TRI·CITY
Mental Health

Mental Health Services Act (MHSA)

ANNUAL UPDATE

FY 2025-26

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MHSA County Compliance Certification

County: TRI-CITY MENTAL HEALTH AUTHORITY

Local Mental Health Director
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Program Lead
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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 2025-26, attached hereto, was adopted by the Tri-City Governing Board on April 16, 2025.

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 2025-26 are true and correct.

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

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

I hereby certify that the MHSA Annual Update FY 2025-26 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.

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

I hereby certify that for the fiscal year ended June 30, 2024, 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 15, 2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, 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.

County Auditor Controller / City Financial Officer	Signature	Date

Executive Summary

Community Program Planning Process

The Community Program Planning process began in the fall of 2024 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 Program 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 Program Planning Survey	Fall 2024
MHSA Community Forums (i.e. Stakeholder Meetings)	9/4/2024 9/5/2024 9/30/2024 11/7/2024 11/21/2024 1/28/2025 1/28/2025 1/29/2025 2/5/2025 (2 meetings)
30-Day Posting of the MHSA Annual Update FY 2025-26	3/7/2025 – 4/8/2025
MHSA Public Hearing and Meeting of the Tri-City Mental Health Commission	4/8/2025
Tri-City Governing Board Approval and Adoption	4/16/2025

MHSA Plan Highlights & Actions Since Previous Annual Update

Community Services and Supports (CSS)

CSS Program	Total Number Served FY 2023-24	Projected Number to be Served FY 2024-25
Full-Service Partnerships	787	608
Community Navigators	1,283	1,073
Wellness Center	1,630	898
Supplemental Crisis Services	592	No projections due to program sunsetting on June 30, 2024
Field Capable Clinical Services for Older Adults	52	35
Permanent Supportive Housing	211	231
Access to Care	2,793	2,793

Prevention and Early Intervention (PEI)

PEI Program	Total Number Served FY 2023-24	Projected Number to be Served FY 2024-25
Community Wellbeing	5,723	5,890
Community Mental Health Trainings	768	921
Stigma Reduction and Suicide Prevention	722	435
Older Adult & Transition Age Youth Wellbeing (Peer Mentor Program)	26	62
Wellness Center PEI /TAY and Older Adults	1,317	1,029
Family Wellbeing	878	519
NAMI: Community Capacity Building Program	176	181
Housing Stability Program	61	78
Therapeutic Community Gardening	330	277
Early Psychosis Program	24	54
School-Based Services	201	289

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.

Demographics

The total population for the Tri-City area is approximately 213,619 residents. Pomona has more than twice the population of the other two cities combined.

Table 1: Population by City

TOTAL POPULATION BY CITY				
	La Verne	**Claremont**	**Pomona**	**Tri-City Area**
Total population	31,239	36,891	145,489	**213,619**

Source: U.S. Census data from 2023 ACS 1-Year Estimates

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

Table 2: Total Population by Age Group

TOTAL POPULATION BY AGE GROUP					
City: **Age group:**	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by Age**
0-14	4,771	4,844	25,340	34,955	16.4%
15-24	4,017	7,371	16,997	28,385	13.3%
25-59	12,756	114,746	75,183	102,685	41.8%
60+	9,695	9,930	26,135	47,594	22.3%
Totals	**31,239**	**36,891**	**145,489**	**213,619**	**100.00%**

Source: U.S. Census data from 2023 ACS 5-Year Estimates

Table 3: Total Population by Race/Ethnicity

TOTAL POPULATION BY RACE/ETHNICITY					
Race	**La Verne**	**Claremont**	**Pomona**	**Tri-City Area**	**% by ethnicity**
African American	1,029	2,006	10,384	13,419	6.3%
Asian Pacific Islander	3,255	5,666	17,599	26,520	12.4%
Native American	80	18	264	362	0.2%
White	14,116	17,631	14,186	45,933	21.5%
Hispanic or Latino/a/x	11,349	8,983	99,600	119,932	56.1%
Another Race	178	284	19,980	1,755	0.8%
Two or more races	1,232	2,303	2,163	5,698	2.7%
Race Totals:	**331,239**	**36,891**	**145,489**	**213,619**	**100.00%**
Ethnicity					
Hispanic/Latino/a/x (if any race)	11,349	8,983	99,600	119,932	56.1%
Not Hispanic or Latino/a/x	19,890	27,908	45,899	93,678	43.9%
Ethnicity Totals:	**31,239**	**36,891**	**145,489**	**213,619**	**100.00%**

Source: U.S. Census data from 2023 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, 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.

With the passing of Proposition 1 in March 2024, MHSA will transition to the Behavioral Health Services Act (BHSA) on July 1, 2026. This current Annual Update plan will remain in effect through fiscal year 2025-26. Any changes will be reflected in the Behavioral Health Services Act Three-Year Plan, which under BHSA, will be called the County Integrated Plan for Behavioral Health Services and Outcomes. Tri-City is committed to continue providing quality, diverse and accessible programming to the community, under the new BHSA guidelines and policy.

Five Components of the Mental Health Services Act

Plan Component	Focus	Year Approved
Community Services and Supports (CSS)	Provides intensive treatment and transition services for people who suffer with serious and persistent mental illness	2009
Prevention and Early Intervention (PEI)	Implement services that promote wellness and prevent suffering from untreated mental illness	2010
Workforce Education and Training (WET)	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 Program Planning Process

The success of the MHSA Community Program 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 program or plan.

One critical component to the stakeholder process is the partnership and collaboration between TCMHA 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 and opportunities for participation regarding specific areas of the community program planning process are listed below:

Mental Health Policy Public comments during Mental Health Commission meetings, Governing Board meetings and other stakeholder events	**Program Planning and Implementation** Stakeholder and Orientation meetings, MHSA workgroups, Community Program Planning Survey, and Wellness Collaboratives	**Monitoring** 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 Annual Community Program Planning Survey, surveys completed following trainings, webinars, and presentations, l Wellness Collaboratives	**Evaluation** Stakeholder and Orientation Meetings, opportunity for questions, MHSA workgroups, review outcomes for programs, 30-day postings and public comments, Public Hearing public comments	**Budget Allocations** 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 tree 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 LGBTQ community; representatives from the Los Angeles County Department of Mental Health (LACDMH) and other county agencies.

Opportunities for collaboration include the following stakeholder engagement activities:

Tri-City Event	Description
MHSA Stakeholder Orientation (Virtual)	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 (Virtual)	These presentations during new employee orientation includes 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 Program Planning Survey	This annual online 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.
Informal Interviews with Community Members/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 (Virtual)	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	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.

The following table reflects specific community program planning activities and collaboration impacting the development of this MHSA Annual Update FY 2025-26:

MHSA Event	Dates	Purpose
MHSA Community Forum at Tri-City	9/4/2024	Orientation to MHSA and introduction to current programs, evaluations, and budgets (Hybrid morning meeting).
MHSA Community Forum at Tri-City	9/5/2024	Orientation to MHSA and introduction to current programs, evaluations, and budgets (Hybrid evening meeting).
MHSA Community Forum *Stakeholder meeting at community location*	9/30/2024	Meeting aimed at children, TAY, families and schools in the service area.
MHSA Community Forum *Stakeholder meeting at community location*	11/7/2024	This stakeholder meeting focused on service providers of children, TAY, families, and Hispanic/Latino/a/x individuals.
MHSA Community Forum *Stakeholder meeting at community location*	11/21/2024	MHSA orientation and introduction with program overview for community group of religious organizations, law enforcement, and other non-profits.
MHSA Community Forum *Stakeholder meeting at community location*	1/28/2025	Meeting presented to university alumni group with graduates, staff, and students representing various concentrations and degrees.
MHSA Community Forum *Stakeholder meeting at community location*	1/28/2025	Meeting presented to a community group with local clinics, government agencies, school district staff and insurance groups, among others.
MHSA Community Forum *Mid-Year Stakeholder Update Meeting*	1/29/2025	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 to a discussion and vote related to how to spend excess CSS dollars.
MHSA Community Forum *Stakeholder meeting at community location*	2/5/2025 (Two Meetings)	Presentation provided to school district employees, parents of k-12 children and various community partners. A morning in-person meeting and evening virtual meeting were provided.
30-Day Posting for Amendment to MHSA Annual Update FY 2025-26	3/7/2025 through 4/8/2025	The MHSA Annual Update FY 2025-2026 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 and Mental Health Commission Meeting	4/8/2025	The 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 2025-26. Feedback from participants will be reviewed and incorporated into this plan. The Mental Health Commission will potentially endorse the plan for submission to Governing Board for consideration of approval and adoption.
Tri-City Governing Board Approval	4/16/2025	Tri-City's Governing Board will meet to approve and adopt the MHSA Annual Update FY 2025-26.

Proposals Approved During the FY 2024-25 Community Program Planning Process

Psychiatric Advanced Directives, (PADs) Phase II Multi-County Collaborative Innovation Project for Tri-City Mental Health Authority

During the MHSA Community Forums held on September 4th and 5th, 2024, stakeholders were provided updates on PADs Phase I, as well as the plan and budget developed to potentially implement PADs Phase II. Stakeholders were given the opportunity to make comments, ask questions and provide feedback on PADs Phase II. Attendees voted on whether they were in favor of moving forward with PADS Phase II and the majority of attendees voted in favor of moving forward with the project.

Voting Results - Are you in favor of moving forward with approving PADS phase II?

Yes	No	Maybe/unsure
87.5%	0%	12.5%

The plan was posted for a 30-day comment period from September 6, 2024, through October 8, 2024. On October 8, 2024, a Public Hearing pertaining to PADs Phase II was held during the regular Tri-City Commission meeting. Following presenting on PADS Phase I background, goals of PADs Phase II, and budget; the Commission moved to endorse the plan. On October 23, 2024, the Tri-City Governing Board met and approved PADs Phase II. With this approval, the plan was added to the Mental Health Services Oversight and Accountability Commission (MHSOAC) consent calendar and was approved on November 21, 2024. With this approval, the Innovations PADs project can continue to Phase II beginning on July 1, 2025.

MHSA Annual Update FY 2024-25 Mid-Year Update: Claremont Gardens Senior Housing Project

Tri-City Mental Health Authority proposed to update its FY 2024-25 MHSA Program Annual Update to utilize existing unspent CSS funding to support the completion of the Claremont Gardens Senior Housing Project at 956 W. Baseline Road, Claremont, California 91711 under the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan in an amount not to exceed three million dollars ($3,000,000). Under the Mental Health Services Act, Counties may use General System Development funds under their CSS plan for costs associated with purchasing, renovating, or constructing of Project-Based Housing (9 C.C.R. § 3630.05). The proposed plan amendment will support the cost of the final renovation of this property.

Under the State MHSA Regulations (9 C.C.R. § 3315(b)), any update to the MHSA Program, other than the required annual update, must undergo a local review process that includes a 30-day public comment period however no public hearing is expressly required. This plan amendment was posted for a 30-day public comment period beginning November 8, 2024, until December 7, 2024, on Tri-City's website as well as all social media sites including Facebook, Instagram, and Twitter. In addition, this amendment was distributed to numerous locations including city halls, libraries, and community

centers. No feedback was received and there were no substantive changes made to the plan. This plan was presented to the Mental Health Commission on November 12, 2024. The Tri-City Governing Board reviewed this amendment on December 18, 2024, approving and adopting the amendment.

Allocate $5,200,000 in Community Services and Supports (CSS) Funds for the Purpose of Expanding Temporary Supportive Housing Options for Tri-City Clients Within the Cities of Pomona, Claremont, and La Verne.

Under California Code of Regulations § 3420.50 Counties are required to spend or transfer Community Services and Supports (CSS) monies within three fiscal years of receiving those funds from the State Controller. If the County fails to spend or transfer these funds out of CSS within that period, the funds become subject to reversion to the Mental Health Services Fund Reversion Account.

Based on the following receipts Tri-City has identified CSS funds that are at risk of reversion by June 30, 2027.

- Average annual CSS amounts received range from $9 to $11 million.
- Fiscal year 23/24 receipts were $16.3 million.
- Fiscal Year 24/25 receipts estimated to be $16.2 million.
- Total amount at risk of reversion at 6/30/27 is estimated to be $5.2 to $8.0 million.

With these funds available, Tri-City engaged community stakeholders, city officials, mental health commissioners, and governing board members, to identify the priority needs and gaps in services for the three cities. The results indicated an overwhelming desire to support the unhoused and homeless individuals located within the Tri-City catchment area.

A recent point-in-time count for homeless individuals revealed the following information indicating a high need for temporary supportive housing specifically in the city of Pomona:

City	Number of Homeless Individuals 2024
Pomona	545
Claremont	18
La Verne	22

Tri-City Mental Health Authority is proposing to expend an estimated $5.2 million dollars in Community Services and Supports (CSS) funds for the purpose of expanding temporary housing options and supportive services for unhoused individuals that are struggling with finding and maintaining housing. [1]

[1]Under the Mental Health Services Act, Counties may use General System Development funds under their CSS plan for costs associated with purchasing, renovating, or constructing of Project-Based Housing (9 C.C.R. § 3630.05).

(C.C.C. § 3420.50) Reversion for Counties: County shall spend CSS Account monies within three (3) fiscal years of receiving those funds from the State Controller, or within three (3) fiscal years of transferring funds from the Prudent Reserve to its CSS Account pursuant to sections 3420.30(g) or 3420.35. If a County fails to spend such funds within three (3) fiscal years, the funds shall revert to the Mental Health Services Fund for deposit into the Reversion Account.

Stakeholder Process

On January 29, 2025, Tri-City Mental Health Authority held a mid-year MHSA Community Forum for stakeholders, staff, and community members. During this meeting, attendees were advised by staff that Tri-City has an excess of CSS funds in the estimated amount of $5.2 million dollars that needs to be spent or transferred prior to June 30, 2027, or be subject to reversion back to the State. Participants were then presented with a list of projects that would meet the criteria for funding with CSS dollars. Participants were asked to rank the options in the order of their top choices. The top two choices that met the criteria for CSS funding were: 1) Purchase an existing building to create a form of bridge housing; and 2) Purchase Scattered Site Housing.

This feedback from stakeholders was then presented to Tri-City's Governing Board on February 19, 2025. The Executive Director for Tri-City then met with city leaders for Pomona, Claremont, and La Verne independently to solicit their input for this project. In addition to the shared consensus and advocacy for supportive housing, these discussions brought forth a secondary list of recommendations which Tri-City will consider as part of its behavioral health transformation process under BHSA in 2026.

After careful consideration of all recommendations, the final decision was made to allocate the unspent CSS funds as follows:

1. To purchase an existing commercial building or residential property, renovating, if necessary, with the goal of creating additional housing options and support services.
2. Partner with local landlords and property managers to purchase individual units in apartment complexes located throughout the cities of Pomona, Claremont, and La Verne for the purpose of providing additional housing options.
3. Increase the number of reserved beds with Hope for Home Shelter located in Pomona.

Once the property(s) have been identified for acquisition, Tri-City staff will seek final approval from the Tri-City Governing Board before proceeding with the purchase(s). In addition, a new contract will be presented for approval to reserve additional beds from the Hope for Home Shelter.

This request is hereby incorporated in this MHSA Annual Update FY 2025-26 to the Three-Year Program and Expenditure Plan FY 2023-24 – 2025-26. This action will also prevent the potential reversion of CSS funds.

Transfer $3,000,000 from the Community Services and Supports plan to Workforce Education and Training and Capital Facilities and Technological Needs plans.

Request for transfer of funds in the amount of $3,000,000 from Community Services and Supports (CSS) to be allocated as follows:

Capital Facilities and Technological Needs (CFTN)	$1,500,000.00
Workforce Education and Training (WET)	$1,500,000.00
Total	**$3,000,000.00**

The Community Service and Supports (CSS) plan, which receives the largest portion of MHSA funding at 76%, provides intensive treatment and transition services for people who experience serious and persistent mental illness or severe emotional disturbances or who are at risk of SMI/SED. In addition, the California Code of Regulations § 3420.10 allows for the transfer of excess funds from the Community Services and Supports (CSS) account to Prudent Reserve, CFTN account and WET account.

This ability to reallocate funds is critical to the sustainability of the Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET) plans since each received only a one-time allocation at the time of approval.

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

Therefore, the $1.5 million dollars in CSS funding from this proposal will be allocated to CFTN to 1) strengthen the technological infrastructure of Tri-City, 2) purchase or lease existing building(s) to create needed office space for staff and 3) reduce the risk of reversion of CSS funds.

Workforce Education and Training (WET) which also received a one-time allocation at the time of approval focuses on strengthening and supporting existing staff and caregivers through trainings while also concentrating on attracting new staff and volunteers to ensure future mental health personnel.

Therefore, the $1.5 million dollars in CSS funding from this proposal will be used to expand Tri-City's training programs, both internal and external (community), as well as provide incentives for recruitment and retention of staff.

This request is hereby incorporated in this MHSA Annual Update FY 2025-26 to the Three-Year Program and Expenditure Plan FY 2023-24 – 2025-26. This action will prevent the potential reversion of CSS funds.

MHSA Community Program Planning Survey

Beginning in July 2024, stakeholders and community partners were invited to participate in Tri-City's MHSA Community Program Planning Survey, which provides an opportunity for stakeholders to share their thoughts and concerns regarding the availability of support services. MHSA Projects Manager partnered with Innovations to update the survey (such as utilize tablets for survey completion and

update the language to be more inclusive) and distribute the Community Program Planning survey (for example station staff where surveys were available for 1:1 support and provide small incentives for completing surveys). Survey results were also collected via QR codes, email, and community meetings.

Pop-Up Tables at Community Centers: Staff set up tables at community centers across the service area to directly engage with community members and assist with completing the survey on-site. To further support this, staff enlisted Community Navigators, who were stationed within these centers, to help individuals take the survey. For older adults who needed additional assistance, one-on-one support was provided to navigate the tablets. This personalized approach made the experience more accessible and comfortable for participants, especially for those who might not be familiar with virtual platforms.

Outreach at High-Engagement Events: In October 2024, staff attended high-traffic community events such as trunk-or-treat in October 2024, which drew significant attendance. Booths were set up where with the QR code and attendees were able to take the survey on their personal devices. For those without a personal phone, tablets were available to facilitate survey completion. This outreach method proved successful, allowing the ability to engage with people in a fast-paced environment and encourage survey participation.

Incentives: To further encourage participation, the incentives such as custom tote bags and other give-away items were provided. These giveaways helped attract more people to take the survey and provided a tangible reward for their time.

Real-Time Feedback: During outreach, staff documented comments and concerns raised by participants. For example, some noted that the survey was too long or that the language used was too advanced. This feedback led to adjustments in the survey to ensure it was easier for responders to understand and complete.

Integration with Focus Groups: To further boost participation, the survey was integrated into focus group sessions facilitated by the Innovations team. At the start of each focus group, participants were introduced to the survey's purpose and completed it during the session. This strategy assisted in reaching more individuals and gather additional insights from focus group participants.

The Community Program Planning Survey

This annual survey is used to identify the needs and priorities of the three cities. Survey results were then incorporated into this MHSA Annual Update FY 2025-26. This survey is just one of many opportunities where stakeholders can share their voice regarding the needs of the communities.

Survey Results

Surveyed participants were asked to identify improvements that Tri-City could make to its programs and services to better meet the needs of the community.

The following chart outlines the specific themes identified based on responses received.

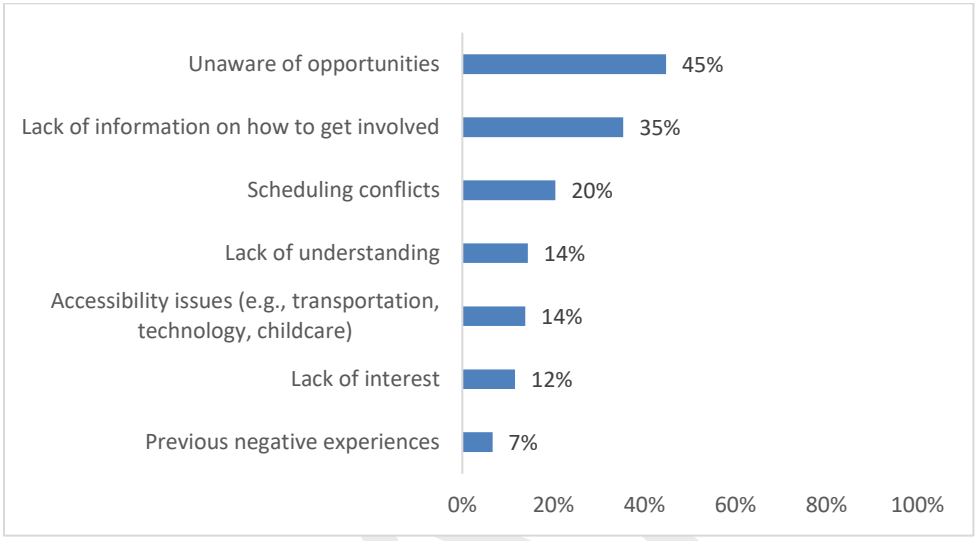
Themes	Count	Percentage
Increased Advertising & Outreach	50	28%
Expanded Services	33	18%
Better Communication & Information	32	18%
Improved Access to Services	9	5%
Community Collaboration & Support	1	1%
Community Feedback	2	1%
Unaware of services offered	5	3%
Satisfaction	18	10%
Uncertain	10	6%
Not Applicable/None	21	11%
Grand Total	**181**	**100%**

The following are a few examples of comments in the highest theme identified, "Increased Advertising & Outreach," made by 28% of survey participants regarding how Tri-City's programs and services can improve to better meet the needs of the community. These comments will be addressed by staff in future MHSA stakeholder meetings and workgroups:

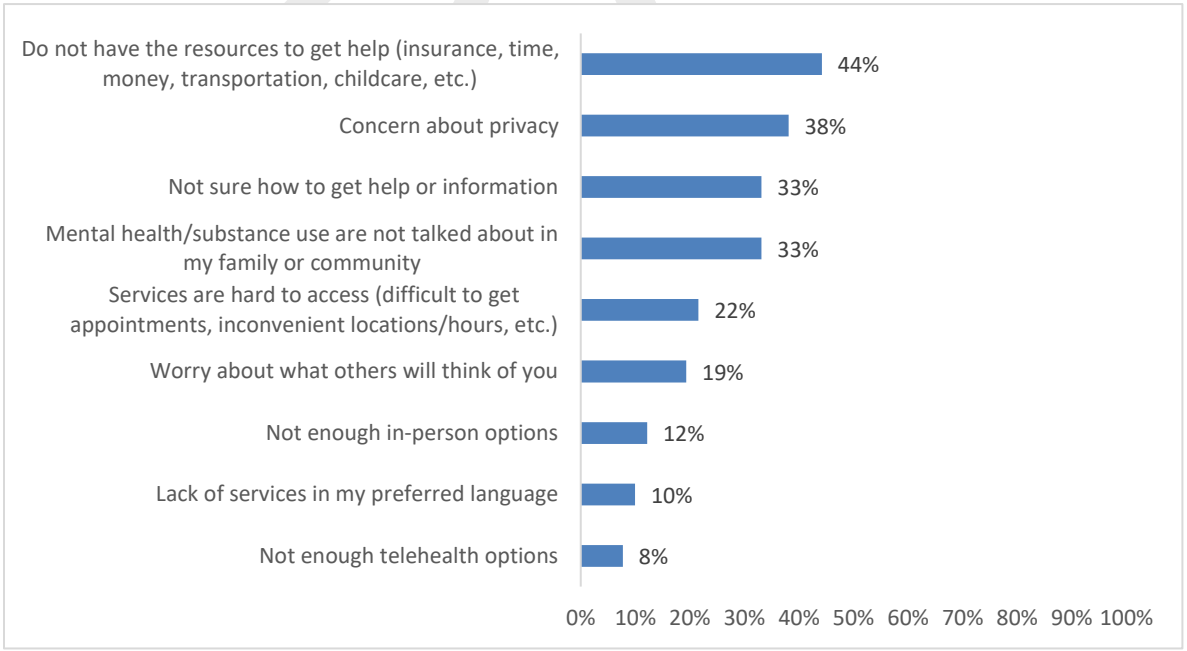
- "More/vast broad communication of your organization's service. I live across the street from your office…and see very little about the organization and services."
- "I think with more advertising and marketing we could be more aware of the resources offered."
- "Connect more with the community."
- "I think more outreach and more advertisement of services/programs."
- "Finding the area that will have the most engagement."
- "Increased community field outreach"
- "Keep showing up to community events"
- "Visit our departments more often and share what your do/what services are available that officer[s] can utilize in the field when dealing with patients."

The following examples show other questions presented to in the Community Program Planning Survey, as well as the results:

1. What obstacles have affected your participation in the mentioned Tri-City Mental Health's activities*, whether in the past or currently? *(Select all that apply)*



2. Please identify the top 3 barriers that you or someone you know face when looking for mental health support. *(Select all that apply)*



* Complete survey results are included in the Appendix

California Proposition 1:
Behavioral Health Services Act (BHSA) and Bond Measure

In March 2024, California voters passed Proposition 1. The two-bill package, Senate Bill (SB) 326 and Assembly Bill (AB) 531 proposed statewide efforts to reform and expand California's behavioral health system and was put on the ballot by the California State Legislature and the Governor. Proposition 1 is Governor Newsom's attempt to Modernize the Mental Health Services Act (MHSA) and increase supportive housing and access to treatment facilities. This will also 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.

30-Day Public Comment and MHSA Public Hearing

The MHSA Annual Update FY 2025-26 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 2023-24. An electronic draft of this Annual Update was posted on Tri-City's website on March 7, 2025, for a 30-day public comment period ending April 8, 2025. 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 document on four different digital platforms.

On April 8, 2025, the Tri-City Mental Health Commission will host the MHSA Public Hearing where community members will be invited to join and review a presentation regarding program updates summarized in the most recent MHSA Annual Update FY 2025-26. Participant feedback to staff will be reviewed and incorporated into this plan. The Mental Health Commission will have the opportunity to endorse the plan for submission to Tri-City's Governing Board for consideration of approval and adoption. The Tri-City Governing Board will be presented this recommendation of the MHSA Annual Update FY 2025-26 on April 16, 2025.

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 for Fiscal Year 2023-24 are highlighted in each program summary by age group, number of clients served, projected number to be served and average cost per person.

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 2021-22	98	162	454	73	**787**
Projected Number to be Served FY 2024-25	110	134	308	56	**608**
Cost Per Person	$17,040	$14,854	$11,670	$10,927	**$54,491**

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 use 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 2023-24, The FSP program has continued to adapt to California Advancing and Innovating Medi-Cal (CalAim) billing reform while ensuring that the clients with the highest needs are effectively served. Staff have prioritized providing field-based services in an efficient manner and continue to provide quality outreach when clients are disengaged.

This fiscal year also displayed an increase in collaboration with school partners. FSP staff have regularly consulted and participated in various school meetings and Individualized Education Plan (IEP) meetings to support client progress. Building and maintaining these connections with the schools in our service area increases the likelihood that we can make our resources known to our districts, communicate referral processes, and support individuals who are in need of services.

There was also a noticeable increase in crises prevention and wrap around support that has been provided for clients. This was evident upon reviewing the data related to crisis occurrences and hospitalizations. The data indicated a small portion of clients served required a higher level of crises intervention service, as well as low numbers related to hospitalizations. This is an ongoing topic of discussion during meetings and supervision, and as a result staff have become better equipped to assess, manage, and incorporate prevention techniques. We can see this work directly impacting our FSP clients in a positive manner.

To enhance quality of care, a support drop-in hour was created in the FSP program for staff who need to consult on cases that may require additional support, feedback on clinical technique or additional wrap around services. It is very beneficial for staff to have a designated time, outside of their regularly scheduled supervision, to bring up questions or seek guidance. That additional staff support directly impacts the quality of care received by the client.

Challenges and Solutions

The FSP program experienced an increase of complex medical conditions reported by clients. To ensure that the individual is being addressed from the perspective of whole person care, linkage to a higher level of care and/or medical attention were indicated. To ease this process of referrals and linkage, staff were educated on Medi-Cal Managed Care Plan, CalAim, Enhanced Care Management (ECM) & other community supports during FSP team meetings, 1:1 supervision, and group supervision. Additionally, training on assessing, evaluating, and managing crisis for medical concerns was offered during team meetings and supervisions.

Release of Information (ROI) documents were revised and that presented a new learning curve regarding how to gather the appropriate information for the document, as well as how to complete the form. FSP teams attended trainings established by the Quality Assurance team to assist in the new documentation process with clients.

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 and influence how individuals conceptualize 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. FSP programs attempt to hire a diverse group of staff that include bilingual abilities to expand our range of services to monolingual communities. We have seen great success with cases when we have been able to assign providers who match cultural and language preferences of clients. To reduce language barriers, the program has utilized a language line, which supports staff

by providing direct access to translation when providing services in the language of the clients we serve.

Additionally, trainings and themes during meetings focus on addressing topics around LGBTQ+ communities. Staff are also provided with access to resources within the community that could support LGBTQ+ clients, including Peer Support Specialists, Peer Mentors, and the Pomona Valley Pride. To support equity efforts, FSP referrals and documentation materials are translated to Spanish, one of the most prominent languages used in this community.

Community Partners

The FSP team and Housing Division team communicate often to discuss available internal and external resources and how to support families who are insufficiently housed. FSP collaborates regularly with internal and external substance use disorder (SUD) programs as well. The Tri-City SUD provider joins FSP meetings to streamline communication and provide feedback when discussing high risk cases. Staff regularly hold treatment team meetings, both with and without family, to make sure that everyone is efficiently and effectively supporting clients in their treatment goals. FSP programs closely work with the three cities' police departments to support clients in crisis as well as with Pomona Valley Hospital Medical Center when Tri-City clients need a higher level of care. Partnering with our local schools within the three cities to provide the younger population with crisis management and support during school hours ensures clients have a safe space at school to receive mental health services. FSP child and TAY programs work with organizations such as San Gabriel Pomona Regional Center to provide clients with specific services including Applied Behavioral Analysis (ABA) and Respite which target behavioral and developmental needs. FSP Programs that work with adults and older adults will partner with organizations such as the Social Security Administration or our internal Wellness Center for groups that target the adult and older adult demographic.

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 and families may have that can impact meeting their recovery goals (i.e., needing SUD services). Collaboration is done through child and family team meetings, treatment team meetings, and regular collateral contact.

Success Story

FSP Adult

An individual was referred to Adult FSP due to several mental health symptoms, substance use, housing, and other healthcare needs. Keeping a person-centered and the whole system of care approach, an array of programs and services were provided to assist the individual meet their goals. Through FSP they obtained a clinical therapist, behavioral health specialist (BHS), peer support specialist (PSS), substance use counselor (COST), psychiatrist, housing specialist (TCMH Housing Dept), healthcare providers, and Enhanced Care Management (ECM) for a Care Management Team (CMT). Through this multidisciplinary support, the client was able to address building independent living skills, process their experiences in therapy, improve money management skills, address substance

use, improve self-care and prioritize medical conditions. Ultimately, the individual was placed in permanent housing and is currently maintaining their sobriety. This is one of many cases that displays FSP's "whatever it takes" approach in supporting community members in need of the types of support that FSP can provide.

FSP Child and Transition Age Youth (TAY)

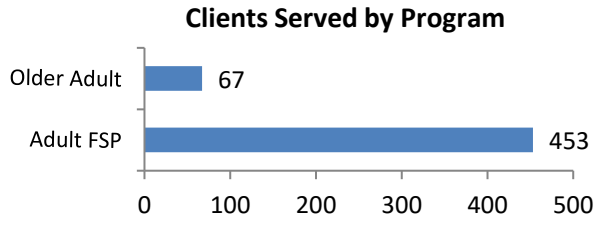
A TAY individual entered services experiencing severe symptoms of psychosis and difficulty completing daily activities without the family's assistance. Since being consistently engaged with all services and utilizing resources outside of session, the individual's activities of daily living have greatly improved. Among reported and observed improvements were increased communication skills, improved boundaries, and ability to express their needs in an appropriate manner. Additionally, the client has been known to actively practice their grounding skills when needed and in various settings. Lastly, the individual has consistently participated in groups, which has led to a sense of community with other TAYs who have experienced similar challenges. As a result, the client has not only felt a decrease in isolation but has been able to offer valuable insight to their peers and be a consistent form of support for them.

Program Summary

How Much Did We Do?

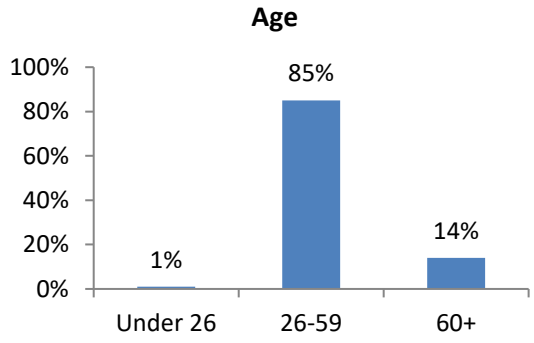
Full-Service Partnership (FSP) – Adult and Older Adult

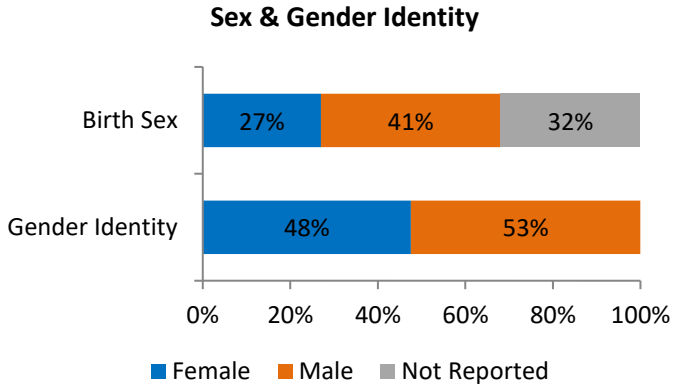
520
Individuals Served

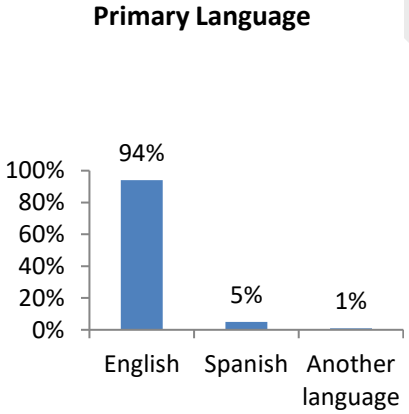


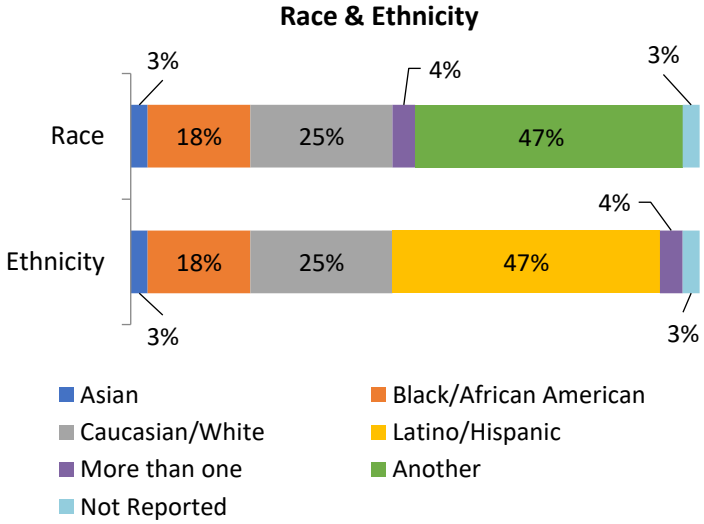
The number of individuals served **increased** from **265** in FY 2022-23 to **520** in FY 2023-24

89% of Adult/Older Adult clients lived in Pomona,
while 3% of clients lived in Claremont, 3% lived in La Verne, and 6% of clients came from other cities

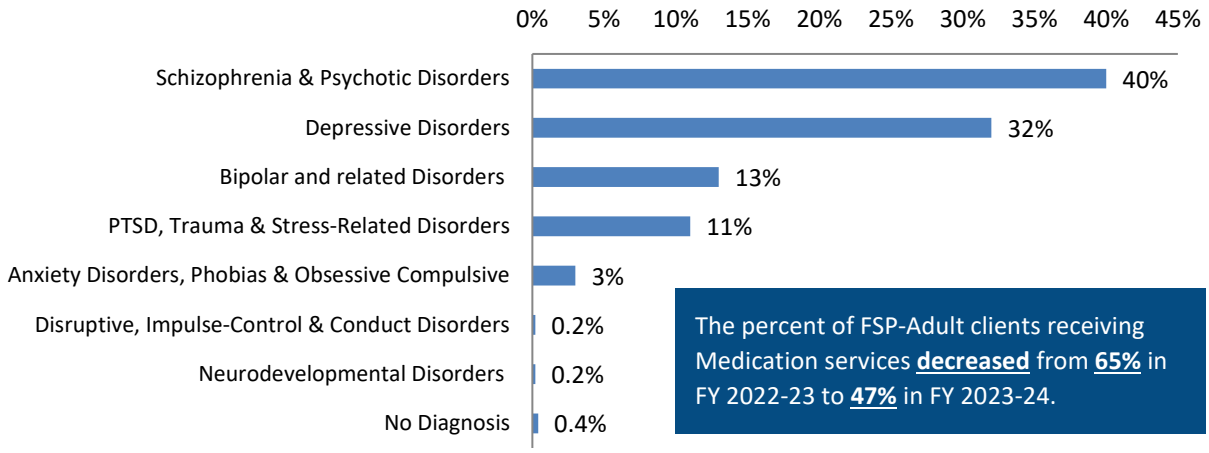






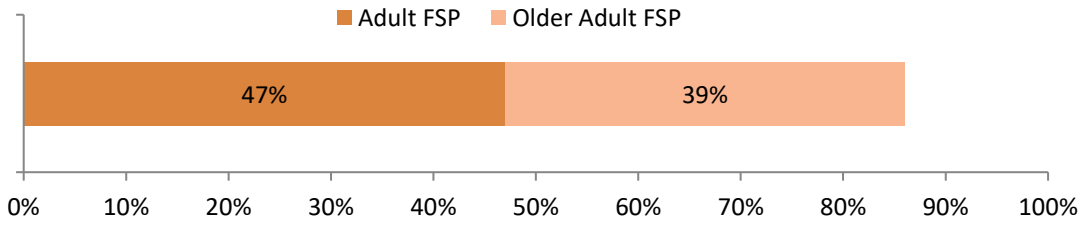


Primary Diagnosis by FSP Adult/Older Adult Clients

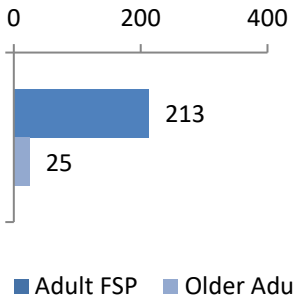


The percent of FSP-Adult clients receiving Medication services **decreased** from **65%** in FY 2022-23 to **47%** in FY 2023-24.

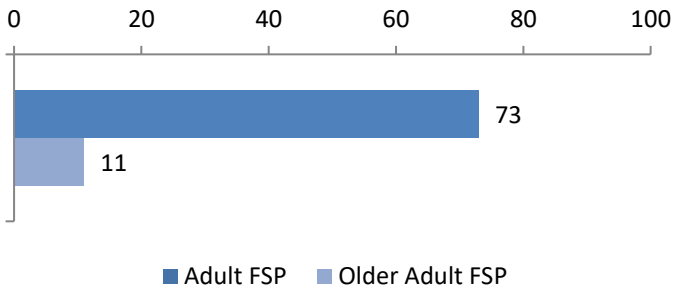
Percent of Clients Receiving Medication Services by Program



Number of Crisis Episodes

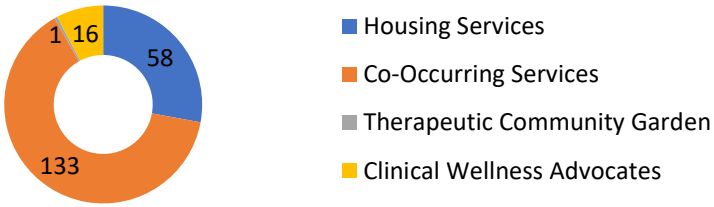


Number of Unique Clients w/ at least 1 Crisis Episodes



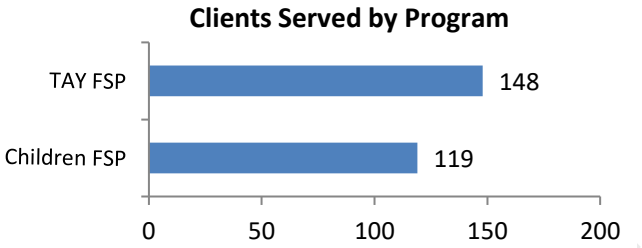
Number of FSP Adult/Older Adult Clients Connected to Other Services

***40%** of FSP clients are connected to other Tri-City*



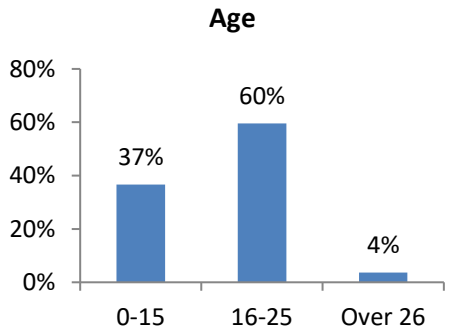
Full-Service Partnership (FSP) – Children and TAY

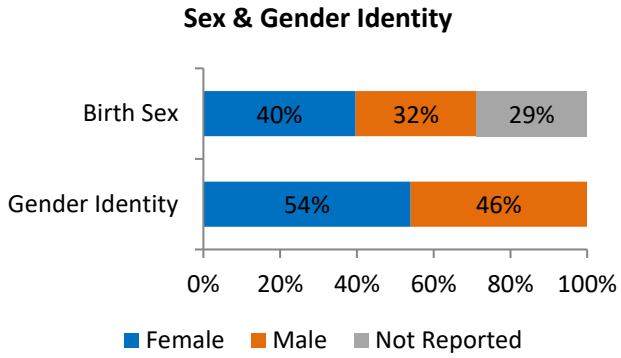
267
Individuals Served

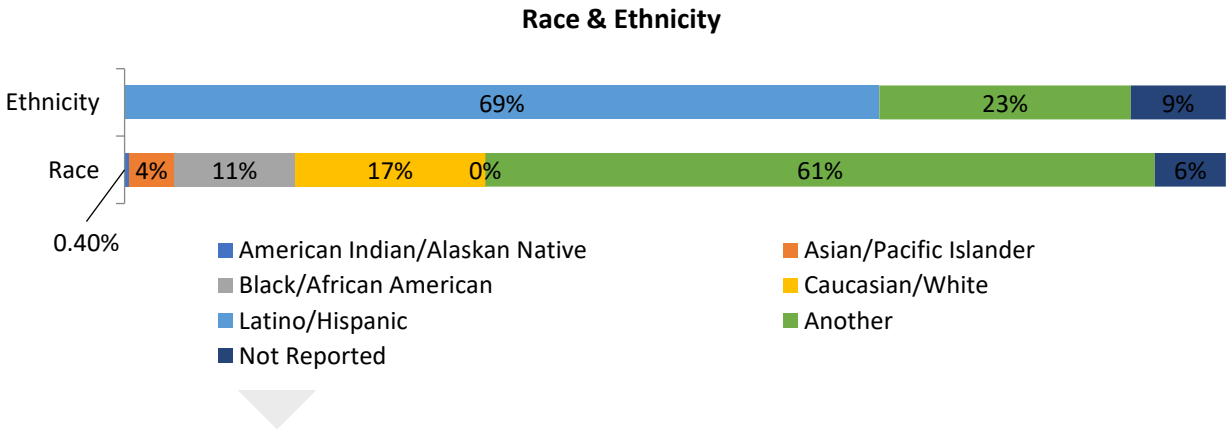


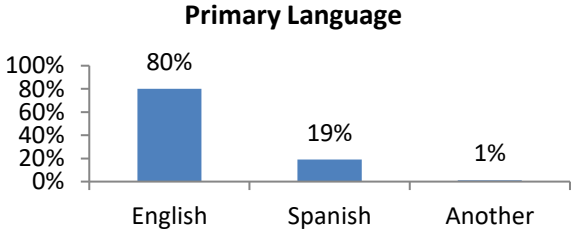
The number of individuals served increased from 225 in FY 2022-23 to 267 in FY 2023-24

84% of FSP CTAY clients lived in Pomona,
while 8% of clients lived in Claremont, 7% lived in La Verne, and 1% of clients came from other cities

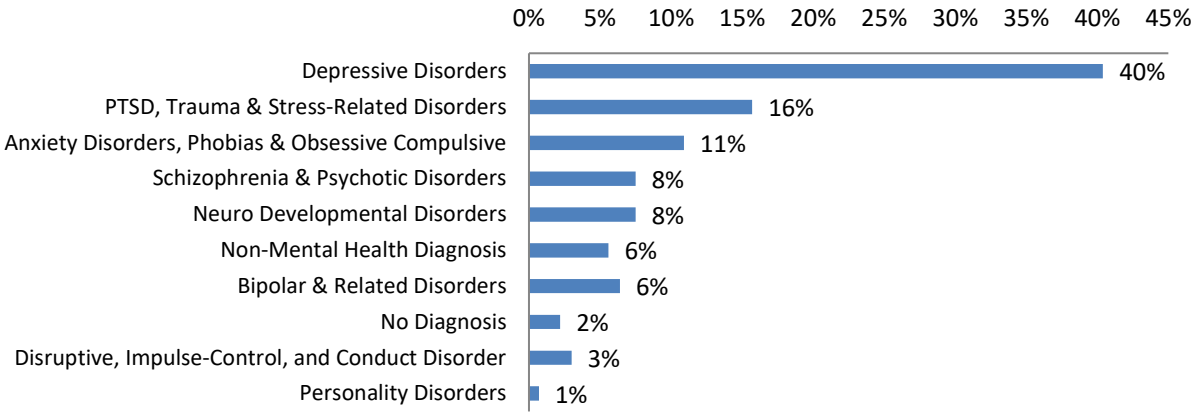




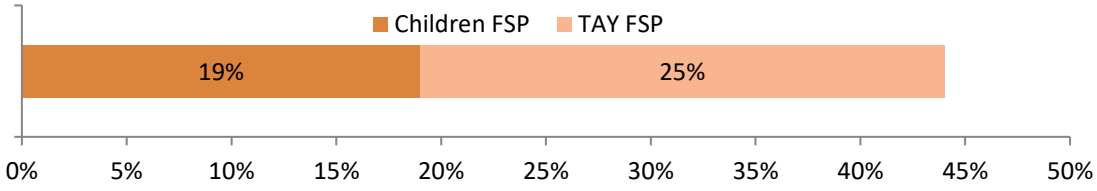




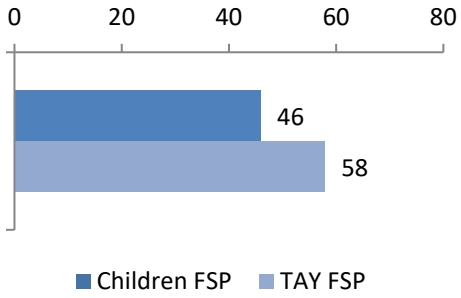
Primary Diagnosis by FSP CTAY Clients



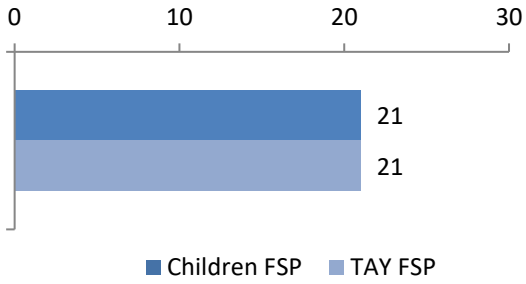
Clients Receiving Medication Services by Program



Number of Crisis Episodes

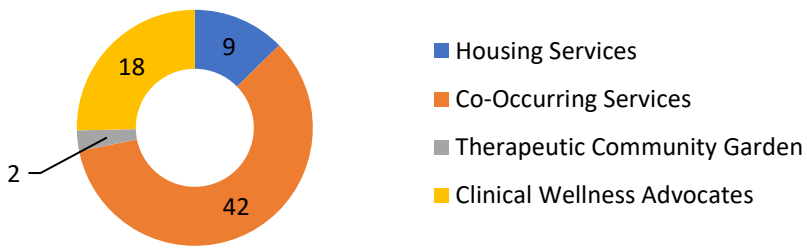


Number of Unique Clients w/ at least 1 Crisis Episodes



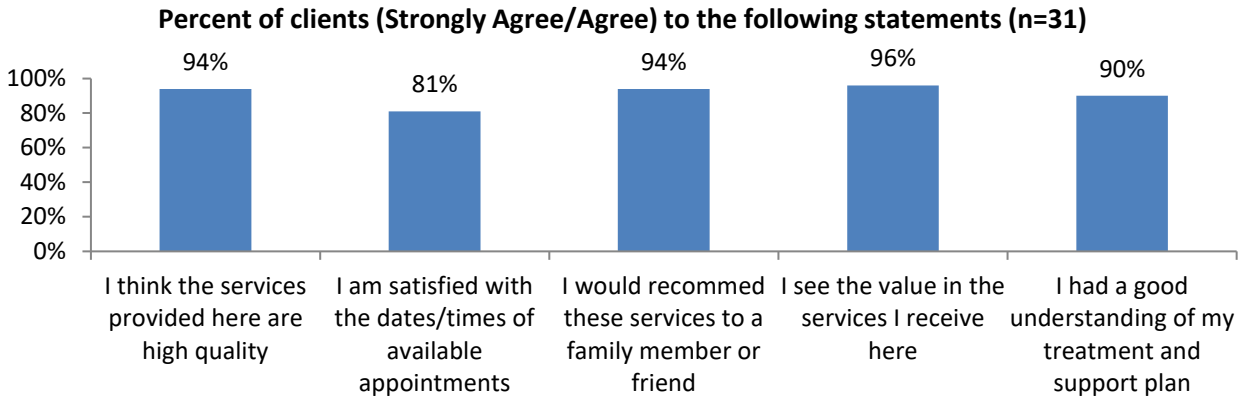
Number of FSP CTAY Clients Connected to Other Services

***27%** of FSP clients are referred to other Tri-City*



How Well Did We Do It?

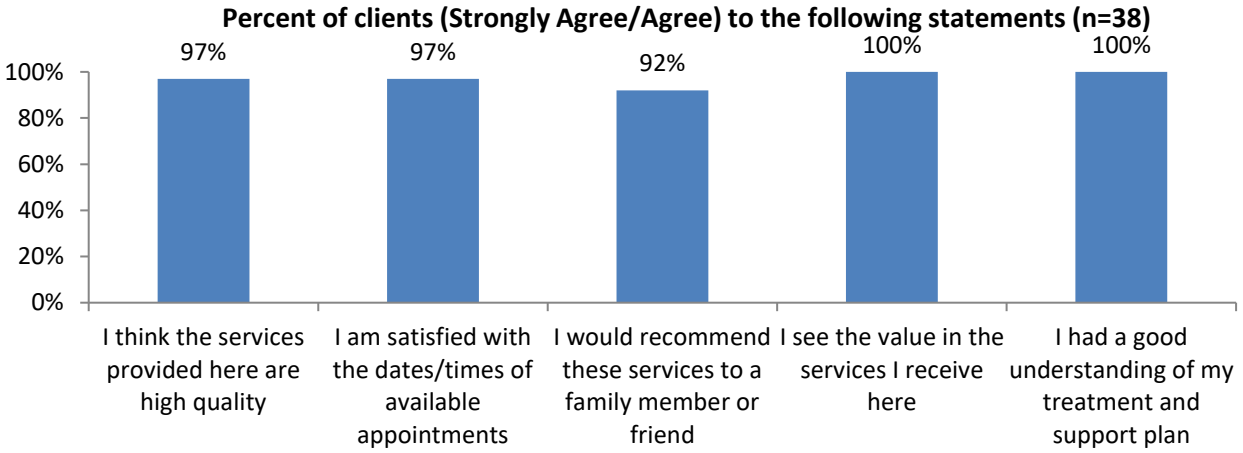
Full-Service Partnership (FSP) – Adult and Older Adult



On average, FSP Adult/Older Adult clients were enrolled for 11 months.

The average time enrolled in FSP Program **decreased** from **17 months** in FY 2022-23 to **11 months** in FY 2023-24.

Full-Service Partnership (FSP) – Children and TAY

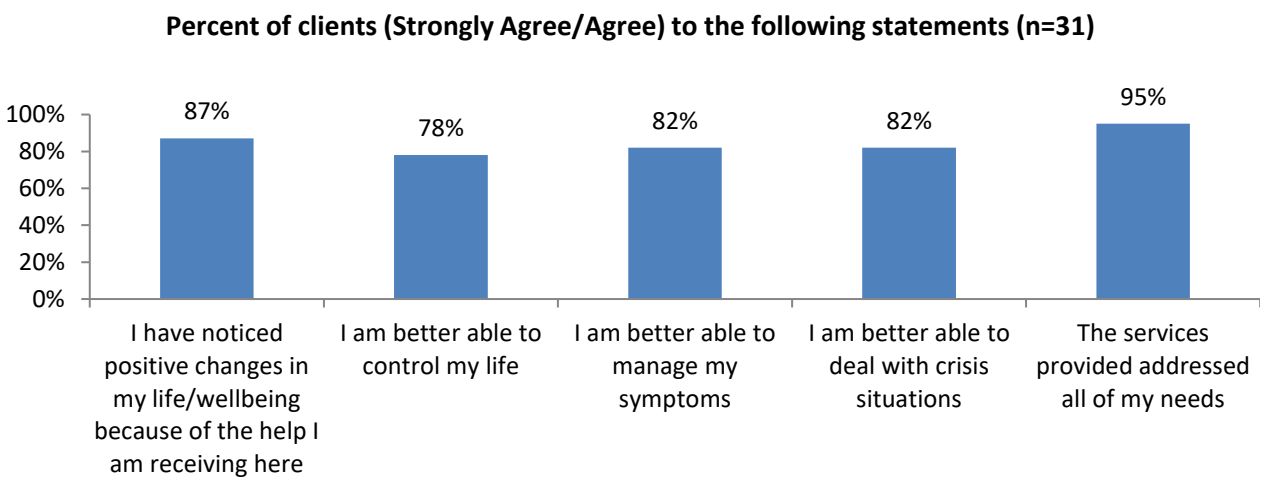


On average, FSP CTAY clients were enrolled for 9 months.

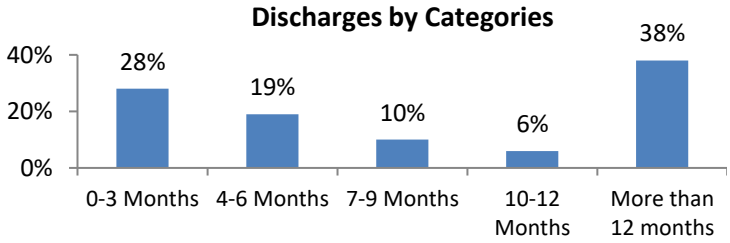
Is Anyone Better Off?

Full-Service Partnership (FSP) – Adult and Older Adult

As a direct result of the services I received:



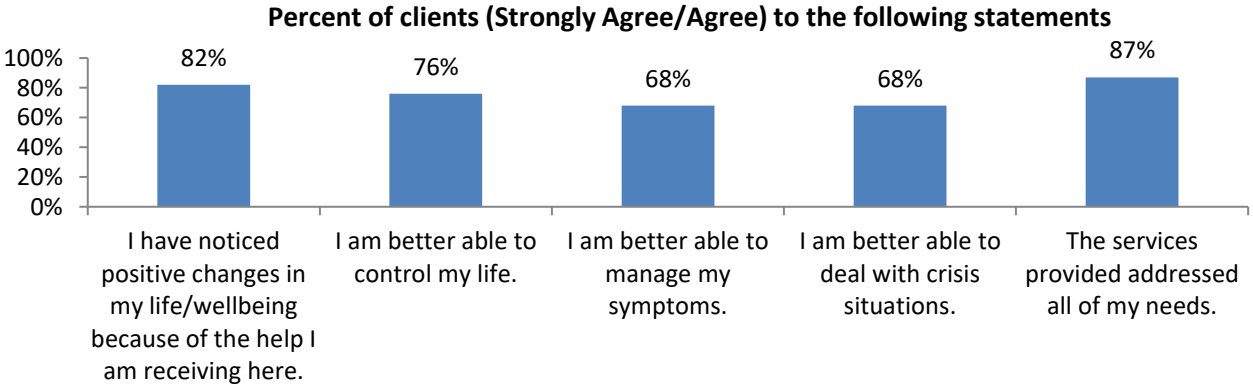
215 Discharges during FY 2023-24



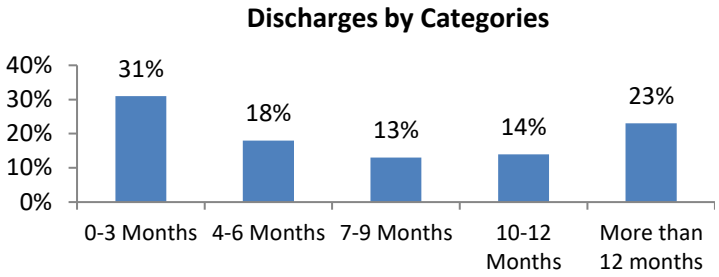
The number of discharges **increased** from **123** in FY 22-23 to **215** in FY 23-24.

Full-Service Partnership (FSP) – Children and TAY

As a direct result of the services I received:



171 Discharges during FY 2023-24



OMA Outcomes for FSP CTAY (n=69)			
OMA Reductions	**Pre-Intake & Intake**	**During FSP Enrollment (Key Event Tracking)**	**Reduction**
Homelessness	7% (n=5)	7% (n=5)	No
Hospitalizations	41% (n=28)	7% (n=2)	Yes
Justice Involvement	10% (n=7)	0% (n=0)	Yes
Expulsions/Suspensions from School	1% (n=1)	0% (n=0)	Yes

OMA Outcomes for FSP Adult/Older Adult (n=216)			
OMA Reductions	**Pre-Intake & Intake**	**During FSP Enrollment (Key Event Tracking)**	**Reduction**
Homelessness	49% (n=106)	47% (n=103)	Yes
Hospitalizations	48% (n=105)	2% (n=5)	Yes
Justice Involvement	10% (n=22)	1% (n=1)	Yes

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+	Not Reported	Total Served
Number Served FY 2023-24	32	95	357	189	N/A	**1,283**
Projected Number to be Served FY 2024-25	27	79	299	158	**510**	**1,073**
Cost Per Person	$706	$706	$706	$706	$706	**$706**

Program Update

The Community Navigator (CN) Program received grant funds for the Homeless Implementation Grant which was approved for use between February 1, 2023 through January 31, 2024. Navigators began spending these funds in July 2023 and utilized the remaining funds during this fiscal year 2023-24. This grant provided funding for short-term motel vouchers, rental and move-in assistance, and furniture assistance.

The Community Navigator program recently applied to the San Gabriel Valley Council of Governments (SGVCOG) for the Housing Solutions Fund (HSF) for homeless prevention funds. The grant was approved in April 2024 and funding should be available next fiscal year 2024-25.

The Community Navigator Program is currently collaborating with the University of La Verne's Accessibility and Student Outreach and Support Services. The University requested a Community Navigator who could be available to assist the students with resources. Currently, one of the Navigators is stationed at the University once a month and available to assist students who may need to meet in person. However, students at the University can contact a CN through the 888 number at any time to schedule a virtual appointment if needed. A flyer with this information has also been distributed to students who attend the University.

Challenges and Solutions

Limited housing and shelter resources are an on-going challenge. There continues to be a high number of families and individuals that experience homelessness in the community. Additionally, resources for emergency shelters, especially for families is very limited in the service area. Issues with finding psychiatrist that take Medi-Cal health plans, and clinicians who do not have long waiting periods has also continued to be a challenge.

The approval of SGVCOG for The Housing Solutions Fund will support in countering these challenges. This program provides cities and service providers flexible funds that will assist individuals experiencing, or at-risk of homelessness, with expenses related to housing, rehousing, and stabilization. These funds will enhance the services that the Community Navigator Program provides, since the program often receives calls from individuals and families who are on a limited income, experiencing homelessness or at risk of homelessness.

Diversity, Equity and Inclusion

The Community Navigator program consists of highly trained individuals who are bilingual and can provide services in English, Spanish and Vietnamese. This has been helpful since there is a high population of Spanish speaking individuals in Pomona as well as a Vietnamese population. In addition, some of the CNs identify with lived experience so they can better connect with clients they serve. Flyers and documents are also provided in other languages requested.

The Community Navigator staff receive ongoing cultural inclusion training to better assist the populations that they serve. In addition, the 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. The CNs are well versed in identifying services internally, and externally via community partner connections including but not limited to sliding scale mental health services, support groups and faith-based counseling. Community Navigators also work closely with local senior centers in the three cities, with some CN staff being stationed at the local community senior centers so that the program can assist older adults with support and resources when needed. The CNs also work closely with community partners whose services are geared towards LGBTQ+ individuals as well as monolingual Spanish speakers.

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 specific 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 Los Angeles Centers for Alcohol & Drug Abuse (L.A. CADA), Community Translational Research Institute (CTRI), East Valley Medical Center, Pomona Pride Center, House of Ruth, Volunteers of America and Just Us 4 Youth.

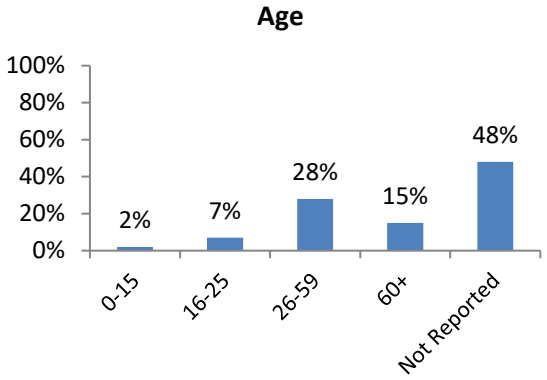
Success Story

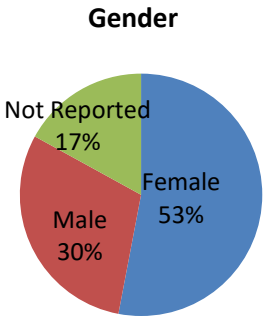
A Community Navigator worked with a single parent who had been unhoused for the past several years with their child. The CN program was able to house them in a motel for a month through the Homeless Prevention Grant. When the voucher expired, the Community Navigator connected the participant to a different crises housing program. The Navigator continued assisting the participant with multiple resources, as well as supporting them in gathering all the documents needed for a section 8 voucher that they had qualified for. Ultimately, the individual submitted all the documents needed, was approved for the section 8 voucher, and was recently housed in their own 2-bedroom apartment. The individual expressed gratitude, excitement, and happiness in being able to finally have their own place with their child, after being unhoused for so many years. With an essential need met, with the support of CNs, the participant was finally able to shift their focus to designing their space and making it a home.

Program Summary

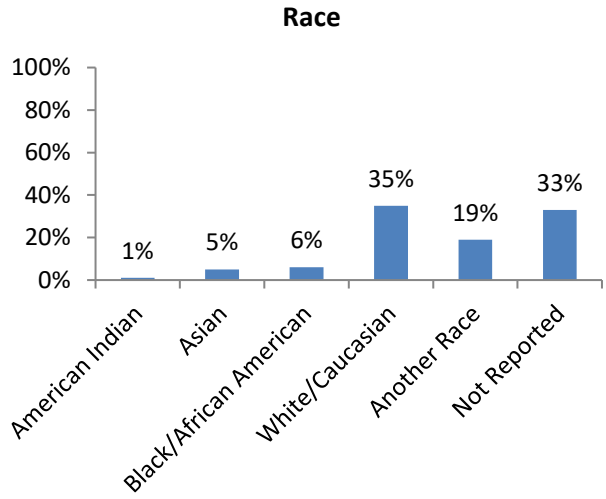
How Much Did We Do?

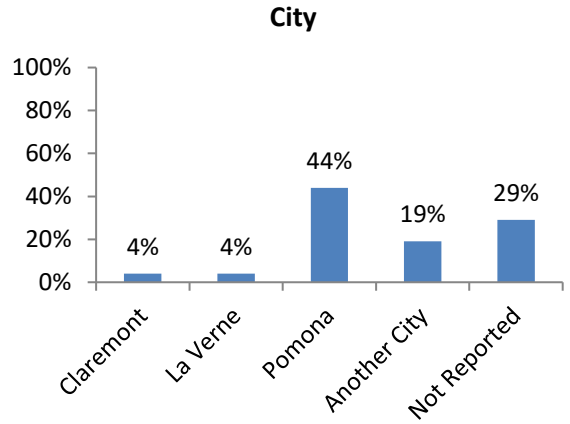
1,283 Individuals Served

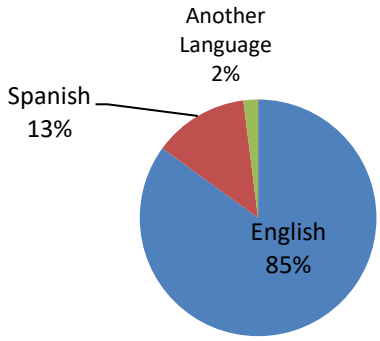




The number of individuals served **increased** from **969** in FY 2022-23 to **1,283** in FY 2023-24.





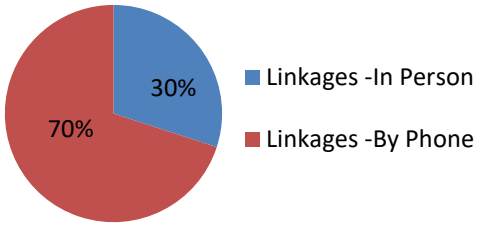


The number of homeless individuals who contacted the community navigators **increased** from **240** in FY 2022-23 to **280** in FY 2023-24.

280

Homeless Individuals who contacted the community navigators

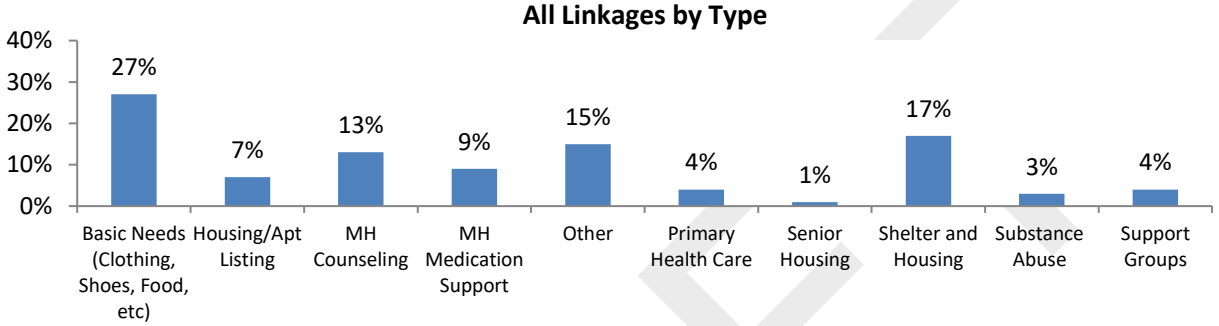
Linkages by Type



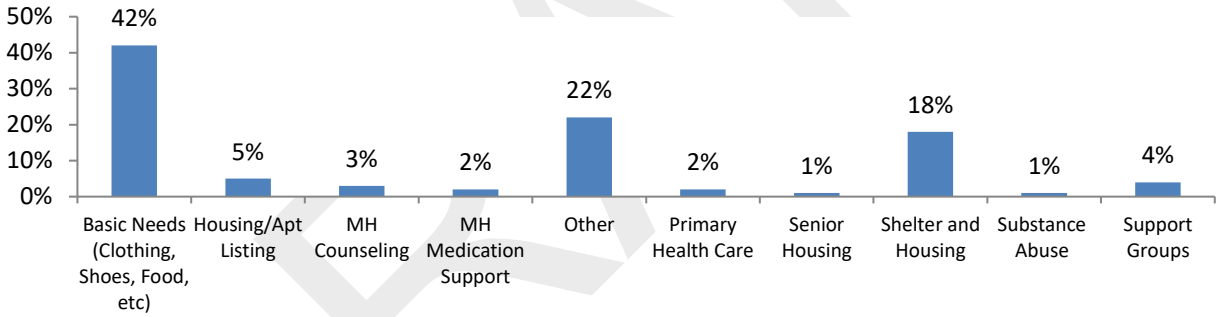
1,888 Linkages made by Community Navigators

The number of linkages made by the community navigators **increased** from **1,371** in FY 2022-23 to **1,888** in FY 2023-24.

All Linkages by Type



In-Person Linkages by Type

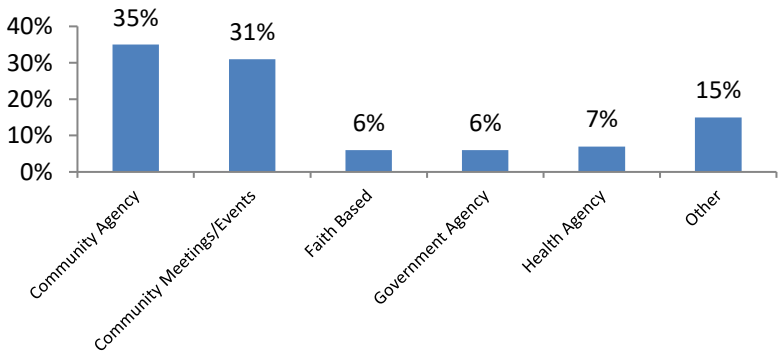


The number of events/locations outreached, and community members engaged **increased** from **31 and 670** in FY 2022-23 to **54 and 981** in FY 2023-24.

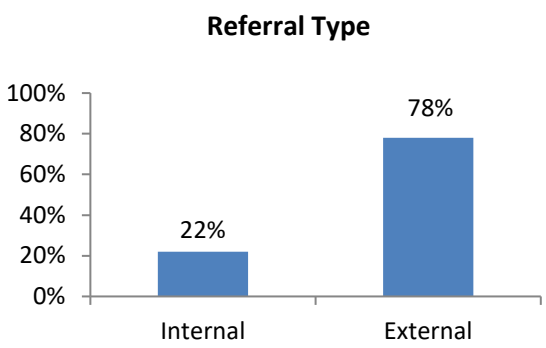
54 Events/Locations Outreached by Navigators

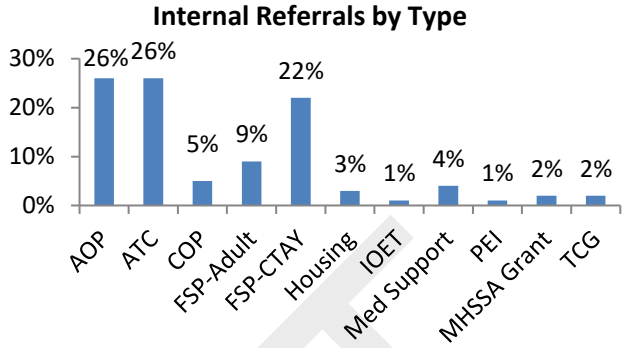
981 Total Community Members engaged by Navigators through Outreach

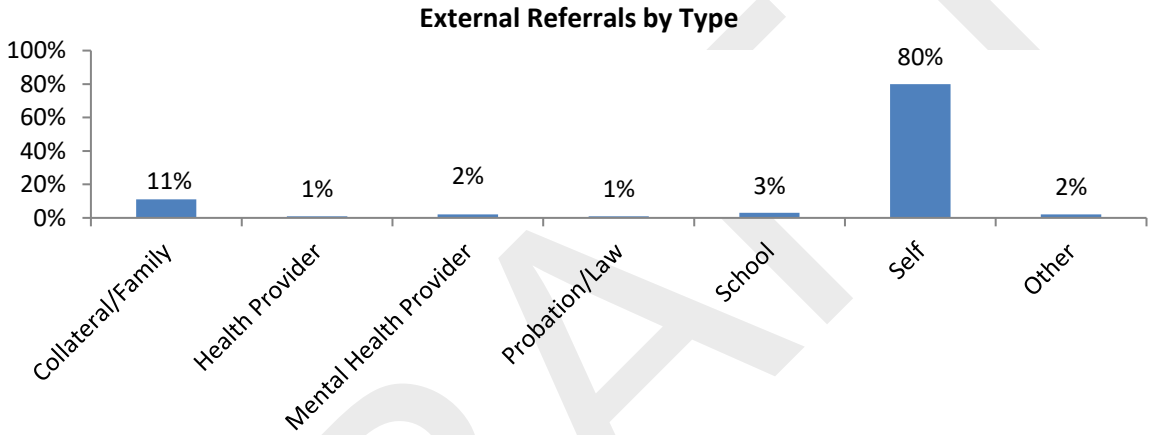
Locations by Type



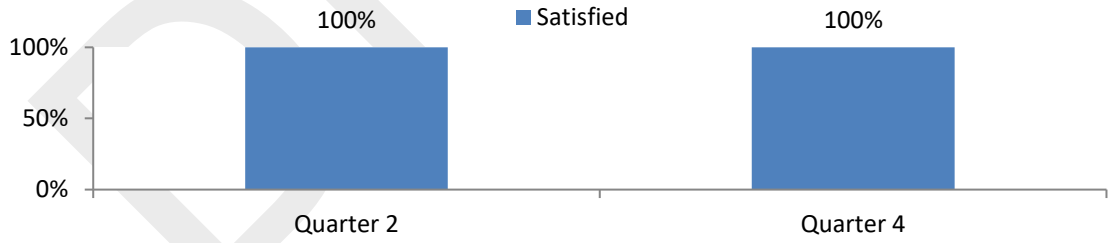
How Well Did We Do It?





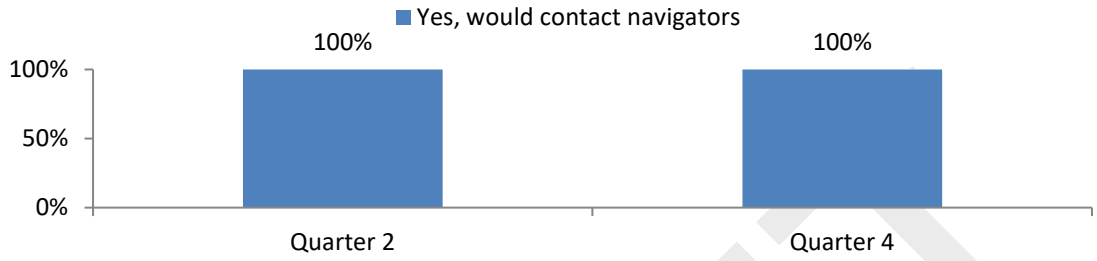


Percentage of Participants Reporting Satisfaction with Services Provided (n=135)



Is Anyone Better Off?

Percentage of Community Partners Reporting that if needed to find community resources again, would you contact the community navigators? (n=28)



How did you benefit from talking with a navigator?

The top three benefits were:

1. Mental Health Counseling/Treatment Assistance: 33% of respondents
2. Housing Assistance: 29% of respondents
3. Social Service Assistance 16% of respondents

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, job fairs, hiring events, recreational activities, and vocational support. Wellness Center staff includes 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 2023-24	55	229	972	265	109	**1,630**
Projected Number to be Served FY 2024-25	30	126	535	146	60	**898**
Cost Per Person	$1,645**	$1,645**	$1,645**	$1,645**	$1,645**	**$1,645****

**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 experienced an increase in individuals served, from 1,009 in FY 2022-23 to 1,630 in FY 2023-24. Multiple hiring events were provided to the community to support those who are actively searching for employment and, combined with other employment supports, 75 individuals obtained employment.

Challenges and Solutions

One challenge faced by the staff during FY 2023-24 was the shift back to in-person appointments and discovering that many individuals still prefer to meet virtually. While some services are still offered as hybrid options, the Employment and Vocational support services encouraged those who were ready, to meet in person for their appointment. The reasoning behind this was that often, interviews are in-person, so practicing face-to-face would replicate an actual interview environment while still providing interview practice that would benefit them in a virtual environment as well.

In the next fiscal year, staff also hope to resume its basic, intermediate, and advanced computer classes at the Wellness Center. COVID restrictions led to significant limitations regarding room capacity, and the computer lab was limited on the number of individuals that could be in the room at the same time. With those limitations reduced, we hope to bring back this resource that has proven to be valuable in the past.

Diversity, Equity and Inclusion

The Wellness Center holds groups that have been created to target specialty populations such as LGBTQ+, Spanish monolingual, older adults, children, and transition age youth. Additionally, vocational and employment services provide support regardless of an individual's age, race, or culture for them to be able to reach their goals of obtaining employment. Wellness Center staff are bilingual, and services can be offered in Spanish and Tagalog. If needed, services also include linguistic support in several other languages.

Groups and services are offered at a range of times throughout the day to increase accessibility and materials are offered in threshold languages. The Wellness Center strives to create a space where individuals can feel safe and heard regardless of any cultural barriers. Additionally, Staff participate in ongoing training to increase cultural competence and gain knowledge about implicit bias.

Community Partners

The Wellness Center works closely with both internal programs and external community organizations to strengthen their network of support. Examples include Generation Her, a teen parent support group, AlaNon for family AA support, Master of Social Work (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 (focusing on a single employer presenting multiple job opportunities they have at their agency or business) and job fairs (feature multiple employers seeking potential candidates). Partners include the United States Postal Service, California Highway Patrol, Employment Development Department, San Bernardino County, On-Time Staffing and FedEx Ground.

Success Story

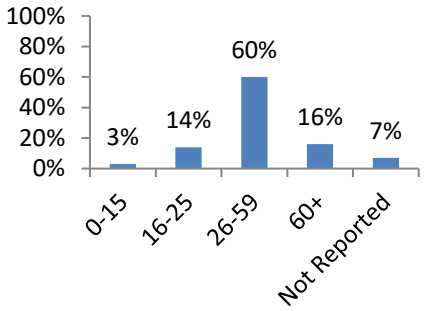
A participant came to the Wellness Center in 2023 to attend the Anxiety Relief group. Participant was experiencing eviction, homelessness and symptoms of anxiety and depression. They started attending groups consistently and gained confidence in their recovery, reporting benefits to their wellbeing and overall ability to socialize. After attending groups at the Wellness Center, they learned about resilience and identified that their current situation was temporary. The groups became a primary source of hope and positivity for them. Soon after, the individual chose to add vocational and employment services to support their goals of increasing income and obtaining housing. Staff supported with job searching, applications, and interviewing. Eventually, the participant successfully received job placements at multiple locations, securing reliable income and making possible the next step of obtaining permanent housing.

Program Summary

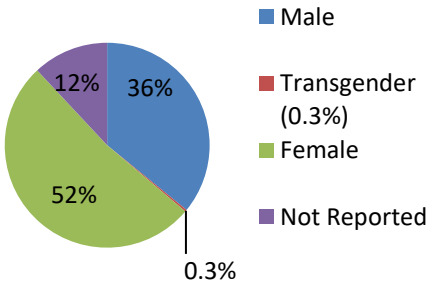
How Much Did We Do?

1,630 Unique Individuals attending Wellness Center

Age Group

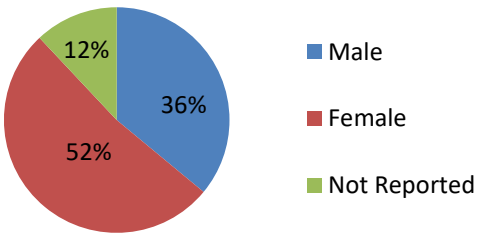


Current Gender Identity

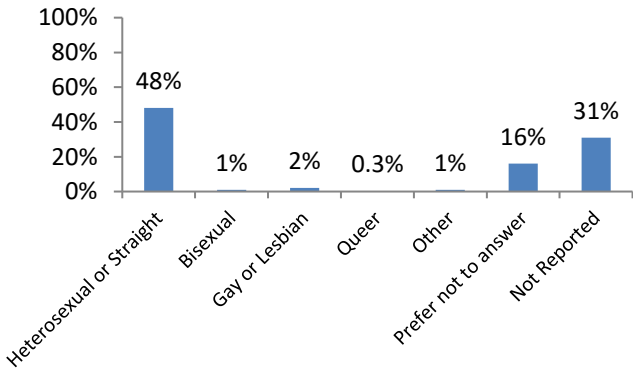


The number of individuals attending Wellness Center **increased** from **1,009** in FY 2022-23 to **1,630** in FY 2023-24.

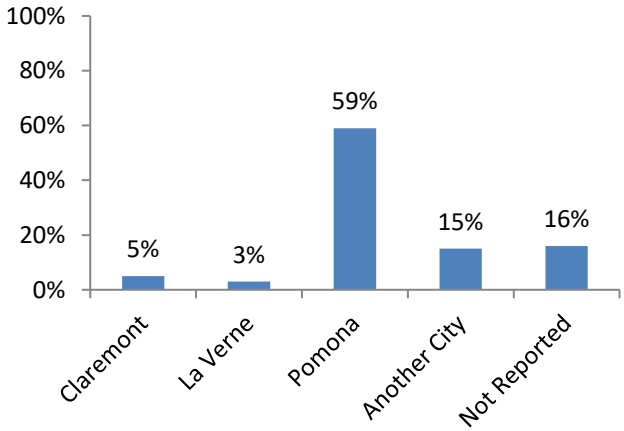
Assigned Gender at Birth



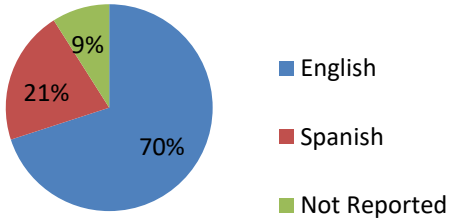
Sexual Orientation

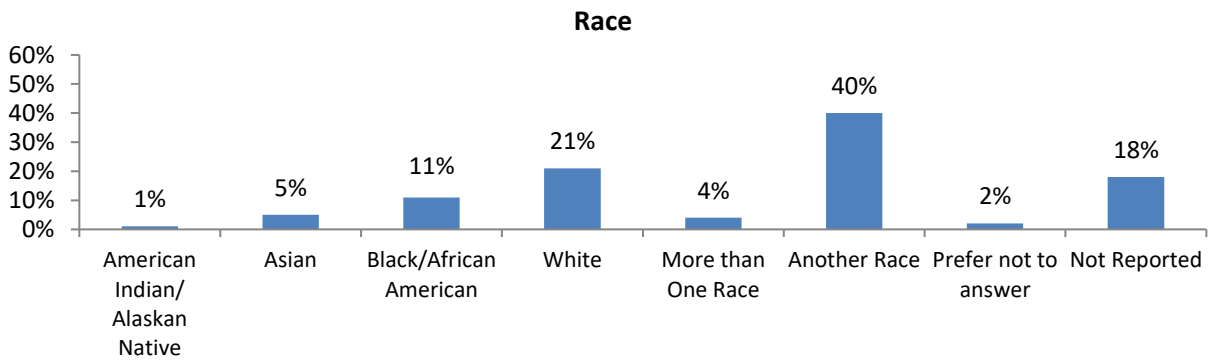


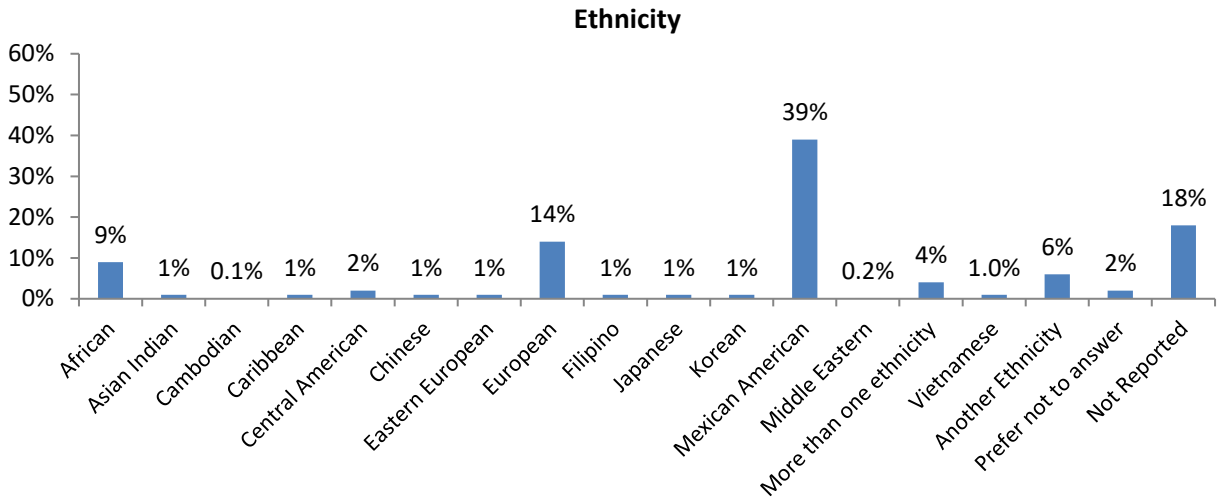
City

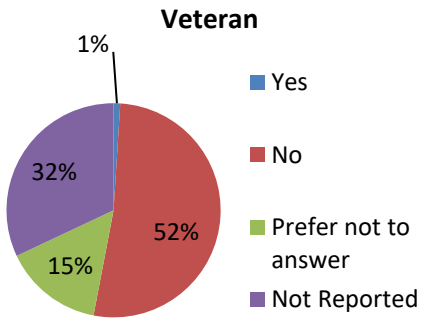


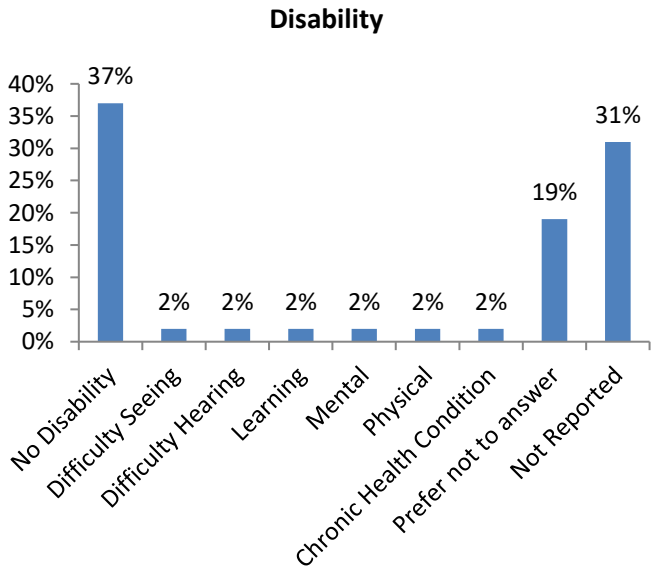
Primary Language




Race
60%
50%
40%
30%
20%
10%
0%
1%
5%
11%
21%
4%
40%
2%
18%
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%
9%
1%
0.1%
1%
2%
1%
1%
14%
1%
1%
1%
39%
0.2%
4%
1.0%
6%
2%
18%
African
Asian Indian
Cambodian
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Japanese
Korean
Mexican American
Middle Eastern
More than one ethnicity
Vietnamese
Another Ethnicity
Prefer not to answer
Not Reported

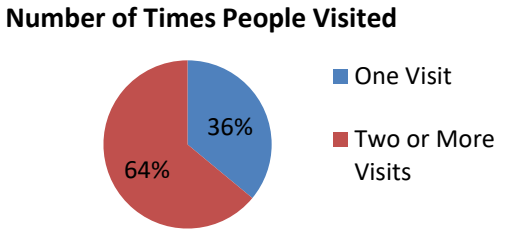

Veteran
1%
32%
52%
15%
Yes
No
Prefer not to answer
Not Reported


Disability
40%
35%
30%
25%
20%
15%
10%
5%
0%
37%
2%
2%
2%
2%
2%
2%
19%
31%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning
Mental
Physical
Chronic Health Condition
Prefer not to answer
Not Reported

How Well Did We Do It?

16,184 Number of Wellness Center Events

(Duplicate Individuals)



Support Group Name	Number of Times Group Was Held	Average Number of Attendees at a Group
Group – Ageless and Unstoppable	29	2
Group – Anger Management	56	10
Group – Anxiety Relief	51	5
Group – Bore no More	12	2
Group – College Wellbeing	5	2
Group – Dual Recovery Anonymous	45	4
Group – Freedom through Reality	50	4
Group – Lose the Blues	43	3
Group – Men's Depression	49	2
Group – One-on-One	14	1
Group – Socialization	49	4
Group – Strong Women	50	7
Group – Women's Self-Esteem	17	2
Group Spanish – Corazón a Corazón	48	2
Group Spanish – Sobrellevando la Ansiedad	10	2
Group Spanish – Socialization	7	1
Group Vocational – Literacy Group	47	2

Contacts/Events by Type	Number of Individuals
Attendance Letter	261
Other	1,313
PC Lab	1,571
Tour	481
Phone Call/Email – Wellness Calls	2,005
Adult Orientation	9
Vocational – Job Search	1.689
Vocational – Computer classes	69
Vocational – Employment/Resume/Interview/Hiring	281

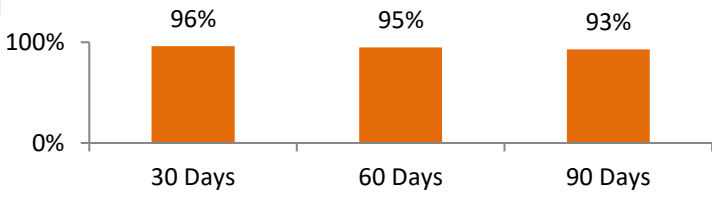
The number of available support groups at Wellness Center **increased** from **16** in FY 2022-23 to **18** in FY 2023-24.

75 Individuals Secured Employment

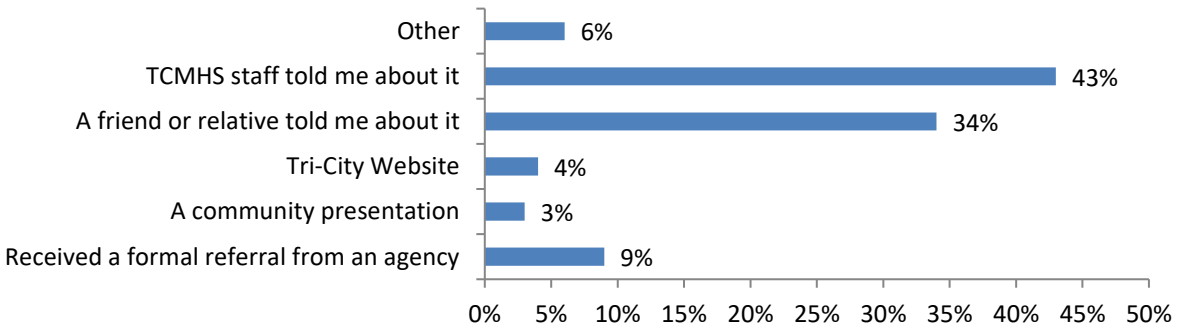
The number of individuals securing employment **increased** from **60** in FY 2022-23 to **75** in FY 2023-24.

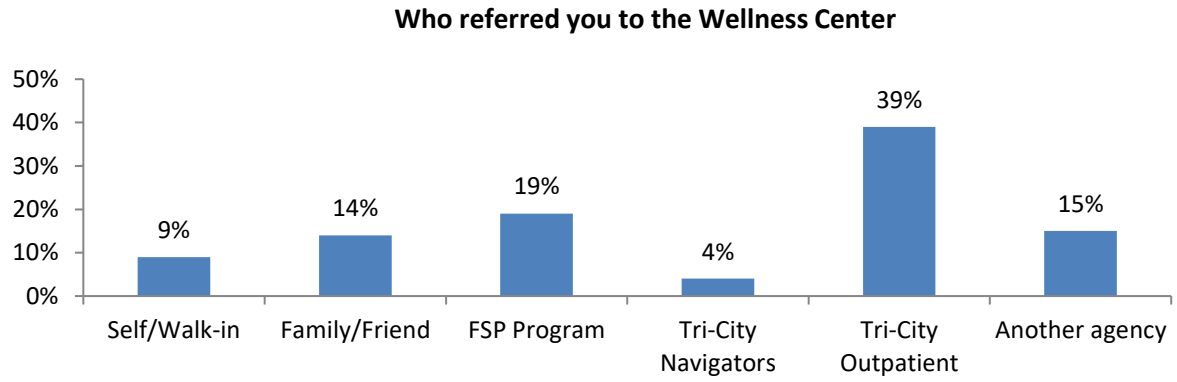
95% Satisfied with the help they get at Wellness Center Programs

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



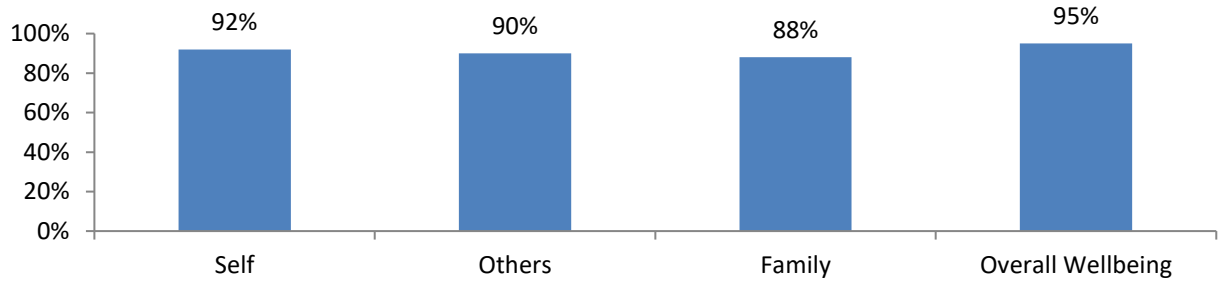
How Did You Learn About the Wellness Center Programs? (Choose All that Apply)





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:



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 2023-24	0	6	50	8	40	**104**
Cost Per Person	$1,056**	$1,056**	$1,056**	$1,056**	$1,056**	**$1,056****
IOET Number Served FY 2023-24	22	45	267	77	77	**488**
Cost Per Person	$1,056**	$1,056**	$1,056**	$1,056**	$1,056**	**$1,056****

*No projections for number to be served were provided due to the program sunsetting on June 30, 2024.

**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 IOET team provided community outreach which included linkage to formal services, medical services and other resources that those in need were struggling to obtain independently. Referrals from external partners remained consistent, with the highest number of referrals coming from Hope for Homes at 52%. The number of individuals outreached in FY 2023-24 decreased from the previous fiscal year, reducing from 714 in FY 2022-23 to 488. There was also a decrease in crisis calls, from 202 in FY 2022-23 to 104 in FY 2023-24.

On February 13, 2024, the team was notified that IOET will sunset as of June 30, 2024. In its place, the Mobile Crisis Care program will be implemented and have a designated staff to respond to crisis in the community with allocated vehicles fully equipped to respond to an array of crisis situations.

Challenges and Solutions

One challenge was balancing the range of crisis situations and clinically appropriate responses. Some individuals required support with obtaining identification cards or eyeglasses while others required more intensive support, such as linkage to services and obtaining assistance for complex medical issues. These requests from community members occurred often, and part of the solution-focused approach to these requests was having appropriate referrals/resources available, linkage support and follow up.

Diversity, Equity and Inclusion

Multiple staff members are bilingual, and brochures are in both English and Spanish. Staff incorporates literature regarding resources and referrals for underserved groups, providing culturally relevant information for those seeking it. Formal and informal services are identified based on need and resources/referrals are provided that meet individuals' preference (such as in-person sessions or phone/virtual). Additionally, all staff complete training related to Diversity, Equity, and Inclusion on a reoccurring basis to be mindful of culture, implicit biases, and to enhance their ability to provide fair and equable service to those in need.

Community Partners

The Supplemental Crisis Services engaged with several community partners with the goal of providing support, referrals, and resources. A few examples of this extensive network of support includes partnerships with the cities of Claremont, La Verne, and Pomona Police Departments, Mission Community Hospital, Pomona Valley Hospital Medical Center, Charter Oak Hospital, Tri-City clinical staff, Tri-City nonclinical staff, Los Angeles Department of Mental Health (LADMH), East Valley Community Health Center, Hope for Homes, local city councils, the Department of Motor Vehicles (DMV), Los Angeles Homeless Services Authority (LAHSA), Project Sister and House of Ruth.

Success Story

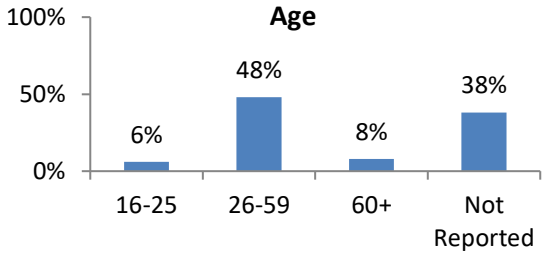
A notable success was the ability to continue receiving steady referrals from our partners in the community. Additionally, calls that were made to the crisis line saw a 16% increase from the previous fiscal year in regard to individuals calling the line due to being a previous client. This displayed a willingness to return to Tri-City as individuals who had been connected previously.

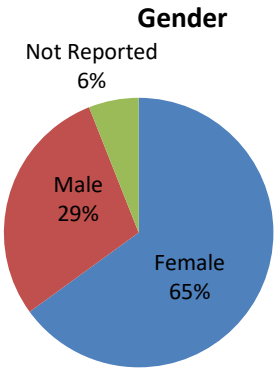
Program Summary

How Much Did We Do?

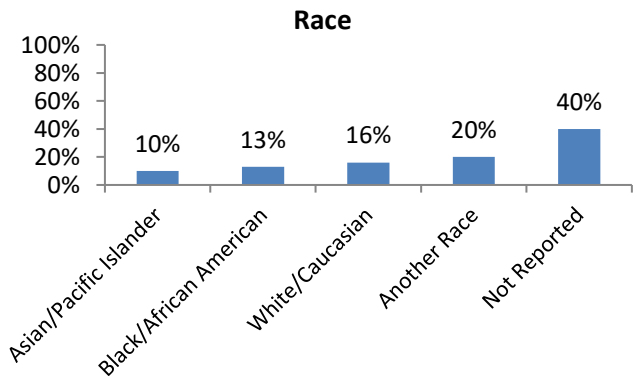
Supplemental Crisis Calls

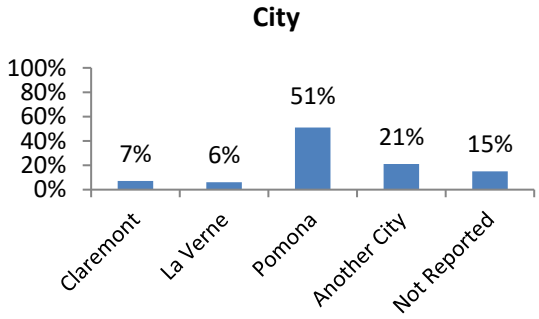
104 Supplemental Crisis Calls

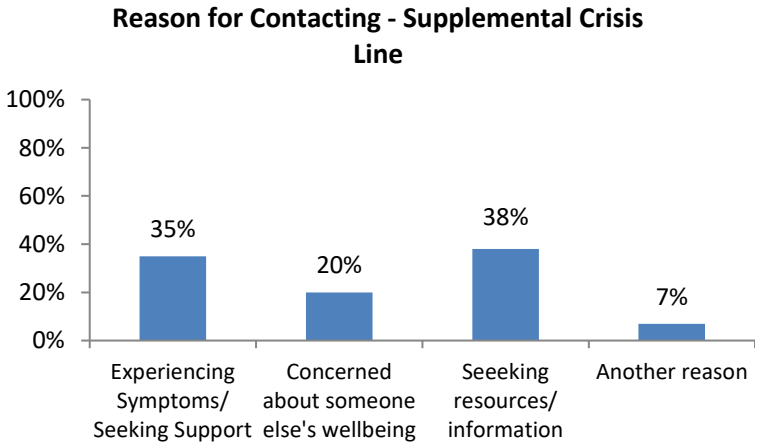


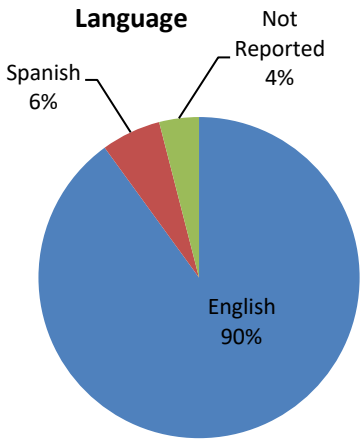


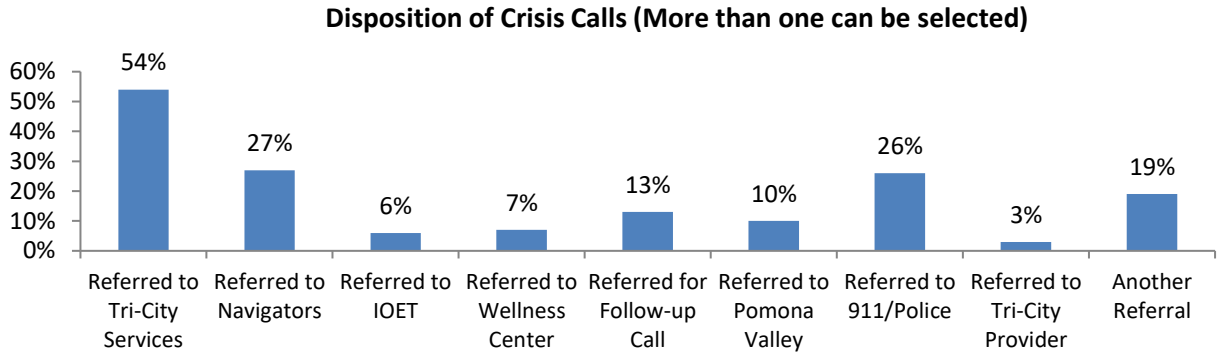
The number of crisis calls **decreased** from **202** in FY 2022-23 to **104** in FY 2023-24.









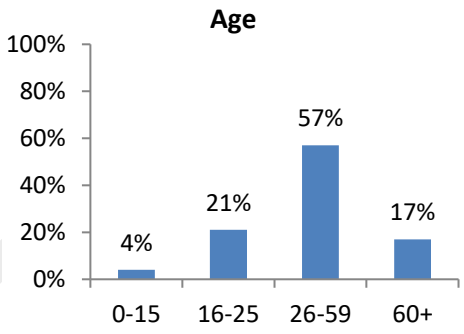


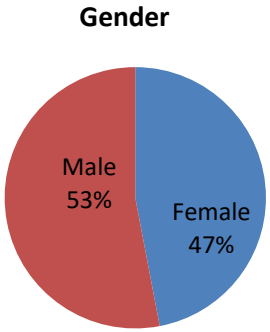
The percent of crisis calls referred to Tri-City Services **increased** from **45%** in FY 2022-23 to **54%** in FY 2023-24.

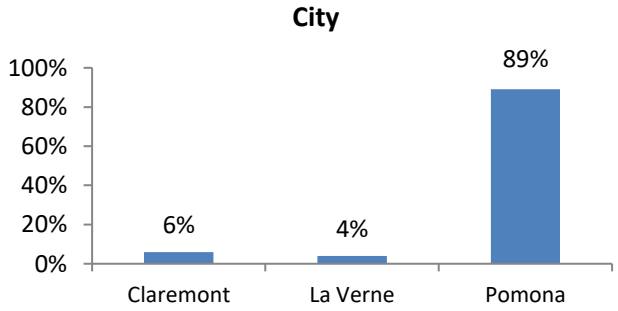
Supplemental Crisis Walk-Ins

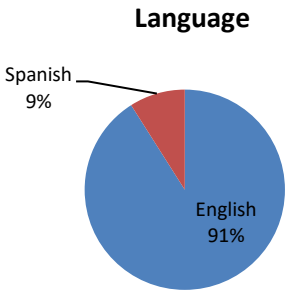
47
Crisis Walk-ins

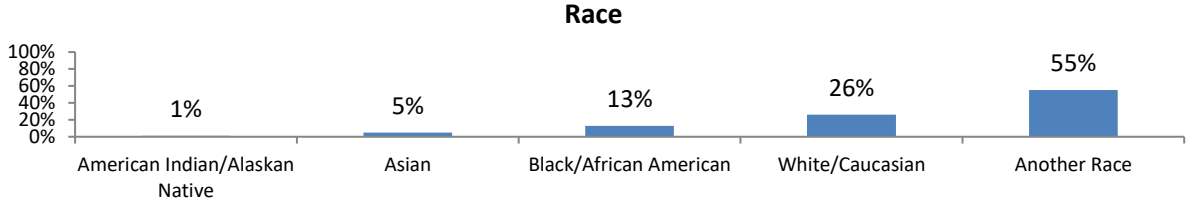
The number crisis walk-in **increased** from **45** in FY 2022-23 to **47** in FY 2023-24.







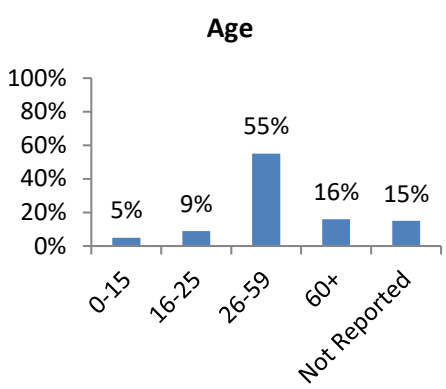


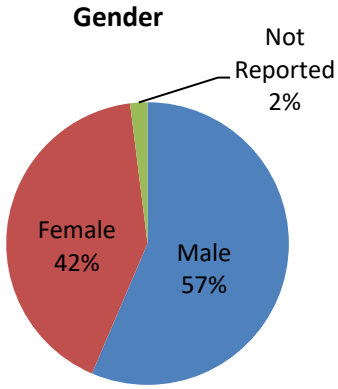


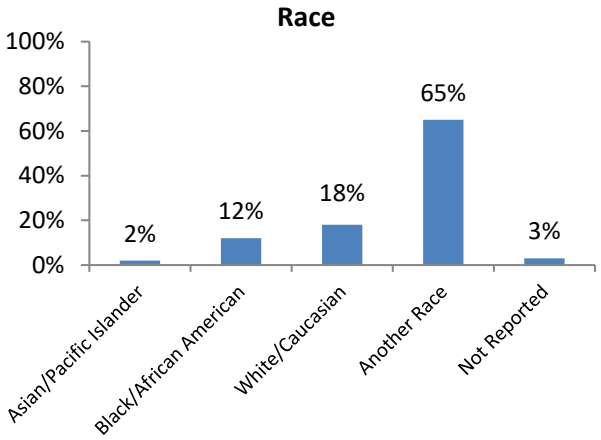
Intensive Outreach and Engagement

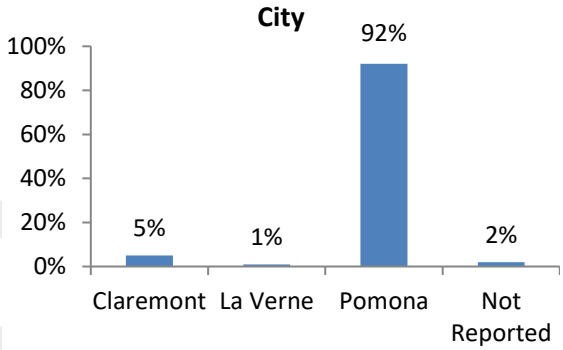
488 Individuals Outreached

The number of individuals outreached **decreased** from **714** in FY 2022-23 to **488** in FY 2023-24.

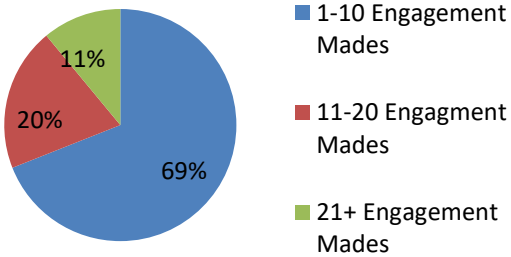




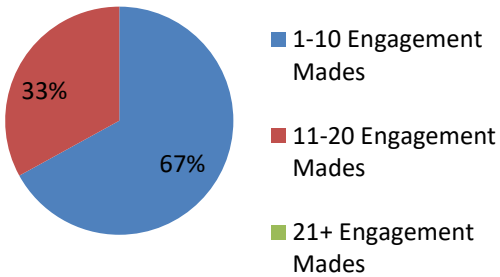




Percent of Engagement Attempts Made by IOET for Closed Individuals



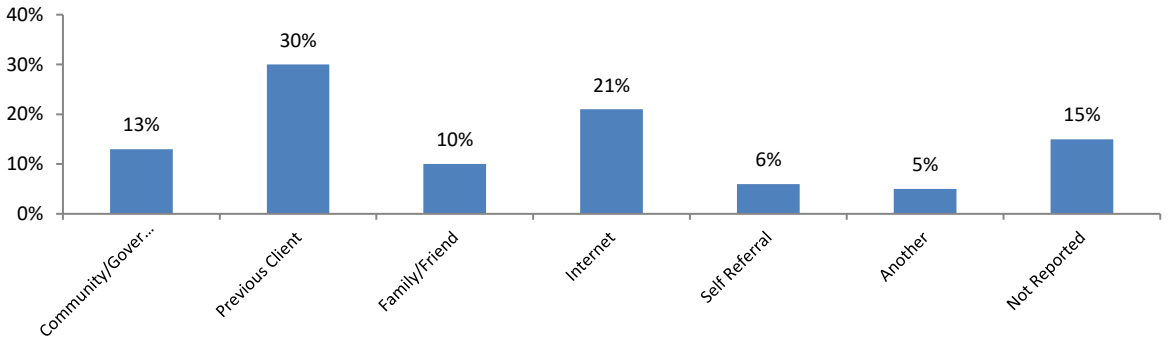
Percent of Engagement Attempts Made by IOET for Individuals currently being Engaged:



How Well Did We Do It?

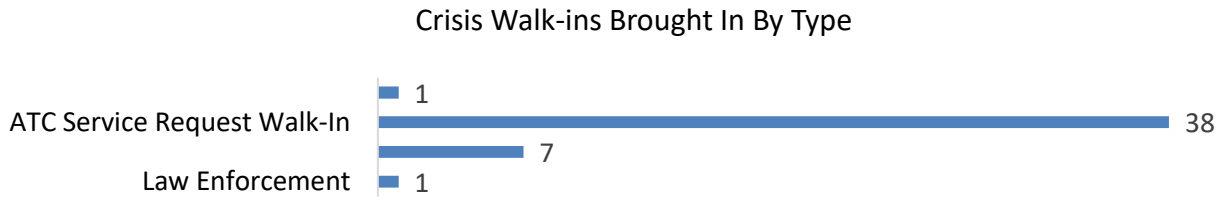
Supplemental Crisis Calls

How did you hear about the Supplemental Crisis Line:

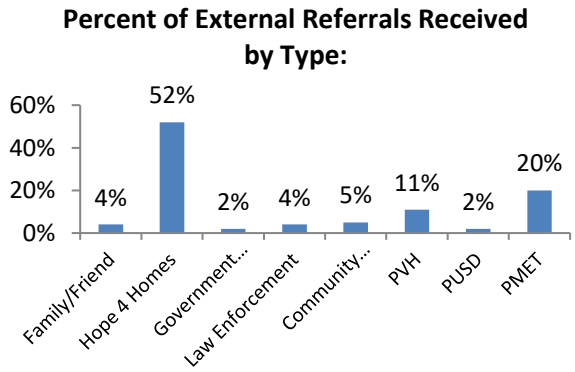


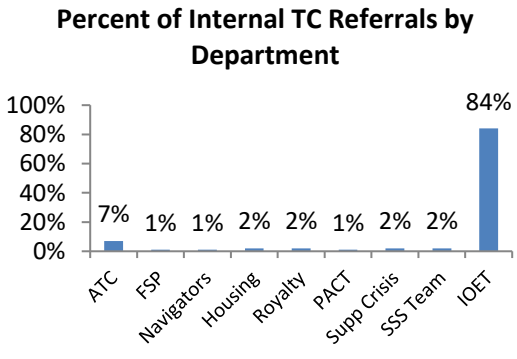
The percent of clients hearing about crisis line from being a previous client **increased** from **16%** in FY 2022-23 to **30%** in FY 2023-24.

Supplemental Crisis Walk-Ins



Intensive Outreach and Engagement





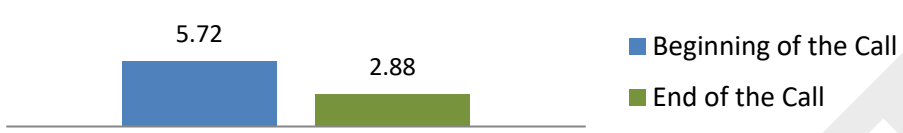
The number of external referrals remained constant with Hope for Homes and PMET-Pomona as the top 2 referrals sources.

Is Anyone Better Off?

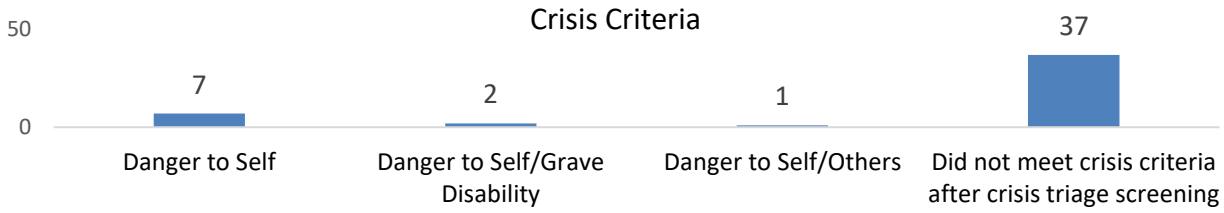
Supplemental Crisis Calls

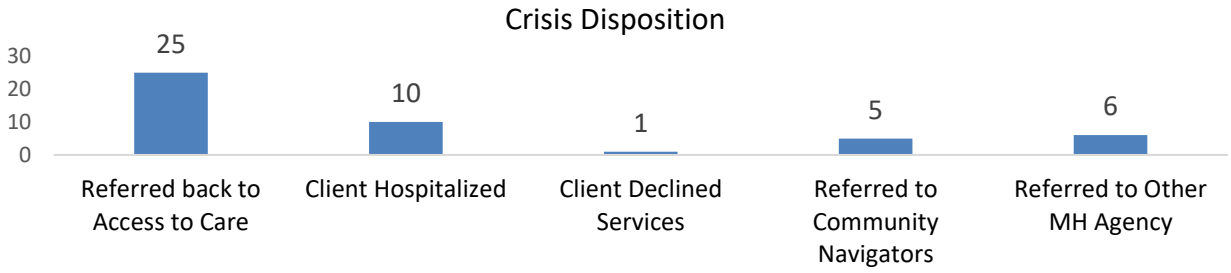
Level of Distress for Crisis Callers

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



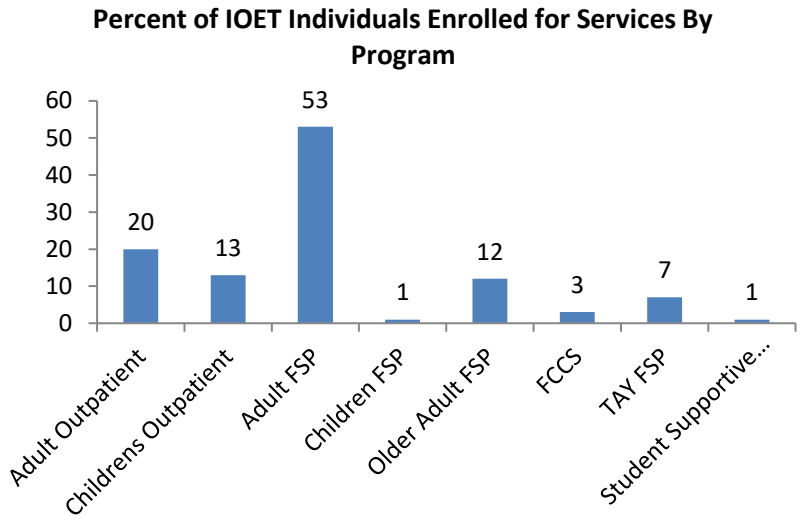


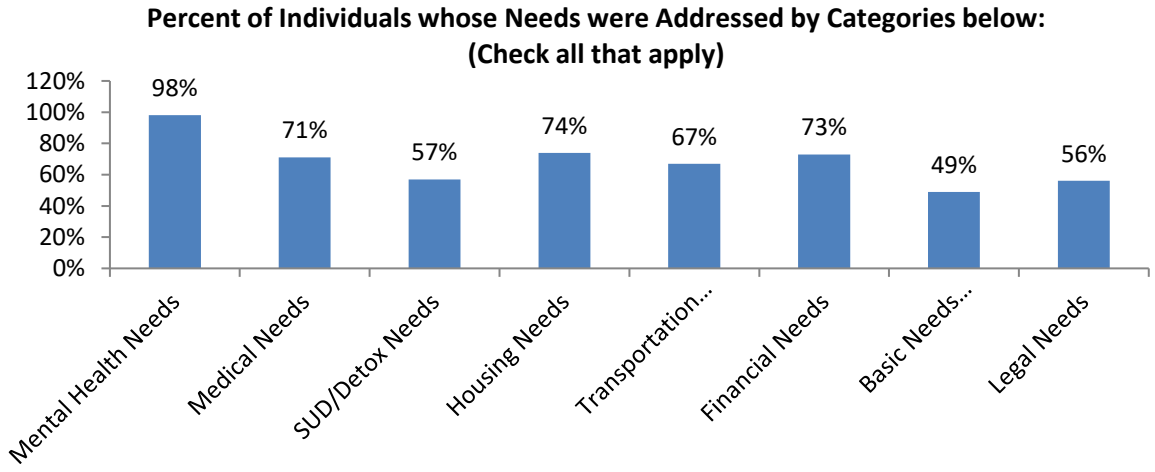
The number crisis walk-ins hospitalized **decreased** from **17** in FY 2022-23 to **10** in FY 2023-24.

51% Crisis Walk-ins were scheduled for intake

Intensive Outreach and Engagement

110 IOET Individuals 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, TCMHA 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 depending on the individual's preference.

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 2023-24	52
Projected Number to be served FY 2024-25	35
Cost Per Person	$5,005

Program Update

During FY 2023-24, Field Capable Clinical Services for Older Adults (FCCS) served 52 unique individuals, a significant increase from the 37 individuals served in FY 2022-23. This increase supported the general upward trend that FCCS has experienced in recent years. To support staff and their growing caseloads, a Support Drop-In Hour was created to address complex and high-risk cases.

Additionally, FCCS witnessed an increase in complex medical conditions experienced by clients. This mirrored similar trends that occurred in other MHSA programs. Accordingly, staff was equipped to refer, provide resources, support with case management, and maintain/obtain relationships with external partners who may be able to offer relevant services to meet client's needs.

Challenges and Solutions

A change in the electronic health system (EHR) Care Plan component led to a new learning curve for FCCS staff. The team was supported in this transition by attending ongoing EHR and Quality Assurance (QA) training. Training included 1:1 support regarding how to add goals in the Care Plan as well as obtaining training materials and a components page for the EHR reflecting the recent changes and expectations.

With an increase in complex medical conditions, many individuals required linkage and referrals to higher levels of care and medical supports. To ease the challenge, staff are versed in reliable community partners to address medical concerns and work with internal Community Navigators when additional support is needed to identify resources available.

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, social services, shelters, medical care, and support with the application process for Medi-Cal benefits.

Ongoing training is provided to FCCS staff regarding cultural competence and implicit bias. Depending on the need, FCCS is also able to refer to the appropriate supports should a client be experiencing physical or mental disability, require assistance with assisted living/senior housing, or obtain waivers for in-home living. Being aware of these resources in the community and partners who work specifically with the older adult population is vital in supporting this underserved demographic.

Community Partners

The Field Capable Clinical Services team collaborates regularly with internal as well as external partners for the purposes of referrals, resources, adjunct services, housing, and transitions, among other purposes. Examples of these collaborations are Los Angeles County Department of Health Services Medical Center for referrals, Pomona Housing Authority and Volunteers of America (VOA) for housing needs, Park Tree (a local pop-up clinic) for medical support, Police Departments in Pomona, Claremont and La Verne for referrals and collaboration, Prototypes and American Recovery Center for substance use treatment, The Department of Public Social Services, and Social Security Administration.

Success Story

An individual was connected to FCCS due to depression, anxiety, isolating behaviors and reducing social interactions with others. Through FCCS, they learned to connect with the community by increasing social interactions and addressing social behaviors. As medication support services were indicated, the individual was linked to the internal medication support services to assist with managing symptoms of depression. Ultimately, they were able to build interpersonal relationships, increase community engagement, and improve overall wellbeing. Some evidence of these improvements experienced were demonstrated in the individual's ability to become an active participant in their community center, host social events in their home, attend the Wellness Center, and attend various senior centers. As goals were met and improvements made in symptoms and impairments, they are now working towards graduation from the FCCS program.

Program Summary

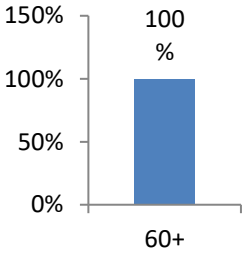
How Much Did We Do?

52
Individuals Served

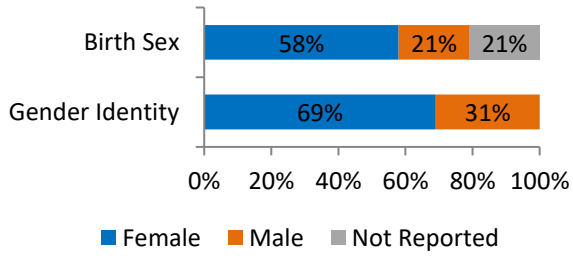
The number of individuals served **increased** from **37** in FY 2022-23 to **52** in FY 2023-24.

83% of FCCS clients lived in Pomona, while 15% of clients lived in Claremont.

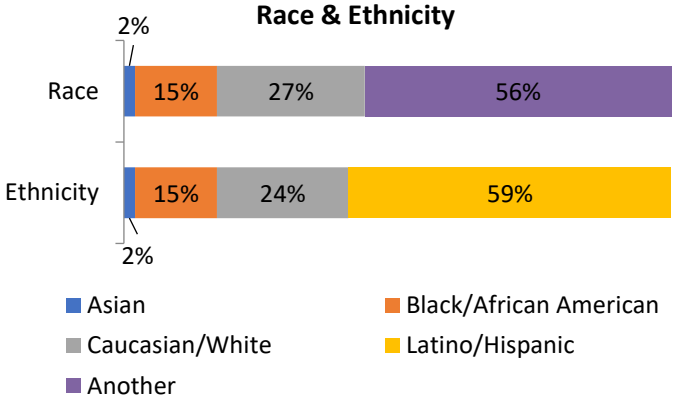
Age



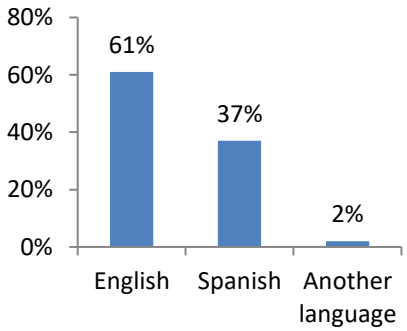
Sex & Gender Identity



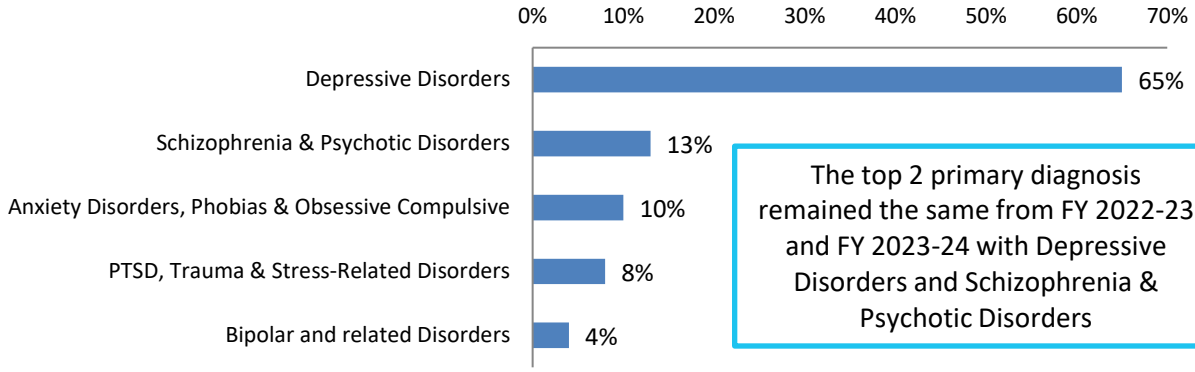
Race & Ethnicity



Primary Language

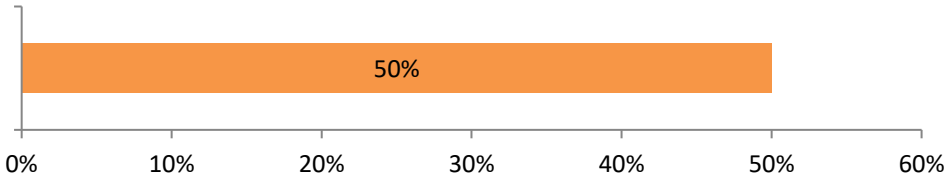


Primary Diagnosis by FCCS Clients

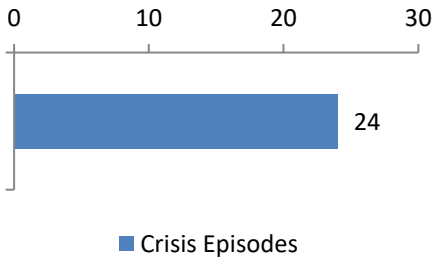


The top 2 primary diagnosis remained the same from FY 2022-23 and FY 2023-24 with Depressive Disorders and Schizophrenia & Psychotic Disorders

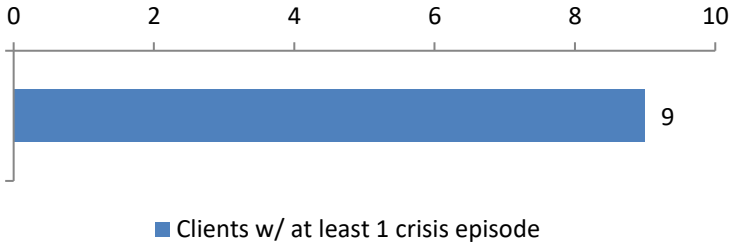
Percent of FCCS Clients Receiving Medication Services



Number of Crisis Episodes

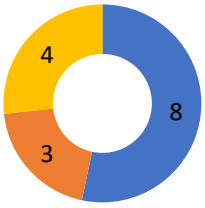


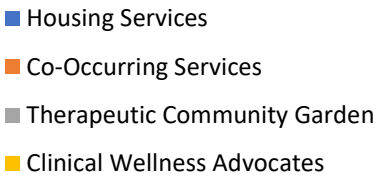
Number of Unique Clients w/ at least 1 Crisis Episodes



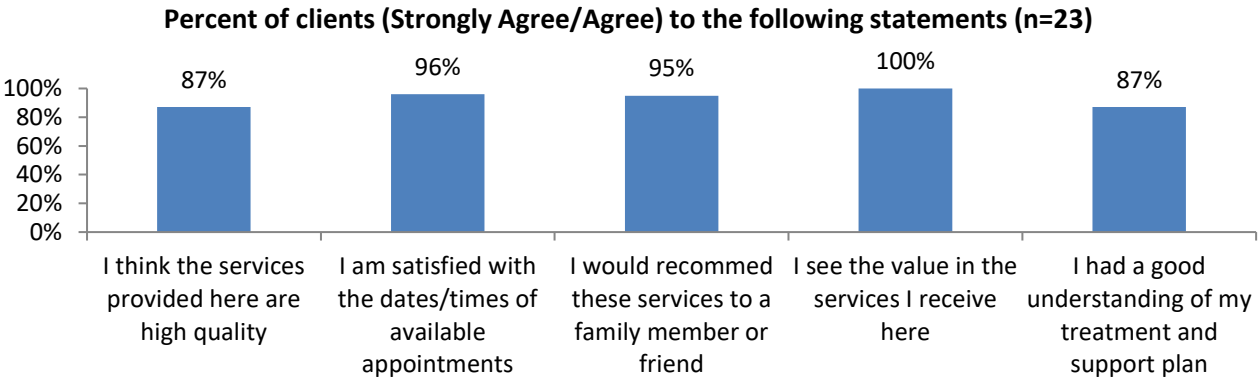
Number of FCCS Clients Connected to Other Services

***29%** of FCCS clients are connected to other Tri-City Services.*





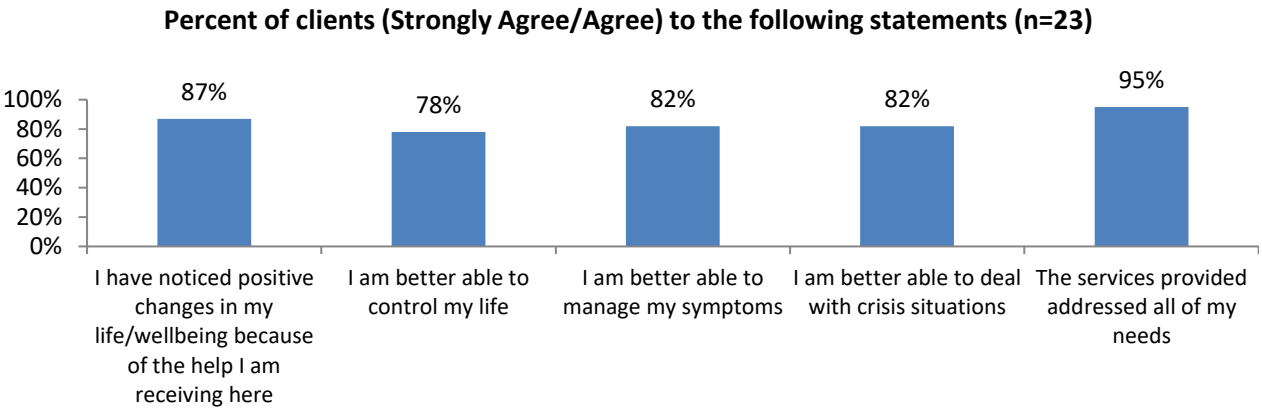
How Well Did We Do It?



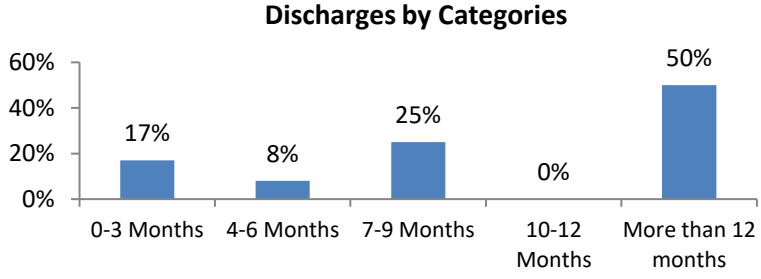
On average, FCCS clients were enrolled for 16 months.

The average enrollment (in months) of FCCS individuals **increased** from **14** in FY 2022-23 to **16** in FY 2023-24.

Is Anyone Better Off?



12 Discharges during FY 2022-23



Permanent Supportive Housing

Program Description

Permanent Supportive Housing units offer living spaces for Tri-City clients 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 2023-24	6	18	138	49	**211**
Projected Number to be Served FY 2024-25	7	20	151	54	**231**

Program Update

On September 14, 2023, the Villa Esperanza hosted its Grand Opening. During the event, two MHSA tenants shared with attendees their story of battling through housing instability and their new outlook on life. Throughout the fiscal year, events and groups become available to tenants such as a biweekly anxiety support group called Color Me Calm, the Good Tenant Curriculum, a gardening group created with the Therapeutic Community Garden, a biweekly food bank in collaboration with Volunteers of America, and an on-site resource fair. A collaboration was also formed with the Step Fund which provides no-interest micro loans to LA County residents who are at imminent risk of homelessness. Another housing location, Holt Family Apartments, added solar panels in June to assist with reducing client's electricity bill.

Permanent Supportive Housing had previously partnered with the Therapeutic Community Garden (TCG) in prepping garden beds at Cedar Springs, one of our housing locations aimed at serving TAY and their families. The RSC at the site has since overseen the gardening group and the beds have flourished. This past fiscal year, the beds have consistently produced, and tenants are able to harvest sunflowers, peppers, corn, broccoli, carrots, beets, anise, kale, green beans, tomatoes, onions, cucumber, cilantro, lemon grass, parsley, jalapenos, habaneros, and basil depending on the season.

The Housing Division began to host Case Conferencing meetings with the clinical teams. Every month, the Housing Division holds an open meeting where clinical teams can ask questions about the process of a referral, inquire on the status of a referral, seek housing resources and present situations they are encountering with client related to housing. By providing this space, clinical staff can get their questions answered in a timely manner, while helping other staff learn about something that may come up later with a client.

Challenges and Solutions

One of the Permanent Supportive Housing locations, Villa Esperanza did not have a permanent property manager at the start of the fiscal year. The previous manager left as FY 2022-23 was ending and in the property management company rotated temporary mangers to oversee the applications and day-to-day business at the site. Towards the end of the fiscal year 2023-24, one manager became permanently placed, which was very positive for the residents to experience consistency and build relationships with one person as opposed to rotating individuals

There were also gaps and inconsistencies in assigned property managers at Cedar Springs, Holt Family Apartments and Parkside Apartments. After some time, new management was assigned to all locations. The RSCs worked closely with new staff and the clients to address any lease violations, rent tracking, any corrections of files, and general support as clients built rapport and new working relationships with incoming staff on the property.

With all properties obtaining stable property managers, the RSCs are working towards bringing back tenant meetings at their respective sites. These meetings allow a space for property management to explain how they are addressing concerns at their sites and build a stronger community as it involves the tenants as part of the solution.

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. Housing Division staff are trained in cultural competency, stigma reduction, and implicit bias. Staff make ongoing efforts to work with clients in identifying their rights regarding housing, including education about tenant rights and legal referrals if needed. For optimal accessibility, all activities at the sites are on the ground floor and have doors wide enough for wheelchairs. Activities vary to include an array of topics that may interest different groups, such as coffee chats, coloring, community game days, gardening activities, and stress relief. RSCs also 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.

Housing Division staff are bilingual in English and Spanish, while other staff identify as having lived experience. Flyers and information are also provided in multiple languages. Reasonable accommodations are always considered, and Housing works with 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 act as a source of referrals for Permanent Supportive Housing. High volume of referrals consistently come from Community Navigators, Adult Outpatient, Full-Service Partnership, Child and Family Services, Therapeutic Community Garden, Access to Care, Wellness Center, Employment Specialists, Clinical Wellness Advocates, and the Co-Occurring Support Team.

Additionally, several external agencies provide supplemental resources to clients to help them obtain and maintain housing, identify resources in the community, address overall wellbeing, support basic needs, promote safety, provide education, inform on tenant rights, address finances, and identify opportunities for select housing expenses to be covered. Some of these external entities include Pomona Housing Authority, APS/CPS Social Workers, Corporation for Supportive Housing, Department of Mental Health, law enforcement, faith community/church leaders, LA County Department of Public Social Services (DPSS), and National Alliance on Mental Health (NAMI).

Success Story

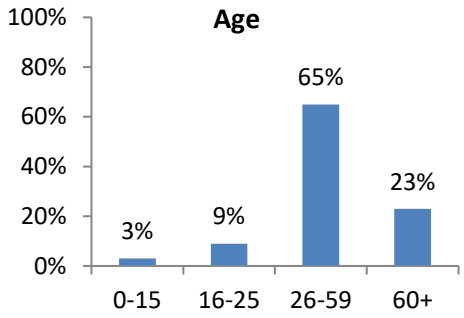
A transition age youth moved into Cedar Springs in 2016 and have continued to maintain a successful tenancy. They recently shared that a roommate was negatively impacting their mental health. While this information had been shared with RSCs before, the tenant was not ready to make a change related to their living environment and the roommate who was negatively affecting them. The RSC supported the tenant in having conversations with the roommate and the clinical team. The conversations took time but eventually a plan was identified for roommate to locate their own housing, allowing the tenant to size down to a one-bedroom apartment and live independently for the first time. The tenant has continued to maintain their housing and noted an improved quality of life since advocating for themselves, making a plan, and executing the plan with all parties involved.

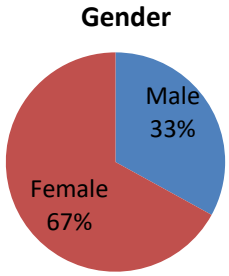
Program Summary

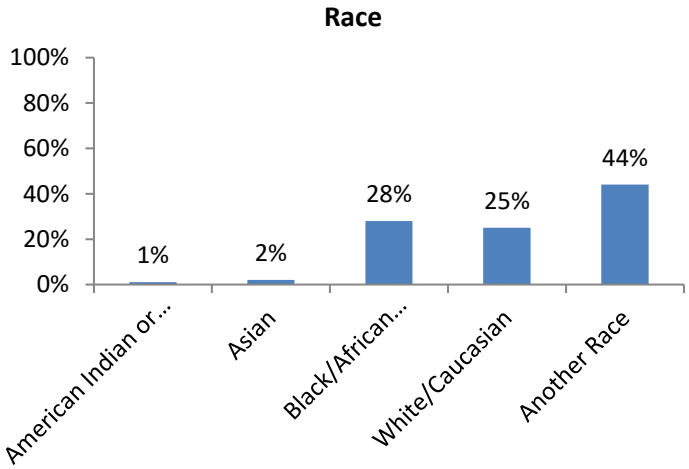
How Much Did We Do?

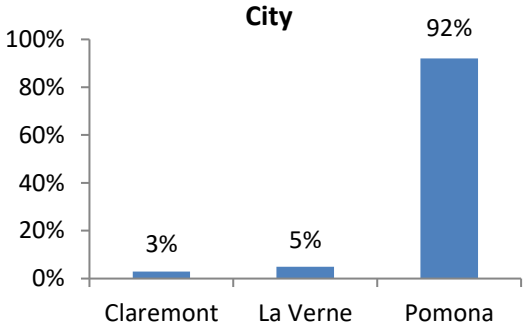
211
Individuals served with Housing needs

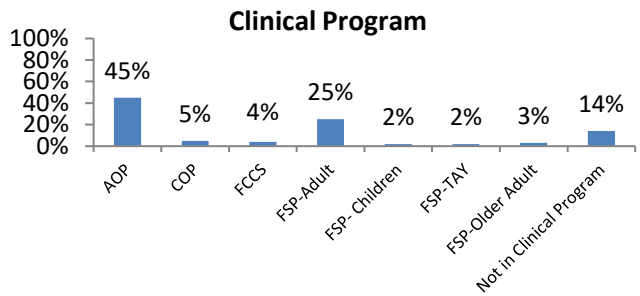
The number of individuals served with housing needs **decreased** from **226** in FY 2022-23 to **211** in FY 2023-24.

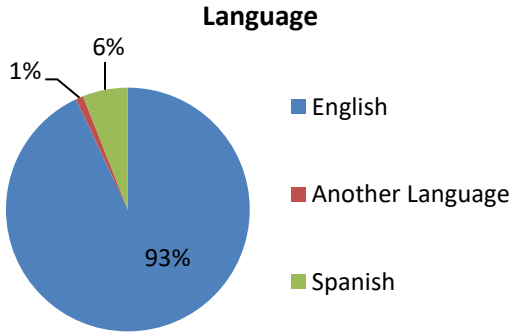








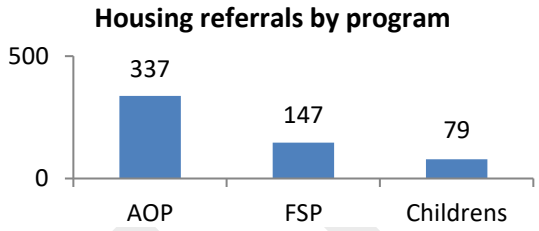




17
Housing Clients Discharged due to "No Further Care Needed"

25
Individuals with Continuum of Care Certificates

563
Housing Referrals Received



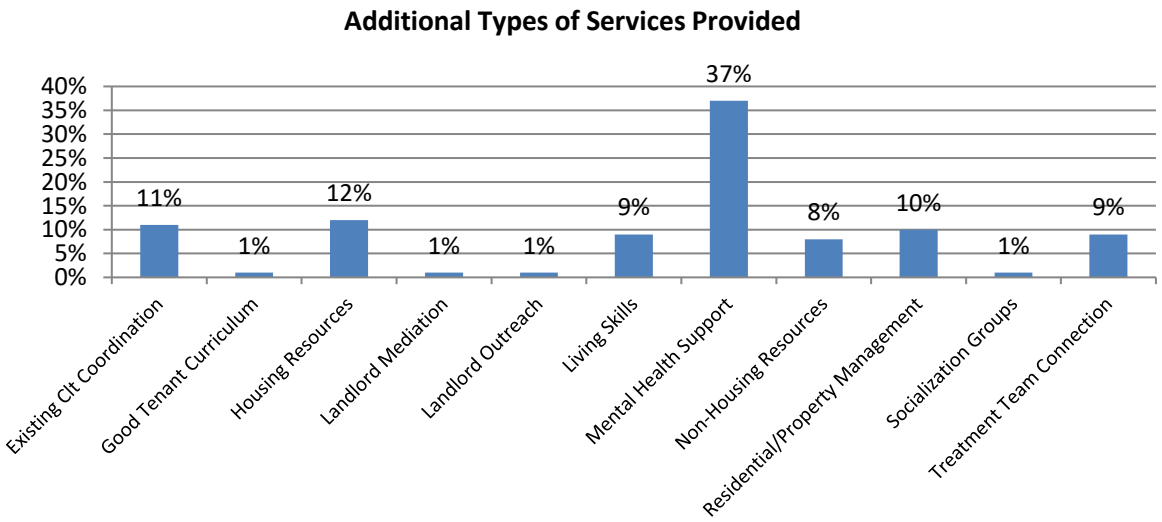
The number of housing referrals **increased** from **353** in FY 2022-23 to **563** in FY 2023-24.

How Well Did We Do It?

1,872
Housing Actions

3.2 years
Average Length of Time Housing Clients Living in Housing Unit

The number of housing actions provided to clients **increased** from **886** in FY 2022-23 to **1,872** in FY 2023-24.



Is Anyone Better Off?

40	102	17	69	100
Unique Individuals Assisted with Eviction Prevention	Unique Individuals Assisted with Maintaining Their Housing	Unique Individuals Secured Housing Either in Tri-City or Elsewhere	Unique Individuals Assisted with Obtaining Housing	Unique Individuals Connected to Housing Resources

Access to Care

Program Description

The Access to Care (ATC) program 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 to determine medical necessity. 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 2023-24	429	529	1,646	189	**0**	**2,793**
Projected Number to be Served FY 2024-25	429	529	1,646	189	**0**	**2,793**
Cost Per Person	$544	$544	$544	$544	N/A	**$544**

Program Update

FY 2023-24 expanded the ATC team by adding a Clinical Supervisor and a Senior Behavioral Health Specialist. The program was also able to fully staff the Office Assistant roles. A variety of methods to complete intake appointments were offered, including face-to-face, video and telephone options. ATC was also able to consistently offer timely appointments to those who were seeking and qualified for intake assessments.

The program also became more efficient in reviewing and approving custody and legal representative documentation. This was accomplished by attending weekly custody documentation consultation meetings with the Chief Compliance Officer and Compliance Administrator, and due to staff meeting knowledge and efficiency goals, these meetings concluded in the same fiscal year.

In the next fiscal year, ATC intends to add two new clinical therapists to the program to assist in maintaining network adequacy guidelines. To accomplish this, ATC will begin to engage in the recruiting and hiring process for these two new positions.

Challenges and Solutions

ATC struggled with a high rate of no-shows to intake assessment appointments in FY 2023-24. As a solution, intake appointments were scheduled with back-up intakes which enable ATC the ability to offer some individuals sooner appointments and give the program the ability to render services even when no-shows occur. Another challenge was the inability to accept verbal consents for obtaining electronic signatures on enrollment documents. The program implemented the use of GETACCEPT in order to obtain signatures and worked alongside the Compliance Administrator and Chief Compliance Officer to ensure appropriate utilization. Lastly, individuals requesting services who did not have Medi-Cal or had another type of healthcare coverage was a challenge this fiscal year. To address this, ATC identified other resources for mental health support when individuals did not have Medi-Cal coverage or had private insurance.

Diversity, Equity and Inclusion

ATC is equipped to link individuals, if needed, to resources related to transportation, food, clothing, shelter, phones, language services (bilingual staff, a language line), as well as provide services offered via a variety of options (in-person, over the phone). The program accommodates individual's work and school schedules to complete service requests at times that work for the potential client.

Staff complete training and webinars related to cultural competency and implicit bias, as well as focus on these areas in supervision. 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 Clinical Services regarding referrals and support for older adults and veterans in the community. The program staff are also able to complete intakes for all ages to qualify for an intake assessment if indicated.

Community Partners

While ATC collaborates with several internal departments, the highest amount of collaboration in relation to intakes, resources and referrals is with the Adult Outpatient Team, 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 treatment, reporting mandates, 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, primary care physicians,

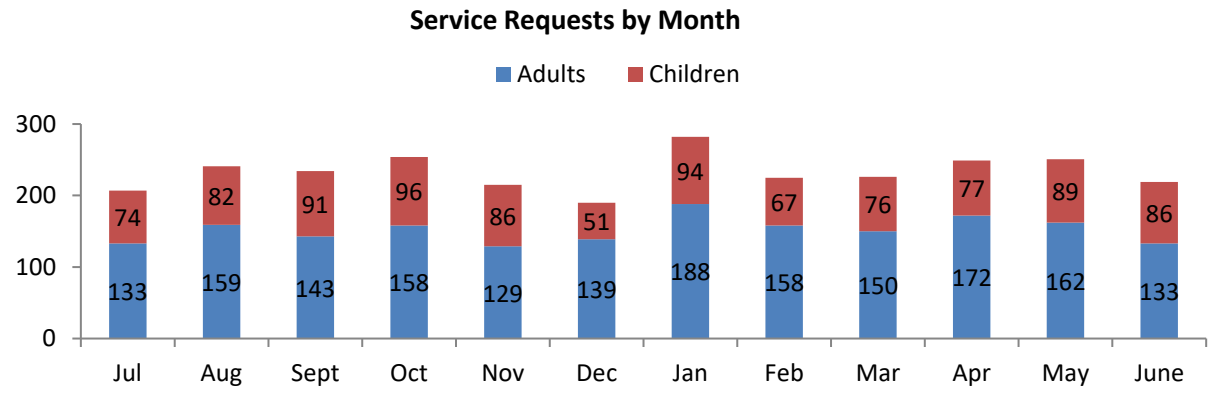
Adult/child Protective Services, Crisis and Trauma Resource Institute, American Recovery Center, Hope for Home and Volunteers of America.

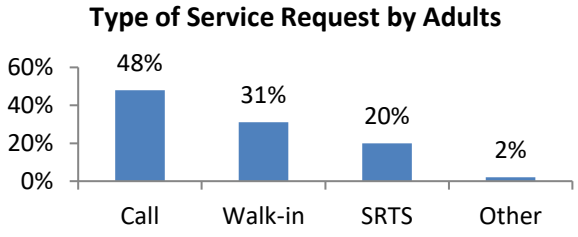
Success Story

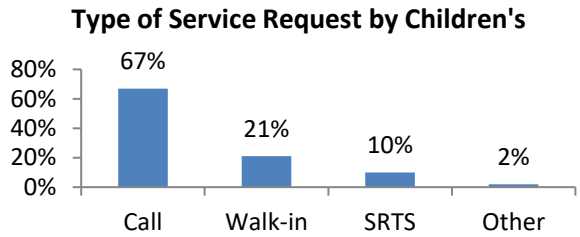
A potential client completed an intake assessment and following the assessment, the determination was made that they did not meet medical necessity for specialty mental health services with Tri City. However, the family had needs pertaining to their young child who was recently diagnosed with Autism and required behavioral support. The intake clinician was able to connect the family to a Peer Support Specialist, and a team member was assigned to help support the family with accessing further resources that would better fit their needs. As a result, the family was connected to the San Gabriel Pomona Regional Center and the caregivers developed the knowledge to advocate for themselves and their child. This is an example of how ATC goes above and beyond to ensure that individuals who come to us in need are supported, even if that means connecting them to another type of agency that may better suit their needs.

Program Summary

How Much Did We Do?





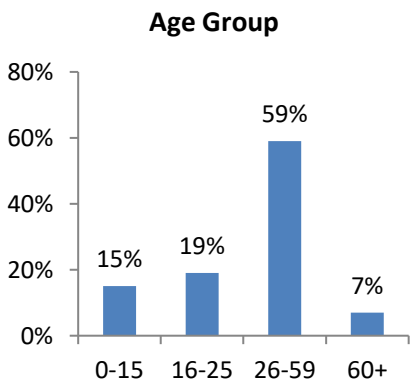


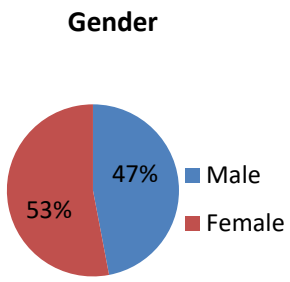
2,793

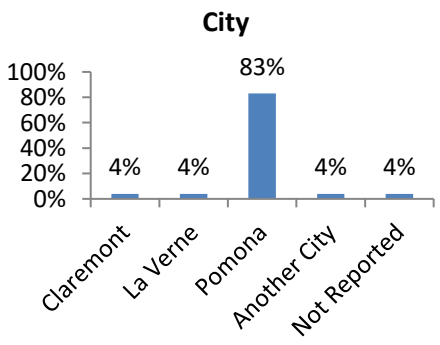
Service Requests

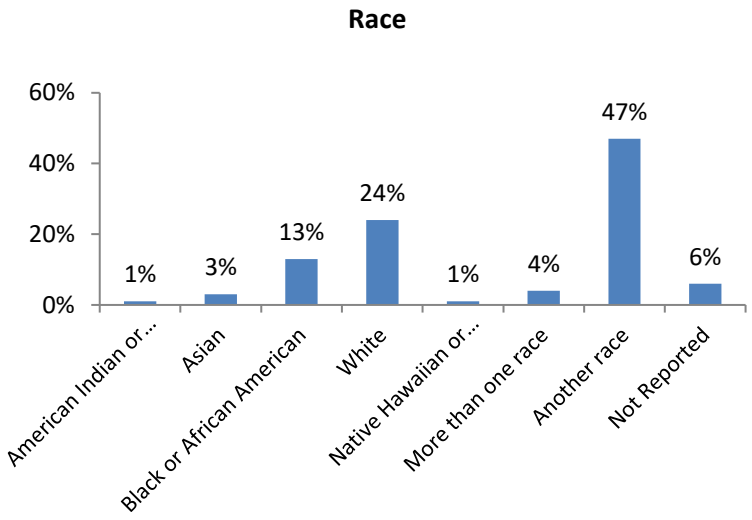
The number of service requests **increased** from **2,517** in FY 2022-23 to **2,793** in FY 2023-24.

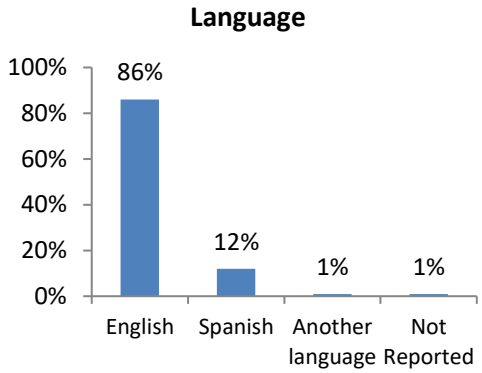
Demographics from All Service Requests











357

Services Request from Hospital Discharges Adults

106

Services Request from Hospital Discharges Children's

2,167

Intake Appointments Scheduled with Individual

The number of hospital discharges for both sites and intake appointments **increased** from **281, 76, and 1,942** in FY 2022-23 to **357, 106, and 2,167** in FY 2023-24.

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

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 and Stigma Reduction/Suicide Prevention Program

Community Capacity Building (Prevention)

Community Wellbeing Program

Program Description

The Community Wellbeing (CWB) program provides grants to local communities and groups in Tri-City's service 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 organizations. 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	12,209

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	3,967	911	640	205	N/A	**5,723**
Projected Number to be Served FY 2024-25	4,083	938	659	211	N/A	**5,890**

Program Update

In FY 2023-24, a total of 13 Community Wellbeing Grants were awarded. The community members served as a result of these grants represented 12,209 individuals, which was a significant increase from 10,809 in FY 2022-23. Notably, the communities being served by these projects provide services to underserved, unserved, and at-risk youth.

During this fiscal year, CWB staff partnered with other Tri-City staff and the Kennedy Austin Foundation to organize an event called "Box of Hope." This event was held at the Tri-City Wellness Center for families in Pomona, Claremont, and La Verne who were grieving the loss of loved ones. The aim was to create a supportive environment where families could feel cared for, heard, and connected to mental health services if necessary. Young members of the Kennedy Austin Foundation crafted and decorated beautiful boxes, each dedicated to the memory of loved ones, which families were able to take home. Additionally, program staff and other Tri-City personnel provided an overview of the services and programs available at Tri-City to assist youth and families in need, and several resource tables with information about Tri-City's programs and services were set up for attendees.

Program staff increased the number of in-person meetings in FY 2023-24 and attended events hosted by grantees and their organizations. This shift has fostered greater community engagement, as grantees can now meet face-to-face. A notable example of this was the final cohort meeting, which was hosted at a grantee's site. During this meeting, recipients of the grant were able to present their projects, share success stories, and discuss challenges they faced throughout the fiscal year. Additionally, they had the chance to network with one another and expressed their appreciation for the opportunity to meet and connect with their peers.

Challenges and Solutions

Grantees reported facing challenges in recruiting participants, both through outreach efforts and adjustments to project delivery. They expressed difficulties in retaining current participants as well as obtaining and attracting new ones. Furthermore, while some participants prefer in-person meetings, there are still many who prefer to connect virtually, and unfortunately, some do not attend either format. Grantees were able to address these challenges by adapting the delivery of their projects based on feedback from their communities. They offered both in-person and virtual options, utilized incentives, provided resources, and leveraged social media to promote a wider range of their services.

Additionally, grantees collaborated with other members of their cohort to promote their services reciprocally and seek advice on effective outreach and service delivery strategies.

Diversity, Equity and Inclusion

CWB staff consists of a bilingual staff member and all materials and presentations are available in English and Spanish. Additionally, a program staff member serves as the Chair for the ¡Adelante! Hispanic & Latino Wellness Committee. Members of ¡Adelante! share ideas and discuss barriers to improving the wellbeing of Latino and Hispanic families and communities. The program also works with community entities that provide services to underserved, unserved and at-risk communities, focusing on ages 0-25.

Additionally, grantees network and collaborate with each other to serve marginalized populations. Training resources related to cultural competence are disseminated to grantees, and the grantees distribute them to their participants. All 13 grantees are offered a diverse range of services, resources and activities, including hygiene products, meals, support groups, creative arts programs, clothing for teens, mental health workshops, afterschool programming, transportation for young mothers, grief and loss support, special needs basketball clinics for self-esteem and team building, art initiatives in open spaces, and an LGBTQ+ Youth Health & Education Wellbeing program. These efforts are aimed at enhancing the well-being of their communities and underserved populations.

Community Partners

In addition to collaborating with several internal programs, CWB works in partnership with several agencies such as: Bithiah's Family Services, Character Champions Foundation, City of Knowledge, City of Pomona, Draper Center for Community Partnerships, 4Kids WorldWide, House of Ruth, Kennedy Austin Foundation, La Verne Youth & Family Action Committee, Pomona Valley Pride, Purpose Church, Sowing Seeds for Life, and The Youth and Family Club of Pomona Valley. These organizations represent an array of services and supports for our community and individuals in the 0-25 age range.

Program staff facilitated connections between various grantees and our Mental Health Trainer, enabling mental health training sessions for their communities to further promote mental health and wellbeing. Grantees also exchanged resources and events from their own communities, and program staff circulated these resources among the cohort and Tri-City staff. Additionally, some grantees reported collaborating with other grant recipients in the cohort.

Success Story

Grantee, Purpose Church Rise Up Program, focuses on transition age youth (16-25) who reside in the Del Rosa and Angela Chanslor neighborhoods in Pomona. Rise Up provides weekly programming centered around social-emotional development via restorative circles, character building and mentorship. A total of 60 youth participates in this program. The Renacimiento Teen Center, where they have their central meeting location, is safe and conducive for this program. Per program staff and leadership, transformations have occurred within some of their attendees. One example is the story of a youth, who for the first year of receiving services, displayed difficulty with concentration,

disruptive behaviors and struggles with the authority figures. Upon entering year two, there was a noticeable change in the attendee. Currently, youth attend the program weekly, actively leads elements of the gathering among their peers, and has become close with his leaders. When leaders at the Rise Up Program approached the individual, inquiring on the change, the response included feedback highlighting staff persistence, accessibility, and genuine empathy for all who entered the program.

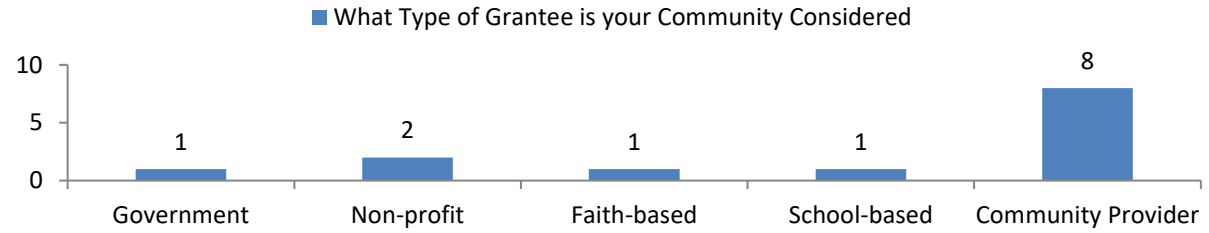
Program Summary

How Much Did We Do?

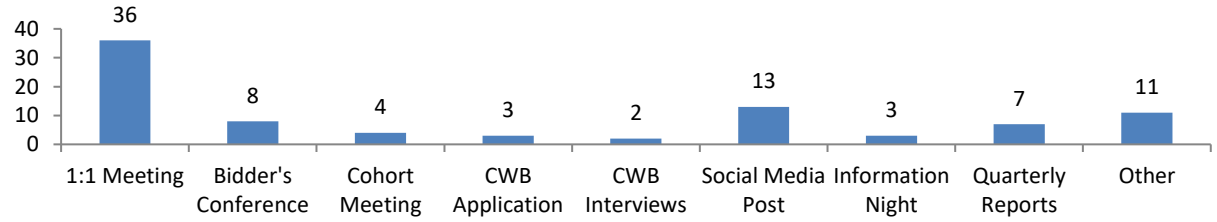
35 Application Reviews → **21 Application Interviews** → **13 Community Grantees Awarded**

12,209 Community Members Represented in all of Grantee Communities

The number of community members represented in all grantee communities **increased** from **10,809** in FY 2022-23 to **12,209** in FY 2023-24.



Number of Events Held by Community Capacity Organizer

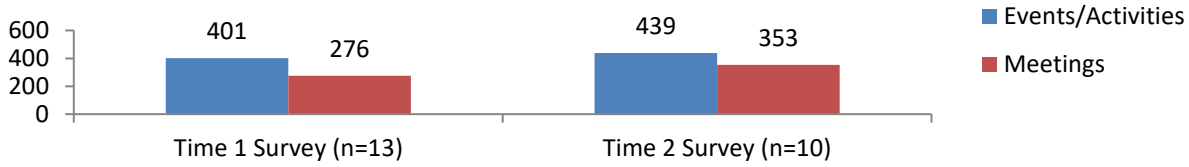


391 Event Attendees

The number of events held **increased** from **81** in FY 2022-23 to **87** in FY 2023-24.

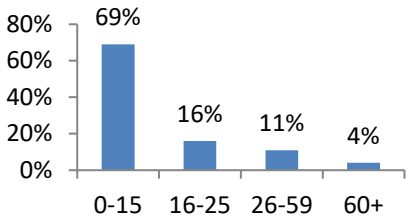
Number of Events/Activities and Meetings Hosted by Grantees

11,506 Attendees for Events/Meetings

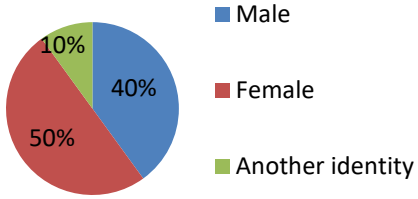


Grantee Community PEI Demographics (13 grantees completed Time 1 Survey)

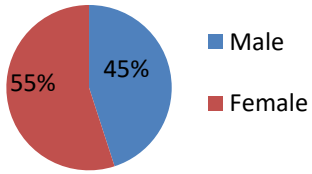
Age Group



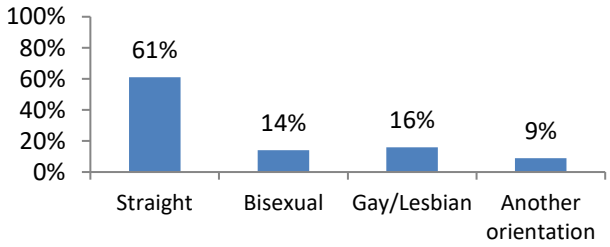
Current Gender Identity



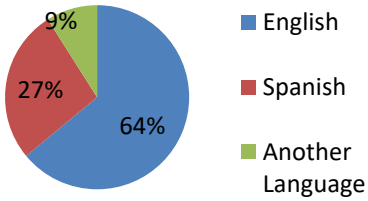
Assigned Gender at Birth



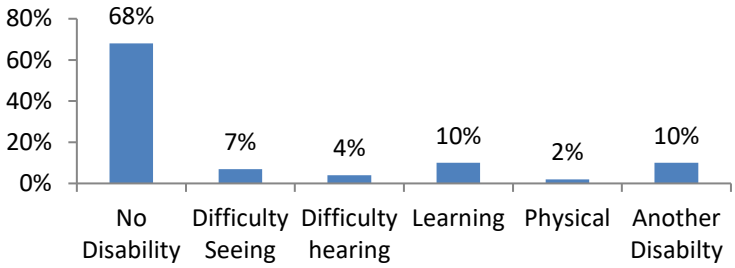
Sexual Orientation



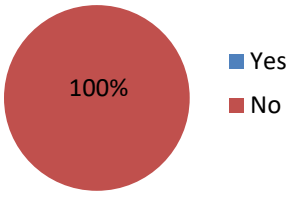
Language

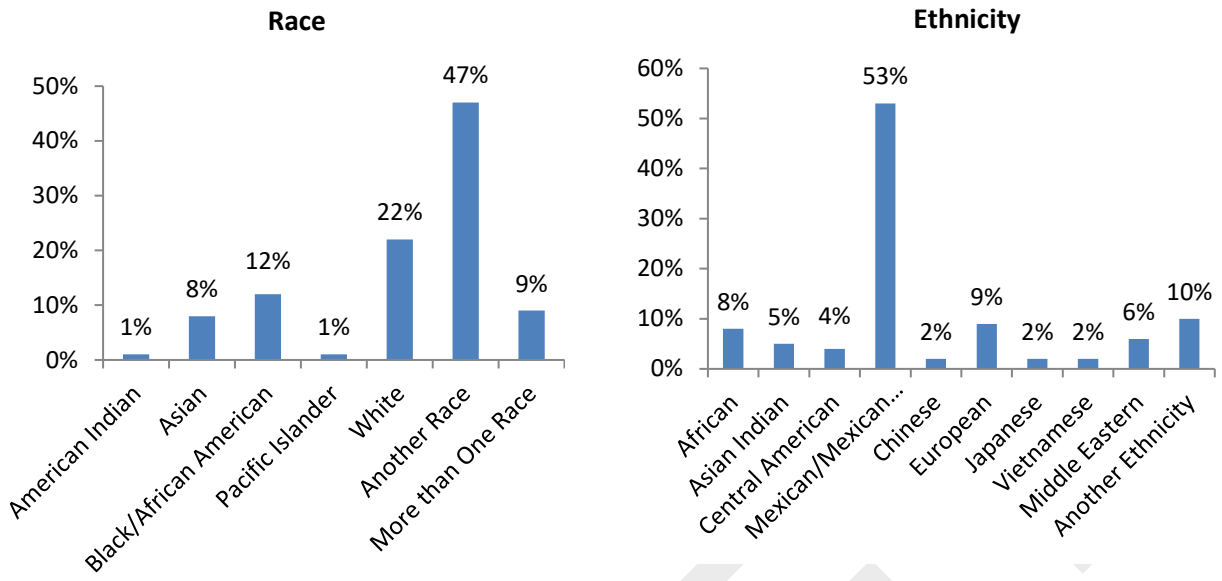


Disability



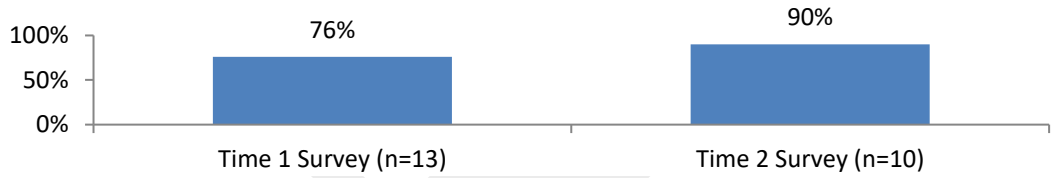
Veteran



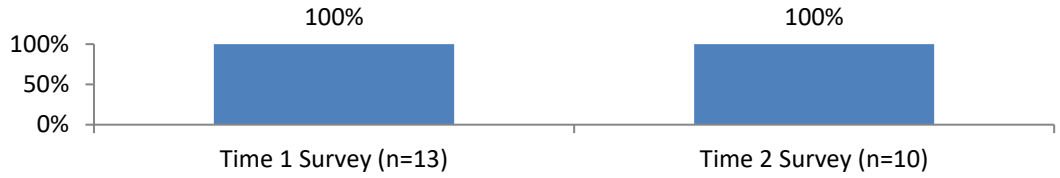


How Well Did We Do It?

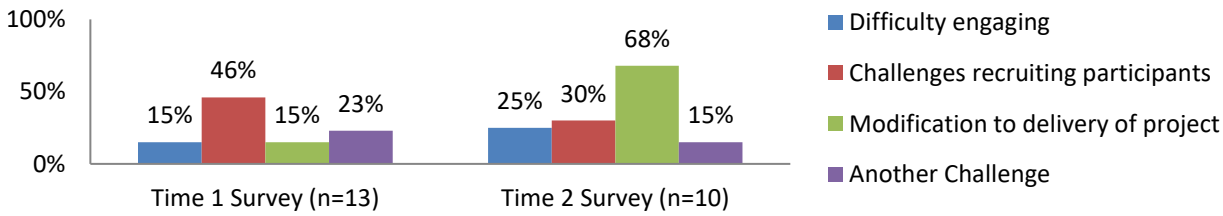
Percentage of Grantees who Report Successful in their Community's Activities:



Percent of Grantees who report they have a better understanding of the services at Tri-City and its mission:

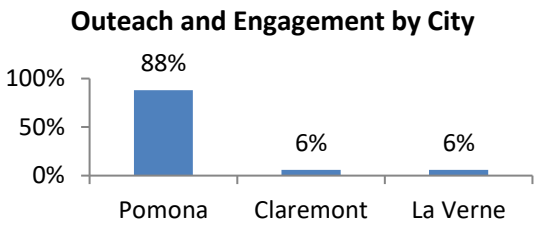


Percent of Grantees who report challenges their communities faced? (Check all that apply)



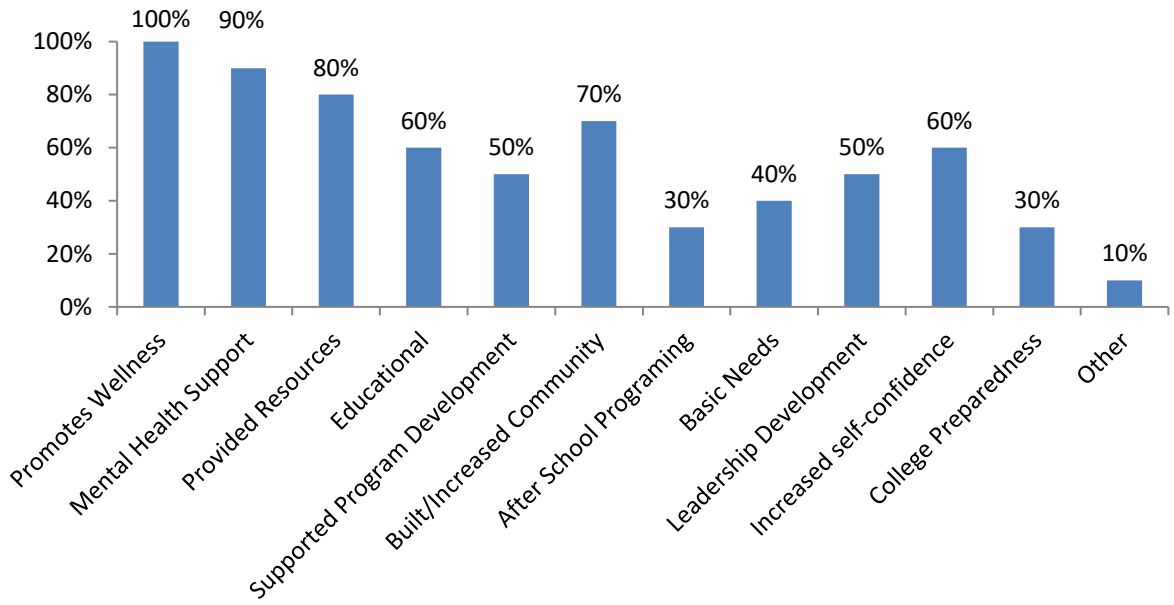
17
Outreach and Engagement Events

29
Individuals Outreached and Engaged

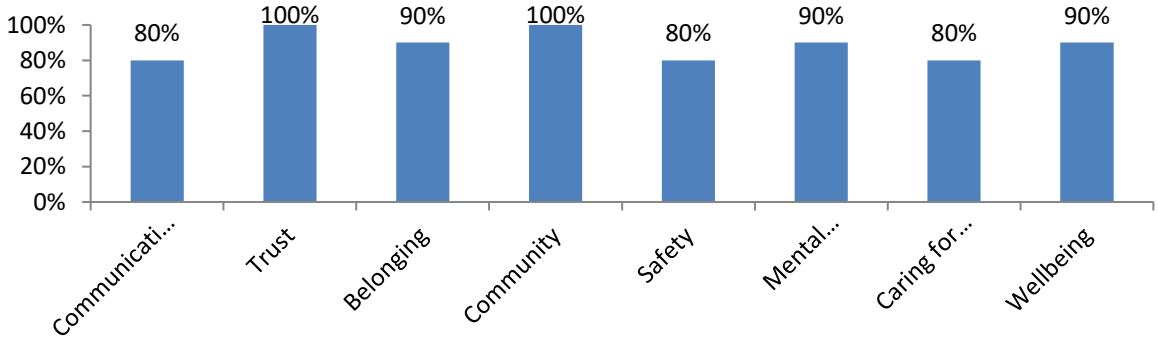


Is Anyone Better Off?

In what ways did your community benefit from this project? (Select all that apply)



As a result of your project efforts, members of the community now have a better sense of: (Select all that apply)



What was the most successful outcome of this project:

- Being able to transport mothers to their appointments, therapy and work!
- Music is proven to empower us, teach us calmness, heal us, and to help us create communities with those around us. Seeing these effects occur in real time was amazing, and I truly feel that the most successful outcome of this project was from the weekly, genuine connections made between mentees and mentors in their lessons.
- That students felt better about themselves (especially those who are unhoused) interacted more with others and were more accepting of other services that improved their lives such as attending our food pantries off campus.
- The CC Kids project has made early childhood wellbeing education more accessible and engaging, and taught that every child, indeed every person, is valuable, lovable and capable (VLC).
- The most successful continues to be the opportunity for our children to socialize and be encouraged in a positive atmosphere.
- The most successful outcome of this project has been our participants' improved well-being. We see a significant change in the lives of many members in less tears and more smiles. As well as new jobs, relationships and community involvement.
- The ultimate aim of the Teen Center project is to empower our teenagers to envision a brighter future and strive toward achieving their individual goals. We believe that this project will attract a significant increase in teen participation.
- We were able to ensure that kids at risk and need had a meal each weekday of the summer

Number of Potential Responders	12,209
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 (Prevention)

Community Mental Health Trainings

Program Description

Tri-City offers free Community Mental Health Trainings (CMHT) to individuals, groups and community 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), Youth Mental Health First Aid (YMHFA), Adverse Childhood Experiences (ACEs), Community Resiliency Model™ (CRM), Motivational Interviewing (MI), Everyday Mental Health (EMH), Stress Management, Self-Esteem/Mental Health, and Wellness Recovery Action Plan. 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.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	98	252	22	396	**768**
Projected Number to be Served FY 2024-25	0	118	302	26	475	**921**

Program Update

The Community Mental Health Training (CMHT) program created and implemented an annual community calendar of trainings offered to the public (cities of Pomona, La Verne, Claremont). Trainings are offered every second Friday of the month. Due to the success of the annual calendar, there has been an increase of community members registering to be a part of the Community Mental Health Trainings Contact List. Through this list, individuals are notified via monthly emails regarding current and upcoming mental health trainings, workshops, and presentations. Sixty-four community members (comprised of school districts, service providers, individual community members, community groups and organizations), are currently registered to receive updates on the Community Mental Health Training program. Additionally, having multiple options available for trainings

continues to be useful, accordingly, CMHT still provides and will continue to provide virtual and in-person training options for accessibility and inclusivity purposes.

Challenges and Solutions

The CMHT program has resumed in-house trainings for Tri-City staff. When scheduling and planning trainings for the community, staff must carefully consider scheduling options and make time available to support not only community members and groups, but also in-house staff. CMHT staff tracks and stays up to date on providing mandatory trainings to agency staff, while supporting the community and their training needs.

To support the organization and administration of trainings, CMHT staff created an In-House Trainings calendar for Tri-City staff to register for mandatory trainings. This allows the CMHT staff to properly organize and schedule for the Tri-City agency, while supporting requests from the community. This also supports in balancing the pre-designated monthly trainings offered to the general public on a monthly basis. Tracking requests also continues to be effective when scheduling trainings, and a vital source in managing organization and efficiency for the program.

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, materials and brochures are available in both English and Spanish, while training also targets service providers that serve and support underserved communities. Continuing to offer trainings virtually supports efforts in eliminating barriers related to lack of transportation or physical mobility and provides easier access allowing everyone to participate and gain knowledge in a safe environment from their preferred location.

Additionally, CMHT trainers complete cultural competence trainings and these concepts are incorporated in the trainings provided to the community. The CMHT program recognizes that cultural backgrounds, gender identities, sexual orientations, languages, ages, and religious beliefs can shape perceptions of mental illness. These factors may hinder some individuals from openly discussing their mental health challenges or seeking necessary support and services. Therefore, CMHT emphasizes in its marketing materials that trainings are available to all residents, service providers, community organizations, and groups in Pomona, Claremont, and La Verne.

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 external partners include Pomona Unified School District and Bonita Unified School District. While examples of internal partners include Tri-City's Mental Health Student Services Act, recipients of the Community Wellbeing Grant Program, interns, Housing Program and the Peer Mentor Program. These partnerships provide consumers of trainings for the CMHT program, support of landlords to increase their understanding of the intersection of mental health and housing needs, and support of school district staff and families.

Success Story

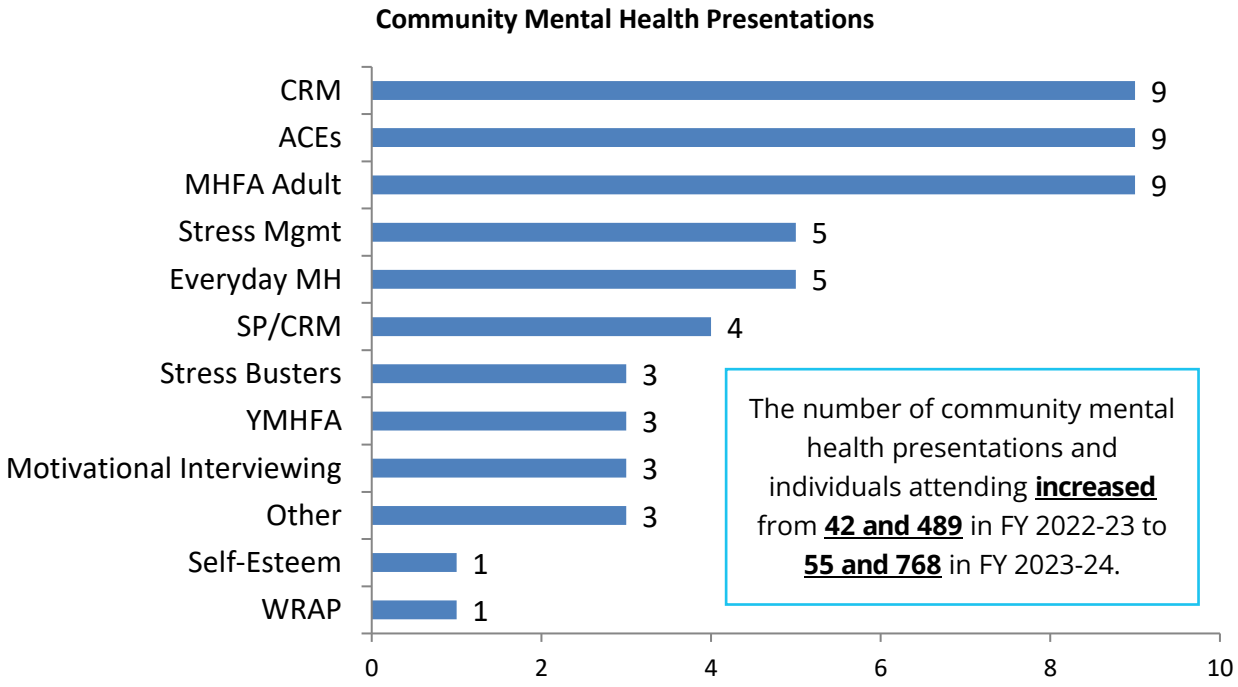
Staff delivered a Mental Health First Aid (MHFA) training to counselors at California Polytechnic University, Pomona. A few weeks after the training, CMHT staff was approached by one of the attendees in the community. The attendee shared their experience with staff, discussing their stepchild's mental health struggles at home. The individual expressed that the training had enabled them to recognize the signs and symptoms of her stepchild's challenges and was able to offer the MHFA action plan to provide the necessary support. As a result, they were able to ensure that the child received the appropriate resources to cope effectively. This community member's feedback emphasized that the MHFA course had been incredibly informative and beneficial in helping them engage with a loved one when they were facing mental health challenges.

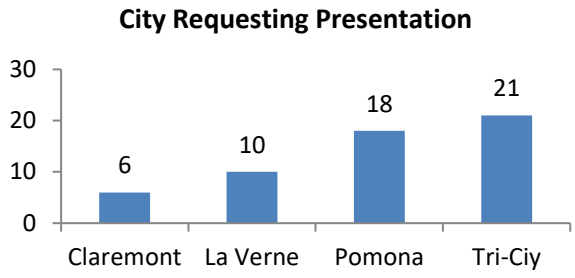
Program Summary

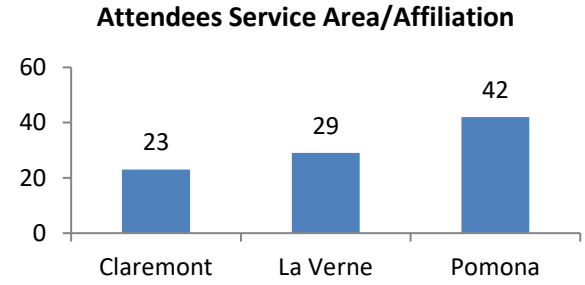
How Much Did We Do?

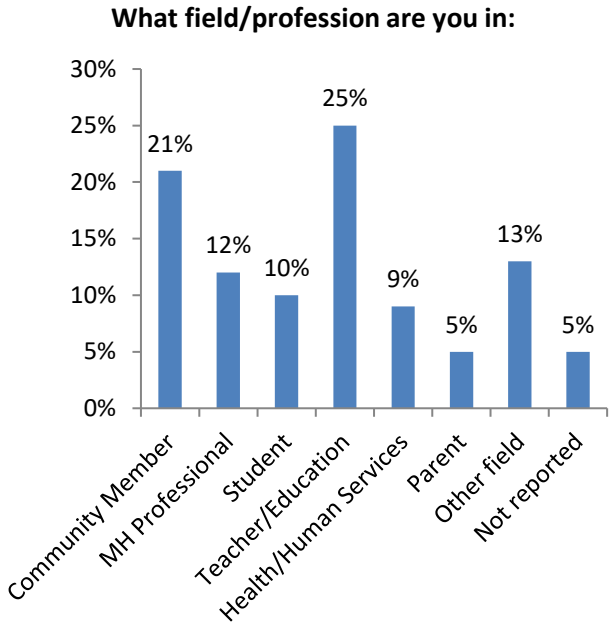
768
Individuals attending Presentations

55
Community Mental Health Presentations Conducted





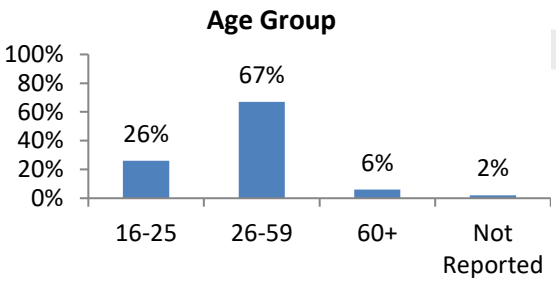


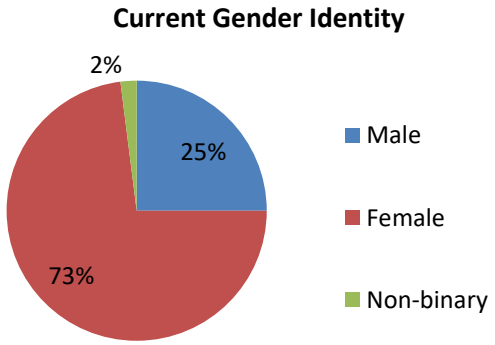


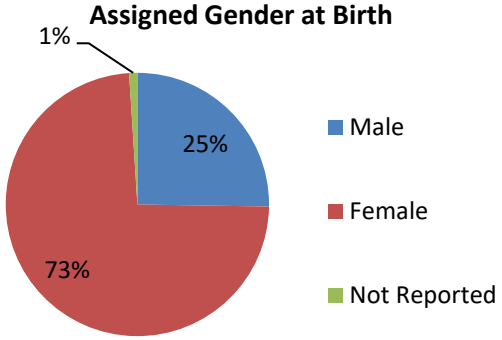
PEI Demographics from Surveys (n= 378)

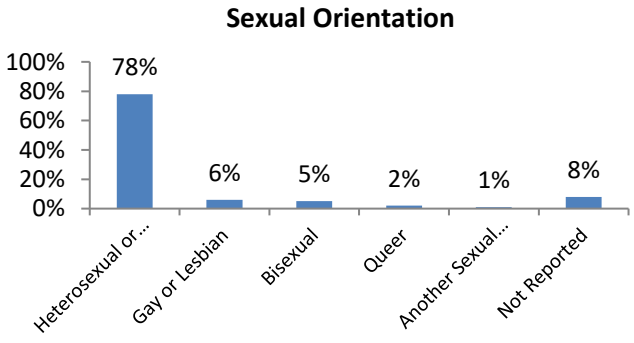
** PEI Demographics only completed by Adults 18+

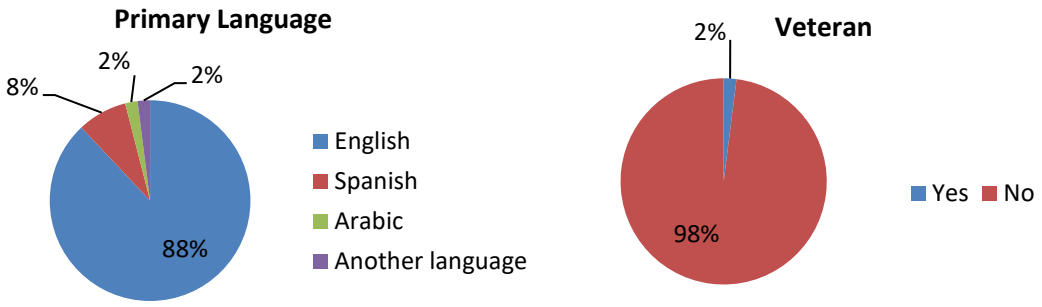
The number of surveys completed **increased** from **72** in FY 2022-23 to **378** in FY 2023-24.

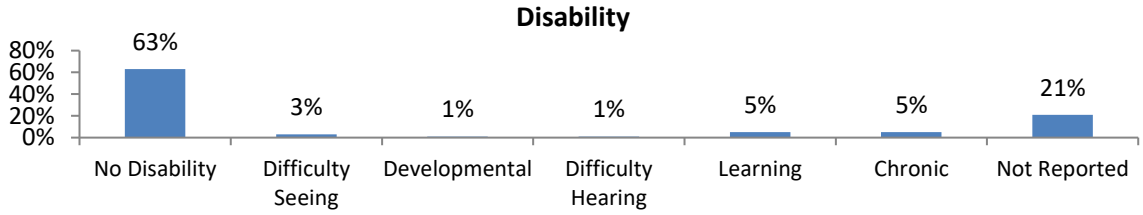


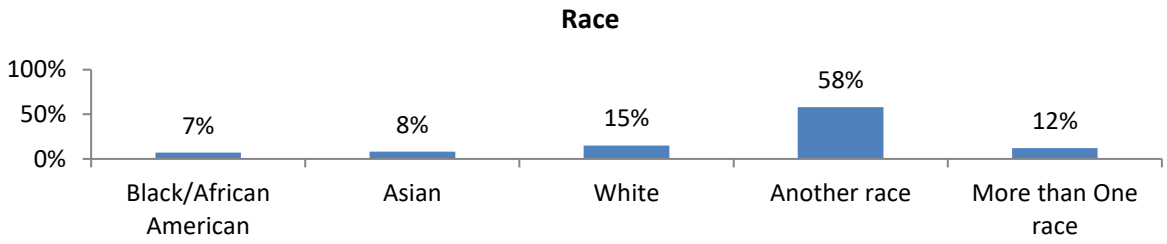


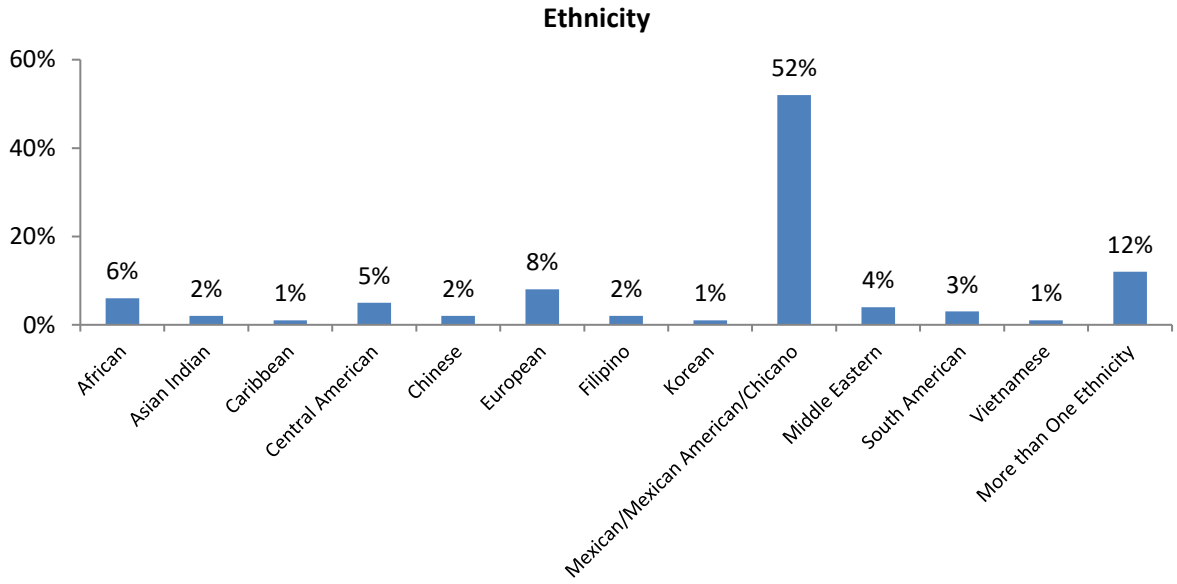





Primary Language
2%
8%
2%
88%
English
Spanish
Arabic
Another language
Veteran
2%
98%
Yes
No

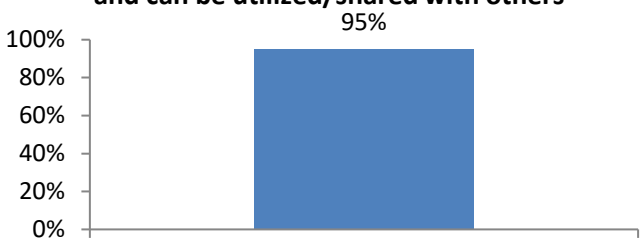

Disability
80%
60%
40%
20%
0%
63%
3%
1%
1%
5%
5%
21%
No Disability
Difficulty Seeing
Developmental
Difficulty Hearing
Learning
Chronic
Not Reported


Race
100%
50%
0%
7%
8%
15%
58%
12%
Black/African American
Asian
White
Another race
More than One race

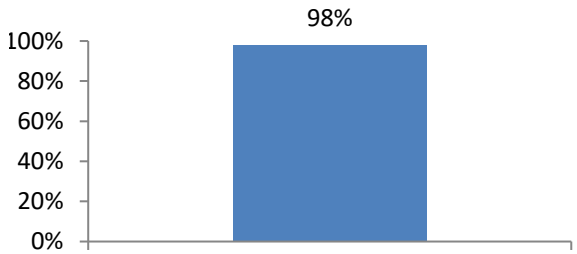

Ethnicity
60%
40%
20%
0%
6%
2%
1%
5%
2%
8%
2%
1%
52%
4%
3%
1%
12%
African
Asian Indian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican/Mexican American/Chicano
Middle Eastern
South American
Vietnamese
More than One Ethnicity

How Well Did We Do It?

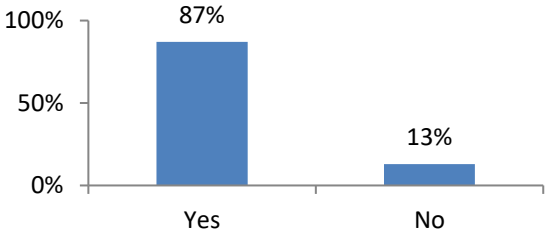
Percentage of participants who report the presentation provided helpful information and can be utilized/shared with others



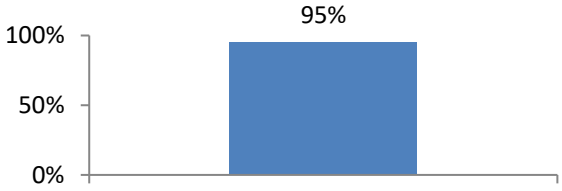
Percentage of participants who rated the presentation as good or excellent:



At any time in your life, have you experienced a traumatic event or mental health challenge?

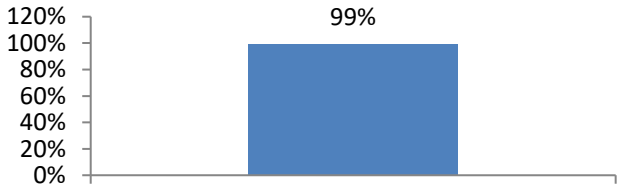


If so, has this presentation provided the support to manage your wellness or recovery?

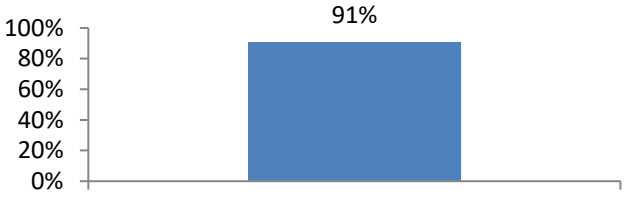


Mental Health First Aid

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

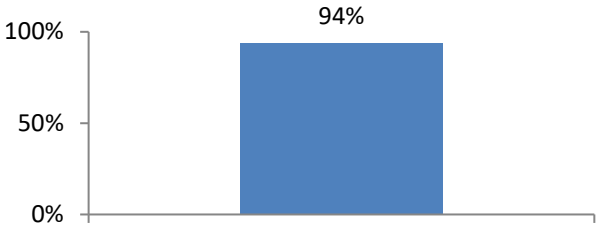


Percentage of participants who can express concerns to any person about mental health signs and symptoms to help that person to seek timely support

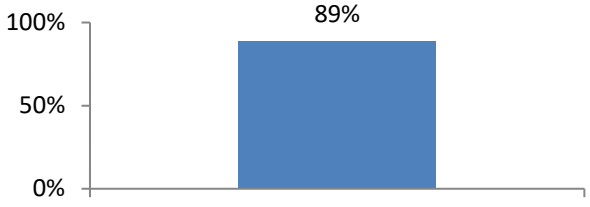


Is Anyone Better Off?

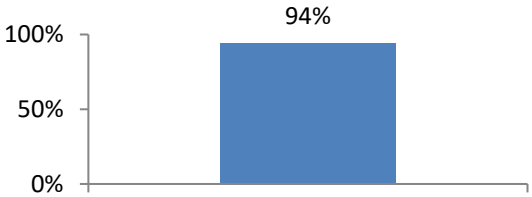
Percentage of participants who report feeling confident in using or applying the information they learned in the presentation



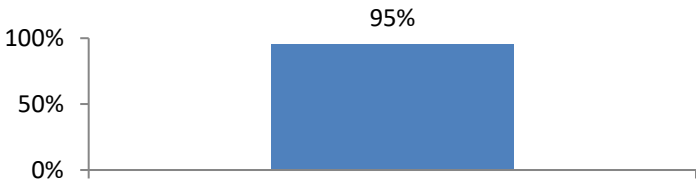
Percent of participants who report feeling more confident reaching out to someone who may be dealing with a mental health /substance use challenge or crisis:



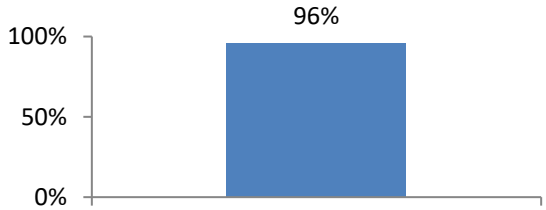
Percentage of participants who would recommend presentation to someone else



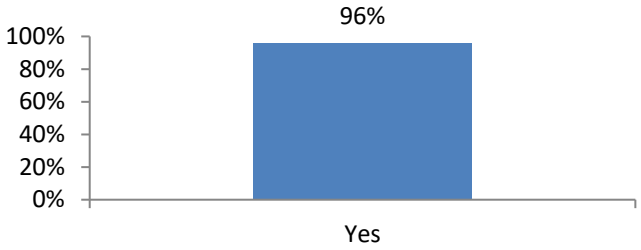
Use ALGEE action plan to connect an adult experiencing signs and symptom(s) of a mental health or substance use challenge or crisis to appropriate help or resources



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



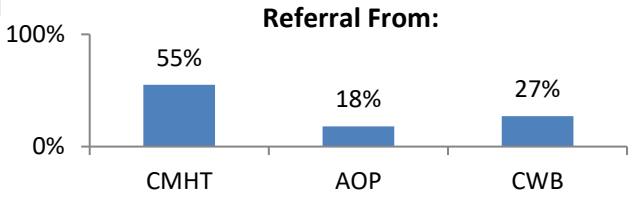
Would you take another MHFA course



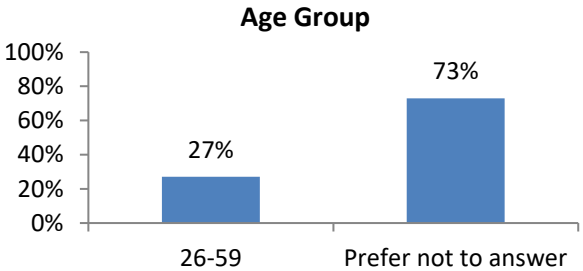
Number of Potential Responders	768
Setting in Which Responders were Engaged	Virtual platforms, Community, Healthcare, Schools, Local Business, Churches, Colleges, Rehabilitation, Regional Centers, Professional Associations, Law Agencies (probation/public defender's office), Department of Mental Health
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.

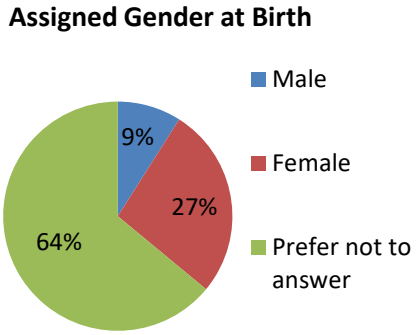
Timely Access to Services for Underserved Populations Strategy

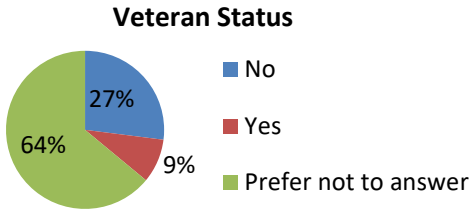
There were 11 MHSA referrals to the CMHT Program

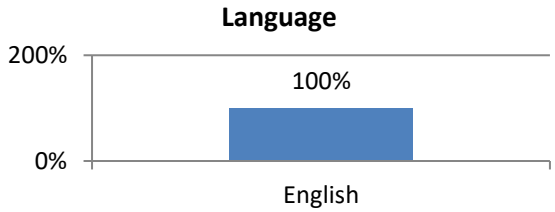


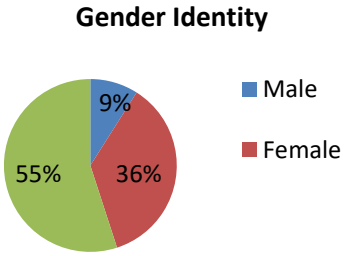
PEI Demographics Based on Referrals

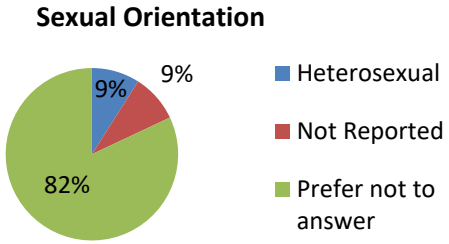


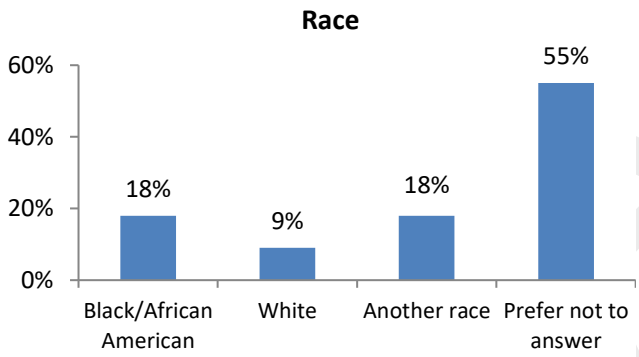


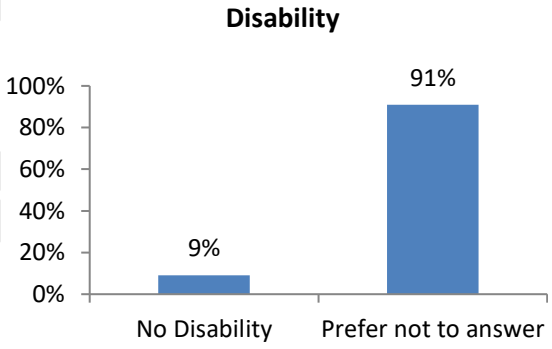

Veteran Status
27%
64%
9%
No
Yes
Prefer not to answer

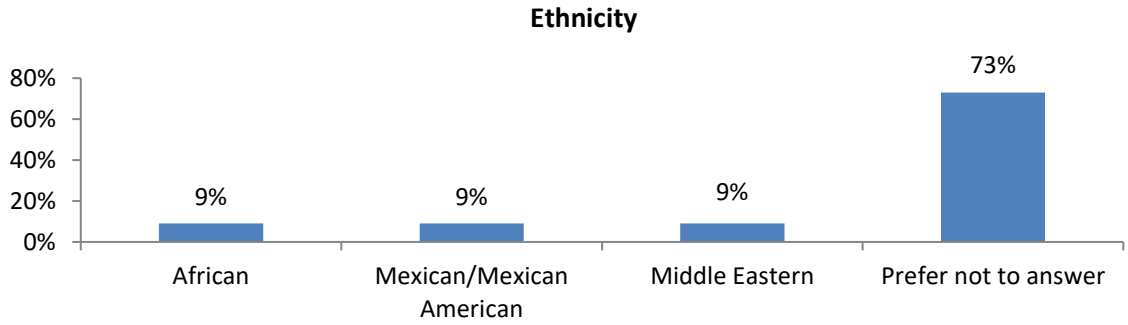

Language
200%
0%
100%
English


Gender Identity
9%
55%
36%
Male
Female


Sexual Orientation
9%
9%
82%
Heterosexual
Not Reported
Prefer not to answer


Race
60%
40%
20%
0%
18%
9%
18%
55%
Black/African American
White
Another race
Prefer not to answer


Disability
100%
80%
60%
40%
20%
0%
9%
91%
No Disability
Prefer not to answer


Ethnicity
80%
60%
40%
20%
0%
9%
9%
9%
73%
African
Mexican/Mexican American
Middle Eastern
Prefer not to answer

Community Capacity Building (Prevention)

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 can 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 can 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 in the community and virtually.
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, TCMH suicide prevention efforts include offering suicide awareness trainings which provide 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 2023-24	0	65	39	16	602	**722**
Projected Number to be Served FY 2024-25	0	39	23	10	363	**435**

Program Update

Suicide Prevention Week was held from September 10-16,2023. Program staff launched a social media campaign to bring suicide prevention awareness to the community and distributed toolkits to local school sites, Tri-City, and community members. Each toolkit included a suicide prevention resource poster, pens, informational cards about Know the Signs, coasters, and stickers.

Additionally, Green Ribbon Week (GRW) was celebrated with a week of events and activities for the public. GRW is an annual recognition that aligns with Tri-City's stigma reduction campaign, encouraging the community to end mental health stigma. Courageous Minds Speakers Bureau, where individuals with lived experience can share their recovery journeys through community presentations, was also hosted during GRW.

During May 2024, Tri-City highlighted May Mental Health Awareness Month. During this month program staff hosted interactive lunch activities at elementary schools, middle schools, high schools and colleges to help promote mental health awareness and Tri-City mental health services. There were also virtual workshops hosted in collaboration with community partners to talk about mental health. In the next fiscal year, the program intends to implement a new suicide prevention training and recruit two cohorts per year for Courageous Minds.

Challenges and Solutions

A challenge experienced by the Stigma Reduction and Suicide Prevention program was engaging with transition age youth (TAY) and getting them involved in stigma reduction events. Lack of TAY attendance was due to barriers such as transportation, lack of parental/guardian support, conflict in scheduling, and/or stigma. Another challenge was that program staff received an overwhelming number of requests to attend or support community events in order to facilitate a stigma reduction activity or promote resources. Unfortunately, some of these requests were declined due to the program being booked frequently. Part of the solution was to provide a warm hand-off between

community partners and other Tri-City programs that could fulfill the request. To address the lack of TAY participation, program staff collaborated with educators and trusted adults that youth have close relationships with that help encourage them to attend stigma reduction events. Additionally, program staff hosted stigma reduction activities/presentations at the school sites to help eliminate transportation barriers. Program staff also plans on collaborating with the Workforce Education & Training Supervisor to recruit TAY service learners and have them participate in stigma reduction and suicide prevention programming.

Diversity, Equity and Inclusion

The Stigma Reduction program is designed to target underserved populations in the community, such as the stigma reduction/suicide prevention presentations, Creative Minds, Courageous Minds Speakers Bureau program, and the social media campaigns. 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. Program staff currently collaborates directly with veterans through a relationship with Hope through Housing. To support the LGBTQ+ community, program staff works with the Pomona Valley Pride, presents stigma reduction workshops across the Tri-City area, and shares relevant LGBTQ+ mental health resources in stigma reduction/suicide prevention presentations.

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 universities the program partners with are Cal Poly Pomona, Claremont High School, Western University, University of La Verne, Pomona College, Claremont McKenna, Pitzer College, Scripps College and Harvey Mudd College. Several K-12 schools are also valuable partners, including those in Pomona Unified School District, Bonita Unified school District, and Claremont Unified School District. 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.

Collaborations with internal programs include the Mental Health Student Services Act, Community Wellbeing Grantees, Peer Mentorship program, Adult Outpatient Services, Children Outpatient Services, Therapeutic Community Gardening, Wellness Center, Community Navigators, and Diversity, Equity, and Inclusion. Some events that manifested from these collaborations were Bee a Pollinator Hero with Therapeutic Community Gardening and Find Your Calm with the Mental Health Student Services Act.

Success Story

Program staff coordinated a Creative Minds – Paint & Sip event at a local boba tea shop in Claremont. The event was a notable success and had received positive feedback from the owner, specifying that they would like to continue this partnership to help combat the stigma, raise mental health awareness, and allow their patrons to feel more part of the community through these community mental health events. Attendees have also shared with program staff that they enjoy these events as they are able to build new connections, have healthy conversations around mental health, and have fun at the free art workshops. Since then, program staff has consistently hosted many Creative Minds art workshops at the local boba shop during FY 2023-2024.

Program Summary

Stigma Reduction, Courageous Minds & Creative Minds

How Much Did We Do?

12
Stigma Reduction Presentations

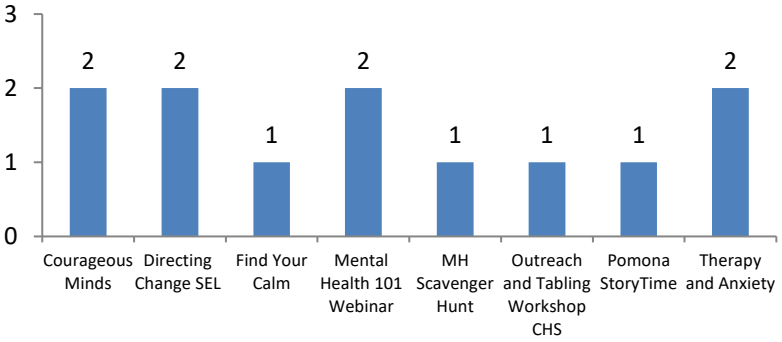
9
Active Courageous Minds Speakers

243
Attendees for Stigma Reduction Presentations

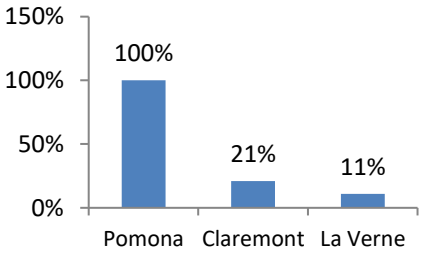
The number of Stigma Reductions presentations **decreased** from **41** in FY 2022-22 to **12** in FY 2023-24.

The number of active courageous minds speakers **increased** from **5** in FY 2022-22 to **8** in FY 2023-24.

Type of Stigma Reduction Presentations



Presentations by City

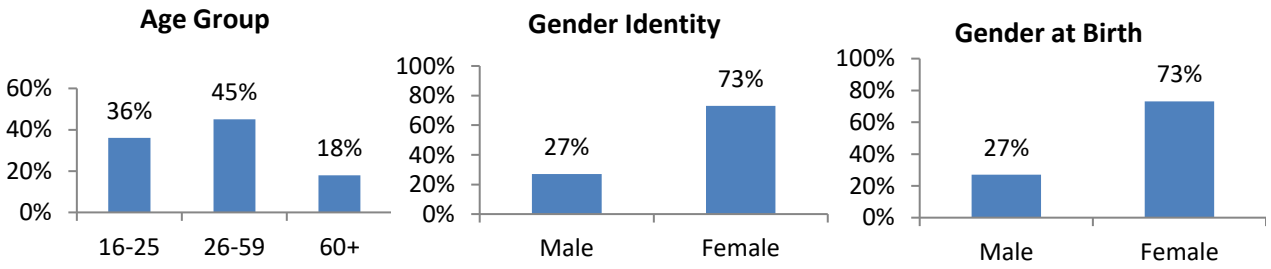


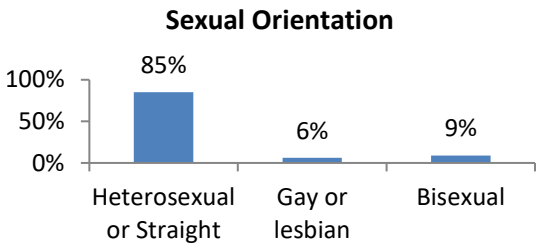
7
Art Events Held

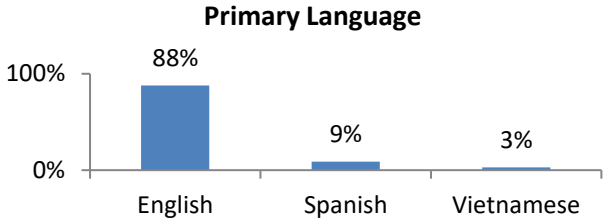
255
Artists Participated in Creative Minds Workshops

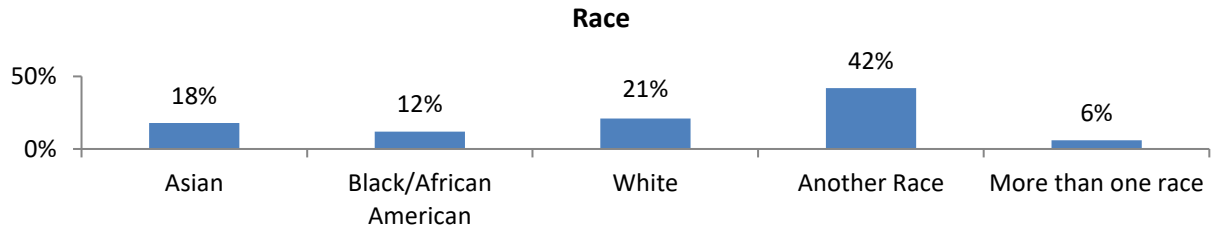
PEI Demographics from Post-Test Stigma Reduction Surveys (n=33)

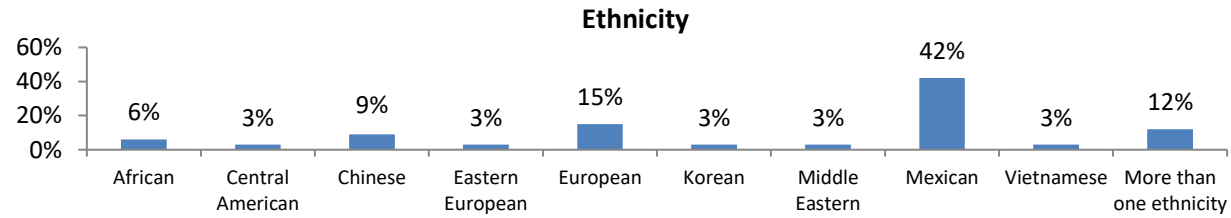
*PEI Demographics Completed Only by Adults 18+

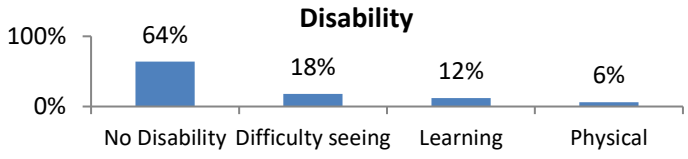


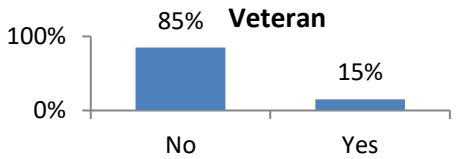


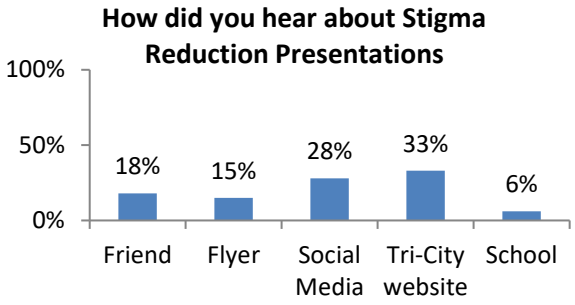


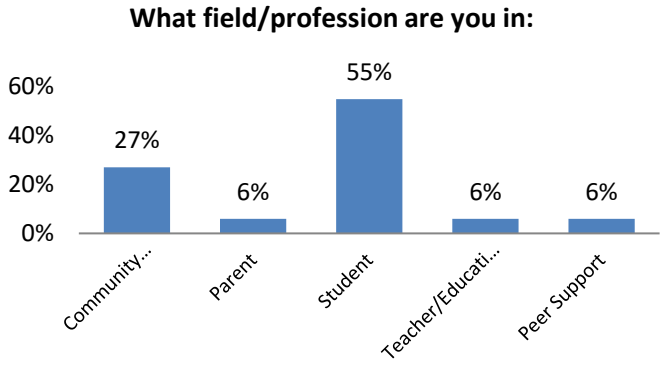












How Well Did We Do It?

243
Individuals Outreached for Stigma Reduction Presentations

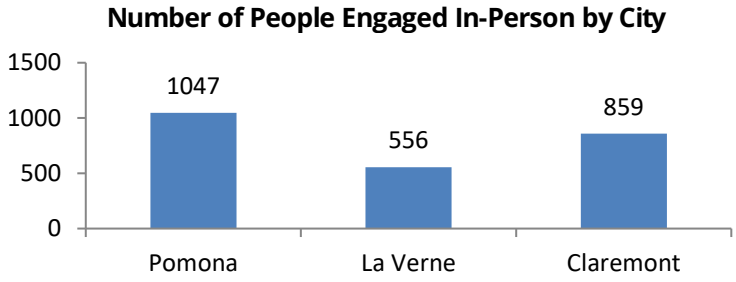
255
Individuals Outreached for Art Gallery/Creative Minds

Promotional Materials & Social Media Engagement for Stigma Reduction

12,093
Promotional Materials

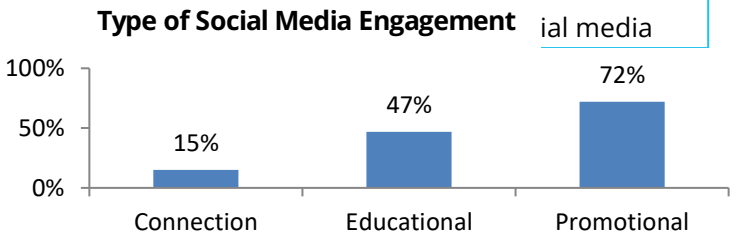
The number of promotional materials & people engaged from outreach **increased** from **8,342 and 1,404** in FY 2022-22 to **12,093 and 2,462** in FY 2023-24.

2,452
People Engaged from Outreach Efforts



6,665
Instagram accounts Reached for Social Media Engagement

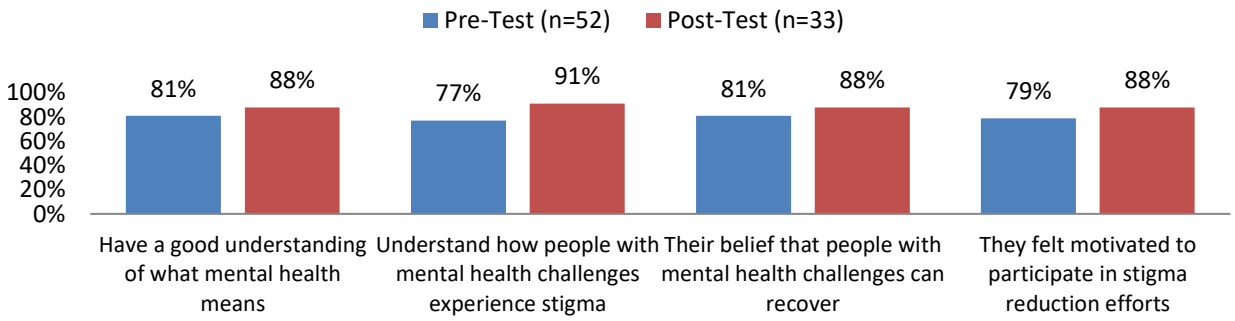
47 post/stories in ial media



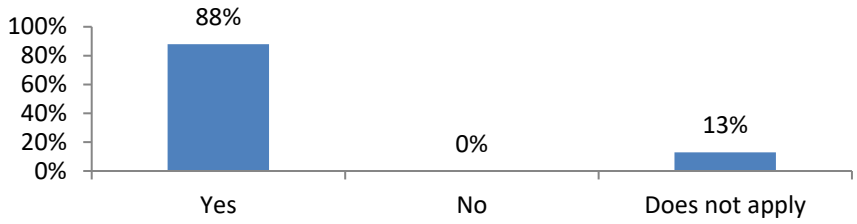
Is Anyone Better Off?

Stigma Reduction

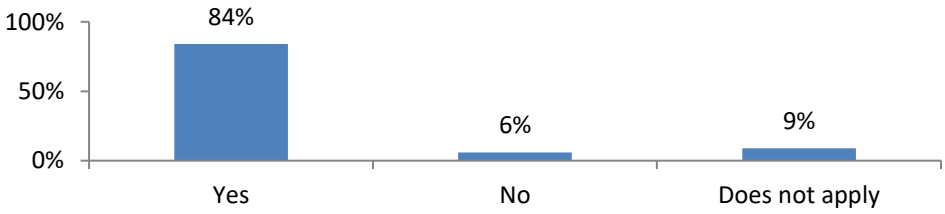
Q.1: Percentage of Stigma Reduction Survey Respondents who reported at Pre and Post Tests



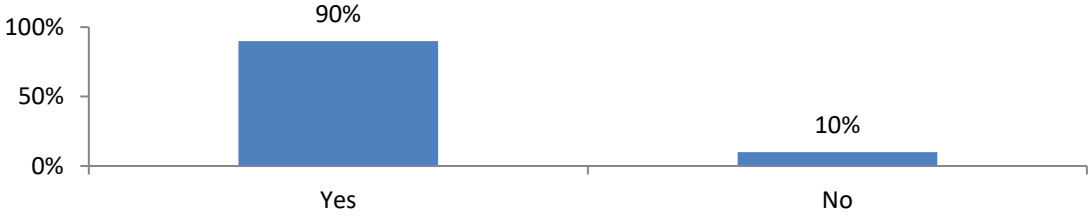
Does Art Help you Manage your Overall Wellbeing:



Q.2: Percentage of Stigma Reduction respondents who reported, "Have experienced any mental health challenges in the past:"



Q.3: Percentage of Stigma Reduction respondents who reported "Yes" to Q.2 and "Has this presentation helped you understand your overall wellbeing:"

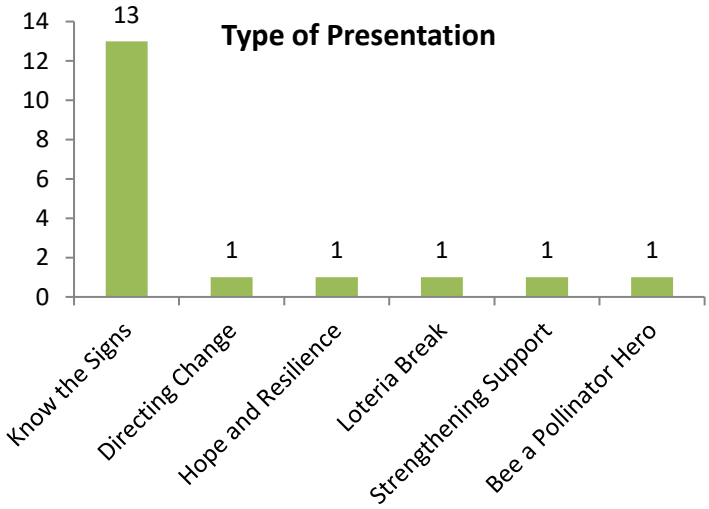


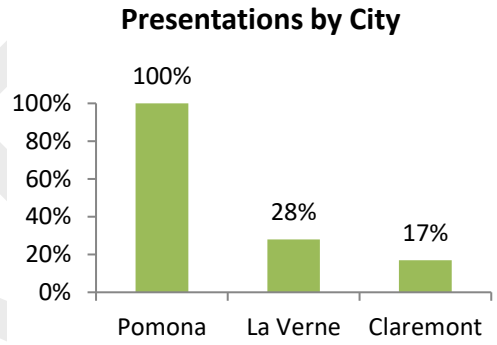
How Much Did We Do?

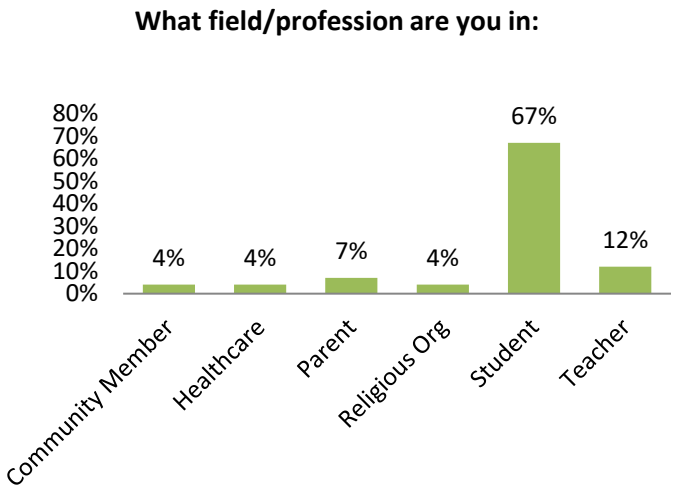
18
Suicide Prevention Presentations

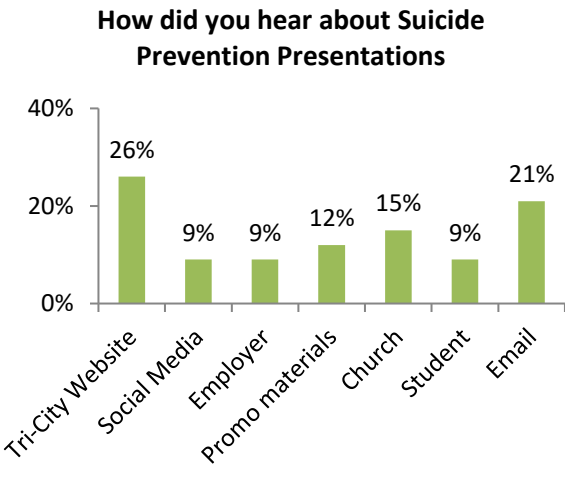
224
Attendees for Suicide Prevention Presentations

The number of Suicide Prevention presentations and attendees **increased** from **15 and 152** in FY 2022-22 to **18 and 224** in FY 2023-24.



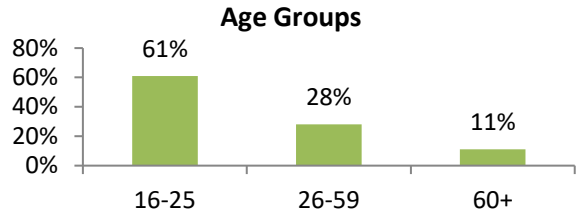


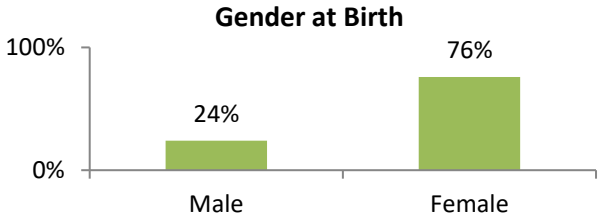


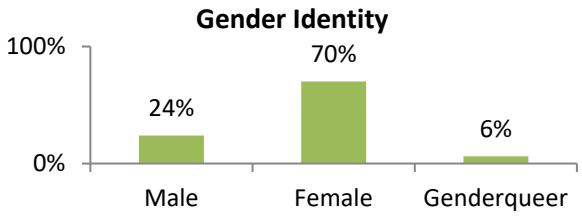


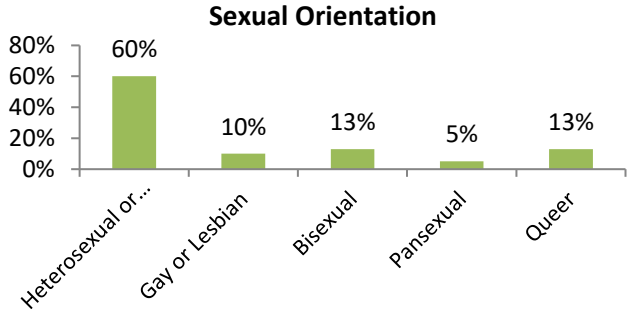
PEI Demographics from Post-Test Suicide Preventions Surveys (n=87)

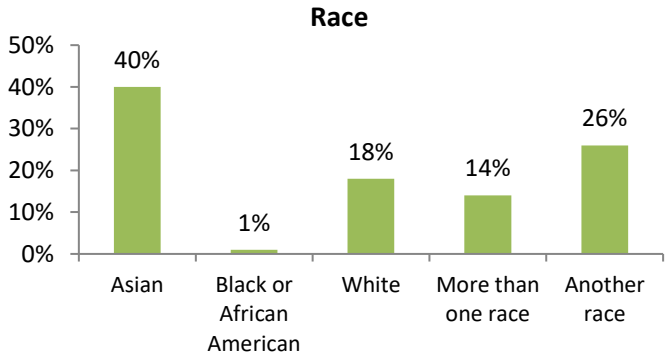
*PEI Demographics Completed Only by Adults 18+

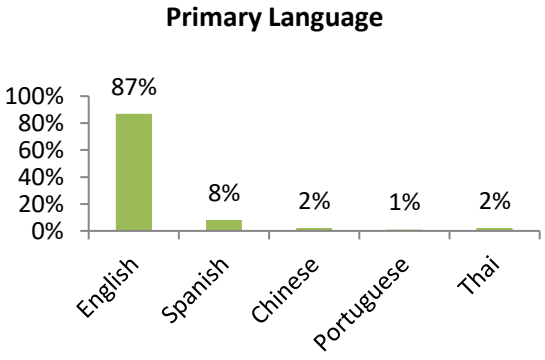


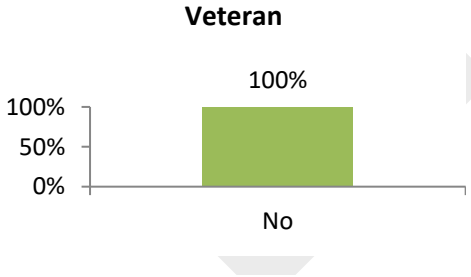


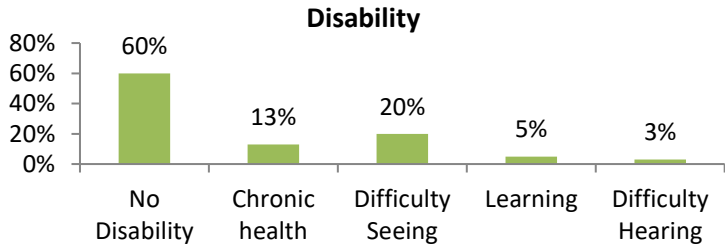


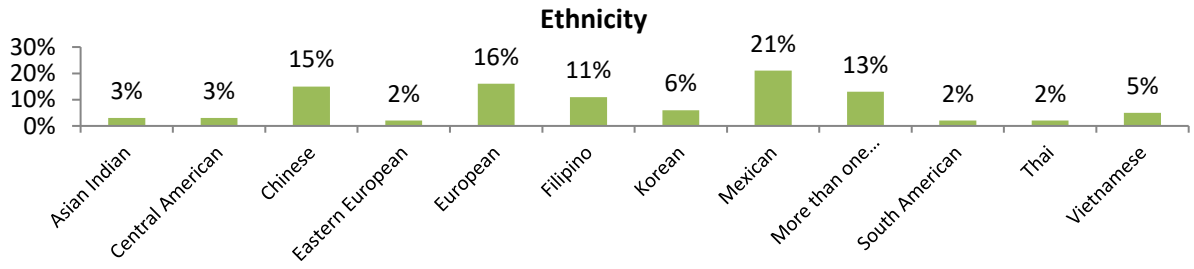












How Well Did We Do It?

224
Individuals Outreached for Suicide Prevention Presentations

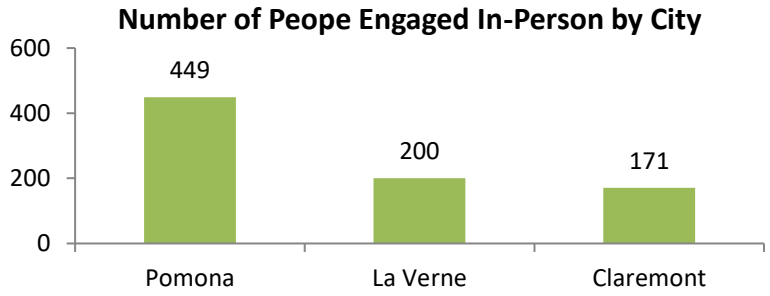
The number of individuals outreached from suicide prevention presentations **increased** from **152** in FY 2022-22 to **224** in FY 2023-24.

Promotional Materials & Social Media Engagement for Suicide Prevention

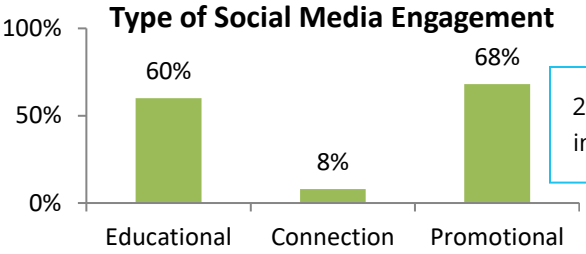
3,065
Promotional Materials

The number of people engaged from outreach **decreased** from **1,161** in FY 2022-22 to **820** in FY 2023-24.

820
People Engaged from Outreach Efforts

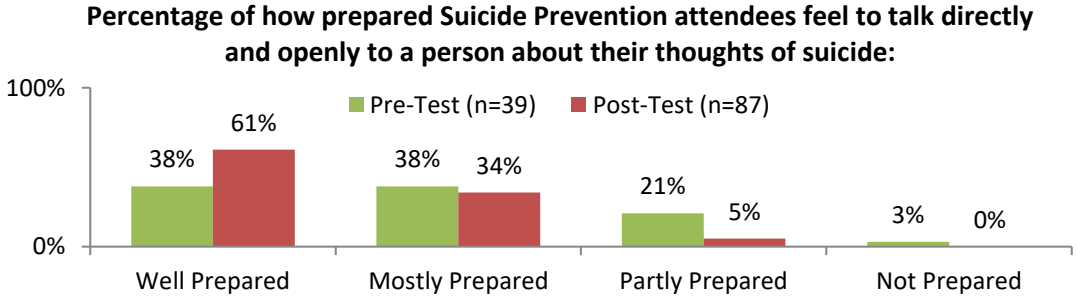


2,580
Instagram accounts Reached for Social Media Engagement

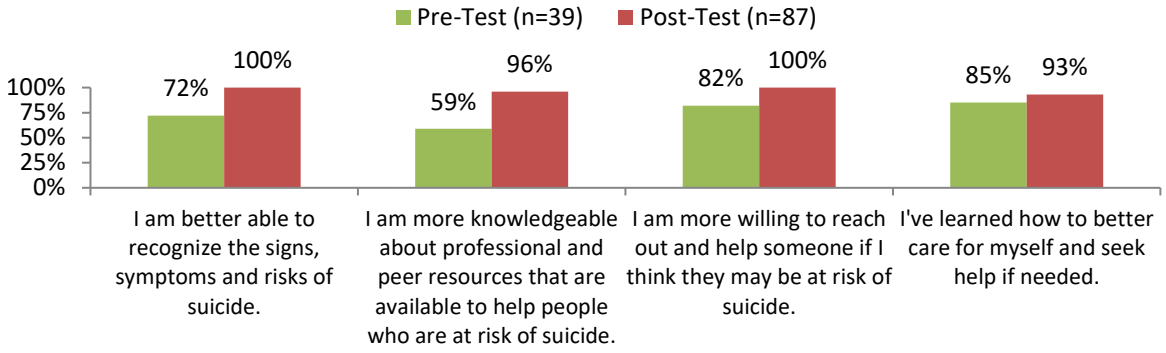


25 post/stories in social media

Is Anyone Better Off?



Percentage of Suicide Prevention Survey Respondents who reported at Pre-Test and Post-Test:



Number of Potential Responders	722
Setting in Which Responders were Engaged	Community, colleges, schools, health Centers, workplace, shelters, online, and outdoors.
Type of Responders Engaged	TAYs, Adults, Seniors, 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

0
MHSA Referrals to Stigma Reduction/ Suicide Prevention Programs

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.

Peer Mentor Program (Prevention & Early Intervention)

Program Description

Trained volunteers (peer mentors) from the Tri-City area provide support to peers (mentees) who are looking for emotional support. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. For every individual they meet with, the role of peer mentors is to listen, help identify strengths and areas of need, identify supports and suggests resources to help address mentee concerns.

Target Population

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

Mentors						
Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	12	10	5	0	**27**
Projected Number to be Served FY 2024-25	0	11	10	5	0	**26**
Cost Per Person	N/A	$2,853	$2,853	$2,853	N/A	**$2,853**

Mentees						
Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	**Total Served**
Number Served FY 2021-22	0	12	9	5	0	**26**
Projected Number to be Served FY 2024-25	0	29	21	12	0	**62**

Program Update

During FY 2023-24, the Peer Mentor program hosted its first Open House Event. The purpose of the event was to promote the program, highlight mentors, and emphasize the work they do for National Mentoring Month. Mentors were able to share how the program has been beneficial to them and highlight benefits of joining the program. Community Mental Health Training staff, also talked about the mental health benefits of volunteering. The program was well attended and received 2 new applications from prospective peer mentors. In total, the Peer Mentor program received 24 applicants in FY 2023-24, a 50% increase from FY 2022-23. Furthermore, 6 peer mentors from the program applied for paid positions at Tri-City Mental Health. Of the 6 who applied, 3 gained employment at the agency. The knowledge and experience they gained from working with mentees in the program was referenced in their applications and interviews.

Challenges and Solutions

With the expansion of our mentor team, the program placed great emphasis on providing comprehensive training and support to the new mentors to ensure their success. While this was an effective approach, it did take up a considerable amount of time due to significant growth of the program. During the FY 2023- 24 the program focused on re-engaging previous mentors in order to have seasoned and experienced mentors to support existing mentee requests. Through in-person lunch opportunities, group wellness retreats and special events, the program emphasized empowering both new and seasoned mentors through tailored training, addressing their concerns, and answering their questions to foster a vibrant and supportive mentor community.

Diversity, Equity and Inclusion

The Peer Mentor program is dedicated to actively seeking new mentor recruits from underserved populations to ensure greater accessibility for mentees from similar communities. The program staff are bilingual in English and Spanish and 23% of the mentors are proficient in a language other than English. Additionally, program staff proactively reach out to underserved communities through events and collaborations with relevant agencies. One of the 15 trainings offered to peer mentors focuses on working with diverse populations. During this training, mentors are informed about some of the

barriers underserved populations can encounter. From a lived experience perspective, a vast number of mentors themselves identify as being part of underserved communities and having diversities within the mentors helps to reduce stigma and support participants in feeling more comfortable when receiving services.

During FY 2023-24, the program connected with the Veteran's Affairs Department at the University of La Verne to provide them with information about the Peer Mentor program. Currently, the Peer Mentor program works with a mentor who identifies as a veteran and has previously mentored veterans.

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 Education and Training, various clinical departments, Community Mental Health Training, Therapeutic Community Gardening, Community Navigators, and the Wellness Center.

Through 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. Additionally, a large portion of mentors are college students, so connections with the universities in the service area are beneficial to the program and to mentees seeking support.

Success Story

An older adult called Tri-City and inquired about receiving services at the Adult Outpatient Clinic. It was clinically determined that they did not meet medical necessity for specialty mental health services, and they were referred to the Wellness Center. Once they began attending the Wellness Center, it was determined that the individual could benefit from 1:1 support, and they were subsequently referred to the Peer Mentor program. The participant reported that they were involved with Tri-City decades ago that they were interested in receiving services based on their history with Tri-City and being aware of the range of services available.

Program Summary

How Much Did We Do?

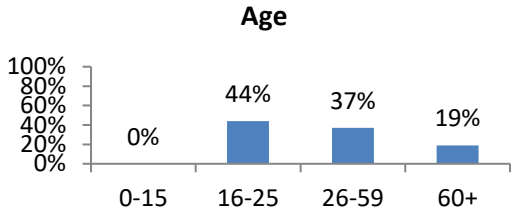
Peer Mentors

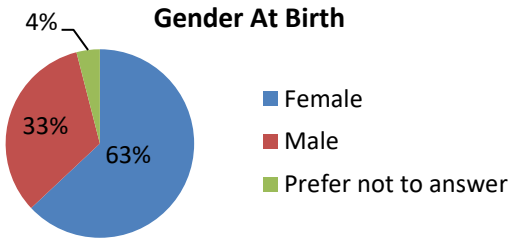
24
Individuals Applied to Peer Mentor Program

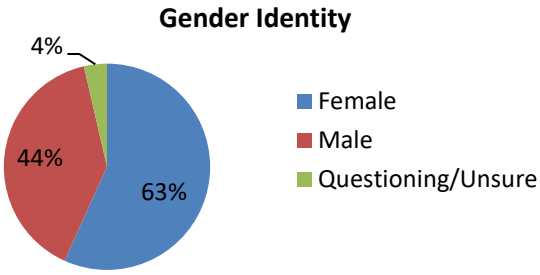
19
Peer Mentor Meetings/Trainings

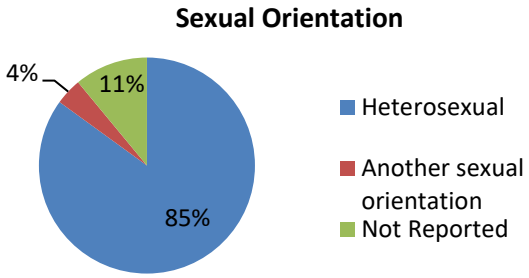
27 Active Peer Mentors
12 New Mentors
15 Returning Mentors

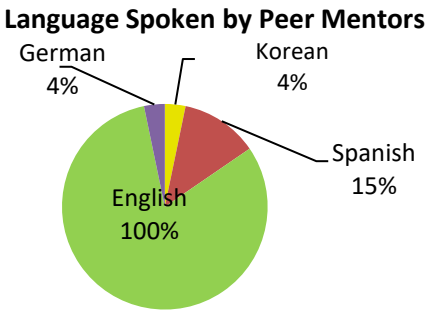
The number of active mentors **increased** from **14 active mentors** in FY 2022-23 to **27 active mentor** in FY 2023-24.

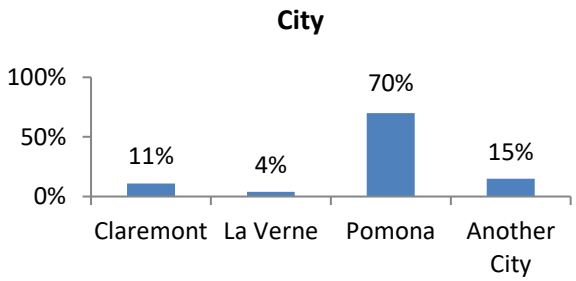




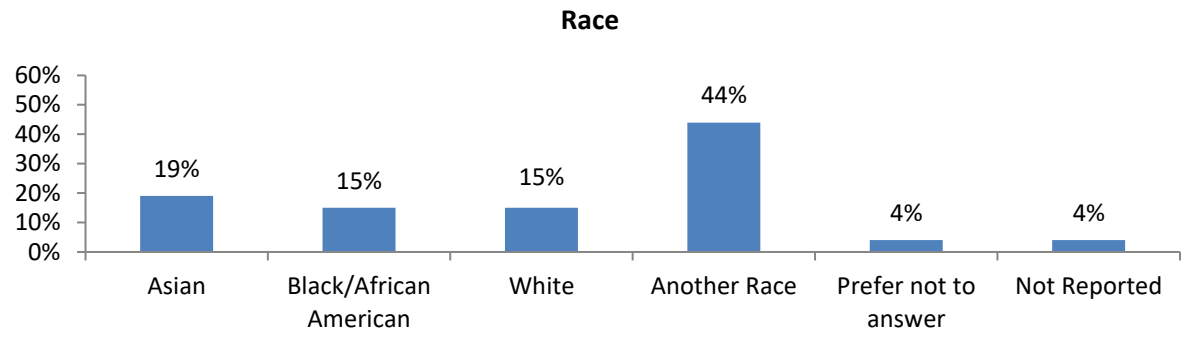


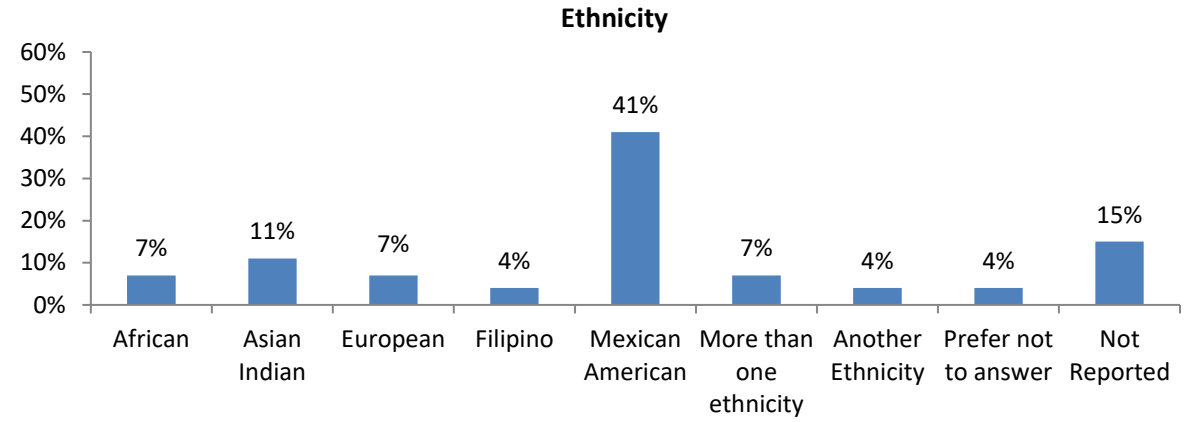


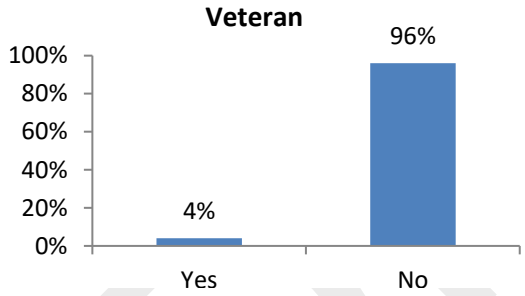


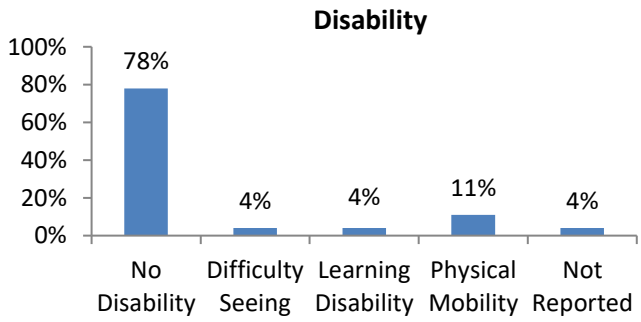


The number of available languages by mentors **increased** from **3 languages** in FY 2022-23 to **4 languages** in FY 2023-24.







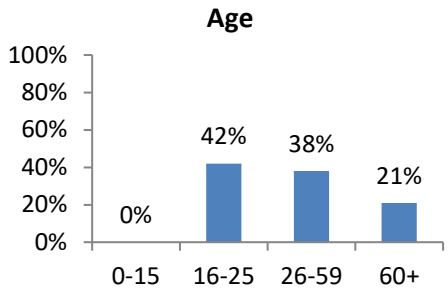


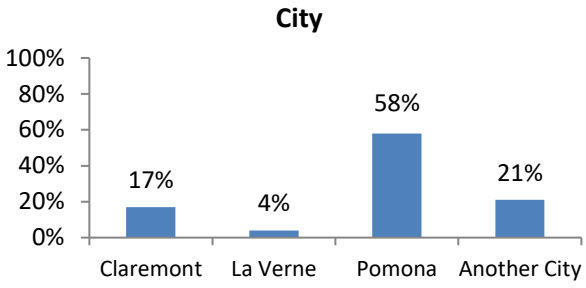
Peer Mentees

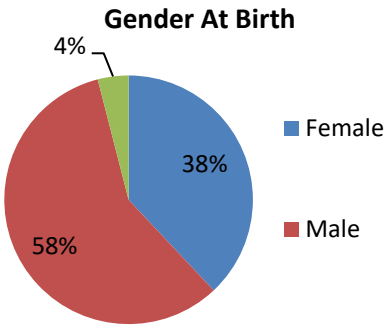
26 Mentees Served

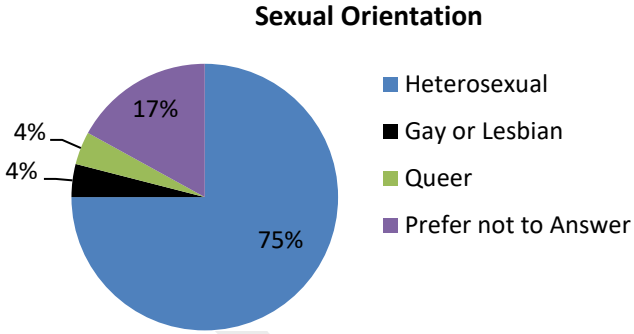
22 Mentee Referrals to the Peer Mentor Program

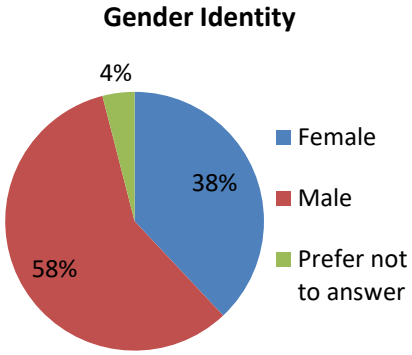
Peer mentees served **decreased** from **40 mentees** in FY 2022-23 to **26 mentees** in FY 2023-24.

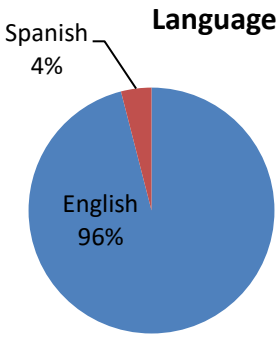

Age
100%
80%
60%
40%
20%
0%
0%
42%
38%
21%
0-15
16-25
26-59
60+

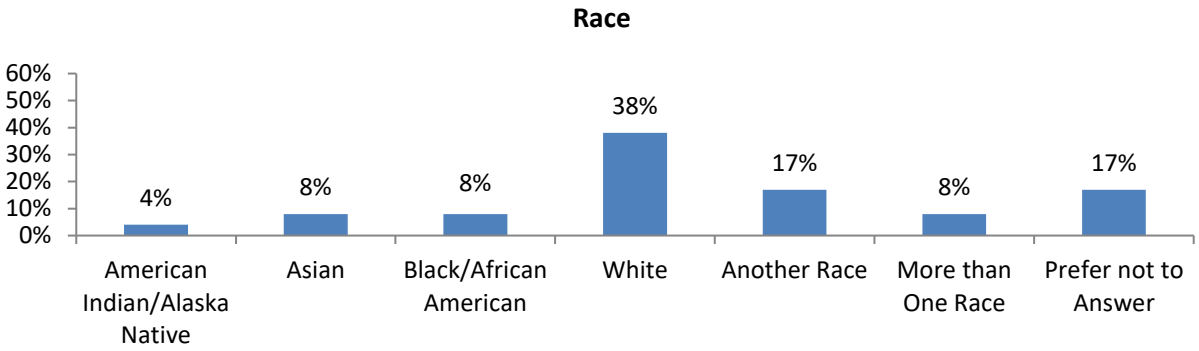

City
100%
80%
60%
40%
20%
0%
17%
4%
58%
21%
Claremont
La Verne
Pomona
Another City

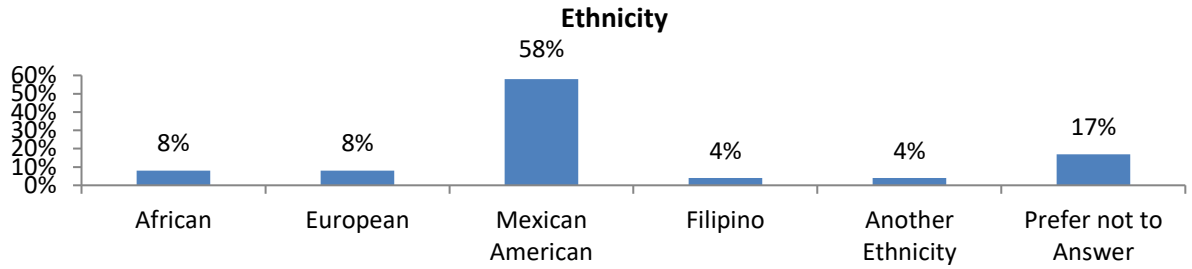

Gender At Birth
4%
38%
58%
Female
Male

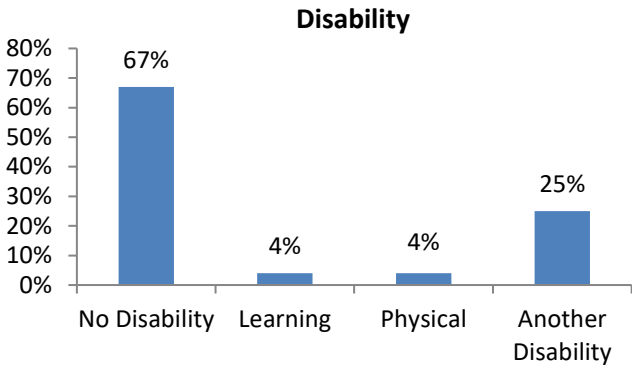

Sexual Orientation
17%
4%
4%
75%
Heterosexual
Gay or Lesbian
Queer
Prefer not to Answer

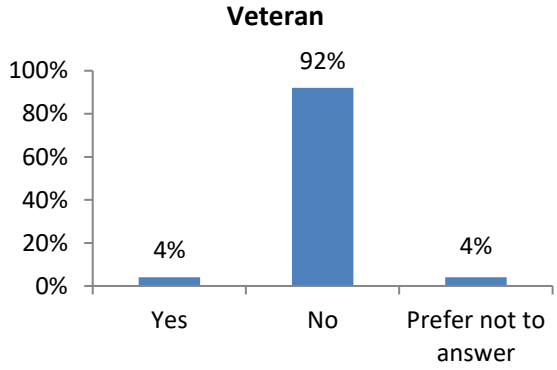

Gender Identity
4%
38%
58%
Female
Male
Prefer not to answer


Language
Spanish
4%
English
96%


Race
60%
50%
40%
30%
20%
10%
0%
4%
8%
8%
38%
17%
8%
17%
American Indian/Alaska Native
Asian
Black/African American
White
Another Race
More than One Race
Prefer not to Answer







How Well Did We Do It?

Peer Mentor

12 out of 24 (50%) Mentor Applicants Became Mentors

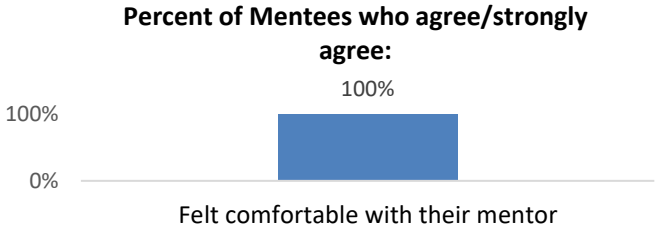
613
Hours Completed by Peer Mentors
Direct Time with Mentees: 245
Trainings and Supervision: 351
Community Engagement: 17

16
Peer Mentors Self-Identify with Lived Experience

Peer mentors self-identifying with lived experience **increased** from **8 mentors** in FY 2022-23 to **16 mentors** in FY 2023-24.

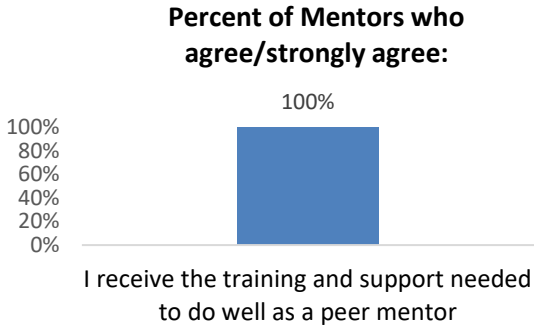
Peer Mentees

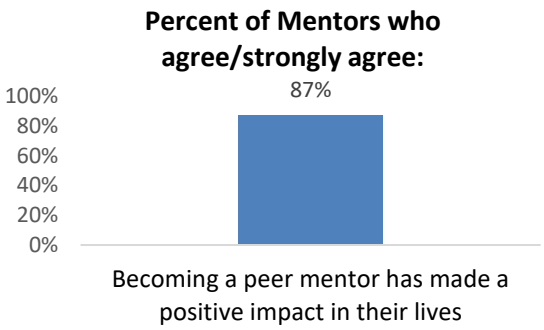
15 out of 22 (68%) Mentee Referrals Became Mentees



Is Anyone Better Off?

Peer Mentors

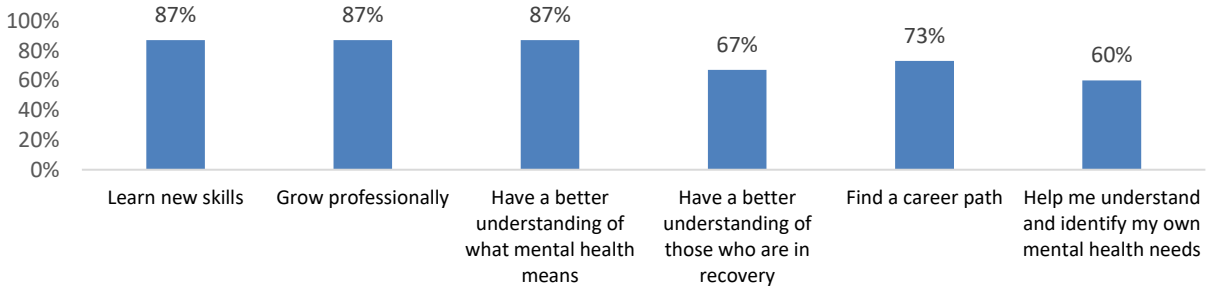




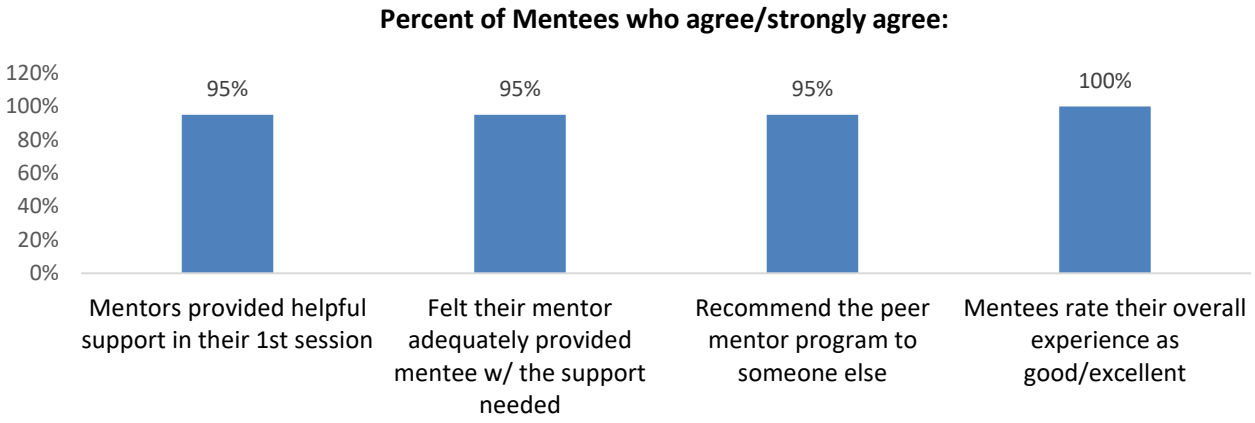
What was your favorite part of being a mentor? (n=13)

List one thing from the peer mentor program you feel was most beneficial (n=13)

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



Peer Mentees



List one thing from the mentee program you feel was most beneficial: (n=9)

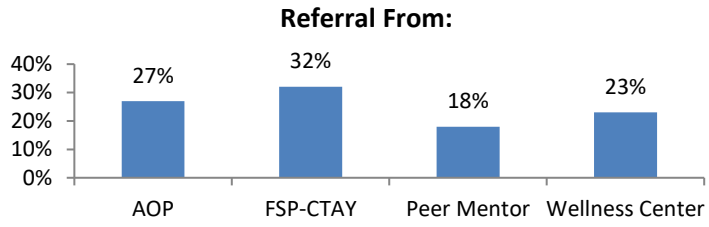
Number of Potential Responders	51
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community
Type of Responders Engaged	TAYs, Adults, Seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, 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

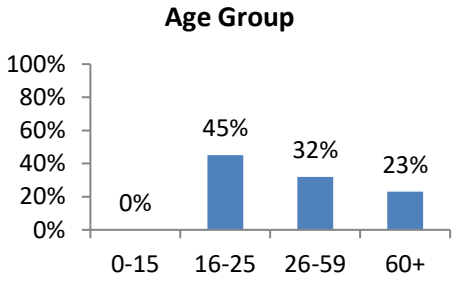
22
MHSA Referrals received by Peer Mentor program

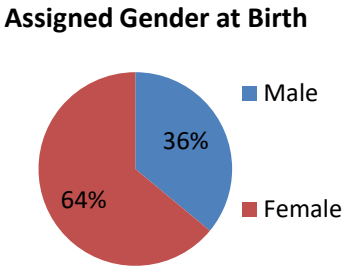
15 out of the 22
Referrals became mentees

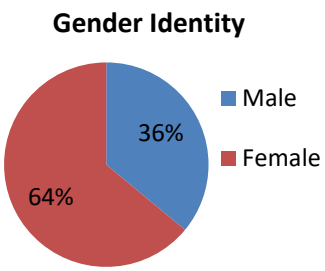
2 Days
Average Time between Referral and becoming a mentee

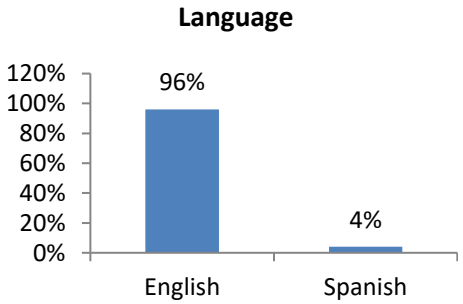


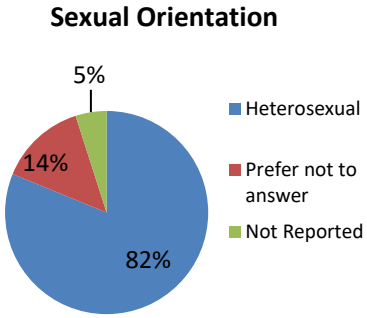
PEI Demographics Based on Referrals

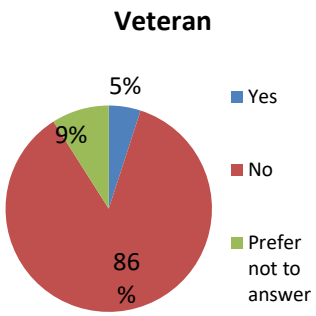


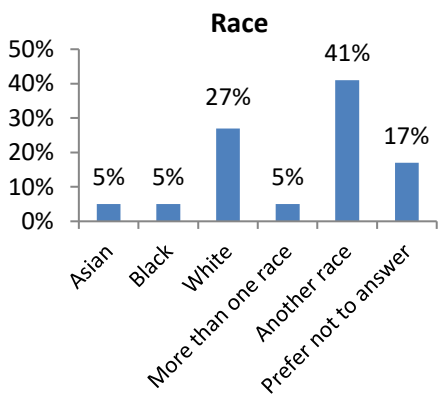


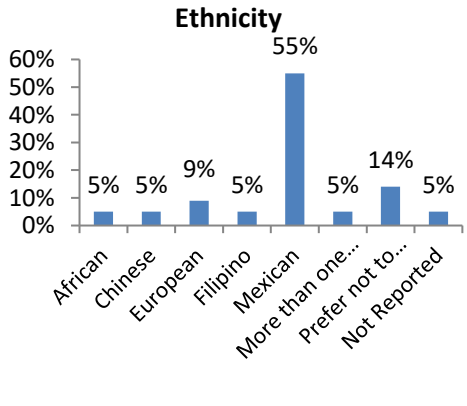


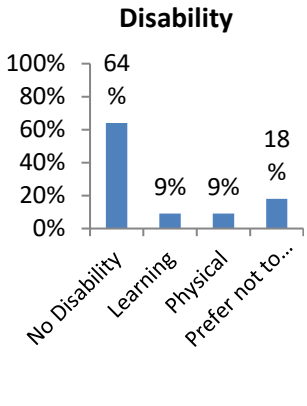












Wellness Center PEI Programs

(Prevention & Early Intervention)

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 specialized populations in need of support, however these populations also tend to be some of the most difficult to engage in and maintain in services. Reasons include issues related to stigma and difficulty with transportation. 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 populations.

Age Group	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	1,152	122	43	0	**1,317**
Projected Number to be Served FY 2024-25	900	95	34	N/A	**1,029**
Cost Per Person	$1,645**	$1,645**	$$1,645***	N/A	**$1,645****

**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 Senior Retreat was held in September 2023 in collaboration with Therapeutic Community Gardening. Participants were able to learn about taking care of succulents, how to plant them, and created terrariums. The participants expressed how grateful they were for the information that they learned during the retreat; emphasizing positive memories were made and connections with others enhanced their social wellness. In August of 2023, the Wellness Center collaborated with the Joselyn Senior Center in Claremont to incorporate in-person support groups at their Center. The program facilitated Senior Calm groups in which participants practiced coping skills and engage in mindfulness activities. The Wellness Center program also hosted a fieldtrip to Pomona College's

Organic Farm. The participants were able to enjoy a day of nature and light lunch under the trees. The seniors expressed high levels of satisfaction during and after the fieldtrip, reporting an appreciation to reconnect with nature.

In November of 2023, the program hosted a TAY harvest event, Fall Y'all. Attendees enjoyed an evening of autumn festivities, socialization with peers, games, and crafts. During the fiscal year, a friendship event also took place where TAY participants celebrated friendships, enjoyed food, engaged in crafts, and won raffle prizes. Towards the end of the fiscal year, the Annual Talent Show was held, giving the TAY participants an opportunity to showcase their talents, and enjoy a free event filled with music, art, poetry, and much more.

Challenges and Solutions

The older adults in the program share that they enjoy groups however have issues with transportation. To alleviate this challenge, we plan to have a designated driver at the Wellness Center to provide transportation. Our participants also express a struggle with symptoms and/or illnesses that prevent them from attending. Some of the older adult participants also report memory issues that impact their ability to recall dates and times of events. To address this challenge, reminder calls are provided, frequent announcements are made, and appointment cards are distributed.

Retaining TAY individuals in groups is a challenge as well. Youth will attend an event on a one-time basis, and not return for groups consistently. It has been reported that some TAY struggle with balancing time for work, school, and support groups. While others state that they have reduced their attendance, or removed themselves from groups completely, due to feeling that the groups were too small. The Wellness Center will continue to conduct outreach in the community, distribute group calendars and event flyers to local school districts, colleges, and other local organizations to address this challenge and connect with the TAY population.

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 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. Programming always includes a welcoming, inclusive, and nonjudgmental environment. Staff are encouraged to take training courses on the importance of diversity and inclusion of all individuals regardless of their sexual orientation. The TAY program also connects participants who identify LGBTQIA+ with Pomona Valley Pride.

Community Partners

For the purposes of collaborative events, workshops, group enrollment, and resource sharing, the Wellness Center program has collaborated with agencies such as Aging Next in La Verne and the Palomares Senior Center in Pomona to support our older adults. Aging Next (older adult volunteers) also visit the Wellness Center to hold meetings. Additionally, local artists from Saint Remy Arts and Culture provide participants with workshops on creating clay artwork.

TAY programming partners with agencies such as the Youth Activity Center in Claremont to develop and present content to their TAY attendees. Some of the topics have included the importance of boundaries and forming and maintaining friendships. The Wellness Center TAY programming also frequently collaborates with the Cal Poly University Village to develop workshops addressing topics such as college struggles and healthy coping strategies that can help college students enhance their mental health.

Success Story

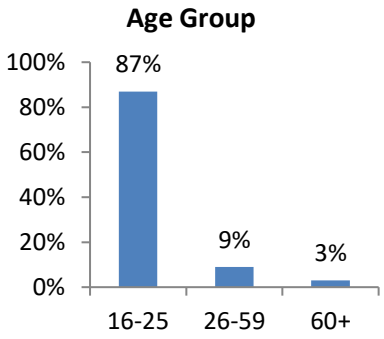
A consistent participant in our older adult support groups expressed struggles with mental health concerns. They highlighted the meaningful impact that the Wellness Center and the senior groups have made in helping manage their symptoms, learn how to cope, and not feel as isolated. They also expressed a benefit in feeling comfortable enough to express themselves in groups and feel supported in a safe environment.

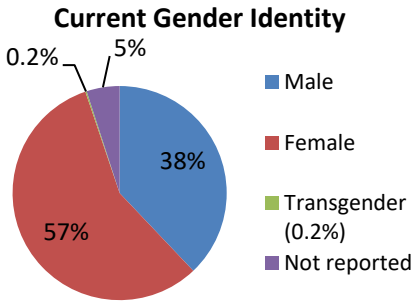
A TAY participant struggled with identifying healthy ways to cope with their mental health challenges. They expressed feelings of boredom and a lack of direction, contributing to coping in unhealthy ways. Currently, the TAY individual participates consistently in the support groups. They report enjoying spending time at the Wellness Center, increasing socialization with others and gaining confidence in vocalizing their needs to others.

Program Summary

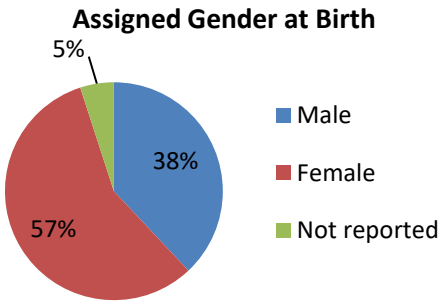
How Much Did We Do?

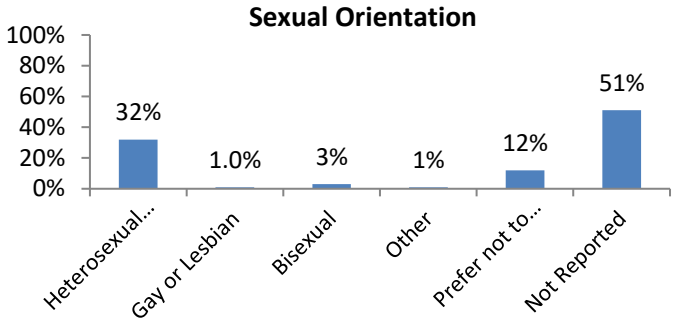
1,317
Unique Individuals attending Wellness Center TAY/Senior

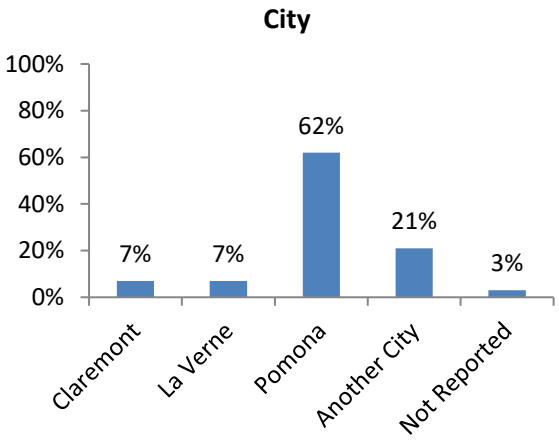


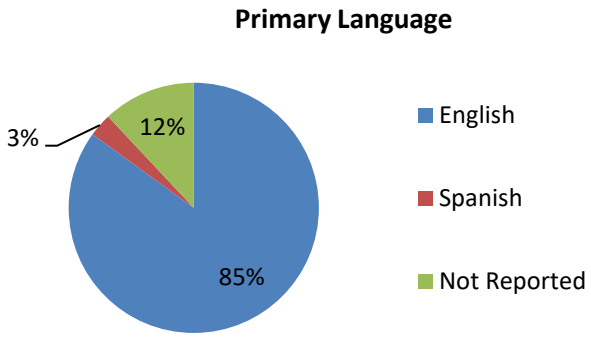


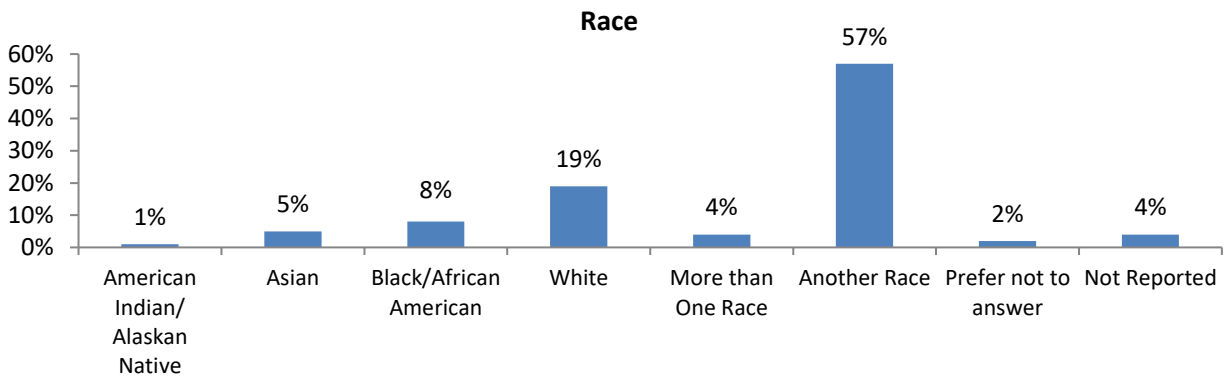
The number of individuals attending Wellness Center TAY/Senior groups **remained constant** from FY 2022-23 to FY 2023-24.



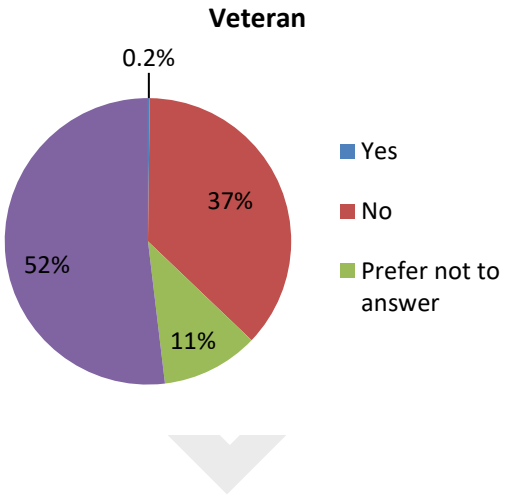


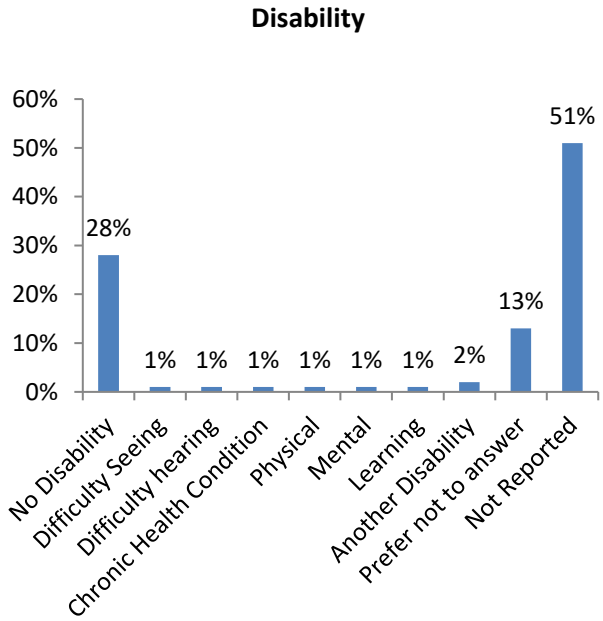





Race
60%
50%
40%
30%
20%
10%
0%
1%
5%
8%
19%
4%
57%
2%
4%
American Indian/ Alaskan Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
8%
1%
0.1%
0.2%
1%
2%
15%
1%
1%
57%
0.2%
1%
0.2%
4%
4%
2%
4%
African
Asian Indian
Camboadian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican/Mexican...
Middle Eastern
Vietnamese
South American
More than one...
Another Ethnicity
Prefer not to answer
Not Reported

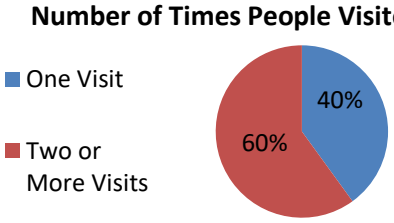

Veteran
0.2%
37%
52%
11%
Yes
No
Prefer not to answer


Disability
60%
50%
40%
30%
20%
10%
0%
28%
1%
1%
1%
1%
1%
1%
2%
13%
51%
No Disability
Difficulty Seeing
Difficulty hearing
Chronic Health Condition
Physical
Mental
Learning
Another Disability
Prefer not to answer
Not Reported

How Well Did We Do It?

4,482
Number of Wellness Center PEI: TAY/Senior Events
(Duplicated Individuals)

Number of Times People Visited

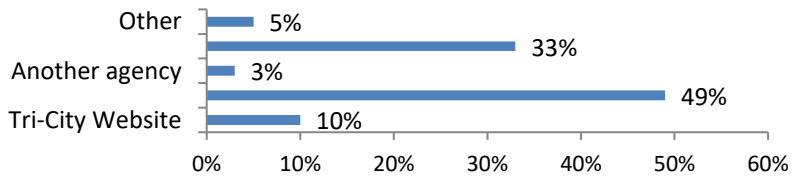


The total number of (duplicated) individuals attending Wellness Center TAY/Senior groups **increased** from **4,435** FY 2022-23 to **4,482** FY 2023-24.

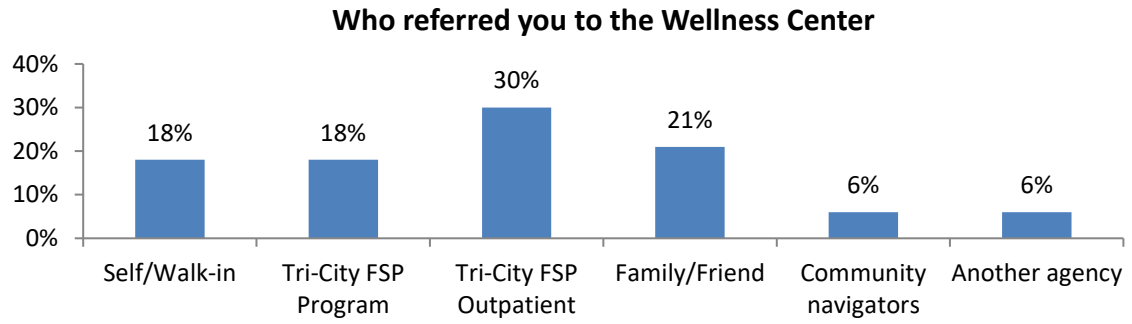
Support Activities Name	Number of Times Activity Was Held	Average Number of Attendees at an Activity
Platica Entre Amigos	29	1
Senior Calm	70	5
Senior Socialization	39	2
Senior Bingo	7	2
Senior Virtual Vacation	1	1
TAY – Brunch Club	32	2
TAY – Friendly Feud	38	1
TAY – Fun with Friends	45	2
TAY – Peace of Mind	41	2
TAY – Popcorn, Peers & Leadership (PPL)	35	2

Contacts by Type	Number of Individuals
TAY – Phone Call - Wellness Calls	1,240

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

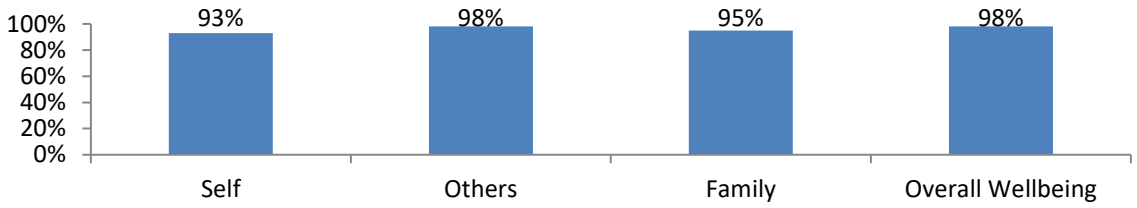


100%
Satisfied with the "help I get at Wellness Center"



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:



Number of Potential Responders	1,317
Setting in Which Responders were Engaged	Virtual platforms, Phone, Community, Wellness Center
Type of Responders Engaged	TAY, 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

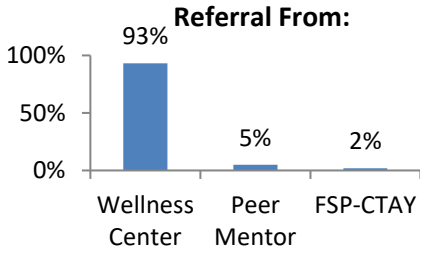
42
Referral coming into Wellness Center TAY

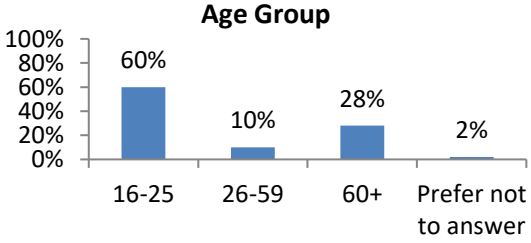
35 out of the 42
Referrals attended a Wellness Center group

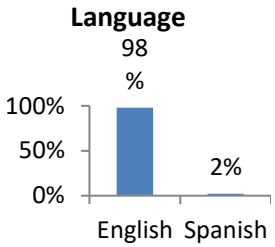
3 Days
Average Time between referral and participation

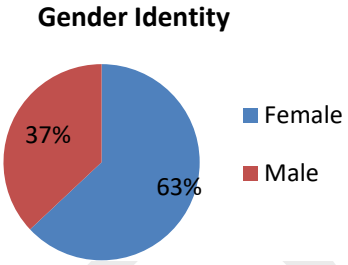
The number Wellness Center referrals **increased** from **6** FY 2022-23 to **42** FY 2023-24.

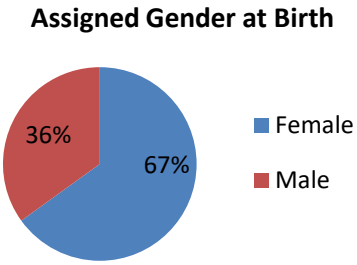
PEI Demographics Based on Referrals

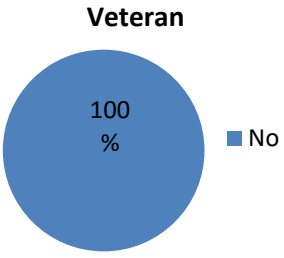


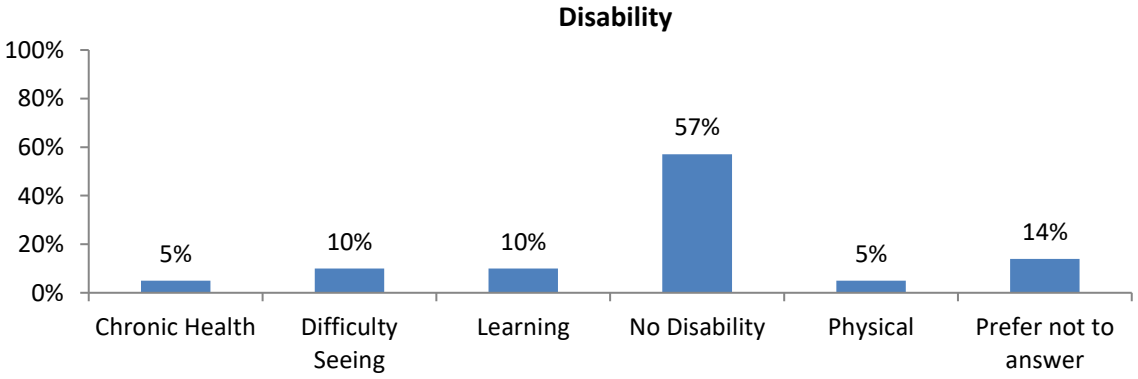


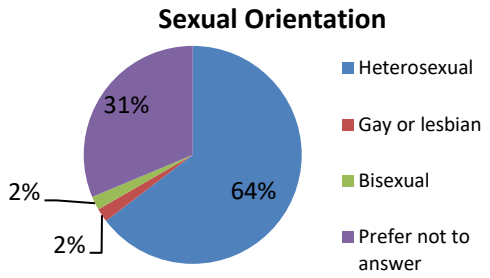


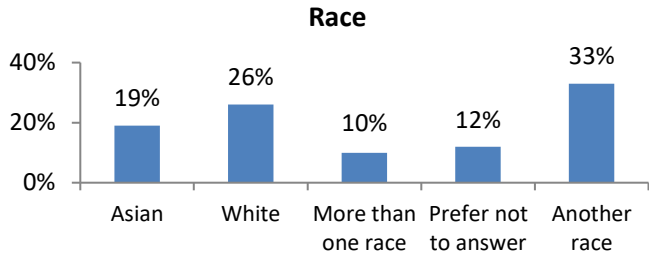


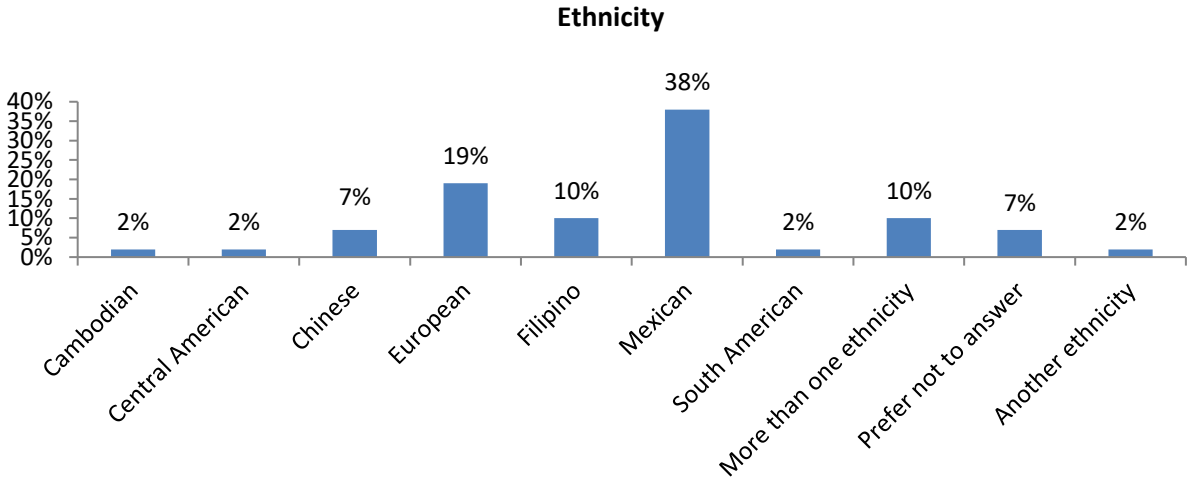







Sexual Orientation
31%
64%
2%
2%
Heterosexual
Gay or lesbian
Bisexual
Prefer not to answer


Race
40%
20%
0%
19%
26%
10%
12%
33%
Asian
White
More than one race
Prefer not to answer
Another race


Ethnicity
40%
35%
30%
25%
20%
15%
10%
5%
0%
2%
2%
7%
19%
10%
38%
2%
10%
7%
2%
Cambodian
Central American
Chinese
European
Filipino
Mexican
South American
More than one ethnicity
Prefer not to answer
Another ethnicity

Family Wellbeing Program

(Prevention & Early Intervention)

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 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 2023-24	184	70	483	88	53	**878**
Projected Number to be Served FY 2024-25	109	41	286	52	31	**519**
Cost Per Person	$263**	$263**	$263**	$263**	$263**	$263**

**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 Family Wellbeing program hosted a Thanksgiving basket giveaway in November, FY 2023-24. The baskets consist of a turkey and all the sides to provide a free meal to families in need. The program also hosted the annual tree lighting for all families in the community. The event was accompanied by hot chocolate, music, singing, and a gift for all the children in attendance. The evening ended with the tree lighting and a holiday movie.

The Wellness Center Summer Camp, for children 7–12 years of age, is a highly anticipated event annually and once again received positive feedback from the community. The Summer Camp provides a positive and safe learning environment where campers can explore, experience educational outings, and participate in an array of activities.

Another update to the Family Wellbeing program was that some of the groups start time was changed to adjust with families' schedules. Additionally, the program hosted groups at the Children's Outpatient clinic to accommodate parents by reducing barriers related to transportation. Lastly, some groups have remained hybrid to accommodate those who experience barriers related to attending groups in-person.

Challenges and Solutions

Challenges experienced during FY 2023-24 included transportation as well as some families not being able to attend groups due to financial hardship. Another challenge for some attendees is the time of the group, one conflict specifically being with after school programs or sports that end late. Lastly, children and teens are typically not able to attend groups if there is no ride available from parents or caregivers. Addressing this challenge is multifaceted, however the program can consider changing the time of additional groups to address attendance. Furthermore, having the groups in a hybrid format could increase attendance as this would expand accessibility.

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. Program and information brochures are available in both English and Spanish.

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 inviting 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, to refer appropriately when individuals are seeking support directly related to culture, gender identity, military status or otherwise. Groups have also been reimagined to be more inclusive, for example, *Mommy and Me* being redesigned to *Baby and Me*.

Community Partners

Family Wellbeing program collaborates with several internal and external partners within the service area. Some internal partnerships include the Adult Outpatient program, Therapeutic Community Gardening and Children's Outpatient program who assist with promoting Summer Camp to their clients, providing general referrals and collaborating on events.

Examples of external partnerships include Gen Her (a non-profit organization who supports single mothers), Parents in Partnership (DCFS program that hosts support groups for families with open court cases), Parents Anonymous (hold certified classes for parents at the Wellness Center), and collaborations with Foothill Family Services (providing groups to individuals seeking parenting, couple and individual support). These collaborations, among others, lead to enhancing existing groups, developing supportive programs, and planning specialty events for the community.

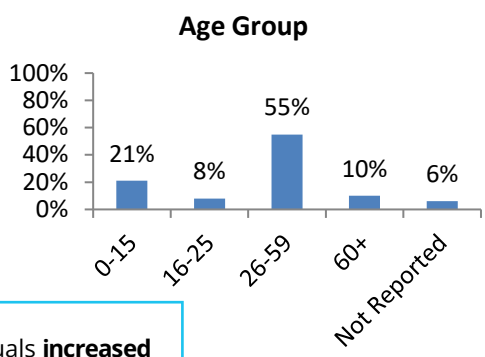
Success Story

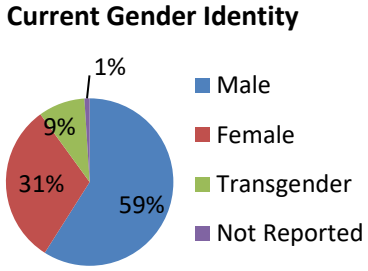
A single parent attending the *Baby and Me* group reported that their child was diagnosed with a learning disability. The parent's goal was to find as many groups as possible and activities in the community in order to support the child and their needs. After attending the *Baby and Me* group regularly, the parent disclosed that the child had displayed noticeable improvements with their speech.

Program Summary

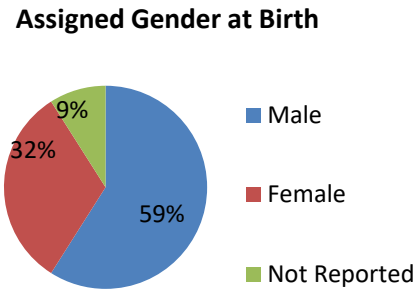
How Much Did We Do?

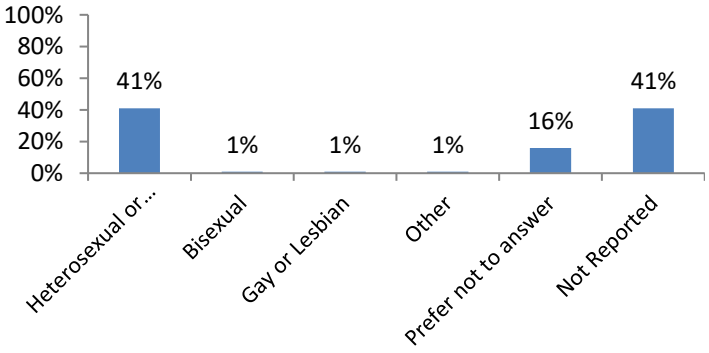
878
Unique Individuals attending Family Wellbeing

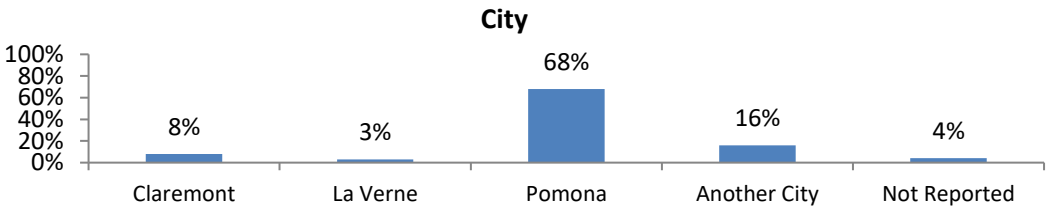


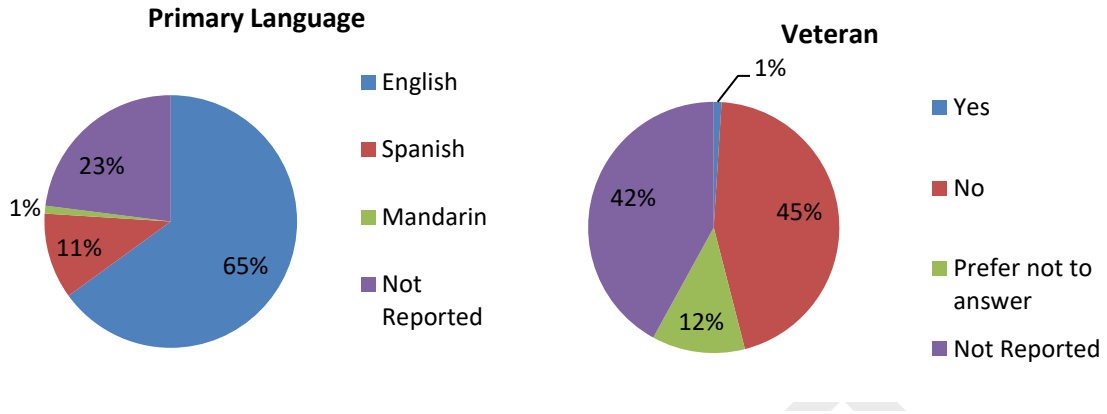


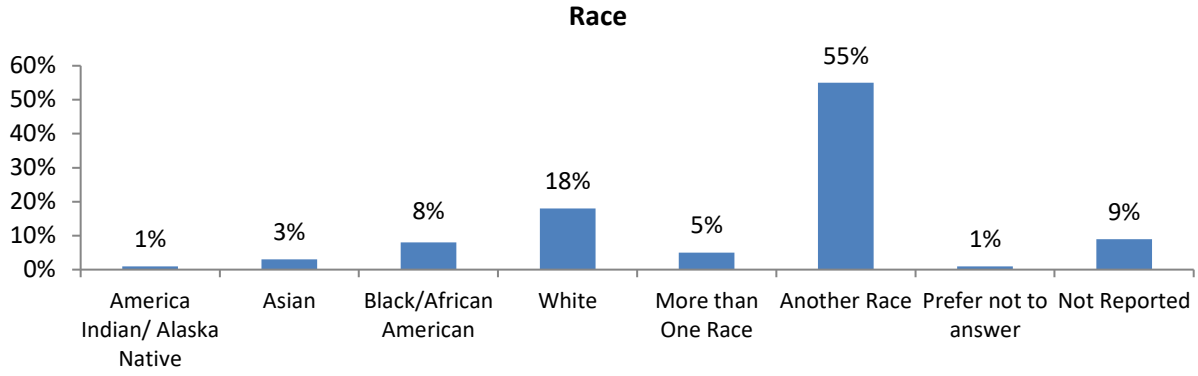
The number of unique individuals **increased** from **522** in FY 2022-23 to **878** in FY 2023-24.

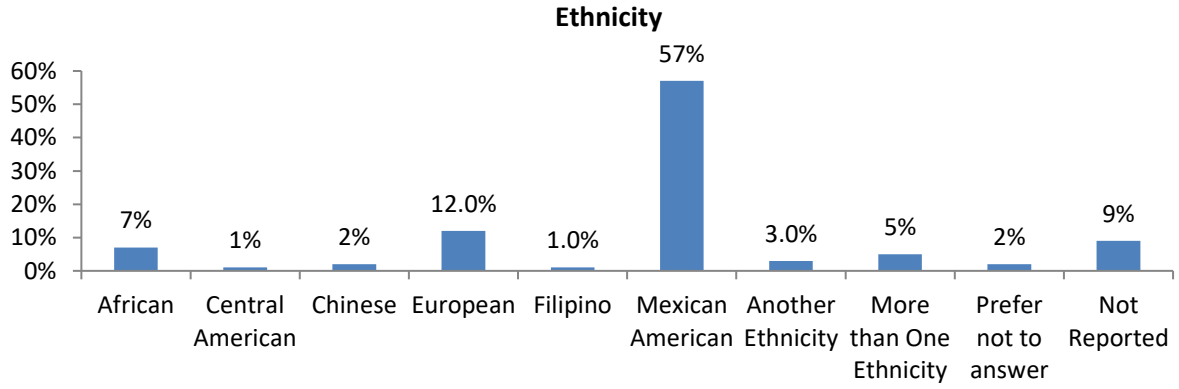


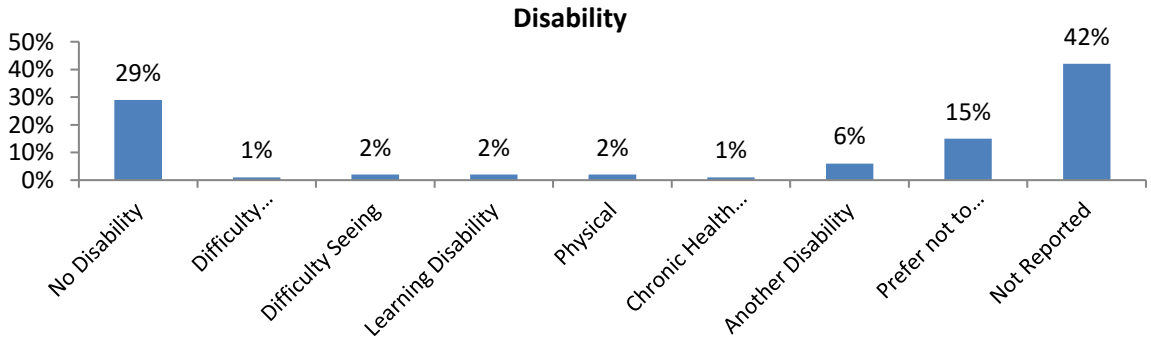





Primary Language
English
Spanish
Mandarin
Not Reported
65%
11%
1%
23%
Veteran
Yes
No
Prefer not to answer
Not Reported
45%
12%
42%
1%

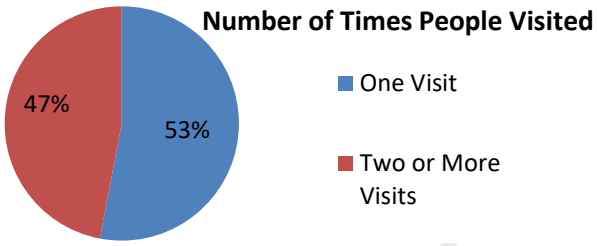

Race
60%
50%
40%
30%
20%
10%
0%
1%
3%
8%
18%
5%
55%
1%
9%
America Indian/ Alaska Native
Asian
Black/African American
White
More than One Race
Another Race
Prefer not to answer
Not Reported


Ethnicity
60%
50%
40%
30%
20%
10%
0%
7%
1%
2%
12.0%
1.0%
57%
3.0%
5%
2%
9%
African
Central American
Chinese
European
Filipino
Mexican American
Another Ethnicity
More than One Ethnicity
Prefer not to answer
Not Reported


Disability
50%
40%
30%
20%
10%
0%
29%
1%
2%
2%
2%
1%
6%
15%
42%
No Disability
Difficulty...
Difficulty Seeing
Learning Disability
Physical
Chronic Health...
Another Disability
Prefer not to...
Not Reported

How Well Did We Do It?

5,129
Number of Family Wellbeing Events
(Duplicated Individuals)

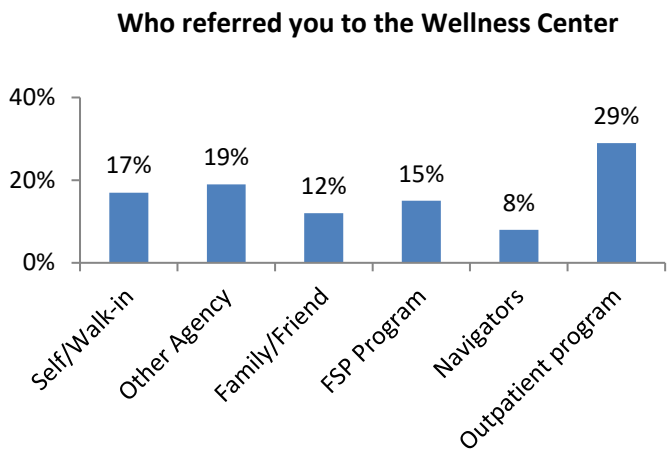


The number of family wellbeing activities **increased** from **9** in FY 2022-23 to **14** in FY 2023-24.

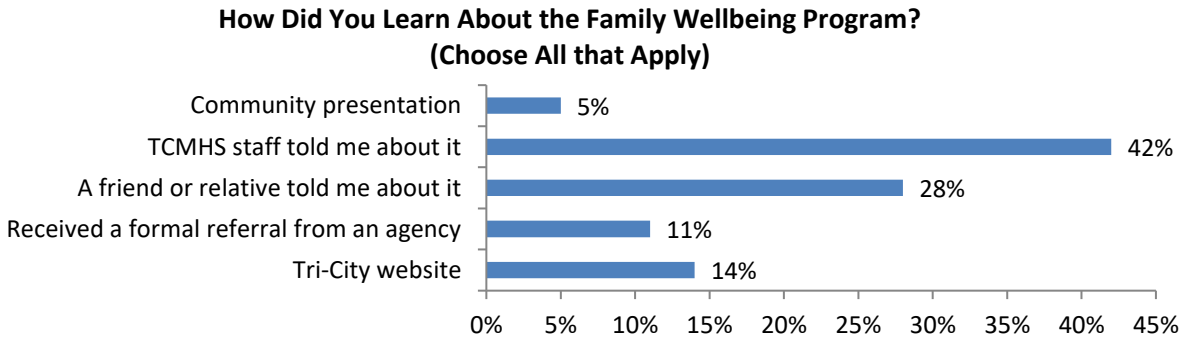
Family Wellbeing Activities	Number of Times Activity Was Held	Average Number of Attendees at an Activity
Arts & Crafts	39	4
Cooking Class	22	4
Grief and Loss	46	4
Kid's Hour	46	3
Limited to Limitless	46	3
Baby & Me	8	3
Movie Night	19	8
Music	36	4
Spirituality	51	5
Summer Camp	26	8
Teen Hour	48	4
United Family	79	7
Walking Adventures	40	2
Writing to Heal	17	3

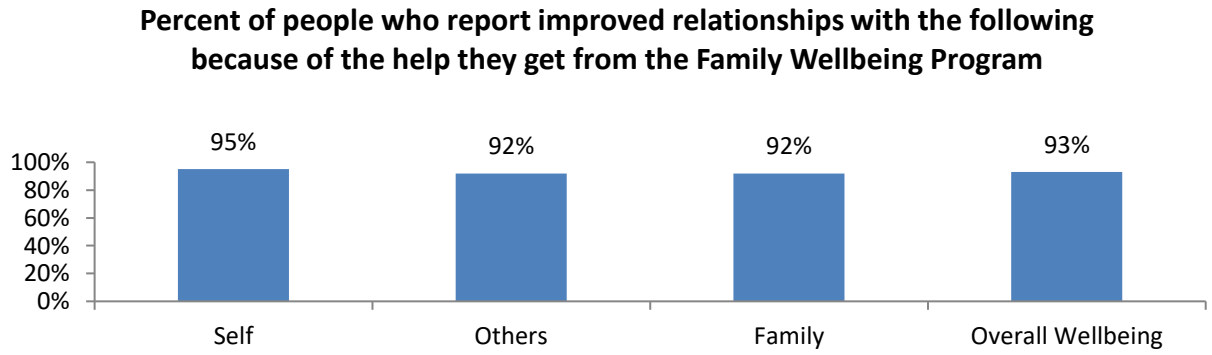
Contacts/Events by Type	Number of Individuals Attending Contacts/Events
Attendance Letter	153
One-on-One	55
MHSA PEI Referrals	163
Other	289
Phone Call/Email	2,051
FWB Meeting/Event	32

97%
Satisfied with the "help I get at Family Wellbeing Program"



Is Anyone Better Off?

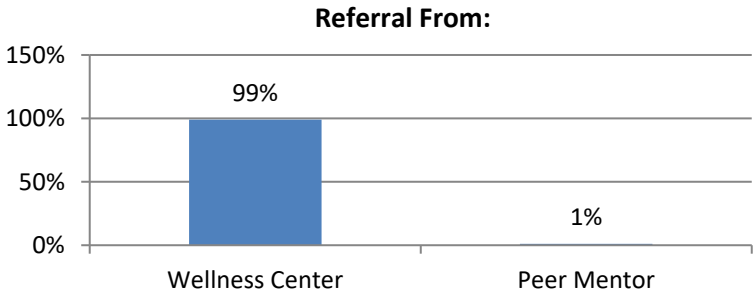




Number of Potential Responders	878
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged 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

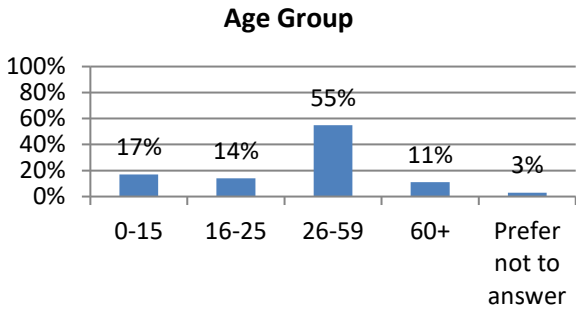
71
MHSA Referrals coming into Family Wellbeing

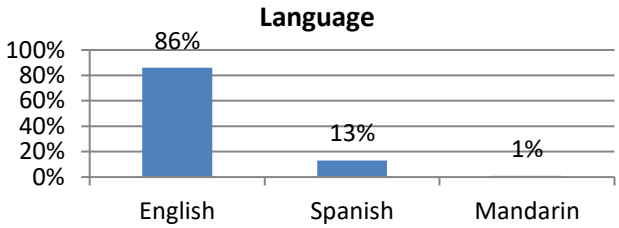


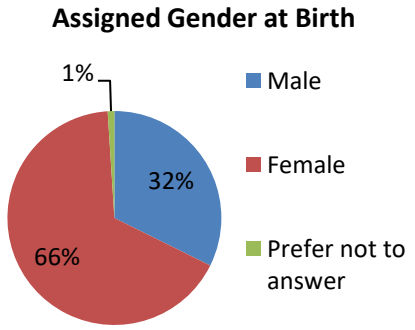
71 out of 71 Referrals Participated in Family Wellbeing Program

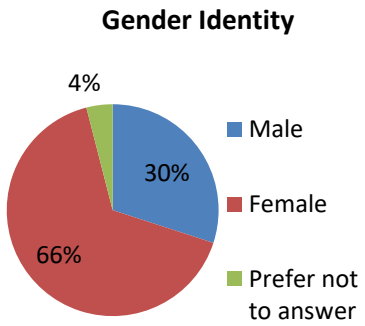
2 Days
Average Time between Referral and Participation in Family Wellbeing Program

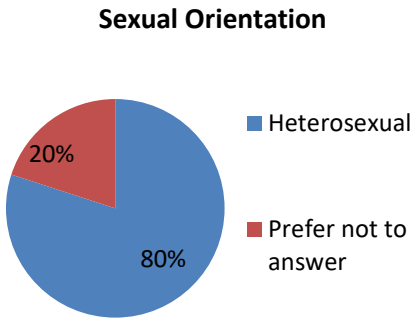
PEI Demographics Based on Referrals

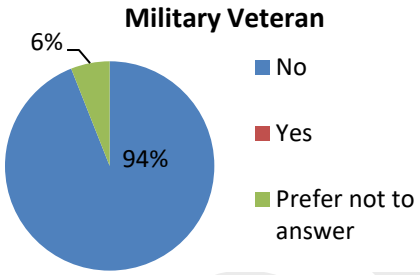


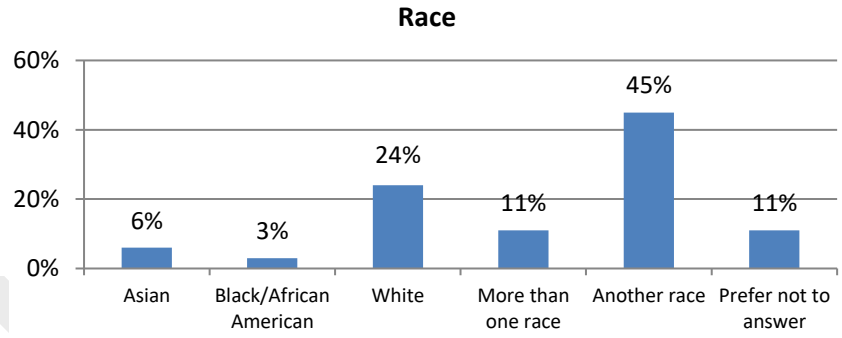


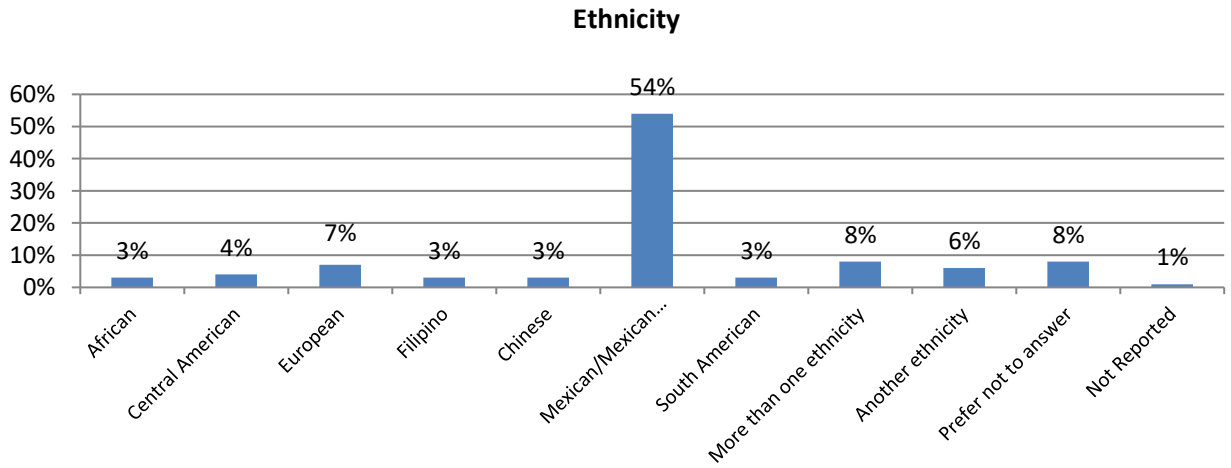


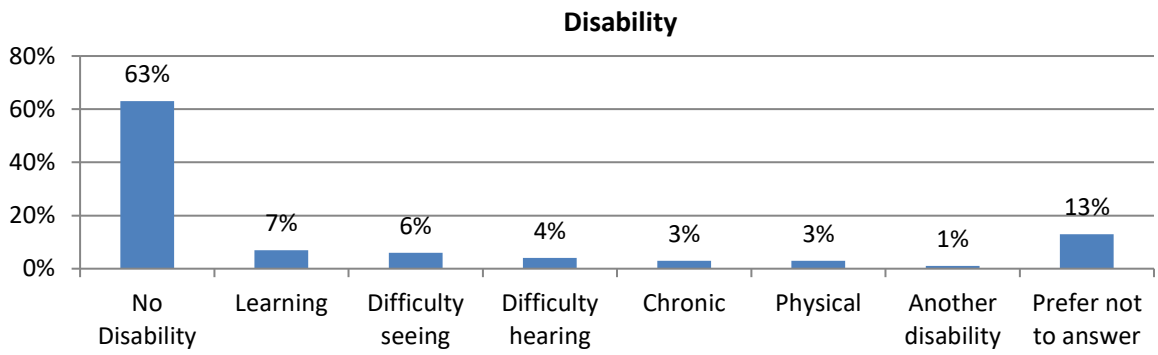











Disability
80%
60%
40%
20%
0%
63%
7%
6%
4%
3%
3%
1%
13%
No Disability
Learning
Difficulty seeing
Difficulty hearing
Chronic
Physical
Another disability
Prefer not to answer

NAMI Community Capacity Building Program

Ending the Silence and NAMI 101 (Prevention)

Program Description

Ending the Silence and NAMI 101 are community presentations offered through 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 presentation 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	4	**Total Number Served FY 2021-22**	176

Program Update

Throughout FY 2023-24, NAMI continued to solidify existing school partnerships as well as build new ones. This work has allowed the program to execute more presentations within the public school system, which is aiding in the goal of reestablishing the frequency of programming that was experienced pre-Covid. Regarding classes and support groups, the program trained several additional facilitators (in English and Spanish), which expands capacity to add more support groups and classes to the calendar and accommodate more community members.

Challenges and Solutions

Toward the beginning of the 2023-24 fiscal year, capacity was a concern. The program lacked enough staff to return to the engagement levels of previous years. Overall, visibility has been a challenge as many community members or organizations report not knowing who NAMI is or what the program does.

Part of the solution is to continue building relationships. The program is very community facing, the board is active and engaged in outreach, and staff are dedicated to building strong partnerships with community organizations and entities to enhance the range of collaboration opportunities. NAMI participates in events, attends campus drop-ins, and works on identifying additional ways to be more visible to the youth.

Diversity, Equity and Inclusion

NAMI 101 and the Ending the Silence 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 how signs and symptoms may not be addressed or acknowledged. 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. Presentations allow space to converse about the specific challenges/stigma/barriers that the LGBTQ+ communities encounter. NAMI also had presenters who identify with this community in the queue to be trained for presentations and this will allow ways to expand on these conversations.

Success Story

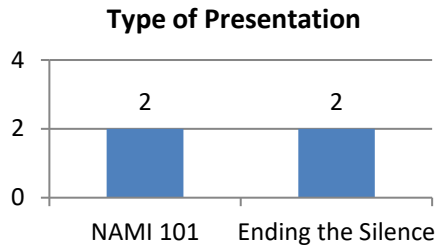
The program received feedback from a community member reporting the benefits they experienced related to being involved in NAMI classes. The individual reported feeling grateful for the program, stating that the classes had been extremely helpful in their journey. They also reported that the topics discussed had never been presented to them in the way they were in the 8-week course, allowing them to form new perspectives and ideas regarding mental health. They also expressed appreciation for the transparency of the group leadership and the opportunity to hear stories from individuals with lived experience.

Program Summary

How Much Did We Do?

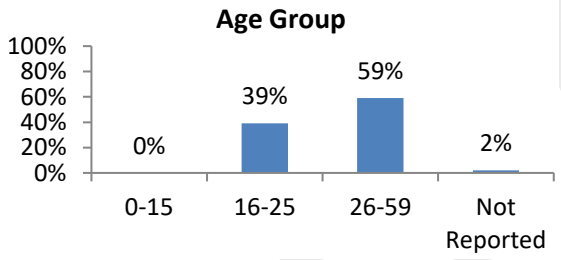
4
Presentations

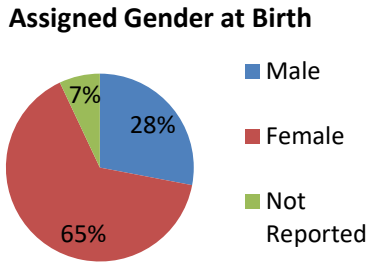
176
Attendees

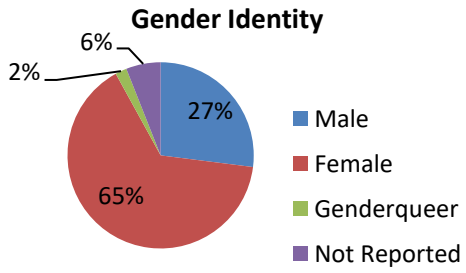


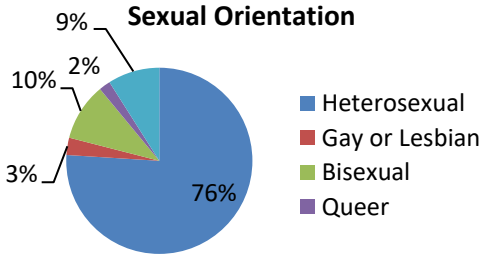
The number of presentations **increased,** and attendees **decreased** from **3 and 359** in FY 2022-23 to **4 and 176** in FY 2023-24.

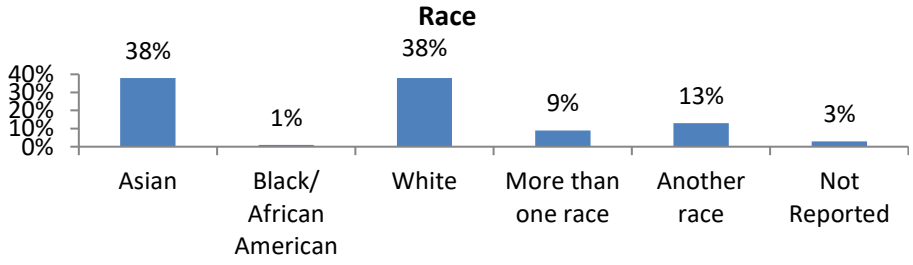
Demographics from Surveys Completed by Participants (n=176)

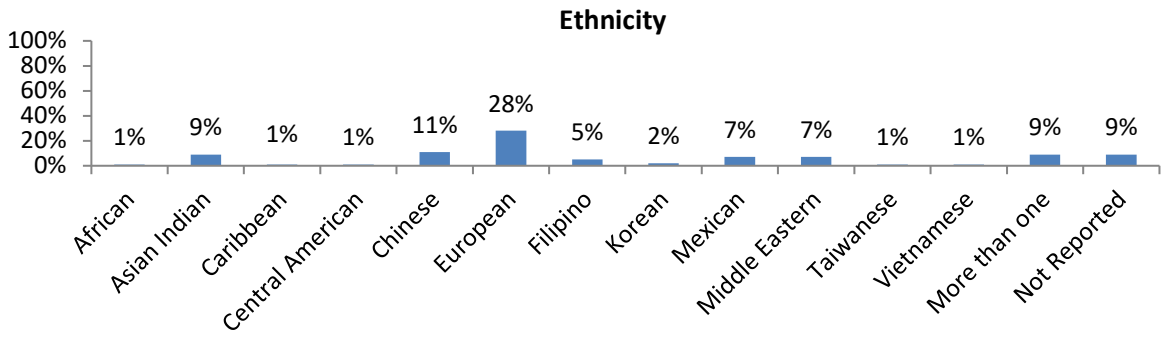


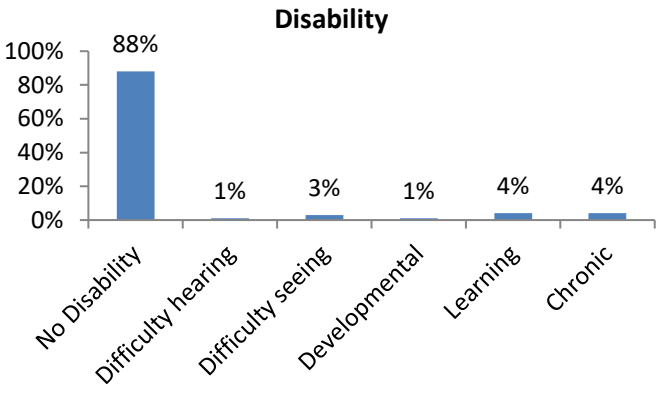


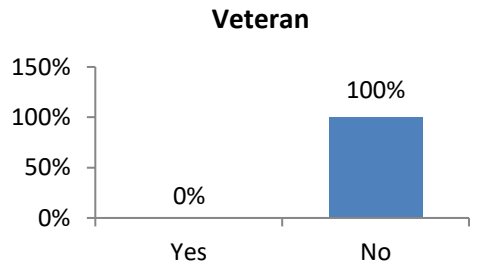


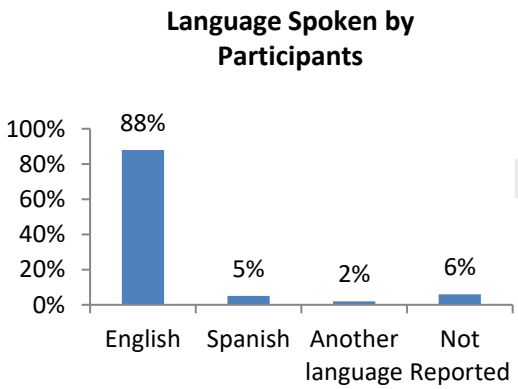


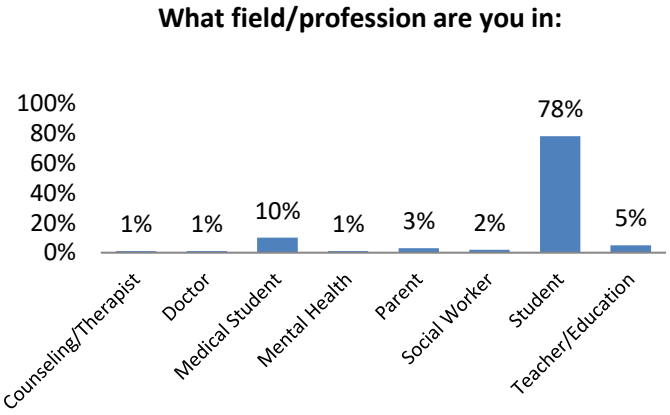


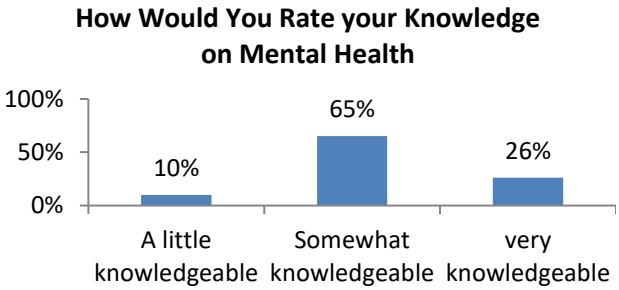

Ethnicity
100%
80%
60%
40%
20%
0%
1%
9%
1%
1%
11%
28%
5%
2%
7%
7%
1%
1%
9%
9%
African
Asian Indian
Caribbean
Central American
Chinese
European
Filipino
Korean
Mexican
Middle Eastern
Taiwanese
Vietnamese
More than one
Not Reported

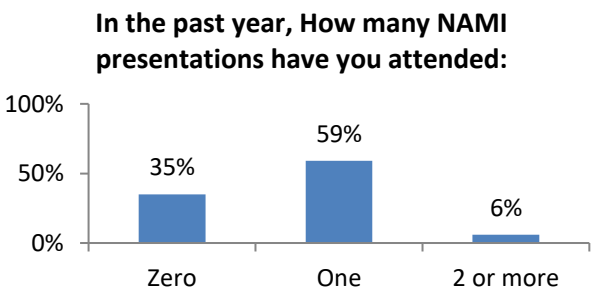

Disability
100%
80%
60%
40%
20%
0%
88%
1%
3%
1%
4%
4%
No Disability
Difficulty hearing
Difficulty seeing
Developmental
Learning
Chronic


Veteran
150%
100%
50%
0%
0%
100%
Yes
No


Language Spoken by Participants
100%
80%
60%
40%
20%
0%
88%
5%
2%
6%
English
Spanish
Another language
Not Reported


What field/profession are you in:
100%
80%
60%
40%
20%
0%
1%
1%
10%
1%
3%
2%
78%
5%
Counseling/Therapist
Doctor
Medical Student
Mental Health
Parent
Social Worker
Student
Teacher/Education


How Would You Rate your Knowledge on Mental Health
100%
50%
0%
10%
65%
26%
A little knowledgeable
Somewhat knowledgeable
very knowledgeable


In the past year, How many NAMI presentations have you attended:
100%
50%
0%
35%
59%
6%
Zero
One
2 or more

How Well Did We Do It?

NAMI 101

97%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges.

92%
Agreed or strongly agreed that the presentation will help me recognize early warning signs of mental health challenges.

Ending the Silence

86%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with student mental health.

93%
Agreed or strongly agreed that the presentation will help me recognize early warning signs of student mental health.

Is Anyone Better Off?

NAMI 101

94%
Agreed or strongly agreed that the presentation provided me with new and useful resources.

98%
Agreed or strongly agreed that the presentation helped me understand the impact of untreated mental health challenges.

Ending the Silence

94%
Agreed or strongly agreed that the presentation provided me with new and useful resources I can use on a regular basis.

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

Number of Potential Responders	165
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 PEI.

Housing Stability Program (Prevention)

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) 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 members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Number Served FY 2023-24	0	0	9	3	49	**61**
Projected Number to be Served FY 2024-25	0	0	12	4	63	**78**
Cost Per Person	$2,710**	$2,710**	$2,710**	$2,710**	$2,710**	**$2,710****

**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 HSP had a vacancy in the Housing Outreach Specialist position that runs the Housing Stability programming. However, towards the beginning of the fiscal year, the program was able to fill the position. Over the course of the year, the Housing Outreach Specialist reestablished groups and workshops to help support the community. In January, the Landlord Hour returned, and the Good Tenant Curriculum resumed. The program continues to look for more spaces to host these group in the community to expand the reach.

The Landlord Hour had a name change in April and is now called the Housing Provider Hour. The term "housing provider" is seen as more inclusive and comprehensive of what the role is. The Housing Provider Hour had more consistent attendance, and the Specialist has built rapport with the providers that attend. In the fiscal year to come, the program intends to create a yearly calendar for Housing Provider Hour in order to identify the topics and presenters in advance, as opposed to waiting month by month. This will help our targeted audience plan better for the meeting and increase attendance.

HSP also would like to develop a spreadsheet as a database of housing providers, along with requirements that each property looks for (income req., pet policy). This will assist the program with a better understanding of the housing climate and support housing staff with providing resources.

Challenges and Solutions

The primary challenge for HSP was lack of engagement in Good Tenant Curriculum from community members. To increase attendance, the groups were moved to properties and hosted in community rooms as opposed to being held only at the Wellness Center. The program also increased outreach by going into the field to meet with new housing providers and attended community events such as Pomona Wellness Center's Housing event and Claremont Housing meetings. There was also an effort made to visit local colleges (Claremont Colleges and Western) and their student housing departments.

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 and groups provide education on protected rights. 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. The program also conducts in-person outreach to senior living and veteran apartments.

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 living facilities, 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 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 notable success for the program this fiscal year was the increased attendance for Housing Provider Hour. Having the opportunity to engage local housing providers creates community, cohesion, provides education, and stigma reduction. These efforts can contribute to tenants maintaining the housing they have established.

Program Summary

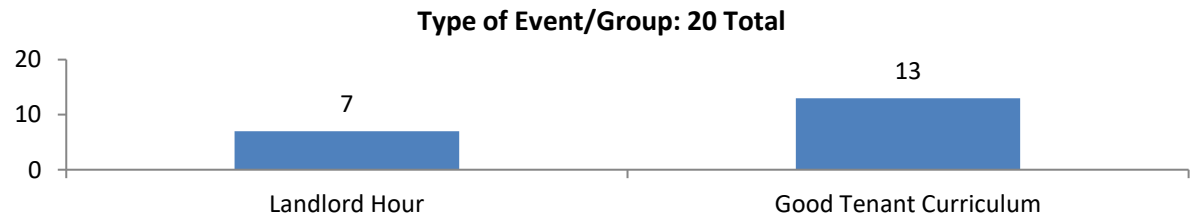
How Much Did We Do?

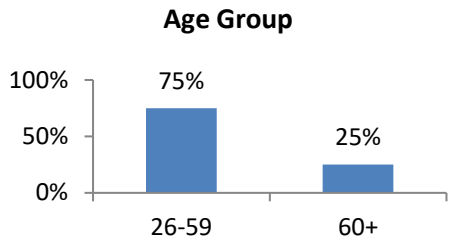
20	11	7	65	22
New Landlord Contacts	Landlord Follow Ups	Landlord Hour Events Held	Total Attendees	Unique Attendees

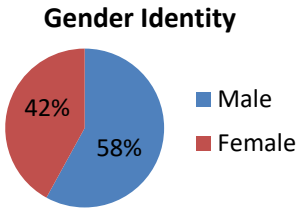
The number of new landlord contacts and follow-ups **increased** from **13 and 2** in FY 2022-23 to **20 and 11** in FY 23-24.

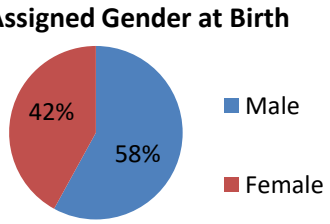
The number of landlord hour events **increased** from **3** in FY 2022-23 to **7** in FY 2023-24.

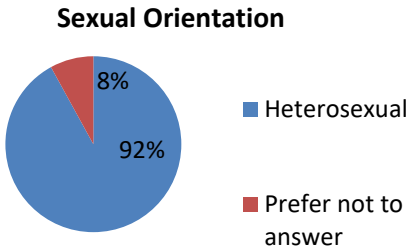
13	19
Housing Groups Held	Total Attendees

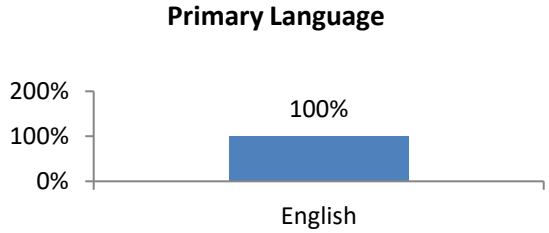


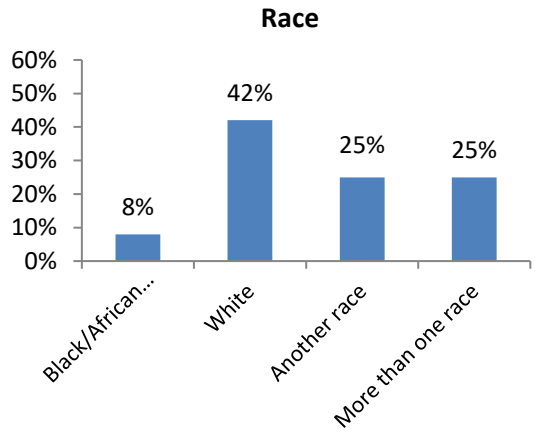

Age Group
100%
50%
0%
75%
25%
26-59
60+

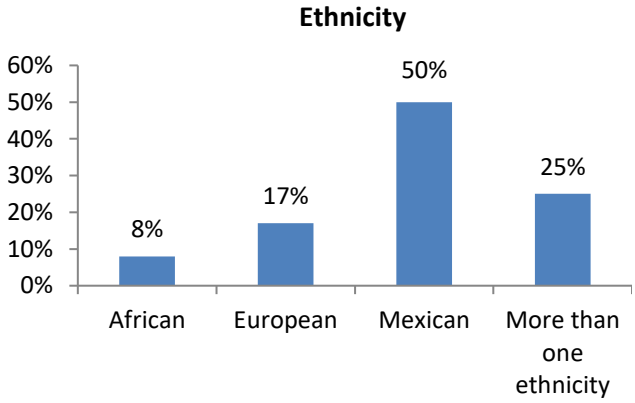

Gender Identity
42%
58%
Male
Female

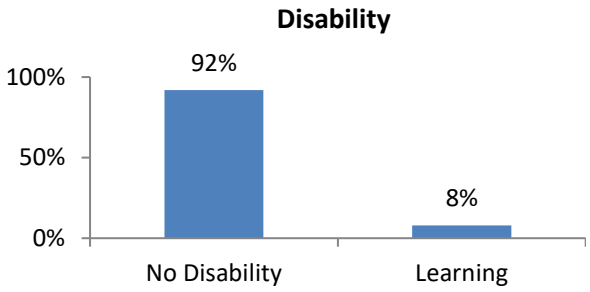

Assigned Gender at Birth
42%
58%
Male
Female

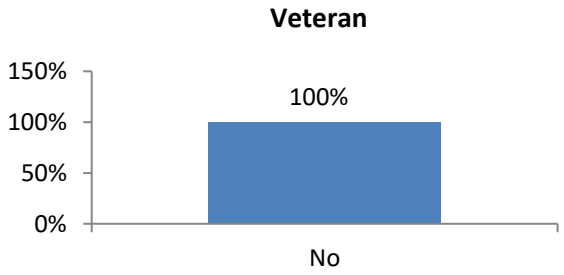

Sexual Orientation
8%
92%
Heterosexual
Prefer not to answer


Primary Language
200%
100%
0%
100%
English


Race
60%
50%
40%
30%
20%
10%
0%
8%
42%
25%
25%
Black/African...
White
Another race
More than one race

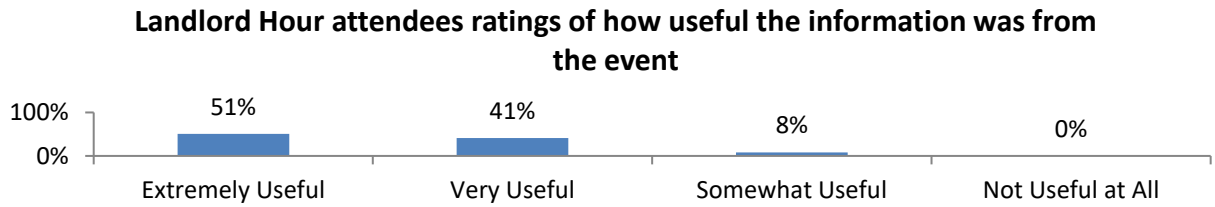

Ethnicity
60%
50%
40%
30%
20%
10%
0%
8%
17%
50%
25%
African
European
Mexican
More than one ethnicity

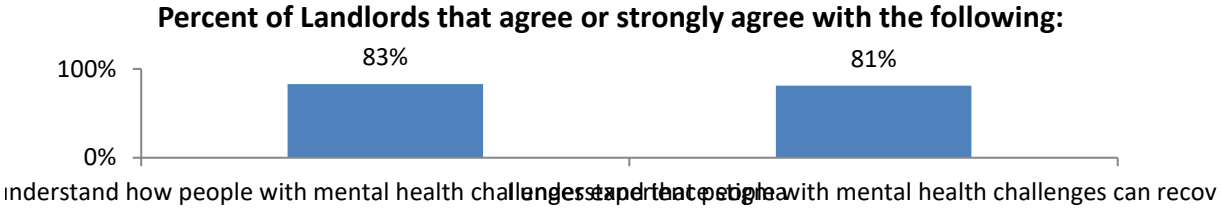

Disability
100%
50%
0%
92%
8%
No Disability
Learning

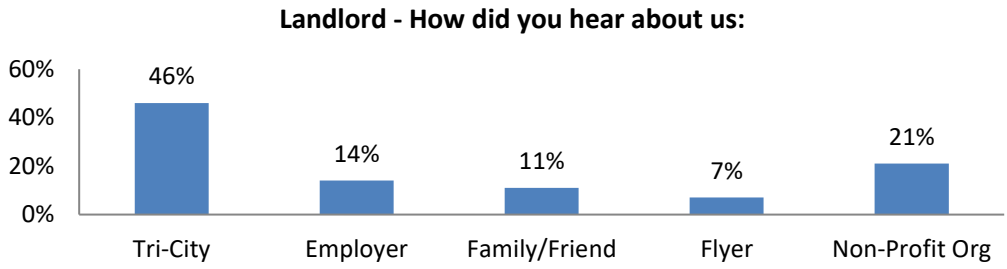

Veteran
150%
100%
50%
0%
100%
No

How Well Did We Do It?

Landlord Hour

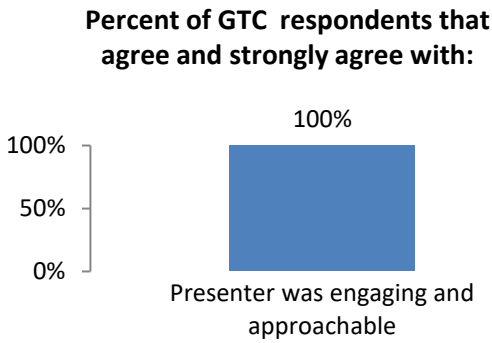


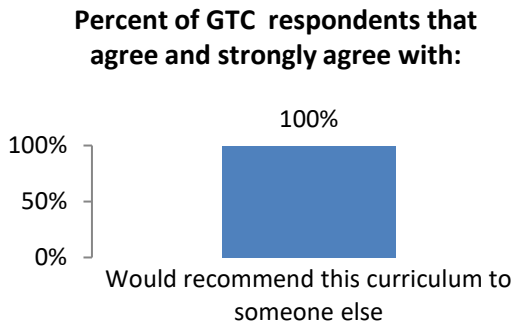




The percent of landlords hearing about the program via Tri-City **increased** from **0%** in FY 2022-23 to **46%** in FY 2023-24.

Good Tenant Curriculum (GTC)

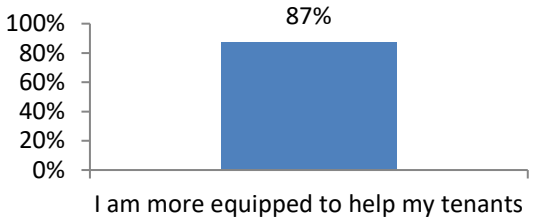




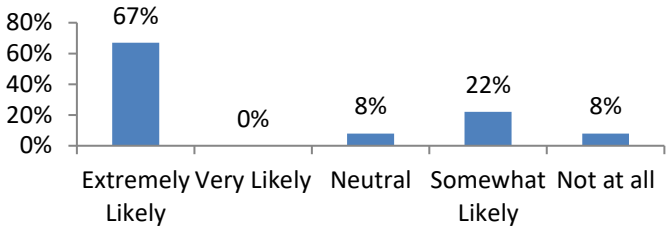
Is Anyone Better Off?

Landlord Hour

Percent of participants, as a result of this training:

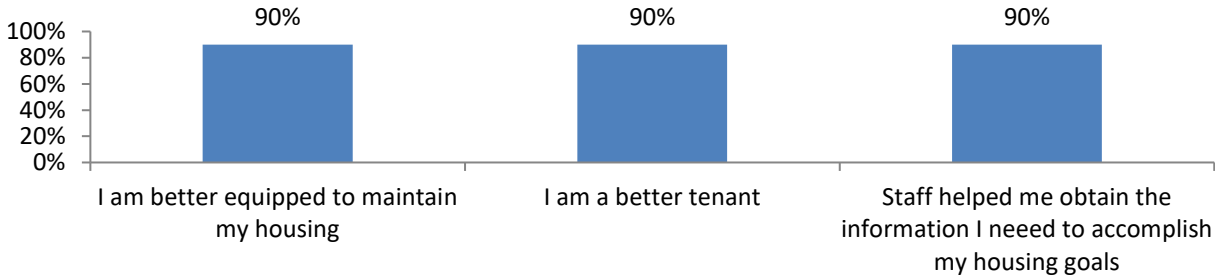


If you suspect someone has a mental health challenge, how likely are you to reach out



Good Tenant Curriculum (GTC)

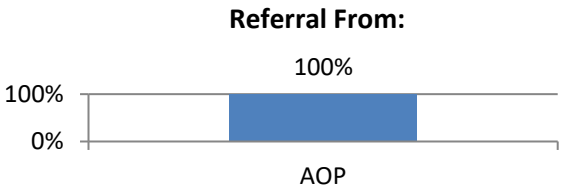
Percent of Good Tenant Curriculum respondents that agree or strongly agree with the following:



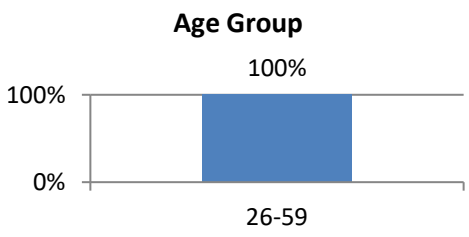
Number of Potential Responders	61
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged 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.

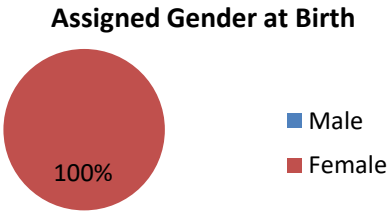
Timely Access to Services for Underserved Populations Strategy

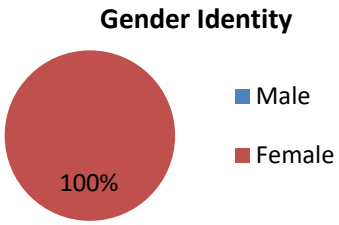
1
MHSA referral into Housing Stability

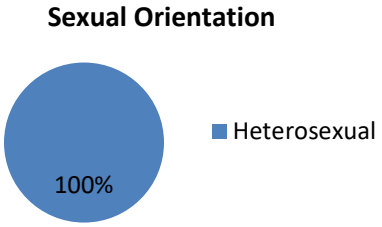


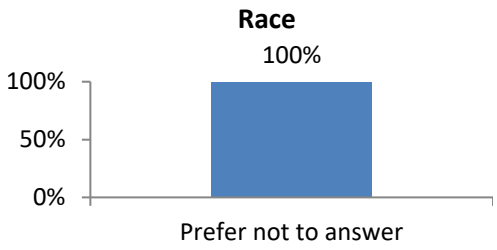
PEI Demographics Based on MHSA Referral

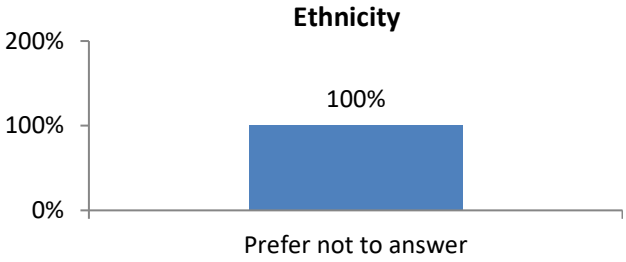


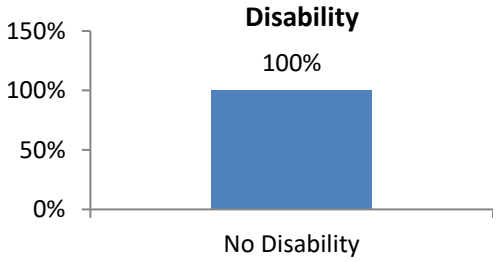


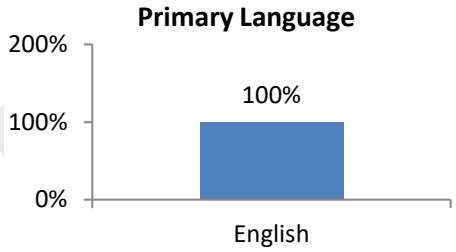

Gender Identity
Male
Female
100%

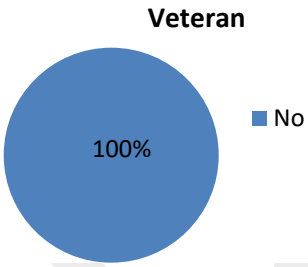

Sexual Orientation
Heterosexual
100%


Race
100%
100%
50%
0%
Prefer not to answer


Ethnicity
200%
100%
0%
100%
Prefer not to answer


Disability
150%
100%
50%
0%
100%
No Disability


Primary Language
200%
100%
0%
100%
English


Veteran
No
100%

Therapeutic Community Gardening

(Early Intervention)

Program Description

Therapeutic Community Gardening (TCG) utilizes 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. Attendees 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 supervisor, two clinical therapists, a behavioral health specialist and community garden farmer. Groups are available in both English and Spanish.

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 2021-22	0	19	58	39	214	**330**
Projected Number to be Served FY 2024-25	0	4	52	22	N/A	**78**
Cost Per Person	N/A	$6,023**	$6,023**	$6,023**	N/A	$6,023**

**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 construction of the rejuvenation project in the garden, which began the previous fiscal year, continued throughout FY 2023-24. TCG also filled a position for a second clinical therapist. With the addition of another team member, the program was able to increase output with regards to curriculum, workshops, and with community partner collaborations. The TCG team doubled the

number of workshops and events in this fiscal year compared to the last fiscal year (FY 2022-23: n = 16, FY 2023-24: n = 32). This increase was also reflected in the number of workshop participants more than doubling from year to year (FY 2022-23 n = 132, FY2023-24 n = 288).

There was also a marked increase in TCG group participant satisfaction and longevity in the program this fiscal year. This is reflected in the data that states the average length of time a participant remained in the program increased to 12 months. Likewise, survey results indicate that 100% of participants enjoyed TCG groups as well as felt more confident in the skills they learned in TCG Groups.

Challenges and Solutions

Construction in the Garden impacted the programs' ability to function at full capacity. For example, TCG was unable to have consistent in-person group and was unable to harvest from the fruit trees or vegetable beds. Furthermore, groups remaining virtual has made it difficult to retain TCG participant attention and interest in the program. Many potential new referrals reported wanting to be involved in the TCG program after attending an in-person event. However, upon learning of the virtual nature of the groups, these new referrals reported wanting to wait until the Garden opens to join. Reaching the child and TAY audience in TCG groups continues to be a challenge. The Youth and Family Groups struggle with retaining participants.

When the Garden opens, many of these challenges will be solved or provide an opportunity for TCG to see if there are other barriers beyond garden access. Currently, the program offers occasional in-person groups with activities for participants to enjoy hands on activities preparation for in-person groups. Another potential solution that has been developed by the team is to collaborate with more internal programs to provide TCG programming that will allow clients and community members to engage with the gardening program (examples of this are collaborations with Wellness Center and Co-Occurring Support Team for workshops). Additionally, creating workshops specifically for the younger demographic has assisted the program in addressing low attendance in youth and family groups.

Diversity, Equity and Inclusion

TCG specifically collaborates with agencies that target groups such as TAY, children, families, Veterans, older adults and the LGBTQ+ 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 Wellness Collaborative, allowing for concepts such as diversity and inclusion to be embedded into TCG curriculum for the community. TCG frequently partners with agencies in Pomona, Claremont and La Verne that target underserved and unserved individuals and families. There are also groups developed specifically for the Spanish speaking community, and flyers are translated into Spanish. Lastly, the cultural significance of food is used in curriculum and this concept has always been well received by community members.

Community Partners

The Therapeutic Community Gardening staff network and collaborate with a multitude of community partners and organizations. Examples include annual events with Cal Poly Pomona Veterans Resource Center, outreach with Pomona Unified School District targeting children and TAY, collaborations with Casa Colina Hospital and Centers for Healthcare, schools in the service area, community centers, and several small businesses.

Other examples of organizations in which TCG engages in strong community partnerships are: Sustainable Claremont, Lopez Urban Farm, Bridge the Gap, Traumatic Brain injury- Outreach, DA Center for The Arts, California Horticultural Therapy Network, Pomona Valley Pride and animal therapy agencies. Outcomes of these connections include development of workshops, general outreach, group referrals, seedling donations, and produce donations to community agencies when available.

Success Story

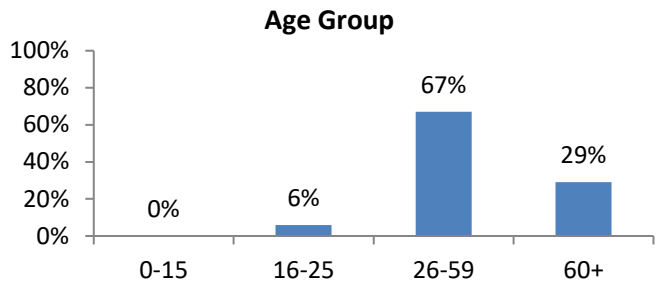
This fiscal year the TCG team provided an in-person group that encouraged participants to socialize face-to-face, as well as prepare them for the eventual transition to in-person groups in the Garden. Participants learned about mindfulness and addressed stress management. Attendees created pressed herb canvas paintings as the hands-on activity. Staff informed participants on the benefits of being in the present moment, while connecting with their senses and learned about how colors can impact our mood. Participants shared their appreciation for the opportunity to interact with each other in-person, create a natural art piece, and gain knowledge about color psychology.

Program Summary

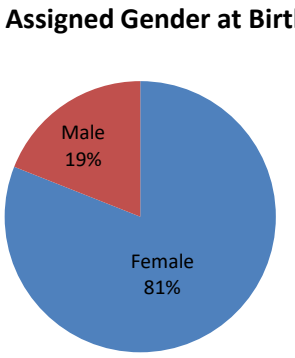
How Much Did We Do?

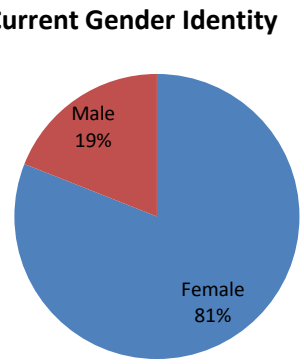
42
Participants Enrolled in TCG Program Groups

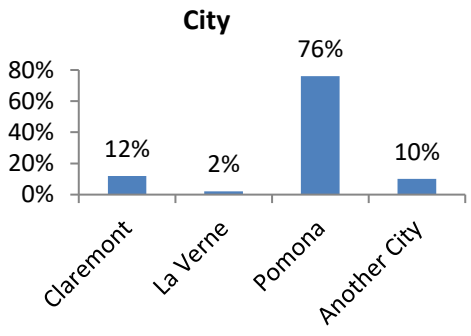
12 Months
Average Length of Time Participants Enrolled in TCG

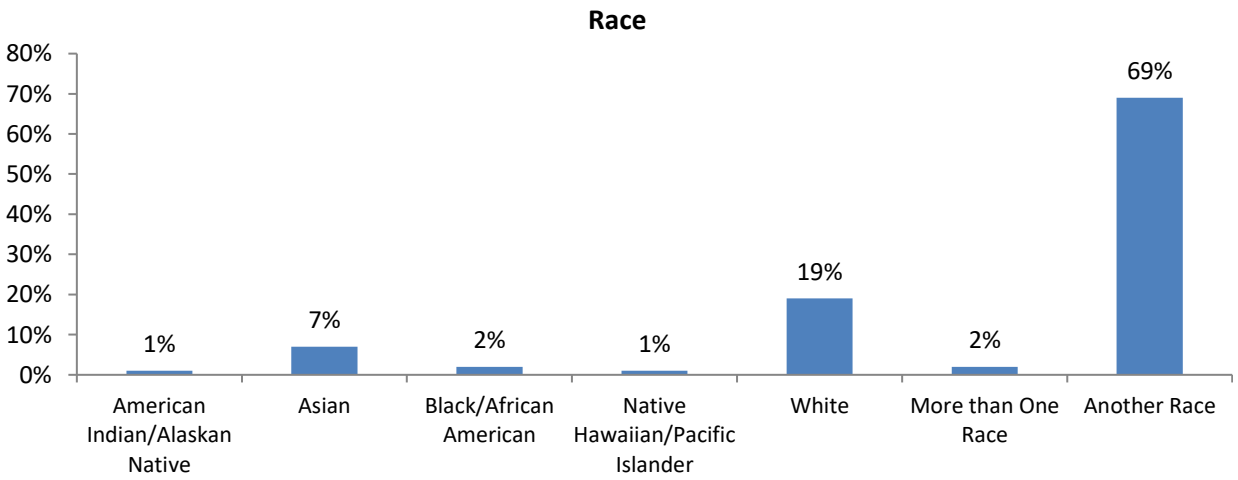


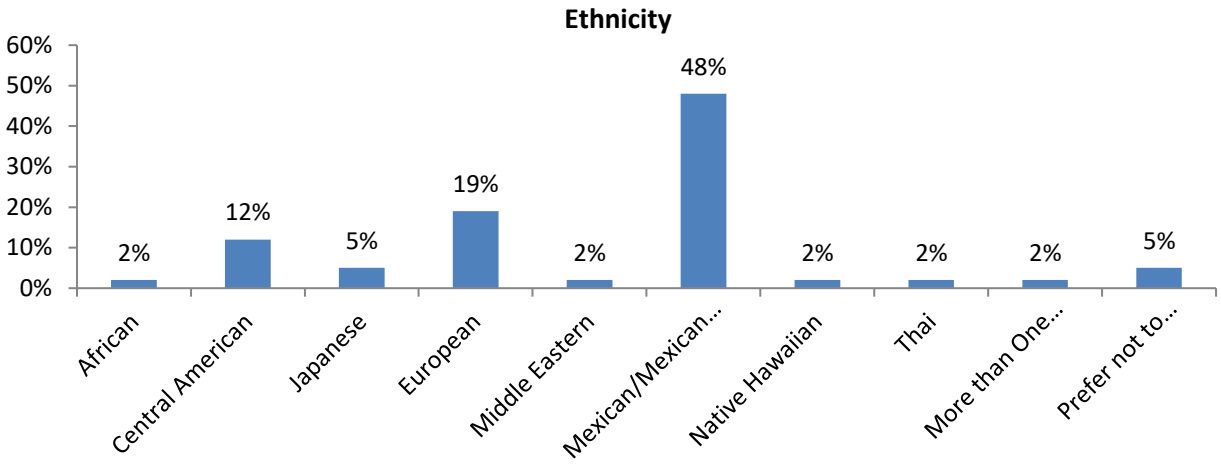
The number of participants enrolled in TCG groups **decreased** from **85** in FY 2022-23 to **42** in FY 2023-24.

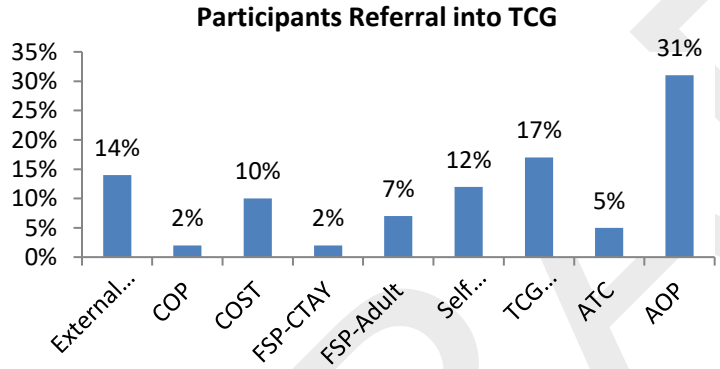


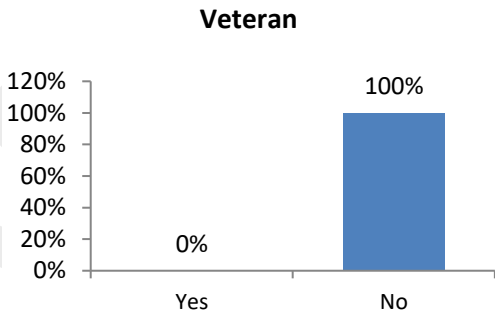


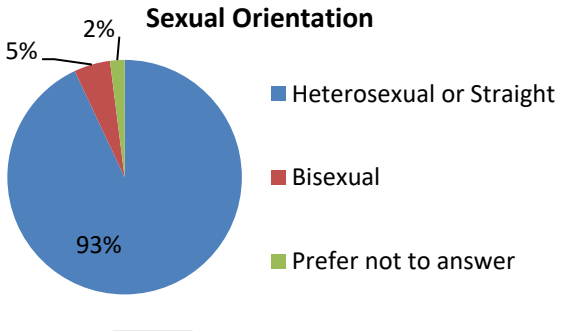


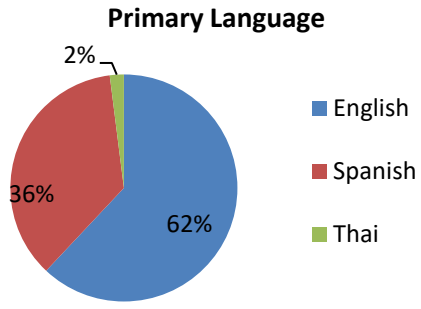


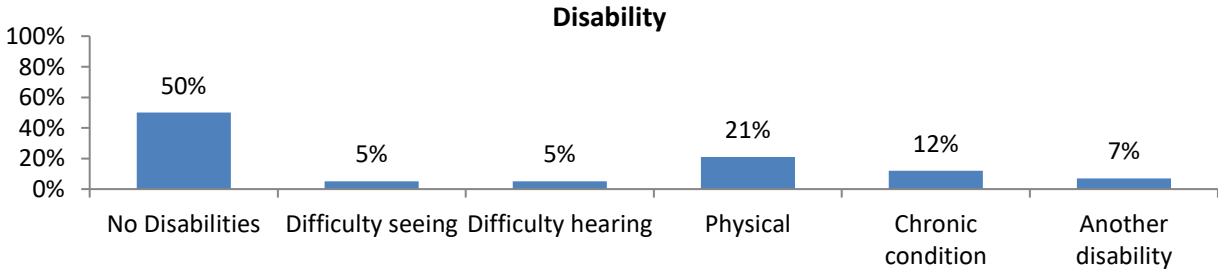

Ethnicity
60%
50%
40%
30%
20%
10%
0%
2%
12%
5%
19%
2%
48%
2%
2%
2%
5%
African
Central American
Japanese
European
Middle Eastern
Mexican/Mexican...
Native Hawaiian
Thai
More than One...
Prefer not to...


Participants Referral into TCG
35%
30%
25%
20%
15%
10%
5%
0%
14%
2%
10%
2%
7%
12%
17%
5%
31%
External...
COP
COST
FSP-CTAY
FSP-Adult
Self...
TCG...
ATC
AOP


Veteran
120%
100%
80%
60%
40%
20%
0%
0%
100%
Yes
No


Sexual Orientation
5%
2%
93%
Heterosexual or Straight
Bisexual
Prefer not to answer


Primary Language
2%
36%
62%
English
Spanish
Thai


Disability
100%
80%
60%
40%
20%
0%
50%
5%
5%
21%
12%
7%
No Disabilities
Difficulty seeing
Difficulty hearing
Physical
Chronic condition
Another disability

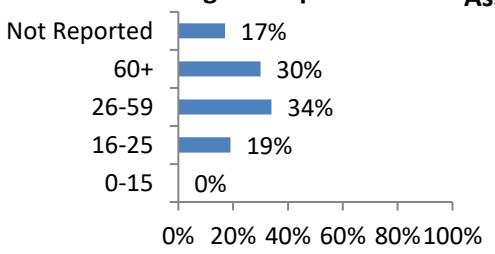
TCG Workshop/Events Survey Demographics (n=89)

32 Workshop/Events

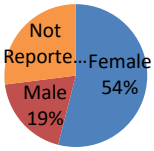
288 Attendees

The number of workshops/events and attendees **increased** from **16 and 132** in FY 2022-23 to **32 and 288** in FY 2023-24.

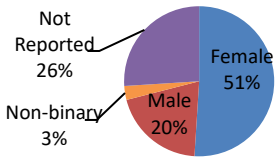
Age Group



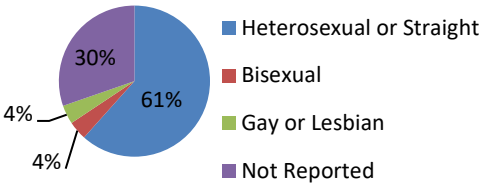
Assigned Gender at Birth



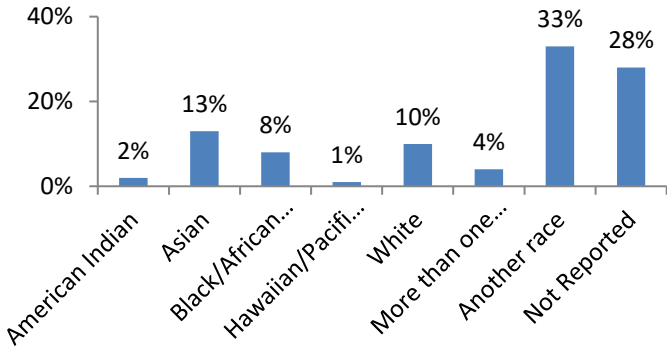
Current Gender Identity



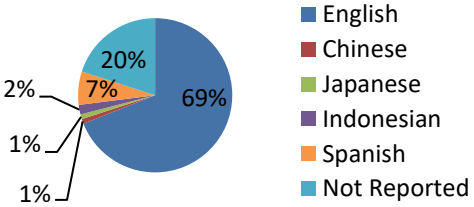
Sexual Orientation



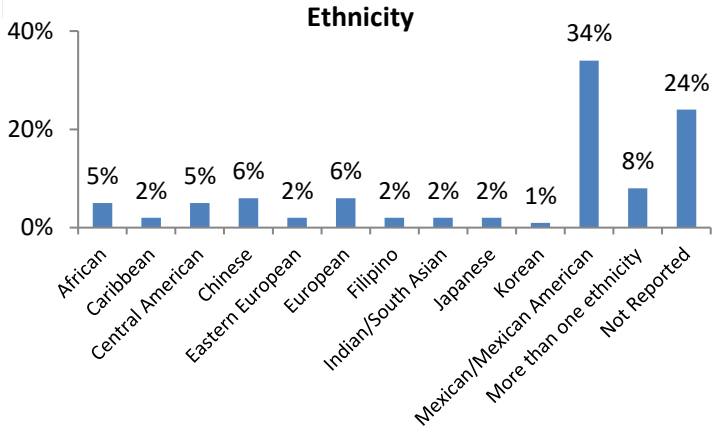
Race



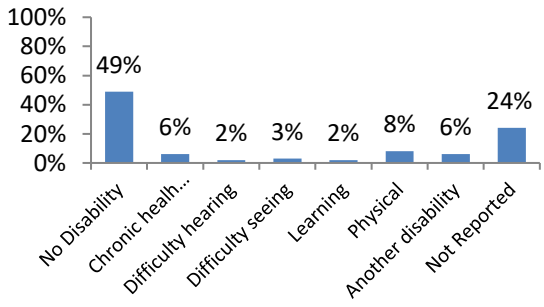
Primary Language



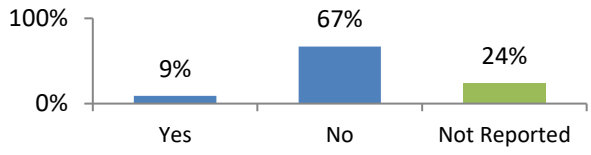
Ethnicity



Disability

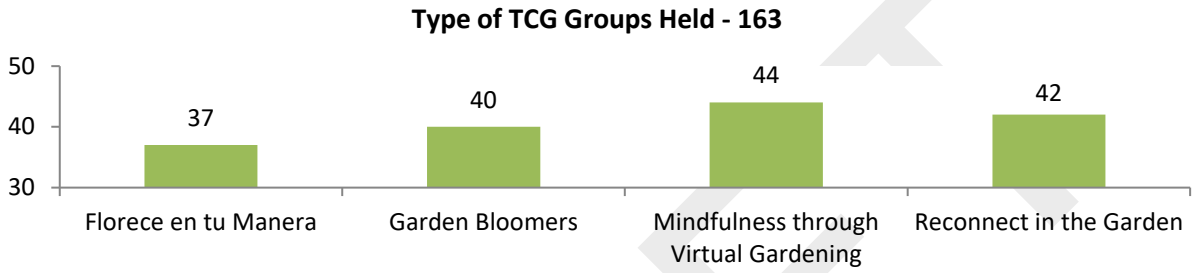


Veteran



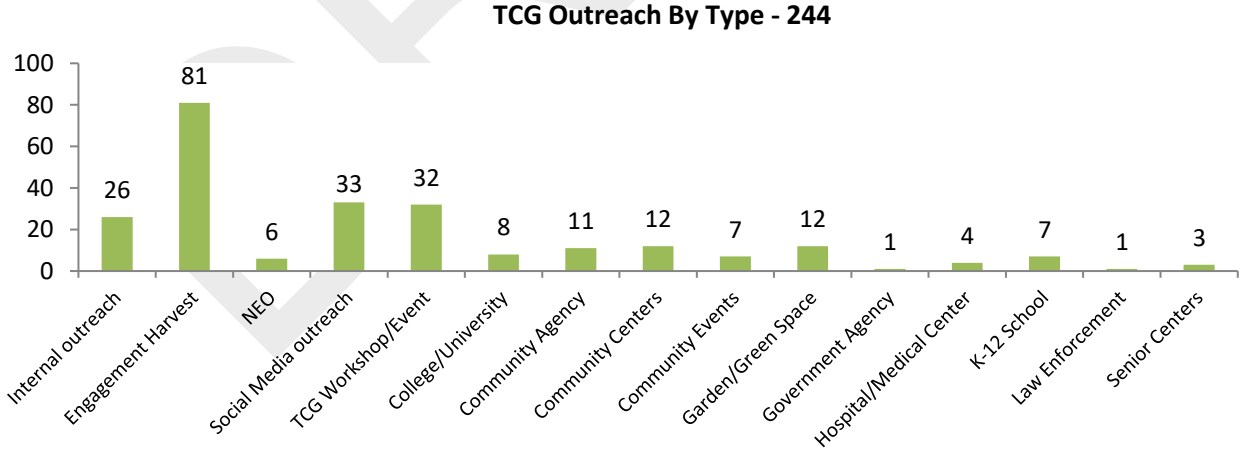
How Well Did We Do It?

163	465
TCG Groups Held	Participants Attending TCG Groups



The number of TCG Groups held **decreased** from **180** in FY 2022-23 to **163** in FY 2023-24.

244	1,867	5,304
Number of TCG Outreach	Number of Individuals Outreached	Number of Individuals Outreached via Social Media



The number of individuals outreached **increased** from **2,557** in FY 2022-23 to **7,171** in FY 2023-24.

Is Anyone Better Off?

TCG Group Survey Responses Based on Completed Surveys (n=17)

100%	94%	88%	100%
TCG participants enjoy participating TCG groups	TCG participants feel more connected to others (peers, family, etc.) because of TCG groups	TCG participants have better communication with others because of TCG	TCG participants feel more confident from the skills learned in TCG

TCG Workshop Survey Responses Based on Completed Surveys (n=89)

93%	85%	91%
TCG participants enjoy participating in TCG workshop or events	TCG participants feel less isolated by attending TCG workshops or events	TCG participants would return to a TCG workshop or event

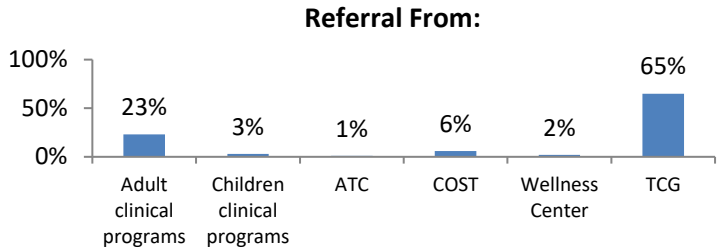
TCG Participant Feedback – How have you benefited from participating in TCG groups?	
It has made me more social through quarantine and everything. I have benefited through it in all aspects of my life.	I have benefited because it has helped me to understand how plant and what soil to use and I now feel more confident in how I am planting.
More knowledgeable about plants and also when provided resources during group has been helpful, keeps me informed.	Getting to know more people. Also having the opportunity to work on more self-awareness and learn mindfulness.
I am a little bit more social in public because of the TCG groups.	I have benefited from TCG when feedback is expressed and there is connection between group participants, and everyone can be themselves.
It has helped me to be more connected with nature evoking calm and relaxation.	I learned a lot about myself.
Building a connection with others. Connection of earth to myself.	I'm inspired to do painting at home. It's therapeutic.
Fun community.	Learning how to propagate properly has been helpful.
My garden is looking good and providing food.	TCG has helped me be myself and open myself up more to who I am. My life is more positive!

TCG Participant – Please share any thoughts, comments you may have about the TCG program, groups, and/or activities:	
I like how the program is led.	Everything is good.
Everything is on point. I always love to learn, and I can share with others.	Everything is nice the way it is, all is good. I really enjoy group.
I enjoy each group meeting.	I am just waiting for the garden to open, although, I do enjoy the virtual groups.
I hope that I am able to participate in person when the garden is open.	I feel that the virtual garden is a great program that opens doors for connection.
I would like the group to be big!	I look forward to going into the real garden soon.
The program is good	TCG program has been above my expectations and group has brought me much joy.
These types of social activities are essential to help PTSD survivors.	I am so impressed in every group and the learning aspect of it.

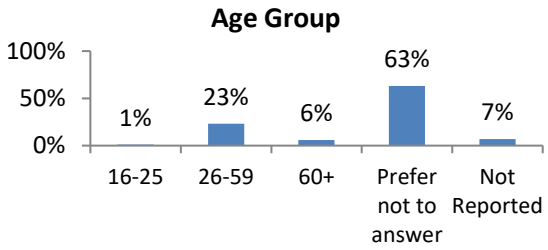
Number of Potential Responders	7,836
Setting in Which Responders were Engaged	Community, schools, health Centers, workplace, and outdoors.
Type of Responders Engaged	TAYs, teachers, LGTBQ, families, religious leaders, and those with lived experience.
Access and Linkage to Treatment Strategy	There were 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.

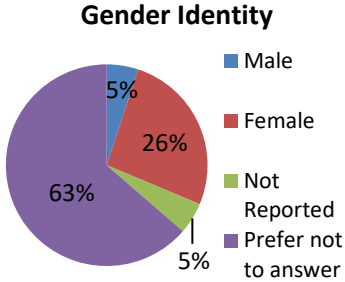
Timely Access to Services for Underserved Populations Strategy

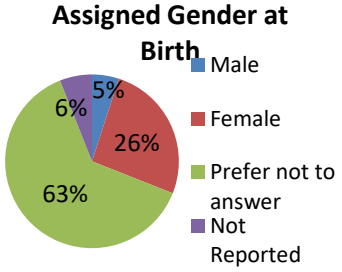
93
MHSA Referrals coming into TCG Program

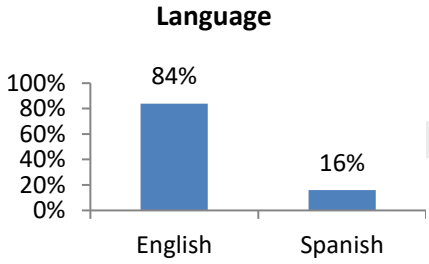


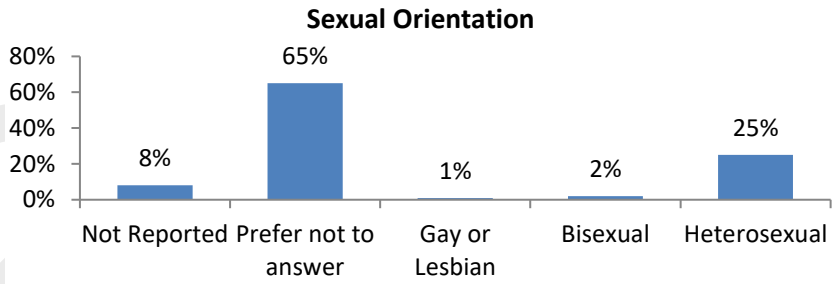
PEI Demographics Based on MHSA Referrals

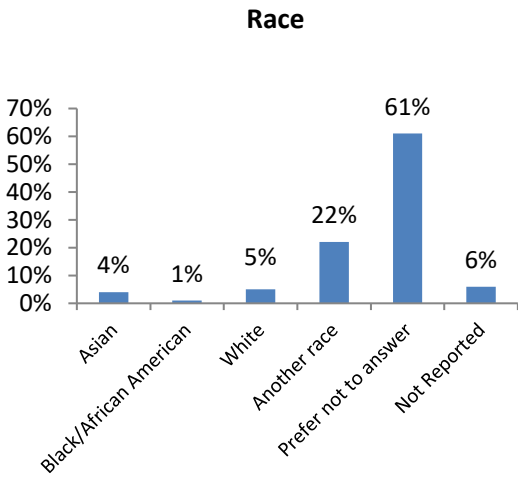


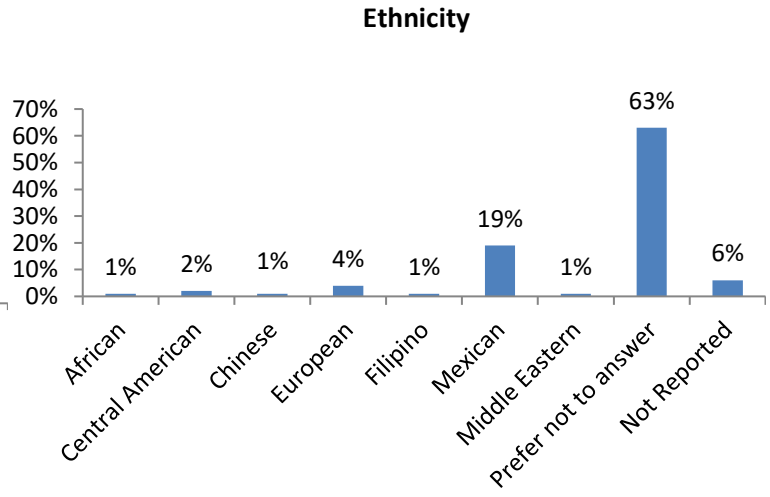


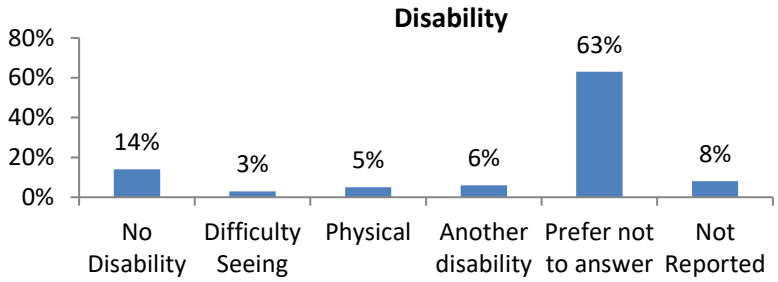


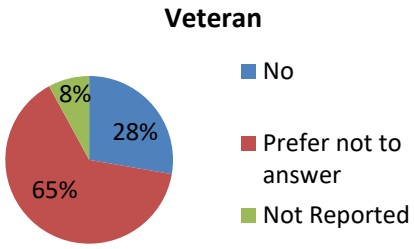









Disability
80%
60%
40%
20%
0%
14%
3%
5%
6%
63%
8%
No Disability
Difficulty Seeing
Physical
Another disability
Prefer not to answer
Not Reported


Veteran
8%
28%
65%
No
Prefer not to answer
Not Reported

Early Psychosis Program

(Prevention & Early Intervention)

Program Description

The Early Psychosis (EP) program is designed for young people who are at risk of developing psychosis or experiencing a first episode psychosis and their families. This coordinated specialty care program is focused on assisting a young person manage their symptoms, prevent deterioration, and equip their family to be the best support for them. Awareness, early detection, and access to services is needed to help young people with psychosis recover. 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, improved function and decrease relapse.

Target Population

Transition age youth (TAY) ages 12 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 2023-24	6	18	0	0	0	**24**
Projected Number to be Served FY 2024-25	14	41	N/A	N/A	N/A	**54**
Cost Per Person	$5,126**	$5,126**	N/A	N/A	N/A	**$5,126****

**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 2023-24, there was an increase in participants whose family were monolingual Spanish speaking. As a result, the caseload for the Spanish speaking clinician and Spanish speaking group grew this year. The EP team established weekly team meetings where staff (including psychiatrist) took the opportunity to discuss important updates and directions in the cases. Due to this care team approach, staff are feeling supported and informed. Notably, clients a have experienced minimal need for crises intervention requiring hospitalization and several client graduations are pending due to

improvements in symptoms and treatment goals being met. A program change was the expanded criteria to allow for onset of symptoms to be within the past 18 months, rather than 12 months to match best practices.

Lastly, EP joined an early psychosis collaborative with other local counties who have established early psychosis programs. The goal of this collaborative is to share knowledge, resources and problem solve to ensure that program is operating within best practices and standards of care. The focus of the next fiscal year will be to improve outcome measures and data tracking. This includes collecting surveys more regularly to ensure that work done is participant informed. Along with this, there will be an increase in community outreach.

Challenges and Solutions

There has been a challenge growing the adult TAY cohort, as most often the TAY are attempting to work or go back to school. As a result, there have been challenges with accepting or consistently participating the multiple services included in the program. Along with this, there has been a slowdown in incoming referrals in the past fiscal year.

To address this challenge, the team has changed time of services and offered it in different modalities. It appears that virtual has been easier to maintain consistent participation for the adult TAY population, whereas the Spanish speaking child cohort tends to be more responsive to in person groups and workshops.

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 a language line. Materials for trainings are available to be translated upon request. The EP team is representative of staff of various cultural backgrounds, ages and languages which allows for representative for the participants. The program includes a peer support specialist who can share their lived experience with participants, in regards to experiences with disparities in the mental health system.

In addition, barriers to seeking services due to stigma, lack of knowledge, or other barriers experienced by individuals who identify as LGBTQIA+ are addressed. Furthermore, client's electronic health record indicates preferred pronouns and/or name to reduce mis-gendering. Workshops and groups also promote inclusivity by allowing time to identify pronouns and preferred names.

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).

Community Partners

Local schools within the service area are the primary community partners for this program (Schools and colleges in Pomona, Claremont, and La Verne). The EP team has a designated peer support

specialist, psychiatrist, and occupational therapist, which makes for effective collaboration inside and outside of treatment. Along with this, in the past fiscal year there has been improved collaboration with the Co-Occurring Support Team (COST). Cost provider has intermittently participated in weekly EP team meetings and regularly participates in care and communication. This has helped to improve treatment outcomes and knowledge for staff.

Success Story

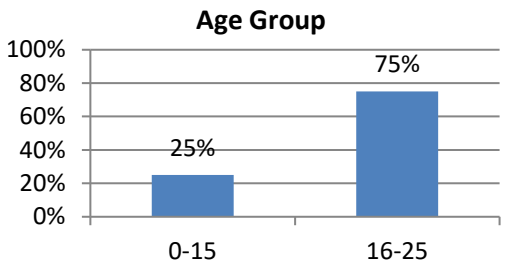
A TAY individual had been involved in the EP program for about a year. The individual had a history of hospitalizations and severe symptoms of psychosis impairing their functioning and leading to risk factors. Due to client's level of psychosis, they were hesitant about treatment recommendations being made, particularly around medication. Their family also struggled with coping with their loved one's symptoms, and not knowing how to best support them. The individual began to severely decompensate, almost requiring hospitalization. The client had access to a clinical therapist, behavioral health specialist, occupational therapist, peer support and psychiatrist. Team members regularly had internal meetings, as well as meetings involving the family. Trust was built and treatment recommendations began to be implemented by the client and family members. The client was able to avoid hospitalization, stabilized, and work has shifted to focusing on independent living skills.

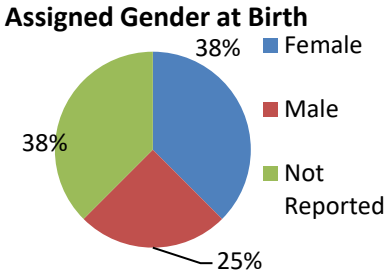
Program Summary

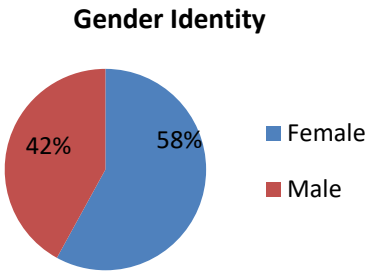
How Much Did We Do?

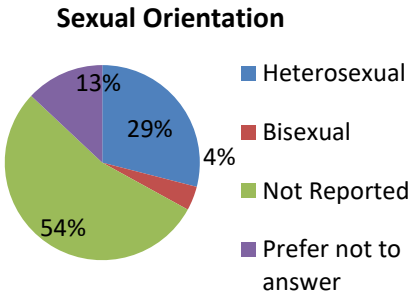
24
Individuals Enrolled In Early Psychosis

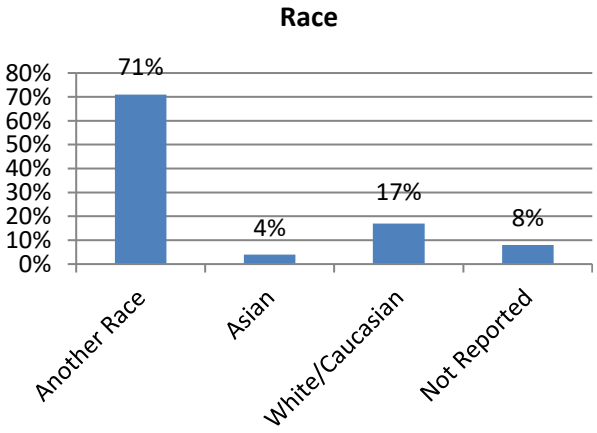
The number of individuals enrolled **increased** from **19** in FY 2022-23 to **24** in FY 2023-24.

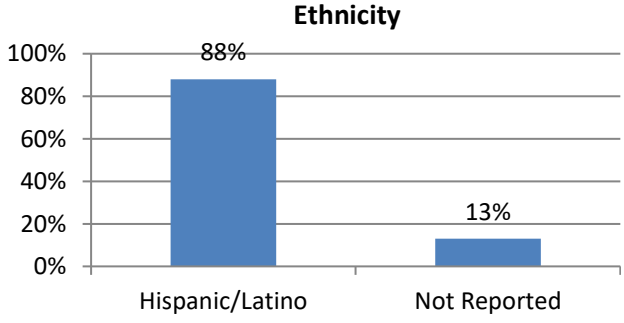


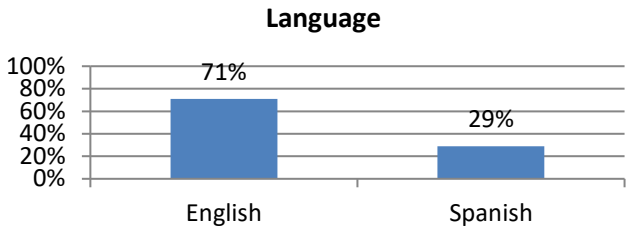


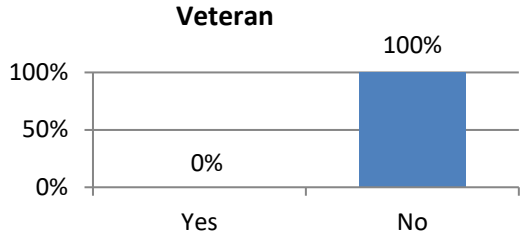


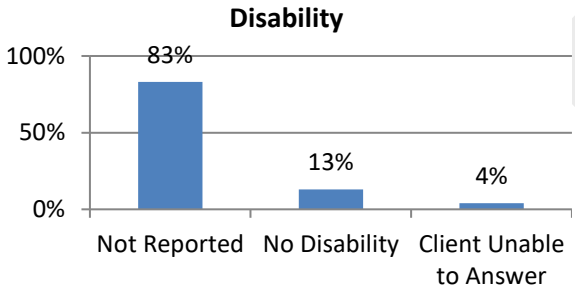


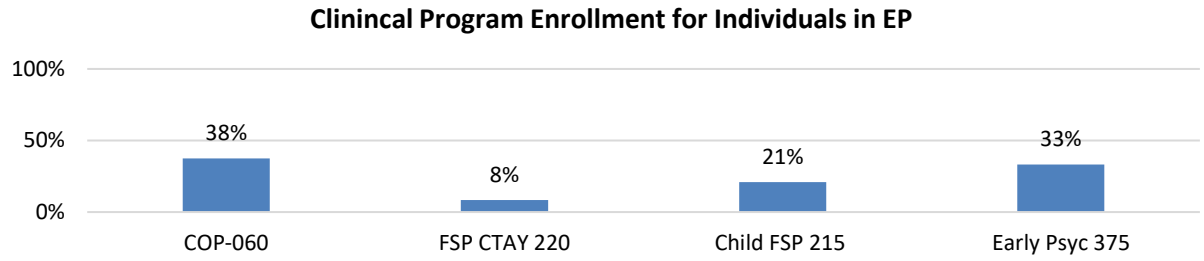








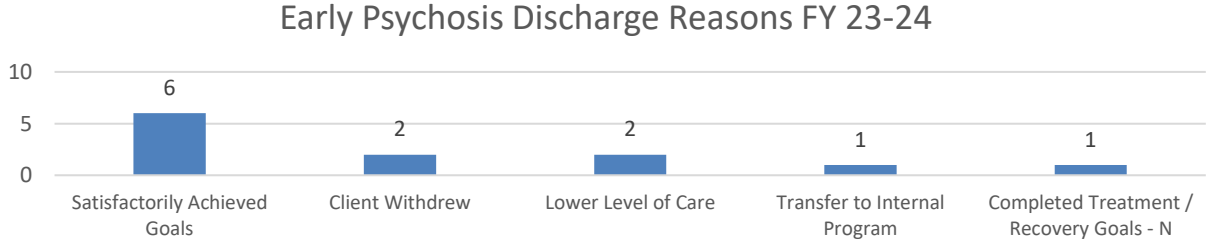




How Well Did We Do It?

Early Psychosis hosted 3 psychoeducation workshops for client and families & 1 community outreach event

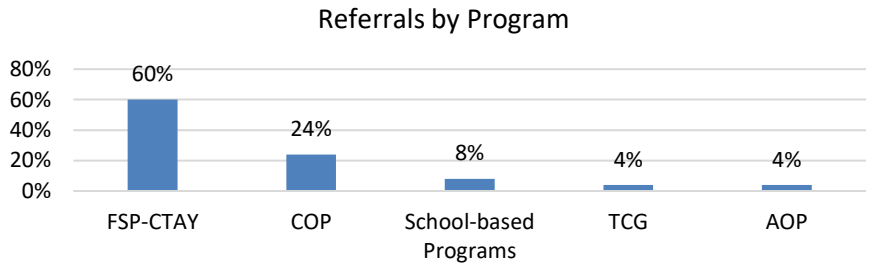
Is Anyone Better Off?



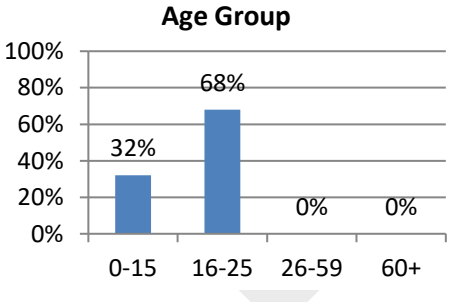
Underserved Populations	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability.
Access and Linkage to Treatment Strategy	Tri-City encouraged access to services 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.

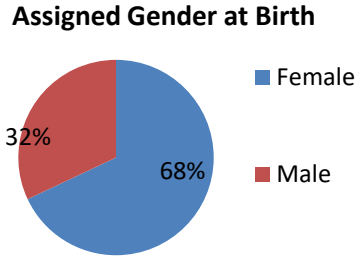
Timely Access to Services for Underserved Populations Strategy

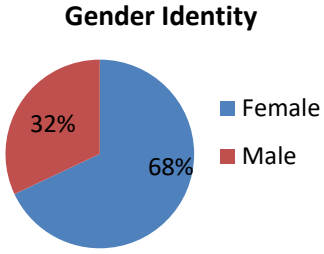
25
MHSA Referrals to Early Psychosis

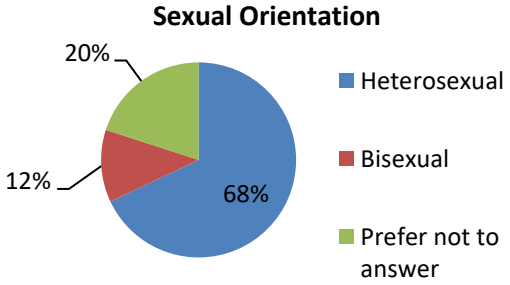


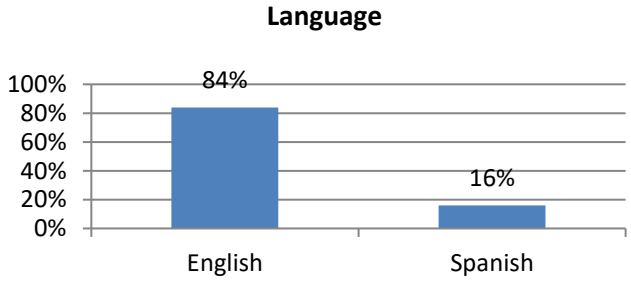
PEI Demographics Based on MHSA Referrals

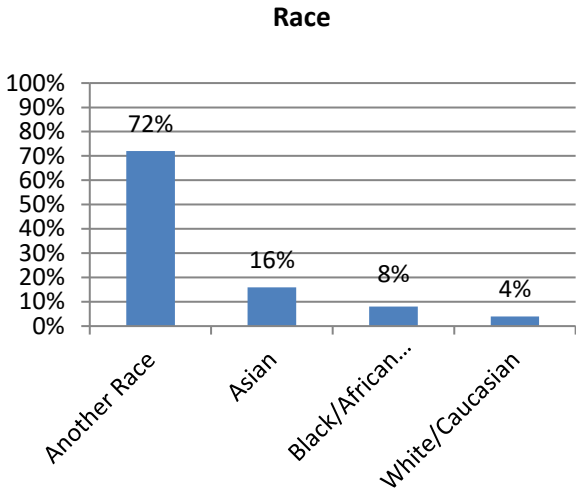


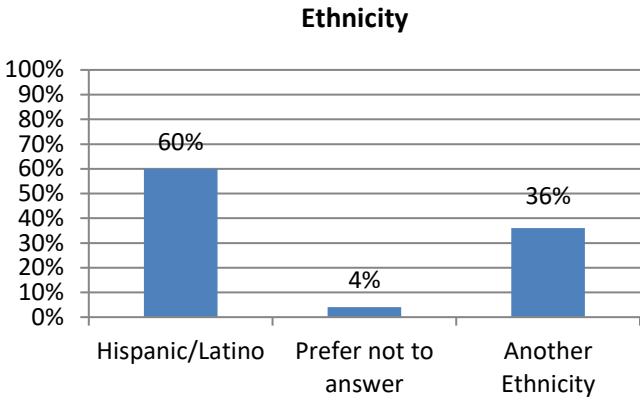


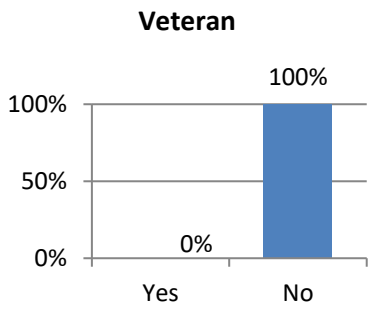


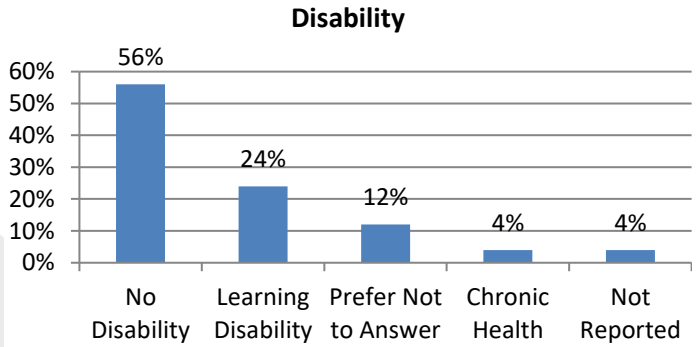





Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
16%
8%
4%
Another Race
Asian
Black/African...
White/Caucasian


Ethnicity
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
4%
36%
Hispanic/Latino
Prefer not to answer
Another Ethnicity


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


Disability
60%
50%
40%
30%
20%
10%
0%
56%
24%
12%
4%
4%
No Disability
Learning Disability
Prefer Not to Answer
Chronic Health
Not Reported

School-Based Services

(Early Intervention)

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 by meeting the youth where they are at.

Target Population

Students attending school in the school districts and colleges located 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 2023-24	123	76	2	N/A	N/A	**201**
Projected Number to be Served FY 2024-25	177	109	3	N/A	N/A	**289**
Cost Per Person	$2,716**	$2,716**	$2,716**	N/A	N/A	**$2,716****

**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

School-Based Services (SBS) experienced an increase in referrals from students at universities. There was also notable increase in new schools reaching out for support and services. The program made an effort to increase outreach and engagement with elementary schools in the city of Claremont and also increased services with the School of Arts and Enterprises. This included crisis support following the death of a student due to an overdose. The SBS program also added a virtual office hour which is open to all school partners to consult on referrals or ask questions.

In the upcoming fiscal year, the program intends to add more collaboration with schools underutilizing SBS services as well as participate in more school events to promote awareness of services (i.e. Back to School Night).

Challenges and Solutions

School partners often are busy and struggle to attend monthly meetings leading to some possible gaps in communication regarding referrals or needs. Additionally, school schedules are different than the typical Tri-City work schedule, leading to difficulty connecting with schools. There was also a decrease in referrals this fiscal year as well as a struggle for families to complete the enrollment process or attend appointments at the clinic.

To address this challenge, SBS offered school partners to meet virtually vs in person. There is also a ongoing effort to make enrollment easier, such as revising interview questions to screen for appropriate candidates and rule in or out services at this level. The program also aims to make services more accessible, collaborate with school partners on different needs and continue to work on becoming the preferred referral for local schools.

Diversity, Equity and Inclusion

SBS staff prioritizes on-site school visits to assist with 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 a language line. 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. There is also support provided to parents, which teaches them gender affirming parenting skills and behaviors.

Community Partners

Community Partners largely consist of local schools and colleges within the Tri-City service area. Some examples include: California Polytechnic University, University of La Verne, Pomona Unified School District (PUSD), Bonita Unified School District (BUSD), Claremont Unified School District (CUSD), and The School of Arts and Enterprise (SOAE). These partnerships foster resource sharing, increase access for students in need of mental health services and generate referrals to the SBS team.

Success Story

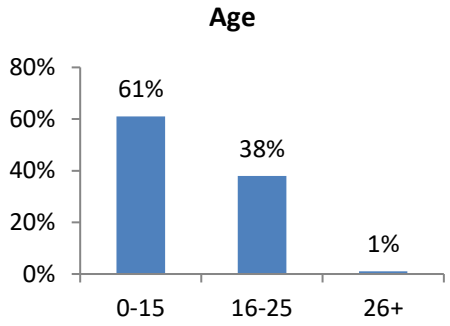
During FY 2023-24, SBS held meetings with district leadership, resulting in dialogue and overviews of program performance at CUSD schools. This resulted in a shift in focus based on client needs identified and research of student demographics. The program was also able to identify new schools as a primary target for service delivery, resulting in an initial connection and service delivery to students at the school. Lastly, the elementary counselor observed a need and services were provided at the identified schools, resulting in increased referrals from all elementary schools at Claremont Unified School District.

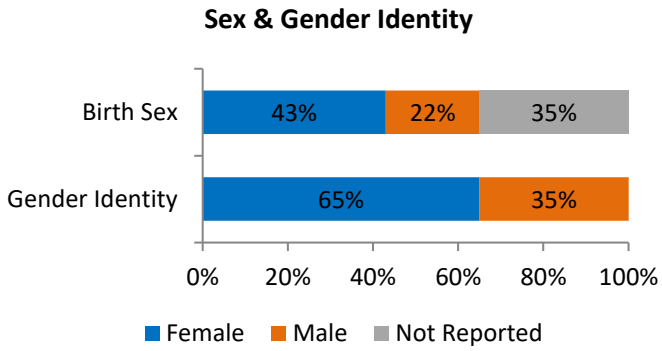
Program Summary

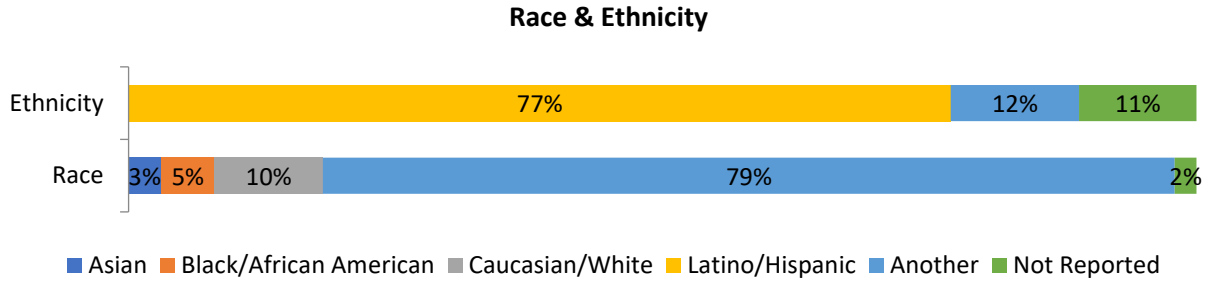
How Much Did We Do?

201
Individuals received a school partnership intervention

91%
of enrolled SPT clients lived in Pomona in 2023-2024
while 4% of clients lived in Claremont and 5% of clients lived in La Verne.







Data not available for Disability and Sexual Orientation

How Well Did We Do It?

SBS Services Provided by Type	Number of Services Provided
Crisis - CA	3
Family Therapy - CA	102
Individual Therapy - CA	2,369
Intensive Care Coordination - CA	8
Plan Development/Tx Planning - CA	282
Psychiatric Evaluation / Assessment - CA	9
Psychosocial Rehabilitation - CA	464
Targeted Case Management - CA	6
Grand Total	**3,243**

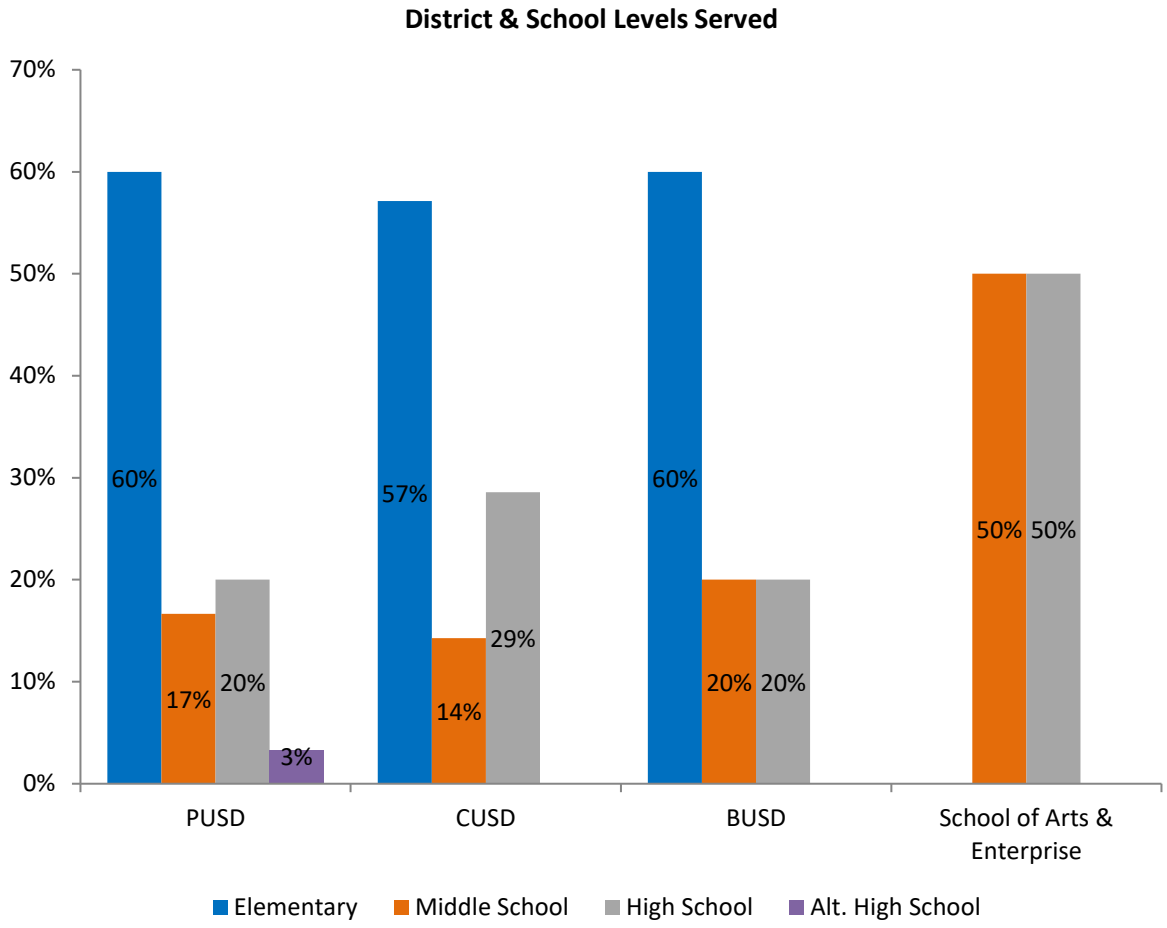
SBS Services Provided by Location	Number of Services Provided
Clinic/Office	1017
Home	42
Other	1
Other Community Location	13
Phone	993
School	610
Telehealth	372
Telehealth - Patient's Home	195
Grand Total	**3,243**

68
Individuals received services at school sites

Individual Therapy account for 73% of School-Based Services
with psychoeducation at 14%, plan development at 9% and family therapy at 3%.

Is Anyone Better Off?

43
Schools served by SBS Staff



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.

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.

Innovation expanded in August 2023 with the addition of an MHSA Program Coordinator for Innovation and a Peer Support Specialist. Tri-City currently has two active projects and one project recently ending.

Help@Hand/Tech Suite

Project Update

Tri-City partnered with CalMHSA in a multi-year Innovation project in which 11 California cities and counties worked together to explore mental health solutions through the use of technology. This project began on January 1, 2019, and ended on December 31, 2023. 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

Challenges and Solutions

The Innovation staff discovered that older adults required more personalized assistance to sign up for the myStrength app. It became clear that simple outreach efforts, such as distributing flyers, were insufficient. During a tabling event at a local community center, the team observed that effective outreach involved more than promotion; it required hands-on help with every step of the sign-up process, including email setup and navigation. The myStrength app's multi-step sign-up process highlighted the need for in-person support to ensure a smoother user experience.

Additionally, there was a challenge related to the technology itself, particularly in educating older adults about digital tools. Virtual Digital Health Literacy (DHL) training sessions had low attendance, which underscored the need for more accessible, in-person training opportunities. To address the challenge of signing up older adults for the myStrength app, the team shifted to providing direct, in-person assistance.

Another challenge was enrollment, retention and repeated use of the app when determining total number served. While 54 individuals were documented as users of the app, 46 followed through to activate an account/profile, while 8 did not. Those who did not activate an account were not able to utilize the application to its full extent and as intended. Additionally, of those who activated an account (46 users), 24 individuals returned to utilize the application one or more times after initial enrollment. As with other programs and projects, increased engagement and retention is always a goal for future endeavors.

Enrolled	Activated	Returning
54	46	24

Diversity, Equity and Inclusion

The myStrength app was made available in both English and Spanish and was accessible via smart phone, tablet or computer. Tablets were provided to individuals who did not have computers or phones to utilize the app. myStrength offered evidenced-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 supported outreach and engagement to older adults and veterans. Resource tables were made available during the center's lunch hours to promote Help@Hand when foot traffic is high. Staff also held a DHL training at the senior center in Claremont to eliminate barriers for our older adults and ensure they could participate.

Community Partners

Innovations relied on community partners and social media posts to help encourage individuals to sign up for myStrength. Community Navigators and other staff supported promoting the myStrength app to the community. Innovation staff worked with market partners, Uptown Studios, who helped create flyers for the three target populations: TAY, older adults and monolingual Spanish speakers.

Other community partners included Cal Poly Pomona and Western University of Health Sciences through the Youth Wellness Symposium collaboration. Through these efforts, DHL workshops were held in Spanish and for older adults. The TAY population was outreached through various connections to schools and colleges.

Psychiatric Advance Directives (PADs) Multi-County Collaborative

Tri-City joined the Psychiatric Advance Directives (PADs) Multi-County Collaborative on July 1, 2022. This Innovations project aims to develop and test the feasibility of Psychiatric Advance Directives (PADs) in California.

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Projected Number to be Served FY 2024-25	N/A	41	11	3	N/A	**55**
Cost Per Person	N/A	$6,818**	$6,818**	$6,818**	N/A	**$6,818****

**The estimated projections were determined by prior participation rates for INN projects and total budget allocated to the INN plan.

Project Update

Project Dates	PADs Phase I: July 1, 2023 to June 30, 2025 PADs Phase II: July 1, 2025 to June 30, 2029
Project Funding Amount	PADs Phase I: $761,672 PADs Phase II: $1,500,000
Target Populations	• Transition age youth and young adults (ages 18 to 25) • Older adults (ages 60+) • Individuals who are homeless or at risk of homelessness

In the peer-led Psychiatric Advance Directives (PADs) project, peers from the communities provided feedback to the technology subcontractor, Chorus, to finalize the PADs platform. By March 2024, two new team members were trained on the PADs platform for participant sign-ups. A specialized version of the PADs platform was developed for law enforcement and hospital staff. Additionally, the marketing subcontractor, Idea Engineering, completed the project's logo and produced new branding materials to boost outreach efforts. Phase II of the project is scheduled to begin on July 1, 2025, following requested endorsement from the Tri-City Mental Health Commission, pending approval by the Tri-City Governing Board and resulting submission to the Mental Health Services Oversight and Accountability Commission. Phase II will involve the enrollment of participants onto the PADs system, and the resulting opportunity to track number served once that data is available.

Challenges and Solutions

Community member perception of PADs was a challenge. Individuals reported discomfort with having their information made available to law enforcement or hospitals. Educating the community about the various concepts involved in PADs was crucial to reducing misconceptions about the platform. For example, it was helpful to alert community members that a PAD is to be filled out with full consent of the individual, it was also beneficial to inform community members that a PAD is not required, in addition to informing individuals about the various ways a PAD can be customized and personalized.

Diversity Equity and Inclusion

Innovation projects focus on increasing access and engagement for underserved populations by introducing and refining mental health approaches that facilitate learning. The PADs project specifically targets transition age youth (TAY). Innovation projects aim to reduce stigma, enhance accessibility, and improve the quality of mental health services, ensuring broader participation across various demographics.

Community Partners

Concepts Forward Consulting (CFC) is the lead project director, overseeing county and subcontractor activities and closely with county and oversight staff to ensure all requirements are met. Idea Engineering (IE), is a full-service marketing agency specializing in community communications and is responsible for developing branding and outreach materials, including flyers, the main PADs website, informational videos, and promotional items. Chorus serves as the technology subcontractor, developing and improving the PADs platform that allows participants to create and access their completed PADs, which will be available to law enforcement, first responders, and hospitals. Painted Brain is also involved in this project due to its alignment with peer-led initiatives. Leveraging their experience in peer advocacy, Painted Brain assists with component identification, peer facilitator curriculum development, and provides Training for the Trainer, ensuring the project's peer-led approach is effectively implemented.

Community Planning Process Project

Age Group	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Not Reported	Total Served
Projected Number to be Served FY 2024-25	N/A	18	252	90	N/A	**360**
Cost Per Person	N/A	$1,403**	$1,403**	$1,403**	N/A	**$1,403****

**The estimated projections were determined by prior participation rates for INN projects and total budget allocated to the INN plan.

Project Update

Project Dates	July 1, 2023 to June 30, 2026
Project Funding Amount	$675,000
Primary Purpose	Promote interagency and community collaboration related to mental health services, supports or outcomes

The Community Planning Process (CPP) project aims to reimagine our current community program planning process by making it more accessible, inclusive, and taking into consideration suggestions made by community members and partners regarding how to make improvements. Innovation funds in the amount of $675,000 are to be used over three years to develop a robust and effective strategic CPP and related activities, resulting in future Innovation plans that are calculated, meaningful, and effective. This includes changes to the CPP survey, peer-support contracts, marketing strategies, focus groups and more. The CPP Innovation plan was posted on August 11, 2023, for a 30-Day review period. Following the 30-day comment period, a Public Hearing was held during the Mental Health Commission meeting on September 12, 2023, and to the Governing Board on September 20, 2023, gaining approval. With Governing Board approval, the plan was submitted to the Mental Health Oversight and Accountability Commission, who approved the project to move forward.

This project partnered with Pomona Consulting Group (PCG), a student-led group from Pomona College, marking Tri-City's first collaboration with PCG. The students provided valuable insights into survey design, marketing, and strategies to engage transition age youth (TAY), aiming to improve survey effectiveness and participation. In the subsequent months, the team refined and finalized an updated version of the CPP survey. Requests for Quotes (RFQs) for marketing and peer consultant

roles were issued, and the team is currently evaluating a Peer Consultant agency for approval and posting an RFQ for marketing services on the Tri-City website. Revised CPP surveys are expected to be distributed during the fall 2024 CPP and subsequent numbers served and resulting data will be captured.

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.

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

During the FY 2023-2024 twelve of our Peer Support Specialist were awarded with $500 stipends through our partnership with SCRP and our WET program funding. Fifty-six staff members were also awarded $7,500 towards their student loans. Twelve staff members also received loan repayment funding through the loan repayment program sponsored by the Southern Counties Regional Partnership (SCRP). There are also efforts being made to allow high school students (16-17) to be able to volunteer year-round, as opposed only having this opportunity available for the Wellness Center Summer Camp. There is also a plan to launch a pilot program at Pomona Unified School District which will allow their students to volunteer during the year. WET also plans on bringing back the Working Independence Skills Helping (WISH) program for clients. WISH helps individuals 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-Learner

Service-Learners (formerly called volunteers) provide 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, and stigma reduction events such as Tri-City's Green Ribbon Week.

Wellness Center Summer Camp

The annual Wellness Center 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

This 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 health. 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. 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 2023-24, WET received feedback regarding the 'value of the experience' for service learners. Through a post survey, service learners provided feedback that provided insight into the way the program is structured, as well as how to address improvements. One solution is to provide a more structured program. This would include required Wellness Center Groups, spending time at the Therapeutic Community Garden, joining stakeholder meetings, attending Mental Health Commission meetings, and Governing Board meetings to help broaden their understanding of Tri-City and how the agency operates. Also revamping the orientation to include a slideshow presentation to cover key points about Tri-City, as well as how to conduct themselves professionally (which was feedback from the Stigma Reduction and Suicide Prevention program on interactions they had with service learners).

Diversity, Equity and Inclusion

INN 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 (i.e. cultural competency and implicit bias).

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, 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?

510	23	40
Service Learner Hours	Service Learner Applications	Trainings, Conferences and Educational Opportunities for Staff

The number of service learner hours, applications and trainings **increased** from **27, 11, and 7** in FY 2022-23 to **510, 23, and 40** in FY 2023-24.

56	12
Tri-City Loan Repayment Program Recipients	SCRP Loan Repayment Program Recipients

How Well Did We Do It?

12	1	1,189
Applicants Became Service Learners	Service Learners were Hired at Tri-City	Courses Completed through Relias Program

The number of applicants who became service learners **increased** from **1** in FY 2022-23 to **12** in FY 2023-24.

Is Anyone Better Off?

100%
Services learners (strongly agree/agree)
"This experience gave them a better understanding of working in Public Behavioral Health."

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.

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 2023-24 impacting the CFTN plan. One major project was the remodeling of the 2001 MHSA Administrative Office building. The majority of the work on this project was completed during the 2023-24 fiscal year. Additionally, the Therapeutic Garden and 2008 Parking Lot construction was largely completed in the same fiscal year as well. Lastly, upgraded network infrastructure (switches and wireless access points) were completed at the 2001 MHSA Administrative Office building, the Wellness Center, and the Claremont Administrative Office building. This upgrade provided staff at these locations with faster speeds and more resilient networks.

MHSA Expenditure Plan

The following section includes information regarding Cost Per Participant for MHSA Programs and TCMHA Staff Demographics

Cost Per Participant

The services provided in Fiscal Year 2023-24 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	98	$17,040
Full-Service Partnership (TAY)	CSS	162	$14,854
Community Navigators	CSS	127	$706**
Wellness Center	CSS	284	$1,645**
Supplemental Crisis Services	CSS	6	$1,056**
Access to Care	CSS	958	$544**
Family Wellbeing Program	Prevention and Early Intervention	254	$263**
Peer Mentor Program (TAY Wellbeing)	Prevention and Early Intervention	12	$278**
Therapeutic Community Gardening	Early Intervention	2	$6,023**
Early Psychosis	Prevention and Early Intervention	24	$5,126**
School-Based Services	Early Intervention	199	$2,716**

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	162	$14,854
Full-Service Partnership (Adult)	CSS	454	$11,670
Full-Service Partnership (Older Adult)	CSS	73	$10,927
Community Navigators	CSS	641	$706**
Wellness Center	CSS	1,466	$1,645**
Supplemental Crisis Services	CSS	64	$1,056**
Access to Care	CSS	2,364	$544**
Field Capable Clinical Services for Older Adults	CSS	52	$5,005
Family Wellbeing Program	Prevention and Early Intervention	641	$263**
Peer Mentor Program (Older Adult Wellbeing)	Prevention and Early Intervention	5	$278**
Therapeutic Community Gardening	Early Intervention	42	$6,023**

** 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 2023-24, Tri-City served approximately 2,960 unduplicated clients who were enrolled in formal services. Tri-City's Fiscal Year 2024-25 budget included a total of 251 Full-time/Equivalent employees and an annual operating budget of approximately $37.5 million dollars.

Capacity Assessment

Tri-City strives to reflect the diversity of its communities through it hiring, languages spoken, and cultural competencies. The following sections reflect TCMHA's efforts to meet the diverse needs of populations served within Pomona, Claremont and La Verne.

Mental health needs of unserved, underserved/inappropriately served, and fully served city residents who qualify for MHSA services:

Recent data were gathered to determine whether those served at Tri-City were representative of the Tri-City area. Participant/client data were compared to U.S. Census data (2021 ACS 5-Year Estimates). Demographic information includes what participants feel comfortable sharing; therefore, there are demographics that are not reported.

Overall, Tri-City is fully serving all age groups with the exception of those in the 60+ age range. With regard to race/ethnicity, services are provided to African Americans and Hispanic/Latino/a/x populations, however, Asian Pacific Islanders, Native Americans and those who identify as having more than one race appear to be underserved. More data will need to be collected to address the high percentage (63%) of those who did not report their race.

Age of Those Served by Tri-City	Percentage		Population of Tri-City Area	Percentage
0-15	16%		0-14	19%
16-25	20%		15-24	17%
26-59	48%		25-59	44%
60+	8%		60+	21%
Not Reported	9%		Not Reported	0%

Race of Those Served at Tri-City	Percentage		Population of Tri-City Area	Percentage
African American	6%		African American	6%
Asian Pacific Islander	2%		Asian Pacific Islander	12%
Native American	0%		Native American	2%
White	9%		White	42%
Another Race	18%		Another Race	26%
Two or More Races	2%		Two or More Races	13%
Not Reported	63%		Not Reported	0%

Ethnicity of Those Served by Tri-City	Percentage		Population of Tri-City Area	Percentage
Hispanic/Latino/a/x	56%		Hispanic/Latino/a/x	59%
Another Ethnicity	30%		Another Ethnicity	41%
Not Reported	14%		Not Reported	0%

Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served:

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	20%	White	15.6%
Hispanic/Latinx	54%	Hispanic/Latinx	61.4%
Asian/Pacific Islander	3%	Asian	10.7%
Black/African American	13%	Black/African American	7.3%
Native American/Alaska Native	0.5%	Native American/Alaska Native	0.5%
Other	3%	Other	2.4%
Two Or More Races	4%	Two Or More Races	1.9%

(Total may not add up to 100 percent, as individuals may select multiple races/ethnicities). Source: U.S. Census data from 2023 DEC Redistricting Data

Assessment of bilingual proficiency in threshold languages:

Bilingual proficiency was assessed by gathering data on the languages spoken by staff. Additionally, Tri-City also provides access to language interpretation services

Approximately 52% of the Tri-City workforce is bilingual. Approximately 46% of the Tri-City workforce is qualified to provide bilingual interpretation services in the threshold language, Spanish. These percentages reflect a significant increase from the previous fiscal year 2022-23.

Number of Staff Certified/Qualified for Bilingual Interpretation		
Language	**# Bilingual**	**% Bilingual**
Spanish (Threshold Language)	96	46.82%
Vietnamese	3	1.46%
French	2	0.97%
Khmer	0	0%
Persian	1	0.48%
Punjabi	1	0.48%
Russian	0	0%
Mandarin & Chinese	0	0%
Hindi	1	0.48%
Japanese	1	0.48%
Tagalog	2	0.97%
Total Bilingual	**107**	**52.14%**

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

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 and 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 a 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.

The strengths and limitations of the city and service providers that impact their ability to meet the needs of racially and ethnically diverse populations:

Service providers are representative of the Tri-City cities for Hispanic/Latino/a/x, Asian Americans, and Black/African Americans. Staff are less represented for Native American/Alaska Natives, Whites, and those who are two or more races.

Possible barriers to implementing the proposed programs/services and methods of addressing these barriers:

Lack of awareness can be a barrier to individuals accessing our programs and utilizing the services. Despite increased outreach and engagement in the community, there is feedback provided indicating individuals in the community do not know what Tri-City is or what the organization does. In an effort to increase awareness Tri-City continues to implement smaller community forums for schools, school district meetings, organizations, faith-based establishments, government agencies, community groups and more. This is increasing the awareness in the community as well as growing our stakeholder list, which is used to inform community members of Tri-City events, stakeholder meetings and public hearings for example.

An additional barrier is stigma. Even in a situation where an individual is aware of Tri-City and its services, there may be resistance, shame or hesitation to reach out for support due to the negative beliefs associated with mental health treatment, support, or illness. Tri-City addresses this directly through many community efforts and engagements. One in particular is the Stigma Reduction and Suicide Prevention program. The program offers free presentations, for the community to raise mental health awareness and inspire conversation. By sharing information and increasing understanding of mental illness and recovery, community members begin to see how stigma is a barrier and can be addressed appropriately so individuals can get their needs met. These conversations have been provided formally, in school settings and for community partner organizations; while also being offered in more casual settings, such as at local tea, boba, and coffee shops.

Continuing efforts to increase awareness and decrease stigma will be a large component that contributes to community members knowing where they can turn when they need additional support and the ability to follow through with reaching out to that support when they need to.

FY 2025/26 Mental Health Services Act Annual Update
Funding Summary

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	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 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	24,523,448	4,078,128	3,670,798	548,773	5,881,190	
2. Estimated New FY 2025/26 Funding	11,518,521	2,879,630	757,797			
3. Transfer in FY 2025/26 [a/]	(3,000,000)	0	0	1,500,000	1,500,000	0
4. Access Local Prudent Reserve in FY 2025/26	0	0				0
5. Estimated Available Funding for FY 2025/26	33,041,969	6,957,758	4,428,595	2,048,773	7,381,190	
B. Estimated FY 2025/26 MHSA Expenditures	15,624,618	3,636,618	1,021,033	456,602	700,000	
G. Estimated FY 2025/26 Unspent Fund Balance	17,417,351	3,321,140	3,407,562	1,592,171	6,681,190	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	2,199,999
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	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.

FY 2025/26 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,874,346	529,145	891,433		453,768	
2. 1b-TAY FSP	1,990,501	336,940	1,257,838		395,723	
3. 1c-Adult FSP	3,594,449	1,200,424	2,295,700		98,325	
4. 1d-Older Adult FSP	611,898	273,143	328,952		9,803	
5.						
Non-FSP Programs						
1. Community Navigators	757,451	757,451				
2. Wellness Center	1,476,861	1,476,861				
3. Field Capable Clinical Services for Older Adults	175,167	11,176	159,129		4,862.00	
4. Permanent Supportive Housing	608,971	603,971				5,000
5. Access To Care	1,520,051	251,088	1,100,514		168,449	
6. Mobile Crisis Care (MCC) Pilot Program Expanding Temporary Supportive Housing	950,757	950,757				
7. Options for Tri-City Clients	5,200,000	5,200,000				
CSS Administration	4,033,662	4,033,662				
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	22,794,114	15,624,618	6,033,566	0	1,130,930	5,000
FSP Programs as Percent of Total	51.7%					

FY 2025/26 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Family Wellbeing	136,400	136,400				
2. Older Adult Wellbeing (Peer Mentor)	91,557	91,557				
3. Transition-Age Youth Wellbeing (Peer Mentor)	104,141	104,141				
4. Community Capacity Building (Community Wellbeing, Stigma Reduction and Suicide Prevention, and Community Mental Health Training)	549,071	549,071				
5. NAMI Community Capacity Building Program (Ending the Silence)	16,500	16,500				
6. Housing Stability Program	211,370	211,370				
PEI Programs - Early Intervention						
7. Older Adult Wellbeing (Peer Mentor)	91,557	91,557				
8. Transition-Age Youth Wellbeing (Peer Mentor)	104,141	104,141				
9. Therapeutic Community Gardening	469,827	469,827				
10. Early Psychosis	276,780	276,780				
11. School Based	784,940	784,940				
PEI Programs - Other						
12.	0	0				
13.	0	0				
14.	0	0				
PEI Administration	768,335	768,335				
PEI Assigned Funds	32,000	32,000				
Total PEI Program Estimated Expenditures	3,604,618	3,636,618	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Psychiatric Advance Directive (PADs) Multi-County Collaborative	375,000	375,000				
2. Community Planning Process for Innovation Project (s)	505,000	505,000				
INN Administration	141,033	141,033				
Total INN Program Estimated Expenditures	1,021,033	1,021,033	0	0	0	0

FY 2025/26 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. A Systematic Approach to Learning and Improvement	296,139	296,139				
2. Engaging Volunteers and Future Employees	34,412	34,412				
WET Administration	126,051	126,051				
Total WET Program Estimated Expenditures	456,602	456,602	-	-	-	-

FY 2025/26 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 3/7/2025

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Technological Needs Projects						
4. Technology Upgrades	700,000	700,000				
5.	0	0				
6.	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	700,000	700,000	0	0	0	0

Appendix