

# FY 2023-2024 Performance Outcomes Report

## Kern County MHSA Community Services & Supports



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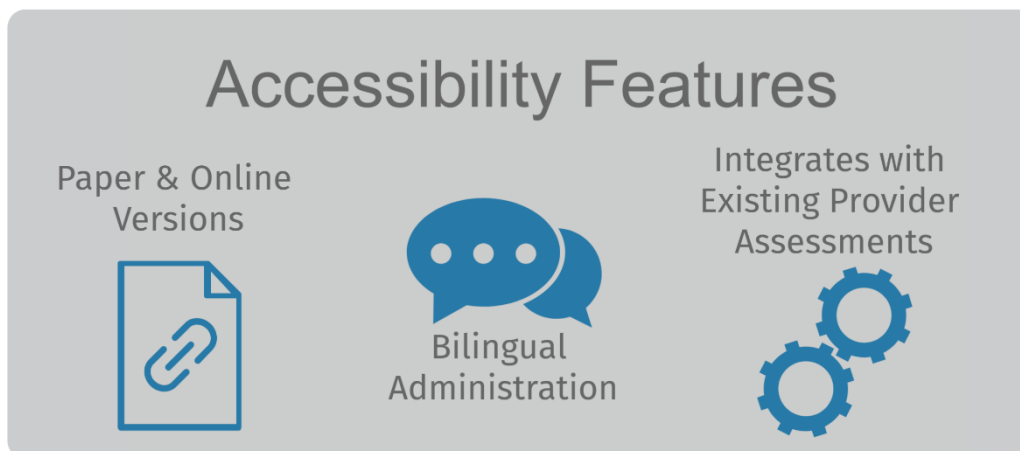
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# METHODOLOGY

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## Evaluation Design

To enhance compliance with Mental Health Services Act (MHSA) reporting regulations, Kern Behavioral Health Services (KernBHRS) contracted with EVALCORP to streamline current data collection structures and develop standardized data collection tools that are in alignment with reporting requirements. A standardized Community Services and Supports (CSS) outcome survey was developed for adults, which includes consumer satisfaction, demographics, and results of generalized measure of psychological distress (SOS-10). This survey is implemented at intake and exit, within the normal timeline for each program. To ensure greater inclusivity and maximum reach, surveys were made available in both online and paper forms as well as in English and Spanish. An overview of data reporting requirements for CSS programs is provided in Appendix A of this report.



## Presentation of Results

Findings are presented (1) in aggregate, across all CSS programs; and (2) by each of the CSS programs required to collect outcome data.

Findings for each program are presented differently depending on how many participants responded to each part of the survey. Sections of surveys for which there were more than 30 responses are shown as percentages. Sections with fewer than 30 responses are shown as counts. Modules with fewer than 10 responses are suppressed to protect the identity of participants. Note that percentages in the report may not always add up to 100% due to rounding.

## Measures

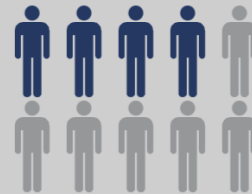
**SOS-10:** The SOS-10 is an evidence-based measure of psychological well-being with 10 items that are rated on a seven-point scale, ranging from 1 (*Never*) to 7 (*All the time or nearly all the time*). The SOS-10 is written to be comparable across many program types that provide psychological and behavioral interventions. It produces scores that can be grouped into four distinct categories of mental health needs: none, mild, moderate, severe. The SOS-10 is sensitive enough to detect early changes in mental health due to treatment. A Spanish translation of the scale is available and has been validated for migrant populations. The SOS-10 has excellent measurement properties (see Blais et al., 1999; Hilsenroth, Ackerman, & Blagys, 2001; Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003).

# CSS: PERFORMANCE OUTCOMES COLLECTION OVERVIEW



As a result of participating  
in a Kern CSS program

**6 in 10**



people moved to a less  
severe level of  
psychological distress.

When asked whether  
they will use what they  
have learned in  
Kern CSS programs,  
**98%** say that  
they will.



When asked if they  
would recommend  
this program to  
others...

**66%**

Strongly agreed

**32%**

Agreed

**2%**

Disagree or  
strongly disagreed

# COMBINED CSS PROGRAM FINDINGS

## Outcome Surveys Collected by Survey Type

Survey results across all CSS programs are reported together in this section of the report (n = 3,438). Among the programs that implemented a pre/post survey design, a total of 1,556 participants completed the intake survey and 457 participants completed the exit survey - a completion rate of 29%. Participants could choose whether to take the survey in English or Spanish. Across all 3,438 surveys, 3,275 were completed in English and 163 were completed in Spanish. All survey responders were 18 years old or older.

	Kern MHA CSS Program Name	Program Category	FY21-22 Outcomes Data	
			Pre	Post
1	Access & Assessment Team and Crisis Walk-In Clinic (CWIC)	Systems Development	-	1,425*
2	Adult Wraparound Core	Systems Development	71	59
3	Recovery and Wellness Centers (RAWC)	Systems Development	1,485	398
	<b>Total</b>		<b>1,556</b>	<b>1,882</b>

\*Access & Assessment Team and Crisis Walk-In Clinic (CWIC) participants were only administered a survey at one time point.

In the program-specific sections, matched pre/post results are only included for a subset of the Adult Wraparound Core clients (n = 14) and RAWC clients (n = 172) for which a valid pre/post match could be verified.

Seven programs are included in this report but did not collect survey data from clients: Assertive Community Treatment; Adult Wraparound; Adult Transition Team; Transition Age Youth; Wellness, Independence, and Senior Enrichment; Youth Multi-Agency Integrated Services Team; Youth Wraparound. For these programs, other sources of data are used.

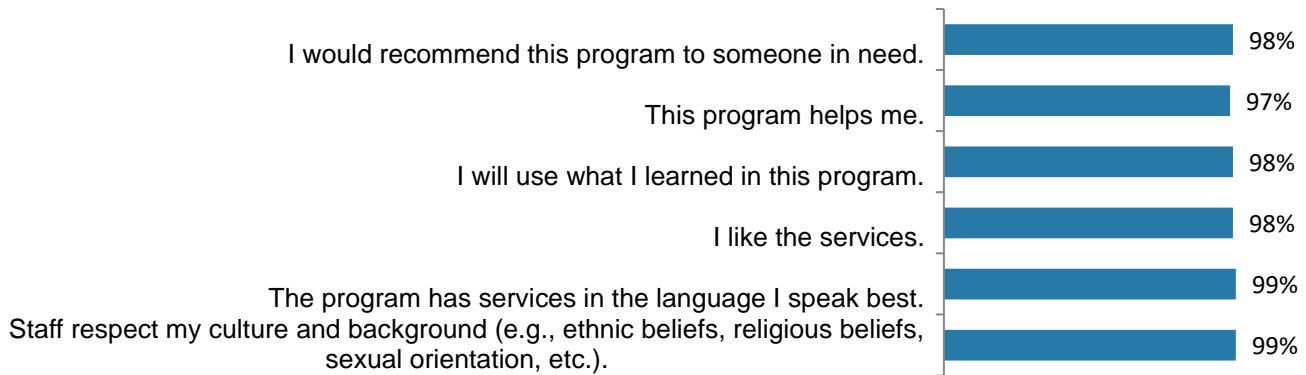
Finally, some CSS programs do not report any data in the Annual Report. The Consumer Family Learning Center (CFLC) program is a resource for community members, no treatment is provided at the CFLC and due to the nature of this program data is not included. Home to Stay and Self-Empowerment Team are auxiliary programs that support Full Service Partnership (FSP) programs.

# COMBINED CSS PROGRAM FINDINGS

## Overall: Self-Report Survey Outcomes

### Program Satisfaction and Cultural Competence (n = 437 - 440)

#### Percent who Agree



### Mental Health Needs Group and Score (n = 186)

SOS-10 Stress and Dysfunction Level	Intake	Follow Up
Minimal (59-40)	14%	43%
Mild (39-33)	9%	16%
Moderate (32-23)	25%	27%
Severe (22-1)	52%	14%
Average SOS-10 Score	27.2 (n = 1,485)	36.6 (n = 411)



**61% of respondents moved from a more severe level of distress to a less severe level of distress by at least one level.**



**34% of respondents moved two levels from a more severe level of distress to a less severe level of distress.**

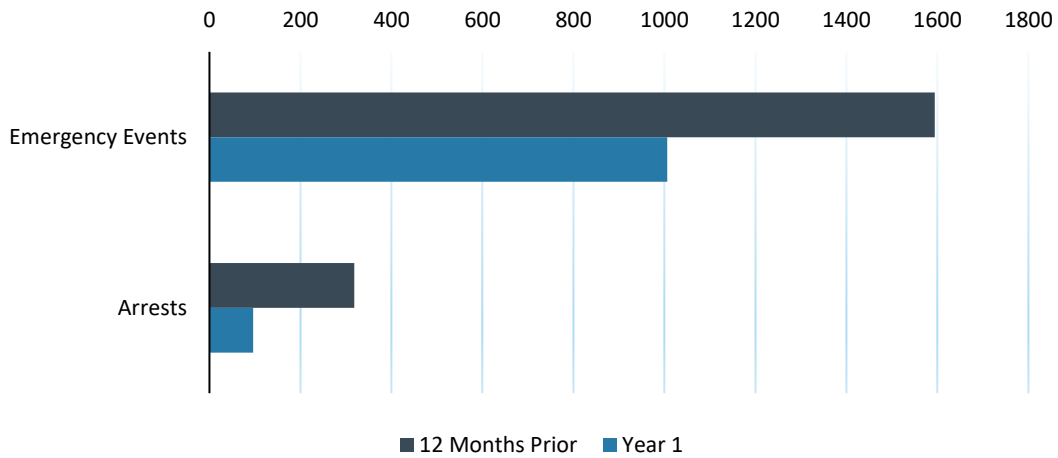


**17% of respondents with a severe level of distress at intake continued the treatment to its conclusion.**

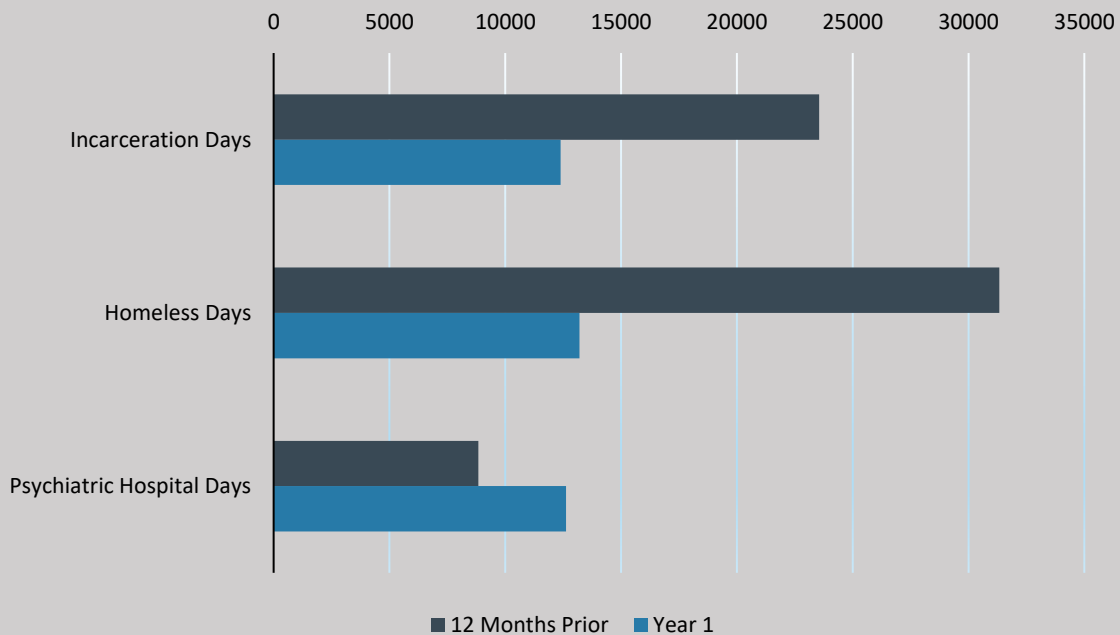
# COMBINED CSS PROGRAM FINDINGS

The number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in Full Service Partnerships. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

## Total Number of Emergency Events and Arrests (n = 957)



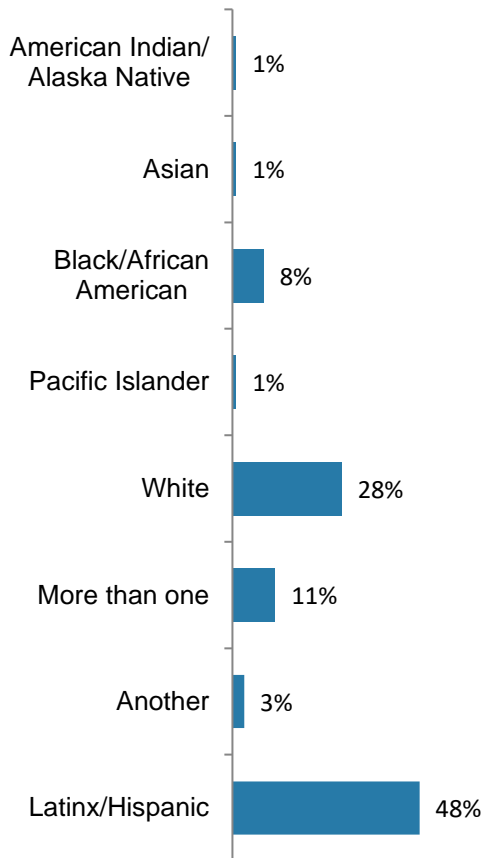
## Total Incarceration, Homeless, and Hospital Days (n = 970)



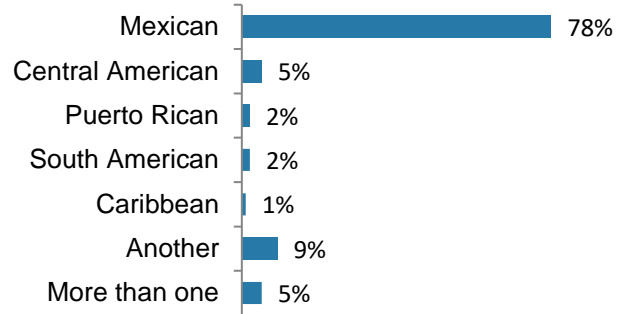
# COMBINED CSS PROGRAM FINDINGS

## Demographics

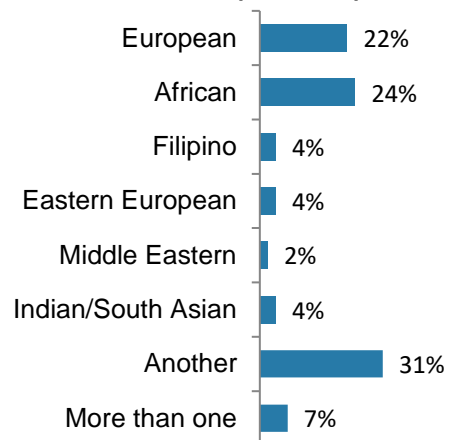
**Race (n = 2,778)**



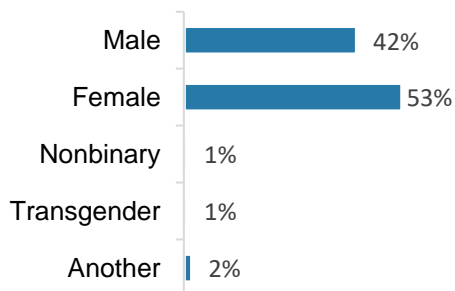
**Ethnicity – Hispanic/Latinx (n = 1,573)**



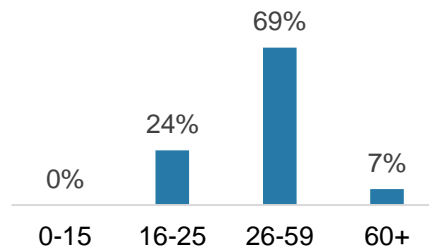
**Ethnicity – Non-Hispanic/Latinx (n = 657)**



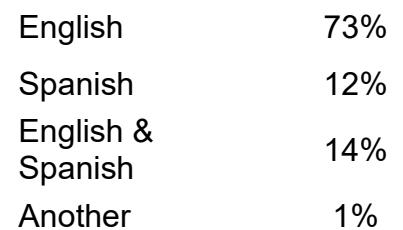
**Gender Identity (n = 2,805)**



**Age (n = 2,411)**



**Language (n = 2,814)**



# ACCESS & ASSESSMENT TEAM AND CRISIS WALK-IN CLINIC

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## Program Description

**Access & Assessment (A&A):** Access and Assessment serves as an access point for individuals seeking linkage to behavioral health services. Clients begin the process by completing a screening on a walk-in basis. Clients may be self-referred or referred by community agencies such as, but not limited to, Child Protective Services, Kern County Public Health, and Kern County Probation. During screenings, clients will meet with a Recovery Specialist to complete a Medi-Cal Screening tool. After the initial screening, clients will meet with a Behavioral Health Therapist to review their mental health history (if applicable), current symptoms, and collateral information provided by third-party supports, including family members and friends. Once the assessment process is complete, clients are linked to the appropriate providers based on their needs.

**Crisis Walk-In Clinic (CWIC):** The Crisis Walk-In Clinic (CWIC) is a client-centered, recovery-oriented behavioral health program serving clients in crisis who require enhanced support to remain in the community but do not require involuntary treatment. The CWIC provides 24/7/365 voluntary crisis care to adults at risk of psychiatric hospitalization and aims to maintain placement in the least restrictive environment that is safely possible.

Referrals to CWIC are accepted from System of Care partners including:

- The Psychiatric Evaluation Center (PEC)
- System of Care outpatient providers (contracted and internal)
- Kern Medical
- The Mobile Evaluation Team (MET)
- Freise Hope House (FHH)
- The Recovery Station

## Updates

- Access and Assessment (A&A) has begun to utilize the Mental Health Non-Psychiatric Timeliness Record to measure the duration between initial request for services to first offered and follow up appointments.
- The Crisis Walk-In Clinic (CWIC) continues to incorporate programmatic and treatment elements to provide exceptional crisis de-escalation services to clients. The team has focused on enhancing collaborations, leading to increased opportunities for client referrals, which are evident in partnerships with various community organizations, including Kern Medical and the Telecare Recovery Station.

# ACCESS & ASSESSMENT TEAM AND CRISIS WALK-IN CLINIC

## Self-Report Survey Outcomes



**Respondents aged 16-25 were more likely to report a severe level of distress (47%) than other age groups.**

**White respondents were more likely to report a severe level of distress (52%) than Latino or Black respondents.**

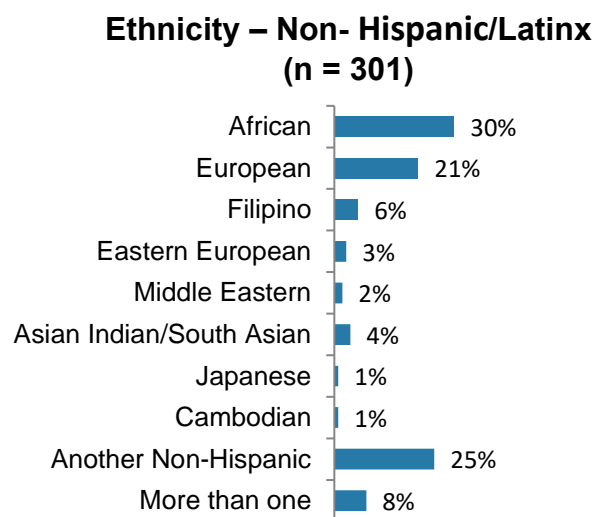
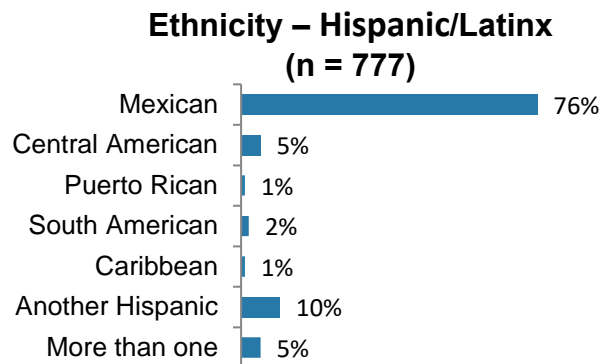
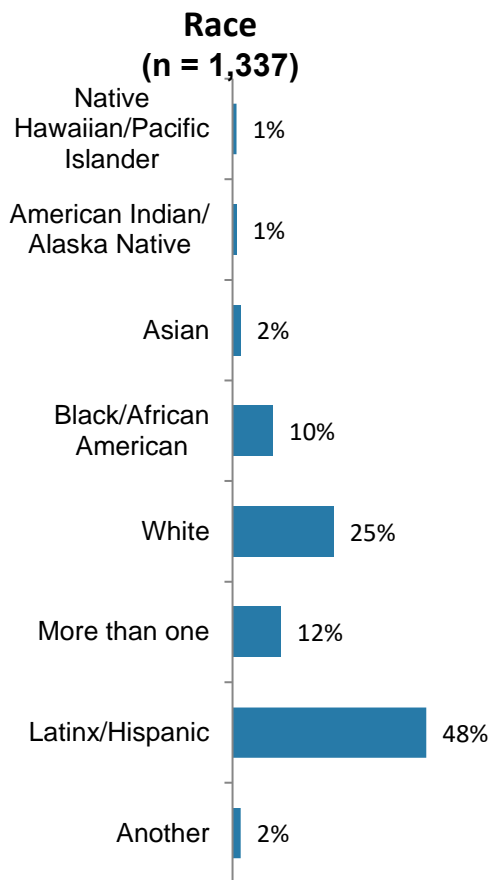
**Respondents who identify as a gender other than male or female were more likely to report a severe level of distress (65%).**

### Mental Health Needs Group and Score (n = 1,317)

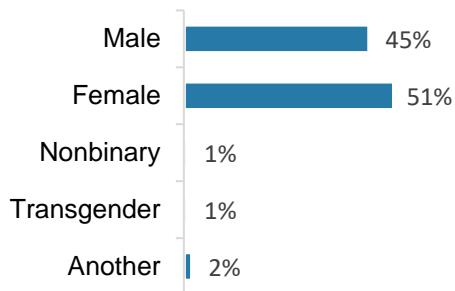
SOS-10 Stress and Dysfunction Level	Intake
Minimal (59-40)	21%
Mild (39-33)	12%
Moderate (32-23)	24%
Severe (22-1)	43%
Average SOS-10 Score	26.6

# ACCESS & ASSESSMENT TEAM AND CRISIS WALK-IN CLINIC

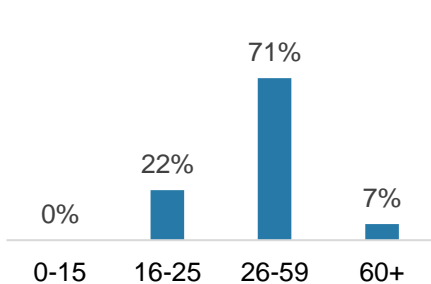
## Partner Demographics



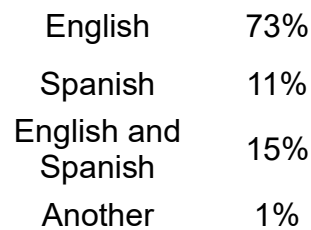
**Gender Identity (n = 1,355)**



**Age (n = 1,034)**



**Language (n = 1,356)**



# ASSERTIVE COMMUNITY TREATMENT (ACT)

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## Program Description

The Assertive Community Treatment (ACT) Full-Service Partnership teams provide specialty mental health care to those with severe and persistent mental illness and/or substance use disorders. The internal KernBHRS ACT team works solely with ACT individuals, while the Telecare FSP team serves both ACT and AB109 individuals. ACT is an evidence-based model characterized as a “hospital without walls.” ACT works intensively with individuals in their homes or other community settings, yielding positive outcomes in helping clients recover in the community rather than in institutional settings.

The ACT Team composition is as follows:

- Recovery Specialists and Aides
- Therapists
- Substance Abuse Specialist
- Mental Health Nurses
- Psychiatrists

Clients are referred to the ACT teams by mental health outpatient treatment teams when more intensive care is necessary. The KernBHRS ACT Supervisor or clinician reviews the referrals, and those that meet the criteria for level 4 AB109 individuals are transferred to the Telecare team. Those served by the ACT teams have lengthy histories of mental health and/or substance use treatment. By the nature of the program, Recovery Specialists and Substance Abuse Specialists may meet with clients several times per week to maintain engagement in treatment and progress toward goals. Individualized care is provided by the Therapists and Psychiatrists. Ongoing consultation takes place with the Staff Nurse for medication management and health education. For physical health care, clients are linked to a primary care provider with whom staff coordinate services. ACT team members may take clients to medical appointments as needed.

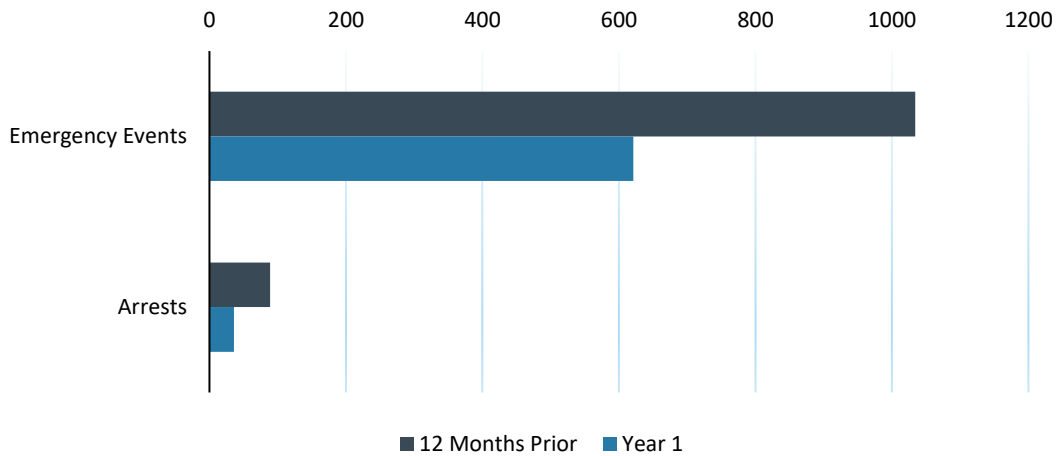
## Updates

- Currently, ACT has 86 clients open to the program; when the ACT team is fully staffed, the program can support up to 100 clients.
- ACT discontinued services with MHS Action and now has a contract with Telecare to assist ACT clients.
- Telecare has a total of 95 clients open to the program.

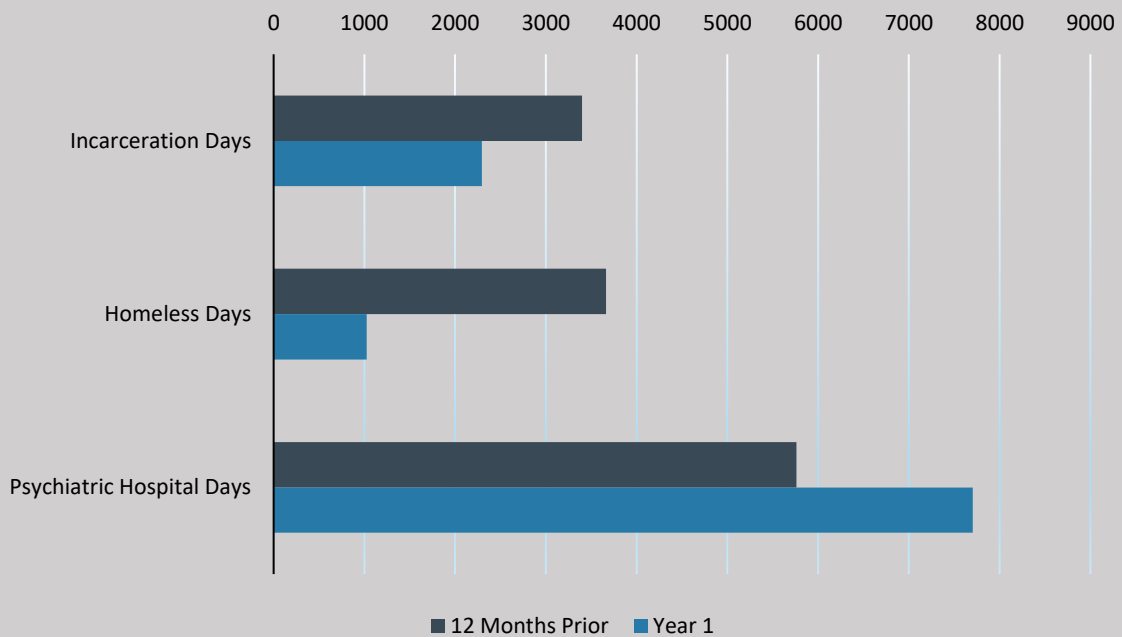
# ASSERTIVE COMMUNITY TREATMENT (ACT)

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in ACT. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 290)



### Total Incarceration, Homeless, and Hospital Days (n = 291)



# ADULT WRAPAROUND

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## Program Description

Adult Wraparound (Adult WRAP) is a Full-Service Partnership offering brief (60 days average) intensified mental health service for adults who are experiencing increased impairments to their life functions because of heightened mental health symptomology. Adult Wraparound staff (Therapist and Recovery Specialist) work in tandem with all internal outpatient treatment teams and contract providers (CGC, CCS, and CSV) to identify clients who are at risk of hospitalization or frequent use of crisis services. They regularly attend team meetings to discuss potential referrals for Adult Wraparound services. The staff collaborates closely with the treatment team to ensure continuity of care and works towards stabilizing the clients' symptoms.

This program offers socialization opportunities, such as ice cream outings, planned activities at local museums and zoos, to promote community engagement and social-skill building. It also reduces the financial impact of hospitalization, arrests, and incarcerations on the community. The team encourages linkage to various community programs, including CFLC, community group therapy, Narcotics Anonymous, and Alcoholics Anonymous.

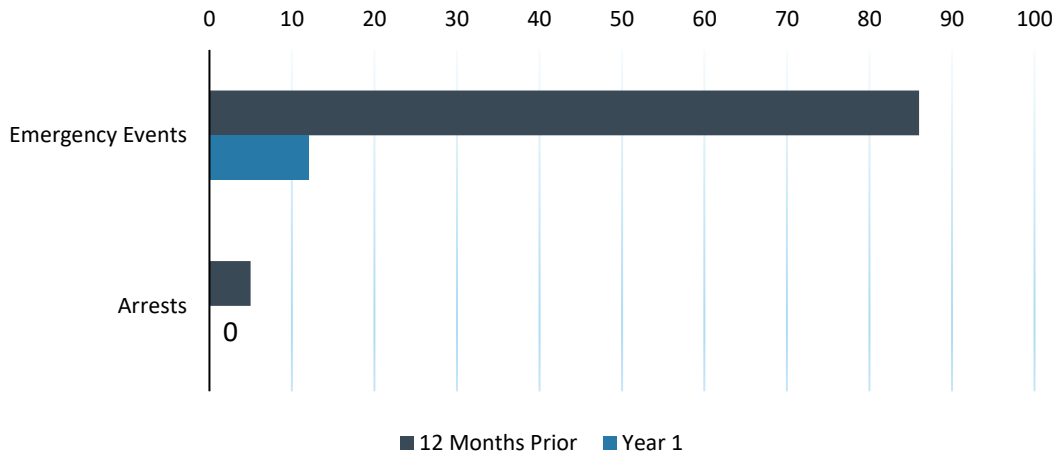
## Updates

- Adult Wraparound continues to accommodate new employees
- Staff branched out to have a Bakersfield Referral Team (BRT) to engage with clients, who require outreach engagement due to high crisis utilization yet are not open to the system.
- Staff continue to assist with the expedition of access to care by completing psychosocial assessments in-house and linking them to appropriate outpatient teams for ongoing care.

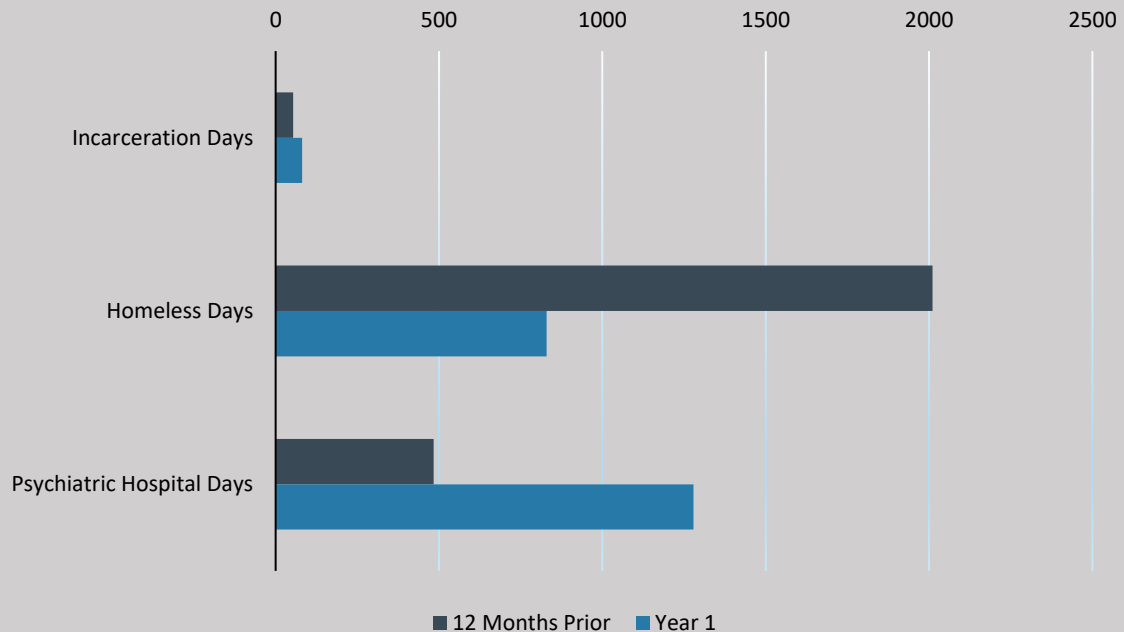
# ADULT WRAPAROUND

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all participants in Adult Wraparound. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

## Total Number of Emergency Events and Arrests (n = 31)



## Total Incarceration, Homeless, and Hospital Days (n = 34)



# ADULT WRAPAROUND CORE

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## Program Description

Adult Wellness and Recovery Action Plan Core (Adult WRAP CORE) is a system development program which offers brief (60-day average) intensive behavioral health services for adults experiencing significant impairment in life functioning due to increased behavioral health symptomology. The client's primary outpatient treatment team refers them when they are at risk of hospitalization and/or frequently utilizing crisis services. Adult WRAP staff are assigned to various outpatient adult treatment teams to provide quick access to intensified services.

Services are based on the needs of the client, which can include multiple interactions per week to daily intervention. Treatment planning is a collaborative process taking an interdisciplinary approach. This approach can include the client, therapist, case manager, support persons, substance use disorder specialist, team supervisor, nurse, psychiatrist, and Adult WRAP staff.

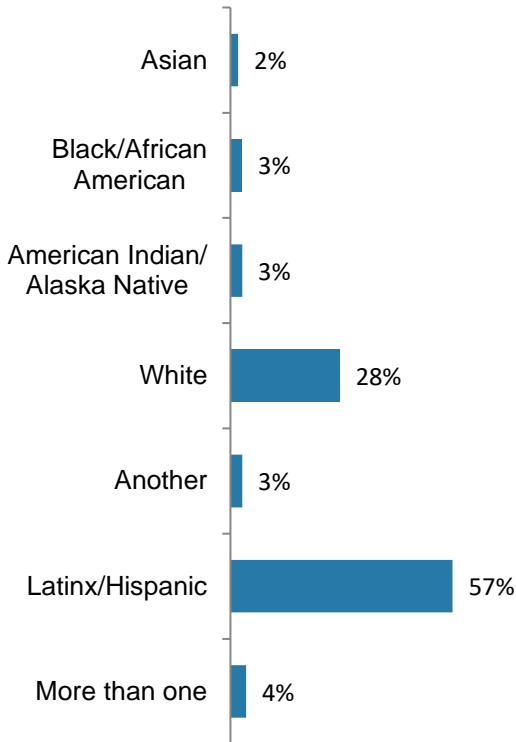
## Updates

- No program updates to report

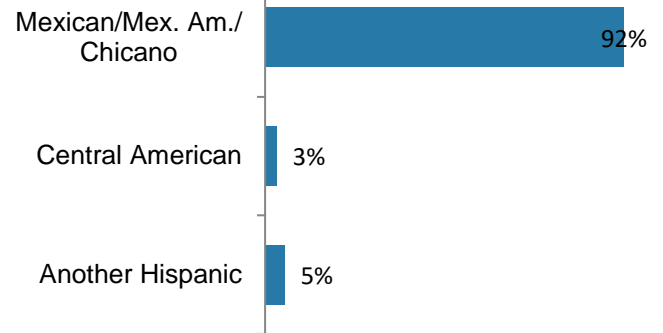
# ADULT WRAPAROUND CORE

## Partner Demographics

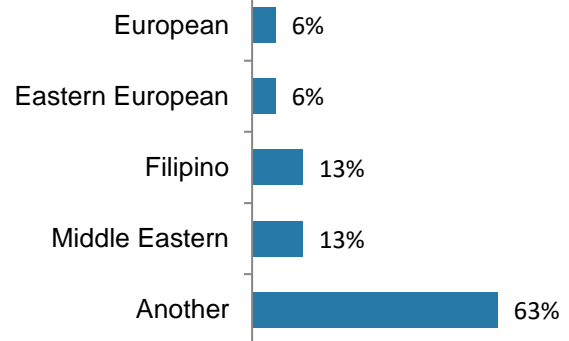
**Race (n = 68)**



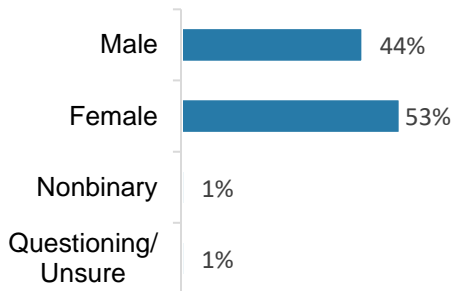
**Ethnicity – Hispanic/Latinx (n = 39)**



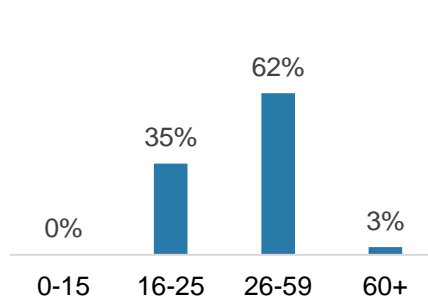
**Ethnicity – Non- Hispanic/Latinx (n = 16)**



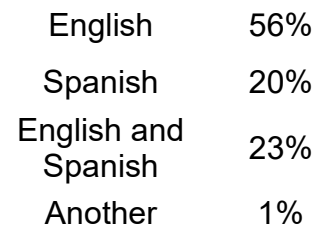
**Gender Identity (n = 70)**



**Age (n = 63)**



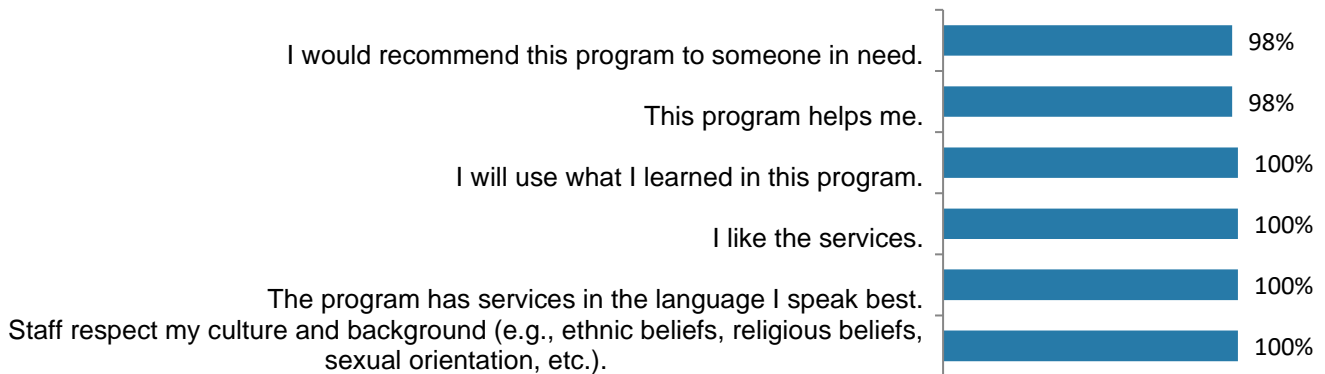
**Language (n = 70)**



# ADULT WRAPAROUND CORE

## Self-Report Survey Outcomes

### Program Satisfaction and Cultural Competency Percent of Participants Who Agree (n = 58 - 59)



### Mental Health Needs Group and Score (n = 14)

SOS-10 Stress and Dysfunction Level	Intake	Follow Up
Minimal (59-40)	14%	57%
Mild (39-33)	21%	21%
Moderate (32-23)	36%	21%
Severe (22-1)	29%	0%
Average SOS-10 Score	32 (n=67)	40 (n=57)



**64% of respondents moved at least one level from a more severe level of distress to a less severe level of distress.**



**29% of respondents moved two levels from a more severe level of distress to a less severe level of distress.**



**22% of respondents with a severe level of distress at intake continued the treatment to its conclusion.**

# ADULT TRANSITION TEAM/HOMELESS ADULT TEAM

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## Program Description

**Adult Transition Team (ATT):** ATT focuses on the reduction and elimination of re-entry into jail or prison while providing specialty mental health treatment for severe and persistent mental illness. Referrals come from many sources, including in-jail assessments, hospitals, or walk-in self-referrals. ATT provides court-ordered diversion services to individuals referred through their attorneys to complete mental health treatment in lieu of jail or prison time. ATT partners with Correctional Behavioral Health staff to link clients to other diversion services. Additionally, ATT outreaches to the adult system of care and contract providers to provide diversion training to support the establishment of diversion services.

**The Homeless Adult Team (HAT):** HAT is a program expansion of ATT. HAT works with clients who are homeless or at risk of becoming homeless, and who also require specialty mental health treatment. HAT clients do not traditionally have lengthy legal histories. Much like its counterpart, ATT, HAT works diligently to eliminate the barriers to housing, benefits, and community resources. HAT collaborates with public agencies and community organizations who work with the homeless. These include Flood Ministries, Veterans Administration, payee service providers, legal assistance programs, sober living environments, and additional agencies providing affordable housing. Based on the needs of the client served KernBHRS offers a variety of service modalities designated to assist the individual in achieving goals related to psychological or social functioning, self-esteem, coping abilities, and external vocational, educational, or social opportunities. The Individual Placement Support Program assists with employment, job development, and education. A Peer Support Specialist is available to assist with client engagement, referrals, and accessing services. Through collaboration with the California Department of Rehabilitation (DOR), individual therapy services, case management, and substance abuse counseling are provided.

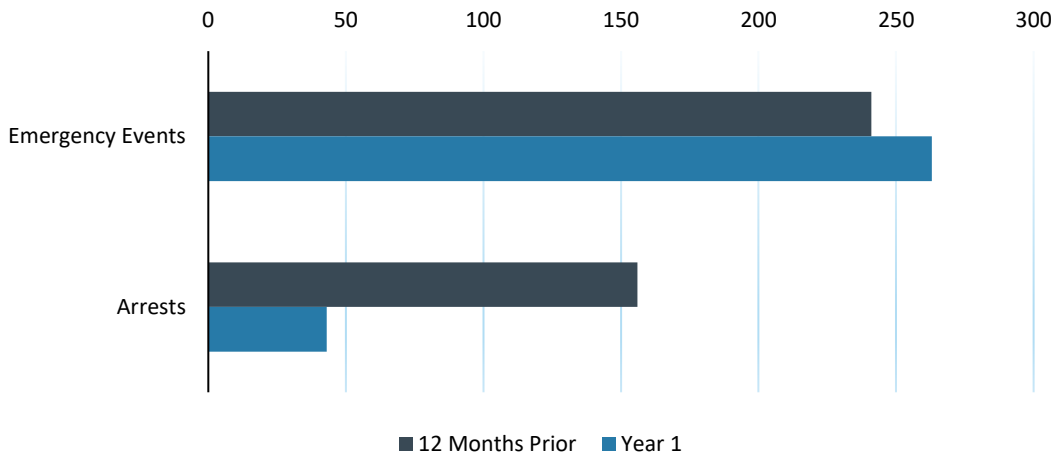
## Updates

- **ATT**
  - ATT team has worked to provide more diverse services to clients, including expanding group services. The team is now offering at least two groups per day and has added several new evidence-based groups, as well as groups aimed at providing opportunities for community engagement and independence.
  - ATT has continued to refine diversion services, enabling staff to refer clients who do not meet ATT or FSP criteria to more appropriate diversion programs.
  - ATT staff has focused on growing their IPS program, assisting individuals in finding employment or educational opportunities in the community despite their history of incarceration. Currently, 50% of the IPS caseload is employed or attending school.
- **HAT**
  - HAT has worked collaboratively with the START team to target individuals identified by the shelters as needing both mental health and substance use services.
  - HAT has expanded its homeless outreach to include Hope on Hart.

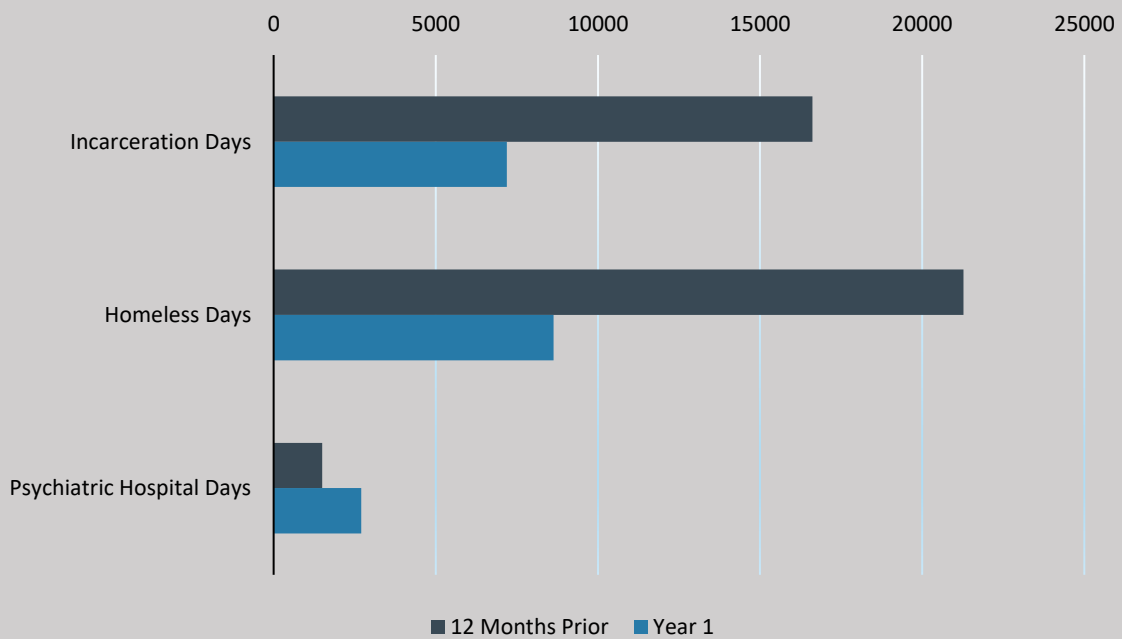
# Adult Transition Team/Homeless Adult Team

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in ATT/HAT. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 193)



### Total Incarceration, Homeless, and Hospital Days (n = 196)



# RECOVERY AND WELLNESS CENTERS (RAWC)

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## Program Description

Recovery and Wellness Centers (RAWC) provide multi-level mental health and substance use treatment services to individuals experiencing challenges in life functioning as the result of mental illness and/or substance use. Treatment is clinically driven based on the client's symptoms. Treatment teams are geographically located throughout the greater Bakersfield area, as well as Wasco. RAWC teams traditionally provide care to those who have either stepped down from intensified services from specialty care programs or inpatient treatment. RAWC staff work in a dyad system comprised of a therapist and a case manager. This dyad takes a client-centered approach with the goal of creating continuity and consistency in treatment thereby improving the delivery of services and providing options to those served. The assigned therapist/clinician assesses acuity and treatment needs using Clinical Practice Guidelines at least once every three months. Changes to service type, duration, and intensity are made accordingly.

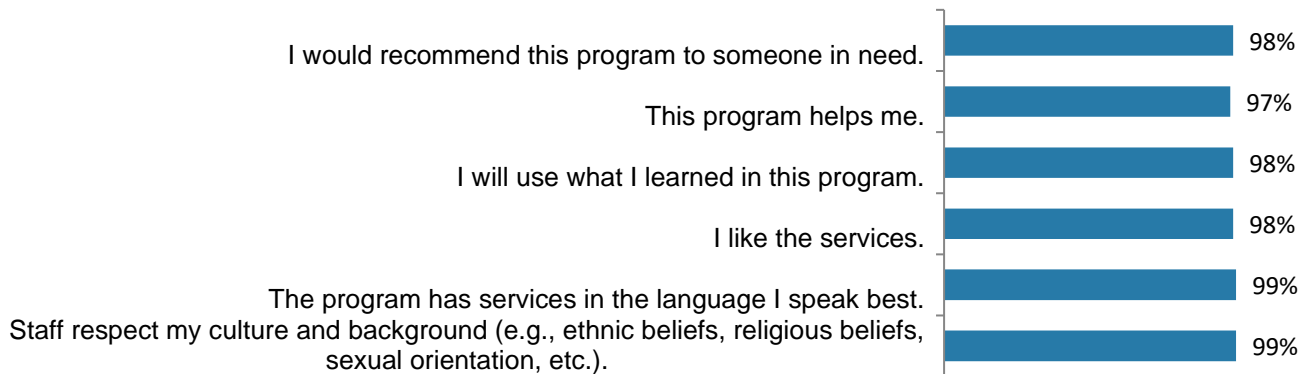
## Updates

- Transition Age Youth (TAY) dyads, designed to serve clients ages 18-24, exist at the BHRS Northeast and Southeast Bakersfield, CGC North Bakersfield, and Clarvida Central Bakersfield RAWC clinics. In December 2023, a TAY dyad was implemented at the West RAWC clinic.

# RECOVERY AND WELLNESS CENTERS (RAWC)

## Self-Report Survey Outcomes

### Program Satisfaction and Cultural Competency Percent of Participants Who Agree (n = 378 - 381)



### Mental Health Needs Group and Score (n = 172)

SOS-10 Stress and Dysfunction Level	Intake	Follow Up
Minimal (59-40)	14%	42%
Mild (39-33)	8%	16%
Moderate (32-23)	24%	27%
Severe (22-1)	54%	15%
Average SOS-10 Score	27 (n = 1,418)	36 (n = 354)



**60% of respondents moved from a more severe level of distress to a less severe level of distress by at least one level.**



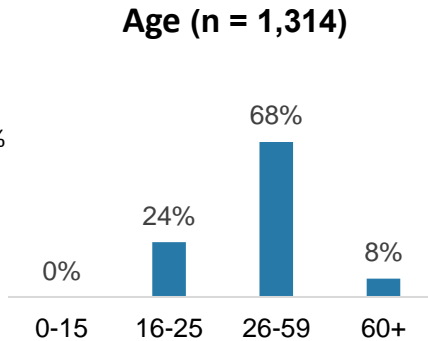
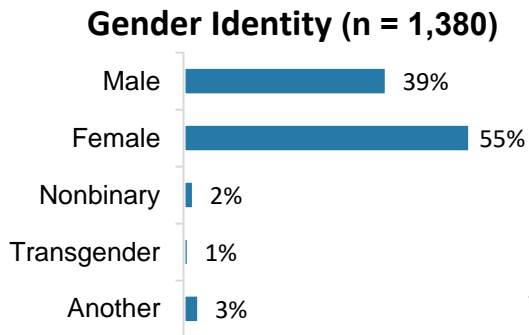
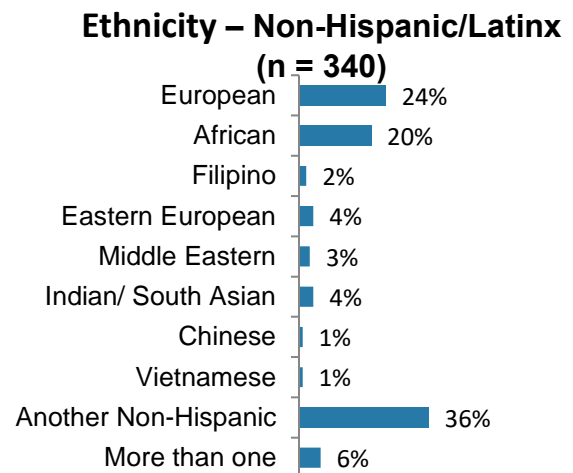
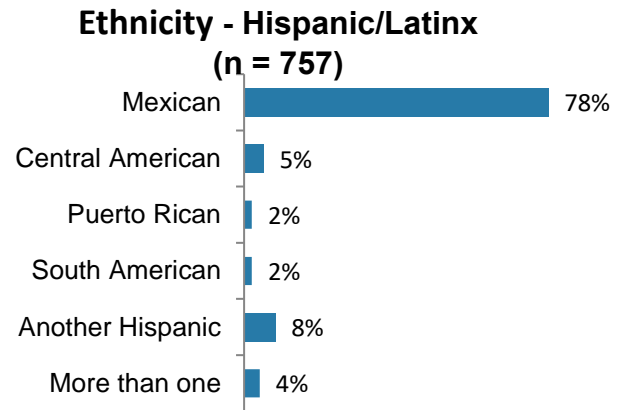
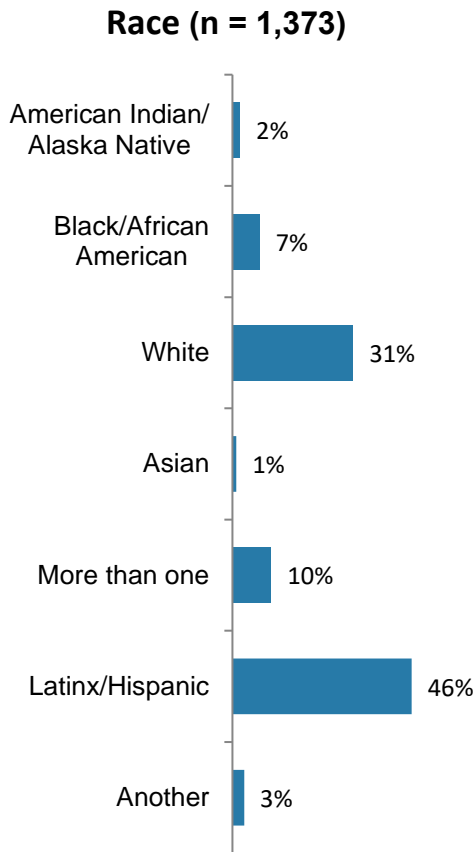
**35% of respondents moved two levels from a more severe level of distress to a less severe level of distress.**



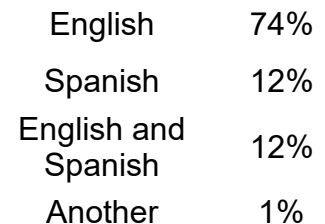
**16% of respondents with a severe level of distress at intake continued the treatment to its conclusion.**

# RECOVERY AND WELLNESS CENTERS (RAWC)

## Partner Demographics



**Language (n = 1,388)**



# TRANSITION AGE YOUTH (TAY)

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## Program Description

The Transition Age Youth (TAY) team is a full-service partnership (FSP) serving young adults ages 16-25, providing services for those struggling with mental health and substance use. It is the only team serving this age-specific population in Kern County. TAY youth may be identified for the program when they move from the Children's System of Care, self-refer, or are referred by the Department of Human Services (DHS), Probation Department, KernBHRS Access and Assessment Center, group homes, schools, hospitals, or contract providers. The team also collaborates with the Kern County Network for Children, Department of Human Services, Kern High School District, and Probation (Dream Center). The Dream Center was designed to create a positive place for foster youth and transitional foster youth to be while providing access to resources.

The TAY team supports the community by working with the Golden Empire Affordable Housing, Inc. and the Housing Authority of Kern to provide 20 one-bedroom subsidized rental units for TAY youth between the ages of 18 – 25 who struggle with mental health and substance use or are at risk of homelessness.

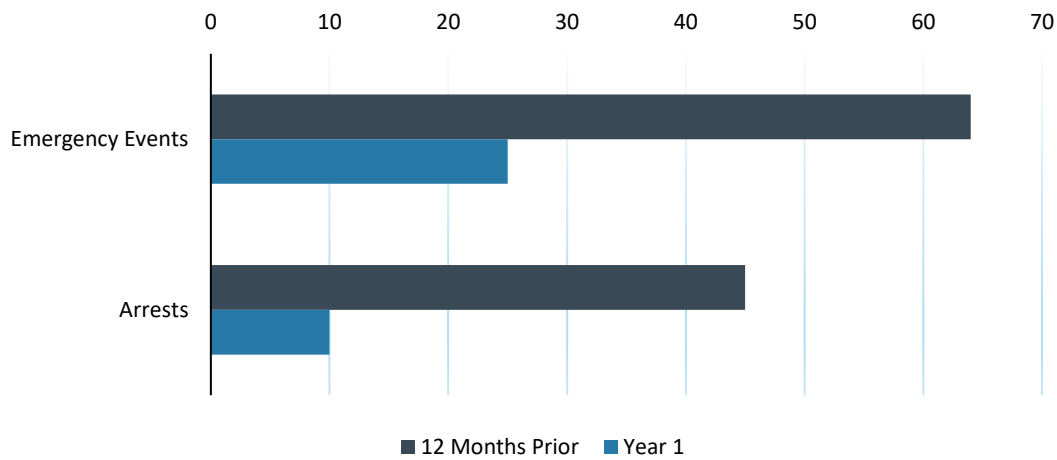
## Updates

- There are two new additional Transitional Housing Program Plus Foster Care (THP-FC) providers (EA Family Services and Covenant Community Services) to provide housing options to extended foster youth. These THP-FC providers have joined the TAY Workgroup Collaborative to support addressing shared objectives of reducing homelessness, addressing mental health and substance use needs, supporting youth with securing and maintaining employment, and achieving education and/or vocational training goals in effort to transition youth into adulthood. Many youths have found it challenging to maintain housing, but with increased housing options and intensified services many youths have found stability.
- The TAY team has successfully implemented the Seeking Safety program at TAY Third Tradition (see Prevention and Early Intervention section of this report) to aid youth with improving their trauma symptoms and reliance on substances to cope by learning healthy coping skills.
- The Individual Placement and Supports (IPS) program continues to be maintained at maximum capacity with several youth securing and maintaining employment.

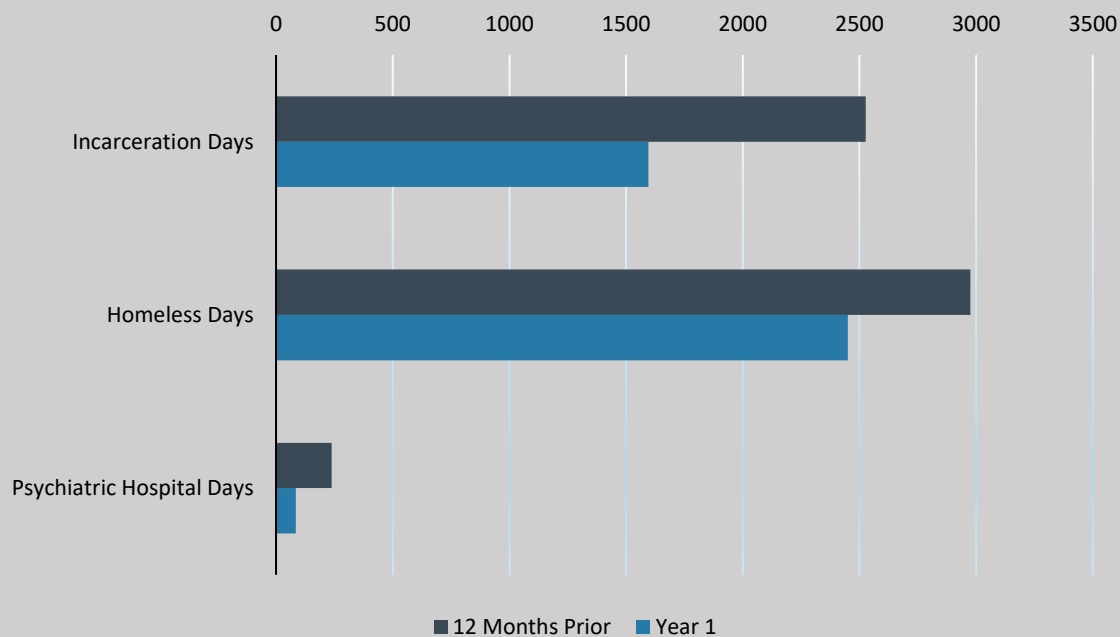
# TRANSITION AGE YOUTH (TAY)

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in TAY. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 159)



### Total Incarceration, Homeless, and Hospital Days (n = 159)



# WELLNESS, INDEPENDENCE, AND SENIOR ENRICHMENT (WISE)

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## Program Description

The Wellness, Independence and Senior Enrichment (WISE) team provides mental health services to the older adult population. WISE clients experience serious mental illness and require services that are delivered through a “whatever it takes” approach. Referrals to the WISE team come from community hospitals, psychiatric hospitals, KBHRS behavioral health teams, the Volunteer Senior Outreach Program, the Access and Assessment Center, Crisis Mobile Evaluation Team, Aging and Adult Services, Independent Living Center, and self-referrals. The WISE team is field-based, involving the provision of services in seniors’ places of abode. The team includes a Geriatric Psychiatrist, Therapists, and Recovery Specialist. Clients are provided evaluation, medication management, therapy, case management, and assistance with obtaining community resources. The Geriatric Psychiatrist may also evaluate and provide integrated care when symptoms are present, offering referrals for physical health care as needed.

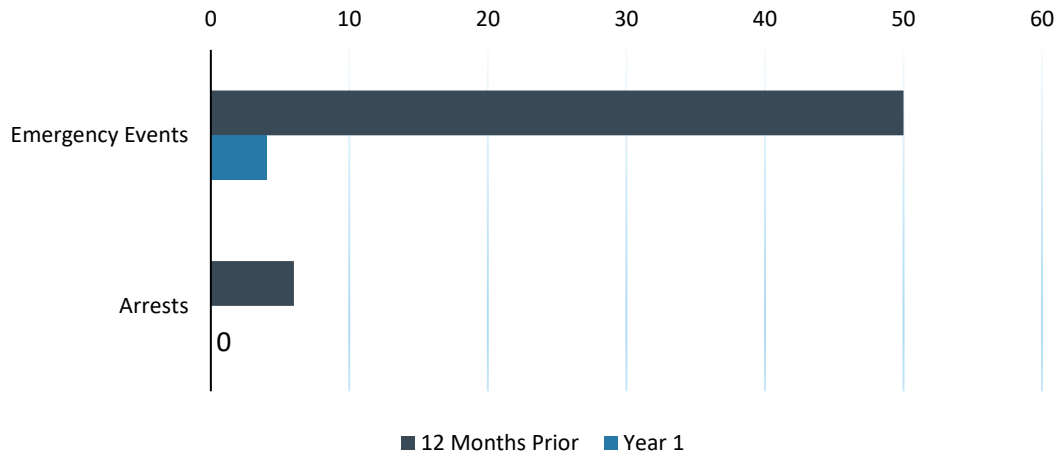
## Updates

- The WISE Team received 93 referrals for fiscal year 23-24. The referrals are expected to increase with an ongoing effort in Outreach and Education activities in the community to target the senior population that traditionally has had low penetration rates.
- The program is fully staffed with one Geriatric Psychiatrist, one Nurse, six Clinicians, two Recovery Specialists and two Support Staff.
- Outcome data is collected through Data Collection Reporting (DCR). Saint Louis University Mental Status (SLUMS), Patient Health Questionnaire-9 (PHQ-9), and General Anxiety Disorder-7 (GAD-7) are the assessment tools currently used to determine the level of impairment and/or functioning and to plan treatment.

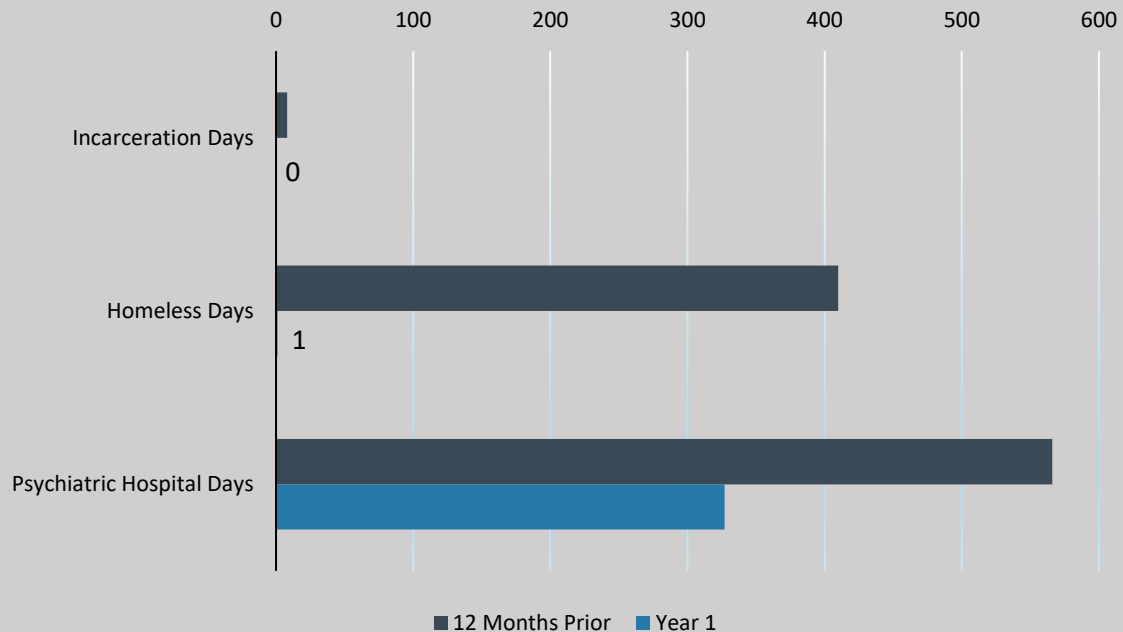
# WELLNESS, INDEPENDENCE, AND SENIOR ENRICHMENT (WISE)

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in WISE. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 70)



### Total Incarceration, Homeless, and Hospital Days (n = 70)



# YOUTH MULTI-AGENCY INTEGRATED SERVICES TEAM (MIST)

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## Program Description

The Youth Multi-Agency Integrated Services (MIST) Team provides a variety of specialty mental health services for children and families. Populations served include youth at risk of losing placement, foster youth (both wards and dependents) and Commercially Sexually Exploited Children (CSEC). Clients referred to the MIST team have been identified as having serious emotional disturbance, severe mental illness, or behavioral issues. Referrals for care come from the Department of Human Services, Probation Department, group homes, schools, KernBHRS, contracted mental health providers, and the Department of Public Health. Staff receive training in a wide array of Cultural Competency topics, enabling MIST to provide sensitive competent services to people of diverse cultures, those in stages of acculturation, and people with varying sexual orientations.

Youth MIST helps parents/caregivers with psychoeducation on their child's mental health symptoms and treatment and how to work with the schools, including the special education and Individual Education Plan (IEP) process. The Youth MIST team works with the entire family, and all members are offered support and mental health services as needed.

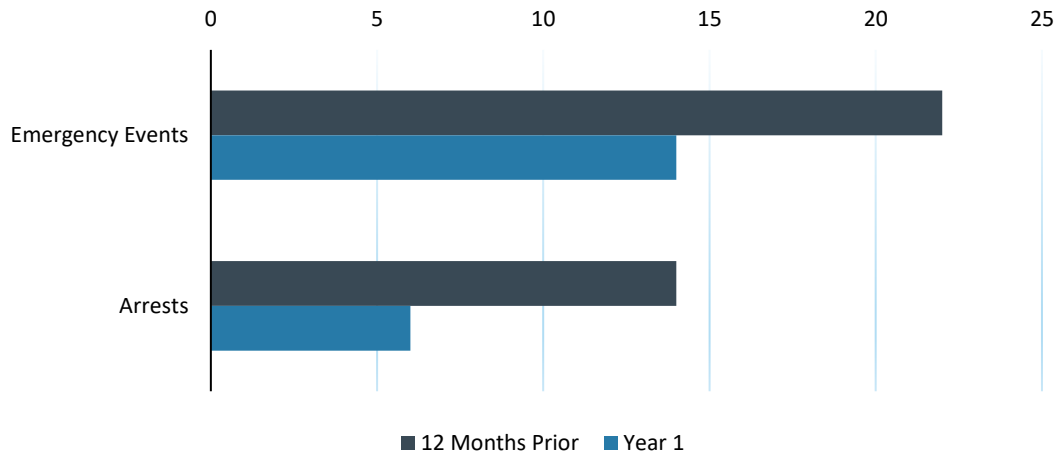
## Updates

- In May of 2024 Youth MIST obtained certification in the Treatment Foster Care-Oregon (TFCO) model. TFCO is an evidence-based practice that has been shown to help youth in placement successfully reunite with a parent or caregiver. This model focuses on intensive services for the youth through therapy and skills training, daily contact with the foster parents to provide support and monitor the youth's functioning, and weekly meetings with the reuniting caregiver to help provide parenting strategies and strengthen the family relationship. Data was collected from 2023 and 2024 on the effectiveness of Youth MIST's implementation of the TFCO program, and it showed that 80% of the youth that participated were able to successfully return to their families or graduate to independent living.

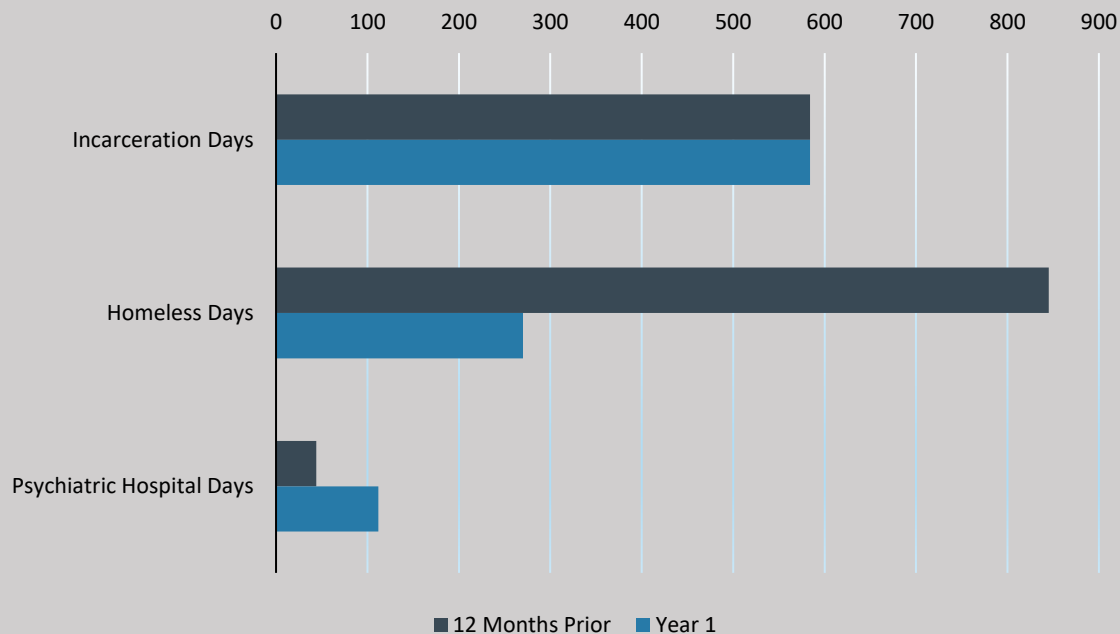
# YOUTH MULTI-AGENCY INTEGRATED SERVICES TEAM (MIST)

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in MIST. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 42)



### Total Incarceration, Homeless, and Hospital Days (n = 44)



# YOUTH WRAPAROUND

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## Program Description

Youth Wraparound is a series of full-service partnership (FSP) teams that provide intensified services for youth at risk of hospitalization, who either meet criteria for Pathway to Well Being services and/or Therapeutic Behavioral Services or are in frequent need of crisis intervention. To ensure services are readily available, Youth Wraparound Teams are located within the Children's provider geographic service areas (GSAs) throughout Kern County. Referrals come from a variety of sources, including self-referrals, schools, the Probation Department, the Department of Human Services, the Mobile Evaluation Team, the Psychiatric Evaluation Center, the SMART Committee, and hospitals. Staff are available after-hours, on weekends and holidays to ensure immediate service delivery occurs during times of crisis. Treatment planning is developed in a Child and Family Team with a focus on meeting the specific needs of the youth and family. The treatment team involves the client, therapist, recovery specialist, parents/guardians, placing agencies, schools, and other child-serving agencies.

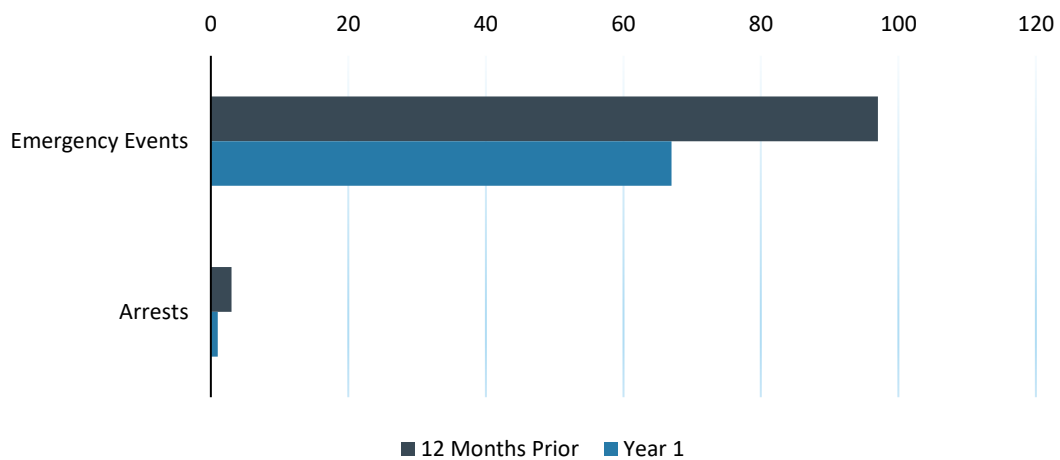
## Updates

- Youth Wraparound provides services in geographic service area (GSA) clinics, homes, schools and communities. In addition, KernBHRS Youth Wraparound continues to co-locate with crisis services at Mary K Shell (MKS) and the Psychiatric Evaluation Center (PEC). The geographic system continues to remediate referrals and work toward increased access to intensified services pre- and post-crisis utilization. This is accomplished with ongoing collaboration with partner and contract agencies.
- BHRS Youth Wraparound will open an office on-site at the new 16-bed minor inpatient facility to increase daily treatment and focus on safe discharges.

# YOUTH WRAPAROUND

Number of emergency events, arrests, days spent incarcerated, days spent homeless, and days spent in psychiatric hospitalization are reported for all partners in Youth Wraparound. These metrics are compared between 12 months prior to treatment and during the first year of treatment.

### Total Number of Emergency Events and Arrests (n = 172)



### Total Incarceration, Homeless, and Hospital Days (n = 176)

