She looked forward to spending time with her son and grandchildren over the holidays and is planning to tackle a kitchen remodel that she has been wanting to do for several years.

A second client is a 60-year-old male who became homeless shortly after enrolling in CareLink case management. His goal was to obtain permanent housing. He worked closely with the Healthy IDEAS practitioner and the homeless shelter staff at Path of Life to follow through with the application process and things he needed to do to get housed. When discouraged, he was reminded of how much he had accomplished with the social worker. He obtained permanent housing in mid-December. He expressed appreciation for the Healthy IDEAS intervention, as well as the Path of Life shelter staff, and now feels comfortable reaching out for help when he needs it, something he would never have done in the past.

PEI Plan Project Area #6: Trauma-Exposed Services

Through the community planning process, the high need for services for trauma exposed individuals was identified as a priority. This project area includes programs that address the impact of trauma for youth, TAY, and adults.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Project Area as Defined by PEI Plan: PEI#6 Trauma Exposed Services

Program Description: Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to address the symptoms youth develop from various traumatic events. CBITS aims to reduce PTSD symptoms while enhancing coping skills, increasing resiliency, and raising peer/parent support.

Number of unduplicated individual participants or audience members during FY 23/24: **313**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	311
Transition Age Youth (16-25)	0
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	2
Race	
American Indian or Alaska Native	12
Asian	10
Black or African American	10
Native Hawaiian or other Pacific Islander	3
White	251
Other	0
More than one race	24
Declined to Answer	3
Ethnicity	
Hispanic or Latino as follows	266
Central American	11
Mexican/Mexican American/Chicano	219
South American	1
Multiple Hispanic	0
Other Hispanic	1
Did not specify Hispanic/Latino group	34
Asian or Pacific Islander as follows	18
Filipino	7
Vietnamese	3
Korean	1
Other Asian/PI	1
Did not specify Asian/PI group	6

Preferred Language	
English	259
Spanish	6
Bilingual	39
Another	0
Declined to Answer	9
Gender	
Male	108
Female	183
Transgender	8
Nonbinary	11
Gender Fluid	1
Declined to Answer	2
Sexual Orientation	
Lesbian	4
Gay	2
Bisexual	25
Yes, did not specify	12
Unknown	19
Another	9
Not LGBQ/Declined to Answer	231/11
Disability	
Yes	33
No	275
Declined to Answer	5
Veteran Status	
Yes	0
No	0
Not Applicable	313

Program Reflection: CBITS

Implementation Successes:

CBITS had a high program completion rate during FY 23/24. Countywide, there were 313 students enrolled in the program with 263 students completing at least eight (8) sessions, for an overall contract completion rate of 91%!

Providers were able to deliver service at new school sites during the program year, broadening the reach of the program across districts. Additionally, partnerships with individual school sites, across districts served, allowed the processes for screening and implementation to be improved. Moreover, there were fewer hiccups with scheduling space at schools, getting consents back from families, and having passes sent for students to attend group.

Training of new facilitators, when there was staff turnover, was able to happen quickly which made sure there was no disruption to service delivery. Overall, staffing was stable across all providers during the program year.

Implementation Challenges:

Caregiver engagement continues to be a challenge across regions and providers. Providers have offered Caregiver Education Sessions in a variety of modalities, languages, locations, and times. Incentives have been offered as another means to increase attendance/participation but did not yield increased participation as hoped.

There was an increase in the severity of trauma exposure and PTSD symptoms. There were many more students that needed additional support, crisis supports/assessments, and CPS reports throughout the course of the program year. These all added to increased feelings of stress and compassion fatigue for program facilitators.

Lessons Learned:

Continuing to nurture relationships with school partners, whether services are facilitated year-round or only part of the school year, is critical to program success. It helps with making sure all the processes from confirming space, pulling students, screening, and getting consent move smoothly and do not cause delay/ disruption in the timeline.

When planning the calendar for the group schedule, advanced preparation for combining sessions when there is not enough time for all 10 weeks of the program, it is best to combine sessions at the end of group.

PTSD symptoms decreased from pre- to post-test with a countywide average of 26.4 at pre to 18.2 at post. However, only 36% of youth saw a decrease to below the clinical threshold. Students are reporting experiencing additional trauma exposures/stressful events during the course of the program, which might explain why PTSD symptoms do not decrease as much as would be expected.

Relevant Examples of Success/Impact:

Providers were able to increase the number of schools that are receiving the CBITS program. Schools have been more receptive to mental health services overall, helping to destigmatize help-seeking behaviors.

Participants are given the opportunity to provide feedback at the completion of the program. Students had the following to say about participating in the program:

- “I learned how to understand my own feelings and that I can take little steps to start doing things I stopped myself from doing after the incident.”
- “I learned how to think more logically about my bad thoughts. Finally talking about what’s been going on has made me feel better. I’ve met people that made me feel safe when I speak about my problems.”
- “The group leaders cared about us and listened to our feelings. I was able to learn multiple new ways to cope.”
- “I learned that I’m not always alone in difficult situations and there is always someone that is here for me no matter what.”

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Seeking Safety

Project Area as Defined by PEI Plan: PEI#6 Trauma Exposed Services

Program Description: An evidence based practice that utilizes cognitive-behavioral therapy model for relapse prevention and coping skills to help participants with PTSD and substance use disorders. It is conducted in group or individual formats.

Number of unduplicated individual participants or audience members during FY 23/24: **154**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	126
Adult (26-59)	28
Older Adult (60+)	0
Declined to Answer	0
Race	
American Indian or Alaska Native	2
Asian	4
Black or African American	13
Native Hawaiian or other Pacific Islander	1
White	125
Other	0
More than one race	9
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	114
Central American	9
Mexican/Mexican American/Chicano	95
South American	0
Multiple Hispanic	0
Other Hispanic	2
Did not specify Hispanic/Latino group	8
Asian as follows	4
Filipino	1
Vietnamese	1
Chinese	1
Thai	1
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	137
Spanish	16
Bilingual	0
Another	0
Declined to Answer	1
Gender	
Male	47
Female	89
Transgender	3
Nonbinary	6
Gender Fluid	6
Declined to Answer	3
Sexual Orientation	
Lesbian	6
Gay	6
Bisexual	20
Yes, did not specify	0
Unknown	2
Another	15
Not LGBQ/Declined to Answer	95/10
Disability	
Yes	8
No	146
Declined to Answer	0
Veteran Status	
Yes	3
No	151
Declined to Answer	0

Program Reflection: Seeking Safety

Implementation Successes:

In FY 23/24, the program saw success in the continued partnerships and relationships that they have managed to build over the years. Operation Safehouse saw this with some school sites by being invited back by school counselors and receiving referrals. Additionally, they were able to table and outreach at different school sites to cast a wide net for students to voluntarily sign-up. Moreover, they were able to partner with other programs within their organization to help increase referrals to the Seeking Safety program.

The RUHS-BH PEI Peers also saw continuity of partnerships and expanding processes to be able to receive referrals. One of these partnerships is with the Sexual Assault and Forensic Evaluation (SAFE) Clinic. The provider was able to set up a referral system with this clinic and follow-up with victims of assault to screen and be able to provide this early intervention program for trauma.

There was a total of 249 individuals screened for this service. Of those, 154 participants went on to attend at least one session, and 79.2% (n=122) of those met the completion criteria by attending six or more sessions. Most participants were transition age youths between the ages of 16-25 (80.5%). Of all program participants, most of them identified as Hispanic/Latinx (74%), and a third of participants identified as LGBTQ+ (30.5%). After completion of the program, participants demonstrated decreases in PTSD symptoms and increases in positive coping skills.

Implementation Challenges:

A challenge that was experienced by both providers was getting people enrolled in the program, particularly those that were in the older TAY demographic (ages 19-25) and adults (ages 26-59). When the use of an interest form was utilized, oftentimes team members were not able to contact those who filled out the form, being met with unresponsiveness to their follow-up calls/texts/emails.

Across both providers, staffing was also a challenge. One of the providers underwent significant leadership changes, which contributed to staff in this program leaving for other opportunities. Onboarding and training new staff took additional time and took away from time spent on service delivery.

For services being provided on school campuses, the providers were met with unique challenges to those locations such as working around school schedules and testing, scarcity of physical space on campus to hold groups, denials of MOUs, and requirements to get parental consent before being able to screen for services. Some school sites and districts expressed wanting to focus on providing their own mental health services and have been restricting access that outside service providers have to their students.

Lessons Learned:

The contracted TAY provider has focused largely on the 16-18 year-old population through school partnerships. When the academic year ended, this resulted in a disruption to service delivery as community-based contacts/outreach was minimal. It also resulted in very low participation from 19-25 year-olds. Technical support to the provider has focused on expanding outreach efforts to include partnerships with other organizations for year-round services, and to increase program schedule flexibility to be able to meet the needs of an older TAY population. Additionally, outreach efforts and a focus on making new contacts in the community were emphasized with the adult service provider.

Program Reflection: Seeking Safety
Relevant Examples of Success/Impact:

Feedback and comments from conclusion of service questionnaires:

- “I came in broken and am leaving more confident. [Facilitator] was amazing. I’m grateful for this program.”
- “Thank you [facilitator] for your patience and allowing for me to be myself. For this to be a class on Zoom, you were able to make me feel like you were in the room with me with your energy.”
- “I am very thankful for this program and for the information. I'm thankful for [facilitator] for easily explaining to be able to understand. Thank you.”
- “The program brought a helpful change in me because before I felt as if I didn’t really have anyone to talk to but when I'm with my friends in session, it is okay to talk.”
- “The program opened my perspective that talking your problems out loud doesn’t make you "weak" or perceived bad. I also really like the drug abuse advice, I'm trying to help myself more.”
- “Every session taught gave me at least one meaningful coping skill and I often learned surprising insights about myself and my situation.”
- “The program helped me understand that it's ok to feel a certain type of way but you have to know how to safely cope with it.”

PEI Plan Project Area #7: Underserved Cultural Populations

Through the community planning process, input was solicited from key community leaders from unserved and underserved cultural populations. The key community leaders gathered feedback and information from the communities that they represent and provided specific PEI recommendations regarding needed services. Specific interventions for the following underserved groups are included: Hispanic/Latino, African American, Native American, and Asian American.

The following tables in this section include data tables for the programs in this project area with the number of unduplicated served, demographics, implementation successes, implementation challenges, lessons learned, and examples of success/impact in the communities they serve.

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Mamás y Bebés (MyB)

Project Area as Defined by PEI Plan: PEI#7 Underserved Cultural Populations

Program Description: Mamás y Bebés (MyB) is a prenatal intervention, focused on both Spanish and English speakers, designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The intervention is an 8-session course that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. The program helps participants create a healthy physical, social, and psychological environment for themselves and their infants.

Number of unduplicated individual participants or audience members during FY 23/24: **255**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	1
Transition Age Youth (16-25)	42
Adult (26-59)	212
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	0
Asian	5
Black or African American	9
Native Hawaiian or other Pacific Islander	0
White	229
Other	2
More than one race	7
Declined to Answer	3

Ethnicity	
Hispanic or Latino as follows	212
Central American	9
Mexican/Mexican American/Chicano	197
South American	0
Multiple Hispanic	0
Other Hispanic	6
Did not specify Hispanic/Latino group	0
Asian as follows	5
Filipino	2
Vietnamese	0
Chinese	0
Other Asian	1
Did not specify Asian group	2

Preferred Language	
English	130
Spanish	107
Bilingual	18
Another	0
Declined to Answer	0

Gender	
Male	0
Female	255
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0

Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	255/0

Disability	
Yes	9
No	246
Declined to Answer	0

Veteran Status	
Yes	2
No	253
Declined to Answer	0

Program Reflection: MyB

Implementation Successes:

In-person classes were offered this year by one provider due to a strategic partnership with a community women's clinic.

Social media outreach has been impactful for this program. All three providers get most of their participants via self-referral from seeing the flyer in a variety of social media sites/groups.

A total of 329 women were screened, 255 enrolled and 231 graduated, a completion rate of 91%! 83% of the women enrolled identified as being Hispanic and 41% identified Spanish as their primary language. This is very much in line with the original population target for the program.

Implementation Challenges:

Internal transitions reduced the availability of staff to do in-person outreach events, forcing staff to rely heavily on social media and email outreach efforts.

There were several moms that experienced pregnancy loss or death of their baby. There are a significant lack of culturally relevant supports and grief & loss supports relevant to miscarriage/still birth/infant loss. Hospital systems are a difficult entity to partner with. They are typically large systems that do not have streamlined ways to get information about groups/supports to their providers to share with their patients. OB/GYN providers screen their patients, but the systems don't generally have good support for pregnancy related/postpartum mental health issues, and they are not open to advertising/promoting outside resources.

School districts have been difficult to partner with this program year. There seems to be such an influx of resources and referrals offered to schools for their families that the districts are at capacity with what they can offer and promote. Some districts also have a difficult time seeing how this program can impact student success and attendance, even when explained during meetings/presentations.

African American/Black women are still hard to reach and significantly underrepresented in program participation. 3.5% of program participants identified as African American/Black. Providers worked through the year to change outreach strategies, including updating flyers and language around the program. But it did not yield the increased enrollment from the African American/Black community that was hoped for.

Lessons Learned:

Despite being "post-COVID" most participants are opting to participate in group virtually rather than in-person. Many moms cite that flexibility and no need for transportation or childcare as benefits to participating virtually. The program does provide childcare, but many moms have children of various ages and being able to participate from home removes significant challenges for them. The likelihood of this program only being offered in-person (as was the case pre-2020) does not seem realistic.

Providers need new strategies to engage our common-sense partners (like physicians and schools) to help meet the needs of the community and program.

Program material is not fully culturally relevant to the African American/Black community.

Relevant Examples of Success/Impact:

At the completion of the program, participants are offered an opportunity to provide feedback:

- "This program helped me in a multitude of ways. I looked forward to coming to class. Thank you!"
- "This class helped my mental health to be strong. I can manage to do small beautiful things everyday. Thank you!"
- "This program helped me feel like I am not alone. It made me feel like part of a community and has taught me new methods to help me cope with sadness, overwhelming feelings, and stress. Thank you."
- "Motherhood is hard, full of challenges, and it was nice to hear that other moms have the same challenges as me. I learned new ways to cope with situations. Thank you for this program."

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Building Resilience in African American Families (BRAAF) - Boys

Project Area as Defined by PEI Plan: PEI#7 Underserved Cultural Populations

Program Description: This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The BRAAF Project will utilize four evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive Behavior Therapy (CBT), Guiding Good Choices (GGC), and Parent Support Groups in three different Riverside County regions.

Number of unduplicated individual participants or audience members during FY 23/24: **24**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	24
Transition Age Youth (16-25)	0
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0

Race	
American Indian or Alaska Native	0
Asian	0
Black or African American	22
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	0
Declined to Answer	2

Ethnicity	
Hispanic or Latino as follows	0
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	0
Asian as follows	0
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	24
Spanish	0
Bilingual	0
Another	0
Declined to Answer	0

Gender	
Male	24
Female	0
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0

Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	24

Disability	
Yes	1
No	23
Declined to Answer	0

Veteran Status	
Yes	0
No	24
Declined to Answer	0

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Building Resilience in African American Families (BRAAF) - Girls

Project Area as Defined by PEI Plan: PEI#7 Underserved Cultural Populations

Program Description: This project is a multi-intervention strategy with prevention and early intervention programs being provided throughout Riverside County. The primary program goals of this project are to reduce the risk of developing mental health problems and to increase resiliency and skill development for the African American population in Riverside County who are most at risk of developing mental health issues. The BRAAF Project will utilize four evidence-based practices: Africentric Youth and Family Rites of Passage Program (ROP), Cognitive Behavior Therapy (CBT), Guiding Good Choices (GGC), and Parent Support Groups in three different Riverside County regions.

Number of unduplicated individual participants or audience members during FY 23/24: **16**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	16
Transition Age Youth (16-25)	0
Adult (26-59)	0
Older Adult (60+)	0
Declined to Answer	0
Race	
American Indian or Alaska Native	0
Asian	0
Black or African American	11
Native Hawaiian or other Pacific Islander	0
White	1
Other	0
More than one race	4
Declined to Answer	0
Ethnicity	
Hispanic or Latino as follows	1
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	1
Asian as follows	0
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	16
Spanish	0
Bilingual	0
Another	0
Declined to Answer	0
Gender	
Male	0
Female	16
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0
Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	16
Disability	
Yes	0
No	16
Declined to Answer	0
Veteran Status	
Yes	0
No	16
Declined to Answer	0

Program Reflection: BRAAF Boys and Girls

Implementation Successes:

Boys BRAAF

In FY 23/24, 24 participants enrolled in the Boys Rites of Passage Program, with 71% (17 youth) completing the 9-month program. The completion goal was 30 youth. The program target is three (3) boys' programs (one per region) with 45 youth completing per year countywide. This fiscal year the boys' program was only available in the Western and Desert regions.

Resilience measures were completed by 16 participants, demonstrating no statistically significant changes in "sense of mastery" or "sense of relatedness", both remaining within the "average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight decrease; however, participants continued to demonstrate high levels of identity centrality. Importantly, the Cohesion subscale exhibited a statistically significant improvement, indicating enhanced familial connections as a result of program participation.

A total of 19 parents participated in the Guiding Good Choices (GGC) program, with a graduation rate of 90% (17 parents). Before and after the course, the parents completed the Alabama Parenting Questionnaire (APQ). The results indicated significant improvements in parental involvement and reductions in inconsistent discipline and corporal punishment. Furthermore, parents reported a notable 67% increase in practicing refusal skills to resist peer pressure and adapting to new parenting styles that create healthy habits with their children.

Sixteen youth participated in Cognitive-Behavioral Therapy (CBT), delivered either in-person or via video conferencing. The effectiveness of CBT was evaluated using the Strengths and Difficulties Questionnaire (SDQ) and the Children's Depression Inventory-II (CDI-II). Fourteen parents completed pre- and post-SDQ surveys for their children, indicating significant decreases in emotional symptoms and overall difficulties, suggesting positive trends in mental health outcomes. While decreases in depressive symptoms were observed, comparisons of pre- and post-CDI-II scores did not yield statistically significant results, with participants remaining within the average range of depression severity.

Girls BRAAF

Sixteen participants between the ages of 11 and 14 enrolled in the program during the FY 23/24. Of the 16 youth, 12 completed the program. The completion goal was 15. The program target is three (3) girls' programs (one per region) with 45 youth completing per year countywide. This fiscal year the girls' program was only available in the Desert region.

Resilience measures were completed by 12 participants, demonstrating no statistically significant changes in "sense of mastery" or "sense of relatedness", both remaining within the "average" range. Scores from the Multidimensional Inventory of Black Identity (MIBI) reflected a slight increase, indicating that participants (n=12) continued to demonstrate high levels of identity centrality. Additionally, there was no statistically significant difference in scores on the Cohesion subscale from pre- to post-assessment, with scores consistently remaining within the 'separated to connected' range on the subscale.

A total of 19 parents participated in at least one session of the Guiding Good Choices (GGC) program, and 7 parents (37%) completed the five-session parenting course during the 2023-2024 fiscal year. The results of the Alabama Parenting Questionnaire (APQ) showed a statistically significant decrease in corporal punishment and in other disciplinary practices, suggesting that parents shifted towards less harsh disciplinary methods. However, across the remaining subscales, no significant changes were observed from pre- to post-assessment.

Twelve youth participated in Cognitive-Behavioral Therapy (CBT). The results indicate a statistically significant change in emotional symptoms, suggesting that the youth improved their behavior after completing one-on-one CBT sessions. Additionally, there was a statistically significant change in peer relationships. For this fiscal year, when comparing the pre- to post-scores on the CDI-II, there was no statistically significant change evident in either emotional behavior or functional problems.

Program Reflection: BRAAF Boys and Girls

Implementation Challenges:

BRAAF was one of the first prevention programs to be implemented in Riverside County starting in 2010. Over the past 14 years of implementation, there were several rounds of RFPs and changes in providers. PEI support for this program includes monthly fidelity meetings with PEI staff, quarterly BRAAF leadership meetings, monthly BRAAF Clinician support meetings, and annual training. Data collection is a requirement to track enrollment and mental health outcomes for both youth and parents. Consistently, data collection has had challenges, and many adjustments have been made to address them. Despite this, outcomes have been static and continue to demonstrate little to no change in participants. The past several years has also shown a sharp decline in enrollment and program completions. The project target is 3 girls' programs and 3 boys' programs per fiscal year, completing a minimum of 90 youth per year. The last several years have fallen well below that target.

FY 22/23 focused on a return to project intent as it was designed by the African American Family Wellness Advisory Group (AAFWAG) as well as re-establishing fidelity to the Rites of Passage and Guiding Good Choices programs. To support a return to program fidelity and contract compliance several resources/ actions were put in place. After receiving a full year of this high-level of support and technical assistance, FY 23/24 has not shown sufficient progress.

Feedback from providers and the community provide additional context. First, parents have expressed a concern that the length of the program impacts school performance negatively, e.g., no time for tutoring if needed. Second, families reported conflicting sports schedules, academic, or familial needs. Parents report to staff that their child is too tired to do their homework, chores, or other responsibilities after a full day of school and extra hours of program. This has resulted in parents having pulled youth from the program. Third, there is a desire for more college readiness programming versus a Rites of Passage program. Furthermore, program staff reported challenges with local churches, schools, and elder communities when attempting to advertise/recruit for the program. Local outreach tabling has not yielded enrollments as expected. Providers have reported faith communities (churches) state that they already have after school programming they would prefer their youth to participate in. Additionally, providers have stated local Black owned businesses are not willing to display BRAAF program flyers. Nguzo Saba principles and Africentric verbiage may present a barrier to African Americans participating in the program.

Lessons Learned:

The BRAAF project was initially designed 15 years ago and much has changed in that time. The needs of the community have changed, and this is reflected in the community feedback highlighting that the program interferes with other needs/activities of families and youth. In addition, the past several years has shown a sharp decline in enrollment and program completions, another indicator that this program does not reflect the needs/desires of the community it aims to serve. Additionally, program outcomes demonstrate little to no change in participants. Moreover, program fidelity and contract compliance challenges continued despite the resources/actions that were put in place. The current structure and poor participation in BRAAF demonstrates that the program is not meeting the needs of the community in its current design. This project ended in June 2024 and will be removed from the PEI plan.

PEI Administration will be working with AAFWAG and the RUHS-BH Cultural Liaison to gather qualitative community-based data. The goal is to better understand the current needs of the African American/Black community in Riverside County and to use this data to inform the service delivery system on how to meet these needs.

Program Reflection: BRAAF Boys and Girls

Relevant Examples of Success/Impact:

Feedback from focus groups included the following comments:

- "I'm more confident in myself."
- "The program helped me "be more concentrated and motivated."
- "...being more respectful"
- "It taught me how to do it and without being told, so I started to do chores at home without being told."
- "I have stress about home, so [staff] helped me with tools to help with that."
- "The start of program, I looked at things at a different perspective then now."
- I dislike the program because "it felt like doing a 7th class."
- I dislike the program because "it was a lot of work."
- "I've see changing with myself and my son, better communication, my boys are more out spoken, the things that they say to me, they say in a more respectful matter. Throughout the program, they've learned to speak to someone that is older than them. And little more teamwork with themselves."
- "Last year was very tough, now I have seen a growth… he explains to me about what he needs from me to be more social. I've notice he has boundaries and respecting those. After identifying what we need from each other, it turned out pretty ok so far. Definitely communication has improved from since we've started the program."
- "Aware in how I react with my son and better communicate with how things can go differently."
- "How to communicate with my grandson more and not to be judgmental."
- "I would like parents to show up to support groups."
- "The driving hours to the program was an issue."
- "I was told that it was going to be more of a male presence, like a father-brother type, there was really no males in the program, mostly women who still did great though."
- "Be more aware of dates and schooling different school districts."
- "The communication was off and in the beginning it was not explained much so in the beginning. No list of what is going on through the year."
- "BRAAF taught me to stop before responding to other people."
- "I had problems with boundaries and BRAAF helped me with that."
- "I used to let people define me, now I don't let that be the case."
- "The program has helped me change the way I feel about culture, we didn't just come from slavery. We were Kings and Queens."
- "People don't know about African American culture, we are inventors."
- "I think that my attitude and my way of thinking changed."
- "To stand up for myself and to communicate what I need."
- "I did not like the lessons."
- "This program helped my daughter to be "aware of their feelings and what's going on and a open line of communication."
- "The scheduling is hard, more parent involvement, help with staff more so that the staff continue doing most of the work."

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Celebrating Families-Strengthening the Circle (Native American Resiliency Project)

Project Area as Defined by PEI Plan: PEI#7 Underserved Cultural Populations

Program Description: The Celebrating Families: Strengthening the Circle Program is a new PEI program that started its service in FY 2021-2022. The primary goals are to increase family interactions, decrease risk of future substance abuse, and to foster the connection to culture in order to prevent the development of behavioral health challenges for the Native American/American Indian population in Riverside County who are highest at risk.

Number of unduplicated individual participants or audience members during FY 23/24: **37**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	5
Adult (26-59)	25
Older Adult (60+)	1
Declined to Answer	6

Race	
American Indian or Alaska Native	30
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	7
Declined to Answer	0

Ethnicity	
Hispanic or Latino as follows	0
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	0
Asian as follows	0
Filipino	0
Vietnamese	0
Chinese	0
Other Asian	0
Did not specify Asian group	0

Preferred Language	
English	37
Spanish	0
Bilingual	0
Another	0
Declined to Answer	0

Gender	
Male	10
Female	27
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0

Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	2
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	35

Disability	
Yes	2
No	31
Declined to Answer	4

Veteran Status	
Yes	0
No	37
Declined to Answer	0

Program Reflection: Native American Resiliency Project

Implementation Successes:

The Wellbriety Celebrating Families (WCF) program was able to provide services to families throughout each region. Additionally, the provider was able to engage the local schools in their Gathering of Native Americans (GONA) planning process to meet the needs of the community and have the event focus on important community concerns through a cultural lens.

The provider was able to reach out to new organizations within the community to help increase outreach efforts, including Olive Crest's monthly Community Days, Betty Ford Native American Families program in the Desert region, and The Happier Life Project in the Mid-County region.

Most enrolled participants (81.1%) identified themselves as American Indian/Alaskan Native with 13 different tribes represented in the WCF program, while the remaining participants (18.9%) reported Multiracial with American Indian/Alaskan Native.

Implementation Challenges:

The program struggled with staff retention and challenges with recruitment and hiring of a clinician. The program's Program Coordinator is a Licensed Clinical Social Worker, but the program did not provide any Cognitive-Behavioral Therapy (CBT) services to any community members during FY 23/24.

Furthermore, there were challenges in recruiting and retaining families in the Wellbriety Celebrating Families program. Families cited competing priorities for their family, such as afterschool sports or extracurricular activities for their children. This led to not being able to serve all the children in a family; parents at times preferred to participate in the program and have their children engaged in other after school activities.

The provider had challenges in locating central and easily accessible locations for families to participate in the program, leading to the offering of mostly virtual classes. Internet connectivity and having enough devices for all family members to have access to utilize the different breakout groups became a challenge and led to families becoming disengaged.

When the provider partnered with other organizations to provide services, there were challenges in having the provider being able to have direct access to the parents and families, leaving them to rely on the partner organization to make contact, keep up with engagement, and following up about completion of program outcome measures. The partnering organizations did not always understand the program components or requirements, which led to the provider accepting people into the Wellbriety Celebrating Families program that were not eligible for that service (e.g., they did not have any children in their care), and therefore their outcome measures were excluded and not valid.

The contract deliverable is to provide services to 60 families that meet graduation requirements countywide. In FY 23/24, 23 families completed the program, and of those, only 12 had matched pre-post measures that could be used for analysis.

Lessons Learned:

The provider learned the importance of having direct communication and engagement with families, and the challenges that can arise when having to rely on partner organizations that lack an understanding of the program.

Relevant Examples of Success/Impact:

Program participants shared what they had learned after participating in the Wellbriety Celebrating Families program:

- "Family boundaries and the importance of teaching kids values and morals, taking care of physical, mental, spiritual, and emotional well-being."
- "How much what I do have a say on the next generation, healthy boundaries, and living skills on family and community."

Riverside University HEALTH SYSTEM Behavioral Health

Prevention and Early Intervention Program Summary

Program Information

Type of Program:	☒ Prevention	☐ Early Intervention	☐ Stigma and Discrimination Reduction
	☐ Outreach	☐ Suicide Prevention	☐ Access and Linkages

Program Name: Keeping Intergenerational Ties in Immigrant Families (KITE)

Project Area as Defined by PEI Plan: PEI#7 Underserved Cultural Populations

Program Description: Keeping Intergenerational Ties in Immigrant Families (KITE) is an evidence-based parenting program based on the Strengthening Intergenerational Ties in Immigrant Families (SITIF) curriculum designed for the Asian American community that teaches behavioral parenting skills to improve intergenerational intimacy. It is a culturally-sensitive, community based intervention to strengthen the intergenerational relationship, and promotes immigrant parents' emotional awareness and empathy for their children's experiences, cognitive knowledge, understanding of differences between their native and American cultures.

Number of unduplicated individual participants or audience members during FY 23/24: **54**

Program Demographics: The following demographic information is unduplicated.

Age	
Children/Youth (0-15)	0
Transition Age Youth (16-25)	0
Adult (26-59)	46
Older Adult (60+)	8
Declined to Answer	0

Race	
American Indian or Alaska Native	0
Asian	54
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	0
Other	0
More than one race	0
Declined to Answer	0

Ethnicity	
Hispanic or Latino as follows	0
Central American	0
Mexican/Mexican American/Chicano	0
South American	0
Multiple Hispanic	0
Other Hispanic	0
Did not specify Hispanic/Latino group	0
Asian as follows	54
Filipino	14
Vietnamese	0
Chinese	33
Other Asian	7
Did not specify Asian group	0

Preferred Language	
English	10
Spanish	0
Bilingual	0
Another	44
Declined to Answer	0

Gender	
Male	19
Female	35
Transgender Male to Female	0
Transgender Female to Male	0
Another	0
Declined to Answer	0

Sexual Orientation	
Lesbian	0
Gay	0
Bisexual	0
Yes, did not specify	0
Unknown	0
Another	0
Not LGBQ/Declined to Answer	54

Disability	
Yes	4
No	50
Declined to Answer	0

Veteran Status	
Yes	3
No	51
Declined to Answer	0

Program Reflection: KITE

Implementation Successes:

For FY 23/24, KITE parenting classes were completed using a combination of virtual (via Zoom), as well as in-person (offered at churches or local schools) options, depending on participants' schedules and preferences. The provider conducted a total of 21 parent workshops in the Western and Mid-County regions combined, surpassing the target goal. The workshop topics continue to be pertinent to AAPI families, including: Five Love Languages of Children, Parent Self-Care, Bicultural Parenting, Navigating School Systems, etc.

The provider conducted 5 parenting class cycles in Chinese, Korean, and Filipino (Tagalog/English), with 67 parents enrolled and 54 parents graduated, which is an 80.6% completion rate. Over the course of the parenting classes, the parent specialists were able to build trusting relationships with the parents, enabling open discussions about the challenges they or their children face. This rapport helped reduce mental health stigma and facilitated linkages to mental health services and other valuable school and community resources.

Implementation Challenges:

API bias-motivated incidents and hate crimes remain prevalent, increasing public unease ahead of the presidential election. Consequently, AAPI communities have been reluctant to attend non-mandatory in-person events, hindering efforts to recruit families for KITE workshops and parent groups.

API parents who have expressed interest in or enrolled in the KITE parenting class did not meet fidelity requirements (e.g., children were outside the target age group, or parents withdrew due to formal transition back to in-person workplace). As a result, the KITE program fell short of its target of 80 combined participants from Western and Mid-County parenting courses.

Lessons Learned:

The provider has promoted their workshops and parenting classes through mass emails and social media, but these efforts have been insufficient for participant recruitment. To address this, they are employing more traditional methods, including visiting and posting flyers at locations frequented by AAPIs, such as schools, churches, restaurants, healthcare providers, markets, and after school tutoring centers. Additionally, one-on-one outreach, engagement with community leaders, and word-of-mouth promotion have proven effective and will continue to be prioritized in FY 24/25.

While participant recruitment remains a challenge, SSG's staff will actively encourage in-person participation in workshops and parenting groups in FY 24/25. However, they are remaining responsive to community needs by offering limited virtual and hybrid sessions for parents facing accessibility challenges. They will also continue to develop relevant workshop topics, such as fostering healthy digital media habits for children, to better engage parents and caregivers. The implementation of incentives for workshop and parenting classes has proven successful in increasing interest, and the provider intends to maintain this approach.

Program Reflection: KITE

Relevant Examples of Success/Impact:

In FY 23/24, the provider continued collaborating with the Corona-Norco Unified School District, offering an in-person course at an elementary school with high API enrollment. Looking ahead to FY 24/25, they anticipate offering more workshops and parenting classes, driven by growing interest from the historically hard-to-engage Filipino community in Mid-County.

Parents completed a post-survey at the conclusion of the program and below are examples of comments received:

- “The way of communicating with my children has changed.”
- “Standing in my child's perspective to view issue.”
- “Through the study of the course, I am no longer anxious. If I change my mood as a parent, everything will change.”
- “I try not to immediately get mad and making an effort to be more patient.”
- “I became more attentive to my child.”
- “I became more aware of how to parent cross culturally.”
- “I don’t know how to praise my daughter before studying the courses. After studying, I often praise her, and the effect is very good.”
- “Will change the way of educating children, insist on praising, discover strengths and actively communicate.”
- “Will see things from the child’s perspective and understand and help them.”
- “Through me changing, my child has slowly positively change. We respect each other more and have a closer relationship.”
- “Know each other more.”
- “There are a lot less conflicts.”
- “She would be more patient and talk to me about the details of class and classmates.”
- “We have better communication with my sons.”