Mental Health Services Act (MHSA)

ANNUAL UPDATE

FY 2024–25

Table of Contents

MHSA County Compliance Certification 3
MHSA County Fiscal Accountability Certification 4
Executive Summary 5
Introduction to Tri-City Mental Health Authority 7
- Demographics 7
- Mental Health Service Act (MHSA) 8
- Five Components of the Mental Health Services Act 9
- MHSA Community Planning Process 9

Community Services and Supports (CSS) 19
- Full-Service Partnerships 20
- Community Navigators 30
- Wellness Center 37
- Supplemental Crisis Services & Intensive Outreach and Engagement Team 44
- Field Capable Clinical Services for Older Adults 53
- Permanent Supportive Housing 58
- Access to Care 63

Prevention and Early Intervention (PEI) 67
- Community Capacity Building Programs 69
  - Community Wellbeing Program 69
  - Community Mental Health Trainings 77
  - Stigma Reduction and Suicide Prevention 84
- Older Adult and Transition Age Youth Wellbeing 95
  - Peer Mentor Program 95
  - Wellness Center PEI Programs Transition Age Youth and Older Adults 106
- Family Wellbeing Program 114
- NAMI Ending the Silence and NAMI 101 122
- Housing Stability Program 127
- Therapeutic Community Gardening 134
- Early Psychosis Program 144
- School-Based Services 151

Innovation (INN) 155
Workforce Education and Training (WET) 159
Capital Facilities and Technological Needs (CFTN) 163
MHSA Expenditure Plan 165
Appendix .....

MHSA County Compliance Certification

County: TRI-CITY MENTAL HEALTH AUTHORITY

Local Mental Health Director
Rimmi Hundal, Executive Director
Telephone Number: (909) 623-6131
E-mail: rhundal@tricitymhs.org

Program Lead
Dana Barford, Director of MHSA and Ethnic Services
Telephone Number: (909) 326-4641
E-mail: dbarford@tricitymhs.org

County Mental Health Mailing Address
1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711

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

This MHSA Annual Update Plan 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 MHSA Annual Update Plan 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 MHSA Annual Update FY 2024–25, attached hereto, was adopted by the Tri-City Governing Board 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 MHSA Annual Update FY 2024–25 are true and correct.

Rimmi Hundal, Executive Director		
Local Mental Health Director/Designee County: TRI-CITY MENTAL HEALTH AUTHORITY	Signature	Date

DRAFT

MHSA County Fiscal Accountability Certification

County/City: TRI-CITY MENTAL HEALTH AUTHORITY
___ Three-Year Program and Expenditure Plan _X_ Annual Update ___ Annual Revenue and Expenditure Report

Local Mental Health Director
Rimmi Hundal, Executive Director
Telephone Number: (909) 623-6131
E-mail: rhundal@tricitymhs.org

County Auditor-Controller/ City Financial Officer
Diana Acosta, Chief Financial Officer
Telephone Number: (909) 451-6434
E-mail: dacosta@tricitymhs.org

Local Mental Health Mailing Address
1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711

I hereby certify that the MHSA Annual Update FY 2024–25 is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

Rimmi Hundal, Executive Director

Local Mental Health Director/Designee County: TRI-CITY MENTAL HEALTH AUTHORITY	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2023, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/ City's financial statements are audited annually by an independent auditor and the most recent audit report is dated November 4, 2022 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2023, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Diana Acosta, Chief Financial Officer

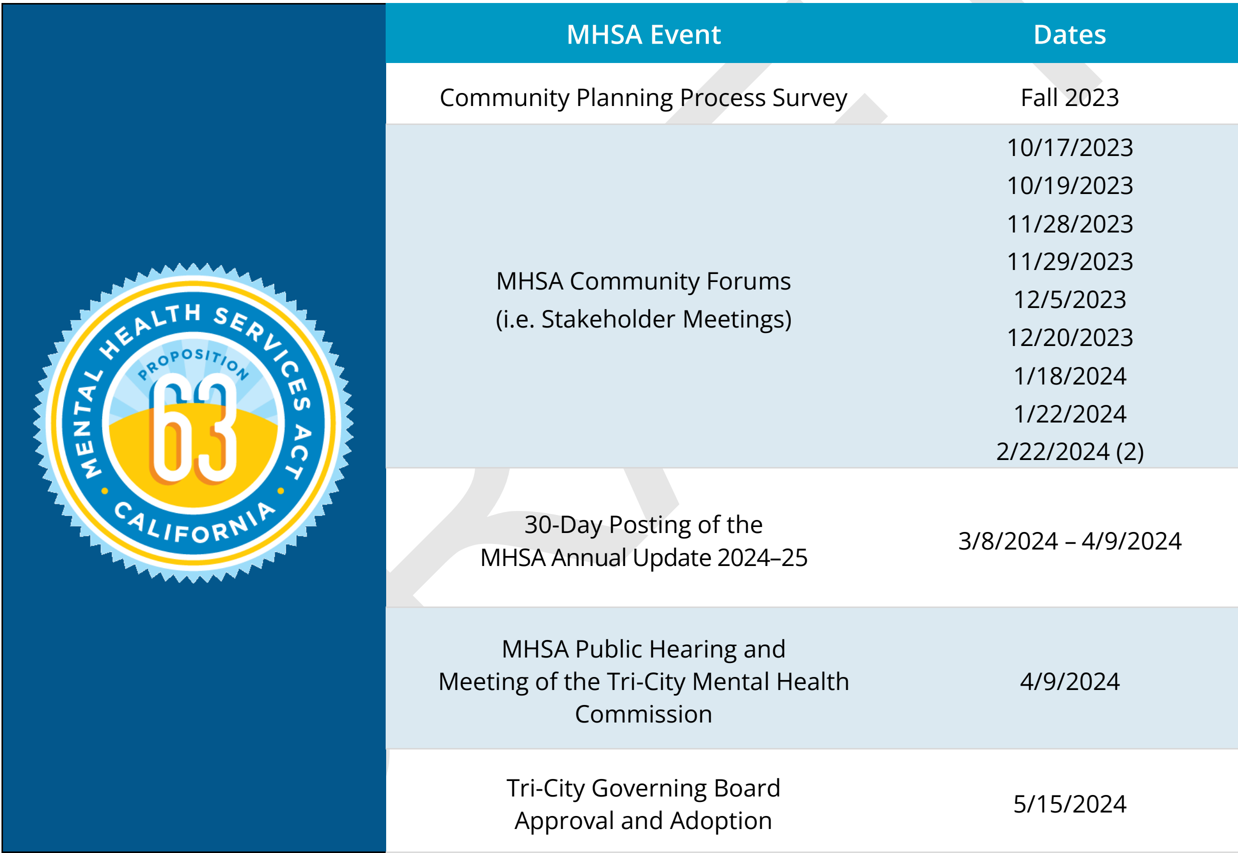
County Auditor Controller / City Financial Officer	Signature	Date

DRAFT

Executive Summary

Community Planning Process

The community planning process began in the fall of 2023 and continued throughout the fiscal year utilizing both in person and virtual platforms. Community members were invited to attend multiple stakeholder meetings and the MHSA Public Hearing. In addition, the community was presented with the annual Community Planning Survey which provided an opportunity for participants to share their feedback regarding possible gaps in service or unmet needs of community members.



MHSA Event	Dates
Community Planning Process Survey	Fall 2023
MHSA Community Forums (i.e. Stakeholder Meetings)	10/17/2023 10/19/2023 11/28/2023 11/29/2023 12/5/2023 12/20/2023 1/18/2024 1/22/2024 2/22/2024 (2)
30-Day Posting of the MHSA Annual Update 2024–25	3/8/2024 – 4/9/2024
MHSA Public Hearing and Meeting of the Tri-City Mental Health Commission	4/9/2024
Tri-City Governing Board Approval and Adoption	5/15/2024

MHSA Plan Highlights & Actions Since Previous Annual Update

Community Services and Supports (CSS)

CSS Program	Total Number Served FY 2022-23
Full-Service Partnerships	490
Full-Service Partnerships Projection for FY 2023-24	436
Community Navigators	969
Wellness Center	1,009
Supplemental Crisis Services	916
Field Capable Clinical Services for Older Adults	37
Permanent Supportive Housing	226
Access to Care	2,517

Prevention and Early Intervention (PEI)

PEI Program	Total Number Served FY 2022-23
Community Wellbeing	10,809
Community Mental Health Trainings	489
Stigma Reduction and Suicide Prevention	404
Older Adult and Transition Age Youth Wellbeing (Peer Mentor Program)	40
Wellness Center PEI /TAY and Older Adults	1,439
Family Wellbeing	522
NAMI: Community Capacity Building/Ending the Silence	359
Housing Stability Program	87
Therapeutic Community Gardening	85
Early Psychosis Program	19
School-Based Services	377

DRAFT

Introduction to Tri-City Mental Health Authority

On June 21, 1960, Tri-City Mental Health Authority (referred to as Tri-City throughout this document) was formed and established through a Joint Powers Authority Agreement (JPA) between the cities of Pomona, Claremont and La Verne. This union established Tri-City as a "county" and mental health authority for these three cities. Since 2008, Tri-City has benefited from funding under the Mental Health Services Act and expanded from a "treatment-only service" agency to a full system of care based on the Recovery Model.

For more than 60 years, Tri-City has provided services that are clinically, culturally, and linguistically appropriate for community members. Tri-City's commitment and belief in wellness and recovery for each of our clients has guided our service delivery and program development. By treating each individual based on their own identified cultural, language and health beliefs, Tri-City is able to demonstrate cultural humility while delivering services that are sensitive to both the customs and cultures of our clients.

DRAFT

Demographics

The total population for the Tri-City area is approximately 219,327 residents. Pomona has more than twice the population of the other two cities combined.

TOTAL POPULATION BY CITY				
	La Verne	**Claremont**	**Pomona**	**Tri-City Area**
Total population	31,423	36,312	151,592	**219,327**
Source: U.S. Census data from 2021 ACS 1-Year Estimates				

The following tables indicate the total population by age group and race/ethnicity:

TOTAL POPULATION BY AGE GROUP					
City: **Age group:**	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by Age**
0-14	5,272	4,953	30,725	40,950	18.70%
15-24	6,978	4,110	25,030	36,118	16.50%
25-59	14,474	13,027	69,702	97,203	44.30%
60+	9,588	9,333	26,135	45,056	20.50%
Totals	**36,312**	**31,423**	**151,592**	**219,327**	**100.00%**
Source: U.S. Census data from 2021 ACS 5-Year Estimates					

TOTAL POPULATION BY RACE/ETHNICITY					
City: **Race:**	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by Ethnicity**
African American	2,116	1,141	8,862	12,219	5.60%
Asian Pacific Islander	5,631	3,133	16,413	25,177	11.50%
Native American	190	270	3,745	4,205	1.90%
White	20,910	20,073	51,051	92,034	41.90%
Other	2,406	2,425	51,441	56,272	25.70%
Two or more races	5,059	4,381	19,980	29,420	13.40%
Race Totals:	**36, 312**	**31,423**	**151,592**	**219,327**	**100.00%**
Ethnicity:					
Hispanic/Latino/a/x	8,691	12,067	108,216	128,974	59.00%
Another Ethnicity	27,621	19,356	43,376	90,353	41.00%
Ethnicity Totals:	**36,312**	**31,423**	**151,592**	**219,327**	**100.00%**
Source: U.S. Census data from 2021 ACS 5-Year Estimates					

Mental Health Service Act (MHSA)

The Mental Health Services Act (MHSA), also known as Proposition 63, has served as the primary source of funding for all MHSA programs for Tri-City Mental Health Authority since 2008. Passed in 2004, the MHSA is funded through a tax imposed on Californians whose income exceeds 1 million dollars. Known as the "millionaire's tax" this initiative is designed to expand and transform California's county mental health system to provide more comprehensive care for those with serious mental illness, specifically in unserved and underserved populations.

DRAFT

Five Components of the Mental Health Services Act

Plan Component	Focus	Year Approved
Community Services and Supports	Provides intensive treatment and transition services for people who suffer with serious and persistent mental illness	2009
Prevention and Early Intervention	Implement services that promote wellness and prevent suffering from untreated mental illness	2010
Workforce Education and Training	Goal is to develop a diverse workforce and provide trainings for current staff	2012
Innovation	Develop new projects to increase access and quality of services to underserved groups	2012
Capital Facilities and Technological Needs	Supports the creation of facilities and technology infrastructure used for the delivery of MHSA services	2013

MHSA Community Planning Process

The success of the MHSA Community Planning Process is built on a strong and effective community partnership. Per the Welfare and Institution Code section 5848, counties are required to collaborate with constituents and stakeholders throughout the planning and development process for any MHSA programs or plans.

One critical component to the stakeholder process is the partnership and collaboration between Tri-City staff and stakeholders throughout the community planning process that includes meaningful stakeholder involvement on: mental health policy, monitoring, quality improvement, evaluation, and budget allocations. (Welfare and Institutions Code (W&I) section 5848).

Stakeholder involvement regarding specific areas of the community planning process is listed below:

DRAFT

Mental Health Policy	Program Planning and Implementation	Monitoring
Public comments during Mental Health Commission meetings, Governing Board meetings and other stakeholder events	Stakeholder and orientation meetings, MHSA workgroups, Community Planning Survey, and Cultural Wellness Advisory Committees	Stakeholder/orientation meetings, MHSA workgroups, review outcomes for programs, 30-Day comment period for MHSA plans and updates, comments made during MHSA Public Hearing
Quality Improvement	**Evaluation**	**Budget Allocations**
Annual Community Planning Survey, surveys completed following trainings, webinars, and presentations, Cultural Wellness Committees	Stakeholder and orientation meetings, opportunity for questions, MHSA workgroups, review outcomes for programs, 30-day postings and public comments, Public Hearing public comments	Stakeholder/orientation meetings, MHSA workgroups, 30-day plan postings and Public Hearing

Community involvement and representation matters, and Tri-City continues to seek the involvement of local community partners, consumers, and stakeholders as we strive to achieve diversity, equity, and inclusion in all aspects of this agency.

Stakeholder perspectives include individuals who receive services; consumers with serious mental illness and/or serious emotional disturbance; family members; community providers, leaders of community groups in unserved and underserved communities, persons recovering from severe mental illness, seniors, adults and families with children with serious mental illness; representatives from the three cities of Claremont, La Verne and Pomona; veterans; representatives from the local school districts, colleges and universities; primary health care providers; law enforcement representatives, mental health, physical health, and drug/alcohol treatment providers; faith-based community representatives; representatives from the LGBTQIA+ community; representatives from the Los Angeles County Department of Mental Health (LACDMH) and other county agencies as well as others.

Opportunities for collaboration include the following stakeholder engagement activities:

DRAFT

Tri-City Event	Description
MHSA Stakeholder Orientation (Hybrid)	This presentation, offered in-person and virtually, encompasses the history of community mental health leading up to the passage of the Mental Health Services Act. Also includes an overview of all MHSA Plans and programs currently implemented through Tri-City's system of care.
MHSA Staff Orientation (Hybrid)	These presentations during new employee orientation include the history of community mental health leading up to the passage of the Mental Health Services Act. Also includes an overview of all MHSA Plans and programs currently implemented through Tri-City's system of care. Staff are also invited to attend stakeholder meetings where additional information is provided.
Community Planning Survey	This annual survey is shared with stakeholders and community partners where they are invited to provide Tri-City staff their thoughts and concerns regarding mental health support services in the cities of Pomona, Claremont, and La Verne. From these responses, future community workgroups and Tri-City staff work in collaboration to develop or expand programs and services based on MHSA guidelines and funding.
Innovation Idea Survey (Online)	The Innovation Idea Survey was created to help community members and stakeholders develop new ideas to be considered for Innovation Projects. Ideas submitted through the survey are discussed during Innovation focus/workgroups.
Community Meetings	Tri-City staff attend multiple community meetings and events to learn first-hand about the needs of the community as well as providing them an opportunity to discuss issues or concerns directly with Tri-City staff.
Interviews with Community Members and Partners	Community members are often interviewed (key informant interviews) and engage in dialogues with Tri-City staff and consultants when community input is critical to informing the decision process. Examples include providing input in the development of Tri-City's new branding campaign and the desired qualifications of a new Executive Director.
Mid-Year Stakeholder Meeting	Stakeholders and community partners are invited to participate in a mid-year stakeholder meeting where they have the opportunity to hear MHSA program updates, review any new MHSA projects or programs, and provide feedback regarding allocation of MHSA funding.
30-Day Posting of 3-Year Plan and Annual Update	All MHSA Three-Year Program and Expenditure Plans and Annual Updates are posted on Tri-City's website and social media for a 30-day review period. In addition, paper copies of the plans are distributed throughout the three cities at local venues such as city halls, libraries, and community centers.
Public Hearing and Mental Health Commission Meeting	The Mental Health Commission hosts an MHSA Public Hearing where community members are invited to join and review a presentation on program updates summarized in the most recent MHSA Three-Year Program and Expenditure plan or Annual Update. Participants can provide feedback to staff which is reviewed and incorporated into the Plan or Update.
Governing Board Meeting/Approval	Community members and stakeholders are invited to all Governing Board meetings and are provided the opportunity to share feedback and ask questions during the public comment period.

DRAFT

The following table reflects specific community planning activities and collaboration impacting the development of this MHSA Annual Update FY 2024-25:

MHSA Event	Dates	Purpose
MHSA Community Forum (i.e. Stakeholder Meetings)	10/17/2023	Orientation to MHSA and introduction to current programs, evaluations, and budgets (in-person)
	10/19/2023	Orientation to MHSA and introduction to current programs, evaluation, and budgets (virtual)
	11/28/2023	Meeting aimed at TAY, families, law enforcement, veterans, and school districts in the service area
	11/29/2023	This stakeholder meeting focused on service providers in our community
	12/5/2023	MHSA orientation and introduction as well as program overview was presented to college students and professors
	12/20/2023	Orientation to MHSA and introduction to current programs, evaluation, and budgets
	1/18/2024	Meeting presented to community partners including law enforcement, local churches, non-profits, k-12 school employees and colleges
	1/22/2024	Meeting presented to community partners via a non-profit community group
	2/22/2024 (2)	During this mid-year stakeholder update, attendees were provided with an update on the potential fiscal impact of Proposition 1 (AB 531 and SB 326). In addition, they were presented with a proposed transfer of CSS funds to WET and CFTN. Lastly, attendees learned about proposal to replace the Supplemental Crisis Services program with the new Mobile Crisis Care (MCC) Pilot Program. Two virtual meetings were held, in the afternoon and evening.
30-Day Posting for MHSA Annual Update FY 2024-25	3/8/2024 through 4/9/2024	The MHSA Annual Update FY 2024-2025 was posted on Tri-City's website and social media for a 30-day review period. In addition, paper copies of the Annual Update were distributed throughout the three cities at local venues such as city halls, libraries, and community centers.
MHSA Public Hearing/ Mental Health Commission Meeting	4/9/2024	The Tri-City Mental Health Commission will host the MHSA Public Hearing where community members are invited to join and review a presentation regarding program updates summarized in the most recent MHSA Annual Update FY 2024-25. Feedback from participants will be reviewed and incorporated into this plan. The Mental Health Commission will be asked to endorse the plan for submission to the Tri-City Governing Board.
Tri-City Governing Board Approval	5/15/2024	The Tri-City Governing Board will meet to approve and adopt the MHSA Annual Update FY 2024-25.

DRAFT

Update on Transfer of Community Services and Support (CSS) Funds to the Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET) Plans

During the MHSA Community Forums held on February 24, 2022, stakeholders approved the transfer of $2.7 million to the Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET) Plans ($1.7 million to CFTN and $1 million to WET) as part of the FY 2022-23 annual Community Planning Process. The $2.7 million was an estimated amount based on projections of revenue at that time. Once the year is over the estimates are re-reviewed and as a result of lower actual receipts, the maximum amount that could be transferred in fiscal year 2022-23 was $2.6 million. In accordance with WIC 5892(b) the maximum amount of CSS Plan dollars that can be transferred out to CFTN or WET Plans is 20% of the average amount of funds allocated to that county for the previous five fiscal years. As a result, the amount that was transferred was $2.6 million ($1,650,000 to the CFTN Plan and $950,000 to the WET Plan, dividing the difference of $100,000 between the two plans).

Proposals Approved During the FY 2023-24 Community Planning Process

On February 22, 2024, stakeholders met to review and provide feedback on MHSA program updates. Afternoon and evening meeting options were available in order to increase accessibility and accommodate all schedules.

1. **A request to stakeholders was presented to utilize Supplemental Crisis Support Services dollars in the amount of $1,760,000 to fund the Mobile Crisis Care (MCC) pilot program for 2 years.**

Some supporting rationale for the request included:

- Centralizing Tri-City efforts to meet specific crisis-related needs of our clients;
- Creation of the MCC program would enable Tri-City to establish a dedicated crisis team equipped to respond to client and community crisis 24/7;
- The MCC program will absorb the responsibilities of both the current Supplemental Crisis Support Services and internal crisis.

The establishment of the MCC would streamline how crisis situations are approached in our community. While Tri-City has historically had proficient and responsive staff manage crisis situations, these staff represent various departments and have other duties such as managing large caseloads, providing psychotherapy services, and administering medication monitoring services. With a dedicated crisis team, crisis response will be the sole focus of staff. Furthermore, the vehicles utilized to respond to a crisis in the community will be equipped for that specific service and fully stocked with items deemed necessary when responding to an array of crisis that an individual may be experiencing.

DRAFT

Voting Results

Seventy-three percent of participants voted in favor of replacing the Supplemental Crisis Services program with the new Mobile Crisis Care (MCC) Pilot Program and reallocating funds in the amount of $1,760,000.00 to fund the MCC. This funding, in part, will support new staff hires necessary to sustain the program.

Position	Number of Staff
Peer Support Specialist II	2
Clinical Therapist II	1
Licensed Psychiatric Technician (LPT)	2
Program Manager (.25 FTE)	.25
Clinical Supervisor II	1
Office Specialist	1

2. **A request to transfer up to $500,000 from the Community Services and Support (CSS) Plan to the Workforce Education and Training (WET) Plan.**

During these meetings, a second request was made for stakeholder support for the transfer of up to $3,000,000 from the Community Services and Supports Plan (CSS) to Workforce Education and Training (WET) Plan and Capital Facilities and Technological Needs (CFTN) Plan.

In February 2024, Tri-City's Chief Financial Officer presented an opportunity to transfer funds from CSS to WET. These excess CSS funds, if not reallocated, are subject to reversion. During the stakeholder meetings in February, attendees were reminded of the function of WET and how reallocation of funds could support Tri-City efforts and the community. Attendees were provided information on how WET supports recruitment, retention, education, and training of current and future members of the community mental health workforce.

Voting Results

Seventy-five percent of stakeholders voted in favor of transferring $500,000 to support Workforce Education and Training (WET). These funds will be used to contribute to the proficiency, efficiency, and effectiveness of our Tri-City staff, as well as communities and student populations who are considering pursuing a career in the mental health field.

3. **A request to transfer up to $2,500,000 from the Community Services and Support (CSS) Plan to the Capital Facilities and Technological Needs (CFTN) Plan.**

A portion of the excess funds available from CSS was also proposed to be transferred to CFTN. While an effective and empathetic workforce is vital to the quality of services Tri-City can provide, staff must also have the necessary tools to complete various roles. CFTN funds provide services and supports such as: The computer lab at the Wellness Center for free public use, purchases and renovations of buildings, Health Insurance Portability and Accountability Act (HIPPA) compliant electronic health records, and strong firewalls for record protection.

DRAFT

Voting Results

Seventy-one percent of stakeholders supported the transfer of up to $2.5 million from the Community Services and Support (CSS) plan to the Capital Facilities and Technological Needs (CFTN) plan. These funds will be utilized to strengthen the infrastructure and technology that Tri-City needs to perform its duties securely, as well as improve the spaces available to our staff and our community.

The following chart provides a visual breakdown of the CSS transfer to both WET and CFTN. It is also important to note that the final amount to be transferred will be *up to* $3,000,000 and is subject to available funds at the time of the transfer:

Workforce Education and Training (WET)	$500,000
Capital Facilities and Technological Needs (CFTN)	$2,500,000
Proposed transfer of funds from CSS to WET and CFTN	**$3,000,000**

MHSA Community Planning Survey

Beginning in September 2023, stakeholders and community partners were invited to complete Tri-City's MHSA Planning Process Survey which provides an opportunity for stakeholders to share their thoughts and concerns regarding the availability of support services. This annual community planning survey is used to identify the needs and priorities of the three cities. These results are then presented to workgroups who review current MHSA programing and make recommendations for staff consideration. Survey results were then incorporated into this MHSA Annual Update FY 2024-25. This survey is just one of many opportunities where stakeholders can share their voice regarding the needs of the communities.

This survey is available in both English and Spanish and sent via email to stakeholders based on a distribution list which is updated throughout the year. In addition, a flyer was created with a QR code and distributed throughout the three cities which allowed participants to complete the survey online. The survey was also presented to specific advocacy groups including four cultural wellness advisory groups and community grant recipients. Lastly, printed versions of the survey are available for those who may not be comfortable or experienced with the virtual platforms.

Survey Results

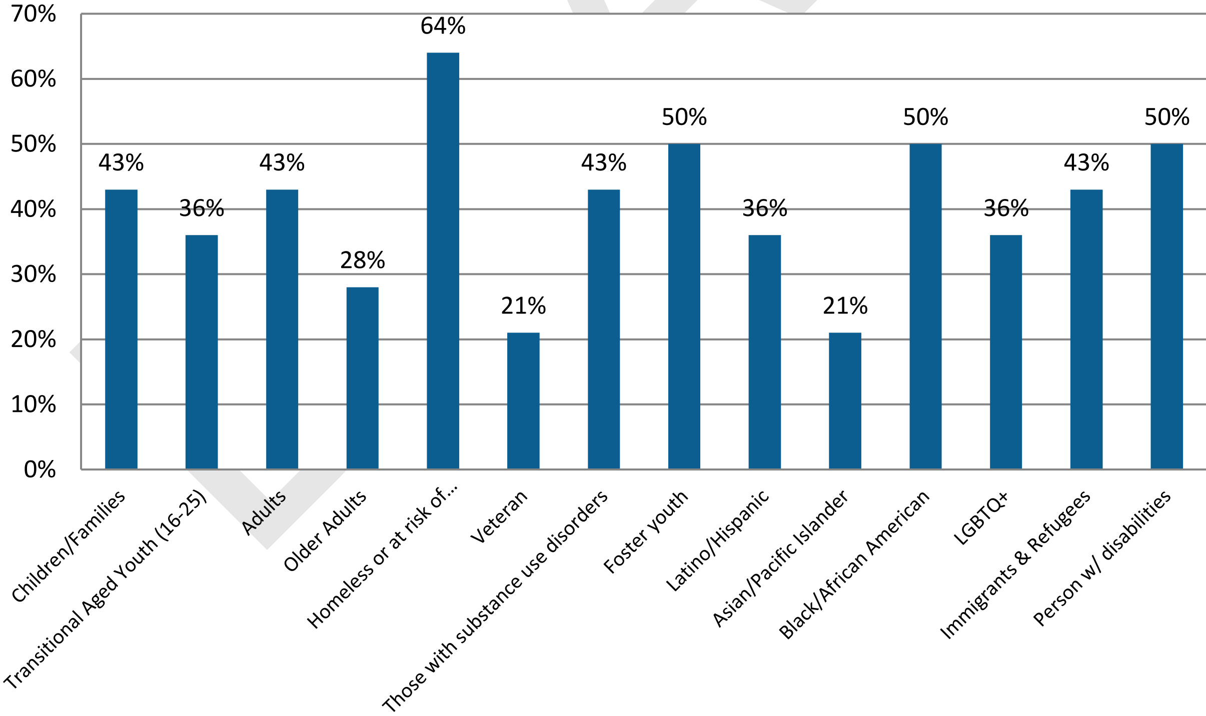
The following are a few examples of comments made by survey participants regarding how they would like to see future MHSA funds used to continue or secure more efficient programing to the community:

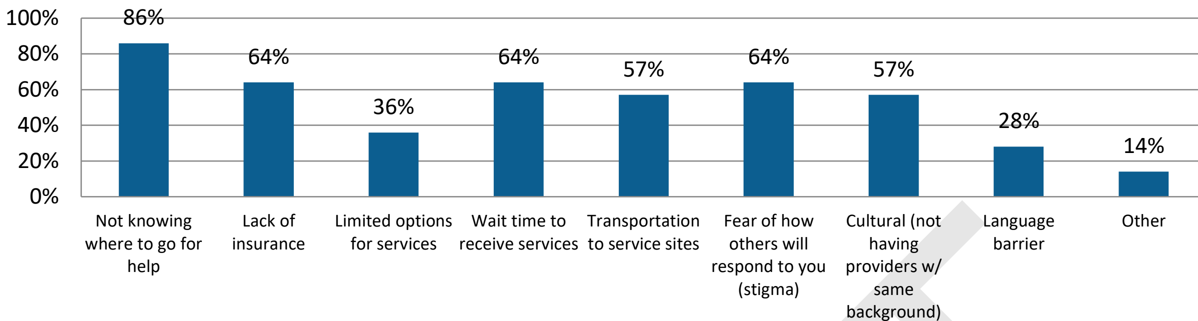
- *You need visibility in a positive way. Partner with on the ground organizations in impactful, significant, and sustainable ways.*
- *I would like more emphasis on building trust with all communities and the understanding that all communities and cultures are better together rather*

DRAFT

than apart. Those in the minority should have the same access and resources as those in the majority in our communities.

- *Outreach, and more programs aimed at building community with the clients you serve. Keeping busy and active is important. Create and/or restart the meetings that had been previously hosted by the Wellness Center such as the peer groups, managing stress, recognizing triggers, coping skills, or day-to-day issues.*
- *Community events in the community rather than just wellness center.*
- *Housing for the unhoused, mental health services for people with severe mental health disorders and substance abuse disorders.*
- *Let the public know -advertise, advertise, advertise! Make sure information about who you are and what you are providing is available (everyone knows the building).*
- *More case managers, more funding for housing, emergency housing funding, funding for Lyft/Uber for clients to get to job and housing opportunities.*





These comments will be addressed by staff in future MHSA stakeholder meetings and workgroups. **Complete survey results are included in the Appendix.**

California Proposition 1: Behavioral Health Services Program and Bond Measure

On March 5, 2024, California voters cast their ballots regarding Proposition 1, Governor Newsom's attempt to Modernize the Mental Health Services Act (MHSA) and increase supportive housing and access to treatment facilities. This measure is designed to improve how California treats mental illness, substance abuse and the homeless by proposing significant revisions to the Mental Health Services Act, a 2004 tax on incomes over a million dollars. Additionally, it would modify how MHSA funds are allocated, and introduce changes related to oversight, accountability, and the community planning process. Proposition 1 also includes a $6.4 billion bond that would create mental health and substance use treatment beds, and housing with supportive services for unhoused Californians with behavioral health challenges.

At the time of the posting of this document, the election results for this ballot measure were still pending and too close to call. The results will not be certified until April 12, 2024. Any projected impact on Tri-City programing will be addressed in future MHSA updates.

30-Day Public Comment Period and Public Hearing

The MHSA Annual Update FY 2024-25 to the Three-Year Program and Expenditure Plan for FY 2023-24—FY 2025-26 provides a comprehensive overview of the MHSA projects and programs funded through the Mental Health Services Act, based on data collected during FY 2022-23. An electronic draft of this Annual Update was posted on Tri-City's website on March 8, 2024 for a 30-day public comment period ending April 9, 2024. In addition, hard copies were circulated throughout the three cities and distributed to public locations including city hall, libraries, community centers and cultural gatherings. Tri-City also utilized social media to circulate the flyer on four different digital platforms.

DRAFT

MHSA Programs

The following pages contain descriptions of each MHSA funded program. The descriptions include updates to the program's development, performance outcomes, and cost per participant calculations for programs that provide direct services.

The services provided during Fiscal Year 2022-23 are highlighted in each program summary by age group, number of clients served, and average cost per person.

DRAFT

DRAFT

Community Services and Supports (CSS)

The Community Services and Supports (CSS) Plan provides intensive treatment and transition services for people who suffer with serious and persistent mental illness or severe emotional disturbances, or who are at risk of SMI/SED.

Full-Service Partnerships
Community Navigators
Wellness Center
Supplemental Crisis Services | Intensive Outreach & Engagement Team
Field Capable Clinical Services for Older Adults
Permanent Supportive Housing
Access to Care

Full-Service Partnerships

Program Description

Full-Service Partnership (FSP) programs are designed for individuals who are experiencing serious emotional disturbance (SED) or severe mental illness (SMI) who would benefit from an intensive service program including housing support. The program uses a "whatever it takes" approach to help individuals achieve their goals. The Mental Health Service Act requires that fifty-one percent or more of the Community Services and Supports funds be used for Full-Service Partnerships programs.

Target Population

Unserved and underserved individuals with serious emotional disturbance (SED) or a severe mental illness (SMI) including children and youth ages 0-15, transition age youth ages 16-25, adults ages 26-59 and older adults ages 60 and over.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Total Served
Number Served FY 2022-23	107	118	228	37	**490**
Projected Number to be Served FY 2023-24	99	99	202	36	**436**
Cost Per Person	$14,143	$18,658	$18,190	$16,745	**N/A**

Program Update

The FSP programs foster a collaborative relationship between Tri-City Mental Health and the client. This may also include the client's family members when appropriate. Through this collaboration, a plan is developed to provide a full spectrum of therapeutic and community services where the client can achieve their identified goals. These support services may be mental health specific or non-mental health specific, and can include housing, employment, education, and integrated treatment of co-occurring mental illness and substance abuse disorders. Personal service coordination/case management is available to assist the client with accessing needed medical, educational, social, vocational rehabilitative and/or other community services.

During FY 2022-23, a total of 490 individuals were served through the FSP programs with the majority of these being adults ages 26 to 59. This number reflects a slight decrease in numbers served in FY 2021-22, which was 485.

DRAFT

Most participants served through the FSP program reside in the city of Pomona and identify their race as Hispanic or Latino. Primary diagnosis for adult FSP clients includes schizophrenia and psychotic disorders followed by depressive disorders. For Child and Transitional Aged Youth (TAY), depressive disorders represented the primary diagnosis followed by Post Traumatic Stress Disorder (PTSD) and Trauma & Stress Related Disorders.

With the implementation of California Advancing and Innovating Medi-Cal (CalAIM), the FSP team has had to adapt to changes in documentation, process, and workflows to ensure that all services are captured in client's electronic health record (EHR). Concurrently, a new EHR was implemented in August 2022, requiring its own learning curve. With these two substantial changes, the FSP supervisors updated internal training and various meetings with the team to help staff adapt to changes and allow opportunity for feedback regarding new workflows.

The FSP team also experienced improvements in staff retention, allowing for increased client care hours and Targeted Case Management (TCM) support. Additional clinical group options were also provided to the community, leading to an increase in available resources for clients, opportunities for building on socialization skills, and peer support.

Lead Clinician and Senior Mental Health Specialist (MHS) positions were also developed as well as MHS group supervision facilitated by Senior MHS and FSP Supervisor. Group supervision for MHS roles increased the knowledge, efficacy, and problem-solving skills of MHS staff in providing effective and ethical services to our clients

Challenges and Solutions

A notable challenge for FSP staff was learning how to utilize the new EHR, Cerner. Implementing the new system was a notable change that impacted workflow as individuals took time out of their day to familiarize themselves with the new system and document accurately. Solutions to this challenge included providing training on the Cerner system, allowing for practice time, increasing office hours for questions related to the EHR, and supervisors investing time to understand the system to better support staff. It was also helpful to allocate time to work on revisions and reduce errors on documentation to ensure that documentation was transcribed in the correct way within the EHR.

Another challenge faced by FSP staff was the changes related to reimbursement for services due to CalAIM reform, such as travel and documentation time no longer being claimable services. A solution to this challenge was to incorporate more collaborative documentation during sessions with clients as well as being more strategic about field visits. FSP staff in the field are encouraged to cluster their appointments to reduce drive time and increase billable services. Additionally, supervisors are assisting with non-billable tasks such as reactivation meetings and closing clients that were never engaged in treatment. Administrative surge dates were also implemented to complete corrections and quality assurance training and materials were disseminated to improve documentation and increase billing for FSP.

There was also a challenge of increased client no shows. Specifically, individuals struggled to attend in person appointments. Teams worked on identifying an appropriate mode of providing services and determining if in-home, office, virtual or telephone sessions would be the best fit on a case-by-case

DRAFT

basis. Training also focused on skills building related to having difficult conversations with clients and conversations about what to expect in treatment. Motivational interviewing skills were reviewed so staff can identify what stage of change their clients are in and provide appropriate interventions to move clients further through the stages of change. It was also helpful to have brainstorming sessions in team meetings to develop action plans that staff can utilize when a client misses their appointment as well as how to support unhoused client's schedule and needs.

Diversity, Equity and Inclusion

Cultural barriers and challenges are regularly discussed in group supervision, individual supervision, and staff meetings. When conceptualizing cases, efforts are made to consider how culture may impact mental health. With the support of supervisors, staff are encouraged to educate themselves on the cultures that they are servicing and familiarize themselves with resources available. Staff are also encouraged to create safe spaces that affirm client identities and to have open, nonjudgmental discussions with consumers about how culture impacts mental health. Often, staff make referrals to Community Wellness Advocates (CWA) or Peer Mentors so that clients/families have a support person that is representative of their culture and background. Undocumented populations are also supported via targeted case management directed at immigration, legal and medical benefits.

In addition, the FSP program seeks to hire staff that are representative of the population we serve and provide services in our threshold languages. When this is not possible, we seek to identify support in the community or within other internal programs that are available to clients (i.e., language line, CWAs, Peer Mentors). This helps to reduce barriers to services.

Training continues to be an ongoing need, especially pertaining to supporting the LGBTQIA+ population. Likewise, plan development that includes community partners assists in supporting the unique needs of specialized populations. Staff ensure that electronic health records also reflect the clients' desires, culture, appropriate pronouns, and preferred name. FSP staff also regularly provide services in the field as barriers related to transportation, mobility or stigma may prevent individuals from coming into the clinic.

Community Partners

The FSP team and Housing Division team communicate often to discuss available resources and how to provide for families who are insufficiently housed. Along with this, the clinical program often collaborates with external housing resources such as Youth Coordinated Entry System (YCES), Family Solutions, House of Ruth, Hope for Homes, Cedar Springs and more. In doing this, clinical teams can better understand resources available and the steps they may need to take to support clients and families obtain resources.

FSP collaborates regularly with internal and external substance use disorder (SUD) programs. The SUD provider joins FSP meetings to streamline communication and provide feedback when discussing high risk cases. Staff regularly hold treatment team meetings together, both with and without family, to make sure that everyone is efficiently and effectively supporting clients in their treatment goals. Internal SUD providers help the clinical team in enrolling clients in external SUD programs (Al-Anon,

DRAFT

Alcoholics Anonymous, American Recovery Center, Prototypes, etc.) and establishing lines of communication.

Treatment teams regularly collaborate with the Department of Child and Family Services (DCFS) and probation. The purpose of this collaboration is to highlight progress, strengths, and potential needs that clients/families may have that can impact meeting recovery goals. These teams come together to support clients/families remove barriers to meeting goals (i.e., needing SUD services). Collaboration is done through child and family team meetings, treatment team meetings, and regular collateral contact. FSP staff also collaborates with local law enforcement to bridge the gap between front-line police officers and community mental health support.

Lastly, when a developmental disability is indicated, the FSP teams collaborate with local regional centers to support the client and their goals.

Success Story

Adult FSP

An adult FSP client struggled with housing instability (moving from a shelter, to living out of their vehicle, to living on the street) and chronic complex medical issues. Ultimately the treatment team was able to support the client in locating permanent housing and paying the fees to recover their vehicle. The treatment team and client also worked together to set and maintain boundaries with others, follow through with medical appointments, link to In Home Supportive Services, and rebuild relationships with their family.

Child and Transition Age Youth (TAY) FSP

A TAY client began to struggle with mental health symptoms when their primary care physician was no longer able to prescribe medications. Client began to experience an increase in auditory hallucinations, increased irritability, and anger outbursts. Initially, there was resistance regarding treatment, however a persistent, skilled, and empathetic clinical team built the bridge to trust and positive change. The client ultimately was able to cease substance use through work with Tri-City's Co-occurring Support Team and enroll in employment assistance from Tri-City's Wellness Center to actively pursue employment.

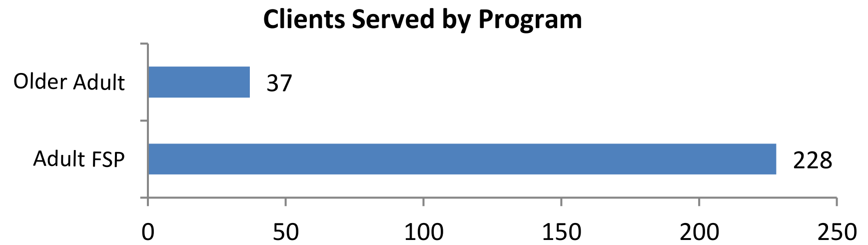
DRAFT

Program Summary

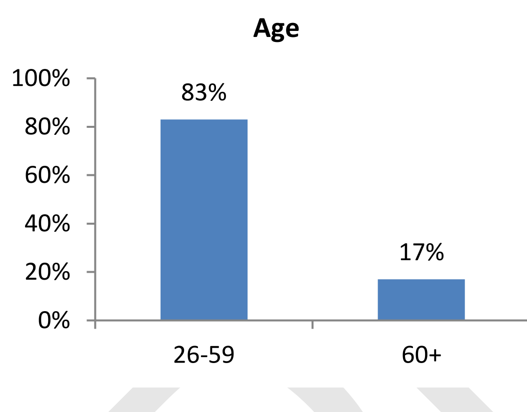
How Much Did We Do?

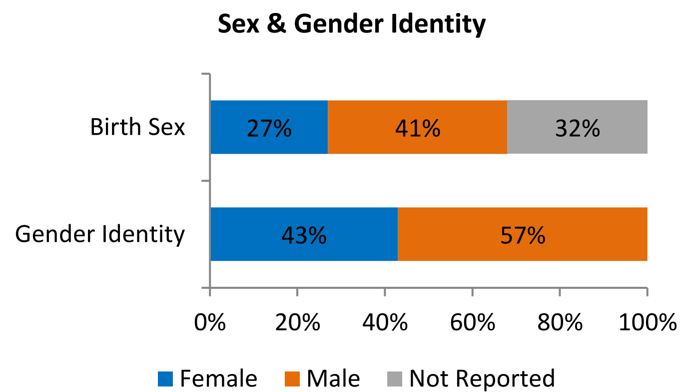
FSP Adult and Older Adult

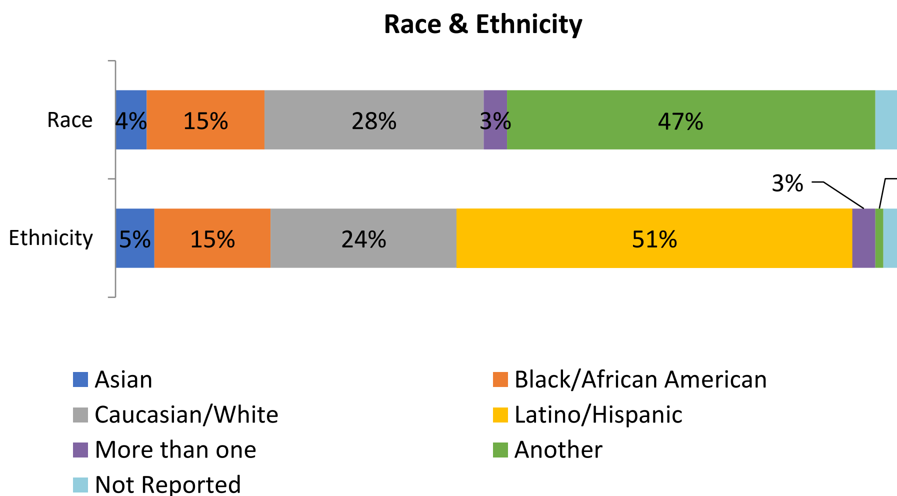
265
Individuals Served

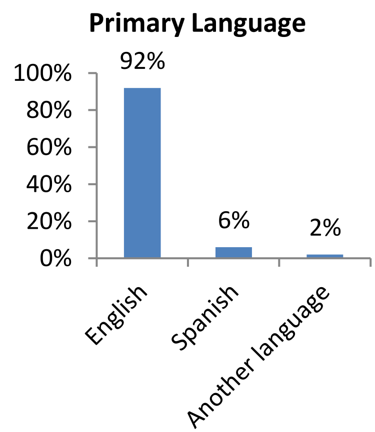


88% of Adult/Older Adult clients lived in Pomona, while **9%** of clients lived in Claremont, **8%** lived in La Verne, and **1%** of clients came from other cities.

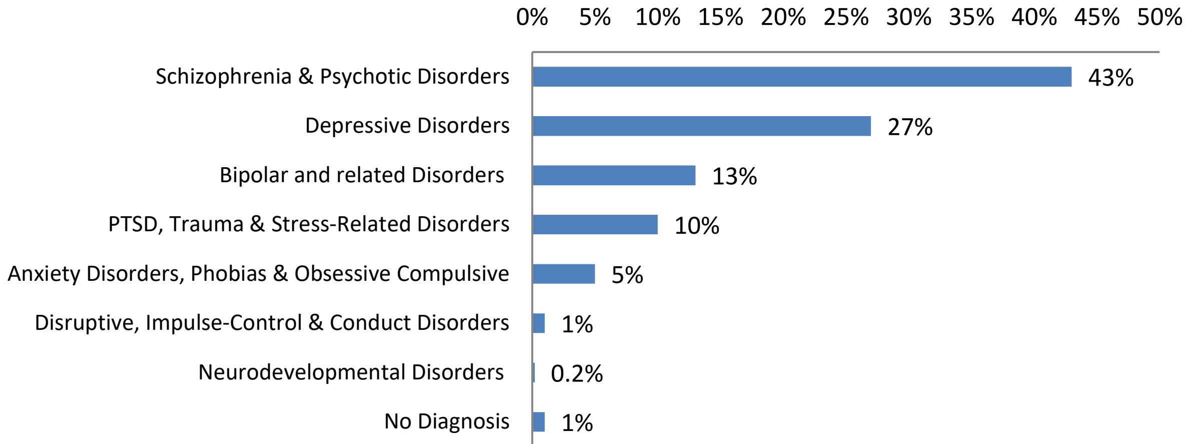




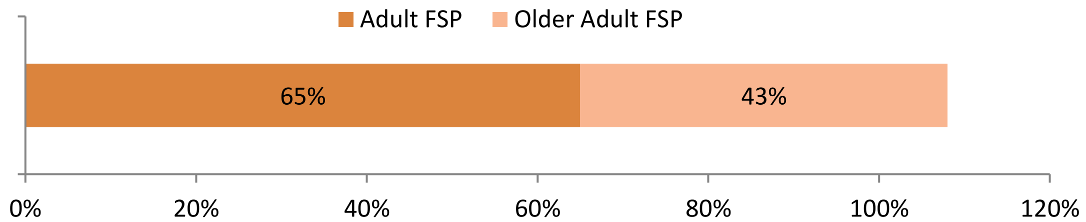




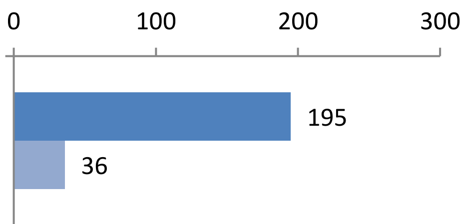
Primary Diagnosis by FSP Adult/Older Adult Clients



Percent of Clients Receiving Medication Services by Program

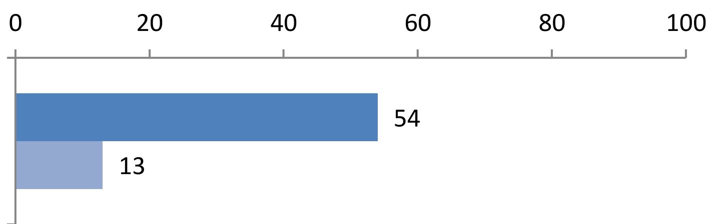


Number of Crisis Episodes



■ Adult FSP ■ Older Adult FSP

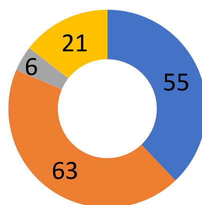
Number of Unique Clients w/ at least 1 Crisis Episodes



■ Adult FSP ■ Older Adult FSP

Number of FSP Adult/Older Adult Clients Connected to Other Services

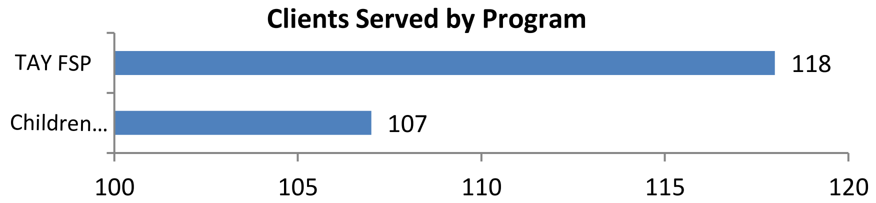
55%
of FSP clients are connected to other Tri-City Services



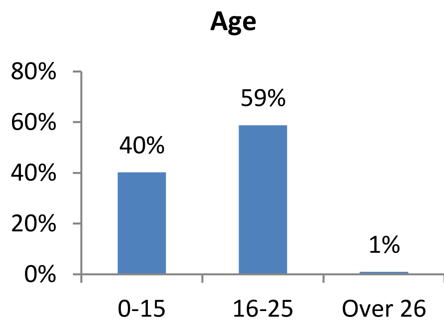
- Housing Services
- Co-Occurring Services
- Therapeutic Community Garden
- Clinical Wellness Advocates

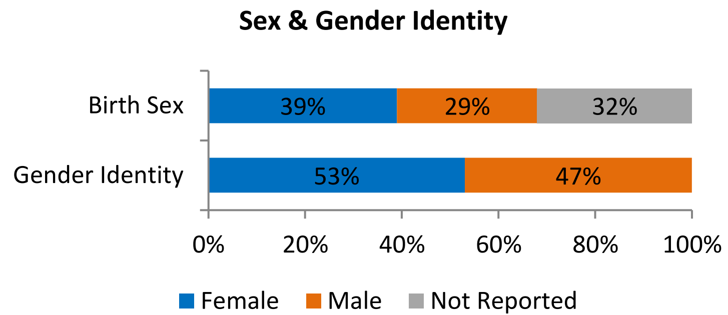
FSP Children and TAY

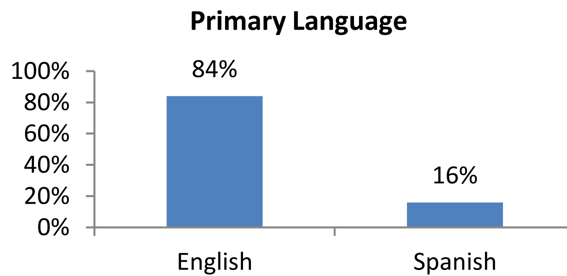
225 Individuals Served

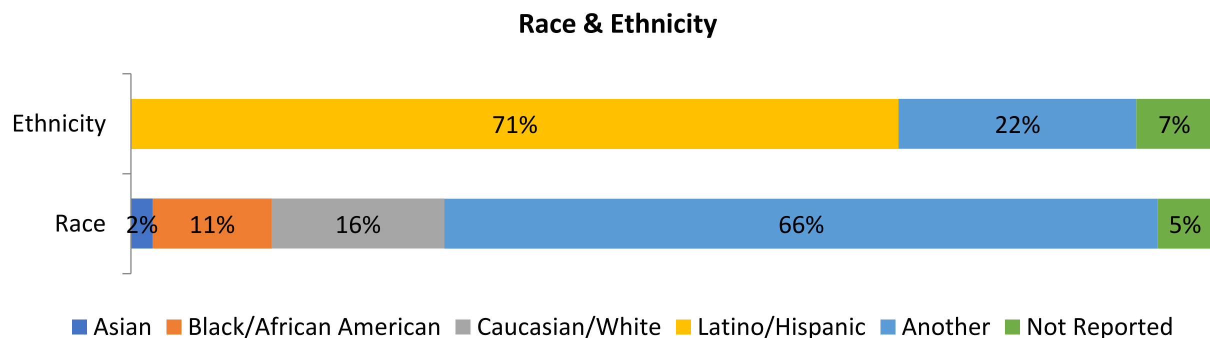


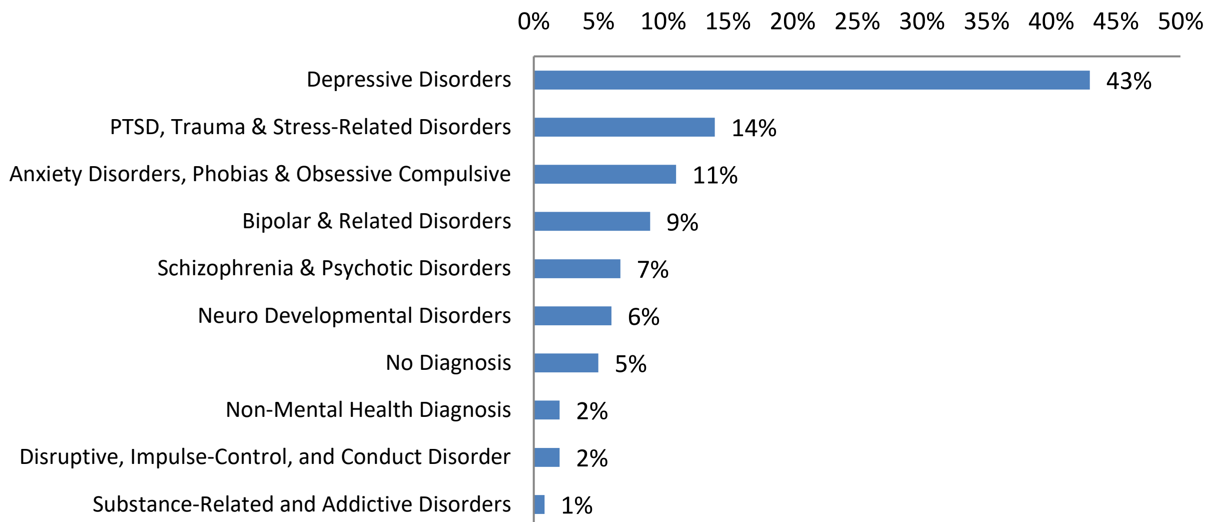
81% of Children/TAY clients lived in Pomona, while **9%** of clients lived in Claremont, **8%** lived in La Verne, and **1%** of clients came from other cities.

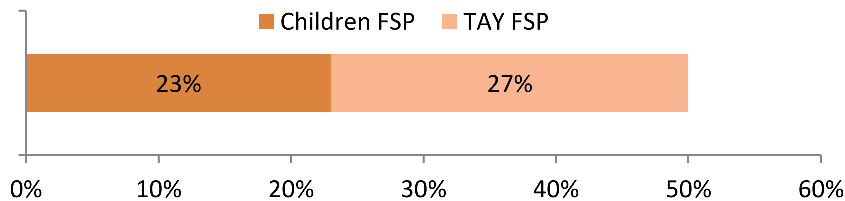


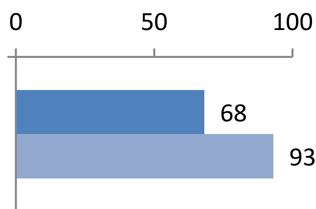


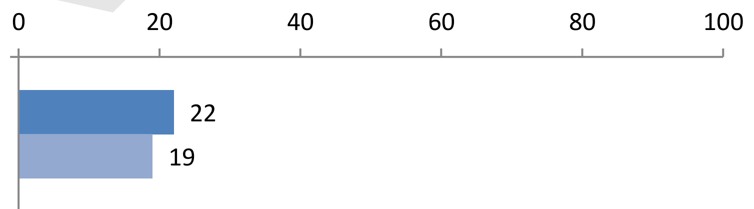






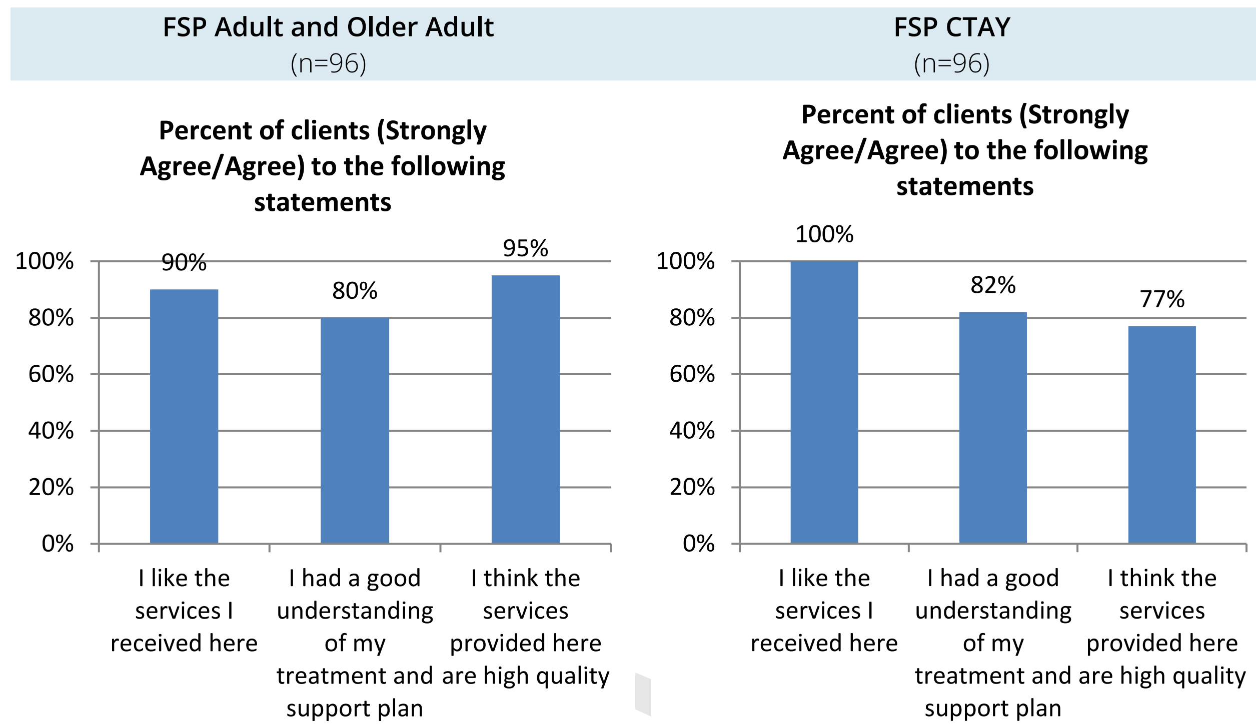






33%
of FSP clients are referred to other Tri-City Services.

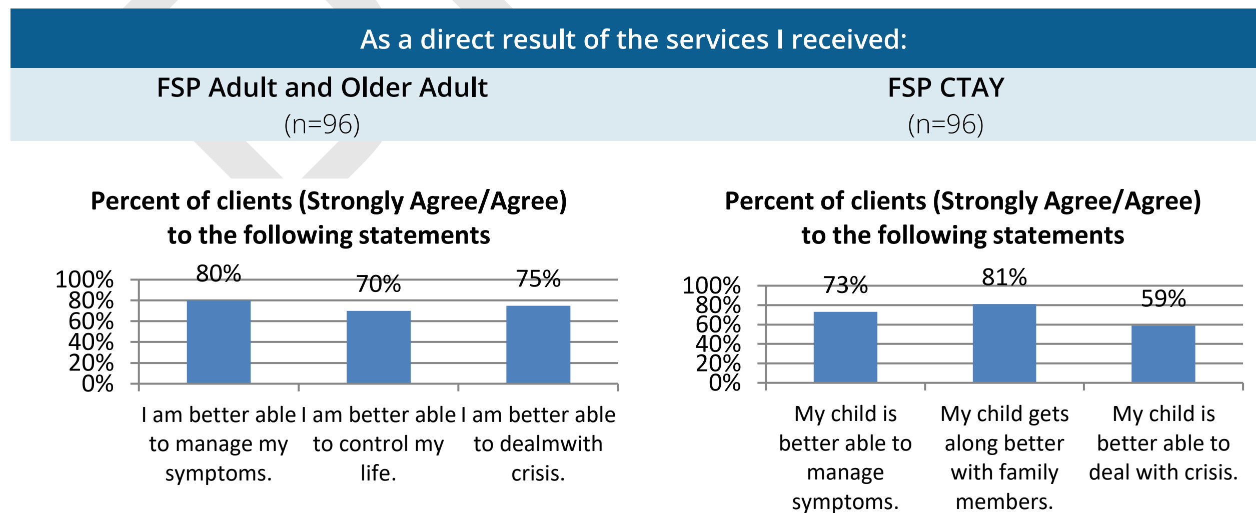
How Well Did We Do It?



On average, FSP Adult/Older Adult clients were enrolled for **17 months.**

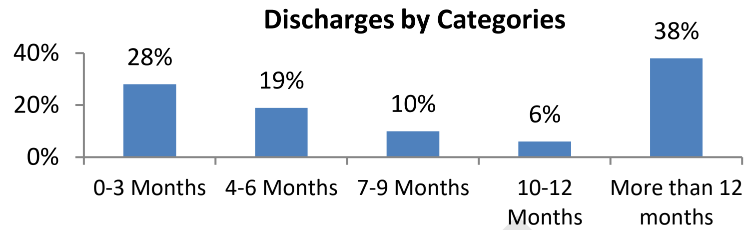
On average, FSP CTAY clients were enrolled for **9 months.**

Is Anyone Better Off?



FSP Adult and Older Adult

123
Discharges during
FY 2022-23



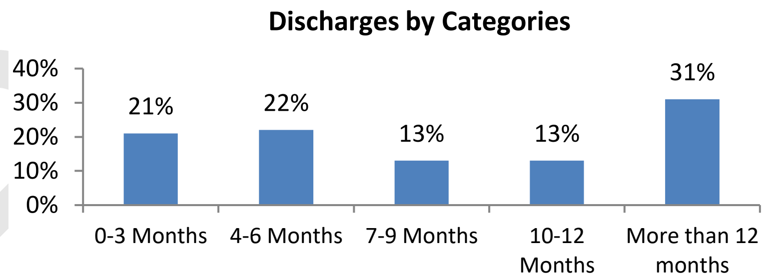
Outcome Measures Application (**OMA**) Outcomes

FSP Adult/Older Adult (n=96)

OMA Reductions	Pre-Intake & Intake	During FSP Enrollment (Key Event Tracking)	Reduction
Justice Involvement	35% (n=34)	2% (n=2)	Yes
Hospitalizations	38% (n=36)	10% (n=10)	Yes
Homelessness	45% (n=43)	42% (n=41)	Yes

FSP Children and TAY

126
Discharges during
FY 2022-23



Outcome Measures Application (**OMA**) Outcomes

FSP CTAY (n=41)

OMA Reductions	Pre-Intake & Intake	During FSP Enrollment (Key Event Tracking)	Reduction
Justice Involvement	12% (n=5)	0% (n=0)	Yes
Hospitalizations	49% (n=20)	22% (n=9)	Yes
Homelessness	0% (n=0)	2% (n=1)	No
Expulsions/Suspensions from School	15% (n=6)	2% (n=1)	Yes

DRAFT

Community Navigators

Program Description

Since 2009, the Community Navigators have served as the primary connection for community members to local resources, including informal community supports and available formal services. In addition, Community Navigators work closely with community partners, non-profit organizations, agencies, community food banks, and faith-based organizations who often contact Community Navigators for assistance. Resources include mental health services, substance use treatment, support groups and parenting classes. Community Navigators also collaborate with local advocacy groups in an effort to build a localized system of care that is responsive to the needs of the clients and community members we serve.

Target Population

Tri-City clients, community members and local organizations who request referrals and linkage to clinically and culturally appropriate resources and services.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown	Total Served
Number Served FY 2022-23	45	63	250	74	537	**969**
Cost Per Person	$607	$607	$607	$607	$607	**$607**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

In FY 2022-23, the Community Navigators (CN) saw a slight decrease in the number of individuals served. In FY 2021-22, the CNs served 1,007 individuals and in FY 2022-23, 969 individuals were served.

The Community Navigators received a high volume of calls related to rental and utility assistance. In collaboration with the City of Pomona, the program received a grant through the San Gabriel Valley Council of Governments (SGVCOG). With this grant, the CNs were able to assist multiple individuals and families with rent, security deposits, and utility assistance. Additionally, the program was also able to help prevent homelessness for many individuals and families within Pomona, Claremont, and La Verne. When funding for the SGVCOG grant ended, the CN Program received additional funds for homeless prevention funds, and short-term motel vouchers, through The Homeless Plan Implantation Grant.

The primary resources requested from the Community Navigators during this time period included mental health counseling, medication support and shelters.

Challenges and Solutions

Limited housing and shelter resources continue to be an on-going challenge. There are a high number of individuals and families that continue to experience homelessness. The Cohort (cities of Pomona, Claremont, and La Verne) lost funding for the Hope for Home beds, a local shelter. In addition, emergency shelters, especially for families, are limited in the service area. Viable solutions include continued collaborations with the Cohort and accessing grant money that addresses homelessness. Placing families and individuals in motels can also allow the program more time to identify other options for long term crises housing, transitional housing, or permanent housing. In the future, the CN program also hopes to identify additional funding for the Cohort beds at Hope for Home to help shelter single adult individuals in a timely manner. The prevention funds will help assist families who need move-in assistance, rental assistance, and assistance with utility bills.

Additional challenges include issues with finding psychiatrists that take Medi-Cal health plans, identifying providers who offer medication support services only (as opposed to those who require simultaneous mental health support from a clinical therapist) and lower level of care clinicians with long wait lists. Possible solutions include CN staff providing assistance to clients with their insurance provider and then following up on linkage. The CN team is also able to refer to the Behavioral Health Urgent Center in the City of Industry, if clients need emergency medication, while they wait for an appointment with a psychiatrist or contact their primary care physician for a temporary prescription for medications. Another identified solution is collaborating with Community Translational Research Institute (CTRI), a community partner. Through a grant that they have received, CTRI can assist with lower-level care mental health services. CTRI may be incorporating a medication support component in the future which may be a helpful resource when clients need this type of support.

Diversity, Equity and Inclusion

The CN program consists of highly trained individuals who are bilingual and can provide services in English, Spanish and Vietnamese. This has proved to be helpful since there is a high population of Spanish speaking individuals in Pomona as well as a Vietnamese population. In addition, some of the navigators identify with lived experience so they can better connect with clients they serve. Flyers and documents are also provided in both English and Spanish.

The CN staff receive ongoing cultural inclusion training to better assist the populations that they serve. In addition, CNs are trained to identify and research any resources that can help further support the mental well-being of individuals who may experience additional cultural barriers. Community Navigators also work closely with local senior centers in the three cities and community partners whose services are geared towards LGBTQIA+ individuals as well as monolingual Spanish speakers.

DRAFT

Community Partners

The Community Navigators collaborate closely with agencies such as Hope for Home Service Center, Los Angeles Centers for Alcohol and Drug Abuse (LACADA), Volunteers of America, Family Solutions, and the Los Angeles Homeless Services Authority (LAHSA) to link individuals to an array of services and resources geared towards those who are experiencing homelessness or housing insecurity.

The CNs also collaborate with the three cities of Pomona, Claremont and La Verne, with a CN stationed in each city to address that community's needs. Additionally, the police departments regularly contact CNs when they encounter individuals in need of resources or homeless assistance.

When individuals are seeking lower level of care services, medical needs or services geared towards specialty populations, CNs collaborate with agencies such as Community Translational Research Institute (CTRI), East Valley Medical Center, Pomona Pride Center and Beinestar Human Services.

Success Story

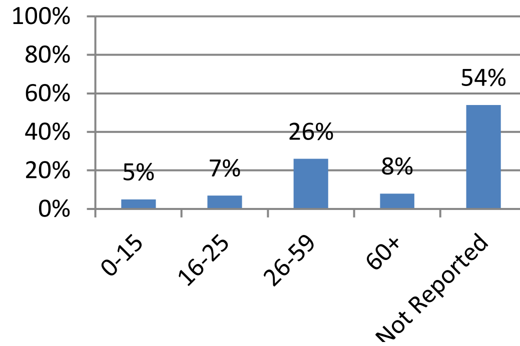
The Community Navigator for the city of La Verne connected with an unsheltered Veteran and began calling different agencies to help with housing. The Veteran, however, was not trusting of the help offered. The Navigator for La Verne continued to develop rapport with the veteran by maintaining weekly contact. After a couple weeks they were connected to LACADA who were able to transport the individual to the Veterans Affairs (VA) to get him registered. The veteran was then able to receive a military ID for the first time, was placed on a wait list for Veterans Affair Supportive Housing (VASH), and ultimately was offered an opportunity for shared Veteran Transitional Housing. With some encouragement and support from the CN, the veteran agreed to try the shared housing. The individual maintained transitional living at this location as well as received assistance with obtaining DD214 military paperwork and a birth certificate. Now, all documentation is ready for when permanent supportive housing becomes available.

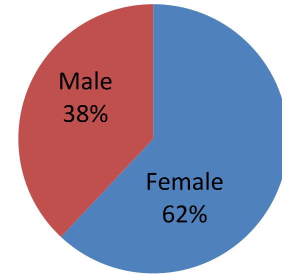
DRAFT

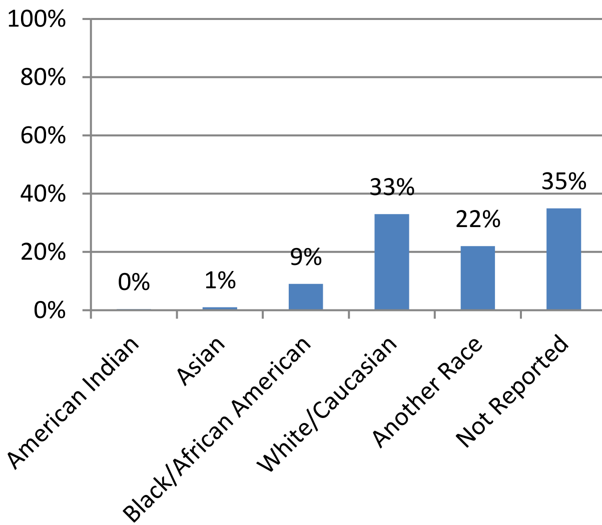
Program Summary

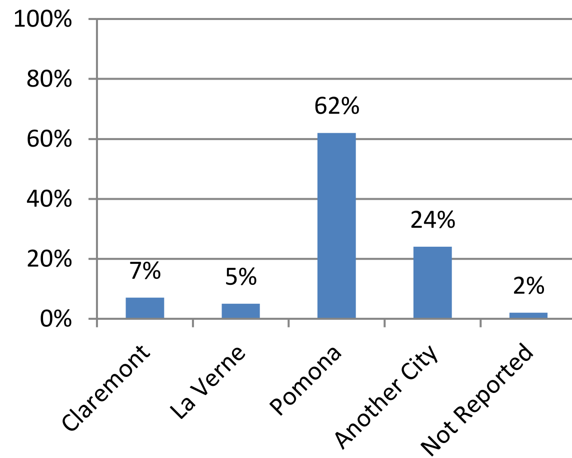
How Much Did We Do?

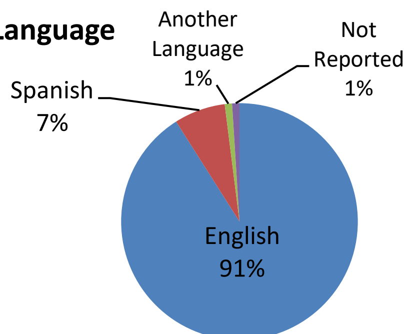
969
Individuals Served



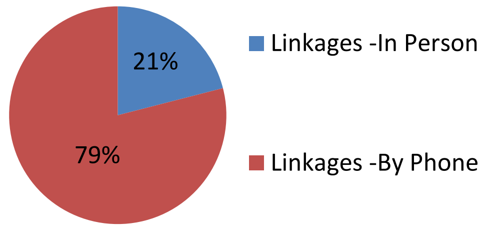




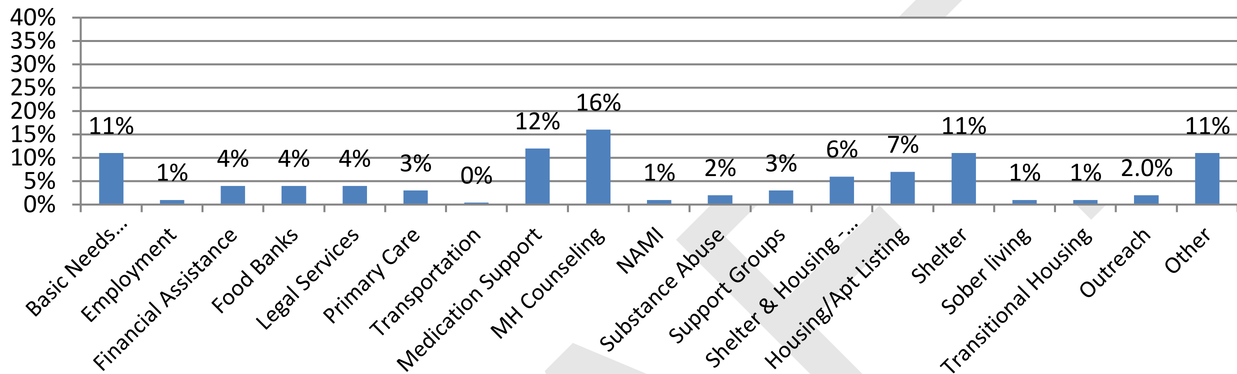


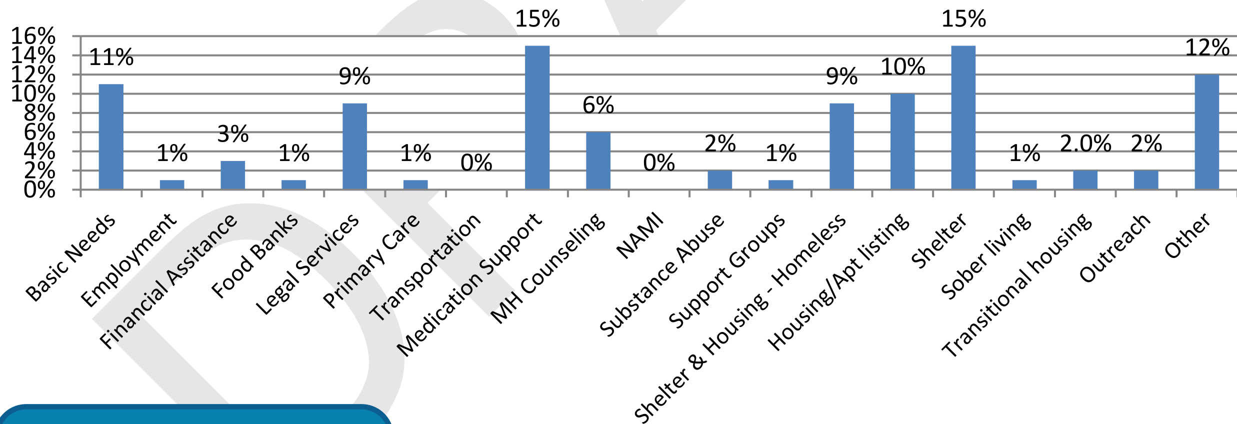


240
Homeless Individuals



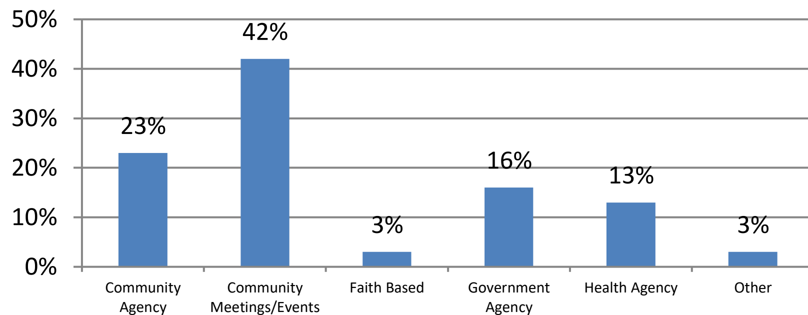
1,371
Linkages made by Community Navigators





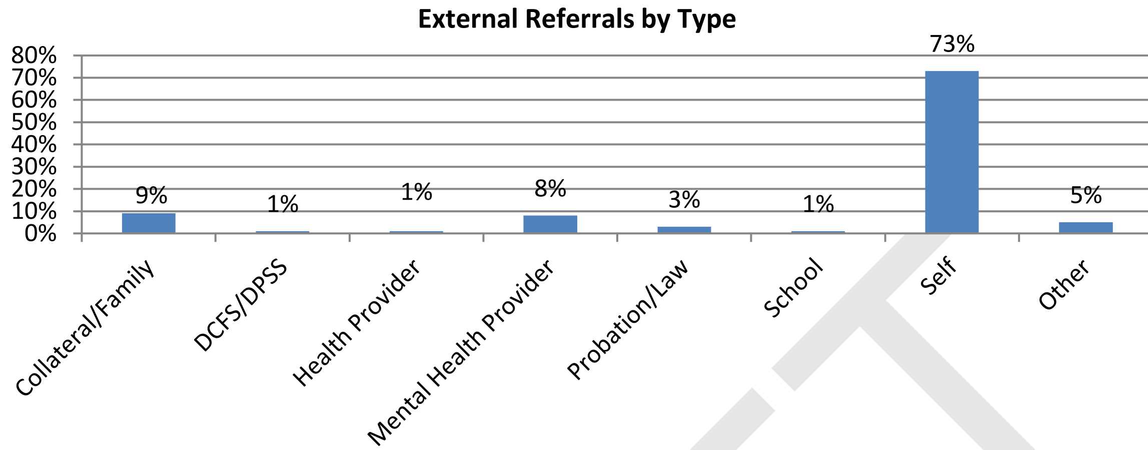
31
Locations Outreached by Navigators

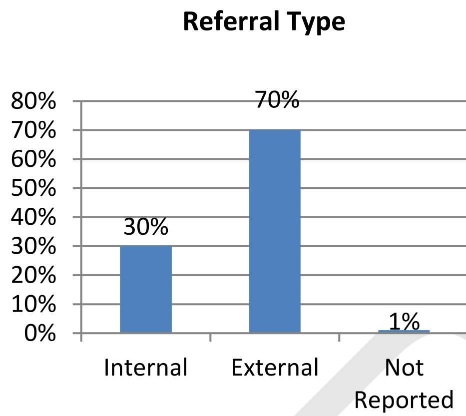
670
Total Community Members engaged by Navigators through Outreach

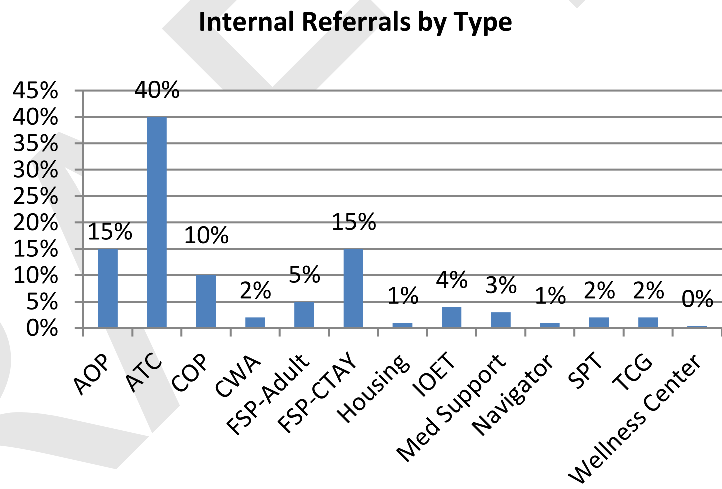


DRAFT

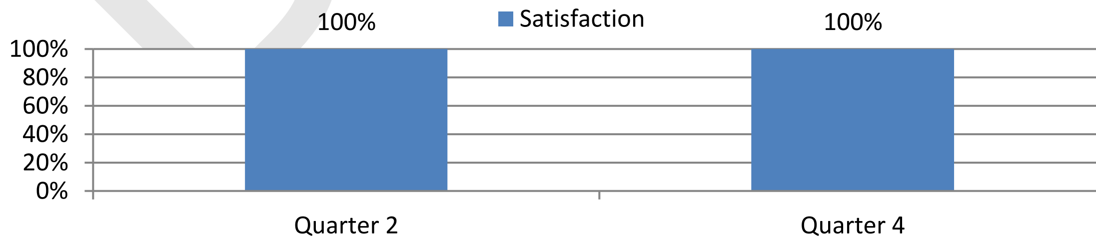
How Well Did We Do It?







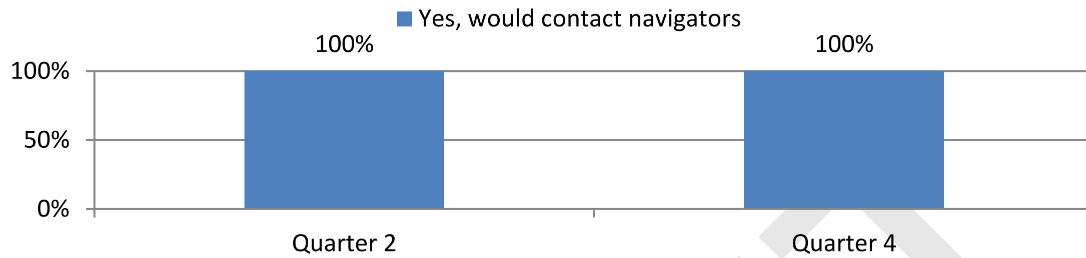
Percentage of Participants Reporting Satisfaction with Services Provided
Respondents (n=123)



DRAFT

Is Anyone Better Off?

Percentage of Community Partners Reporting that if needed to find community resources again, would you contact the community navigators?
Respondents (n=22)



How did you benefit from talking with a navigator?

The top three benefits were:

1. Mental Health Counseling/Treatment Assistance **(39% of respondents)**
2. Housing Assistance **(25% of respondents)**
3. Social Service Assistance **(13% of respondents)**

DRAFT

Wellness Center

Program Description

The Wellness Center serves as a community hub that sponsors support groups and provides an array of holistic services through collaboration with other community partners. Specialized services include activities focused on TAY, older adults, and employment support. Services include support groups, educational resources and workshops, recreational activities, employment, and vocational support. Wellness staff include peer advocates, volunteers and clinical staff who can help participants engage in support services designed to increase wellbeing.

Target Population

The Wellness Center promotes recovery, resiliency, and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	29	180	656	103	41	**1,009**
Cost Per Person	$584	$584	$584	$584	$584	**$584**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The Wellness Center staff were able to offer 16 support groups utilizing primarily a virtual platform. In addition, 1,009 individuals utilized the services at the Wellness Center (groups, activities, employment support, etc.). Multiple hiring events were provided to the community to support those who are actively searching for employment and, combined with other employment supports, 62 individuals obtained employment.

Challenges and Solutions

The biggest challenge faced by the staff during FY 2022-23 was continuing to provide services on a virtual platform. This was a particular barrier for those not familiar or comfortable with the technology, as well as individuals who did not have access to computers or smart phones. Additionally, while the Wellness Center has a computer lab that can fit up to 14 people at a time, the lab was only

DRAFT

able to allow 4 individuals due to social distancing. One solution to the reported challenges was the Wellness Center resuming in person services towards the end of the fiscal year in June 2023. This allowed for in person services such as groups, activities, employment, mock interviews, and budgeting workshops.

Another challenge was the pausing of the computer classes offered by the Wellness Center due to the capacity of the computer lab being reduced. The Wellness Center hopes to resume its computer classes in the future and bring back basic, intermediate, and advanced classes free for the community.

Diversity, Equity and Inclusion

Cultural inclusion is critical to the success of the Wellness Center and groups have been implemented to target specialty populations such as LGBTQIA+, Spanish monolingual, older adults, children, and transition age youth. These services are free, include linguistic support offered in several languages, and are offered at a range of times throughout the day to increase accessibility. Materials are offered in threshold languages and the Wellness Center strives to create a space where individuals can feel safe and heard. Staff participates in ongoing training to increase cultural competence and gain knowledge about implicit bias.

Community Partners

The Wellness Center works closely with outside community organizations to strengthen their network of support. Examples include: Generation Her, a teen parent support group, AlaNon for family AA support, MSW Consortium for workforce development and other local community-based organizations for specific age-related services. Additionally, the Wellness Center has partnered with several external businesses and organizations during Hiring Events such as San Gabriel Transit Inc., FedEx Ground, US Postal Service, Goodwill SoCal, OPARC, and the Pomona Fairplex.

Success Story

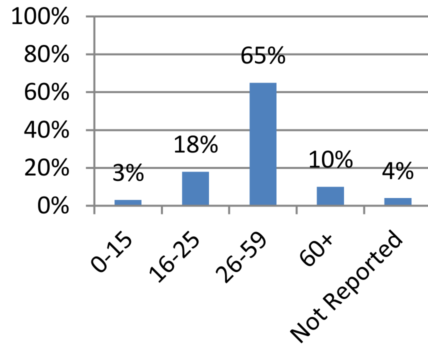
An individual called the Wellness Center seeking assistance with securing employment. Wellness Center staff supported the individual and partnered with them throughout the process of creating a professional resume, signing up for an email account to open communication routes with potential employers, and provided a job packet which contained several current businesses and organizations that were actively hiring. Wellness Center support also included job searching, application support, mock interviews, and designing an account on a job search website. The individual expressed gratitude and excitement related to being empowered with so many options to find employment. Ultimately, they interviewed for a job that was part-time, secured employment, and was subsequently offered a full-time position. The individual has maintained employment and as a result, has improved the overall quality of life and no longer faces housing insecurity.

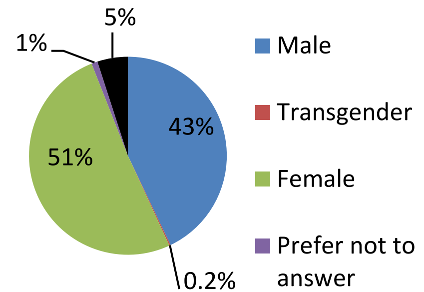
DRAFT

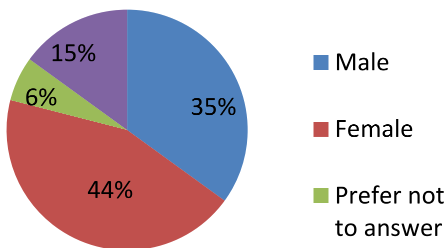
Program Summary

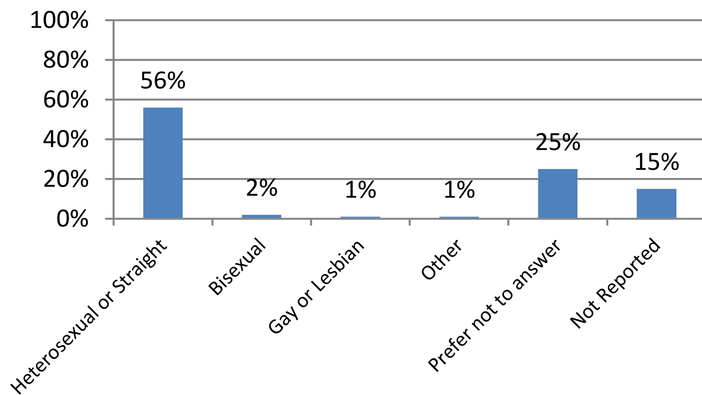
How Much Did We Do?

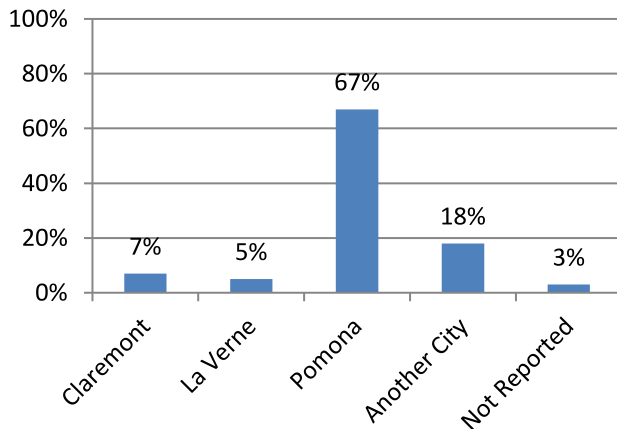
1,009
Individuals attending Wellness Center

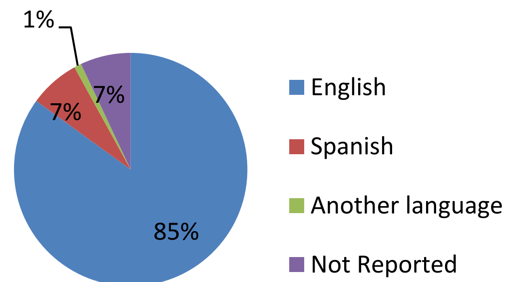


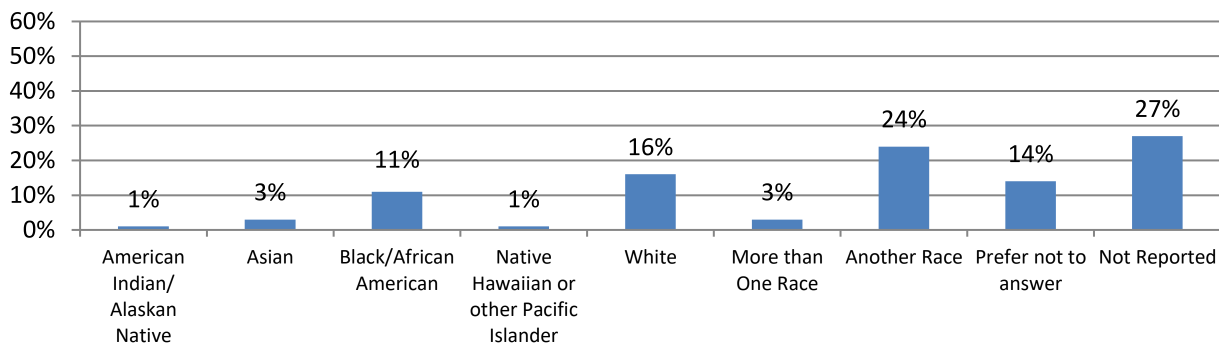


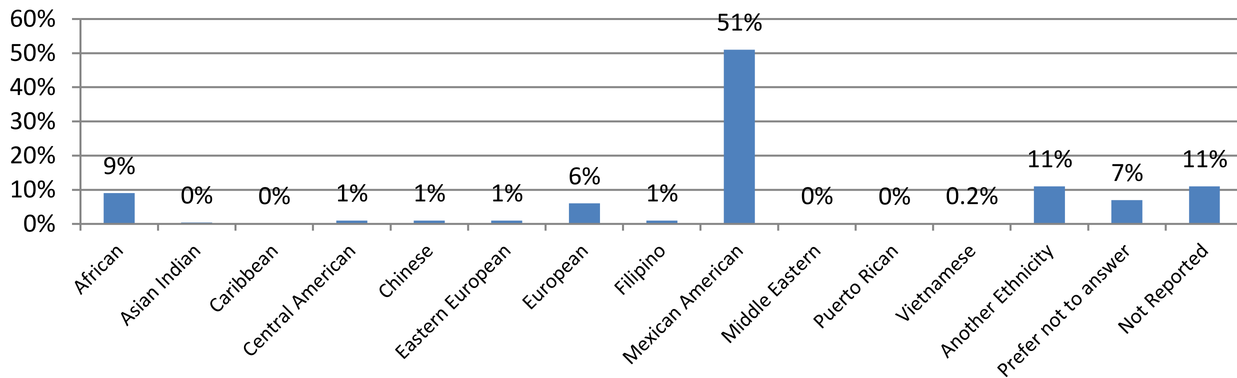


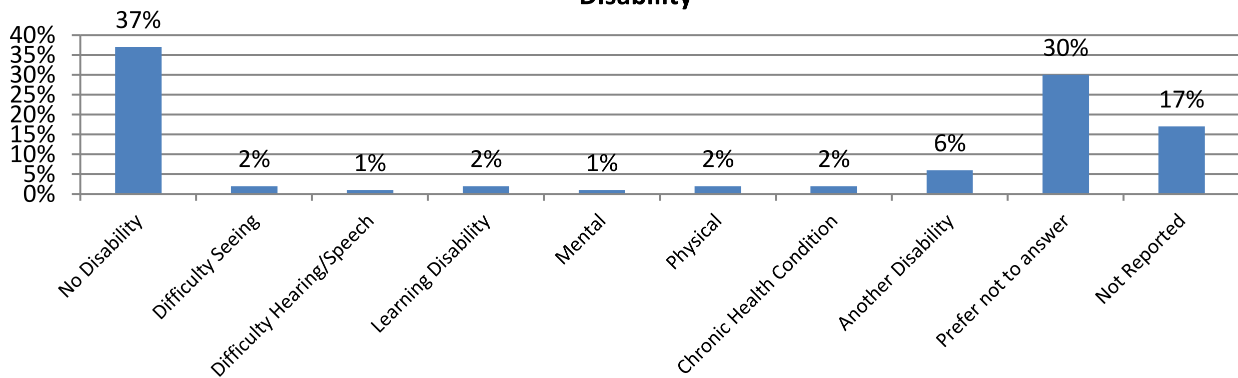


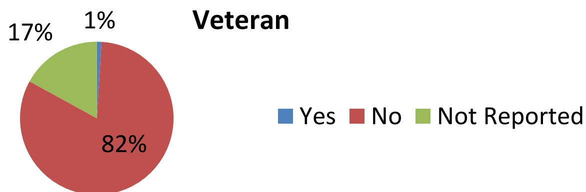





Race
60%
50%
40%
30%
20%
10%
0%
1%
3%
11%
1%
16%
3%
24%
14%
27%
American Indian/ Alaskan Native
Asian
Black/African American
Native Hawaiian or other Pacific Islander
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
9%
0%
0%
1%
1%
1%
6%
1%
51%
0%
0%
0.2%
11%
7%
11%
African
Asian Indian
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Mexican American
Middle Eastern
Puerto Rican
Vietnamese
Another Ethnicity
Prefer not to answer
Not Reported

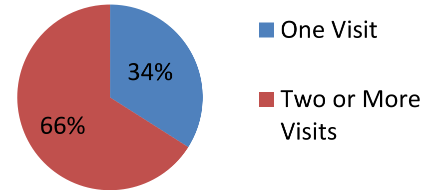

Disability
40%
35%
30%
25%
20%
15%
10%
5%
0%
37%
2%
1%
2%
1%
2%
2%
6%
30%
17%
No Disability
Difficulty Seeing
Difficulty Hearing/Speech
Learning Disability
Mental
Physical
Chronic Health Condition
Another Disability
Prefer not to answer
Not Reported


Veteran
17%
1%
82%
Yes
No
Not Reported

How Well Did We Do It?

16,498
Number of Wellness Center CSS Events (Duplicated Individuals)

Number of Times People Visited



Group Name	Number of Times Group Was Held	Average Number of Attendees at a Group
Anger Management	71	11
Anxiety Relief	82	4
Bore No More	24	2
Dual Recovery Anonymous	50	4
Freedom Through Reality	58	4
Lose the Blues	46	4
Men's Depression	78	3
Socialization	49	3
Strong Women	63	5
Women's Self-Esteem	52	3
Español – Comadres y Compadres	51	3
Español – Sobrellevando La Ansiedad	42	3
Español – Corazón a Corazón	22	2
Español – Socialización	52	2
Vocational – Employment Workshop	41	1
Vocational – Literacy Group	38	2

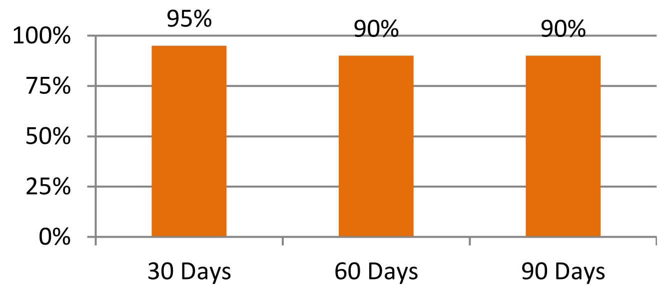
DRAFT

Contacts by Type	Number of Times Contact was made
Attendance Letter	389
Other	604
PC Lab	588
Tour	153
Phone Call/Email – Wellness Calls	1,894
Adult Orientation	7
Vocational – Job Search	1,044
Vocational – Resume/Interview	74
Vocational – Work Maintenance	9
Vocational – Hiring Event	31

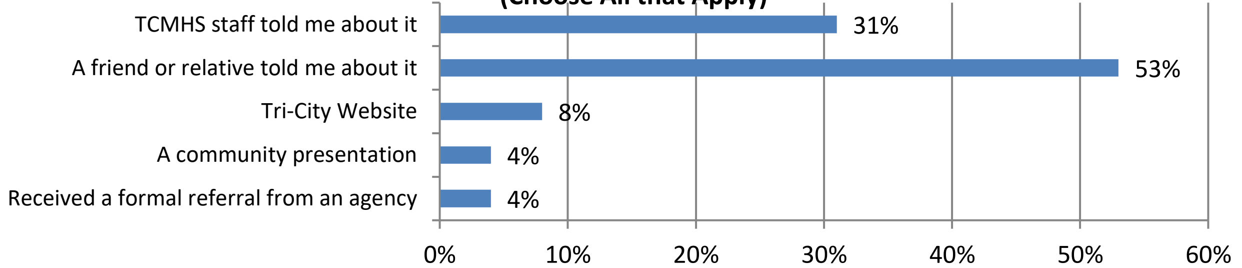
60
Individuals Secured Employment

96%
Satisfied with the help they get at Wellness Center Programs

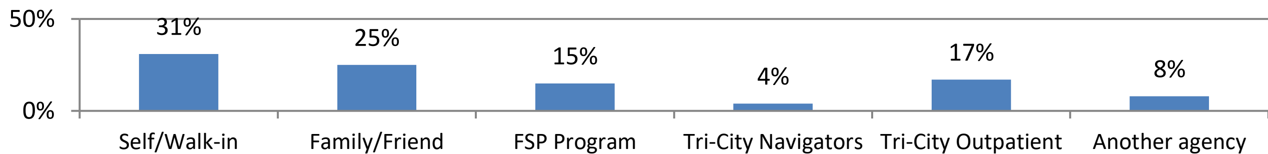
Percent of Individuals who Maintain Employment at 30 Days · 60 Days · 90 Days



How Did You Learn About the Wellness Center Programs? (Choose All that Apply)

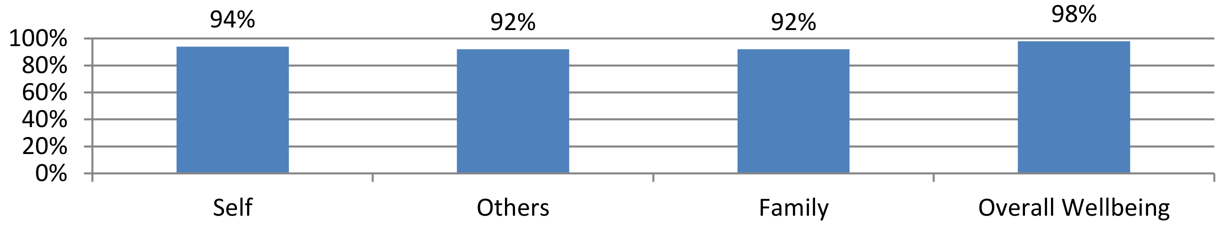


Who referred you to the Wellness Center



Is Anyone Better Off?

Percent of people who report improved relationships with the following because of the help they get from the Wellness Center Programs



DRAFT

Supplemental Crisis Services

& Intensive Outreach and Engagement Team

Program Description

The Supplemental Crisis Services (SCS) program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMHA services. Crisis walk-in services are also available during business hours at Tri-City's clinic location. Through follow-up efforts by the Intensive Outreach and Engagement Team (IOET), individuals located in the community who are having difficulty connecting with and maintaining mental health support can receive services in an effort to help reduce the number of repeat hospitalizations and guide these individuals to the most appropriate care.

Target Population

The SCS targets individuals in crisis and currently not enrolled in Tri-City for services. The program is geared towards serving those who are seeking mental health support after-hours and individuals located in the community who are having difficulty connecting with and maintaining mental health support.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Supp Crisis Number Served FY 2022-23	0	17	88	21	76	**202**
Cost Per Person	$775	$775	$775	$775	$775	**$775**
IOET Number Served FY 2022-23	36	63	416	81	118	**714**
Cost Per Person	$775	$775	$775	$775	$775	**$775**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

DRAFT

Program Update

During FY 2022-23, the Supplemental Crisis Services (SCS) received 202 after-hour crisis calls. Program staff regularly demonstrated the ability to decrease the level of stress for callers (1 mild and 10 severe). The mean level of caller distress decreased from 3.43 at the beginning of the call, to 2.12 at the end of the call. The reported primary reason for contacting the SCS was seeking resources/information, followed by experiencing symptoms/seeking support.

The Intensive Outreach and Engagement Team (IOET) was specifically designed to reach underserved populations. The IOET utilizes a field-based approach to outreach to known "hot spots" within the communities including encampments, parks, abandoned buildings, freeway underpasses, Hope 4 Home service center and home visits. They offer a whole-person system of care, in which staff address all aspects of the individual's needs. This team of highly qualified staff receive the highest number of crisis referrals of all departments within Tri-City. In FY 2022-23, the IOET served 982 individuals with 342 cases opened for services within Tri-City Mental Health, primarily in adult outpatient services.

The 2022-23 fiscal year brought significant change to IOET as a trend of reintegration began. There was an overall increase in face-to-face encounters as people began to reduce the need/desire for virtual or telephone services. Multiple systems of care county-wide began to provide face-to-face services again which was extremely helpful for unsheltered individuals who did not have access to phones or email. These factors were a benefit to IOET in regard to engaging and providing services to individuals in our catchment area.

Challenges and Solutions

A notable challenge experienced in FY 2022-23 was the lack of co-occurring services available in the catchment area. This made the referral process difficult as appropriate services needed to be identified and available for new clients. Additionally, lack of available and affordable housing continues to be a challenge. One solution that assisted IOET in supporting every individual was utilizing a whole-person care model that fully integrates family medicine, psychiatry, referrals, resources, and chemical dependency. It is also part of IOET's approach to practice in accordance with an understanding that each individual in need of housing has unique needs. The IOET literally and figuratively meets every individual "where they are at."

Diversity, Equity and Inclusion

The IOET has multiple staff members that are bi-lingual. All IOET brochures are in both English and The IOET demonstrates a non-judgmental approach when working with individuals. Each person is treated on an individual basis and without the use of labels. The IOET incorporates literature regarding resources and referrals geared towards providing information that is culturally relevant on how to access both formal and informal services through several different avenues (traditional office, phone, or other electronic media). This allows for the individual to choose an entry point that is most comfortable and conducive to their specific needs.

DRAFT

The IOET is committed to removing barriers before they encounter individuals in need. Examples of these anticipated barriers include eliminating any narrative, legal status, criminal history, medical issues, identity, religion, or other extenuating factor, as long as there is not eminent danger and policy allows, in order to provide fair and equable service to those in need.

Community Partners

The Intensive Outreach and Engagement Team is actively engaged with several community partners with the goal of providing the highest quality of support and resources. A few examples of this extensive network of support includes partnerships with the cities of Claremont, La Verne, and Pomona Police Departments, Los Angeles Homeless Services Authority (LAHSA), Union Station Homeless Services, American Recovery Center (ARC), Department of Public Social Services, Prototypes (Drug Rehabilitation), East Valley Community Health Center, Hope for Homes, Express Pharmacy, and Mission Community Hospital.

Success Story

SCS encourage the celebration of any success, small or large, for individuals that are served through this program. Every milestone reached by the individual and the team is a victory. SCS consistently view any progress from this perspective, and when done so as a team, are given an opportunity to celebrate individual’s successes no matter how large or small they may be. A notable achievement of SCS in FY 2022-23 is that a total of 961 individuals were served.

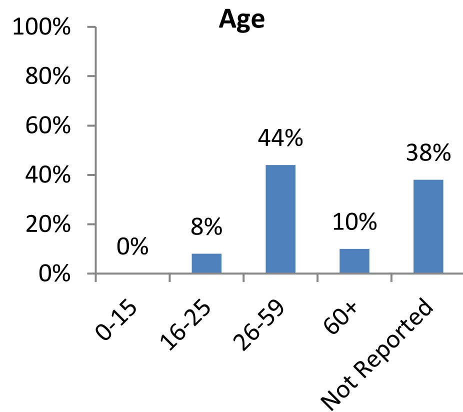
DRAFT

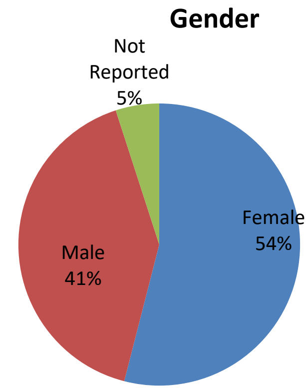
Program Summary

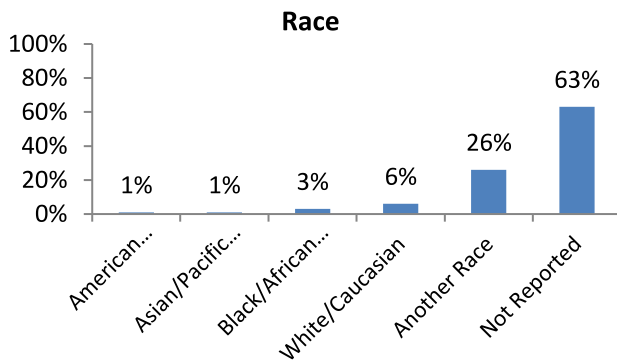
How Much Did We Do?

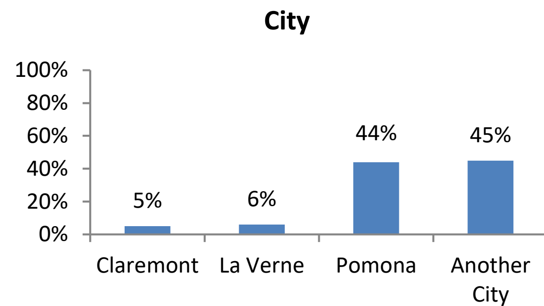
Supplemental Crisis Calls

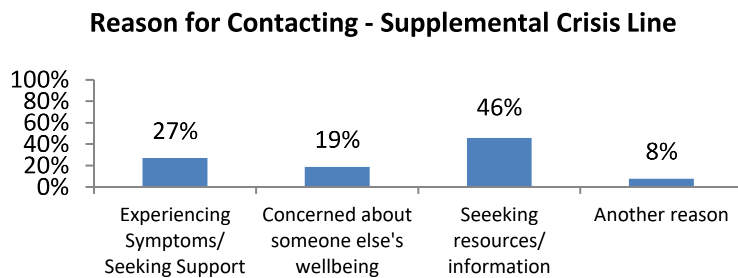
202
Supplemental Crisis Calls

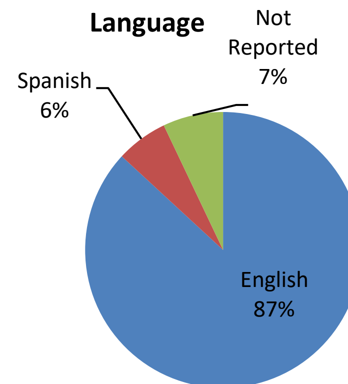


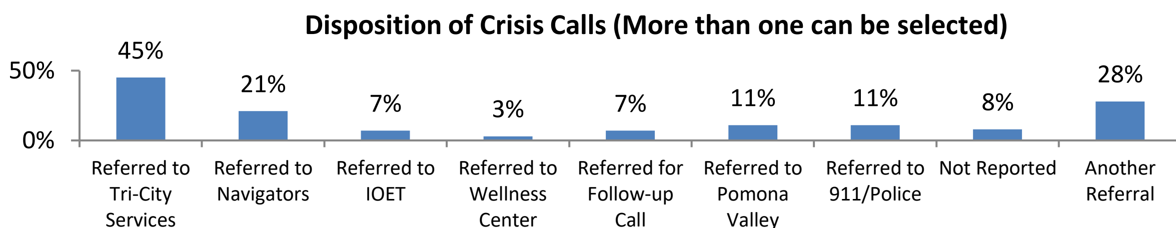






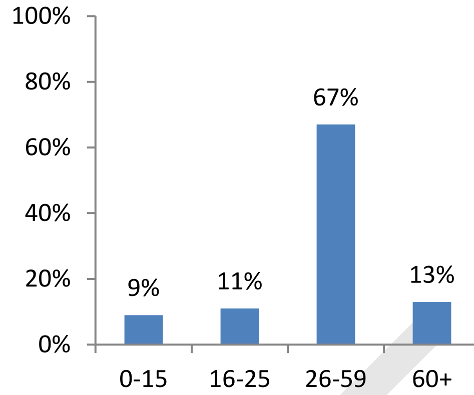


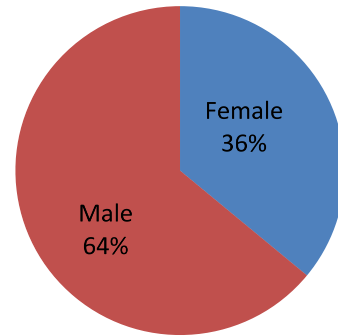


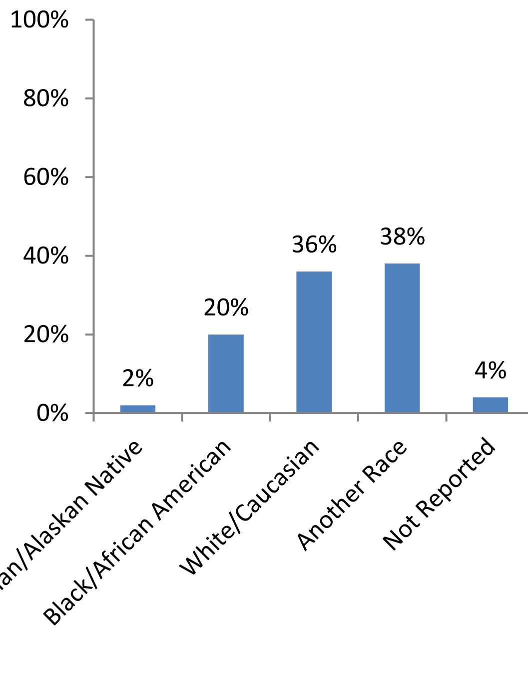


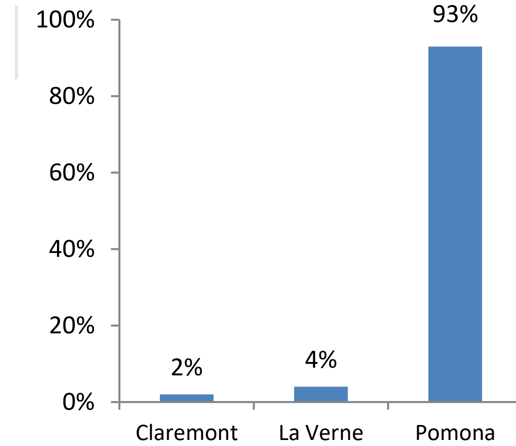
Supplemental Crisis Walk-Ins

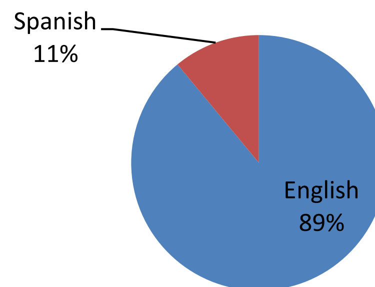
45
Crisis Walk-ins





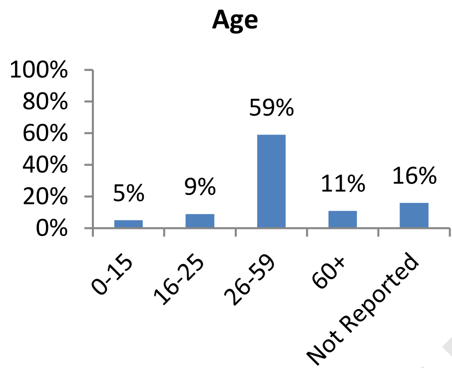


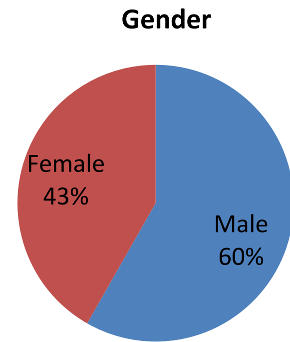


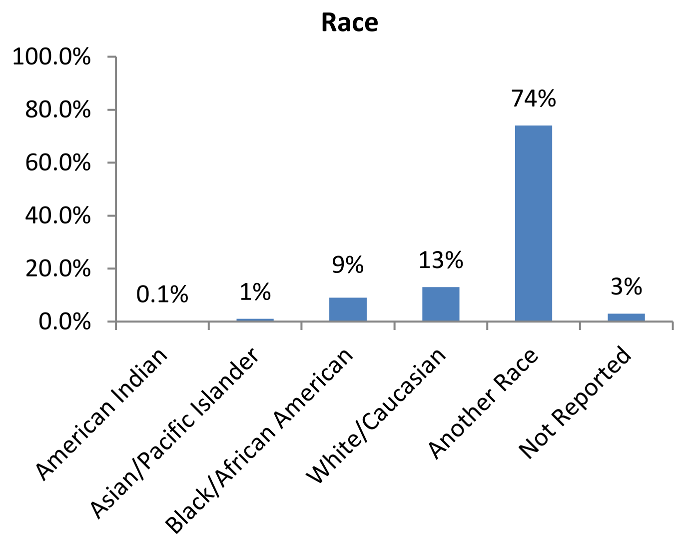


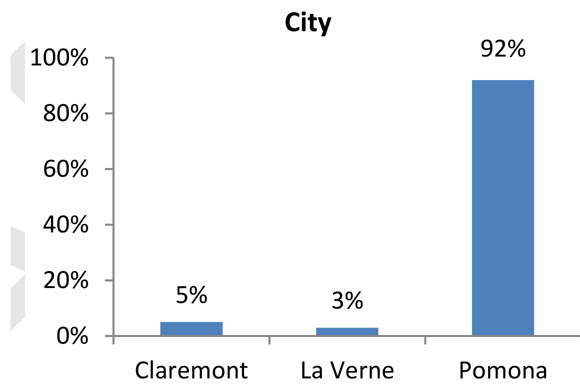
Intensive Outreach and Engagement (IOET)

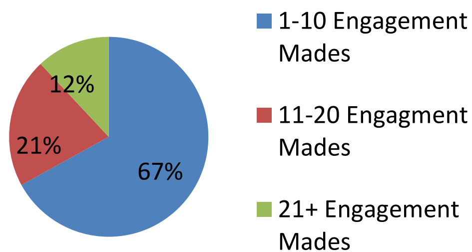
714 Individuals Outreached

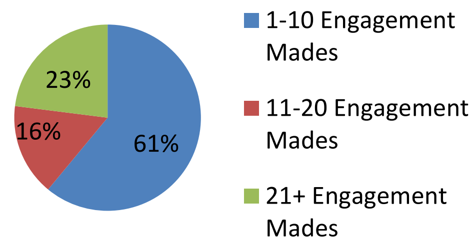






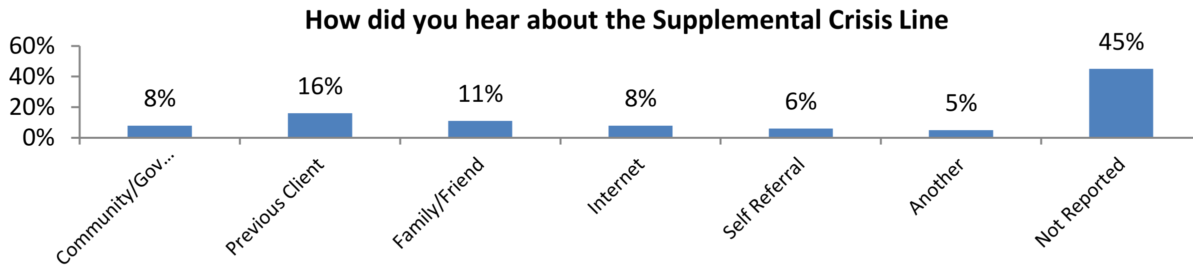




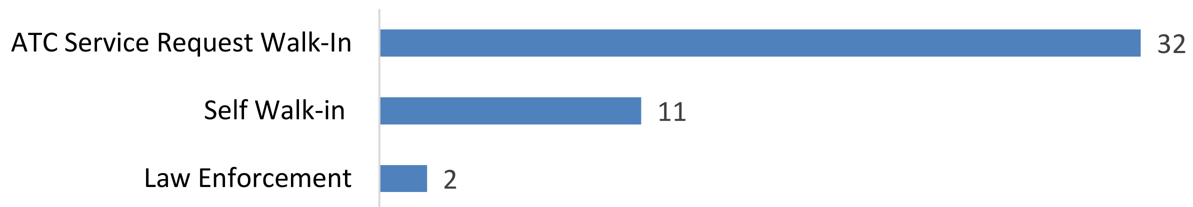


How Well Did We Do It?

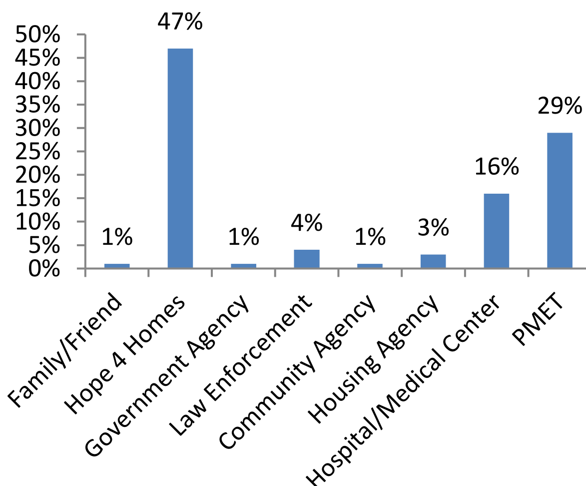
Supplemental Crisis Calls

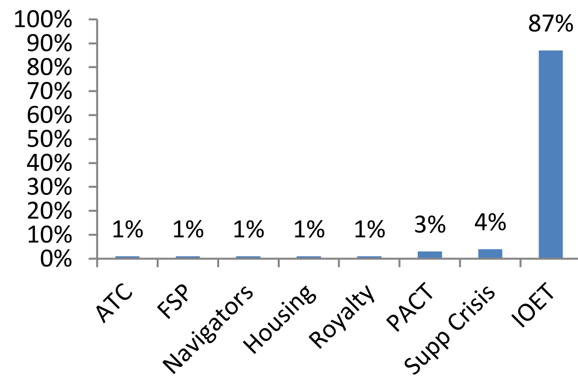


Supplemental Crisis Walk-Ins



Intensive Outreach and Engagement (IOET)



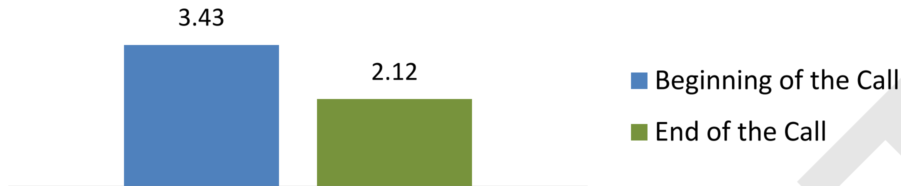


Is Anyone Better Off?

Supplemental Crisis Calls

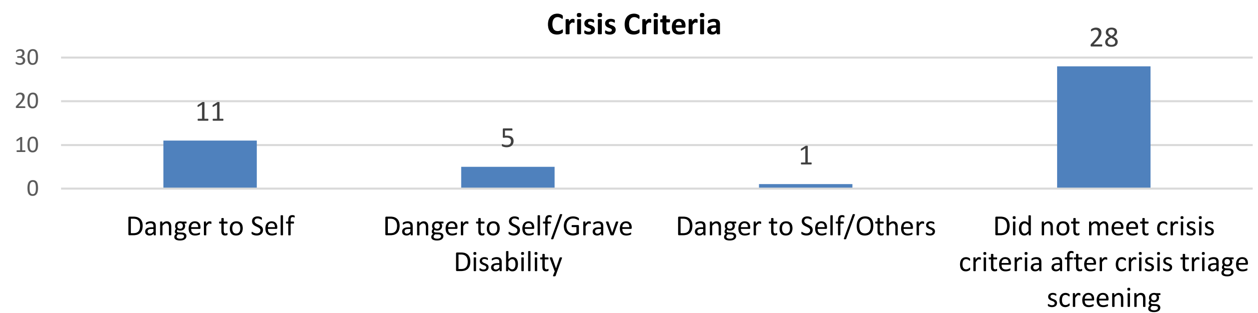
Level of Distress for Crisis Callers

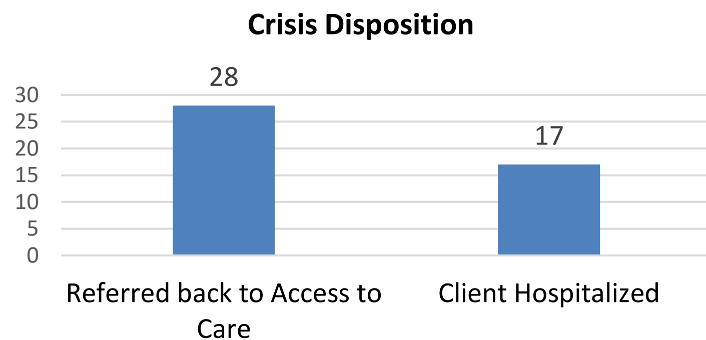
Callers rated their level of distress at the beginning of the phone call and at the end on a 1 to 10 scale where 1 = mild and 10 = severe (higher rating means greater level of distress).



Supplemental Crisis Walk-Ins

Respondents (n=45)

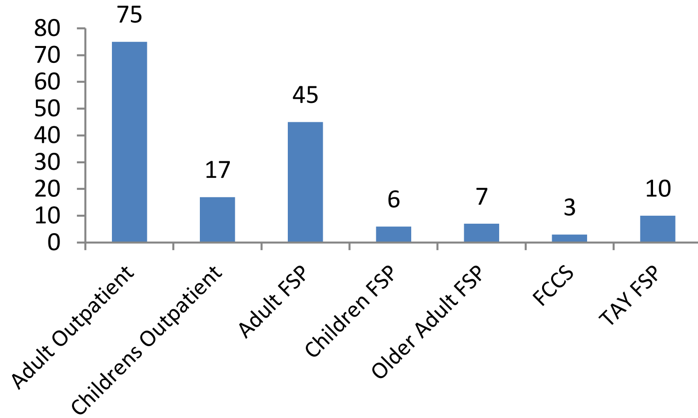


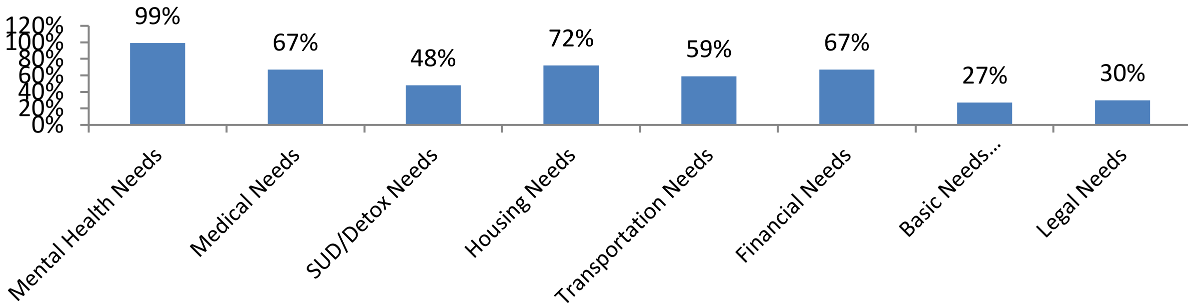


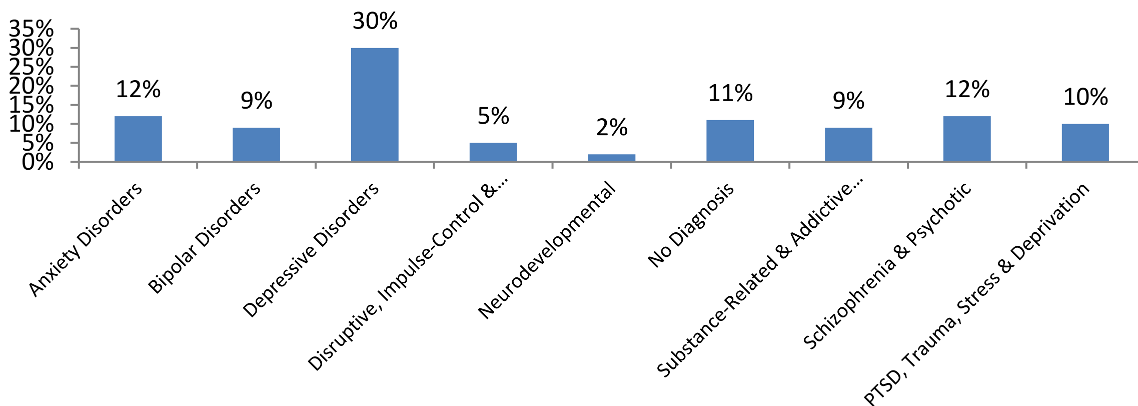
47%
Crisis Walk-ins were scheduled for intake

Intensive Outreach and Engagement (IOET)

163
IOET Individuals who were Enrolled for Services at Tri-City







Field Capable Clinical Services for Older Adults

Program Description

Through the Field Capable Clinical Services for Older Adults (FCCS) program, Tri-City staff members provide mental health services to older adults ages 60 and above. FCCS offers an alternative to traditional mental health services for older adults who may be unable to access services due to impaired mobility, lack of transportation, stigma, or other limitations. Available services include but are not limited to 1) bio-psycho-social assessment 2) individual and group counseling 3) psychiatric and medication follow-up 4) case management and 5) referrals to appropriate community support services. These services are provided at locations convenient to older adults, including in-home, senior centers, medical facilities, and other community settings.

Target Population

Older adults, ages 60 and over, who are experiencing barriers to mental health service due to a variety of issues including lack of transportation, stigma, or isolation.

Age Group	Older Adults 60+
Number Served FY 2022-23	37
Cost Per Person	$3,308

Program Update

During FY 2022-23, Field Capable Clinical Services for Older Adults (FCCS) served 37 unique individuals. 84% of individuals served reside in the city of Pomona. The primary diagnosis seen for FY 2022-23 is depressive disorders followed by schizophrenia and psychotic disorders. The average length of enrollment is 14 months.

Overall, client care hours increased in FCCS. Interdepartmental meetings were also added in collaboration with Housing and Adult Clinical teams in order to promote client's housing needs. Housing for this age group is a critical factor for recovery for this population. During this past fiscal year, 48% of enrolled individuals in FCCS were connected to other Tri-City services such as housing, co-occurring services, Clinical Wellness Advocates, and the Therapeutic Community Garden. This is evidence that individuals are being served with whole-person care approaches.

DRAFT

Challenges and Solutions

A lack of understanding of substance use disorders (SUD) and their complexities was identified within the FCCS team. The FCCS team spent time completing additional trainings to learn about SUD treatment options. Specifically, staff set time aside to train in Medication-Assisted Treatment (MAT) and Vivitrol. With a better understanding of opioid use disorders and possible treatments, the FCCS team increased its ability to support clients appropriately.

Diversity, Equity and Inclusion

The FCCS program continues to be led by a bilingual (Spanish speaking) clinician. In addition, all program brochures are available in both English and Spanish and an approved language line is also available. Community Navigators are available to provide culturally appropriate resources for clients as needed. The FCCS team also supports undocumented individuals in targeted case management, resource identification and linkage to services supporting issues related to immigration, legal support, and medical benefits. Ongoing training is provided to FCCS staff regarding cultural competence and implicit bias.

Community Partners

Tri-City's FCCS team collaborates regularly with internal as well as external partners such as Los Angeles County Department of Health Services Medical Center (for referral purposes), Pomona Housing Authority, Park Tree (a local pop-up clinic), Police Departments in Pomona, Claremont and La Verne, Prototypes (substance use treatment center), American Recovery Center and Volunteers of America (VOA) homeless outreach.

Success Story

An FCCS client struggled with housing instability throughout enrollment. They resided at a local shelter for years and exhibited difficulty identifying a housing preference. The FCCS team was able to collaborate with client and staff at the shelter to determine the best placement options. The client was able to explore an array of living settings including independent living, transitional living, and assisted living. Ultimately, they were linked to a private apartment. The individual was able to process fears about independent living with their therapist, work on skills building with their mental health specialist, and link to In Home Supportive Services (IHSS) to assist with additional needs. The client continues to work with the treatment team on adjustments to independent living and still maintains their housing.

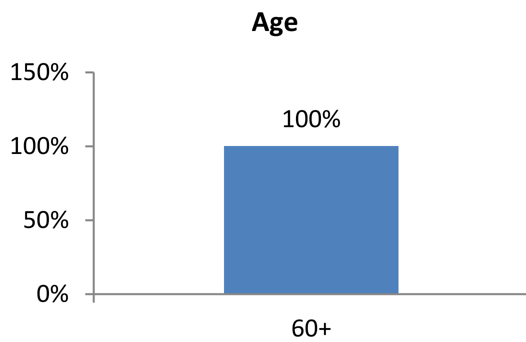
DRAFT

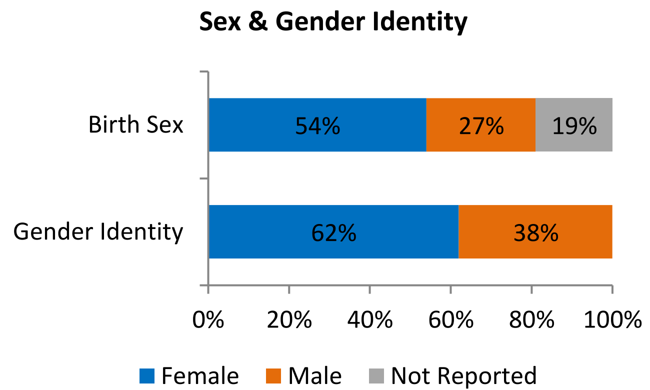
Program Summary

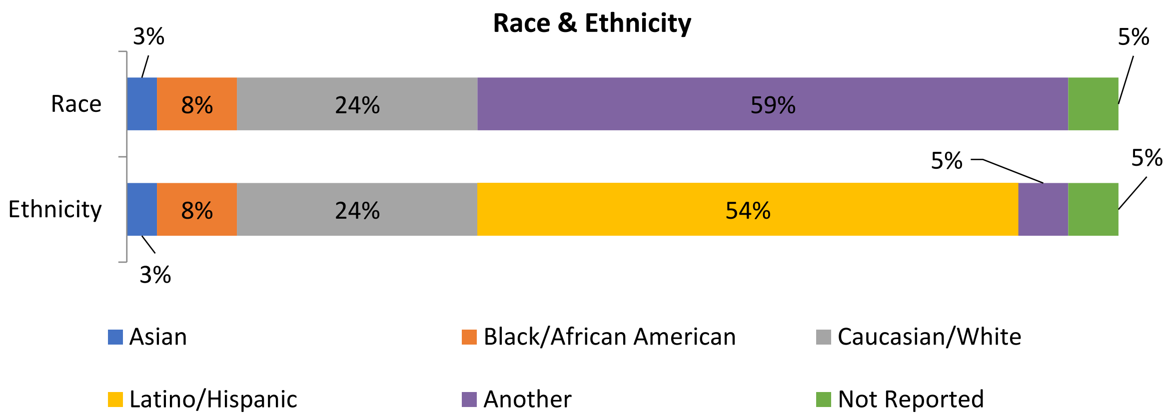
How Much Did We Do?

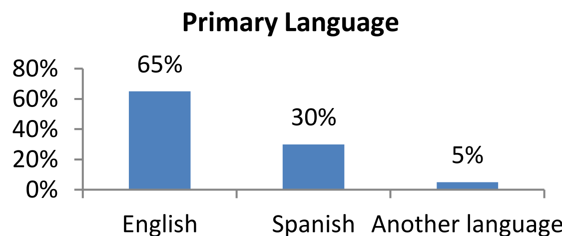
37
Individuals Served

84% of FCCS clients lived in Pomona, while **16%** of clients lived in Claremont

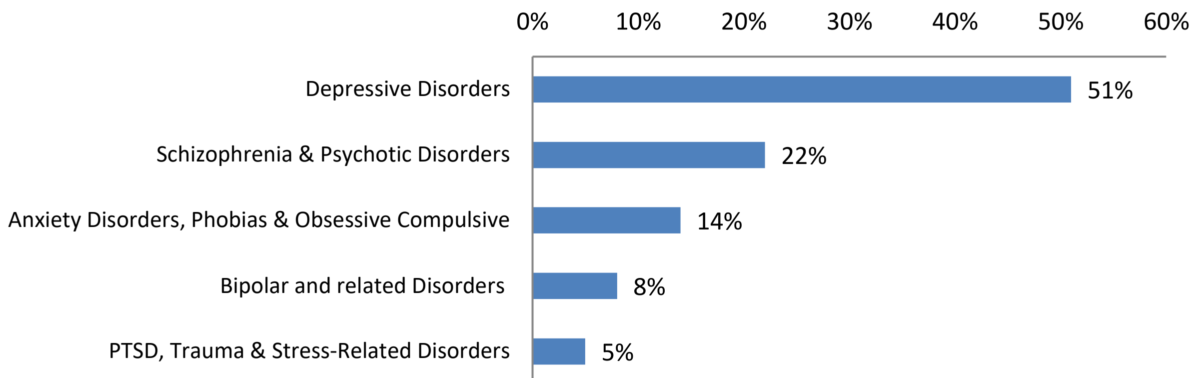




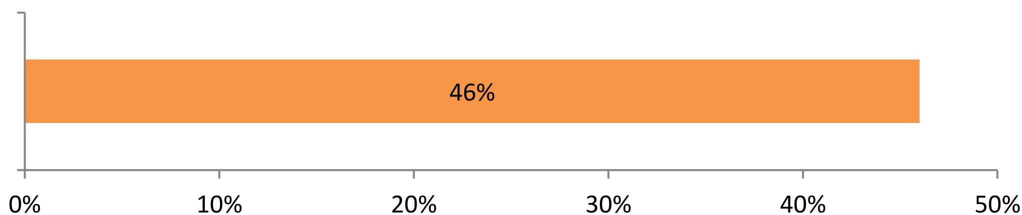


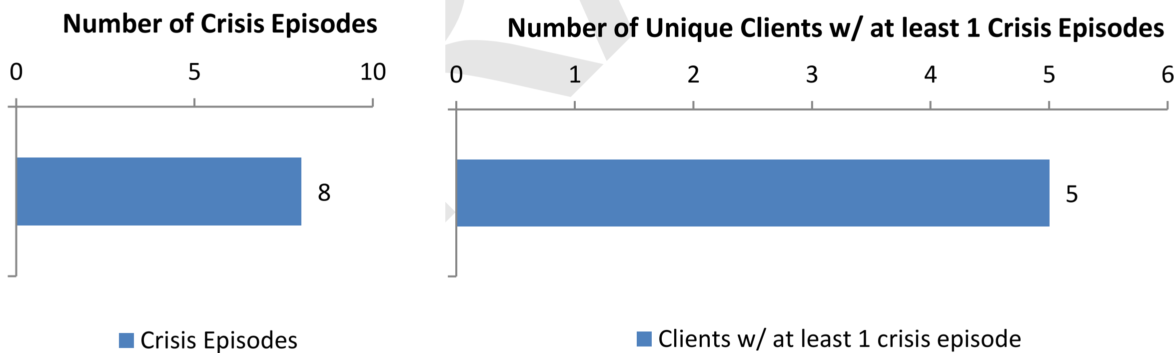


Primary Diagnosis by FCCS Clients



Percent of FCCS Clients Receiving Medication Services



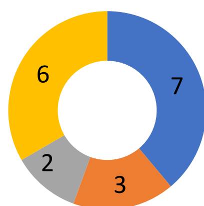


Crisis Episodes

Clients w/ at least 1 crisis episode

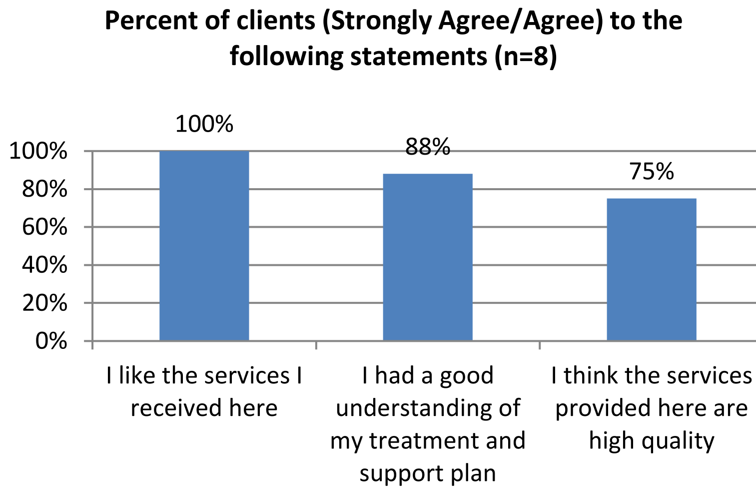
Number of FCCS Clients Connected to Other Services

48% of FSP clients are connected to other Tri-City Services.



Housing Services
Co-Occurring Services
Therapeutic Community Garden
Clinical Wellness Advocates

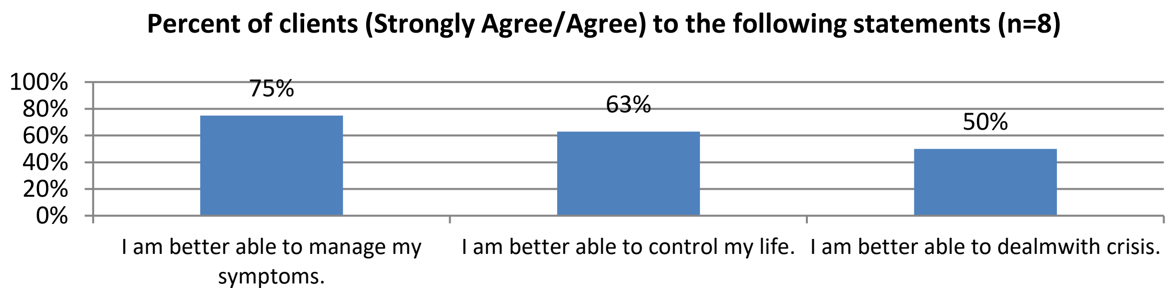
How Well Did We Do It?



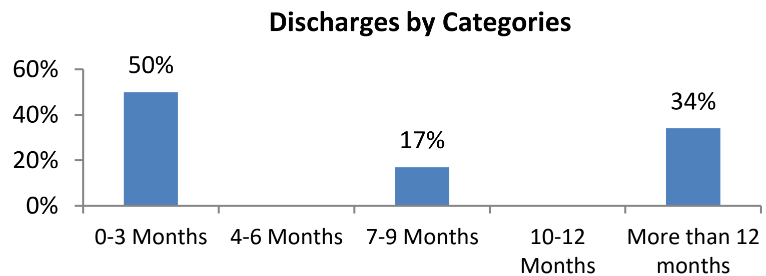
On average, FCCS clients were enrolled for **14 months**

Is Anyone Better Off?

As a direct result of the services I received:



6
Discharges during FY 2022-23



Permanent Supportive Housing

Program Description

Tri-City's Permanent Supportive Housing units offer living spaces for Tri-City clients who are currently receiving mental health services and their families in the cities of Claremont, La Verne and Pomona. Residential Service Coordinators (RSCs) are located at these sites to offer support and act as a liaison between tenants and the property staff. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration.

Target Population

Tri-City clients living with severe and persistent mental illness and their family members.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Total Served
Number Served FY 2022-23	9	20	145	52	**226**

Program Update

Permanent Supportive Housing experienced an increase in referrals during FY 2022-23. During the first half of the fiscal year 121 referrals were received, the number almost doubled in the second half of the fiscal year to 232 referrals. Of the 353 referrals, 192 identified as being homeless and 292 referrals reported having incomes at or below $2,000.

Tri-City has partnered with Jamboree Housing Corporation and the City of Pomona on a new Permanent Supportive Housing site, Villa Esperanza (VE). FPI Management is the property management company that has been selected to oversee the property. The move-ins for VE were originally expected to start in November, however construction delays and obtaining a Certificate of Occupancy delayed the process. A temporary Certificate of Occupancy was obtained on March 25, 2023, which allowed tenants to begin to move in. Tri-City has 10 units at VE and by the end of the fiscal year, 4 of the 10 MHSA unit applicants were approved and moved into their new homes.

Challenges and Solutions

Many clients request assistance with housing support, however barriers such as low income and high rent make it very difficult. Part of the multifaceted solution is linkage and referrals to internal and external agencies to support with enrolling in General Relief (GR), employment options through the

DRAFT

Wellness Center, and linkage to the Community Navigators. Additionally, as a future goal, Permanent Supportive Housing hopes to expand Roommate 101 training to focus on shared housing as an option to increase the likelihood of obtaining affording housing.

During FY 2022-23, the program experienced staff changes on the property management side. Parkside Family Apartments had a change in Regional Property Manager (PM) and a temporary Property Manager stepped in to replace the previous PM at Holt Family Apartments. Changes like these can be difficult for tenants as they must build a new working relationship with incoming staff. A promising solution to this challenge was a transitional period where the new RSC at Holt was able to train with the previous RSC. This supported building rapport with tenants and property management.

Villa Esperanza was met with constructions delays that pushed back when the building could be occupied. Solutions for the presented challenge was RSC staff availability. The RSC for Villa Esperanza, with the help of other team members from the Housing Division, ensured VE applicants had access to someone at Tri-City to help with the application process and ensure securing the necessary documents. By the end of the fiscal year 4 out of 10 MHSA units had been processed and approved.

Diversity, Equity and Inclusion

Tri-City's Housing programs offer fair housing to clients and their families regardless of status, culture, ethnicity, sex, gender, religion, or otherwise. The Housing Division staff are trained in cultural competency and work with clients to help identify their rights regarding housing. For optimal accessibility, all activities at our sites are on the ground floor and have doors wide enough for wheelchairs. The Permanent Supportive Housing program is also flexible with outreach locations and times. RSCs provide in-home services for tenants and offer computer access/support which has been well received with older adults and Spanish speaking tenants. In addition, Pride Month is celebrated with monthly activities and stigma reduction is addressed through webinars.

Four of the seven Housing Division staff are bilingual in English and Spanish. The team has access to a language line. Also, communication is maintained with clients and the community by providing flyers and information in multiple languages.

During Housing Division (HD) groups, if clients identify that they encounter some type of obstacle due to something related to being part of an underserved community, the HD team shares information about reasonable accommodations and works with housing owners and property managers to make accommodations for someone with a disability to ensure they have fair and equitable use of their unit.

Community Partners

Every Tri-City department is highly involved and a source of referrals for Permanent Supportive Housing, especially the Community Navigators, Adult Outpatient, Full Service Partnership, Child and Family Services, Therapeutic Community Garden, Intensive Outreach and Engagement Team, Access to Care, Wellness Center, Employment Specialists, Clinical Wellness Advocates and the Co-Occurring Support Team.

DRAFT

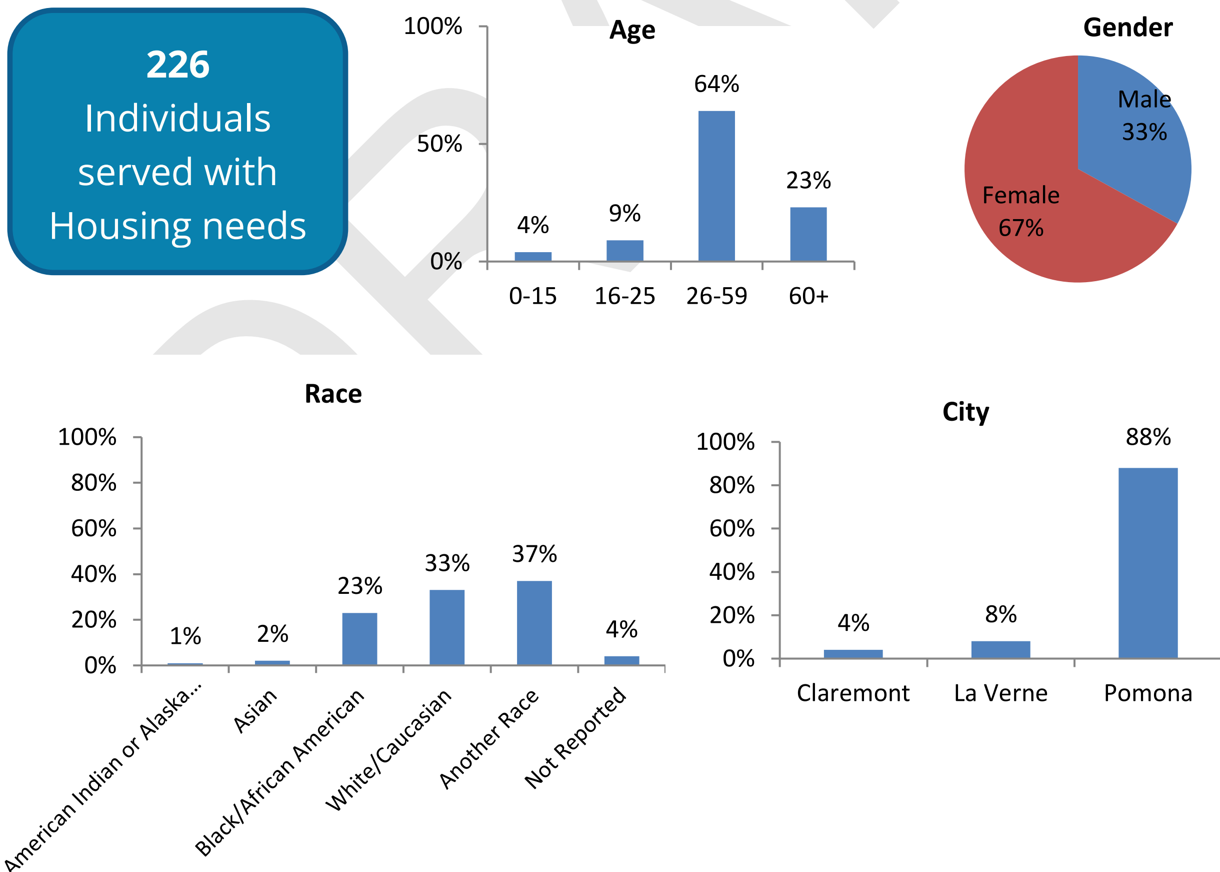
Additionally, several external agencies provide additional resources to clients to help them obtain and maintain housing, such as: Pomona Housing Authority, Family Solutions, Levine Management (property the RSC works with), owners/developers, David & Margaret Youth and Family Services, A Community of Friends, Neighborhood Legal Services Los Angeles, Los Angeles Homeless Services Authority, and Los Angeles County Development Authority.

Success Story

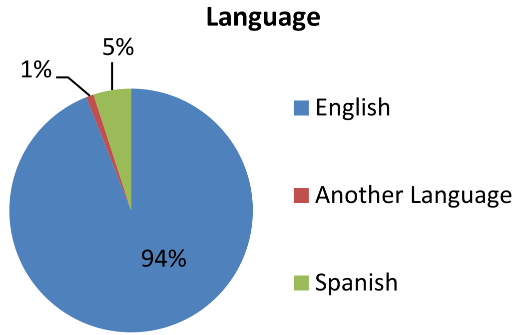
Permanent Supportive Housing engaged a new TAY client who was able to successfully move into youth housing. Following the move into the property, they immediately showed interest in some of the on-site activities. They inquired about the garden beds at the site, began planting flowers, and harvesting the many on-site fruit trees. Since moving in, the new tenant gained employment and enrolled in a community college to continue their education. Tenant actively engages with all team members and is thriving.

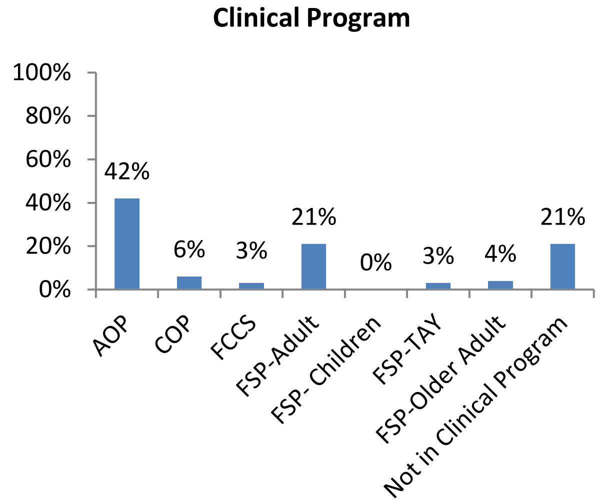
Program Summary

How Much Did We Do?



DRAFT

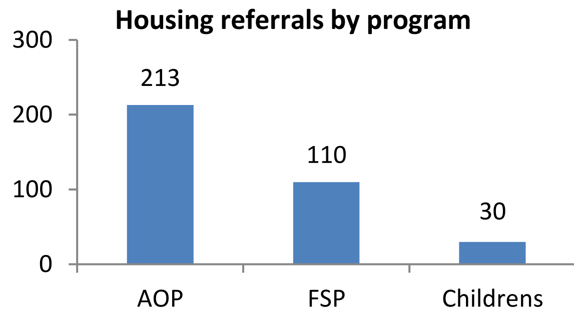




34
Housing Clients Discharged due to "No Further Care Needed"

28
Individuals with Continuum of Care Certificates

353
Housing Referrals Received



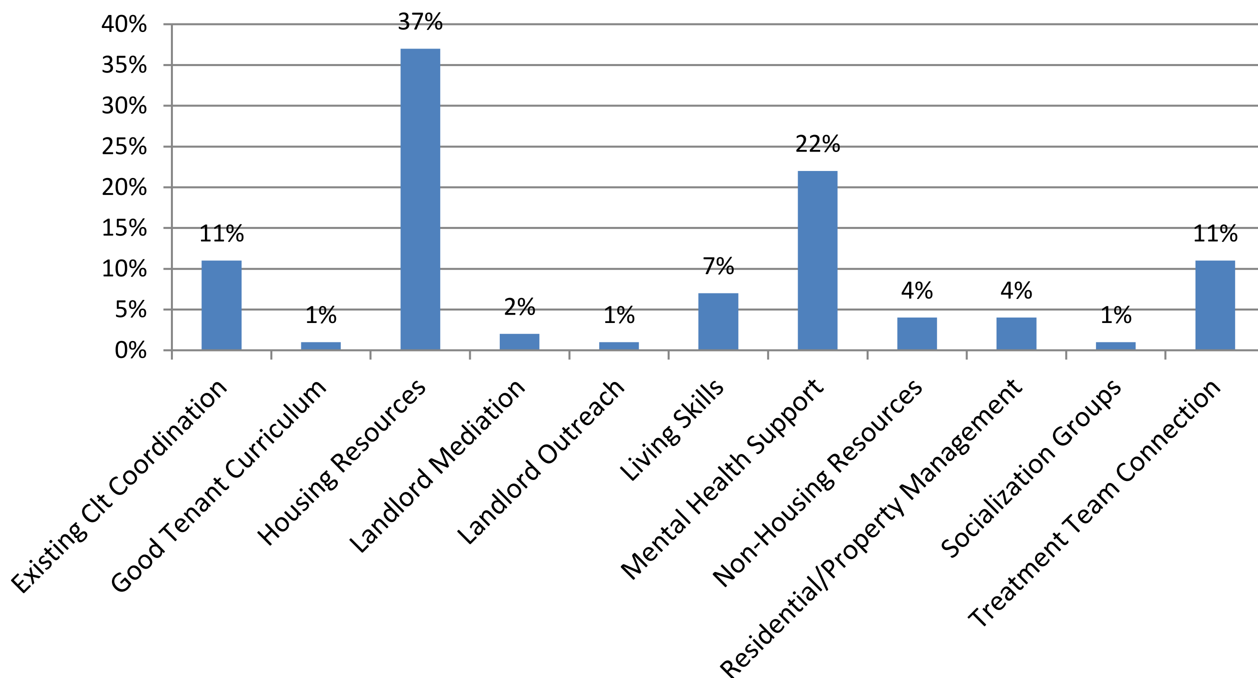
How Well Did We Do It?

886
Housing Actions

3 years
Average Length of Time Clients Living in Housing Unit

DRAFT

Additional Types of Services Provided



Is Anyone Better Off?

Access to Care

Program Description

The Access to Care (ATC) serves as the main entry point for individuals interested in receiving specialty mental health services from Tri-City Mental Health. Individuals seeking services can access care either by calling, walk-in, or via referral. The inquiring individual will discuss the presenting problems and needs with a mental health professional before scheduling an intake appointment. If needs are better served through another Tri-City program, or with a community provider, ATC staff will provide referrals and a warm hand-off to ensure linkage to the services that are appropriate. ATC's overall goal is to support recovery and assist community members in accessing mental health services to best meet their needs.

Target Population

The ATC serves community members seeking mental health services including children, TAY, adult, and older adults.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not reported	Total Served
Number Served FY 2022-23	323	446	1,557	191	0	**2,517**
Cost Per Person	$457	$457	$457	$457	N/A	**$457**

Program Update

FY 2022-23 was a time of growth for ATC. Two additional Mental Health Specialist (MHS) and one Program Support position were added to the program. Additionally, the number of non-Medi-Cal clients was reduced by supporting these individuals with linkage to insurance or affordable services, as opposed to processing these individuals as self-pay. This approach provided the individual or family with the appropriate services needed while being more cost effective as an agency.

Historically, the intake and assessment process used to diagnose and determine medical necessity is lengthy. In FY 2022-2023, ATC implemented a shorter intake assessment. This provided less time the prospective client would need to set aside for the intake, as well as decreased the administrative time needed for clinical staff to complete the entire intake assessment process.

DRAFT

Challenges and Solutions

Access to Care experienced difficulty adhering to network adequacy timelines for intake appointments. At one point, the program fell out of compliance in offering timely appointments. However, within the same fiscal year were able to reduce delays and offer timely appointments once again.

A high rate of no-shows to intake assessment appointments was also a challenge in FY 2022-23. As a solution, express/back-up intakes, standby que, and waitlists were developed to assist with the high rate of no-shows and improve adherence to network adequacy guidelines. To further resolve this challenge, supervisors were added to the intake rotation.

Diversity, Equity and Inclusion

Access to Care is equipped to link individuals, if needed, to resources related to transportation, food, clothing, shelter, phones, language services (bilingual staff, language line), as well as provide services offered via a variety of platforms (in-person, over the phone).

Staff complete training and webinars related to cultural competency and implicit bias. Barriers related to seeking/adhering to mental health services due to culture or stigma are regularly discussed in individual and group supervision. Staff also work with their supervisors to address issues relevant to the LGBTQ+ population during intake and service requests and are equipped to provide community supports geared towards the LGBTQ+ community.

ATC regularly collaborates with the Community Navigators and Field Capable Community Services regarding referrals and support for older adults and veterans in our community.

Community Partners

While ATC collaborates with several internal departments, the highest amount of collaboration in relation to intakes and referrals is with the Adult Outpatient Team, Wellness Center, Co-Occurring Support Team, Full Service Partnership, Children and Family Department, Intensive Outreach and Engagement Team, Crisis Department, Community Navigators, and the School Partnership team. External partnerships are another source for referrals, resources, substance use and housing support. Some examples of external partnerships are: multiple local hospitals, Department of Public Social Services, local colleges, East Valley Community Clinic/Behavioral Department, Park Tree Community Clinic, Prototypes, Pacific Clinics, David & Margaret Youth and Family Services, Department of Child and Family Services, Five Acres, various Primary Care Physicians, Adult/child Protective Services, Crisis and Trauma Resource Institute, American Recovery Center, Hope for Homes and Volunteers of America.

DRAFT

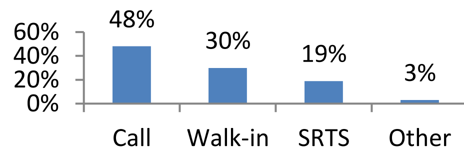
Success Story

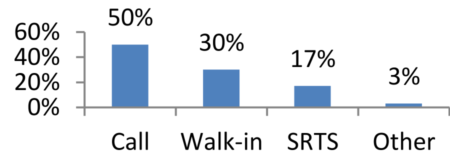
Often when people are feeling overwhelmed or in distress, they may not know who, or how, to reach out for support. Likewise, a concerned family member or friend may not know how to support their loved ones in getting the support and help they need. Recently, a concerned parent brought their child to ATC to access services. This parent was aware of the positive outcomes of seeking mental health treatment, and hoped their child would have the same experience. Someone referring a loved one for support is a strong testament to the services that Tri-City has to offer. ATC has received several positive reports about individuals self-referring or referring a friend/loved one due to hearing about the positive impact the services have had on others.

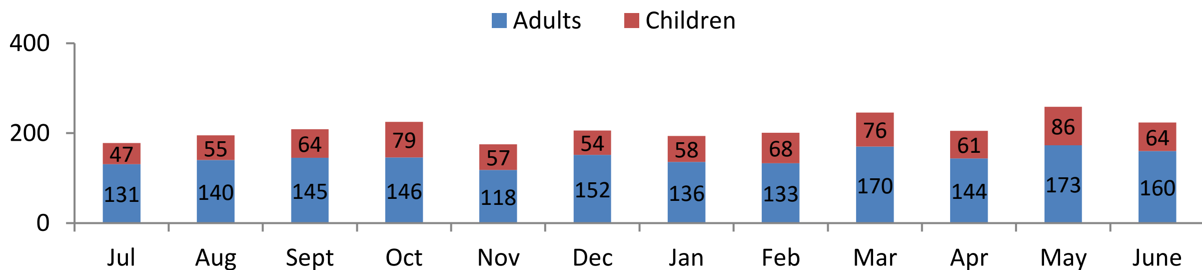
Program Summary

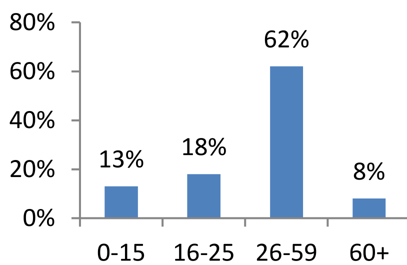
How Much Did We Do?

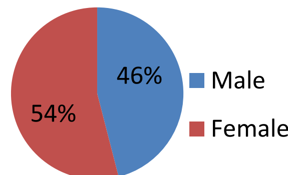
2,517
Service Requests

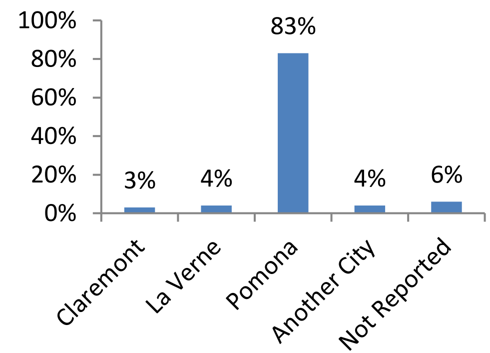


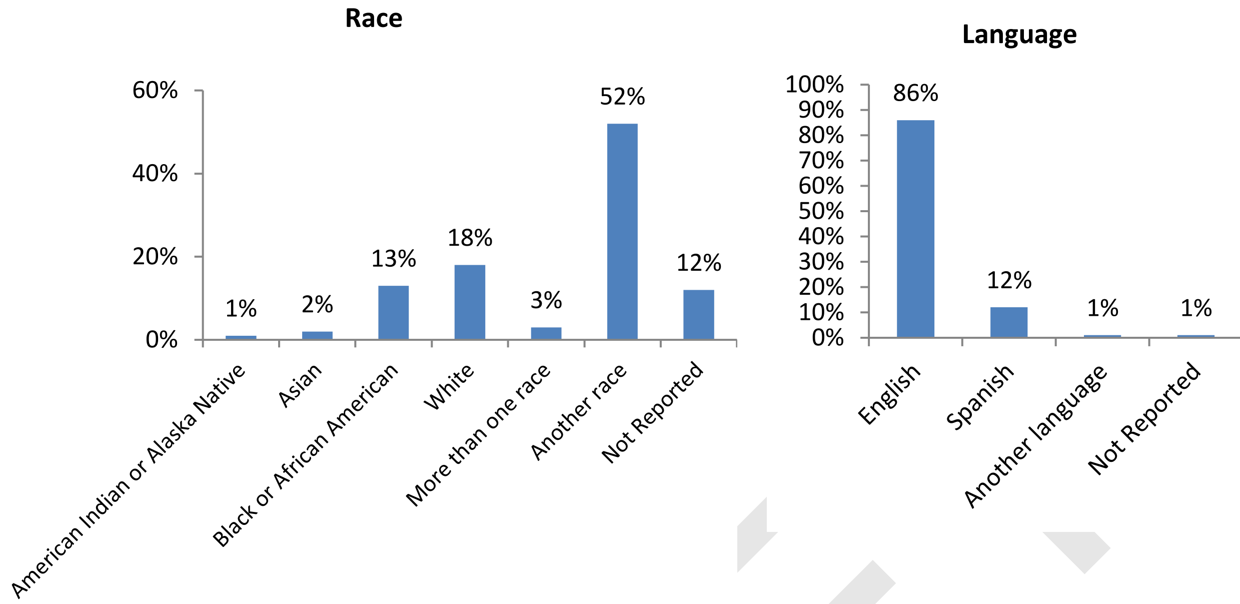












281
Services Request from Hospital Discharges Adults

76
Services Request from Hospital Discharges Children

1,942
Intake Appointments Given to Client

DRAFT

Prevention and Early Intervention (PEI)

The Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services and supports, in addition to stigma reduction and suicide prevention efforts.

Community Wellbeing Program
Community Mental Health Trainings
Stigma Reduction and Suicide Prevention
Older Adult Wellbeing/Peer Mentor Program
Transition Age Youth Wellbeing/ Peer Mentor Program
Family Wellbeing Program
NAMI – Ending the Silence and NAMI 101
Housing Stability
Therapeutic Community Gardening
Early Psychosis Program
School-Based Services

DRAFT

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. **Prevention Program**
   a. Housing Stability Program
   b. Therapeutic Community Gardening
2. **Early Intervention Program**
   a. Early Psychosis Program
   b. TAY and Older Adult Wellbeing (Peer Mentor Program)
   c. Therapeutic Community Gardening
   d. School-Based Services
3. **Access and Linkage to Treatment Program**
   a. Early Psychosis Program
   b. Family Wellbeing Program
   c. Housing Stability Program
   d. TAY and Older Adult Wellbeing (Peer Mentor Program)
   e. Therapeutic Community Gardening
   f. Wellness Center (TAY and Older Adults)
4. **Stigma and Discrimination Reduction**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
5. **Outreach for Increasing Recognition for Early Signs of Mental Illness Program**
   a. Community Mental Health Trainings
   b. Community Wellbeing Program
   c. Early Psychosis Program
   d. Family Wellbeing Program
   e. Housing Stability Program
   f. TAY and Older Adult Wellbeing (Peer Mentor Program)
   g. Therapeutic Community Gardening
   h. Wellness Center (TAY and Older Adults)
6. **Suicide Prevention**
   a. Stigma Reduction/Suicide Prevention
   b. NAMI: Ending the Silence and NAMI 101
   c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Community Capacity Building Programs

Community Capacity Building is comprised of three programs: Community Wellbeing Program, Community Mental Health Trainings/Trainers and Stigma Reduction/Suicide Prevention Program

Community Capacity Building

Community Wellbeing Program

Program Description

The Community Wellbeing (CWB) program provides grants to local communities and groups in Tri-City's catchment area to assist them in strengthening their capacity to increase social connection and wellbeing. Through grants totaling up to $10,000, community projects are funded to increase awareness of mental health and wellbeing in addition to providing opportunities for these communities to network and build collaboration with other local communities. Tri-City provides technical assistance including collecting data, outcome measures, and helping grantees evaluate the impact of their projects.

Target Population

The Community Wellbeing (CWB) program has dedicated its efforts to improving the wellbeing of children and transition-age youth ages 0 to 25. The CWB program serves communities and groups located in the cities of Claremont, La Verne and Pomona who are either comprised of youth or fund projects that directly benefit them.

Community Grants Awarded	Community Members Represented
13	10,809

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	2,176	4,311	1,131	531	N/A	**8,149**

DRAFT

Program Update

In FY 2022-23, a total of 13 Community Wellbeing Grants were awarded. These communities represented 10,809 members who will have the opportunity to participate in these community-designed and led wellbeing projects. Notably, the communities being served by these projects provide services to underserved and unserved youth. In addition, many expressed gratitude regarding being a part of the CWB grant program and were eager to learn more about other Tri-City programs and services.

During this fiscal year, the CWB program staff utilized social media platforms such as Instagram and Facebook for Grantee Spotlights. The purpose of these Grantee Spotlights is to bring awareness to who the grantees are and increase their visibility in our community. Grantees reported an increase in community members inquiring about their programing as a result of increased visibility via social media.

Each quarter grantees provide financial reports to Tri-City which reflect their spending and verify that remaining funds are in line with their project's needs.

Challenges and Solutions

Grantees were provided both joint meetings with all cohort representatives as well as one-on-one meetings to discuss individual needs, challenges and updates experienced. Grantees exhibited low attendance as many participants reported burn out from virtual meetings. Conversely, some grantees shared that their participants reported feeling fearful about meeting in-person and prefer to only meet virtually. A solution presented was offering the grantees hybrid options for meeting, this met the needs of all participants. Grantees also collaborated with other grantees in the cohort to plan events and build connections with their participants.

Outreach for the program was a challenge. It was difficult to spread the word about the Community Wellbeing Grant, with only virtual options at the time. The CWB staff increased their use of technology and social media to meet this challenge. Program staff utilized email, social media, and the Tri-City website to promote the grant. Program staff also utilized current grantees to help with spreading the word about the Community Wellbeing Grant program. Community members shared that they heard about the important meetings and deadlines for the grant via social media. Program staff also reached out to Tri-City Community Navigators to help promote the Community Wellbeing Grant.

Diversity, Equity and Inclusion

CWB staff consists of a bilingual staff member and all materials and presentations are available in English and Spanish. The program works with community entities that provide services to underserved and unserved communities, focusing on ages 0-25. Grantees also network and collaborate with each other to serve marginalized populations. Trainings resources related to cultural competence are disseminated to grantees, and the grantees distribute them to their participants. The CWB program also works closely with the RAINBOW Wellness Collaborative and the Pomona Pride Center which support the LGBTQIA+ population.

DRAFT

Community Partners

In addition to collaborating with several internal programs, CWB works in partnership with several agencies such as: Assistance League of Pomona Valley, Bithiah's Family Services, Bright Prospect, dA Center for the Arts, God's Pantry, Health Bridges, Just Us 4 Youth, La Verne Youth & Family Action Committee, Pomona Hope, Pomona Pride Center, Pomona Students Union, Pomona Youth Prevention Program/NCADD-ESGPV and Purpose Church. These organizations represent an array of services and supports for our community and the 0-25 population.

Program staff also connected various grantees to Tri-City's Community Mental Health Trainer to continue to promote mental health and wellbeing. Grantees also shared resources and events in their communities, and program staff shared these resources with the cohort as well as Tri-City staff. Some grantees also shared that they participated and collaborated with other grantees in the cohort. One example was Bithiah's Family Services and Just Us 4 Youth, who collaborated on a project and will apply for a grant next year.

Success Story

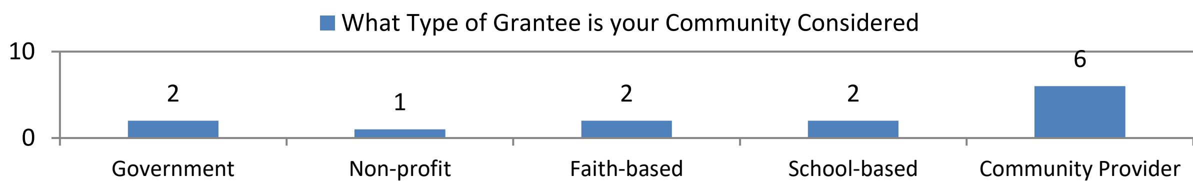
Grantee, Bright Prospect's Community Wellbeing Academy, is a series of workshops focused on mental health awareness and wellbeing for students ages 14-25 and their parents. Together, students and their parents or guardians had the opportunity to hear from mental health professionals and learn how to reinforce positive mental health habits at home. Through this project, students learned to support their own mental health while building community with each other to support their peers.

This is Bright Prospect's last year of receiving a Community Wellbeing Grant for their project Community Wellbeing Academy. Their project leader has been instrumental in making sure their project is successful and meeting all their project goals. CWB reached out to their project leader and invited her to be part of our selection committee for the next fiscal year. The selection committee is responsible for reading applications and interviewing potential grantees for the new fiscal year. Bright Prospect's project leader joined our selection committee and brought valuable insight, feedback, and knowledge to the selection committee from a grantee perspective.

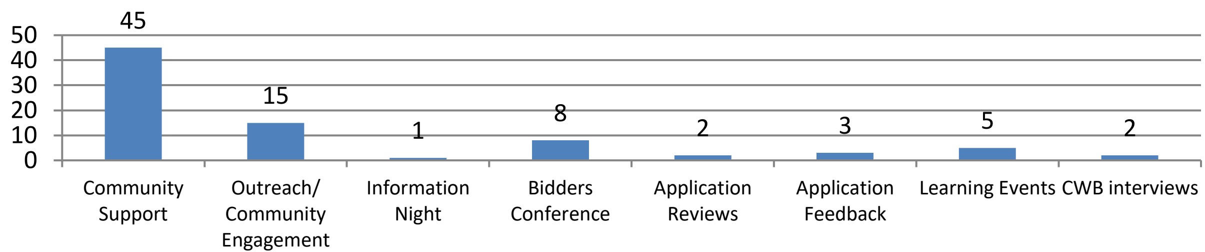
DRAFT

Program Summary

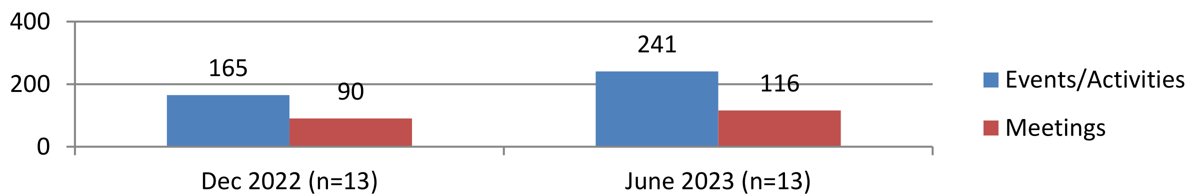
How Much Did We Do?

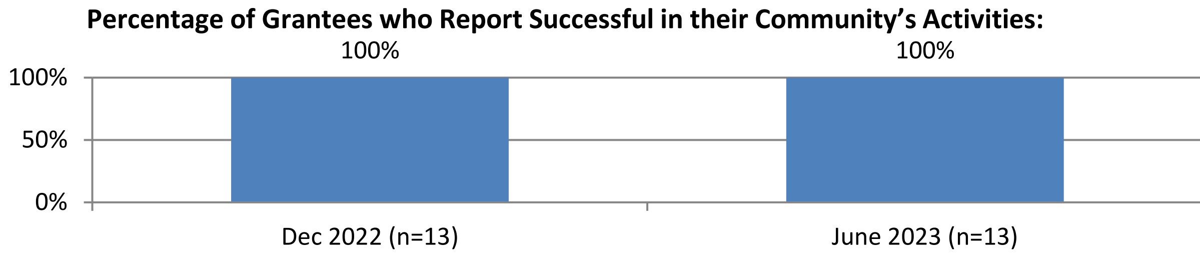


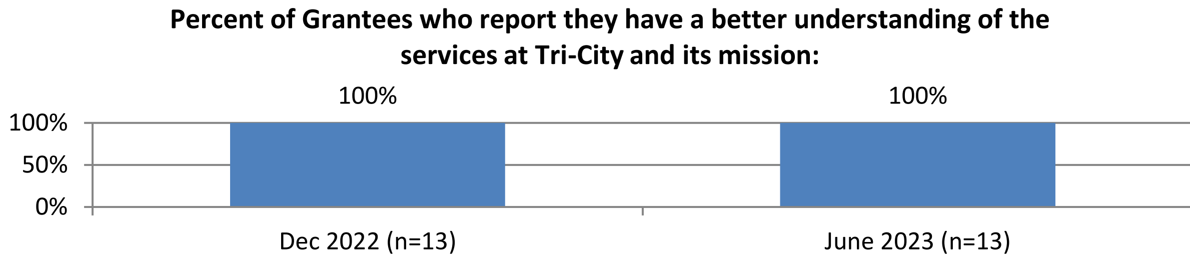
295 Attendees for Events listed below



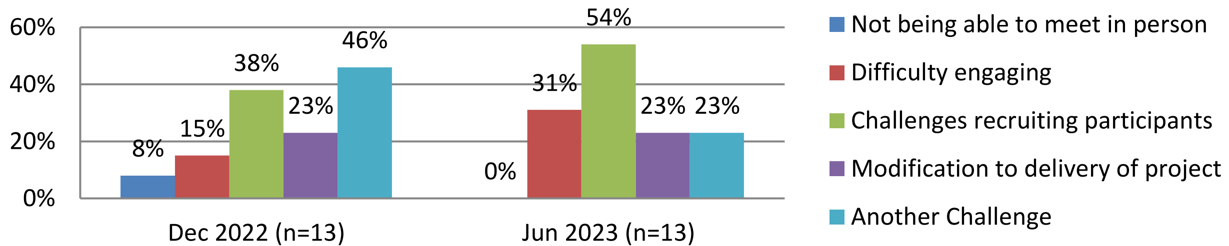
12,874 Attendees for Events listed below:

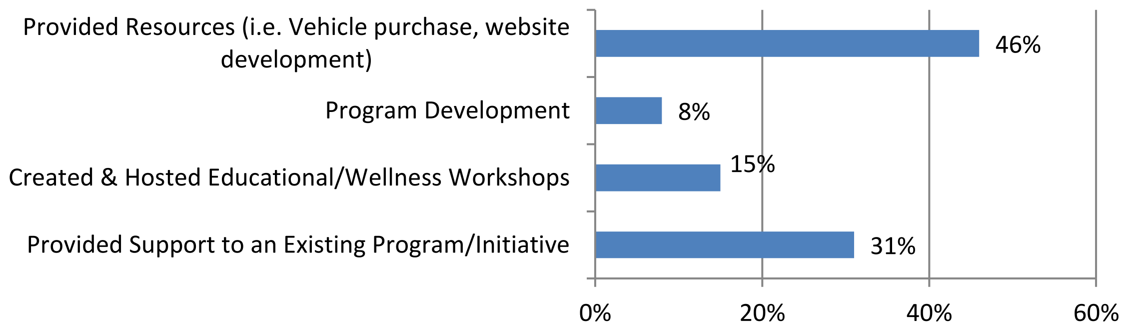




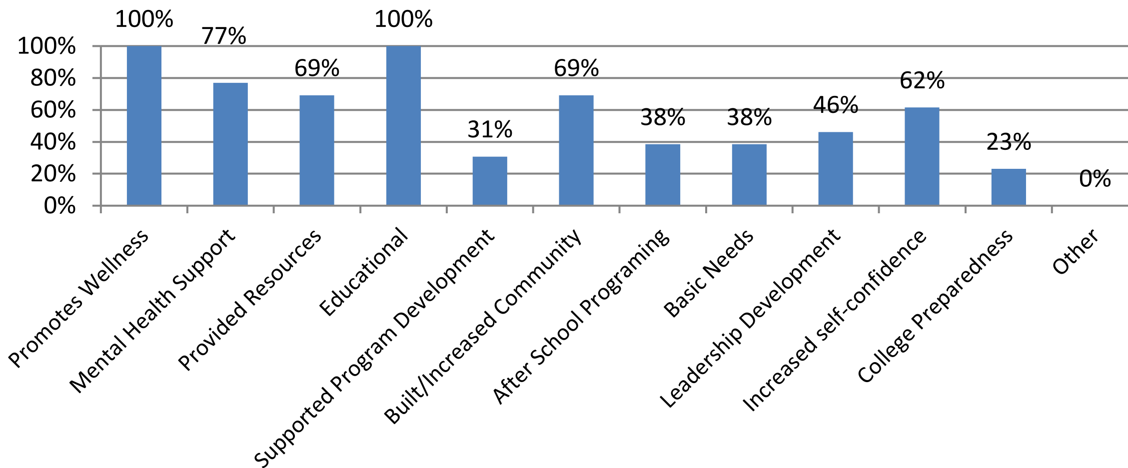


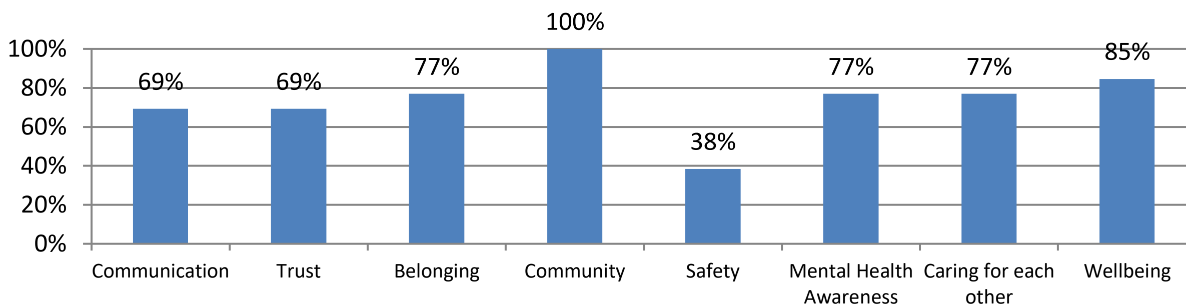
How Well Did We Do It?





Is Anyone Better Off?

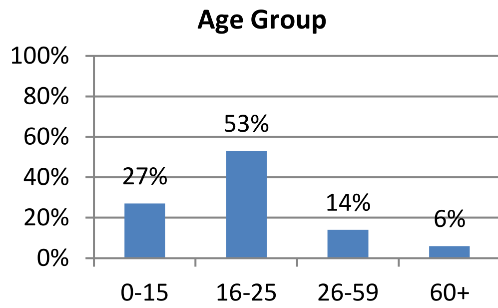


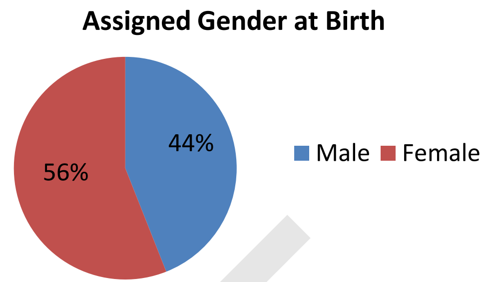


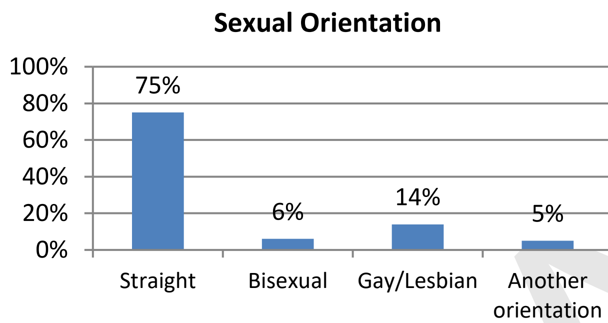
What was the most successful outcome of this project:

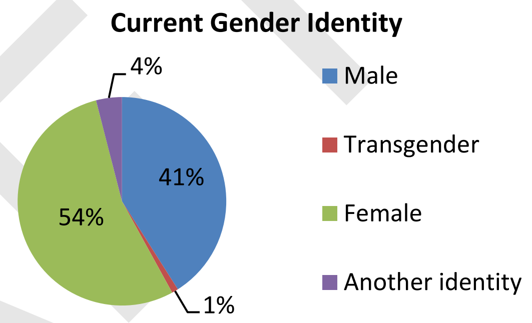
- Built a sense of community.
- Empower participants about MH stigma in their communities.
- Providing resources to the summer lunch program.
- Participants have a sense of community and belonging.
- Providing resources to students and educating them about mental health and wellness.
- Seeing children and their families who were strangers at the start become friends.
- Students are showing improved self-esteem and self-care.
- That we exceeded the number of teens helped than originally projected.
- Improving youth wellness and mental health.
- building community through discussions around mental health through workshops.
- Educating students on the importance of confidence and responsibility.
- Implementing the mentorship program.
- Providing basic needs to women.

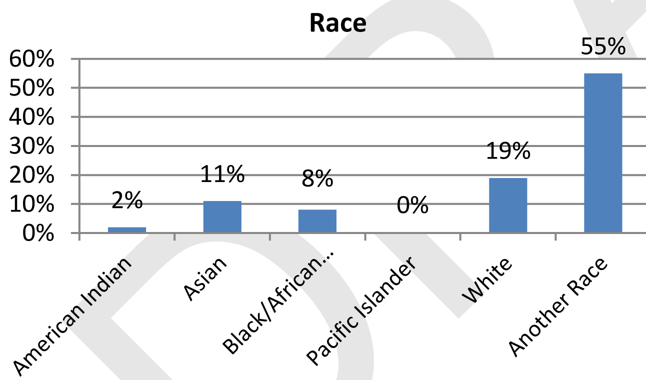
Grantee Community PEI Demographics (13 grantees completed December 2022 survey)

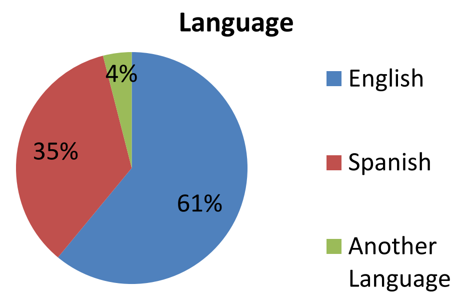


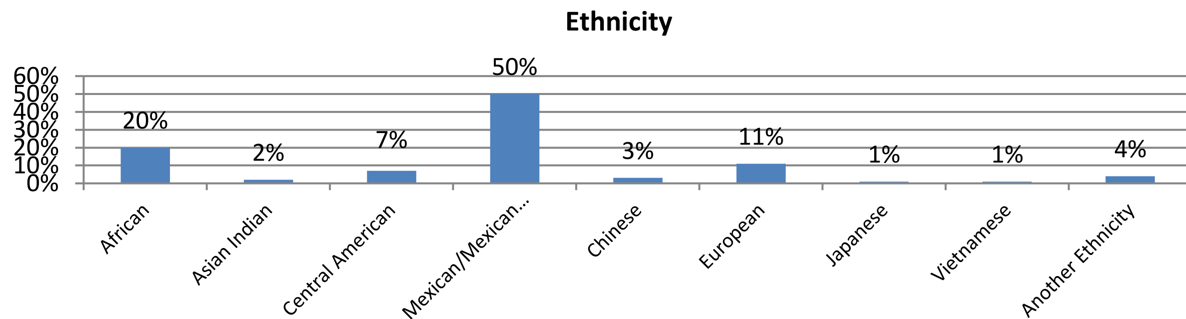




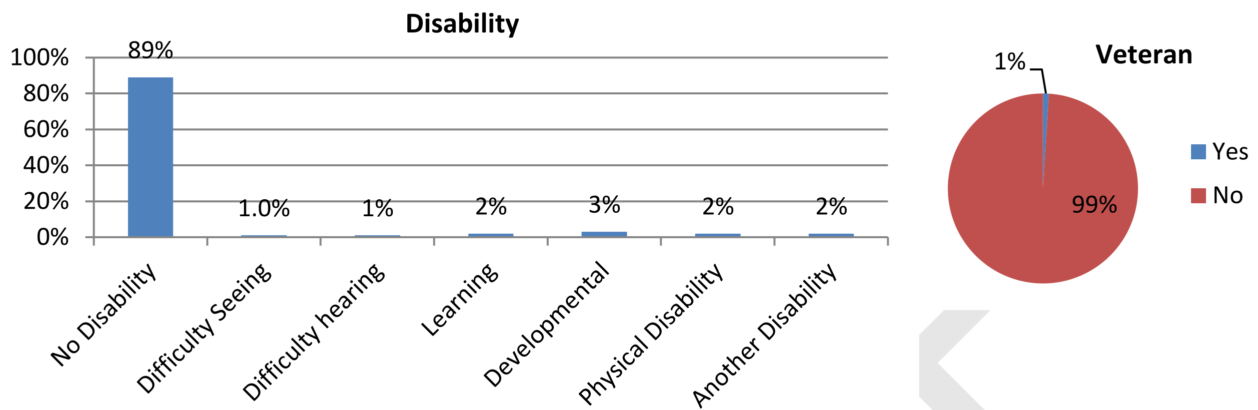








DRAFT



Number of Potential Responders	12,874
Setting in Which Responders were Engaged	Community, Schools, Workplace, Virtual Platforms (e.g. Zoom), and Phone (e.g. conference calls)
Type of Responders Engaged	TAYs, teachers, LGTBQ+, families, students, service providers, faith-based individuals, and those with lived experience.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

There were 0 MHSA referrals to Community Wellbeing Program

Community Capacity Building

Community Mental Health Trainings

Program Description

Community Mental Health Trainers (CMHT) offer free group trainings to community members and partners in the Tri-City service area of Claremont, La Verne and Pomona. These trainings are designed to provide participants with the skills and information they need to support themselves, friends, families, and others in mental wellness. These free trauma-informed and evidence-based trainings include Mental Health First Aid (MHFA), Adverse Childhood Experiences (ACEs), Community Resiliency Model™ (CRM), Motivational Interviewing (MI), and Everyday Mental Health (EMH) as well as workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes. These trainings are offered virtually and in-person.

Target Population

Community members, community-based organizations, local schools, agencies, and Tri-City staff who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Community Mental Health Trainings	Number of Individuals Trained
42	489

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	0	29	37	5	418	**489**

Program Update

The Community Mental Health Training (CMHT) program began to see an increase in individuals requesting in-person trainings as opposed to the virtual option used last fiscal year, due to COVID-19. In addition to the five primary trainings offered, CMHT also provided trainings related to nutrition and wellness, everyday mental health (covers basic information pertaining to general mental health and wellness), self-esteem, stress management, Black, Indigenous, People of Color (BIPOC) mental health, and the Wellness Recovery Action Plan (WRAP). The program also had new opportunities to present to the cities of La Verne and Claremont, via presentations to the La Verne City Services and Police Department as well as Claremont High School students interested in learning about Tri-City and opportunities in the field of behavioral health.

DRAFT

Significant ratings from participants include: 84% of participants reported feeling confident in using or applying the skills learned in the training. Additionally, 97% of participants reported that they would recommend the training to others.

Challenges and Solutions

Challenges included transitioning from virtual to in-person platforms, while keeping hybrid options available. Solutions included reviewing Tri-City and CMHT documents/forms and consulting with MHSA PEI Program Supervisor about policy and procedures. This assisted CMHT to be better equipped when planning and setting up trainings for community and staff.

Challenges also included identifying potential attendee activators/triggers during in-person presentations and addressing how to keep a training environment safe and supportive for individuals who may be experiencing discomfort or stress during attendance. Solutions included having additional staff to support, provide disclaimers about activating content, and allow attendees to step away as often or needed before returning to the remainder of the training.

Diversity, Equity and Inclusion

The Community Mental Health Training team consists of bilingual staff who are available to offer trainings in both English and Spanish. In addition, most materials and brochures are available in both English and Spanish. Continuing to offer trainings virtually also supports efforts in eliminating barriers related to lack of transportation or physical mobility. Additionally, trainers complete cultural competence trainings and these concepts are incorporated in the trainings provided to the community.

Community Partners

Community engagement is key to the success of the CMHT. Partners include local colleges, school districts, law enforcement, community-based organizations, and faith-based organizations. Some examples of community partners include: David and Margaret Youth and Family Services, Youth Build Charter, Bright Prospect, Volunteers of America, Bonita Unified School District, Cal Poly Pomona Veterans Resource Center, and Community Wellbeing Grant recipients.

Success Story

A community partner, Western University, provided a list of accomplishments to the CMHT program during FY 2022-23. The University included a list of accomplishments in their staff council newsletter and shared that through the assistance of the CMHT program, they were able to certify nineteen staff members in Mental Health First Aid.

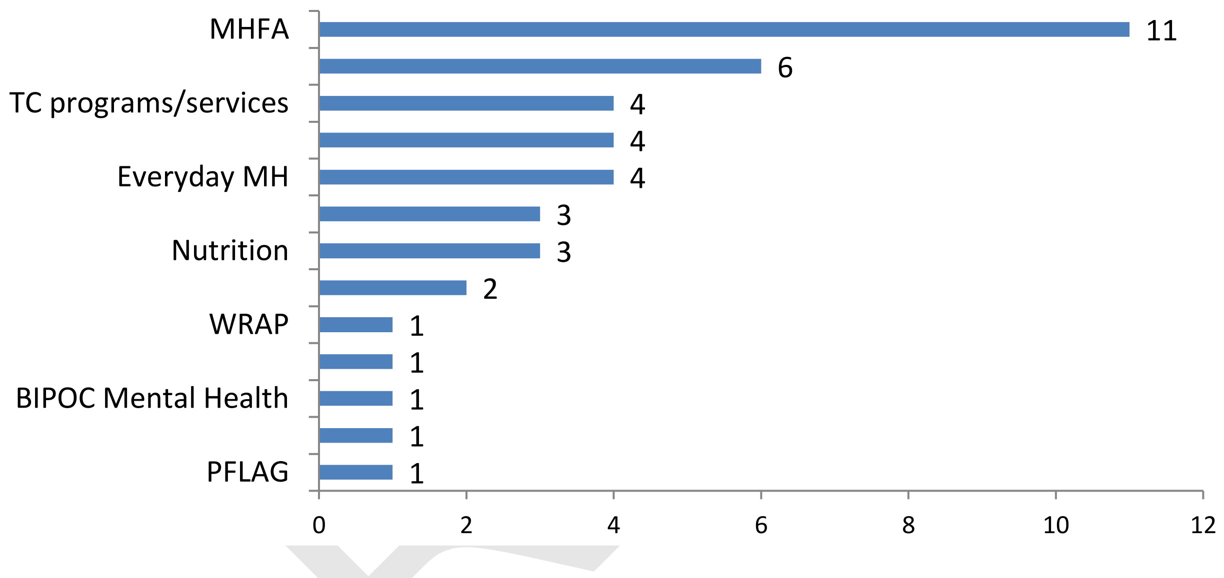
DRAFT

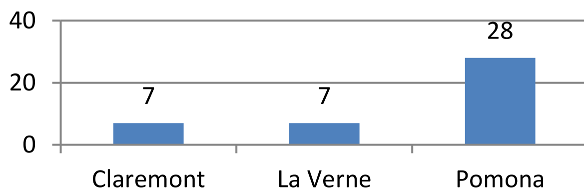
Program Summary

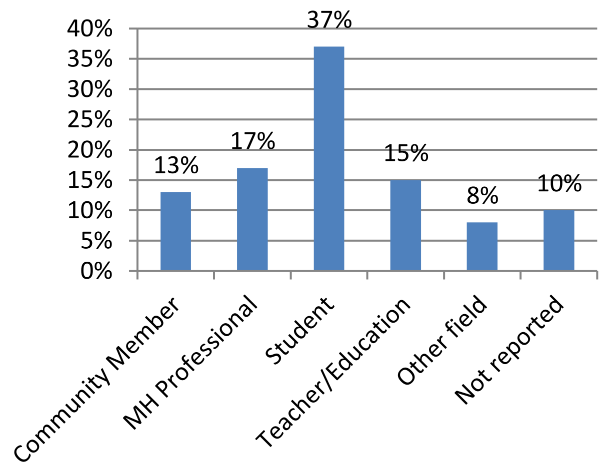
How Much Did We Do?

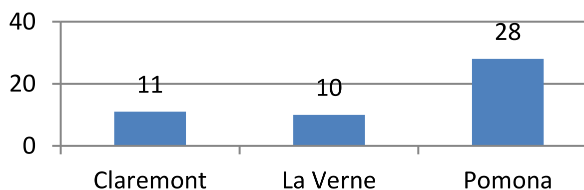
489
Individuals attending Presentations

42
Community Mental Health Presentations Conducted



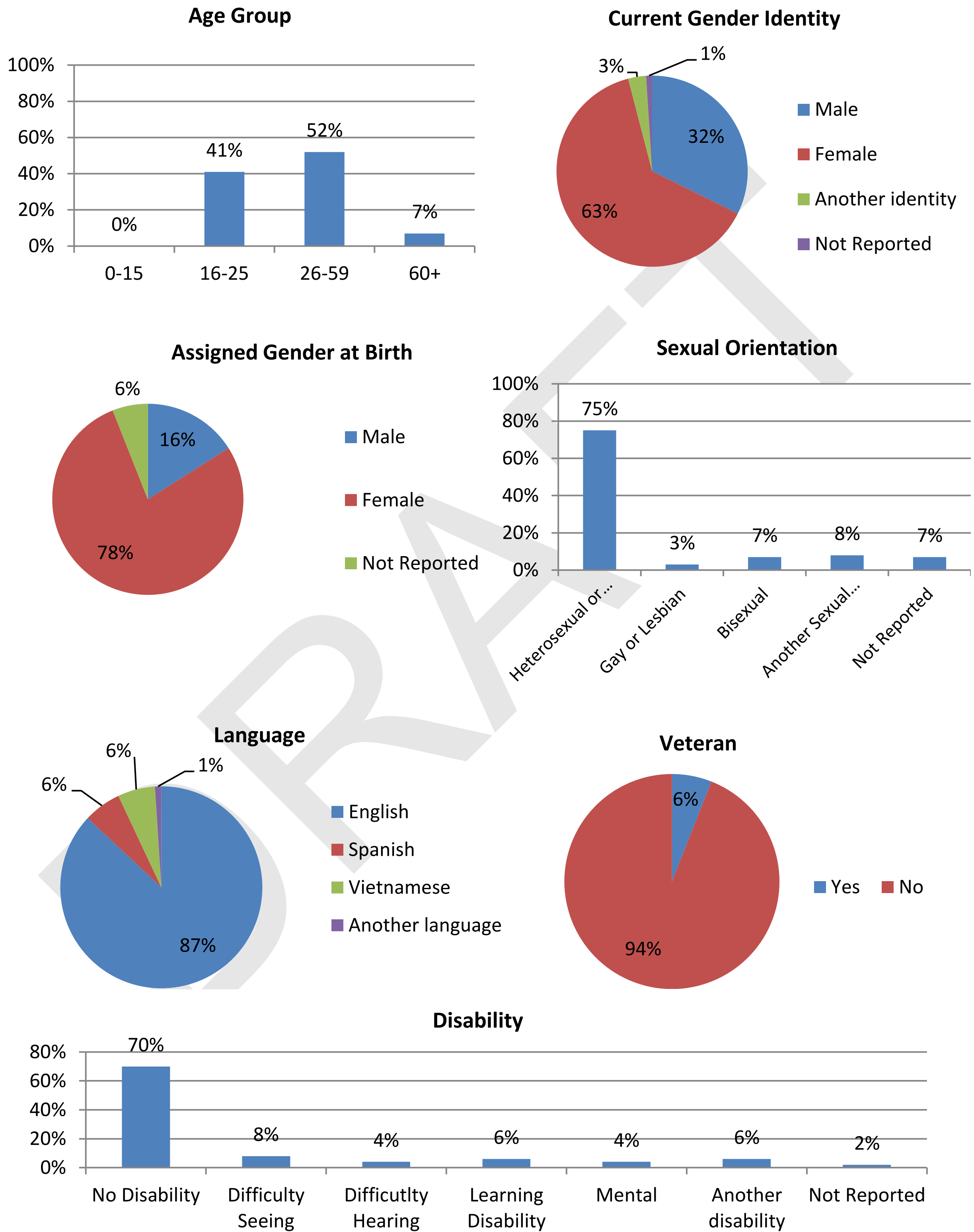




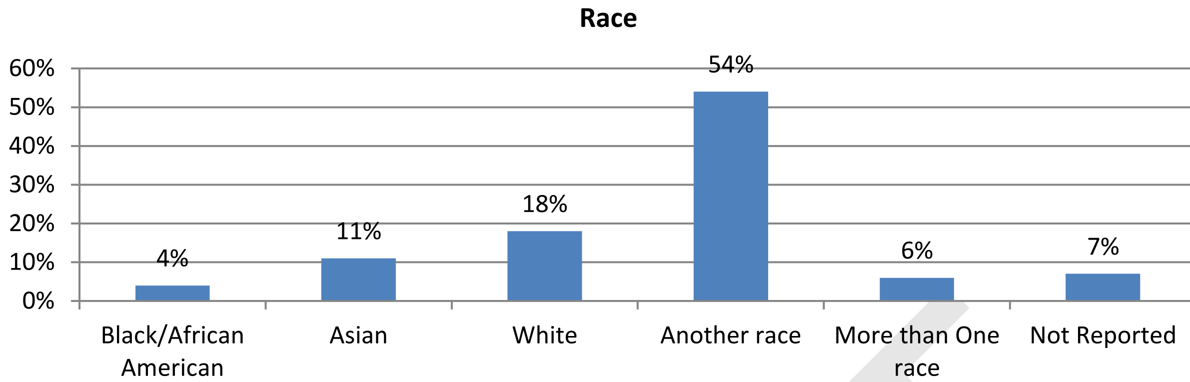


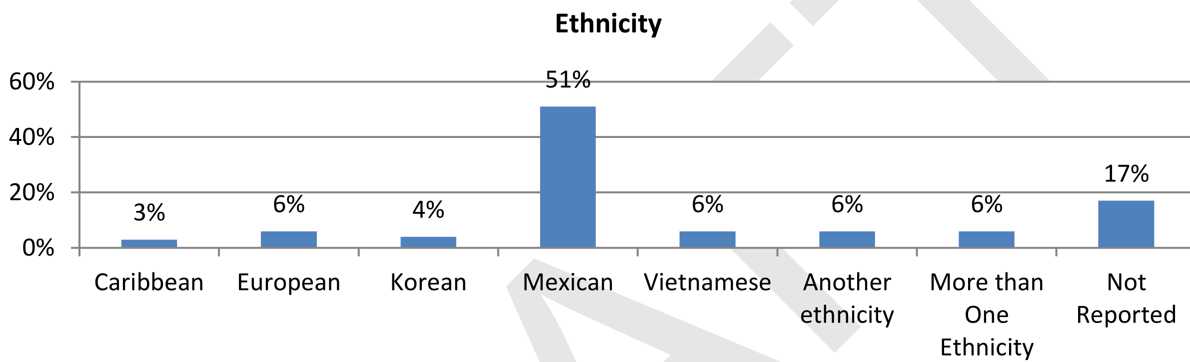
PEI Demographics from Surveys (Survey Responses = 72)

PEI Demographics only completed by Adults 18+

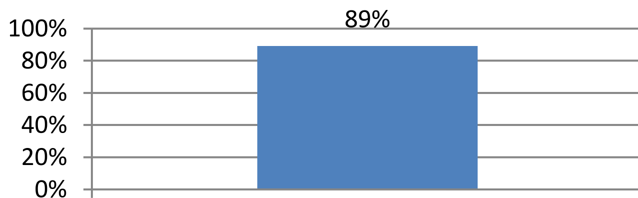


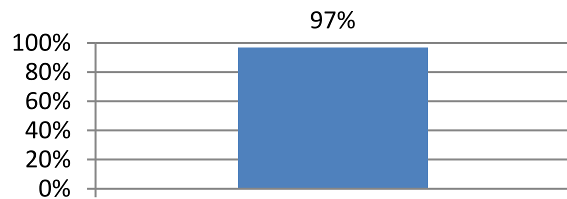
DRAFT

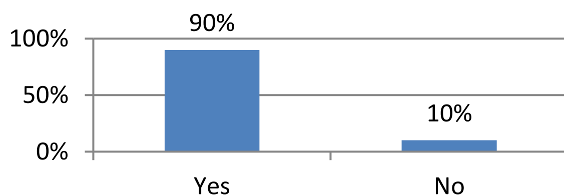


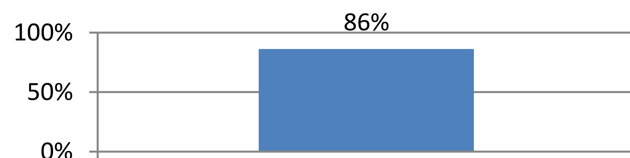


How Well Did We Do It?



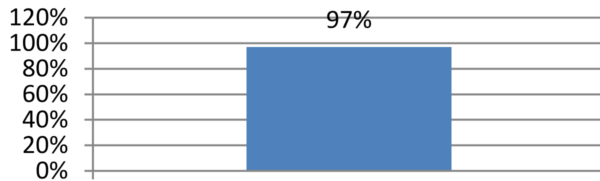




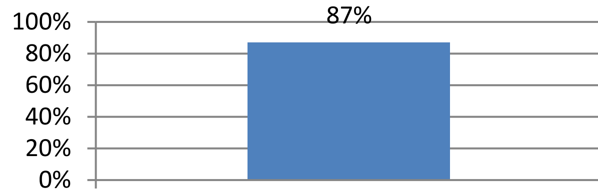


Mental Health First Aid (MHFA)

Percentage of participants who report increased knowledge about recognizing the signs and symptoms of mental health or substance use challenges



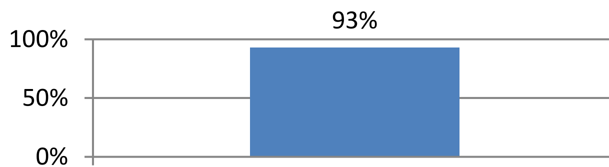
Percentage of participants who can express concerns to any person about mental health signs and symptoms to help that person to seek timely support



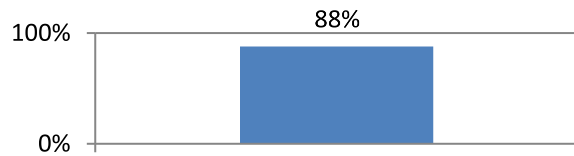
Is Anyone Better Off?

Mental Health First Aid (MHFA)

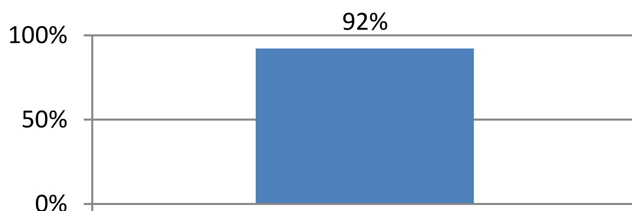
Percentage of participants who report feeling confident in using or applying the information they learned in the presentation



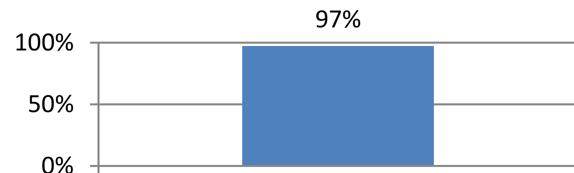
Percent of participants who report feeling more confident reaching out to someone who may be dealing with a mental health /substance use...



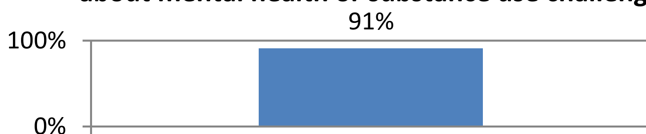
Percentage of participants who would recommend presentation to someone else



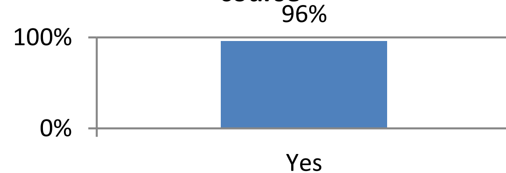
Use ALGEE action plan to connect an adult experiencing signs and symptom(s) of a mental health or substance use challenge or crisis to...



Have a supportive conversation with anyone about mental health or substance use challenges.



Would you take another MHFA course

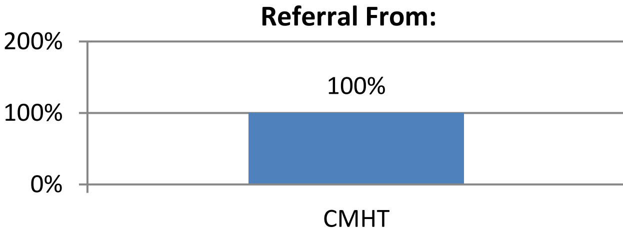


Number of Potential Responders	489
Setting in Which Responders were Engaged	Virtual platforms, Community, Healthcare, Schools, Local Business, Churches, Colleges, Rehabilitation, Regional Centers, Professional Associations, Law Agencies (probation/public defender's office), Department of Mental Health
Type of Responders Engaged	TAYs, Adults, Seniors, Landlords, Parents, Residents, Consumers, Faith Based Organizations, Community Based Organizations, Service Providers and Students
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

*Individuals preferred not to answer for all 12 referral demographic responses

There were 12 MHSA referrals to the CMHT Program



DRAFT

Community Capacity Building

Stigma Reduction and Suicide Prevention

Program Description

Tri-City is committed to supporting the strengths of each individual participant in their journey of recovery. Tri-City stigma reduction efforts on our website, via workshops and various community events are designed to empower individuals experiencing mental health challenges while generating awareness to the stigma associated with mental illness. Some efforts of the program include Green Ribbon Week, as well as state and nationally recognized campaigns including Mental Health Awareness Month, Black Indigenous and People of Color (BIPOC) Mental Health Awareness Month and Suicide Prevention Awareness Month.

Through a series of activities designed to support changes in attitudes, knowledge and behavior around the stigma related to mental illness, participants are able to have a voice in supporting not only their own recovery, but also influence the attitudes and beliefs of those who are touched by their stories.

These activities include:

1. **Courageous Minds Speakers Bureau**: Individuals with lived experience have the opportunity to share their personal stories of recovery through community presentations hosted throughout the year;
2. **Creative Minds**: Provides a unique opportunity for consumers and community members, both with and without a mental health condition, to create artwork that connects with their wellness, recovery and mental wellbeing. Art workshops and events are hosted virtually and in the community;
3. **Directing Change Program and Film Contest**: A statewide program with the mission to educate young people about suicide prevention, mental health and social justice through short films and art projects. Tri-City has a dedicated landing page where community members can view youth short film submissions from students in Pomona, Claremont and La Verne. Past award winners are listed here as well;
4. **Green Ribbon Week**: Each year, during the third week of March, Tri-City hosts stigma reduction presentations and collaborative community activities and distributes posters and green ribbons to promote mental health awareness in Pomona, Claremont and La Verne.

For each of these activities, consumer feedback is captured through program surveys which are administered several times per year as well as surveys specific to each event or presentation. In addition, Tri-City suicide prevention efforts include offering suicide awareness trainings which provide

DRAFT

participants with the skills needed to recognize the signs of suicide and connect individuals quickly and safely to appropriate resources and support services.

Target Population

Community members and partners including local colleges, schools, agencies, organizations, and Tri-City staff.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	0	18	44	14	475	**551**

Program Update

During fiscal year 2022-23, the Stigma Reduction and Suicide Prevention program continued to host a variety of activities designed to continue to efforts to reduce the impact of mental health stigma and reduce the risk of suicide in our three cities. These activities included:

September is designated as Suicide Prevention Awareness Month and Suicide Prevention Week was held nationwide from September 5-11, 2022. Throughout the month and during this awareness week, program staff launched a social media campaign for suicide prevention awareness and distributed toolkits to local school sites, Tri-City, and community members.

Green Ribbon Week (GRW**)** is an annual recognition that aligns with Tri-City's stigma reduction efforts that encourages the community to end mental health stigma. GRW is a week-long series of workshops and events that educate community members, clients, and participants about stigma, the impact it has on our individual and collective mental health, and how to take action to fight against stigma in our community. The Courageous Minds Speakers Bureau was also featured during Green Ribbon Week where a community member shared their mental health journey and recovery.

During Mental Health Awareness Month, the Creative Minds Art Gallery was showcased at the dA Center for the Arts at Pomona's 2nd Saturday Art Walk. This year's art theme was "How do you take action for mental health for young people?" Thirty-six submissions of artwork were presented highlighting the valuable impact of this artistic channel for supporting an individual's wellbeing.

A partnership with the School of Art and Enterprise led to program staff facilitating thirty-two stigma reduction presentations during class periods. Program staff also re-launched Courageous Minds Speakers Bureau program and gained two new speakers. Lastly, the Directing Change landing page was launched online, where community members can view youth short film submissions, from the Tri-City service area and statewide, about suicide prevention and notable award winners.

DRAFT

Challenges and Solutions

Program staff received a tremendous number of requests to attend events and facilitate activities related to stigma reduction. Due to staff capacity, several of these invitations were not possible to accept. A solution was for the Stigma Reduction and Suicide Prevention program to refer to other departments that could attend and support the community requests.

Another challenge was low attendance when hosting in-person Tri-City events. A solution to this concern was collaborating with community partners and hosting events in their space where community members feel more comfortable and inclined to attend.

Diversity, Equity and Inclusion

The stigma reduction programing is designed to target underserved populations in the community. Program staff also collaborates with Tri-City's Diversity, Equity, and Inclusion program via workshops, events, and social media campaigns. The program strives to help reduce stigma in the community across all cultures, backgrounds, and identities. By increasing mental health literacy among the Tri-City community members, they are more likely to reach out for help when needed. Lastly, staff utilize translation support for presentations and documents when requested and regularly participate in cultural competence trainings.

Community Partners

The Stigma Reduction and Suicide Prevention Program partners with several internal and external entities. Local school districts, colleges and universities are valuable partners in spreading the word regarding stigma awareness and reduction. Some schools the program partners with are Cal Poly Pomona, Claremont High School, Mt. View Elementary, University of La Verne, Pomona Unified School District, and School of Arts and Enterprise.

Other outside agencies include CalMHSA, Directing Change, Tracks Activity Center (TAC), Youth Activity Center (YAC), La Verne Community Center, Hope through Housing, Pomona Public Library, Claremont Public Library, La Verne Public Library and several small businesses in the service area.

Success Story

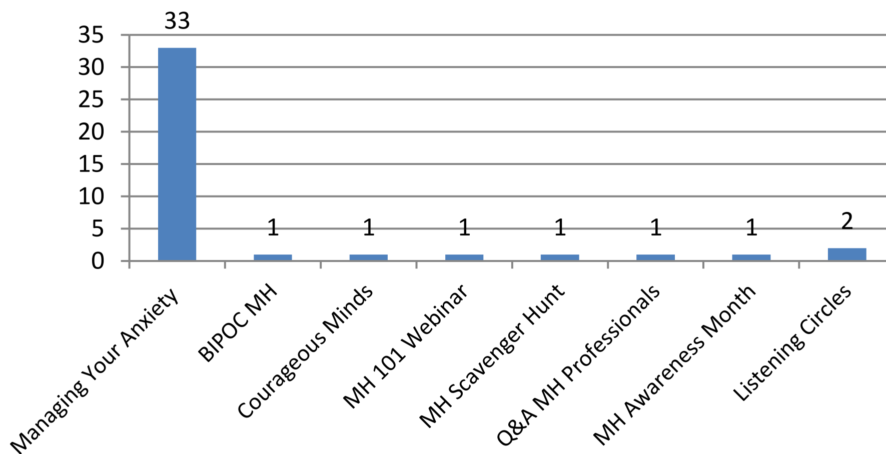
Program staff reached out to several school sites throughout September 2022 for Suicide Prevention Awareness Month in an effort to raise awareness and take action for suicide prevention. For the first time, Western University showed interest in working together to conduct a suicide prevention event for their graduate students. Following the event, the university reported to Stigma Reduction and Suicide Prevention staff that they would like to continue supporting efforts to reduce stigma and turn this into an annual event due to its success.

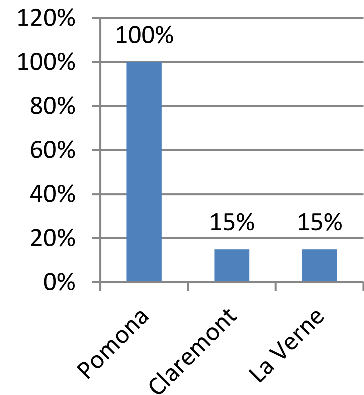
DRAFT

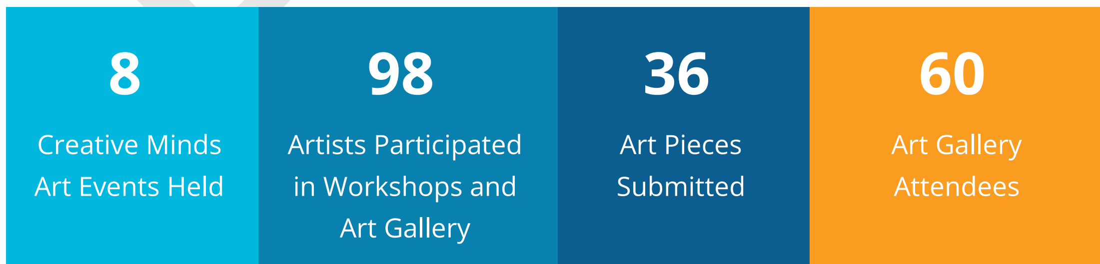
Program Summary

How Much Did We Do?

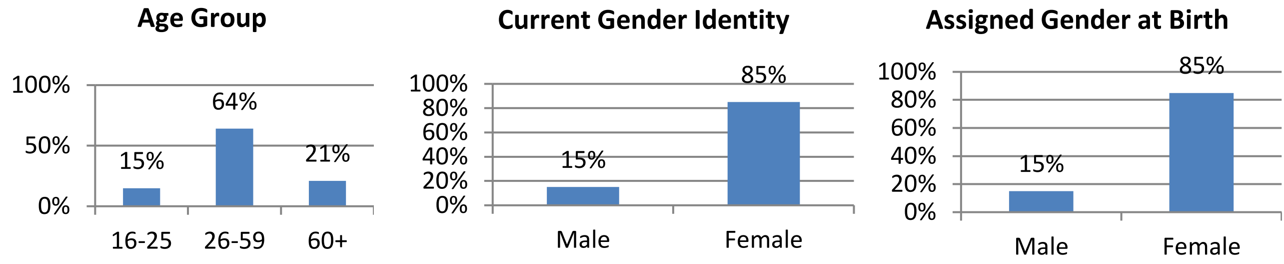
Stigma Reduction (Courageous Minds/Creative Minds)

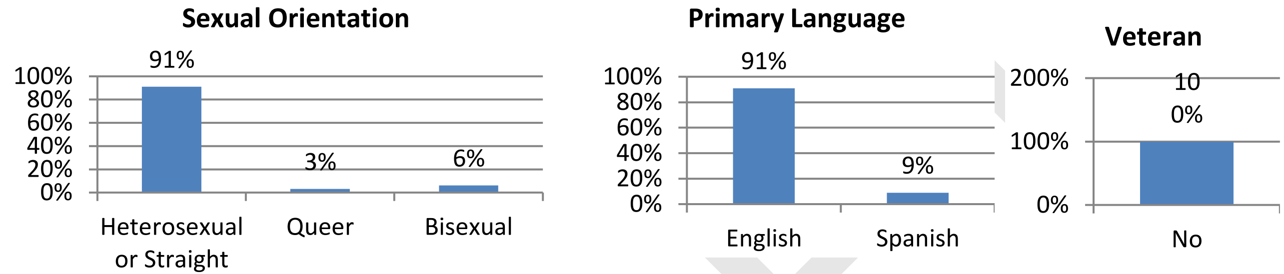


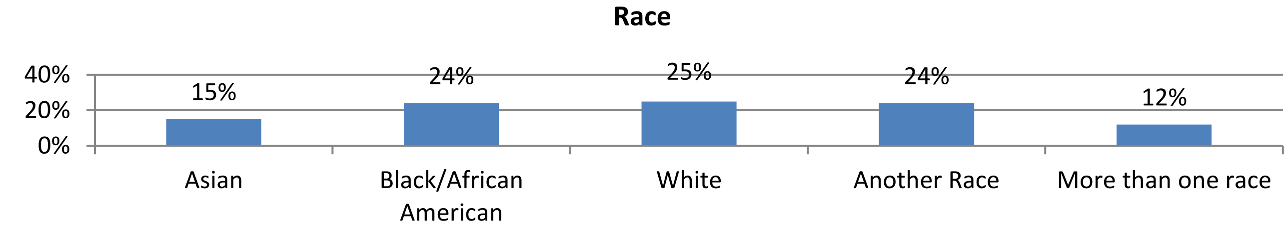


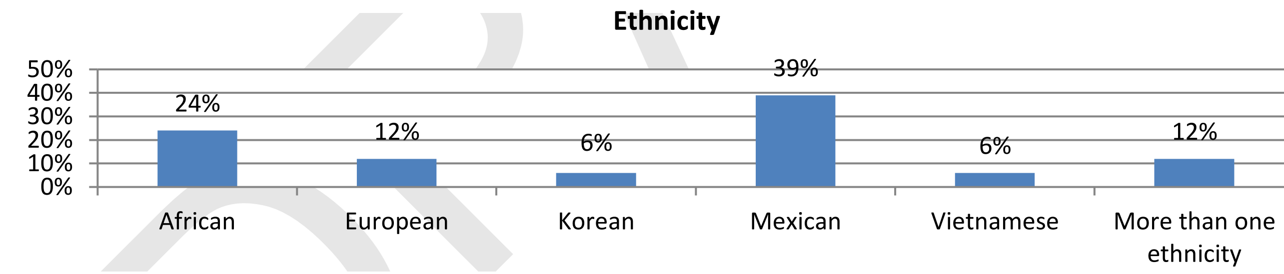


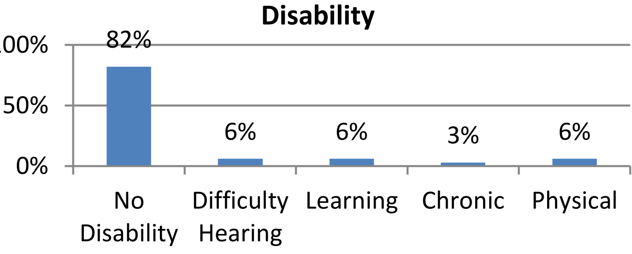
PEI Demographics from Post-Test Stigma Reduction Surveys (Responses = 33)

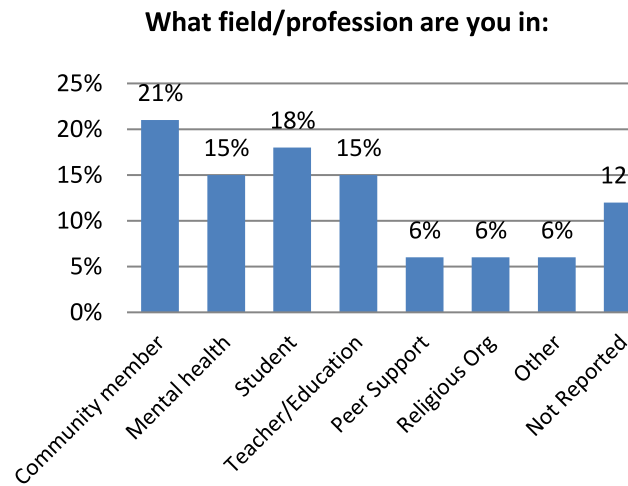


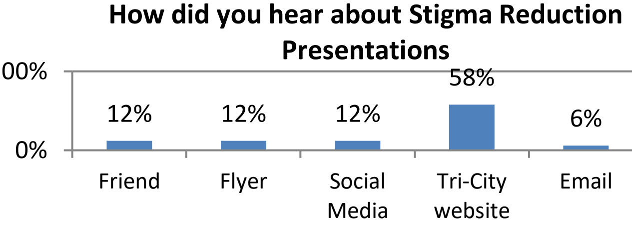












How Well Did We Do It?

399
Individuals Outreached for Stigma Reduction

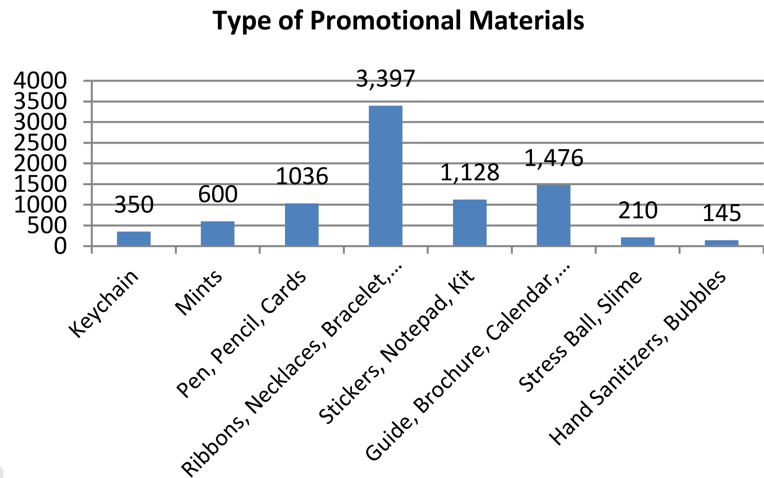
158
Individuals Outreached for Art Gallery/Creative Minds

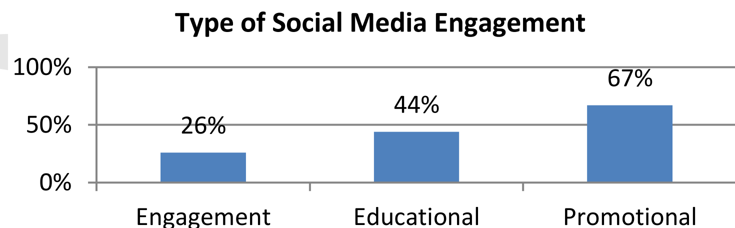
Promotional Materials & Social Media Engagement for Stigma Reduction

8,342
Promotional Materials

1,404
People Engaged from Outreach

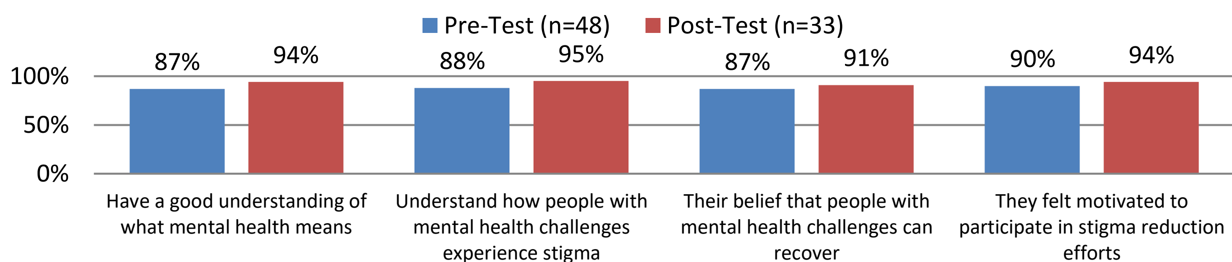
9,766
Instagram accounts Reached for Social Media Engagement





Is Anyone Better Off?

Percentage of Stigma Reduction Survey Respondents who reported, as a result of the presentations:

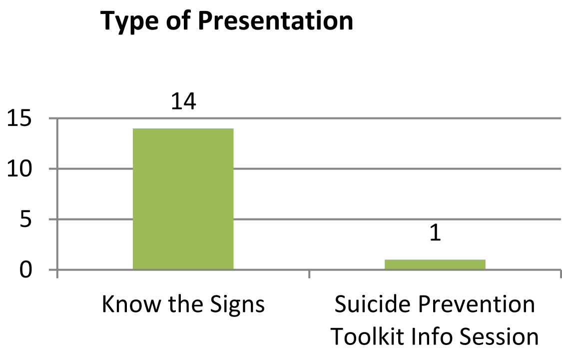


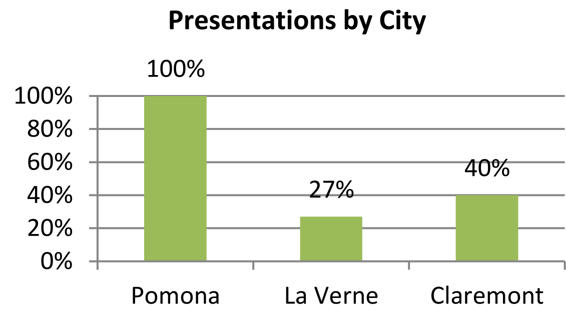
Suicide Prevention

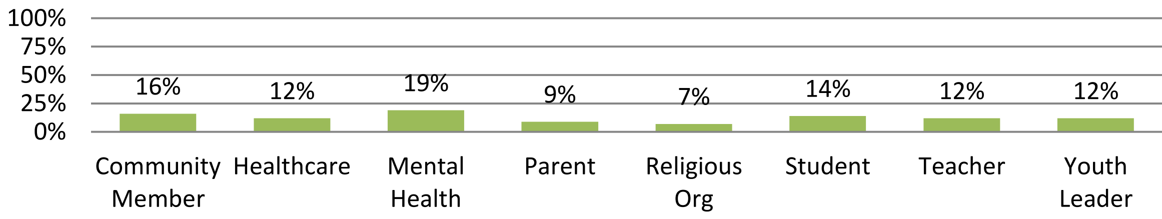
How Much Did We Do?

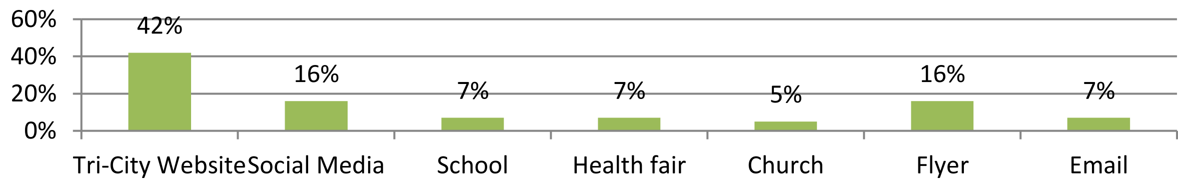
15 Presentations

152 Attendees for Suicide Prevention Presentations

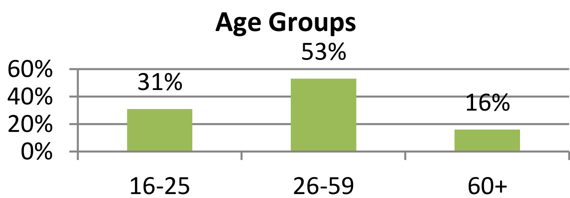


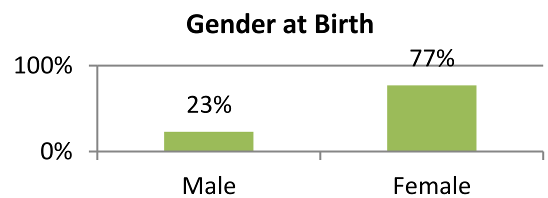


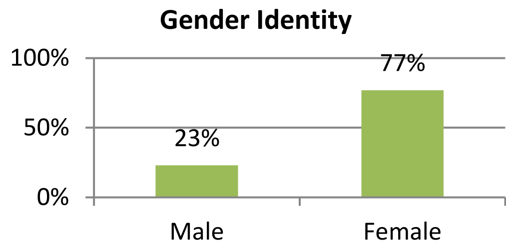


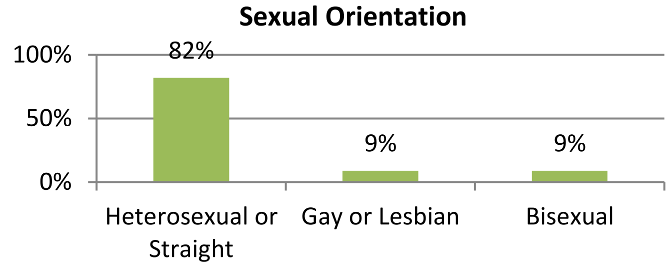


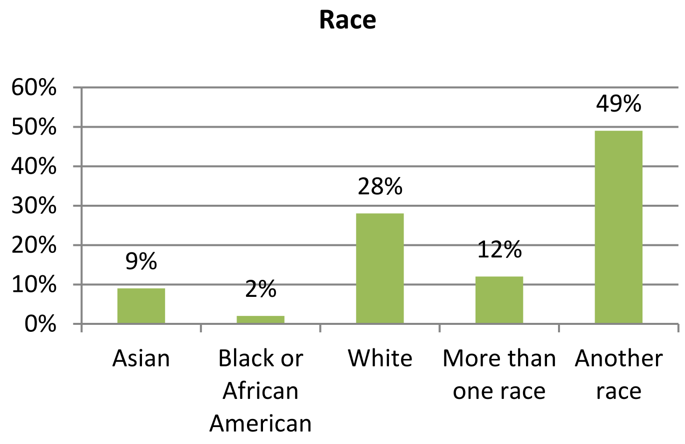
PEI Demographics from Post-Test Suicide Prevention Surveys (Responses = 43)

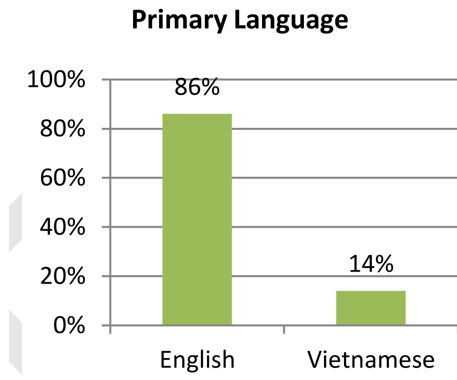


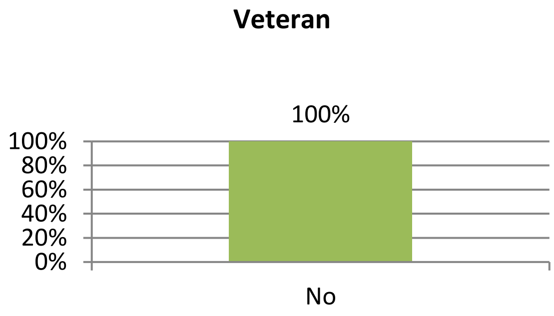


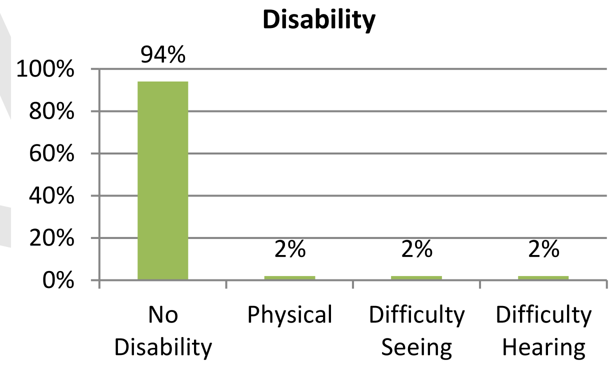

Gender Identity
100%
50%
0%
23%
77%
Male
Female

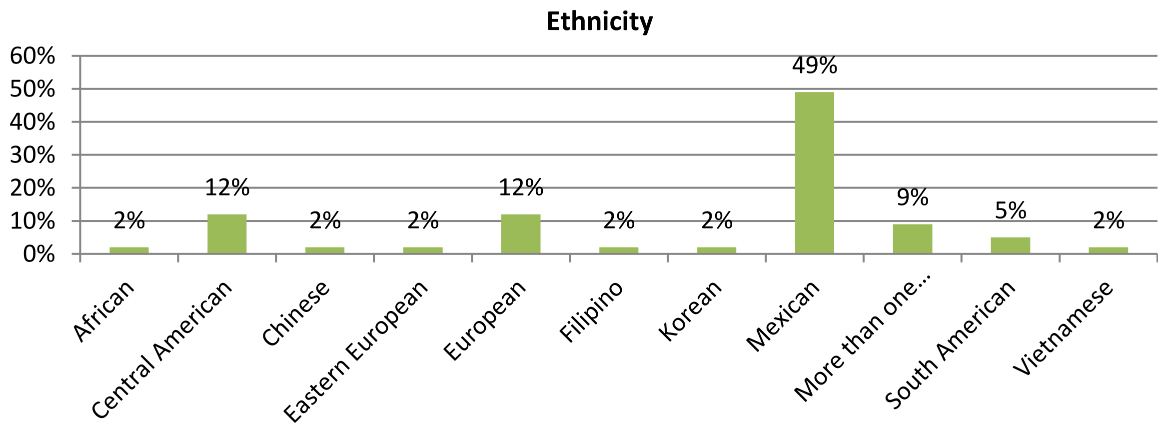

Sexual Orientation
100%
50%
0%
82%
9%
9%
Heterosexual or Straight
Gay or Lesbian
Bisexual


Race
60%
50%
40%
30%
20%
10%
0%
9%
2%
28%
12%
49%
Asian
Black or African American
White
More than one race
Another race


Primary Language
100%
80%
60%
40%
20%
0%
86%
14%
English
Vietnamese


Veteran
100%
80%
60%
40%
20%
0%
100%
No


Disability
100%
80%
60%
40%
20%
0%
94%
2%
2%
2%
No Disability
Physical
Difficulty Seeing
Difficulty Hearing


Ethnicity
60%
50%
40%
30%
20%
10%
0%
2%
12%
2%
2%
12%
2%
2%
49%
9%
5%
2%
African
Central American
Chinese
Eastern European
European
Filipino
Korean
Mexican
More than one...
South American
Vietnamese

How Well Did We Do It?

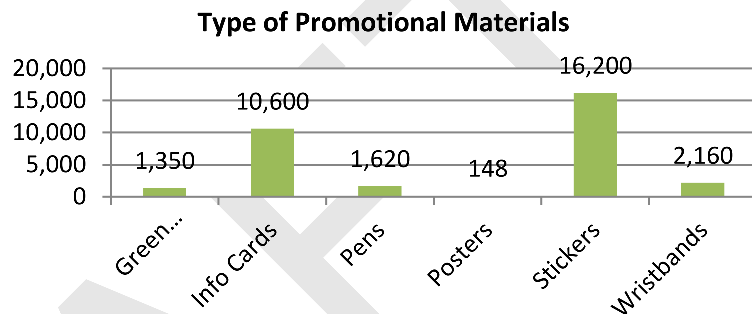
152
Individuals Outreached for Suicide Prevention

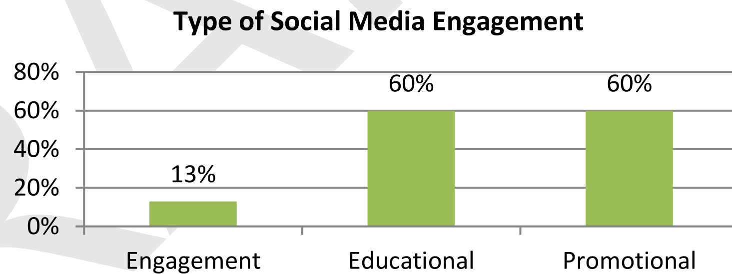
Promotional Materials & Social Media Engagement for Suicide Prevention

32,078
Promotional Materials

1,161
People Engaged from Outreach

1,662
Instagram accounts Reached for Social Media Engagement

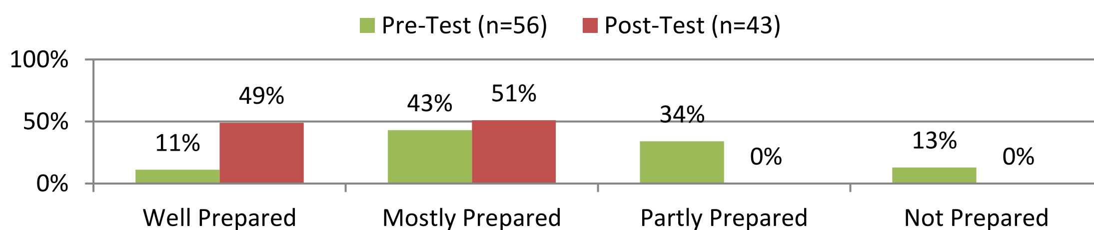




15 post/stories in social media

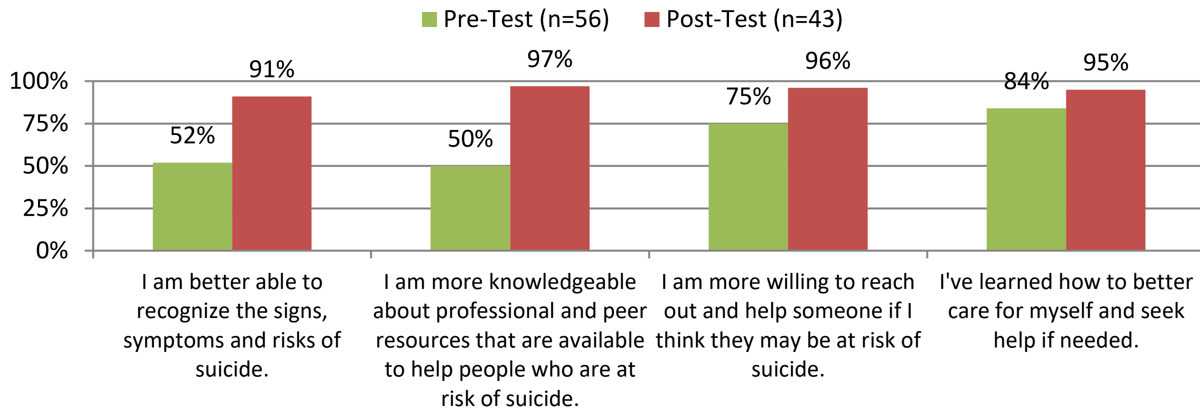
Is Anyone Better Off?

Percentage of how prepared Suicide Prevention attendees feel to talk directly and openly to a person about their thoughts of suicide:



DRAFT

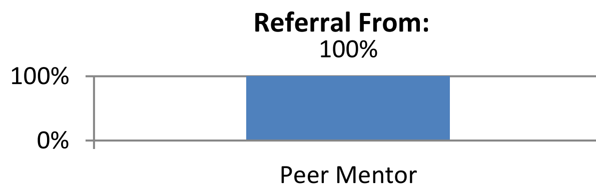
Percentage of Suicide Prevention Survey Respondents who reported, as a result of the presentations:



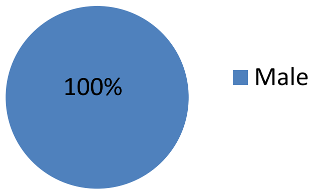
Number of Potential Responders	709
Setting in Which Responders were Engaged	Community, colleges, schools, health centers, workplace, shelters, online, and outdoors
Type of Responders Engaged	TAY, adults, older adults, teachers, LGTBQ, families, suicide attempters/survivors, religious leaders, and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

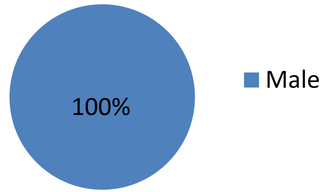
Timely Access to Services for Underserved Populations Strategy

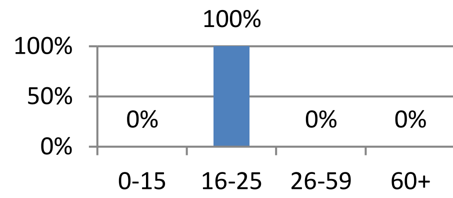
1 MHSA Referral to Stigma Reduction/ Suicide Prevention Programs

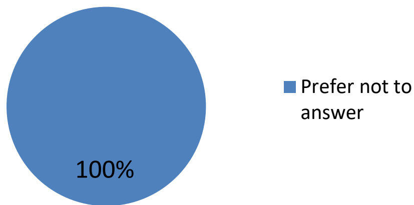


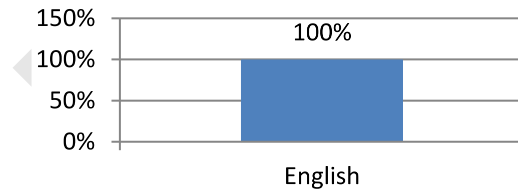
PEI Demographics Based on MHSA Referrals

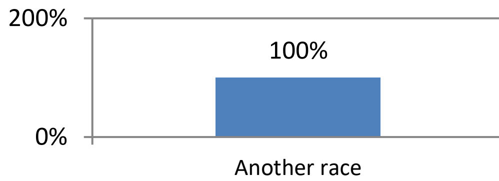


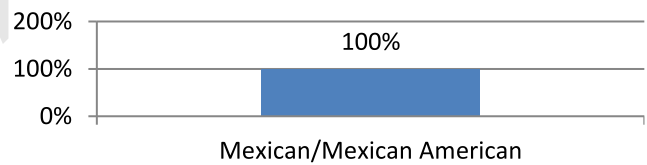


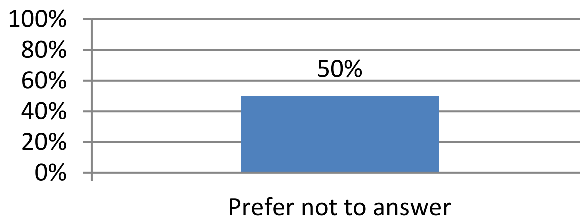


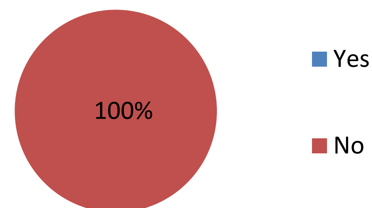












Peer Mentor and Wellness Center PEI Programs

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: The Peer Mentor program and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

DRAFT

Peer Mentor Program

Program Description

Trained volunteers (peer mentors) from the Tri-City area provide support to peers (mentees) who are in emotional distress. Through their own lived experiences, peer mentors are uniquely qualified to offer encouragement, guidance, and hope to their peers. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally relevant for each mentee.

Target Population

All community members with a focus on the specialized populations of transition age youth (TAY ages 18-25) and older adults (ages 60 and over).

Mentors	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	0	6	5	3	0	**14**
Cost Per Person	$2,853	$2,853	$2,853	$2,853	N/A	**$2,853**
Mentees	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	**Total Served**
Number Served FY 2022-23	0	17	16	7	0	**40**

Program Update

During FY 2022-23, the Peer Mentor Program had 14 active mentors who provided one-on-one services to 40 mentees. Peer Mentors completed a total of 811 hours which included direct service with mentees, training, meetings, supervision, and community engagement events. These numbers

are an increase of almost double the service learner hours from the previous fiscal year and reflect the increased community engagement activities during FY 2022-23.

One hundred percent of mentors say that becoming a mentor has had a positive impact in their lives when surveyed. One hundred percent of mentees rate their overall experience with their Peer Mentors as good or excellent and felt their mentors adequately provided the support needed.

To outreach and engage community members, the Peer Mentor program utilized Tri-City's social media accounts to recruit new mentors and highlight existing mentors. The program also anticipates providing wellness activities and roundtables to the community to further increase the breadth of support.

Challenges and Solutions

Due to various reasons such as finding employment, beginning graduate studies, and other life obligations the Peer Mentor program lost 15 mentors during FY 2022-23. To meet this challenge, outreach efforts to recruit more mentors were increased, including working closely with the Workforce Education and Training (WET) interim supervisor and the WET supervisor respectively. Program staff also attended community engagement events and used social media to promote the program. Ultimately, the program was able to gain 12 new mentors.

Diversity, Equity and Inclusion

The Peer Mentor program strives to recruit members from underserved populations to be more accessible to mentees who come from similar backgrounds. Additionally, mentors attend multiple training courses each year that teach them how to support these individuals. Diversity within the mentor cohort helps to reduce stigma and helps participants feel more comfortable receiving services. Furthermore, 64% of mentors are either an older adult or are TAY; 28% of mentors say they have a disability.

Throughout the program year, peer mentors participate in over seventeen training courses that aim to reduce stigma surrounding mental health and increase knowledge and understanding of barriers to accessing mental health services. The program also provides training that assist mentors in learning how to support those who identify as LGBTQ+.

Program staff is bilingual in English and Spanish. Additionally, 36% of mentors speak Spanish and 7% of mentors speak Korean. The Peer Mentor program also actively recruits mentors who identify as an older adult or veteran as a crucial component to reducing stigma. In FY 2022-23, 18% of mentors identified as older adults.

Community Partners

The Peer Mentor program has several interdepartmental collaborations to support the community, recruit mentors and enroll mentees. Some of the collaborations include Stigma Reduction, Workforce

DRAFT

Education and Training, clinical departments, Community Mental Health Trainers, Therapeutic Community Garden, Navigators, and the Wellness Center.

Through various events and activities, these collaborations provide opportunities for mentor recruitment, mentee referrals, trainings, and community resources. Mentors also gain knowledge about Tri-City services to refer, or provide resources to their mentees when necessary.

Success Story

During FY 2022-23, a peer mentor who had been with the program for several years was able to achieve many personal and professional milestones in their life. The mentor was able to earn a college degree while they served as a mentor. Additionally, the mentor referenced their experience in the program to apply for post graduate programs. They were excited to share an acceptance letter to a graduate school and credited the Peer Mentor program in assisting them in identifying their career path.

DRAFT

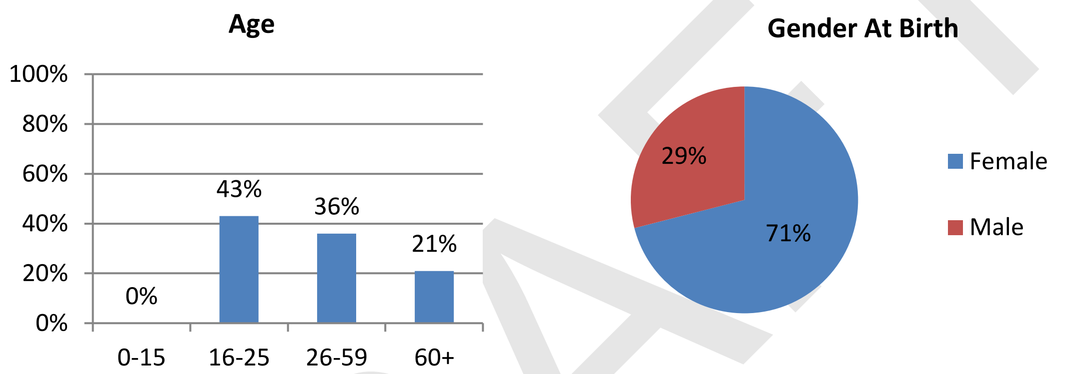
Program Summary

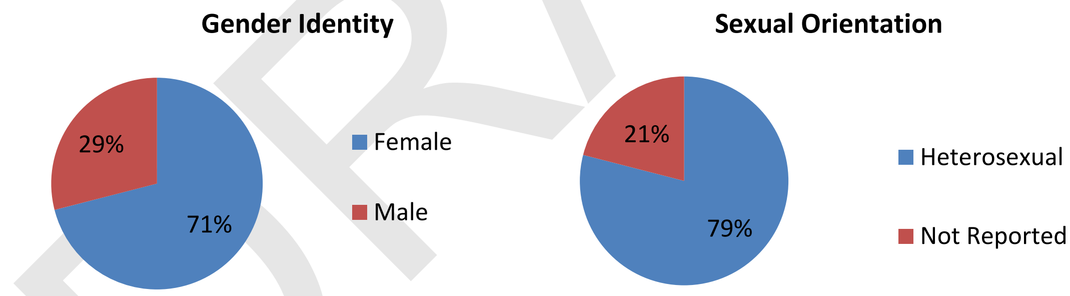
How Much Did We Do?

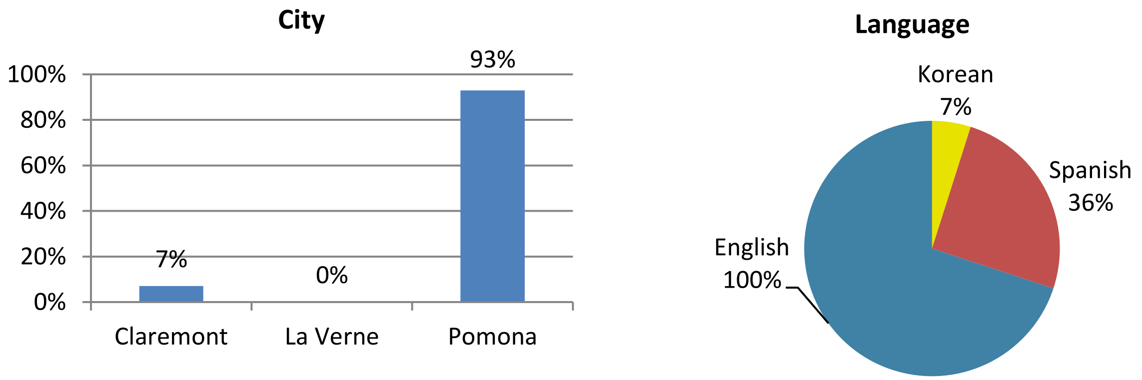
Peer Mentors

14
Active Peer Mentors

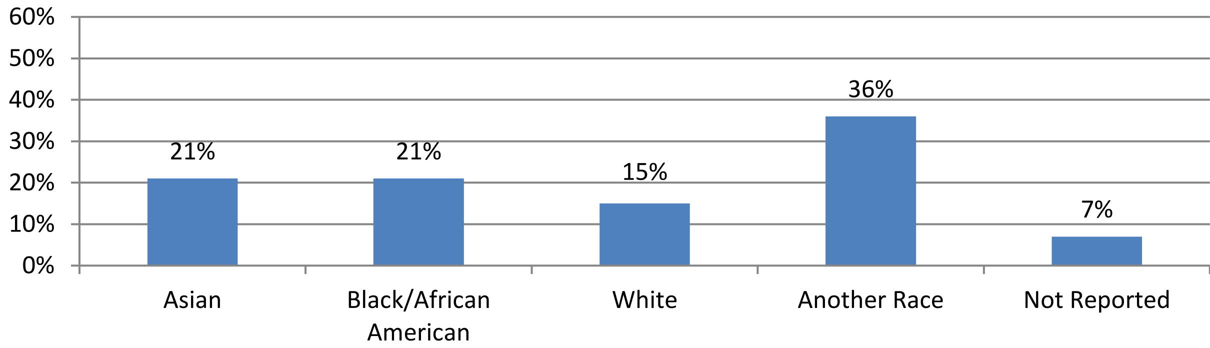
17
Peer Mentor Meetings Trainings offered to Peer Mentors

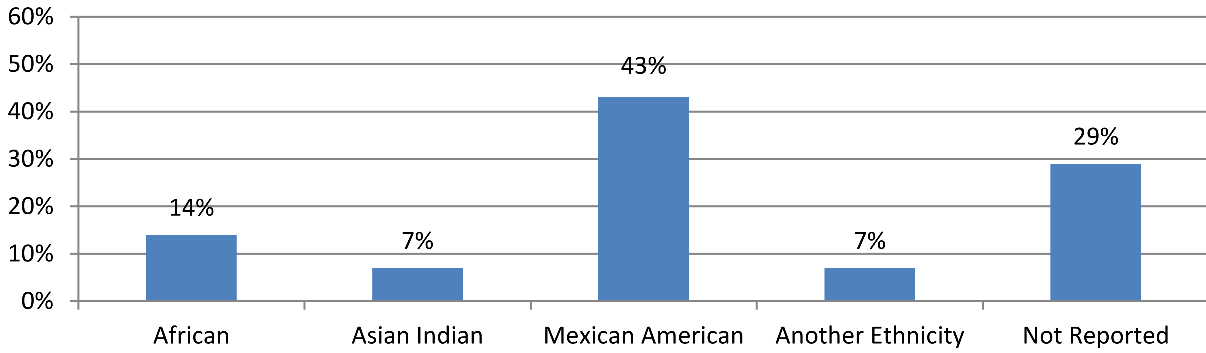


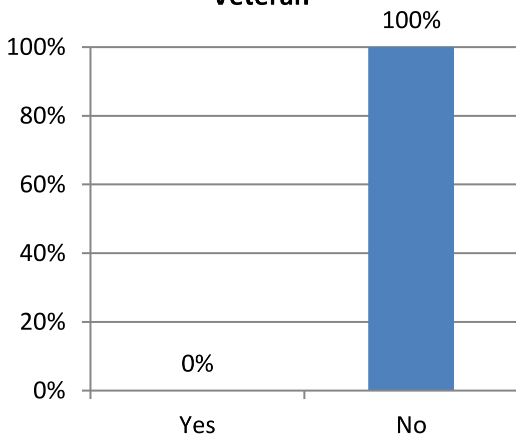


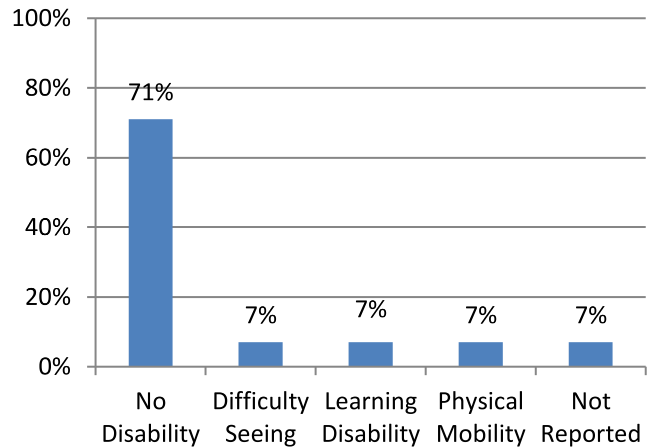


DRAFT


Race
60%
50%
40%
30%
20%
10%
0%
21%
21%
15%
36%
7%
Asian
Black/African American
White
Another Race
Not Reported

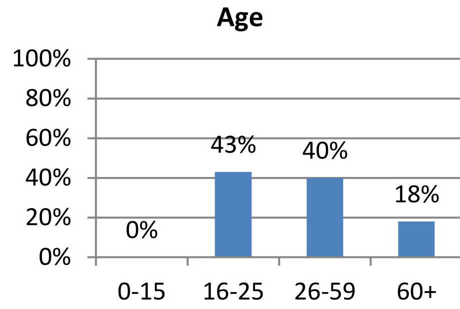

Ethnicity
60%
50%
40%
30%
20%
10%
0%
14%
7%
43%
7%
29%
African
Asian Indian
Mexican American
Another Ethnicity
Not Reported

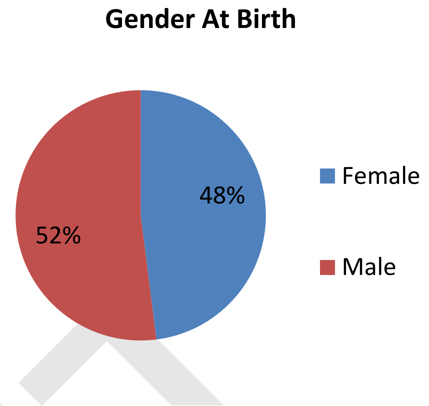

Veteran
100%
80%
60%
40%
20%
0%
0%
100%
Yes
No

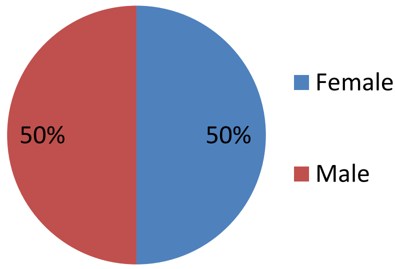

Disability
100%
80%
60%
40%
20%
0%
71%
7%
7%
7%
7%
No Disability
Difficulty Seeing
Learning Disability
Physical Mobility
Not Reported

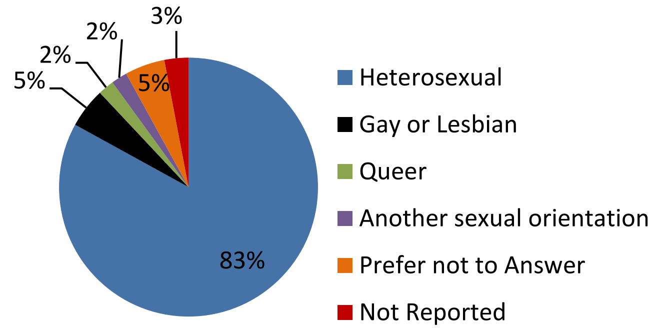
Peer Mentees

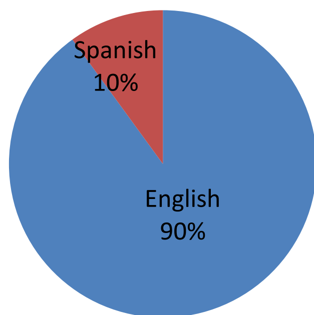
40 Mentees Served

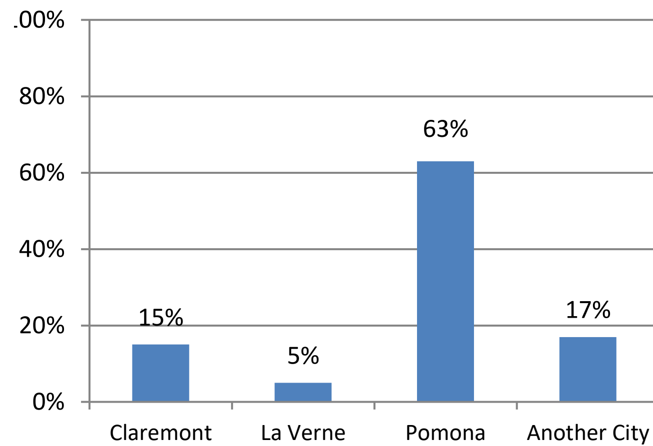


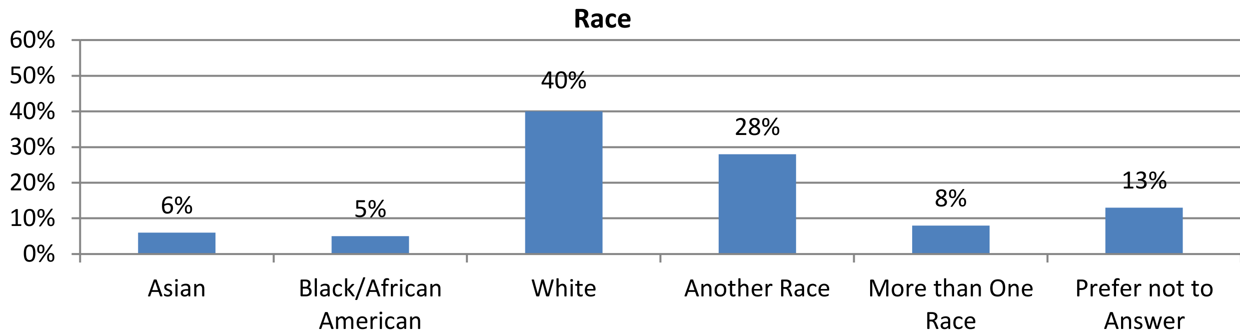


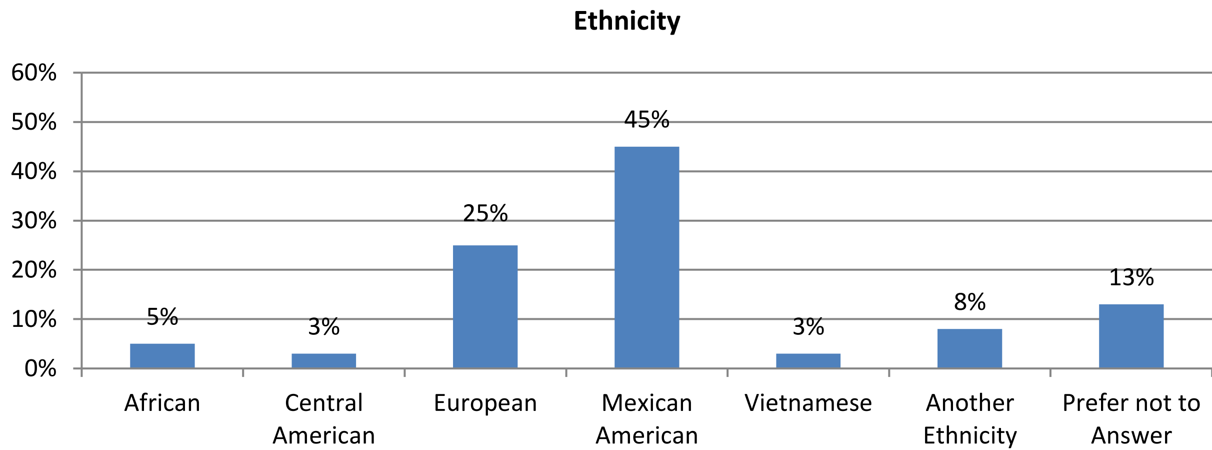


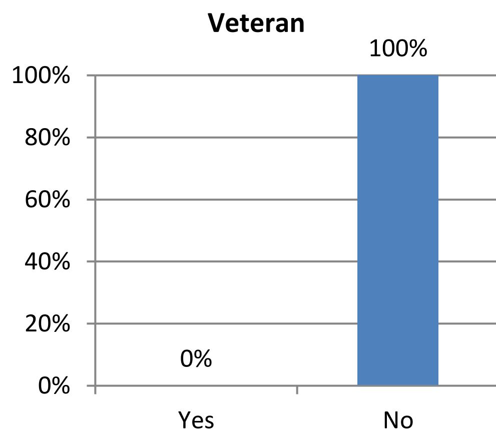


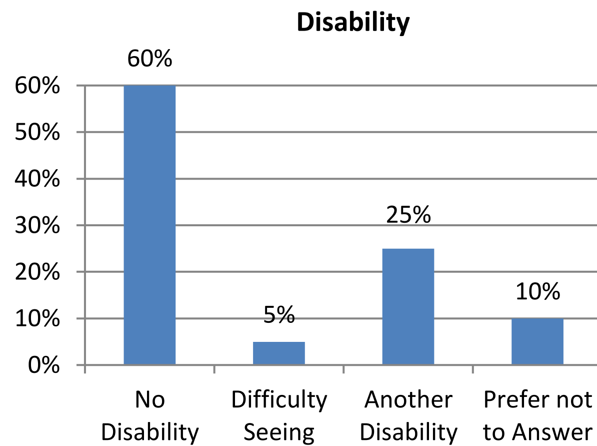





Race
60%
50%
40%
30%
20%
10%
0%
6%
5%
40%
28%
8%
13%
Asian
Black/African American
White
Another Race
More than One Race
Prefer not to Answer

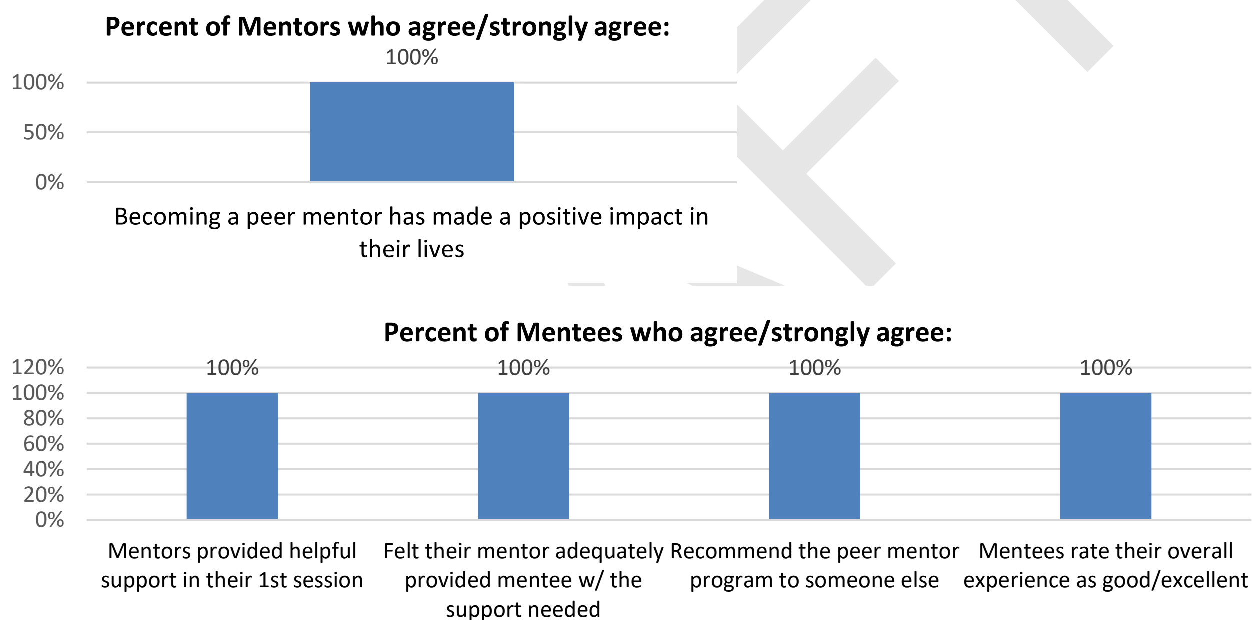

Ethnicity
60%
50%
40%
30%
20%
10%
0%
5%
3%
25%
45%
3%
8%
13%
African
Central American
European
Mexican American
Vietnamese
Another Ethnicity
Prefer not to Answer


Veteran
100%
80%
60%
40%
20%
0%
0%
100%
Yes
No


Disability
60%
50%
40%
30%
20%
10%
0%
60%
5%
25%
10%
No Disability
Difficulty Seeing
Another Disability
Prefer not to Answer

How Well Did We Do It?

Is Anyone Better Off?

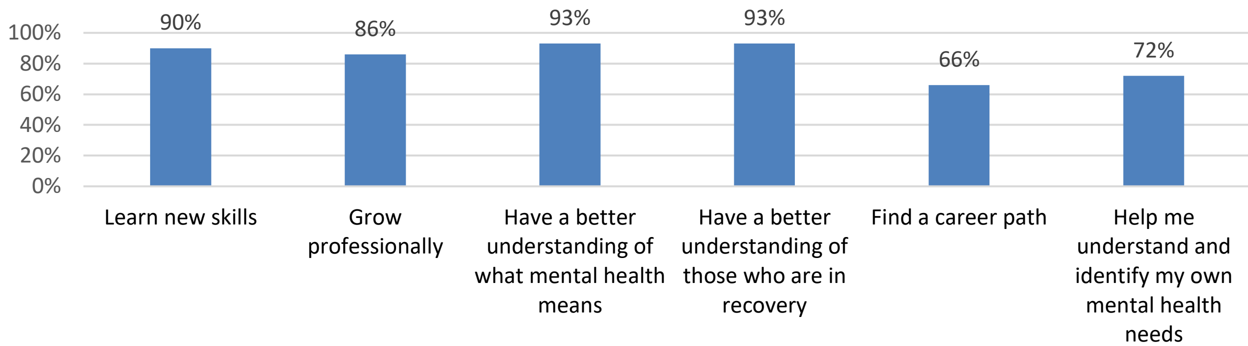


Peer Mentor Open-Ended Questions

What was your favorite part of being a mentor? (24 total respondents)

List one thing from the peer mentor program you feel was most beneficial (21 total respondents)

How has the program helped you personally as Mentor: (Check all that apply)



Mentee Open-Ended Questions

List one thing from the mentee program you feel was most beneficial (8 total respondents)

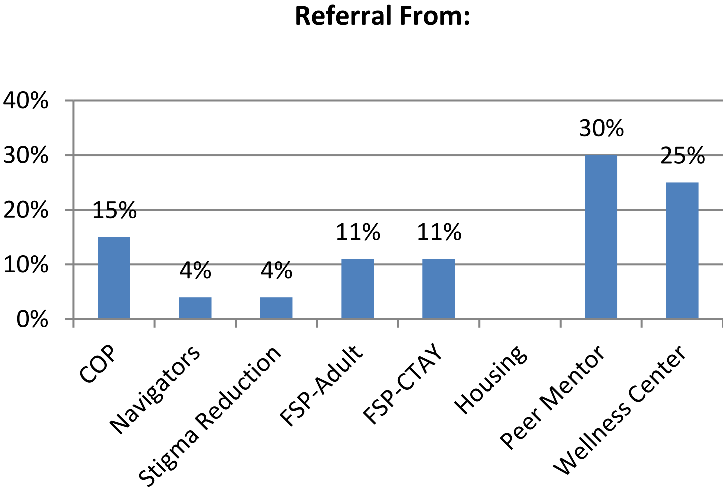
Number of Potential Responders	54
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community,
Type of Responders Engaged	TAY, adults, seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

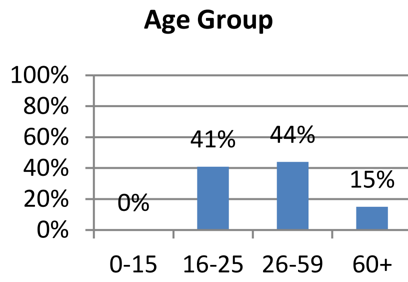
26
MHSA Referrals received by Peer Mentor program

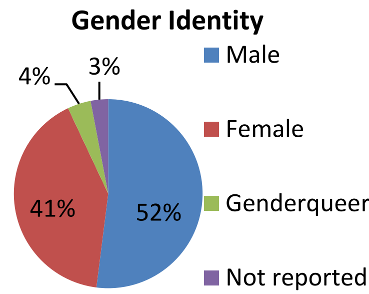
19 out of the 26
Referrals became mentee

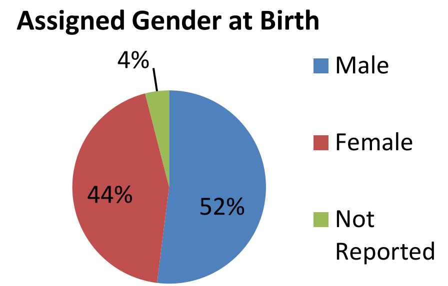
2.5 Days
Average Time between Referral and becoming a mentee

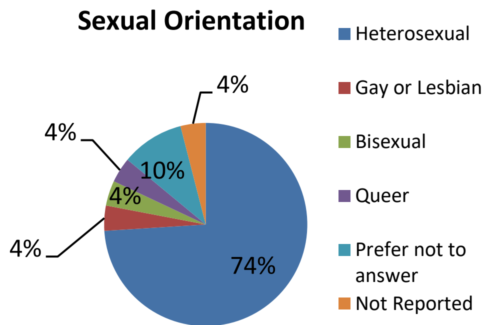


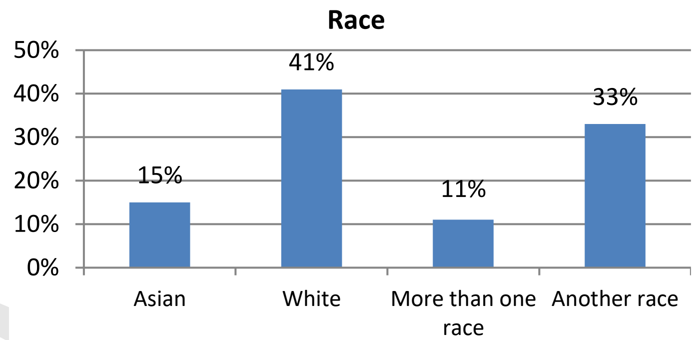
PEI Demographics Based on Referrals

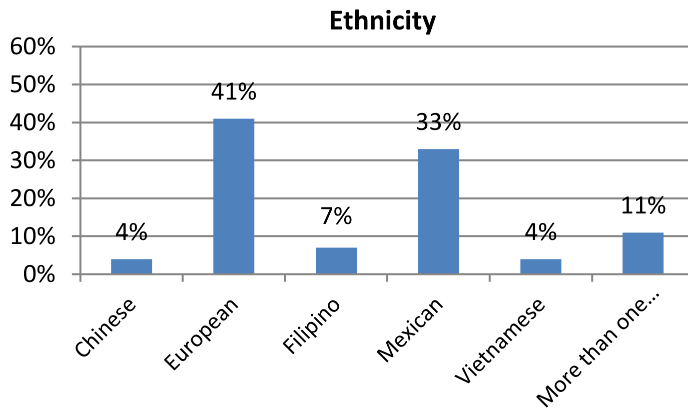


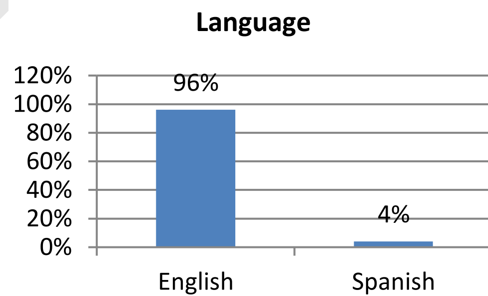


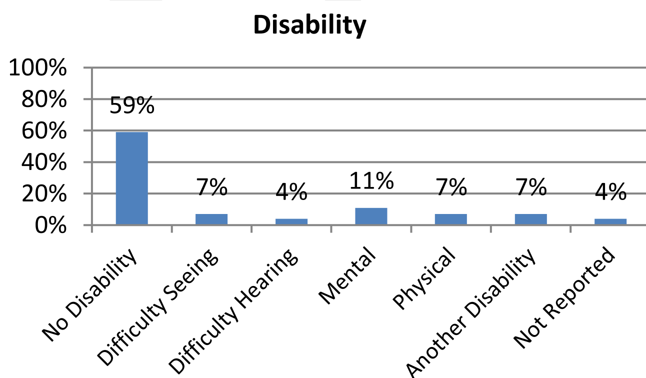


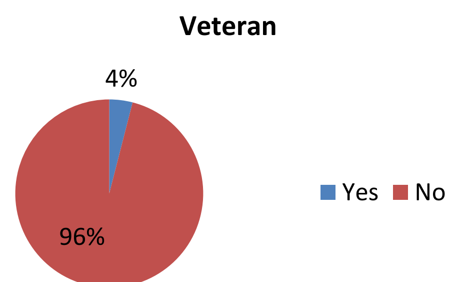












Wellness Center PEI Programs

Transition Age Youth and Older Adults

Program Description

Individuals attending the transition age youth (TAY) and older adult programming located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition age youth (TAY) and older adults are considered critical populations in need of support yet tend to be some of the most difficult to engage. Reasons include issues related to stigma and difficulty with transportation. In an effort to meet the needs of these individuals, the Wellness Center utilizes Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these individuals.

Wellness Center PEI						
Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	4	1,376	20	39	0	**1,439**
Cost Per Person	$584	$584	$584	$584	N/A	**$584**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The transition age youth (TAY) and older adult programing at the Wellness Center transitioned from virtual groups to in person support groups. Additionally, there were several events held at the Wellness Center and in the community.

Tri-City, in partnership with Pomona Youth Prevention Council (PYPC) and local community partners such as the Western University of Health Sciences, Project Sister, Prototypes, and the National Council on Alcoholism and Drug Dependence (NCADD) of East San Gabriel and Pomona Valleys, hosted A Happy Me, A Happy We: Learn to Thrive on April 29, 2023. Hosted at the Western University of Health Sciences, this free half-day symposium provided a safe and supportive space to empower youth and young adults ages 12 to 18 in Pomona, Claremont and La Verne to develop and identify sustainable wellness practices and knowledge to thrive in their respective life paths. This youth symposium

DRAFT

connected the TAY Wellbeing program, as well as other Tri-City PEI programs, to educators, students, parents, and communities with a focus on mental health and wellness.

Another large event held for the community was the annual TAY talent show. Members of the community were able to share their talents at the Wellness Center through music, art, and poetry. The Wellness Center also hosted the Senior Season of Giving event in December 2022. This was the first in person winter holiday event since COVID 2020. The participants were able to reconnect with old friends and socialize with each other. The participants reported feeling happier now that the Wellness Center was open to facilitate in person events.

The TAY programs at the Wellness Center plan to have more groups and events tailored to assist and engage the TAY population. These include future in person groups at Cal Poly University Village (student housing) and a Veterans support group at the University of La Verne. Additionally, the older adult programing plans to have more groups and events tailored to assist and engage the older adults, such as a cooking class and a possible craft/ fashion group. In person meditation and mindfulness groups are also in the planning phase to be held at local senior centers in our service area.

Challenges and Solutions

The Wellness Center TAY program has noticed the TAY population struggle to return to in-person programing. Youth are reporting that they would like to join groups, however struggle with balancing time for work and school. Thus, identifying difficulties with prioritizing mental health needs. A solution to this problem is hosting in-person groups out in the community. During FY 2022-23, collaboration began with Cal Poly Pomona to host an in-person group at one of their sites in the future. Additionally, increased outreach in the community and fostering more connections with the local colleges and other organizations will support TAY in addressing mental health and wellness.

The older adults in the program share that they enjoy the groups, however barriers related to transportation impact their ability to attend. Participants also express excitement about our programs and events prior to the day of the activity, yet on the day of the activity individuals will miss due to reported illness or medical issue. A solution that can have an impact on older adult attendance in the future is designating a driver at the Wellness Center to provide transportation.

Diversity, Equity and Inclusion

The Wellness Center includes Spanish speaking staff and materials, and resources are available for non-English speaking participants. Furthermore, the Center hosts several support groups for non-English speaking individuals.

The TAY and older adult programing offered at the Wellness Center is open to everyone. The TAY Resource Center is a designated safe place to provide support and serve the specific needs of the TAY community. Activities and groups are created based on the needs and requests of the participants. Workshops and events are designed and tailored to meet the interests of the attendees. Staff are also regularly trained on specialized populations, diversity/inclusion, cultural competence, and culture-centered approaches to recovery.

DRAFT

Community Partners

The older adult and TAY programing at the Wellness Center have many internal and external community partnerships that are vital to the sustainability of the program. The Wellness Center collaborates with several entities and senior centers in the service area that support older adults. Outside organizations will also host events or hold meetings at the Center. This has resulted in new participants, as members of the outside groups will then express interest in services and attend internal events.

WC staff regularly collaborate with youth centers to increase outreach to TAY and provide resources. During collaborations with local youth centers, topics of interest are discussed, and programing is developed to present to TAY attendees throughout the three cities. Some focuses of presentations during FY 2022-23 were: the importance of boundaries, forming and maintaining friendships, and relationship issues. New programing will be developed as well related to feedback received from the youth and students. Some areas TAY would like to focus on in the future are challenges managing anxiety and stress, as well as the uncertainty of the pandemic and the economy.

Success Story

A consistent attendee of the older adult groups has historically brought positivity and encouragement to other participants at the Wellness Center. With some encouragement and support from Wellness Advocates and Mental Health Specialists, the individual began to lead their own support groups through an external partner.

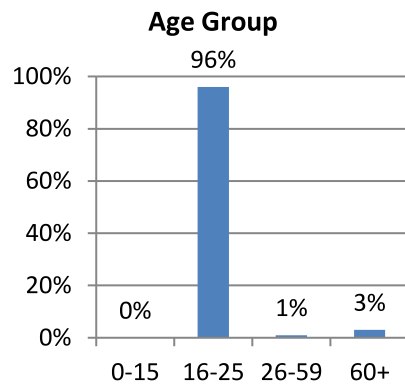
A TAY participant who was initially more reserved in groups and would not actively participate, became more open. Gradually their participation and verbal exchanges increased. The individual shared that they applied to a position in the mental health field.

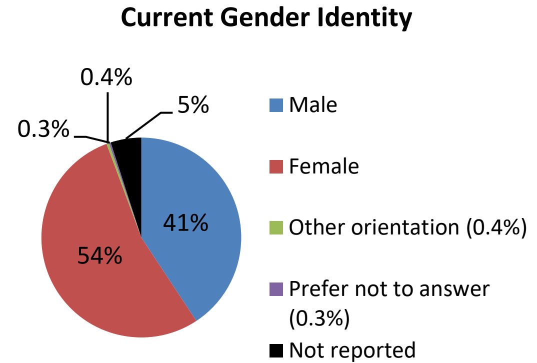
DRAFT

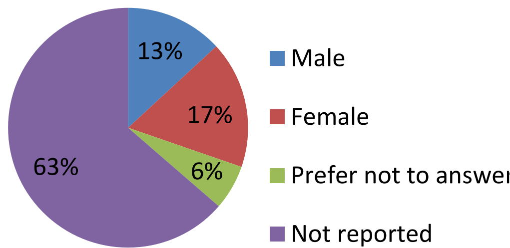
Program Summary

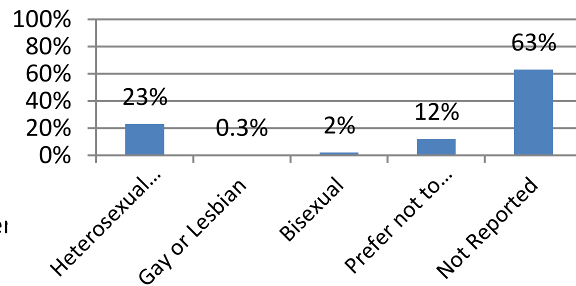
How Much Did We Do?

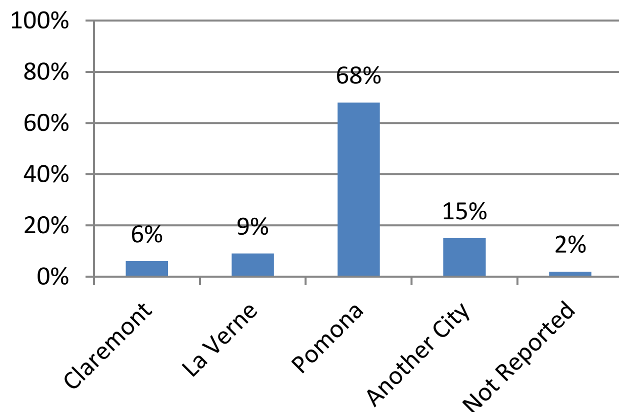
1,439
Individuals attending Wellness Center TAY/Senior

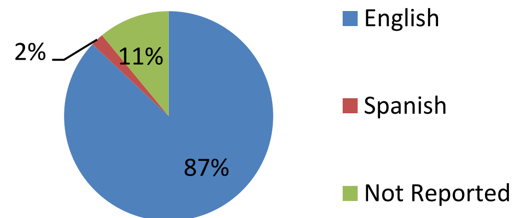


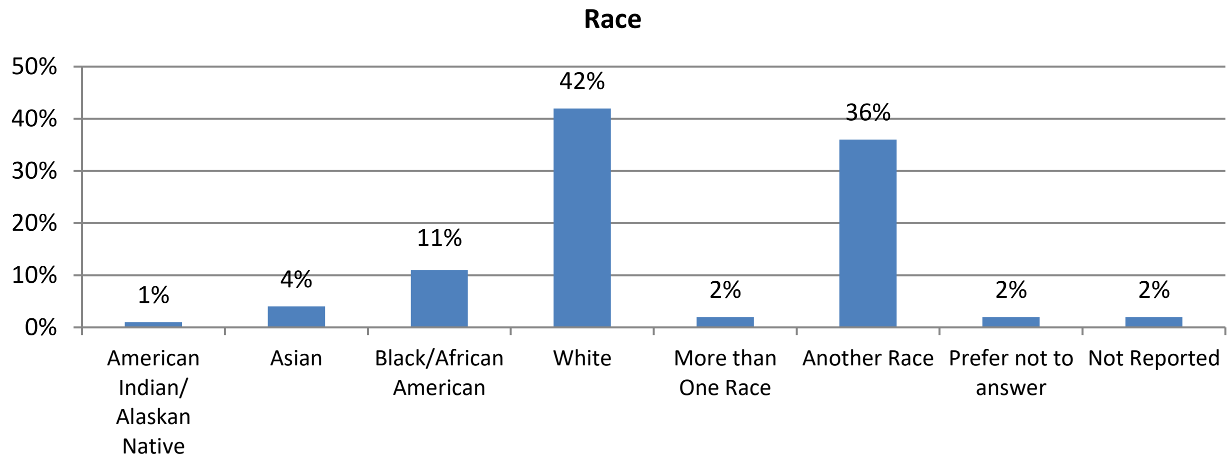


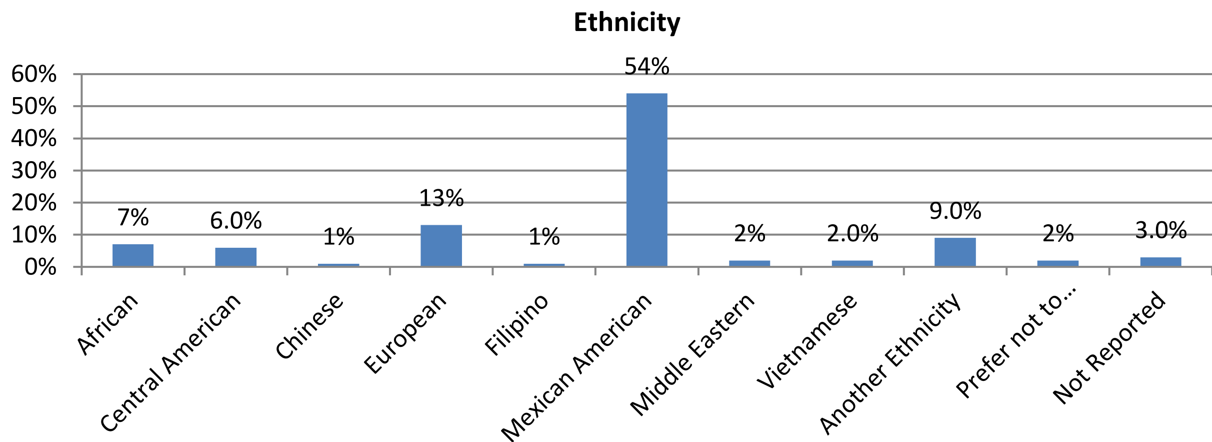


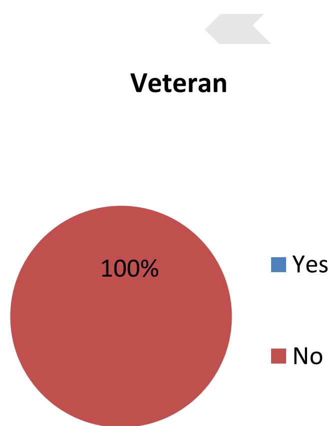


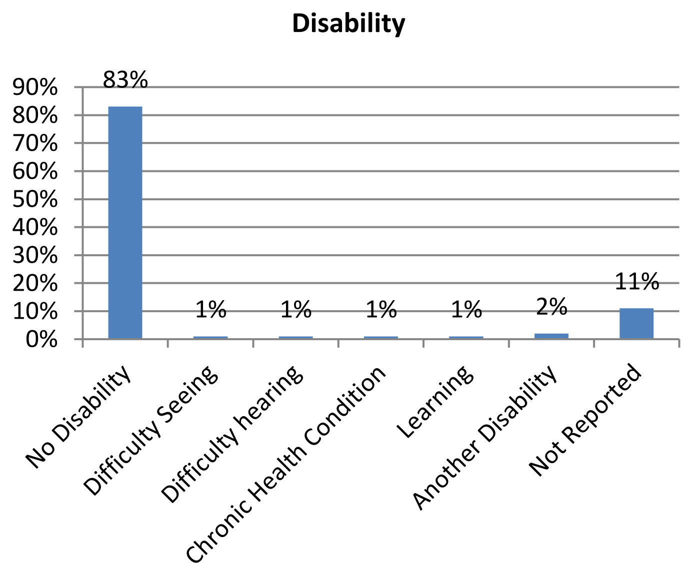





Race
50%
40%
30%
20%
10%
0%
1%
4%
11%
42%
2%
36%
2%
2%
American Indian/ Alaskan Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
7%
6.0%
1%
13%
1%
54%
2%
2.0%
9.0%
2%
3.0%
African
Central American
Chinese
European
Filipino
Mexican American
Middle Eastern
Vietnamese
Another Ethnicity
Prefer not to...
Not Reported

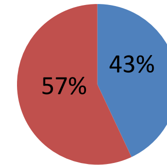

Veteran
100%
Yes
No


Disability
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83%
1%
1%
1%
1%
2%
11%
No Disability
Difficulty Seeing
Difficulty hearing
Chronic Health Condition
Learning
Another Disability
Not Reported

How Well Did We Do It?

4,435
Number of Wellness Center PEI: TAY/Senior Events
(Duplicated Individuals)

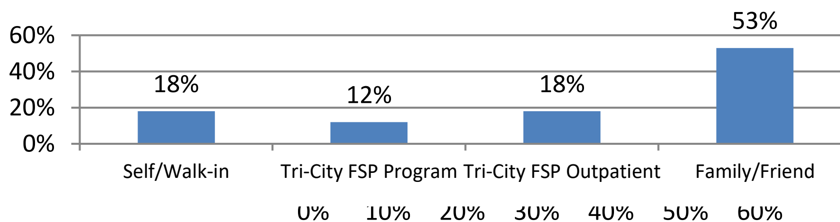
Number of Times People Visited



Group Name	Number of Times Group Was Held	Average Number of Attendees at a Group
Platica Entre Amigos	39	2
Senior Calm	48	3
Senior Socialization	55	3
Senior Bingo	7	2
Senior Virtual Vacation	8	2
TAY – Friendly Feud	40	2
TAY – Breakfast Club	13	1
TAY – Peace of Mind	27	2
TAY – Pizza, Peers and Leadership	31	2
TAY – Real Talk	8	1
TAY – Together We Stand/Fun with Friends	8	1

Contacts by Type	Number of Times Contact was Made
TAY Events	4
TAY – Phone Call - Wellness Calls	3,798

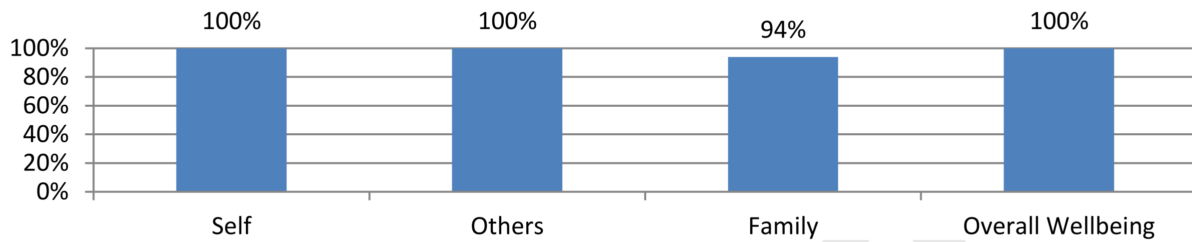
Who referred you to the Wellness Center



100%
Satisfied with the help I get at Wellness Center

DRAFT

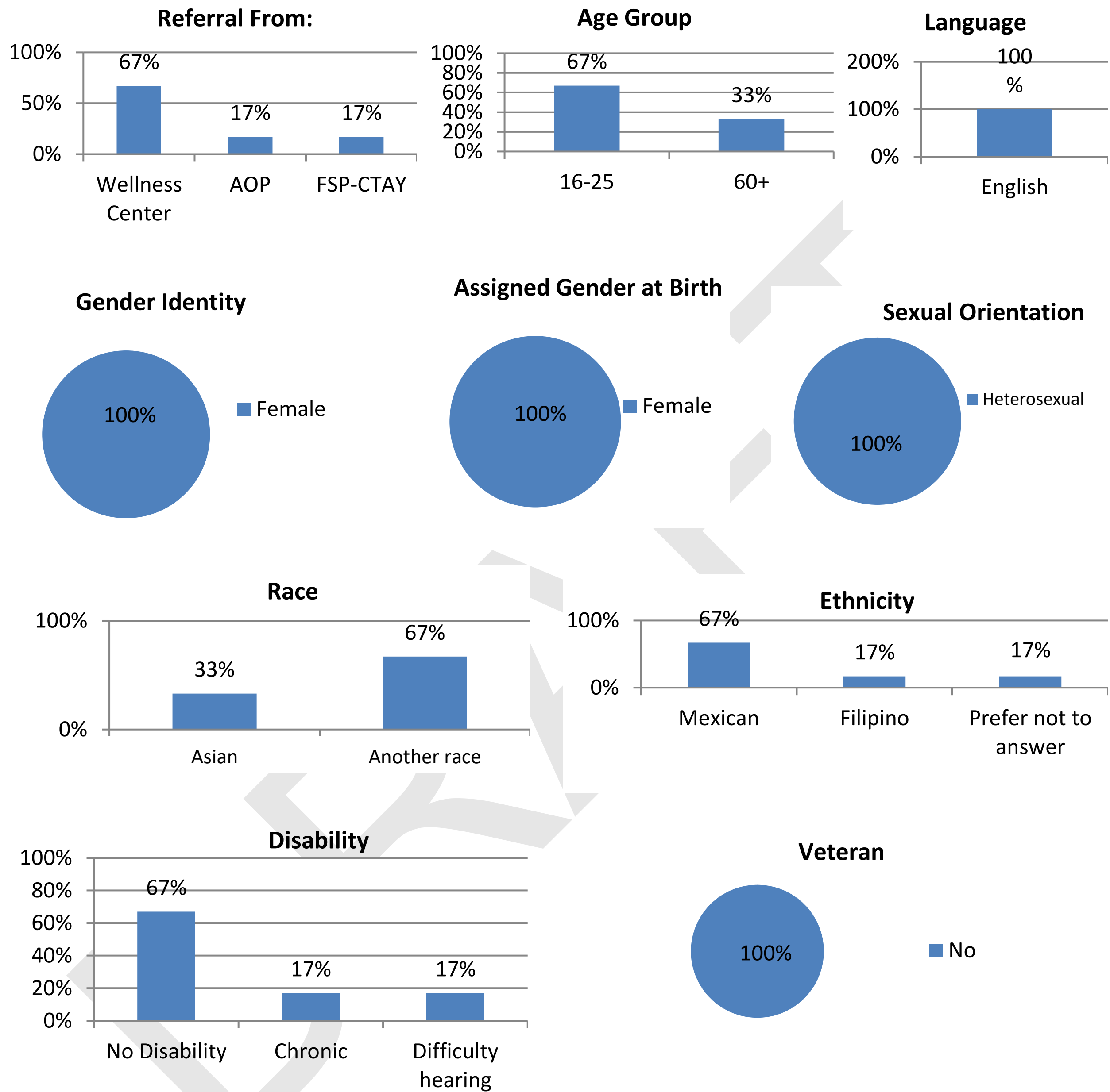
Is Anyone Better Off?



Number of Potential Responders	1,439
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community, Wellness Center
Type of Responders Engaged	TAYs, Adults, Seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

PEI Demographics Based on Referrals



Family Wellbeing Program

Program Description

The Family Wellbeing (FWB) program consists of a dynamic set of programing focused on addressing the needs of families and caregivers of people experiencing mental health challenges. Programing includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g., exercise, cooking) and other interests that can attract family members and caregivers from vulnerable communities into peer-supported experiences. By creating a positive and nurturing support system, family members are provided the knowledge and skills necessary to increase the wellbeing of all members.

Target Population

Family members and caregivers of people who struggle with mental illness, especially those from unserved and under-served communities.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	123	96	255	48	0	**522**
Cost Per Person	$230	$230	$230	$230	N/A	**$230**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

As the Wellness Center began to return to in-person services, the FWB program was able to host in person events and activities. To name a few, the 13th Annual Summer Camp for ages 7-12 returned, which included 4 weeks of programing for children. FWB was also able to commence family movie nights on select Fridays, which included free snacks and beverages. Support during the holidays was also a focus, providing events for the whole family and turkey basket giveaways.

During FY 2022-23, the Family Wellbeing program began to plan for future groups to enhance community support. These include a Mommy and Me class, cooking class, caregivers support group, and karaoke.

DRAFT

Challenges and Solutions

One of the challenges experienced during FY 2022-23 was group attendance. Participants expressed that transportation was a barrier, especially with increased gas prices and lack of funds. Additionally, parents from support groups shared that they were not able to attend groups during the day due to work schedules. Lastly, Kids Zone attendance was low, and feedback included that several of the children were involved with after school activities, impacting group attendance.

A solution to assist with low attendance was moving the group times to accommodate participant's schedules. Which did have a positive impact on attendance. Additionally, Kids Zone created the option for children and families to attend in person or virtually. Providing this option to families led to an increase in attendance.

Diversity, Equity and Inclusion

Family Wellbeing staff are bilingual and diverse in race, ethnic background, cultures, age, and sexual orientation which helps to reduce stigma and barriers to seeking services.

Staff attend various community events to meet with children and families to reduce barriers when accessing mental health services. By engaging families using personal stories of success and asking participants to share their experience in groups, staff attempt to reduce the stigma surrounding mental health services. Staff are also well versed in internal and external community resources, in order to refer appropriately when individuals are seeking support directly related to culture, gender identity, military status or otherwise.

Programing is available in both English and Spanish and Family Wellbeing information brochures are available in both English and Spanish.

Community Partners

Family Wellbeing program collaborates with several internal and external partners within the service area. The Tri-City Children's Outpatient department provided an opportunity for their clients to attend Summer Camp and hold groups at the Wellness Center. LA Care (health plan) has been crucial regarding referrals for families; particularly to United Family group. FWB works closely with the Stigma Reduction and Suicide Prevention programing as well, collaborating on vital prevention and early intervention efforts. Collaborations with Tracks Activity Center (TAC) at El Roble Middle School led to monthly mental health workshops for teens.

These collaborations, among others, support with improving existing groups, creating supportive programs, and planning specialty events for the community.

DRAFT

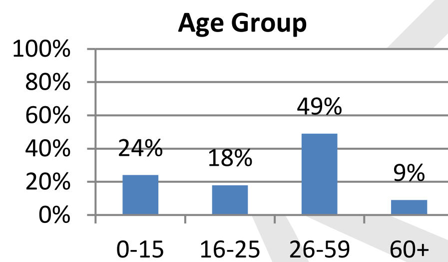
Success Story

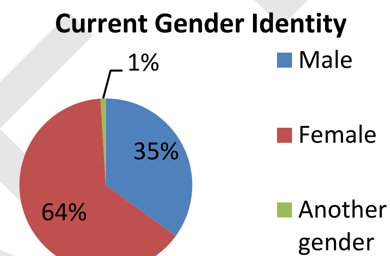
A single parent was required to attend parenting classes in order to gain full custody of their child. This young parent experienced feeling overwhelmed and hopeless. They began to attend the group, sharing frustrations related to the case and looking forward to the closure. The individual shared about difficulties related to being a single parent and the amount of responsibility that comes with that role. After a long process, and much commitment and follow through by the individual, they were granted full custody of their child.

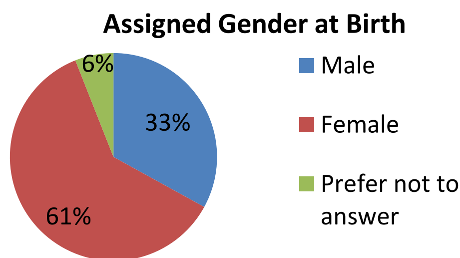
Program Summary

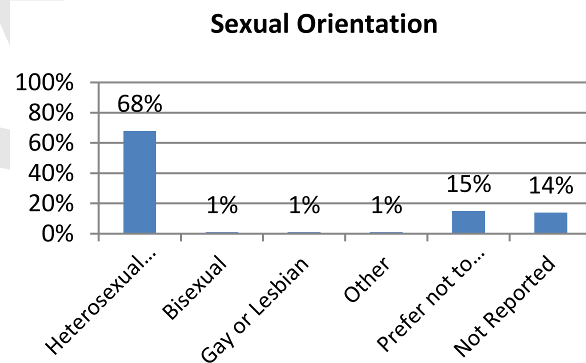
How Much Did We Do?

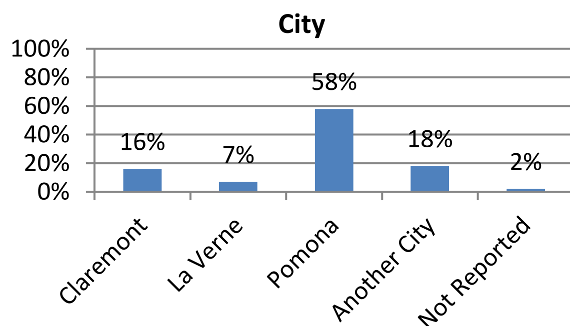
522
Individuals attending Family Wellbeing

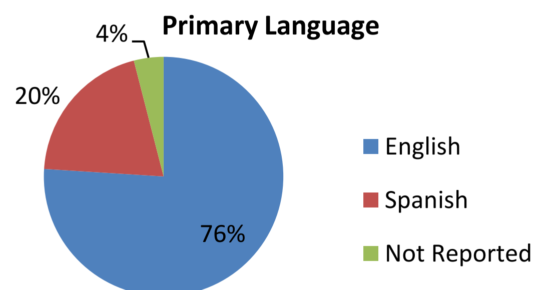


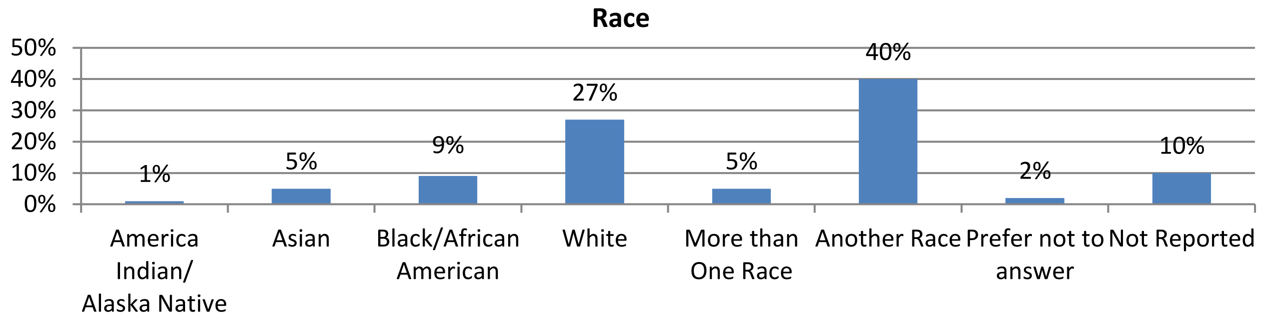


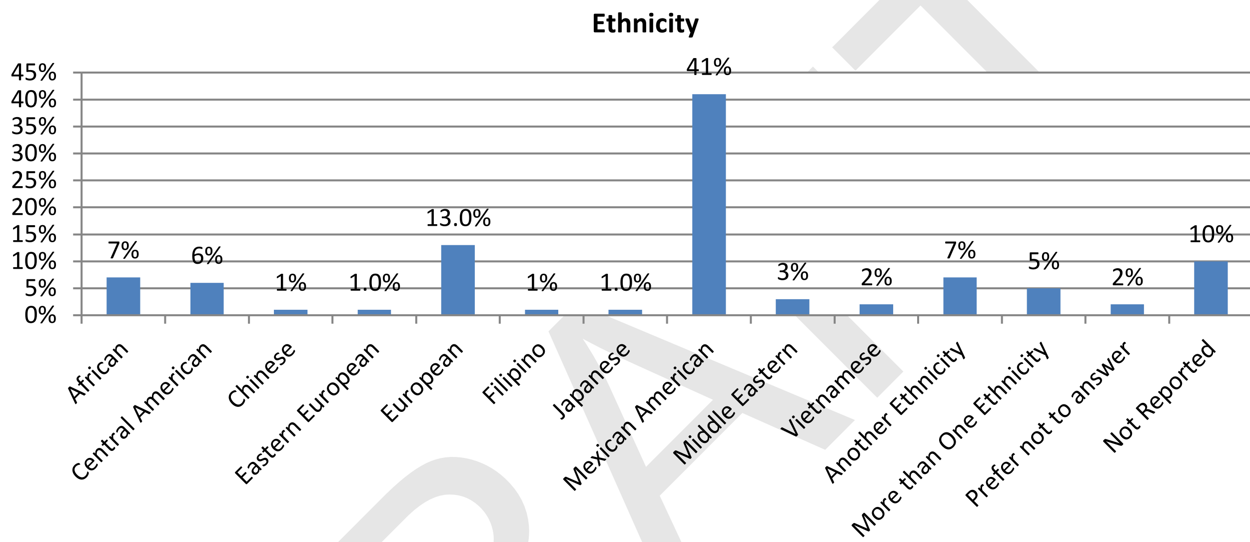


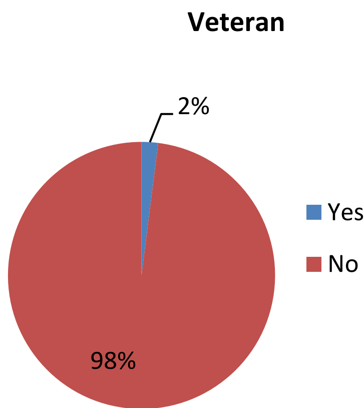


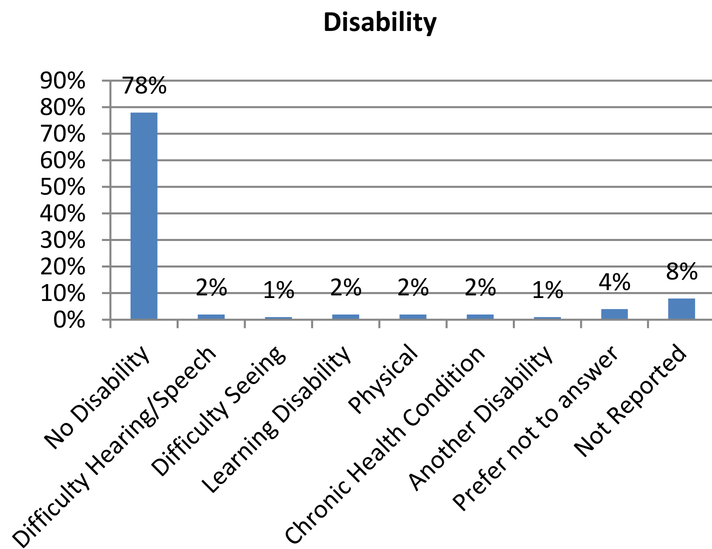





Race
50%
40%
30%
20%
10%
0%
1%
5%
9%
27%
5%
40%
2%
10%
America Indian/ Alaska Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported

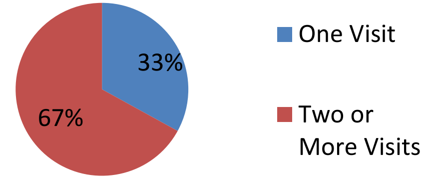

Ethnicity
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
6%
1%
1.0%
13.0%
1%
1.0%
41%
3%
2%
7%
5%
2%
10%
African
Central American
Chinese
Eastern European
European
Filipino
Japanese
Mexican American
Middle Eastern
Vietnamese
Another Ethnicity
More than One Ethnicity
Prefer not to answer
Not Reported


Veteran
2%
98%
Yes
No


Disability
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
2%
1%
2%
2%
2%
1%
4%
8%
No Disability
Difficulty Hearing/Speech
Difficulty Seeing
Learning Disability
Physical
Chronic Health Condition
Another Disability
Prefer not to answer
Not Reported

How Well Did We Do It?

6,998
Number of Family Wellbeing Events
(Duplicated Individuals)

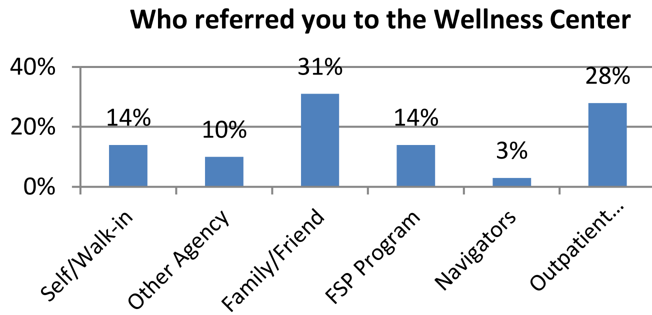


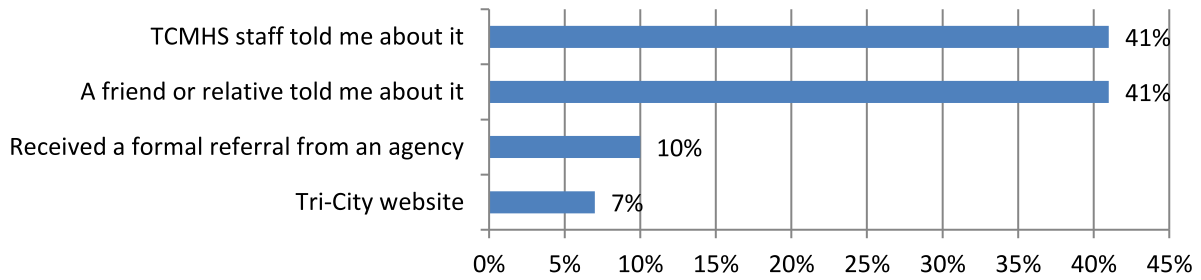
Group Name	Number of Times Group Was Held	Average Number of Attendees at a Group
Arts and Crafts	64	3
Grief & Loss	62	6
Kid's Hour	56	2
Limited to Limitless	65	3
Spirituality	56	4
Summer Camp	9	4
Teen Hour	55	3
United Family	177	5
Walking Adventures	4	3

Contacts by Type	Number of Times Contact was Made
Attendance Letter	241
One-on-One	22
MHSA PEI Referrals	148
Other	335
Phone Call/Email	3,819
FWB Event	81

DRAFT

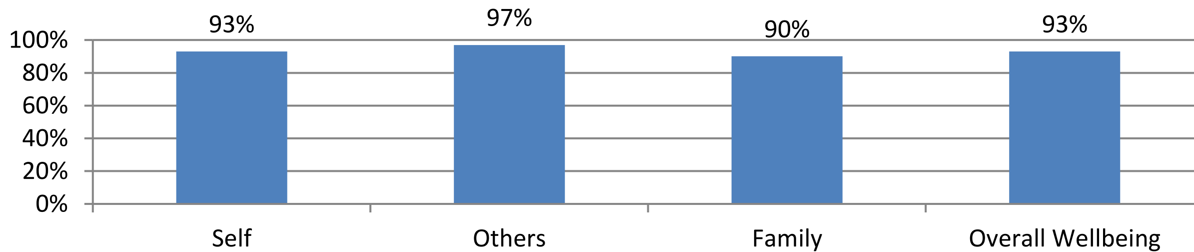
100%
Satisfied with the help I get at Family Wellbeing Program





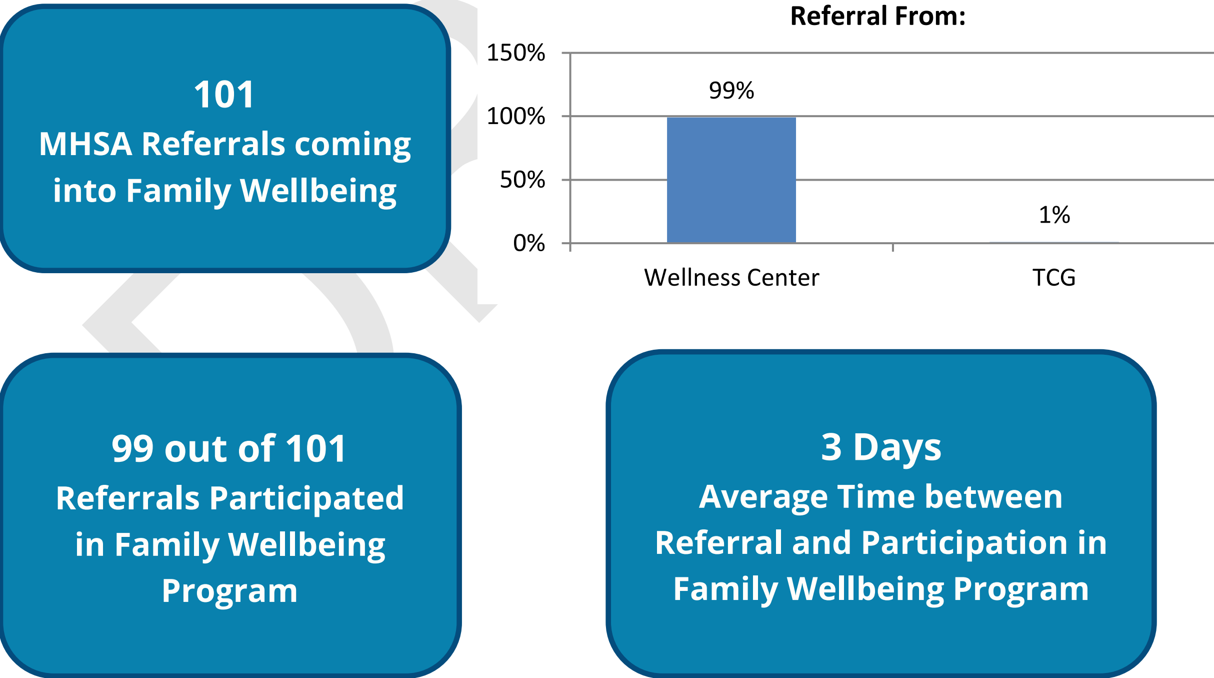
Is Anyone Better Off?

Percent of people who report improved relationships with the following because of the help they get from the Family Wellbeing Program:

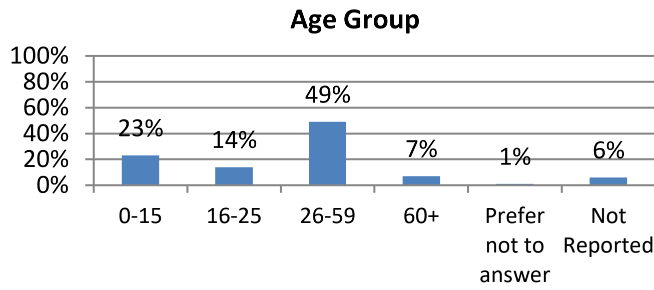


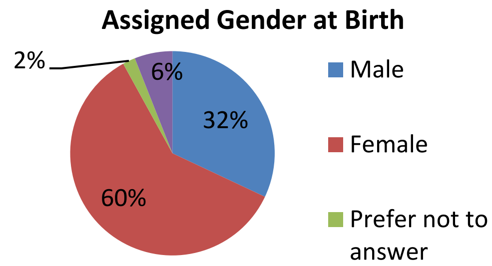
Number of Potential Responders	522
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community, Wellness Center
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

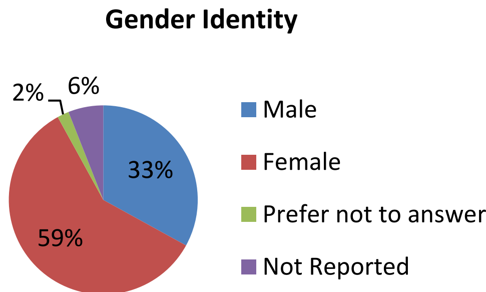
Timely Access to Services for Underserved Populations Strategy

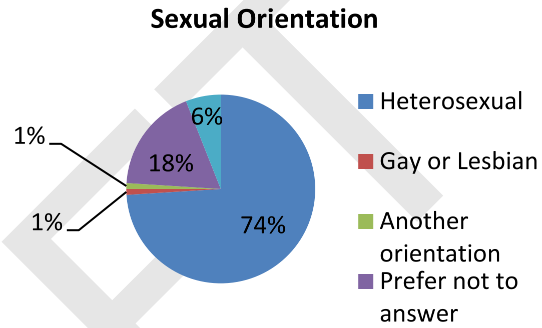


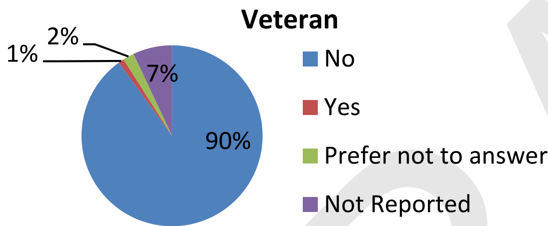
PEI Demographics Based on Referrals

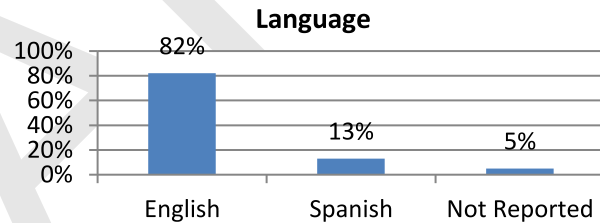


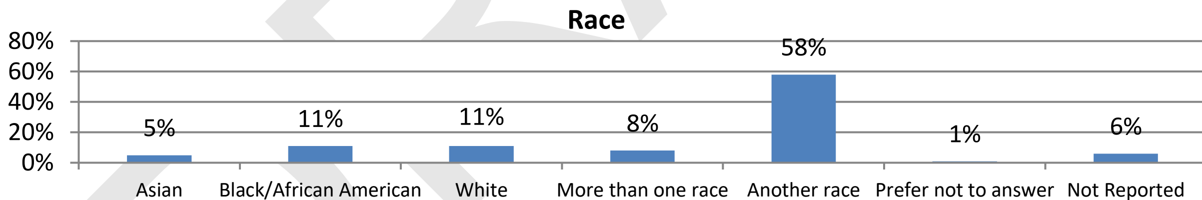


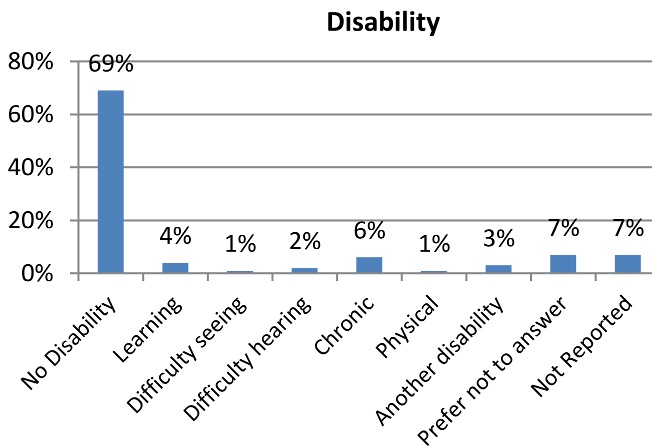


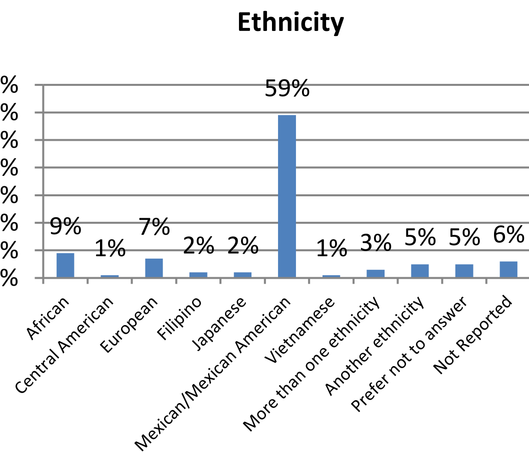












Community Capacity Building

NAMI Ending the Silence and NAMI 101

Program Description

Ending the Silence and NAMI 101 are community presentations offered by the National Alliance on Mental Illness (NAMI) and provide an overview of emotional disorders and mental health conditions commonly experienced among children, adolescents and youth.

Ending the Silence is a 50-minute program designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

The second presentation, NAMI 101, is designed to strengthen program participants' knowledge while providing a more solid development of skills through structured content. The topics to be covered in NAMI 101 include: an overview of what mental illness is; how to maintain wellness; how to identify symptom triggers; how to identify a support system; mental health warning signs; empathy; boundary setting; and self-care.

Target Population

Both programs target middle and high school students; teachers and school staff; and adults with middle or high school youth.

Number of Presentations	3	Total Number Served FY 2022-23	359

Program Update

Throughout FY 2022-23 NAMI was able to strengthen their support group facilitation team and continued to strengthen relationships with other local entities and schools to bring more presentations to our students and community members.

NAMI also focused on continuing to support our Spanish language programing. A Spanish version of the Family-to-Family group has not been held in recent years, so plans to bring this back to the community is a current goal.

Progress has been made in bringing on three new facilitators and additional peers have also joined the team. These individuals have valuable stories, lived experience and knowledge that can enhance the learning experience and activities during the presentations.

DRAFT

Challenges and Solutions

A challenge for NAMI currently is capacity. Working with a small team has many advantages, conversely, it also makes it difficult to accommodate everything that is set out to be accomplished. For example, NAMI is experiencing difficulties actively and sustainably expanding their programing to reach more underserved populations.

A solution that has supported the program in meeting this challenge is connecting with and training individuals who represent underserved populations. They have also increased outreach and actively building relationships with organizations who directly support individuals in underserved populations. There has also been an increase in outreach specifically for recruiting volunteers.

Diversity, Equity and Inclusion

NAMI 101 and the Ending the Silence program are available in both English and Spanish and are facilitated by a diverse set of trainers who incorporate concepts such as how cultural difference can contribute to mental health conditions and/or signs and symptoms not being addressed or acknowledged. Training materials are also available in Spanish. Additionally, some trainers identify as having lived experience. NAMI partners with several external entities that support older adults and veterans and is equipped to provide referrals and resources to these entities when needed.

Success Story

NAMI and its participants were able to engage with equine learning and animal therapy with Paws 4 Success. The focuses of these trainings are effective communication and boundaries. This collaboration brings an exciting and effective opportunity for families as they engage in a truly unique modality.

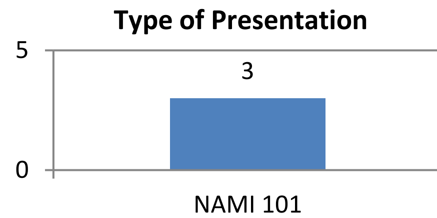
DRAFT

Program Summary

How Much Did We Do?

3 Presentations

359 Attendees



How Well Did We Do It?

264 Surveys Completed

96%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges.

94%
Agreed or strongly agreed that the presentation will help me recognize early warning signs of mental health challenges.

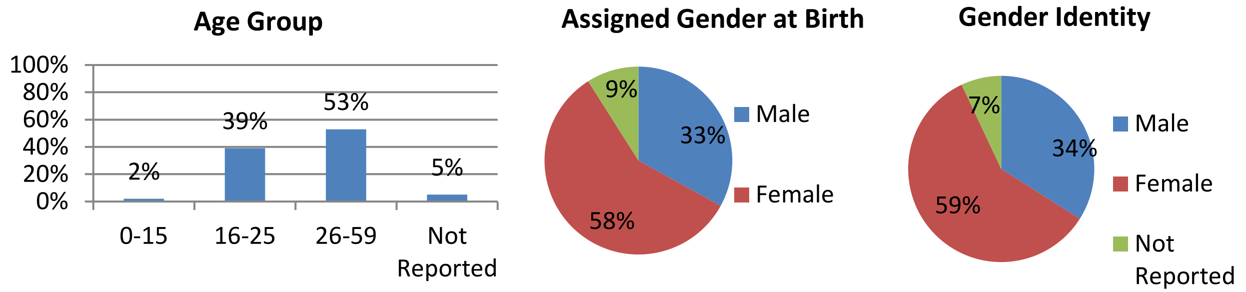
Is Anyone Better Off?

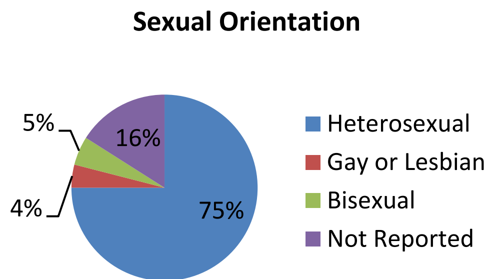
91%
Agreed or strongly agreed that the presentation provided me with new and useful resources.

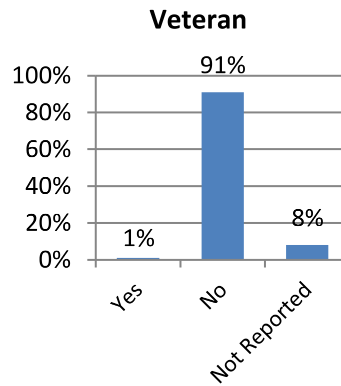
96%
Agreed or strongly agreed that the presentation helped me understand the impact of untreated mental health challenges.

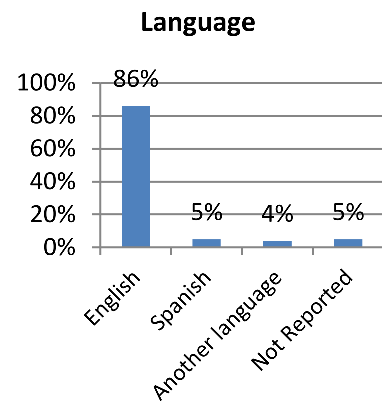
DRAFT

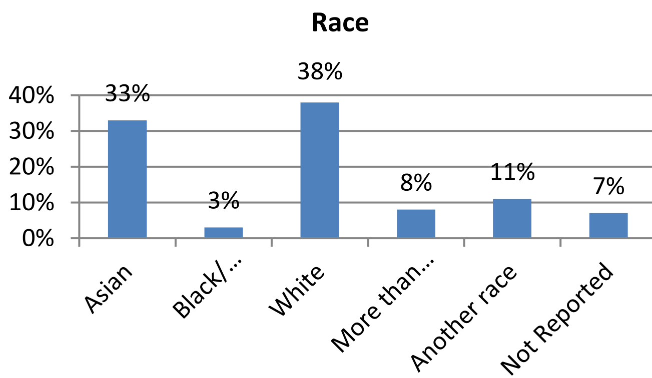
Demographics from Surveys Completed by Participants

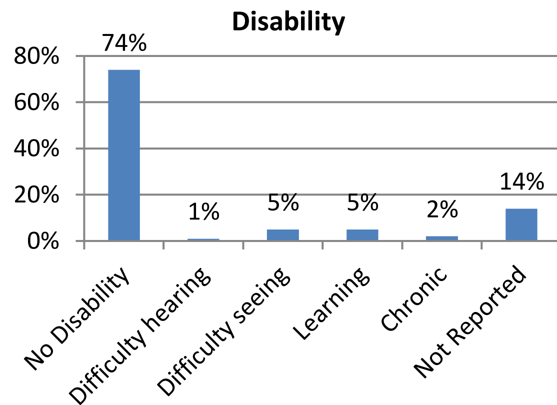


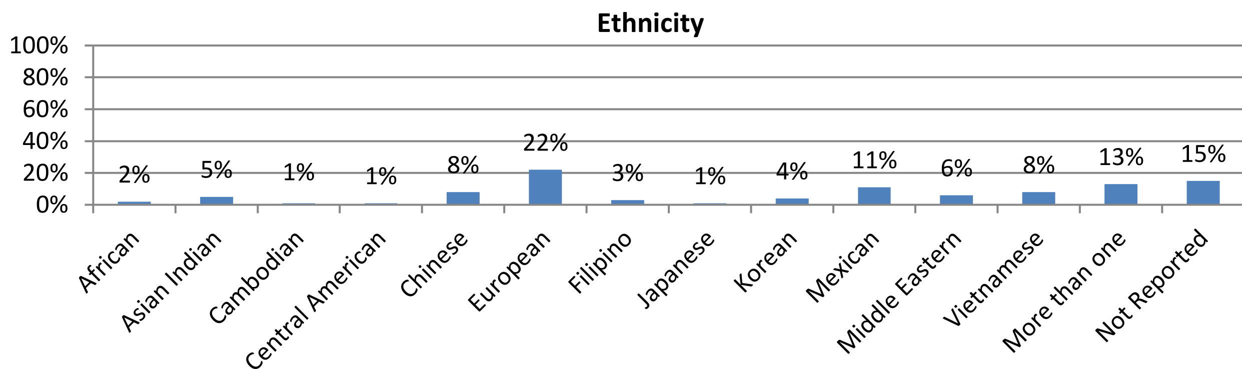












Number of Potential Responders	359
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Parents and teachers
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

Timely Access to Services for Underserved Populations Strategy

There were 0 MHSA referrals to NAMI

DRAFT

Housing Stability Program

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health and overall wellness. Tri-City Housing Division (HD) staff work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program (HSP) is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Landlords, property owners and property managers in the Tri-City area who could have tenants experiencing mental illness who need support to maintain their current housing or to find a more appropriate place of residence. Program staff work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

New Landlords Engaged	Landlord Hour Meetings Held	Attendees (Unique)	Repeat Attendees (Duplicates)
13	3	4	4

Program Update

The HSP participated in the planning sessions and resource fair for *A Happy Me, A Happy We: Learn to Thrive*, Youth Wellness Symposium, in partnership with other PEI programs and local community partners. A series of informational flyers were created geared towards the transition age youth. The housing team engaged the young people by inquiring about post grade school plans. The HSP shared the reality of housing cost and level of responsibility that comes with independent living to help them create realistic goals and consider benefits of increasing their income via higher learning or career programs. They were also reminded of roommate options and spent some time considering what makes an appropriate roommate. Following the symposium, new handouts were created to highlight the information presented to the TAY and use in the future.

The Housing Division will be taking the Roommate 101 training developed for the Permanent Supportive Housing (PSH) sites and expand it to group format for the community. Edits will be made to tailor it to the TAY population and identify additional locations to present the information. Staff plan on tailoring the 9-week Good Tenant Curriculum to be more appealing and interesting to the TAY population.

DRAFT

Challenges and Solutions

The Housing Division staff position that oversees the Housing Stability programs was vacant at the beginning of FY 2022-23. Tri-City were able to hire new staff in August 2022, however the position was vacant again 8 months later. With reduced staff in this area, the Landlord Hour and Good Tenant Curriculum groups at the Wellness Center and at Cedar Springs were paused. Groups are intended to commence once new staff are hired again. Some solutions that aided in addressing the challenges was support from Residential Service Coordinators (RSCs). The RSC at the TAY housing location was able to continue presenting information on the Good Tenant Curriculum at their site. Also, recruitment for the vacant position began immediately so that the groups could be brought back as quickly as possible.

Diversity, Equity and Inclusion

The Housing Stability Program offers fair housing to all clients and their families regardless of status. In addition, the Housing Division staff are trained in cultural competency, stigma reduction, and aware of fair housing law. Staff are bilingual in English and Spanish. The language line is available as well if assistance is needed in a different language. Communication is maintained by distributing flyers in multiple languages throughout the sites.

Staff are aware of resources pertaining to specialized populations, referral processes and accommodations. Older adults who may not feel comfortable with technology are able to have their services in-home.

Monthly meetings, Mental Health First Aid training and stigma reduction training are offered to landlords, owners, and property managers to help them better understand and support individuals with mental illness.

Community Partners

In addition to referrals made within Tri-City's own departments, the Housing Division staff work collaboratively with outside community partners including landlords in the community, Volunteers of America, Catholic Charities, Family Solutions, Union Station, Pomona Housing Authority, sober livings, Los Angeles County Development Authority, Housing Rights Center, Neighborhood Legal Services, House of Ruth, Pomona Youth Prevention Council and Just Us 4 Youth. These entities, among others, work in collaboration with HSP in order to provide/receive referrals, educate/empower tenants, support landlords and property managers in appropriately recognizing and responding to individuals with symptoms of mental illness and provide additional resources inside and outside of Tri-City.

Success Story

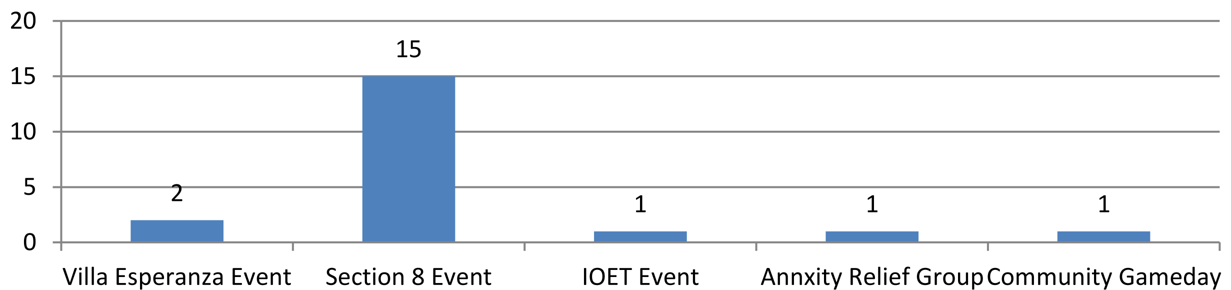
A Happy Me, A Happy We: Learn to Thrive, Youth Wellness Symposium was a great success for the community, external partners, and the HSP. Students were able to view life after high school through a more thoughtful lens. With this new perspective, students took into consideration all that is needed

DRAFT

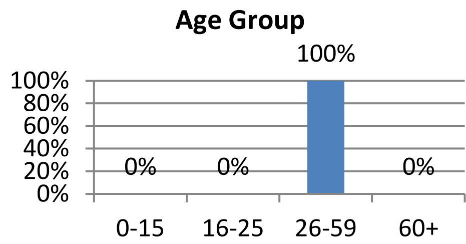
to live independently. Discussions about career advancement, college degrees, increasing income and considering living with family or roommates were highlighted. The event itself was a success, furthermore, new documents were created specifically for TAY who are approaching stages where more independence is being sought, with a realistic take on what it means to obtain and sustain that independence when it comes to housing.

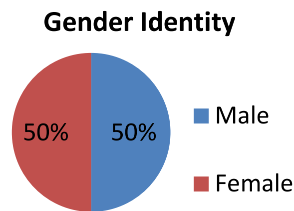
Program Summary

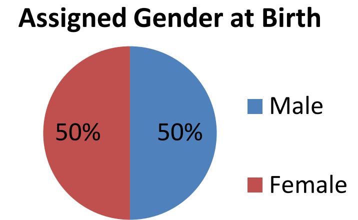
How Much Did We Do?

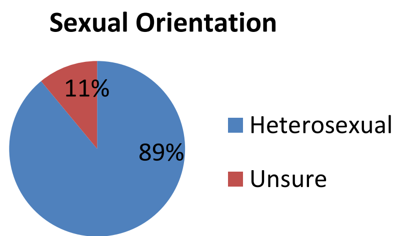


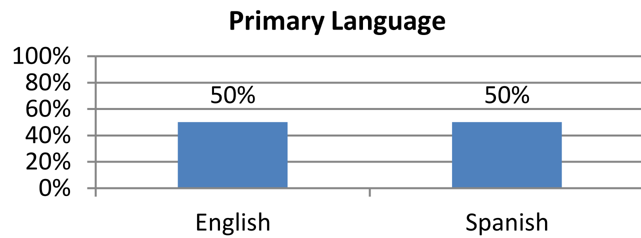
PEI Demographics

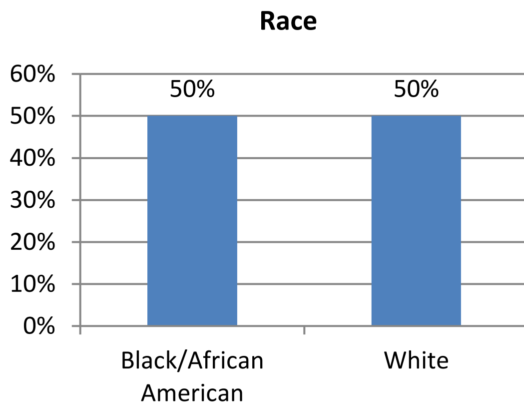


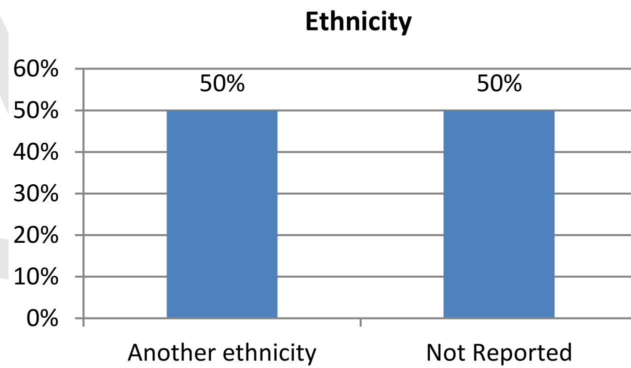


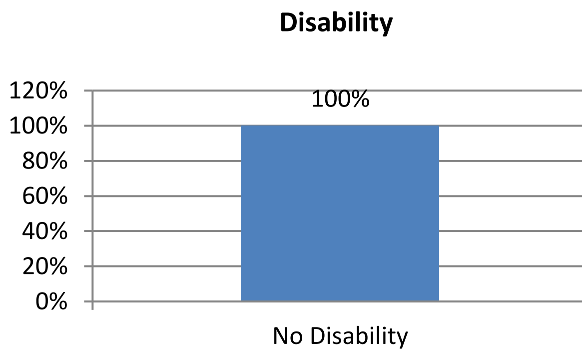


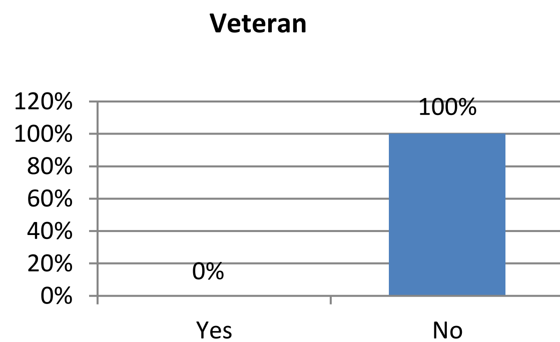






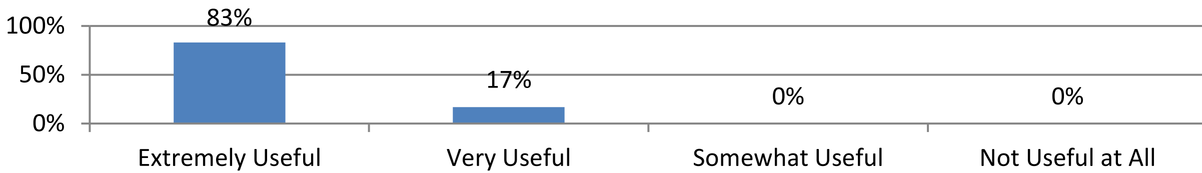




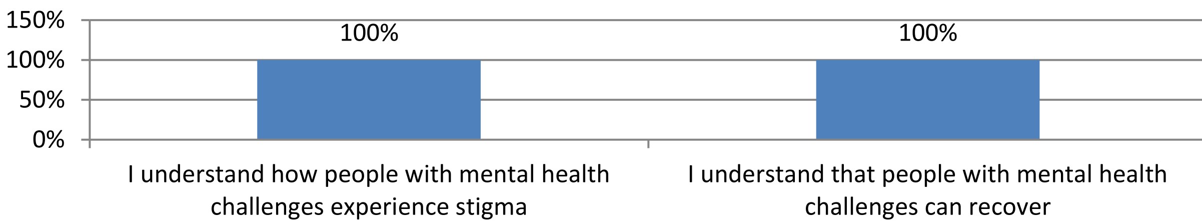


How Well Did We Do It?

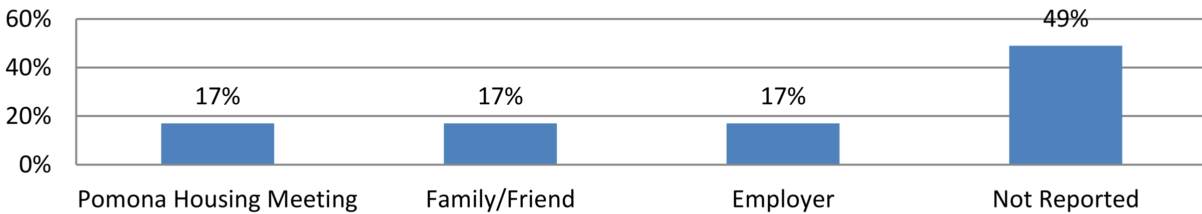
Landlord Hour attendees ratings of how useful the information was from the event.



Percent of Landlords that agree or strongly agree with the following:

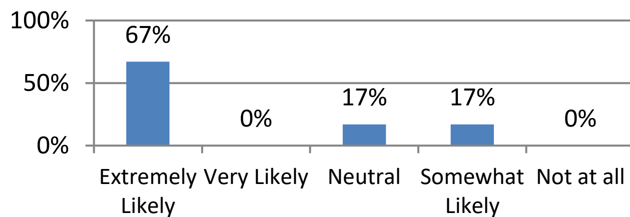


Landlord - How did you hear about us:

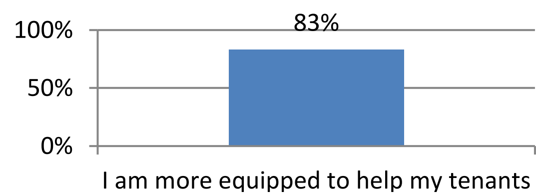


Is Anyone Better Off?

How likely are you to reach out to Tri-City, if you suspect someone has a mental health challenge:



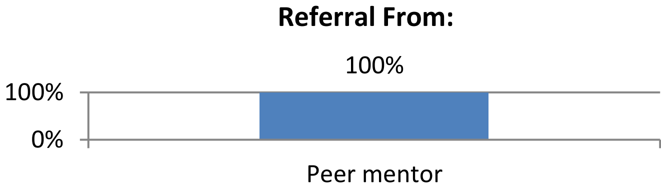
Percent of participants, as a result of this training:



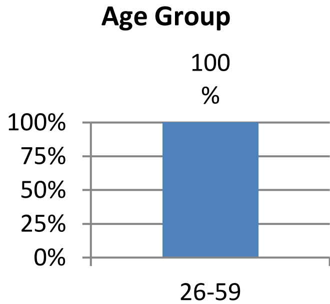
Number of Potential Responders	100
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

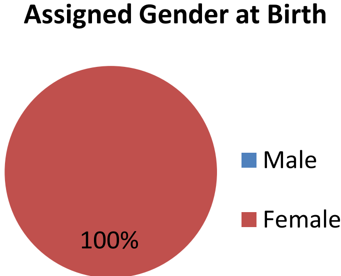
Timely Access to Services for Underserved Populations Strategy

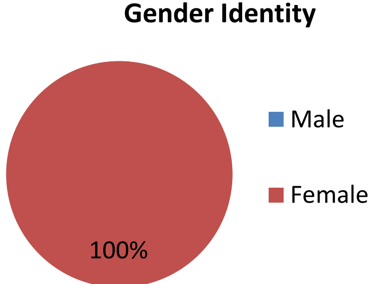
1
MHSA referral into Housing Stability



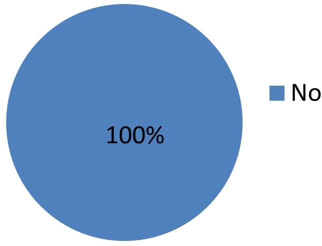
PEI Demographics Based on MHSA Referrals



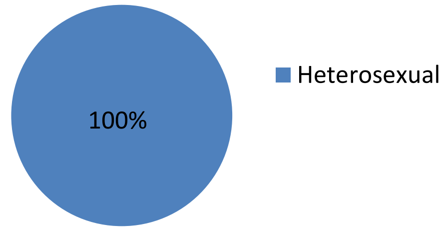




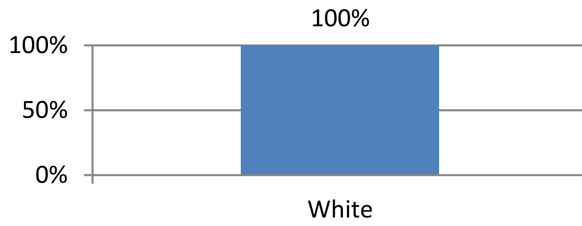
Veteran



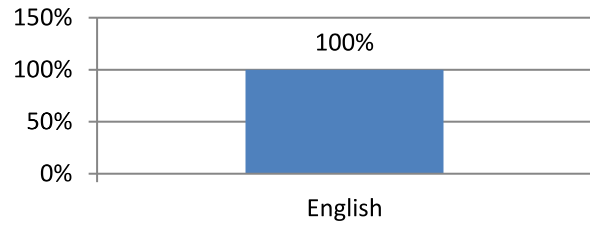
Sexual Orientation



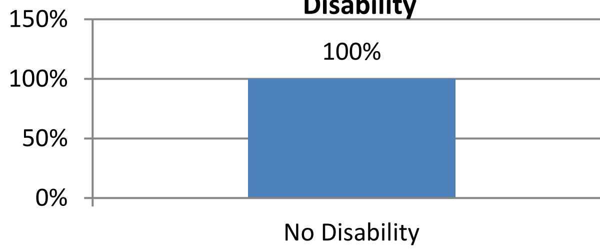
Race



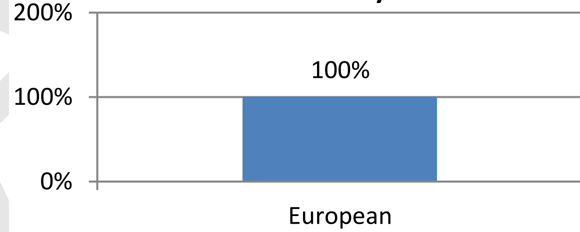
Primary Language



Disability



Ethnicity



Therapeutic Community Gardening

Program Description

The Therapeutic Community Gardening program utilized therapeutic horticulture, a process of incorporating the relationship between individuals and nature as a form of therapy and rehabilitation with the goal of decreasing isolation and increasing mental health benefits through gardening activities and group therapy exercises. The Garden offers the perfect setting for promoting mindfulness, healing, resiliency, support, and growth for participants. Gardeners learn to plant, maintain, and harvest organic fruits, vegetables, flowers, and other crops for therapeutic purposes and symptom management. TCG staff includes a clinical program manager, clinical therapist, mental health specialist and community garden farmer.

Target Population

Community members including unserved and underserved populations, adults, transition age youth, families with children, older adults, and veterans.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	4	31	93	33	56	**217**
Cost Per Person	$2,163	$2,163	$2,163	$2,163	$2,163	**$2,163**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

The majority of TCG reoccurring groups were held virtually. As such, harvest pick-ups and drop offs were provided to participants to maintain engagement with plant materials for self-soothing or mindfulness techniques. While the groups were virtual, several in person workshops and events were offered at Tri-City and throughout the service area at community partner's sites. Outreach in FY 2022-23, increased by a total of 1,250 more people than the program was able to outreach in the previous fiscal year.

The team collaborated with TCG participants and the landscape architect to solidify plant and tree selection for the garden rejuvenation project. The project broke ground in May 2023 and the community looks forward to an opening of a new garden for therapeutic horticulture activities.

DRAFT

The TCG partnered with Tri-City psychiatrists to allow medical resident rotations the ability to shadow TCG groups to learn about the application of therapeutic horticulture.

After the completion of the garden beautification project, the goal will be to increase in person groups, create new interactive groups that incorporate movement (i.e., dance, walking) and the garden, and create a group specifically geared to the LGBTQIA+ community.

Challenges and Solutions

Construction began in the garden which limited availability of harvests to provide to participants. Another challenge was the lack of participation in certain groups (TAY and Family groups) as this demographic has been difficult to outreach, enroll, and maintain. Lastly, participants struggled at times accessing virtual groups and navigating the platform.

One solution to the challenges presented is the reopening of the garden. With an in-person option in a natural setting, attendance is predicted to improve in both family and TAY groups. Historically, attendance has been better with these demographics when the sessions take place in the garden. Additionally, the team engaged in outreach and events geared towards child and TAY populations with the goal of enrolling participants. To trouble shoot the technology barriers, TCG worked one-on-one with individuals to ensure access to virtual groups.

Diversity, Equity and Inclusion

The TCG specifically collaborates with agencies that target groups such as TAY, children, families, Veterans, older adults and the LGBTQIA+ community. When harvest is available, a food security program exists that provides excess produce to community members and agencies in need. Staff regularly attend cultural competence trainings and its staff are bilingual in both English and Spanish. A staff member is also the chair of the RAINBOW Advisory Council, bringing inclusion and diversity to the department and approaches to imbed into weekly curriculum provided to the community.

Community Partners

The Therapeutic Community Garden staff network and collaborate with a multitude of community partners and organizations. Examples include 1) local food banks where garden produce in shared in support of their food insecurity programs, 2) annual events with Cal Poly Pomona Veterans Resource Center targets veterans and their families, offering wellness support through free TCG groups, 3) outreach with Pomona Unified School District targeting Children and TAY youth as well as their families, 4) partnered with Tri-City psychiatrists to arrange for medical residents on a psychiatry rotation an opportunity to shadow and learn about the application of therapeutic horticulture.

Other examples of organizations in which TCG engages in strong community partnerships are: Sustainable Claremont, Casa Colina Hospital and Centers for Healthcare, Lopez Urban Farm, Bridge the Gap, Traumatic Brain injury- Outreach, DA Center for The Arts, California Horticultural Therapy Network, Pomona Pride Center and animal therapy agencies. Interactions proposed for these events

DRAFT

include workshops, outreach, group referrals, seedling donation and produce donations to community agencies.

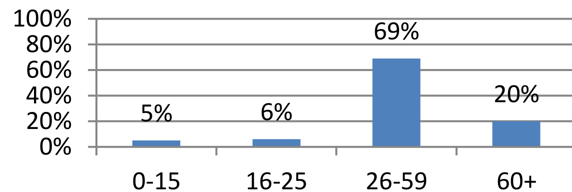
Success Story

One individual from a Spanish speaking group disclosed positive outcomes from attending TCG groups and events. This individual reported feeling a sense of community and enhanced socialization. They also disclosed that the therapeutic horticulture groups provide an enjoyable experience that they are able to look forward to on a weekly basis. As this person's social and emotional wellness has been impacted, per participant report, their overall mental health has improved. Additionally, the participants expressed that they have made progress in overall symptom management since joining the group. Overall, they feel more connected to themselves, others, and the natural environment.

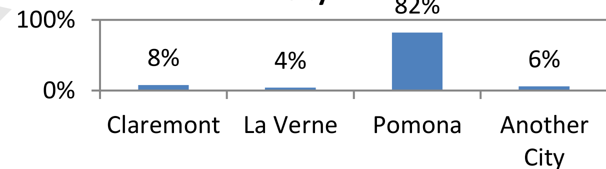
Program Summary

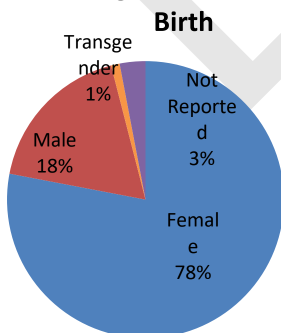
How Much Did We Do?

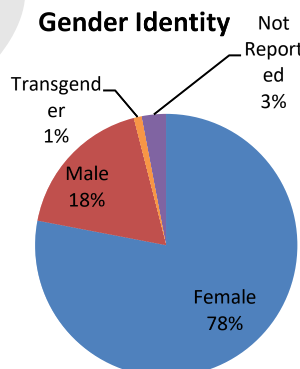
85
Participants Enrolled in TCG Program

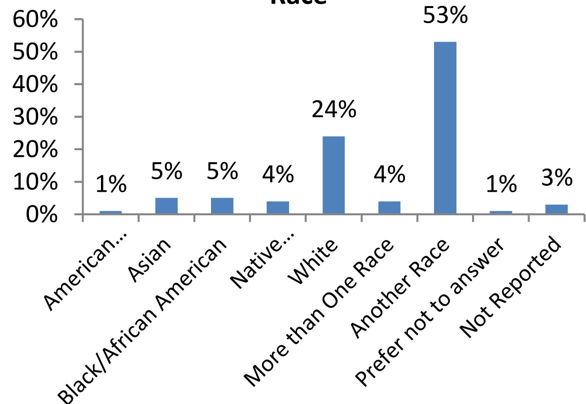


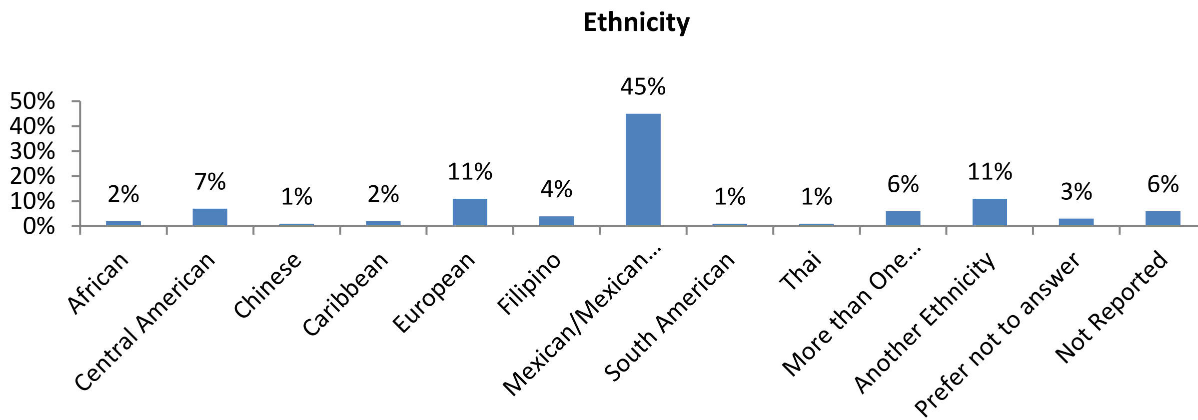
8 Months
Average Length of Time Participants Enrolled in TCG

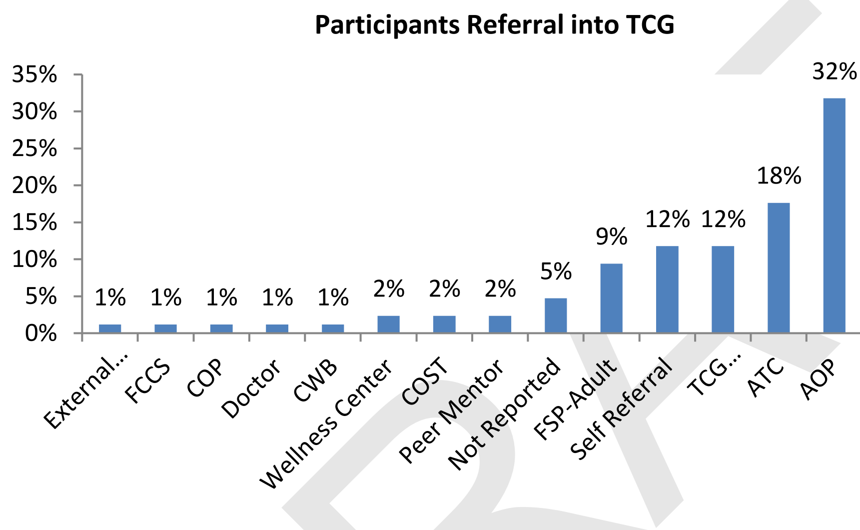


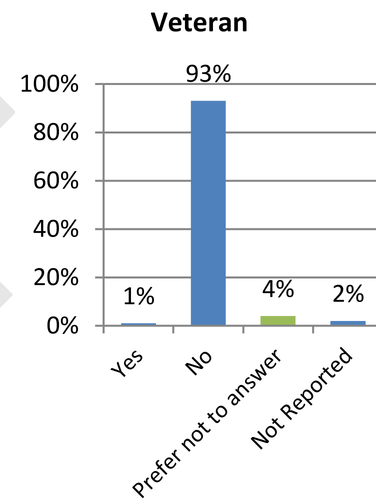


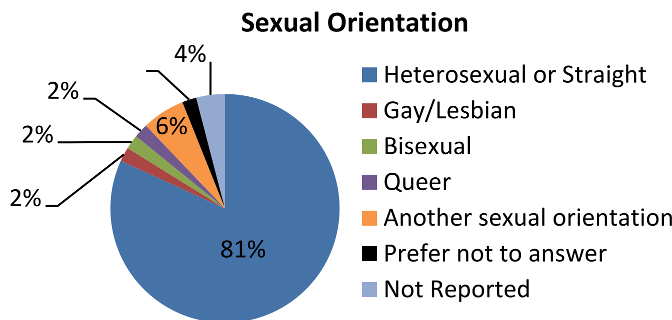


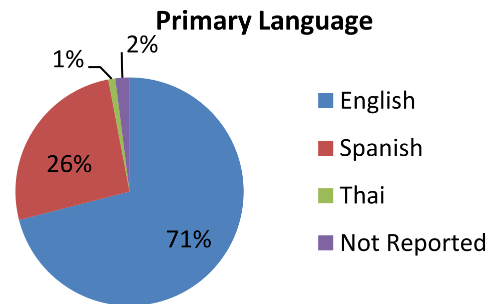


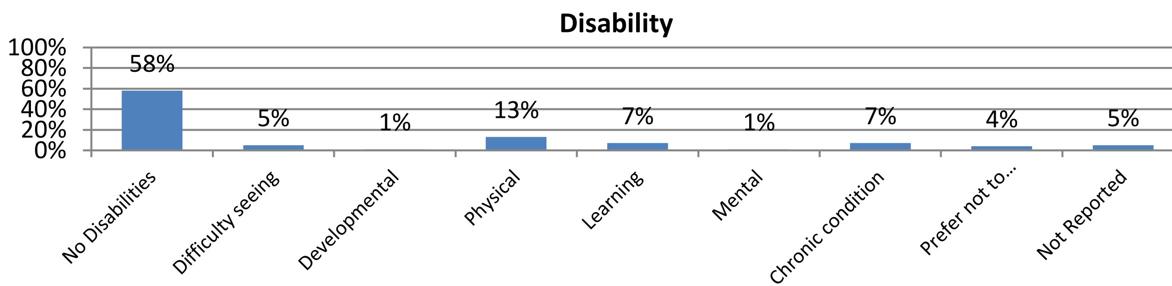

Ethnicity
50%
40%
30%
20%
10%
0%
2%
7%
1%
2%
11%
4%
45%
1%
1%
6%
11%
3%
6%
African
Central American
Chinese
Caribbean
European
Filipino
Mexican/Mexican...
South American
Thai
More than One...
Another Ethnicity
Prefer not to answer
Not Reported


Participants Referral into TCG
35%
30%
25%
20%
15%
10%
5%
0%
1%
1%
1%
1%
1%
2%
2%
2%
5%
9%
12%
12%
18%
32%
External...
FCCS
COP
Doctor
CWB
Wellness Center
COST
Peer Mentor
Not Reported
FSP-Adult
Self Referral
TCG...
ATC
AOP


Veteran
100%
80%
60%
40%
20%
0%
1%
93%
4%
2%
Yes
No
Prefer not to answer
Not Reported


Sexual Orientation
4%
2%
2%
2%
6%
81%
Heterosexual or Straight
Gay/Lesbian
Bisexual
Queer
Another sexual orientation
Prefer not to answer
Not Reported

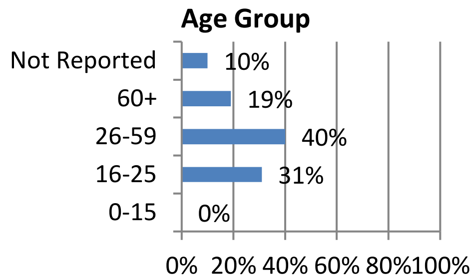

Primary Language
1%
2%
26%
71%
English
Spanish
Thai
Not Reported

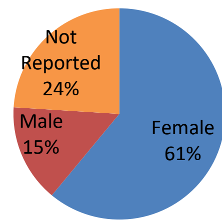

Disability
100%
80%
60%
40%
20%
0%
58%
5%
1%
13%
7%
1%
7%
4%
5%
No Disabilities
Difficulty seeing
Developmental
Physical
Learning
Mental
Chronic condition
Prefer not to...
Not Reported

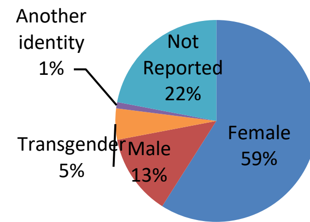
TCG Workshop/Events (Survey Demographics n=85)

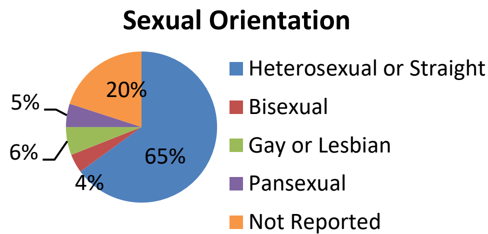
16 Workshop/Events

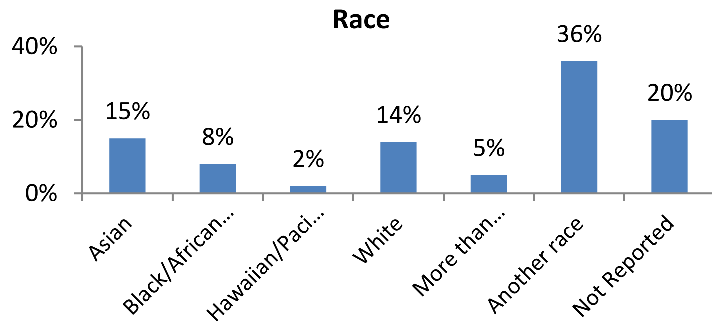
132 Attendees

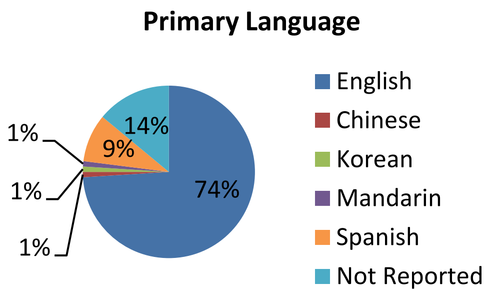


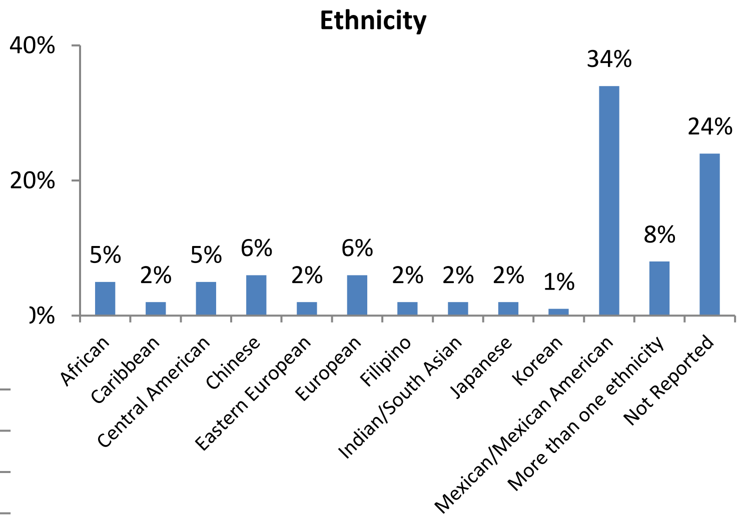


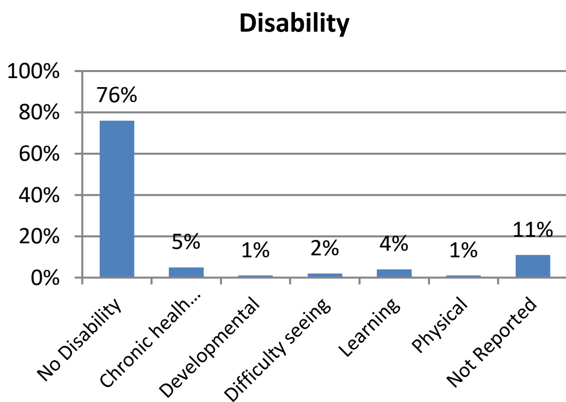


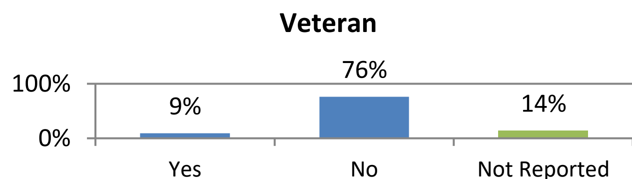




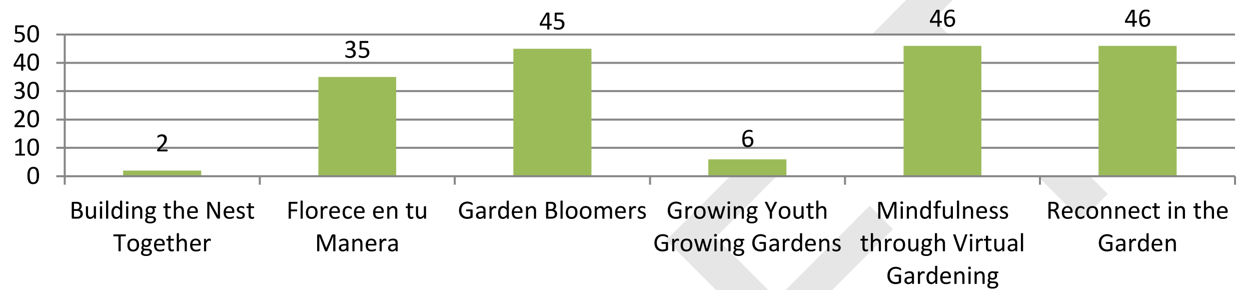


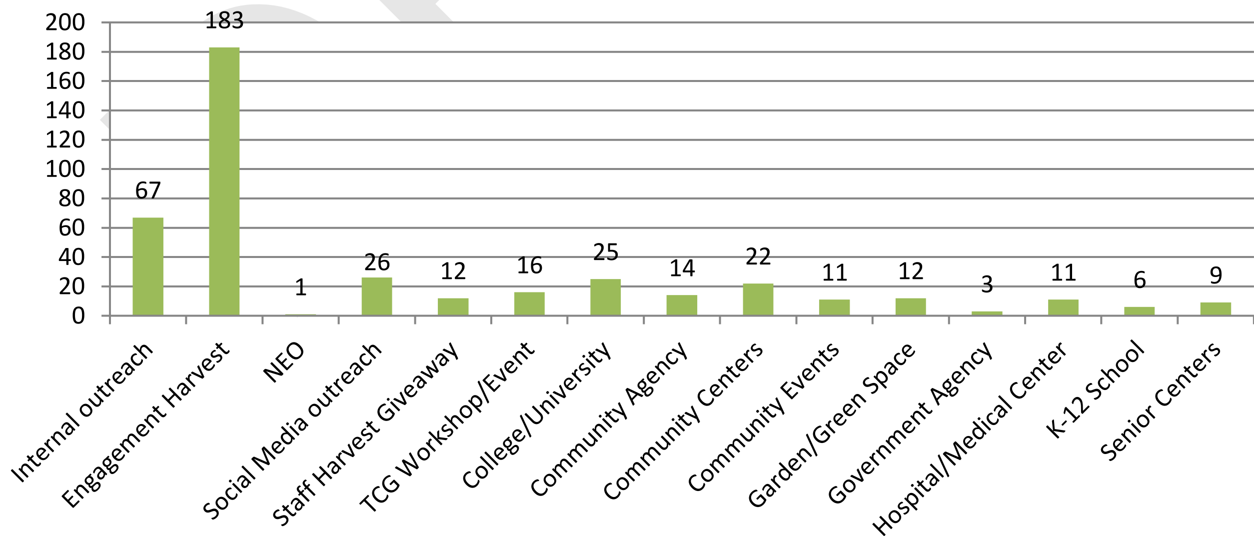






How Well Did We Do It?

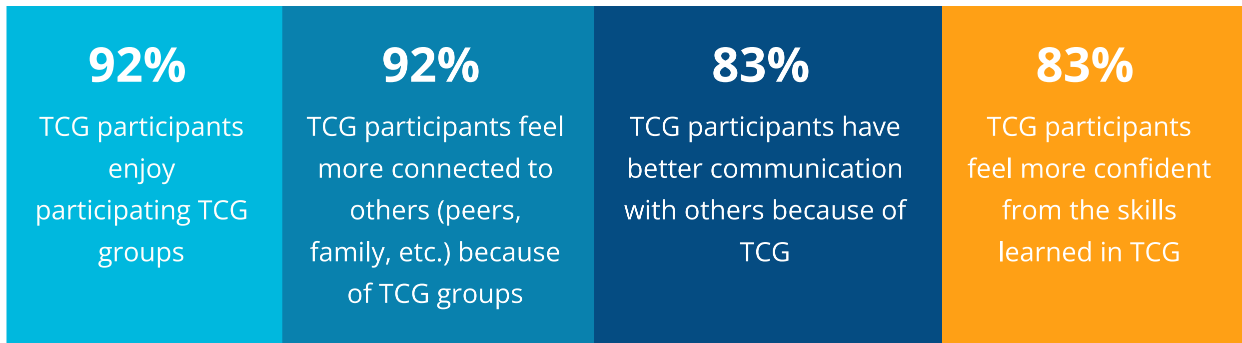




DRAFT

Is Anyone Better Off?

TCG Group Survey Responses Based on Completed Surveys (n=24)



TCG Workshop Survey Responses Based on Completed Surveys (n=85)

TCG Participant Feedback – Please share any thoughts, comments you may have about the TCG program, groups, and/or activities:

- Everything has been good overall.
- I always gain something out of TCG, which is good. Also, when groups open up in person, I would like transportation assistance.
- I enjoy learning from the staff and other participants. I feel at ease when I attend the groups.
- I just want to say, everyone in the groups is awesome and loves the way it is.
- I love it all! Being in community, the group, and learning new ways to cope.
- I think that this project works well because the leaders are passionate about what they are doing.
- I'm really interested in groups, the only problem is I have trouble getting into the groups, I have trouble with my phone.
- Keep it as it is.
- Am so thankful for you and your family there
- Given knowledge and insight into why people are sometimes so uptight. Helps me cope with pain and anxiety. Thank You.
- I am just so very happy to be part of TCG and love gardening! The garden helps me move forward and also the groups.
- I like the group that I'm in and I recommend it to my friends.
- I really like that TCG goes out in the community and does things with the community. I don't know any other organization that does that as much as you.
- I truly enjoy gardening group. I find it very therapeutic thank you.
- keep up the good work.
- Maybe guide meditation.
- Thank you for the support.
- Thank you very much for youth, family.

DRAFT

TCG Participant Feedback – How have you benefited from participating in TCG groups?

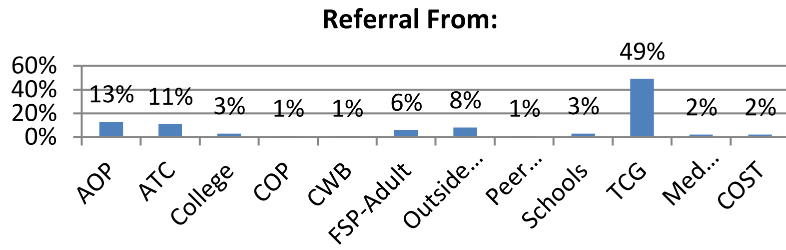
- All the information given during group has been very helpful, especially when the curriculum enhances my well-being. I get good vibes.
- I am making new friends and learning from the leaders and the participants.
- I have benefited from expanding my social skills, and I know it will take some time.
- I have benefited from TCG because it feels good to not feel alone and be listened to, I feel heard.
- I'm a little calmer. My anxiety is not as bad as it was before.
- It's helping my slowly learn something new and I really look forward to be in garden.
- "I've learned so much! Lots of stuff is so new to me and I can't to start growing stuff.
- Knowing that I am not alone and that we are more connected to nature in different ways! Its up to us how we take care of each other and our plants!
- Very much I take care of plants, water them weekly and have a place to see other people who come back each week.
- Being blessed with harvest and learning how to properly harvest and take care of a garden.
- Being present and seen as a person.
- I benefit from connecting with others and what they talk about in the groups. It makes me feel more open to share in the group and I learn a lot every time I attend a group.
- It helps me open up more with my anxiety and depression.
- I am having a better lifestyle.
- It made me feel more confident. It made me feel like I'm a part of a community. It made me feel less isolated. Everyone is so cool. The people that show up are so nice. You want to be there and be a part of it.
- Just great support and openness.
- Learned new coping skills.
- Mental Wellness and social support.
- Planting makes my life less stressful.
- To be able to meet other participants, they are very helpful and the speaker was very informative.
- Relaxing Self Confidence Empathy.

DRAFT

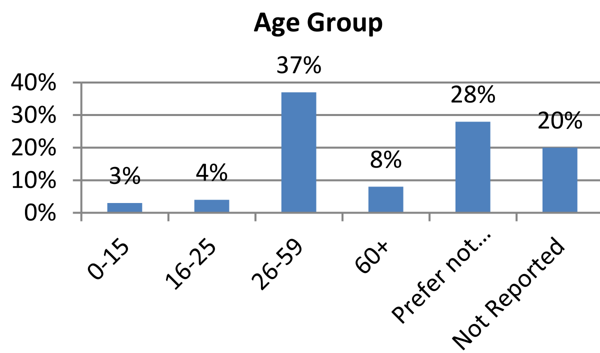
Number of Potential Responders	85
Setting in Which Responders were Engaged	Community, schools, health Centers, workplace, and outdoors.
Type of Responders Engaged	TAYs, teachers, LGTBQ, families, religious leaders, and those with lived experience.
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

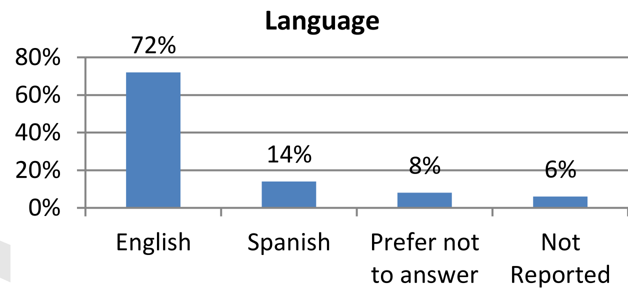
Timely Access to Services for Underserved Populations Strategy

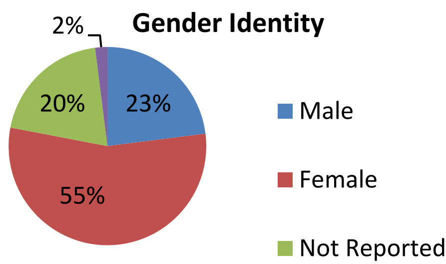
142
MHSA Referrals coming into TCG Program

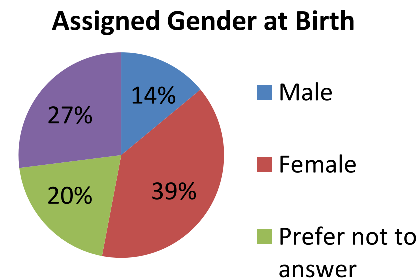


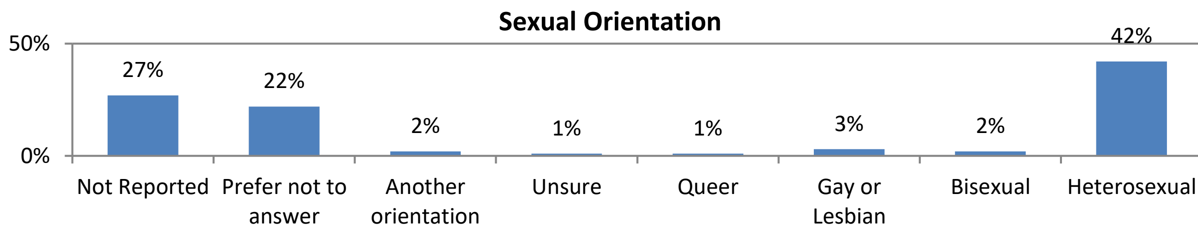
PEI Demographics Based on MHSA Referrals

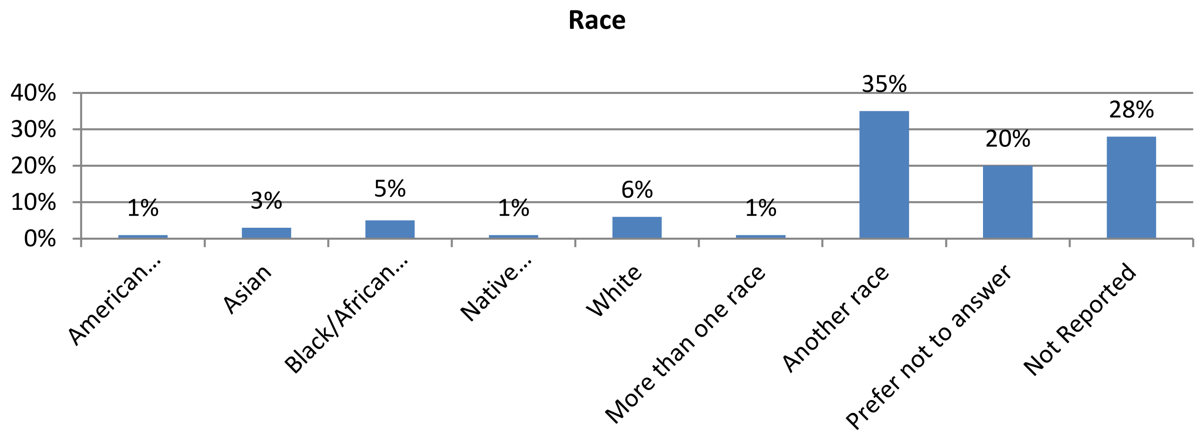


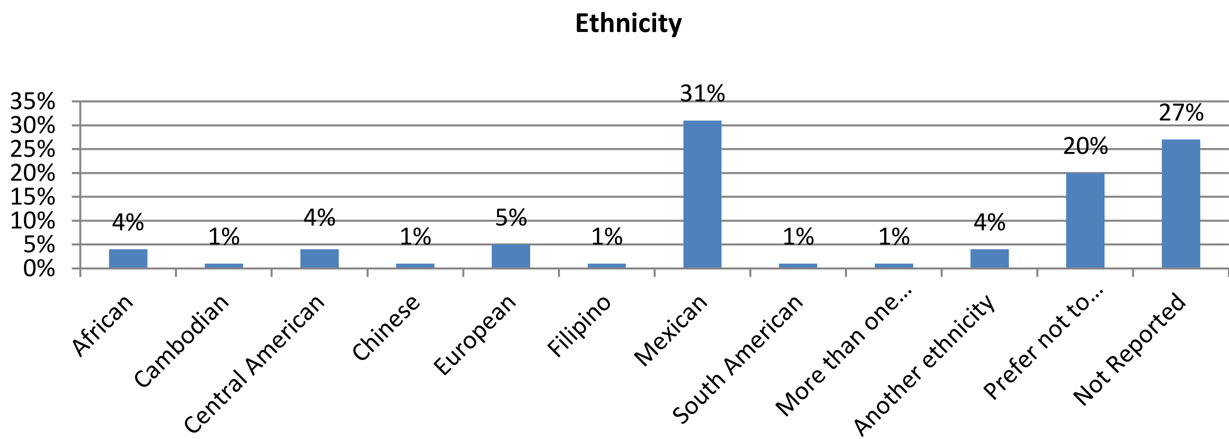


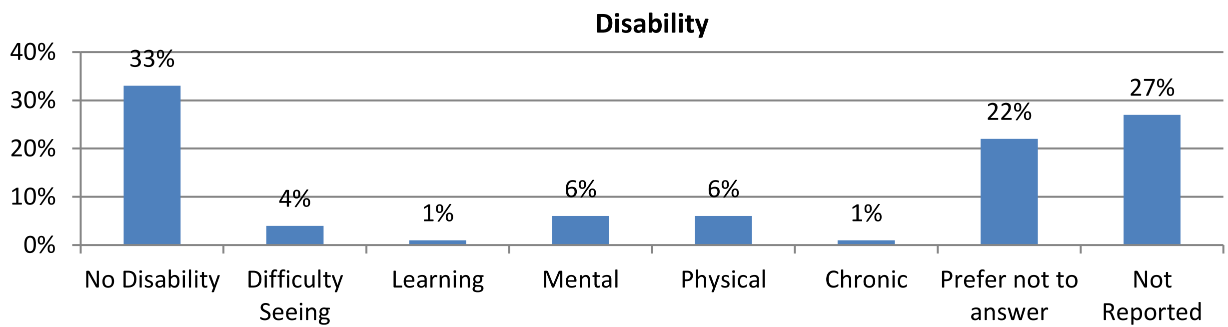


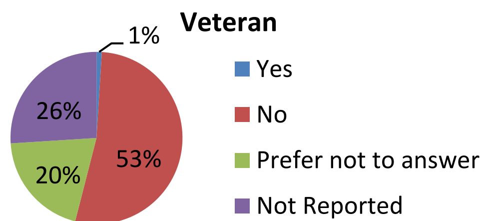





Race
40%
30%
20%
10%
0%
1%
3%
5%
1%
6%
1%
35%
20%
28%
American...
Asian
Black/African...
Native...
White
More than one race
Another race
Prefer not to answer
Not Reported


Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
4%
1%
4%
1%
5%
1%
31%
1%
1%
4%
20%
27%
African
Cambodian
Central American
Chinese
European
Filipino
Mexican
South American
More than one...
Another ethnicity
Prefer not to...
Not Reported


Disability
40%
30%
20%
10%
0%
33%
4%
1%
6%
6%
1%
22%
27%
No Disability
Difficulty Seeing
Learning
Mental
Physical
Chronic
Prefer not to answer
Not Reported


Veteran
1%
26%
53%
20%
Yes
No
Prefer not to answer
Not Reported

Early Psychosis Program

Program Description

The Early Psychosis Program (EPP) is designed for young people and their families who are at risk of developing psychosis or experiencing a first episode of psychosis. This coordinated specialty care program is focused on assisting a young person manage their symptoms, prevent deterioration, and equip their family to be a support system. Awareness, early detection, and access to services is needed to help young people with psychosis pursue recovery. Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components- community outreach, assessment, and treatment to reduce symptoms, improve function and decrease relapse.

Target Population

Transition age youth (TAY) ages 16 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	7	12	0	0	0	**19**
Cost Per Person	$9,386	$9,386	N/A	N/A	N/A	**$9,386**

**These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

Program Update

In FY 2022-23, the EPP expanded its services to offer 3 multifamily groups for its participants, which included a group for TAY and 2 groups for ages 12-16 (English and Spanish). The EPP also saw an increase in Spanish speaking referrals. The program also obtained a dedicated peer support specialist.

In addition, the way team meetings occurred was restructured. This helped to ensure team cohesion and investment in their services and program. This also helped create a more productive workflow, ensure that referrals were being managed efficiently, and that participants were getting effective care.

DRAFT

The process from referral to enrollment has greatly improved due to implementing lessons learned from past challenges. The team has streamlined the process for outreaching and enrolling a client into the program to ensure the best care is provided in a timely manner.

EPP is making efforts to ensure that all services that can be billable move in that direction. This will help improve the sustainability of the program. Likewise, increasing enrollment by strengthening outreach and collaboration with schools we will serve in this area is an ongoing effort.

Challenges and Solutions

Consistent engagement in multifamily groups was a challenge in FY 2022-23. Now that staff are feeling more versed in the model, they are beginning to brainstorm how they can bring creativity into their work to improve participant engagement and staff enjoyment. Brainstorming different ways to increase engagement has been an ongoing topic of team meetings.

Becoming efficient in completion of the Structured Interview for Psychotic-Risk Syndrome (SIPPS) was a challenge. The clinical recommendation for this tool has been to complete within an hour and score in same session. As this is a new skill staff are developing it has been an area of growth. Staff attend monthly meetings with an outside consultant regarding SIPPS. In this meeting, staff are brainstorming and role play how to complete this tool more efficiently. Along with this, goals and deadlines will be established to help promote staff's progress.

As this is a newer program, workflows and processes continue to be in development and a work in progress. The Leadership Team will ensure that formalizing workflows is a priority and enlist feedback from staff and Best Practices department to ensure the process is feasible.

Diversity, Equity and Inclusion

The Early Psychosis Program consists of multicultural staff who provide services in both English and Spanish. Workshops and webinars, including outreach and engagement, are also available in both languages. Additional languages are available via the LanguageLine. Materials for trainings are available to be translated upon request.

In addition, barriers to seeking services due to stigma, lack of knowledge, or other barriers experienced by individuals who identify as gay, lesbian, bisexual, transgender, or questioning are addressed. Furthermore, client's electronic health record indicates preferred pronouns and/or name so as to reduce mis-gendering.

The program does allow for servicing participants who have no insurance or alternative insurance, removing insurance as a barrier to accessing services. Barriers related to socioeconomic status, transportation or otherwise are also reduced by offering sessions in a variety of ways (virtual, in person, home, school, in office).

DRAFT

Community Partners

Local schools are the primary community partners for this program. Additionally, this fiscal year the team began collaborating more with the Co-Occurring Support Team (COST) program at Tri-City. Learning about the impact of substance use on mental health has been a great need for the participants in the program. Providers from COST have been involved more in team meetings to help with brainstorming about how to best care for clients and maintain a multidisciplinary approach to best serve individuals. Along with this, COST provider has attended multi family groups to support any participants that may bring up substance use as a challenge.

Success Story

A client was experiencing severe symptoms of psychosis leading to hospitalizations, family conflict, risky behaviors, and poor academic performance. The client and their parent were able to quickly engage in the early psychosis program. The individual ultimately took on the role of a mentor for the other participants. At one point in treatment the client regressed, however was able to reengage in treatment, reduce risky behaviors and improve their relationship with the parent. The individual ultimately graduated from treatment and successfully graduated from high school.

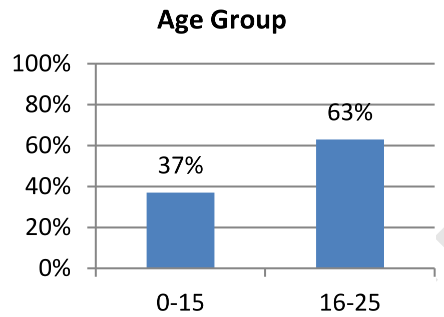
Another significant component of this success story is the collaboration and implementation of a PIER approach, including group work, individual sessions, occupational therapy services, lived experience, and psychiatry.

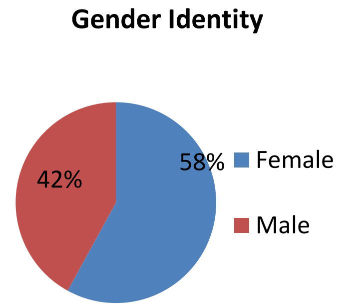
DRAFT

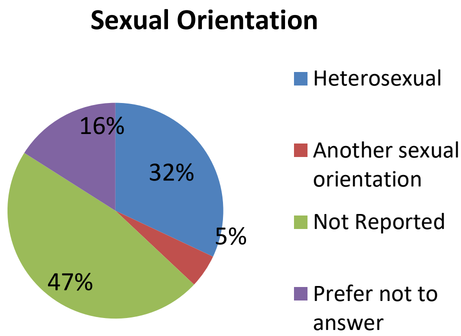
Program Summary

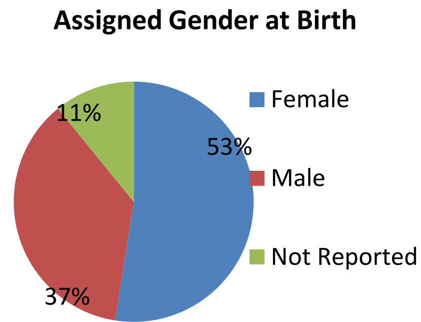
How Much Did We Do?

19
Individuals Enrolled In Early Psychosis

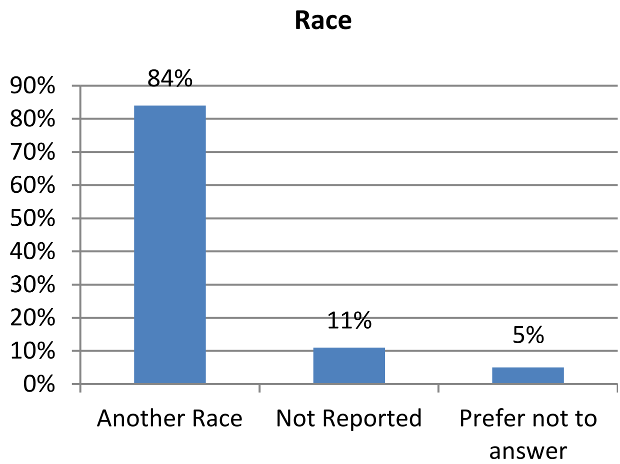


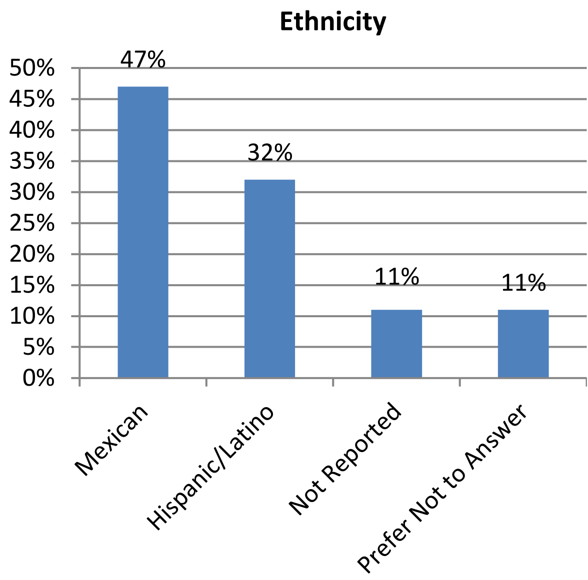


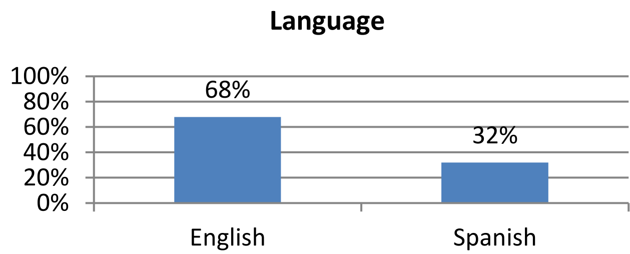


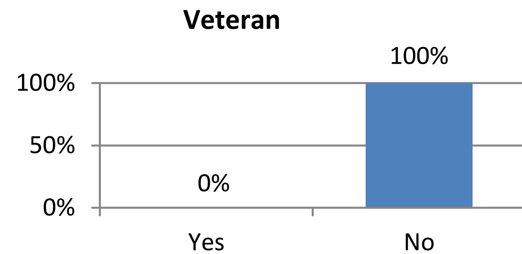


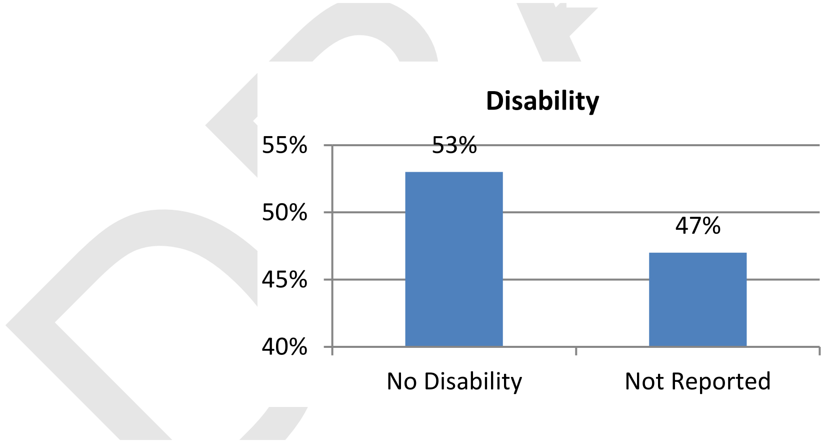
DRAFT

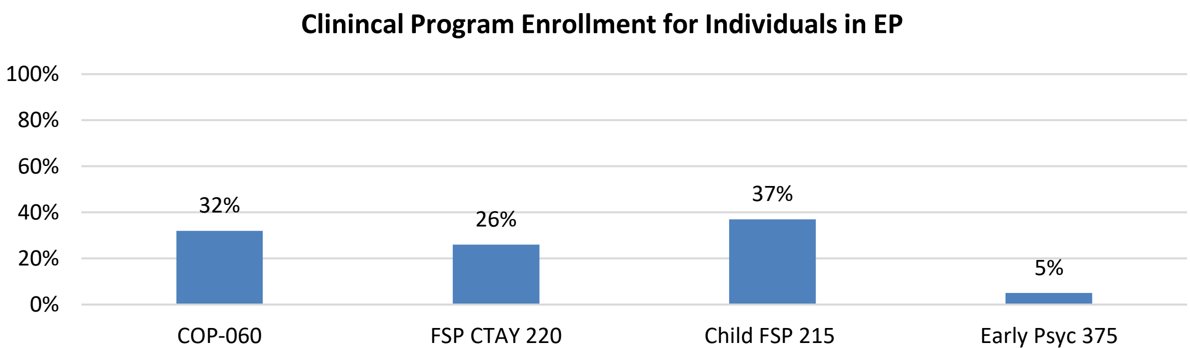

Race
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
84%
11%
5%
Another Race
Not Reported
Prefer not to answer


Ethnicity
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
47%
32%
11%
11%
Mexican
Hispanic/Latino
Not Reported
Prefer Not to Answer


Language
100%
80%
60%
40%
20%
0%
68%
32%
English
Spanish


Veteran
100%
50%
0%
0%
100%
Yes
No

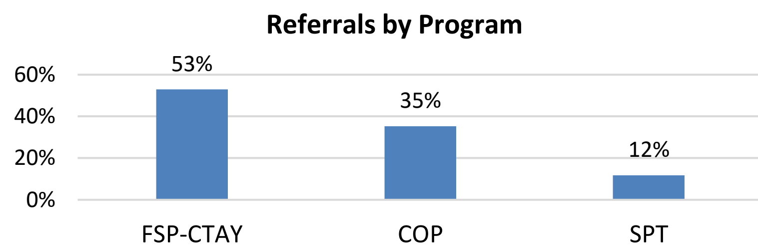

Disability
55%
50%
45%
40%
53%
47%
No Disability
Not Reported


Clinincal Program Enrollment for Individuals in EP
100%
80%
60%
40%
20%
0%
32%
26%
37%
5%
COP-060
FSP CTAY 220
Child FSP 215
Early Psyc 375

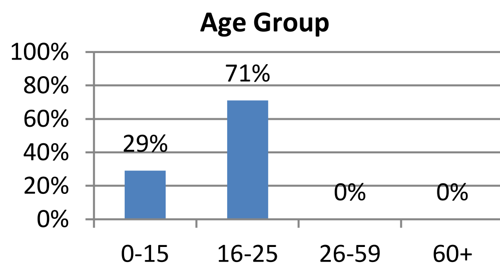
Number of Potential Responders	10
Setting in Which Responders were Engaged	Mental health centers
Type of Responders Engaged	Clients
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

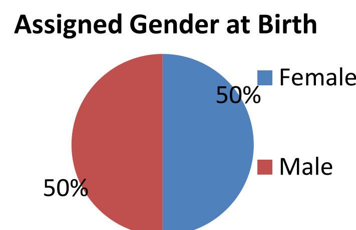
Timely Access to Services for Underserved Populations Strategy

17
MHSA Referrals to Early Psychosis

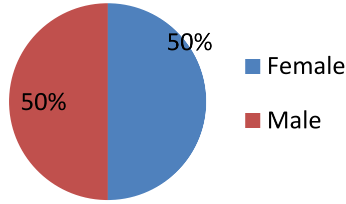


PEI Demographics Based on MSHA Referrals

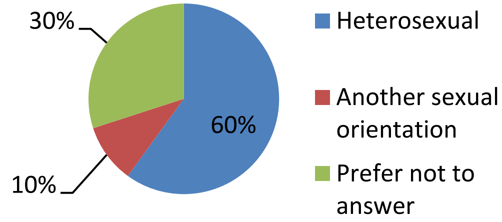




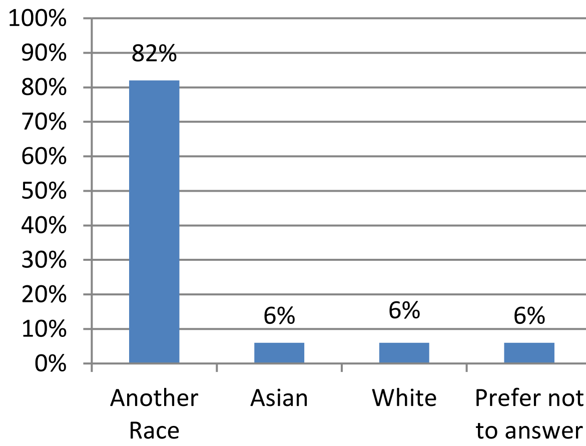
Gender Identity



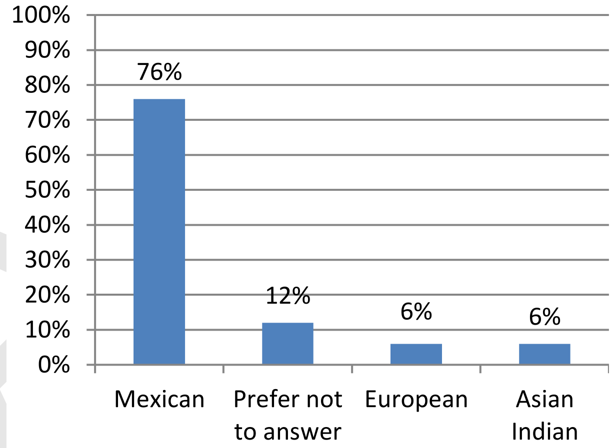
Sexual Orientation



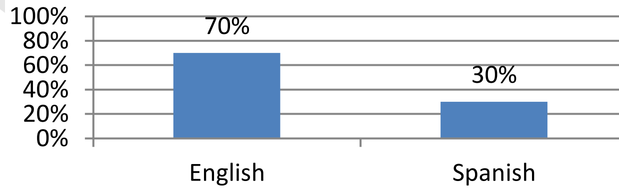
Race



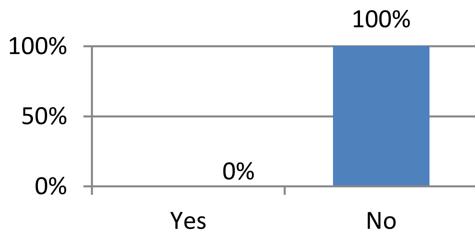
Ethnicity



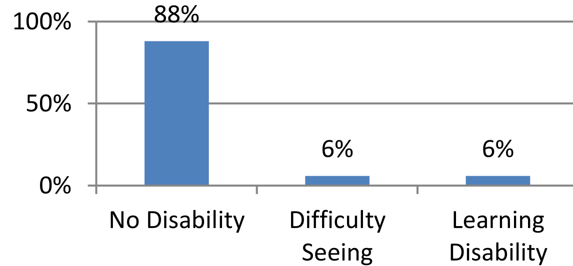
Language



Veteran



Disability



School-Based Services

Program Description

School-Based Services (SBS) provide services to students directly on local school campuses during school hours. SBS bridge the gap between community mental health services and local schools, reducing barriers to accessibility.

Target Population

Students attending school in the school districts and colleges that fall within the Tri-City service area (Pomona, Claremont and La Verne).

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2022-23	280	97	0	0	0	**377**
Cost Per Person	$1,916	$1,916	N/A	N/A	N/A	**$1,916**

Program Update

SBS staff partnered with Mental Health Services Act (MHSA) and Mental Health Student Services Act (MHSSA) programs to increase support and outreach efforts to our local schools. The outreach events included Back to School Nights, resource fairs, and wellness promoting events, across our school partners in the Pomona, Claremont, and Bonita Unified School Districts. Following collaborative discussions, Tri-City established a memorandum of understanding (MOU) with all three Tri-City area school districts, as well as the School of Arts and Enterprise. The program also made an effort to establish relationships with local universities by conducting collaborative meetings with California Polytechnic State University, Pomona (Cal Poly) and University of La Verne (ULV).

An improved process for school referrals was also established, leading to enhanced response time and collaboration with referral resources. Increased collaboration and improved workflow, in part, contributed to SBS staff experiencing and increase in referrals, from 270 in FY 2021-22 to 400 in FY 2022-23.

A future consideration will be to implement substance use disorder and awareness to students and families. As teens access to substances such as fentanyl increases, so too does the need for co-occurring services and support. Training staff on working with co-occurring disorders as well as how Narcan can be a potential resource for families will be vital.

DRAFT

Challenges and Solutions

The California Advancing and Innovating Medi-Cal (CalAIM) reform, which included new documentation and limitations on travel reimbursement, created challenges to previous program structure and implementation. Teaching staff how to maximize their days by clustering travel time and scheduling multiple clients in a single school location assisted with limitations on travel reimbursement. Coaching staff on the use of collaborative documentation was also a support. Quality Assurance and Quality Improvement also supported these efforts by providing SBS staff with training to help with new Electronic Health Records (EHR) and CalAIM reform. This will continue to be a work in progress.

School partners struggled to identify appropriate referrals during the past fiscal year, for example, sending referrals to SBS that were either out of area or who have private insurance. This led to SBS staff spending more time on non-billable tasks such as linking families to their providers and addressing appropriate referrals. A notable solution to this challenge was maintaining open channels of communication with school partners to address barriers to referrals, review referral criteria, and address challenges with families connecting to services. SBS staff also identified new partners at the schools and built connections between the SBS program and the schools by increasing communication with individuals such as principals, school counselors and psychologists.

Diversity, Equity and Inclusion

SBS staff increased the frequency of on-site school visits in FY 2022-23. This assisted in removing barriers to attending services such as transportation. Although a big focus of services is to provide treatment at school, both treatment and intake services are being offered in the office and via telehealth to increase families' access to mental health services. Additionally, parents/caregivers are included in the client's services to better assess the needs, create realistic goals and interventions for clients, and provide access to resources.

Spanish speaking clients have access to bilingual staff, and other languages are offered through the LanguageLine. A diverse group of providers supports the SBS team in increasing representation for the community leading to improved engagement in services. Additionally, all documents are translated in the threshold languages.

The SBS team educates themselves on barriers and stigma the LGBTQ+ community may experience by reviewing available community resources, completing trainings, and attending department meetings focusing on this population. Inclusivity is also ensured through electronic health records reflecting the client's desires and culture needs such as appropriate pronouns and names.

Community Partners

Community Partners largely consist of local schools and colleges within the Tri-City service area. Some examples include: Pomona Unified School District (PUSD), Bonita Unified School District (BUSD), Claremont Unified School District (CUSD), School of Arts and Enterprise (SOAE), the University of La Verne (ULV) and Cal Poly Pomona (CPP). These partnerships foster resource sharing, increase access

DRAFT

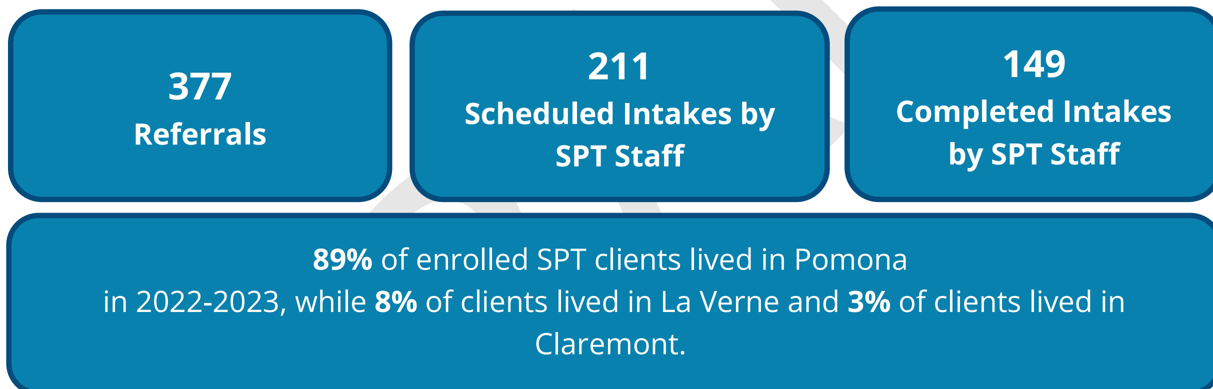
for students in need of mental health services, and generate referrals to the SBS team. Furthermore, SBS staff are increasing treatment team meetings internally to support client goals. During FY 2022-23, increased collaboration occurred with departments such as Child Outpatient (COP), Full Service Partnership (FSP), and Mental Health Student Services Act (MHSSA).

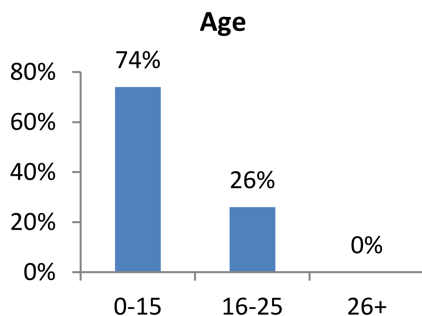
Success Story

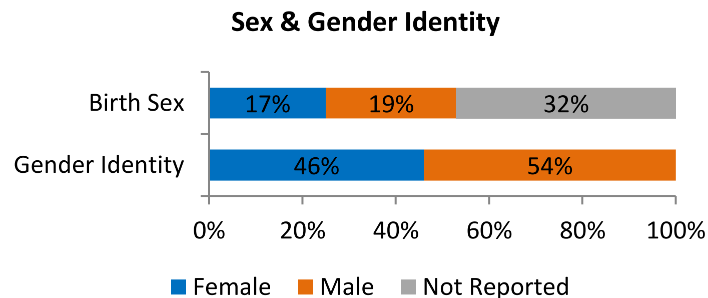
During FY 2022-23, SBS program experienced positive outcomes from increasing communication and collaboration with our community partners. Increasing contacts with the various school districts, colleges, and internal departments led to improved communication and workflow. Specifically, improving collaboration and consultation amongst the school personnel, mental health team and crisis team bolstered referrals and formed reciprocal connections that ultimately benefit the communities of Pomona, Claremont, and La Verne.

Program Summary

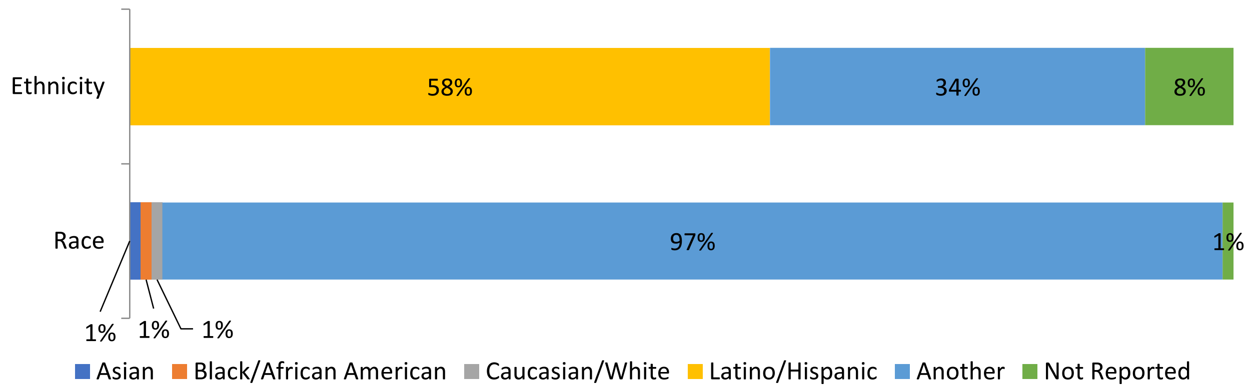
How Much Did We Do?

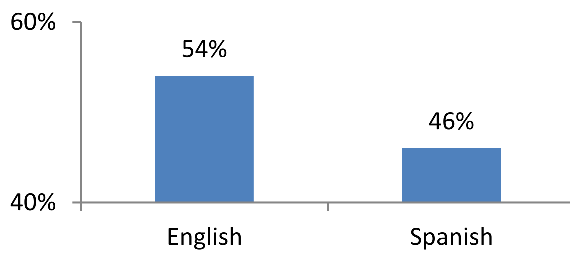






Disability & Sexual Orientation Data not available





DRAFT

Innovation (INN)

The Innovation (INN) Plan consists of short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

DRAFT

Innovation (INN)

Innovation projects are designed to evaluate the effectiveness of new or changed practices in the field of mental health, with a primary focus on learning. Innovation provides county-administered mental health systems in California the opportunity to "try out" new or changed approaches that can inform current and future mental health practices. These projects are intended and implemented as time-limited (maximum of five years), after which an alternative source of funding must be identified if the project is deemed successful.

Help@Hand/Tech Suite Project

In August 2022 the implementation of the digital app myStrength was launched. Staff worked with market partners Uptown Studios who helped create flyers for the 3 target populations: TAY, Older Adults and Mono-lingual Spanish speakers. Uptown also created a community partner toolkit which allowed staff to share flyers, pre-worded email blast, & social media post with our community partners throughout the 3 cities. The toolkit was extremely helpful in giving the community partners an overview of the Help@Hand and myStrength implementation. Upon launch, thirty-one participants signed in the first month. Uptown Studios also helped with social media by creating social media profiles for Facebook, Twitter, and Instagram specifically for the Help@Hand/myStrength project, titled TriCityWellness. Staff held two digital health literacy workshops in Spanish, a digital health literacy workshop for Seniors and hosted multiple tables at various events including Cal Poly Pomona and Youth Wellness Symposium where myStrength was shared with the community, specifically the TAY population.

On December 31, 2023, the Help@Hand Innovation project was completed. For more information and details regarding the outcomes of this project, please see the *Help@Hand Innovation Project Final Report* located in the appendix of this Annual Update.

Project Dates	January 1, 2019 to December 31, 2023
Project Funding Amount	$1,674,700
Target Populations	• Transition age youth and college students (up to age 25) • Older adults (ages 60+) • Non-English-speaking clients and community members who may be experiencing stigma and language barriers

DRAFT

Psychiatric Advance Directives (PADs)

Tri-City joined the Psychiatric Advance Directives Multi-County Collaborative on July 1, 2022. In September 2022 the seven counties met in person for a collaborative convening to explore the goals for the project and subcontractor roles. Following the meeting, stakeholder engagement became a focus. An informal informational night for first responders and law enforcement was held to share the goals of the project and recruit for workgroups. Another informational meeting was provided for the Los Angels County Probation office to encourage their participation and to gain insight into their thoughts on the project. Two in person stakeholder meetings were held in April for peers and caregivers/stakeholders. There was also ongoing collaboration with the marketing subcontractor to help develop a logo for the project. All counties met again in March 2023 to continue the work on this project. The technology subcontractor was able to share a preview of what the technology would look like.

Program Update

Innovation held five workgroups during FY 2022-23. The workgroups started out with high attendance however attrition did occur. By the third workgroup inquiries began regarding how to get more involvement in the workgroups and stakeholder participation. This led to the development of the new Innovation plan to utilize Innovation funding for the Community Planning Process. A concept paper was drafted and stakeholders in the workgroup ultimately approved the plan. It was presented to the MHSOAC for technical support/assistance in May to ensure viability. Staff anticipate final approval and implementation of this Innovation project, *Community Planning Process for Innovation Project(s)* in the fall of 2023

Challenges and Solutions

Challenges faced during fiscal year 2022-2023 were related to staffing. The program coordinator was the sole person running 2 projects, and this impacted the ability to recruit community members to utilize the app. Innovations relied on social media post and community partners to help encourage individuals to sign up to use myStrength. Community Navigators and other staff supported promoting the myStrength app and PADs projects when out in the community. A Peer Support Specialist was also hired for Innovation who focuses on community engagement, encourages participation, and signs community members up for the myStrength app. With the new hire, the Innovation team now consists of Supervisor, Program Coordinator, and Peer Support Specialist.

There was difficulty engaging and maintaining stakeholders in our innovation workgroups and project development. Several reported burnout related to virtual meetings and would prefer in-person meetings that were utilized in the past. To address the issues with stakeholder engagement, we worked with the smaller group and developed a new Innovation plan utilizing Innovation funds for the Community Planning Process. This plan will be implemented beginning FY 2023-24 upon approval by the MHSOAC.

DRAFT

Diversity, Equity and Inclusion

Innovation focuses on creating new programs or adjusting current programs to help serve the underserved populations. The programing specifically targets TAY, older adults, and monolingual Spanish speakers to help bridge the gap between formal services and those in need of services to support mental health and wellness. Marketing materials and social media postings are inclusive of all races, ethnicities, genders and ages. Digital Health Literacy trainings are provided in English or Spanish and the new Program Coordinator for Innovation is bilingual in Spanish.

The app myStrength is available in both English and Spanish and is accessible via smart phone, tablet, laptop or desktop computer. Innovation staff loan tablets to individuals who do not have access to a smartphone or computer. MyStrength offers evidence-based LGBTQ+ behavioral health resources such as informative content, interactive quizzes, and worksheets that discuss LGBTQ+ pride, allyship, depression, and shame in LGBTQ+ communities.

Partnering with local senior centers within our three cities supports outreach and engagement to older adults and veterans. Resource tables are available during the center's lunch hours to promote various innovation projects when foot traffic is high. Staff also held a digital health literacy training at the senior center in Claremont in an effort to eliminate barriers for our older adults and ensure they could participate.

Community Partners

Painted Brain, an innovative peer-run mental health arts and tech organization, assist staff with "Appy Hours" and Digital Health Literacy Workshops. Uptown Studios supports Innovations marketing efforts and created a community partner toolkit to help spread the word about myStrength. They also support social media that was created specifically for this project. Jaguar Computer Systems provides support with computer tablets and formats the tablets up with the myStrength app as well as provides IT support as needed.

The PADs project has subcontractors who work with all 7 counties. Idea Engineering is the marketing/design organization who is helping to develop the flyers, website, and logos we will use for the project. Chorus, our technology contractor, develops the technology platform that will house the completed PADs created by consumers/clients as well as be accessible by law enforcement, first responders, hospitals, and county staff as needed.

DRAFT

Workforce Education and Training (WET)

The Workforce Education and Training (WET) Plan focuses its efforts on strengthening and supporting existing staff and caregivers through trainings while focusing on attracting new staff and volunteers to ensure future mental health personnel.

DRAFT

Workforce Education and Training (WET)

The Workforce Education and Training plan is dedicated to training and supporting the people who are charged with the delivery of the services and supports. This includes clinical staff providing treatment services, staff who provide prevention and wellbeing supports, family and community caregivers and volunteers who offer informal support to loved ones and others.

A second component of this plan is the recruiting of students, community members, and volunteers to expand the recovery and wellbeing support provided by staff. It is clear the demand for mental health services in the Tri-City area far exceeds the current and projected availability of staff. By increasing the pool of interest in the mental health system, these efforts can work to generate new staff members over time by encouraging high school and college students to realistically consider a career in the community mental health field.

Program Update

Tri-City partnered with California Mental Health Services Authority (CalMHSA) and Los Angeles County Department of Mental Health (LACDMH), to certify individuals with lived experience to become Peer Support Specialists. Four of our Clinical Wellness Advocates (CWA) were grandfathered in and received scholarships to take the exam for certification.

Staff had the opportunity to attend 11 trainings and conferences throughout FY 2022-23. Staff completed 21,788 courses through Relias, an online e-learning system that contains over 400 behavioral health courses.

Tri-City's Loan Repayment program was launched for the first time in FY 2022-23. There were 37 applicants and 29 of the applicants were awarded $7,500 each towards their student loans. The program aims at supporting staff while increasing retention of personnel.

A future goal is to reinstate the Working Independence Skills Helping (WISH) program. WISH helps individuals with mental illness build their self-confidence and self-esteem while gaining viable skills to further their professional and employment growth. The eight-week program emphasizes team building, conflict resolution, communication and employment skills building.

Pathway to Career Opportunities: Service-Learning

Service-Learner

Service-Learners (formerly called volunteers) provides support in many of the MHSA programs offered by Tri-City. Service-Learners participate in various community events throughout the year such as community meetings, holiday parade, and stigma reduction events such as Tri-City's Green Ribbon Week.

DRAFT

Summer Camp

Summer Camp provides a unique opportunity for individuals ages 16 and over who are interested in working with children to volunteer and provide support to a four-week day camp facilitated by Tri-City Wellness Center staff.

Peer Mentor Program

The program runs annually from September through May. The program is comprised of a committed diverse group of individuals with various backgrounds, culture, identities and lived experiences age 18 and over. Participants gain hands-on experience working with individuals in community mental. The program provides extensive training and supervision on numerous topics focusing on mental health, mental wellbeing and personal growth.

Relias Training

Relias is an online e-learning system that is a recognized leader in online training services for the healthcare industry. During FY 2022-23, 21,788 online courses were completed by Tri-City staff, increasing their capacity to provide informed care to clients as well as meeting requirements for licensure. Relias is self-paced and serves staff who are required to complete a set of courses, provides an opportunity to pursue courses that are of interest, and is a viable resource for obtaining continuing education units (CEUs).

Challenges and Solutions

During FT 2022-23, WET experienced turnover in staff which resulted in the lack of a WET supervisor for 5 months. During this time the recruitment for services learners dwindled. There were 11 applications for service learning and 1 of those applications were accepted to become a service learner. This volunteer role was able to complete 27 hours total of service.

Ways to address these challenges are continuing to outreach to high schools and colleges for volunteers, especially considering that this demographic is actively considering a career path. The service learning/volunteer programs can also be enhanced and updated. One example would be to create more structured goals for each service learner that can be reviewed and discussed at the end of their service.

Diversity, Equity and Inclusion

Tri-City strives to engage underserved populations by communicating in ways that are accessible to all members of the community. This includes communicating via a variety of social media platforms and incorporating messaging that is reflective of the diverse populations that we serve and containing messaging that is often directly relevant to the experiences of these populations within our service area. The perspectives of members of these underserved communities are considered in the selection of content that is represented on social media, and in the selection of trainings that are offered to staff.

DRAFT

Tri-City supports staff in building their capacity to address barriers related to disparities. The service learner program is designed to welcome individuals from any background to volunteer their time to participate in various community events throughout the year. Events include community meetings, holiday parade, and stigma reduction events such as Tri-City's Green Ribbon Week. Additionally, depending on the assignment, they can volunteer and suggest different ways to engage individuals experiencing different disparities.

Program Summary

How Much Did We Do?

27	11	11
Service Learner Hours	Service Learner Applications	Trainings, Conferences and Educational Opportunities for Staff

How Well Did We Do It?

1	0	21,788
Applicants Became Service Learners	Service Learners were Hired at Tri-City	Courses Completed through Relias Program

DRAFT

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) Plan focuses on improvements to facilities, infrastructure, and technology of the local mental health system.

DRAFT

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) component of the Mental Health Services Act allocates funds for projects designed to improve the infrastructure of community mental health including the purchase, development or renovation of buildings used to house and support MHSA programs and staff. The technological portion of this plan supports counties in transforming existing clinical and administrative technology systems while increasing access to mental health records and information electronically for consumers and family members.

Program Update

There were several notable events in FY 2022-23 impacting the CFTN plan. The first is the rejuvenation project for the Therapeutic Community Garden. Reoccurring groups have largely been virtual due to COVID-19 and with construction beginning in the garden, groups will remain virtual during construction. The community has expressed great interest and excitement for the garden construction to be complete, as the therapeutic horticulture modality is very impactful in a natural environment that is safe and accessible.

Some other notable CFTN projects in the fiscal year were electrical upgrades for the 2001 MHSA Administrative Office building, power upgrades and remodeling. All sites were provided with new desk phones and hardware support. There were also security upgrades with the purchase of Meraki security cameras and a one-year license for the services.

DRAFT

MHSA Expenditure Plan

The following section includes information regarding Cost Per Participant for MHSA Programs and Tri-City Staff Demographics

DRAFT

Cost Per Participant

The services provided in Fiscal Year 2022-23 are summarized in the table below per the guidelines for this Annual Update by age group, number of clients served, and average cost per person:

Summary of MHSA Programs Serving Children, Including TAY			
Program Name	Type of Program	Unique Clients Served	Cost Per Person
Full Service Partnership (Child)	CSS	107	$14,143
Full Service Partnership (TAY)	CSS	118	$18,658
Community Navigators	CSS	242	$607**
Wellness Center	CSS	1,617	$584**
Supplemental Crisis Services	CSS	156	$775**
Access to Care	CSS	769	$457**
Family Wellbeing Program	Prevention and Early Intervention	219	$230**
Peer Mentor Program (TAY Wellbeing)	Prevention and Early Intervention	23	$2,853
Therapeutic Community Gardening	Early Intervention	47	$2,163**
Early Psychosis	Prevention and Early Intervention	19	$9,386**
School-Based Services	Early Intervention	377	$1,916**

DRAFT

Summary of MHSA Programs Serving Adults and Older Adults, Including TAY			
Program Name	**Type of Program**	**Unique Clients Served**	**Cost Per Person**
Full Service Partnership (TAY)	CSS	118	$18,658
Full Service Partnership (Adult)	CSS	228	$18,190
Full Service Partnership (Older Adult)	CSS	37	$16,745
Community Navigators	CSS	727	$607**
Wellness Center	CSS	832	$584**
Supplemental Crisis Services	CSS	804	$775**
Access to Care	CSS	1,748	$457**
Field Capable Clinical Services for Older Adults	CSS	37	$3,308
Family Wellbeing Program	Prevention and Early Intervention	303	$230**
Peer Mentor Program (Older Adult Wellbeing)	Prevention and Early Intervention	31	$2,853
Therapeutic Community Gardening	Early Intervention	170	$2,163**

** These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.

In FY 2022-23, Tri-City served approximately 2,449 unduplicated clients who were enrolled in formal services. Tri-City's Fiscal Year 2023-24 Budget included a total of 250 Full-time/Equivalent employees and an annual operating budget of approximately $37.5 million dollars. Tri-City strives to reflect the diversity of its communities through it hiring, languages spoken, and cultural competencies.

The following chart reflects a comparison between Tri-City staff and the demographics of the cities we serve. The Hispanic/Latinx, Black/African American and Native Hawaiian/Pacific Islander populations are successfully represented by Tri-City staff while the Native American/Alaska Native populations continue to be a focus for recruitment.

DRAFT

HR Staff Data compared to Tri-City Race Demographics			
Demographic for Cities of Claremont, La Verne and Pomona	Percent of Population	Demographics for Tri-City Mental Health Staff	Percent of Staff
White	41.90%	White	15.89%
Hispanic/Latinx	59.00%	Hispanic/Latinx	61.21%
Asian/Pacific Islander	11.50%	Asian	11.22%
Black/African American	5.60%	Black/African American	8.41%
Native American/Alaska Native	1.90%	Native American/Alaska Native	0.47%
Other	25.70%	Other	0.93%
Two Or More Races	13.40%	Two Or More Races	1.87%

(Total may not add up to 100 percent, as individuals may select multiple races/ethnicities).
Source: U.S. Census data from 2020 DEC Redistricting Data

Approximately 33% of the Tri-City Workforce is bilingual. Approximately 27% of the Tri-City workforce is qualified to provide bilingual interpretation services, in the threshold Language Spanish.

Number of Staff Certified/Qualified for Bilingual Interpretation		
Language	# Bilingual	% Bilingual
Spanish (Threshold Language)	59	27.57%
Vietnamese	2	0.93%
French	2	0.93%
Khmer	1	0.47%
Persian	1	0.47%
Punjabi	1	0.47%
Russian	1	0.47%
Mandarin & Chinese	0	0.10%
Hindi	1	0.47%
Japanese	1	0.47%
Tagalog	2	0.93%
Total Bilingual	**71**	**33.18%**

Source: HR Bilingual Staff Report and CC Plan Population Demographic Language Data.

DRAFT

As with many agencies and organizations, Tri-City has struggled with both staff recruitment and retention. In an effort to recruit, train and attract a workforce that mirrors our client population, Tri-City's Human Resources Department actively seeks out recruitment advertisement opportunities with a variety of culturally specific organizations and associations. We advertise with and participate in employment fairs with the Network of Social Workers, the County Behavioral Health Directors Association of California (CBHDA), the Collaborative to Improve Behavioral Health Access (CIBHA), the African American Mental Health Conference, the Latino Behavioral Health Conference and Mental Health America. Additionally, WET program staff actively outreaches to students from high schools and universities within our service area. The goal of this outreach is to educate and encourage students about the potential of working within the community mental health system. Through student career fairs, class specific presentations, Tri-City staff engage residents and students of the three cities to participate as Service-Learners, a volunteer program to support Tri-City staff and departments to meet the needs of consumers and community members.

Tri-City has emphasized the value of those with lived experience within our workforce and has made a concerted effort to include peers throughout our system of care. Peers, representatives of the population we serve, and our clients are also included in our Service-Learning program.

In addition, Tri-City's implementation of hiring incentives such as our sign-on bonus, hybrid work schedules, hazard and longevity pay have helped to create a more attractive compensation and benefit package to attract staff and we often survey our current workforce for ideas on attractive benefits and incentives.

Lastly, each month Tri-City staff review and prepare reports for the Governing Board which reflect our current staffing including diversity and comparison to the community we serve. Through this practice, staff are able to determine the limitations of our agency and able to address these concerns on a monthly basis.

DRAFT

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

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/8/2024

	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 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	17,424,481	3,927,958	1,749,760	988,832	4,240,745	
2. Estimated New FY 2024/25 Funding	10,745,803	2,686,451	706,961			
3. Transfer in FY 2024/25[a/]	(3,000,000)	0	0	500,000	2,500,000	0
4. Access Local Prudent Reserve in FY 2024/25	0	0				0
5. Estimated Available Funding for FY 2024/25	25,170,284	6,614,409	2,456,721	1,488,832	6,740,745	
B. Estimated FY 2024/25 MHSA Expenditures	12,056,637	4,006,412	629,986	782,756	655,700	
G. Estimated FY 2024/25 Unspent Fund Balance	13,113,647	2,607,997	1,826,735	706,076	6,085,045	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	2,199,999
2. Contributions to the Local Prudent Reserve in FY 2024/25	0
3. Distributions from the Local Prudent Reserve in FY 2024/25	0
4. Estimated Local Prudent Reserve Balance on June 30, 2025	2,199,999

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.

DRAFT

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

County: **TRI-CITY MENTAL HEALTH AUTHORITY**　　　　Date: 3/8/2024

	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. 1a-Child FSP	1,587,410	503,948	588,139		495,323	
2. 1b-TAY FSP	2,107,224	870,907	844,920		391,397	
3. 1c-Adult FSP	4,044,970	2,224,263	1,698,364		122,343	
4. 1d-Older Adult FSP	631,668	417,023	214,645			
5.	0					
Non-FSP Programs						
1. Community Navigators	746,584	746,584				
2. Wellness Center	1,524,313	1,524,313				
3. Field Capable Clinical Services for Older Adults	121,640	27,541	94,099		-	
4. Permanent Supportive Housing	639,524	634,524				5,000
5. Access To Care	765,276	765,276				
6. Mobile Crisis Care (MCC) Pilot Program	1,638,028	905,483	547,221		185,324	
CSS Administration	3,436,775	3,436,775				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	17,243,412	12,056,637	3,987,388	0	1,194,387	5,000
FSP Programs as Percent of Total	69.4%					

DRAFT

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

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/8/2024

	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. Family Wellbeing	150,254	150,254				
2. Older Adult Wellbeing (Peer Mentor)	92,189	92,189				
3. Transition-Age Youth Wellbeing (Peer Mentor)	99,395	99,395				
4. Community Capacity Building (Community Wellbeing, Stigma Reduction and Suicide Prevention, and Community Mental Health Training)	530,267	530,267				
5. NAMI Community Capacity Building Program (Ending the Silence)	11,833	11,833				
6. Housing Stability Program	222,962	222,962				
PEI Programs - Early Intervention						
7. Older Adult Wellbeing (Peer Mentor)	92,189	92,189				
8. Transition-Age Youth Wellbeing (Peer Mentor)	99,395	99,395				
9. Therapeutic Community Gardening	515,787	515,787				
10. Early Psychosis	227,690	227,690				
11. School Based	1,198,022	1,198,022				
PEI Programs - Other						
12.	0	0				
13.	0	0				
14.	0	0				
PEI Administration	672,429	672,429				
PEI Assigned Funds	94,000	94,000				
Total PEI Program Estimated Expenditures	3,912,412	4,006,412	0	0	0	0

DRAFT

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

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/8/2024

	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. Help @ Hand	0	0				
2. Psychiatric Advance Directive (PADs) Multi-County Collaborative	269,994	269,994				
3. Community Planning Process for Innovation Project (s)	225,000	225,000				
INN Administration	134,992	134,992				
Total INN Program Estimated Expenditures	629,986	629,986	0	0	0	0

DRAFT

FY 2024/25 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY**

Date: 3/8/2024

	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. A Systematic Approach to Learning and Improvement	343,742	343,742				
2. Engaging Volunteers and Future Employees	282,956	282,956				
3.	0					
WET Administration	156,058	156,058				
Total WET Program Estimated Expenditures	782,756	782,756	0	0	0	0

DRAFT

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

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/8/2024

	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. Electrical Upgrade & Office Space Remodel	300,000	300,000				
2. Capital Improvements to Therapeutic Community Garden	100,000	100,000				
3.						
CFTN Programs - Technological Needs Projects						
4. Technology Upgrades	255,700	255,700				
5.	0	0				
6.	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	655,700	655,700	0	0	0	0

DRAFT

Appendix

DRAFT