Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors

From: Louise F. Rogers, Chief, Health System
David A. Young, Director, Behavioral Health and Recovery Services

Subject: San Mateo County Mental Health Services Act Three-Year Plan and Annual Update, AB114 Reversion Plan and Innovation Plan

RECOMMENDATION:

Adopt a resolution authorizing the approval and submission of San Mateo County's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY's 2017-20 and Annual Update; including a "Reversion Plan", which entails an updated Innovations spending plan to avoid funds being reverted to the state Department of Health Care Services as required under AB114.

BACKGROUND:

In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA), which created additional state funds to expand mental health services. Since 2006, MHSA resources and expenditures have been approved by your Board as part of the larger Health System budget. Since 2012, State legislation has required an MHSA Three-Year Program and Expenditure Plan and Annual Updates to be approved by each county Boards of Supervisors. The Mental Health and Substance Abuse Recovery Commission (MHSARC) receives public comments and makes a recommendation for approval by the Board of Supervisors.

On January 27, 2015, your Board approved the MHSA Three-Year Plan for FY 2014-15 through FY 2016-17.

DISCUSSION:

In 2017, Behavioral Health and Recovery Services (BHRS) conducted a comprehensive evaluation of programs and a public comment process concerning MHSA services. This process, called Community Program Planning (CPP), was launched to develop the next MHSA Three-Year Plan. The CPP process included a countywide needs assessment, strategy development, and prioritization phase. Planning was led by the MHSA Manager, the Director of the Office of Diversity and Equity, and the BHRS Director, and engaged the MHSARC and the MHSA Steering Committees as well. Approximately 300 diverse stakeholders participated through multiple input sessions were held across the County. BHRS engaged in separate focused planning processes for the following three key areas:

1) **Prevention and Early Intervention (PEI) for Ages 0-25:** MHSA guidelines require that at least 51% of PEI allocations fund programs for children, youth and transition-age youth. Between October and December 2017, a taskforce of PEI experts, leaders, clients/consumers, family members, and community members convened for three 2-hour planning meetings. Taskforce participants reviewed data, prioritized issues, helped develop a final set of recommendations across various areas, and prioritized programming for youth mental health crisis support and prevention. The recommendations are included as part of the enclosed MHSA Three-Year Plan.

2) **Assembly Bill (AB) 114 Reversion:** AB 114, enacted in 2017, was one-time legislation to allow counties to submit a plan by July 1, 2018, for spending of funds that would otherwise revert. MHSA requires funds that are allocated to a county, but not spent within three years, to be returned to the state for distribution to other counties. BHRS received notification on May 3, 2018, that a total of $4,256,155 was subject to reversion. This entailed $3,832,545 for Innovation projects and $423,610 for Workforce, Education and Training.

3) **Innovations (INN):** The MHSA Innovations (INN) component requires counties to allocate 5% of MHSA funds to pilot and evaluate innovative projects in order to advance new best practices. San Mateo County's Reversion Plan will apply the Innovation funds subject to reversion under AB 114 to a statewide Behavioral Health Technology Innovation Collaborative that will include San Mateo County. This project will pilot technology-based behavioral health and wellness interventions intended to: increase access to mental health care; promote early detection of mental health symptoms; and predict the onset of mental illness. By participating in this multi-county effort, BHRS will be applying these funds to San Mateo County projects, although they will be administrated through a statewide joint powers entity (CalMHSA).

Full Service Partnerships (FSP)

Every year a status report on the impact of Full Service Partnerships (FSP) is provided to your Board. FSPs are one of the core programs funded by MHSA; the service model provides intensive "whatever it takes" mental health services and supports to eligible youth and transition-aged youth (TAY), adults, and medically fragile older-adult clients.

During the first year of the FSPs, clients demonstrated positive health outcomes, particularly for reducing arrests, decreases in mental and physical health emergencies, and lower school suspensions for youth. These positive outcomes are maintained when viewed across four to five years of continued participation. Specific outcomes for youth (school attendance, grades and suspensions) demonstrated some variability across years of participation, although this observation entails a small number of clients and it involves the highest risk youth. Thus, conclusions should not be over-interpreted. The complete FSP outcome report is enclosed as part of the MHSA Three-Year Plan; a chart summarizing improvement is detailed below.

Improvement in Outcomes by Age Group, Year before FSP Compared with First Year in FSP

FSP Outcomes	Child (n = 134)			TAY (n = 203)			Adult (n = 310)			Older adult (n = 54)		
	Year Prior	1 Year	Improve-ment	Year Prior	1 Year	Improve-ment	Year Prior	1 Year	Improve-ment	Year Prior	1 Year	Improve-ment
Homelessness	9	7	22%	28	26	7%	84	59	28%	**	**	**
Detention/ Incarceration	21	25	-24%	39	32	16%	47	34	30%	**	**	**
Arrests	24	8	**67%**	53	18	**65%**	47	6	**87%**	**	**	**
Mental Health Emergencies	54	5	**89%**	85	28	**67%**	127	56	**57%**	12	7	42%
Physical Health Emergencies	12	0	**100%**	49	6	**88%**	71	25	**65%**	17	12	29%
School Suspensions	34	17	**47%**	20	6	**72%**	**	**	**	**	**	**
Attendance Ratings*	3.8	4.1	10%	3.8	3.7	-4%	**	**	**	**	**	**
Grade Ratings*	2.7	3.1	14%	2.9	2.9	1%	**	**	**	**	**	**
Employment	**	**	**	**	**	**	30	42	26%	**	**	**

* School attendance and grades are ratings on a 1-5 scale (higher is better).
** Not Applicable

The MHSARC reviewed and recommended that your Board approve the MHSA Three-Year Program & Expenditure Plan and the Annual Update on July 5, 2017, and September 6, 2017, respectively. The MHSARC reviewed PEI Ages 0-25 and recommended that your Board approve the recommendations on February 7, 2018, and the AB114 Reversion Plan and Innovation Plan on June 6, 2018. This year the AB114 Plan to spend MHSA Funds and a new Innovation Plan are included for approval. Note that submission of these plans was delayed because key information was not provided by DHCS until May, 2018. Thus, the extensive process required to fully evaluate our MHSA programs, complete the public comment period, and conduct the review process for the Three-Year Plan could not be initiated until that time.

The Resolution has been reviewed and approved by County Counsel as to form.

The MHSA Three-Year Plan Program and Expenditure Plan, Annual Update, AB 114 Reversion Plan, and MHSA Innovation Plan contribute to the Shared Vision 2025 outcome of a Healthy Community by expanding recovery-based mental health programs for people with serious mental illness, reducing the long-term negative impact from untreated mental illness, and preventing mental illness from becoming severe and disabling. It is projected that 85% of FSP clients shall be maintained at a current or lower level of care. A client is considered "maintained at the current or lower level of care" if, during the fiscal year, they did not have a new admission to a higher level of care, or had one or more new admissions to a program with the same or lower level of care.

PERFORMANCE MEASURE(S):

Measure	FY 2017-18 Actual	FY 2018-19 Projected
Percentage of FSP clients maintained at current or lower level of care	87% 427 of 489 clients	85% 416 of 489 clients

FISCAL IMPACT:

There is no Net County Cost associated with this plan. BHRS received $29.9 million in FY 2016-2017 and $32.9 million in FY 2017-18. We anticipate a reduction in MHSA revenue for FY 2018-19 because of the state direction of MHSA funds to the implementation of “No Place Like Home” legislation. Funds that are not yet allocated through our internal planning process or RFP to the community are held in a “Trust” account. This account is also used to manage the fluctuations in funding that occur from year to year as well as to support maintenance of effort and cost increases for current programs.

RESOLUTION NO. 076048

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

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RESOLUTION AUTHORIZING THE APPROVAL AND SUBMISSION OF SAN MATEO COUNTY'S MENTAL HEALTH SERVICES ACT (MHSA) THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FY'S 2017-20 AND ANNUAL UPDATE; INCLUDING A "REVERSION PLAN", WHICH ENTAILS AN UPDATED INNOVATIONS SPENDING PLAN TO AVOID FUNDS BEING REVERTED TO THE STATE DEPARTMENT OF HEALTH CARE SERVICES AS REQUIRED UNDER AB114

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA),

WHEREAS, since 2012 state legislation requires counties to seek approval of their MHSA Three-Year Program and Expenditure Plans and Annual Updates from their Board of Supervisors; and

WHEREAS, Assembly Bill 114 Reversion Plan and the Mental Health Services Act Innovation Plan are also included for approval; and

WHEREAS, Behavioral Health and Recovery Services has engaged in a public comment process of at least thirty days and public hearing to review and comment on the plans; and

WHEREAS, the Mental Health and Substance Recovery Commission has

reviewed the public comments and recommended approval of the plans to your Board.

NOW THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that this Board of Supervisors accepts the MHSA Three-Year Program and Expenditure Plan for Fiscal Year 2018-20, Annual Update, which includes the AB 114 Reversion Plan and the Mental Health Services Act Innovation Plan and approves its submission to the State Department of Health Care Services.

* * * * * *

RESOLUTION NUMBER: 076048

Regularly passed and adopted this 7th day of August, 2018.

AYES and in favor of said resolution:

Supervisors: *DAVE PINE*

CAROLE GROOM

DON HORSLEY

WARREN SLOCUM

DAVID J. CANEPA

NOES and against said resolution:

Supervisors: *NONE*

President, Board of Supervisors
County of San Mateo
State of California

Certificate of Delivery

I certify that a copy of the original resolution filed in the Office of the Clerk of the Board of Supervisors of San Mateo County has been delivered to the President of the Board of Supervisors.

Deputy Clerk of the Board of Supervisors

COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH
& RECOVERY SERVICES

San Mateo County Mental Health Services Act

Three-Year Program and Expenditure Plan FY 17-18 through FY 19-20
& Annual Update FY 17-18

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: County of San Mateo

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: David A. Young, PhD, MPH	Name: Doris Y. Estremera, MPH
Telephone Number: (650) 573-2748	Telephone Number: (650) 573-2889
E-mail: dyoung@smcgov.org	E-mail: destremera@smcgov.org
Local Mental Health Mailing Address: San Mateo County, Behavioral Health and Recovery Services (BHRS) 2000 Alameda de las Pulgas, Ste. 235 San Mateo, CA 94403	

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 nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on August 7, 2018.

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

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

Louise F. Rogers, Chief, Health System
(on behalf of David A. Young, Director, BHRS)
Local Mental Health Director (PRINT)

Signature

Date 8/13/18

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: County of San Mateo

☒ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: David A. Young, PhD, MPH	Name: Juan Raigoza
Telephone Number: (650) 573-2748	Telephone Number: (650) 363-4777
E-mail: dyoung@smcgov.org	E-mail: controller@smcgov.org

Local Mental Health Mailing Address:
San Mateo County, Behavioral Health and Recovery Services (BHRS)
2000 Alameda de las Pulgas, Ste 235
San Mateo, CA 94403

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report 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.

Louise F. Rogers, Chief, Health System
(on behalf of David A. Young, Director, BHRS)
Local Mental Health Director (PRINT)

Signature 8/13/18
Date

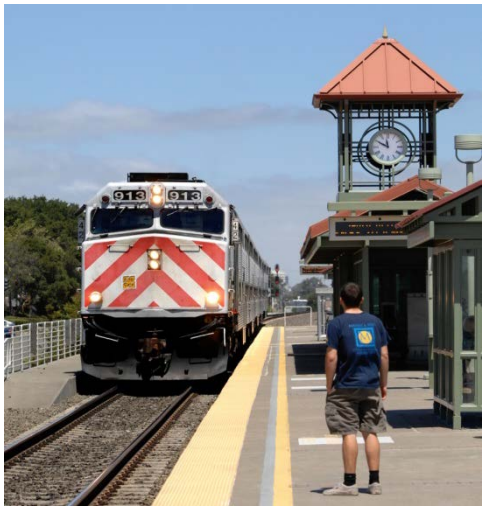
I hereby certify that for the fiscal year ended June 30, 2017, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/22/17 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2017, 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.

Juan Raigoza
County Auditor Controller / City Financial Officer (PRINT)

Signature Kim Nah Le 8/23/18
Date
for Juan Raigoza

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)



INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

Located on the San Francisco Peninsula, San Mateo County is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The County was formed in April 1856 out of the southern portion of then-San Francisco County. Within its 455 square miles, the County is known for a mild climate and scenic vistas. It is home to some of the most spectacular and varied geography in the United States that includes redwood forests, rolling hills, farmland, tidal marshes, creeks and beaches.

The County is committed to building a healthy community. In collaboration with community-based partners, the County provides access to health care services, especially to the underserved and unserved as well as creating a safe and convenient opportunities for physical activities. Much of the shoreline along the San Francisco Bay is part of the San Francisco Bay Trail. This trail provides residents and visitors alike with miles of biking and walking in the numerous park and recreation areas, and trails.

The County has long been a center for innovation. It is home to numerous colleges and research parks and is within the "golden triangle" of three of the top research institutions in the world: Stanford University, the University of California at San Francisco and the University of California at Berkeley. Today, San Mateo County's bioscience, computer software, green technology, hospitality, financial management, health care and transportation companies are industry leaders.

Situated in San Mateo County is San Francisco International Airport, the second largest and busiest airport in California, and the Port of Redwood City, which is the only deep water port in the Southern part of the San Francisco Bay. These economic hubs have added to the rapidly growing vitality of the County.

COUNTY OF SAN MATEO MISSION

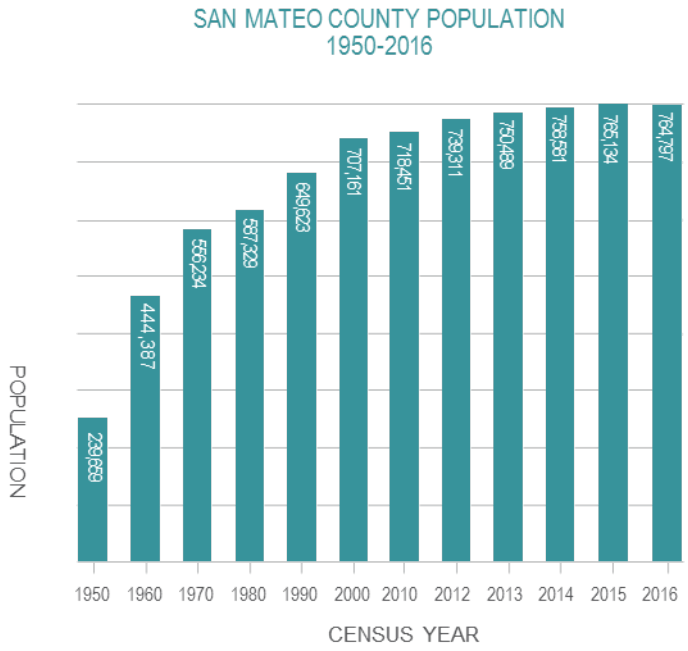
San Mateo County government protects and enhances the health, safety, welfare and natural resources of the community, and provides quality services that benefit and enrich the lives of the people of this community.

We are committed to:

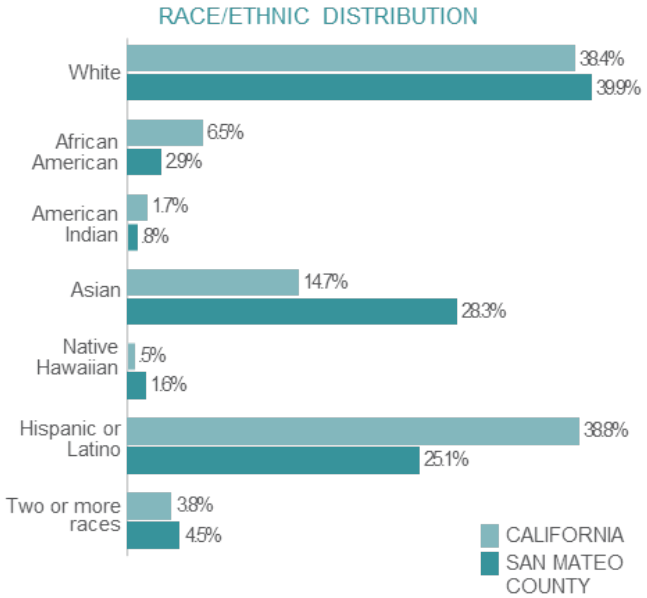
- The highest standards of public service;
- A common vision of responsiveness;
- The highest standards of ethical conduct;
- Treating people with respect and dignity.

The 2016 population estimated by the U.S. Census Bureau was 764,797 — a 6.4 percent jump over the 2010 Census. Daly City remains the most populous city followed by San Mateo and Redwood City.

The median age of San Mateo County residents was 39.3 years compared to the state's median age of 35.2 years, according to the 2010 Census. Projections indicate future decades will see a significant spike in the county's population 65 years and older. In 2015, the Census estimated 6 percent of the population was under 5 years old, 21.2 percent were under 18 and 15 percent were 65 or older.



As the County's population continues to shift, the racial and ethnic composition continues to diversify. More than 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well," according to the 2011-2015 Census estimates. As of January 1, 2015, San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog and Russian (as identified by Health Plan of San Mateo). The Health System identified Tongan, Samoan as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.



MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars translating to about $25.5 million annual average for San Mateo County in the last five years through Fiscal Year 2016-17.

PRINCIPLES AND FUNDING BOUNDARIES

MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. MHSA provides funding for treatment, prevention and early intervention, outreach, support services, family involvement, and programs to increase access to services for underserved communities. Core values include:

◆ Community collaboration ◆ Cultural competence ◆ Consumer and family driven services
◆ Focus on wellness, recovery, resiliency ◆ Integrated service experience

MHSA provides funding for Community Program Planning activities, which include stakeholder engagement in planning, implementation and evaluation. Other programming is grouped into Components each with funding allocation and reversion guidelines.

Component*	Funding Allocation	Reversion Period
Community Services and Supports (CSS)	76%	3 years
Prevention and Early Intervention (PEI)	19%	3 years
Innovations (INN)	5%	3 years
Workforce Education and Training (WET)	One Time Funding FY 06/07 and FY 07/08	10 years (expended)
Capital Facilities and Information Technology (CF/IT)	One Time Funding FY 07/08 and FY 08/09	10 years(expended)
Housing	One Time Funding FY 07/08 Unencumbered Funds FY 15/16	10 years (expended) 3 years (expended)

**For a description of each component and additional statewide MHSA information, please visit the California Mental Health Oversight and Accountability Commission website, mhsoac.ca.gov/component .*

SAN MATEO COUNTY APPROACH

In San Mateo County, MHSA dollars are highly leveraged maximizing the resources available to achieve the desired outcomes of our plan. MHSA-funded activities further the Behavioral Health and Recovery Services (BHRS) department's five strategic themes of quality services and supports; using resources wisely; community partnerships; workforce excellence; and authentic and responsive organization. And our enterprise outcomes of improving the quality of life for consumers and family members; improving operational efficiency; staff satisfaction and contribution; and adding value to the community.

STAKEHOLDER INPUT

STAKEHOLDER INPUT

The San Mateo County Behavioral Health and Recovery Services (BHRS) promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning.

COMMUNITY SERVICE AREAS (CSA)

One of these system-wide planning and transformation activities is the Community Service Area (CSA) model development that was undertaken in 2012, by BHRS. CSAs provide a perfect opportunity to explore what integration could look like for San Mateo County by bringing together local resources from different fields—education, health care, nonprofits, faith-based organizations, law enforcement and others—together to connect people to mental health or substance use prevention, early intervention, treatment, and recovery supports in designated areas in the county. The following regional CSA's were established; shifting the entire County and MHSA activities to this new service delivery approach:

- South CSA (San Carlos, Redwood City, Woodside, Atherton, W. Menlo Park, Portola Valley)
- Central CSA (Burlingame, Hillsborough, San Mateo, Foster City, Belmont)
- Coastside CSA (Half Moon Bay, La Honda, Pescadero)
- East Palo Alto CSA (East Menlo Park, East Palo Alto)
- Northwest and Northeast CSA (Daly City, Pacifica, Colma, Brisbane, South San Francisco, San Bruno, Millbrae)

The Community Advisory Committees (CAC) along with a CSA Manager, guide the work of the CSAs and implementation of their community specific and community-driven action plans. The goal is that the CAC be comprised of 51% clients and family members. These permanent committees have an important role in the local system transformation, its values, activities and directions, including MHSA Community Program Planning (CPP) processes.

To-date, each CSA has hosted multiple days of partnering, community events focused on local priority issues (e.g. strengthening service organizations collaboration, violence prevention, chronic homelessness, etc.), have localized field crisis efforts and CAC's are meeting regularly to implement their action plans. For more on the CSA model please visit www.smchealth.org/community-service-areas.

INPUT STRUCTURE

In 2005, BHRS devised a local planning process and structure to seek input from the broad San Mateo County stakeholder community. This planning and input structure has been strengthened in recent years and serves as the framework for all the planning activities related to MHSA. The Mental Health and Substance Abuse Recovery Commission (MHSARC), formerly the Mental Health Board, is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on the monthly MHSARC meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates. The MHSARC meetings are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad and increasing network of contacts including community partners and County agencies, as well as consumer and advocacy organizations, and the general public.

MENTAL HEALTH SERVICES ACT STEERING COMMITTEE

The MHSA Steering Committee was also created in 2005 and continues to play a critical role in the development of MHSA program and expenditure plans. In 2016, the MHSA Steering Committee was restructured to strengthen the representation of diverse stakeholders and now includes membership targets, guidelines and an application process, these documents were included in a previous Annual Update and are available on the MHSA website, smchealth.org/mhsa. The MHSA Steering Committee makes recommendations to the planning and services development process and as a group, assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The Steering Committee meetings are open to the public and include time for public comment as well as means for submission of written comments.

The MHSARC commissioners are all members of the MHSA Steering Committee. The MHSA Steering Committee is co-chaired by a member of the San Mateo County BoS and by the Chair of the MHSARC. Comprised of over 40 community leaders representing the diverse San Mateo community including behavioral health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non-behavioral health constituencies (County leadership, Education, Healthcare, Criminal Justice, Probation, Courts, among others). Additionally, all members of the MHSARC are members of the MHSA Steering Committee.

MHSA Steering Committee Members*

Stakeholder Group	Name(s)	Title (if applicable)	Organization Affiliation (if applicable)
Family Member	Patricia Way**	Chair, MHSARC	
SMC District 1	David Pine**	Supervisor, District 1	Board of Supervisors
Client/Consumer	Aisha Williams		Lived Experience Academy
Client/Consumer Client/Consumer - Adults	Alan Cochran Jairo Wilches	 Liaison and BHRS Wellness Champion	Lived Experience Academy BHRS, Office of Family and Consumer Affairs
Client/Consumer - Adults	Michael Lim		
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Client/Consumer - Adults	Patrick Field		
Client/Consumer – Older Adult	Carmen Lee	Program Director	Stamp Out Stigma
Client/Consumer - SA	Jose Solano		BHRS, Pathways Program
Cultural Competence & Diversity	Jei Africa	Director	Office of Diversity & Equity
Education	Jenee Littrell	Administrator	SMCOE, Safe and Supportive Schools
Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer		California Clubhouse
Family Member	Yolanda Novello	Family Partner	BHRS
Other - Advocate	Randall Fox	Health, Law and Policy Advocate	Former MHSARC Chairman
Other - Aging and Adult	Michelle Makino	Program Services Mgr	SMC Aging & Adult Services
Other - Domestic Violence	Caitlin Billings		Community Overcoming Relationship Abuse - CORA
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Felton Institute - PREP
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Provider of MH/SU Svcs	Clarise Blanchard	Interim Executive Director	Pyramid Alternatives
Provider of MH/SU Svcs	Gloria Gutierrez	MH Counselor	BHRS
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of Social Services	Kava Tulua		One East Palo Alto and East Palo Alto Partnership for Mental Healt Outreach
Provider of Social Services	Mary Bier		North County Outreach Collaborative
Provider of Social Services	Rev. William Chester McCall		Multicultural Counselling & Educational Services of the Bay Area
Provider of Social Services	Sheri Broussard		HIP Housing

**Membership as of October 2017*
*** MHSA Steering Committee Chairs*

MHSARC Commission Members*

Stakeholder Group	Name(s)	Title (if applicable)
Family Member	Patricia Way	Chair
SMC District 1	David Pine	Supervisor, District 1
SMC District 1	Randy Torrijos	Staff to David Pine
Client	Rocio Cornejo	Vice Chair
Client	Wanda Thompson	Member at Large
Client	Patrisha Ragins	Member
Client	Rodney Roddewig	Member
Client	Carol Marble	Member
Client	Kate Pfaff	Member
Client – SA	Eduardo Tirado	Member
Family Member	Bill Nash	Member
Family Member	Dorothy Christian	Member
Law Enforcement	Eric Wollman	Member
Public	Josephine Thompson	Member
Public	Betty Savin	Member
Public	Cherry Leung	Member

** MHSARC members are MHSA Steering Committee members (membership as of October 2017)*

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for at least a 30-day public comment period for stakeholders and any interested party to review and comment. Additionally, the local mental health board conducts a public hearing at the close of the 30-day comment period. The Three-Year Program & Expenditure Plan Fiscal Year (FY) 2017-18 through 2019-20 and Annual Update FY 2016-2017 (covering data from FY 2015-2016) was presented at the MHSARC and open to 30-day public comment in three-parts:

1. **Three-Year Program Plan** and **Expenditure Plan** - June 7, 2017
2. **Fiscal Year 2016-2017Annual Update** (covering data from FY 2015-2016) - July 5, 2017.
3. **Three-Year Program Plan for Prevention and Early Intervention Ages 0-25** and **Expenditure Plan** - January 3, 2018.

Please see Appendix 1 for all public comments received during the three-year planning phase. The complete Three-Year Plan and Annual Update is submitted to the San Mateo County local Board of Supervisors for adoption and to the County of San Mateo Controller's Office to certify

expenditures before final submission to the State of California Mental Health Services Oversight and Accountability Commission (MHSOAC).

Various means are used to circulate information about the availability of the plan and request for public comment and include:

- Flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,800 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by the MHSARC. Planning was led by the MHSA Manager and the Director of BHRS along with the MHSARC and the MHSA Steering Committee.

A draft CPP process was presented to and vetted by the MHSARC on December 7, 2016. The MHSARC was asked for their input and comments on the process and what other stakeholder groups should we be reaching out to in each of the CPP Phases.

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers for the CPP Launch session where they would be providing input and public comment. Discussion items included, 1) Background on MHSA; 2) What to expect at the CPP Launch session; and 2) How to prepare a public comment.

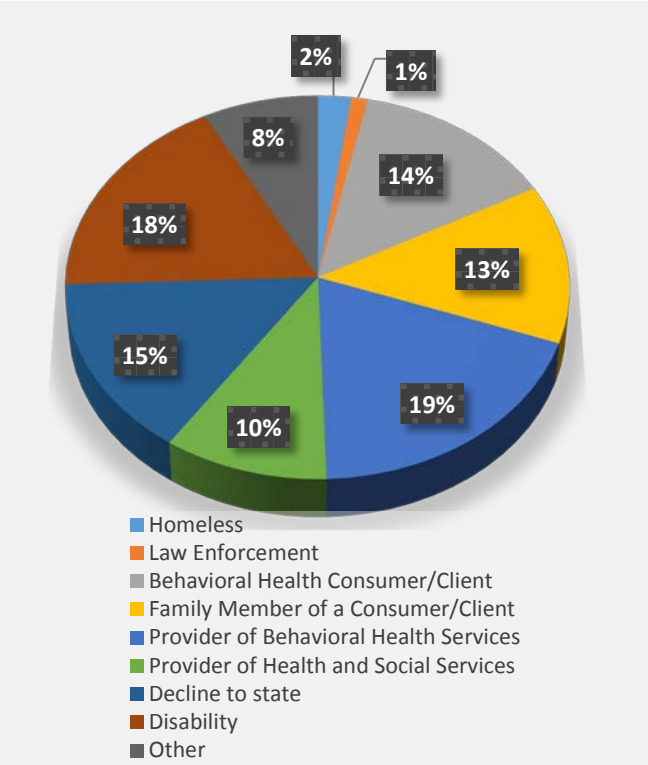
Extensive outreach was conducted to promote two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Samoan. Stipends to consumers/clients and their family members, language interpretation, child care for families and refreshments were provided at each of these sessions.

Over 270 participated in the sessions, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members and 36 stipends were provided.

The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in the north part of the county as well.

See Appendix 2, Community Program Planning Participant Demographics, for additional data.

Represented Groups



Input Sessions

Date	Stakeholder Group
12/7/16	**MHSARC and MHSA Steering Committee (Input on CPP Process)**
2/15/17	MHSARC Adult Committee
2/15/17	NAMI Board Meeting
2/16/17	Filipino Mental Health Initiative
2/21/17	Coastside Community Service Area
2/21/17	Northwest Community Service Area
3/1/17	MHSARC Older Adult Committee
3/2/17	Central Community Service Area
3/2/17	Peer Recovery Collaborative
3/3/17	Diversity and Equity Council
3/3/17	Northwest School-Based Mental Health Collaborative
3/7/17	Pacific Islander Initiative
3/7/17	Coastside School-Based Mental Health Collaborative
3/8/17	AOD Change Agents/CARE Committee
3/9/17	**Peer Recovery Collaborative (Pre-Launch Session)**
3/9/17	East Palo Alto Community Service Area
3/9/17	Central School Collaborative
3/13/17	**MHSA Steering Committee (CPP Launch)**
3/14/17	African American Community Initiative
3/16/17	Ravenswood School-Based Mental Health Collaborative
3/17/17	South Community Service Area and Child/Youth Committee
3/23/17	Chinese Health Initiative
3/23/17	Northeast School-Based Mental Health Collaborative
3/28/17	Latino Collaborative
4/10/17	Coastside Youth Advisory Committee
4/11/17	Spirituality Initiative
4/13/17	**East Palo Alto (Community Prioritization Session)**
4/18/17	**Coastside (Community Prioritization Session)**
4/19/17	MHSARC Child and Youth Committee
4/20/17	Native American Initiative
4/20/17	Contractor's Association
4/21/17	Latino Immigrant Parent Group
4/24/17	Veterans
4/25/17	TAY recipients of services
4/26/17	**MHSA Steering Committee (CPP Prioritization)**

PHASE 1. NEEDS ANALYSIS

To build off of the previous Community Program Planning (CPP) process in FY 2014/15, stakeholders including clients, family members, community partners and organizations were asked to think about current services as they relate to the gaps in services identified in FY 2014/15 (listed below), specific service categories and populations served to identify any additional gaps in services:

- Cultural humility and stigma
- Timely access
- Services for peers and families
- Services for adults and older adults
- Early intervention
- Services for children and TAY
- Co-occurring services
- Criminal justice involvement

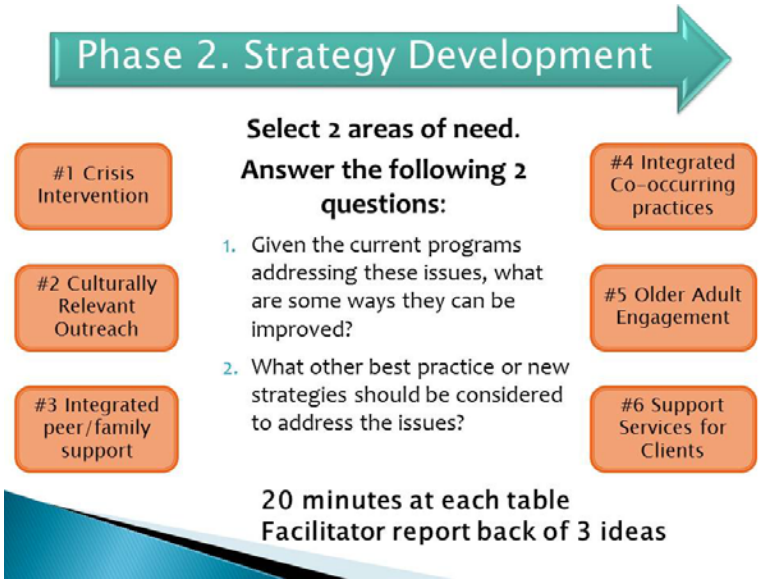
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

- From your perpective, do these MHSA services effectively [e.g. serve the cultural and linguistic needs of your target communities, address timely access for your target communities, serve the behavioral healthcare needs of clients and families, etc.]? What's working well? What improvements are needed?
  Probes: Do these services address principles of wellness and recovery? stigma?
- Are current collaborations effective in reaching and serving target communities? What is working well? What's missing?

All comments received up to the date of the CPP Launch Session on March 13th were grouped into themes and presented at the CPP Launch. Additional input was sought regarding both the needs/service gaps and whether there were any voices (or communities) missing from the Needs Analysis phase. See Appendix 3, Needs Analysis Summary of Input, for the complete list of themes and comments received. The CPP Launch Session was a joint MHSARC and MHSA Steering Committee meeting and included a facilitated community input. Agenda items included 1) an MHSA Housing proposal for use of unencumbered housing funds 2) public comment from clients, families and community members on priority needs and gaps in mental health services, and 3) breakout groups to begin developing strategies to address the key needs/service gaps identified. About 120 clients, families, community members and stakeholders attended the CPP Launch Session. See Appendix 4 for all CPP Launch Session materials, handouts, minutes and attendance.

PHASE 2. STRATEGY DEVELOPMENT

The Strategy Development Phase was kicked off at the CPP Launch Session on March 13, 2017. Findings from the initial input sessions were shared at the CPP Launch Session including relevant strategy ideas.



While the above six need/gaps in services were identified, there was also an overarching theme that arose from the input sessions, which brought to surface common questions in MHSA planning: do we build upon existing MHSA-funded programs or do we create new programs? Input session participants identified the need to consider both. It has been 10 years since the inception of MHSA and most programs have not received additional resources (aside from Cost of Living increases to the contracts) to expand services and/or clients served, especially for those programs that are resulting in positive behavioral health outcomes.

Three key next steps for the CPP process were identified at the CPP Launch Session:

- Additional input sessions with vulnerable populations and key stakeholders identified.
- Additional strategy development sessions in isolated and higher need communities, in particular East Palo Alto and the Coastside/South Coast region.
- Follow up meetings with all MHSA-funded programs to identify priority program challenges, needs and possible strategies to address these.

PHASE 3. PLAN DEVELOPMENT

The final Phase of the CPP Process was kicked off at the CPP Prioritization Session on April 26, 2017. The meeting goals were three-fold:

1. Present strategy recommendations, results from the Community Input Sessions and prepared public comments in support of each recommendation.
2. Provide meeting participants the opportunity to bring forward any additional strategy recommendations and to prioritize the additional recommendations.
3. Prioritize across all strategies proposed (MHSA Steering Committee only) to help identify the recommendations to include in the MHSA Three-Year Plan.

See Appendix 5 Priority Strategies – Summary of Results and Appendix 6 for all CPP Prioritization Session materials, handouts, minutes and attendance. The final MHSA Three-Year Plan was developed by the MHSA Manager considering priorities identified through stakeholder input from previous years, new priorities identified through this year's CPP process, and the fiscal landscape for the next three years.

PREVENTION AND EARLY INTERVENTION (PEI), AGES 0-25 TASKFORCE

During the CPP process, the need to convene a Taskforce of PEI experts, leaders, clients/consumers and family, and community members to develop specific strategic and programmatic recommendations for children 0-25, was identified for the following reasons:

- Projections for the next three years show an average of a little over five million dollars growth in MHSA revenue.
- MHSA guidelines require at least 51% of PEI allocations fund programs for children, youth and transition-age youth. Any PEI expansions will need to focus on this population to maintain the requirement.
- The last PEI taskforce was assembled in 2006 and since then, learnings and best practices have emerged and context has shifted.

Between October-December 2017, a PEI Ages 0-25 special taskforce was convened for three 2-hour meetings. Participants reviewed MHSA Three-Year Plan CPP data, prioritized across issues, and helped develop a final set of recommendations for the MHSA Three-Year Plan. The specific areas considered in the development of recommendations included; youth mental health crisis support and prevention; juvenile justice involved transition-age youth; early identification and treatment for children ages 0-5; school and community connectedness; and substance use/mental health evidence-based programs for youth. Three of the five areas were prioritized pending funding availability and the results of two key community planning efforts that would be important to leverage and support.

- **Youth mental health crisis support and prevention** is to be funded immediately and planning efforts are underway to launch a Request for Proposal (RFP) process.
- **Coordinated Services for Children 0-5** - First 5 SMC is nearing the completion of their Early Childhood Mental Health Systems Initiative.
- **Juvenile Justice Involved TAY -** Health Policy and Planning unit of the San Mateo County Health System will be doing a community planning process in high need, high readiness communities; the Human Impact Partners organization is working with health departments Statewide on criminal justice system reform goals.

The recommendations from the PEI Taskforce were presented to the MHSARC on January 3, 2018. The MHSARC voted to open a 30-day public comment and subsequently voted to close the public comment period after a Public Hearing on February 6, 2018. See Appendix 7 for the PEI Taskforce prioritized recommendations and all taskforce materials, handouts, minutes and attendance.

REVERSION PLANNING

During the CPP process, the need to engage in a separate process to develop a plan for Innovation funds that are subject to reversion was also identified. Due to lack of guidance on amounts subject to reversion and a process to revert funds, a one-time legislation Assembly Bill (AB) 114 was enacted allowing Counties to submit a plan by July 1, 2018 for expending their respective funds that are subject to reversion by June 30, 2020. The legislation provides additional provisions that establish a balanced approach to MHSA reversion for both past and future funds including:

- Notification of funds subject to reversion and appeal instructions will be provided to Counties.
- Reallocated funds must be spent in the same component (i.e. Prevention, and Early Intervention, Innovation, etc.) originally allocated to.
- The 3-year reversion time frame for innovation funds will now commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while awaiting approval.
- For funds moving forward, reversion guidelines will be provided (expected May 2018).

The San Mateo County Revenue and Expense Report for FY 16/17 was submitted April 30, 2018 and subsequently a second updated notice of unspent MHSA funds subject to reversion was received on May 3, 2018. A total of $4,256,155 was determined reverted as of July 1, 2017 and reallocated back to San Mateo County for AB 114 planning. Reallocated funds must be spent in the same component originally allocated to therefore; $3,832,545 will be allocated to Innovation and $423,610 to Workforce, Education and Training. The AB 114 Reversion Plan was presented to the MHSARC on May 2, 2018 where the MHSARC voted to open a 30-day public comment. On June 6, 2018 the MHSARC voted to close the public comment period after a Public Hearing and reviewing public comments and updates made to the plan. See Appendix 8 for the complete AB 114 Program and Expenditure Plan to Spend Reallocated MHSA Funds.

Enclosure 1 5/2/2018

Department of Health Care Services
MHSA Funds Subject to Reversion by Fiscal Year by Component

San Mateo	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ 423,610		$ 423,610
FY 2007-08	$ -	$ -			$ -	$ -
FY 2008-09	$ -	$ -	$ 1,048,126			$ 1,048,126
FY 2009-10	$ -	$ -	$ 246,912			$ 246,912
FY 2010-11	$ -	$ -	$ 793,069			$ 793,069
FY 2011-12	$ -	$ -	$ -			$ -
FY 2012-13	$ -	$ -	$ -			$ -
FY 2013-14	$ -	$ -	$ 786,230			$ 786,230
FY 2014-15	$ -	$ -	$ 958,208			$ 958,208
Total	$ -	$ -	$ 3,832,545	$ 423,610	$ -	$ 4,256,155

$ - No Funds Subject to Reversion
ARER expenditure data is not complete

INNOVATION PLANNING

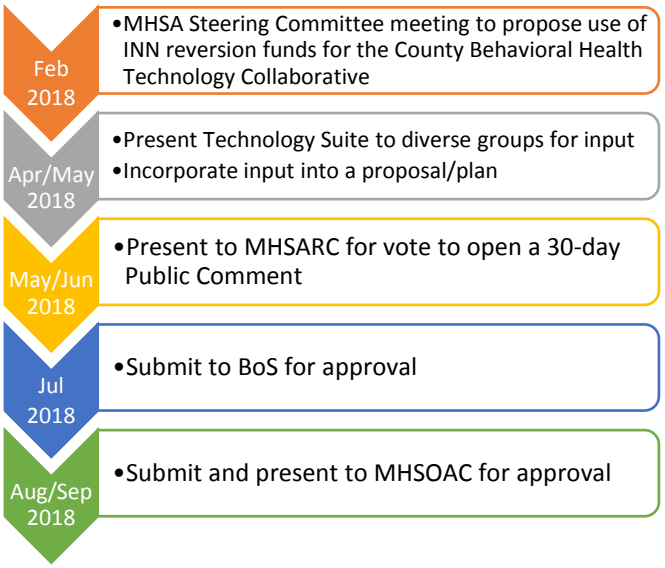
On February 16, 2018 the MHSA Steering Committee met and reviewed the AB 114 legislation and requirements and prioritized AB 114 reallocated Innovation funds for technology interventions based on 1) an unmet need in San Mateo County for technology-based interventions to support isolated adults and transition age youth and 2) the opportunity presented to join a statewide County Behavioral Health Technology Innovation Collaborative to pilot technology based –interventions.

In San Mateo County, Technology-based interventions were prioritized as part of the FY 2014-17 Community Program Planning (CPP) process and a comprehensive Innovation project development process. Due to capacity and challenges with the technology vendor's ability to pilot their apps with more acute clients, we did not pursue formal approval for the projects.

The statewide County Behavioral Health Technology Innovation Collaborative will allow San Mateo County BHRS to pilot technology based -interventions that support behavioral health and wellness intended to; increase access to mental health care; promote early detection of mental health symptoms; and predict the onset of mental illness. Specifically, a Technology Suite of mobile apps was being developed and include:

- Peer chat and digital therapeutics
- Virtual evidence-based therapy using an avatar
- Utilizing passive smartphone data for early detection and intervention

To ensure these mobile apps are relevant and specific to San Mateo County needs a CPP process that included 14 community meetings aimed to 1) inform community members about the proposed the Technology Suite and 2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about the Innovation Projects and the Mental Health Services Act to ensure their ability to meaningfully participate. A preliminary Innovation Plan was presented to the MHSARC on May 2, 2018 where the MHSARC voted to open a 30-day public comment. On June 6, 2018 the MHSARC subsequently voted to close the public comment period after a Public Hearing and reviewing public comments and updates made to the plan. See Appendix 9 for the complete San Mateo County Innovation Plan - Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Behavioral Health Interventions.



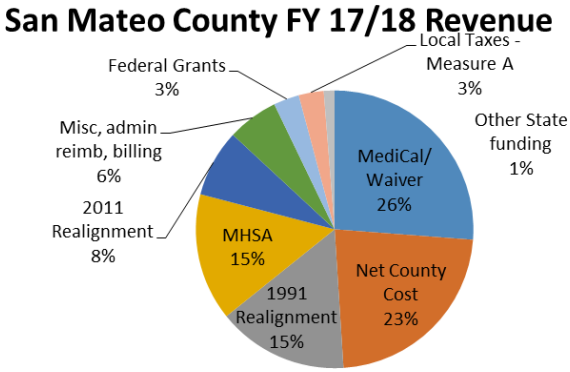
Innovation Plan Community Input Sessions

Date	Session
4/17/17	Coastside Service Area
4/17/17	Peer Recovery Collaborative
4/17/17	Northwest/Northeast Service Area
4/26/17	Youth Commission
4/30/17	Family Partners & Peer Workers
5/1/17	Monolingual Spanish Community
5/2/17	Older Adults
5/2/17	MHSARC – Public Comment
5/3/17	South County Service Area
5/3/17	Central Service Area
5/4/17	Diversity and Equity Council
5/8/17	BHRS Management
5/8/17	Monolingual Chinese Community
5/10/17	East Palo Alto Service Area

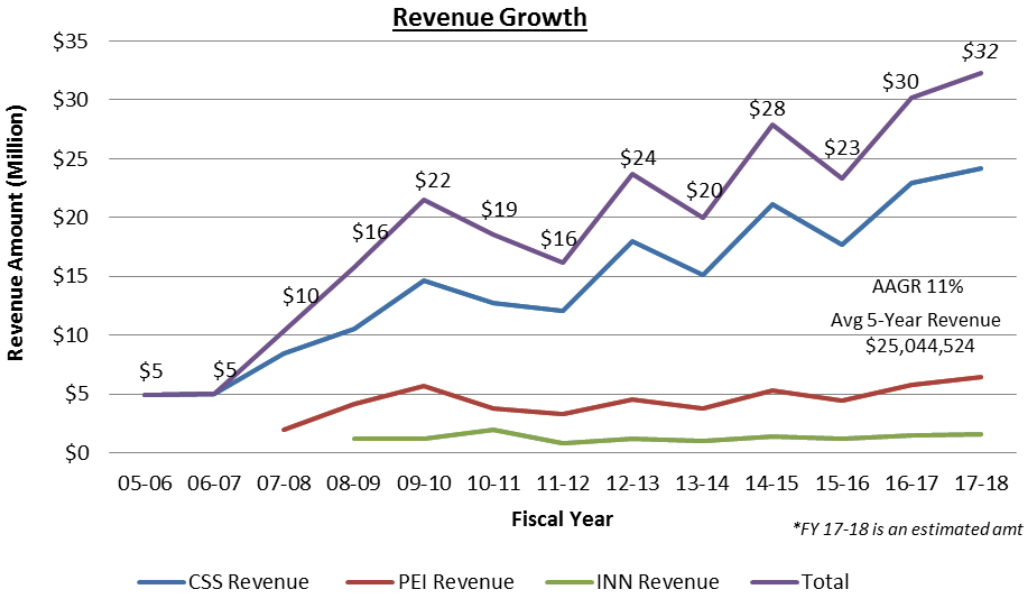
FUNDING SUMMARY

FUNDING SUMMARY

MHSA has provided a dedicated funding stream for transformation of the behavioral health services and improving the quality of life for individuals living with mental illness. Statewide it represents a little under a third of community mental health funding. In San Mateo County it represents about 15% of the behavioral health revenue, translating to $25.5 million annual average for San Mateo County in the last five years through Fiscal Year 2016-17.



The annual revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that take into account information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association (CBHDA), and ongoing internal analyses of the State's fiscal situation. MHSA revenue is driven by the economy and only one tenth of 1% of tax payers are subject to the MHSA tax. The following chart shows annual revenue allocation for San Mateo County since the inception of MHSA. Initially, in Fiscal Years (FY) 04-05 and FY 05-06, funding was received for Community Services and Supports (CSS) only. Prevention and Early Intervention (PEI) and Innovations (INN) dollars were released in FY 07-08 and FY 08-09, respectively. Commencing July 1, 2012, the County began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation that fiscal year. Additionally, changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in an additional increase in funding in FY 14-15.



FUNDING CONSIDERATIONS

MHSA Funding Guidelines

Following are a few funding requirements and guidelines that influence expenditure planning:

- 75-80% of total annual revenue must be allocated to CSS .
  - At least 51% of CSS must be spent on FSPs.
- 25-20% of total annual revenue must be allocated to PEI.
  - At least 51% of PEI must be spent on programs serving ages 0-25.
- 5% of total annual revenue must be allocated to INN.
- Up to 20% of the average of previous 5-year revenue may be spent on Prudent Reserve, CF/T and/or WET.
- Up to 5% of total annual revenue may be spent on planning processes.

San Mateo County must take a prudent approach to volatile MHSA resources, sustaining core programs that were prioritized by stakeholders during initial MHSA planning and strengthening the areas that are most vulnerable and critical to getting us closer to our goal of becoming an integrated, responsive, effective system of care for behavioral health clients

Prudent Reserve

The State requires Counties to establish a Prudent Reserve to ensure that unforeseen decreases in the revenue would not cause programs to cease. Department of Health Care Services (DHCS) Info Notice 11-05 rescinded the 50% Prudent Reserve requirement and left it up to the counties to determine an appropriate reserve level. MHSA fiscal consultants have recommended 50% of the total local revenue or 80% of CSS as an appropriate level of reserve. San Mateo County's Prudent Reserve remains at $600,000 and we have opted to leave additional unspent funds in an MHSA Trust Fund instead of the Prudent Reserve; as we await further guidelines on how we would be able to access funds if needed. Currently, San Mateo County MHSA Trust Fund and Prudent Reserve together totals about $23 million. With a $15-18 million target reserve and $7 million accounted for in current projects, there is a small to no excess reserve, see figure below. With expected increasing revenues, any future excess reserve will be used to advance MHSA program priorities, within funding guidelines. BHRS is beginning a strategic planning process this summer that will engage stakeholders, community partners and staff in creating a vision for behavioral health in our County; this will further inform MHSA funding priorities.

Reserve Scenarios

50% of Total Revenue Reserve	
Trust Fund (Unspent)	$22,581,911
Committed Amount for INN and WET	-$7,016,452
Prudent Reserve	+$600,000
Estimate Reserve Goal	- $15,000, 000
Excess Reserve	**$1,165,459**

80% of CSS Reserve	
Trust Fund (Unspent)	$22,581,911
Committed Amount for INN and WET	-$7,016,452
Prudent Reserve	+$600,000
Estimate Reserve Goal	- $18,000, 000
Excess Reserve	($1,834,541)

MHSA One-Time Allocations

There are three MHSA funding components that were designated one-time allocation with a 10-year reversion, Workforce Education and Training (WET), Housing, and Information Technology and Capital Facilities (IT/CF), which was fully expended on BHRS electronic health record system in FY 08/09. The following is an update on the remaining two components:

WET – $3,437,600 was allocated to WET for 10 years through what was expected to be FY 17-18, according to a letter provided by the California Department of Mental Health on October 27, 2011. A recent DHCS Info Notice No. 17-059, determined that WET funding allocated in FY 07-08 expire FY 16-17, therefore an AB114 Reversion Plan for WET is being submitted, see Appendix 8. To sustain the most impactful elements of the WET component moving forward, WET 10-Year Impact and Sustainability Report, see Appendix 10, was released and presented to the MHSARC on February 7, 2018. The recommendation is to transfer $500,000 from CSS to WET to continue funding WET activities.

Housing – on June 2, 2015, the San Mateo County Board of Supervisors adopted a resolution approving the request to release of unencumbered Housing funds per AB 1929; a total of $1,073,038 was received by BHRS. A plan for the use of unencumbered Housing funds was presented to the MHSA Steering Committee on March 2017 and funds are expected to be expended by end of fiscal year 2017-2018 by the Affordable Housing Fund administered by the Department of Housing for the development of affordable housing. The housing units will lead to 12 additional units for MHSA Full Service Partnership clients. See the Housing component section in the Annual Update for additional details.

No Place Like Home Legislation Local Impact

The "No Place Like Home" legislation relies on MHSA funds to securitize a $2 billion bond for chronically homeless individuals with serious mental illness. In order to help inform local analysis of the impacts, the County Behavioral Health Director's Association (CBHDA) developed estimates of statewide and county-by-county impacts. San Mateo County cost would be $2 million, taken "off the top" of MHSA revenues each month, which means decreased expansion monies for MHSA programming is expected in FY 2018-19.

EXPENDITURE SUMMARY AND PRIORITY EXPANSIONS

A summary of MHSA expenditures by component for the next three years is enclosed, see Appendix 11. During the Three-Year Plan for FY 2014-15 through FY 16-17, significant decrease in PEI revenue was projected and BHRS anticipated having overall spending in the Three-Year Plan to decrease as well to make up for this deficit. While there was a $5 million decrease in FY 15-16, the following year brought a significant increase. Revenue maintenance coupled with unspent funds from previous years and savings from the Total Wellness (now funded by the Health Plan of San Mateo) allowed for implementation of MHSA priority expansions as shown below.

Component	Updated Priority Expansions FY 14-17	Implemented	FY
CSS, FSP	Drop-in Center (DIC) in South County	**YES** Edgewood DIC	15/16
	FSP slots for transition age youth (TAY)	**YES** Edgewood TAY FSP	15/16
	Wraparound services for children and youth	**YES** Edgewood C/Y FSP	15/16
	FSP slots for older adults	**YES** 50 FSP slots - Laura's Law	16/17
CSS, Non-FSP	Support and assistance program to connect MI with vocational, social and other services	**YES** The California Clubhouse	14/15
	Expansion of supports for transition age youth	**YES** YTAC Peer Support Worker	16/17
	Expansion of supports for isolated older adults	**NO**	Expected 18/19
PEI	Culturally aligned and community-defined outreach with a focus on emerging communities and outcome-based practices	**YES** LGBTQ and Pacific Islander Outreach Workers	16/17
	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts	**NO**	Expected 18/19

MHSA-specific priorities identified by stakeholders in previous planning years, that have not been implemented, remain top priorities moving forward:

PRIORITY EXPANSIONS FOR THREE-YEAR PLAN

Component	Updated Priority Expansions	Estimated Cost Per Fiscal Year
CSS General Systems Development	Expansion of supports for older adults *	$130,000
	Mobile mental health and wellness services to expand access to Coastside behavioral health clients and families	$400,00
CSS Outreach & Engagement	Expansion of culturally responsive outreach strategies to effectively link high-risk, isolated and emerging cultural and ethnic groups to needed services	$50,000
	TOTAL CSS	**$580,000**

Component	Updated Priority Expansions **	Estimated Cost Per Fiscal Year
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	$50,000
	Youth mental health crisis support and prevention**	$600,000
	After-care services for early psychosis treatment for reengagement, maintenance and family navigator support	$230,000
	TOTAL PEI	**$650, 000**

* Reprioritized from Previous Expansion Plan

** Added 2/7/17 based on the PEI Taskforce Recommendations approved by the MHSARC; see the Community Program Planning (CPP) process section. After-care services for early psychosis was originally prioritized during the CPP process pending outcomes of the PEI Taskforce, which required a focus on programs strictly serving children and youth ages 0-25 to maintain the 51% PEI requirement.

THREE-YEAR PROGRAM PLAN
FY 2017-2018 THROUGH 2019-2020

THREE-YEAR PROGRAM PLAN FY 2017-2020

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) that addresses each MHSA component and include expenditure projections.The San Mateo County MHSA Three-Year Plan aligns with the Behavioral Health and Recovery Services (BHRS) of the San Mateo County Health System's commitment a holistic view to the health and well-being of individuals; placing high value in care coordination, collaboration and integration, prevention and early intervention, data-driven interventions, cost control, quality improvement, and meaningful outcomes.

MHSA-funded activities described in this Three-Year Plan also support and further BHRS' nine strategic initiatives, which represent the main areas of focus of work. These include:

- advance prevention and early intervention;
- build organizational capacity;
- empower consumers and family members;
- be prepared for the unexpected;
- enhance systems and supports;
- foster "total wellness" understood as an approach to health that includes both the behavioral and the physical;
- promote diversity and equity;
- cultivate learning and improvement; and
- be welcoming and engaging to those who seek our services and work with us.

The following pages describe the MHSA Three-Year Plan programs and priorities developed taking specific priorities identified through stakeholder input from previous years, new priorities identified through this year's Community Program Planning process, and the fiscal projections for the next three years. Our multi-year approach facilitates stability, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years to cushion lower revenue years.

COMMUNITY SERVICE AND SUPPORTS (CSS)

CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance with a focus on un-served and underserved populations. CSS is the largest MHSA component, approximately 75-80% of MHSA funding. There are three different service categories; Full Service Partnerships (FSP), System Development (SD), and Outreach and Engagement (O&E). At least 51% of CSS funds must be spent on FSPs and focus on un-served and underserved populations.

FULL SERVICE PARTNERSHIP (FSP)

FSPs include 24 hours a day, 7 days a week services; peer supports; high staff to client ratios for intensive behavioral health treatment including medications; linkage to housing; supported education and employment; treatment for co-occurring disorders; skills based interventions, among others. The target population for FSPs include, high risk children and youth who would otherwise be placed in a group home; seriously mentally ill and dually diagnosed adults including those eligible for diversion from criminal justice incarceration; incarcerated individuals; persons placed in locked facilities who can succeed in the community with intensive supports; and individuals with frequent emergency room visits, hospitalizations, and homelessness; and seriously mentally ill older adults at risk of or currently institutionalized who could live in a community setting with intensive supports.

Current programs under CSS FSP component category will continue. In FY 2017-18 through FY 2019-20, the following FSP services will be provided:

Children and Youth Full Service Partnerships - helps our highest risk children and youth with serious emotional disorders remain in their communities and with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for intensive school-based services, school-based milieu services, and the non-public school setting, will continue. FSPs for children and youth will also serve youth placed in foster care temporarily outside of the County to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to San Mateo County.

Projected number of children and youth to be served through FSPs: 105 (added 5 slots)

Transitional Age Youth (TAY) Full Service Partnerships - provides intensive community based supports and services to youth identified as having the "highest needs" who are between the ages of 16-25. Specialized services to TAY with serious emotional disorders are provided to assist them to remain in or return to their communities, support positive emancipation including transition from foster care and juvenile justice, secure, safe, and stable housing and achieve education and employment goals. TAY FSPs helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system.

TAY FSPs will continue to provide enhanced supported education services to TAY with emotional and behavioral difficulties and/or substance use issues. Outreach activities engage TAY in educational or vocational activities for educational plans and employment. Housing services for TAY will provide housing subsidies and a small cluster of apartments. Teaching daily living skills, medication management, household safety/cleanliness, budgeting, and roommate negation skills are a part of the treatment and education of the youth.

Projected number of TAY to be served through FSPs: 50 Comprehensive FSPs (added 10 slots), 40 Enhanced Education, 20 Supported Housing

Adult and Older Adult Full Service Partnerships – provides services specific to maximize social and daily living skills and facilitate use of in-home supportive agencies. Services are provided to our highest risk adults, highest risk older adults/medically fragile adults. The overall goal of the adult FSPs is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The goal of the FSP is to facilitate or offer "whatever it takes" to ensure that consumers remain in the least restrictive setting possible through the provision of a range of community-based services and supports delivered by a multidisciplinary team. A housing program provides FSP members stable housing by providing additional oversight and support to enable members who might otherwise be at risk of losing their housing to stay consistently housed. This also includes some supplementing of residential care facilities for clients who require this level of supervision and services.

Projected number of adults, older adults and medically fragile individuals to be served: 252 plus housing supports

OUTREACH AND ENGAGEMENT (O&E)

San Mateo's MHSA-funded Outreach and Engagement program strategy increase access and improves linkages to behavioral health services for underserved communities. Current programs under this component category will continue. BHRS has seen a consistent increase in representation of underserved communities in our system since these MHSA-funded strategies were deployed. Strategies include:

Community outreach collaboratives **-** intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; linking and referring residents to culturally and linguistically competent behavioral health, public health and social services; and providing input into the development of MHSA funded services and other BHRS program initiatives.

Projected number of people reached: 6,000

Pre-crisis response **-** provides outreach, engagement, assessment, crisis intervention, case management and support services to individuals who are experiencing severe emotional distress and their families/caretakers.

Projected number of people reached: 100

Primary care outreach **-** identifies and engages individuals presenting for healthcare services that have significant needs for behavioral health services.

Projected number of people reached: 500

GENERAL SYSTEM DEVELOPMENT (GSD)

System development initiatives strengthen and expand our internal capacity to respond to service demands by funding culturally competent clinical positions trained in cutting edge evidence-based practices; peer support services; and supported education/employment, to name a few. Current programs under this component category will continue and include:

Older adult system of care – to create integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and community, in optimal health and sustaining independence and family/community connections.

Projected number of older adult consumers/clients served: 775

Criminal justice system involvement – to provide treatment and support services to seriously mentally ill non-violent offenders and divert from incarceration into community-based services.

Projected number of mentally ill non-violent offenders consumers/clients served: 80

Co-occurring services –to support services for clients with co-occurring mental health and substance use disorders with additional bed days (for residential providers) or additional hours of service (for non-residential providers), or to enhance/supplement services provided to clients already in treatment.

Projected number of Units of Service for co-occurring consumers/clients served: 4,152

Child Welfare programs – to support services for high risk children/youth referred through child welfare programs.

Projected number of high-risk children/youth served: 100

Dual diagnosis, developmental disabilities services– to serve the special mental health needs of clients with developmental disabilities with comprehensive mental health treatment including medication management.

Projected number of mentally ill consumers/clients with developmental disabilities served: 40

Peer and family partners – to support employment of consumer/client and family partners with lived experience within the county behavioral health system of care, which recognizes the special contributions and perspectives of behavioral health consumers/family members and encourages the valuable role of peer support and case management.

Projected number of consumers/clients served through peer support strategies: 350

Wellness centers – to support wellness and recovery of clients and their families in the community. Provide opportunities for increased socialization, employment, education, resource sharing and self-advocacy.

Projected number of consumers/clients served through drop-in centers: 100

Evidence-based practices (EBP) – to support provision of evidence-based services throughout BHRS for youth and adult consumers/clients.

Projected number of consumers/clients served by EBP clinicians: 1,000

PREVENTION AND EARLY INTERVENTION (PEI)

PEI interventions target individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders such as schizophrenia. PEI programs are designed and implemented to help create access and linkage to treatment, improve timely access to mental Health services for individuals and/or families from underserved populations and are non-stigmatizing and non-discriminatory. San Mateo has focused its PEI dollars primarily on evidence-based interventions that have a proven track of success. PEI is approximately 15-20% of the MHSA budget with 51% of PEI funds be spent on children and youth ages 0 to 25. Counties are required to include:

- At least one Prevention program to reduce risk factors for developing a potentially serious mental illness and to build protective factors.
- At least one Early Intervention program to provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence.
- At least one Outreach program for increasing recognition of early signs of mental illness through engaging, encouraging, educating, and/or training potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

In addition Counties may include one or more stigma and discrimination reduction programs and suicide prevention programs. Current programs under the PEI will continue. In FY 2017-18 through FY 20119-20, the following PEI services will be provided:

PEI INTERVENTIONS (AGES 0-25)

Early childhood community program – supports healthy social emotional development of children through community outreach, case management, parent education, mental health consultation, and child-parent psychotherapy services to families with young children.

Projected number of children and families with young children to be served: 80

School-age youth programs – will serve children and youth in grades K-12 either administered by a school or a community-based organization in cooperation with schools. This program provides population and group based interventions to at-risk children and youth, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. There are four interventions under this category: Teaching Pro-social Skills, Project SUCCESS, Seeking Safety, and the Middle School Initiative, Project Grow.

Projected number of school-age youth to be served 380

Crisis hotline and intervention – a free, confidential 24-hour, seven days a week crisis intervention hotline for San Mateo County residents provided by trained volunteer/staff. Provide peer phone counseling linkages to resources that may help.

Projected number of school-age youth to be served 100

EARLY INTERVENTION

Integration with primary care –identifies persons in need of behavioral health services in the primary care setting, connecting people to needed services. Strategies include system-wide co-location of BHRS practitioners in primary care environments to facilitate referrals, perform assessments, and refer to appropriate behavioral health services.

Projected number of clients served 600

911 mental health assessment and referral - specially trained paramedic responds to law enforcement requests for individuals having a behavioral health emergency.

Projected number of school-age youth to be served 5,500 calls

Prevention of early onset of psychotic disorders – to provide a comprehensive program of science-based early diagnosis, treatment, and rehabilitation services for psychotic disorders such as schizophrenia. This program aims to prevent the onset of full psychosis, and, in cases in which full psychosis has already occurred, seeks to remit the disease and to rehabilitate cognitive capacities damaged by the disease.

Projected number of school-age youth to be served 100

PREVENTION, RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS, ACCESS AND LINKAGE TO TREATMENT

Office of Diversity and Equity (ODE) programs – ODE programs promotes cultural competence and address health inequities through information and data, training, dialogue and collaboration regarding diversity and social justice. The current programs under ODE that will continue in FY 13-14 through 16-17 include culturally-relevant provider trainings, Digital Storytelling, Mental Health First Aid for adults and youth, Parent Project, Photovoice, and the Health Equity Initiatives. In addition, two programs were started this FY 13-14, the Chinese Outreach Worker pilot project and the Health Ambassador Program.

Projected number of people reached through ODE programs: 1,600

STIGMA AND DISCRIMINATION REDUCTION & SUICIDE PREVENTION

Stigma Free San Mateo County, Be the ONE campaign - is an initiative by San Mateo County's Behavioral Health and Recovery Services (BHRS) to eliminate stigma and end the discrimination against people with mental illness and substance use issues in San Mateo County. It is an extension of stigma reduction work started years ago as part of the Anti-Stigma Initiative.

Suicide Prevention - For over three years, San Mateo County has convened a Suicide Prevention Committee that has examined ways to improve policies and systems to prevent suicide. The Committee is comprised of both BHRS staff and community members, and address issues such as community mental health education and awareness, gatekeeper trainings, and provider trainings on suicide ideation and intervention. Activities have included suicide prevention presentations at agencies and community meetings, partner meetings with the County Office of Education, and data updates.

Projected number of participants served: 800

PEI STATEWIDE PROJECTS

California Behavioral Health Services Authority (CalBHSA) implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalBHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services. San Mateo County will continue to contribute 2% of PEI funding for sustainability of these projects.

INNOVATION

On July 28, 2016, three MHSA INN project plans were presented to the State of California, Mental Health Services Oversight and Accountability Commission (MHSOAC). All three projects were approved and will continue implementation through FY 2018-19.

The Health Ambassador Program for Youth (HAP-Y) - will adapt, pilot and evaluate a psycho-educational process (based on an adult Health Ambassador Program) to train youth ages 16-25 as ambassadors for mental health awareness, stigma reduction and in turn increase access to mental health services. The project will be administered by StarVista, who's role includes supporting the youth post-graduation with opportunities to engage in community presentations, outreach, advisory roles, etc.

Projected number of participants served: 30 graduates

The LGBTQ Behavioral Health Coordinated Services Center (The Center) - will provide a coordinated approach across mental health treatment, recovery and supports forLGBTQ high risk LGBTQ communities and include the collaboration of multiple agencies. The Center will include a space where groups, events and other activities will be held and feature the coordination of three components; 1) a social and community component; 2) a clinical component; and 3) a resource component.

Projected number of participants served through outreach encounters - 5,000; unduplicated referrals - 300-400; clients served in clinical services (group participants, case management, more intensive services) - 50-80.

The Neurosequential Model of Therapeutics (NMT) - within an Adult Service System will adapt, pilot and evaluate the application of the NMT approach (primarily used with youth) to an adult population, within the BHRS Adult System of Care. NMT locates the neurobiological reason for an individual's behavioral problems and, if appropriate, provides a holistic approach integrated with multiple forms of targeted therapies that may include music, dance, yoga, drumming, therapeutic massage, etc.

Projected number of participants served: 100

WORKFORCE EDUCATION & TRAINING (WET)

Workforce Education and Training (WET) is an MHSA funding component that is designated one-time allocation with a 10 year reversion. WET funds, totaling $3,437,600, were allocated for 10 years. In the spring of 2017, the BHRS Office of Diversity and Equity (ODE) hired an independent consultant to assess the impact of WET and identify priorities that would shape the future landscape. A WET 10-Year Impact and Sustainability Report, see Appendix 10, was released and presented to the MHSARC on February 7, 2018 recommending $500,000 to be transferred from CSS to WET to sustain the most effective and impactful elements of WET investments. The following components will continue:

Training, technical assistance, and capacity building - Training opportunities have greatly increased the capacity of community members and providers to respond to behavioral health issues; use evidence-based practices to help address an array of mental illness identification strategies including suicidality; and address public perception on behavioral health issues (stigma, suicide, etc.).

Workforce staffing support -The plan and all BHRS training activities are overseen by a Workforce Development Director and a 0.5 FTE Community Resource Specialist. This team has system wide responsibility for managing implementation, reporting and evaluation of the MHSA Education and Training Plan.

Training and technical assistance for and by consumers and family members – This program aims at providing a range of trainings activities, as follows:

- Trainings delivered by and for consumers and family members;
- Trainings provided by consumers and family members to providers and the general public to increase understanding of mental health issues and to reduce stigma;
- Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports;

In addition, this program also provides for selected consumers and family members to attend leadership trainings to support increased involvement of consumers and family members in various committee, commission, and planning roles.

Trainings to support wellness and recovery – San Mateo County BHRS engages in training to extend and support consumer wellness and recovery. An example of an activity to this end is the implementation of Wellness Recovery Action Plan Trainings (WRAP). WRAP is a self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers

"[trainings] helped me see my clients in a new light and really, really show respect to them and support them." – BHRS clinician

with co-occurring disorders. With a train-the-trainer approach, consumers, family members, and selected staff (County and contracted providers) are trained as Master Trainers. The "Master Trainers" then provide training and support in developing WRAP plans for consumers and staff throughout our system.

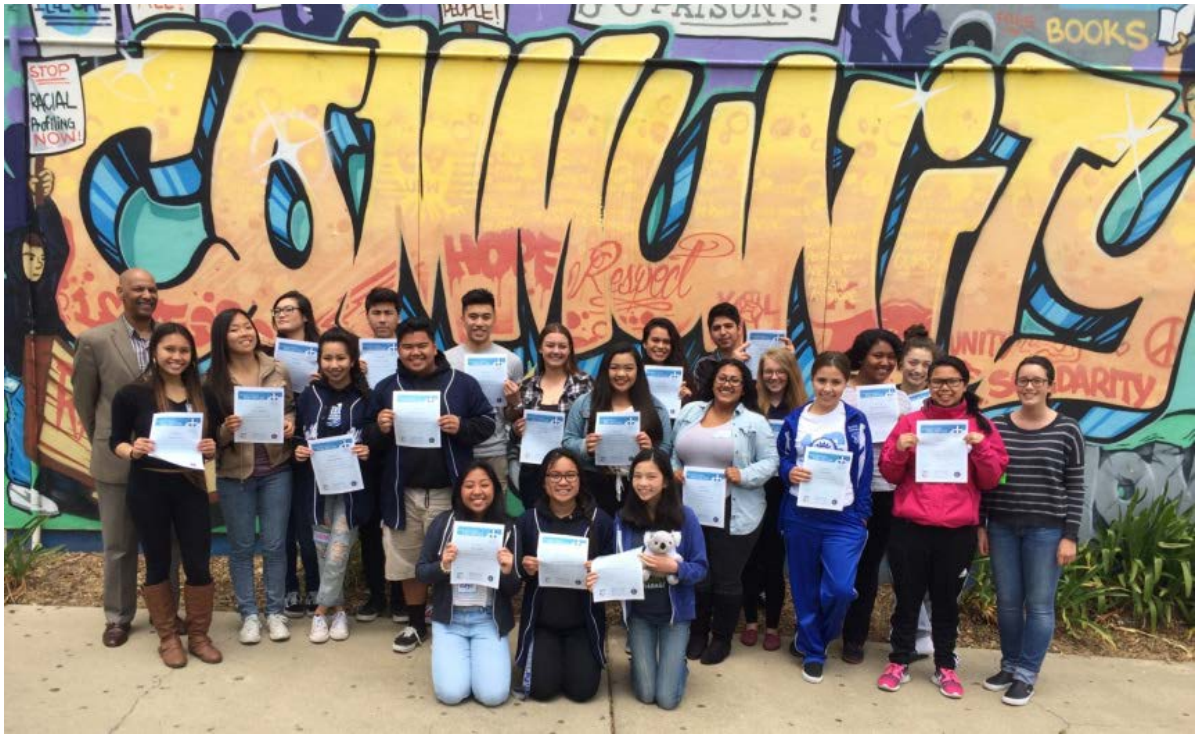
Cultural competence training – Training in the area of cultural competence is designed to reduce health disparities in our community, to provide instruction in culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. Trainings are also used to help support key Health Equity Initiatives (HEI).

Evidence-based practices training for system transformation – System transformation is supported through an ongoing series of trainings that increase utilization of evidence-based treatment practices that better engage consumers and family members as partners in treatment and that contribute to improved consumer quality of life. Recommendations for training on evidence-based practices (EBPs) to incorporate into the different series may come from consumers, family members, or public and private agency staff by submitting a form to the Workforce Development Director, who then submits the request to the Training Committee for consideration. Suggested trainings shall be consistent with the values of the MHSA and shall contribute to the creation of a more culturally competent system.

Mental health career pathway programs – Multiple workgroup discussions concluded that strategies are necessary to address ongoing vacancies in positions which are difficult to fill. Strategies include:

- Attract prospective candidates to hard-to-fill positions via addressing barriers in the application process and incentives
- Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system
- Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in behavioral health.
- Hire and retain diverse staff to better reflect diversity of client population
- Expand existing efforts and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system
- Ongoing engagement and development of client and family workers

Financial incentive programs/Stipend Internships – to create a more culturally competent system**,** this program provides stipends to trainees from local universities who contribute to expand the diversity as well as the linguistic and cultural competence of our workforce. Our stipend program for interns offers a fixed amount to students in our system to assist in covering their expenses in hopes they will pursue careers in public mental health.



ANNUAL UPDATE
FY 2017-2018

(program highlights and data from FY 2015-2016 services)

ANNUAL UPDATE FY 2017-18

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. The Annual Update includes any changes to the Plan and expenditures.

Given that data for a full fiscal year is not readily available by the time plans need to be submitted to the State, this Annual Update discusses program highlights and data from FY 2015-16.

COMMUNITY SERVICES AND SUPPORTS

Community Services & Support (CSS) provides direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED). Housing is a large part of the CSS. Required service categories include:

- **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, which include mental health and non-mental health services and supports in order to advance the client's goals and support the client's recovery, wellness and resilience.

- **General Systems Development (GSD)** improves the County's mental health service delivery system. GSS may only be used for; mental health treatment, including alternative and culturally specific treatments; peer support; supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education; wellness centers; personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services; needs assessment; individual Services and Supports Plan development; crisis intervention/stabilization services; family education services; improve the county mental health service delivery system; develop and implement strategies for reducing ethnic/racial disparities.

- **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

COMMUNITY SERVICE & SUPPORT (CSS)

FULL SERVICE PARTNERSHIPS (FSP)

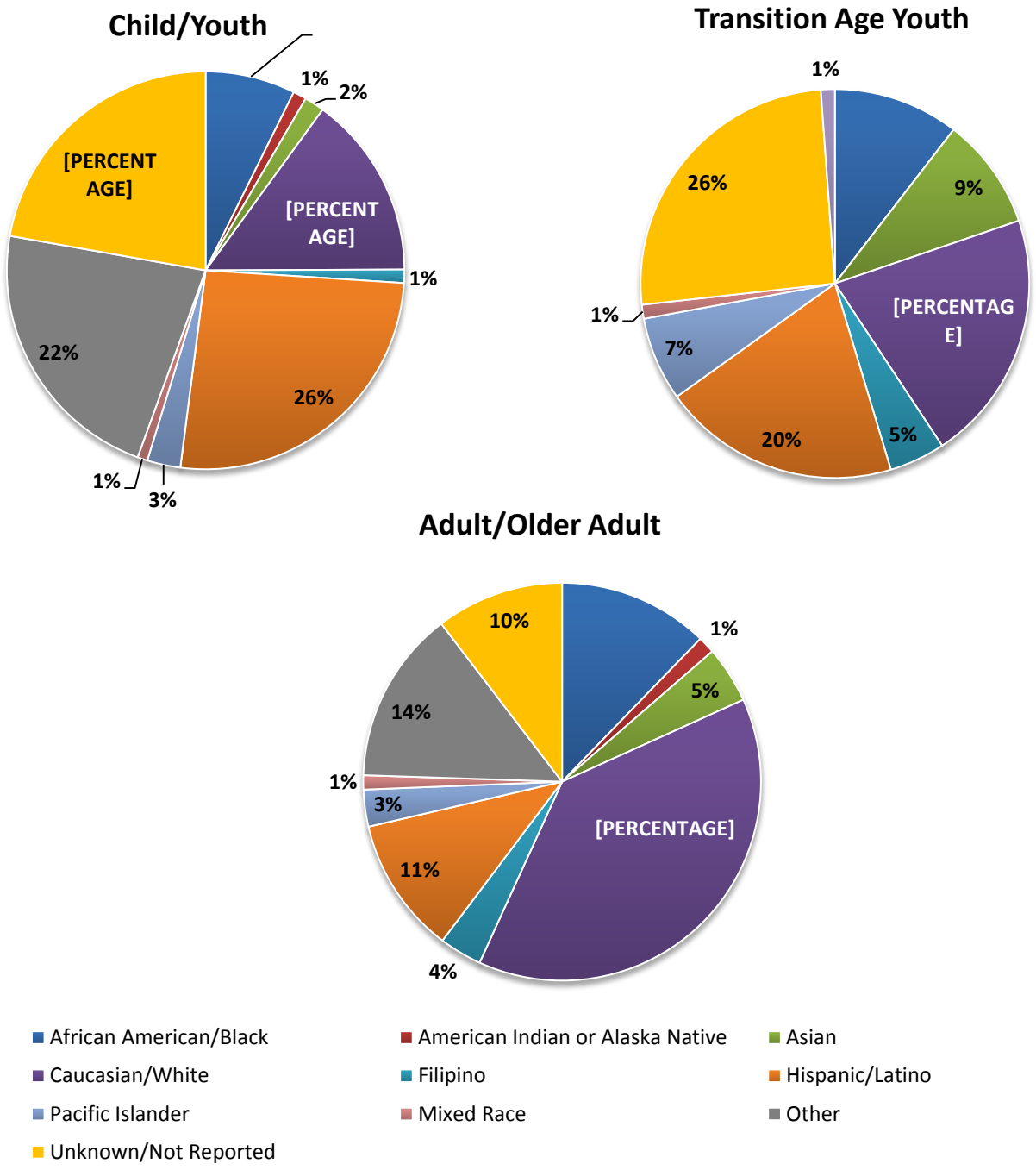
Within San Mateo County, the initial FSP programs, Edgewood, Fred Finch, and Telecare, have been fully operational since 2006. A fourth site, Caminar's Adult FSP, was added in 2009. FSP programs do "whatever it takes" to help seriously mentally ill adults, children, transition-age youth and their families on their path to recovery and wellness. Edgewood Center and Fred Finch Youth Center serve children, youth and transition age youth (C/Y/TAY) using the Wraparound model and Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

Based on currently contracted amounts and slots, the average FSP cost per person is $26,650 with age breakdowns in the table below. Clients enter and discontinue participation throughout the year, cost per person based on clients served was $ Cost per person figures do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

Program	FY 15-16 Clients served	FSP slots	Cost per person*
Children/Youth (C/Y) FSP's	**149**	**100**	**$42,388**
C/Y in Out-of-County Foster Care Settings FSP (Fred Finch)	30	20	$27,792
Integrated FSP "SAYFE" (Edgewood)	59	40	$47,052
Comprehensive FSP "Turning Point" (Edgewood)	60	40	$45,022
Transitional Age Youth (TAY) FSP's	**105**	**40**	**$45,022**
Comprehensive FSP "Turning Point" (Edgewood)	50	40	$45,022
Enhanced Supported Education Services (Caminar)	43	40**	$4,236
Supported Housing Services (MHA)	12	20**	$17,166
Adult/Older Adult FSP's	**287**	**252**	**$17,489**
Adult and Older Adult/Medically Fragile FSP (Telecare)	245	207	$16,686
Housing Support (Telecare)	110	90**	$15,723
Comprehensive FSP (Caminar)	34	30	$27,854
Housing Support (Caminar)	---	18**	$9,630
Integrated FSP (Mateo Lodge)	14	15	$7,847

*Calculated based on # of contracted slots; there are reimbursements and other revenues sources associated with FSP's that decrease the final MHSA funding contribution.
** Contracted service goal

FSP RACE/ETHNICITY DEMOGRAPHICS BY AGE GROUP



FSP PERFORMANCE OUTCOMES

As part of San Mateo County's implementation and evaluation of the FSP programs, American Institutes for Research (AIR) analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness.

Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs include data in 10 domains; residential (e.g. homeless, emergency shelter, apartment alone) education (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance abuse, and for older adults, activities of daily living and instrumental activities of daily living.

FSP PERFORMANCE OUTCOMES BY AGE GROUP

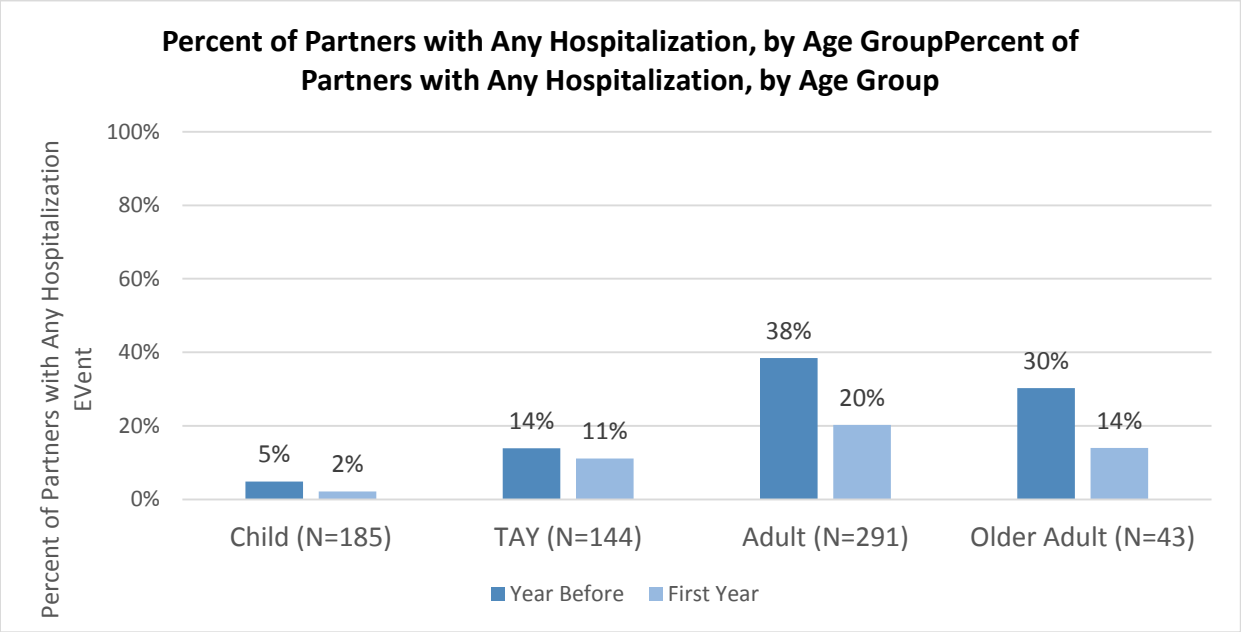
The table, below is the percent improvement from the year just prior to participating in the FSP and the first year in FSP, by age group. During the first year of FSPs, clients continue to demonstrate positive health outcomes in particular for arrests, mental and physical health emergencies and school suspensions for youth. These positive outcomes are mostly maintained when looking across four or five years of continued participation. Specific outcomes for youth (school attendance, grades and suspensions) demonstrated some variability across years of participation, although it is a small number of the most high-risk youth and should not be over-interpreted. The complete FSP outcome report is enclosed, see Appendix 12. Edgewood and Fred Finch served Child clients (aged 6-21) and Transition Age Youth (TAY) clients (aged 17-25). Telecare and Caminar served primarily Adult clients (aged 26-59). Some clients began FSP as TAY, and some clients began FSP as an Older Adult (OA) (aged 60+).

Self-reported Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Homelessness	50%	18.4%	30%	**
Detention or Incarceration	(50%)	23%	27%	**
Arrests	68.1%	76%	86%	**
Mental Health Emergencies	86.1%	74%	57%	41%
Physical Health Emergencies	100%	67%	66%	30%
School Suspensions	41%	76%	**	**
Attendance Ratings	8%	(1)%	**	**
Grade Ratings	11%	6%	**	**
Employment	**	**	37%	**

* With the exception of attendance and grade ratings, the table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP.

** Not Reported

Consistent from 2015 findings, there was a notable improvement across all ages for two key dimensions for FSPs, Hospitalizations and Psychiatric Emergency Service (PES) visits. The table below shows the percent of clients with any hospitalization decreases after joining FSP for all age groups. Adults experienced the greatest percentage point reduction from 38% of partners with any hospitalization before FSP decreasing to 20% during FSP.



See Appendix 12 for the full report of outcomes developed by the American Institute for Research in partnership with BHRS.

CHILDREN AND YOUTH (C/Y) PROGRAM HIGHLIGHTS

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: "TURNING POINT" AND "SAYFE"

Edgewood's comprehensive FSP Service has the capacity to serve 85 youths at any given time through our Turning Point – Child and Youth (C/Y, 45 slots) and Short-term Adjunctive Youth and Family Engagement (SAYFE, 40 slots) programs.

Youths are primarily referred to the programs through Human Services Agency (HSA – child welfare), Juvenile Probation, San Mateo County Clinics, and Schools (typically with an IEP for emotional disturbance in place). Our treatment is provided in effort to help stabilize a youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.).

The comprehensive FSP provides a variety of services to youths and their families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These

services may include case management, 24/7 crisis support, family conferencing, individual therapy, family therapy, group therapy, family partner services, caregiver support groups, behavior support, Therapeutic Behavioral Services (TBS), access to our After School Intensive Services (ASIS) program (youths aged 6-14) and access to the Supporting Emerging Adults (SEA) program at Edgewood's Drop In Centers (youths 18-25).

DEMOGRAPHICS

A total of 130 unduplicated youths were served through our programs in FY15-16. The census was slightly higher (70 youths) in C/Y compared to (60 youths in) SAYFE. While there was a range of ages served, 85% of youths were clustered around adolescence (12-18) and it is notable that Edgewood FSP has not seen as many emerging adults under care.

Total Clients Served			
130			
Male	72	Female	58
Race/Ethnicity			
Latino/Other Spanish-American	40%		
White/Caucasian	23%		
Black/African American	17%		
Middle Eastern/North African	4%		
Pacific Islander	2%		
Pilipino/Filipino	2%		
American Indian/Alaskan Native	1%		
Chicano/Mexican-American	1%		
Chinese/Chinese-American	1%		
Other	1%		

PROGRAM IMPACT

During the 2015-2016 Fiscal Year, the FSP services in San Mateo County expanded. When Edgewood began delivering services in 2006, services started out with the Turning Point program for children and youth, Therapeutic Behavioral Services, a Drop-In Center (North), and the After Hours Crisis Line. In 2009, Edgewood added SAYFE and the After School Intensive Services (ASIS) programs. During the FY15-16, Edgewood added a second Drop-In Center (South) as well increased the capacity of the child and youth programs to serve an additional 15 clients.

Nearly all of Edgewood youth are affected by complex trauma at a personal, familial, intergenerational, societal, and cultural level. In order to treat these complex needs, Edgewood

utilizes a multifaceted approach to help children, youth, and their families achieve independence, stability, and wellness within the context of their family, community, and culture. Our services include comprehensive mental health treatment, case coordination, skills training, and 24/7 crisis support.

SUCCESSES/CHALLENGES

A 15 year old female was referred to Turning Point – C/Y services in September 2015 to address her depressive symptoms (e.g., multiple suicide attempts, low frustration tolerance, and anger outbursts) and high risk behaviors (e.g., AWOL gestures, property destruction, and physical aggression). Adequate supervision was a concern as the youth's grandmother, her primary caregiver, was overwhelmed with caring for the youth and the youth's two and three year old nieces. What is more, the youth was nine months pregnant at the time of her referral. C/Y services supported the youth and family by identifying their needs and linking them to resources such as local food banks, clothing closets, and housing opportunities. The family partner supported the grandmother in the development of coping skills, identifying areas of interest, and the emphasized the importance of self-care. The youth received support surrounding the development of coping strategies, self-esteem building, and assertive communication skills. Since the birth of her daughter, the youth has reported a sharp decrease in suicidal ideation. She has constantly utilizes coping strategies when triggered, has ceased her engagement in high risk behaviors, and is adequately caring for her daughter. Most recently, the youth was able to obtain and maintained employment.

The high cost of living continues to present a challenge for Edgewood families and staff who are unable to locate affordable and suitable housing. Staff meet outside of the home, to ensure that youth have the emotional and physical space to engage in treatment. In the scenario that families relocate to other counties, Edgewood staff work with the families to ensure that there are resources in place prior to their move to ensure continuity of care. Staffs are encouraged to use satellite offices to do their paperwork resulting in a reduction of time are commuting and driving between community-based appointments. Finally, in the next fiscal year, Edgewood will increase the mileage reimbursement amount to the IRS rate.

There were struggles to recruit and retain bilingual and bicultural staff who are qualified to adequately treat the population that Edgewood serves. In order to mitigate this challenge, workloads were paired down to be more reasonable and to accommodate predictable short-term increases (due to youth/family crises or vacant positions). In times where Edgewood was unable to meet the language capacity of a family (e.g., ASL) interpretation services were contracted.

There are several caregivers with undiagnosed and untreated mental and physical health issues of their own, which seem to affect their ability to fully engage in their children's treatment. Edgewood provides case management assistance and family partners to support caregivers to help prevent responsibilities falling to the youths in the home. Additionally, Edgewood makes every effort to connect caregivers to their own adult mental health professionals.

FRED FINCH YOUTH CENTER: EAST BAY WRAP PROGRAM

Fred Finch Youth Center (FFYC) provides a wraparound-services model in the East Bay Wrap Full Service Partnership (EBW-FSP) to promote wellness, self-sufficiency, and self-care/healing to youth who are San Mateo County Court Dependents who now live out of County. When foster youth live out of their court dependent county, they often have difficulty accessing mental health services. The wraparound model helps provide intensive community based care that is rooted in a strengths-based approach. The youth and family receive individualized services to maximize families' capacity to meet their child's needs and thereby reduce the need for residential placement. Many of the youth we serve are also eligible for Katie A subclass membership.

DEMOGRAPHICS

Total Clients Served			
17			
Male	9	Female	8
Race/Ethnicity			
Black/African American		32%	
Mexican-American/Chicano		17%	
Other		15%	
Latino		14%	
White/Caucasian		13%	
Asian		6%	

PROGRAM IMPACT

The program employs 2.5 full time Master's level care coordinators, one full time bilingual Youth Partner, and one full-time Parent Partner. Both peer partner positions require lived experience. All staff utilizes CBT, ACT, Behavior Modification and Motivational Interviewing approaches to treatment. The team also approaches the work from a trauma informed perspective with an understanding that early trauma impacts brain development and an important area of focus must be on sensory integration and self-regulation skill building.

SUCCESSES/CHALLENGES

A central component of the service is the Child and Family Team meetings that all interested parties are invited to attend in order to review strengths and develop treatment plans that have measurable objectives to address needs. According to outcome data, 90% of youth saw a decrease in the severity of their mental health symptoms since intake resulting in a decrease of hospitalization rates.

The enrollment is consistently below target numbers. Fred Finch continues to take steps to encourage referrals to the FSP. Based on enrollment data, Fred Finch FSP has the capacity to serve 20 youth, during FY15-16, Fred Finch was at 85% of capacity for the year averaging 17 youth enrolled per month.

TRANSITION AGE YOUTH (TAY) PROGRAM HIGHLIGHTS

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: TAY PROGRAM

The TAY-FSP Program provides intensive community based supports and services to transition age youth identified as having the "highest needs" in San Mateo County. The referral process is restricted to representatives of BHRS or a contractor of BHRS, the Human Service Agency, and the juvenile/adult justice system.

Transitioning from adolescence to adulthood is challenging for any young adult, those referred to the TAY-FSP program present with an array of risk factors and complex mental/physical health conditions making this transition infinitely more difficult. As the traditional milestones of adulthood continue to be pushed to later years, there is a noticeable extension and slowdown of the transition to adulthood. There is a movement among clinicians, sociologists, researchers, educators, and general practitioners for the acceptance of a new phase of development, 'emerging adulthood.' The TAY-FSP program has embraced this term as it offers a deeper understanding and acceptance of what occurs for anyone between the ages of 17-25. Acknowledging that it is not "just a transition" but in fact a unique period of life when individuals are learning to accept responsibility for themselves, make independent choices, and practice the behaviors and skills needed for managing adulthood, empowers our transition age youth and validates their experience.

The TAY-FSP program relies on a diverse staff and innovative program model to effectively meet the needs of this vulnerable and often marginalized population. Specific supports and services provided by our multi-disciplinary team include: case management, mental health

treatment (assessment, therapy, medication management, and psychiatry), family support, crisis prevention and intervention, skill building (independent living, relational, safety, and emotional/behavioral), socialization and recreational activities, peer and family relationship building, academic support and coordination, employment exploration, and housing support.

DEMOGRAPHICS

During FY15-16 the program had a capacity to serve 40 individuals between the ages of 17-25 at one time; the program served 54 unduplicated TAY clients; 37 individuals who identified as male and 17 who identified as female with an average age of 20 years old. The following number are approximate of total client's served:

Total Clients Served			
54			
Male	37	Female	17
Race/Ethnicity			
Latino/Other Spanish-American		30%	
White/Caucasian		20%	
Black/African American		15%	
Pacific Islander		15%	
Asian		7%	
American Indian/Alaskan Native		4%	
Other		9%	

- 89% of total served have a history of trauma.
- 83% of total served were considered "severely impaired" due to symptoms of Bipolar, Schizophrenia, Schizoaffective, and Major Depressive disorders.
- 66% of total served did not have a primary care doctor at referral, and most of these had not seen a dentist or eye doctor in over a year.
- 33% of total served had a cognitive impairment or delay.
- 27% of total served were using substances (most commonly marijuana) with noticeable negative impact on their daily functioning. Examples of this impact included: hallucinations, disorientation, decreased problem-solving skills, decreased ability to retain information, increased worry, and increased forgetfulness.
- 24% of total served had a physical health condition which impacted their daily functioning and/or their mental health. Examples of these conditions: diabetes, cerebral palsy, chronic pain, arthritis, hepatitis, hyperthyroidism, polycystic ovarian syndrome, obesity, asthma, and heart conditions.

PROGRAM IMPACT

During FY15-16 TAY-FSP had 16 youth graduate from the program. The term "graduation" is applied when youth have met most or all of their treatment goals and are stepping down to a lower level of care. Transition age youth living with a mental health condition often find entering the workforce or attending college an overwhelming task, yet they recognize this is what their peers are doing and what is expected during these transitional years. Often their symptoms greatly impact their ability to function day to day. When there is a need for intensive interventions, including psychiatric emergency visits, acute hospitalizations, and daily suicide assessments and treatment team visits, all other endeavors are put aside or on hold. Still, youth are often penalized for the symptoms of their mental health condition or for accessing treatment. In this past year multiple youth faced school failure, homelessness, and loss of employment due to professionals/ community lacking information about symptoms or stigma.

Because TAY clients' mental health condition is so severe to limit or even prevent them from engaging in significant employment, 41% of the youth served during this reporting period received disability benefits. Of those, 72% had a family member or provider acting as their representative payee. In order to aid youth in engaging in daily activities, explore career paths, and increase their peer-social networks each treatment team partners with the youth to identify holistic goals. These include exploring areas of life such as: employment, education, health, housing, finances, spirituality, relationships, recreation, and culture. Additionally treatment teams' work with youth to address basic needs, support them in addressing legal issues, and teach self-advocacy skills. In the instances where youth are involved with other providers, we aim to bring everyone together in order to ensure collaboration, and decrease barriers for the youth as they navigate the adult systems. Other providers that served our transition age youth: adult probation, health clinics, housing programs/entities, high school educational programs, conservators, social workers, and vocational programs.

- This year 7 (of the 54 youth served) were on adult probation.
- This year 3 (of the 54 youth served) were on a mental health (LPS) conservatorship.

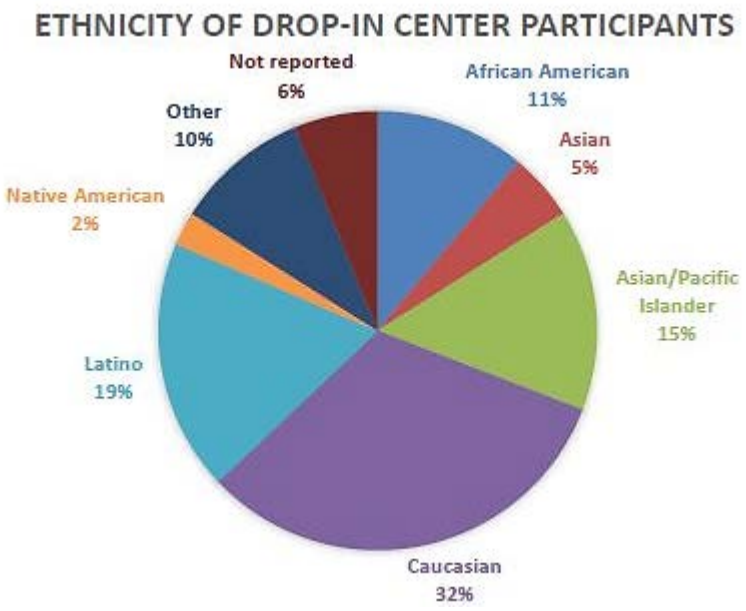
To ensure caregivers and family members stay connected to their youth, the TAY-FSP program has a dedicated team serving these individuals. Typically, when a youth turns 18, families lose access to services or are denied communication with providers due to their child's legal status as an adult. Families of youth with mental health conditions report feeling stigmatized and shamed; in our experience connecting them to a caregivers with lived experience and community groups for support and advocacy reduces isolation and stigma.

- 24 unique individuals participated in our family support activities
- 47 unique individuals participated in one-to-one family support

This year two new items were offered to family members and caregivers.

- Creation of our Family Survival Skills Workshops. This series was created in response to family/caregiver requests to "learn and practice skills that will help us to manage more effectively the challenging situations that arise when you have a loved one with a serious mental illness." The workshops were held monthly, were available in English and Spanish, included dinner, and were open to caregivers/family members of enrolled youth and those whose youth graduated (or was discharged) from the TAY FSP program.
- The Transition Age Youth Family Connections monthly newsletter. The newsletter was created as a way to share information about topics relevant to caregivers and their adult children, in order to inform them of community activities, and as a way to connect with family members or supporters who were not actively connected to our program. The newsletter is made available in English and Spanish languages.

The Drop-In Center: North, a component of Edgewood FSP, provides basic needs and resources including: hot meals, hygiene supplies, laundry, bus tokens, Internet and phone access, clothes, and educational and peer support services to emerging adults between the ages of 18-25. These youth often have been impacted by substance abuse, homelessness, violence, and/or mental illness. During FY15-16, the Drop-In Center served 81 unduplicated transition age you. Of those, 70% who attended were from the community and unattached to Edgewood programs. Edgewood hopes to lay the groundwork for a trusting relationship through a welcoming approach and unconditional positive regard while serving the basic needs of emerging adults may increase the likelihood of individual engagement and later participation in additional supports and services.



SUCCESSES/CHALLENGES

This next fiscal year Edgewood is looking forward to the opening of a second drop-in center location, this one in the southern part of the county. Edgewood has secured a site near local bus lines, in close proximity to other transition age youth service providers, and in an area familiar to the transition age youth population. Like the Drop-In Center North, this site will be staffed by Peer Partners, provide a range of activities and workshops throughout the month that address the various interests and needs of this population, and will allow for participant voice and feedback at all levels.

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: TAY SUPPORTIVE HOUSING

Addressing the housing needs of San Mateo County's TAY population is an important aspect of the work of the Edgewood TAY-FSP program. Made possible by a joint partnership with the Mental Health Association (MHA) of San Mateo, Edgewood is able to provide housing subsidies and MHSA housing monies to reduce the risk of homelessness and increase the probability of stable housing as youth transition to adulthood. Teaching daily living skills, medication management, household safety/cleanliness, budgeting, and roommate relationship skills are a part of the treatment and education of the youth accessing housing support and subsidies from the TAY-FSP program.

DEMOGRAPHICS

Total Clients Receiving MHSA Housing Funds	
12	
Race/Ethnicity	
White/Caucasian	50%
Latino/Other Spanish-American	17%
Asian	17%
Black/African American	8%
Other	8%

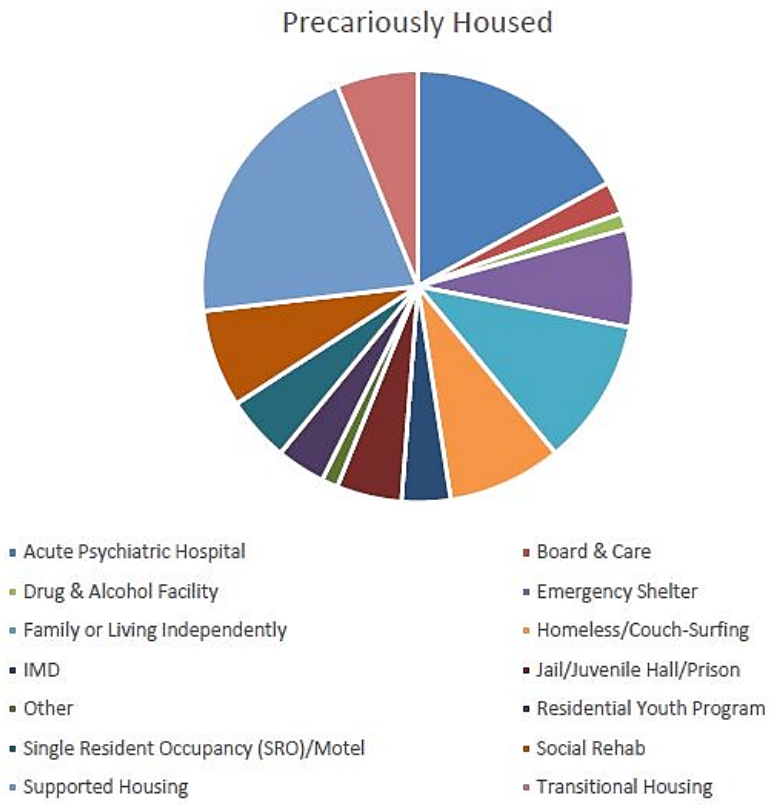
PROGRAM IMPACT

Housing is an ongoing issue in the county of San Mateo, and the transition age youth population continues to struggle to access safe, supportive and appropriate settings. Similarly, families are feeling the pressure regarding housing. Many face tough decisions regarding paying more for rent, taking on additional work, leaving a job in order to make more money

elsewhere, moving in with others, relocating to another part of San Mateo County, or leaving the county altogether.

Given the high acuity level and multiple risk factors of the transition age youth Edgewood serves, identifying housing options which are safe, supportive and age appropriate continue to be the primary focus. After 10 years of providing FSP level services to transition age youth, Edgewood have identified two housing cohorts within this TAY-FSP population as *stably housed* and *precariously housed*. *Stably housed* is defined as housing situations that are not time limited or conditional, pose little risk to personal safety, provide for adequate health and wellbeing, and promote recovery and growth. Of the 54 total transition age youth served by the TAY-FSP during FY15-16, 26 youth are considered stably housed. Among the 26 youth, 83% of the time youth were living with family or independently. When the youth were not with family or living independently they were in acute psychiatric settings and/or homeless/couch-surfing.

Precariously housed is defined as housing situations that are limited or conditional, have some form of criteria or evaluation that must be met/maintained in order to access this setting, pose a risk to interpersonal safety or do not offer a locus of control regarding personal safety, and do not consistently promote wellness and recovery. Of the 54 transition age youth served, 28 are considered 'precariously housed.' The graph below shows the settings most commonly used by our transition age youth during FY15-16.



SUCCESSES/CHALLENGES

Stably housed individuals are not time limited or conditional; pose little risk to personal safety; provide for adequate health and wellbeing; and promote recovery and growth. An example would be Jeremiah. He is 19 years old, identifies as male, and is a person of color. He lives with immediate and extended family members. As a child he received school-based mental health services and was in special education classes due to his impaired cognitive functioning and emotional disturbance. His behavioral outbursts stemmed from his depression, low frustration tolerance, and inability to read social cues. Due to his behaviors and lack of social skills, Jeremiah was often taken advantage of by peers who used him to steal items from stores and people; they promised him friendship and camaraderie, and in his mind he was being a good friend. The legal system did not agree and Jeremiah was in and out of the juvenile courts and detention on several occasions. These interruptions negatively impacted his academic performance. During these years his family cared for him and advocated for more treatment and support. Now, as a 19 year old, Jeremiah is on adult probation, and he has been hospitalized twice since turning 19. In each instance where Jeremiah was in jail or at the hospital he returned to his family home. Jeremiah does not want to leave his parents' home, and says he will be ready for a job, "in a few years." Jeremiah's family want him to live with them and state they are committed to supporting him and keeping him safe throughout his life.

For precariously housed individuals, they pose a risk to interpersonal safety or do not offer a locus of control regarding personal safety; and do not consistently promote wellness and recovery. An example would be Yulia. Yulia is 24 years old, identifies as a lesbian female, and is currently single. She immigrated to this country from Eastern Europe with her mother. Her most stable housing experience was between the ages of 5-12 when she lived with her parents and paternal grandparents. Within her first 3 years of being in the United States she had lived in approximately 4 settings with both relatives and non-relatives, witnessed family violence, experienced her own trauma, and struggled to adapt to the culture and academic standards of this country. She began developing symptoms of bipolar disorder during her first semester of college and spent the next 2 years cycling through hospitals and transitional housing programs. At age 24 she attends community college, receives SSI benefits, and is able to work approximately 10-15 hours a week. Her acute psychiatric hospitalizations have decreased to 2-3 times a year, the length of her stay has decreased, and her ability to return to baseline has dramatically improved. Still, with each hospitalization she faces the possibility of losing her subsidized apartment. After her last hospitalization she was told by the on-site manager that her behaviors (when she is in a manic state) are too disruptive to other residents and her housing is now at risk.

CAMINAR: SUPPORTIVE EDUCATION PROGRAM

Caminar's Supported Education program at the College of San Mateo has been highly successful in supporting individuals with mental health/emotional needs in attending college and achieving academic, vocational, and/or personal goals. This program was established in the spring of 1991 from collaboration with the College of San Mateo, Caminar, and the County of San Mateo's BHRS program. The program's unique approach combines special emphasis on instruction, educational accommodations and peer support to assist students to succeed in college. Traditionally, the attrition rate for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills, and low self-esteem. However, this program has become an innovative leader in reversing this trend.

PROGRAM IMPACT

Caminar's Supported Education Program provides students with the opportunity to experience a safe beginning or re-entry to college and to acquire skills to be a successful student. Students can receive classroom accommodations, college counseling, priority registration, and individual support for academic needs. Classes can lead to certificates, degrees, and a life-changing experience.

FY15-16 Caminar's Supportive Education Program served 43 unduplicated clients was served resulting in an average GPA of 3.0.

In FY15-16, two classes were offered at the College of San Mateo Introduction to Peer Counseling and Advanced Peer Counseling. This study track provides training for students interested in working as a peer mentor in the human services field. The Supportive Education Program is actively involved in the community by providing weekly education support at Edgewood's Drop In Center, weekly cooking groups at Caminar's Young Adult Independent Living (YAIL) program, weekly social outings coordinated with Caminar's residential programs, campus visits at Mill's College and College of San Mateo, resource fairs, individualized on and off-campus tutoring, and drop-in support on and off campus.

DEMOGRAPHICS

Total Clients Served
43

SUCCESSES/CHALLENGES

In FY15-16 six TAY were able to maintain their education pursuit throughout the year that was in part due to ongoing quarterly workshops focused on client self-care. This reporting year, Caminar's Supportive Education Program created and implemented "FutureViews", a Skyline College student support and development program focusing on vocational independence and empowerment through workforce and academics.

The program experienced several challenges that has led to deterring a client's success in the program. Housing stability poses a challenge as youth are at risk of homelessness and often lack the resources to ensure a stable environment that the program relies on. Furthermore, foster youth are particularly at risk interrupting potential success due to personal crisis, poor support system, and an increase in symptoms.

ADULT/OLDER ADULT PROGRAM HIGHLIGHTS

TELECARE, INC.: ADULT, OLDER ADULT, AND MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Additionally, the Outreach and Support Services portion targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities.

Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

DEMOGRAPHICS

Total Clients Served	
245	
Race/Ethnicity	
African American/Black	12%
American Indian/Alaskan Native	1%
Asian	5%

Caucasian/White	39%
Filipino	4%
Hispanic/Latino	11%
Pacific Islander	3%
Mixed Race	1%
Other	14%
Unknown/Not Reported	10%

PROGRAM IMPACT

The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed living in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors. The program also follows the model and philosophies of California's AB 2034 Homeless Mentally Ill Adult programs and the assertive community treatment (ACT) approach, aiming to use community-based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services Division, community agencies, and from individuals/family members.

A full-time nurse enables the treatment team to more effectively collaborate with primary care providers and assist consumers in both their communications with their primary care doctors and in their follow-up. The licensed clinicians in the team oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family, contingent on the consumer's wishes. Peer Partners provide support, information and practical assistance with routine tasks, and cultivate a system of volunteer support. Similarly, when a family is involved and the consumer is supportive of their involvement, a Family/Caregiver Partner works with the family to build their capacity in supporting their loved one.

CAMINAR: FSP FOR ADULTS AND OLDER ADULTS/MEDICALLY FRAGILE

Caminar was contracted to provide these services beginning October 2009 for a maximum of 30 enrollees. The FSP provides intensive case management services including psychiatric services, injections (in-home when necessary), daily in-home medication monitoring and weekly medi-sets (medication management system). Nurses provide in-home assistance with teaching skills to manage diabetes, assessment, coordination and communication with medical providers. On occasion psychiatrists see clients in their homes/in the field. The FSP transports clients to appointments, offers after-hours warm-line, and 24/7 emergency response.

DEMOGRAPHICS

Total Clients Served	
34	
Race/Ethnicity	
African American/Black	6%
Asian	3%
Caucasian/White	62%
Filipino	12%
Hispanic/Latino	14%
Pacific Islander	3%

PROGRAM IMPACT

The following are average outcomes for FY15-16 for the FSP Program:

Outcome	# Clients
Homelessness	9%
Hospitalization	35%
Incarceration	6%
Stable Housing	90%

In addition, this year 30% of clients provided their own transportation and 96% of Caminar's FSP clients lived in satisfactory living environments such as apartments, SRO hotels, independent supportive housing, or with family.

SUCCESSES/CHALLENGES

The limited housing options for our clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for the FSP and intensive case management programs. Landlords can rent to higher paying consumers and are choosing to do so. Along with limited resources for adequate housing, more of Caminar's clients are finding themselves utilizing services at hospitals and/or engaging in activities around increased substance use and abuse. Caminar clients reflect an aging population and as such have an increase in medical needs and their medical issues become a dominant.

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

Mateo Lodge was contracted to provide 50 hours of service per week for 3 different levels of intensity; task oriented case management supplemental case management, and FSP clinical case management.

DEMOGRAPHICS

Total Clients Served	
36	
Race/Ethnicity	
African American/Black	14%
Asian	2%
Caucasian/White	44%
Filipino	2%
Hispanic/Latino	28%
Other	10%

PROGRAM IMPACT

Mateo Lodge Embedded Case Management (ECM) closed 17 cases during FY15-16. Staff provided evening and weekend coverage on an as needed basis from the mobile support team as part of their agency to further support at risk client needs.

Outcome	# Clients
Stabilized back to team	10
Community Case Management	2
Supported Community Housing	1
Higher Level FSP	1
Refused Case Management	1
Moved out of County	1
Deceased	1

SUCCESSES/CHALLENGES

One client was remarkable as he was poorly engaged with clinical team, a high utilizer of emergency services, and facing deportation. He completed an Alcohol and Other Drug (AOD) program and was successfully engaged by case manager and was stabilized back to his care team.

Due to the level of impairment of the clients referred, it has been challenging to make connection with the client when they do not show for their appointments. There are clients who are homeless, with no social support, who unless they contact the clinic or are in hospital or jail, could not be contacted. The Case Manager makes every attempt to meet clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, hospital, jail, and joint home visits with a member of the treatment team. The best outcomes for ECM clients exist when there is a warm handoff from their clinical treatment team.

GENERAL SYSTEM DEVELOPMENT (GSD)

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

OASIS serves a client population that is aging, increasingly fragile and medically complex. OASIS clients come into the program with multiple co-occurring conditions related to physical health, cognitive impairment, substance use, functional limitations and social isolation in addition to their serious mental health conditions. This requires more hands-on case management support and assistance to enable these clients to remain living in a community based-setting. The case management provided also necessitates greater collaboration among the OASIS psychiatrists and primary care providers due to complex medical conditions and comorbid with their serious mental health conditions.

Total Clients Served	Cost per Client
147	**$2,852.32**

DEMOGRAPHICS

In the FY15-16, OASIS served a total of 297 clients. This included 190 clients carried over from the last fiscal year, 51 new open cases, and 56 clients discharged this year.

14% of the OASIS clients were monolingual Spanish speaking, and 12% of the clients in the program were Chinese speaking.

Total Clients Served	
297	
Case Specifications	
New Cases	51
Discharges	56
Carried Over Cases	197
Language	
English	73%
Spanish	14%
Chinese	12%

PROGRAM IMPACT

Among the 56 discharged cases, 21% discharged to SNF due to higher level of care needs, 7% due to dementia becoming the primary diagnosis and PCP providing the follow-up care, 14% of the discharged clients died due to medical complications, 13% moved out of county due to the tight housing market and high cost of living, 7% moved back to country of origin, 12% declined the home visiting program services, 7% requested to be transferred back to regional clinic for follow-up care, 5% had no mental health needs, 5% were lost to services despite outreach attempts, and 9% of the clients improved enough to be followed by their PCP.

SUCCESSES/CHALLENGES

Housing the OASIS clients in a community setting with the necessary supportive services is becoming an increasing challenge. There is a very limited supply of licensed board and care providers willing to care for these clients with their multiple health issues and needs and their limited financial resources. In addition there is currently no Intermediate Care Facility level of service in San Mateo County making it more difficult to maintain these clients in the community as their care needs increase. The support to OASIS clients is enhanced by the strong commitment and dedication of the direct service staff that regularly go the extra mile to ensure that the clients not only get the essential care they need but to provide the emotional and concrete support needed to help their clients have the highest quality of life possible and to remain residing in the community for as long as they safely can in accordance with their wishes.

PATHWAYS COURT MENTAL HEALTH PROGRAM

Pathways Program is a mental health court developed in collaboration with San Mateo County Courts, Probation, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health, NAMI, Behavioral Health and Recovery Services clinics, specialty teams and its contractors. The Pathways program goal is to avoid incarceration of seriously mentally ill individuals and offer an alternative route through the criminal justice system. Eligible clients must be adults 18 and older, living in San Mateo County, diagnosed with a serious mental illness, has a statutory eligibility for probation, and agrees to fulfill Pathways program requirement. Since the inception of the program, Pathways has graduated 91 clients by providing them with an opportunity to remain in the community with increased treatment support and tailored supervision.

Total Clients Served	Cost per Client
132	**$2,568**

DEMOGRAPHICS

Total Clients Served			
42			
Male	29	Female	13
Race/Ethnicity			
White/Caucasian		28%	
Hispanic/Latino		28%	
Asian		16%	
Other		17%	
Age			
18-25		19%	
26-59		64%	
60+		17%	

PROGRAM IMPACT

The Pathways Mental Health Court Program had a total of 42 clients this in FY15-16. Among those clients, six clients graduate from trauma informed Seeking Safety classes, one client from a substance abuse program, five clients completed social rehabilitations programs, four clients obtained full-time, part-time employment, or volunteering opportunities, and one client obtained permanent housing. Pathways celebrated 9 clients who successfully completed Probation. Clients who graduated have both their court fines and fees deleted as part of them successfully terminating Probation.

SUCCESSES/CHALLENGES

The Pathways Clubhouse celebrates its 5th year of providing a socialization group for men and women in our program. The Lead Clinician and Senior Peer Support Worker facilitate the Clubhouse and invite Pathways Alumni to serve as role models who give and receive support. It is with great privilege that the Mental Health Court encourages Clubhouse attendance as a source of psycho-education and a space for socialization.

Pathways hired a full-time Lead Clinician who completes assessments and reports while also facilitating therapy and Clubhouse groups; a full time contracted clinical to compete assessments, reports, and treatment plans; and a full-time Senior Peer Support Worker. With Pathways staffing at full capacity has allowed the program to operate at full potential.

STARVISTA: G.I.R.L.S PROGRAM

The initial focus of the GIRLS Program is addressing the trauma and co-occurring issues of the participants of the program by developing a treatment plan and strategies supporting recovery from both mental health and substance use issues introducing Cognitive Behavioral Treatment (CBT) strategies to promote healthy choices and encouraging a clean and sober lifestyle. Equally important is the understanding the clients emotional situation by initiating a psychological evaluation which helps identifying relevant mental health issues that are impacting a participant and may be creating challenges and impeding a participant's progress. Additionally, the trauma issues impacting this population are significant and substantial and require specialized training and intervention skills

The program consists of three phases:

Phase I – in-custody intervention which may range from 90-180 days. Activities include crisis stabilization, substance abuse and mental health assessment, individual and group treatment, alcohol and other drug treatment groups, multi-family groups, treatment planning, meeting with the probation officer, and pre-release transition planning.

Phase II – consists of out-of-custody interventions, which may range from 90-180 days. Activities include individual and group treatment, completion of multi-family groups, treatment planning, and meeting with the probation officer. GEP (GIRLS Empowerment program) consists of out-of-custody interventions, which may range from 90-180 days for girls who are attending school at Kemp Camp. Activities include individual and group treatment, treatment planning, and meeting with the probation officer.

Phase III – outpatient out-of-custody interventions, which may range from 90-180 days. Clients in this phase of the program attend treatment one day a week and receive one group and one individual counseling session. Treatment has also devised a maintenance phase for girls who are ready to progress from several group sessions a week to solely individual counseling sessions.

It has been observed generally by StarVista staff that the girls entering the Program continue to have more complex issues, including significant substance abuse, mental health issues, sexual trauma/commercial sexual exploitation, histories of running away, attachment issues, and family-of-origin issues that make it challenging for them to complete tasks necessary for release into Phase II. Additionally, there are significant levels of gang involvement and sexual exploitation, which adds an additional layer of complexity to this work.

Total Clients Served	Cost per Client
44	**$4,473**

DEMOGRAPHICS

Total Clients Served	
44	
Race/Ethnicity	
Hispanic/Latino	50%
African-American	9%
Pacific Islander	11%
Filipino	9%
Other	21%
Age	
0-15	45%
16-25	55%

PROGRAM IMPACT

The GIRLS Program is an intensive dual diagnosis (substance abuse and co-occurring mental health diagnosis) treatment program for adolescent females who have significant histories with substance use, trauma, Child Protective Services, and the juvenile court system. The girls are granted this program in lieu of placement such as incarceration at the Youth Services Center or a group home. StarVista is contracted with BHRS to provide services to 10 girls with co-occurring disorders.

The girls are between the ages of 12 – 18 years old. Referrals may be made at the pre-trial and dispositional hearing stages and either the Court or the Probation Department may identify a program candidate. Program referrals may be initially screened by the Inter-Agency Placement Review Committee (IPRC). The purpose of the IPRC is to conduct case evaluations for appropriate placement planning for juveniles in cases before the Department of Children and

Families Services and the Department of Probation. IPRC members include representatives from Mental Health, the Department of Human Services Department of Probation, and County Office of Education. The program has the capacity and desire to serve all ethnicities and races.

The primary short-term outcome is a demonstrated increase in engagement for both clients and their families. Additionally, clients are engaged in school and have made academic progress, increase in cooperative family unit, increase in positive peer relationships, and an increase in pro-social activities.)? Outcomes are measured by self-report, family report, probation report, and school report. Pre/post surveys and questionnaires are utilized and outcomes based on girls completing the 6-12 month program indicate:

- 70% increase in positive individual engagement
- 36% increase in positive family unit
- 41% increase in positive academic engagement
- 64% increase in positive peer relationship
- 52% increase in pro-social activities

SUCCESSES/CHALLENGES

StarVista is proud to support youth in the GIRLS program at Camp Kemp. This year, 10 clients graduated and completed GIRLS Program successfully. Throughout the year, StarVista has facilitated groups to encourage active lifestyles, rapport building, mental health, substance use treatment and social events. In addition to the therapy groups, StarVista's GIRLS staff facilitated Zumba groups, which have been something that many of the girls have very much enjoyed and appreciated. In collaboration with BHRS, staff also facilitated groups on human sexuality as well. This is an important and relevant topic for the girls and generally the clients have been highly engaged. Lastly, as an exciting development, a new 8 week group led by a former GIRLS Program client and a classmate of hers from San Jose State. StarVista collaborated with BHRS to assist with the facilitation of this group. Not only does it encourage growth for current and former participants in the GIRLS program, but it also stands as a great model for the current participants on what they can achieve while in the program and beyond.

One of the challenges within the team has been the level of staff turnover and how to train staff to work effectively with very complex clients and within the Camp Kemp system. Three interns were recruited for the next intern year starting in August and reviewed and redesigned the intern training in the hope that interns and new staff can orient more easily to the program requirements. StarVista understands the importance of staff retention, however building and maintaining rapport with staff members within the multi-disciplinary team is challenging with increased turn over. StarVista Management is problem solving staff retention plans as well as

providing “self-care days” to support mental health and decrease the chance of burn out with staff. In the last few months there have been a series of clients that are involved with both probation and HSA. The difficulty of finding an appropriate placement for these clients has caused concern for their ongoing well-being and safety and the StarVista team has struggled with how to best support clients in these situations.

PUENTE CLINIC

This specialty clinic sponsored by Behavioral Health and Recovery Services, Golden Gate Regional Center (GGRC) and Health Plan of San Mateo (HPSM) serves the special mental health needs of clients with developmental disabilities. Since the inception of The Puente Clinic in 2008 until June 30, 2016, Puente has received 356 referrals and currently 253 are being served.

MHSA funds a 0.5 FTE Psychiatrist and a 0.5 FTE marriage and family therapist.

Total Clients Served	Cost per Client
43	**$3,386**

DEMOGRAPHICS

Total Clients Served
19

PROGRAM IMPACT

Adults with intellectual disabilities may be referred to the Puente Clinic by a BHRS clinician or GGRC Case Manager. Puente staff will respond to the referring clinician if additional information is needed. In FY15-16, Puente received 23 referrals with 19 accepted for service. Of the four referrals not selected for service, two women were psychotherapy referrals who were not, truly, desirous of receiving therapy so did not enter into a therapeutic relationship. One was determined could benefit from behavioral intervention and was referred to Creating Behavioral and Educational Momentum (CBEM), a behavioral crisis team specializing in serving individuals with intellectual disabilities, a vendor of the Golden Gate Regional Center. The final referral was determined to require specialty AOD treatment and is being helped by BHRS Adult Resource Management (ARM)

Puente offers one-time consultation with a therapist and a psychiatrist if required. For continuing cases, comprehensive mental health treatment including medication management will be provided for clients meeting the following priority criteria:

- Recently returned to the community from Developmental Center
- Recently returned to the community from locked or delayed egress facility.
- At-risk for admission to higher level of care
- Requires in-home services as clinically determined
- Frequent psychiatric Emergency Services contact
- Complex diagnostic issues or polypharmacy

SUCCESSES/CHALLENGES

A success story includes a 47 year-old Asian female client with moderate-severe intellectual deficit who is well-known to the Puente Clinic team practice. The client resides in a group home in San Mateo County with 5 other residents. The client's maladaptive behaviors included yelling, physical aggression to staff and other clients, self-injury behaviors, and property destruction. The client was considered a disruption to other residents because the client routinely attacked housemates when they entered common areas in the house that AL considered "her" space. The client's maladaptive behaviors had always been difficult to manage through medication; behavioral modifications, as managed by the household behaviorist, rendered only moderate response.

In March 2016, caretakers at the group home notified Puente Clinic staff about intensification of the client's maladaptive behaviors. Fortunately, the client lived in a group home with well trained staff who maintained exceptionally well-documented behavior logs. After studying the logs, it became clear that worsening behavior coincided with client's menstrual cycle. Through careful medication management the client's group home reported a "significant improvement" in behaviors.

CALIFORNIA CLUBHOUSE

The California Clubhouse is a social and vocational rehabilitation program for adults who suffer from mental illness. The Clubhouse is a membership-based service that creates a community of support through collegial relationships committed to the vocational and social recovery. California Clubhouse assists, supports, and empowers members to achieve their goals of increased socialization, employment, education, independence and self-advocacy.

DEMOGRAPHICS

Total Enrolled Members Served	
75	
Race/Ethnicity	
Caucasian/White	51%
Hispanic/Latino	16%
African-American	9%
Asian	6%
Pacific Islander	1%
Other	7%
Age	
20-25	7%
26-30	9%
31-40	25%
41-50	16%
51-60	25%
61-70	16%

PROGRAM IMPACT

Since the beginning of the fiscal year, membership has increased from 21 members to 75 members, a 260% increase and the number of members served in the Clubhouse increased from 17 members monthly to 75 members, an increase of 160%. During this reporting year, the Clubhouse began recording the number of hours members have spent in the Clubhouse on a monthly basis. During the reporting year, the Clubhouse served a total of 75 clients for a total of 9840.3 hours.

According to one member, “the Clubhouse has blossomed in many respects. All in all, based on the average number of members using the service of our Clubhouse, you can gather what a tremendous impact we make in the lives of our members. Together, we grow our skill set by contributing our strengths to the community, creating a unique character for ourselves, which all together contributes to the thriving of our community.”

SUCCESSES/CHALLENGES

The Clubhouse is a peer-run organization that provides meaningful work for all members throughout the work-ordered day. The Work-Ordered Day includes a wide variety of daily tasks and special projects for members including technology projects. All talents and strengths are incorporated throughout this work. Members frequently report benefits from the increased productivity and sense of accomplishment they achieve by participating in the Work Ordered Day. Members and staff conduct two unit meetings daily to coordinate projects and tasks,

identify upcoming events, review a daily Standard, and celebrate clubhouse and individual celebrations. Issues and concerns are also addressed at these meetings with larger discussions scheduled for the weekly well attended Community Meeting. Many members have assumed leadership in the planning, operation, documentation.

In addition to the work-ordered day, social programming has grown in popularity. Social programming is held in evenings and/or on weekends. The activities are planned by members and staff during the Community meeting. The programming has included large scale activities such as visiting the Monterey Bay Aquarium, Alcatraz, the Academy of Science, Healing Voices Movie Screening, Pride Celebration, San Mateo County Fair, Downtown San Mateo Festival, picnics, and hikes. Smaller scale events include board games and dinner, bowling, karaoke, and art socials. We have celebrated every holiday on the actual day. Our holiday socials are highly attended averaging 15-20 members in addition to staff, family and board members.

SENIOR PEER COUNSELING

The Senior Peer Counseling Program, provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipino and LGBT volunteers.

Total Clients Served	Cost per Client
474	**$615**

DEMOGRAPHICS

Total Clients Served	
474	
Race/Ethnicity	
Hispanic/Latino	44%
Filipino	24%
Asian	7%
Other	25%
Age	
60+	100%
Language	
English	25%
Spanish	44%
Chinese	7%

PROGRAM IMPACT

In order to serve more people with the current resource of peer counselors the program offers weekly support groups at various community sites. There are currently five groups in senior/community centers or other non-profit agencies throughout San Mateo County. The group sessions have different formats. Some meetings are organized as an open discussion which gives everyone an opportunity to engage and express their sentiments, thoughts, concerns, and feelings. Other meetings are topic based discussions, and/or presentations from outside speakers. This year specific areas explored include:

- How to protect yourself from scams and abuse
- Healthy Aging
- Choosing healthy food to help your body and mood
- Mindfulness
- Film showing and discussion: Being Mortal
- How thoughts hurt or help your life
- Domestic Violence
- Medicare-MediCal
- Taking care of yourself in the winter
- Feelings about holidays
- Memoir writing

During the reporting year, three 36 hour volunteer trainings were conducted, two in English and one in Spanish. During the English Spring training we provided break-out meetings in Mandarin with Chinese volunteers to support their learning. Upon completion of the senior peer counseling training 95% of all new volunteers felt prepared to start working with clients. Training was rated as Excellent or Good by 100% of participants.

Year to date 124 new clients entered the program and 144 clients were closed to services. There are currently 330 active clients in the program and 474 senior peer counseling clients have been served during the fiscal year year, 112% of goal. Of the active clients, 133 clients are seen weekly on an individual basis and 197 clients are participating in a group.

SUCCESSES/CHALLENGES

Successes during the fiscal year included increased outcomes in recruitment and overall participation. The recruitment goal set for this year is to recruit 60 new peer counselors. 82 counselors were recruited, 136 percent of goal. The training goal set for this year is to train 36 new peer counselors. There were 34 counselors that completed the training, 94 percent of goal. Finally, through this year the program had 133 senior peer counselors participating in the program, 148 percent of goal.

Recruitment strategies have also expanded. Staff and volunteers have worked with their media contacts to include information about SPC programs and upcoming volunteer training in the following venues: FilAm Star and The Philippine News, Chinese community newspapers Sing Tao, World Journal, News for Chinese, and The Asian Journal, through a Spanish speaking Univision radio program, El Tecolete. English speaking media include Foster City Islander, Pacifica Tribune, RSVP, Everything South City, Craig's list, SM Pride Initiative, Daly City Partnership, Twitter.com/Volunteer Source, Next Door, and SM County Health Network San Mateo Times and San Mateo Journal, and the Redwood Shores Pilot.

Though recruitment efforts and program awareness have improved, the program continues to be challenged by a growing waiting list for those requesting the service. The continual challenge is to have volunteers who are willing to provide service to some of the participants on our waiting list. Our volunteers want to see clients who live within their communities. It has been increasingly difficult to recruit and retain volunteers who are committed to the program.

CO-OCCURING CONTRACTS WITH ALCOHOL & OTHER DRUG PROVIDERS

BHRS contracts with nine AOD providers for either additional residential treatment bed days, additional non-residential treatment service hours, or to enhance services provided to clients already in residential or non-residential treatment.

UNITS OF SERVICE (UOS) DELIVERED

Total Contracted Providers			
9			
Provider	**UOS Delivered**	**Contracted Amount**	**% Fulfilled**
El Centro de Libertad	266	266	100%
HR360 – Women's Recovery Association)	433	407	108%
Our Common Ground	1768	624	286%
Pyramid Alternatives	912	715	128%
Service League of San Mateo	1260	1260	100%
Free At Last	326	327	100%
Project 90	508	553	92%

PEER SUPPORT WORKERS & FAMILY PARTNERS

San Mateo County BHRS continues to support Peer Support Workers and Family Partners employed throughout the Youth and Adult Systems. These workers provide a very special type of direct service and support to BHRS consumers/clients: they bring the unique support that comes from the perspective of those experiencing recovery, either in their own personal lives, or as relatives of someone personally affected. They know firsthand the challenges of living with and recovering from a behavioral health diagnosis, and work collaboratively with our clients based on that shared experience.

Peer Support Workers Total Clients Served	Cost per Client
194	**$2,879.00**
Family Partners Total Clients Served	**Cost per Client**
146	**$3,193.16**

PEER SUPPORT WORKERS

In the adult systems, there are 14 Peer Support Workers who have personal lived experience as a consumer/client. These positions are mostly full time, civil service positions embedded in clinical teams. The Peer Support Workers represent diverse cultural and linguistic experiences, including bicultural and bilingual Spanish, Tagalog and Chinese as well as English speaking African American and Caucasian persons.

Peer Support Workers assist Adult clients in the following ways: Facilitate groups such as WRAP, WRAP for housing, Dual Diagnosis Group, Welcome Registration/Orientation for new clients, Mindfulness, Healthy Eating, Arts and Crafts, Healthy Living, Ash Thinkers, Ash Kickers, Chinese Family Support Group, Cooking with Ease and Stress Management. Peer Support Workers also help clients with some case management activities such as finding housing, connecting to vocational resources, applying for benefits and providing transportation.

Peer Support Workers bring their lived experience to the broader community by participating on community groups and initiatives such as: African American Initiative, Co-Occurring Committee, Lived Experience Speakers Academy and Speakers Bureau, Housing Committee, Mental Health and Education Workforce Collaborative: Integrated Care, Co-Occurring Change Agents, Housing Operations and Policy Committee and Education, and the Community Service Area planning, among others.

FAMILY PARTNERS

In the Youth System, there are 8 Family Partners with lived experience as a family member of someone with behavioral/mental health challenges. All but one position is full time and all are civil service positions. 7 Family Partners are embedded on the youth clinical service teams, 1 Family Partner was recently hired to support the Office of Diversity and Equity, and 1 Family Partner is on the Adult Pathways Mental Health Court team. The Family Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish and Tongan, as well as English speaking African American.

BHRS Family Partners can be referred to provide support for families who are not receiving services on the teams that they are embedded on. Cultural and linguistic matches are a key factor in making these assignments.

Family Partners provide individual support to parents of the youth, sharing their lived experience with the families they serve. Some case management is part of their support of the families. They also provide group support to parents/caregivers by providing educational activities around children and their mental health. Groups co-facilitated by Family Partners include: Wellness Recovery Action Planning (WRAP), Parent Project, Equip Educate and Support (EES), Parent support groups, and NAMI Basics.

FPs also bring their lived experience to the broader community by participating on the following community groups and initiatives: African American Initiative, Latino Collaborative, and North County Outreach Committee.

EVIDENCED-BASED PRACTICE (EBP) EXPANSION

System transformation is supported through an ongoing series of trainings that increase utilization of evidence-based treatment practices that better engage consumers and family members as partners in treatment and that contribute to improved consumer quality of life. MHSA funding supports staffing specialized in the provision of evidence-based services throughout the system, for youth and adult clients.

Total Youth Clients Served	Cost per Client
258	**$2,185**
Total Adult Clients Served	**Cost per Client**
686	**$1,190**

CHILD WELFARE PARTNERS

The Prenatal-to-Three program supports families of pregnant women and children to age five who receive Medi-Cal services in San Mateo County. Services include home visits, case management, substance abuse/recovery support, and psychiatric treatment to help women manage their mental wellness during their pregnancy and postpartum period. As part of the 2009-10 MHSA expansion plan, BHRS partially funds clinicians serving high-risk children/youth through the Prenatal-to-Three program. As part of the 2009-10 MHSA expansion plan, BHRS partially funds two clinicians serving high-risk children/youth referred through Child Welfare to Partners program.

Total Clients Served	Cost per Client
105	**$3,901**

OUTREACH AND ENGAGEMENT (O&E)

The Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. BHRS has seen a consistent increase in representation of these communities in its system since the strategies were deployed. Strategies include community outreach collaborative, pre-crisis response, and primary care-based efforts.

PRE-CRISIS RESPONSE

MATEO LODGE: FAMILY ASSERTIVE SUPPORT TEAM (FAST)

MHSA funding for pre-crisis response began in May 2013. Mateo Lodge was contracted to provide in-home outreach services that offer engagement, assessment, crisis intervention, case management and support services to individuals, family and caretakers. FAST provides early intervention and assessment and works with the family over a 2-3 month period. Services include behavioral health and community resource education, linkages to outpatient mental health care and rehabilitation and recovery services, and short-term counseling, support, and case management. The FAST team consists of clinical case managers, peer and family partners, and a psychiatrist.

Total Clients Served	Cost per Client
88	**$2,841**

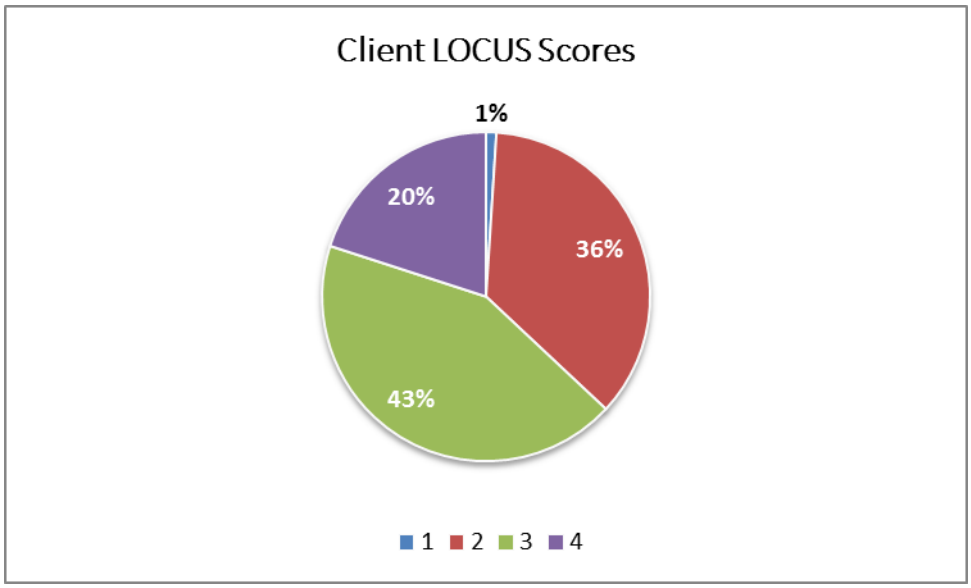
DEMOGRAPHICS

Total Clients Served			
88			
Male	56	Female	32
Race/Ethnicity			
Caucasian/White		37%	
Hispanic/Latino		19%	
Filipino		12%	
Native American		3%	
African-American/Black		4%	
Middle-Eastern		6%	
Pacific Islander		3%	
Asian		11%	
Age			
18-30		37%	
31-45		34%	
46+		29%	

PROGRAM IMPACT

Clients are given a score based on their LOCUS (Level of Care Utilization System) on a scale from 1-4. This tool is used to help determine the resource intensity needs of individuals who receive adult mental health services. A low LOCUS score means a lower level of care while a high score means a higher level of care.

The following represents the level of resource intensity of the total clients served:



Linkage to Services					
BHRS Outpatient	33	Shelter	15	DMV Assistance	3
Motel	19	Supported Housing	3	SSI Assistance	15
Redwood House	13	Vocational/Volunteer	10	Physical Health	13
Transitional Residential	13	Education	5	Board and Care	2
Food Assistance	12	WRA	2	Alcohol & Other Drugs	17
Section 8/Other Housing	6	VA	1	None	29

SUCCESSES/CHALLENGES

Due to the level of impairment of the clients referred, it has been challenging to make connection with the client when they do not show for their appointments. There are clients who are homeless, with no social support, who unless they contact the clinic or are in hospital or jail, could not be contacted. The Case Manager makes every attempt to meet clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits, use of natural family support, and case conference with outpatient community partners, hospital, and jail.

COMMUNITY OUTREACH COLLABORATIVES

Community outreach collaboratives are funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). The collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse and increase awareness of and access and linkages to culturally and linguistically competent behavioral health, entitlement programs, and social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSA funded services.

During FY 2015-2016, SMC BHRS outreach providers reported a total of 5,556 attendees at outreach events—1,102 attendees reached through individual outreach events and 4,454 attendees reached across 107 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events. See Appendix 13 for the full report and evaluation of the Outreach Collaborative strategy.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

North County Outreach Collaborative outreach is conducted by Asian American Recovery Services (AARS), Daly City Peninsula Partnership Collaborative (DCP), Daly City Youth Health Center (DCYHC), Pacifica Collaborative, and Pyramid Alternatives. The goals of NCOC include: 1) establishing strong collaborations with culturally/ linguistically diverse community members; 2) referring 325 clients to BHRS for mental health and substance abuse services; 3) establishing strong linkages between community and BHRS.

DEMOGRAPHICS

Total Clients Outreached					
4,744					
Male	1,823	Female	2,642	Other	279
Race/Ethnicity					
White	32%				
African American/Black	3%				
Hispanic/Latino	8%				
Filipino	14%				
Asian	11%				
Pacific Islander	12%				
Multi-Racial	9%				
Other	2%				
Unknown	9%				
Age					
0-15	6%				
16-25	25%				
26-59	59%				
60+	5%				
Unknown	9%				
Underserved Communities					
Risk for Homelessness	49%				
Homeless	9%				
Visually Impaired	18%				
Hearing Impaired	9%				
Veterans	16%				

PROGRAM IMPACT

NCOC partners are actively involved in the BHRS Health Equity Initiatives: PRIDE, Chinese Health Initiative, Spirituality Initiative, Pacific Islander Initiative, and the Filipino Mental Health Initiative. Through the partnership of this work, there are now sub committees formed to address specific needs such a LQBTQQ Filipino subcommittee, and a LGBTQQ North County subcommittee group, both addressing the needs of those specific groups. The Community Outreach Team (COT) also worked with the Spirituality Initiative and the Daly City Partnership to work directly with a few pastors in both Pacifica and Daly City and have discussions on ways to share information and resources. A few churches opened up their doors to the community resources, however there were some restrictions on some of the information that would be handed out. The staff was understanding and debriefed with the team acknowledging that getting in the door is a huge obstacle so being censored with what information we share is okay for now. Staff expressed the importance of taking it one step at a time. Pyramid Alternatives staff has also been able to go to Chinese churches and do presentations about services provided such as parenting in Cantonese and other support services also offered through the county. NCOC COT has continued to build relationships with Asian owned business in San Mateo County that mentor students in school. From presentations with the students' parents, staff was invited to speak at other venues to share information and resources in Cantonese. This has been very successful in reaching the Chinese community that is often disconnected from services that are available for them.

SUCCESSES/CHALLENGES

COT staff was able to establish a relationship with a young man, who was released from prison, went to culinary school and opened a Hawaiian Restaurant while running a project to help other ex-felons get experience in working for a restaurant while supporting each other through fellowship. Even though the owner is from San Francisco, he has extended his support to all Pacific Islander events and gatherings in San Mateo County and has donated bottles to the COT staff for outreach efforts. Being of Samoan and Latin decent and raised in an abusive environment, he has made it a life time commitment to give back to his people and share awareness while helping provide opportunities for others. An example of this is when a single Pacific Islander mother from Daly City had contacted the COT staff concerned about her transitional age son who was continuously getting in trouble with the law and she was afraid he would end up in the penitentiary if he kept on this path. Staff had a in-depth discussion with the mother about the Parent Project and was able to connect her and her son with the project/business owner. This resulted in the transitional aged youth being offered an opportunity to work at the restaurant.

EAST PALO ALTO PARTNERSHIP FOR MENTAL HEALTH OUTREACH (EPAPMHO)

Outreach and linkage services to gain access to Medi-Cal, other public health services, behavioral health, and other services is conducted by a partnership with El Concilio of San Mateo County, Free at Last, the Multicultural Counseling and Education Services of the Bay Area (MCESBA) and One East Palo Alto. EPA PMHO is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness and access to culturally and linguistically appropriate services. EPAPMHO provides the following services including:

- Technical assistance to BHRS initiatives to increase community education activities and integration of mental health services with other community organizations.
- Community Outreach and Access (marketing and publicity, including translation).
- Promote increased East Palo Alto resident participation in County-wide mental health functions and decision-making processes.
- Sustain and strengthen education materials for and conduct outreach to residents regarding mental health education and awareness.

DEMOGRAPHICS

Total Clients Outreached					
812					
Male	333	Female	465	Other	14
Race/Ethnicity					
Pacific Islander			27%		
Hispanic/Latino			25%		
African American/Black			24%		
Multi-Racial			10%		
White			9%		
Filipino			2%		
Asian			2%		
Other			1%		
Age					
0-15			1%		
16-25			38%		
26-59			54%		
60+			7%		
Underserved Communities					
Risk for Homelessness			35%		
Homeless			45%		
Visually Impaired			7%		
Hearing Impaired			7%		
Veterans			5%		

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. Ravenswood outreach and engagement services are funded at 40% under CSS and the remaining 60% is funded through Prevention and Early Intervention.

The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for the underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.

Total Clients Served	Cost per Client
497	**$139**

PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services for underserved populations and reducing the 7 negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes. Service categories include:

- **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

- **Prevention** programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.

- **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

- **Access and Linkage to Treatment** are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

- **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.

- **Suicide Prevention** programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI AGES 0-25

The following programs serve children and youth ages 0-25 exclusively and some combine both Prevention and Early Intervention strategies. MHSA guidelines require is 19% of the MHSA budget to fund PEI and 51% of PEI budget to fund program for children and youth.

STARVISTA: EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

ECCT employs both prevention (60%) and early intervention (40%) strategies. ECCT incorporates several major components that build on current models in the community, in order to support healthy social emotional development of young children. The ECCT comprises a community outreach worker, an early childhood mental health consultant, and a licensed clinician and targets a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners and support families.

The ECCT delivers three distinct service modalities that serve at risk children and families: 1) Clinical Services, 2) Case management/Parent Education services, and 3) Mental health consultations with childcare and early child development program staff and parents served by these centers. In addition, the ECCT team conducts extensive outreach in the community to build a more collaborative, interdisciplinary system of services for infants, toddlers and families.

The ECCT focuses services on the Coastside community - a low-income, rural, coastal community geographically isolated community - comprised of Half Moon Bay, La Honda, Pescadero, Moss Beach, Montara and the unincorporated coastal communities of El Granada, Miramar and Princeton-By-The-Sea. While comprised of very small cities and unincorporated areas located significant distances from one another, collectively Coastside comprises 60% of the total area of the entire County while having a small fraction of the population. To better serve this disperse community, ECCT has built strong relationships with key community partners and successfully refers families to the local school district, other StarVista services, Coastside Mental Health clinic and Pre-to-Three Program , among others. Additionally, ECCT works with these partners to address gaps and needs in the community and to address the existing system of care for families with young children living in the Coastside areas.

Total Clients Served	Cost per Client
78	**$4,847**

DEMOGRAPHICS

Total Clients Served			
78			
Male	49	Female	29
Race/Ethnicity			
Hispanic/Latino		82%	
Caucasian/White		6%	
African-American/Black		1%	
Multi-Ethnic		8%	
Other		3%	
Age			
0-15		100%	

PROGRAM IMPACT

As a result of mental health consultation services, 13 families have increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. This has been observed through informal conversations with parents over the course of their work with the consultant. Though most parents were given satisfaction surveys to complete this year, none were returned. Parents and teachers also noted differences in children's behaviors: progress towards achieving goals formed at the beginning of case consultation was evidenced in 11 of the 13 more intensive consultation cases. Progress was not achieved in two cases due to parents' decisions to withdraw their children from the program in which the consultant was working. In each of these cases, the consultant offered support during the transition out of the program, though neither parent was interested in this transitional support. Additionally, 8 families have received referrals to additional services in the community.

Parents receiving child-parent psychotherapy services complete pre and posttest assessments using the Child Behavior Checklist (CBCL). Additional measures are available to the clinicians to use with families such as the Parent Relationship Questionnaire (PRQ), the Parenting Stress Index (PSI), and Keys to Interactive Parenting Scale (KIPS). However, these measures are no longer required in an effort to reduce the amount of assessments completed by the family. ECCT aim was to address the concern from previous reports related to whether multiple assessments were beneficial to treatment. When parents complete the CBCL, many children score with either a clinical concern or borderline concern of behaviors such as anxious/depressed, withdrawn, aggressive behaviors, pervasive developmental problems, and internalizing or externalizing problems. In the post data we gathered children decrease from clinical scores to normal in aggressive behaviors as well as a decrease from borderline scores to normal scores in pervasive developmental problems.

SUCCESSES/CHALLENGES

A success and a challenge has been the ability to manage the caseloads as a result of an increase of referrals within the Half Moon Bay community. Fortunately, due to the expansion of the ECCT from other sources of funding, a part-time clinician has been able to work with the Pescadero and La Honda referrals that have been referred to the Half Moon Bay Community Team. In the next fiscal year, the ECCT focus will be on how to manage the anticipated increased referrals since. We continue to receive feedback from families informally and through a continued increase in referrals that the ability of the ECC team members to meet them in their homes or in a community location is of primary concern, especially in the ways this allows families to access mental health or parent support services without feelings of shame or stigma.

PROJECT SUCCESS

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is an early intervention program. Initiated in 2013, Puente de la Costa Sur delivers Project SUCCESS services at three San Mateo South Coast schools: La Honda Elementary, Pescadero Middle School and Pescadero High School, and in 2014-15, Puente added a fourth site, Pescadero Elementary School. Project SUCCESS groups introduces coping skills, communication, decision-making and other social skills. The SUCCESS groups and the school-wide presentations also serve as a point-of-entry to individual counseling services available at all four schools. Groups are designed to meet once per week for 8 weeks with the exception of the high school group which has met consistently once per week since being launched in Sept 2013.

PROGRAM IMPACT

Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals in the schools to provide a full range of prevention and early intervention services. Project SUCCESS counselors use the following intervention strategies: information dissemination, normative and prevention education, problem identification and referral, community-based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The contract describes counselors as primarily working with adolescents individually and in small groups; conducting large group prevention/ education discussions and programs, training and consulting on prevention issues with alternative school staff; coordinating the substance abuse services and policies of the school and refer and following-up with students and families needing substance abuse treatment or mental health services in the community.

TEACHING PRO-SOCIAL SKILLS (TPS)

TPS is an early intervention program. The Human Services Agency (HSA) delivers TPS groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up in a low-income household and community; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others.

Total Clients Served	Cost per Client
96	**$1,356**

DEMOGRAHPICS

Total Clients Served	
96	
Race/Ethnicity	
Hispanic/Latino	60%
African-American/Black	7%
Pacific Islander	3%
Asian	14%
Multi-Ethnic	7%
Other	8%
Age	
0-15	100%
Language	
English	41%
Spanish	49%
Tagalog	6%
Other	4%

PROGRAM IMPACT

During the fiscal year 2015-2016, from October 2015 to June 2016, two 7 to ten week sessions have taken place in 8 Family resource centers. There were 17 total groups facilitated throughout the year. The groups consisted of:

FRC Location	Number of Groups Facilitated	Elementary Grade Level	Total Clients Served
Bayshore	4	K-3rd	24
Belle Haven	2	4th	11
Taft	2	K-1st and 3-4th	14
Hoover	1	1st	4
LEAD	2	2-3rd	11
Woodrow Wilson	2	2nd & 4th	12
JFK Daly City	2	2-3rd	12
Sunset Ridge	1	3rd & 5th	8

The TPS pre and post- test is the primary tool used to evaluate the effectiveness on the behavior changes and skill acquisition of the participants. The teachers are asked to fill out a 60 skill Teacher Skillstreaming Checklist prior to the group starting.

Overall there was significant positive behavior change in the TPS participants as evidenced by the individual and overall improvement in scores. There were 5 sites where the average change surpassed 10%. Having a lead TPS Facilitator throughout the duration of the 2015-2016 academic year helped us serve more children at more sites than our program was able to last year. Those are all possible contributing factors that lead to the improvement in scores. By continuing our efforts to increase parent and teacher communication and parent involvement, we are confident that TPS can be more impactful on the behavior of the students, and provide a foundation of positive social skill-building.

SUCCESSES/CHALLENGES

The lead facilitator observed significant behavior changes among the students in such areas as understanding and coping with their feelings, dealing with their anger, apologizing, showing more empathy, and using self-control. These behavior changes often occurred with minimal guidance from the facilitators. The students were consistently praised for their efforts, which appeared to have had a positive impact on the students by validating their behavior change. This lead facilitator noticed that the students who were shy and had trouble making friends at the beginning stages of the group had become more outgoing and confident by the end of the group. One particular student who was in 4th grade at Belle Haven was initially shy; she did not speak unless spoken to, and had very few friends in school. She made great efforts to learn and apply the skills to situations. By the end of group, she was playing on the playground with one of her group mates and was observed making the effort to ask to play with others. A lot of the students who had behavior problems in their classrooms did make some changes by the end of group. We were halfway through the session and one of the 1st grade teachers at Woodrow Wilson came up to the CW and PSW to informed them that two of her students that were

participating in the group had been listening and thinking before they reacted to certain situations due to the skills that they had been learning in group.

Even with the noted successes of the TPS groups, there were some challenges and areas that will be targeted for improvement for the next school year. Homework was given out to the students at the end of each session but there were a low number of students that completed and turned in their homework even when incentives were offered. Although a letter describing the nature and purpose of the weekly assignments was sent home with the students at the commencement of groups, many parents did not appear to follow through with their children.

STARVISTA: CRISIS HOTLINE – YOUTH OUTREACH AND INTERVENTION TEAM

The Crisis Hotline and Youth Outreach and Intervention Team employ both early intervention (70%) and prevention (30%) strategies for school age youth experiencing a mental health crisis. StarVista provides a free, confidential 24-hour, seven days a week crisis intervention hotline. Trained volunteers and staff provide referrals for community resources and services for anyone who feels sad, hopeless, or suicidal; family and friends who are concerned about a loved one; anyone interested in mental health treatment and service referrals; and/or anyone who just needs some support through a personal crisis.

The Youth Outreach Team MHSA-funded mental health clinician provides case management, follow-up phone consultation, youth outreach intervention in schools, clinical training and supervision, and outreach presentations in suicide prevention.

Total Clients Served	Cost per Client
67	**$1,765**

Total Clients Served	
67	
Case Management	
New Cases/Follow-Up Consultation	41
Total Session Provided	91
Youth Outreach Intervention at School Sites	
Initial Interventions/New Youth Served	26
Follow-Up Sessions	85
Follow-Up Contact with Collateral Contacts	36
Community Outreach Presentations	
Youth & Adults Served	3392

FELTON INSTITUTE: PREVENTION AND RECOVERY IN EARLY PSYCHOSIS (PREP)

The target age group for PREP is 70% youth ages 0-25. PREP braids together five evidence-based practices into one integrated treatment approach, and uses community education and outreach to facilitate early identification of individuals at risk of psychosis. Felton Institute's (formerly Family Service Agency) PREP program identifies and intervenes with transition age youth (14-25 years) experiencing a recent onset episode of psychosis and their families. The PREP Program provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services. PREP is administered by Felton Institute.

Total Clients Served	Cost per Client
104	**$7,923**

DEMOGRAPHICS

Total Clients Served	
104	
Race/Ethnicity	
Asian	16%
African-American/Black	5%
Pacific Islander	1%
Hispanic/Latino	37%
Filipino	11%
Native American	2%
White	23%
Multi-Ethnic	2%
Other	3%
Age	
0-15	4%
16-25	84%
26-59	12%
Language	
English	93%
Spanish	4%%

Tagalog	1%%
Other	1%
Underserved Communities	
LGBTQ	6%
Homeless	4%
Vision Impaired	1%
Disability	8%

PROGRAM IMPACT

Hospitalizations Reduction: There were 27 clients enrolled in PREP for at least 12 months in FY 2015-16. Compared to 12 months prior to their admission, 13 (48%) of these clients experienced a reduction in acute hospitalization episodes and 14 (52%) experienced a reduction in days hospitalized. Note that for many clients their period of time in PREP was longer than 12 months, meaning that our comparison was being prior hospitalizations spanning only a 12 month period, but post-entry hospitalization spanning a period of time from 12 to 24 months. Overall, 21 (78%) clients enrolled in PREP for at least 12 months maintained their current or a lower level of care and 17(63%) did not experience any hospitalizations. If we examine hospitalization rates and days for all 27 clients enrolled for at least 12 months, we see an overall reduction in hospitalization from 30 in the 12 months prior to 20 episodes in 12-24 months after entering PREP (a 33% reduction) and 285 hospital days in the 12 months prior to entry compared to 221 in the 12-24 months after entering PREP.

Medication Adherence Increase: Baseline and latest semi-annual MARS scores from clients' evaluations were used to assess change in medication adherence. Out of 16 clients for whom both data points were available, 9 (56%) showed an increase in self-reported medication adherence.

Satisfactory Vocational and Educational Engagement: Out of 27 clients enrolled in PREP for at least 12 months, 21 (77%) maintained their current educational or vocational activities or were engaged in new ones during FY 2015-16. Educational and vocational engagement included part- and full-time employment, part- and full-time school, vocational training, or volunteer activities.

Service Satisfaction: Latest semi-annual SSS score from clients' evaluations was used to assess service satisfaction. Out of 34 clients for whom these scores were available, 31 (91%) indicated that they were highly satisfied with the overall service delivery (average SSS score of 3.5 or greater).

SUCCESSES/CHALLENGES

Important areas to look at in terms of growth are the number participants served by BEAM, the percentage of served clients who were ultimately treated in PREP and BEAM, and the overall number of participants treated by the program in FY 2015-16. A Year-to-Year Comparison of FY 2014-15 and FY 2015-16 shows the growth experienced by PREP/BEAM.

FY	Served	Treated	% Treated
14-15	105	60	57%
15-16	74	55	74%

Participants Served speaks to individuals who receive an Assessment for Eligibility and Participants Treated refers to those who are found to be eligible following the Assessment process and enrolled into full services. Historically, one of the challenges experienced at PREP/BEAM has been the perception that eligibility is too exclusive. This year the program increased the inclusion rate and treated more participants than ever before.

The increased inclusion rate was made possible by adopting new eligibility standards that include psychosis as a symptom domain rather than limiting eligibility to only specific diagnoses, enrolling Ultra High Risk (UHR) participants for the first time, and providing intensive targeted outreach to inform community partners and stakeholders of new criteria. Treating UHR participants has been an expectation and goal of PREP/BEAM. This year the program built the capacity to work with the UHR population and has three UHR participants currently enrolled in treatment. Additionally, through increased and targeted outreach, the program now has better relationships with several schools and district staff as well as the local hospitals resulting in increased referrals and better coordination of care. In spite of this tremendous growth, the year was not without its challenges and PREP staff worked hard to address two identified primary challenges. The first challenge was maintaining PREP's presence throughout the county as a county-wide provider with a relatively small team. The second of these challenges being that support staff held blended roles reducing the effectiveness of those roles.

The strategy that has been developed to address the first challenge was to utilize San Mateo County's six CSA regions to coordinate and streamline caseloads and community partnerships. Each direct service staff member will be responsible for a region and their caseload will contain the program participants from that region. The staff will attend the CSA meeting and School Based Mental Health meeting for their region and in doing so maintains the presence of PREP/BEAM while also becoming more familiar with our community partners in their region.

Addressing the second challenge has involved growth within PREP leadership with the addition of a Supported Employment and Education Services Director a Peer and Family Services Director. With their leadership the restructuring of support staff positions within PREP was made possible and as the program embarks on FY16/17 there are now dedicated positions for Employment and Education Specialist, Peer Support Specialist, and Family Support Specialist.

SAN MATEO COUNTY BHRS: PRIMARY CARE INTERFACE

Primary Care Interface focuses on identifying persons in need of behavioral health services in the primary care setting, thus connecting people to needed services. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of the IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness (SMI), and are unlikely to seek services from the formal mental health system.

Total Clients Served	Cost per Client
578	**$711.52**

DEMOGRAPHICS

Total Clients Served
2725

PROGRAM IMPACT

The Interface program is successful in providing behavioral health services to underserved populations such as clients with mild to moderate mental illness. Clients served in one of the county's primary care clinics with ACE coverage would have very limited options for "affordable" behavioral health services elsewhere. The Interface program provides assessment, brief treatment (1-8 counseling sessions), co-occurring case management and psychiatric support to clients referred by primary care.

Providers continue to bring access issues for underserved communities to the attention of direct service providers and leadership. Providing appointments after 5pm is an effort to improve access to an underserved community. Often times clients request an appointment after work as many do not get paid time off. Also, parents/caregivers request an appointment after school to reduce missed classroom time. One additional staff member who provides direct service to both youth and adult moved to a 4/10 schedule this past fiscal year allowing for longer days to accommodate more client appointments after 5pm.

Interface clients continue to be referred to PPN (private provider network) if they are mild to moderate and seeking a therapist for ongoing counseling, need a provider that can accommodate a weekend appointment or speak their native language not available by an Interface therapist such as: Russian, Tagalog or Farsi.

The impact and success of the Primary Care Interface Medication Assisted Treatment (MAT) has been encouraging. Over the past fiscal year 495 clients were referred for co-occurring case management. Some of these clients were anonymously highlighted in success stories shared with BHRS providers and leadership. Clients were successful in reducing or abstaining from use of substances, reconnecting with family members, securing housing or employment and reducing symptoms of depression and/or anxiety.

SUCCESS/CHALLENGES

The collaboration between Interface and the Sequoia Family Resource Center (counseling services provided by HSA at Sequoia High School) is a response to meeting the needs of the community. A gap in services was identified for clients in need of a psychiatric consult due to the Sequoia Family Resource Center not having psychiatric support. Both teams met to develop a protocol that included psychiatric consultation with Interface psychiatrist and/or assistance with linkage to ACCESS or a regional clinic if client was identified as SMI.

One of the challenges over the last few months of the fiscal year was staff turnover. Two licensed Spanish speaking clinicians resigned and both serve the same clinic. It has been a challenge to recruit for these positions due to the language requirement and it's a competitive recruitment as several other programs are looking to fill Spanish speaking positions.

In an effort to address this challenge Interface staff assigned to other clinics is providing coverage and the program specialist and unit chief have assisted with triaging referrals and providing direct client care. It is less than ideal, but a good work around while we continue to recruit Spanish speaking staff to meet the needs of the clinic/community.

SAN MATEO MEDICAL CENTER: MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program began in 2005 with one unit covering the entire county. Due to the program's success and at the request of law enforcement, AMR began staffing SMART with two units in 2015 with additional funding from a variety of sources.

A memorandum of understanding was developed for the SMART team by the San Mateo County Health System and the American Medical Response West in which specially trained paramedic responds to law enforcement Code 2EMS requests for individuals having a behavioral health emergency. The SMART paramedic performs a mental health assessment, places a 5150 hold if needed and transports the client to Psychiatric Emergency Services or, in consultation with County staff, arranges for appropriate services. Access to SMART is only available through the County's 911 system.

PROGRAM IMPACT

Paramedics in the SMART program, freed from the need to rush patients to a hospital and get back in service as quickly as possible, can interview family members or friends of a patient, contact a patient's therapist and conduct an assessment to determine the best course of action.

Total Calls Received	
5,616	
Average Response Time	
July 1st – December 31st 2015	18 minutes
January 1st – June 30th 2016	16 minutes
Average Response Volume by Day	
Monday	443
Tuesday	433
Wednesday	403
Thursday	435
Friday	420
Saturday	342
Sunday	332

PREVENTION

OFFICE OF DIVERSITY AND EQUITY (ODE)

The Mental Health Services Act provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County this led to the formal establishment of the Office of Diversity and Equity (ODE) in 2009. ODE advances health equity in behavioral health outcomes of marginalized communities. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services, ODE works to promote cultural humility and inclusion within the County's behavioral health service system and in partnerships with communities through the following programs:

- Health Equity Initiatives
- Health Ambassador Program
- Adult Mental Health First Aid
- Digital Storytelling & Photovoice
- Stigma Free San Mateo – Be the ONE Campaign
- San Mateo County Suicide Prevention Committee (SPC)

HEALTH EQUITY INITIATIVES (HEI)

The HEI strategy was created to address access and quality of care issues among underserved, unserved, and inappropriately served communities. ODE provides oversight to nine Health Equity Initiatives (HEIs) representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino Collaborative; Native American Initiative; Pacific Islander Initiative; PRIDE Initiative; Spirituality Initiative; and the Diversity and Equity Council. HEIs are comprised of San Mateo BHRS staff, community-based health and social service agencies, clients and their family members, and community members. The HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader. HEIs implement activities throughout San Mateo County that are intended to:

- Decrease stigma
- Educate and empower community members
- Support wellness and recovery
- Build culturally responsive services

In FY15-16, through presentations, events, and trainings the HEIs reached an estimated 4,672 community members. See Appendix 14 for the 10-year Impact Report on the HEIs.

DIVERSITY AND EQUITY COUNCIL (DEC)

The Diversity and Equity Council (DEC) works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the Cultural Competence Committee. This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of ODE.

Mission, Vision, & Objectives

The Council serves as an advisory board to assure BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Highlights & Accomplishments

The DEC's enduring commitment to promoting the principles of health equity, cultural competency, and diversity within San Mateo BHRS helps ensure service providers and staff is equipped with the knowledge and skills needed to effectively serve the diverse members of San Mateo County. Since its inception, community participation in the meetings has grown and includes BHRS staff, community partner agencies, leaders, clients, and family members.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

African American Community Initiative (AACI) efforts began in 2007 and were led by African American BHRS staff members committed to: increasing the number of African American clinicians working within BHRS; improving the cultural sensitivity of clinicians to better serve the African American community; and empowering African Americans to advocate for equality and access to mental health services. The AACI works towards these goals by providing support and information about mental health and recovery services to BHRS clients and San Mateo County residents.

Mission, Vision, and Objectives

The AACI has defined its vision as working to improve health outcomes and reduce health disparities for African Americans in San Mateo County and has identified the following objectives as necessary steps towards achieving this vision:

1. Increase awareness and involvement of community members in the African American Community Initiative.
2. Increase knowledge and utilization of BHRS mental health services among African American community members in San Mateo County.
3. Link African American community members to BHRS education and training programs such as Mental Health First Aid, Parent Project, and the Health Ambassador Program.
4. Advocate for the employment of at least one African American clinician in each Community Service Area of San Mateo County BHRS.
5. Provide San Mateo County BHRS with research regarding the African American community as a result of focus groups, community-based research, and surveying through the Office of Consumer Affairs.
6. Conduct at least one annual community-based outreach event to build support for AACI.
7. Partner with other organizations and HEIs to support AACI, African American clients, and professionals.

Highlights & Accomplishments

Since its initial formation in 2007, the AACI has organized and participated in a number of events that help advance the objectives described above. Notable achievements include: establishing a partnership with the African American Community Health Advisory Council (AACHAC) which works with businesses, corporations, CBOs, health educators, and the faith-based community to promote health and wellness; consistent engagement of African American BHRS clients in AACI monthly meetings; and ongoing community outreach and wellness and recovery activities.

In FY15-16, the AACI participated and/or hosted the following events and activities:

- Annual African American Community Health Advisory Committee (AACHAC) Men's Health Symposium
- AACHAC 8th Annual "Celebrating Me: Taking Care of My Own Well-Being Women's Health Conference
- 2016 San Mateo County LGBTQ PRIDE Celebration
- AACHAC Mental Wellness: Mental Health and Well-Being of Today's Youth and Teens

CHINESE HEALTH INITIATIVE (CHI)

The Chinese Health Initiative (CHI) efforts began in 2007 by San Mateo BHRS staff members who were committed to providing and advocating for culturally and linguistically accessible and responsive services within the San Mateo County Health System. By collaborating with partners, conducting community outreach, and providing service referrals, CHI members work to empower Chinese residents to seek services for mental health and substance use issues.

Mission, Vision, and Objectives

The Chinese Health Initiative works to improve engagement and utilization of BHRS mental health and substance abuse services among the Chinese community. In order to ensure the services Chinese clients receive are culturally-sensitive and appropriate, CHI works to increase provider capacity to serve Chinese clients by advocating for the hiring of Chinese staff who are able to reflect the culture and language needs of Chinese clients. Much of CHI's work is focused on reducing the stigma associated with seeking services for mental health issues and accessing care. Recognizing a need for targeted community outreach and engagement, CHI advocated and received funding for a Chinese Outreach Worker position.

Highlights & Accomplishments

Since 2007, the Chinese Health Initiative has worked to ensure that BHRS services are culturally and linguistically appropriate, while also working to increase knowledge and utilization of BHRS services among Chinese community members.

In FY15-16, CHI participated and/or hosted the following events and activities:

- Mills High Schools and CHI: Achieving Success & Balance in the Modern Day, How to Help your Child Survive and Thrive in their High School and College Years.
- Recruited a BHRS Chinese Community Health Worker
- Mental Health Screening and Referral presentation to Chinese Hospital clinicians on how to screen for depression.
- NICOS Chinese Health Initiative Gambling Addiction Provider Training

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

The Filipino Mental Health Initiative (FMHI) formed as a result of a series of focus groups conducted in 2005 by San Mateo County BHRS. During these focus groups, community members, providers, and staff members discussed issues pertaining to mental health, stigma, and barriers to accessing care among Filipinos living in San Mateo County. Following these focus groups, in 2006 interested members formed a group with funds made available from the Mental Health Services Act to support Filipino families not yet connected to services. In 2010, FMHI was formally established as one of ODE's nine Health Equity Initiatives.

Mission, Vision, & Objectives

The FMHI seeks to improve the well-being of Filipinos in San Mateo County by reducing the stigma associated with mental health issues, increasing access to services, and empowering the community to advocate for their mental health. The FMHI works to connect individuals to appropriate health, mental health, and social services through community outreach and engagement. By collaborating and working with providers, the FMHI also works to ensure that culturally appropriate services are available to Filipino residents. **Highlights & Accomplishments**

FMHI members have worked with community members and community-based agencies to provide opportunities for young adults, parents, and individuals to discuss mental health issues in the context of Filipino cultural values and traditions. FMHI members also serve on one of three subcommittees focused on addressing the various cross-sections of the Filipino community: youth, elders, and LGBTQ individuals.

In FY15-16, FMHI participated and/or hosted the following events and activities:

- Working with Filipino Youth Provider Training
- Filipino Consultation Group at Fred Finch Youth Center
- Understanding the needs of Filipino LGBTQ Community Focus Group
- Westmoor High School Youth Focus Group: Taking Charge of Your Health and Wellness
- South San Francisco High School Parents Night: How to be Successful in High School and Beyond

LATINO COLLABORATIVE

While the Latino Collaborative (LC) efforts began in 2008, its founding members have been committed to giving voice to the Latino community since the late 1980s. During these initial meetings, a small group of Latino providers met informally to address issues pertaining to health disparities and access within the Latino community and San Mateo County mental health services. These meetings continued and in 2004, a core group of Latino providers requested a Latino-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino population.

Mission, Vision, & Objectives

The Latino Collaborative's mission includes critically exploring the social, cultural, and historical perspectives of Latino residents within San Mateo County. The Latino Collaborative gives a voice to the Latino community by working together to support mind, body, soul and healthcare practices that are culturally appropriate. The Latino Collaborative has defined its mission as:

1. Creating stronger, safer, and more resilient families through holistic practices.
2. Promoting stigma-free environments.
3. Providing fair access to health and social services, independent of health insurance coverage.
4. Appreciating and respecting traditional practices.
5. Recognizing and incorporating Latino history, culture, and language into BHRS 2017 18

Highlights & Accomplishments

The Latino Collaborative's long-standing commitment to honoring the cultural and historical perspectives of Latinos has resulted in the creation of services, events, and resources that are grounded in the principles of cultural humility.

In FY15-16, FMHI participated and/or hosted the following events and activities:

- San Mateo County's 3rd annual Latino Health Forum: Sana Sana, Colita de Rana.
- Three community presentations on how to obtain mental health services

NATIVE AMERICAN INITIATIVE (NAI)

The Native American Initiative (NAI) is one of the newer Health Equity Initiatives, established in 2012. Inherent to their work is building appreciation and respect for Native American history, culture, and spiritual healing practices.

Mission, Vision, & Objective

The NAI has defined its mission as generating a comprehensive revival of the Native American community in San Mateo County by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices. The NAI's vision is to provide support and build a safe environment for the Native American community in San Mateo. Additionally their goal is to appreciate and respect Native American history, culture, spiritual, and healing practices. The NAI strives to reduce stigma, provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners. The NAI has further developed and articulated the following objectives:

1. Increase Awareness: Improve visibility of the challenges faced by Native Americans and provide support for the Native American community in San Mateo.
2. Outreach and Education: Outreach to and educate San Mateo County employees and community partners on how better to serve the Native American community.
3. Welcome and Support: Welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating the San Mateo County health care system.
4. Strengthen our Community: Provide opportunities for Native Americans to strengthen their skills and create collaboration for guidance, education, and celebration of the Native American community.

Highlights & Accomplishments

The NAI has not only provided mental health resources to San Mateo County residents, but has also contributed to the professional development of San Mateo BHRS providers through trainings and workshops Initiative members have organized.

In FY15-16, NAI participated and/or hosted the following events and activities:

- Trust the Wisdom of Your Soul: Native American Mental Health Training
- Mental Health Disparities in Native American

PACIFIC ISLANDER INITIATIVE (PII)

The Pacific Islander Initiative (PII) was initially formed by community members and BHRS staff in 2006 after a needs assessment conducted in 2005 identified particular areas of need among Pacific Islanders living in San Mateo County. The PII focuses on addressing health disparities within the Pacific Islander community by working to make services accessible and culturally-appropriate and by increasing awareness of and connections to existing mental and behavioral health services.

Mission, Vision, & Objectives

The PII's mission is to raise awareness of mental health issues in the Pacific Islander community in order to address the stigma associated with mental illness and substance abuse. The PII envisions a healthy community that feels supported by service providers, is accepting of individuals experiencing mental illness or substance abuse challenges, and is knowledgeable of the various resources and services that are available to address mental and behavioral health needs. The goals and objectives of the PII are organized into three main categories:

1. Education and Awareness: Increase the visibility of challenges experienced by Pacific Islanders and promotes community resources that support the community.
2. Prevention: Actively support activities that promote positive behavioral and physical health through community engagement.
3. Capacity Building and Leadership: Provide opportunities for service providers and local Pacific Islander leaders to develop their skills and capacity for providing services to Pacific Islanders that are culturally appropriate.

Highlights & Accomplishments

The PII's commitment to actively supporting and engaging with community members has allowed members to become trusted and valued resources within the community. This is particularly evident in the support they have provided family members and caregivers, as detailed below.

PRIDE INITIATIVE

The PRIDE Initiative was founded in April 2007, and was one of the first LGBTQ focused efforts in San Mateo County. The Initiative is comprised of individuals concerned about the well-being of lesbian, gay, bisexual, transgender, queer, questioning, and intersex individuals (LGBTQQI) in San Mateo County.

Mission, Vision, & Objectives

The PRIDE Initiative has defined its mission as being committed to fostering a welcoming environment for the lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQQI) communities living and working in San Mateo County through an interdisciplinary and inclusive approach. The Initiative collaborates with individuals, organizations, and providers working to ensure services are sensitive and respectful of LGBTQQI issues. PRIDE envisions an inclusive future in San Mateo County grounded in equality and parity for LGBTQQI communities across the County. PRIDE objectives have been defined as:

1. Engage LGBTQQI communities.
2. Increase networking opportunities among providers.
3. Provide workshops, educational events, and materials that improve care of LGBTQQI individuals.
4. Assess and address gaps in care.

Highlights & Accomplishments

While the PRIDE Initiative organizes a number of community-based events, one of their most notable accomplishments has been the establishment of an annual county-wide LGBTQQI pride celebration. Following the inaugural Pride Parade and celebration in June 2013, the Board of Supervisors formally recognized June as LGBTQ Pride Month in San Mateo County.

In FY15-16, PRIDE participated and/or hosted the following events and activities:

- San Mateo County 4th Annual PRIDE celebration
- Capuchino High School Safe and Inclusive Schools presentation
- Daly City Partnership's Health Aging Response Team LGBTQ Seniors presentation
- Transgender 102 Seminar
- LGBTQ 101 for Mental Health Association Board & Care Operators
- Candlelight Vigil for Victims in Orlando

SPIRITUALITY INITIATIVE (SI)

The Spirituality Initiative (SI) began in 2009, and works to foster opportunities for clients, providers, and community members to explore the relationship that spirituality has with mental health, substance use, and treatment.

Mission, Vision, & Objectives

The SI envisions a health system that embraces and integrates spirituality when working with clients, families, and communities. They have defined three core principles that guide their work:

1. Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.
2. Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.
3. Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

The SI has demonstrated how an HEI can work to impact both individual and system-level change. By developing a Spirituality Policy (further described in the case study on the following pages) that shapes the practice of San Mateo BHRS providers system-wide, and offering trainings that work to change individual practices, the Spirituality Initiative is fostering change at multiple levels.

In FY15-16, SI participated and/or hosted the following events and activities:

- San Mateo Medical Center Grand Rounds: Bridging Spirituality within Clinical Practice
- Spirituality and Substance Use Treatment

HEALTH AMBASSADOR PROGRAM (HAP)

ODE launched the Health Ambassador Program (HAP) in 2013 as a response to feedback from the graduates of the Parent Project© who wanted to continue learning about how to appropriately respond behavioral health issues. Many of these graduates wanted to further what they learned from the PP classes but also wanted to remain connected to the ODE. Community members are encouraged to participate in a series of workshops and trainings hosted by ODE. HAP graduates gained vital tools and knowledge to become an informed community participant (and leader). All Health Ambassadors begin by graduating from the Parent Project - a 12-week course that teaches parents the skills to improve their relationship with their children as well as effective prevention and intervention strategies. After completion of the Parent Project, individuals continue to increase their skills and knowledge in behavioral health and substance use related topics by completing four of the eight public education programs offered by ODE.

Individuals interested in broadening their skills on how to help people who have a mental illness or may be experiencing a mental health crisis are encouraged to attend an 8-hour Mental Health First Aid (MHFA) certification training, the 12-week NAMI Family to Family program, the Applied Suicide Intervention Skills Training (ASIST), and/or a Wellness Recovery Action Plan (WRAP) workshop. All programs increase an individual's mental health literacy and reduces stigma.

Community members with lived experience who are interested in sharing their story can participate in an 8-hour BHRS Lived Experience Educational Workgroup, Photo Voice Project and/or Digital Story Telling workshop. All three opportunities provide individuals an opportunity to use their voice and share their unique story related to health, mental health and substance abuse issues. Health Ambassadors are also encouraged to be part of the BHRS Health Equity Initiatives. In this work, individuals engage in outreach, education and dialogue with members of our communities to reach our goal of a stigma free County.

Becoming a Health Ambassador can potentially lead to opportunities to work and volunteer amongst other dedicated individuals; teach both youth and adult courses in their community; assist in identifying unmet needs in their community and help create change; or become a Community worker/Family Partner.

RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ADULT MENTAL HEALTH FIRST AID (MHFA)

Mental Health First Aid (MHFA) is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. MHFA is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and reviews common treatments. Those who take the 8-hour course to become certified as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

The 8-hour MHFA USA course has benefited diverse professions, including: primary care professionals, employers and business leaders, faith communities, school personnel and educators, state police and corrections officers, nursing home staff, mental health authorities, state policymakers, volunteers, young people, families and the general public.

DEMOGRAPHICS

Total Clients Served			
255			
Male	64	Female	191
Race/Ethnicity			
African American	7%		
Chinese	5%		
Filipino	9%		
Latino	43%		
Native American	0%		
Pacific Islander	4%		
White	18%		
More than one race	5%		
Age			
18-25	22%		
26-29	8%		
30-39	16%		
40-49	23%		
50-59	17%		
60+	12%		

PROGRAM IMPACT

In FY 15-16, there were 12 MHFA class sessions, where out of 255 attendees, 240 graduated the course. Five of the twelves sessions were focused on community colleges in San Mateo County, including Skyline and Canada College. Other sessions included three caregiver focused audiences, one probation, and one for Community Legal Services of East Palo Alto. Two of the twelve sessions were in Spanish, which was possible through ODE's partnership with Aging and Older Adult Services, In Home Supportive Services.

STIGMA DISCRIMINATION AND SUICIDE PREVENTION

STIGMA FREE SAN MATEO COUNTY – BE THE ONE CAMPAIGN

Be the One is San Mateo County's anti-stigma campaign that aims to eliminate stigma around mental and substance use conditions by raising awareness, building empathy and inspiring action. *Be the One* can mean many things to different people. Be the One can mean that ONE in four people have a mental health condition yet less than half are getting the help they need—many because they are afraid others will judge them. Be the One can also mean that ONE person or organization can make a difference in supporting wellness and recovery for others.

Throughout the 2015-2016 fiscal year, the *Be the One* campaign included educational and community events, including presentations, photo exhibits, speaker panels, interactive photo booth, annual proclamation and kickoff event.

Our stigma discrimination reduction efforts aim to improve system of care by building partnerships with public and non-profit providers and reducing barriers for the community, including language access and childcare. *Be the One* hosted community outreach events that shared resources (public and non-profit providers) of where people can learn more about behavioral health and where people can get appropriate health they need. Providers we refer to include San Mateo Medical Center, StarVista, Caminar, Heart and Soul, Inc. and many more. All public outreach events were offered the option of interpreter services if requested.

FY15-16 activities included:

- 9/1/15 Be the One Photo Booth at Recovery Month Resource Fair
- 9/14/15 Be the One Photo Booth at Heart & Soul Open House
- 9/15/15 Be the One Photo Booth at Recovery Month Picnic
- 9/25/15 Be the One Photo Booth at Suicide Prevention Forum
- 9/26/15 Be the One Photo Booth at Latino Health Forum

- 9/30/15 Images of Stigma Presentation at Skyline College
- 10/22/15 Be the One Photo Booth at Housing Hero Awards
- 10/26/15 Images of Stigma Presentation at Skyline College
- 11/16/15 Images of Stigma Photovoice Exhibit at Skyline College
- 2/23/16 Images of Stigma Presentation at Skyline College
- 2/25/16 Be the One Photo Booth at School Wellness Alliance Meeting
- 3/15/16 Images of Stigma Presentation at Skyline College
- 3/19/16 Be the One Photo Booth at San Mateo County Youth Conference
- 4/26/15 Board of Supervisors Mental Health Awareness Month Proclamation
- 5/4/16 Mental Health Awareness Month Kickoff
- 5/24/16: Lived Experience Academy Speakers Panel

See Appendix 15: CalMHSA Statewide PEI Project 2015-2016 County Impact Report.

SAN MATEO COUNTY SUICIDE PREVENTION COMMITTEE (SPC)

In the fall of 2014, the San Mateo County Prevention Committee completed a strategic planning session to identify existing interventions and which additional interventions are still needed to prevent suicide in San Mateo County. This committee is comprised of behavioral health staff, community partners (e.g. Caltrain, County Office of Education, etc.), and concerned community members. The results of this strategic planning session were used to create this Suicide Prevention Report. The report outlines four suicide prevention strategies, the desired outcome of each strategy, descriptions of the organizations and programs that are addressing each strategy, and potential future activities to better implement each strategy.

The overall goal is to provide a roadmap of what suicide prevention efforts and services are available and what still needs to be developed to reduce suicide in San Mateo County. There are three overarching strategies for suicide prevention in San Mateo County.

Strategy 1: Create a System of Suicide Prevention

- Enhance links between systems and programs and identify gaps in services.
- Deliver integrated services and establish formal partnerships that foster communication and coordination.
- Integrate suicide prevention programs into K-12 and higher education institutions.
- Develop programs that reduce gaps for underserved populations.
- Ensure that San Mateo County has at least one accredited suicide prevention hotline.
- *Strategy 2: Implement Training and Workforce Enhancements to Prevent Suicide*
- Increase the priority of suicide prevention training through outreach.
- Establish annual targets for suicide prevention training that identify individuals and occupations that will receive the training as well as training models used.

Strategy 3: Educate Communities to Take Action

- Build grassroots outreach and engagement efforts to meet local needs for suicide prevention.
- Engage and educate local media about their role in promoting suicide prevention.
- Educate communities to identify, respond to, and refer people demonstrating acute potential suicide warning signs.
- Promote and provide suicide prevention education.
- Develop and disseminate directory on local suicide prevention/ intervention services.
- Incorporate and build capacity for peer support and peer operated service models.

Strategy 4: Improve Suicide Prevention Program Effectiveness and System Accountability

- Increase local capacity for data collection, reporting, surveillance and dissemination regarding suicide.
- Build local capacity to evaluate suicide prevention programs.
- Establish and enhance capacity of forensic and clinical reviews of suicide deaths.
- Work with Coroner's Office to enhance reporting systems to improve consistency and accuracy of suicide deaths.

In addition to developing the Suicide Prevention Roadmap, the Suicide Prevention Committee was also worked with the San Mateo County Office of Education to develop a Suicide Prevention School Protocol to be used in all 23 school districts. FY15-16 activities included:

- 6/24/15 Suicide Prevention Committee Meeting
- 8/26/15 Suicide Prevention Committee Meeting
- 9/25/15 Speak Up, Save a Life: Suicide Prevention Forum
- 10/28/15 Suicide Prevention Committee Meeting
- 12/9/15 Suicide Prevention Committee Meeting
- 12/14/15 Suicide Prevention School Protocol Workgroup (First Session)
- 1/28/16 Suicide Prevention School Protocol Workgroup (Second Session)
- 12/17/16 Suicide Prevention School Protocol Workgroup (Third Session)
- 2/24/16 Suicide Prevention Committee Meeting
- 3/23/16 Suicide Prevention School Protocol Workgroup (Fourth Session)
- 4/15/16 Suicide Prevention School Protocol Workgroup (Fifth Session)
- 4/27/16 Suicide Prevention Committee Meeting
- 6/13/16 Suicide Prevention School Protocol Workgroup (Sixth Session)
- 6/22/16 Suicide Prevention Committee Meeting

DIGITAL STORYTELLING & PHOTOVOICE

In 2011, ODE embarked on a "Storytelling Project" that emphasizes the use of personal stories as a means to draw communal attention to mental health and wellness, while reducing stigma and broadening the definition of recovery, workshops consider social factors such as racism, discrimination, and poverty. Participants are asked to share their stories through words, photos, drawings, personal mementos, and even music. The stories shared have been both personal and powerful; they've created a sense of connection and have been transforming.

ODE continues this powerful storytelling work with Digital Storytelling and Photovoice. ODE partners with community-based organizations, schools, faith-based organizations, correctional institutions and other sectors of the community to offer these storytelling opportunitie. These stories help shed light on important social issues including stigma around mental health and substance abuse and empower others with lived experience to share their stories. In FY15-16 Digital Storytelling and Photovoice workshops took place serving 15 clients/consumers and family members:

- Digital Storytelling Workshop: Health Ambassador Program.
  Theme: Overcoming Challenges.
- Photovoice Workshop: Health Ambassador Program – Spanish
- Photovoice Workshop: Older Adults

ACCESS AND LINKAGE TO TREATMENT

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. Ravenswood Family Health Center services are funded at 40% under CSS and the remaining 60% is funded through Prevention and Early Intervention. The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for SMI and SED clients.

Total Clients Served	Cost per Client
497	**$139**

SENIOR PEER COUNSELING

The Senior Peer Counseling Program, provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipino and LGBT volunteers. Senior Peer Counseling services are funded at 50% CSS and 50% PEI.

Total Clients Served	Cost per Client
474	**$615**

DEMOGRAPHICS

Total Clients Served	
474	
Race/Ethnicity	
Hispanic/Latino	44%
Filipino	24%
Asian	7%
Other	25%
Age	
60+	100%
Language	
English	25%
Spanish	44%
Chinese	7%

PROGRAM IMPACT

In order to serve more people with the current resource of peer counselors the program offers weekly support groups at various community sites. There are currently five groups in senior/community centers or other non-profit agencies. Some meetings are organized as an open discussion which gives everyone an opportunity to engage and express their sentiments, thoughts, concerns, and feelings. Other meetings are topic based discussions, and/or presentations from outside speakers. This year specific areas explored include:

- How to protect yourself from scams and abuse
- Healthy Aging
- Choosing healthy food to help your body and mood

- Mindfulness
- Film showing and discussion: Being Mortal
- How thoughts hurt or help your life
- Domestic Violence
- Medicare-MediCal
- Taking care of yourself in the winter
- Feelings about holidays
- Memoir writing

During the reporting year, three 36 hour volunteer trainings were conducted, two in English and one in Spanish. During the English Spring training we provided break-out meetings in Mandarin with Chinese volunteers to support their learning. Upon completion of the senior peer counseling training 95% of all new volunteers felt prepared to start working with clients. Training was rated as Excellent or Good by 100% of participants.

Year to date 124 new clients entered the program and 144 clients were closed to services. There are currently 330 active clients in the program and 474 senior peer counseling clients have been served during the fiscal year year, 112% of goal. Of the active clients, 133 clients are seen weekly on an individual basis and 197 clients are participating in a group.

SUCCESSES/CHALLENGES

Successes during the fiscal year included increased outcomes in recruitment and overall participation. The recruitment goal was to recruit 60 new peer counselors. 82 counselors were recruited, 136% of goal. The training goal set for this year is to train 36 new peer counselors. There were 34 counselors that completed the training, 94% of goal. Finally, through this year the program had 133 senior peer counselors participating in the program, 148% of goal.

Staff and volunteers have worked with media contacts to include information about SPC programs and upcoming volunteer training in the following: FilAm Star and The Philippine News, Chinese community newspapers Sing Tao, World Journal, News for Chinese, and The Asian Journal, through a Spanish speaking Univision radio program, El Tecolete. English speaking media include Foster City Islander, Pacifica Tribune, RSVP, Everything South City, Craig's list, SM Pride Initiative, Daly City Partnership, Twitter.com/Volunteer Source, Next Door, and Health Network San Mateo Times and San Mateo Journal, and the Redwood Shores Pilot.

Though recruitment efforts and program awareness have improved, the program continues to be challenged by a growing waiting list for those requesting the service. The continual challenge is to have volunteers who are willing to provide service to some of the participants on our waiting list. Our volunteers want to see clients who live within their communities. It has been increasingly difficult to recruit and retain volunteers who are committed to the program.

INNOVATIONS (INN)

INNOVATIONS (INN)

INN projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a behavioral health practice or approach that is new; make a change to an existing practice, including application to a different population; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature). The State requires submission and approval of INN plans prior to use of funds. In FY15-16, no MHSA INN project plans were presented for approval. The development MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process. Current programs include:

1. **Pride Center** - In its first year of implementation, the Pride Center opened in a central location in San Mateo County accessible to public transportation. It is too early to measure whether access to behavioral health services has increased for LGBTQ+ community. Yet, the Center reached more than 1,000 people during its first month. The Pride Center staff are developing strategies to address access for all geographic and demographic subgroups in the county and will be receiving Medi-Cal certification, which may increase the number of people it can serve.

   "The Pride Center is a great place where me and my family can just be. I love the atmosphere, the support, the intersectionality, and all the rainbows!" -High school student in San Mateo County

2. **Health Ambassador Program for Youth (HAP-Y) –** The first year of HAP-Y implementation focused on recruitment and training of Youth ambassadors. Only preliminary data is available to answer the first evaluation question: to what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates? Post training, youth ambassadors reported feeling overall: more comfortable talking about mental health, part of the community, more comfortable speaking up and engaging in productive disagreements, that their opinion was important, they listen to other people's opinions and tried to understand each other's perspectives. In the following years, measures will include, how HAP-Y influences mental health knowledge and mental health stigma, youth access to mental health services, and the mental health system as whole.

3. **Neurosequential Model of Therapeutics (NMT) in an Adult System of Care** – during the first year of implementation, 12 providers within the BHRS Adult System of Care began NMT training and served 20 diverse clients. Providers experienced some difficulties in learning and adapting the NMT approach to an adult population including clients' ability to recall information about past experiences, the length of the assessment, and the natural learning curve of the trainees. Over the next year, client-level data will be continued to be collected to examine changes in behavioral health outcomes.

WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION AND TRAINING (WET)

WET exists to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers. As described earlier WET was designated one-time allocation totaling $3,437,600 with a 10 year reversion period. In the spring of 2017, the BHRS Office of Diversity and Equity (ODE) hired an independent consultant to assess the impact of WET and identify priorities that would shape the future landscape. A WET 10-Year Impact and Sustainability Report, see Appendix 10 recommending $500,000 to be transferred from CSS to WET to sustain the most effective and impactful elements of WET investments. Following are some highlights:

WET Impact

Prior to MHSA WET, there were fewer staff trainings offered annually and topics skewed toward direct clinical training due to norms and an emphasis on medical interventions. In more recent years, training topics included cultural humility, co-occurring care, trauma-informed care, crisis management and safety and self-care. From 2014-17, 95 trainings were provided to over 3,000 staff, contract and community providers. Additionally, MHSA WET allowed for trainings for and by clients/consumers and family members aimed to increase understanding of mental health issues and reduce stigma and increase knowledge of substance use/abuse issues, recovery and resilience, and available treatments and supports and support leadership development of clients/consumers and family members.

WET Recommendations

1: A Systemic Approach to Workforce Education and Training

Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals should be the standard including cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration and self-care. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation.

"[trainings] helped me see my clients in a new light and really, really show respect to them and support them." – BHRS clinician

2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

LEA has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce and, providing knowledge and skills in the area of stigma reduction and advocacy, empowering and inspiring participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence.

3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff.

TRAINING BY/FOR CONSUMERS AND FAMILY MEMBERS

LIVED EXPERIENCE ACADEMY (LEA)

The Lived Experience Academy is a program designed for individuals living with mental health and/or substance use challenges and/or their family members. Participants are selected to participate in a 5-session training which prepares them to share their stories to empower themselves, reduce stigma, and educate clinicians, professionals, and community members about behavioral health conditions. The program upholds the core value that lived experience is its own form of expertise, and that integrating people with lived experience into the workforce is a vital type of workforce diversity.

FY 2015-2016 Lived Experience Academy training facts:

- Annual training
- Five 2-hour sessions
- 15/15 participants graduated
- Five previous LEA graduates co-facilitated the LEA training

Graduates of the LEA are eligible to go on to be a part of the Speakers' Bureau and receive a stipend to present their stories with behavioral health staff and community members at trainings and community events. This includes the opportunity to participate in Digital Storytelling workshops, and create a video which narrates an individual's' personal history. Participants are paid for participating in the training and when they speak for a speakers' bureau event.

LIVED EXPERIENCE ADVOCACY ACADEMY (LEAA)

The Lived Experience *Advocacy* Academy is a training program designed for individuals living with mental health and/or substance use challenges and/or their family members, who have graduated the Lived Experience Academy and want to get involved in advocacy work. It is considered a second tier training which builds on the skills developed in the LEA. Its goal is to prepare graduates for joining and participating on BHRS committees and commissions.

FY 2015-2016 LEAA training facts:

- Annual training
- Six 2-hour sessions
- 10/10 participants graduated

Graduation from the *Advocacy* Academy results in the opportunity to participate on county commissions, committees, and other decision-making bodies. Participants improve on their skills in advocating for themselves and their communities and in bringing the voices of those with lived experience to the decision-making table. Participants are paid for participating in the training and are offered a stipend for attending committee and commission meetings.

LIVED EXPERIENCE EVENT SUPPORT TRAINING

The Lived Experience Event Support Training was piloted during fiscal year 2015-2016. It is a 3-hour training designed to teach LEA graduates how to provide technical and logistical support for BHRS training, events, and the anti-stigma campaign "Be the One" photo booth. Five LEA graduates participated in this training in 2015-2016 and then went on provide paid event support throughout the year (see Behavioral Health Career Pathways sections for more details).

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP has served as an excellent way to promote wellness and recovery for clients/consumers and staff in the behavioral health system. In 2015-2016, Voices of Recovery coordinated San Mateo County's WRAP efforts. This included a 2-day "Create Your Own WRAP" training in November 2015 that 41 people attended, followed by a 5-day WRAP facilitator training in April 2016 in which 19 new facilitators were certified. In total, there were 25 WRAP groups offered throughout San Mateo County with 847 participants.

SYSTEM TRANSFORMATION AND WORKFORCE DEVELOPMENT

During 2015-2016, the BHRS WET program was staffed by 1 FTE WET Coordinator, 1 FTE WET project support specialist, and .6 FTE Office Specialist/CEU Coordinator. The Workforce Development and Education Committee (WDEC) and the Lived Experience Education Workgroup (LEEW) continued to serve as advisory committees/workgroups for the WET program during this fiscal year. During 2015-2016, the WDEC met bimonthly for a total of 6 times and the LEEW met monthly for a total of 10 times. Each WDEC meeting focused on one of four identified workforce development priorities—1) Peers and Family Members in the Workforce, 2) Diversity in the Workforce, 3) Behavioral Health Career Pathways and 4) Hard-To-Fill Positions. WDEC Meeting Focus:

Meeting Date	Meeting Focus
August 2015	Establishing Structure of WDEC Meetings
October 2015	Peers and Family Members in the Workforce
December 2015	Diversity in the Workforce
February 2016	Peers and Family Members in the Workforce
April 2016	Behavioral Health Career Pathways
June 2016	WET Priorities for the future

The LEEW meetings are focused on building workforce development, training, and advocacy opportunities within BHRS for clients/consumers and family members and on planning and supporting our Lived Experience Academy Trainings. During this fiscal year, the meetings have focused on supporting members' participation in speaking engagements, BHRS-related committees and commissions, other peer-led organizations and activities, and peer-focused conferences.

WISE RECOVERY 101 AND PEER SUPPORT 101

In 2015-2016, the Workforce Integration Support and Education (WISE) program of NorCal MHA provided two trainings on Recovery 101 and Peer Support 101. They held two separate sessions – one designed specifically for supervisors and the other for peer workers and peer volunteers. In FY15-16, 34 participants attended these trainings. WISE has offered a series of ongoing trainings to support peers in the workforce that will be offered in 2016-2017.

TRAININGS FOR PEER SUPPORT WORKERS/FAMILY PARTNERS

Inspired at Work provided a series of four 2-hours trainings and one 7-hour retreat for BHRS and contract agency peer workers in 2015-2016 to support them in their positions. A fifth 2-hour training on countertransference was presented by the BHRS Training Coordinator. The training topics included:

1. "What's Happiness Got to Do with it?" (21 attended)
2. "Boundaries and Ethics" (19 attended)
3. "Strength Based Practice"(19 attended)
4. "Risk and Safety in the Field" (11 attended)
5. “Responding Effectively to Countertransference” (15 attended)
6. "BHRS Peer Support Worker/Family Partner Retreat" (18 attended)

EVIDENCED-BASED, COMMUNITY-BASED, AND PROMISING PRACTICE TRAININGS FOR SYSTEM TRANSFORMATION

The Practice Evaluation Committee was formed to carry out the Selection of Evidence Based and Community-Defined Practice Policy. The committee consists of 12 BHRS staff from different disciplines, divisions, and areas of focus and one client/consumer. The committee met to set up guidelines for its processes. It reviewed and approved one proposal this year for the use of EMDR as a clinical intervention and submitted its recommendation to executive management and youth policy to make implementation decisions. The list of BHRS already-approved clinical and non-clinical interventions is still in process in efforts to make it as specific and comprehensive as possible.

CULTURAL COMPETENCE TRAININGS

CULTURAL HUMILITY

Dr. Melanie Tervalon presented a system-wide three-hour training on Cultural Humility: Working in Partnership with Family and Communities in October 2015 for BHRS and contract staff to improve the cultural responsiveness of our system of care. This training reached a total of 96 attendees. This training was followed by a second in-depth six-week Training of Trainers (TOT) from January to April 2016. The second TOT cohort included nine BHRS and contract agency staff who applied for the training to become able to provide the training throughout our system of care for other staff. The first cohort of trainers continued to have bimonthly community of dialogue meetings. For 2015-2016, the TOT trainers conducted nine trainings.

CULTURALLY RESPONSIVE CLINICAL SUPERVISION

Leanna Lewis, LCSW conducted a culturally responsive clinical supervision training that was offered twice in June of 2016. This training focused on teaching supervisors how to use cultural humility and critical self-reflection to improve their supervision of their colleagues and to create a more collaborative and supportive work environment. In total, 71 participants attended.

WORKING EFFECTIVELY WITH INTERPRETERS IN A BEHAVIORAL HEALTH SETTING

This mandatory direct-service staff training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they don't speak the client's language. The training was offered twice in 2015-2016 in the Fall (October 2015) and Spring (May 2016). In total, 80 attended the Fall training and 41 attended the Spring training. Providers are required to retake this training every 5 years.

SPIRITUALITY TRAINING

The Spirituality Initiative presented a panel presentation and discussion at the BHRS Psychiatric Grand Rounds in 2015-2016 to talk about the integration of spirituality in treatment from multiple perspectives. In total, 56 participants attended.

CULTURAL COMPETENCE TRAININGS ADDRESSING SPECIFIC POPULATIONS

The Health Equity Initiatives and workgroups took the lead in creating and/or sponsoring trainings on specific marginalized populations in San Mateo County.

- Filipino Youth
- LGBTQ Youth UNIQUE Training
- LGBTQ 102: Clinical Practice, Theory, and Intersectionality
- Native American Mental Health
- Arab Community Workgroup: Health and Well-Being

BHRS New-Hire Orientation

The BHRS New-Hire Orientation was provided to new BHRS staff in fiscal year 2015-2016. The Orientation was adapted from the feedback and recommendations of the first cohort in 2014-2015. It consisted of a series of three 3-hour sessions (and one make-up session) that took place over the course of 4 months. The goal was to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore the possibilities for career advancement, and to feel invested in and supported by BHRS as an organization. This training series was made mandatory during this fiscal year and will continue to be so in future years. The new employees who had been hired within the last year were invited to participate in the Orientation. The average number of attendees per session was 38. The session topics were as follows:

1. Orientation to What We Do at BHRS and BHRS Programs and Partnerships
2. Who We Serve
3. Career Path and Professional Development Opportunities in BHRS and Keys to Success at BHRS

BHRS COLLEGE

The BHRS Leadership College provides an opportunity for BHRS staff to learn about facets critical to the successful operation of BHRS. The College supports staff in considering their career development goals and is part of a succession planning strategy. The information and experiences received from participation gives staff an understanding of key policy, fiscal, operational and planning responsibilities that BHRS executes as part of its business practices. In 2015-2016, 24 employees applied and participated in the college cohort. The BHRS College consists of 9-sessions. Staff need to attend 7 of 9 sessions to graduate the College. They are eligible to make up missed sessions the next time the College is offered. In 2015-2016, 18 completed the college. The nine session topics were as follows:

1. Behavioral Health: History and Policy
2. Strategic Planning
3. Health System and Health Policy
4. County Governance and Administration
5. Quality Improvement, Performance Measurement, and Customer Service
6. Finance and Budgeting
7. Community Partnerships, Requests for Proposals, and Contracting
8. LEAP Servant Leadership
9. BHRS Moves Toward the Future

BEHAVIORAL HEALTH CAREER PATHWAYS PROGRAM

The following three objectives were established from the MHSA guidelines and the 2014 stakeholder process for the WET Plan Update in San Mateo County to promote behavioral health career pathways:

ATTRACT CANDIDATES TO HARD-TO-FILL POSITIONS AND INCREASE STAFF DIVERSITY

The state-funded Mental Health Loan Assumption Program (MHLAP) continued to be implemented in San Mateo County BHRS to address 1) attracting, hiring, and retaining staff in hard-to-fill positions and 2) increasing diversity of staff and retaining diverse staff. The MHLAP program provides student loan forgiveness for BHRS and contract staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or have experience working in underserved areas. Applicants receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation. In FY15-16, $197,383 was awarded to 23 recipients.

The Workforce Development and Education Committee (WDEC) addressed the issue of staff diversity through data gathering and analysis of the current diversity of the BHRS workforce and of the county workforce as a whole. From that data and through discussion, the WDEC developed a series of recommendations to the Director of the ODE and the Director of BHRS.

Since February 2016, the Director of ODE and the Director of BHRS have dedicated the monthly BHRS Leadership meetings to focusing on how to make BHRS a truly multicultural organization that supports and encourages diversity. These meetings have allowed leadership staff the opportunity to process their own personal and professional experiences as well as identify steps and changes that BHRS needs make in this area. Workgroups are being made to address recruiting practices. Needed trainings have been identified and planned through this process and a BHRS leadership retreat is being planned for Fall 2016. In 2015-2016, ODE participated in the quarterly Equal Employment Opportunity Committee (EEOC) meetings to discuss and address issues of equity and diversity throughout the county system.

Fiscal Year	# of Awards
2008-09 2	**2**
2009-10 6	**6**
2010-11 9	**9**
2011-12 11	**11**
2012-13 17	**17**
2013-14 22	**22**
2014-15 17	**17**
2015-16 23	**23**

PROMOTE THE BEHAVIORAL HEALTH FIELD

Intern/Trainee Programs **(Clinical and ODE)**

The BHRS clinical intern/trainee program provides clinical training opportunities each year at BHRS worksites throughout the county. BHRS partners and contracts with multiple graduate schools in the Bay Area and from other regions of the country to provide education, training, and clinical practice experiences for students. In 2015-2016, there were 41 BHRS interns and trainees placed at 15 different worksites throughout San Mateo County BHRS. The interns and trainees represented multiple professional disciplines including Alcohol and Other Drug certificate, doctoral psychology, MSW, MFT, and nurse practitioner students and interns. They received multiple training opportunities including a 2-day orientation that included sessions on crisis management, trauma-informed care, wellness and recovery, self-care, and health equity and a mid-year training on cultural humility. They each attended a weekly or biweekly regional didactic seminar at one of 4 sites. They were also invited to attend all of the system-wide trainings (listed earlier in this document). Fifteen of these trainees/interns received a $5,000 stipend as part of our Cultural Stipend Internship Program for their contributions to improving the cultural competence and cultural humility of our system of care (see full description below under Financial Incentives Programs).

The ODEintern training program consists of undergraduate, graduate and recent graduate students who want experience in behavioral health careers through focusing on health equity and social justice work. In 2015-2016, ODE had 3 interns whose work focused on our Suicide Prevention initiative, Parent Project program, and Mental Health First Aid and Digital Storytelling programs. ODE interns receive a $5,000 stipend for their work. The 2015-2016 ODE internship program included a training series of 5 workshops introducing interns on the following topics: Organization, Trauma, Cultural Humility, Political Astuteness and Recovery.

CAREER PATHWAYS AND ONGOING DEVELOPMENT FOR CLIENTS/CONSUMERS AND FAMILY MEMBERS

The Lived Experience Academy Opportunities

By way of the Lived Experience Academy, clients/consumers and family members were offered various paid opportunities during the 2015-2016 fiscal year. Opportunities included participating in up to 3 annual trainings, speaking in front of an audience, and providing support to BHRS events and trainings. An “event” was classified as one organized program which could have included multiple clients/consumers and family members. An “opportunity” captured each client/consumer and family member paid to work an “event”.

FY 2015-2016 Paid Opportunities for Clients/Consumers and Family Members:

- Number of Paid Opportunities (includes trainings, speaking opportunities and event support opportunities): 217
- Number of Paid Events (includes total number of speaking and event support events): 76
- Number of Paid Speaking Opportunities: 25
- Number of Paid Speaking Events: 13
- Number of Event Support Opportunities: 24

Opportunities outside BHRS:

- Number of weekly groups conducted by Lived Experience Speakers on the inpatient psychiatric unit 3AB as San Mateo Medical Center: 80
- Number of attendees at Unit 3AB Lived Experience groups: Total number of attendees: 228
- Number of Star Vista Volunteer Training Suicide Presentations conducted by a Lived Experience Academy Speaker: 2

Lived Experience Scholarship Program

The Lived Experience Scholarship program provides up to $500 in scholarship to individual behavioral health clients, consumers, and family members to pursue their academic goals toward a behavioral health profession. In FY15-16, 11 recipients were awarded.

FINANCIAL INCENTIVES

CULTURAL STIPEND INTERNSHIP PROGRAM

The Cultural Stipend Internship Program awarded a $5,000 annual stipend to 15 BHRS clinical interns for the 2015-2016 fiscal year. Fifteen out of fifteen completed the program. Interns were selected based on their identifying and having experience with a marginalized community. First priority was given to those from communities of color and those with fluency in a language spoken by communities of color. Secondary priority was put on identifying as Lesbian Gay Bisexual Transgender Queer (LGBTQ), someone living with a disability, from a rural area, or another marginalized group.

Intern Demographics

- White: 40%
- Mixed Race (any race): 26%
- People of Color (POC): 60%
- LGBTQ: 26%
- Non-POC, non-LGBT: 13%

In exchange for the stipend award of $5,000, interns were asked to complete a year-long project and participate in one of nine community-led Health Equity Initiatives.

Projects for FY 2015-2016:

- Workshop about mental health services for Latino Community
- Presentation about Native American Health Disparities
- Monthly Newsletter for Latino Community
- Research Paper on Racism in Psychological Assessment
- Communications Plan for LGBTQ Community
- Presentation on how to access Mental Health services for Arab Community
- Qualitative research with community of color health equity groups on the topic of collaboration with LGBTQ communities
- Workshop for Filipino High School Students
- Survey on Spirituality with clients and clinicians (conducted by two interns)
- Presentation on Intersectional LGBTQ Approaches for clinicians
- Presentation for Arab Community (conducted by two interns)
- Focus groups on barriers for the African American community in accessing services
- Photo Voice With Older Adults
- Presentation for Chinese parents

HOUSING

HOUSING

MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless. BHRS collaborated with the Department of Housing and the Human Services Agency's Shelter Services Division (HOPE Plan staff) to plan and implement the MHSA Housing program in the County.

In September 2014, AB 1929 was passed which allowed counties to request and use unencumbered MHSA Housing Program funds to provide housing assistance. The San Mateo County Board of Supervisors adopted a resolution approving the request to release of these funds; a total of $1,073,038 was received from the Housing Program to be held in trust for housing assistance services. A plan for the use of unencumbered Housing funds was presented to the MHSA Steering Committee in March 2017 and BHRS contributed the unencumbered to the Affordable Housing Fund administered by the Department of Housing for the development of affordable housing, which led to 12 additional MHSA units as demonstrated below.

Year	Housing Development and Location	UNITS
2009	Cedar Street Apartments 104 Cedar St., Redwood City	5 MHSA units 14 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	10 MHSA units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks	15 MHSA units 16 total units
Expected 2018	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
Expected 2018	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
		62 Total MHSA units

CAPITAL FACILITIES & INFORMATION TECHNOLOGY (CF/IT)

CAPITAL FACILITIES & INFORMATION TECH (CF/IT)

ECLINICAL CARE

San Mateo County has had no viable opportunities under the Capital Facilities section of this component due to the fact that the guidelines limit use of these funds only to County owned and operated facilities. Virtually all of San Mateo's behavioral health facilities are not owned but leased by the County, and a considerable portion of our services are delivered in partnership with community-based organizations.

Through a robust stakeholder process it was decided to focus all resources of this component to fund eClinical Care, an integrated business and clinical information system (electronic health record) as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

There are no additional programs planned or projected funding available for this component

APPENDICES

APPENDIX 1

My name is Christopher Jump, I am the Program Manager at Heart & Soul, Inc. and a proud member of the Peer Recovery Collaborative. Peer Recovery Collaborative, please stand up.

I am here to address the need for Peer Run Organizations such as Heart & Soul, Inc., California Clubhouse and Voices of Recovery to be the first at the table, representing the consumer voice at stakeholders meetings and asking for our input on peer support services.

As someone who struggled with extreme states of sadness for years, it was the support of peers and finding stable housing that made the difference for me. Through housing, I was able to go back to school and earn my peer-counseling certificate. I was able to find a job that I love.
Through the support of my peers I was able to unlearn the negative message that I was telling myself and help me to see my worth and value. Through housing and the support of peers, I have been able to be medication free for eight years.

We as peers must have a larger voice in the community. We are the ones that are there, working with the folks that come to our centers. We are the ones celebrating their victories and providing support when the weight of the world seems heavy. I have seen participants walk into our centers in a state of suicide ideation and walk out saying, "I may not feel better, but I have something to look forward to. I have a safe space to process what is happening in my life. Where I can be accepted and welcomed."
I have seen participants come to our centers and later on go back to school and earn degrees. I have seen peers come to our centers and begin volunteering at our centers. Peer have come to our centers and gone on to find gainful employment. Peer Run agencies, such as ours, should be the first considered for funding for peer support services.

Because of the difference peer run agencies make, there is a need for a peer run respite center. A place where a person who is in distress can go and receive support from others that have their own personal experience as well. A safe place where they can process what is happening and receive support. That is what I needed. A safe space where I could go for a couple of days and get a grip on what was happening in my life.

Can I count on you to help bring a Peer Run Respite Center to San Mateo County?

My name is Michael Horgan and I am the Program Coordinator with Heart and Soul. For those unfamiliar with Heart and Soul, we are a peer run agency that promotes wellness, recovery, and peer support for those who suffer from mental health challenges.

I am proposing a peer respite here in San Mateo County. Peer respites, staffed with both peers and clinicians, are voluntary, short term residential programs designed to provide a safe, supportive, and non-intrusive place for individuals experiencing trauma or at risk of a psychiatric crisis.

For many mental health patients service users traditional psychiatric emergency rooms are invasive, sometimes traumatic, and often carry a stigma. This could be avoided if a peer run respite were available, providing a safe homelike environment where peers are empathetic just through their own shared experience with emotional and psychological pain. For some individuals peer respites offer empowerments and increased meaningful choices for recovery and decrease the behavioral health systems reliance on costly, coercive, and less personal services.

Quite surprisingly a recent study of 150 patients have shown that 70% of peer respite users needed no further emergency or inpatient services after a stay of 14 days.

In my own experience, years ago I was homeless and living in my car for 14 months in which time I was symptomatic with ADD. Psych emergency wasn't an option primarily because of stories I've heard and the stigma of having to report a hospitalization in the future. Had there been a peer run respite as an alternative I would of made a beeline to it's doors.

So once again I urge the county to consider establishing and maintaining a peer run respite to offer a sold alternative to the traditional psych emergency and inpatient services.

Thank you for your time.

Talking Points for MHSA Mini Presentation

Monday, March 13, 2017

Identifying the Need – What the Program Does

1. In NAMI's 43-year history, we have never approached the County for funding.

2. We are advocating now because we have identified a significant need within the mental health system of care in SMC that has been proven in 3 other Bay Area communities – Alameda County South, Santa Clara County, San Francisco and soon to be in Contra Costa County. **We need to bring this program to our San Mateo County community also.**

3. One of the most significant times for a person who has been hospitalized in an in-patient psychiatric unit is the 2 -3 days before discharge and subsequent transition back into the community.

4. At this time, in San Mateo County, upon discharge the individual has no one who can relate to what they have gone through or what support might be needed for them to continue on their road to recovery. This transition is generally not well served by a case manager or even a loving family member.

5. Mentors on Discharge is a program that addresses the gap between a person's imminent discharge and their post-discharge transition period. There is currently NO program like this in San Mateo County.

   Mentors, who have had similar past experiences, support the individual as a peer, along their journey to wellness by developing a trusted relationship during their hospitalization which continues for up to 4 months upon leaving the hospital.

   Having a Mentor, who is trusted, increases the likelihood of the Individual's success in learning to manage their mental health and live well in recovery with their diagnosis.

6. The benefits of the program include:
   a. Reducing the rate of re-hospitalization as measured by the length of time between hospitalizations
   b. A more empowered and prepared Individual ready to life their life
   c. The number of hospital admissions avoided
   d. The reduction in hospital costs
      (for Alameda County South at John George Hospital, using 60 as the base number of program participants, there was a savings of $824,500 to the hospital & a reduction in hospitalizations of 72%).

7. The Mentors on Discharge program offers an individual support during those critical first months after discharge to ensure they are not alone on their journey.

8. Thank you and we are hopeful that we can address this critical need in our community in the near future!

"There is identified need within the mental health system of care in San Mateo County that has been proven in three other Bay Area communities – Alameda County, Santa Clara County, San Francisco and soon to be Contra Costa County. At this time, in San Mateo County, upon discharge the individual has no one who can relate to what they have gone through or what support might be needed for them to continue on their road to recovery. This transition is generally not well served by a case manager or a loving family member. *Mentors on Discharge* is a program that addresses the gap between a person's imminent discharge and their post-discharge transition period. There is currently no program like this in San Mateo County. Mentors, who have had similar past experiences, support the individual as a peer, along their journey to wellness by developing a trusted relationship during their hospitalization which continues for up to four months upon leaving the hospital. Having a mentor, who is trusted, increases the likelihood of the individual's success in learning to manage their mental health and live well in recovery with their diagnosis. The benefits of the program include: reducing the rate of re-hospitalization as measure by the length of time between hospitalizations; a more empowered and prepared individual read to live their lives; the number of hospital admissions avoided; the reduction in hospital costs. The Mentors on Discharge offers an individual support during those critical first months after discharge to ensure they are not alone on their journey."

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: ERIK McCREADY Agency/Organization: California Clubhouse

Phone Number: 707.217.9168 Email address: ERIKMCREADY@GMAIL.COM

Mailing address: 1967 TICONDEROGA DR.

Stakeholder group you identify with (check all that apply):

X Mental Health Client/Consumer
__ AOD Client/Consumer
__ Family Member of Client/Consumer
__ Community Member
__ Community Agency
__ Social Services/Human Services Provider
__ Mental Health Provider
__ Substance Use Provider
__ Health Provider
__ Education
__ Law Enforcement/Criminal Justice

Please provide comment/feedback:

I AM REPRESENTING CALIFORNIA CLUBHOUSE AND AM ADVOCATING OUR 130 member clubhouse. I CAN ATTEST THAT ALL OF OUR MEMBERS BENEFIT AND THE TOTAL NUMBER OF HOSPITALIZATIONS AMONG OUR MEMBERS HAS DROPPED, THE WORK ORIENTED DAY AND SOCIAL ACTIVITIES HAS SIGNIFICANTLY IMPROVED THE LIFE OF ME AND MANY OTHERS.

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: EDDRENA PETERS Agency/Organization: _____

Phone Number: (650) 921-5151 Email address: eddrenapeters@gmail.com

Mailing address: 210 N DELAWARE #B SAN MATEO, CA-94401

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer __ AOD Client/Consumer

__✓__ Family Member of Client/Consumer __ Community Member

__ Community Agency __ Social Services/Human Services Provider

__ Mental Health Provider __ Substance Use Provider __ Health Provider

__ Education __ Law Enforcement/Criminal Justice

Please provide comment/feedback:

EXPAND AFTER CARE SERVICES 25-35yr olds GRADUATING FROM THE TAY FSP. Plus 24 Hour SUPPORTED HOUSING FOR THOSE Adults

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address: _____

Mailing address: _____

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer
__ AOD Client/Consumer
✓ Family Member of Client/Consumer
__ Community Member
__ Community Agency
__ Social Services/Human Services Provider
✓ Mental Health Provider
__ Substance Use Provider
__ Health Provider
__ Education
__ Law Enforcement/Criminal Justice

Please provide comment/feedback: Prevention of

Just as the "Early Psychosis" graduates need aftercare support, so do the emerging adults who graduate or otherwise transition from the TAY FSP. Their needs are not the same as older adults.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
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San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address: _____

Mailing address: _____

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer __ AOD Client/Consumer

__ Family Member of Client/Consumer X Community Member

__ Community Agency __ Social Services/Human Services Provider

__ Mental Health Provider __ Substance Use Provider __ Health Provider

__ Education __ Law Enforcement/Criminal Justice

Please provide comment/feedback:

M

Please increase culturally sensitive ~~SEO~~ outreach, education & engagement SERVICES FOR CHINESE COMMUNITY. ~~SE~~ STIGMA IS A BIG BARRIER IN our community and we need more culturally sensitive ~~more~~ outreach to engage the family and the person in service as it ~~has~~ ~~generally~~ generally takes a longer period of time and # of meetings to build trust with and engage this community. They are very reluctant to →

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

Comments:

Acknowledge they need help or get help. This includes the family member and the individual as it is very shameful ~~to~~ for them.

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Velisha Soroosh Agency/Organization: TeleCare

Phone Number: (650) 518-0929 Email address: VelishaSoroosh@gmail.com

Mailing address: 1321 Marshall st # 302 RWC. 94063

Stakeholder group you identify with (check all that apply):

- ✓ Mental Health Client/Consumer
- ___ AOD Client/Consumer
- ___ Family Member of Client/Consumer
- ___ Community Member
- ___ Community Agency
- ___ Social Services/Human Services Provider
- ___ Mental Health Provider
- ___ Substance Use Provider
- ___ Health Provider
- ___ Education
- ___ Law Enforcement/Criminal Justice

Please provide comment/feedback:

I am a Consumer of MH at Telecare Because of Housing Funding, I've Been Fortunate Enough To Benefit, Tody I Go To college, Volunteer at Telecare For 3 yrs, Also my Home Keeps me able To Be Independent, Reliable, and most Important Med- Compliant.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
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San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Christopher Jump Agency/Organization: Hearts & Souls

Phone Number: 622-4961 Email address: christopher.j@heartsandsoulsinc.org

Mailing address: 210 Industrial Rd #205 San Carlos, CA. 94070

Stakeholder group you identify with (check all that apply):

___ Mental Health Client/Consumer	___ AOD Client/Consumer	
___ Family Member of Client/Consumer	___ Community Member	
✓ Community Agency	___ Social Services/Human Services Provider	
___ Mental Health Provider	___ Substance Use Provider	___ Health Provider
___ Education	___ Law Enforcement/Criminal Justice	

Please provide comment/feedback:

Need for a peer run respite center

Need for more investment in peer support

Need for more affordable housing

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Ashley Agency/Organization: _____

Phone Number: 6789256862 Email address: ashleyhlangston@gmail.com

Mailing address: 906 15th Ave, Redwood City, CA 94063

Stakeholder group you identify with (check all that apply):

- ___ Mental Health Client/Consumer
- ___ AOD Client/Consumer
- ✓ Family Member of Client/Consumer
- ✓ Community Member
- ___ Community Agency
- ✓ Social Services/Human Services Provider
- ___ Mental Health Provider
- ___ Substance Use Provider
- ___ Health Provider
- ___ Education
- ___ Law Enforcement/Criminal Justice

Please provide comment/feedback:

I recently moved to San Mateo county and left my little brother on the East coast. He was diagnosed with schizophrenia six maths ago and I do not know where I would be without NAMI's programs and support. I wish my brother could be here to receive the local resources that would be available to him. In particular, the Mentorson Discharge (MoD)

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

Comments:

and Peer Pals programs would be life changing. MoD partners recently discharged patients with paid peer mentors who understand what the patient is going through at a time when it is needed most. This offers a lifeline ~~to~~ via a connection to a member of the community who does not judge the individual. I have heard my brother lament that no one understands him, no one has experienced what he has, and that all of his friends have 'moved on' with their lives leaving him behind and alone. I cannot stress enough what a program like MoD (starting when the patient is hospitalized) and Peer Pals (~~after~~ after the patient is discharged from the hospital) would mean to my brother and how special NAMI San Mateo is for providing these services. However, they need help to pay more mentor and to pay mentors (higher wage) more. Often, these peer mentors struggle to find gainful employment or have to choose between being a mentor and having a higher paying job. The service these mentors provide is vital for individuals with mental illness. Please help to make the option of serving as a mentor a viable option for these individuals.

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: JUDY SCHUTZMAN Agency/Organization: _____

Phone Number: 650.595.2577 Email address: JUDYSCHUTZMAN@AOL.COM

Mailing address: 3141 MELENDY DR SAN CARLOS 94070

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer	__ AOD Client/Consumer	
X Family Member of Client/Consumer	X Community Member	
__ Community Agency	__ Social Services/Human Services Provider	
__ Mental Health Provider	__ Substance Use Provider	__ Health Provider
__ Education	__ Law Enforcement/Criminal Justice	

Please provide comment/feedback:

EXPANSION OF EMERGENCY, RESIDENTIAL AND ACUTE HOUSING WITH MHSA $$ IS IMPRACTICAL GIVEN THE AVAILABILITY & COST OF HOUSING IN THE COUNTY.

STRONGLY SUPPORT OUTREACH SERVICES TO ISOLATED OLDER ADULTS, CAREGIVING MIGRANTS, AND CULTURALLY UNDERSERVED GROUPS

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: JEAN CHEN Agency/Organization: NAMI

Phone Number: 650-888-1790 Email address: jeanchencc@hotmail.com

Mailing address: 65 CROWN Court San Mateo CA 94402

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer
__ AOD Client/Consumer
X Family Member of Client/Consumer
__ Community Member
__ Community Agency
__ Social Services/Human Services Provider
__ Mental Health Provider
__ Substance Use Provider
__ Health Provider
__ Education
__ Law Enforcement/Criminal Justice

Please provide comment/feedback:

Some of the provider's service are overlaped. provider should work together. to minimun the cost of service. Since funding is limited consolidate service to make money spending smart.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

Comments:

For some of MHSA Service not even has representive to present their servic their funding should cut or elimate because they do not care.

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Helene Z. Agency/Organization: NAMI

Phone Number: 638-0804 Email address: hzimmer@namisanmateo.org.

Mailing address: 1650 Bael Place #130, San Mateo

Stakeholder group you identify with (check all that apply):

- ✓ Mental Health Client/Consumer
- ✓ Family Member of Client/Consumer
- ✓ Community Member
- ✓ Education
- __ AOD Client/Consumer
- __ Community Agency
- __ Social Services/Human Services Provider
- __ Mental Health Provider
- __ Substance Use Provider
- __ Health Provider
- __ Law Enforcement/Criminal Justice

Please provide comment/feedback:

- The service categories do not cover the education + support needs for families
- Support Peer Programs - pre inpatient discharge + post discharge follow up - Build + strengthen our current programs.
- The "PEER + FAMILY SUPPORT NEEDS IN SERVICES" - EXPAND FAMILY TO FAMILY SERVICES IS WHAT NAMI IS ALL ABOUT - IT'S JUST DIFFERENT WORDING

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Riley Agency/Organization: California Clubhouse

Phone Number: _____ Email address: _____

Mailing address: _____

Stakeholder group you identify with (check all that apply):

- [x] Mental Health Client/Consumer
- [ ] AOD Client/Consumer
- [ ] Family Member of Client/Consumer
- [ ] Community Member
- [x] Community Agency
- [ ] Social Services/Human Services Provider
- [ ] Mental Health Provider
- [ ] Substance Use Provider
- [ ] Health Provider
- [ ] Education
- [ ] Law Enforcement/Criminal Justice

Please provide comment/feedback:

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Kim Gillette Agency/Organization: DCYHC

Phone Number: 650-985-7013 Email address: kgillette@dalycityyouth.org

Mailing address: _____

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer	__ AOD Client/Consumer
__ Family Member of Client/Consumer	__ Community Member
X Community Agency	__ Social Services/Human Services Provider
X Mental Health Provider	__ Substance Use Provider
__ Education	__ Law Enforcement/Criminal Justice

X Health Provider

Please provide comment/feedback:

Thank you for taking the time to listen to all of the needs of the community.

It is so important that we remember how large & diverse this county is. We need to prioritize North San Mateo county services along w/ other hard to reach populations.

We also need to prioritize services to youth & working to decrease stigma at an early age.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

Comments:

It is unfortunate that this process came off as competitive. It would be helpful if we could find a way to discuss this as a team working together & not against other organizations.

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Amaal Agency/Organization: California Clubhouse

Phone Number: (650) 749-7753 Email address: amaalgg@gmail.com

Mailing address: _____

Stakeholder group you identify with (check all that apply):

- [X] Mental Health Client/Consumer
- [ ] AOD Client/Consumer
- [ ] Family Member of Client/Consumer
- [X] Community Member
- [ ] Community Agency
- [ ] Social Services/Human Services Provider
- [ ] Mental Health Provider
- [ ] Substance Use Provider
- [ ] Health Provider
- [ ] Education
- [ ] Law Enforcement/Criminal Justice

Please provide comment/feedback:

California clubhouse is a fantastic organization that has helped me and many of my friends immensely. It deserves to have additional expansion funding so it can continue to help people with mental illness in the community.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Brian J Wilson Agency/Organization: ?

Phone Number 6507307756 Email address: jameswilsonjoy61@GMAIL.com

Mailing address: 157 EL Granada 94018

~~Stakeholder group~~ you identify with (check all that apply):

__ ~~Mental Health~~ Client/Consumer __ AOD Client/Consumer

__ Family Member of Client/Consumer __ Community Member

__ Community Agency __ Social Services/Human Services Provider

__ Mental Health Provider __ Substance Use Provider __ Health Provider

__ Education __ Law Enforcement/Criminal Justice

IN Peercasling class

Please provide comment/feedback:

Need people TO GO TO Help People/cts That cant Leave CAMP site Busses TO seek Help IN H.M.B

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address: _____

Mailing address: _____

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer
__ AOD Client/Consumer
X Family Member of Client/Consumer
__ Community Member
__ Community Agency
__ Social Services/Human Services Provider
X Mental Health Provider
__ Substance Use Provider
__ Health Provider
__ Education
__ Law Enforcement/Criminal Justice

Please provide comment/feedback:

All the needs and requests are so important. Please consider supporting a community that is isolated. Help the Coast develop a Center of services like the Barbara Mattern Center and the EPA community Center! The community really needs it.

The stigma on the Coast has been a difficult barrier to breakdown due to the rural nature of the community and limited resources to really make a big impact.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Yolanda Ramirez Agency/Organization: BHRS

Phone Number: 650-346-4831 Email address: ymramirez@smcgov.org

Mailing address: 727 Shasta St. Redwood City, CA 94063

Stakeholder group you identify with (check all that apply):

- ___ Mental Health Client/Consumer
- ___ AOD Client/Consumer
- ✓ Family Member of Client/Consumer
- ✓ Community Member
- ___ Community Agency
- ___ Social Services/Human Services Provider
- ✓ Mental Health Provider
- ___ Substance Use Provider
- ___ Health Provider
- ___ Education
- ___ Law Enforcement/Criminal Justice

Please provide comment/feedback:

I support the Peers and Family Support Models to increase engagement of clients and caregivers in services.

I support Prevention-Community Engagement and empowerment recommendations to have more leaders in our community.

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: AMADA ESPINOZA Agency/Organization: BHRS Health Ambassador

Phone Number: 650-445-1596 Email address: amadaespinoza10@yahoo.com

Mailing address: _____

Stakeholder group you identify with (check all that apply):

__ Mental Health Client/Consumer
__ AOD Client/Consumer
✓ Family Member of Client/Consumer
__ Community Member
__ Community Agency
__ Social Services/Human Services Provider
__ Mental Health Provider
__ Substance Use Provider
__ Health Provider
__ Education
__ Law Enforcement/Criminal Justice

Please provide comment/feedback: Como madre de una cliente de saludmental agradezco mucho por todos los servicios que ha recibido mi hija que se ha recuperado muy bien gracias a todos esos servicios, Por esto pido que el comité nos siga apoyando económicamente para que todas las familias sigan teniendo esperanza porque la recuperacion es posible mientras tengamos apoyo.

Gracias por todo

A Espinoza

Please turn over →

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Mark Hanson Agency/Organization: NAMI San Mateo County

Phone Number: 415-205-8859 Email address: markhanson640@comcast.net

Mailing address: markhanson640@comcast.net

Stakeholder group you identify with (check all that apply):

- ___ Mental Health Client/Consumer
- ___ AOD Client/Consumer
- X Family Member of Client/Consumer
- X Community Member
- ___ Community Agency
- ___ Social Services/Human Services Provider
- ___ Mental Health Provider
- ___ Substance Use Provider
- ___ Health Provider
- X Education
- ___ Law Enforcement/Criminal Justice

Please provide comment/feedback:

Feel that their is a big transition gap for consumers that are hospitalized and their transition back into the community after hospitalization. Most hospitals depend on the social worker to make out-patient Recommendations for further training + counseling. Unfortunately, most consumers do not trust or Relate to their social workers and social workers follow up post hospitalization is lacking. So, I feel some mentor program or peer to peer program should start during the hospitalization process and continue after

Please turn over →

Comments:

hospitalization to provide a smoother transition back into the Community. A consumer is much more likely to listen to another Consumer who has had similar experiances as a mentor. Many Counties in the Bay Area have implemented a program called "Mentors on Discharge" being Ciel Used by NAMI very successfully Reducing additional hospitalizations)

San Mateo County needs a program like This now!

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: Janice Hawley Agency/Organization: VRS/North County Clinic/Peer Support Worker Part Time

Phone Number: 484-437-3279 Email address: canajazz@gmail.com

Mailing address: 120 N. San Mateo Dr, #101, San Mateo 94401

Stakeholder group you identify with (check all that apply):

- [X] Mental Health Client/Consumer
- [ ] AOD Client/Consumer
- [ ] Family Member of Client/Consumer
- [ ] Community Member
- [ ] Community Agency
- [ ] Social Services/Human Services Provider
- [ ] Mental Health Provider
- [ ] Substance Use Provider
- [ ] Health Provider
- [ ] Education
- [ ] Law Enforcement/Criminal Justice

Please provide comment/feedback:

This was/is my first time attending a MHSA mtg. I've been strongly impressed by the dedication displayed here along with the empathy and commitment toward those with M/I.

I have been and was again today struck by the Coastside needs (I wish I were bilingual so that I could help in this area). As a Senior affordable housing is critical to me. I appreciate hearing about your efforts. I wish that there were

Please turn over →

You may send your comments via email or post to Doris Estremera, MPH, MHSA Manager, mhsa@smcgov.org
225 37th Avenue, 3rd Floor, San Mateo, CA 94403

Comments:

More peer counselor/peer support positions; MHSA ends in 8 mos and I would love to continue giving back. Aside from that selfish desire, I cannot stress how helpful peer positions are — to the clients as well as to the providers!

Subject: _____ Date: _____

Peer Supported Living
we need a place in
each area of the county
not just 1

San Mateo County Health System
Behavioral Health and Recovery Services
Mental Health Services Act

Public Comment Form

Personal information (OPTIONAL)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address:_____

Mailing address: _____

Stakeholder group you identify with (check all that apply):

_x__ Mental Health Client/Consumer ___ AOD Client/Consumer

_x__ Family Member of Client/Consumer ___ Community Member

___ Community Agency ___ Social Services/Human Services Provider

___ Mental Health Provider ___ Substance Use Provider ___ Health Provider

___ Education ___ Law Enforcement/Criminal Justice

Please provide comment/feedback:

Hi, my name is Audrey. I am from San Mateo County and a member of and volunteer for NAMI SMC.

My 22-year old son has benefitted greatly from the Mentors at Discharge program provided by NAMI Santa Clara Co. His mentor has helped him cope with his illness and befriended him long term. I would like to see this program made available to individuals being discharged from San Mateo County hospitals as well, and I believe that it is a program worthy of public funding.

NAMI's family-to-family and peer-to-peer education programs and other resources are also essential for individuals and families, who need information and support that would otherwise be difficult to get without great expense, if at all.

I therefore urge the Committee to vote yes on the proposed funding for NAMI SMC.

Thank you.

Lisa Thorsen-Spano – email 04/20/17

To whom it may concern;
I would like to express my enthusiastic support for the funding of a clinician position at the crisis center through Star Vista.
I have been a school counselor in the San Bruno Park School District for over 20 years. We desperately need community agency support to meet the needs of our students. We have been fortunate to have Star Vista clinicians assist us with individual student needs, student counseling, and educational presentations for our staff members.
Thank you for your consideration in this important matter.
Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Lisa Thorsen-Spano, Ph.D., MFT, PPS
District Counselor
San Bruno Park School District

Judy Romero – email 04/24/17

Hello, my name is Judy Romero and I am the Director of the Sequoia Teen Resource Center at Sequoia High School in Redwood City. We have had a partnership with StarVista Crisis Center for the past 12 years. The Crisis Center has supported Sequoia High School by providing class presentations on suicide prevention. Recently the Crisis Center presented to all our Physical Education Classes. In the past the Crisis Center has also provided suicide prevention training for school staff. For the past 12 years the Crisis Center has participated in our annual Health Fair providing information to students and teachers. In March 2017 there were 762 students that attended the Health Fair. In addition, we've had Crisis Center counseling interns come to Sequoia High School to provide crisis counseling to students. StarVista Crisis Center has been a great asset to have as a partner.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Judy Romero

Courtney Coburn – email 04/24/17

StarVista has been a remarkable resource and tool for not only our students, but our school and community. Star Vista has not only been there for our students in crisis through the crisis hotline, they have also served as a community connection for families, have come to campus to check in on the safety of our students and have even lined up short term counseling for students who were not receiving services outside of school. StarVista has been a tremendous resource for us, and we hope to be able to utilize their important resources for years to come! This very much fills a need that we lack along the coast side as mental health resources are so limited.

Melissa Ambrose – email 04/25/17

Hello ~

I am writing you to express my deep appreciation for the Crisis Clinician position currently funded at Star Vista. I am a Wellness Counselor in Jefferson Union High School District, and I am grateful we can call Star Vista when we have a student who very much needs therapy, but can't get it through insurance or for financial reasons. The clinician comes to school and works with students and their families with the compassion and non-judgment that allows students to heal and grow. Additionally, the Crisis Clinician comes to schools to do staff development about crucial topics like suicide prevention. It is truly an invaluable position and I so hope you continue funding it. Considering the serious lack of services in North County, we really need Star Vista.

Thanks,

Melissa Ambrose, LCSW/PPS
Wellness Counselor
Community Service Coordinator
Oceana High School
(650) 550-7307

Margaret Lavin – email 04/25/17

I am happy to write about the benefits Redwood City School District has received from StarVista. As the Director of Student Services, I have worked directly with clinicians and Narges Zohoury Dillon, the Program Director. The clinicians have worked with our most vulnerable students and families. They have counseled these kids while they spend time at our Opportunity School and

follow up with them when they returned to the regular school population. They have always been thoughtful, respectful, professional, and accessible.

I have referred families on a number of occasions to the Crisis Center where they have received expert advice. Many of our 16 schools have taken advantage of StarVista's education programs through whole school presentations and small group interventions.

StarVista has become an invaluable asset to our school district's continued efforts to improve mental health education and family engagement. StarVista programs are an integral part of sustaining and building positive school climates.

If you have any questions or need further elaboration, please don't hesitate to contact me.

Sincerely,
--
Margaret Lavin, M.Ed
Director of Student Services
Redwood City School District
650-423-2277

Kevin Bond – email 04/26/17

San Mateo County is having a boom in tech workers and San Francisco and San Mateo counties are the tech capitals of the world. This is not going to just all of a sudden stop. There are many people in this county who suffer from mental health problems and the most basic part of that problem is housing. Every bit of housing in the county is now prohibitively expensive and we must find a way to insure that there is adequate housing for those who are marginalized by mental health. I propose small apartments that don't disrupt the landscape and can have up to 12 units in them and divide them between low cost and mental health populations. We need lots of these! If they are not designated to that population and instead go to the general population, the rents become financially unsustainable for the mental health population. These units don't make developers rich, they provide necessary housing for people who need it. When I was growing up in Redwood City, Agnews State Hospital housed many mental health patients. That responsibility rests largely on the families and the state and counties to handle now that there are very few state institutions. Without housing, you can't move forward.

Kevin Bond
A concerned Redwood City resident

Joann Watkins – email 04/26/17

Deficit on the south coast of funding for comprehensive generational trauma informed therapy. The money for early prevention and education does not speak to the trauma that affects this population, where there is limited accesss to treatment and enrichment programs afforded to participants in other areas of the county. Currently our prevention and early intervention funds target AOD prevention and the target age range from 9-18, we are missing the rest of the population.
My work over the past 10 years at Puente has made clear what the literature and research now has proven, that Trauma work and access to mental health care is critical to our families success.Through the use of the ACE Questionaire and the useof NMT and CBT therapies and access to enrichment programs can interrupt the cycle of trauma.

Roxana Ruan – email 05/07/17

My name is Roxana Ruan. I live in San Carlos and work in Redwood City. My first language is Cantonese. I know Shiyu Zhang, the Chinese Outreach Worker, through NAMI San Mateo. I was looking for a psychiatrist for my nephew on my own for 4 months. I went to a few nonprofit organizations and hospitals, and had no luck finding a doctor. NAMI San Mateo suggested me to call Shiyu. Shiyu did things efficiently. She set up an appointment for my nephew with a county clinician the next day. Shiyu listened to my frustration. She was very patient with me, and found the best solution with me. I like Shiyu because she is not only bilingual, but she also knows both American and Chinese cultures well. For example, I didn't have to explain in detail about China's one-child policy to her and I could see that she understood my nephew's unfair treatment being the second child in the family. I also have limits to explain this mental health issue. I just spoke a word or phrase and Shiyu understood what I was trying to say, and she helped me interpret properly. Finally I found a psychiatrist through Shiyu. I really appreciated Shiyu's Chinese Outreach Worker position. She did more than just provide a phone number or a website. I know there are more Chinese residents in San Mateo community that really need the Chinese Outreach Worker to help them find the right direction in their daily need. I believe San Mateo County residents would be happy to have outreach and education programs for the Chinese community. This is my voice, and I am sure this also the voice of many other Chinese in the community.

Tania Chan – email 06/15/18

1. Focus more on prevention (versus early intervention and treatment) for the Chinese community (e.g. public education)
2. Build capacity to address domestic violence, child abuse and elder abuse in Chinese community (e.g. bilingual support group facilitators/instructors)

Sharon Roth – email 07/06/17

I am a V.P. of NAMI SMC and the Criminal Justice Chair. Former very active member of the MHSARC of SMC. NAMI has provided advocacy, support and education for family members and consumers of this county for many years. Many of our programs have been copied by the county. We always provided these services at no cost. So it did not cost the county anything for salaries or benefits. We are now requesting much needed funds to expand our services to consumers and family members. Our Peer classes, Mentors on Discharge, Provider Program and Parents & Teachers as Allies, will continue to benefit this county, and we hope that we can count on our Board of Supervisors and BHRS of San Mateo to help us fund these programs.

Gregg Hardin – email 07/06/17

Hello, my name is Gregg C Hardin and I am from San Mateo County.

I am a volunteer for NAMI and help with the newsletter doing graphic design work for them.

I am writing to support the MHSA Funding for NAMI SMC.

My story is that I am a recent graduate of San Francisco State, even though I have had severe mental illness, and NAMI was the one organization that believed that I could go to school and graduate with a bachelor's degree. The other organizations thought it was just a pipe dream. Even my therapist didn't believe I could do it! Well, I did graduate and did well in school and now I work for NAMI as the volunteer newsletter editor. NAMI needs to stay afloat to help others like myself in their endeavors and help them to thrive and live happy, healthy lives. Without NAMI's support it would have been much harder for me to go through school and they have been instrumental in my success. Thank you for hearing my story!

For all of these reasons, I urge the committee to vote Yes on the proposed policy changes to help fund NAMI SMC.

Dana Foley – email 07/06/17

Hello.
My name is dana foley, and I have been co-facilitating NAMI's Peer-to-Peer course and their Connection group for over two years...These NAMI programs educate about mental illness, create a sense of community (which is crucial when you are depressed and want to isolate and/or harm yourself), and advocate for the rights and safety of those with mental illness.

I can't emphasize enough the impact these two programs have had on my life, and those peers who also struggle on a day-to-day basis with their mental illnesses.

My life has been so enriched by NAMI that I will continue to get other peers involved with this wonderful organization.

But we need your support...We need funding to keep these programs going. Please help us.

Thank you.
-dana foley ;-) Namaste

Cheri Hahne – email 07/07/17

I'm pleased to be able to advocate for the County's financial support for NAMI's Community Support Programs -- because I almost wasn't here to do so.

I entered the byzantine world of being a "Consumer" of mental health care in 1999 for the first time in my life. NAMI's support and programs were invaluable to helping me as I needed to learn so much when so fragile. The people have been wonderful to work with; and programs offered -- free to Consumers -- and the work they have done in the behavioral health community through the years in the County are phenomenal. From providing a warm line and single point of contact to find mental health resources when needed to the education, family, and peer programs and outreach, NAMI proves daily its worth in free services to the Consumers and healthcare Providers in San Mateo County.

I was a NAMI Walk Team Captain in 2005, and have found a variety of ways to financially support NAMI San Mateo through the years. I always remind people that despite its name, there is no national organization funding NAMI San Mateo--it's all up to us. And now I ask for the County's financial support for NAMI for the first time to be able to expand these programs to reach even more who will benefit as I have from them.

There is never as much funding for all the Community Support Services desired, but NAMI San Mateo's already-established, well-run, and dollar-wise programs, make the County's financial support both an efficient and effective allocation.

Thanks you,

Cheri Hahne

Barbara Nevins – 07/07/17

NAMI is a huge asset to San Mateo County. My sister a resident and homeowner in SMC for over 40 years is mentally ill. I have been a resident of SMC for 23 years. NAMI provides invaluable support groups to family members like me. This group helps me deal with and manage my sister in her own home. I believe that it is to the county's advantage to keep the mentally ill off the streets and out of public institutions and NAMI works to this end.

Maria – email 07/07/17

My name is Maria. I live in San Mateo County with my parents, both of whom suffer from depression. I am a member of NAMI.
My parents usually take turns breaking down, but ten years ago they were both incapable of helping one another. I felt very confused helpless because I was unable to help them. I felt so alone and depressed. I felt completely ostracized.
Last year, my father got sick again. I wanted, needed a support group. I thought about founding one, but ended discovering that NAMI exists. Through NAMI's 12 week program, I got education and moral support and understanding. The family-2-family program helped me to take care of myself and my family. The program continues to help me through continued social events.
For all of these reasons, I urge the Committee to support NAMI SMC in its endeavors to help families and individuals - in the County - facing mental health challenges.

Regards & Best Wishes,
Maria

Lisa Krackov – email 07/07/17

Hello,

My name is Lisa Krackov and I live and work in the San Mateo County. I strongly urge our county to provide local funding. I am an educator. I have seen how mental illness effects students and their families. Treatment and support can be both expensive and challenging to find. NAMI offers family support groups, as well as educates its members. I have literally seen families emerge from the secrecy and stigma of mental illness to acceptance, community, and hope. Providing local funds for San Mateo NAMI is a win for our entire county.
Thank you for your consideration.
Sincerely,
Lisa Krackov

Martin Verhoef – 07/07/17

To Whom it may concern,

NAMI has been an indispensable organization in helping our son and us as parents on how to deal and treat the mental health problems my son is suffering. There advise, treatment and help in specific problem situation has been and still is an essential part of our son's well being. I greatly recommend NAMI to be supported in any way possible.
--
Martin Verhoef

Debra Mechanic – email 07/07/17

My family have been NAMI members for over 40 years; when NAMI was then called PAMI (Parents of the Mentally Ill). When my sister began to show signs of severe depression and later diagnosed as a Schizophrenic my family was at a loss. The treatment was barbaric; and resources and support was nowhere to be found. Thank God for NAMI. My parents began attending NAMI support groups and took Family to Family; and became better equipped to deal with the long road ahead. They no longer felt alone. Today my sister is living mentally well and lives independently. She herself has completed Peer to Peer and is still active with NAMI. I am extremely grateful to NAMI for giving my parents the help, respect and resources they desperately needed. I hope the Board of Supervisors will recognize the valuable work that NAMI SMC does and provides to our county and will financially support NAMI's cause. The education and support NAMI SMC provides is essential!

Lee Nash – email 07/07/17

I first became involved with NAMI SMC when my 29 year old daughter became ill with PTSD and anxiety after being in a 8 year abusive marriage. We knew nothing about mental illness until she first became ill. It wasn't until I discovered NAMI SMC that we realized we didn't need to struggle with her issues by ourselves. Taking NAMI's Family to Family Class was a lifesaver for my husband and myself, especially learning about what our daughter was experiencing. Through NAMI SMC's Family to Family Class and later their support group, we learned that we weren't alone with our experiences and learned the tools to be able to help our daughter and ourselves. While attending the support group, I learned of the opening for Education Coordinator in their office and 2 years later, I still love what I do. I am forever grateful to NAMI for their education and support.

Sincerely,
Lee T. Nash

Bonnie McNamara – email 07/09/17

NAMI San Mateo County is a very important resource for families who have a loved one suffering from a mental illness.
These families are often times in tremendous chaos and caught up in so much fear.
NAMI San Mateo County offers a gentle place to land and begin the process of comfort, support and education to the families in our county.
They give such great support in so many areas of mental illness.
And all of their services are free, that is of such great importance because the last thing families should have to worry about is "how will they be able to afford much needed support"...
It is crucial for NAMI to stay up and running and I'm very proud to say I'm a member for 20 years and will continue to support such a great grass roots nonprofit organization.

Bonnie McNamara
tombonniemac@aol.com

Meg Brosnan – email 07/10/17

Dear SMCHS,
I urge you to support the invaluable services provided by NAMI for those suffering from mental health issues AND their families and friends. That group must be a large majority of San Mateo County residents, because most of us, at some point in our lives, are affected by someone in our family or community who is suffering from a mental health disorder. Everyone in my family has struggled to cope with one family member who suffers from a schizophrenic disorder. We

struggle to maintain the relationship, to provide emotional and financial support, to keep him safe, and to try to take care of ourselves and the rest of the family at the same time. We benefited from NAMI's Family-to-Family class, where we received vital information and connected with others in a similar situation.

With mental health problems, the tragedy is not just the terrible symptoms of the disorder for the individual, but how little it is understood, how difficult it is to get effective treatment, and how little empathy and support there is for the individual and his family. NAMI is a shining example of a group that is working to change this.

Please grant funding to this exceptional organization, NAMI. Thank you.

Margaret Brosnan
Redwood City

APPENDIX 2

Community Program Planning (CPP) Process

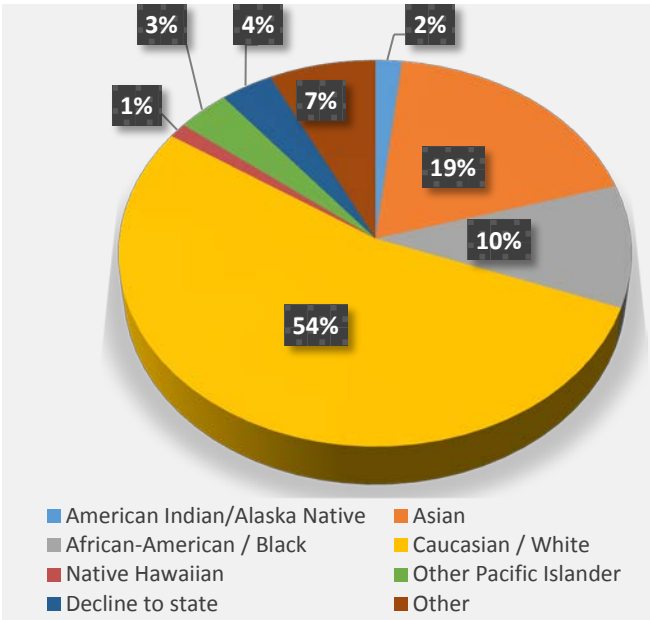
San Mateo County is committed to engaging a diverse group of stakeholders using a Community Program Planning (CPP) process to ensure that communities that are experiencing mental health and substance abuse issues are heard in each phase of the process. Input is gathered at existing County meetings, targeted input sessions, online surveys, and through formal public comment. During the FY 17-20 Three Year Planning Process, San Mateo County hosted two public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Over 270 participants were in attendance, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members. 36 stipends were provided to consumers/clients and family members for their input.

Participant Demographics

Participant Demographics help us understand how far our CPP efforts reach when engaging San Mateo County's diverse communities.

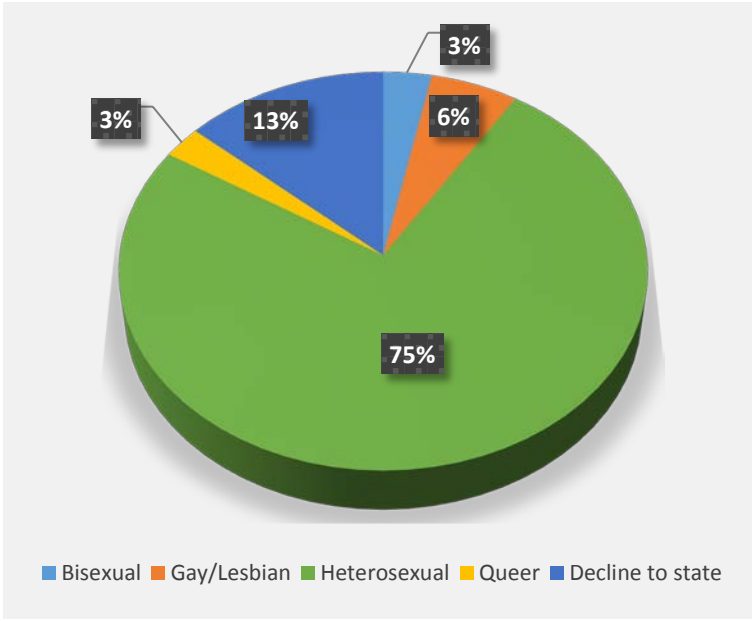
CPP Participant Demographic Sheets Collected			
156			
Male	59	**Female**	97
Age		**Age**	
16-25	3	**16-25**	3
26-59	36	**26-59**	63
60+	20	**60+**	31
Veteran Status			
3		3	

Race

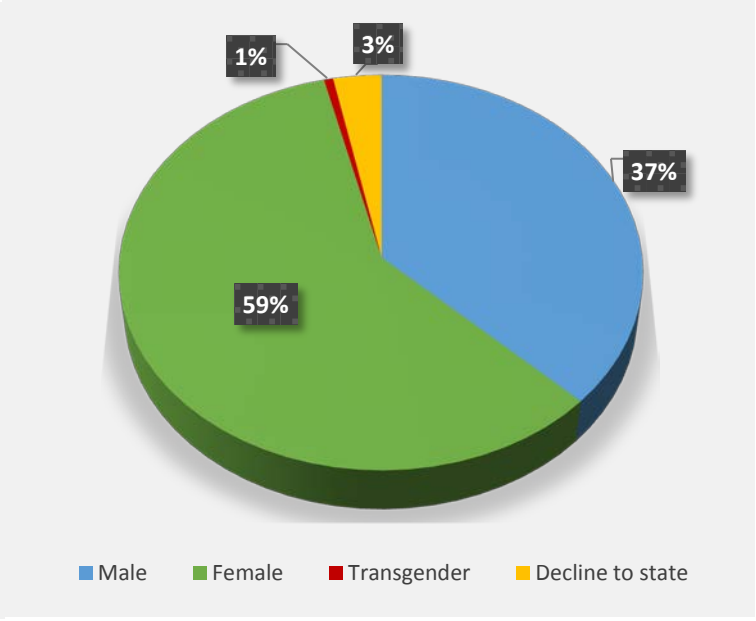


Ethnicity

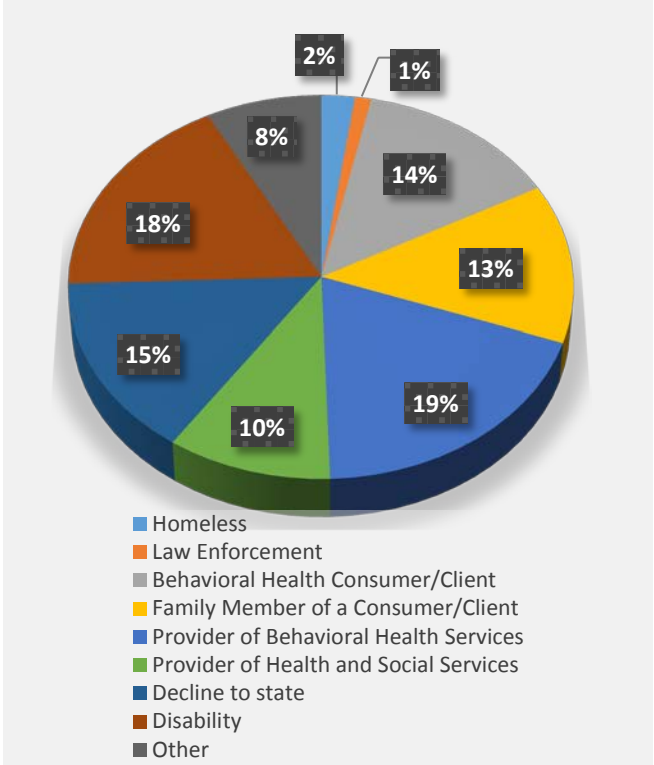
Sexual Orientation



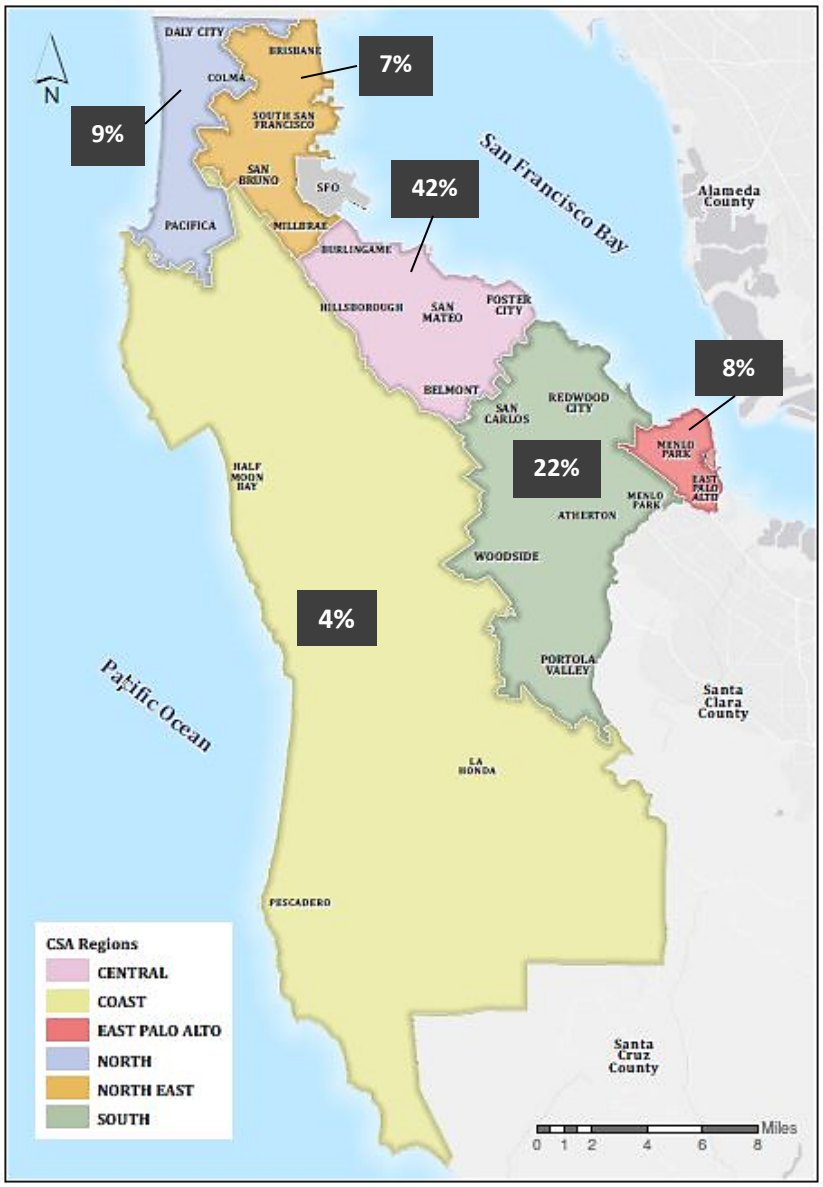
Gender Identity



Represented Groups



Represented Service Areas*



*There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in north county as well.

APPENDIX 3

Phase I. Needs Analysis – Summary of Input

THEMES/NEEDS	Stakeholder Groups

Top cross-cutting themes:
1. Support services to enable clients to participate in treatment – childcare, transportation
2. Engagement/integration of older adults across services
3. Expanded culturally relevant outreach services to link individuals
4. Improved crisis intervention services (schools/community)
5. Integration of peer/family support across services
6. Integration of co-occurring alcohol and other drug recovery-based practices across services
Other:
• Housing
• School staff training
• Cultural Humility/Competence in Service Delivery
• Homeless mental health clients
• Other prevention service needs
• TAY services
• Services for SMI individuals with private insurance
• Services for low to moderate clients
• Suicide Prevention
• Staff self-care
• Non-profit Infrastructure
• After school services
• Foster care placement
• Technology
• Supported employment
• Re-certification of peer run services
• Commercially and Sexually Exploited Children (CSEC)
• Other parent/family needs
• Law enforcement
• Contractors
	• Central Community Service Area (C-CSA)
	• Coastside CSA(CS-CSA)/
	• Coastside Youth Advisory (CS-CSA/Y)/Families (CS-CSA/F)
	• East Palo Alto CSA (EPA-CSA)
	• Northwest CSA (NW-CSA)
	• South CSA (S-CSA) & Child/Youth Committee (S-CSA C/Y)
	• Diversity and Equity Council (DEC)
	• Health Equity Initiatives (HEI)
	  o African American Community Initiative
	  o Chinese Health Initiative
	  o Filipino Mental Health Initiative
	  o Latino Collaborative
	  o Native American Initiative
	  o Pacific Islander Initiative
	  o PRIDE Initiative
	  o Spirituality Initiative
	• Change Agents/CARE Committee (AOD)
	• National Alliance on Mental Illness (NAMI)
	• Peer Recovery Collaborative (PRC)
	• MHSARC Older Adult Committee (MHSARC-OA)
	• MHSARC Adult Committee(MHSARC-A)
	• MHSARC Child and Youth Committee (MHSARC-C)
	• Coastside School Based Mental Health Collaborative (CS-SBMHC)
	• Central School Based Mental Health Collaborative (C-SBMHC)
	• Northwest School Based Mental Health Collaborative (NW-SBMHC)
	• Northeast School Based Mental Health Collaborative (NE-SBMHC)
	• Ravenswood/South School Collaborative (R-SBMHC)
	• Contractor Association (CA)

Phase I. Needs Analysis – Stakeholder Input

NEED	Comments (Stakeholder Group)	Strategy Ideas
Support services for clients – childcare, transportation	• Transportation to get to services is an issue – both fiscal and time it takes to get somewhere. Clinicians are often running around. Central has bus tokens yet, a lot of missed appointments due to transportation (C-CSA) • There is limited transportation for staff/family to get to important and helpful prevention trainings. (CS-SBMHC, HEI) • Transportation is an issue and makes access to behavioral health services difficult for the Coastside – the distance to travel from one place to another. In particular Pescadero/La Honda is far from the clinic, there is a bus but it's limited in service. (CS-CSA) • There is a shortage of access and transportation for services in the county for school aged children. (NW-SBMHC) • Transportation is an issue for older adults and adults. Redi-Wheels does not have enough capacity. Lack of transportation is negatively affecting consumers and is linked to treatment compliance and housing, Stanford study (MHSARC-OA, MHSARC-A) • There is a need for more childcare services for PEI engagement events, trainings, programs (DEC) • There is a lack of access and transportation for services/events within the county (DEC) • Daytime hours for child care are needed (HEI-LC) • Need in-home support services after hours (MHSARC-C)	• Need uber driver that is trained to work with mental health clients, to get clients to services (SF has a program with Lyft for seniors) • The Women's Enrichment Center will pick up/drop off clients, Sitake does this for AOD clients and it's proven to work • Clubhouse just got a van to cover all of San Mateo County • Provide community-based trainings on the Coast to alleviate some transportation issues (HEI-LC) • Coastside programs may need to consider a shuttle system, while other programs may need drivers or navigators/peer workers to accompany the client (MHSARC-C)

NEED	Comments (Stakeholder Group)	Strategy Ideas
Engagement/ integration of older adults across the system	• How do we reach older generation for mental health services, they can't go to you; you have to go to them, especially elders; through family support and engagement, community outreach, meeting places for seniors (HEI) • CSA's are largely ignoring needs of older adults; this should be integrated into all services. There are no older adults in the committees, no outreach, no robust involvement. There is a disconnection between services for older adults and the broader BHRS services and county-wide services (MHSARC-OA) • The suicide prevention initiative needs to also focus on older adults given the numbers. Also, on the 75+ (medically fragile) which typically tends to be the younger end of the older adults that get engaged (MHSARC-OA). • More training for primary care providers servicing older adults, if they didn't get diagnosed early enough for mental health issues there are misconceptions of the needs an older adult may present (MHSARC-OA). • The 3AB (psychiatric inpatient unit) don't know what to do with frail older adult male and will put them in with the females (MHSARC-OA). • Isolation of seniors needs to be addressed - Most programs, service providers and physicians don't have this lens. (MHSARC-OA). • Wellness and care coordination for seniors needs to have a layer of childcare, as seniors are often taking care of grandchildren (HEI-CHI)	• Senior peer counseling trainings can help promote wellness (HEI) • The Senior Peer Counseling program is an access point for older adults and a great resource to link individuals to services (MHSARC-OA) • Maybe a mental health checklist for primary care providers (MHSARC-OA) • The gatekeeper model may be a great way to address this. Meals on Wheels drivers, mailman, providers. We need to reach out to these individuals that have contact with older adults and provide them training to recognize signs of isolation (MHSARC-OA) • Suggestion for peer workers to make in-home visits to reduce isolation, particularly among older adults (HEI-CHI)

NEED	Comments (Stakeholder Group)	Strategy Ideas
Expanded culturally relevant outreach services to link individuals to services	• There are outreach collaboratives in the north and south, services in the coastside are limited (CS-CSA) • Stigma is a big issue in rural areas, everyone knows each other… individuals will stay isolated because of the stigma, don't feel safe and are discriminated against (CS-CSA) • Outreach events should have a cultural specific representative to help services be better received. (HEI) • Having a liaison with the programs to be a guest speaker from each community/CSA (HEI-LC) • Having a relatable figure to destigmatize MI is very important to the AA community. AACI has a list of well-qualified and powerful speakers, but budgets for AACI events are insufficient (HEI-AACI) • Trainings/events should be based on topics that are more relevant to specific cultural communities, e.g. health disparities as related to MH (hypertension/stress & perceived racism), family stress/parenting AA child (HEI-AACI) • There needs to be more outreach to let the specific cultural communities know what resources are out there including the reduction of stigma. (HEI) • There is a growing need for LGBTQ resources in North County. How can the new LGBTQ Coordinated Care center satellite to targeted areas? (NW-SBMHC) • A larger effort for collaboration between the faith based community and schools, and cultural groups to attend to the mental health needs of Pacific Islanders, Filipinos. (HEI, C-SBMHC) • Greater collaboration with libraries (HEI-CHI)	• Case managers should also be cultural broker to build the relationships with the communities to disseminate information and services. The case manager would: speak the language, live in the community, Ideally the same age-group of the target population • Digital Storytelling has been very effective for targeted cultural groups. Bringing that program into schools would greatly benefit normalizing mental illness to reduce the stigma in the community. (HEI) • Using social centers as a place to showcase services on a regular basis and targeting specific cultural groups and age groups (HEI) • Broadcasting messages using local based newspapers, community centers, malls and other gathering areas/events (HEI) • Counselors and schools distribution of materials would be effective in reaching youth and parents. (HEI) • Expanded funding to have speakers

	• There needs to be bilingual/bicultural staff in each team within the BHRS clinics (HEI-CHI) • Make the connections between spirituality and lived experience; create a series of digital storytelling that reframes how mental illness is viewed in the faith-based community. (HEI-SI) • Outreach to faith community: Staff bandwidth and time are a barrier to making the connection with the community. There needs to be greater collaboration between the SI and other HEIs to develop the connection between spirituality and treatment. Could the spirituality Initiative act as the umbrella to the leaders in the community? (HEI-SI) • Engagement disconnect from the community, need a reframing of outreach/public awareness campaign. There are a lot of services but information in not getting out – stigma, awareness (MHSARC-C) • Contractors are serving the clients that have already been in the health system; outreach and case management to serve a larger population is unbillable. (CA)	at events (HEI-AACI) • Having peer support/LEA integrated into community trainings/events would be a good way to achieve a relatable figure (HEI-AACI) • Outreach workers should be agile classified (HEI-CHI) • Can there be a position in some of the county's larger CBOs to require an invested staff person in that CBO to serve as the liaison between SI and their community? This person could help with facilitation of trainings to providers. (HEI-SI) • Outreach ideas for NA community: sponsoring a community event with known NA community centers, CA Indian Day in Sacramento, Elders gathering in Mt. Madonna Park in Gilroy (HEI-NAI).

NEED	Comments (Stakeholder Group)	Strategy Ideas
Improved crisis intervention services (schools/community)	• There are limited resources for low to moderate clients – the clinics receive referrals from schools and the students don't meet the criteria for services. Students with insurance need help navigating the system, they end up taking up a lot of time from mental hlth resources (CS-CSA) • Schools have one clinician on site and academic counselors, they can't handle severe trauma so they call on the clinician. Schools don't have the funding to do what SUHSD or SMUHSD have done. Oceana has 600 students for one wellness counselor (LCSW). (NW-CSA) • Students are sometimes interviewed/screened 5 times (school staff, law enforcement, SMART, hospital, etc.) before they get to the hospital where they are then released. (NW-CSA) • In addition, school staff need to be educated to minimize more stress and traumatization, as well as knowing linkages and resources (S-CSA) • Mobile crisis response in the County is slow (C-CSA, DEC) • Crisis Intervention Team (CIT) training needs to reach more law enforcement and district attorneys too • SMART needs to be expanded and receive further support. Difficult to get a hold of them(CS-SBMHC, NW-CSA, CS-CSA) • There needs to be more follow up for clients that receive mobile services (SMART, FAST) (HEI) • Mobile crisis team with peer partners, SMART and StarVista Youth Intervention Team need help responding (MHSARC-C) • Schools are relying heavily on the contractors in the county for crisis intervention services (CA) • The medical model of the billing is not fitting the need for the clients and services that are required for providing MH services in the community	• A mobile crisis team for youth in schools and for after 3pm at homes would help with triaging and having counseling on site with 2x per week therapy regardless of insurance (CS-CSA) • Mobile crisis service for youth would help schools navigate students in need without bringing law enforcement on site, can link families to treatment if not a 5150 and follow them until they receive treatment. (NW-CSA, , NW-SBMHC) • In addition, warm handoffs/re-entry meetings between post-hospitalization, school-based staff, and community care such as FSPs. (NW-SBMHC. S-CSA) • Mobile response services for high ER users (R-SBMHC) • Respite services for students that they can go to voluntarily—there is nothing like this in North County (NE-SBMHC)

	(CA)	
NEED	**Comments (Stakeholder Group)**	**Strategy Ideas**
Integration of peer/family support across services	• Need more family partners in the adult system of care, they have been great for youth clients in YTAC and Pathways Program (C-CSA) • Peer workers in the adult system are being used differently depending where they are. Some peer workers don't engage with families. Adults have a case managers but need peer interaction (C-CSA) • Family Partners are engaging and empowering but there needs to be more of them. How can we recruit and train for our CBOs (DEC) • There needs to be a peer component to mobile crisis response (C-CSA) • There needs to be more family support groups and training on living with a family member with moderate to severe mental illness (NAMI) • More Peer Partners that work with FSP services. Peer Partners were perceived as effective in PES. (NAMI) • Peer Support model and services should be integrated into service for clients – ex. Serenity House has not peer support services (PRC) • Need a 24/7 peer run respite center (PRC) • Peer transitional support to connect individuals to services before they deteriorate and go to the PES • Peer support for youth; often, TAY need a relatable figure to start the conversation about MH and treatment-seeking behaviors (HEI-AACI, S-CSA)	• Would be good to have peer worker positions help peers navigate the system, provide them 101 services training.(C-CSA) • peer warm line or peer mobile outreach program (PRC) • Suggestion for peer workers to make in-home visits to reduce isolation, particularly among older adults (HEI-CHI)

NEED	Comments (Stakeholder Group)	Strategy Ideas
Integration of co-occurring alcohol and other drug recovery-based practices across services	• Substance abuse prevention services in schools (CS-SBMHC) • Co-occurring issues for older adults is an important topic (MHSARC-OA) • FSP services need more attention to co-occurring disorders. (NAMI) • CSS services – AOD groups that are run by AOD folks. Co-occurring providers in CSS. (AOD) • BHRS clinics – Specifically, need screening and linkage to the AOD services at clinics. Pre-treatment and support by ways of system navigation… tertiary prevention methods. (AOD) • Co-occurring capacity and MH staff at AOD respite locations, clinics and at in-patient treatment centers (AOD) • Shelters – We have clients that need services but there is always a barrier that is preventing them from getting what they need. (AOD) • Provider network – We provider network that refer to for co-occurring services. However, need help with supportive services (AOD) • AOD programs – Many of the AOD programs are 12-step and there needs to be something that works for the whole person. (AOD) • EBP for co-occurring services. (AOD) • There needs to be more linear support from court to treatment for co-occurring clients (NAMI) • AOD/BHRS interagency teams should be located in highest-need communities (R-SBMHC) • School-based mental health centers should be able to refer to AOD prevention/outpatient/inpatient programs (R-SBMHC)	(AOD) • Co-occurring providers in clinics. • Resource navigators in shelters to navigate the AOD system. • A case manager that was attached to each provider network that helped navigate care in the case for more supportive services for individuals with co-occurring challenges. • MH staff in AOD clinics to provide individual therapy and • MH staff in-house to serve the needs of the more severe co-occurring clients • Bring more counseling and AOD resources to Half Moon Bay (CS-CSA/F) • Dedicated client navigators to assist in helping clients receive complex case management and dual-diagnosis treatment.

Housing	• We need to increase the housing dollars in the FSPs – housing market (C-CSA) • Need to leverage MHSA funds to subsidize housing and more SLE beds that will help with the continuum of care. (AOD) • Need capacity (supportive services, case management) to support individuals in **maintaining their housing** (CS-CSA) • FSP's do not have enough funding to provide supporting services and housing for clients. Slots to housing are not one-to-one (MHSARC-A) • There is a gap between acute and Board and Care level support. Clients that can't be out and about on their own need the case management but shouldn't be locked up either. (MHSARC-A) • Need affordable support, there is a lack of board and care (MHSARC-OA) • Need to broaden picture of housing… something to help individuals transition out, between a shelter and supportive housing. (MHSARC-A) • More respite housing for adults and youth (MHSARC-A, C-SBMHCA) • Need housing navigators when in crisis – the system is so onerous and agencies (Adobe, Life Moves) are difficult to get to, people have to go to their locations, need someone that's out in the community and a peer. (PRC)	• "The Suites" are a great option, they are licensed as an adult residential with a clinical overlay and there is no time limit. Clients focus on skills building. It's important for recovery that clients not worry about housing. • A 24/7 peer run respite center (short-term, 2 weeks max), a step down that's non-clinical. Will help divert a crisis/deescalates situations, provides support groups and other community support services, mentorship and peer support will be a part of it, self-referral based
School staff training	• Need to figure out how to support teachers to attend trainings like YMHFA, in the Coast especially it is difficult to get subs and they can't attend the all-day training. (CS-CSA) • There is a substitute teacher crisis. Is there a way that we can subsidize the substitutes to allow our teachers to attend trainings (CS-SBMHC) • There needs to be more coverage for school-based staff who want to attend trainings on cultural topics. (DEC) • There needs to be more support for school-based education around mental illness. More classes for students, relief for school staff to attend county trainings. (NW, NE-SBMHC's) • School-based evidence based practices should be implemented and	• Maybe provide funds to the district to pay the teachers and offer the trainings during PD days, $150 workshop rate/employee (CS-CSA, NE-SBMHC) • Is there a way that we can subsidize the substitutes to allow our teachers to attend important trainings (CS-SBMHC) • Bilingual and bicultural school resource workers—maybe they can

	improving the clinical support for school-based counselors that hold a caseload in a large school population. (NW, R, NE-SBMHC's) • Supportive services, case managers, resource navigators, mentors provide more room to increase acute response needs and safe and supportive services, especially beneficial to newly integrated students who require more support (R-SBMHC) • Current MHFA/Y-MHFA courses should be integrated into professional development time in the district calendar (R-SBMHC) • Trained SE curriculum to educate elementary in the classroom; there is a need for a (separate?) SE curriculum for teachers so that they don't have to give up their classroom time for outside educator (NE-SBMHC) • Schools need stigma-reduction programs because teachers are scared to confront an issue if it is perceived as a MH condition (NE-SBMHC) • SRO program should be kept intact and make sure teachers are trained (NE-SBMHC) • Teachers should be required to attend MHFA trainings (HEI-LC)	use a peer worker (HEI-CHI) • There is already a school-based MH clinician doing suicide assessment at elementary level, who is responsible for the high-end need kids; suggestion to increase the number of staff (including in-house staff) for MH clinicians for the district. • Stipends for interns to come in from outside universities/colleges (NE-SBMHC) • More therapists within schools to help youth with depression and bullying (CS-CSA/F)
Cultural Humility/Competence in Service Delivery	• Need cultural sensitivity and capacity to support individuals in maintaining their housing (CS-CSA) • Cultural humility should be incorporated into CIT training (HEI, PRC) • School based counselors identify a need for more trauma-informed care trainings be offered to school staff and law enforcement. (NW-SBMHC) • When there are cultural trainings, they have a lot of interest and energy behind them before/after but then there is no follow up (HEI) • Cultural framework that restricts how often Filipinos use public services in fear of stigma. Filipino clinicians can help ease that.(HEI) • How to work with Filipino families training (HEI) • Cultural awareness trainings specific to the Latino population for providers and school staff (HEI-LC) • Can we integrate mindfulness training into cultural awareness trainings, and can this be provided by the same providers who work with our	• Traveling chaplain for BHRS clinic locations. Currently in the Medical Center, can this be expanded to the outpatient treatment centers? (HEI-SI) • Traveling chaplain/spiritual leader will help with outreach to faith community (HEI-SI) • A spiritual advisor could provide TA to providers (HEI-SI) • Create a spiritual resource guide for providers (possible project for a future CSIP intern?) (HEI-SI) • CME/CEU committee is too

	clients? (HEI-LC) • There is a need for a cultural center for low-income Latino population (CS-CSA/F) • More discussion needed on how spirituality can be integrated into treatment (HEI-SI) • Collaboration with other counties' NA centers is needed – SMC resident outlined that she often has to go out of county for NA events because nothing is offered within (HEI-NAI) • History of government agency has oppressed NA population. The perception of MH services in this community goes beyond stigma and shame (HEI-NAI) • To better serve the NA community, there needs to be a dialogue with the person and explaining what it is that we are doing (HEI-NAI) • Bridging the gap between the NA community and MH/AOD treatment: connecting the spirituality of mental health symptoms with Western medicine, stigma of mental illness (NA reject the word "mental"); trust is important and following cultural norms by contacting the leader is one of the first steps in helping those needing treatment to seek it out (HEI-NAI) • Honoring traditional healing practices in treatment- NA community should be consulted to receive feedback to honor traditional practices (HEI-NAI) • The cost of having staff attend trainings it too high to be consistently offered (CC-CYO) (CA)	stringent—can more brown bag events be help to drum up support and build the trust of the community? (HEI-NAI) • Allow contractors to have access to a portion of WET funds to access training in cultural competency and professional development to retain staff (CA)
Bilingual, Bicultural Capacity	• There is a need for a bilingual psychologist for individuals with substance abuse issues on the coast (CS-CSA) • Shortage of bilingual and bicultural clinicians on the Coast (CS-SBMHC) • Schools have one therapist for the entire school and often time don't have the language capacity (CS-CSA) • Retention of staff that reflects the population is a problem. (NW-CSA) • Lack of bilingual and Spanish-speaking providers in TBS (therapeutic	• MHSA can invest in teams/staff to help prevent burnout and provide training and infrastructure support. (NW-CSA) • Bilingual and bicultural school resource workers—maybe they can use a peer worker (HEI-CHI)

	services, Fred Finch wrap around model) (S-CSA) • There needs to be bilingual/bicultural staff in each team within the BHRS clinics (HEI-CHI) • The health system needs to respond to the community for language access needs in accordance to their open door policy (CA) • The risk of providing language services expecting a reimbursement is a hard sell to the Boards. If we provide LA services, it can get the program operating on a deficit and fast (CA)	• Bilingual pay differential built into the contracts to attract and retain competent workforce (CA)
Homeless mental health clients	• Increased collaboration with shelter services for the homeless, there is no region-specific support. (CS-CSA) • Services for homeless with mental health needs. There has been an increase of SMI clients and a "daytime gap" when not in shelters, gravitate to Free At Last, the Mouton Center, the library. (EPA-CSA) • Need help with connecting clients to supportive services like mental health shelters, it's a complicated process. (EPA-CSA) • Homeless that have out of county MediCal, transfer can take over 45 days, if need drug tx it makes it even more challenging (EPA-CSA)	• Mobile core services like showers for SMI homeless clients •
Other prevention service needs	• Additional parenting groups would help with coping and being able to address and prevent issues (CS-CSA, CS-CSA/Y, CS-CSA/F) • AOD prevention work to avoid the repeated tx (AOD, NAMI) • Build partnerships among HEI's, CSA's, and CBO's (e.g. YMCA, Boys and Girls Club) (HEI-AACI) • Programs that are working well: Teaching Pro-Social Skills, StarVista Crisis Line, Positive Parenting Program (great EBP option, targets parents of 12-17-year-olds, available in 13 languages, but expensive to get people certified) (S-CSA) Comments specifically about ODE and ODE programs: • There is a need for the expansion of programs across the county, specifically ODE programs. (DEC) • Better coordination of ODE programs (i.e. create a series of trainings that	• More funding allocated to facilitators at school-based sites (R-SBMHC) • Positive Parenting Program (UK), similar to Parent Project but focuses on relationships instead of the authoritative perspective(R-SBMHC, HEI-CHI) • Seven Challenges Model (harm reduction decision-making approach and coping skills) – need to involve parents and schools (S-CSA) • Parent Project Loving Solutions for

	are offered and promoted together: Parent Project + MHFA, LEA + HAP, etc.) (HEI-AACI) • Better integration of ODE programs in schools (HAP, PP, MHFA) (HEI-CHI) • ODE programs need to be advertised and done in collaboration with HEI, community clinics, and CBO's (HEI-LC) • PP is not culturally sensitive to the Chinese community (HEI-CHI) PP needs to be advertised in the schools, and offered in the day and in another location (clinics, schools); Spanish classes need to have increased availability and be more easily obtained; increase the number of facilitators, and more family partners who speak Spanish to support PP (HEI-LC) • LEA needs to have better coordination with services, broaden recruitment of diversity (specifically, more AA members are needed), and integrate skills development for advocacy (HEI-AACI) • Digital storytelling- the staff is limited and the concept is hard to understand (HEI-LC) • Digital storytelling is too expensive for partners to administer (HEI-NAI)	5-10 year olds (S-CSA, HEI-LC) • PP curriculum accessible in more languages/cultures, specifically Chinese (S-CSA) • MHFA curriculum in more languages (e.g. Chinese, Tagalog), and for elementary/middle school (S-CSA)
TAY services	• College prep/there needs to be a larger connection between youth and educational resources to motivate them to enter college (HEI-AACI) • There needs to be greater collaboration with community leaders to provide information on career involvements, e.g. a track for AA youth to become involved in/exposed to MH careers (HEI-AACI) • Need for peer support groups for youth and families that create safe and welcoming spaces for youth to discuss mental health challenges (HEI-AACI) • Youth mentoring and empowerment classes/institution (R-SBMHC) • There is a demand for therapists with specialization in adolescents specifically positioned in community health centers (R-SBMHC) • Marijuana Substance Use Training- there is an increase in kids using marijuana and drugs on school campuses, schools can't keep suspending	• Emerging leaders program for TAY to engage youth through positive relationship building (HEI-AACI) • Peer support for TAY (mentioned under integration of peer/family support across services) & peer support groups leveraging MHFA/YMHFA (HEI-AACI&CHI, CS-CSA/F) • On-campus wellness program with dedicated coordinators who serve as liaisons with the community, modelled after SFUSD (R-SBMHC)

	kids, and messaging to not smoke doesn't seem to be working; messaging needs to be more straight forward, need to educate youth to avoid marijuana for health reasons, need to provide strategies for parents (education, information), and the medium of the message has to change (storytelling, photo voice, etc.) (S-CSA) • There is a need for more health education programming at the HS level that integrates MH (NE-SBMHC) • Educating youth on how to recognize MH symptoms (HEI-LC)	• Age 14-18 DIC with flex funds and county staff dedicated to getting kids connected to services (YMCA, activities, etc.) (S-CSA) • Free, safe space to open up about anxiety, depression, feelings that we experience on the coast, modeled after Edgewood DIC (CS-CSA/Y) • Resources and safe spaces for students within schools (CS-CSA/Y) • Develop youth leaders who can provide advocacy and advocate for funds for resources (CS-CSA/F)
Services for low to moderate clients	• Limited resources for low to moderate clients – the clinics receive referrals from schools and the students don't meet the criteria. (CS-CSA) • MHSA definitions for SMI/SED makes it difficult for outreach, weren't able to address needs of those with less severe MI… this led to the system of care, which helped with those that didn't meet the criteria of the 3rd floor [BHRS clinic]. Ravenswood has alleviated some of this as well but there are limitations. Need more if not SMI (EPA-CSA)	• A mobile crisis team for youth in schools and for after 3pm at homes would help with triaging and having counseling on site with 2x per week therapy regardless of insurance •
Services for clients with private insurance	• Limited substance abuse prevention svcs for private insurance and nearly unavailable for public ins due to bandwidth of programs. (CS-SBMHC) • SMI individuals with private insurance do not have access to BHRS services. How and what services can families access that are available	•
Suicide Prevention	• JUHSD needs equity in resources compared to other school districts, Bayshore and Robertson have been targets for ICE and have had increased suicide attempts (NW-CSA) • Suicide prevention for older adults is an important topic (MHSARC-OA) • Suicide ideation is increasing and starting at a younger age (MHSARC-C)	•
Staff self-care	• Need mental health support for mental health providers (NW-CSA)	• Expand meditation room in each of

	• Facilitators need more support (training, self-care) in digital storytelling (DEC)	the BHRS clinics (currently the North County clinic has an employee meditation room, and clients are allowed to be brought in with staff.) (HEI-SI)
Non-profit Infrastructure	• There is a huge amount of staff turnover in in non-profits, it's a disservice to clients. Mateo Lodge has had long staying staff, may be good to do a case study and see how they are able to keep their staff (C-CSA)	•
After school services	• Children/youth need after school activities that are appropriate for children with mental health challenges, somewhere to go • There is a need for MH services outside of school hours/summertime; this programming should provide meals to clients (R-SBMHC) • Need for counseling in schools, clinics, sheriff's office, clubs and extra-curricular activities (CS-CSA/F)	•
Foster care placement	• Foster placement and continuum of care is large barrier in providing services to school-based children requiring relocation. (NW-SBMHC)	•
Technology	• Look at technology fixes – teleconference to link psychiatry services (NW-CSA) • Contractors can't keep up with technology (i.e. LMS, software upgrade, telemedicine). Infrastructure of IT needs support—can MHSA funding support this? (CA)	•
Supported employment	• Better collaboration with supported employment programs like VRS for educ and support. Clients need promotion opportunities(MHSARC-A)	•
Re-certification of peer run services	• Can there be a way to package trainings for recertification of peer-run services. This is done at CSM, could this be replicated in the county?	•
Commercially and Sexually Exploited Children (CSEC)	• Need awareness, strategies, and protocols (S-CSA)	
Parent/Family needs that did not fit into	• Need for advocacy on how to work with the school to learn how to talk when there are concerns—youth have shown some interest in this.	

any of the above categories	Parents need more education on how to access resources and learn the institution of mental health services (HEI-LC) • Take into account parents' point of view about their children's needs, and provide opportunities to listen to the voices and opinions of community members (CS-CSA/F) • More therapists for children in the community (for families) (CS-CSA/F)	
Law enforcement	• Need trauma-informed training for law enforcement (MHSARC-C) • Law enforcement and CIT training in support of CBOs (CA)	
Contractors (comments that did not fit into any of the above categories)	• Using MHSA dollars in the spirit of how MHSA was intended to bridge the gap for services that are not categorized in Medi-Cal reimbursement schedule. • Contractors need to show impact but are under-resourced to do so. More resources and support for evaluations are needed. • Contractors can use the language access line—the right to language access signage is putting contractors in position to provide these services but is unable to do so. It's misleading to the client. (CA)	• Can local colleges develop programs that are MHSA-funded that help with incentivizing working with contractors (i.e. stipends, scholarships, loan assistance)?

Notes:

-CS-CSA/F wants a safe and free/affordable resource center that provides youth activities, tutoring, support groups, culture workshops, a transport system, leadership training, legal services, and mental health services. Unclear who this targets, but this was not included under after school or TAY services since not all of the envisioned services are specific to youth.

APPENDIX 4

Be the one to help

Mental Health Service Act (MHSA) Three-Year Planning Launch

Join behavioral health advocates, providers and clients and provide your input on the next 3 years of MHSA priorities.

- Learn about current MHSA funded programs
- Share and discuss MHSA programs key successes, needs and evaluation findings
- Make recommendations on the MHSA 3-Year Plan development process
- Identify and prioritize future strategies for consideration

All MHSA meetings are open to the public

- Stipends are available for consumers/clients
- Language interpretation is provided as needed*
- Childcare is provided as needed*
- Light refreshments will be provided

*please reserve these services by March 6th by contacting Colin Hart at (650) 573-5062 or chart@smcgov.org

DATE

Monday, March 13, 2017
3:00 pm – 5:00 pm

San Mateo County Health System
225 37th Avenue, Room 100
San Mateo, CA 94403

Contact

Doris Estremera, MHSA Manager
(650)573-2889
mhsa@smcgov.org

COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

smchealth.org/BHRS/MHSA

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

San Mateo County Health System
Behavioral Health and Recovery Services Division

Mental Health Services Act (MHSA) Three-Year Plan Launch

Monday, March 13, 2016 / 3:00 - 5:00 PM
Health System Campus, Room 100, 225 37th Ave., San Mateo, CA

MINUTES

1. Welcome & Introductions 3:10 PM

Supervisor Dave Pine, District 1, Board of Supervisors

2. MHSA Background 3:15 PM

Doris Estremera, MHSA Manager

The background of MHSA components and annual allocated funding was explained. This included reviewing Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovations (INN), Workforce Education and Training (WET), Capital Facilities and Information Technology, and Housing.

The Community Program Planning (CPP) Process consists of the consistent input of the MHSARC and the Steering Committee and the broader stakeholder input gathered during the three year plan. During the Three-Year Plan CPP Process, this meeting is the launch for the MHSA Three-Year Planning process that is set out to engage a broad group of stakeholders to gather input on existing programs and to prioritize needs. Once recommendations on programs and strategies and priority needs are established, they will be presented to the MHSARC where a 30-day public comment period and a public hearing.

3. Input 3:25 PM

- AB1929 Housing Funds

Steve Kaplan, Director BHRS
Janet Stone, Housing Policy & Development Manager

BHRS has approximately $1.2 million of Mental Health Services Act (MHSA) Housing funds that are under the County's control. The agency is collaborating with the Department of Housing (DOH) to develop a project that would provide permanent affordable housing to persons with severe mental health illness. DOH would partner with an experienced, qualified developer to complete, own, and operate the project. DOH is reviewing its project pipeline and considering two models. The first would be to acquire a small or mid-size multi-family building in which approximately five units would be dedicated to serving the MHSA-supported residents. The other model would be to acquire a shared home with approximately five bedrooms to serve the MHSA-supported residents. The project would need to be within close proximity to reliable transit.

DOH plans to include language regarding targeting a development for MSHA-supported residents in the Request for Proposals to developers to be released this spring. The MHSA funding may be used for capital improvements or operating reserves related to the development. The funds must be expended by December of 2018.

4. Strategy Brainstorm Activity 3:40 PM

- Review preliminary findings

Doris Estremera, MHSA Manager

During the first phase of the CPP process, input on needs and gaps in services was sought, as of the date of the MHSA Three-Year Plan Launch, 15 out of 24 input sessions with diverse stakeholder groups had been completed. The list of stakeholder groups was shared with the audience. Feedback from the public was asked for whose voice was missing from the list: Contractor's Association, immigrants, law enforcement, youth, veterans, Institute for Human and Social Development, older adults, and FAST. It was explained that MHSA funded programs would receive a one-on-one meeting to discuss specific program and client needs further. A question was asked regarding how we will ensure that voices of low income individuals or other marginalized communities are heard given that these communities do not typically attend the input sessions. There will be additional sessions held in isolated and higher need communities like East Palo Alto and the Coastside/Pescadero.

The goal during the input sessions was to assess the current MHSA funded programs by understanding what's working well across the BHRS system, and what needs improvement. Using the feedback received so far, some of the input was shared with the audience about what needs improvement. Additional input sought from the audience. Helene Zimmerman of NAMI, Michael Horgan from California Clubhouse, and Christopher Jump from Heart & Soul provided public comment, attached.

Members of audience were asked to participate in a community input session by selecting one of the key preliminary themes from the needs assessment phase (Crisis Intervention, Culturally Relevant Outreach, Integrated Peer/Family Support, Integrated Co-Occurring Practices, Older Adult Engagement, and Support Services for Clients) and to work with the facilitator to answer the following questions, see attached breakout notes.

1) Given the current programs addressing these issues, what are some ways they can be improved?
2) What other best practice or new strategies should be considered to address the issues?

Next steps will include Completing Phase 1 – additional input sessions, needs and follow up with MHSA funded programs; Recommended strategies and prioritization at next MHSA Community Input meeting; Final plan development and presentation to the MHSARC and 30 Day Public Comment and Public Hearing; Present to the Board of Supervisors for adoption; Controller to certify expenditures; Submit to the State MHSOAC

5. Adjourn 4:45 PM

MARK YOUR CALENDARS!

MHSA Three-Year Plan Prioritization - Community Input Meeting

Group #1: Crisis Intervention

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- SMART
- FAST
- CIT
- StarVista Crisis Hotline

Q2: What other best practices or new strategies should be considered to address the issues?

- Youth transitioning from foster care. How can we better serve the population and improve the continuity of care?
- Practical solutions for folks who do not identify as having mental illness.
- Increase resources to connect clients with therapy and case management in the community, at home, and in clincis.
- Identify resources for family members that include crisis response for families.
- Broaden the use of peer support and community liaisons to help clients receive timely access to care.
- School based response & funding for suicide prevention + family support for youth
    - Mobile crisis response funding/ home based services. Geographically/ dif. Regions
- Look into: HEAD SPACE (Santa Clara County)
    - Can we better serve the mild-moderate mental illness population?
    - Increase infrastructure for crisis response and provide respite opportunities for youth and adults via drop-in center
- Expansion of CIT, FAST
    - Increase cultural humility training of responders and be understanding and practice co-occurring capabilities by starting at using the language of recovery.
    - Increase the age group of the population served, including adults/older adults.
- Increase urgent care services w/ direct link to ACCESS call center and services on site
- SMART is great at transportation, but they need to provide more than just that.
- Prevention and & reintegration services for those that don't have Medi-Cal/Medicare

Group #2: Culturally Relevant Outreach

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- NCOC
- EPAPMHO
- HEI's
- Chinese Outreach Worker

Q2: What other best practices or new strategies should be considered to address the issues?

- Parent Project – often there is a shortage of the amount of food. Can there be more food to ensure everyone is fed?
- Parent project is not culturally sensitive. There are many different family dynamics that are presented in culturally and ethnically diverse communities. Look into the Positive Parenting Program widely used in UK.
- Improve the collaboration between HEIs. For example, PRIDE and Filipino Mental Health Initiative could collaborate to meet the identified community need.
- Listen to the community and implement their ideas.
- Extend the term or create an agile position for the Chinese community worker because of huge stigma in the Chinese community, especially due to immigration changes. There is a clear need and a relationship has been built between the outreach worker and the community is important to maintain.
- Collaborate between HEI and County Counsel to support the community.
- Create new cultural groups based on population of the region and support these communities to be self-sustainable.
- Recruit therapists that represent the cultures mentoring program
- Alternative to talk-therapy (ex. Gardening) that are culturally appropriate.
- Utilizing community services as a process of recovery (eg. Church)
- Open public spaces for healing exercise (eg. Tai-chi)
- Housing for interns of behavioral health services + SMC employees + Community Based Organizations employees

Group #3: Integrating Peer/Family Support

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- Peer recovery collaborative
- Lived Experience Academy
- Peer/Family Partners

Q2: What other best practices or new strategies should be considered to address the issues?

- Administrative Infrastructure
- Transportation- public or private
- Expanding Peer Support Training
- Parent Support for Increasing/Teen/Independent Children
- Family Systems Training
- Family Support – Educational Programs
- Family has limited support without violating HIPPA
- More Outreach
- Dealing with Stigma-More educational programs dealing with Stigma
- Disbursing educational information within the community
- Mentorship Program/Expanding Mentorship Program
- Mentor/Mentorship Program at time of discharge
- Family Program
- A Parallel Family-to-Family Program
- Look into “Raising the Voice” Program
- More money for brochures
- Peer counseling classes at the college level
- Address experience and training opportunities after training
- Looking for Outside Service Providers
- Crisis Intervention Training
- VRS Coordination

Group #4: Integrated Co-Occurring Practices

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- AOD Provider Contracts

Q2: What other best practices or new strategies should be considered to address the issues?

- Adaptation of programs using:
  - Cultural humility, LGBT
  - Variety of programs beyond Legacy 12-step
- Collaboration of programs to better understand service provision
  - Inter-agency referrals
  - Evaluative needs and services
- Broaden the training requirements in Request For Proposals for AOD programs
- 360° evaluation of programs consumer/recovery community and staff
- Continuum of Care
  - Trauma informed care needs to go a step further to increase the system of care once in recovery and thereafter.
  - Trauma informed care needs to increase capacity to be able to treat
- Each AOD program needs to have a MH specialist/counselor/team on staff
  - Including at our Resource Centers
- In the case of discharge continuity of care is in place that places the client first using:
  - Peer support/family partners
  - Associate Social Worker

Group #5: Older Adult Engagement

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- Senior Peer Counseling
- OASIS

Q2: What other best practices or new strategies should be considered to address the issues?

- Recruit Older Adults to participate in advisory groups, etc.
- Transportation for seniors to services.
- Reminders: phone, etc. Often elders are missing appointment due to non-compliance.
- Outreach to OA housing/boarding care etc.
- Promote volunteerism via the clinical community
- Better non computer related outreach
- Senior Peer Counseling Program
    - Recruitment for volunteers
- Recruitment for clients.
- Engage family to collaborate with care providers
- Specific, targeted anti-stigma
    - Ex: Lived Experience/digital story telling
- Expand Lived Experience/Lived Experience Education Workgroup
- Develop questionnaire to assess interests/ availability
- Integrate Behavioral Health and Older Adults
- Look into Second Harvest food for elders that are receiving BHRS services
- Engaging gate keepers of the older adults.
    - No early meetings or evenings
    - Provide snacks/coffee
    - Mid-day is best

Group #6 Support Services for Clients

Q1: Given the current programs addressing these issues, what are some ways they can be improved?

- Samtrans (Not a program) "Redi wheels."
- Lyft (provides discounts?).
- Kinship Program (Edgewood).
- Seniors in RWC; On-line program to pick up/drop off (volunteers matched with needs).

    - California Clubhouse has an existing partnership with Stanford to understand barriers experienced by peers =Need expansion of support services offered through MHSA.
    - More attention and support needed for out of hospital transition of clients (outpatient) Youth out of treatment also.
    - More support needed for peers beginning employment or reentry into workforce-follow up support.

Q2: What other best practices or new strategies should be considered to address the issues?

- Work to support what already exists; focus on process improvement.
    - Details- communication between driver and dispatcher. Example: need for wheelchair not communicated w/ transportation service, resulting in delay of service or cancellation.
- Need for transportation is well known, but no conversation or opportunity for improving current system to improve communication (cultural sensitivity) with mental health clients = fragmented system.
- Work on driver's skills for working with MH clients, there is stigma in many cases once destination is revealed.
- Work on or expand on who is allowed to drive clients, it is a critical need, currently NOT reimbursable or funded for staff or providers providing transportation.
- Have child seats and booster seats available for clients.
- Transportation IS part of MH services NOT separate.
- Childcare should be an option for group meetings.
    - Encourage or support after school programs that can help clients be available for afternoon appointments/services.
- PRC topic> "Housing Navigator" someone to collect all housing information and be point of reference across groups and organizations.
- PREP current transportation challenges serve as an example of the gaps in support services:
    - Currently only have one vehicle to transport clients to peer support groups.
    - Group facilitator begins pick up route 2hrs before class, and then drives 2hrs after to drop off.
    - Transportation needed throughout county, but only have capacity to provide service to Pacifica and Daly City.
    - Solution to upgrade vehicle and look for new driver (not facilitator), but there is no funding to cover all of county and a new driver would require pulling someone else from current staff.
    - PREP also provides bus tokens, which are good for local clients but those from farther areas (coast side) = 2hr+ bus ride.

Mental Health Services Act Three-Year Planning Launch

March 13, 2017

San Mateo County Health System
Behavioral Health and Recovery Services
www.smchealth.org/mhsa

Agenda

- MHSA Background
- Update and Input on AB1929 Housing Funds
- Community Program Planning Process
  - Review preliminary findings
- Strategy Brainstorm Activity

Background

- Proposition 63 (2004)
  - 1% tax on personal income in excess of $1 mill
  - Fundable activities are grouped into **Components**
  - Guiding principles include community collaboration, health equity, consumer and family driven services, focus on wellness, recovery and resiliency, integrated experience
  - San Mateo County took an integrated approach

Corresponding Handouts:

- MHSA Info Sheet
- MHSA Funded Program List by Component

Planning & Reporting Requirements

- Community Program Planning (CPP) Process
  - MHSARC and Steering Committee
  - Broader community input for 3- Year Plan
- Three-Year Plan & Annual Updates
  - Annual Updates - progress, changes, outcomes/data
  - Three-Year Plan - builds on existing programs and prioritizes needs
  - 30 day public review period followed by public hearing
- Timeline
  - Three-Year Implementation Phase: July 2014 – June 2017
  - Three-Year Planning Phase: January 2017 – June 2017

Update on AB 1929 – Unspent Housing Dollars

- Background
  - MHSA Housing dollars funded 4 housing developments, total of 50 units for FSP clients
  - AB 1929 unused funds - rental assistance or subsidies; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing
- Proposal: 2821 El Camino Real

Comments, questions?

Community Program Planning (CPP)

* Experiences with MHSA funded programs, behavioral health services (what's working well, improvements needed)
* Review of evaluation and impact reports
* Recommendations for next steps

* Review Phase 1 findings and recommendations
* Make further recommendations on programs, strategies and priority needs

Today's focus

* Presentation to MHSARC
* Public Comment
* Public Hearing
* BoS adoption

Community Input

March: Review of Phase 1, Stakeholder Training and Strategy Brainstorm

April/May: Community Input and Prioritization

Updated 3/2017

Phase 1. Needs Analysis

- Sought input from 15 diverse groups, see handout, 9 more to go
  - Overarching theme… follow up needed
  - Crosscutting needs… begin to address today
  - Other needs… follow up needed
- Who's voice is missing?

Corresponding Handout:

- Community Input Sessions

Phase 1. Needs Analysis

- Overarching theme:

  Assess **current MHSA funded programs**

  - 10 years since the inception of MHSA
  - Have made updates to RFPs and contract terms based on contract monitoring, outcome data and regular reporting, evaluations/impact reports
  - Need a concerted effort across all programs
- Next steps:
  - follow up with funded programs
  - present recommendations at next Steering Cmtee

Corresponding Handout:

- Outcome Reporting and Evaluation

Phase 1. Needs Analysis

- What's working well (across the BHRS system)
  - Collaborations - CSA's, Peer Recovery Collaborative, Outreach Collaboratives
  - Peer/Family Partners, California Clubhouse
  - ODE Prevention Programs – MHFA, Parent Project, Digital Storytelling, Stigma Reduction
  - Lived Experience Academy, Vocational Rehabilitation Services for skills building and employment support
  - Senior Peer Counseling Program
  - PREP/BEAM and IMAT "Case Management"

Additional input?

Phase 1. Needs Analysis

- What needs improvement?
  - **Support services** to enable clients to participate in treatment – childcare, transportation
  - Engagement/integration of **older adults** across services
  - Expanded **culturally relevant outreach** services to link individuals to services
  - Improved **crisis intervention** services (schools/community)
  - Integration of **peer/family support** across services
  - Integration of **co-occurring** alcohol and other drug recovery-based practices across services

Additional input?

Corresponding Handout:

- Phase 1. Summary of Input

Phase 2. Community Input

Select 2 areas of need to help brainstorm strategies to address them. Answer the following **two questions:**

1. Given the current programs addressing these issues, what are some ways they can be improved?
2. What other best practice or new strategies should be considered to address the issues?

- #1 Crisis Intervention
- #2 Culturally Relevant Outreach
- #3 Integrated peer/family support
- #4 Integrated Co-occurring practices
- #5 Older Adult Engagement
- #6 Support Services for Clients

20 minutes at each table
Facilitator report back of 3 ideas at the end

Next Steps

- Complete Phase 1 – additional input sessions, needs and follow up with MHSA funded programs
- Recommended strategies and prioritization at next MHSA Community Input meeting:
  - April 26, 2017 / 4-7pm,
  - Health System Campus, Room 100
  - 225 37th Ave. San Mateo
- Final plan development and presentation to the MHSARC and 30 Day Public Comment and Public Hearing
- Present to the Board of Supervisors for adoption
- Controller to certify expenditures
- Submit to the State MHSOAC

Thank You!

Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

San Mateo County Health System, Behavioral Health and Recovery Services

Mental Health Services Act (MHSA) Components and Programs

FY 2016 – 2017

MHSA Component	Service Category	Programs*
Community and Services Support (CSS)	**Full Service Partnerships (FSP)**	Children and Youth • Edgewood - Short-term Adjunctive Youth and Family Engagement (SAYFE) FSP • Edgewood - Comprehensive "Turning Point" FSP • Fred Finch - Out-of-County Foster Care FSP Transition Age Youth (TAY) • Caminar - Enhanced Supportive Education Services FSP • Edgewood - Comprehensive "Turning Point" FSP • Mental Health Association - FSP Supported Housing Adult /Older Adult • Telecare – FSP and Housing Support • Caminar - FSP and Housing Support • Mateo Lodge - South County Integrated FSP
	General System Development (GSD)	• Older Adult System of Integrated Services (OASIS) • Senior Peer Counseling Services (50% CSS; 50%PEI) • Pathways, Court Mental Health • Pathways, Co-Occurring Housing Services System Transformation & Effectiveness Strategies • Peer Consumer and Family Partners • Co-Occurring Contracts with AOD Providers • Juvenile Girls Program • Child Welfare Partners • Puente Clinic for Developmentally Disabled • The California Clubhouse • The Barbara A. Mouton Multicultural Wellness Center • Evidence Based Practices (EBP) and Services
	Outreach and Engagement (O&E)	• Family Assertive Support Team (FAST) • Outreach Collaborative - North County Outreach Collaborative (NCOC) and East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) • Ravenswood Family Health Center (40% CSS; 60%PEI) • BHRS Staff Positions
Housing	**Housing**	• Cedar Street Apartments in Redwood City (2009) • El Camino Apartments in South San Francisco (2010) • Delaware Pacific Apartments in San Mateo(2011) • Waverly Place Apartments in North Fair Oaks (2016)

3/13/2017

San Mateo County Health System, Behavioral Health and Recovery Services

Mental Health Services Act (MHSA) Components and Programs

FY 2016 – 2017

MHSA Component	Service Category	Programs*
Prevention and Early Intervention (PEI)	**Prevention & Early Intervention (Ages 0 – 25)**	• Early Childhood Community Team (ECCT) Community Interventions for School Age and TAY • Project SUCCESS • Seeking Safety • Middle School Initiative, Project Grow • Teaching Pro-Social Skills
	Prevention	Office of Diversity and Equity • Parent Project • Health Ambassador Program • Digital Storytelling and Photovoice • Health Equity Initiatives (HEI)
	Early Intervention	Community Outreach, Engagement and Capacity Building • Crisis Hotline - Spanish licensed mental health clinician • SMC Mental Assessment and Referral Team (SMART) • San Mateo Medical Center, Early Referral Program • Prevention and Recovery in Early Psychosis (PREP) • Primary Care Interface
	Recognition of Early Signs of MI	• Adult Mental Health First Aid
	Access and Linkage to Treatment	• Ravenswood Family Health Center (40% CSS; 60%PEI) • Senior Peer Counseling (50% CSS; 50%PEI) • HEI Outreach Worker Program
	Stigma and Discrimination and Suicide Prevention	• Stigma Free San Mateo County – Be the ONE Campaign • San Mateo County Suicide Prevention Committee (SPC)
Innovations (INN)	N/A	• Health Ambassador Program – Youth • LGBTQ Behavioral Health Coordinated Services Center • Neurosequential Model of Therapeutics (NMT) - Adults
Workforce and Education Training (WET)	N/A	• Training by/for Consumers and Family Members – Lived Experience Academy, Wellness Recovery Action Plan • System Transformation and Workforce Development • Behavioral Health Career Pathways Program • Financial Incentives – Cultural Stipends, Loan Assumption
Capital Facilities and Information Tech (CF/IT)	N/A	• eClinical Care (launched in 2008-09)

*In San Mateo County, MHSA funds are integrated throughout the system, which means the funding is highly leveraged and many of these programs are funded by other sources.

3/13/2017

San Mateo County Health System
Behavioral Health and Recovery Services (BHRS)

Mental Health Services Act (MHSA)

Background

Proposition 63, now known as the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over one million dollars translating to about $23 million average for San Mateo County annually in the last four years through Fiscal Year 2015-16.

Principles and Funding Boundaries

MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness by providing funding for effective treatment, prevention and early intervention, outreach support services and family involvement, and programs to increase access and reduce inequities for unserved, underserved and inappropriately served populations. MHSA core values include:

◆ Community collaboration ◆ Cultural competence ◆ Consumer and family driven services
◆ Focus on wellness, recovery, resiliency ◆ Integrated service experience for clients and family members

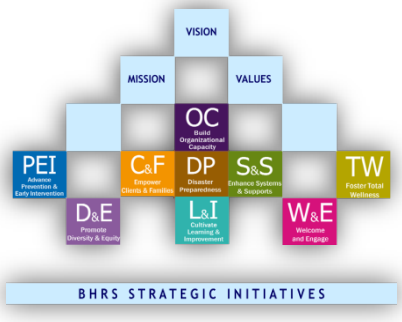
MHSA provides funding for Community Program Planning (CPP) activities, which include extensive stakeholder processes in planning, implementation and evaluation. MHSA funded programming and activities are grouped into "Components" each one with its own set of guidelines and rules:

Community Services and Supports (CSS)	Prevention and Early Intervention (PEI)	Innovative Programs (INN)	Workforce Education and Training (WET)	Capital Facilities and Information Technology (CF/IT)	Housing

MHSA funding is allocated as follows across the components:

- CSS: 75-80% of funds with at least 51% on the most acute clients through Full Service Partnerships
- PEI: 15-20% with at least 51% on ages 0-25 and not on individuals who are already known to have a mental illness, with one exception: early onset of psychotic disorders.
- INN: 5% of the county's annual PEI and CSS funds
- One-time funds were allocated to WET, CF/TN, and Housing

San Mateo County Approach



In San Mateo County, MHSA dollars are virtually everywhere in the BHRS system, which means they are highly leveraged. MHSA-funded activities further BHRS' nine strategic initiatives to advance Prevention and Early Intervention; build Organizational Capacity; empower Consumers and Family Members; Disaster Preparedness; enhance Systems and Supports; foster Total Wellness; promote Diversity and Equity; cultivate Learning and Improvement; and be Welcoming and Engaging to those who seek our services and work with us.

Visit www.smchealth.org/bhrs/mhsa for more information
For questions contact Doris Estremera, MHSA Manager at (650)573-2889 or destremera@smcgov.org

Program and Expenditure Planning

Counties are required to prepare for and submit a Three-Year MHSA Plan and Annual Updates**.**

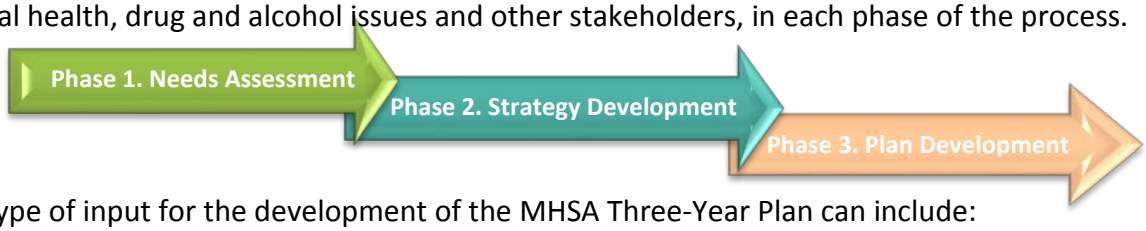
The **MHSA Three-Year Plan** is developed in collaboration with clients and families receiving services, community members, staff, community agencies and other stakeholder to describe programs and services that will be funded by MHSA and prioritizes any new programs, strategies and/or expansions. It includes the following elements:

1. Existing MHSA funded program descriptions and goals for each of the required MHSA components[1]
2. Priority needs or gaps in services as identified by the planning process. These are implemented year round if funding becomes available[2]
3. Expenditure projections based on estimated revenues and unspent funds

Each Three-Year Plan development honors and builds upon existing funded programs and input received through previous planning. MHSA funded programs are evaluated throughout their implementation, adjustments are made as needed and outcomes shared to inform recommendations about continuing and or ending a program. All agencies funded to provide MHSA services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process. To receive notification of BHRS funding opportunities, please subscribe at www.smchealth.org/rfps.

Stakeholder and Community Input

MHSA planning uses a Community Program Planning (CPP) process to engage clients and families experiencing mental health, drug and alcohol issues and other stakeholders, in each phase of the process.



The type of input for the development of the MHSA Three-Year Plan can include:

- Highlighting what's working well (programs, program components, efforts)
- Identifying what needs improvement, what's missing from both the CPP and services
- Prioritizing identified needs for potential future funding
- Developing ideas to address priority needs and potentially serve as the basis for future RFPs

Input is gathered at existing community meetings, specific input sessions, through surveys, and as formal public comment during the required 30-Day Public Comment and Public Hearing for the Annual Updates and Three-Year Plan. To receive notification of input opportunities please subscribe at www.smhealth.org/mhsa.

Current Timeline

- **Three-Year Plan Implementation:** July 1, 2014 – June 30, 2017
- **Annual Updates Due:** December 2015, December 2016, December 2017
- **Next Three-Year Planning Phase:** January 2017 – June 2017
- **Next Three-Year MHSA Plan Due:** December 2017

[1] See www.smchealth.org/mhsa Plan and Components section for a description of each required component.

[2] Counties receive monthly MHSA allocations based on actual accrual of tax revenue, making it difficult to know exact allocations of funding that will be available for new programs and/or priority strategies or expansions. This means RFP's for new programs can be released at any time within the Three-Year Plan implementation.

Phase I. Needs Analysis – Summary of Input

THEMES/NEEDS	Stakeholder Groups

Top cross-cutting themes:
1. Support services to enable clients to participate in treatment – childcare, transportation
2. Engagement/integration of older adults across services
3. Expanded culturally relevant outreach services to link individuals
4. Improved crisis intervention services (schools/community)
5. Integration of peer/family support across services
6. Integration of co-occurring alcohol and other drug recovery-based practices across services
Follow-up needed:
• Housing
• School staff training
• Cultural Humility/Competence in Service Delivery
  o Bilingual, Bicultural Capacity
• Homeless mental health clients
• Other prevention service needs
The following were mentioned 1- 2 times
• Services for SMI individuals with private insurance
• Services for low to moderate clients
• Suicide Prevention
• Staff self-care
• Non-profit Infrastructure
• After school services
• Foster care placement
• Technology
• Supported employment
• Re-certification of peer run services
	• Central Community Service Area (C-CSA)
	• Coastside CSA(CS-CSA)
	• East Palo Alto CSA (EPA-CSA)
	• Northwest CSA (NW-CSA)
	• South CSA (S-CSA)
	• Diversity and Equity Council (DEC)
	• Health Equity Initiatives (HEI)
	  o African American Community Initiative
	  o Chinese Health Initiative
	  o Filipino Mental Health Initiative
	  o Latino Collaborative
	  o Native American Initiative
	  o Pacific Islander Initiative
	  o PRIDE Initiative
	  o Spirituality Initiative
	• Change Agents/CARE Committee (AOD)
	• National Alliance on Mental Illness (NAMI)
	• Peer Recovery Collaborative (PRC)
	• MHSARC Older Adult Committee (MHSARC-OA)
	• MHSARC Adult Committee(MHSARC-A)
	• MHSARC Child and Youth Committee (MHSARC-C)
	• Coastside School Based Mental Health Collaborative (CS-SBMHC)
	• Central School Based Mental Health Collaborative (C-SBMHC)
	• Northwest School Based Mental Health Collaborative (NW-SBMHC)
	• Northeast School Based Mental Health Collaborative (NE-SBMHC)
	• Ravenswood School Collaborative (R-SBMHC)

San Mateo County Health System
Behavioral Health and Recovery Services (BHRS)

Mental Health Services Act (MHSA)
Summary of Outcome Reporting and Evaluation Activities

MHSA Component	Service Category	Outcome Reporting	Formal Eval/ Impact Analysis
Community Services & Supports (75%)	Full Service Partnerships (51%)		
	o Children, Youth and Transition Age Youth FSPs	✓	✓
	o Adult and Older Adult FSPs	✓	✓
	General System Development		
	o Older Adult System of Integrated Services	✓	
	o Senior Peer Counseling Services	✓	
	o Pathways Program	✓	
	o Peer and Family Partners	✓	
	o Co-occurring Alcohol and Other Drugs Providers	✓	
	o Juvenile Girls Program	✓	
	o Child Welfare Partners	✓	
	o Puente Clinic for Developmentally Disabled	✓	
	o The California Clubhouse	✓	
	o The Mouton Multicultural Wellness Center	✓	
	o Evidence-based Practice Providers		
	Outreach and Engagement		
	o Family Assertive Support Team	✓	
	o Outreach Collaboratives (EPAPMHO, NCOC)	✓	✓
	o Ravenswood Family Health Center	✓	
Prevention & Early Intervention (20%)	Ages 0-25 Programs (50%)		
	o Early Childhood Community Team	✓	✓
	o Project SUCCESS	✓	✓
	o Seeking Safety	✓	✓
	o Project Grow	✓	✓
	o Teaching Pro-social Skills	✓	✓
	Early Intervention Programs		
	o Crisis Hotline	✓	✓
	o Prevention and Recovery in Early Psychosis (PREP)	✓	✓
	o SMART & SMMC		
	All Ages - Office of Diversity and Equity		
	o Diversity & Equity Council /Health Equity Initiatives	✓	✓
	o Digital Storytelling and Photovoice	✓	
	o Adult Mental Health First Aid	✓	✓
	o Health Ambassador Program	✓	
	o Be the One Campaign	✓	
	o Suicide Prevention Initiative	✓	
Workforce Education	o Workforce Dev (Lived Experience Academy, Cultural Stipends)	✓	✓*
	o Workforce Education and Training	✓	✓*
Innovations (5%)	Current Innovative Projects (2017-2020)		
	o Health Ambassador Program – Youth	✓	✓*
	o LGBTQ Coordinated Center	✓	✓*
	o NMT – Adult System of Care	✓	✓*

*in progress

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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	ERIC MERRIMAN	CC MEMBER	California Clubhouse		
	JANE foley	NAMI mentor	NAMI	janefoley2@me.com	
	Janet Stone	Housing Policy Manager	SMCo - Dept. of Housing	jstone@smchousing.org	

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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	FAITH CHAND				
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	PAUL Hunt		CALIFORNIA Club House		
	Laura Mobraten		NAMI		
	JUDY SINGER		NAMI		
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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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	Jeanette Heffernan	member	Ca Clubhouse		Jeanette Heffernan
	Grace Hand		—	—	
	John England		—		
	Paul [illegible]		Mollie Angles		
	Agnes Conic		California Clubhouse		Agnes M Conic
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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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consumer	May Chen				May Chen
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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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	~~Marilyn Pearson~~		Public		
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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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Client/Consumer - Adults	Michael Lim			mhl-lim@outlook.com	
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.	michaelhorgan@me.com	
Client/Consumer - Adults	Patrick Field			pfield3311@gmail.com	
Client/Consumer - Adults	Rodney Roddewig*	MHSARC Commissioner	MHSARC	rrodney2k6@gmail.com	
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Client/Consumer - SA	Eduardo Tirado*	MHSARC Commissioner	Voices of Recovery	etirado@vorsmc.org	
Client/Consumer - SA	Louise Orellana*	MHSARC Commissioner	Voices of Recovery	lorellana@vorsmc.org	
Client/Consumer and Veterans	Edmund Bridges*	MHSARC Commissioner		edmund.bridges@vfrsolutions.org	
Cultural Competence & Divers	Jei Africa	Director	Office of Diversity & Equity	jafrica@smcgov.org	
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Disabilities	Maisoon Sahouria		Center for Independence	maisoons@cidsanmateo.org	
Disabilities	Vincent Merola	Systems Change	Center for Independence	vincentm@cidsanmateo.org	
East Palo Alto Community	Rev. William Chester McCall		Multicultural Counselling & Educational Services of the Bay Area	chester.wellness@gmail.com	
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Family Member	Judith Schutzman*	MHSARC Commissioner		judyschutzman@aol.com	
Family Member	Juliana Fuerbringer		California Clubhouse	julianafuer@gmail.com	
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Law Enforcement	Eric Wollman*	MHSARC Commissioner	Burlingame Police	mmortz@burlingamepolice.org	

Other - Advocate	Randall Fox	Health, Law and Policy Advocate	Former MHSARC Chairman	randallfox@sbcglobal.net	
Other - Aging and Adult Servic	Michelle Makino	Program Services Manager	SMC Health System, Aging & Adult Services	mmakino@smcgov.org	
Other - Domestic Violence	Caitlin Billings		Community Overcoming Relationship Abuse - CORA	caitlinb@corasupport.org	
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery	raymills71@gmail.com	
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.	cardumh@heartandsoulinc.org	
Provider of MH/SU Svcs	Clarise Blanchard	Director of Substance Abuse and Co-occurring Disorders	Star Vista and BHRS Contractors Association	cblanchard@star-vista.org	
Provider of MH/SU Svcs	Gloria Gutierrez	MH Counselor	BHRS	GGutierrez@smcgov.org	
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Provider of Social Services	Sheri Broussard		HIP Housing	sbroussard@hiphousing.org	
Public	Betty Savin*	MHSARC Commissioner		bettysavin@yahoo.com	
Public	Cherry Leung*	MHSARC Commissioner		cherry.leung@ucsf.edu	
Public	Josephine Thompson*	MHSARC Commissioner			
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APPENDIX 5

MHSA Prioritization Session - Steering Committee Voting Results

MHSA Steering Committee members rated each recommendation proposed using the following scale: 1-Not a Priority, 2-Low Priority, 3-Somewhat Priority, 4-Moderate Priority, 5-High Priority, 6- Essential Priority.

The results are weighted votes across recommendations receiving a vote of 4, 5 or 6. If additional MHSA funding becomes available, these priorities help inform any new programs, strategies or expansions.

Community Services & Supports (CSS)

Service Category	Priority Recommendations	Weighted Priority Votes
Wellness Services for Migrant Populations	Mobile mental health and wellness services to expand access to Coastside behavioral health clients and families	**91**
Outreach Collaboratives	Expansion of culturally responsive resources and outreach strategies to effectively link high-risk, isolated and emerging cultural and ethnic groups to needed services	**83**
Outreach & Engagement	Coordinated outreach to Chinese community to increase access to behavioral health services	**75**
Pre-Crisis Outreach & Response	Bilingual, bicultural family/peer support workers to respond and connect with families in the community	**74**
Homeless Mental Health	Drop-in center in East Palo Alto that targets homeless adults with behavioral health challenges	
Supported Services for Client Recovery	Expansion of supported education and employment programs based on recovery-oriented, evidence-based practices	
Peer and Family Support	Peer support and follow up care for individuals pre and post discharge from psychiatric hospitalization	
Peer and Family Support	Peer-run warm-line for over-the-phone, non-crisis, support for families and individuals with mental health challenges	**70**
Transition Age Youth (TAY) FSP	Emergency housing that is designed for and specializes in the needs of TAY with serious mental health challenges	**69**
Adult and Older Adult FSP	Expansion of supportive housing services for adults and older adults with serious mental health challenges	
Children and Youth (C/Y) FSP	Expansion of residential treatment services for C/Y with serious emotional and behavioral problem	**67**
Criminal Justice Involvement	Assertive case management to follow up and provide recovery oriented support to criminal justice involved clients in their communities	**66**
Child Welfare Involvement	Specialized, intensive case management for caregivers with mental health challenges with children who are high risk for abuse and neglect	**63**
Older Adult System of Care	Expansion of bilingual peer support workers to help with transportation, system and service navigation and support to isolated monolingual seniors	**62**
Co-occurring Integration	Countywide co-occurring coordination entity	**51**
Intellectually Disabled Dual Diagnosis	Specialty case management services for intellectually disabled clients with psychiatric service needs	**39**

MHSA Prioritization Session - Steering Committee Voting Results

MHSA - Prevention & Early Intervention (PEI)

Service Category	Priority Recommendations	Weighted Priority Votes
Prevention of Early Psychosis	1. After-care services for early psychosis treatment alumni that includes booster sessions and reengagement, maintenance and family navigator support	**74**
Crisis Response	2. Expansion of school and community crisis response services (e.g. mobile crisis response team, 24/7 response, etc.)	**54**
Primary Care Integration	3. Expansion of service for timely triaging of high volume referrals, crisis response and warm hand off support for clients	**48**
Community Engagement and Empowerment	4. Empower and build the capacity of community leaders to meaningfully engage in decision making boards, commissions, and committees, and advocate for themselves and their communities	**40**

PEI component requires that at least 51% of funds go to programs serving individuals ages 0-25, including school-based strategies. This service category was not included in the prioritization session. It was proposed that a taskforce of subject matter experts be brought together for two follow up meeting between July and September to prioritize programs and services with as specific emphasis on school-based, evidence-based services, to meet the 51% PEI funding requirement. The taskforce will present their recommendation to the Mental Health and Substance Abuse Commission during in the Fall of 2017 for voting and opening of a 30-day public comment. If you are interested in participating in this taskforce, please email your interest to mhsa@smcgov.org

APPENDIX 6

Be the one to help

Mental Health Service Act (MHSA) 3-Year Plan Prioritization Session

Open to the public! Join behavioral health advocates, providers and clients to prioritize strategies for the next 3 years of MHSA.

- Provide your input and public comment on the MHSA 3-Year Plan Priorities
- Learn about MHSA programs key successes, needs and evaluation findings

- ❖ **Stipends** are available for consumers/clients
- ❖ **Language interpretation** is provided as needed*
- ❖ **Childcare** is provided as needed*
- ❖ Refreshments will be provided

*please reserve these services by April 12th by contacting Colin Hart at (650) 573-5062 or chart@smcgov.org

COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE

Wednesday April 26th, 2017
4:00 pm – 7:00 pm

Veterans Memorial Senior Center
Redwood Room
1455 Madison Avenue
Redwood City, CA 94061

Public Transportation:
From Redwood City Station take SamTrans route 274 to Jefferson Ave & Ave Del Ora. Cross Jefferson Ave. and walk 2 minutes on Nevada Street. VMCS will be on your right.

Contact:

Doris Estremera, MHSA Manager
(650)573-2889
mhsa@smcgov.org

www.smchealth.org/MHSA

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

San Mateo County Health System
Behavioral Health and Recovery Services Division

Mental Health Services Act (MHSA) Three-Year Plan Prioritization Session

Wednesday, April 26, 2017 / 4-7pm
Veterans Memorial Senior Center, Redwood Room
1455 Madison Ave, Redwood City, CA

MINUTES

1. Welcome 4:10 PM

Supervisor Dave Pine, District 1, Board of Supervisors
Steve Kaplan, Director BHRS

2. MHSA Overview 4:15 PM

- Community Program Planning Process — *Doris Estremera, MHSA Manager*

MHSA background information was provided: Prop 63, voted in 2004 by California voters, imposes a 1% tax on personal income in excess of $1M. Funding is allocated to Counties to transform the mental health system. MHS Components and percent allocated funding and one-time funding components were explained. This included reviewing Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovations (INN), Workforce Education and Training (WET), Capital Facilities and Information Technology, and Housing.

MHSA Planning requirements were explained including required stakeholder engagement, called the Community Program Planning process. The MHSA Steering Committee meets twice a year, there is a 30 day public comment and public hearing process on all MHSA Annual Updates. The Annual Update is a report of services provided over the year, activities, program outcomes, evaluations. During a the 3-Year planning phase, more thorough input is sought through a Needs Analysis and a Strategy Development Phase. It is an opportunity to hear from the community and prioritize needs in the event that there is additional funding (tax revenue).

3. Review of Recommended Strategies 4:30 PM

- Prepared Public Comments

Before beginning the review of recommended strategies for the next three years, a few items were brought forward for consideration:

1) Priority recommendations identified in 2014-17 planning remain a priority. Expansion of supports for isolated older adults was the one priority that was not implemented. If funding becomes available this will be implemented first
2) PEI component requires that at least 51% of funds go to programs serving individuals ages 0-25, including school-based strategies. It was proposed that a taskforce of subject matter experts be brought together for two follow up meeting between July and September to prioritize programs and services with as specific emphasis on school-based, evidence-based

services, to meet the 51% PEI funding requirement. If you are interested in participating in this taskforce, please email your interest to mhsa@smcgov.org

Review of the 17 priority recommendation began, prepared Public Comments included:

- ***Children and Youth (C/Y) FSP***
  - *Speaker: Susan Howe, Edgewood*
    - *Edgewood serves Transitioned Aged Youth (TAY) who are 17-25 year olds*
    - *Edgewood TAY are the most vulnerable and most resilient of this age range*
      - *75% are out of homes*
      - *90% have experienced trauma*
      - *Stay an average length of 2 years*
    - *TAY are*
      - *Developmentally attuned*
      - *Emerging adults*
      - *In a time of transition*
    - *Transition are largely due to gap in housing*
      - *Lack of housing undermines progress and growth*
    - *There is no TAY specific housing or shelter*

- ***Adult and Older Adult FSP***
  - *Speaker: Lenore Gutelli, Caminar*
    - *Oversees Full Service Partnership (FSP) which are full wrap around services*
    - *There are 30 FSP slots*
    - *FSP Case Managers have a tough job*
    - *FSP clients are the most severe of those with mental illness*
    - *It's hard to find support clients because of the lack of funding*
    - *Clients struggle with basic needs (e.g. bathing, cutting nails, interviewing as a prospective tenant)*
    - *Case managers advocate everyday*
    - *FSP clients include 75 and 80 year olds who are struggling*
    - *Caminar needs more resources to continue to do job they are doing*
  - *Speaker: Kevin Jones, Telecare*
    - *It starts with a place to live*
    - *Full service partnerships*
    - *MHSA housing funding has not increased in years or ever*
    - *Locked setting cost $7,000/month*
    - *Our current subsidy for housing is $500*
    - *Sustainable financially*
    - *MHSA outcomes are all amazing*

- ***Criminal Justice Involvement***
  - *Speaker: Jose Solano, Pathways*
    - *Current client of Pathways program*
    - *Pathways is the reason for his success*
    - *Case manager Teresa helped him*

        - *He was diagnosed with schizophrenia*
        - *Today, he has been clean for 3 years and 9 months*
        - *He has a 3.47 GPA with all As and Bs*
        - *Pathways paid for 3 consecutive semesters at CSM to make it happen*
        - *He now has two degrees from CSM*
        - *He wanted to make Pathways proud by paying for his own program*
        - *He recommends Pathways to be a high priority for funding consideration*
    - *Speaker: Nubia Barraza, StarVista's Girl's Program*
        - *She is the lead therapist and program coordinator*
        - *Girl's camp changed her outlook on therapy*
        - *Girl's camp has previously received MHSA funding*

- ***Outreach Collaboratives***
    - *Speaker: Kava Tulua, One East Palo Alto*
        - *Coordinator of Mental Health initiative for One East Palo Alto*
        - *Clients now go to service providers (versus service providers needing to outreach to bring clients to services)*
        - *Outreach has huge impact on community*
    - *Speaker: Mary Bier, North County Outreach Collaborative*
        - *Many community partners and spaces*
        - *Our main goal is to educate people about services available to them and reduce stigma and increase access to services*
        - *The only way we can achieve this goal is to build relationships and trust*
        - *Focused outreach*
            - *Faith in action*
                - *Worked in 4 churches*
                - *Connected to services immediately for those tenants whose rent increased*

- ***Pre-Crisis Outreach & Response***
    - *Speaker: Ian Adamson, Family Assertive Support Team (FAST)*
        - *Clients stay involved 3-6 months until family member is connected to services they need*
        - *Tremendous need for Spanish speaking staff – area of expansion*

- ***Older Adults System of Care***
    - *Speaker: Joicy Mean, Older Adult System of Integrated Services (OASIS)*
        - *More medically vulnerable seniors in OASIS programs*
        - *OASIS has Chinese speaking and Spanish speaking case managers*
        - *OASIS needs more peer support community workers (bilingual)*
        - *It takes a longer time to help seniors (e.g. they may lose their driver's license)*

- ***Supported Services for Clients in Recovery***
    - *Speaker: Riley, California Clubhouse*
        - *Has a mental illness and is a member of California Clubhouse*
        - *Wasn't qualified for Vocational Rehabilitation Services and Caminar (these programs only accepted clients by referral)*

        - *He kept looking for employment*
        - *California Clubhouse was the open door for him*
        - *California Clubhouse matched him with a retail store*
        - *He has been employed halftime for about 6 months*
        - *As a result of this job, he has more earned income and feels less isolated*
        - *His experience shows that someone with mental illness can be part of the team*
        - *At his work, he says "have a great day!" and really meant it*
        - *He now sees the world as a more friendly place*
    - *Speaker (Digital Story): [Insert Name], Caminar*
        - *Chris Robinson*
        - *Digital Story by College of San Mateo student*

- ***Wellness Services for Migrant Populations***
    - *Speaker: Ziomara Ochoa, Clinical Services Manager*
        - *Coastside*
        - *For people to access services, they have to leave their community*
        - *Coastside has been a community that has been forgotten*
    - *Speaker: Yolanda Novelo, Peer Support Worker*
        - *She represents a community that has a lot of intergenerational trauma*
        - *She never thought her family would receive mental health services*
        - *Her daughter was suicidal*
        - *Her daughter was traumatized when she was 2 years old (sexually molested)*
        - *Yolanda was being trained and learning skills from the Parent Project for her daughter to feel safe to talk to her*
        - *It is hard to reach services outside Coastside*
        - *She was able to receive services after being designated with higher level of care*
        - *Many Coastside families make minimum wages (less than she does)*
        - *To go to the other side of the hill, they have to lose a day of work*
- ***Homeless Mental Health***
    - *Speaker: Dr. Faye McNair-Knox, One East Palo Alto (OEPA)*
        - *OEPA Executive Director since 2004*
        - *Homelessness is the biggest social issue in East Palo Alto*
        - *OEPA has been able to rally a lot of support to lack of access to mental health services in East Palo Alto*
        - *Multicultural Wellness Center*
            - *Dr. McNair-Knox is proud of work that has been done to have a safe space for individuals to receive information and get referred – community center*
        - *Took major organizing effort to get shelter at EPA*
        - *EPA has one of the highest homeless populations in the County of San Mateo*
        - *OEPA finds a lot of overlap with those who are unhoused and have mental health conditions*

- ***Prevention of Early Psychosis***
    - *Speaker: Bruce Adams, PREP/BEAM*

        - *Many individuals graduate from PREP/BEAM*
        - *There is anxiety that comes with excitement of graduation*
        - *PREP/BEAM graduates are discharged to lower level of care*
        - *What happens after PREP?*
        - *Recovery is a journey (not a destination)*
        - *PREP/BEAM would like to provide this after care approach (e.g. support group) and show long term outcomes*
    - *Speaker: Mike, PREP/BEAM*
        - *Family Support Specialist for PREP/BEAM*
        - *Son is a graduate of PREP/BEAM*
        - *He went from psychosis to community college to attending University of Arizona, Tuscon*
        - *The work that PREP/BEAM does is meaningful and real*
        - *Everyone in this team is fully committed to it*

- ***Crisis Response***
    - *Speaker: Narges Dillon, StaVista*
        - *Director of StarVista Crisis Center*
        - *StarVista Crisis Center serves thousands of callers per year and provides school presentations*
        - *There is a need for increased prevention and intervention for school-aged youth*
        - *More people come forward when they attend school presentation*
        - *StarVista gets more and more requests for younger students*
        - *Hopes to advocate for appropriate assessment especially most vulnerable young people*

- ***Community Engagement and Empowerment***
    - *Speaker: Yolanda Ramirez, San Mateo County Behavioral Health and Recovery Services*
        - *Lives in San Mateo*
        - *Has two kids*
        - *Family Partner for County of San Mateo*
        - *6 years ago, almost lost her daughter with a suicide attempt*
        - *Participated in Parent Project and became a Health Ambassador Program*
        - *Her daughter is now in recovery*
        - *Was a family partner for Edgewood*

4. Additional Input & Prioritization (All participants) 6:00 PM
Open Public Comment

Additional recommendations were brought forward for consideration and all participants were given two votes to prioritize across these additional recommendations. A peer-run warm-line, peer support during and after discharge from psychiatric hospitalization and a coordinated approach to outreach in the Chinese community were prioritized and added to the 17 recommendations for voting by the Steering Committee

Public Comments included:

- **Veterans**
  - *Speaker: Soni Adams, Department of Veteran Affairs (VA)*
    - *Nice to be in solidarity with amazing people*
    - *Working for VA, understands issues of severe mental illness and suicide*
    - *Veterans have twice the rate of completed rates of suicide than civilians*
    - *Some (not all) veterans have access to VA care based on certain criteria*
    - *There is a need to create a form of transportation to link veterans to resources*
    - *Such transportation would*
      - *Reduce acute hospitalizations*
      - *Improve access to quality care*
      - *Open up and streamline services to others in community who don't' have VA for their health care*
  - *Speaker: Donald DC Barlow, VA Palo Alto*
    - *Peer Support Specialist at VA Palo Alto*
    - *Mental Health Intensive Case Management*
    - *Consumer of correctional institutional setting*
    - *Minority veterans coordinator*
    - *Whole health coach*
    - *Help veterans transition out of treatment court*
    - *When on parole and homeless, did not have transportation or funds*
    - *Transportation accessibility to mental health care providers*
    - *Echo voices of his peers and consumers of various products MHSA/BHRS offers*
    - *Just don't show how to get there but also help people get there (transportation) so they can get the product and services that they need*
    - *Open up mental health services that don't qualify*

- ***Linda, Telecare Client***
  - *Was kicked out of the apartment*
  - *Sleeping at park benches*
  - *Sleeping at airports*
  - *Sleeping on the streets until she met Telecare*
  - *There were shelters that only let people stay there for 30 days*
  - *They gave her a shelter for 2 years*
  - *She has an apartment and been there for 2.5 years*

- ***Valisha, Consumer***
  - *Consumer for almost 7 years*
  - *Today, in school and drug free*

- ***Darrell, Concerned Citizen***
  - *Not associated with any proposed recommendation*
  - *Happy to see so many good programs*
  - *In and out of many hospitals*

- *His one ask is that programming be created in neighborhoods so that they are accessible and easy to find*

- **Steve Sust, Chinese Health Initiative**
  - *No systematic or coordinated education, outreach and referrals for the Chinese community in this county.*
    - *No one speaking Mandarin/Cantonese to answer ACCESS line (despite Chinese being a threshold language)*
    - *No psychoeducation that is linguistically and culturally appropriate for Chinese community*
    - *Chinese Community Outreach Worker position is scheduled to end June 30, 2017 with no confirmed plan of continuing this position*
  - Recommendation: *Systematic or coordinated education, outreach and referrals for the Chinese community in this county.*

- ***Michael Horgan, Heart & Soul, Inc.***
  - *Recommends peer run respite*
  - *Safe and home like environment*
  - *Offer empowerment and meaningful choices*
  - *Provide a much needed alternative for those seeking help from trauma or at risk for psychiatric illness*

- **Helene Zimmerman, NAMI San Mateo County**
  - *Mentally ill from borderline personality disorder*
  - *Started attending connecting meeting*
  - *Graduated from peer to peer meeting*
  - *Pals and the mentors – often their first paid opportunity after mental health life transition*

- ***Dana, NAMI San Mateo County***
  - *Took and graduated NAMI peer to peer course*
  - *Trained to teach the course in 2014*
  - *Facilitates connection group*
  - *Peer to peer program*
  - *Hold a job for the last 11 years*
  - *What was missing for her was the sense of community*
  - *You can do quite well but still feeling not connected to other people*
  - *NAMI creates a sense of community*
  - *NAMI has great programs based on research*
  - *Support mentors on discharge and peer pals program*

- ***Christopher Jump, Heart and Soul, Inc and Peer Recovery Collaborative***
  - *Member Peer Collaborative*
  - *Larger peer voice in the community*
  - *Experienced extreme states of sadness*
  - *Constantly beaten and belittled*
  - *Physically and verbally abused (parents said they wanted to kill him)*
  - *He thought he was worthless*

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Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
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Client/Consumer	Alan Cochran ✓		Lived Experience Academy	ak_cochran@yahoo.com	
Public	Betty Savin*	MHSARC Commissioner		bettysavin@yahoo.com	
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Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.	cardumh@heartandsoulinc.org	
Client/Consumer – Older Adult	Carmen Lee	Program Director	Stamp Out Stigma	carmensos@aol.com	
Client/Consumer - SA	Carol Marble*	MHSARC Commissioner		carolmarb@aol.com	
Public	Cherry Leung*	MHSARC Commissioner		cherry.leung@ucsf.edu	
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Disabilities	David DeNola		Center for Independence	davidd@cidsanmateo.org	
San Mateo County District 1	David Pine* ✓	Supervisor, District 1	Board of Supervisors	DPine@smcgov.org	
Family Member	Dorothy Christian* ✓	MHSARC Commissioner		Dchristian28@yahoo.com	Dorothy Christian
Health Care	Dr. Dan Becker	Medical Director	Mills Peninsula Health Svcs	beckerdf@sutterhealth.org	
Client/Consumer - SA	Eduardo Tirado*	MHSARC Commissioner	Voices of Recovery	etirado@vorsmc.org	
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Public	Josephine Thompson*	MHSARC Commissioner			
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Client/Consumer - Adults	Michael S. Horgan ✓	Program Coordinator	Heart & Soul, Inc.	michaelhorgan@me.com	

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Client/Consumer - Adults	Patrick Field			pfield3311@gmail.com	
Client/Consumer	Patrisha Ragins*	MHSARC Commissioner		patrisharagins@yahoo.com	
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East Palo Alto Community	Rev. William Chester McCall ✓		Multicultural Counselling & Educational Services of the Bay Area	chester.wellness@gmail.com	
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Client/Consumer	Wanda Thompson*	MHSARC Commissioner		w.thompson1967@yahoo.com	
Family Member	Yolanda Novello ✓	Family Partner	BHRS	YNovelo@smcgov.org	

Present via phone

Kava Tulua ✓ Mental Health Initiatives Coordinator One East Palo Alto ktulua@epapa.org

Mental Health Service Act (MHSA)

Three- Year Plan Prioritization Session

April 26, 2017

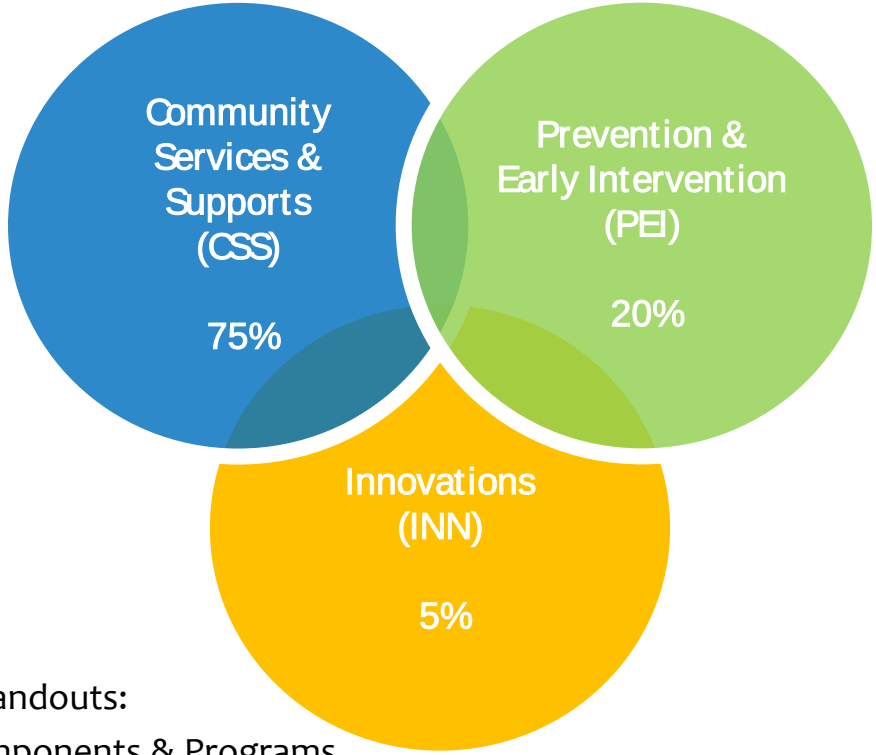
San Mateo County Health System
Behavioral Health and Recovery Services
www.smchealth.org/ mhsa

Agenda

- ☑ MHSA Overview & Community Program Planning Findings
- ☑ Review of Recommended Strategies
- ☑ Additional Input
- ☑ Steering Committee Voting/ Prioritizing Across all Strategies

Mental Health Services Act (MHSA) – Prop 63, 2004

1% tax on personal income in excess of $1 mill



One-time Funding

- Housing Developments
- Capital Facilities & Information Technology
- Workforce Education & Training

Corresponding Handouts:

- MHSA Components & Programs

MHSA Planning Requirements

- Stakeholder Engagement
- Annual Update
- Three-Year Plan

Whats in the 3-Year Plan

Current Program Description and Goals

Priority Strategies

Budget and Fiscal Considerations

Community Program Planning Process

- Experiences with MHSA funded programs, behavioral health services (what's working well, improvements needed)
- Review of evaluation and impact reports
- Recommendations for next steps

- Review Phase 1 findings and recommendations
- Make further recommendations on programs, strategies and priority needs

Finalizing today!

- Presentation to MHSARC
- Public Comment
- Public Hearing
- BoS adoption

Community Input

Dec - Feb | Feb -Apr | May - June

Phase 1. Needs Analysis

- 28 groups/collaboratives/committees
- 30 MHSA-funded programs
- 7 add'l vulnerable groups
  - Veterans, transition age youth client, immigrant families, youth

Community Input

Phase 2. Strategy Development

- MHSA-funded programs
- Community prioritization sessions (Coast, EPA)
  - Will review strategies today
- Input sessions & 3-Year Plan Launch brainstorm
- Add'l considerations – prioritization session

Community Input

Prevention & Early Intervention

Ages 0-25

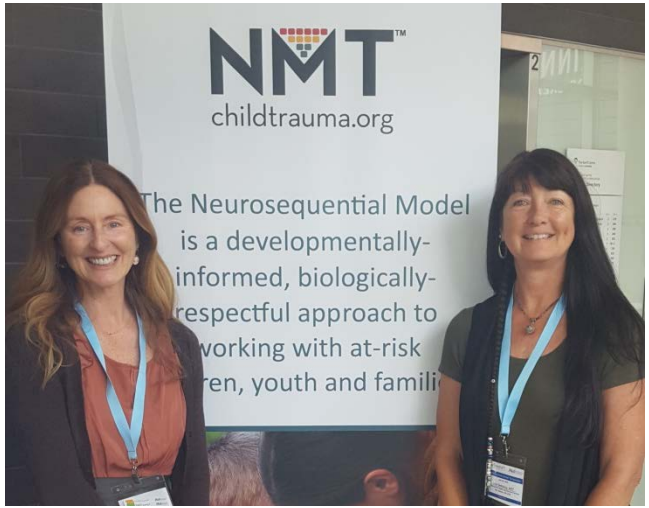
- Need to strengthen this service category
  - 50% of PEI funding, school-based services
- Special Taskforce to start in July
  - Meet twice between July and September
  - Email your interest to mhsa@smcgov.org
- Themes

FY 2014-17 Priority Expansions

Remain a priority

Component	Updated Priority Expansions FY 14-17	Implemented	FY
CSS, FSP	Support and assistance program to connect MI with vocational, social and other services	**YES** Calif. Clubhouse	14/15
	Drop-in Center (DIC) in South County	**YES** Edgewood DIC	15/16
	FSP slots for transition age youth (TAY) with housing	**YES** Edgewood TAY FSP	15/16
	Wraparound services for children and youth (C/Y)*	**YES** Edgewood C/Y FSP	15/16
	FSP slots for older adults	**YES** 50 FSP slots through Laura's Law	TBD
CSS, Non-FSP	Expansion of supports for transition age youth	**YES** YTAC Peer Support Worker	16/17
	Expansion of supports for isolated older adults	**NO**	TBD
PEI	Culturally aligned and community-defined outreach with a focus on emerging communities and outcome-based practices	**YES** LGBTQ and Pacific Islander Outreach Workers	16/17
	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts	**IN PROGRESS**	Expected 16/17

Review of Recommended Strategies



Additional Input & Prioritization

- Top Themes & Strategies
- Other?

Corresponding Handouts:

- Phase 1. Summary of Input

MHSA Steering Committee Voting & Prioritization

Next Steps

- Plan presentation on June 7th MHSARC meeting
- 30 Day Public Comment and Public Hearing

- Present to the Board of Supervisors for adoption
- Controller to certify expenditures
- Submit to the State MHSOAC

Thank you!

Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

San Mateo County Health System, Behavioral Health and Recovery Services

Mental Health Services Act (MHSA) Components and Programs

FY 2016 – 2017

MHSA Component	Service Category	Programs*
Community and Services Support (CSS)	**Full Service Partnerships (FSP)**	Children and Youth • Edgewood Short-term Adjunctive Youth and Family Engagement (SAYFE) FSP • Edgewood Comprehensive "Turning Point" FSP • Fred Finch Out-of-County Foster Care FSP Transition Age Youth (TAY) • Edgewood Comprehensive "Turning Point" FSP and o North and South Drop-in Centers o Caminar Enhanced Supportive Education Services o Mental Health Association Supported Housing Adult /Older Adult • Telecare – FSP and Housing Support • Caminar - FSP and Housing Support • Mateo Lodge - South County Integrated FSP
	General System Development (GSD)	• Older Adult System of Integrated Services (OASIS) • Senior Peer Counseling Services (50% CSS; 50%PEI) • Pathways, Court Mental Health • Pathways, Co-Occurring Housing Services • Juvenile Girls Program • Co-Occurring Contracts with AOD Providers • Child Welfare Partners • Puente Clinic • Peer Consumer and Family Partners • The California Clubhouse • The Barbara A. Mouton Multicultural Wellness Center • Evidence Based Practices (EBP) and Services
	Outreach and Engagement (O&E)	• Family Assertive Support Team (FAST) • North County Outreach Collaborative (NCOC) • East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and East Palo Alto Behavioral Health Advisory Group (EPABHAG) • Ravenswood Family Health Center (40% CSS; 60%PEI) • BHRS Staff Positions
Housing	**Housing**	• Cedar Street Apartments in Redwood City (2009) • El Camino Apartments in South San Francisco (2010) • Delaware Pacific Apartments in San Mateo(2011) • Waverly Place Apartments in North Fair Oaks (2017)

4/24/2017

San Mateo County Health System, Behavioral Health and Recovery Services

Mental Health Services Act (MHSA) Components and Programs

FY 2016 – 2017

MHSA Component	Service Category	Programs*
Prevention and Early Intervention (PEI)	**Prevention & Early Intervention (Ages 0 – 25)**	• Early Childhood Community Team (ECCT) Community Interventions for School Age and TAY • Project SUCCESS • Seeking Safety • Teaching Pro-Social Skills
	Early Intervention	• Primary Care Interface • Prevention and Recovery in Early Psychosis (PREP) • Crisis Hotline, Youth Outreach and Intervention Team • SMC Mental Assessment and Referral Team (SMART)
	Prevention	Office of Diversity and Equity (ODE) • Health Equity Initiatives (HEI) • Health Ambassador Program • Digital Storytelling and Photovoice
	Recognition of Early Signs of MI	• Adult Mental Health First Aid
	Stigma Discrimination and Suicide Prevention	• Stigma Free San Mateo County – Be the ONE Campaign • San Mateo County Suicide Prevention Committee (SPC)
	Access and Linkage to Treatment	• Ravenswood Family Health Center (40% CSS; 60%PEI) • Senior Peer Counseling (50% CSS; 50%PEI) • HEI Outreach Worker Program
Innovations (INN)	N/A	• Health Ambassador Program – Youth • LGBTQ Behavioral Health Coordinated Services Center • Neurosequential Model of Therapeutics (NMT) – Adults
Workforce and Education Training (WET)	N/A	• Training by/for Consumers and Family Members – Lived Experience Academy, Wellness Recovery Action Plan • System Transformation and Workforce Development • Behavioral Health Career Pathways Program • Financial Incentives – Cultural Stipends, Loan Assumption
Capital Facilities and Information Tech (CF/IT)	N/A	• eClinical Care (launched in 2008-09)

*In San Mateo County, MHSA funds are integrated throughout the system, which means the funding is highly leveraged and many of these programs are funded by other sources.

San Mateo County Behavioral Health & Recovery Services (BHRS)
MHSA 3-Year Plan FY 16/17 to FY 19/20 - Community Program Planning Process

Phase II. Strategy Development – Community Services & Supports

	MHSA Service Category	MHSA Funded Program Outcomes (FY 2015-16)	Service Gap	Priority Recommendation	NOTES

1	Children and Youth (C/Y) FSP	Turning Point & SAYFE (Edgewood)
		• 130 unduplicated C/Y served
		• Outcomes for C/Y completing at least 1 year of FSP
		  ○ 93% decrease in mental health emergencies
		  ○ 100% decrease in physical health emergencies
			Youth that require residential placement are often referred to or maintained at FSP (lower level of care) because of the lack of funding and resources	Expansion of residential treatment services for C/Y with serious emotional and behavioral problems	

2	Transition Age Youth (TAY) FSP	Turning Point & Drop-in Centers (Edgewood)
		• 54 unduplicated TAY served
		• Outcomes for TAY completing at least 1 year of FSP
		  ○ 70% decrease in arrests
		  ○ 68% decrease in mental health emergencies
		  ○ 85% decrease in physical health emergencies
		• 121 unduplicated TAY served YTD at Drop-in Centers
			TAY are among the fastest-growing segments of the homeless population. For TAY with traumatic histories, mental illness or mental health symptoms, supported and specialized housing during the important transition from adolescence to adulthood is especially critical	Emergency housing that is designed for and specializes in the needs of TAY (17-25years) with serious mental health challenges	

3	Adult and Older Adult FSP	Telecare, Caminar and Mateo Lodge
		• Outcomes for adults completing at least 1 year of FSP
		  ○ 21% decrease in homelessness
		  ○ 86% decrease in arrests
		  ○ 53% decrease in mental health emergencies
			There are insufficient resources help FSP participants stay housed and live independent, stable and productive lives in the community, including housing subsidies and being able to keep clients engaged and safe in the community when homeless	Expansion of supportive housing services for adults and older adults with serious mental health challenges	

4	Criminal Justice Involvement	Pathways (BHRS) • 14 admissions • 9 obtained employment, 3 enrolled in higher ed • 10 graduated from a treatment program Juvenile Girls Program (StarVista) • 44 clients served • 70% increase in positive individual engagement • 41% increase in positive academic engagement	Follow up care and services for clients to help with stabilization, maintenance, and support with employment, education, substance use treatment and other goals	Assertive case management to follow up with and provide recovery oriented support to clients in their communities	

	MHSA Service Category	MHSA Funded Program Outcomes (FY 2015-16)	Service Gap	Priority Recommendation	NOTES
5	Outreach Collaboratives	EPAPMHO (OEPA) and NCOC (HR360) • 5,556 individuals engaged in meaningful outreach • 51% represented underserved ethnic communities including African American, Chinese, Filipino, Mexican, Samoan, Tongan and multiracial • Referrals made to mental health, substance use, social services, medical, housing, legal, finance, food	Outreach and engagement data shows an increase in high risk populations (at-risk for homelessness and older adults) and emerging cultural groups (Arab-American, LGBTQ) and need to reach geographically isolated communities	Expansion of culturally responsive resources and outreach strategies to effectively link high-risk, isolated and emerging cultural and ethnic groups to needed behavioral health services	
6	Pre-Crisis Outreach & Response	FAST (Mateo Lodge) • 88 clients served, 69% referrals received from families • 213 linkages made (27% BHRS, 11% benefits, 10% food assistance, 6% AOD)	Pre-crisis outreach support services for monolingual families who are not engaged or connected with behavioral health services	Bilingual, bicultural family/peer support workers to respond and connect with families in the community	
7	Intellectually Disabled Dual Diagnosis	Puente Clinic (BHRS) • Avg 50 new clients, 20 discharged, total caseload 250 • Of 20 high service utilizing clients, use of psychiatric emergency service decreased and there was no acute inpatient service	Intellectually disabled adults with mental health challenges often require long-term case management including linking to community resources and medical care, coordinating and monitoring services, etc. With the current caseload and expected increase in the next few years, it is imperative that clients receive specialized supports	Specialty case management services for intellectually disabled clients with psychiatric service needs	
8	Child Welfare Involvement	Partners for Safe and Healthy Children (BHRS) • 151 children served • High risk children are reunited with families	Resources for caregivers who suffer from mental health challenges but may not qualify for SMI services	Specialized, intensive case management for caregivers with mental health challenges with children who are high risk for abuse and neglect	
9	Co-Occurring AOD/MH Integration	Co-occurring treatment contracts (7 providers) • 5,396 units of service provided for clients with mental health issues (additional bed days or hours of service) • 30% of all AOD clients had mental health issues • 35% decrease in outpatient emergency services • 50% decrease in 24-hour hospital stays at discharge	Sustaining and supporting co-occurring competency among providers (integrated care, cross-training and coordinated systems for mental health clients with alcohol and other drug disorders)	Countywide co-occurring coordination entity	

	MHSA Service Category	MHSA Funded Program Outcomes (FY 2015-16)	Service Gap	Priority Recommendation	NOTES
10	Older Adults System of Care	OASIS (BHRS) • 286 clients served • 20% monolingual Spanish and Chinese / 0% pre-MHSA • Clients maintain in the community vs. assisted living Senior Peer Counseling (Peninsula Family Services) • 474 clients served, 112% of goal • 34 counselors completed the training, 94% of goal • Support groups offered in Mandarin and Spanish, and for Filipino clients	Monolingual older adults with mental health challenges are especially vulnerable to isolation, are often housed with no language support services and require much more intensive case management to help them with system navigation	Expansion of bilingual peer support workers to help with transportation, system and service navigation and support to isolated monolingual seniors	
11	Supported Services for Clients in Recovery	Caminar Supported Education (SE) Program • 113 unduplicated clients received SE services • 86% retention in courses • 43 TAY clients received SE services California Clubhouse • 82 members received 16,000 hours of prevocational training, education and social supports • 15 members were supported in employment • Successfully piloted first Transitional Employment	Supported education services and comprehensive employment options with ongoing support by peers and staff are needed for people with serious mental illness who 1) have yet to join the workforce 2) are held back by poor work histories, and/or (3) need build/renew confidence	Expansion of supported education and employment programs based on recovery-oriented, evidence-based practices	
12	Wellness Services for Migrant Populations	No current program	Low income isolated migrant clients and their families living on the Coastside have limited options to receive support, information, skills building and mental health and wellness services, including multiple forms of targeted therapies such as music, dance, yoga, drumming, etc.	Mobile mental health and wellness services to expand access to Coastside isolated low income migrant families	
13	Homeless Mental Health	No current program	As much as one-third of homeless suffers from severe mental illness. In East Palo Alto homeless with mental health challenges do not have a place to go during the daytime to receive social and support services	Drop-in center in East Palo Alto that targets homeless adults with behavioral health challenges	

San Mateo County Behavioral Health & Recovery Services (BHRS)
MHSA 3-Year Plan FY 16/17 to FY 19/20 - Community Program Planning Process

Phase II. Strategy Development – Prevention & Early Intervention

	MHSA Service Category	MHSA Funded Program Outcomes (FY 2015-16)	Service Gap	Priority Recommendation	NOTES
1	Primary Care Integration	Primary Care Interface (BHRS) • Over 2,000 clients served annually, 27 SMI referred • Approx 170 referrals per month from primary care • In co-occurring case management, 73 clients received Vivitrol injection, 61% decrease of ED/PES admissions	High volume of referrals has led to clients lost in follow-up, decreased response rate, linkages made and effective response	Expansion of service for timely triaging of high volume referrals, crisis response and warm hand off support	
2	Prevention of Early Psychosis	PREP (Felton Institute) • 74 clients served, 74% treated • 48% reduction in acute hospitalization episodes • 78% maintained current or lower level of care • 77% maintained current education or vocational	There is no long-term specialized follow up care or maintenance support once graduated from early psychosis treatment for clients to maintain gains made in the course of treatment.	After-care services for early psychosis treatment alumni that includes booster sessions and reengagement, maintenance and family navigator support	
3	Crisis Response	Hotline, school crisis intervention and outreach (StarVista) • 9,000 calls and 99 received 147 follow up calls • 100 youth sessions to 33 youth • 4,012 youth served through suicide prevention ed SMART (American Medical Response West) • 2 SMART vehicles respond 12hrs/day, 7 days/week • 4,254 residents served since inception	Suicide ideation and behavioral health crisis is increasing and showing up at a younger age in youth. The StarVista Youth Intervention Team is the only available assessment and follow up service for crisis intervention at school sites.	Expansion of school and community crisis response services (e.g. mobile crisis response team, 24/7 response, etc.)	
4	Community Engagement and Empowerment	Health Ambassador Program • 23 Health Ambassadors have graduated • 21 courses were offered, 395 participants Lived Experience Academy • 15 LEA Speaking graduates, 10 Advocacy graduates • 13 speaking engagements, 11 LEEW meetings	Training and support to further integrate lived experience and community voices and expertise in decision-making bodies to help advance stigma and discrimination prevention efforts that are community-identified	Empower and build the capacity of community leaders to meaningfully engage in decision making boards, commissions, and committees, and advocate for themselves and their communities	

APPENDIX 7

Be the one to help

Mental Health Services Act (MHSA) Prevention and Early Intervention Task Force

Open to the public! Join behavioral health advocates, providers and clients to develop prevention and early intervention recommendations for youth ages 0-25 years.

- Join us for a time-limited special taskforce with the goal of developing recommendations for prevention and early intervention programming for children, youth, and transitional age youth, a prioritized component of MHSA.
- Hear from current MHSA prevention and early intervention programs for youth age 0-25 and provide your input on best practices and gaps.
- Provide your expertise and recommendations on key strategies and programming moving forward.

❖ **Stipends** are available for consumers/clients

❖ **Language interpretation** is provided as needed*

❖ **Childcare** is provided as needed*

❖ Refreshments will be provided

*please reserve these services 2 weeks in advance of the meeting by contacting Hillary Chu at (650) 372-6157 or hcchu@smcgov.org

DATES

Friday, October 27th, 12 pm - 2 pm
Friday, November 17th, 2 pm - 4pm
Friday, December 8th, 2 pm - 4 pm

Human Services Agency, Jupiter Room
264 Harbor Boulevard, Building A
Belmont, CA 94002

Contact:
Doris Estremera, MHSA Manager
(650)573-2889, mhsa@smcgov.org

www.smchealth.org/MHSA

COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

San Mateo County Behavioral Health & Recovery (BHRS)

BHRS' Prevention Framework prioritizes a continuum of care approach that not only includes traditional programming aimed at individual behavior change and early intervention but also organizational practices and policy change, new partnerships, and taking a comprehensive approach to understanding and addressing the underlying determinants of behavioral health .

Mental Health Services Act (MHSA) PEI Programs & Strategies, 2017

Current PEI Programs (ages 0-25)	Prevention ↑Protective ↓Risk Factors	Early Intervention Tx Early in Emergence	Access and Linkage to Tx	Timely Access	Non-Stigmatizing/Discriminatory	At Risk Communities	Impact of Trauma	MH/ Substance Use Integration	Juvenile Justice Involvement	Family and Peer Partner Integration	System Continuity	Geographic Diversity
Early Childhood Community Team (ages 0-5)	Individual & Environmental											North County* Coastside
Teaching Pro-Social Skills (ages 6-9)	Individual											North County Central County South County
Project SUCCESS (ages 5-18)	Individual											South Coast
Seeking Safety (ages 15-25)	Individual											North County South County South Coast
Crisis Hotline and Intervention Team	Individual & Environmental											County-wide
			Required of all PEI Programs				San Mateo County Priorities					

*expanded North County and added South County and South Coast with Measure A funds

Selective
Indicated
Universal

Early Childhood	Transition Age
School Age	All Children and Youth

2017 PEI Ages 0-25 Taskforce Planning / updated 11.29.

San Mateo County Health System, Behavioral Health and Recovery Services

Mental Health Services Act (MHSA)

Prevention and Early Intervention Programs and Funding

Required Service Category	Programs	FY 15/16 Amount
Prevention & Early Intervention (Ages 0 – 25)	• Early Childhood Community Team	$389,384
	• Project SUCCESS	$269,088
	• Seeking Safety	$163,000
	• Teaching Pro-Social Skills	$200,000
	• Crisis Hotline, Youth Outreach and Intervention	$112,551
	• Prevention and Recovery in Early Psychosis, 70%	$456,066
	• Office of Diversity and Equity - Prevention, Stigma Discrimination and Suicide Prevention, 50%	$400,611
	TOTAL - Ages 0-25	**$1,990,700 (50%)**
Early Intervention	• Prevention and Recovery in Early Psychosis, 30%	$195,457
	• Primary Care Interface	$975,347
	• SMC Mental Assessment and Referral Team (SMART)	$145,000
Prevention	Office of Diversity and Equity (ODE), 50% • Health Equity Initiatives • Health Ambassador Program	$400,611
Stigma Discrimination and Suicide Prevention	• Digital Storytelling and Photovoice • Be the ONE Campaign • San Mateo County Suicide Prevention Committee	
Recognition of Early Signs of MI	• Adult Mental Health First Aid	$22,130
Access and Linkage to Treatment	• Ravenswood Family Health Center (60%PEI, 40%CSS)	$106,000
	• Senior Peer Counseling (50%PEI, 50%CSS)	$141,570
	Total - Adults	**$1,985,115 (50%)**
	Grand Total - All PEI	**$3,976,815**

PEI **Average (**FY 15/16 - FY 18/19) Annual Estimated Revenue: **$5,749,712**

Visit www.smchealth.org/bhrs/mhsa for more information *2/12/2018*

For questions contact Doris Estremera, MHSA Manager at (650)573-2889 or mhsa@smcgov.org

MHSA Prevention and Early Intervention Terms

Definitions from PEI Regulations, Effective Oct. 6, 2015

Prevention:
Reduce risk factors for developing a potentially serious mental illness and to build protective factors for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.

Early Intervention:
Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

Access and Linkage to Treatment:
Connecting children and youth with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

Timely Access:
Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

Non-stigmatizing and non-discriminatory:
Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

Evidence-Based Practice (EBP):
Activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population, including, but not limited to, scientific peer-reviewed research using randomized clinical trials.

Promising Practice:
Programs and activities for which there is research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.

Community and/or Practice-Based Evidence:
Community and or practice-based evidence means a set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically. Community and or practice-defined evidence takes a number of factors into consideration, including worldview, historical, and social contexts of a given population or community, which are culturally rooted.

Prevention and Early Intervention Task Force

MHSA Funded PEI Program Summary #1

Early Childhood Community Team (ECCT)

Provider: **StarVista**

Clients served
FY 14-15: **75**
FY 13-14: **83**

Background – Early Childhood Community Team (ECCT) incorporates three service components that build on current models already operative in San Mateo County. The three service modalities are: 1) Clinical Services, 2) Case management services, and 3) Mental health consultations with childcare and early child development project staff and parents served by these centers. In addition, the ECCT team conducts extensive outreach in the community to build a more collaborative, interdisciplinary system of services for infants, toddlers and families. The ECCT is designed to support the healthy social emotional development of young children. ECCT is comprised of a community outreach worker, an early childhood mental health consultant, and a licensed clinician. BHRS PEI funding is supporting one Coastside team located in Half Moon Bay and providing funding for the clinical treatment component of a North Coast ECCT (First 5 and private funding support the other components).

Client Served Demographics

Demographics	**2013-2014**		**2014-2015**	
Total enrollment	83		75	
Ethnicity	#	%	#	%
Latino	73	90%	66	88%
Caucasian	4	5%	2	2.6%
Mixed Race	3	3.6%	3	4%
Middle Eastern	1	<1%	0	0%
African American	1	<1%	2	2.6%
Other	1	<1%	2	2.6%

	2013-2014		**2014-2015**	
Primary Language	#	%	#	%
Spanish	62	75%	61	80%
English	16	19%	13	17.3%
Bilingual	3	3.6%	0	0%
Other	2	2.4%	2	2.6%

Fiscal Year 2014-2015 Evaluation Summary

Impact

ECCT engaged relatively high numbers of high-risk, difficult to engage families, served under-served populations (2013-14: 90% Latino, 75% Spanish-speaking; 2014-15: 88% Latino, 80% Spanish-speaking) and provided the range of services identified in the contract. Pre-post assessments strongly suggests that the ECCT is having a positive impact on the children, teachers, and families being served. Qualitative data collected in 2014-15 from the Program Manager support this. Satisfaction surveys indicate that both parents and teachers are highly satisfied with ECCT.

Challenges and Recommendations

- Staff retention: training for new staff on managing challenging behaviors.
- Lack of clarity around ECCT's role and responsibilities in Kick-Off to Kindergarten: the school district and ECCT could identify a local child development specialist to facilitate a conversation about concerns from both sides, and develop a shared understanding of how the program should operate.
- Data collection: use a tickler system to notify clinical staff to schedule post-tests, develop a database system that aligns participation with assessment data, expand use of satisfaction surveys, and create data reports.
- North County engagement/penetration: clarify purpose and North County engagement strategies, add funding for consultation and a part-time clinical team to round out the North County team and enhance collaboration in this region (these steps were undertaken throughout 2013-15).

Prevention and Early Intervention Task Force

MHSA Funded PEI Program Summary #2

Teaching Pro-Social Skills (TPS)

Provider: **HSA**

Clients served
FY 14-15: **37**
FY 13-14: **38**

sites
FY 14-15: **10**
FY 13-14: **5**

Background – Since 2007, HSA has operated Teaching Pro-social Skills (TPS) groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others. Teaching Pro-social Skills is based on Aggression Replacement Training (ART). ART is an evidence-based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS. While originally designed for older youth with juvenile justice involvement, TPS and ART have been utilized in dozens of health and human service contexts including with: nurses, home attendant care providers, undergraduate students, military personnel, counselors, teachers, and with youth beginning as early as Kindergarten. TPS training is provided by the California Institute of Mental Health using the TPS curriculum develop by Skillstreaming. Skillstreaming for Elementary School children employs a four-part training approach—modeling, role-playing, performance feedback, and generalization—to teach essential prosocial skills to elementary school students.

Client Served Demographics

Demographics	**2013-2014**		**2014-2015**	
Total enrollment	38		37	
Ethnicity	#	%	#	%
Latino	Data not collected		25	68%
African American			6	14%
Asian			4	11%
Caucasian			1	3%
Pacific Islander			1	3%

	2013-2014		**2014-2015**	
Age	#	%	#	%
Six	Data not collected		6	14%
Seven			13	35%
Eight			7	19%
Nine			11	32%

Fiscal Year 2014-2015 Evaluation Summary

Impact

The evidence from data available is that TPS has a strong positive impact, but teacher post-test completion is inconsistent. At each site where TPS was offered, the program successfully targeted and served the students at highest risk of social emotional problems, as determined by the teachers, who are best able to make this assessment.

Challenges and Recommendations

- Impact of personnel changes: TPS was not delivered consistently at all sites in 2014-15 due to the loss of the TPS director resulted in inconsistent management of sites throughout the 2014-15 year.
- Insufficient communication with teachers and parents: a clear protocol for teachers to complete the post-test is needed to ensure a more valid assessment of impact services. Teacher and parent satisfaction surveys should also be administered.
- TPS struggled with getting students to turn in their TPS "homework": facilitators could make a greater effort to engage parents. One example is to send home a monthly bulletin describing the skills being worked on and how parents can reinforce what is being learned. This should enhance student learning, as well as increase parental understanding of the program. A similar monthly bulletin can be provided to teachers.

Gibson & Associates conducted an evaluation of 10 PEI projects, the full report is available on www.smchealth.org

Prevention and Early Intervention Task Force

MHSA Funded PEI Program Summary #3

Project SUCCESS

Provider: **Puente de la Costa Sur**

Clients served
FY 14-15: **46 in groups, 7 in individual services**
FY 13-14: **27 in groups, 14 in individual services**

sites
FY 14-15: **4**
FY 13-14: **3**

Background – Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals in the schools to provide a full range of prevention and early intervention services. Project SUCCESS counselors strategies include: information dissemination, normative and prevention education, problem identification and referral, community-based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. Puente de la Costa Sur delivered Project SUCCESS services at La Honda Elementary, Pescadero Middle School and Pescadero High School, and in 2014-15 added a fourth site, Pescadero Elementary. Puente also delivers a range of educational and prevention services in large, school-wide presentations, particularly at the high school. The SUCCESS groups and the school-wide presentations serve as a point-of-entry to counseling available at all schools.

Client Served Demographics

Demographics	**2013-2014**		**2014-2015**	
	Groups	Individual Treatment	Groups	Individual Treatment
Total enrollment	27	14	46	7
La Honda ES	12	6	12	2
Pescadero ES	N/A		14	3
Pescader MS	5	2	6	0
Pescadero HS	10	6	14	2

Fiscal Year 2014-2015 Evaluation Summary

Impact

The demographic profiles of the schools served are consistent with the County's priority of serving populations that are historically under-served. The San Mateo South Coast has also been identified in numerous County reports as being an under-served community. In 2013-14, Puente used the Hemingway Connectedness Subscale to assess students' declines and gains. Only 15 students from La Honda ES completed this assessment. Statistically significant gains were found in self-esteem and students' view of their future, while statistically significant declines were found in student relationships with the neighborhood and siblings. In 2014-15, Puente used the DAP, and a total of 35 students representing all schools responded. Internal assets, social competencies, and positive values were entirely positive, with 77-86% of students making gains. In 2014-15, 12 middle and high school students representing 60% of Project SUCCESS participants responded with a very high level of satisfaction with the groups.

Challenges and Recommendations

- In 2013-14, Project SUCCESS had very low enrollment. Sustained negotiations with the district and sites resulted in accommodations that resulted in almost doubling the number of students served.
- Satisfaction surveys: It was recommended that satisfaction data be collected at the last session of groups and last individual session at all sites, from teachers at all sites, and parents participating in parent groups.
- Recommendations: increase services to middle school students; continue outreach to elementary school parent; increase numbers served across all ages, and increase the percentage of students completing pre and post DAP assessments.

Gibson & Associates conducted an evaluation of 10 PEI projects, the full report is available on www.smchealth.org

Prevention and Early Intervention Task Force

MHSA Funded PEI Program Summary #4

Seeking Safety

Providers: **El Centro**

Clients served
FY 14-15: **33**
FY 13-14: **40**

$43,000 (total)

Background – Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations. The key principles of Seeking Safety are: 1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); 2. Integrated treatment (working on both PTSD and substance abuse at the same time); 3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; 4. Four content areas: cognitive, behavioral, interpersonal, case management; and 5. Clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Since 2011 El Centro delivers weekly Seeking Safety group sessions at El Centro's Redwood City clinic and in Half Moon Bay. El Centro named its Seeking Safety program the AC-OK Program to convey a more positive image. El Centro's AC-OK Seeking Safety program targets Transition Age Youth and young adults, the vast majority of whom were referred by the Department of Probation.

Client Served Demographics

Demographics	**2013-2014***		**2014-2015**	
Total enrollment	40		33	
Ethnicity	#	%	#	%
Latino	17	51.5%	25	75.8%
Caucasian	13	39.4%	6	18.2%
African American	2	6.1%	1	3.0%
Pacific Islander	2	6.1%	1	3.0%
Multi	0	0	0	0
Asian	0	0	0	0
Native American	0	0	0	0
Other	6	18.2%	0	0
Age at Intake	#	%	#	%
15-17	0	0	0	0
18-20	15	37.5%	10	30.3%
21-23	15	37.5%	8	24.2%
23+	10	25%	15	45.4%
Gender	#	%	#	%
Male	28	70%	1	81.8%
Female	12	30%	1	19.2%
Transgender	0	0	0	0
Referral Source	#	%	#	%
Probation	33	82.5%	31	93.94%
Other	7	17.5%	2	6.06%

*The demographic data presented were reported as part of a 2015 evaluation of PEI programs. A later review of El Centro's files as part of another contract revealed errors in data collection that dramatically impacted this reporting. This later report showed that 86 individuals were enrolled in FY 2013-14, 68 in Redwood City and 18 in Half Moon Bay.

Gibson & Associates conducted an evaluation of 10 PEI projects, the full report is available on www.smchealth.org

Fiscal Year 2014-2015 Evaluation Summary

Impact

El Centro was able to sustain participation in groups held in Redwood City between 2013-14 and 2014-15. However, despite significant outreach, they were unable to engage enough clients to hold any groups in Half Moon Bay in FY 2014-15. El Centro did hold individual counseling sessions for TAY in Half Moon Bay.

To assess AC-OK clients' reductions in stress, depression, anxiety, and problems with family and peers, El Centro administered the Addiction Severity Index (ASI). Results suggested that the AC-OK groups have a positive but inconsistent impact on clients managing modest levels of alcohol and drug use and family and peer conflict. However, only 11% of clients took both the pre and post-test, making it hard to attribute much validity to these findings. In 2013-14, clients were extremely satisfied with services across all items. In 2014-15, no satisfaction data was collected.

Challenges and Recommendations

In 2011 Caminar was also contracted to implement the YES! Program to deliver Seeking Safety groups at six discrete locations serving transition age youth. Caminar's YES! Program targetted Transition Age Youth through its contacts with community-based organizations. Caminar did not to seek continuing funds for this program, recommendations below are addressed to BHRS and contracted agencies operating Seeking Safety groups in 2015-16 and beyond:

- Communication with host agencies (schools, mental health clinics, juvenile facilities, etc.) is important to extending the impact of the program and enabling host staff to discuss the groups with participants in a more informed manner;
- Participants indicated that they did not feel that the groups were having a significant impact upon their ability to manage drugs or conflict with families. It would be worthwhile for BHRS leadership to consult to monitor outcomes related to the areas where groups did not achieve their goals. If it is found that the new Seeking Safety groups are equally challenged, then it would be worthwhile consulting the literature and making adjustments or augmentations to program design to address this challenge; and
- Consistency in attendance correlated highly with better outcomes. Caminar was working with a population that faced significant barriers in maintaining consistent attendance, yet improved in this regard in 2014-15. Future contracts should contain requirements to collect and share data *at the client level*.

El Centro:

- Data collection: Data provided for the evaluation was not representative during either evaluation year. The evaluator recommended that BHRS meet with the CEO, Clinical Supervisor and Program Manager to develop a reporting schedule through which BHRS would receive interim reports that demonstrate the collection of data. As a follow up, El Centro upgraded their server/network hardware in 2016, so data reporting should be improved moving forward.
- Participation levels: In 2014-15, El Centro served 20% fewer clients than in the previous FY. The evaluator recommended that during the above meeting, El Centro leadership and BHRS managers also develop a set of benchmarks as indicators of improved service delivery (and data collection).
- Lack of services at Half Moon Bay: El Centro and BHRS should discuss the viability of continued El Centro service to HMB. For whatever reasons, El Centro has not been able to address the unmet need in HMB, and it may be that reallocating the funds supporting El Centro's HMB operation to another agency OR relocating El Centro's AC-OK services to another community in the peninsula may make sense, with one possible community being East Palo Alto.

Prevention and Early Intervention Task Force

MHSA Funded PEI Program Summary #5

Crisis Hotline, Youth Outreach Team

Background – StarVista operates the Crisis Intervention and Suicide Prevention Center, a program comprised of a 24-hour phone Hotline, teen chat room, and a Youth Intervention Team that works primarily through schools countywide offering both crisis intervention services when a student is in crisis, training for school personnel and prevention education for thousands of middle and high school students.

As part of this contract, StarVista also operates a Youth Intervention Team housed at the Crisis Intervention and Suicide Prevention Center. The Team is led by the Prevention Program Director and Prevention Center Clinical Supervisor and supported by an unlicensed intern. The team responds to requests from schools, providing crisis intervention services to youth (which can include short-term counseling for youth in crisis), consultation and training to school staff, and provision of referrals for youth and families as clinically indicated.

Client Served Demographics

	2013-2014	2014-2015
Total number of crisis calls	14,965	14,237
One-hour presentations	61	123
Students served	2494	3617
Schools served	14	11
School districts served	9	6
Youth Outreach Team consultations	21	31

Fiscal Year 2014-2015 Evaluation Summary

Impact

Data from the American Association of Suicidology's 2015 accreditation report, Crisis Line volunteer survey, Teen Chat Line survey, survey and structured interviews of school personnel served by the Youth Intervention Team, and the California Network of Suicide Prevention survey of hotline callers demonstrate that StarVista's hotline, chat, crisis intervention, and suicide prevention services are having a very positive impact upon the individuals and school targeted by their services.

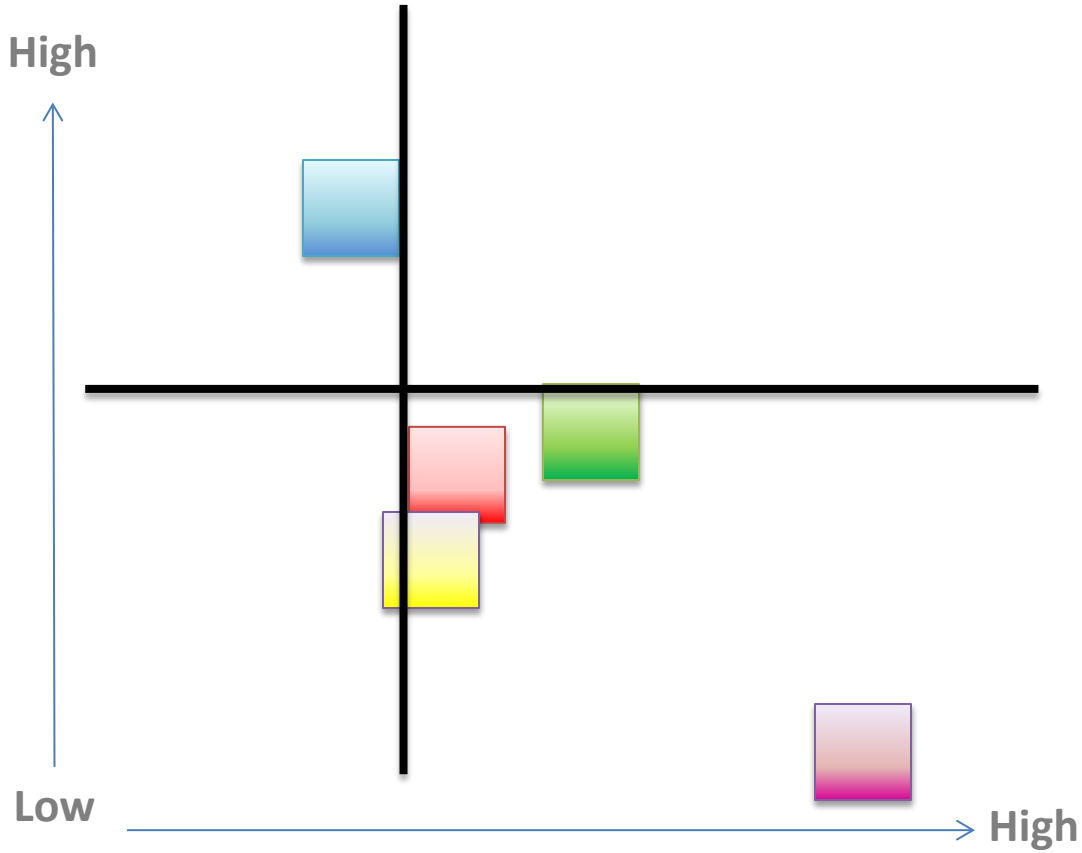
Results of the survey and structured interviews of school personnel served by the Youth Intervention Team and the California Network of Suicide Prevention survey of hotline callers indicate that clients are highly satisfied with both the hotline and Youth Intervention Team services. The large number of positive comments about staff support, training and volunteer camaraderie in expressed in the Crisis Line and Teen Chat Line volunteer surveys are indicative of a well-managed program that, despite operating in extremely stressful contexts, has achieved a very positive moral among the volunteers. Additionally, volunteers felt well-trained and callers felt that they were heard and supported by those volunteers.

Challenges and Recommendations

- Language: StarVista volunteers have the capability to transfer callers to crisis lines that offer services in different languages. MHSA also funds a Spanish-speaking clinician, which has been difficult to fill.
- Out-of-date referral information/lack of automation or easy access to information and/or outside support: StarVista incorporated a FileMakerPro database in 2014-15; the Director of Wellness and Recovery Services identified the need for support from staff to continuously update it.
- Data collection: at the end of a school crisis intervention, the primary school contact should complete a brief online survey; utilize a crisis intervention incident report to capture demographic data of students served, services delivered, and a brief summary of the nature of the crisis and outcome; establish a data entry procedure.

Gibson & Associates conducted an evaluation of 10 PEI projects, the full report is available on www.smchealth.org

Priority Matrix



Impact

- Upstream Prevention
- Research-Driven
- MHSA Requirements
- SMC MHSA Values

Effort

- Involved Partners
- Current Initiative
- Stakeholder Support
- Cost/resources

Fist to 5 Agreement

5.5 Youth Mobile Crisis Support	5-Love it!
4.1 Juvenile Justice Involved TAY	4 -Good Idea
4.0 Community Schools	
3.2 Drop-in Services for high-risk TAY	3 -Good Enough
2.5 Coordinated Services for Children 0-5	2-Not Bad
	1-Reservation

San Mateo County Behavioral Health & Recovery Services
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Taskforce

MHSA PEI Priority Issue: Responding to youth mental health emergencies

Recommendation:
Expansion of mobile mental health crisis support for youth during school hours and after school in the community and including evidence-based mental health crisis prevention efforts such as training of youth, parents and school staff on identifying signs of mental illness, reducing stigma and supporting youth mental health and knowledge of available local resources (e.g. Question Persuade Refer training). **Cost: $600,000/year**

Outcomes:
Decreased psychiatric emergency services youth visits
Decreased hospitalization for self-inflicted injury /mental health issues
Decreased emergency calls to law enforcement for youth in crisis
Decreased juvenile detention due to mental health needs
Improved individual level outcomes (recognizing symptoms, confidence to help/refer youth, etc.)

Research/Data:
Kidsdata.org:

	Suicidal Ideation (2011-13) % of 9 and 11th graders	**Self-Inflicted Injury Hospitalizations (2014)** Rate per 100,000	**Hospitalization for MH Issues (2015)** Rate per 1,000	**Depression-Related Feelings (2011-13)** % of 7,9, 11th graders
San Mateo	19.9%	71.2*	6.1	30.7%
California	18.5%	43.1	5.1	30%

***SMC has the highest rate per 100,000 youth compared to neighboring counties (has been increasing each year)

San Mateo County BoS Adolescent Report (2014-15):

- 70% of school students sampled reporting being depressed, anxious, or emotionally stressed.
- 38% of females and 23% of males reported having suicidal thoughts
- Stigma - youth who have mental health problems are more likely to have felt discriminated against than youth who have no mental health problems.

From Providers:

- Suicidal thoughts, emotional health concerns are on the rise and starting at a younger age
- StarVista reported an over triple increase crisis intervention services from FY15-16 to FY 16-17 with no added resources and funding cuts to the youth-focused crisis hotline
- In 2015, estimated 743 unique youth psychiatric emergency service visits (almost 1,000 total visits)
- 13.6% of calls to SMART units were from schools

Promising practices:

- **Youth mobile crisis response services** -
    - Safe Alternatives for Treating Youth (SAFTY)[1] from Santa Barbara County provides services to youth in collaboration with Crisis and Recovery Emergency Services. SAFTY provides crisis intervention, in-home support and linkage to services. The goal is to decrease psychiatric hospitalization and use of emergency rooms, juvenile detention and law enforcement for mental health crisis.

[1] https://www.casapacifica.org/programs_services/santa_barbara_county/Safe_Alternatives_for_Treating_Youth_SAFTY

- **Evidence-based Trainings for prevention and stigma reduction-**
    - Applied Suicide Intervention Skills Training (ASIST) [2] is a 2- day training that provides families, friends, and other community members and those in formal helping roles with skills to ensure that they are prepared to provide suicide first aid to help a person at risk stay safe and seek further help.
    - Youth Mental Health First Aid (YMHFA)[3] is an 8-hour training designed for adults who regularly interact with youth ages 12-18 to teach them how to help an adolescent who is experiencing a mental health or addictions challenge or is in crisis.
    - Question, Persuade, and Refer (QPR)[4] is a 1-3 hour adaptable training providing innovative, practical and proven suicide prevention tools. How to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

    - Evidence-based trainings in San Mateo County, FY 2016-17

	# Trainings/yr	# Individuals Trained	Audience
YMHFA	20	420	40% CBOs/Community, 33% School staff, 8% Probation/AOD, 14% Parents
ASIST	2	45	60% CBO's, 32% BHRS, 8% School staff

    - Other trainings such as Suicide is Preventable, Know the Signs, etc.

	# Trainings/yr	# Individuals Trained	Audience
BHRS (Crisis Coordinator)	67	1860	51% Schools, 24% Law Enforcement, 13% Parents, 6% BHRS, 5% CBO
StarVista	76	4638 yth, 973 adults	70% Schools, 21% CBO, 5% Parents, 4% Other

- **School crisis response plans–**
    - SMCOE Suicide Prevention Protocol[5] outlines administrative procedures for intervening with suicidal and self-injurious students and guidelines to school crisis teams after a student death by suicide
    - SFUSD School Crisis Response Manual[6] - guidelines for school crisis response teams and the roles of its members; protocols for delivering crisis intervention services; and protocols for notifying team members, school staff, students, parents, and the community of information about a crisis.

[2] https://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist
[3] https://www.mentalhealthfirstaid.org
[4] https://www.qprinstitute.com/about-qpr
[5] San Mateo County Office of Education (2017), San Mateo County Schools Suicide Prevention Protocol
[6] https://www.sccoe.org/depts/schoolhealth/PublishingImages/Pages/Student-Wellness/SFUSD%20Crisis%20Response%20Manual.pdf

Priority Issue: Prevention, early identification and treatment for children age birth-5

Recommendation:
Strengthen the development of Help Me Grow, a centralized access, outreach and provider/system network to promote cross-sector collaboration and amongst early childhood support services, identification and screening and treatment providers. **Cost: $300,000/year**

Outcomes:
Increased parent/community connectedness
Increased parent mental health screening
Increased universal screening of children
Increased early mental health identification

From Research/Data:

- High quality birth-to-five programs can deliver a 13% return on investment. The earlier the investment, the higher the return.[1]
- 90% of a child's brain development happens before age 5. Attention to supporting the early years can change lifetime trajectory. [2]
- Only 53% of parents report being asked to complete a questionnaire about their specific concerns or observations about their child's development, communication, or social behaviors.[3]

Silicon Valley Community Foundation Center for Early Learning

- Only 29% of pediatricians universally screen at 6 months visits, 69% at 18 months, 36% at 30 month visit
- 36% of parents reported chronic sadness or depression that interfered with their daily lives at some point within the previous year. Of which, 45% of low-income parents compared with 34% of middle-to-high-income parents reported these symptoms
- Parent/community connectedness: low-income families report less support in times of need, lower enrollment in preschool, less satisfaction with elementary schools, lower participation in enrichment activities, and less enrollment in formalized child care

Promising practices[4]:

- Family Supports -
    - Home visiting programs connect mothers with health insurance, education/employment and community resources, develop parenting skills and often include case management. Nurse Family Partnerships[5], Early Head Start[6], Parents as Teachers[7] home visiting model, Mental Health Home Visiting, Family Connections[8] provide home visiting services in San Mateo County. Over a 5 year period, 947 parents and 843 children in San Mateo County ages birth-5 were referred to behavioral health services by home visiting programs.[9]

[1] www.heckmanequation.org. Invest in quality early childhood development.
[2] https://developingchild.harvard.edu/
[3] Childhealthdata.org (2010)
[4] First 5 San Mateo County (2017) Developing Systems to Serve the Mental Health Needs of Children 0-5 in SMC: A Landscape Scan
[5] https://www.nursefamilypartnership.org
[6] http://www.ihsdinc.org/early-head-start/
[7] https://parentsasteachers.org/evidence-based-model/
[8] http://www.familyconnections.org/
[9] https://www.childrennow.org/files/8015/0179/3314/CN-HV-San-Mateo-8-03-17_noref.pdf

- Other programs that provide education and support services (case management, skill development, and other services) such as the Early Childhood Community Team (ECCT)[10] and Prenatal to Three.[11]
- BHRS family partners host Friday Cafes and Parent Cafes[12] as support systems for families.

- Provider training –
  - The Teaching Pyramid[13] approach is a provider training that help prevent challenging behaviors in the classroom. ECCT also provides consultation to early childhood providers.
  - Trauma informed system of care and ACES Connection[14] – to prevent, bring awareness and educate providers about the impact and care of adverse childhood experiences (neglect, abuse, divorce, etc).

- Parenting curriculum-based education –
  - Triple P[15] helps build protective factors and reduce risk; Parent Project[16] helps parents learn and practice parenting skills and get information about resources and other support available in their communities.

- Routine screening (parental depression and of children)
  - Indiana's Medicaid authority and mental health programs standardization of health and behavioral health screenings for prenatal and postpartum women

- Cross-sector collaboration and coordination
  - Help Me Grow[17] - an evidence-based model that works to promote cross-sector collaboration in order to build efficient and effective early childhood systems. Help Me Grow is not a stand-alone program, but rather a system model that utilizes and builds on things already in place in order to develop and enhance a comprehensive approach to early childhood system building in any given community. Core components:
    - Centralized Access Point: assists families and professionals in connecting children to appropriate community-based programs and services (often a telephone access point or warm-line)
    - Family & Community Outreach: supports education to advance developmental promotion, and also grows awareness of the system and the services that it offers to families and community-facing providers
    - Child Health Care Provider Outreach: supports early detection and intervention, and loops the medical home into the system
    - Data Collection: supports evaluation, helps identify systemic gaps, bolsters advocacy efforts, and guides quality improvement so the system is constantly becoming better.

[10] http://www.star-vista.org/whatwedo_services/education/children/early_childhood_community_team.html
[11] http://www.smchealth.org/pre3
[12] http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/
[13] https://cainclusion.org/teachingpyramid/
[14] http://www.acesconnection.com/
[15] https://parentsplace.jfcs.org/find-help/learn/triple-p-program/
[16] http://www.smchealth.org/parentproject
[17] https://helpmegrownational.org/

Priority Issue: Improving school and community connectedness

Recommendation:
Support Community School development, school sites as hubs for collaboration and services, supports, linkages and opportunities for children, youth, families and communities in high need, high utilization neighborhoods.
Cost: minimum $550,000/year for 1 school site total.

***** Diversified funding strategy is recommended for Community Schools model. Economies of scale can be accomplished with a district-wide priority.

Outcomes:

- Increased family participation in school decision-making – representation on school boards, parent/teacher conferences
- Positive adult and peer relationships
- Diverse students, staff, and families feel safe and welcomed
- Decreased incidents of bullying
- Increased early mental health identification
- Academic success – grades, graduation, dropouts

From Research/Data:

- School connectedness is the strongest protective to decrease substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury.
- School connectedness is second in importance, after family connectedness, as a protective factor against emotional distress, disordered eating, and suicidal ideation and attempts. [1]
- Victims of bullying are at risk of depression, anxiety, suicidal behavior, physical health problems, low academic achievement, and poor social and school adjustment.[2] 34% of all public school students in San Mateo County surveyed reported being bullied or harassed at school in the past year.[3]
- There are distinct neighborhoods in the San Mateo Foster City School District (11,977 students and 20 schools) and San Bruno Park Elementary School District (2, 727 students, 8 schools that have high concentration of children and youth who enter Juvenile Probation, BHRS and Child Welfare systems and other indicators of need and have low readiness based on community assets (Big Lift districts, community collaboratives and organizations and resource agencies).[4]

Kidsdata.org:

- Connectedness indicators for San Mateo County youth are overall positive compared to neighboring counties and California yet, there are disparities by race specifically for African American (AA), Hispanic/Latino (H/L) and Pacific Islander (PI) youth.

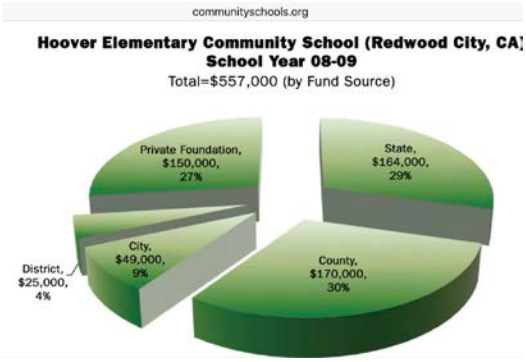
[1] Resnick MD, Bearman PS, Blum RW, et al. (1998) Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health
[2] American Educational Research Association. (2013). Prevention of bullying in schools, colleges, and universities: Research report and recommendations.
[3] Kidsdata.org (2011-13)
[4] *In Progress, not yet published:* San Mateo County Health System, Human Services Agency, Probation, Office of Education and First Five of San Mateo County (2017). Community Collaboration for Children's Success Analysis of Community Need and Planning Readiness in San Mateo County.

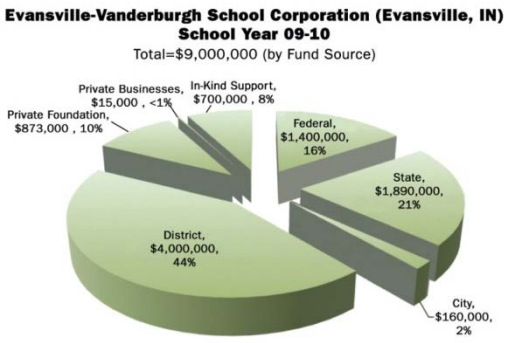
	Caring Adults in the Community Low level of agreement	High Expectations from Teachers and Others Low level of agreement	School Connectedness Low level of agreement	Caring Adults at School Low level of agreement	Meaningful Participation at School Low level of agreement
San Mateo County	All – 6.8% AA – 10.8% H/L – 8.1% PI – 8.2%	All – 5.1% AA – 12.0% H/L – 6.4% PI – 5.3%	All – 7.8% AA – 12.4% H/L – 10.3% PI – 8.4%	All – 7.7% AA – 14.0% H/L – 9.8% PI – 9.4%	All – 27.8% AA – 35.1% H/L – 34.7% PI – 25.0%
California	8.9%	7.6%	11.6%	12.1%	33.9%

Promising practices:

- Full Service Schools provide integrated, comprehensive, and intensive services to children and their families. Students in a full-service schools gained access to services-particularly mental health services-faster. [5] In schools with school-based health clinics, fewer students reported considering suicide compared to national statistics.[6]
-
    - Family Resource Centers[7] are on school sites and offer parent support and education groups, crisis intervention, health workshops, mental health counseling, linkages to resources and services, access to food, medical, housing, and cash aid services. FRC's are located in Daly City, Pacifica, San Mateo/Foster City, Redwood City, East Menlo Park, East Palo Alto and Pescadero/La Honda.

    - Community Schools[8] offer wrap-around services and opportunities such as physical and mental healthcare, parenting education, legal support, afterschool programming, emergency food, and other safety nets. There are six community schools in the Redwood City School District.





- Hoover Elementary Community School in Redwood City (747 students) received diversified funding from the School District, City, County, State and Private Foundations.
- Evansville-Vanderburgh School Corporation accomplished economies of scale by prioritizing Community Schools for 22,000 students in 38 schools.

[5] Flaherty, Weist, & Warner (1996). School-based mental health services in the United States: history, current models and needs.
[6] Kisker & Brown (1996)Do school-based health centers improve adolescents' access to health care, health status, and risk-taking behavior?
[7] http://hsa.smcgov.org/family-resource-centers
[8] http://www.communityschools.org

San Mateo County Behavioral Health & Recovery Services
Mental Health Services Act (MHSA)
Prevention and Early Intervention (PEI) Taskforce

MHSA PEI Priority Issue: Supportive services for high-risk Transition Age Youth (TAY)

Recommendation #1:
Neighborhood specific drop-in services for high-risk TAY located in community identified as high need, high utilization that offer support services including educational, vocational, mindfulness and other skill development, linkages, peer-to-peer supports and provision of a trained adult mentor. **Cost: $450,000/year**

Recommendation #2:
Support services for TAY involved in juvenile justice and foster care that would start before transitioning out and continue as re-entry/aftercare service to provide educational, vocational mindfulness and other skill development, linkages, peer-to-peer supports and provision of a trained adult mentor. **Cost: $200,000/year**

Outcomes:
Increased linkages to mental health services
Decreased recidivism
Increased self-sufficiency (vocational, educational achievements, housing)
Improved individual level outcomes (stable relationships, skill development)
Community rates of substance abuse and other behavioral problems

From Research/Data:

- Most vulnerable TAY[1]:
  - Youth who are impoverished and racial and ethnic minorities (universal prevention)
  - Youth who transition out of foster care (selective, indicated, system-level)
  - Youth in the juvenile justice system – transition age youth with behavioral health problems are at increased risk for involvement in the justice system compared with their peers. The goal would be to decrease recidivism (selective, indicated, system-level).[2]
- There are distinct neighborhoods in Daly City, South San Francisco, Redwood City/North Fair Oaks, Menlo Park and East Palo Alto that hold high concentration of children and youth who enter Juvenile Probation, BHRS and Child Welfare systems and high planning readiness based on community assets (Big Lift districts, community collaboratives and organizations and resource agencies).[3]

	CA	SM
JUVENILE JUSTICE INVOLVEMENT		
Juvenile arrest rate (per 1,000)	5.3	3.9
Juvenile arrests	21,381	277
Recidivism rate	37.3%	36%
Depression/anxiety among youth on court-ordered probation	40-70%	44.3%
AOD use among youth on court-ordered probation		63.6%
FOSTER CARE SYSTEM INVOLVEMENT		
Foster care rate (per 1,000)	5.8	1.8
Re-entry into foster care	11.8%	18.3%

Sources: CA Dept. of Corrections and Rehabilitation (2016), SMC Juvenile Probation Department (2014), Berkeley Center for Criminal Justice (2010)

[1] Berzin (2010). Vulnerability in the Transition to Adulthood: Defining Risk Based on Youth Profiles
[2] Zajac, K., Sheidow, A. J., & Davis, M. (2013). Transition age youth with mental health challenges in the juvenile justice system.
[3] *In Progress, not yet published:* San Mateo County Health System, Human Services Agency, Probation, Office of Education and First Five of San Mateo County (2017). Community Collaboration for Children's Success Analysis of Community Need and Planning Readiness in San Mateo County.

- Research estimates that among juvenile detainees, 19-29.2% had ever thought about suicide, and 11-15% had ever attempted suicide.[4]
- Adolescents who have been in foster care are nearly 2.5 times more likely to seriously consider suicide than other youth, and nearly four times more likely to have attempted suicide.[5]

Promising practices:

- Educational and Vocational Supports[6] -
    - Check and Connect[7] aims to increase students' educational engagement through systematic monitoring of academic performance; building of individualized problem-solving skills; and provision of a trained mentor who partners with the family, school, and community.
    - John H. Chafee Foster Care Independent Living Program[8] – applicable to both foster care and justice involved youth – activities help youth achieve self-sufficiency and include, but are not limited to, help with education, employment, financial management, housing, emotional support and assured connections to caring adults provides support services.
- Neighborhood Drop-in Centers – can provide educational, vocational supports and social supports and linkages to services.
- Re-entry and aftercare – aimed to reduce recidivism and capacity building (Fresh Lifelines for Youth[9]) – can include support services such as job/skills training, leadership and one-on-one mentoring acquisition of housing *and mental health treatment (not PEI).* Most successful when involving treatment.
- Coordination of Care – often part of re-entry programs (Project Connect[10]) link juvenile probation and mental health, facilitate referrals, screening and training of probation officers.
- Policy Recommendations – Mandatory transition planning in the juvenile justice system, trauma-informed care, coordination

SAMHSA Healthy Transitions[11] program focus on outreach and engagement strategies, including the use of peer-to-peer and family supports, social media, and coordination across care delivery systems, including vocational training and higher education.

Mind Body Awareness (MBA) Project[12] provide classes that foster authentic relationships with youth to develop leadership, relationship building, communication, compassion and empathy, mindfulness practices. MBA is offered at San Mateo County Probation, Camp Glenwood.

Transitional Housing Placement Plus (THP-Plus)[13] for former juvenile justice and foster youth provide affordable housing and comprehensive supportive services for up to 24 months to help former foster care and probation youth ages 18 to 24 make a successful transition from out-of-home placements to independent living. THP-Plus is offered by HSA in SMC

Court Appointed Special Advocate (CASA)[14] in SMC pairs abused and neglected foster youth with one consistent, caring volunteer advocate, trained to address each child's needs in the court and the community.

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[4] National Action Alliance for Suicide Prevention (2013) Suicidal Ideation and Behavior among Youth in Juvenile Justice: A Review of the Literature
[5] A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention (2012) National Strategy for Suicide Prevention: Goals and Objectives for Action.
[6] Zajac, K., Sheidow, A. J., & Davis, M. (2013). Transition age youth with mental health challenges in the juvenile justice system.
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[8] Foster EM, Gifford EJ (2005). The transition to adulthood for youth leaving public systems: Challenges to policies and research.
[9] http://flyprogram.org/about/what-we-do/mission-history/
[10] Wasserman et al. (2009) Evaluating Project Connect: improving juvenile probationers' mh/su service access.
[11] https://www.samhsa.gov/nitt-ta/healthy-transitions-grant-information
[12] http://www.mbaproject.org/
[13] http://thpplus.org/about-thp-plus/program-information-history/
[14] http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.5332511/k.7D2A/Evidence_of_Effectiveness.htm

MHSA Prevention and Early Intervention Task Force

Attendance Log

WELLNESS • RECOVERY • RESILIENCE

Last Name	First Name	Oct. 27	Nov. 17	Dec. 8	Organization/Agency or Client/Consumer	
Bier	Mary			X	NCOC	
Bruton	Noelle	X	X	X	BHRS	
Chen	Nancy	X	X	X	BHRS-ODE	
Cornejo	Rocio	X			NAMO/MHSARC	
Demarco	Toni	X		X	BHRS	
Dillon	Narges	X	X	X	Star Vista	
Dobkin	Sarah	X	X	X	Star Vista	
Ehrhorn	Peter	X	X	X	Star Vista	
Espinoza	Jason		X		OHS	
Fones	Donovan	X	X	X	HSA CFS	
Fong	Doug	X	X	X	BHRS	
Fox	Martin	X	X	X	SMC Veterans Coalition	
Henricks	Molly	X	X	X	BHRS	
Hong	Susan	X			Edgewood	
Hughes	Suzanne	X			One Life	
Keene	Hertrudez		X		Life Moves	
Knight	Fernando	X	X		Life Moods	
Littrell	Jenei		X		SMCOE	

MHSA Prevention and Early Intervention Task Force

Attendance Log

WELLNESS • RECOVERY • RESILIENCE

Last Name	First Name	Oct. 27	Nov. 17	Dec. 8	Organization/Agency or Client/Consumer	
Lui	Kristie	X		X	BHRS	
Marroquin	Cindy	X			RTS	
Misslin	Jessica	X	X		Sand Hill Foundation	
Ochoa	Ziomara	X	X		BHRS	
Powell	Angela		X		Star Vista	
Richard	Hope	X			MHA	
Roberts	Emily	X	X	X	First 5 SMC	
Rutherford	Jim	X	X	X	BHRS	
Saven	Betty	X	X	X	MHSARC	
Scott	Raynard	X			Life Moods	
Sorooshian	Velisha	X			Telecare	
Srinivasan	Srija	X	X	X	Health System	
Staurt	Darren	X			MHA	
Stoll	Michael	X			El Centro	
Torrijos	Randy		X		SMC BOS D1	
Valdivias	Luis	X		X	El Centro de Libertad	
Valladares	Eric		X		Star Vista	
Wallace	Michael			X	El Centro de Libertad	

MHSA Prevention and Early Intervention Task Force

Attendance Log

WELLNESS • RECOVERY • RESILIENCE

Last Name	First Name	Oct. 27	Nov. 17	Dec. 8	Organization/Agency or Client/Consumer	
Watkin	Joann	X	X		Puente	
Way	Pat			X	MHSARC	
Young	David	X			BHRS	

APPENDIX 8

COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH
& RECOVERY SERVICES

SAN MATEO COUNTY

MENTAL HEALTH SERVICES ACT (MHSA)

PROGRAM AND EXPENDITURE PLAN TO SPEND REALLOCATED MHSA FUNDS

May 2, 2018

*Pursuant to Assembly Bill 114 and Department of Health Care Services (DHCS) Info Notice No. 17-059

TABLE OF CONTENTS

MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for behavioral health services by imposing a 1% tax on personal income over one million dollars translating to about $25.5 million average for San Mateo County annually in the last five years through Fiscal Year (FY) 2016-17.

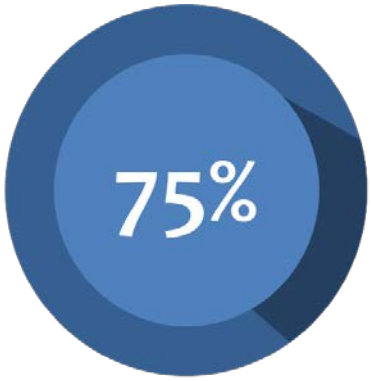
MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities.

◆ Community collaboration ◆ Cultural competence ◆ Consumer and family driven services

◆ Focus on wellness, recovery, resiliency ◆ Integrated service experience

MHSA provides funding for Community Program Planning (CPP) activities, which includes stakeholder involvement in planning, implementation and evaluation. In San Mateo County, MHSA dollars are virtually everywhere in the BHRS system and highly leveraged. MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules.

Community Services & Supports (CSS)



CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance.

Prevention & Early Intervention (PEI)

PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders.

Innovation (INN)

INN funds projects to introduce new approaches or community-drive best practices that have not been proven to be effective.

For a full list of MHSA funded programs by component, visit the San Mateo County MHSA website at www.smchealth.org/mhsa.

ASSEMBLY BILL 114

MHSA legislation requires local Counties to revert (return) funds to the State that have not been spent within the required 3-year time frame for the primary MHSA programs. Due to a lack of guidance on amounts subject to reversion and a process to revert funds, a one-time legislation (AB 114) was enacted allowing Counties to submit a plan by July 1, 2018 for expending their respective funds that are subject to reversion by June 30, 2020. The legislation provides additional provisions that establish a balanced approach to MHSA reversion for both past and future funds including:

- Notification of funds subject to reversion and appeal instructions will be provided.
- Reallocated funds must be spent in the same component (i.e. Prevention, and Early Intervention, Innovation, etc.) originally allocated to.
- The 3-year reversion time frame for innovation funds will commence upon approval of the project plans; minimizing the reversion risk for funds while awaiting approval.
- For funds moving forward, reversion guidelines will be provided in the near future.

SAN MATEO COUNTY IMPACT

San Mateo County Behavioral Health and Recovery Services (BHRS) received notice on December 28, 2017 through Department of Health Care Services (DHCS) Information Notice 17-059 that $2,888,006 is subject to reversion for the MHSA Innovation (INN) component. As of the notice, the San Mateo County MHSA Revenue and Expense Report (RER) for FY 16/17 had not been submitted to DHCS, which meant that FY 14/15 funds subject to reversion were not included. A second notice was received on May 3, 2018 with the adjustment. The current amounts subject to reversion is 1) $3,832,545; and 2) $423,610 in Workforce Education and Training (WET), a one-time funding allocation received in FY 06/07 with a 10-year reversion period.

As of original posting of this reversion plan, San Mateo County expected to submit AB 114 Reversion Plans for three components. Based on DHCS second notice of unspent funds subject to reversion, we will only submit INN and WET reversion plans. All identified reversion funds will be captured in our plan, thus preserving these funds for San Mateo County's needs.

Enclosure 1 5/2/2018

Department of Health Care Services
MHSA Funds Subject to Reversion by Fiscal Year by Component

San Mateo	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ 423,610		$ 423,610
FY 2007-08	$ -	$ -			$ -	$ -
FY 2008-09	$ -	$ -	$ 1,048,126			$ 1,048,126
FY 2009-10	$ -	$ -	$ 246,912			$ 246,912
FY 2010-11	$ -	$ -	$ 793,069			$ 793,069
FY 2011-12	$ -	$ -	$ -			$ -
FY 2012-13	$ -	$ -	$ -			$ -
FY 2013-14	$ -	$ -	$ 786,230			$ 786,230
FY 2014-15	$ -	$ -	$ 958,208			$ 958,208
Total	$ -	$ -	$ 3,832,545	$ 423,610	$ -	$ 4,256,155

$ - No Funds Subject to Reversion
ARER expenditure data is not complete

STAKEHOLDER INPUT

San Mateo County has a local planning structure to engage a broad and diverse San Mateo County stakeholder community. The MHSA Steering Committee makes recommendations to the planning and services development process and assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The Steering Committee helps prioritize strategies for potential funding that then move forward to the Mental Health and Substance Abuse Recovery Commission (MHSARC) for a 30-day public comment period, public hearing and final recommendations to the San Mateo County Board of Supervisors (BoS) for approval before submitting any plans or updates to DHCS.

MHSARC members are all members of the MHSA Steering Committee, commissioners are involved in MHSA planning activities providing input and receiving regular updates as a standing agenda item on the monthly MHSARC meetings. The Steering Committee meetings are open to the public and include time for public comment, including a means for submission of written comments. The MHSA Steering Committee is comprised of over 40 community leaders representing the diverse San Mateo community including behavioral health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non-behavioral health constituencies (education, healthcare, criminal justice, among others).

COMMUNITY PROGRAM PLANNING PROCESS (CPP)

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by the MHSARC. Planning was led by the MHSA Manager and the Director of BHRS and staffed by the Office of Diversity and Equity.

Input for Phase 1. Needs Analysis and and Phase 2. Strategy Development was sought from 31 diverse community groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members.

Additionally, over thirty key interviews were conducted with MHSA funded program contacts including managers and contract agencies. A Pre-Launch session was held with

clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery.

Over 270 participated in two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members, 36 stipends were provided. The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to address this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside.

San Mateo County AB 114 Reversion Plans were developed based the comprehensive CPP process described above. Specific CPP activities for each component are included in the respective AB 114 Reversion Plans.

AB 114 REVERSION PLAN – INNOVATION (INN)

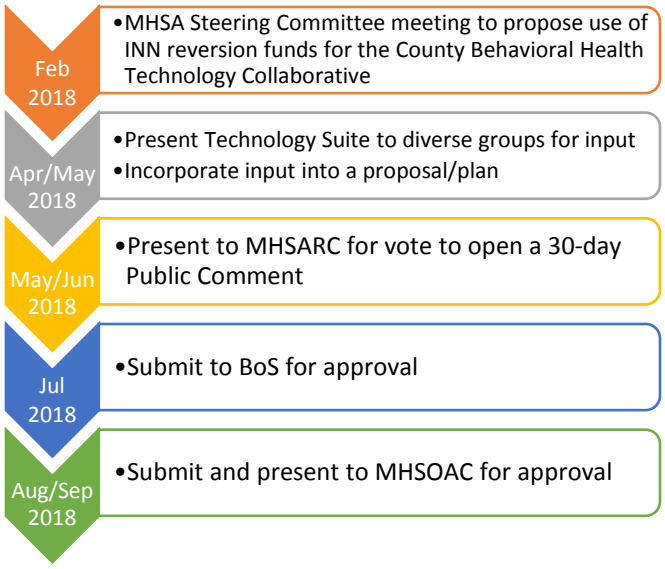
Purpose: to pilot technology based -interventions that support behavioral health and wellness and are intended to; increase access to mental health care; promote early detection of mental health symptoms; and predict the onset of mental illness.

Rationale: On February 16, 2018 the MHSA Steering Committee met and reviewed the AB 114 legislation and requirements. A focus on technology-based interventions was prioritized for the AB 114 Reversion Plan given the following:

- **Un-met need** - technology-based interventions to support isolated adults and transition age youth was prioritized as part of the 2014-17 CPP process and a comprehensive Innovation project development process. Due to capacity and challenges with the technology vendor's ability to pilot their apps with more acute clients, we did not pursue formal approval for the projects.
- **Opportunity** - Los Angeles and Kern Counties proposed a collaborative approach to counties statewide to bring technology-based solutions to behavioral health. Specifically, a Technology Suite of mobile apps was being developed and include:
    - Peer chat and digital therapeutics
    - Virtual evidence-based therapy using an avatar
    - Utilizing passive smartphone data for early detection and intervention

San Mateo County will join the County Behavioral Health Technology Innovation Collaborative, which will allow the development of behavioral health technology interventions that are adapted to meet unique San Mateo County community needs and leverage economies of scale for planning, implementation and evaluation. INN projects require a comprehensive process to develop a plan that meets the INN legislation and guidelines. In an effort to ensure the technology interventions are meaningful, accessible and relevant a comprehensive stakeholder engagement process was initiated in mid-April and will continue through mid-May.

A preliminary INN plan and budget was presented to the MHSARC on May 2, 2018, the MHSARC voted to open to 30-day public comment and conduct a public hearing at close of the public comment period, at which all community input and public comment will be discussed and incorporated into the INN plan as appropriate. See Appendix A. San Mateo County Innovation Plan, public comments received will be updated after the closing of the public comment period on June 6, 2018 and the final plan will be posted on the MHSA website, www.scmhealth.org/mhsa after approval by the State of California Mental Health Services Oversight Committee (MHSOAC).



Total funding amount: $3,846,214, pending expenditure adjustment in FY 15/16 of -$13,669

By joining the County Behavioral Health Technology Innovation Collaborative, San Mateo County is agreeing to contribute to a statewide pool of INN funds. CalMHSA, a Joint Powers of Authority, will serve as a fiscal intermediary and in a project management role to facilitate contracting with technology vendors, support a shared evaluation, and maximize planning outreach and marketing. The budget is divided into four main components:

Core Technology

$992,578*

Future Technology

$1,465,591*

Local Programming

$1,046,500

Statewide Marketing & Evaluation

$367,498

*subject to change pending final negotiations with vendors

Core Technology development includes technology vendor fees (start-up, development, licensure, etc.), subject-matter experts and overhead. This will fund the development of all three generic apps 24/7 peer chat; wellness avatar and use of smartphone passive data.

Future Technology development will be reserved for customization and additions to the generic apps. Subject matter expert(s) will work with the vendors to assure apps are effectively maintained as well as advanced per County needs and goals.

Local Programming category allows us to keep funding locally (outside of what we contribute to CalMHSA) to implement the strategies needed to support culturally responsive implementation and can include training of staff and peer workers, contracting with peer/family support agencies and agencies/groups serving monolingual Spanish and Chinese communities and local outreach and marketing efforts and materials.

Statewide Marketing & Evaluation is statewide promotion at strategic access points and marketing within school systems, social media, public locations, etc. Data collection, analysis and performance monitoring will also be managed by CalMHSA.

Local Fund budget breakdown

Local Funds Items/Personnel	Cost	Total Amount	Budget Justification
Peer and Family partner specialists	150,000/year x 2 years	$300,000	Contract(s) to support peer end-users, face-to-face support services to users, outreach and training of BHRS staff and network providers.
Spanish and Chinese community specialists	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Older Adult peer and family partners	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Youth peer workers	$100,000/year x 2 years	$200,000	Contract(s) to support peer end-users, face-to-face support services to users and outreach.
Local Communications and Marketing	$5,000 / year x 2 years	$10,000	Social media boosts ($500), printing ($500), SamTrans/CalTrain Adcards ($3000), Daily Journal/EPA Times ($400), incentives ($600) / year
Planning and administration	15% of operating x 2 years	$136,500	Coordination of staff training, planning, approval and request for proposals processes, market and development, final reports
	TOTAL	**$1,046,500**	

County Behavioral Health Technology Collaborative budget breakdown

*Vendor rates are in the process of being negotiated and subject to change

SAN MATEO COUNTY TECH SUITE BUDGET

Tech Suite Budget:	2,825,667	Relative Size Unit:	3.34	% of Experts:	5.00%	Total INN Budget:	3,872,167

Total Expenses for Desired Duration of Innovation Project (per annual budget below)									
	Overhead	Experts	Vendor #1 (7 Cups)	Vendor #2 (Mindstrong)	Vendor #3 (CBT/EBP)	Future Apps	Evaluator	Otrch & Mktg	Local Funds
Start-Up			$100,227	$83,522	$33,409	$116,931	$116,931	$33,409	
Development			100,227	100,227	33,409	100,227	0	50,113	
Licensure			100,227	100,227	66,818	167,045	100,227	66,818	
Other	141,283	133,000				1,081,388			1,046,500
Total	$141,283	$133,000	$300,681	$283,976	$133,636	$1,465,591	$217,158	$150,340	$1,046,500

$2,825,667 Total Budgeted Amount per new fee schedule (no local funds)

Expenses	FY17/18	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23	Innovation Total	% of Total
CalMHSA Overhead (5%)		$ 141,283	$ -	$ -			$ 141,283	5.0%
Experts		$ 46,000	$ 46,000	$ 41,000			$ 133,000	4.7%
Vendor #1								
Start-Up Fee		$ 100,227	$ -	$ -			$ 100,227	
Development Fund		100,227	-	-			100,227	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #1 Subtotal		**$ 200,454**	**$ 50,113**	**$ 50,113**			**$ 300,681**	**10.6%**
Vendor #2								
Start-Up Fee		$ 83,522	$ -	$ -			$ 83,522	
Development Fund		100,227	-	-			100,227	
Licensure Fees			50,113	50,113			100,227	
Vendor #2 Subtotal		**$ 183,749**	**$ 50,113**	**$ 50,113**			**$ 283,976**	**10.0%**
Vendor #3								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		33,409	-	-			33,409	
Licensure Fees			33,409	33,409			66,818	
Vendor #3 Subtotal		**$ 66,818**	**$ 33,409**	**$ 33,409**			**$ 133,636**	**4.7%**
Future Apps/Vendors								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		100,227	-	-			100,227	
Licensure Fees			83,522	83,522			167,045	
Local Customization		360,463	360,463	360,463			1,081,388	
Vendor #4 Subtotal		**$ 577,621**	**$ 443,985**	**$ 443,985**			**$ 1,465,591**	**51.9%**
Vendor #5: (Evaluator)								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		-	-	-			-	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #5 Subtotal		**$ 116,931**	**$ 50,113**	**$ 50,113**			**$ 217,158**	**7.7%**
Vendor #6: (Outreach & Marketing)								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		50,113	-	-			50,113	
Licensure Fees			33,409	33,409			66,818	
Vendor #6 Subtotal		**$ 83,522**	**$ 33,409**	**$ 33,409**			**$ 150,340**	**5.3%**
Subtotals								
Start-Up Fee		$ 484,430	$ -	$ -	$ -	$ -	$ 484,430	17.1%
Development Fund		384,203	-	-	-	-	384,203	13.6%
Licensure Fees		-	300,681	300,681	-	-	601,362	21.3%
Local Customization		360,463	360,463	360,463	-	-	1,081,388	38.3%
Vendor Subtotals		**$ 1,229,096**	**$ 661,144**	**$ 661,144**	**$ -**	**$ -**	**$ 2,551,383**	**90.3%**
TOTAL EXPENSES		**$ 1,416,380**	**$ 707,144**	**$ 702,144**	**$ -**	**$ -**	**$ 2,825,667**	**100.0%**

AB 114 REVERSION PLAN – WORKFORCE EDUCATION AND TRAINING (WET)

Purpose: to continue the current WET plan budget through FY 17/18, which includes implementation of targeted recommendations from the 10-Year WET Impact & Sustainability Report released February 2018, see Appendix B.

Rationale: WET was designated one-time MHSA allocation to Counties with a 10 year reversion. $3,437,600 was allocated to San Mateo County. BHRS is prepared to sustain the most effective and impactful elements of this component. Continued investment in WET is critical to supporting BHRS' strategic initiatives and priorities, and for creating a system of care that is responsive to MHSA core values of building community collaboration, cultural humility, consumer and family driven services, a focus on wellness, recovery, and resilience, and an integrated service experience. To prepare for sustainability of WET, an independent consultant was hired to support a comprehensive CPP process for WET and included the following:

- Survey for Staff, CBO Partners, Contractors
- Survey for Cultural Competency Stipend Intern Program Participants
- Interviews of Cultural Competency Stipend Intern Program Participants
- Survey for Lived Experience Academy Participants
- Interviews of Lived Experience Academy Participants
- Listening Session with the Lived Experience Education Workgroup (LEEW)World Café with the Workforce Development and Education Committee

Materials reviewed also included the LEEW Enhancement report, training logs, pre/post-tests and evaluations collected at trainings, budgets, WET and MHSA plans and annual updates, etc. A WET 10-year Impact & Sustainability Report was published in February 2018, which included impact analysis and a vision for WET and recommendations based on a comprehensive stakeholder input process.

According to a letter provided to CBHDA by the California Department of Mental Health, WET funds received in FY 06/07 and FY 07/08 revert on 2017 and 2018 respectively. In the DHCS Info Notice No. 17-059, we were informed that WET funding allocated in FY 07/08 expired FY 16/17 as it includes the year when funding was made available. Given this discrepancy we will use unspent funds to complete the FY 17/18 WET program plan implementation.

Total funding amount: $ 423,610

BHRS Workforce Education & Training FY 17/18 Budget

Workforce Staffing and Support • WET Coordinator ($126,025) • Program Specialist ($59,133) • Office Specialist ($48,526)	$233,610
Trainings for System Transformation • Cultural Humility • SOGI • Harm Reduction/Motivational Interviewing • Family Therapy • Trauma-informed Care • Cognitive Behavioral Therapy • Recovery 101 • ASIST • Law & Ethics (Behavioral Health) • Managing Assaultive Behavior • Dialectical Behavior Therapy • Provider Vicarious Traumatization/Self Care/Wellness Trainings • Training Logistics (space rentals, etc.)	$100,000
Trainings by/for Consumers/Family Members • Voices of Recovery-WRAP • Human Trafficking • HEI Training Support • Peer Worker 101 • Advocacy Training • Provider Vicarious Traumatization/Self Care/Wellness Trainings • Conferences/Trainings	$55,000
Behavioral Career Pathways/Financial Incentives • CSIP/ODE Stipends • Lived Experience Scholarship • BHRS Clinical Internship Planning & Implementation • APA Continuing Education (CESA application)	35,000
Total	**$423,610**

30-DAY PUBLIC COMMENT & UPDATES TO THE PLAN

Pursuant to Assembly Bill 114 and Department of Health Care Services Info Notice No. 17-059, the San Mateo County Program and Expenditure Plan to Spend Reallocated MHSA Funds was posted on the San Mateo County website and presented to the MHSARC on May 2, 2018. The MHSARC voted to open to 30-day public comment and conducted a public hearing on June 6, 2018 at close of the public comment period. Following are the key updates made to the proposed plan and public comments received during the 30 day public comment period. The final steps before commencing implementation of the plan include a presentation to the Board of Supervisor for adoption of the plan and to the Controller to certify expenditures, within 90 days of posting of the plan on May 2nd. For the INN component plan, a final approval by the State of California Mental Health Services Oversight Committee (MHSOAC) is required.

Key updates to the plan:

- Adjusted reversion amounts and budgets for INN and WET components
- Removed PEI reversion plan, no PEI dollars are subject to reversion
- Clarified WET reversion plan to include use of unspent funds for FY 17/18 expenditures
- Added Appendix A: *San Mateo County Innovation Plan: Increasing Access to Behavioral Health Services and Supports Utilizing a Suite of Technology-Based Behavioral Health Interventions*
- Added Appendix B: *10-Year WET Impact and Sustainability Report*

Public comments received:

**This section to be updated following the closing of the 30 day public comment period and public hearing on June 6, 2018. The responses to the technology questions will also be updated, before requesting BoS approval, based on any additional information we receive from technical assistance providers and counties that are beginning implementation of the innovation.*

<u>MHSARC Opening of the 30-Day Public Comment Period (5/2/18)</u>

Q: Behavioral Health/Mental Health has very strict legal protection in CA as far as what records can be subpoena and HIPAA, what's being looked at to capture these apps in that type of legal protection? The more you change the language from mental health the more you'll have the argument against those legal protections. What is being considered in that regard?

A: We are talking to CalMHSA as the technical assistance and project management entity and we will ask how HIPAA shows up, what does that look like, what data can you have and not

have. They are free applications and they are not supposed to replace clinical treatment so there might be different legislation attached to that because it is not treatment.

Q: Let me clarify…thinking less along the lines of HIPAA and more along the lines of…Let's say you're in a car accident and you can subpoena someone's medical record if you're the plaintiff but you can't get the mental health records but you can subpoena a Fitbit and you can subpoena Facebook. What type of protections would there be around these types of apps that would prevent the information (which is extremely sensitive) and mental health related in order for them to fall under that legal protection?

A: We will ask CalMHSA and other counties Los Angeles County and Kern County, which have started implementation, how they are addressing this issue.

Q: I'm assuming the app will be available on the app store and google play. How would people get access to it and is it open to the public for use?

A: it's free and its open to the public. I don't know where it can live yet, wherever folks can get apps.

Q: Question regarding the chat. Is that like Facetime and is there a limit? Because I speak only Chinese and will I understand the other participants? I don't want people to see me, how does that work? Is there an age limit for groups, are they only for adults, how do they verify the age? Can a 10-year-old pretend to be 30? Do we see the people in the group or is it typing?

A: If we don't have an answer to your question, we will catalog it. We will never answer a question that we don't have the answer to. It's typing, more like text messaging on the online platform. Most of the groups are broken down by age. I don't know how they would verify age of someone using the service. You also asked about language availability and that is something we have heard throughout the county making sure there's language availability in the threshold languages also cultural relevance/sensitivity and we will pursue Chinese translation for any prioritized apps by the Chinese monolingual community.

Q: Is there an entry level age? Does someone have to be 18 or older to use because if you drop it down to youth it becomes even more dicey as far as privacy goes.

A: We've heard some parents raise concerns about their young children having access to being on the internet too much and not being able to monitor their time/activity. That was one of the recommendations is that the county decide the age threshold.

Q: Who controls the content that's built on this, that's so complicated to do. Are you building on something that's already in place?

A: Yes, we are building on something that's in place as far as the three technology interventions available for customization. We also have the opportunity to develop new apps and will work with the vendors on this. This question has come up at previous meetings. While we don't have the full answer right now, it's important that we are asking these questions because these are questions we will bring up when we begin working with the vendors. The County has not selected a vendor.

Comment: Our technology requires that we get in front of this, early intervention. As you look at age thresholds it might be appropriate that you consider that we have people as young as 14 in our program.

Response: Thank you, we will take that into consideration for customization of the app.

Q: Is Noni [avatar for virtual-based therapy] available 24 hours?

A: Yes, the website is available 24 hours, 7 days a week. That's one of the reason for doing this app is to have something available 24 hours for people who are isolated. With the live Peer Listeners being nationwide, there's always someone to talk to on the app.

Q: How are the Peer Listeners screened who are doing that job? How they screened? How are they trained? How are they monitored?

A: The Peer Listeners go through a training and also if the Peer Listener is not a fit for someone, they can speak with someone else.

Q: Will the 24/7 service link to a help access line?

A: That has been a request from this community. That consideration will be raised so that it can be a prioritized feature of the app.

Q: How is this going to work for people who are isolated, especially if they don't have iPhones or computers? Has the county thought of providing all of that? Because that will be a challenge for some folks.

A: The county will need support around how to reach folks who are isolated. Some suggestions have been to go to places where people are. Not the places you think they, go to the places you know they are. This might not be the best way to engage everyone. If you are someone who doesn't have access to the internet or a smart phone, it might not be the best fit for you. It's just one of many options.

Comment: Maybe law enforcement and emergency responders can roll it out to people. They see people that others don't.

Response: Thank you, we will add that to the implementation considerations.

Q: You talked about an evaluation process, what does that like?

A: The part of the evaluation process that is in the plan is around gathering data, either doing focus groups or surveys. One suggestion was to put a survey in the app so people can interact and say how it is working for them so that data can come back. Additionally, as part of the statewide collaborative, an evaluation consultant has been identified and will support evaluation plan and tool development.

Q: With Wellness tools, does that include pharmacy integration? Is there a way for it to link into have you picked up your meds or reminder to pick up your meds, as well as taking and refilling the meds?

A: This is a consideration we can take into the process of customizing this app

Q: Will the chat box have EBP type tools?

A: This is a consideration we can take into the process of customizing this app

APPENDIX A: SAN MATEO COUNTY INNOVATION PLAN

San Mateo County MHSA Innovation Plan
Increasing Access to Behavioral Health Services and Supports Utilizing a Suite of Technology-Based Behavioral Health Interventions

I. Project Overview

1). Primary Problem

a) What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

With a population estimate of approximately 764,797, San Mateo County is one of the larger suburbs on the San Francisco Peninsula. Santa Mateo County is also home to a diverse range of races and ethnicities.[1] White residents comprise the largest proportion of residents (39.5%), followed by Asian or Pacific Islander (27.8 %) and Hispanic or Latino residents (24.8%). More than 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well," according to the 2011-2015 Census estimates. As of January 1, 2015, San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese) and Tagalog.

It is important to note the diversity of the County because each community experiences different culturally-specific challenges in their ability to access the mental health services they need. During San Mateo County's FY 17-20 Mental Health Services Act (MHSA) Three-Year Community Program Planning (CPP) process and through a series of stakeholder meetings held in April and May of 2018, stakeholders voiced a need for new approaches to connect and engage mental health clients/consumers to services and supports, especially for **isolated older adults**, **transition-age youth in crisis** and underserved racial and ethnic communities. Specifically, the **Spanish and Chinese monolingual communities** within San Mateo have been identified as un-, under-, and inappropriately served groups and prioritized through the CPP process. Some of the identified barriers to accessing mental health services for these diverse communities include:

- stigma of mental illness,
- isolation paired with geographic and transportation challenges,
- and services not being culturally relevant and/or linguistically accessible.

Additionally, the MHSA CPP process revealed that these persistent barriers also make service engagement and participation particularly difficult for transition-aged youth (TAY) in crisis and older adults with more severe symptoms that may result in isolation.

[1] https://datausa.io/profile/geo/san-mateo-county-ca/#category_age

b) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Los Angeles and Kern Counties initiated a collaborative approach that invites counties statewide to bring technology-based solutions to behavioral health, forming the County Behavioral Health Technology Collaborative. Given that San Mateo County's Behavioral Health and Recovery Services (BHRS) prioritized technology innovations in the FY 14-17 planning process and reinstated this priority in the most recent FY 17-20 planning process, San Mateo County joined the County Behavioral Health Technology Collaborative. This project plans to utilize technology-based services and supports to increase access and linkages that have never been tested by a collaborative effort among county public mental health systems.

The purpose of this innovation concept is to:

- Create and advance a suite of technology-based mental health solutions to detect, recognize, and acknowledge mental health symptoms in a timely manner;
- Reduce stigma associated with mental health issues while increasing access to care;
- Increase purpose, belonging, and social connectedness of individuals served; and
- Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery.

San Mateo County saw this Innovation project as an opportunity to leverage the subject matter expertise, app development management and collaborative learning approach with the goal to reach mental health clients not currently connecting with the public mental health system with apps that are responsive to specific cultural and linguistic needs, as well as connecting clients/consumers who find it challenging to receive or access mental health services in traditional office settings.

Specifically, San Mateo County sought the opportunity to leverage technology to:

- Reach and engage four priority populations with mental health services and supports
- Reduce the burden of transportation by providing alternative methods for engaging in recovery and wellness activities that do not require travelling to a physical location, such as an office or clinic.

2). What has been done elsewhere to address your primary problem?

a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

Across the state and nation, the broader mental health community has designed, implemented, and evaluated a number of initiatives that seek to address issues that impact service engagement and participation for youth, older adults, and culturally and linguistically isolated communities. Despite a multitude of investments to implement cultural-specific mental health practices that reduce disparities; grow a bilingual/bicultural mental health workforce that is reflective of communities being served; and transcend the barriers of transportation, geography, and the reliance on in-person services; disparities in service access and participation remain persistent issues to be addressed.

San Mateo County opted in to the County Behavioral Health Technology Collaborative led by Los Angeles and Kern Counties, which aims to bring interactive technology–based mental health solutions into the public mental health system through a highly innovative set or "suite" of mobile apps. Los Angeles and Kern Counties have conducted a review of the field of mental health and found that utilizing a suite of technology-based mental health services has never been used in a public mental health care setting or in a multi-county collaborative setting. Because the use of technology-based interventions in mental health is an emerging field, there are many opportunities to pilot these innovative approaches to close gaps in the existing literature and knowledge about promising practices, including:

- Practices for mitigating limitations in access to technology or internet service for low income clients/consumers;
- Practices to integrate technology-based interventions into existing in-person/community based mental health services with providers;
- Negotiating use of technology while complying with data security and HIPAA requirements of a public mental health system; and
- Launching a county-wide technology intervention suite tailored to meet the needs of the County's unique target populations.

San Mateo County's specific investments seek to leverage the multi-county collaborative efforts and further seek to understand the extent to which the "tech suite" engages and supports the four identified priority populations. This contribution may support other counties across the state to consider if technology-based solutions may support engagement in recovery and wellness with other un, under, and inappropriately served groups beyond the four identified by San Mateo County. By opting in to the County Behavioral Health Collaborative, San Mateo County has learned from counties taking the lead in incorporating emerging research into their pilots of innovative technology solutions. The Collaborative shared information with the County

about the breadth and capabilities of technology options available. The County then conducted preliminary literature reviews to identify practices and approaches in the research on technology-based interventions. While platforms and interventions differ, and the specific options chosen will be informed by input gathered during the CPP, emerging research suggests that technology-based interventions have the potential to increase access to mental health services and support ongoing recovery for clients/consumers not already engaged in services.

At this time, there appear to be no other public mental health systems using a collaborative model to roll out suites of innovative technology-based interventions to clients/consumers, and as a result, there is no information about this delivery model in the literature. The lack of information presents an opportunity for the proposed pilots to add to the knowledge of utilizing technology-based practices in a public mental health system context. Additionally, the National Institute of Mental Health (NIMH) has identified several gaps in research that require additional investigation. Regarding whether these interventions are effective, NIMH points out that some recently-developed technology-based interventions are not yet supported by scientific evidence that they work or that they are as effective as traditional methods. There is also a lack of information about which apps work best for different populations based on their needs. Addressing HIPAA and other data security concerns are a high priority and best practices in this area are still being developed.

3). The Proposed Project

Describe the Innovative Project you are proposing. Note that the "project" might consist of a process, the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may wish to identify how you plan to implement the project, the relevant participants/roles, what participants will typically experience, and any other key activities associated with development and implementation. Provide a brief narrative overview description of the proposed project.

a) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

b) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

Project Purpose

The purpose of this project is to determine if a suite of technology-based mental health apps will

1) Connect transition-age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services;
2) Improve access to mental health services and supports; and
3) Improve wellness and recovery outcomes for those who engage with the mobile apps.

The project aims to connect, increase access to and regular engagement with mental health services and supports for individuals who are struggling to connect with traditional mental health supports (for a myriad of reasons) through increasingly familiar technology devices, like smart phones, tablets, and computers.

Project Description

San Mateo County and its collaborative county partners will utilize a suite of technology-based mental health services and solutions. Through active online engagement, this project will identify those in need of mental health services and offer innovative techniques and approaches to engagement in recovery and wellness activities. This project also serves to reduce the stigma associated with mental health treatment by using virtual engagement strategies. The County plans to adopt interventions within the three domains that are part of the collaborative technology suite depending on specific needs as identified by the four target groups.

- **Online Peer Chat and Support Groups:** Online Peer Chat and Support Groups utilize online chat capability designed to engage, educate, assess and intervene with individuals experiencing symptoms of mental illness. Though research on online peer chat and support has increased in recent years, many researchers concluded that there is an overall lack of evidence on the effectiveness of online peer chat on consumer outcomes in general and among different subpopulations. However, existing research suggests that people with serious mental illness who accessed online peer support experienced greater social connectedness and learned strategies for coping with daily challenges of living with mental health issues. Online peer support was also found to show promise as an intervention to assist clients/consumers in gaining insight about their situation and developing a sense of empowerment and hope.

- **Virtual Therapy Using an Avatar:** This range of apps offers virtual manualized evidence-based interventions delivered via an avatar powered by artificial intelligence (AI), such as mindfulness exercises and cognitive behavioral or dialectical behavior interventions delivered in a simple, intuitive fashion. For apps within this category of interventions, research varies widely depending on how the intervention was designed and the mental health issues clients/consumers were experiencing at the time of evaluation. For example, some virtual therapy models are specifically designed to support clients/consumers with anxiety disorders. Interventions also vary along a spectrum of automation from providing therapy services where a clinician is represented as an

avatar, to an avatar completely driven by AI with no human involvement. While some research suggests that avatar-based mental health interventions are promising, researchers view this as a nascent area of research and call for additional studies.[2]

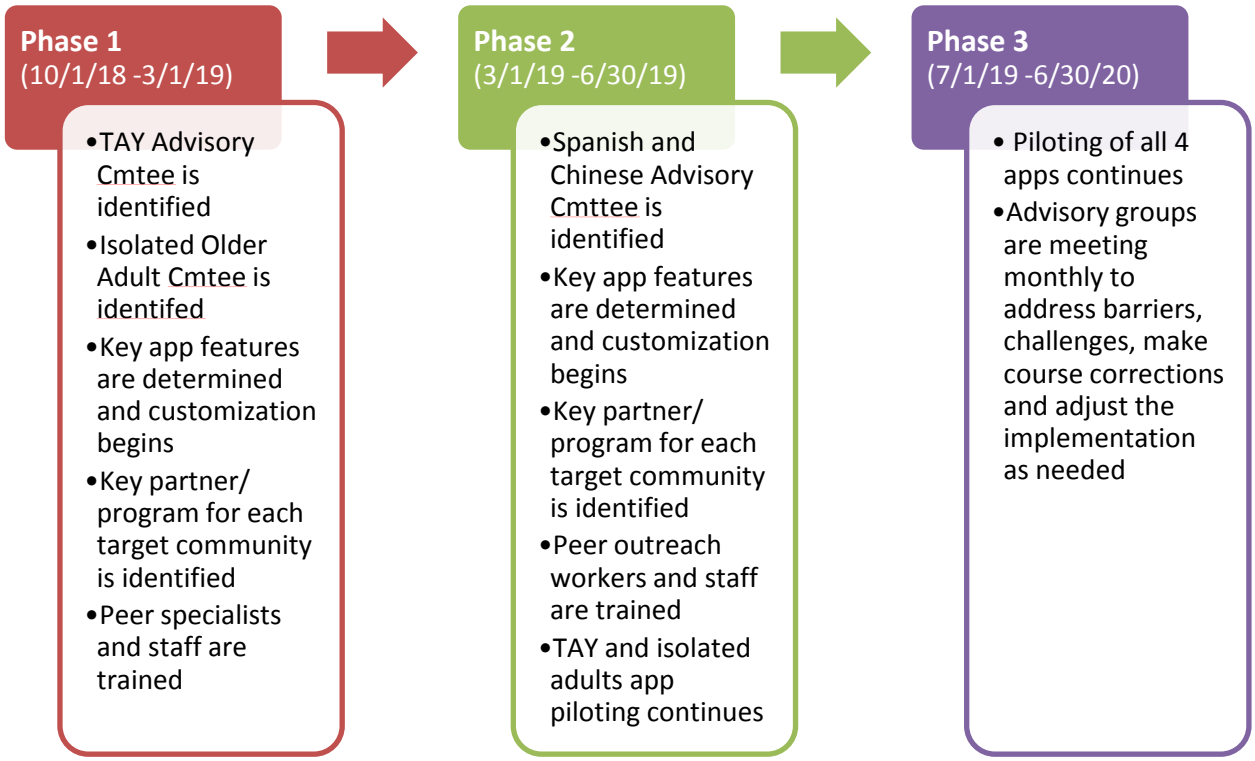
- **Digital Phenotyping:** The proposed plan includes an interactive approach to digital phenotyping where the technology is able to monitor cell phone usage (passive data) and interact with the user through a pop-up chat function to promote increased user understanding of thought and feeling states. Web-based analytics then inform targeted communications and recommend interventions. Digital phenotyping can detect subtle social or behavioral red flags clients/consumers experience between outpatient appointments and evaluations, which may indicate early onset of serious symptoms. For example, decreased communication, motor activity, or changes in speech or sleep patterns may be a harbinger of relapse for some clients/consumers. Preliminary research has found that using digital phenotyping in a mental health context shows promise as a method to identify symptoms early and prompt intervention before clients/consumers escalate to crisis or psychiatric relapse, thus averting the disruption, cost, and potential tragedy associated with repeat crises.[3]

Project Implementation

San Mateo County will take a measured and client-centered approach to the implementation of these technological apps, as described below. Based on initial findings from the Innovation CPP Process, the following is a suggested phased approach to app development and customization based on readiness (key stakeholders engagement, current programs and infrastructure to support implementation) from each of the target communities.

[2] Rehm, C. I., Foenander, E., Wallace, K., Abbott, J.-A. M., Kyrios, M., & Thomas, N. (2016). What Role Can Avatars Play in e-Mental Health Interventions? Exploring New Models of Client–Therapist Interaction. Psychiatry. https://doi.org/10.3389/fpsyt.2016.00186

[3] Onnela, J.-P., & Rauch, S. (2016). Harnessing Smartphone-Based Digital Phenotyping to Enhance Behavioral and Mental Health. Neuropsychopharmacology, 1691–1696. https://doi:10.1038/npp.2016.7



1. Conduct outreach and recruitment for Tech Suite Advisory Committees. This project will convene an advisory committee per target community composed of mental health clients/consumers, family members, community members, culturally specific providers, and mental health providers to help design and oversee the Tech Suite implementation rollout and evaluation. The County will work to identify key stakeholders within each community for recruitment, and reach out to these parties communicating a clear vision, purpose, and role for group members with explicit time commitment and expectations.

2. Identify and customize most appropriate apps to respond to specific needs of San Mateo target communities. Initial findings from the Innovation CPP process suggest that some apps may be better suited to support and address key issues with each community. For example, Youth expressed discomfort with "serious" mental health support and suggested that youth would be more open to trying apps they perceived as "low-key" and casual. Some youth were interested in less intensive apps that are useful for one-time stress reduction (such as an app that provides prompt for breathing exercises to navigate through moments of panic or anxiety). Given this specific input, the Virtual Therapy app may be most appropriate. However, for transition age youth in crisis (target population), the app should be able to connect youth to local crisis line and other resources. Further considerations brought up during the CPP process is that the County will need to develop a crisis response plan and communicate it clearly to all

using the apps so that youth will connect with crisis services when needed. Lessons learned from other counties involved in the Collaborative will also help customize Tech Suite apps specifically for a San Mateo County user audience.

3. Create a strategic approach with Tech Suite Advisory Committee to access points to expose individuals to technology-based mental health solutions, including:
    - Engaging the school systems, including colleges and universities, to promote use of services and supports
    - Partnering with those providing services and supports to at-risk Transition Aged Youth, including working with mental health providers, social workers, and foster-care advocates who frequently interface with young adults.
    - Leveraging social media, public websites and other media to promote use of technology-based services
    - Working with mental health organizations (National Alliance for Mental Illness) and culturally-specific community health workers (Promotores), the LGBTQ Center, peer-based community learning centers, and local support groups to promote use of technology-based services
    - Collaborate with those providing services to older adults at risk for isolation, including working with senior apartment complexes, senior centers, and faith-based organizations who outreach to seniors
    - Work with local public locations, including agencies, libraries and other resources to promote technology-based use
    - For isolated people and those who are not engaged in services fully or at all, it will be important to conduct outreach in places they already go to and with people they already interact with such as faith based communities; salons/barber shops; grocery stores; Laundromats, libraries, hospitals/Clinics/Primary health care facilities; case workers; law enforcement and first responders, etc.

4. Identify peer/family specialists to conduct training of BHRS staff and community partners. This will provide an overview training to BHRS providers, contracted providers, peers specialists, and other key stakeholders on how to access the apps, HIPPA implications, and crisis roles and responsibilities. Trainings will be structured to provide a didactic overview of materials, discussion, and a space for demonstrations of the apps. Program staff and peers will be ready to support clients in use of apps and clinical integration as relevant.

5. Early phase of evaluation plan is completed. This will include the initial prep phase and developing of tracking processes to support daily monitoring of activities, challenges and identification of any needed course corrections.

6. Information security is in place, implement technology-based mental health interventions designed to engage, educate, assess, and intervene with individuals experiencing symptoms of

mental illness. San Mateo will roll out the technology suite for transition age youth and isolated seniors first. Customized services will include:

- Virtual peer chatting with trained and certified peers with lived experience
- Virtual support communities for populations including those experiencing behavioral health-related symptoms and family members of those with mental illness
- Virtual chat options for parents of children and adults receiving behavioral health care
- Virtual interventions like mindfulness exercises and Dialectical Behavior Therapy (DBT)
- Referral process for those requiring additional in-person services or supports through the San Mateo Behavioral Health and Recovery Services System of Care.

7. Data collection and analysis of outcome evaluation of all elements of the project, including:
   - Increased wellbeing of those utilizing services
   - Reduced duration of untreated/undertreated mental illness
   - Increased ability for users to identify cognitive, emotional and behavioral changes and actively address them
   - Increased quality of life, measured objectively and subjectively by both the user and by indicators such as activity level, employment, school involvement, etc.

Qualifications for Innovative Project

In accordance with the three specified approaches in CCR, Title 9, Section 3910 (a), this project: Introduces a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Why is this Innovative?

This project will use technology-based services and supports to engage populations not previously engaged through outreach and education efforts. While private industry technology-based services have been used in public health institutions, technology-based services and supports to increase access and linkages have never been tested by multiple public mental health departments across several counties.

Why is this an appropriate approach for San Mateo?

San Mateo County plans to use technology as a means of reaching and engaging those with mental health issues, which may be particularly appropriate and helpful for unserved and underserved populations, which were previously unidentified through culturally-relevant platforms.

4). Innovative Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing

that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.

b) If you are applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?

Through the utilization of technological apps, this project seeks to engage mental health clients/consumers in mental health services, promote social connectivity with peers, and mitigate the barriers of stigma for culturally specific communicates by creating culturally responsive options to mental health services. This Tech Suite Innovation Project is a County priority, because the MHSA process identified that despite various approaches to outreach there are still underserved populations struggling to engage in services. These specific populations were identified as: (1) isolated older adults, (2) Transition Aged Youth in crisis, (3) Latino mental health clients/consumers, and (4) Chinese mental health clients/consumers. Mental health issues can be compounded by symptoms and experiences of isolation. Clients/consumers who struggle to connect to in-person traditional services either because of mental health stigma, transportation barriers, or other difficulties still deserve venues to get help. Over the years, technology has advanced and can be customized to meet the needs of these isolated community members.

This project seeks to test out use of a set of technology tools to provide alternative mechanisms for support to individuals who may need mental health care and to reach these individuals for whom San Mateo has not been successful in identifying or engaging through methods that are relevant to these specific populations. This project will strengthen and expand the County's use of peer support and culturally responsive technology apps through a virtual service delivery that has never been used by BHRS before.

5). Learning Goals/Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.

a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The Tech Suite pilot is intended to provide an opportunity for the County to reach *three main learning goals*:

1. Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services;

2. Does engaging with the apps promote access to mental health services and supports?

3. Does engaging with the apps effectively promote wellness and recovery?

The County prioritized these goals in order to respond to the needs identified through the various community planning initiatives it has conducted and to utilize MHSA Innovation funding to expand access to mental health services for unserved and underserved community members. Learning within the field of technology-based mental health interventions is developing as the technology emerges and people are beginning to use it and provide feedback. These learning goals guide the County in contributing to the knowledge in this nascent field of research and practice.

6). Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your "sample size") required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:

- ***a) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?***
- ***b) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.***
- ***c) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?***

d) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?

e) What is the preliminary plan for how the data will be entered and analyzed?

Target Population

The target participants include those who were identified as unserved or underserved during the FY 17-20 Mental MHSA Three-Year CPP and through a series of stakeholder meetings held in April and May of 2018: isolated older adults, transition-age youth in crisis, and monolingual Chinese and Spanish speaking residents. The Tech Suite will be evaluated using a mixed methods approach to meet the learning goals.

Learning Goal 1: Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services? The evaluation will use surveys embedded in the apps to determine the extent and level of engagement among the target populations.

Learning Goal 2: Does engaging with the apps promote access to mental health services and supports? Qualitative data will be used to better understand what is effective at promoting engagement or what can be improved to improve engagement.

Learning Goal 3: Does engaging with the apps effectively promote wellness and recovery? Qualitative analysis will be used to provide context for quantitative data and develop an understanding of clients/consumers' experience and perspectives on using the apps and whether the apps supported their wellness and recovery. Quantitative data will be gathered specifically for the digital phenotyping app by the statewide evaluation vendor, other data may be available through surveys that assess self-reported wellness outcomes.

Data sources to support the evaluation will include:

- **Participant Survey:** The County will gather quantitative data through surveys on the apps that invite clients/consumers to rate their wellness and recovery.
- **Focus Groups and Interviews:** The County will gather qualitative data through a process of interviews and focus groups with the target populations about their experience using the apps and their perspective on the extent to which they engaged in the apps and the apps supported their wellness and recovery, access to both in-person and online services and to understand the level of engagement of the target participants due to the participation in Tech Suite services.
- **App Usage Data:** Evaluation data will be gathered about who is engaging in online services through the apps and their level of engagement to understand how the Tech Suite is engaging target participants.

A Statewide evaluator has been selected to support statewide evaluation goals, phenotyping data and app usage data. It is still to be determined if the statewide evaluator will be able to

support local learning goals. During the INN CPP local process, stakeholders were concerned about the possibility of further isolation of individuals using the apps and the importance of not replacing in-person interaction and services. It was due to this feedback that we added Learning Goal 1. The County will contract an independent evaluator if needed to ensure that local stakeholder questions and learning opportunities are supported. The Tech Suite Advisory Committee will inform the evaluation process. The committee will be composed of stakeholders required by MHSA as well as representatives from the target population communities. The Advisory Committee will meet quarterly to have opportunities to review and engage with the data.

7). Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BHRS Managers are assigned contract management responsibilities and meet with contractors on a monthly basis initially and as things rollout on a quarterly basis to discuss progress, challenges and support needed. The MHSA Manager with support from an MHSA project coordinator will oversee all MHSA program evaluation deliverables and work with evaluation contractors on a regular basis. The Tech Suite Advisory Committee will inform the evaluation process.

II. Additional Information for Regulatory Requirements

1). Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

a) ***Adoption by County Board of Supervisors. Please present evidence to demonstrate that your County Board of Supervisors has approved the proposed project. Evidence may include explicit approval as a stand-alone proposal or as part of a Three-Year Plan or Annual Update; or inclusion of funding authority in your departmental budget. If your project has not been reviewed in one of these ways by your Board of Supervisors, please explain how and when you expect to obtain approval prior to your intended start date.***

b) ***Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA). Welfare and Institutions Code (WIC) 5847(b)(8) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements."***

c) Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA. WIC 5847(b)(9) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act." Of particular concern to the Commission is evidence that the County has satisfied any fiscal accountability reporting requirements to DHCS and the MHSOAC, such as submission of required Annual Revenue and Expenditure Reports or an explanation as to when any outstanding ARERs will be completed and filed.

d) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.

The INN Project proposal was presented to the San Mateo County Board of Supervisors as part of the MHSA FY 2017-2020 Three-Year Plan and Annual Update on August 7, 2018. The resolution authorizing the approval of the MHSA Three-Year Plan and Annual Update, AB114 Reversion Plan and Innovation Plan and the County Compliance and Fiscal Accountability Certifications of the plans will be submitted to the MHSOAC as indicated.

2). Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community. Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

During San Mateo's FY 17-20 MHSA Three Year Planning Process, the Department gathered input at existing County meetings and targeted input sessions, through online surveys, and through formal public comment. In the spring of 2017, San Mateo hosted two public meetings, a CPP Launch Session and a CCP Prioritization Session. Over 270 participants were in attendance, and 156 demographic sheets were collected; 37% identified as clients/consumers and family members. Participants represented groups set forth in the MHSA legislation, including homeless individuals, law enforcement, mental health clients/consumers and family members, mental health providers, health and social service providers, and individuals with disabilities. The racial and ethnic diversity of the community was reflected in the planning process, see Appendix 1.

From these community engagement activities, San Mateo County learned about the specific populations being un/underserved as (1) isolated older adults, (2) transition aged youth in crisis (TAY), Latino mental health clients/consumers, and Chinese mental health clients/consumers.

In April and May of 2018, San Mateo began a Community Planning Process that included 14 community meetings aimed to (1) inform community members about proposed the Technology Suite INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about the Innovation Projects and the Mental Health Services Act to ensure their ability to meaningfully participate. See Appendix 2 for all materials developed for stakeholder engagement. The stakeholder groups included were:

AB 114 Innovation Plan Community Forum Schedule

Session	Date	Time	Location
Coastside CSA	17-Apr	8:30am	225 S Cabrillo Hwy. Halfmoon Bay, 1st Floor Conference Room
Peer Recovery Collaborative	17-Apr	12:00pm	210 Industrial Road San Carlos, Suite 102
Northwest/Northeast CSA	17-Apr	3:30pm	725 Price St Daly City
Youth Commission	26-Apr	6:30pm	Closed session
Family Partners & Peer Workers	30-Apr	2:00pm	Closed session
Monolingual Spanish	1-May	6:00pm	802 Brewster Ave Redwood City
Older Adults	2-May	10:00am	2000 Alameda de las Pulgas, San Mateo, Room 208
MHSARC – Public Comment	2-May	3:00pm	225 37th Ave. San Mateo, Room 100
South County	3-May	10:00am	Friendship Center, 802 Brewster Ave, Redwood City
Central CSA	3-May	3:30pm	2000 Alameda de Las Pulgas, San Mateo, Room 201
Diversity and Equity Council	4-May	11:00am	609 Price Ave. Redwood City, Room 107
BHRS Management	8-May	9:00am	Closed session
Monolingual Chinese	8-May	11:00am	2000 Alameda de las Pulgas, San Mateo, Room 208
East Palo Alto CSA	10-May	1:00pm	2415 University Ave , East Palo Alto, Community Room

Feedback from the initial five stakeholder meetings included the following. Stakeholders expressed an interest in utilizing technology to help these isolated communities, and made suggestions broken down in the following categories.

Outreach and Engagement

- Tailor outreach and educational materials about the apps to specific target populations.
- Develop materials that can be advertised on bus stops, television, tabling events, and sent out in mailers.

- Incentivize/ leverage partnerships with monolingual communities, community colleges, schools, peer mentors, case managers, hospitals, Institute on Aging, primary care health providers, and other key stakeholders that can support outreach.
- Include representatives from these diverse target populations in outreach and engagement planning and application implementation.
- Ensure outreach and educational materials are accessible and available in the County's threshold languages

Access and Inclusion for Underserved Populations

- Services should be available in all threshold languages.
- Provide training for clients/consumers who are less tech savvy.
- Consider ensuring boundaries of youth and young adult's utilization of technology [when in-person supports are needed].
- Learn from other counties in the collaborative how to reach older adults who may be difficult to reach.
- Consider providing a stipend to give clients/consumers without a smartphone or computer device they can use to access the app services, or internet for those who are not currently connected.
- Consider utilizing current peers specialists for virtual services delivery.
- Leveraged technology to help bring people out of isolation, such as connecting clients/consumers with helpful resources like WRAP and personalized outreach.
- Coordinate with mental health open houses to help people become familiar with the in-person options the community has to offer.
- Provide transit to isolated individuals to support them becoming involved in mental health resources beyond the apps.
- Allow apps to be available to anyone in San Mateo (regardless of enrollment in traditional services).

Crisis

- Develop protocols for how to support mental health clients/consumers if application detects strong language that may indicate a crisis or venting.
- Consider mechanisms to trigger law enforcement or 911 dispatcher when necessary, and determine decision-making authority and conditions that should trigger a phone call.

Evaluation

- Consider doing an initial pilot with smaller groups.
- Develop a questionnaire to measure success within the application.

Using the Apps

- Provide choices and options for clients/consumers to be able to change peer listeners to find someone they feel the most comfortable speaking with.
- Develop the Personal Wellness Avatar application to learn information and adapt to the individual's needs, and refine the interventions it offers to consumer son an ongoing basis.

San Mateo County continued to gather feedback about the implementation of the Tech Suite apps and integrate the feedback from community into overall approaches to the plan. See Appendix 3 for a summary of notes. The key adjustments made to the plan based on the final feedback where:

1. A phased approach to implementation and piloting one app with a small subpopulation, given that there are four target communities;
2. Adjusted the target population based on this smaller pilot
3. Added a learning goal related to connecting individuals to in-person services, stakeholders felt strongly that the apps are not to replace human interaction and commented their concern that technology can potentially further isolate individuals.

3). Primary Purpose

Select one of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups

The primary purpose of this project is to i***ncrease access to mental health services for the four specified underserved populations***, (1) isolated older adults, (2) transition aged youth (TAY) in crisis, (3) monolingual Spanish-speaking, and (4) monolingual Chinese-speaking communities.

4). MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach.

The MHSA innovation best applicable to this project is the ***introduction of a new mental health practice or approach***.

5). Population

a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?
b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.
c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain

The specific target groups for San Mateo County Innovation Project are:

- Isolated older adults
- Youth in crisis, and
- Monolingual Chinese and Spanish-speaking communities.

Total number of individuals served

For the past three years, San Mateo County MHSA Outreach Collaboratives meaningfully engage an average of 3% of their respective geographic areas, 1% are referred to mental health or substance use services, often through a warm hand-off. The Outreach Collaboratives employ a promotores/health navigator model of outreach and we would expect to utilize the same outreach model for these special populations and thus expect the same reach for a county-wide approach. We will determine appropriate numbers of individuals to be served once the key program partner is identified for the smaller pilot. In the meantime, population wide estimates are provided below. These will represent the potential reach of full-fledged programming, the actual reach will become more accurate as key programs and partners are identified.

- Age-specific populations – in the general population there are 208,000 older adults 55+ in San Mateo County; 1% of this is 2,080. 55-69 year olds account for the majority of adults that receive specialty mental health services. In San Mateo County FY 15-16, there were 29,614 adults age 45-64 and 19,161 adults 65+ eligible for specialty mental health services. 1% of the older adult eligible population is 488. For transition aged youth (15-24) population is 82,700; 1% of this is 827. In San Mateo County FY 15-16, there were 944 youth age 12-17 and 378 youth age 18-20 eligible for specialty mental health services. 1% of this is 13.
- Cultural-specific populations - 1% of the County's Latino population of 66,600 is 700 individuals. It is possible that 2% of the population is receiving mental health services, and ½ of those community members are likely not getting the mental health supports that they need. Similarly, for the Chinese community 1% of the County's Chinese population of 25,000, which is 250 individuals. It is possible that 2% of the population is receiving mental health services, and ½ of those community members are likely not getting the mental health supports that they need.
- Medi-Cal enrollees - BHRS served 5% (5,826) of the average unduplicated Medi-Cal enrollees. This Innovation project intends to serve 1,165 target for beneficiaries in the system through staff and/or peer introductions.

6). MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your INN Project, please explain why.

a) Community Collaboration
b) Cultural Competency
c) Client-Driven
d) Family-Driven
e) Wellness, Recovery, and Resilience-Focused

f) Integrated Service Experience for Clients and Families

This San Mateo Innovation Plan is informed and reflective of the MHSA legislation key components listed above.

- **Community Collaboration:** The need for new approaches to services was derived from a collaborative community stakeholder process, and this project will seek to work with community members through the Tech Suite Advisory Committee to ensure San Mateo stakeholders will continue to inform the implementation of this Innovation Plan.
- **Cultural Competency:** Technology supports will have the capability to engage and address underserved communities who need a more culturally responsive approach. Additionally, San Mateo will involve diverse stakeholders in the development of these apps to ensure they are culturally competent.
- **Client/Family Driven:** The proposed apps are self-directed and customized by the clients/consumers and family members, which ensures their ability to be client and family driven.
- **Wellness, Recovery, and Resilience-Focused:** Through virtual peer chat and online communities, users can access individuals with lived experiences that are modeling recovery. Additionally, these apps include recovery-orientation platforms that remind clients/consumers of self-care practices, and specific skills like mindfulness exercises.
- **Integrated Service Experience for Clients and Families:** One possibility for these apps is the ability to connect clients/consumers and family members to service providers, which would support an integration of mental health services.

7). Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

Individuals experiencing serious mental health issues will receive services from this proposed project. The Technology Application Suite is intended to support self-directed recovery efforts, but not interrupt the continuity of care already provided by the County.

8). Innovation Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) Explain how you plan to ensure that the Project evaluation is culturally competent.

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

San Mateo County will utilize two mechanisms to ensure the project evaluation is culturally competent and employs meaningful stakeholder participation. First, the County will convene an Evaluation Steering Committee that will inform and oversee the evaluation process. The committee will be composed of stakeholders required by MHSA as well as representatives from the target population communities. The Steering Committee will meet quarterly to have

opportunities to vet the data and evaluation methods. Secondly, in alignment with MHSA guidelines, the County will ensure that the Steering Committee members reflect the County's cultural diversity. With diverse cultural representation and an ongoing, proactive approach to sharing information and gathering feedback from the Steering Committee, the project evaluation process will be culturally competent. The Steering Committee will also reflect the diversity of stakeholder perspectives, including consumer, County, and CBO providers. Additionally, the Steering Committee's involvement during the evaluation process will provide opportunities for stakeholders to meaningfully engage in the evaluation by providing feedback and direction regarding the evaluation methods and findings, and sharing information from their respective communities with the evaluators.

9). Deciding Whether and How to Continue the Project without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

Data analytics and evaluation coupled with local qualitative data, will inform sustainability at the conclusion of this project. Factors that will be taken into consideration include user satisfaction, outcomes, and overall effectiveness of the suite of apps. If deemed successful, if funding allows and if stakeholders (through the MHSA Three-Year Community Program Planning process) prioritize the continued funding of this program, continuation of the project or its components may be funded by MHSA.

10). Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

a) ***How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?***
b) ***b) How will program participants or other stakeholders be involved in communication efforts?***

KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

As this project is a multi-county collaboration, we are partnering with CalMHSA to conduct an evaluation about successful practices and lessons learned. Those results will be disseminated for all counties (e.g. list serves) and throughout the stakeholders (standing meetings) providing oversight for this project. Program participants may choose to opt in to provide feedback through surveys, which will be included in the communication regarding results. **Keywords:** Some possible keywords or phrases that could be used to help find this project are: *therapy apps, online peer support, and mindfulness exercises, and wellness activities.*

11). Timeline

a) Specify the total timeframe (duration) of the INN Project: 3Years 0 Months

b) Specify the expected start date and end date of your INN Project: October 1, 2019 Start Date June 2020 End Date Note: Please allow processing time for approval following official submission of the INN Project Description.

c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for

- ***i. Development and refinement of the new or changed approach;***
- ***ii. Evaluation of the INN Project;***
- ***iii. Decision-making, including meaningful involvement of stakeholders;***
- ***iv. Communication of results and lessons learned.***

Application and Evaluation Plan	Community Outreach & Education	Implementation and Evaluation
Finalize participation agreement with MHSOAC – October 2018	Request for Proposals to select and award contracts for outreach and marketing– Jan 2019	Begin second cohort of Advisory Committees – July 2019
Launch first cohort of Advisory Committees to discuss expectations, timeline, etc. - October 2018	Training of Peer specialists, outreach workers – Jan 2019	Health Navigators are in the community to support individuals with the app – July 2019
Launch meeting with subject matter experts and vendors to discuss adaptations, support needed – Nov 2018	Launch meeting with contractors to discuss scope of work – March 2019	Develop qualitative data collection plan to supplement statewide evaluation indicators– Jan 2020
Identify indicators and evaluation plan – Jan 2019	Peer specialists, partners and outreach workers to train providers and conduct outreach – March 2019	
Milestones: Apps ready for Launch	**Milestones: Community Awareness of Apps**	**Milestones: Mental Health Consumer and Families utilizing Apps and Data are being collected**

12). Budget Narrative

Total funding amount: As of May 3, 2018, San Mateo County received notice from the Department of Health Care Services (DHCS) that **$3,832, 545** are subject to reversion. The full amount will be allocated to this INN Project, as per the submitted Assembly Bill 114 Plan to Spend Reallocated MHSA Funds. The corresponding fiscal years for reallocated funds are included in the DHCS Enclosure 1 table below:

Enclosure 1 5/2/2018

Department of Health Care Services
MHSA Funds Subject to Reversion by Fiscal Year by Component

San Mateo	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ 423,610		$ 423,610
FY 2007-08	$ -	$ -			$ -	$ -
FY 2008-09	$ -	$ -	$ 1,048,126			$ 1,048,126
FY 2009-10	$ -	$ -	$ 246,912			$ 246,912
FY 2010-11	$ -	$ -	$ 793,069			$ 793,069
FY 2011-12	$ -	$ -	$ -			$ -
FY 2012-13	$ -	$ -	$ -			$ -
FY 2013-14	$ -	$ -	$ 786,230			$ 786,230
FY 2014-15	$ -	$ -	$ 958,208			$ 958,208
Total	$ -	$ -	$ 3,832,545	$ 423,610	$ -	$ 4,256,155

$ - No Funds Subject to Reversion
ARER expenditure data is not complete

By joining the County Behavioral Health Technology Innovation Collaborative, San Mateo County is agreeing to contribute to a statewide pool of INN funds. CalMHSA, a Joint Powers of Authority, will serve as a fiscal intermediary and in a project management role to facilitate contracting with technology vendors, support a shared evaluation, and maximize planning outreach and marketing. The budget is divided into four main components:

Local Programming
(Stakeholder driven)

$1,046,500

Future Technology
(Stakeholder driven)

$1,465,591*

Core Technology
(Statewide contribution)

$992,578*

Outreach & Evaluation
(Statewide contribution)

$367,498*

**subject to change pending final negotiations with vendors*

The majority of the INN funds (66% - $2,512,091) will be driven by local stakeholders through our Advisory Committees and include the following:

- **Local Programming** category allows us to keep funding locally (outside of what we contribute to CalMHSA) to implement the strategies needed to support culturally responsive implementation and can include training of staff and peer workers, contracting with peer/family support agencies and agencies/groups serving monolingual Spanish and Chinese communities and local outreach and marketing efforts and materials.
- **Future Technology** development will be reserved for local stakeholder customization and/or additions to the generic apps. The Advisory Committee will work with subject matter expert(s) at CalMHSA and the vendors to assure apps are effectively maintained as well as advanced per County needs and goals. For example, during our local stakeholder process stakeholders identified the need for care coordination capacity to support the Chinese monolingual speaking community. For youth in crisis, the capacity to identify and show on a local map, safe places for youth to go when in need was identified.

The Statewide contribution to the collaborative approach is 33% of the budget and totals $1,320,454:

- **Core Technology** development includes technology vendor fees (start-up, development, licensure, etc.), subject-matter experts and overhead. This will fund the development of all three generic apps 24/7 peer chat; wellness avatar and use of smartphone passive data.
- **Outreach & Evaluation** is statewide promotion at strategic access points and marketing within school systems, social media, public locations, etc. Data collection, analysis and performance monitoring will also be managed by CalMHSA.

Local Programming Budget Breakdown

*The Advisory Committee will be engaged in determining priorities for local programming, the breakdown below is offered as a starting point.

Local Funds Items/Personnel	Cost	Total for 2 years	Budget Justification
Peer and Family partner specialists	150,000/year	$300,000	Peer-run contract agency to support end-users, face-to-face support services, outreach and training of BHRS staff, including providers, peer and family partner staff and network providers. Will include at minimum: • 1 Peer Outreach Worker: $44K/year • 1 Peer Specialist to support system-wide training: $50K
Spanish and Chinese community specialists	$100,000/year	$200,000	Contract agency with expertise in Spanish/Chinese community behavioral health outreach to support peer end-users, face-to-face support services to users and outreach. Will include at minimum 2 Peer Outreach Workers: $44K/year
Older Adult peer and family partners	$100,000/year	$200,000	Contract agency with expertise in Older Adult behavioral health outreach and engagement to support peer end-users, face-to-face support services to users and outreach. Will include at minimum 2 Peer Outreach Workers: $44K/year
Youth peer workers	$100,000/year	$200,000	Contract agency with expertise in Youth behavioral health outreach and engagement to support peer end-users, face-to-face support services to users and outreach. Will include at minimum 2 Peer Outreach Workers: $44K/year
Local Communications and Marketing	$5,000 / year	$10,000	Social media boosts ($500), printing ($500), SamTrans/CalTrain Adcards ($3000), Daily Journal/EPA Times ($400), incentives ($600) / year
Planning and administration	15% of operating	$136,500	Coordination of staff training, planning, approval and request for proposals processes, market and development, final reports
	TOTAL	**$1,046,500**	

Core Technology, Future Technology and Outreach and Evaluation Budget Breakdown

*vendor amounts are subject to change pending final negotiations.

SAN MATEO COUNTY TECH SUITE BUDGET

Tech Suite Budget:	2,825,667	Relative Size Unit:	3.34	% of Experts:	5.00%	Total INN Budget:	3,872,167

Total Expenses for Desired Duration of Innovation Project (per annual budget below)

	Overhead	Experts	Vendor #1 (7 Cups)	Vendor #2 (Mindstrong)	Vendor #3 (CBT/EBP)	Future Apps	Evaluator	Otrch & Mktg	Local Funds
Start-Up			$100,227	$83,522	$33,409	$116,931	$116,931	$33,409	
Development			100,227	100,227	33,409	100,227	0	50,113	
Licensure			100,227	100,227	66,818	167,045	100,227	66,818	
Other	141,283	133,000				1,081,388			1,046,500
Total	$141,283	$133,000	$300,681	$283,976	$133,636	$1,465,591	$217,158	$150,340	$1,046,500

$2,825,667 Total Budgeted Amount per new fee schedule (no local funds)

Expenses	FY17/18	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23	Innovation Total	% of Total
CalMHSA Overhead (5%)		$ 141,283	$ -	$ -			$ 141,283	5.0%
Experts		$ 46,000	$ 46,000	$ 41,000			$ 133,000	4.7%
Vendor #1								
Start-Up Fee		$ 100,227	$ -	$ -			$ 100,227	
Development Fund		100,227	-	-			100,227	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #1 Subtotal		**$ 200,454**	**$ 50,113**	**$ 50,113**			**$ 300,681**	**10.6%**
Vendor #2								
Start-Up Fee		$ 83,522	$ -	$ -			$ 83,522	
Development Fund		100,227	-	-			100,227	
Licensure Fees			50,113	50,113			100,227	
Vendor #2 Subtotal		**$ 183,749**	**$ 50,113**	**$ 50,113**			**$ 283,976**	**10.0%**
Vendor #3								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		33,409	-	-			33,409	
Licensure Fees			33,409	33,409			66,818	
Vendor #3 Subtotal		**$ 66,818**	**$ 33,409**	**$ 33,409**			**$ 133,636**	**4.7%**
Future Apps/Vendors								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		100,227	-	-			100,227	
Licensure Fees			83,522	83,522			167,045	
Local Customization		360,463	360,463	360,463			1,081,388	
Vendor #4 Subtotal		**$ 577,621**	**$ 443,985**	**$ 443,985**			**$ 1,465,591**	**51.9%**
Vendor #5: (Evaluator)								
Start-Up Fee		$ 116,931	$ -	$ -			$ 116,931	
Development Fund		-	-	-			-	
Licensure Fees (75% in 18/19, 25% in 19/20)			50,113	50,113			100,227	
Vendor #5 Subtotal		**$ 116,931**	**$ 50,113**	**$ 50,113**			**$ 217,158**	**7.7%**
Vendor #6: (Outreach & Marketing)								
Start-Up Fee		$ 33,409	$ -	$ -			$ 33,409	
Development Fund		50,113	-	-			50,113	
Licensure Fees			33,409	33,409			66,818	
Vendor #6 Subtotal		**$ 83,522**	**$ 33,409**	**$ 33,409**			**$ 150,340**	**5.3%**
Subtotals								
Start-Up Fee		$ 484,430	$ -	$ -	$ -	$ -	$ 484,430	17.1%
Development Fund		384,203	-	-	-	-	384,203	13.6%
Licensure Fees		-	300,681	300,681	-	-	601,362	21.3%
Local Customization		360,463	360,463	360,463	-	-	1,081,388	38.3%
Vendor Subtotals		**$ 1,229,096**	**$ 661,144**	**$ 661,144**	**$ -**	**$ -**	**$ 2,551,383**	**90.3%**
TOTAL EXPENSES		**$ 1,416,380**	**$ 707,144**	**$ 702,144**	**$ -**	**$ -**	**$ 2,825,667**	**100.0%**

Appendix 1

Community Program Planning (CPP) Process

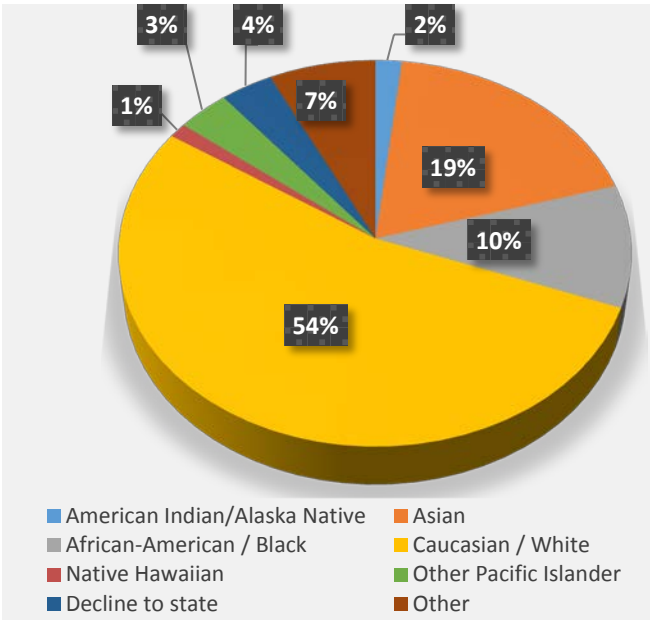
San Mateo County is committed to engaging a diverse group of stakeholders using a Community Program Planning (CPP) process to ensure that communities that are experiencing mental health and substance abuse issues are heard in each phase of the process. Input is gathered at existing County meetings, targeted input sessions, online surveys, and through formal public comment. During the FY 17-20 Three Year Planning Process, San Mateo County hosted two public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Over 270 participants were in attendance, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members. 36 stipends were provided to consumers/clients and family members for their input.

Participant Demographics

Participant Demographics help us understand how far our CPP efforts reach when engaging San Mateo County's diverse communities.

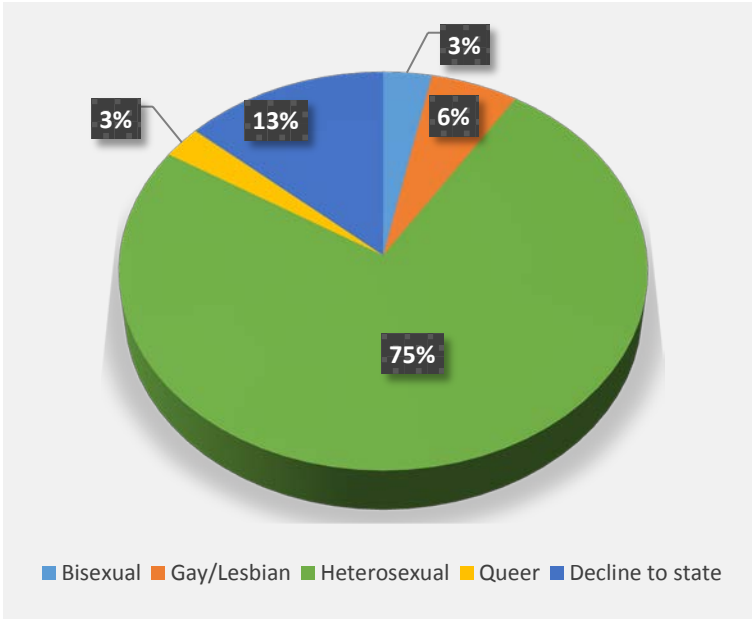
CPP Participant Demographic Sheets Collected			
156			
Male	59	**Female**	97
Age		**Age**	
16-25	3	**16-25**	3
26-59	36	**26-59**	63
60+	20	**60+**	31
Veteran Status			
3		3	

Race

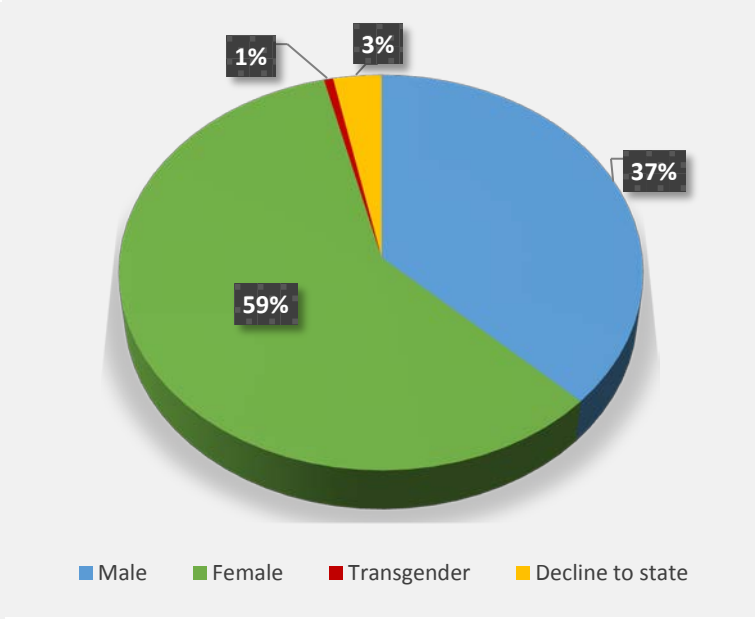


Ethnicity

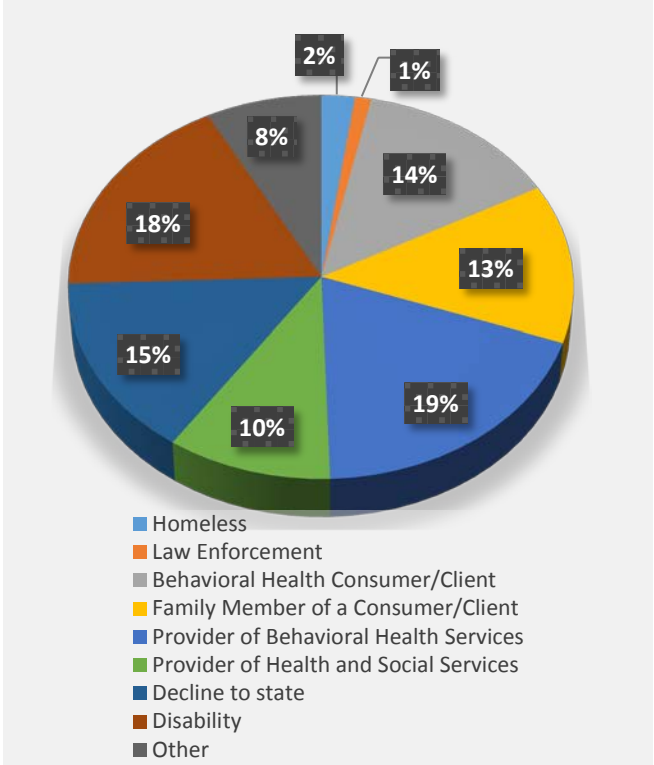
Sexual Orientation



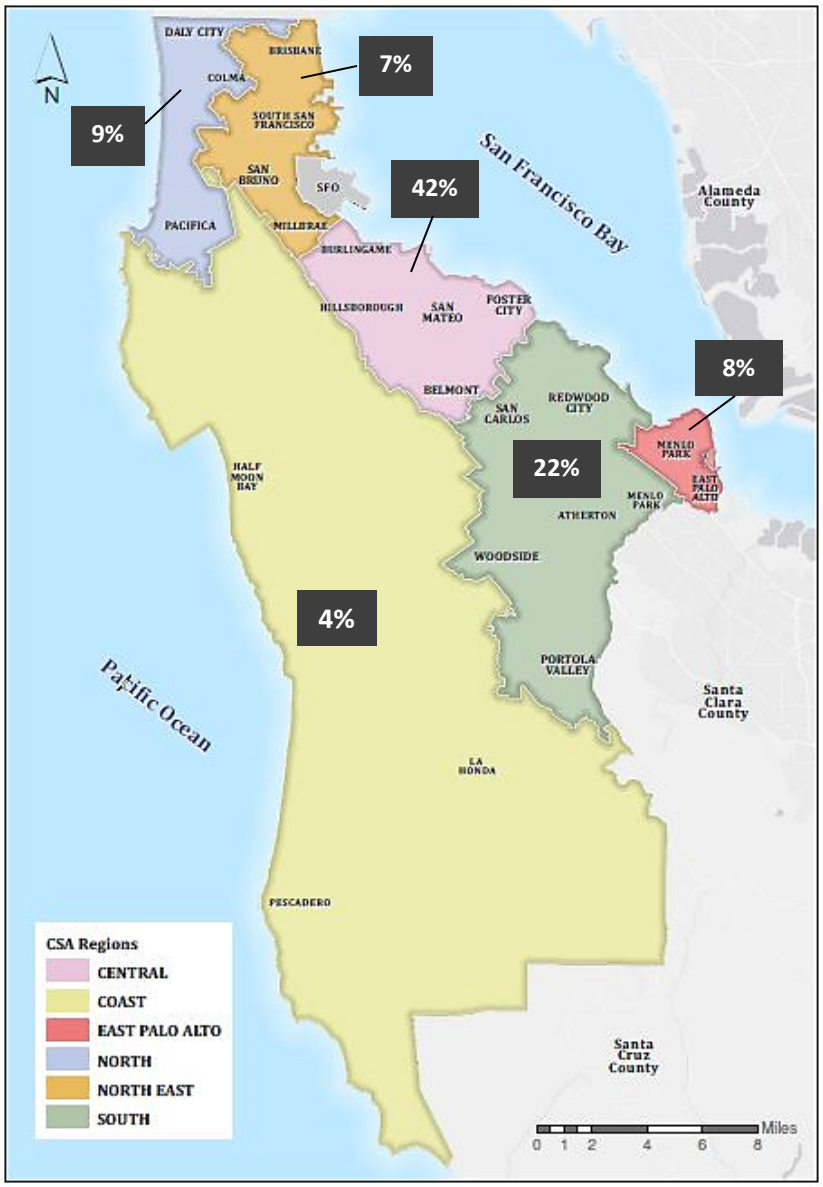
Gender Identity



Represented Groups



Represented Service Areas*



*There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in north county as well.

Appendix 2

San Mateo Behavioral Health and Recovery Services

SAN MATEO COUNTY INNOVATION PLAN TECH SUITE

INN Plan Development

April - May 2018

Agenda

- Introduction
- Background
- Overview of the Tech Suite
- Community Input
- Next Steps

Introduction

About RDA: RDA is working with San Mateo County to develop its Tech Suite Innovation Plan.

Check-in: Please share your name and stakeholder affiliation.

Goals

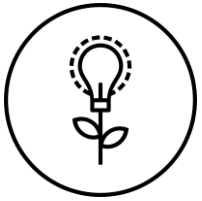
Share information about the Tech Suite

Respond to questions and concerns

Gather feedback about how to refine the plan to meet San Mateo County's unique needs

Discuss implementation considerations to refine how the plan is rolled out

MHSA Innovation Overview



The Mental Health Services Act (MHSA) sets aside funding for counties to promote innovative projects to meet mental health needs in new ways.

Innovation projects…

- Have never been done before or are modified to happen in a new setting

Current Status

Need Identified

San Mateo County's 2014 MHSA Plan identified need for tech innovations for youth in crisis and isolated adults and older adults

Opportunity

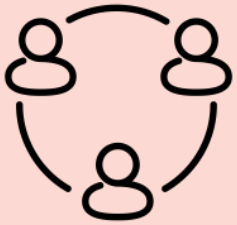
Los Angeles and Kern Counties formed the ***County Behavioral Health Technology Collaborative*** to bring technology-based solutions to behavioral health

San Mateo County Opts In

San Mateo County opted-in to the Collaborative

Community Input (Today!)

San Mateo solicits community input to help shape the technology suite



County Behavioral Health Technology Collaborative:
Multi-county collaborative with several pre-qualified vendors ready to provide a variety of apps for mental health support.

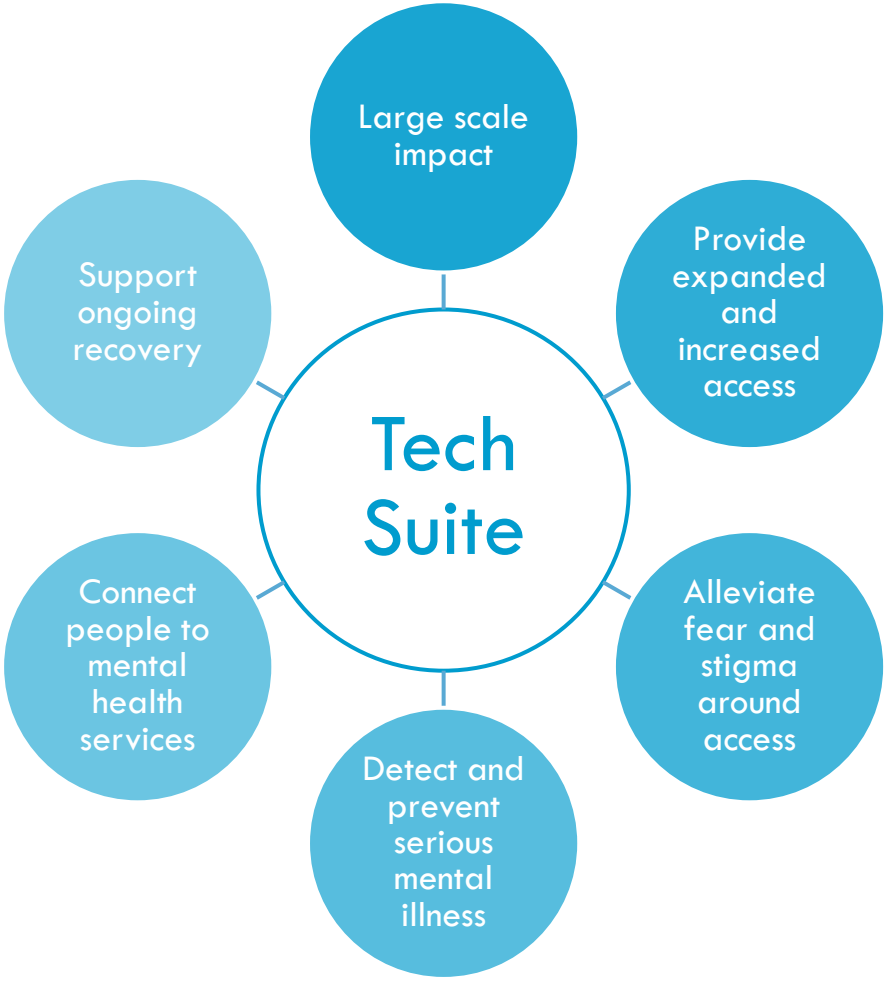
Tech Suite Description

The Tech Suite is a collection of innovative apps from different vendors that support wellness and recovery.

The apps are designed to:

- Engage people who are disconnected from services
- Remind clients to engage in wellness and recovery
- Increase socialization through online platforms
- Support ongoing mental health recovery

Tech Suite Benefits



- Utilizes commonly used devices like smartphones to expand access to services
- Makes it easy for youth to connect mental health services
- Promotes connection for isolated adults and older adults
- Increases language accessibility (Apps can be modified to provide services in clients' preferred language)

Overview of Tech Suite Components

Tech Suite Interventions

Outreach to connect people to tech suite services

24/7 Peer Chat and Online Support Apps

- Chat with trained peer mentor or peer groups

Personalized Wellness Avatar

- Scripted mindfulness exercises and behavioral therapy interventions

Wellness Apps

- Analyzes cell phone data and recommends interventions

Evaluation to determine effectiveness and adjust services

24/7 Peer Chat and Online Support

Clients or their loved ones can chat with support groups or peers with lived experience, online or via text

How do they work?

- Anyone can join an online chat group with trained peer listeners on topics such as depression or anxiety
- Individuals can chat one-on-one with a peer with similar lived experience
- Family members of people with mental health issues can engage in support groups online

Who can these apps benefit?

- Youth and clients comfortable with text and chat
- Isolated individuals
- Individuals who prefer anonymity or have fear/stigma around seeking support
- Clients with limited access to in-person support groups/peer support

Personalized/Wellness Avatar

Clients can sign up to receive reminders to engage in wellness activities such as mindfulness exercises

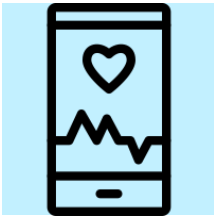
How do they work?

- Clients can sign up to receive regular notifications about wellness activities to support their recovery and wellbeing
- Clients can interact with an online avatar that recommends wellness activities based on how their interact with the app

Who can these apps benefit?

- Youth and clients comfortable with communicating by text
- Isolated individuals
- Individuals who prefer anonymity or have fear/stigma around mental health
- Clients with limited access to in-person support groups/peer support

Wellness Apps



Clients can give permission to use their cell phone data to identify changes in behavior that might identify the need for additional support

How do they work?

- Clients can opt in to allow the app to identify patterns in their text behavior that may indicate changes in mental health
- The app interacts clients with via text or chat to increase their understanding of their thoughts and feeling states

Who can these apps benefit?

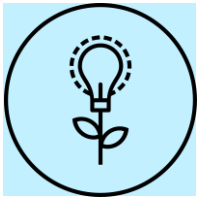
- Individuals who prefer to interact with virtual technology
- Isolated individuals
- Individuals who need ongoing recovery support

Community Input

What questions do you have about the Tech Suite components or planning process?

What would you want the County to consider before implementing these innovative interventions?

What are the needs that these apps can help meet? What components do you think would be most helpful to you/your community/ the community you serve?



What do you want to learn from the pilot process?

Next Steps

April/May	• Gather community feedback and input
May	• Post plan for 30-day public comment period
June	• Mental Health Board public hearing
June	• Board of Supervisors for approval
July	• Submit to MHSOAC for approval

Thank you!

For further information, please contact:

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kubozoh@resourcedevelopment.net

Innovation Tech Suite Overview

San Mateo County Behavioral Health and Recovery Services (BHRS) is piloting an MHSA Innovation project that brings together technology-based interventions designed to support mental health and wellness, using devices like smartphones. The apps vary by vendor and fall into three categories: peer chat and online support, personalized wellness avatar, and wellness apps.

Tech Suite Components

Tech Suite Component	What is this App?	How does it work?	Why is it helpful?
 **Peer Chat and Online Support**	Connects clients/consumers and their loved ones with online support groups and/or peers	The Peer Chat & Online support app gives clients/consumers & their loved ones a variety of options for online peer support (e.g. text, chat group)	• Expands access for those who prefer to remain anonymous. • Provides services in client/consumers' preferred language. • Promotes connection for youth and isolated adults
 **Personalized Wellness Avatar**	Links clients/consumers to personalized wellness activities through an avatar	Clients/consumers can choose to receive prompts and reminders to engage in wellness based on their preferences.	• Expands access for clients/consumers who have limited access to in-person services, avoid in-person services due to stigma, or prefer anonymity.
 **Wellness Apps**	Uses cell phone data to provide a safety net of support for someone	Clients/consumers can give permission to an app to use their cell phone data to receive reminders for wellness activities or share selected data with their current provider.	• Suggests wellness activities based on data collected. • Alerts mental health providers if a client/consumer needs additional support.

创新技术套件概述

San Mateo 郡行为健康和康复服务 (Behavioral Health and Recovery Services, BHRS) 正在试行一项精神健康服务法 (Mental Health Services Act, MHSA) 创新项目，该项目通过使用智能手机等设备，将旨在支持心理健康和保健的基于技术的干预措施汇集在一起。这些应用程序因供应商而异，可分为三类：同侪聊天和在线支持、个性化健康头像和健康应用程序。

技术套件组成

技术套件组成	此应用程序的功能是？	如何运作？	有何助益？
 同侪聊天和在线支持	将客户/消费者和其亲人与在线支持团队和/或同侪连接起来	同侪聊天和在线支持应用程序为客户/消费者及其亲人提供了多种在线同侪支持选项（例如文本、群聊）	• 帮助那些更倾向保持匿名的人士扩大获取范围。 • 以客户/消费者的首选语言提供服务。 • 促进青年和孤立的成年人的联系
 个性化健康头像	通过头像将客户/消费者与个性化健康活动相连接	客户/消费者可以选择接收提示和提醒，以根据自己的喜好参与健康活动。	• 针对获取现场服务能力有限的、因受到耻辱而避免进行面对面服务的、或倾向匿名的人士，扩大其访问范围。
 健康应用程序	使用手机数据为某人提供安全支持网络	客户/消费者可以授权应用程序使用其手机数据，以接收健康活动的提醒或与他们的当前提供者共享特定数据。	• 根据收集的数据提供健康活动建议。 • 如果客户/消费者需要额外支持，可通知精神健康提供者。

Descripción del paquete tecnológico de innovación

Los Servicios de Salud del Comportamiento y Recuperación del Condado de San Mateo (San Mateo County Behavioral Health and Recovery Services, BHRS) están probando un proyecto piloto de innovación de la Ley de Servicios de Salud Mental (Mental Health Service Act, MHSA) que reúne intervenciones basadas en la tecnología diseñadas para ayudar a la salud mental y el bienestar con el uso de dispositivos como los teléfonos inteligentes. Las aplicaciones varían según el proveedor y se dividen en tres categorías: chat y apoyo en línea con iguales, avatar de bienestar personalizado y aplicaciones de bienestar.

Componentes del paquete tecnológico

Componente del paquete tecnológico	¿Qué es esta aplicación?	¿Cómo funciona?	¿Por qué es útil?
 **Chat y apoyo en línea con iguales**	Conecta a los clientes o consumidores y a sus seres queridos con grupos de apoyo en línea o con iguales.	La aplicación de chat con iguales y apoyo en línea les brinda a los clientes, consumidores y a sus seres queridos una variedad de opciones de apoyo con iguales en línea (por ejemplo, texto, chat grupal).	• Aumenta el acceso de aquellos que prefieren permanecer en el anonimato. • Proporciona servicios en el idioma preferido del cliente o consumidor. • Promueve la conexión para los jóvenes y los adultos aislados.
 **Avatar de bienestar personalizado**	Enlaza a los clientes o consumidores a actividades de bienestar personalizadas a través de un avatar.	Los clientes o consumidores pueden escoger recibir instrucciones y recordatorios para involucrarse en el bienestar de acuerdo con sus preferencias.	• Incrementa el acceso de los clientes o consumidores que tienen acceso limitado a servicios presenciales, que evitan los servicios presenciales debido al estigma o que prefieren el anonimato.
 **Aplicaciones de bienestar**	Utilizan los datos del teléfono celular para brindar una red segura de apoyo para alguien.	Los clientes o consumidores pueden dar permiso a una aplicación para que use los datos del teléfono celular para recibir recordatorios de actividades de bienestar o compartir datos seleccionados con su proveedor actual.	• Sugiere actividades de bienestar con base en los datos recolectados. • Les avisa a los proveedores de salud mental si un cliente o consumidor necesita más ayuda.

Tech Suite Frequently Asked Questions

Peer Chat and Online Support

Will clients/consumers be able to chat with a real person?

Yes, clients/consumers will chat with real people who have lived experience and are trained to listen and provide support through chat.

Are the peers/support group moderators certified?

Depending on the app, the peer listeners and support group moderators are trained and may either be paid or volunteers.

Is it confidential?

Depending on the app and service, clients/consumers may choose to share their name or remain anonymous. Personal information is never shared with the listeners or anyone else.

How much does it cost?

Depending on the app, peer chat and online support groups are free. Some apps offer free peer chat and support groups, but may also offer additional services for a fee.

Are there peers/support groups available in other language?

Depending on the app, some services are available in multiple languages.

Therapy/Wellness Avatar

Will users be able to talk with a real person?

Depending on the app, users will be able to engage with an "avatar" that uses artificial intelligence to gather information about how they're doing and recommend wellness activities to meet their needs. The avatar will communicate with users in a way that is similar to a real person, but is a program designed to understand information they provide and suggest ways to engage in wellness, such as remembering to take medication or practicing meditation or self-care.

Will the avatar replace a human connection with a real person?

No, these apps are designed to provide users additional support when they need it, not replace other wellness activities like talking with a therapist or other professional.

How will the avatar know whether someone is in a crisis situation or connect them to additional crisis services in the community?

The avatar uses advanced technology that can analyze information they share when they interact with it to determine whether they are experiencing certain challenges or symptoms. The County will work with vendors who can modify apps to provide information about local resources.

Are there apps that provide services in other languages?

Depending on the app, some services are available in multiple languages.

Wellness Apps

How do the apps work?

Depending on the app, users can choose to allow their phone to review data about usage, such as whether they have left their home that day or the words and ideas they type in texts. The app will monitor that data to identify signs that might mean they are not feeling so great. For example, if their phone hasn't left the location of their home in over 24 hours, the app might suggest actions they can take to make sure they connect with their support network such as calling a friend. If their text behavior changes, such as if they start using different words or communicating different ideas than they usually do, the app may prompt them to check in with how they are feeling or remember to take their medication as scheduled. If they choose to do so, some apps may send this information to a provider users know and trust so the provider can check in.

What information will the app collect?

The information varies depending on the app and what options users select. Generally, apps will collect data about their phone usage, such as whether they have left their home or the words and ideas they type in texts.

Who will have access to information my phone collects?

User information will not be shared with anyone unless they choose to share it with a qualified health professional they already know.

Will the app record information about me or listen in on my phone conversations?

No, the app will not record any data users do not want it to and does not allow their phone to record conversations.

Will the government have access to my data?

No, the app will not share any information with anyone unless users want to share it with a qualified health professional they already know.

Appendix 3

Summary of Community Meeting Notes

Customization for Target Populations-Community-wide

- **Crisis.** Apps should be able to connect people to local crisis line and other resources. The County will need to develop a crisis response plan and communicate it clearly to all using the apps. Stakeholders expressed concern that people will only talk to the avatar app and will not connect with crisis services when needed. Some were concerned that law enforcement would be contacted based on certain language or behavior, while others were concerned that law enforcement would not be contacted.
- **Culture, language, and age fit.** Apps should be designed to respond to the needs of specific age groups and culture/ethnic groups. Apps should also be linguistically and culturally appropriate. Representatives from target populations should be included in the process to design the apps and the outreach/training efforts. Multimedia capability such as videos and voice recognition can provide options for people to engage in ways that are most comfortable for them.
- **Model apps for design inspiration.** Apps that people are already using or are designed for certain populations should be the design models for the tech suite (e.g. Wobot, for youth, WeChat for the Chinese community, What's App for Latino community).
- **Integrate with existing services.** Apps should integrate with existing in-person mental health services, 211, and the crisis line to the extent possible.
- **Stigma and design preferences.** Apps should use imagery and language that is upbeat, positive, and age appropriate. Language should focus on "stress," "health," and "wellness." Marketing them to the general public as something other than mental health may be helpful.
- **Data security and liability.** Data security and liability around crisis are a significant concern. The County will need to develop a plan to mitigate liability issues and manage data security. Stakeholders asked for the county to specifically consider/name who gets access to the data collected from users, how it is stored, and who is responsible. Stakeholders suggested that the apps need safeguards to protect consumers from hackers and predators.
- **Training/Certification of Peer Listeners.** Many raised questions about the qualifications, (are peers mandated reporters?) and training of peer listeners and stated a preference that peer listeners be local peer specialists that are familiar with existing resources and are representative of the County's cultural and linguistic diversity. Stakeholders suggested the peer listeners receive training on how to initiate escalation of support if someone is experiencing a crisis.
- **Substance use.** Stakeholders suggested that many mental health consumers who are isolating may be coping/ struggling with substance use issues. These apps should be inclusive of wellness approaches for substance use, and SUD providers can provide input on SUD support in app design.

Youth

- Youth stakeholders and youth advocates suggested the county partner with student/youth-run mental health organizations and advocates to select/design the apps.

- Youth stakeholders and youth advocates suggested that customization for youth include games, puzzles, and mindfulness activities. Specifically, these apps should less "text heavy" and provide more mechanisms to "swipe" and be interactive with wellness interventions.
- Considerations for apps for youth include implementing Wobot or designing an app similar to Wobot for youth (similar to avatar option) Other apps youth mentioned as potential design models were Calm and Clue.
- Some youth expressed interest in apps that provide capability to anonymously refer friends so the app can contact the referred person.
- Ease of access is important for this population, and youth suggested that a questionnaire could help people find the right service for them.
- Due to the barriers of stigma, youth suggested using language like "overall health, "wellness," "stress reduction" (esp. related to academic pressure) instead of mental health. Imagery should be positive, upbeat, "lifestyle" focused, and youth-friendly.
- This population needs a range of options for levels of support. Youth expressed discomfort with "serious" mental health support and suggested more that youth would be more open to trying apps they perceived as "low-key" and casual. Some youth were interested in less intensive apps that are useful for one-time stress reduction (such as an app that provides prompt for breathing exercises to navigate through moments of panic or anxiety).

Older Adults

- To avoid stigma, the apps should not use language like "mental health," but instead, focus on more universal issues that most older adults may face, such as connection, socializing, and loneliness. Apps and outreach materials should emphasize that aging is a universal experience and brings up issues for "all of us." Older Adults suggested the county connect with Reframing Aging at the Aging Institute for inspiration and guidance.
- Older adults emphasized that ease of access is a priority. Customization for these apps should include large font, video and voice recognition, and simple and straight-forward design.
- Navigation and training on how to use the apps will be needed for this population. This support will need to be available on an ongoing basis, or at least a few times in-person, to be most effective for older adults.
- Commission on Aging and AARP may be able to provide input to help customize the app.

Consumers

- Peer listeners should be able to provide information about existing in-person services in the local area.
- Apps should provide opportunities for online WRAP groups that could bring people together and help reduce stigma. Apps should provide information about in-person peer support events/groups/resources, and provide ongoing support to work towards goals
- Nutrition support info overlaps with mental health. Info about nutrition can be helpful.
- Apps should provide info about SSI and other benefit recertification.

Parents

- Include supportive tips and techniques for parents to respond to and support their children experiencing mental health issues, as well as local resources available. Information about techniques and local resources should be listed by age group.
- The apps may be helpful in supporting parents and helping them engage in self-care during stressful experiences navigating their children's mental health challenges; this may need to be a self-care/support app specifically designed for parents and family members.
- Apps should be able to notify multiple people in case of an emergency (e.g. if someone programs a wellness app to contact a provider, they can also program it to contact their parents to help).

- The apps could potentially be useful for pregnant mothers during and after pregnancy, particularly if they experience post-partum depression.

Monolingual Spanish-speaking community

- For people with limited literacy and/or challenges texting typing, stakeholders suggested having an option to record conversations for example “what’s app” so you can have an entire conversation through a text mechanism, but without texting.
- Stakeholders suggested that because of stigma, it may be challenging to get people to use the apps. Marketing them to the general public as something other than mental health may be helpful and/or marketing app under another name may be helpful (e.g. "YouTube Health")
- Multimedia capability such as videos and voice recognition may provide options for people to engage in ways that are most comfortable for them.
- Apps should be designed in a way that looks visually happy, attractive, fun. There should be happy, attractive people of color featured in any imagery.

Monolingual Chinese-speaking community

- The County will need to expand the capacity of bilingual outreach support.
- Provide information about local resources available in Chinese.
- Consider insurance implications before linking people to services that would not be covered for them.
- Chinese communities are already using WeChat, WhatsApp, and Facebook. These are familiar and good models for design. Stakeholders suggested integration with these apps to make intake from these apps easy for clients.
- Language to use could include “wellness,” “stress,” and “health”.
- Some people might have different perceptions of simplified and traditional Cantonese, so apps may need to be available in both.
- Visual design should emphasize physical health and not point to mental health.

Providers/CSA

- Providers suggested that it wellness teams may benefit from these methods of staying connected and monitoring client status.
- Apps should be able to provide clients info about physical wellness indicators and activities. Consider options to integrate with Fit Bit and programming in wellness activities that include physical wellness.
- Apps should be able to connect people to the 6 core service agencies: food, shelter, health, etc.
- Potential pilot groups may be:
    - TAY, age groups most likely to engage
    - Parents of young children: pre-3
    - Isolated coastal community, especially for Spanish language services using voice recognition

Implementation Considerations Communitywide

- Piloting the apps with a smaller subpopulation will help inform implementation and design that is relevant to people of different languages, ages, and cultures.
- The County will need to protect sensitive information such as immigration status. Some parents are afraid that seeking help for their children will involve CPS. Outreach to parents will need to let parents know that they will be safe using the apps and that CPS will not be notified or involved.
- For isolated people and those who are not engaged in services fully or at all, it will be important to conduct outreach in places they already go to and with people they already interact with:
    - Faith based communities
    - Salons/barber shops
    - Grocery stores
    - Laundromat
    - Libraries
    - Hospitals/Clinics/Primary health care facilities
    - Case workers
    - Law enforcement and first responders
    - Peninsula Family Services
    - 70 Strong
    - One Degree, org who recently launched “Help Me Grow” a supportive/interactive online resource center
    - Incorporate app and/or collocate (peer?) support with existing networks, see “Star Vista”
    - (Early) Head Start
    - One Stop Service Locations Jails
    - Health Plan
    - Community orgs
    - Support team, FAST

  - Primary Care Interface Team
  - Coastside Clinic, medical clinics, providers
  - Families who contact the Office of Consumer & Family Affairs
  - Core Service Agency
  - Peer organizations such as Heart and Soul, California Clubhouse; peer support workers
  - Community health advocates in health system → it may be challenging for them to provide support, but INN funds can support training and outreach
  - Total Wellness
  - Substance use providers serving co-occurring population
  - People who distribute cellphones, they will need to be trained to help people load apps and teach clients how to use them
- The County should develop a sustainability plan to:
  - Prevent the service/app from disappearing on people who are using it after the 3 year implementation period after consumers have begun to use it
  - Keep the service free for clients after the 3-year implementation period

Youth

- Stakeholders suggested partnering with schools and the School District to support implementation, education, and outreach about the apps- This information should clarify privacy and ensure that parents don't have to know youth are using the apps. Demos should emphasize anonymity and privacy features.
- Youth also suggested partnering with student/youth-run mental health organizations and advocates to conduct outreach.
- There is some concern that some youth use their phones instead of connecting to other resources. The County should consider how to ensure that these apps are helpful for youth, without suggesting that apps could replace other services.
- Education and outreach about the apps will be necessary to ensure engagement. Engagement venues can include the list below. These venues and people may also be helpful in training people to use the apps:
  - Youth ambassadors
  - HAP-Y
  - Schools/teachers
  - Local events
  - Libraries
  - WRAP groups
  - Social workers
  - Parenting classes/groups
  - Promotores

Older Adults

- Training and tech support to download and program the apps will need to be available as one-on-one help or a series of small workshops. This support will need to be available on an ongoing basis, or at least a few times per person, to be most effective for older adults.

- Senior Coastsiders are already are conducting outreach/meal delivery and could be trained to provide outreach, training, and tech support to older adults.
- Venues for outreach:
    - Veterans Hospitals
    - Home care providers
    - Pharmacists
    - Board and Care facilities
    - Faith-based communities
    - Aging adult service workers
    - NAMI
    - Assisted living facilities
    - Senior housing
    - Friendship Centers
    - Senior Centers
- To engage more isolated older adults, it will be important to go to them. Residence managers and case managers can be a good point of contact for isolated people. Doctors, physicians, courses and other health care providers can also be a point of contact. The apps may be helpful for isolated older adults not going to senior centers. Effective methods for reaching out to those more isolated individuals may include:
    - TV ads
    - Offer to come to people's homes to show them how to use the apps
    - Workshops at drop-in centers
    - Daily Journal ads
    - Flyers in places people go to such as grocery stores, pharmacies
    - Primary and mental health care providers
    - Heart and Soul staff trained to present information about the apps
    - Senior centers
    - OASIS for homebound older adults

Consumers

- Consider utilizing County Peer Specialists to support outreach efforts.
- People who use the apps may be able to share information about the apps with their roommates/others in their residential situation as a successful means of outreach.

Parents

- Outreach venues:

- Parenting social media groups
- Parenting classes and support offered through BHRS

Monolingual Spanish-speaking community

- Community members suggested that the county train the Health Ambassador Program and Health Ambassador Program-Youth on how to use these apps to better reach community members.
- Outreach and engagement should include Promotores and social workers, and other systems in which who should go to schools, events, libraries, WRAP groups, social workers, and community events.

Monolingual Chinese-speaking community

- Star Vista services are currently provided in Chinese. The County should consider linking with existing services.
- Outreach needs to emphasize confidentiality
- Include translators in conversations about the apps to ensure that the concept is accurately translated. [The correct translation for stigma is word that is less strong in connotation than "shame" and is closer to "wrong perception" or "labeling"]
- Outreach partners:
  - Senior center
  - Chinese Heath Initiative
  - Radio and TV
  - Churches/faith based communities
  - Doctors in Chinese clinics: Northeast Medical Services and Chinese Hospital, both in Daly City
  - Ensure sufficient time and translation during outreach process. Provide traditional and simplified language options for outreach and apps. Proficient translation is crucial. Make everything available in both Mandarin and Cantonese.
  - Community organizations

Providers

- Apps could increase access by directly connecting people to call center. Need to strengthen crisis line to support demand from apps.
- Health care providers may be able to contribute funding to develop and maintain apps. People could specify their insurance coverage to be able to view options that are covered by their insurance. Explore opportunities to coordinate with other providers beyond Medi-Cal.

Evaluation/Learning Goals from Community

- Does the Tech Suite effectively connect people with mental health services?
- What works best for the priority populations?
- What are clients' experiences with the apps?
- Who uses the apps (e.g. demographics)?

- What lessons are there from Los Angeles and Kern counties?
- Do the apps help clients regulate their medication/wellness?

APPENDIX 9

San Mateo County
Mental Health Services Act (MHSA)

Workforce Education and Training (WET)
10-Year Impact and Sustainability Report



Embracing Diversity Advancing Equity
Behavioral Health & Recovery Services
SAN MATEO COUNTY
Office of Diversity and Equity

Office of Diversity and Equity

San Mateo County Behavioral Health and Recovery Services

February 2018

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Introduction

Background

The Mental Health Services Act (MHSA) was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. It provides funding for treatment, prevention and early intervention, outreach, support services, family involvement, and programs to increase access to services for underserved communities.

Workforce Education and Training (WET) received a total one-time $3,437,600 funding allocation in FY's 2006-07 and 2007-08, with a reversion period (timeframe for expending the allocated funds) of 10 years. With MHSA WET funding ending in 2017-18, BHRS is preparing to sustain the most effective and impactful elements of these investments. Continued investment in WET is critical to supporting BHRS' strategic initiatives and priorities, and for creating a system of care that is responsive to MHSA core values of building community collaboration, cultural humility, consumer and family driven services, a focus on wellness, recovery, and resilience, and an integrated service experience.

This report provides an overview of the impacts of MHSA WET investments in the 10 years of implementation by San Mateo County Behavioral Health and Recovery Services (BHRS), stakeholder priorities, and BHRS' vision for WET as a commitment to building knowledge, skills, and core values.

San Mateo County WET Program

After two years of stakeholder engagement and plan development, the San Mateo County WET Plan was approved and enacted in 2009. Current components of the WET Plan include:

1. **Workforce staffing support –** A WET coordinator, a Community Program Specialist, and an Administrative Assistant provide system wide responsibility for managing implementation, reporting and evaluation of all BHRS training activities.
2. **Training, technical assistance, and capacity building –** Trainings to increase the capacity of providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. Additionally, use of evidence-based and community-defined promising practices has increased as a result of training.
3. **Behavioral health career pathways programs –** Strategies that are necessary to address ongoing vacancies in positions which are difficult to fill.
4. **Financial Incentives –** to create a more culturally competent system**,** this program provides stipends to trainees from local universities who contribute diversity as well as the linguistic and cultural humility of BHRS.

Summary of Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained, total of $500,000 per year, through the following three strategy recommendations:

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS. Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation.

- **Sustainability strategy** – a transfer from MHSA CSS will sustain foundational knowledge and training that supports system transformation ($100,000) and the workforce staffing ($260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce and, providing knowledge and skills in the area of stigma reduction and advocacy, empowering and inspiring participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence. Creating pathways for individuals with lived experience requires a systemic and integrated approach.

- **Sustainability strategy –** consolidation of the peer and family partners strategies ($60,000) currently funded by MHSA, CSS General Systems Development component.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level. More has to be done to recruit , hire and retain diverse staff.

- **Sustainability strategy –** a transfer from MHSA CSS ($80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Overview

In the spring of 2017, San Mateo County Behavioral Health and Recovery Services' Office of Diversity and Equity hired independent consultant Sean Kirkpatrick to assess the impact of WET and identify priorities that would shape the future landscape. Engagement included the following:

- WET Survey for Staff, CBO Partners, Contractors
- Survey for Cultural Competency Stipend Intern Program Participants
- Interviews of Cultural Competency Stipend Intern Program Participants
- Listening Session with the Lived Experience Education Workgroup
- Survey for Lived Experience Academy Participants
- Interviews of Lived Experience Academy Participants
- World Café with the Workforce Development and Education Committee
- LEEW Enhancement report (prepared separately by another contractor)

Materials reviewed in preparation of this report also included training logs, pre/post-tests for trainings, evaluations collected during trainings, reports developed, WET Plans and annual updates, etc.

WET Planning

WET planning has always been built on stakeholder input and feedback. The planning process has targeted a diverse group of San Mateo County community members, clients/consumers of BHRS and their family members, BHRS and contract agency staff (including peer and family workers), and community-based organizations and partners, including Health Equity Initiatives. Online surveys, focus groups, in-person group dialogue and key informant interviews have been deployed to capture the input of over 800 stakeholders.

The foundation for the first WET Plan (FY 2009-10) was based on several planning efforts: 1) the MHSA Community Services and Supports (CSS) planning, which engaged a wide range of stakeholders including members of historically unserved and underserved communities; 2) the Joint Labor/Management Initiative, which was formed to create a framework for addressing both the conditions of employment and the approach to providing staff development; and 3) a planning workgroup, which began developing a vision and set of values and principles to ensure that workforce development, education and training initiatives within BHRS were consistent with the vision and values established through the CSS planning process. For the second planning phase (FY 2011-13), a Training Survey based on the priorities of the previous plan was added. The original planning workgroup was comprised of BHRS leadership, managers, line staff, consumers, family members, and representatives of community-based organizations. The group identified foundational knowledge, a wide range of competencies that are viewed as central to supporting system transformation and core of the WET Plan.

Currently, the formal governing and advisory bodies ensure that workforce development, education and training initiatives meet the needs of BHRS' clients/consumers, family members and the community.

- **Workforce Development and Education Committee (WDEC)** meets bi-monthly to ensure training and workforce development plan implementation; identify barriers to the training and workforce plans, create strategies to address the barriers, and accountability. The WDEC is facilitated by the WET Coordinator.
- **Lived Experience Education Workgroup (LEEW)** meets monthly to focus on building workforce development, training, and advocacy opportunities within BHRS for clients/consumers and family members, and planning and supporting the Lived Experience Academy Trainings. LEEW is composed of people who have completed the Lived Experience Academy and other people with Lived Experience. The content of the meetings includes discussion of member participation in speaking engagements, BHRS-related committees and commissions, and sharing their Lived Experience stories. Additionally, members discuss announcements, other peer-led organizations and peer-focused conferences.

WET Plan Components

Over the course of WET implementation, the strategies and investments for WET have shifted to meet the evolving training needs of BHRS. A Child Psychiatry Fellowship was initiated in 2007-08 in response to a critical, historically hard-to-fill position within the San Mateo County BHRS system and as part of the It was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings, as well as provide education to a new generation of psychiatrists about recovery- and strength-based service delivery.

Workforce Staffing Support

As each phase of WET implementation brought about increases in scale and need, the WET Team expanded to include a Coordinator, a Community Program Specialist, and an Office Specialist. The WET Coordinator is generally tasked with oversight of the WET Programs and their implementation, the WET Team, and related WET workgroups/committees; evaluation of WET Programs; facilitation of the Workforce Development and Education Committee (WDEC) and the Practice Evaluation Committee; and participation in several BHRS Workgroups. The WET Community Program Specialist implements and facilitates the WET Programs, including BHRS Training Plan trainings; and oversees internship recruitment, the Cultural Competency Stipend Internship Program, the Lived Experience Academy, the Lived Experience Education Workgroup (LEEW), and the Cultural Humility Trainers. Lastly, the WET Office Specialist provides administrative support and documentation for all WET Programs and trainings. The WET Team members are also the administrative staff responsible for administering the Learning Management System for all BHRS trainings. Currently, WET operates under the Office of Diversity and Equity (ODE), and is supervised by the ODE Director. This shift happened three years ago and has enhanced the focus of WET to embed cultural humility, as well as to support the core values of MHSA.

Training, Technical Assistance, and Capacity Building

Training opportunities have greatly increased the capacity of community members and providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. The strategy also supports system transformation by providing training and technical assistance on utilizing evidence-based practices (EBPs) and community-defined treatment practices (CDPs). Sub-categories for training, technical assistance and capacity building are:

1. **Trainings to support wellness and recovery** – San Mateo County BHRS offers trainings to extend and support consumer wellness and recovery, examples include:
    - *Wellness Recovery Action Plan (WRAP)* trainings. WRAP is an evidence-based, self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. With a train-the-trainer approach, consumers, family members, contracted providers, and County staff are trained as Master Trainers. The Master Trainers then provide training and support in developing WRAP plans for consumers and staff throughout the system.
    - *WISE Recovery 101 and Peer Support 101* Two separate trainings that have been designed for supervisors and peer workers to support understand and support the participation of Peer Workers in the BHRS provided programs and services.
    - *Trainings for Peer Support Workers/Family Partners* a series of trainings designed to address topics and concerns encountered by Peer Support Workers/Family Partners in managing their roles and responsibilities within BHRS.

2. **Training and technical assistance for and by consumers and family members –** these have included a range of trainings activities, for example:
    - Trainings delivered by and for consumers and family members.
        - *Paving the Way,* a San Mateo model that provides training and supports for consumers and family members joining the BHRS workforce
        - *Hope Awards,* which highlights personal stories while educating consumers, families, staff, and the general public about recovery and stigma; and
        - *Inspired at Work,* a program that provides a framework for consumers and family members to get support for entering and remaining in the workforce.
    - Trainings provided by consumers and family members to reduce stigma.
        - *Stamp Out Stigma,* a community advocacy and educational outreach program in which individuals with mental illness share their personal experiences with the community at large
        - *Breaking the Silence,* a training activity designed to address issues of gender identification in youth and the effects of community violence; and
        - *Consumer-led trainings* by transitional age youth for audiences of all ages.
    - Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports.
        - *NAMI's Provider Education Training*, an intensive training for providers led by consumers, family members, and experts;
        - *Peer to Peer,* a NAMI-sponsored nine-week course taught by consumers to consumers about mental health, treatments, and recovery; and
        - *Voices of Recovery,* a client and family-driven advocacy and support program for those who have been affected by addiction.

- Trainings for consumers and family members on leadership skill development to support increased involvement of consumers and family members in various committee, commission, and planning roles:
    - *California Mental Health Advocates for Children and Youth Conference*
    - *The Village* educational visits*;* and
    - *NAMI, Heart & Soul,* and other community-based training activities to help perfect the leadership skills of consumers and family members.

3. **Cultural humility trainings –** trainings in the area of cultural humility are designed to reduce health disparities in the community; provide instruction in culturally and linguistically competent services; and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. Examples include:
    - *Working Effectively with Interpreters in Behavioral Health Settings*
    - *Culturally Responsive Supervision*, and
    - *Building Bridges to Diversity and Inclusion: Cultural Humility for Non-Clinical Staff.*

    The Health Equity Initiatives work with the WET team to create and support trainings to address special populations and appropriately serve marginalized communities, examples include:
    - *Native American Mental Health: Historical Trauma and Healing Practices*
    - *Working with Filipino Youth,* and
    - *Understanding Issues in the Queer Experience (UNIQUE)*.

4. **Evidence-based practices (EBPs) –** for system transformation are supported through an ongoing series of trainings that increase utilization of EBPs. Such practices aim to engage consumers and family members as partners in treatment, and thus contribute to improved consumer quality of life. The WET Coordinator facilitates the Practice Evaluation Committee which carries out the selection of evidence-based and community-defined practice policy. Examples include:
    - *Functional Family Therapy,* a family-based intervention with at-risk youth in the criminal justice system that focuses on using family and consumer strengths to help youth gain control of their behaviors
    - *Trauma-Focused Cognitive Behavioral Therapy,* a model that integrates cognitive and behavioral interventions with traditional child abuse therapies and focuses on enhancement of interpersonal trust and empowerment; and
    - *Dialectical Behavior Therapy,* a practice focused on developing skills to more effectively deal with distress.

Behavioral Health Career Pathways Programs

The Behavioral Health Career Pathways Programs aim is to recruit, hire, support, and retain diverse staff in behavioral health careers. After the first WET Plan (FY 2009-10) established core program areas, subsequent WET Plans refined strategies. Some program areas were not retained in subsequent plans including the Behavioral Health and Human Resources Forums and the specific Behavioral Health Career Pathways Program with high school students.

1. **Attract prospective candidates to hard-to-fill positions** (including child/adolescent psychiatrists, psychiatric mental health nurses, and *promotores*/navigators) by addressing application barriers and providing incentives. Programs San Mateo County participated in included:
   - *Mental Health Loan Assumption Program (MHLAP)* – provides student loan forgiveness for BHRS and contractor staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or experience working in underserved areas. Trainees receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation. In fiscal year 2015-16, 25 BHRS awardees received stipends totaling $197,383.
   - *Behavioral Health and Human Resources Forums* – hosted by the Greater Bay Area Mental Health & Education Workforce Collaborative, the purpose of these forums was to influence county behavioral health human resources practices and priorities toward hiring staff who reflect the composition of the community being served. This program was discontinued.
   - *Child Psychiatry Fellowship* – was initiated in 2007-08 and responded to a critical, historically hard-to-fill position within the San Mateo County BHRS system. The Fellowship was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. This program was discontinued.
2. **Promote the mental/behavioral health field in academic institutions** where potential employees are training in order to attract individuals to the public mental health system in general, and to hard-to-fill positions in particular.
   - *Intern/Trainee Program* – BHRS partners and contracts with graduate school in the Bay Area to provide education, training, and clinical practice for their students at various behavioral health worksites in the County to provide training opportunities for psychology interns, masters-level trainees, alcohol and drug certificate program students, and psychiatric residents each year. Students are welcome to attend any of the five didactic training seminars throughout the county. There are bi-monthly psychiatric grand rounds that are open to all staff and students. Regular in-service training and specialized staff training are also available for students to attend. Additional skills training in wellness and recovery; crisis response, suicide and trauma; cultural humility; integrated care; and co-occurring mental health and substance use disorders were added to the internships.
3. **Promote interest among and provide opportunities for youth/Transition Age Youth (TAY)**
   - *Behavioral Health Career Pathways Program* – Encourages San Mateo County high school students to explore future careers in behavioral health, increases students' understanding of individuals with behavioral health challenges, and reduces stigma. This program was discontinued in FY 15/16.
4. **Create new career pathways and expand existing efforts for consumers and family members** in the workforce to allow for advancement within BHRS and in other parts of the County system.
   - *Lived Experience Education Workgroup/Lived Experience Academy* – Prepares clients/consumers and family members for workforce entry, advocacy roles, participation on committees and commissions, etc.
   - *BHRS New-Hire Orientation* – Starting in 2014-15, BHRS employees receive a 3-session orientation designed in part to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore possibilities for career advancement, and to feel invested in and supported.
5. **Increase diversity of staff to better reflect our client population and retain diverse staff**.
   - *Cultural Competency Stipend Internship Program* – this program shifted to Financial Incentives Program defined below to provide interns with school expense support.

Financial Incentive Programs

The Financial Incentive Program goal is to **increase the availability of culturally and linguistically competent services to all consumers and family members of BHRS**, and to increase trainees' knowledge and understanding of the values and commitments of recovery- and strengths-based services offered.

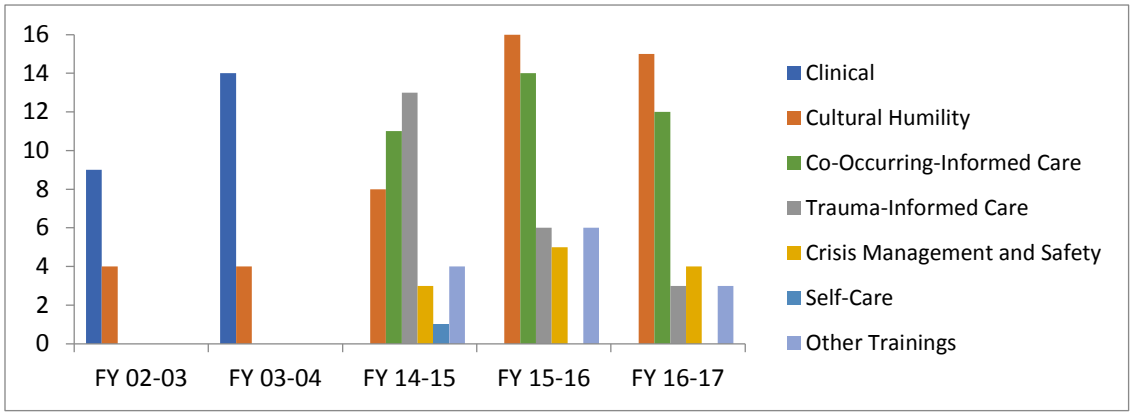
1. *Lived Experience Scholarship* – provides up to $500 for clients/consumers or family members to pursue their academic goals toward a clinical, administrative, or management career in behavioral health. Applicants must be current or former BHRS clients/consumers or family members, residents of San Mateo County, and registered for at least six units in a vocational, 2-year college, 4-year college, credential, or graduate program.
2. *Cultural Competency Stipend Internship Program (CCSIP)* – created to support behavioral health graduate students who contribute to the cultural humility/responsiveness of BHRS through linguistic capability, cultural identity and/or experience working with and advocating for special populations represented in San Mateo County. Up to 10 trainees are selected based on their bicultural/bilingual capabilities, with preference given to those who identify or have experience working with special populations. As the program evolved interns were required to interact with and learn from members of the Health Equity Initiatives and other systems-change initiatives. Stipend amounts average $5,000 per participant.

Evolution of WET Priorities

Prior to implementation of the MHSA WET strategy, the landscape was far less robust, with fewer trainings offered annually. Furthermore, topics skewed toward direct clinical training due to norms and an emphasis on medical intervention. For example, 60% of the trainings offered in FY 2002-03 had a clinical focus (e.g. Methadone, Antipsychotics, Risk Management, etc.); in FY 2003-04, 78% had a clinical focus. Cultural humility-focused trainings at this time included Latinos and Mental Health, Cultural Values and End of Life, and a Cultural Competence and Mental Health Summit.

In more recent years, the number and variety of trainings offered have increased significantly. Between 2014 and 2017, BHRS invested $1,308,920 of MHSA funding in WET, providing 95 trainings to over 3,000 people in the same timeframe. In addition to cultural humility trainings spearheaded by the Office of Diversity and Equity, these trainings focused on co-occurring-informed care, trauma-informed care and crisis management and safety, a shift visible in the graph below.

Types of Trainings Offered by Fiscal Year



Overall, this increase in diversity of training offerings reflects BHRS' intentionality to invest in training. While it is possible that data collection on training type was lacking prior to the implementation of MHSA, this investment also reflects a response to shifts in training needs, either from the providers or the clients. Additionally, the annual training participant numbers have been relatively stable from year to year; however, there has been an increase in the number of trainings offered. This may signify that more people are being trained across more topics. Throughout the initial planning of WET and iterations of the plan, diverse stakeholders have been engaged to help shape future training topic priorities in four areas (Foundational Knowledge, Special Populations, Clinical Competencies and Skills and Treatment Practices) as described below.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values of San Mateo County behavioral health programs that all employees, regardless of position, should know and understand. Topics for Foundational Knowledge trainings have evolved and expanded in various iterations of WET Plans.

Table 1. Foundational Knowledge Trainings Prioritized

Topic	FY 2009-10	FY 2011-14	FY 2014-17
Cultural competence/humility	X	X	X
Stigma reduction	X	X	X
Self-care	X	X	X
Consumer and family training and support/support and integration of families in treatment	X		X
Customer service	X		
HIPAA and confidentiality	X		
Developing consumer-centered system	X		
Crisis management and safety		X	X
Legal and ethical issues		X	X
Partnering and Collaboration		X	X
Integration of Primary Care and Behavioral Health		X	X
Knowledge of BHRS and Partner Programs		X	X
Spirituality and Behavioral Health		X	X
Managing Assaultive Behavior		X	
Trauma/trauma-informed care			X
Co-occurring-informed care			X
Wellness and Recovery			X
Quality Improvement/Documentation			X
Welcoming and Engagement			X
Inclusion of Indigenous Healing Practices in Tx			X

Special Populations

WET Plans also identified special populations for whom behavioral health staff should receive tailored trainings to effectively treat and serve these special populations. Language used to identify these communities changed over time. The 2014-17 WET Planning stakeholder groups and surveys identified certain cultural groups as special populations, evidence of increased awareness that culture and community-specific trainings help improve quality of services for these groups.

Table 2. Special Populations Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
LGBTQQI	LGBTQQI	The LGBTQQI – emphasis on the transgender community
Gender-responsive treatment	Survivors of domestic violence	The Chinese Community
Infants and early childhood	Chinese	The Pacific Islander Community
Developmental disabilities	Filipino	The African-American Community
Abused children	Pacific Islander	The Latino/Hispanic Community
Family law participants	African American	"At-risk" Youth and Transitional Age Youth
Adult survivors of abuse	Latino	Individuals in the Criminal Justice System
PTSD	Co-occurring Disorders	The Aging and Older Adult Population
Geriatric		Individuals with Co-Occurring Mental Health and Substance Use Conditions
Cognitive disorders		Individuals with developmental disabilities – Pervasive Developmental Disabilities
Victims of domestic violence		

The 2014-17 WET Plan identified only 4 cultural communities as special populations (the Chinese Community, Pacific Islander Community, African-American Community and Latino/Hispanic Community). A more recent survey in 2017 identified 10 cultural communities meriting training attention (the African American Community, Arab Community, Asian American Community, Black Community, Chinese Community, Filipino Community, Indigenous Community, Native American Community, Latina/a/x Community [including youth and families], and Pacific Islander Community). Survey respondents additionally indicated need for trainings that address the experiences of marginalized communities, newly immigrated communities, the LGBTQ community (with a focus on transgender people), and spiritually-based communities.

Clinical Competencies and Skills

In addition to Foundational Knowledge, stakeholder groups and surveys identified key areas of clinical competency that should be prioritized for staff training. In various WET Plans, these areas included:

Table 3. Key Areas of Clinical Competency Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
Motivational Interviewing	Culturally appropriate responding	Assessing and Treating Suicide Risk/Harm
Integrated treatment of co-occurring disorders	Working with complicated families	Trauma-Informed Care
Cultural humility in clinical assessment	Assessment and Diagnostic skills for substance abuse	Assessment and Diagnosis of MH and SU Conditions
Support of informed consent and choice	Motivational enhancement	Working Effectively with Complicated Families
Wellness Recovery Action Planning	Assessment and Diagnostic skills for mental health	Self-Care
Illness management and recovery	Personality Disorder	Client-Centered Treatment Planning and Documentation
	Relapse Prevention	Crisis Management/Safety
	Assessing Strengths and needs	Working Effectively with Undocumented Families
	Mindfulness Skills	Assessing/Managing Assaultive Behavior
	Client Centered tx planning and documentation	Professional Ethics
		Motivational Enhancement/ Engagement in Treatment
		Relapse Prevention
		Cultural Humility
		Partnering and Collaboration
		Co-occurring Informed Care
		Wellness and Recovery
		Mindfulness Skills
		Group Treatment Skills
		Clinical Supervision
		Integration of family partners/ peers support workers in Tx
		Clinical Case Management
		Integration of Spirituality
		Integration of non-traditional healing practices

Treatment Practices

Stakeholders including consumers and their family members, administrative and managerial staff, and direct services staff identified a number of specific treatment practices to include in the FY 2009-10 WET Plan. Over time, the Specific Treatment Practices became more aligned with State- and Federal-level interventions and requirements, as well as such emerging trends as mindfulness-based interventions.

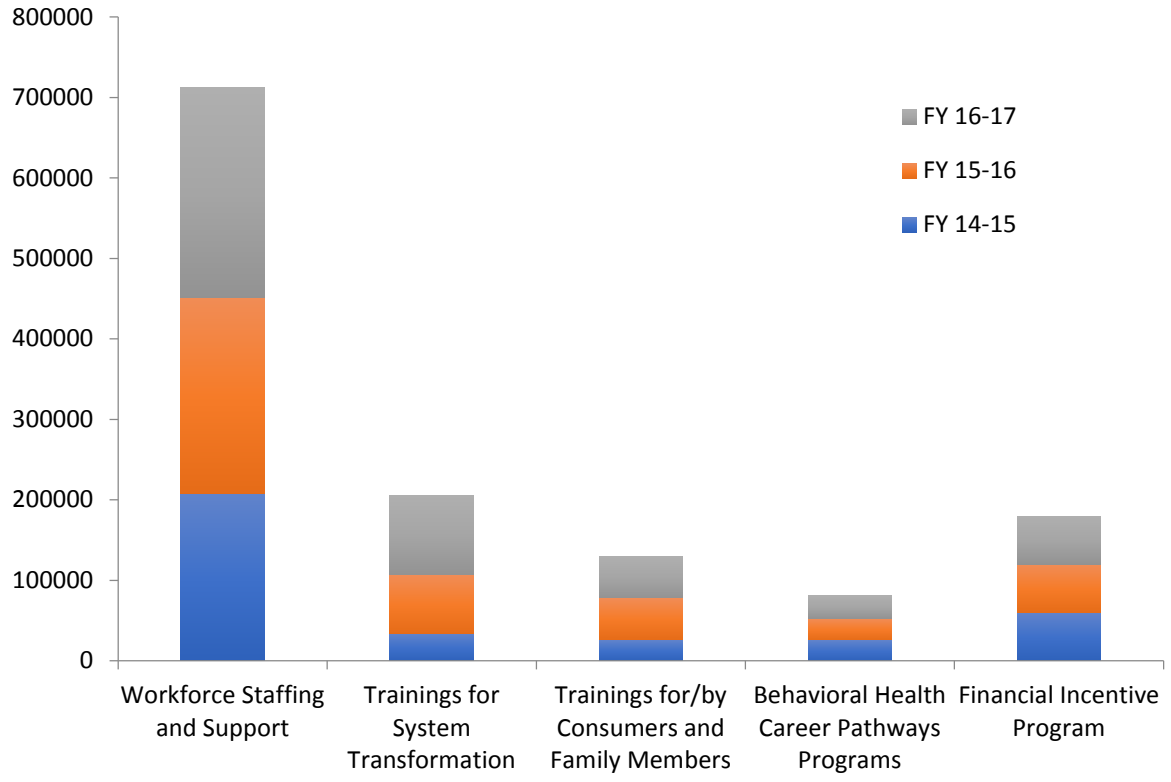
Table 4. Treatment Practices

FY 2009-10	FY 2011-14	FY 2014-17
Cognitive Behavioral Therapy (CBT)	Trauma Focused CBT	Trauma-Informed Care
Trauma-focused CBT	Advanced CBT	DBT/ DBT Informed Treatment
Family Psycho-Education	Solution focused Treatment	Seeking Safety
Supported Employment	Trauma Recovery and Empowerment Model	CBT for Psychosis
Assertive Community Treatment (ACT)	Seeking Safety	Motivational Interviewing
System of Care and Wraparound	Group Treatment Methods	Brief Family Therapy Models
Dialectical Behavioral Therapy (DBT)	Relapse Prevention	Mindfulness-Based Interventions
Functional Family Therapy (FFT)	DBT	Attachment-Based Therapy Models
Aggression Replacement Therapy (ART)	Brief and Strategic Family Therapy	Wellness Recovery Action Plan
	Family Therapy	Solution Focused Therapy
		Cultural Humility
		Relapse Prevention Therapy
		EMDR
		Brief Psychodynamic Therapy
		Group Treatment
		Somatic Therapy
		NMT
		CBT for Insomnia
		Peer Support/Peer Counseling
		Outcome Informed Services

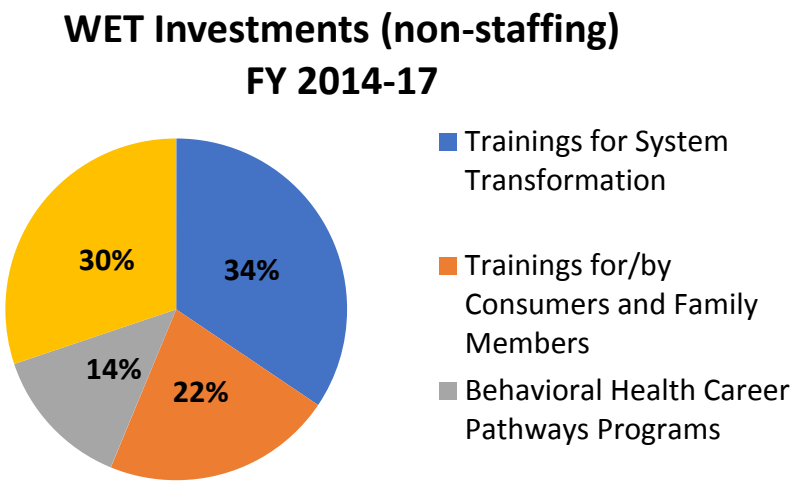
Fiscal Investments

Workforce Education and Training (WET) received a total $3,437,600 funding allocation in FYs 2006-07 and 2007-08. In FYs 2014-17, BHRS invested $1,308,920 of the total allocation to WET activities. Following is a snapshot of the funding distribution by year and categories based on the WET Plan. There are six categories that reflect the components of the WET Plan, with Training, Technical Assistance and Capacity Building divided into two subcategories, Trainings for System Transformation and Trainings for/by Consumers and Family Members.

Overall Distribution of WET Investments (2014-17)



- **Workforce Staffing and Support**, which accounted for over 50% of the total investment ($712,316). Prior to the 2014-17 WET Plan, the WET team had the equivalent of 1.5 full-time staff (referred to as 1.5 FTE), but MHSA funding allowed the team to increase to 2.0 FTE in FY 2014-15 and currently, 3.0 FTE. This additional staffing proved crucial to sustaining the 2014-17 WET Plan, particularly to support trainings, which also received substantial increases in funding.



- **Trainings for System Transformation** represented 34% of non-staffing WET investments. From FY 2014-15 to FY 2016-17, funding in this category increased nearly three-fold, from $34,150 to $98,650. With this funding, BHRS was able to offer substantially more trainings designed to reduce health disparities in the community, provide instruction in culturally and linguistically competent services, and increase access, capacity, and understanding of mental health issues; as well as more trainings on evidence-based practices. This funding also enabled BHRS to partner with community groups and offer educational and training activities to consumers, family members, providers, and those working and living in the community.
- **Trainings by and for Consumers and Family Members** nearly doubled between FY 2014-15 and FY 2016-17, from $26,354 to $51,900, and accounted for 22% of total non-staffing investments from 2014-17. These trainings aimed to increase understanding of mental health issues and reduce stigma among consumers, family members, and the general public. Trainings also increased consumers' and family members' knowledge of substance use/abuse issues, recovery and resilience, and available treatments and supports. This funding also enabled consumers and family members to attend leadership trainings to support their increased involvement in various committee, commission, and planning roles. Taken as a whole, these substantial increases in training investments represent BHRS' commitment to reducing health disparities, providing culturally and linguistically competent services, increasing understanding of mental health issues, and empowering consumers and family members.
- **The Behavioral Health Career Pathways Program** investments remained relatively stable and included the Intern/Trainee Program and Behavioral Health Career Pathways Program to encourage San Mateo County high school students to explore future careers in behavioral health. Together, they accounted for 14% of total non-staffing investments from 2014-17. The Intern/Trainee Program increased by only $1,000 per year between FY 2014-17, while funding for the Behavioral Health Career Pathways Program remained at a stable $25,000 annually and was discontinued FY 2016-17.
- **Financial Incentive Program** consisted of the Cultural Competency Stipend Internship Program (CCSIP) and the Lived Experience Scholarship Funds and represented 30% of non-staffing investments. CCSIP funding remained at a consistent $50,000 annually and The Lived Experience scholarship remained at a consistent $10,000 annually between FY 2014-17.

Stakeholder Input

The stakeholder engagement process included the WET Survey for staff, community-based partners, and contractors, and the Workforce Development and Education Committee World Café. The data collected during this process is being used to develop staff training priorities for the next three years of WET Planning (2017-20). As with the previous WET plan, there are four major areas/topics of training: Foundational Knowledge, Special Populations, Clinical Competencies and Skills, and Treatment Practices.

Survey Results - Priority Training Areas

The WET Survey for staff, community-based partners, and contractors was administered to all BHRS and contract agency staff in all positions (i.e. clinical, administrative, managerial, peer positions, etc.). The survey asked respondents about priority areas and training topics; specifically, areas/topics in which they would like their providers to be trained, and in which they would like to receive training.

Overall Training Priorities

All survey respondents were asked to identify BHRS' top training needs as a free response; this allowed us to see whether responses clustered around similar themes without providing options that would bias responses. Given that many respondents have direct contact with clients/consumers, it is unsurprising that the most frequently identified training were related to treatment modalities and clinical interests:

- **Evidence-based practices (EBPs)** – such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy (DBT), and Eye Movement Desensitization and Reprocessing, Motivational Interviewing.
- **Required trainings** – such as for the Board of Behavioral Sciences (AIDS/HIV training, Law & Ethics training) and Alcohol and Other Drugs contractor required trainings (EBPs, Title 22, CLAS).
- **Other Treatments/interventions** – including psychosocial interventions, peer support integration models, sexual abuse prevention and interventions, and non-verbal modalities such as art therapy and play therapy.
- **Cultural humility** – free responses included trainings on cultural differences, white privilege and systemic oppression, cultural humility/diversity conversations, social equity trainings
- **Career development** – several other responses mentioned topics related to career development, including peer training for certification, culturally informed supervision training, and training on becoming a clinical supervisor.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values that all employees, regardless of position, should know and understand. Staff, community-based partners, and contractors identified the following top training areas, in order of priority:

- Trauma-informed care
- Self-care
- Co-occurring-informed care
- Welcoming and engaging all clients/consumers
- Cultural humility/responsiveness

Clinical Competencies and Skills

Staff who have direct contact with clients/consumers were asked about their priorities with regards to training in clinical competencies. These staff provide direct assessment and treatment-related services, including intake/assessment, counseling, advocacy, and education for consumers and/or family members. The following top clinical areas were identified, in order of priority:

- Trauma-informed care
- Co-occurring-informed care
- Self-care
- Alcohol and other substance use
- Assessing/treating suicide risk/harm
- Assessment and diagnosis of mental health and substance abuse conditions

Clinical staff were also interested in receiving more training in the following priority EBPs:

- Neurosequential Model of Therapeutics (NMT)
- Mindfulness-based interventions
- Attachment-based therapy models
- Motivational Interviewing (MI)
- Eye Movement Desensitization and Reprocessing (EMDR)

Clinical staff were asked about specific mental health conditions/diagnoses for which they would like more training. This question received fewer responses overall, most were interested in:

- Personality disorders (e.g. narcissistic personality disorder, borderline personality disorder, etc.).
- Psychotic disorders
- Co-occurring conditions with mental health, substance use, and physical health issues
- Trauma and trauma-focused care

Administrative Staff Training Priorities

Administrative staff included front office, reception, fiscal/billing, support, contracts, quality management, and information technology staff. Their top five training priorities were:

- Managing crisis phone calls
- Engagement and welcoming
- De-escalation of conflict
- Self-care for administrative staff
- Roles and responsibilities when engaging with consumers/family members

Managers/Supervisors Training Priorities

Managers and supervisors oversee staff performance, as well as programmatic and clinical operations. Their top five training priorities were:

- Creating safety and trust among teams
- How to give and receive feedback in a culturally sensitive/responsive way
- How to facilitate dialogues on racism, sexism, etc.
- Increasing staff motivation
- Documentation for supervisors of interns and trainees

Training Modality and Structure

Hands-on interactive/experiential workshops were the most preferred training modality, followed by in-house expert consultations. Case presentations/consultations, didactic lectures, ongoing seminars, and coaching were also preferred by many respondents. In their free responses, respondents also recommended mentoring, videos for training (separate from Webinars), and in-person "behind the mirror" trainings with real clients as other training modalities to consider.

The most preferred structure and length of trainings were half-day trainings (starting in the morning) and full-day trainings. Half-day trainings (starting in the afternoon), two-hour trainings, and one-hour trainings were preferred half as frequently.

Other recommendations related to modality and structure included offering more trainings in general, offering trainings more than once to provide more opportunities to attend, offering small group trainings, and incorporating more group interaction within trainings. Some of these recommendations clearly complement each other; for example, small group trainings can accommodate more group interaction within each training. An example of how WET has already responded to such recommendations is the "Becoming Visible" training on Sexual Orientation and Gender Identity: this training is being offered twice a month in FY 17-18 in order to reach a broad audience, including BHRS staff, community partners, and contractors.

Workforce Development and Education Committee Priorities

On April 28, 2017, a World Café-stylei session was facilitated for the Workforce Development and Education Committee (WDEC). Six BHRS staff members and four representatives from community-based partners (Caminar, Daly City Youth Health Center, Edgewood and Your Strength to Heal) participated; all participants are current members of WDEC. The session focused on three topics: Training Priorities, the Impact of WET, and the WDEC's Vision for WET moving forward.

WDEC Identified Training Priorities

Participants identified the following training priority areas: data collection and management using a health equity frame, alcohol and other drugs, certification tracks for individuals with lived experience, trauma-informed systems, self-care, and specific trainings.

- **Data Collection and Management Using a Health Equity Frame –** the group recommended that there be trainings on performing community assessments and data collection to inform equitable quality services. These trainings should use CLAS requirements as a core principle for providers, and not only for prevention staff. One participant also recommended using process evaluations to assess the efficacy of training implementation.

- **Alcohol and Other Drugs –** several training priorities in the area of alcohol and other drugs (AOD) were identified, including substance use, co-occurring-informed care, and including more people with substance use lived experience on training panels. One participant observed that AOD treatment is different from mental health treatment, and that more training specific to AOD would improve this understanding.

[i] http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/

- **Certification Tracks for Individuals with Lived Experience –** several participants indicated that there is a need for certification tracks, especially for peer support workers. Certification tracks would allow individuals with lived experience to find new career paths within clinical/support fields without needing to complete a graduate school track. An example of such a program was the AOD Training Academy held in FY 2017-18.

- **Trauma-Informed Systems –** the group felt that BHRS needs to move beyond trauma-informed care to deeper trainings that support the development of a trauma-informed system. Participants noted that this effort should be staged across three to five years and monitored at each step so that the transformation to a trauma-informed system is carried through. Related trainings should also include the importance of culturally-informed care. Training administrators would also be needed to evaluate the utility of trauma-informed principles in their work. A Bay Area initiative, Trauma Transformed, focused on developing trauma-informed systems was mentioned as a potential resource[ii].

- **Self-Care –** continued attention to self-care should be a priority, as the group felt that it was "not happening" with consistency and clarity of purpose. One recommendation was to use trainings as settings for self-care and processing, with the goal of creating a culture where staff build more self-care into their daily work.

- **Specific Training Topics –** in addition to the training areas described, participants identified the following specific trainings and training topics as priorities:
  - Acuity and risk increase
  - Cult abuse
  - Culturally appropriate trainings, especially on suicide
  - Harm reduction
  - Human trafficking
  - Practical skills, especially for people in direct service
  - How to use community resources and free support services
  - Suicide among specific population (e.g. Dr. Joyce Chu's suicide among Chinese adolescents)
  - Recovery oriented clinical services
  - CBT
  - CBT for Psychosis
  - Child Management techniques
  - Collaborative Problem-Solving for Clinicians and Social Workers
  - DBT
  - EMDR
  - Motivational Interviewing
  - NMT
  - Positive Parenting Program
  - Psychoeducational
  - Substance use prevention
  - Relapse Prevention
  - Crisis/suicide/assault intervention (i.e. Crisis Intervention Training)
  - Tobacco Cessation
  - Clients' stories

[ii] http://traumatransformed.org/

WET Impact

Both survey respondents and the WDEC where asked about how WET has shaped the culture of BHRS, as well as how trainings have impacted them individually. Overall, stakeholder input was positive and majority of stakeholders acknowledged how WET trainings are able to shape BHRS' culture and enhance services by providing opportunities for all to learn and practice cultural humility, igniting much needed system transformations, allowing for new insight and awareness, promoting dialogue, increasing understanding, and ultimately better serving clients.

There were specific programs/trainings that were mentioned as being particularly impactful including the Lived Experience Academy, Neurosequential Model of Therapeutics (NMT), Seeking Safety, the Health Ambassador Program, Mental Health First Aid, Health Equity Initiatives, anti-stigma work, and the internship program. The following themes capture the comments from the perspective of survey respondents and WDEC participants:

Improving Cultural Humility

The most commonly mentioned accomplishments of WET in shaping the culture of BHRS were related to improving cultural humility, multiculturalism, and cultural sensitivity. Many respondents also felt that they had been personally impacted by cultural humility-related trainings, with one writing that such trainings gave them "greater awareness and better practice methods on how to work with specific populations." Leanna Lewis' trainings and consultations on cultural humility were mentioned specifically, but culturally informed trainings in general have also made a difference.

Increasing Focus on Trauma-Informed Care

WET trainings have had an impact on increasing focus on trauma-informed care. Participants observed that cultural humility and trauma are the "big platforms" for BHRS/ODE's WET investments. It was noted that people continue to ask for more trainings, it is a constant request. It was also noted that because trainings are left to individual choice versus being a requirement for all, it may not be sufficient to laying the groundwork for trauma-informed systems change.

Cultural Humility and Trauma Informed

"Cultural Humility gave me a helpful frame for addressing a microaggression I experienced, which was empowering."

[trainings on cultural humility] "open the door for difficult and important conversations amongst staff."

"become very sensitive to the impact trauma has on myself and others. I am aware that there is so much I don't know and need to learn as I interact with others."

Creating a Culture of Learning

BHRS' 20-hour training requirement was identified as having an impact on the institutional culture of learning and growing. Several respondents felt that having more trainings available was helpful to their work. Other clinicians stated that trainings related to licensing and opportunities to earn CEUs were valuable.

Improving the Standard of Care

The impact of WET on cultural humility was even more poignant in relation to how trainings affected providers. Exposure to cultural humility-related trainings permeates into providers' work and interactions with clients/consumers. Additionally, several respondents felt that trainings helped enhance providers' clinical skills.

Valuing Lived Experience

The Lived Experience Academy (LEA) and Lived Experience Education Workgroup (LEEW) were especially important for increasing peer support and training. The establishment of LEEW was cited by many respondents as crucial to welcoming staff with lived experience into BHRS, impacting BHRS' culture. Other respondents felt that incorporating lived experience into trainings increased their level of support for the work of lived experience staff, as well as enhanced connections among different staff.

Building Capacity for Co-occurring Care

While systems for co-occurring AOD and mental health capability have developed, participants felt that resources were still needed. There are greater interactions and integration of services between substance abuse providers and mental health treatment providers, and more interaction with other systems such as health and criminal justice, towards an Organized Delivery System. Additionally, these efforts have helped to identify change agents from all agencies, giving people within the system a place for networking, cross-training and cross-pollination, resulting in a significant shift in the work and moving the work out of prior silos.

Increasing Awareness of the Importance of Self-Care

Participants noted the importance of self-care and trainings related to it yet, awareness of the importance of self-care is not sufficient to creating a system that supports it across all staff levels. It was noted that lots of workers burn out, and they have no ability or mechanism to refresh within their current work environment. Additionally, there are still legal obstacles and limitations in place because of the union. There is still very little preventive care for this workforce, and employees have to fight for their self-care needs to be honored.

Culture of Learning

"I have appreciated being exposed to dialogue that I can bring back and apply directly."

"Hearing a perspective of the people I work with in words that resonate with me so that I can listen to people better."

"[Trainings have] encourage[d] ongoing learning to better serve clients at BHRS."

"Learning empowers me to keep fighting the good fight!"

Standard of Care

[trainings] "have allowed providers of treatment to explore new possibilities and promote insight and awareness."

"Ongoing education is so important for a clinician. It really raises our standard of care."

Lived Experience

"incorporating lived experience at trainings has help[ed] me and others put a face to the training...very important...please keep this up."

Focusing on Client Centered Services

Participants acknowledged that WET investments have helped impact the focus on client outcomes. All decisions (clinical and non-clinical) should be made through the lens of how they will benefit clients and families. "Client-centered" is more than clinical, and involved continuous quality improvement, not just quality assurance. Efforts should be made such that all decisions should derive from client- and family-centered perspective, and that we are present for them and coming from a place of love vs. judgment.

Challenges

Need to Focus on Systemic Changes

WDEC participants noted that they feel that there needs to be more conversation about how to perpetuate systemic changes fostered by trainings so that they result in systems transformation. These transformations need to be seen in policies and qualities of leadership. There is a need to create ways of measuring the impacts of workforce education and training that are aligned with the goals of systems change. This was also mentioned by survey respondents on a number of occasions as they discussed trauma informed care and self-care for example and the feeling that there is still not a system that can support full implementation.

Systemic Transformation

"The goal should be a systemic transformation that includes everyone, from janitor to judge."

Additional Comments

A small number of survey respondents were "not sure" or felt that they had not been impacted by trainings. One respondent noted that the WET investments have tended to privilege mental health over AOD, noting how this "shapes what staff perceive as priorities; because most training are focused on mental health, it is perceived as a priority over substance use."

Vision for WET Moving Forward

Cultural Humility

Stakeholders were also asked about what areas of training should receive ongoing investments. Cultural humility (multiculturalism, social equity, power/privilege, etc.) and culturally informed trainings received the most responses, with one respondent writing, "Cultural Humility is an entry point, but we need to dig deeper!" At least one respondent also noted that the Health Equity Initiatives have an important role to play as trainers and providers of key information and perspectives, stating that they would like to see ongoing investment in trainings from such teams as the Native American Initiative, Latino Collaborative, and PRIDE Initiative.

Trauma-Informed System and Self-Care

Trainings on trauma-informed care and NMT received the second-highest number of responses followed by Self-Care. Specifically, continuing to invest in building a *trauma-informed system* – moving beyond trauma-informed care – built on social determinants of health as a foundation with the vision of building a permanent culture within BHRS' network of providers and organizations. Participants connect this vision to a system that supports *self-care* as well. Specifically, there needs to be a greater focus on self-care to prevent burnout in the workforce and continued investment in WRAP trainings.

Youth Career Path Development

Another vision is connected to workforce development through a focus on *youth career path development* in behavioral health fields. One participant pointed to youth training being done in the Filipino community as an example. Participants also would like to see greater youth representation in regional meetings.

Lived Experience-Focused Trainings

WDEC participants see a continued investment in *lived experience-focused training*, with a goal of honoring lived experience people by making trainings more inclusive and welcoming. WDEC would also like to see more lived experience people in trainings as a goal moving forward. *Certification courses* were mentioned as a vision.

Alcohol and Other Drugs (AOD)

Several participants would also like to emphasize AOD moving forward. Recommendations include addressing *the needs of AOD treatment providers* who often face barriers to training due to the nature of their work (such as evening hours, financial constraints, long commutes, etc.) that limit their ability to participate in, and benefit from, training opportunities. There is a wish for AOD providers and interns to collaborate more. Lastly, there is a vision is to create and support a culture that recognizes that "sobriety does not equal wellness," and that being sober is just the beginning of the journey to recovery.

Specific Trainings

The group would like to see *guiding principles for all trainings/programs* developed by BHRS/ODE, and that these be a focus of future trainings. Other program ideas include:

- Service learning projects
- Training focused on long-term recovery such as Voices of Recovery
- Human trafficking training
- Family treatment models
- Training to SOGI standards (it was noted that San Francisco Department of Public Health makes training on gender orientation mandatory, and that this should be considered).
- Trainings from the Bay Area Regional Health Inequities Initiative[iii] (County of San Mateo Public Health, Policy and Planning Department is a member of the initiative)
- Grant writing and organizational development

[iii] http://www.barhii.org

Other Comments

- **System Change –** Focusing the work of the WET Coordinator on system change priorities
- **Decentralized Training System** – Developing policies and structures for training that can be developed in house
- **System Orientation for Contractors** – using BHRS College for contractors to learn about BHRS. Related to this, the group suggested that there be a survey to identify who can offer specific trainings and experiences within BHRS in order to maximize internal resources as well as acknowledge strengths that are untapped within the system.
- **Improved Communications of Trainings** – there was a request for improved communications so that training opportunities are seen earlier, and for a more integrated communication system that is connected to calendaring.
- **Intern Training Manual** –that can be used system-wide towards improving clarity of goals, tracking of outcomes, and continuity in order to level the field of practice. Should include an interview process for interns.
- **Crisis Intervention Team (CIT) Shared Curriculum** –develop a strategy for sharing curriculum across the system with providers.
- **Online Training** – it was observed that the system is not meeting its goals for providing webinars, while also noting that face-to-face training is a preference that might be impacting this outcome.

Lived Experience Education Workgroup and Lived Experience Academy

In addition to the surveys and dialogues conducted with staff and providers as described above, it was important to delve deeper into WET funded programs.

Overview

The **Lived Experience Education Workgroup (LEEW)** engages clients, consumers, and family members and prepares them for workforce entry, advocacy roles, participation in public committees/commissions, and other empowering activities. In addition to those with lived experience, BHRS and contractor staff also participate in the LEEW, which oversees the **Lived Experience Academy (LEA)**. Graduates of LEA train to share their stories as a tool for self-empowerment, stigma reduction, and public education about behavioral health issues through the LEA Speaker's Bureau. Speakers are compensated at a rate of $35 per hour to speak at BHRS trainings and events throughout San Mateo County.

As of Spring 2017, there were approximately 40 LEEW members, with 20 active members. The Enhancement of Lived Experience Workgroup Report, submitted to ODE/BHRS in March 2017, found that this is less than what is needed for clients/consumers with lived experience to be fully represented throughout the system of care. Specifically, additional consumers and family members would enhance the work of the Community Service Areas (CSAs) and Health Equity Initiatives (HEIs), as well as increase participation in competitive employment. In 2016, LEEW members participated in the Mental Health and Substance Abuse Recovery Commission; BHRS Quality Improvement/Quality Management; Workforce Development Meetings; Housing, Operations & Planning meetings; CSA committees; and various ODE HEIs.

Participating in LEA had positive and far-reaching impacts on BHRS consumers. As one Listening Session participant described it:

"Empowering.
Non-shameful.
A supportive journey.
I felt that I was not just a consumer, but part of the team. My mentally ill children have a different experience of me now.
We all have our individual stories. This helped me with my children, moving them from street drugs to taking their meds, and they are now open to seeing the psychiatrist."

Methods

"I've gone from a really good life to nothing to starting to build my life back up again…If not for LEA and other classes offered by BHRS, I would not be where I am today."

- LEA participant

In the Spring 2017, three methods of data collection were used in this evaluation conducted:

- **LEA Survey –** current and former LEA participants were surveyed about their perceived outcomes and level of agreement to a series of statements.
- **LEEW Listening Session –** current and former LEA participants were invited to attend the Listening Session held on April 4, 2017. The focus of was LEA's impact on community involvement and personal and professional development.
- **LEA Interviews** – former LEA participants were interviewed for a deeper perspective of LEA's impacts.

Results

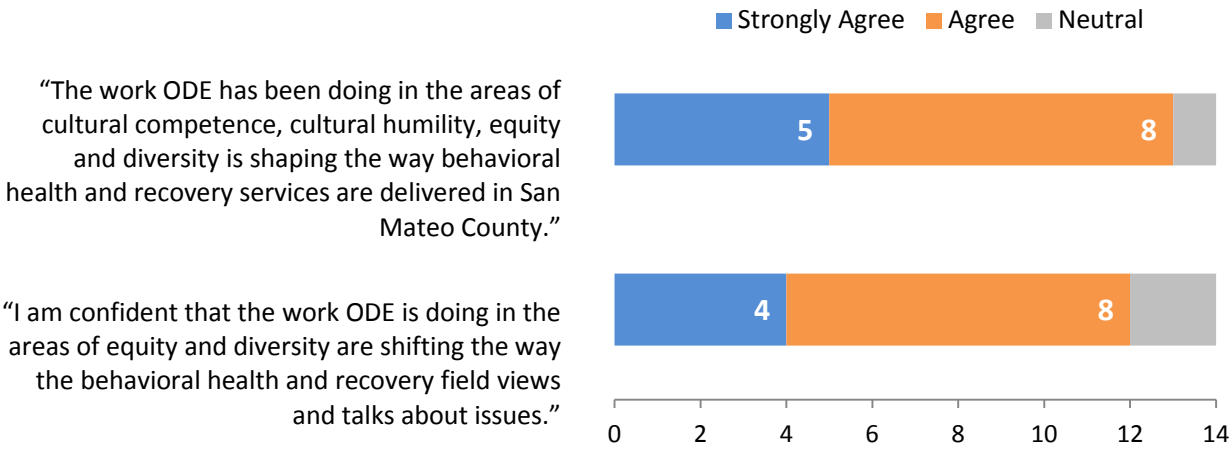
Lived Experience Academy Survey

A total of 14 current and former LEA participants responded to the WET Survey. Almost all respondents felt that LEA met its goal of preparing graduates for workforce entry, providing them with knowledge and skills necessary to work in behavioral health. Almost all survey respondents also felt empowered to share their stories as a result of their participation in LEA.

Survey respondents identified two main areas of impact on their current work and/or professional development: (1) improved ability to participate in the behavioral health workforce, and (2) increased comfort and confidence in sharing their own story.

Open-ended responses to the survey indicated that participation in LEA helped trainees process their feelings and support others, "Initially, LEA helped me process my own feelings about the experience, and I went on to become increasingly effective at supporting other family members in learning effective advocacy skills." Another participant wrote, "I am advocating more for people who are either not aware of the opportunities for them to speak up or unable to because of the severity of their condition."

Furthermore, survey responses highlighted the value of LEA's close partnership with ODE, as respondents expressed confidence in the positive impacts of ODE's work. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.



In their open-ended responses, survey respondents also identified at least two areas of improvement for LEA: (1) increasing the number of speaking opportunities, and (2) having ongoing, additional training, with more cohorts of LEA annually. Some examples of responses include the following:

> *"I wish there were more opportunities for me to be able to use the new capabilities I achieved through the Lived Experience Academy."*
>
> *"I had a great experience going through the LEA…I wish there were more opportunities for speaking."*
>
> *"There should be more training so people can have more tools in the box."*
>
> *"Keep supporting this important group, INCREASE number of academies each year. Use your contract agencies to leverage your capacity to teach this."*

Taken as a whole, these survey responses indicate that LEA is a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. Not only does LEA arm graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and support others. Additional training opportunities and speaking engagements would help increase the presence and inclusion of individuals with lived experience in the behavioral health workforce.

Lived Experience Education Workgroup Listening Session

A total of 16 LEEW members participated in the Listening Session, including ODE/BHRS staff and LEA participants who are currently employed within BHRS or with partner CBO's. The Listening Session focused on LEA's impact on personal and professional development, as well as community involvement. Among the strongest outcomes of LEA identified by the Listening Session participants were **empowerment**, increased **confidence** and **reduced shame**, and **reduced isolation**.

"My story is empowering, I can now sit comfortably with diverse clients, they tell me that I am of service. There is a life after hospitalization. LEA helped me with my story, which I share."

"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."

"I am no longer ashamed about my condition."

With specific regards to motivational interviewing training, participants noted, "[it] bolstered my self-confidence," and, "The program teaches us to fight against self-stigma."

Greater confidence

"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."

Community-building aspects of LEA were also noted, with Listening Session participants speaking specifically to how LEA helped **reduced feelings of isolation**:

"I was isolated from my family. The LEA Speakers Bureau helped me to talk to my family and get through to them about what triggers me and what helps."

"We all shine because of the program. It is like family – non-judgmental, reduces loneliness, very therapeutic."

"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."

"I'm homeless but I don't feel homeless."

Reduced Isolation

"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."

Listening Session participants also shared that LEA was intimately connected to their **healing**, with one participant saying that they, "Found it very healing and liberating…telling your story lifts you." Another noted the **transformative** nature of the process, saying, "To be able to look in the mirror and say 'I forgive myself' has been transformed into acceptance, 'I accept myself.'" In the realm of professional development, Listening Session participants noted increased **empathy** and improved **communication**.

Empathy

"I've been part of the County system for the past 20 years. Through LEA, I saw that I was more like clients than I had acknowledged."

Communication Skills

"The experience of going through LEA has helped my communications skills, I am amazed at myself that I could share without crying."

"I have so many stories. Which to tell? The tools we learned in LEA were useful for helping me organize my thoughts."

Lived Experience Academy Interviews

"Without LEA, many of us would not be where we are today. We wouldn't feel like we have the support of the public or BHRS or the Health System of San Mateo County at all."

- LEA participant

Three former LEA participants were interviewed. The interviewees represented participation across the timeline of LEA program implementation, with participants from the 2012, 2013, and 2015 cohorts. They represented ethnic/racial diversity, with one African American, one Latino/a, and one Asian (Chinese) American participant. Two were male and one was female.

All three have sustained their involvement with LEEW: two have participated in facilitating the most recent LEA training, and two have additionally trained as presenters for BHRS. All three are also involved in the work of related efforts (e.g. participation in HEIs, specific committees, and other mental health consumer-led organizations such as NAMI and California Clubhouse).

The interviewees identified three key areas in which LEA made a discernable impact: at the **individual/personal level, the community level, and the systemic level.** The interviewees also expressed some disappointments, which revolved mainly around changes to the program.

- **Individual/Personal Level –** all three interviewees identified specific areas for skills and awareness that they gained through participation in the LEA, and similar to the Listening Session offered examples including increased **confidence** and a sense of **empowerment**, while feeling reduced shame and stigma.

  "LEA helped shape my participation and contribution, boosted my confidence and how I carry myself."

  "LEA helped take away the shame, and gave me confidence to share my story."

  "A lot of weight was lifted off of me once I could share my story. I was really ashamed of many things."

  "For many years, I felt so much shame, which prevented me from doing so many things. I felt weird and that I didn't belong. I used to pray that God would send me something awful so I can finally appreciate what I have. Shame, self-hate, guilt about mom, dad, little brother's experience of my illness."

  "A big challenge for us is stigma, most importantly self-stigma. When we feel that there is something wrong with us, it is difficult for us. When we tell our stories, it helps us to shed our self-stigma. It helps normalize things for us."

Empowerment

"I had never shared my story with anyone before… It felt really empowering, I wanted to share my story with a larger audience."

"I was nervous when I first spoke about my story, I was only comfortable in meetings where I knew everyone. To talk to others, doctors, classrooms, nursing school students, etc., was difficult for me. I've spoken through NAMI and other orgs. The training really helped me learn to speak more confidently."

The interviewees also echoed that LEA helped with their **recovery**:

"To have this training to help tell our stories, it has helped me with my recovery process also."

"The more we feel that we have support from others, the more it helps with our recovery process.

Beyond personal gains and healing, the interviewees also spoke of the importance of sharing their stories. They recognized the **value** of speaking with confidence about their experience in supporting and educating others and a sense of **validation** that allowed participants to reach beyond themselves, be part of the wider community, and help others:

"To be able to go through the training was exhilarating for me, being able to present to different groups, hear feedback, being able to provide support and advice for people. Hearing the feedback and responses was something I had not expected. People were genuinely interested in learning more, and this helped dispel some of the internalized shame I felt. I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

"I feel valued that I can help other people."

Confidence

"I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

Recovery

It's when we feel it is ok internally to have a mental health issue and that we are not going to be treated as a leper of some sort, we begin to be more of an advocate.

Validation

"The more we are validated for our feelings, the more comfortable we are in speaking out for our needs. We have a better ability to attend BHRS committee meeting to give our input about what is missing or overlooked or could be more helpful for us."

Similar to the Listening Session participants, interviewees also noted an increased sense of community through the LEA and reduced isolation:

> *"LEA has the feeling of community that other trainings I have been through don't – community, genuine compassion and love."*

> *"I am definitely excited about the prospects of bringing my consumer perspective to this work in the future. It really feels like a family and community."*

- **Community Level** – the interviewees expressed an eagerness to **participate** in participation in public committees/commissions, and other empowering activities:

  "If it wasn't for lived experience and advocacy trainings…I have been able to do so much more than before. I have participated in the Spirituality Initiative, Youth and Children's Services Committee (my son has mental health issues so I am a consumer and a family member), the Chinese Health Initiative...I attended the symposiums on Spirituality."

Furthermore, the importance of sharing their stories, as well as the boost in confidence to do so, was best expressed by the interviewees' newfound ability to advocate for themselves and others. **Advocacy** and an eagerness to give voice to others were brought up several times:

> *"[LEA] helped me learn how to advocate for others with tact."*

> *"[LEA] helped me advocate for myself when my rent was being raised with the Housing Authority and my landlord."*

> *"As I took advantage of more opportunities, I had more capacity to help."*

> *"The way I see it, we who have mental health issues do not speak out for ourselves (the majority of us), so those of us who can have a responsibility to speak out for those who cannot."*

Advocacy

"My goal is always to give a voice to others who are silenced or feel that they have to hide due to stigma. I hope my voice can help give voice to others."

"I not only advocate for myself, but try to advocate for others to benefit their situation."

Areas of advocacy need included decriminalization of the mentally ill, disability benefits, regulations that limit income for those receiving the benefit, and loss of life insurance policy due to it being seen as an "asset." This respondent further noted that the income limits and benefit amounts are not realistic given the cost of living in the Bay Area.

- **Systemic Level** – the interviewees identified three areas of systemic impact due to the investment made in the LEA. These impacts fall broadly into the following areas: *Lived Experience Voices, Workforce Diversity,* and *Movement-Building & Advocacy Opportunities.*

All three interviewees shared how their LEA training made it possible for them to present their stories in an array of settings, and how their voices made an impact on the way behavioral health professionals viewed people with lived experience:

> *"I was able to do presentations last year for the psychology interns coming into the hospital, 10-12 students working on their doctorates, through the Spirituality Initiative."*
>
> *"Since the course, I have spoken to middle and high school age children, to MFT trainees, pharmacology students, etc. It helps them understand what we go through, what are the challenges, and also how to work with us better. I have also spoken with people who run the 24-hour suicide prevention hotline, their feedback is that it helps them understand our mindset so they can do their job better."*

Lived Experience Voices

"Before the advocacy group training, they didn't have consumers attending these meetings to give them direct feedback. It is tremendously helpful to them to hear from us."

The interviewees also spoke to how LEA training made a difference in their own professional development, allowing them to enter and be successful in the behavioral health workforce.

> *"I work with CA Clubhouse, Heart and Soul, Stamping Out Stigma, the Peer Association we just started. … None of the things, awards, recognition, etc., plus my own desire to share my story, none of that would have happened without LEA."*

Significantly, the interviewees also discussed how LEA training and empowerment could build toward a collective movement. One interviewee shared a vision of shared advocacy paving the way to make bigger and more meaningful impacts.

Movement Building

"By training people with lived experience to share their stories, it builds a grassroots movement to help voice our concerns in a public arena."

> *"I have overcome a lot in the past 8 years, but I am at the point of wanting to have a bigger impact. People with insurance and/or money, they are living on the island of themselves. NAMI and CA Clubhouse are on their own islands. How do we get them to come together to coalesce and speak with a shared voice to make meaningful legislative changes? State, federal, local Board of Supervisors."*

Challenges

LEA interviewees shared some of their disappointments in the recent direction of LEA and LEEW. Many of these disappointments were related to changes in **program structure**, while others were related to the limited **opportunities available** for LEA graduates:

> *"I don't think the program is the same. Only one of their [recent] 8 graduates came to LEEW meeting. The curriculum has changed, no longer using the 7 elements of public speaking training. There are only 5 sessions now. They didn't use the seasoned facilitators from previous classes [this last round]. I have some dissatisfaction with LEEW group and how it is being held. They are doing only one LEA per year now, and we only have stuff to do during MH Awareness Month and Recovery Month/Suicide Prevention Initiative events."*

"The class size has been cut in half - only one group, and only 5 classes, and smaller group going through the LEA. We had 12-15 per group go through the whole thing in the past, with 25 people going through each year, now only 6-7 in the past year. There should be LEA in Spring and Fall, and Advocacy training in the summer."

"We used to have a lot more opportunities to speak, more happens in May which is mental health awareness month and in September which is suicide prevention month, but other months there are fewer opportunities. After the sessions and graduating, we were part of a Speakers Bureau, but not sure if I am still on the list. I wonder whether it is really active and actively managed by anyone. We used to have more opportunities to speak, was very active at one point."

"I want more speaking engagements. There are opportunities through Heart and Soul and NAMI, [and] LEA participants need to be connected."

"I would do more year-round advocacy, not enough opportunities for LEA participants currently."

"If the right opportunities come up, I would be interested. I have volunteered a lot - I've looked at RFPs, offered IT background to gather data, looking at data when it is related, they haven't taken me up on it. Even if they don't have funds, they could create volunteer opportunities for us that help with our sense of self-worth and recovery. I don't see people open to having volunteers in BHRS. I know of a handful of LEA participants who are working with BHRS as family partners or peer supports, there are a few of us, but few and far between."

Interviewees also expressed dissatisfaction with the **stipend levels**, a concern echoed in the WET Survey and Listening Session. While LEA Speakers Bureau participants previously received a stipend of $35/hour for speaking engagements, more recent LEA participants have been paid only $25. In a separate report,[iv] LEEW members also shared that the process of getting merited stipends appeared inconsistent. For some LEEW members, lack of clarity on whether ODE or the Office of Consumer and Family Affairs is responsible for distributing stipends led to significant delays in receiving stipends. In addition, LEEW members raised questions about whether LEEW members who are employed by BHRS or community-based contractors are eligible to receive stipends. From these accounts, it seems that changes in stipends – both amount and policy – have not been **clearly communicated**.

Perhaps one of the most revealing ways in which former LEA participants expressed their appreciation for the skills and community gained from their participation was in their desire for BHRS to support high-quality programming for people with lived experience, which stems from their belief that LEA helped them. Their hope is for programs like LEA to be available in order to help others.

"My vision is that BHRS starts taking care of this because it helps people, not just to do it."

"I just want it to be the same high quality it was in the past. Nothing bad to say about LEA in and of itself, it has helped a lot of people. Don't kill it, take care of it. We want it to be around for other people to enjoy and benefit from. It has helped a lot of people in different ways."

[iv] Enhancement of Lived Experience Workgroup Report by Ellie Dwyer, March 2017

Recommendations for LEEW and LEA

The following recommendations for LEEW and LEA are based on the results of the WET Survey and stakeholder feedback from the LEEW Listening Session and LEA Former Participant Interviews.

More trainings for leaders with lived experience

LEEW members would like to see more investments in training for leaders with lived experience, including more LEA cohorts, with more sessions. Refresher trainings were deemed useful, with particular interest in advocacy training (Advocacy Academy).

More opportunities to use skills learned from LEA

Noting that "sharing your story takes practice," LEEW members voiced interest in having more speaking engagements. Because of the empowerment, confidence, and value LEA graduates experience through sharing their stories, having such opportunities on a regular basis would greatly benefit LEEW members. Hearing the voices of people with lived experience would help clients and clinical trainees better understand the population they serve as well.

Integrate LEA into all consumers' recovery

Many Listening Session participants and interviewees said that LEA was integral to their recovery. They suggested that, for consumers who are ready, being able to go through a program that builds skills and confidence in sharing their stories should be an opportunity available to all. One former LEA participant stated, "If I had the ability, I would use my magic wand to make those who are at a level of readiness and recovery to take the LEA. It would be a formal part of peoples' recovery."

Cultural Competency Stipend Internship

Overview

The goal of the **Cultural Competency Stipend Internship (CCSIP)** is to provide more culturally responsive services to clients and the community. Up to 20 stipends are awarded annually to interns who are providing mental health and alcohol and other drug services within the Older Adult, Adult, and Youth systems of care, or interns who are providing coordination and logistical support in the Office of Diversity and Equity (ODE). Stipends are awarded based upon the trainees' ability to add to the cultural competence of services BHRS provides. Recipients of the stipend are required to participate in a Health Equity Initiative (HEI) project/program by attending the monthly initiative meetings and helping organize events and activities. They also conduct a cultural competence project during the year that is aimed at improving the cultural responsiveness of our services and educating our staff as negotiated between the trainee/intern and the HEI co-chair.

Participating in CCSIP was a valuable experience. As one respondent wrote:

"This was a wonderful experience and I am so thankful for the opportunity. I would like to return to the Latino Collaborative once I return to the Bay Area after internship next year."

Highest priority is given to applicants who are bilingual and/or bicultural and whose cultural background and experience is similar to the clients he or she will serve or to an identified underserved population in the community for whom we would like to have more outreach. It is also a priority to award stipends to students who have personal or previous experience serving marginalized populations including:

- Gay/lesbian/bisexual/transgender/queer/intersex/two-spirit or gender-nonconforming clients
- Individuals or family members of individuals with lived experience
- Individuals with physical disabilities
- Individuals with lived experience as inmates in correctional settings

In FY 2015-16 CCSIP participants conducted projects in support of the Spirituality Initiative, the Filipino Mental Health Initiative, the Latino Collaborative, the Native American Initiative, the African American Community Initiative, the PRIDE Initiative, the Arab Community Workgroup, the Diversity and Equity Council, and the Chinese Health Initiative. Their projects included:

Surveys and Assessments:

- Two county-wide surveys that assessed clinician comfort in addressing spirituality in treatment in order to determine the impact of spirituality training and advocacy efforts on clinician practices. The surveys also sought to understand client perspectives on spirituality in treatment.
- An assessment of why African American males receive longer and harsher sentencing than European American males who have committed similar crimes through an examination of the role of psychological assessments in the sentencing process.
- Focus groups with African American/Black consumers and clients of BHRS to better understand how African Americans feel about and perceive access to care, welcoming at clinics and service points of entry, information provided and its relevance, treatment options and opportunities, experiential perceptions regarding Cultural Humility, and thoughts about what could be done better to improve their treatment experiences and outcomes.

Example of past CCSIP Projects:

A survey-based assessment of clinician comfort in addressing spirituality in treatment

Workshop on mental health and socio-emotional issues for a Filipino Barkada student group

Monthly newsletter with mental health information for the Latino Community

Community-Specific Workshops and Presentations:

- Creation and facilitation of a workshop on mental health and socio-emotional issues at Westmoor High School for the Filipino *Barkada* student group.
- A presentation on mental health issues and services at the Moonridge facility in Half Moon Bay, which offers affordable housing through Mid-Peninsula to agriculture workers.
- A presentation to San Mateo County providers and the community on Native American mental health and strategies for working with the Native American community to improve health outcomes in this population. This project was part of a larger workshop that integrated various aspects of Native American healing practices, as well as experiential activities involving drumming.
- A presentation at the Mills High School Wellness Panel on childhood development and parent-child-teen communication in Mandarin Chinese.
- A three-day PhotoVoice workshop for older adult (age 60 and older) clients of BHRS.

Outreach Efforts:

- Creation of a subscription-based monthly newsletter to increase access to mental health information for the Latinos.
- Development of an up-to-date and sustainable social media presence and Website for the PRIDE Initiative that provides LGBTQQI2S individuals in San Mateo County with information about events, groups, and services for the community
- Direct outreach from the PRIDE Initiative to other HEIs in order to facilitate a conversation about the issues faced by the LGBTQ subpopulations of their respective communities.
- An outreach event and presentation to Arab communities in San Mateo County on behavioral health and recovery resources, services and issues.

Methods

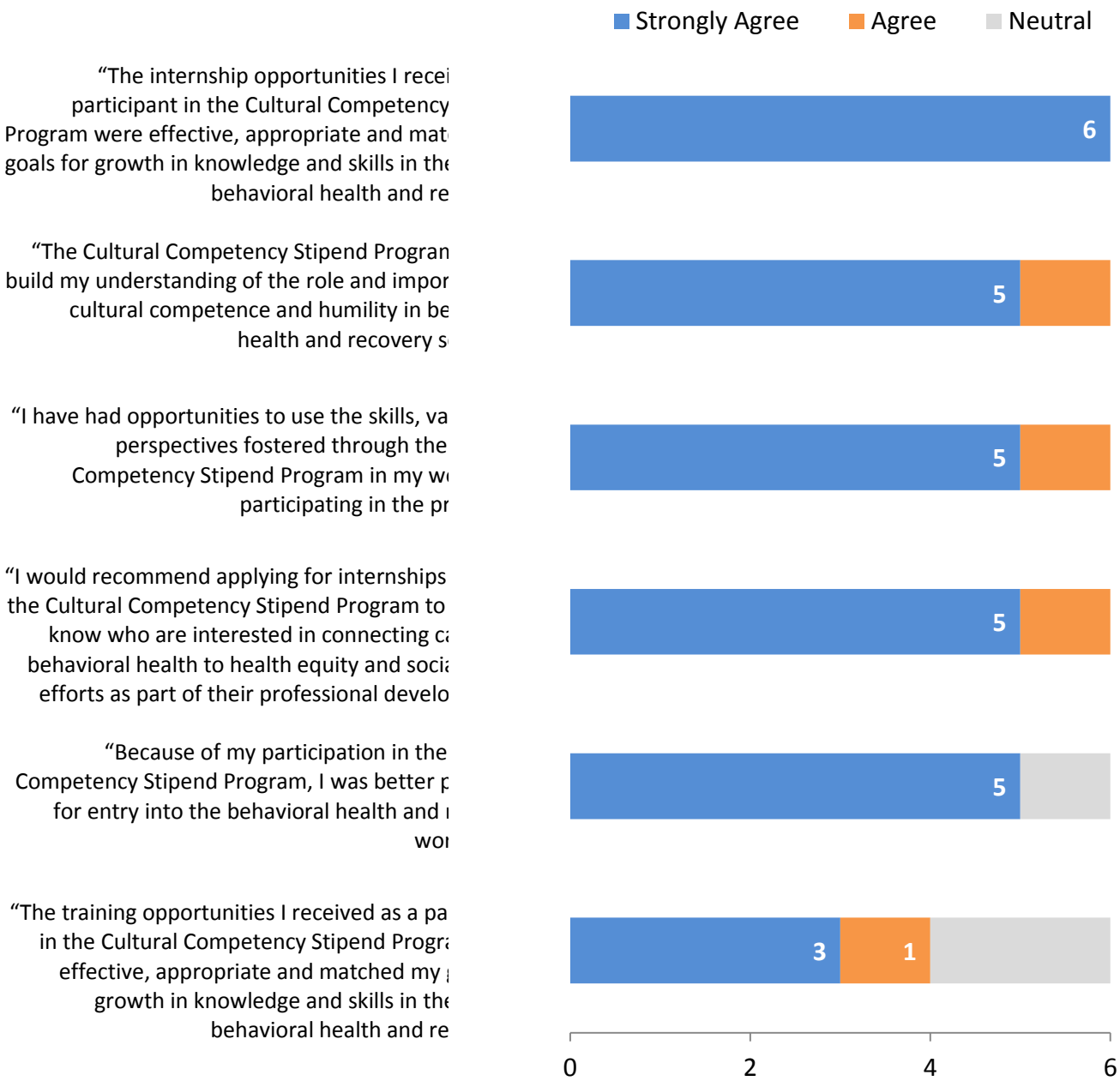
Two methods of data collection were used for the CCSIP evaluation:

- **CCSIP Survey –** current and former CCSIP participants were surveyed about their experiences in CCSIP, and level of agreement on a series of statements.
- **CCSIP Interviews** – former participants were interviewed for a deeper perspective of impacts.

Results

WET Survey for Cultural Competency Stipend Internship Program Participants

A total of six current and former CCSIP participants responded to the WET Survey. All respondents strongly agreed that CCSIP matched their goals for growth in knowledge and skills in the area of behavioral health and recovery, and all agreed that CCSIP helped build their understanding of the role and importance of cultural competence and humility in behavioral health and recovery settings.

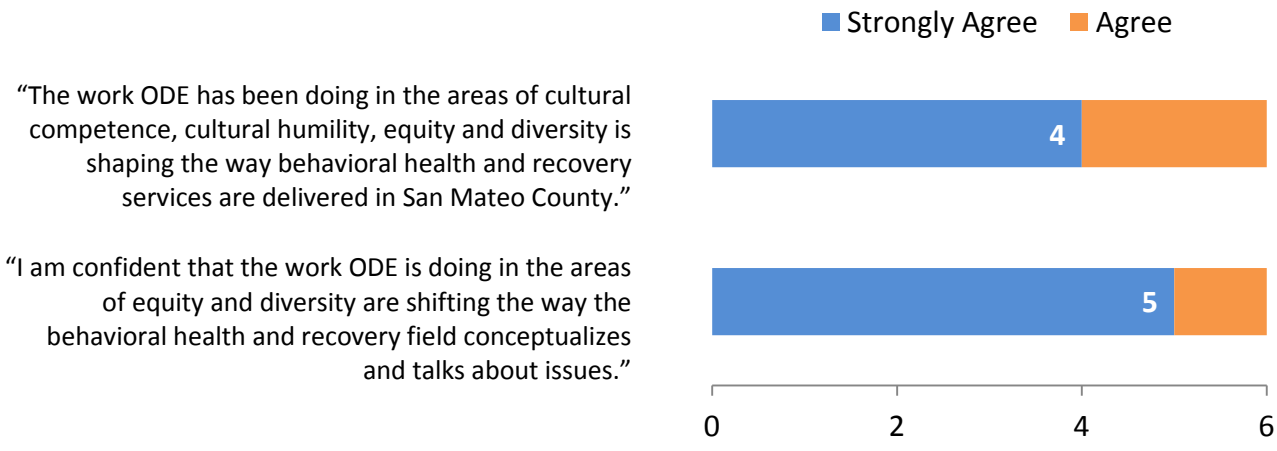


In their open-ended responses, survey respondents also spoke of how CCSIP increased their awareness of diversity-related issues, including privilege and power differentials:

> *"I have become very involved in the various events that various initiates have offered after seeing the tremendous amount of work that goes into hosting an event. These events have truly developed my awareness and understanding of other cultures, which has allowed me to be more mindful and culturally sensitive when providing treatment to someone of a different race/ethnicity/ spiritual community."*
>
> *"[I am] more aware of diversity related concerns and needs assessment."*
>
> *"I am thinking about issues of privilege and power in the therapy room in deeper ways."*
>
> *"I have realized how fortunate I am to have attended a Master's program that places such a strong emphasis on cultural humility. Much of the information presented through the initiative was not new to me, but I was glad to be involved in raising awareness in the county."*
>
> *"It has allowed me to gain a deeper understanding of the Latino community and the services that the entire county (outside of just BHRS) has for this population. It has also allowed me to see where the areas of strength/deficit are when providing mental health services to this community, therefore giving me an idea of how I may be able to improve this system when I complete graduate school."*

Thus, the main areas of impact on CCSIP trainees' work were (1) **increased knowledge and skills** in behavioral health and recovery, including the roles of cultural competence, cultural humility, health equity, and social justice; and (2) **deeper understanding and awareness of diversity**, including how specific communities view mental health services.

Furthermore, survey responses highlighted the value of housing CCSIP within ODE, as respondents expressed **confidence in the positive impacts of ODE's work**. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.



In their open-ended responses, survey respondents spoke about the challenges of participating in CCSIP, which were primarily logistical in nature.

1. The HEI schedule and the schedule for the regular intern program should be aligned. For at least one intern, the regularly scheduled meeting of the assigned HEI coincided with the intern seminar, leading to the intern to nearly drop out of CCSIP. Moreover, they "did not receive any support or assistance from CCSIP regarding this issue."
2. The time constraints for the internship project were not realistic. While interns are expected to devote 10 hours per week to CCSIP, much more work occurred toward the end of the year, when data had to be compiled and final papers written. One intern who wrote about this challenge suggested two possible solutions: 1. It was very challenging to get approval for their project, and had the project been approved sooner, they would have had more time to implement it. 2. CCSIP interns can work together to make the project more manageable.

Taken as a whole, the survey responses indicate that CCSIP is a valuable resource for preparing future clinicians to better understand issues related to diversity, marginalized communities, privilege, and power. Its emphasis on cultural humility and cultural competence helped foster skills, values, and perspectives that participants found useful. Some logistical coordination would improve the interns' ability to contribute to their assigned HEI's during an already busy and stressful intern year. Nonetheless, feedback from CCSIP participants was overwhelmingly positive.

Cultural Competency Stipend Internship Program Former Participant Interviews

Three former CCSIP participants were interviewed. Two interviewees participated in the 2015-16 cohort, and one participated in 2013-14. They represented ethnic/racial diversity, with one African American, one Asian (Chinese), and one Middle Eastern (Egyptian) participant. All three were female. Two interviewees worked on projects that supported specific HEIs (African American Community Initiative and Chinese Health Initiative), while the third supported the work of the Arab Community Workgroup.

All three have sustained some level of involvement with BHRS and/or the County. One continued supporting the African American Community Initiative past their intern year. Another was hired as the Chinese community outreach worker for ODE to host events, connect clients and consumers to services, and participate in the Chinese Health Initiative's work around stigma reduction, mental health awareness, and help-seeking in the Chinese community. The third is currently a provider in the BHRS system of care, and is a member of the Bay Area Muslim Therapists group. As part of her CCSIP project, she gave a presentation to the Arab community; after her intern year, she reached out to high schools in Daly City with a plan of doing presentations and support groups in the next year. While the former participants who were interviewed may thus be somewhat self-selecting, they and the internship supervisor felt that their experiences were representative of the average intern's participation in CCSIP.

The interviewees identified two key areas of impact: at the ***individual/personal level*** and the ***community level.*** The interviewees also gave feedback on the program, particularly around the level of support they received, and made recommendations.

- **Individual/Personal Level** – broadly, the interviewees felt that they gained a better understanding of **working with marginalized communities**, new **connections** and networks, and **professional development** and growth as therapists as a result of their participation in CCSIP. Some specific examples they offered included:

  "All those connections I made with the County through the internship have helped my work with clients now. Exposure to classes and workshops and digital storytelling, the network I have now."

  "I will be going back to get my PsyD, my CCSIP experience will be helpful in my career later. I want to work with Chinese families as a therapist, there is a large population in the Bay Area, might intern at RAMS at some point."

Understanding of Marginalized Communities

"I appreciated working in the community…I now understand the challenges of working with monolingual Chinese speakers better."

Another significant impact of participation in CCSIP was the opportunity to **serve communities** with which the interviewees identified:

Commitment to Serving Own Community

"Without CCSIP, I would not have had as strong a feeling about wanting to work with my community."

"I think the internship solidified my want and need to work in the Arab community, address stigma, identify resources. Being able to present on mental health was amazing, a lot of people shared their fears, experiences of being discriminated against, fears of seeking services. Being able to offer a space to do that was very impactful. It has given me more of a drive to work with this population… without CCSIP, I would not have had as strong a feeling about wanting to work with my community. The experience helped open the door to work with the Arab population."

"When I was an undergraduate, I was in a different state, so this was a great opportunity for me to work in my community for the first time, the other state was not diverse. Great to meet other people with similar interests."

"It really helped me personally to be more motivated to help my own community. I would not have stepped into community mental health if I had not participated in the CCSIP program."

- **Community Level** – for the interviewees, working within the County system was a powerful way to make a **broad impact**; the County brought greater visibility and legitimization of their work:

  "I think the opportunity to have an impact, to be involved in health equity initiatives or work groups, doing PhotoVoice or presentations in a specific community, was incredible. Doing it on a County-wide level is special. Having support and funding from the County, food provided by BHRS, etc. … Because it was through the County, this holds more meaning. A lot of the attendees of our presentation were recent immigrants, they didn't know the structure or the meaning, but having the County behind the work is really important. More access, resources, partnership."

  "I think the thing I appreciate the most is that San Mateo County has this kind of opportunity. I was exposed to lots of different ways to interact with the community through ODE, also being able to do the mental health work at the same time. I feel that San Mateo County is the leader in having these conversations about equity and diversity."

  Another interviewee noted the work still to be done:

  "I would like to think that the work we did made some progress. Having honest and open conversations about mental health is a success. I hope for more. I hope the community is able to access more resources. There are more amplified needs now due to the current context.

Making Broad Community Impact

"…having the County behind the work is really important. More access, resources, partnership."

"I feel that San Mateo County is the leader in having these conversations about equity and diversity within the County."

Challenges

When asked about what they found challenging about participating in CCSIP, the majority of the interviewees' comments revolved around the support they received. While one interviewee found CCSIP support to be "just right," others would have preferred more **guidance**. Many of the former participants' comments indicated that the trainees would have liked more **clarity on expectations**, especially with regard to splitting their time between clinical hours and completing their CCSIP projects. They struggled with balancing the **expectations of their various supervisors**, who had differing levels of support for interns' projects (one comment suggested that some supervisors did not take CCSIP seriously). Some comments indicated that there was room for ODE to work more closely with clinical supervisors in order to better integrate CCSIP and clinical training. For example, one interviewee was able to limit her clinical caseload in order to accommodate the CCSIP project, but this appears to be a rare exception.

Additional comments indicated that CCSIP participants would have benefitted from **basic skills training** such as project coordination, community outreach, and time management. The interviewees expressed a need for general help, but beyond additional training, they were not specific about what kind of help was needed. One interviewee had knowledge of a coordinator who was later hired to "help interns get the support that they need", and she seemed to view this support from ODE positively.

The interviewees found the CCSIP **time allotted overwhelming**, yet insufficient. Many interns were required to devote as many as 20-24 hours on clinical training on top of school commitments and other responsibilities, so the additional hours for the CCSIP project were often difficult to incorporate into

their usual work day. At the same time, the interns were very enthusiastic about the cultural competence work, and wanted to be actively involved with ODE's work as well as the HEIs. For example, the intern who worked with the African American Community Initiative (AACI) worked on three different projects during her intern year, and found that untenable. Reflecting on her year with CCSIP, she stated that she "I could have easily spent all 20 hours with the African American Community Initiative."

When the interviewees were asked about the **stipend amount** ($5000), their responses were mixed. While they felt that it was helpful, especially in terms of not having to take out as much in loans, the amount "could have been more," and ran out quickly for most. Suggestions included having fewer interns, each of whom would receive a larger stipend; splitting extra funding among CCSIP participants; and splitting the stipend into two separate checks. Some interviewees thought that the offered amount was less than what other organizations were offering, while others felt that it was more. The fact that the County covered mileage was helpful.

In addition to sharing the views expressed above, the intern who worked with the Arab Community Workgroup had some specific concerns about the **continuity** of the Workgroup. While her work with the Arab Community Workgroup was impactful, she expressed disappointment that it did not continue, nor did it lead to the establishment of a formal HEI. She has attempted to reconnect and help with this effort; but it is not realistically possible for her to carry her CCSIP work forward outside of her current role without some form of compensation. She also expressed a desire for opportunities to provide feedback and stay connected with the County. Her comments indicated that she would have liked to see some plan for sustainability, as well as some formal network for staying involved.

These final thoughts reflect how uniquely devoted CCSIP participants are to serving their communities. By rooting their work in cultural competence and cultural humility, CCSIP interns help the program meet its goal of providing more culturally responsive services to clients and the community. As this last interviewee stated:

> *"many choose to be part of CCSIP for personal and professional reasons, [to be] part of the community."*

Recommendations for CCSIP

The following recommendations for CCSIP are based on the results of the Survey and Interviews.

Basic skills training

Only two-thirds of the survey participants felt that CCSIP training opportunities were effective and appropriate, and matched their goals for growth in knowledge and skills. As we are unable to follow up with the one-third of respondents who did not agree, we use the responses of the former participant Interviews to inform us on what was missing. These responses indicate that CCSIP interns could benefit from training on such basic skills as project coordination, community outreach, and time management. While this additional training may seem excessive at first, the responses indicate that some upfront investment in these ancillary skills may help set CCSIP participants up for success during the rest of their intern year. These trainings could be provided or coordinated by ODE, a strategy that could also help CCSIP participants feel more supported by and connected to ODE's work. Another suggestion could be to let the interns choose a number of skills workshops, and get feedback at the end of the year on which trainings were most useful during their internship.

Better coordination between CCSIP and clinical supervision

The former participant interviews indicated that major challenges throughout the year were understanding the expectations of various supervisors and, often, lack of support from clinical supervisors. The interviewees also noted that there was room for ODE to work more closely with clinical supervisors in order to clarify expectations and time commitments with regard to CCSIP and clinical training. Better coordination between the two programs might strengthen clinical support for trainees' participation in CCSIP, and help legitimize the CCSIP projects in the eyes of the clinical staff. It could, in some cases, also help CCSIP participants limit their clinical caseload in order to balance the time with their CCSIP projects.

Sustainability of CCSIP projects

One former participant interviewee noted that once an intern's year is over, their relationship with the County essentially ceases, and their project might not continue. While this is not necessarily a widely held view, it makes sense to invest in the sustainability of the CCSIP projects. One way that ODE does this is by ensuring that the CCSIP interns' work supports the work of the HEI's, which have more consistency in terms of membership and participation from year to year. ODE could also encourage or require interns to incorporate a sustainability plan or component into their project proposals. Another way might be to actively encourage new interns to continue the work of previous projects; however, that could be challenging because much of the interns' work hinges on the relationships they build with County staff and community members.

Sustainability Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained through the following three strategy recommendations: 1) A Systemic Approach to Workforce Education and Training; 2) Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation; and the 3) Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff.

WET sustainability ($500,000 per year) was prioritized through the planning process for the FY 2017-2020 Three Year Program Plan as vetted by the MHSA Steering Committee, presented to the Mental Health and Substance Abuse Recovery Commission and opening of a 30-day public comment period and public hearing process.

Table 5. WET Sustainability - Recommended Components and Cost

WET Recommended Components	Sustainability Amount
Workforce Staffing and Support	$260,000
Trainings for System Transformation	$100,000
Trainings for/by Consumers and Family Members including LEA, LEW and LE stipends	$60,000
Behavioral Health Career Programs including MHLAP, Internship, BHRS Career Orientation, CCSIP, and MCOD recruitment/ hiring/ retention strategies	$80,000
TOTAL	$500,000

In 2008, counties received guidance[v] regarding the continuation and funding of WET approved projects through other MHSA components. The two relevant options for BHRS are transferring MHSA Community Services and Support (CSS) funding (not to exceed 20% of the average amount of MHSA funds allocated for the previous five years) and consolidating programs across other MHSA components.

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS as demonstrated by stakeholder perceived key benefits of WET including; Improving Cultural Humility, Increasing Focus on Trauma-informed Care, Creating a Culture of Learning, Improved Standard of Care, Valuing Lived Experience, Building Capacity for Co-occurring Service, Increased Awareness on Importance of Self-Care and Client-Centered Services. Additionally, expansion to include those with lived experience, community partners, contract providers, and interns, which were not supported with much intentionality prior to MHSA WET.

Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation. Additionally,

[v] Department of Health Care Services Information Notice #08-16, published April 4, 2008

measuring the impacts of workforce education and training in alignment with systems change goals, will ensure meaningful activities and appropriate investments.

An example of a systemic approach to transformation is BHRS investments to cultural humility. Championing cultural humility was held as a primary responsibility of the state-mandated Ethnic Services Manager and a cultural competence committee (the Diversity and Equity Council) within the Office of Diversity and Equity (ODE). With MHSA WET investments, resources were made available to develop a training infrastructure for cultural humility priorities. ODE worked with the Quality Improvement Committee to develop policies that reinforced the importance of cultural humility as a standard of quality care; staff with direct client contact are required to participate in the Working Effectively with Interpreters training. Additionally, ODE's Health Equity Initiatives have brought valuable perspectives, insights and liaisons into the BHRS system. HEIs provide critical community voices to the shaping of BHRS' vision and programming rooted in the communities. Most recently, BHRS Leadership' commitment to Multi-Cultural Organizational Development (MCOD) engaged BHRS supervisors and managers in monthly dialogues needed to help BHRS realize the potential of cultural humility and inclusion through strategies aimed at personal, interpersonal, and organization levels; setting goals to address implicit bias, power and privilege and around recruitment and hiring, leadership development and training (including making Cultural Humility a required training of all staff), and engaging in challenging topics about race and culture.

Sustainability strategy

A transfer from MHSA CSS will sustain foundational knowledge and other training that supports system transformation ($100,000) and the workforce staffing ($260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. And, the LEA has not only does LEA provided graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence.

Creating pathways for individuals with lived experience requires a systemic and integrated approach. Moving forward, Training By/For Consumers and Family Members will include the Lived Experience Academy (LEA) and Speakers' Bureau ($15,000), Lived Experience Stipends ($10,000) and other trainings such as Recovery and Peer Support 101, Inspired at Work trainings for BHRS Peer Support Workers/Family Partners, Wellness Recovery Action Plans, etc. ($35,000).

Currently, Peer Support Workers and Family Partners employed throughout the BHRS Youth and Adult Systems are funded through MHSA CSS and supported by the Office of Consumer and Family Affairs (OCFA), a team of diverse consumers and family members with lived experience. It makes sense for OCFA to oversee this strategy with support from WET staff to help coordinate the system-wide trainings. An additional consideration would be for OCFA to contract the Lived Experience Academy, Speakers' Bureau and Stipends to a collaboration of consumer and family member agencies, linking this strategy to

other similar efforts in the community and create a more integrated system. Furthermore, this would provide participants access to the full array of resources held by partner organizations, while at the same time giving an opportunity for leadership development to clients and family members receiving supports and services at or through their specific organization.

Sustainability strategy

Consolidation of the peer and family partners strategies currently funded by MHSA, which also includes the California Clubhouse among other programs will not only sustain but better integrate this programmatic strategy. The recommendation ($60,000) will be funded through CSS General Systems Development component of MHSA.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level.

The WET team will continue promoting/monitoring the Mental Health Loan Assumption Program (awards are provided by the State) supporting and strengthening the internship programs ($55,000) including the CCSIP stipends and specifically paying attention to the challenges in terms of greater support, communication and basic skills training identified by former participants.

More has to be done to recruit , hire and retain diverse staff. The recent MCOD goals include strategies aimed at recruitment, hiring and retaining diverse staff. Currently there is a committee, led by the Director of Adult System of Care and made up of diverse staff looking at specific strategies. A review of the original WET approved plan indicates funding was set aside ($25,000) for development of targeted materials, outreach and recruitment efforts at schools and cultural/ethnic specific organizations (Historically Black Organizations, etc.), mentoring and developing specific training "promotion readiness" for staff, among other strategies.

Sustainability strategy

A transfer from MHSA CSS ($80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Conclusion

This report provides a documentation of the perceived impact that WET funded trainings and programs have had on staff, community-based partners, and contractors over the past 10 years. The interviews with former participants of two programs, LEA and the CSIP allowed for a deeper look into longer-term impacts these programs have had on clients/consumers, family members and behavioral health graduate students.

Throughout the 10 years WET priorities evolved, programs were discontinued, priority efforts (specifically, cultural humility, trauma-informed care, co-occurring care and lived experience integration) were refined. While most of these priorities require a more integrated and systemic approach for meaningful transformation, there is undoubtedly positive impacts, culture shifts and appreciation by stakeholders across the system including staff, partner agencies and clients/consumers and family members. This report has shed light on some areas of further development and improvement and it is expected that strategies will continue to evolve. Given this and the fact that WET funding is now directly tied to service components of MHSA, it will be crucial that the community program planning process incorporate workforce training and development assessment and prioritization where needed.

The Behavioral Health and Recovery Services, Office of Diversity and Equity, Workforce Education and Training look forward to another 10 years of meaningful trainings, programs and most importantly system transformation to better serve the San Mateo County community and especially clients/consumers and family members.

Lived Experience Academy Participants

- *"It made me more confident to present to people who have no idea what it is like to have a serious mental illness, to be able to see me. That is very empowering."*
- *I have emerged a more compassionate person, the experience has paved the road for what I want to do, what I am passionate about. I want to be a MFT*

Behavioral Health System of Care Staff

- *"[trainings] helped me see my clients in a new light and really, really show respect to them and support them."*

APPENDIX 10

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Mateo

Date: 2/1/18

	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 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,668,725	1,365,571	517,168			
2. Estimated New FY2017/18 Funding	24,182,520	6,448,672	1,612,168			
3. Transfer in FY2017/18[a/]	(423,610)			423,610	0	0
4. Access Local Prudent Reserve in FY2017/18	0	0				0
5. Estimated Available Funding for FY2017/18	26,427,635	7,814,243	2,129,336	423,610	0	
B. Estimated FY2017/18 MHSA Expenditures	21,469,505	5,083,101	1,095,000	423,610	0	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,958,130	2,731,142	1,034,336	0	0	
2. Estimated New FY2018/19 Funding	23,943,089	6,384,824	5,428,750			
3. Transfer in FY2018/19[a/]	(500,000)			500,000	0	0
4. Access Local Prudent Reserve in FY2018/19	0	0				0
5. Estimated Available Funding for FY2018/19	28,401,219	9,115,966	6,463,086	500,000	0	
D. Estimated FY2018/19 Expenditures	22,049,505	5,833,101	2,795,000	500,000	0	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,351,715	3,282,865	3,668,086	0	0	
2. Estimated New FY2019/20 Funding	23,473,616	6,259,631	1,564,908			
3. Transfer in FY2019/20a/	(500,000)			500,000	0	0
4. Access Local Prudent Reserve in FY2019/20	0	0				0
5. Estimated Available Funding for FY2019/20	29,325,331	9,542,496	5,232,994	500,000	0	
F. Estimated FY2019/20 Expenditures	22,049,505	5,833,101	3,195,000	500,000	0	
G. Estimated FY2019/20 Unspent Fund Balance	7,275,826	3,709,395	2,037,994	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	600,000
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	600,000
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	600,000
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	600,000

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.

50%

Community Services and Supports (CSS) Component Worksheet

County: San Mateo

Date: 2/1/18

	Fiscal Year 2017/18					
	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. Children and Youth	5,778,549	3,709,606	744,698	0	91,946	1,232,298
2. Transition Age Youth	3,886,894	3,525,019	329,306	0	0	32,569
3. Adults and Older Adults	7,969,304	4,351,310	1,547,926	0	62,443	2,007,625
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Outreach and Engagement	845,561	761,644	68,551	0	0	15,366
2. Criminal Justice Initiative	531,947	531,947	0	0	0	0
3. Older Adult System of Care	1,151,830	898,427	0	0	0	253,403
4. Co-Occurring Support Services	861,913	861,913	0	0	0	0
5. System Transformation	3,652,799	2,909,169	500,385	34,903	139,613	68,729
6. Peer and Family Supports	2,162,840	2,162,840	0	0	0	0
7.	0		0	0	0	0
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	4,175,391	1,757,630	758,705	510,687	551,040	597,329
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	31,017,027	21,469,505	3,949,571	545,590	845,042	4,207,319
FSP Programs as Percent of Total	82.1%	54.0%				

50%

Community Services and Supports (CSS) Component Worksheet

County: San Mateo

Date: 2/1/18

	Fiscal Year 2018/19					
	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. Children and Youth	5,778,549	3,709,606	744,698	0	91,946	1,232,298
2. Transition Age Youth	3,886,894	3,525,019	329,306	0	0	32,569
3. Adults and Older Adults	7,969,304	4,351,310	1,547,926	0	62,443	2,007,625
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Outreach and Engagement	845,561	761,644	68,551	0	0	15,366
2. Criminal Justice Initiative	531,947	531,947	0	0	0	0
3. Older Adult System of Care	1,151,830	898,427	0	0	0	253,403
4. Co-Occurring Support Services	861,913	861,913	0	0	0	0
5. System Transformation	3,652,799	2,909,169	500,385	34,903	139,613	68,729
6. Peer and Family Supports	2,162,840	2,162,840	0	0	0	0
7. Expansion - Supports for Older Adults	130,000	130,000	0	0	0	0
8. Expansion - Coastside Wellness Center	450,000	450,000	0	0	0	0
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	4,175,391	1,757,630	758,705	510,687	551,040	597,329
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	31,597,027	22,049,505	3,949,571	545,590	845,042	4,207,319
FSP Programs as Percent of Total	80.0%	52.5%				

50%

Community Services and Supports (CSS) Component Worksheet

County: San Mateo

Date: 2/1/18

	Fiscal Year 2019/20					
	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. Children and Youth	5,778,549	3,709,606	744,698	0	91,946	1,232,298
2. Transition Age Youth	3,886,894	3,525,019	329,306	0	0	32,569
3. Adults and Older Adults	7,969,304	4,351,310	1,547,926	0	62,443	2,007,625
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Outreach and Engagement	845,561	761,644	68,551	0	0	15,366
2. Criminal Justice Initiative	531,947	531,947	0	0	0	0
3. Older Adult System of Care	1,151,830	898,427	0	0	0	253,403
4. Co-Occurring Support Services	861,913	861,913	0	0	0	0
5. System Transformation	3,652,799	2,909,169	500,385	34,903	139,613	68,729
6. Peer and Family Supports	2,162,840	2,162,840	0	0	0	0
7. Expansion - Supports for Older Adults	130,000	130,000	0	0	0	0
8. Expansion - Coastside Wellness Center	450,000	450,000	0	0	0	0
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	4,175,391	1,757,630	758,705	510,687	551,040	597,329
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	31,597,027	22,049,505	3,949,571	545,590	845,042	4,207,319
FSP Programs as Percent of Total	80.0%	52.5%				

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2017/18					
	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. Early Childhood Community Team	421,349	409,087	0	0	0	12,262
2. Community Interventions for School Age a	663,865	660,213	0	0	0	3,652
3. and Capacity Building	425,053	373,687	40,399	0	0	10,967
4. Recognition of Early Signs of MI	10,000	10,000	0	0	0	0
5. Stigma and Discrimination	334,099	334,099	0	0	0	0
6. Suicide Prevention	78,225	78,225	0	0	0	0
7. Access & Linkage to Treatment	386,820	386,820	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Onset of Psychotic Disorders	814,210	814,210	0	0	0	0
12. Primary Care/MH Integration	1,175,192	1,060,538	0	0	0	114,654
13. Youth Crisis Response and Prevention	185,746	118,246	0	0	0	67,500
14. SMART	145,000	145,000	0	0	0	0
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	717,471	692,976				24,495
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	5,357,030	5,083,101	40,399	0	0	233,530

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2018/19					
	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. Early Childhood Community Team	421,349	409,087	0	0	0	12,262
2. Community Interventions for School Age a	663,865	660,213	0	0	0	3,652
3. and Capacity Building	425,053	373,687	40,399	0	0	10,967
4. Recognition of Early Signs of MI	10,000	10,000	0	0	0	0
5. Stigma and Discrimination	334,099	334,099	0	0	0	0
6. Suicide Prevention	78,225	78,225	0	0	0	0
7. Access & Linkage to Treatment	386,820	386,820	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Onset of Psychotic Disorders	814,210	814,210	0	0	0	0
12. Primary Care/MH Integration	1,175,192	1,060,538	0	0	0	114,654
13. Youth Crisis Response and Prevention	185,746	118,246	0	0	0	67,500
14. SMART	145,000	145,000	0	0	0	0
15. Expansion - Crisis Intervention	664,866	600,000	64,866	0	0	0
16. Expansion - TIS Ages 0-25	150,000	150,000	0	0	0	0
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	717,471	692,976				24,495
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,171,896	5,833,101	105,265	0	0	233,530

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2019/20					
	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. Early Childhood Community Team	421,349	409,087	0	0	0	12,262
2. Community Interventions for School Age a	663,865	660,213	0	0	0	3,652
3. and Capacity Building	425,053	373,687	40,399	0	0	10,967
4. Recognition of Early Signs of MI	10,000	10,000	0	0	0	0
5. Stigma and Discrimination	334,099	334,099	0	0	0	0
6. Suicide Prevention	78,225	78,225	0	0	0	0
7. Access & Linkage to Treatment	386,820	386,820	0	0	0	0
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Onset of Psychotic Disorders	814,210	814,210	0	0	0	0
12. Primary Care/MH Integration	1,175,192	1,060,538	0	0	0	114,654
13. Youth Crisis Response and Prevention	185,746	118,246	0	0	0	67,500
14. SMART	145,000	145,000	0	0	0	0
15. Expansion - Crisis Intervention	664,866	600,000	64,866	0	0	0
16. Expansion -TIS Ages 0-25	150,000	150,000	0	0	0	0
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	717,471	692,976				24,495
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,171,896	5,833,101	105,265	0	0	233,530

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2017/18					
	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. LGBTQ Coordinated Services Center	767,000	767,000				
2. Health Amabassador Program - Youth	250,000	250,000				
3. NMT - Adults	78,000	78,000				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	1,095,000	1,095,000	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2018/19					
	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. LGBTQ Coordinated Services Center	767,000	767,000				
2. Health Amabassador Program - Youth	250,000	250,000				
3. NMT - Adults	78,000	78,000				
4. AB114 - Technology Collaborative	1,700,000	1,700,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	2,795,000	2,795,000	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2019/20					
	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. LGBTQ Coordinated Services Center	767,000	767,000				
2. Health Amabassador Program - Youth	250,000	250,000				
3. NMT - Adults	78,000	78,000				
4. AB114 - Technology Collaborative	2,100,000	2,100,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	3,195,000	3,195,000	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2017/18					
	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. Training and Technical Assistance	124,550	123,503	0	0	0	1,047
2. Behavioral Health Career Pathways	37,000	35,455	0	0	0	1,545
3. Internship Program	100,000	47,400	0	0	0	52,600
4.						
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	244,043	236,077				7,966
Total WET Program Estimated Expenditures	505,593	442,435	0	0	0	63,158

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2018/19					
	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. Trainings for System Transformation	100,848	100,000	0	0	0	848
2. Trainings for/by Consumers and Family Members	60,509	60,000	0	0	0	509
3. Behavioral Health Career Programs	25,000	25,000	0	0	0	0
4. Internship Program	100,000	55,000	0	0	0	45,000
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	268,773	260,000	0	0	0	8,773
Total WET Program Estimated Expenditures	555,130	500,000	0	0	0	55,130

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 2/1/18

	Fiscal Year 2019/20					
	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. Trainings for System Transformation	100,848	100,000	0	0	0	848
2. Trainings for/by Consumers and Family Members	60,509	60,000	0	0	0	509
3. Behavioral Health Career Programs	25,000	25,000	0	0	0	0
4. Internship Program	100,000	55,000	0	0	0	45,000
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	268,773	260,000	0	0	0	8,773
Total WET Program Estimated Expenditures	555,130	500,000	0	0	0	55,130

APPENDIX 11

AIR®

AMERICAN INSTITUTES FOR RESEARCH®

Full Service Partnership (FSP) Outcomes

Findings from 2015-2016 Fiscal Year

Elizabeth Mokyr Horner, PhD, MPP

Yongqiu Chen, MPA

Anita Poon

Quy Nhi Cap, MPH

MAY 2017

Full Service Partnership (FSP) Outcomes

Findings from 2015-2016 Fiscal Year

May 2017

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Contents

Executive Summary

This report shows outcomes for child, transitional age youth (TAY), adult, and older adult clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in San Mateo County. These data are collected by providers via discussions with partners and should thus be viewed as self-report. Among the providers included in these analyses (Fred Finch, Edgewood, Caminar, and Telecare), 664 [1] partners completed a full year with FSP since program inception.

Exhibit 1, below, presents the percent improvement between the year just prior to FSP and the first year with FSP, by age group. Percent improvement is the percent change in the percent of partners with any events. For example, the percent of child partners experiencing homelessness changed from 6.6% before FSP to 3.3% in the first year with FSP, a 50% improvement.

In sum, the vast majority of the outcomes improve (22 of 24 outcomes) for all reported age groups. As can be seen in Exhibit 1, there are improvements comparing the year prior to FSP to the first year of FSP for partners in all age groups for the following self-reported outcomes: homelessness, arrests, mental health emergencies, and physical health emergencies. In addition, for children and TAY partners, school suspensions decrease and grade ratings increase, and for adult partners, the percent with any employment increases. However, there are two outcomes for which there is no improvement. First, while children partners have improvements in school attendance during the first year on FSP, TAY partners show no change. Second, although the percent of TAY and adult partners with an episode of detention or incarceration decreases, the percent of children with an episode increases.

Exhibit 1: Percent Improvement in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

Self-reported Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Homelessness	50%	18.4%	30%	**
Detention or Incarceration	(50%)	23%	27%	**
Arrests	68.1%	76%	86%	**
Mental Health Emergencies	86.1%	74%	57%	41%
Physical Health Emergencies	100%	67%	66%	30%
School Suspensions	41%	76%	**	**
Attendance Ratings	8%	(1)%	**	**
Grade Ratings	11%	6%	**	**
Employment	**	**	37%	**

* With the exception of attendance and grade ratings, the table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP.

[1] The number of partners considered as having completed a full year with FSP decreased from 669 in the previous report (calendar year 2015) to 664 (fiscal year 2015-16). The reason for the decrease is that, in accordance with the state template, only the most recent partnership is considered for individuals with multiple FSP partnerships. Thus, there are five individuals who had completed a full year with FSP previously, ended their FSP partnership, and then returned to FSP. These individuals are now included in the group of individuals on FSP but who have not yet completed a full year.

** Not Reported

Introduction

This memo reports on outcomes for clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in San Mateo County, who were served by Edgewood, Fred Finch, Caminar, and Telecare. The data used for this report are collected by providers via self-report from the partners.

The following report will explore how the first year with FSP differs from the year just prior to joining the FSP program, for child, transitional age youth (TAY), adult, and older adult individuals who complete at least one full year with FSP. All outcomes are stratified by client age when they join FSP. The outcomes provided for each age group are displayed in Exhibit 2, below.

Exhibit 2: Outcomes Presented by Age Group

Outcome	Child (n = 122)	TAY (n = 185)	Adult (n = 303)	Older adult (n = 54)
Homelessness	X	X	X	
Detention or Incarceration	X	X	X	
Arrests	X	X	X	
Mental Health Emergencies	X	X	X	X
Physical Health Emergencies	X	X	X	X
School Suspensions	X	X		
Attendance Ratings	X	X		
Grade Ratings	X	X		
Employment			X	

The intake assessment, called the Partnership Assessment Form (PAF), includes information on wellbeing across a variety of measures (e.g., residential setting), at the start of FSP and over the twelve months just prior. While a partner, data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

Additional information on how FSP partners fare over their tenure with FSP are presented in Appendix A. In addition, details on our methodology are presented in Appendix B.

Outcomes for Child Partners

The following section presents outcomes for the 122 child (aged 16 and younger) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Department of Juvenile Justice, Juvenile Hall, Jail, or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported suspensions**: measured by suspensions in past 12 months (PAF) and date suspended (KET)
7. **Average school attendance ranking**: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)
8. **Average school grade ranking**: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)

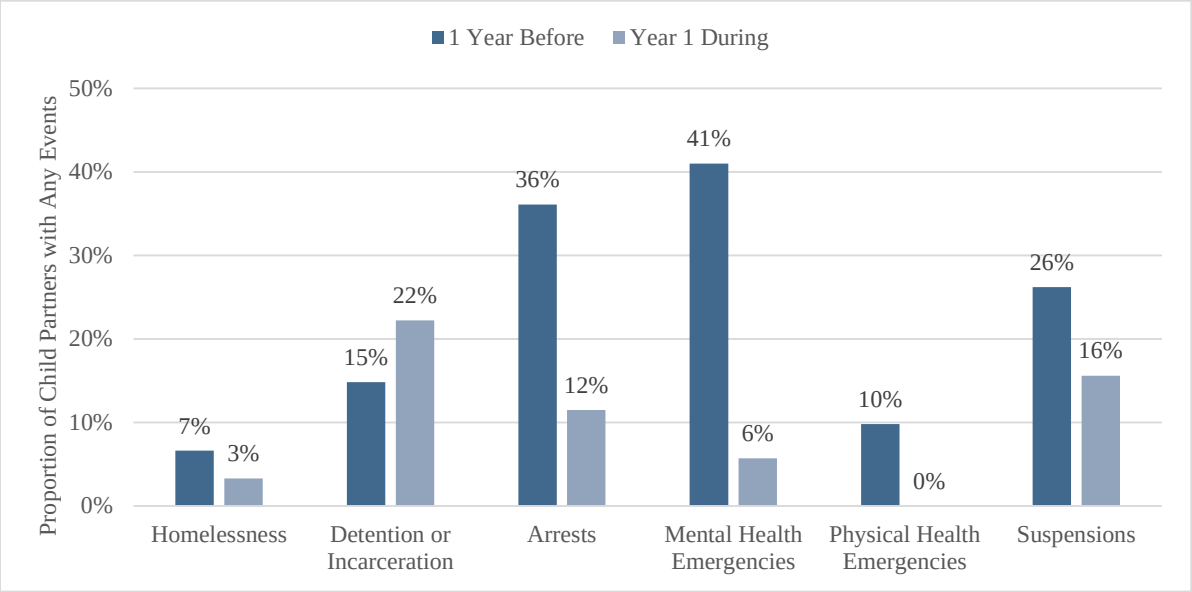
Note that employment is not presented for this cohort because it is not relevant for this age group. The results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP.

For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For details on the methodological approach, see Appendix B.

Results

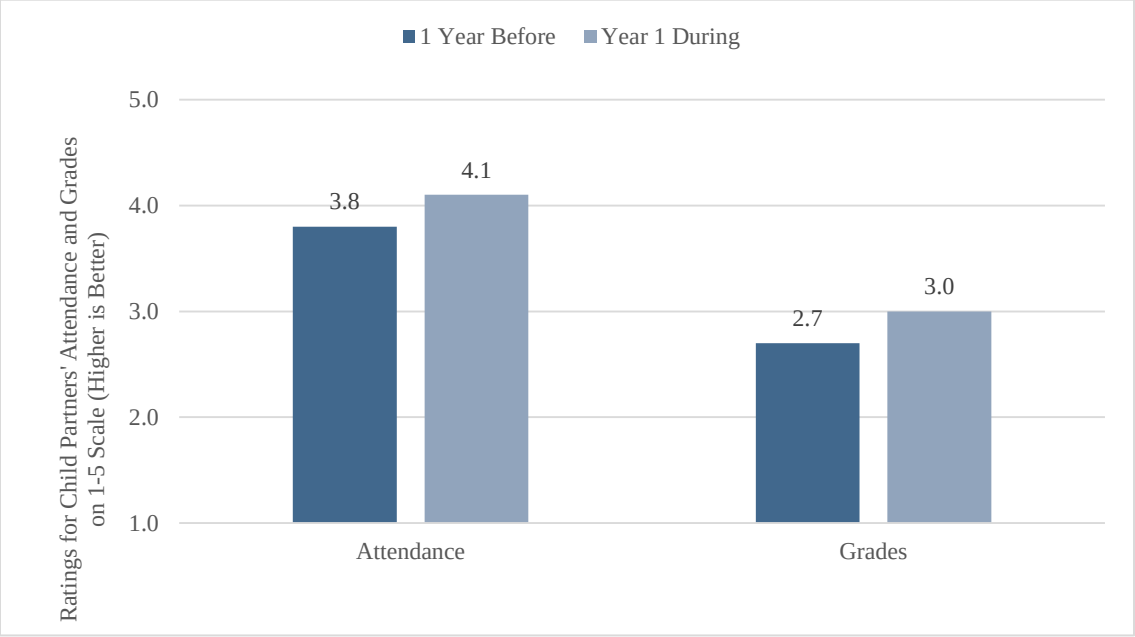
Exhibit 3 shows the comparison of outcomes in the year prior to FSP to the first year on the program for child partners. As can be seen, homelessness decreases. In addition, though there is a small increase in the percentage of partners who had any incarceration incident, the percentage of partners with arrests decreases. The percentage of partners with self-reported mental health and physical health emergencies decreases. Finally, there is a reduction in the percentage of child partners getting suspended from school.

Exhibit 3: Outcomes for Child Partners Completing One Year with FSP (n = 122)



Outcomes on school attendance and grades are presented below in Exhibit 4. As can be seen, attendance and grades for child partners improve modestly. Recall that these ratings are on a 1-5 scale, coded such that a higher score is better.

Exhibit 4: School Outcomes for Child Partners Completing One Year with FSP (n = 122)



Outcomes for TAY Partners

The following section presents outcomes for the 185 TAY (aged 17 - 25) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Department of Juvenile Justice, Juvenile Hall, Jail, or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported suspensions***: measured by suspensions in past 12 months (PAF) and date suspended (KET)
7. **Average school attendance ranking***: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)
8. **Average school grade ranking***: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)

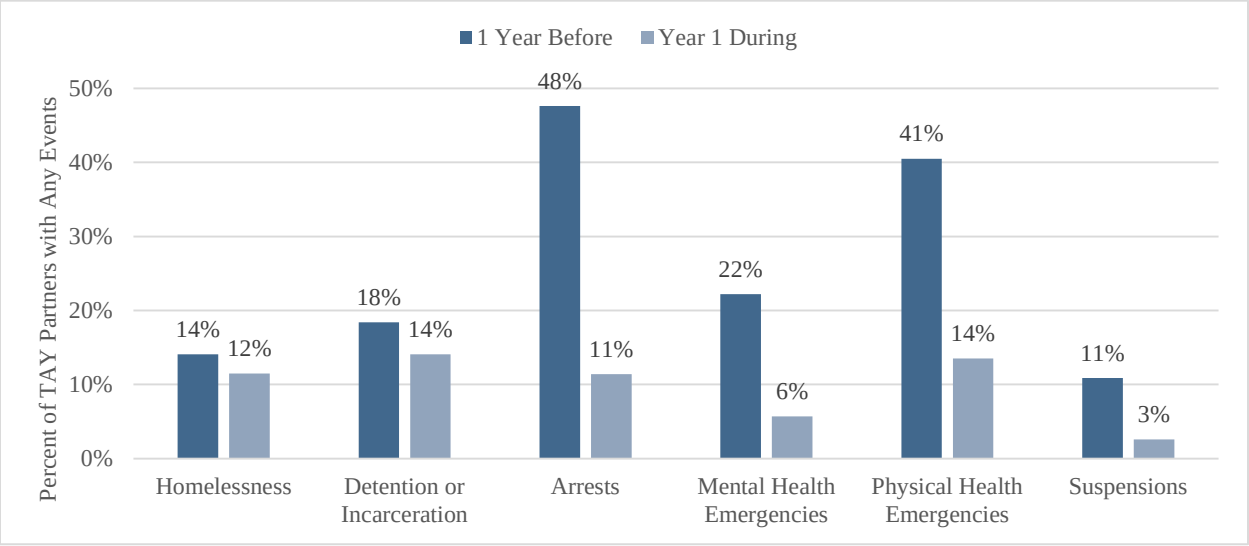
* Note that employment is not presented for this cohort because many of these individuals are in school. The 28 TAY in Telecare and Caminar are excluded from these outcomes because of missing data.

The results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP. For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For details on the methodological approach, see Appendix B.

Results

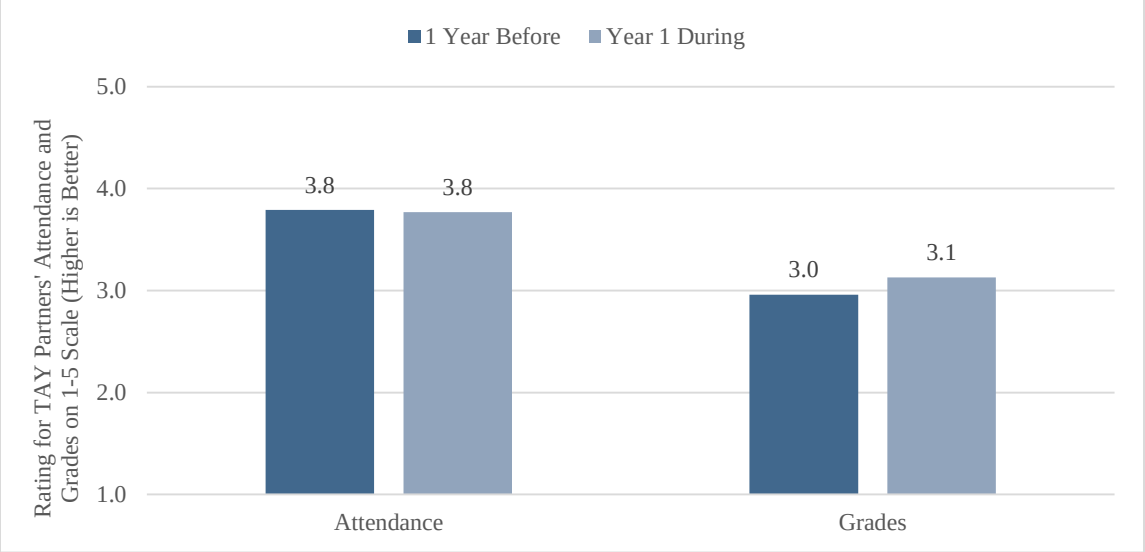
Results for TAY are presented below in Exhibit 5. The percentage of partners with days spent homeless decrease modestly. There are decreases across the other major outcomes: partners with incarceration incidents, arrests, self-reported mental and physical health emergencies, and suspensions. Note that the TAY sample for suspensions excludes the 28 Caminar and Telecare TAYs and the resulting number of partners is 157.

Exhibit 5: Outcomes for TAY Partners Completing One Year with FSP (n = 185)



Outcomes on school attendance and grades are presented in Exhibit 6. Attendance and grades for TAY partners change little. These ratings are on a 1-5 scale; a higher score is better.

Exhibit 6: School Outcomes for TAY Partners Completing One Year with FSP (n = 157)



Outcomes for Adults

The following section presents outcomes for the 303 adult (aged 26-59) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Jail or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported employment**: measured by employment in past 12 months (PAF) and date employment change (KET)

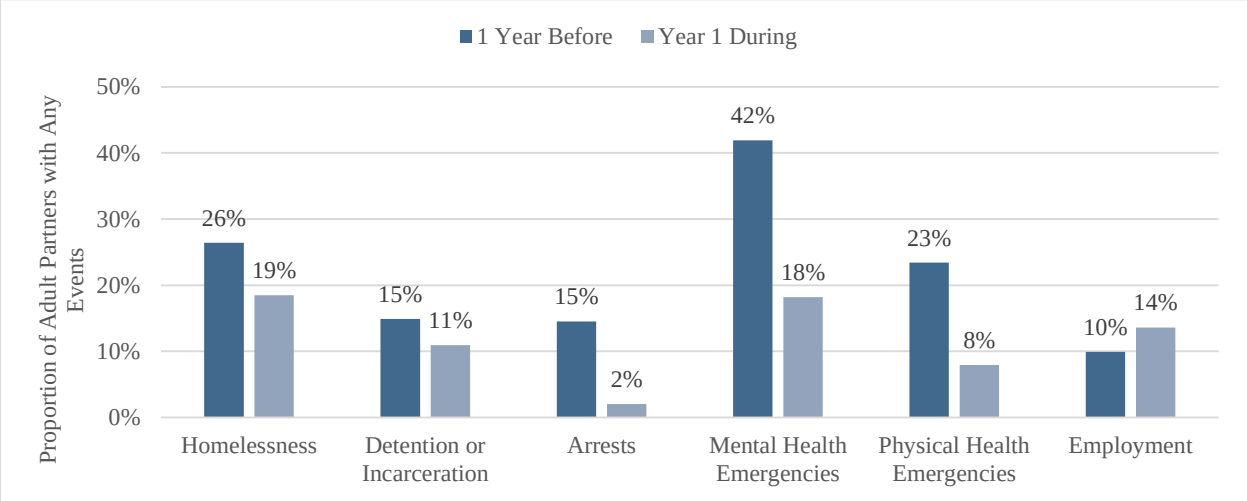
Note that school outcomes are not presented for this cohort because it is not relevant for this age group.

Again, the results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP. For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For details on the methodological approach, see Appendix B.

Results

First, please find the comparison of outcomes in the year prior to FSP to the first year on the program for adult partners in Exhibit 7. Homelessness, incarceration, arrests, as well as self-reported mental and physical health emergencies all decrease. In addition, employment increases.

Exhibit 7: Outcomes for Adult Partners Completing One Year with FSP (n = 303)



Outcomes for Older Adults

The following section presents outcomes for the 54 adult (aged 60 and older) FSP partners.

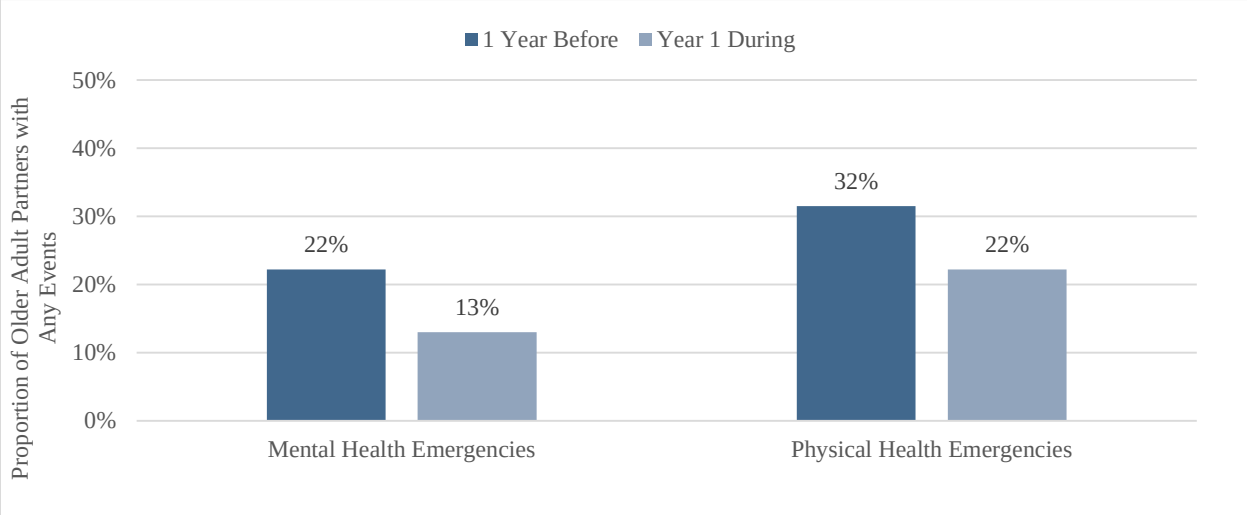
1. **Partners with any reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
2. **Partners with any reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)

Note that school outcomes are not presented for this cohort because it is not relevant for this age group. In addition, employment, homelessness, incarceration, and arrest outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are less than 5 older adult partners total with any of these events).

Results

Next, below in Exhibit 8, please find the comparison of outcomes in the year prior to FSP to the first year on the program for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies also decrease.

Exhibit 8: Outcomes for Older Adult Partners Completing One Year with FSP (n = 54)



Appendix A: Additional Detail on Outcomes

This section provides more details on the results presented above. To show more granular outcomes for groups of individuals large enough to interpret, here we combine child with TAY partners and adult with older adult partners, except where explicitly noted. No outcomes are presented for any group of partners with 50 or fewer individuals.

Residential Setting

A list of all residential settings and how they are categorized, is presented in Appendix B with the methodological approach.

First, Exhibit A1 presents the percentage of child and TAY partners spending any time in various residential settings. As can be seen, there are decreases in the percentage of clients with events in nearly all of the residential settings (except living alone or with others, paying rent).

Exhibit A1: Any Time in Residential Setting - Child and TAY Partners Completing 1 Year (n = 307)

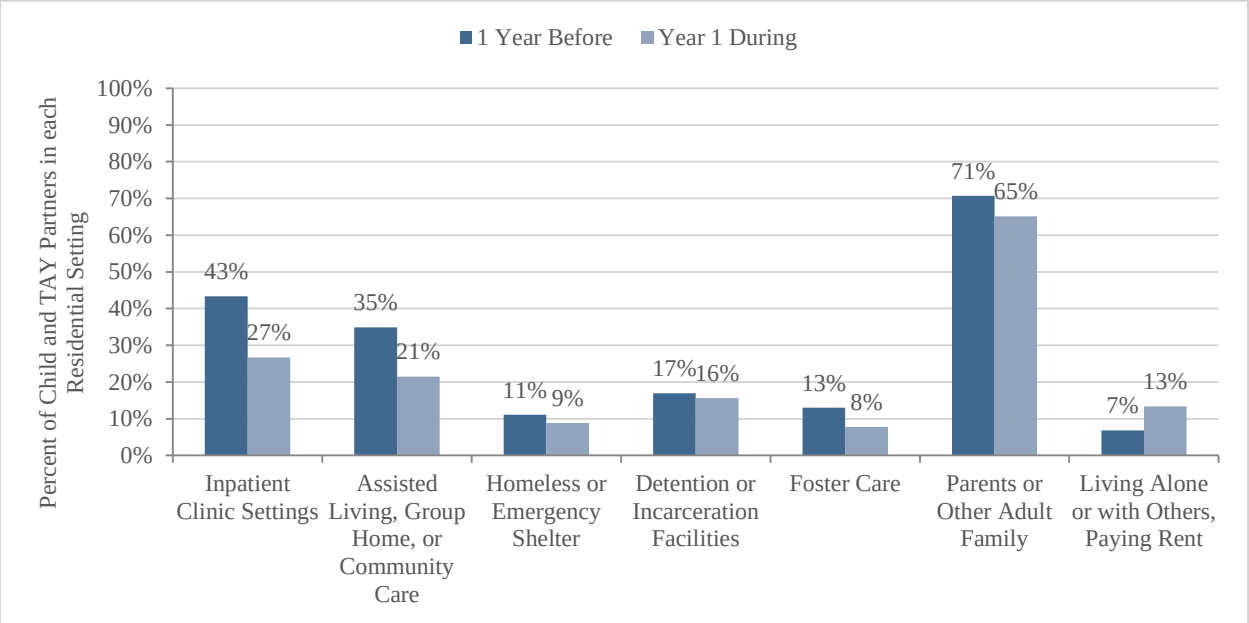
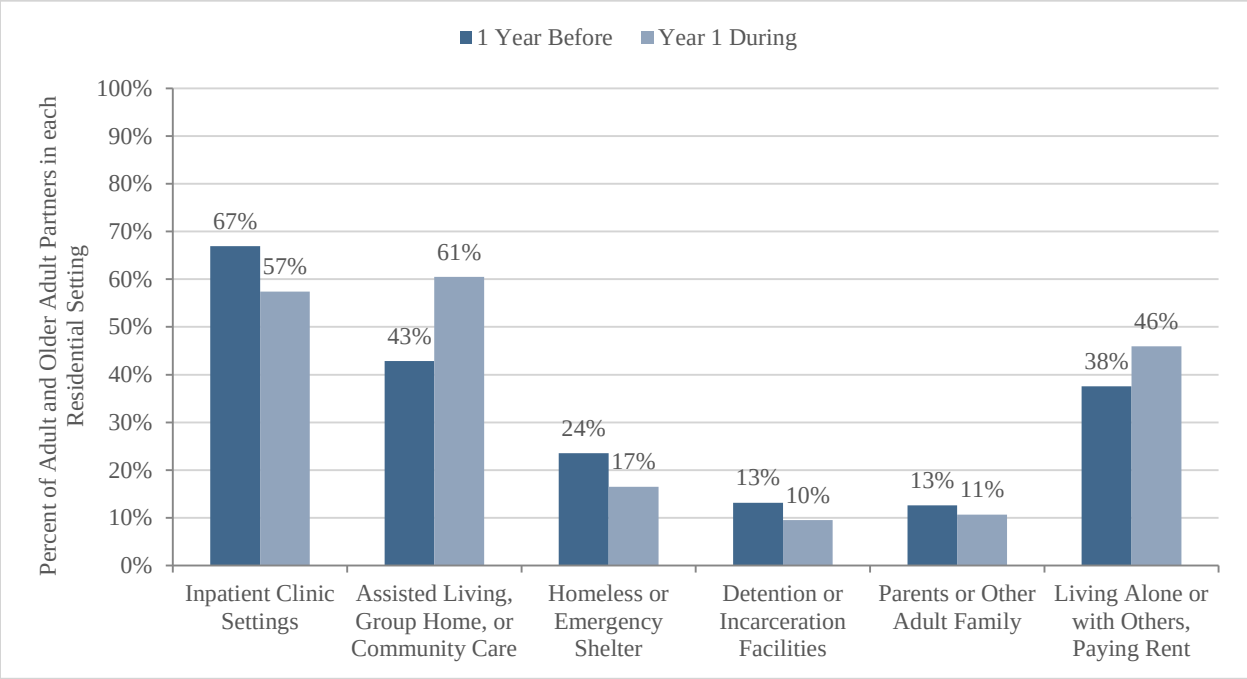


Exhibit A2 presents the residential settings for adult and older adult clients. As can be seen, the percent of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreases. In contrast, the percent living in an assisted living, group home, or community care environment, or living alone or with others, paying rent increases.

Exhibit A2: Any Time in Residential Settings – Adult and Older Clients Completing 1 Year (n = 357)



Arrests

Exhibit A3 presents the percentage of child and TAY partners with any arrests, broken down by tenure with FSP and year of program. Arrests are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A3: Any Arrests – Child and TAY Partners

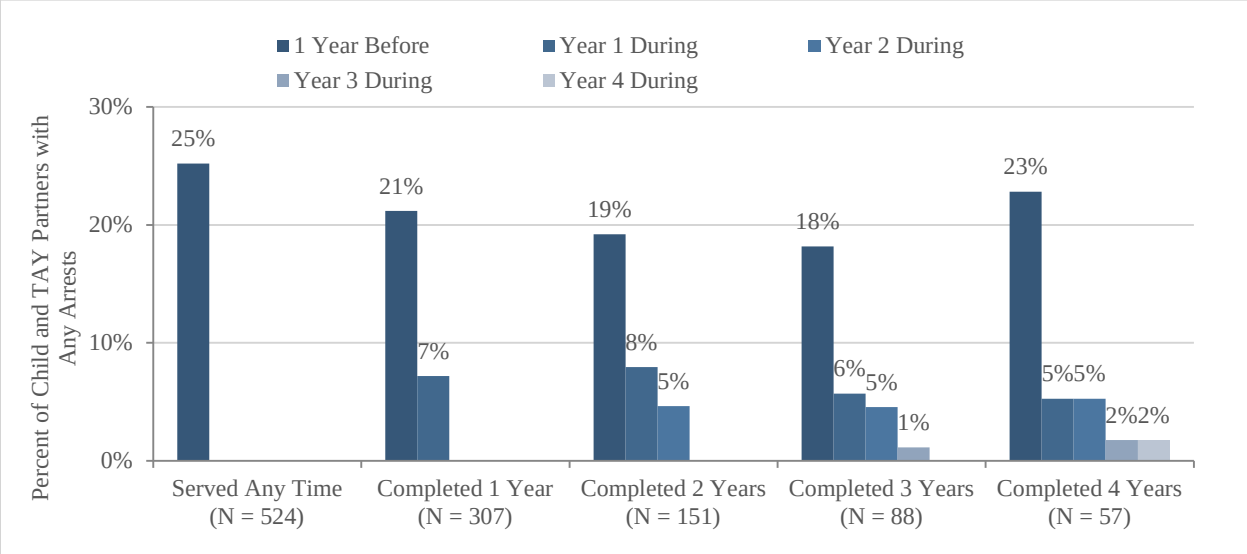
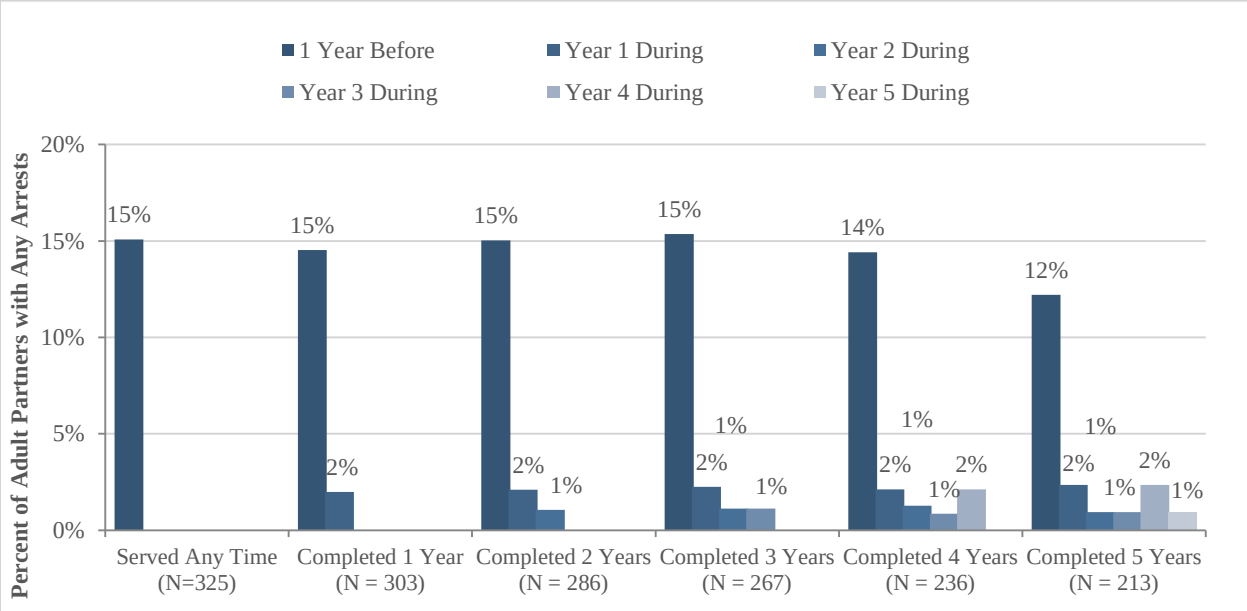


Exhibit A4 presents the percentage of adult partners with any arrests, broken down by tenure with FSP and year of program. Older adults are not included in these analyses because of insufficient observations with any arrests. As can be seen, arrests are more common among adult

partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A4: Any Arrests – Adult Partners



Self-reported Mental Health Emergencies

Exhibit A5 presents the percentage of child and TAY partners with any self-reported mental health emergencies, broken down by tenure with FSP and year of program. As can be seen, mental health emergencies as measured by self-report are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A5: Mental Health Emergencies – Child and TAY Partners

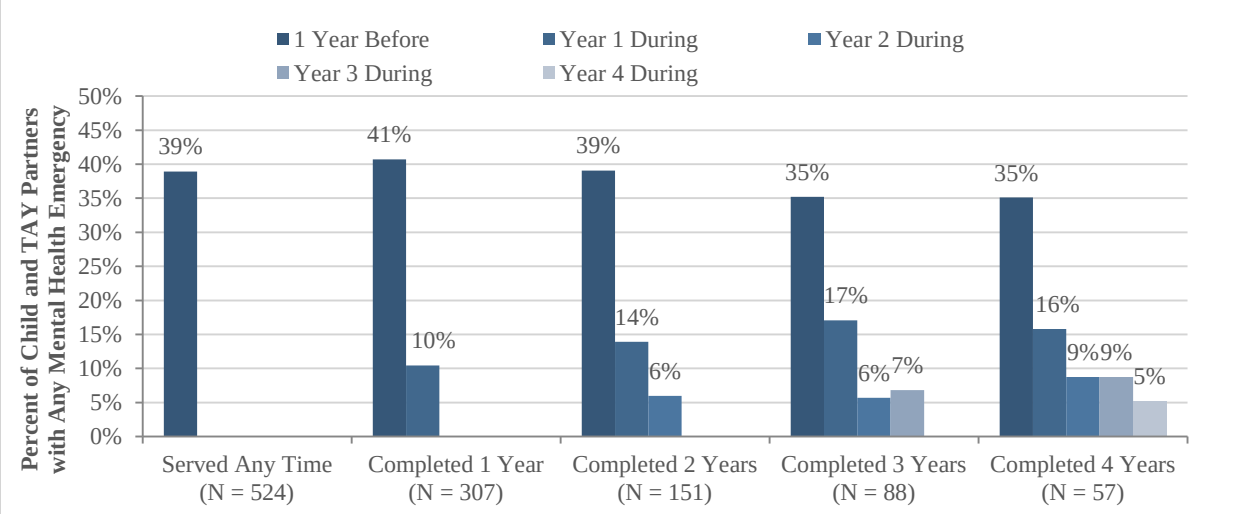
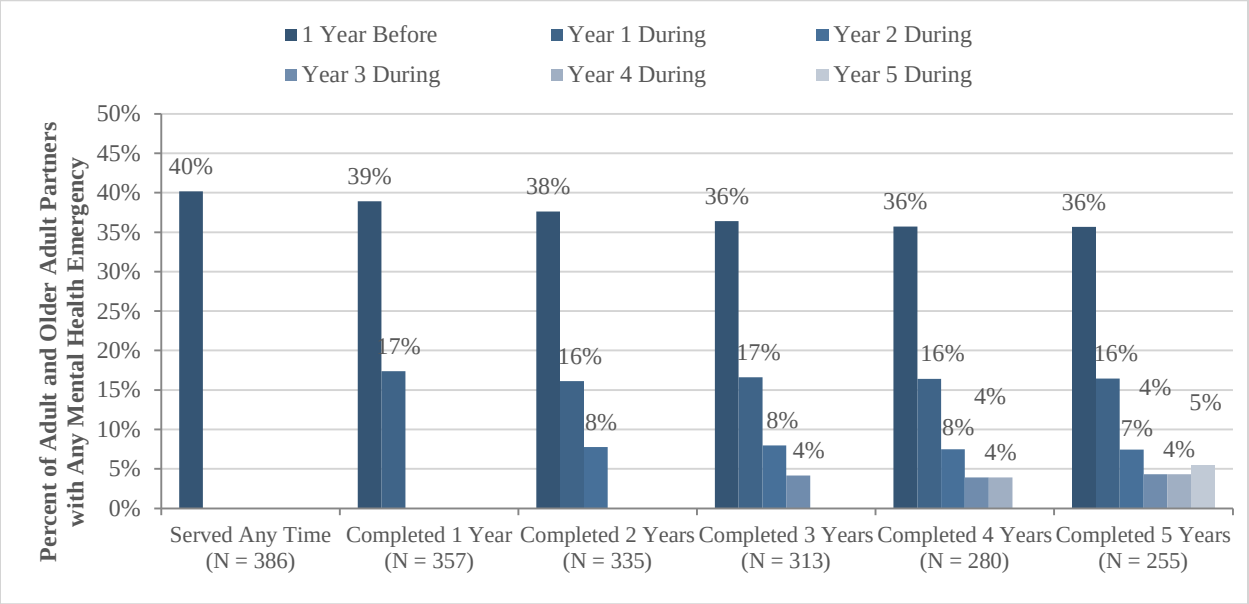


Exhibit A6 presents the percentage of adult and older adult partners with any self-reported mental health emergencies, broken down by tenure with FSP and year of program. Mental health

emergencies as measured by self-report are more common among adult and older adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A6: Mental Health Emergencies – Adult and Older Adult Partners



Self-reported Physical Health Emergencies

Exhibit A7 presents the percentage of child and TAY partners with any self-reported physical health emergencies, broken down by tenure with FSP and year of program. Physical health emergencies, as measured by self-report, are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A7: Physical Health Emergencies – Child and TAY Partners

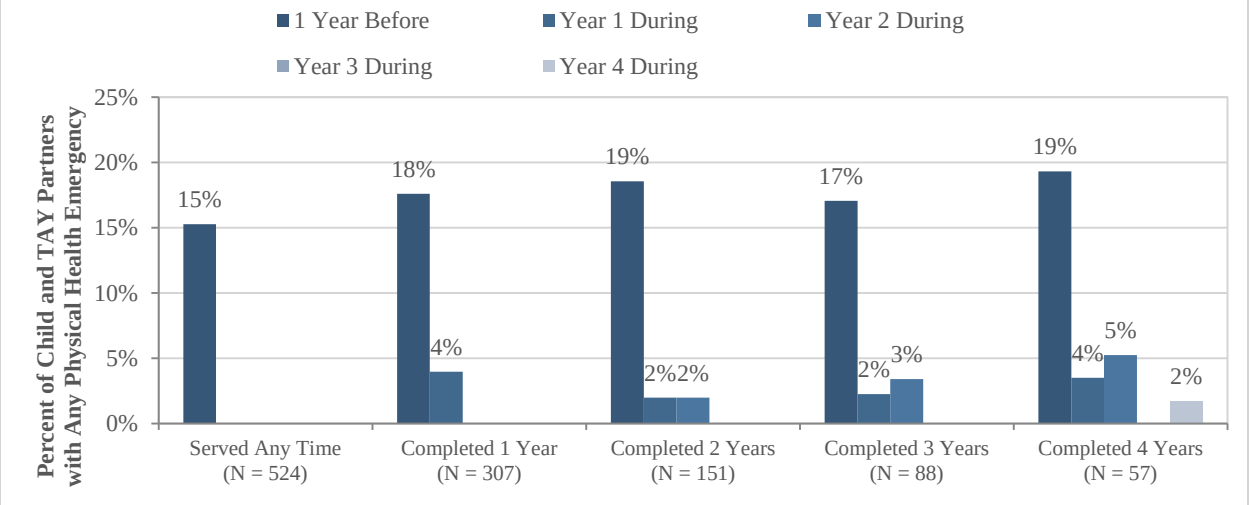


Exhibit A8 presents the percent of adult and older adult partners with any self-reported physical health emergencies, broken down by tenure with FSP and year of program. Physical health

emergencies as measured by self-report are more common among adult and older adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A8: Physical Health Emergencies – Adult and Older Adult Partners

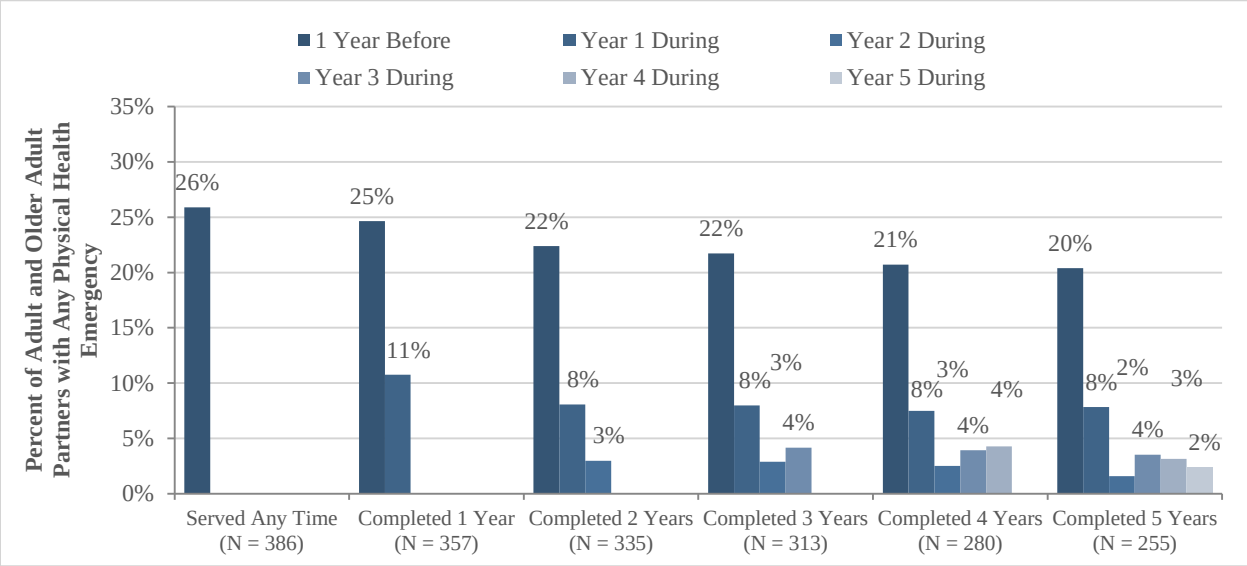
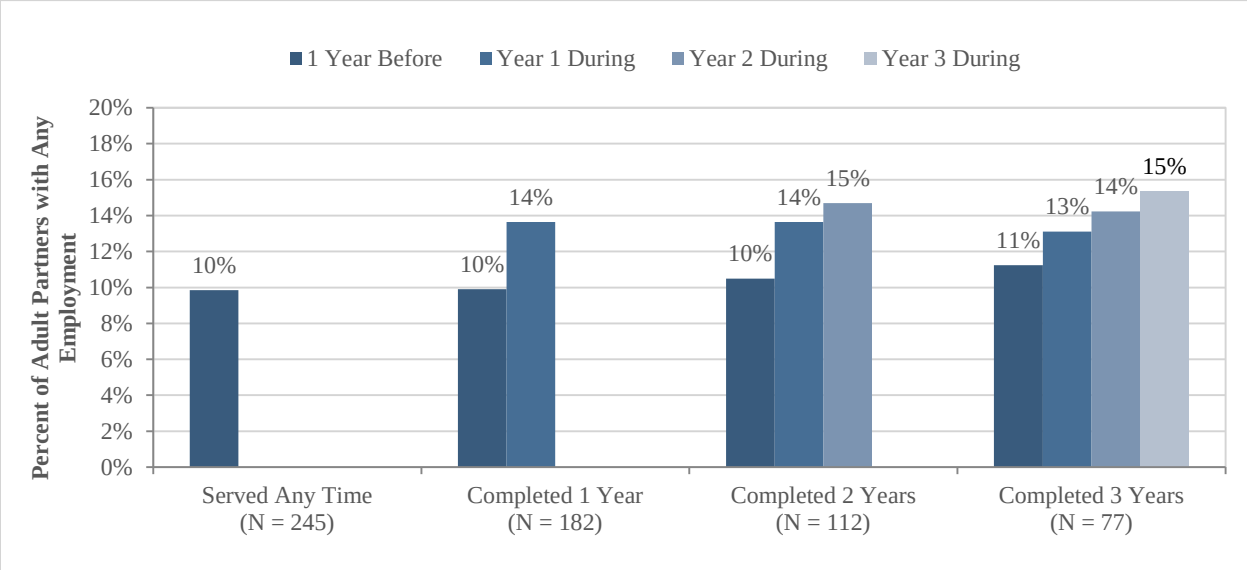


Exhibit A9 presents the percent of adult partners with any reported employment, broken down by tenure with FSP and year of program. Older adults are not included in these analyses because of insufficient observations with any employment. Having any employment among adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A9: Employment – Adult Partners



School Outcomes

Exhibits A10, A11, and A12 present school outcomes for child and TAY partners affiliated with Edgewood and Fred Finch. The small number of TAY partners affiliated with Caminar and Telecare are omitted from these analyses due to limited data on school performance.

Exhibit A10 presents the percent of child and TAY partners with any reported school suspensions, broken down by tenure with FSP and year of program. School suspensions are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across the next FSP year.

Exhibit A10: School Suspensions – Child and TAY Partners

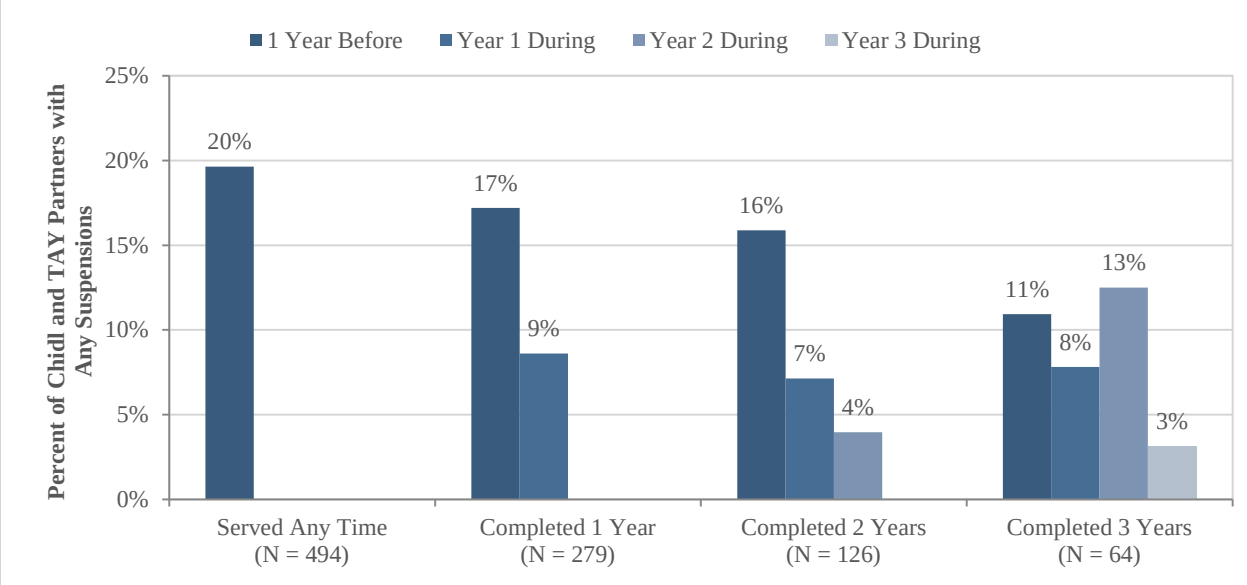


Exhibit A11 presents the average attendance rating (1-5) for child and TAY partners, broken down by tenure with FSP and year of program. Note that not all FSP partners in these age groups have data on attendance, and those who do have data on attendance do not necessarily have it at every three-month assessment. School attendance increases slightly once partners are on FSP. Attendance appears to dip during the third year, but this represents a small number of individuals and should not be over interpreted.

Exhibit A11: Ratings of Attendance – Child and TAY Partners (Rating 1 – 5; Higher is Better)

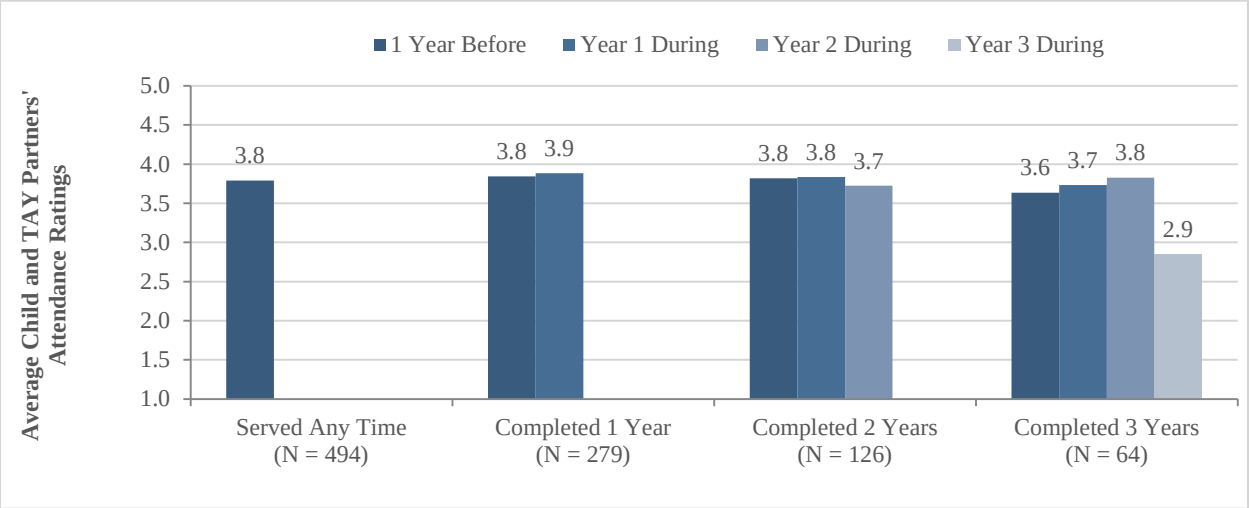
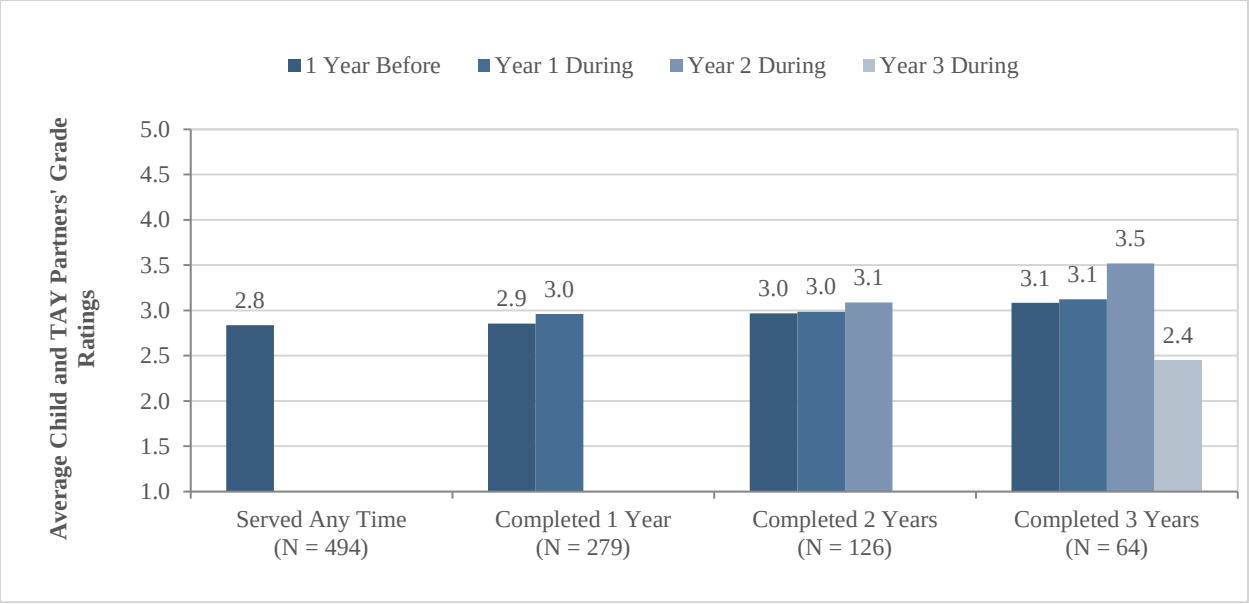


Exhibit A12 presents the average grades rating (1-5) for child and TAY partners, broken down by tenure with FSP and year of program. Note that not all FSP partners in these age groups have data on grades, and those who do have data on grades do not necessarily have it at every three-month assessment. School grades increase slightly once partners are on FSP. Grades appear to dip during the third year, but this represents a small number of individuals and should not be over interpreted.

Exhibit A12: Ratings of Grades – Child and TAY Partners (Rating 1 – 5; Higher is Better)



Appendix B: Methods

Three datasets were obtained: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. Caminar and Edgewood/Fred Finch provided their datasets in a Microsoft Excel format while Telecare provided a raw Microsoft Access database, which included data on individuals who were not affiliated with FSP.

For Telecare only, we limited the dataset to FSP partners using the Client Admission data and the System Agency Program.

Edgewood/Fred Finch serve child partners and TAY partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Exhibit B1 below describes the age group of partners completing at least one full year of FSP by provider. Note that Edgewood/Fred Finch data are presented together.

Exhibit B1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch	Caminar	Telecare	Total
Child (aged 16 and younger)	122	--	--	122
TAY (aged 17 – 25)	157	4	24	185
Adult (aged 26 -59)	--	49	254	303
Older Adult (aged 60+)	--	6	48	54
Total	279	59	326	664

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent Global ID, as indicated in the State's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the PAF data.

- For Caminar and Edgewood/Fred Finch, this was done using the variable *Age Group*.
  - Caminar: a value of (7) indicated a TAY partner, a value of (4) indicated an adult partner, and a value of (10) indicated an older adult partner.
  - Edgewood/Fred Finch: a value of (1) indicated a child partner, and a value of (4) indicated a TAY partner.
  - In both cases, this was confirmed using the *Age* variable.
- For Telecare data, partners were given a PAF appropriate for their age; the partner type was identified by the *Form Type* variable (TAY_PAF; Adult_PAF; or OA_PAF).

Partnership date and *end date* were determined as follows: End date was determined by the reported date of the partnership status change in the KET, if the status is indicated to be "discontinued." For clients still enrolled as of the data acquisition at the end of the year, we assigned an end date of June 30, 2016.

All data management and analysis was conducted in Stata. All code is available upon request. Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in the table below (Exhibit B2).
2. The baseline data was populated using the variable *PastTwelveDays* collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. First residential status for partners once they join FSP is determined by the *Current* variable, collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one *Current* location. In this case, if there was one residence with a later value for *DateResidentialChange*, this value was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year on FSP.
4. Additional residential settings for the first year were found using the KET data if the *DateResidentialChange* variable is within the first year with FSP as determined by the partnership date. If no residential data were captured by a KET, it was assumed that the individual stayed in their original residential setting.

Exhibit B2: Residential Categories

Category	Telecare Setting Value[2]	Caminar, Edgewood, and Fred Finch Setting Value[3]
With family or parents		
With parents	1	1
With other family	2	2
Alone		
Apartment alone or with spouse	3	3
Single occupancy (must hold lease)	4	19
Foster home		
Foster home with relative	5	4
Foster home with non-relative	6	5
Homeless or Emergency Shelter		
Emergency shelter	7	6
Homeless	8	7
Assisted living, group home, or community care		
Individual placement	9	20
Assisted living facility	10	28
Congregate placement	11	21
Community care	12	22
Group home (Level 0-11)	16	11
Group home (Level 12-14)	17	12
Community treatment	18	13
Residential treatment	19	14
Inpatient Facility		
Acute medical	13	8
Psychiatric hospital (other than state)	14	9
Psychiatric hospital (state)	15	10
Nursing facility, physical	20	23
Nursing facility, psychiatric	21	24
Long-term care	22	25
Incarcerated		
Juvenile Hall	23	15
Division of Juvenile Justice	24	16
Jail	30	27
Prison	31	26
Other / Don't Know		
Don't know	0	18
Other	49	17

[2] Setting names determined by *Setting* variable in Telecare data.
[3] Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Arrests

1. The baseline data was populated using the variable *ArrestsPast12* collected by the PAF. Individuals with blank data in this variable were assumed to have zero arrests in the year prior to FSP.

2. Ongoing arrests were populated using the variable indicating the date of arrest (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. We assumed that no information on arrests in the KET indicated that no arrests had occurred in the first year on FSP.

Mental and Physical Health Emergencies

1. The baseline data was populated using the variable *MenRelated* and *PhysRelated* for mental and physical emergencies, respectively, as collected by the PAF. Individuals with blank data in this variable were assumed to have zero emergencies of that type in the year prior to FSP.

2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (1=physical; 2=mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood and Fred Finch data were excluded.

1. The baseline data was populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):

    a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

    b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using the variable indicating the date of employment change (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. A change is considered as indicating some employment if the new employment status code indicated competitive employment or other employment (again, variable names differ by data set).

We assumed that no information on employment in the KET indicated that the original employment status sustained.

School Outcomes

School outcomes were generated for child and TAY partners affiliated with Edgewood and Fred Finch only. Caminar and Telecare TAY, adult, and older adult partners were excluded. Note that these outcomes are presented as though they represent outcomes for *all* child and TAY partners; however, we do not know how many of these partners are enrolled in school.

Suspensions

1. The baseline data was populated using the variable *SuspensionPast12* collected by the PAF. Individuals with blank data in this variable were assumed to have zero suspensions in the year prior to FSP.

2. Ongoing suspensions were populated using the variable indicating the date of suspension (*DateSuspension*) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. We assumed that no information on suspensions in the KET indicated that no suspensions had occurred in the first year on FSP.

Grades and Attendance

Note that grades and attendance are cardinal rankings. They are reported as ranging from 1 to 5, where lower indicates a better outcome. For the purposes of reporting, we reverse-coded these outcomes such that a 5 indicates a better outcome.

1. The baseline data was populated using the variables *GradesPast12* and *AttendancePast12* from the PAF data. Individuals with blank data in this variable were excluded.

2. Ongoing rankings of grades and attendance were gathered using the *GradesCurrent* and *AttendanceCurrent* from the PAF (for the first ranking) and the 3M forms. Again, individuals with blank data are excluded.

3. Because there were multiple observations for each person in each year, first averages by person by year were created; then averages by year.

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APPENDIX 12

AMERICAN INSTITUTES FOR RESEARCH®

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2015-2016

Anita Poon; Wendy Lee, MPH; Grace Wang, PhD, MPH

JANUARY 2017

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2015-2016

January 2017

Anita Poon; Wendy Lee, MPH; Grace Wang, PhD, MPH

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Contents

Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes overall collaborative and provider-specific outreach efforts across individual and group outreach events that occurred in fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016). We also present some historical data from FY 2014-2015 to show how outreach has changed over time.

Total Attendance

For FY 2015-2016, SMC BHRS providers reported a total of 5,556 attendees at all outreach events. Of these, 1,102 attendees were reached through individual outreach events and 4,454 attendees were reached across 107 group outreach events.

Demographics of outreach attendees

NCOC

NCOC individual outreach attendees were primarily adults and transition-age youth (84%) and with unknown insurance (59%). Individual and group outreach attendees were typically female (56%). Almost half of attendees were White or Filipino (46%). Attendees also reported being part of one or more special populations (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans). Of those reporting special population status, 58% were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO individual outreach attendees were largely adults and transition-age youth (92%) and without insurance (46%). Individual and group outreach attendees were usually female (57%). Almost half of attendees were Black or Mexican (48%). Of those reporting special population status, 80% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

The average length of NCOC individual outreach events was 34.9 minutes in FY 2015-2016. Of the 353 individual outreach events, most occurred in other community locations not listed (50%),

used Medicaid Administrative Activities (MAA) code 401 (Discounted Medi-Cal outreach, 37%), were conducted in English (94%), and included mental health outreach (35%) and mental health referrals (31%). Providers also made 483 referrals to other services, including legal services and housing.

NCOC group outreach events lasted 103.1 minutes on average. Of the 4,391 group outreach events, most were conducted in English (96%) and held in other community locations not listed (52%). These events most frequently used MAA code 401 (Discounted Medi-Cal outreach, 56%).

EPAPMHO

The 749 EPAPMHO individual outreach events were an average of 37.2 minutes each. These events were typically administered in English (67%), in the office (31%), and using MAA code 400 (Medi-Cal outreach, 72%). EPAPMHO individual outreach events also included mental health outreach (40%) and substance abuse outreach (22%). A total of 1,416 referrals were made to other services, including medical care and housing.

Of the 63 EPAPMHO group outreach events, the average event lasted 48.1 minutes. Half of group outreach events were conducted in Samoan (50%) and in homes (50%). These events used MAA code 400 (Medi-Cal outreach, 100%).

Recommendations

Based on FY 2015-2016 data, we recommend the following to enhance outreach and improve data collection. To enhance outreach, we suggest that SMC BHRS work with providers to:

- Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness.
- Share best practices across providers for reaching special populations.

To improve data collection, we recommend SMC BHRS work with providers to:

- Minimize missing data.
- Treat race/ethnicity as mutually exclusive categories.
- Report data collection and entry challenges as they occur.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults [Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)] in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of and access and linkages to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix A for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2015-2016 and outreach event attendees. We also present some historical data from FY 2014-2015 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix B to I.

Overall Outreach

During FY 2015-2016, SMC BHRS outreach providers reported a total of 5,556 attendees at outreach events—1,102 attendees reached through individual outreach events and 4,454 attendees reached across 107 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2015-2016.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2015-2016

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	150	1,502	1,652
Daly City Peninsula Partnership Collaborative	61	140	201
Daly City Youth Health Center	23	476	499
Pacifica Collaborative	23	2,069	2,092
Pyramid Alternatives	96	204	300
Total (NCOC)	**353**	**4,391**	**4,744**
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	53	0*	53
Free at Last	373	0*	373
Multicultural Counseling and Education Services of the Bay Area	323	63	386
Total (EPAPMHO)	**749**	**63**	**812**
Total (NCOC and EPAPMHO)	**1,102**	**4,454**	**5,556**

Notes: *Providers did not report data for FY 2015-2016. **Counts are not necessarily unique individuals.

Compared to FY 2014-2015, the total number of NCOC outreach attendees increased, whereas EPAPMHO outreach attendees decreased. Between FY 2014-2015 and FY 2015-2016, NCOC individual outreach attendees decreased from 450 to 353, and NCOC group outreach attendees increased from 3,939 to 4,391. In contrast, EPAPMHO individual outreach attendees increased from 451 to 749, and EPAPMHO group outreach attendees decreased from 497 to 63.

Table 2 presents outreach event attendees' race/ethnicity for FY 2014-2015 and FY 2015-2016 within each collaborative. Increases of 5% or more between the two years are shaded in green; decreases are shaded in red. Additional details on race/ethnicity by quarter for FY 2015-2016 are presented later in the report (pages 8 and 15).

Table 2. Race/Ethnicity by Collaborative, FY 2014-2016

	NCOC		EPAPMHO	
Race/Ethnicity	**FY 2014-2015**	**FY 2015-FY2016**	**FY 2014-2015**	**FY 2015-FY2016**
Black	172 (5%)	153 (3%)	131 (14%)	77 (9%)
White	335 (10%)	1,501 (32%)	39 (4%)	194 (24%)
American Indian	7 (<1%)	48 (1%)	0 (0%)	0 (0%)
Middle Eastern	7 (<1%)	60 (1%)	0 (0%)	7 (1%)
Mexican	144 (4%)	260 (5%)	44 (5%)	195 (24%)
Puerto Rican	1 (<1%)	6 (<1%)	1 (<1%)	1 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Latino	273 (8%)	87 (2%)	150 (15%)	4 (<1%)
Filipino	577 (17%)	678 (14%)	12 (1%)	18 (2%)
Chinese	192 (6%)	246 (5%)	0 (0%)	2 (<1%)
Japanese	14 (<1%)	30 (1%)	0 (0%)	0 (0%)
Korean	21 (1%)	29 (1%)	0 (0%)	0 (0%)
South Asian	26 (1%)	16 (<1%)	0 (0%)	2 (<1%)
Vietnamese	35 (1%)	23 (<1%)	1 (<1%)	2 (<1%)
Cambodian	18 (1%)	1 (<1%)	0 (0%)	0 (0%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Laotian	1 (<1%)	2 (<1%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tongan	183 (5%)	236 (5%)	283 (29%)	85 (10%)
Samoan	353 (10%)	343 (7%)	106 (11%)	117 (14%)
Fijian	9 (<1%)	24 (1%)	1 (<1%)	0 (0%)
Hawaiian	48 (1%)	29 (1%)	3 (<1%)	13 (2%)
Guamanian	10 (1%)	25 (1%)	1 (<1%)	6 (1%)
Multi-racial	72 (2%)	428 (9%)	39 (4%)	2 (<1%)
Other Race	432 (13%)	95 (2%)	26 (3%)	4 (<1%)
Unknown Race	504 (15%)	440 (9%)	131 (14%)	83 (10%)
Total	**3,434**	**4,760**	**968**	**812**

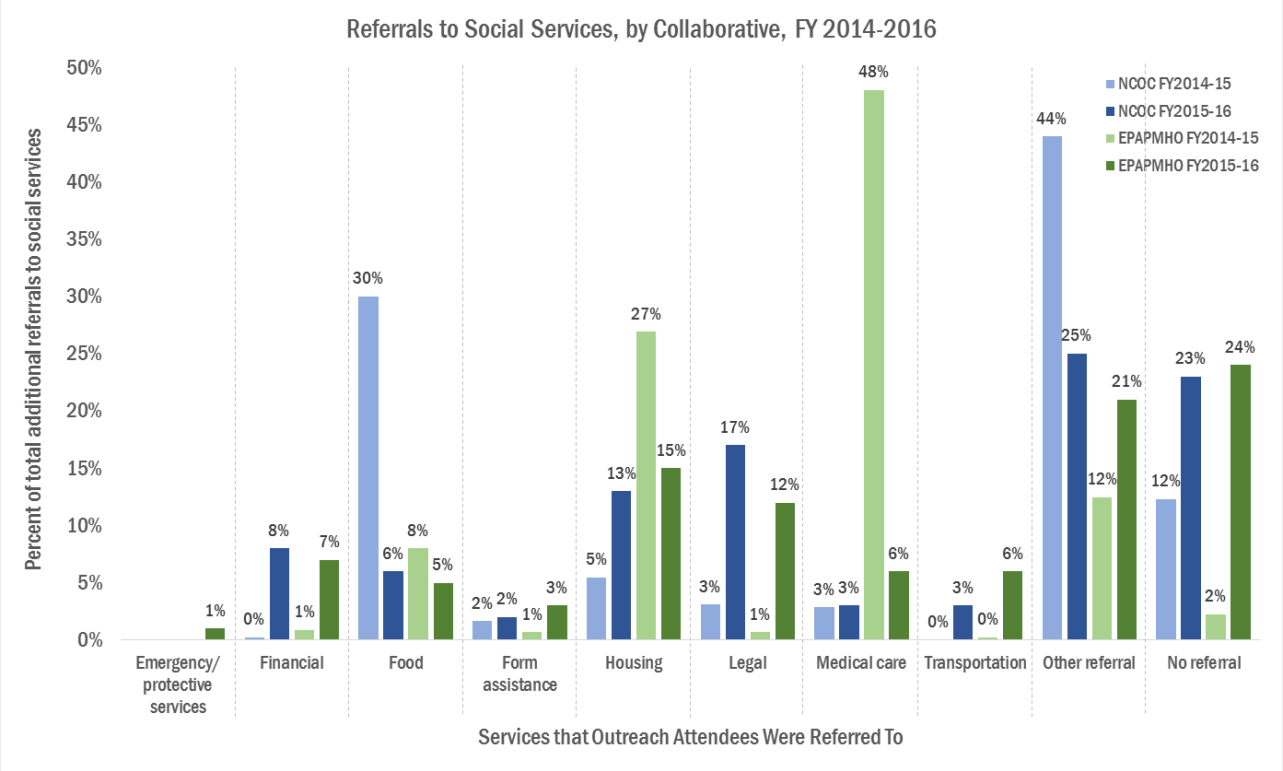
Note: Percentages may not sum to 100% because of rounding.

Figure 2 presents referrals to social services, by collaborative for both FY 2014-2015 and FY 2015-2016. The percentages shown represent percent of total referrals to social services. Both NCOC and EPAPMHO had increases in the numbers of referrals to social services.

- In FY 2015-2016, NCOC had 629 referrals to social services, as compared to 423 referrals in the prior FY. In FY 2015-2016, EPAPMHO had 1,527 referrals to social services, as compared to 450 referrals in the prior FY.
- As a percent of all referrals, both NCOC and EPAPMHO had increases in Financial, Legal, and Transportation referrals between FY 2014-2015 and FY 2015-2016.

- In FY 2015-2016, NCOC had decreases in the percent of food and other referrals compared to FY 2014-2015. In FY 2015-2016, EPAPMHO had decreases in the percent of housing and medical care referrals compared to the prior FY.

Figure 2. Referrals to Social Services, by Collaborative, FY 2014-2016



Note: Percentages may not sum to 100% because of rounding.

NCOC

In FY 2015-2016, there were 4,744 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: NCOC individual outreach attendees were adults (26-59 years, 59%), transition-age youth (16-25 years, 25%), older adults (60 years or older, 5%), and children (0-15 years, 2%) in FY 2015-2016. Nine percent of attendees were of an unknown age. See **Table 3** for the number of individual outreach attendees representing each reported age group, by quarter. Providers were not asked to report group outreach data on age for FY 2015-2016.

Table 3. Age of Individual Outreach Attendees Served by NCOC, FY 2015-2016

Age Group	Q1	Q2	Q3	Q4	Total
Adults (26-59)	91 (52%)	43 (74%)	32 (62%)	43 (62%)	209 (59%)
Transition-age youth (16-25)	44 (25%)	12 (21%)	15 (29%)	16 (23%)	87 (25%)
Unknown age	31 (18%)	0 (0%)	1 (2%)	0 (0%)	32 (9%)
Older adults (60+)	8 (5%)	3 (5%)	4 (8%)	4 (6%)	19 (5%)
Children (0-15)	0 (0%)	0 (0%)	0 (0%)	6 (9%)	6 (2%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across NCOC individual and group outreach events were females (56%), males (38%), and other genders (6%) in FY 2015-2016. See **Table 4** for the number of individual and group outreach attendees reporting each gender type, by quarter.

Table 4. Gender of Outreach Attendees Served By NCOC, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	419 (58%)	818 (57%)	695 (49%)	710 (61%)	2,642 (56%)
Male	234 (33%)	561 (39%)	588 (42%)	440 (38%)	1,823 (38%)
Other gender	64 (9%)	66 (5%)	131 (9%)	18 (2%)	279 (6%)
Total	**717**	**1,445**	**1,414**	**1,168**	**4,744**

Note: Percentages may not sum to 100% because of rounding

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all NCOC attendees were White (32%), Filipino (14%), and multi-racial (9%). Nine percent of attendees were of an unknown race. See **Table 5** for the number of attendees representing each reported racial/ethnic group, by quarter.

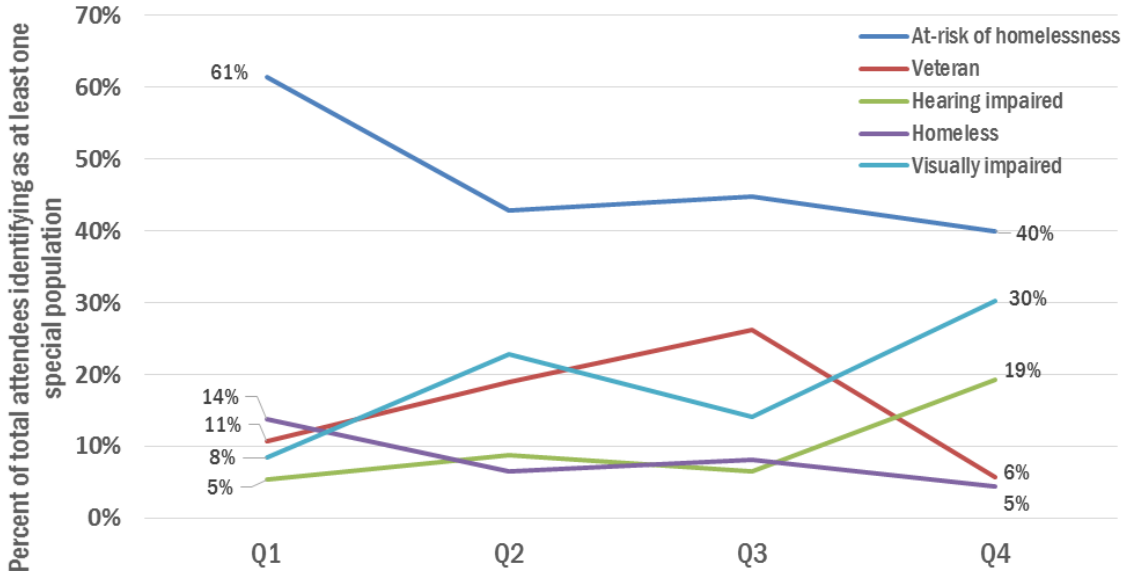
Table 5. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2015-2016

Race/ethnicity	Q1	Q2	Q3	Q4	Total
White	269 (37%)	601 (42%)	549 (38%)	82 (7%)	1,501 (32%)
Black	26 (4%)	44 (3%)	43 (3%)	40 (3%)	153 (3%)
Middle Eastern	11 (2%)	17 (1%)	18 (1%)	14 (1%)	60 (1%)
American Indian	5 (1%)	17 (1%)	20 (1%)	6 (1%)	48 (1%)
Mexican	47 (7%)	54 (4%)	37 (3%)	122 (10%)	260 (5%)
Other Latino	30 (4%)	25 (2%)	32 (2%)	0 (0%)	87 (2%)
Puerto Rican	1 (<1%)	0 (0%)	3 (<1%)	2 (<1%)	6 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Filipino	89 (12%)	171 (12%)	233 (16%)	185 (16%)	678 (14%)
Chinese	31 (4%)	73 (5%)	61 (4%)	81 (7%)	246 (5%)
Japanese	13 (2%)	5 (<1%)	7 (<1%)	5 (<1%)	30 (1%)
Korean	2 (<1%)	5 (<1%)	16 (1%)	6 (1%)	29 (1%)
Vietnamese	1 (<1%)	7 (<1%)	10 (1%)	5 (<1%)	23 (<1%)
South Asian	3 (<1%)	3 (<1%)	7 (<1%)	3 (<1%)	16 (<1%)
Laotian	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	1 (<1%)	1 (<1%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Samoan	47 (7%)	97 (7%)	57 (4%)	142 (12%)	343 (7%)
Tongan	15 (2%)	43 (3%)	18 (1%)	160 (14%)	236 (5%)
Hawaiian	3 (<1%)	8 (1%)	11 (1%)	7 (1%)	29 (1%)
Guamanian	0 (0%)	6 (<1%)	2 (<1%)	17 (1%)	25 (1%)
Fijian	0 (0%)	4 (<1%)	4 (<1%)	16 (1%)	24 (1%)
Unknown Race	58 (8%)	138 (10%)	236 (17%)	8 (1%)	440 (9%)
Multi-racial	51 (7%)	101 (7%)	53 (4%)	223 (19%)	428 (9%)
Other Race	15 (2%)	26 (2%)	11 (1%)	43 (4%)	95 (2%)
Total**	**718**	**1,445**	**1,429**	**1,168**	**4,760**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: NCOC individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 49% were at risk for homelessness, 18% were visually impaired, 16% were veterans, 9% were hearing impaired, and 9% were homeless. Refer to **Figure 3** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 3. Special Populations Served By NCOC, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: NCOC individual outreach attendees were with unknown insurance (59%), with other insurance (17%), with Medi-Cal (17%), without insurance (4%), or with Medicare (3%) in FY 2015-2016. Less than 1% of attendees reported having more than one type of insurance. See **Table 6** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 6. Insurance Coverage for NCOC Outreach Attendees, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Unknown Insurance	104 (60%)	40 (69%)	29 (56%)	35 (51%)	208 (59%)
Other Insurance	22 (13%)	6 (10%)	7 (13%)	25 (36%)	60 (17%)
Medi-Cal	33 (19%)	10 (17%)	9 (17%)	7 (10%)	59 (17%)
Uninsured	9 (5%)	1 (2%)	5 (10%)	0 (0%)	15 (4%)
Medicare	5 (3%)	1 (2%)	2 (4%)	2 (3%)	10 (3%)
More than 1 type	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**174**	**58**	**52**	**69**	**353**

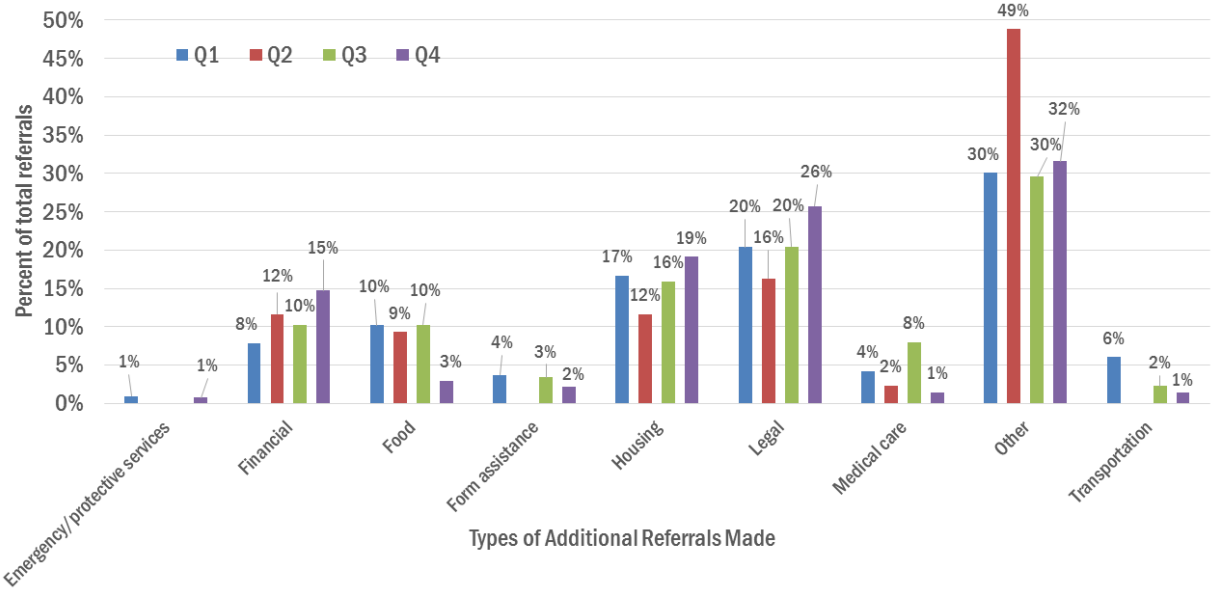
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Twenty percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Use Referrals: NCOC individual outreach events included mental health referrals (45%) and substance abuse referrals (14%) in FY 2015-2016.

Referrals to Social Services: Providers made 483 referrals to 353 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for other referrals not listed (32%), legal services (22%), and housing (17%). In **Figure 4**, we summarize the percentage of attendees receiving a given type of referral, by quarter.

Figure 4. Referrals to Social Services, FY 2015-2016



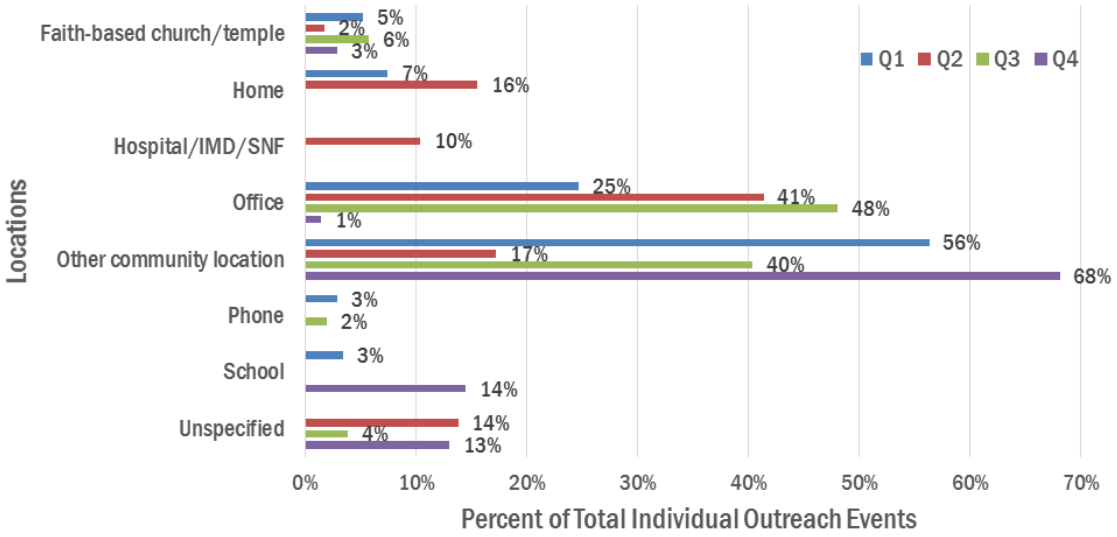
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations not listed[1] (50%) and in the office (26%) in FY 2015-2016. **Figure 5** presents individual outreach event locations in FY 2015-2016, by quarter.

[1] Due to the high percentage of individual outreach events reported to be held in "other community locations," we have modified future outreach forms (starting in FY 2016-2017) to include a free-response space for providers to include additional information about these other locations. Moving forward, this will allow us to better understand what these additional outreach locations are and to meet the needs of outreach attendees.

Figure 5. Locations of NCOC Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC individual outreach events was 34.9 minutes. Average length was 31.0 minutes in Q1, 42.8 minutes in Q2, 51.1 minutes in Q3, and 25.7 minutes in Q4.

MAA code: NCOC individual outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 37%), 400 (Medi-Cal outreach, 32%), 403 (Referral in crisis situations for non-open cases, 5%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA code 404 (Case management of non-open cases) was not used. Twenty-five percent of MAA codes were reported as N/A.

Language: NCOC individual outreach events were conducted in English (94%), Spanish (4%), Tagalog (1%), and Mandarin (1%). See **Table 7** for group outreach events by language.

Table 7. Number of NCOC Individual Outreach Events By Language, FY 2015-2016

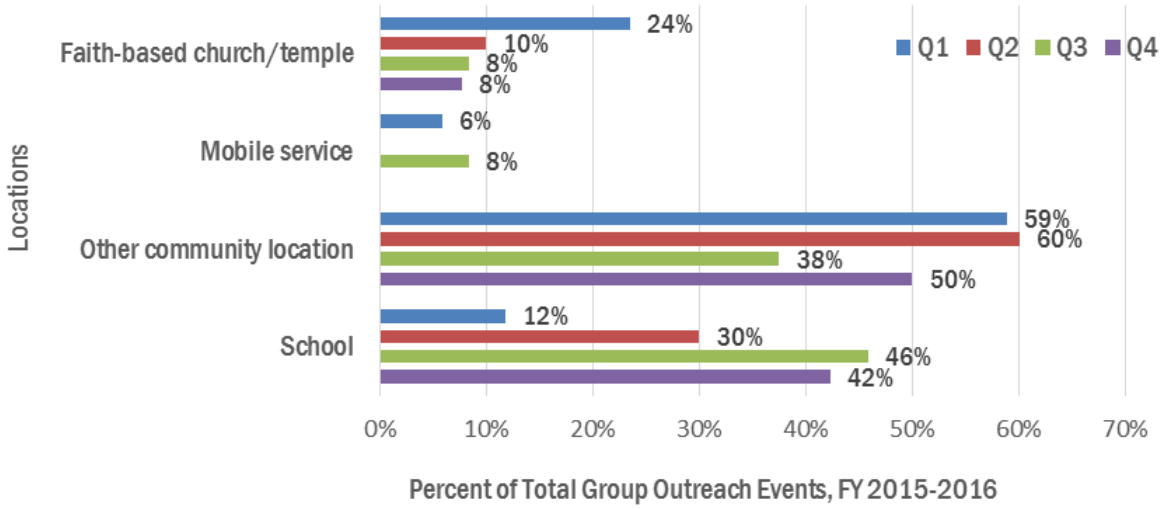
Language	Q1	Q2	Q3	Q4	Total
English	163 (94%)	53 (91%)	50 (96%)	67 (97%)	333 (94%)
Spanish	7 (4%)	5 (9%)	1 (2%)	1 (1%)	14 (4%)
Tagalog	3 (2%)	0 (0%)	0 (0%)	0 (0%)	3 (1%)
Mandarin	0 (0%)	0 (0%)	1 (2%)	1 (1%)	2 (1%)
Other	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tongan, Vietnamese, and unknown language.

Group outreach event characteristics

Location: NCOC group outreach events largely occurred at other community locations not listed (52%) and at school (34%) in FY 2015-2016. **Figure 6** presents group outreach event locations in FY 2015-2016, by quarter.

Figure 6. Location of NCOC Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC group outreach events was 103.1 minutes. By quarter, average length of outreach was 123.4 minutes in Q1, 105.1 minutes in Q2, 80.3 minutes in Q3, and 108.4 minutes in Q4.

MAA code: NCOC group outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 56%), 400 (Medi-Cal outreach, 24%), and 403 (Referral in crisis situations for non-open cases, 2%) in FY 2015-2016. MAA codes 404 (Case management of non-open cases) and 410 (Non-SPMP case management of non-open cases) were not used. Eighteen percent of MAA codes were reported as N/A.

Language: NCOC group outreach events were conducted in English (96%), Mandarin (1%), and Spanish (1%). See **Table 8** below for the breakdown of group outreach events by the language of administration.

Table 8. Number of NCOC Group Outreach Events By Language, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
English	17 (100%)	30 (97%)	24 (100%)	24 (89%)	95 (96%)
Other	0 (0%)	1 (3%)	0 (0%)	1 (4%)	2 (2%)
Mandarin	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Spanish	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Total	**17**	**31**	**24**	**27**	**99**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tagalog, Tongan, Vietnamese, and unknown language.

EPAPMHO

In FY 2015-2016, there were 812 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual outreach attendees were adults (26-59 years, 54%), transition-age youth (16-25 years, 38%), older adults (60+ years or older, 7%), and children (0-15 years, <1%) in FY 2015-2016. Less than one percent of attendees were of an unknown age. See **Table 9** for the number of individual outreach attendees representing each reported age group, by quarter. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Table 9. Age of Individual Outreach Attendees Served By EPAPMHO, FY 2015-2016

Age	Q1	Q2	Q3	Q4	Total
Adults (26-59)	149 (70%)	88 (45%)	98 (46%)	73 (59%)	408 (54%)
Transition-age youth (16-25)	57 (27%)	94 (48%)	97 (45%)	33 (27%)	281 (38%)
Older adults (60+)	8 (4%)	14 (7%)	18 (8%)	16 (13%)	56 (7%)
Children (0-15)	0 (0%)	0 (0%)	1 (<1%)	1 (1%)	2 (<1%)
Unknown age	0 (0%)	1 (1%)	1 (<1%)	0 (0%)	2 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across EPAPMHO individual and group outreach events were females (57%), males (41%), and other genders (2%) in FY 2015-2016. See **Table 10** for the number of individual and group outreach attendees representing each reported gender, by quarter.

Table 10. Gender of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	121 (51%)	139 (63%)	120 (56%)	85 (61%)	465 (57%)
Male	113 (48%)	81 (36%)	86 (40%)	53 (38%)	333 (41%)
Other gender	2 (1%)	2 (1%)	9 (4%)	1 (1%)	14 (2%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding.

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (24%), Black (24%), and Tongan (14%). Less than one percent of attendees were of an unknown race. See **Table 11** for the number of attendees representing each reported racial/ethnic group, by quarter.

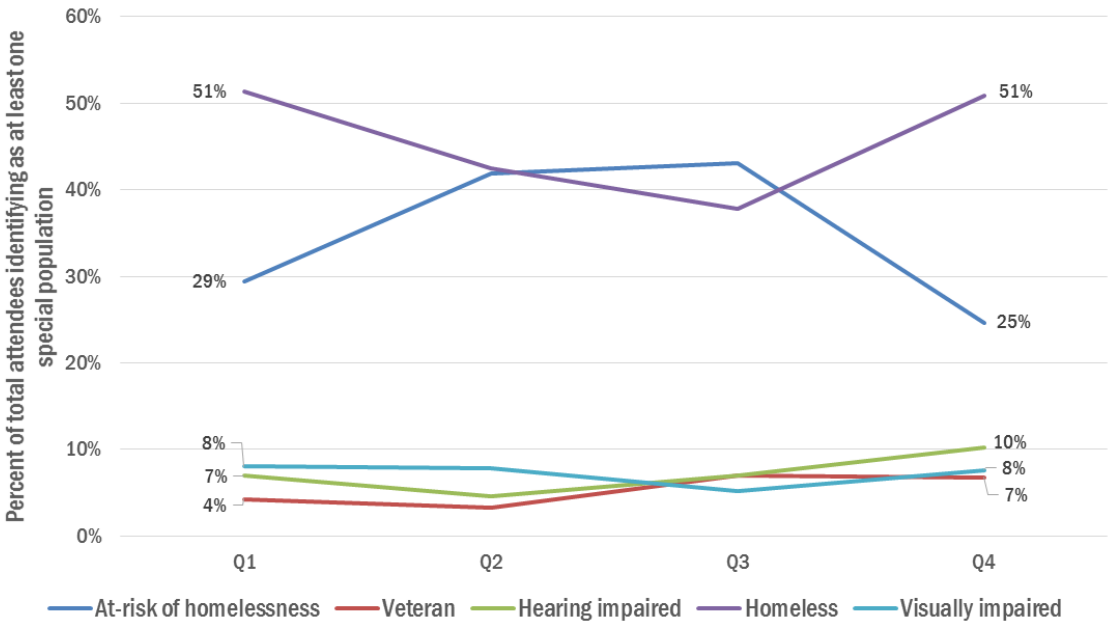
Table 11. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
Black	54 (23%)	57 (26%)	53 (25%)	30 (17%)	194 (24%)
White	27 (11%)	16 (7%)	21 (9%)	13 (9%)	77 (9%)
American Indian	3 (1%)	1 (<1%)	2 (1%)	1 (1%)	7 (1%)
Mexican	63 (27%)	44 (20%)	53 (25%)	35 (25%)	195 (24%)
Puerto Rican	2 (1%)	0 (0%)	2 (1%)	0 (0%)	4 (<1%)
Cuban	0 (0%)	1 (<1%)	0 (0%)	0 (0%)	1 (<1%)
Filipino	5 (2%)	4 (2%)	6 (3%)	3 (2%)	18 (2%)
Chinese	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
South Asian	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Vietnamese	2 (1%)	0 (0%)	0 (0%)	0 (0%)	2 (<1%)
Tongan	30 (13%)	35 (16%)	32 (15%)	20 (14%)	117 (14%)
Samoan	21 (9%)	24 (11%)	14 (7%)	26 (19%)	85 (10%)
Fijian	4 (2%)	6 (3%)	3 (1%)	0 (0%)	13 (2%)
Hawaiian	3 (1%)	2 (1%)	1 (<1%)	0 (0%)	6 (1%)
Multi-racial	19 (8%)	28 (13%)	25 (12%)	11 (8%)	83 (10%)
Other Race	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Unknown Race	0 (0%)	2 (1%)	2 (1%)	0 (0%)	4 (<1%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding. The following racial/ethnic groups were options but were not reported by providers in FY 2015-2016: Middle Eastern, Other Latino, Japanese, Korean, Cambodian, Hmong, Laotian, Mien, and Guamanian.

Special populations: EPAPMHO individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 45% were homeless, 35% were at risk for homelessness, 7% were visually impaired, 7% were hearing impaired, and 5% were veterans. Refer to **Figure 7** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 7. Special Populations Served by EPAPMHO, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: EPAPMHO individual outreach attendees were without insurance (46%), with Medi-Cal (28%), with other insurance not listed (11%), with Medicare (8%), or with unknown insurance (4%). Three percent of attendees reported having more than one type of insurance. See **Table 12** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 12. Insurance Coverage, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Uninsured	131 (61%)	85 (43%)	89 (41%)	42 (34%)	347 (46%)
Medi-Cal	64 (30%)	49 (25%)	60 (28%)	40 (33%)	213 (28%)
Other Insurance	4 (2%)	23 (12%)	29 (13%)	23 (19%)	79 (11%)
Medicare	13 (6%)	17 (9%)	15 (7%)	12 (10%)	57 (8%)
Unknown Insurance	2 (1%)	12 (6%)	10 (5%)	3 (2%)	27 (4%)
More than 1 type	0 (0%)	11 (6%)	12 (6%)	3 (2%)	26 (3%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**214**	**197**	**215**	**123**	**749**

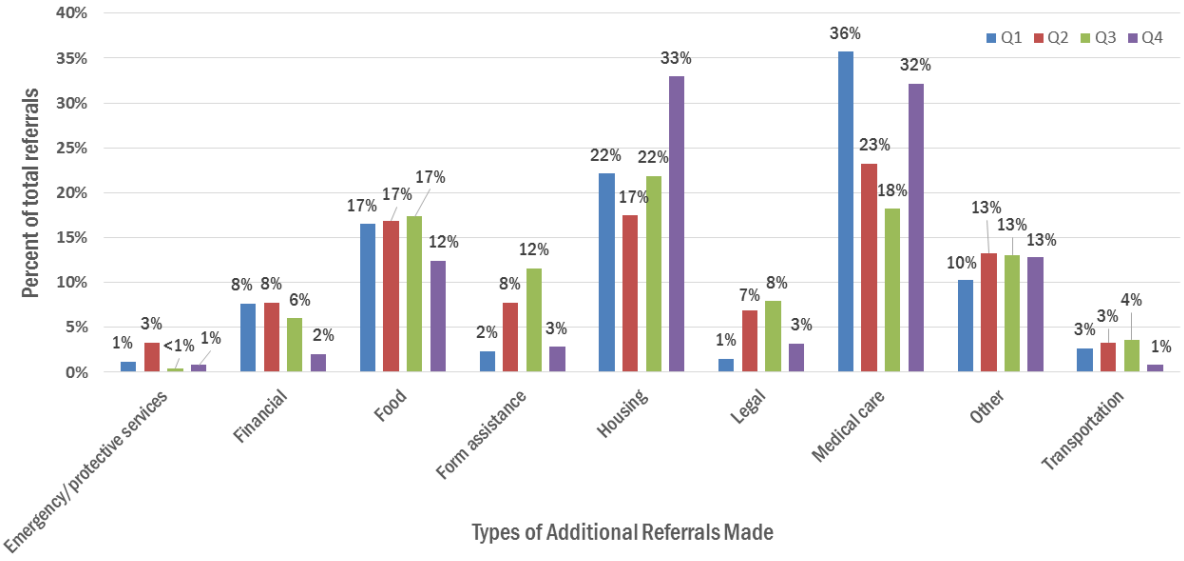
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Thirty-three percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Use Referrals: EPAPMHO individual outreach events included substance abuse referrals (30%) and mental health referrals (26%) in FY 2015-2016.

Referrals to Social Services: Providers made 1,416 referrals to 749 EPAPMHO individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for medical care (26%), housing (23%), and food (16%). **Figure 8** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 8. Referrals to Social Services, FY 2015-2016

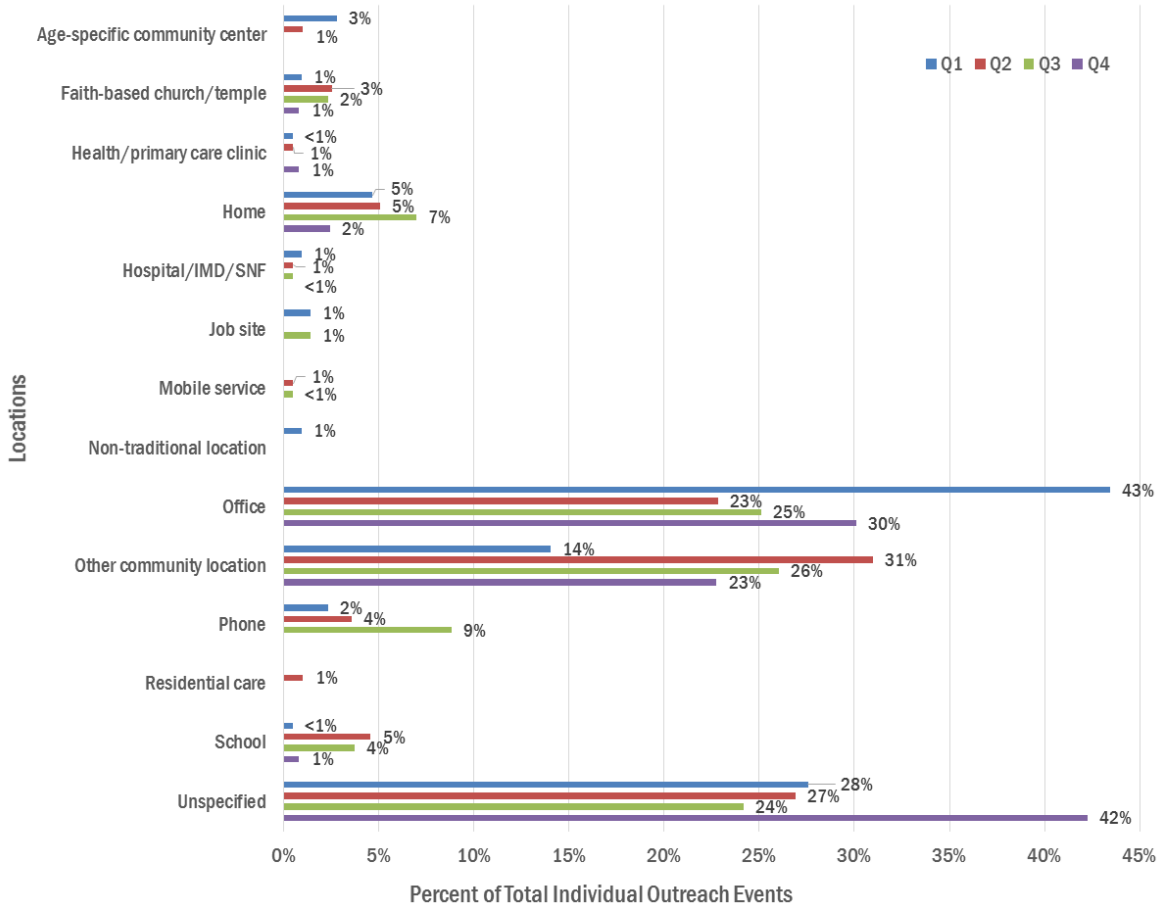


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: EPAPMHO individual outreach events typically occurred in the office (31%), unspecified locations (29%), and other community locations not listed (23%) in FY 2015-2016. See **Figure 9** for a summary of individual outreach events by location.

Figure 9. Location of EPAPMHO Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO individual outreach events was 37.2 minutes. By quarter, average length of outreach was 38.6 minutes in Q1, 35.5 minutes in Q2, 40.5 minutes in Q3, and 32.0 minutes in Q4.

MAA code: EPAPMHO individual outreach events used MAA codes 400 (Medi-Cal outreach, 72%), 401 (Discounted Medi-Cal outreach, 27%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA codes 403 (Referral in crisis situations for non-open cases) and 404 (Case management of non-open cases) were not used. None of the MAA codes were reported as N/A.

Language: EPAPMHO individual outreach events were conducted in English (67%), Spanish (19%), Tongan (9%), Samoan (4%), and American/Other Sign Language (<1%). See **Table 13** below for the breakdown of group outreach events by the language of administration.

Table 13. Languages, FY 2015-2016

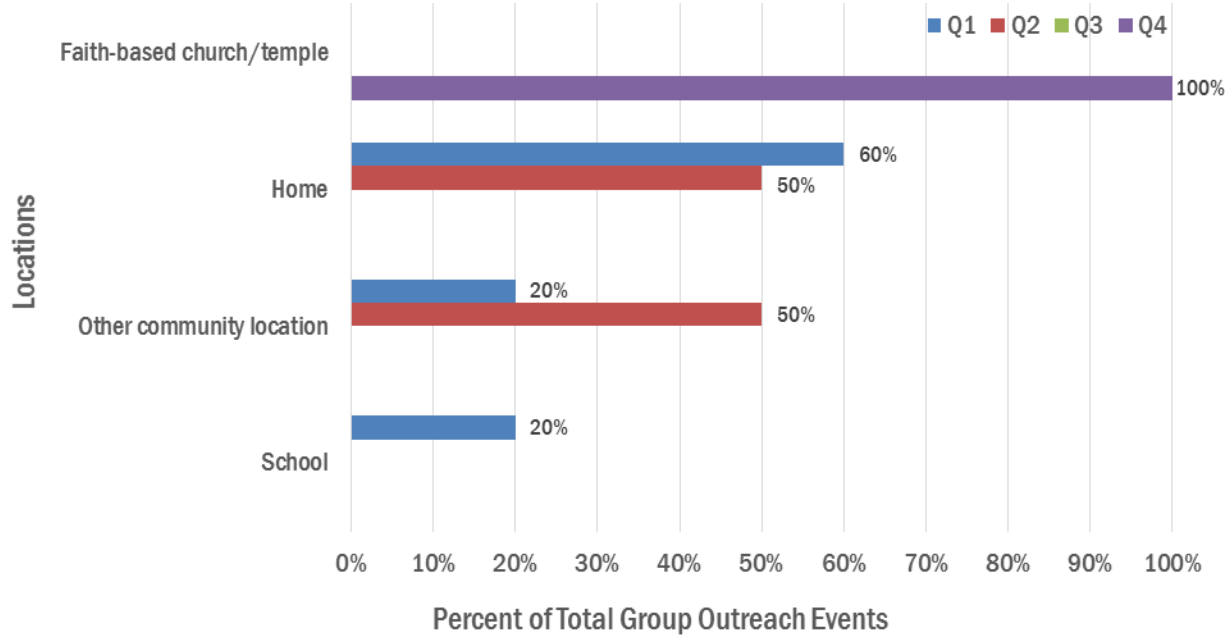
Language	Q1	Q2	Q3	Q4	Total
English	156 (73%)	140 (71%)	148 (69%)	60 (49%)	504 (67%)
Spanish	39 (18%)	32 (16%)	34 (16%)	37 (30%)	142 (19%)
Tongan	14 (7%)	16 (8%)	25 (12%)	15 (12%)	70 (9%)
Samoan	5 (2%)	9 (5%)	7 (3%)	10 (8%)	31 (4%)
American/Other Sign Language	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (<1%)
Other	0 (0%)	0 (0%)	1 (<1%)	0 (0%)	1 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: Cambodian, Mandarin, Portuguese, Tagalog, Vietnamese, and unknown language.

Group outreach event characteristics

Locations: EPAPMHO group outreach events were held in the home (50%), at other community locations not listed (25%), at school (13%), and at faith-based churches/temples (13%) in FY 2015-2016. Refer to **Figure 10** for a breakdown of group outreach events by location.

Figure 10. Locations of EPAPMHO Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO group outreach events was 48.1 minutes. By quarter, average length of outreach was 38.0 minutes in Q1, 75.0 minutes in Q2, and 45.0 minutes in Q4. Only Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported these data and for only Q1, Q2, and Q4 of this FY.

MAA code: EPAPMHO group outreach events used only MAA code 400 (Medi-Cal outreach, 100%) in FY 2015-2016.

Language: EPAPMHO group outreach events were conducted in Samoan (50%), Tongan (38%), and English (13%). See **Table 14** below for the breakdown of group outreach events by the language of administration.

Table 14. Languages, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
Samoan	3 (60%)	1 (50%)	0 (0%)	0 (0%)	4 (50%)
Tongan	2 (40%)	0 (0%)	0 (0%)	1 (100%)	3 (38%)
English	0 (0%)	1 (50%)	0 (0%)	0 (0%)	1 (13%)
Total	**5**	**2**	**0**	**1**	**8**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Mandarin, Other, Portuguese, Spanish, Tagalog, Vietnamese, and unknown language.s

Outreach Summaries by Provider

We analyzed outreach efforts by provider and created provider-specific summaries to help SMC BHRS and its providers better understand each organization's outreach efforts. Please refer to **Appendix B-I** for these provider-specific summaries. In each provider summary, we highlight key observations on outreach location, language, insurance, race/ethnicity, and specific groups of interest for both individual and group outreach efforts.

Recommendations

Based on these data about SMC BHRS outreach services provided during FY 2015-2016, we recommend the following to enhance outreach and data collection efforts.

Enhance outreach

Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America. Although 19% of San Mateo County's senior (age 65 years and older) population reported needing help for emotional/mental health problems of use of alcohol/drugs in 2015, only 5% of NCOC and 7% of EPAPMHO outreach event attendees were older adults (age 60 and older).[2] Among persons who identify as Latino/Hispanic and report needing help for emotional/mental health problems of use of alcohol/drugs in San Mateo County in 2015, 57% are Central American and 14% are Mexican.[2] However, over 80% of Latino/Hispanic outreach attendees identified as Mexican among the two collaboratives combined.

Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness. Almost 1,000 outreach attendees across both collaboratives reported being homeless or being at risk for homeless in FY 2015-2016 (467 for NCOC, and 957 for EPAPMHO). (Attendees may not be unique individuals.) However, providers documented only 400 referrals to housing resources during individual events, and it is unclear whether housing resources were offered at group events. In addition to housing resources, these specific populations may need referrals to additional services (such as food or medical care).

Share best practices across providers for reaching special populations. For example, some providers report more attendees who are at-risk for homelessness, whereas other providers report more attendees who are veterans. Providers can share what strategies have worked best for special populations.

Improve data collection

Minimize missing data. It is unclear whether quarterly changes in number of outreach events and attendees were actual changes or related to missing data. For example, some providers reported no group outreach events in some quarters, and other providers reported changes in attendee number from quarter to quarter. To ensure that these observations are not related to missing data, we recommend SMC BHRS work with providers to:

[2] UCLA Center for Health Policy Research. AskCHIS 2015. Available at http://ask.chis.ucla.edu.

- Enter outreach data immediately after the outreach event or monthly, at minimum. This may help to minimize loss of records before data entry.
- Check SurveyMonkey data quarterly with AIR support. We suggest for AIR to provide a list of events that have been entered electronically so that providers can verify that no events are missing.

Treat race/ethnicity as mutually exclusive categories. We recommend that providers include attendees who endorse multiple race/ethnicity groups only once under "two or more races" to ensure mutually exclusive race/ethnicity categories. At this time, total counts for race/ethnicity in group outreach events are larger than the total number of group outreach attendees. Providers may have classified an attendee under several race/ethnicity categories and as "two or more races."

Report data collection and entry challenges as they occur. We recommend that providers report challenges with collecting new demographic items to SMC BHRS and AIR as challenges arise so we can develop solutions together before the end of the FY. The California State Mental Health Services Oversight and Accountability Commission included new demographic requirements for MHSA prevention and early intervention reporting. For consistency across MHSA programs in San Mateo County, BHRS and AIR worked together to revise individual and group outreach forms. In brief, we added gender identity and sexual orientation categories. For disabilities, we added categories to capture client needs and groups reached. We also added county of residence. These data will be collected in FY 2016-2017.

Appendix A. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (*e.g.*, location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.

For MAA codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (*e.g.*, race), per quarter
- Denominator = total number of attendees, per quarter

Appendix B. FY 2015-2016 Outreach, Asian American Recovery Services

Outreach Event Characteristics

For FY 2015-2016, Asian American Recovery Services (AARS) reported a total of 1,652 outreach attendees—150 individual outreach attendees and 1,502 group outreach attendees. **Table B1** shows outreach event location, MAA code, and language.

Table B1. Characteristics of AARS Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Office	19 (12.7%)	
Other community location	123 (82.0%)	40 (87.0%)
Phone	5 (3.3%)	
School	1 (0.7%)	6 (13.0%)
Unspecified location	2 (1.3%)	
Total	**150**	**46**
MAA code		
400	2 (1.3%)	
401	113 (75.3%)	45 (97.8%)
403	4 (2.7%)	1 (2.2%)
N/A	31 (20.7%)	
Total	**148**	**46**
Language		
English	150 (100.0%)	45 (97.8%)
Spanish		1 (2.2%)
Total	**150**	**46**
Average length of contact	**34.39 minutes**	**98.33 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table B2 presents the demographics for individual and group outreach attendees served by AARS. Most outreach attendees served by AARS were between the ages of 26-59 (individual outreach data only), self-reported as female (62.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were multi-racial (18.6%), Samoan (18.3%), Tongan (13.7%), and Filipino (13.0%).

Table B2. Demographics of Outreach Attendees Served By AARS, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	4 (2.7%)
Transition-age youth (16-25)	56 (37.3%)
Adults (26-59)	82 (54.7%)
Older adults (60+)	8 (5.3%)
Unknown age	0 (0.0%)
Total	**150**
Gender	
Female	1,034 (62.6%)
Male	611 (37.0%)
Other gender	7 (0.4%)
Total	**1,652**
Sexual Orientation	
LGBTQ	121 (7.3%)
Race/Ethnicity	
Black	43 (2.6%)
White	159 (9.6%)
American Indian	13 (0.8%)
Middle Eastern	8 (0.5%)
Mexican	112 (6.8%)
Puerto Rican	2 (0.1%)
Cuban	0 (0.0%)
Other Latino	2 (0.1%)
Filipino	215 (13.0%)
Chinese	97 (5.91%)
Japanese	7 (0.4%)
Korean	5 (0.3%)
South Asian	0 (0.0%)
Vietnamese	8 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	2 (0.1%)
Mien	0 (0.0%)
Tongan	226 (13.7%)
Samoan	303 (18.3%)
Fijian	24 (1.5%)
Hawaiian	18 (1.1%)
Guamanian	25 (1.5%)
Multi-racial	308 18.6%)
Other Race	68 (4.1%)

	Total
Unknown Race	7 (0.4%)
Total	**1,652**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, AARS reported 344 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**8.2%**; n=136) or visually impaired (**6.5%**; n=108). Other attendees representing special populations were hearing impaired (**2.8%**; n=46), homeless (**1.9%**; n=32), and veterans (**1.3%**; n=22).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**72.7%**; n=109). More than one in four individual outreach attendees received a referral to substance abuse services (**26.7%**; n=42). Individual outreach events also resulted in 362 referrals to social services (**Table B3**). AARS made other (35.4%) or legal (27.3%) referrals most often.

Table B3. Referrals to Social Services Provided By AARS, FY 2015-2016

Referrals	Total
No referral	*4*
Emergency/protective services	1 (0.3%)
Financial	49 (13.5%)
Food	9 (2.5%)
Form assistance	4 (1.1%)
Housing	54 (14.9%)
Legal	99 (27.3%)
Medical care	11 (3.0%)
Other	128 (35.4%)
Transportation	7 (1.9%)
Total	**362**

Note: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix C. FY 2015-2016 Outreach, Daly City Peninsula Partnership Collaborative

Outreach Event Characteristics

For FY 2015-2016, Daly City Peninsula Partnership Collaborative (DCPPC) reported a total of 201 outreach attendees—61 individual outreach attendees and 140 group outreach attendees. **Table C1** shows outreach event location, MAA code, and language. DCPPC did not report any group outreach data in Q2.

Table C1. Characteristics of DCPPC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Home	21 (34.4%)	
Office	1 (1.6%)	
Other community location	37 (60.7%)	2 (50.0%)
School	2 (3.3%)	2 (50.0%)
Total	**61**	**4**
MAA code		
400	11 (18.0%)	4 (100.0%)
401	19 (31.1%)	
N/A	31 (50.8%)	
Total	**61**	**4**
Language		
English	46 (75.4%)	4 (100.0%)
Spanish	12 (19.7%)	
Tagalog	3 (4.9%)	
Total	**61**	**4**
Average length of contact	**30.43 minutes**	**120.0 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table C2 presents the demographics for individual and group outreach attendees served by DCPPC. Most outreach attendees served by DCPPC were of unknown age (individual outreach data only), self-reported as female (72.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (23.9%), Mexican (23.4%), and Filipino (22.4%).

Table C2. Demographics of Outreach Attendees Served By DCPPC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	3 (4.9%)
Adults (26-59)	25 (41.0%)
Older adults (60+)	2 (3.3%)
Unknown age	31 (50.8%)
Total	**61**
Gender	
Female	146 (72.6%)
Male	43 (21.4%)
Other gender	12 (6.0%)
Total	**201**
Sexual Orientation	
LGBTQ	7 (3.5%)
Race/Ethnicity	
Black	5 (2.5%)
White	48 (23.9%)
American Indian	1 (0.5%)
Middle Eastern	5 (2.5%)
Mexican	47 (23.4%)
Puerto Rican	2 (1.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	45 (22.4%)
Chinese	15 (7.5%)
Japanese	3 (1.5%)
Korean	1 (0.5%)
South Asian	0 (0.0%)
Vietnamese	2 (1.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	6 (3.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	14 (7.0%)

	Total
Other Race	2 (1.0%)
Unknown Race	5 (2.5%)
Total	**201**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCPPC reported 14 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**3.0%**; n=6) or hearing impaired (**2.0%**; n=4). Other attendees representing special populations were veterans (**1.0%**; n=2) or vision impaired (**1.0%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Six outreach attendees received referrals to mental health services (**9.8%**; n=6). One individual outreach attendee received a referral to substance abuse services (**1.6%**; n=1). Individual outreach events also resulted in 49 referrals to social services (**Table C3**). DCPPC made other (40.8%), food (22.4%), or housing (22.4%) referrals most often.

Table C3. Referrals to Social Services Provided By DCPPC, FY 2015-2016

Referrals	Total
No referral	*31*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	11 (22.4%)
Form assistance	2 (4.1%)
Housing	11 (22.4%)
Legal	5 (10.2%)
Medical care	0 (0.0%)
Other	20 (40.8%)
Transportation	0 (0.0%)
Total	**49**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix D. FY 2015-2016 Outreach, Daly City Youth Health Center

Outreach Event Characteristics

For FY 2015-2016, Daly City Youth Health Center (DCYHC) reported a total of 499 outreach attendees—23 individual outreach attendees and 476 group outreach attendees. **Table D1** shows outreach event location, MAA code, and language.

Table D1. Characteristics of DCYHC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	2 (8.7%)	1 (5.3%)
Office	5 (21.7%)	
Other community location	3 (13.0%)	1 (5.3%)
School	5 (21.7%)	15 (78.9%)
Unspecified location	8 (34.8%)	
Total	**23**	**17**
MAA code		
400	2 (8.7%)	6 (31.6%)
401		7 (36.8%)
403		1 (5.3%)
410	3 (13.0%)	
N/A	18 (78.3%)	5 (26.3%)
Total	**23**	**19**
Language		
English	22 (95.7%)	18 (94.7%)
Spanish	1 (4.3%)	
Other language		1 (5.3%)
Total	**23**	**19**
Average length of contact	**17.83 minutes**	**96.63 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table D2 presents the demographics for individual and group outreach attendees served by DCYHC. Most outreach attendees served by DCYHC were adults aged 26-59 (individual outreach data only), self-reported as female (54.3%), and represented many race and ethnicities.

The most frequently reported races/ethnicities were Filipino (37.8%), Unknown (13.1%), and Mexican (12.3%).

Table D2. Demographics of Outreach Attendees Served By DCYHC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	1 (4.3%)
Adults (26-59)	22 (95.7%)
Older adults (60+)	0 (0.0%)
Unknown age	0 (0.0%)
Total	**23**
Gender	
Female	271 (54.3%)
Male	161 (32.3%)
Other gender	67 (13.4%)
Total	**201**
Sexual Orientation	
LGBTQ	40 (8.0%)
Race/Ethnicity	
Black	25 (5.0%)
White	58 (11.5%)
American Indian	2 (0.4%)
Middle Eastern	10 (2.0%)
Mexican	62 (12.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	6 (1.2%)
Filipino	191 (37.8%)
Chinese	24 (4.8%)
Japanese	5 (1.0%)
Korean	2 (0.4%)
South Asian	3 (0.6%)
Vietnamese	2 (0.4%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)

	Total
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	41 (8.1%)
Other Race	8 (1.6%)
Unknown Race	66 (13.1%)
Total	**505**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCYHC reported 2 outreach attendees representing special populations through individual and group outreach, reaching attendees who were at risk for homelessness (**0.2%**; n=1) or veterans (**0.2%**; n=1).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**65.2%**; n=15). Two individual outreach attendees received a referral to substance abuse services (**4.3%**; n=2). Individual outreach events also resulted in 13 referrals to social services (**Table D3**). DCYHC made medical care (53.8%) and other (23.1%) referrals most often.

Table D3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

Referrals	Total
No referral	15
Emergency/protective services	0 (0.0%)
Financial	1 (7.7%)
Food	1 (7.7%)
Form assistance	0 (0.0%)
Housing	1 (7.7%)
Legal	0 (0.0%)
Medical care	7 (53.8%)
Other	3 (23.1%)
Transportation	0 (0.0%)
Total	**13**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix E. FY 2015-2016 Outreach, El Concilio

Outreach Event Characteristics

For FY 2015-2016, El Concilio reported a total of 53 outreach attendees, all from individual outreach. El Concilio did not report any group outreach events during FY 2015-2016. **Table E1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table E1. Characteristics of El Concilio Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Health/primary care clinic	1 (1.9%)
Office	50 (94.3%)
Phone	2 (3.8%)
Total	**53**
MAA code	
400	49 (92.5%)
410	4 (7.5%)
Total	**53**
Language	
English	15 (28.3%)
Spanish	38 (71.7%)
Total	**53**
Average length of contact	**24.58 minutes**

Notes: Only the categories where data was reported are presented.

Demographics

Table E2 presents the demographics for individual and group outreach attendees served by El Concilio. Most outreach attendees served by El Concilio were adults aged 26-59 and self-reported as female (88.7%). Outreach attendees identified as Mexican (73.6%), Black (13.2%), or Multi-Race (13.2%).

Table E2. Demographics of Outreach Attendees Served By El Concilio, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (1.9%)
Transition-age youth (16-25)	10 (18.9%)
Adults (26-59)	38 (71.7%)
Older adults (60+)	4 (7.5%)
Unknown age	0 (0.0%)
Total	**53**
Gender	
Female	47 (88.7%)
Male	6 (11.3%)
Other gender	0 (0.0%)
Total	**53**
Sexual Orientation	
LGBTQ	1 (1.9%)
Race/Ethnicity	
Black	7 (13.2%)
White	0 (0.0%)
American Indian	0 (0.0%)
Middle Eastern	0 (0.0%)
Mexican	39 (73.6%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	0 (0.0%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	0 (0.0%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	7 (13.2%)
Other Race	0 (0.0%)

	Total
Unknown Race	0 (0.0%)
Total	**53**

Special Populations

In FY 2015-2016, El Concilio reported 35 outreach attendees representing special populations, most commonly reaching attendees who were homeless (**34.0%**; n=18). Other attendees representing special populations were at risk of homelessness (**17.0%**; n=9), hearing impaired (**11.3%**; n=6), or vision impaired (**3.8%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Nine individual outreach attendees received referrals to mental health services (**17.0%**; n=9). There were no referrals to substance abuse services. Individual outreach events also resulted in 57 referrals to social services (**Table E3**). El Concilio made Housing (33.3%) and Food (24.6%) referrals most often.

Table E3. Referrals to Social Services Provided By El Concilio, FY 2015-2016

Referrals	Total
No referral	*10*
Emergency/protective services	1 (1.8%)
Financial	0 (0.0%)
Food	14 (24.6%)
Form assistance	6 (10.5%)
Housing	19 (33.3%)
Legal	4 (7.0%)
Medical care	1 (1.8%)
Other	9 (15.8%)
Transportation	3 (5.3%)
Total	**57**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix F. FY 2015-2016 Outreach, Free At Last

Outreach Event Characteristics

For FY 2015-2016, Free At Last reported a total of 373 outreach attendees, all from individual outreach. Free At Last did not report any group outreach events during FY 2015-2016. **Table F1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table F1. Characteristics of Free At Last Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Office	173 (46.4%)
Unspecified location	200 (53.6%)
Total	**373**
MAA code	
400	172 (46.1%)
401	201 (53.9%)
Total	**373**
Language	
English	280 (75.1%)
Spanish	93 (24.9%)
Total	**373**
Average length of contact	**24.58 minutes**

Note: Only the categories where data was reported are presented.

Demographics

Table F2 presents the demographics for individual and group outreach attendees served by Free At Last. Most outreach attendees served by Free At Last were adults aged 26-59 and self-reported as male (50.7%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Mexican (34.9%) and Black (33.8%).

Table F2. Demographics of Outreach Attendees Served By Free At Last, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	89 (23.9%)
Adults (26-59)	261 (70.0%)
Older adults (60+)	23 (6.2%)
Unknown age	0 (0.0%)
Total	**373**
Gender	
Female	182 (48.8%)
Male	189 (50.7%)
Other gender	2 (0.5%)
Total	**373**
Sexual Orientation	
LGBTQ	80 (21.4%)
Race/Ethnicity	
Black	126 (33.8%)
White	68 (18.2%)
American Indian	3 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	130 (34.9%)
Puerto Rican	3 (0.8%)
Cuban	1 (0.3%)
Other Latino	0 (0.0%)
Filipino	14 (3.8%)
Chinese	2 (0.5%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.3%)
Vietnamese	2 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	11 (2.9%)
Samoan	2 (0.5%)
Fijian	1 (0.3%)
Hawaiian	2 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	5 (1.3%)
Other Race	2 (05%)

Unknown Race	0 (0.0%)
Total	**373**

Special Populations

In FY 2015-2016, Free At Last reported 438 outreach attendees representing special populations. The total number of special population attendees reached exceeds total attendee count, because a single attendee may identify as more than one group (*e.g.,* both homeless and vision impaired). Most commonly reached special population attendees were homeless (**56.3%**; n=210) or at risk of homelessness (**33.8%**; n=126). Other attendees representing special populations were vision impaired (**10.5%**; n=39), hearing impaired (**9.1%**; n=34), and veterans (**7.8%**; n=29).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eighteen percent of individual outreach attendees received referrals to mental health services (**18.0%**; n=67). The majority of attendees received referrals to substance abuse services (**59.8%**; n=223). Individual outreach events also resulted in 567 referrals to social services (**Table F3**). Free at Last made Medical Care (49.0%) and Housing (30.7%) referrals most often.

Table F3. Referrals to Social Services Provided By Free At Last, FY 2015-2016

Referrals	Total *
No referral	*80*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	2 (0.4%)
Form assistance	0 (0.0%)
Housing	174 (30.7%)
Legal	1 (0.2%)
Medical care	278 (49.0%)
Other	111 (19.6%)
Transportation	1 (0.2%)
Total	**567**

Note: * Total number of referrals may exceed total attendee count, because an individual outreach event may have more than one referral. The percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” “Total” represents all referrals except “no referral.”

Appendix G. FY 2015-2016 Outreach, Multicultural Counseling and Education Services of the Bay Area

Outreach Event Characteristics

For FY 2015-2016, Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported a total of 386 outreach attendees—323 individual outreach attendees and 63 group outreach attendees. **Table G1** shows outreach event location, MAA code, and language. MCESBA did not report any group outreach data for Q3.

Table G1. Characteristics of MCESBA Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Age-specific community center	8 (2.5%)	
Faith-based church/temple	13 (4.0%)	1 (2.2%)
Health/primary care clinic	2 (0.6%)	
Home	38 (11.8%)	4 (8.7%)
Job site	6 (1.9%)	
Mobile service	2 (0.6%)	
Office	6 (1.9%)	
Phone	29 (9.0%)	
Residential care	2 (0.6%)	
School	19 (5.9%)	1 (2.2%)
Other community location	175 (54.2%)	2 (4.3%)
Unspecified location	16 (5.0%)	
Total	**323**	**8**
MAA code		
400	322 (99.7%)	8 (100.0%)
404	1 (0.3%)	
Total	**323**	**8**
Language		
American/Other Sign Language	1 (0.3%)	
English	209 (54.4%)	1 (12.5%)
Samoan	31 (9.6%)	4 (50.0%)
Spanish	11 (3.4%)	
Tongan	70 (18.9%)	3 (37.5%)
Other language	1 (0.3%)	
Total	**323**	**8**
Average length of contact	**42.57 minutes**	**48.13 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table G2 presents the demographics for individual and group outreach attendees served by MCESBA. Most outreach attendees served by MCESBA were transition-age youth aged 16-25 (individual outreach data only), self-reported as female (61.1%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Tongan (36.2%) and Samoan (23.9%).

Table G2. Demographics of Outreach Attendees Served By MCESBA, FY 2015-2016

Referrals	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (0.3%)
Transition-age youth (16-25)	182 (56.3%)
Adults (26-59)	109 (33.7%)
Older adults (60+)	29 (9.0%)
Unknown age	2 (0.6%)
Total	**323**
Gender	
Female	236 (61.1%)
Male	138 (35.8%)
Other gender	12 (3.1%)
Total	**386**
Sexual Orientation	
LGBTQ	14 (3.6%)
Race/Ethnicity	
Black	61 (12.3%)
White	9 (1.8%)
American Indian	4 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	26 (5.3%)
Puerto Rican	1 (0.2%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	4 (0.8%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.2%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)

Referrals	Total
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	179 (36.2%)
Samoan	118 (23.9%)
Fijian	12 (2.4%)
Hawaiian	4 (0.8%)
Guamanian	0 (0.0%)
Multi-racial	71 (14.4%)
Other Race	0 (0.0%)
Unknown Race	4 (0.8%)
Total	**494**

Note: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 157 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**22.5%**; n=126). Other attendees representing special populations were homeless (**22.5%**; n=87), hearing impaired (**1.0%**; n=4), vision impaired (**1.0%**; n=4), and veterans (**1.0%**; n=4).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. More than one third of outreach attendees received referrals to mental health services (**37.8%**; n=122). Five individual outreach attendees received a referral to substance abuse services (**1.5%**; n=5). Individual outreach events also resulted in 792 referrals to social services to other services (**Table G3**). MCESBA made Food (26.9%) referrals most often.

Table G3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

	Total
No referral	*21*
Emergency/protective services	19 (2.4%)
Financial	87 (11.0%)
Food	213 (26.9%)
Form assistance	91 (11.5%)
Housing	129 (16.3%)

	Total
Legal	70 (8.8%)
Medical care	91 (11.5%)
Other	56 (7.1%)
Transportation	36 (4.5%)
Total	**792**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding "no referral." Total represents all referrals except "no referral."

Appendix H. FY 2015-2016 Outreach, Pacifica Collaborative

Outreach Event Characteristics

For FY 2015-2016, Pacifica Collaborative reported a total of 2,092 outreach attendees—23 individual outreach attendees and 2,069 group outreach attendees. The following characteristics of the outreach events are presented separately for individual and group outreach because they are reported at the attendee-level for individual outreach, versus at the event-level for group outreach (**Table H1**).

Table H1. Characteristics of Pacifica Collaborative Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	13 (56.5%)	9 (39.1%)
Home	1 (4.3%)	
Mobile service		3 (13.0%)
School		6 (26.1%)
Other community location	9 (39.1%)	5 (21.7%)
Total	**23**	**23**
MAA code		
400	2 (8.7%)	7 (30.4%)
403	13 (56.5%)	
N/A	8 (34.8%)	13 (56.5%)
Total	**23**	**23**
Language		
English	23 (100.0%)	22 (95.7%)
Other language		1 (4.3%)
Total	**23**	**23**
Average length of contact	**21.61 minutes**	**93.09 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table H2 presents the demographics for individual and group outreach attendees served by Pacifica Collaborative. Most outreach attendees served by Pacifica Collaborative were adults aged 26-59 (individual outreach data only), self-reported as female (48.8%), and represented many race and ethnicities. The most frequently reported races/ethnicities was White (54.6%).

Table H2. Demographics of Outreach Attendees Served By Pacifica Collaborative, FY 2015-2016

	Total
Age	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	2 (8.7%)
Adults (26-59)	18 (78.3%)
Older adults (60+)	3 (13.0%)
Total	**23**
Gender	
Female	1,020 (48.8%)
Male	880 (42.1%)
Other gender	192 (9.2%)
Total	**2,092**
Sexual Orientation	
LGBTQ	95 (4.5%)
Race/Ethnicity	
Black	67 (3.2%)
White	1,147 (54.6%)
American Indian	32 (1.5%)
Middle Eastern	30 (1.4%)
Mexican	7 (0.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	79 (3.8%)
Filipino	195 (9.3%)
Chinese	52 (2.5%)
Japanese	11 (0.5%)
Korean	20 (1.0%)
South Asian	5 (0.2%)
Vietnamese	10 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	8 (0.4%)
Samoan	32 (1.5%)
Fijian	0 (0.0%)
Hawaiian	11 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	40 (1.9%)
Other Race	0 (0.0%)
Unknown Race	354 (16.8%)
Total	**2,102**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, Pacifica Collaborative reported 416 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**11.7%**; n=224). Other attendees representing special populations were veterans (**4.7%**; n=98), homeless (**1.9%**; n=40), hearing impaired (**1.0%**; n=20), and vision impaired (**0.7%**; n=14).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**73.9%**; n=17). Six individual outreach attendees received a referral to substance abuse services (**26.1%**; n=6). Individual outreach events also resulted in 56 referrals to social services (**Table H3**). Pacifica Collaborative made Food (26.9%) and Housing (26.8%) referrals most often.

Table H3. Referrals to Social Services Provided By Pacifica Collaborative, FY 2015-2016

Referrals	Total
No referral	*3*
Emergency/protective services	2 (3.6%)
Financial	1 (1.8%)
Food	18 (32.1%)
Form assistance	8 (14.3%)
Housing	15 (26.8%)
Legal	0 (0.0%)
Medical care	0 (0.0%)
Other	2 (3.6%)
Transportation	10 (179%)
Total	**56**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral”. Total represents all referrals except “no referral”.

Appendix I. FY 2015-2016 Outreach, Pyramid Alternatives

Outreach Event Characteristics

For FY 2015-2016, Pyramid Alternatives reported a total of 300 outreach attendees—96 individual outreach attendees and 204 group outreach attendees. **Table I1** shows outreach event location, MAA code, and language.

Table I1. Characteristics of Pyramid Alternatives Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple		1 (14.3%)
Hospital/IMD/SNF	6 (6.3%)	
Office	68 (70.8%)	
Phone	1 (1.0%)	
School	8 (8.3%)	4 (57.1%)
Other community location	4 (4.2%)	2 (28.6%)
Unspecified location	9 (9.4%)	
Total	**96**	**7**
MAA code		
400	96 (100.0%)	7 (100.0%)
Total	**96**	**7**
Language		
English	92 (95.8%)	6 (85.7%)
Mandarin	2 (2.1%)	1 (14.3%)
Spanish	1 (1.0%)	
Other language	1 (1.0%)	
Total	**96**	**7**
Average length of contact	**45.66 minutes**	**175.7 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table I2 presents the demographics for individual and group outreach attendees served by Pyramid Alternatives. Most outreach attendees served by Pyramid Alternatives were adults aged 26-59 (individual outreach data only), self-reported as female (57.0%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (29.7%) and Chinese (19.3%).

Table I2. Demographics of Outreach Attendees Served By Pyramid Alternatives, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	2 (2.1%)
Transition-age youth (16-25)	25 (26.0%)
Adults (26-59)	62 (64.6%)
Older adults (60+)	6 (6.3%)
Unknown age	1 (1.0%)
Total	**96**
Gender	
Female	171 (57.0%)
Male	128 (42.7%)
Other gender	1 (0.3%)
Total	**300**
Sexual Orientation	
LGBTQ	14 (4.7%)
Race/Ethnicity	
Black	13 (4.3%)
White	89 (29.7%)
American Indian	0 (0.0%)
Middle Eastern	7 (2.3%)
Mexican	32 (10.7%)
Puerto Rican	1 (0.3%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	32 (10.7%)
Chinese	58 (19.3%)
Japanese	4 (1.3%)
Korean	1 (03%)
South Asian	8 (2.7%)
Vietnamese	1 (0.3%)
Cambodian	1 (0.3%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	2 (0.7%)
Samoan	2 (0.7%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	25 (8.3%)

	Total
Other Race	16 (5.3%)
Unknown Race	8 (2.7%)
Total	**300**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 367 outreach attendees representing special populations, most commonly reaching attendees who were vision impaired (**6.7%**; n=20). Other attendees representing special populations were at risk of homelessness (**2.7%**; n=8), hearing impaired (**1.7%**; n=5), and veterans (**1.0%**; n=3).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eleven outreach attendees received referrals to mental health services (**11.5%**; n=11). There were no referrals to substance abuse services. Individual outreach events also resulted in 3 referrals to social services (**Table I3**).

Table I3. Referrals to Social Services Provided By Pyramid Alternatives Collaborative, FY 2015-2016

Referrals	Total
No referral	*93*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	0 (0.0%)
Form assistance	0 (0.0%)
Housing	0 (0.0%)
Legal	0 (0.0%)
Medical care	1 (33.3%)
Other	2 (66.7%)
Transportation	0 (0.0%)
Total	**3**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

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COUNTY OF SAN MATEO
HEALTH SYSTEM

Stephen Kaplan
Director

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May 1, 2017

Dear Colleagues and Community Partners,

This past year, the Behavioral Health and Recovery Services (BHRS) set out to better understand the impact that Mental Health Services Act (MHSA) outreach and engagement efforts are having in terms of increasing access and improving linkages to behavioral health services for underserved communities, specifically from two community outreach collaboratives, the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC).

The MHSA was approved by California voters in 2004 and provides funding for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components with the largest component, Community Services and Supports (CSS), intended to provide direct services to individuals with severe mental health challenges. A service category under CSS is Outreach and Engagement (O&E). In San Mateo County, O&E strategies include the community outreach collaboratives, pre-crisis response and primary care-based efforts.

Starting in 2015, the American Institute on Research (AIR) has provided BHRS with technical assistance on the EPAPMHO and NCOC data collection and reporting. AIR provides a summary of the data submitted on an annual basis. To enhance the learnings from this data, BHRS contracted with an independent consulting firm, Harder+Company Community Research, to conduct a formal qualitative evaluation. The final reports from both AIR and Harder+Co are available on our MHSA website, www.smhealth.org/mhsa.

Here are a few highlights across both reports:

- Activities and events organized by each collaborative are driven by and responsive to the community needs in terms of the resources provided and the alignment of cultural, social and linguistic supports.
- The strong collaborations have facilitated warm hand-offs between agencies and have provided a gateway to a range of services to support wellness, recovery and access.
- In FY 2015-16, between the two collaboratives, 5,556 individuals were engaged through meaningful outreach. Of these, 51% represented underserved ethnic communities including specifically African-American, Mexican, Filipino, Chinese, Tongan, Samoan and multiracial communities.
    - EPAPMHO individual outreach efforts included 26% mental health referrals, 30% substance abuse referrals and 1,416 social service referrals to 749 individuals including medical care, housing and food services.
    - NCOC individual outreach efforts included 45% mental health referrals, 14% substance abuse referrals and 483 social service referrals to 353 individuals including legal, housing and financial services.

MHSA OUTREACH COLLABORATIVE EVALUATION COVER LETTER

It is clear that much has been accomplished in terms of education and awareness for underserved communities and referrals to services focused on the whole person's needs. Yet, it is difficult to measure the direct impact these efforts are having on complex barriers to care, such as stigma and cultural and ethnic disparities to access.

While specific recommendations have been identified in each report based on the data collected, it is important to concurrently consider the overall challenges evoked by both reports, the expanded outreach supports since the launch of the outreach collaborative strategy in 2006 and broader BHRS efforts. In particular, how we integrate the Network of Care, Community Service Areas, the Office of Diversity and Equity, Health Equity Initiatives and the Outreach Worker Program and other efforts implemented since 2006. Following are overall considerations to be able to continue supporting and improving the outreach collaborative strategy and better integrate across the system:

- ✓ Coordinate and articulate the goals of the outreach collaborative strategy across both the north county region, including Pacifica and the East Palo Alto community.
    - o Benchmarks and activities are expected to look different given the unique needs and demographics of each community but the overall goals should align.
    - o Integrate broader outreach and support goals and activities, recognizing the intersection of outreach to increase access for individuals with severe mental illness (SMI) and outreach efforts for prevention, stigma reduction and meaningful engagement.
- ✓ Identify meaningful indicators of success for the outreach collaboratives including tracking SMI referral follow through where appropriate.
- ✓ Integrate efforts and activities to include special populations as identified in the AIR report, at-risk for homelessness, older adults and emerging communities and expanded needs in the broader San Mateo County (e.g. Arab-American, LGBTQ, geographically isolated communities, etc.)
- ✓ Coordinate and articulate MHSA-wide efforts and indicators to measure stigma reduction and improvements in cultural and ethnic disparities as they relate to access to behavioral health services in San Mateo County.

To support the findings of these reports as outlined above, a priority recommendation was put forward through the MHSA Community Program Planning process for consideration.

We anticipate this report will provide additional considerations to our ongoing dialogue with community partners, clients/consumers, family members, service providers and others about best practices in outreach and engagement. We welcome your comments and suggestions by emailing Doris Estremera, MHSA Manager at mhsa@smcgov.org.

Thank you for your continued support.

Stephen Kaplan, LCSW
Director, Behavioral Health and Recovery Services

San Mateo County Mental Health Services Act

Community Outreach & Engagement

Findings from interviews with North County Outreach Collaborative & East Palo Alto Partnership for Mental Health Outreach members

January 31, 2017

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Embracing Diversity Advancing Equity

Behavioral Health & Recovery Services

SAN MATEO COUNTY

Office of Diversity and Equity

Contents

Executive Summary

Background

The San Mateo County Behavioral Health and Recovery Services (BHRS) Outreach and Engagement strategy works to increase the awareness of and access to behavioral health services for underserved communities within San Mateo County. San Mateo BHRS does this by funding two Outreach Collaboratives, the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). Wanting to learn more about the work of these two collaboratives, San Mateo BHRS contracted with Harder+Company Community Research, and independent consulting firm, to conduct an evaluation.

The findings presented in this report were gathered from interviews with EPAPMHO and NCOC members, and focused on developing an understanding of the identified goals of each collaborative; processes and activities each collaborative is implementing as they work toward their goals; strengths and successes of each collaborative; and additional resources or support that would benefit the collaboratives.

Key Highlights

Perspectives shared by interviewees suggest that members of NCOC and EPAPMHO are collectively working to increase access to mental health services among community members, while also providing information focused on reducing the stigma associated with mental health. Key findings include:

- **EPAPMHO and NCOC members demonstrate a commitment to serving the community members of their respective regions.** The activities and events organized by each collaborative are driven by community need. Furthermore, the strong relationships each of the collaboratives have with community members and community-based service agencies within each of their respective communities allows them to create and provide resources that are aligned with the cultural, social, and linguistic needs of East Palo Alto and North County residents.

- **The successes NCOC and EPAPMHO have experienced can be attributed to the strong relationships members have been able to form with one another.** These strong inter-collaborative relationships facilitate warm hand-offs between agencies and encourage information and resource-sharing among member agencies.

- **NCOC and EPAPMHO members are committed to providing opportunities for authentic community engagement.** Interview findings reflect a high level of commitment among NCOC and EPAPMHO members, as evidenced by regular attendance at quarterly and/or monthly meetings and participation in outreach events and activities.

Recommendations

After reviewing the information gathered during interviews with NCOC and EPAPMHO members, the following recommendations emerged.

- **Each collaborative, in partnership with San Mateo BHRS, should establish regular (e.g., annual) review of each collaborative's goals.** While NCOC and EPAPMHO members are able to articulate their respective goals, setting aside time to review goals and reflect on progress would provide opportunities for reflection and refinement.

- **Each collaborative should develop internal indicators to track and monitor progress.** While NCOC and EPAPMHO members often pointed to individual contract goals as benchmarks of progress, developing indicators to track each collaborative's efforts as a whole would be beneficial.

- **Develop additional data collection activities to assess the over-arching goals of the collaboratives.** After developing internal indicators, additional data will need to be collected to help measure progress.

- **Consider assessing whether benefits of participating in the collaboratives extend beyond the participating members to the organizational level.** While interviewees noted strong relationships and understanding of the services member agencies provide, it would be worth exploring how staff members at the member agencies perceive and understand the work of each collaborative.

- **The San Mateo BHRS MHSA Manager should continue to attend NCOC and EPAPMHO meetings.** Members noted having regular communication with San Mateo BHRS is necessary to the collaboratives' success.

- **San Mateo County BHRS should consider providing additional resources and supports that will build capacity within each outreach collaborative.** While interviewees often mentioned the need for increased funding, they would also like to receive other resources such as an Outreach & Engagement intern.

- **Develop an inter-agency client referral form.** The current level of collaboration among members would be conducive to the development of a form and would help agencies record and monitor their outputs.

Introduction

The Mental Health Services Act

In 2004, Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters to provide funding to counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into five components: 1) Community Services and Supports; 2) Prevention and Early Intervention; 3) Innovation; 4) Capital Facilities and Technological Needs; and 5) Workforce Education and Training[1]. The Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness and is focused on community collaboration and serving unserved and underserved populations. Counties are able to apply for CSS funds from three different service categories: 1) Full Service Partnerships; 2) General System Development; and 3) Outreach and Engagement[2].

MHSA Outreach and Engagement Strategy

The San Mateo County Behavioral Health and Recovery Services (BHRS) MHSA Outreach and Engagement strategy works to increase access and improve linkages to behavioral health services for underserved communities. BHRS has observed increases in representation of these communities in its service system since the outreach strategy was deployed. Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (hereafter referred to as EPAPMHO or the Partnership) and the North County Outreach Collaborative (hereafter referred to as NCOC or the Collaborative), with each working to engage with particular underserved populations and communities. EPAPMHO focuses their outreach efforts on at-risk youth, transitional-aged youth (TAY), and underserved adults, with a specific focus on Latino, African American, Pacific Islander, and LGBTQ communities. While NCOC focuses their community engagement efforts on rural and/or ethnic communities, including Chinese, Filipino, Latino, Pacific Islander, and LGBTQ populations in the North County region of San Mateo.

The outreach collaboratives are intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; and linking residents to culturally and linguistically competent public health and social services.

Report Purpose

Wanting to learn more about the work of their two Community Outreach Collaboratives (North County Outreach Collaborative and the East Palo Alto Partnership for Mental Health Outreach), San Mateo BHRS contracted with Harder+Company Community Research to conduct an evaluation. The goals of the evaluation were to:

[1] http://www.mhsoac.ca.gov/components

[2] http://www.dhcs.ca.gov/services/MH/Documents/FSP_FAQs_04-17-09.pdf

- Better understand the work and processes of each of the collaboratives
- Assess the level of collaboration within each collaborative
- Identify recommendations for the collaboratives to consider as they continue to plan and conduct community-based outreach activities and events

After attending meetings with NCOC and the EPAPMHO, Harder+Company determined individual interviews would be the most effective process for gathering information from collaborative members. Further details regarding the interview and analysis processes are described in Appendix 1. The following sections of the report present findings gathered from interviews with collaborative members and include recommendations for San Mateo BHRS and the outreach collaboratives to consider as they further develop and define their outreach and community engagement efforts.

East Palo Alto Partnership for Mental Health Outreach

History of the East Palo Alto Partnership for Mental Health Outreach

As described in the methods section (Appendix 1), Partnership members and San Mateo BHRS staff noted that key to the Partnership's success to date is the improved relationship between San Mateo BHRS and East Palo Alto community members. As such, a subset of interviews were conducted with key EPAPMHO partners to understand the history between San Mateo BHRS and East Palo Alto. Findings from these interviews are documented in the timeline included in Appendix 2.

Key Themes

A number of key themes emerged from interviews with Partnership members. These themes provide perspectives about the benefits of participating in the Partnership, Partnership goals and how they are created, and strengths and successes of the Partnership.

Benefits of participating in the Partnership

Interview participants were asked to explain the benefits of participating in the Partnership. The themes that emerged from the interviews are described below.

Participating in the Partnership has enabled members to develop strong interagency bonds and gain an increased understanding of each individual agency's work. These dynamics ultimately help the members effectively refer clients to the services they need.

- **Engaging in the Partnership has provided opportunities for members to learn from one another.** Several participants expressed that a key benefit of participating in the Partnership is that they have been able to connect with one another and learn about the services each of the member agencies provide. As a result, they are better able to help community members access services in a streamlined way through what some refer to as "warm handoffs". One participant explained: "We benefit, also, from the partnership in terms of the accessibility. We know the names of the people that we work with, the therapist that they are working with, that facilitates an easy access when we have a patient that needs to be seen for mental health issues or services."

- **Clients are the primary beneficiaries of the Partnership.** Aside from the benefits that participating in the Partnership provides among the agencies, several participants emphasized that clients ultimately benefit from the Partnership the most. The Partnership's outreach and education activities focused on reducing the stigma associated with seeking mental health services aims to facilitate the process of connecting community

> **"I think the biggest benefit [is that] clients are benefitting from the Partnership… Whenever someone is in need of a referral, we provide the referral. We [will] walk them to the clinic."**

members to services. In particular, their interagency relationships serve to guide clients along the right channels in order to attain the specific services that they need. One participant described the mutually beneficial dynamic of the Partnership: "If community members come to us through different services, [we are] like a gateway to other services. The biggest thing is we educate the clients on stigma and mental health issues. At the same time… [if] someone is in need of a referral, we provide the referral."

Goals of the Partnership

Participants were asked to describe the primary goals of the Partnership and how they were identified, as well as any indicators that had been developed to measure progress towards achieving their goals. The key takeaways from their responses include the following:

- **All members interviewed were aligned in their definitions of the Partnership's primary goals.** Overall, the participants described similar goals the Partnership is working towards, as articulated by one participant: "It's stigma reduction, communitywide and also as individualized client services that we provide. Stigma reduction, education, and information dissemination to the different segments in the community." A few participants also underlined their function of serving as a "bridge to specialized services that are needed" by community members. These participants also noted that without the collaboration between Partnership members, this function would not be able to occur.

"[Our goals are] stigma reduction, education, and information dissemination to the different segments of the community."

When participants were asked to describe how the Partnership's goals were identified, mixed viewpoints were shared. Some believe they were determined at the Partnership's inception, while others explained that they were developed over time through communication with fellow agencies and/or San Mateo BHRS.

- **Some Participants were unsure how the Partnership's goals were identified, and noted that the goals were already established prior to them joining the Partnership.** One participant stated that he did not know how the Partnership's goals were identified, as he had only been working in his role for one year and felt that he had "walked into an already established program." Another inferred that the need for access to services by community members, stigma reduction, and mental health education inspired the formation of the Partnership, and thus the Partnership's goals are grounded in working to answer the following questions: "How do we break the stigma?", "How do we educate?", and "How do we access services?" Another shared that there have been difficulties in coming to a consensus about the Partnership's goals due to differing experiences and viewpoints among the partners. She explained: "We came in and battled it out. I tell you it was not an easy thing. We were not on the same page in a lot of ways." However, during these discussions members were able to come together to "decide on goals and our purpose" and develop a course of action based on identified community need.

- **Other participants mentioned coming together as a group to develop goals by discussing needs and challenges that the community members are faced with.** One participant explained that the Partnership shares identified community needs with each other and/or San Mateo BHRS, which prompts a collaborative effort among partners with certain specialties to organize an action plan, such as strategies for outreach. Furthermore, this participant emphasized the framing of their

efforts based on the needs of the community. She described the process of serving as a community "safety net" which, over time, evolves into establishing "systems or interfaces to both communicate and provide service[s]" to community members. Participants were asked to share how they assess whether their goals have been met. All participants had a clear sense of how their work is measured. There was a consensus among members interviewed that the indicators for achieving their goals were centered on meeting numerical benchmarks in their individual contracts.

- **Individual agencies have their own contractual requirements regarding outreach and referrals.** Participants explained that according to their contracts, they are prompted to reach particular numbers of outreach and referrals each year as a way to gauge their success as it relates to the Partnership's goals. One participant shared: "Individualized, as an agency, we have a certain commitment that we have to comply with every year. In terms of how many people do we provide education, how many people we do provide successful referral? We keep track of that on a monthly basis." Keeping track of these objectives each month helps members document their efforts and review progress to date. The Partnership also uses the annual Family Awareness Night event as a time to reflect on the work the Partnership has accomplished over the year and assess progress towards reaching their goals. While Partnership members use individual contract numbers to determine progress, having indicators to track the Partnership's progress as a whole would be beneficial.

Strengths and Successes of the Partnership

Participants pinpointed Partnership processes that are working well, which contributes to their key successes:

- **Regular meetings among members of the Partnership have helped their relationships improve over the years.** One participant felt that remaining apprised of each other's work, concerns, and challenges through their regular meetings have been a positive and conducive experience: "The meetings we have quarterly that we all come and discuss the changes, the updates, sharing our own particular issues that we may have, I think that's a good thing." Other participants specified that the quarterly meetings in particular "help facilitate the work" moving forward, which contributes to their success because they are able to learn from each other, and that these regular meetings have also enabled members of the Partnership to reach a stage where they are "now open to each other than before." Another participant felt that consistent attendance at these regular meetings (i.e., quarterly meetings) signifies the commitment of the members: "I think there is a very authentic involvement of all the partners in providing services that can make a difference in the community. That's one. Also the commitment to participate in all the meetings and the planning process to facilitate the services."

"I think there is a very authentic involvement of all the partners in providing services that can make a difference in the community."

- **Communication with mental health providers to connect clients to services has been particularly successful.** One participant highlighted that her experience partnering with a mental health provider, has led to a mutual collaboration for successfully identifying the needs of clients. She said: "For me what's working effectively is that we have a very good system of communicating with the Palo Alto Community Counseling Center." This partnership allows providers in EPAPMHO to regularly meet with staff from the Counseling Center to discuss client needs and identify community services that will help address these needs. Furthermore, she notes that where "the Partnership for us has been very successful is the

accessing of services." The communication Partnership members have with providers has strengthened over time and has led to successful working relationships among various community-based agencies.

- **While the commitment of the Partnership members has been strong, members may benefit from more opportunities to come together and reflect on the work that has taken place.** One participant commended fellow members of the Partnership for their strong commitment and work-ethic, and feels that it is important to engage in activities that help to re-invigorate everyone's commitment by reflecting on their past work. She explained: "I think anytime you are tackling a challenging issue and you are successful in getting people to engage in working through those challenges, and [when] that work takes place over many years there is a need for rejuvenation. Probably even in rejuvenation, re-commitment."

- **Partnership events such as the annual Family Awareness Night have consistently been recognized as a key success of the Partnership.** Most participants distinguished Family Awareness Night as a key success of the Partnership, as it serves as an opportunity to engage with various communities through a number of educational activities. Participants noted that the event continues to expand each year and now includes several activities that provide community members with "hands on experience of wellness." Another participant emphasized the positive impact that the event has on both the Partnership members and the community: "[The event is] a very authentic involvement of all the partners in providing services that make a difference in the community." When reflecting on factors contributing to the success of Family Awareness Night, one Partnership member explained that the "collective voice" the Partnership is able to represent allows for the representation of "bilingual and bi-cultural issues" that historically are not considered when planning and organizing community-based events. The Partnership's commitment to aligning services and information with the cultural, linguistic, and social practices of the populations they aim to serve contributes to successful outreach and engagement within the community.

"The clients come out, and they have a great time…Since last year, we've been doing these hands on experience of wellness and the partners are just bringing in more and more of their clients. That stands out every year for the partners. Bringing out their client and having them experience this great night of community with everybody."

Relationship with San Mateo Behavioral Health and Recovery Services

Participants were asked to reflect on how the Partnership's relationship with San Mateo BHRS has changed over time and any additional supports the County could provide to help the Partnership achieve its goals.

- **Partnership members recognize that San Mateo BHRS has contributed to the Partnership's work, and thus appreciate the various levels of participation by the staff.** Overall, members of the Partnership feel that that their relationship with San Mateo BHRS has been positive and helpful. One participant expressed: "I think it's really important. They are the drivers. They've got the funding for resources. They have opened their doors to us, their hearts to us." Furthermore, she remarked: "They meet with us. They are there; they are supporting our efforts…" A few other participants explained that the Partnership has been able to leverage their relationship with San Mateo BHRS to engage staff in their various efforts & initiatives (e.g., Family Awareness Night). Another participant mentioned that his agency benefits directly from the participation of key BHRS staff, including the MHSA Manager as well as clinical practitioners, who have been involved in "providing training and facilitating different activities and also participating in the meetings."

Furthermore, he described his appreciation for having "access to [San Mateo BHRS] staff," noting that the open working relationship between the County and local service providers helps Partnership members connect community members to services.

- **Although San Mateo BHRS's presence and various levels of involvement with the Partnership have been helpful, some feel that challenges still exist.** Some participants feel that there are constant changes in processes that are difficult to keep up with, and thus would like to be informed about the changes in order to effectively carry out their work. One participant explained: "We have our challenges. The constant changing can be a challenge at times, trying to keep up with the new requirements that are imposed on [San Mateo BHRS], that they have to incorporate in our contract and the work we do for them." Additionally, interviewees noted they would like to see BHRS offer additional County resources to the Partnership, such as placing an intern within the Partnership: "I know that BHRS has an internship program…but we haven't [been connected] with any of the interns."

- **Funding emerged as a major challenge for a few participants.**[3] Funding has been specified by several participants as a major challenge among the Partnership members. One participant noted having to pay for items using their personal funds: "There's this ongoing conversation with my staff about the funding resources available to do the work. There hasn't been an increase in funding, I know, since the contract was issued." While the Partnership's contract with the County is only intended to provide outreach-related funds, and is not intended to provide resources to individual agencies, it is important to consider how the financial constraints Partnership members may be working under influences the outreach activities they are able to commit to.

[3] When asked about challenges, most participants identified challenges within their own organizations and few challenges experienced with the Partnership. Only challenges related to the Partnership are included in this report.

North County Outreach Collaborative

Key Themes

Benefits of participating in the Collaborative

Interview participants were asked to explain the benefits of participating in the Collaborative. Interview responses indicate that regular meetings and learning about the work of partner agencies has led to the development of strong relationships among NCOC members.

Collaborative members have built strong relationships with one another while increasing knowledge and awareness about the services that each member agency offers. Together, these factors help Collaborative members effectively connect clients to services.

- **Regular check-ins at meetings, working together on projects, or tabling at various events have been important relationship-building activities.** One participant used the word "family" to describe the Collaborative, and reflected on the value of building various relationships with fellow members as well as their constituents. She explained how "working with each other as individuals and as a collective to see what our strengths are and how we can help" allowed members to interact with community members "as a full force, not just as one person," which has contributed to stronger connections with community members in need of services.

- **Learning about the work of other partners provides perspective on how the Collaborative is a dynamic team working toward common goals with respect to mental health services.** One participant remarked: "Each of us filled a niche for mental health services in a different way. I think it really gave [us a] better perspective as to where people in the city can seek services; how we can better work together to make sure that we're hitting all the underserved communities in our area." The interactions between Collaborative members have particularly helped reflect their unified commitment to the communities they serve. One participant commented on the value of NCOC members being "a vast network of people doing like-minded work across the county. It allows us to do warm hand-offs for outreach efforts for referrals, and I think that has really benefitted our community." She also highlighted the benefit of members being visible and serving various communities across the county, and felt that the level of collaboration among NCOC members has allowed the Collaborative to develop a strong presence in each of the communities members work within, "so everybody who's involved in the North County Outreach Collaborative has a presence wherever we go."

- **The Collaboration between the agencies has been valuable, especially with regards to making referrals to one another in an efficient manner.** One participant remarked that having a strong understanding of the services provided by each member agency has enabled her to refer clients to fellow NCOC member organizations that

"Because there are so many agencies involved, it's connected all of us to the work that we each do in our separate communities so that we have a presence in each of our communities, so everybody who's involved in the North County Outreach Collaborative has a presence wherever we go."

provide the particular services a client may requesting. The relationships and knowledge of one another's work has allowed members to easily contact a member organization to present the client's needs and inquire whether they can provide assistance. Another participant expressed that "the monthly meetings [have] enabled me to connect so much deeper with the other organizations involved. It really does feel like collaboration. We've been able to not only refer the clients to each other [but] we've [also] been doing more outreach together. It's really strengthened our collaboration."

- **Through outreach activities, members are also able to learn about the needs of community members/groups.** Being part of the Collaborative has enabled partners to have opportunities to interact with the communities they are working to serve. These interactions allow NCOC members to ascertain the service needs of the various populations they are working to serve. One participant expressed that as a liaison between the community and local government, "the biggest benefit is that I get to talk to the people in the community, and know their needs, in terms of mental health. Then through that I also build really good connections with other service providers."

Goals of the Collaborative

Participants were asked to describe the primary goals of the Collaborative and how they were identified, as well as indicators for achieving their goals. Interviewee responses indicate a unified understanding of the Collaborative's goals but also point to a lack of clarity regarding how the goals were developed.

- **All members interviewed were aligned in their definitions of the Collaborative's primary goals.** Participants articulated that the primary goals of the Collaborative include decreasing the stigma of seeking mental health services, and increasing access to mental health services. Some participants emphasized the importance of conducting outreach to underserved communities who would not usually seek mental health services. One participant explained that an important facet of the Collaborative's efforts is to "connect people to services where they're needed, so going out into the community and meeting people where they are [is] really important because people have a hard time accessing services because there's such a stigma around accessing services."

There were mixed responses when participants were asked about the process of identifying the Collaborative's goals, as two different viewpoints were expressed:

- **Some members perceive that the goals are prescribed by the County.** These participants conveyed that the goals of the Collaborative were in existence as recurring contractual goals since the Collaborative was established, with newer members expressing that the goals were developed prior to their involvement with the NCOC.

- **Other members described a strategic planning process that was used to determine the Collaborative's goals.** Some participants shared that the goals of the Collaborative have been regularly discussed and reassessed through various meetings and retreats. One participant stated: "We meet every year to look at what worked, what didn't work, and what our goals are going to be for this year." These yearly meetings are particularly beneficial in helping to identify changes that need to be made or services that need to be provided for certain communities. She

"I think the primary goal of the Collaborative is to connect people and share resources and then connect people to services where they're needed, so going out into the community and meeting people where they are [is] really important because people have a hard time accessing services because there's such a stigma around accessing services."

explained that as a result of collaborative efforts, and in response to community need, goals of the Collaborative have also shifted: “We’ve had to amend our contracts a little bit each time, because that’s changed according to the need, and according to what we’ve already done. There have been things that we’ve done and done really well, and the community is now doing them, so we have to work on a different part of the community where there’s a need.”

Participants were asked to share how they assess whether their goals have been met. A few had a clear sense of how their work is measured.

- **Some members shared that the primary indicator for assessing whether goals have been met can be attained from assessing outreach numbers through monthly reporting.** For a few participants, the indicators used to gauge whether their goals have been met are through what has been reported on a monthly basis, for example: how many families that they were able to complete outreach for, or the number of client referrals they’ve had. Discussions about this during general meetings have been helpful, but the Collaborative is still determining the best way to track each agency’s outreach efforts and how these efforts reflect the work of the entire Collaborative.

Many participants, however, commented on the complexities that arise when tracking their work, as they did not feel that there was a clear uniform procedure for tracking outreach contacts and monitoring outreach data. Limitations and challenges concerning the processes of completing current outreach forms and data entry on SurveyMonkey were also mentioned.

“There’s a half-sheet that we have to have everyone fill out that we speak to, and that’s been extremely difficult to do. It’s almost like a little invasive.”

- **Creating measurable objectives has been a challenge.** Many participants expressed challenges in measuring the extent to which their goals have been met. Reasons for this include the lack of a tracking process for a variety of activities specific to their organization’s work, including measures in place to indicate if they are reaching a particular population, verifying the sources of their referrals, and gathering how many contacts are connected or linked to services. One participant shared: “We are able to show that we have our flyers and make referrals, but to then track, 'Yes, this client went here and this linkage was made' has been challenging. That's been an ongoing problem because our services typically don't enable that to happen. That's something that has been communicated since I have been involved in this grant."

- **It has been difficult to record the work being done.** Considering the dynamic nature of their work internally and externally, some participants expressed the difficulty of recording the work that they have done, as there are certain pieces that are hard to track, such as outreach events where members are speaking to large groups or classrooms. As one participant explained, it can often feel like an invasion of privacy when asking an event attendee to complete an outreach form: “There’s a half-sheet that we have to have everyone fill out that we speak to, and that's been extremely difficult to do. It's almost like a little invasive." Another participant expressed her desire for real-time access to the SurveyMonkey data members of the Collaborative submit to the County. Having timely access to the data would allow Collaborative members to utilize the data to help inform outreach events and activities.

- **Information may be recorded, but how the output translates as markers for achieving goals is not clear.** A participant expressed the challenge of tracking and measuring referrals, as well as how it relates to

whether goals are being met: “I know that when we do our stats, we turn them in, but I don’t know if it really identifies if we are really reaching this population. How do you measure the referral coming back?” Another participant said: “I feel like in the past we’ve had these big overarching goals but have had a harder time really being able to measure them to concrete number or actions that we’re doing it cause increasing access and decreasing stigma are really overarching ideas.”

- **Utilizing an inter-agency referral form amongst the Collaborative would be mutually beneficial for the members and their clients.** One participant suggested the development and usage of a client referral form, which could become a best practice for tracking information to improve organization methods and outcomes. The participant explained: “Something that's been talked about from the beginning has been making an inter-agency referral form and I have yet to see that actually happen. I feel like at this point, especially with the fact that our collaboration is so strong and the fact that we meet so regularly, I feel like that we now could actually carry that out. "

There is a great deal of work being done to meet the Collaborative goals, but challenges also exist. Participants described some of the challenges they have experienced with regards to stigma reduction and community outreach.

- **Breaking down stigma relating to mental health services has been difficult but the dynamic work of the Collaborative is helping address these challenges.** Several participants noted that while the stigma associated with seeking mental health services is a common challenge across cultural groups and populations the teamwork between Collaborative members is helping address these challenges. “I may be doing [work with one population] and [other members] may be doing [work with another community], but we’re always keeping each other abreast of what’s going on. We each come [to this work] with a special part, each with the common goals of how to do better outreach, how to better connect with folks, how to get folks more engaged…”

- **While community events are central to the Collaborative’s goals, there is often limited capacity to staff and attend events.** The Collaborative has identified outreach opportunities and community events that are important activities for meeting their goals, but experience challenges with respect to time limitations, as well as the agencies’ staffing capacity for attending or participating in the various events. One participant mentioned that personnel resources can be strained, as many staff members wear multiple hats. Additionally, events may be focused on populations that fall outside of an agency’s target groups, but as NCOC members, staff are still expected to participate. She explained that “it is a Collaborative, and so when we have these events, which may really not serve any of the population that we serve, we still show up because of the fact that you can’t staff your event without the whole.” She also noted that individuals who staff the events tend to be the same few Collaborative members and that the work could be more evenly distributed among all members.

“It is a Collaborative, and so when we have these events, which may not serve any of the population we serve, we still show up because of the fact that you can’t staff your event without the whole.”

Strengths and Successes of the Collaborative

Participants pinpointed Collaborative processes that are working well, which not only reflects the level of collaboration among NCOC members, but also contributes to their key successes:

- **The Collaborative members have been able to form relationships with other community organizations.** Two participants shared that their key successes thus far have included making successful connections with faith leaders in the community. One participant mentioned: "...we made [connections] with a couple of churches and had some great conversations with churches and are looking at presenting at some of their youth groups." Another participant also considered engaging the faith community (as well as other community leaders) to be a big success: "I think you need to highlight that, because it's been really hard to do. For us, personally, we've been able to create relationships between our community-based organizations, and we've been able to create relationships with our city leaders, our city manager, and our city council-members, to where they're starting to work together on policy initiatives for rent and affordable housing, so that's all because of our outreach [efforts]."

- **Consistency in the Collaborative's events and activities has helped their outreach efforts.** One participant noted how regular meetings and events have allowed Collaborative members to establish strong working relationships and develop a unified vision for their work. These regular meetings have "…manifested in us doing more outreach together. We're more visible at different community events by having a table. We've done a lot more around branding ourselves…It seems like we have more of a common voice and vision…" These activities in turn have resulted in the Collaborative having a recognizable presence among community members.

"What's been working well is the consistency around collaboration…All the organizations continue to come to the table on a monthly basis, wanting to work together. That's manifested in us doing more outreach together. We're more visible at different community events by having a table. "

Relationship with San Mateo Behavioral Health and Recovery Services

Participants were asked to reflect on how the Collaborative's relationship with San Mateo BHRS has changed over time and any additional supports the County could provide to help the Collaborative achieve its goals.

- **San Mateo BHRS's relationship with the Collaborative has improved for some, as the County has begun to provide more guidance and rationale regarding decision-making processes; however, others feel that challenges still exist.** Most participants expressed that the Collaborative's relationship with San Mateo BHRS is continuing to improve, as opposed to earlier years where there was more of a "disconnect" between assigned goals and the Collaborative's ability to accomplish them. However, some participants shared that they would like San Mateo BHRS to help them "brainstorm [measurable] objectives" and would like more guidance and direction from the County about work the Collaborative should be expected to achieve within a year and how the Collaborative could measure their success.

- **The MHSA Manager's presence at Collaborative meetings is valued.** Participants are particularly satisfied with the presence and guidance that the MHSA Manager provides regarding their work, and feel that she is more clearly defining expectations for the Collaborative. She has been described as a "real advocate" and has positively made a "big difference". One participant explained: "She's been really great in keeping contact with us and keeping us updated…She's been really good about that…The communication [from the County] was not [always] consistent."

"I think [the MHSA Manager] who has been our liaison now has been really helpful. She's been really great in keeping in contact with us and keeping us updated and if she needs something she'll let us know. If there's a change she'll let us know."

- **Participants' responses were mixed regarding the challenges they have experienced, as many addressed issues related to funding.** When speaking about funding, participants noted two distinct funding-related issues, funding individual programs receive and funding provided to the Collaborative. Some participants recognized that funding for their services will be an ongoing challenge, and hope that San Mateo BHRS can assist in that area. Given that the focus of the interviews was understanding challenges related to the Collaborative, we have only presented funding-related challenges that are relevant to NCOC. One participant shared that San Mateo BHRS has "made it easier for us to do our job by continuing to renew this funding with less effort on our part…I feel like them renewing the grant ongoing like this has really, really helped us do our work more effectively. You don't see that very often. That's a big thing to credit them on." Another participant observed an overall imbalance with regards to the distribution of resources and funding in North County: "North County seems to continue to have fewer resources and less funding. This has been something that we have been communicating for a while now. A lot of services and funding tends to go more towards central and especially the southern parts of San Mateo County. The northern part has seemed to have less. We've really been advocates for more services to come up north. BHRS has helped that, but I think we could continue to use even more of their support. To have services and funding be distributed more equally throughout the county."

- **There is a variety of additional supports that participants feel would be helpful. Despite some expressing an overall appreciation of San Mateo BHRS's assistance, some also felt there are particular aspects that could be improved.** One participant would find it helpful to be supplied with updated, educational resources and handouts: "BHRS providing outreach materials once a year, or at the beginning of the year, such as pamphlets that provide information about their services [that] could be passed out and shared with the community."

"Because we've been able to get our reports in, keeping them up to date…I feel like them renewing the grant ongoing like this has really, really helped us do our work more effectively."

Recommendations

Perspectives shared by interviewees suggest that members of the North County Outreach Collaborative and East Palo Alto Partnership for Mental Health Outreach are collectively working to increase access to mental health services among community members. Collaborative and Partnership members noted that many of the successes of the respective collaboratives can be attributed to the relationships members have been able to establish with one another. As NCOC and EPAPMHO continue to work towards reducing the stigma associated with mental health and accessing services, as well as provide outreach and education about mental health and County- and community-based services, we offer the recommendations listed below for San Mateo BHRS, NCOC, and EPAPMHO to consider.

- **Establish regular (e.g., annual) review of each collaborative's goals.** While both NCOC and EPAPMHO members were unified in defining their respective goals, members were not aligned regarding the process for defining and reviewing goals. Setting aside time each year to review goals will not only establish an internal process, but will also provide dedicated time for collaborative members to reflect on the work from the previous year and refine goals as needed.

- **Develop internal indicators to track and monitor progress.** Although NCOC and EPAPMHO members submit data to the County, several interviewees noted a lack of clearly defined indicators to track and monitor their progress. Indicators could include items such as number of outreach events attended each month, approximate number of outreach participants at each event, number of new partnerships formed with other agencies, number of events attended by each collaborative member, etc. Progress and updates regarding each indicator could be reviewed during monthly meetings. Furthermore, indicators would also provide key information related to progress made on achieving each collaborative's broader goals.

- **Develop additional data collection activities to assess the over-arching goals of the collaboratives.** Although interview findings indicate that collaborative members are satisfied with the work they are doing towards reaching their high-level goals (e.g., stigma reduction, increased awareness about services) there is little data about how effective these efforts are. Additional data collection efforts aimed at understanding effectiveness would help identify how the collaboratives are working towards these goals. Data collection efforts could include interviews or focus groups with individuals that have accessed services as a result of information provided by the collaboratives, or surveys with staff members working at agencies that receive clients referred to services by the collaboratives. The survey administered during the Family Awareness Night would serve as a starting point for EPAPMHO members when considering additional data they may want to collect from attendees.

- **Consider assessing whether benefits of participating in the collaboratives extend beyond the participating members to the organizational level.** While interviewees noted that a common benefit to participating in the collaboratives have been the relationships members have established with one another, it would be worth exploring if these benefits extend to the organizations members work for. In order for the benefits of participating in the collaborative to be sustainable, they must

extend beyond the participating member to the member agency as a whole. This could be assessed in a number of ways, such as conducting surveys or interviews with member agency staff about their perspectives of the collaborative, including perceived benefit of having staff participate, benefits to clients, and/or information or resources they would like the collaborative to provide.

- **The San Mateo BHRS MHSA Manager should continue to attend NCOC and EPAPMHO meetings.** Having the MHSA Manager regularly attend collaborative meetings helps maintain regular communication between the collaboratives and San Mateo County BHRS. During these meetings the MHSA Manager is able to clarify expectations and provide updates to members. Regular data sharing would also be valuable during these meetings and allow NCOC and EPAPMHO members to receive outreach summary data in a timely manner.

- **San Mateo County BHRS should consider providing additional resources and supports that will build capacity within each outreach collaborative.** While both collaboratives noted improved relationships with San Mateo County BHRS, members would like access to additional County resources, such as having an intern work with the respective collaboratives. Additionally, NCOC members in particular noted they would like support from San Mateo BHRS to help develop and articulate measureable goals and objectives. Providing opportunities for collaborative members to review outreach data submitted to the County in the context of goals (e.g., stigma reduction, increased awareness of services) would help collaborative members identify connections between data and outcomes, but would also encourage identification of indicators or benchmarks to help determine progress.

- **Develop an inter-agency client referral form.** NCOC interviewees noted that Collaborative members have discussed the idea of creating an inter-agency client referral form for a number of years. Members also noted that the current level of collaboration among members would be conducive to the development of a form, with many noting that they would like the Collaborative to take steps to developing the form. Improved tracking methods between Collaborative members, such as inter-agency client referral forms, would help agencies record and monitor their outputs, which can serve as indicators to gauge whether outreach goals are being met. While EPAPMHO members did not specifically discuss creating an inter-agency client referral form, this type of tool would provide members with valuable information regarding the types and number of linkages to services that are made when Partnership members refer clients to one another.

Appendix 1: Methods & Interview Protocols

In collaboration with the San Mateo County BHRS Mental Health Services Manager and the Director of the Office of Diversity and Equity, Harder+Company developed an interview protocol that asked collaborative members to reflect on their involvement with NCOC or EPAPMHO. The questions asked interviewees to describe the primary goals of their collaborative, internal processes for organizing events and identifying community partners, as well as challenges facing the collaborative.

Before interviews were scheduled, the Executive Director and the Special Projects Consultant from One East Palo Alto, the San Mateo BHRS Mental Health Services Manager, and members of the Harder+Company team met to review the interview protocol and list of interview participants. During this meeting, One East Palo Alto and San Mateo BHRS staff noted that it would also be worthwhile to document the series of events that led to the creation of the East Palo Alto Partnership for Mental Health Outreach. One East Palo Alto provided a list of four individuals who would be able to speak to the history of the Partnership. Harder+Company developed a separate protocol for these interviews that focused on identifying the elements that contributed to the development of the Partnership.

Following development of the interview protocol, the Harder+Company research team sent interview invitations to seven individual members of NCOC and ten individuals (six current members of the Partnership and four past members) associated with the EPAPMHO. The lists were compiled in collaboration by San Mateo Behavioral Health and Recovery Services and collaborative members. All 17 invited interviewees agreed to participate in a 20-30-minute phone interview with a Harder+Company team member. With permission from the participants, interviews were recorded for note-taking and transcription purposes.

After the audio files were transcribed, content analysis was employed to identify and categorize themes that emerged from the interviews. Two members of the Harder+Company research team separately reviewed and identified thematic codes for each of the interview transcripts. Following this review process, the team members came together to discuss common themes and develop a report outline.

Findings from the subset of interviews documenting the establishment of the EPAPMHO are documented in the timeline included as Appendix 2. These interviews highlighted how the County's relationship with East Palo Alto shifted as a result of planning for the award of State Mental Health Services Act funds.

Interview Protocol: Collaborative Members

Introduction

Thank you for taking the time to speak with me today. I work for Harder+Company Community Research, a consulting firm that is conducting interviews with participants of the [East Palo Alto Partnership for Mental Health Outreach/North County Outreach Collaborative] on behalf of the County of San Mateo Behavioral Health & Recovery Services. San Mateo BHRS seeks to better understand and support the work [Partnership/Collaborative] members are engaged in. During the interview I will ask you to reflect on work that has taken place, about your experience and perspective of the [Partnership's/Collaborative's] efforts, as well as future goals of the [Partnership/Collaborative].

This interview will take approximately 30 minutes. I encourage you to be as honest as possible in your responses. If there is a question you prefer to not answer, please let me know. Everything we talk about today is confidential, meaning that we won't use any identifying information when presenting our findings.

For notetaking purposes, I would like to record today's conversation. Is that OK? Only the Harder+Company team and our transcription service will have access to this recording. The recording will be deleted once our work is complete.

Do you have any questions before we begin?

Background

1. To start, can you tell me a little bit about your role with the [East Palo Alto Partnership for Mental Health Outreach/North County Outreach Collaborative]?

    a) How long have you been a member of the [Partnership/Collaborative]?

    b) During the time you have been a member of the [Partnership/Collaborative], has your role changed? If so, how?

2. I'm interested in learning about the benefits participating in the [Partnership/Collaborative] provides to both you and your organization. What are some of the key benefits participating in the [Partnership/Collaborative] provides?

[Probes: exposure to new organizations, learning from others, cross-sector engagement, opportunities to partner with other organizations, coordination of services and referrals, etc.]

Understanding the Partnership/Collaborative

3. How would you describe the primary goals of the [Partnership/Collaborative]?

    a) How were these goals developed/identified?

    b) How is the [Partnership/Collaborative] working to meet these goals?

    c) How will the [Partnership/Collaborative] know if goals are met/ achieved? [Probe: Has the [Partnership/Collaborative] identified indicators? Does the [Partnership/Collaborative] have a process or structure in place to review and refine goals?]

4. Given the [Partnership's/Collaborative's] goals you described above, are there processes/activities you see as working particularly well or not well within the [Partnership/Collaborative]?

[Probes: What do you see as working well? What do you see as not working well? What type of improvements should be made to ensure the [Partnership/Collaborative] is working toward its goals?]

5. How would you describe San Mateo Behavioral Health & Recovery Services' role in your [Partnership/Collaborative]? [Probes: advisor, institutional support, service/referral oversight, etc.]

a) What would you say they are doing well?

b) Where have there been challenges? Has BHRS done anything to help address these challenges?

c) Are there supports you would like BHRS to provide?

6. It is my understanding that a key priority for the [Partnership/Collaborative] is to organize community outreach activities. Can you tell me about the types of community outreach activities that are co-organized and/or co-sponsored by the [Partnership/Collaborative]?

a) What is the planning and implementation process like? (e.g., Are members assigned roles? How are decisions made? How, if at all, do members share about upcoming events their respective organizations are hosting?)

7. What do you see as the most important challenge facing current outreach efforts?

a) How might these challenges be addressed?

8. Based on the types of outreach activities your organization and the [Partnership/Collaborative] engage in, would you say there are current gaps in services for specific populations (e.g., transitional-aged youth, homeless/unstably housed, etc.)?

a) How might these gaps in services be addressed?

9. Who are the key community-based partners the [Partnership/Collaborative] works with (this can include any community-based entity that are or are not current members of the Partnership, e.g., CBOs, churches, non-traditional partners, etc.)?

a) How were these partnerships established?

b) Does the [Partnership/Collaborative] have a process for identifying potential new community partners?

c) Are there any community partners that should be involved who currently are not? What are challenges to their involvement?

10. Thinking about the work that has taken place this year, can you tell me about a key success of the [Partnership/Collaborative]?

a) What factors contributed to this success?

b) How does this success relate to the goals of the Partnership?

11. How is information shared among [Partnership/Collaborative] members? Among community partners?

a) Do you have recommendations for improving how information is shared?

12. Those are all my questions. Is there anything else you would like to share that you haven't yet had a chance to discuss?

Interview Protocol: Additional EPAPMHO Interviews

Introduction

Thank you for taking the time to speak with me today. I work for Harder+Company Community Research, a consulting firm that is working with the County of San Mateo Behavioral Health & Recovery Services. We are currently conducting interviews with members of the East Palo Alto Partnership for Mental Health Outreach to better understand the work Partnership members are engaged in. San Mateo BHRS is also interested in documenting the history of the Partnership. Kava and Dr. Faye recommended we speak with you in order to better understand your role in the development of the Partnership. During the interview I will ask you to reflect on how the Partnership was established, the work that has taken place, and your experience and perspective of the Partnership's efforts.

This interview will take approximately 20 minutes. I encourage you to be as honest as possible in your responses. If there is a question you prefer to not answer, please let me know. Everything we talk about today is confidential, meaning that we won't use any identifying information when presenting our findings.

For notetaking purposes, I would like to record today's conversation. Is that OK? Only the Harder+Company team and our transcription service will have access to this recording. The recording will be deleted once our work is complete.

Do you have any questions before we begin?

Background & Involvement with the Partnership

1. To start, can you tell me a little bit about your background and the organization you currently work for?

These next few questions ask you to reflect on the processes and decisions that led to the establishment of the East Palo Alto Partnership for Mental Health Outreach.

2. To begin, can you tell me a little bit about your role with helping establish the East Palo Alto Partnership for Mental Health Outreach?

    a) Are you currently involved with the Partnership? If so, how?

3. What elements were in place that allowed for the establishment of the Partnership to take place?

[Probes: Funding? Community need? Key players?]

4. Is there anything you would have changed about how the Partnership was established?

Understanding the Partnership

5. How would you describe the initial goals of the partnership?

6. Thinking about the work that has taken place, can you tell me about a key success of the Partnership?

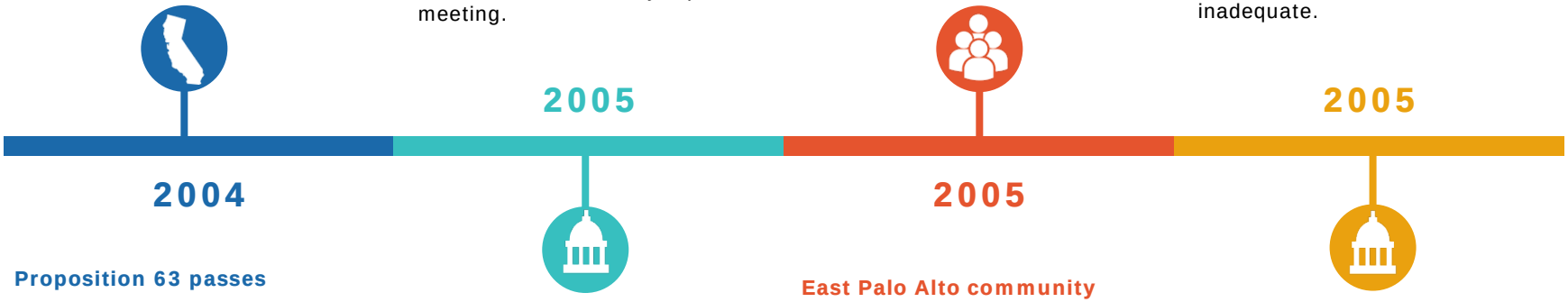
    a) What factors contributed to this success?

    b) What would you say are some of the challenges for future successes and achievements for the Partnership?

7. From your perspective, has San Mateo County BHRS' relationship with East Palo Alto providers changed as a result of the partnership? If so, how? [Probes: Helped establish trust? Increased institutional support provided by the County? Helped establish partnerships between service providers and contract partners?]

8. Those are all my questions. Is there anything else you would like to share that you haven't yet had a chance to discuss?

Appendix 2: History of San Mateo BHRS & EPAPMHO



2004

Proposition 63 passes

The Mental Health Services Act (MHSA) passes in 2004, signaling the first opportunity in many years for the California Department of Mental Health (DMH) to provide funding and resources to County mental health programs.
To receive MHSA funds, the County must collaborate with community members and stakeholders to develop plans for how funding would be used.

2005

San Mateo County MHSA planning begins

In preparation for receiving MHSA funds, the County begins to host meetings with community agencies to better understand unmet community needs.
County identifies East Palo Alto as a high-need community and schedules a community-input meeting.

2005

East Palo Alto community agencies organize

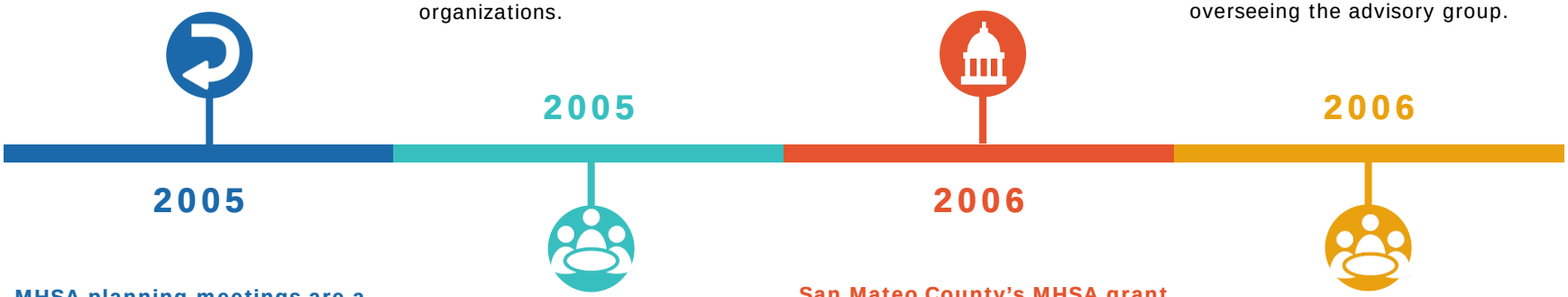
A community member involved with County MHSA-related criminal justice meetings alerts other community agencies & leaders to the potential opportunity the MHSA planning meeting will have on EPA resources.
As a result, EPA community leaders organize other key agencies and community members to attend the County MHSA planning meeting.

2005

San Mateo County holds MHSA planning meeting in EPA

EPA community members express concerns about the adequacy of the County's proposed MHSA plan to address critical needs of the EPA community. Community members also note that the County's process for understanding community need is inadequate.

"What we heard was: 'You all are not present in this community. You are not partners'…That was really the turnaround…we want[ed] to enter into a different kind of relationship." – San Mateo BHRS staff member



MHSA planning meetings are a turning point in the County's relationship with EPA

During the initial planning meeting, County employees recognized a necessary shift needed to occur in how the County engages with EPA residents & organizations. County staff expressed a commitment to work with the community to determine how to move forward, and follow-up meetings were organized to further discuss issues and concerns raised by community members.

One East Palo Alto serves as convening agency

OEPA hosts follow-up meetings with County and EPA community members. Meetings include representatives from key organizations throughout the community such as: Ravenswood Family Health Center, Free At Last, and faith-based organizations.

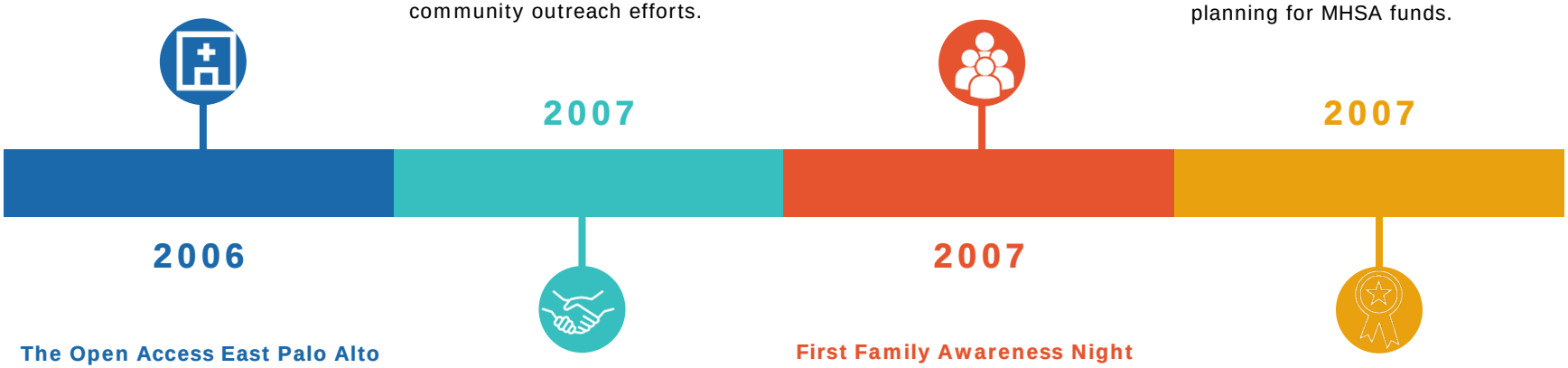
San Mateo County's MHSA grant proposal is approved

In preparation for receiving funds, conversations shift as EPA community members begin discussing specific initiatives to fund. Proposed activities reflect two primary goals held by EPA community members: 1) Provide equitable access to mental health services for un-served/under-served EPA residents; and 2) Ensure County staff is culturally competent and ethnically diverse.

East Palo Alto Behavioral Health Advisory Group (EPABHAG) is established

EPA community members and County staff recognize the need to formally establish an advisory group that will oversee the design of mental health services and programs for EPA residents. OEPA's convening role posits them to serve as the lead agency overseeing the advisory group.

"One East Palo Alto as the convening organization provides structure to whatever the community is trying to do…they [provide] the structure for us so we're focused on whatever the issue is at the time." – EPABHAG member



The Open Access East Palo Alto Project launches

In partnership with the EPABHAG, San Mateo County begins providing same-day access to mental health services at their EPA clinic. This requires staff training and a redesign of the clinic environment. Within the first seven months of providing same day services, there was a 30% increase in the clinic's caseload. EPABHAG members were essential to ensuring services were culturally appropriate and sensitive.

East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) is established

Recognizing the importance of community engagement in connecting EPA residents to services, San Mateo County provides additional funds to lead agency, OEPA, to oversee community outreach efforts.

First Family Awareness Night event is held

In partnership with One East Palo Alto, the EPABHAG organizes and hosts the first Family Awareness Night community event.
The event provides community members with information about mental health, mental health illness, stigma, and services available within the community. The success of the first Family Awareness Night resulted in the event becoming an annual function.

The Partnership & San Mateo County Behavioral Health and Recovery Services are recognized for their collaborative efforts

The Partnership and San Mateo County jointly apply for a STAR award documenting the success of the Open Access Project. Partnership and County staff are invited to speak with San Diego County regarding the success of the Open Access Project. The presentation also documents how the County's relationship with East Palo Alto shifted as a result of planning for MHSA funds.

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2015-2016

Anita Poon; Wendy Lee, MPH; Grace Wang, PhD, MPH

JANUARY 2017

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Contents

Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes overall collaborative and provider-specific outreach efforts across individual and group outreach events that occurred in fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016). We also present some historical data from FY 2014-2015 to show how outreach has changed over time.

Total Attendance

For FY 2015-2016, SMC BHRS providers reported a total of 5,556 attendees at all outreach events. Of these, 1,102 attendees were reached through individual outreach events and 4,454 attendees were reached across 107 group outreach events.

Demographics of outreach attendees

NCOC

NCOC individual outreach attendees were primarily adults and transition-age youth (84%) and with unknown insurance (59%). Individual and group outreach attendees were typically female (56%). Almost half of attendees were White or Filipino (46%). Attendees also reported being part of one or more special populations (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans). Of those reporting special population status, 58% were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO individual outreach attendees were largely adults and transition-age youth (92%) and without insurance (46%). Individual and group outreach attendees were usually female (57%). Almost half of attendees were Black or Mexican (48%). Of those reporting special population status, 80% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

The average length of NCOC individual outreach events was 34.9 minutes in FY 2015-2016. Of the 353 individual outreach events, most occurred in other community locations not listed (50%),

used Medicaid Administrative Activities (MAA) code 401 (Discounted Medi-Cal outreach, 37%), were conducted in English (94%), and included mental health outreach (35%) and mental health referrals (31%). Providers also made 483 referrals to other services, including legal services and housing.

NCOC group outreach events lasted 103.1 minutes on average. Of the 4,391 group outreach events, most were conducted in English (96%) and held in other community locations not listed (52%). These events most frequently used MAA code 401 (Discounted Medi-Cal outreach, 56%).

EPAPMHO

The 749 EPAPMHO individual outreach events were an average of 37.2 minutes each. These events were typically administered in English (67%), in the office (31%), and using MAA code 400 (Medi-Cal outreach, 72%). EPAPMHO individual outreach events also included mental health outreach (40%) and substance abuse outreach (22%). A total of 1,416 referrals were made to other services, including medical care and housing.

Of the 63 EPAPMHO group outreach events, the average event lasted 48.1 minutes. Half of group outreach events were conducted in Samoan (50%) and in homes (50%). These events used MAA code 400 (Medi-Cal outreach, 100%).

Recommendations

Based on FY 2015-2016 data, we recommend the following to enhance outreach and improve data collection. To enhance outreach, we suggest that SMC BHRS work with providers to:

- Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness.
- Share best practices across providers for reaching special populations.

To improve data collection, we recommend SMC BHRS work with providers to:

- Minimize missing data.
- Treat race/ethnicity as mutually exclusive categories.
- Report data collection and entry challenges as they occur.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults [Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)] in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of and access and linkages to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2015-2016 (July 1, 2015 through June 30, 2016) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix A for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2015-2016 and outreach event attendees. We also present some historical data from FY 2014-2015 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix B to I.

Overall Outreach

During FY 2015-2016, SMC BHRS outreach providers reported a total of 5,556 attendees at outreach events—1,102 attendees reached through individual outreach events and 4,454 attendees reached across 107 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2015-2016.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2015-2016

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	150	1,502	1,652
Daly City Peninsula Partnership Collaborative	61	140	201
Daly City Youth Health Center	23	476	499
Pacifica Collaborative	23	2,069	2,092
Pyramid Alternatives	96	204	300
Total (NCOC)	**353**	**4,391**	**4,744**
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	53	0*	53
Free at Last	373	0*	373
Multicultural Counseling and Education Services of the Bay Area	323	63	386
Total (EPAPMHO)	**749**	**63**	**812**
Total (NCOC and EPAPMHO)	**1,102**	**4,454**	**5,556**

Notes: *Providers did not report data for FY 2015-2016. **Counts are not necessarily unique individuals.

Compared to FY 2014-2015, the total number of NCOC outreach attendees increased, whereas EPAPMHO outreach attendees decreased. Between FY 2014-2015 and FY 2015-2016, NCOC individual outreach attendees decreased from 450 to 353, and NCOC group outreach attendees increased from 3,939 to 4,391. In contrast, EPAPMHO individual outreach attendees increased from 451 to 749, and EPAPMHO group outreach attendees decreased from 497 to 63.

Table 2 presents outreach event attendees' race/ethnicity for FY 2014-2015 and FY 2015-2016 within each collaborative. Increases of 5% or more between the two years are shaded in green; decreases are shaded in red. Additional details on race/ethnicity by quarter for FY 2015-2016 are presented later in the report (pages 8 and 15).

Table 2. Race/Ethnicity by Collaborative, FY 2014-2016

	NCOC		EPAPMHO	
Race/Ethnicity	**FY 2014-2015**	**FY 2015-FY2016**	**FY 2014-2015**	**FY 2015-FY2016**
Black	172 (5%)	153 (3%)	131 (14%)	77 (9%)
White	335 (10%)	1,501 (32%)	39 (4%)	194 (24%)
American Indian	7 (<1%)	48 (1%)	0 (0%)	0 (0%)
Middle Eastern	7 (<1%)	60 (1%)	0 (0%)	7 (1%)
Mexican	144 (4%)	260 (5%)	44 (5%)	195 (24%)
Puerto Rican	1 (<1%)	6 (<1%)	1 (<1%)	1 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Latino	273 (8%)	87 (2%)	150 (15%)	4 (<1%)
Filipino	577 (17%)	678 (14%)	12 (1%)	18 (2%)
Chinese	192 (6%)	246 (5%)	0 (0%)	2 (<1%)
Japanese	14 (<1%)	30 (1%)	0 (0%)	0 (0%)
Korean	21 (1%)	29 (1%)	0 (0%)	0 (0%)
South Asian	26 (1%)	16 (<1%)	0 (0%)	2 (<1%)
Vietnamese	35 (1%)	23 (<1%)	1 (<1%)	2 (<1%)
Cambodian	18 (1%)	1 (<1%)	0 (0%)	0 (0%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Laotian	1 (<1%)	2 (<1%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tongan	183 (5%)	236 (5%)	283 (29%)	85 (10%)
Samoan	353 (10%)	343 (7%)	106 (11%)	117 (14%)
Fijian	9 (<1%)	24 (1%)	1 (<1%)	0 (0%)
Hawaiian	48 (1%)	29 (1%)	3 (<1%)	13 (2%)
Guamanian	10 (1%)	25 (1%)	1 (<1%)	6 (1%)
Multi-racial	72 (2%)	428 (9%)	39 (4%)	2 (<1%)
Other Race	432 (13%)	95 (2%)	26 (3%)	4 (<1%)
Unknown Race	504 (15%)	440 (9%)	131 (14%)	83 (10%)
Total	**3,434**	**4,760**	**968**	**812**

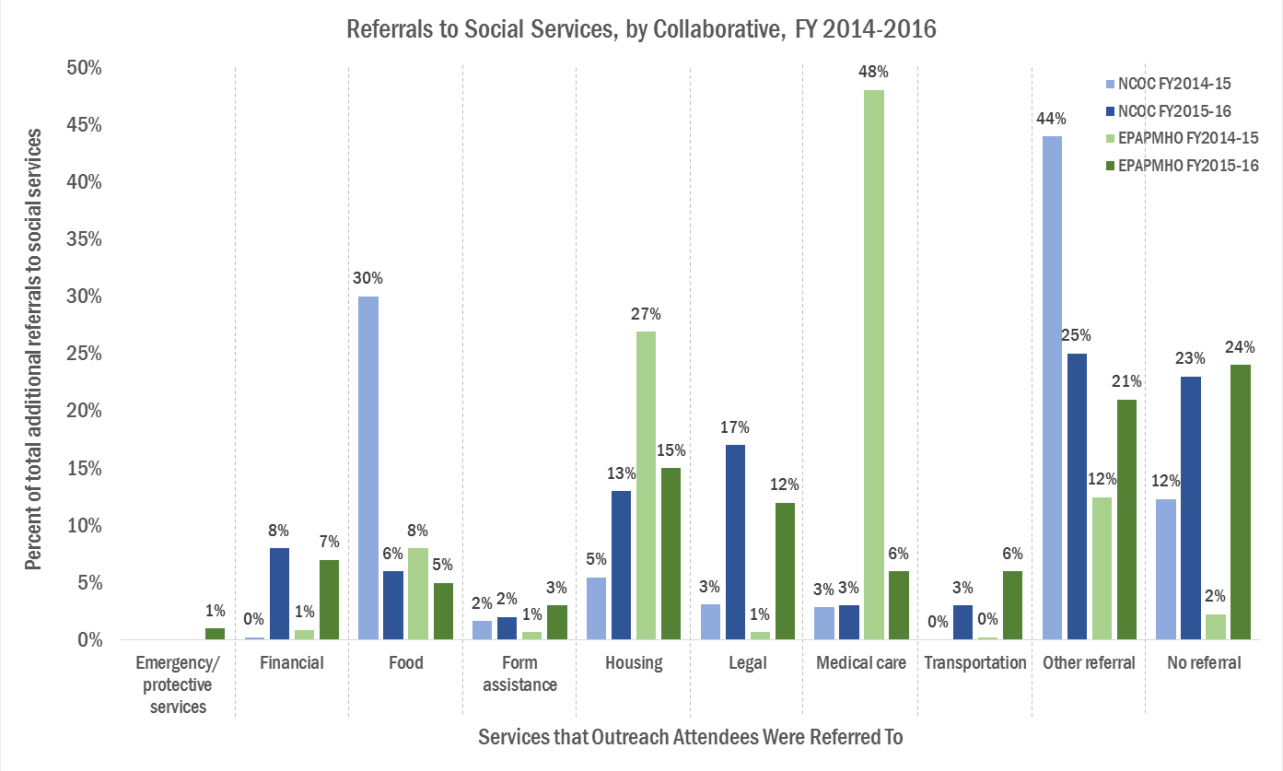
Note: Percentages may not sum to 100% because of rounding.

Figure 2 presents referrals to social services, by collaborative for both FY 2014-2015 and FY 2015-2016. The percentages shown represent percent of total referrals to social services. Both NCOC and EPAPMHO had increases in the numbers of referrals to social services.

- In FY 2015-2016, NCOC had 629 referrals to social services, as compared to 423 referrals in the prior FY. In FY 2015-2016, EPAPMHO had 1,527 referrals to social services, as compared to 450 referrals in the prior FY.
- As a percent of all referrals, both NCOC and EPAPMHO had increases in Financial, Legal, and Transportation referrals between FY 2014-2015 and FY 2015-2016.

- In FY 2015-2016, NCOC had decreases in the percent of food and other referrals compared to FY 2014-2015. In FY 2015-2016, EPAPMHO had decreases in the percent of housing and medical care referrals compared to the prior FY.

Figure 2. Referrals to Social Services, by Collaborative, FY 2014-2016



Note: Percentages may not sum to 100% because of rounding.

NCOC

In FY 2015-2016, there were 4,744 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: NCOC individual outreach attendees were adults (26-59 years, 59%), transition-age youth (16-25 years, 25%), older adults (60 years or older, 5%), and children (0-15 years, 2%) in FY 2015-2016. Nine percent of attendees were of an unknown age. See **Table 3** for the number of individual outreach attendees representing each reported age group, by quarter. Providers were not asked to report group outreach data on age for FY 2015-2016.

Table 3. Age of Individual Outreach Attendees Served by NCOC, FY 2015-2016

Age Group	Q1	Q2	Q3	Q4	Total
Adults (26-59)	91 (52%)	43 (74%)	32 (62%)	43 (62%)	209 (59%)
Transition-age youth (16-25)	44 (25%)	12 (21%)	15 (29%)	16 (23%)	87 (25%)
Unknown age	31 (18%)	0 (0%)	1 (2%)	0 (0%)	32 (9%)
Older adults (60+)	8 (5%)	3 (5%)	4 (8%)	4 (6%)	19 (5%)
Children (0-15)	0 (0%)	0 (0%)	0 (0%)	6 (9%)	6 (2%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across NCOC individual and group outreach events were females (56%), males (38%), and other genders (6%) in FY 2015-2016. See **Table 4** for the number of individual and group outreach attendees reporting each gender type, by quarter.

Table 4. Gender of Outreach Attendees Served By NCOC, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	419 (58%)	818 (57%)	695 (49%)	710 (61%)	2,642 (56%)
Male	234 (33%)	561 (39%)	588 (42%)	440 (38%)	1,823 (38%)
Other gender	64 (9%)	66 (5%)	131 (9%)	18 (2%)	279 (6%)
Total	**717**	**1,445**	**1,414**	**1,168**	**4,744**

Note: Percentages may not sum to 100% because of rounding

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all NCOC attendees were White (32%), Filipino (14%), and multi-racial (9%). Nine percent of attendees were of an unknown race. See **Table 5** for the number of attendees representing each reported racial/ethnic group, by quarter.

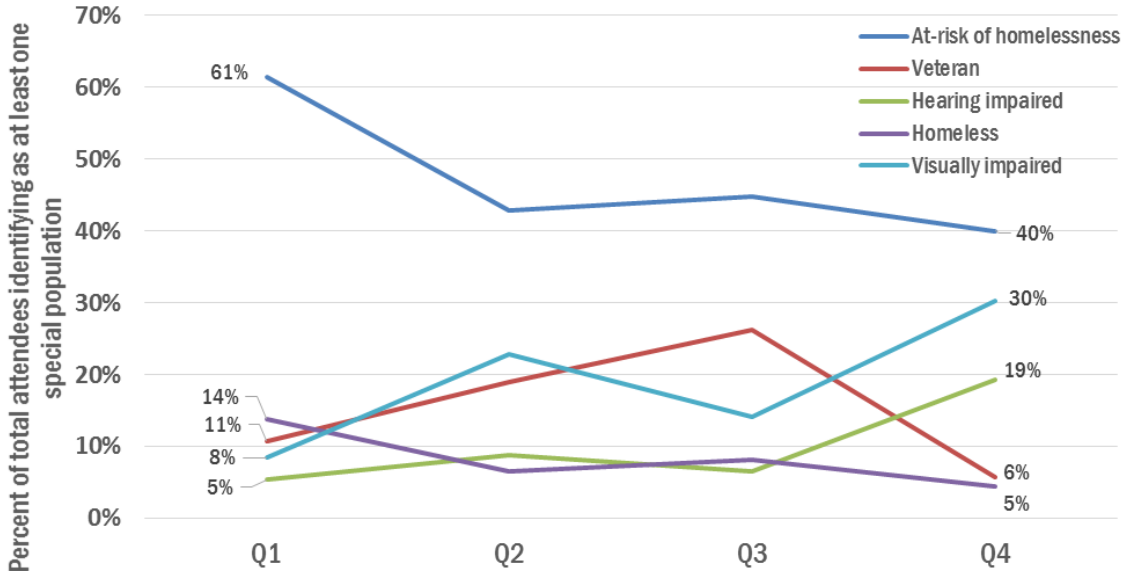
Table 5. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2015-2016

Race/ethnicity	Q1	Q2	Q3	Q4	Total
White	269 (37%)	601 (42%)	549 (38%)	82 (7%)	1,501 (32%)
Black	26 (4%)	44 (3%)	43 (3%)	40 (3%)	153 (3%)
Middle Eastern	11 (2%)	17 (1%)	18 (1%)	14 (1%)	60 (1%)
American Indian	5 (1%)	17 (1%)	20 (1%)	6 (1%)	48 (1%)
Mexican	47 (7%)	54 (4%)	37 (3%)	122 (10%)	260 (5%)
Other Latino	30 (4%)	25 (2%)	32 (2%)	0 (0%)	87 (2%)
Puerto Rican	1 (<1%)	0 (0%)	3 (<1%)	2 (<1%)	6 (<1%)
Cuban	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Filipino	89 (12%)	171 (12%)	233 (16%)	185 (16%)	678 (14%)
Chinese	31 (4%)	73 (5%)	61 (4%)	81 (7%)	246 (5%)
Japanese	13 (2%)	5 (<1%)	7 (<1%)	5 (<1%)	30 (1%)
Korean	2 (<1%)	5 (<1%)	16 (1%)	6 (1%)	29 (1%)
Vietnamese	1 (<1%)	7 (<1%)	10 (1%)	5 (<1%)	23 (<1%)
South Asian	3 (<1%)	3 (<1%)	7 (<1%)	3 (<1%)	16 (<1%)
Laotian	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	1 (<1%)	1 (<1%)
Hmong	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Samoan	47 (7%)	97 (7%)	57 (4%)	142 (12%)	343 (7%)
Tongan	15 (2%)	43 (3%)	18 (1%)	160 (14%)	236 (5%)
Hawaiian	3 (<1%)	8 (1%)	11 (1%)	7 (1%)	29 (1%)
Guamanian	0 (0%)	6 (<1%)	2 (<1%)	17 (1%)	25 (1%)
Fijian	0 (0%)	4 (<1%)	4 (<1%)	16 (1%)	24 (1%)
Unknown Race	58 (8%)	138 (10%)	236 (17%)	8 (1%)	440 (9%)
Multi-racial	51 (7%)	101 (7%)	53 (4%)	223 (19%)	428 (9%)
Other Race	15 (2%)	26 (2%)	11 (1%)	43 (4%)	95 (2%)
Total**	**718**	**1,445**	**1,429**	**1,168**	**4,760**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: NCOC individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 49% were at risk for homelessness, 18% were visually impaired, 16% were veterans, 9% were hearing impaired, and 9% were homeless. Refer to **Figure 3** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 3. Special Populations Served By NCOC, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: NCOC individual outreach attendees were with unknown insurance (59%), with other insurance (17%), with Medi-Cal (17%), without insurance (4%), or with Medicare (3%) in FY 2015-2016. Less than 1% of attendees reported having more than one type of insurance. See **Table 6** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 6. Insurance Coverage for NCOC Outreach Attendees, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Unknown Insurance	104 (60%)	40 (69%)	29 (56%)	35 (51%)	208 (59%)
Other Insurance	22 (13%)	6 (10%)	7 (13%)	25 (36%)	60 (17%)
Medi-Cal	33 (19%)	10 (17%)	9 (17%)	7 (10%)	59 (17%)
Uninsured	9 (5%)	1 (2%)	5 (10%)	0 (0%)	15 (4%)
Medicare	5 (3%)	1 (2%)	2 (4%)	2 (3%)	10 (3%)
More than 1 type	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**174**	**58**	**52**	**69**	**353**

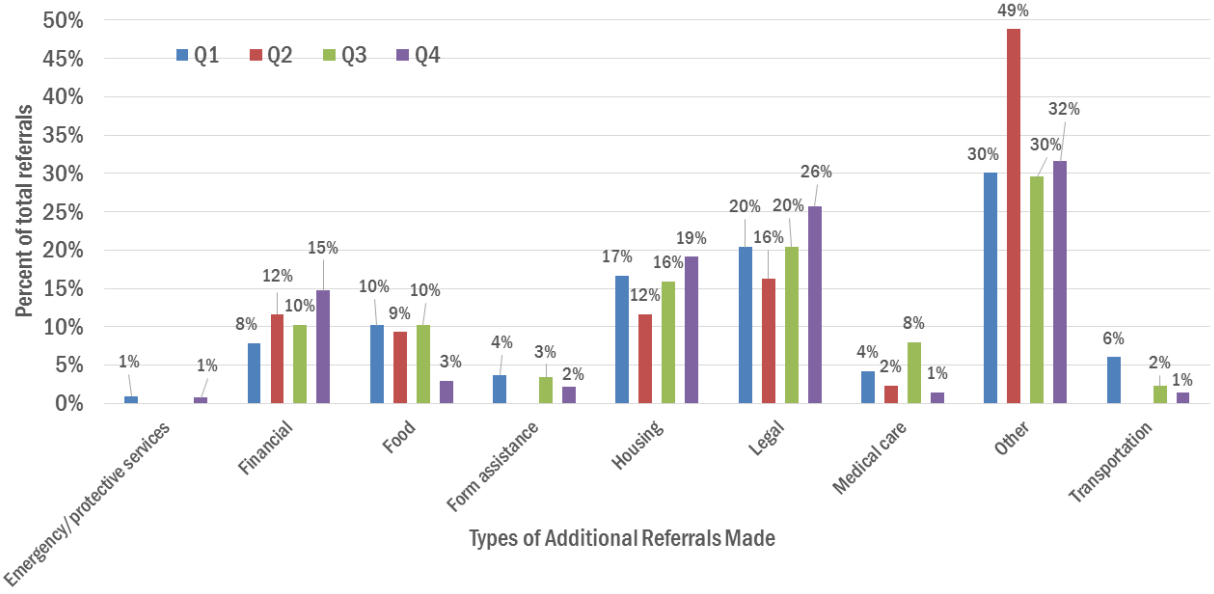
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Twenty percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Use Referrals: NCOC individual outreach events included mental health referrals (45%) and substance abuse referrals (14%) in FY 2015-2016.

Referrals to Social Services: Providers made 483 referrals to 353 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for other referrals not listed (32%), legal services (22%), and housing (17%). In **Figure 4**, we summarize the percentage of attendees receiving a given type of referral, by quarter.

Figure 4. Referrals to Social Services, FY 2015-2016



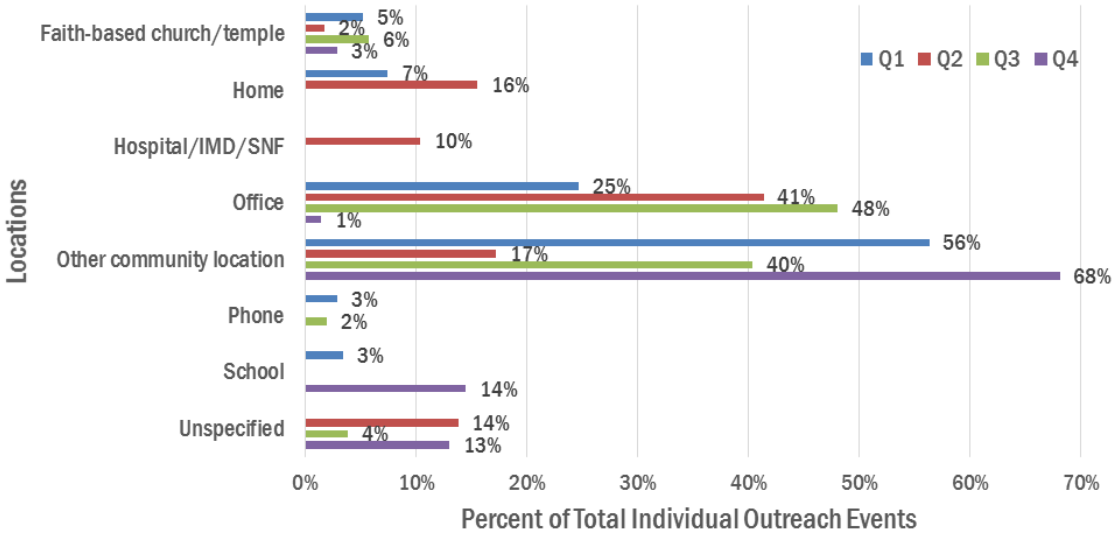
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations not listed[1] (50%) and in the office (26%) in FY 2015-2016. **Figure 5** presents individual outreach event locations in FY 2015-2016, by quarter.

[1] Due to the high percentage of individual outreach events reported to be held in "other community locations," we have modified future outreach forms (starting in FY 2016-2017) to include a free-response space for providers to include additional information about these other locations. Moving forward, this will allow us to better understand what these additional outreach locations are and to meet the needs of outreach attendees.

Figure 5. Locations of NCOC Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC individual outreach events was 34.9 minutes. Average length was 31.0 minutes in Q1, 42.8 minutes in Q2, 51.1 minutes in Q3, and 25.7 minutes in Q4.

MAA code: NCOC individual outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 37%), 400 (Medi-Cal outreach, 32%), 403 (Referral in crisis situations for non-open cases, 5%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA code 404 (Case management of non-open cases) was not used. Twenty-five percent of MAA codes were reported as N/A.

Language: NCOC individual outreach events were conducted in English (94%), Spanish (4%), Tagalog (1%), and Mandarin (1%). See **Table 7** for group outreach events by language.

Table 7. Number of NCOC Individual Outreach Events By Language, FY 2015-2016

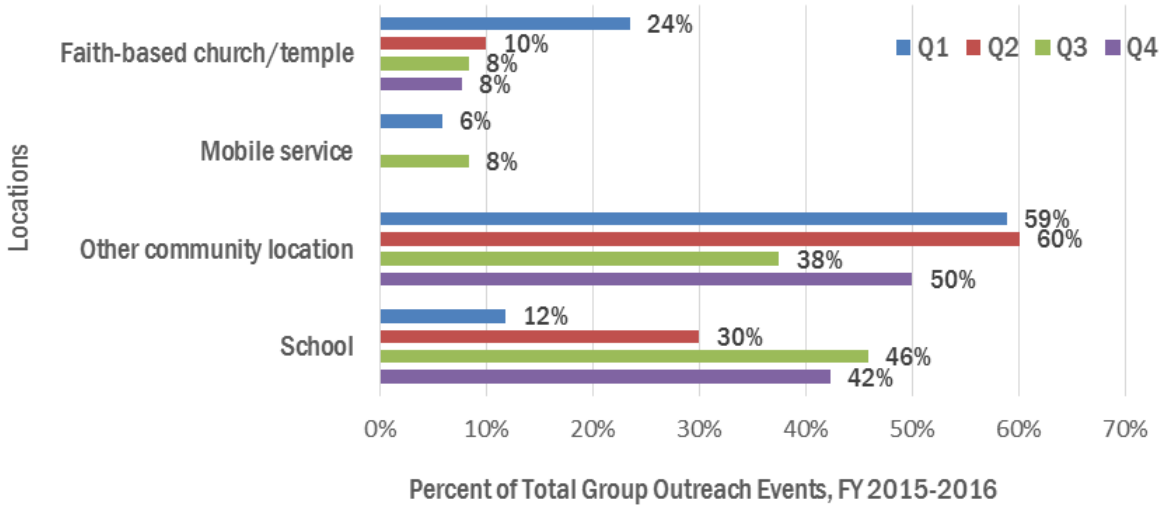
Language	Q1	Q2	Q3	Q4	Total
English	163 (94%)	53 (91%)	50 (96%)	67 (97%)	333 (94%)
Spanish	7 (4%)	5 (9%)	1 (2%)	1 (1%)	14 (4%)
Tagalog	3 (2%)	0 (0%)	0 (0%)	0 (0%)	3 (1%)
Mandarin	0 (0%)	0 (0%)	1 (2%)	1 (1%)	2 (1%)
Other	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Total	**174**	**58**	**52**	**69**	**353**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tongan, Vietnamese, and unknown language.

Group outreach event characteristics

Location: NCOC group outreach events largely occurred at other community locations not listed (52%) and at school (34%) in FY 2015-2016. **Figure 6** presents group outreach event locations in FY 2015-2016, by quarter.

Figure 6. Location of NCOC Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of NCOC group outreach events was 103.1 minutes. By quarter, average length of outreach was 123.4 minutes in Q1, 105.1 minutes in Q2, 80.3 minutes in Q3, and 108.4 minutes in Q4.

MAA code: NCOC group outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 56%), 400 (Medi-Cal outreach, 24%), and 403 (Referral in crisis situations for non-open cases, 2%) in FY 2015-2016. MAA codes 404 (Case management of non-open cases) and 410 (Non-SPMP case management of non-open cases) were not used. Eighteen percent of MAA codes were reported as N/A.

Language: NCOC group outreach events were conducted in English (96%), Mandarin (1%), and Spanish (1%). See **Table 8** below for the breakdown of group outreach events by the language of administration.

Table 8. Number of NCOC Group Outreach Events By Language, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
English	17 (100%)	30 (97%)	24 (100%)	24 (89%)	95 (96%)
Other	0 (0%)	1 (3%)	0 (0%)	1 (4%)	2 (2%)
Mandarin	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Spanish	0 (0%)	0 (0%)	0 (0%)	1 (4%)	1 (1%)
Total	**17**	**31**	**24**	**27**	**99**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Portuguese, Samoan, Tagalog, Tongan, Vietnamese, and unknown language.

EPAPMHO

In FY 2015-2016, there were 812 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual outreach attendees were adults (26-59 years, 54%), transition-age youth (16-25 years, 38%), older adults (60+ years or older, 7%), and children (0-15 years, <1%) in FY 2015-2016. Less than one percent of attendees were of an unknown age. See **Table 9** for the number of individual outreach attendees representing each reported age group, by quarter. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Table 9. Age of Individual Outreach Attendees Served By EPAPMHO, FY 2015-2016

Age	Q1	Q2	Q3	Q4	Total
Adults (26-59)	149 (70%)	88 (45%)	98 (46%)	73 (59%)	408 (54%)
Transition-age youth (16-25)	57 (27%)	94 (48%)	97 (45%)	33 (27%)	281 (38%)
Older adults (60+)	8 (4%)	14 (7%)	18 (8%)	16 (13%)	56 (7%)
Children (0-15)	0 (0%)	0 (0%)	1 (<1%)	1 (1%)	2 (<1%)
Unknown age	0 (0%)	1 (1%)	1 (<1%)	0 (0%)	2 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on age for FY 2015-2016.

Gender: Attendees across EPAPMHO individual and group outreach events were females (57%), males (41%), and other genders (2%) in FY 2015-2016. See **Table 10** for the number of individual and group outreach attendees representing each reported gender, by quarter.

Table 10. Gender of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Gender	Q1	Q2	Q3	Q4	Total
Female	121 (51%)	139 (63%)	120 (56%)	85 (61%)	465 (57%)
Male	113 (48%)	81 (36%)	86 (40%)	53 (38%)	333 (41%)
Other gender	2 (1%)	2 (1%)	9 (4%)	1 (1%)	14 (2%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding.

Race and ethnicity: In FY 2015-2016, the three largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (24%), Black (24%), and Tongan (14%). Less than one percent of attendees were of an unknown race. See **Table 11** for the number of attendees representing each reported racial/ethnic group, by quarter.

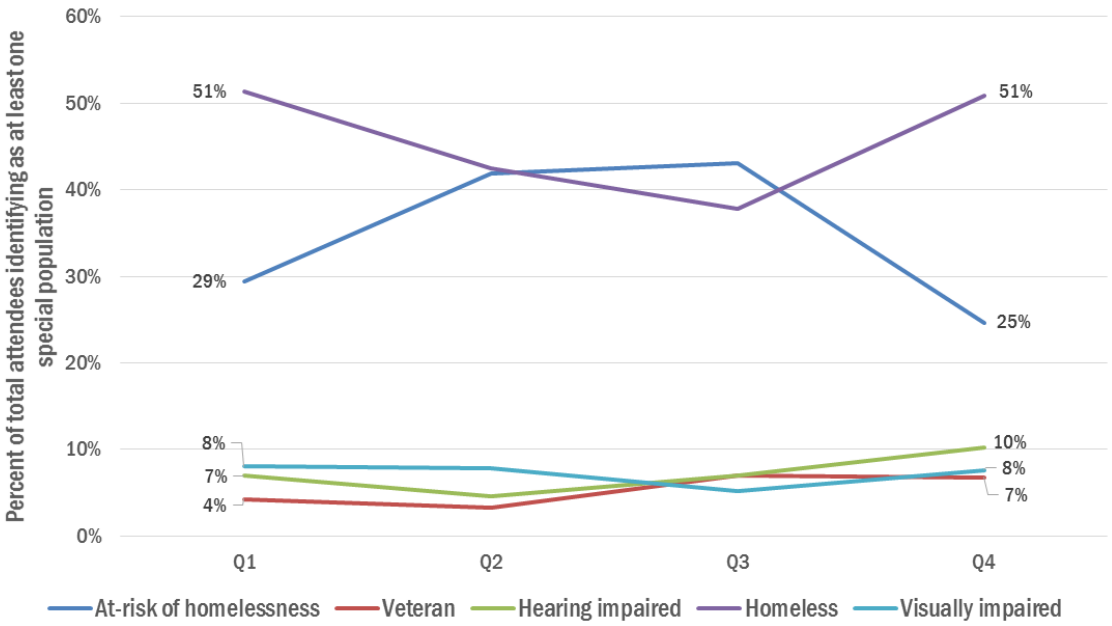
Table 11. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2015-2016

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
Black	54 (23%)	57 (26%)	53 (25%)	30 (17%)	194 (24%)
White	27 (11%)	16 (7%)	21 (9%)	13 (9%)	77 (9%)
American Indian	3 (1%)	1 (<1%)	2 (1%)	1 (1%)	7 (1%)
Mexican	63 (27%)	44 (20%)	53 (25%)	35 (25%)	195 (24%)
Puerto Rican	2 (1%)	0 (0%)	2 (1%)	0 (0%)	4 (<1%)
Cuban	0 (0%)	1 (<1%)	0 (0%)	0 (0%)	1 (<1%)
Filipino	5 (2%)	4 (2%)	6 (3%)	3 (2%)	18 (2%)
Chinese	1 (<1%)	0 (0%)	1 (<1%)	0 (0%)	2 (<1%)
South Asian	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Vietnamese	2 (1%)	0 (0%)	0 (0%)	0 (0%)	2 (<1%)
Tongan	30 (13%)	35 (16%)	32 (15%)	20 (14%)	117 (14%)
Samoan	21 (9%)	24 (11%)	14 (7%)	26 (19%)	85 (10%)
Fijian	4 (2%)	6 (3%)	3 (1%)	0 (0%)	13 (2%)
Hawaiian	3 (1%)	2 (1%)	1 (<1%)	0 (0%)	6 (1%)
Multi-racial	19 (8%)	28 (13%)	25 (12%)	11 (8%)	83 (10%)
Other Race	1 (<1%)	1 (<1%)	0 (0%)	0 (0%)	2 (<1%)
Unknown Race	0 (0%)	2 (1%)	2 (1%)	0 (0%)	4 (<1%)
Total	**236**	**222**	**215**	**139**	**812**

Note: Percentages may not sum to 100% because of rounding. The following racial/ethnic groups were options but were not reported by providers in FY 2015-2016: Middle Eastern, Other Latino, Japanese, Korean, Cambodian, Hmong, Laotian, Mien, and Guamanian.

Special populations: EPAPMHO individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 45% were homeless, 35% were at risk for homelessness, 7% were visually impaired, 7% were hearing impaired, and 5% were veterans. Refer to **Figure 7** for the percentage of attendees representing each special population in FY 2015-2016, by quarter.

Figure 7. Special Populations Served by EPAPMHO, FY 2015-2016



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: EPAPMHO individual outreach attendees were without insurance (46%), with Medi-Cal (28%), with other insurance not listed (11%), with Medicare (8%), or with unknown insurance (4%). Three percent of attendees reported having more than one type of insurance. See **Table 12** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 12. Insurance Coverage, FY 2015-2016

Insurance Type	Q1	Q2	Q3	Q4	Total
Uninsured	131 (61%)	85 (43%)	89 (41%)	42 (34%)	347 (46%)
Medi-Cal	64 (30%)	49 (25%)	60 (28%)	40 (33%)	213 (28%)
Other Insurance	4 (2%)	23 (12%)	29 (13%)	23 (19%)	79 (11%)
Medicare	13 (6%)	17 (9%)	15 (7%)	12 (10%)	57 (8%)
Unknown Insurance	2 (1%)	12 (6%)	10 (5%)	3 (2%)	27 (4%)
More than 1 type	0 (0%)	11 (6%)	12 (6%)	3 (2%)	26 (3%)
Healthy Families	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Healthy Kids	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**214**	**197**	**215**	**123**	**749**

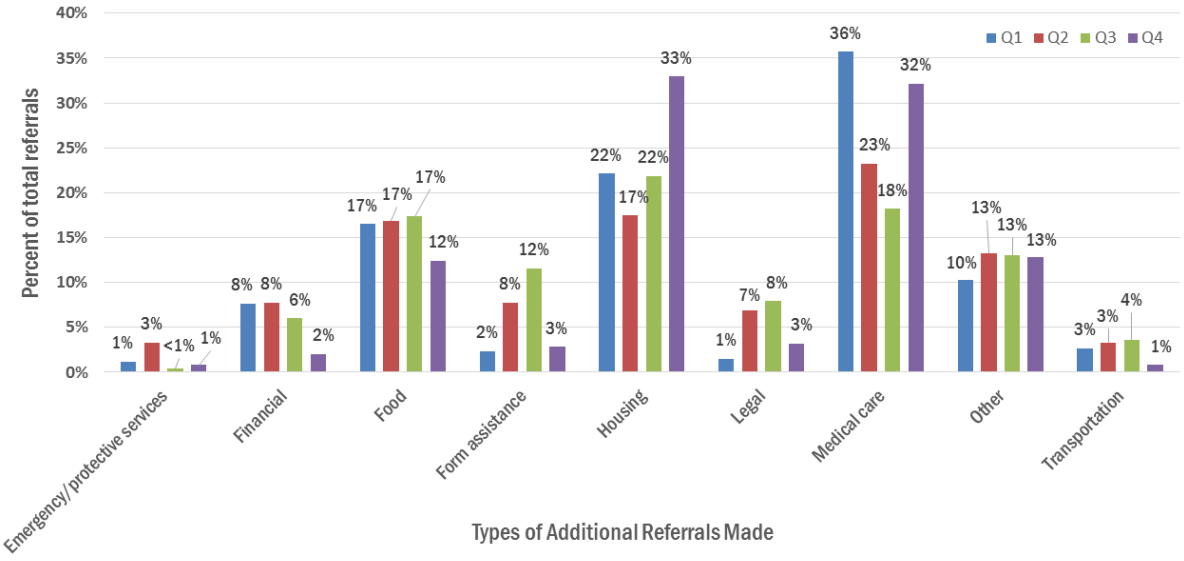
Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2015-2016.

Previous contact: Thirty-three percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Use Referrals: EPAPMHO individual outreach events included substance abuse referrals (30%) and mental health referrals (26%) in FY 2015-2016.

Referrals to Social Services: Providers made 1,416 referrals to 749 EPAPMHO individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for medical care (26%), housing (23%), and food (16%). **Figure 8** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 8. Referrals to Social Services, FY 2015-2016

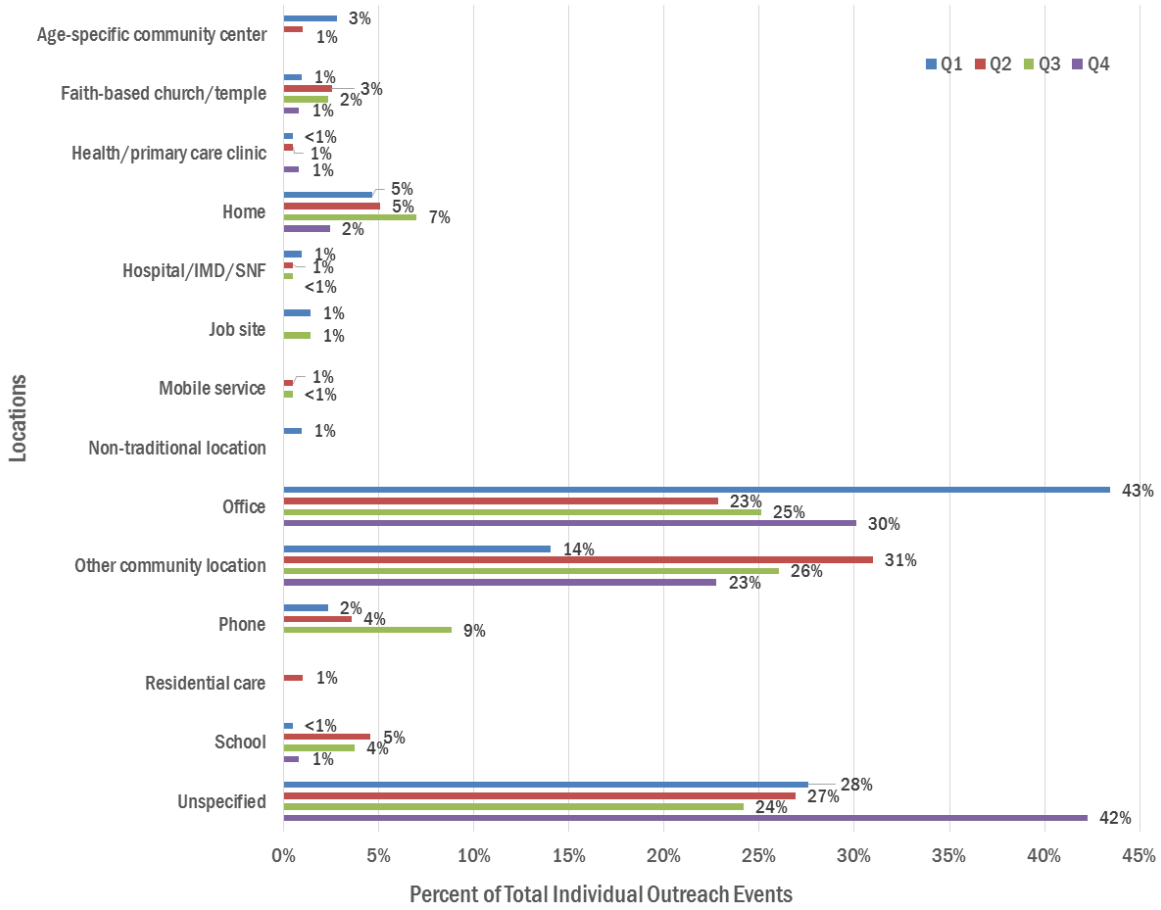


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2015-2016.

Individual outreach event characteristics

Location: EPAPMHO individual outreach events typically occurred in the office (31%), unspecified locations (29%), and other community locations not listed (23%) in FY 2015-2016. See **Figure 9** for a summary of individual outreach events by location.

Figure 9. Location of EPAPMHO Individual Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO individual outreach events was 37.2 minutes. By quarter, average length of outreach was 38.6 minutes in Q1, 35.5 minutes in Q2, 40.5 minutes in Q3, and 32.0 minutes in Q4.

MAA code: EPAPMHO individual outreach events used MAA codes 400 (Medi-Cal outreach, 72%), 401 (Discounted Medi-Cal outreach, 27%), and 410 (Non-SPMP case management of non-open cases, 1%) in FY 2015-2016. MAA codes 403 (Referral in crisis situations for non-open cases) and 404 (Case management of non-open cases) were not used. None of the MAA codes were reported as N/A.

Language: EPAPMHO individual outreach events were conducted in English (67%), Spanish (19%), Tongan (9%), Samoan (4%), and American/Other Sign Language (<1%). See **Table 13** below for the breakdown of group outreach events by the language of administration.

Table 13. Languages, FY 2015-2016

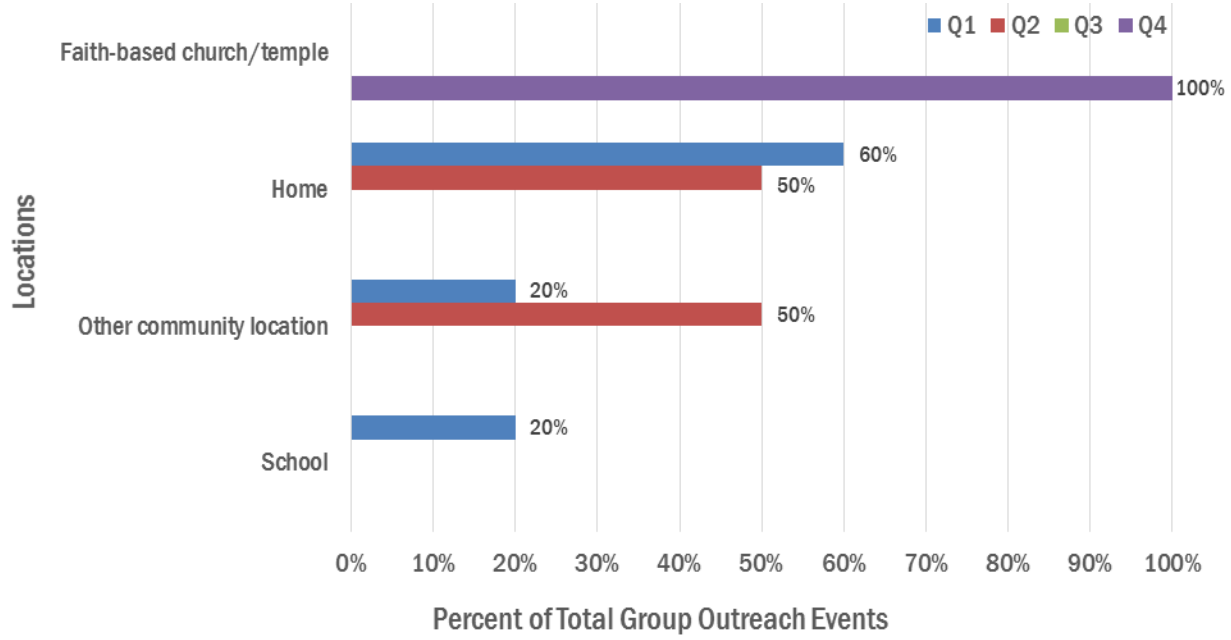
Language	Q1	Q2	Q3	Q4	Total
English	156 (73%)	140 (71%)	148 (69%)	60 (49%)	504 (67%)
Spanish	39 (18%)	32 (16%)	34 (16%)	37 (30%)	142 (19%)
Tongan	14 (7%)	16 (8%)	25 (12%)	15 (12%)	70 (9%)
Samoan	5 (2%)	9 (5%)	7 (3%)	10 (8%)	31 (4%)
American/Other Sign Language	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (<1%)
Other	0 (0%)	0 (0%)	1 (<1%)	0 (0%)	1 (<1%)
Total	**214**	**197**	**215**	**123**	**749**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: Cambodian, Mandarin, Portuguese, Tagalog, Vietnamese, and unknown language.

Group outreach event characteristics

Locations: EPAPMHO group outreach events were held in the home (50%), at other community locations not listed (25%), at school (13%), and at faith-based churches/temples (13%) in FY 2015-2016. Refer to **Figure 10** for a breakdown of group outreach events by location.

Figure 10. Locations of EPAPMHO Group Outreach Events, FY 2015-2016



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2015-2016, the average length of EPAPMHO group outreach events was 48.1 minutes. By quarter, average length of outreach was 38.0 minutes in Q1, 75.0 minutes in Q2, and 45.0 minutes in Q4. Only Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported these data and for only Q1, Q2, and Q4 of this FY.

MAA code: EPAPMHO group outreach events used only MAA code 400 (Medi-Cal outreach, 100%) in FY 2015-2016.

Language: EPAPMHO group outreach events were conducted in Samoan (50%), Tongan (38%), and English (13%). See **Table 14** below for the breakdown of group outreach events by the language of administration.

Table 14. Languages, FY 2015-2016

Language	Q1	Q2	Q3	Q4	Total
Samoan	3 (60%)	1 (50%)	0 (0%)	0 (0%)	4 (50%)
Tongan	2 (40%)	0 (0%)	0 (0%)	1 (100%)	3 (38%)
English	0 (0%)	1 (50%)	0 (0%)	0 (0%)	1 (13%)
Total	**5**	**2**	**0**	**1**	**8**

Note: Percentages may not sum to 100% because of rounding. The following languages were options but were not reported by providers in FY 2015-2016: American/Other Sign Language, Cambodian, Mandarin, Other, Portuguese, Spanish, Tagalog, Vietnamese, and unknown language.s

Outreach Summaries by Provider

We analyzed outreach efforts by provider and created provider-specific summaries to help SMC BHRS and its providers better understand each organization's outreach efforts. Please refer to **Appendix B-I** for these provider-specific summaries. In each provider summary, we highlight key observations on outreach location, language, insurance, race/ethnicity, and specific groups of interest for both individual and group outreach efforts.

Recommendations

Based on these data about SMC BHRS outreach services provided during FY 2015-2016, we recommend the following to enhance outreach and data collection efforts.

Enhance outreach

Tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America. Although 19% of San Mateo County's senior (age 65 years and older) population reported needing help for emotional/mental health problems of use of alcohol/drugs in 2015, only 5% of NCOC and 7% of EPAPMHO outreach event attendees were older adults (age 60 and older).[2] Among persons who identify as Latino/Hispanic and report needing help for emotional/mental health problems of use of alcohol/drugs in San Mateo County in 2015, 57% are Central American and 14% are Mexican.[2] However, over 80% of Latino/Hispanic outreach attendees identified as Mexican among the two collaboratives combined.

Identify housing-related resources that may be especially useful for those who are homeless or at risk for homelessness. Almost 1,000 outreach attendees across both collaboratives reported being homeless or being at risk for homeless in FY 2015-2016 (467 for NCOC, and 957 for EPAPMHO). (Attendees may not be unique individuals.) However, providers documented only 400 referrals to housing resources during individual events, and it is unclear whether housing resources were offered at group events. In addition to housing resources, these specific populations may need referrals to additional services (such as food or medical care).

Share best practices across providers for reaching special populations. For example, some providers report more attendees who are at-risk for homelessness, whereas other providers report more attendees who are veterans. Providers can share what strategies have worked best for special populations.

Improve data collection

Minimize missing data. It is unclear whether quarterly changes in number of outreach events and attendees were actual changes or related to missing data. For example, some providers reported no group outreach events in some quarters, and other providers reported changes in attendee number from quarter to quarter. To ensure that these observations are not related to missing data, we recommend SMC BHRS work with providers to:

[2] UCLA Center for Health Policy Research. AskCHIS 2015. Available at http://ask.chis.ucla.edu.

- Enter outreach data immediately after the outreach event or monthly, at minimum. This may help to minimize loss of records before data entry.
- Check SurveyMonkey data quarterly with AIR support. We suggest for AIR to provide a list of events that have been entered electronically so that providers can verify that no events are missing.

Treat race/ethnicity as mutually exclusive categories. We recommend that providers include attendees who endorse multiple race/ethnicity groups only once under "two or more races" to ensure mutually exclusive race/ethnicity categories. At this time, total counts for race/ethnicity in group outreach events are larger than the total number of group outreach attendees. Providers may have classified an attendee under several race/ethnicity categories and as "two or more races."

Report data collection and entry challenges as they occur. We recommend that providers report challenges with collecting new demographic items to SMC BHRS and AIR as challenges arise so we can develop solutions together before the end of the FY. The California State Mental Health Services Oversight and Accountability Commission included new demographic requirements for MHSA prevention and early intervention reporting. For consistency across MHSA programs in San Mateo County, BHRS and AIR worked together to revise individual and group outreach forms. In brief, we added gender identity and sexual orientation categories. For disabilities, we added categories to capture client needs and groups reached. We also added county of residence. These data will be collected in FY 2016-2017.

Appendix A. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (*e.g.*, location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.

For MAA codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (*e.g.*, race), per quarter
- Denominator = total number of attendees, per quarter

Appendix B. FY 2015-2016 Outreach, Asian American Recovery Services

Outreach Event Characteristics

For FY 2015-2016, Asian American Recovery Services (AARS) reported a total of 1,652 outreach attendees—150 individual outreach attendees and 1,502 group outreach attendees. **Table B1** shows outreach event location, MAA code, and language.

Table B1. Characteristics of AARS Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Office	19 (12.7%)	
Other community location	123 (82.0%)	40 (87.0%)
Phone	5 (3.3%)	
School	1 (0.7%)	6 (13.0%)
Unspecified location	2 (1.3%)	
Total	**150**	**46**
MAA code		
400	2 (1.3%)	
401	113 (75.3%)	45 (97.8%)
403	4 (2.7%)	1 (2.2%)
N/A	31 (20.7%)	
Total	**148**	**46**
Language		
English	150 (100.0%)	45 (97.8%)
Spanish		1 (2.2%)
Total	**150**	**46**
Average length of contact	**34.39 minutes**	**98.33 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table B2 presents the demographics for individual and group outreach attendees served by AARS. Most outreach attendees served by AARS were between the ages of 26-59 (individual outreach data only), self-reported as female (62.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were multi-racial (18.6%), Samoan (18.3%), Tongan (13.7%), and Filipino (13.0%).

Table B2. Demographics of Outreach Attendees Served By AARS, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	4 (2.7%)
Transition-age youth (16-25)	56 (37.3%)
Adults (26-59)	82 (54.7%)
Older adults (60+)	8 (5.3%)
Unknown age	0 (0.0%)
Total	**150**
Gender	
Female	1,034 (62.6%)
Male	611 (37.0%)
Other gender	7 (0.4%)
Total	**1,652**
Sexual Orientation	
LGBTQ	121 (7.3%)
Race/Ethnicity	
Black	43 (2.6%)
White	159 (9.6%)
American Indian	13 (0.8%)
Middle Eastern	8 (0.5%)
Mexican	112 (6.8%)
Puerto Rican	2 (0.1%)
Cuban	0 (0.0%)
Other Latino	2 (0.1%)
Filipino	215 (13.0%)
Chinese	97 (5.91%)
Japanese	7 (0.4%)
Korean	5 (0.3%)
South Asian	0 (0.0%)
Vietnamese	8 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	2 (0.1%)
Mien	0 (0.0%)
Tongan	226 (13.7%)
Samoan	303 (18.3%)
Fijian	24 (1.5%)
Hawaiian	18 (1.1%)
Guamanian	25 (1.5%)
Multi-racial	308 18.6%)
Other Race	68 (4.1%)

	Total
Unknown Race	7 (0.4%)
Total	**1,652**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, AARS reported 344 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**8.2%**; n=136) or visually impaired (**6.5%**; n=108). Other attendees representing special populations were hearing impaired (**2.8%**; n=46), homeless (**1.9%**; n=32), and veterans (**1.3%**; n=22).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**72.7%**; n=109). More than one in four individual outreach attendees received a referral to substance abuse services (**26.7%**; n=42). Individual outreach events also resulted in 362 referrals to social services (**Table B3**). AARS made other (35.4%) or legal (27.3%) referrals most often.

Table B3. Referrals to Social Services Provided By AARS, FY 2015-2016

Referrals	Total
No referral	*4*
Emergency/protective services	1 (0.3%)
Financial	49 (13.5%)
Food	9 (2.5%)
Form assistance	4 (1.1%)
Housing	54 (14.9%)
Legal	99 (27.3%)
Medical care	11 (3.0%)
Other	128 (35.4%)
Transportation	7 (1.9%)
Total	**362**

Note: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix C. FY 2015-2016 Outreach, Daly City Peninsula Partnership Collaborative

Outreach Event Characteristics

For FY 2015-2016, Daly City Peninsula Partnership Collaborative (DCPPC) reported a total of 201 outreach attendees—61 individual outreach attendees and 140 group outreach attendees. **Table C1** shows outreach event location, MAA code, and language. DCPPC did not report any group outreach data in Q2.

Table C1. Characteristics of DCPPC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Home	21 (34.4%)	
Office	1 (1.6%)	
Other community location	37 (60.7%)	2 (50.0%)
School	2 (3.3%)	2 (50.0%)
Total	**61**	**4**
MAA code		
400	11 (18.0%)	4 (100.0%)
401	19 (31.1%)	
N/A	31 (50.8%)	
Total	**61**	**4**
Language		
English	46 (75.4%)	4 (100.0%)
Spanish	12 (19.7%)	
Tagalog	3 (4.9%)	
Total	**61**	**4**
Average length of contact	**30.43 minutes**	**120.0 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table C2 presents the demographics for individual and group outreach attendees served by DCPPC. Most outreach attendees served by DCPPC were of unknown age (individual outreach data only), self-reported as female (72.6%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (23.9%), Mexican (23.4%), and Filipino (22.4%).

Table C2. Demographics of Outreach Attendees Served By DCPPC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	3 (4.9%)
Adults (26-59)	25 (41.0%)
Older adults (60+)	2 (3.3%)
Unknown age	31 (50.8%)
Total	**61**
Gender	
Female	146 (72.6%)
Male	43 (21.4%)
Other gender	12 (6.0%)
Total	**201**
Sexual Orientation	
LGBTQ	7 (3.5%)
Race/Ethnicity	
Black	5 (2.5%)
White	48 (23.9%)
American Indian	1 (0.5%)
Middle Eastern	5 (2.5%)
Mexican	47 (23.4%)
Puerto Rican	2 (1.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	45 (22.4%)
Chinese	15 (7.5%)
Japanese	3 (1.5%)
Korean	1 (0.5%)
South Asian	0 (0.0%)
Vietnamese	2 (1.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	6 (3.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	14 (7.0%)

	Total
Other Race	2 (1.0%)
Unknown Race	5 (2.5%)
Total	**201**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCPPC reported 14 outreach attendees representing special populations through individual and group outreach, most commonly reaching attendees who were at risk for homelessness (**3.0%**; n=6) or hearing impaired (**2.0%**; n=4). Other attendees representing special populations were veterans (**1.0%**; n=2) or vision impaired (**1.0%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Six outreach attendees received referrals to mental health services (**9.8%**; n=6). One individual outreach attendee received a referral to substance abuse services (**1.6%**; n=1). Individual outreach events also resulted in 49 referrals to social services (**Table C3**). DCPPC made other (40.8%), food (22.4%), or housing (22.4%) referrals most often.

Table C3. Referrals to Social Services Provided By DCPPC, FY 2015-2016

Referrals	Total
No referral	*31*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	11 (22.4%)
Form assistance	2 (4.1%)
Housing	11 (22.4%)
Legal	5 (10.2%)
Medical care	0 (0.0%)
Other	20 (40.8%)
Transportation	0 (0.0%)
Total	**49**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix D. FY 2015-2016 Outreach, Daly City Youth Health Center

Outreach Event Characteristics

For FY 2015-2016, Daly City Youth Health Center (DCYHC) reported a total of 499 outreach attendees—23 individual outreach attendees and 476 group outreach attendees. **Table D1** shows outreach event location, MAA code, and language.

Table D1. Characteristics of DCYHC Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	2 (8.7%)	1 (5.3%)
Office	5 (21.7%)	
Other community location	3 (13.0%)	1 (5.3%)
School	5 (21.7%)	15 (78.9%)
Unspecified location	8 (34.8%)	
Total	**23**	**17**
MAA code		
400	2 (8.7%)	6 (31.6%)
401		7 (36.8%)
403		1 (5.3%)
410	3 (13.0%)	
N/A	18 (78.3%)	5 (26.3%)
Total	**23**	**19**
Language		
English	22 (95.7%)	18 (94.7%)
Spanish	1 (4.3%)	
Other language		1 (5.3%)
Total	**23**	**19**
Average length of contact	**17.83 minutes**	**96.63 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table D2 presents the demographics for individual and group outreach attendees served by DCYHC. Most outreach attendees served by DCYHC were adults aged 26-59 (individual outreach data only), self-reported as female (54.3%), and represented many race and ethnicities.

The most frequently reported races/ethnicities were Filipino (37.8%), Unknown (13.1%), and Mexican (12.3%).

Table D2. Demographics of Outreach Attendees Served By DCYHC, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	1 (4.3%)
Adults (26-59)	22 (95.7%)
Older adults (60+)	0 (0.0%)
Unknown age	0 (0.0%)
Total	**23**
Gender	
Female	271 (54.3%)
Male	161 (32.3%)
Other gender	67 (13.4%)
Total	**201**
Sexual Orientation	
LGBTQ	40 (8.0%)
Race/Ethnicity	
Black	25 (5.0%)
White	58 (11.5%)
American Indian	2 (0.4%)
Middle Eastern	10 (2.0%)
Mexican	62 (12.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	6 (1.2%)
Filipino	191 (37.8%)
Chinese	24 (4.8%)
Japanese	5 (1.0%)
Korean	2 (0.4%)
South Asian	3 (0.6%)
Vietnamese	2 (0.4%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)

	Total
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	41 (8.1%)
Other Race	8 (1.6%)
Unknown Race	66 (13.1%)
Total	**505**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, DCYHC reported 2 outreach attendees representing special populations through individual and group outreach, reaching attendees who were at risk for homelessness (**0.2%**; n=1) or veterans (**0.2%**; n=1).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**65.2%**; n=15). Two individual outreach attendees received a referral to substance abuse services (**4.3%**; n=2). Individual outreach events also resulted in 13 referrals to social services (**Table D3**). DCYHC made medical care (53.8%) and other (23.1%) referrals most often.

Table D3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

Referrals	Total
No referral	15
Emergency/protective services	0 (0.0%)
Financial	1 (7.7%)
Food	1 (7.7%)
Form assistance	0 (0.0%)
Housing	1 (7.7%)
Legal	0 (0.0%)
Medical care	7 (53.8%)
Other	3 (23.1%)
Transportation	0 (0.0%)
Total	**13**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix E. FY 2015-2016 Outreach, El Concilio

Outreach Event Characteristics

For FY 2015-2016, El Concilio reported a total of 53 outreach attendees, all from individual outreach. El Concilio did not report any group outreach events during FY 2015-2016. **Table E1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table E1. Characteristics of El Concilio Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Health/primary care clinic	1 (1.9%)
Office	50 (94.3%)
Phone	2 (3.8%)
Total	**53**
MAA code	
400	49 (92.5%)
410	4 (7.5%)
Total	**53**
Language	
English	15 (28.3%)
Spanish	38 (71.7%)
Total	**53**
Average length of contact	**24.58 minutes**

Notes: Only the categories where data was reported are presented.

Demographics

Table E2 presents the demographics for individual and group outreach attendees served by El Concilio. Most outreach attendees served by El Concilio were adults aged 26-59 and self-reported as female (88.7%). Outreach attendees identified as Mexican (73.6%), Black (13.2%), or Multi-Race (13.2%).

Table E2. Demographics of Outreach Attendees Served By El Concilio, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (1.9%)
Transition-age youth (16-25)	10 (18.9%)
Adults (26-59)	38 (71.7%)
Older adults (60+)	4 (7.5%)
Unknown age	0 (0.0%)
Total	**53**
Gender	
Female	47 (88.7%)
Male	6 (11.3%)
Other gender	0 (0.0%)
Total	**53**
Sexual Orientation	
LGBTQ	1 (1.9%)
Race/Ethnicity	
Black	7 (13.2%)
White	0 (0.0%)
American Indian	0 (0.0%)
Middle Eastern	0 (0.0%)
Mexican	39 (73.6%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	0 (0.0%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	0 (0.0%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	0 (0.0%)
Samoan	0 (0.0%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	7 (13.2%)
Other Race	0 (0.0%)

	Total
Unknown Race	0 (0.0%)
Total	**53**

Special Populations

In FY 2015-2016, El Concilio reported 35 outreach attendees representing special populations, most commonly reaching attendees who were homeless (**34.0%**; n=18). Other attendees representing special populations were at risk of homelessness (**17.0%**; n=9), hearing impaired (**11.3%**; n=6), or vision impaired (**3.8%**; n=2).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Nine individual outreach attendees received referrals to mental health services (**17.0%**; n=9). There were no referrals to substance abuse services. Individual outreach events also resulted in 57 referrals to social services (**Table E3**). El Concilio made Housing (33.3%) and Food (24.6%) referrals most often.

Table E3. Referrals to Social Services Provided By El Concilio, FY 2015-2016

Referrals	Total
No referral	*10*
Emergency/protective services	1 (1.8%)
Financial	0 (0.0%)
Food	14 (24.6%)
Form assistance	6 (10.5%)
Housing	19 (33.3%)
Legal	4 (7.0%)
Medical care	1 (1.8%)
Other	9 (15.8%)
Transportation	3 (5.3%)
Total	**57**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

Appendix F. FY 2015-2016 Outreach, Free At Last

Outreach Event Characteristics

For FY 2015-2016, Free At Last reported a total of 373 outreach attendees, all from individual outreach. Free At Last did not report any group outreach events during FY 2015-2016. **Table F1** shows outreach event location, MAA code, and language, reported at the attendee-level.

Table F1. Characteristics of Free At Last Outreach Events, FY 2015-2016

	Individual Outreach
Location	**Total Attendees**
Office	173 (46.4%)
Unspecified location	200 (53.6%)
Total	**373**
MAA code	
400	172 (46.1%)
401	201 (53.9%)
Total	**373**
Language	
English	280 (75.1%)
Spanish	93 (24.9%)
Total	**373**
Average length of contact	**24.58 minutes**

Note: Only the categories where data was reported are presented.

Demographics

Table F2 presents the demographics for individual and group outreach attendees served by Free At Last. Most outreach attendees served by Free At Last were adults aged 26-59 and self-reported as male (50.7%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Mexican (34.9%) and Black (33.8%).

Table F2. Demographics of Outreach Attendees Served By Free At Last, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	89 (23.9%)
Adults (26-59)	261 (70.0%)
Older adults (60+)	23 (6.2%)
Unknown age	0 (0.0%)
Total	**373**
Gender	
Female	182 (48.8%)
Male	189 (50.7%)
Other gender	2 (0.5%)
Total	**373**
Sexual Orientation	
LGBTQ	80 (21.4%)
Race/Ethnicity	
Black	126 (33.8%)
White	68 (18.2%)
American Indian	3 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	130 (34.9%)
Puerto Rican	3 (0.8%)
Cuban	1 (0.3%)
Other Latino	0 (0.0%)
Filipino	14 (3.8%)
Chinese	2 (0.5%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.3%)
Vietnamese	2 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	11 (2.9%)
Samoan	2 (0.5%)
Fijian	1 (0.3%)
Hawaiian	2 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	5 (1.3%)
Other Race	2 (05%)

Unknown Race	0 (0.0%)
Total	**373**

Special Populations

In FY 2015-2016, Free At Last reported 438 outreach attendees representing special populations. The total number of special population attendees reached exceeds total attendee count, because a single attendee may identify as more than one group (*e.g.,* both homeless and vision impaired). Most commonly reached special population attendees were homeless (**56.3%**; n=210) or at risk of homelessness (**33.8%**; n=126). Other attendees representing special populations were vision impaired (**10.5%**; n=39), hearing impaired (**9.1%**; n=34), and veterans (**7.8%**; n=29).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eighteen percent of individual outreach attendees received referrals to mental health services (**18.0%**; n=67). The majority of attendees received referrals to substance abuse services (**59.8%**; n=223). Individual outreach events also resulted in 567 referrals to social services (**Table F3**). Free at Last made Medical Care (49.0%) and Housing (30.7%) referrals most often.

Table F3. Referrals to Social Services Provided By Free At Last, FY 2015-2016

Referrals	Total *
No referral	*80*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	2 (0.4%)
Form assistance	0 (0.0%)
Housing	174 (30.7%)
Legal	1 (0.2%)
Medical care	278 (49.0%)
Other	111 (19.6%)
Transportation	1 (0.2%)
Total	**567**

Note: * Total number of referrals may exceed total attendee count, because an individual outreach event may have more than one referral. The percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” “Total” represents all referrals except “no referral.”

Appendix G. FY 2015-2016 Outreach, Multicultural Counseling and Education Services of the Bay Area

Outreach Event Characteristics

For FY 2015-2016, Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported a total of 386 outreach attendees—323 individual outreach attendees and 63 group outreach attendees. **Table G1** shows outreach event location, MAA code, and language. MCESBA did not report any group outreach data for Q3.

Table G1. Characteristics of MCESBA Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Age-specific community center	8 (2.5%)	
Faith-based church/temple	13 (4.0%)	1 (2.2%)
Health/primary care clinic	2 (0.6%)	
Home	38 (11.8%)	4 (8.7%)
Job site	6 (1.9%)	
Mobile service	2 (0.6%)	
Office	6 (1.9%)	
Phone	29 (9.0%)	
Residential care	2 (0.6%)	
School	19 (5.9%)	1 (2.2%)
Other community location	175 (54.2%)	2 (4.3%)
Unspecified location	16 (5.0%)	
Total	**323**	**8**
MAA code		
400	322 (99.7%)	8 (100.0%)
404	1 (0.3%)	
Total	**323**	**8**
Language		
American/Other Sign Language	1 (0.3%)	
English	209 (54.4%)	1 (12.5%)
Samoan	31 (9.6%)	4 (50.0%)
Spanish	11 (3.4%)	
Tongan	70 (18.9%)	3 (37.5%)
Other language	1 (0.3%)	
Total	**323**	**8**
Average length of contact	**42.57 minutes**	**48.13 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table G2 presents the demographics for individual and group outreach attendees served by MCESBA. Most outreach attendees served by MCESBA were transition-age youth aged 16-25 (individual outreach data only), self-reported as female (61.1%), and represented many race and ethnicities. The most frequently reported races/ethnicities were Tongan (36.2%) and Samoan (23.9%).

Table G2. Demographics of Outreach Attendees Served By MCESBA, FY 2015-2016

Referrals	Total
Age (individual outreach attendees only)	
Children (0-15)	1 (0.3%)
Transition-age youth (16-25)	182 (56.3%)
Adults (26-59)	109 (33.7%)
Older adults (60+)	29 (9.0%)
Unknown age	2 (0.6%)
Total	**323**
Gender	
Female	236 (61.1%)
Male	138 (35.8%)
Other gender	12 (3.1%)
Total	**386**
Sexual Orientation	
LGBTQ	14 (3.6%)
Race/Ethnicity	
Black	61 (12.3%)
White	9 (1.8%)
American Indian	4 (0.8%)
Middle Eastern	0 (0.0%)
Mexican	26 (5.3%)
Puerto Rican	1 (0.2%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	4 (0.8%)
Chinese	0 (0.0%)
Japanese	0 (0.0%)
Korean	0 (0.0%)
South Asian	1 (0.2%)
Vietnamese	0 (0.0%)
Cambodian	0 (0.0%)

Referrals	Total
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	179 (36.2%)
Samoan	118 (23.9%)
Fijian	12 (2.4%)
Hawaiian	4 (0.8%)
Guamanian	0 (0.0%)
Multi-racial	71 (14.4%)
Other Race	0 (0.0%)
Unknown Race	4 (0.8%)
Total	**494**

Note: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 157 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**22.5%**; n=126). Other attendees representing special populations were homeless (**22.5%**; n=87), hearing impaired (**1.0%**; n=4), vision impaired (**1.0%**; n=4), and veterans (**1.0%**; n=4).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. More than one third of outreach attendees received referrals to mental health services (**37.8%**; n=122). Five individual outreach attendees received a referral to substance abuse services (**1.5%**; n=5). Individual outreach events also resulted in 792 referrals to social services to other services (**Table G3**). MCESBA made Food (26.9%) referrals most often.

Table G3. Referrals to Social Services Provided By DCYHC, FY 2015-2016

	Total
No referral	*21*
Emergency/protective services	19 (2.4%)
Financial	87 (11.0%)
Food	213 (26.9%)
Form assistance	91 (11.5%)
Housing	129 (16.3%)

	Total
Legal	70 (8.8%)
Medical care	91 (11.5%)
Other	56 (7.1%)
Transportation	36 (4.5%)
Total	**792**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding "no referral." Total represents all referrals except "no referral."

Appendix H. FY 2015-2016 Outreach, Pacifica Collaborative

Outreach Event Characteristics

For FY 2015-2016, Pacifica Collaborative reported a total of 2,092 outreach attendees—23 individual outreach attendees and 2,069 group outreach attendees. The following characteristics of the outreach events are presented separately for individual and group outreach because they are reported at the attendee-level for individual outreach, versus at the event-level for group outreach (**Table H1**).

Table H1. Characteristics of Pacifica Collaborative Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple	13 (56.5%)	9 (39.1%)
Home	1 (4.3%)	
Mobile service		3 (13.0%)
School		6 (26.1%)
Other community location	9 (39.1%)	5 (21.7%)
Total	**23**	**23**
MAA code		
400	2 (8.7%)	7 (30.4%)
403	13 (56.5%)	
N/A	8 (34.8%)	13 (56.5%)
Total	**23**	**23**
Language		
English	23 (100.0%)	22 (95.7%)
Other language		1 (4.3%)
Total	**23**	**23**
Average length of contact	**21.61 minutes**	**93.09 minutes**

Note: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table H2 presents the demographics for individual and group outreach attendees served by Pacifica Collaborative. Most outreach attendees served by Pacifica Collaborative were adults aged 26-59 (individual outreach data only), self-reported as female (48.8%), and represented many race and ethnicities. The most frequently reported races/ethnicities was White (54.6%).

Table H2. Demographics of Outreach Attendees Served By Pacifica Collaborative, FY 2015-2016

	Total
Age	
Children (0-15)	0 (0.0%)
Transition-age youth (16-25)	2 (8.7%)
Adults (26-59)	18 (78.3%)
Older adults (60+)	3 (13.0%)
Total	**23**
Gender	
Female	1,020 (48.8%)
Male	880 (42.1%)
Other gender	192 (9.2%)
Total	**2,092**
Sexual Orientation	
LGBTQ	95 (4.5%)
Race/Ethnicity	
Black	67 (3.2%)
White	1,147 (54.6%)
American Indian	32 (1.5%)
Middle Eastern	30 (1.4%)
Mexican	7 (0.3%)
Puerto Rican	0 (0.0%)
Cuban	0 (0.0%)
Other Latino	79 (3.8%)
Filipino	195 (9.3%)
Chinese	52 (2.5%)
Japanese	11 (0.5%)
Korean	20 (1.0%)
South Asian	5 (0.2%)
Vietnamese	10 (0.5%)
Cambodian	0 (0.0%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	8 (0.4%)
Samoan	32 (1.5%)
Fijian	0 (0.0%)
Hawaiian	11 (0.5%)
Guamanian	0 (0.0%)
Multi-racial	40 (1.9%)
Other Race	0 (0.0%)
Unknown Race	354 (16.8%)
Total	**2,102**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, Pacifica Collaborative reported 416 outreach attendees representing special populations, most commonly reaching attendees who were at risk of homelessness (**11.7%**; n=224). Other attendees representing special populations were veterans (**4.7%**; n=98), homeless (**1.9%**; n=40), hearing impaired (**1.0%**; n=20), and vision impaired (**0.7%**; n=14).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. The majority of individual outreach attendees received referrals to mental health services (**73.9%**; n=17). Six individual outreach attendees received a referral to substance abuse services (**26.1%**; n=6). Individual outreach events also resulted in 56 referrals to social services (**Table H3**). Pacifica Collaborative made Food (26.9%) and Housing (26.8%) referrals most often.

Table H3. Referrals to Social Services Provided By Pacifica Collaborative, FY 2015-2016

Referrals	Total
No referral	*3*
Emergency/protective services	2 (3.6%)
Financial	1 (1.8%)
Food	18 (32.1%)
Form assistance	8 (14.3%)
Housing	15 (26.8%)
Legal	0 (0.0%)
Medical care	0 (0.0%)
Other	2 (3.6%)
Transportation	10 (179%)
Total	**56**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral”. Total represents all referrals except “no referral”.

Appendix I. FY 2015-2016 Outreach, Pyramid Alternatives

Outreach Event Characteristics

For FY 2015-2016, Pyramid Alternatives reported a total of 300 outreach attendees—96 individual outreach attendees and 204 group outreach attendees. **Table I1** shows outreach event location, MAA code, and language.

Table I1. Characteristics of Pyramid Alternatives Outreach Events, FY 2015-2016

	Individual Outreach	Group Outreach
Location	**Total Attendees**	**Total Events**
Faith-based church/temple		1 (14.3%)
Hospital/IMD/SNF	6 (6.3%)	
Office	68 (70.8%)	
Phone	1 (1.0%)	
School	8 (8.3%)	4 (57.1%)
Other community location	4 (4.2%)	2 (28.6%)
Unspecified location	9 (9.4%)	
Total	**96**	**7**
MAA code		
400	96 (100.0%)	7 (100.0%)
Total	**96**	**7**
Language		
English	92 (95.8%)	6 (85.7%)
Mandarin	2 (2.1%)	1 (14.3%)
Spanish	1 (1.0%)	
Other language	1 (1.0%)	
Total	**96**	**7**
Average length of contact	**45.66 minutes**	**175.7 minutes**

Notes: Only the categories where data was reported are presented. Blank cells are categories that apply to one type of outreach but not the other (e.g., individual outreach has data under a category, but not group data).

Demographics

Table I2 presents the demographics for individual and group outreach attendees served by Pyramid Alternatives. Most outreach attendees served by Pyramid Alternatives were adults aged 26-59 (individual outreach data only), self-reported as female (57.0%), and represented many race and ethnicities. The most frequently reported races/ethnicities were White (29.7%) and Chinese (19.3%).

Table I2. Demographics of Outreach Attendees Served By Pyramid Alternatives, FY 2015-2016

	Total
Age (individual outreach attendees only)	
Children (0-15)	2 (2.1%)
Transition-age youth (16-25)	25 (26.0%)
Adults (26-59)	62 (64.6%)
Older adults (60+)	6 (6.3%)
Unknown age	1 (1.0%)
Total	**96**
Gender	
Female	171 (57.0%)
Male	128 (42.7%)
Other gender	1 (0.3%)
Total	**300**
Sexual Orientation	
LGBTQ	14 (4.7%)
Race/Ethnicity	
Black	13 (4.3%)
White	89 (29.7%)
American Indian	0 (0.0%)
Middle Eastern	7 (2.3%)
Mexican	32 (10.7%)
Puerto Rican	1 (0.3%)
Cuban	0 (0.0%)
Other Latino	0 (0.0%)
Filipino	32 (10.7%)
Chinese	58 (19.3%)
Japanese	4 (1.3%)
Korean	1 (03%)
South Asian	8 (2.7%)
Vietnamese	1 (0.3%)
Cambodian	1 (0.3%)
Hmong	0 (0.0%)
Laotian	0 (0.0%)
Mien	0 (0.0%)
Tongan	2 (0.7%)
Samoan	2 (0.7%)
Fijian	0 (0.0%)
Hawaiian	0 (0.0%)
Guamanian	0 (0.0%)
Multi-racial	25 (8.3%)

	Total
Other Race	16 (5.3%)
Unknown Race	8 (2.7%)
Total	**300**

Notes: Provider organizations were not asked to report group outreach data on age for FY 2015-2016. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special Populations

In FY 2015-2016, MCESBA reported 367 outreach attendees representing special populations, most commonly reaching attendees who were vision impaired (**6.7%**; n=20). Other attendees representing special populations were at risk of homelessness (**2.7%**; n=8), hearing impaired (**1.7%**; n=5), and veterans (**1.0%**; n=3).

Referrals

Referrals to mental health and substance abuse services were reported for individual outreach attendees. Eleven outreach attendees received referrals to mental health services (**11.5%**; n=11). There were no referrals to substance abuse services. Individual outreach events also resulted in 3 referrals to social services (**Table I3**).

Table I3. Referrals to Social Services Provided By Pyramid Alternatives Collaborative, FY 2015-2016

Referrals	Total
No referral	*93*
Emergency/protective services	0 (0.0%)
Financial	0 (0.0%)
Food	0 (0.0%)
Form assistance	0 (0.0%)
Housing	0 (0.0%)
Legal	0 (0.0%)
Medical care	1 (33.3%)
Other	2 (66.7%)
Transportation	0 (0.0%)
Total	**3**

Notes: An individual outreach event may have more than one referral, so the percentages shown are calculated out of the sum of all referrals to social services, excluding “no referral.” Total represents all referrals except “no referral.”

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APPENDIX 13

January 31, 2017

Health Equity Initiatives: A Ten-Year Review

The Office of Diversity & Equity's strategy to create equitable access to behavioral health services

harder + co | community research

Introduction Letter

Dear Colleagues,

As part of the San Mateo County Health System's Behavioral Health and Recovery Services (BHRS), the Office of Diversity and Equity (ODE) values and amplifies the voices of underserved, unserved, and inappropriately served community members in conversations about wellness, recovery, and resilience. We strive to make behavioral health services culturally appropriate and mental wellness accessible for all San Mateo County residents.

The Health Equity Initiatives (HEIs) provide one path for ODE to link community needs to County and community-based resources. Funded by the Mental Health Services Act (MHSA) since 2007, the HEIs have built on the work done by BHRS' Cultural Competence Committee. The HEIs work to decrease stigma, educate and empower community members, support wellness and recovery, and build culturally responsive services. Over their ten-year history, the HEIs have hosted events and trainings, implemented culturally-responsible policy interventions, and created safe ways to engage with behavioral health services for residents whose identities might otherwise keep them away.

This past year, BHRS hired an independent consultant, Harder+Company Community Research, to understand the impact HEIs have had on using collected data from quarterly reports, activities and events and interviews to provide a window into a few HEI case studies. Three critical lessons were identified:

- HEIs provide a valuable, meaningful and authentic connection to on-the-ground community needs and interests and impact awareness and access of BHRS services
- HEIs can influence innovative and community-aligned policies and practices related to mental wellness, recovery, and resilience.
- HEI work must be resourced appropriately to create consistency and advance the development of culturally responsive access to services.

To the co-chairs and members who have dedicated their time to the HEIs over the past ten years, we say thank you. Your dedication and hard work have been substantiated by this document and have illuminated a new path towards health equity for other individuals and agencies. We hope this document will be a tool to inspire organizations and community members to think and act creatively to address health inequities. We also hope that other health systems and jurisdictions will be able to apply the lessons the HEIs have learned while tailoring the work to their specific communities.

Thank you for your support.

Stephen Kaplan, LCSW
Behavioral Health and Recovery Services
San Mateo County Health System

Jei Africa, PsyD, MSCP, CATC-V
Office of Diversity and Equity
Behavioral Health and Recovery Services
San Mateo County Health System

Contents

Report Overview

This report documents and synthesizes a subset of the work that the Office of Diversity and Equity (ODE), a department within San Mateo Behavioral Health and Recovery Services (BHRS), has been engaged in for the last several years. ODE, although formally established in 2009, has been engaged in, overseen and/or sponsored the work of nine Health Equity Initiatives (HEIs) for the past ten years. Recognizing that a number of years have passed since the first Health Equity Initiative was informally established, ODE contracted Harder+Company Community Research (Harder+Company) to produce a report highlighting the work and impact[1] of the HEIs.

Report Structure

The report begins with a brief background and timeline of the Office of Diversity and Equity and the Health Equity Initiatives. The report provides overviews of each of the nine HEIs and includes the following information for each HEI:

- Background
- Mission, Vision, Objectives
- Key highlights and accomplishments to date

As many of the activities planned and organized by the HEIs are related to goals of engaging with community members to reduce stigma and increase access to services, and promoting principles of cultural humility and health equity among San Mateo BHRS staff, key highlights and accomplishments have been categorized as *Community Outreach & Engagement* or *Strengthening Cultural Competency and Practice*. The final sections of the report include a summary of the HEIs impact to date as well as recommendations for ODE and San Mateo BHRS to consider moving forward.

The report also includes three case studies to demonstrate the impact HEIs have had at a systems-level. Information for the case studies was gathered during semi-structured phone interviews with a representative from each of the three HEIs (the Chinese Health Initiative, the PRIDE Initiative, and the Spirituality Initiative). While all HEIs contribute to BHRS and community wide system-level changes, as can be seen in the HEI key highlights and accomplishments sections, due to limited resources three were selected to provide in-depth examples of their impact.

Data Sources and Limitations

The Harder+Company research team, with the support of ODE staff, identified and obtained existing data sources from each of the HEIs: HEI webpages; quarterly reports and work plans; logic models; and/or additional reports produced by various HEIs. Materials were reviewed and key events, accomplishments, goals and

[1] In the field of evaluation, the term "impact" is primarily used when discussing findings from a specific type of an evaluation, an impact evaluation. Here, the term is used to describe the perceived benefits and effects the HEIs have had on community members, San Mateo BHRS staff, and systems of care as an impact evaluation design was not feasible for this report.

objectives were noted.

While we were able to collect information about each of the nine HEIs, it is important to acknowledge the limitations of our data sources. The information found in the quarterly reports includes process-type information, such as copies of meeting agendas, meeting minutes, and sign-in sheets. While this information provides details regarding events and activities each of the HEIs planned or participated in, it does not always include additional information regarding content of the events, attendance, or participant feedback. Furthermore, quarterly reports were not consistently submitted by the HEIs. As such, this report may not accurately reflect all of the work each of the HEIs has conducted over the past several years. It is also important to note that at the time of writing this report, the HEIs were in the process of developing work plans for 2017-2019.

Background

Office of Diversity and Equity

The Office of Diversity and Equity (ODE), a department within San Mateo County's Behavioral Health and Recovery Services (BHRS) division, is dedicated to supporting the wellness and recovery of under- and inadequately-served communities in San Mateo County. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services, ODE works to promote cultural competence and cultural humility within the County's behavioral health service system. A report detailing their principles and approach to providing services, as well as the initial efforts of many of the Health Equity Initiatives, were documented in a 2014 report, *Eliminating Disparities, Inequities, & Stigma in Behavioral Health*.[2]

History

The Mental Health Services Act (MHSA) provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County this led to the formal establishment of ODE in 2009. ODE serves as a resource for trainings, thought partnership, and recommended best practices concerning health disparities, health equity, cultural competence, and cultural humility for BHRS staff and partner agencies throughout San Mateo County. Before becoming formally recognized in 2009, the origins of ODE began in the late 1990s when a few BHRS staff members would informally meet to discuss issues of race, ethnicity, and culture within their clinical work. Many of these members now serve on the Diversity and Equity Council, one of the nine Health Equity Initiatives within ODE. (Please see the timeline on the following pages for additional historical information.)

Vision

As the number of staff within ODE has increased over the years, the vision of the department's work has also grown. While ODE staff and programs bring a lens of cultural humility and health equity when approaching their work, they would like these principles and associated practices to be adopted, implemented, and reflected in all BHRS programs. This also includes acknowledging the impact of systemic and institutional barriers that may be perpetuated within the BHRS system of care and the quality of services community members receive.

ODE's Health Equity Initiative Strategy

The HEI strategy was created to address access and quality of care issues among

[2] A full copy of this report is available to download on the ODE website, www.smchealth.org/ode

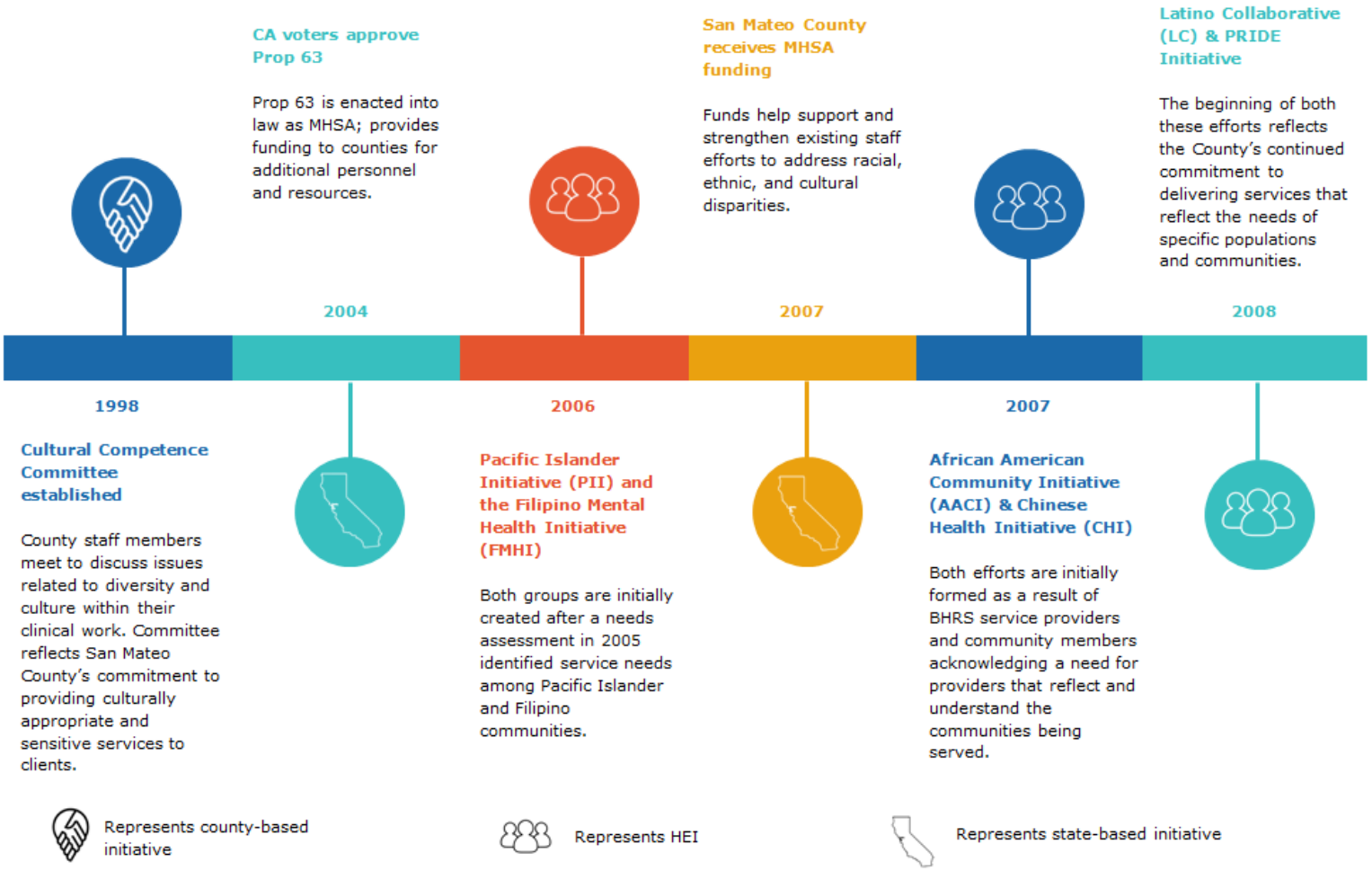
underserved, unserved, and inappropriately served communities. ODE provides oversight to nine Health Equity Initiatives (HEIs) representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino Collaborative; Native American Initiative; Pacific Islander Initiative; PRIDE Initiative; Spirituality Initiative; and the Diversity and Equity Council.

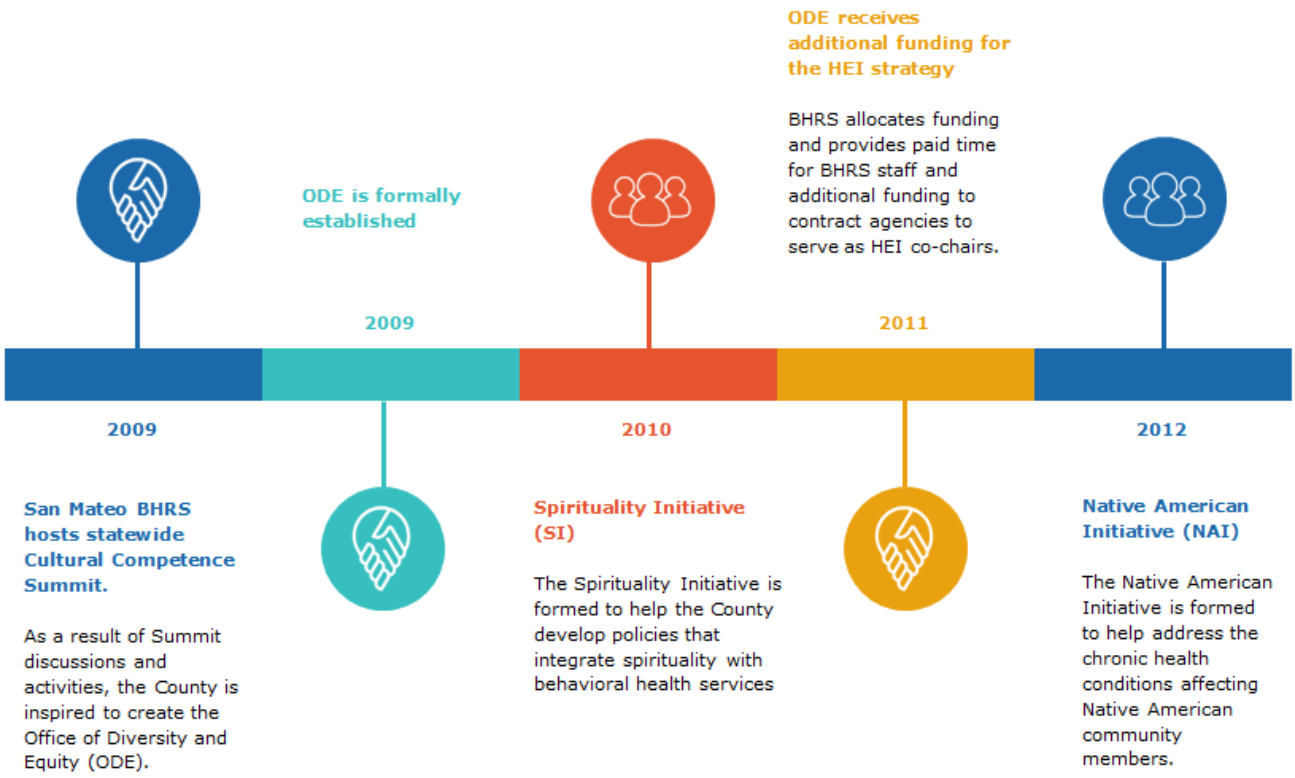
HEIs are comprised of San Mateo BHRS staff, community-based health and social service agencies, clients and their family members, and community members. The HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader.

HEIs implement activities throughout San Mateo County that are intended to:

- Decrease stigma
- Educate and empower community members
- Support wellness and recovery
- Build culturally responsive services

Timeline of ODE & the HEIs




2009
ODE is formally established
2009
2010
Spirituality Initiative (SI)
The Spirituality Initiative is formed to help the County develop policies that integrate spirituality with behavioral health services
ODE receives additional funding for the HEI strategy
BHRS allocates funding and provides paid time for BHRS staff and additional funding to contract agencies to serve as HEI co-chairs.
2011
2012
Native American Initiative (NAI)
The Native American Initiative is formed to help address the chronic health conditions affecting Native American community members.
San Mateo BHRS hosts statewide Cultural Competence Summit.
As a result of Summit discussions and activities, the County is inspired to create the Office of Diversity and Equity (ODE).

African American Commmuity Initiative

Background

African American Community Initiative (AACI) efforts began in 2007 and were led by African American BHRS staff members committed to: increasing the number of African American clinicians working within BHRS; improving the cultural sensitivity of clinicians to better serve the African American community; and empowering African Americans to advocate for equality and access to mental health services. The AACI works towards these goals by providing support and information about mental health and recovery services to BHRS clients and San Mateo County residents.

Prior to formalizing itself as the AACI, the group met informally and in November 2007, hosted a roundtable discussion with BHRS staff, representatives from community-based organizations, service providers, and community members to identify and discuss the mental and physical health needs of African Americans in San Mateo County. Roundtable attendees also considered issues of recruitment, retention, and promotion of African American staff within the San Mateo County Health System. Discussion participants identified a need for more African American clinicians within San Mateo County, as well as clinicians that implement culturally sensitive and appropriate practices.

Mission, Vision, and Objectives

The AACI has defined its vision as working to improve health outcomes and reduce health disparities for African Americans in San Mateo County and has identified the following objectives as necessary steps towards achieving this vision:

1. Increase **awareness** and **involvement** of community members in the African American Community Initiative

2. Increase **knowledge** and **utilization** of BHRS mental health services among African American community members in San Mateo County

3. Link African American community members to BHRS **education** and **training programs** such as Mental Health First Aid, Parent Project, and the Health Ambassador Program

4. Advocate for the **employment** of at least one African American clinician in each Community Service Area of San Mateo County BHRS

5. Provide San Mateo County BHRS with research regarding the African American community as a result of focus groups, **community-based research**, and surveying through the Office of Consumer Affairs

6. Conduct at least one annual **community-based outreach** event to build support for AACI

7. **Partner** with other organizations and HEIs to support AACI, African American clients, and professionals

Highlights & Accomplishments

Since its initial formation in 2007, the AACI has organized and participated in a number of events that help advance the objectives described above. Notable achievements include: establishing a partnership with the African American Community Health Advisory Council (AACHAC) which works with businesses, corporations, CBOs, health educators, and the faith-based community to promote health and wellness; consistent engagement of African American BHRS clients in AACI monthly meetings; and ongoing community outreach and wellness and recovery activities.

Community Outreach & Engagement

- Co-sponsor annual Black History Month Summits with AACHAC
- Attend and host workshops at the annual Family Awareness Night event sponsored by One East Palo Alto (approximately 150 attendees)[3]
- Participate and provide outreach services during the annual AACHAC's Women's Health Conferences and Men's Health Symposia (approximately 500 attendees/event)
- Organized community events, such as Family Day at the Park and African American Parents' Night
- Provide outreach services at various community events, such as Soul Stroll (approximately 1750 attendees) and Stand Up for Mental Health Wellness (approximately 100 attendees)
- Host Digital Storytelling and Wellness Recovery Action Plan® (WRAP) groups for San Mateo BHRS African American clients
- Provide resources and information regarding mental health and recovery services during the annual county-wide Recovery Happens resource fair (approximately 600 attendees)

Strengthening Cultural Competency and Practice

- Hosted *Upward Mobility in Behavioral Health & Recovery Services* Workforce Education and Training session
- Hosted Brown Bags and presentations for BHRS staff on a variety of topics, such as African American women and depression
- Produced a white paper presenting recommendations for hiring, supporting, and promoting African American staff and managers, as well as recommendations for mental health services for African American community members

[3] When available, we have included the approximate number of event attendees as noted in HEI quarterly reports

- Supervise Cultural Stipend Interns. Past interns have:

    - Conducted focus groups with African American BHRS clients. As a result of feedback received during the focus group, AACI organized a ten-week support group for African American clients.

    - Researched culturally-based practices for providers and recommend implementing a manual entitled *Empathize, Engage, and Empower: A Training Manual for Mental Health Professionals to Build Individual, Organizational, & System Level Cultural Competence Working with African American Male Youth*

Chinese Health Initiative

Background

The Chinese Health Initiative (CHI) efforts began in 2007 by San Mateo BHRS staff members who were committed to providing and advocating for culturally and linguistically accessible and responsive services within the San Mateo County Health System. By collaborating with partners, conducting community outreach, and providing service referrals, CHI members work to empower Chinese residents to seek services for mental health and substance use issues.

Mission, Vision, and Objectives

The Chinese Health Initiative works to improve engagement and utilization of BHRS mental health and substance abuse services among Chinese community members. In order to ensure the services Chinese clients receive are culturally-sensitive and appropriate, CHI works to increase provider capacity to serve Chinese clients by advocating for the hiring of Chinese staff who are able to reflect the culture and language needs of Chinese clients.

Much of CHI's work is focused on reducing the stigma associated with seeking services for mental health issues and accessing care provided through the County Health System. Recognizing a need for targeted community outreach and engagement, CHI advocated and received funding for a Chinese Outreach Worker position. This work is further described in the case study summary on page 13.

Highlights & Accomplishments

Since 2007, the Chinese Health Initiative has worked to ensure that BHRS services are culturally and linguistically appropriate, while also working to increase knowledge and utilization of BHRS services among Chinese community members.

Community Outreach & Engagement

- Organized Qi Gong trainings, a form of complementary medicine which has been found to help to reduce stress, increase vitality, and enhance the immune system
- Regularly solicit information regarding needs and concerns of Chinese community members by partnering with the local Sing Tao newspaper and Chinese radio station, local churches, elderly care facilities, and local high schools
- Conduct formal needs assessments, including supporting the Stanford Psychiatry Department with conducting mental health focus groups for parents and teens, and guiding 1,100 students at Mills High School in San Mateo through a student mental health needs assessment
- Facilitate monthly support groups for family members of individuals living with mental illness

- Provide resources and information to community members attending a number of events, including the California Health and Public Utilities Commission Health, Wellness, and Safety Expo (approximately 28 attendees), Millbrae Health Fair (approximately 30 attendees), Aragon High School Wellness Expo (approximately 150 students), Hillsdale High School Resource Fair (approximately 50 attendees), and various other educational and outreach events

- Provide targeted activities for various sectors of the Chinese community including clients, seniors, parents, students, and the community at large. Activities include:

    - Facilitated Wellness and Recovery Action Plan® (WRAP) in Cantonese and Mandarin for BHRS clients (approximately 8 attendees)

    - Partnered with Self Help for the Elderly to provide depression screenings, education, and referrals to seniors

    - Partnered with Stanford University to facilitate parent-child workshops for Asian families

    - Facilitated Digital Storytelling workshops with students at the College of San Mateo

    - Mentored high school students in developing a skit and accompanying workshop about body image

    - Hosted the *Cultivating Wellness Forum* with San Mateo BHRS employees, community agencies, providers, and community members on topics related to cultivating mental wellness for the Chinese community

    - Organized presentations (e.g., *Achieving Success and Balance in the Modern Day*) at local high schools (approximately 87 attendees) and churches (approximately 50 attendees) to provide information to parents about the importance of mental wellness

- Promoted awareness about careers in mental health by participating at Career Day at local high schools, including collaborating with the Filipino Mental Health Initiative to co-host a Mental Health Careers Question and Answer session for students at Jefferson High School in Daly City

Strengthening Cultural Competency and Practice

- Host provider and education training workshops, such as *Indigenous Healing: Traditional Chinese Healing Practice (approximately 83 attendees), How to Work Effectively with Chinese Patients,* and *Problem Gambling in the Asian Population* (presented by NICOS-Chinese Health Coalition)

- In collaboration with the Psychiatric Training Program of the San Mateo Health System, offered a training to psychiatry residents on how to assess suicide risk among Chinese American immigrants using culturally-based evaluations (approximately 80 attendees)

- Regularly collaborate with other BHRS to staff to ensure services are culturally appropriate, such as partnering with an Alcohol and Other Drugs (AOD) Program Analyst to develop a focus group survey that was culturally appropriate for the Chinese community and inviting community members to review Chinese translated BHRS documents for linguistic accuracy and cultural sensitivity prior to making them available to clients

- Submitted a white paper entitled, *Recommendations for Improving Access for Chinese Speaking Residents of San Mateo County*

- Supervise Cultural Stipend Interns. Past interns have:

    - Compiled resources gathered during informational interviews with Bay Area service organizations focused on documenting accessible and culturally sensitive mental health resources for the Chinese community

Influencing Organization-Level Changes to Improve Access to Care

The Chinese Health Initiative (CHI) influenced system-level change in two large healthcare agencies that has led to improvements in serving the Chinese community in San Mateo County. Through a pilot project, which provided funding for a Chinese Outreach Worker, CHI contributed to the creation of a mental health program in a local clinic, and helped develop and establish a screening and referral system within the largest healthcare plan in the County.

CHI first documented the need for a Chinese Outreach Worker position in a 2011 white paper they submitted to the Office of Diversity and Equity, describing the perceived underutilization of BHRS services among Chinese community members. A CHI member that was hired specifically to serve clients preferring to receive services from a Chinese-speaking clinician noted that during her first five years she served less than 10 Chinese-speaking clients. Additionally, clinicians facilitating a Chinese Family Support Group discovered that many Chinese individuals had little knowledge about available mental health and recovery services. During these support group sessions, clinicians came to understand the challenge of overcoming stigma associated with mental health within the Chinese culture. As it is common in Chinese culture to minimize the severity of one's problems or issues, when Chinese clients are asked to explain and describe their issues during intake and assessment sessions, many do not feel comfortable sharing the severity of their issues, resulting in many not meeting eligibility thresholds for services. In light of these factors, CHI advocated for a dedicated position to engage with community members in a culturally-appropriate manner that would hopefully lead to increased service utilization among Chinese residents of San Mateo County.

The first Chinese Outreach Worker was hired in June 2014 and held the position until April 2015. During this time the Outreach Worker created linguistically- and culturally-appropriate outreach materials, conducted outreach and education sessions to community organizations, created strong partnerships with other community based organizations, healthcare agencies and local high schools, and ultimately linked 42 Chinese clients to behavioral health services. The Outreach Worker was also able to establish an important and strategic partnership with North East Medical Services (NEMS) in Daly City. As a result of this partnership, NEMS gained a better understanding of the types of services and programs offered within BHRS and began to refer more clients for services. Additionally, as CHI and NEMS began to discuss the mental health needs of the Chinese population within the County, it became clear that there was a need for services for individuals with mild-to-moderate health issues that fall outside of the targeted scope of Severe Mental Illness (SMI) as determined by MHSA. As a result, **NEMS decided to open their own Mental Health Services program within their Daly City clinic.** The Outreach Worker was eventually hired by NEMS to assist with patient outreach and engagement.

The second Outreach Worker held the position from January 2016 – June 2016 and was able to continue expanding on and establishing key partnerships with agencies, community organizations, and local schools. In particular, a collaboration with the Health Plan of San Mateo (HPSM) and the Access Center of BHRS, led to the development of **a screening and referral system for Chinese-speaking primary care clients.** The Outreach Worker worked with HPSM staff to create a protocol for referring patients to the BHRS Health System, and with the help of HPSM was able to identify all Chinese-speaking primary care providers in San Mateo County. The Outreach Worker personally reached out to each provider and shared information about the referral protocol.

The current Outreach Worker started in October 2016 and continues to build on previous efforts, including expanding upon the referral system to include education to staff regarding mental health screening, training on the use of a Chinese translated depression screening tool, and piloting the usage of an anxiety screening tool in adult, child, and adolescent populations.

CHI members have identified several challenges limiting the success and potential of this position. The Chinese Health Outreach Worker position is funded as a part-time position with no benefits. As such, it has proven to be challenging to recruit and maintain qualified applicants. CHI members would like to see the position funded as a full-time position including benefits with the hope that this will help attract applicants and decrease turn-over.

Filipino Mental Health Initiative

Background

The Filipino Mental Health Initiative (FMHI) formed as a result of a series of focus groups conducted in 2005 by San Mateo County BHRS. During these focus groups, community members, providers, and staff members discussed issues pertaining to mental health, stigma, and barriers to accessing care among Filipinos living in San Mateo County. Following these focus groups, in 2006 interested members formed a group with funds made available from the Mental Health Services Act to support Filipino families not yet connected to services. In 2010, FMHI was formally established as one of ODE's nine Health Equity Initiatives.

Mission, Vision, & Objectives

The FMHI seeks to improve the well-being of Filipinos in San Mateo County by reducing the stigma associated with mental health issues, increasing access to services, and empowering the community to advocate for their mental health. The FMHI works to connect individuals to appropriate health, mental health, and social services through community outreach and engagement. By collaborating and working with providers, the FMHI also works to ensure that culturally appropriate services are available to Filipino residents.

Highlights & Accomplishments

For over the past ten years, FMHI members have worked with community members and community-based agencies to provide opportunities for young adults, parents, and individuals to discuss mental health issues in the context of Filipino cultural values and traditions. FMHI members also serve on one of three subcommittees focused on addressing the various cross-sections of the Filipino community: youth, elders, and LGBTQ individuals.

Community Outreach & Engagement

- Regularly provide targeted presentations and workshops on behavioral health related topics for various sectors of the Filipino community, including clients, senior citizens, parents, and students.
    - Collaborate with local high school students to provide mental health workshops, including an 8-week course at Westmoor High in Daly City
    - Facilitated a workshop about identity development and mental health during the *24th Annual Uniting Pilipino Students for Success (UPSS)*(approximately 12 workshop attendees)
    - Conducted a mental health awareness presentation and coordinated a Mental Health First Aid training with a local church for Filipino older adults

- Organized and conducted community presentations entitled, *How to be Successful in High School and Beyond*. The presentations provided an overview of the types of mental health challenges that may emerge during adolescence and included information about social media and on-line bullying. Separate community presentations were designed for both students and parents

- Regularly host "Sala Talks" with Filipino youth attending local high schools. These events create an informal space for Filipino youth to discuss issues and challenges they may be experiencing, such as anxiety about college, intergenerational differences with parents/caregivers and coping with social/emotional stressors

- Develop multi-media behavioral health information for the Filipino community

    - Created a PSA available on YouTube titled, *A Family's Cry for Help*, which aimed to show the silent suffering that can exist in multi-generational Filipino households

    - Created a video, *Paving the Way for Community Wellness*, highlighting founding members and the origins of the FMHI; the video is used to in community events to provide information about mental illness in the Filipino community

    - Developed and disseminated over 5,000 community resource directories highlighting Filipino-specific services

    - Facilitated a three month Photovoice project with Filipino youth attending a local high school

- Co-sponsored a variety of community events such as, *Behind the Smiles: Coping with Life's Challenges* (approximately 30 attendees) and a screening of the film, *Mga Anino Ng Kahapon*, depicting a family's struggle with mental illness (approximately 60 attendees)

- Provide resources to community members attending community events, such as the *Filipino Health Day* (approximately 15 attendees), and *Alliance for Community Empowerment (ALLICE)* (approximately 150 attendees)

- In 2016, the FMHI celebrated their ten-year anniversary with a community resource event at the San Bruno Community Center. Community members learned about the signs and symptoms of emotional distress, met with local service providers, and received information about community-based resources

Strengthening Cultural Competency and Practice

- Conducted the first Filipino LGBTQ needs assessment in San Mateo County to learn how to engage and better serve the community

- Signed an agreement with the Philippine Consulate to support those immigrating from the Philippines, FMHI serves as a primary resource for this community in San Mateo County

- Assisted in establishing a sister-chapter of FMHI in San Francisco

- Initiated a monthly case consultation group for providers to discuss mental health issues specific to the Filipino-American culture

- Supervise Cultural Stipend Interns. Past interns have:

    - Conducted a series of focus groups with Filipino BHRS providers to identify potential barriers Filipinos may experience when pursuing a career in mental and behavioral health

    - Developed and administered a survey to assess stigma within the Filipino community in San Mateo County

    - Collaborated with local colleges to provide mental health forums, education, and information to Filipino students about working in the mental health field

    - Provided regular trainings for providers to learn how to serve Filipino clients with cultural humility, respect, and awareness

    - Coordinated with local faith-based clergy to help them identify signs and symptoms of mental distress and how/where to direct members to seek services

Latino Collaborative

Background

While the Latino Collaborative (LC) efforts began in 2008, its founding members have been committed to giving voice to the Latino community since the late 1980s. During these initial meetings, a small group of Latino providers met informally to address issues pertaining to health disparities and access within the Latino community and San Mateo County mental health services.

These meetings continued and in 2004, a core group of Latino providers requested a Latino-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino population.

Also in 2004, at the request of the State Department of Mental Health, San Mateo County participated in a Latino Access Study, which explored barriers Latinos experience when attempting to access mental health services. Findings from the study, and insight gathered during years of meeting informally, helped Latino providers engage in a dialogue with other County staff and supervisors about how the County could address the needs of the Latino community.

The LC continues to focus on increasing access to services and culturally sensitive treatment. LC members believe that mental health and substance use services that integrate Latino culture, heritage, spirituality, and family values will lead to improved health and well-being among Latino clients.

Mission, Vision, & Objectives

The LC's mission includes critically exploring the social, cultural, and historical perspectives of Latino residents within San Mateo County. The LC gives a voice to the Latino community by working together to support mind, body, soul and healthcare practices that are culturally appropriate. The LC has defined its mission as:

1. Creating stronger, safer, and more resilient families through holistic practices
2. Promoting stigma-free environments
3. Providing fair access to health and social services, independent of health insurance coverage
4. Appreciating and respecting traditional practices
5. Recognizing and incorporating Latino history, culture, and language into BHRS

Highlights & Accomplishments

The LC's long-standing commitment to honoring the cultural and historical perspectives of Latinos has resulted in the creation of services, events, and resources that are grounded in the principles of cultural humility.

Community Outreach & Engagement

- Presented at the Latino Behavioral Health Institute Conference and California State Cultural Summit
- Hosted a drumming event with Drs. Sal Nunez and Concha Saucedo entitled, *Drumming & Spirituality as a Method of Healing* (approximately 80 attendees)
- Regularly partner with community organizations and agencies to host an annual Latino Health Forum, *Sana, Sana, Colita de Rana!* The multigenerational family event includes panel discussions on a variety of topics, including diabetes, nutrition, depression, and anxiety. The forum also provides space for discussion of issues that are of particular concern for Latino community members, such as stigma, immigration, poverty, and oppression (approximately 300+ attendees).
- Collaborated with Peninsula Conflict Resolution Center to host a "generational fishbowl" to address youth gang violence in South San Francisco
- Collaborate with various cross-sector agencies, such as those focusing on housing, to provide support to low-income Latino families in need
- Partner with Alcohol and Other Drug (AOD) Services to decrease the stigma experienced by many in the dual-diagnosis community

Strengthening Cultural Competency and Practice

- Presentation to providers entitled, *Devils, witches, evil eye, and other themes found in Latino clients who have been diagnosed with a psychotic disorder: Cultural themes or psychosis?*
- In partnership with Workforce Development, supported a mentoring program for staff regarding clinical, administrative, clerical, and management-level professional development
- Presentation to providers entitled, *Clinical Supervision & Consultation: A Multicultural Perspective*
- Presentation to 16 MSW students at Cal State University, East Bay entitled, *Using Culture to Create a Familiar Environment for Clients*
- Ongoing participation in Spanish-speaking county-wide consultation team meetings to discuss clinical cases

Native American Initiative

Background

The Native American Initiative (NAI) is one of the newer Health Equity Initiatives, established in 2012. Inherent to their work is building appreciation and respect for Native American history, culture, and spiritual healing practices.

Mission, Vision, & Objectives

The NAI has defined its mission as generating a comprehensive revival of the Native American community in San Mateo County by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices.

The NAI's vision is to provide support and build a safe environment for the Native American community in San Mateo. Additionally their goal is to appreciate and respect Native American history, culture, spiritual, and healing practices. The NAI strives to reduce stigma, provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners.

The NAI has further developed and articulated the following objectives:

1. **Increase Awareness:** Improve visibility of the challenges faced by Native Americans and provide support for the Native American community in San Mateo.

2. **Outreach and Education:** Outreach to and educate San Mateo County employees and community partners on how better to serve the Native American community.

3. **Welcome and Support:** Welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating the San Mateo County health care system.

4. **Strengthen our Community:** Provide opportunities for Native Americans to strengthen their skills and create collaboration for guidance, education, and celebration of the Native American community.

Highlights & Accomplishments

The NAI has not only provided mental health resources to San Mateo County residents, but has also contributed to the professional development of San Mateo BHRS providers through trainings and workshops Initiative members have organized.

Community Engagement & Outreach

- Provide resources during the annual county-wide Recovery Happens resource fair (approximately 600 attendees)

- Attended the Chico-Historical Trauma and Native Americans conference

Strengthening Cultural Competency and Practice

- Foster relationships with Native American/indigenous organizations across the region and refer Native American and indigenous clients to culturally appropriate out-of-County resources (when appropriate)

- Organized and facilitated a discussion for BHRS staff, partner agencies, and community members, entitled *Historical Trauma and Native Americans* (approximately 26 attendees)

- Organized and facilitated a discussion of substance use among Native Americans, with a particular emphasis on dispelling myths about how Native Americans were introduced to alcohol

- Wrote *California Reducing Disparities Project: Native American Strategic Planning Work Group Report*, which included recommendations for creating culturally competent prevention and early intervention efforts to promote the well-being of Native Americans in San Mateo County

Pacific Islander Initiative

Background

The Pacific Islander Initiative (PII) was initially formed by community members and BHRS staff in 2006 after a needs assessment conducted in 2005 identified particular areas of need among Pacific Islanders living in San Mateo County. The PII focuses on addressing health disparities within the Pacific Islander community by working to make services accessible and culturally-appropriate and by increasing awareness of and connections to existing mental and behavioral health services.

Mission, Vision, & Objectives

The PII's mission is to raise awareness of mental health issues in the Pacific Islander community in order to address the stigma associated with mental illness and substance abuse.

The PII envisions a healthy community that feels supported by service providers, is accepting of individuals experiencing mental illness or substance abuse challenges, and is knowledgeable of the various resources and services that are available to address mental and behavioral health needs.

The goals and objectives of the PII are organized into three main categories and listed below.

- **Education and Awareness**: Increase the visibility of challenges experienced by Pacific Islanders and promote community resources that support the Pacific Islander community.
- **Prevention**: Actively support activities that promote positive behavioral and physical health through community engagement.
- **Capacity Building and Leadership**: Provide opportunities for service providers and local Pacific Islander leaders to develop their skills and capacity for providing services to Pacific Islanders that are culturally appropriate.

Highlights & Accomplishments

The PII's commitment to actively supporting and engaging with community members has allowed members to become trusted and valued resources within the community. This is particularly evident in the support they have provided family members and caregivers, as detailed below.

Community Outreach & Engagement

- To date the PII has facilitated five Pacific Islander-focused Parent Project sessions in East Palo Alto, South San Francisco, Redwood City and San Mateo (approximately 100+ parent participants)
- Co-facilitated East Palo Alto Mental Health Support Groups

- At the request of the San Mateo Police Department, PII members were asked to participate in and provide translation services during a mediation meeting between police officers and family members of a Tongan woman who committed suicide

- Hosted "fishbowl" forums that provide an opportunity for youth and parents to communicate openly with one another. The forums also provide a space for parents and children to discuss differences in Pacific Islander and American cultures (approximately 50+ attendees)

- Collaborate with other community-based initiatives and service agencies, including Journey to Empowerment, Samoan Mental Health Initiative, and the Mouton Center, to provide resources and information to Pacific Islander community members

- Created an Anti-Stigma vignette that focused on stigma of mental health in the Pacific Islander community

- Hosted a Pacific Islander Wellness Resource Fair with presentations on mental health, resources, and screenings

Strengthening Cultural Competency and Practice

- Provided training on Pacific Islander cultural sensitivity to the Youth and Adult Care Teams at Central County Clinic

- Provided "How to serve the Pacific Islander community" trainings to providers

- PII members participated in a training to become Digital Storytelling workshop facilitators and Mental Health First Aid trainers. As part of the Digital Storytelling training, participating members created digital stories presented as part of a community outreach event (approximately 56 attendees)

PRIDE Initiative

Background

The PRIDE Initiative was founded in April 2007, and was one of the first LGBTQ-focused efforts in San Mateo County. The Initiative is comprised of individuals concerned about the well-being of lesbian, gay, bisexual, transgender, queer, questioning, and intersex individuals (LGBTQQI) in San Mateo County.

Mission, Vision, & Objectives

The PRIDE Initiative has defined its mission as being committed to fostering a welcoming environment for the lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQQI) communities living and working in San Mateo County through an interdisciplinary and inclusive approach. The Initiative collaborates with individuals, organizations, and providers working to ensure services are sensitive and respectful of LGBTQQI issues.

PRIDE envisions an inclusive future in San Mateo County grounded in equality and parity for LGBTQQI communities across the County.

PRIDE objectives have been defined as:

1. Engage LGBTQQI communities
2. Increase networking opportunities among providers
3. Provide workshops, educational events, and materials that improve care of LGBTQQI individuals
4. Assess and address gaps in care.

Highlights & Accomplishments

While the PRIDE Initiative organizes a number of community-based events, one of their most notable accomplishments has been the establishment of an annual county-wide LGBTQQI pride celebration. Following the inaugural Pride Parade and celebration in June 2013, the Board of Supervisors formally recognized June as LGBTQ Pride Month in San Mateo County.

Community Outreach & Engagement

- Hosted Transgender Day of Visibility and LGBTQQI Community Nights (approximately 100+ attendees)
- Attend and share resources during the annual county-wide Recovery Happens resource fair (approximately 600 attendees)
- Regularly provide resources and information to community members attending events, such as the Daly City Youth Health Center Health Fair (approximately 120 attendees), the Westmoor High School Health Fair (approximately 200 attendees), and the San Mateo County

Cultural Fair (approximately 200 attendees)

- Support the San Mateo Youth County Commission as "Adult Allies"
- Established the inaugural county-wide Pride celebration and continue to organize Pride events each June. Prior to PRIDE's work, no formal Pride events took place within the County.

Strengthening Cultural Competency and Practice

- The PRIDE Initiative regularly provides trainings to other programs within the County about LGBTQQI issues and how to better serve LGBTQQI clients, such as the *Transgender 102 Seminar Series* (approximately 45 attendees)
- Facilitated an *LGBTQ 101* training for the Mental Health Association (approximately 19 attendees)
- Facilitated a training focused on how to work with LGBTQ seniors for the Daly City Partnership's Healthy Aging Response Team hotline volunteers (approximately 12 attendees)
- Support Cultural Stipend Interns. Past interns have:
    - Established strong partnerships with other HEIs to help facilitate outreach to other communities
    - Developed a communications plan to increase the PRIDE Initiative's online and social media presence
    - Created an LGBTQQI-focused training manual for behavioral health providers

Advocating for Culturally Responsive Services

While establishing and organizing annual Pride events has been a key success of the PRIDE Initiative, the more recent success of advocating for funding to open San Mateo County's first LGBTQ Behavioral Health Coordinated Services Center (The Center), has the potential to greatly impact the types and quality of services available to LGBTQQI individuals living in San Mateo County.

The PRIDE Initiative was instrumental in the development of a proposal for The Center. The strength of the proposal was a key factor in the County's decision to award MHSA Innovation funds to open the proposed center.

The proposal explained that LGBTQQI individuals are at increased risk for mental health disorders given their experience with stress related to subtle or overt acts of homophobia, biphobia, and transphobia, and as such, need access to service providers and resources that are reflective and sensitive of their experiences and needs. The proposed Center will be a collaboration of multiple agencies that will work to provide support to high-risk LGBTQQI individuals through peer-based supports, with the goal of becoming a centralized resource for mental health services. The PRIDE Initiative hopes the Center will promote interagency collaboration, coordination, and communication, which will lead to increased access to mental health services among LGBTQQI individuals, and ultimately, improved mental health outcomes.

When reflecting on the MHSA Steering Committee's decision to pursue Innovation funds for the proposed Center, a PRIDE Initiative member identified three key factors that contributed to the decision. First, the number of people interested in participating in the PRIDE Initiative has increased each year. This increase is in part due to exposure the Initiative receives each year during the annual Pride event, as well as the increased social media presence the Initiative has as a result of the work of PRIDE Initiative interns. Secondly, San Mateo County is supportive of LGBTQQI efforts and continues to increase its understanding of why LGBTQQI-focused services are needed. Lastly, key leaders at various levels of San Mateo County (e.g., the Health System, Board of Supervisors, LGBTQ Commission, and community-based service agencies) have been supportive of the PRIDE Initiative's advocacy efforts to elevate the importance of providing LGBTQQIS-sensitive and appropriate services.

While the work of the PRIDE Initiative has contributed to county-wide recognition of LGBTQQI issues, the co-chair identified areas the Initiative is working to strengthen in the coming years. Namely, the PRIDE Initiative would like to strengthen its collaboration and partnership with other HEIs and the LGBTQ Commission. By collaborating with other HEIs, the PRIDE Initiative is hoping to increase its knowledge of LGBTQQI issues that are present within various cultures and communities. Additionally, the Initiative would like to engage in dialogue with HEI members about issues of intersectionality and how each HEI can work to understand and address topics of intersectionality that community members and BHRS clients may be dealing with.

The PRIDE Initiative co-chair also noted that it would be important to clarify and discuss the roles of the PRIDE Initiative, the LGBTQ Commission, and the type of partnership the two groups envision. While the two have co-sponsored events in the past, the opening of the LGBTQ Center provides an opportunity for both groups to collaborate and contribute to the Center's success.

Spirituality Initiative

Background

The Spirituality Initiative (SI) began in 2009, and works to foster opportunities for clients, providers, and community members to explore the relationship that spirituality has with mental health, substance use, and treatment.

As part of their planning process, the SI conducted a survey with clients, family members, and clinicians to assess and understand if and how spirituality plays a part in the lives of people dealing with mental and behavioral health issues. Results from this survey indicated that of the 482 community members that responded to the survey, approximately 80% strongly agreed or agreed with the statement, "Spirituality is important to me". Furthermore, 75% strongly agreed or agreed with the statement, "Spirituality is an important aspect of wellness and recovery and it should be incorporated in my mental health and substance abuse care." Among the approximately 200 BHRS service providers that completed the survey, 77% agreed or strongly agreed with the idea that spirituality is an important aspect of wellness and recovery, and should be incorporated into a client's care; however, only 42% of SMBHRS staff responded that they are encouraged to discuss spirituality with their clients. Results of the survey suggested that while spirituality may be an important part of a client's recovery, clinicians may benefit from resources and trainings about how to best engage clients in discussions about spirituality.

Mission, Vision, & Objectives

The SI envisions a health system that embraces and integrates spirituality when working with clients, families, and communities. They have defined three core principles that guide their work:

- **Hope.** The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.
- **Inclusiveness.** The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.
- **Cultural humility.** The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

The SI objectives include:

- Promote the vital role of spirituality in the recovery journeys of many who live with mental health and/or substance use conditions, those for whom faith is a key component
- Foster hope, which is a simple yet powerful tool that promotes recovery
- Welcome everyone into recovery regardless of their spiritual beliefs and practices
- Cultivate respect and openness, which are necessary for creating a welcoming space for everyone to recover within the greater community

- Provide basic mental health education to faith-based organizations and connect faith-based organizations with mental health educational classes or resources at BHRS

- Equip congregations to welcome and provide social support to individuals struggling to achieve mental wellness

Highlights & Accomplishments

The SI has demonstrated how an HEI can work to impact both individual and system-level change. By developing a Spirituality Policy (further described in the case study on the following pages) that shapes the practice of San Mateo BHRS providers system-wide, and offering trainings that work to change individual practices, the Spirituality Initiative is fostering change at multiple levels.

Community Outreach & Engagement

- Foster ongoing relationships and enable capacity-building with local faith leaders to help them respond to the behavioral health needs of congregation members

- Regularly participate in the annual Recovery Happens resource Fair (approximately 600 attendees)

- Participate in monthly state-wide conference calls with representatives from other counties to discuss strategies for addressing spirituality in mental and behavioral health counseling settings

- Facilitated a Digital Storytelling workshop with community members about spirituality and recovery

- Facilitated a Photovoice workshop with community members focused on exploring stigma and spirituality

- Attended the statewide California Mental Health & Spirituality Conference to provide technical assistance to other Counties that were looking to start a similar spirituality initiative; facilitated two workshops, one provided the history of the Spirituality Initiative in San Mateo County, the second focused on the integration of spirituality into the BHRS system of care

- Organized the first Interfaith National Day of Prayer and Recovery where diverse faiths, faith and secular leaders, and clients came together in the effort to unite in prayer, share information, remove stigma, blame, and fear associated with mental illness and substance use and share stories of faith and recovery

Strengthening Cultural Competency and Practice

- The Spirituality Initiative has designed and created a number of trainings and events for clinicians, service providers, and community members. Trainings include *Spirituality 101* and *Spirituality 102*, a six-week train-the-trainer program with San Mateo BHRS staff

- Developed a Spirituality Policy that was adopted by San Mateo BHRS to incorporate spiritual understanding into mental healthcare

- Developed various resources for providers including a Spirituality Postcard that lists how providers might explore spirituality with clients

- Presented at a Grand Rounds training, *Bridging Spirituality within Clinical Practice*, for San Mateo County physicians (approximately 70 attendees)

Creating Department-Level Policies and Trainings

After considering the results of their initial survey and discussing how best to engage San Mateo BHRS staff in spirituality-based discussions, the Spirituality Initiative designed a training program, Spirituality 101. This county-wide training was first conducted in 2011, and was focused on providing information about how the field of psychiatry could incorporate spirituality-related topics in their service models.

As a result of these trainings, the Spirituality Initiative discovered San Mateo BHRS would benefit from a policy that would guide providers as they begin to think about how to integrate spirituality into their work. The policy includes guidelines intended to assist clinical staff as they discuss and address the spiritual beliefs and practices of their clients. The document includes when and how clinicians may assess their clients' experience and beliefs regarding spirituality, and how the information they gather may inform their treatment plans. The policy also includes guidelines about what types of activities providers can and cannot engage in in order to comply with guidelines preventing state-sponsored religious activity.

In order to ensure the policy was understood by San Mateo BHRS staff, members of the Spirituality Initiative met with BHRS programs to review the content and intent of the policy and answer any questions individuals had about how to use the guidelines set forth in the policy. As a result of these meetings, the Spirituality Initiative designed two more county-wide Spirituality 101 and 102 trainings.

As the Spirituality Initiative has continued to strategically plan its work, they have moved away from providing large one-time trainings, and now plan and develop trainings as requested. BHRS programs, clinics, and community partner agencies will often submit a training request based upon their particular client population or program need. The Spirituality Initiative then plans, develops, and delivers a program that is tailored to the learning goals of a specific program or clinic. These trainings have been very well-received and the demand for trainings continues to increase.

The Spirituality Initiative is looking to strengthen and expand its work by continuing to develop and provide trainings for County programs, and hopes that by providing space for clinicians to review case studies, they will develop strategies for initiating spirituality-based conversations with their clients. Additionally, the Spirituality Initiative is hoping to collaborate with other HEIs to learn about the role spirituality plays in other communities and cultures, and how their trainings may be adapted to reflect the cultural context of various populations.

Diversity and Equity Council

Background

The Diversity and Equity Council (DEC) works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the Cultural Competence Committee. This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of the Office of Diversity and Equity.

Mission, Vision, & Objectives

The Council serves as an advisory board to assure San Mateo BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Highlights & Accomplishments

The DEC's enduring commitment to promoting the principles of health equity, cultural competency, and diversity within San Mateo BHRS helps ensure service providers and staff are equipped with the knowledge and skills needed to effectively serve the diverse members of San Mateo County. Since its inception, community participation in the meetings has grown and includes BHRS staff, community partner agencies, leaders, clients, and family members.

Community Outreach & Engagement

- Since 2013, sponsor an Annual Mental Health Awareness kick-off event and coordination of events across the county
- Conduct ongoing outreach to include community-based partners, clients, and family members in DEC meetings and events

Strengthening Cultural Competency and Practice

- Successfully advocated with the BHRS Director to provide compensation for HEI members that serve as leaders and co-chairs
- Developed internal workgroups (Linguistic Access, Co-Occurring, Workforce Development, and Legitimization) to help align DEC efforts with existing BHRS efforts
- Regularly consult with BHRS regarding contract monitoring and AVATAR assessments

- Regularly provide input and feedback for various San Mateo BHRS efforts, including the MHSA community planning process, and Workforce Education and Training planning

- Reserve time during each DEC meeting for "Diversity Dialogue"; this includes presentations from other DEC members, San Mateo BHRS staff, or community-based service agencies about resources, programs, and tools that are available to help address unmet needs and barriers to services that community members may experience

- In collaboration with Dr. Jei Africa, DEC developed a framework for ODE's approach to addressing health disparities, health inequities, and stigma associated with mental health and substance abuse. This framework, depicted in a "fish" diagram, illustrates the approach to cultural competency and humility employed by ODE and DEC. The (A copy of the fish diagram is included as Appendix 1)

- Collaborated with other HEIs to create and screen digital stories as a way to showcase diverse experiences with mental health and substance abuse

Summary of HEI Impact

Supporting the work of the nine Health Equity Initiatives is one way in which the Office of Diversity and Equity and San Mateo Behavioral Health and Recovery Services are working to support the wellness and recovery of under- and inadequately-served communities in San Mateo County. By investing in the HEI strategy, ODE and San Mateo BHRS are promoting efforts to address issues of health equity and social justice at the individual, institutional, and community levels. The cross-cutting themes that reflect the value and impact of the HEI's are summarized below.

The Health Equity Initiatives are integral partners in conducting meaningful and authentic community outreach and engagement.

- Based on the number of community events each of the HEIs have organized and hosted over the past ten years, we can estimate that thousands of individuals and families across San Mateo County have benefitted from the efforts of the HEIs.

- Given each HEI's focus on a specific population or community, targeted outreach efforts have been designed to reach racial, ethnic, and cultural communities that have been historically under-served within behavioral health and recovery services.

The knowledge, and lived experience of HEI members allows them to consider and address stigma-related issues that may be specific to certain populations and sub-groups.

- Having an understanding of how an individual's attitude towards mental health, substance abuse, and accessing services is shaped by their racial, ethnic, sexual, and gender identities allows HEI members to develop outreach materials, resources, and community events that reflect a nuanced understanding of stigma and barriers to accessing services.

Given the connections and relationships HEI members have with various community groups and populations, the HEIs have been able to increase awareness of BHRS services among San Mateo County residents.

- Being able to develop and design resources that reflect the cultural and linguistic needs of a population, allows the HEIs to disseminate information in a manner that reflects the language, values, and beliefs of a given population or community.

- Having access to information and resources that acknowledge an individual's identity and lived experience, provides community members with the opportunity to see their needs and beliefs reflected within the agency working to serve them.

The community knowledge and relationships HEI members possess, allows them to strengthen the practice of other San Mateo BHRS staff and community-based service agencies in order to better serve communities in culturally appropriately and respectful ways.

- HEI members are not only able to use their own experiences when sharing

how to work with a specific community or population, but are also able to draw upon information they gather from individuals and families while participating in community outreach and engagement efforts. This knowledge helps inform and shape San Mateo BHRS policies and practices that are responsive to community needs.

- The HEIs increase awareness and understanding among San Mateo BHRS staff regarding issues that affect the populations they serve by hosting brown bags, provider trainings, and inviting San Mateo BHRS staff to attend community-based events.

- By remaining connected to the community, the HEIs help keep San Mateo BHRS apprised of community issues and concerns in order to develop resources and information that are responsive to changing community need.

Recommendations & Considerations

In order to further the efforts and impact of each of the Health Equity Initiatives and advance system-level change towards addressing health inequities and racial disparities, we offer the following recommendations and considerations. These include process-type recommendations that will ensure the work and efforts of the HEIs are adequately documented and reported, as well as internal recommendations that consider how San Mateo Behavioral Health and Recovery Services may better support the HEIs.

Provide resources and supports to the HEIs to help with the development of workplans, quarterly reports, and annual reports. In speaking with members from some of the HEIs, it became clear that HEI co-chairs and members often do not have the resources needed to create and review workplans, compile quarterly and annual reports, and keep detailed records regarding events and activities.

- **Consider how the new Community Health Planner position may help support the HEIs.** The new Community Health Planner could offer support and capacity building to HEI co-chairs and members in order to better capture the work each of the HEIs produce. The Community Health Planner could meet with HEI co-chairs quarterly to review logic models, workplans, and quarterly reports to ensure HEIs are accurately capturing their efforts. The Community Health Planner could also help facilitate and document event or project debriefs/After Action Reviews.

- **Create dedicated HEI co-chair BHRS staff positions.** Currently, BHRS staff that volunteer as co-chairs are allotted four hours per pay period to support HEI activities and all HEI co-chair related work is performed in addition to co-chairs' full-time positions. While it is voluntary and a decision that is supported by their supervisors, it is often difficult for the co-chairs to consistently implement HEI workplans within the four hours allotted for co-chair duties. Additionally, in order to further promote the impact of the HEIs, it is necessary to commit staff hours to the work. BHRS positions that have integrated HEI responsibilities in their job descriptions will ensure consistency in the work and keep BHRS at the forefront of addressing health disparities, inequities, and stigma while increasing access to mental health and substance use service for communities most in need.

- **Regularly recognize and share HEI accomplishments and successes.** In order to increase support for and recognition of HEI efforts, we recommend highlighting HEI efforts with San Mateo BHRS staff and partners. Similar to the case studies included in this report, sharing key events, programmatic contributions, or HEI-developed materials will not only increase awareness of HEI efforts, but will encourage others to utilize the skills and expertise of HEIs when planning and designing events, activities, resources, etc.

Strengthen the documenting and reporting process for the Health Equity Initiatives. In order for the HEIs to make others aware of their accomplishments and efforts, it is important that their activities are consistently and thoroughly captured. Based on our review of the quarterly reports we have included specific recommendations below.

- **Consider revising the quarterly report template.** During our review of each HEI's quarterly reports, we encountered several limitations with trying to gain an accurate understanding of the work and accomplishments each of the HEIs have been responsible for. While this was in part due to the inconsistency of quarterly reports, the information included in the reports varied both within and among the HEIs. We recommend asking the HEIs to provide more information about key events, information related to planning events, and details about any partners they may have collaborated with. We also recommend asking the HEIs to report on workplan progress to date in the quarterly reports.

- **Encourage HEIs to conduct debriefs or After Action Reviews immediately following events or projects.** While the quarterly reports often listed the types of events HEIs organized or hosted, and/or included flyers and agendas from events, details were scarce about the perceived success of an event or project. Some HEIs did include event debriefs as part of their meeting minutes but it would be a helpful tool for all HEIs to conduct debriefs or After Action Reviews (AARs) (see Appendix 2 for a sample AAR). These debriefs or AARs would allow HEI members to celebrate their successes, reflect upon events or projects, document what worked well, and identify areas for improvement. The information gleaned from the AAR's (which should be documented) would be useful when developing workplans and refining HEI goals.

- **Require each HEI to submit a two-year workplan**. Very few HEIs had workplans (when available, most were for 2014-2016). Having the HEIs spend time revisiting their logic model, goals, and objectives will help with understanding how their various activities and events align to their overall goals and desired outcomes. Additionally, having documented workplans will help assess the progress and productivity of each HEI.

- **Consider implementing an annual report.** This report could expand upon the quarterly reports and ask HEIs to reflect on their workplan goals, as well as the goals identified in their logic model. Additionally, it would be valuable to ask the HEIs to reflect and document key successes and highlights from the year, as well as any challenges they experienced. Lastly, HEIs could include information about how the challenges and lessons learned during the year will inform planning for the next year and any potential revisions to their workplan. An annual report would allow the HEIs and the Office of Diversity and Equity to gather in-depth information pertaining to specific efforts or activities of the HEIs, similar to the case studies that are included in this report.

- **Consider conducting a rigorous evaluation of the HEI strategy.** After implementation of the aforementioned recommendations has been underway for a few years, it may be valuable to conduct a follow-up evaluation that is designed to further assess the impact of the HEI strategy. Having robust and consistent data across all of the HEIs, as well as increased capacity among HEI co-chairs, members, and BHRS staff will allow for engagement in additional data collection activities necessary for a more rigorous evaluation. In order to explore the impact the HEI strategy it will also be important to assess the perspectives and experiences of community members, community service agencies, and San Mateo BHRS

staff that have participated in HEI-organized events, trainings, workshops, support groups, etc. This type of data collection will require collaboration among HEI co-chairs and members, BHRS staff, community members, and an evaluator.

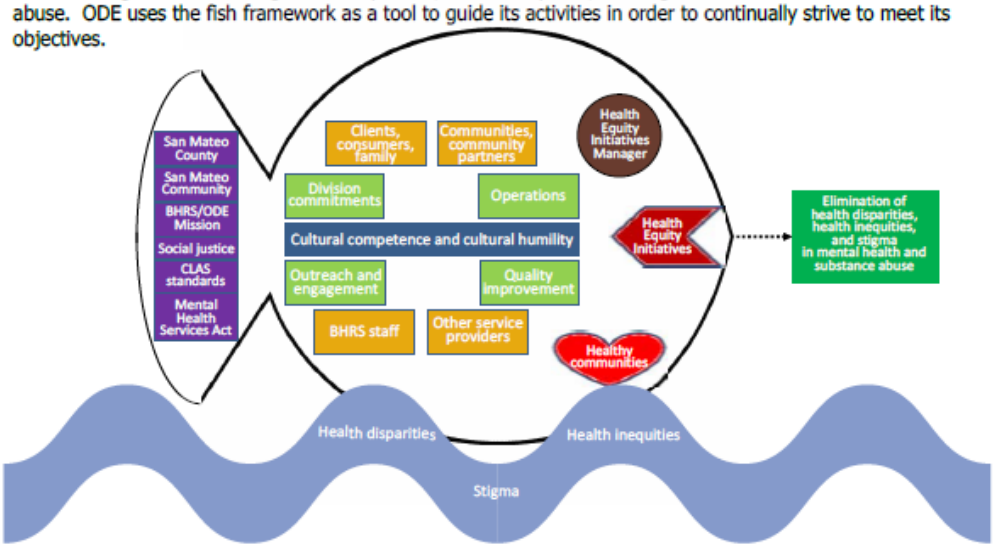
Provide opportunities for HEIs to regularly contribute to San Mateo BHRS decision-making and planning efforts.

- **Consider how HEI co-chairs and members can support San Mateo BHRS efforts to develop policies, practices, and programs to support the wellness and recovery of under- and inadequately-served communities in San Mateo County.** Given HEI co-chairs' and members' knowledge, experience, and ties to specific communities and populations, they have the potential to serve as valuable consultants as San Mateo BHRS develops and refines services and programs. San Mateo BHRS should also consider additional resources that can be allocated to help support HEI consulting services.

Appendix 1: DEC Fish Diagram

ODE's Framework

Rooted in a Japanese diagram *Ishikawa*, ODE's fish framework comprises elements and metaphors. This framework was adapted from the BHRS fish framework, which was developed through multiple discussions within the BHRS Cultural Competence Council about how to best meet the needs of San Mateo's diverse communities. The fish, a growing and evolving being, represents ODE's evolving and ever-adaptable approach to meet the goal of eliminating health disparities, health inequities, and stigma in mental health and substance abuse. ODE uses the fish framework as a tool to guide its activities in order to continually strive to meet its objectives.



The fins of the tail are the drivers of the fish. They propel ODE along on its path. These include San Mateo County, the San Mateo Community, BHRS/ODE's mission and values, social justice, Culturally and Linguistically Appropriate Services (CLAS) Standards, and the Mental Health Services Act.

The backbone of the fish is cultural competence and cultural humility. These concepts hold the fish together, and are the basis for all of ODE's work.

There are two types of main lifelines or organs of the fish. The first type represents the groups that ODE works with, including clients, consumers, family members, communities, community partners, BHRS staff, and other service providers.

The second type of organs represent ODE's activities, including Division commitments, operations and staff, outreach and engagement, and quality improvement.

The eye of the fish is the Health Equity Initiatives Manager, who provides the vision and oversight of the rest of the fish's body.

At the core or heart of the fish are healthy communities.

The mouth of the fish is the means by which it receives its nourishment. The Health Equity Initiatives that developed through staff and community collaboration and advocacy efforts provide numerous opportunities to network, dialogue, and influence system changes and practice.

Metaphorically, the fish is swimming upstream in waters filled health disparities, health inequities, and stigma.

Success is realized when the goal of eliminating health disparities, health inequities, and stigma for mental health and substance abuse is attained for the San Mateo community.

Appendix 2: Sample After Action Review Questions

After Action Review Sample Questions

Sample questions from betterevaluation.org

1. What was supposed to happen?
2. What actually happened?
3. Why were there differences between what was supposed to happen and what actually happened?
4. What worked?
5. What didn't work?
6. Why?
7. What would we do differently next time?

Sample questions from Fourth Quadrant Partners

1. What were our intended results?
2. What were our actual results?
3. What caused our results?
4. What will we sustain or improve?
5. What is our next opportunity to test what we learned?

NOTES

Behavioral Health & Recovery Services
SAN MATEO COUNTY
Office of Diversity and Equity

harder+co community research

harderco.com

Harder+Company Community Research works with public- and social-sector organizations across the United States to learn about their impact and sharpen their strategies to advance social change. Since 1986, our data-driven, culturally-responsive approach has helped hundreds of organizations contribute to positive social impact for vulnerable communities. Learn more at www.harderco.com. Follow us on Twitter: @harderco.

APPENDIX 14

CalMHSA Statewide PEI Project 2015-2016 County Impact Report: **San Mateo**

County FY 2015/2016 contribution to Statewide PEI Project:
$90,508.00 (2% of local MHSA PEI Funds)

In fiscal year 2015-2016, 42 counties collectively pooled local PEI funds through CalMHSA to support the first year implementation of the Statewide PEI Project. Statewide, the funding supported programs such as maintaining and expanding social marketing campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to counties, schools and local community based organizations, providing stigma reduction trainings to diverse audiences, and building the capacities of higher education schools to address stigma reduction and suicide prevention.

The information below highlights some key activities that were specifically implemented within San Mateo County in 2015-2016.

Agencies, Schools and Organizations Reached with Statewide PEI Programs
There were a total of 6 local agencies, schools and organizations that received outreach materials, training, technical assistance or a presentation about stigma reduction and suicide prevention through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

County agencies:

San Mateo County Behavioral Health
San Mateo Office of Education
San Mateo County Youth Commission

Schools:

Summit Public schools
College of San Mateo
Skyline College

Technical Assistance

Technical Assistance

- The EMM Resource Navigators attended and provided technical assistance at a meeting regarding student mental health at the request of San Mateo County Behavioral Health.
- The EMM Resource Navigators connected staff from San Mateo County to Dr. Patrick Arbor to speak at an event regarding older adults and suicide prevention.
- The EMM Resource Navigators reviewed the resources on the San Mateo County portion of the Know the Signs website and reviewed the instructions to update the resources. To support the county's communication team, the Know the Signs Guide to use Social Media for Suicide Prevention and social media posts in English and Spanish were shared.

- Received monthly emails from Resource Navigator, which included Each Mind Matters updates, description of new resources, and identifying relevant resources that support specific target audiences.
- County had continual access to a designated Each Mind Matters Resource Navigator.
- Had access to and participated in CalMHSA's monthly County Liaison calls.

Dissemination of outreach resources

Between July 1, 2015- June 30, 2016 a total of over 3,800 materials across Each Mind Matters programs and initiatives were disseminated throughout the county. In addition, the county received numerous reminders to access and share resources electronically via www.yourvoicecounts.org and http://catalogue.eachmindmatters.org/.

Directing Change Materials	81
Each Mind Matters Promotional Items	1,941
Know the Signs Outreach Materials	1,842

Directing Change

There were 2 Directing Change submissions from San Mateo County in 2016. Schools and/or organizations that submitted Directing Change videos included:

- San Mateo County Youth Commission
- Summit Public Schools

View the winning Directing Change videos developed within the county here: http://www.directingchange.org/films-by-county/#San Mateo.

Walk In Our Shoes

While there were no Walk In Our Shoes performances in San Mateo County, all counties had access to the parent and teacher tools and full Walk In Our Shoes performance on video at www.walkinourshoes.org.

Higher Education

College of San Mateo and Skyline College received Kognito mental health and suicide prevention online trainings, training a total of 944 individuals.

In addition, College of San Mateo was engaged in increasing the local capacity of its Active Minds Chapter, reaching students about mental health, stigma and suicide prevention.