MENTAL HEALTH SERVICES ACT

Annual Update for Programs & Expenditures
Fiscal Year (FY) 2024-25

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

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**This section to be completed after Board of Supervisor approval*

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INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

Located in the Bay Area, 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. Nearly three quarters of the county is open space and agriculture remains a vital contributor to the economy and culture. The County has long been a center for innovation. 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 County is committed to building a healthy community. The County of San Mateo Shared Vision 2025 places an emphasis on the interconnectedness of all communities, and specifically of county policies and programs. Shared Vision 2025 is for a sustainable San Mateo County that is 1) healthy, 2) prosperous, 3) livable, 4) environmentally conscious, 5) collaborative community.

BEHAVIORAL HEALTH AND RECOVERY SERVICES

Behavioral Health and Recovery Services (BHRS), a division of San Mateo County Health, provides services for residents who are on Medi-Cal or are uninsured including children, youth, families, adults and older adults, for the prevention, early intervention, and treatment of mental illness and/or substance use conditions. We are committed to supporting treatment of the whole person to achieve wellness and recovery, and promoting the physical and behavioral health of individuals, families and communities we serve.

The following statements were developed out of a dialogue involving consumers, family members, community members, staff and providers sharing their hopes for BHRS.

BHRS Vision: We envision safer communities for all where individuals may realize a meaningful life and the challenges of mental health and/or substance use are addressed in a respectful, compassionate, holistic and effective manner. Inclusion and equity are valued and central to our work. Our diverse communities are honored and strengthened because of our differences.

BHRS Mission

We provide prevention, treatment and recovery services to inspire hope, resiliency and connection with others to enhance the lives of those affected by mental health and/or substance use challenges. We are dedicated to advancing health and social equity for all people in San Mateo County and for all communities. We are committed to being an organization that values inclusion and equity for all.

BHRS Values

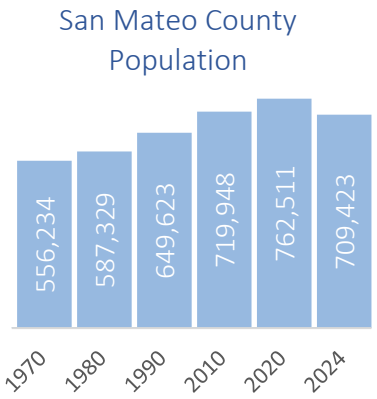
- *Person and Family Centered*: We promote culturally responsive person-and-family centered recovery.
- *Potential*: We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery
- *Power*: The people, families and communities we serve, and the members of our workforce guide the care we provide and shape policies and practices.
- *Partnerships:* We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity
- *Performance*: We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and additions and to promote the health of the individuals, families and communities we serve.

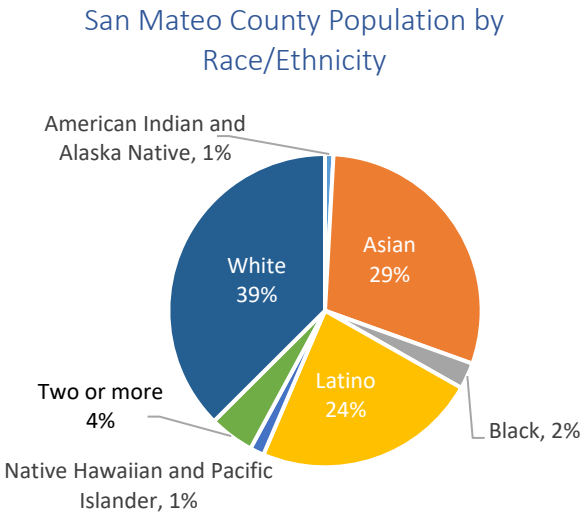
SAN MATEO COUNTY DEMOGRAPHICS

The 2024 estimated population of San Mateo County continues to decrease at 709,423 – with the largest decline of 3.1% between 2020 and 2021. Daly City remains the most populous city followed by San Mateo and Redwood City.

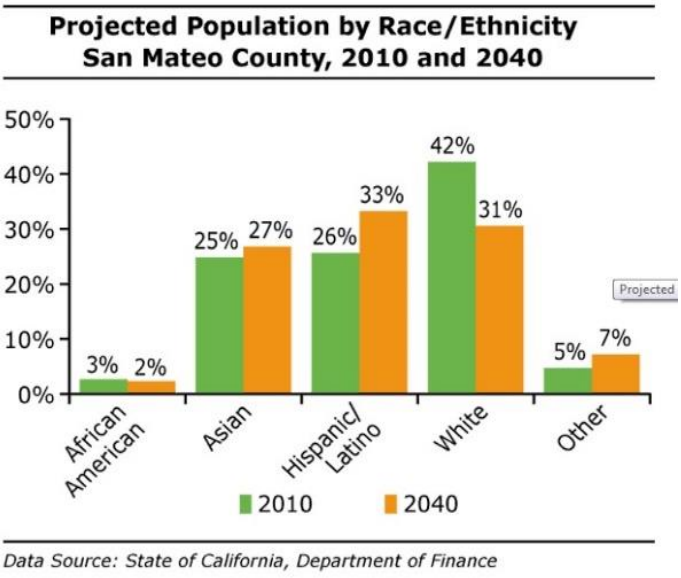
The estimated median age of residents is 39.8 and a median household income of $128,091. While The town of Portola Valley has the highest median age of 51.3 years while East Palo Alto a much less affluent community has the lowest at 28.1 years; an indicator of health inequities.

As the County's population continues to shift, it also continues to grow in diversity. 45.57% of residents speak a language other than English at home, and 35.01% are foreign born. San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog and Russian (as identified by Health Plan of San Mateo). County Health identified Tongan, Samoan as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.





By 2040, San Mateo County is projected to have a majority non-White population. The White population is projected to decrease by 11%. The Latino and Asian communities are projected to increase by 7% and 2%, respectively[1]. Additionally, the projected population by age group shows that residents 65 and older are projected to almost double.



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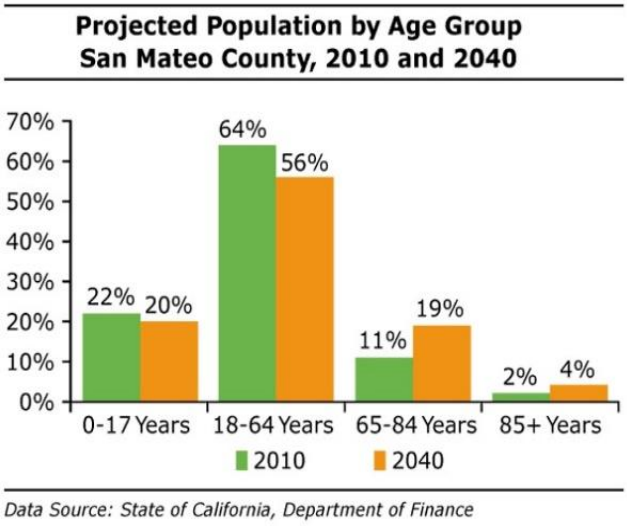


Data Source: State of California, Department of Finance

[1] sustainablesanmateo.org

MHSA BACKGROUND

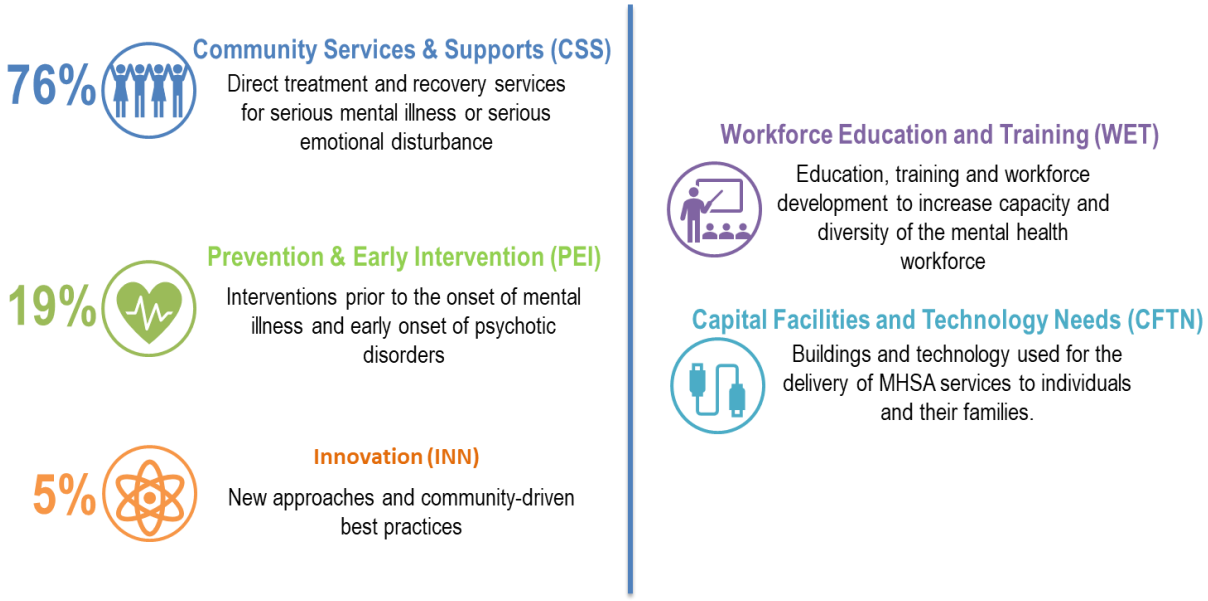
Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. San Mateo County received an annual average of $41.2 million, in the last five years through Fiscal Year (FY) 2022-23.

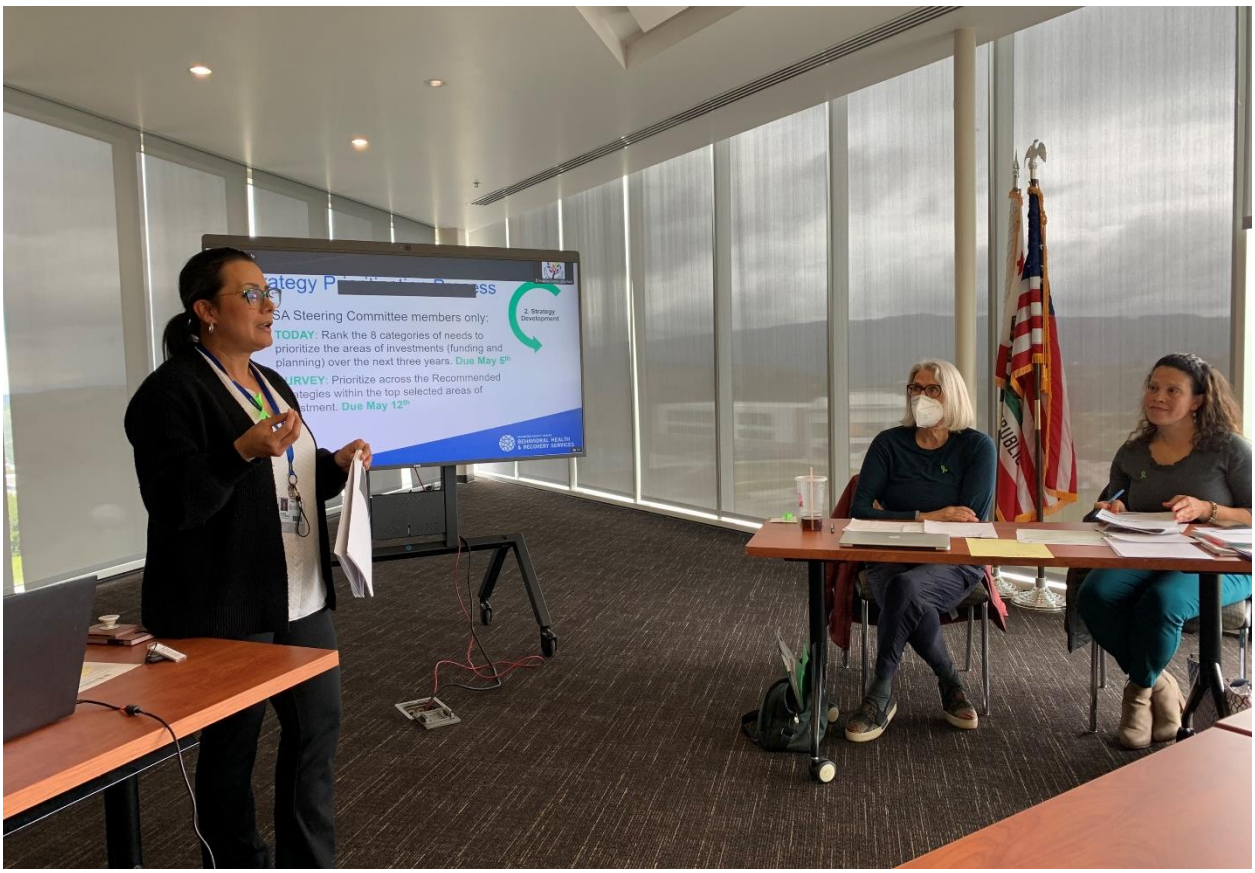
MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and guiding principles:

◆ 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. MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules:





COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING (CPP)

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 considered in MHSA planning. The Behavioral Health Commission (BHC), the local "mental health board", is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on their monthly meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates.

MHSA STEERING COMMITTEE

The MHSA Steering Committee continues to play a critical role in the development of MHSA program and expenditure plans in San Mateo County. 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.

MHSA Steering Committee Roles and Responsibilities were developed to strengthen the representation of diverse stakeholders by including member composition goals related to stakeholder groups (e.g., at least 50% represent clients/consumers and families of clients/consumers; at least 50% represent marginalized cultural and ethnic groups; maximum of two member representatives from any one agency, etc.). In response to ongoing feedback from stakeholders the MHSA Steering Committee was established as a standing committee in the by-laws of the BHC, San Mateo County's local mental health board, which requires the appointment of 1-2 chairperson(s) to the committee.

The MHSA Steering Committee meets four times per year in February, May, September and December. All MHSA Steering Committee meeting materials including slides, minutes and handouts can be found on the MHSA website, www.smchealth.org/MHSA, under the MHSA Steering Committee tab.

Fiscal Year (FY) 2023-24 MHSA Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization/Affiliation (If applicable)
Family Member	Jean Perry	MHSA Co-chairperson	Behavioral Health Commission, Lived Experience Education Workgroup (LEEW)
Public	Leticia Bido	MHSA Co-chairperson	Behavioral Health Commission
Client/Consumers	Jairo Wilches	Program Coordinator	BHRS, Office of Consumer and Family Affairs (OCFA)
Cultural Responsiveness	Maria Lorente-Foresti	Director	BHRS, Office of Diversity and Equity
Cultural Responsiveness	Kava Tulua	Executive Director	One East Palo Alto
Family Member	Chris Rasmussen	Chair	Behavioral Health Commission
Family Member	Juliana Fuerbringer	Board Member	California Clubhouse
Health Care	Jackie Almes	Youth Behavioral Health Programs	Peninsula Health Care District
Health Care	Jessica Ho/ Vivian Liang	Govt and Community Affairs Manager	North East Medical Services
Other - Peer Support	ShaRon Heath	Executive Director	Voices of Recovery
Provider of Behavioral Health Services	Adriana Furuzawa	Division Director	Family Service Agency
Provider of Behavioral Health Services	Melissa Platte	Executive Director	Mental Health Association
Provider of Behavioral Health Services	Mary Bier	Coordinator	North County Outreach Collaborative
Public	Michael Lim	Commissioner	Behavioral Health Commission, LEEW
Public	Paul Nichols	Commissioner	Behavioral Health Commission
Public	Sheila Brar	Commissioner	Behavioral Health Commission

STAKEHOLDER ENGAGEMENT

MHSA Steering Committee meetings are open to the public and diverse stakeholder participation is promoted through various means, including flyers, emails, announcements, postings, community partners, clients/consumers, community leaders, and the general public.

Representation Across Diverse Race/Ethnicity Demographics Groups

When comparing race/ethnicity demographics of MHSA Steering Committee participants to San Mateo County census data, all communities are represented. The most notable improvement is in the engagement of Asian/Asian American identifying communities, which were underrepresented by 10% in FY 2021-22 and 15% in FY 2020-21.

The following table includes San Mateo County demographics and MHSA Steering Committee participants demographics for unique participants throughout FY 2023-24.

San Mateo County Census Race/Ethnicity		Steering Committee Participation Race/Ethnicity	
White alone, not Hispanic	39%	White/Caucasian	39%
Asian	29%	Asian Indian/South Asian, Chinese, Filipino*	24%
Hispanic or Latino	24%	Hispanic/Latino/x	17%
Black or African American	2%	Black/African-American	9%
Native Hawaiian or Pacific Islander	1%	Native Hawaiian or Pacific Islander	4%
American Indian, Alaskan Native	1%		0%
Two or More	4%	Two or More*	4%
		Another Race/Ethnicity	0%

** Combined to allow for comparison as per MHSA legislation but, represented uniquely below*

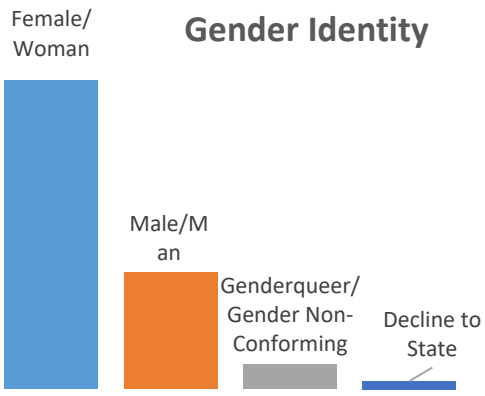
MHSA planning continues to engage diverse communities through regional collaboratives – North County Outreach Collaborative, the East Palo Alto Community Service Area and the Coastside Collaborative – and through the Office of Diversity and Equity's Health Equity Initiatives (HEIs). HEIs represent diverse cultural and ethnic groups including the African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Native and Indigenous Peoples Initiative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, and the Diversity and Equity Council.

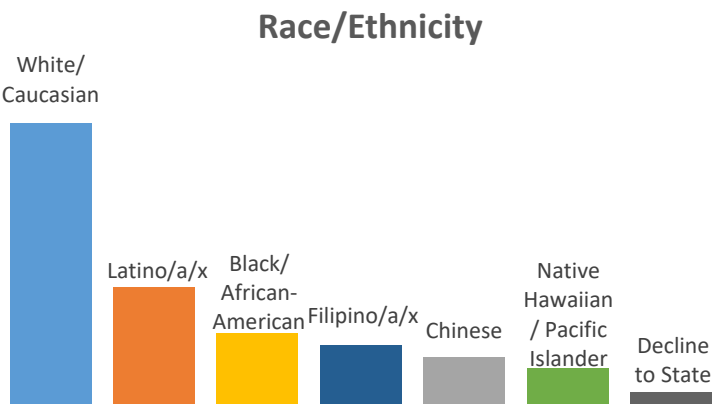
MHSA Steering Committee Participant Demographics, FY 2023-24

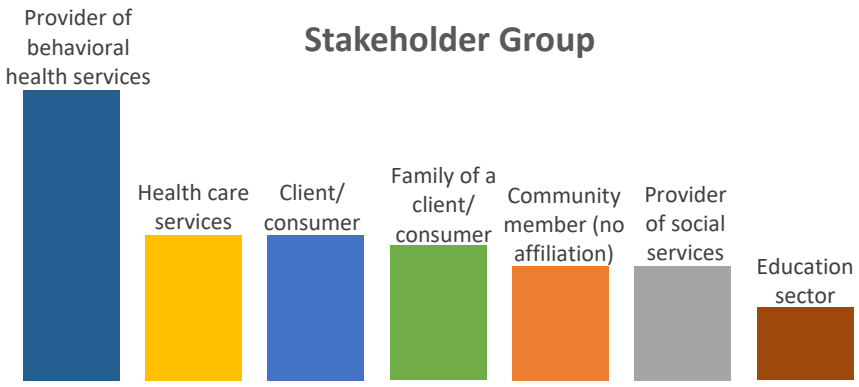
- Combined for Sep 2023, Dec 2023, and Feb 2024

What is your age range?	
16-25	4%
26-59	68%
60-73	28%

What part of the county do you live in or work in?	
Central County	49%
North County	13%
South County	13%
Coastside	4%
County-wide	15%
East Palo Alto/Belle Haven	1%
N/A (outside of County)	4%







Peer, Client/Consumer and Family Engagement in MHSA

MHSA is committed to engaging individuals with lived experience in planning, implementation and evaluation. Participation and expertise of individuals with lived experience is promoted and compensated with stipends. During the FY 2022-23 reporting year of the enclosed MHSA Annual Update, a total of $19,290 or 642 stipends ($30 per stipend for up to 2 hours of participation in any one activity) were provided to clients and family members of clients participating in MHSA-funded activities.

Activity (FY 2022-23)	Stipend $ Amount Distributed	# Unique recipients
Health Equity Initiatives	$9,210	51
Help@Hand Evaluation	$1,590	22
Advocacy Council	$2,100	12
BHC Adult Committee	$270	4
Crisis Care Mobile Units Feedback	$30	1
Crisis Intervention Team	$60	1
Cordilleras Renaming Committee	$120	2
Mental Health Month Planning	$300	6
MHSA Innovations Workgroup	$120	2
MHSA 3-Year Plan Workgroup	$300	2
MHSA Public Comment Video	$60	1
MHSA Steering Committee	$180	4
MHSARC Adult Recovery Committee	$30	1
Recovery Happens Planning Committee	$240	4
Suicide Prevention Committee	$990	9
MHA Picnic Tabling Event	$120	2
Spanish Family Support Group	$90	1
African American Community Assessment	$450	15
Canyon Oaks Youth Center Surveys	$480	15
Minimum Standards Focus Group	$30	1
Advocacy Academy - Spanish	$2,400	11
FSP Evaluation Key Informant Interview	$120	4
TOTAL	**$19,290**	

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 Behavioral Health Commission (BHC) conducts a public hearing at the close of the 30-day comment period.

The MHSA Annual Update for FY 2024-25 with program data from FY 2022-23 was presented on March 6, 2024, to the BHC. The BHC voted to open a 30-day public comment period and held a Public Hearing. The BHC reviewed the public comments received, voted to close the public comment period on April 6, 2024, and to submit the MHSA Annual Update to the Board of Supervisors. Please see Appendix 1 for the presentation materials to the BHC and all public comments received. *[To be updated after the closing of the 30-day public comment process]*

The MHSA Annual Updates are 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) and the Department of Health Care Services (DHCS).

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

- Announcements at internal and external community meetings
- Announcements to programs engaging diverse families and communities (Health Equity Initiatives, Health Ambassador Program, Lived Experience Academy, etc.)
- E-mails disseminating information to an MHSA distribution list of over 2,400 subscribers; and the Office of Diversity and Equity distribution list of over 2,100 subscribers
- Word of mouth on the part of committed staff and active stakeholders
- Posting on the MHSA webpage smchealth.org/MHSA, the BHRS Blog, smcbhrsblog.org, and the BHRS Director's Update, https://www.smchealth.org/post/directors-update, which reaches over 2,600 subscribers

MHSA WORKGROUPS

The MHSA Steering Committee hosts up to two small workgroups per year focused on a specific MHSA topic that is aligned with MHSA planning needs or programs and services that may require more intensive input, improvements and/or other recommendations. Previous MHSA Workgroups have focused on housing, full service partnerships, innovation, and community program planning. The workgroups are open to public participation, are time-limited and 10-12 participants are selected via an interest survey.

COMMUNICATIONS WORKGROUP

Between October and December 2023, an MHSA Communications Workgroup was convened made up of diverse stakeholders including clients, family members, community members, service providers

and BHRS staff. The workgroup met monthly with the goal of enhancing public awareness and understanding of the transformative impact of MHSA on behavioral health in the San Mateo County community.

MHSA Communication Workgroup Members *(10 were selected, 8 attended regularly)*

Participant	Organization and/or Affiliations	Stakeholder Group
Brenda Nuñez	StarVista; BHRS Diversity and Equity Council	Provider of other social services; youth development and advocacy
Charo Martinez	BHRS Office of Diversity and Equity, Latino Collaborative and Pride Initiative	Provider of other social services; cultural competency and diversity; LGBTQ+
Jean Perry	Behavioral Health Commission (BHC)	Families of clients/consumers
Lanajean Vecchione	Lived Experience Academy (LEA), Advocacy Academy, Diversity and Equity Council	Client/Consumer of behavioral health services; families of clients/consumers; cultural competence and diversity; People living with disabilities; peer support
Pat Willard	Peninsual Anti-Racism Coalition	Families of clients/consumers; cultural competence and diversity
Rachel Day	National Alliance on Mental Illness, Mental Health Association of San Mateo County	Client/Consumer of behavioral health services; families of clients/consumers; providers of behavioral health services
William Elting	Lived Experience Education Workgroup, One New Heartbeat, BHC Youth Committee, Heart & Soul, Suicide Prevention Committee, MHFA Instructor, LEA Advocacy Academy	Client/Consumer of behavioral health services
Leti Bido	Behavioral Health Commission	Families of clients/consumers

The MHSA Communications Workgroup was facilitated by an independent consultant, The Social Changery. Specific objectives of the group included:

1) Review focus group feedback to help inform communication strategies.
2) Provide input on a marketing campaign strategy that will include a slogan, key messages, services and stories to highlight and inclusive means to reach diverse communities.
3) Review and advise on a social media plan and content development.

Four focus groups were conducted by The Social Changery with over 70 total participants to meaningfully engage individuals ages 16-60+ and ensure recommendations would resonate with diverse audiences. Priority was placed on gathering insights from BHRS transition-age youth, adult clients, family members, and stakeholders. Facilitation prioritized a culturally sensitive and inclusive approach and included language appropriate groups in English, Spanish, and Chinese.

Key Findings included:

- Awareness of MHSA varies among communities.
- Program coordinators and community-based agencies play a pivotal role as trusted messengers.
- Connecting MHSA to local, trusted community programs and existing County Health brand is preferable to reinforce value.

- Participants spoke highly of the programs they were aware of but were unaware of connection with MHSA.
- MHSA awareness is not consistent across groups and most participants associated MHSA with the state not local efforts.

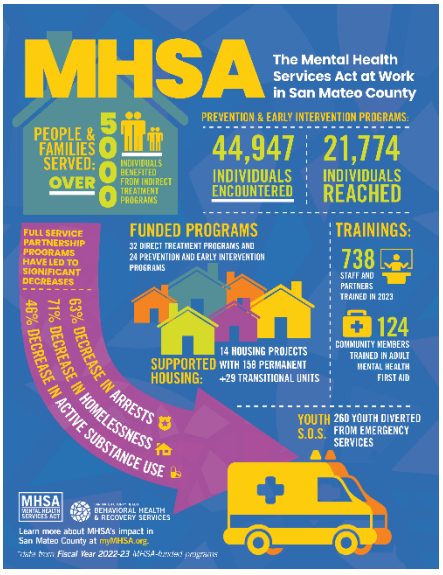
Key Recommendations and Strategies include:

- Generate recognition and understanding of MHSA among stakeholders and decision-makers.
  - Build brand recognition through logo and co-branding with County Health and BHRS.
  - Emphasize the role of MHSA in funding programs that stakeholders know and trust.
- Equip CBOs with resources to educate and inform the communities they serve about the importance of MHSA funding for critical programs.
  - Collaborate with and provide educational institutions, community centers, and local organizations with information materials and guidelines for promoting MHSA funded programs and services.
- Develop and promote resource awareness available to stakeholders and their families that showcase the impact of MHSA funding.
  - Develop a single page microsite.
  - Launch an advertising campaign.
  - Engage in media relations to highlight individual success stories and testimonials of local MHSA impact focused on individual direct, tangible effects on lives.

"My Journey, My MHSA" Campaign

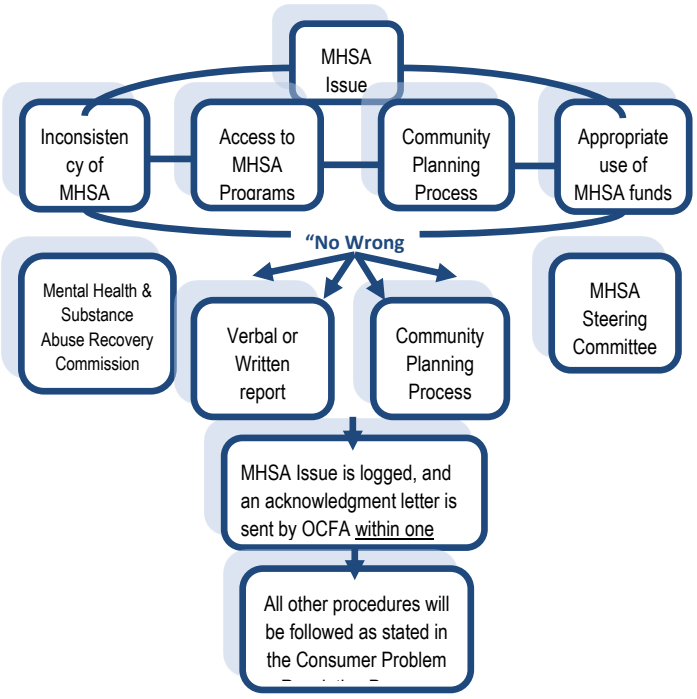
The "My Journey, My MHSA" campaign was developed to meet the recommended strategies, see Appendix 2 to view the resources included in the campaign:

- Infographic Poster to share about the impact of MHSA.
- Partner Toolkit for stakeholders to help share the message of the campaign. It includes a tagline to use on materials, logos and posts for MHSA-funded programs and partners to share on social media.
- Digital billboard visible on Highway 101 southbound, in the city of San Carlos.
- Digital ads posted online and connecting viewers to www.MyMHSA.org - a mechanism to: 1) link to BHRS services; or 2) learn more about MHSA.
- MHSA Impact Report to share data, highlights and stories of the impact MHSA has had in San Mateo County.



ISSUE RESOLUTIONS

MHSA Issue Resolution Process (IRP)



The purpose of the MHSA IRP is to resolve process-related issues with 1) the MHSA Community Program Planning (CPP) process; 2) consistency between approved MHSA plans and program implementation; and 3) the provision of MHSA funded programs.

In San Mateo County, the MHSA IRP (BHRS Policy: 20-10) is integrated into the broader BHRS Problem Resolution Process facilitated by the Office of Consumer and Family Affairs (OCFA) to support clients in filing grievances about services received from BHRS or contracted providers, ensuring that client issues are heard and investigated. BHRS clients receive client rights information upon admission to any program, which includes information on the right to a problem resolution process and how to file a grievance, appeal or request a state fair hearing after exhausting the internal problem resolution process.

For the FY 2022-23 reporting year of this MHSA Annual Update, there were 22 quality of care-related grievances filed with the BHRS Office of Consumer and Family Affairs (OCFA) for MHSA funded programs. There were no MHSA process-related grievances.

Category of grievance (FY 2022-23)	# of grievances	Outcome (from the client's perspective: was the outcome Favorable, Partially Favorable, Not Favorable?)
Access: Services not available	1	Partially Favorable
Case Management: Assessment, care or process concerns	6	3 Favorable, 1 Partially favorable, 1 Not favorable, 1 No Response
Customer Service: Interactions with plan services concerns	1	Partially Favorable
Quality of Care: Effectiveness, efficiency, acceptability concerns	10	3 Favorable, 3 Partially favorable, 2 Not favorable, 1 No Response
Abuse, Neglect, Exploitation: Potential or actual client harm	3	1 Favorable, 2 Partially favorable
Other Reasons	1	Partially favorable

FISCAL SUMMARY

FISCAL SUMMARY

This Fiscal Summary section includes MHSA funding requirements and locally-developed guiding principles, history of revenues and expenditures, available unspent funds, reserve amounts, reversion projections and new funding allocations and ongoing priorities. See Appendix 3 for the FY 2024-25 Funding Summary by component.

MHSA FUNDING REQUIREMENTS

MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules:

Component	Categories	Funding Allocation	Reversion Period
Community Services and Supports (CSS)	Full Service Partnerships (FSP) General Systems Development (GSD) Outreach and Engagement (O&E)	76% (51% of CSS must be allocated to FSP)	3 years
Prevention and Early Intervention (PEI)	Early Intervention Prevention Recognition of Signs of Mental Illness Stigma and Discrimination Access and Linkages	19% (51% of PEI must be allocated to program serving ages 0-25)	3 years
Innovations (INN)		5%	3 years

Additionally, Counties received one-time allocations in three additional Components, listed in the table below. Locally, ongoing annual and one-time allocations are prioritized to sustain the work in these components, as per the following guidelines:

- Up to 20% of the average 5-year MHSA revenue from the CSS Component can be allocated to WET, CFTN and Prudent Reserve.
- A maximum of 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years maximum of 33% may fund the Prudent Reserve.
- Up to 5% of total annual revenue may be spent on administration and community planning processes.

Component	Amount Received	Reversion Period
Workforce Education and Training (WET)	$3,437,600 FY 2006-07 and 2007-08	10 years (expended)
Capital Facilities and Technology Needs (CFTN)	$7,302,687 FY 2007-08	10 years(expended)
Housing	$6,762,000 FY 2007-08	10 years (expended)
	Unencumbered FY 2015-16	3 years (expended)

MHSA FUNDING PRINCIPLES

MHSA Funding Principles build from the County Health division budget balancing principles to guide MHSA reduction and allocation decisions when needed. MHSA funding is allocated based on the most current MHSA Three-Year Plan and subsequent Annual Updates. Any funding priorities being considered outside of the MHSA Three-Year Plan priorities require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

The MHSA Funding Principles were presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout the county that was expected to have implications for MHSA funding. These Funding Principles continue to lead budget decisions.

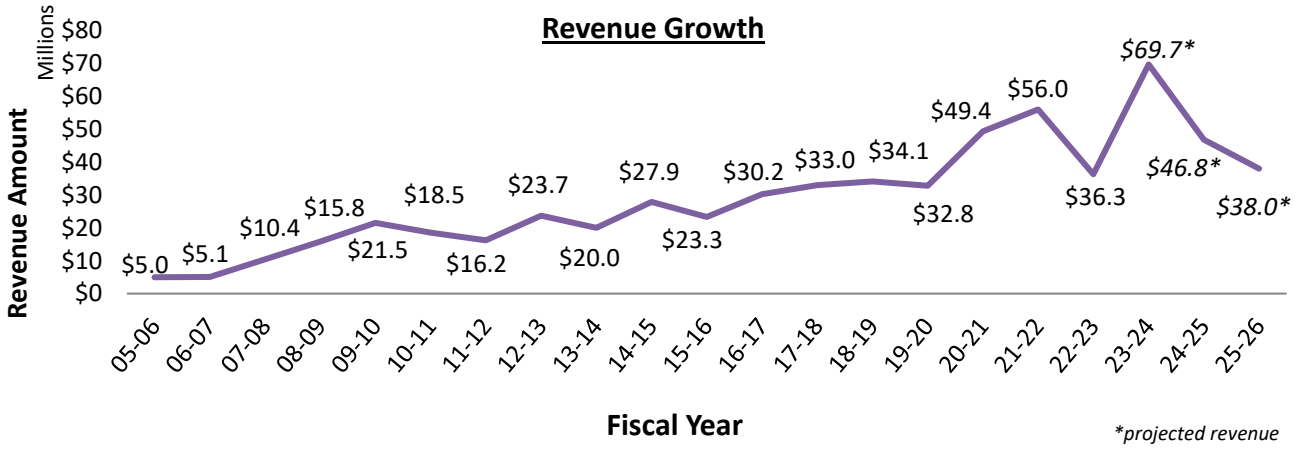
- *Maintain MHSA required funding allocations.*
- *Sustain and strengthen existing MHSA programs* - MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.
- *Maximize revenue sources* - billing and fiscal practices to draw down every possible dollar from other revenue sources (e.g., Medi-Cal) should be improved as relevant for MHSA funded programs.
- *Sustain geographic, cultural, ethnic, and/or linguistic equity* - MHSA aims to reduce inequities and address gaps in services; reductions in budget should not impact any community group disproportionately.
- *Prioritize direct services to clients* - direct services will be prioritized, over indirect services, as necessary to strengthen services to clients and mitigate impact during budget reductions. Indirect services are activities not directly related to client care (e.g., program evaluation, general administration, staff training).
- *Prioritize prevention efforts* - at minimum, 19% allocation to Prevention and Early Intervention (PEI) should be maintained and additionally the impact across the spectrum of PEI services and services that address the root causes of behavioral health issues in communities should be prioritized.
- *Utilize MHSA reserves over multi-year period* - MHSA reserves should be used strategically to mitigate impact to services and planned expansions during budget reductions.
- *Evaluate potential reduction or allocation scenarios* – All funding decisions should be assessed against BHRS's Mission, Vision and Values and when relevant against County Health Budget Balancing Principles.

ANNUAL REVENUE GROWTH

Statewide, MHSA represents a little under a third of community mental health funding. In San Mateo County, MHSA represents about 15% of BHRS revenue. The five-year average annual revenue for San Mateo County, through FY 2021-22, totaled $39.2 million.

MHSA funding is based on various projections that consider 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. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that impacted the decreases and increases in revenues throughout the years:

- FY 2005-06 and FY 2006-07: Community Services and Supports (CSS) funding only.
- FY 2007-08 and FY 2008-09: Prevention and Early Intervention (PEI) and Innovations (INN) funding were released in those years, respectively.
- FY 2010-11 and FY 2011-12: the California recession of 2009 led to decreased revenues.
- FY 2012-13: Counties began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation.
- FY 2014-15: changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in a "one time" increase.
- FY 2019-20: "No Place Like Home" estimated cost for San Mateo County is $1.3 million, taken from revenue growth or "off the top." Additionally, there was an extension of filing of taxes to July 2020, due to COVID-19 pandemic.
- FY 2020-21 to 2021-22: unanticipated revenue increases due to 2020 delayed tax filing and COVID-19 pandemic.
- FY 2023-24: increases due to delayed tax filings and an unprecedented one-time adjustment of actual revenues received from taxpayers during the COVID-19 pandemic.
- FY 2024-25 and FY 2025-26: decreases due to projected statewide recession.



PROPOSITION 1 - LOCAL IMPACT

Subject to voter approval on the March 2024 ballot, Proposition 1 will reform the Mental Health Services Act (MHSA) into the Behavioral Health Services Act (BHSA) and authorize $6.38 billion in bond funding for supportive housing and behavioral health treatment beds.

Given uncertainty in actual impacts of Proposition 1, the MHSA Three-Year Plan funding priorities will remain with no additional expansions and all MHSA-funded programs and services will continue through June 30, 2026. Starting FY 2026-27, if Proposition 1 passes, funding will be redirected from current MHSA allocations to meet the new funding requirements – as demonstrated in the following table.

BHSA Funding Allocation Categories*	BHSA Amount	Current MHSA Amount	Amount to Meet Requirement
Housing Interventions (23%)	$12,768,073	$6,375,362	$6,392,711
Full-Service Partnerships (32%)	$17,764,276	$17,463,790	$300,486
Behavioral Health Services and Supports (BHSS) – Early Intervention (12%)	$12,740,316	$8,510,521	$4,229,795
BHSS – Other Services (11%)	$12,240,696	$27,342,114	($15,101,418)
State Allocation**	$2,984,589	0	$2,984,589
Administrative Expansions	$1,193,836	0	$1,193,836

**estimates based on the current FY 2024-25 MHSA ongoing budget, leveraging transfer allowances between categories; actual funding amounts will depend on future revenues.*
***estimated impact to the overall MHSA budget based on the new 10% of revenue State allocation*

Redirection of funds will most significantly impact the following types of programs and services.

- $8.0 (43%) from **outpatient treatment** programs.
- $4.3M (100%) from **population-based prevention** programs.
- $2.8M (100%) from **innovation and technology** projects.

BHRS is exploring strategies to mitigate the impact of Proposition 1, including:

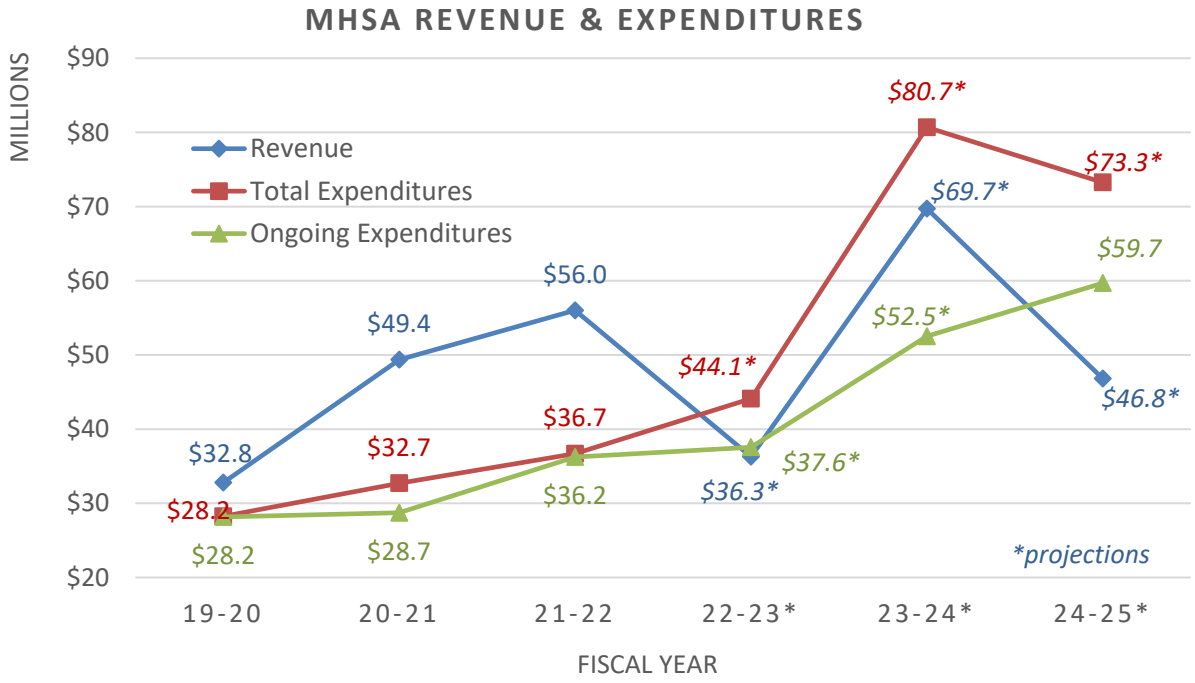
1. Restructuring programs to meet the new funding requirements.
2. Identifying alternate funding sources.
3. Planning for new positions to support the significant expansions to planning, fiscal and performance outcome reporting requirements.

Decisions related to restructuring programs and/or termination of any services if Proposition 1 passes will require a Community Program Planning process, per the legislation. This process will consider program outcomes, equitable impact and engage stakeholders, community-based organizations, the Behavioral Health Commission, and the Board of Supervisors.

ONGOING OVER-REVENUE BUDGET STRATEGY

San Mateo County's MHSA ongoing budget targeted the 5-year average revenue, as a strategy to maintain sufficient expenditures, avoid reversion and to not overcommit revenues. Starting FY 2021-22, the strategy shifted to an over-revenue budget. This allows us to spend down unprecedented high revenues received. The proposed ongoing budget for FY 2024-25 is at $65.2M. The 5-year average revenue is $41.2M.

The following MHSA Revenue and Expenditure chart depicts MHSA Revenue in blue, Total Expenditures (including one-time allocations) in red, and Ongoing Expenditures in green per FY. Ideally counties are spending at the same rate as they are receiving revenues yet, annual MHSA revenue distributions are volatile and often difficult to project. For example, at the start of the COVID-19 pandemic, a recession was projected. Counties across the state immediately shifted their three-year planning to either include reductions in programming or keep their ongoing budget status quo for FY 2020-21, as was the case in San Mateo. Actual revenues increased that year, through FY 2021-22 and included an unprecedented significant one-time adjustment in FY 2023-24.



ONE-TIME SPEND PLAN STRATEGY

Planning for one-time funding is another strategy utilized to spend down unanticipated revenue increases. The following is an analysis of funding availability for one-time spending. Given the projected recession, a decrease in revenue is anticipated and may require the use of reserve to cover the overage in FY 2025-26 expenditures.

Annual Unspent Projections at Fiscal Year (FY) -end			
	FY 2023-24	**FY 2024-25**	**FY 2025-26**
Projected Revenue	$71,121,540	$47,746,625	$38,798,004
Ongoing Budget Expenditures	*$52,519,237*	*$59,691,785*	*$59,691,785*
One-Time Plan Expenditures	*$10,415,000*	*$12,650,000*	*$11,030,000*
Trust Fund Balance	*$83,208,757*	*$58,613,597*	*$26,689,816*
Obligated Funds:	**$63,180,560**	**$49,684,952**	**$39,214,750**
Reserve	$28,362,318	$28,362,318	$28,362,318
5% Innovation (INN)	*$3,556,077*	*$2,387,331*	*$1,939,900*
INN Ongoing	*$6,777,165*	*$7,440,303*	*$8,903,072*
WET/CFTN/Housing Encumbered	*$800,000*	*$460,000*	*$16,448*
$34.1M One-Time Spend Plan	*$23,680,000*	*$11,030,000*	*$0*
Available for One-Time Planning	***$20,028,197***	***$8,928,645***	***$12,524,934***

The MHSA Three-Year Plan FY 2023-26 included a process for identifying "big-ticket" items for a $34.1M One-Time Spend Plan. These items included: 1) Housing Development; 2) Capital Facilities; 3) Technology; and 4) System Transformation Projects. Implementation of this $34.1M one-time plan will continue through FY 2025-26. Following is an updated plan based on expenditures to-date:

$34.1M One-Time Spend Plan						
Priority	**Item**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**	**Description**
Housing	Hotel/Property Acquisition		$11,000,000		$11,000,000	Hotels/properties for transitional and/or supportive housing.
	Supportive Housing Units		$5,000,000		$5,000,000	25 supported units for BHRS clients via Department of Housing (DoH) Affordable Housing Notification of Funding Availability (NOFA) - Jul 2022.
	Board and Care Buyout			$1,800,000	$1,800,000	Behavioral Health Continuum Infrastructure Grant (BHCIG) - 10% match required.
Capital Facilities	Clinic Renovations	$700,000	$5,300,000	$2,000,000	$8,000,000	Renovations focused on improving safety at BHRS clinical sites and creating spaces that are welcoming for clients.
	Methadone Clinic		$1,800,000		$1,800,000	BHCIG - 10% match. On Veterans Administration campus in Menlo Park w/Santa Clara County.
	Youth Crisis Stabilization and Crisis Residential			$590,000	$590,000	BHICG - applying until round 6.
	2191-95 El Camino Real Property Renovations	$50,000	$200,000		$250,000	Newly purchased property to be used by California Clubhouse and Voices of Recovery renovation and security enhancements.

Priority	Item	FY 23-24	FY 24-25	FY 25-26	TOTAL	Description
Technology Needs	Asset Refresh	$260,000	$400,000	$540,000	$1,200,000	Computer/phone refresh and service coverage for BHRS.
System Transformation	Trauma Informed Systems		$100,000	$100,000	$200,000	Estimated cost for a limited-term position services for Trauma Informed and Employee Wellness supports.
	Youth Crisis Continuum of Care Consultant	$100,000	$100,000		$200,000	Estimated cost for consultant services to assist with BHRS System transformation around Youth Crisis Continuum of Care.
	Early Childhood, Children and Youth Collaborative	$555,000	$425,000		$980,000	Early Childhood Mental Health Network: expansion of trauma-informed services - training, capacity building, implementation San Mateo County Collaborative for Children and Youth: to design an implement county-wide plan.
	Contractor Infrastructure		$2,500,000		$2,500,000	Infrastructure and training support for contracted providers to advance equity priorities and CalAIM payment reform.
	Communications	$140,000	$335,000	$100,000	$575,000	SMCHealth.org website update; a more interactive and robust BHRS site + consultant to support series of BHRS/MHSA highlights and short 1-2 min videos.
	GRAND TOTALS	**$25,940,000**	**$3,125,000**	**$5,030,000**	**$34,095,000**	

TOTAL OPERATIONAL RESERVE

Counties are required to establish a Prudent Reserve to ensure the County programs will be able to serve clients should MHSA revenues drop. The California Department of Health Care Services (DHCS) Information Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the 5-year average Community Services and Supports (CSS) revenue received. For San Mateo County, this corresponds to $8,879,780, of which $4,755,145 was transferred to the Prudent Reserve in FY 2021-22 and $600,000 in FY 2008-09. The remaining $3,524,635 will be transferred in FY 2024-25. The exact amount will depend on revenue received. Only 20% of the MHSA 5-year revenue average can be transferred to the Prudent Reserve, CFTN and WET in a given year.

Additionally, as per the FY 2019-20 MHSA Annual Update, the MHSA Steering Committee, the Behavioral Health Commission (local mental health board), and the Board of Supervisors, reviewed and approved a recommended Total Operational Reserve of 50% (Prudent Reserve + additional operating reserve), of the highest annual revenue for San Mateo County, which currently equals $28,362,318. The additional Operational Reserve is maintained with local unspent funds. This allows

the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, in the event that revenue decline is less than the State's threshold or funding is needed in a timely manner. Given the anomaly projected revenue increase in FY 2023-24, the recommendation is to keep the operational reserve at the $28,362,318 level.

REVERSION

MHSA legislation requires that MHSA funding under the key components (CSS, PEI and INN) be spent within 3-years, or it must be returned to the State for reallocation to other mental health agencies. San Mateo County's annual MHSA spending in CSS and PEI targets the 5-year average revenue and more recently is over revenue to avoid reversion. As long as the budget amount is expended as planned, there is no risk of reversion for CSS and PEI. For the INN component, Assembly Bill (AB) 114 established that the 3-year reversion time frame for INN funds commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while planning for new projects and/or awaiting approval by the MHSOAC.

HOUSING FUNDS

DHCS Information Notice 16-025 required Counties to complete *Ongoing Fund Release Authorization* for both existing and future unencumbered San Mateo County MHSA Housing Program funds (e.g., funds that are no longer required by a housing project, accrued interest, and/or other funds receive on behalf of the counties). Funds will be released annually to Counties with a three-year reversion term. The MHSA Housing Initiative Taskforce prioritized these funds to support ongoing "housing assistance" in the form of flexible funding for clients for housing related expenses (moving costs, deposits, first month rent). These unencumbered housing funds will be used for this flexible fund.

SUMMARY OF FISCAL PRIORITIES

The fiscal priorities set forth in the FY 2023-26 MHSA Three Year Plan will continue as planned:

- Continue implementing the $34.1M One-Time Spend Plan through FY 2025-26.
- Continue implementing the MHSA ongoing budget total of $59.7M and priorities:
    - Full Service Partnerships (FSP) including Community Assistance, Recovery and Empowerment (CARE) Court FSP and FSP Housing supports.
    - Behavioral Health Workforce priorities related to workforce capacity development, recruitment and retention strategies.
    - Prevention and Early Intervention priorities related to improving access to services specifically for youth and the Chinese community, implementing crisis continuum priorities and substance use prevention strategies.

See Appendix 3 for the updated FY 2024-25 Annual Update Funding Summary by component.

ANNUAL UPDATE
FY 2024-25

(Includes highlights and data from FY 2022-23 programs)

ANNUAL UPDATE FY 2024-25 (DATA FROM FY 2022-23)

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. This Annual Update will focus on presenting the latest set of full FY 2022-23 data, including program and fiscal planning highlights and updates, grievance data, program outcomes, and evaluation reports.

EVALUATION ACTIVITIES

MHSA PEI DATA COLLECTION AND REPORTING FRAMEWORK

In May 2023, PEI programs that primarily collect population-level data, or duplicated individuals served, were incorporated into the PEI Data Collection and Reporting Framework to allow for a broader evaluation of the impact of all MHSA PEI-funded programs. These programs focus on community awareness campaigns, education, and trainings and include The Parent Project®, Health Equity Initiatives, Mental Health First Aid, Suicide Prevention, and Storytelling - Photovoice. Standardized questions based on the **Outcome Indicators** were identified and were embedded into each program's respective evaluation surveys beginning in FY 2023-24. See Appendix 4 for the updated PEI Data Collection and Reporting Framework. Additional PEI programs, such as the Outreach Collaboratives, will be incorporated over time. Programs that focus exclusively on systems development, such as Trauma- and Resiliency-Informed Systems Initiative (TRISI), are not captured in this framework, as the evaluation focus of these programs is on measuring organizational capacity.

The original PEI Data Collection and Reporting Framework was developed in June 2022 by an independent consultant, Resource Development Associates (RDA), in alignment with MHSA requirements, BHRS Office of Diversity and Equity's (ODE) Theory of Change, which engaged clients, families, community partners, BHRS staff and County departments, and through discussions with local MHSA PEI-funded programs. The framework focuses on individual demographics, referrals to BHRS and other health and social services and individual outcomes that could be analyzed across PEI programs that collect individual-level program data, or unduplicated individuals served. Data is collected across 9 Outcome Domains including:

- Access to services
- Community advocacy
- Connection and support
- Cultural identity/cultural humility
- General mental health
- Improved knowledge, skills, and/or abilities
- Self-empowerment
- Stigma reduction
- Utilization of emergency services

ONGOING EVALUATION REPORTS

Independent evaluation consultants provide annual evaluation reports for Full Service Partnerships (FSP), Outreach Collaboratives, Adult Mental Health First Aid, Parent Project, and Innovation Projects. Appendices 2-8 include the completed final evaluation reports as follows:

- Annual FSP Evaluation Report: American Institutes for Research (AIR) analyzes FSP data for youth, transition age youth and adults to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Appendix 5 includes the completed FSP Evaluation Report.
- Annual Outreach Collaboratives Evaluation Report: AIR also supports evaluation and analyses of the PEI Outreach Collaboratives. See Appendix 6, Outreach Collaborative Evaluation Report.
- Annual Adult Mental Health First Aid (AMHFA) Report: Resource Development Associates (RDA) supported the evaluation and analysis of AMHFA courses, see Appendix 7.
- Innovation (INN) Projects: RDA provided comprehensive evaluation reports for the following Innovation projects.
    - Final Help@Hand (Tech Suite) INN Evaluation Report - a statewide initiative to bring technology-based solutions to county behavioral health systems.
    - Year 2 Kapwa Kultural Center and Cafe (Social Enterprise) INN Evaluation Report: a social enterprise cafe and cultural hub for Filipino/a/x youth in northern San Mateo County, see Appendix 8.

COMMUNITY SERVICES & SUPPORTS (CSS)

FULL SERVICE PARTNERSHIP (FSP) PROGRAMS

FSP programs do "whatever it takes" to serve medically fragile older adults, adults, transition-age youth, and children, youth, and their families that are living with serious mental health challenges and help them on their path to recovery and wellness. 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.

In San Mateo County, the FSP programs, Edgewood, Fred Finch, and Telecare, have been fully operational since 2006. A fourth site, Caminar 's Adult FSP, was added in 2009. Edgewood Center and Fred Finch Youth Center serve children, youth, and transition age youth (C/Y/TAY) using the Wraparound model[2] and Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

The cost figures below 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 2022-23 FSP slots	FY 2022-23 clients served	Cost per client*	Cost per slot
Children/Youth (C/Y) FSP's				
Out-of-County Foster Care Settings FSP	10	4	$58,999	$23,600
Integrated FSP "SAYFE"	25	32	$67,559	$72,062
Comprehensive FSP "Turning Point"	40	69	$42,661	$64,414
Transitional Age Youth (TAY) FSP's				
Comprehensive FSP "Turning Point" FSP	50	62	$50,933	$63,157
Adult/Older Adult FSP's				
Adult and Older Adult/Medically Fragile FSP	207	254	$11,610	$14,246
Comprehensive FSP	30	31	$55,262	$57,104
Assisted Outpatient Treatment (AOT) FSP	50	61	$13,318	$16,248
South County Clinic Embedded FSP	15	10	$13,119	$8,746

*Calculated based on clients served during the fiscal year and the MHSA funding contribution only (not including housing); this is not representative of the full cost of providing services. There are also reimbursements and other revenues sources associated with FSP's that may decrease the final MHSA funding contribution.

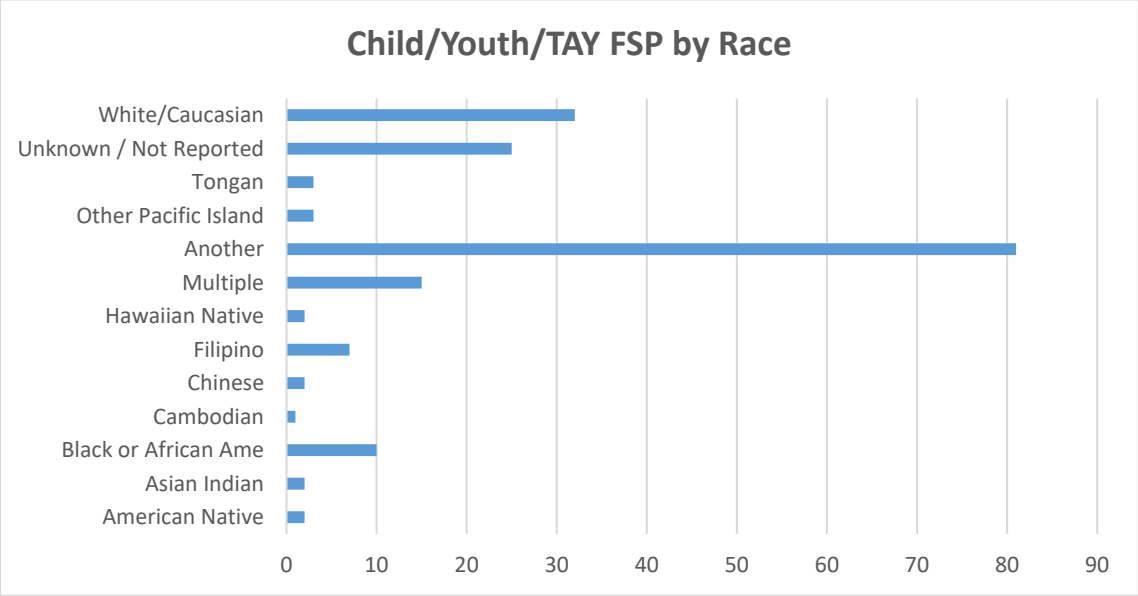
[2] Wraparound models emphasize the importance of care coordination across a support network, which many include their family, friends, teachers, mental health professionals, and other community members. The models also encourage caregivers, and mental health professionals to collaborate on the development of a treatment plan and to identify strengths that can be leveraged to support behavioral change: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c11-28.pdf.

Demographics

Child/Youth and Transition Age Youth FSP Client Demographics

FY 2022-23 (total clients = 167)

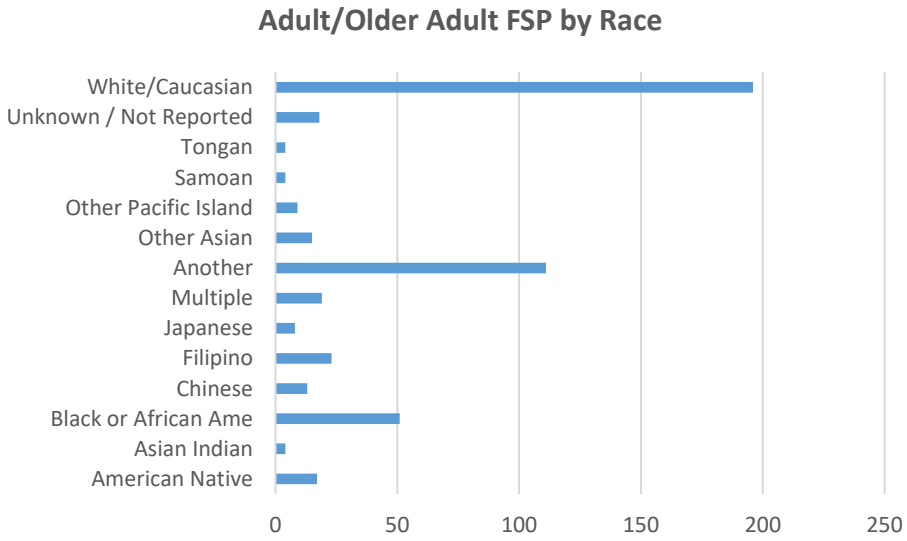
Percent of FSP Clients by Ethnicity	
Hispanic or Latino	60%
Not Hispanic or Latino	29%
Unknown / Not Reported	11%

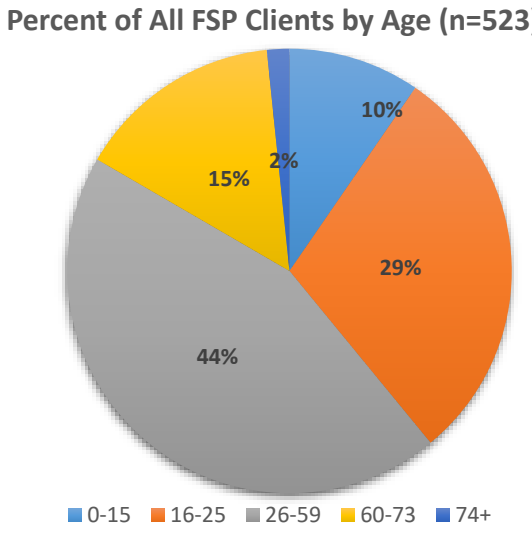


Adult and Older Adult FSP Client Demographics

FY 2022-23 (total clients = 356)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	29%
Not Hispanic or Latino	63%
Unknown / Not Reported	8%





Outcomes

As part of San Mateo County's implementation and evaluation of the FSP programs an independent consultant 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 (e.g., physical health emergencies, psychiatric emergency services (PES) and hospitalizations), health status, substance use, and for older adults, activities of daily living. Data from FSP participants is collected by providers via self-reported intake assessment, key event tracking and 3-month assessments. See Appendix 5 for the complete FSP Evaluation Report for FY 2022-23. The tables below present a highlight of the percent improvement between the year just prior to FSP and the first year with FSP, by age group.

Exhibit 1. Percent Change in Outcomes Among Caminar Adults and Older Adults, Year Before FSP Compared with First Year With FSP.

FSP outcomes	Adults (25 to 59 years)			Older Adults (60 years and older)		
Self-reported outcomes	***N = 116***			***N = 24***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	48 (41%)	35 (30%)	-27%	5 (21%)	4 (17%)	-40%
Detention or incarceration	35 (30%)	22 (19%)	-37%*	3 (13%)	3 (13%)	-25%
Employment	1 (1%)	5 (4%)	400%	0 (0%)	0 (0%)	N/A
Arrests	20 (17%)	4 (3%)	-80%*	3 (13%)	1 (4%)	-75%
Mental health emergencies	86 (74%)	32 (28%)	-63%*	13 (54%)	4 (17%)	-69%*
Physical health emergencies	50 (43%)	17 (15%)	-66%*	6 (25%)	4 (17%)	-43%
Active Substance Use Disorder (SUD)	62 (53%)	59 (51%)	-5%	5 (21%)	5 (21%)	0%
SUD treatment	27 (23%)	33 (28%)	22%	3 (13%)	2 (8%)	-33%
Emergency Service Utilization (EHR) data	***N = 388***			***N = 80***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	124 (32%)	57 (15%)	-54%*	22 (28%)	12 (15%)	-45%
Hospital days per partner	11.5	3.8	-67%*	9.9	4.3	-36%
Psychiatric emergency services (PES)	206 (54%)	148 (39%)	-28%*	33 (43%)	21 (25%)	-36%*
PES event per partner	1.6	1.0	-36%*	1.1	0.6	-44%

Note. EHR = electronic health record. Self-reported outcomes do not include Telecare. Exhibit 1 indicates the change in the number of partners with the outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 1 to indicate the number of partners with the outcome of interest, and percentages are presented in parentheses. For self-reported outcomes, there are only 24 older adult partners; therefore, caution is needed when interpreting the results with small sample size. The percentage difference with employment for older adults is reported as N/A, as the percentage of older partners with employment was 0% in the prior year and in the year after (from 0% to 0%). Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Exhibit 2. Percent Change in Outcomes for Children and TAY, Year Before FSP Compared with First Year With FSP

FSP outcomes	Child (16 years and younger)			TAY (17 to 25 years)		
Self-reported outcomes	***N = 232***			***N = 287***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	9 (4%)	8 (4%)	-11%	35 (12%)	34 (12%)	-3%
Detention or incarceration	28 (12%)	28 (12%)	0%	40 (14%)	32 (11%)	-20%
Arrests	30 (13%)	10 (4%)	-67%*	65 (23%)	20 (7%)	-69%*
Mental health emergencies	88(38%)	10 (4%)	-89%*	131 (46%)	29 (10%)	-78%*
Physical health emergencies	17 (7%)	1 (0%)	-94%*	60 (21%)	2 (21%)	-92%*
Suspensions	47 (20%)	21 (9%)	-55%*	26 (9%)	2 (2%)	-77%*
Grade	3.35	2.97	-11%*	3.23	3.12	-3%
Attendance	2.23	1.94	-13%*	2.44	2.49	2%
Emergency Service Utilization (EHR data)	***N = 213***			***N = 225***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	-70%*	27 (12%)	16 (7%)	-41%
Hospital days per partner	1.2	0.5	-91%	4.3	2.1	-51%
Psychiatric emergency services (PES)	51 (24%)	23 (11%)	-55%*	94 (42%)	55 (24%)	-41%*
PES event per partner	0.5	0.2	-53%*	1.1	0.7	-38%*

Note. EHR = electronic health record. Exhibit 2 indicates the change in the number of partners with outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 2 to indicate the number of partners with outcome of interest, and percentages are presented in parentheses. Percent change is the change in the number of partners with the outcome of interest in the year after joining an FSP as compared with the year just prior to FSP relative to the year prior to participating in an FSP out of the total number of partners. Blue font indicates a statistically significant positive percent change. Red (and bold) font indicates a statistically significant negative percent change. Black font indicates outcomes did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP. *Indicates a change significantly different from 0 at 0.05 significance level.

CHILDREN AND YOUTH (C/Y) FSP WRAPAROUND

Children and Youth FSP Wraparound programs help the highest risk children and youth with serious emotional disorders to achieve independence, stability, and wellness within the context of their cultures, communities, and family/caregiver units, and to remain living in their respective communities with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. FSP Wraparound services will be based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help them progress toward recovery, health, and well-being. Services are delivered by specialized multi-disciplinary FSP Wraparound Teams and obtain Wraparound certification from the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS).

INTEGRATED FSP "SAYFE"

The Short-Term Adjunctive and Family Engagement (SAYFE) is a comprehensive, full-service partnership (FSP) program designed to support 35 of the county's highest risk and most vulnerable children/youth and their families to maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and families are best served and supported in the context of their unique family system, culture, and community. The SAYFE program is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family/caregiver. SAYFE seeks to stabilize youth in their communities using natural support structures and through working in collaboration with San Mateo County and external resources. The SAYFE Program serves their clients through augmenting and extending the clinical work and existing treatment plan within the outpatient and Therapeutic Day School (TDS) programs and clients who are currently being served by BHRS regional clinic.

Youths are primarily referred to the SAYFE program through Human Services Agency (HSA – child welfare), Juvenile Probation, BHRS regional clinics, and Schools (typically with an IEP for emotional disturbance in place). The treatment is provided to help stabilize 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.).

All programs under the umbrella of the Youth FSP are guided by a strong belief in:

1) Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2) Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:

- Severely Emotionally Disturbed (SED)[3] and dually diagnosed children and youth (ages 6 to 21, when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth (C/Y) who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless C/Y, and Transition Aged Youth (TAY).
- C/Y and TAY exiting school-based or IEP-driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.

[3] SED are one or more mental, behavioral, or emotional disorder(s) in children, youth and transition age youth diagnosis resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in the SAYFE program are between the ages of 6-18 years, at risk for placement in an intensive school-based program or are currently being served in a BHRS regional clinic and are at risk for out-of-home placement.

Program Impact

SAYFE	FY 2022-23
Total unduplicated clients served	32
Total unduplicated families served	33
Total cost per client	$67,559
Cost per contracted slot	$72,062

The SAYFE program works alongside the BHRS Primary Clinician and utilizes the Wraparound model of care for children, youth, and families engaged in its program. The SAYFE program provides a variety of services to youths and her/his/their families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include:

- Family Therapy, focusing on the care and management of client's mental health condition within the family system.
- Group Therapy, with the client's goals for more than two or more family members that focus primarily on symptom reduction to improve functional impairments.
- Collateral Services, provided to support one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness.
- Rehabilitation Services, to assist in improving, maintaining, or restoring functional skills, daily living skills, medication compliance, and access to support resources.
- 24/7 Crisis Support
- Behavior Coaching Services
- Psychiatry services

Additionally, wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of youth and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Improves timely access & linkages for underserved populations: The SAYFE program works in collaboration with BHRS staff and other members of the treatment team to ensure timely access and appropriate linkages to services. The Clinical Intake Coordinator contacts the referral party within 5 business days following the authorization for SAYFE services by BHRS representative and opens the Admin Reporting Unit (RU) to track referral progress within 24 hours of receiving the referral from

Interagency Placement Review Committee (IPRC). The SAYFE program follows a detailed process to ensure that the treatment team is working in collaboration with the BHRS staff to maintain continuity of care for clients and families.

Reduces stigma and discrimination: The SAYFE program utilizes the Wraparound model of care for children, youth, and families engaged in the program. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and achieve their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when compared to traditional treatment planning, results in care plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan is driven by the youth and families' strengths and perspectives. Treatment goals and objectives are developed with the youth and family and are written in their own words.

The SAYFE program has integrated Family Conferencing into the treatment process to increase engagement and review progress with the family. The Family Conference is family-driven, strength-based, and promotes self-reliance. The Family Conference is a process that brings together the youth, the family, and their natural resources to explore Decision-Making and Problem-Solving for multiple needs and to develop an integrated and comprehensive plan to support youth and their families.

Lastly, all SAYFE staff are required to complete eight (8) hours of diversity training annually to increase cultural humility and reduce stigma and discrimination.

Increases number of individuals receiving public health services: The SAYFE program engages the whole family system in wraparound services to address the needs of the youth, parents/caregivers, and siblings. The treatment team utilizes a holistic approach and works to stabilize the caregivers so they can support the youth's recovery. All family members have access to after-hours crisis line, are asked to identify case management needs/resources, and are included in family therapy sessions when appropriate. In addition, the SAYFE Family Partners and SAYFE Case Managers facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) as needed. The SAYFE team provides crisis/brief intervention services for caregivers and siblings and refers them to primary care or community resources as needed.

The SAYFE Family Partners provide support and encouragement to the parents/caregivers to enhance the family's community and natural supports, and other supports identified in the individualized service plan. The SAYFE Family Partners also provide educational and parenting support to the parents/caregivers focusing on mental illness, co-occurring disorders, and accessing community parenting resources.

Edgewood operates the only program in San Mateo County focused on kinship families those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When the SAYFE program serves kinship families, the team connects them to the Kinship Support Network to enhance the wraparound

services to include caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite care.

Reduces disparities in access to care: The SAYFE program provides flexible services to youth and families in various settings to increase accessibility to care. Services are provided at home, school, Edgewood offices, via telehealth, or in other community locations throughout San Mateo County before and after school and work hours to accommodate busy schedules. Furthermore, SAYFE has English/Spanish speaking bilingual and bicultural staff (clinicians, case managers, family partners, behavior coaches, and crisis response counselors) who provide culturally and linguistically matched services. The bilingual/bicultural staff invest additional time into explaining services, translating documents, interpreting for meetings, and providing education and advocacy regarding cultural differences. Literature and resources are provided to the family in their preferred language when possible. When SAYFE is unable to meet the language needs of a family, interpreter services are utilized.

Financial support is provided to the families when necessary to aid in their access to community resources to promote their recovery. For example, SAYFE provides financial support for food, clothing, shelter, or recreational activities while the family is waiting to receive their benefits. The Case Managers and Family Partners work with the caregivers to identify resources and help them build the skills to access them independently. During the last year, SAYFE provided 5 youth scholarships to engage in summer activities of their choice to learn new coping and social skills to support their treatment goals.

Implements recovery principles: The SAYFE program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:

- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training.
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence.

In addition, the SAYFE treatment team provides harm reduction, Stages of Change model for youth with co-occurring disorders. The SAYFE team consults with the BHRS contractor where substance use is determined to be life-threatening and will implement more assertive interventions. For any youth with a recent history of suicide ideation and/or attempts, the SAYFE staff conduct a thorough suicide risk assessment within 72 hours of the initial meeting. Safety plans and treatment plans are created which address risk and recovery principles for all youth and their families.

Successes

The following qualitative FY 2022-23 success stories highlight the support the SAYFE team provides to each youth and family during their time in the program:

Client Success Story #1: An 18-year-old male youth was referred to the SAYFE program when he was 16 years-old due to severe anxiety and depression which impacted school engagement, peer and

family relationships, and overall hope for the future. He had frequent thoughts of self-harm and suicidal and homicidal ideation. His parents had a very contentious divorce, did not get along, and shared custody of the youth. His parents' divorce and tumultuous relationship impacted the youth's ability to openly express his feelings and envision his brighter future.

When the youth first started with the SAYFE program, the father opted not to participate and only gave permission for the mother to participate with their son. The youth expressed significant anger and resentment toward his father for events that occurred in his childhood. Mother reported that client was impacted by his relationship with the father and was hesitant to utilize resources and interventions offered by the team due to fear of repercussions from the father. The SAYFE team engaged the client and mother in family therapy, case management, and behavior coaching services. Youth developed a trusting relationship with his behavior coach and began talking about his mental health and well-being while in his mother's care. He was encouraged to discuss his struggles in family therapy with his mother and relied on the support of the team to help his mother understand his needs.

The SAYFE team supported the youth and family through multiple psychiatric hospitalizations during their time in the program. They utilized the crisis line for intervention as needed to assess for safety and for support after hours. The mother withdrew consent for services and the team worked diligently to engage the father in wraparound services so that the youth could continue to receive support from the team as he transitioned to adulthood. When the father commenced services, he began learning about his son's mental health and emotional needs and learned the skills to support him. The father used the case manager and behavior coach's support to help the youth identify career goals and prepare for college.

Although father reported to the team that therapy was "uncomfortable" for him because he "wasn't good" at talking about feelings and emotions, he participated in weekly family therapy with his son and was able to develop skills to support his son's emotional needs. The father utilized collateral sessions to reflect on questions or concerns about his son and implemented the interventions as needed. The youth obtained his driver's permit, was accepted into college, and was able to openly express both positive and negative feelings with his father.

At the time of discharge from the SAYFE program, the father thanked the treatment team for working to engage him in his son's treatment because he learned a lot about his son's experiences and how to support him.

Client Success Story #2: An 11-year-old female youth was referred to the SAYFE program due to significant symptoms of depression which impacted her ability to attend school and form peer relationships. Mother struggled to support the youth's basic physical and emotional needs due to her trauma history. The youth was primarily cared for by her 17-year-old sister because her mother lacked confidence in her own parenting skills and ability. Mother relied solely on older sister and the SAYFE team to support client because she would become overwhelmed and scared by the youth's aggressive behaviors (youth would self-harm or become physically aggressive with mother).

Furthermore, youth would refuse to go to school, reported plans to self-harm or die, and the mother would defer to her older daughter and become unresponsive in times of crisis. The mother and older

sister worked with the SAYFE team to develop a safety plan and utilize the crisis line if the youth thought about harming herself or others. The family clinician, case manager, and family partner worked closely with this family to support them with basic needs, parenting and communication skills, and psychoeducation. The youth began to attend school regularly for the first time in 2 years, the mother developed parenting skills and has become more independent in her ability to access community resources, the older sister was accepted to college away from home, and the number of hospitalizations has significantly decreased.

Mother now feels confident in her ability to parent her child with the support of the team while her daughter is away. She has developed a trusting relationship with her family partner and has asked for support to access her own individual therapy. Mother relies tremendously on the SAYFE team for support; however, she has acknowledged that she wants and needs to learn how to develop these skills so that she can support herself and her children independently.

Client Success Story #3: Another 11-year-old youth was referred to SAYFE wraparound services for support with school refusal and significant anxiety symptoms. The youth had not attended school since 3rd grade, two years prior. The mother was hesitant to accept services from the team and asked that the team only work with her daughter.

The family clinician, case manager, and family partner worked to explain the program and the importance of her involvement in services to support her child. Mother was adamant that she only wanted the team to focus on the school attendance, and not anything else. Youth initially refused to meet with the team and tried to avoid eye contact during meetings. The SAYFE clinician collaborated with the BHRS clinician to engage youth in joint meetings to increase her comfort level. The team began to develop a rapport with the mother by respecting her request to only focus on her daughter's school attendance to start. Eventually, the team was able to engage the youth in sessions. The youth began to attend school, develop peer relationships, and engage in the community. The family clinician moved at a pace that was comfortable for the family and, overtime, the youth and mother began to use sessions to appropriately identify and process feelings.

Furthermore, the case manager worked with the youth to identify interests and engage in community activities. They visited an animal shelter together, practiced photography with the youth's new camera, and discussed the youth's goals for middle school. The mother has used the case manager's support for enrolling the youth in middle school and ensuring her IEP services are considered by the district. Furthermore, the case manager helped the family with access to resources when they experienced a traumatic event, and the family has highlighted their appreciation for the support in conversations with the County and School Districts. Mother is not open to utilizing the support of the family partner yet, but the team is hopeful that she will access the support when she is ready.

Challenges

During the FY 2022-23, the SAYFE program continued to assess and address ongoing challenges around the increasing cost of living and lack of qualified applicants to retain staff and fill open positions. The high cost of living in San Mateo County and surrounding areas continues to present a

challenge for families and staff who are unable to obtain affordable and suitable housing for their families' needs. Due to this challenge, more San Mateo County residents are relocating out of the area, which has led to increased job openings and a smaller pool of qualified applicants county-wide. This has made it more difficult to hire and retain staff who receive competitive salary offers.

Additionally, most families who continue to reside in San Mateo County are working multiple jobs to afford housing and other necessities to keep up with the increased cost of living. Therefore, families are less available for appointments outside of school and work and the commitment required with additional services is stressful and overwhelming. The financial stress and pressure have led to an increase in need for mental health services and a lack of resources to support the demand. The SAYFE program leadership has implemented strategies to increase client engagement, staff retention, and hiring. Program staff have increased flexibility for morning and evening appointments to accommodate families' availability, and the program offers telehealth appointments when appropriate to allow greater access to services. SAYFE also offers financial support for families to decrease financial burden, so they can engage in services to support their youth.

Demographics

N = 32	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	72%	American Indian/Indigenous	0%
16-25	28%	Other Asian	0%
26-59	0%	Latinx	71.88%
60-73	0%	Pacific Islander	0%
74+	0%	Another race/ethnicity	78.13%
		Unknown/Not Reported	6.25%
Gender Identity		Arab/Middle Eastern	0%
Male/Man/Cisgender	67.71%	Black/African/-American	3.13%
Female/Woman/Cisgender woman	59%	White/Caucasian	37.50%
Other	41.%	Asian Indian/South Asian	0%
Decline to state	0%	Multiple	9.38%
Questioning or unsure	0%	Filipino	6.25%

COMPREHENSIVE FSP "TURNING POINT"

Part of the Youth Full-Service Partnership (FSP), Turning Point Child and Youth (TPCY) Program is designed to support the county's most vulnerable youth and their families to maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and families are best served and supported in the context of their unique family system, culture, and community.

The Turning Point Child and Youth (TPCY) program is a comprehensive program for 45 of the highest risk children/youth living in San Mateo County. TPCY is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family. Youths are primarily referred to TPCY program through Human Services Agency (HSA – child welfare), Juvenile Probation, BHRS regional clinics, and Schools (typically with an IEP for emotional disturbance in place). The 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.)

All programs under the umbrella of the Youth FSP are guided by a strong belief in:

1. Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2. Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:

- Severely Emotionally Disturbed (SED) and dually diagnosed children and youth (ages 6 to 21), including 16/17 old when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless children and youth / Transitional Aged Youth (TAY).
- Children and youth / TAY exiting school-based or IEP-driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in the Turning Point Child/ Youth (CY):

- Are ages 6-21 years old.
- Are at risk for placement in a level 10-14 residential facility or "stepping down" from a level 10-14 residential facility: and
- Must be currently involved in Child and Family Services (Child Welfare) or Probation.

Edgewood's Turning Point CY program works with children, youth, and emerging adults as well as their families to provide services including:

- 24/7 Crisis Support
- Case Management
- Individual and Family Therapy
- Psychiatric Assessments and Medication Support

- Peer Support for Youth and Parents
- Therapeutic After-School Programming
- Housing Support
- Independent Living Skills Development

These services ensure that youth are successful in their transition from higher levels of care back into the community. The TPCY program utilizes the Wraparound model of care for children, youth, and families engaged in its program. In the Youth FSP, the TPCY program provides various services to youths and their families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include: individual therapy with the client's goals that focus primarily on symptom reduction as a meant to improve functional impairments; Group Therapy with the client's goals for more than two or more family members that focus mainly on symptom reduction as a means to improve functional impairments; Family Therapy focuses on the care and management of client's mental health condition within the family system; Collateral services provide support to one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness; and Rehabilitation Services assist in improving, maintaining or restoring functional skills, daily living skills, medication compliance, and access to support resources.

Also, the families and youths have access to the Crisis Response Services provided by the Youth FSP team, which is available twenty-four (24) hours on the weekends and evenings. Families and youth also have access to Behavior Coaching Services and Psychiatry services.

Additionally, wraparound plans are more holistic than traditional care plans. They are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop youth and family members' problem-solving skills, coping skills, and self-efficacy. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Program Impact

Comprehensive FSP	FY 2022-23
Total clients served	69
Total cost per client	$42,661
Cost per contracted slot	$65,414

Improves timely access & linkages for underserved populations: The Youth FSP Turning Point CY program works in collaboration with the other BHRS staff and other providers to assure implementation of each enrollee's Care Plan. The Youth FSP Clinical Intake Coordinator contacts the referent party no later than five (5) business days following authorization by BHRS designated representative and opens the Admin Reporting Unit (RU) within 24 hours of receiving the referral from the Interagency Placement Review Committee (IPRC) team.

Reduces stigma and discrimination: The Turning Point CY program utilizes the Wraparound model of care for children, youth, and families engaged in its program. Wraparound is an intensive, holistic,

evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan prioritizes the youth, the families, or other caregivers' strengths and perspectives.

In addition, TPCY provides Family Conferencing in the care planning process. The Family Conference is family driven, strength-based, and promotes self-reliance. The Family Conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families and to develop an integrated and comprehensive plan for youth and their families/caregivers.

The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

Increases number of individuals receiving public health services: The Youth FSP programs address the whole family and provide support to parents/caregivers when they have mental health or substance abuse needs. The Turning Point CY Family Partners and Case Managers facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division. The Turning Point CY team will provide crisis/brief intervention services to those not meeting criteria and referring them to primary care or community resources, as needed.

The Turning Point CY's treatment team provides support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services and support as identified in the individualized care plan. The Turning Point CY Family Partners provide educational support and linkage focusing on mental illness, co-occurring disorders, and finding resources.

Edgewood operates the only program in San Mateo County focused on kinship families- those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When Turning Point CY serves kinship families, they are also connected to the Kinship Support Network to enhance the wrap-around services to include caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite.

Reduces disparities in access to care: All programs under the umbrella of the Youth FSP are guided by a strong belief in:

- Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
- Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

Implements recovery principles: The Youth FSP, Turning Point CY program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:

- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training.
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence.

Wraparound is a comprehensive, strengths-based, planning process put in place to respond to a serious mental health or behavioral challenge involving children or youth. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve their well-being. Wraparound is also a team-driven process. From the start, a child and family team are formed and works directly with the family as they identify their own needs and strengths. The team develops a service plan that describes specific strategies for meeting the needs identified by the family. The service plan is individualized, with strategies that reflect the child and family's culture and preferences. Wraparound is intended to allow children to live and grow up in a safe, stable, permanent family environment. The Wraparound process can:

- strengths by creating a strength-based intervention plan with a child and family team.
- Promote youth and parent involvement with family voice, choice, and preference.
- Use community-based services.
- Create independence and stability.
- Provide services that fit a child and family's identified needs, culture, and preferences.
- Create one plan to coordinate responses in all life domains.
- Focus on achieving positive goals.

High-Fidelity Wraparound refers to adherence to all the four phases and all the 10 principles to maximize the full benefit of possible success and to maximize the possible positive outcome of the plan.

Successes

The following qualitative FY 2022-23 success story highlights the support the TPCY team provides to each youth and family during their time in the program:

“Mohammed”* is a 10-year-old boy referred to the Turning Point C/Y Wraparound Program from the Daly City Youth Health Center. He and his family currently live in an apartment in Daly City. Mohammed is currently in the fifth grade at his local elementary school.

Mohammed was referred to therapy originally by his school providers and his mother due to symptoms and behaviors, following a traumatic event in the home in which the father was arrested after being violent towards the mother. This was a highly traumatic incident that happened in front of Muhammad and his other siblings. This event was precipitated by years of domestic violence by the

father and witnessed by the children in the home. The father was jailed and prohibited through a protective order from being in contact with the children. This left the mother as the sole caregiver and breadwinner of the family's four children.

The family is originally from an Island Nation in South Asia. The family immigrated to the United States when Mohammed was two years old due to ongoing war in their country and economic difficulties they were facing. Most of the extended family remain in their country of origin. The mother and children have had limited access to family and natural supports in their new community. English is not the mother's first language, which presented a challenge for her in adjusting. The mother historically had not worked outside of the home, and thus when she became the sole responsible parent, she needed to find a job and other financial supports.

Wraparound services were requested to assist the youth with navigating severe irritability, concentration issues, sadness, and tearfulness, consistent fatigue, and daily school refusal. Mohammed would regularly cry and make repeated attempts to stop his mother from walking him to school. He would yell and shove when irritated and refuse to abide by limits and consequences set by the mother. Mother reported extreme distress with the behaviors exhibited by Mohammed and her other children. The elder sibling also had significant school refusal behaviors at the time of referral.

Wraparound services started for this family and included an individual Clinician, Family Partner, Behavior Coach, Care Coordinator, Youth Specialist, and Crisis Response Services. Providers went out to the home to meet with Mohammed and his mother for services. While at the home, the service providers noted significant issues with cleanliness, heating, and safety concerns in the apartment. It was noted that the mother had been working on being organized and on hoarding prior to the referral. There were problems with the plumbing, heating, and unsafe conditions, such as nails coming up from the floor. The care coordinator and family partner worked with the mother to identify solutions to these concerns to improve the safety and cleanliness of the home environment. The mother expressed significant concern with addressing the issues with the landlord, due to fear of retaliation and fear that she may lose her housing. The treatment team respected the mother's voice and choice in this matter and offered alternate solutions to address the issues.

The Care Coordinator requested flex funds to address plumbing concerns in the kitchen and bathroom and worked with a contractor to make these repairs. The Care Coordinator purchased and delivered heaters for the home as well. The Family Partner focused on the organization and cleanliness of the home by working collaboratively with the mother to clean and organize. This was done together with the mother and family partner side-by-side. Strategies were shared regarding how to engage the children in maintenance of the home and teaching cleanliness strategies.

During this time, the Mental Health Clinician and Behavior Coach worked directly with the youth to engage him in treatment sessions. When the treatment providers came out to the home, they often found the youth pretending to be asleep, covering himself with a blanket, and declining to speak; or going into a room and closing the door to avoid treatment sessions. This type of avoidance has lasted throughout treatment but has lessened over time and the youth has come to engage somewhat in treatment meetings. The Mental Health Clinician and Behavior Coach have worked with mother

teaching strategies to help her, engage the youth in treatment meetings, as well as to support the youth with attending school.

The Family Partner went on to support mother with navigating transportation issues as she did not have a car, and to support her with finding and maintaining a job which she had not previously had prior to the incarceration of the father. Additionally, the Family Partner supported the mother with navigating and maintaining her employment while managing the needs of her four children, daycare, family illness, and school refusal issues. The Care Coordinator and treatment team worked to engage the school principal and school psychologist in ongoing discussions and meetings to explore strategies that will assist the youth in attending school more regularly. Accommodation was made by the school to reward the youth for school attendance. Plans were put into place to allow the youth to take space often throughout the school day in a less structured, calm environment. The mother is currently highly involved in the discussions and planning with the school and pleased with the plans that were made to support her son with attending.

Throughout time in the Wraparound program the Mental Health Clinician as well as the Youth Specialist and Behavior Coach have worked directly with the youth encouraging him and strategizing with him to leave the home and attend school. The work has been challenging and many times the youth was unwilling or unable to participate in the treatment meetings. The team, however, persisted.

The youth ultimately did not return to in-person services at his elementary school last year. Over the summer the work continued with the youth by the treatment team and the parent. The family partner encouraged the mother to take the youth on a tour of his new middle school that he was expected to start at the beginning of this school year. The youth was open to touring the school with mother during the summertime. With ongoing support from the treatment team, encouragement, and knowing he had already been on the campus, The youth was successfully able to overcome his anxieties and start attending school in person when middle school started this fall. So far, the youth has continued with his school success and been attending daily. The treatment team has seen this as a major success and functional improvement.

Currently, the treatment team has moved into supporting the family with the return of father to the home. Following the traumatic event in the home that led to the referral to wraparound services, the father was jailed and prohibited through a protective order from being in contact with the mother and children. During treatment, the protective order was lifted. In recent months, the mother reported to the treatment team she intended to welcome the father back to the family home. The treatment team worked with the mother and the father's probation officer to determine what support would be needed as he transitioned back into the daily lives of the children.

Currently the father, mother, and children are working with the wraparound team on this next phase of treatment. The team will work further with the family around safety, communication, and healing from trauma.

*The name and some identifying factors have been changed to protect the youth’s identity.
Quantitative data were provided through the submission of documentation to the state database and unfortunately do not receive the aggregate results of these data.

Challenges

The Turning Point CY program continues to face certain barriers in providing services to referred families. One of the key barriers is lack of staffing. It has become increasingly difficult across the state, and in the Wraparound program, to locate, hire, train, and retain high-quality candidates. A particular difficulty has been hiring and retaining Peer Family Partners and Mental Health Clinicians to provide individual and family therapy to families. This is a challenge faced by mental health programs and regions across the state. Turning Point CY is a similar position of navigating this shortage of mental health staff it its program.

Another significant barrier to providing the highest quality of wraparound services is the ongoing COVID-19 protocols and restrictions. Like other programs, Turning Point CY continues to face difficulty with providing services to families in person, as COVID-19 infections continue to occur. It is inhibiting the program's ability to provide in person services at the family homes, schools, and other community locations due to the protocols and policies that serve to limit face-to-face interactions, and limit outside providers from coming into facilities, and being welcomed at the homes.

Lastly, another significant challenge and barrier is that of language capacity needs. In the Turning Point Wraparound program, families from diverse background with diverse primary languages spoken in the home are referred. The language capacity of program staff is not as diverse as that of its clients. This represents a challenge in properly serving a wide variety of families, particularly caregivers, who may be monolingual in a language that the provider is not proficient in. Although interpretation services for treatment meetings and conferences are available, it is preferable for the clients to have staff that are proficient in their preferred language. This can limit the effectiveness of interventions and the rapport that is developed between the client and the staff members.

Demographics

N = 69	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	72%	American Indian/Indigenous	3.32%
16-25	28%	Samoan	1.45%
26-59	0%	Latinx	59.42%
60-73	0%	Other Pacific Islander	1.45%
74+	0%	Another race/ethnicity	59.42%
		Unknown/Not Reported	21.74%
Gender Identity		Tongan	1.45%
Male/Man/Cisgender	41%	Black/African/-American	2.90%
Female/Woman/Cisgender woman	59%	White/Caucasian	21.74%
Other	0.%	Asian Indian/South Asian	1.45%
Decline to state	0%	Multiple	10.14%
Questioning or unsure	0%	Filipino	5.80%

OUT-OF-COUNTY FOSTER CARE FSP

Through the collaborative relationship between San Mateo County and Fred Finch Youth & Family Services (FF), the East Bay Wraparound (EBW) formed a Full-Service Partnership (FSP) in 2010. The EBW-FSP program provides a full spectrum of community-based services to enable participants to achieve their identified goals. FF provides a wraparound services model to promote wellness, self-sufficiency, and self-care/healing to youth who are San Mateo County Court dependents (foster youth) who currently live outside of the county.

Wraparound services are a comprehensive and holistic way of providing care when children or youth experience serious mental health or behavioral challenges. All services are strengths-based, needs-driven and collaborative. The focus is on building individual and family strengths to help families achieve positive goals and improve well-being. The team, which is made up of many community partners, the family, youth, social workers, child welfare providers, Court Appointed Special Advocate (CASAs), and EBW staff all work together to develop an individualized service plan to meet a youth and family's identified needs, culture, and preferences. Every youth and family have a voice, choice, and preference. EBW services foster independence and stability in each youth and family.

EBW serves youth in foster care placements outside of San Mateo County who are at risk of losing their current residence and/or at risk for placement in a higher level of care. This program services youth aged six to twenty-one, as well as their foster parents/caregivers and parents/family members. Typically, this population of youth has experienced some crisis or safety issue in their home or has had a history of multiple placements.

Services include community-based, in-home, individual, and family therapy; individual rehabilitation/intensive home-based services; case management, including linking participants and families to natural and community resources, and intensive care coordination; psychoeducation; integrated medication support services; and crisis intervention. Services are available to participants and their families twenty-four hours a day, given a target population prone to significant emotional and behavioral disruptions resulting from family stress, extreme behaviors, and care fatigue. Typically, service delivery occurs in the afternoon and evening. Staff tailor service delivery schedules for each participant’s convenience. Participants can access services on weekends and after-hours through the on-call service.

Program Impact

Out-of-County FSP	FY 2022-23
Total clients served	4
Total cost per client	$58,999
Cost per contracted slots	$23,600

Timely Access and Linkage: The East Bay Wrap (EBW) program has a “do what it takes” motto. EBW is committed to opening all new referrals within a 10-day period. Linking families to needed services

occurs at the initial case opening and throughout every episode of care. EBW staff frequently partner with many community-based organizations, nonprofits, and social service foundations to decrease many remnants of social and economic disruptions caused by COVID-19 for wraparound families.

Reducing Stigma and Discrimination: There are many ways in which EBW is striving to reduce mental health stigma. The team is staffed with youth and parent partners who have lived experience. Families have reported that having a staff team member who has navigated similar struggles helps them to feel less judged and "able to be themselves" thus creating a more therapeutic environment for permanent change to occur. EBW also provides advocacy and psychosocial education about the three stigmas of mental health (public, self and systemic) to families, participants, and natural supports to reduce stigma and shame around accessing mental health services. EBW staff are encouraged to use each participant's preferred identity first language in reference to their mental health challenges and disabilities. Using a participant's preferred identity language actively empowers EBW participants and their families to realize that their mental health challenges and disabilities are important parts of their identity that should be held without shame while also acknowledging the intersectionality of their many identities. The program is also improving organizational and individual cultural humility through education, training, workforce development, hiring strategies, and policy changes.

Increased Number of Individuals Receiving Public Health Services: Wraparound services remove many of the barriers to families receiving therapeutic services. All services are provided in the safest, most accessible, and least restrictive environment to decrease financial, time and distance barriers often associated with receiving care. EBW staff often have sessions in a participant's home and/or community locations (parks, schools, and community spaces).

Reduced Disparities in Access to Care: Individuals from vulnerable populations, the Bay Area's unserved, underserved, under-resourced, and ineffectively served individuals and families, often face barriers to accessing care in the Bay Area. Program staff participate in community outreach efforts and fund-raising events to increase access to care.

Recovery Principles: EBW is guided by the overarching recovery principle of caring for the whole individual. All care is individualized and person-centered. Staff acknowledge and believe that there are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences, and cultural backgrounds.

Successes

The program received 1 additional referral compared to previous years. Most participants in the program experienced a noticeable decrease in symptoms.

Challenges

Despite an additional referral this fiscal year, low enrollment in the program as well as decreased referrals continue to be a challenge for the sustainability of the program. While referrals have been historically low given this service is specific to youth placed out-of-county, the challenge continues to be addressed at quarterly oversight meetings with Fred Finch and BHRS. The Child Welfare unit supervisor attends Children and Family Services (CFS) leadership meetings and reminds new supervisors of this resource. Additionally, Presumptive Transfer has led to decreased referrals; Presumptive Transfer includes the prompt transfer of the responsibility for providing and paying for specialty mental health services for children and youth in foster care who are placed outside of the county in which they came into care.

Demographics

N=4	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	75%	American Indian/Indigenous	0%
16-25	25%	Hawaiian Native	0%
26-59	0%	Latinx	75%
60-73	0%	Pacific Islander	0%
74+	0%	Another race/ethnicity	50%
		Unknown/Not Reported	25%
Gender Identity		Other Pacific Islander	0%
Male/Man/Cisgender	75%	Black/African/-American	25%
Female/Woman/Cisgender woman	25%	White/Caucasian	25%
Other	0.%	Asian Indian/South Asian	0%
Decline to state	0%	Cambodian	0%
Questioning or unsure	0%	Chinese	0%

TRANSITION AGE YOUTH (TAY) FSP

TAY FSPs provide intensive community-based supports and services to youth identified as having the "highest needs" and can include transition age youth 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, involvement in the juvenile justice system and improves the quality of life for youth clients.

COMPREHENSIVE TAY FSP + DROP-IN CENTER

Edgewood's Transitional Age Youth Full Service Partnership (TAY FSP) program is a specialized mental health program designed to meet the unique needs of high risk and highly acute transition age youth between the ages of 17-25 in San Mateo County; 16 year olds and up to age 18 that are still enrolled in high school will continue to be served by the Turning Point C/Y FSP. Considered the last treatment option prior to a residential placement, the TAY FSP program provides intensive, round the clock support to help youth reach and maintain stability in the community and transition into adulthood.

The TAY FSP program works to address the youth's identified needs while also building awareness around the choices and behaviors that oftentimes lead to isolation, hospitalization, incarceration, homelessness, and increasingly risky substance use. BHRS refers youth who are residents of San Mateo County, between the ages of 17-25, and meet at least one of the following eligibility criteria:

- Considered a person who has been diagnosed as Severely Emotionally Disturbed (SED), Severely Mentally Ill (SMI)[4], and/or dually diagnosed with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays in the past 2 years.
- Exiting school-based mental health or IEP driven services and meeting criteria as SED, SMI or dually diagnosed
- SED or SMI and homeless or at-risk of homelessness
- SED and/or dually diagnosed and at risk of out-of-home placement or returning from residential placement.
- Newly identified individuals who are experiencing "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice and/or child welfare systems.

The TAY FSP engages as much of the youth's biological family, chosen family, and other permanent, supportive adults to support the youth's treatment, but most importantly to be the network of support once youth have graduated from the program.

While the internal team creates a comprehensive network of support around each youth, the overarching goal is for youth to develop skills, strengthen their natural support system, and learn when and how to deploy their tools for healthy, independent living.

The TAY FSP program offers a wide range of services to best address the needs of young people struggling with mental health. These services include:

- Age-Specific groups and activities
- Independent Living Skill Acquisition
- Crisis Response
- Educational/Vocational Support
- Financial and Housing Support
- Linkage to Resources
- Career and Education Guidance

[4] SMI are one or more mental, behavioral, or emotional disorder(s) in adults and older adults diagnosis resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

- Peer to Peer Support
- Family Conferencing
- Individual and Family therapy
- Case Management and Care Coordination
- Psychiatry

Their multidisciplinary, multicultural, multilingual team of providers engage youth in the menu of services including case management, clinical treatment (psychiatry, individual therapy, and family therapy as needed), crisis prevention/intervention, support network building and engagement, and medication management.

The TAY Drop-In Centers, located in San Bruno and Redwood City, are community resource centers catering to transition age youth between the ages of 18-25 years (up to their 26th birthday). Due to concerns with separating of minors from adults, and other risks and potential liability, the program is not available for 16-17 year olds. Each peer-led site serves as a safe and confidential space offering free resources, activities and workshops, and opportunities for socialization and peer connection. Success at the Drop-in Centers is measured individually and is fluid according to how each transition age youth participant defines self-efficacy. The primary goals of the Drop-In Centers are to promote socialization and community connection, support academic/vocational exploration and growth, encourage the development of independent living skills, and empower rising leaders and advocates.

The target population of the Drop-In Centers are individuals between the ages of 18-25 years. The individuals are guided by Peer Partners, young adults who have been through similar life experiences, are an invaluable resource to the Drop-In Center participants. Employing people with lived experience in peer worker roles to support others brings a tremendous range of benefits. Peer Partners know what it is like to go through uniquely difficult situations and life experiences and can share their experiences of recovery, growth, and resilience. Peer Partners who are living well represent hope that is often missing in the Drop-In Center participant's lives.

Peer Partners facilitate a safe and welcoming environment using empathy, validation, constructive feedback, and unconditional support. Peer Partners are trained in Youth Development, Harm Reduction, and peer counseling techniques. Peer Partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities. Primary program activities/interventions provided include:

- Regularly scheduled programming such as community outings, social activities, personal growth focus groups, and wellness workshops.
- On-site resources including opportunities for partnerships with community programs, links to services external to Edgewood, and access to basic needs like healthy meals, technology, clothing, and hygiene products.
- Peer Partners lead activities that support 18-25-year-old participants in building the necessary skills to successfully transition to adulthood.
- Three to four on-site events per year that include two Health Education Fairs, a Back to School Distribution, and the popular Hoodie Haul which distributes winter apparel and resources to the community of Transitional Age Youth.

Program Impact

Comprehensive TAY FSP	FY 2022-23
Total clients served in FSP	62
Total clients served in Drop-In Center	145
Total cost per client	$50,933
Cost per contracted slot	$63,157

Improves timely access & linkages for underserved populations: The TAY program has developed the intake process to ensure timely access and linkages for underserved populations through the following steps; utilizing a clinical intake coordinator to ensure quick turnaround with new referrals; gathering all necessary documentation and information immediately; and swiftly assign clients to treatment teams. The initial screening and assessment are used to identify needs and make initial linkages to services.

Reduces stigma and discrimination: TAY program staff are engaged in ongoing training and coaching to address issues of inherent stigma and discrimination faced by themselves and clients. Team members are strong advocates for clients when they face these issues during their treatment.

Increases number of individuals receiving public health services: The TAY program works closely with the Drop-In Centers to provide workshops and psycho education opportunities for both TAY clients and other community members utilizing the Drop-In Centers. TAY program staff provide clients and their families support with referral information to access their own services as needed.

Reduces disparities in access to care: The TAY program is designed to engage in treating the most underserved populations. The program has bi-lingual team members and the ability to successfully engage translation services. Team members work in the community and meet clients wherever they are at, this includes homes, businesses, public spaces, County offices, neighborhoods, and anywhere else deemed necessary to provide services to the clients.

Implements recovery principles: The TAY FSP program implements Edgewood's trauma informed principles through training and incorporating the principles in goals set at both a leadership and cohort level. Program leadership emphasizes a trauma informed lens at all levels of the program. Safety is prioritized for clients and staff. Transparency and follow-through with clients and their support networks build trusting relationships. Staff work across teams to train, consult, and support each other; while clients are connected with each other in workshops, Drop-In Centers, and social outings. Staff collaborate with clients and their supports to identify goals and build treatment plans. All team members bring a therapeutic lens to their work to build healing relationships at all levels. TAY staff voices are valued and welcomed in program decisions, as are client voices in treatment decisions. The TAY team values its diverse, multicultural members and clients. Issues of diversity, equity, inclusion, race, ethnicity, and culture are discussed and addressed at both the staff and client level of the program.

Successes

The TAY FSP program is especially proud of a recent graduate of the program that has moved away to begin attending college at Sonoma State. This client entered the program with a diagnosis of acute anxiety that had prevented her from fully engaging in high school, social relationships, and employment. The TAY treatment team was able to build trusting relationships, engage client in therapy, behavior coaching, and utilize case management to connect her to support systems. With this support in place, the client was able to gain acceptance to college, successfully navigate enrollment and the move to campus, complete her treatment goals, and graduate from the TAY program.

Since the pandemic, the TAY Drop-In Centers have increased the number of on-site participants, almost three times as much since 2019. The increased attendance is attributed to the centers' commitment to providing relevant and meaningful resources and support to the TAY community including hosting four major distribution events, increase in community outings, and providing basic needs such as food and personal care items. With additional grant funding, the Drop-In Centers also provided seasonal specific clothing (hoodies, scarves, gloves, and other outerwear), devices like tablets and laptops that help connect TAY to educational and health resources, health equipment (yoga mats, fidgets, prescription eyewear, and more), hygiene and personal care products, and backpacks and school supplies.

As a testament to the Drop-In Centers ability to support many TAY in San Mateo County, the centers' continue to receive grant funding from the Chan Zuckerberg Initiative, the Sequoia Health Care District and the San Bruno Community Foundation to provide ongoing health resource support and other basic needs to TAY who continued to struggle even as the community has overcome the COVID-19 pandemic. This past year, of the 145 TAY served through at the Drop-In Center, 52 were new participants. Additionally, the grant from the SBCF will give the Drop-In Centers the ability to reach more TAY in the community through the Mobile Drop-In Center van which will provide resources to TAY located in underserved communities like East Palo Alto, the Coast, and North County.

One example of the Drop-In Centers successful efforts was expressed by a TAY participant who regularly receives basic-need resources and engages in center activities. This TAY lives independently and is currently enrolled in a vocational program. The TAY utilizes Drop-In Center support to supplement the limited income they have and has expressed to the team that if it wasn't for the hygiene supplies and food they receive from the program, they would not be able to "survive" living alone. This TAY also has developed a trusting relationship with the Peer Partners who are able to give them guidance and support with challenging peer relationships. The TAY participant hopes to finish their vocational program within two years and will continue to seek support at the Drop-In Centers so they can fulfill their ultimate goal of being an independent adult.

Challenges

The biggest ongoing challenge faced by the TAY program is low client engagement. Many clients that are referred to the program have barriers to engagement such as: acute symptoms, unstable housing,

distrust of County, substance use, and transportation issues. TAY program staff focus on a combination of relationship building to foster connection, quick delivery of vital resources to address client's needs, and targeted interventions to stabilize mental health symptoms. A greater focus on "warm hand-offs" and increased periods of crossover between the referring programs and the TAY FSP program could help mitigate some of the ongoing engagement issues.

The TAY Drop-In Centers main challenge continues to be lack of staffing. Edgewood Center's Drop-In Centers carry out various projects, activities, and events, which require a certain amount of staff support. Without the proper amount of staffing, the Drop-In Centers are unable to open each center five days a week. The Drop-In Centers also has been impacted by the increase in the cost of operating the center. Janitorial services have increased to the point where the number of days the centers are cleaned and maintained has had to be reduced. Also, the inflated cost of grocery items, including food and cleaning supplies has impacted the Drop-In Centers ability to provide basic resources to its participants. The increased cost of these operating expenses is crucial to resolve as it can impact the participant experience and environment the Drop-In Centers create for TAY.

Demographics

62 Participants	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	0%	American Indian/Indigenous	3.23%
16-25	100%	Hawaiian Native	3.23%
26-59	0%	Latinx	54.84 %
60-73	0%	Pacific Islander	7.87%
74+	0%	Another race/ethnicity	54.84%
		Unknown/Not Reported	14.52%
Gender Identity		Other Pacific Islander	1.61%
Male/Man/Cisgender	38.71%	Black/African/-American	11.29%
Female/Woman/Cisgender woman	61.29%	White/Caucasian	25.81%
Other	0.%	Asian Indian/South Asian	1.61%
Decline to state	0%	Cambodian	1.61%
Questioning or unsure	0%	Chinese	3.23%
		Multiple	12.90%
		Filipino	4.84%
		Tongan	3.23%

ENHANCED SUPPORTED EDUCATION

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 BHRS. 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 because 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.

In addition to the campus presence, the Supported Education program has an extensive presence in the community, with regular weekly groups at Caminar's residential programs such as skills groups, self-care groups, activity groups, and processing groups. The program also has a twice weekly virtual drop-in time for clients to get school and career assistance.

The Supported Education program is also a part of Caminar's Diversity and Equity Committee and the BHC Adult and TAY subcommittees. The Supported Education program strives to reach out and engage individuals who can benefit from engagement in the supported education program. To this end, the supported education program team has reached out to a wide number of community programs throughout the fiscal year, to reach out and engage clients into supported education services, thereby initiating a pathway of recovery, support, and empowerment. Once engaged in the supported education program, clients begin to see their potential and the opportunities available to them. Classes and groups also build on recovery principals such as Wellness Recovery Action Plan (WRAP), personal and career skills-building, resource education and linkage, empowerment through education and career development, leadership potential, a peer support group, and engagement utilizing active listening, motivational interviewing, and supportive engagement.

Providing a pathway for clients into a new identity as a student, Peer Counselor, or other career pathway greatly increases personal self-esteem and helps re-write the 'client' narrative, thereby decreasing the stigma commonly associated with persons receiving behavioral health services.

Program Impact

Supported Education	FY 2022-23
Total clients served	109
Total cost per client	$1,874

Improves timely access & linkages for underserved populations: The program participates in outreach activities throughout the county such as the 'Recovery Happens' events, San Mateo Adult School Resource Fair, and at other community events and programs working with underserved populations.

Reduces stigma and discrimination: When mental health consumers participate in the peer counseling class or classes with support at local colleges, they begin to internalize a new, healthier identity as a 'student' not as a 'client' or 'patient'.

Increases number of individuals receiving public health services: As a participant in the program, individuals receive a personalized assessment of needs and linkage to resources, as well as learning needs assessment and resource linkage skills in the peer counseling class.

Reduces disparities in access to care: Supported Education instruction builds personal and peer counselor advocacy skills, as well as promoting access to services throughout the community. There are no requirements or barriers for participation in the supported education program, and because of an 'open door' policy, individuals having difficulty identifying and linking to traditional services find that they can have personal support for linkage to other resources and services.

Implements recovery principles: The Supported Education program is built around supporting, teaching, and implementing recovery principles. The peer counseling class focuses on learning and being able to model personal wellness through covering essential recovery practices such as WRAP skills, harm reduction, motivational interviewing skills, active listening, while supporting consumer growth and skills acquisition. Staff also conduct community groups that focus on skill building for personal growth and self-care activities and skills.

The supported education program focuses on connecting individuals with educational and vocational services and by providing individualized supports. With these supports, during the FY 2022-23, students attending Fall and Spring semesters of the Peer Counseling program, had GPA and retention rates are as follows:

- Achieved an overall GPA of 3.2
- Attained a retention rate of 81%

Additionally, through the development of supports such as staff and student support groups, the individual client benefits from a supportive, nurturing, and empowering environment that fosters self-reliance, self-care, and in turn decreases the isolation and stresses that often precipitates an increase in symptoms or a decrease in functioning.

- 100% Reported that their class experience was satisfactory or above.

Curriculum Summary:

- Peer Counseling Class 1 Fall. Orientation, digital literacy, academic skills HIPAA, boundaries, Carl Rogers active listening, hierarchy of needs, Humanistic Psychology, overview of academic programs, group facilitation, communication essentials, roles of families and consumers, WRAP, ACA code of ethics, self-care, diversity and equity programs, and the models of recovery.
- Peer Counseling Class 2 Spring. Review of active listening, Motivational Interviewing/ stages of change, Harm Reduction/AOD/co-occurring models, Trauma Informed Care, classical/operant conditioning, Cognitive Behavioral Theory, problem solving/conflict resolution, the role of advocacy, assessment concepts, developing a treatment plan, writing progress notes/ documentation guidelines, and a career project.

Course Outcomes:

- *Fall Semester*- 8 students completed the Peer Counseling 1 class.
- *Spring Semester*- 5 students completed the Peer Counseling 2 class.
- 6 students are working in human services/mental health field, 1 is continuing school.
- The program served 109 unduplicated clients, with 20 TAY (transition-age-adults).
- 207 Hours of service were provided (12,440 minutes).
- 30 engagement activities for TAY were offered (classes, groups, outings, one to one).

Successes

One recent peer counseling graduate of both peer counseling 1 in the Fall and peer counseling 2 in the Spring, obtained employment at a community agency which is strong in advocacy, and is also enrolled at the local college's Alcohol and Other Drugs studies, with plans to attend in the Fall semester of 2023.The Supported Education program was also able to offer classes for one of the community programs in Vallejo, Solano County on-line. The Supported Education program will be offering hybrid classes for FY 2023-24 to be able to meet prospective student's needs.

Challenges

Housing affordability continues to be a major hurdle for stability for community members. Many have moved out of the area in hopes of securing more affordable housing. Some individuals who have had to relocate have continued participation in the program and have utilized new skills to secure employment and continued academic participation in other California counties.

Demographics

Age (N = 14)	#	%	Sex assigned at birth (N = 123)	#	%
Age 0-15	10	9%	Male	30	24%
Age 16-25	3	3%	Female	91	74%
26-59	98	86%	Decline to state	1	1%
60+	2	2%			
decline to state	1	1%			
Primary language (N = 123)		**%**	**Intersex (N = 110)**	**#**	**%**
English	21	17%	Yes	2	2%
Spanish	98	80%	No	104	95%
Mandarin	1	1%	Decline to state	3	3%
Cantonese	0	0%			
Tagalog	1	1%			
Russian	0	0%			
Samoan	0	0%			

Tongan	0	0%			
Another language	1	1%			
Race/Ethnicity (N = 117)		**%**	**Gender Identity (N = 122)**	**#**	**%**
American Indian/ Alaska Native/	0	0%	Male/Man/ Cisgender	31	25%
Asian	2	2%	Female/ Woman/ Cisgender Woman	86	70%
Eastern Europe	0	0%	Transgender Male	0	0%
European	0	0%	Transgender Woman	1	1%
Arab/Middle Eastern	0	0%	Questioning/ unsure	0	0%
Black/ African- American	2	2%	Genderqueer/ Nonconforming	0	0%
White/ Caucasian	3	3%	Indigenous gender identity	0	0%
Asian Indian/ South Asian	1	1%	Another gender identity	0	0%
Caribbean	0	0%	Decline to state	4	3%
Fijian	1	1%	**Sexual Orientation (N = 104)**	**#**	**%**
Cambodian	0	0%	Gay, lesbian, homosexual	0	0%
Central American	16	14%	Straight or heterosexual	87	84%
Guamanian	0	0%	Bisexual	0	0%
Chinese	1	1%	Decline to state	15	14%
Mexican/ Chicano	66	56%	Queer	0	0%
Native Hawaiian	0	0%	Pansexual	0	0%
Filipino	3	3%	Asexual	0	0%
Puerto Rican	1	1%	Questioning or unsure	2	2%
Samoan	1	1%	Indigenous Sexual orientation	0	0%
Japanese	0	0%	Another sexual orientation	0	0%
South American	10	9%	**Disability/Learning difficulty (N = 117)**	**#**	**%**
Tongan	0	0%	Difficulty seeing	8	7%
Korean	0	0%	Difficulty hearing or having speech	2	2%
Vietnamese	0	0%	Dementia	1	1%
Another race/ ethnicity	9	8%	Developmental disability	0	0%
Veteran (N = 122)	**#**	**%**	Physical/ mobility disability	0	0%
Yes	2	2%	Chronic health condition	0	0%
No	116	95%	Learning disability	3	3%
Decline to state	2	2%	I do not have a disability	86	74%
			Another disability	1	1%
			Decline to state	7	6%

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Outreach and Support Services 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.

Telecare FSP, via the integrated teams model uses daily morning huddles to assertively coordinate and track the various service needs for every individual the teams serve. Including benefits acquisition, psychiatric appointments and medication, case management and evidence-based rehabilitation and other promising practices, the teams proactively identify needs and gaps in service and provide, broker, or advocate for those necessary services or resources. The concentrated effort of each team affords the opportunity to engage in continual improvement for clients lives by circling back on progress made in all the areas identified.

Telecare delivers excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes and dreams. Utilizing a team-based approach, clients have 24/7 access to a team member that has working knowledge of their hopes and dreams, treatment plan goals, interventions that have worked and those that do not. Furthermore, each team incorporates titrated services ranging from the most intensive (FSP level) through Case Management and into Wellness.

These levels allow members to progress in their recovery journey while keeping their support team intact and allows for aging members to move back into higher levels of support, keeping their support team intact. All service recipients are adults or older adults that are on their recovery journey from complex behavioral health challenges including serious and persistent mental illness, co-occurring medical issues, substance use, criminogenic profiles and more.

Activities, services, and interventions include but are not limited to assessment and treatment planning, psychiatry, case management, medication support, vocational development/ brokerage, supported education brokerage, numerous evidence based and promising practices such as Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Seeking Safety, Recovery Centered Clinical Systems (RCCS), Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.

Program Impact

Telecare Adult/Older Adult FSP	FY 2022-23
Total clients served	254
Total cost per client	$11,610
Cost per contracted slots	$14,246

Improves timely access & linkages for underserved populations: With very few exceptions, initial meetings with new clients occur in less than 3 business days of the referral. Engagement, assessment, and treatment plan development start in that initial meeting.

Reduces stigma and discrimination: The multi-disciplinary teams are comprised of varying professions (Case Managers, Licensed Clinicians, Nurses, and a Prescriber). Still, they also comprise a high number of individuals with lived experience. Approximately 80% of the Telecare teams are individuals on their recovery journey. This normalizes the process, establishes rapport, and reduces stigma.

Increases number of individuals receiving public health services: The program takes almost all client referrals, with few exceptions. They refer, link, and connect clients with various public health providers. Within the first two weeks of working with a new member, the team searches for benefits to which the member is entitled and helps establish those benefits for the member.

Reduces disparities in access to care: Daily team huddles are conducted, and members' circumstances are reviewed to ensure that all members have access to but are not limited to the following: psychiatric and medical care, financial benefits, access to housing options, food security, vocational and educational resources. Furthermore, as part of BHRS' effort to improve care coordination for individuals with complex needs, Telecare FSP participates in cross-over collaborative efforts and has representation at the planning level.

Implements recovery principles: Telecare's clinical model, Recovery Centered Clinical Systems (RCCS), is at the core of operations. The staff focus on recovery in the aspects of the care provided. Staff also partner with the person using Motivational Interviewing (MI) and Recovery Centered Clinical System conversations to highlight their choices in both interventions and desired outcomes.

Successes

The program uses intentional service delivery--based on a person's stated preference of goals, staff know what behaviors they want to address and what interventions they will use prior to meeting with the clients.

Client Success Story #1: "Ann" came to telecare with a history of homelessness, substance use challenges, and legal issues. After more than ten years living on the streets of the peninsula, she was enrolled with Telecare as well as at the Catherine Center, where with support she was able to thrive and participate in the program for over a year and a half. During this time, she enrolled in college courses, and is still actively working towards her paralegal certificate. Last semester she made honor roll at her school. While pursuing this degree, she successfully transitioned from Catherine Center to

Spring St. shelter, to transitional housing, and currently has her own apartment. She has over 4 years of sobriety and continues to stay connected within the AOD community participating in groups and trying to help others through sharing her story. With all her hard work she recently reconnected with her daughter and additionally works as an ally for the LGBTQ community, participating in events such as Pacifica's Pride Parade this year.

Throughout this time, the team supported her with weekly meetings at Catherine Center, and eventually preparing her for discharge, supporting Ivy with moving to temporary housing (hotel, where she was granted temporary assistance via her school funding). The team then arranged a referral to Spring St. Shelter and supported her with getting into there. After continued meetings with case managers, monthly psychiatric appointments, and consistent participation by the client, she was able to obtain a housing voucher. The program supported her with moving to her apartment and with finding information regarding food support due to semi-isolated area of apartment. Also, while the client was in transitional housing, the team supported her in obtaining medication, and medication management. The program continued to increase support when needed including supporting the client in navigating enrollment in school.

As a full-service partnership, the program supported her with various aspects of her life including, but not limited to examining plans, discussing future goals, and assisting her with identifying steps needed to obtain them.

Client Success Story #2: "Diane" was referred to Telecare in January 2023 due to hospitalizations stemming from eloping behaviors and the inability to care for herself. Diane would leave her father's home in Menlo Park and go missing for weeks, ultimately being found by police in a state of illness, disorientation, and dysregulation.

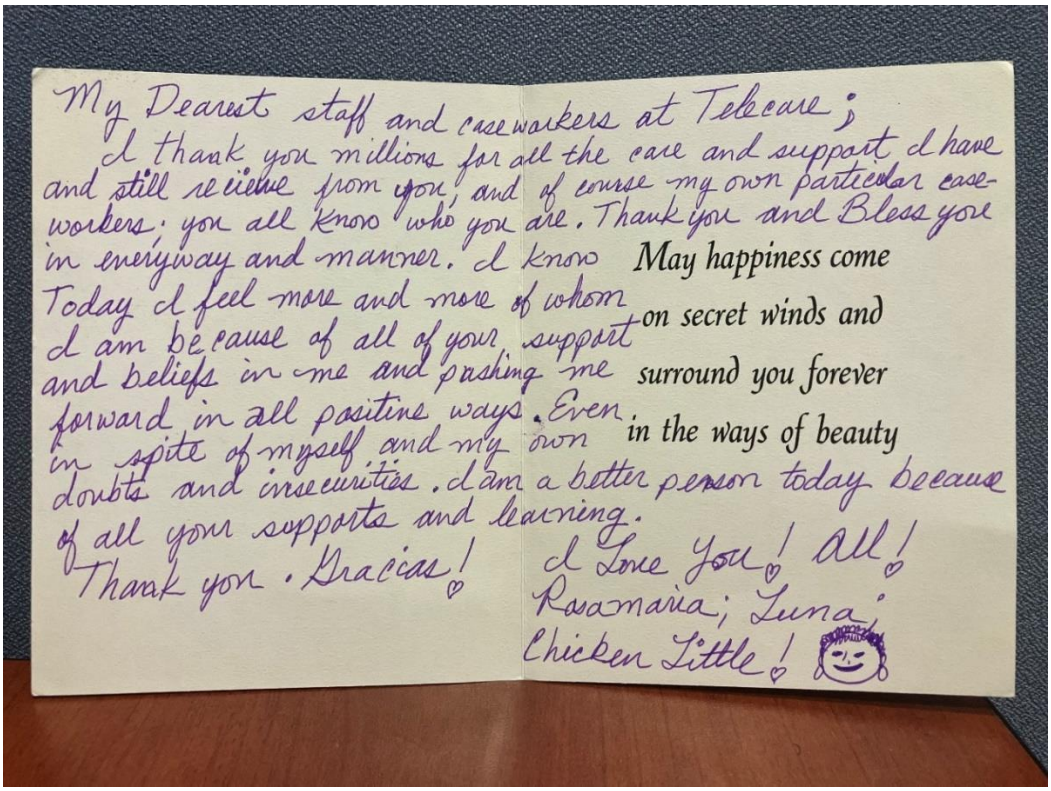
The program established a working relationship with Diane and her family and assisted to have her formally assessed for intellectual disabilities. The program initiated an assessment appointment with Golden Gate Regional Center (GGRC) and helped transfer her living situation to a more secure setting with enriching opportunities and advocated for conservatorship for her.

Currently Diane lives at Cordilleras MHRC as a conserved adult with GGRC services. She regularly sees her father and participates in group activities at her residence. Telecare FSP played a vital role in engaging community resources to create a clear path for Diane so that she can have a higher quality of life.

Client Success Story #3: Three years ago, "David's" world seemed to crumble when he faced the devastating loss of his mother. The pain was unbearable, and he found himself struggling to cope with both the grief and challenges life threw at him.

However, amidst the depth of his despair, he remained hopeful. The first step was seeking the support he needed. He began attending therapy sessions, where he learned healthy ways to process his emotions and develop coping skills. His partnership with the team and therapy has helped him gain the confidence to embark on his journey to continue his education. He is now enrolled in community college classes and will be starting in the fall.

See also a note from a client below:



Challenges

During the pandemic it was challenging to provide group services and interventions. However, now that restrictions have eased, the program has been able to start several groups such as: art therapy, processing group, co-occurring, cooking safety, life skills, etc. The program aggressively pursues measures to continue to improve services to the clients. Staff use a variety of tools including in-person and virtual appointments, technology that allows documentation in the field with the client served, increased response and flexibility, etc. Telecare's ability to act proactively, swiftly, and competently in serving the clients is evident. The program is deeply committed to the mission of excellence in San Mateo County.

Demographics

254 Participants	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	0%	American Indian/Indigenous	5.51%
16-25	4%	Other Asian	3.93%
26-59	67.32%	Latinx	30.71%
60-73	25.19%	Pacific Islander	7.87%
74+	3%	Another race/ethnicity	32.28%

		Decline to state	0%
Gender Identity		Arab/Middle Eastern	0.9%
Male/Man/Cisgender	67.71%	Black/African/-American	15.35%
Female/Woman/Cisgender woman	32.28%	White/Caucasian	57.09%
Other	0.%	Asian Indian/South Asian	.39%
Decline to state	0%	Central American	0%
Questioning or unsure	0%	Chinese	3.54%
		Mexican/Chicano	0%
		Filipino	5.12%
		Japanese	2.36%

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

Caminar's FSP program is designed to serve the highest risk adults and highest risk older adults that are medically fragile. Most adults with SMI served by FSP have histories of hospitalization, institutionalization, and substance use, are not engaged in medical treatment, and have difficulty participating in structured activities and living independently. Older adults often have cognitive impairments and medical comorbidities.

The FSP program assists clients to enroll and once enrolled, to achieve independence, stability, and wellness within the context of their culture and communities. The goal of this program is to divert clients from the criminal justice system and acute long-term institutional levels of care and help them succeed in the community and to achieve their wellness and recovery goals, maximize their use of community resources, integrate client's family members or other support people into their treatment, achieve wellness, independence, and improved quality of life.

Caminar FSP has a staffing ratio of 10:1, staff to consumers. FSP has the capacity to serve 30 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, medication non-compliance, and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services, include money management, assisting with employment opportunities, social rehab and assistance with referrals and housing. Caminar also provides community-based nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7, crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help to plan for linkage to and coordination with primary care services, with the intent of the strengthening the client's ability to access healthcare services and ensuring follow up with detailed care plans.

Program Impact

Caminar Adult/Older Adult FSP	FY 2022-23
Total clients served	31
Total cost per client	$55,262
Cost per contracted slot	$57,104

Caminar FSP reduces risk by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability and its implementation of the Pro-Act training. All management staff is trained and certified to initiate involuntary hospitalization, when indicated. The program limits school failure and drop out through its Supported Education program and helps lower unemployment by utilizing its Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and in San Mateo County, in particular. Through its Supported Housing program, Caminar provides housing options to clients in need of independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, Single Room Occupancy (SRO) rooms, shelters, and unlicensed room and boards.

Once a client is referred to Caminar services, staff attempts to initiate contact for Case Management within two (2) business days and psychiatry within 5 business days. Clients are assessed rapidly and comprehensively by case managers, a psychiatrist, and Clinic Manager/Registered Nurse (RN). The Clinic Manager/RN completes a Nursing Assessment for all clients admitted to the program. Furthermore, FSP also utilizes a Mediation Assistance Program (MAP) to increase medication compliance and to reduce the risk of clients overtaking or undertaking their medications.

By utilizing the social rehabilitation model, which provides for a non-judgmental, normalized environment which emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination the population often faces. The team ensures linkage to outside community providers for primary care and ongoing collaboration with said providers; this helps ensure that Caminar's clients are receiving public health services. By partnering with other non-profit agencies, Caminar helps reduce the disparities in access to care. Finally, Caminar utilizes interventions such as Harm Reduction, Motivational Interviewing (MI), Dialectical behavior therapy (DBT), and Wellness Recovery Action Plans (WRAP) to help strengthen the gains made by clients and to implement the principles of recovery throughout all its programs.

Successes

Client Success Story: "Jane" has shown tremendous improvement in the past year. The case manager has been able to utilize Motivational Interviewing techniques as well as a client center approach to meet the client where she is. Jane has gone from hesitant to engage in treatment to now being fully engaged with her case manager. She has been utilizing her coping skills when she faces challenging situations and meets weekly with her therapist and and case manager to work on her goals. Recently, the client requested In Home Support Services (IHSS) and with the support of her case manager was approved. Jane prepared for the interview and role played with case manager to

ensure she was feeling prepared for the interview. Jane reports “I have been able to get my IHSS worker and have been in my apartment for a few years now and I like living here. Thank you for your help."

Keeping clients housed: Caminar has seen a positive impact of intensive services for clients who generally struggle to maintain housing or habitable living environments. With the support of Case managers, clients are being connected to in home services and being provided education on maintaining a habitable home, roommate conflict resolution, and money management education so rent is paid consistently.

Implementing Evidenced Based Practice Tools: Caminar has adopted the use of Outcome Questionnaire (OQ). OQ Measures are the most researched and validated outcome measurement tools available. The first administration captures a baseline level of distress. Routine administrations allow you to quickly assess any changes in symptoms and problematic behavior and accurately measure change. Using predictive algorithms that have been proven to be accurate, the system serves as an early warning system alerting the provider if a client is moving away from expected progress in treatment. Responses provided by the client can assist in treatment planning and help guide the therapeutic direction by identifying strengths and areas of concern.

Challenges

Insufficient number of board and cares for clients has been a challenge. Board and cares are not a one size fits all, and therefore, not all clients are a fit for a specific board and care. Another challenge that FSP clients faced in FY 2022-23 was the limited housing available for clients that are on social security income.

Many FSP has clients that are homeless and not able to maintain their housing due to their symptoms. Caminar’s case managers have worked collaboratively with other providers to ensure clients get an apartment. However, due to client’s symptoms and the criteria for securing an apartment, it has been challenging for the clients to keep an apartment and they end up homeless.

Housing subsidies that are linked to FSP have been a barrier to stepping down clients. If they are stepped down to a lower level of care, they lose their subsidy, which means they lose their housing. This also ties up the funds for new clients. The program continues to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the FSP program.

Demographics

**The following demographics are for Caminar’s Adult/Older Adult FSP and AOT FSP combined:*

92 Participants	**FY 2022-23**		**FY 2022-23**
Age		**Race/Ethnicity**	
0-15	0%	American Indian/Indigenous	3.26%
16-25	9%	Other Asian	2.17%
26-59	74%	Latinx	23.91%

60-73	17%	Multiple	2.17%
74+	0%	Another race/ethnicity	25%
		Unknown/Not Reported	10.87%
Gender Identity		Other Asian	4.35%
Male/Man/Cisgender	70%	Black/African/-American	11.96%
Female/Woman/Cisgender woman	30%	White/Caucasian	50.0%
Other	0.%	Asian Indian/South Asian	3.26%
Decline to state	0%	Central American	0%
Questioning or unsure	0%	Chinese	4.35%
		Tongan	1.09%
		Filipino	10.87%
		Japanese	2.17%

ASSISTED OUTPATIENT TREATMENT OR "LAURA'S LAW" FSP

The purpose of Assisted Outpatient Treatment Full Service Partnership (AOT FSP) is to provide services to individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model (ACT).

AOT target population are adult San Mateo County residents living with serious mental illness who meet the following eligibility criteria as specified in Assembly Bill 1421: clients unable to "survive safely" in the community without "supervision"; history of "lack of compliance with treatment" as evidenced by at least one of the following: a. hospitalized/incarcerated two or more times in the last 36 months due to a mental illness or b. violent behavior towards self or others in the last 48 months; and clients who were previously offered treatment on a voluntary basis and refused it or are considered "deteriorating."

Program activities include engaging Individuals who have not had a successful and lasting connection to treatment and recovery services. Diversion from the criminal justice system and/or acute and long-term Institutional levels of care (locked facilities) SMI and complex Individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support.

AOT has a staffing ratio of staff to consumers, with a ratio of 10:1 and with a capacity to serve 50 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, medication non-compliance and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Caminar maximizes use of community resources as opposed to costly crisis, emergency, and institutional care. Staff utilize strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with

those systems and sectors. AOT establishes and solidifies linkages to medical, health care coverage, social services, and income benefits.

Caminar provides interventions and evidence based practices such as Assertive Community Treatment (ACT), Motivational Interviewing, Feedback informed Treatment (FIT), Outcome Questionnaire (OQ), Cognitive Behavioral Therapy (CBT), Harm Reduction, Seeking Safety, Trauma Informed Services, Stages of Change, Crisis Intervention and Management, Medication Assistance Program (MAP), Wellness Recovery Action Plans (WRAP), and Recovery-based treatment.

Program Impact

AOT (Laura's Law) FSP	FY 2022-23
Total clients served	61
Total cost per client	$13,318
Cost per contracted slot	$16,248

Caminar reduces risk by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability and its implementation of the Pro-Act training. All management staff is trained and certified to initiate involuntary hospitalization, when indicated. The program limits school failure and drop out through its Supported Education program and helps lower unemployment by utilizing its Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and in San Mateo County, in particular. Through its Supported Housing program, Caminar provides housing options to clients in need of independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, SRO rooms, shelters, and unlicensed room and boards.

Once a client is referred to Caminar services, staff attempts to initiate contact for Case Management within two (2) business days and psychiatry within 5 business days. Clients are assessed rapidly and comprehensively by case managers, a psychiatrist, and Clinic Manager/RN. The Clinic Manager/RN completes a Nursing Assessment for all clients admitted to the program. Furthermore, FSP also utilizes a Mediation Assistance Program (MAP) to increase medication compliance and to reduce the risk of clients overtaking or undertaking their medications.

By utilizing the social rehabilitation model, which provides for a non-judgmental, normalized environment which emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination the population often faces. The team ensures linkage to outside community providers for primary care and ongoing collaboration with said providers; this helps ensure that Caminar's clients are receiving public health services. By partnering with other non-profit agencies, Caminar helps reduce the disparities in access to care. Finally, Caminar utilizes Harm Reduction, MI, DBT and WRAP to help strengthen the gains made by clients and to implement the principles of recovery throughout all its programs.

Successes

Client Success Story #1: AOT client, "Jim," was able to reach his goal of obtaining full-time employment. He was referred to Jobs Plus and got a full-time job and has been maintaining this job for over a year now. Jim was also able to repair his relationship with his parents/family with the support of psychiatry services and case management. When he first joined AOT, his father did not want Jim at home for several reasons such as being unemployed, in and out of the hospitals, very symptomatic, refusing to take his prescribed medications, lack of coping skills, wrecking vehicles etc. Now, Jim is engaged with his treatment team, and he was able to repair the relationship with both his father and mother. Jim is no longer in and out of the hospitals and he is welcomed back home with parents.

Client Success Story #2: When "Jane" was referred to Caminar AOT, she was completely disengaged and seriously functionally impaired as evidenced by an inability to interact with others other than her father and unable to work or go to school. With the support of Caminar Case Management and psychiatry services, she has been doing much better and has increased her ability to manage her symptoms. She is regularly taking her medications now. She also has maintained engagement with Case Management 1-3x/week and attends psychiatry appointments as scheduled. Jane has gotten to a place where she feels ready to start moving towards her goals, and recently started going back to school.

Client Success Story #3: "Joe" is currently living at a hotel. He is currently working in construction. When Joe was referred to the Caminar AOT, he was rapidly cycling through multiple hospitalizations. He suffered with intense suicidal thoughts and exhibited high levels of anxiety and alcohol abuse. He was referred to Caminar AOT to receive psychiatry, case management and therapy. Case management provided support to the client with medication, symptom management, and with obtaining housing. Joe is currently working full-time, attending psychiatry appointments 1x/a month, and case management 2-x/weekly. He has moved forward to apply for independent housing and is in the process of getting his own studio. Joe began attending AA meetings on Zoom. The client had been experiencing flash backs of PTSD when in shelters and consumed alcohol to intoxication, but now that Caminar is supporting him, he expresses the intention to receive therapy and actively move forward toward his goals.

Reducing the high utilization of crisis services: Caminar AOT has seen a positive impact of intensive services for some of the highest utilizers of emergency services decline with infrequent visits to Psychiatric Emergency Services (PES) and general emergency visits.

Cultural responsiveness trainings: Caminar values the importance of training its staff to be culturally responsive in the care they provide their diverse clients. In FY 2022-23, several trainings were provided to staff including:

- *Building a Multi-Cultural Care Environment*
- *Groundwork for Multi-Cultural Care*
- *Cultural Competence for Supervisors*
- *Cultural Diversity*
- *Implicit Biased Training*

- *Becoming Visible – Using Cultural Humility in Asking Sexual Orientation Gender Identity (SOGI) Questions"*
- *Cultural Humility 101: Building Bridges to Diversity & Inclusion*

Challenges

Increase in high risk violent and sexual offenders: With the new law SB317 the program continues to have an influx in new client referrals with recent and histories of sexual and physical assaults without the capacity to meet the needs and challenges presented with this increase.

The limited housing options for clients given the continued increase in housing costs in the Bay Area along continues to be the biggest challenge for AOT. Lack of availably of appropriate level of housing for the level of functioning of the clients the program serves is a significant challenge.

Housing subsidies that are linked to AOT have been a barrier to stepping down clients. If they are stepped down to a lower level of care, they lose their subsidy, which means they lose their housing. Program staff continue to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the AOT program.

Demographics

**The following demographics are for Caminar's Adult/Older Adult FSP and AOT FSP combined:*

N = 92	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	0%	American Indian/Indigenous	3.26%
16-25	9%	Other Asian	2.17%
26-59	74%	Latinx	23.91%
60-73	17%	Multiple	2.17%
74+	0%	Another race/ethnicity	25%
		Unknown/Not Reported	10.87%
Gender Identity		Other Asian	4.35%
Male/Man/Cisgender	70%	Black/African/-American	11.96%
Female/Woman/Cisgender woman	30%	White/Caucasian	50.0%
Other	0.%	Asian Indian/South Asian	3.26%
Decline to state	0%	Central American	0%
Questioning or unsure	0%	Chinese	4.35%
		Tongan	1.09%
		Filipino	10.87%
		Japanese	2.17%

EMBEDDED SOUTH COUNTY FSP

The South County Adult Behavioral Health Outpatient Clinic serves complex adult client population living with serious mental illness (SMI) and/or Substance Use Disorders (SUD). Due to the location of the clinic the program serves as the catchment area providing services to individuals from the women's and men's County jail facilities, Redwood House crisis residential, Cordilleras Mental Health Rehabilitation Centers (MHRC), three inpatient SUD treatment programs, and two homeless shelters. The typical client served are considered at risk of self-harm or neglect, recently hospitalized for mental health, poorly engaged in treatment, have co-occurring SUD, often homeless, have trust issue stemming from mental health diagnosis, and have limited community resources.

During FY 2022-23, Mateo Lodge was contracted to provide 50 hours of Embedded Case Management (ECM) services per week for 3 different levels of intensity for BHRS South County Clinic clients (A - Task oriented case management 1-2 months duration, B - Supplemental case management 4-6 months duration, and C - FSP clinical case management 6 -12months duration). The program was staffed by one staff 4 days a week for 40 hours/week for this reporting cycle.

Clients receive 1–3 hours of direct CM contact per week and CM carry a weighted caseload of 10-12 clients as FSP level clients receive 3 – 5 hours or weekly support. There are currently 10 ECM clients, of which 1 also receives housing voucher support. The voucher-based clients receive quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/appointments. At the close of the fiscal year, there was no waitlist for services.

Each ECM client meets with their embedded case manager and completes a "Needs Assessment" to facilitate client goals. The engagement process is critical in building trust, reduce stigma, and is highly client centered.

ECM staff are bilingual Spanish and have participated in professional development opportunities/training including: Cultural Competency, SOGI, Assaultive Behavior, Motivational Interviewing, BHRS required documentation and compliance trainings. Additionally, ECM CM attend quarterly meetings with Mateo Lodge, weekly supervision, and bi-weekly staff meeting at South County Clinic. Staff development is targeted to further strengthen ECM awareness of community services, improve cultural appropriate services, and to deepen clinical knowledge of the population of clients served to employ best strategies/practice.

Program Impact

Integrated FSP – South County	FY 2022-23
Total clients served	10
Total cost per client	$13,119
Cost per contracted slot	$8,746

South County has complex impaired SMI clients as the catchment area services the County jails, Redwood House crisis residential, Cordilleras, three social rehabilitation board & care placements, three inpatient SUD treatment programs, and two homeless shelters. The main barrier for clients

served through ECM are limited housing, communication by telephone due to homelessness, co-occurring SUD disorders, trust issues stemming from mental health diagnosis, and limited resources for undocumented clients. As the ECM is adjunct provider, consultation and updates with treatment team is paramount for client care.

Most of the referrals for the ECM program are to improve client's engagement with their treatment teams (not making it to appointments) and/or because clients are not psychiatrically stable. In this reporting, all new client referrals were to reduce hospital and psychiatric emergency service (PES) encounters. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Use of culturally appropriate community agencies (faith based, Club House, Pride Center) has helped support recovery when limited financial and family support exists. Assisting clients with task activities such as obtaining cell phone, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the Case Manager.

The Case Manager makes every attempt to meet clients in the community and assess for food insecurity, linkage to mental health services/primary care, referrals to In-home Services, and support housing goals/needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, 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 and collaboration with valued community partners.

Successes

Client Success Story: A longtime ECM female client living in MHA housing struggling with medication compliance, has forged strong trusted alliance with ECM provider. Client had persistent delusions that her food and water was tainted resulting in poor medication compliance, poor nutrition, and hospitalizations. ECM collaborated with treating psychiatrist and nurse to learn of medication options to present to the client. The ECM leveraged the trusted relationship and provided psychoeducation on the benefits of a long-acting injection (LAI) medication as a treatment option. The client agreed to the LAI after declining for the past four years. The client has not had a hospitalization in past 12 months and no longer restricts diet based on delusions.

Challenges

The current barrier of not being fully staffed continued into the FY 2022-23. The contract of 50 hours limits the number of clients being served. Mateo Lodge has referred task-oriented referrals to other programs and remain focused on the more severe and intense cases needing support over a year or two period. Staff are mindful of safety concerns and are unable to accept some referrals that may need a male provider only. A new rehabilitation group has been initiated on-site to teach/educate clients on the use of cell phones and technology to improve communication and attendance with providers.

Demographics

N = 10	FY 2022-23		FY 2022-23
Age		**Race/Ethnicity**	
0-15	0%	American Indian/Indigenous	0%
16-25	0%	Other Asian	10%
26-59	60%	Latinx	30%
60-73	30%	Multiple	0%
74+	10%	Another race/ethnicity	0%
		Unknown/Not Reported	2.36%
Gender Identity		Arab/Middle Eastern	0%
Male/Man/Cisgender	30%	Black/African/-American	10%
Female/Woman/Cisgender woman	70%	White/Caucasian	50%
Other	0.%	Samoan	10%
Decline to state	0%	Central American	0%
Questioning or unsure	0%	Chinese	0%

HOUSING SUPPORTS

Housing supports can include various strategies including scattered site housing, augmented board and cares, room and boards, temporary shelter beds, transitional housing and permanent supportive housing, amongst other strategies. Additionally, a comprehensive continuum of services can include pre-housing engagement strategies such as drop-in centers, field services targeting the homeless, and linkages and peer support post-psychiatric emergency, hospitalization and incarceration.

TRANSITION AGE YOUTH (TAY) FSP HOUSING

The Supported Housing Program for TAY in FSP programs provides housing supports, housing and property management for up to thirty (30) TAY ages 18-25 and emancipated minors ages 16-18, in various sites, units in scattered sites, assisted living, board and care and locations throughout San Mateo County. The housing services were provided by Mental Health Association to Edgewood's TAY "Turning Point" FSP. Mental Health Association offers integrated housing and support services geared toward achieving maximum levels of residential stability and improved health outcomes for TAY. Services provided include:

- Locate and obtain needed units of housing.
- Ensure that leased housing remains in clean, safe, and habitable condition.
- Collaborate on a regular basis with the FSP provider.

- Utilize creative, harm reduction-based techniques beyond standard property management practices and activities.
- Manage relationship with property owners including timely payment of rent, monitoring and enforcement of lease provisions, and problem solving.
- Occupational Therapist services to support the TAY resident.

Program Impact

TAY Supported Housing	FY 2022-23
Total clients served	5
Total cost per client	$84,321

Client demographics and outcomes are those of Edgewood's Comprehensive FSP program for TAY listed above. Mental Health Association (MHA) is also able to provide ongoing support to youth as needed, once they end FSP services, through their Support and Advocacy for Young Adults in Transition (SAYAT) program, which offers intensive case management and support services to facilitate successful independent living.

ADULT/OLDER ADULT SUPPORTED HOUSING

Supported Housing is for individuals living with serious mental illness who are experiencing or at risk of homelessness, receiving wraparound services such as daily living skills coaching, harm reduction and motivational interviewing interventions and other supports to help them maintain their housing.

Successes

Belmont Apartments: Of the 24 resident units, 7 formerly homeless adults living with serious mental illness and SUD are original tenants, having moved in when the project opened more than 17 years ago. Three of the current tenants have been in residence for more than 13 years and 11 have been in residence for over one year. The eligibility for Belmont Apartments did not and does not include an MHSA eligibility designation, however the agency is confident that at least 75% of current residents would be so designated if needed.

Cedar Street Apartments: Of the 14 resident units, 5 formerly homeless adults living with serious mental illness and SUD are original tenants, having moved in when the project opened more than 11 years ago. One of the original tenants passed away, 7 residents have been tenants for 5 years or more and 2 residents have been residents for at least 3 years. Of the 14 units, 5 are designated MHSA units. However, 10 current tenants were officially designated as MHSA eligible. Since opening there have been several residents with complex medical conditions including a resident who was told she had less than 6 months to live. The Registered Nurse (RN) and nursing staff worked closely with her, she was provided a fully handicap accessible unit, and she was connected to other support services both

inside and outside the apartment, including food delivery. As a result, her lifespan was extended by 5 years during which time the program staff were also able to connect her to her family and at the end of her life, her family was making regular visits. There is currently a resident who is close to end-stage Parkinson's disease. He is an original tenant who resided on the second floor. Upon diagnosis staff were able to move him to a handicap adaptable/accessible first floor unit, trading with another resident. He continues to receive assistance from MHA Case Management, RN, and Occupational Therapists, has an in-home support provider and is fully supported by other residents who help him shop, bring him meals they prepare for him, and offer to bring him to the community room for activities. He truly is part of a caring community.

Waverly Place Apartments: Of the 15 resident units, 9 formerly chronically homeless adults living with serious mental illness and SUD are original tenants, having moved in when the project opened more than 5 years ago. All units are designated as MHSA units. Several residents have already successfully lived at Waverly Place Apartments longer than they have lived anywhere else as adults. Two residents have significant medical conditions and are working with the program's Registered Nurse and Occupational Therapists to ensure they receive the care they need as well as to provide assistance in making and keeping medical appointments.

Challenges

Belmont Apartments: COVID-19 created the greatest challenge for both staff and residents. For those clients who had been employed, their work ended, and resulted in long period of inactivity. For the better part of two years, MHA staff were the only in-person peopl residents were seeing, and safety protocols made even that more difficult. Staff continue working to repair some of the interpersonal damage that resulted. In addition, several of the tenants' treatment team staff moved to remote work, retired, or simply moving away. As a result, some tenants disconnected from services which resulted in not taking medications, not seeing a professional for treatment, and for several individuals, having their episode with BHRS closed due to not being seen or attending appointments. It is a major lift to try to repair those relationships as well.

As a result of the subsidies for the units coming through HUD as Permanent Supportive Housing subsidies, the program is also now required to use the Coordinated Entry System (CES) for referrals which has proven challenging as the information provided is all self-reported, and securing documentation to meet eligibility requirements is time consuming. Finally, many of the individuals referred through the CES process do not currently have an interest in participating in BHRS, which means that MHA staff are often the only providers they see.

Cedar Street Apartments: The program is facing the fact that its residents are aging and with that comes physical and medical challenges that were not originally envisioned when the program was opened. Additional funding has been raised to allow to the program to have an RN working on-site part-time as well as Occupational Therapy services available to the residents. The addition of this staff has helped to keep residents out of the emergency room and/or hospital.

Waverly Place Apartments: Although Waverly opened two years prior to the COVID-19 shutdowns, many of the residents, all of whom were chronically homeless, were still in early stages of treatment and recovery. When the shutdown occurred, many completely disconnected from services and increased their usage of substances, with resultant behavior issues and problems which challenged the entire community. Combining that with a moratorium on evictions also resulted in significant issues and problems for individuals that bled into the Waverly Place community.

Challenges across each apartment facility: For Belmont, Cedar Street, and Waverly Place Apartments alike, COVID-19 created the greatest challenge for both staff and residents. For the better part of two years, MHA staff were the only in-person people residents were seeing, and safety protocols made even that more difficult. Staff were advised not to enter tenant units unless necessary and to meet one-on-one in the community room, rather than in apartments. This also meant that community rooms were closed for most community building activities. Staff is now working to repair some of the interpersonal damage that resulted. In addition, as with the Belmont Apartments, several of the tenants' treatment team staff moved to remote work, retired, or simply moving away. As a result, some tenants disconnected from services which resulted in not taking medications, not seeing a professional for treatment, and for several individuals, having their episode with BHRS closed due to not being seen or attending appointments. It is a major lift to try to repair those relationships as well.

AUGMENTED BOARD AND CARES (B&C)

The purpose of the Board and Cares (B&C) program is to provide a supported living environment for clients living with severe mental illness (SMI) and/or substance use issues. The 10 contracted facilities provide SMI client's an opportunity to live in the community in a supported living environment.

One BHRS staff member oversees the program as the designated B&C liaison. The B&C liaison oversees admissions to and discharges from 10 BHRS-contracted B&Cs, processes referrals to B&Cs, completes assessments, and provides care coordination with the treatment team.

The target population is adults with SMI who have completed a social rehabilitation program, are stepping down from residential facilities at institutions for mental disease (IMD) level of care, or locked settings, or are self-referred from the community. They are psychiatrically stable, compliant with medications, and in need of a supported living environment. Clients are members of the Health Plan of San Mateo (HPSM) and have either Social Security Administration or General Assistance benefits.

Activities for clients include:

- Each B&C operator provides three meals a day and medication management, which includes storing and administration of medications. The operators regularly collaborate with the client's treatment team and conservator (if there is one) about client's progress and address any issues that impact the client's placement.

- The B&C Operators work in close collaboration with the BHRS B&C liaison. The role of the B&C Liaison is to support the client's transition into the B&C, oversee and coordinate their care, and ensure the B&C addresses issues that impact placement.
- In addition, BHRS provides and facilitates a series of mental health groups for clients at the B&C facilities. Curriculums for these groups have included Seeking Safety, Illness and Recovery Management, Dual Diagnosis, and Wellness Recovery Action Plan (WRAP). MHSA funds continue to support these MH groups at the B&C facilities and incentives that are built into the B&Cs' existing contracts, to benefit and support its clients.
- The B&C team created a protocol for B&C providers to make the admission criteria and process for referral clearer. The B&C liaison now uses a checklist during site visits to ensure that all aspects of the B&Cs are reviewed and screened every month.
- The program added a board and care incentive. If the B&C Operator can keep their occupancy at 95% before the end of the fiscal year, they would earn an incentive based on how many beds are in the facility. This incentive honors the operators' work and encourages the ease and timeliness of referrals and filling beds.
- Another new program activity that supports referrals for peer members through the Helping Our Peers Emerge (HOPE) peer mentor program using MHSA Innovation funds. When the B&C Liaison goes on site visits, they ask the B&C Operators if there are any clients who may benefit from being referred to the peer mentor program. This strategy was implemented to support clients in being able to stabilize in placement. The program has also utilized Serenity House more, a crisis residential program, to help address placement issues.

Activities for facility operators:

- The B&C Liaison develops and coordinates a training schedule for the B&C Operators. The trainings increase the B&C Operator's capacity to address the needs of the SMI clients in their care as well as fulfill their CEU requirements.

Program Impact

Board and Cares	FY 2022-23
Total clients served	116
Total cost per client	$1,966

Improves timely access & linkages for underserved populations: BHRS B&C liaison promptly processes referrals and screens them for appropriate level of care. When placements open at the operator sites, the B&C Liaison promptly links and prepares the referred client for transition to their site. Program staff keep track of the referred clients and the barriers that impact placement. The B&C Liaison regularly contacts and coordinates with the B&C Operators, treatment team, and the conservator (if there is one) to address and meet the needs of the clients at the facilities. There is a strong focus on coordinating care of the clients in the facilities and promptly address issues as they come up. Program staff works on housing retention to make sure clients who have had difficulty maintaining placements in the past maintain their placement in board and care facilities.

Reduces stigma and discrimination: The assessment procedure includes a 15-item checklist to determine eligibility for B&C placement. The program ensures that any barriers encountered by eligible clients is promptly addressed. Any indications of discrimination or expressed concerns by clients, and appropriate steps are taken to address the issues. Additionally, the B&C Liaison contacts the B&C regularly to check in on and evaluate clients' care and makes monthly in-person visits to the facilities. If needed, complex case conferences are organized, in which all parties involved such as conservator, treatment team and case managers discuss supports and resources needed to successfully transition a client to placement or address any challenging situations. In these meetings staff also address any forms of stigma and discrimination that need attention. Through trainings and close coordination with the B&C Operators staff shows how disruptive behavior is often stemming from mental health challenges and not because they are "bad". BHRS staff provide trainings to B&C Operators on diversity and equity topics such as Cultural Humility, Implicit Bias, Sexual Orientation, Gender Identity, Neurosequential Model of Therapeutics (NMT), Trauma and Trauma Informed Care, and Recovery Model. BHRS makes it a priority to ensure clients are treated with respect and dignity.

Reduces disparities in access to care: The BHRS contracted B&C facilities are specifically for clients that have mental illness and or co-occurring substance use issues. All clients placed at the B&C are connected to BHRS regional clinics or a Full-Service Partnership Program, and thus their psychiatric and medical needs are attended to. If they are determined to need higher level of mental health services, then appropriate steps are taken to access such services in a timely manner. The B&C Liaison is regularly working with B&C Operators and the treatment team to assess whether clients are getting the appropriate level of care services and able to access the needed services.

Implements recovery principles: Clients with substance abuse problems are appropriately referred to Substance Use Disorder (SUD) programs. The B&C Operators are trained on the possibility of relapse and work with the client's treatment team and the B&C Liaison to develop a plan to support the client based on Recovery principles. One B&C facility specializes in serving clients with substance use issues. Interventions are considered and implemented based on the Recovery Model. The training module for B&C Operators also include trainings around recovery principles. Another platform in which recovery principles are implemented are case conferences, where providers at various levels gather to discuss how to continue supporting clients along the recovery principles and ensuring that there is follow through and oversight. BHRS Clinicians offer recovery-oriented groups at different B&C facilities throughout the program. The groups have included Seeking Safety, Illness Management and Recovery, and a Dual Diagnosis Group.

The next section provides a comparison of emergency service utilization data from three months before and after the clients were admitted to the B&C Program. It also displays the breakdown of the B&C episodes which were open at any time during FY 2022-23. The open episodes did not have a discharge date, or the discharge date was within FY 2023-2023.

Table 1 below summarizes the engagement of B&C clients with other BHRS programs by displaying the total number of opened episodes (see definition above) and the average number of episodes per client. For clients who were admitted and actively part of the B&C program during the FY 2022-23, during the three months before program admission, there were 36 total episodes opened with an

average of 0.32 episodes. During the three months following their admission, the total and average number of episodes increased to 58 and 0.51, respectively.

Table 1. Engagement of B&C Clients With Other Programs (*N* = 116; FY 2022-23)

	During Three Months Before Admission	During Three Months After Admission
Number of Total Episodes Opened with Other Programs	36	58
Average Number of Episodes Opened per Client with Other Programs	0.32	0.51

Table 2 summarizes the emergency service utilization information for the 116 clients who were admitted and actively part of the B&C program during the FY 2022-23. Three months before program admission, there were 14 psychiatric emergency episodes (PES) episodes, while there were no PES admissions 3 months after enrollment of the program. There were no inpatient/residential episodes or days of stay among B&C clients before and after enrollment in the program.

Table 2. B&C Clients' Emergency Service Utilization (*N* = 116; FY 2022-23)

	3 months before admission	3 months after admission
Number of PES episodes	14	0
Number of inpatient/residential episodes	0	0
Total inpatient/residential stays (days)	0	0

Successes

In the past fiscal year, the B&C team was able to receive one-time, add-on funding of $100,000. The program was able to use the funds to upgrade the B&C facilities, for example replacing beds, furniture, garage doors, or flooring. This was beneficial to B&C Operators and improved facilities for clients who were staying there. B&C Operators have been particularly successful in supporting clients in the program this year. Operators go out of their way to support clients at their facility. For example, an operator created a home environment for a client by cooking soft foods for them as they could not eat solid foods. If a client is in an Adult Residential Facility (ARF), but a Residential Care Facility for the Elderly (RCFE) would be more appropriate for their needs, for example to address challenges around ambulation, they support the clients in moving to the next level of care. The following client story highlights the success of clients who receive services from the Board & Cares program.

Client Success Story: Client A is a 58-year-old African American male who has been at Bruce Badilla, an Adult Residential Facility for clients with dual diagnosis, for five years. He is diagnosed with Major Depressive D/O with Psychotic Features, Alcohol Use D/O in Remission. He has a long history of psychiatric hospitalizations and of not engaging and following up with services and has struggled with many years of substance use and homelessness before coming to BHRS. Additionally, he has a long

history of childhood trauma, related to facing abuse as an orphan, and trauma from many years of alcoholism and homelessness. After many years of struggle and relapse, he hit rock bottom and subsequently agreed to go to Redwood House Crisis Residential following a psychiatric hospitalization. While he was at Redwood House, he was motivated to receive the help he needed. This was the first time that he agreed to get mental health services and be an active participant in his treatment. He made significant progress and was able to transition to a lower level of care placement at Bruce Badilla.

Since residing at Bruce Badilla, he has been very motivated in his recovery and actively participates in his mental health treatment. He has been clean and sober for 5 ½ years. He is connected with North County Mental Health Clinic, where he receives therapy, case management, medication management, and vocational support services. He is socially engaged and participates in peer social clubs through Heart and Soul Peer Agency. He also attends Alcoholics Anonymous (AA) meetings in the community to maintain his recovery and sobriety. He is supportive and an inspiration to other residents at Bruce Badilla and to others in the community and is well liked by his peers. He actively participates in the weekly Dual Diagnosis Group at Bruce Badilla, where he very often takes a lead role in the group. He is very open and honest about his struggles with mental health and alcoholism. He continues to utilize his coping skills and is committed to his recovery.

He has also become very connected to his adoptive family, who have become a meaningful part of his life. He has learned to establish boundaries and to do the hard work needed to maintain his recovery. Since becoming more present with his life goals and hopes, he has worked for a very long time to become employed. After working diligently with a job coach, developing employment skills, and persistently applying for jobs for 1-2 years, he was recently successful in obtaining a job. Four months ago, he was hired and continues to work as a part-time retail cashier, in which he must interact and be of service to others.

He is demonstrating that he feels sure about himself and what he wants for his life. He has become more invested in the vision for his life and the long-term goal of moving into his own Supported Apartment. He has begun working with his case manager at the North County Mental Health Clinic to prepare for what is necessary to live on his own. He recognizes that it takes time, work, and preparation for this to happen, and is prepared to learn, work hard, and take the necessary steps to successfully meet that goal one day.

Challenges

An ongoing challenge for the program is the decreasing number of board and care beds available in San Mateo County, especially for the RCFEs and older adults who have ambulation needs. Although no facilities closed this year, the possibility of additional closures continues to be a concern. In the event of a facility closure, the program has processes in place to identify places where they can move existing clients. The client story below highlights some of the challenges related to board and care placements.

Another ongoing challenge for the program is staffing. The program is mindful of operator's staff who are moving closer to retirement, which would result in reduced staff in upcoming years. The program is thinking of and planning ways to promote and market themselves to recruit new Operators who are passionate about working with eligible clients.

To address this issue, the program has applied for a grant through which they can increase the number of beds at a facility. This would take place by contracting with an out of county provider that would provide additional 26 beds at a facility.

Client Challenge Story: Client B, a resilient 59-year-old Caucasian male, diagnosed with Major Depressive D/O, Polysubstance Use D/O in remission, Neurocognitive D/O due to multiple etiologies and Chronic Pain, came to Blanca's Care Home, an Adult Residential Facility (ARF) in San Mateo on 12/30/2021. He had transitioned from Redwood House Crisis Residential after an extensive period of homelessness, eviction from placement, and ER visits and hospitalizations. Client B had experienced significant TBI and bodily injuries from a motorcycle accident a few years before and was experiencing a lot of pain and loss. He was grieving the loss of his previous life and the level of functioning he once had. He struggled with all the complex impairments and how much support he r now required. He very much saw himself as his higher functioning self and was often resistant to others and opportunities for assistance that he needed based on his current functioning. His depression was tied to his loss of self-esteem and the chronic pain he endured. During his time at Redwood House, this was the first time that he truly engaged with services. They were able to empower him through his losses and actively engage him in his care, so that he was able to get well enough to step down to a board and care placement.

Client B did very well at Blanca's when he first arrived. He felt connected and cared for. For his first meal at Blanca's, the B&C operator asked him what he would love for breakfast and made him feel welcomed and accepted. He was attending to his Activities of Daily Living (ADLs) and engaging with peers and staff. Client B did well for most of his 1st year or so, all while suffering from chronic pain. Due to being in recovery, Client B was somewhat resistant to support for his chronic pain from his care team. He declined linkage to the Pain Management Clinic and any medication to alleviate the chronic pain. However, starting a year ago, Client B's pain and limited mobility due to his back injuries became more pronounced, and he became unable to use the bathroom for urination. This progressed to incontinence and soiling of his mattress daily. Due to his pain, he could not independently attend to his incontinence and needed daily assistance. Due to his mobility issues and unsteady gait, he was unable to do his ADLs independently. Because Blanca's is an ARF, clients at this level of care are expected to be independent with ADLs and manage incontinence independently. This became a critical issue, with Client B questioning whether he could be managed at Blanca's or needed a higher level of care placement.

As a result of these issues, the CARE Team, Treatment Team, and Facilities Utilization Management (FUM) team first began meeting weekly, discussing, and implementing different clinical interventions to engage and assist Client B, with the hope of maintaining his current placement, given his desire to be there and the meaningful relationships that he had developed. At first, Client B appeared to be experiencing some improvement, but this was short-lived. After the initial period of improvement, he stopped responding to interventions, most likely due to his increasing chronic pain and mobility

issues. It was ultimately determined that Client B needed rehabilitation at a Skilled Nursing Facility (SNF) and a higher level of Care. In collaboration with all involved, program staff pursued those options diligently, as such facilities are not easy to come by. However, more recently, he was able to be placed at a SNF. This was a success story to begin with but became a challenge as the needs and functioning of clients change due to various impairments that they face all the time. Client B is not an exception – as clients' impairments get worse, as they continue to face complex medical issues, as they get older, etc., they need alternative placements, which are scarce and challenging to access.

Demographics

Table 3 below summarizes the demographic information for the 116 clients who were admitted and already actively a part of the of the B&C program during the FY 2022-23. About 60% of the clients are between the ages of 26 to 59, while the remaining 43% are 60 years old or older. Most clients speak English as their primary language (81.9%), while the remaining 7.0% speak Spanish (5.2%), Arabic (0.9%), or Tagalog (0.9%). 46.6% of clients identify as White or Caucasian, with the second and third largest groups being other (10.3%) and Filipino (6.9%), respectively. It is important to note, however, that 20.7% of clients did not report information on their race. 53.4% of clients are not Hispanic or Latino, but 34.5% did not report information on their ethnicity. Most clients are male (67.2%).

Table 3. Demographic Data of B&C Client List (FY 2022-23)

Age	Number of clients	Percentage in total
0–15	0	0.0
16–25	0	0.0
26–59	50	43.1
60+	66	56.9
Primary language	**Number of clients**	**Percentage in total**
English	95	81.9
Spanish	6	5.2
Arabic	1	0.9
Tagalog	1	0.9
Unknown/not reported	13	11.2
Race	**Number of clients**	**Percentage in total**
White/Caucasian	54	46.6
Other	12	10.3
Filipino	8	6.9
Black or African American	7	6.0
Japanese	3	2.6
Chinese	2	1.7
Other Pacific Islander	2	1.7
Multiple	2	1.7
Asian Indian	1	0.9
Other Asian	1	0.9
Unknown/not reported	24	20.7

Ethnicity	Number of clients	Percentage in total
Not Hispanic or Latino	62	53.4
Hispanic or Latino	14	12.1
Unknown/not reported	40	34.5
Sex assigned at birth	**Number of clients**	**Percentage in total**
Male	78	67.2
Female	31	26.7
Unknown/not reported	7	6.0

General System Development (GSD)

General Systems Development (GSD) in San Mateo County has been primarily focused on supportive services for individuals with mental illness through integration of peer and family partners throughout the behavioral health system of care, and community peer run and peer focused wellness centers; system transformation strategies that support integration of services across various sectors impacting individuals with mental illness' lives including co-occurring substance use, dual diagnosis intellectual disability, criminal justice, child welfare, aging; and integrating evidence-base practice clinicians throughout the system.

CO-OCCURRING INTEGRATION

CO-OCCURRING INTEGRATIONS, PROVIDERS & STAFF

MHSA co-occurring funding supports substance use providers and BHRS Alcohol and Other Drug unit staff to ensure integration of mental health services in substance use practices. Two clinical consultants provide co-occurring capacity development trainings to BHRS staff and multiple agencies, consultation for complex co-occurring clients and system transformation support.

Program Impact

Clients served by Co-occurring Staff	FY 2022-23
Total clients served	297
Total cost per client*	$950

The clients served includes data from BHRS staff providing co-occurring services. The clinical contracted providers that support co-occurring capacity development to BHRS staff and contracts accomplished the following in FY 2022-23:

Q1 July 2022 – September 2022

- Training / Technical Assistance (TA):
  - CalAIM Tools review & feedback, Annual review
  - StarVista annual staff and intern training
  - Reopening Planning and implementation: Palm Ave Detox
  - On boarding trainings – new staff Horizon Palm Ave Detox (Clinical milieu, boundaries, trauma, and resiliency)
  - Community Reinvestment grant program review
- Strengthening BHRS Partnerships:
  - Recovery Provider engagement with the System of Care (MOUs w/ collaborative meetings):
  - BHRS Analysts: consultation and provider communication related to Recovery Services and co-modalities.
- Care Coordination:
  - Facilitated outpatient treatment session on provision, availability, and expansion of Recovery Services across continuum within system of care.

Q2 October 2022 – December 2022

- Training / TA:
  - Training – peer staff and SMI
  - StarVista In person trainings: Effective crisis intervention
  - Develop script and trainings: MAT introduction into residential intake process and recovery services.
- Strengthening BHRS Partnerships:
  - Client feedback initiative work plan development
- Care Coordination:
  - Hope House – ASAM 3.3 LOC utilization and coordination

Q3 January 2023 – March 2023

- Training / TA:
  - BHRS Analyst – Recovery Services training and rollout to expanded AOD provider group
  - AOD Treatment Provider meeting: ASAM LOC: Delivering Recovery Services
  - In person: 5 programs: RS LOC services training for program staff
  - Article review, comment and distribution
  - De-escalation training: BHRS Office of Consumer and Family Affairs
  - Medication dispensing procedures and form review and training: Horizon, Palm Ave
  - MAT policy training: Sikite, The Latino Commission
  - Review and report back on grant opportunity: increase MAT services in DHCS licensed facilities.
  - Coordinated training for Sobering St: Blood Borne pathogens, IR response
  - BHRS Analyst team: tracking and recording billable hours for DHCS Recovery Services
- Strengthening BHRS Partnerships:

    - MOU coordination and connection between AOD providers in each level of care
    - Office of Consumer and Family Affairs: peer team support and problem solving
    - Criminal Justice Initiative review and report back: drug court background, judge perspective and stigma landscape evaluation
- Care Coordination:
    - Palm Ave leadership – consultation re: coordination between levels of care
    - Recovery Services step down, transfer and new admit problem solving for providers

Q4 April 2023 – June 2023

- Training / TA:
    - AOD treatment providers – facility safety and hygiene for residential programs
    - MAT policy and script; El Centro de Libertad
    - Trainings for Service League Hope House: ASAM 3.3, Motivational Strategies, Tools for BH challenges in milieu
    - Prepared follow up actions for StarVista (IR response) around facility safety
    - AOD treatment provider meeting – CalAIM updates, consultation
    - Boundaries training: HR360 MAT outpatient program
    - Updated training list of topics for agencies receiving TA
    - Met with Free at Last – training needs planning
    - Treatment Plan training: El Centro de Libertad
    - Resiliency/grit and team working guidelines developed and delivered – StarVista
    - OCG: training needs and planning in relationship to recent critical incidents
    - Medication training and best practices – Palm Ave Detox
- Care Coordination:
    - CA Peer Counseling regs and implications for Medi-Cal billing
    - Sobering Station consultation to promote coordination between levels of care

CO-OCCURRING YOUTH RESIDENTIAL

During the reporting period, challenges continued with the identified provider for youth residential services. BHRS pays single case agreements (SCA) with The Camp in Santa Cruz County, at a rate of ~ $32,000 for a 30 day placement for one youth. While The Camp is not Drug Medi-Cal certified, BHRS has been using The Camp for the last several youth placements as issues have arisen with other providers related to overall loss of funding from other counties and quality concerns.

For both sustainability and quality reasons, Bay Area counties explored a Participation Agreement with CalMHSA, who would serve as the fiscal sponsor, for dedicated youth residential capacity. CalMHSA has since stepped back given some quality concerns.

RECOVERY SUPPORT SERVICES

Voices of Recovery San Mateo County (VORSMC) is the only peer-run recovery services organization in San Mateo County for individuals seeking and maintaining long-term recovery. VORSMC envisions a world in which recovery from addiction is both a commonplace and a celebrated reality, a world in which the entire spectrum of effective prevention, treatment, and recovery support services are available and accessible to all who might benefit from them.

Established in 2009, VORSMC's mission is to create peer-led opportunities for education, wellness, advocacy, and support services for individuals in or in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families. Each year, they provide free direct services to over 500 unduplicated clients, including low-income, houseless, LGBTQIA+, BIPOC, and justice-involved populations in San Mateo County. They have offices in Belmont and East Palo Alto.

VORSMC is a Black-Woman-led organization with a diverse staff–many of which have lived experience of recovering from addiction. They utilize the Wellness Recovery Action Plan (WRAP) program, a peer-led, evidence-based practice, to structure recovery services and support for the county's most vulnerable populations.

The agency works to prevent relapse, sustain long-term recovery, and support family members affected by addiction. The agency also helps develop employment opportunities and engages in community outreach to promote addiction-free lifestyles. VORSMC's WRAP program is an evidence-based, peer-led practice that has been nationally recognized by SAMHSA as an effective way to help marginalized populations, including people of color and persons reentering the community from incarcerated settings, maintain their recovery from addiction and mental health issues.

WRAP is based on the premise that everyone is an expert on self, and there is no judgment about others. People sharing their lived experiences within the group reduces stigma's effect by helping others disclose their experiences with mental illness, treatment, and or recovery. The program understands that self-stigma has a damaging effect on the lives of people with mental illness, and although medical perspectives might discourage participants from identifying with their illness, WRAP encourages public disclosure which promotes empowerment and reduces self-stigma.

Program Impact

Voices of Recovery	FY 2022-23
Total clients served	503
Total cost per client*	$327

VORSMC program resources are offered to partner organizations across the county and through Zoom sessions; they are open to the public, offering the ability to directly access its target population. VORSMC continues to offer groups hybrid communication through Zoom, their website, Facebook, YouTube, and other media avenues, since the potential end of the pandemic. This allows

them to improve their access and linkages to the populations that they were unable to serve before the pandemic and to provide services that are convenient, accessible, and acceptable in a culturally appropriate setting.

VORSMC offers groups designed and implemented in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being labeled as an alcoholic/addict or diagnosed with a mental illness, having a mental illness, or seeking mental health services, and making services accessible, welcoming, and positive having their groups facilitated by peers with lived experience. VORSMC facilitators use non-stigmatizing and non-discriminatory approaches that include sharing personal stories that are positive, factual messages, and tools they have learned to use to focus on recovery, wellness, and resilience, using culturally appropriate language, practices, and promoting positive attitudes.

VORSMC provides free services to all individuals, which helps to increase the number of individuals seeking service, they also provide mentorship from their WRAP facilitators, referral to residential treatment providers, and public health services if required. Their online resource presence helps individuals access other services; housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.

Disparities in access to care are a major issue with the peers that VORSMC services. The majority of VORSMC participants do not have insurance and have difficulties seeking care, even after the pandemic because they lack the technology for use. VORSMC aids in reducing disparities by allowing onsite use of computers and aiding with application processes. VORSMC's partnership with the different Health Equity Initiatives helps with their advocacy to increase the awareness of racial disparities and advocate for more minority physicians and therapists in San Mateo County, VORSMC prioritizes the elimination of racial and ethnic health disparities as a top priority.

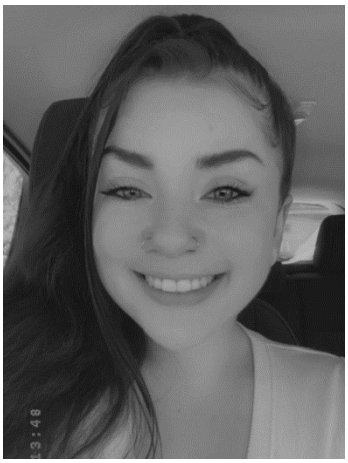
VORSMC Implements *recovery principles* in their groups by adhering to the ten core principles of recovery.

1. Self-direction: WRAP participants are encouraged and guided to set their own path to recovery.
2. Individualized and person-centered: WRAP helps participants to set their own individualized recovery pathway based on their own strengths, needs, preferences, experiences, and cultural backgrounds.
3. Empowerment: WRAP participants are empowered to choose among options and participate in all decisions that affect them.
4. Holistic: WRAP has a very integrated approach to a participant's recovery and helps participants focus on their life, including mind, body, spirit, and community.
5. Nonlinear: WRAP sets a Non-linear tone to discussing and approaching recovery by emphasizing the importance of continual growth despite occasional setbacks
6. Strengths-based: WRAP helps participants think about their own strengths and empowers them into using their strengths in their recovery journey.
7. Peer support: In an 8-week WRAP program, the participants receive mentorship from their WRAP facilitators and continue to receive peer support for up to one year after

completion of the program. While in these groups, peer coordinators offer support in accessing services and help create links to housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.

8. Respect: WRAP groups are facilitated by their facilitators in such a manner that it provides participants with a space to be themselves and share their experiences in a manner that is positive.
9. Responsibility: Their program emphasizes the importance of personal responsibility in approaching one's recovery.
10. Hope: This is the central theme of their WRAP programs and the participants when asked in the post-completion survey agree they have hope after completing their WRAP groups.

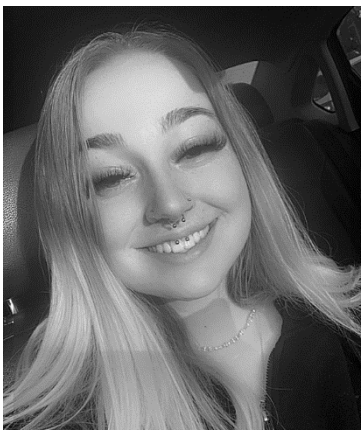
Successes



VORSMC continues to provide intervention in many ways. Since the pandemic, VORMC offers hybrid groups with virtual support and peer mentoring. The pandemic caused an increase in Peers returning to use substances and alcohol with no help and support. In response, the program offers support to Peers to enter Detox and residential treatment centers. This support has contributed to Peers returning to the recovery community and receiving the support that they need. VORMC continues to support Peers with virtual support and are slowly returning to in-person support. The following are real stories that show the impact of the support VORMC provides.

Client Success Story #1: "My name is Sydney and I'm a young woman in recovery from substance abuse and mental health challenges. Today, I am proud to say that I have 2 years clean and sober. The start of my downfall was when my parents got divorced when I was 12. With my brother's addiction at its peak, my newly founded love for abusing my mind, body, and soul with substances arose. From that point on, I had my fair share of self-harm, suicidal ideations, and major self-esteem issues. I've experienced abuse in many forms, along with neglect and abandonment. I have been around so much chaos, I didn't know what peace was when faced with it. I know what it's like being so low, I thought staying down was better than putting in the work to get back up. I had no tools whatsoever. I wasn't living, I was surviving. After fighting with myself, my mind, and the demons I encountered for 7 years, I decided to put down the shield. A month after turning 18, I decided to enter a residential treatment program where I was introduced to WRAP and Voices of Recovery. Within 2 months of being out of my program is when I committed to building and using my WRAP. Since then, it's changed my life. Over a year and a half later, I have more supporters now than I've ever had. I have wellness tools and action plans for when life shows up, because trust me it still does. I am working on myself daily and have achieved things I never thought I could've. I am finally on the path that I was meant to be on. For the first time in 7 years, I can say with confidence; I am truly, genuinely happy. "

Client Success Story #2: "My name is Yazmin and I have struggled with mental health issues since a young age, specifically Bipolar 2 and behavioral disorders. At 13 my mental stability went very downhill, I battled with self-harm, suicidal ideations, and addiction throughout my teenage years. I received improper psychiatric treatment for years and that caused myself harm and suicidal ideations to worsen and worsen. As my mental stability worsened, I was abused in different forms and was at rock bottom. At 18 I began dating a man and very quickly got attached due to my vulnerability stemming from how unstable I was. Very soon into our relationship he became abusive, and the abuse increased until I left.



Today I am proud to say that I am actively receiving psychiatric help and am mentally stable, I left an abusive relationship, and now I am working to get my college degree. I am continuing to work and fight for myself, and my support team has helped me get to where I am now. I never thought I would get to where I am today, but I know I am only going to get better and better."

Challenges

VORSMC continues to service a large community of Hispanic, monolingual Spanish residents. Hiring bilingual staff to meet the needs of this population has been challenging. Additionally, space continues to be a challenge for VORSMC, as they lack adequate space to provide support for the recovery community. Lastly, the lack of capacity to develop new trainings, and hold educational trainings for staff, volunteers, and the community due to inadequate equipment and space.

Demographics

	FY 22-23		FY 22-23
Primary Language		**Sex Assigned at Birth**	
English	67%	Male	76%
Spanish	33%	Female	21%
Age		**Gender Identity**	
0-15	0%	Male/Man/Cisgender	63%
16-25	5%	Female/Woman/Cisgender Woman	27%
26-59	61%	Non Binary/Gender non-conforming	1%
60+	1%	Other	6%
Decline to State	33%	Decline to state/Unknown	3%
Race/Ethnicity		**Sexual Orientation**	
Native Hawaiian/Pacific Islander	2%	Gay, lesbian, homosexual	2%
Black/African-American	7%	Straight or heterosexual	48%
White/Caucasian	21%	Bisexual	1%

Mexican/Chicano/Hispanic/Latinx	31%	Queer	1%
Declined/Unknown	5%	Another sexual orientation	1%
Another race/ethnicity	34%	Declined to answer/unknown	47%

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

The purpose of the Older Adult System of Integrated Services (OASIS) program is to provide outpatient, field-based mental health services for homebound elderly individuals with severe mental illness (SMI) and co-occurring medical diagnoses and functional limitations. The program helps elderly individuals live independently in the community with an improved quality of life. It serves elderly individuals ages 60 and over who have an SMI diagnosis and are homebound due to mobility issues and functional limitations.

Program staff include four BHRS therapists, three BHRS psychiatrists, one BHRS community mental health nurse, one peer support worker, one BHRS resident psychiatrist, and a Vocational Rehabilitation Services (VRS) worker who assists with transportation services for clients. They work closely with BHRS regional clinics, the Ron Robinson Senior Care Center, the Institute of Aging, Upward Health, and other primary care providers for referrals. OASIS and BHRS facilitated interventions include psychiatric assessment and treatment, psychiatric-medication evaluation and monitoring, clinical case management, rehabilitation counseling, individual or family therapy, peer support, psychoeducation, and collateral support with other community services.

Program Impact

OASIS	FY 2022-23
Total clients served	161
Total cost per client	$6,487

Improves Timely Access and Linkages for Underserved Populations: The program improves timely access to care for prospective clients by following established procedures. These procedures connect all individuals who meet minimum eligibility requirements with case management services within three days of referral, a standard that OASIS achieved in FY 2022-23. From there, if a client needs to meet with a psychiatrist, they are generally assigned one within a week of their case manager placement and have their first visit 4–6 days later. The OASIS team recently made several changes to their referral workflows to make the process as streamlined as possible. Prior to FY 2022-23, it took

up to 1 month for clients to be fully connected to services. Over the last 2 years, OASIS staff have ensured timely access to critical mental health services that improve clients' overall well-being.[5]

Reduces Stigma and Discrimination: Most clients served by this program are from underserved communities. The OASIS team works to provide case management, therapy, psychiatry, medical care, transportation services, and referrals to food assistance programs or other community-based services to help clients achieve a healthier life. The program recently connected with Project Sentinel, a service that provides housing advocacy and solutions. Project Sentinel often sees clients who are pushed out of their housing because of their age, cognitive decline, or an SMI diagnosis, and the organization provides legal aid and consultation to restore clients' prior housing arrangements. OASIS staff are also involved with BHRS Health Equity Initiatives that support older adults' well-being.

Increases the Number of Individuals Receiving Public Health Services: Over the past year, the county's older population has remained the same, and the program has received one to two referrals per month. Because the county's population has remained the same, the number of individuals receiving OASIS services has not significantly increased.

Reduces Disparities in Access to Care: The program partners with the Ron Robinson Senior Care Center to ensure clients' medical needs are met. The program continues to collaborate with Puente Clinic, a coastal community-based organization serving clients who live alone and farther away from inland services. In addition, the OASIS team connects clients with the Coastside Adult Day Health Center, an organization that runs an adult day-care program. The clinic provides clients with an opportunity to connect with other community members through participation in on-site activities, and it employs a range of health care providers. When clients are unable to live independently at home, staff also continue to connect them to board and care facilities. Board and care facilities are senior living facilities that care for residents who need assistance but do not require ongoing, skilled nursing care.

Over the past year, the OASIS program also has reduced disparities in access to care by contributing to a cross-department effort to promote equitable access to COVID-19 vaccines. As part of this effort, the OASIS team developed a protocol for new clients to ensure they are informed about the latest vaccines, which is especially important because OASIS clients' advanced age makes them more vulnerable to disease. At initial intake, program staff document the client's COVID-19 vaccination history and whether they are interested in receiving support accessing the latest vaccines in the future. Some clients are unable to recall their vaccination history. In these cases, OASIS staff work with primary care physicians and nurse practitioners to get access to these data. In addition to offering informational updates, the OASIS team also transports and/or escorts clients to and from their vaccination appointments. The OASIS team's participation in this initiative has broken down some informational barriers between the primary and behavioral health systems.

Implements Recovery Principles: OASIS staff have continued to implement recovery principles this year. Program leadership has expanded staff capacity to provide trauma-informed care by setting up new workflows and training related to the management of clients' hoarding issues. For example, the

[5] The State of California's timely access standard requires health plans to connect patients with mental health services within 2 weeks of the initial request.

team has arranged for clients with hoarding tendencies to undergo Neurosequential Model of Therapeutics assessments because brain scan results often inform helpful modifications to clients' treatment plans. OASIS has contracted with providers who go into the community and help clients with decluttering, which makes their home environments safer. In FY 2022-23, OASIS leadership plans to have a doctor from Stanford do a full consultation and lead an educational session to certify staff in hoarding training and hoarding therapy modalities.

An example of care coordination has been staff's ability to connect clients with Upward Health, an organization that consults with clients to address their concerns about housing or health issues and assesses whether a client needs additional in-home supportive services (IHSS). OASIS staff also work with the Health Plan of San Mateo (HPSM) to increase the level of support provided by IHSS caregivers. As a result of working with HPSM, OASIS staff were able to get clients more hours with an IHSS caregiver or, if that was not suitable, make the case for a different level of care. After learning that older adult clients were often getting confused by the number of providers going into their home, OASIS staff began tracking the organizations involved with each client's care and suggesting modifications informed by clients' stated preferences for working with specific teams. The OASIS team's strong working relationships with BHRS providers helped them manage the care provided to clients within Residential Care Facilities for the Elderly (RCFEs) as well as with board and cares facilities. Over the past year, the OASIS team has excelled at consulting with other teams and keeping them informed of OASIS's program services. For example, staff frequently offer to check whether a client managed by another County team is eligible for Upward Health's support or IHSS services.

Another example of the OASIS team's commitment to recovery principles is their efforts to ensure clients receive culturally sensitive care. The OASIS program's case management team is composed of staff with diverse backgrounds who have strong connections with the communities they serve. Over the past year, the team lost a psychiatrist who spoke Mandarin and Cantonese. Because a high proportion of the population living in the northern parts of the county identify as Asian or Pacific Islander, the team prioritized recruiting a new case manager who speaks Mandarin. This case manager accompanies the psychiatrist to provide translation services when meeting with clients.

Other ways that the program implements recovery principles include collaborating with families to build a strong support network for each client and advocating for clients to keep their housing placements. The team is well versed in consultations with family members and children, often advising family caregivers on how to mitigate issues between clients and housing authorities. For example, one client was at risk of eviction in FY 2022-23 because they had violated a rental agreement. The OASIS case manager collaborated with their daughter, who was one of the client's primary caregivers, to resolve the dispute, ensuring that the landlord would not move forward with eviction proceedings.

Finally, the OASIS program facilitates community members' involvement in clients' recovery. For example, OASIS has a part-time peer worker who helps advocate for clients. The program also has two individuals training to become VRS drivers; such drivers often build strong connections with clients while providing them with transportation services.

This section provides a comparison of emergency service utilization data from periods that extend to 3 months before and after the clients were admitted to the OASIS Program. The program does not collect any other outcome data that can be used to display its impact.

Table 1 summarizes the emergency service utilization information for the clients who were admitted and actively a part of the OASIS program during the FY 2022-23. During the 3 months before program admission, there were 13 psychiatric emergency services (PES) episodes and one inpatient/residential episode with 4 days of stay among the OASIS clients. During the 3 months following their admission, none of the OASIS clients had a record of using the same health care services.

Table 1. OASIS Clients' Emergency Service Utilization (FY 2022-23)

	3 months before admission	3 months after admission
# of PES	13	0
# of inpatient/residential episodes	1	0
Total inpatient residential stays (days)	4	0

Successes

The OASIS team has celebrated systemic successes this past year, putting processes in place that allowed staff to spend more face-to-face time with clients and connect them with a greater number of in-person services. For example, staff have begun referring clients to the California Clubhouse, a social and vocational rehabilitation program for county residents diagnosed with a mental illness, as well as to the Coastside Adult Day Health Center. Clients have benefitted from the emotional and psychological stimulation they derive from participating in these activities.

Another success for the OASIS team is that it has mitigated staffing issues from prior years. The staff currently consists of 2 VRS workers, 5 case managers, a nurse, three psychiatrists, and a resident that comes in quarterly.

The client success stories below highlight improvements clients have made after receiving services from the OASIS program.

Client Success Story #1: An OASIS client was recently referred to the OASIS team by the Central County BHRS regional clinic in collaboration with her primary care physician. This client is 88 years old and medically frail, and she lives with her disabled adult son, who suffered a tragic accident many years ago, resulting in a debilitating traumatic brain injury. During the first encounter, it was evident that they were struggling to manage on their own. Her medications needed to be reconciled and correctly dispensed, and they were unable to properly shop or cook their own meals. They did not have a caregiver coming to the home because they did not follow up with IHSS for the annual recertification, and this service was discontinued. One of the many strengths of the OASIS team is that staff see the clients in their home environment and work with the client and family system to provide the support needed to stabilize the situation. The client has been with the OASIS team for less than 4 months, and she has improved psychiatrically now that she is more consistent with her medications. Her daughter, who lives outside the County of San Mateo, confirmed the significant improvement experienced since OASIS started providing services for the client at home. The client is

able to keep her medical appointments, including trips to new referrals and to laboratories for tests. There was a big gap in care prior to involvement in the program because her disabled son was no longer able to drive her to her medical appointments. Finally, she has been referred for in-home support service, and the case manager is directly involved throughout the entire process to make sure this service is not terminated again.

Client Success Story #2: A client has been working with the OASIS team for a few years. He used to live independently in his apartment and receive psychiatric care from the OASIS psychiatrist. He had not had any manic or depressive episodes throughout the duration of his treatment despite having a history of psychiatric hospitalizations. He lost his only daughter about 4 years ago; the OASIS team helped him cope with this grave loss, and he remained stable psychiatrically with medication management and therapy. The team worked closely with him during the pandemic and was able to reach out to him at home when all other clinics were closed. The patient has a severe hearing impairment, and telephone or telehealth sessions were not an option for him during the pandemic. Seeing him in the outdoor area of his home allowed the team to monitor him closely and helped the client continue receiving the important psychiatric treatment he needed. About 1 year ago, his health started deteriorating, and he was ultimately hospitalized at San Mateo Medical Center with severe hemodynamic instability and inability to sit or walk. The patient remained hospitalized for a few months and later transferred to a skilled nursing facility. The OASIS team worked with his inpatient doctors and nurses to gather information and advocate for him. The psychiatric liaison service and collaboration of care provided by the OASIS team helped the client communicate with his doctors and treatment team at the hospital and outside agencies. This collaboration and advocacy helped plan a safe discharge from the hospital to a local board and care that is acceptable to the client, and he reports feeling happy about it.

Client Success Story #3: An OASIS client has been working with the OASIS team for over 1 decade. During the pandemic, she became more isolated at home, could not go to the clinic for her psychiatric appointments, stopped taking her medications, and became psychotic. She refused to let caretakers or case managers come to her home because of her increased paranoia, and on a few occasions, she tried chasing people away with a kitchen/cooking tool; this was threatening to those who visited her, so people stopped going to her door or trying to help her. She has a daughter who lived 2 hours away, but her daughter was not able to visit regularly. The patient was at risk of losing her apartment or getting transferred to a hospital or nursing home if her psychiatric and medical issues continued to deteriorate. The case was transferred from a BHRS regional clinic to the OASIS team, and the team diligently worked on building trust with the patient and communicating closely with her family. The patient accepted medications, including injectable antipsychotic medications, which made medication compliance much easier. Her psychosis improved greatly, and she started feeling better. She can now live in her apartment with the help of a caregiver and her daughter. She gets psychiatric care at home, and her daughter has increased efforts to spend more time with her. The OASIS team has helped provide the psychiatric and case management support the patient needs to help her remain stable in the community and avoid hospitalization or nursing home placement.

Challenges

OASIS staff encountered challenges related to an increasing complexity of clients, are coordination and communication in FY 2022-23. One challenge involved managing complications that arose from a client's decision to connect with an outside service. Outside providers might prescribe a medication that is contraindicated with another medication that the client is currently taking at the direction of their OASIS provider. Continuity of care and communication were also big challenges. Sometimes, OASIS staff have no choice but to suggest an out-of-county placement, which can be stressful for both the client and the team. A lack of resources in a certain area often makes it difficult to know where to place the client, particularly if there are shortages of facilities that can accommodate clients with serious physical or mental health needs. Sometimes, clients placed with providers outside of the county become unresponsive to OASIS staff's outreach, and they are dropped from the program's active caseload.

Client Challenge Story: An OASIS client, a 72-year-old female living alone, has medical issues, no social supports, and a severe hoarding disorder. She is depressed/anxious and asked for help but did not qualify for any public benefits due to her income. For over 20 years, the client has had a psychologist with whom she meets weekly. The psychologist is an independent provider, not part of BHRS. The client has been frustrated and has felt unable to manage her affairs (lost her important medical/financial papers at home) and has not been able to pay her bills on time (utility expenses, medical, etc.). Adult Protective Services (APS) was referred, and she declined to work with them multiple times. The OASIS team has tried to work with her; for example, the psychiatrist checks in with her periodically, and the case manager used via Neurosequential Model of Therapeutics funds to provide her with a vendor to help organize her paperwork every week for nearly 6 months until all her papers were categorized. The OASIS program also provided information and assistance so that she can get her state checks directly deposited in her bank account instead of mailed to her (she has lost many of the checks over the past 2 years), advocated for her so that she does not need to pay for a past ambulance bill, ensured that Medicare would reissue her lost checks, and helped her to talk to her bank (per her request) so the bank could help her set up automatic payments for her bills, among other things. However, the client continued to ask for help, said she needs someone to "organize her documents" (help sort out her paperwork) free of charge, and refused APS's assistance to declutter her home even though it is a very high fire risk. She felt that she was promised "the help she needs" when she enrolled in OASIS and has thus insisted on reading the clinical charts to find evidence to support her claim.

OASIS leadership suggested potential solutions for mitigating these challenges, most of which involve enhanced coordination with other BHRS teams to verify that clients are not receiving the same service elsewhere. To this end, the OASIS team has met regularly with HPSM staff. The team has also increased the frequency of meetings with the Facilities Utilization Management (FUM) team, which does approvals for some of OASIS's licensed contracted facilities. However, it remains challenging to monitor clients' use of providers who have not contracted with OASIS. Program staff are currently trying to track where their clients are living to get a better picture of the percentages who reside in their own home, a licensed skilled nursing facility, a board and care facility run by an OASIS-contracted provider, or a board and care facility run by providers who have contracted with another

county team. Knowing clients' current residence is key to effectively advocating for them. Maintaining accurate data on client residences often means OASIS staff are updated more quickly if a client needs to go to the hospital.

Finally, staff acknowledged that the current shortage of residential-facility providers is a huge constraint. Many clients could benefit from comprehensive care services available at residential facilities, but there simply are not enough open beds to accommodate the demand.

Demographics

Table 2 below summarizes the demographic information of the 161 clients who were admitted and actively a part of the OASIS program during FY 2022-23. All but three were 60 years or older. A majority were female (74.5%). A plurality identified as non-White (39.1%; not including those with unknown/not reported data). A majority spoke English as their primary language (69.6%), and 30.4% reported a language other than English as their primary language, including 14.3% of clients who mainly spoke Spanish, 7.5% Mandarin, and 3.7% Cantonese. Furthermore, a little more than one-fifth identified as Hispanic or Latino. It is important to note, however, that 23% of respondents did not report information on their race, and 24.2% did not report information on their ethnicity.

Table 2. Demographic Data: BHRS OASIS Client List (FY 2022-23)

Age	Number of clients	Share of total (%)
0–15	0	0.0
16–25	0	0.0
26–59	3	1.9
60+	158	98.1
Primary language	**Number of clients**	**Share of total (%)**
English	112	69.6
Spanish	23	14.3
Mandarin	12	7.5
Cantonese	6	3.7
Unknown/not reported	4	2.5
Russian	2	1.2
Tagalog	1	0.6
Other Chinese language	1	0.6
Race	**Number of clients**	**Share of total (%)**
White/Caucasian	61	37.9
Unknown/not reported	37	23.0
Other	29	18.0
Chinese	13	8.1
Black	10	6.2
Multiple	3	1.9
Japanese	3	1.9
Filipino	2	1.2

American Native	1	0.6
Asian Indian	1	0.6
Korean	1	0.6
Ethnicity	**Number of clients**	**Share of total (%)**
Not Hispanic or Latino	86	53.4
Unknown/not reported	39	24.2
Hispanic or Latino	36	22.4
Sex assigned at birth	**Number of clients**	**Share of total (%)**
Female	120	74.5
Male	41	25.5
Sexual orientation	**Number of clients**	**Share of total (%)**
Unknown/not reported	152	94.4
Straight or heterosexual	7	4.3
Decline to state	2	1.2

PEER COUNSELING

The Peer Counseling, formerly Senior Peer Counseling, from the Peninsula Family Service (50% CSS, 50% PEI) is comprised of specially trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+. Peer Counseling provides peer support by trained and supervised older adult volunteers. The program serves older adults, 55 years and older, who reside in San Mateo County who are isolated, depressed, and anxious. The program targets underserved older adult population who may be monolingual in Spanish, Mandarin, Cantonese, Tagalog and to participants who identify as LGBTQ+.

In FY 2022-23, the Peer Counseling served 240 unduplicated individuals in San Mateo County through their one-on-one peer counseling and group sessions. Program outcomes, successes and challenges are included in the PEI section of this MHSA Annual Update document.

CRIMINAL JUSTICE INTEGRATION

PATHWAYS COURT MENTAL HEALTH PROGRAM + HOUSING

Pathways—a partnership among the San Mateo County Superior Court, Probation Department, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health Services, National Alliance on Mental Illness (NAMI), and BHRS—is an alternative to incarceration for eligible adult residents of San Mateo County. The Pathways program serves individuals (clients) living with a

functionally impairing serious mental illness (SMI) who have been arrested for a crime, are statutorily eligible for probation, and agree to undergo Pathways-supported treatment and community rehabilitation in lieu of incarceration.

Since Pathways began in 2006, 156 participants have graduated. During the reporting period for FY 2022-23, Pathways employed four case managers, two full-time clinicians, and one mental health program specialist who collectively served 47 clients. The Pathways judge presents all program graduates with signed certificates and waives court costs in recognition of clients' hard work. In addition, some graduates' legal charges are expunged.

Most applicants are admitted to the program shortly after entering a guilty or no contest plea, though a small number enroll prior to the plea process through an Intensive Mental Health Diversion initiative that ultimately allows clients to pursue dismissal of their charges. Once enrolled in Pathways, clients receive intensive case management and individualized treatment services for their SMI and substance use disorders (SUDs).

Primary program activities include referrals to other health care providers and social needs supports, individual and group therapy, psychoeducational services, probation supervision, crisis management, and facilitation of peer support and mentoring services. Case managers provide clients with logistical support, including assistance with Medi-Cal and other benefit program applications as well as warm handoffs to BHRS regional clinicians, primary care providers, SUD treatment services, and housing agencies, as needed.

In addition to providing intensive case management services, Pathways staff lead rehabilitation skills groups and organize community-building activities. Pathways' lead clinician and a peer support worker co-facilitate the Pathways Clubhouse, a weekly socialization and skills group designed to build clients' communication skills and alleviate their SMI and SUD symptoms. Pathways also offers process-oriented groups—one for men and another for women—that meet weekly to reinforce existing support systems and promote healthy coping skills. Lastly, Pathways runs two cognitive behavioral therapy (CBT) groups. The two clinicians and two case managers who facilitate these groups apply evidence-based CBT practices from the thinking for a change model, which teaches cognitive interventions that can disrupt and replace antisocial thought processes.

As in prior years, Pathways hosted multiple in-person or virtual social events in FY 2022-23 that enabled clients to build and maintain relationships with other program participants, staff, program graduates from prior years, and community members. Pathways graduates from past years often attend the annual picnic, among other events, and serve as role models for current Pathways' participants.

Program Impact

Pathways	FY 2022-23
Total clients served	47
Total cost per client	$4,063

Increasing Public Health Services Utilization through Engagement with Community Partners: In FY 2022-23, Pathways staff continued to educate community partners and attorneys about the program referral process. Heightened awareness of the Pathways program and its mission tends to drive increases in referrals, which can ultimately lead to more widespread utilization of public health services among eligible residents in need of treatment for a SMI.

Improving Timely Access for Recently Incarcerated Clients Through Intensive Case Management: Under California's timely access mandate, the Health Plan of San Mateo (HPSM) is required to provide mental health services within 2 weeks of the initial request. The Pathways program's intensive case management team helps the HPSM fulfill this mandate by working expeditiously to place newly referred Medi-Cal clients with an outpatient mental health provider following their release from jail. The timeliness of this referral process is also important because client adherence to a psychiatric medication treatment regimen is often a precondition for acceptance into the program.

At the time of referral, many eligible clients are still incarcerated. Therefore, Pathways staff must coordinate with BHRS regional clinic providers and Correctional Health Services to complete the intake assessment, schedule a psychiatry appointment, and arrange for prescription fills, ideally the same day as the client's release. The BHRS Case Management Team must act quickly and resourcefully to secure psychiatric medication for newly referred individuals who have not previously been seen at one of the BHRS regional clinics, as there is often a short waiting period for new clients. Proactive coordination is also crucial to obtaining medications in a timely manner for individuals whose health insurance coverage is through Kaiser Permanente, which will not pay for prescriptions filled at unaffiliated pharmacies.

Reducing Stigma and Discrimination by Educating Clients and Engaging with Community Partners: After enrolling clients in the program, Pathways staff take proactive, concrete steps to combat stigma and discrimination related to clients' mental health and SUD diagnoses. Some examples include:

- Providing a safe space for clients to speak openly about their struggles with mental illness and addiction during group-based skills sessions.
- Collaborating with local NAMI and other community-based partners to organize and promote various educational activities, including the annual NAMI awareness walk, mental health month speaking engagements, and suicide prevention initiatives.
- Encouraging clients to enroll in the Office of Consumer and Family Affair's Lived Experiences Academy. In FY 2022-23, two Pathways clients completed this 8-week program, which trains participants to share details of their experiences related to mental health and/or substance use challenges. This has helped clients empower themselves, further the healing process, fight stigma, and educate others about behavioral health conditions. Both clients are now pursuing their peer certification, a statewide accreditation that would enable them to do paid work for local advocacy and/or peer support programs.

Addressing Disparities in Access to Care through Intensive Case Management: Pathways staff routinely help clients from traditionally underserved populations overcome barriers to using public health services. After experiencing the stress of incarceration and the court system, many newly referred clients appear to have difficulty independently navigating their health care options. The

Pathways team supports clients by guiding them through all the steps required to obtain appropriate services in a timely manner. When the stigma associated with certain offenses proves problematic, Pathways staff will also advocate for clients' rights to receive care. For example, some clinicians refuse to serve clients with physical assault, sexual offense, or arson charges until Pathways staff develop and adhere to a detailed risk-mitigation plan (e.g., accompanying clients during office visits).

Implementing Recovery Principles: Pathways staff demonstrate their commitment to using several recovery principles, as described below:

- Promoting Care Integration: Staff schedule recurring case conferences with the care team for clients who have enrolled in a residential or outpatient SUD treatment program. This coordination is critical to ensuring the timely development of either (a) a transitional care plan, or (b) documentation that the court must review before issuing a mandate for continued treatment in a residential facility. Case conferences also keep program staff apprised of Pathways clients' relapses, which often require treatment plan modifications. For example, staff often provide struggling clients with more intensive case management services to minimize the risk that clients fail to attend subsequent appointments with clinicians and/or probation officers.
- Facilitating the Involvement of Community Members: Staff connect clients with SMI and a co-occurring SUD with the Voices of Recovery, a nonprofit organization that fosters "peer-led opportunities for education, wellness, advocacy and support services for individuals seeking long-term recovery from alcohol and other drugs."
- Delivering Trauma-Informed Care: Pathways employs staff with specialized training in recovery counseling who organize recovery events tailored to the needs of current clients and program graduates.

This section provides a comparison of data from periods that extend to 3 months before and after the clients were admitted to the Pathways Mental Health Court Program. It also displays further details on events such as probation violations and being taken into custody, as well as Pathways clients' housing and employment status.

Table 1 summarizes the emergency service utilization information for the 58 clients who were admitted and actively a part of the Pathways program during FY 2022-23. During the 3 months before program admission, there were 20 psychiatric emergency services (PES) episodes and one inpatient/residential episode with nine days of stay among Pathways clients. During the 3 months following their admission, none of the Pathways clients had a record of using the same health care services.

Number of unduplicated clients served: 58 active participants.

Table 1. Pathways Clients' Emergency Service Utilization (FY 2022-23)

	3 months before admission	3 months after admission
# of PES episodes	20	0
# of inpatient/residential stays (days)	1	0
Total inpatient residential stays (days)	9	0

Table 2 displays Pathways clients' probation violations before and after they were admitted to the program. Among the 47 clients with probation violation data who were admitted and actively a part of the Pathways program during FY 2022-23, nine (19.1%) had a probation violation before they were admitted to the program, and 17 (36.2%) had a probation violation after they were admitted to the program. Among the nine clients who had a probation violation before admission, three also had a probation violation after admission.

Table 2. Pathways Clients' Probation Violations (FY 2022-23)

	Before admission	After admission
Number of clients with probation violation	9	17
Percentage of clients with probation violation	19.1	36.2

Table 3 displays the number and the proportion of Pathways clients who were taken into custody before and after they were admitted to the program. Among the 47 clients with custody data who were admitted and actively a part of the Pathways program during FY 2022-23, 43 (91.5%) were taken into custody before they were admitted to the program, and only seven (14.9%) were taken into custody after they were admitted to the program. All seven clients (14.9%) who were taken into custody after they were admitted to the program were taken into custody before admission as well; three clients (6.4%) were not taken into custody before or after they were admitted to the program.

Table 3. Pathways Clients Taken Into Custody (FY 2022-23)

	Before admission	After admission	Both before and after admission	Never
Number of clients taken into custody	43	7	7	3
Percentage of clients taken into custody	91.5%	14.9%	14.9%	6.4%

Table 4 summarizes the housing information for clients with housing data who were admitted and actively part of the Pathways program during FY 2022-23. Almost half (44.7%) reported living in a home or an apartment, and seven (14.9%) reported living in a residential setting.

Table 4. Pathways Clients' Housing Status (FY 2022-23)

Housing	Number of clients	Percentage of clients
Home/apartment	21	44.7%
Residential	7	14.9%
Sober living environment	2	4.3%
Homeless	1	2.1%
Other	3	6.4%
Unknown	13	27.7%
Total	**47**	**100.0%**

Table 5 summarizes the employment information for clients who were admitted and actively part of the Pathways program during FY 2022-23. Among these clients, 36.2% reported being employed, and 42.6% reported being unemployed. Slightly more than 20% had unknown status.

Table 5. Pathways Clients' Employment Status (FY 2022-23)

Employment	Number of clients	Proportion of clients
Not employed	17	36.2%
Employed	20	42.6%
Unknown	10	21.3%
Total	**47**	**100.0%**

Successes

Program leadership highlighted Pathway's weekly socialization and skills-building groups as particularly successful this year, boasting high attendance and engagement levels. The men's, women's, and CBT skills groups all help clients learn about and practice healthy coping skills in response to hypothetical or actual difficulties described by group members during the sessions. Pathways staff noted that, over time, the close rapport and trust that develops between group participants gives clients a sense of safety, agency, and confidence.

In FY 2022-23, Pathways staff also took additional steps to promote group cohesion and bonding, funding a greater number of peer-led activities to ensure clients met their own needs for in-person socialization even during months that the Saturday Clubhouse met virtually. Staff planned a few of the FY 2022-23 social outings, but most of the activities, which included seeing a movie in theaters, bowling, grabbing ice cream, and taking a trip to Golden Gate Bridge, were organized by one or more clients who took the initiative to plan an event. Staff credited the recent surge in peer-led activities to the closer, more enduring friendships they have observed among some clients. The following success story illustrates how the Pathways program can be a transformative experience for some clients, especially those without a preexisting social network.

Client Success Story: One client has experienced immense personal and professional growth over the last year. When he first joined Pathways, he avoided social interactions and struggled to find stable employment. Although a few organizations said they wanted to move forward with the hiring process, many subsequently rescinded their offers or terminated his employment within his first few weeks on the job after background checks revealed his extensive criminal record. Between July 2022 and December 2022, he applied to over 30 different jobs without achieving any permanent results. He also appeared reticent to share much about his struggles, limiting contributions in weekly skills group discussions to a single sentence and choosing not to engage in conversations with staff who offered support. However, over time, this client gradually became less distrustful of others and more comfortable participating in group activities. In February 2023, he finally got hired by an organization that still retains him on staff, and his manager has repeatedly praised his reliable performance. Since then, Pathways staff have noticed marked improvements in his mood and social skills. During group

meetings, the client began communicating much more openly, sharing that he learned how to set boundaries and recently rekindled his relationships with family members. In group meetings, he also expressed appreciation for the positive impact of his participation with Pathways, explaining that he simply did not have friends before joining the program. He has a much more active social life now, reportedly even hosting a party at his house over the summer. Staff also mentioned that they have recently observed him asking some new people he met to share their phone number.

Challenges

Pathways staff encountered case management challenges in FY 2022-23 stemming from new requirements for pre-plea clients.[6] For example, San Mateo County Superior Court and District Attorney staff recently decided to require the submission of weekly lab test results as a condition for participation in the Intensive Mental Health Diversion program. Court staff will use these lab results to verify clients' compliance with behavioral contracts that prohibit them from using illicit drugs to maintain eligibility for future dismissal of their charges. The BHRS regional clinics will prioritize running these tests and submitting the paperwork to the courts in a timely manner, but Kaiser Permanente—the sole provider for some clients—is not under any mandate to run tests so frequently. When those court orders first took effect, Pathways staff spent hours coordinating with Kaiser-affiliated providers, explaining the new bloodwork requirements for pre-plea clients, and following up to ensure results were documented properly and transmitted to the court for review by each deadline. One of the first two Pathways clients to successfully complete requirements had Kaiser health insurance.

Addressing Challenges Related to Clients' Enrollment in Residential SUD Treatment Facilities: Managing initial residential treatment placements and the formulation of transition plans for clients with a co-occurring SUD continued to be challenging in FY 2022-23. For example, local residential treatment facilities are sometimes unable to accommodate transgender clients, requiring Pathways to identify a more distant facility that can provide appropriate services. In cases where placements proved challenging, Pathways relied on the support of BHRS Alcohol and Other Drug Services staff. Strict rules and schedules at most residential treatment facilities have also negatively affected program engagement and retention levels. For example, residential treatment programs sometimes require clients to participate in scheduled activities that conflict with Pathways' skills group meetings, making it more difficult for those clients to maintain a strong connection to the Pathways community. More significantly, some clients have discontinued their participation in Pathways because they find it too difficult to adhere to strict no-smoking policies in place at residential facilities. These clients struggle to give up smoking nicotine cigarettes while simultaneously undergoing treatment for their addiction to a more harmful substance.

Mitigating Care Coordination Challenges Stemming from Recent Drug Medi-Cal Changes: Recent regulatory changes also complicated care coordination for Pathways clients with a co-occurring SUD

[6] Pre-plea applicants are permitted to enroll in the program before entering an innocent, guilty, or no contest plea and can thus seek dismissal of the charges from their criminal record. In contrast, most other applicants are admitted to the program shortly after entering a guilty or no contest plea but prior to sentencing. Post-plea clients cannot have their charges dismissed, though they can choose to pursue expungement.

in FY 2022-23. Previously, program staff could issue a directive for clients to enroll in a residential treatment facility for up to 90 days. However, effective January 2023, Drug Medi-Cal only authorizes residential treatment services in 30-day increments and requires a court mandate to approve coverage for longer stays. In response to these changes, program staff adjusted the timing of their case conferences with providers, scheduling meetings by the 15th or 20th day of clients' stay in residential facilities. This allows staff enough time to either prepare (a) a transitional care plan in advance of the client's discharge after 30 days or (b) documentation for court staff demonstrating the need for an extended stay. Because most clients require treatment for more than 30 days, Pathways staff also serve as a liaison between providers and the court staff now responsible for mandating extended residential treatment stays.

Addressing Staffing Shortages: High staff turnover and difficulty filling vacancies quickly also proved challenging in FY 2022-23. The departures of two staff members, for which positions remained vacant for 6 and 12 months, forced the remaining staff to take on even greater caseloads. Staffing shortages required leadership to temporarily suspend nonessential activities, such as community outreach and presentations focused on educating county residents about the program.

Troubleshooting Barriers to Helping Clients Obtain Stable Housing: Finally, limitations to the use of MHSA funds make it difficult to support clients in securing stable, long-term housing, which was the single greatest unmet need in FY 2022-23. For clients who cannot afford to pay local rental rates, the program could only disburse MHSA funds once or twice to help cover a few months of rental expenses. Clients transitioning from residential treatment facilities to a sober living environment (SLE) only need temporary assistance to secure a space in an SLE because they regain eligibility for housing benefits following their discharge. In those cases, Pathways staff leveraged connections to BHRS Alcohol and Other Drug Services staff to obtain criminal justice fund disbursements in support of clients' transition to an SLE. However, Pathways staff hope to secure other sources of noncontract funding in future years to address unmet needs for housing.

Demographics

Number of unduplicated clients served: 58 active participants.

Table below summarizes the demographic information of the 58 clients who were admitted and actively a part of the Pathways program during FY 2022-23.

Age	Number of clients	Share of total (%)
0–15	0	0.0
16–25	6	10.3
26–59	49	84.5
60+	3	5.2
Primary language	**Number of clients**	**Share of total (%)**
English	49	84.5
Spanish	7	12.1
Unknown / Not Reported	2	3.4

Race	Number of clients	Share of total (%)
White/Caucasian	12	20.7
Other	13	22.4
Black or African American	8	13.8
Filipino	2	3.4
Mixed race	4	6.9
Chinese	1	1.7
Samoan	1	1.7
Unknown/not reported	17	29.3
Ethnicity	**Number of clients**	**Share of total (%)**
Not Hispanic or Latino	31	53.4
Hispanic or Latino	17	29.3
Unknown / Not Reported	10	17.2
Sex assigned at birth	**Number of clients**	**Share of total (%)**
Male	42	72.4
Female	15	25.9
Unknown / Not Reported	1	1.7
Sexual orientation	**Number of clients**	**Share of total (%)**
Straight or heterosexual	33	56.9
Declined to state (or no entry)	4	6.9
Gay, lesbian, homosexual	4	6.9
Unknown / Not Reported	17	29.3

PATHWAYS, CO-OCCURRING HOUSING SERVICES

Pathways still has 2 contracted beds at Maple Street Shelter. 1 is dedicated for male identified clients, and 1 for female identified clients. A challenge experienced with housing clients at this shelter is due to COVID-19. The facility completely shuts down and does not allow new admissions until they are COVID-19-free. This can take about two weeks to 8 weeks at a time.

- 1 client occupied male beds.
- 0 clients occupied female beds.

OTHER SYSTEM DEVELOPMENT

Other System Development efforts help improve the behavioral health service delivery system across various sectors and areas of focus.

PRENATAL-TO-THREE (CHILD WELFARE PROGRAM)

The purpose of the San Mateo County Prenatal to Three Initiative is to provide pregnant mothers and parents or caregivers of children through age 5 with mental health treatment and other social needs resources that promote their well-being. Specifically, staff serve women eligible for Medi-Cal who have been diagnosed with a serious mental illness (SMI) and require psychotherapy and medication management of their symptoms. In addition, staff provide services designed to support early infant development and improve parent-child relationships when physical, developmental, or social risk factors are present. The initiative encompasses three programs with unique provider pools and referral workflows:

- The Prenatal to Three program coordinates mental health treatment and psychoeducation for pregnant women, postpartum women up to 1 year after childbirth, and children through age 5 who choose to receive program services after being referred[7] by County Health, Family Health Services, pediatricians, obstetrician-gynecologists, or staff from the BHRS Access Call Center.
- The Partners for Safe and Healthy Children program manages mental health treatment and psychoeducation for families with children through age 5 who have an open Children and Family Services (CFS) case.
- The Prenatal to Three Teen Parent program serves pregnant teenagers, teenage mothers up to 1 year after childbirth, and children through age 5 with teenage mothers.

Prenatal to Three Initiative activities include conducting initial mental health assessments, which inform the creation of treatment plans; providing psychotherapy and psychoeducation to clients; and offering case management services, including referrals to psychiatrists, alcohol, and other drug (AOD) treatment providers, and community-based organizations. While therapeutic interventions vary depending on the needs of the client, program clinicians commonly provide some form of child-parent psychotherapy as well as specialized care for prenatal and postpartum clients. In addition, several staff are trained in the Neurosequential Model of Therapeutics approach, trauma-informed cognitive behavioral therapy, eye movement desensitization and reprocessing psychotherapy, occupational therapy, and infant massage.

All Prenatal to Three Initiative staff strive to provide trauma-informed care and resource linkages that improve clients' quality of life. For example, all clinicians rely on several assessment tools to screen for mental illness in adults[8] and identify developmental areas of children that may have been affected by trauma.[9] This, in turn, determines the care interventions that are recommended, which often include play-based therapy for children through age 5, individual therapy for adults, and dyadic therapy for caregivers. Prenatal to Three Initiative staff also address unmet social needs by distributing free household items, such as diapers, or by connecting families with affordable housing support resources.

[7] These organizations use the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire-9 screening tools to assess adult patients' eligibility for the Prenatal to Three program before making referrals. They also use the Pediatric Hurt-Insult-Threaten-Scream-Sex to screen for child abuse.

[8] Staff screen adult clients for mental illness using the Generalized Anxiety Disorder (GAD-7), Beck's Anxiety Inventory, and Beck's Depression Inventory tools. They diagnose them with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

[9] Staff screen children of adult clients using the Newborn Behavioral Observations scale, the Child and Adolescent Needs and Strengths assessment, the Ages and Stages Questionnaire, the Pediatric Symptom Checklist, and the Child Behavior Checklist.

Staff in the Partners for Safe and Healthy Children program have additional responsibilities. They attend the CFS court case and coordinate referrals for any judge-mandated activities, which often include family therapy, parenting classes, or anger management sessions. Finally, case managers for the Partners for Safe and Healthy Children program conduct regular home visits and attend Child Family Teaming (CFT) events.[10]

Program Impact

Child Welfare Partners	FY 2022-23
Total clients served	505
Total cost per client*	$1,178

Improving Timely Access for Underserved Populations Through Case Triaging: Under California's timely access mandate,[11] the Health Plan of San Mateo is required to provide mental health services within 2 weeks of the initial request. The Prenatal to Three Initiative improves timely access and linkages for underserved populations by following procedures designed to connect Medi-Cal clients to appropriate mental health services within the required time frame. Protocols for individuals referred by a County provider or Access Call Center staff differ from the protocols for individuals referred by CFS staff. These differences are described in greater detail below:

- Nonurgent Referrals: Prenatal to Three and Prenatal to Three Teen Parent program staff make at least three phone-based contact attempts within 10 business days of receiving nonurgent referrals. Details are captured in a Client Services Information (CSI) assessment record. If staff are unable to reach the referred individual, they send them a letter explaining how they can begin receiving program services and listing other county-based resources.
- Crisis and Urgent CFS Referrals: For CFS referrals categorized as an emergency, Partners for Safe and Healthy Children staff are expected to contact the referred individual within 24 hours. Noncrisis referrals from CFS are to be addressed within 48 hours.

Improving Linkages Through Development of Universal Screening and Care Transition Protocols: In FY 2022-23, Prenatal to Three Initiative staff participated in a series of stakeholder meetings convened to discuss the design and implementation of standardized screening and care transition tools, which all counties are required to adopt under the Department of Health Care Services' California Advancing and Innovating Medi-Cal (CalAIM) initiative. These new screening and care transition workflows are expected to further reduce wait times for newly referred clients in future years.

Reducing Client Stigma Through Psychoeducation and Investments in Culturally Sensitive Care: As in prior years, Prenatal to Three Initiative staff help reduce the prevalence and severity of stigma experienced by clients by providing psychoeducation during routine therapy sessions and special group sessions. In FY 2022-23, initiative staff also participated in a cultural humility discussion led by the Office of Diversity and Equity staff. Prenatal to Three Initiative leadership encourage clinicians to

[10] CFT events are recurring meetings attended by clients and members of their support network, including local school, probation, BHRS, and CFS staff as well as other health care providers. CFT is a collaborative, strengths-based approach to supporting families involved with the court system, and it prioritizes consideration of clients' stated needs and preferences.
[11] For more information, see https://www.vchealthcareplan.org/providers/docs/CATimelyAccessLegislationAndRequirements.pdf.

enroll in various cultural humility trainings throughout the year to expand their tool kits for serving clients of diverse backgrounds, who are more likely to have experienced discrimination-related stress that can exacerbate mental health issues.

Addressing Disparities in Access to Care Through Multimodal Visits: Moreover, the Prenatal to Three Initiative reduces disparities in access to care by tailoring service delivery methods to meet the needs of each client. Many Medi-Cal clients lack access to reliable transportation, making it much more difficult for them to travel to clinicians' offices for mental health care. As in past years, initiative staff overcame these obstacles by offering to conduct therapy and intensive case management services during home visits. In FY 2022-23, the Prenatal to Three Initiative expanded the range of services available through home visits, offering all clients the option to attend psychiatric care appointments with a clinician who travels to their residence. For clients who prefer to attend an in-person appointment at the clinic, the initiative issues vouchers covering the costs of taxi rides to and from the office. While telehealth visits are still available[12], staff have observed that a greater number of clients are choosing in-person care over virtual appointments in FY 2022-23 relative to prior years.

Increasing Use of Public Health Services Through Intensive Case Management: Prenatal to Three Initiative staff regularly increase the number of individuals receiving public health services by connecting referred individuals to appropriate mental health services. However, staff vacancies made it more difficult to process high volumes of referrals in FY 2022-23, as discussed in the Challenges section of this report.

Implementing Recovery Principles: Finally, Prenatal to Three Initiative staff demonstrate their commitment to using several recovery principles, as described below:

- Delivering Culturally Sensitive Care: Supervisors have prioritized the hiring of bilingual staff, including up to six interns on an annual basis, to better serve the large number of clients who are monolingual Spanish speaking.
- Facilitating the Involvement of Community Members: Initiative staff organize informal support group activities called Café con Padres (Coffee with Parents). Clients are paired with other parents trained as family partners—peer support workers with relevant lived experience—to discuss their recent life challenges and come up with strategies for parenting effectively while simultaneously managing SMI and/or substance use disorder (SUD) symptoms.
- Promoting Care Integration Across Providers: Staff regularly pursue opportunities to collaborate with BHRS staff from other divisions. For example, many Prenatal to Three Initiative therapists attend clients' appointments with a psychiatrist to provide emotional support.

[12] Clients cannot attend all of their appointments virtually because the program must fulfill minimum standards of care, which require clinicians to meet with each client in person at least once a month.

- Providing Trauma-Informed Care: In FY 2022-23, leadership began recruiting to fill an AOD specialist staff position that had been created in the prior year to expand the program's capacity for SUD treatment referrals and care coordination.

This section provides a comparison of emergency service utilization data from periods that extend to 3 months before and after the clients were admitted to the Prenatal to Three Initiative. Table 1 summarizes the emergency service utilization information for the clients who were admitted and actively part of the Prenatal to Three Initiative during FY 2022-23. During the 3 months before program admission, there were 422 psychiatric emergency services (PES) episodes, one inpatient/residential episode, and four total days of inpatient residential stay among the Prenatal to Three clients. Out of the 422 PES episodes, 409 were reported on the day of admission. During the 3 months following clients' admission, none of the Prenatal to Three clients had a record of using the same health care services.

Table 1. Prenatal to Three Clients' Emergency Service Utilization (FY 2022-23)

	3 months before (including the day of) admission	3 months after admission
# of PES episodes	422*	0
# of inpatient/residential episodes	1	0
Total inpatient/residential stay (days)	4	0

* 409 PES episodes were reported on the day of admission.

Successes

The initiative's intensive case management services were particularly successful in FY 2022-23. Clinicians have increasingly offered in-person crisis intervention services to clients facing significant life stressors. For example, one clinician spent hours visiting a client who was experiencing extremely high anxiety following an incident that nearly resulted in their eviction from a homeless shelter. This clinician provided much-needed emotional support during an extremely difficult period.

Since FY 2021-22, the Prenatal to Three Initiative's occupational therapist has administered sensory interventions that produce clinically significant improvements in clients' self-awareness and resiliency. This clinician uses the Integrated Listening System's Focus Listening Program to rewire the brain in adult caregivers and any of their children who are affected by frequent emotional dysregulation, high anxiety, inattention, and auditory hypersensitivity, among other conditions. Clients wear a special headset that delivers auditory and vibrational sensations while completing a movement task for the first 15 minutes and a simple cognitive task or quiet activity for the remaining 15 minutes. One adult caregiver and her young child benefitted immensely in FY 2022-23 from a combination of talk therapy and Integrated Listening System sessions, as described in the next section.

Client Success Story #1: Before starting occupational therapy sessions, this client's son presented with severe hyperactivity, sensory sensitivity, and difficulty maintaining focus and following verbal instructions. When the initiative's occupational therapist first administered the sensory motor

protocol to this child, he was unable to keep his headphones on for more than a few minutes at a time, requiring breaks and redirection to continue with the session. He also had trouble staying engaged with the movement-based task or behaving appropriately during the quiet activity. However, the child's functioning steadily improved as the program's occupational therapist continued to supervise his work on the sensory motor protocol during weekly sessions at the clinic and periodic home visits. The clinician also trained the child's caregiver to independently administer the protocol at home because repetition is key to achieving changes in neural connections linked with positive behavioral changes. After completing the 60 protocol hours this child had been assigned, he was able to fully participate in each of the movement-based and quiet activities, following all instructions without requiring redirection to task during the entirety of a 30-minute session. Notably, the child learned how to transition appropriately as the session came to an end, which his caregiver described as a huge relief.

Challenges

Addressing Staffing Shortages: Similar to last fiscal year, the most significant challenge experienced by Prenatal to Three Initiative leadership has been difficulty retaining current staff and hiring qualified candidates to fill open positions. Currently, there are three vacant full-time positions, and two vacant Extra-Help positions.[13] High caseloads have increased the burden on remaining staff members, leading to widespread burnout and influencing some clinicians' decisions not to return to work following parental leave. Relaxing some of the County's restrictions on employment terms for Prenatal to Three Initiative staff, such as rules barring them from offering part-time clinical roles, could help them retain existing staff who have become mothers and would prefer not to work a full-time job. The initiative is already using approved strategies for expediting the hiring of backfills, such as offering hiring bonuses to secure quicker placements of qualified applicants in hard-to-fill specialty services positions. Because a large proportion of their clients are monolingual Spanish speaking, the Prenatal to Three Initiative has also prioritized recruiting bilingual providers through outreach to professional associations and other organizations who work closely with the Latino population.

Managing Difficulties with Referral Processing and Tracking: Due to ongoing personnel shortages and consistently high volumes of client referral paperwork submitted by community partners, Prenatal to Three Initiative staff continued to find it cumbersome to manage program referrals. High staff turnover coupled with procedural changes that the has iteratively introduced as it moves toward full compliance with California Advancing and Innovating Medi-Cal in FY 2022-23 have also required more trainings on the referrals process. For example, after BHRS transitioned to an updated electronic health records system in FY 2022-23, clinicians had to participate in several trainings to become more comfortable using it. Staff anticipate the need to schedule additional training sessions in FY 2023-24 following implementation of the new universal screening tools and countywide documentation system.

[13] Extra-Help positions "are primarily used to staff seasonal assignments and assist departments during brief periods of heightened workloads." Individuals hired to fill Extra-Help positions can only work a total of 1,040 hours per year, meaning that they are limited to providing 6 months of full-time labor or 12 months of part-time work.

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As in the previous fiscal year, program staff continued to receive a significant number of referrals of clients with mild to moderate mental illness. Such clients are ineligible to participate in Prenatal to Three Initiative programs, which only serve individuals living with serious mental illness (SMI). In response to this year's personnel shortages, staff trained one family partner on protocols for assessing whether referrals meet Prenatal to Three Initiative eligibility criteria.

Navigating Surge in Intimate Partner Violence Cases and Secondary Trauma in Staff: As in the previous fiscal year, complex cases, such as those stemming from a client's exposure to intimate partner violence or their struggles with addiction, impacted staff well-being in FY 2022-23. Of note, clinicians observed an increase in the overall prevalence and severity of intimate partner violence, recalling the loss of as many as three or four clients in FY 2022-23 whose deaths were linked to their abusive partners. Staff regularly connect clients who are suspected of or confirmed to be victims of intimate partner violence to Community Overcoming Relationship Abuse (CORA), a provider of comprehensive intimate partner abuse prevention services, including crisis intervention, housing assistance, and legal services. However, clinicians sometimes report feeling helpless when resource constraints, such as the lack of available space in safe houses or an overburdened legal support team, prevent clients at risk of exposure to intimate partner violence from receiving timely assistance. Initiative leadership plans to identify and deploy new strategies in FY 2022-23 for mitigating the trauma staff experience after learning about the intimate partner violence endured by their clients.

Building Staff Capacity to Better Serve Clients with SUDs: As mentioned previously, leadership is currently trying to fill a newly vacant AOD specialist position that was created last year to provide staff with ongoing education on effective case management for clients with a co-occurring SUD. In response to prior feedback that some clinicians felt unqualified to discuss substance use problems with clients, Prenatal to Three Initiative leadership arranged for an AOD manager and program specialist to deliver a presentation in FY 2022-23 covering SUD screening and referral best practices. While additional education may be required before all clinicians feel more comfortable serving clients with co-occurring SUDs, staff appreciated the guidance AOD instructors provided on specific client cases during the Q&A portion of the presentation.

Troubleshooting Paucity of Affordable Housing Resources: Finally, Prenatal to Three Initiative found that it has proven increasingly difficult to help clients find a safe, affordable place to live, which they attributed to lengthy waitlists for free or partially subsidized housing in FY 2022-23. The initiative is in the process of identifying new resources and ways to assist clients in need of housing, such as the client whose story is presented in the following section.

Client Success Story: One client spent months waiting to move into a local apartment after demonstrating remarkable improvements in her ability to manage SMI symptoms and responsibly care for her child. This client had dedicated over a year of her life to meeting case plan objectives required of a child reunification award, regularly attending parent education classes and, later, passing observational tests scheduled during a 30-day trial custody period. The fact that this client's child was recently approved to be fully returned to her care is a testament to both the client's hard work and the excellent support services provided by Partners for Safe and Healthy Children program staff. Unfortunately, the paucity of local housing units available through the U.S. Department of Housing and Urban Development's voucher program for non-elderly residents with a disability

significantly delayed this client's placement in long-term, non-shelter housing. Two to 3 months following their reunification, the client and her child finally moved from a shelter into their own apartment. However, program staff noted that the delay exacerbated mental health issues for both parent and child; the latter had already experienced a lot of stressful changes over the last 2 years: removal from their mother's home, transfer to the residence of a foster parent, and move into the shelter following reunification.

Demographics

The table below summarizes the demographic information for the 505 clients who were admitted and actively a part of the of the Prenatal to Three Initiative during FY 2022-23.

Age	Number of clients	Share in total (%)
0–15	62	12.3
16–25	130	25.7
26–59	313	62.0
60+	0	0.00
Primary language	**Number of clients**	**Share in total (%)**
Spanish	272	53.9
English	188	37.2
Unknown/not reported	23	4.6
Portuguese	11	2.2
Russian	3	0.6
Arabic	3	0.6
Farsi	2	0.4
Tagalog	2	0.4
Other Chinese language	1	0.2
Race	**Number of clients**	**Share in total (%)**
Other	323	64.0
Unknown/not reported	129	25.5
White/Caucasian	15	3.0
Multiple	11	2.2
Black or African American	8	1.6
Filipino	5	1.0
Asian Indian	4	0.8
Hispanic or Latino	2	0.4
Other Asian	2	0.4
Chinese	1	0.2
Samoan	1	0.2
Ethnicity	**Number of clients**	**Share in total (%)**
Hispanic or Latino	344	68.1
Unknown/not reported	96	19.0
Not Hispanic or Latino	65	12.9

Sex assigned at birth	Number of clients	Share in total (%)
Female	472	93.5
Male	32	6.3
Unknown/not reported	1	0.2
Sexual orientation	**Number of clients**	**Share in total (%)**
Unknown/not reported	481	95.2
Straight or heterosexual	19	3.8
Bisexual	4	0.8
Declined to state	1	0.2

PUENTE CLINIC

Puente Clinic was created in 2007 under BHRS to accommodate the sudden increase of psychiatric service need due to the closure of Agnews Developmental Center and relocation of many intellectually disabled adults to San Mateo County. The word "Puente" means "Bridge" in Spanish, and it implies to help clients bridge what could be a life of dependence and isolation to a life of independence and integration with the whole community. Clients with intellectual disability have higher comorbid psychiatric disorders, face more stressors and traumatic exposure in life, and experience more stigmatization and discrimination. But limits in communication/cognitive ability and aberrant brain development/function make it challenging for behavioral health providers to assess, diagnose, and treat these clients. Clinical staff at the Puente Clinic are trained and experienced in working with adult clients with both intellectual disability and psychiatric conditions. In carrying out this unique function, Puente Clinic collaborates closely with the San Mateo County Branch of the Golden Gate Region Center (GGRC), which coordinates essential benefits (daily living, housing, etc.) for county residents who have intellectual disabilities. Puente Clinic serves as the lead clinical team in BHRS to receive psychiatric service referrals from GGRC. The team provides assessment, psychotherapy, and medication management, and coordinates case management with GGRC social worker/case managers. Currently, Puente Clinic has one full time Licensed Social Worker, one 80% full time equivalent (FTE) Psychiatrists, one half-time Nurse Practitioner, and a vacancy for a half-time Psychiatrist. A typical client referred to Puente Clinic is someone having mild to severe intellectual disability, often with significant limits in communication ability, with one or more of the following conditions:

1. Client is returning to the community from a developmental center or a locked or delayed egress facility.
2. Client is at risk for a higher level of care.
3. Client requires in-home services as clinically determined.
4. Client has had multiple psychiatric emergency services contact.
5. Client has complex diagnostic issues or polypharmacy.

Program Impact

Puente Clinic – Dual Diagnosis	FY 2022-23
Total clients served*	264
Total cost per client	$1,408

Improves timely access & linkages for underserved populations: Puente Clinic and GGRC have jointly created a referral form (updated in Spring 2023) to facilitate recording and transmitting of comprehensive referral information. This special arrangement allows dedicated attention to clients dually diagnosed with intellectual disability and mental illness, as this client population often gets ignored and underserved due to limited ability to self-advocate and self-refer. A GGRC social worker sends this Referral Form to the Puente Clinic's social worker to initiate a screening process to identify Medi-Cal clients who meet medical necessity criteria. Once the Puente Clinic receives this form, the case is quickly reviewed for appropriate level of service and treatment provider. Prior to COVID-19, Puente was an in-person only service. During COVID-19, it became a telepsychiatry only service, and is now a hybrid model of in-person and telehealth. The clients get to determine which service method is best for them. Clients with limited communication ability tend to stay with the Puente Clinic providers, but clients with fair communication skills could also be served by other BHRS regional clinics. When a client's symptoms are in the Mild-to-Moderate range, referral to Private Provider Network will be made.

Reduce stigma and discrimination: The establishment of Puente Clinic was meant to create a special workforce with expertise in treating clients with both intellectual disability and severe mental illness. By removing barriers to care, this clinical team helps to reduce stigmatization and discrimination that clients with intellectual disability often experience. Co-location of Puente Clinic and several other BHRS clinical teams helps to normalize a sense of being welcome when these clients come to the clinic location, as they are treated with the same attention and respect as others. In addition, the Puente Clinic providers regularly offer training to other BHRS teams to inform skills and knowledge that help working with clients of this population. Puente Clinic also actively participates in the training of psychiatric residents, LMFT/LCSW interns, and nurse practitioner trainees on best practice in working with intellectually disabled clients, to reduce resistance of mental health providers in serving this client population.

Increases number of individuals receiving public health services: The need for psychiatric services for intellectually disabled clients has increased in the last few years. Some of these clients are served in the BHRS regional clinics while the ones with the greatest need for specialization are referred to the Puente Clinic. In addition to enhancing referral pathways to help with access to behavioral health treatment, the Puente Clinic providers also facilitate connecting clients with primary care providers and other specialty services that are covered by Medi-Cal benefits. In addition, there is a communication channel among the leadership of Puente Clinic, GGRC, and the Health Plan of San Mateo (HPSM) to resolve conflicts that cause barriers to care. Minimally every quarter these three entities meet to discuss ways to improve public health services.

Reduces disparities in access to care: Puente Clinic clients come from a diverse social background. Each provider has received multiple Cultural Humility trainings and applies the learning to clinical care and service coordination involving clients, families, caretakers, and parallel professionals. The Puente

Clinic providers constantly help clients who cannot advocate for themselves to pursue ancillary services that cover needed social benefits. In clinical sessions, interpretation services are provided as needed through phone or in-person arrangement, which includes sign-language interpretation.

Implements recovery principles: The Puente Clinic providers infuse hopefulness in clients, families, and caretakers, to help each client to achieve the highest level of functioning one could get. The successful outpatient treatment model that Puente Clinic provides helps client to live in the least restrictive setting in the community. Many clients of the Clinic came out of institution setting, such as a Development Center, where clients often experienced multiple types of traumas of verbal and physical nature, but Puente Clinic helps these clients to process their trauma experience, and to recover over time. When a client is cognitively capable, supportive psychotherapeutic treatment is always provided to enhance personal agency in achieving life goals. The Clinic works closely with GGRC and Department of Rehabilitation to find the best educational and vocational opportunities for clients, and works with local community groups to promote social connection and increase of educational resources for clients.

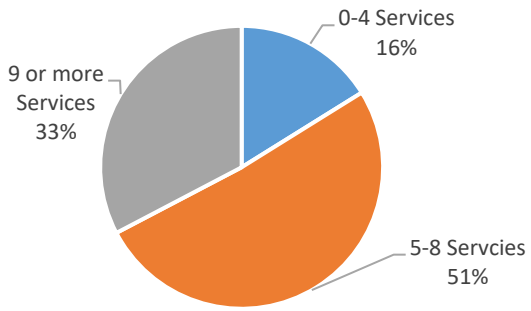
Psychiatric Emergency Services (PES) Utilization: One of the outcome data Puente Clinic continues to track is PES utilization at the San Mateo Medical Center, which is the triage center for acute psychiatric emergency in the county. A visit to PES can result in involuntary hospitalization, and sometimes seclusion and/or restraints; this experience can be traumatizing for the intellectually disabled population that Puente Clinic serves. Puente Clinic attempts to prevent and reduce the number of PES visits through individual psychotherapy, medication management, and close collaboration with GGRC and its support teams are needed to reduce disruptive and aggressive behaviors and to maintain stability in high-risk clients. Despite these interventions, Puente Clinic clients sometimes have episodes of aggression towards self or others that requires a PES visit.

In FY 2022-23, Puente clients had a significant reduction in total episodes in PES. While the number of clients served remained the same as FY 2021-22 (8), the number of PES episodes dropped from 21 to 11. This reduction reflects nearly a 50% reduction in PES visits throughout the year.

Medication-Related Episodes: In FY 2022-23, the Puente Clinic began tracking the number of billable medication-related episodes per year per client. This number reflects the level of medication-related psychiatric interventions needed for the year. Medication-related episodes included initial assessments, medication follow-up visits (in person, telehealth, or face-to-face), and phone calls when medications or side effects were discussed. For example, a stable client who is seen once every three months might have 4 medication support visits in the year; a client with active medication changes might require monthly visits, and register 12 medication support episodes per year.

For FY 2022-23, approximately one-sixth of the client required 0-4 medication services, and one-third required more than 9 medication services. That left approximately one-half of clients requiring 5-8 services in the year.

Puente Clinic Medication-Related Episodes
FY2022-2023



Successes

Client Success Story #1: 28-year-old female (named RSC) with moderate intellectual disability from progressive mitochondrial disorder and congenital visual and hearing impairments, began showing signs of depression at 25 years old. She lives in the community with her mother who is her primary caretaker and conservator. RSC is followed by Stanford Neurology for progressive ataxia and fine and gross motor loss. Despite their great care, client continues to experience increasing difficulty managing adaptive items such as her walker, large crayons, and large water cup, due to progressive skill loss. RSC was referred to Puente Clinic after her mother noticed a dysphoric quality, very out of character, consisting of anger, sadness, mood swings, and outbursts. Typical situation involved daughter playing happily, then explode into frustration with yelling or criticizing her mother, and then resume the happy playing. Outbursts occurred several times a week and included yelling and occasional physical aggression. Mother also described onset of OCD-like rigidity to schedules with poor tolerance for deviations from expected patterns or norms. This caused client to "shut down" when she would refuse to cooperate or engage, which negatively impacted household functioning (late for appointments, transportation issues, interrupted medical visits, etc.). An antidepressant (sertraline) in a low dose solution was initiated. Within a few days, client began refusing food (presumably due to gastrointestinal symptoms, a common side effect of antidepressants.) Sertraline was discontinued and another antidepressant solution (escitalopram) was initiated with nearly immediate benefit. Client continues low-dose escitalopram with a significant improvement in mood, outlook, ability to tolerate routine frustrations and less clingy anxious dependence on mother. RSC can tolerate frustrating and angst-provoking events that she previously would have triggered severe decompensation, including tolerating her mother's absence during Mom's first vacation in 28 years (a week-long trip to Alaska) without incident. RSC remains a happy and engaging young woman who enjoys coloring books and all things Disney.

Client Success Story #2: 28-year-old male (named ER) with a history of bipolar disorder and autism who had multiple past medication trials consulted for worsening symptoms of mania, aggression, insomnia, with significant weight loss. Upon first visit was noted to have significant upper extremity and facial involuntary movements consistent with tardive dyskinesia a long-term side effect of

medication. These movements were very distressing for the client, and this led to a regression in his verbal and functional abilities. His abnormal movement scale (AIMS) score at presentation was 21, corresponding to severe abnormal movements. A specialized medication was immediately started to reduce these side effects, and medications that may have been exacerbating the effects were slowly tapered down. Currently two months into treatment he is exhibiting zero signs of tardive dyskinesia with an involuntary movement (AIMS) score of 0, corresponding to no observable abnormal movements. He has had no more episodes of aggression, is eating and sleeping well, and has started to gain back the weight he had lost. His caregivers report, "His old self is back, this is the person we know." The client himself says, "I don't feel mad anymore. I can do chores again."

Challenges

Client Challenge Story #1: 40-year-old non-verbal female (named LJ) with moderate intellectual disability, impulse control disorder, intermittent explosive disorder, mood lability suggestive of bipolar spectrum disorder and congenital deafness has been followed by Puente Clinic since 2014 after the retirement of her community psychiatrist. She lives in a behaviorally based board and care with five other females. Her mother died when she was a teen and has been cared for by her loving aunt who continues to allow LJ to visit her home on weekends. Caretakers identify indiscriminate irritability and aggression occurring in a semi-cyclic pattern towards peers, staff, and property without obvious antecedent as disruptive to household functioning and exceedingly difficult to manage. Her aggression consists of expressions of hateful grimacing, threatening gestures involving choking action and physical assault of other residents at the board and care. Occasionally, she acts aggressively towards her aunt which tends to be a sign of worsening behavior. For many years, her rage would arise spontaneously and be directed at pulling the TV off the wall or smashing lamps or dishes; this has abated now. She has been trialed on numerous medications in many classes (antidepressant duloxetine; ant-anxiety medication benzodiazepines; mood stabilizers valproic acid and lithium; antipsychotics risperidone, Vraylar, Caplyta, lurasidone, duloxetine, perphenazine, quetiapine, and aripiprazole). Risperidone had a good effect for many years, but her history of rising prolactin levels undermined her continuing an effective dose. Her history of high prolactin and complex metabolic status continue to undermine the safety of behavioral meds. Behavioral interventions have included Creating Behavioral + Educational Momentum (CBEM), but they were flummoxed and bewildered by LJ's inability to respond to reward. Currently, plan involves an 18-week long cross-taper of valproic acid to lamotrigine for mood stabilization while she continues the antipsychotic medications Caplyta and low-dose risperidone for bipolar spectrum disorder and duloxetine as an antidepressant.

Client Challenge Story #2: 59-year-old man (named DF) with intellectual disability and schizoaffective disorder had developed a severe pneumonia and was placed on hospice care. During this time due to his change in health and sensorium, his psychiatric medications were significantly reduced. However, with great support from his caregivers he was able to make a full physical recovery and was discharged from hospice. He was returned to Puente clinic, however since his medications were reduced, he began exhibiting significant schizoaffective symptoms, paranoia, hallucinations,

insomnia, physical aggression, property destruction. His paranoia involved negative ideas about others of a different ethnicity than he which made the situation more emotionally taxing for his caregivers. Close work with him and his care team included safety planning, medication management in a way that both managed symptoms and avoided significant side effect, as well as supportive work around racial trauma. Emergency support was utilized when symptoms became dangerous at home, however the access to emergency or inpatient treatment is quite difficult for clients with significant intellectual disability. The Puente Clinic continues to do their best to help clients and caregivers achieve stability utilize resources available for support, but access and communication between different services is a work in progress.

Demographics

Plans to collect data currently not collected: In FY 2021-22, 5.82% of Puente clients had unknown/not recorded ethnicity. In FY 2022-23, Puente Clinic's goal was to reduce this to 0%, but this goal was not achieved. For FY 2023-24, Puente Clinic's goal will be to reduce unknown/not recorded ethnicity to 0%. The following table includes any client who had an episode open for at least one day during FY 2022-23. Clients were counted in multiple race groups if they indicated belonging to multiple races.

FY 2022-23	**N = 264**		**N = 264**
Age		**Sex at Birth**	
10-19	0.38%	Male	60.23%
20-29	12.45%	Female	40.15%
30-39	16.98%		
40-49	18.11%		
50-59	22.64%		
60-69	23.40%		
70-79	5.66%		
Race		**Ethnicity**	
White or Caucasian	49.62%	Not of Hispanic Origin	61.74%
Black or African American	12.12%	Not Hispanic or Latino	17.42%
Other Race	11.36%	Hispanic or Latino	14.39%
Chinese	7.20%	Unknown/Not Reported	5.68%
Unknown / Not Reported	7.20%	Other Hispanic	0.76%
Filipino	5.30%		
Mixed Race	1.89%		
Korean	1.14%		
American Indian or Alaska Native	1.14%		
Other Asian	0.76%		
Vietnamese	0.38%		
Other Asian or Pacific Islander	0.38%		
Japanese	0.38%		
No Race Recorded	0.76%		

The Neurosequential Model of Therapeutics (NMT) program aims to improve the well-being of clients who have experienced severe trauma. To this end, the NMT program manager provides training and ongoing technical assistance to county clinicians tasked with delivering intensive mental health services to individuals with serious mental illness (SMI) from one or more of the following groups:

- General adult clients (ages 26+)
- Transition Age Youth (TAY) clients (ages 16–25)
- Criminal justice-involved clients re-entering the community following incarceration.

Requirements for Initial NMT Certification

- Possess at least a master's degree and serve in a clinical role (i.e., as a nurse, psychologist, psychiatrist, marriage and family therapist, social worker, or occupational therapist).
- Attend 9-week six core strengths training class.
- Participate in 10-month NMT course (Phase I Training).
- Complete 10 client assessments.

Requirements for Annual NMT Recertification

- Complete a minimum of five client assessments.

Requirements for NMT Mentor Certification

- Participate in five drop-in sessions (Phase II training).
- Complete 10 client assessments.

Training and Certification in NMT: Twice annually, the NMT program offers a 9-week, 18-hour class on the Six Core Strengths[14], a framework devised by neuroscientist Bruce Perry to explain how trauma disrupts children's development. The Six Core Strengths training is a prerequisite for a 10-month course (Phase I Training) that teaches county clinicians how to conduct NMT assessments for adults and guides them through the process of obtaining their certification. NMT-certified providers rely on assessments of clients' functional capacities in four domains—sensory integration, self-regulation, relational, and cognitive—to inform the selection of individualized therapeutic interventions for the three populations mentioned above.

Eleven county clinicians who work with adult clients currently hold an NMT certification, which requires a total investment of about 120 training and study hours.[15] Over the course of FY 2022-23, the NMT program manager led a technical assistance program to support existing licensed NMT practitioners in lieu of offering an NMT-certification training course. The program consisted of five drop-in sessions, during which certified clinicians could draw on the support of the NMT manager while completing an assessment for one of their clients. The purpose of this Phase II training is to prepare clinicians to become mentors.[16] NMT program mentors are expected to feel comfortable leading the six core strengths training and coaching Phase I trainees on the client assessment process.

Providing NMT Assessments and Trauma-Informed Care: NMT-trained clinicians perform two primary activities: (1) conducting initial and follow-up NMT assessments and (2) creating and refining customized treatment recommendations. As part of the initial assessment, clinicians collect

[14] The six core strengths are attachment, self-regulation, affiliation, attunement, tolerance, and respect. They develop sequentially. For example, the first listed strength, attachment, underpins the growth of self-regulation skills. For more information, see https://www.buckeyeranch.org/assets/media/documents/Core%20Strengths%20for%20Healthy%20Child%20Development.pdf.

[15] Instruction consists of didactics, prerecorded Perry case presentations, one-on-one mentoring on how to use the tool, discussion of required readings, case reviews (including treatment planning), a day-long video training, and a live assessment.

[16] For more information on Phase I and Phase II training, please see https://www.smchealth.org/sites/main/files/file-attachments/san-mateo-inn_nmt_final-evaluation-report_revised_2020123_stc.pdf?1638919557.

information about a client's adverse experiences as well as their relational history, noting any evidence of past difficulty building and maintaining healthy relationships, and document observations of the client's current presentation[17] and relational health. Entering this data into the NMT portal generates a metric known as a brain map that shows functioning for the client side-by-side with the brain map for a healthy adult of the same chronological age. Clinicians review the brain map to identify relative strengths and vulnerabilities across the four functional domains (sensory integration, self-regulation, relational, and cognitive).

Based on this analysis, clinicians recommend specific therapeutic interventions that promote the development of functional capacities within the domain(s) in which the client showed the largest deficits. Program staff commonly refer clients to one or more MHSA-funded contracted service providers that offer guided therapeutic activities, including trauma-informed yoga, equine therapy, swimming, martial arts, art, music, and intensive speech therapy. In addition, the NMT program provides flex funding to cover the cost of gym memberships and finances clients' self-care tools, including weighted blankets, sound machines, and gliders. Clients' use of these self-care tools and engagement in group-based therapeutic activities complement traditional talk-based therapy and psychiatric medications. Six months to a year after generating the most recent brain map, clinicians administer follow-up assessments to facilitate analyses of changes in clients' brain functioning.

Program Impact

Trauma-Informed Interventions (NMT)	FY 2022-23
Total clients served*	90
Total cost per client	$2,334

Implementing recovery principles: The NMT program fulfills MHSA objectives primarily through its commitment to implementing recovery principles, as described below:

- *Delivering trauma-informed care* – NMT-trained clinicians match interventions with the developmental readiness of the client and strive to foster an environment that feels safe to the client. In FY 2022-23, the NMT program bolstered its commitment to trauma-informed care by adding a Trauma 101 section to its Six Core Strengths training course for county clinicians.
- *Promoting care integration* – NMT-trained clinicians also connect with other providers to develop individualized care plans that minimize distress commonly experienced by clients in other health care settings. For example, clinicians sometimes present a client's sensory profile data in meetings with residential treatment providers to explain why the client may be acting

[17] The client's current presentation is summarized using information collected from an initial mental health assessment, subsequent mental status exams, psychiatric evaluations, adult sensory profiles, and the NMT-certified clinicians' case notes.

out in this setting, and to recommend accommodations that they may need to function optimally. In FY 2022-23, the NMT program secured additional funding for therapeutics supplies (e.g., rocking chairs, weighted blankets) made available to clients enrolled in a Cordilleras Mental Health Center residential treatment program.

Reducing discrimination by educating providers and public assistance program staff: Finding certain diagnoses in a client's medical record (e.g., a personality disorder) can automatically cause clinicians to assume that the client will be difficult because they are likely to have boundary issues. However, the NMT model promotes greater compassion for neurodiversity by helping clinicians better understand past experiences that have caused the client to present in a maladaptive way to get their needs met. Clinicians also use NMT findings to counter unconscious biases of judges, probation officers, and other staff involved in child protective services cases; residential treatment facility staff; and employees of other community-based organizations.

Addressing disparities in access to care by funding trauma-informed services and supports: The NMT program reduces disparities in access to high-quality, trauma-informed care by empowering BHRS clinicians to connect low-income clients with additional services and resources that clients could not otherwise afford, including equine therapy, intensive speech services, and rocking chairs. In FY 2022-23, the NMT program received a greater proportion of its referrals from two BHRS specialty programs: 1) the Older Adult System of Integrated Services (OASIS) program, and 2) the Facilities Utilization Management (FUM) team. Because neither specialty team have any NMT-certified staff, NMT program leadership invested more time speaking with clients from these populations to better understand the services and supports that would best meet their needs. This process has often culminated in creative uses of flex funds. For example, the NMT program covered the cost of a specialist who visits the home of an elderly patient with SMI and hoarding tendencies once a week to help them organize. Another clinician helped a new TAY client who lived in a residential facility obtain special exercise equipment after they expressed an interest in taking boxing classes.

Augmenting provider capacity to handle increases in public health service utilization: The NMT program manager routinely coaches clinicians on ways they can conduct NMT assessments more efficiently. Over time, this technical assistance has enabled trained providers to treat a greater number of residents with developmentally appropriate mental health services. The NMT program manager has also frequently offered to conduct an initial NMT assessment on behalf of overburdened BHRS clinicians, providing additional staff capacity when caseloads and demand increase.

Electronic health records did not contain any psychiatric emergency services (PES) episodes or Inpatient/Residential visits for clients who were admitted and actively part of the NMT program during the FY 2022-23 during 3 months before and after their admission. In this section, the breakdown of the NMT clients is presented by report status, changes in scores for clients with a follow-up report, and comparison between the client score and associated age typical score.

Table 1 below summarizes the report status provided by the NMT program during the FY 2022-23. Of the 87 clients referred during the FY 2022-23, 44.8 percent (n=39) of clients had no report, 34.5 percent (n=30) of clients had a follow-up report, and 20.7 percent of clients (n=18) had only one report.

Table 1. NMT Clients' Report Status (FY 2022-23)

	Number of Clients	Proportion of Clients (%)
No Report	39	44.8
Has Follow-Up Report	30	34.5
Has Only One Report	18	20.7
Total	**87**	**100.0**

Table 2 below summarizes the change in scores for clients with a follow-up report provided by the NMT program by score type during the FY 2022-23. For those with an increase in score, 70.0 percent (n=21) of clients improved their relational score and 66.7 percent (n=20) improved their self-regulation score. For those with no change in score, 16.7 percent (n=5) of clients improved their sensory integration score and cognitive score, respectively. For those with a decrease in score, 30.0 percent (n=9) decreased their sensory integration and self-regulation scores, respectively.

Table 2. NMT Clients' Change in Scores for Client with a Follow-Up Report (n=30) (FY 2022-23)

	Increase in Score		No Change in Score		Decrease in Score	
	Number of Clients	Proportion of Clients (%)	Number of Clients	Proportion of Clients (%)	Number of Clients	Proportion of Clients (%)
Sensory Integration Score	16	53.3	5	16.7	9	30.0
Self-Regulation Score	19	63.3	2	6.7	9	30.0
Relational Score	21	70.0	4	13.3	5	16.7
Cognitive Score	20	66.7	5	16.7	5	16.7

Table 3 below summarizes the change in percentage point for scores by type between baseline and the follow-up report provided by the NMT program by score type during the FY 2022-23. On average, there was a 6.9 percent increase between baseline and follow-up for the self-regulation score, and a 6.4 percent increase for the relational score.

Table 3. NMT Clients' Score / Age Typical Score (n=30) (FY 2022-23)

	Baseline - Average Client Score / Age Typical Score (%)	Follow-Up - Average Client Score / Age Typical Score (%)	Change (%)
Sensory Integration Score	81.2	84.2	3.0
Self Regulation Score	70.0	76.9	6.9
Relational Score	74.0	80.4	6.4
Cognitive Score	81.2	85.7	4.5

Successes

TAY clients – those who are between the ages of 18 and 25 – showed the greatest improvements in their relational, cognitive, sensory integration, and self-regulation abilities in FY 2022-23. Because the NMT program served a greater number of TAY clients FY 2022-23 compared to prior years, NMT-trained clinicians spent more time this year thinking through how to tailor therapeutic interventions and supports to the needs of this population. For example, in response to observations that many of their 18- to 20-year-old clients suffered from loneliness, clinicians have increasingly arranged for flex funding to cover the purchase of weighted plush animals and other soothing items that appeal to TAY clients. In FY 2022-23, the NMT program also executed a new contract with the Riekes Center for Human Enhancement, which offers classes designed to help students accomplish their individual goals and build character in a non-judgmental environment. In addition to participating in creative arts, athletics, and/or nature awareness classes at the Riekes Center, TAY clients have also benefitted from their access to the center's state-of-the-art gym facilities and one-on-one mentoring services.

Over FY 2022-23, NMT clients – especially those from the pain clinic – have continued to benefit from their participation in group-based or private yoga. Pain clinic clients' receptiveness to engaging in trauma-informed yoga is especially important because many have relied on medications for a long time and have difficulty accepting support outside of medication. The instructor's understanding of addiction and mobility issues reportedly helps NMT clients feel safe when practicing yoga.

Clients have also undergone remarkable transformations in FY 2022-23 through their participation in other guided therapeutic activities. Once such client, whose story is described in detail below, was relieved to find that equine therapy helped alleviate her anxiety.

Client Success Story #1: One client, who had been homeless for a few months prior to her enrollment in the NMT program, was initially very guarded when meeting new people. Due to post-traumatic stress disorder (PTSD) and alcohol use disorder (AUD) diagnoses, she often experienced high anxiety, and it took several months for her to feel comfortable opening up with her therapist. Eventually, the client agreed to participate in equine therapy, which she described as "an experience I'll never forget" in a written statement about the NMT program's positive impact on her life. The following is an excerpt from that letter:

> *"I was a little skeptical about the horses and the therapy, maybe even a little resistant to it, but it turned out great. I had a lot of different kinds of therapy and therapists before, but this was something really different. The horse therapy really helped my anxiety and feel safer in the world in general. The staff was amazing, and just interacting with them helped me be less anxious around people and start to have a different perception of life. The horses were so different with a lot of personality and energies to them. The animals also had stories that helped me connect with them".*

This client's quality of life has improved dramatically since becoming involved in the program. After her therapist helped arrange for her transfer to a smaller, less overwhelming shelter, she was promptly invited to participate in a rapid re-housing program that facilitated her placement in a studio apartment. She is currently working for a non-profit social services organization and recently reconnected with her family. NMT program staff recently referred the client to a pro-bono/low-cost

attorney who will help her obtain a work permit through the Deferred Action for Childhood Arrivals (DACA) policy. Once this paperwork is finalized, the client plans to pursue job opportunities in the tech field.

As noted earlier, the NMT program has received a greater proportion of referrals from specialty teams in FY 2022-23 than in previous years. The story presented below demonstrates how the NMT program's brain mapping and talk therapy services, coupled with purchases of therapeutic items, helped catalyze and sustain behavioral improvements by an adult client referred through the Partners for Safe and Health Children program.

Client Success Story #2: When he first began receiving NMT program services in February 2022, this client had been using drugs and temporarily lost custody of his two young children. However, he decided to commit to treatment for his addiction in an effort to be approved for reunification with his children. Between February 2022 and May 2023, NMT-trained clinicians created three brain maps. They used the first brain map to identify domains that could be targeted for improvement through specific therapeutic interventions and conducted subsequent mapping assessments to measure the impact of treatment. These trauma-informed interventions complemented the extended-release naltrexone injections the client received from a substance use disorder treatment provider. Because the client and his children were drawn to similar, soothing scents, NMT staff also arranged to purchase a diffuser for the client and a scented stuffed animal for one of his children. In addition to leading talk therapy sessions, his clinician also accompanied the client on walks because exercise helped the client maintain his sobriety. Toward the end of his involvement with the program, he obtained a housing voucher and regained custody of his two children. The client also appeared steadfast in his commitment to sobriety, relying on a glider swing and a tea kettle, both supplied by the NMT program, to self-soothe in lieu of other, less healthy coping mechanisms.

Challenges

Addressing declines in NMT program referrals from BHRS regional clinics: Staffing shortages and correspondingly higher caseloads among regional clinic staff, who serve more clients than the BHRS's specialty teams, contributed to declines in NMT program referrals from BHRS regional clinics in FY 2022-23 relative to past years. BHRS regional clinicians, who are often overwhelmed by caseloads, are simply less willing to coordinate with NMT program staff to arrange for assessments to be completed for their adult clients, let alone enroll in future NMT certification courses. The ideal long-term solution to these capacity constraints would be for San Mateo County leadership to fund new mental health positions and streamline their hiring practices. However, NMT program staff also plan to adjust their recruitment strategy, as well as the design of next year's training program, to incentivize participation by clinicians and their mentors. Because the NMT program appears to be less visible to BHRS regional clinicians who serve adult clients than to specialty TAY program staff, NMT program management are renewing their efforts to secure the support of BHRS regional clinic leadership. Supervisors can boost client referrals and clinician training enrollment numbers by touting the benefits of the NMT program in communications with staff.

Developing programmatic changes to improve NMT mentors' supervision of NMT trainees: NMT program staff also plan to modify the structure of next year's NMT certification course to reduce burden on mentors. Typically, Phase I NMT trainees conduct their first five assessments with the support of a mentor, whose detailed guidance can cause each map can take upwards of an hour-and-a-half. Because mentors often have competing priorities as supervisors to multiple clinicians, it is often difficult for new trainees to finish all 10 assessments that the governing body requires of applicants for an initial certification. To mitigate this problem, the NMT program manager plans to create a smaller FY 2023-24 training cohort and to provide supervision for some or all the guided assessments during a scheduled training session. This should reduce the amount of time that it takes to complete the remaining maps required to obtain certification.

Incentivizing NMT-trained clinicians to maintain their licenses: In the prior year (FY 2021-22), the NMT program manager had trouble incentivizing some existing NMT-certified staff to complete the five assessments required to maintain their license. As mentioned previously, the NMT program manager led a technical assistance program in FY 2022-23 geared specifically towards supporting already-certified clinicians conduct assessments for at least five of their current clients. However, the NMT program manager has also approached NMT-certified supervisors, who no longer have caseloads, for support in completing maps for clients referred by specialty programs like OASIS or other residential care management programs. This strategy has helped the NMT program manage the increase in specialty team referrals and prevent certification lapses by NMT mentors, which would otherwise impair BHRS' capacity to train new applicants.

Tailoring services and supports to better serve clients from residential facilities: A surge in referrals of clients from residential facilities may also require the NMT program to recruit new community partners and/or train existing partners how to most effectively mentor clients who have difficulty functioning independently. Much more so than others served by the NMT program, clients staying in residential facilities suffer from loneliness and harbor distrust of people outside of their medical team. It is especially important to connect these clients to other places within their local community where they feel safe. The NMT program has taken initial steps to better serve clients who live in residential facilities, such as TAY clients from the Edgewood center, by partnering with the Art of Yoga to offer TAY clients weekly yoga classes. In future years, it may be beneficial to educate community partners on best practices for addressing behavioral and psychological issues that hinder the development of residential clients' sensory integration, self-regulation, relational, and cognitive skills.

Managing high volumes of administrative tasks through process improvements: As in the FY 2021-22, NMT program staff struggled to manage the high volume of administrative tasks, which include managing contracts with external service providers, tracking flex funds, and processing adjunct services referrals. These tasks reduce the time the NMT program manager has available to spend on client services – completing brain maps – or expanding provider capacity through training and coordinating visits with various BHRS teams. Beginning in FY 2023-24, NMT program staff plan to enlist the support of another clinician, who has offered to create a spreadsheet template that they will use to track referrals for NMT program goods and services. Over FY 2022-23, NMT program staff also continued to explore options for tracking and notifying NMT-certified clinicians of pending map updates for existing NMT clients. Ideally, clinicians should create a new map every 6 months to a year

to assess changes in each client's functioning, which would then inform decisions to continue or modify specific therapeutic interventions. Unfortunately, some clients were not remapped as frequently this year. In FY 2023-24, staff will strive to update a list containing the names of active NMT clients and the date of their most recent assessment on a more regular basis. Reminder emails will be sent to clinicians when one of their clients is due for a new map in the near future.

Demographics

The table below summarizes the demographic information for the 90 clients who were admitted and actively a part of the of the NMT program during the FY 2022-23. Forty-eight percent of the clients are between the ages of 26 to 59, while 40% are between the ages of 16 and 25. Most clients are female (almost 75%) and speak English as their primary language (60%). In addition, 13.3% of clients report Spanish as their primary language, and 31.1% identify as Hispanic or Latino. Approximately 27% of clients identify as a race not listed and 26.0% as White or Caucasian. It is important to note, however, that 40% of respondents did not report information on their race, approximately 38% did not report information on their ethnicity, and 82.2% did not report on their sexual orientation.

Demographic Data – Neurosequential Model of Therapeutics (NMT) Program, Adult Client List

Age	Number of Clients	Total # of Clients	Share in Total (%)
0–15	0	90	0.0
16–25	36	90	40.0
26–59	43	90	47.8
60+	11	90	12.2
Primary Language	**Number of Clients**	**Total # of Clients**	**Share in Total (%)**
English	54	90	60.0
Spanish	12	90	13.3
Portuguese	2	90	2.2
Unknown / Not Reported	22	90	24.4
Race	**Number of Clients**	**Total # of Clients**	**Share in Total (%)**
Other	24	90	26.7
White/Caucasian	23	90	25.6
Multiple	3	90	3.3
Black or African American	2	90	2.2
Hawaiian Native	1	90	1.1
Tongan	1	90	1.1
Unknown / Not Reported	36	90	40.0
Ethnicity	**Number of Clients**	**Total # of Clients**	**Share in Total (%)**
Hispanic or Latino	28	90	31.1
Not Hispanic or Latino	28	90	31.1
Unknown / Not Reported	34	90	37.8
Sex Assigned at Birth	**Number of Clients**	**Total # of Clients**	**Share in Total (%)**
Female	67	90	74.4

Male	20	90	22.2
Unknown / Not Reported	3	90	3.3
Sexual Orientation	**Number of Clients**	**Total # of Clients**	**Share in Total (%)**
Straight or heterosexual	13	90	14.4
Bisexual	2	90	2.2
Decline to state	1	90	1.1
Unknown / Not Reported	74	90	82.2

EVIDENCED-BASED PRACTICE (EBP)

System transformation is supported through Workforce Education and Training ongoing series of trainings to increase the utilization of evidence-based treatment practices across the BHRS system of care and better engage consumers and family members as partners in treatment and contribute to improved consumer quality of life. MHSA funding supports clinical staffing including Marriage and Family Therapists, Psychiatric Social Workers, Mental Health Counselors specialized in providing services for youth and adult clients and to expand the delivery of EBP practices. These positions are placed throughout BHRS regional clinics and programs.

Evidence-Based Practice Clinicians	FY 22-23
Total clients served	1,249
Total cost per client	$1,228

SCHOOL-BASED MENTAL HEALTH

The School-Based Mental Health (SBMH) program identifies students living with serious mental illness (SMI) and connects them with appropriate behavioral health services that support students to continue receiving classroom instruction. In FY 2022-23, SBMH staff provided clinical assessment; talk, art, and play therapy; and case management services to 345 students across 23 school districts. Roughly 80% of participating students are eligible for Medi-Cal. Staff serve the following groups:

- Newly referred students expected to meet medical necessity criteria for an individualized education program (IEP) on the basis of SMI screening results.
- Current special education students with ongoing SMI needs identified in a prior school year.

Primary program activities include reviewing SMI screening results; conducting the initial assessment required for an IEP package submission; presenting assessment findings at an IEP meeting; developing a treatment plan in collaboration with each student, their caregivers, and their instructors; delivering behavioral health services outlined in each IEP; contributing to annual IEP progress reports; assigning family partners to support caregiver(s); and conducting ongoing consultations with special education instructors, school counselors or psychologists, caregiver(s), and others who comprise each student's support network.

A manager and four supervisors oversee SBMH program operations, assigning one of 22 BHRS behavioral health clinicians to newly enrolled students and serving as liaisons between each school

district's staff and BHRS-affiliated service providers. Before a student begins receiving school-based behavioral health support, a SBMH supervisor will first review a SMI screening form submitted by school staff. For appropriate referrals, an SBMH clinician will then conduct an assessment with the student to determine whether their behavioral health challenges meet the diagnostic criteria for an SMI diagnosis and to identify behavioral health services that may support optimal school functioning. Finally, the SBMH clinician will present a subset of the assessment results at an IEP meeting. If the IEP team agrees with the clinician's recommendation for services, the clinician will work with the student's support network to finalize the treatment plan. While the services covered by each student's IEP vary, SBMH clinicians can provide individual and group therapy during school hours as well as family counseling outside of school. Medi-Cal students can also meet with BHRS psychiatrists outside of school to receive prescription medications to support behavioral health goals.

SBMH clinicians may also recommend that school staff refer students with maladaptive behaviors (but not at a level to receive an IEP) to either the Fred Finch Youth Center or Edgewood Center for wraparound services. The wraparound model is designed to prevent higher-level placements, such as residential placement, incarceration, or hospitalization, by helping students develop self-calming skills and embrace other strategies for curbing inappropriate behaviors. In those cases, SBMH clinicians and educators will present at a meeting of the Identification, Placement, and Review Committee to request approval for the referral.

In addition to delivering services required by the school district under the terms of each IEP, SBMH clinicians facilitate student referrals to off-site providers of other behavioral health services. Many students are encouraged to participate in movement-based therapeutic activities, such as yoga and equine therapy sessions led by Neurosequential Model of Therapeutics program partners. Furthermore, SBMH clinicians refer students who could benefit from and meet eligibility criteria for Therapeutic Behavioral Services (TBS) to the Fred Finch Youth Center.

Program Impact

School-Based Mental Health	FY 2022-23
Total clients served*	345 0
Total cost per client	$1,449

Increases number of individuals receiving public health services and reduces disparities in access to care: In FY 2022-23, the SBMH program continued to increase the total number of students living with SMI receiving public health services and reduce disparities in access to care by shifting staff to school districts with a greater number of traditionally underserved Medi-Cal-eligible students. These staff reassignments were necessary as there is a higher unmet need for specialty mental health services in districts with a greater number of students from low-income families. Coordinating behavioral health service visits with students in school reduced barriers to care for students whose parents work multiple jobs or rely solely on public transportation, as these factors can make it difficult to arrange for recurring mental health clinic visits.

Improves timely access & linkages for underserved populations: The speed with which materials for the IEP package are developed by individual school staff is the greatest driver of timely access to care. In FY 2022-23, SBMH program staff continued to expedite this process by creating a standard referral screening form and a secure mailbox for receiving completed forms. After receiving new referrals, program staff assessed eligibility and informed school staff of any additional documentation required to proceed with an assessment and presentation at an IEP meeting. Staff also articulate clear definitions for conditions that qualify as SMI to reduce the number of referrals they receive for students with mild or moderate mental health conditions. These methods provide timely access to care for eligible students. In lieu of these, students would have to navigate outpatient services, which may make it harder to access necessary services.

Reduces stigma and discrimination: The SBMH program continued to reduce the prevalence and severity of stigma felt by special education students and their caregivers, by doing the following:

- Providing students with the support they need to remain in their current classrooms; this promotes feelings of inclusion that would not be possible if behavioral disruptions persisted and required a transfer to a more secluded environment.
- Providing parents with psychoeducation to help them understand and navigate two disparate systems—the special education and mental health systems—without feeling stigmatized by caring for youth with "special needs". For example,
    - Parents could learn skills and share experiences with others in a parent group called Parent Project. Family partners were also available to provide destigmatizing support.

In addition, BHRS clinicians strived to mitigate discriminatory attitudes toward students with SMI by arranging to speak with special education instructors. Program staff collect and share background information on individual students and their families, including key challenges and limitations. They then use this information to suggest ways educators might work more effectively with those students.

Implements recovery principles: In FY 2022-23, program staff continued to demonstrate a commitment to implementing recovery principles. SBMH program clinicians promoted a high degree of student and family involvement in the development of treatment plan goals to make it more of a collaborative process, empowering them to take an active role in their own care. Patient self-activation is also accomplished through referrals to TBS clinicians, who can help students learn to verbalize their needs and advocate for themselves. Moreover, staff provide culturally sensitive care by matching families to culturally appropriate services. For example, family partners can advocate on behalf of families to access interpreter or translation services in the school setting. These family partners often attend IEP meetings and provide a bridge to ensure that monolingual Spanish-speaking parents or other non-English-speaking parents understand the school culture, the IEP process, and key points conveyed in meetings. Program staff also coordinate "family café" events for caregivers and family partners that function as support groups, thereby facilitating the involvement of community members. Finally, program staff promote trauma-informed care by funding students' participation in movement-based therapeutic activities, such as yoga and equine therapy, which evidence suggests can improve self-regulation in clients with a history of trauma.

This section provides a comparison of emergency service utilization data from periods that extend to three months before and after the clients were admitted to the SBMH Program. It also displays further details on SBMH clients' status of IEP and non-IEP goals.

Table 1 summarizes the emergency service utilization information for the clients who were admitted and actively a part of the SBMH program during the FY 2022-23. During the three months before program admission, there were 6 psychiatric emergency services (PES) episodes and no inpatient/residential episodes or days of stay among the SBMH clients. During the three months following their admission, none of the SBMH clients has a record of using the same healthcare services.

Table 1. SBMH Clients' Emergency Service Utilization (FY 2022-23)

	3 Months Before Admission	3 Months After Admission
# of PES Episodes	6	0
# of Inpatient/Residential Stay (days)	0	0
Total Inpatient Residential Stay (days)	0	0

Table 2 below summarizes the status of IEP goals for the clients who were admitted and actively a part of the SBMH program during the FY 2022-23. Although two-thirds of the clients have completed or partially completed the goals, close to a third have not completed the IEP goals.

Table 2. Status of SBMH Clients' IEP Goals (FY 2022-23)

IEP Goal Completion Status	Number of clients	Proportion of clients
Not completed	29	36.3%
Completed	26	32.5%
Partially completed	24	30.0%
Unknown	1	1.3%
Total	**80**	**100.0%**

Table 3 summarizes the status of non-IEP goals for the 80 clients who were admitted and actively a part of the SBMH program during FY 2022-23. Almost 38% did not complete the non-IEP goals, 33.8% partially completed them, and 27.5% completed them.

Table 3. Status of SBMH Clients' Non-IEP Goals (FY 2022-23)

Non-IEP Goal Completion Status	Number of clients	Proportion of clients
Not completed	30	37.5%
Partially completed	27	33.8%
Completed	22	27.5%
Unknown	1	1.3%
Total	**80**	**100.0%**

Successes:

In FY 2022-23, the SBMH program observed successes in providing services to vulnerable populations, such as unhoused families and exploited youth, through increased case management and collaboration with San Mateo County departments and school districts. For example, staff provided unhoused families with housing and food and ensured that children were enrolled in school. The program and BHRS aided a hospitalized client, whose primary stressor was homelessness, in finding temporary housing. The program also provided transportation services from homeless shelters or motels with the support of school districts. To protect clients who required a higher level of care, the program worked with the San Mateo County Office of Education (SMCOE) and with school districts to ensure client safety.

Another successful intervention was the program's continuity of care. In prior years, an outside assessor conducted an assessment, and then a clinician provided services to a client. In FY 2022-23, clinicians began both conducting assessments and providing services to clients. Having the same person provide both assessments and services increased continuity of care and proved to be a more efficient method of screening.

Clients have experienced several successes through their connection to SBMH. For example, among clients who recently graduated from high school, their involvement with the program allowed them to be easily transferred to a transitional-age youth program, where they could continue receiving mental health services or be connected to other agencies throughout their transition to adulthood. Additionally, the program reduced the number of hospitalizations by placing clients in more intensive care settings or residential placements. The success story below illustrates the program's positive impact on the client's ability to speak, identify needs, and verbalize feelings.

Client Success Story: A 10-year-old client was referred to SBMH because she was experiencing severe anxiety in school that led to her presenting as selectively mute. At the time of referral, teachers and her parents noted that the client was not doing well in school, would isolate herself, and would not participate in classroom activities. Her school team even considered a more restrictive school setting because she was falling behind academically. This client has now been meeting with her clinician for a year. During treatment, they focused on building a trusting therapeutic relationship, exposure therapy, and cognitive and behavioral therapy. This client has made strides in treatment, and her school special education team has been able to note the progress. Recently, her school team noted that the client is speaking at school, is engaging in classroom activities, has a friend group, and is engaging in full conversations with her therapist. In treatment, she is now able to speak, identify feelings, verbalize her needs, and scaffold information to apply techniques learned across all settings.

Challenges

One challenge the program faced during FY 2022-23 was not being able to provide services to students over the summer because school was not in session and students were not enrolled in an extended school year. The only way to enroll students with private insurance was if they have extended school year services in their IEP, but one obstacle was districts not agreeing to include

mental health services as part of the IEP when there were no academic structures in place over the summer. To address this challenge, the program worked with families to connect students with a different therapist during the summer months.

There was a disparity between Medi-Cal clients and privately insured clients when it came to receiving access to services. Medi-Cal clients received more services throughout the school year. The program contracted with the school districts, and more than 80% of students were on Medi-Cal, which presented no extra cost for the district. However, the district paid for the services of the 20% of students on private insurance. The services had to be outlined in the IEP, and if they were, SBMH could provide those services to students over the summer. The program would like to provide more services to privately insured students, and the gap in access to services these clients face is a contractual issue. These challenges can be mitigated through revised contracts with the districts.

Some districts currently do not pay for wraparound services at the Edgewood Center. As a result, some students with higher needs do not receive these services. To mitigate these challenges, the program would need to renegotiate aspects of these students' contracts with districts, particularly the accessibility of wraparound services and the gap between students who have Medi-Cal and those who have private insurance.

Demographics

The table below summarizes the demographic information of the 80 clients who were admitted and actively part of the of the SBMH program during FY 2022-23.

Age	Number of clients	N	Share of total (%)
0–15	23	80	28.7
16–25	57	80	71.3
Primary language	**Number of clients**	**N**	**Share of total (%)**
English	65	80	81.3
Spanish	12	80	15.0
American Sign Language	1	80	1.3
Unknown/not reported	2	80	2.5
Race	**Number of clients**	**N**	**Share of total (%)**
White/Caucasian	26	80	32.5
Other	26	80	32.5
Multiple	8	80	10.0
Black or African American	3	80	3.8
Filipino	2	80	2.5
Unknown/not reported	15	80	18.8
Ethnicity	**Number of clients**	**N**	**Share of total (%)**
Not Hispanic or Latino	36	80	45.0
Hispanic or Latino	35	80	43.8
Unknown/not reported	9	80	11.3

Sex assigned at birth	Number of clients	N	Share of total (%)
Male	46	80	57.5
Female	34	80	42.5
Sexual orientation	**Number of clients**	**N**	**Share of total (%)**
Straight or heterosexual	3	80	3.8
Something else, please describe	1	80	1.3
Transgender	1	80	1.3
Bisexual	1	80	1.3
Decline to state	1	80	1.3
Unknown/not reported	73	80	91.3

CRISIS COORDINATION

The Manager of the Crisis, Outreach, and Engagement team at BHRS manages four programs: Crisis Response, Psychiatric Emergency Response Team (PERT), Healthcare for the Homeless (HCH), and Homeless Engagement Assessment and Linkage (HEAL). The role was established about 3 years ago by the BHRS Deputy Director of Adult/Older Adult Services who restructured the reporting of these programs under one manager. This role includes developing and supporting new grant funding opportunities related to behavioral health crisis response services, outreach, and engagement.

The Crisis Manager attends behavioral health crisis related meetings as well as supervising staff, partnering, and interfacing with the public, and coordinating with other partners or systems in refining and developing processes and new services to address behavioral health crisis needs in the community. There have also been new initiatives under Crisis, Outreach, and Engagement related to the homeless population in the county (e.g., addressing the homeless population's needs within the Leveraging Equal Access Program [LEAP]). The Crisis Manager partners with other systems to ensure there is a unified response in the delivery of behavioral health crisis and follow-up services.

The Crisis Manager interacts with many other teams within BHRS and is unique in that they interact with both adult and youth-focused programs, populations, and both adult and youth team leadership, managers, supervisors, and program specialists. In addition, whenever a new crisis case may impact an existing BHRS client, the Crisis Manager will interact with the team addressing the crisis case including the manager and supervisor.

Program Impact

The crisis services vision in San Mateo County includes continuing to improve provision of timely response to behavioral health crises for all youth and adults in San Mateo County regardless of their insurance status as well as provide quality care and needed follow-up on those services. The Crisis Manager strives to provide crisis services in a timely, respectful, and culturally responsive person-centered manner. All behavioral health crisis programs would also be coordinated for easy access and uniformed standards of care.

Successes

Successes in this FY 2022-23 were tied largely to: (1) multiple large scale crisis response by our BHRS Crisis Response Team (CRT) that the Crisis Services Manager oversees and supports for responding to and providing immediate, short-term emotional support to the victims and survivors of community crises and/or tragic events in our county; (2) planning and preparing for the implementation of a county-wide 24/7 mobile crisis response service, the first of its kind in our county; and (3) proactively working with systems' partners and community stakeholders in addressing the increasing needs of our homeless community in our county.

One of the roles of the Crisis Services Manager is to support the training, mobilization, and operation of the BHRS CRT composed of "volunteer" clinicians from across BHRS, in provision of psychological first aid, emotional support, acute crisis assessment, and short-term linkages for needed services to the victims and survivors soon after a large-scale community crisis. These CRT responses during FY 2022-23 included the extensive support provided to the farm-worker survivors and families of the mass shooting in Half Moon Bay in January 2023, the victims of '22 winter storms, and multiple tragic events happening in various San Mateo County's school districts ranging from extensive sexual assaults of students by their teacher, to youth suicide, to other accidental tragedies.

In addition, the Crisis Services Manager has been leading on the planning, designing, and upcoming implementation of a 24/7 non-armed mental health mobile crisis response service in our county responding to the extensive stakeholder need-assessment process our county embarked on in 2022 as well as the CA DHCS' expectation of Medi-Cal Mobile Crisis Response Implementation Benefits released in June 2023. For the first time in our county's history, there will be a county-wide mobile crisis response service to address behavioral health crises by a team of licensed mental health clinician and a peer support staff/family partner; this mobile crisis response when launched in summer 2024 will be available in our county to "anyone, anywhere, anytime."

Finally, the Crisis Services Manager has been working with various stakeholders including but not limited to Center for the Homelessness, Human Services Agency, San Mateo Health, Correctional Health, SMMC LEAP Institute, BHRS Executive Members on redesigning and emboldening the partnership and coordination with other Homeless Outreach Teams (HOT) in our county to increase capacity, efficiency, timely coordination, and communication in supporting our homeless individuals county-wide.

Challenges

With the increasing needs and requests for crisis-related services and support in our community as well as the increasing complexities of our homeless populations compounded by the new expectations from State and County on these responses, the challenge remains with "same human resource for increasing demands on crises and homelessness". It has been increasingly difficult to pay equal and undivided attention to all these needs by one (and only one) Crisis Services Manager across all ages, all regions, and at times, for 24/7

PEER SUPPORT WORKERS & FAMILY PARTNERS

BHRS continues to support Peer Support Specialists (PSS), Peer Support Workers (PSW), Family Partners (FP) and Family Peer Support Specialists (FPSS) employed throughout the Youth and Adult systems of care. 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 the clients based on that shared experience.

Peer Supports: There are 13 PSS/PSW positions in the BHRS adult system funded by MHSA. They are embedded throughout the system in a variety of teams: Older Adult system of Integrated Services (OASIS), Pathways, and at the 5 BHRS regional clinics. One part-time PSW position was made full time. The PSS/PSW are:

- 6 PSS on the Adult Clinical Services Teams (full time positions)
- 1 PSS on the Transition Age Youth (TAY) Program (full time position)
- 1 PSW is in the Older Adult System of Integrated Services (OASIS) Team (part time position)
- 1 PSS on the Crisis & Outreach Team (full time position)
- 1 PSS on the re-entry Program BHRS David Lewis Center (full time position)
- 1 PSW on the re-entry Program BHRS David Lewis Center (full time position)
- 1 Senior Community Worker on the Adult Services Teams (full time position)
- 1 Senior Community Worker on the Pathways Team (full time position)

The PSS/PSW are culturally, racially, ethnically, and linguistically diverse. This includes Chinese, Pacific Islander, Latino, Caucasian, African American and LGBTQ staff, several of whom are immigrant bilingual and bi-cultural. PSS/PSW staff inspire clients through sharing their personal experience with mental health and/or Alcohol and Other Drug (AOD) services which helps clients realize the benefits of such services. They also help them overcome barriers to participation in mental health and AOD services. Support clients with developing and maintaining treatment goals and plan.

Family Supports: There are 6 Family Peer Support Specialists (FPSS) and 2 Family Partners (FP) with lived experience as a family member of someone with behavioral health challenges working in BHRS. There are 2 vacant positions. The Family Partners are:

- 5 FP/FPSS are embedded in the youth clinical services teams. (full-time positions)
- 1 FP is on the Adult Pathways Mental Health court team. (full-time position)
- 1 FPSS is on the School-Based Mental Health Team (full-time position)
- 1 FP (Vacant) on the Youth Services Center Team - Juvenile Justice System (full-time position)
- 1 FP on the Pre-3 Program (part-time position)
- 1 FP (Vacant) on the Transition Age Youth Program (Extra-Help position)

Family Partners represent diverse cultural and linguistic experiences, including bicultural and bilingual in English, Spanish, and Tongan. BHRS FP/FPSS 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 key factors in making these assignments.

FP/FPSS provide individual support to parents of youth and young adults, sharing their lived experiences with the families they serve. Some case management is part of their support of families. They also provide group support to parents/caregivers by providing educational activities around children and their mental health.

FP/FPSS also bring their lived experience to the broader community by participating in the following community groups, committees, and initiatives: Latino/a/x Collaborative, Pacific Islander Initiative, North County Outreach Collaborative, Immigrant Forum, Pride Initiative, Long-term Shelter Stayers Multi-Disciplinary Team to share resources and strategize on ways to support individuals in shelters to access stable housing, and Bay Area Regional Pacific Islander Taskforce, and Behavioral Health Commission Youth Committee Meeting.

Program Impact

Peer and Family Partners	FY 2022-23
Total clients served	372
Total cost per client	$4,741

BHRS FPS/FPSSs work to improve the quality of life of the programs' clients and focuses on aspects such as hope and purpose that may be difficult to measure. Unlike the Medical Model, the Recovery Model used by PSS/PSW does not focus on symptoms reduction measures, which are more scientifically-based, and it works by creating trust and collaboration over time rather than through short and relatively infrequent visits with highly specialized providers.

In addition to supporting clients with taking informed choices that support their health, the work of PSS/PSW is designed to assist clients with their finding and keeping a home, finding meaningful daily activities that bring them closer to their life goals, and creating a life in community with the rest of the community members.

Implementing recovery principles: Recovery principles are embedded in Peer Support Competencies trainings and practices. For example, PSS/PSW focus on life goals and desires, emphasizing clients' strengths to promote a recovery-oriented approach.

Enhanced Access and Linkages for Underserved Populations: PSS/PSW continues to play a crucial role in improving access and linkages for underserved populations. Their responsibilities include facilitating new client orientations, conducting outreach, and providing warm handoffs to community resources. Additionally, PSS/PSW contribute to system navigation and orientation, fostering cultural bridging among clients, providers, and stakeholders.

Stigma and Discrimination Reduction: PSSs actively engage in anti-stigma training, integrated into their curriculums. Regular discussions during PSS/PSW Consultation meetings address bias, prejudice,

and discrimination. PSS/PSW openly sharing personal recovery stories has contributed to reducing stigma and discrimination.

Increased Utilization of Public Health Services: PSS/PSW play a crucial role in orienting clients and facilitating navigation across various health systems. Their support extends beyond the Behavioral Health System, linking clients to other components of the Health Department System, thereby enhancing public health service utilization.

Access to care: PSS/PSW have played a key role in reducing disparities in access to care, particularly in underserved communities. Their outreach efforts, rooted in lived experience, have fostered trust and improved access to healthcare services in these areas.

Peer Staff: During the FY 2022-23, the PSS/PSW served over 213 clients. The fact that most of these clients are continuing their collaboration with PSS/PSW serves as a compelling indication that the efforts of the PSS/PSW are making a meaningful impact, contributing to the enhancement of these clients' lives and their pursuit of recovery in their communities. PSWs/PSSs supported clients in FY 2022-23 in the following ways:

- Affordable Housing: Applying for assistance, completing referrals, and maintenance.
- Linking to mental health and AOD services and counseling.
- Facilitating the transition to a higher level of care.
- Connecting to vocational resources.
- Applying for benefits, process with Medi-Cal, SSI, Unemployment SSDI, linking to the Department of Rehabilitation, filing to receive general assistance and food stamps.
- Providing transportation support to acquire medical or mental health services.
- Assisting with the distribution of phones for clients to attend appointments.
- Supporting clients with phone technology.
- Connecting to in-person and virtual Peer Support Services provided through contracted agencies such as Heart and Soul, California Clubhouse, Voices of Recovery and The Barbara A. Multicultural Wellness Center.
- Navigating the BHRS system as well as providing linkage to community resources and services from other Health Department divisions such as the San Mateo Medical Center.

PSS/PSWs facilitated Support and skill-based groups with clients on in-person limited basis due to COVID-19 restrictions. These included:

- 12 Virtual groups for clients to learn how to access affordable housing resources while learning WRAP tools. Groups were facilitated on a weekly basis and averaged 3-5 participants per group and served clients in South County.
- 10 in person introduction to technology rehabilitation groups supported clients in using their County provided cell phones to gain access to care and community resources. Groups averaged 3-8 clients and served clients at South County and Coastside.

San Mateo County BHRS contracted with Painted Brain to provide a 60-hour training for new PSS/PSW PSS/PSW Trainings FY 2022-23 included:

- 80-Hour Training for Medi-Cal Peer Support Specialist Certification
- 2-hour Peer Ethics and Personal Disclosure

- 2-hour in-Person De-escalation Training
- 2 cohorts of 10-hour Study Groups and Test Prep to take the CalMHSA Medi-Cal Peer Support Specialist Exam, facilitated by CASRA. 15 participants per group.
- 10-hour Documentation Training with Recovery in Mind for Peer Support Staff
- 2-Hour Confidentiality & HIPAA for BHRS Mental Health and AOD
- 2-Hour IT Security Awareness Training
- 2-Hour Preventing Workplace Harassment for Employees
- 2-hour BHRS Critical Incident Reporting and Webinar
- 2-hour Integrating Peer Support in Behavioral Health Settings
- Client Treatment & Recovery Plan for BHRS Mental Health: Clinical Staff
- Progress Notes for BHRS: Part 1, Writing progress notes
- Progress Notes for BHRS: Part 2, Group progress notes
- Progress Notes for BHRS: Part 3, Billing for progress notes
- Compliance Training for BHRS: All New Staff
- QM Webinar: CalAIM Informational Recording
- Working Effectively with Limited English Proficient Clients and interpreters Training
- Fraud, Waste, & Abuse Training for BHRS

PSS/PSW staff bring their lived experience to the broader community by participating in community groups and BHRS Health Equity Initiatives and MHSA meetings. PSS/PSW staff participated in a day-long retreat held at the Foster City Recreation Center. The retreat focused on fostering team cohesion, emphasizing wellness, and promoting self-care. The agenda included discussions on successes and challenges related to the peer certification process, featuring a dedicated question-and-answer session for identifying opportunities for system improvements.

Additionally, a creative component engaged PSS/PSWs in a wellness craft project focused on the creation of live plant terrariums. The afternoon session featured yoga instructors that facilitated breathing exercises and light yoga activities. The day concluded with team-building games, to increase trust, collaboration, and personal well-being.

Family Partner Staff: The BHRS FP/FPSS Team served over 132 unduplicated families, mostly from underserved communities. All support groups and educational workshops were held virtually and in person to support these families with emotional support and essential community resources.

2 Family Partners were part of 6 panel interviews to hire clinicians from the School Based Team and the Shasta Youth Team. Groups co-facilitated by FP/FPSS during FY 2022-23 included:

- 1 in-person *Nami Basics* in Spanish - 6-weeks (20 parents/caregivers).
- 24 bimonthly Hybrid Parent Café groups at the Coastside Clinic in Spanish for Parents/Caregivers of youth clients (6-8 participants).
- 12 monthly in-person Spanish Parent Cafés - South Youth Shasta Clinic (3-5 parents per group).
- 3 Virtual Parent Project “the essence of Mana” 12-week course meeting weekly to support parents/ caregivers develop communication skills and tips leading to more love and nurturing family relations (15-17 participants per group).

- 1 In-Person Skill-building Group, “How to Support my Teenager in Transition to Adulthood (TAY)” Workshop for parents of youth in transition age (15 participants).
- 9 Parent Café Support Groups held in English and Spanish for Parents/Caregivers of the North County Youth Clinic ((3-4 parents per group).

Some Presentations by FP/FPSS during FY 2022-23 included:

- Community and Family Engagement Café for Providers Working with Families
- One Presentation about the Family Partner Services with the South School-Based team.

Some of the trainings/conferences the FPS/FPSSs participated in during FY 2022-23:

- 80- Hour Training for Medi-Cal Peer Support Specialist Certification
- 2-hour Peer Ethics and Personal Disclosure
- 12- hour Community Reinforcement and Family Training (CRAFT), AOD education program
- 2 of 2-hour virtual and 1 in-person Friday C.A.F.E. (Community And Family Engagement) is a professional peer support network for family-facing professionals based in early learning programs, schools, nonprofits, and government agencies in San Mateo County.
- 2- hour In-Person De-escalation Training
- 2 – 2-hour Study groups to prepare to take the CalMHSA Medi-Cal Peer Support Specialist Exam, facilitated by CASRA. 15 participants per group.
- 10-hour Documentation Training with Recovery in Mind for Peer Support Staff
- 2-day Conference and pre-conference for parents and caregivers. 2 Family Partners and the Family Education and Support Coordinator attended the California Mental Health Advocates for Children and Youth
- Confidentiality & HIPAA for BHRS Mental Health and AOD
- Disconnect From Work After Work
- Episode 2 - The Story We Tell
- How Does Bias Feel?
- Episode 3 - The House We Live In
- Approaching New Customers Module
- How to talk (and listen) to transgender people: Jackson Bird
- Talking about Age: A Seat at the Table
- IT Security Awareness Training
- Preventing Workplace Harassment for Employees (2022)
- Mental Health: We're All in This Together
- Discussing Culturally Sensitive Topics
- BHRS Critical Incident Reporting and Webinar
- Identifying and Handling a Person with Drug-Seeking Behaviors
- Integrating Peer Support in Behavioral Health Settings
- Client Treatment & Recovery Plan for BHRS Mental Health: Clinical Staff
- Progress Notes for BHRS: Part 1, Writing progress notes
- Progress Notes for BHRS: Part 2, Group progress notes
- Progress Notes for BHRS: Part 3, Billing for progress notes

- Introduction to the BHRS Avatar Electronic Medical Record: All New Avatar Users
- BHRS Consent Forms in Avatar & Consent Tracking Widget
- Compliance Training for BHRS: All New Staff
- QM Webinar: CalAIM Informational Recording
- Avatar: Multi-factor Authentication
- County of San Mateo Code of Conduct / Ethics Training
- Color Blind or Color Brave?: Mellody Hobson
- Law and Ethics for Behavioral Health Providers
- BHRS Neurosequential Model of Therapeutics (NMT) Core Strengths 14-hour training
- Talking about White Privilege: A Seat at the Table
- Learning Styles: Managing Multiple Learning Styles
- Managing Assaultive Behaviors Training
- Working Effectively with Limited English Proficient Clients and interpreters Training
- BHRS Lived Experience Academy. 12-Hour Training
- Fraud, Waste, & Abuse Training for BHRS

Some of the committees for outreach and support to the community the FPS/FPSSs participated in:

- 9 monthly Immigrant Forum
- 10 monthly Pacific Islander Initiative Committee
- 7Monthly Latino/a/x Collaborative Meetings
- California Systems of Care (CSOC) Bay Area Regional. Meetings held quarterly with behavioral health directors and FP/FPSS
- 3 Monthly Behavioral Health Commission Youth Committee Meetings

Consultation Groups for FP/FPSS and supervisors:

- 20 FP/FPSS Consultation Meetings
- 6 Consultations Meetings for supervisors of FP/FPSS

Successes

Staffing: A Peer Support Worker position was converted from an Extra Help position to a full-time civil service permanent position.

DHCS implementation of the Medi-Cal Peer Support Specialist: Human Resources conducted a Job study for PSW Classification and created a new Peer Support Specialist I/II classification series. On April 6, 2023, it was presented to the Civil Service Commission, and the Board of Supervisors approved it on April 25, 2023, with a salary of 10% above the PSW. The Peer Support Specialist I/II classification was approved, and PSWs who already had their certification were eligible for retro pay to June 26, 2022. During this FY 2022-23, 8 FPs (2 of them are no longer in this role) and 12 PSWs completed the certification requirements and got certified.

Capacity Building: One Family Peer Support Specialist participated in the Trauma and Resiliency Informed Systems Initiative (TRISI) Cohort Learning experience brought to you by First 5 San Mateo

County in partnership with the Institute of Development. The cohort met monthly to help the organizations take the initial steps to prepare for the paradigm shift to centering their work and the environment they work into one that is trauma- and resiliency-informed.

Client Story: *"Thanks to the Parent Cafe group and the Family Partner Sonia for continuing hosting the Parent Café Groups, I continue to learn how to support my children better and not feel so alone on this path. I also share experiences with my colleagues and don't feel alone dealing with my children's challenges. In this and other groups, I have met other parents who support me and who, together hand in hand, are learning to be better parents."*

Francisca S., Half Moon Bay, CA

Parent Café Coastside – June 2023

Parent Café Coastside – May 2023

NAMI Basics Class in Spanish – November 2022

Challenges

Peer Support: The organizational structure of PSS/PSW staff within distinct teams and under different supervisors poses a significant challenge. Having teams under various leaderships creates complexities in consistency and uniformity of services provided, in data collection and coordination of education and trainings. The decentralized nature of these teams can lead to challenges in

maintaining a cohesive and standardized approach and information gathering. Additionally, coordinating education and training initiatives becomes intricate, as each team operates under different protocols and serving different types of clients.

Family Partners: Post-Pandemic resulted in an increase of youth presenting with chronic Social Anxiety, which impacted their engagement in school, with peers, family, and treatment. Families continue to be face challenges as result of the pandemic. Many have not fully recovered emotionally and economically. In addition, homelessness, and lack of affordable housing in San Mateo County continues to be a challenge for families and a barrier to accessing mental health treatment.

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

The Barbara A. Mouton Multicultural Wellness Center (Mouton Center) provides behavioral health clients and their family members, culturally diverse community-based programs, support and linkages to services and resources as needed in the East Palo Alto community. To that end, the program creates a safe and supportive environment for adults with mental illness and/or co-occurring addiction challenges and their families who are multiracial, multicultural, and multigenerational through various strategies. The Mouton Center:

Reduces stigma and discrimination - through Mental Health First Aid (MHFA), culturally responsive peer support groups, Wellness Recovery Action Plan (WRAP) groups, etc., stigma and discrimination are addressed with participants by facilitating discussions about mental health. Understanding results in empathy and authentic concern for those suffering with a mental illness and empowers them to speak-up on behalf of others.

Increases number of individuals receiving public health services - The Mouton Center staff facilitate connections between people who may need mental health and/or substance use services or other professional services to relevant programming and/or treatment by conducting the following:

- Performing initial screening and engaging potential clients
- Providing brief interventions to motivate more extensive assessment and intervention.
- Referring members who may need behavioral health services to appropriate agencies in the behavioral health system of care for assessment and follow up treatment as needed.

Reduces disparities in access to care - The Mouton Center opened its doors in June 2009 to reduce the disparities in accessing mental health services in East Palo Alto as well as to reduce the stigma associated with mental health. To this end, The Mouton Center has been a safe haven for consumers to gather, pursue leisure activities and be in community with one another without judgement. The program has been the connection to mental health services for the consumers and through its programs, services and classes reduce disparities in access to care and the stigma associated with being identified as one needing mental health services.

Program Impact

Mouton Center	FY 2022-23
Total clients served	28
Total cost per client	$7,438

The Barbara A. Mouton Multicultural Wellness Center (the Mouton Center) reported 28 outreach events, all of which were individual events. There were 28 total attendees. Individual outreach events lasted from 45 to 55 minutes and 50 minutes on average. Outreach activities at the Mouton Center:

- Events most frequently took place in unspecified locations (89.3%; *n* = 25). Other event locations and their respective percentages are shown in Exhibit 1.
- Events were conducted in English (60.7%; *n* = 17), Tongan (32.1%; *n* = 9), and Spanish (7.1%; *n* = 2).
- Events resulted in 26 mental health referrals and no substance use treatment referrals.

Outreach event attendees:

- Most attendees were female (57.1%; *n* = 16); 43% were male (42.9%; *n* = 12).
- Attendees identified as female (57.1%; *n* = 16) or male (42.9%; *n* = 12).
- All attendees identify as heterosexual.
- Attendees were adults (26–59 years of age, 50%; *n* = 14), older adults (60 years of age and older, 39.3%; *n* = 11), or transition-age youth (16–25 years of age, 10.7%; *n* = 3).
- Attendees were Tongan (39.3%; *n* = 11), Mexican/Chicano (25%; *n* = 7), White (21.4%; *n* = 6), or Asian (7.1%; *n* = 2; See Exhibit 2). Two attendees declined to state their race/ethnicity.

Successes

Since the pandemic, The Mouton Center gradually opened its programming hours and activities to the community during this fiscal year. A great success is the launching of Wellness Wednesdays for the community in May, 2023. Wellness Wednesdays are sessions that are open to the community to come and focus on their wellness while enjoying a healing activity. Topics and activities have included painting, candlemaking, journaling, sharing ones narrative, etc. One of TMC's clients, Timoteo reported at one the sessions, that he was so excited to get to come back to the wellness center because he always feels welcomed and relaxed when he attends so he was grateful to be able to participate in the sessions. Another mother noted that she has a son with special needs so she attends the evening painting sessions as a selfcare activity for herself so she can in turn, take care of her son's needs. There are many other stories of community members who have been attending these sessions who have all agreed that wellness offerings are a great way of care for oneself in order to then care for their families and community at large.

Challenges

The Mouton Center, like so many other organizations, has been challenged by staff shortages. Since the pandemic, it's been a great challenge to hire staff. Some staff who have been hired have come for a short period but have had to leave for various reasons. The organization continues to pivot to meet the challenge and hold job fairs and open houses to attract interest and new members.

Demographics

Exhibit 1. Counts and Percentages of Events by Location Type: Mouton Center Outreach Events

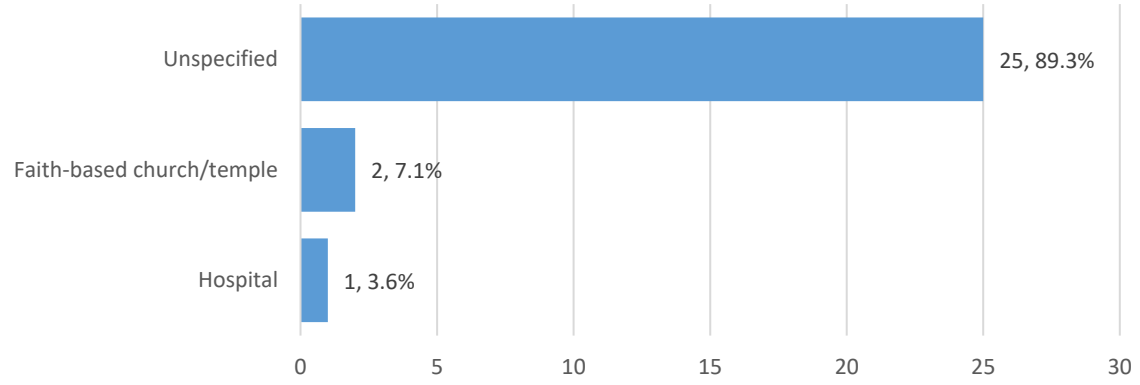
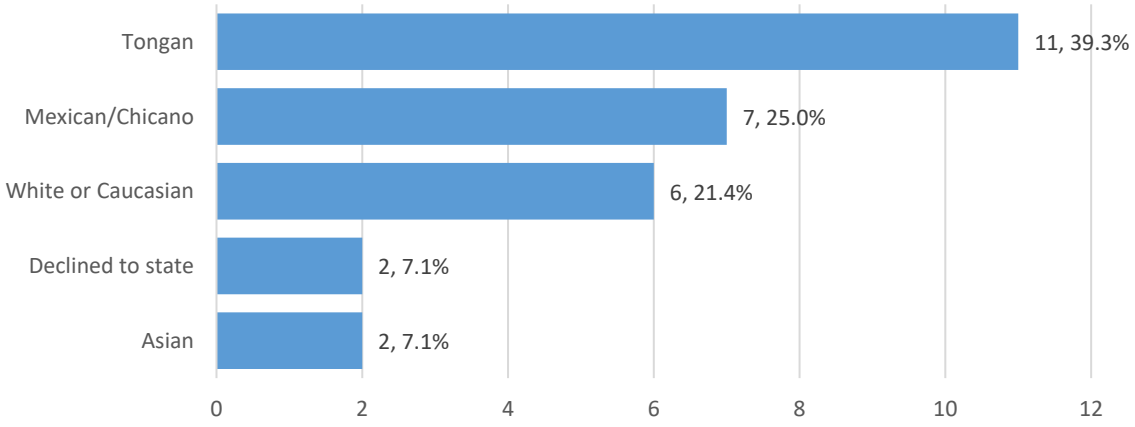


Exhibit 2. Counts and Percentages of Racial/Ethnic Categories: Mouton Center Attendees



In FY 2022-23, Mouton Center attendees at outreach events reported being in special population groups. Out of the 28 people who attended Mouton events, two were hearing impaired (7.1%), and one had a physical/mobility disability (3.6%). Most attendees (89.3%) declined to state a special population group.

CALIFORNIA CLUBHOUSE

California Clubhouse's (The Clubhouse) mission is to give those whose lives have been disrupted by mental illness the opportunity to recover meaningful work and relationships as they reintegrate into the broader community. The Clubhouse provides social and rehabilitative services to adults 18+ living with a serious mental illness.

Program components include:

1. Work Ordered Day: Members and staff work side by side, as colleagues, performing the work of the Clubhouse. To ensure equity of access and engagement, all operations of the Clubhouse are open to members and staff to participate in. From planning and cooking meals to preparing and taking the bank deposit to the bank, members are involved. The Clubhouse hosts a weekly Community Meeting where policies and procedures are created and implemented through consensus decision making of members and staff, not administration.
2. Employment Services: The Clubhouse supports members in going back to work. Transitional Employment is a hallmark of Clubhouses around the world. Transitional Employment (TEs) is a highly structured program for members returning to work in local business and industry. TEs are "real world" jobs that include extensive on-the-job and off-site support from Clubhouse staff and other members. Colleagues work to find TEs for the organization. The Clubhouse Career Development program offers employment readiness skills - hosting weekly job search and job club activities to promote employment and to guide and support members with obtaining employment, technology support, and other necessary skills.
3. Education Services: Members looking to go back to school can find support at the Clubhouse.
4. Wellness Program: Mental and Physical health go hand in hand at the Clubhouse.
5. Social: From in-house art nights to hikes at the beach, the Clubhouse believes that building meaningful connections leads to healthier lives.
6. Young Adult Program: Mental illness frequently strikes first in young adulthood, and many struggle for years to find supportive paths toward hope and stability. Clubhouse works to create these paths.

California Clubhouse is part of a worldwide organization, Clubhouse International. Clubhouses are united through their adherence to a set of international Standards (developed by members and staff) that guide the Clubhouse in the values of the Clubhouse Model, providing a bill of rights to members and a code of ethics for staff, board, and volunteers. Every two years the worldwide Clubhouse community (including California Clubhouse) reviews these Standards and amends them as necessary, ensuring Clubhouses remain places of respect, dignity, and opportunity for members.

Program Impact

California Clubhouse	FY 2022-23
Total clients served	154
Total cost per client*	$2,235

Based on a global model recognized by the World Health Organization (WHO) and recipient of the Conrad N. Hilton Humanitarian Prize, California Clubhouse services led to improved health outcomes, shorter hospital stays, reduced suicide and incarceration rates, and reduced public subsidies. Founded in 2015, California Clubhouse is a sustainable community of people who are working together to achieve common goals and increase hope, health, self-confidence, and self-sufficiency.

Clubhouses are holistic, inclusive, sustainable, responsive, and yield better employment rates, improved well-being compared with individuals receiving psychiatric services without Clubhouse membership, and better physical and mental health. Program data is evaluated annually by the Program for Clubhouse Research at the University of Massachusetts Medical School. WHO now features the Clubhouse model in its New Guidance on Mental Health Services.

The Clubhouse programs are organized around a belief that work, and work-mediated relationships, are restorative and provide a firm foundation for growth and important individual achievement and the belief that normalized social and recreational opportunities are an important part of a person's path to recovery. The Clubhouse recognizes the stigma that surrounds individuals living with certain diagnoses and aims to contribute to the rejuvenation of equitable aid to those in society experiencing wrongful oppression. Every member of The Clubhouse community has equal access to all programs, services, and advocacy assistance offered. Membership is free and without time limits.

Using a peer-method of support has allowed The Clubhouse to expand their impact while keeping staffing cost-efficient. In addition, members who have benefitted from new skills & knowledge gained from their time at Clubhouse often return to assist peers in improving their own lives and aid in their journeys of recovery. Key indicators in the member satisfaction survey are as follows:

Reduce the duration of untreated mental illness and prevent mental illness from becoming severe and disabling (Prolonged suffering): Since joining the Clubhouse, my quality of life has improved in the following ways (check all that apply).

- Improved hygiene 33%
- Improved wellness (exercise, mindful of what I eat, practice self-care) 40%
- Increased social relationships (peer support system) 65%
- Increased independence 29%
- Improved Mood 65%
- Increased treatment/medication compliance 19%
- Increased participating in other community programs 25%

Unemployment:

- I have noticed an improvement in my mental health after attending California Clubhouse regularly. 53% Agree or Strongly Agree
- I belong to a supportive community at California Clubhouse. 83% Agree or Strongly Agree
- Since joining the Clubhouse, my interest in employment or furthering my education has increased. 63% Yes
- Since joining the Clubhouse, I have furthered my education. 42% Agree
- Since joining the Clubhouse, I have started employment. 20% Agree
- Secured a job 10%

- Enrolled in school 13%

Homelessness:

- Secured independent or supported housing 12%
- Reduced hospital visits 35%

The Clubhouse does not officially collect the following data: Incarcerations, Suicide, School failure or dropout - Removal of children from their homes.

Primary Qualitative/Quantitative Indicators to assess progress and engage in continuous improvement:

- Increased member participation
- Increase in members employed or enrolled in higher education programs
- Members report optimized overall health and functioning, increased positive self-esteem, better self-care, enhanced personal health and wellness of members, and increased work-readiness.

Successes

“Reach Out” is a unique, key component to The Clubhouse’s sense of community. The Clubhouse staff does regular check-ins with all active members primarily by phone, but also through email, physical mail, and at times in-person visits (including hospitals) when members are unable to get to the clubhouse. This helps The Clubhouse maintain its community-centric culture and identify when community-members are in needby reaching out to members who may be going through crisis, hospitalized, or have sudden changes in their involvement is of particular focus.

The Clubhouse offers a series of effective methods for early intervention and preventative measures designed to deescalate mental health crises. These methods lessen the need for psychiatric hospitalization and mandatory in-patient treatment, which can often be very traumatic experiences for the individual experiencing crises.

“Collaboration” is the foundation of creating social structures that promote equitable health and wellness for all communities, especially ones that are marginalized. In addition to other community based organizations that work under the umbrella of the Behavioral Health and Recovery System, there is also collaboration with organizations outside of mental health. Members are diverse with a broad range of support needs. The Clubhouse partners with local schools and colleges, other social service and social justice organizations, local small businesses, cities and County leadership.

The Clubhouse is more than its activities... the community itself is healing and encouraging:

> *"I haven't had a lot of support. My family didn't understand me and even though I was given some tools, I didn't use them," she said. "Here everyone has been so welcoming that I've been able to put the tools into effect. I was just looking for a way to give back to the community and this fits me like a glove."-Leslie (member)*
>
> *"California Clubhouse impacted my life by guiding me through my healing journey and helping me find my inner peace. They've given me endless opportunities to socialize and meet*

vocational goals and for that I'll be forever grateful." -Carmen Redondo, Young Adult Member Co-Facilitator

"When I'm with my peers, the staff, and participating in the program at Clubhouse, my mental illness symptoms go away. When I am isolated and not part of the community I am tormented. So I have to take extra medication that cause side effects that are very annoying. In all my mental health programs I have experienced, they see you as your illness first. At California Clubhouse I am treated as an individual and not as my diagnosis. That makes the difference between whether I'm happy or not." -Colette

Short-term Success: Increased staffing, membership growth and increased participation rates; increased wellness and young adult programming; expanded pre-employment, job placement, job training and job retention services.

Long-term Success: BHRS has purchased a property in San Mateo that The Clubhouse will use through a complementary agreement. In their current building they have suffered a sewer flood and an electrical fire and have maintained services throughout the pandemic in spite of physical disruption. The new space is almost twice the size. Relocation to this building will enable them to increase the number of people served and increase services. In a new, state of the art, larger, centrally located building, The Clubhouse will operate a cost-effective model providing members, families, and communities significantly more value for money than other approaches; it will be a Community Rehabilitation Program (CRPI) Provider with the California Department of Rehabilitation generating state funding addressing the “epidemic of loneliness and isolation”.

Challenges

Short-term Challenge: Post pandemic, the Clubhouse faced a staff shortage which temporarily limited the ability to build membership and grow programs. Since that time, the Clubhouse has hired several new staff. While seasoning staff, there can be some minor disruption in programming. However, it also gives members and opportunity to develop even more leadership in the organization.

Long-term Challenge: Outgrowing the current building and having suffered many facility setbacks (flood, electrical fire, etc.), location does not lend itself to the best transportation access.

Demographics

Primary Language		Sex Assigned at Birth	
English	97%	Male	50%
Spanish	2%	Female	46%
Another language	1%	Decline to state	4%

Age		**Gender Identity**	
0-15	0%	Male/Man/Cisgender	47%
16-25	5%	Female/Woman/Cisgender Woman	46%
26-59	64%	Transgender Male	0%
60+	28%	Genderqueer/Nonconforming	1%
Decline to state	3%	Questioning/ Unsure	1%
		Decline to State	5%
Race/Ethnicity		**Sexual Orientation**	
Asian	3%	Gay, lesbian, homosexual	1%
Black/African-American	6%	Straight or heterosexual	73%
White/Caucasian	52%	Queer	0%
American Indian/Alaska Native/ Indigenous	0%	Pansexual	0%
Mexican/Chicano/Hispanic/Latinx	1%	Bisexual	7%
Arab/ Middle Eastern	0%	Another sexual orientation	2%
Central American	0%	Decline to state	17%
Filipino	2%		
Puerto Rican	0%	**Veteran**	
Samoan	0%	Yes	4%
Tongan	0%	No	96%
Japanese	0%		
Korean	0%		
Vietnamese	1%		
Another race/ethnicity	27%		

PRIMARY CARE INTEGRATION

Primary care integration strategies identify 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.

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS, 80% PEI. PCI integrates mental health services within primary care. The program started in 1995 and partners with San Mateo County primary care clinics to provide easier access to mental health services at one clinic and is now embedded in five different primary care clinics throughout the county. Since its inception, the

program staff grew from one therapist and nurse to a multidisciplinary team with more than 23 staff who are marriage or family therapists, licensed clinical social workers, and case managers.

In FY 2022-23, the PCI program served 617 unduplicated individuals in San Mateo County. Clients are mostly referred out, based on their needs, into psychiatry, therapy, case management, or all three in some cases. The PCI program also provides direct substance use counseling. Program outcomes are included in the PEI section of this MHSA Annual Update document.

INFRASTRUCTURE STRATEGIES

Infrastructure strategies funds BHRS administration, information technology (IT), support staff, evaluation consultants, and the Contractor's Association.

CONTRACTOR'S ASSOCIATION

The Contractor's Association Grant Funding program exists to fund organizations that contract with BHRS to be able to:

- Improve capacity to provide integrated models for addressing trauma and co-occurring disorders.
- Improve its capacity to incorporate evidence-based practices into day-to-day resources.
- Improve its cultural competency; and
- Improve its capabilities to collaborate, partner and share resources and information with other Association Members.

Caminar acts as the fiscal agent, oversight and accountability to this program. See Appendix 9 for the data on each funding recipient and what needs were met.

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 pre-crisis response, and primary care-based linkages.

FAMILY ASSERTIVE SUPPORT TEAM (FAST)

The Family Assertive Support Team (FAST) is an in-home outreach and support services program. FAST's purpose is to assess, educate, assist, support, and link families and adult mental health/substance use consumers that are living with their family (two or more people with close and enduring emotional ties) to appropriate mental health and substance use services and a myriad of other resources and opportunities suitable to the individuals' needs and goals.

Examples of FAST activities and interventions include: Crisis Intervention, facilitating 5150, collaborating with law enforcement in service of clients and family, forensic mental health linkage, diagnosis, psychiatric and medication consult, motivational interviewing, destigmatizing mental health, obtaining benefits such as disability/housing/financial/legal/food/clothes, etc., connecting to Behavioral health and AOD services, primary care, peer support, shelter, social rehabilitation, permanent housing. FAST utilizes collaboration and "warm handoff" to facilitate best outcomes.

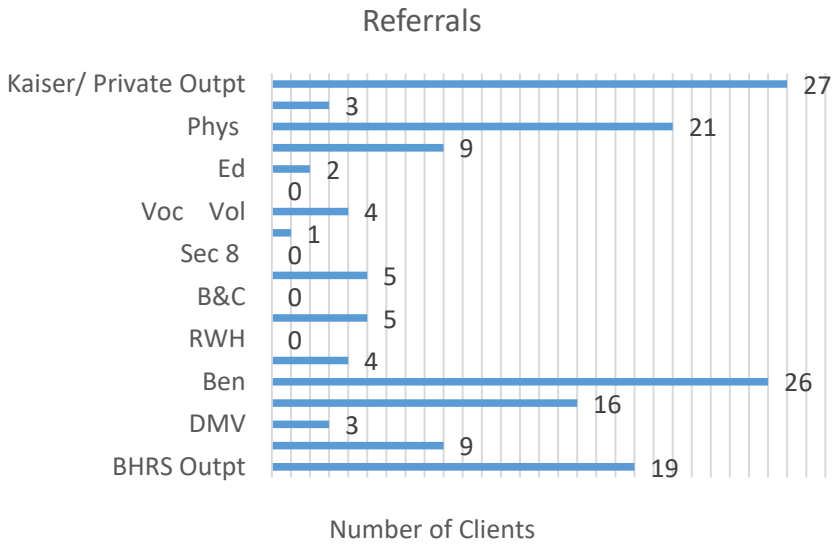
FAST is comprised of a Licensed Mental Health Clinician, Psychiatrist for consultation, and two paraprofessionals. FAST works in mostly in dyads with mental health consumers and their families. One person is assigned to the family (Family Partner) and the other assigned to the consumer (Peer Provider). These units provide assessment, intervention, establish goals, and plan implementation. FAST has interpreter services in Spanish, Mandarin, and Tagalog.

Program Impact

Pre-Crisis (FAST)	FY 2022-23
Total clients served	73
Total cost per client	$4,462

FAST collects the following data: age, gender, diagnosis, LOCUS score, county region, ethnicity, referral source, type of contact, referral outcome, prior connection to mental health services, pre and post hospitalization/jail contact. There were 73 clients served by FAST in FY 2022-23. Of these there were zero homicides and zero suicides. The rate of hospitalization and incarceration was significantly higher pre- contact with FAST and significantly reduced-post contact with FAST. Of the 73 clients, 60 of them had zero contact or current connection with outpatient mental health services prior to FAST contact. Of the 73 clients, 55 were successfully connected to outpatient mental health services/AOD, post FAST contact. The majority of those not connected were connected to some level of social services, benefits, housing, medical services, etc.

The collected LOCUS scores indicate majority of clients were experience Serious Mental Illness (SMI) with significant disability and in need for behavioral health treatment and adjunct services post FAST. The ethnicity of clients served closely reflect demographic distribution San Mateo County residents. The ages of FAST clients ranged from young adults to older adults, but younger adults predominated. The negative outcomes and concomitant suffering for individual and family alike were diminished from contact with FAST: psychoeducation and proper linkage to appropriate services. The few who chose not to engage in treatment will likely resurface and another opportunity for FAST to connect them to outpatient services or ancillary services will present itself.



Successes

Client Success Story #1: "Gordon"

"To whom it may concern,

I want to make this testimonial and express my deep gratitude for the FAST organization. I have a friend who suffers from severe schizophrenia. She was homeless and has been staying on my sofa for two years. During Covid 2020 there was nowhere to go. I was unable to visit any clinics. I spoke to organizations but was basically told to stay in touch as nothing could be done. What made the problem worse was that my friend refused any kind of assistance, medication, etc.

In August 2022 I was told about the FAST organization. I contacted them. The team Immediately came to my apartment to meet my friend. They could see the desperate need for psychiatric attention. However, because of the system if the person refuses then there is nothing that can be done, regardless of how bad the condition.

Through excellent organization the team was able to help me get my friend hospitalized and medicated. After three weeks my friend came back to the apartment. She is now a full participant with North County Behavioral Health Clinic. She understands the importance of taking her medication. She participates with all her appointments.

She has even gotten a job and can work. It is a miracle. A complete turnaround. The answer to prayer. All of this could not have been done without FAST organization.

It is extremely difficult navigating the system to get folks the psychiatric care they need. It is overwhelming and very frustrating. I feel for the families and friends of those trying to get their loved one's help. Sometimes it feels like one door after another closes, and it is very easy to give up and lose hope. FAST absolutely turned it all around. They were fast, informative, and got right down to business. We worked as a team, and my friend is on the path of healing. A

complete turnaround. Certainly, there is still a way to go, but the largest difficulty has been resolved. She and I would not be where we are today without FAST.

Sincerely, Gordon"

Client Success Story # 2: "Aphrodite"

"To Whom it may concern,

I am writing regarding the FAST TEAM that was instrumental in helping us get back on our feet in a critical time in our lives!

Bonnie and Matt came to our rescue with their wonderful caring personalities and counseling. Matt listened to me and my daughter. Bonnie is very kind and caring while being very professional and helpful to my daughter with mental illness. Matt gave us beneficial counselling due to his background in Psychology. They are both a huge asset to your program. We will always be grateful and indebted to them and the FAST TEAM for helping us in our time of need!

Sincerely, "Aphrodite""

Client Success Story #3: "Cherry"

"Dear Ian Adamson,

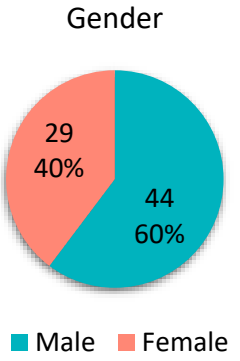
I would like to thank FAST TEAM for all the help they have given me with my daughter, who has mental health issues that I couldn't understand or help her with. The FAST support team Bonnie and Susan have explained what they can do and the process to come over to my home, to give my daughter and me the support, hope and understanding we need is incredible. Twice a week this support team comes over and builds a relationship of trust with my daughter. She spends 18-20 hours in her room daily and hasn't left the house in 4 years. Talks to voices that only she hears and many more mental health issues. This FAST TEAM has made so much progress with her in such a short time it is remarkable. Our hope is to get her to a hospital where she can get the professional help she needs. These Ladies from FAST are making the steps for this to happen.

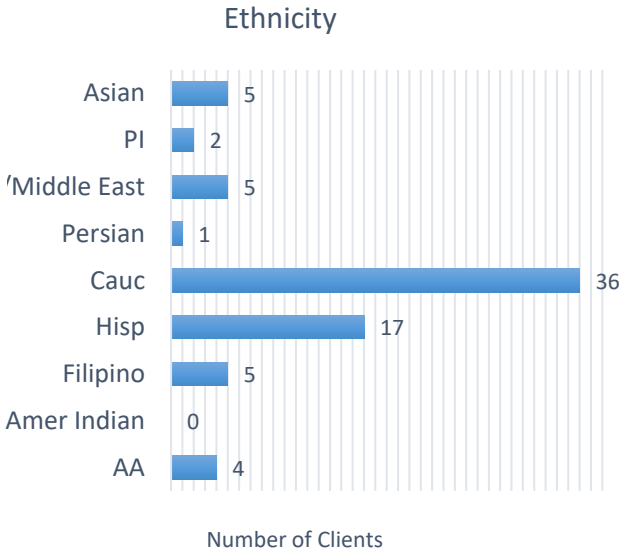
Thank You FAST TEAM!!! Cherry"

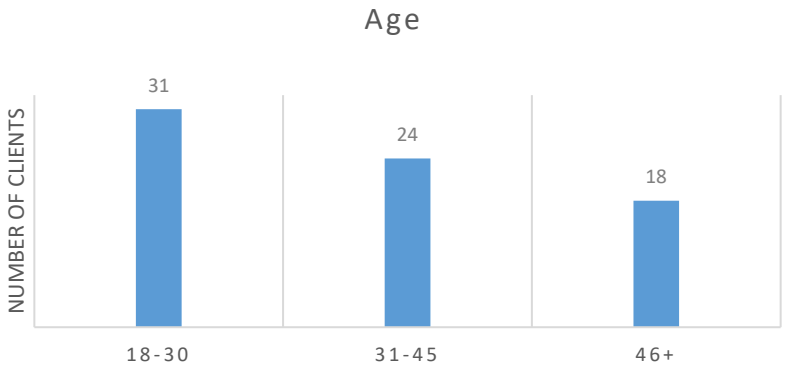
Challenges

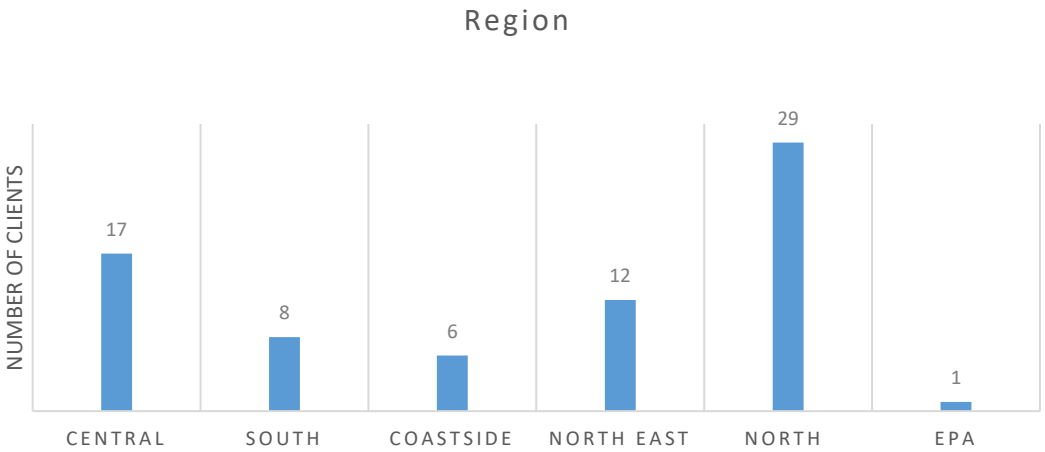
One challenge that FAST encountered during the FY 2022-23 is the symptom of anosognosia, "the inability or refusal to recognize a defect or disorder that is clinically evident". This is something that FAST encounters regularly in its work that makes it difficult to successfully achieve intended outcomes with clients.

Demographics









THE CARIÑO PROJECT (COASTSIDE MULTICULTURAL WELLNESS)

The Cariño Project is funded 80% CSS, 20% PEI. The program opens pathways for increased services on the Coastside, limited in services. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. A home visiting model is often used to serve families. Ayudando Latinos a Soñar (ALAS) is committed to meeting the client where they are, both emotionally and physically.

In FY 2022-23, the Cariño Project served 590 unduplicated in San Mateo County through their clinical component (therapy and case management). 2,159 individuals (duplicated) were also engaged through various services including groups, training, arts activities, and other supports.

Program outcomes are included in the PEI section of this MHSA Annual Update document.

ADULT RESOURCE MANAGEMENT

The Adult Resource Management (ARM) program provides trauma-informed and culturally responsive mental health support to adults with a serious mental illness (SMI) and co-occurring substance use or mental health disorders who are homeless or at risk of becoming homeless.[18] The program provides early identification, engagement, and case management services to eligible adults.

ARM's outreach and support services team works in collaboration with Psychiatric Emergency Services and Psychiatric Inpatient Services at San Mateo Medical Center, the Maguire Correctional Facility, the Mental Health Association Spring Street Homeless Shelter, Shelter Network's shelters, Palm Avenue Detox (operated by Horizons Services), and the Mateo Lodge mobile support team. The support consists of case management provided by four mental health counselors (MHCs) that serve San Mateo County residents in the field. Funded by a Substance Abuse and Mental Health Services Administration block grant, the ARM supervisor reviews Intensive Case Management (ICM) referrals from psychiatric hospitals and mental health rehabilitation centers. The ARM team also processes referrals from the San Mateo Medical Center (SMMC) Psychiatric Emergency Services (PES) and the Facilities Utilization Management teams, connecting clients with services available through the mental health shelter beds, crisis residential facilities, and/or social rehabilitation facilities, as appropriate. Each MHC is assigned one or more specific subunit tasks, as described below.

- ICM/Outreach and Support:
  All four MHCs are assigned to this subunit. Referrals focus on clients who are being discharged from psychiatric hospitals and MHRCs and are in temporary need of ICM support until other community resources, such as a full-service partnership (FSP) or a BHRS regional clinic case manager, can take over. The ARM team also receives referrals from BHRS regional clinics that need field support for clients who are at high risk for re-hospitalization.

[18] At risk of becoming homeless criteria and definition: https://files.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf.

- Maple Street & Safe Harbor Liaison:
  Two of the four MHCs are assigned to either the Maple or Safe Harbor Shelter. If no other outpatient-based team serves at the shelter, they provide intensive field case management. Otherwise, they function as the liaison between the shelter and other BHRS programs and resources, such as FSPs or a BHRS regional clinic's embedded FSP counselor.
- PES/Alcohol and Other Drugs (AOD) Coordination:
  Two of the four MHCs work with clients in need of detox and AOD treatment follow-up and linkage. They receive their referrals directly from community members, or SMMC PES staff during the morning briefing meetings.
- Transportation Coordination: All MHC and PES staff operate a patient transportation shuttle on a rotating schedule. They provide transport for clients with an SMI to medical, behavioral health, and court appointments in the community in addition to transporting clients to and from facilities located in other counties.

Program Impact

Arm	FY 2022-23
Total clients served	73
Total cost per client	$23,571

Improves timely access and linkages for underserved populations: Over the past year, the ARM program has started admitting each client within 3 days of receiving a referral. Staff recently gave a presentation to correctional health providers about ARM program services. They explained the referral process and provided guidance on implementing warm handoffs. The team regularly discusses specific, culturally attuned strategies that staff can use to increase engagement with individuals from underserved populations.

Reduces stigma and discrimination: In the past year, ARM staff have attended at least one Cultural Humility Training run by BHRS. They also actively engage in discussions about the impact of stigma on ARM clients diagnosed with a SMI or a co-occurring SUD. The ARM supervisor incorporates cultural humility and trauma- informed frameworks during both one-on-one and staff-wide meetings. The ARM team has also updated their referral form to be more inclusive and reflective of a broader range of gender identity and pronoun preferences.

Increase the number of individuals receiving public health services: The ARM team connects clients to different public health service programs to improve overall well-being. Some of these public health services include CalFresh, General Assistance, Supplemental Security Income (SSI) program benefits, housing assistance and support programs, and primary health programs. The team continues to attend PES meetings at the SMMC to provide linkages to mental health and SUD services.

Reduce disparities in access to care: The ARM team continues to work with the Office of Consumers and Family Affair (OCFA) to get clients cell phones so they can access services, keep appointments, and stay connected with providers. The ARM supervisor also has ongoing discussions with staff regarding strategies for addressing health disparities during both one-on-one and staff-wide meetings.

Implements recovery principles: The ARM team continues to have discussions around recovery principles, particularly how these principles impact and inform the services that ARM staff provide in the community. Over the past year, the program saw an increased focus on and discussions about populations impacted by fentanyl and methamphetamine use. For example, there was ongoing implementation of harm reduction approaches and motivational interviewing frameworks to engage clients in recovery. The ARM team also worked closely with Palm Avenue Detox, which reopened this past year, to help link clients in need of SUD detox services. The team continues to collaborate on referrals with other contracted SUD treatment providers and case management teams, such as Caminar's Project Ninety, HealthRIGHT 360's Women's Recovery Association, and BHRS's Integrated Medication Assisted Treatment team.

This section provides a comparison of emergency service utilization data from periods that extend to three months before and after the clients were admitted to the ARM Program. It also displays the breakdown of the ARM services by subunit, and further details within each subunit.

Table 1 summarizes the emergency service utilization information for the 73 clients who were admitted and actively part of the ARM program during the FY 2022-23.

Table 1. ARM Clients' Emergency Service Utilization (FY 2022-23)

	3 Months Before Admission	3 Months After Admission
# of PES Episodes	13	0
# of Inpatient/Residential Episodes	6	0
Total Inpatient/Residential Stay (days)	100	0

Table 2 summarizes the services provided by the ARM program by subunits during the FY 2022-23. The total number of clients (n=73) by subunit exceeds the total number of clients served by the ARM Program in general (n=68), as some of the clients received both ICM and shelter services. During FY 2022-23, 51.9 percent (n=40) of clients received ICM/Outreach and Support services, 39.2 percent (n=31) of clients used Maple Street & Safe Harbor shelters, and 2.7 percent of clients (n=2) received Transportation Coordination services.

Table 2. Services by Subunit (FY 2022-23)

Subunits	Number of Clients	Proportion of Clients (%)
ICM/Outreach and Support	40	54.8
Maple Street & Safe Harbor Liaison	31	42.5
Transportation Coordination	2	2.7
Total	73	100.0

Table 3 summarizes the status of ICM clients for the ARM program during the FY 2022-23. Most of the clients were in the program (55%), while 32.5 percent of the clients completed their goals and were discharged.

Table 3. Intensive Case Management - Client Status (FY 2022-23)

Status of ICM Clients	Number of Clients	Proportion of Clients (%)
Active	22	55.0
Completed Goals	13	32.5
Client did not engage	3	7.5
Not admitted to program	2	5.0
Total	40	100.0

Table 4 displays the breakdown of mental health shelters. Most of the clients attended Safe Harbor (58.1%) during the FY 2022-23.

Table 4. Mental Health Shelters (FY 2022-23)

Mental Health Shelters	Number of Clients	Proportion of Clients (%)
Safe Harbor	18	58.1
Maple Street	13	41.9
Total	31	100.0

Table 5 below summarizes the transportation destinations for the two clients who utilized the transportation coordination services provided by the ARM program during the FY 2022-23.

Table 5. Transportation Coordination Services (FY 2022-23)

Transportation Destinations	Number of Transports	Proportion of Transports (%)
Central County BHRS Clinic	4	57.1
San Mateo Medical Center	2	28.6
Millbrae's Assisted Living	1	14.3
Total	7	100.0

Successes

Three therapeutic approaches were particularly successful this year: use of motivational interviewing, prioritization of harm reduction measures, and trauma-informed supports. These interventions seemed to be particularly successful with the populations that ARM serves who are homeless and have significant trauma histories and other co-occurring conditions. The client story below highlights an example of the success of the use of the Neurosequential Model of Therapeutics (NMT) program.

Client Success Story #1: In FY 2022-23, a homeless client diagnosed with depression and post-traumatic stress disorder was referred to the ARM team for ongoing support while she resided at a shelter. Initially, she had a hard time connecting with others and presented with high levels of anxiety and depression. Because she had experienced childhood trauma, ARM staff decided to refer her to

the NMT program for an assessment with an NMT-certified provider. Through her participation in the program, the client was referred to equine therapy, which she found to be of tremendous help. She later reported that this activity reduced her levels of anxiety and improved her ability to connect with others. Since ARM program staff referred this client to an NMT-certified provider, her symptoms became less acute, and her day-to-day functioning improved significantly. For example, she was able to obtain subsidized housing and is currently employed with one of ARM's partner agencies.

The story below highlights a client's personal successes after being connected with the ARM program.

Client Success Story #2: In FY 2022-23, the ARM Team received a referral for a client with SMI who had been kicked out of her family's residence earlier that day. The ARM team assigned a staff member to her case within hours of receiving the referral. Working closely with other providers and agencies, the ARM case manager arranged to pick the client up from a bus stop and take her to a shelter. While she resided at the shelter, ARM staff continued to work with client, coordinating mental health treatment services and helping her obtain a housing voucher. Since connecting with the ARM program, this client has secured a job and moved into permanent subsidized housing. She has continued to work closely with her treatment team, experiencing significant improvements in her mental health of late, and has developed closer ties to some members of her family.

Challenges

Intermittent staff vacancies in FY 2022-23 made it challenging to provide services to certain populations. For example, in 2022, the program received a referral for a client with a significant trauma history who was currently experiencing intimate partner violence and preferred to speak with a female MHC. While the client eventually received appropriate treatment services through a different BHRS program, the ARM team was unable to provide assistance because ARM's only female MHC was on leave at the time of the referral.

Historically, the ARM team has attended the SMMC PES team's morning huddles, where they would receive on-site referrals for clients in need of SUD treatment services and supports. However, the timing of this meeting sometimes makes it challenging to complete warm handoffs, especially for clients admitted overnight, who are usually not awake in the morning.

ARM leadership plans to recruit new hires with more diverse backgrounds, especially those with sociodemographic characteristics and lived experiences similar to ARM clients. Additional supports planned for FY 2023-24 include advanced staff training on topics such as motivational interviewing, harm reduction, and safety in the field.

Demographics

Table 6 summarizes the demographic information for the 68 clients who were admitted and actively a part of the of the ARM program during FY 2022-23. About 63% were between the ages of 26 to 59, and 32.04% were 60 or older. A majority were male (almost 56%) and spoke English as their primary language (51.5%). In addition, 1.5% reported Spanish as their primary language, and 17.6% identified

as Hispanic or Latino. A further 31% identified as White or Caucasian, 16.2% as Black, and 10.3% as multiple races. It is important to note, however, that 13.2% did not report information on their race, and approximately 67% did not report information on their ethnicity.

Table 6. Demographic Data of ARM Client List (FY 2022-23)

Age	Number of clients	Total number of clients	Percentage of total
0–15	2	68	2.9
16–25	1	68	1.5
26–59	43	68	63.2
60+	22	68	32.4
Primary language	**Number of clients**	**Total number of clients**	**Percentage of total**
English	35	68	51.5
Spanish	1	68	1.5
Unknown/not reported	32	68	47.1
Race	**Number of clients**	**Total number of clients**	**Percentage of total**
White/Caucasian	21	68	30.9
Other	13	68	19.1
Black or African American	11	68	16.2
Asian	7	68	10.3
Multiple	7	68	10.3
Unknown/not reported	9	68	13.2
Ethnicity	**Number of clients**	**Total number of clients**	**Percentage of total**
Hispanic or Latino	12	68	17.6
Chinese	3	68	4.4
Native American	2	68	2.9
African American	1	68	1.5
Japanese	1	68	1.5
Pakistani	1	68	1.5
Tongan	1	68	1.5
Filipino	1	68	1.5
Unknown/not reported	46	68	67.6
Sex assigned at birth	**Number of clients**	**Total number of clients**	**Percentage of total**
Male	38	68	55.9
Female	26	68	38.2
Unknown/not reported	4	68	5.9
Sexual orientation	**Number of clients**	**Total number of clients**	**Percentage of total**
Straight or heterosexual	36	68	52.9
Lesbian or gay	4	68	5.9
Queer	1	68	1.5
Unknown/not reported	27	68	39.7

HOUSING LOCATOR, OUTREACH AND MAINTENANCE

The Housing Locator, Outreach and Maintenance program will provide housing locator services provided by mental health counselors and peer navigators; the development and maintenance of a new BHRS Housing website with real-time housing availability information; linkages to BHRS case managers; and landlord engagement including community mental health awareness. Outreach and field-based services will be provided to support ongoing and long-term housing retention including a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development.

This program was anticipated to launch this FY 2022-23. However, implementation was delayed due to the administrative Request for Proposal (RFP) processes that BHRS had to prioritize for various programs. This program is anticipated to launch next FY 2023-24.

HEAL PROGRAM HOMELESS OUTREACH

The Homeless Engagement Assessment and Linkage (HEAL) program partner certified treatment clinicians with the Homeless Outreach Team (HOT) team and Healthcare for the Homeless (HCH) outreach workers to bring a higher level of direct treatment and case management to the homeless out in the field. The HEAL team provides field-based mental health and addiction treatment, but also case management, referrals, and "warm hand-offs" to the regional health and street medicine services.

Two clinicians were hired in FY 2021-22 and implementation began in FY 2022-23. A full program report with client outcomes will be provided in the next Annual Update.

Program Impact

HEAL	FY 2022-23
Total clients served	55
Total cost per client	$5,909

THE SAN MATEO COUNTY PRIDE CENTER

The Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

In FY 2022-23, the Pride Center served 149 unduplicated individuals in San Mateo County through their clinical component (therapy and case management). 9,357 individuals (duplicated) were also engaged through various services including peer groups, youth and older adult focused services, training, events, outreach, and other activities.

Program outcomes are included in the PEI section of this MHSA Annual Update document.

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center 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 FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto with severe mental illness/serious emotional disturbance to primary care based mental health treatment or to specialty mental health.

Ravenswood	FY 2022-23
Total clients served	386
Total cost per client	$47

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. 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 BHRS 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: PREVENTION

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.

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0 through 5 or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions and supports can make a difference in a child's earliest years and for many years thereafter. ECCT is made up of three interconnected roles that support the community and families in different ways.

1. The Community Worker (CW) provides case management, parent education to the families, facilitates play and support groups, and develops and maintains community partnerships.
2. The Mental Health Clinician (MHC) provides Child Parent Psychotherapy (CPP) informed therapeutic support to families as well as using other attachment/relationship based clinical modalities as appropriate. CPP is a specific intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing challenges related to attachment, and/or behavioral problems, including posttraumatic stress disorder. The primary goal of CPP is to support and strengthen the relationship between a child and his/her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning.
3. The Early Childhood Mental Health Consultants (ECMHC) provide ongoing support to childcare providers in preschool settings with the goal of establishing a safe and trusting relationship that supports teachers in building their capacity of self-reflection, understanding of the child's experience and fostering an inclusive classroom where all children can receive high quality care. Consultation services also provide more intensive case support for children who have been identified with significant needs or who are at risk of losing placement at their site. For this more intensive work, ongoing support is provided for parents in hopes of bridging the child's home and school experience and creating a feeling of continuity of care.

Program Impact

Early Childhood Community Team*	FY 2022-23
Clients served (unduplicated)	19
Cost per client	$23,986
Individuals reached (duplicated)	270
Total Served	289

** Unduplicated clients served are the children/families that participated in individual or group therapy, individuals reached includes parent/caregiver groups, teacher consultations, etc.*

Outcome Indicators

Domain	Indicators/Questions	#	%
Connection & Support	Number of parents/caregivers who improved familial connection and support as measured by improvement in Protective Factors Survey Score	4 of 4	100%
Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting (group services)	4 of 4	100%
Connection & Support	Due to my engagement in this program, I feel more connected to other parents in my community (group)	2 of 3	67%
Stigma Reduction	I feel more comfortable talking about my and my child's mental health/ children in my classroom (population: group, teacher consultations, and one-on-one services) How effective was the consultant in contributing to your understanding of the family's situation and its effects on the child's current behaviors? I feel more comfortable seeking out resources for myself and/or my child	4 of 4 5 5 of 5	100% 73% 100%
Knowledge/ access to services	Due to my engagement, I know where to go in my community for resources and support. (population = groups, teacher consultations, and one-on-one services)	4 of 4	100%
Community Advocacy	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and 1:1)	4 of 4	100%
Cultural Identity/ Humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	4 of 4	100%

Demographics

Total Children	Male	Female	0-5	Ethnicity	Language
42	19	16	9	0 Asian	13 English
				5 Caucasian	29 Spanish
				37 Latinx	

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	0	0
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	Not Tracked	Not Tracked	19
TOTAL	Not Tracked	Not Tracked	19

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	1	Legal	2
Financial/ Employment	0	Medical care	0
Food	9	Transportation	0
Form assistance	1	Health Insurance	0
Housing/ Shelter	7	Cultural, non-traditional care	0
Other	1	**TOTAL**	**21**

Program Narrative

Weekly Child-Parent Psychotherapy was offered to 15 children and their caregivers in the Coastside community. Weekly services included child/parent therapy, family therapy, collateral individual sessions with caregivers, and additional collateral contacts such as school observations, participation in IEP meetings, etc. Most participants receive psychotherapy services for at least one year.

The Community Worker provided support and services to 134 caregivers and (indirectly) their children, which includes assessment of needs, case management, providing activities that support the caregiver/child relationship and the child's development, and parent education.

To reach more caregivers and to share parenting resources and information, an ECCT Community Worker and Program Manager participated on a panel during 2 Half Moon Bay community Facebook

Live events. The Facebook Live events engaged approximately 60 caregivers and have been viewed hundreds of times since then. Although there is no way to track specific communities that the caregivers are from, the event did target the Half Moon Bay community and was advertised in that community.

Mental health consultation services were provided to 5 childcare programs in the Coastside region serving 21 children and 6 staff. Although there was an increase in the number of children, families and providers being served compared to the last few years, enrollments continued to be somewhat lower than pre-pandemic as some families continue to worry about possible exposure to COVID-19. There were gaps in services due to weather damage at some of the sites. Finally, there was some disruption in services following the shooting in Half Moon Bay when much of the community experienced distress and developed serious concerns about safety.

Consultants adjust the intensity of their services to meet the specific needs of families. Some families that have less intense needs are provided "Light Touch" services. The consultant meets with these families for 1- 5 sessions to provide support and any needed referrals. For families with more intensive needs, consultants provide "Case Consultation" services that last as long as necessary to address the more complex needs. Consultation activities include individual and group mental health consultation meetings with childcare providers and site supervisors, individual meetings with parents, parent workshops, observations of classrooms and individual children, as well as assistance with resources and referrals if/when needed. This year consultants facilitated 4 workshops for parents on topics including child development, inclusion, and the power of relationship. There has been a shift to more live services, though the program continues to have a hybrid model to accommodate family preferences.

Mental Health Consultants, Mental Health Clinicians and Community Workers all meet as a team twice per month (at a minimum) to ensure collaboration of shared cases as well as to provide a space where clients are "held" and teams can brainstorm together on best practices, possible referrals and how to continue to provide attuned and "in depth" care.

Improves Timely Access and Linkages for underserved populations: ECCT receives referrals from schools, community partners, and from other StarVista programs. In addition to outreach efforts that lead to self-referrals, there often are families that self-refer after hearing about supports and services from other families that have worked with ECCT.

Once a referral is received, the Intake Coordinator connects with the caregivers within two-three business days and completes a detailed phone Intake. The phone Intake involves listening to the caregiver's immediate concerns, gathering information on what supports/services they are interested in and what risk factors are known. Depending on what the caregiver shares, the family may be referred right away to community resources outside of ECCT. In addition, families are connected with a Community Worker and/or Mental Health Clinician, as appropriate and given staff availability. The goal is to be able to begin services as soon as possible. For any families on the Wait List, the Intake

Coordinator follows up with them regularly to check in, assess for any changes in needs, and provide any new information on available groups and/or resources that may be relevant to their needs.

Beginning at Intake, staff of ECCT meet caregivers where they are in terms of how they feel about any referrals being made and their level of comfort with engaging in services. Families are encouraged to talk about any worries or hesitations they might have regarding engaging in services, which sometimes includes caregivers sharing negative experiences they have had in seeking support in the past, as well as stigma around mental health within their own culture and/or family. ECCT staff are thoughtful and intentional in building a trusted relationship and in providing a safe space for families to explore any hesitations to connecting with ECCT and other services. ECCT builds upon this trusted relationship to support families in connecting with various public health services and other core agencies and community programs.

The Intake Coordinator communicates with community partners and keeps a schedule of upcoming groups, events, and new resources. She informs families of these community resources when relevant to a family's needs. Offering a variety of groups open to caregivers at Intake has allowed parents the opportunity to connect with parent support groups offered at various times. Family needs are continuously assessed, and additional referrals are provided as needs are identified.

Remaining connected within the community, holding face-to-face introductions, and being available to answer questions are part of the foundation of success of ECCT. ECCT staff attend events in the community to build community relationships and to connect with families about ECCT services. Part of the goal within ECCT is to support and empower caregivers to be aware of, and able to access, resources within their community- a piece that will last long after their work with ECCT services end.

Mental Health Consultants are ready to support children who have been identified by teaching staff as needing more intensive services due to behavioral, social emotional and/or developmental concerns. Sites that have regular access to a consultant can very quickly connect a child with mental health services and can ensure timely linkages to services that support not just the child, but also the family. Mental Health consultation support allows for ongoing communication about children in the classroom and families served in the program. At some sites, teachers have been able to identify children even before they start the program, through ASQ screening done at enrollment. The ASQ screening provides an opportunity to discuss consultation services with parents, and to initiate a referral to ECCT prior to school starting. This allows for early identification and timely referrals that ensure that the child receives the support they need to thrive in the classroom. In other circumstances, classroom staff can check in with parents to discuss the benefits of bringing in a consultant to support them in better understanding the child within the context of the classroom. When the parent has consented, consultants can conduct classroom observations of the child, as well as meet with teachers and parents to gather information on factors that may be contributing to the child's challenging behavior. Through this process, teachers and families come together to complete assessment tools that provide a richer and broader picture of what is happening at home and at school. It is through this deeper understanding of the child that the consultant, teacher, and parent can develop and implement more attuned strategies for supporting the child's social-emotional

development. When indicated, children are referred to further assessments and/or services that target their specific developmental needs.

Through Light Tough consultation services, if a family has been identified, or has on their own requested additional support, consultants provide them linkages to community resources. This year Light Touch services referred families to special education services within the school district, mental health services for additional members of the family, housing resources, Domestic Violence support, and Legal Aid Services, among others.

The regular presence of a Mental Health Consultant on site has proven, over the years, to be an effective way of increasing parents' willingness to connect with a consultant for Mental Health Services. This has been true for parents who are accessing services for the first time, as well as for those who have not had a positive experience with mental health services in the past. For many families the preschool is a safe and trusted place, thanks to the positive relationships they form with staff. Parents seem more willing to sit with a Mental Health Consultant when the service is being suggested by a trusted teacher or family support staff. ECCT's flexible approach allows staff to "sit" with parents for several sessions to thoughtfully assess their needs, to explore possible barriers to accessing services, and to offer information about the potential benefits of therapy or other valuable services. When parents decide they would like mental health services for their child, the ECCT model allows for a warm handoff to the clinician. Warm handoffs have been shown to increase the commitment to, and engagement with, treatment. When parents are referred out for their own individual therapy with partnering agencies, consultants provide the time and space for them to be ready to connect with more intensive services. In the same way, consultants, who all are trained clinicians, can "hold" the family using a therapeutic approach while they are on any waitlist for services. Once families are linked to other services, the consultants provide continuity by continuing to work with the clients within the school, and by collaborating closely with clinicians, community workers, early intervention supports, social workers or any other provider that works with the family.

Reducing disparities in access to care and implementing recovery principles: At the core of the work within ECCT is the relationship staff have with family members. Treating the family with respect, with cultural humility and within the family's preferred language is essential. Central to the work is the belief that the relationship between ECCT staff and caregivers is parallel to the relationship between child and caregiver. Beginning at Intake the intent is to gather information from the caregivers and allow their input to guide the services, treatment goals and pace of the work, using strength-based language. Meeting caregivers where they are at, and truly allowing their family's needs, concerns, culture, and beliefs to drive the work, is at the heart of the ECCT program. For this to occur, open communication and respect are key. ECCT staff remain curious with families and allow the work to follow the needs of the family, not from goals determined by ECCT staff. At regular points throughout the work, within all the roles of ECCT, there is time set aside to reflect on the work, progress, and challenges. This affords the opportunity to evaluate the caregiver's experience and make any adjustments as needed.

It is essential for ECCT to maintain a connection to the community and to develop an understanding of the community and its needs. Knowing community resources, trends, and challenges allows greater understanding of the daily challenges that families encounter and allows ECCT staff to have a more holistic approach when providing support to families. Many families, due to the ongoing political climate, have remained hesitant to connect with some services due to fear of deportation. Many fear that accessing services, even emergency COVID-19 relief programs, may impact the family's eligibility to apply for a green card. Community Workers are available to support families with any appointments they are concerned about, and to help relieve some of the anxiety the families were going through.

ECCT's core tenets of flexibility and commitment to understanding multiple perspectives allow for the unique tailoring of services, not just for the clients served, but also for the larger systems involved. Consistent Mental Health staff meetings, which occur at least monthly but ideally weekly, are a way of ensuring regular communication with staff about their own needs, as well as the needs of the children and families they serve. ECCT's culturally sensitive and social justice-oriented framework encourages discussion of issues such as disparity, inequity, systemic oppression, community violence and immigration trauma, to provide a safe space where healing can occur.

Consultants and site staff discuss language barriers, cultural differences, and various disparities, and explore ways these issues impact the staff's connection to the children and families. Space is provided for caregivers to explore ways their own trauma might impact their work. Within the context of a safe and trusting relationship with the consultant, site staff can explore their implicit biases and how those biases may affect their understanding of a child and of a family's experience. It is believed that only in understanding and addressing these deeper issues, can teachers build a solid connection with children and families. Increasing empathy and understanding allows staff to develop more effective interventions and strategies, while creating a more inclusive and sensitive classroom environment.

The Intake Coordinator, Mental Health Clinician, Mental Health Consultants, and the Community Worker are primarily bilingual in Spanish and English. Staff are required to complete a minimum of 8 hours of diversity training annually to integrate a more culturally responsive approach to their work.

This past year the Half Moon Bay community has experienced increased trauma and subsequent needs due to events like the farmworker shooting and harsh weather. No two sites were affected in the same way; even within programs in the same larger agency. ECCT consultants and the ECMHC Manager met often with site supervisors, Directors, and agency administrators to get as much information as possible about the functioning of the sites, and to attune services to emergent needs as much as possible. The past two years have been filled with uncertainty, challenges, fears, and anxiety as well as chronic stress for many teachers. This year teachers continued to report high levels of stress, burnout, and fatigue due to issues such as illness, short staffing, children displaying higher than normal separation anxiety and social emotional delays. The consultation space proved especially important for them to be able to express and work through their complex feelings.

The consultation framework stems from a belief that, in teachers being able to share their experiences and having a trusted mental health professional "hold" their experience with them, they are better able to "show up" for the children and families in their care. For many teachers, the therapeutic space that is offered in consultation is the main place where they can check in around their mental and emotional health. Through an attachment lens, ECCT can ensure that the needs of the site staff are met so that they, in turn, can show up for the children under their care and be better able to meet their needs.

Consultation services also supported children displaying challenging behaviors, reducing their risk of suspension and expulsion, and supporting the school's capacity to sustain these children in their programs. Out of the 21 children who were provided with intensive case consultation services, none were expelled or suspended. Consultants and teachers often use consultation meetings to explore possible meaning behind behavior, and to better understand a child's needs. Consistent meetings allow consultants and teachers to follow up and reflect on which types of interventions work, and which need to be modified or changed completely. Finding what "works" takes multiple tries and tremendous effort on the part of the teaching staff. One of the main ways that consultants support teachers in these efforts is by conducting classroom observations to "bear witness" to the teachers' classroom experiences. Consultants then offer a reflective space where teachers can share what was happening, their own personal experiences, and any challenges and successes. Through this reflective approach, teachers are invited to develop an awareness of their own experience in a particular moment, and thus become more grounded and intentional in their work. Teachers who report being self-aware and intentional also report feeling more regulated and better able to seek out support when needed.

Lastly, another important component of the program is to work with community partners to ensure comprehensive services to families. The ECCT team regularly connects families with programs that provide ongoing support. When gaps in services are identified, the ECCT attempts to fill those gaps in the short-term. Having regular conversations with other community providers allows for coordinated attempts to identify and fill any such gaps, and to advocate for additional services, on behalf of families in need. The Community Worker maintains strong relationships with both community members and community providers. These relationships have been crucial to getting families connected with much needed services.

Successes

Client Success Story: Antonio* is a five-year-old Latino boy who lives with both parents, his older sister, and his maternal grandparents in a home in Half Moon Bay. Antonio was referred for services at StarVista when he was two years old. At the time he was having behavior problems at home and at the daycare school he was attending. His struggles included hitting, crying, not listening, having tantrums, and struggling with change. He had language delays that contributed to his difficulty expressing emotions and needs.

The clinician met with Antonio and his mother, Lucia*, once a week for therapy, via zoom. Therapy focused on helping Lucia understand Antonio's language delays, and on teaching her ways to help him communicate and manage his emotions. The clinician also met with teachers at his day care and his new school to offer suggestions and guidance on ways to support Antonio. The clinician used guided play therapy, introducing activities designed to improve socio-emotional, physical, language and cognitive development. In therapy, Antonio used play with toys to recreate things that may have occurred during his day, and Lucia was asked to join in. The therapist modeled how to use the play to introduce solutions to problems, strategies for calming intense emotions, and language to express wants and needs. Antonio learned how to use his words, to walk away when he was upset, to talk to teachers, and to use breathing exercises that helped him successfully regulate his emotions. Lucia reports that Antonio is thriving and continues to learn as he is growing older. She reports that he continues to do well in school. *Pseudonyms

Challenges

During the FY 2022-23, families continued to struggle with housing, resource disparities, and financial and food instabilities. Many of the families served experienced employment changes that resulted in an inability to pay rent. There was a great discrepancy between the number of housing resources in the community, and the number of families in need. Families experienced barriers to attaining needed resources due to documentation requirements for aid. Living within a small community, families sometimes hesitated to seek support, for fear of stigma around receiving mental health and/or other related services. Finally, the overwhelming amount of stress many families experienced made it difficult for them to find the time and energy required to seek out and connect with services.

The number of in person services increased this year, but not to pre-pandemic rates. Dyadic work via telehealth platforms has proven challenging with this age group, despite efforts of clinicians to offer engaging and interactive activities. Staffing shortage: An ongoing challenge is the scarcity of qualified applicants to fill open positions. Although new staff were hired this fiscal year, several positions remain open, and months often go by with no applicants. Having open positions places stress on existing staff and prevents staff from meeting all expectations placed on the program. ECCT continues to work closely with its Human Relations department to seek creative ways of advertising its positions.

Another ongoing challenge continues to be available resources for those who age out of the ECCT program. There have been significant challenges within the communities of Half Moon Bay and La Honda/Pescadero in terms of programs available for continued mental health and case management support post- ECCT. Assisting families in transferring to Coastside Mental Health, Puente, and School based services has been challenging at times.

PROJECT SUCCESS

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is an evidence-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures. Project SUCCESS is a SAMHSA model program that prevents and reduces substance misuse and associated behavioral problems among high-risk youth ages 9-18. Project SUCCESS is offered by a local non-profit Puente de la Costa Sur.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered to all three school campuses in the La Honda-Pescadero Unified School District (LHPUSD). The school district's small size provides an opportunity for every student in the district, ages 9 to18, to participate in one or more Project SUCCESS activities. Each academic school year, a passive consent letter explaining Project SUCCESS curriculum is sent to all parents with children ages 9 to 18. There is an opportunity for parents to have their child opt out with a signature at the bottom of the consent letter. Project SUCCESS activities include:

1. Social Emotional Learning
2. Psychoeducation workshops with students, parents, and community members
3. Individual and family counseling services
4. Parent and Teacher consultation
5. Mental health community awareness and education

Program Impact

Project SUCCESS	FY 2022-23
Clients served (unduplicated)*	21
Cost per client	$14,997
Individuals reached (duplicated)	242
Total Served	328

** Unduplicated clients served are the students that participated in the intervention and individual and family therapy, individuals reached includes parent/teacher consultations, and community awareness and education.*

Outcome Indicators

- Puente is unable to report on general mental health outcomes for the individual and group therapy participants for FY 2022-23 as no post-surveys were collected due to significant staff

shortages. The team is actively working to fill vacancies and train staff on data collection to provide a comprehensive data report for FY 2023-24.

- Several vacancies have been filled since the start of FY 2023-24, including the Clinical Supervisor and an additional Mental Health Clinician. Each of these roles will support data collection moving forward. In addition, Puente is actively working on a Protocols and Procedures document. This document will be used as a guide on referrals, eligibility, appointments, documentation, data, among other themes.

Demographics

Demographic data was not collected during the FY 2022-23 due to the staff shortages mentioned above. Staff has begun to collect this data upon receival of referral. Clinicians will begin inputting this information on a timely basis. New staff that joined team in FY 2023-24 will support all aspects of data collection.

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals		2	2
Substance Use Disorders (SUD) Referrals			
Other Mental Health (MH) Referrals		1	1
TOTAL		3	3

Referrals to Other Services

Puente was not able to collect information for the Social Determinants of Health Screener, which would bolster referrals to other services, due to staff shortages at the time the data template was finalized. The Clinical Director will be working with the Program Associate and CMHW clinicians to ensure that all demographic data will be collected on an ongoing basis through next reporting period.

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	2	Legal	0
Financial/ Employment	2	Medical care	2
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	1	Cultural, non-traditional care	0
Other	1	**TOTAL**	**7**

Program Narrative

- For FY 2022-23, primary program activities included delivering the Project SUCCESS prevention and early intervention curriculum to all thirty 4th and 5th graders in the school district and a cohort of eleven high school students. The intervention consisted of individual and family counseling services; parent and teacher consultation; and mental health community awareness and education. The 5th grade classrooms received 6 lessons of Project SUCCESS (copying skills, effects to the body, etc.). Each academic school year, a passive consent letter explaining the Project SUCCESS curriculum is sent to all parents/ guardians with children ages 9 to 11 and high school students ages 14-17. There is an opportunity for parents to have their child opt out of the workshops with a signature at the bottom of the consent letter. There were no parents/guardians who wanted their child to opt out of the program.
- An 8thgrade Project SUCCESS group was offered to the all-8th graders at the middle school. The group was offered during a free period (instead of integrated into an existing class). This change was not successful as no students attended.

Other primary activities provided through Project SUCCESS include:

- Individual and family counseling services: Community Mental Health and Wellness team (CMHW) clinicians provided therapy to 95 unique individuals, ages 5-79. Most participants met with their therapists weekly and 85% of participants were connected to the LHPUSD community in some way (students, parents/ guardians and extended family members of children enrolled, and school staff and administrators). CMHW clinicians also provided case management for participants to support connections through referrals for Medicare/Medi-Cal coverage, medical and dental procedures, educational assessments, and other social services.
- Parent and teacher consultation: CMHW clinicians provided approximately 12-15 consultations per month to parents/guardians and school staff during the school year.

Improves timely access and linkages for underserved populations: Puente's service region is home to San Mateo County's most underserved population. Participants either live or work in Pescadero, La Honda, San Gregorio, or Loma Mar. Many participants face numerous challenges including accessing mental health care. The CMHW team offers free counseling to all individuals in Puente's geographic region regardless of an individual's socioeconomic or legal status.

Reduces stigma and discrimination: Project SUCCESS provides opportunities for students ages 9 to 18, and their families to engage with trained mental health clinicians in an educational format, workshop format, and therapeutic sessions to build relationships that break down the stigma of mental health and substance use issues and reduce the stigma for seeking treatment. Puente's CMHW team promotes mental health awareness, provides education in accessible formats, and makes access to mental health services easy through a simple referral process. As the team built back services, Puente prioritized the need in school communities. When the team began to be on campus and in classrooms, students, school staff, and their families began to seek out services again. The

presence was hopefully seen as a normalization of seeking mental health services, which is a component of reducing stigma and discrimination.

All CMHW clinicians are trained in cultural humility and through a diversity, equity, and inclusion framework which reduces language barriers and cultural biases.

Increase number of individuals receiving public health services: By providing free services within Puente's geographic region, Puente increases the number of individuals receiving public health services. In addition, Puente provides services to all youth in the district school that they would otherwise not receive.

Reduces disparities in access to care: Through Project SUCCESS, all La Honda-Pescadero Unified School District students have access to this program. Puente's goal is to eliminate health disparities and improve access to healthcare services for vulnerable populations on the South Coast including mental health care. By providing greater access to mental health care services, Puente seeks to improve participants' mental wellness and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group mental health services and significantly reduces the disparities that exist in the mental health system by providing this ease of services.

Implements recovery principles: Project SUCCESS is an early prevention and intervention programs that is designed to mitigate the need for recovery services. Puente provides alcohol and other drug referral services as needed.

Other activities that benefit SUCCESS participants: Puente has begun providing community healing circles, based on the La Cultura Cura model. La Cultura Cura is a transformative health and healing philosophy that recognizes the authentic cultural values, traditions and indigenous practices that exist within an individual, family, and community and that these values and practices can be a pathway to healthy development, restoration, and lifelong well-being. This culturally based framework focuses on building on the natural opportunity factors and on what is healthy within an individual, family, community, or culture.

Successes

The FY 22-23 was filled with many successes for Project SUCCESS. Here are some examples:

Elementary School Project Success: In this year's Project Success program, Puente strove to give the students clear and unbiased information on drugs and alcohol. This was done to not vilify the substances or the individuals who use them but rather give them information on what the substance does to the body, why individuals may use substances, and what are some alternative practices to help with challenging times.

The students were able to understand, retain and generalize the information. When teaching the continuum of use, students successfully placed individuals in the example vignettes on the continuum

and participated in thoughtful discussions about the examples. In the program, staff chose to humanize those struggling with substance use by identifying why someone might turn to drugs and alcohol. In response, the students showed great compassion and empathy for the struggle someone who is using substances might be dealing with. They recognized stresses in life and how they could be so difficult that drugs and alcohol could be seen as a way to "numb" or "escape" from those things. They were able to have thoughtful discussions on alternative coping strategies and identify which they already used. At times they were surprised to find out that things they already did, such as playing with friends and decompressing with tv and video games, would be considered a coping strategy for stressful times. While completing the final project, creating a fidget that included a word that would remind them of their favorite coping strategy, they supported their peers and reflected on the Project Success program.

Client Success Story*:* While working with an individual client, the client suffered the loss of a loved one through a drug overdose. The treatment plan was immediately adjusted to address and support the student through this tragedy. The already existing therapeutic relationship between the staff and the client provided a safe and supportive environment for the student to use art to explore the concept of death and how their experience had created a shattering in their life. Through this process they were able to both fall apart and then begin to put the pieces back together.

Challenges

Staffing: Puente's full-time Clinical Director left in October 2022, and the team transitioned to an interim contractor to provide clinical support, while the Program Director provided administrative support. It had been challenging for Puente to hire a clinical director. Therefore, after consideration, Puente leadership implemented a new structure that includes a Clinical Supervisor and Program Manager instead of Single Clinical Program Director. Puente utilized an external recruiter to support hiring for this program. The Program Manager was hired in April 2023. The Clinical Supervisor started August 18th, 2023. This new structure allows for more flexibility in hiring and is a path for succession planning to avoid gaps in leadership when transitions occur. The program manager oversees all personnel, administrative, operations, grants, and referrals for the team, and works closely with the Clinical Supervisor who oversees clinical supervision and programming.

Data collection: Given the staffing turnover and lack of staffing, the focus in 2023 shifted to provision of services. Survey data collection was not completed. This missed opportunity negatively impacts the reporting of program successes and overall outcomes. New data collection and tracking processes have already been put into place by the Program Manager that exist in a central location to avoid disruptions due to natural turnover or unexpected changes.

Individual referral: During the FY 2022-23, participants who sought individual therapy services were added to a waiting list. This was due to staffing availability. During the transition, Puente contracted with a licensed clinical therapist who provided individual therapy via telehealth. During the referral process participants were contacted by CMHW Program Associate to inform them about the waiting list timeframe, offer other resources, and provide monthly check-ins during the time they waited to

be assigned to a clinician. Although participants could be assigned to a contractor, it was noted that participants wanted to wait until services would be in Puente and in-person.

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

Trauma-Informed Co-occurring Services for Youth target youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for ACEs. Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. Trauma-Informed Co-occurring Services for Youth consists of three required components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

- The Group-Based Intervention component utilizes evidence-based or promising practice intervention or curriculum to address trauma and substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an alternate culturally relevant intervention/curriculum. Agencies target at least 8 youth per cohort and each cohort consists of at least 8 sessions for the intervention and 1 session for youth engagement opportunities.
- The Community Engagement component address community-level challenges that are necessary for positive youth outcomes. Agencies provide at least two foundational trauma-informed trainings for adults that interact with their youth cohort participants (parents, teachers, probation officers, service providers, etc.) to create trauma-informed supports for youth. This component also encourages agencies to connect the cohort youth to leadership opportunities such as the BHRS Office of Diversity and Equity (ODE) Health Ambassador Program for Youth and the Alcohol and Other Drug (AOD) youth prevention programs.
- The Social Determinants of Health (SDOH) Screening and Referrals component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment, etc.) can account for up to 40 percent of individual health outcomes. Agencies screen youth participants at to support appropriate referrals and identifying community-based social service resources and social needs and/or gaps.

Four agencies provide interventions as follows:

- Mindfulness-Based Substance Abuse Treatment (MBSAT)
    - StarVista provides 6 cohorts per year in North County and South County
    - Puente de la Costa Sur provides 2 cohorts per year in the South Coast region
    - YMCA Bureau of San Mateo County provides 2 cohorts per year in South San Francisco
- GiraSol (formerly Panche Be Youth Project)
    - The Latino Commission provides 2 cohorts per year in South County for girls.

Mindfulness-Based Substance Abuse Treatment (MBSAT)

MBSAT is a group-based curriculum incorporating mindfulness, self-awareness, and substance use treatment strategies with adolescents dealing with substance use/misuse. MBSAT provides adolescents with the ability to improve their decision-making skills and reduce unhealthy behaviors through learning emotional awareness and choosing how to respond (versus react) to stressful situations, how specific types of drugs affect the body and the brain, and how family, peers, and the external environment can contribute to drug use. MBSAT strives to offer youth an empowered approach to substance use prevention rather than programs that teach "just don't do (drugs)." MBSAT is designed for use with adolescents and uses adult facilitators to model authenticity and build healthy relationships.

MBSAT – PUENTE DE LA COSTA SUR (PUENTE)

MBSAT is designed for use with adolescents and young adults, ages 15-25, and uses adult facilitators as leaders of the group to model authenticity and building healthy relationships. Puente's Community Mental Health and Wellness (CMHW) clinical staff, trained in cultural humility and trauma-informed care, facilitate this group. All Puente CMHW staff are either licensed or pre-licensed by the Board of Behavioral Sciences. MBSAT is offered to high school students in the La Honda-Pescadero Unified School District (LHPUSD), as well as young adults in the community.

Program Impact

MBSAT - Puente*	FY 2022-23
Clients served (unduplicated)	11
Cost per client	$882
Individuals reached (duplicated)	242
Total Served	328

Outcome Indicators

- Puente is unable to report on general mental health outcomes for the individual and group therapy participants for FY 2022-23 as no post-surveys were collected due to significant staff shortages. The team is actively working to fill vacancies and train staff on data collection to provide a comprehensive data report for FY 2023-24.
- Several vacancies have been filled since the start of FY 2023-24, including the Clinical Supervisor and an additional Mental Health Clinician. Each of these roles will support data collection moving forward. In addition, Puente is actively working on a Protocols and Procedures document. This document will be used as a guide on referrals, eligibility, appointments, documentation, data, among other themes.

Demographics

Demographic data was not collected during the FY 2022-23 due to the staff shortages mentioned above. Staff has begun to collect this data upon receival of referral. Clinicians will begin inputting this information on a timely basis. New staff that joined team in FY 2023-24 will support all aspects of data collection.

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals		2	2
Substance Use Disorders (SUD) Referrals			
Other Mental Health (MH) Referrals		1	1
TOTAL		**3**	**3**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	2	Legal	0
Financial/ Employment	2	Medical care	2
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	1	Cultural, non-traditional care	0
Other	1	**TOTAL**	**7**

Program Narrative

- A TIY/MBSAT group was offered to all high school students. The group was offered during a free period and 11 students participated.
- See PROJECT SUCCESS section for additional program narrative for Puente's PEI programs.

Successes

High School Group: Eleven high school students participated in a four-week workshop series. The students were able to give input on what topics they would like to be discussed and chose to focus

mainly on stress and anxiety and their effects. The students learned about the cognitive triangle and reflected on how negative self-talk has affected their lives. They had thoughtful discussions on how they could practice breaking the cycle of negative self-talk. The students reflected that the series helped them understand stress and anxiety and identify strategies to help lessen the impact.

At the end of the workshop series students were able to recognize that stress and anxiety can show up in different ways and can be felt in the body as well as seen in behavior and thought processes. They were able to identify how stress and anxiety impacted their own lives as well as what symptoms they noticed in themselves. Ending the series with positive coping strategies allowed the students to recognize strategies they already use as well as be exposed to and practice new strategies. During the MBSAT group, the clinicians who led the group where able to pre-plan with one of the high school seniors around content and topics of interest. This pre-planning increased engagement and relevancy.

Challenges

Puente's full-time Clinical Director left in October 2022, and the team transitioned to an interim contractor to provide clinical support, while the Program Director provided administrative support. It had been challenging for Puente to hire a clinical director. Therefore, after consideration, Puente leadership implemented a new structure that includes a Clinical Supervisor and Program Manager instead. The Program Manager was hired in April 2023. The Clinical Supervisor started August 18th, 2023. This new structure allows for more flexibility in hiring and is a path for succession planning to avoid gaps in leadership when transitions occur. The program manager oversees all personnel, administrative, operations, grants, and referrals for the team, and works closely with the Clinical Supervisor who oversees clinical supervision and programming.

Data collection: Given the staffing turnover and lack of staffing, the focus in 2023 shifted to provision of services. Survey data collection was not completed. This missed opportunity negatively impacts the reporting of program successes and overall outcomes. New data collection and tracking processes have already been put into place by the Program Manager that exist in a central location to avoid disruptions due to natural turnover or unexpected changes.

MBSAT - STARVISTA

MBSAT is offered as part of the StarVista Insights Program. The purpose of the Insights Program is to improve the lives of transition-age youth (TAY) who are dealing with issues around substance use, trauma, emotional regulation, family conflict, unhealthy relationships, and/or any other factor limiting their healthy development and overall happiness. Their mindfulness groups focus on important life skills such as self-awareness, enhancing emotional well-being, and reducing substance-use though healthier coping mechanisms and informed decision-making. With the right tools, youth

can better manage life challenges in the moment instead of allowing emotions to lead to poor judgement, risky decisions, and eventually negative or dire consequences.

Group facilitators work with participants to understand that mindfulness is a broad term that touches on practices that range from formal meditation to making informed, on-the-spot decisions. A favorite tool to teach youth is the TAP acronym. It stands for Take (a breath), Acknowledge (the situation), and Proceed. This TAP acronym is also shorthand for popular slang youth use when they need to check in with others or themselves: They will say something like “let’s tap in” to mean that they’d like to know what’s going on/catch-up, check in. This popular youth slang is used as a bridge to a new practice. Calling on the TAP acronym can support youth to make better decisions in the heat of a risky situation. It is this kind of practical use of mindfulness that is important to bring to youth. After all, at its most basic, it means to be present to whatever is unfolding with an attitude of non-reactivity and non-judgment. This produces a state of equanimity and calm, a disposition which most decision-making can benefit from.

The curriculum covers topics of substance use, cravings, triggers, emotional awareness, brain function, family systems, peer systems and environmental influences on behavior. Each group provides an opportunity to explore multiple meditation interventions focusing on specific practices, such as but not limited to meditation of the breath, body, and environment. By providing youth with the space to calmly explore their true internal states, (and therefore limitations and challenges but also goals and strengths), they can bring the fruits of their insights into their everyday experience through better choices. So often, negative experiences come down to split decisions made in a momentary lack of clarity and poor judgement, leading to many more moments of anguish and discomfort. With continued utilization of these strategies towards managing their intrapersonal and interpersonal relationships and an ongoing commitment to self-understanding and actualization, youth can change begin to transform their lives towards greater agency and overall well-being.

Over the last two years, with the appropriate safety protocols in place, staff have been able to provide in-person services for clients who feel that this is most conducive to a better experience. The program material has been adapted to deal with the challenge of the ongoing COVID-19 pandemic. Staff are working diligently to continue to bring support emphasizing emotional regulation to help youth cultivate and grow their resilient capacities during these uncertain times.

To ensure steady yet sustainable growth of the program, staff are ramping up offerings of mindfulness groups for TAY youth by working with various community-based organizations and school districts. Any transition-aged youth (typically ages 15-25) are welcome to participate, and staff are open to working with any organization serving this population. Their commitment to work with diverse community sites (school, afterschool program, transitional housing program, etc.) has led to an increase in the number of youths served (104 participants during the fiscal year). Groups are organized to make the setting age-appropriate (groups are composed of individuals ages 14-17 and 18-25). Currently, clinicians are traveling to various sites, and the hope is to return to these sites and extend beyond them to serve anyone who can benefit from these services.

Program Impact

MBSAT - StarVista*	FY 2022-23
Clients served (unduplicated)	87
Cost per client	$1,034
Individuals reached (duplicated)	81
Total Served	168

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Outcome Indicators

Domain	Indicators/Questions	# Agree	%
Improved Knowledge/ skills and/or abilities	*Because I participated in this program, when I want to feel happier, I think about something different.*	48	69%
	Because I participated in this program, when I want to feel less bad (e.g., sad, angry or worried), I think about something different.	48	69%
	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.	48	69%
	Because I participated in this program, when I want to feel happier about something, I change the way I'm thinking about it.	48	69%
	Because I participated in this program, I manage my feelings about things by changing the way I think about them.	40	57%
Stigma Reduction	*Due to this program, I accept people who are different from me*	NA*	NA*
	Due to this program, I express my feelings in a proper way	NA*	NA*
	Due to this program, I seek advice from people I look up to	NA*	NA*

** Data Not Collected*

Demographics

Age	%	Race	%
6-15yo	29%	White	16%
16-25yo	71%	Latinx/Hispanic	36%
Primary Language	**%**	Indigenous/Native American/	10%
English	85%	Pacific Islander/Hawaiian	4%

Spanish	13%	Black	10%
French	2%	Other	22%
Other	0%		
Sex Assigned At Birth	**%**	**Ethnicity**	**%**
Female	54%	African	2%
Male	40%	Asian	16%
Decline to state	6%	Middle Eastern	7
Intersex	**%**	Latinx	39%
Yes	2%	European	9%
No	90%	Other	2%
Decline to state	8%	Decline to state	9%
Gender Identity	**%**	**Disability**	**%**
Female/Woman/Cisgender Woman	38%	Difficulty seeing	6%
Male/Man/Cisgender Man	53%	Difficulty hearing or having speech understood	3%
Questioning or unsure	2%	Memory Issue	3%
Decline to State	8%	Decline to State	6%
		No	73%
		Veteran	**%**
Sexual Orientation	**%**	No	96%
Asexual	4%	Decline to state	4%
Bisexual	15%	**City/Region**	%
Gay or Lesbian	2%	North	19%
Decline to State	4%	Central	21%
Questioning	2%	South	47%
Pansexual	6%	Other	7%
Heterosexual	65%	Decline to State	6%

** Unable to collect demographic data for about 20 percent of clients served as with the previous FY. The goal moving forward is to have the first session where all forms are completed.*

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	1	1
Substance Use Disorders (SUD) Referrals	1	0	1

Other Mental Health (MH) Referrals	1	0	1
TOTAL	**2**	**1**	**3**

Referrals to Other Services – Did not start utilizing the form until the end of the fiscal year.

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	1	**TOTAL**	**1**

Improves timely access and linkages for underserved populations: Many clients are the first in their families to access services. StarVista works with partner agencies and individual participants to determine the best date/time/access point for participation. Additionally, now the program provides an online/at-home format allowing for greater reach and accessibility for those clients and/or programs with interest in telehealth services. Through a special grant, StarVista has been able to secure cellular phones with cameras for clients who indicate that they would most benefit from remote services due to transportation issues but do not have a phone of their own.

Reduces stigma and discrimination: The mindfulness program is not focused on "telling youth what to do and what not to do". This approach is helpful in reducing internalized shame/shame directed at youth because by leading with this, they do not feel like their choices are being perceived as "good" or "bad" or scrutinized for morality or worthiness. By working with youth to understand the influence of personal, familial, societal, and systemic pressures on their everyday decision-making abilities, counselors can also work with them to find those key moments where they can exercise agency and choice within the myriad social, political, and economic dynamics at play. While they can recognize their agency, they can also see that some of their choices are heavily pressured by external factors. Taking all this into account, the program focuses on developing a practice of making more informed decisions – decisions that are based on desired long-term outcomes, rather than immediate gratification or reactivity.

The program encourages a high level of peer engagement, thus creating a deeper rapport, comfort, and safety for participants. Facilitators steer away from strict didactic top-down approaches where the clinician/authority figure is the source of knowledge. This approach creates a socio-corrective experience for youth which they are not accustomed to but is believed to be imperative in reducing stigma; if youth can speak to their life experiences with authority, they can begin to take control and feel pride in their self-awareness and future decisions- the opposite of shame. By working closely with others in similar situations, youth can see that they are not the only ones dealing with difficult situations; there are others with whom to share without the judgement they may expect from others who do not share their experience. These kinds of connections among participants help normalize the

kinds of conversations that the program supports (motivations for drug use, healthy coping, problem-solving, healthy decision-making, etc.) beyond the life of the program.

As has been seen, the onset of the COVID-19 pandemic has normalized conversation around mental health to a high degree. Many youth that have been involved in the juvenile justice, probation, homeless networks, foster care, etc. have expressed feeling powerless within those systems. As noted above, this program provides TAY with the psychoeducation, skill-building and decision-making abilities needed to overcome obstacles leading to their own solutions and positive outcome, and thus, a sense of empowerment and self-definition. Furthermore, the conversations and skills taught in the program can help participants to better contextualize their past experiences as the result of not having the proper resources or tools along their own personal choices rather than just some inherent flaw in their character or a reductive attribution to personal choices. In this way, the hope is to help them destigmatize not only their present and future, but also their pasts.

Increases number of individuals receiving public health services: To ensure that participants can meaningfully participate in the program, clinicians assess for an array of needs throughout treatment and connect participants with the appropriate public service as needed. StarVista collaborates with partner sites, other StarVista programs, and makes referrals to other San Mateo County services and programs to coordinate the appropriate level of care for all participants. StarVista has implemented services at high schools where youth can easily access and receive its services with no additional travel and screening by school counselors or teachers who see needs that can be addressed.

Reduces disparities in access to care: By targeting underserved populations, this program directly increases the number of individuals receiving public health services, thus reducing the disparity in access to care. Transportation can often be a barrier to access and increases these disparities for young people with limited resources. This program travels to the participants, removing transportation as a challenge in accessing services. Additionally, the program's online platform offers a variety of time slots to accommodate the variety of work schedules, home-life schedules, and school schedules. StarVista is also able to provide phones for youth who need a cellular device so that they can participate in remote services. Staff encourage participants to access other safety net programs and normalize accessing such programs throughout the lifespan.

Implements recovery principles: By emphasizing increased awareness and acceptance as core elements of mindfulness, individuals can patiently implement critical principles to their recovery. Teaching mindfulness encourages the implementation of self-actualized, self-directed factors that the individual identifies through the recovery process. Mindfulness is rooted in holistic, strength-based, person-centered, and self-directed elements – all key principles of recovery.

Other activities that benefit clients: Clinicians support the client by accessing services and resources as needed. Case management services are provided outside of the group so that clinicians can assess the best resources and services that can meet their needs. Clinicians also work with participant's parents to access resources such as medical and or mental health counseling for themselves, the latter is seen as deeply connected to the youth's success in the program.

Successes

Client Success Story: "Jasmine"* is an 18-year-old recent high school graduate who is currently enrolled in the MBSAT group. She started the program in August 2022, anxious and hesitant to begin therapy again with a new therapist after having taken a break for 2 years. Throughout the services, she has learned to conquer her fear of sharing about difficult circumstances in her life and continues to courageously utilize services to their fullest extent.

When she began her time in the program, Jasmine was nervous to start therapy again. She shared that meeting new people in the group and developing trust with others made her anxious, but she needed support during her gap year. She had just started a new job and would get panic attacks before she would go to work, in fear she would make mistakes and disappoint her team. She was using marijuana daily as a coping mechanism to numb her anxiety and depression. Jasmine constantly wrestled with thoughts rooted in her low self-esteem, feelings of worthlessness, and low self-confidence. Jasmine reported a history of self-harm, hospitalization, and suicidal ideation. She had minimal supportive relationships and struggled to open up to those around her in the beginning often active listening to fellow group members, which left her feeling isolated and alone with her mental health issues. Even during the two years she was not in therapy, Jasmine demonstrated immense perseverance through these hardships, and maintained the will to achieve her goals and live a healthier lifestyle in this new stage of adulthood.

As time went on in treatment, Jasmine would express vocally and emotionally her struggles with one story then with validation and encouragement continued. This often led to her processing a bit of her past trauma, family problems, and the triggers for her substance use and emotional dysregulation. She then was referred into the program where she would continue her deep dive into her trauma and vocalized her ups and downs of her emotional states, and her experiences of self-harm urges and suicidal ideation which would often reveal themselves at night. Sessions would be spent brainstorming suitable coping skills, creating routines, and processing the deeply rooted traumas she was holding.

Around week 7-8 of treatment for both the MBSAT program and individually with applying some mindfulness exercises in session and taking time to process through her mixed emotions, she revealed that her father had recently relapsed on his alcohol use, and enrolled himself in AA meetings, which she was proud of, but anxious about. She opened up about needing to take on a caregiver role for her father for many years when he was often intoxicated.

There have been other times such as this when topics would trigger difficult emotions for Jasmine, and she has shown considerable progress learning how to self-soothe and openly verbalize her feelings when various topics would bring up past trauma. These self-soothing skills have also bled into her everyday life. She has shown immense resilience coping with her symptoms of depression, developing a strong routine, and healthy coping skills such as journaling, taking a drive around her

neighborhood while jamming to her favorite songs, and confiding in her closest friends. While her symptoms still exist, she has reported that she has learned through services how to cope with her anxiety utilizing mindfulness and different acronyms that she can apply in her daily life (i.e., STIC and TAP). Jasmine has reported with use of treatment now that her father and her relationship has since improved and grown into one of gratitude and honesty while support of his engagement in AA meetings. She's shared with her father's support and treatment she has gained the motivation to achieve her future goals of going back to school to become a forensic psychologist. She has also shown considerable progress in reducing her substance use and not needing to use for emotional reasons. Jasmine continues to be a joy to work with as barriers and challenges arise and proves to be a resilient and an empowered woman.

* Name has been changed to protect confidentiality.

Challenges

Some groups were difficult initially. It was challenging to demonstrate to clients the power of mindfulness, especially through a zoom platform where clients struggled to show their faces on camera. Engagement is difficult to confirm through telehealth with little to no follow-up in session. Solutions to mitigate these challenges of mindfulness through zoom include taking more time to frame the specific activity (not just mindfulness as a whole) and its purpose, that may be helpful. Also, coming up with post-activity questions that specifically pertain to that activity, instead of "how did it feel?" or "what came up for you?" it may elicit more responses (assuming the clients engaged in the activity).

Another group challenge has fluctuated in terms of membership and attendance, which may affect the groups' bonding at times. They have been a little more reserved in the past and members are hesitant to speak up when the space is left open for answering. Solution includes creating new ways to participate instead of having members assert themselves into the conversation. Going around in a circle seemed to prompt more participation and writing things down also seemed to help. Clinicians notice that some of them tend to process more internally than others. Sometimes groups in the beginning, have some hesitancy to share due to the new relationships, so the members were quieter. The solution being with time and consistent attendance, members might be more open to share especially as all the members opened up space for conversation well.

A challenge includes as the group grew throughout the weeks, the biggest challenge was finding time for everyone to check in about what they needed to check in about and intentionally integrate the mindfulness curriculum into the group's topic. The sessions mainly addressed topics the group members wanted to talk about and some mention of mindful thinking or mindfulness activity. Clinicians believe mindfulness will become more applicable and relatable if it's more intentionally integrated into the topics the group is bringing up, which they plan to do this coming year.

MBSAT - YMCA

As of July 1, 2023, the Youth Service Bureau (YSB) has seamlessly integrated into the newly established Mental Health Branch of the YMCA of San Francisco. Operating within this framework, the YSB dedicates itself to delivering vital mental health services within three South San Francisco high school campuses. Specifically, South San Francisco High School and El Camino High School are the schools covered by this contract. The YSB's focus is on adolescents aged 14 to 18 who are enrolled in high school. The provision of services by High School Safety Advocates (SSAs) is inclusive and accessible to all students on campus.

Under the umbrella of the YMCA High School SSAs, a diverse array of services and groups is offered, featuring the First Stop group. This group employs the Mindfulness Based Substance Abuse Treatment (MBSAT) curriculum, designed for youth engaging with school-based services for both prevention and substance use concerns. Referrals to these services stem from various sources, including school staff, administrators, counselors, and parents. The flexible nature of the MBSAT curriculum and interventions allows for their delivery either in group settings or on an individual basis, effectively catering to the unique needs of each student.

The primary objective of the High School SSA program is to bolster high school students' access to mental health assistance, concentrating on early intervention and prevention, while simultaneously addressing crucial safety concerns. Collaborating closely with school personnel, SSA staff contribute to fostering secure environments within campuses. Their roles encompass conflict intervention, employing restorative justice methods for conflict resolution, proactively countering potential instances of bullying, self-harm, suicide, and substance abuse. Furthermore, the program endeavors to offer alternative avenues that help high school students steer clear of involvement in the criminal justice system. Through the therapeutic framework embraced by SSAs, they cultivate relationships that empower youth to collaborate with a trustworthy adult figure. This alliance facilitates the imparting of problem-solving skills and techniques to navigate challenges, both within the school environment and the home setting. The overarching goals of the program encompass:

- reduce youth violence, gang participation, substance abuse, and involvement in the criminal justice system.
- identify any risk to self or others, and secure appropriate services to ensure youths’ safety.
- change at-risk youths’ behaviors to increase personal responsibility, risk avoidance, protective behaviors, and resiliency.
- provide the following developmental inputs to promote positive behavioral change: safe environments, supportive adults, and a variety of programs and interventions matched to youths’ risk levels.
- measure the impacts of developmental inputs as indicators of positive behavioral change.

The High School SSA team engages with students on campus through a diverse range of activities and interventions. Those students identified as requiring a higher level of care can be directed to the YMCA for individual or family therapy on an outpatient basis. A significant component of the YSB High

School SSAs' work with referred students revolves around case management. YSB SSAs handle a substantial number of referrals and, via thorough assessments, ascertain the most appropriate approach based on each student's individual needs. Moreover, the possibility of directing students towards external agencies or resources is also considered.

Additionally, in collaboration with the school district, the YSB of the YMCA plays a role in the Alternatives to Suspension (ATS) initiative in South San Francisco. This program offers a structured day of therapeutic support to address the underlying causes of behavior, aiming to enhance the students' academic success upon their return after suspension. Both high school and middle school students who have faced suspension are served. The YSB continues to reinforce connections and support for students who have been suspended due to substance use on campus. These students are encouraged to seek ongoing assistance from the high school SSAs, thereby fostering interventions and early prevention efforts, including the utilization of the MBSAT curriculum. The ensuing services are accessible on campus, facilitated by the High School SSAs.

Additionally, High School SSA staff provide outreach and education activities with schools to enhance strategies for reducing risk factors and substance use through discussions with students, workshops, and parent workshops.

Program Impact

MBSAT - YMCA*	FY 2022-23
Clients served (unduplicated)	15
Cost per client	$2,000
Individuals reached (duplicated)	0
Total Served	15

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Referrals

YMCA clinicians on campus did not make any outside/other referrals for the clients they provided service to. The most common referral made with school-based services was to the YSB clinic for mental health outpatient clinic services. YMCA did not capture SDOH data during the FY 2022-23 but has created a form to capture the SDOH data moving forward. This data will be reflected in the FY 2023-24 report.

Demographics

Age	%	Race	%
6-15yo	60%	White/Caucasian	6%
16-25yo	40%	Latinx/Hispanic	40%

Primary Language	%	Indigenous/Native American/	13%
English	74%	Asian	20%
Spanish	26%	Black/African American	6%
Other	0%	Multiple Races	26%
Sex Assigned At Birth	**%**	**Ethnicity**	**%**
Female	26%	African	0%
Male	74%	Filipino	26%
Decline to state	0%	Chicano/Mexican American	13%
Intersex	**%**	Latinx	0%
Information not collected		European	0%
		Other	0%
		Decline to state	60%
Gender Identity	**%**	**Disability**	**%**
Female/Woman/Cisgender Woman	26%	No	26%
Male/Man/Cisgender Man	74%	Difficulty hearing or having speech understood	0%
Questioning or unsure	0%	Memory Issue	0%
Decline to State	0%	Decline to State	74%
		Veteran	**%**
Sexual Orientation	**%**	No	100%
Asexual	0%	Decline to state	0%
Bisexual	0%	**City/Region**	%
Gay or Lesbian	0%	North	100%
Decline to State	68%	Central	0%
Questioning	6%	South	0%
Pansexual	0%	Other	0%
Heterosexual	26%	Decline to State	0%

Demographic data collection challenges and agency plans to address these challenges: Social Determinants of Health Screener data will be collected using a Microsoft Form that will be given to MBSAT participants upon enrolling in the program. The data will collect client names that will then be able to be parallel tracked to participant data in the YMCA EHR then subsequently moved into PEI reporting requirements.

Other demographic fields not collected include intersex, which is not currently included in YMCA EHR demographic data. While this data is understood to be required by BHRS, the YMCA will have to explore avenues to create a field for this question in the EHR platform.

Data fields for sexual orientation and disabilities were not consistent between all participant data, there are currently ideas for gathering that information consistently moving forward. Solutions include creating a checklist for required data fields for YMCA High School SSAs and implementing an EHR required field function. EHR implementation can be slow, but efforts will be made to support YMCA High School SSAs in the process.

Program Narrative

The YMCA High School SSAs handle a substantial influx of referrals throughout the academic year for a variety of reasons. All students referred to the SSAs undergo comprehensive assessments, leading to the identification of the most suitable course of action. An inherent benefit of the high school SSA program is that the students have attained an age where they can independently consent to services. While efforts are made to involve parents or caregivers, such involvement is not obligatory for ensuring prompt access to on-campus services. Should it be determined that a student requires referrals or connections to additional services or resources, the SSAs can promptly initiate those linkages in most cases. Referrals primarily for outpatient therapy services are directly channeled to the YMCA clinic, which accommodates Medi-Cal and extends fee-based options. The clinic operates on a sliding scale, providing financial assistance to individuals and families in need.

In cases where it is determined that the student would benefit from external support, the SSA will facilitate suitable referrals. Moreover, the SSAs have the capacity to guide students towards Care Solace, a resource that facilitates connections with community-based mental healthcare providers through the school district. Through the collaborative endeavors of the YMCA and the school partnerships, concerted actions are taken to mitigate disparities in access to care. The YMCA Community Resource Center (CRC) serves as a pivotal agency offering an array of essential services, encompassing provisions such as food assistance, housing and shelter resources, aid for homelessness, as well as short-term financial support for rental, deposits, mortgages, and utility bills. These services are extended to residents of South San Francisco, San Bruno, and Brisbane. In instances where a student's family necessitates fundamental resources or referrals to these core services, the process of linkage initiation is executed promptly and efficiently.

The YSB of the YMCA High School SSA program effectively contributes to destigmatizing mental health concerns due to its integration within the school community and close collaboration with the counseling team. This integration often enhances trust-building, particularly among certain students who find reassurance in the fact that YSB SSAs are affiliated with an external agency. The presence of a reliable adult figure on campus, capable of extending individual and group support, goes a long way in normalizing mental health services. Such engagement opportunities lay the foundation for lifelong habits of seeking assistance and support, greatly benefiting youth. Notably, the absence of traditional therapeutic services provided by SSAs on campus enhances accessibility while simultaneously reducing disparities in accessing essential services. A significant aspect of this lies in the alignment of YSB SSAs' cultural backgrounds with those of the student and family communities they serve. This

congruence fosters heightened engagement and connection, effectively countering stigma and discrimination.

The YSB's Mindfulness-Based Substance Abuse Treatment (MBSAT) program and curriculum actively foster mindfulness practices and self-awareness, aiming to facilitate a transition towards healthier choices. Within this framework, the recovery principles of empowerment and peer support take center stage, actively motivating young individuals to play an integral role in their journey by making informed decisions and setting meaningful goals. The MBSAT curriculum offers a wealth of psychoeducational content, equipping youth with accurate and practical information to guide their decision-making. This curriculum is adaptable, allowing for both group-based and individual sessions, ensuring that services are tailored to address the specific needs of each youth in the most effective manner.

The YMCA demonstrates a steadfast commitment to operating as a Trauma-Informed System (TIS), underpinned by a profound dedication to cultural humility and the promotion of racial equity within its workforce and training programs. The TIS framework is founded upon two pivotal principles: a comprehensive grasp of the nature and repercussions of trauma and recovery, as well as a keen awareness of socio-cultural trauma and structural oppression. This approach is embedded not only within the YSB of the YMCA's internal operations but also extends to interactions with students, clients, families, and the entirety of its community partners.

This approach effectively acknowledges that both individual and systemic racism, along with oppressive structures, can perpetuate trauma within the students and families receiving support from the SSAs on campus. The YSB of the YMCA employs proactive measures to recognize dynamics of power and privilege, actively confront individual and systemic racism, and champion anti-racist practices. These actions are taken to curtail discrimination, while simultaneously valuing and nurturing the distinctive strengths and resilience of students who navigate historical and present-day traumas.

The YMCA remains steadfast in its pursuit of racial equity through collaboration with hired consultants. The current Phase Three entails comprehensive leadership coaching, further staff training, and an emphasis on ongoing professional development. Simultaneously, the YSB is embarking on the integration of Healing Centered Engagement (HCE) practices among its staff and trainees. HCE presents a strengths-based framework that fosters a holistic perspective on healing, with culture and identity occupying a central role in personal well-being.

The goal is that these initiatives, accompanied by progress in other areas, will not only enhance staff retention and recruitment but also ultimately translate into enhanced support for the students served by the YMCA. Guided by an unwavering commitment, the YMCA prioritizes the hiring of staff members who resonate with the student population. This effort stands to amplify engagement and bolster the self-esteem of students, especially those originating from historically marginalized Black, Indigenous, People of Color (BIPOC) communities. For effective support of BIPOC staff, the YMCA

recognizes the critical need to wholeheartedly embrace and uphold racial equity within the workplace.

Successes

The following account is a narrative provided by the SSA at South San Francisco High School within the FY 2022-23. To safeguard client confidentiality, names and identifying details have been omitted. The employed intervention entailed the utilization of the Mindfulness Based Substance Abuse Treatment curriculum in a group setting. The narrative highlights key themes such as accessing substance abuse services, the reduction of stigma, and the crucial role of a trusted adult in supporting youth recovery and resilience.

Client Success Story: 17-year-old Latino male, was referred due to suspension of substance use during his junior and senior year of high school. Client presented stress and anxiety as evidenced by bouncing of the knees and quiet tone of voice. Client was distracted through the first five sessions of First Stop Group. Clinician facilitated space for group to express their values, beliefs, and family systems to increase emotional regulation. Clinician facilitated art activities for check-ins and mindfulness practices to increase self-awareness. Client showed interest in art activities and showed concentration to detail in his art. Client expressed his art through paper, pencil, markers, and chalk. Client reported through his art the difficulty maintaining a relationship with his mother due to his substance use. Client reported he had been using marijuana since the age of twelve since moving from Mexico to the US. Client reported his use of substance came from dad who also uses substances to relieve stress and anxiety. Client reported he “was no longer motivated” to graduate high school because “teachers didn't care” and would “kick him out of class”. Client reported he felt that because he was suspended for substance use, he was "marked as a bad kid”. Yet, client showed up to school every day and went to First Stop Group consistently. For the last five sessions of First Stop, client began to lead the group in check-ins and meditation.

Client had consistent attendance in the First Stop Group and participated in all activities. Client showed interest in meditative practice and expressed “willing to practice breathing more.” After First Stop Group, the client found his voice and advocated for himself and expressed interest in individual check-ins throughout the rest of the school year with the SSA. The client had difficulty finishing his credits and was unable to walk for graduation. However, client expressed that his goal was to finish in adult school to get his GED. Clinician assisted client in making goal sheets. Client’s goal sheets included becoming a “music producer, finishing his GED, getting a good job, helping his family, and maybe getting out of South City”. After making his goal sheets, client reported he followed up with the Academy of Arts in San Francisco for the music production program. Client was able to identify the reason for his substance use, which included environmental and social factors. Client was able to identify his community among his classmates (his classmates would reach out to SSA regarding their concern for him). The client was able to identify core strengths, such as creating art and music, to cope instead of using substances. The client was able to increase his emotional regulation by

communicating his presenting problems, his needs, and his goals. The client was able to find accountability for his past mistakes and found strength in re-identifying himself. The client was able to find vulnerability among himself and expressed the need for support. On the last week of school, client reached out to clinician and expressed gratitude for the “connection”. Client reported, “thank you Ms. V, for giving me a place to just be me.”

Challenges

Throughout the FY 2022-23, several challenges and hurdles emerged, including a noticeable surge in referrals directed towards YMCA SSAs working on high school campuses. Notably, the youth referred displayed heightened levels of need, further intensifying the demands on the system. This translated to YMCA High School SSAs' caseloads reaching their limits quite early in the academic year once again. This trend has persisted since the return to in-person learning following the COVID-19 pandemic's shelter-in-place period.

The amplified workload, compounded by the pressures stemming from school systems, significantly contributed to burnout. YMCA High School SSAs found themselves pushed beyond their capacities, operating at a pace that was unsustainable. Recognizing this strain, proactive measures were initiated for the current school year. These measures included the establishment of caseload maximums, the formulation of precise guidelines for specific school sites, and outreach initiatives aimed at fostering improved communication. These efforts were designed to alleviate the impact on YMCA High School SSAs, thereby fostering a more sustainable and effective support system.

Since the transition and subsequent integration of the Electronic Health Record (EHR) across the YMCA organization in November 2021, specific challenges have surfaced. The initial aspiration of utilizing the EHR to encompass screenings and surveys aimed at capturing desired outcomes, beyond merely demographic data, has encountered obstacles. This can be attributed to the scale of the YMCA of San Francisco and the multifaceted needs spanning various branches within the organization. Consequently, the anticipated timelines for deliverables have extended beyond the initial expectations.

One notable example is the Social Determinants of Health Screener (SDOH), which has not been incorporated as intended. In response to this, an alternative strategy will be implemented, entailing the utilization of a self-report survey for all youth engaged in MBSAT First Stop interventions on campus. This will ensure the independent collection of the pertinent data to enhance the accuracy and effectiveness of the assessment process and meet contractual requirements. Other plans to enhance the EHR are to capitalize on the changes that can be made within the existing system. These modifications encompass close collaboration with the YMCA Information Technology (IT) support team to devise strategies for enhancing platform performance. Notably, any alterations to the EHR necessitate rollout planning, comprehensive training, and ongoing support for YMCA SSAs and staff to adapt and transition.

During the FY 22-23, the YMCA SSA at South San Francisco High School was invited to participate in the parent-teacher night. During this event, a 30-minute presentation was delivered to the attending parents and teachers, highlighting the range of services and resources available, including the MBSAT First Stop group. Regrettably, the post-presentation survey was not administered to the participants, resulting in the inability to gather any data from this interaction. To rectify this, a process has been implemented in the current fiscal year, ensuring contractual obligations are fulfilled and relevant data is collected. YMCA High School SSAs have been provided with the survey link, and efforts will be made to attend school functions such as parent-teacher events and teacher staff meetings.

Continuing obstacles persist in the implementation of the San Mateo County EHR Avatar, which was initially discussed for reporting purposes under the contract. Challenges have emerged concerning the coordination between IT departments and the installation of devices. These issues have persisted since FY 20-21. Unfortunately, the credentialing process did not result in success and did not elicit any response or feedback, even after submitting the required forms multiple times.

The MBSAT First Stop group maintains lower enrollment than anticipated, despite the growing count of youths reportedly engaging in substance use and being detected on campus. The figures presented in the substance education intervention for the Alternative to Suspension (ATS) program should ideally be reflected in the number of youths referred to the SSAs for participation in the First Stop groups. The data illustrates that most referrals to the MBSAT First Stop program originate from the ATS program, therefore, the hope is to increase the number of youths referred to these services. Unfortunately, school counselors and administrators also make use of other interventions which can divert from First Stop groups.

During the FY 2022-23, a discernible trend emerged across multiple districts, affecting both middle and high school students, characterized by a decline in group participation. Traditionally, YMCA SSAs in both middle and high school settings have experienced high group enrollment and participation rates. What has been observed, however, is not only a decrease in group referrals but also a decreased desire among teenage youth to participate and engage in groups.

This trend, spanning multiple schools, age groups, and districts, appears indicative of a widespread shift in previously established social and cultural norms. While there is no data to support this shift, several hypotheses are being explored. One possible explanation considers the aftermath of the pandemic, where there might be a heightened need for individualized support because of isolation and the prevalence of virtual/online schooling. Another hypothesis acknowledges the growing influence of social media on young individuals, with concerns about the potential dissemination of sensitive or private information shared within group settings on various social media platforms.

Dedicated to enhancing group referrals and participation, measures will be implemented, encompassing on-campus outreach and collaborative efforts with programs and partners. Meanwhile, the YMCA SSAs will continue to customize their approach to cater to the distinct needs of the referred youth. This commitment involves delivering a range of therapeutic services, targeted interventions, crisis support, and vital resources, all tailored to best suit individual needs.

GIRASOL (FORMERLY PANCHE BE YOUTH PROJECT)

The Latino Commission is the one agency that proposed an alternate culturally relevant intervention/curriculum, GiraSol (formerly The Panche Be Youth Project). The services still consist of three required components; Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

The GIRASOL curriculum debuted at The Latino Commission's San Bruno location Spring 2023 serving female- identified youth in the South Bay Area. The Spring cohort was successful across many areas, primarily in the area of increasing and strengthening youth participants' ability to cope, manage and transform mental health symptoms and intersecting adversity, through culturally- rooted protective factors, skill and knowledge development, and enhancing their trust and use of healthy peer, adult/ family and community support systems. Youth participants engaged in 14 consecutive educational and skill- building sessions of an integrative, unique, and culturally- rooted curriculum, offered 60 hours of culturally- rooted educational workshops Program outcomes contributed and nurtured youth participants' emotional, social, and psychological development, fostering a sense of belonging, security, and well-being rooted in strong values, culture, community, and healthy relationships.

Program Impact

MBSAT - GiraSol	FY 2022-23
Clients served (unduplicated)	8
Cost per client	$3,750
Individuals reached (duplicated)	0
Total Served	8

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	1	0	1
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	0	0	0
TOTAL	**1**	**0**	**1**

Note: Most successful participants enrolled in the Girasol program (5 of 7) were already enrolled in mental health outpatient services and/ or academic support services. Program staff facilitated several individual sessions, follow- up and reminder calls and contact to both client and parent to support attendance and engagement and increased motivation to attend and benefit from these external services. Some clients benefited from program staff serving as advocates in supporting positive communication about client/ family's needs and preferences (language, cultural approach).

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	1	Medical care	0
Food	0	Transportation	1
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	0	**TOTAL**	**2**

Demographics

Demographics will not be reported here to protect confidentiality of the of the small number of program participants.

Program Narrative

Overall, the program resulted in three primary successful outcomes:

1) Improved Mental Health/ Reduced Substance Misuse
    - Participants benefited from the programs' focus on strengthening resilience and protective factors, introduction of traditional concepts of wellness, cycles/ stages of life and developmentally appropriate behavior change strategies resulting in a reduction of harmful behaviors, substance misuse and cultural stigma relating to mental health and substance use.
    - Improved Well-being: A holistic approach that addresses cultural identity, self-concept, mental health, and healthy relationships can lead to overall improved well-being for participants.
    - Each participant received screening and assessment of the "presentation" and impact of substance use and mental health symptoms, mental health and prevention education, and weekly counseling sessions that offered interventions relevant to maintaining safety and reducing risk enhancing behaviors.

- Participants demonstrated the use of effective coping skills to manage the impacts of social determinants of health, reducing the negative effects of adverse circumstances and the use of high-risk behaviors and substance misuse as a result.
- Youth expressed motivation and connection to the practical use of culturally rooted teachings, they reported gaining a deeper understanding of their cultural heritage and values and the significance of their cultural identity as a source of strength.
- The program taught and modeled the use of tools and action steps that lead to building healthy relationships and communication, laying the foundation for a supportive and positive growth- centered environment.

2) Increased Self- Efficacy, Empowerment & Leadership
   - Participants who engaged actively in the program, utilized traditional teachings and identity reclamation to overcome challenges and engage in healthier lifestyle choices, translating traditional/ indigenous values into contemporary youth culture, relationships, and society. Reclaiming identity and self-concept can empower young individuals, helping them to embrace their cultural heritage and become agents of positive change in their communities.
   - Youth participants reported an increase in skill and tools that can be used to navigate challenges with self- esteem, peers, and family.
   - Youth participants directly addressed the individual and community impacts of social determinants of health, empowering and enabling participants to understand their role and responsibility to contribute to community healing and resilience-building.
   - The Spring 2023 Cohort was primarily diverse in the range of participant age, country of origin and generation in the US. Facilitated through a range of dynamic art-, movement- and reflection- based activities, each participant was enabled to guide each other through important reflections and decision making. Participants dismantled harmful gender- assigned roles, stereotypes relating to friendship and healthy relationships, learned and practiced building healthy relationships with peers in- and outside of their grade, school and neighborhoods.
   - After the completion of the program, youth participants reported an increase in feeling supported and understood by peers, and supportive adults, experienced emotional well- being as evidenced by a decrease in mental health symptoms. Youth participants reported an enhanced ability to identify characteristics of a stable, healthy environment(s) and relationships (home, school, community, family), academic re-focus, better- informed decision making and higher self- esteem and confidence in making and reaching their goals.
3) Strengthened Community Connections & Healthy Relationships
   - *Parents & Family:* Youth participants developed effective communication skills, such as active listening, expressing healthy, honest emotions, and resolving conflicts constructively. Youth reported that when these skills were used, they enjoyed open and honest dialogue with their parents, there was an increase in trust, understanding

and mutual respect. Youth were also able to share key teachings from the program with parents and family members, where previously they would have not.

- Parents of successful participants reported benefitting from supportive resources, strengthened parenting skills, reduced parent- youth conflict (as defined by a marked decrease in frequency and intensity over the programming period), and positive behavior changes evidenced within familial/ household relationships. Parents are more hopeful that their youth will be more likely to seek guidance from trusted adults, themselves (the parents) and other elders in their family (parents, and other trusted adults) during critical developmental stages. Parents reported an increase in trust and confidence in their youth's decision making and behaviors.
- *Adults & Community:* Participants engaged in regular and consistent programming led by two clinical professionals, who are both connected and accessible within the youths' community settings. Curriculum indigenous teachings reinforced characteristics of healthy adult relationships, strengthening community bonds, and building reference/ lived experiencing trusting community- based health professionals for future use/ access to resources.
- Participants each connected to specific resources, referrals and ongoing support from relevant programs or services to their and their family's needs.
- Youth participants identified and developed an intricate support system and network of personal, professional and community resources, suitable for a range of individualized needs (mental health, peer relationships, communication, academic, health & wellness).
- Increased Awareness: As participants engage with culturally rooted teachings, they can gain a deeper understanding of their heritage and the significance of their cultural identity.

Cultural identity plays a crucial role as a protective factor and strategy for the prevention of substance abuse. Embracing and maintaining a strong cultural identity can act as a powerful shield against engaging in harmful behaviors like substance misuse. Here are some ways GIRASOL contributed to prevention:

- Sense of Belonging: Culturally rooted practices promoted a strong sense of belonging to the youth's community, which provided them with a support system and a network of individuals who share similar values and beliefs. This sense of belonging reduced feelings of isolation and peer pressure, decreased the likelihood of turning to substance abuse to" fit in" or cope with stress.
- Protective Values and Norms: Participants who identified strongly with their culture at the end of the program, were more likely to align with these protective values and norms, making them less susceptible to the influence of substance-using peers.

- Cultural Traditions and Activities: Engaging in culturally significant traditions and activities provided participants with a sense of purpose and fulfillment, reducing the desire to turn to substance use or misunderstand mental health symptoms as a way of seeking pleasure or escape; instead participants learned to embrace their cultural identity, fosters a positive self-concept and self-esteem, sense of pride and self-worth, which can act as a buffer against substance abuse and peer pressure.

Changes for next FY: The Latino Commission will host two cohorts in FY 2023-24 in San Mateo County. Both will serve monolingual and bilingual Latina, Latin American- female identified youth ages 12-18. The program will continue to expand on its first cohort where a wide range of intersecting issues were addressed through the GIRASOL curriculum. Additional program alumni serve as ambassadors of the values and lessons of the program to allow for a more expansive enrollment experience.

Successes

- Community Building: Working with different community partners and school sites allowed for a diverse pool of participants in age, culture, and neighborhood.
- Consistency in Program Fidelity, Facilitation and Delivery: As a result of each facilitator's certification in this curriculum, monthly support and training workshops were provided for facilitators to discuss program implementation, curricular questions and approaches to a range of scenarios presenting in each program. This national network allowed for productive trouble-shooting and creative strategizing around unique age- and culturally- specific dynamics that required appropriate adaptations.
- Program Monitoring & Ongoing Training from the Executive Director and Curriculum authors were important to ensuring a standard quality in the services provided.
- Holistic Approach to Wellness: The program offered a range of approaches to learning, dynamic activities and culturally- rooted teachings allowed for youth to explore various aspects of well-being beyond individual behavior, such as family dynamics/ relationships, community involvement, and spiritual practices. These activities were adaptable for each participant to use “to fit” their own personal cultural identity and provided a safe space to discuss and address issues related to stigma and mental health.
- Increased Cultural Understanding/ Humility: The program fostered increased cultural understanding among youth participants from diverse backgrounds and cultures. Engaging with various cultural practices and teachings promoted empathy, open- mindedness and respect for different traditions, cultures, and communities.
- Cultural Relevance = Increase Self-Esteem, minimized high risk behaviors. The foundation of the program acknowledges, embraces cultural- rootedness, topics resonated (were familiar) with participants, leading to higher levels of engagement and active participation. The group’s diverse range of youth participants provides opportunities for cross-cultural interactions, fostering the development of strong peer connections and a sense of community.

- Data Collection: Measuring the program's impact and effectiveness on a diverse group required collecting and analyzing data that is sensitive to cultural nuances and variations.

Participants demonstrated significant changes in their behavior, mental health symptoms and overall substance use. Many youths expressed histories of mistrust and/ or disrespect with health providers, community workers and school staff. Program facilitators supported participants to overcome cultural stigmas related to mental health and substance use, feelings of shame and guilt, by working hard to build rapport with participants and their families.

Challenges

- Coordination and communication with multiple school sites and community partners was challenging since the agency primarily focuses on adult treatment and recovery. While coordination with these partners was challenging in the beginning, staff were able to identify key partners and leaders at specific school sites and neighborhoods where the target population became most interested. Since this was the first GIRASOL program at TLC, outreach required additional exposure to the curriculum, target participants and opportunities to build trust with the program to receive successful referrals for the program. As a result of these initial efforts there were some key takeaways to better collaborate with community partners:
    - Beginning programming earlier in the Spring to minimize disruptions to sessions.
    - Coordinating transportation support for this program was essentially though not initially planned as the program was held at a satellite site versus an on campus or community center. Participants came from within 3-15 miles from the agency.
- Next cohort will benefit from an increase in support from diverse communities and stakeholders- as a crucial strategy for the success of the program. Some communities may be more receptive to the program's goals, while others may be hesitant or resistant.
- Tailoring/adapting program curriculum to diverse age and cultural groups: Meeting the unique needs and developmental stages of participants across this diverse range of ages proved to be challenging. Union and trust in the group culture and dynamic took longer than usual; facilitators adapted content and activities to be developmentally appropriate for the group.
- Balancing Traditional/ Indigenous teachings with Contemporary realities: Integrating cultural teachings with evidence-based prevention strategies required storytelling (traditional teaching strategy) and lived- experience of this translation to prove adaptable for the youth and bring balance between traditional practices and contemporary realities.

Despite these challenges, GIRASOL- a culturally rooted substance use prevention and stigma reducing program had a profound and positive impact on their well-being, fostering inclusive and supportive communities. Flexibility, cultural competence, and ongoing collaboration with stakeholders are key to navigating these complexities and achieving future success within the program.

HEALTH AMBASSADOR PROGRAM - YOUTH (HAP-Y)

The Health Ambassador Program for Youth (HAP-Y) engages youth (ages 16-24) in trainings, conversations, and workshops around mental health, substance use and wellness. The goal of the program is for participants to become behavioral health agents in their communities and work to reduce stigma through behavioral health awareness presentations and resource sharing. To prepare youth to support their peers, youth participate in an extensive 14-week training program that focuses on psychoeducation and suicide prevention workshops. Some of the topics included as part of the curriculum include:

- Be Sensitive Be Brave for Mental Health and for Suicide Prevention
- Wellness Recovery Action Plan (WRAP, offered through One New Heartbeat)
- Storytelling through Photovoice
- Mood and Personality Disorders
- Consent and Healthy Relationships
- Eating Disorders
- Self-Care
- Substance Use Prevention

To encourage youth to actively advocate for behavioral health and wellness, participants are asked to participate in three community involvement activities in which they educate their peers, share resources, and share personal lived experience (when appropriate). The community presentation that ambassadors conduct is in their communities. The presentation entails a brief introduction to behavioral health, discussing stigma and how it plays a role in individuals seeking support for their behavioral health. The presentation also has a focus on depression, stress, anxiety, and healthy coping skills to address those symptoms. The presentation ends with Suicide prevention- recognizing the signs that a peer may be thinking about suicide and how to support that person. Resources are provided both at the beginning and at the end of the presentation.

Program Impact

HAP-Y*	FY 2022-23
Clients served (unduplicated)	43
Cost per client	$5,988
Individuals reached (duplicated)	739
Total Served	782

** Unduplicated clients served are the youth Health Ambassadors, individuals reached includes the broader community receiving training, education from the ambassadors.*

Outcome Indicators

Domain	Indicators/Questions	#	%
Self-Empowerment	Participating in HAP-Y, led me to consider a career in mental health-related field (cohort)	33	77%
Stigma Reduction	I feel comfortable discussing topics related to mental health. (Cohort)	37	86%
	I feel comfortable discussing topics related to mental health. (Audience)	286	48%
	I feel comfortable seeking mental health services (Audience)	282	47%
Knowledge & Access	I know who to call or access online if I need mental health services.	354	59%
Community Advocacy	After participating in HAP-Y, I am able to contribute to other people's learning about mental health.	40	93%
Improve Knowledge, skills and/or abilities	HAP-Y provided me with knowledge and skills that I continue to use.	41	95%

Demographics

Age (N=53)	%	Sex assigned at birth	%
Age 0-15	6%	Female	42%
Age 16-25	94%	Male	41%
		Another	4%
Primary language	**%**	Decline to State	13%
English	100.00%	**Gender Identity**	**%**
Race	**%**	Female/Woman/Cisgender Woman	58%
Asian/Asian American	36%	Male/Man/Cisgender Man	9%
Black/African American	2%	Genderqueer/Gender nonconforming	4%
Hispanic/Latinx/a/o	30%	Questioning or unsure	4%
Native American/ Indigenous	4%	Transgender Woman/Trans-Fem/Woman	4%
Native Hawaiian/Pacific Islander	2%	Transgender Man/Trans-Masc/Man	0%
White/Caucasian	26%	Another	9%
Decline to State	0%	Decline to state	6%
		Sexual Orientation	**%**
		Asexual	4%
		Bisexual	23%
Ethnicity	**%**	Gay or Lesbian	6%
Asian Indian/South Asian	6%	Straight or Heterosexual	42%
Chinese	15%	Indigenous sexual orientation	0.00%
Central American	9%	Pansexual	8%
Eastern European	0%	Queer	4%
European	9%	Questioning or unsure	6%
Filipinx/a/o	0%	Another	0%

Mexican/Chicanx/a/o	15%	Decline to State	0%
Puerto Rican	0%	**City/Region**	**%**
Vietnamese	0%	Pacifica	0%
Another	13%	Foster City	6%
Decline to State	0%	San Bruno	8%
Disability/Learning Difficulty	**%**	Redwood City	13%
Chronic health condition	2%	San Mateo	11%
Difficulty seeing	9%	Daly City	2%
Another	3%	Burlingame	4%
Decline to State	6%	Millbrae	6%
No	58%	South San Francisco	11%

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	0	0
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	8	0	8
TOTAL	**8**	**0**	**8**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	0	**TOTAL**	**0**

Program Narrative

A major goal of HAP-Y programming is to work towards stigma reduction around mental health and help-seeking services to support mental health. Education and conversations support this goal by normalizing topics that are highly stigmatized, such as: suicide prevention, substance use prevention, mental health illnesses, and help-seeking. The educative conversations help clarify and demystify any misconceptions on mental health. HAP-Y programming continuously highlights that stigma serves as a barrier for individuals who may need support but are hesitant to reach out because of the stigma.

The conversations give the participants a safe place to learn and remove any negative preconceptions surrounding mental health. By end of programming, participants feel empowered and ready to bring the conversation to their community. Here is a direct quote from a participant from the Winter cohort:

> *"Early during the cohort, I struggled with sharing personal experiences, but it was comforting to hear other people's stories and I felt like I connected to many experiences so much. The experience has made me more comfortable in speaking about my mental health experiences, and it has made me realize how much mental health is a part of my life."*

HAP-Ys goal to reduce stigma goes beyond the three cohorts that take place each year; HAP-Y has a community-wide impact made possible by peer-presentations led by ambassadors. Community presentations are a meaningful way to bring awareness to mental health, normalize the conversation, encourage resource-sharing and help-seeking behaviors. The presentations have been effective in having a valuable impact on the audience. Below are direct quotes from an audience member that help illustrate the power of the community presentations and how it helped increase confidence in talking about mental health and encourages community members to reach out for support:

> *"Yes, the presentation was helpful, as I am someone who struggles with mental health from time to time, especially with having depression. Now I know I have access to more resources than I thought."*

> *"I became more confident and comfortable with discussing mental health topics because I know more than I did before."*

Throughout the years HAP-Y has been hosted in different parts of the San Mateo County to accommodate for youth who live all over the region. With the onset of the COVID-19 pandemic, in 2020 HAP-Y moved online, with meetings conducted via zoom. Being virtual has had an influence in reducing disparities in access to the HAP-Y program.

Throughout HAP-Y 14-week training program, the importance of self-care is necessary in achieving and maintaining wellness. Self-care includes asking for support either from a friend or a trained professional when needed. With each meeting, resources are shared relating to the topic of discussion. As part of the HAP-Y training, the program includes the WRAP workshop, or Wellness Recovery Action Plan. Over the course of 8 sessions the youth learn and reflect on their stressors, wellness tools, and support system. In the end, participants have created a custom plan that will guide them through their recovery journey in maintaining their wellness.

Successes

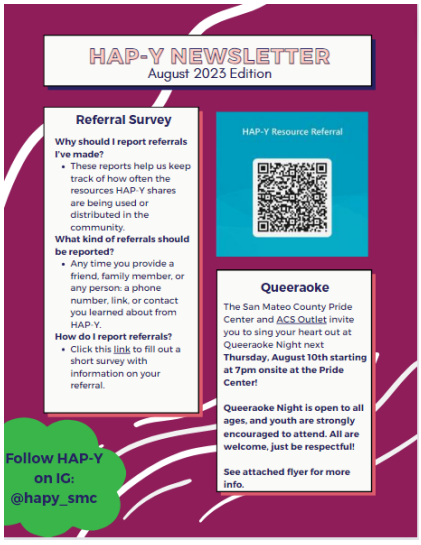
This FY HAP-Y has had many successes. One big success that is worth highlighting is HAP-Ys Instagram launch that was scheduled to go live for Mental Health Month and HAP-Ys 7th year anniversary, in May 2023. HAP-Ys focus on social media presence came upon the request from ambassadors for a

space where they can stay in touch and continue to be informed on HAP-Y updates. The launch of the social media page allowed for innovative engagement of past HAP-Y participants which supported HAP-Ys goal to continue to engage participants. One way that Instagram supported this is through the "Where Are You Now" Campaign. For this project ambassadors from former cohorts were asked a set of questions to hear from them that would be published on HAP-Ys page. The questions included:

- What Cohort You Participated In?
- Where Are You Now? (Getting ready for College, Graduating College, Preparing for Grad School, starting your Career)
- What is your favorite memory of HAP-Y is and/or How has HAP-Y continued to impact you?

This campaign continues to be a great way to engage past HAP-Y ambassadors and create an online community. Below is an example of a post from a participant in HAP-Ys very fist cohort:

"I participated in the first cohort. I am currently pursuing my bachelor's degree in Psychology. This coming fall, I will officially be in my last year of university. I'm also currently working in partnership with a clinic for learning disabilities to create a social media presence for them.
Despite participating in HAP-Y about 6 years ago, the experience and knowledge that I gained during my time with HAP-Y still continues to motivate me today. All that I learned still sticks with me in my memory and I often look back and remember that HAP-Y is the root of which I decided I wanted to pursue psychology."



Another success has been HAP-Y's newsletter which is sent out to ambassadors monthly. The newsletter highlights HAP-Y updates, upcoming events, and work/volunteer opportunities. This has been a huge success as it's received positive feedback from current and past ambassadors. Below is an example of what the newsletter typically looks like.

A continued success has been HAP-Ys Photovoice workshops. Photovoice has been a part of HAP-Ys curriculum since the beginning of programming. Through Photovoice workshop, participants can reflect on their stories of resiliency, perseverance, hope, and self-empowerment and shared them in a way that inspires action and change. Youth have expressed big appreciation for the storytelling circle that takes place on the last day of HAP-Y, sharing that the space allows for authentic and vulnerable connection that is, otherwise, not available. Below is a photovoice from this fiscal year programming.

Transition

Sometimes, making a change in your life is the best thing you can do. Especially if you find yourself living in a way that makes you miserable. I used to live that way, and sometimes, I still do. I was constantly told who I should be, how I should talk, act, dress. At an early age, my politeness and good behavior were praised by adults; but the truth was– I just didn't say much, and when I did, I only said what they wanted to hear. This ended up causing a lot of issues for me later in life, in formulating my own identity. I wasn't my own person. At a concerningly young age, I started showing signs of Major Depressive Disorder, and the symptoms only got worse. Something had to change, and my body and mind were signaling to me that something was wrong. I started thinking: What do I want? Not what they want, but what do I want? I was exhausted from living as someone who wasn't me. I was exhausted from saying "yes" when I really wanted to say "no". I was exhausted from pretending to be content every time someone referred to me as a girl. I was exhausted. So, when I stumbled upon an opportunity to leave my old life behind, I took it. I'll be honest, things did not magically get better. It's been a bit over a year now, and I'm still healing. I often get asked if I feel sad that I was cheated out of a happy childhood, but I'm not. As I go into my senior year of high school, a lot of uncertainty lies ahead, but I'm not scared anymore. I'm not prepared, in fact I don't think I ever will be, but I embrace the excitement of life.

Lastly, this last fiscal year HAP-Y saw an increase in community presentations, there were 43 presentations and ambassadors reached an audience of over 600. The presentation has been proved to be effective providing audience members information on resources, 56% of the respondents said they know how to always access support, "all of the time". The quotes below from audience members show the effectiveness of presentation in encouraging help-seeking, normalizing the conversation, and increasing knowledge on resources.

> "It taught me more about mental health resources and being able to open up and teaching me how to give my friends who are struggling and help me understand more stigma."
>
> "It reminds me that there is always help out there. Even though I feel there was not a ton of new information it made me feel a bit more comfortable reaching out for help."

Challenges

HAP-Ys continues to impact participants even after their 14-week commitment, this is something that HAP-Y is working to better capture. One way that participants continue to use HAP-Ys content is through resource sharing amongst their peers/community. Efforts have been made by HAP-Y staff to capture those referrals but have not been successful. HAP-Y staff have created and distributed a

survey to collect this information. Through the referral survey, ambassadors can share any referrals that can be to a friend, family member, and/or peer. In the survey participants are also asked how the experience of sharing a resource was for them. A summary for what the resource referral survey is and a link to access it was shared in HAP-Y monthly newsletters. Email reminders are sent out to ambassadors encouraging them to utilize the Referral Survey. For the upcoming fiscal year, the idea of resource-sharing will be addressed directly during weekly meetings. This way, participants can be made aware of the survey, and they can continuously be reminded to share resources with peers.

HAP-Y is truly a community effort, the curriculum is made up of various community presenters/trainers, both within StarVista and the wider San Mateo County community. A challenge that HAP-Y is currently facing is maintaining curriculum as guest speakers/presenters transition in/out of roles and no longer able to support HAP-Y. While trying to find a replacement for presenters (on topics such as: Personality Disorders, Depressive Disorders: Bipolar and Major Depressive Disorder, and Psychotic Disorders), HAP-Y staff are also working on addressing the changing needs of participants and work towards updating curriculum so that the focus is on topics of prevalence to the youth. To support the HAP-Y curriculum, the program coordinator will continue to outreach and collaborate with potential organizations/presenters.

TRAUMA INFORMED 0-5 SYSTEMS

In FY 2022-23, First 5 San Mateo County (F5SMC) continued its multi-sector initiative to transform the service sector for young children and their families. The Trauma- and Resiliency- Informed Systems Initiative (TRISI) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level. The strategies and targets for the Initiative include:

- Training and support for child- and family-serving organizations to imbed trauma-informed practices in their internal operations,
- Training and resources on trauma-informed practices for professionals working with children and families, and
- Education for parents to help recognize the signs and symptoms of trauma.

The current initiative focus is primarily on the first level shown above; training and support for child- and family serving organizations to embed trauma-informed practices in their internal operations.

Through an extensive planning process with cross-sector partners, the Initiative has established the following areas of focus:

- Systems Strengthening: Focused on system leaders, organizational leaders, policymakers.
- Practice Improvement: Focused on organizational leaders, managers, all staff.
- Initiative Evaluation: To measure strides made by organizations to become more trauma- and resiliency-informed.

Progress to date prior to this reporting period includes:

- *Online Resource Hub*: Development of a local online resource hub targeted at providers and other interested community members.
- *Market Assessment Survey*: Creation, dissemination, and analysis of an online Market Assessment Survey designed to gauge the interest of local stakeholders in family-serving organizations in trauma-informed training and stages of organizational readiness.
- *Countywide Trauma Convening*: Hosting of a full-day Culture of Care Convening focused on supporting trauma-informed organizational practices for child- and family-serving organizations attended by over 150 individuals and 40+ agencies.
- *Organizational Assessment Tool*: Identification of an organizational assessment tool to determine stages of readiness and areas for growth for child- and family-focused organizations interested in furthering their TIO practices; outreach/ education to publicize the tool for first tranche of organizations; linkage and support for completing the tool and disseminating results internally for said orgs.
- *Trauma-Informed Organization Cohorts and Coaching:* Supported the deepening of TIO practices for an initial round of organizations by offering ongoing training, support, and action plans through group work in cohorts and specific agency-focused goals through coaching.
- *Development of TRISI 2.0*: Planned for and designed the second phase of the assessment, cohort, and coaching model with and for three of the largest child- and family-serving public agencies in San Mateo County.

In the FY 2022-23, activities centered on partnering with three large agencies or County departments with a focus on serving families and children. These agencies, which collectively employ nearly 1,000 staff, made a joint decision to prioritize trauma-informed organizational practices. Grant activities to support the three agencies included three of the strategies noted previously: Trauma-informed coaching, cross-agency cohorts, and trauma-informed organizational assessments. For the coaching offering, agencies identified a diverse group of internal stakeholders that represented various divisions and levels of power or influence within their agency with the intention of creating a structure and strategy to help support TIO practices. The cohort members- similarly diverse in their roles and divisions, met with staff from the other two agencies to learn about the principles of trauma-informed organizational practice and to discuss experiences and reflect on opportunities for growth. The Trauma-Informed Organizational Practices Assessment was made available to all staff at all three agencies to complete.

Program Impact

Trauma-Informed 0-5 Systems	FY 2022-23
Total clients served	446
Total cost per client	$336

For the purposes of the report, the "clients" served are, most directly, the staff and providers working within the target agencies that serve children and families in San Mateo County. In this context, the MHSA Intended Outcomes would be sought for providers within the community who work to serve the public. While the TIO Assessment Tool does not ask questions about the mental health status or outcomes for agency staff, the overarching intention of building a community of trauma-informed organizations is consistent with supporting positive mental health practices and outcomes for staff of child and family serving organizations.

To this end, the data gathered from 446 staff participants within seven of the eight agencies that completed the TIO Assessment Tool for TRISI 1.0 and the subsequent analysis in the previous fiscal year is included again here as TRISI 1.0 TIO Assessment Data Report. The aggregate level TIO Assessment data for the three new participating agencies for TRISI 2.0 will be collected during FY 2022-23 and will therefore be shared in a following report.

TRISI 1.0

In 2023, 4 participants responded to a survey (to which all TRISI 1.0 participants were invited) about their experiences in the previous two years.

- Their organization's greatest strengths in being trauma and resiliency informed:
    - Creating safe spaces to receive feedback and to thoughtfully integrate that feedback into the organizational structure.
    - Increased awareness of the effects of trauma on our staff, volunteers, and clients.
    - Willingness to learn more.
    - Commitment to be a healing-centered organization.
- Their organization's areas of greatest potential improvement related to becoming trauma and resiliency informed:
    - Redeveloping their policies to be more trauma and resiliency informed.
    - Transparency and taking meaningful action based on input from staff at all levels.
    - Training and role playing.
    - Having a consistent support system to share and receive feedback and advice.
    - Proactive safeguards for experiencing secondary trauma.
- Kinds of support that would most help their organization to continue to become more trauma and resiliency informed:
    - Spaces like TRISI would continue to be beneficial, especially for more staff to participate in.
    - Continued support from a coach.
    - Addressing hard conversations and working on it in the trauma and resiliency lens.
    - Training and role playing/review of actual/real-life scenarios.

TRISI 2.0

Each of the organizations had substantially different trajectories, experiences, and progress during the implementation of TRISI 2.0. None of the organizations achieved the primary deliverable of the initiative by the end of June 2023 – developing a roadmap for becoming more trauma and resiliency informed organizations.

Throughout the initiative, the TRISI 2.0 agencies successfully increased awareness of the importance and complexity of doing this kind of work in large, complicated organizations. They have restructured and established different ways of tackling TRISI-related organizational change. Each organization has received their assessment results, which can be used to guide future change (with or without their TRISI coach).

The agencies experienced several challenges as they rolled out and implemented the initiative:

- Integrating the TRISI work with past efforts related to trauma-informed care and systems, and other, existing initiatives within their organizations (e.g., equity
- Building buy-in and consistent engagement of managers and staff throughout their organizations.
- The timing of the assessment and the availability of results was too late for the results to be used in the development of roadmaps/action plans before the end of June 2023.

In 2023, six TRISI 2.0 participants completed a survey about their experiences (all participants in cohorts and coaching were invited).

- 50% of respondents found the launch event to be *extremely valuable* or *quite valuable*.
- 50% of respondents found that completing the Trauma Informed Organization Assessment survey was *extremely valuable*.
- 50% of respondents reported that the cohort meetings with other participating organizations (facilitated by Dr. Tasha Parker) found them to be *extremely valuable*.
- 67% of respondents who participated in the organizational coaching (with Dr. Tasha Parker, Dr. Ken Epstein, or Antoine Moore) found it to be *extremely valuable*.
- 100% of respondents *agreed* or *strongly agreed* that the F5SMC Staff and TRISI Consultants were respectful in their interactions with staff at their organization during TRISI activities.
- 100% of respondents *agreed* or *strongly agreed* that staff from their own and other organizations were respectful and supportive in their interactions during TRISI activities.
- 50% of respondents *strongly agreed* that TRISI activities were a productive use of their time.

- 83% of respondents *agreed* or *strongly agreed* that the F5SMC Staff and TRISI Consultants were open to feedback and would shift the approach as needed to better meet participants' needs.
- 83% of respondents *agreed* or *strongly agreed* that they acquired more knowledge through participating in TRISI activities about what it means to be a trauma-and resiliency-informed organization.

Successes

The primary success of this year was that three large public agencies came together with an intention of prioritizing trauma-informed organizational practices and committed to offering the three-pronged approach of TIO assessment, multi-agency cohorts, and agency coaching for their staff. This alone was a monumental achievement, particularly for large public bureaucracies. The commitment of the leaders within these agencies was critical to this Initiative getting buy-in and lift within their agencies. Additionally, the TRISI Implementation Team, made up of consultants and staff with nuanced skill sets, worked diligently and flexibly to respond to the fluid needs of the project and its rollout.

More specifically, the successes of this year according to the lead representatives of the participating agencies and via a broader survey distributed to TRISI 2.0 participants include the following (please also note that the total number of survey participants was 6, so the N may not be a representative):

- High completion rates of TIO Practice Assessment Tool by all three agencies
- Responsiveness of TRISI team to pivot and adapt to the needs voiced by agency leads
- Respectful facilitation and participation within the coaching groups and cohorts
- Overall effectiveness of agency coaching
- Acquisition of knowledge about what it means to be a trauma- and resiliency-informed organization.

Challenges

The theme of the year was growth and learning for all, and likely most for the TRISI Implementation Team and the agency initiative leads. It is no small feat to launch an initiative focused on culture change for a large countywide bureaucracy, let alone three simultaneously. This was evident from the continuous feedback from agency leads who worked diligently to build buy-in and traction with their staff and the Implementation Team, who accepted input with grace and flexibility to respond. The learnings were many and served to inform several shifts in the structure of the TRISI offering for the three target agencies moving forward.

For example, the multi-agency cohorts proved challenging as an early step in the trauma-informed process due to pronounced differences in agency culture and roles. This has resulted in a decision to hold off on the cohorts for the FY 2023-24 and to instead prioritize deeper and more tailored work

within the individual agencies to sync up with internal priorities and initiatives and to meet participants where they are on their trauma-informed journeys. Some additional challenges noted in the survey of participants from the target agencies include the following:

- About half of participants in the TRISI launch event and TRISI activities did not feel that these activities were a productive use of their time
- Only half of participants felt that completing the TIO Assessment was a good use of time.

As noted, several changes in the structure and offerings for the initiative have been adapted because of this feedback to be increasingly responsive to the unique needs of each agency.

PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

YOUTH CRISIS RESPONSE & PREVENTION

The Youth Stabilization, Opportunity, and Support (Youth S.O.S) Team provides over the phone and/or in-person response to youth (ages 0-25) living in San Mateo County that are experiencing an escalation in mental health symptoms. Symptoms may range from suicidal ideation to undiagnosed mental health disorders. The Youth S.O.S team is staffed with mental health clinicians and family partners (and one youth peer partner). Together those roles provide comprehensive suicide and crisis assessment, psychoeducation, brief individual counseling, and case management for family needs. In addition to responding to families in crisis, the Youth S.O.S team provides San Mateo County schools assistance with suicide assessments and/or crisis intervention.

This program prioritizes marginalized ethnic, linguistic, and cultural communities in San Mateo County. This includes youth that have experienced abuse, are currently or have formerly been in foster care, experienced unstable housing/homelessness as well as youth that belong to the LGBTQ+ community. The Youth S.O.S Team is also responsible for in-person mobile crisis response for the California Family Urgent Response System (CAL-FURS) to support current and former foster youth as well as their caregivers when crisis occurs. The CAL-FURS program states that, “FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth.”

The overall goals of the Youth Stabilization Opportunity and Support (Youth S.O.S.) team is to decrease youth psychiatric emergency service visits, decrease hospitalization for self-harm, decrease emergency calls to law enforcement for youth in crisis, and improve family/caregivers’ ability to navigate crisis and increase access of services. As the mobile responders for CAL-FURS, the team’s goal also strives to maintain and support stability of youth in foster care placement and improve trust between youth and caregivers.

Program Impact

Youth SOS*	FY 2022-23
Clients served (unduplicated)	30
Cost per client	$31,401
Individuals reached (duplicated)	141
Hotline phone calls	11570
Total Served	11,741

** Unduplicated clients served are youth served by the mobile crisis response, individuals reached includes the family members or caregivers of youth served and/or individuals reached through outreach/education.*

24/7 CRISIS HOTLINE	
	Total
Total number of calls	11570
Average length of calls (minutes)	9.3
Number of follow up requests	89
Number of follow ups provided	115
Percentage of callers who receive service linkages and referrals to service providers as appropriate	100%
TEEN CRISIS SERVICES (WEB BASED SERVICES, TEXT SUITE PILOT)	
	Total
Total number of chats	42
Total number of texts	25
Total site views	11336
SUICIDE PREVENTION PRESENTATIONS AND OUTREACH	
	Total
Total Number of Tabling Events	14
Total Number of Contacts at Tabling Events	735
Total number of presentations	78
Number of adults served	776
number of youth served	949
number of youth requesting follow up	36
number of youth who received follow up	17
Youth Stabilization Opportunity and Support (YSOS)	
	Total
Total number of referrals	127
Total number of in person responses	21
Total number of youth served with in-person response	16
Response Time	
Immediate (1 hour)	6
Delayed (3 hours)	0

Follow Up (24+ hours)	14
Phone Consultations / De-escalation	
School /Community Provider	35
Youth	8
Caregiver/Family Member	60
Percentage of youth deferred from psychiatric hospitalization through means of Safety Plan	100%
Total number of youth deferred from use of psychiatric emergency services through means of safety plan	72
Total number of youth referred to psychiatric emergency services after in-person crisis response	0
Total number of youth whose in-person crisis response resulted in incarceration	0
Family Urgent Response System (FURS)	
	Total
Total number of referrals	7
Total number of in person response	0
Total number of youth served with in person response	0
Response Time	
Immediate (1 hour)	0
Delayed (3 hours)	0
Follow Up (24+ hours)	0
no in person response occurred	6

Outcome Indicators

Domain	Indicators/Questions	#	%
Improved knowledge, skills, and/or ability	Number of youths who learned a new coping strategy to increase mental, emotional, and relational functioning.	30	100%
Connection and Support	Number of youths who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	28	93%
Self-Empowerment	Number of youths who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	29	97%
Knowledge & Access to Services	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support. Population= family members/caregivers of youth)	30	100%
Utilization of Emergency Services	Youth Diverted from use of psychiatric emergency services) population- youth who received Youth SOS services) Youth that did not require law enforcement intervention (population- youth SOS services)	30 30	100% 100%

Demographics

Demographic data collection was a challenge this year. When referrals come into the hotline, there is very little data collection that happens outside of checking for eligibility of services (age and location). When the referral is transferred to the SOS clinician their initial focus is determining what type of response type would be most appropriate for the client. A lot of calls have remained at this stage or other supports were called in. Because of that, data is limited to that which can be gathered from the client's narrative of what is going on. To rectify this in the coming year, the manager will be conducting training for all staff around demographic data collection for phone only interventions.

Age (N=31)	%	City/Region	%
Age 0-15	58%	Pacifica	10%
Age 16-25	42%	Half Moon Bay	3%
Primary language	**%**	San Bruno	10%
English	97%	Redwood City	26%
Spanish	3%	San Mateo	32%
		Levasy	3%
Asian/Asian American		Santa Clara	0%
Black/African American		San Jose	0%
Hispanic/Latinx/a/o		South San Francisco	6%
Middle Eastern		Menlo Park	6%
White/Caucasian		Burlingame	1%
Decline to State		Other	
Gender Identity	**%**	**Sexual Orientation**	**%**
Female/Woman/Cisgender Woman	39%	Straight or Heterosexual	26%
Male/Man/Cisgender Man	39%	N/A/Don't Know	74%
Transgender Male/Trans Man	0%		
N/A/Don't Know	24%		
Nonbinary/Genderqueer	0%		

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	3	6	9
Substance Use Disorders (SUD) Referrals	4	2	6
Other Mental Health (MH) Referrals	1	12	13
TOTAL	**8**	**20**	**28**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	2	Legal	3
Financial/ Employment	0	Medical care	7
Food	1	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	6	Cultural, non-traditional care	0
Other	3	**TOTAL**	**22**

Program Narrative

The Youth S.O.S. team provides telephone de-escalation or in person response to youth and families in crisis, and until all concerns have been addressed by providing trauma informed de-escalation strategies. Clinicians will assess for higher level interventions at the time of initial crisis and will also provide follow-up care as needed/requested by the youth or families. The multi-disciplinary team will provide appropriate resources to the youth and family at the time of response and through follow-up, which may include:

- Linkage to existing services
- Coordination with physician and/or psychiatrist
- Basic needs assessment
- Other community supports.

These interventions support awareness and knowledge of services to underserved population and will support families in better understanding and obtaining access to public health services. The family partners work alongside the family to support them with psychoeducation around mental health and mental health services. Many families that come into SOS services have high stigmas around receiving support from systems of care. The family partners work with them to break down these stigmas in a non-judgmental way. The family partners offer support services to any family that is not already connected to care.

Successes

Over the last year, SOS has been able to support many families when they are in their hardest moments. The team strives to meet clients where they are at in a trauma-informed and culturally appropriate way**.**

Client Story #1: One client was a 17-year-old gay male who was going through their first break up. The referral came in as he was sitting at the top of a parking structure contemplating jumping off. One of the SOS clinicians was able to speak with him and provide crisis de-escalation and a thorough suicide assessment. The SOS clinician was able to get him home safely and began seeing him for individual services in the follow up care. Due to his sexuality, the client did not want his caregivers

knowing about him accessing services. He was able to work with the Youth Peer Specialist to get connected to services that will allow minor consent so that he can continue with therapy services after the follow up services were complete.

Client Story #2: that highlights the culturally appropriate work the SOS team does was with a single mother and her 16-year-old son. The mother called the SOS team after her son came home seemingly intoxicated on cannabis. The mother and her son had immigrated to the US from South America (Venezuela) when her son was 9 years old. The mother had come here for better opportunities for her son and herself (she was enrolled in a nursing program). While mother and son both were proficient in English, they felt more comfortable communicating in Spanish. The team's bilingual clinician was able to come out to their home and provide services in the language both parties felt most comfortable in. The clinician was also an immigrant from South America and was able to build rapport quickly with the family and provide resources to services where the clients cultural identity would be honored and respected.

Challenges

The team faced two main challenges during the FY 2022-23 that both feed into one another. The first challenge is data collection, as mentioned previously. The second challenge that came up was a lack of in-person responses. Since last year the team has become more proactive about offering in-person support to every call. However, the program has not seen the increase it was expecting. This may be in part due to the confusion of who the services are meant for and when it is appropriate to use the service. Most calls received were inappropriate for an in-person response (with the top two calls either being a need of EMS services or that there is no current crisis occurring). To address this challenge, the Youth SOS team will be providing more training in the community about the service and when to call. They will also be attending more tabling and outreach events so that they can interact with the populations that will use the service.

PREVENTION: COMMUNITY ENGAGEMENT AND CAPACITY BUILDING

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 BHRS and in partnerships with communities through the following programs:

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

Program Impact

The Office of Diversity and Equity measures progress along 5 indicators. These definitions are influenced by (1) public health frameworks and (3) ODE's mission, values, and strategy.

- Self-Empowerment – enhanced sense of control and ownership of the decisions that affect one's life
- Community Advocacy (or Community Empowerment) – Increased ability of the community to influence decisions and practices of a behavioral health system that affect their community
- Cultural Humility– heightened self-awareness of community members' culture impacting their behavioral health outcomes; heightened responsiveness of behavioral health programs and services for diverse cultural communities serve
- Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills, and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social and cultural barriers.
- Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions.

ODE (Across all programs)	FY 2022-23
Individual clients served (unduplicated)	1,900
Individuals reached (duplicated)	24,963
Total Individual Reached	26,863

HEALTH EQUITY INITIATIVES (HEI)

In 1998, BHRS workforce employees began to have serious conversations about racial and ethnic gaps within the department's services, including the lack of diversity and cultural sensitivity within the clinical work that the County offered. From these conversations, the staff realized that there was a need to address the access and quality of care issues among underserved, unserved, and inappropriately served communities within the County.

Over time, several priority communities were identified, including African Americans, Chinese residents, Filipinos, Latino/a/x people, Native and Indigenous People, Pacific Islanders, and LGBTQQI people. Out of both opportunity and great need, BHRS created nine Health Equity Initiatives (HEIs) that have become vehicles to promote cultural humility and community empowerment. Each of the nine HEIs addresses health disparities, inequities, and stigma by working collaboratively to bring together mental health professionals, residents, clinicians, organizations, and stakeholders on a regular basis to provide outreach, programs, and advocacy towards meaningful solutions for the communities. HEIs implement activities that are intended to:

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

ODE provides oversight to nine HEIs representing specific ethnic and cultural communities that have been historically marginalized. Below is a high-level statement of purpose for each initiative:

- African American Community Initiative (AACI) aims to be a known resource and support system for African American community members facing challenges with finding and utilizing mental health services while addressing inequalities faced by African-Americans in the County.
- Chinese Health Initiative (CHI) works with the community to empower and to support better outcomes for prevention, outreach, and referrals, while also advocating for services to be in the appropriate language and culturally relevant to community members.
- Filipino Mental Health Initiative (FMHI) seeks to connect and empower Filipinos towards mental health and social services and reducing stigma, while advocating for culturally appropriate services through provider collaboration.
- Latino/a/x Collaborative (LC) promotes holistic practices that integrate Latino/a/x heritage, culture, spirituality, and family values to destigmatize mental health services and treatments in the community.
- Native and Indigenous Peoples Initiative (NIPI) was created to bring a comprehensive revival of Native American community in San Mateo County through awareness, health education, and outreach which honors culturally appropriate, traditional, Native healing practices.
- Pacific Islander Initiative (PII) aims to address health disparities experienced by Pacific Islander families and to help change systems and policies to better meet community needs through awareness, prevention, capacity building, and leadership.

- Using an interdisciplinary and inclusive approach, the PRIDE Initiative seeks to support and advocate for the well-being of lesbian, gay bisexual, transgender, queer, questioning, intersex, and two-spirit (LGBTQQI) communities across the County.
- The Spirituality Initiative (SI) works to build opportunities for community members, families, and providers to collaboratively explore, increase awareness of, and support spirituality and its relationship to health and well-being.
- The Diversity and Equity Council (DEC) is 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.

Program Impact

Health Equity Initiatives	FY 2022-23
Individuals reached (duplicated)	7,763
Total cost per client	$21

** Unable to report unduplicated clients; HEIs focused on broad community awareness and system change strategies (presentations, events and trainings).*

Health Equity Initiatives hosted various events, trainings, and presentations as means of reducing stigma, raising awareness and increasing access to behavioral health services. Overall, HEIs held 23 community-driven events and 21 presentations related to behavioral health and addiction.

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 and meet the Department of Health Care Services' Cultural Competence Plan Requirements (per California Code of Regulations, Title 9, Section 1810.410).

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

One of the goals of the Diversity and Equity Council (DEC) in FY 2022-23 was to implement their strategic plan developed in the last FY 2021-22. This made the DEC more deliberate in the

information and resources shared in its transition from COVID-19 response work to more direct activities to advance health equity. The group identified three areas of focus including:

- serving in an advisory role for BHRS programs and practices
- continuing to be a space of collaboration for community-based organizations and HEIs
- developing a hub of information for San Mateo County communities at large

The DEC's strategic plan helped ground members towards goals and allowed co-chairs to track its effectiveness. High participation and engagement have led to important conversations on how the DEC can continue to advance and encourage new members joining the initiative. Furthermore, DEC has started to explore aspirations to build more youth participation in DEC with the support of an intern and the Health Ambassador Program for Youth. To elevate partners in the County and support efforts of improving linkages for underserved populations, DEC organized the following presentations this fiscal year:

- Latino/a/x Collaborative and Heart and Soul
- StarVista Crisis Center
- Mental Health Association
- Kapwa Kultural Center and Cafe
- Health Plan of San Mateo
- BHRS Quality Management PIP
- MHSA 3-year Planning input session
- BHRS Pharmacotherapy for Opioid Use Disorder PIP
- Mental Health and Opioid Use

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 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:

- Awareness: Increase overall community awareness and involvement of community members in African American Community Initiative

- Utilization/Access: Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.
- Education/Training: Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.
- Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each service area of BHRS.
- Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.
- Outreach: Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out to the African American community.
- Partnership: Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and African American clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments

To reduce disparities in access of care, the African American Community Initiative (AACI) sought to foster deep relationships and connection among African American residents. One of those efforts was illustrated in this year's hybrid Black History Month celebration, which centered around the theme of self-determination and resilience of African Americans. The program included live singing of the Black National Anthem, traditional music from Zimbabwe, resource tabling from several health agencies across the County, intimate talks around COVID-19, Health, Wellness, and Black Mental Health with physicians, and a recognition that honored East Palo Alto African American residents and their many contributions to their communities. In FY 2022-23, AACI hosted the following events:

- Black History Month Celebration
- Juneteenth Celebration
- Black History Month Collaboration with Alameda County

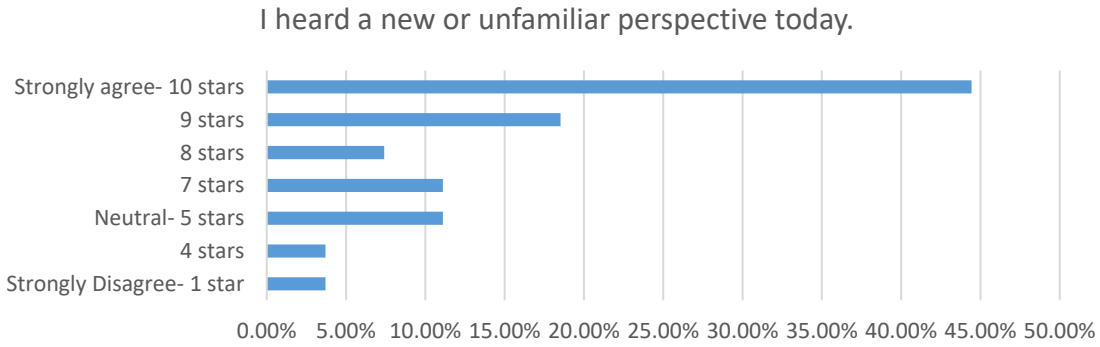
Highlights from the Juneteenth Celebration with Voices of Recovery San Mateo, with the theme of "Discovering/Recovering Our Roots: The Continued Journey of Black Struggle.":

- An estimated 180 participants attended this event in East Palo Alto Academy.
- A total of 19 viewers joined the live-streamed event on Zoom
- 163 demographic sheets were collected with an incentive of receiving a dinner ticket.
- 27 event evaluation surveys were collected in person at the event and a follow-up email after.
- Event partners include Spirituality Initiative, Bay Area Community Health Advisory Council, Stanford Medicine, the County of San Mateo, and San Mateo Behavioral Health and Recovery Service's Office of Diversity and Equity.

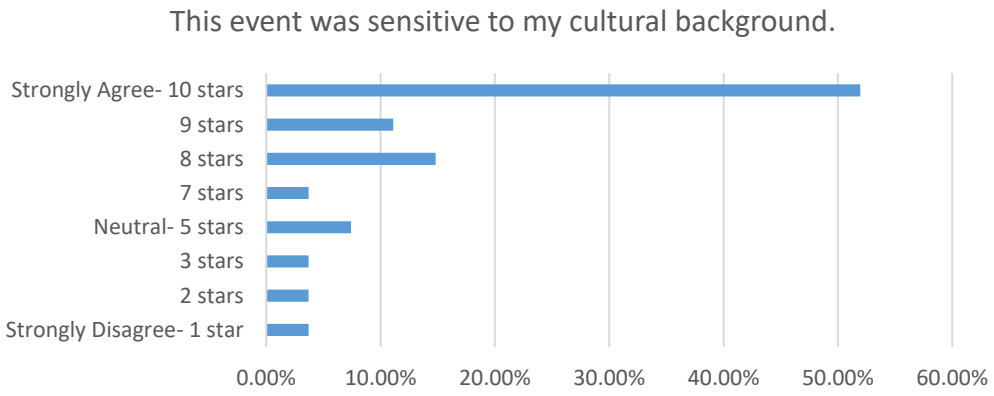
Event Evaluation Responses

- On a scale of 1-10 stars, please rate the number of stars that describes your response.

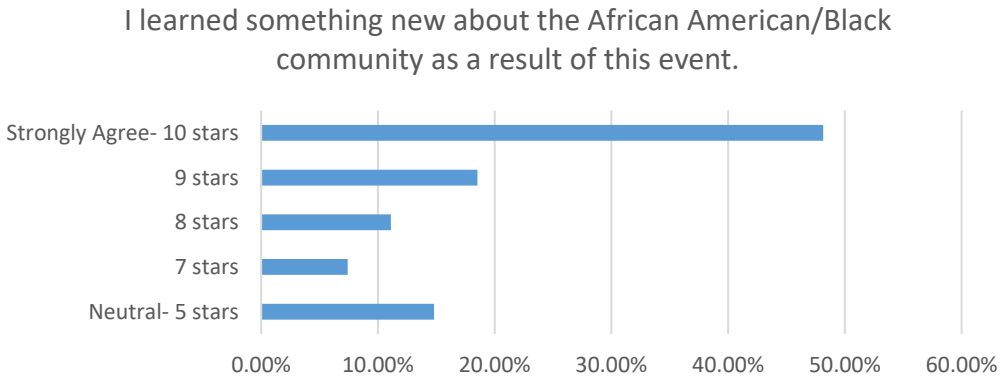
AVERAGE RATING: 8.2 stars



AVERAGE RATING: 8.2 stars

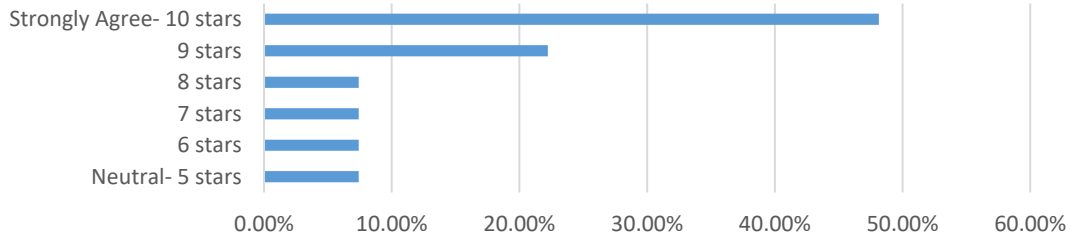


AVERAGE RATING: 8.6 stars



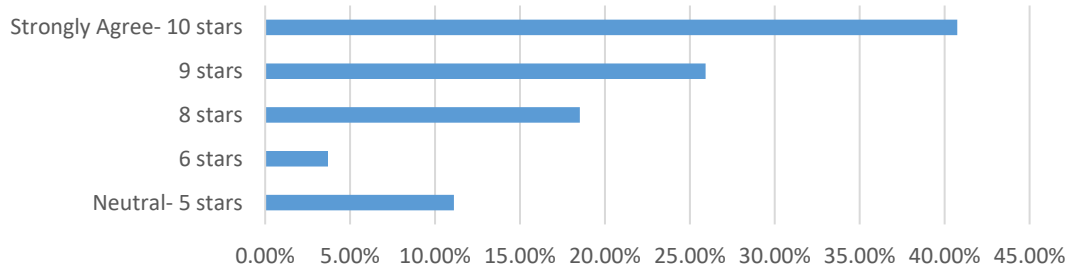
AVERAGE RATING: 8.7 stars

Because of this event, I see new ways to improve mental health/reduce substance use for people areound me.



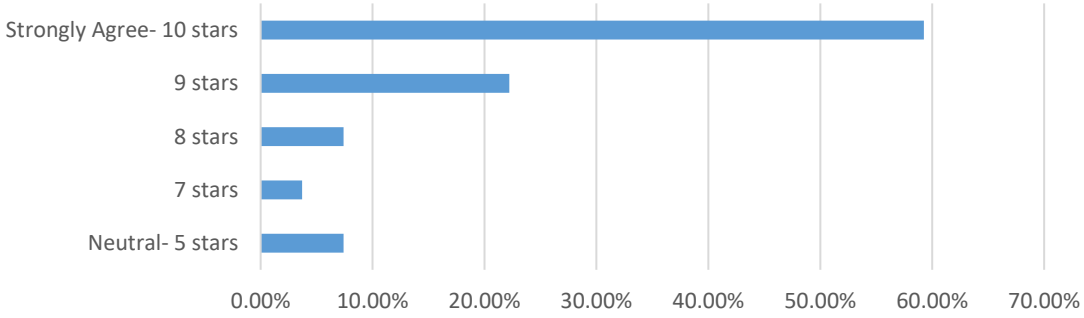
AVERAGE RATING: 8.7 stars

I learned somehting new about behavioral health, mental health, or substance use.

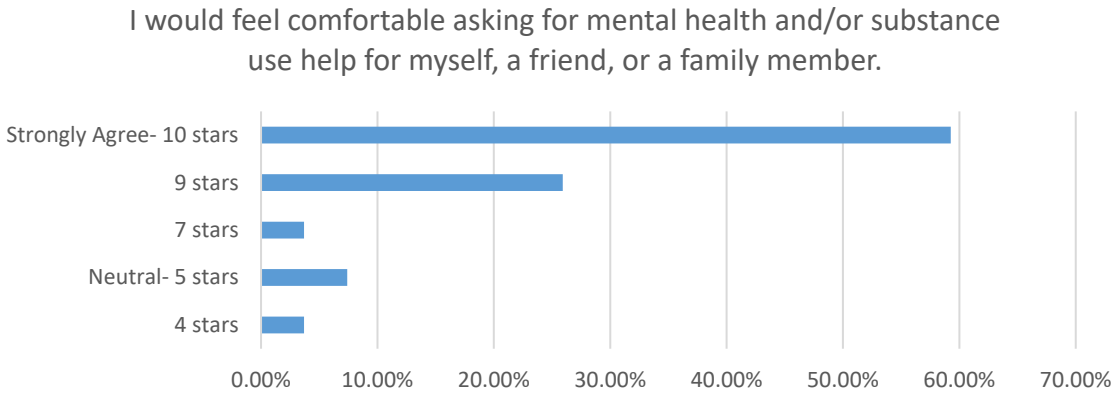


AVERAGE RATING: 9.2 stars

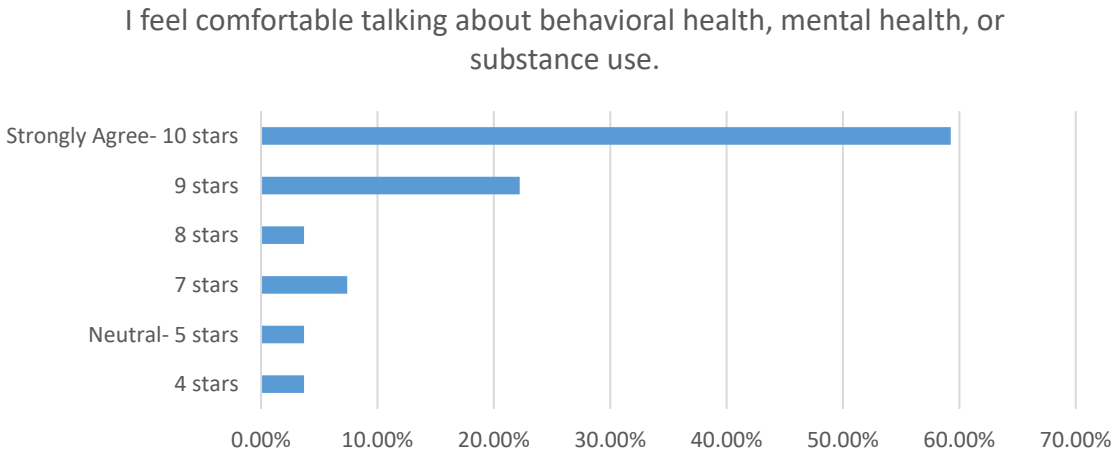
I know whom to contact for mental health or addiction care.



AVERAGE RATING: 9 stars



AVERAGE RATING: 9.1 stars



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 use 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 which has since been funneled into a contract with an outside agency.

Highlights & Accomplishments

During FY 2022-23, the Chinese Health Initiative (CHI) hosted several forums for community members, BHRS staff, and other County stakeholders openly discussed resources and support across the County. In partnership with a variety of organizations, agencies, and County programs, CHI focused this year on providing timely information and education. Below is a list of presentations and training opportunities that CHI organized and hosted:

- Civic Leadership USA
- Heart and Soul Open House
- Chinese Herbs and Dietary Recovery for COVID-19
- Hepatitis B: Screening and Prevention
- Social Security and Disability Benefits
- Health Policy and Planning in San Mateo County
- MHSA 3-year planning community input
- Addiction Treatment
- Community Collaboration Process for Public Health
- Medicare Open Enrollment Updates

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

The Filipino Mental Health Initiative (FMHI) began as an informal gathering of Filipino clinicians from BHRS North County Clinic and local community-based organizations in the 90s with the intent to support and elevate the needs of Filipino families and provide mental health outreach and education. A series of focus groups were 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 MHSA 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

In FY 2022-23, the Filipino Mental Health Initiative (FMHI) has integrated more culturally affirming, relevant, innovative, and diverse practices into their offerings for mental wellness support and building community. FMHI's core intention was to spread a message of hope and foster a sense of empowerment that resonates with members' unique identities and experiences by exploring decolonization and shared experiences of systemic oppression. One significant addition has been the incorporation of *kuwentuhan*, or storytelling, in FMHI workshops like the *Mano Po* Project. This approach was intended to create a safe, open space for members to share their experiences, and to destigmatize mental wellness. Additional presentations organized by FMHI include:

- Kapwa Soul Sessions
- Serramonte District 5 Resource Fair
- Ethnic Studies Filipino/a/x Community Issues
- Visioning Board Workshop: Power of Pause
- City College SF Mental Health Panel
- Daly City Mental Health Month Proclamation

LATINO/A/X COLLABORATIVE

While the Latino/a/x 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/a/x providers met informally to address issues pertaining to health disparities and access within the Latino/a/x community and mental health services. These meetings continued and in 2004, a core group of Latino providers requested a Latino/a/x-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino/a/x providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino/a/x population.

Mission, Vision, & Objectives

The Latino/a/x Collaborative's mission includes critically exploring the social, cultural, and historical perspectives of Latino/a/x residents within San Mateo County. The Latino/a/x 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/a/x Collaborative has defined its mission as:

- Creating stronger, safer, and more resilient families through holistic practices.
- Promoting stigma-free environments.
- Providing fair access to health and social services, independent of health insurance coverage.

- Appreciating and respecting traditional practices.
- Recognizing and incorporating Latino/a/x history, culture, and language into BHRS

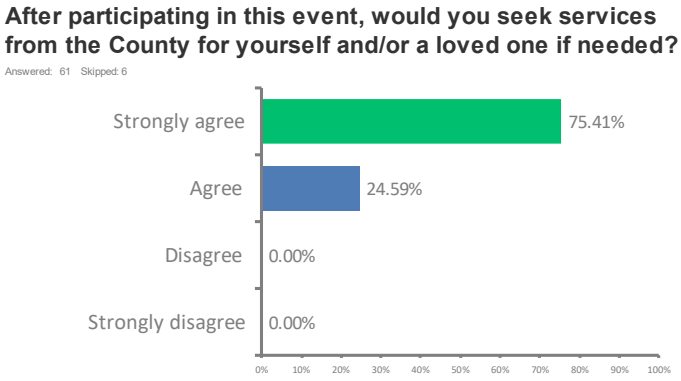
Highlights & Accomplishments

In FY 2022-23, the Latino/a/x Collaborative has increased its focus to centralize community input and become a hub of information sharing. In doing so, LC has had consistent attendance with its members this year and increased the promotion of resources and services for Latinx communities to help fill the health disparity gap among Latinx communities in the County. LC participated and/or hosted the following events and activities:

- Pride Celebration and Parade
- Day of Prayer
- Annual Health Forum "¡Sana, Sana! "Colita de Rana! Cuidate Hoy Para Un Mejor Mañana
- Cesar Chavez Day

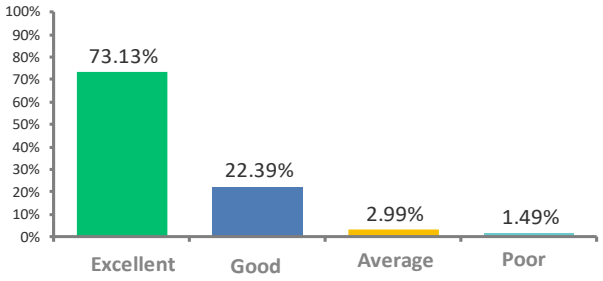
Highlights from Cesar Chavez Celebration- March 31, 2023:

- In partnership with *Voices of Recovery-SMC*, BHRS', *Office of Diversity and Equity*, *Latino Collaborative* hosted a cultural celebration, with the objective of advancing health equity by improving knowledge of and access to community services, such as mental health, recovery, and other county support services, to the Latino/a/x and Filipino/a/x community members.
- In order to empower community members, presentations focused on highlighting the "*Strength and Resilience of Community*," which was the event's theme.
- This event included resource tables, cultural presentations, and gift card drawings.
- Other organizational and agency partnerships included: Voices of Recovery-SMC, (Primary Host); ALAS (non-profit CBO in HMB); Filipinx Mental Health Initiative; San Mateo County Human Services Agency
- Translation and interpretation services were provided in Spanish and English.
- An estimated 140 community members attended the first annual *Cesar Chavez Celebration.*
- 129 participants completed the demographic survey and 67 participants provided feedback through an end-of-event evaluation.



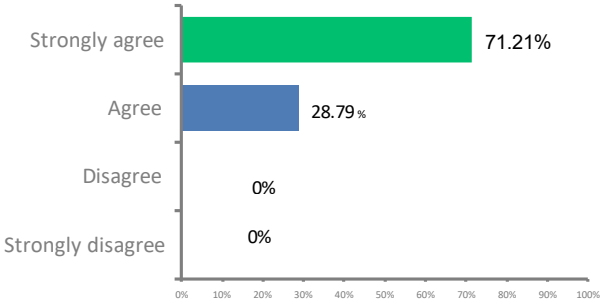
How would you rate this event?

Answered: 67 Skipped: 0



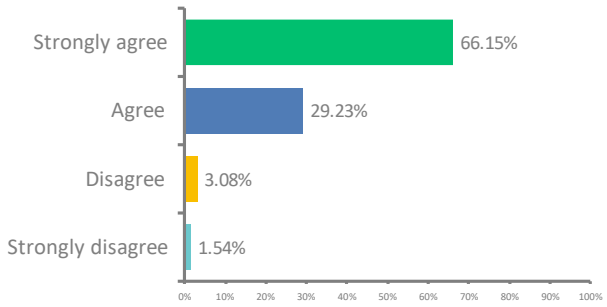
The information presented was current and accurate.

Answered: 66 Skipped: 1



This event was sensitive to my cultural background

Answered: 65 Skipped: 2



NATIVE AND INDIGENOUS INITIATIVE (NIPI)

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

Mission, Vision, & Objective

NIPI has defined its mission as generating a comprehensive revival of the Native American and indigenous community by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices. NIPIs vision is to provide support and build a safe environment for the Native American and indigenous communities. NIPIs goal is to appreciate and respect indigenous history, culture, spiritual, and healing practices. The NIPI strives to reduce stigma, provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners.

The NIPI has further developed and articulated the following objectives:

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

Highlights & Accomplishments

Since its official launch in 2012, the Native and Indigenous Peoples Initiative (NIPI) has been steadily growing impact within the County. This is demonstrated in the most recent development of the Honoring Indigenous People Statement from the County, which sought NIPI's thought partnership and feedback along with the Ramaytush Ohlone Association, the Confederation of Ohlone People and the Tamien Nation. This statement is now being used across the County to open meetings in effort to honor Native Tribes' resilience and build awareness of the original inhabitants of the region. Additionally, NIPI has been invited to offer welcoming remarks and blessings to several behavioral health events throughout the County, including community-based organization partners, Health Equity Initiatives, the Commissions of Disabilities, San Mateo Libraries, and the International Indian Treaty Council. NIPI has offered traditional healing practices including events and trainings, using a clinical lens, that have been well received: n FY 2022-23, NIPI participated and/or hosted the following events and activities:

- Medicinal Drumming
- Native American Historical Trauma

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 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 to address the stigma associated with mental illness and substance use. The PII envisions a healthy community that feels supported by service providers, is accepting of individuals experiencing mental illness or substance use 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 according to four pillars identified by members:

- Service Accessibility
- Sustainability and Funding
- Mental Health Career Pipeline
- Community Partnership

Highlights & Accomplishments

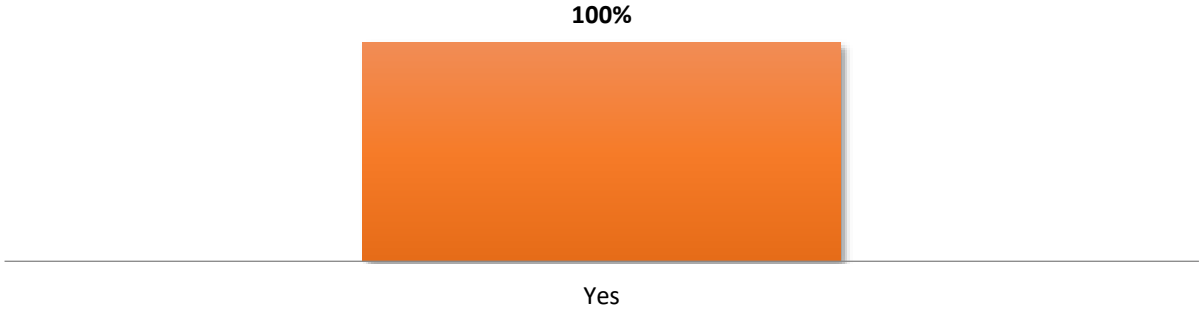
The Pacific Islander Initiative (PII) has continued to focus on reducing stigma and increasing awareness and resources about suicide prevention in Pacific Islander communities. Significantly, in FY 22-23, PII successfully hosted a Pacific Islander Wellness Gathering that brought together community members, behavioral health agencies, and other stakeholders to increase linkages for Pacific Islanders. From this event, many families shared that they were unaware of these services and that they felt more secure knowing that there are Pacific Islanders mental health providers who look like them. An additional activity that PII participated in was in the collaboration with CHI and FMHI to create a May Asian American, Native Hawaiian, and Pacific Islanders Heritage Month Proclamation uplifting the resilience and solidarity across their communities.

Highlights from the Pacific Islander Wellness Gathering:

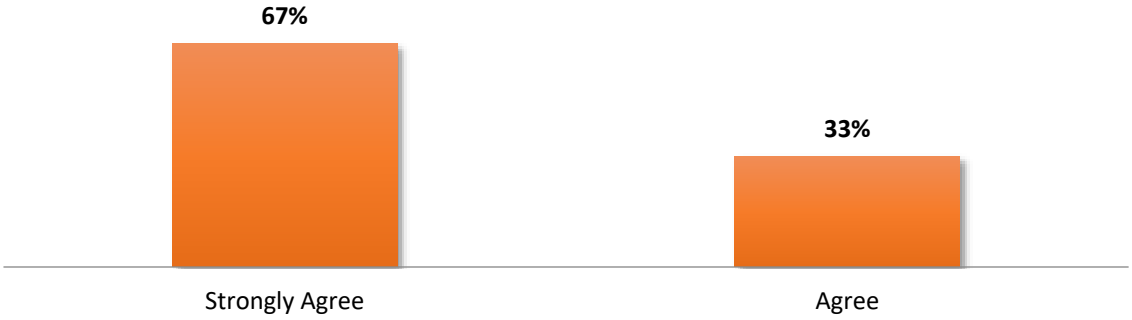
- Over 30 participants attended this intimate event, which was a part of Mental Health Month.
- 7 survey responses were collected using the Event Evaluation for 2023 May Mental Health Month prompts. Survey respondents were entered into a raffle if they provided contact information that were disaggregated from the survey anonymous and voluntary report.
- Data limitations include the following: 4 incomplete demographic sheets.

As a direct result of this program, I have learned more about mental health and/or substance use services that I can reach out to.

As a direct result of this program, I am more likely to believe people with mental health and/or substance use conditions contribute much to society.



support for a mental health and/or substance use condition if I need it.



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).

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 or LGBTQ+) 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 LGBTQ+ issues. PRIDE envisions an inclusive future in San Mateo County grounded in equality and parity for LGBTQ+ communities across the County. PRIDE objectives have been defined as:

- Engage LGBTQ+ communities.
- Increase networking opportunities among providers.
- Provide workshops, educational events, and materials that improve care of LGBTQ+.
- Assess and address gaps in care.

Highlights & Accomplishments

In FY 2022-23, The PRIDE Initiative (PRIDE) has expanded its reach to include even more diversity, collaboration, and intersectionality in its activities and events. Most significantly, as with other years, the PRIDE initiative pours its energy and time into planning and organizing the Pride Annual Pride Celebration—and this year's celebration included the first-ever parade. Especially in the current rollback of LGBTQIA+ rights, the PRIDE initiative pushes opportunities to shed light on the diverse and complex needs of LGBTQIA+ people, to identify and promote LGBTQIA+ services and providers in the local community, and to address transgender violence.

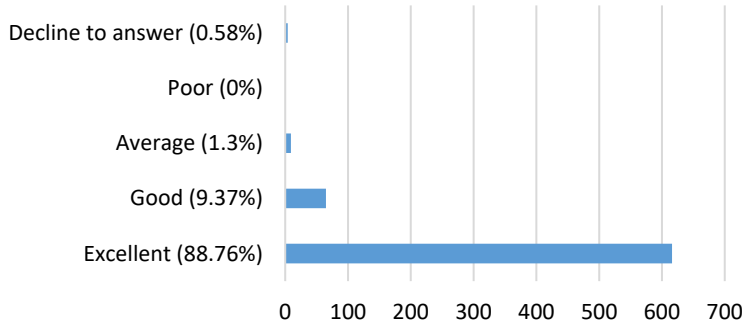
In FY 2022-23, PRIDE participated and/or hosted the following events and activities:

- Pride Bingo
- African American Community Assessment: LGBTQIA+ Focus Group
- MHSA 3 Year Community Session
- TransACTION Day of Change

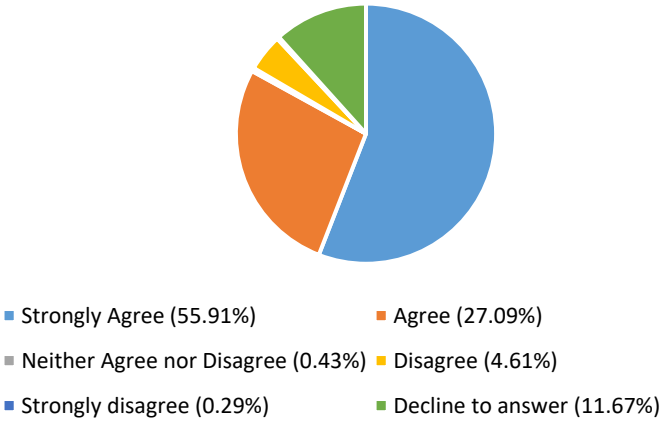
Highlights from Price Day Celebration:

- An estimated 4,000 people joined the Pride Celebration and First-ever Pride Parade in San Mateo County.
- 694 participants provided feedback through a survey for this event.

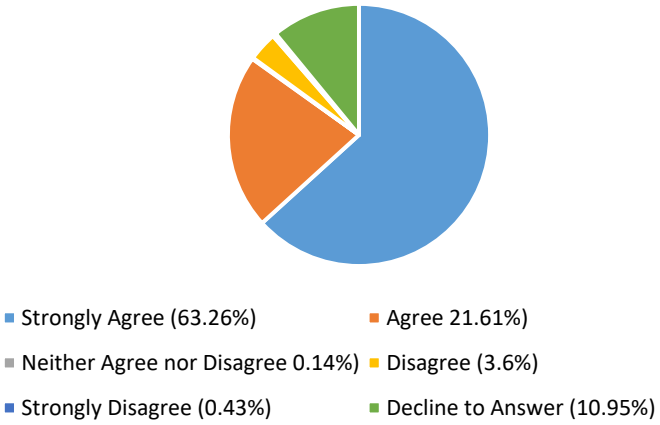
How would you rate this event?



I know where to obtain services from San Mateo County for mental health and/or substance use conditions.



This event was sensitive to my cultural background.



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:

- 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.

Highlights & Accomplishments

In FY 2022-23, the Spirituality Initiative (SI) has provided a backbone and support to its members, other HEIs, and beyond to embody hope in the County. For instance, at SI monthly meetings, members have consistently volunteered to take responsibility of sharing a meditation for the group, ranging from prayers and poems to testimonies that ground is in the collective humanity, faith, and recovery journeys. This simple, yet profound practice, offers a pathway to reduce stigma and to implement recovery principles into the core of SI. Furthermore, SI has helped lead two successful presentations for older adults in Daly City in partnership with Mental Health Month, Chinese Health Initiative, Aging and Adult Services, Northeast Medical Services, and Daly City. These presentations highlighted the growing concerns of scams and social isolation within older adults. Lastly, SI has notably empowered community members to outreach and promote mental health resources at several community events.

Highlights from the two-art workshop series for older adults and adults with disabilities:

- Topics were Scam Prevention and Social Isolation
- Other organizational and agency partnership include: the City of Daly City, North East Medical Services, Self Help for the Elderly, San Mateo Aging and Adult Services, Commission on Aging and the San Mateo Behavioral Health and Recovery Services Office of Diversity and Equity Chinese Health Initiative
- Translation and interpretation services were provided in Chinese (Cantonese).

HEALTH AMBASSADOR PROGRAM - ADULT

BHRS Health Ambassador Program (HAP) was created in 2014 out of a desire for community members, who are committed to helping their families and neighbors, improve their quality of life, continue learning, and increase their involvement in community services. To become a Health Ambassador, community members must complete 5 of the 11 courses offered: The Parent Project, Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA), Wellness Recovery Action Plan (WRAP), NAMI Family to Family, NAMI Basics, Applied Suicide Intervention Skills Training (ASIST), Photovoice Project, Digital Storytelling, Stigma Free San Mateo, and the Lived Experience Academy. The BHRS Health Ambassador Program was created in recognition of the important role that community members serve in effectively reaching out to others. HAP goals include:

- Increase community awareness of services available in San Mateo County and help connect individuals to appropriate care and support.
- Reduce the stigma of mental health and substance use.
- Improve the community's ability to recognize the signs and symptoms of mental health and/or substance use issues and implement social change.
- Foster community support and involvement in BHRS' vision to improve services.
- Assist communities in practicing prevention and early intervention, leading to healthier and longer families.

Program Impact

Health Ambassador Program	FY 2022-23
Clients served (unduplicated)	63
Cost per client	$2,420
Individuals reached (duplicated)	5,000

** Unduplicated clients served include only the Health Ambassadors that were engaged during the FY, individuals reached includes the community that received training, education, workshops, etc.*

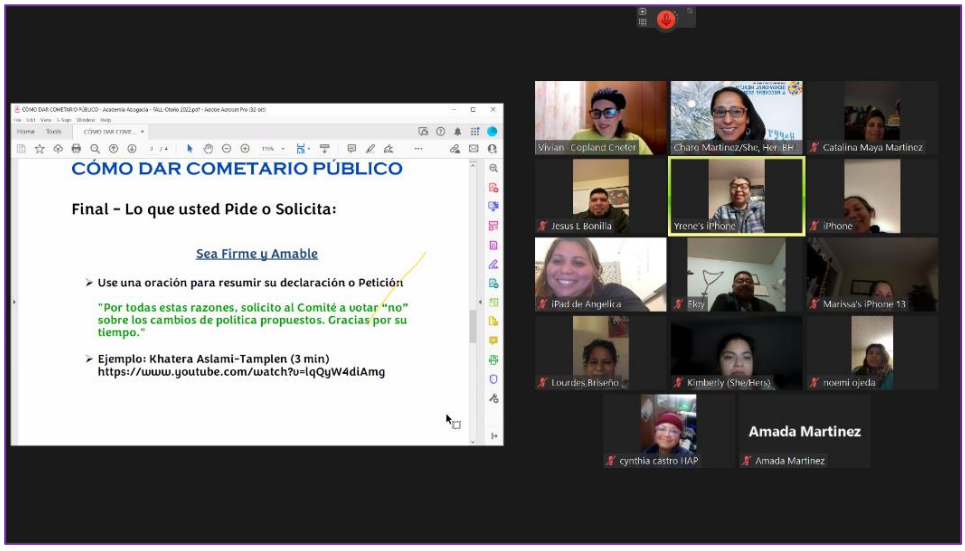
Program Highlights:

- Process for supporting resource tables during events established: Due to an increase in tabling opportunities at events throughout San Mateo County this year, Ambassador support was streamlined, and guidelines were set to direct future Ambassadors/volunteers to engage

community, collect demographic data, and distribute resources on behalf of BHRS Office of Diversity and Equity (ODE). HAP supported 24 resource tables, reaching over 1,600 people.

HAP's behavioral health resources table at the Transgender Day of Change (right) and the San Bruno Children's Book Fair (left).

- Trainings: To build capacity, HAP collaborated with the Office of Consumer and Family Affairs (OCFA) to host an Advocacy Academy for current health Ambassadors to improve engagement skills and sharing of information with BHRS & County leadership. The Advocacy Academy training was provided for the first time in Spanish. Health Ambassadors requested this training in a MHSA 3-year planning meeting in 2020. Specific trainings were provided in response to unique Ambassador needs around behavioral health topics.



"With the guidance we received in this training, we were able to organize ourselves [Ambassadors], have clarity, be specific and to the point to attract attention and communicate better. Thank you for the opportunity to be part of Advocacy Academy, the first in Spanish. With the tools provided, I feel empowered to use my voice and defend my rights." BHRS-Ambassador

"Thanks for this training. I learned that it is easier to understand the system when we are educated about the issues that we so not dare to talk about and ask for help. Also, I feel I need to practice on talking to the point when I do a public comment or advocate for myself and children." BHRS-Ambassador

- Response to community needs: HAP was key in responding to the mental health needs of families and students at Aragon High School following the suicide of a student in late 2022. As a request from the school administrators, HAP in collaboration with KARA Grief Support, and BHRS, hosted a healing circle for families and subsequently, provided trainings around suicide prevention and accessing BHRS services for the broader Aragon High School community. This resulted in 8 parents from the school to become Health Ambassadors to further their knowledge/participation and led to a greater partnership with the San Mateo Unified High School District to distribute suicide prevention trainings/resources across the district. This also created an opportunity for Ambassadors to take a leadership role in this work and expand their scope to become facilitators of these trainings.

  Another significant collaboration included the participation of HAP in the March 15th Jackie Speier Dialogue with Latinx Mothers. Retired Congresswoman Jackie Speier, San Mateo County Health Director Louise Rogers and ODE hosted a virtual event to better understand the needs of Latinx mothers. BHRS Health Ambassadors attended and provided authentic and compassionate dialogue on concerns around access to services, behavioral health needs for children, economic and employment challenges, and the desire for youth support in different areas of their lives. Ambassadors shared thoughtful recommendations and hopes for mothers balancing many needs to provide the best life for their children.

- Working with Resource Development Associates (RDA) to improve data collection & identification of trends: In FY 2022-23 HAP worked with RDA, a consulting group, to develop a data collection plan and tools to track demographics, social determinants of health and referrals provided to Health Ambassadors and their families and data from event participants – prospective ambassadors. While better data analysis tools and improved report systems will be explored in FY 2023-24, the information to date has emphasized an increase in the number of Ambassadors who are recipients of U-visas and that more than 80% who entered BHRS/HAP to support their children's or family members mental health needs are now receiving BHRS services for themselves. Such findings highlight the support, stigma reduction, and warm hand-off HAP can foster for Ambassadors and participants. In addition, through a new referral tracking system, HAP will be able to report next fiscal year the cases where the mental health and substance use referrals are provided to other agencies, and within BHRS.
- Role expansion from recipients to facilitators: To address the high need for community

outreach and support, Ambassadors were trained to facilitate Parent Project, NAMI Basics, Stigma Free San Mateo, and *Reconozca Las Señales* (Know the Signs) trainings. Building capacity of ambassadors to provide these trainings through the lens of their own lived experience has not only expanded the reach of these important trainings and the promotion of BHRS services but improved connection with training attendees.

- Team building: This year HAP worked on strategies to promote team identification, unification, and sense of belonging within BHRS. From more preparation sessions to support events to program promotional materials, this created a sense of empowerment and encouragement to expand participation. Also, HAP paired experienced with new Ambassadors from different cultural backgrounds to increase capacity building, inclusion, and experience in supporting training and events.

- During FY 2022-23, BHRS Health Ambassadors' work expanded to partner organizations such as Heart and Soul Inc., NAMI San Mateo, and NAMI National, where they volunteered to support patients and community members. By participating as Board Members, Commissioners, Facilitators, and Wellness Coaches, and sharing their lived experienced, knowledge and advocacy, the Ambassadors helped shape the mental health system to improve services and reduce stigma.

  "I serve both peers and family members. In the classes and the support groups I facilitate, I reach a large group of people to whom I refer different services. It is a calling to help others; for me, it's especially in the mental health field. I have a passion for what I do, and helping others fulfills me". BHRS-Ambassador

Successes

In FY 22-23, HAP continued to expand supports for BHRS-Ambassadors and community at large. There was an increase in participation in a variety of events and interventions. There was also a focus on building Ambassador capacity to facilitate BHRS information to the public and to also provide information back to BHRS on the client/consumer experience including being part of focus groups for MHSA Community Planning Process and the Behavioral Health Commission on Children & Youth Services Committee. Improvements in data collection also allowed for trends to be identified to better inform future activities and resources. There are currently **65 Ambassadors** that are active and provide varying supports for BHRS services, outreach, and early interventions.

- ODE staff support: The addition of ODE staff this year helped improve data collection, data logging, and following up on interested community members in joining HAP. Additional staff support also helped the program coordinator dedicate more 1:1 support for individual Ambassadors and the development of HAP to support other departments within BHRS and San Mateo County.

Challenges

There remains a need to find tools to identify ways to collect and report data to showcase the extraordinary work that BHRS-Ambassadors do to refer people to mental health and substance use services both within BHRS and to outside services. In the next fiscal year, the HAP team plans to update the HAP data collection tools, including updating all training data collection forms, and to utilize a data collection platform to retrieve the information collected at resource tables, and through the Social Determinants of Health questionaries and the HAP annual evaluations.

INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ADULT MENTAL HEALTH FIRST AID (MHFA)

Adult Mental Health First Aid (AMHFA, the program, or the course) is an 8-hour public education provided by the BHRS Office of Diversity and Equity (ODE). The course introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. AMHFA aims to teach community members and partners in San Mateo County by:

- Incorporating culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to marginalized populations in a more culturally responsive way.
- Sharing mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.
- Sharing local resources participants can refer to for professional behavioral health support, including public health services.
- Partnering with agencies that connect marginalized communities to care, including those serving older adults and immigrant communities to reduce disparities in access to care.

BHRS ODE works in partnership with other community organizations to facilitate AMHFA courses. Between July 2022 – June 2023 (FY 2022-23), BHRS ODE contracted with trained instructors from Peninsula Conflict Resolution Center and Hope Oriented Wellness to facilitate courses, in addition to individual contractors. Course instructors provided 10 AMHFA courses to over 124 participants. Course participants include community members from a variety of backgrounds.

In addition to the AMHFA course offerings, participants complete five surveys throughout the program to assess course outcomes. The five forms include (1) an application, (2) a pre-program survey, (3) a post-program survey, (4) a course evaluation form, and (5) a six-month follow-up survey. These surveys collect demographic and contact information. These surveys also evaluate outcomes by assessing participants' confidence and changes in knowledge about mental health concepts.

AMHFA aims to teach community members and partners in San Mateo County about mental health risk factors, warning signs of mental health problems, and the importance of early intervention. The course also builds participants' skills in how to help an individual in crisis or experiencing a mental health challenge, shares information about mental health concepts, and disrupts common misconceptions about mental health. Surveys collected from AMHFA participants demonstrates course outcomes aligned to each of these aims.

Specifically, AMHFA incorporates culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way. As a result, AMHFA seeks to improve timely access and linkages for underserved populations.

AMHFA also partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth. Moreover, AMHFA participants come from a diverse range of experiences, including a diversity of spoken languages, races, ethnicities, and group affiliations. Through this diverse program reach, AMHFA effectively reduces disparities in access to care. Finally, AMHFA implements the recovery principles of support since participants are equipped with knowledge that empowers them to provide hope and support to those facing mental health issues in their everyday lives.

Program Impact

Adult Mental Health First Aid	FY 2022-23
Total clients served	124
Total cost per client	$580

As aforementioned, the five forms collected from participants to assess course outcomes include: (1) an application (n= 119) and (2) pre-program survey (n= 107), (3) a post-program survey (n= 86), (4) a course evaluation form (n= 78), and (5) a six-month follow-up survey (n= 9). The application gathers demographic and contact information and assesses participants' confidence to apply mental health first aid concepts in real life. The same questions are asked in the post-course evaluation form in addition to other post-course questions. After six-months of course completion, participants are invited to answer the same set of questions as those in the application and evaluation form. In addition, participants are asked to complete a pre- and post-program survey to assess their change in knowledge about mental health concepts. Analysis of pre- and post-program surveys requires that an individual complete both surveys and answer all questions. Incomplete data, such as when a participant only completed either the pre- or post-survey rather than both or skipped individual questions, were not analyzed.

There was an increase in correct answers across all questions from the pre-program to post-program survey, indicating that the course effectively communicated educational material on mental health. Specifically, participants' awareness of the signs of a mental health episode and knowledge about common mental health disorders increased notably. For example, the following two questions had the most significant increase in correct responses from the pre to post survey:

"People with mental illness are more likely to commit violent crimes." (Pre: 66% said 'False'; Post: 91% said 'False')

"You should not ask someone if they are feeling suicidal because it will put the idea in their head." (Pre: 81% said 'False'; Post: 94% said 'False')

Additionally, participants were also asked about their confidence in assisting someone in crisis or experiencing a mental health challenge prior to the course through the initial application and after the course through the six-month follow-up survey. Based on the results, all indicators of confidence increased by 50 to 56% from course application to the six-month follow-up survey, with all or nearly all respondents indicating confidence in each area. The three questions with the most significant increase in sense of confidence from the pre- to post-survey were:

"I feel confident that I can…Recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crises." (Pre: 44% Strongly agreed or agreed; Post: 100%)

"I feel confident that I can…Assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help." (Pre: 22% Strongly agreed or agreed; Post: 78%)

"I feel confident that I can…Assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports." (Pre: 33% Strongly agreed or agreed; Post: 89%)

The course evaluation form also assessed whether participants have a better understanding of how mental health and substance use challenges affects different cultures after participating in the course. Through the course evaluation form, 79% of participants (N=57) agreed or strongly agreed with the statement: *"As a result of this training, I have a better understanding of how mental health and substance use challenges affects different cultures."* In comparison, only 50% of these same participants agreed or strongly agreed with this statement in their application prior to the course. This comparison shows that there was a 29% increase in understanding at the point of the evaluation.

Additionally, the course evaluation form assessed cultural relevance of the course by asking participant agreeability to the following statement: *"This training was relevant to me and my cultural background and experiences (race, ethnicity, gender, religion, etc.)."* Through the evaluation (N=78), 81% of participants agreed or strongly agreed with this statement, acknowledging that the AMHFA course was culturally relevant to most participants.

Findings from the pre- and post-program surveys indicate that participants gained knowledge about various mental health concepts and about intervening in a mental health crisis as a result of the AMHFA course. Additionally, a comparison of pre-course application responses to post-evaluation responses indicates that participants gained a sense of confidence in translating concepts learned in AMHFA to real-life. Thus, participants not only learned mental health first aid concepts, but also felt confident in doing so in their work and out in the community. With this knowledge and skillset, AMHFA participants are better equipped to reduce the duration of untreated mental illness, prevent mental illness from becoming severe and disabling, and reduce negative outcomes that may result from untreated mental illness.

Successes

The San Mateo AMHFA program is proud of the knowledge the course imparts on participants and the impact the course has on participants' ability to apply concepts and skills in real-life. With these skills, program participants can provide essential support to community members during these highly stressful times. Participants who completed the six-month follow-up survey provided examples of them recognizing signs of a mental health crisis, reaching out and listening to those who were experiencing a mental health or substance use challenge, and connecting others to services, such as drug counseling and therapy. In addition to the data gleaned from the program surveys, the following participant testimonials convey the impacts of the program:

"[I was] speaking to a friend who was depressed, and I recognized signs and offered some therapists to see if she wanted. We spoke about counseling, and she felt comfortable enough to attend the session." - Six-Month Follow-Up Assessment Respondent

"*Friend texted with [a] hopeless message. We talked. I listened. They were not experiencing suicidal thoughts. I left the door open to talking further [and] my friend expressed a plan to continue professional support. I followed up with a text the next day*." - Six-Month Follow-Up Assessment Respondent.

Challenges

The COVID-19 pandemic and other local and global crises required urgent attention from contracted agencies and their staff. As a result, AMHFA was offered to a lesser extent than in previous pre-pandemic years. Additionally, pandemic-related health orders required contracted agencies to only provide AMHFA classes virtually, which resulted in low participation. This shift to virtual facilitation also resulted in data collection challenges as participants could only complete evaluation forms online via SurveyMonkey, which limited participation due to digital literacy and technology availability. Additionally, challenges with the survey platform features and the length of the online assessments also affected assessment completion rates.

Although the data collected from participants offered valuable insight into the participant profile and experience as well as program outcomes, as with any evaluation, there were limitations to data collection that impacted the analysis and presentation of data:

- Data were only available for eight of the 10 classes offered during FY 22-23. In addition, for each of the eight classes, participants did not always complete all forms. Moreover, because data collection happened at several points in time, the number of respondents varied by form and a very small number of participants completed all five forms (n=8).
- The response rate (n=9) is especially low for the six-month follow-up assessment, which limited the program's ability to analyze the impact of the course six months after completion and does not allow for the generalization of results and findings from this evaluation.

Despite the many challenges, the COVID-19 pandemic also brought to light opportunities. First, the shift to virtual instruction allowed AMHFA to reach individuals who would not have been able to attend the courses due to transportation barriers. Specifically, the National Council for Mental Wellbeing ('National Council') created a curriculum to support virtual learning through both the "Blended Virtual" and "Blended In Person" course offerings, where participants can either complete the pre-work and the course partially or completely online. Additionally, class schedules were adjusted to support virtual facilitation. As a result, AMHFA leveraged these advantages by continuing to offer virtual and blended models in the current fiscal year while reinstating in-person courses. By offering courses in a variety of modalities, AMHFA sought to address barriers and increase accessibility for a wider array of participants.

Demographics

During FY 2022-23, AMHFA contractors served at least 124 participants across 10 classes. The AMHFA course served a diverse group of community members and partners in San Mateo County. The age of AMHFA participants ranged from 18 years old to over 60 years old, with two-thirds of participants (65%) between 26 and 59 years old.

Participants reported representing a variety of groups, with the most common identifiers being community members (37, 30%), providers of health and social services (11, 9%), and family members of a consumer/client (7, 6%). Notably, a large portion of participants selected multiple group affiliations (26, 21%), further supporting that AMHFA had participants representing many different capacities and fields ranging from education to healthcare.

Age Groups	%	Primary Language	%
18-25	8%	English	65%
26-59	65%	Spanish	13%
60+	18%	Cantonese	9%
Declined to State	4%	Another language	6%
Unknown/Not Reported	5%	Unknown/Not Reported	6%
Gender	**%**	**City of Residence**	**%**
Female/Woman/Cisgender Woman	63%	South San Francisco	24%
Male/Man/Cisgender Man	21%	Daly City	0%
Another gender	2%	Pacifica	0%
Decline to state	8%	Millbrae	13%
Unknown/Not Reported	6%	Belmont	5%
Race and Ethnicity	**%**	San Mateo	5%
Asian or Asian American	27%	Half Moon Bay	15%
White or Caucasian	27%	San Francisco	10%
Black or African American	4%	Another city	17%
Hispanic or Latino/a/x	14%	Unknown/Not Reported	12%
Bi- or multi-racial	14%	**Group Representation**	**%**
Another race or ethnicity	6%	Community member	30%
Decline to state	4%	Providers of health and social services	9%
Unknown/Not Reported	6%	Family member of client	6%
		Provider of behavioral health services	9%
		Multiple group affiliations	21%
		Another Group	9%
		Decline to state	15%

MENTAL HEALTH AWARENESS AND #BETHEONESMC CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative and aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. #BeTheOneSMC can mean many things to different people. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in the community.
Primary program activities and/or interventions provided include:

- Annual May Mental Health Month (MHM) Observance: This is one of the biggest mental health observances of the year for San Mateo County. San Mateo County aligns with the statewide efforts and 2023 theme "#Share4MH."
- Planning Committee: which provided guidance and oversight for the 2023 MHM countywide virtual and in-person events. Planning committee members included clients/consumers, family members, county staff and community-based organization staff. Planning committee meetings convened from March to June 2023.

Image: 2023 MHM Planning Committee, April 17, 2023

- Advocacy Days: are various days in April and May where community members can make public comment and advocate for mental health at local city and county meetings that proclaim May Mental Health Month. The County of San Mateo and 17 out of 20 San Mateo County cities proclaimed 2023 May Mental Health Month (up from 15 out of 20 in 2022). In 2023, the County and 7 local cities (up from 5 cities in 2022) also expressed support for May Mental Health Month by lighting up their government buildings in green (up from 5 cities in 2022); the 7 cities include Brisbane, Hillsborough, Millbrae, Pacifica, Redwood City, San Carlos,

and South San Francisco. Like previous years, one city (Half Moon Bay) raised a green flag on their government building to also show support for May Mental Health Month.

Image: San Carlos, May 2023


Image: South San Francisco, May 2023

- Mini-Grants and Event Support: is an opportunity for County and community partners to apply for modest amount of monetary funding and event support for their May Mental Health Month event. The process includes application, selection, event support, deliverable review and fund disbursement. Event Support includes:
    - Input/ideas on event theme, programming, communication/outreach and logistics (up to 2 hours consultation)
    - Speakers with lived mental health and/or substance use experience
    - Digital stories for screening
    - Photo voices for exhibits
    - Event templates (flyer, presentation slides, chat script)
    - Event promotion on website and social media (Facebook, Twitter, blog and email)
    - Interpretation/translation with County Health Contractors
    - Mini-Grants ranged from $200-600. A total of $2,500 of mini-grant funding was distributed to 7 grantee recipients, including the following:
        - Cabrillo Unified School District (Caroline Morton)
        - California Clubhouse (Erica Horn)
        - City of Belmont (Brigitte Shearer)
        - iVisualeyez (Jack Vu)
        - San Carlos Parks and Recreation Youth Center (Emma Licko)
        - Star Vista (Allie Rogge)
        - Youth Community Service (Taz Stahlnecker)
- Reaching Diverse Audiences: is one of the measures of success for San Mateo County's May Mental Health Month. One way to reach this goal is to prioritize Mini-Grant applicants who may reach to diverse communities in high need of mental health resources, including (but not limited to) the following groups:
    - Children, Youth and Young Adults (0-17 and 18-25 years)

- Older Adults (55+ years old)
- LGBTQ+ community
- Men or boys
- Women or girls
- People of color or racial/ethnic minority
- Veterans
- Immigrants
- People without stable housing

- Communication Campaign: which promoted May Mental Health Month through the following below communication channels. New graphics and content align with the statewide #Share4MH campaign.
  - Website included schedule of events, ways to get involved and resources for behavioral health
  - Social Media campaign included 9 social media posted across San Mateo County Health Facebook, Instagram, Twitter and BHRS Blog. Among Facebook, Instagram, Twitter, the hasthtag #Share4MH was featured and shared by organizations and individuals, including, StarVista, City of Brisbane and County of San Mateo
  - Email Blasts – 5 weekly email blasts staff and community partners
  - Outreach Materials – created and mailed by state and distributed by Mental Health Month Planning Committee and County staff.

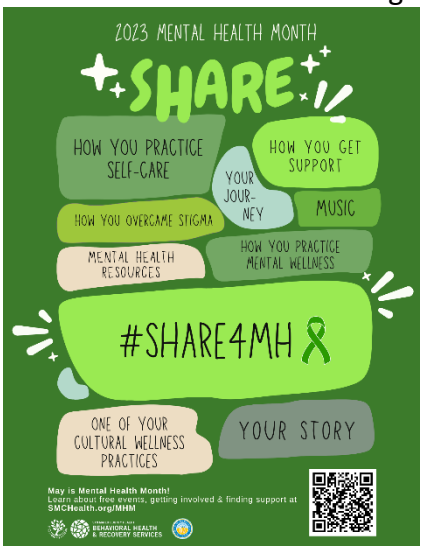


Image: Promotional Flyer for 2023 May Mental Health Month


Image: Outreach Material Distribution, April 27, 2023

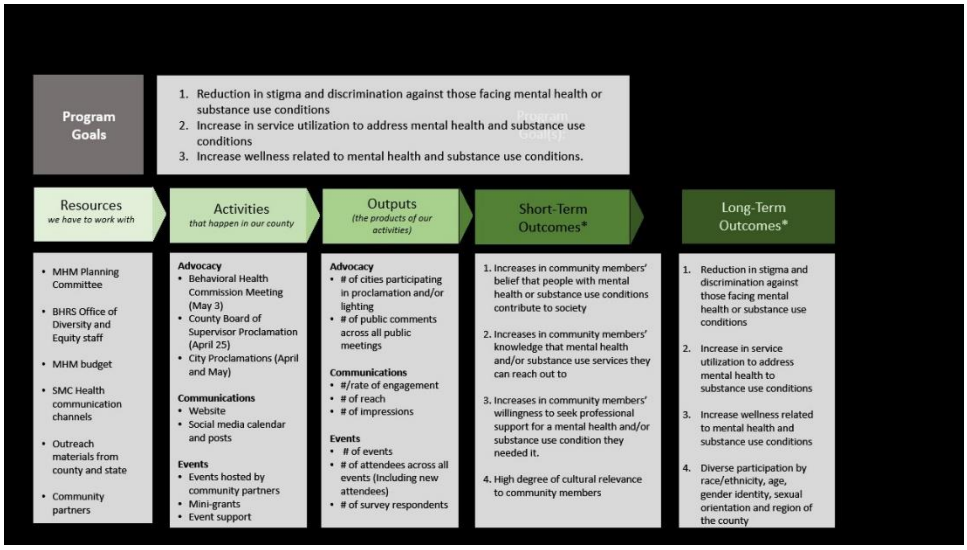
Program impact

Mental Health Awareness	FY 2022-23
Total unduplicated individuals served	1200
Total duplicated individuals served	17,200
Total cost per client	$123

The #BeTheOneSMC (Stigma Discrimination Reduction) initiative:

- Improves timely access and linkage to treatment for underserved populations (#1) and increases the number of individuals receiving public health services (#3) by raising awareness in the community about behavioral health resources through online communication and outreach.
- Reduces stigma and discrimination (#2) by providing education and sharing stories of those with lived experience through community advocacy days, events, and communication campaign.
- Reduces disparities and inequities to access to care (#4) by hosting activities that target specific marginalized communities in different regions of the county. For 2022-23, specific marginalized communities targeted including youth, older adults, veterans, and Pacific Islanders.
- Implements recovery principles (#5) by integrating key recovery principles (particularly individualized and person-centered, respect, and hope) in the communication messages and framing of events.

Logic Model: this 2023 May Mental Health Month was the first year a logic model was created and used. Not all metrics were collected and reported.



Events: There was a total of over 23 MHM events with an estimated reach of 1,200 individuals. 83 survey responses were collected from 13 out of 23 events. Results are shown below

- 93% (77/83) agreed or strongly agreed that as a direct result of this program, they have learned MORE about mental health and/or substance use services that they can reach out to.
- 82% (68/83) agreed or strongly agreed, that as a direct result of this program, they are MORE willing to seek professional support for a mental health and/or substance use condition if they need it.
- 88% (73/83) agreed and strongly agreed that this program was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc)
- 88% (73/83) agreed or strongly agreed that as a direct result of this program, they are MORE likely to believe people with mental health and/or substance use conditions contribute much to society.

Communications:

- Website - total page views = 2,083 and unique page views = 1,434
- Social Media - ~15,000 people reach on posts and ~487 engagements
- Email blasts emailed to below distribution lists and # of subscribers.
    - BHRS All Staff: # of subscribers: 500
    - BHRS Office of Diversity and Equity: # of subscribers: 2188
    - Suicide Prevention Committee: # of subscribers: 289
    - May Mental Health Month Planning Committee: # of subscribers: 210

Successes

ODE is especially proud of supporting the Spirituality Initiative which co-organized a two-part workshop series during Mental Health Month for older adults and adults with disabilities. The topics were covering Scam Prevention (May 15, 2023) and Social Isolation (May 30, 2023). Both events were held at the Doelger Senior Center in Daly City and included resource tables, presentations, and gift card drawings. Other organizational and agency partnership include: Chinese Health Initiative, the City of Daly City, Northeast Medical Services, Self Help for the Elderly, San Mateo Aging and Adult Services, Commission on Aging and the BHRS Office of Diversity and Equity Chinese Health Initiative. Translation and interpretation services were provided in Chinese (Cantonese). For each of the two events, there were about 50 demographic survey responses received. Around 30 event evaluations were received for each of the events. One BHRS older adult client stated, “Thank you for your email and your admirable leadership efforts in making San Mateo County celebrating Mental Health Month a great success with an event addressing older adults & Isolation to raise awareness!! Thank you on behalf of community members and look forward to seeing these informative resourceful events in the future” (BHRS Client).

Image: Social Isolation Event, Doelger Senior Center, May 2023

Challenges

The main challenges and areas of growth relate to broadening reach and increasing response rate to evaluation. While 2023 May Mental Health Month improved in terms of a wider reach, particularly marginalized communities, there is still a lot to grow and improve upon in this area. Like what was stated in last fiscal year's report, solutions to mitigate the challenge of broader outreach include:

- Create a communication map with special emphasis on marginalized communities with greater behavioral health need (based on available county or state data)
- Targeted outreach (e.g., newsletters, radio, online forums, chat, print)

2023 May Mental Health Month also collected more evaluations than the previous year. Nevertheless, it would be ideal if the evaluation response rate was higher, and respondents were more reflective of the demographics of the San Mateo County community.

Demographics (N=83)

Age	**%**	**Gender Identity**	**%**
Age 0-25	216%	Male/Man/ Cisgender	33%
26-59	57%	Female/ Woman/ Cisgender Woman	60%
60+	18%	Transgender Male	0%
decline to state	0%	Questioning	0%
Race/Ethnicity	**%**	Genderqueer/ Nonconforming	1%
Asian or Asian American	27%	Another gender identity	0%
Black/ African- American	4%	Decline to state	1%
White/ Caucasian	41%	Transgender Woman	0%
Latino/a/x or Hispanic	22%	**Disability/ Learning difficulty**	**%**

Native Hawaiian or Pacific Islander	5%	Physical/ mobility disability	N/A
Declined to State	1%	Chronic health condition	N/A
Another race/ ethnicity or Mixed Race	0%	Cognitive Disability	N/A
Sexual Orientation	**%**	I do not have a disability	N/A
Gay, lesbian, homosexual	7%	Another disability	N/A
Straight or heterosexual	76%	Decline to state	N/A
Bisexual	5%		
Queer	0%		
Pansexual	2%		
Asexual	0%		
Questioning or unsure	0%		
Another Sexual orientation	2%		
Decline to state	10%		

SUICIDE PREVENTION

The Suicide Prevention program aims to coordinate efforts to prevent suicide in the San Mateo County community. The primary program activities and/or interventions provided include:

- Suicide Prevention Committee (SPC): The mission of the San Mateo County Suicide Prevention Committee (SPC) is to provide oversight and direction to suicide prevention efforts in San Mateo County. Created in 2009, this coalition consists of passionate suicide prevention advocates, including suicide attempt survivors, suicide loss survivors and representatives from behavioral health, primary care, emergency health services, social services, law enforcement, transportation, education, communication & media, art & culture, spirituality & faith, and community members (see data in program impact section below).
- September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how everyone has a role in preventing suicide (see data in program impact section below)

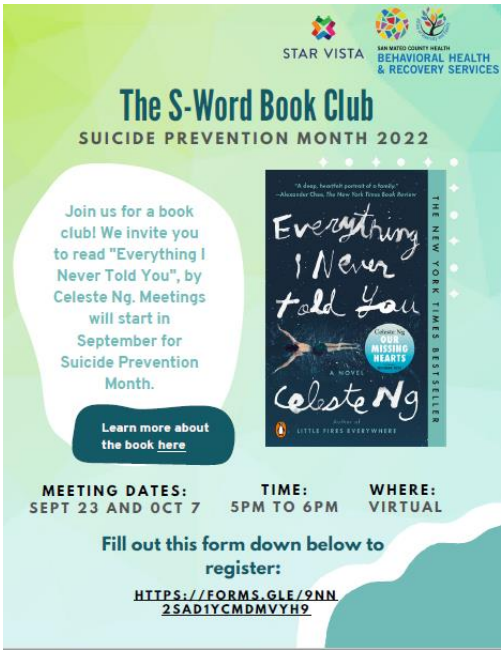
  Suicide Prevention Trainings: The Adult Mental Health First Aid- MHFA and Be Sensitive Be Brave Training were also part of the Suicide Prevention Program and there are separate annual reports for each.

Program Impact

Suicide Prevention	FY 2022-23
Total clients served (unduplicated)	700
Total cost per client	$210

- Suicide Prevention Committee (SPC): The SPC uses its strategic plan to prioritize and connect efforts to reduce suicide overall and among specific high-risk communities. SPC prioritized the following workgroups for the following timeframes:
    - July – December 2022: Networked Partnerships and Resource Dissemination Workgroups
    - January – June 2023: Resource Coordination & Development
- September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how everyone has a role in preventing suicide. The 2022 SPM statewide theme was "Take Action for Suicide Prevention: Thriving At All Ages" and local hashtag was #SMCTakeAction4MH. SPM activities included:
    - Advocacy Days are various days in August and September where community members can make public comment and advocate for suicide prevention at local city and county meetings that proclaim September Suicide Prevention Month. The County of San Mateo and 19 out of 20 San Mateo County cities proclaimed 2022 September Suicide Prevention Month (up from 17 out of 20 in 2021). In 2022, the County buildings were lit purple and teal for the first time for SPM.
    - Mini-Grants and Event Support is an opportunity for County and community partners to apply for modest amount of monetary funding and event support for their September Suicide Prevention Month event. The process includes application, selection, event support, deliverable review, and fund disbursement.
    - Reaching Diverse Audiences is one of the measures of success for San Mateo County's September Suicide Prevention Month. One way to reach this goal is to prioritize Mini-Grant applicants who may reach to diverse communities in high need of suicide prevention resources, including youth, older adults, LGBTQ+ community, indigenous people, Pacific Islanders, veterans, professions at risk.
    - Event Support includes:
        - Input/ideas on event theme, programming, communication/outreach and logistics (up to 2 hours consultation)
        - Speakers with lived mental health and/or substance use experience
        - Digital stories for screening
        - Photo voices for exhibits
        - Event templates (flyer, presentation slides, chat script)
        - Event promotion on website and social media (Facebook, Twitter, blog and email networks)

        - Interpretation/translation with County Health Contractors
    - Mini-Grants ranged were $200-300. $300 was distributed to 1 grantee recipient, Star Vista Health Ambassador Youth. Event details below.
        - 2 events hosted by community partners, including a book club and open mic event. The first event was focused on youth and the second event was open to all ages. Flyers for both events are below.
        - 20-30 estimated to have attended the 2 SPM events



Images: Flyer for one event of one of the 2023 SPM Mini-Grantees and flyer for an SPM event hosted by community partner.

- Communication Campaign which promoted September Suicide Prevention Month through the below communication channels. New graphics and content align with the statewide theme “Take Action for Suicide Prevention: Thriving At All Ages” and local hashtag #SMCTakeAction4MH.
    - Website included schedule of events, ways to get involved and resources for behavioral health
    - Social Media campaign included 7 social media posted across San Mateo County Health Facebook, Instagram, Twitter and BHRS Blog. Among Facebook, Instagram, Twitter, the hasthtag #SMCTakeAction4MH was featured and shared by organizations and individuals, including StarVista, City of Menlo Park, Menlo Park Library, County of San Mateo
    - Email Blasts – 1 promo email blast distributed to behavioral health staff, community partners and community members

- Outreach Materials – created and mailed by state and distributed by Suicide Prevention Committee and County staff. For example, Redwood City staff distributed suicide prevention ribbons to first responders (police, fire) and Youth Commissioners received mental health thrival kits, https://thrivalkits.ca, shoebox sized kits that students fill with small, meaningful items as they complete wellbeing challenges and activities throughout the school year.

- Suicide Prevention Trainings: The below programs were also part of the Suicide Prevention Program. and there are separate annual reports for each of the below programs.
  - Adult Mental Health First Aid (see section on Adult Mental Health First Aid)
  - Be Sensitive Be Brave Trainings: In FY 2022-23, Community Connections Psychological Associates, Inc. (CCPA) provided three different program activities towards the goal of culturally responsive community trainings in mental health and suicide prevention training:
    - Delivery of 24 culturally-infused community trainings: CCPA delivered 24 culturally responsive Be Sensitive Be Brave for Mental Health (BSBB for Mental Health) or Be Sensitive Be Brave for Suicide Prevention (BSBB for SP) trainings in San Mateo County, serving 516 unique individuals.
    - Building capacity for the trainings: To build up trainer capacity, CCPA trained 3 individuals to become BSBB trainers who can deliver either the BSBB for MH and SP trainings within San Mateo County.
    - Delivery of BSBB trainings in Tongan for Pacific Islander individuals: Finally, CCPA performed a linguistic and cultural adaptation of the BSBB for MH and BSBB for SP trainings for the Tongan-speaking Pacific Islander community. Within the process of cultural and linguistic adaptation, CCPA delivered four (4) trainings in Tongan (2 BSBB for MH and 2 BSBB for SP) for pilot testing in San Mateo County, to a total of 55 Tongan-speaking individuals.

Successes

The Suicide Prevention Program is especially proud of the Mini-Grants and Event Support program that allows clients/consumers, family members and community members to initiate and lead a community event for September Suicide Prevention Month. The below are quotes is from client/peers and Suicide Prevention Committee Members:

> *"Suicide Prevention Month 2022 allowed Peers and SMC Staff to work alongside each other to be of service and meet the needs of our SMC Communities at large."*
>
> *"We are often able to interact with diverse communities throughout the length of San Mateo County.*

"Partnerships with SMC Libraries, such as with Fiona Potter and the Redwood City Library, gave us all an open door to communicating the facts about Suicide and the truths on how the action of choosing to end One's life can be preventable."

"There are SMC citizens I met through this September's work who I was able to reconnect with at later times in 2022 and here during 2023 and offer further assistance."

"As a particular instance, Jessica (who I met at the Redwood City Library), a single Mother of 3 for over 10 years, has been matched with resources to assist Her in Her wellness and open the door of possibilities to support Her daughter who was a victim of sexual abuse and the feelings of poor self-worth that follow such horrible life experiences. Jessica is very grateful for her connections with Us. I communicate with Jessica often."

"There are other individuals i met in September 2023 that i have re-engaged with at St. Raymonds Parish here in my Hometown of Menlo Park. Thanks to Allie Rogge of Star Vista, St. Raymonds parishioners were well informed by Her presentation on 988. They asked many questions of Allie."

"SPM is a source of meeting the needs of Our #Community and must be constantly supported and allowed to flourish. Please be aware that the core value of SPM is 'Nothing about Us without Us.' "

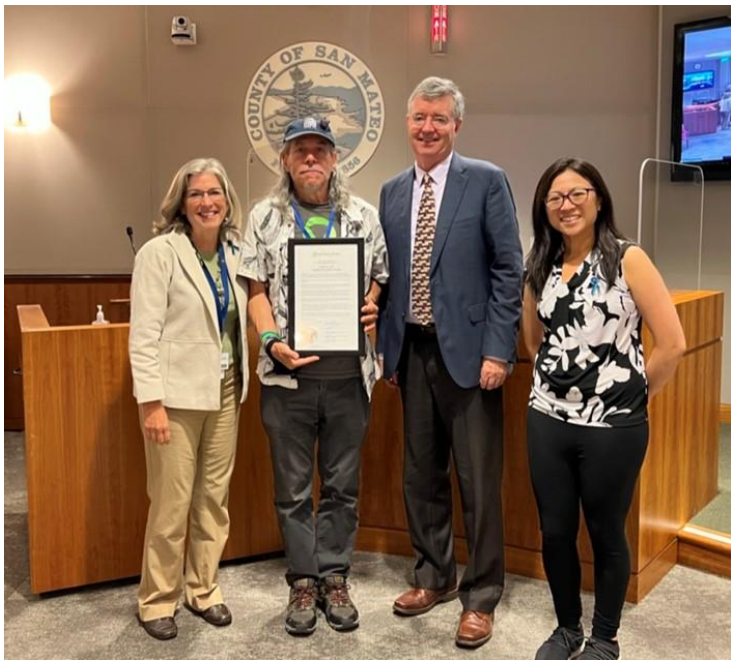


Image: 2022 September Suicide Prevention Month Proclamation, From Left to Right -Behavioral Health & Recovery Services Interim Director Lisa Mancini, Client/Peer/Suicide Prevention Committee Member John Butler, Board of Supervisor President Dave Pine, Suicide Prevention Committee Co-Chair Sylvia Tang, September 13, 2022

Another key accomplishment during the FY 2022-23 was the Be Sensitive Be Brave Tongan Training Adaptation in partnership with Dr. Joyce Chu and leaders in the San Mateo County Tongan-speaking Pacific Islander community, San Mateo County helped complete the Be Sensitive Be Brave adaptation for Tongan speaking community (first and only linguistically and culturally adapted mental health/suicide prevention community helper training for Tongan community). Examples of participant input is listed below:

Question: Kātaki ‘o vahevahe mai ha fa‘ahinga fakamatala fekau‘aki mo e ngaahi mālohinga ‘o e akó ni : Please share any comments about strengths of this training:	
Tongan	**English**
Tuku ha taimi ‘i he kamata‘anga ‘o e kalasí ke fakahoko ai e saveá (kimu‘a) mo kinautolu ‘oku kau maí pea fakakakato. ‘Oku totonu ke tānaki ‘a e saveá kimu‘a pea toki kamatá.	Take time in the beginning of the class to go over the survey (pre) with the participants and to complete. Surveys should be collected before starting.
Fokotu‘u ki he hingoa ‘o e kalasi ke faka‘aonga‘i e ngaahi fo‘i lea ‘oku ‘ikai faka‘atamai hange ko e "hala ki he mama" pe "hiki hake ‘a e kavenga pea ke fakamama‘i."	Suggestion for the title of the class to use non-mental terms such as “a pathway to light” or “Lift the burden and to Enlighten.”
Na‘e fakahoko ‘e he ngaahi ako ko ‘ení ha fu‘u fie ma‘u lahi ki he kolo Tongá; fokotu‘u ange ‘e kinautolu ‘oku kau maí ke hokohoko atu ‘a e kalasí ‘o ‘oua na‘a toe si‘i hifo he tu‘o Na‘e vahevahe ‘e ha tokotaha na‘e kau mai ‘a e founga na‘e ‘ikai ke ne fu‘u sai‘ia ai ‘i he‘ene ha‘u ki he kalasí ‘i he taimi na‘á ne ma‘u ai ‘a e Na‘á ne hounga‘ia ‘aupito ‘i he‘ene ha‘ú, kuó ne ako ha me‘a lahi fekau‘aki mo e mo‘ui lelei faka‘atamaí mo fakapapau ke fakaafe‘i hono ngaahi kaungāme‘á ki he kalasi hokó.	These trainings fulfilled a big need for the Tongan community; participants suggested continuing the class at least once annually. A participant shared how she was so negative about coming to the class when she got the invitation. She was so very grateful that she came, she has learned a lot about mental health and had vowed to invite her friends to the next class.
Hokohoko atu hono langa ‘o e ngaahi polokalama fakakolo ‘e lava ke tokoni ki hono poupou‘i ‘o e mo‘ui lelei faka‘atamai ‘i he kolo Tonga.	Continue to build community programs that can help support mental health in the Tongan community.

Challenges

The main challenge was implementing the Suicide Prevention Committee Workgroups because members are volunteers and there were competing priorities during the fiscal year – including onboarding new full-time Suicide Prevention Training Coordinator, increasing trainer instructor pool, development contracts for trainings, reviewing and processing data in more depth, and preparing for Suicide Prevention Month.

Demographics

Age	N=202	Total	%
Age 0-15	2	2	.1%
Age 16-25	44	46	21.8%
26-59	124	170	61.4%
60+	24	194	11.9%
decline to state	8	202	4.0%
Primary language	N=226	Total	%
English	159	159	70.4%
Spanish	21	180	9.3%
Mandarin	2	182	.9%
Cantonese	1	183	.4%
Tagalog	5	188	2.2%
Samoan	1	189	.4%
Tongan	35	224	15.5%
Another language	2	226	.9%
Race/Ethnicity	N=211	Total	%
American Indian/ Alaska Native/ Indigenous	3	3	1.4%
Asian	31	34	14.7%
Arab/Middle Eastern	3	37	1.4%
Black/ African- American	8	45	3.8%
White/ Caucasian	80	125	37.9%
Native Hawaiian	8	133	3.8%
Tongan	43	176	20.4%
Another race/ ethnicity: Hispanic / Latinx	35	211	16.6%
Gender Identity	N=212	Total	%
Male/Man/ Cisgender	51	51	24.1%
Female/ Woman/ Cisgender Woman	140	191	66.0%
Genderqueer/ Nonconforming	12	203	5.7%
Another gender identity	1	204	.5%
Decline to state	8	212	3.8%

Sexual Orientation	N=210	Total	%
Gay, lesbian, homosexual	7	7	3.3%
Straight or heterosexual	160	167	76.2%
Bisexual	6	173	2.9%
Decline to state	17	190	8.1%
Queer	18	208	8.6%
Pansexual	1	209	.5%
Another sexual orientation	1	210	.5%

PEI STATEWIDE PROJECTS

California Mental Health Services Authority (CalMHSA)

CalMHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services. CalMHSA provides BHRS with technical assistance and implements PEI Statewide Projects across the topics of Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative.

The Take Action May is Mental Health Matters Month 2023 included a few highlights:

- 14.5+ million touchpoints across the State
- 252,720 toolkit materials distributed across the State
- 131,486, a 27x increase, Take Action website sessions
- 13,514 resources were downloaded from the Take Action website, a 9x increase
- 59,474 post engagements from influencer partners

EARLY INTERVENTION

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program is to provide San Mateo County's residents with a comprehensive assessment in the field and offer an alternative to Psychiatric Emergency Services when appropriate; or if needed to write a hold status and provide secure transportation to the hospital. SMART serve any resident in psychiatric crisis regardless of age as identified by Law Enforcement. Primary program activities include consultation to law enforcement on scene. SMART can write a 5150 hold if needed and transport the person. If the individual does not meet the 5150 criteria the SMART medic can provide

support and transportation to an alternate destination, i.e., crisis residential facility, doctor's office, detox, shelter, home, etc.

Program Impact

SMART	FY 2022-23
Total calls received	286
Total cost per client	$522

The San Mateo Mental Health Assessment & Referral Team (SMART) contract with American Medical Response (AMR) has been providing 5150 evaluation and transport services since 2005. The SMART goals and measures for FY 2022-23 are below. Both goals have been met successfully.

- SMART's first goal is to divert 10 % of calls where a 5150 was not already placed. AMR has succeeded in surpassing this goal. In FY 2022-23, AMR diverted 46.7% in the first quarter, 41.4% in the second quarter, 47.1% in the third quarter, 32.1% in the fourth quarter.
- SMART's second goal is to respond to 75% of appropriate calls for service. SMART had 286 calls with the highest volume of calls was Tuesday through Thursday. AMR has also succeeded in surpassing this second goal by responding to all appropriate calls for service. In FY 2022-23 AMR responded to 92.5% in the first quarter and 88.6% in the second quarter, 84.3% in the third quarter, 89.3% in the fourth quarter.

SMART evaluates people in the field or at individual residences upon being activated by a law enforcement officer and connects people to behavioral health services upon stabilizing the individuals that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and treatment for many people timely, especially at the moments when they needed the services the most i.e., when they are contemplating harms to self, to others, or are at the verge of grave disability.

SMART Medics evaluate individuals for both physical and mental health issues including suicidal ideation and direct people to the appropriate resources. SMART also responds to many people under 18 who are in emotional crises – often peer related problems, family issues, and/or substance use issues as means to cope with life stresses. By addressing the youth's concerns and getting supportive and protective factors in place so that the youth can receive needed support timelier, which then support the youth to be more likely to remain in school and helps the family unit to stay intact. This is also achieved when SMART responds to parents in behavioral health crises and get them directly involved in services, so they can provide for their children.

SMART responds to many homeless severely mentally ill adults, in their encampments, shelter, or the San Mateo Navigation Center. By getting these sheltered/unsheltered homeless individuals evaluated timely and facilitating access to the right level of medications and services, their mental illnesses are stabilized sooner and resources to address their homelessness can be made available to them.

SMART also connects individuals who are not already on a 5150-hold but meeting criteria for stabilization services to such programs for treatment, an example of which is Serenity House.

SMART works closely with the San Mateo's law enforcement co-responder mobile crisis team of Community Wellness and Crisis Response Team (CWCRT) in their implementation cities to provide 5150 evaluation, involuntary hold, and connection to needed higher level of treatment or outpatient care to facilitate timelier linkage to needed level of care interventions.

EARLY PSYCHOSIS PROGRAM- (RE)MIND

The (re)MIND® (formerly PREP) program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for schizophrenia spectrum disorders. (re)MIND® delivers comprehensive assessment and treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/BEAM aftercare program – (re)MIND® Alumni – was developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention.

The (re)MIND® and BEAM programs serve the following regardless of insurance status:

- Residents of San Mateo County *-and-*
- Between the ages of 14 and 35 *-and-*
- Identified as being at risk for the development of psychosis (having subthreshold symptoms that do not meet justification for a diagnosis OR having a first degree relative with a history of psychosis AND a recent significant decline in age-appropriate functioning) *-or-*
- Have developed symptoms of psychosis for the first time in the past two years.

In addition, (re)MIND® Alumni serves individuals who have graduated from (re)MIND/BEAM and elect to receive active support to maintain engagement in educational or vocational activities, and further develop skills to self-navigate community resources. (re)MIND® provides a wide array of services designed to wrap around the individual and their family members involved in treatment. Services start with an outreach and education campaign that helps members of the community and providers detect early warning signs and reduce the stigma associated with psychosis. Once a youth or young adult has been identified and referred to the program, they receive a comprehensive, research-validated diagnostic assessment to determine their diagnosis with high degree of accuracy and their eligibility for early intervention services.

Following assessment, individuals participate in assessment feedback session(s) where they receive psychoeducation on diagnosis and treatment options. Besides early diagnosis, program services include up to two years of:

- Cognitive Behavioral Therapy for Psychosis (CBTp)
- Algorithm-guided medication management

- Individual peer and family support services
- Psychoeducational Multifamily Groups (MFG)
- Supported Employment and Education using Individual Placement and Support (IPS)
- Strength-based care management
- Community-building activities such as orientation for new participants and their families

Upon completion of services, either by reaching two years in the program or by achieving treatment and recovery goals early, program participants take part in a graduation ceremony to acknowledge their accomplishments and positive transitions. After graduating, participants are offered an opportunity to extend care with their (re)MIND®/BEAM treatment team at a lower intensity of services for up to a total maximum of 4 years through the (re)MIND® Alumni program, to maintain treatment progress, successfully transition to higher levels of education and employment advancement, and to empower social supports to sustain the participant's recovery.

Program Impact

(re)MIND *	FY 2022-23
Clients served (unduplicated)	79
Cost per client	$3,338
Individuals reached (duplicated)	40
Total Served	**119**

** Unduplicated clients served are individuals that receive early psychosis treatment and aftercare, individuals reached includes families and caregivers.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism) for participants and alumni	77/79	97%
	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to follow-up for participants and alumni) – in program >1yr for assessment of score change	77/79	97%
Utilization of emergency/ crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	16/23	70%
Self-empowerment	"Due to this program, I can take control of aspects of my life" Agree; Agree Strongly for participants and alumni	26/28	93%

Demographics

Age (N=79)	%	Gender Identity	%
Ages 0-15	8%	Female/Woman/Cisgender Woman	45%
Ages 16-25	75%	Male/Man/Cisgender Man	47%
Ages 26-39	17%	Genderqueer/Gender nonconforming	4%
Primary language	**%**	Trans Male	4%
English	99%	**Sexual Orientation**	**%**
Spanish	1%	Gay or Lesbian	4%
Race	**%**	Straight or Heterosexual	53%
Asian/Asian American	13%	Questioning or unsure	6%
Black/African American	13%	Another	29%
Hispanic/Latinx/a/o	32%	Decline to State	8%
Native American/ Indigenous	1%		
Native Hawaiian/Pacific Islander	16%	**City/Region**	**%**
White/Caucasian	22%	Central County	25%
Other	0%	North County	48%
More than one race	8%	South County	20%
Decline to State	0%	East Palo Alto/Bell	4%
Ethnicity	**%**		
Asian Indian/South Asian	0%	Korean	1%
Black/African American	10%	Vietnamese	1%
Chinese	8%	Other Pacific Islander	1%
Central American	3%	South American	4%
Eastern European	3%	White	9%
European	9%	More than one ethnicity	0%
Filipinx/a/o	13%	Another	0%
Mexican/Chicanx/a/o	27%	Decline to State	0%
Disability/Learning difficulty	**%**		
Chronic health condition	1%		
Learning disability	1%		
Unknown	0%		
No	91%		
Decline to State	5%		

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	7	7
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	0	0	0
TOTAL	**0**	**7**	**7**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	13	Legal	1
Financial/ Employment	2	Medical care	4
Food	0	Transportation	0
Form assistance	0	Health Insurance	6
Housing/ Shelter	2	Cultural, non-traditional care	0
Other*	13	**TOTAL**	**41**

Other" category consisted of school-based referrals/supports, GED classes, and gender support.

Program Narrative

*Improves timely access & linkages for underserved populations: (*re)MIND® and (re)MIND® Alumni are stepped model of care programs designed to detect signs and risk states for severe mental illness at the earliest possible stages. Program eligibility includes individuals at risk for developing severe mental illness (prevention) as well as those with a recent onset of symptoms (early intervention). This allows program staff to intervene as early as possible limiting the duration of untreated mental illness and preventing symptoms from worsening by working with the individual and their family toward a path of recovery and ultimately illness remission. State timely access standards are upheld with all clients to expedite time to intake and services.

Reduce Stigma and discrimination: An important function of the program is to equip mental health providers and the community at large to identify early warning signs of psychosis. This function is provided by program staff through targeted community outreach and educational presentations. As a result of these activities, two major goals are achieved: 1) The importance of early intervention in preventing severe mental illness from limiting an individual's potential to achieve their hopes and dreams; and 2) The community broaden their understanding of psychotic experiences existing in a continuum of common human experiences rather than limited to a pathological condition. Due to the changing needs of individuals and families during the COVID-19 pandemic, the team's outreach programming was adapted to a digital format through didactic trainings, community presentations

and open house meet-and-greets over telehealth platforms. The number of individual outreaches decreased, but the participation in community sponsored committees like Diversity and Equity Council, Sexual Orientation and Gender Identity (SOGI) Collaborative, and School-Based Initiatives increased. Face to face outreaches continue to increase as more programs open fully.

Increases number of individuals receiving public health services: (re)MIND® and (re)MIND® Alumni work with public partners such as BHRS YTAC network to support youth who are transitioning out of high school-based services and would otherwise lose contact with the public mental health system. Through these partnerships, youth maintain a safety net within the mental health system until they can access public benefits and get the necessary services directly. This results in a seamless care continuum that benefits the youth and family in need of services and helps to ensure that youth in transition to adulthood do not fall through the cracks.

Reduce disparities in access to care: Prevention and early intervention services for psychosis are not yet widely available and there are barriers that are commonly experienced by those in need of these services. One such barrier addressed by the (re)MIND® and (re)MIND® Alumni programs is that insurance status is not a factor for accessing care. This eliminates barriers to specialized treatment at the earliest point in time possible. Another barrier commonly experienced by this population can be access to reliable and safe transportation. The program addresses this barrier with services offered in the community at conveniently accessible locations for program participants. During the COVID-19 pandemic, program expanded digital options for accessing care including through phone and telehealth services. Program applied for grant funding to help clients gain access to needed technology and services to access care. Clients had the opportunity to use staff support to set up cell phone plans, data networks, and to have access to donated tablets to better help them access care equitably. Services are now fully offered in all formats, increasing the ability to meet all clients where they need to be seen.

Implements recovery principles: At (re)MIND® and (re)MIND® Alumni the power of the participant's goals, dreams, and aspirations guide and drive treatment. The participant's multidisciplinary team uses a holistic, strength-based approach to instill hope, empower the participant's voice, and identify the participant's goals to develop a plan centered around them. Program participants are recognized as having subject-matter expertise about themselves and are an active and central part of their own treatment team.

Successes

Client Success Story: This story is shared with the explicit permission of the client. Client was a Latina female enrolled in program at age 16 with intrusive religious-themed delusional thinking that had impacted her focus in school and her relationships with her parents and sister, who she believed to be possessed by demons. She had three inpatient psychiatric hospitalizations, had run away from home, and was living in a teen shelter shortly before entering program, which only heightened her

paranoia about others. With her family support, she was able to take advantage of all program specialties including medication management, peer support, individual therapy and supported education and employment. She was able to stabilize and return to school, and eventually graduated from high school and began to attend local college. She decided to take advantage of (re)MIND® Aftercare program and continued to be in one of the first cohort of graduates from the additional two years that extension offers. She and her family moved out of county after graduation, but one day she saw a familiar logo at a job fair in her new city. She applied for and attained employment as a peer mentor at one of the other Felton Institute (re)MIND® programs, continuing to use her strength and learned skills to reduce stigma and help guide the next generation of individuals experiencing psychosis.

Challenges

Currently the program is at capacity with a waitlist of 15 participants, even with full or almost full staffing. This means that the program's outreach is working to help connect clients to needed services, and that there is an intense need for these services county-wide. The solution is reviewing level of care of individual clients and increasing the raw number of clients that each therapist caries while decreasing the number of weekly services. This is working well for clients in the Alumni program, who have already completed their first two years and are increasingly independent and using resources local to them without needing staff involvement.

Local outreach presentations have also suffered this year from differing requirements of each individual agency or population with the degree of in-person connections available. All agencies (including Felton) have had difficulty with learning new formats of outreach and getting back into physical contact with key staff. Program management also had a maternity leave, which revealed that most staff are not versed in outreach presentation procedures, as most of it had run through management beforehand. The solution will be to standardize physical and digital presentation formats and train staff in giving them, both so that more staff will be available to meet with stakeholders in the community directly, and so that program will have a set catalogue of presentations and accommodations that agencies can pick from.

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS, 80% PEI. The purpose of the Primary Care Interface (PCI) program is to integrate mental health services into primary care. The program partners with San Mateo County primary care clinics to provide easier access to mental health services. It started in 1995 at one clinic and is now embedded in five primary care clinics throughout the county. Since its inception, the program's staff has grown from one therapist and nurse to a

multidisciplinary team of more than 23 staff members, including marriage or family therapists, licensed clinical social workers, and case managers.

The program serves all age groups, from children as young as 3 to the geriatric population. The program is offered to those with mild to moderate mental health issues. Around 60% to 70% of clients are covered by Medi-Cal, while the remaining clients are covered through the county health insurance program, Access, and Care for Everyone.

Primary Program Screenings, Activities, and Interventions Provided: The primary care clinics use the Patient Health Questionnaire-2 and -9 as well as the Adverse Childhood Experiences Questionnaire to screen adults and children visiting the clinics. Once diagnosed with a mild or moderate mental health condition or risk factor, clients are referred, based on their needs, to psychiatry, therapy, and/or case management. Referrals are also made to provide support for treating alcohol use disorder (AUD) and other substance use disorders (SUDs).

New Activities and Interventions Targeting SUDs: New interventions and activities undertaken in FY 2022-23 included the creation of a virtual alcohol and other drug services (AOD) resource group and the implementation of a contingency management group, which refers to a type of behavioral therapy, for AOD clients through Pear Therapeutics. Through this external agency, PCI was able to purchase prescriptions that were issued by the clients' psychiatrists. Additionally, to address opioid use, Pear Therapeutics provided a curriculum and modules for clients to complete.

Program Impact

Primary Care Interface *	FY 2022-23
Clients served (unduplicated)	617
Individuals reached (duplicated)	1618
Cost per client	$424

The table above summarizes the number of clients served through the PCI program during FY 2022-23. The program served 2,224 referred individuals, and there were completed intakes for 606 unduplicated clients. The remaining 1,618 referrals were from outreach or triage and did not result in completed intakes. These referrals also included duplicates because one individual could be referred more than once.

Providing Timely Access to Services: PCI program staff continued to work on site in primary care. This allowed integrated teams at the same site to screen and manage a variety of issues efficiently and in collaboration with one another. Additionally, the program observed recent improvements in timely access to psychiatric services.

Increasing the Number of Individuals Receiving Public Health Services: The PCI program still relies on Private Provider Network (PPN) referrals to meet high demand for mental health services, meaning

that clients who may not need case management or a prescriber attached to them are referred to providers in the Private Provider Network instead of turning down clients or making them wait. In terms of engagement and outreach, program staff are developing a plan to promote greater engagement with existing clients, many of whom are unresponsive to calls or text reminders. To reduce time spent on phone outreach to individual patients, staff are planning to encourage existing clients to Drop-In at their convenience to learn more about available mental health services and, if interested, enroll in individual therapy. This allows staff to dedicate more time to delivery of public health services during medical appointments.

Reducing Stigma and Discrimination for Clients and Reducing Disparities in Access to Care: The program helps reduce stigma for clients enrolled in it. For example, clients can maintain anonymity in AOD resource groups held on Zoom by turning their camera off and not having their real name displayed. To reduce disparities in access to care, case managers provide services in clients' homes, which helps those who are unable to physically come into the clinic feel supported. The program continues to offer virtual appointments before and after standard working hours, which is helpful for clients who cannot leave work to attend an appointment. Moreover, PCI clinicians coordinate with providers at the BHRS regional clinics to perform warm handoffs of PCI clients. These strategies enable PCI clients, many of whom come from underserved populations, to get better access to care.

Implementing Recovery Principles: The PCI program has implemented recovery principles in different ways. First, many clients have an SUD diagnosis and a mental health diagnosis that require *trauma-informed treatment approaches* and *coordination across providers.* Providers in the PCI program are targeting these co-occurring diagnoses through eye movement desensitization and reprocessing (EMDR) therapy to help these individuals process and recover from severe trauma and SUD. Second, diversity, equity, and inclusion initiatives are supported by a new mandatory cultural humility training session for all staff. Third, the program partnered with colleagues in a new clinic that primarily serves immigrant populations, and these colleagues have been able to provide resources for new clients on immunizations, physical examinations, mental health services, and social services.

Table 1 summarizes clients' perceptions of the PCI program's impact on their lives on a Likert scale during FY 2022-23. Out of the 625 survey respondents, about 85% (533) did not respond to the three questions shown in the table. Out of the 92 clients who answered the survey, a majority either agreed (43.5%) or strongly agreed (23.9%) that they were better able to manage their symptoms and participate in daily life. A tie of 38% agreed and were neutral that they thought more positively about challenges and believed the decisions and steps they took impacted their outcome. In addition, 40.2% agreed that they learned skills and strategies to cope with stressors.

Table 1. PCI Clients' Perceptions of the Program's Impact on Their Lives

Response	Number of clients	Proportion of all survey respondents	Proportion of survey respondents who answered question
As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.			
Strongly agree	22	3.5%	23.9%

Response	Number of clients	Proportion of all survey respondents	Proportion of survey respondents who answered question
Agree	40	6.4%	43.5%
Neutral	27	4.3%	29.3%
Disagree	2	0.3%	2.2%
Strongly disagree	1	0.2%	1.1%
No response	533	85.3%	N/A
Total	**625**	**100%**	**100%**
As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.			
Strongly agree	20	3.2%	21.7%
Agree	35	5.6%	38.0%
Neutral	35	5.6%	38.0%
Disagree	1	0.2%	1.1%
Strongly disagree	1	0.2%	1.1%
N/A	533	85.3%	N/A
Total*	**625**	**100%**	**100%**
As a result of participating in this program, I learned skills and strategies to cope with stressors.			
Strongly agree	22	3.5%	23.9%
Agree	37	5.9%	40.2%
Neutral	31	5.0%	33.7%
Disagree	1	0.2%	1.1%
Strongly disagree	1	0.2%	1.1%
N/A	533	85.3%	N/A
Total	**625**	**100%**	

*Values presented for the proportion of survey respondents who answered the second question shown in this table do not sum to 100% due to rounding (21.74% rounded down to 21.7%, 38.04% rounded down to 38.0%, 1.09% rounded up to 1.1%).

Demographics

Table 2 summarizes the demographic information for the 617 clients who were admitted and actively a part of the PCI program during the FY 2022-23. The largest proportion of clients (39.7%) were between the ages of 26 and 59, followed by clients between the ages of 0 and 15 (34.7%). A majority were female (57.5%). A large majority (79.9%) identified as Hispanic or Latino. In addition, 82% identified as another race and 7.5% as White/Caucasian.

Table 2. Demographic Data of PCI Client List (FY 2022-23)

Age Category	Number of Clients	Total Number of Clients	Share in Total (%)
0–15	214	617	34.7
16–25	119	617	19.3
26–59	245	617	39.7

60+	39	617	6.3
Race	**Number of clients**		**Share in total (%)**
Other	506	617	82.0
White/Caucasian	46	617	7.5
Black	12	617	1.9
Other Asian	7	617	1.1
Filipino	6	617	1.0
Multiple	5	617	0.8
Chinese	4	617	0.6
Unknown / Not Reported	31	617	5.0
Ethnicity	**Number of Clients**		**Share in Total (%)**
Hispanic or Latino	493	617	79.9
Not Hispanic or Latino	105	617	17.0
Unknown / Not Reported	19	617	3.1
Sex Assigned at Birth	**Number of Clients**		**Share in Total (%)**
Female	355	617	57.5
Male	262	617	42.5
Sexual Orientation	**Number of Clients**		**Share in Total (%)**
Straight or heterosexual	78	617	12.6
Bisexual	4	617	0.6
Lesbian, gay, or homosexual	3	617	0.5
Decline to state	4	617	0.6
Unknown / Not Reported	528	617	85.6

Referrals

Table 3 summarizes FY 2022-23 PCI program referral information. Throughout the year, there were 2,316 total referrals. Of the referrals received, 678 resulted in program enrollment, representing 606 unduplicated engaged clients with completed intakes. The average duration of untreated mental illness was 29 days. The average length of time between referral date and enrollment date was 23 days, ranging from 0 to 370 days.

Table 3. Data on PCI Referrals Received and PCI Clients' Emergency Service Utilization(FY 2022-23)

Referral information	
Total number of referrals received to the program	2,316
Total number of referrals that resulted in program enrollment (number engaged)	678 (606)
Clinical Services	
Average duration of untreated mental illness (days)	29.12
Average length of time between referral date and enrollment date (days)	22.53
Minimum length of time (days)	0
Maximum length of time (days)	370

Table 4 summarizes the types of behavioral health referrals made as part of the PCI program during FY 2022-23. During the year, there were 335 total behavioral health referrals, with 46 referrals to programs within the agency and 289 to other agencies. There were a total of 19 serious mental illness (SMI) referrals, 27 SUD referrals, and 289 other mental health referrals. More SMI referrals were made to programs within the agency than to other agencies, but there were significantly more mental health referrals to other agencies.

Table 4. Behavioral Health Referrals Made on Behalf of PCI Clients by Referral Type (FY 2022-23)

Type of referrals	FY referrals to programs within agency	FY referrals to other agencies	FY total
SMI referrals	18	1	19
SUD referrals	12	15	27
Other mental health referrals	16	273	289
Total	**46**	**289**	**335**

Table 5 summarizes the types of referrals made to all other service providers as part of the PCI program during FY 2022-23. During the year, there were 622 total referrals to non-behavioral health service providers, with the top three referral types being other (*n* = 355), food (*n* = 168), and a tie between health insurance (*n* = 23) and housing shelter (*n* = 23).

Table 5. Referrals to Other Services Made on Behalf of PCI Clients by Referral Type (FY 2022-23)

Types of referrals	FY total
Other	355
Food	168
Health insurance	23
Housing shelter	23
Legal	20
Medical care	9
Emergency Protective Services	8
Financial employment	8
Transportation	7
Form assistance	1
Cultural/nontraditional care	0
Total	**622**

Successes

In FY 2022-23, one of the PCI program's biggest successes was the virtual AOD resource group held on Zoom. Anyone in the county, including individuals in recovery, their friends, and their families, could attend a session and learn about medication-assisted treatment and residential treatment. Because of this service, the program successfully connected more individuals to residential treatment, AOD resources, and medication-assisted treatment services. One client, whose story is described below, successfully completed treatment for AUD and saw improvements in his mental health.

Client Story: When a 72-year-old male client with a history of panic disorder, agoraphobia, excessive alcohol consumption, and involvement in the criminal justice system first started receiving PCI services, his health was steadily declining. He was at risk of losing his housing and was not able to consistently set boundaries with others. In the PCI program, this client saw a therapist for EMDR treatment, a case manager for co-occurring AUD, and a Bridges to Wellness care navigator for additional support. Through these interventions, in particular the EMDR treatment, the PCI team was able to target trauma that occurred when this client was 5 years old. He was able to process this trauma in treatment, and now, at 72 years old, he has shared with treatment team members that he feels like a new person. By the time his services were completed, he was able to engage in self-care, set boundaries, and maintain stable housing. He started to go out into the community and engage with others, attending church and visiting friends, among other activities. This client has since remained sober and has had no further involvement with the criminal justice system.

PCI leadership's decision to continue offering telehealth services for clients beyond the height of the COVID-19 pandemic represents another successful approach to care for clients with mild to moderate mental illness. The telehealth services help clients attend their appointment before or after work as they don't need to commute to the clinic. By maintaining a hybrid model that affords clients the choice of accessing in-person or virtual treatment services, show rates have improved.

Challenges

One consistent challenge the PCI program faced in FY 2022-23 was maintaining adequate staffing and filling vacant positions. Specifically, there were difficulties in recruiting Spanish-speaking staff. There is a high need for Spanish-speaking staff in the clinics, and the capacity for the clinics to serve Spanish-speaking patients can be limited if they cannot find staff who speak Spanish. This situation resulted in a reliance on language-interpreter services. In a therapy appointment in which a client speaks Spanish and a therapist does not, an interpreter is required, and the session can take a longer time. Additionally, some conversations may not work as well across different languages as they would if both the therapist and client were speaking the same language.

Another factor that made it particularly difficult to fill vacant Extra-Help positions in FY 2022-23 was that individuals hired to fill Extra-Help positions can only work a total of 1,040 hours per year, meaning that they are limited to providing 6 months of full-time labor or 12 months of part-time

work. PCI currently has four vacant Extra-Help positions, and the difficulties in hiring for this position impact timely access to services. As a result, work typically delegated to Extra-Help employees is relayed to current staff members, which may lead to burnout. To work around PCI clinician's high caseloads, the program is referring some clients to providers within their Private Provider Network.

Another challenge is inefficiency in the process of connecting a newly referred client to services through the Health Plan of San Mateo (HPSM). The number of steps in this process as well as having many intermediary processes reportedly contributed to longer wait times for new clients. Cutting or simplifying some of these steps to connect clients to appropriate mental health services and lower the chances of loss to follow-up has been recommended. The story presented below highlights the difficulties clients and staff experience with the current referral process.

Client Challenges Story: In FY 2022-23, a 50-year-old female client experienced some difficulty getting connected to PCI services. During her initial referral, this client reported experiencing depression because of grief and loss over the dissolution of her marriage as well as the death of her daughter. The client's current episode of depression also exacerbated Post-Traumatic Stress Disorder (PTSD) symptoms caused by early childhood trauma. When seeking services, a client usually fills out a form, which is then sent to the BHRS call center, and then forwarded to HPSM staff. A HPSM employee then calls the client with a provider match within 1-3 days and schedules an appointment on their behalf. A few weeks after this client's initial referral, she called the PCI Program Manager and shared that no one had contacted her with a provider match yet. The Program Manager gave this client a phone number for HPSM staff, but almost two months later, the client reached out again to say that she still had not heard from HPSM. When the Program Manager contacted HPSM over email to troubleshoot the delay, staff claimed that they had called the client multiple times, but she never answered. Three months after their initial referral, the client was finally connected to services.

Relatedly, the program faces significant administrative burdens given the high volume of forms and documentation the PCI team is responsible for processing. This paperwork must be filled out for each client, regardless of whether they decide to engage with program services, which ultimately leads to staff spending a large percentage of time on administrative work. To mitigate this challenge, the program is looking to create an administrative position to support the completion of paperwork.

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center 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 FQHC 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 FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto to primary care based mental health services or to specialty mental health at BHRS.

Ravenswood	FY 2022-23
Total clients served	386
Total cost per client	$47

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) 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 use 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.

See Appendix 6 for the full FY 2022-23 Outreach Collaborative Annual Report.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

The North County Outreach Collaborative (NCOC) consists of five partner agencies located in the north sector of San Mateo County and they are the Daly City Partnership, the Daly City Youth Health Center, the Pacifica Collaborative, StarVista, and Asian American Recovery Services/HealthRright360 (see description below). The North County Outreach Collaborative's primary goals are to connect individuals who need mental health services, alcohol & substance abuse treatment, and other social services. The NCOC aims to reduce stigma and discrimination of mental health, alcohol, and other drug issues within the community by increasing awareness of available resources through education and creating access to care. NCOC continues to also be a bridge for service providers to better understand the diverse populations they work with. In addition to connecting with the underserved communities, NCOC has focused on their effective collaborative relationships with culturally and linguistically diverse community members to enhance the BHRS's capacity and overall system performance in addressing the needs of various populations that are prominent in the North County of San Mateo such as, Filipino, Pacific Islander, Latin, Chinese and LGBTQ+.

The collaborative has learned that to help create linkages to services, knowing the individuals improves the connection with assisting in a warm hand off. Trust is the key factor to helping make the connection to services with diverse individuals and the NCOC recognizes that often they are planting the seeds of information in their various communities. The NCOC recognizes that being a consistent presence in the community allows them to then be able to water those informational seeds that were previously planted with reassurance that support is here to help. NCOC also works with service providers to better understand the diverse community and their cultural beliefs and practices. The Community Outreach Team (COT) often is the bridge and foundation that helps make the connection. When community members recognize a friendly face, a relationship has already begun, and they are then are more likely to step towards seeking support. The organic bond that has grown with this team has truly transformed lives. When one is working with a situation, and it is heavy, a COT team member can step in and lighten the load by carrying part of the weight. All COT members attest to the magical formula that uplifts their spirits to continue with this work, especially when things have gotten so heavy and gloomy since the pandemic.

The following is an overview of the North County Collaborative five agencies that reside and serve in the North sector of San Mateo County.

- Daly City Youth Health Center (DCYHC) provides effective, safe, and respectful health services to underserved youth and young adults, aged 12-24, in North San Mateo County (NSMC) at no cost to them. DCYHC provides physician-led primary healthcare, counseling services from licensed therapists, sexual health education and social and emotional development from health educators. Every medical and counseling appointment that DCHYC provides to its client base, which is composed of low-income youth, is an example of a reduction of the disparity of access to care and an increase in the number of underserved youths receiving public health services in the community. In addition, DCYHC strives to schedule appointments to ensure that the youth receive timely access to the care that they need.
- Asian American Recovery Services (AARS) is a program of HealthRight360 and provides culturally competent service to the Asian, Pacific Islander, Filipino and other ethnically diverse communities. AARS is dedicated to reducing the impact and incidence of substance use. Programs serve youth, adults, and families in San Mateo County. AARS offers programs and services, each tailored to meet the needs of the clients/participants. Their culturally oriented, gender responsive approaches are delivered by multicultural staff who are a part of the communities they serve. AARS partners with government agencies, community based and ethnic specific organizations to strengthen the support networks available to clients/participants to engage in research and advocacy. AARS offers culturally tailored community building activities that motivate the population they serve to be resilient and healthy.
- StarVista's Counseling Center holds the NCOC partnership for StarVista. It is committed to assuring that contracted services are provided, in collaboration with other StarVista programs. The Counseling Center provides affordable clinical services to children, youth, adults, couples,

and families in San Mateo County. Other StarVista programs focus on specific populations such as pregnant mothers and families with young children, transitional age youth, the LBGTQ+ community, and individuals struggling with addiction. Some programs have specialized goals such as crisis intervention, building healthy families and teaching positive parenting, child abuse prevention and treatment, substance use recovery, supporting the LGBTQ+ community, and connecting vulnerable individuals to needed resources. Programs aim to transform lives by helping individuals improve relationships, adjust to life changes, manage work and homework stress, resolve family conflict and communication issues, improve mood, behavior, and self-esteem, learn new parenting skills, alleviate depression and anxiety, and work through identity issues, personal crises, and trauma. All programs have a holistic, culturally respectful, strengths-based and trauma informed approach.

- The Daly City Partnership (DCP) provides mental health therapy to individuals, families, groups. Mental health (MH) services provided to all ages, primarily in Daly City and northern San Mateo County and primarily low-income participants. Participant race, ethnicity and age demographics mirror the overall low-income population in Daly City and the surrounding area. Individual and Group therapy in diverse community settings, virtually, and through referrals from community partners, such as public schools and local non-profits. Facilitate and organize collaboration with partner agencies for services to all clients.

- The Pacifica Collaborative's (PAC) purpose is to connect people, share resources and support one another to enrich the community. Pacifica Collaborative started in 1999 and has consistently connected the community to each other and to resources since that time. The Pacifica Resource Center's mission is to support the economic security of Pacifica families and individuals by providing a safety net of food, housing assistance, and other critical services, including coaching, advocacy, information, and referral. Their vision is to ensure the basic needs of every Pacifican are met so that each member of their community can thrive. The Pacifica School District Mission is that the community it serves, and the children they cherish, together prepare each child to meet the challenges of the future by providing an equitable, rigorous academic program which nurtures curiosity and inspires joy, confidence, and achievement in learning. Target and focused activities and interventions are the Pacifica Collaborative Monthly Meeting, Pacifica Collaborative United in Love Campaign, Sector outreach facilitated by members of the Pacifica Collaborative, Houseless on the Coast Outreach Team, Safe Parking Permit Program outreach and engagement, Outreach during monthly food distribution, Outreach at all Pacifica School District events, community meetings and open house on school campus, LGBTQ+ outreach, programming, and training in partnership with CoastPride. The Target Population for PAC is low income, people at risk of or experiencing homelessness, families and children affected by mental health issues, Chinese, Filipino, Latino, African American/Black, Pacific Islander and LGBTQ communities of all ages.; Faith Community; Business Community.

Program Impact

NCOC	FY 2022-23
Total clients served	4,573
Total cost per client	$26

Daly City Youth Health Center (DCYHC): DCYHC uses an evidence-based outcome measurement system, PCOMS (Partners for Change Outcome Management System) for collecting metrics. Client wellbeing as well as client-therapist relationship measures are collected at each session and aggregated to display treatment effectiveness. PCOMS is a well-researched, quality improvement strategy that boils down to this: partnering with clients to identify those who aren't responding to clinical interventions and addressing the lack of progress in a proactive way that keeps clients engaged while therapists collaboratively seek new directions. PCOMS has been shown to be consumer-friendly, highly feasible for clinicians, and importantly, repeatedly demonstrated to dramatically improve the quality and efficiency of services in peer-reviewed, published studies conducted across a range of settings, including public behavioral health. Measures collected at the beginning and end of every session allow us to gauge client progress across various life domains and the strength of the therapeutic relationship. In 22-23, 78.5% of their clients overall, have achieved reliable or clinically significant change. This is an 8% increase compared to last year's data. Daly City Youth Health Center (DCYHC) mental health therapists use the Patient Health Questionnaire (PHQ)-9 to identify and treat depression, the Generalized Anxiety Disorder (GAD)-7 to monitor anxiety, and the Alcohol Use Disorders Identification Consumption (AUDIT C) and the NIDA Modified Assist for to monitor substance abuse. During treatment, mental health challenges are both reduced and prevented from becoming more severe as clients receive therapy and then continue to answer the survey questions which relate to their care. Their development is tracked through both the survey data and continued clinical assessments. Through the hard work invested by both the client and therapist, there is a very good chance that improvement will take place and that any existing challenges will not become more severe. Each DCYHC mental health client receives a therapy plan that is individually tailored to their specific needs and continues to be adjusted through the therapeutic process. The clinic plans are designed and proven to treat and often reduce depression, anxiety, and substance abuse—all of which can reduce the likelihood of suicide, prolonged suffering, incarceration, homelessness, academic failure, removal of children from their homes, and unemployment.

The following are outcomes for DCYHC for FY 2022-23:

- 1-on-1 counseling for 200 people: 1-on-1 counseling was provided for 197 people in FY 22-23
- Conduct 100 outreach efforts: They reached 111 outreach efforts in FY 22-23
- Enroll 10 people per month in benefits via an on-site Benefits Analyst: They enrolled around 5 people on average per month.

- Facilitate 2 Emotional Intelligence workshops and host peer support groups: DCYHC clinicians facilitated 12 ongoing groups focused on emotional intelligence for youth ranging in age between 6-26.
- Participate in 12 outreach events per year: DCYHC participated in 21 outreach events in the FY 2022-23. Outreaching in high schools, universities, and community events. There was a total of 658 attendees.
- Participate in 2 nontraditional provider collaborations per month: DCYHC clinicians regularly collaborate with community partners in support of their clients, connecting them to services, gathering important information, and assisting them in engaging in community events. This year, they established 2 new additional community partnerships.
- Participate in at least one Strong Provider Collaboration event annually: DCYHC attended DCP meetings throughout the year.
- Identify local providers that provide culturally sensitive services for their target populations: In FY 2022-23, they created an extensive list of local community resources that offer culturally sensitive services to clients and regularly connect clients to these resources as needed. This year, they have updated and increased the list.
- Provide community education presentations at collaborative meetings, in classrooms, and in the community: DCYHC has provided education presentations in numerous forums during the year. They have trained clinicians and supervisors in other community-based organizations, informed community partners about their services, and offered workshops for caregivers at local school districts on trauma informed care.
- Provide translation services for ODE forms and flyers (English to Tagalog): DCYHC regularly uses translation services for meetings, phone calls, and form translation in working with monolingual clients and families.
- Participate in meetings for the Filipino Mental Health Initiative and Community Service Areas: DCYHC took part in regular meetings for the Filipino Mental Health Initiative.
- Conduct one anti-stigma event per year at the local high school: DCYCH PLAY staff conducted multiple such events throughout the year across JUHSD schools.
- Attend HEI meetings to engage with members and promote future events/services specific to the population: DCYHC leadership have attended HEI meetings.
- Attend quarterly business networking events: DCYHC leadership have attended a variety of networking events during the year.
- Participate in the San Mateo County Contractors' and Providers' Monthly Meeting: They have regularly attended and participated in meetings.
- Participate in NCOC quarterly/steering committee meetings: They are in regular attendance.
- Participate in monthly COT (Community Outreach Team) meetings: They are in regular attendance.
- Provide training for Outreach Workers: Their outreach workers undergo extensive weekly training to provide trauma informed and culturally responsive care to the community. Their

Executive Director provides additional training to providers across the Bay Area on trauma informed care.

- Provide oversight and monitor NCOC Blog Site: DCYHC has greatly increased their social media outreach this year. They experienced a setback in losing a social media intern but have hired a new one to start in August.

Asian American Recovery Services (AARS): During the first part of FY 2022-23, AARS was still meeting with their clients/participants virtually as a safety precaution due to the unpredictable waves of the pandemic. In the beginning of the calendar year several AARS programs began to slowly increase to in person meetings/activities. Many were uncertain about returning to in person, however the need for social interaction was crucial to many of their clients and participants mental well-being so the staff continued to support and encourage folks to return to somewhat normalcy during life post pandemic. Staff reported that this was a slow incremental process for all involved and even though individuals were trying to go back to their normal way of living, the pandemic had its own aftereffects where folks still had anxiety, depression and greatly in need of social services. This was universal for all regardless of if they were part of AOD services, therapy, or prevention early intervention. AARS was actively consistent with providing psychoeducational and informative spaces for the Pacific Islander Community with their Journey to Empowerment. This was a space for the community to go and share stories and discuss topics that are often taboo in the Pasifika communities. It was created at the request of a Tongan community member who wanted a place for her Pacific Islanders to come and fellowship and talk about things that are unspoken in their community like marriage, family, therapy, and healing. From this request, AARS staff and other community partners and leaders were able to turn this into a reality. AARS has been able to guide and help empower community individuals to co-facilitate workshops. Some of the topics covered were:

- Reflection of 10 Years(20 participants)
- Game Night (9 participants)
- Reflections and Intentions (9 participants)
- Heal & Paint (29 participants)
- Name that Tune- Healing with Music (30 participants)
- “Heal & Paint” (26 participants)
- “All About Love”-“Heal & Paint (23 participants)
- Fa’atasi Game Night (33 participants).

During the FY 2022-23 AARS was able to make connections with the extended Pasifika community like Back on Track -American Samoa, Samoana International Virtual Summit Committee, Kevin Lee-Chomoru PHD candidate at MIT reaching out regarding Pasifika Strong and then connecting Kevin with Bishop Taulauga Elisia who is charge of the Samoan Ward in Pacifica, connect Karl-Touch Therapy and intro to UTOPIA, and Connect Cindy with We Are Samoa CA. AARS found that they were the bridge to connecting many Pacific Islanders together to meet, great, learn about each other and possibly support each other’s projects/programs. During this FY 2022-23 AARS did presentations with the community on the stigma free work that they are doing in San Mateo County. They presented at

the Samoana International Virtual Summit, Mental Health Oversight Committee - public comment section, California Institute for Behavioral Health Solutions, Healthy Relationships for Our Children, Soalaupule presentation, and a presentation for Dr. Shawnterra Moore- Superintendent of South San Francisco Unified School District. In the later part of the fiscal year AARS conducted outreach in person at the following community events for their programs and their NCOC partners:

- Pasifika Feats (22 people)
- PIEFEST- Stem for Pacific Islander kids at Lemo Foundation in Redwood City (81 people)
- Sister to Sister Girls Empowerment Conference – South San Francisco (64 people)
- Parkside Intermediate Career Technical Education Showcase – San Bruno
- Feolani Festival- Samoan Community Development Center, Vasa Conference City College of San Francisco, Dave Canapea Community Resource Fair- Serramonte Mall Daly City (104 people)
- Pacific Islands Together -SHINE Family Day- Daly City (21 people)
- Soalaupule Series- International, Pacific Islander Day- San Mateo County Fair (13 people)
- United Territory Of Pacific Islanders Alliance Gala, Fononga Alumaga(23 people)
- Community Showcase (18 people)
- Daly City Family Day (32 people)
- AAPI Community Connections (51 people)
- Daly City Family Day (32 people)
- All My Uso's Community BBQ (234 people)

AARS created a way to stay connected to the community virtually because of the pandemic by having weekly conversations with various Pasifika individuals in the community to share awareness and resources of upcoming Pacific Islander programs, local events, and community partner programming along with other needed resources. *Talanoa* means talk story and AARS acknowledges that to empower the Pacific Islander communities voice, they have to encourage folks to rise up and use their voices on platforms they are comfortable with. Essence of MANA knows that to continue to break down the walls of stigma in the Pacific Islander Community they must continue to provide safe spaces and uplift the communities voices. Some speakers and topics for Talanoa Tuesday were: Tracy Cook-Williams her topic was Pasifika Creatives Series with a highlight on Female Representation in Street Art ,Using Art for Pacific Islander Youth to Heal and her involvement with IKUNA, MANA Check In with Community Announcements & Events, Tali Alisa Hafoka about Pasifika Creatives Series Art and Painting tying Pasifika Culture in to Art Cultural Representation, Koreena Ortiz-Tanuvasa about Waves of Leaders Series Pacific Islander Youth Programming (SCDC, PIYA, Ala Mai, PI's in Higher Ed), Kevin Lujan Lee with Waves of Leaders Series PASIFIKA Strong, Pacific Islander Community Org Resource List, Alina Faaola with Waves of Leaders Series, OPIN (Oakland Pacific Islander Network) Pacific Islander Youth Programming with Talanoa Feud Community Engagement and virtual game night, Lenna Malieitulua and Richard So with SF HEP B Free Hepatitis B Awareness in Pacific Islander Community. Listed here are some additional event topics during the FY 2022-23 and numbers of individuals reached.

- New Years Post (254 people)

- Epi Aumavave Grand Opening of Le Maota Space (1104 people)
- Alisi Tulua COVID-19 (1158 people)
- Alex Niuatoa TOA Strength Heartwork Higher Education & Working with Pacific Islander Youth Reached (647 people)
- MANA Team (446 people)
- Nia Unga Elite Financial Team (636 people)
- Joey Joleen Mataele Leiti's in Waiting Documentary Being a Fa'afine and LGBTQ+ Advocacy and Human Rights Heartwork for LGBTQ+ Community (771 people)
- Bell Taulua Re-Entry and Recovery FOU Movement Heartwork Self-Journey after Incarceration Healing and Giving back to the Community after Time Served (1307 people)
- Daniel Nava and Marcelle Valdez Sister to Sister Outreach (539 people)
- Kala Faleola Kina Organics Brand – Carrying On Tongan Grandmother's Legacy Tongan Engineer Pacific Islander Women in STEM (454 people)
- Sister to Sister San Mateo County Girls Empowerment Conference (126 people)
- Hinano Tanielu and Namuali'I Tofa Sosefina the Movie, Dr. Samara Suafoa Higher Education Journey through Educational System as an Educator Representation (919 people)
- Pasifika Immigration and Legal Rights with Leah Tuisavalalo (910 people)
- We Are Samoa Resource Event-Cultural Specific Programming and Events with We Are Samoa California (2651 people)
- Pacific Islander Wellness Fair on Treasure Island with Meri VeaVea & Jen Upuresa (1104 people)
- Celebrating 3 Years of Talanoa Tuesday with TALAVERSARY (1294 people)
- PSA for TT (396 people)
- First Samoan Administrator/Principal of Carson High School Working with Pasifika Youth with Dr. Diane Faatai (1411 people)
- Turning Grief in to Progress Soalaupule Gun Violence effects on Pasifika Community with Easther Mulipola of Project Respect (985 people)
- PIVP Pacific Islander Parenting with Brittany Afu (1214 people)
- UTOPIA 25th Anniversary Pasifika LGBTQ with Mata Finau of UTOPIA SF (672 people)
- Public Service Announcement (991 people)
- Community Announcements and Check In with MANA (451 people)
- Next Goal Wins LGBTQ+ Advocacy First Transgender Woman to play in Soccer World Cup with Jaiyah Saelua (1503 people).

StarVista: Many StarVista programs provide direct clinical services and, in doing so, reduce the duration of untreated mental illness, and prevent mental illness from becoming severe and disabling. In the FY 2022-23, StarVista provided direct services to 1,250 individuals living in North County. Crisis Intervention Services were provided to 29 North County citizens through the Crisis Intervention and

Suicide Prevention program and the Youth SOS program. Additional individuals received crisis services through the Community Wellness and Crisis Response Team, a collaboration in Daly City and South San Francisco that assists law enforcement when they respond to community members experiencing mental health crisis. Finally, additional individuals received crisis services through the Health Ambassador Program for Youth, counselors placed in schools throughout the community, and crisis intervention offered to clients who presented in crisis during ongoing treatment. They currently do not have an efficient way of tracking the services across programs and are working with their data team to develop methods of tracking the data more efficiently and accurately. Multiple StarVista programs (e.g., First Chance, Insights, SOY, Victim Impact Awareness) work with individuals who have been court ordered to treatment through diversion programs or have been released from prison or jail and have mandated treatment as part of their parole or probation. Treatment focuses on developing skills to avoid future legal involvement or incarceration. Clients in many StarVista programs experience housing insecurity and assisting them in finding resources for secure housing becomes a primary focus of care. The StarVista school-based programs have a primary focus of assisting students in resolving barriers to successful school attendance and performance. School based programs worked with 289 North County students this fiscal year. Multiple StarVista programs (e.g., Child and Parent Services, Differential Response, Healthy Homes, Early Childhood Community Team, Early Childhood Community Mental Health Consultation) focus on care for families that are at risk of having children removed from the home. Case Management and therapeutic services are offered to assist parents in overcoming the challenges (e.g., the stress of food and housing insecurity, domestic violence, mental health issues, poverty, and discrimination) that can contribute to incidents of abuse and neglect. Support is provided to other caregivers involved with the children to expand the scope of support to the children and families. 359 North County children/families received services from these programs during the fiscal year. Multiple programs (Daybreak, Women's Enrichment Center, Insights) provide support in writing resumes and developing interview and job skills for transitional aged individuals, youth who have been in foster care, adults seeking work after periods of incarceration or unemployment due to homelessness or addiction, etc.

The Daly City Partnership's (DCP): DCPs unique collaborative efforts between internal departments and associated programs creates an environment in which warm handoffs are not only possible, but frequent, timely and expedient. The Daly City Community Service Center, a San Mateo County CORE agency, served over 4,600 households and 10,800 individuals (about the seating capacity of Cameron basketball stadium at Duke University) with a wide range of emergency services impacting the social determinants of health, including food, clothing and household items, shelter initial assessment and referral, direct rent and emergency financial assistance, information and referral, advocacy and seasonal programs (toys for holidays, back to school resources and supplies, etc.). Over 60 households with 200 individuals were assisted with utilities (water, electricity, etc.), while 240 households with 655 households received deposit and/or rental assistance. 140 households with 327 individuals were referred to other agencies for rental assistance. DCP found that clients who come in for emergency financial assistance often are in heightened mental states and operating it what seems to be their flight/fight/freeze/fawn response state. Many appear angry, in

tears, unable to focus, etc. After receiving assistance, the clients express their gratitude for the thousands of dollars of assistance (for example through the state COVID-19 impact program "Housing is Key", for which DCP continues to serve as a Local Partner in their Network). Additionally, over 95% of households surveyed rate the program at a 4 or 5 – happy or very happy – with the services they received, while 100% report they remain stably housed 6 months from the time they received rental assistance from the programs.

Daly City Partnership's program Our Second Home (OSH) continued to offer on-site, teletherapy and virtual therapy. OSH has adapted and has managed to continually collaborate with partner agencies such as the school districts and the Daly City Youth Health Center. The mental health program has continued to offer no-cost therapy to their clients. They are in the process of working with insurance companies to process medical payments for future billings. Looking at the total sessions offered during this fiscal year, despite all obstacles, OSH remained committed to serving their community.

Although the world is in a "post-pandemic" world, clients continually express major anxiety and depression due to COVID-19 job losses, higher gas, food and utilities while at the same time, much less resources. The focus of most of the LMFT sessions has been to alleviate anxiety and help those focus on how to make the best out of this situation. During this time, social injustice continued to take place and rocked America to its core. Most client sessions have been finding ways to deal with the ups and downs of the pandemic and dealing with their own feelings. Throughout the school year, many of their clients still came from the following locations: General Pershing State Preschool (GP), FD Roosevelt K-8th (FDR), Daly City Community Service Center (DCCSC), and Our Second Home (OSH), Summit Shasta, OLPH and Thomas R. Pollicita. All locations are in Daly City. Many new clients were added that included teachers, school staff, mental health professionals, medical professionals, and many other individuals. Fentanyl became the newest crisis that clients are dealing with, alongside the death of young people in the community. Supervision of MFT Trainees began in August with the supervision of 3 trainees. They are expanding the intern program for locations within the DCP. All supervisees are under the license of the LMFT. OSH hired three additional summer interns with weekly supervision. Clients at OSH are referred from all over the school district, but primarily received via OSH, General Pershing State Preschool, Daly City Community Service Center, Fernando Rivera Middle School, Franklin D. Roosevelt Elementary School, Susan B. Anthony School, Daniel Webster Elementary School. The following are outcomes for DCP:

- Provide holistic therapies (yoga, art, music) & programs for children with special needs, & those with ACE factors: Clients are offered individual, group, couples and family therapy in the form of Solution Focused Therapy, Cognitive Behavior Therapy, Emotion Focused Therapy as well as Art, Drama and Play Therapy.
- Market and manage a wrap- around information and assistance program for families in the community, including community outreach and social media: In addition to postings on Facebook, Twitter, Next Door and the city's monthly newsletter, known as "Daly Wire", Daly City Partnership and OSH post news of classes and events on a quarterly basis through

Constant Contact, which has a list serve of nearly 2,000. This past year, OSH received over 500 inquiries regarding childcare, preschools, and events. Due to COVID-19, OSH's inquiries continue to address the need for food and housing assistance, and OSH continues to be instrumental in clients' accessibility to their online rental assistance application and COVID-19 resource page.

- Family and children's group and individual therapy for uninsured, under supported, and underinsured referred families: The monthly "Special Needs Support Group" and social/emotional reading workshops at the preschool continues to take place via Zoom. Over a dozen families participated during the FY 2022-23 and appreciated the connection and the continued efforts to keep this group going virtually.
- Provide Individual and Group Therapy: Clients range in age from 3-84 years of age, and come with some presenting issues such as; COVID-19, depression, suicidal ideation, suicidal attempts, domestic violence, child abuse, child neglect, social anxiety, anger, post-traumatic stress, marital issues, self-harm, child pornography, cutting, drug and substance abuse, illnesses contributing to anxiety, sexual molestation of minors, and self-esteem. Implementations of safety plans were available to clients. Safety plans are given to clients after initial assessments have been done. Appropriate resources will also be given to best meet their needs. Some of these resources have been to local food banks, shelters, psychiatric wards, clothing resources, transportation issues, housing issues, and medical information. A Daly City Partnership Staff shared: *"Handing a client, a phone number is not enough, but rather ensuring them that their needs will be met to the best of our ability."*

The Pacifica Collaborative: the following are outcomes for FY 2022-23:

- Pacifica Collaborative members participated in 12 outreach events. Through the Pacifica Resource Center, Pacifica Senior Services and Pacifica Libraries, 4,972 people were reached during the bi-monthly events. Group outreach is conducted at the food distribution event. Congregate lunch programs, family events at the library and during food distribution events. Pacifica Collaborative provided health education information, mental health resources and resources during these events. 2500 fliers were distributed over the course of the year.
- Pacifica Collaborative members connected 15 individuals to services through warm handoffs and direct referrals. Referrals were made to Pacifica Resource Center, Daly City Youth Health Center, Daly City Partnership and Star Vista. Community Outreach Team connections and relationships nurture the warm handoffs between agencies.
- The Pacifica Collaborative hosted 12 monthly meetings where all sectors of the community come together to support each other's work and enrich the community. Monthly attendance at the meetings averaged 20 people. Sectors of the members include Pacifica Library, Pacifica School District, Pacifica Prevention Partnership, Pacifica Research Center, Pacific Beach Coalition, Pacifica School Volunteers, Pacific Coast Television, Pacifica Police Department, HIP Housing, Project Sentinel, Jefferson Union High School District, Daly City Youth Health Center, HEalthRight360. Connections that happen in the monthly meetings allow for the nurturing of

relationships and supporting each other's work by volunteering for events, broadcasting events, fundraising and resource sharing.

- Pacifica Resource Center identified two Chinese speaking volunteers to come to the center and provide translation services as needed. This creates a network of local providers/support services that can provide culturally sensitive services.
- Pacifica Collaborative staff represents NCOC on the MHSA Steering Committee. They attended quarterly meetings and participated in a workgroup.
- Pacifica Collaborative members participated in the Spirituality Initiative Meetings.
- Pacifica collaborative participated in 2 Targeted Anti-Stigma workshops. Pacifica's Youth and Family Summit included youth-led workshops on mental health and substance use, as well as digital storytelling that told the stories of youth who felt stigmatized by being in recovery)
- Pacifica Collaborative participated in 8 Community Outreach Team Meetings
- Pacifica collaborative Staff participated a a member of the board of directors for CoastPride. Through this involvement, LGBTQ+ resources were brought to the residents of Pescadero, Half Moon Bay and Pacifica. LGBTQ Outreach and Collaboration: Coast Pride Board Member Strategy: Monthly meetings and Pride coordination

Successes

Daly City Youth Health Center: PLAY squad members have continued to flourish in the after-school program. PLAY has seen an increase in recruitment and participation after making improvements in their curriculum. This program continues to build strong and supportive relationships throughout the JUHSD schools. August Thornton-Wilson was part of the Squad Leadership at Terra Nova and became a Youth Staff:

"I learned from PLAY to make sure to bring up the people who are feeling alienated or left behind, and how to do that better. More generally I feel like I've really developed my ability to teach. I love that this program and the Daly City Youth Health Center offer so much direct and easy to access support. For my skills development in PLAY I've been able to talk with role models about what I want to get better at and visions I see for the Squad. Then Squad put me in a position to be a role model and someone who helps others, so I could kind of return the favor. The health center services are very nice to have, the idea that I can get counseling easily if I'm in need is really comforting. They're unique from my school's counselors because they feel disconnected from the institution of school, which is generally the reason I would feel in need of counseling PLAY has really supported me, I was in it through quarantine and took on gradually more responsible roles, and that entire time it's served as a sort of cornerstone activity for me. I've always focused on my teaching abilities; PLAY allowed me to develop those skills greatly. As well it was always a nice social event and a thing I could find responsibility and direction in, when I was lacking things that could offer both. The direction it gave was perfect since it provided goals like increasing Squad cohesion, things that were feasible, but not required for me to complete. In short, every action I took felt like it was important and moving

towards a goal, but I never felt an intense pressure to achieve that goal, and it never weighed on my mental state. On becoming youth staff I became more able to not just work towards goals for myself, but direct others in working towards goals. In that I learned how to lead in an environment I had experienced before. Overall great experiences have resulted from PLAY."

Asian American Recovery Services Success: During this year, AARs has been the go-to, or go to connect for many folks resulting in AARS being a bridge for those in need of making some type of connection to services. When inquiring how individuals heard of AARS, many responses were through social media or posting of their flyers. Being consistently visible in the public's eye can have great results however, there is a catch. To build content means you must constantly be on a media platform, and for AARS seasoned staff this can be done, however it is limited to one venue, not as others are able to use multiple platforms at one time. Still this platform has helped them be more visible and consistent in what they do with limited staff.

StarVista: StarVista programs address more than presenting symptoms and problems, and additionally focus on the values, strengths, and life goals of clients. Evidence supported interventions are used to teach mindfulness and affect regulation, positive communication and problem-solving skills, symptom management, etc. In addition, interventions designed to increase self-compassion, self-understanding and values driven life choices are utilized. Client directed, whole person, culturally sensitive, trauma informed, and strengths-based care is highlighted. The following is a success story from one of the school-based programs that illustrates that treatment extends far beyond simply completing the school year.

Client Success Story #1: Finn*, a gender non-conforming 17-year-old Caucasian older adult, initially was referred for services due to struggles making connections with peers and extreme symptoms of anxiety and depression. Finn had fallen behind in school during the year and found themselves not able to fully engage with academics due to lack of interest and motivation. Finn also had not fulfilled the required 30 hours of community services for graduation, which was a sore topic for them.

Initially, Finn presented as uncomfortable and somewhat disengaged. They were reluctant to share thoughts and emotions. Although it took a little longer than usual to build rapport with Finn, it was evident that they lacked any safe space to freely share emotions and concerns.

The counselor soon discovered that Finn was incredibly intelligent and had many creative pursuits that included writing short stories, baking, drawing, writing poetry, and a love for theater. Through a strengths-based model, the counselor highlighted Finn's creative pursuits and used them as a foundation from which Finn learned to express their emotions, to communicate with others, and to reduce stress. The counselor used activities that Finn enjoyed guiding self-exploration and identity building during sessions.

Finn and their counselor explored many options for life after high school. Finn enjoyed taking trades courses such as woodworking and welding. They thought, if anything, they could go into the trades and do welding because they did not have the mental bandwidth to continue along the path of

regular education. Finn was presented with the opportunity to volunteer with the local repertory theater to build sets for an upcoming production, and they took it.

During Finn's last session, their affect was different. There was an overall feeling of hope as they discussed a welding school in Tulsa, OK that Finn's uncle had told them about. The counselor and Finn researched Tulsa and discovered there was a vibrant theater scene there, and many opportunities to build skills in the field of creative arts.

Through therapy, Finn came to realize that there was a place within the creative fields that needed trades people. Working alongside professionals in set design, Finn discovered that a career in theater and the arts could be possible and is within reach. Finn completed all the requirements for graduation and is better acquainting themselves to trades programs. Upon completing therapy, Finn acknowledged ways he had grown in self-confidence and self-worth through the process of therapy.

Daly City Partnership

"*I finally realized that I am no longer a victim but am a survivor."*

"I realize that I am not alone"

"DCP has helped me in more ways than I can mention."

"I wrote a paper about DCP and I received an "A"!"

"I don't know where I would be without therapy each week"

"*My husband was going to kill me and my son. You saved our lives and I am so thankful" ---forward a few years later: we are doing so well and every day, all I can do is thank DCP again and again and again!"*

"I never knew how much therapy would help."

"When all I see id darkness, you help me to see hope"

"I hope this program never stops"

"The abuse was horrendous and the beatings even worse". "I am so glad I found you and all that you have done"

A young mother comes into the staff's office, not sure what to do or how to do it and wants to show staff pictures. Staff were hoping not to have to see the graphic pictures but knowing that they must be able to compose themselves, for the sake of the client. Fortunately, the pictures were not found on their person, and she said she will find them. Forward three years: "I have an amazing life and amazing children and you taught me how to stand strong and firm and that hope is here. You showed me how to process my grief and trauma and how to love myself. You have helped me tremendously and I will never forget what DCP has done for me." This client would be one of their many success stories from the benefit of weekly therapy.

On a different note, the staff has had the job of helping those who have no hope and whose loss consumes them to the point of ending their life. "*There is no more reason to live and what's the point of even trying*". The tragic death of a 12-year-old due to overdose hit hard with their family friends, classmates, and staff. The demand for brain-mental health was overwhelming and DCP stood up to the task and offered multiple therapeutic services to all. Depression, guilt, anger, trauma, and increased suicidal ideation were just some of the presenting issues to this death. Their clinicians had to process their own thoughts and feelings over this issue.

Client Success Story #2: An older adult female (69) who has a history of substance use issues, mental health issues and physical disabilities was renting a room in a house for $1200 per month. Her income was only $600. This led her to make many hasty decisions which put her into a large amount of debt. The stress of trying to live beyond her means also led to increased substance use and poor physical health. She caught COVID in early 2022 and her family came to the facilitator of the Pacifica Collaborative seeking services. The family was referred to Pacifica Resource Center who was very familiar with the woman in need of services and had already established a relationship with her. This allowed for a base of trust and the family came in together to create a plan. It was very difficult, but the family decided the only path forward would be for the woman to access homeless services, work with a case manager and seek out a permanent housing voucher. The woman moved into Coast House interim housing in HMB.

"*It was scary and sad when I first moved into Coast House. Now, I am more relaxed than ever before as I do not have to hustle to make rent. I have a case manager onsite, there are meals, laundry services and access to medical care. I have found ways to be of service with the other clients on site and we have a sense of community. I feel cared for and hopeful for my future."*

"My sisters and I all feel confident that this was the best course for our sister. We are so happy that she is getting healthy and helping others while participating in case management. We sleep better at night with less worrying about her."

Pacifica's Safe Parking Permit Program: The City of Pacifica has implemented a Safe Parking Permit Program for people living in motorhomes who want to seek services to find permanent housing. The program started on July 2022. The program could not be placed in a parking lot so there are 13 spots across the city in public right of ways. Unfortunately, 4 of the 13 spots are being appealed to the California Coastal Commission. Currently all 9 available spots are being occupied and four on the waiting list. Those people are connected to the Pacifica Resource Center for case management and any other services necessary. There have been three permit holders who have received lifetime housing vouchers. This is a huge success.

Challenges

Daly City Partnership: There were many challenges this year due to COVID-19 and all the post-Pandemic realities, such as food shortages, utility increase, gas price hikes, failing to requalify for CalWORKs benefits. Many clients were added due to the pandemic. DCP shared the biggest challenge was not enough therapists to meet the high demand of incoming clients. Most low-income individuals had limited access to teleservices due to outdated devices, low internet data, etc. This in itself is not acceptable. Increased funding would help with many of these areas, as well as being able to offer individuals affordable internet and up to date devices on a possible "borrow" program.

One challenge Daly City Youth Health Center experienced this year was that 2 of their behavioral health interns left the traineeship program in the middle of the year. They had a caseload of about 10 clients each that were reassigned to other clinicians. This resulted in a heavier caseload than usual for some of the trainees and a discontinued path of care for the clients. DCP was able to work through those obstacles through team effort while also making sure they were meeting their clients' needs. To mitigate those challenges, they decided to only accept 12 trainees for the upcoming year instead of the 14 they originally had this year. They made their interview process more robust and thoroughly explained to the applicants the expectations of their program. They emphasized the high needs of their vulnerable community and made it apparent what the requirements are to thrive in their traineeship. Additionally, they created a new training curriculum with clear objectives to present to the trainees when they first come in August. Their Outreach Coordinator streamlined the entire traineeship program and will be the main person of contact to help and guide trainees throughout the whole year.

Asian American Recovery Services: During this year, AARs has been the go-to, or go to connect for many folks resulting in AARS being a bridge for those in need of making some type of connection to services. When inquiring how individuals heard of AARS, many responses were through social media or posting of their flyers. Being consistently visible in the public's eye can have great results however, there is a catch. To build content means you must constantly be on a media platform, and for AARS seasoned staff this can be done, however it is limited to one venue, not as others are able to use multiple platforms at one time. Still this platform has helped them be more visible and consistent in what they do with limited staff.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) collaborative is comprised of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psychoeducation, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL) and 'Anamatangi Polynesian Voices (APV). The program goals are as follows:

- Increase access for marginalized ethnic, cultural and linguistic communities accessing and receiving behavioral health services. The collaborative will facilitate connections between people who need mental health and substance use services to responsive programming (e.g., Parent Project, Mental Health First Aid, WRAP, support services, etc.) and/or treatment. Specifically, looking at how to increase access for children with seriously emotionally disturbed (SED) and adults and older adults with serious mental illness (SMI) or at high risk for higher level of care due to mental illness.
- Strengthen collaboration and integration. Establish effective collaborative relationships with culturally and linguistically diverse agencies and community members to enhance behavioral health capacity and overall quality of services provided to diverse populations. The Collaboration will improve communication and coordination among community agencies involved and with broader relevant efforts through the Office of Diversity and Equity (ODE), Health Equity Initiatives (HEI) and others.
- Establish strong linkages between the community and BHRS). It is expected that there will be considerable collaboration that would include but not be limited to mutual learning. The Outreach Workers will receive trainings from BHRS and the Office of Diversity and Equity to support outreach activities as needed (e.g., Using Cultural Humility in Asking Sexual Orientation Gender Identity (SOGI) Questions, Health Equity Initiative sponsored trainings, etc.) Partnership with the BHRS regional clinic(s), Access Call Center referral team and many other points of entry to behavioral health services will be prioritized by BHRS. Likewise, the collaborative agencies and outreach workers will work with BHRS regarding strategies to improve access to behavioral health services. They will build linkages between community members and BHRS to share vital community information through the participation input sessions, planning processes and/or decision-making meetings (e.g., boards and commissions, steering committees, advisory councils, etc.).
- Reduce stigma, including self-stigma and discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services. The Outreach Workers will make services accessible, welcoming and positive through community approaches that focus on recovery, wellness and resilience, use of culturally appropriate practices including provision of other social services and engaging family members, speaking the language, efforts that address multiple social stigmas such as race and sexual orientation, and employment of peers. Specific anti-stigma activities can include, but not be limited to, community- wide awareness campaigns, education and training, etc.

The target populations served by EPAPBHO are marginalized ethnic, linguistic and cultural communities in the region including Latino, Pacific Islanders, African American/Black, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) communities of all ages. EPAPBHO services are based on two key models of community engagement, the community outreach worker model and community-based organization collaboration.

- Outreach Workers (also known as *promotores*/health navigators) connect with and facilitate access for marginalized populations through culturally and language appropriate outreach and education and provide linkage and a warm hand-off of individuals to services. Outreach Workers are usually members of the communities within which they outreach to. They speak the same language, come from the same community and share life experiences with the community members they serve. Outreach Workers use a variety of methods to make contact with the community. From group gatherings in individuals' homes to street outreach and large community meetings, as well as make direct contact with target audiences, warm hand-offs and convey crucial information to provide community support and access to services.
- Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy and offering ongoing presence and opportunities for community members to engage in services.

Program Impact

EPAPBHO	FY 2022-23
Total clients served	946
Total cost per client	$116

Improves timely access and linkages for underserved populations: Historically, the population served by EPAPBHO are undercounted and underserved. The partnership's on-going interventions provide timely access and linkages to treatment. For example, during initial screening, outreach workers engage clients when they either come in for services or when they are engaged in the community. During the verbal assessment, outreach workers help clients with presenting needs for which they are seeking services. Outreach workers listen non-judgmentally, assessing for risk of suicide or harm to self or others, give reassurance that there are local programs and services that will address whatever their specific need or concern may be. If/when appropriate, an immediate referral to the appropriate agencies in SMCBHRS' SoC is made for assessment and follow up treatment. In most cases, partners make warm hand-off referrals by accompanying the consumer member to the agency and depending on their request, participate in the initial assessment appointment. This has become a standard practice for all EPAPBHO partners particularly among monolingual speakers who need translation services and rely on an ambassador that they know and trust.

Reduces stigma and discrimination: EPAPBHO partners are founding members of the East Palo Alto Behavioral Health Advisory Group (EPABHAG), convened by OEPA. EPABHAG was created as an advocacy group to ensure that quality mental health services are provided to EPA residents. Over the

years, it has partnered with BHRS leadership to ensure that programs provided are created by the community and for the community. Major goals of the work have been to raise awareness of mental health issues and reduce the stigma associated with those issues. To this end, EPABHAG has held 12 annual Family Awareness Night events to achieve these goals with the most recent event held May 30th. Since its inception, EPABHAG has served over 1,000 residents through these events and have addressed topics including but are not limited to mental health vs. mental illness, stigma, trauma, substance use, wellness, and faith.

Increases number of individuals receiving public health services: EPAPBHO partners facilitate connections between people who may need mental health and substance use services or other social services and relevant programming and/or treatment by:

- Performing initial screening and engaging potential clients
- Provide brief interventions to engage clients
- Refer members who may need behavioral health services to appropriate agencies in the SMCBHRS System of Care for assessment and follow up treatment as needed.

Additionally, for most clients, continued support is needed to encourage participation in follow-up treatment. On many occasions, this means providing transportation when the services are outside of the East Palo Alto community, making a phone call as a reminder and as needed, accompanying them to sessions.

Reduces disparities in access to care: (See comments above regarding stigma and discrimination):

Implements recovery principles: EPAPBHO partners incorporate the five key recovery concepts into outreach efforts as follows.

- Hope – People who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
- Personal Responsibility – It's up to individual, with the assistance of others, to take action and do what needs to be done to keep themselves well.
- Education – Encouraging learning all what one is experiencing so they can make good decisions about all aspects of their life.
- Self-Advocacy – Teaching how to effectively reach out to others so that one can get what it is that one needs, wants and deserves to support wellness and recovery.
- Support – Allowing others to provide support while working toward one's wellness and giving support to others will help one feel better and enhance the quality of one's life.

Successes

Anamatangi Polynesian Voices (APV) recognizes that a multi-level approach to addressing the issues experienced by youth and young adults (in-school students and out-of-school) have been the intervention needed to succeed in serving families. Yet another successful intervention provided by Mamadee 'Uhile is her work at the Juvenile system in the County. Mamadee has been working with

young people who have been referred to her by County Probation to provide intervention for these young men and their families. With her cultural/linguistic intervention, Mamadee has been successful in serving the young men and their families and connecting them to other programs in the community.

Client Success Story:

Dates of Service: May 2023- July 2023
Requested Services: Medi-Cal, Mental health and general advocacy
Family Size: 1
City of Residence: EPA
"Mr. F" arrived to the U.S. in 2019 stayed past the return date to the Kingdom of Tonga. He's been living at Fofo'anga in East Palo Alto since 2021. His Leg was amputated due to diabetes. He came to Anamatangi because other members in the Tongan community told him that APV could help him with his medical situation. APV helped him be a part of some activities like being at the COVID-19 Pop-up clinics. He took the vaccine due to the help provided by APV. APV had to be the translator for him at some medical because he doesn't speak English. His appointments at Ravenswood Clinic and Stanford Medical. Mr. F is disabled but still gets around to help with cultural activities like singing. Mr. F is part of the Cultural practitioners of Anamatangi. He shared knowledge of the four pillars of Tongan culture created by Queen Salote so he's helped APV and vice versa. Mr. F lost his teeth and through the help of APV was able to refer him to Stanford for dental work. Mr. F is an integral part of the cultural practitioner program of Anamatangi as he has shown up to support APV at town hall meetings, take the mic programs and some of the festivals.

El Concilio of San Mateo County (ECSMC) continues to be successful in engaging community members, assessing them for mental health needs, and referring them to services. In particular, a single mother of two children walked into ECSMC offices because her electricity had been shut off for two days. She was very distressed and nervous because her food had spoiled from having her electricity shut off. ECSMC's Case Worker was able to assist her with submitting a LIHEAP application and have her electricity restored in a span of a few hours. She was referred to Nuestra Casa and Ecumenical Hunger Program (EHP) for some meals and food for the coming weeks. The client was so grateful and relieved with the assistance. In working with this client, staff was also able to see that she could benefit from mental health counseling, so she was referred.

Free at Last (FAL) is still doing well with people who are fully recovering. Patients can receive continuing assistance from FAL if they are struggling with co-occurring disorders or mental health issues. FAL continues to work in partnership with the East Palo Alto System of Care, which includes the Ravenswood Community Health Center, EHP, and the East Palo Alto Community Counseling Center. FAL staff members continue to assist those who have successfully finished residential treatment by assisting them with finding employment, referring them to SLE housing, shelters and or returning to their families.

The Barbara A. Mouton Multicultural Wellness Center (The Mouton Center/TMC) although not part of the EPAPBHO partnership per se, TMC referrals are entered into the EPAPBHO online system and are part of the partnership meetings with the San Mateo County MHSA Manager and EPACCC staff. Since the pandemic, TMC gradually opened its programming hours and activities to the community during this fiscal year. A great success for The Mouton Center is the launching of Wellness Wednesdays for the community in May, 2023. Wellness Wednesdays are sessions that are open to the community to come and focus on their wellness while enjoying a healing activity. Topics and activities have included painting, candle making, journaling, sharing ones narrative, etc.. One of TMC's clients, T reported at one the sessions, that he was so excited to get to come back to the wellness center because he always feels welcomed and relaxed when he attends so he was grateful to be able to participate in the sessions. Another mother noted that she has a son with special needs so she attends the evening painting sessions as a selfcare activity for herself so she can in turn, take care of her son's needs. There are many other stories of community members who have been attending these sessions who have all agreed that wellness offerings are a great way of care for oneself in order to then care for their families and community at large.

Challenges

APV challenges have been the ongoing need to train APV field representatives/community ambassadors to take charge of the work. APV seeks the support of the clients such as Mr. F to continue the community engagement and connection to the community. Staff will be developing a basic readiness training for potential community *promotoras* and champions to continue to uplift the organization's work in the community.

ECSMC hasn't encountered challenges with engaging clients and making referrals, but in general what is noticed is that the community doesn't treat mental health as equally as important as one's physical health. Those that do seek assistance, maybe don't find what they are looking for, because people don't believe that psychologists and psychiatrists can help them with their emotional health. There is still a lot of stigma around seeking mental health and misunderstandings with what a therapist can help with. Other clients, mainly, Spanish-speaking and Latinx community, have mentioned that they haven't had a good experience with their therapist or that they are put on a long waitlist and haven't been called for an appointment. Therefore, they give up and don't pursue getting assistance. Case Workers see that there is a large need for culturally and linguistically appropriate mental health services for the community. It can't stress enough the importance of making culturally relevant mental health services more accessible and creating a pipeline of mental health professionals that come from communities of color and specifically, those that the organization serves.

FAL still encounters challenges because of the COVID-19 pandemic's efficacy and the way it has changed how FAL may provide outreach services for the community. Due to Drug Medical's limitations, outreach staff members are unable to bring individuals directly into the treatment program. Pay salary limits are still an issue for FAL and continue to struggle with hiring more staff for

outreach initiatives. FAL continues to follow health department regulations to safeguard the health of staff and clients and collaborate closely with the County to do so. If Drug Medical were to expand their service area and grant agency permission to provide services outside of San Mateo County, this would have an impact on FAL's ability to continue to support the community. Future solutions to mitigate these challenges would be to hire more outreach workers at market rates for skilled workers.

TMC, like so many other organizations have been challenged by staff shortage. Since the pandemic, it's been a great challenge to hire staff. Some staff who have been hired have come for a short period but have had to leave for various reasons. The organization continues to pivot to meet the challenge and hold job fairs and open houses to attract interest and new members.

COASTSIDE COLLABORATIVE

The Coastside Collaborative provides culturally-responsive outreach to the Coastside community and targets a broad community network with the goal of strengthening service collaboration, coordination, and integration into the Coastside region of San Mateo County. The Collaborative is co-chaired by the Youth Leadership Institute (YLI) and Ayudando Latinos a Soñar (ALAS).

Program Impact

Coastside Collaborative	FY 2022-23
Total members	94
Total cost per client	$478

Out of 94 Coastside Collaborative members, 8 new members participated during the FY 2022-23 and 2 new steering committee members were added: La Costa Adult School and Cabrillo Unified School District. The following data points describe the groups among the Coastside Collaborative: CBO or contract agency staff (30%), Other community members (6%), BHRS Staff (4%), Other County staff (e.g., Family Health, HSA) (4%), Family members (1%), Clients (0%), N/A (55%). The following priorities and goals were addressed during FY 2022-23:

- Community Resource Guide: The Coastside Collaborative revised the resource guide, incorporating information about Coastside services. Special emphasis was placed on highlighting the need for Mental Health resources within the Collaborative Resource Guide. Distribution includes various platforms such as city websites, the chamber's local website, and ALAS.

- BHRS MHSA 3-Year Planning Process: Active participation in the planning process related to BHRS Mental Health Services Act over the next three years was a key priority for the Collaborative.
- AllCove Presentation on Youth Mental Health Integrated Centers: Collaboration with AllCove aimed to enhance youth mental health services through integrated centers, reflecting a commitment to the well-being of young individuals in the community.
- COVID-19 Updates and Vaccine Equity: The Collaborative prioritized addressing COVID-19 concerns by emphasizing preventive measures, including vaccination, ventilation, and mask usage. The goal was to ensure equity in vaccine distribution.
- Communication Challenges During Storms: A focus was placed on identifying and strategizing solutions for communication challenges that arise during adverse weather conditions, ensuring effective communication within the community during such events.
- Storm/Flood Impacts and Youth Assessments: The Collaborative created a youth needs and challenges survey to better understand and address the specific needs of young individuals in the area. The data gathered includes information on sources for flooding-related information, preferences for accessing emergency support, impacts of flooding, supply needs, and opinions on family preparedness plans. Respondents access information from various sources such as schools, city websites, social media, TV, and YouTube. While some have family preparedness plans and express interest in learning more, others feel less affected, with differing needs for supplies and support.
- Fire Season Preparedness: The Collaborative ensured community preparedness for fire seasons by hosting CalFire presentations, focusing on educating and preparing the community for potential fire incidents.
- Tree Removal Safety: To enhance safety and prevent potential hazards, the Collaborative clarified and shared details regarding tree removal, addressing safety concerns in the community.
- Half Moon Bay Shooting Incident: In response to the shooting incident in Half Moon Bay, the Collaborative addressed the aftermath and impact, with a focus on providing community support and considering mental health implications.

Successes

The collaborative's efforts in updating and enhancing the Community Resource Guide, along with plans for widespread distribution both in print and online, have improved access to vital information for residents. Effective communication and awareness about COVID-19 preventive measures demonstrate the Collaborative's commitment to community health. Successful assessment and mitigation of storm and flood impacts and improved communication strategies during adverse weather conditions showcase the Collaborative's resilience in addressing critical issues.

Challenges

A significant obstacle is a need for increased support from partner agencies in the planning, facilitating, and documenting of the collaborative efforts, emphasizing the importance of cultivating stronger partnerships. Ongoing efforts are needed to address mental health concerns, particularly in the aftermath of incidents like the Half Moon Bay shooting, highlighting the necessity for sustained focus on mental health initiatives and community support systems. Identified gaps in community awareness about mental health resources indicate the need for persistent outreach efforts. Furthermore, challenges in affordable housing for farmworkers and essential workers emphasize the importance of advocating for housing initiatives tailored to these specific needs.

Future Needs: Looking ahead, the Coastside Collaborative identified key future needs to further enhance its impact on the community. Plans include the expansion of the Collaborative Resource Guide by exploring opportunities to incorporate additional categories and organizations. Emphasizing support for housing initiatives is crucial to addressing challenges in affordable housing for farmworkers and essential workers. Establishing mechanisms for feedback and evaluation will enable the Collaborative to adapt its strategies based on community needs, ensuring effectiveness. A continued focus on mental health initiatives, with proactive measures to address community concerns, remains a priority. Additionally, sustained collaboration with various organizations and exploration of new partnerships were highlighted as essential steps to meet the evolving needs of the community, fostering resilience and responsiveness in future endeavors.

CARIÑO PROJECT (COASTSIDE MULTICULTURAL WELLNESS)

The Cariño Project is funded 80% CSS, 20% PEI. The program opens pathways for increased services on the Coastside, limited in services. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. Staff often use a home visiting model to serve families. Ayudando Latinos a Soñar (ALAS) is committed to meeting the client where they are, both emotionally and physically.

In FY 2022-23, the Cariño Project served 140 unduplicated individuals in San Mateo County through their clinical component (therapy). 2,159 individuals (duplicated) were also engaged through various services including groups, training, arts activities and other supports.

The Cariño Project was founded on the opportunity to create new models of mental health and wellness wrap-around services that are grounded in cultural frameworks of intervention. The program opens pathways for increased services on the Coastside, limited in services. MHSA funding has allowed growth in programming and staff to increase wellness support services across the Coast.

ALAS is centered on honoring the client and their cultural wealth. The program believes that each person and family is rooted in a history of tradition and culture that strengthens who they are, which should be honored and valued. Operating from a strengths-based and cultural wealth perspective, ALAS values each person, family, and child, embracing each person's identity, sexual orientation, race, ethnicity, and cultural background/s. The Cariño project strengthens opportunities to work closely with expanded community groups. This was especially true in light of some unfortunate events in Half Moon Bay that ALAS responded to. Community members affected by the flooding in early January and the tragic shooting later that month put a spotlight on the services that ALAS provides and how ALAS was there for the community in every way possible.

Program Impact

Cariño Project *	FY 2022-23
Clients served (unduplicated)	140
Cost per client	$536
Individuals reached (duplicated)	2,659
Total Served	2,749

** unduplicated clients served are individuals that received therapy and/or case management services, individuals reached includes the community at-large, families and others engaged through support groups, events, arts and other activities.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	Due to this program, I am better able to cope with stressors in my life Due to participating in this program, I have experienced an improvement in my overall mental health Due to participating in this program, I have an improved ability to manage my mental health symptoms (clinical; follow-up/discharge)	9 of 9 8 of 9 8 of 9	100 % 89% 89%
Self-Empowerment	Due to participating in this program, I am better able to support myself and/or my family (case management)	45 of 52	87%
Knowledge, Skills, and/or Abilities	Due to the Cariño Project, I learned something that is useful to me.	67 of 73	92%
Cultural Identity	Due to the Cariño Project, I feel more connected to my culture	65 of 73	89%
Connection and Support	Due to the Cariño Project, I feel more connected to my community	68 of 73	93%
Stigma Reduction	I feel more comfortable talking about mental health since I started attending Cariño Project counseling sessions	20 of 22	91%

Demographics

Age (N=93)	%	Gender Identity	%
Ages 0-15	.1%	Female/Woman/Cisgender Woman	74%
Ages 16-25	7%	Male/Man/Cisgender Man	21%
Ages 26-39	26%	Genderqueer/Gender nonconforming	0%
Ages 40-59	41%	Unknown	1%
Ages 60+	12%	Decline to State	4%
Decline to State	.1%	**Sexual Orientation**	**%**
Primary language	**%**	Straight or Heterosexual	82%
English	6%	Gay or Lesbian	.1%
Spanish	94%	Decline to State	17%
Race	**%**	**City/Region**	**%**
Asian/Asian American	1%	San Gregario	1%
Black/African American	1%	Half Moon Bay	80%
Hispanic/Latinx/a/o	95%	Moss Beach	8%
White/Caucasian	0%	Montara	1%
More than one race	2%	San Mateo	1%
Unknown	0%	Unknown/Other	9%
Decline to State	1%	**Disability/Learning difficulty**	**%**
Ethnicity	**%**	Chronic health condition	9%
Central American	12%	Physical/mobility disability	1%
Mexican/Chicanx/a/o	81%	Difficulty seeing	4%
Decline to State	1%	Mental disability	0%
Another ethnicity	6%	Multiple	7%
		No	80%

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	N/A	0	0
Substance Use Disorders (SUD) Referrals	N/A	2	2
Other Mental Health (MH) Referrals	44	21	65
TOTAL	**44**	**23**	**67**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	1	Legal	27

Financial/ Employment	8	Medical care	22
Food	7	Transportation	0
Form assistance	0	Health Insurance	79
Housing/ Shelter	29	Cultural, non-traditional care	9
Other	33	**TOTAL**	**215**

Program Narrative

Improves timely access & linkages for underserved populations: Through the Cariño Project, ALAS provides wrap around services that connect clients to best services to address the whole person. At ALAS there is an open-door process for all to come in to be met by its staff who triage them to the best program and service for them. ALAS trains its team to meet with each client and review and assess all supports that can be given to them whether directly from ALAS or in the community and through county resources. ALAS screens clients for their direct needs and do a full assessment. In addition, whichever program a client enters, ALAS staff assess and refer for other ALAS services. ALAS has strong community partnerships and is familiar with programs across the County programs and processes which gives its staff the breadth of resources to be able to provide additional referrals within a timely manner.

Reduces stigma and discrimination: The Cariño Project has been very successful at growing and bringing the community into the ALAS program. This has happened because ALAS has brought visibility and advocacy which reduces isolation and stigma. Through the program outreach, the engagement with community and education, the program has seen a demand for increased mental health services- there is a growing need for more mental health in the Latino community. More Latinos are talking about mental health and are asking for counseling. Cariño project has grown its reach and as a result there is education, trust, and a place that community members feel safe to come to. In addition, the program's commitment to culture, to advocacy and to community organizing on the Coast with the Cariño project has also reduced stigma for the Latino community. The program is not just about delivering a service but about fostering an environment where the consumer becomes part of the program, part of the process and has input for what they want.

Increases number of individuals receiving public health services: Through the case management component of the Cariño Project there has been an increase the number of individuals receiving public health. The number has risen significantly as part of the program's work supporting enrollment in health insurance, in understanding county programs for health and wellness, and connecting to ALAS free mental health programs and workshops. The program also connects clients to the County specialist for insurance enrollment and have created a space for her to come into ALAS and meet community members on the ALAS Equity Express bus for the services. At all levels staff are engaged with making sure that they are increasing positive health.

Reduces disparities in access to care: The Cariño project which is free has been a key part of reducing disparities in access to care. Many community members participate in multiple services across ALAS

programs. The Cariño project is about identifying challenges and barriers for community members to access care and ALAS is very involved in advocacy and problem solving in this area. Most importantly the funding and program of the Cariño project has given ALAS has given ability to grow the services to the community which has been significant.

Implements recovery principles: The Cariño project strives to implement best practices that support and heal the client for the long term. Through this program, ALAS provides a breadth of services that meet the client where they are at and are able to identify a variety of ways to provide support. The program staff also work to connect the whole family to services when possible- providing for the wraparound of the individual and family. Through an engaged cultural entry point ALAS provides case management, mental health, advocacy, accompaniment, education, and community support.

Other activities that benefit clients: ALAS works closely with El Centro to provide substance abuse support and refer clients to the County for programs and mental health services that extend beyond services for mild to moderate. ALAS is very committed to ongoing follow up and check in with clients to see how they are and make sure they are connected and doing well. ALAS takes a whole family and community approach, engaging not only the individual but their family and community.

THE SAN MATEO COUNTY PRIDE CENTER

The Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

The Clinical Program of the Pride Center provides high quality, LGBTQ+ affirming behavioral and mental health services to marginalized and at-risk LGBTQ+ community members in San Mateo County. Clinical services include individual therapy, relationship therapy, family therapy, group therapy, and case management. The Pride Center work is strength-based and trauma-informed, engaging both natural supports and the whole family whenever possible. The primary purpose is to assist clients, their families, and their communities in reducing stigma and supporting the creation of safe, affirming environments for LGBTQ+ clients. To this end, services are aimed at not only reducing high-risk symptoms such as self-harming behaviors and trauma symptoms, but also at providing family support and education to non-affirming family members. Lastly, in addition to offering direct clinical care, the program's clinical team provides extensive consultation and LGBTQ+ training for other mental health and medical service providers; school administrators and educators; parents of LGBTQ+ youth; students; LGBTQ+ older adults; and the general public.

Program Impact

Pride Center	FY 2022-23
Clients served (unduplicated)	149
Cost per client	$2,138
Individuals reached (duplicated)	9,357
Total Served	9506

** unduplicated clients served are individuals that received therapy and case management, individuals reached includes all other individuals that participated in peer groups, youth and older adult services, trainings, outreach and events.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	CANS + ANSA* Depression subscales* (Population: Therapy Services) - improved/ remained the same CANS + ANSA Anxiety subscales* (Population: Therapy Services) - improved/remained the same	43 of 49 39 of 49	87% 80%
	Number of clients who reported an improvement in their mental health as measured by: *"How would you rate your mental health in the last 30 days?"* (Population: Therapy Services) - improved/remained	43 of 47	91%
	Number of clients who reported an improvement in their ability to cope with stress as measured by the following "*How would you rate your ability to cope with stress in the last 30 days?"* (Population: Therapy Services) - improved/remained the same	41 of 47	87%
Improved knowledge, skills, and/or abilities	ANSA Interpersonal/Social Connectedness + CANS Interpersonal subscales (Population: Therapy Services) - improved/ remained the same	39 of 49	80%
Connection and Support	ANSA Natural Supports + CANS Community Connection subscales (Population: Therapy Services) - improved/ remained the same	39 of 49	80%
Self-Empowerment	Number of clients who reported improved self-empowerment as measured by the following: "*I am confident I can affect my life through the decisions I make."* (Population: Therapy Services) - improved/ remained the same	12 of 18	66%
Stigma Reduction	Number of clients who reported reduced self-stigma as measured by the following*: "I feel comfortable talking about my sexual orientation."* (Population: Therapy Services) - improved/ remained the same	15 of 18	83%

	Number of clients who reported reduced self-stigma as measured by the following: *"I feel comfortable talking about my gender identity."* (Population: Therapy Services) - improved/ remained the same	14 of 18	77%

*The DEPRESSION and ANXIETY subscales of the CANS and ANSA assessments are considered "Needs" and scored between 0-3. A score of "0" indicates no need is present, whereas a "3" demonstrates high need. The INTERPERSONAL and NATURAL SUPPORTS subscales are considered "Strengths" and also scored between 0-3. For strengths, a score of "0" indicates a positive core strength and a score of "3" indicates no strength is identified.

Demographics

Pride Center is currently working on a system to track non-clinical demographic data more effectively and accurately (e.g., peer group participants, older adult program participants, community event attendees etc.). Some ideas include using ETO (their electronic health record system). The demographic collection process has to be transparent, inclusive, and accessible.

Age (N=149)	**%**	**Gender Identity**	**%**
Ages 0-15	10%	Female/Woman/Cisgender Woman	13%
Ages 16-25	35%	Male/Man/Cisgender Man	9%
Ages 26-39	37%	Genderqueer/Gender nonconforming	20%
Ages 40-59	14%	Questioning or unsure	2%
Ages 60+	3%	Trans Man	24%
Decline to state	1%	Trans Woman	22%
Primary language	**%**	Another	2%
English	93%	Decline to state	8%
Another/Decline to state	7%		
Race	**%**	**Sexual Orientation**	**%**
Asian/Asian American	19%	Asexual	7%
Black/African American	1%	Bisexual	8%
Hispanic/Latinx/a/o	10%	Gay or Lesbian	23%
Native American/ Indigenous	2%	Pan Sexual	8%
Native Hawaiian/Pacific Islander	2%	Queer	10%
White/Caucasian	44%	Straight or Heterosexual	6%
Another	1%	Questioning or unsure	10%
More than one race	11%	More than one	6%
Decline to State	11%	Decline to State	19%
Ethnicity	**%**	**City/Region**	**%**
African	2%	Atherton	1%
Chinese	7%	Belmont	4%
Central American	5%	Daly City	5%

Eastern European	7%	East Palo Alto	1%
European	23%	El Granada	1%
Filipinx/a/o	7%	Foster City	4%
Mexican/Chicanx/a/o	9%	Half Moon Bay	1%
Middle Eastern	1%	Hillsborough	1%
Vietnamese	1%	La Honda	0%
More than one ethnicity	10%	Menlo Park	4%
Another	4%	Pacifica	4%
Decline to State	24%	Redwood City	13%
Disability/Learning difficulty	**%**	San Bruno	5%
Chronic health condition	3%	San Carlos	4%
Difficulty seeing	3%	San Mateo	15%
Mental disability	20%	South San Francisco	5%
Another	14%	Woodside	0%
More than one	5%	Out-of-County	31%
No	29%	Decline to state	1%
Decline to state	36%		

Referrals

Types of Referrals	FY # Referrals within agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	n/a	At least 2	
Substance Use Disorders (SUD) Referrals	At least 2	At least 1	
Other Mental Health (MH) Referrals	At least 4	At least 17	
TOTAL	**At least 6**	**At least 19**	**26**

Types of Referrals	FY Total #
Emergency/ Protective services	N/A
Financial/ Employment	5
Food	12
Form assistance	2
Housing/ Shelter	9
Legal	15
Medical care	23
Transportation	5
Health Insurance	22
Cultural, non-traditional care	N/A
Other	35
TOTAL	**128**

Program Narrative

Improves timely access and linkages for underserved populations: The Pride Center provides underserved and marginalized participants multiple avenues through which to access services and receive LGBTQ+ affirming treatment and connections to resources:

Functional One-Stop Shop and Resource Hub: The Pride Center is unique in that it offers not only direct mental health services, but also community-building social events, educational trainings/workshops, pathways to leadership and community empowerment, as well as direct access to resources and local service providers to improve the overall health and wellbeing of local LGBTQ+ individuals and the LGBTQ+ community countywide. At every facet of Pride Center programming there is an opportunity for individuals to learn more about and gain access to clinical services and resources.

- Clinical Referrals: Within two business days of receiving referrals, Pride Center clinical staff attempts to contact the referred individual to provide more information about case management and/or mental health services, assess any immediate needs the individual may have, provide resources and/or information as needed, and schedule a screening appointment. The Clinical Program Coordinator and Intake Coordinator assumes responsibility for managing incoming counseling inquiries. Coordinated with the clinical team, staff work on waitlist procedures to improve initial response times and decrease the amount of time it takes to get clients enrolled in services. The Clinical Program Coordinator is also frequently in contact with StarVista's Database Management team for continued process evaluation.
- Prioritization of underserved and marginalized groups: As a whole, Pride Center staff have decided to prioritize services to underserved and undertreated individuals and members of high risk, marginalized, and otherwise vulnerable groups (e.g. non-heterosexual, non-cisgender members of the LGBTQ+ community, transgender and genderqueer/non-conforming/variant minorities, people of color, low-income individuals, victims of abuse, bullying, and/or crime, etc.). Low-fee and pro bono services have been offered to undocumented clients or those faced with financial hardship.
- Meeting individuals where they're at: The Pride Center follows a client-centered approach. Treatment planning is done in collaboration with the client and goals are what the client themselves wants to work on rather than what the clinician thinks may benefit them. For example, if a client wants to work on reducing substance use but does not want to become abstinent, the clinician will utilize a harm-reduction focused approach to treatment rather than abstinence focused. Additionally, the clinical team makes efforts to work around potential barriers to care -- such as food access, transportation, and housing status -- by assisting clients in navigating community resources either through direct case management or collaborating with the client's assigned non-Pride Center caseworker.

Reduces stigma and discrimination: The Clinical Program reduces stigma and discrimination by:

- Organizing and participating in community and social events that foster positive representation of the LGBTQ+ community. Pride Center staff and programs directly reflect the diverse community and individuals served.
- Empowering vulnerable community members through mentorship, guidance, and psychoeducation around coping skills and strategies to help manage and overcome stressful circumstances.
- Educating LGBTQ+ families, both directly and indirectly through collaboration with peer support workers, to increase families' acceptance, understanding, and support of their LGBTQ+ family members, reducing stigma and fostering a protective factor for clients. Furthermore, clinicians are well-equipped in providing appropriate resources to LGBTQ+ family members to educate themselves in better understanding and supporting their LGBTQ+ family member.

Increases number of individuals receiving public health services: The clinical team has continued its outreach efforts to increase community engagement with the agency's psychotherapy and case management services. Outreach has included active participation in LGBTQ-specific Listservs such as Mind the Gap, Gaylesta and Bay Area Open Minds as well as building relationships with practitioners at other local agencies such as CORA, the Felton Institute, and the Edison Clinic, among others. The clinical team also continues to strengthen relationships with partner agencies.

Reduces disparities in access to care: The Pride Center is committed to providing mental health services to the LGBTQ+ community throughout San Mateo County. To reduce disparities in access to care, clinical services are prioritized to individuals who:

- Are members of marginalized and underserved communities.
- Have untreated or undertreated behavioral needs, including mental health and/or substance-abuse related needs.
- Have experienced emotional/behavioral disturbances over a prolonged period of time causing difficulty and distress in relationships at home, school, work and/or community.
- Are at high risk for increasing levels of severity of presenting issues without mental health intervention.
- Are homeless or at risk of becoming homeless.
- Lack safety due to domestic violence/abuse.
- Are low income.
- Experience isolation and/or social anxiety.
- Demonstrate self-endangering behavior and/or history of suicide attempts or ideation.
- Are victims of or witnesses to violent crimes (bullying, gun violence, domestic violence, etc.).

Whenever possible, Pride Center staff also provide resources and information to clients to help improve their access to services by reducing barriers preventing them from receiving the support they need. For example, some clients requesting services have not had access to a phone and/or suffer from severe agoraphobia (fear of leaving the house). Staff have provided county resources that

provide no fee or low fee cell phones to these community members. Staff have also offered to meet clients in the field and have encouraged folks to make use of the Non-Emergency Medical Transportation benefit offered to Health Plan of San Mateo members, which is able to provide free transportation to eligible clients so that they can visit the Pride Center to receive clinical services. Similarly, encrypted, HIPAA compliant teletherapy services is utilized. This technology allows for clinical staff to provide essential services to clients who may be homebound or unable to physically visit the center (such as folks with chemical sensitivity issues or individuals with disabilities).

Implements recovery principles:

- Development of Positive Coping Skills - Clinicians utilize CBT as well as Seeking Safety interventions to help clients develop a broad spectrum of healthy coping skills tailored to their individual needs. Coping skills are practiced both in-session with the therapist as well as assigned as homework to help clients build new patterns of addressing stressful, potentially triggering scenarios.
- Harm Reduction - When working with substance use, clinicians take a client-centered approach, meeting the client wherever they are in their recovery and following the client's goals. If a client does not want to cease substance use, clinicians utilize a harm-reduction approach to help the client decrease the likelihood of injury or overdose while using and help refer for higher level services if the need is indicated. Additionally, if the client's goal is to reduce their substance use rather than to be completely abstinence, clinicians work with clients to support this goal.
- Client-centered, Trauma-informed Approach - Treatment goals are client-centered and treatment plans are created in session in collaboration with the client. The Pride Center does have a strict policy around the presence of substances on-site, which carried over into the telehealth platform for therapy services and is reliant on client's self-report. Clinicians also utilize Motivational Interviewing tailored to whichever stage of change clients are in. All clinical treatment is trauma-informed, starting with the initial assessment. Substance use is addressed along with present trauma-related symptoms, rather than treating dual diagnoses separately.

Other activities that benefit clients:

- Clinical: Reducing Gender Dysphoria - The Pride Center clinical team continues to support clients in navigating and accessing medically necessary transgender-affirming care to help alleviate feelings of gender dysphoria. The Pride Center clinical team supports transgender, gender-diverse, and non-binary clients in this way by assisting with legal name and gender marker changes on identity documents; writing letters of support for clients to access both hormone therapy (HRT) and gender affirming surgeries; connecting clients to resources and providers for services such as gender-affirming voice training; and more. With the support of the Pride Center, clients report that living their authentic lives and feeling safe to truly be themselves has a significant positive impact on their

mental health and wellbeing.

- CLINICAL (Cont.): Therapy services at the Pride Center aim to include not only acute care of currently presenting symptoms, but also prevention-focused interventions. Such interventions include safety planning, collaborating with other care providers such as psychiatrists and case managers, as well as psychoeducation of client (and family, when applicable) around diagnosis and care options.
- CLINICAL (Cont.): Clinicians regularly provide clients with community resources and socialization opportunities, as needed, and requested, by clients. These resources are vital to decreasing social isolation, creating routine, and increasing quality of life for clients with severe and persistent mental health challenges.
- Peer Support Groups: The Peer Support Group Program strives to accomplish the MHSA Intended outcomes. The Peer Support Program helps participants mental health by holding a space where many people can socialize with others and form a sense of community. This is a critical step addressing the isolation that many LGBTQ+ folks experience. The Peer Support Groups also help prevent ongoing mental health issues from progressing to mental illness. Community, relationships, and belonging are a critical part of an individual's mental and wellness.
- Training/Education: The Training and Education program reduces stigma and discrimination by educating local community members and other service providers through trainings and consultation on topics such as sexual orientation, gender identity, and their impacts on the health and wellbeing of the LGBTQ+ community. Staff work to increase collective understanding about the relevant issues LGBTQ+ people face, both past and present. Staff also works to incorporate the principles of cultural humility alongside tips on how to be a stronger LGBTQ+ advocate.

Successes

For the first three years of the San Mateo County Pride Center's existence, the program operated exclusively in person. In 2020 the pandemic changed the world, and the program was thrust into virtual services like most other community centers. Collectively, the Pride Center team surveyed its clients and community directly on how to serve *them* best moving forward as the world began to physically reopen again. It was clear that both options to access its programs and services, in person and remote, were needed. The program's greatest challenge of integrating its work into a hybrid format on top of its already full daily agendas began. This effort then became one of the Pride Center's greatest successes and triumphs.

The community seemed to agree. The Pride Center's Grand Reopening Event was attended by just over 200 individuals including key partners, stakeholders, and funders! The program hosted the following guest speakers: Board of Supervisors' President Dave Pine (he/him), BHRS Director Dr. Jei Africa (he/him), and San Mateo City Mayor, Amo Lee (she/her). Having such strong county leaders demonstrating their support for the center and the LGBTQ+ community, for whom some

of them are a part of, was impactful for many. Only mere months following the physical reopening, the county further solidified its support for the LGBTQ+ community by granting the Pride Center $500,000 from its Measure K surplus funding budget. The impact of this financial award is immeasurable.

The Pride Center has been incredibly privileged to be housed in a county with such supportive government bodies. Although there's been an increase in anti-LGBTQ+ hate occurrences, the team and county residents continue to be visible and advocate for equity. Some of the Pride Center programming and educational resources focused on supporting trans and gender diverse individuals most. This decision was intentional knowing that trans/gender diverse folks are often targeted most by hate crimes and hate legislation. Through the Pride Center's robust case management program, its workshop Resource Roadmap, created to build the competency of service providers to support trans/gender diverse folks, was translated into downloadable brochures for the website. Transgender Day of Remembrance (TDOR), which commemorates the murders of trans people each year, was pivoted into an advocacy event TransACTION Day of Change (TDAC). The event is planned by a group of community leaders and volunteers, spearheaded by the Director of the LGBTQ+ Commission, Tanya Beat (she/her).

During TDAC, several resource booths were present, "Break the Binary" buttons and other visibility items were available, and attendees were encouraged to sign an allegiance wall committing to help #EndTDOR. Additionally, an advocate's guide was created, "Building Blocks for Breaking the Binary", which listed tools on how to better support and/or advocate for trans/gender diverse individuals. The resources listed were carefully chosen and provided in a multitude of formats (such as podcasts, movies, books, etc.) to be as accessible as possible. This guide also lives on the Pride Center website.

All the above accomplishments could not have happened without the supplemental skills and talent of the Pride Center team and the additional support of partners and volunteers. To shift from in-person to virtual to hybrid, from threat to security, and from mourning into action, are only a few ways that staff has demonstrated the importance of perspective, teamwork, and collaboration. Within the Pride Center, staff often say, "each of us takes the lead in our roles, but no one works in isolation." Pride Center staff call themselves a team and are, indeed, proud of the Pride Center.

Clinical/Case Management Successes: During this fiscal year, the Pride Center successfully re-opened its door for in-person programs and services for the first time since the beginning of the COVID-19 pandemic. Re-opening its doors for in-person therapy and case management sessions has led to greater accessibility of programs and resources and increased community connections.

Client Success Story #1: 16-year-old female queer-identified client had been experiencing increased anxiety for several months. Due to anxiety, she would regularly miss school, fall behind on assignments, and was increasingly stressed (exacerbating her anxiety). To get the

client onto a 504 plan the high school needed a letter of support from client's Pride Center therapist. The client's therapist enthusiastically wrote a letter of support for client to receive a 504 plan from her school. Once the 504 plan was implemented the therapist guided the client in talking with client's teachers about this plan and advocating for herself to best utilize this plan. A few weeks later, the client reported that she had conversations with several of her teachers and that she felt a lot less stress since she had more flexibility with turning in assignments. This decrease in stress led to a decrease in anxiety and an increase in joy and motivation for the client.

Client Success Story #2: A trans-masculine young adult enrolled in both therapy and case management secured stable housing and employment after being unemployed and houseless for some time. This client was also able to successfully change their legal name and gender marker after attending the Pride Center's Legal Name and Gender Change workshop.

Supporting Transgender, Gender Diverse and Non-Binary Individuals:

- 2 out of 3 clients supported by the program's Clinical Program (67%) identified as: Transgender, Gender Diverse, and/or Non-binary during this FY 2022-23 period.
- The Pride Center clinical team supports clients in navigating and accessing medically necessary transgender-affirming care to help alleviate feelings of gender dysphoria. With the support of the Pride Center, clients report that living their authentic lives and feeling safe to truly be themselves has a significant positive impact on their mental health and wellbeing.
- The Pride Center clinical team supports transgender, gender-diverse, and non-binary clients by: assisting with legal name and gender marker changes on identity documents; writing letters of support to help clients to access hormone therapy (HRT) and/or gender affirming surgeries; connecting clients to resources and providers for services such as gender-affirming voice training; and more.
    - 4 clients received letters of support for gender-affirming surgeries from Pride Center clinicians; 2 clients successfully received top surgery; 1 client successfully received bottom surgery; and several clients gained access to gender-affirming voice training.
    - The Legal Name and Gender Change Workshop has served 409 individuals to date. During the FY 2022-23 period, 73 individuals attended.
- Pride Center continued to successfully promote and distribute the Resource Roadmap service-provider trainings and community brochure collection to support transgender, gender diverse, and non-binary (TGNB+) individuals throughout San Mateo County and beyond. The brochures have been well received by both community members and providers alike, who use them as tools to share gender-affirming resources with clients of their own. This project was sponsored by a grant received from Kaiser Permanent Northern California Community Benefit Programs. The Resource Roadmap brochure collection can be accessed at: https://sanmateopride.org/resource-roadmap.

Client Quotes from the Mental Health Self-Assessment Survey:

"I've really enjoyed working with Men Chun and am so grateful for all the counseling services I've received at the Pride Center. It has been an amazing resource for me!"

"Having a therapist who is a similar age as me definitely helps with them being more relatable."

"I feel that I am ready to take this step in figuring out my identity, and orientation to alleviate deeper unresolved questions, doubts, fears, and sources of frustration/sadness. I look forward to working with the Pride Center to achieve a better understanding of self, and move forward in life."

"Y'all are great I would have such a difficult time without yall ilu <3"

Client Quotes from the Name and Gender Change Workshop:

"As someone who grew up in San Mateo County and relocated before the Pride Center opened, it was so heartwarming to receive this information and guidance from folks in that area and know that others in my hometown are able to receive services there."

"I just wanted to say thank you again, I finally got my first papers back from the courts and I really wouldn't have even gotten through that step without you guys and the workshop. You all having this resource available for the community is amazing and really I am just so appreciative and hope you are all able to continue for as long as name/gender change is difficult for folks."

"Last year in December my mom and I had a zoom meeting with you and you helped us understand what we needed to do to get my legal name changed. Now I've completed the process and am just waiting to get my new birth certificate in the mail so I can get a new ID! Talking to you was so helpful in navigating the process and I'm so grateful for your help. Thank you so much."

"Thank you again for simply being here. It gets easier when you know you aren't doing this alone and without help."

Quantitative Feedback from the Name and Gender Change Workshop:

- 97% of attendees were "very satisfied" with the workshop overall.
- 98% of attendees agree the workshop helped them "feel more prepared and confident in their ability to navigate the legal name and gender change process". (Self-Empowerment)
- 90% of attendees were "very likely" to recommend this workshop to a friend or someone they know.

Community Events: Pride Center's Gran Re-Opening Party- March, 2023: Over 200 attendees ranging from community members to partner/collaborative organizations. Several elected officials & county representatives present to share brief speeches (Supervisor Dave Pine, Dr. Jei Africa, &Mayor Amourence Lee)

Pride Center's Grand Re-opening Party

San Mateo County Pride Celebration 2023 – June 10th, 2023

At the 11th annual San Mateo County Pride Celebration, hundreds of folks visited the Pride Center booth. Many asked questions about what different flags and identities represented. Approximately 4,000 people attended the celebration and parade. This year's celebration was significant because it included San Mateo County's first ever PRIDE parade! The parade was met with great interest from the community.

TransAction Day of Change (TDAC) – November 18, 2022

Collaborative effort among LGBTQIA+ Commission, Pride Initiative, and Pride Center to bring more thoughtful awareness AND action efforts to address Transgender Day of Remembrance. Event consisted of: Over 20 resource booths/tables; a community vigil; allegiance wall for signing dedication to ending TDOR; candlelight vigil for trans lives lost from FY 2021-22; COVID-19 vaccination van.

Community Partnerships and Collaborative Events:

- This FY 2022-23, Pride Center collaborated with several community organizations, like the San Mateo County Parks Foundation and held a total of 3 outdoor hike & history tour events in collaboration w/ Peninsula Family Service to over 20 community members.
- In November 2022 (Q2), the Pride Center co-hosted Trans* Action Day of Change, an observance of Transgender Day of Remembrance with multiple organizations throughout San Mateo County. During this event, they distributed the "Building Blocks for Breaking the Binary" guide to share resources to community members who want to be better Trans* advocates. To access the document, please click this link. This document continues to be used in ongoing outreach.
- In December 2022 (Q2), the Pride Center shared the "Giving Back this Holi-Gay Season: Supporting Local LGBTQ+ Organizations" holiday media campaign. To access this document, please click this link.
- In April 2023 (Q3) The Pride Center hosted their reopening event. After 3 years of providing all virtual programming, the San Mateo County Pride Center hosted a reopening party on Friday, March 24. During this event, they hosted a resource table where community members were invited to learn and relearn about their programs and services. For the duration of the event, the resource table was busy. For a recap of the event, click this link: https://sanmateopride.org/2023/03/gratitude-and-appreciation/

See the table below with information about the Pride Center's social media growth this year:

Platform	Q1	Q4	Growth
Facebook: Likes	1158	1206	48 likes
Facebook: Follows	1437	1448	11 follows
Instagram	1744	2072	328 followers
Twitter	361	370	9 followers
LiveImpact (listserv)	2929	3031	102 sign ups

Challenges

Overall: Throughout the year, anti-LGBTQ+ legislation climbed. Hate incidents and crimes rose against the LGBTQ+ community and against other marginalized groups. In San Mateo County, there were protests LGBTQ+ events, additional hate crimes, and hate speech incidents reported. The escalation in LGBTQ+ hate locally, statewide, and nationally led the Pride Center to create crisis protocols and invest in internal emergency alert systems. The Pride Center Director dedicated his time investigating crisis systems and attending trainings and national discussions.

With the rise in anti-LGBTQ+ occurrences, the demands on the Pride Center's programs and services increased beyond its capacity. Clinical waitlists were frequent. Trainings were being scheduled at least four months out into the year. And staff could not ignore the hate that hit home. The program was short-staffed, like most non-profits, for much of the year, making it hard to meet deliverables and the demands for services.

As beloved as the physical Pride Center is as well, the center itself is sadly becoming its own limitation. Even with a small team relative for the number of programs and services that it provides, the center has outgrown the size of the space. The center lacks enough office space, meeting, and therapy rooms, and it's not accessible for many individuals. The location has stairs within it, limited space for seating, a lack of event space, etc. Earlier in the year, the Pride Center even flooded! During the work to repair the damage, the center was fortunate enough to upgrade the carpeting, some furniture, etc. However, the center remains too small for current needs.

General/Programmatic Challenges:

- During COVID-19, therapy services were provided exclusively via telehealth (e.g., on Zoom). During this time, all clinical paperwork was completed online as well. Staff had difficulties figuring out best practices for how to do intake paperwork in person after they had gotten used to doing all paperwork online.
- The doors to the Pride Center have been re-opened to the community for in-person visits three days per week since early April 2023. One challenge that has come up is working on-site with limited staff on hand. Having only a few staff onsite per day makes things like supporting drop-in community members/clients difficult. Navigating best practices for how to handle situations like this with limited staff onsite has been challenging.
- Anti-LGBTQ+ issues, both locally and nationally, have affected the mental health of many Pride Center clients in a negative way. Several transgender clients have shared that they are concerned about transitioning due to fear of discrimination and potential danger to themselves. Furthermore, with things like anti-LGBTQ+ legislative bills being proposed and passed, across the country has led to rampant misinformation, especially with some parents of transgender clients.
    - Example: at least 5 trans clients at the Pride Center reported feeling afraid to transition due to safety concerns; this has been a barrier to these clients being their authentic selves.
- Some clients had challenges obtaining hormone replacement therapy (HRT) and transition related meds/materials (e.g., needles) on a consistent basis. Some clients also found it more difficult to get letters of support.

PEER COUNSELING PROGRAM

The Peer Counseling Program, formerly Senior Peer Counseling, from the Peninsula Family Service (50% CSS, 50% PEI) is comprised of specially trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief.

The Peer Counseling Program supports San Mateo County residents, 55 years and older who may be depressed, lonely and isolated through weekly one-on-one meetings and group support, matching with trained peer volunteers who share similar cultures, language, and backgrounds. The program targets the underserved communities including Chinese-speaking, Filipino, Spanish-speaking, and the LGBTQ+ older adults. The program recruit volunteers who attend an initial 30+ hour peer counseling training, background checks and then monthly clinical supervision and in-services trainings. Once background checks are complete, the volunteer is matched with at least one participant and they meet on a weekly basis via phone, Zoom or in-person meeting. Some volunteer also attends group facilitators training to be qualified to lead a support group in San Mateo County. The program provided training in English, Spanish and Chinese (for 1st time). The peer counselor's goal is to provide emotional support and connect the participant to needed resources. Trained peer counselors also provide weekly drop-in group support in Let's Talk Groups which are also held in person or via Zoom.

Program Impact

Peer Counseling	FY 2022-23
Total clients served	603 (individual)
Total cost per client	$542

Outcome Indicators

Domain	Indicators/Questions	#	%
Stigma Reduction	Due to this program, I feel more comfortable talking about my problems (internal/self) Due to this program, I feel more comfortable reaching out for emotional support (Seeking Help/Treatment)	Ind: 36 of 25 Group: 35 of 41 Ind: 16 of 25 Group: 34 of 41	87% 86% 63% 84%
Improved knowledge, skills, and/or abilities	The program improved my knowledge and abilities to seek support. As a result of participating in this program, I am connected to community resources.	Ind: 17 of 25 Group: 34 of 41 Ind: 21 of 25 Group: 34 of 41	67% 82% 84% 85%
Connection and Support	As a result of this program, I feel supported.	Ind: 21 of 25 Group: 34 of 41	85% 84%
Self Empowerment	Due to this program, I think more positively about challenges in my life Due to participating in this program, I believe that I can affect my life through decisions that I make	Ind: 16 of 25 Group: 35 of 41 Ind: 15 of 25 Group: 32 of 41	63% 86% 61% 78%

General Mental Health	As a result of participating in this program, I feel less stressed	Ind: 17 of 25 Group: 36 of 41	67% 89%

This evaluation sought to understand the impact of the Peer Counseling Program on the beneficiaries – one-on-one and group participants – and to identify program areas that need improvement. Although those who participated in the feedback gathering were not representative of all program participants, the information gathered does contain useful insights that will inform decisions. Overall, PCP participants expressed their appreciation of being part of the program. They also thanked Peninsula Family Service for maintaining these services despite the challenges brought upon us by shortage on staff. They provided feedback on their experience with the program and suggested ideas for its improvement.

Demographics FY 2022-23

Age (N=603 group and 1:1))	%	Gender Identity	%
Ages 40-59	5%	Female/Woman/Cisgender Woman	69%
Ages 60+	82%	Male/Man/Cisgender Man	30%
Unknown	13%	Unknown	1%
Primary language	**%**	**City/Region**	**%**
English	68%	Belmont	1%
Spanish	15%	Burlingame	3%
Cantonese	2%	Daly City	14%
Chinese	5%	East Palo Alto	1%
Mandarin	4%	Foster City	2%
Japanese	1%	Half Moon Bay	6%
Tagalog	4%	Menlo Park	3%
Unknown	14%	Millbrae	2%
Ethnicity	**%**	Moss Beach	1%
Asian	1%	Pacifica	5%
Asian Indian/South Asian	5%	Palo Alto	1%
Black / African American	1%	Redwood City	17%
Central American	2%	San Bruno	3%
Chinese	15%	San Carlos	2%
Korean	1%	San Mateo	27%
Filipino	5%	South San Francisco	4%
Hispanic/Latino	13%	Unknown/Another	23%
Japanese	1%		
Mexican/Chicanx/a/o	4%		
Puerto Rican	1%		
South American	1%		
White / Caucasian	37%		
Another	25%		

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	40	40
Substance Use Disorders (SUD) Referrals	0	5	5
Other Mental Health (MH) Referrals	254	2	256
TOTAL	**254**	**47**	**301**

List of programs/treatment referred to (aggregate information, not individual):

- San Mateo county mental health clinic
- San Mateo County BHRS
- KARA – grief support
- ACCESS –mental health support

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	7	Legal	7
Financial/ Employment	5	Medical care	35
Food	27	Transportation	62
Form assistance	25	Health Insurance	17
Housing/ Shelter	50	Cultural, non-traditional care	19
Other	22	**TOTAL**	**276**

Program Narrative

Improves timely access & linkages for underserved populations: The Peer Counseling Program targets the underserved population of older adults and one of the goals is to connect their participants to other resources in the community, including professional mental health care, including You Talk We listen, short term counseling program provided by PFS, BHRS, KARA, Mission hospice, San Mateo Pride Center, etc., when appropriate.

Reduces stigma and discrimination: An older adult is more likely to be open to and accept support from someone of their own age and background than from a "professional therapist." This program helps remove stigma by developing positive trusting relationships between adults who are struggling and a peer who can not only provide compassion and empathy but can also normalize mental health issues through sharing their own personal stories and the stories of others with a volunteer or in group settings. Volunteers can use lists of educational tools that they learned from their training to engage their participants, which are including active listening, assertive communication, coping with anxiety/depression/loneliness, etc. Volunteers can also gain support and consultation with clinical consultants monthly.

Increases number of individuals receiving public health services: Peer Counselors provide referrals to public health when appropriate. Peer counselors also learn about public health services during clinical supervision and in service training and therefore are more likely to access them themselves.

Reduces disparities in access to care: According to the California Master Plan for Aging (MPA), which was approved in 2021, older adults are at particular risk for mental health issues, like depression and anxiety. PFS trained peer counselors and weekly Let's Talk groups are successful communities for older adults in San Mateo County. Building these volunteer-based communities helps older adults be able to talk about their feelings, get emotional support, connect with each other, advocate for their own needs and help each other out during difficult times. They get a wider range of access to care and reduces disparities.

Other activities that benefit clients: Peer Counselors connect with older adults who may not access other mental health services due to the stigma of seeking help. Counselors develop a trusting relationship with the participant.

During the FY 2022-23, PFS provided roughly 6,000 hours of counseling to San Mateo residents. Additionally, PFS increased the number of Peer Counseling groups across San Mateo County to 27. PFS recently completed its annual Peer Counseling participant and volunteer surveys. The results and participant comments show the program's tremendous value.

In terms of volunteer recruitment, PFS continues to actively seek more counselors who can meet the needs of its diverse participant base. The program successfully recruited 25 new volunteers for the last peer counseling training in the fall of 2022 and 2021 of them became active volunteer counselors. 8 of them are Chinese, and most of them don't understand or speak English. They still completed the training by using live google translate. This spring, eight new Chinese-speaking volunteers completed a five-week training session to help meet the region's demand for more Chinese-speaking volunteer counselors. It is the first time offering Chinese training since the start of the program.

Volunteer Peer Counselors continue to engage with their Clinical Supervisors to learn research-based techniques that will help them best meet the individual needs of participants. However, due to staff transitions, PFS has not been able to offer monthly in-service trainings for volunteer Peer Counselors since March. These trainings will resume once the program is fully staffed. The program is especially proud of its support groups, which are all facilitated by the trained volunteers. PFS had more than 26 groups among San Mateo County in the last year.

Kapihan: Every Tuesday, a group Filipino participants gather weekly at Lincoln Park Community Center in Daly City. The program continues to thrive since its inception ten years ago as a Let's Talk program called *KAPIHAN* (a Tagalog word meaning a place to gather for coffee). The program is now in person after two years of virtual and hybrid zoom for a couple of years due to the pandemic. Participants join for a lively discussion and activities. There is a memoir writing and sharing of diverse topics where everyone participates candidly as well as a segment on community resources and current events. Staff and participants look forward to monthly birthday and milestone events, sharing food and socializing. making it real special for the celebrants. Staff introduced Hula dancing which is now part of Lincoln Center activity with an hour of instruction from volunteers. The group joined activities within the community and celebrated a Cultural Event at Lincoln Center. Wearing traditional Filipiniana outfits, everyone enjoyed the musical presentations and luncheon.

Let's talk at teatime with Asian Indian: A weekly program formed a year ago, PFS introduced a zoom group for Asian Indians residing within the San Mateo County. Early this year, the group met in

person and had an afternoon of tea and shared special dishes they prepared. It was an opportunity for them to see each other and also a despedida for a member who was moving back to India. It was heartwarming to experience the camaraderie and joy they shared in seeing their zoom friends face to face. The member who moved to India keeps connected with the group and joins weekly at 5 AM, India time. A successful virtual group, many are retired professionals and each participant share their views on selfcare, current events, health, life experience and travels. They continue to get more members and recently they were so delighted to welcome new participants from other cultures. Their facilitator, a retired technical specialist, shares his knowledge of yoga and encourages topics on peace, contentment, and gratitude.

Lesbians 55 + sharing and caring: This group meets every Friday afternoon at 3 PM. Led by a Peer Counselor who is also a poet, she starts their weekly zoom segment with an inspirational poem. Their most recent topics and conversations were about the PRIDE events celebrated in June. A group open to sharing the latest news and developments within the community, it continues to flourish with dedicated participation from enthusiastic members, open minded and willing to share their views with trust and respect.

Successes

Client Success Story: Earlier this year, one of Peninsula Family Service's (PFS) long-term service Chinese participants passed away in a nursing home. She had no family, was alone, isolated, did not speak any English, and felt helpless for life. Before the pandemic, the program's counselor would visit her once a week to help her with her needs, call her, talk to her because she has severe diabetes and poor eyesight. The counselor reads the newspaper to her and gives her a magnifying glass to read when she wants to read. Due to her vision problems, she fell several times, lost all important documents, and it took staff three months to replace everything. When the outbreak hit, she fell in the street while visiting a doctor and broke her arm and leg. With no family to care for her, she had to move to a nursing home where she stayed for three years. Her physical condition deteriorated. PFS program staff kept encouraging her, and in response she said that the staff gave her the strength to live. After the epidemic stabilized, the counselor visited her many times, and she was very happy! Before she died, she told staff that Peninsula Family Service was her lifesaver.

Challenges

It has been challenging for PFS to recruit large numbers of volunteers and host trainings while being short staffed. The program's English coordinator left in March, and PFS was not able to find a replacement until June. In addition, the LGBTQ and Spanish Coordinator also left two important positions that remain vacant. The Program director position was also vacant through July.

Another challenge for the program is that since clinical supervision groups are meeting by Zoom it has been more difficult to collect monthly visit forms and other participant documents from volunteers. The program has put systems in place to address some of these challenges for the FY 2023-24.

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, facilitating collaboration to deliver client-and family-driven services, providing outreach to unserved and underserved populations, tailoring services that are linguistically and culturally responsive and relevant, and including the viewpoints and expertise of clients and their families/caregivers. WET was designated one-time allocation totaling $3,437,600 with a 10-year reversion period. WET activities will continue to be funded by MHSA at $500,000 per year.

As part of the mission of the BHRS Office of Diversity and Equity (ODE), which is "…in collaboration with and for community members, ODE advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo County;" the WET Team, informed by broader social justice and equity efforts, a wellness and recovery orientation and two advisory committees, strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the BHRS workforce, consumers/family members, and community partners.

There are several distinct populations served directly by the WET Team. The BHRS Workforce, BHRS contractors that provide behavioral health services, consumers and family members and subgroups of those populations actively participate in the program activities. For example, WET program areas such as the BHRS Clinical Internship/ODE Internship programs are implemented for Interns and other non-licensed/certified staff/community providers to gain knowledge and supervised professional experience in a local government setting. One of the broader objectives of the internship programs is to attract and retain a diverse workforce to better serve the San Mateo County communities.

As a program area of ODE, the WET Team also focuses on providing program activities that are in alignment with the best practices established by ODE and policies implemented by San Mateo County which includes modeling the ODE Team values across the work. For instance, pronouns are disclosed when introducing oneself at trainings and meetings. The WET Team program areas may be categorized into three broad areas. Training and Technical Assistance, Behavioral Health Career Pathways and WET Workplace Enhancement Projects. The annual training plan and education sessions to provide up-to-date information on practices, policies and interventions approved for use in BHRS is an integral component of the Training and Technical Assistance area. Interns who have obtained an internship in one of the more than 20 clinic and program training sites can collaborate with the BHRS ODE Health Equity Initiatives through the Cultural Stipend Internship Program which is supported by the Behavior Health Career Pathways program area.

Program Impact

Training, Education and Development: the WET Team provides programs that build the capacity of the workforce, community providers, and consumers and family members primarily through training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services provided by the County. These communities include ethnic/racial communities, communities' members with limited English

proficiency and member of the LGBTQ+ communities. However, there are sometimes barriers which may hinder the timely access to services. Some of those barriers might include lack of language services, issues around cultural humility, lack of knowledge of trauma informed care practices and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers and community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer lack of access to services or insufficient services. By attending some events as a constant presence, trust is built, and communities are more likely to reach out when they or someone they know may need of services. Equity is a core principle in WET trainings. In FY 2022-23, WET trainings were only offered to BHRS Staff and Contracted Providers. The Total number of WET Implemented/Supported trainings was 43 with 738 attendees.

- Total number of ASIST/Suicide Prevention Trainings: 0 (Living works only allowed for in-person training, which was not possible during the FY 2022-23
- Total number of Cultural Humility/Working with Interpreters/SOGI (including Training of Trainers): 24
- Total number of For/By Consumers & Family Members: 2 (Be Sensitive Be Brave)

**Other trainings include: Embracing Difference Through the Lens of Cultural Humility: Focus on Implicit Bias, Clinical Supervisors Trainings, Internship Orientation, Prevention and Management of Assaultive Behavior (Beginner + Advanced), Neurosequential Model Treatment (NMT) 6 core series, Navigating Behavioral Health, Psychological First Aid, Law and Ethics training, School Based Law and Ethics, WRAP Training (Fall Session)

Cultural Stipend Internship Program (CSIP): The WET team oversees the management and implementation of the CSIP program. This program provides an opportunity for BHRS clinical interns to pair with a specific Health Equity Initiative (HEI) and develop projects focused on the demographics of their respective HEI. CSIP recipients are selected based on 1) expressed interest in and commitment to cultural awareness and social justice in the community and in clinical settings 2) personal identification with marginalized communities 3) and/or lived experience with behavioral health conditions. Priority is also considered for those interns with non-English language capacity and cultural identity with that language. During FY 22-23, 16 students submitted applications for CSIP consideration. Of the 16 candidates, 7 were selected based on their qualifications and dedication to advancing BHRS' efforts at creating a more inclusive community. Below are highlights from the last round of CSIP projects.

- Latino Collaborative – Power of Pause - Art for Wellness, Survey of 25 clinicians with accompanying art activity, created platform to elevate clinicians' voices & tailor an experience allowing clinicians to reflect, process, dream & remember their "why" that propels them forward. Results were that stress levels were cut in half following the art exercise which provided clinicians their moment of pause. The collective response was rejuvenation.
- Pacific Islander Initiative – Virtual presentation and research, focus was mental health and culturally specific service delivery considerations and challenges, researched data and discovered a lack of culturally informed care practices and services for these populations (Micronesian, Melanesian, Polynesian). Noted the lack of quantitative and qualitative data available regarding these populations in the Bay Area.

- Filipino Mental Health Initiative – Stigma reduction-based workshop facilitated with high school students in Daly City - Jefferson High school, where topics of mental health and socioemotional issues were discussed and identified how they are impacting the community and preventing them from seeking mental health services. Cultural aspects including mental health terms/vocabulary, Filipino culture, and the stigmas in the community were covered and helped to bridge a gap among high school aged participants.
- Spirituality Initiative – Presentation bridging Spirituality with AOD services, focus to create stronger, deeper relationships within the community and to open new pathways & opportunities for collaborating with programs moving forward so it can be integrated into the initiative's objectives. Resulting in collaboration with Hope House, Spirituality Initiative and Voices of Recovery – in essence combining spirituality, mental health, and recovery services.
- Chinese Health Initiative – Central Clinic, workshop on mental health and Asian culture, 1.5 hours with Asian-American high school students centered on the intersection of Asian-American culture & mental health from book, Permission to come home: reclaiming mental health as Asian Americans (Wang, 2022). Goal is to name covert rules or mindsets from cultural backgrounds & bring them to the participants awareness, focused on identity work, aimed to encourage participants to give themselves permission to show up differently from how their culture or family expects. Coordinated CHI and Mental Health Advancement Initiative (MHAI) club of Mills High School in SM to present one monthly meeting – 5 mentors and approximately 10 students. Created power point presentation w/2 mindfulness exercises, pre & post surveys, and worksheet packet to be completed during workshop. Results were 90% of students agreed or strongly agreed to "I can identify and name aspects of my culture that don't align with my values" and "I feel like I have a choice in ending intergenerational trauma."
- Diversity & Equity Council – Increasing youth involvement in HEIs, focus is to increase young adult and youth participation in County decisions surrounding policy creation and HEIs, Star Vista Health Ambassadors Program was selected as the pilot program site with the goal to increase collaboration with youth groups to garner as much youth representation possible through community outreach. Presenting the connection between behaviors and the health & well-being of body, mind, and spirit. Surveyed 13 youth/young adults at HAP-Y – 5/13 interested in BHRS careers, increase internship opportunities & volunteering opportunities for credit, partner w/school & university counselors to spread the word, increase media in school newsletters and library boards, college student unions and school clubs, being asked their opinion and request to participate, more community events & meetings geared toward youth in the afternoon & weekends, support for meetings – transportation, recorded meetings requested.

Successes

- Hiring of Workforce, Education and Training (WET) Positions – Both the WET Director and Internship Coordinator positions were filled towards the latter part of the fiscal year which allowed the department to move forward with internship and training efforts. It also alleviated the increased workload for other staff within the department.

- WET 3-Year Plan – The WET team was tasked with developing a 3-year plan focused on improving ways to better support BHRS workforce. This plan incorporated feedback from surveys and input sessions held with contractors, community members and staff from various departments within BHRS. The WET team will continue to use this plan as a guide to address the needs of the workforce for the next several years.
- Increased Access to Continuing Education Units (CEUs) – Many staff require CEUs to maintain their licenses/certifications. The WET team helped expand access to CEUs by increasing utilization of the RELIAS library, building training curriculums tailored to specific licensure needs and revamping the CEU application process for BHRS related trainings. Increasing access to CEUs is one of the tools the WET team is utilizing to improve retention efforts among staff.
- Improved Training Promotional Effort – Some of the feedback received from the WET 3-year survey was focused on improving the advertising and promotion of WET related trainings. Some of the workforce felt that they did not receive enough notification to sign-up for certain trainings. The WET team responded by creating an external calendar for staff that displayed all the scheduled trainings for the entire fiscal year. The WET team also improved efforts at increasing email correspondence to remind staff of upcoming trainings.
- Number of CSIP Recipients – Despite having a reduced departmental workforce, the WET team was able to award 7 students with a cultural stipend. This stipend awarded students for their efforts at developing a project with their assigned HEI. These projects helped with advancing BHRS' efforts at creating a more inclusive community.
- DEI Efforts – The WET team is working on updating terminology used in recruitment materials to be more inclusive to better support the outreach efforts. Some studies show that inequitable and exclusionary language can cause a 40% decline in potential staffing interest. In updating language and terminology, the team hopes to improve recruitment efforts for students and potential staff alike.
- Expanded Equity Awards- This past year, the WET team brought back the Equity Awards which focuses on recognizing staff members who have made efforts in advancing equity, diversity, cultural humility, and inclusion within BHRS. Criteria for nominations was expanded to include all staff and not just those in leadership roles.
- Improved Collaboration with BHRS Clinical Supervisors – The COVID-19 pandemic significantly impacted both internship recruitment efforts and the ability for existing supervisory staff to participate in the internship process. In response, the WET team met with BHRS clinical supervisors to review and improve current recruitment and internship program practices. One of the outcomes of this collaboration was to make practices around representation at internship fairs more equitable. Clinical supervisors interested in participating in the BHRS internship program can now advocate and sign-up for specific internship fairs with support from the WET internship coordinator.
- Increased Efforts at Expanding In-person Trainings – Staff, contractor and community trainings were significantly impacted by the COVID-19 pandemic as many had to either be canceled or shifted to a virtual space. Even as COVID-19 restrictions were lifted, many sites did not allow

or did not have the capacity to hold in-person trainings. The WET teams continued outreach and relationship building has yielded several opportunities to bring back in-person trainings. Several of WET's trainings including Applied Suicide Intervention Skills (ASIST) are now returning to in-person which will help better reach BHRS workforce and community.

Challenges

- Position Vacancy – Both the WET Director and Internship Coordinator roles were vacant much of this past year. These roles are vital to program oversight, implementation, leadership, and recruitment. These vacancies impacted the small staff remaining within the department and division. The remaining WET departmental staff had to fill in when and where they could which stretched all staff members to an unideal capacity. Vacancy of these positions also impacted training efforts. The WET team was simply unable to coordinate and implement the number of trainings that have occurred historically.
- Agency Wide Staff Shortages – BHRS has experienced staff shortages across all departments. The department did not have the capacity to fulfill the needed positions to support the internship program. These shortages also caused current staff to take on additional work which hindered their ability to participate in and trainings.
- COVID-19 Reverberations – Some clinical placement sites were heavily impacted by the pandemic. Some sites were unable to fill vacant positions, which in turn, led to staff being overburdened. Many of the Health Equity Initiatives (HEIs) and clinical placement sites were unable to accept interns and requested time off from the program. Additionally, WET trainings were restricted to virtual spaces which created some barriers for staff, contractors, and community members. ASIST trainings could not be implemented as these must occur in-person.

Innovations

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. The development MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process.

The Kapwa Kultural Center and Cafe– a social enterprise cafe and cultural hub for Filipino/a/x youth in northern San Mateo County – was the one INN project that was active in San Mateo County through FY 2022-23 (please see Appendices 4 and 5 for the INN Evaluation Reports):

The following five projects were approved by the board and launched August 1, 2023:

1. *Adult Residential In-Home Support Element (ARISE)*. The ARISE program creates a model for residential in-home services to support clients with a serious mental illness (SMI) and/or substance use disorder (SUD) who are at risk of losing their housing. Residential in-home support workers—approved in-home support services (IHSS) providers—will be provided with specialized training an in collaboration with a peer support staff and an occupational therapist.
2. *Mobile Behavioral Health Services for Farmworkers.* The program will provide direct behavioral health mobile services and wraparound resources in Spanish to farmworkers and their families. It integrates cultural arts practices as a pathway for engaging farmworkers and their families with behavioral health services spanning prevention, early intervention, treatment, and recovery.
3. *Music Therapy for Asians and Asian Americans.* Service provider: This project will provide music therapy as a culturally responsive approach for Asian/Asian Americans to reducing stigma, increasing behavioral health literacy, and promoting linkages to behavioral health services and building protective factors to prevent behavioral health challenges and crises.
4. *Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS).* The PIONEERS Program addresses wellness and behavioral health needs of Native Hawaiian and Pacific Islander (NHPI) youth and young adults through providing linkages to services, empowerment, leadership development and community advocacy.
5. *Recovery Connection Drop-in Center.* This center will provide drop-in services for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. The Recovery Connection will center around Wellness Recovery Action Plan (WRAP) programming, use a peer support model, provide linkages as needed and serve as a training center to expand capacity countywide.

HOUSING

HOUSING

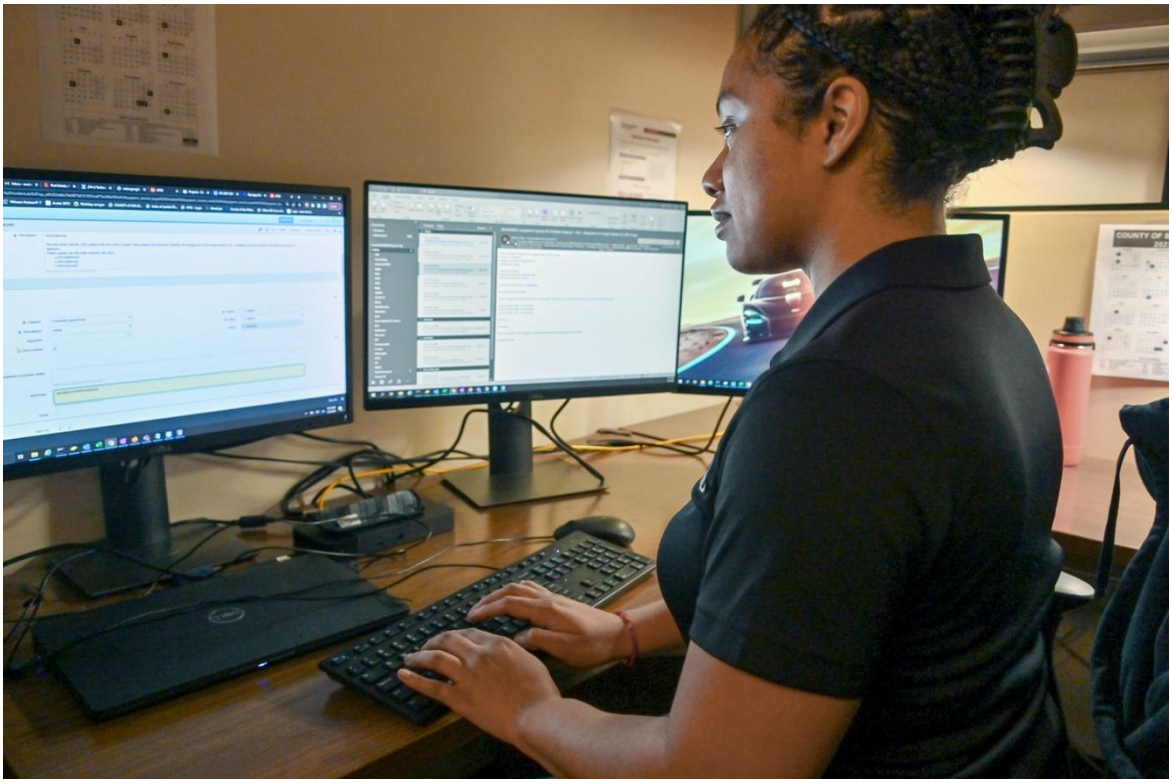
MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless. BHRS collaborated with the Department of Housing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

The MHSA Housing Taskforce Recommendations from May 2021 included the allocation $10M to develop supportive housing units as part of the local Department of Housing Affordable Housing Funds (AHF) Projects. It was estimated that the County could develop about 24 units per $5M contribution. Two separate Notices of Funding Availability (NOFA) have gone out in the Summer of 2021 and 2022 to select the housing project developers.

- Year 1 – 25 MHSA units in East Palo Alto, North Fair Oaks and South San Francisco
- Year 2 – 25 MHSA units in Redwood City and Daly City

As part of the MHSA Three-Year Plan strategy recommendations from the Community Program Planning process is the development of supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement. This is something to be explored as investments in housing developments continue.

Year	Housing Development and Location	Units
2009	Cedar Street Apartments 104 Cedar St., Redwood City	14 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
2019	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
2019	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
TBD	AHF NOFA 9.0 and AHF NOFA 10.0	50 MHSA units
		121 Total MHSA Units



CAPITAL FACILITIES & TECHNOLOGY NEEDS(CFTN)

CAPITAL FACILITIES & TECHNOLOGY NEEDS (CFTN)

At the initiation of MHSA, 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. Through a robust stakeholder process it was decided to focus all initial CFTN resources 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.

During the pandemic, devices (phones, tablets) and data plans were provided to BHRS clients to support their engagement with telehealth and other online supports, as part of a one-year one-time funding. Starting in FY 2021-22, stakeholders prioritized the continuation of the program. MHSA now funds the ongoing procurement of devices with data plans for BHRS clients. Additionally, basic technology supports for clients are provided via a virtual and/or over-the-phone IT Ticket System and digital literacy training for peer staff through a contract with Painted Brain, a peer run organization with technology expertise.

$330,000 per year is allocated to CFTN ongoing for client devices and data plans. A part-time peer worker under the OCFA was recently hired to support device distribution and training plan, and this would include improved tracking, data collection and reporting on the projects impact as it relates to improving client engagement in behavioral health and recovery services.

APPENDIX 1. MHSA ANNUAL UPDATE MATERIALS & PUBLIC COMMENTS

**Public comments to be added after the closing of the 30-day public comment process*

APPENDIX 2. “MY JOURNEY, MY MHSA” CAMPAIGN

"My Journey, My MHSA" Campaign

www.MyMHSA.org

- MHSA - Mental Health Services Act - is a 1% tax in California on personal income over $1M.
- It has provided a dedicated source of funding for county behavioral health departments across the state and funds many programs you know, may work in or manage.
- This campaign was a direct request from community partners and stakeholders of MHSA who want to bring awareness about MHSA and the impact it has had on San Mateo County.

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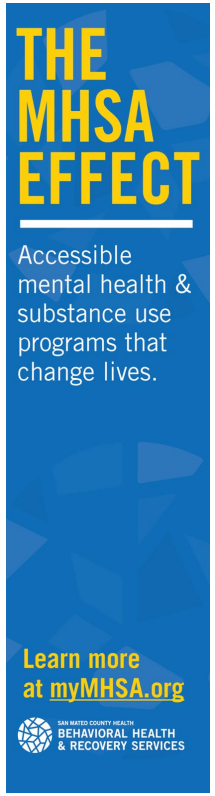
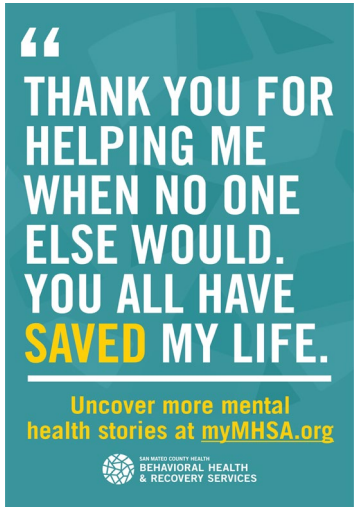
Digital Billboards

To reach broad audience driving by and target them with digital ads online. Visible on Highway 101 Southbound in the city of San Carlos!

Digital Ads

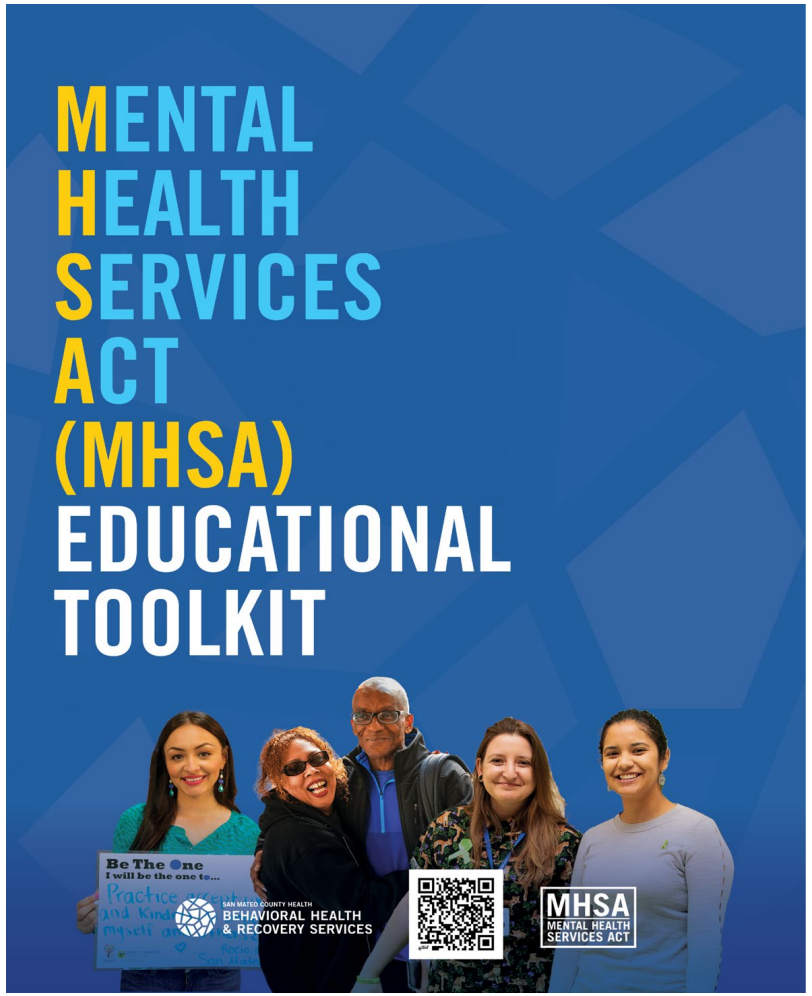
To reach a broad audience online, connecting viewers to www.MyMHSA.org - a mechanism to: 1) link to BHRS services; or 2) learn more about MHSA.





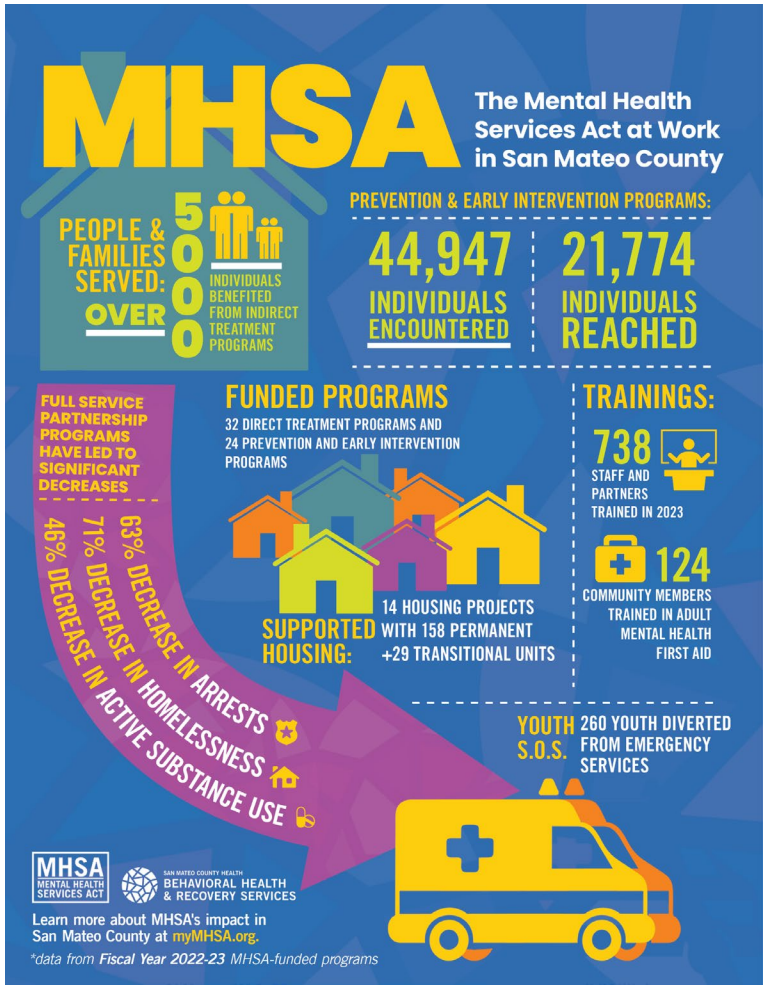
MHSA Toolkit + Infographic

To help us share the campaign!



The toolkit includes a tagline to use on materials, logos and posts for those of you who manage MHSA-funded programs and to share on social media.

The infographic share overall reach and impact of MHSA in San Mateo County.



APPENDIX 3. FUNDING SUMMARY BY COMPONENT

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Service Act (MHSA) Budget

Fiscal Year 2024-25

Community Services and Supports (CSS)			
Service Category	Program	BHRS Staff/Agency	TOTAL FY 23-24
Full Service Partnership (FSP)	**Children and Youth (C/Y)**		
	Integrated SAYFE	Edgewood	$1,127,675
	Comprehensive C/Y "Turning Point"	Edgewood	$3,042,595
	Out-of-County Foster Care	Fred Finch	$180,802
	Transition Age Youth (TAY)		
	Enhanced Education (TAY)	Caminar	$210,413
	Comprehensive TAY "Turning Point"	Edgewood	$3,301,352
	Adult & Older Adult		
	Adult and Older Adult FSP	Telecare	$2,216,135
	Adult and Older Adult FSP	Caminar	$727,424
	Assisted Outpatient Tx (AOT) FSP	Caminar; BHRS Staff	$1,226,191
	FSP Increases	TBD	$2,000,000
	Embedded South County FSP	Mateo Lodge	$150,535
	Care Courts FSP	TBD	$2,812,334
	Flexible Funds		
	C/Y/TAY FSP Flex Funds	BHRS	$375,000
	Adult/Older Adult FSP Flex Funds	BHRS	$1,380,000
	Housing Supports		
	TAY Supported Housing	Mental Health Association	$489,065
	Telecare Adult and Older Adult FSP Housing	Telecare	$1,519,394
	Caminar FSP/AOT Housing Support Program	Caminar	$581,637
	FSP Housing Increases	TBD	$2,404,290
	Board and Care	Various	$3,142,969
	Adult/Older Adult Supported Housing Services	Mental Health Association	$222,040
		TOTAL FSP	**$27,109,851**
General System Development (GSD)	**Substance Use Integration**		
	Substance Use Providers	Various; BHRS Staff	$742,955
	Substance Use Residentials (Youth and Adults)	HR360; TBD	$635,820
	Recovery Support Services	VoR	$245,047
	The Cariño Project – SU Services (80%CSS)	El Centro de Libertad	$62,000
	Older Adult System of Care		
	OASIS; hoarding resources	BHRS Staff	$977,195
	Senior Peer Couseling (50% CSS)	Peninsula Family Services	$191,862
	Criminal Justice Integration		
	Pathways, Court Mental Health	BHRS Staff; MHA	$220,564
	Criminal Justice Restoration and Diversion	BHRS Staff	$250,000
	Pathways, Housing Services	Life Moves	$125,718
	Other System Development		
	Pre-to-Three Initiative (Child Welfare Partners)	BHRS Staff	$677,598
	Puente Clinic	BHRS Staff	$457,736
	Trauma-Informed Interventions (NMT)	Various; MHA	$943,838
	EBP Clinicians	BHRS Staff	$1,824,235
	School-based MH	BHRS Staff	$317,319
	Crisis Management	BHRS Staff	$334,340
	Peer and Family Partner Support		
	Peer Workers and Family Partners	BHRS Staff	$2,033,683
	OCFA Stipends	MHA; BHRS	$45,609
	Multicultural Wellness Center	One EPA	$220,956
	The California Clubhouse	California Clubhouse	$395,716
	Peer Support; Supported Employment	Heart and Soul; Painted Brain; TBD	$1,241,855
	Primary Care Integration		
	Primary Care Interface (20% CSS)	BHRS Staff	$196,782
	Ravenswood Family Health Center (40% CSS)	Ravenswood	$18,082

Mental Health Service Act (MHSA) Budget

Fiscal Year 2024-25

	Infrastructure Strategies		
	IT and Support Staff	BHRS Staff	$1,131,530
	Communications + Language Services	Various	$257,138
	Contractor's Association	Caminar	$218,670
	CSS Evaluations	AIR, PWA, AHDS	$217,627
	CSS Planning	Various	$151,952
	CSS Admin	BHRS Staff	$740,449
		GSD	**$14,876,275**
Outreach and Engagement (O&E)	Family Assertive Support Team (FAST)	Mateo Lodge	$373,768
	Coastside Multicultural Wellness (20% CSS)	ALAS	$87,500
	Adult Resource Management (ARM)	BHRS Staff	$1,823,274
	Housing Locator, Outreach and Maintenance	TBD	$1,075,000
	HEAL Program - Homeless Outreach	BHRS Staff	$325,000
	SMC Pride Center (35% CSS)	StarVista	$332,382
		TOTAL O&E	**$4,016,924**
		GRAND TOTAL CSS	**$44,985,895**
		Percent FSP (51% required)	60%
		Percent CSS (76% target)	**76%**

Workforce Education and Training (WET)			
	System-wide Training	BHRS Staff; Various	$1,600,000
	Recruitment/Retention Program	CalMHSA; Various	$700,000
	Training for/by Consumer (LEA, Advocacy Academy, Peer Leadership)	OCFA Various	$280,000
		TOTAL WET	$2,580,000

Capital Facilities and Technology Needs (CFTN)			
	Client Devices	T-Mobile Government	$330,000
	Client Device Applications (Apps)	PDT, Wysa	$300,000
		TOTAL CFTN	$630,000

Prevention and Early Intervention (PEI)			
Service Category	Program	BHRS Staff/Agency	TOTAL FY 23-24
Prevention & Early Intervention	Early Childhood Community Team (ECCT)	StarVista	$483,496
	Community Interventions for School Age & TAY		
	School-Based Counselors	SMCOE	$60,000
	Trauma-Informed Services for Youth	Latino Commission; Puente de la Costa Sur; StarVista; YMCA	$520,000
	Brief Intervention Model (INSPIRE)	DCYHC	$100,000
	Youth Crisis Response (Hotline + Youth S.O.S)	StarVista	$1,038,911
Prevention	Trauma-Informed Systems (Ages 0-5)	First5 SMC	$150,000
	Community Outreach, Engagement and Capacity Building		$0
	Substance Use Prevention	TBD; BHRS Staff	$577,305
	Office of Diversity and Equity	BHRS Staff	$483,247
	Health Equity Initiatives	Co-chairs; BHRS Staff	$333,739
	Health Ambassador Program	BHRS Staff	$165,024
	Health Ambassador Program - Youth	StarVista	$304,115
	Parent Project	OneEPA, StarVista, PCRC; BHRS Sta	$288,787
Recognition of Early Signs of MI	Youth and Adult Mental Health First Aid	OneEPA, PCRC, StarVista, HOPE	$322,291
Stigma Discrimination and Suicide Prevention	Digital Storytelling and Photovoice	BHRS Staff; YLI	$281,685
	Mental Health Awareness; Be the ONE	BHRS Staff; CalMHSA	$212,560
	SMC Suicide Prevention Roadmap	BHRS Staff; CalMHSA	$242,560

Mental Health Service Act (MHSA) Budget

Fiscal Year 2024-25

Early Intervention	SMART	American Med Response West	$134,529
	Primary Care Based (80% PEI)	BHRS Staff; Ravenswood	$1,104,276
	Early Psychosis	Felton Institute	$589,164
	Crisis Response (Adult S.O.S.)	StarVista	$650,000
Access & Linkage to Treatment	North County Outreach	HealthRight 360	$370,000
	East Palo Alto Outreach	One EPA	$225,724
	Coastside Community Engagement (80%PEI)	ALAS; YLI	$360,927
	SMC Pride Center (65% PEI)	StarVista	$617,281
	allcove Youth Drop-In Center	Peninsula Health Care District	$500,000
	Older Adult Peer Counseling (50% PEI)+ Outreach	Peninsula Family Service	$513,727
	PEI Admin	BHRS Staff	$439,752
	PEI Planning	Various	$170,207
	PEI Evaluation	AHDS; Alison H.	$367,662
		GRAND TOTAL PEI	$11,606,969
		Percent Ages 0-25 (51% required)	58%
		Percent PEI (19% target)	19%

Innovations (INN)			
	Social Enterprise	Daly City Partnership	$523,755
	PIONEERS	HR360 AARS	$297,345
	Adult Residential In-home Support Element (ARISE)	Mental Health Association	$330,000
	Mobile Behavioral Health - Farmworkers	Ayudando Latinos a Sonar (ALAS)	$485,000
	Music Therapy for Asian/Asian Americans	NEMS/Creative Vibes Therapy	$236,223
	Recovery Connection Drop-In Center	Voices of Recovery	$573,530
	Admin/Overhead	BHRS	$200,000
	INN Evaluation	RDA; AIR; CCPA (Joyce Chu)	$218,650
		TOTAL INN	$2,864,503

Obligated Funds			
	Total Reserve		28,362,318
	Innovation- Approved Projects		3,005,434
	Innovation 5% - Unallocated		6,612,637
	Housing Funds		18,878
	One-Time Spend Plan (CFTN)		7,700,000
	One-Time Spend Plan (Housing)		11,000,000
	One-Time Spend Plan (System Transformation)		3,450,000
		TOTAL Obligated	60,149,267

		Total Ongoing Budget	$62,667,367
		One-Time	$22,168,878
		MHSA GRAND TOTAL BUDGET	**$84,836,245**

APPENDIX 4. PEI DATA COLLECTION & REPORTING FRAMEWORK (UPDATED)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Mental Health Service Act (MHSA)

Prevention and Early Intervention (PEI)
Data Collection and Reporting Framework

Originally Prepared by RDA Consulting, June 2022
RDACONSULTING.COM |

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SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table of Contents

Project Background

In June 2018, the California Mental Health Services Oversight and Accountability Commission updated the reporting requirements for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). Programs funded through the PEI component of MHSA, which is intended to prevent mental illness from becoming severe and disabling, can focus on prevention, early intervention, or a combination of both. The new reporting requirements focus on individual demographics, referrals and access to treatment, and individual outcomes.

San Mateo Behavioral Health & Recovery Services (BHRS) contracted with RDA Consulting (RDA) to provide outcome data planning and technical assistance for San Mateo County's PEI programs that provide some component of individual-level services.[1] The project aimed to identify a reporting framework in which PEI data and individual outcomes could be analyzed across all PEI-funded programs. The framework that was developed uses a set of 9 Outcome Domains that were identified in alignment with MHSA requirements, our local BHRS Office of Diversity and Equity's (ODE) strategic planning, and through this project's exploration with contracted providers and BHRS staff of the expected outcomes across the current PEI-funded programs.

The initial implementation of this framework, completed in June 2022, focused on programs that collect individual-level data, or unduplicated individuals served. Starting in May 2023, non-individual level programs- those that primarily collect population-level data, or duplicated individuals served, were incorporated to allow for a broader assessment of the impact of PEI programs. These programs focus on community awareness campaigns, education, and trainings and include The Parent Project®, Health Equity Initiatives, Mental Health First Aid, Suicide Prevention, and Photovoice/Storytelling. Standardized questions based on the Outcome Indicators were identified and were embedded into each program's respective evaluation surveys beginning in FY 2023-24. Additional PEI programs such as the Outreach Collaboratives and newly launched programs such as PEARLS (Program to Encourage Active, Rewarding Lives) for older adults and allcove® youth drop-in centers will be incorporated starting in the Spring 2024. Programs that focus exclusively on systems development, such as Trauma- and Resiliency-Informed Systems Initiative (TRISI), are not captured in this framework, as the evaluation focus of these programs is on measuring organizational capacity building and not individual or population level impacts.

This document outlines a PEI Data Collection and Reporting Framework, highlighting the key decisions points that were made to inform the framework, and provides visual summaries of how the currently funded PEI programs will be reporting data and outcomes based on this framework.

[1] PEI programs that primarily provide awareness, referrals and system-change services are unable to collect unduplicated individual-level data and were not included in the original PEI data collection and reporting framework.

PEI Program Reporting

MHSA legislation requires counties to fund specific types of programs under the following program areas: prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment, stigma and discrimination reduction, and suicide prevention. Funding will continue to be allocated in these program areas. Additionally, PEI programs must address three strategies and collect specified data in each of these strategies: 1) Access & Linkage to Treatment, 2) Timely Access to Services for Underserved Populations, and 3) Stigma & Discrimination Reduction.

Key Decision Point

How PEI programs were categorized for data reporting purposes:

1. **Prevention Programs:** focus on *outreach and education*.
2. **Prevention and Early Intervention Programs:** include both an *outreach/education* component as well as early intervention *clinical services*.
3. **Early Intervention Programs:** primarily provide one-on-one early intervention *clinical services*.

The programs provide services across the spectrum of prevention and early intervention, from awareness and education initiatives to outreach and programs that create entry ways into clinical short-term treatment services. For the purposes of this reporting framework and data collection activities, programs were categorized to reflect this spectrum of prevention and early intervention: (1) Prevention Programs, (2) combined Prevention and Early Intervention Programs, and (3) Early Intervention Programs. The San Mateo County MHSA PEI funded programs included in this framework are listed in Table 1 by these three reporting categories and the required MHSA strategies.

Table 1. Programs by PEI Component and Strategies

PEI Component	PEI Program	Agency	PEI Strategies		
			Access & Linkage to Treatment	Timely Access to Services for Underserved	Stigma & Discrimination Reduction
Prevention	Health Ambassador Program (HAP)	BHRS			✓
	Youth Health Ambassador Program (Y-HAP)	StarVista			✓
	Health Equity Initiatives (HEI's)	BHRS			✓
	Mental Health First Aid	BHRS			✓
	Mindfulness-Based Substance Abuse Treatment (MBSAT)	Puente de la Costa Sur, YMCA, and StarVista	✓		
	Panche/GiraSol	The Latino Commission	✓		
	Parent Project®	BHRS			✓
	Photovoice	BHRS			✓
	Suicide Prevention	BHRS			✓
Prevention & Early Intervention	Early Childhood Community Team (ECCT)	StarVista		✓	✓
	Project SUCCESS	Puente de la Costa Sur		✓	
	The Cariño Project	ALAS		✓	✓
	Peer Counseling	Peninsula Family Service		✓	✓
	Youth S.O.S.	StarVista	✓		
Early Intervention	Primary Care Interface	BHRS	✓	✓	
	re(MIND)® Early Psychosis Program	Felton Institute	✓	✓	
	The Pride Center	StarVista	✓	✓	

PEI Data Collection and Reporting Framework

This PEI Data Collection and Reporting Framework uses standardized reporting templates through which all PEI programs will report their data. It also includes individualized PEI Program Crosswalks that outline the specific reporting expectations for each program (see Appendix A for each program's crosswalk). This approach allows programs to clearly identify how their specific program data aligns with the framework.

The standard reporting templates are: 1) the MHSA Annual Reporting Template, which includes preset sections for narrative and tables to report aggregate data, and 2) a PEI Data Template which includes preset spreadsheets for programs to report individual-level and population-level data. Each program's individualized crosswalk identifies the MHSA reporting requirements for:

1. Individuals served (unduplicated)
2. Individuals reached (duplicated)
3. Demographics
4. Referrals
5. Individual-level outcomes

Unduplicated Individuals Served, Individuals "Reached" and Demographics

Key Decision Points

How PEI programs will report unduplicated vs. duplicated data:

- **Unduplicated Individuals Served:** During the initial phase of the rollout of this framework that focused on individual-level programs, all programs identified at least one primary program component for which they would report the required unduplicated number of individuals served. A program could select more than one primary component but will be required to report an unduplicated count for their program. For example, if a program's primary components are short-term clinical therapy and case management, an individual receiving both services would only be captured once in the unduplicated number of individuals served.
- **Individuals "Reached":** Programs also identified components through which they may have a broader reach, such as outreach or educational activities. The number reported under this "reach" category does not need to be an unduplicated count. For example, if a program offers workshops as another program component, they can report on the number of workshops attendees over the course of the reporting period, which may include some duplicate individuals who attended multiple activities. Newer programs added to this framework will report under this category.
- **Demographics:** Programs will collect full demographic data on unduplicated individuals served through their primary program components. Full demographics will be reported in the standardized San Mateo County format, which addresses the MHSA PEI requirements and local community input received regarding how we ask sensitive questions regarding race, ethnicity, and language (REAL) and sexual orientation, gender identity, and expression (SOGIE). For individuals "reached", the program may collect a standardized shortened list of demographic data. For example, in group settings, such as workshops or classes, or at large events. Demographic information is not required for light-touch outreach activities.

Table 2. PEI Program Components for Individuals Served and Individuals "Reached"

PEI Component	PEI Program	Unduplicated individuals served through primary program component(s)	Individuals reached through other program components, may be duplicated
Prevention	Health Ambassador Program	Health ambassadors	Individuals reached through outreach and presentations
	Youth HAP	Cohort	Individuals reached through outreach and presentations
	Health Equity Initiatives (HEIs)	NA	Individuals reached through outreach, presentations, and other events
	Mental Health First Aid	Training Participants	Individuals reached through outreach, presentations, and other events
	Mindfulness-Based Substance Abuse Treatment	Youth cohort	Individuals reached through outreach/presentations, family members of youth, providers
	Panche/GiraSol	Youth	Family members
	Parent Project®	Cohort	Individuals reached through outreach and presentations
	Photovoice	Cohort	Individuals reached through outreach and presentations
	Suicide Prevention	NA	Individuals reached through presentations and trainings, and other events
Prevention & Early Intervention	Early Childhood Community Team	Children receiving one-on-one services (including direct therapy) and participating in groups	Parents/caregivers in groups, teachers who receive consultations, children reached by consultations
	Project SUCCESS	Group services and one-on-one counseling	N/A
	The Cariño Project	Clinical services	Case management services and individuals reached through workshops, events
	Peer Counseling	One-on-one peer counseling and groups	N/A
	Youth S.O.S.	Mobile crisis response	Family members of youth served, individuals reached through outreach/education
Early Intervention	Primary Care Interface	Counseling, case management, psychiatry	N/A
	re(MIND)® Early Psychosis Program*	Early psychosis treatment and re(MIND) Alumni	Family members/caregivers
	The Pride Center	Therapy and case management	Peer groups, trainings, consultations

Referrals

Key Decision Points

How PEI programs will report on referrals:

- **Referrals into Early Intervention Programs:** Collecting extensive data on referrals into the PEI programs is not possible for prevention-focused programs. Therefore, referral to and enrollment into a PEI program will only be collected from Early Intervention Programs. Individuals enrolling into an Early Intervention Program will likely have a period of untreated mental illness to report as part of a formal intake process. These Early Intervention Programs will also collect referral data into their programs and report on the MHSA requirements for the average duration of untreated mental illness and the interval between a referral and participation in early intervention treatment.
- **Referrals to SMI, SUD, and other MH Services:** Prevention-focused programs often make referrals to a higher level of care for SMI, SUD, and other mental health needs. As these referrals are made to different programs within an agency or to outside agencies that generally use different electronic health record systems or other data systems, collecting additional data on the duration of untreated mental illness or interval between referral and actual enrollment is not feasible. Therefore, Prevention Programs that make referrals to SMI, SUD, or other mental health services will only report on the number of referrals made for each category of referrals and indicate whether those referrals were made within the PEI-program's agency, or to a County* service or other outside agency.
- **Referral Data Reporting:** Programs will be asked to provide unduplicated individual-level data, from their primary program component, on any referrals made to SMI/SUD/Other MH, social services, and other services. If collected, referrals made for individuals reached through other program components will also be reported. These referral data will be reported on separate tabs of the PEI data template spreadsheet. If programs do not have a process to collect individual-level data on referrals made through other (non-primary) program components, they may choose to only report aggregate totals for those referrals.

** Treatment services/programs provided, funded, administered, or overseen by the County can report sources of referrals and data related to average duration of untreated mental illness and the interval between a referral and participation in treatment. This will not be reported by the PEI Programs.*

Individual/Program Outcomes

The individual/program outcomes section of the MHSA Annual Reporting Template includes three subsections:

1. **Increased protective factors/decreased risk factors and/or increased recovery indicators/decreased symptoms:** All programs will report under this section.
    - Prevention Programs will primarily report on increased protective factors/decreased risk factors, and

- Early Intervention Programs will primarily report on increased recovery indicators/decreased symptoms.

2. **Stigma reduction:** Only programs with a stigma reduction strategy will report outcomes in this subsection. Programs not included in the stigma reduction strategy category may report outcomes related to stigma reduction in the other two outcome sections.
3. **Additional program and/or individual outcomes:** All programs can report additional outcomes under this section.

As previously discussed, to allow for BHRS to assess the impact across all its PEI-funded programs, this data collection and reporting framework uses a set of Outcome Domains under which programs can report their specific data. The subsections listed above requires that PEI programs identify a corresponding Outcome Domain for each data point. See Appendix B for a complete visual overview of the domains that will be reported on for each program and see Appendix C for a full inventory of the specific data indicators that will be reported.

The **PEI Outcome Domains** used in this framework include:

- Access to services
- Community advocacy/Empowerment
- Connection and support
- Cultural identity/cultural humility
- General mental health
- Improved knowledge, skills, and/or abilities
- Self-empowerment
- Stigma reduction
- Utilization of emergency services

Increased Protective Factors/Decreased Risk Factors and/or Increased Recovery Indicators/Decreased Symptoms

Key decision points:

Key Decision Point

How PEI Programs will report on Increased Protective Factors/Decreased Risk Factors or Increased Recovery Indicators/Decreased Symptoms

- The outcomes that programs select for this subsection must demonstrate the impact on individuals served through the program's primary component(s). For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the outcomes reported under this subsection should focus on the youth receiving clinical therapy.

Table 3. Primary Program Component Individual Outcomes (7A)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program		✓	✓				✓			
	Youth Health Ambassador Program			✓				✓			
	Health Equity Initiatives				✓		✓	✓	✓		
	Mental Health First Aid				✓		✓		✓		
	Mindfulness-Based Substance Abuse Treatment						✓				
	Panche/GiraSol	✓			✓			✓	✓		
	The Parent Project®						✓	✓	✓		
	Photovoice		✓					✓	✓		
	Suicide Prevention			✓			✓		✓		
Prevention & Early Intervention	Early Childhood Community Team			✓			✓				
	Project SUCCESS						✓	✓	✓		
	The Cariño Project					✓					
	Peer Counseling			✓		✓					
	Youth S.O.S.			✓			✓	✓			
	re(MIND)® Early Psychosis Program					✓				✓	
	The Pride Center			✓		✓	✓				

Key Decision Point

How PEI Programs will report on Stigma Reduction

- To better define the type of stigma reduction impact and to align this reporting framework with other program impacts, the stigma reduction outcome section is broken into three concepts of stigma reduction: (1) Self/internalized, (2) Seeking help/treatment, and (3) Public/external. Programs may choose to report on indicators aligned with any of the stigma reduction concepts. See Table 4 for each program's stigma reduction concepts.

Stigma Reduction

Table 4. Stigma Reduction Outcomes

PEI Component	PEI Program	Self/ Internalized	Seeking Help/Treatment	Public/External	Not Required to Report on Stigma Reduction
Prevention	Health Ambassador Program		✓	✓	
	Youth Health Ambassador Program	✓	✓		
	Health Equity Initiatives	✓		✓	
	Mental Health First Aid			✓	
	Mindfulness-Based Substance Abuse Treatment				✓
	Panche/GiraSol				✓
	The Parent Project®	✓			
	Photovoice	✓		✓	
	Suicide Prevention	✓			
Prevention & Early Intervention	Early Childhood Community Team	✓	✓		
	Project SUCCESS				✓
	The Cariño Project	✓			
	Peer Counseling	✓	✓		
	Youth S.O.S.				✓
Early Intervention	Primary Care Interface				✓
	re(MIND)® Early Psychosis Program				✓
	Pride Center				✓

Other Individual/Program Outcomes

Key Decision Point

How PEI Programs will report on Other Individual/Program Outcomes

- The outcomes that programs select for this subsection may demonstrate either additional impact of the program on individuals served through the program's primary component(s) or the impact on individuals reached through the program's other components. For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the program may choose to report on additional outcomes for the youth receiving clinical therapy and/or family members attending workshops.

Table 5. Additional Program/Individual Outcomes (7C)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program	✓					✓				
	Youth Health Ambassador Program	✓	✓				✓				
	Health Equity Initiatives		✓								
	Mental Health First Aid										
	Mindfulness-Based Substance Abuse Treatment						✓				
	Panche/GiraSol			✓			✓				
	The Parent Project®				✓						
	Photovoice				✓		✓				
	Suicide Prevention				✓						
Prevention & Early Intervention	Early Childhood Community Team	✓	✓		✓						
	Project SUCCESS					✓					
	The Cariño Project			✓	✓		✓				
	Peer Counseling	✓				✓					
	Youth S.O.S.	✓								✓	
Early Intervention	Primary Care Interface					✓	✓	✓			
	re(MIND)® Early Psychosis Program							✓	✓		✓
	The Pride Center			✓		✓	✓	✓	✓		

Appendix A: Program Crosswalks

This appendix includes the crosswalks for the following programs:

- The Cariño Project
- Early Childhood Community Team
- Health Ambassador Program
- Health Equity Initiatives
- Mental Health First Aid
- Mindfulness-Based Substance Abuse Treatment
- Panche/GiraSol
- The Parent Project®
- Peer Counseling
- Photovoice
- The Pride Center
- Primary Care Interface
- Project SUCCESS
- re(MIND)® Early Psychosis Program
- Suicide Prevention
- Youth Health Ambassador Program
- Youth S.O.S.

THE CARIÑO PROJECT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Unduplicated number of individuals served in primary program components (clinical)	Clinical spreadsheet
	PEI Data Template, Individual Demographics (long) tab	Demographics of unduplicated individuals served in clinical component	Demographics collected from clinical participants
	5	Duplicated number of individuals served through other program components (case management, events, workshops, groups, and outreach activities)	Attendance and outreach tracking logs, case management spreadsheet
	PEI Data Template, Individual Demographics (short) tab	Demographics of individuals reached through other program components (case management, events, workshops, groups, and outreach activities), may be duplicated *Note: You may submit additional demographic data for case management participants on this tab since you are using the long demographic form for case management.*	Demographics of duplicated attendees collected from the participant survey provided to attendees or events, groups, workshops, and any outreach activities and demographics of case management participants.
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)	SMI referrals from the Clinical spreadsheet, SMI referral log (If you start making referrals for substance use treatment, you can add a column to the referral log tab to capture whether the referral is SMI or SUD.) Also non-SMI mental health referrals to organizations outside ALAS will be captured in the Case Management spreadsheet, Mental health referral tracking tab and noted as Other in Column F.
		Programs or treatment referred to	

	PEI Data Template, Referrals Out tab	Individual-level data on mental health and substance use referrals to other agencies and within ALAS		Same as above
Referrals to other services	6C	Number of referrals to other services by type		Case management spreadsheet, social referral tracking tab
	PEI Data, Referrals Out tab	Individual-level data on referrals to other services		Same as above
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	Number who experience an overall improvement in their mental health (clinical population)	#/% of clinical participants who improved rating for question #1 from intake clinical self-assessment to ongoing/discharge clinical self-assessment (taken every 6 months)
		Domain: General mental health	Number who reported an improved ability to manage mental health symptoms (clinical population)	#/% of clinical participants who improved rating for question #2 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General mental health	Number who reported an improved ability to cope with stressors (clinical population)	#/% of clinical participants who improved rating for question #3 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General mental health	Number who reported that the services they are receiving are helping them to do better in daily life (clinical population)	#/% of clinical participants who improved rating for question #7 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Number of participants who reported feeling more comfortable talking about mental health since they began attending sessions (clinical population)	#/% of participants who selected somewhat agree or agree on question #8 on the ongoing/discharge clinical self-assessment (use the latest assessment per individual)

Additional Individual/ Program Outcomes	7C	Domain: Cultural identity	Number who felt more connected to their culture (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #4.
		Domain: Connection and Support	Number who reported being better able to support themselves and/or their family after receiving services (case management population)	#/% of case management survey respondents who selected somewhat agree or agree on question #8.
		Domain: Improved knowledge, skills, and/or abilities	Number who learned something new that was useful to them (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #6.

EARLY CHILDHOOD COMMUNITY TEAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	5	Number of individuals reached in all other program components (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
	PEI Data Template	Demographics of individuals reached in all other program components, (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
Referrals to your PEI program	6A	Number of referrals into ECCT		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
	PEI Data Template	Individual-level data on referrals into ECCT		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH) *Note: SMI referrals should include referrals to any services for beyond mild to moderate needs.*		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective	7A	Domain: Improved knowledge, skills, and/or abilities	Number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an improvement in	Parent Stress Index, ETO

Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms			their Parent Stress Index score (population = one-on-one services)	
		Domain: Connection and support	Number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score (population = one-on-one services)	Protective Factors Survey, ETO
		Domain: Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting. (population = group services)	End of year/group survey, ETO
		Domain: Connection and support	Due to my engagement in this program, I feel more connected to other parents in my community. (population = group services)	End of year/group survey, ETO
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Number who experience changes in attitudes, knowledge, or behavior related to mental illness – I feel more comfortable talking about my and my child's mental health/children in my classroom. (population = group, teacher consultations, and one-on-one services)	End of year/group survey, ETO
		Stigma (Seeking Help/Treatment)	Number who experience changes in attitudes, knowledge, or behavior related to seeking mental health services. – I felt more comfortable seeking out resources for my child. (population = group, teacher consultations, and one-on-one services)	End of Year/Group Survey
Additional Individual/Program Outcomes	7C	Domain: Access to services	Due to my engagement, I know where to go in my community for resources and support. (population	End of Year/Group Survey

			= groups, teacher consultations, and one-on-one services)	
		Domain: Community advocacy	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and one-on-one services)	End of Year/Group Survey
		Domain: Cultural identity/humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	End of Year/Group Survey

HEALTH AMBASSADOR PROGRAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (ambassadors)		Existing intake log
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long form on ambassador intake)		Existing intake log
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	PEI Data Template	Individual-level data on SDOH responses		Referral/SDOH tracking log
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
		Programs or treatment referred to		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Individual/Participant Outcomes – Increased	7A	Domain: Connection and support	Due to my participation in HAP courses and/or activities, I feel more connected to my family. (population = HAP ambassadors)	HAP Ambassador Annual Survey

Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms		Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = HEI event participant).	HAP Ambassador Annual Survey
		Domain: Community advocacy	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community. (population = HAP ambassadors)	HAP Ambassador Annual Survey
		Domain: Self-empowerment	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children. (population = HAP ambassadors)	HAP Ambassador Annual Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Seeking Help/Treatment)	Due to my participation in this course, I feel more comfortable seeking mental health services for myself and/or my family. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Stigma (Public/External)	My participation in this course has helped improve my understanding of how stigma impacts people living with mental health problems and/or substance abuse. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my personal and/or family life. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Domain: Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my community. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)

		Domain: Access to services	Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)

Health Equity Initiatives

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	5	~~Number of unduplicated individuals served in primary program component (HEI Participants)~~		~~Existing intake log~~
	PEI Data Template	~~Demographics of unduplicated individuals served in primary program component (HEI Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	PEI Data Template	Individual-level data on SDOH responses		Survey, Excel Document
~~Mental health and substance use referrals to other agencies and within your agency~~	~~6B~~	~~Number of referrals by type of treatment referred to (SMI, SUD, or other MH)~~		~~Referral/SDOH tracking log~~
		~~Programs or treatment referred to~~		~~Referral/SDOH tracking log~~
	~~PEI Data Template~~	~~Individual-level data on mental health and substance use referrals to other agencies and within your agency~~		~~Referral/SDOH tracking log~~
~~Referrals to other services~~	~~6C~~	~~Number of referrals by type~~		~~Program Data~~
	~~PEI Data Template~~	~~Individual-level data on referrals to other services~~		~~Referral/SDOH tracking log~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-Empowerment	Due to this program/training/event, I am more confident in my ability to advocate for the behavioral health needs of myself and/or my child/ren and/or another family member (population = HEI event participant).	Participant Survey
		Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = HEI event participant).	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
		Domain: Improved knowledge, skills, and/or abilities	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access mental health and substance use services (population = HEI event participant).	Participant Survey
Stigma Reduction	7B	Stigma (public external)	This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society (population = HEI event participant).	Participant Survey
		Stigma (Self/Internalized)	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use (population = HEI event participant).	Participant Survey
Additional Client/Program Outcomes	7C	Domain: Community advocacy	Due to my participation in this program/training/event, I feel more confident in my ability to create change in my community around mental health or substance use conditions (population = HEI event participant).	Participant Survey

Mental Health First Aid

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
	~~5~~	~~Number of unduplicated individuals served in primary program component (SP Training Participants)~~	~~Existing intake log~~

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	~~PEI Data Template~~	~~Individual-level data on SDOH responses~~		~~Survey, Excel Document~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Cultural identity/humility	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures (population = MHFA course participant).	Participant Survey
		Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = MHFA course participant).	Participant Survey
		Domain: Improved knowledge, skills, and/or abilities	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services (population = MHFA course participant).	Participant Survey
Stigma Reduction	7B	Stigma (Public/External)	This course affirmed that people with mental illness are capable and able to make positive contributions to society (population = MHFA course participant).	Participant Survey

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used *Note: Each MBSAT agency can complete the sources based on its processes.*
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (youth cohort)	
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth cohort) (long)	
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated	
	PEI Data Template	Demographics of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated (short)	
	PEI Data Template	Individual-level data on social determinants of health screener responses	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both youth cohort members and family members.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for youth cohort members. You do not need to report a individual ID for referrals made for family members.*	
	6C	Number of referrals by type	

Referrals to other services		*Note: You can report on referrals provided to both youth cohort members and family members.*		
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for family members.*		
Individual/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or abilities	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better. (population = youth cohort)	Revised ERQ (post program only)
		Domain: Improved knowledge, skills, and/or abilities	Because I participated in this program, I control my feelings about things by changing the way I think about them. (population = youth cohort)	Revised ERQ (post program only)
		Domain: Improved knowledge, skills, and/or abilities	When I want to feel better about something, I change the way I'm thinking about it. (population = youth cohort)	Revised ERQ (post program only)
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
		Domain: Improved knowledge, skills, and/or abilities	As a result of participating in this program, I believe that recovery from trauma is possible. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
		Domain: Improved knowledge, skills, and/or abilities	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being). (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey

		Domain: Improved knowledge, skills, and/or abilities	As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice (TIP). (population = Trauma 101 attendees – providers only)	Trauma 101 post survey

GIRASOL (FORMERLY THE PANCHE BE YOUTH PROJECT)

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Individual-level data on social determinants of health screener responses		Intake form
	5	Number of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
	PEI Data Template	Demographics of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		Program Data
		Programs or treatment referred to		Program Data
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		Program Data
Referrals to other services	6C	Number of referrals by type		Program Data
	PEI Data Template	Individual-level data on referrals to other services		Program Data
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-empowerment	I have "control" of my own narrative, design my own narrative, go for my dreams. (population = youth)	Youth Pre/Post Survey
		Domain: Stigma reduction (Self/Internal)	I feel more comfortable speaking about mental health challenges. (population = youth)	Youth Pre/Post Survey
		Domain: Access to services	I know at least one place I can go for mental health services. (population = youth)	Youth Pre/Post Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
		Domain: Cultural identity/humility	I feel proud and connected to my cultural roots. (population = youth)	Youth Pre/Post Survey
		Domain: Cultural identity/humility	I can name three positive values from my culture. (population = youth)	Youth Pre/Post Survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and abilities	Parent perception of improved behavior/academics of daughter (population = family members)	Parent Survey
		Domain: Connection and support	Improved relationship between parent/sibling and daughter (population = family members)	Parent Survey

Parent Project®

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (client) information and demographics	5	Number of unduplicated individuals served in primary program component (Parent Project® participants)		Existing intake log
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (Parent Project® participants)		Existing intake log
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	PEI Data Template	Client-level data on SDOH responses		Referral/SDOH tracking log
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) Note: Report on referrals provided to Parent Project® participants.		Referral/SDOH tracking log
		Programs or treatment referred to		Referral/SDOH tracking log
	PEI Data Template	Client-level data on mental health and substance use referrals.		Referral/SDOH tracking log
Referrals to other services	6C	Number of referrals by type		Referral/SDOH tracking log
	PEI Data Template	Client-level data on referrals to other services		Referral/SDOH tracking log
Client/ Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk	7A	Domain: Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned knowledge and skills that I can use to access mental health or substance use services (for myself or my family). (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)

Factors/Symptoms				
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internal)	Due to my participation in this course, I feel more comfortable talking about my mental health and/or substance use. (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)
Additional Client/Program Outcomes	7C	Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion) were affirmed by taking the Parent Project® course. (population = Parent Project® course members, unduplicated)	Parent Project® course Survey (collected from each course participant at end of course)

PEER COUNSELING

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual/ Participant information and demographics	5	Number of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions)		ETO
	PEI data template	Demographics of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions) *Note: Please provide an explanation in section 5 of the annual report template stating the reason why Peer Counseling is not reporting SOGI data for its unduplicated individuals served.*		ETO
Referrals to your PEI program	6A	Number of referrals to Peer Counseling		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH)		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	As a result of participating in this program, I feel less stressed.	Participant survey
		Domain: Connection and support	As a result of participating in this program, I feel supported.	Participant survey
Stigma Reduction	7B	Stigma (Self/Internalized)	Due to this program, I feel more comfortable talking about my problems.	Participant survey

		Stigma (Seeking Help/Treatment)	Due to this program, I feel more comfortable reaching out for emotional support.	Participant survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	The program improved my knowledge and abilities to seek support.	Participant survey
		Domain: Access to services	As a result of participating in this program, I am connected to community resources.	Participant survey

Photovoice

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Client information and demographics	~~5~~	~~Number of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (SP Training Participants)~~		~~Existing intake log~~
	PEI Data Template	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	5	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations/events) may be duplicated (short)		Audience survey
	~~PEI Data Template~~	~~Individual-level data on SDOH responses~~		~~Survey, Excel Document~~
Client Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Community advocacy/ empowerment	Due to my participation in this workshop, I feel more confident in my ability to create change in my community around mental health and substance use conditions by telling my story (population = Photovoice course participant).	Participant Survey
		Domain: Self-Empowerment	As a result of this program, I am more willing to seek professional support for a mental health and/or substance use condition if I need it (population = Photovoice course participant).	Participant Survey
Individual Outcomes – Stigma Reduction		Stigma (Self/Internal)	Due to this workshop, I feel more comfortable talking about my mental health and/or substance use (population = Photovoice course participant).	Participant Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
	7B	Domain: Stigma (public/external)	As a direct result of this program, I am MORE likely to believe that people with mental illness are capable and able to make positive contributions to society (population = Photovoice course participant).	Participant Survey
Additional Individual/ Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	Through my participation in this workshop, I have learned knowledge and skills that I can use to access mental health and substance use health services (population = Photovoice course participant).	Participant Survey
		Domain: Cultural identity/humility	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures (population = MHFA course participant).	Participant Survey
		Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = Photovoice course participant).	Participant Survey

THE PRIDE CENTER

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (therapy and case management)	ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (therapy and case management)	ETO / Participant Information Form
	5	Number of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Spreadsheet (for now)
	PEI Data Template	Demographics of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Participant Information Form
Referrals to your PEI program	6A	Number of referrals to PEI program *Note: Referral counts should be unduplicated for the "primary program component" - case management or therapy services, but not duplicated even if someone was referred to both. If a family is referred, count each individual separately.*	ETO
		Number of referrals that resulted in enrollment (number engaged)	ETO
		Duration of untreated mental illness *Maybe appropriate for screening or assessment questions.*	ETO
		Average interval between referral and enrollment	ETO

		Minimum length of time from referral to enrollment		ETO
		Maximum length of time from referral to enrollment		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or MH) to other agencies and within StarVista		Spreadsheet (for now)
		Programs or treatment referred to		Spreadsheet (for now)
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within StarVista		
Referrals to other services	6C	Number of referrals by type		Spreadsheet (for now)
	PEI Data Template	Individual-level data on referrals to other services		
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	Number of individuals who experienced reduced depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score. (population = youth and adult therapy services)	CANS/ANSA
		Domain: General mental health	Number of individuals who experienced reduced anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score. (population = youth and adult therapy services)	CANS/ANSA
		Domain: Improved knowledge, skills, and/or abilities	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score (population = youth therapy services) and by a reduction in their ANSA Interpersonal/social connectedness subscale score (population = adult therapy services).	CANS/ANSA
		Domain: Connection and Support	Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score (population = youth therapy services) and by a reduction in their ANSA	CANS/ANSA

			Community Connection subscale score. (population = adult therapy services)	
Additional Individual/Program Outcomes	7C	Domain: General Mental Health	Number of individuals who reported an improvement in their mental health as measured by the following: "How would you rate your mental health in the last 30 days?" (population = therapy services)	Mental Health Self-Assessment
		Domain: General Mental Health	Number of individuals who reported an improvement in their ability to cope with stress as measured by the following: "How would you rate your ability to cope with stress in the last 30 days?" (population = therapy services)	Mental Health Self-Assessment
		Domain: Self-empowerment	Number of individuals who reported improved self-empowerment as measured by the following: "I am confident I can affect my life through the decisions I make?" (population = therapy services)	Mental Health Assessment
		Domain: Stigma Reduction	Number of individuals who reported reduced self-stigma as measured by the following: "I feel comfortable talking about my sexual orientation and/or gender identity?" (population = therapy services)	Mental Health Assessment
		Domain: Improved knowledge, skills, and/or abilities	Number of individuals who reported improved knowledge as measured by the following: "After this training, I now have a strong understanding of issues impacting the LGBTQ+ community." (population = individuals reached in other program components)	Individual survey
		Domain: Connection and support	Number of individuals who reported feeling more connected as measured by the following: "I feel more socially connected by participating in Pride Center programs and services." (population = individuals reached in other program components)	Individual survey

PRIMARY CARE INTERFACE

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	"Interface Episode by referral source" report in Avatar
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	Avatar report
Referrals to your PEI program	6A	Number of referrals to Primary Care Interface	"Interface Episode by referral source" report in Avatar
		Number of referrals that resulted in enrollment (number engaged – defined as having completed intake)	
		Average duration of untreated mental illness (*if available - time between the self-reported onset of symptoms that brought them into treatment this time and entry into treatment(intake)*)	
		Average interval between referral date and enrollment date (date assessment received)	
		Minimum length of time from referral to enrollment	
		Maximum length of time from referral to enrollment	
	PEI Data Template	Individual-level data on referrals into Primacy Care Interface	AVATAR
Mental health and substance use referrals to other agencies **and** within your agency	6B	Number of referrals by type of treatment referred to Region, SUD, or other MH within BHRS (Pre-to-3, TAY, AOD IMAT)	
		Programs or treatment referred to outside agencies (AOD In/out pt; PPN, CORA, KARA, School)	

	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies (from PCI, in disposition?) and within your agency (BHRS)		AVATAR
Referrals to other services (Other than SUD or MH)	6C	Number of referrals by type (Housing, food, Social worker, Job, etc.)		
	PEI Data Template	Individual-level data on referrals to other services		AVATAR
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General Mental Health	Number who experience reduced anxiety symptoms (as measured by a change in their GAD-7 overall score)	AVATAR GAD-7 Scale
		Domain: General Mental Health	Number who experience reduced depressive symptoms (as measured by a change in their PHQ-9 overall score)	AVATAR PHQ-9 Scale
Additional Individual/Program Outcomes	7C	Domain: General mental health	As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.	
		Domain: Self-empowerment	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	
		Domain: Improved knowledge, skills, and/or abilities	As a result of participation in this program, I learned skills and strategies to cope with stressors.	

PROJECT SUCCESS

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
	PEI Data Template	Demographics of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		TheraNest platform; Excel spreadsheet
		Programs or treatment referred to		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on mental health and substance use referrals		TheraNest platform; Excel spreadsheet
Referrals to other services	6C	Number of referrals by type		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on referrals to other services		TheraNest platform; Excel spreadsheet
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Stigma reduction (Self/Internalized)	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs. (population = groups)	Group post survey
		Domain: Self-empowerment	Puente's Project Success helped me understand how to better manage how I respond to my thoughts and feelings. (population = groups)	Group post survey

		Domain: Improved knowledge, skills, and/or abilities	Due to this program, I learned skills that help me to express my emotions and opinions more effectively. (population = groups)	Group post survey
Additional Individual/Program Outcomes	7C	Domain: General mental health	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	PHQ-9 – [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]
		Domain: General mental health	Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	GAD-7 - [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (early psychosis treatment and re(MIND) Alumni *(only count BEAM aftercare)*)		EHR
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (early psychosis treatment and BEAM aftercare)		EHR
	5	Number of individuals served in other program components (family members/caregivers), may be duplicated		EHR
Referrals to your PEI program	6A	Number referrals to re(MIND)		EHR
		Number engaged/enrolled in re(MIND)		EHR
		Average duration of untreated psychosis		EHR
		Average interval between referral and enrollment		EHR
		Minimum length of time from referral to enrollment		EHR
		Maximum length of time from referral to enrollment		EHR
	PEI Data Template	Individual-level data on referrals to re(MIND)		EHR
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		EHR
		Programs or treatment referred to		EHR
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency (internal transfers to BEAM)		EHR
Referrals to other services	6C	Number of referrals by type		EHR
	PEI Data Template	Individual-level data on referrals to other services		EHR
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators;	7A	Domain: Utilization of emergency/crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	EHR
		Domain: General mental health	Improvement engagement in meaningful activities (employment, academic	EHR

Decreased Risk Factors/Symptoms			placement/progression, volunteerism) for participants and alumni	
		Domain: General mental health	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to followup for participants and alumni	EHR
Additional Individual/Program Outcomes	7C	Domain: Stigma (Self/Internalized)	"Due to this program, I am able to understand myself better." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Stigma (Externalized)	"I think that people with mental health challenges can lead healthy lives." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Self-empowerment	"Due to this program, I can take control of aspects of my life" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Other - Contracted Satisfaction	"I am satisfied with the services I have received at (re)MIND/BEAM program" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey

Suicide Prevention

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (client) information and demographics	5	Number of unduplicated individuals served in primary program component (Suicide Prevention participants)		Existing intake log
	~~PEI Data Template~~	~~Demographics of unduplicated individuals served in primary program component (Suicide Prevention participants)~~		~~Existing intake log~~
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	~~PEI Data Template~~	~~Client-level data on SDOH responses~~		~~Referral/SDOH tracking log~~
Client/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or abilities	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to access behavioral health services (population = SP event participant).	Participant Survey
		Domain: Connection and Support	Due to my participation in this program/training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide (population = SP event participant).	Participant Survey
Individual Outcomes – Stigma Reduction	7B	Domain: Stigma (Self/Internalized)	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use (population = SP event participant).	Participant Survey
Additional Client/Program Outcomes	7C	Domain: Cultural identity/humility	I feel like my identity, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event (population = SP event participant).	Participant Survey

YOUTH HEALTH AMBASSADOR PROGRAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (cohort)		Demographics Survey - Cohort
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long)		Demographics Survey- Cohort
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Audience survey
	PEI Data Template	Demographics of individuals reached in all other program components, may be duplicated (short)		Audience survey
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both cohort members and audience members.*		Survey, Excel Document
		Programs or treatment referred to		Excel Document
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both cohort members and audience members.*		Excel Document
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Individual/Participant Outcomes – Increased Protective Factors/Improved	7A	Domain: Connection and support	I feel that I am part of a community. (population = cohort)	Cohort Exit-Survey
		Domain: Self-empowerment	I have a positive attitude about myself. (population = cohort)	Cohort Exit-Survey

Recovery Indicators; Decreased Risk Factors/Symptoms		Domain: Self-empowerment	Due to my participation in HAP-Y, I am interested in pursuing a career in mental health. (population = cohort)	Cohort Exit-Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	I feel comfortable discussing topics related to mental health. (population = cohort and audience)	Exit-Survey and Audience Survey
		Stigma (Seeking Help/Treatment)	I feel comfortable seeking mental health services. (population = cohort and audience)	Exit-Survey and Audience Survey
Additional Individual/Program Outcomes	7C	Domain: Community advocacy	Due to this program, I am more confident in my ability to create change in my community. (population = cohort)	Cohort Exit Survey
		Domain: Access to services	I know who to call or access online if I need mental health services. (population = audience)	Audience Survey
		Domain: Improved knowledge, skills, and/or abilities	HAP-Y provided me with knowledge and skills that I continued to use. (population = cohort)	Cohort Exit-Survey

YOUTH S.O.S.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (mobile crisis response)	
	PEI data template	Demographics of unduplicated individuals served in primary program component (mobile crisis response)	
	5	Number of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
	PEI data template	Demographics of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
Referrals to your PEI program	6A	Number of referrals to Youth S.O.S. (crisis calls)	
		Number of referrals that resulted in enrollment/number engaged (Youth S.O.S. goes out)	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH) *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency *Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.*	
Referrals to other services	6C	Number of referrals by type *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.*	

Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or ability	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning. (population = youth who received Youth S.O.S. services)	Intake form-Intervention section
		Domain: Connection and Support	Number of youths who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Follow-up rating form
		Domain: Self-empowerment	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high. (population = youth who received Youth S.O.S. services)	Follow-up rating form
Additional Individual/Program Outcomes	7C	Domain: Utilization of emergency services	Youth diverted from use of psychiatric emergency services (population = youth who received Youth S.O.S. services)	
		Domain: Utilization of emergency services	Youth will not require law enforcement intervention (population = youth who received Youth S.O.S. services)	
		Domain: Access to services	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support. (population = family members/caregivers of youth)	

Appendix B: Outcome Domain Summary

Table 6 includes all outcome domains reported on by each program. Blue check marks represent outcomes for the program's primary components and orange check marks represent outcomes for the program's other components.

Table 6. PEI Program and Individual Outcome Summary

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction (Self/internalized)	Stigma reduction (Seeking help)	Stigma reduction (Public/external)	Utilization of emergency services
Prevention	HAP	✓	✓	✓	✓		✓	✓	✓	✓		
	HAP-Youth	✓	✓	✓			✓	✓	✓✓	✓✓		
	HEIs		✓		✓		✓	✓	✓		✓	
	MHFA				✓		✓				✓	
	MBSAT						✓✓					
	GiraSol	✓		✓	✓		✓	✓	✓			
	The Parent Project@				✓		✓		✓			
	Photovoice		✓		✓		✓	✓	✓		✓	
	Suicide Prevention			✓	✓		✓		✓			
Prevention & Early Intervention	ECCT	✓ ✓	✓ ✓	✓	✓✓		✓		✓✓	✓✓		
	Project SUCCESS					✓	✓	✓	✓			
	Cariño Project			✓	✓	✓	✓		✓			
	Peer Counseling	✓		✓		✓	✓		✓	✓		
	Youth S.O.S.	✓		✓			✓	✓				✓
Early Intervention	Primary Care Interface					✓	✓	✓				
	re(MIND)®					✓		✓	✓		✓	✓
	The Pride Center			✓✓		✓	✓✓	✓	✓			

Appendix C: Outcome Indicators

Table 7 provides an inventory of all indicators reported by PEI programs, by Outcome Domain.

Table 7. PEI Outcome Domains and Indicators

Outcome Domains	Sample outcome questions/statements	Program using indicator
Access to services	Due to my engagement, I know where to go in my community for resources and support.	ECCT
	As a result of participating in this program, I am connected to community resources.	Peer Counseling
	I know who to call or access online if I need mental health services.	HAP-Y
	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support.	Youth S.O.S.
	I know at least one place I can go for mental health services.	Panche/GiraSol
	Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful.	HAP
Community advocacy/ empowerment	Due to my engagement, I feel more empowered to advocate for myself and my child's needs.	ECCT
	Due to this program, I am more confident in my ability to create change in my community.	HAP-Y
	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community.	HAP
	Due to my participation in this event/program/training, I feel more confident in my ability to create change in my community around mental health or substance use conditions.	HEI's, Photovoice
Connection and support	Due to this program, I am better able to support myself and/or my family.	Cariño Project
	Improved relationship between parent/sibling and daughter	Panche/GiraSol
	Number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score	ECCT
	Due to my engagement in this program, I feel more connected to other parents in my community.	ECCT
	As a result of participating in this program, I feel supported.	Peer Counseling

	I feel that I am part of a community.	HAP-Y
	Number of youth who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Youth S.O.S.
	Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score for youth and by a reduction in their ANSA Community Connection subscale score for adults.	Pride Center
	I feel more socially connected by participating in Pride Center programs and services.	Pride Center
	Due to my participation in HAP courses and/or activities, I feel more connected to my family.	HAP
Cultural identity/ cultural humility	Due to participating in this program, I feel more connected to my culture.	Cariño Project
	I feel like my identity is affirmed by this program.	ECCT
	I feel proud and connected to my cultural roots.	Panche/GiraSol
	I can name three positive values from my culture.	Panche/GiraSol
	I feel like my identify, cultural background, and experiences (race, ethnicity, gender, sexual orientation, religion, etc.) were affirmed by this program/training/event.	HEI's, MHFA, Parent Project®, Suicide Prevention, HAP, Photovoice
	As a result of this course, I have a better understanding of how mental health and substance use challenges affect different cultures.	MHFA, Photovoice
General mental health	As a result of participating in this program, I feel less stressed.	Peer Counseling
	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	Project SUCCESS, Primary Care Interface
	Decrease in depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score	Pride Center
	Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	Project SUCCESS, Primary Care Interface
	Decreased in anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score	Pride Center
	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism)	re(MIND)®

	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to followup	re(MIND)®
	Number who experience an overall improvement in their mental health	Cariño Project, Pride Center
	Number who reported an improved ability to manage mental health symptoms	Cariño Project, Primary Care Interface
	Number who reported an improved ability to cope with stressors	Cariño Project, Pride Center
	Due to my participation in this program/training/event, I am more willing to reach out and help someone if I think they may be at risk of suicide.	Suicide Prevention
	Number who reported that the services they are receiving are helping them to do better in daily life	Cariño Project
Improved knowledge, skills, and/or abilities	Due to this program, I learned something that is useful to me.	Cariño Project
	Parent perception of improved behavior/academics of daughter	Panche/GiraSol
	Number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an improvement in their Parent Stress Index score.	ECCT
	Due to my engagement in this program, I feel more confident in my parenting.	ECCT
	The program improved my knowledge and abilities to seek support.	Peer Counseling
	Due to this program, I learned skills that help me to express my emotions and opinions more effectively.	Project SUCCESS
	HAP-Y provided me with knowledge and skills that I continued to use.	Y-HAP
	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning.	Youth S.O.S.
	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score for youth and by a reduction in their ANSA Interpersonal/social connectedness subscale score for adults	Pride Center
	After this training, I now have a strong understanding of issues impacting the LGBTQ+ community.	Pride Center

	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.	MBSAT
	Because I participated in this program, I control my feelings about things by changing the way I think about them.	MBSAT
	When I want to feel better about something, I change the way I'm thinking about it.	MBSAT
	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being.	MBSAT
	As a result of participating in this program, I believe that recovery from trauma is possible.	MBSAT
	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being).	MBSAT
	As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice (TIP).	MBSAT
	Through my participation in this event/program/training, I have learned knowledge and skills that I can use to mental health and substance use services.	HEI's, MHFA Parent Project®, Suicide Prevention
	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my community.	HAP
	As a result of participation in this program, I learned skills and strategies to cope with stressors.	Primary Care Interface
Self-empowerment	I am confident that I can affect my life through decisions that I make.	Pride Center
	I have "control" of my own narrative, design my own narrative, go for my dreams.	Panche/GiraSol
	Puente's Project Success helped me understand how to better manage how I respond to my thoughts and feelings.	Project SUCCESS
	Due to this program, I can take control of aspects of my life.	re(MIND)®
	I have a positive attitude about myself.	HAP-Y
	Due to my participation in HAP-Y, I am interested in pursuing a career in mental health.	HAP-Y
	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	Youth S.O.S.
	Due to my participation in courses and/or activities, I am more confident in my ability to advocate for the behavioral	Parent Project®, HAP, HEI's

	health needs of myself and/or advocate for my child/children.	
	As a result of this program, I am more willing to seek professional support for a mental health and/or substance use condition if I need it.	Photovoice
	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	Primary Care Interface
Stigma reduction (self/internalized)	Due to this program, I feel more comfortable talking about mental health since I began attending sessions.	Cariño Project
	I feel more comfortable talking about my and my child's mental health/children in my classroom.	ECCT
	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs.	Project SUCCESS
	Due to this program, I am able to understand myself better.	re(MIND)®
	I feel more comfortable speaking about mental health challenges.	Panche/GiraSol,
	Due to this program, I feel more comfortable talking about my problems.	Peer Counseling
	I feel comfortable discussing topics related to mental health.	Y-HAP
	I feel comfortable talking about my sexual orientation and/or gender identity.	Pride Center
	Due to this program/training/event, I feel more comfortable talking about *my* mental health or substance use.	HEI's, Suicide Prevention, Parent Project®, Photovoice
Stigma reduction (seeking help/ treatment)	I felt more comfortable seeking out resources for my child.	ECCT
	I feel comfortable seeking mental health services.	Y-HAP
	Due to this program, I feel more comfortable reaching out for emotional support.	Peer Counseling
	Due to my participation in this course, I feel more comfortable seeking mental health services for myself and/or my family.	HAP
Stigma reduction (public/external)	I think people with mental health challenges can lead healthy lives.	re(MIND)®
	My participation in this course has helped improve my understanding of how stigma impacts people living with mental health problems and/or substance abuse.	HAP

	This program/training/event affirmed that people with mental illness are capable and able to make positive contributions to society.	HEI's, MHFA, Photovoice
Utilization of emergency services	Reduction in hospitalizations (both number of days and number of episodes)	re(MIND)®
	Youth diverted from use of psychiatric emergency services	Youth S.O.S.
	Youth will not require law enforcement intervention	Youth S.O.S.
Other	Contracted satisfaction: I am satisfied with the services I have received at (re)MIND/BEAM.	re(MIND)®

APPENDIX 5. FSP EVALUATION REPORT, FY 2023-23

Full Service Partnership Outcomes

Findings From Fiscal Year 2022–2023

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San Mateo County Behavioral Health and Recovery Services

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Executive Summary

The objective of this annual report is to provide a comprehensive assessment and evaluation of the Full Service Partnership program for Fiscal Year 2022 through 2023 (FY 2022–2023). Full service partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County-contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research® (AIR®) is working with San Mateo County (the County) to understand how enrollment in FSPs promotes resilience and improves the health outcomes of individuals served. AIR conducted a mixed-methods study using both primary and secondary data sources to evaluate the FSP program in FY 2022–2023. The data sources for this annual report include: (1) self-reported survey data from clients, (2) health care utilization data from electronic health records (EHRs), and (3) in-depth client and provider interviews. Specifically, this evaluation report summarizes demographics and outcomes for individual clients (hereafter, partners) enrolled in the FSP program in FY 2022–2023 and describes partners' and treatment team members' perspectives and experiences with FSP.

The County currently has four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch),[1] serving children, youth, and transitional age youth (TAY), and Caminar and Telecare, serving adults and older adults. *This year's report includes self-reported data from Edgewood/Fred Finch and Caminar since FSP inception in 2006. Telecare modified its EHR system for FSP program data in December 2018 and has encountered challenges in providing the data prior to the EHR system conversion. Due to the change, we report data for Telecare from December 2018 to June 2023 separately.*

Exhibits 1 and 2 present outcomes of the FSP program in the County for children (16 years and younger), TAY (16–25 years), adults (25–59 years), and older adults (60 years and older). Self-reported FSP outcomes presented in Exhibits 1 and 2 were obtained only from Edgewood/Fred Finch and Caminar. Because of the aforementioned changes in the reporting systems for Telecare, those data are provided in Exhibit 4.

For all outcomes, we compared the year just prior to enrollment in an FSP and the first year enrolled in an FSP. Blue font in Exhibits 1 and 2 indicates a statistically significant positive percent change. Red (and bold) font indicates a statistically significant negative percent change (e.g., worse academic grades for children and TAY partners). Black font indicates that there was no change, or there is a non-statistically significant change from the year before and the first year of enrollment in an FSP. Percent change is the change in the number of partners with the

[1] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

outcome of interest (e.g., homelessness, incarceration, mental health emergencies) in the year after joining an FSP relative to the year prior to participating in an FSP out of the total number of partners in that age group. For example, out of 116 adult partners, 48 experienced homelessness before enrollment in FSP. This number changed to 35 in the first year following FSP, which is a 27% improvement. We first provide self-reported and EHR outcomes for adults and older adults, followed by child and TAY partners.

Self-Reported Outcomes (Caminar) for Adults and Older Adults. For adults and older adults, most self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP. This is shown in the top portion of Exhibit 1.

- Thirteen out of a combined 16 outcomes improved for adult and older adult Caminar partners. Fewer adult and older adult partners experienced homelessness, detention or incarceration, arrests, and mental and physical health emergencies. In addition, employment increased among adult partners. More adult partners reported having substance use disorder treatment in the first year of an FSP compared with the year before. Five (4 adults and 1 older adult) out of the 13 total improvements were statistically significant.
- Among Caminar partners, no older adults reported being employed before and after they joined FSP. The same number (*N* = 5) of older adults reported substance use disorders before and after they joined FSP. Fewer older adult partners (3 vs. 2) reported receiving treatment for substance use disorder. However, given the smaller sample size of the older adults, we should be cautious in interpreting a change with small magnitude.

Health Care Utilization (EHR Data) for Adults and Older Adults. For adult and older adult partners, we detected improvements in outcomes from the year before an FSP compared with the first year in an FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of partners with any hospitalization,
- decrease in mean hospital days per partner,
- decrease in the percentage of partners using any psychiatric emergency services (PES), and
- decrease in mean PES events per partner.

These changes were all statistically significant for adults as seen in the bottom portion of Exhibit 1, while only the decrease in percentage of partner use of PES was statistically significant for older adults.

Exhibit 1. Percent Change in Outcomes Among Caminar Adults and Older Adults, Year Before FSP Compared with First Year With FSP

FSP outcomes	Adults (25 to 59 years)			Older Adults (60 years and older)		
Self-reported outcomes	***N = 116***			***N = 24***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	48 (41%)	35 (30%)	-27%	5 (21%)	4 (17%)	-40%
Detention or incarceration	35 (30%)	22 (19%)	-37%*	3 (13%)	3 (13%)	-25%
Employment	1 (1%)	5 (4%)	400%	0 (0%)	0 (0%)	N/A
Arrests	20 (17%)	4 (3%)	-80%*	3 (13%)	1 (4%)	-75%
Mental health emergencies	86 (74%)	32 (28%)	-63%*	13 (54%)	4 (17%)	-69%*
Physical health emergencies	50 (43%)	17 (15%)	-66%*	6 (25%)	4 (17%)	-43%
Active substance use disorder (SUD)	62 (53%)	59 (51%)	-5%	5 (21%)	5 (21%)	0%
SUD treatment	27 (23%)	33 (28%)	22%	3 (13%)	2 (8%)	-33%
Health care utilization (EHR data)	***N = 388***			***N = 80***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	124 (32%)	57 (15%)	-54%*	22 (28%)	12 (15%)	-45%
Hospital days per partner	11.5	3.8	-67%*	9.9	4.3	-36%
PES	206 (54%)	148 (39%)	-28%*	33 (43%)	21 (25%)	-36%*
PES event per partner	1.6	1.0	-36%*	1.1	0.6	-44%

Note. Self-reported outcomes do not include Telecare. SUD = substance use disorder; EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Exhibit 1 indicates the change in the number of partners with the outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 1 to indicate the number of partners with the outcome of interest, and percentages are presented in parentheses. For example, in the Yr before column, there were 48 adults who experienced homelessness, which is 41% of all 116 adults. In the Yr after column, there were 35 adults who experienced homelessness, which is 30% of all adults. For self-reported outcomes, there are only 24 older adult partners; therefore, caution is needed when interpreting the results with small sample size. The percentage difference with employment for older adults is reported as N/A, as the percentage of older partners with employment was 0% in the prior year and in the year after (from 0% to 0%). Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Self-Reported Outcomes (Edgewood/Fred Finch) for Child and TAY Partners. The trends for child and TAY partners are similar to those for adult and older adult partners (as shown in the top portion of Exhibit 2), where most of the self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP.

- Twelve out of a combined 16 outcomes improved for child and TAY partners. Fewer child and TAY partners experienced homelessness, arrests, mental and physical health emergencies, and school suspensions. There was an improvement in detention or incarceration and rating of school attendance among TAY partners, but not among child partners. Among these 12 outcomes, eight improvements were statistically significant.
- Three outcomes worsened for child or TAY partners. For child partners, there were statistically significant decreases between the year prior to FSP and the first year after FSP enrollment for both academic grades and attendance. TAY partners reported decreased academic grades during the first year after enrolling in an FSP program, but this change was not statistically significant.

Health Care Utilization (EHR Data) for Child and TAY Partners. For child and TAY partners, we detected improvements in outcomes from the year before FSP compared with the first year of FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a:

- decrease in the percentage of partners with any hospitalization,
- decrease in mean hospital days per partner,
- decrease in the percentage of partners using any PES, and
- decrease in mean PES events per partner.

As shown in the lower portion of Exhibit 2, these changes were statistically significant for child partners for all outcomes except mean hospital days per partner; only the decline in use of PES was statistically significant for TAY partners.

Exhibit 2. Percent Change in Outcomes for Children and TAY, Year Before FSP Compared with First Year With FSP

FSP outcomes	Child (16 years and younger)			TAY (17 to 25 years)		
Self-reported outcomes	***N = 232***			***N = 287***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	9 (4%)	8 (4%)	-11%	35 (12%)	34 (12%)	-3%
Detention or incarceration	28 (12%)	28 (12%)	0%	40 (14%)	32 (11%)	-20%
Arrests	30 (13%)	10 (4%)	-67%*	65 (23%)	20 (7%)	-69%*
Mental health emergencies	88(38%)	10 (4%)	-89%*	131 (46%)	29 (10%)	-78%*
Physical health emergencies	17 (7%)	1 (0%)	-94%*	60 (21%)	2 (21%)	-92%*
Suspensions	47 (20%)	21 (9%)	-55%*	26 (9%)	2 (2%)	-77%*
Grade	3.35	2.97	**-11%***	3.23	3.12	-3%
Attendance	2.23	1.94	**-13%***	2.44	2.49	2%
Health Care Utilization (EHR data)	***N = 213***			***N = 225***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	-70%*	27 (12%)	16 (7%)	-41%
Hospital days per partner	1.2	0.5	-91%	4.3	2.1	-51%
PES	51 (24%)	23 (11%)	-55%*	94 (42%)	55 (24%)	-41%*
PES event per partner	0.5	0.2	-53%*	1.1	0.7	-38%*

Note. EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Exhibit 2 indicates the change in the number of partners with outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 2 to indicate the number of partners with outcome of interest, and percentages are presented in parentheses. Percent change is the change in the number of partners with the outcome of interest in the year after joining an FSP as compared with the year just prior to FSP relative to the year prior to participating in an FSP out of the total number of partners. Blue font indicates a statistically significant positive percent change. Red (and bold) font indicates a statistically significant negative percent change. Black font indicates outcomes did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP. *Indicates a change significantly different from 0 at 0.05 significance level.

Exhibit 3 describes the hospitalization outcomes for all partners across all age groups who joined the FSP program since 2006, completed one full year or more in an FSP program, and had EHR health utilization data. Among these partners, we looked at their mean health utilization outcomes in the first year of FSP and the year prior to FSP. As shown, FSP partners had significantly improved hospitalization outcomes across all measures. Exhibits 19-22 further

show reductions in hospitalization and PES health care utilization outcomes over the years since the inception of the FSP program.

Exhibit 3. Hospitalization Outcomes for FSP Partners (*N* = 906)

	Percentage/Mean		95% confidence interval
	Percentage of partners with any hospitalization*		
1 year before	20%		(18%–23%)
Year 1 during	10%		(8%–12%)
	Mean number of hospital days*		
1 year before	7.12		(5.69–8.56)
Year 1 during	2.54		(1.74–3.34)
	Percentage of partners with any PES event*		
1 year before	42%		(39%–46%)
Year 1 during	27%		(24%–30%)
	Mean PES events, per partner*		
1 year before	1.16		(1.01–1.31)
Year 1 during	0.71		(0.59–0.83)

Note. PES = psychiatric emergency services. * Significance testing was conducted using chi-square tests for percentages and *t* tests for means; results are statistically significant at the 5% level.

Because of the issue with Telecare's incomplete data noted earlier, we conducted a separate analysis for the self-reported Telecare data. Exhibit 4 shows self-reported outcomes among Telecare partners for the year before FSP compared with the first year with FSP. There were 107 partners in the Telecare survey data who completed at least a year of an FSP between December 2018 through June 30, 2023. Our analysis combined all age groups (TAY, adults, and older adults) served by Telecare for this separate analysis because of the small sample size.

Exhibit 4 shows improvements for Telecare partners on homelessness, arrests, and active substance use disorder, with all decreases in these negative events being statistically significant. No change was observed for employment outcomes of Telecare partners. Telecare partners had poorer outcomes after joining an FSP in three outcome areas: more Telecare partners reported being detained or incarcerated or having mental and physical health emergencies in the first year of an FSP compared to the year prior to the FSP. However, the change was only statistically significant for the increased experience of mental health emergencies. Fewer partners reported receiving treatment for substance use disorder,

although the change was not statistically significant. This may be interpreted as a positive change if it is a result of better screening and referral into treatment when needed. We also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment.

Exhibit 4. Percent Change in Outcomes Among Telecare Partners, Year Before FSP Compared with First Year With FSP

FSP self-reported outcomes	Everyone *N* = 107		
	Yr before	*Yr after*	*Change*
Homelessness	31 (29%)	9 (8%)	-71%*
Detention or incarceration	27 (25%)	29 (27%)	7%
Employment	0 (0%)	0 (0%)	N/A
Arrests	35 (33%)	13 12%)	-63%*
Mental health emergencies	17 (16%)	40 (37%)	**135%***
Physical health emergencies	12 (11%)	18 (17%)	50%
Active SUD	69 (61%)	35 (33%)	-46%*
SUD treatment	8 (7%)	4 (4%)	-50%

Note. SUD = substance use disorder; Yr = year. Exhibit 4 indicates the change in the percentage of partners with any events, comparing the year just prior to FSP with the first year with FSP. The percent difference with employment is reported as N/A because the percentage of partners with employment in the year before and in the year after is 0% (from 0% to 0%). Thus, the denominator is 0. Blue font indicates outcomes that significantly improved. Red (and bold) font indicates outcomes that significantly worsened. Red (and bold) font indicates a statistically significant worse change in outcome. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Outcomes from Key Informant Interviews with FSP Treatment Team Staff and Clients. Many FSP partners and treatment team members we interviewed said they were satisfied with the program but had specific recommendations to improve the program in the future. Exhibit 5 discusses key findings from these interviews.

Exhibit 5. Summary of FSP Treatment Team Staff and Client Interview Findings

Key Treatment Team and Client Experiences with the FSP Program	
Overall experience with the program	• Clients noted supportive and satisfactory experiences with the FSP program and attributed the program with improved mental health and quality of life. Clients appreciated the wide range of services provided, such as stable housing. • Social network and mental health support: Treatment team members identified social networks and support and access to mental health resources as the greatest unmet needs among clients.
Referral process and initiation of treatment	• Treatment team members were generally satisfied with existing referral processes. They noted the most successful referrals have a streamlined process, defined steps, and clear communication channels. • Challenges: Providers mentioned sometimes receiving incomplete or inaccurate data and suggested an enhanced referral process with more in-depth background reporting.
Experiences with program services and care	• Experiences with program services: Clients were quickly able to access FSP services after referrals, and program staff created a safe, comfortable environment for them in the clinics. • Experiences with case managers and providers: Clients referenced strong rapport and relationships with FSP staff. Clients mentioned that case managers provided services to reduce barriers, such as bus passes or transportation to appointments, and connected clients with external programs for additional support.
Perspectives on the impact of the COVID-19 pandemic	• Clients said that the transition from in-person to remote services during the COVID-19 pandemic was challenging and not as effective as in-person services. Some clients were not comfortable using videoconferencing; therefore, their services were interrupted during the pandemic. • Providers noted difficulties in providing services, particularly for clients who are homeless and were not able to meet in person. Transportation to appointments had to be outsourced.
Overall satisfaction with the program	• Providers reported high levels of satisfaction with the FSP program. They attributed this to client success after enrollment and the dedication of staff. • Clients noted improvements in their quality of life after enrolling in the FSP program and attributed this satisfaction to the support of FSP staff.

Overall, the interviews highlight the positive influence of the FSP program on client well-being that is consistent with improvement in client outcomes seen in the quantitative data results. For example, FSP clients reported feeling more independent after enrolling in the program, particularly among individuals who were previously incarcerated. These findings align with the

declines we see in incarceration rates from the year prior to being in FSP and the first year enrolled.

Most interviewees reported being satisfied with the program; however, some noted some areas of the FSP program that could be improved. Exhibit 6 summarizes recommendations based on these findings.

Exhibit 6. Recommendations Based on FSP Treatment Team and Client Interview Findings

Recommendations	
Recommendation 1: Strengthen communication between clients and treatment team	• Develop standardized introductory text for treatment team members to follow during the initial intake • Provide guidelines to case managers for responding in a timely manner to client inquiries and messages
Recommendation 2: Improve staff retention through additional staff training, mental health and safety resources, and community building	• Implement a comprehensive staff training program • Provide mental health resources for staff, such as counseling services, stress management workshops, and mental health days • Incorporate team-building activities • Offer incentives to boost longer-term retention
Recommendation 3: Increase workforce and staff diversity	• Expand the number of case managers, and redistribute some tasks to other staff (e.g., administrative assistants) • Increase the number of multilingual staff to cater to the needs of clients • Conduct diversity and inclusion training sessions
Recommendation 4: Expand access to and availability of FSP sessions	• Offer emergency or urgent sessions • Provide options for virtual visits
Recommendation 5: Ensure consistent case manager assignments	• Create and disseminate a provider-level survey before new cases are assigned to assess individual case managers' strengths and workload capacities • Set clear guidelines for assigning case managers, and only move case managers from clients in exceptional circumstances
Recommendation 6: Streamline care coordination and data management	• Establish a standardized client progress assessment form to facilitate information gathering, management and sharing • Consider implementing a HIPAA-compliant document management system, or use EHRs to facilitate information gathering, management and sharing across team members
Recommendation 7: Consider providing housing coordination during discharge	• Provide housing assistance like vouchers and coordination to clients during discharge

Background and Introduction

The Mental Health Services Act (MHSA), enacted in 2005, provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through full service partnerships (FSPs). FSPs provide individualized, integrated mental health services; flexible funding; intensive case management; and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. There are currently four comprehensive FSP providers in the County: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch),[2] serving children, youth, and transitional age youth (TAY), and Caminar and Telecare, serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in an FSP is promoting resiliency and improving the health outcomes of the County's clients living with mental illness. A combination of qualitative and quantitative data provide the basis of findings for this year's report. Specifically, two quantitative data sources are used: (1) self-reported survey data collected by providers from FSP clients (hereafter, partners) and (2) electronic health records (EHRs) obtained through the County's Avatar system. In addition, this year's report includes qualitative data collected from FSP clients and treatment team members. These data encompass 23 completed interviews, with 9 clients and 14 treatment team members from 3 FSP service providers: Edgewood Center, Caminar, and Telecare. Due to competing demands, treatment team members and clients from Fred Finch were unable to participate in the interviews.

This year's report includes self-reported data from all Edgewood/Fred Finch and Caminar providers since FSP inception (2006). Telecare changed its EHR system for FSP program data in the middle of 2018 and is having technical difficulties providing the data prior to the change of the EHR system. Because of this change, we report data from Telecare from December 2018 to June 2023 separately.

For the self-reported data, providers collected initial survey data through an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the 12-month "lookback" window of the year prior to FSP enrollment. Providers gather survey data on partners during their participation in an FSP 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

[2] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

residential setting). FSP partners are also assessed every three months using the 3-Month (3M) forms. Changes in partner outcomes are gathered by comparing data at baseline from PAF forms to follow-up data from KET and 3M forms.

EHR data collected through the County Avatar system contains longitudinal partner-level information on demographics, FSP participation, hospitalizations, and psychiatric emergency services (PES) utilization before and after FSP enrollment. The Avatar system is limited to individuals who obtain emergency care in the County hospitals. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in partners' self-reported and hospitalization outcomes in two consecutive years: (1) the baseline year, that is, the 12 months prior to enrollment in an FSP program; and (2) the first full 12 months of the partner's FSP participation. Children (ages 16 and younger), transitional age youth (TAY; ages 17 to 25), adults (ages 25 to 59), and older adults (ages 60 and older) were included in the analysis if they had completed at least 1 full year with an FSP program by June 30, 2023 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years since inception of the program (2006) as well as annually, by year of FSP program enrollment.

Appendices provide details on our methodology as well as detailed findings for each outcome. Appendix A presents additional detail on residential outcomes. Appendix B provides outcomes for individual FSP providers. Appendix C provides methodology for the self-reported outcomes and EHR-based hospitalization outcomes (i.e., "quantitative methodology"). Appendix D provides methodology for the qualitative interviews (i.e., "qualitative methodology").

Self-Reported Outcomes

Overview

This section presents outcomes for 766 FSP partners across four FSP providers. The results presented in this section compare the first year enrolled in an FSP with the year prior to FSP enrollment for partners completing at least 1 year in an FSP program.

- The Caminar section presents outcomes for 116 adult (ages 26–59) FSP partners and 24 older adult (ages 60 and older) FSP partners who joined and completed at least 1 year in an FSP since 2006.[3]
- The Edgewood/Fred Finch section below presents outcomes for 232 child (ages 16 and younger) FSP partners and 287 TAY (ages 17–25) FSP partners.
- The Telecare section presents outcomes for 107 FSP partners regardless of age. Because of the small sample size, we have combined findings for all age groups when reporting findings for Telecare partners.

Telecare changed its EHR system on December 1, 2018, and was only able to provide the data after the conversion date due to data reliability issues. Because of the incompleteness of the Telecare data, we conducted a separate analysis for Telecare.

In this section, we first provide a list of self-reported outcomes collected by all providers. We then present findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception, followed by findings from the analysis using Telecare data since December 2018.

Outcomes Assessed

We describe the self-reported outcomes below. Most of these outcomes are broken down by age group. Note that employment, homelessness, arrests, and incarceration outcomes are not presented for adults ages 60 or older, as there are insufficient observations in this age group for meaningful interpretation.

1. **Partners with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (sources: PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting indicating jail or prison (sources: PAF and KET)

[3] Caminar's self-reported data also includes 55 TAY (ages 17–25); however, we excluded them from the analysis due to lack of ongoing data collection.

3. **Partners with any reported employment:** measured by employment in past 12 months and date of employment change (sources: PAF and KET)[4]
4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (sources: PAF and KET)
5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (sources: PAF and KET)
6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (sources: PAF and KET)
7. **Partners with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular updates (sources: PAF and 3M)
8. **Partners in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular updates (sources: PAF and 3M)[5]

In addition, we also examined three outcomes specific to child and TAY partners:

1. **Partners with any reported suspensions:** measured by suspensions in past 12 months (source: PAF) and date suspended (source: KET)
2. **Average school attendance self-rating:** an ordinal ranking (1–5) indicating overall attendance; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)
3. **Average school grade self-rating:** an ordinal ranking (1–5) indicating overall grades; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

Mental and Physical Health Emergencies by Living Situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the partner's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or foster family, living alone, and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospital setting).

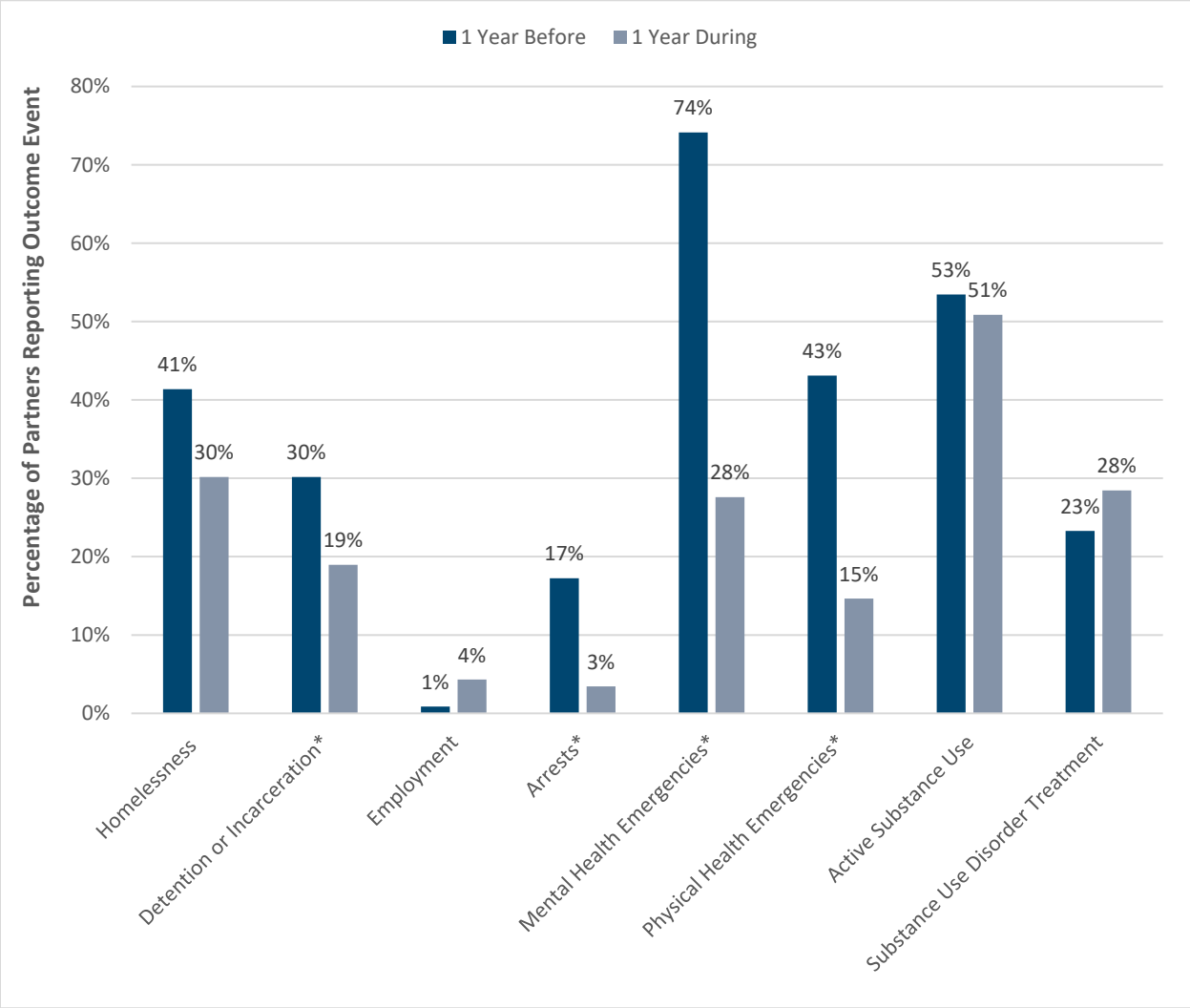
[4] Employment outcome is not applicable to child and TAY partners.
[5] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care. However, if more partners have substance use disorder, there would be more partners reporting receiving treatment.

Caminar

Self-Reported Outcomes by Age Group

Adults. Exhibit 7 compares outcomes for adult partners (ages 26–59) in the year prior to FSP enrollment with their first year in an FSP. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance use problems decreased after enrollment in FSP. Employment and reported treatment of substance use disorder increased. These findings demonstrate improvements for adult partners in the first year of FSP enrollment for all outcomes. The improvements for detention or incarceration, arrests, and mental and physical health emergencies are statistically significant.

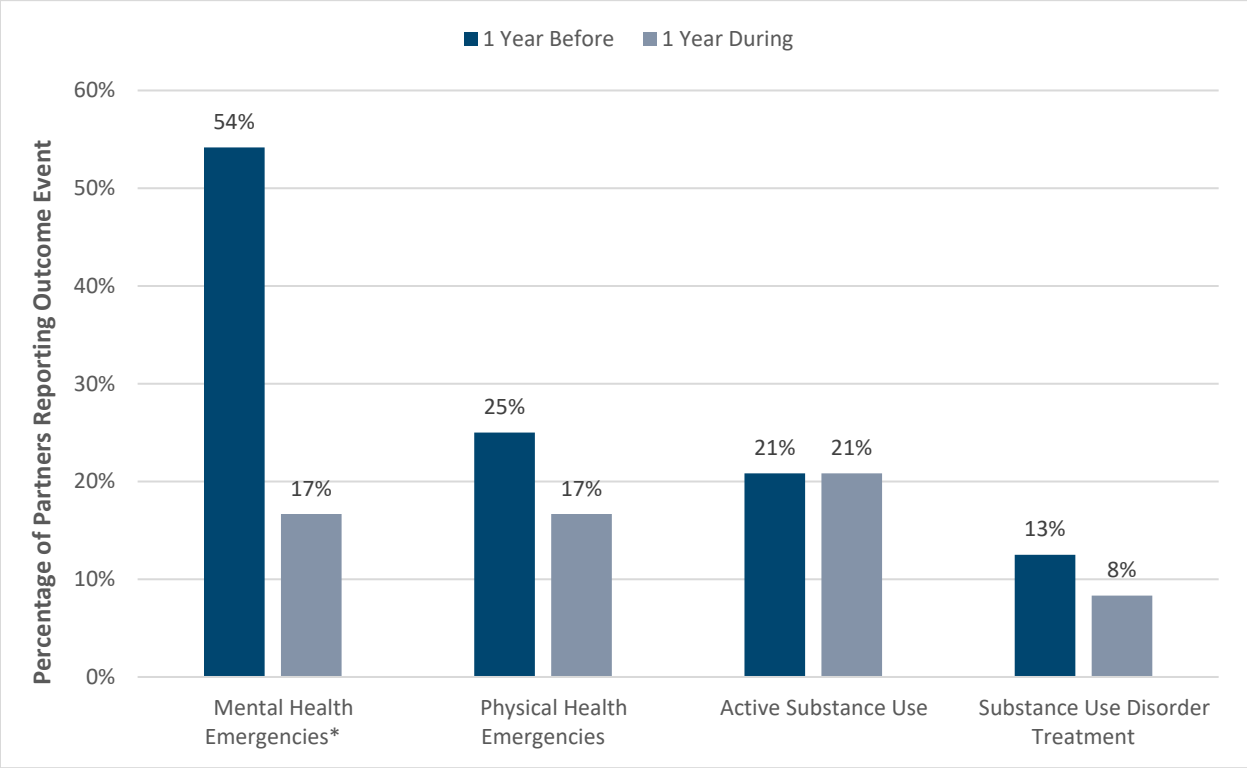
Exhibit 7. Outcomes for Adult Partners Completing One Year with FSP (*N* = 116)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Older Adults. Exhibit 8 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult partners (age 60 and above). Similar to adult partners, self-reported mental and physical health emergencies decreased. The decrease in mental health emergencies is the only statistically significant outcome for older adults. Each of these demonstrated improvement for older adult partners in the first year of FSP enrollment. The same number of older adults (*N* = 5) reported having an active substance abuse problem after enrollment in FSP. Slightly fewer older adults (from three in the year prior to two in the first year of FSP) reported treatment for a substance use disorder during the first year of FSP enrollment compared with 1 year before. Given the small sample size, these results are inconclusive.

Exhibit 8. Outcomes for Older Adult Partners Completing One Year with FSP (*N* = 24)

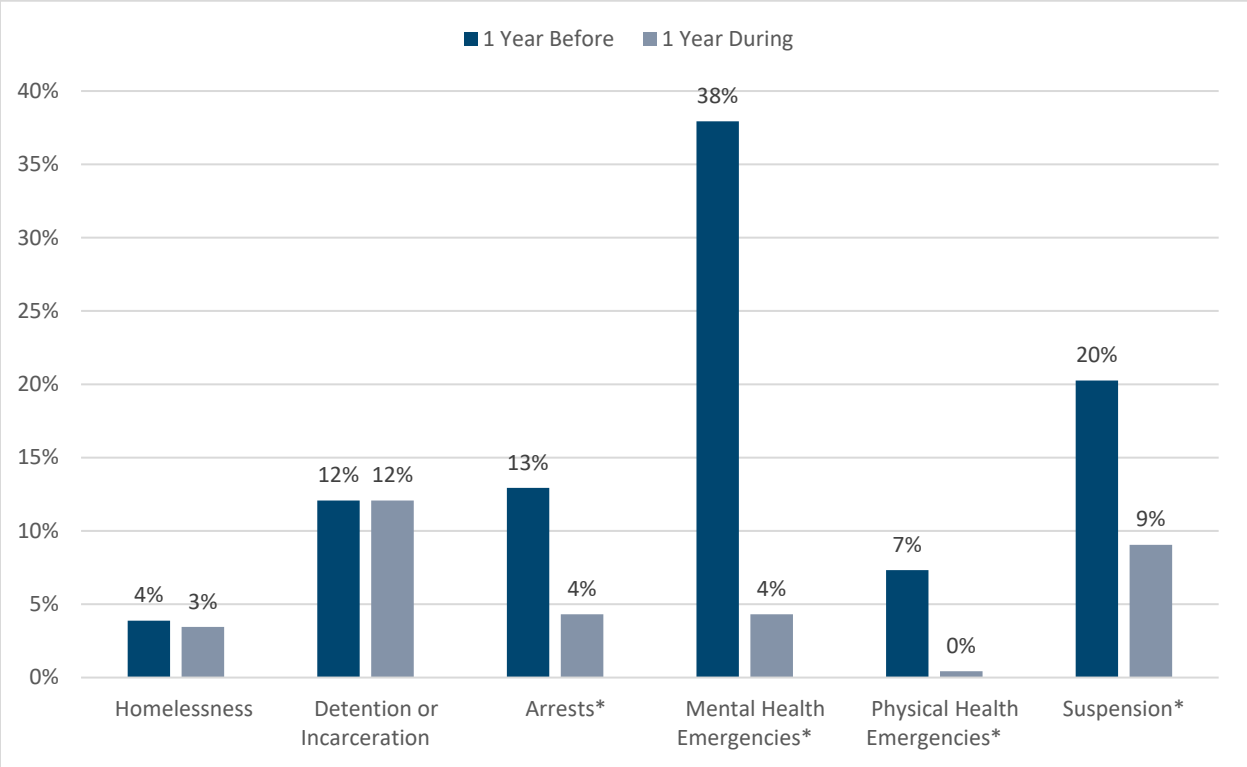


Note. Employment, homelessness, arrests, and incarceration outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Edgewood/Fred Finch

Children. Exhibit 9 shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child partners (age 16 and younger). There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in an FSP program. There is a significant decrease in the incidence of mental health emergencies from the year prior to the first year of FSP (38% vs. 4%). Conversely, detention or incarceration remained the same for children (28 incidents in the first year with FSP and 28 in the year prior to FSP enrollment). However, the incidence of arrests reduced after enrollment in FSP (10 in the first year with FSP compared with 30 in the year just prior). The decline in arrests, mental and physical health emergencies, and school suspensions are statistically significant.

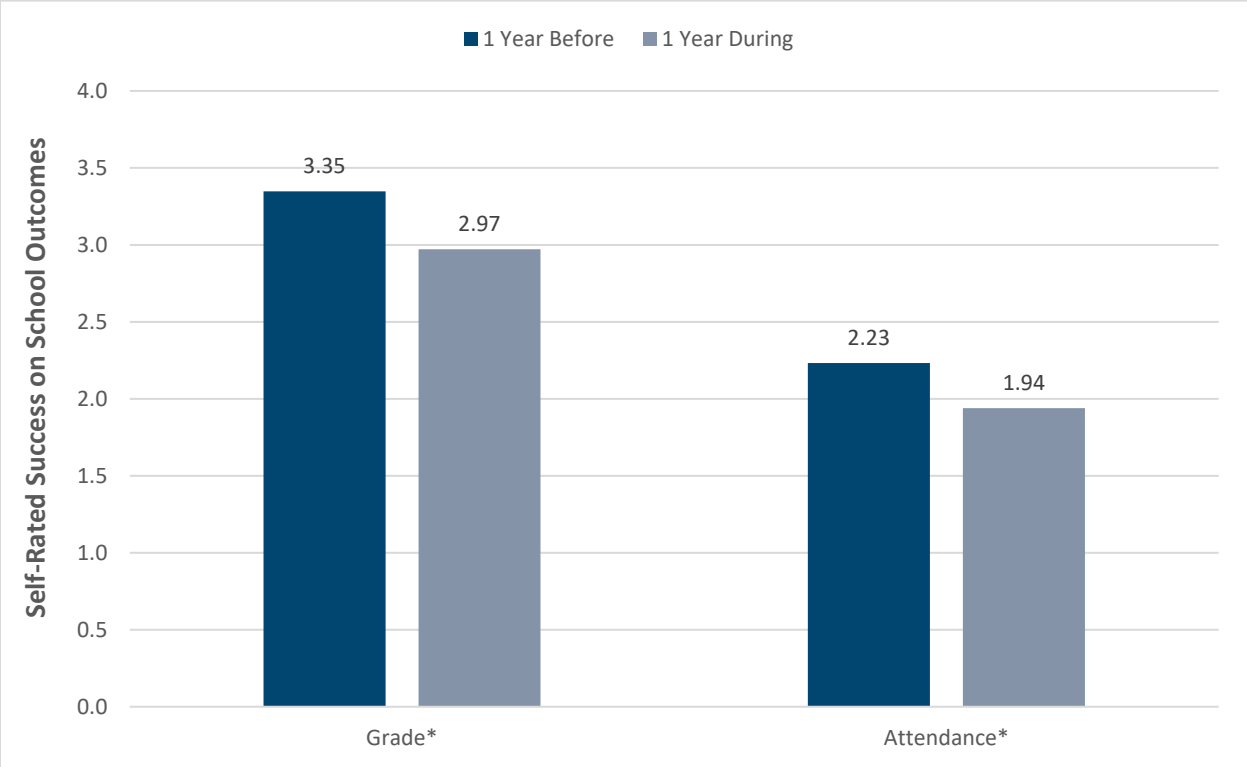
Exhibit 9. Outcomes for Child Partners Completing One Year with FSP (*N* = 232)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 10 presents outcomes on self-rated school attendance and grades. School attendance and grades for child partners declined modestly after enrolling in an FSP program. These ratings are on a 1–5 scale, coded such that a higher score is better. Though relatively small, the decreases in school attendance and grades are statistically significant.

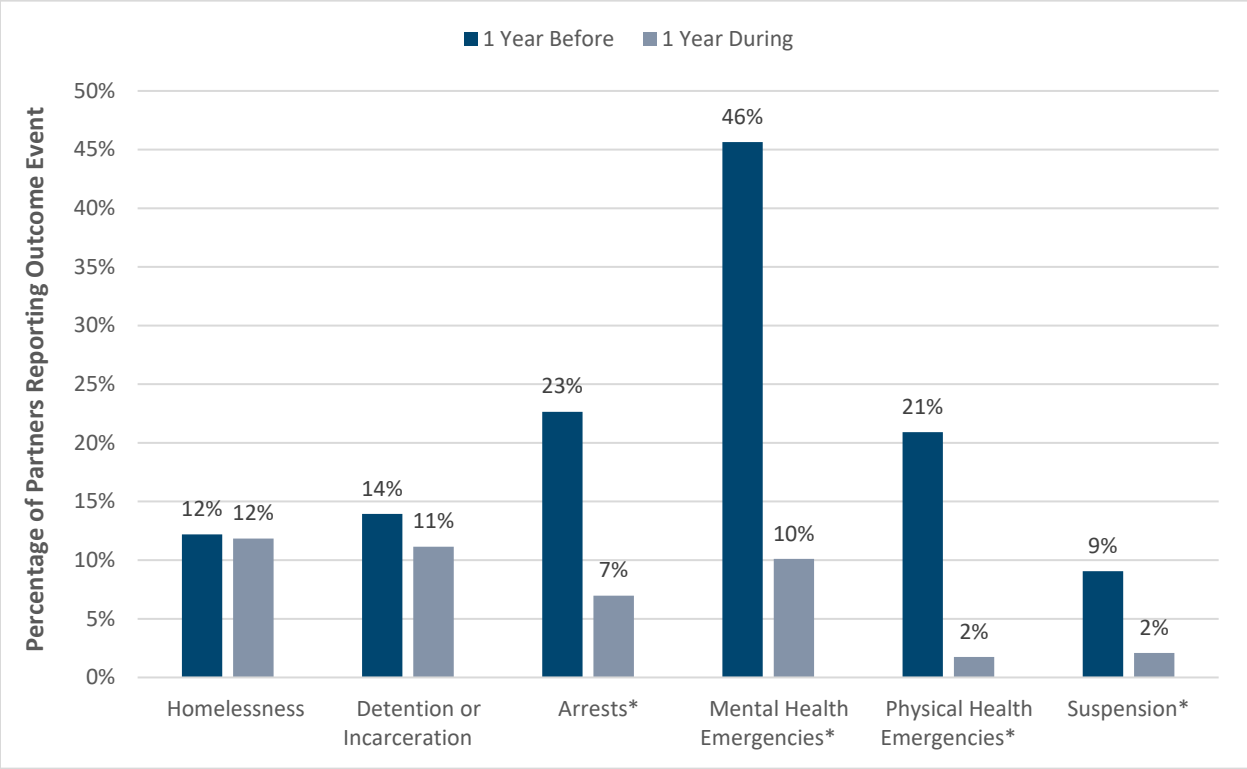
Exhibit 10. School Outcomes for Child Partners Completing One Year with FSP (*N* = 232)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale, coded such that a higher score is better.

TAY. Exhibit 11 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY partners.[6] All self-reported outcomes decreased (an improved status), among which improvements on arrest, mental and physical health emergencies, as well as school suspensions are statistically significant.

Exhibit 11. Outcomes for TAY Partners Completing One Year with FSP (*N* = 287)

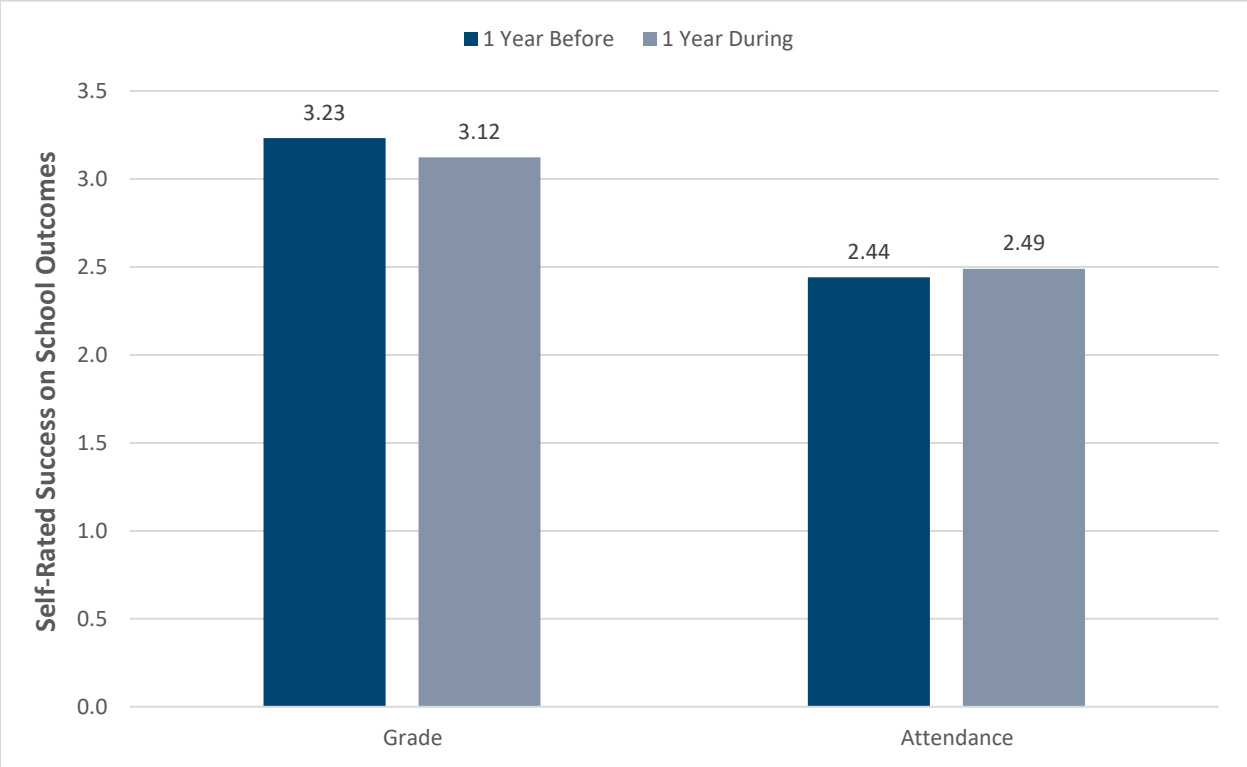


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

[6] The older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY-specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 12 below shows outcomes on school attendance and grades for TAY partners. These ratings are on a 1–5 scale; a higher score is better. There was a small decrease in grades and a slight increase in attendance after enrollment in an FSP. Neither outcome showed a statistically significant difference after FSP enrollment.

Exhibit 12. School Outcomes for TAY Partners Completing One Year with FSP (*N* = 287)

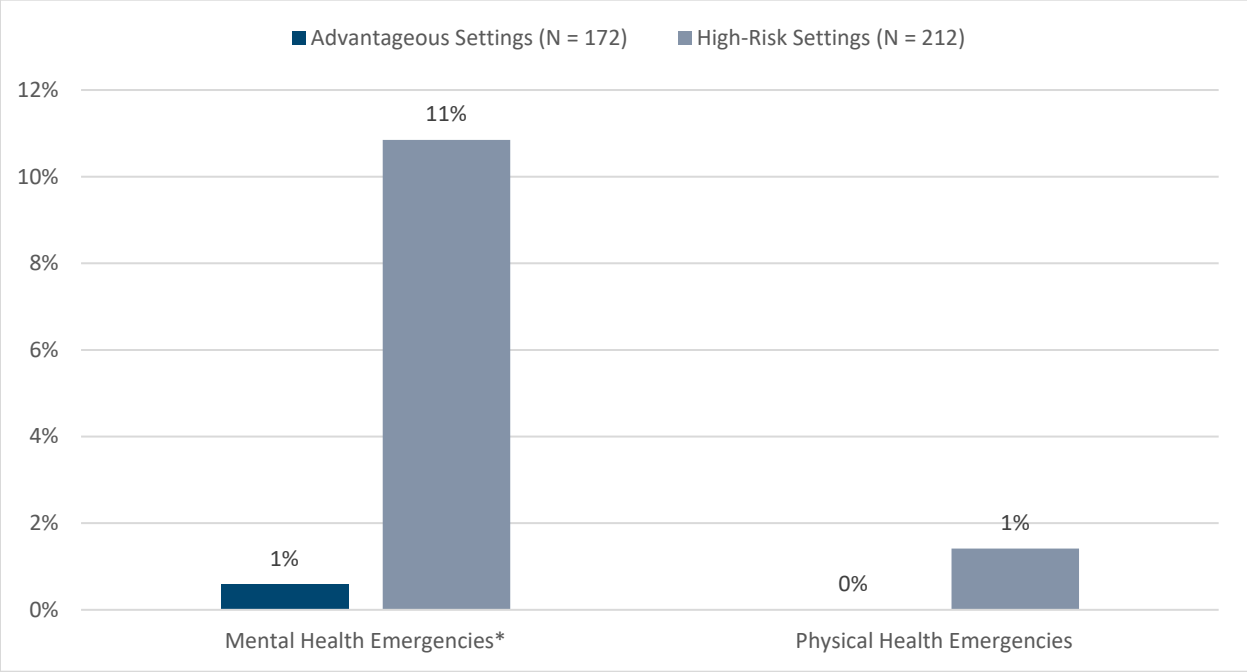


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale; a higher score is better.

Mental and Physical Health Emergencies by Living Situation

Exhibit 13 shows the mental and physical health emergencies in adult and older adult partners living in advantageous versus higher risk living situations in the first year of participating in an FSP. Advantageous settings are defined as living with family or foster family, living alone, and paying rent, or living in group care or assisted living. High-risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown below, both mental and physical health emergencies were more common among individuals in a high-risk residential setting in their first year of FSP participation.

Exhibit 13. Emergency Outcomes as a Function of Residential Setting



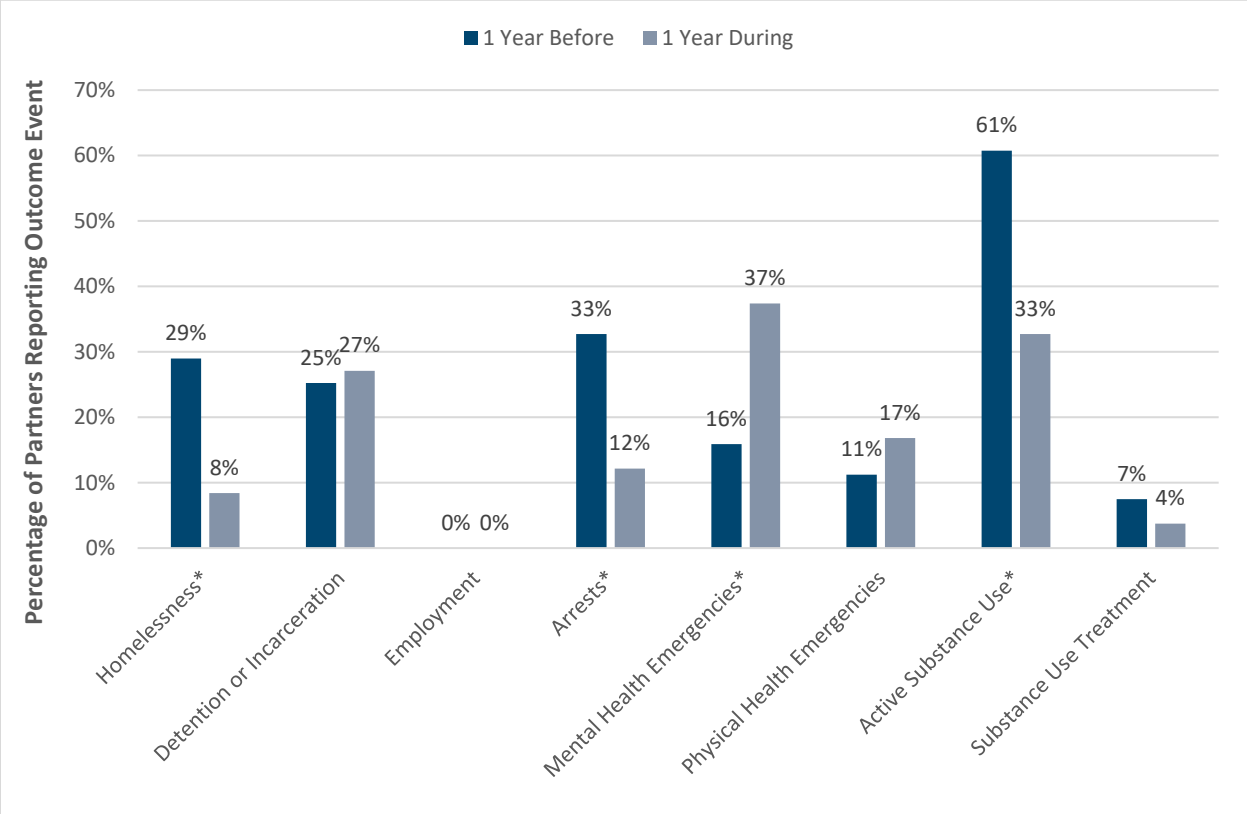
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Telecare

Self-Reported Outcomes—Adults and Older Adults

Telecare data includes 85 adult and older adult partners who have completed at least 1 year of FSP as of June 30, 2023. Because of the small sample size, we have combined findings for all age groups. Exhibit 14 shows the comparison of outcomes for all Telecare partners in the year prior to FSP enrollment with the first year in an FSP. Homelessness, arrests, and substance use disorders decreased after enrollment in an FSP. Each of these outcomes demonstrates improvements for partners in the first year of FSP enrollment. Mental and physical health emergencies were higher in Telecare partners a year after enrollment in an FSP program, although this increase was only significant for mental health emergencies. In addition, fewer Telecare partners reported receiving treatment for substance use disorders one year during the FSP program compared with 1 year before enrollment. However, we also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment. The decrease in homelessness, arrests, mental health emergencies, and active substance abuse problems is statistically significant.

Exhibit 14. Outcomes for Telecare Partners Completing One Year with FSP (*N* = 107)

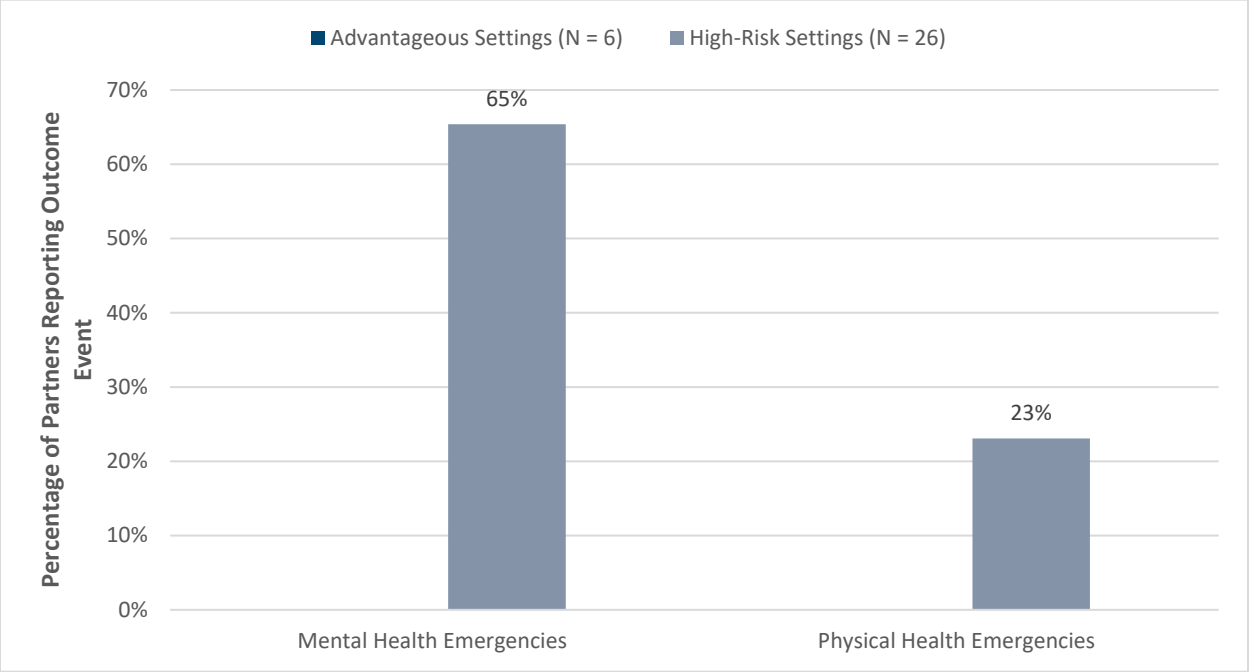


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Mental and Physical Health Emergencies by Living Situation

Exhibit 15 shows the mental and physical health emergencies in adult and older adult partners living in advantageous versus higher risk living situations in the first year of an FSP. Mental and physical health emergencies only happened with individuals who lived in at least one high-risk residential setting in their first year of FSP participation; there were no mental or physical health emergencies for adult and older adult partners only living in advantageous situations, though the sample size for this subgroup is small (*N* = 6).

Exhibit 15. Emergency Outcomes as a Function of Residential Setting Among Telecare Partners



Health Care Utilization Overall and Over Time

Overview

This section describes (a) overall health care utilization across all partners from the beginning of an FSP program, (b) health care utilization by age group from the beginning of an FSP program, and (c) health care utilization for partners by year (2006–2023).

Using the County's EHR data, we present four hospitalization outcomes for 906 total FSP partners including 213 child, 225 TAY, 388 adult, and 80 older adult FSP partners:

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months
4. **Average number of PES events:** the number of PES events in the past 12 months

Overall Health Care Utilization Outcomes Across All Partners

We detected statistically significant changes in outcomes from the year before FSP compared with the first year in FSP for all hospitalization outcomes (Exhibit 16). Percentage of partners with any hospitalization decreased by half from 20% before FSP to 10% during FSP. The average number of days spent in the hospital decreased from 7.12 days before FSP to 2.54 days during FSP. Percentage of partners with any PES decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.16 events before FSP to 0.71 events during FSP.

Exhibit 16. FSP Partners Have Significantly Improved Hospitalization Outcomes (*N* = 906)

	Percentage/Mean	95% confidence interval
Percentage of partners with any hospitalization*		
1 year before	20%	(18%–23%)
Year 1 during	10%	(8%–12%)
Mean number of hospital days*		
1 year before	7.12	(5.69–8.56)
Year 1 during	2.54	(1.74–3.34)
Percentage of partners with any PES event*		

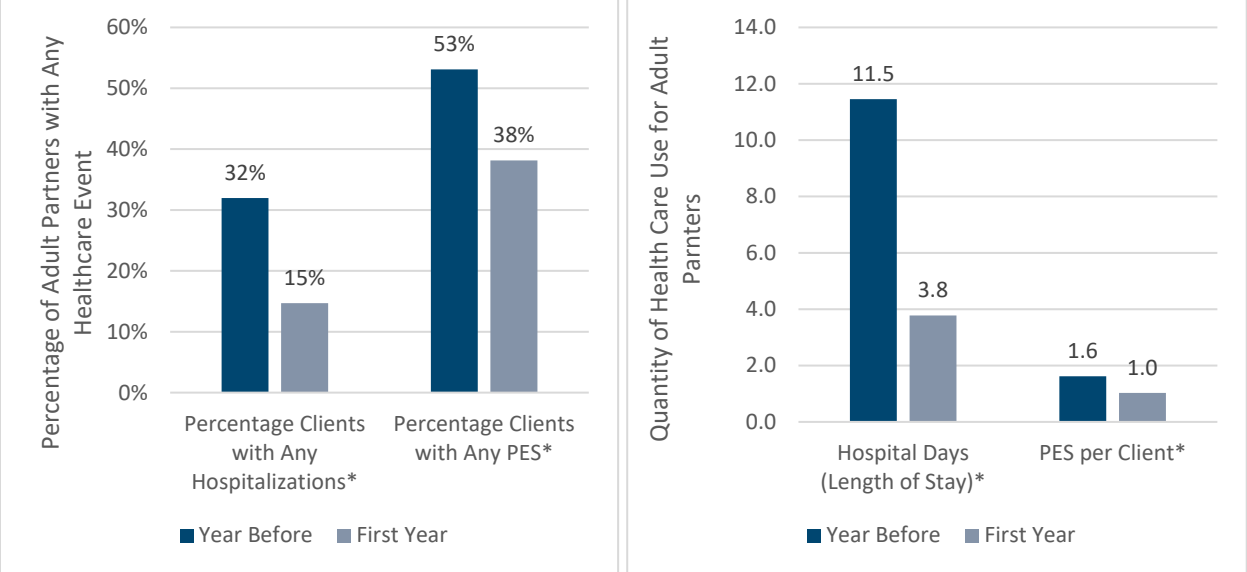
	Percentage/Mean	95% confidence interval
1 year before	42%	(39%–46%)
Year 1 during	27%	(24%–30%)
Mean PES events, per partner*		
1 year before	1.16	(1.01–1.31)
Year 1 during	0.71	(0.59–0.83)

* Significance testing was conducted using chi-square tests for percentages and *t* tests for means; results are statistically significant at the 5% level.

Health Care Utilization for FSP Partners by Age Group

Hospitalization outcomes are presented in Exhibits 17–20 by age group. For all four age groups, the percentage of FSP partners with any hospitalization or PES event showed a statistically significant decrease after joining an FSP. The mean number of hospital days experienced by FSP partners and average number of PES events also had a statistically significant decrease after FSP enrollment for all age groups.

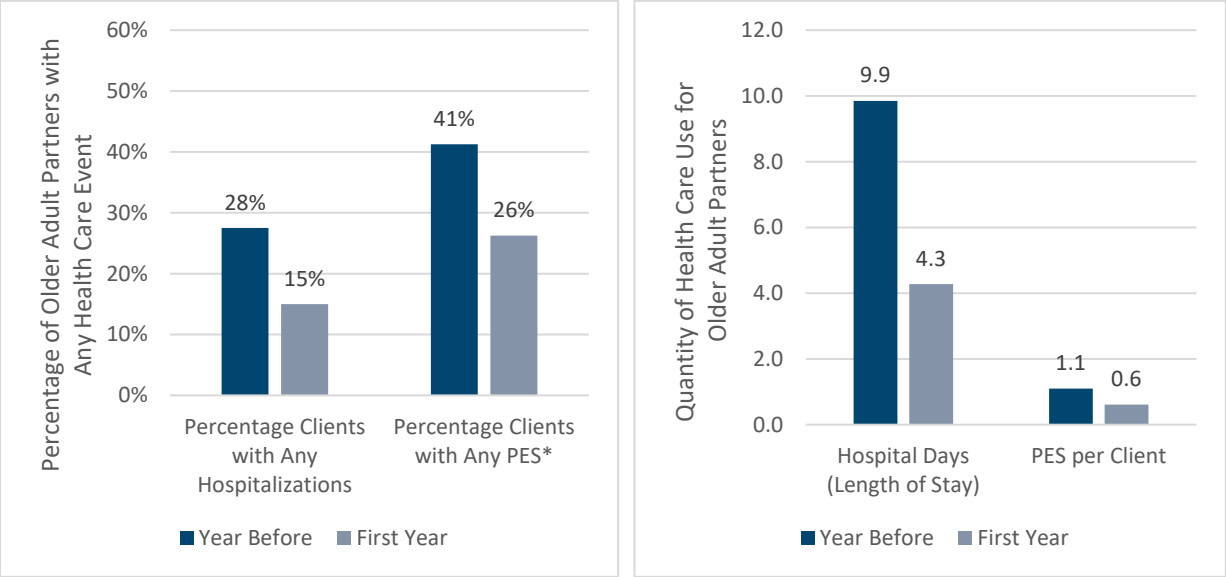
Exhibit 17. Hospitalization and PES Outcomes for Adult Partners Completing One Year with FSP (*N* = 388)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

- All four outcomes are statistically significant for adults.

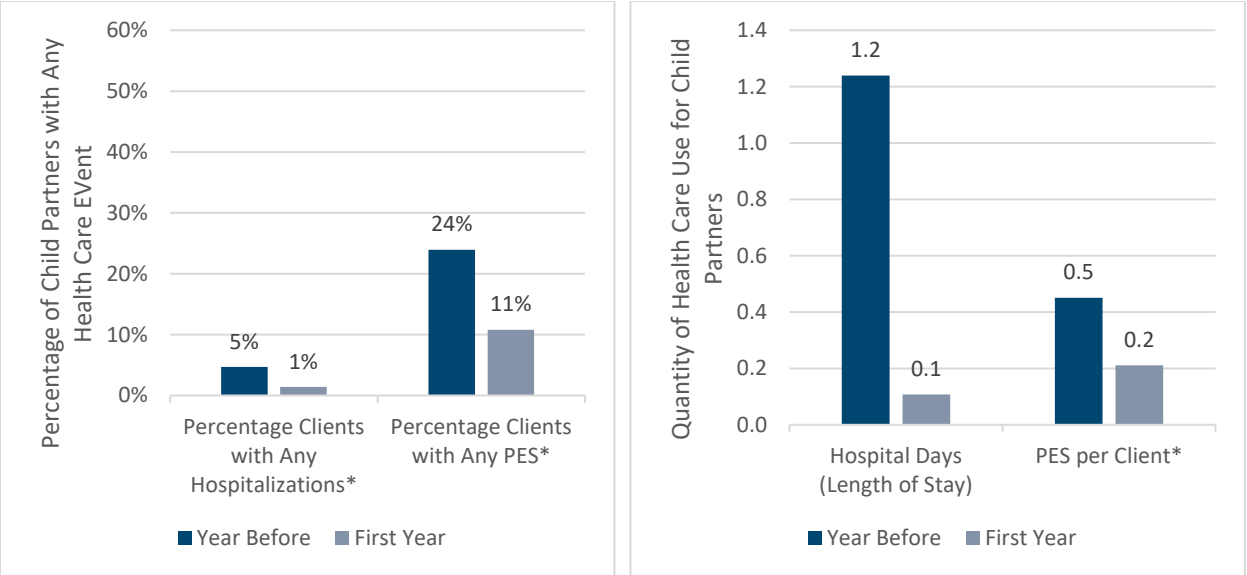
Exhibit 18. Hospitalization and PES Outcomes for Older Adult Partners Completing One Year with FSP (*N* = 80)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

- For older adults, only the change in percentage of partners receiving PES is statistically significant.

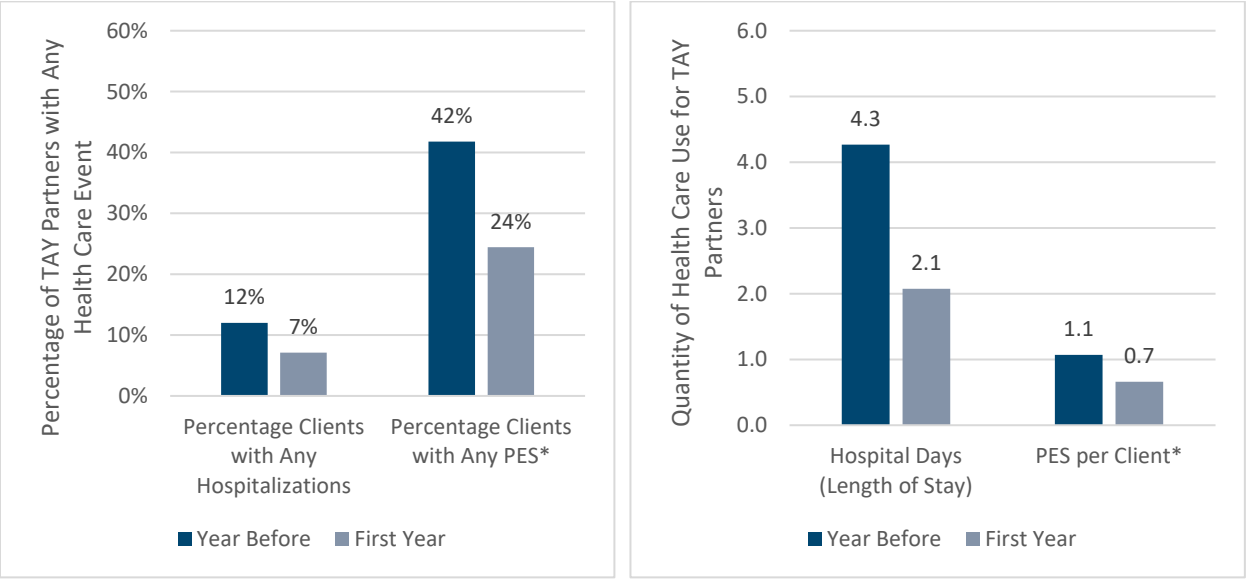
Exhibit 19. Hospitalization and PES Outcomes for Child Partners Completing One Year with FSP (*N* = 213)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

- All but the change in outcome for mean hospital stays are statistically significant for children.

Exhibit 20. Hospitalization and PES Outcomes for TAY Partners Completing 1 Year with FSP (*N* = 225)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

- For TAY, the change in percentage of partners with PES and the change in mean number of PES events are statistically significant.

Health Care Utilization for FSP Partners Over Time

Exhibits 21–23 show the four health care utilization outcomes, including the percentage of partners with any hospitalization, mean hospital days per partner, percentage of partners using any PES, and mean PES event per partner, stratified by year of enrollment. As Exhibit 21 shows, every year the percentage of partners with any hospitalization decreased after joining an FSP program. Statisical significance was not calculated for differences by each enrollment year.

Exhibit 21. Percentage of Partners with Any Hospitalization by FSP Enrollment Year

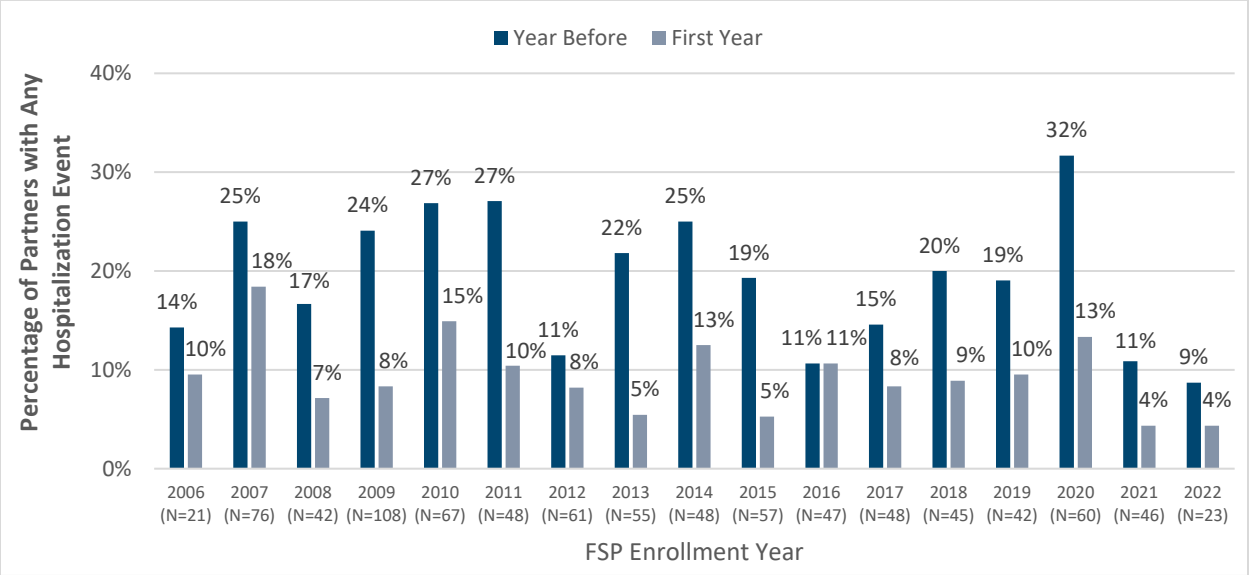


Exhibit 22 displays the mean hospital days per partner by enrollment year. Apart from the 2006, 2007, and the most recent 2022 cohort, all other years show a decrease in the average hospital days from the year before FSP to the first year of FSP enrollment. Hospital days increased by an average of one day from the prior year for the 2022 enrollment cohort.

Exhibit 22. Mean Number of Hospital Days by FSP Enrollment Year

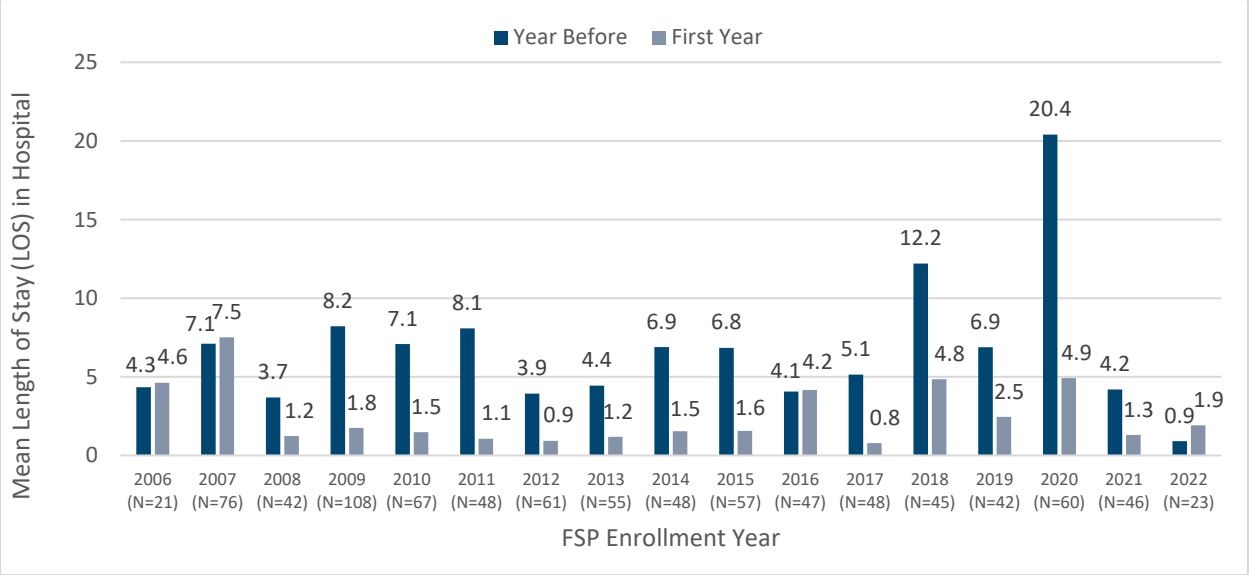


Exhibit 23 displays the percentage of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event from the year before FSP to the first year of FSP enrollment.

Exhibit 23. Percentage of Partners with Any PES Event by FSP Enrollment Year

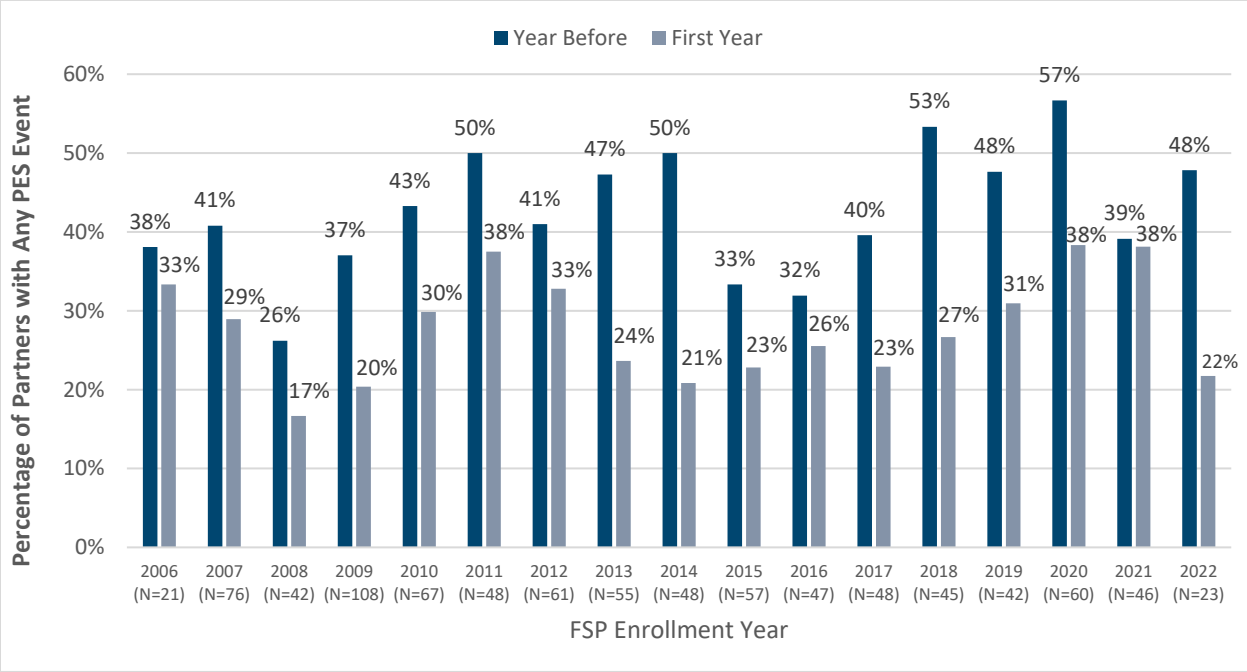
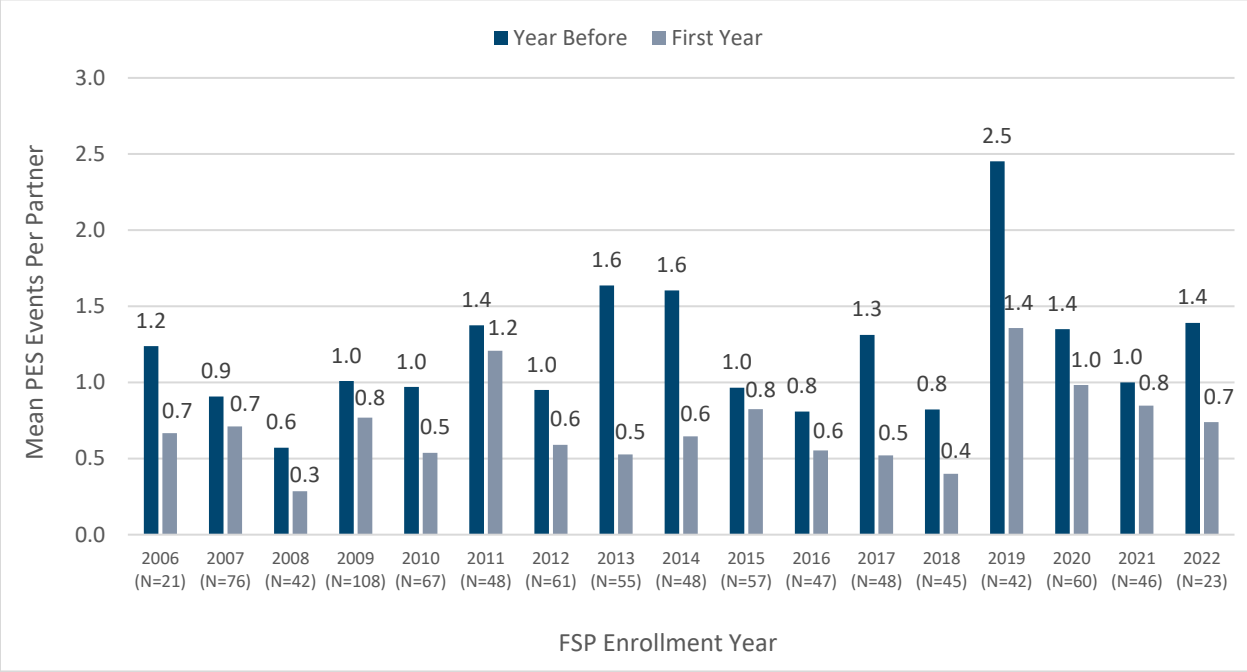


Exhibit 24 displays the mean PES events per partner by FSP enrollment year. All cohorts experienced a reduction in PES events from the year before FSP to the first year of FSP enrollment.

Exhibit 24. Mean PES Events by FSP Enrollment Year



Qualitative Analysis

In this year's evaluation report, in addition to the quantitative assessment using self-reported and EHR data, AIR conducted qualitative data collection and analysis to complement the final evaluation for FY 2022–2023. AIR conducted key informant interviews (KIIs) with FSP clients and members of the wraparound treatment team to understand their experiences with the FSP program, perceptions of impact, and factors affecting the implementation of the FSPs in San Mateo County. Below we present the analysis results for the completed KIIs.

Qualitative Evaluation Questions

The qualitative data collection and analysis aimed to answer the following Evaluation questions.

Clients

1. Client experiences – how do clients perceive their experience with FSPs?
2. Interaction with wraparound treatment team – how is the wraparound treatment team helping clients achieve their goals?
3. Impact of pandemic – in what ways did the COVID-19 pandemic affect FSP services and client experiences?
4. Future of FSP – what changes do clients recommend for improving their FSP experience?

Treatment Team Members

1. Wraparound treatment team (integrated and comprehensive) experiences – how does the wraparound treatment team perceive their experience with FSP?
2. Client services and outcomes – in what ways are wraparound treatment team members using the FSP program to address the behavioral health needs of clients they serve? How is success measured?
3. Impact of pandemic – how did the COVID-19 pandemic affect ways in which services were provided for the FSP program?
4. Future of FSP – what changes do wraparound treatment team members recommend for improving the FSP program?

FSP Treatment Team and Client Interview Findings

This section presents findings from interviews conducted with nine FSP clients (six adult and older adult clients; three parents of youth program clients) and 14 FSP treatment team members across three service providers, including Edgewood, Telecare, and Caminar. AIR spoke with three parents of youth program clients who received services from Edgewood, 3 adult and older adult clients from Telecare, and three adult and older adult clients from Caminar. Of the 14 treatment team members we interviewed, four worked at Edgewood, four worked at Telecare, and six worked at Caminar. Findings describe clients' and treatment team members':

- overall experience and satisfaction with the FSP program
- perspectives on referrals and initiation of treatment
- experience with FSP services and care
- opinions about FSP program services provided in response to needs
- perspectives on the impact of the pandemic

We refer to the FSP clients we interviewed, including parents of youth program clients, as "clients," FSP treatment team members as "treatment team members," and FSP service providers (i.e., Edgewood, Telecare, and Caminar) as "service providers."

Overall Experience and Satisfaction with the FSP Program

Clients' Experience

Overall Experience

Adult clients, **older adult** clients, and **parents** of youth program clients reported that they had overall supportive and satisfactory experiences with the FSP program and expressed appreciation for its positive impact on their or their child's mental health. In terms of improved quality of life, one **adult** client attributed the improvement of their mental health to the program and stated,

> *"It's hard for me to put in words how much I appreciate this program and the people involved in it that have come into my life because it's made it a better life for me, and I'm a happier person now than I was, and a lot of it has to do with this program."*
> (An **adult** client)

Clients also shared that the program's services were beneficial, and they were able to access a multitude of resources, such as stable housing. These services provided clients with the support

they needed and contributed to the improvement in their quality of life. For example, one **adult** client expressed gratitude that *"I'm not living in the homeless shelters or on the side of the hot freeway anymore,"* and another **adult** client explained that *"it's got so many services that helped me out with so much stuff and were really supportive to me toward everything I need."*

Two clients, one **parent** of a youth program client and one **adult** client, indicated that the support they received from staff members was encouraging. The **parent** of the youth program client appreciated that staff members were easily accessible, and said, *"When my daughter has had a crisis, they have always been available to talk."* The **adult** client shared similar sentiments and explained that when they felt depressed or low in mood, their case manager was available to talk and go on a walk with them. After going on these walks, this client felt supported by their case manager and experienced a lift in their mood. They elaborated,

> *"Sometimes I get depressed and my mood's really down, and then when I see the case manager, she'll lift me up and make me feel better just going for a walk. What we do is, she meets me at my house and we go for a walk down to the ocean… And it lifts my mood sometimes… She try (sic.) and cheer me up a little bit and helps me a little bit, so it's nice."* (An **adult** client)

Satisfaction Scale

Clients were asked to rate their satisfaction with the FSP program on a scale from 0 to 10, where 0 suggested that the client felt not at all satisfied, and 10 indicated that the client felt extremely satisfied. Over half of clients gave the program a score of 9 or higher, while the remaining rated the program between 5 and 8. All 9 clients provided a score for the FSP program.

One **adult** client, who gave the program a score of 10, cited personal growth as the primary reason for their high level of satisfaction. This client shared that their mental health significantly improved after enrollment in the FSP program and said,

> *"I'm doing better than I've ever done, really, in my life. My mental health's doing much better than it's ever done, and it's a prime example of people watching over me and getting the support I need and the love from my family…I never done this well mentally in my entire life, so I'm grateful for that."* (An **adult** client)

Another **adult** client, who gave the program a score of 6, referenced an initial lack of communication as the reason for their lower level of satisfaction. However, they noted that there has been a recent improvement in communication and frequency of check-ins with staff members.

> *"Now that they're kicking in a little bit more frequently and checking in with me, I guess I'd say a six...It was a three though, the first year and a half to two years…They were very absent in my first two years as far as when they would show up and how they provided services."* (An **adult** client)

Treatment Team Experience

Overall Experience

Overall, treatment team members from both **adult and youth** programs reported being satisfied with the work they are doing under the FSP programs. They referenced working with dedicated and passionate team members, helping clients solve their challenges, and enjoying the work as reasons for their overall satisfaction. A treatment team member from an **adult** program said,

> *"What I enjoy about it is that it provides me with constant challenges to work on and to try and overcome, so it's not boring. We are, I think, pretty good at selecting from people who are passionate about working with very difficult, often some of the most difficult clients in the county, and they require a great deal of moral support as it relates to really supporting them in doing, number one, a good job from a clinical perspective; number two, making sure that safety is provided for and so forth. Again, I really love doing mental health and challenging situations, so I enjoy it."* (A treatment team member from an **adult** program)

When asked about their experiences collaborating with others on the treatment team, treatment team members from both **adult and youth** programs also reported overall satisfaction. One treatment team member from an **adult** program said, *"Teamwork is a big part of what we do. We try our best to support each other and we never want to draw a line in the sand when it comes to the success of our members or our clients."* While many treatment team members reported having good cohesion within their existing teams, they also described challenges related to burnout and staff retention as well as communication with newer staff, management, or external agents. Treatment team members from both **adult and youth** programs stressed the importance of increased communication and collaboration among treatment team members, especially given turnover among staff. A treatment team member from an **adult** program said,

> *"I think we just need continuing communication and following up, constantly following up and not letting the ball drop. Because what happens sometimes is either there's a change of guard and then you have to start all the way from scratch. So, I think maintaining a history of a client is also important. Usually what happens is I'll get a new case manager and then she'll come up to me with this big whole list of, 'Oh my God, my*

client needs this, this, this, this.' And I'm like, 'Yeah, this has been an ongoing issue with your client and we've not been able to fix it.' So, I think what they need to do is make sure that each client has a background in a, like, face sheet (...) So I think communication and keeping track of what's happening with each client when there's a turnover transition, like a change of guard, would be good. So, we're not starting from scratch again." (A treatment team member from an **adult** program)

A treatment team member from a **youth** program said,

> *"I think if the actual TAY FSP members, if we met in some way regularly and talked about the clients, because maybe they have a client who would really benefit from the drop-in centers, but they haven't really talked to that person yet. Maybe we can be that kind of liaison for them. And I know that the clients who do go to the drop-in centers, we do talk about them with their treatment team. So that is helpful. So just maintaining that would be good."* (A treatment team member from a **youth** program)

Perspectives on Referrals and Initiation of Treatment

Experiences with FSP Program Referrals

Client Experiences

Sources of referral seem to vary between **youth and adults**. All **parents** stated that their children were referred by their clinicians, including therapists, psychiatrists, and pediatricians from school, clinic, or hospital settings. Among **adults**, a few clients noted that they were connected to the FSP program when they were in jail, one client mentioned that they were referred from a rehab facility, and another client was referred from the hospital. Clients did not raise any issues or concerns in this process.

> *"Initially I was in, before I went to jail, I was living in encampments on the side of the freeway. I think when I was in jail, they set me up with Telecare services before I was discharged. So, when I got into the recovery house, Free at Last, case managers started visiting me to see the doctor on the laptop. And so, I got prescription medication, and approved with disability pretty quickly. But I believe it was a service that was connected with me before I was discharged from jail. So, I had psychiatric services."*
> (An **Adult** client)

Clients described their goals when joining the FSP program. **Parents** of youth clients aimed to improve their children's mental health and obtain emotional help. One **parent** mentioned that their child has serious depression and has made several suicide attempts, so they hoped the program could help mitigate the depression and suicidal ideation. As for **adults**, some mentioned that they would like the FSP program to help them stay off drugs, get housing and

employment, become independent, improve their mental health, and alleviate depression symptoms.

> *"So, my child had a mental health crisis and wanted to take his own life four times. He was accepted in three different hospitals, in San Mateo, San Francisco, and Sacramento. So, he had a therapist in [a clinic], and that therapist decided that he needed to be part of a more consistent program, where he could receive attention more frequently, including a weekly therapy session. So, they referred me to the [Service Provider] program. I was referred there from that clinic, also from my child's school, also from the hospital…" (A **parent**)*

> *"Well, I wanted to get clean and sober, and I wanted a roof over my head, and I wanted to get a real job...and I was on the street homeless and it was just a real bad role. So, I tried to hook up with, first [Service Provider], and then [Service Provider], to help me out." (An older **adult** client)*

Treatment Team Experiences

Treatment team members from **adult and youth** programs noted that clients are typically referred to their organizations from the San Mateo County's Behavioral Health and Recovery Services (BHRS), which decides which service provider is more appropriate for a client in need of services. After the initial referral, programs typically have an intake process in place in which treatment team case managers and other treatment team members collect additional client information, share program materials with clients, and identify treatment goals.

Most treatment team members interviewed said they were satisfied with existing referral processes they have in place. What makes referral processes successful, according to treatment team members, is having a streamlined process, defined steps, and clear communication channels that allow the team to start serving a client as soon as they are referred. As mentioned by one treatment team member from a **youth** program, "*We definitely have our protocols to start serving [and] start moving like busy bees as soon as we get the referral […]. What I can tell you is that as soon as we get a referral from my supervisor, we have already a team that we start communicating [with]. So, the communication piece definitely in coordination is something that works well*."

However, while they operate well overall, some treatment team members from **adult** programs mentioned that they sometimes receive inaccurate client data or insufficient background information during referral processes. This makes the intake and onboarding process, as well as the experience of providing treatment and services, less efficient. The following treatment team members from **adult** programs, for example, shared how getting incomplete or incorrect information during a referral process can complicate or slow down the process of onboarding

clients or developing a pertinent treatment plan, or can raise issues when allocating a client in proper housing:

> *"The case manager gets a referral packet about a client's medications and diagnosis. The referrals [our case managers] get are not the best because they often do not have background information. [They then do their] own intake where they ask questions about their history, but this often takes months. There is information that professionals know and psychiatrists know, which they [the health care professionals] do not share. If the referral process was more in depth, it would make the process of onboarding clients easier."* (A treatment team member from an **adult** program)

> *"If I'm not given accurate information [during the referral process]; if they [the client] sugarcoat it or kind of hide something and then we find out that something happened, that this client was actually evicted or is about to be evicted, then you're just enabling [...]it's a snowball effect and it affects other people living around them and then affects the neighbors, then affects the property management then, and then the bigger picture is if it affects the partnership, and then we lose the apartment, and then I can't house clients. Then it affects the clients directly that way, too. So, I need accurate reporting on that*." (A treatment team member from an **adult** program)

Receiving accurate and detailed information is helpful for the intake/onboarding process for a client.

> *"We try to get as much information along with the referral packet as possible. That includes previous hospitalizations and discharge summaries for mental health organizations for those hospitalizations or incarceration if there's interaction with correctional health. Med lists, stuff like that…receiving sufficient documentation. Now, of course, sometimes that's not available, but receiving it when it is, is super helpful."* (A treatment team member from an **adult** program)

Experience with Intakes and Initial Interaction

Client Experiences

Some clients we interviewed have been with the FSP program for more than 10 years, and others started receiving program services in the past 1–3 years. In general, clients reported neutral experiences in their first interaction with the FSP program. Two clients mentioned that the first appointment was about information gathering and introducing the program and the services, and another client noted that they did not know what to talk about with their therapist in the initial appointments, which has improved over time. Two clients expressed some frustration about their initial interaction, which occurred during the COVID-19 pandemic.

One of them noted that their first appointment was during the pandemic, and the program staff showed up without notice at their recovery house for their first virtual appointment. The other client also mentioned that their first appointments (in the past year or so) were over the phone, and it took more effort to get in-person appointments.

> *"They just arrived at the recovery house and was like, 'We have a doctor's appointment on the laptop that we have to do.' And since it was COVID-19, we had to take precautions for me to be set up in a separate house that didn't bring the case manager in and exposed anybody else that was in the residential treatment house. And so, it was really awkward and they didn't preannounce that they were making an appointment or anything with me. They just showed up and had the laptop for me to meet with the doctor.*" (An **adult** client)

Another client also mentioned that their first few appointments (in the past year or so) were over the phone, and it took more effort to get in-person appointments.

Treatment Team Experiences

According to treatment team members from **adult** programs, all programs have clearly defined intake processes that take place in the following days or weeks after a client has been referred and assigned to a program. Intake processes include sharing informative program materials with clients about existing FSP services and safety plans; collecting client information (e.g., contact information, other background information, family and medical history, substance use and housing history) that adds (or corrects) initial information received during referral processes; completing client forms; assessing client needs and problems; identifying existing legal issues (e.g., conservatorship), release of information forms (ROIs), and emergency contacts; defining client goals; and elucidating appropriate services or a treatment plan or problem list in order to achieve said goals.

For **adult** programs, case managers take the lead as the initial point of contact during a client's intake. They often collaborate with other treatment team members (including therapists or clinicians) throughout the intake process, each meeting with the client at different moments to collect all necessary information. Additionally, housing staff may also conduct their own intake processes, which include their own assessment and research into a client's prior residential information.

As a result of the intake process, and based on each client's goals, some **adult** programs develop a treatment plan, which is designed by the clinical team in collaboration with the case manager. Each treatment plan is unique and follows the needs of the client as well as the

assessment by the clinical team. According to a treatment team member from an **adult** program:

> *"… [the treatment plan] is client based. They work with the client directly to see what types of goals or interventions they would like. [The treatment team] worked with a client recently who felt isolated and lonely; they explored what that would look like and how to support her by connecting her with resources like the YMCA […] The client and the [case manager] develop this, and the client has to sign this when it's completed."* (A treatment team member from an **adult** program)

Other **adult** programs have decided to stop designing defined treatment plans and instead create problem lists for clients that they address throughout treatment and services. As one treatment team member from an **adult** program said:

> "*We don't necessarily do a treatment plan anymore. We have problem lists. We kind of identify whatever was on the referral on the problem list, and then as we meet with the client and we talk with them and get to know them more, we can add more items to their list. For example, some of the things that we have frequently on people's problem lists are needs assistance with accessing community resources or communicating with providers. We can support them with those things. It's not a formal treatment plan, but we talk to them about their goals and then we provide interventions to support them to take steps to get towards their goals).*" (A treatment team member from an **adult** program)

Interview participants who were treatment team members from **youth** programs did not serve in roles where they took part in the intake process; however, they shared that they do collect demographic information from clients. One treatment team member from a **youth** program said,

> *"We ask demographics, for when we report out, of course, so we'll ask in terms of race, gender identity, also system involvement…but we'll ask if they had IEPs in schools, or if they're in the foster youth system, et cetera. Then we also ask what they are interested in. Are they interested in...is it socialization with their community? Are they interested in getting food or hygiene or bus tickets? Like physical resources. Or if they're interested in learning how to get a job or applying for school. Things like that."*

These participants did not mention involvement in the development of clients' treatment plans. One treatment team member said that in their role they collaborate with clients' treatment plans, but they also create their own behavior plan. They said,

> *"So, although I'm working under the diagnosis from the clinician, I'll create a behavior plan specific to the behaviors that are occurring due to the diagnosis. So those will range*

from aggressive behaviors to isolation, suicidal ideation, school refusal, elopement, just to name a few. And so, what I do is create a plan to solely focus on minimizing and reducing those behaviors." Another treatment team member said they create a plan of care with their clients. They said, *"We have what we call plan of care. So, we have once a month family meetings that we call family conferences. We all gather together. When I say we as the treatment team, the facilitator, who is very neutral, doesn't know much about the family, and it is their voice. They choose the different domains."*

Experience with FSP Services and Care

Clients' Experience

Experience with Case Managers

In general, clients are satisfied with and appreciative of the support from their case managers, although people may have varied experience depending on who they work with. Several themes emerged from clients' feedback, including accessibility and responsiveness, support and guidance, variability in case manager assignment, trust and communication issues, and skills and personalities.

- **Accessibility and Responsiveness:** Some clients reported that their case managers were highly accessible and responsive. They appreciated being able to reach out to them even outside of scheduled meetings. However, others had a different experience, where they felt that the case managers were not as responsive as they would have liked, often attributing this to case managers being assigned too many clients.

  "And she's pretty good when she's around, but she's not always around 'cause she's got a lot of clients, and sometimes I can't get ahold of her and sometimes things don't work out, but I'm still hanging in there with her, and seeing what we can get accomplished and that's all I can do... just hang in there with her." (An older **adult** client)

One older **adult** client shared that engaging in more discussions with staff about external resources, such as stable housing, would be beneficial. They expressed frustration that staff members occasionally missed scheduled meetings where they were supposed to discuss obtaining access to long-term housing and stated that *"…If I'm waiting on these people and they don't come by it really frustrates me, but I got to wait on them because I can't do it myself. I can't do it myself."* One **parent** of a youth program client had a similar perspective about communication and mentioned that *"there is not as much communication as I would like."* This **parent** added that, after coming back from a vacation, they did not hear from staff members about scheduling more therapy appointments for their child. They stated that regular therapy sessions helped their child by allowing her to *"express herself better, talk more, and overall*

share what she was feeling in a better way," and felt that engaging in more communication with staff members to schedule consistent therapy appointments, would be beneficial.

- **Support and Guidance:** A recurring theme was the valuable support and guidance that case managers provided. Some clients felt that case managers were effective in understanding their issues and guiding them toward solutions. Especially when the clients were dealing with emotional concerns or insecurity, case managers were acknowledged for offering reassurance and stability.

  "*Well, just a lot of insight like with questions that I have about certain things and stuff about recovery and staying stable and stuff like that. When I get insecure about like when my mom passes away, what I'm going to do with myself? That is when [case manager] helps me, reminds me that everything's going to be all right and stuff like that. I'm really grateful for what [case manager] does."* (An **adult** client)

- **Variability in Case Manager Assignments:** Some clients expressed dissatisfaction with being assigned to different case managers. They noted that they were not always sure who their assigned case manager was, which sometimes led to issues in communication. Additionally, they experienced variation in the quality of service and responsiveness from different case managers.

  "That really varies because each week I have a different case manager assigned to me. And [CM1] will be my next week's case manager, and they never respond to my text messages and never show up for any appointments when I'm assigned to him. But then there's [CM2] and [CM3] who call and check in on me when they're assigned to me for the week that they have." (An **adult** client)

- **Trust and Communication Issues:** Trust emerged as an important factor in the client-case manager relationship. Some clients felt uneasy having certain case managers involved in personal aspects of their lives, due to concerns about judgment or lack of trust. This sometimes created a barrier in communication and collaboration.

- **Case Manager Skills and Attributes:** The personality and skills of case managers played a role in client satisfaction. For example, clients spoke highly of case managers who they felt were empathetic, supportive, and efficient. However, clients were less satisfied with case managers they perceived as unresponsive or lacking in communication skills.

Experience with Other Treatment Team Staff

In general, clients had positive experiences with other treatment team members, including psychiatrists, therapists, and other staff. Many clients appreciate the support and assistance they receive from the clinicians in the FSP program and acknowledge the positive impact on their mental and physical health from clinicians and other staff. Some clients noted that

there are areas for improvement, including ensuring consistency in therapy sessions, and improving attention and preparation for appointments. Additionally, the personal connection and comfort level between the clients and the clinicians emerged as an important factor in the clients' satisfaction and perceived effectiveness of the services. We summarized some emerging themes below:

- **Positive Impact:** Several clients shared that the other (than case managers) members of the wraparound team played an essential role in supporting their children or themselves. For example, one client spoke positively about how the wraparound team helped their son with emotional regulation, communication skills, and organization of thoughts. Another client expressed satisfaction with the support from a therapist and how it led to significant improvements in their life. One client felt comfortable with their psychiatrist, appreciating her therapeutic approach and consistent encouragement towards achieving personal goals, such as sobriety, eating healthy, and maintaining wellness.

  > *"So they had helped him stabilize and grow up emotionally so that he wouldn't get exasperated over everything...And I think they also helped him quite a bit with his confidence to socialize with his peers […]Trying to get him organized and thinking through things...So they helped him get his thoughts in chronological order, where before he was really just spread out everywhere. […] they really helped with his communication skills quite a bit."* (A **parent**)

- **Personal Connection and Comfort:** A few clients felt comfortable and connected with their psychiatrists, therapists, and other staff, indicating that this connection was crucial for them. They appreciated when their treatment team members were attentive and understanding, making them feel valued and understood.

- **Lack of Attention or Not Meeting Clients' Needs:** However, some clients shared concerns regarding inconsistencies in services and a lack of preparation or attention from certain clinicians. One client mentioned frustration with a psychiatrist who seemed unprepared and distracted during appointments, which led to confusion about medication. Another client expressed dissatisfaction with their therapy, feeling it wasn't meeting their needs.

  > *"And that's because when I'm on the phone with [psychiatrist] or on the laptop with him, a majority of the times he's commuting into work and doesn't have my file with him or we're over the phone and he's had people come into his office and have conversations with him while I'm trying to have an appointment with him over the phone. So, I just have gotten frustrated that he doesn't seem to remember who I am or remember what medications we're even discussing because he's not prepared, or his attention's distracted. So, they're going to have me meet with a new doctor."* (An **adult** client)

- **Lack of Regular and Consistent Sessions:** One **parent** raised a significant concern for the availability and consistency of therapy sessions. They specifically emphasized the need for more frequent and consistent sessions for their child, who was struggling with mental health issues, including recurring suicidal ideation. The lack of regular sessions was seen as detrimental to the daughter's well-being.

  "And since April, they've now only been able to schedule one appointment with my daughter. Only one! What I see is that the time it's taking…. I've always fought for her, to get her treatment. […] And now, next week, [Treatment Team Member] also cancelled because she will be out, and my daughter will again go on for two weeks without a session. So, what I want to say is that I do think my daughter has improved with this program, but I still feel she needs more intensity, more frequency of a treatment. […] I was just saying that I do see changes in my daughter, especially when the therapy is more consistent and regular. But now, I see her more unbalanced." (A **parent**)

- **Concern about Unusual Therapy Methods:** One **parent** reported a concerning experience with a behavioral health therapist who employed unorthodox methods, such as having the child eat chili peppers during therapy. This led to a breakdown in communication and trust between the family and the program.

  "*The second session was also at home. And for that session they made my child eat chili peppers. And when I saw that, it didn't seem right to me. I don't know much about this, but I kept my mouth shut. So, I didn't agree with eating the chilis as part of the therapy. But if that's how it works, I'll let it be*." (A **parent**)

- **Expansion and Clarity about FSP Services:** One **parent** of a youth program client recommended that the program should be expanded and offered to more people, and specifically suggested having group sessions for teenagers, so *"they can feel stronger or more confident"* as a result. One **adult** client expressed that they were still uninformed about different aspects of the FSP program, including what the program is supposed to provide and what they should expect from staff members. They elaborated,

  *"Just the fact that I'm still uninformed or don't have a real definition of what a full-service provider provides. I feel like I'm in the dark about what relationship we're supposed to actually have in that title. So, it would be helpful to be more informed of what I could expect from them and not just fumble through it. And to have a clear idea of what I can anticipate in their provisions would be helpful." (An **adult** client)*

Treatment Team Experience

Assessing Client Progress

The way service providers assess clients' progress varies between them, and also may be different depending on each client's needs. Treatment team members from an **adult** program said once a final treatment plan with goals has been defined for a client (which can take up to 30 or 90 days, depending on the case), they re-asses client progress every three months and, in conversation with the client, identify barriers and completed goals, and update the treatment plan accordingly. To record these assessments, some staff from this service provider use Credible, an electronic software that records each client's treatment plan. Treatment team members also log progress notes in every assessment, which explains how each service provided is helping achieve each goal. While treatment team members had positive opinions about this assessment process, one treatment team member thought that the software choice was unnecessarily complicated and not user-friendly.

For this service provider, housing specialists have a regular inspection process in which they assess client's home safety and maintenance. They do not have standardized indicators, as housing challenges and needs vary client to client, but do ensure to check in on housing situations on a semi-annual basis:

> *"What we do is a semi-annual housing inspection. And we go to each apartment and of course we see how they keep their place. We do safety checks. Like, if the furniture is too close to the furnaces or if the boxes are blocking up the furnaces, if the entrances are blocked… So, we do an assessment of safety, we do an assessment of maintenance needs, and making sure that the clients are not housing unauthorized guests. When we notice that the client does not meet expectations, we address those expectations."* (A treatment team member from an **adult** program)

Treatment team members from another **adult** program do not have a predefined structure to assess progress. The treatment team track advances in each case's progress notes and decides on a client-to-client basis how often to meet and discuss updates to a client's problem list. As explained by one treatment team member:

> *"So, I don't think that there's necessarily one specific way that we track progress overall. I think a lot of it is in conversations that we're having with our clients and observations that we're making. And I think most case managers probably document that in their progress notes. [...] I think that our program is still trying to figure out a better system to update [problem lists]. There's some things that the case managers are limited to where we can update. We can only add Z codes if we don't have any type of certification or license. And so, there's some things that we might need our supervisors or our nurse to*

assess for before we can add them to problem list. So, we don't have a system right now, but definitely, annually, when we're doing their consent packets and we're reviewing their chart, we look at those problem lists." (A treatment team member from an **adult** program)

Lastly, treatment team members of a **youth** program shared a variety of ways they assess progress among clients. One treatment team member from a **youth** program said that behavioral coaches and mental health clinicians, who have weekly sessions with young clients, use a client dashboard that tracks client symptoms, behavior, and mood. This dashboard can then be used to generate data summaries that track client progress, can be shared with the parents and families, and inform any changes in the provision of services:

> *"[The Dashboard] is kind of an Excel sheet that we keep and it's a number system. Kind of like a graph scale that we're able to input numbers to say: 'This week, behaviors happened three times a week for X amount of minutes.' And then it provides us a graph to see: Was this week a good week? Was it tougher? And that way it helps us to track the progress. And then also checking in on those weekly treatment team meetings with the team to see what's coming up in session with them when they're with the client, while also checking in with the parents for collateral to see what's going on in the home and see how effective are the tools that we're implementing to manage the behaviors and symptoms." (A treatment team member from a **youth** program)*

Other treatment team members from this **youth** program described using a web-based platform to track clients' goals and take notes on their progress. One treatment team member said, "*Sometimes I might see a treatment goal like, 'Client aims to practice meditation twice a week,' or something. So, I might check in and be like, 'Hey, are you into mindfulness at all?' And then we'll talk about it and then we'll see how far they've gotten with that goal.*"

Involving Family Members

When asked how treatment team members involve family members or caregivers while treating clients, programs that serve **adults and older adults** shared that they gather information about their clients' family members or caregivers at intake and do not involve them without clients' permission. For example, four treatment team members mentioned that a release of information (ROI) form needs to be completed for treatment team members to communicate with their clients' family members or caregivers. A treatment team member from an **adult** program described the process of involving a client's family member, and how it can be beneficial to a client's treatment. They said,

> *"For instance, we get a new client and the client says, I have a really close relationship with my mom, so we have to get permission. Hey, do you give me permission to speak to your*

mom about your program goals and improvement and things overall, everything, the client says, yes, they sign, they give us the contact information, and then we just connect with them, if the client is disengaged a little bit or for whatever reason, we need to call their mom. If the mom was on the ROI release of information, we contact the mom. And sometimes it helps us a lot because sometimes the clients are not very honest or cannot always be honest with us. So, getting someone else's point of view of, let's say the client lives with the mom and the mom can give us her point of view and help her, hey, your mom said that you need help with, I don't know, locating a job still and kind of helping us connect to help the client." (A treatment team member from an **adult** program)

One treatment team member from a **youth** program said they meet with the parents or caregivers of clients weekly as a way to involve them in a client's treatment. They said,

> *"What we do is we like to collect kind of behavioral reports from the parents. What were symptoms like, overall mood, any behaviors that were exhibited that were a challenge, and also positive things. When behaviors came up, were they able to utilize the tools? And then within those meetings we start to build kind of their toolbox. So, we introduce them to coping skills, how to be that person that is able to co-regulate their child by using the tools. So, a lot of times what I do is I'll role play with the family or the parents, depending on who is involved."* (A treatment team member from a **youth** program)

This treatment team member also shared that parents and caregivers have access to a crisis line that can assist them if conflict arises with the client after hours when treatment team members are not available.

Two treatment team members from **youth** programs said in their roles they do not communicate with clients' family members. One treatment team member said, *"We can't really talk to their caregivers or parents or anything like that because of our confidentiality agreement. So, we can't even disclose if they've been to the center or not."*

Overall Successes and Challenges

When reflecting upon the overall successes and challenges of their FSP program, treatment team members felt overwhelmingly proud of the positive impact it has on their clients' lives. Treatment team members also shared what they perceived to be key successes and strengths of their programs, as well as relevant challenges or limitations.

- **Large Interdisciplinary Treatment Teams:** A first major strength highlighted by treatment team members from **adult and youth** programs was the fact that the FSPs counted on a large treatment team, which includes members from different backgrounds. Treatment team members valued the drive and commitment among their coworkers. While one

treatment team member from an **adult** program said that the varied expertise allowed staff to learn from each other and problem solve more creatively, another valued the internal supervisions among team members:

> *"[Our main] strength I think is definitely having the huge wraparound team. And not only with the team being kind of large and supportive in that way, but we also meet for individual supervision. And then we have our pod meetings, which is similar to group supervision where we can really rely on management to help if we're struggling at any point with a case that we're feeling stuck and we're kind of hitting a wall, just getting that further consultation."* (A treatment team member from a **youth** program)

- **Integration into Community and Social Networks:** A major success of the program mentioned by treatment team members is helping clients integrate into and participate with the communities around them. While mental health services or housing support, both for individuals as well as entire families, are key pieces of the work conducted by the service providers, treatment team members saw them as steppingstones that allow clients to then connect with others and live independent lives. As said by one treatment team member, connecting clients with surrounding community activities provides a sense of autonomy that can significantly improve clients' quality of life:

  > *"I think for a lot of our clients [this program has] given them the opportunity to not be in an institution, and I think that that is really important. I think that we do have some clients who are fairly low functioning, but with the proper support, they are able to live at the community level and have some sense of freedom and independence. I think that it has definitely had a positive impact on the quality of life."* (A treatment team member from an **adult** program)

- **Strong Rapport and Relationship with Clients:** Treatment team members from **adult and youth** programs highlighted the rapport and relationship building between case managers and clients and mentioned the importance of providing a space and a connection for clients to be seen and heard by building an empathetic relationship as a key strength:

  > "*A lot of clients come to me and say they're so appreciative of [program], that [program] is there for them to support them and listen to them and help them and guide them. And they're very, very, very, very appreciative of the support that they get from the case management team. Providing them empathy and just listening to them... It's very important for them to be heard and not just told what to do."* (A treatment team member from an **adult** program)

- **Limited Funding and Resources:** Multiple treatment team members from **adult and youth** programs mentioned limited funding as an important challenge faced by the FSP programs. One treatment team member from an **adult** program, for example, said that they felt

constrained with the available funding to support clients' everyday needs, and wished that additional program funds were available to finance gift cards, transportation costs, or other logistical needs that clients often struggle to cover themselves. Another treatment team member from an **adult** program said that limited program resources directly impacts program staff, as it reduces the amount of available trainings, keeps salaries low, and may make treatment team members feel undervalued:

> *"I think the main challenge is not having the resources to do things. First, there's not a good support system for our staff to have the training, and the education, and the confidence to go out and do the interventions and skills that we need to do. I think we have very poor training in our program and I'm very vocal about that. And I've tried to mitigate that by creating trainings, but there's just a lack of time. […] And then of course pay. Pay is low for what we do. I've advocated for raises and stuff and been told no multiple times, which if I do ever leave this position, it'll probably be because I make as much as the next person that just started a week ago and doesn't have any skill. So, I feel really undervalued in my position."* (A treatment team member from an **adult** program)

- **Staff Capacity and Staff Turnover:** Another limitation is the capacity of treatment team members from both **adult and youth** programs and staff rotation, which overburdens existing staff and creates challenges when building rapport with clients. One treatment team member from an **adult** program said this was particularly challenging for case managers and behavioral health staff, who find themselves having to support too many clients at once: *"People are overworked. Ideally this program should work, but people are given too many cases. People are given too many crises to deal with at a time."* While more than half of treatment team members interviewed did not think that staff turnover was frequent, those who mentioned it said it could strongly hinder the relationship-building process between program staff and clients, many of which are navigating challenging emotional experiences:

  > *"I know it's a nonprofit and we have a lot of people and a lot of [turnover]. So, people come and go and I see families many times get affected by that because they come to us with trauma. Sometimes losses, so even losing a person that is part of their [treatment] team is a big loss for them. They have connection, they develop rapport […]. So, I wish we didn't have to do that, but it's part of life and people move on. That will be something that I see as a limitation."* (A treatment team member from a **youth** program)

Treatment team members from **adult** programs made recommendations that would help mitigate the challenges related to staff retention and burn out. This includes providing higher pay, more trainings for new and existing staff, and increased community building and mental health support. One treatment team member from an **adult** program said:

> *"The training, the support for staff, and retention of staff is the problem because we get really talented people. We get people that go out there and do it really well, and then they leave and our clients suffer. And I think if we supported staff more, if they didn't feel like they didn't know what they were doing ... we've had a lot of clients in the past couple months pass away from accidents or physical health conditions. And I just talked to somebody this morning who was like, 'I just need to keep working.' And I'm like, 'No, you've had two clients die this year, and one was this week.' And I'm like, 'You should take some time off.' But again, there's no support for her to know what to do. And I'm fearful that she's going to burn out because she's dealing with intense things without support. So, I think the biggest thing is the training and support for staff."* (A treatment team member from an **adult** program)

Treatment team members also made recommendations that would improve overall program operations. For example, a treatment team member from an **adult** program mentioned that they are getting more clients with a history of violence as a result of a state-level court changes, which may be a safety concern for their staff. They said:

> *"Some changes were made on the state level as it relates to us getting clients from the courts [...] we also get clients with quite a substantial history of violence. And I'm a manager, I got to look out for my staff's safety too. And we have to navigate some pretty dicey situations where we have, I need to provide for both the safety of my staff in addition to the safety of the client […] "in addition to the lame 4% [cost of living increase]. I'm sorry, I can't mince my words on that. It's so profoundly disappointing. My staff deserve to get paid better than that. Especially given all of the inflation. And we can't compete with other counties. We can't compete with other counties' CBOs. We can't compete with [another service provider]. And the thing is, it's psychologically difficult work."* (A treatment team member from an **adult** program)

One treatment team member from an **adult** program and one treatment team member from a **youth** program requested bigger budgets that would go towards client and staff resources. Three treatment team members from **youth** programs requested more time and space to collaborate and communicate with upper management and other treatment team members. One treatment team member from a **youth** program said, *"I really wish we had some kind of meeting or something where we all come together and all discuss the clients and things like that. Because for now, when we do have meetings with clients, it's really just me and the other full-time staff members talking with the treatment team members, and then I relay it to the other peer partners, but not as good."* Another treatment team from a **youth** program said, *"I would also say with upper management, just being able to collaborate more frequently with the treatment teams since we're kind of doing the groundwork, and they'll check in periodically*

more so when crisis arrives. But I think it's important for them to know, too, just kind of what's going on more frequently with the families that we're working with."

- **Lack of Language Diversity:** Three treatment team members (two from **adult** programs and one from a **youth** program) mentioned the need for more bilingual staff members. While all service providers had staff that spoke Spanish on their treatment teams, some specific roles did not have a bilingual member. Additionally, one treatment team member from an **adult** program said that they would like to have more staff that also spoke other languages, not only Spanish, to help all other non-English speaking clients.

  > *"I wish we could have more bilingual clinicians that they can really serve a specific need. If there's a language barrier, of course there's bilingual team members within the team like myself, but let's say a therapist will be a better fit if [he/she] speaks the same language of the parent."* (A treatment team member from a **youth** program)

- **Keeping Housing:** Four treatment team members from **adult** programs described the extensive challenges of not only finding housing for their clients but also ensuring they remain housed. Respondents said that being able to stay in a home for an extended period is a major challenge they regularly encounter in their work, given the struggles that many clients have with substance use or conducting activities of daily living. One respondent highlighted that the biggest barrier to successfully keeping long-term housing is substance use, as it can negatively affect relationship with property managers, neighbors, or other community members in a significant way. In turn, housing specialists emphasize the need to communicate effectively with clinical and mental health members of the treatment team in order to provide continuous coordinated support:

  > *"It's more difficult when the client has substance use issues. And that's the challenge when it comes to housing. Just because once they're under the influence it's very difficult. Unless they're high functioning alcoholic or high functioning, it's very difficult for them to maintain their housing [...] when they come out and start behaving, interacting inappropriately with other people around them, that causes a lot of friction. That's when property management gets involved. And then we have to either find other housing for them because it's very difficult" (*A treatment team member from an **adult** program*)*

Two treatment team members from **adult** programs also had recommendations regarding housing. One treatment team member said, "*A day center for the homeless to me is the biggest need with San Mateo County."* Another treatment team member recommended disconnecting housing from their program entirely, suggesting that clients' access to housing funding operates more independently than access to other program services. They said,

"We really need housing to not be connected to the program. That's gumming up the works. Because we have clients that could otherwise step down to another program, but their housing funding through the subsidy program is connected to the program itself. And what happens is, yeah sure, I could discharge a client and they will lose their housing in decomp in short order. That's not a wise clinical choice, but it's an artificial barrier that's put in by the system, the way the system is operating. What would be much better is to have access to vouchers for our clients in the AOT program where they can get their housing and it doesn't matter what program they're in. That way we can step them down and they're not at risk of losing housing, and then therefore decomping, and they can continue their journey and step up into a different program as necessary or something like that." (A treatment team member from an **adult** program)

FSP Program Services Provided in Response to Clients' Needs

The following section lists the various services that were mentioned both in client and treatment team member interviews. In accordance with the FSPs "all it takes" model, the services provided to clients are varied and tailored to individual needs. In general, all clients have received some degree of case management services, and either therapy or psychiatric services (or both). Some clients also receive logistical support and assistance with activities of daily living (ADLs), such as transportation, housing, parental and family support.

- **Case Management:** Clients have case managers assigned to them, with whom they typically meet once a week or once every two weeks. The case managers may rotate, and clients can meet them in person or via call. Case managers tend to be the main point of contact for clients, from the moment they initiate services. According to treatment team members, case managers coach clients throughout activities of daily living (such as managing budgets or personal hygiene), guide them through different services provided by the FSP, and provide socioemotional support by accompanying clients and checking in on them regularly.

  "Linking coordination, processing their emotions, it varies from client to client. A client who wants to be connected to housing would be linked to vouchers or shelters depending on the client's need. ADLs, [if they] have a hard time managing, and if their hygiene has decreased, she will check in with them to assess barriers and then develop a plan to connect them to portable showers. If a client reports depression, she will call them to meet in person, if they report suicidal ideation, they will make a safety plan regarding triggers and how she can support them. (A treatment team member from an **adult** program)

  "We do a little bit of everything. So sometimes we have clients who are homeless so we will connect them with core agencies if they're interested in being placed at a shelter. Or

if they need access to food we can connect them to food resources, things like that. A lot of referring and connecting to resources. We also have some people who are not living at a supervised placement, and so they might need more help, more assistance with medication. And so, we might deliver their medications weekly to them and kind of talk to them more about that, and how they're doing with taking them on their own and if they need additional support with that. We go to appointments with members if they want us to. We provide transportation if needed. And then, we also provide support with psychiatric appointment." (A treatment team member from an **adult** program)

- **Mental Health Services:** Clients also receive therapy services. Sessions typically take place once or twice a week. Family members are sometimes involved in these sessions, especially when servicing younger populations. Treatment team members highlight that therapy sessions, which may address a variety of issues such as anger management and coping tools, are key to helping clients in other aspects, such as maintaining housing or employment.
- **Psychiatry Services:** Clients have access to a psychiatrist for medication management about once every three weeks or a month. The meetings with psychiatrists can be in person, though often are conducted remotely (e.g., via Zoom or phone call).
- **Transportation Assistance:** Some clients receive assistance with transportation, but mostly on special occasions or for appointments. For instance, one **parent** mentioned their child being taken to bowling on his birthday, and another mentioned receiving help with transportation for housing-related appointments and renewing a driving license. One **adult** client mentioned that the FSP program helped them receive services from a program that offers free bus or shuttle rides for the disabled. Case managers are most often the team member who provides transportation services or accompanies clients getting around when needed.

  "Oh, [Case Manager] has always offered me transportation to my psychiatry appointment if I ever wanted to go down there and see her in person. She's taken me to DMV to renew my license." (An **adult** client)

  "Same thing I mentioned before when clients need a lot of transportation. A lot of clients need transportation services and they oftentimes have a preference of me transporting the clients, which I don't mind in that time that we are in the car. I take advantage to get to know the client more. Things like that. And the client… maybe because my client is Spanish speaking and she knows that I speak Spanish and I can translate for her. Maybe that's why she has a preference of me taking her." (A treatment team member from an **adult** program)

- **Housing Assistance:** Clients receive support in searching for and securing housing. Some clients stay at housing facilities associated with the service providers. However, some clients reported difficulties in receiving adequate assistance, and one client reported that she had received a housing voucher but was not able to get help from the program staff in house hunting. Among the service providers, some have staff focused exclusively on helping clients find and secure housing, such as housing specialists or housing coordinators who work collaboratively with case managers. Housing staff also work to ensure clients stay housed by helping them understand leases, keep houses clean, and ensure they follow tenant rules.

  > *"And that's really been pushed hard by the director of the homeless shelter that I was staying at. She called a few times to ask why they weren't providing services and they hustled to provide a case manager within 24 hours to get me grocery shopping or help me move into my apartment and whatnot. Because they weren't really helping me apartment hunt when I got a housing voucher, like they should have. So, I learned through the director of the housing or the homeless shelter that they were supposed to be providing more than they were."* (An **adult** client)

- **Parental and Family Support:** In addition to supporting the clients, the program also helps the family members. For example, one **parent** mentioned that there is a staff member who helps them as a parent, and that there is a teenage peer who meets with their child.

  > *"In addition to the therapist we see a total of four people. The therapist, the psychiatrist, a man who helps me as a parent, and a younger teenager who also meets with [child client]. She now goes mostly in-person. Only the psychiatrist is via zoom."* (A **parent**)

One **parent** stated that a therapist from the FSP program coordinated an emergency response when their child took many pills, though this action was taken without the consent of the family member and led to dissatisfaction with the program.

> *"So, the next week my daughter started to take pills again, all the Benadryl. I found her, gave her milk, and told her I would take her to the doctor. So, I reached out to [a therapist] and I told her: look, I'm taking my daughter to the hospital because she took many pills, and I'm letting you know. And [the therapist] said, OK, you can take her to the hospital or I can send our team. I and I said, don't worry, I'm letting you know that I will take her. Well, then the problem happened: as soon as I put on my shoes, I had five emergency vehicles here at my home. So, she called them. I had only called her to let her know what was going on. But I was very upset because they didn't respect what I had told them. What the ambulance was going to do, taking my daughter to the hospital, is what I was going to do."* (A **parent**)

In addition to identifying the different services provided, treatment team members were also asked what they thought was the greatest need they encountered among their clients. Interestingly, treatment team members mentioned a wide range of priorities they considered as the highest need among clients. Multiple treatment team members from **adult and youth** programs mentioned social networks and support as the greatest need, as clients often felt lonely and had to navigate the challenges of creating bonds while experiencing mental health and housing challenges. As mentioned by the following treatment team members:

> *"I think that the biggest need is connection and social support. And maybe that's bias because of the pandemic. Most of the people I work with complain about feeling really lonely, really isolated, really not understood, really craving thought discussions with other people. Especially into the other problem is that they're really seen as just very much their mental health condition, not as people; and they're only surrounded by people that are also experiencing similar mental health conditions. […] They feel really lonely, they feel really disconnected from the world, and I think that's the biggest need is to feel like they are connected to people because that will help with building self-esteem and interacting with the world. It's the biggest thing I see."* (A treatment team member from an **adult** program)

> *"The greatest need that I've noticed in the years that I've worked with [service provider] is that I would say 75% of the clients that are referred to us and that we take have no family contacts. And so, they kind of draw to us because clients look to us as family. The main way that we address the need is we, well, under our contract we have to meet with the member and have at least two contacts with the member per week. But for clients who need more attention than that, then we will definitely make that decision that we need to see them more than two times a week."* (A treatment team member from an **adult** program)

Multiple treatment team members from **adult and youth** programs said that the greatest need among clients was managing activities of daily living, including tasks like managing personal finances, applying to jobs, accessing social benefits, upkeeping personal hygiene, and cleaning their apartments.

> *"Probably budgeting their finances. A lot of our members receive social security benefits, so they're on a pretty fixed income. And then connecting their other resources, so if they need to get CalFresh or if they are interested in building job skills, getting connected to VRS, which is vocational rehabilitation services. And then sometimes, it's just kind of coaching them on their ADLs. We have some clients who have a low level of insight, and so talking to them about what a hygiene routine looks like, how often you should be*

showering, what it looks like to take a shower, what kind of items do you need." (A treatment team member from an **adult** program)

Accessing mental and behavioral health support was also mentioned as a greatest need, especially for individuals who faced suicidal ideation and aggressive behaviors. Treatment team members from **adult and youth** programs highlighted the importance of this need, as mental health challenges impact a variety of other aspects of life, such as finding and maintaining housing or employment, academic performance, or adherence to prescription medication.

> *"Overall, if I have to categorize, I would say there's a lot of aggressive behaviors that I'm seeing, needing support with a lot of suicidal ideation, school refusal [...] So those are some of the needs that I feel like I work on with the clients the most, is those kind of behaviors that are impacting just their day-to-day functioning."* (A treatment team member from a **youth** program)

Impact of the COVID-19 Pandemic

Client Experience

When clients were asked about the impact of the COVID-19 pandemic on FSP program services, four of them indicated that the services they received were negatively affected. Clients' perspectives about the impact of the pandemic included inaccessibility of program services or external resources, virtual services being less effective than in-person services, and difficulty adhering to the six-foot social distancing requirement. For example, one older **adult** client expressed that the pandemic created a barrier to accessing treatment services and external resources, including stable housing. They stated,

> *"The COVID-19 really made everything haywire. It made everything a lot worse, and harder to get services…Harder to go to a house long term."* (An **older adult** client)

One **parent** shared that when their child's services transitioned to virtual platforms, they were not as effective as in-person services. They explained that *"it wasn't like they weren't trying, but I really do think…just being in front of them is a better situation."* An **adult** client indicated that they met with their case manager, who helped set up a computer for virtual counseling appointments, but they could not adhere to the six-foot social distancing requirement during these in-person interactions. They further articulated that having the case manager sit next to them during their virtual appointments was uncomfortable, and said,

> *"There was no way to not be six feet from each other. So, I felt like we were constantly being exposed to whatever case manager was handling my case at the time... And even if we were gloved and masked, we still would have to sit next to each other while [the doctor] would be trying to have a small counseling session with me. And that made it awkward because it didn't feel confidential."* (An **adult** client)

Although their services were impacted by the pandemic, clients shared that treatment team members continued to support them. One older **adult** client expressed appreciation that treatment team members called frequently to check on them, brought food for them, and continued to offer transportation services.

> *"Well, during COVID they brought me food. They called and checked in and if I needed transportation, they were there for that...Yeah, they just been through everything."* (An **older adult** client)

The second client, a **parent** of a youth program client, also indicated that they received food assistance from the program, and said,

> *"During the pandemic they helped us with some cards we used for food."* (A **Parent**)

On the other hand, one **adult** client reported that the services they received during the pandemic was actually increased and mentioned that they were able to get vaccines earlier through the help of the FSP program. They also noted that infected people from their housing program were adequately isolated and were provided with meal and supplies.

> "*It actually increased. I was able to get the vaccine during the first wave of vaccination, because where I live in my apartment, it's an enclosed apartment building. So, we were able to get the vaccine at the first wave of them giving out the vaccine. [...] And we only had three COVID incidents in our 33 dwellings, 33 apartments. And we only had three cases and then they isolated us. I didn't get COVID, but the people that did were provided with meals in their rooms so they can isolate. They provided them with everything that they needed to. They quarantined one of the restrooms for them. They kept them isolated from the rest of us so we wouldn't have an outbreak.*"
> (An **adult** client)

Treatment Team Experience

Like clients, treatment team members from **adult and youth** programs also noted that the services they offered were negatively impacted. Treatment team members perspectives about the impact of the pandemic included having to limit services and resources, pivoting to meeting clients outside or virtually, and inability to connect or get in touch with clients easily.
A treatment team member from an **adult** program said,

> *"COVID was a struggle because even though we worked through COVID, it changed our operating system because we used to have clients that come into our office, and for clients that were homeless, it kind of felt like they always had a place to go. We went into COVID and we didn't have that option because clients weren't able to come into our office and we still aren't having clients come into our office. That's a big piece that our*

clients are missing. [...] it affected us in a big way because, during COVID, even though we were still working and were making contact with our members, we were only making contact through phone calls. And if a client had an appointment before the pandemic, we would take our clients to appointments. But once the pandemic hit, we had to start outsourcing transportation for our clients to get to appointments because we weren't allowed to transport with clients." (A treatment team member from an **adult** program)

A treatment team member from a **youth** program agreed that in-person services were impacted by the pandemic, but shared ways that their clients have adapted to the changes. They said,

"Well, definitely I believe that being one-on-one, eye to eye contact, being in person, hands on, yes, that definitely [was] impacted. But at the same time, until this day now, even though we can meet in person, at least with me, most of my families, they choose to be still [on] Zoom. And the reason being is because... they're saving on gas or time or they're tired from work. That means they're going to have more quality time with the families. So, we adapt." (A treatment team member from a **youth** program)

Recommendations

This section presents recommendations for both future data collection and the FSP program implementation based on the report findings.

Overarching Recommendations

Overall, the combined findings across the self-reported data, EHR data, and client and treatment team member interviews suggest that the FSP program has improved outcomes across all populations served. Furthermore, the key-informant interviews illustrate a high level of satisfaction with the program. These findings suggest the program should continue to expand and serve the needs of county residents. At the same, while there is consistent evidence of improved client-level outcomes each year, the data collection process and content from interviews help illuminate some challenges and possible solutions.

Quantitative Data Collection

Currently, Telecare cannot provide FSP partners' data prior to December 2018. Therefore, the sample size for Telecare does not reflect the actual enrollment and impact of the FSP program for those enrolled with Telecare. AIR recommends integrating Telecare data into the existing self-reported data from Edgewood/Fred Finch and Caminar providers for analysis in future quantitative program evaluations. Doing so will allow us to report consolidated results for all providers since FSP inception in 2006 and enhance data completeness and quality. AIR is in ongoing conversations with Telecare to develop a process to upload their historical and current data to the state data reporting system. AIR is working with Telecare to convert their self-reported data into the accepted format by the state reporting system that can then be merged with data from the other FSP providers.

Qualitative Data Collection

Improving Recruitment Strategies

This year we conducted the first qualitative data collection to better understand the implementation of the FSP program. We planned to complete 30-35 interviews, with the expectation that we would recruit roughly equal numbers of participants from all four service providers (Caminar, Telecare, Edgewood, and Fred Finch). However, Fred Finch was unable to identify any interested clients or treatment team members, resulting in 23 completed interviews. After discussion with the SMC BHRS team, we decided to conclude the qualitative data collection with the 23 interviews. Based on our experience in this year's recruitment, inputs from the SMC, and our experience from other similar qualitative data collection

activities, we propose the following recommendations for improving recruitment for future data collection.

- **Earlier recruitment activities:** Starting the planning for recruitment earlier can provide ample time to identify, approach, and secure commitments from potential interviewees. It allows for addressing any unforeseen challenges and gives participants adequate time to adjust their schedules. In addition, more frequent reminders and check-ins as needed could help improve recruitment of clients and treatment team members.
- **Tailor outreach**: We recommend customizing outreach efforts for each service provider. Before the recruitment activities, it might be helpful to have a virtual meeting with each service provider's stakeholders, where we could introduce the project's aim and significance. We can use these meetings to understand their unique challenges and work with them to co-create recruitment strategies that suit their contexts.
- **Future RFP requirements**: If feasible, SMC may consider adding a requirement for service providers participating in data collection activities in future RFP releases.

Future Program Implementation

Strengthen Communication between Clients and Treatment Team

Although clients reported satisfaction with their case managers and treatment team, they noted some areas of improvement. Some clients mentioned an initial lack of communication with their therapist that affected their satisfaction with the program, and one commented that their initial interactions with team members felt unstructured. Given the initial intake is typically the first exposure clients have with the FSP program, it is necessary to ensure the process is thorough and informative and sets a positive tone to build rapport moving forward. To address this gap, we recommend BHRS should work with service providers to develop standardized introductory text for team members to follow during the initial intake. The introduction could provide clear and comprehensive information about the treatment team members, their roles, and the services they offer. This information will help set clear expectations from the beginning and ensure that all clients, regardless of treatment team member, understand who will be involved in their care journey and what to expect in follow- up care.

Beyond the initial intake with client, it is important to ensure team members provide more consistent and responsive communication throughout the course of program interactions. To this end, we suggest providing guidelines to case managers for responding in a timely manner to client inquiries and messages. If a case manager is managing a large caseload, FSP service providers could consider implementing systems that ensure clients' messages are acknowledged and addressed within a reasonable timeframe. Another strategy would be to

establish a feedback mechanism where clients can provide input on their experiences with specific treatment team members. Brief surveys can help identify areas for improvement and ensure that adjustments are made based on client feedback.

Improve Staff Retention through Additional Staff Training, Community Building, and Mental Health and Safety Resources

The treatment team is the backbone of the FSP program, and continual investment in team members is crucial to creating and maintaining effective relationship-building with clients. Interviews with treatment team members highlighted concerns around staff burnout and a desire for increased collaboration among them. To address noted challenges, we recommend a multifaceted approach that focuses on providing treatment team members with enhanced staff training, mental health resources, and team-building initiatives:

- **Implementation of a comprehensive and ongoing staff training program.** Some treatment team members suggested that enhanced staff training programs may aid in improving staff retention. One treatment team member noted that greater substance use disorder training would be helpful since it is an emerging area with broad impact across various team members. AIR recommends BHRS should work with service providers to offer more ongoing staff training opportunities, especially for specialties like SUD, with an emphasis on hands-on engagement and structured training for new staff. This training should also emphasize effective client engagement, communication, and rapport-building skills. By broadening the skill set of the treatment team members, they will be better equipped to manage their caseloads and provide more personalized support to clients.
- **Provide mental health resources.** In addition to training opportunities, steps should be taken to prioritize the mental health and well-being of the staff. Several team members reported feeling burnt out due to the challenging and potentially dangerous situations with clients. We suggest BHRS work with the service providers to offer their staff mental health workdays and accessible mental health resources, such as counseling services and stress management workshops through something like an Employee Assistance Program. Additionally, one treatment team member mentioned they would like resources to feel better equipped when facing potentially dangerous client situations. We recommend establishing protocols and resources to address potential secondary trauma or burnout that may arise from working with clients dealing with challenging emotional experiences.
- **Incorporate team-building activities.** Another important step that can be taken is to create a supportive working environment. This can mitigate feelings of burnout and encourage team members to collaborate, share insights, and learn from one another. Additionally, there is documented evidence that team bonding activities can boost motivation, increase employee engagement, and improve confidence, all of which contribute to greater morale

and productivity in their role.[7] To foster a sense of community among the treatment team members and address burnout and isolation concerns, we recommend the implementation of team-building activities. Other ideas include creating in-person or virtual staff support groups and forums for sharing experiences and strategies.

- **Incentives to boost longer-term retention.** We suggest the implementation of longer-term retention strategies that go beyond immediate staff concerns. This would include offering career development opportunities, pathways for advancement, and incentives for long-term service, such as special recognitions or rewards for staff member dedication on significant anniversaries or career milestones.

By combining these measures, FSP service providers can build more resilient and effective FSP treatment teams. This, in turn, will strengthen client-staff relationships, improve program outcomes, and reduce staff turnover rates, benefiting both the staff and the clients they serve.

Expand workforce and increase diversity

While clients are satisfied and appreciative for the services they received from treatment team members, especially their case managers, some clients expressed frustration that sometimes their case managers are not available for their needs, and other clients requested more frequent psychiatric services. Understandably, given the workload of treatment team members and the varying and greater needs of program clients, it is difficult to accommodate all the requests from clients. Addressing such an issue may require workforce adjustments. In addition to the staff retention measures we recommended above, if resources permit, we recommend BHRS work with service providers to recruit additional team members, especially case managers, to not only better serve FSP clients but also alleviate the burden for current members. Another strategy to consider is redistribution of tasks. If possible, non-essential tasks can be redistributed so that essential team members like case managers can focus on core responsibilities. This can be done by hiring administrative assistants or employing technological tools.

In the process of expanding the workforce, we recommend a focus on increasing workforce diversity. FSP clients come from various culture and background and may use a primary language that is different from English. A few treatment team members mentioned the need for more bilingual staff members. Having a workforce that mirrors the diversity of the clientele may enhance service delivery and ensure that clients feel understood and represented. Increased linguistic competency can also ensure clear communication and build trust with

[7] Nielsen, K., Nielsen, M. B., Ogbonnaya, C., Känsälä, M., Saari, E., & Isaksson, K. (2017). Workplace resources to improve both employee well-being and performance: A systematic review and meta-analysis. *Work & Stress, 31*(2), 101-120.

clients. In addition, it may be beneficial to conduct diversity and inclusion training sessions for all staff members to foster a workplace culture of understanding and respect, ensuring that clients from all backgrounds feel welcome and understood.

Expand access to and availability of FSP sessions

Some clients, including a **parent** of a child with suicidal ideation, expressed concerns about securing consistent therapy sessions. A potential first step to fill this gap is by conducting a comprehensive assessment of the treatment team's capacity to offer more sessions. Specifically, FSP providers should consider offering "emergency" or "urgent" sessions to accommodate clients' needs, especially when urgent or critical. Another viable option is for FSP providers to hold "office hours" or a regularly scheduled block of time each week for urgent/emergent issues. As needed, a mix of in-person and virtual sessions can be offered to increase flexibility and accessibility to align with clients' preferences and circumstances. Research suggests that virtual therapy options are as effective as face-to-face sessions while reducing traditional burdens related to travel and transportation.[8] Some clients may be even more comfortable with virtual sessions, especially younger clients who are used to interacting with people through technology.[9] Although some clients reported that they prefer in-person services, virtual sessions can serve as an effective alternative to address clients' urgent psychiatric care needs when case managers need more flexible scheduling options.

Ensure consistent case manager assignments

Relatedly, one theme underlying limited session availability and communication that emerged from the interviews is inconsistent case manager assignments. Some clients voiced that inconsistent case manager assignments resulted in communication problems and differing service quality levels. Given these concerns, AIR recommends that BHRS should work with the FSP service providers to set clear guidelines for assigning case managers and only stray from them in exceptional circumstances. This might involve a provider-level survey before new cases are assigned to assess individual strengths and workload capacities. Caseload distribution should only be done if providers are overwhelmed with too many cases or crises to manage simultaneously. Assigning clients to the same case manager whenever possible can help foster a sense of continuity and trust, leading to better client-staff relationships and improved outcomes.

[8] Carlbring, P., Andersson, G., Cuijpers, P., Riper, H. and Hedman-Lagerlöf, E., 2018. Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis. *Cognitive behaviour therapy, 47*(1), pp.1-18.

[9] Sweeney, G. M., Donovan, C. L., March, S., & Forbes, Y. (2019). Logging into therapy: Adolescent perceptions of online therapies for mental health problems. *Internet interventions, 15*, 93-99.

Streamline care coordination efforts and data management between staff members

Treatment team members shared different ways of managing and sharing clients' progress, needs, and other information. Some service providers use tools such as dashboards to record and track information about the clients. Other service providers elect to use informal ways through conversations, note-taking, and group meetings to gauge client progress. While multiple ways work, some treatment team members noted issues when taking over the caseloads of previous or departing staff members due to a lack of standardized assessment, often relying instead on progress notes to determine the frequency of meetings, treatment plans and updates for individual clients. Gathering all the necessary information from across varying sources requires additional time and can contribute to delays in the onboarding process. The feedback from treatment team members highlights the need for improved communication practices within and across programs. To provide transitional support, we recommend BHRS collaborate with providers to establish a standardized client data system, including a standard client progress assessment form, to facilitate information gathering, management and sharing across team members. Efficient sharing and documentation are pivotal not only for streamlined operations but also to maintain data integrity and security, especially when it involves sensitive client information. Service providers can consider implementing a HIPAA-compliant document management system or a built-in mechanism through the electronic health record system currently in use. Such systems not only allow for centralized storage of data and facilitate easy access by authorized team members from any location and on any device, but also enable role-based access to the sensitive client information.

Consider providing housing coordination and assistance for discharged clients

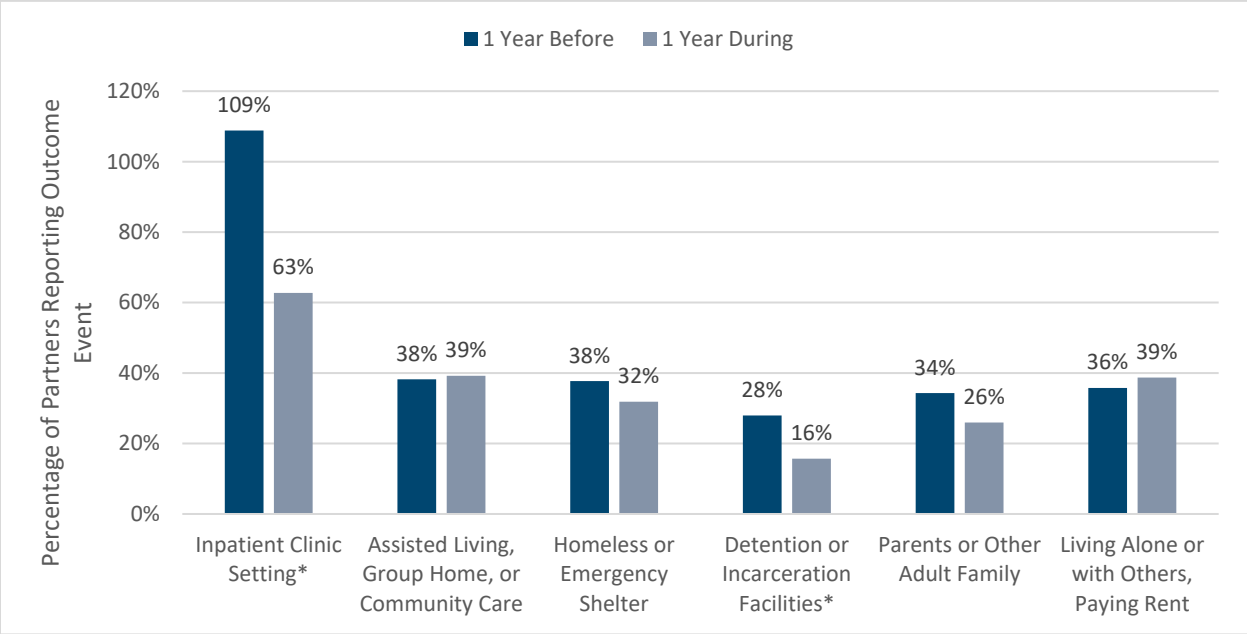
A treatment team member provided perspectives on housing that may need to be considered. They noted that they have clients who are ready to be discharged from the FSP program, but their housing funding is connected to the FSP program. Therefore, discharging a client means that they would lose their housing. To address this dilemma, we recommend BHRS work with service providers to provide housing coordination and assistance, in the form of housing vouchers for example, for discharged clients. Such measures could help discharged clients to transition back to independent living in the community and could alleviate the treatment team's hesitation about discharging a client, which in turn may help save FSP program resources and distribute those to other clients in need.

Appendix A. Additional Detail on Residential Outcomes

For residential setting outcomes by full service partnership (FSP) provider, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. There are currently four comprehensive FSP providers in San Mateo County (the County): Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch), serving children, youth, and transitional age youth, and Caminar and Telecare, serving adults and older adults. A list of all residential settings and how they are categorized is presented in Appendix C with the methodological approach.

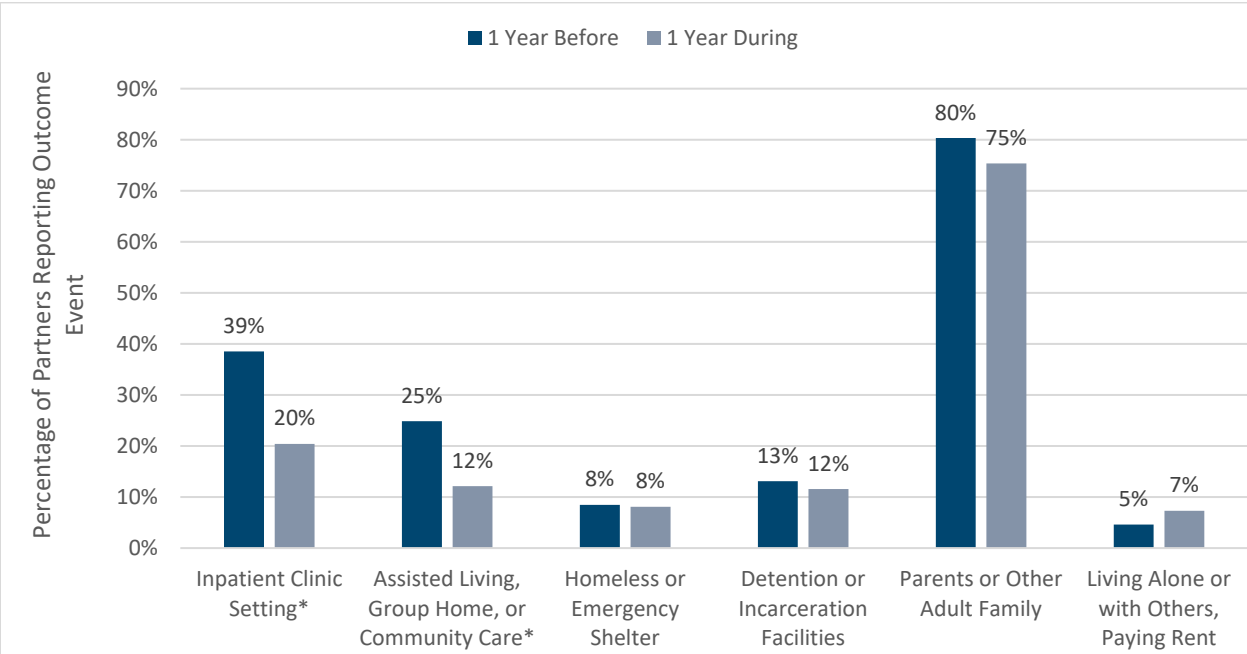
We used self-reported data from Caminar for Exhibit A1, data from Edgewood/Fred Finch for Exhibit A2, and data from Telecare for Exhibit A3. As shown in Exhibits A1–A3, the percentage of clients reporting any time in an inpatient clinic or living with parents decreased. Further, the percentage of clients who were homeless or living in a shelter decreased for Caminar and Telecare and remained the same for Edgewood/Fred Finch partners. In contrast, the percentage of clients who reported any time living alone or with others/paying rent increased or remained the same, signaling some improvement in independence. Inconsistency across providers is observed for clients reporting any time in assisted living, group home, or community care environment, where the percentage for Caminar and Telecare partners increased between the two consecutive years, and the percentage for Edgewood/Fred Finch partners decreased. For detention or incarceration facilities, there were reductions in percentage of partners reporting any time in such facilities for Caminar and Edgewood/Fred Finch; the percentage increased among Telecare partners but is not statistically significant. Asterisks in the exhibits denote outcomes that are statistically significant.

Exhibit A1. Percentage of Caminar Partners Completing One Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 204)



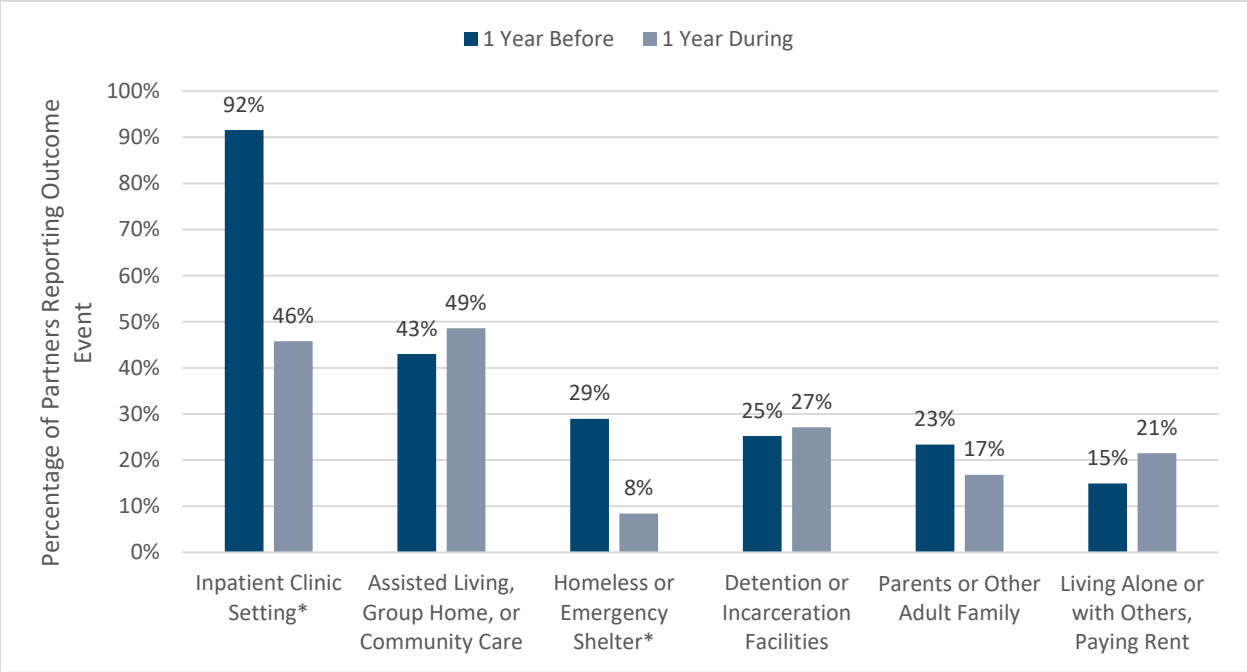
Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit A2. Percentage of Edgewood/Fred Finch Partners Completing One Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 519)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit A3. Percentage of Telecare Partners Completing One Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 107)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Appendix B. Additional Detail on Outcomes by FSP Providers

This section provides outcomes by each provider.

Exhibits B1–B3 present the percentage of partners with any events the year just prior to full service partnership (FSP) enrollment and the first year in an FSP, as well as the percent improvement for each FSP provider. Percent improvement is the change in percentage of partners who experienced the named event in the first year of FSP participation relative to the percentage of partners experiencing the event in the year prior to participating in an FSP.

As shown in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. Among these, outcomes on detention or incarceration, arrests, mental, and physical health emergencies are statistically significant.

Exhibit B1. Percentage of Caminar Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 204)

Survey outcomes, Caminar	1 year before	Year 1 during	Change (%)
Homelessness	38%	32%	-16%
Detention or incarceration	28%	16%	-44%*
Employment	1%	3%	400%
Arrests	21%	4%	-79%*
Mental health emergencies	71%	27%	-62%*
Physical health emergencies	38%	12%	-69%*
Active substance use disorder	49%	47%	-5%
Substance use disorder treatment	19%	22%	15%

Note. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Exhibit B2 shows improvement for Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch) partners in all outcomes except for self-rated academic grade and school attendance. All but the outcomes on homelessness and detention or incarceration are statistically significant.

Exhibit B2. Percentage of Edgewood/Fred Finch Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 519)

Survey outcomes, Edgewood/Fred Finch	1 year before	Year 1 during	Change (%)
Homelessness	9%	8%	-5%
Detention or incarceration	13%	12%	-12%
Arrests	18%	6%	-68%*
Mental health emergencies	42%	8%	-82%*
Physical health emergencies	15%	1%	-92%*
Suspension	14%	5%	-63%*
Academic grade	3.31	3.02	**-9%***
School attendance rating	2.30	2.13	**-8%***

Note. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

As shown below in Exhibit B3, there are improvements when comparing the year prior to FSP to the first year during FSP for Telecare on four out of eight available self-reported outcomes. Of these, outcomes on homelessness, arrests, and active substance use disorder are statistically significant. Worsened outcomes are observed for detention and incarceration, and mental and physical health emergencies, though only the outcome for mental health emergencies is statistically significant. Additionally, fewer partners reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may help explain the decrease in reported treatment. The percent difference with employment is reported as N/A because the percentage of partners with employment did not change (from 0% to 0%). Therefore, the denominator is 0.

Exhibit B3. Percentage of Telecare Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the First Year of FSP Participation) (*N* = 107)

Survey outcomes, Telecare	1 year before	Year 1 during	Change (%)
Homelessness	29%	8%	-71%*
Detention or incarceration	25%	27%	7%
Employment	0%	0%	N/A
Arrests	33%	12%	-63%*
Mental health emergencies	16%	37%	**135%***
Physical health emergencies	11%	17%	50%
Active substance use disorder	61%	33%	-46%*
Substance use disorder treatment	7%	4%	-50%

Note. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Appendix C. Quantitative Methods

Methodology for Full Service Partnership Survey Data Analysis

The full service partnership (FSP) survey data are collected by providers through discussions with partners and should thus be viewed as self-reported outcomes. Among the providers included in these analyses (Edgewood Center and Fred Finch Youth Center [hereafter, Edgewood/Fred Finch], Caminar, and Telecare), 830 partners completed a Partner Assessment Form (PAF) at intake and completed a full year with FSP since program inception.

In general, three data sets are obtained for this report: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. All providers provide their data sets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Because of data reliability issues, Telecare only provided the data after its data system change—that is, data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch partners, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child partners and transitional age youth (TAY) partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Caminar's older TAY partners (N = 64) are excluded from the TAY-specific self-reported outcomes because Caminar does not reliably complete the ongoing program surveys for this age group (i.e., KET, 3M). Exhibit C1 describes the age group of partners completing at least 1 full year of FSP from 2006 to 2023 by provider. For Telecare, these data include December 2018 through June 2023.

Exhibit C1. Age Distribution of Partners with Minimum of One Full Year of FSP Participation, by Provider

Age group	Edgewood/ Fred Finch	Caminar	Telecare	Total[a]
Child (ages 16 and younger)	232	—	—	232
TAY (ages 17–25)	287	64	10	361
Adult (ages 26–59)	—	116	70	186
Older Adult (ages 60+)	—	24	27	51
Total	519	204	107	830

[a] Telecare partners in the analysis include only those who joined the FSP after December 1, 2018, due to data availability. Telecare partners were not reported in the survey outcomes by age group. A separate analysis was conducted for Telecare partners; it combines all age groups because of small sample size.

A comprehensive 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 participation in an FSP (using Global ID), as indicated in the state's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the partnership assessment form (PAF) data.

- For Caminar and Edgewood/Fred Finch, this was done by selecting records with specific Age Group codes, which are:
  - Caminar: Selected records with Age Group codes of "7" (TAY partner, ages 17 to 25), "4" (adult partner, ages 25 to 59), and "10" (older adult partner, ages 60 and older).
  - Edgewood/Fred Finch: Selected records with Age Group codes of "1" (child partner, ages 16 and younger) and "4" (TAY partner, ages 17 to 25).
  - In both cases, this was confirmed using the data file's continuous *Age* variable.
- For Telecare data, partners were given an age appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF," "Adult_PAF," and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2023.

All data management and analysis were conducted in Stata. 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 Exhibit C2.
2. The baseline data were populated using the variable *PastTwelveDays* (Caminar and Edgewood/Fred Finch) or *res_past12m_days_int* (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. The partner's first residential status after they joined FSP is determined by the *Current* (Caminar and Edgewood/Fred Finch) or *res_curr_dsr* (Telecare) collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there was one residence with a later date (as indicated by the variable *DateResidentialChange* [Caminar and Edgewood/Fred Finch] or *main_resident_date* [Telecare]), this residence was the first residential setting. If the residences were marked with the same date, both were considered part of the partner's first year in an FSP.
4. Additional residential settings for the first year were found using the key event tracking (KET) data, inclusive of all residence types listed with a corresponding date of residential change (*DateResidentialChange* [Caminar and Edgewood/Fred Finch] or *main_resident_date* [Telecare]) occurring within one year of the FSP partnership start date. If no residential data were captured after the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2. Residential Setting Categories and Corresponding Classification Values Used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with nonrelative	5

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
Homeless or emergency shelter	
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Level 0–11)	11
Group home (Level 12–14)	12
Community treatment	13
Residential treatment	14
Inpatient facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't know	
Don't know	18
Other	17

[a] Setting names determined by the following guide:
http://www.dmh.ca.gov/POQI/docs/FSP_Data_Dictionary_October_2011.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a nonzero, nonblank value for one of the following variables (note that variable names differ slightly by data set):
    a. Any competitive employment in the past 12 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 the past 12 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 any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in an FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the partner was assumed to have zero arrests in the year prior to FSP.
2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET contained no information on arrests, the partner was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* [Caminar and Edgewood/Fred Finch] or *emr_mental_p12* [Telecare]) and physical health emergencies (*PhysRelated* [Caminar and Edgewood/Fred Finch] or *emr_physical_p12* [Telecare]), respectively. If either of these fields were blank, the partner was assumed to have had 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, if the date is within the first year with an FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1" = physical; "2" = mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year of an FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* [Caminar and Edgewood/Fred Finch] or *sub_co_mh_sa_probl_past* [Telecare]) and participation in substance use disorder treatment and recovery services (*AbuseServices* [Caminar and Edgewood/Fred Finch] or *sub_sa_services_now* [Telecare]). If these fields were blank, the partner was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.
2. Ongoing substance use disorder data were populated using the 3-month data variables of the same name. Any record of an active substance use disorder or participation in a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for County EHR Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain emergency care in the San Mateo County (the County) hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 906 partners who were both (a) included in the County's EHR system and (b) completed 1 full year or more in an FSP program by the June 2023 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2023.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and psychiatric emergency services (PES) admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the corresponding program codes. In addition, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3. Program Codes Among Clients Ever in an FSP

Program code	Program value
Psychiatric hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric emergency services	
410702	Z410702 SMMC PES-termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Note. Data represent all utilization from FSP clients for these codes, as pulled from Avatar on October 17, 2023.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode_history* table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the County's EHR data and the FSP survey data. This is likely because of the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the County's EHR data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

Appendix D. Qualitative Methods

Methodology for Full Service Partnership Interviews

Participants

This analysis included 23 completed interviews with 9 clients and 14 treatment team members. AIR worked with San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) staff and the four FSP service providers (Exhibit D1) to recruit clients and treatment team members. Exhibit D2 presents the number and types of clients and wraparound treatment team members that we have interviewed and included in this analysis across the FSP service providers. Note that we were not able to recruit participants, either treatment team members or clients, from Fred Finch after several attempts.

Exhibit D1. FSP Service Providers

Service Provider	Description	Population served
Edgewood Center	Edgewood's FSP provides services to help clients stabilize and maintain current placements, while offering comprehensive mental health services.	Children, youth, and transitional age youth (TAY)
Fred Finch Youth Center	Fred Finch Youth & Family Services FSP serves foster youth and provides an array of services to promote wellness, resilience, and stability in the youth's home. Services include safety planning and behavioral interventions, as well as family and individual support.	
Caminar	Caminar FSP provides services to individuals who are among those in most need in San Mateo County and integrates streamlined, holistic health care utilizing the best-practice model of assertive community treatment. The team includes the added benefit of medical clinic services and a 24-hour on-call emergency response service.	Adults and older adults
Telecare	Telecare FSP provides "Integrated Service Delivery" to San Mateo County residents who have symptoms commonly associated with a profound psychiatric disability (or disabilities) and who may also have co-occurring disorders (such as substance use or medical conditions), and serious life stressors such as problems obtaining or maintaining housing or involvement with the legal system.	

Exhibit D2. Summary of Interviewees

FSP Service Provider(s)	Clients	Wraparound Treatment Team
Edgewood Center **Fred Finch Youth Center***	3 parents of youth program clients who have accessed services through FSP in the last year or are currently accessing services through FSP	• Program manager (1) • Emerging adult partner/Peer partner (1) • Family partner (1) • Behavior coach (1)
Caminar **Telecare**	3 older adult clients and 3 adult clients who have accessed services through FSP in the last year or are currently accessing services through FSP	• Program manager (2) • Case managers (4) • Behavioral health clinician(s)/Substance use specialist(s) (1) • Crisis response workers (1) • Housing specialists (2)
Total Interviewees	**9**	**14**

*Fred Finch Youth Center was not able to identify any participants.

Interview Format and Length

Each interview lasted about 30 minutes in length and was conducted virtually using Zoom software. When participants had technical difficulty with the Zoom software, we conducted interviews by directly calling clients or treatment team members. The interviewer obtained consent and permission from all participants before starting the recording. There was one participant who did not want to be recorded, for which a note-taker joined the interview and took notes.

Analysis

All interviews except one were recorded and transcribed. For the interview that was not recorded, we used the notes from the interview for the analysis. A deductive method was used to code the transcripts. We then conducted a thematic analysis of the concepts, exploring similarities and differences within and across participants.

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APPENDIX 6. OUTREACH COLLABORATIVES REPORT, FY 2022-23

San Mateo County Behavioral Health and Recovery Services Provider Outreach Annual Report

Fiscal Year 2022–2023

Koray Caglayan, PhD; Brooke Shearon, MPP

December 2023

American Institutes for Research® | AIR.ORG

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Contents

Exhibits

Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act, which provides funding to counties for mental health services by imposing a 1% tax on individuals with personal income in excess of $1 million. The Community Services and Supports component of the act was created to provide direct services to individuals with severe mental illness. The component includes 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). These organizations provide outreach and engagement activities to residents of San Mateo County. Each collaborative also has providers who provide direct services to the populations they serve.

This report summarizes self-reported data from attendees at individual and group outreach events that occurred in fiscal year (FY) 2022–2023 (July 1, 2022–June 30, 2023). Appendices A through H show data for five providers participating in NCOC and three providers participating in EPAPHMO. We also present self-reported data from these outreach events since FY2018–2019 to show how attendance has changed over time.

Total Attendance

For FY2022–2023, SMC BHRS providers reported that there were 5,519 attendees at all outreach events, which reflects a 30.7% decrease in total attendance compared with FY2021–2022 (which saw 7,961 attendees). A decline in attendance at group events attributed to this decrease. During FY2022–2023, SMC providers reached 4,601 attendees across 179 group outreach events, while during FY2021–2022, providers reached 7,144 attendees across 174 group outreach events. The attendance at group outreach events decreased by 35.6% between FY2021–2022 and FY2022–2023. The attendance at individual outreach events showed a modest increase of 12.4%, with an additional 101 attendees served in FY2022–2023 than in FY2021–2022.

Demographic Characteristics of Outreach Attendees

NCOC

There were 4,573 attendees at NCOC outreach events. Among attendees at NCOC outreach events, the most common age group was adults (31%). Over half the attendees were female (58%). The three largest racial/ethnic groups were White (22%), multiracial (12.6%), or Filipino (10.8%). Twelve percent of attendees declined to state their race or ethnicity. Of those

reporting special population status (e.g., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans), 10% of attendees reported being at risk for homelessness, and 7% of attendees reported having a physical or mobility disability.

EPAPMHO

There were 946 attendees at EPAPMHO outreach events. Most attendees were adults (58%) and females (52%). The greatest proportion of attendees by race/ethnicity were Mexican (33%), followed by Native Hawaiian or Pacific Islander (26%). Of those reporting special population status, 48% were at risk for being homeless and 32% were homeless.

Outreach Event Characteristics

NCOC

NCOC individual outreach events ranged from 3 minutes to 2 hours and averaged 38 minutes. Most individual outreach events took place in schools (33%) and over the phone (24%). Most individual outreach events were conducted in English (87.2%), followed by Spanish (11.7%).

NCOC group outreach events ranged from 30 minutes to 6 hours and averaged 83 minutes. Of the 148 group outreach events, most were conducted in schools (39%) or virtually (35%). Most group outreach events were conducted in English (93%), followed by Spanish (5%).

NCOC individual outreach events resulted in mental health referrals (27%) and substance use referrals (3%). Providers made 757 social service referrals for 366 NCOC individual outreach attendees. Among social services referrals, the top five types of referrals were in medical care (24%), other services (20%), food (16%), cultural services (14%), and financial services (8%; see Exhibit 5a) .

EPAPMHO

EPAPMHO individual outreach events lasted from 5 to 35 minutes and averaged 16 minutes. Most outreach events took place over the phone (54%) or in offices (34%). More than half were held in Spanish (60%).

There were 31 EPAPMHO group outreach events that lasted from 30 minutes to 5 hours. Most outreach events occurred in various community locations (39%) and offices (26%) and were conducted in Tongan (42%).

EPAPMHO individual outreach events resulted in mental health referrals (14%) and substance use referrals (72%). Providers made 1,096 referrals for 552 individual outreach attendees. The top five types of other social services referrals made for individual outreach attendees were for

medical care (39%), housing (37%), and form assistance (6%), other services (5%), and health insurance (4%; .

Recommendations

We have the following recommendations based on FY2022–2023 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those intended to improve data collection.

Providing outreach in different languages and offering non-office visits and virtual appointments may have resulted in modest increases in the number of participants attending individual outreach events this year.

Continue to conduct outreach in languages other than English. This past reporting year, outreach events were conducted in languages that represented the residents served by the participating providers. For example, the EPAPMHO collaborative conducted outreach in Spanish because the Mexican population was the largest racial/ethnic population attending these events. Similarly, other EPAPMHO individual outreach events were offered in Tongan and Samoan because participants indicated that these were their preferred languages. Conducting outreach in languages other than English can ensure that the SMC BHRS outreach program is serving the needs of the county's non-English-speaking population. Although there was a modest increase in the number of individual outreach events, there was a sharp decline in attendees at group events. We suggest that collaboratives, in particular NCOC, consider conducting some group outreach events in preferred languages of the county residents, such as Tagalog, Samoan, and Tongan. These strategies may help improve attendance at group events in the coming years.

Continue to offer non-office locations for group and individual outreach events. Data show that many outreach events were conducted in communities and in nontraditional locations, such as over the phone and through telehealth services. Although this may have originally been in response to the COVID-19 pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will give county residents multiple options to avail themselves of the services offered through the program.

Provide social service referrals to attendees at group outreach events as well. The county provides referrals to social services like housing and form assistance to those who attend individual outreach events. The county could consider offering similar referrals to social services during group outreach events as this will help to address attendees' needs and improve their overall health and well-being.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which provides funding to counties for mental health services by imposing a 1% tax on personal income of more than $1 million. Activities funded by MHSA are grouped into various components. 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 with an integrated service experience. CSS has three service categories: (a) Full-Service Partnerships, (b) General Systems Development Funds, and (c) Outreach and Engagement.

The San Mateo County Behavioral Health and Recovery Service (SMC BHRS) MHSA Outreach and Engagement strategy aims to increase access and improve 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 the representation of underserved communities in its system since the strategies were deployed.

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). EPAPMHO caters to transition-age youth and adults; Latino, African American, and Pacific Islander communities; and people who identify as lesbian, gay, bisexual, transgender, and questioning in East Palo Alto. NCOC caters to rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander) and lesbian, gay, bisexual, transgender, and questioning communities in the North County region, including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, and education and outreach to decrease stigma related to mental illness and substance use. They work to increase awareness of and access and linkages to culturally and linguistically competent services for behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure that those in need receive appropriate services such as food, housing, and medical care. Finally, they promote and facilitate resident input into the development of MHSA-funded services and other BHRS program initiatives.

The American Institutes for Research® (AIR®) has supported SMC BHRS in reporting findings from the county's outreach activities since fiscal year (FY) 2014–2015. This annual report provides details on outreach activities conducted by providers in FY2022–2023 (July 1, 2022–June 30, 2023). Providers collected outreach data using an electronic form (SurveyMonkey®) that gathers self-reported information from attendees. AIR created this form

based on interviews with San Mateo County staff and focus groups with providers. After data are entered, AIR cleans them and calculates aggregated counts and percentages to describe outreach activities.

This report focuses on EPAPMHO and NCOC outreach events that occurred during FY2022–2023. We also present historical data from FY2014–2015 to FY2021–2022 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. Summaries are also available to help SMC BHRS and its providers enhance their understanding of each individual provider's outreach efforts. Please refer to Appendices A–H for provider-specific summaries. Exhibit 1 displays the number of outreach attendees in FY2022–2023 by event type (i.e., individual or group) for NCOC providers, including Asian American Recovery Services, Daly City Peninsula Partnership Collaborative, Daly City Youth Health Center, Pacifica Collaborative, and StarVista; and for EPAPHMO providers, including Anamatangi Polynesian Voices, El Concilio, and Free At Last.

Overall Outreach

During FY2022–2023, there were 5,519 attendees at outreach events—918 attendees at individual outreach events and 4,601 attendees across 179 group outreach events. An individual outreach event included a single attendee, while group outreach events included multiple attendees. As stated earlier in this document, the count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Exhibit 1 shows the number of outreach attendees by collaborative, provider, and event type (i.e., individual or group), for FY2022–2023.

Exhibit 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY2022–2023

Provider organization	Number of individual outreach attendees	Number of attendees at group outreach events	Total attendees reported across all events
NCOC			
Asian American Recovery Services	133	959	1,092
Daly City Peninsula Partnership Collaborative	120	1,028	1,148
Daly City Youth Health Center	64	594	658

Provider organization	Number of individual outreach attendees	Number of attendees at group outreach events	Total attendees reported across all events
Pacifica Collaborative	12	1,615	1,627
StarVista	37	11	48
NCOC total	366	4,207	4,573
EPAPMHO			
Anamatangi Polynesian Voices	24	394	418
El Concilio	92	0	92
Free At Last	436	0	436
EPAPMHO total	552	394	946
NCOC and EPAPMHO total	918	4,601	5,519

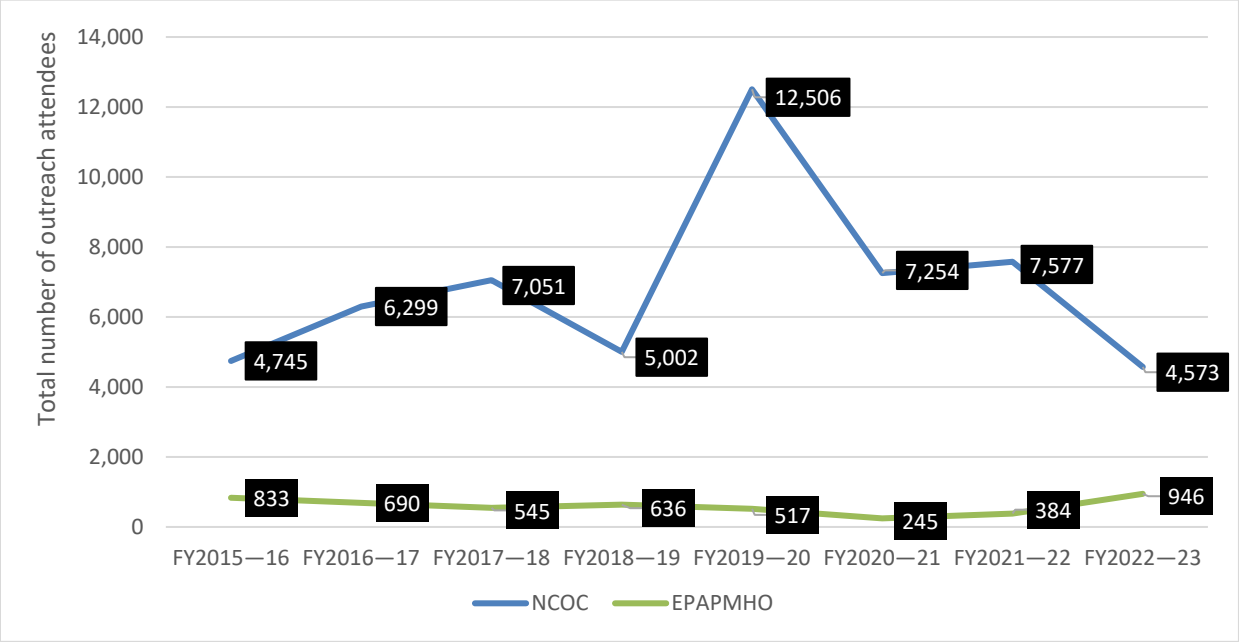
Note. NCOC = North County Outreach Collaborative; EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. Multicultural Counseling and Education Services of the Bay Area changed its name to Anamatangi Polynesian voices.

The NCOC is expected to serve a larger proportion of the outreach collaborative effort because it serves the entire northern region of San Mateo County (estimated population = 139,919), including the cities of Colma, Daly City, and Pacifica. The population of these cities is five times the population of the city of East Palo Alto, which is served by EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach), such as community-wide fairs, more feasible. In contrast, East Palo Alto spans 2.5 square miles, making an individual approach to outreach more achievable.

Exhibit 2 shows the trends in the number of outreach attendees over the years for both collaboratives. The number of NCOC outreach attendees increased annually from 2014 to 2020, with the exception of from FY2018–2019. In FY 2019–2020, the number of NCOC attendees increased significantly likely due to more individuals seeking mental health services during the COVID-19 pandemic. The COVID-19 regional stay-at-home order was issued on March 16, 2020, and services provided from March 2020 to June 2020 showed an increase in outreach because many more residents were likely seeking mental health services in response to the pandemic. Events sponsored by the Daly City Peninsula Partnership Collaborative and the Daly City Youth Health Center also addressed food security during the pandemic (FY2019–2020) by distributing food during the events. A higher attendance at these events may contribute to an overall increase seen in FY2019–2020. There was a sharp decrease in attendance in FY2022–2023 from FY2021–2022.

The number of EPAPMHO outreach attendees decreased from FY2014 to FY2021 but increased from FY2020 to FY2023. The number of outreach attendees served this year was similar to in FY2014–2015.

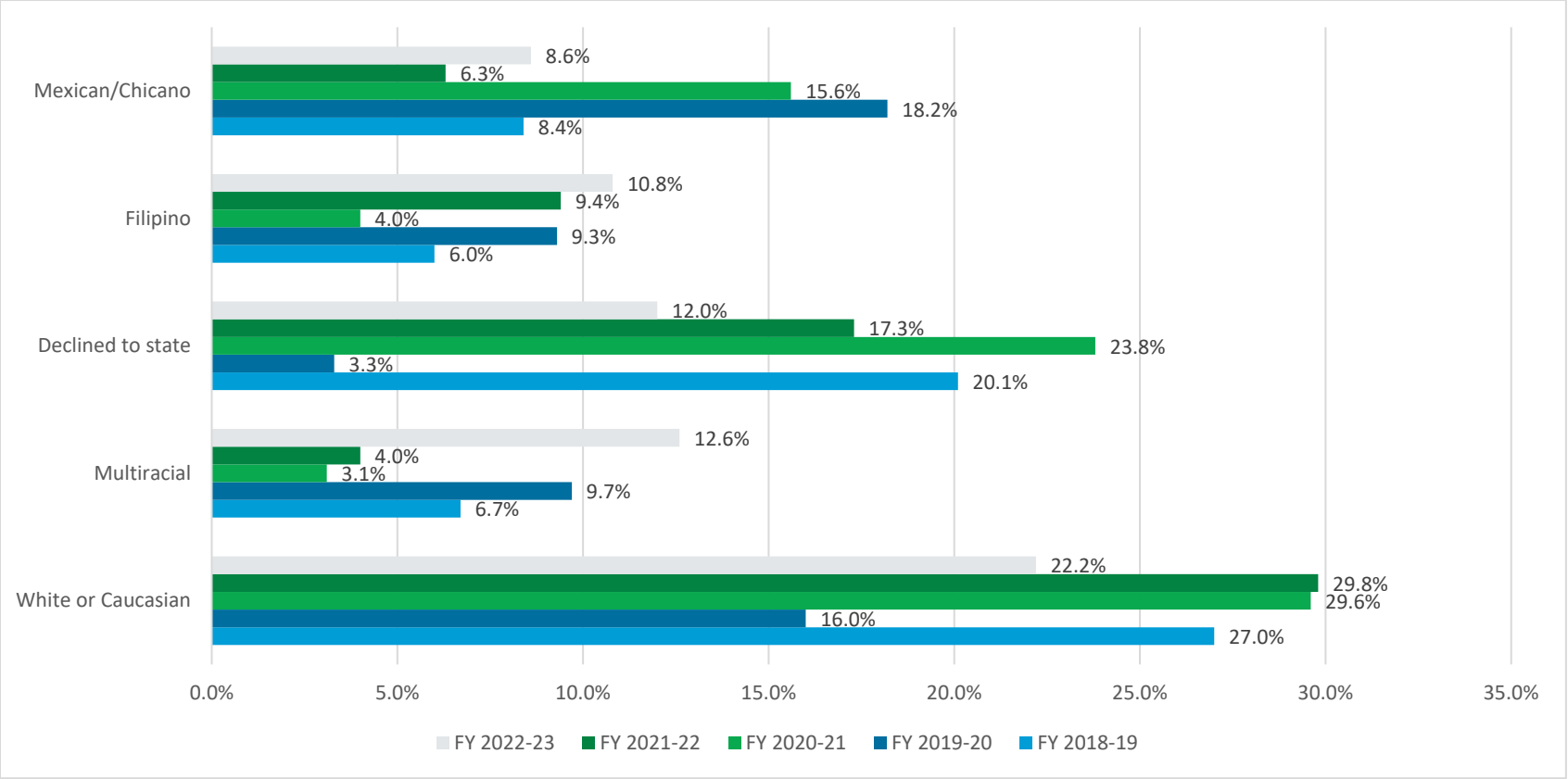
Exhibit 2. Total Outreach Attendees by Collaborative, FY2014–2023



Note. FY = fiscal year; NCOC = North County Outreach Collaborative; EPAPMHO = East Palo Alto Partnership for Mental Health Outreach. The number of attendees from previous fiscal years is slightly higher than the number reported in the previous reports because some outreach data were reported after that fiscal year.

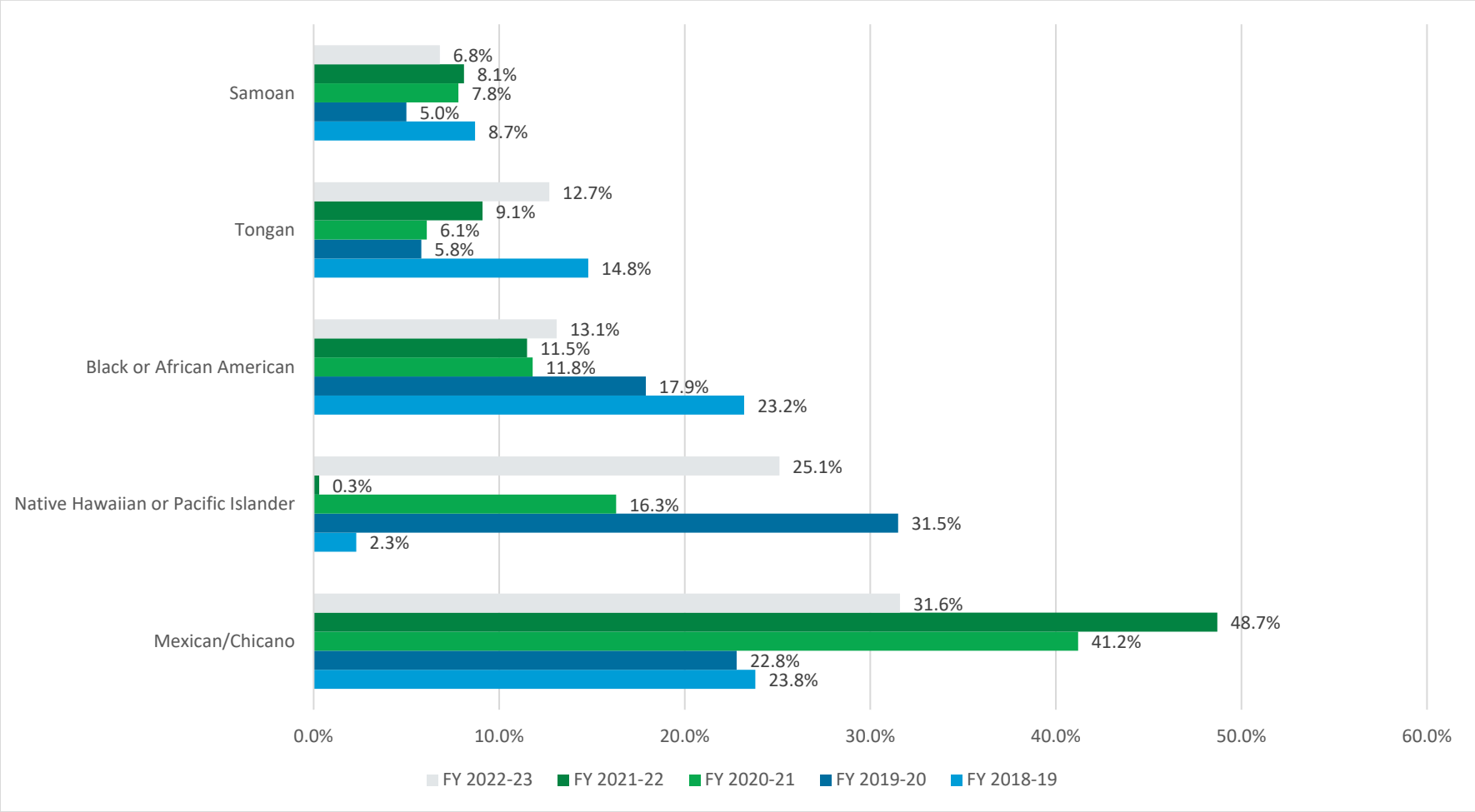
Exhibits 3a and 3b present the proportion of the top five racial/ethnic groups served by individual and group outreach in FY2022–2023 and trends over the past 4 fiscal years (i.e., FY2018–2019, FY2019–2020, FY2020–2021, and FY2021–2022), within each collaborative. A table with the entire breakdown of racial/ethnic groups from FY2018–2019 to FY2022–2023 is presented in Appendix I.

Exhibit 3a. Percentage of the Top Five Racial/Ethnic Groups Served by NCOC in FY2022–2023 and Trends in Prior Years, FY2018–2019 to FY2022–2023



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Exhibit 3b. Percentage of the Top Five Racial/Ethnic Groups Served by EPAPMHO in FY2022–2023 and Trends in Prior Years, FY2018–2019 to FY2022–2023



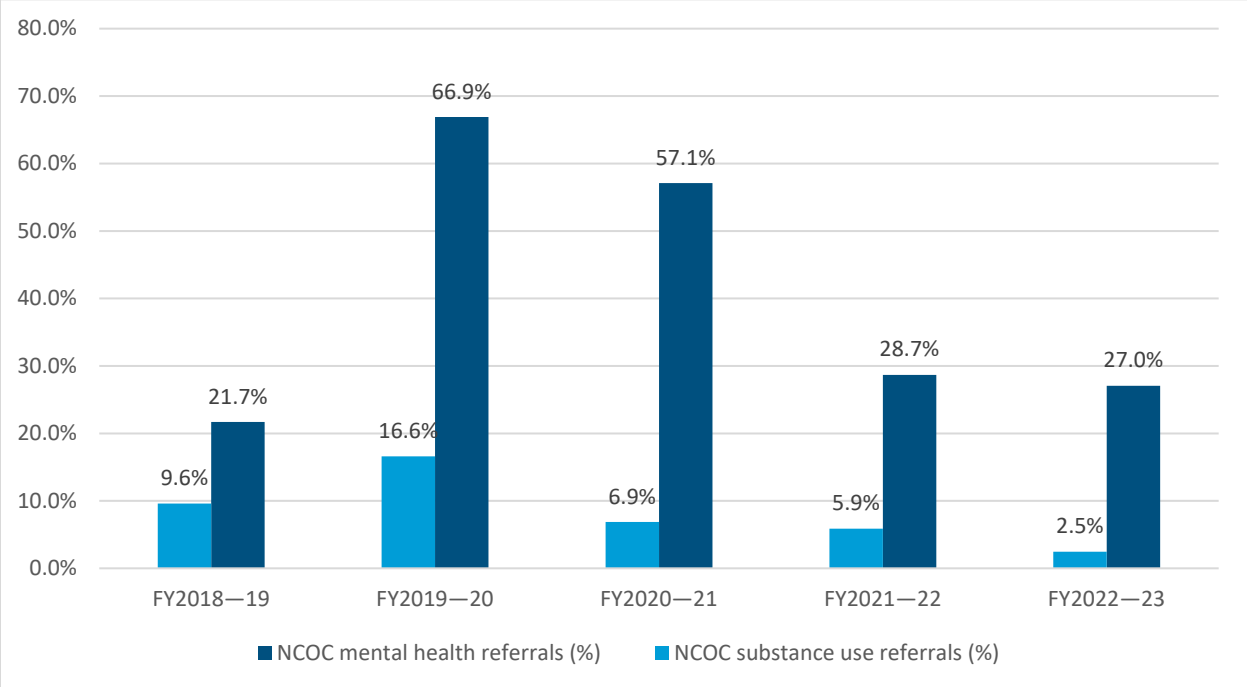
Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

The NCOC has seen decreased outreach numbers this year compared to FY2021–2022 (see **Exhibit 2**), and there are a few key differences in the racial/ethnic demographics of the outreach attendees. For example, the proportion of White or Caucasian attendees decreased in FY2022–2023 compared with FY2021–2021, while the proportion of multiracial, Filipino, and Mexican/Chicano attendees increased. The proportion of attendees who declined to state their race/ethnicity decreased in FY2022–2023 to 12% from 23.8% in FY2020–2021.

The EPAPMHO has seen increased outreach numbers this year compared with FY2021–2022 (see **Exhibit 2**), and there are a few key differences in the racial/ethnic demographics of the outreach attendees. From FY2021–2022 to FY2022–2023, there has been an observed increase in attendance by Native Hawaiian/Pacific Islander and Tongan attendees at these events. However, there has been a decrease in attendees self-reporting their race/ethnicity as Mexican and Samoan.

Exhibit 4a presents the percentages of mental health and substance use referrals by NCOC from FY2018–2019 through FY2022–2023. Compared with FY2021–2022, the percentage of mental health referrals among all referrals did not display a significant change in FY2022–2023, while the substance abuse referrals decreased by 3.4% points.

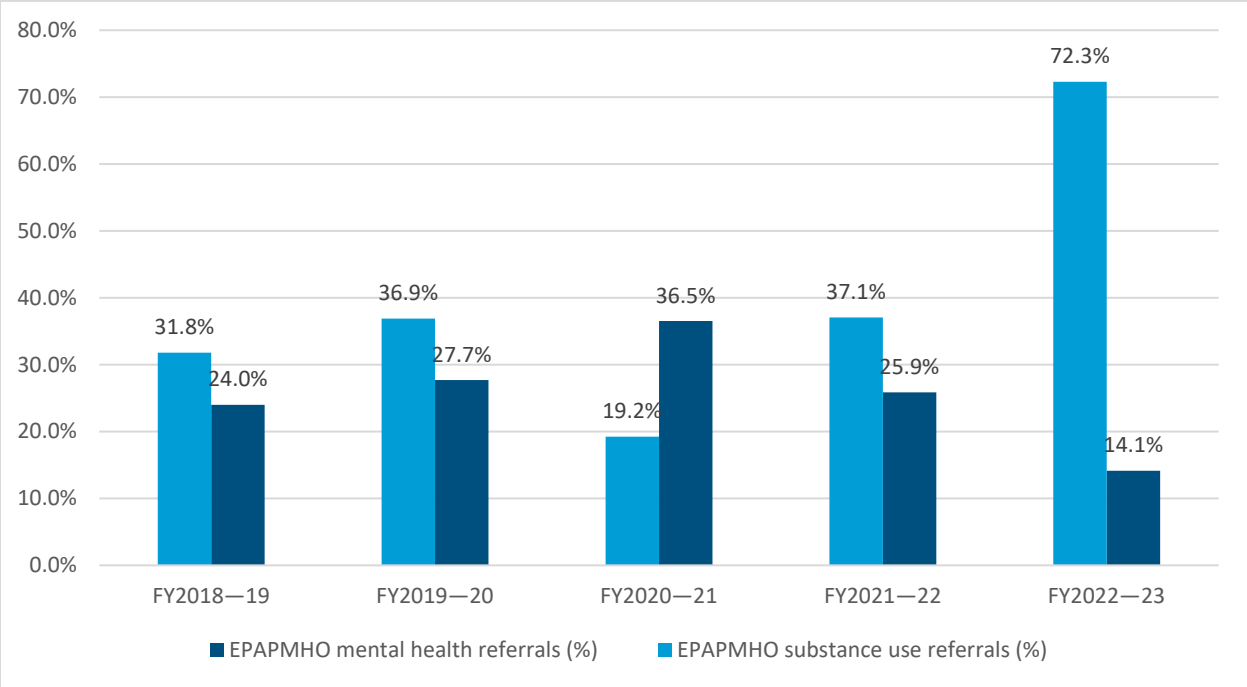
Exhibit 4a. Percentage of Mental Health/Substance Use Referrals by NCOC, FY2018–2019 to FY2022–2023



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

Exhibit 4b presents the percentages of mental health and substance use referrals by EPAPMHO from FY2018–2018 through FY2022–2023. Compared with FY2021–2022, the percentage of mental health referrals decreased by 11.8 percentage points in FY2022–2023. The percentage of substance abuse referrals almost doubled in FY2022–2023 compared with FY2021-2022.

Exhibit 4b. Percentage of Mental Health/Substance Use Referrals by EPAPMHO, FY2018–2019 to FY2022–2023



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year.

Of the 4,573 individuals who attended NCOC events in FY2022–2023, 16.5% had referrals to social services. The percentage of referrals to social services increased over FY2021–2022: of the 7,577 individuals who attended NCOC events in FY2021–2022, 14.3% had referrals to social services. Of the 946 individuals who attended EPAPMHO events in FY2022–2023, there were 1,096 referrals to social services. The number of referrals to social services decreased from FY2022–2022: of the 384 individuals who attended EPAPMHO events in FY2021–2022, there were 1,081 referrals. **Exhibits 5a and 5b** present the shares of the top five social services to which individual outreach event attendees were referred to in FY2022–2023 and the previous four fiscal years (FY2021–2022, FY2020–2021, FY2019–2020, FY2018–2019).

- In FY2022–2023, NCOC saw increases in the proportion of legal, housing assistance, cultural care, and medical care services compared with the prior year. On the other hand, the percentage of referrals for financial assistance decreased in FY2022–2023 compared with the previous year.
- In FY2022–2023, EPAPMHO saw increases in the proportion of referrals for health insurance, housing, and medical care services. On the other hand, the percentage of referrals for food, legal, and form assistance decreased in FY2022–2023 compared with the previous year.

Exhibit 5a. Referrals to Social Services Made by NCOC, FY2018–2019 to FY2022–2023

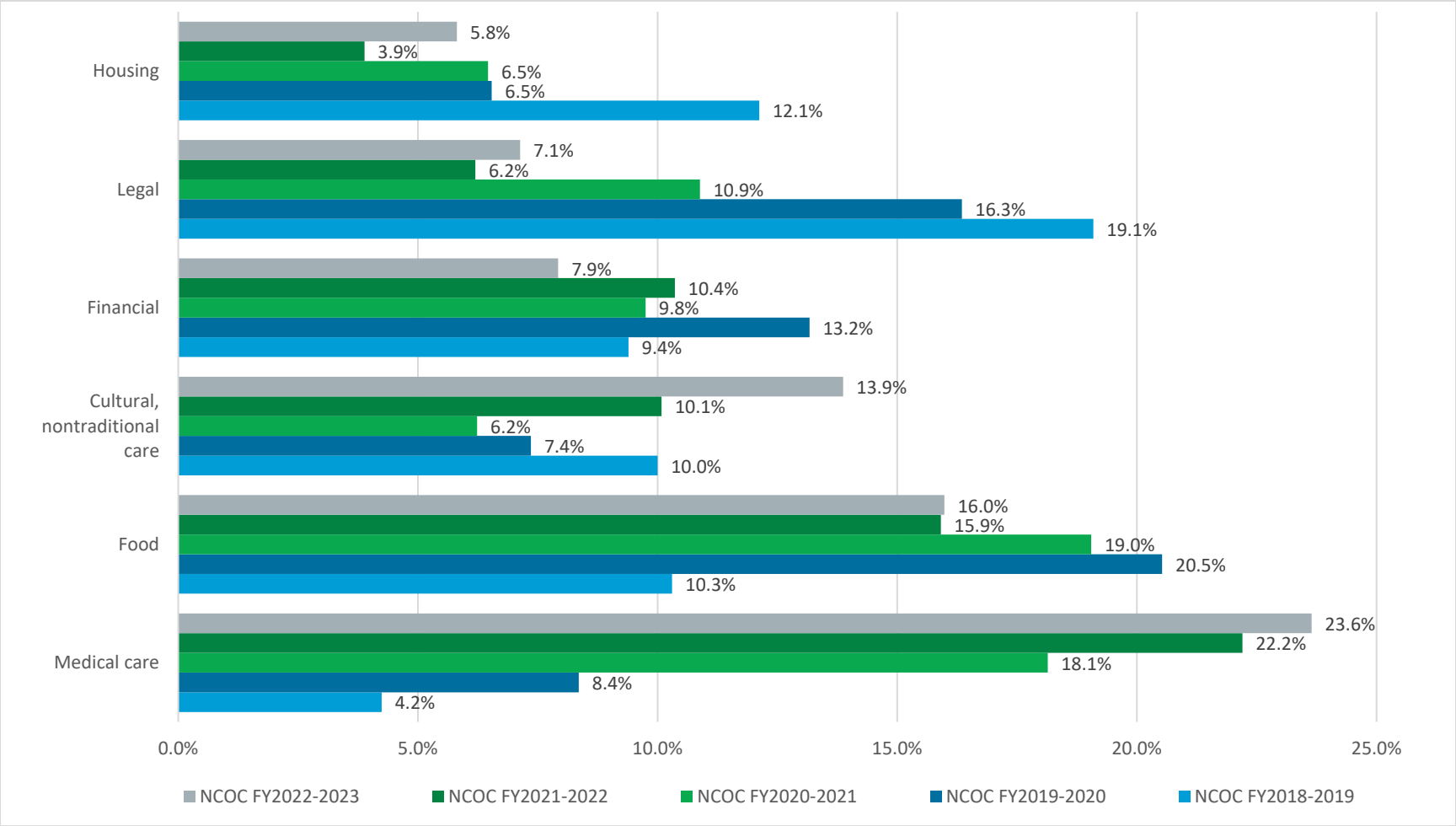
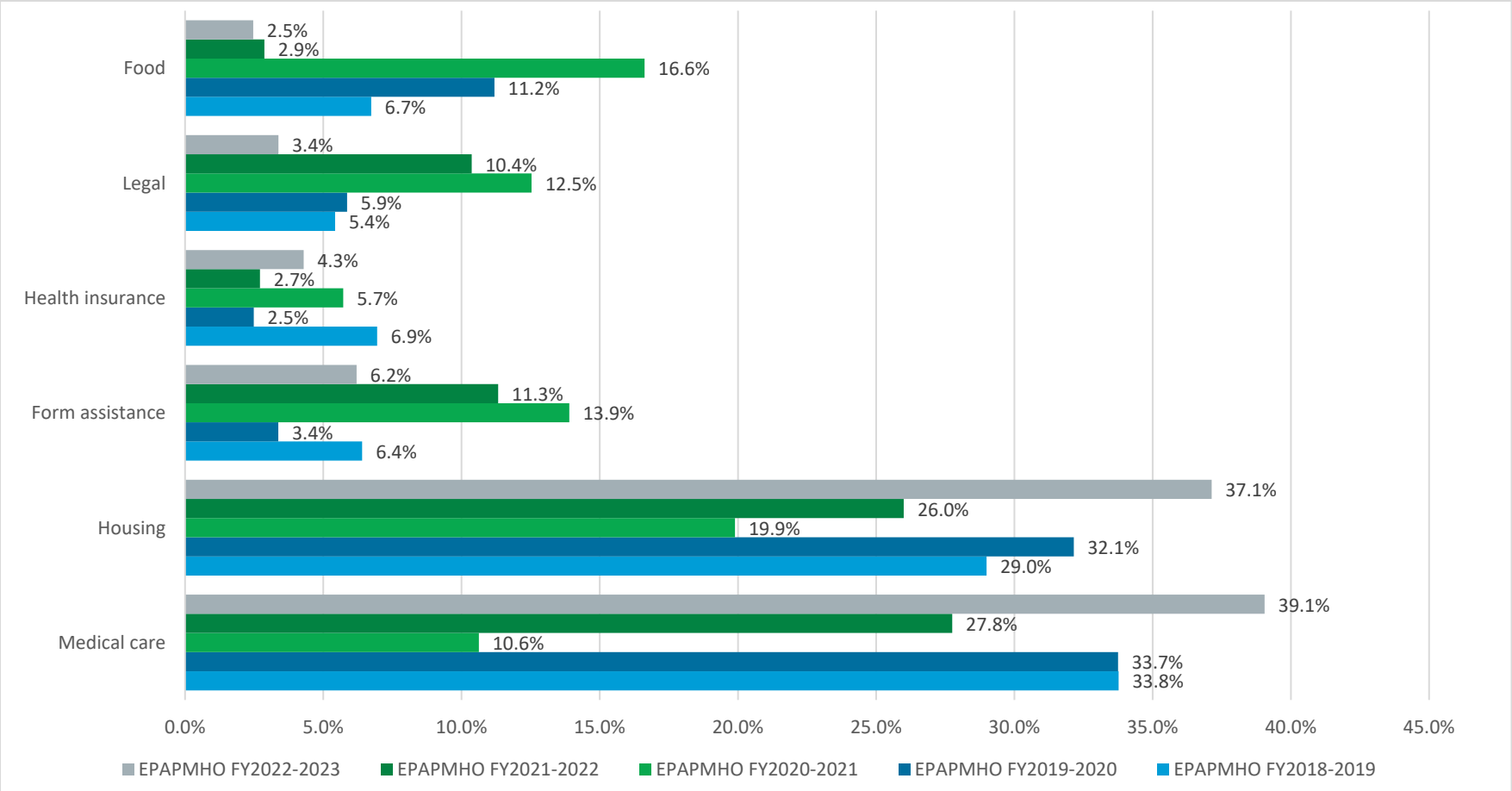


Exhibit 5b. Referrals to Social Services Made by EPAPMHO, FY2018–2019 to FY2021–2022



The following sections provide details about the attendees at group and individual outreach events across the two collaboratives and their respective provider organizations in FY2022–2023.

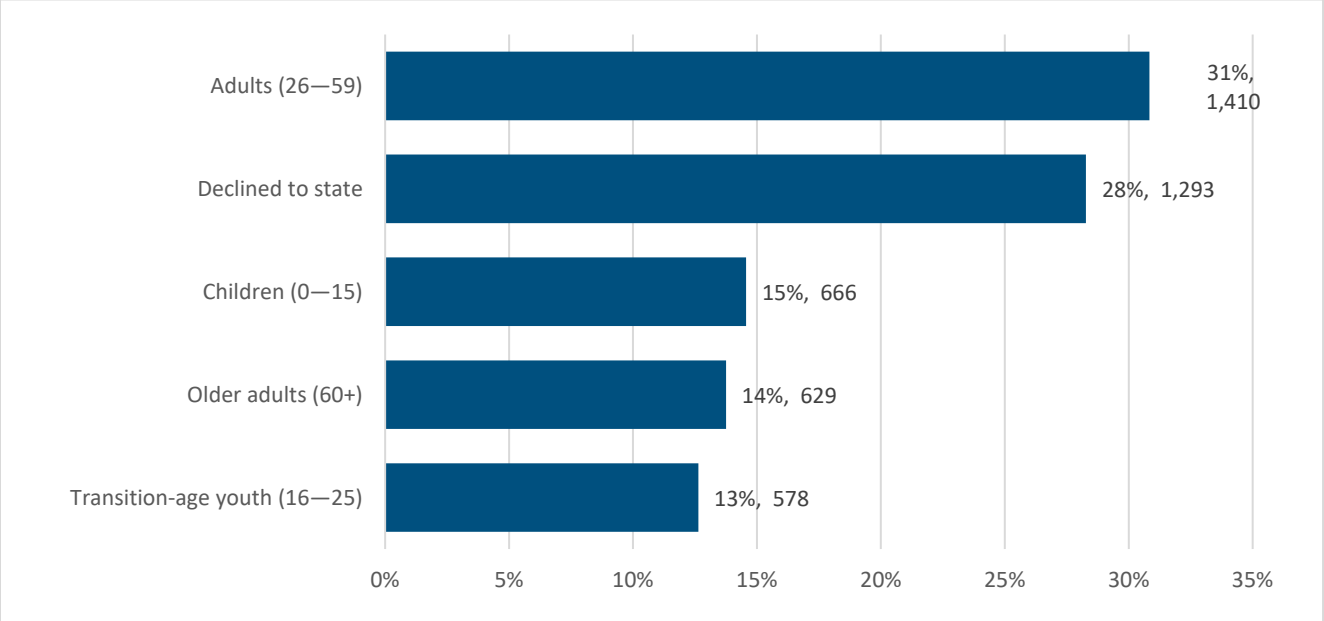
North County Outreach Collaborative

This section provides details about 4,573 attendees at NCOC group and individual outreach events across the five provider organizations in FY2022–2023.

Demographics

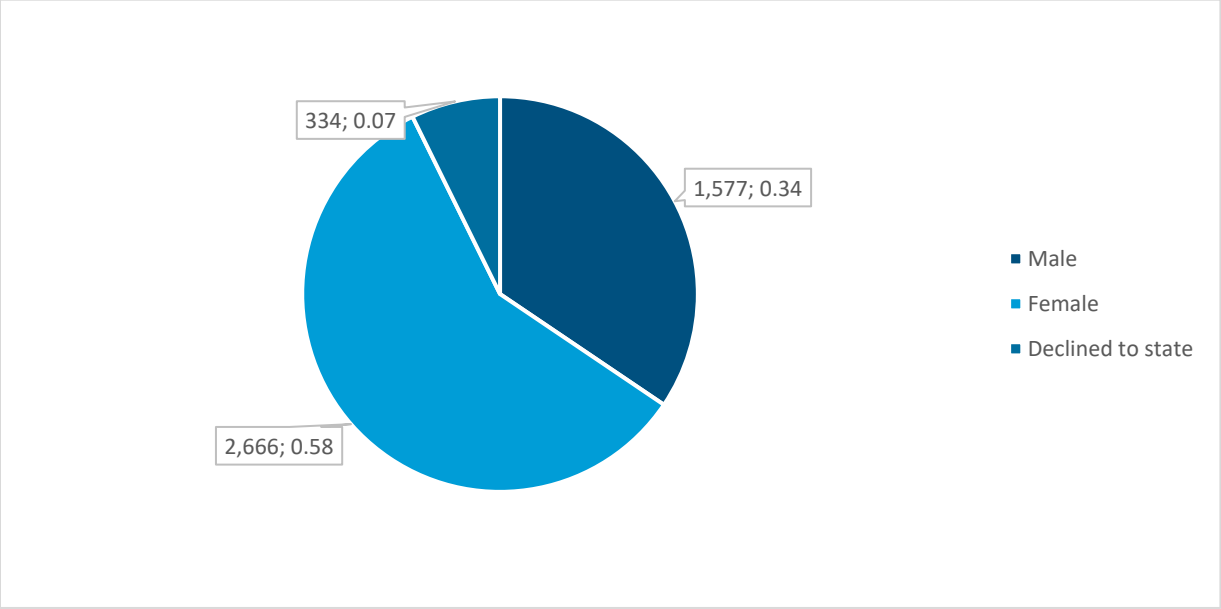
Age: Attendees across NCOC outreach events were adults (26–59 years of age; 31%), children (0–15 years of age; 15%), older adults (60 years of age and older; 14%), and transition-age youth (16–25 years of age; 13%) in FY2022–2023. Twenty-eight percent of attendees declined to state their age. See **Exhibit 6** for the number and percentage of total outreach attendees representing each reported age group.

Exhibit 6. Age of Total Outreach Attendees Served by NCOC, FY2022–2023



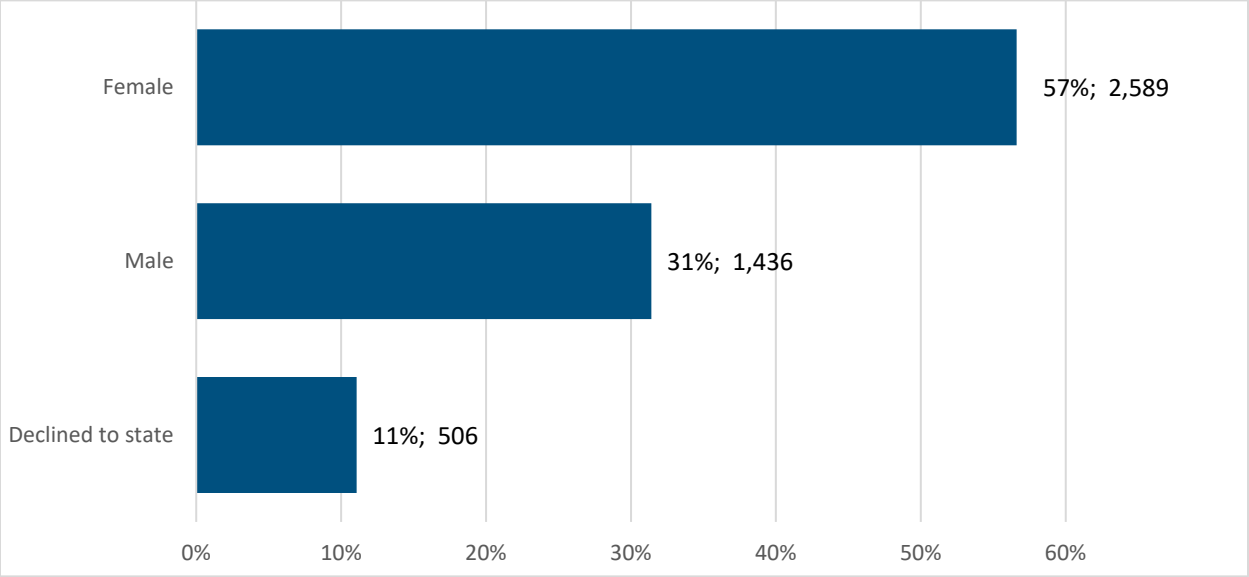
Sex at birth: Exhibit 7 shows the sex at birth of attendees across NCOC group and individual outreach events for FY2022–2023. Attendees indicated their sex at birth as female (58%) or male (35%), or they declined to state their sex at birth (7%).

Exhibit 7. Sex at Birth of Outreach Attendees Served By NCOC, FY2022–2023



Gender: Exhibit 8 shows the gender of attendees across NCOC group and individual outreach events for FY2022–2023. Then majority of attendees identified as female (57%), and 31% of attendees identified as male. Other gender identities, which are not displayed in Exhibit 8 due to the small sample size, were female-to-male transgender (*n* = 14), genderqueer (*n* = 12), Gender questioning (*n* = 8), male-to-female transgender (*n* = 6), other gender (*n* = 5), and Indigenous gender identity (*n* = 1). Eleven percent of the attendees declined to state their gender.

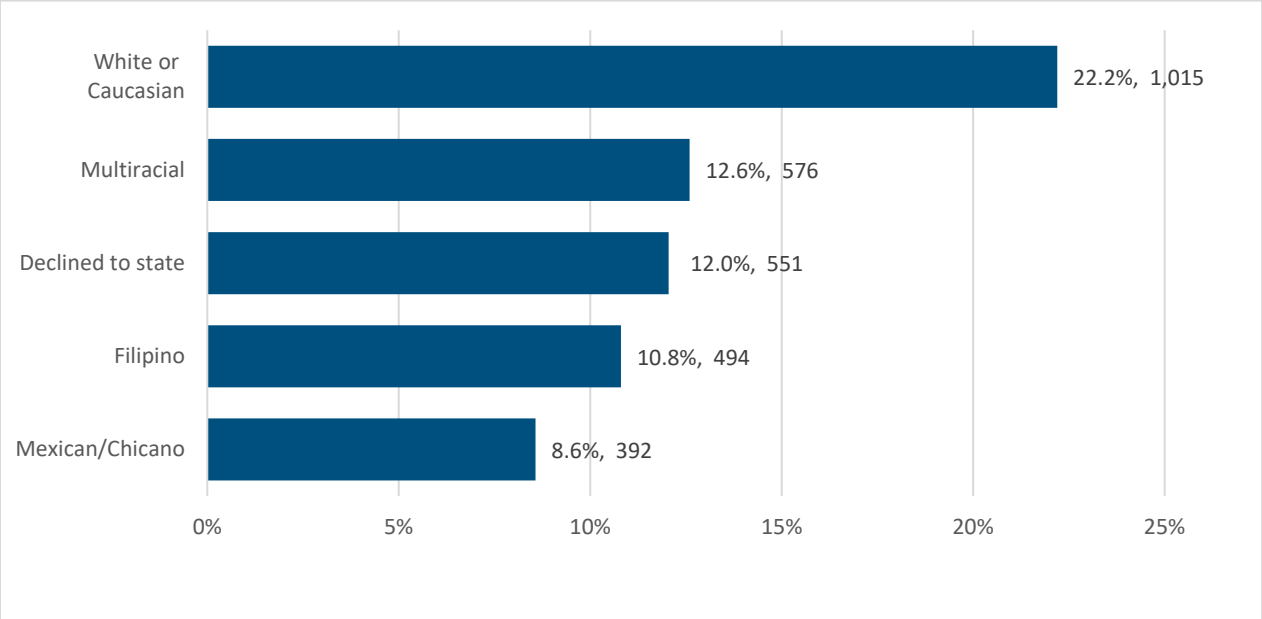
Exhibit 8. Gender of Outreach Attendees Served By NCOC, FY2022–2023



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.

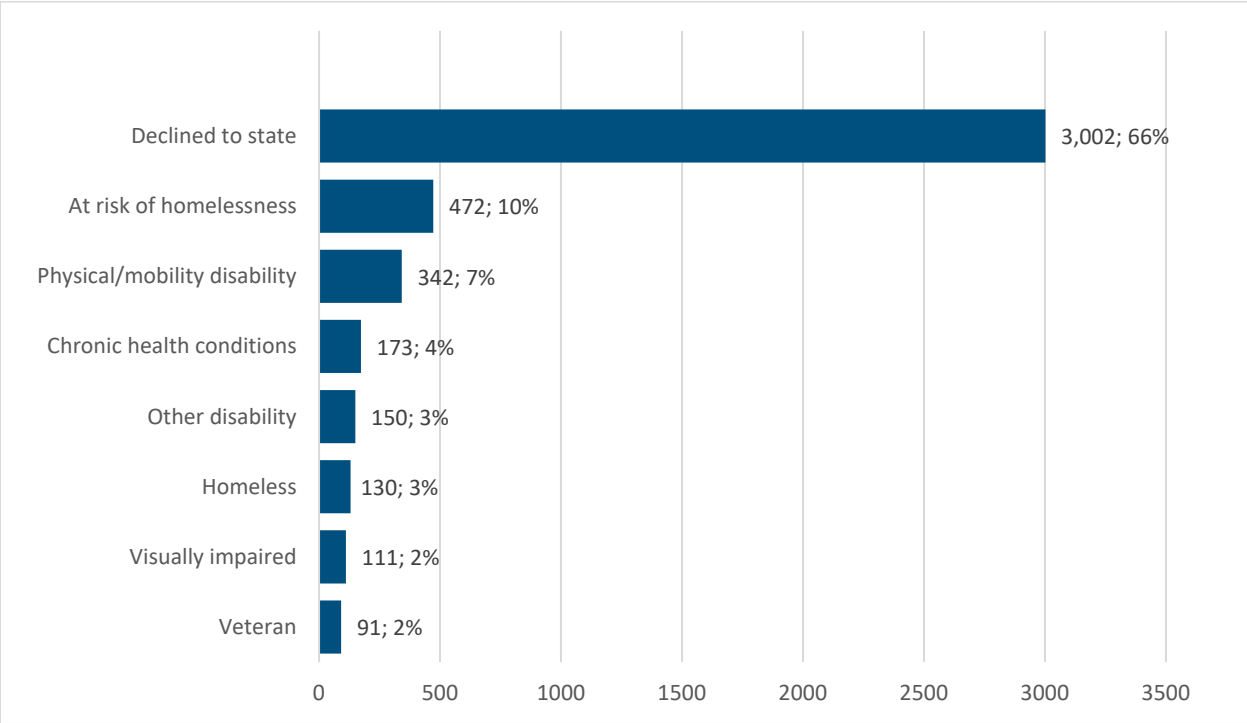
Race and ethnicity: In FY2022–2023, the three largest racial/ethnic groups represented by all NCOC attendees were White (22.2%), multiracial (12.6%), and Filipino (10.8%). Nine percent of the attendees were Mexican/Chicano, and 12% declined to state their race. See **Exhibit 9** for the percentage of attendees representing each reported racial/ethnic group.

Exhibit 9. Race and Ethnicity of Outreach Attendees Served By NCOC, FY2022–2023



Special populations: Out of the 4,573 people who attended NCOC outreach events, 10% reported being at risk of homelessness, 7% reported a physical or mobility disability issue, and 4% reported chronic health conditions as one of the special needs they had. Most attendees (66%) declined to state a special need in FY2022–2023. Please refer to **Exhibit 10** for the number of attendees representing each special population in FY2022–2023.

Exhibit 10. Special Populations Served By NCOC, FY2022–2023

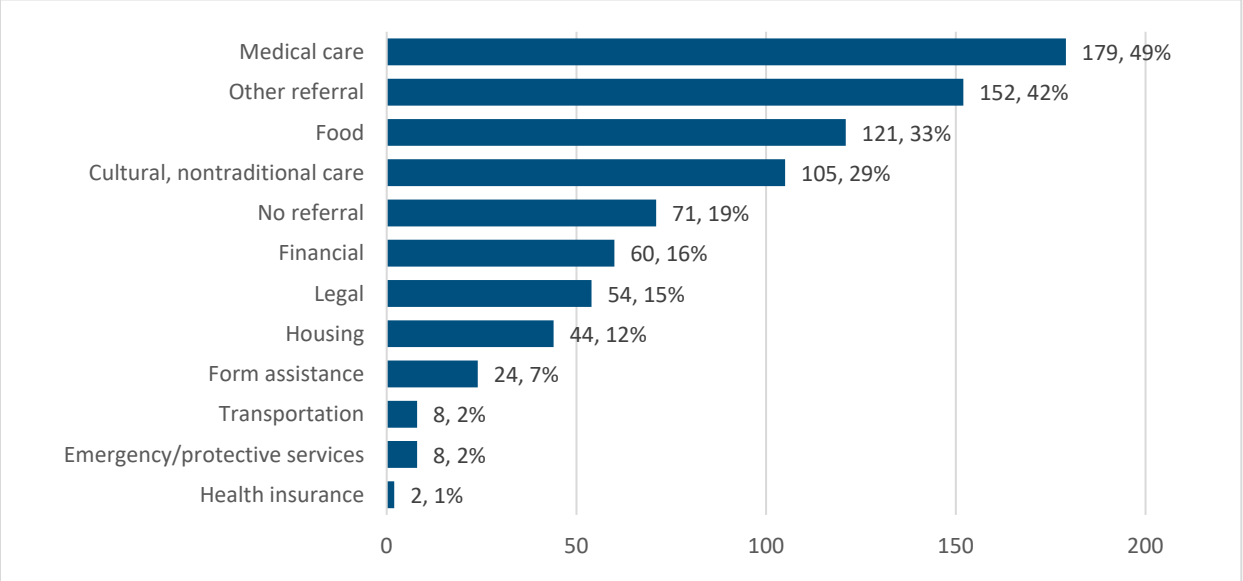


Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Attendees could be included in more than one special population. Percentages may not sum to 100% because of rounding. Due to small group sizes, the graph does not display 193 attendees who belonged to the following special population groups: hearing impairment (*n* = 66), developmental disability (*n* = 63), learning disability (*n* = 57), and dementia (*n* = 7).

Mental health/substance use referrals: NCOC individual outreach events resulted in mental health referrals (27%) and substance use referrals (2.5%) in FY2022–2023.

Referrals to social services: Providers made 757 referrals for 366 NCOC individual outreach attendees. Out of the 366 people who attended individual NCOC events, 49% were referred to medical care services; 42% were referred to other services, such as COVID-19 testing and vaccination, EOM Parent Project the Home Energy Assistance Program (HEAP), and mental health services; and 33% were referred to food services. **Exhibit 11** summarizes the number and percentage of attendees receiving a given type of referral in FY2022–2023.

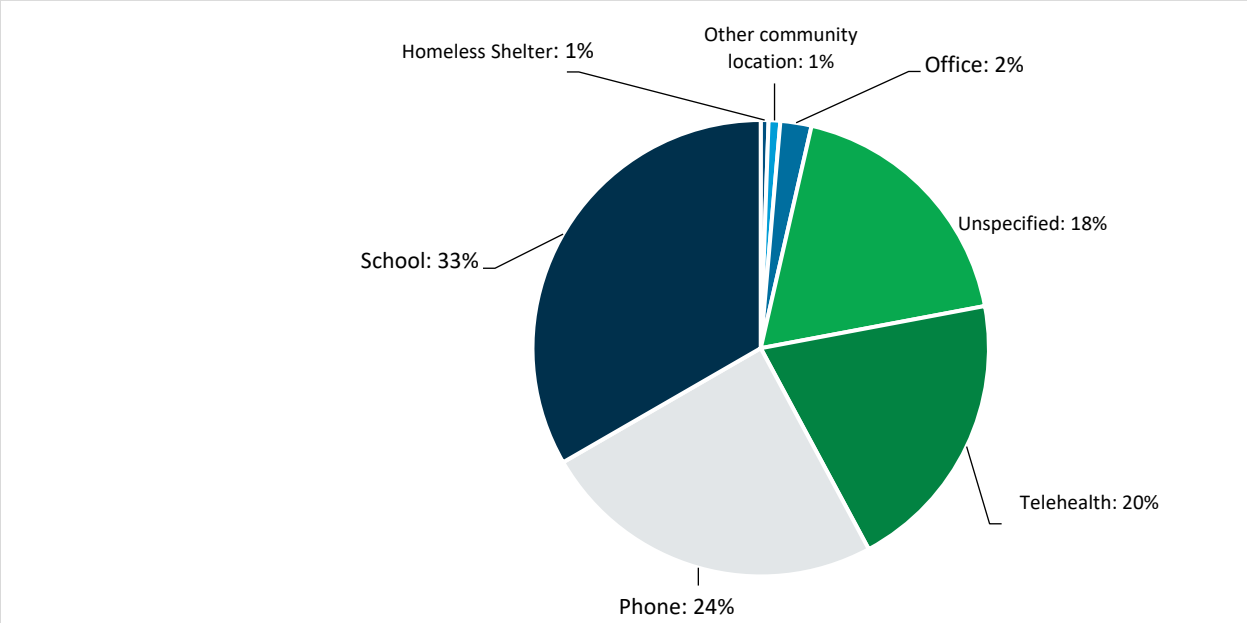
Exhibit 11. Referrals to Social Services, FY2022–2023



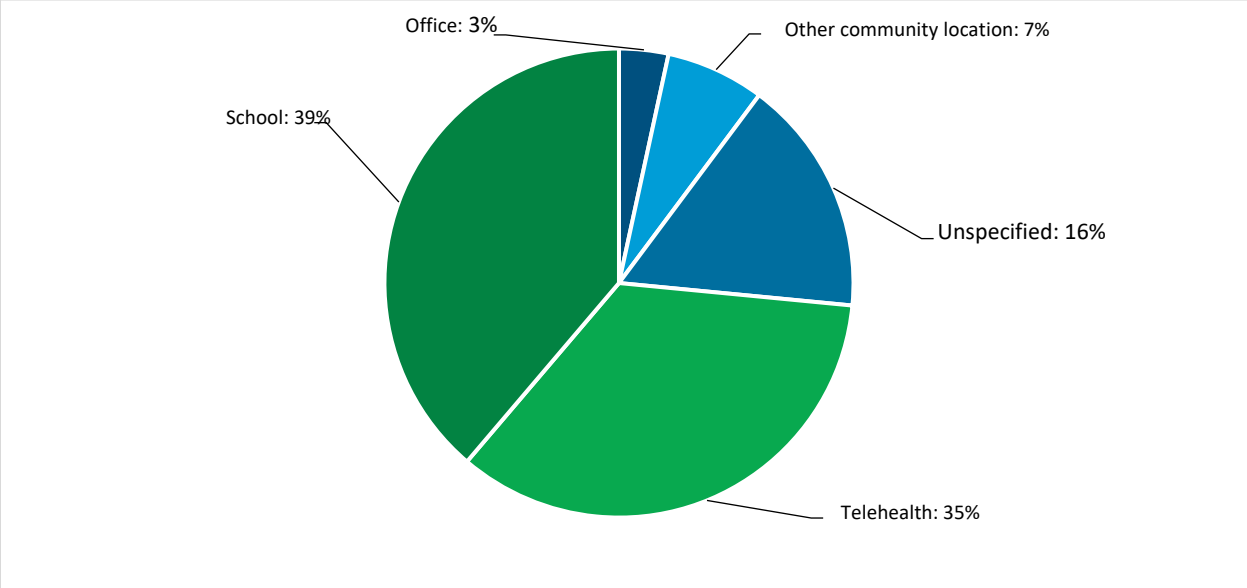
Event Characteristics

Location: Exhibits 12 and 13 present the locations for individual and group outreach events in FY2022–2023. NCOC individual outreach events occurred primarily at school (33%) or over the phone (24%) in FY2022–2023. Group outreach events occurred primarily at school (39%), via telehealth (35%), and at other community locations (7%). Other community locations included places such as Boys & Girls Clubs, community centers, the Daly City Youth Health Center, health fairs, fairgrounds, malls, and public parks. The "Other locations" category includes all the locations that were reported that make up less than 10% of the total locations reported.

Exhibit 12. Locations of NCOC Individual Outreach Events, FY2022–2023



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.



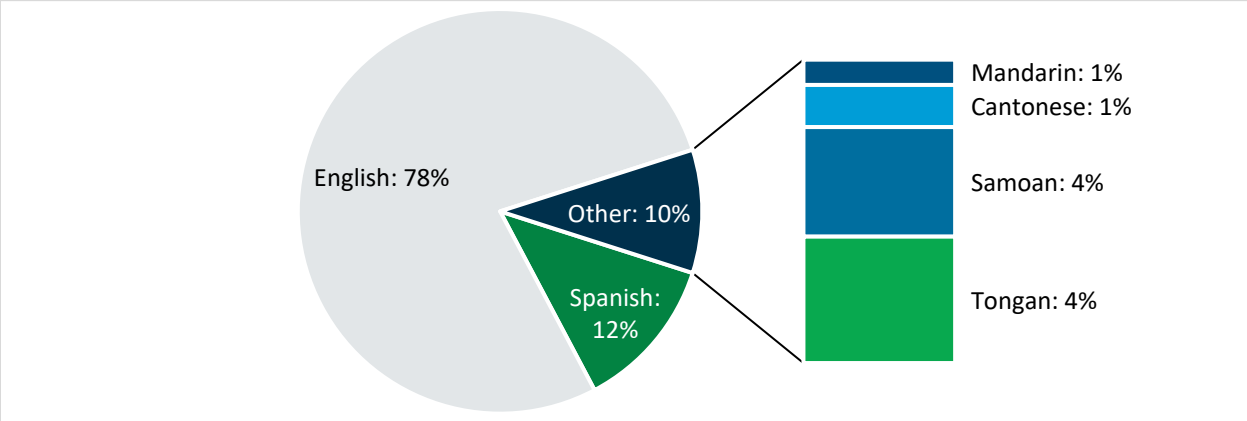
Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.

Length of contact: For FY2022–2023, the individual outreach events ranged from 3 to 120 minutes and lasted 38 minutes on average. The average length of NCOC group outreach events ranged from 30 to 360 minutes and lasted 83 minutes on average.

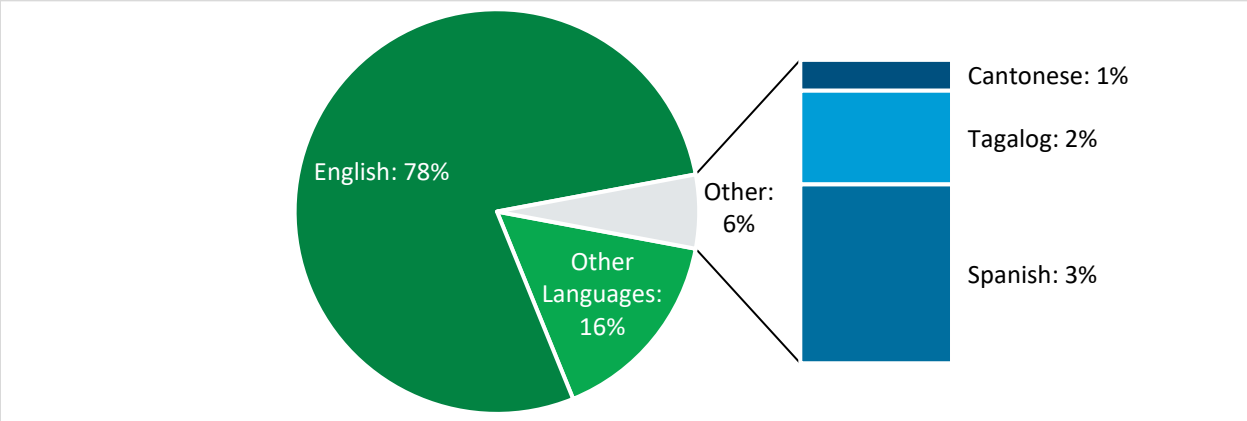
Language used: NCOC individual outreach events were conducted in English (87.2%) and Spanish (11.7%) in FY2022–2023. NCOC group outreach events were conducted in English (92.6%) and Spanish (5.4%) in FY2022–2023.

Preferred language: Exhibits 14 and 15 present breakdowns of the preferred languages at individual and group outreach events in FY2022–2023. NCOC individual outreach attendees preferred English (78%), Spanish (12%), and other languages (6%). NCOC group outreach attendees preferred English (78%), other languages (16%), Tagalog (2%), and Spanish (3%).

Exhibit 14. Preferred Languages of NCOC Individual Outreach Attendees, FY2022–2023



Note. NCOC = North County Outreach Collaborative; FY = fiscal year.



Note. NCOC = North County Outreach Collaborative; FY = fiscal year. Percentages may not sum to 100% because of rounding.

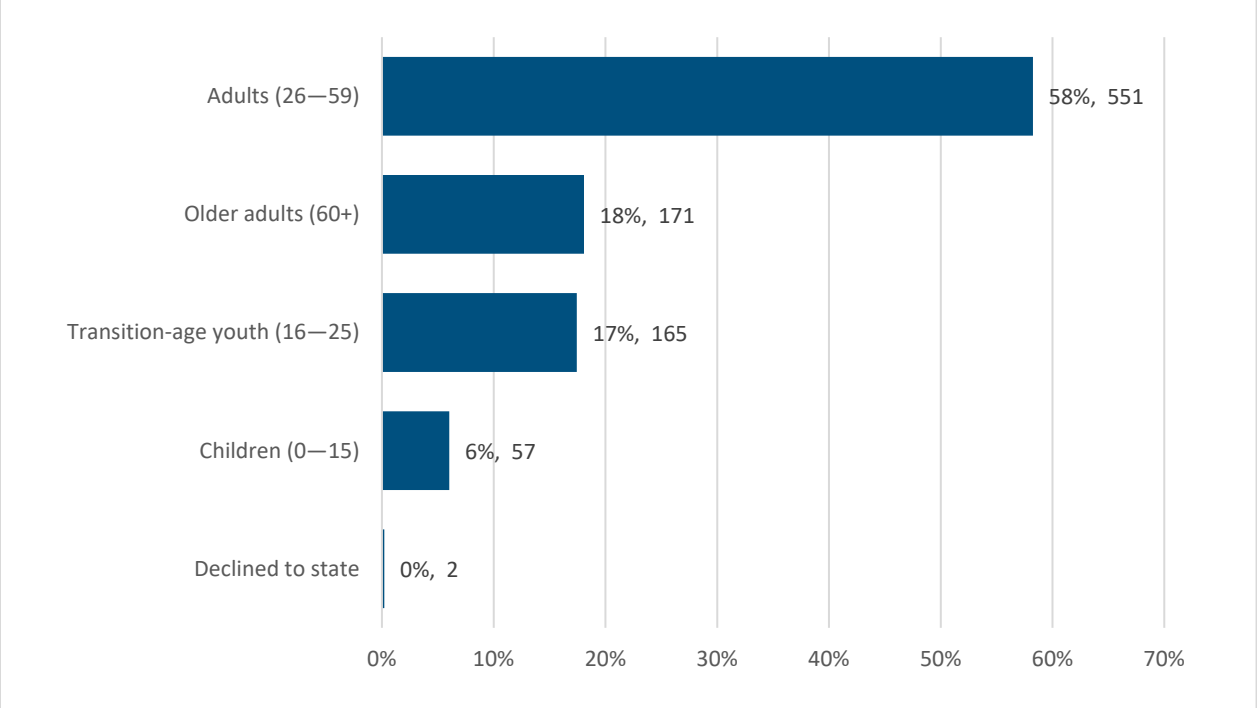
East Palo Alto Partnership for Mental Health Outreach

This section provides details about 946 attendees at EPAPMHO group and individual outreach events across three provider organizations in FY2022–2023.

Demographics

Age: Of the EPAPMHO FY2022–2023 individual and group outreach attendees, 58% were adults (26–59 years of age), 18% were older adults (60+ years of age and older), 17% were transition-age youth (16–25 years of age), and 6% were children (0–15 years of age). See **Exhibit 16** for the number and percentage of outreach attendees representing each reported age group.

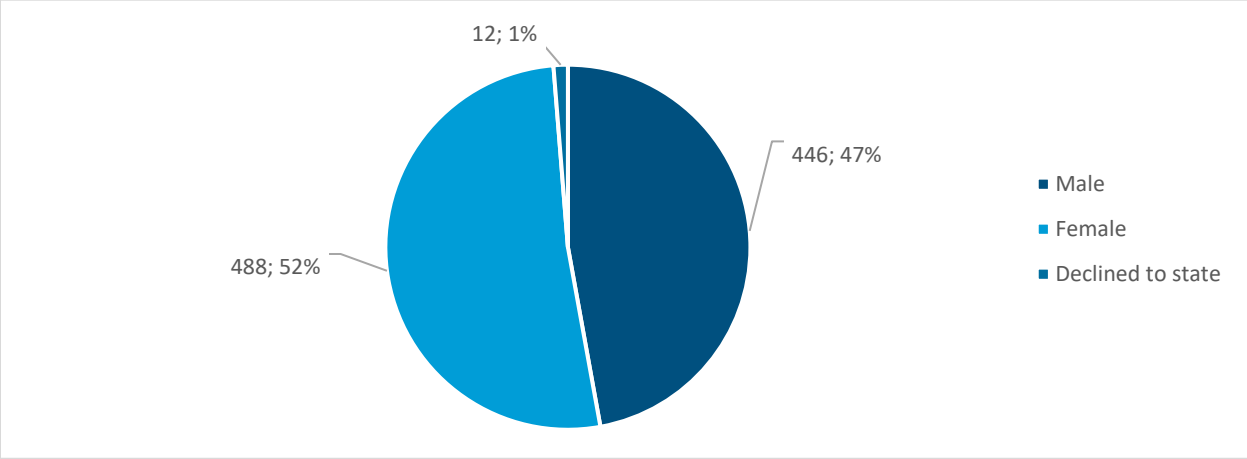
Exhibit 16. Age of Outreach Attendees Served By EPAPMHO, FY2022–2023



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. The total count for age reported may exceed the total number of attendees because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%. Note that the "Declined to state" category is 0% in the exhibit due to rounding; however, 0.21% declined to state their age.

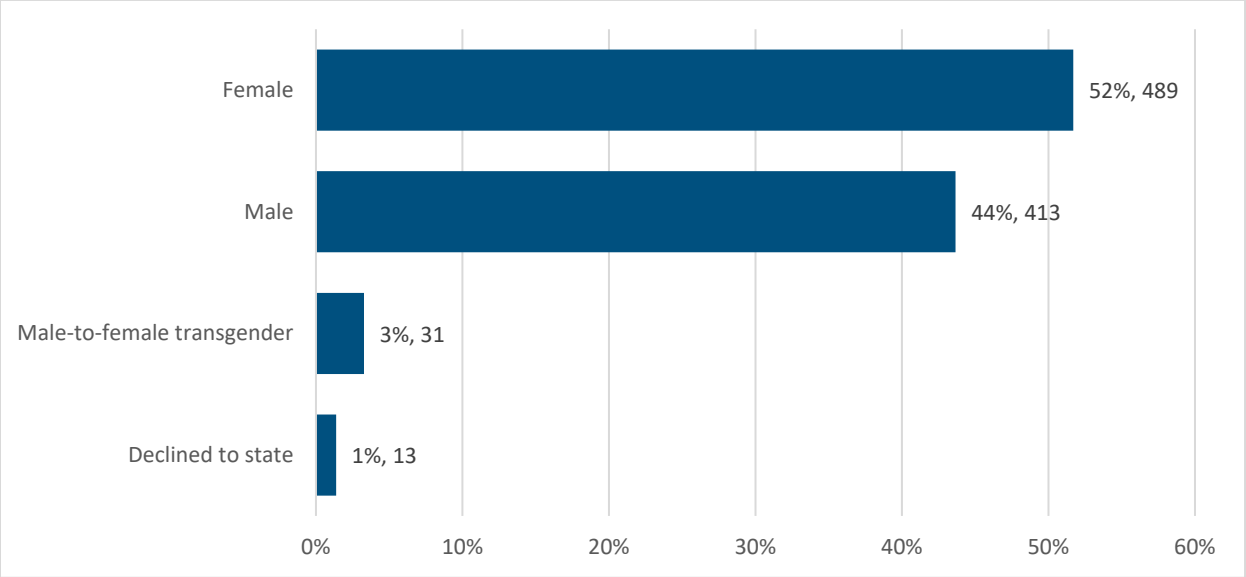
Sex at birth: Attendees across EPAPMHO outreach events indicated their sex at birth as female (52%) or male (47%). See **Exhibit 17** for the number and percentage of outreach attendees reporting sex at birth.

Exhibit 17. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY2022–2023



Gender: Attendees across EPAPMHO individual and group outreach events identified themselves as female (52%), male (44%), or male-to-female transgender (3%). See **Exhibit 18** for the number and percentage of individual and group outreach attendees representing each reported gender.

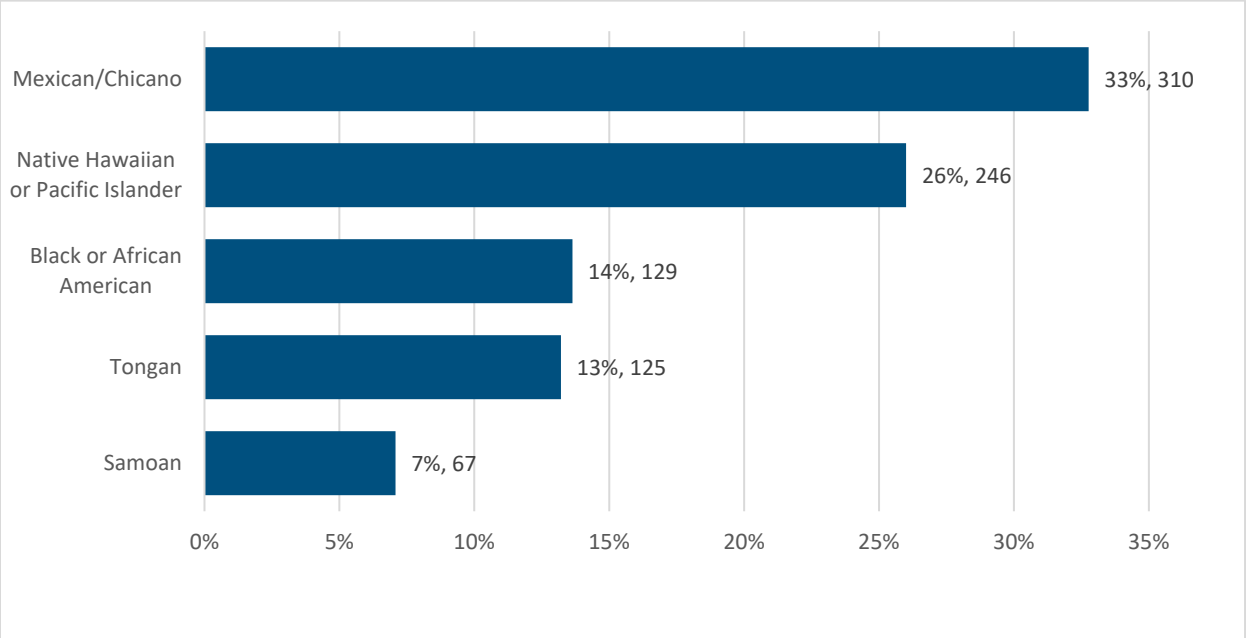
Exhibit 18. Gender of Outreach Attendees Served By EPAPMHO, FY2022–2023



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. Gender identities, which are not displayed due to small samples, were female-to-male transgender person (*n* = 2) and Indigenous gender identity (*n* = 1).

Race and ethnicity: In FY2022–2023, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican or Chicano (32%), Native Hawaiian or Pacific Islander (25%), Black or African-American (13%), Tongan (13%), and Samoan (7%). See **Exhibit 19** for the number and percentage of attendees representing each reported racial/ethnic group.

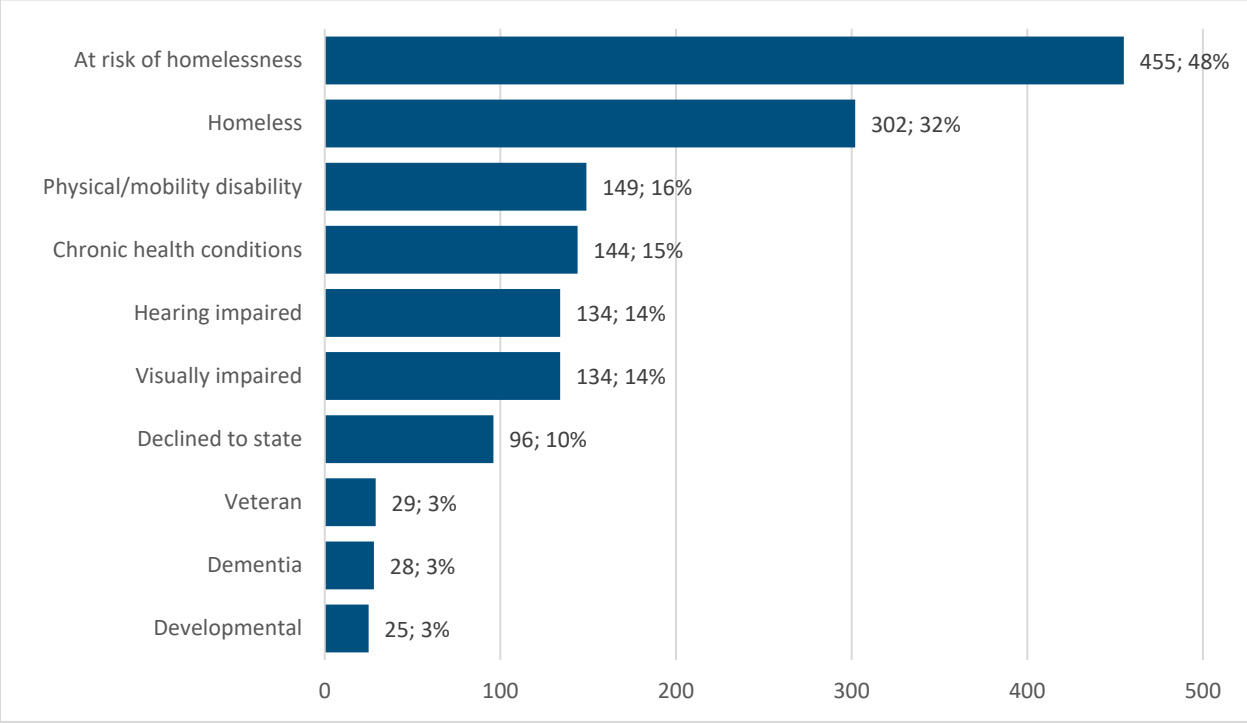
Exhibit 19. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY2022–2023



Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; FY = fiscal year. The graph does not display 105 attendees belonging to various race/ethnicity groups due to small n within each group. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals in two or more race/ethnicity groups, leading to extra counts in some cases for the group outreach attendees. Therefore, the percentages may add up to more than 100%.

Special populations: Out of the 946 people who attended EPAPHMO events, 48% reported being at risk of homelessness, 32% reported homelessness, 16% reported a physical or mobility disability issue, 15% reported chronic health conditions, 14% reported hearing impairment, and 14% reported visual impairment as one of the special needs they have. Refer to **Exhibit 20** for the number and proportion of attendees representing each special population in FY2022–2023.

Exhibit 20. Special Populations Served by EPAPMHO, FY2022–2023

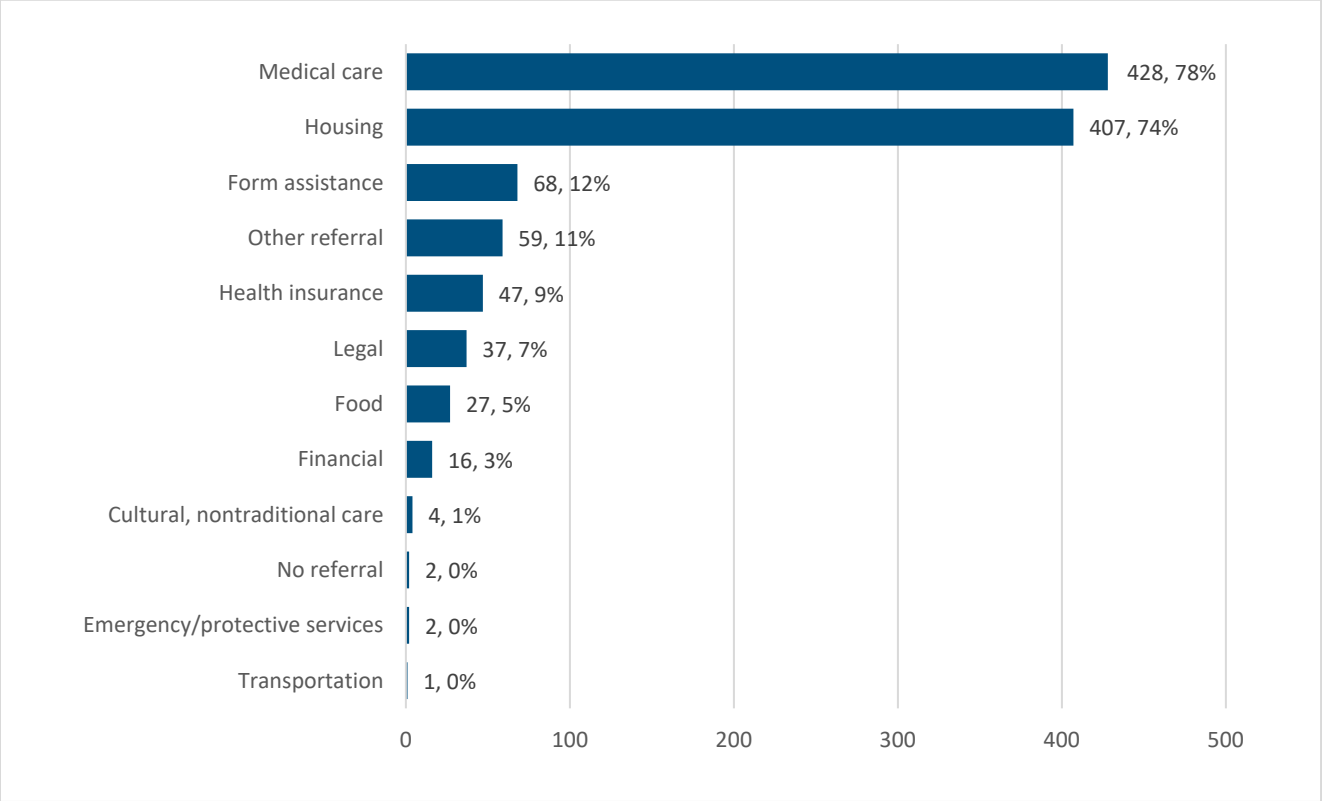


Additional Outreach Characteristics (Individual Outreach Events Only)

Mental health/substance use referrals: EPAPMHO individual outreach events resulted in mental health referrals (14.1%) and substance use referrals (72.3%) in FY2022–2023.

Referrals to social services: Providers made 1,096 referrals to 552 EPAPMHO individual outreach attendees. Out of the 522 people who attended individual EPAPHMO events, 78% were referred to medical care services; 74% were referred to housing services; 12% were referred to form assistance services; 11 % were refrred to other services, such as COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program, and mental health services, and 33% were referred to food services. **Exhibit 21** summarizes the number of attendees receiving a given type of referral.

Exhibit 21. Referrals to Social Services, FY2022–2023



Notes. FY = fiscal year. Only individual outreach events (*n* = 552) offer service referrals. Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%. Other referrals include services related to COVID-19 testing and vaccination, EOM Parent Project, the Home Energy Assistance Program, and mental health services.

Event Characteristics

Location: EPAPMHO individual outreach events occurred over the phone (54%), in offices (34%), or at unspecified locations (10%). **Exhibit 22** presents individual outreach event locations. **Exhibit 23** presents the group outreach events. They occurred in other community locations (39%), unspecified locations (32%), an office (26%), or a mobile service (3%).

Exhibit 22. Location of EPAPMHO Individual Outreach Events, FY2022–2023

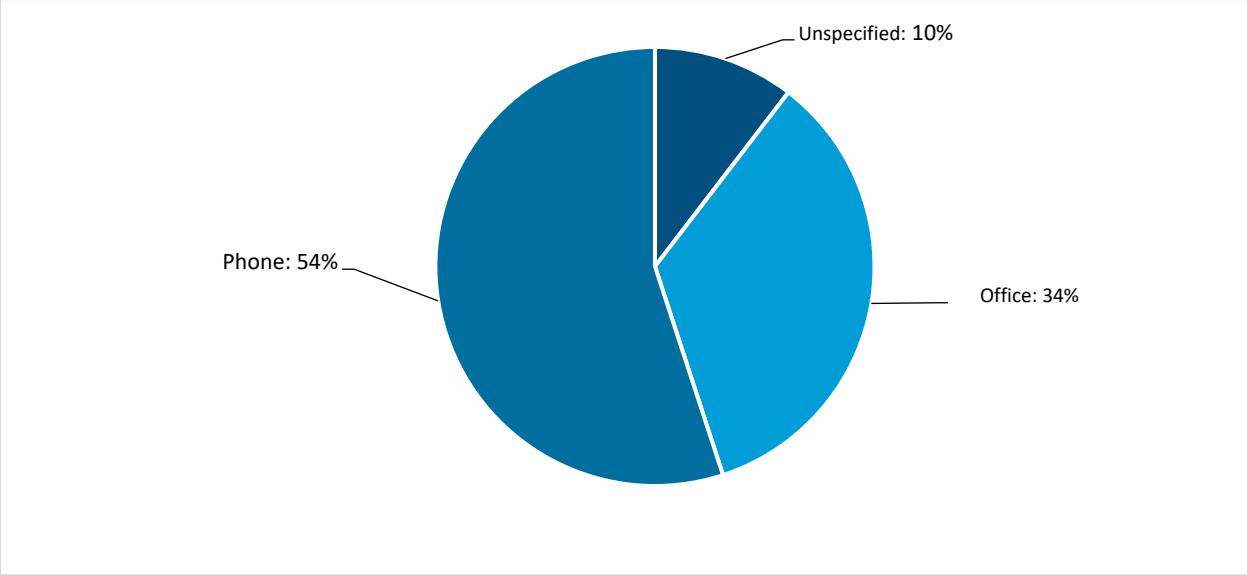
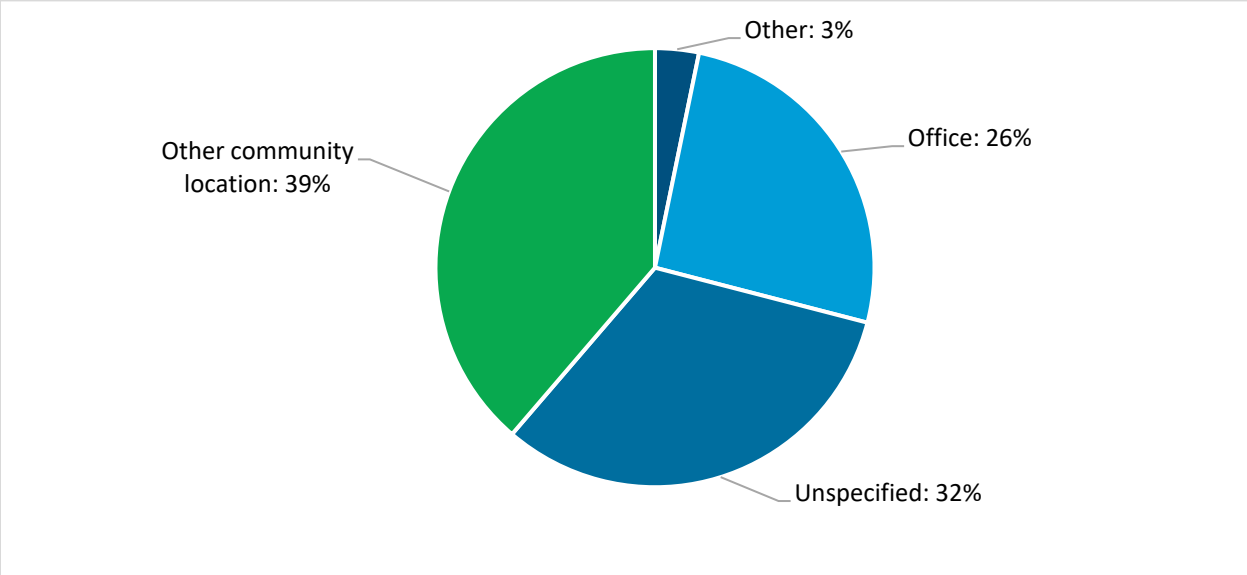


Exhibit 23. Location of EPAPMHO Group Outreach Events, FY2022–2023



Length of contact: In FY2022–2023, the individual outreach events lasted from 5 to 35 minutes and averaged 16 minutes. The group outreach events lasted from 30 minutes to 300 minutes.

Language used: EPAPMHO individual outreach events were conducted in Spanish (60%), English (36%), Samoan (2%), and Tongan (1.6%). The group outreach events were conducted in Tongan (41.9%), English (32.3%), and Samoan (25.8%).

Preferred language: EPAPMHO individual outreach attendees preferred Spanish (62%), English (33%), Tongan (2%), and Samoan (2%). Attendees at the EPAPMHO group outreach events preferred Tongan (40%), English (27%), and Samoan (21%). **Exhibits 24 and 25** present breakdowns of preferred languages at individual and group outreach events in FY2022–2023.

Exhibit 24. Preferred Languages of EPAPMHO Individual Outreach Attendees, FY2022–2023

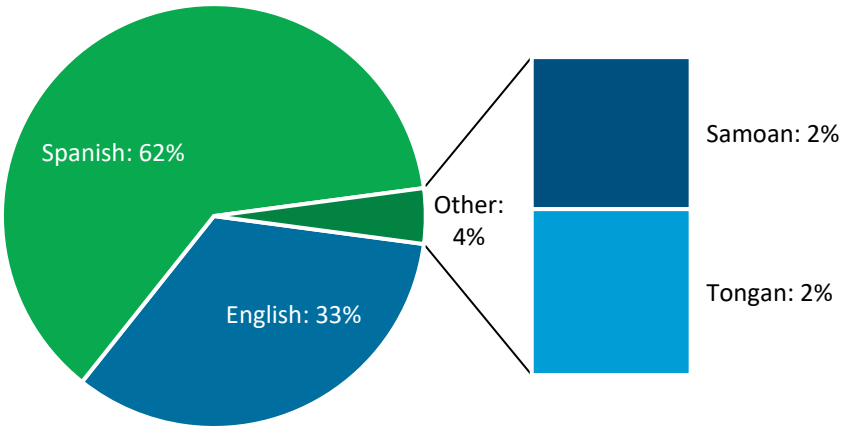
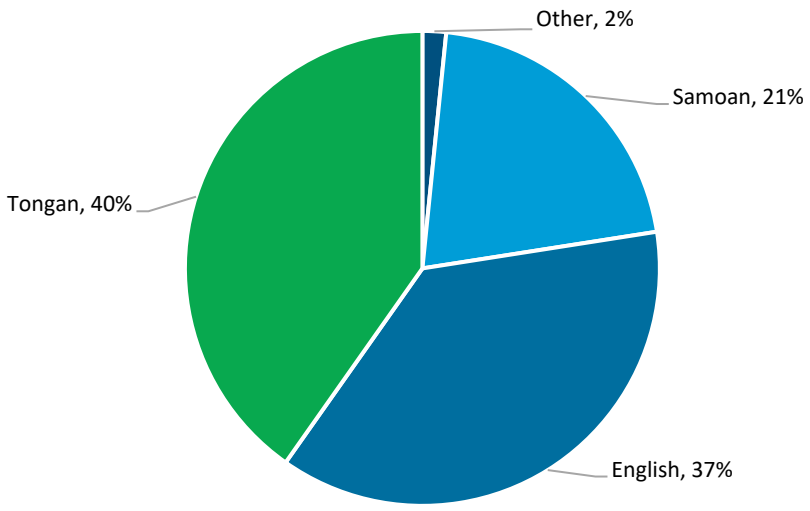


Exhibit 25. Preferred Languages of EPAPMHO Group Outreach Attendees, FY2022–2023



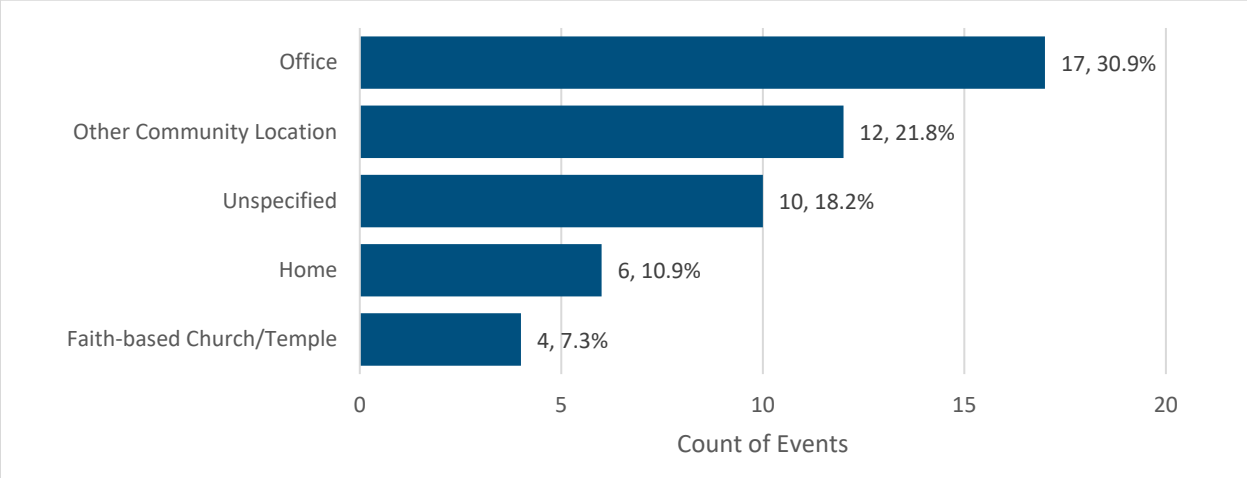
Appendix A. FY2022–2023 Outreach, Anamatangi Polynesian Voices

For FY2022–2023, Anamatangi Polynesian Voices reported 55 outreach events, which included 24 individual events and 31 group events. There were 418 attendees across all events. All individual events lasted for 30 minutes. The group outreach events ranged from 30 to 300 minutes and lasted for 119 minutes on average.

Outreach events

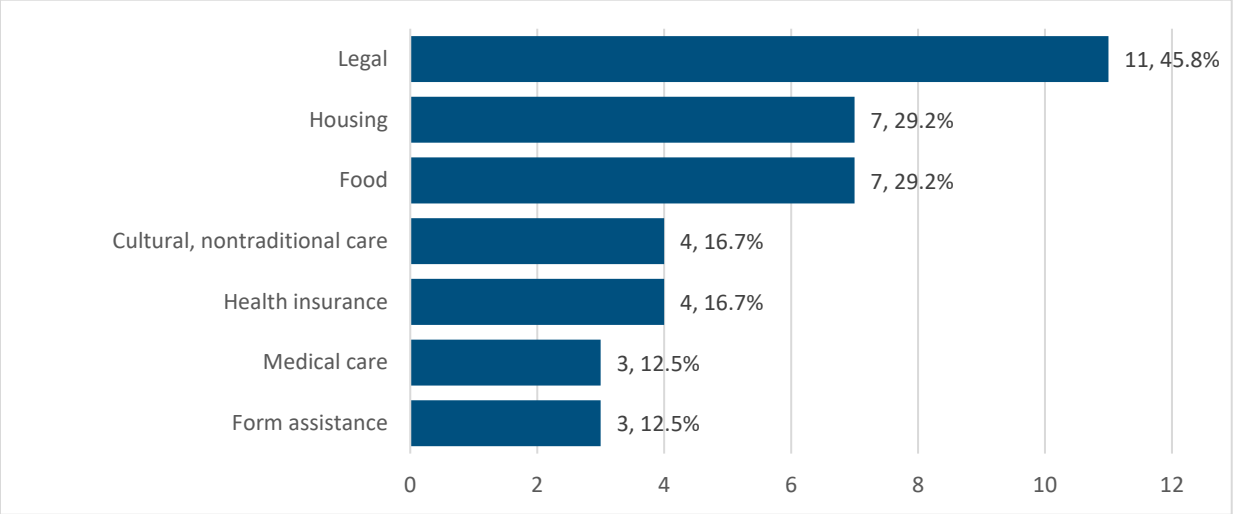
- Most frequently took place in an office (**30.9%**; *n* = 17). Other locations for events and their respective values are shown in **Exhibit A1.**
- Were conducted in Tongan (**40%**; *n* = 22), Samoan (**34.5%**; *n* = 19), and English (**25.5%**; *n* = 14).
- Resulted in 24 mental health referrals and 1 substance use treatment referral.
- There were 41 referrals to social services for individuals who attended the individual events. (See **Exhibit A2**.) Individual outreach event attendees (n = 24) were referred to legal (45.8%; *n* = 11); housing (**29.2%**, *n* = 7); food (**29.2%**; *n* = 7) services; cultural, nontraditional care (**16.7%**, *n* = 4); health insurance (**16.7%**, *n* = 4); medical care (**12.5%**; *n* = 3); form assistance (**12.5%**; *n* = 3) services; financial (**4.2%**; *n* = 1) services; and emergency/protective services (**4.2%**; *n* = 1).

Exhibit A1. Counts and Percentages of Events by Location Type: Anamatangi Polynesian Voices Outreach Events, FY2022–2023



Note. These events were not displayed in the graph above due to the small n: Age-specific Community Center (*n* = 1), Home Shelter (*n* = 1), Job Site (*n* = 1), Mobile Service (*n* = 1), Phone (*n* = 1), and Residential Care (*n* = 1).

Exhibit A2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Anamatangi Polynesian Voices, FY2022–2023

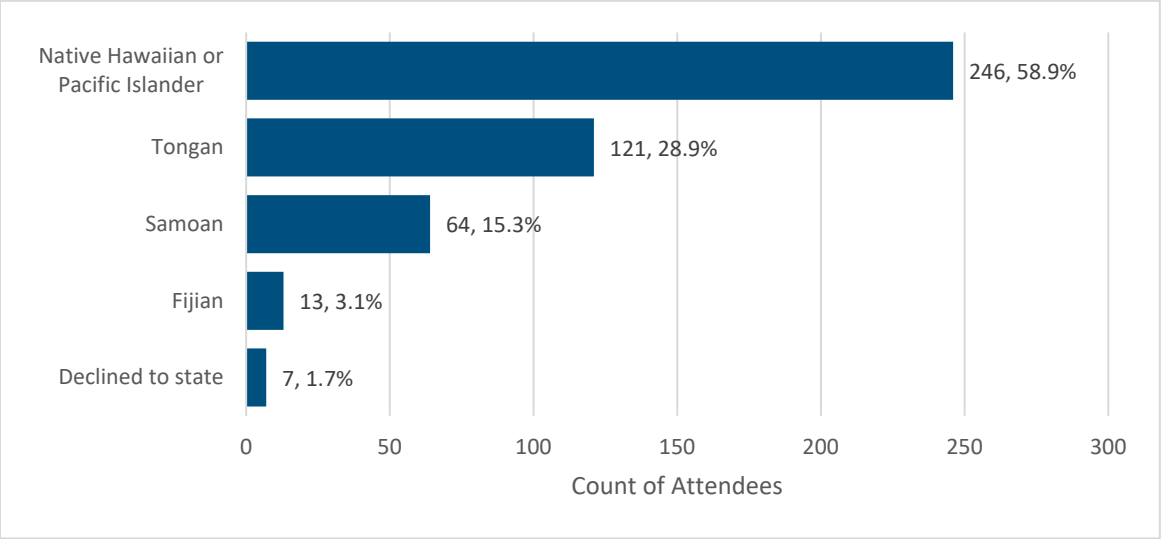


2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: Financial (*n* = 1) and Emergency/Protective services *(n* = 1).

Demographics of Outreach event attendees

- 53% were female (**53.1%**; *n* = 222); 44% were male (**44%**, *n* = 184); 2.9% declined to state (**2.9%**, *n* = 12).
- 52.9% identified their gender as female (**52.7%**; *n* = 221); 44% identified as male (**44%**; *n* = 184); 13 declined to state (**3.1%**); 1 (**0.2%**) reported an Indigenous gender identity.
- Identified as straight (**94%**; *n* = 393), gay/lesbian (**5.7%**; *n* = 24), other (**5.7%**; *n* = 24), queer (**0.5%**; *n* = 2), and declined to state (**0.2%**; *n* = 1).
- Included adults (26–59 years of age; **30.4%**; *n* = 127), older adults (60 years of age and older; **32.8%**; *n* = 137), transition-age youth (16–25 years of age; **22.7%**; *n* = 95), and youth (15 years of age and younger; **13.6%**, *n=57*). Two attendees declined to state their age (**0.5%**; *n* = 2).
- Were primarily Native Hawaiian (**58.9%**, *n* = 246) or Tongan (**28.9%**; *n* = 121). (See **Exhibit A3.**)

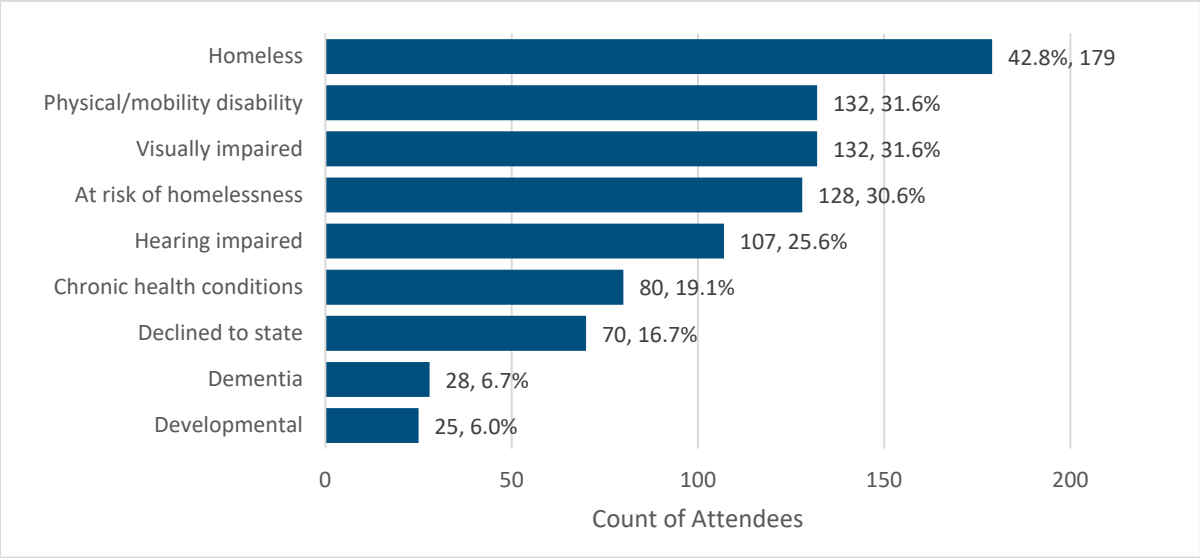
Exhibit A3. Counts and Percentages of Racial/Ethnic Categories: Anamatangi Polynesian Voices Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. There were three clients whose racial/ethnic categories are not displayed in the graph above due to the small n (n=1 for each of these racial/ethnic categories: Multi-racial (*n* = 1), Mexican/Chicano (*n* = 1), and Caribbean (*n* = 1).

Note that special populations are defined as those with special needs in the categories defined in Exhibit A4.

Exhibit A4. Counts and Percentages of Special Populations: Anamatangi Polynesian Voices Attendees at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Other disability (*n* = 11) and Learning disability (*n* = 1).

Appendix B. FY2022–2023 Outreach, Asian American Recovery Services (AARS)

For FY2022–2023, Asian American Recovery Services (AARS) reported 152 outreach events, which included 133 individual events and 19 group events. There were 1092 attendees. Individual outreach events ranged from 10 to 120 minutes and on an average lasted for 36 minutes. The group outreach events ranged from 60 to 120 minutes and lasted for 69 minutes on an average.

Outreach events

- Were most often at unspecified locations (**55.3%**, n=84) or held over the phone (**36.8%**, *n* = 56). Other locations of events and their respective values are shown in **Exhibit B1**.
- Were conducted in English (**100%**; *n* = 152).
- Resulted in 22 mental health referrals and 8 substance use treatment referrals at individual outreach events.
- There were 519 referrals to social services for individuals who attended the individual events. (See **Exhibit B2**.) Individual outreach event attendees (n = 133) were referred to other referrals (**100.0%**; *n* = 133) including services related to COVID-19 testing and vaccinations, EOM Parent Project, the Home Energy Assistance Program (HEAP), and mental health; cultural, non-traditional care (**78.9%**, *n* = 105); food (**73.7%**; *n* = 98); medical care (**39.1%**, *n* = 52); legal services (**33.1%**, *n* = 44); financial services (**32.3%**; *n* = 43); housing services (**18.0%**, n = 24), form assistance (**12.8%**; *n* = 17) services, transportation (**1.5%**, *n* = 2) services, no referral (**1.5%**, *n* = 2), and health insurance (**0.8%**, *n* = 1)

Exhibit B1 Counts and Percentages of Events by Location Type: AARS Outreach Events, FY2022–2023

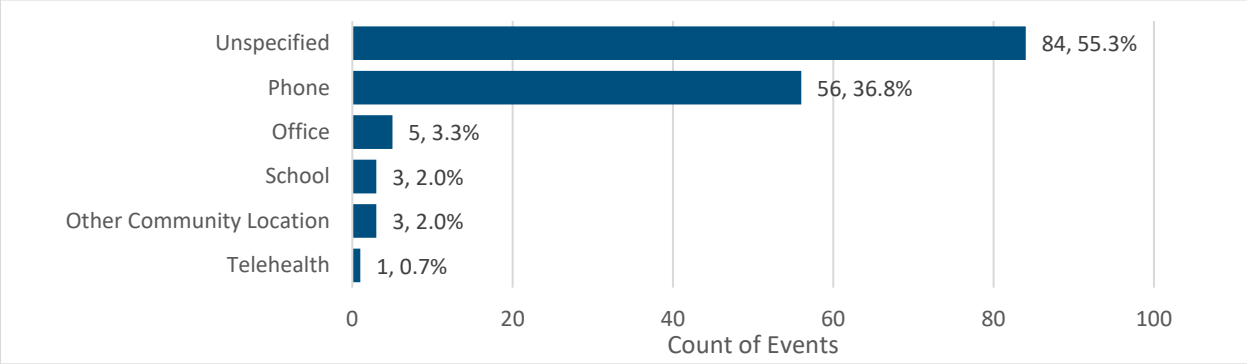
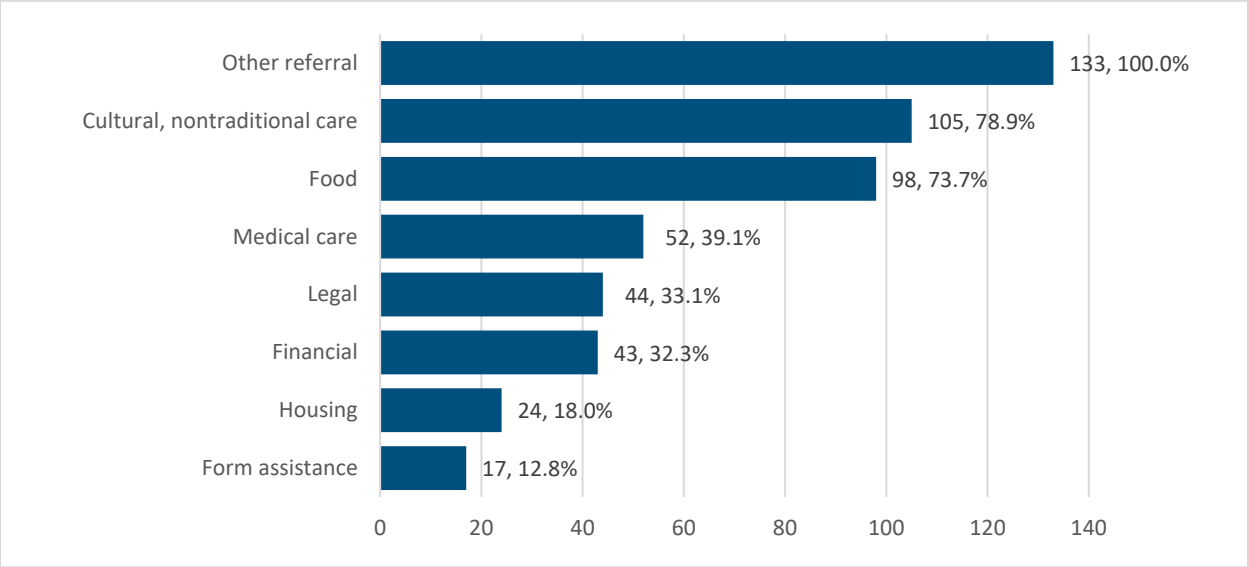


Exhibit B2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: AARS, FY2022–2023



Notes. 1) Only individual outreach events (n = 133) offer service referrals.

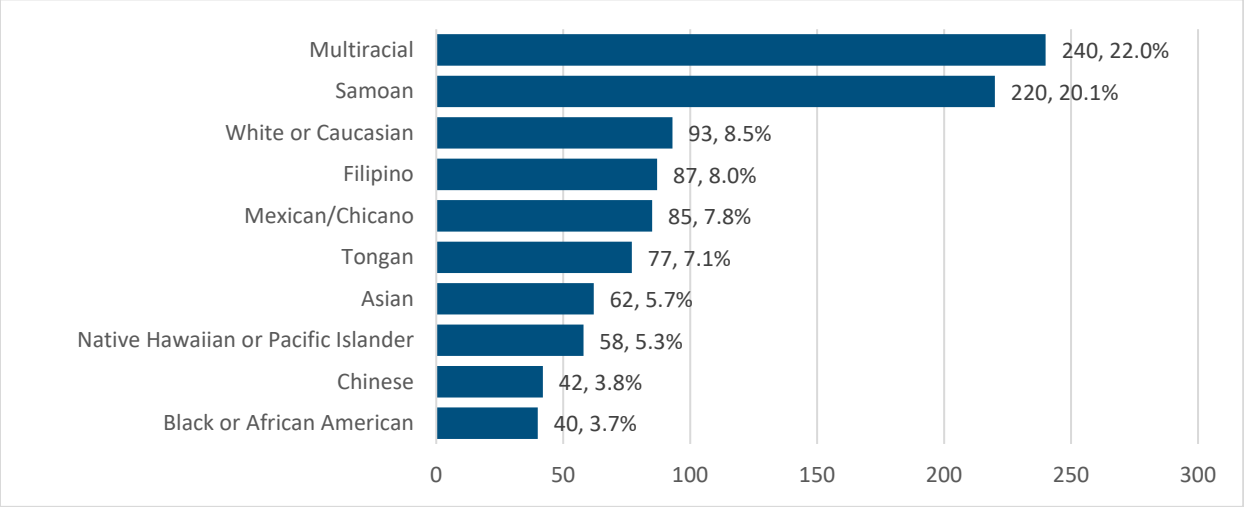
3) These referral types were not displayed in the graph above due to the small n: Transportation *(n* = 2*),* No Referral *(n* = 1*),* and Health insurance *(n* =1*).*

Demographics of Outreach event attendees

- Were female (**65.1%;** *n* = 711). Thirty percent were male (**33.6%;** *n* = 367). Close to 2% declined to report their sex at birth (1.6%; *n* = 17). The remaining were intersex (0.3%; *n* = 3).
- Identified their gender as female (**69.2%;** *n* = 756), male (**26.9%;** *n* = 294); female-to-male transgender (**0.4%;** *n* = 4); queer (**0.2%;** *n* = 2); an Indigenous gender identity (**0.1%;** *n* = 1); and other (**0.3%;** *n* = 3). Thirty-two attendees declined to state their gender (2.9%).
- Identified as heterosexual (**77.5%;** *n* = 846), gay/lesbian (**4.3%;** *n* = 47), bisexual (**2.1%;** *n* = 23), queer (**1.7%;** *n* = 19), questioning orientation (**0.5%;** *n* = 6); pansexual (**0.03%;** *n* = 3); and an Indigenous gender identity (**1.0%;** *n* = 11). The remaining attendees either declined to state their sexual orientation (**14.4%;** *n* = 157) or indicated an orientation that was not listed (**0.9%;** n=10).
- Included adults (26–59 years of age; **48.5%**; *n* = 530), children (15 years of age and younger; **21.6%**; *n* = 236), transition-age youth (16–25 years of age; **17.1%;** *n* = 187), and older adults (60 years of age and older; **11.4%;** *n* = 125). 17 attendees declined to state their age (**1.6%**).

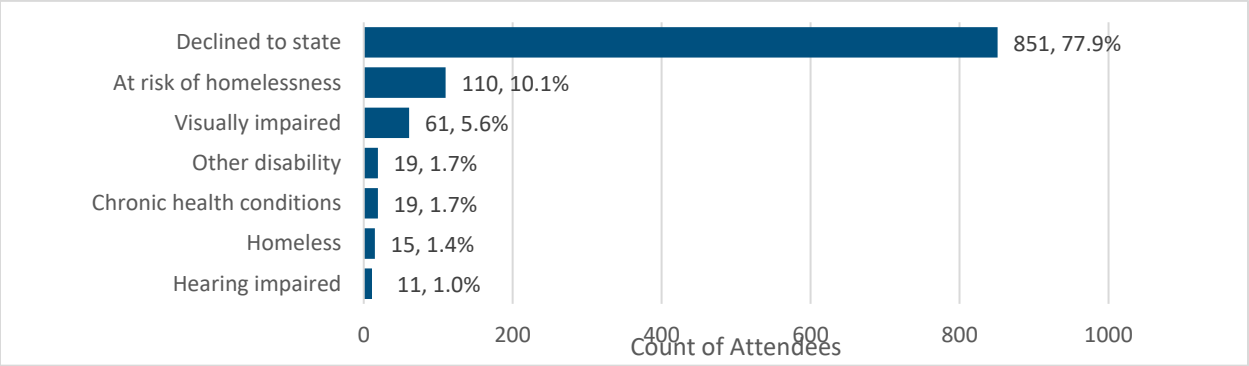
- Were primarily multi-racial (**22%;** n=240), Samoan (**20.1%;** *n* = 220), White or Caucasian (**8.5%**; *n* = 93), and Filipino (**8.0%**; *n*= 87). (See **Exhibit B3**.)

Exhibit B3. Counts and Percentages of Racial/Ethnic Categories: AARS Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. racial/ethnic categories were not displayed in the graph above due to the small n: Declined to state (*n* = 16), other race (*n* = 15), Central American (*n* = 15), Middle Eastern (*n* = 12), American Indian, Alaskan Native, or Indigenous (*n* = 8), Asian Indian/South Asian (*n* = 7), Japanese (*n* = 4), Fijian (*n* = 3), Puerto Rican (*n* = 3), European (*n* = 2), Chamorro (*n* = 2) African (*n* = 1), and Cambodian (*n* = 1).

Exhibit B4. Counts and Percentages of Special Populations: AARS Attendees at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Physical/mobility disability (*n* = 10), Veteran (*n* = 6), Learning disability (*n* = 5), and Developmental (*n* = 1.

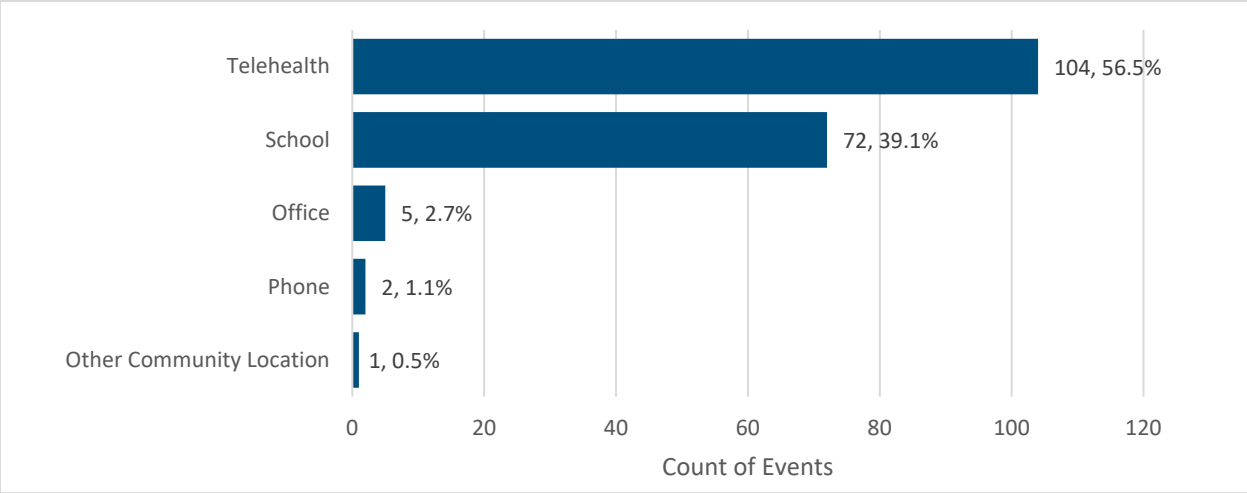
Appendix C. FY2022–2023 Outreach, Daly City Peninsula Partnership Collaborative

For FY2022–2023, Daly City Peninsula Partnership Collaborative reported 184 outreach events, including 120 individual events and 64 group events. There were 1148 attendees at these events. Individual outreach events ranged from 45 to 60 minutes and lasted for 45 minutes on average. The group outreach events ranged from 30 to 360 minutes and lasted for 93 minutes on average.

Outreach events

- Took place via telehealth most often (**56.5%;** *n* = 104). Other locations of events and their respective values are shown in **Exhibit C1.**
- Were conducted in English (**100%;** *n* = 184).
- Resulted in four mental health referrals and no substance use treatment referrals at the individual outreach events.
- There were 120 referrals to social services for individuals who attended the individual events. All individual outreach event attendees (*n* = 120) were referred to receive medical care.

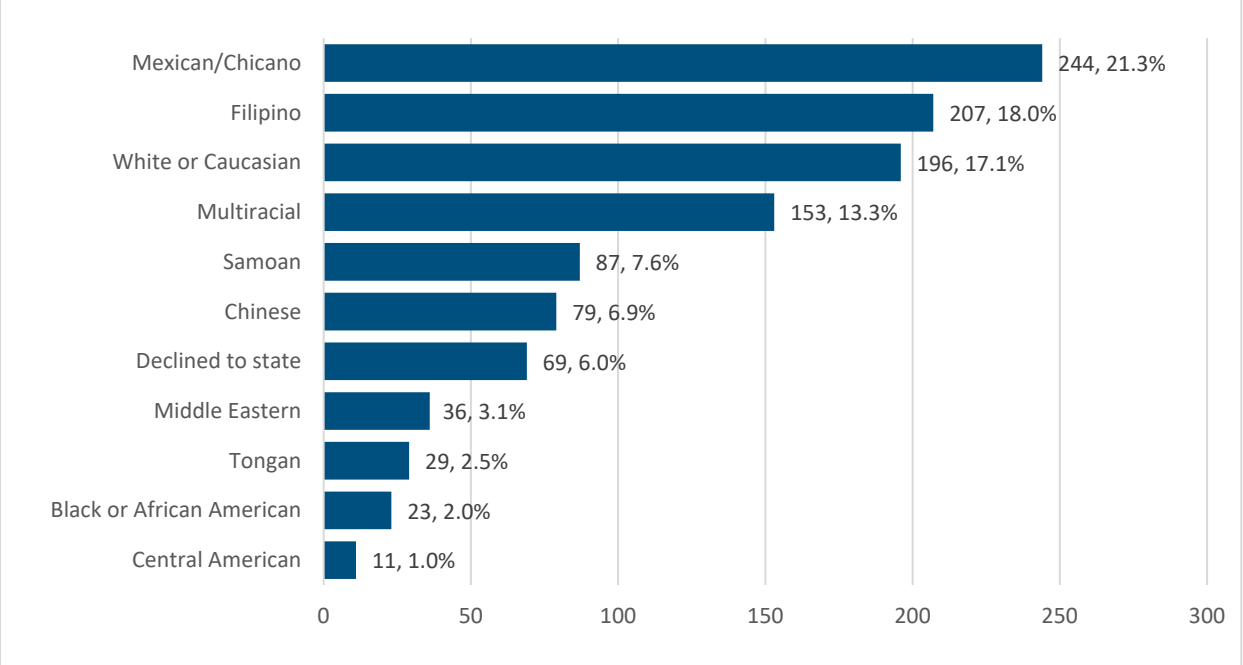
Exhibit C1. Counts and Percentages of Events by Location Type: Daly Center Peninsula Partnership Collaborative Outreach Events, FY2022–2023



Outreach event attendees

- Were female (**65.3%;** *n* = 750) and male (**31.2%;** *n* = 358). Some (**3.6%;** *n* = 41) declined to state their sex at birth.
- Identified their gender as female (**65.3%;** *n* = 752), male (**31%**; *n* = 357), female-to-male transgender (**0.1%**; *n*= 1), and not listed (**1%**; *n*= 1). Some (**3.5%**; *n* = 40) declined to state their gender.
- Identified as heterosexual (**36.0%;** *n* = 413), gay/lesbian (**4.2%;** *n* = 48), bisexual (**0.01%**; *n* = 1), queer (**0.2%;** *n* = 2), questioning (**0.2%;** *n* = 2), or other (**0.1%,** *n* = 1). 682 attendees declined to state their sexual orientation (**59.4%).**
- Included adults (26–59 years of age; **2.7%;** *n* = 31), children (15 years of age and younger; **5.7%;** *n* = 65), older adults (60 years of age and older; **0.5%**; *n* = 6), and transition-age youth (16–25 years of age; **1.6%;** *n* = 18). Almost ninety percent of attendees (**89.5%;** *n* = 1028) declined to state their age.
- Were most frequently of Mexican/Chicano (**21.3%;** *n* = 244), Filipino (**18.0%;** *n* = 207), or White/Caucasian (**17.1%;** *n* = 196) race/ethnicity (See **Exhibit C2**.)

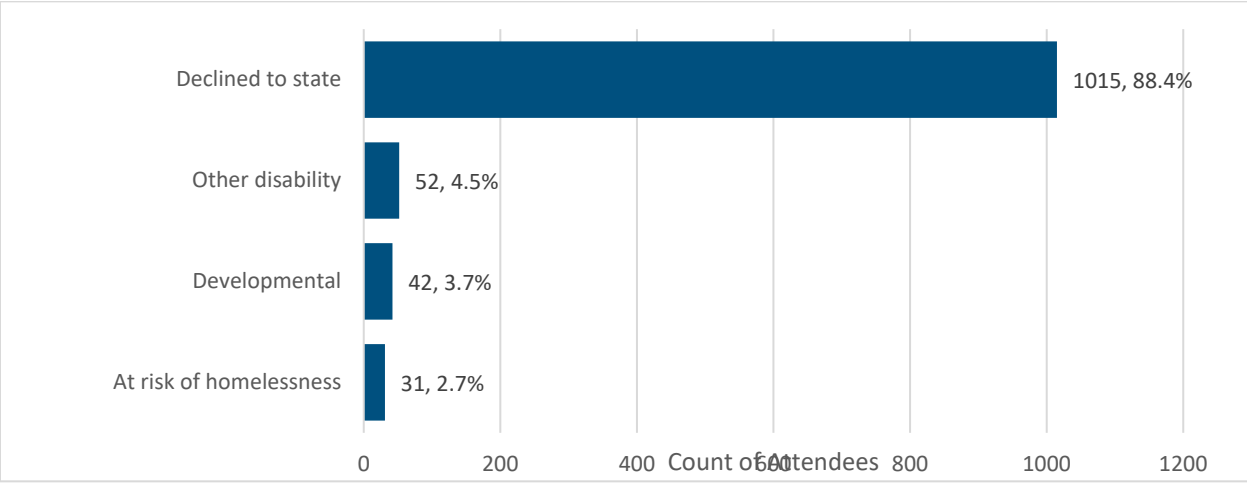
Exhibit C2. Counts and Percentages of Racial/Ethnic Categories: Daly City Peninsula Partnership Collaborative Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Other race (*n* = 6), Korean (*n* = 6), South American (*n* = 5), Asian Indian/South Asian (*n* = 3), and Vietnamese (*n* = 2).

In FY2022–2023 out of the 1148 people who attended Daly Center Peninsula Partnership events, 4.5% reported other disability, 3.7% a developmental disability, and 2.7% being at risk of homelessness as one of the special needs they have. Most of these attendees (**88.4%**) declined to state being in a special population group. They also reported having a physical/mobility disability, a hearing impairment, a learning disability, chronic health conditions, and veteran status among their special needs. (See **Exhibit C3.**)

Exhibit C3. Counts and Percentages of Special Populations: Daly City Peninsula Partnership Collaborative at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Physical/mobility disability (*n* = 6), hearing impaired (*n* = 6), learning disability (*n* = 4),chronic health conditions (*n* = 2), and veteran status (*n* = 1).

Appendix D. FY2022–2023 Outreach, Daly City Youth Center

For FY2022–2023, Daly City Youth Center reported 113 outreach events, including 64 individual events and 49 group events. There were 658 attendees. Individual outreach events ranged from 3 to 120 minutes and lasted for 30 minutes on average. The group outreach events ranged from 30 to 210 minutes and lasted for 69 minutes on average.

Outreach events

- Took place at schools most of the time (**77%**, *n* = 87). Other locations for events and their respective values are shown in **Exhibit D1.**
- Were conducted in English (**62.8%**, *n* = 71), Spanish (**31%,** *n* = 35), and Tagalog (**6.2%**, *n*= 7).
- Resulted in 34 mental health referrals and no substance use treatment referrals at the individual outreach events.
- There were five referrals to social services for individuals who attended the individual events. (See **Exhibit D2**). Most of the individual outreach event attendees (*n* = 64) were not referred to a social service in FY2022–23 (**96.9%,** *n* = 62). Of the two attendees with referrals, there were two referrals to other social services, one referral to housing services, one referral to food services, and one referral to financial services.

Exhibit D1. Daly City Youth Center Locations of Outreach Events, FY2022–2023

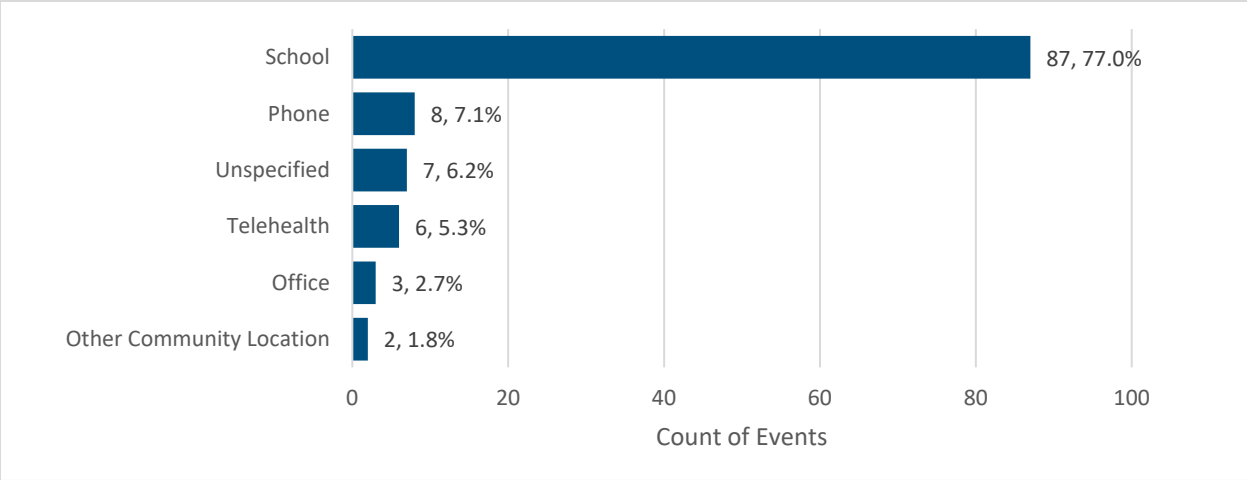
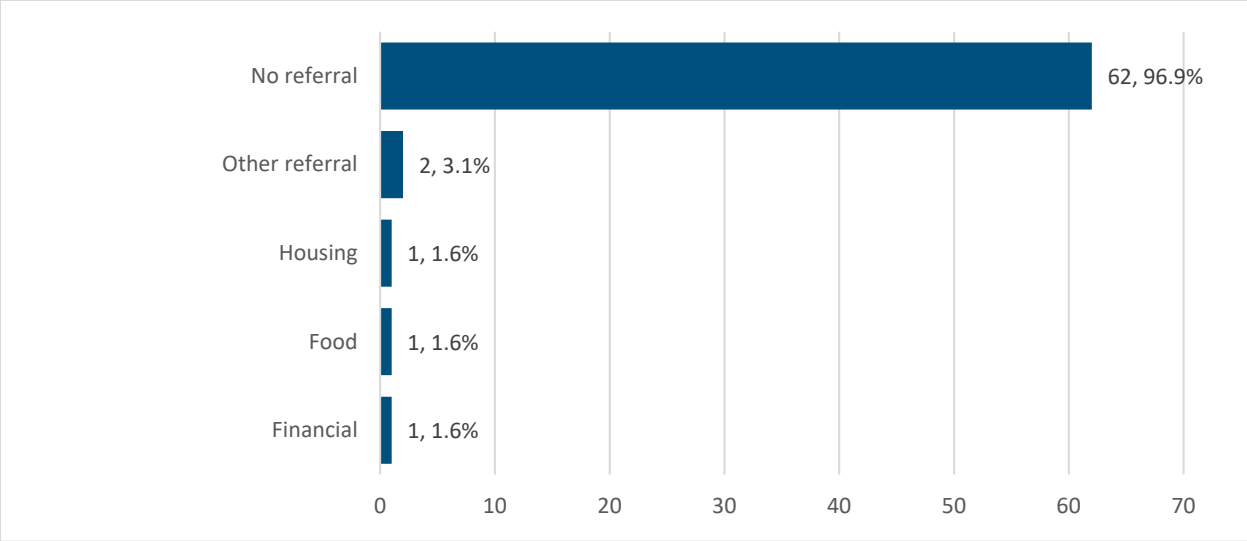


Exhibit D2. Daly City Youth Center Social Services Referrals, FY2022–2023

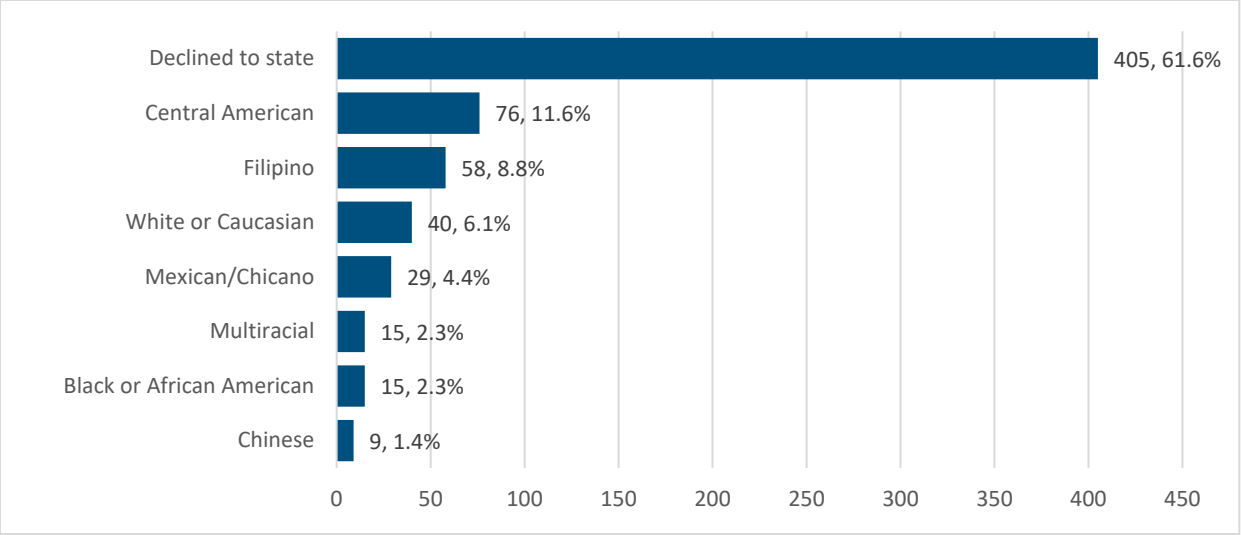


Notes. 1) Only individual outreach events (n = 64) offer service referrals. 2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.

Demographics of Outreach event attendees

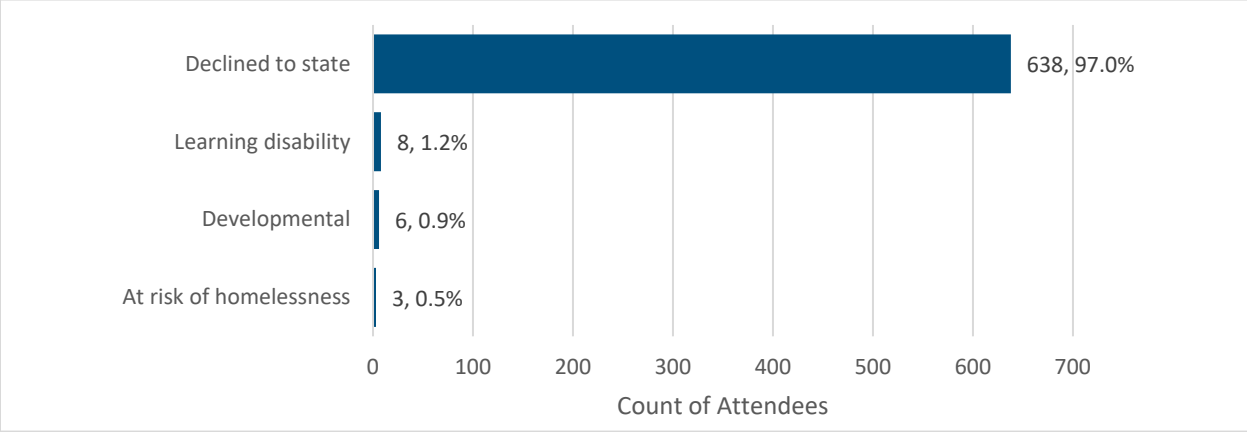
- Identified their gender as male (**22.3%;** *n* = 147) or female (**15.6%**; *n* =103). One attendee reported another gender (**0.2%**), and 407 attendees declined to state their gender (**61.9%**).
- Identified as heterosexual (**10.8%;** *n* = 71), questioning (**1.4%;** *n* = 9), gay/lesbian (**0.2%;** *n* =1), and bisexual (**0.3%;** *n* = 2). Most declined to state their sexual orientation (**87.2%;** *n* = 574), and some identified as a sexual orientation that was not listed (**0.2%;** *n* = 1).
- Included children (15 years of age and younger; **33.2%**; *n* = 218), transition-age youth (16–25 years of age, **19.9%;** *n* = 131), adults (26–59 years of age; **10.5%**; *n* = 69), older adults (older than 60 years of age; **2.4%;** *n*= 16). The remaining attendees (**34.0%;** *n* = 224) declined to state their age.
- Declined to state their race (**61.6%**; *n* = 405). The remaining attendees were primarily Central American (**11.6%;** *n* = 76), Filipino (**8.8%;** *n* = 58), White or Caucasian (**6.1%;** *n* = 40), Mexican/Chicano (**4.4%;** *n* = 29), multi-racial (**2.3%;** *n* = 15), Black or African-American (**2.3%;** *n* = 15), or Chinese (**1.4%;** *n* = 9). (See **Exhibit D3**.)

Exhibit D3. Daly City Youth Center Attendees by Top Racial/Ethnic Category, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: South American (*n* = 4), Samoan (*n* = 2), Asian Indian/South Asian (*n* = 2),Middle Eastern (*n* = 1), European (*n* = 1),and American Indian, Alaskan Native, and Indigenous (*n* = 1).

In FY2022–2023, of the 658 people that attended Daly City Youth Center events, 97.0% declined to state any special population group, 1.2% reported learning disability, 0.9% reported developmental disability, and 0.5% reported being at risk for homelessness as one their special needs. (See **Exhibit D4.**) They also reported being homeless, having another disability, or having chronic health conditions among their special needs.



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Homeless (*n* = 1), Other disability (*n* = 1), and Chronic health conditions (*n* = 1).

Appendix E. FY2022–2023 Outreach, El Concilio

For FY2022–2023, El Concilio reported 92 outreach events, all of which were individual events. There were 92 attendees. Individual outreach events ranged from 10 to 20 minutes and lasted for 12 minutes on average.

Outreach events

- Most took place in an office (**73.9%**; n = 68). Other locations of events and their respective values are shown in **Exhibit E1.**
- Were conducted in Spanish (**85.9%**; n =79) and English (**14.1%**; n = 13).
- Resulted in 31 mental health referrals and one substance use treatment referral at the individual outreach events.
- There were 197 referrals to social services for individuals who attended the individual events. (See **Exhibit E2.**) Individual outreach event attendees (n = 92) were referred to form assistance (**68.5%**; n = 63), other services (**64.1%**; n = 59), legal (**27.2%**; n = 25) services, food (**20.7%**, n = 19) services, financial (**16.3%**, n = 15) services, housing (**8.7%**, n = 8) services, medical care (**4.3%**, n = 4), health insurance (**3.3%**, n = 3), no referral (**2.2%**, n = 2), and emergency/protective services (**1.1%**, n = 1)

Exhibit E1. Counts and Percentages of Events by Location Type: El Concilio Outreach Events, FY2022–2023

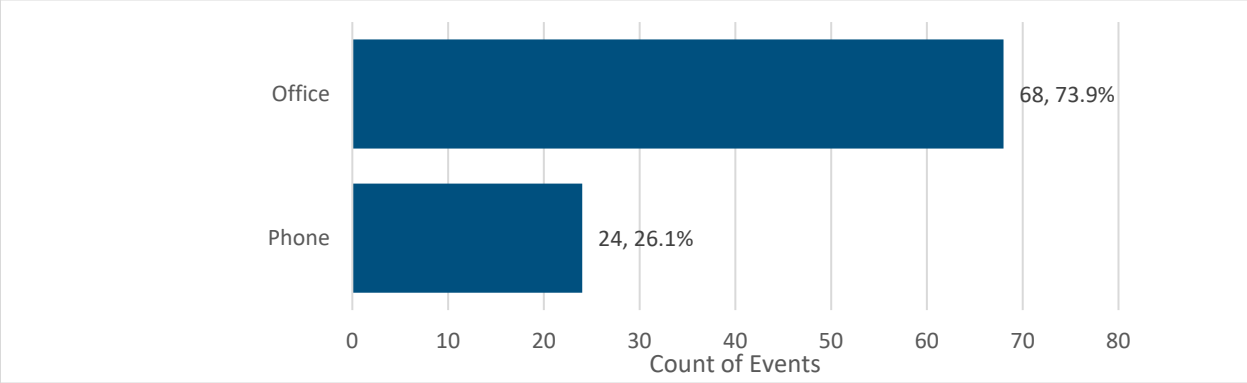
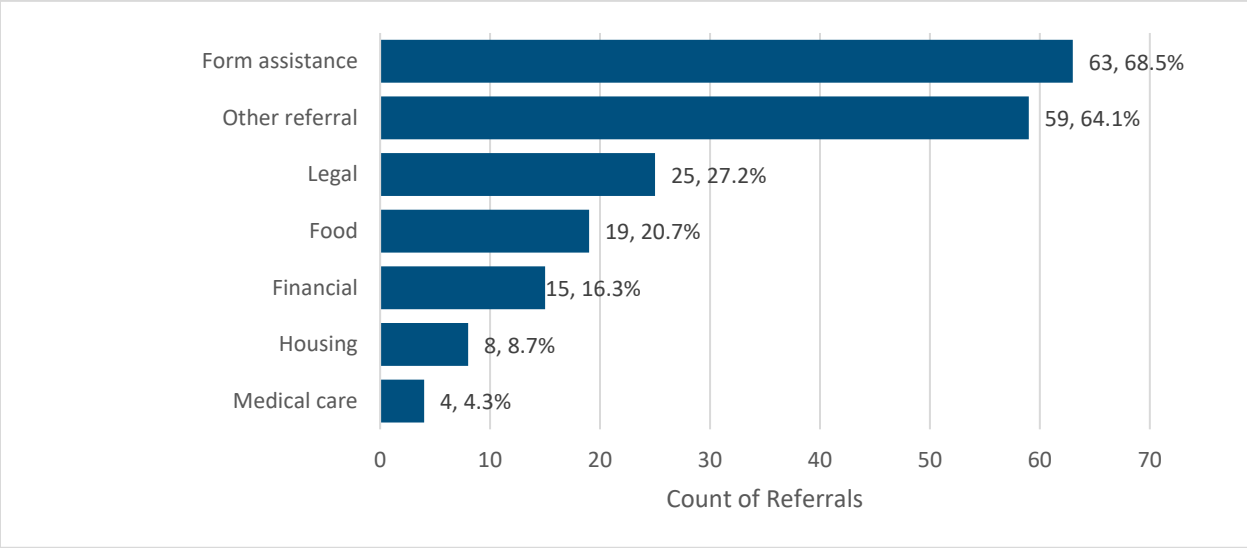


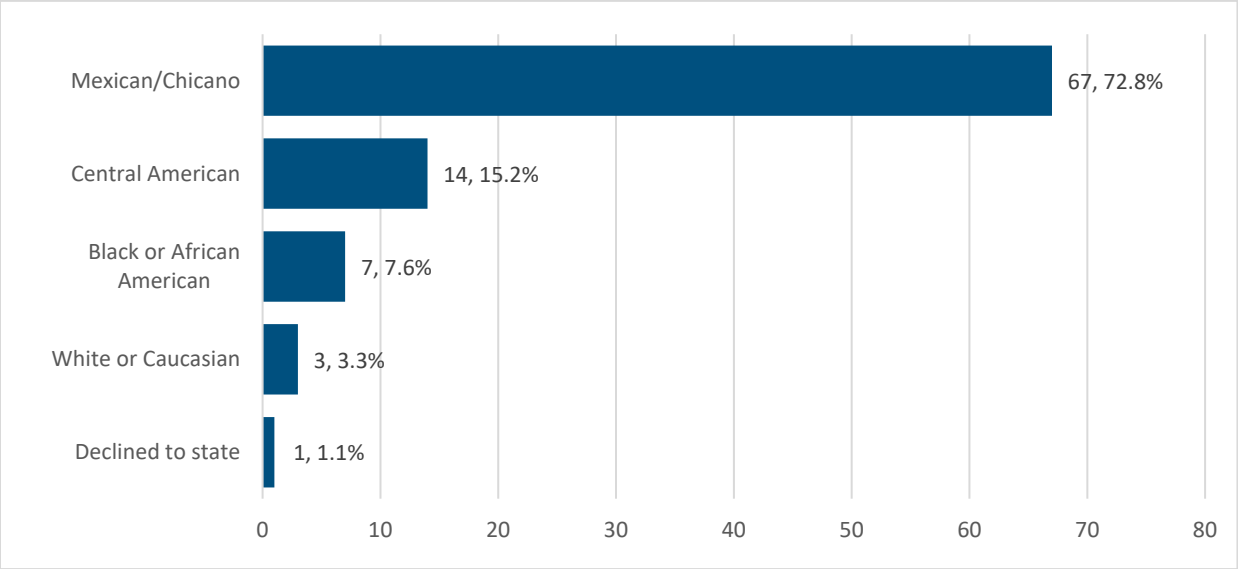
Exhibit E2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: El Concilio, FY2022–2023



Notes. 1) Only individual outreach events (n = 92) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: Health insurance (*n* = 3), No referral (*n* = 2) and Emergency/Protective services (*n* = 1).

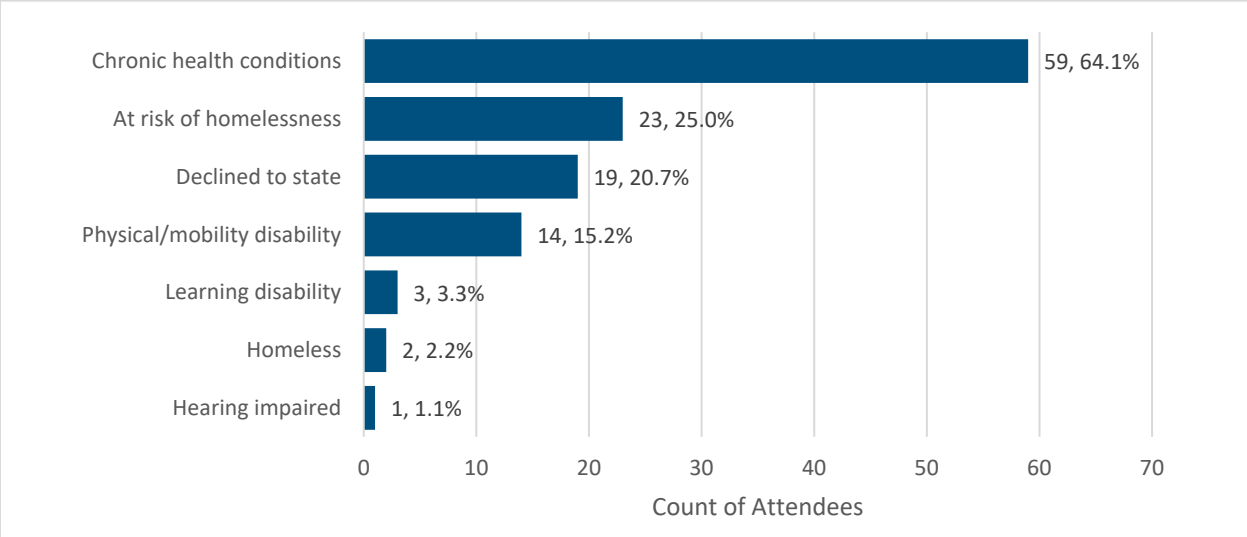
- Most often were female (**94.6%**; n = 87); 15% were male (**5.4%**; n =5).
- Were heterosexual (**98.9%**; n = 91) and bisexual (**1.1%**; n = 1)
- Included adults (26–59 years of age, **90.2%**; n = 83), and older adults (60 years, **9.8%**; n = 9).
- Race/ethnicities most frequently reported by outreach event attendees were Mexican/Chicano (**72.8%**; n =67), Central American (**15.2%**; n = 14), Black or African American (**7.6%**; n = 7), and White or Caucasian (**3.3%**; n = 3). One attendee declined to state their race/ethnicity (**1.1%**). (See **Exhibit E3.**)

Exhibit E3. Counts and Percentages of Racial/Ethnic Categories: El Concilio Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity.

In FY2022–2023, of the 92 people who attended El Concilio events, 64.1% had chronic health conditions, 25.0% were at risk for homelessness, 20.7% declined to state any special needs, and 15.2% had a physical/mobility disability. (See **Exhibit E4**.) They also reported having a learning disability, being homeless, or having a hearing impairment.



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix F. FY2022–2023 Outreach, Free At Last

For FY2022–2023, Free At Last reported 436 outreach events, all of which were individual events. There were 436 attendees. The events ranged from 5 to 35 minutes and were for 17 minutes on average.

Outreach events

- Most frequently took place over the phone (**62.2%;** *n* = 271) and in an office (**25%;** *n* = 109), as shown in **Exhibit F1.**
- Were conducted in Spanish (**58%;** *n* = 253), English (**41.7%;** *n* = 182), and Mandarin (**0.2%;** *n* = 1).
- Resulted in 23 mental health referrals and 397 substance use referrals at the individual outreach events.
- There were 858 referrals to social services for individuals who attended the individual events. (See **Exhibit F2**.) Individual outreach event attendees (*n* = 436) were referred to medical care (**96.6%;** *n* = 421), housing (**89.9%;** *n* = 392), health insurance (**9.2%;** *n* = 40), form assistance (**0.5%;** *n* = 2), transportation (**0.2%**, *n* = 1), food (**0.2%,** *n* = 1), and legal services (**0.2%,** *n* = 1).

Exhibit F1. Counts and Percentages of Events by Location Type: Free at Last Attendees at Outreach Events, FY2022–2023

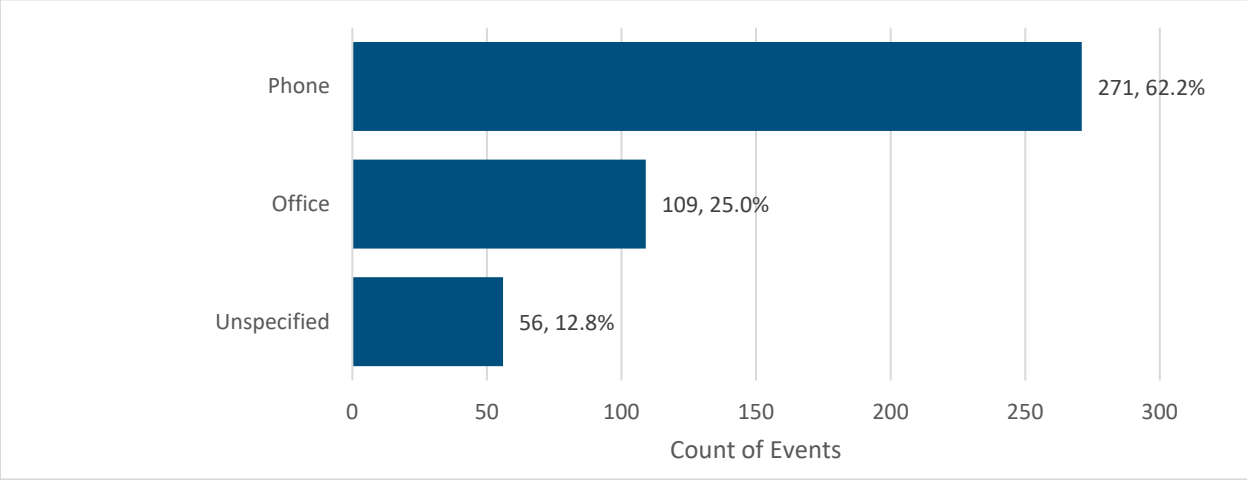
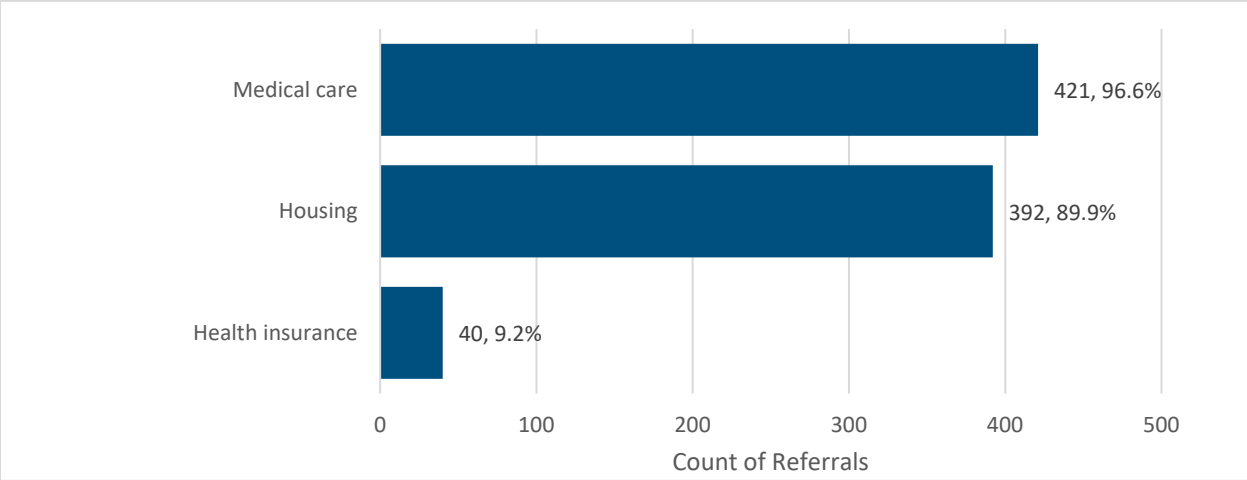


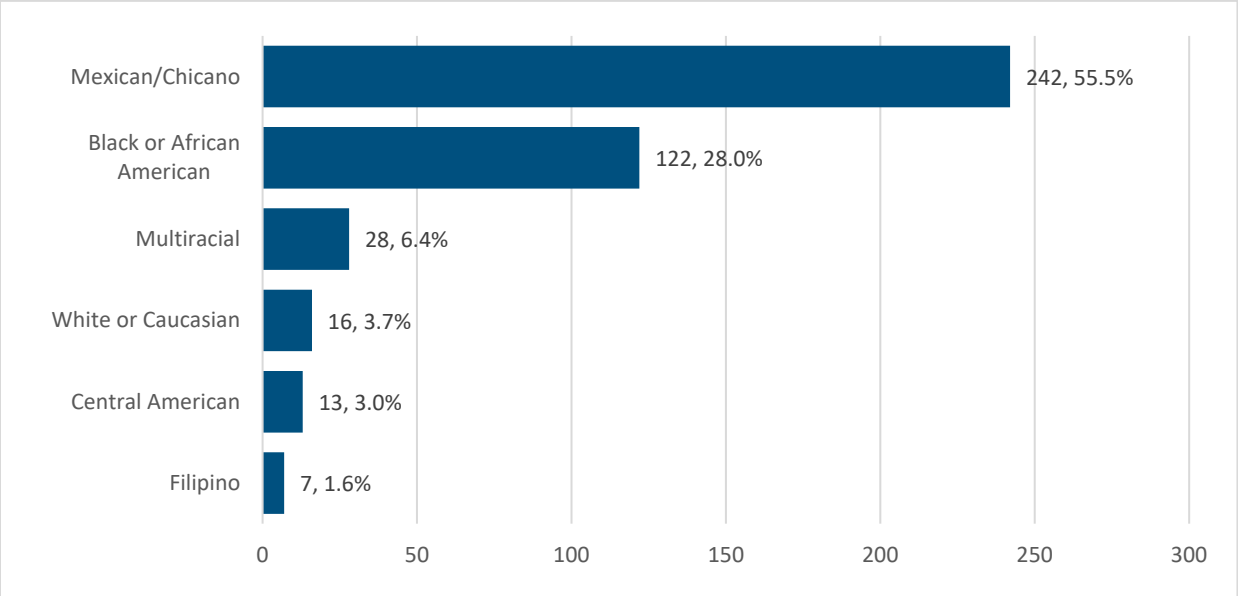
Exhibit F2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Free at Last, FY2022–2023



Notes. 1) Only individual outreach events (n = 436) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3) These referral types were not displayed in the graph above due to the small n: Form assistance (*n* = 2), Transportation (*n* = 1),Legal (*n* = 1), and Food (*n* = 1).

- Most often were male (**58.9%;** *n* = 257); 41.1% were female (**41.1%;** *n* = 179).
- Identified their gender as male most of the time (**51.4%;** *n* = 224); identified as female (**41.5%;** *n* = 181); female-to-male transgender (**0.5%,** *n* = 2); male-to-female transgender (**7.1%,** *n* = 31).
- Identified as heterosexual (**65.4%;** *n* = 285), gay/lesbian (**23.6%;** *n* = 103), bisexual (**22.7%;** *n* = 99), or pansexual (**4.1%**; *n* = 18).
- Included adults (26–59 years of age, **78.2%;** *n* = 341) transition-age youth (16–25 years of age, **16.1%;** *n* = 70), and older adults (60 years or older, **5.7%;** *n*= 25).
- Most frequently self-reported race/ethnicity category as Mexican or Chicano (**55.5%;** *n* = 242), Black or African American (**28%;** *n* = 122), or more than one race (**6.4%;** *n* = 28). (See **Exhibit F3**.)

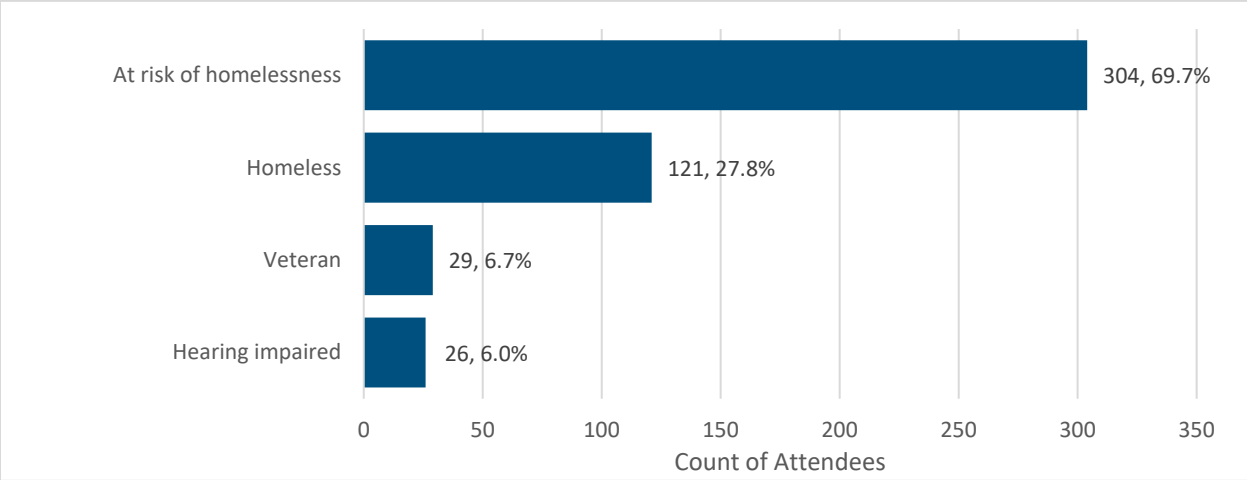
Exhibit F3. Counts and Percentages of Racial/Ethnic Categories: Free at Last Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Tongan (*n* = 4), Samoan (*n* = 3) and Asian (*n* = 1).

In FY2022–2023, out of the 436 people who attended Free at Last events, 69.7% were at risk for homelessness, 27.8% were homeless, 6.7% were a veteran, and 6.0% reported having a hearing impairment. (See **Exhibit F4**.) They also reported having chronic health conditions, physical/mobility disabilities, or being visually impaired as one their special needs.

Exhibit F4. Counts and Percentages of Special Populations: Free at Last Attendees at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Declined to state (*n* = 7), chronic health conditions (*n* = 5), physical/mobility disability (*n* = 3), and visually impaired (*n* = 2).

Appendix G. FY2022–2023 Outreach, Pacifica Collaborative

For FY2022–2023, Pacifica Collaborative reported 27 outreach events, including 15 individual outreach events and 12 group outreach events. There were 1627 attendees. Individual outreach events ranged from 15 to 30 minutes and lasted for an average of 25 minutes. Group outreach events ranged from 60 to 240 minutes and lasted an average of 108 minutes.

Outreach events

- Most frequently took place at school (**59.3%;** *n* = 16), a community location (**25.9%;** *n*=7), age-specific community center (**11.1%;** *n* = 3), or virtually (**3.7%;** *n* = 1). (See **Exhibit G1)**
- Were conducted in English (**96.3%;** *n* = 26) and Spanish (**3.7%;** *n*= 1).
- Resulted in 11 mental health referrals and 1 substance use treatment referral.
- There were 17 referrals to social services for individuals who attended the individual events.. (See **Exhibit G2**). Individual outreach event attendees (*n* = 12) were referred to food (**41.7%;** *n* = 5), housing (**33.3%;** *n* = 4), transportation (**16.7%;** *n* = 2), form assistance ((**16.7%;** *n* = 2), financial (**16.7%;** *n* = 2), medical care (**8.3%,** *n* = 1), and legal (**8.3%,** *n* = 1) services.

Exhibit G1. Counts and Percentages of Events by Location Type: Pacifica Collaborative Outreach Events, FY2022–2023

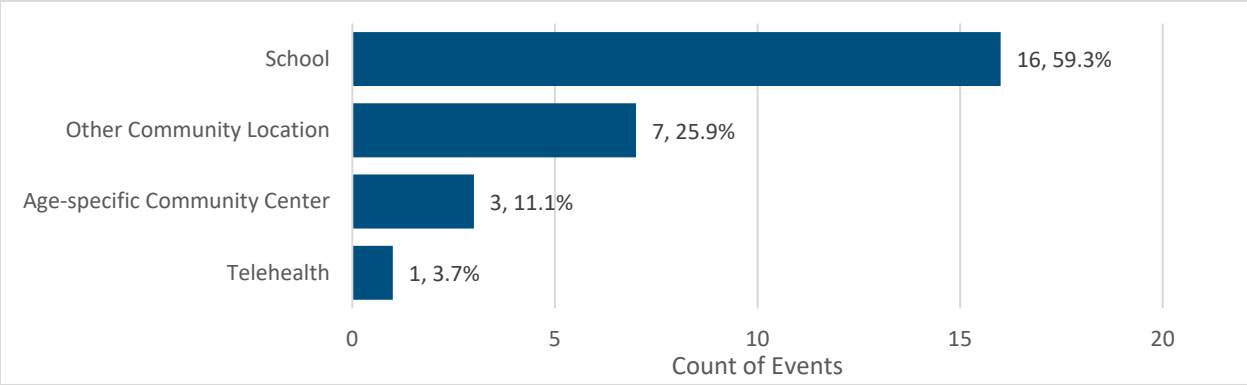
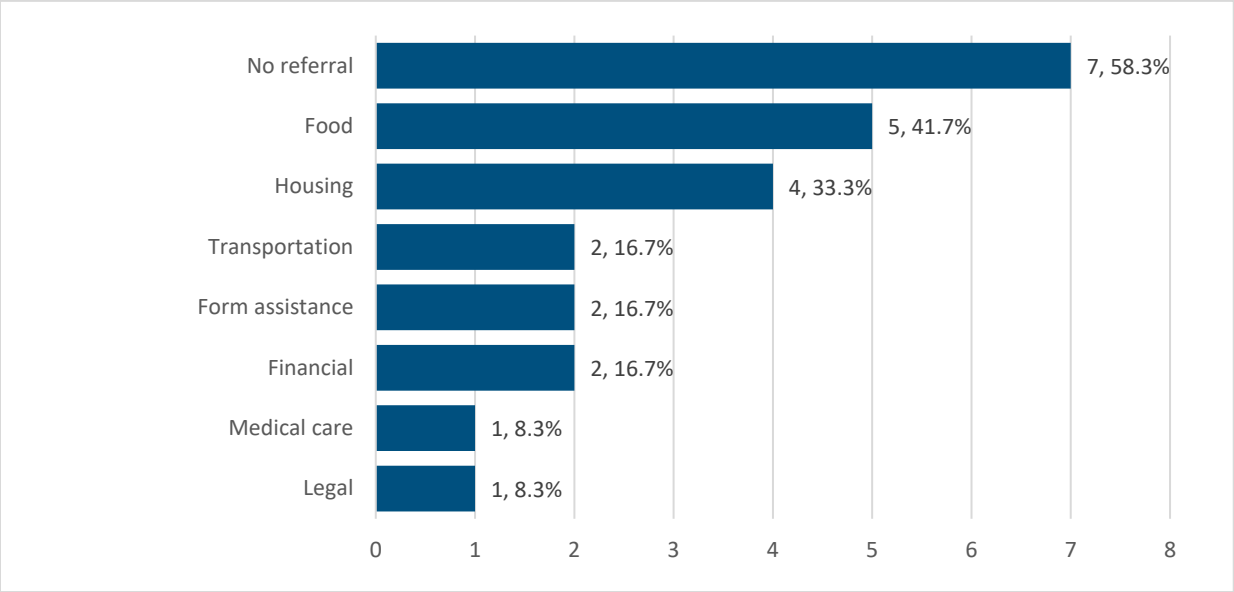


Exhibit G2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: Pacifica Collaborative, FY2022–2023



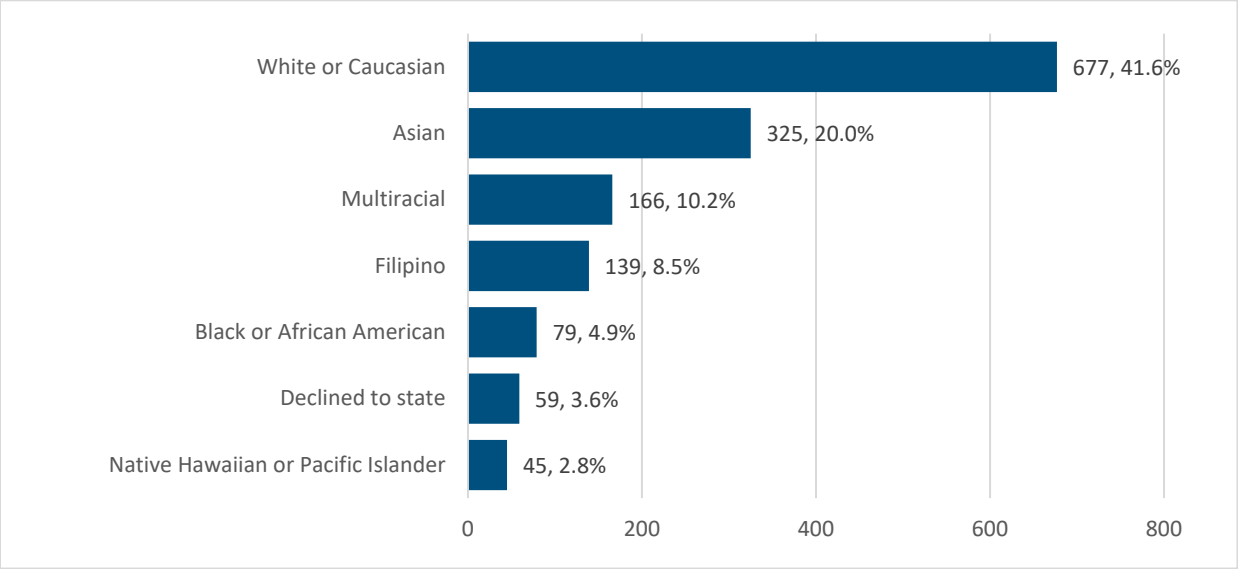
Notes. 1) Only individual outreach events (n = 12) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.

Outreach event attendees

- Identified their gender as female (**58.4%;** *n* = 950), male (**38.7%;** *n* = 629), female to male transgender (**0.6%;** *n* = 9), male to female transgender (**0.4%;** *n* = 6), and genderqueer (**0.6%;** *n* = 10). There were 16 (**1.0%**) attendees who declined to state their gender.
- Identified as heterosexual (**77.7%;** *n* = 1264), gay/lesbian (**12.0%;** *n* = 195), bisexual (**3.6%;** *n* = 59), queer (**2.8%;** *n* = 45), or questioning (**0.4%;** *n* = 7). Almost **4%** of attendees (*n* = 59) declined to state their sexual orientation.
- Included adults (26–59 years of age, **46.1%;** *n* = 750),older adults (60 years of age and older, **29.6%**; *n* = 482), transition-age youth (16–25 years of age, **14.8%;** *n* = 240), and children and teens (0–15 years of age, **8.7%**; *n* = 142) There were 13 (**0.8%**) attendees who declined to state their age.

- The highest percentages of identified race/ethnicity include White or Caucasian (**41.6%;** *n* = 677), Asian (**20%;** *n* = 325), multi-racial (**10.2%;** *n*=166), or Filipino (**8.5%;** *n*= 139). (See **Exhibit G3 for the remaining identified race/ethnicity groups**.)

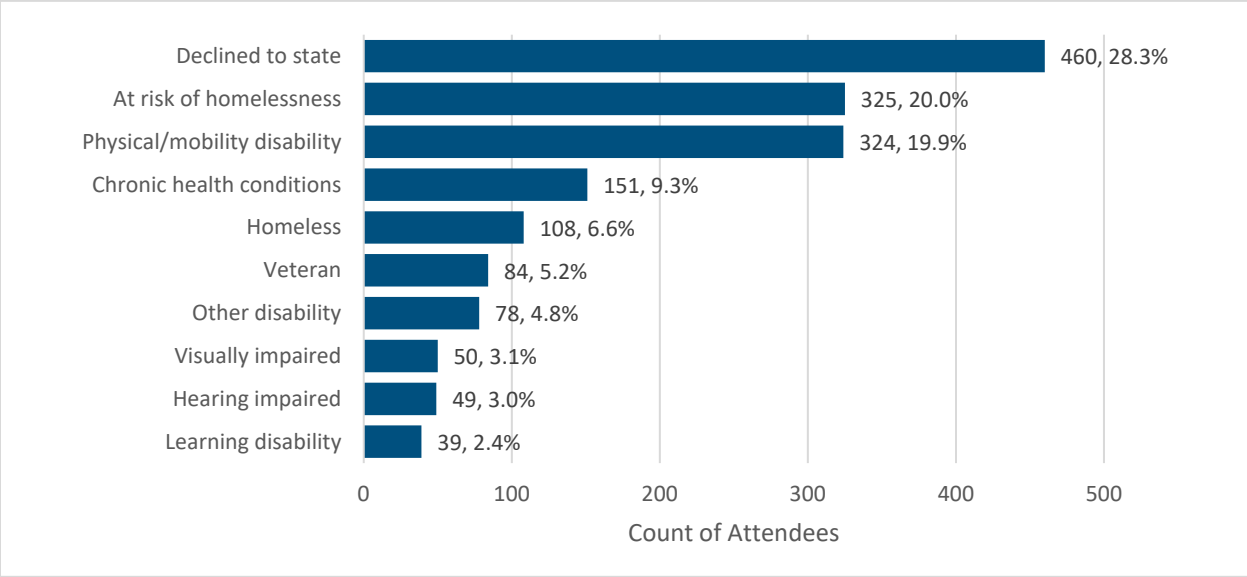
Exhibit G3. Counts and Percentages of Racial/Ethnic Categories: Pacific Collaborative Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. There were 137 clients whose racial/ethnic categories are not displayed in the graph above due to the small n. These racial/ethnic categories were not displayed in the graph above due to the small n: Mexican/Chicano (*n* = 30), Chinese (*n* = 28), American Indian Alaskan Native, or Indigenous (*n* = 28), Asian Indian/South Asian (*n* = 18), Samoan (*n* = 16), Japanese (*n* = 9), Fijian (*n* = 7),and Tongan (*n* = 5),

In FY2022–2023, of the 1627 people that attended Pacifica Collaborative events, 28.3% declined to state their special needs, 20.0% were at risk for homelessness, 19.9% reported having a physical/mobility disability, and 9.3% had chronic health conditions. (See **Exhibit G4**.) They also reported being homeless, being a veteran, having other disabilities, being visually impaired, being hearing impaired, having a learning disability, having a developmental disability, or having dementia among their special needs.

Exhibit G4. Counts and Percentages of Special Populations: Pacifica Collaborative Attendees at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%. These special populations were not displayed in the graph above due to the small n: Developmental disability (*n* = 14) and Dementia (*n* = 7).

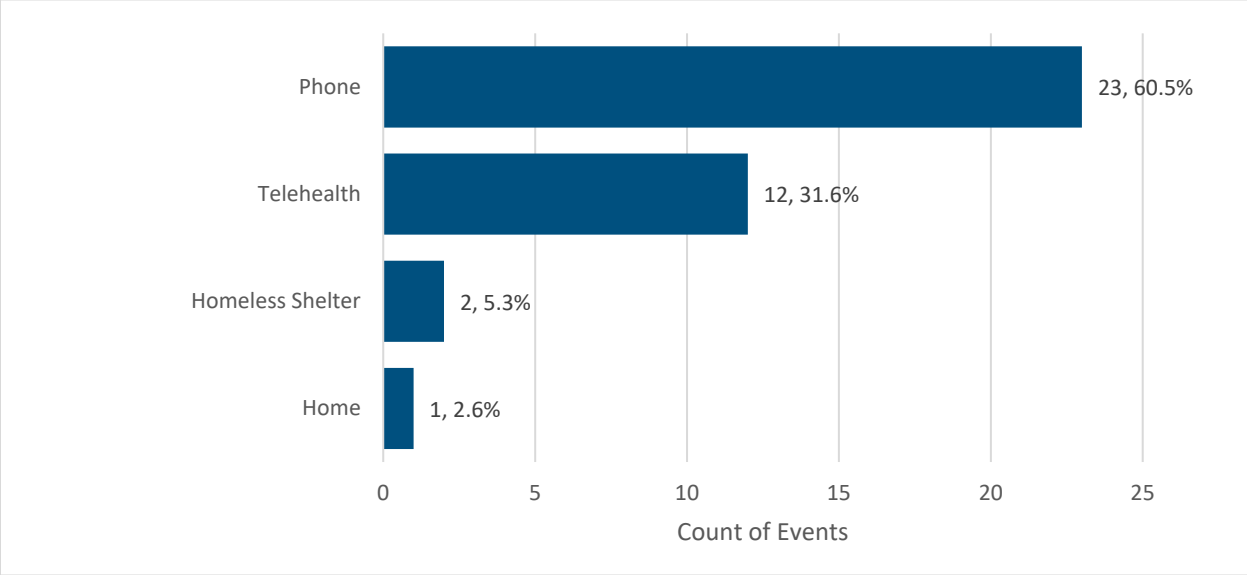
Appendix H. FY2022–2023 Outreach, StarVista

For FY2022–2023, StarVista reported 37 individual outreach events, and one group outreach event with eleven attendees, resulting in a total of 48 attendees. Individual outreach events ranged from 10 to 90 minutes and lasted for 38 minutes on average. The group outreach event lasted for 60 minutes.

Outreach events

- Most frequently took place on the phone (**60.5%;** *n* = 23) or telehealth (**31.6%;** *n*=12). Other locations for events and their respective values are shown in **Exhibit H1.**
- Were conducted in English (**60.5%;** *n* = 23) and Spanish (**39.5%;** *n*= 15).
- Resulted in 28 mental health referrals.
- There were 96 referrals to social services for individuals who attended the individual events. (See **Exhibit H2**). Individual outreach event attendees (n = 37) were referred to other referrals (**45.9%;** *n* = 17), food (**45.9%;** *n* = 17), housing (**40.5%,** *n* = 15), financial (**37.8%,** *n* = 14), legal (**24.3%,** *n* = 9), emergency/protective (**21.6%,** *n* = 8), medical care (**16.2%,** *n* = 6), form assistance (**13.5%,** *n* = 5), transportation (**10.8%,** *n* = 4), and health insurance (**2.7%,** *n* = 1) services.

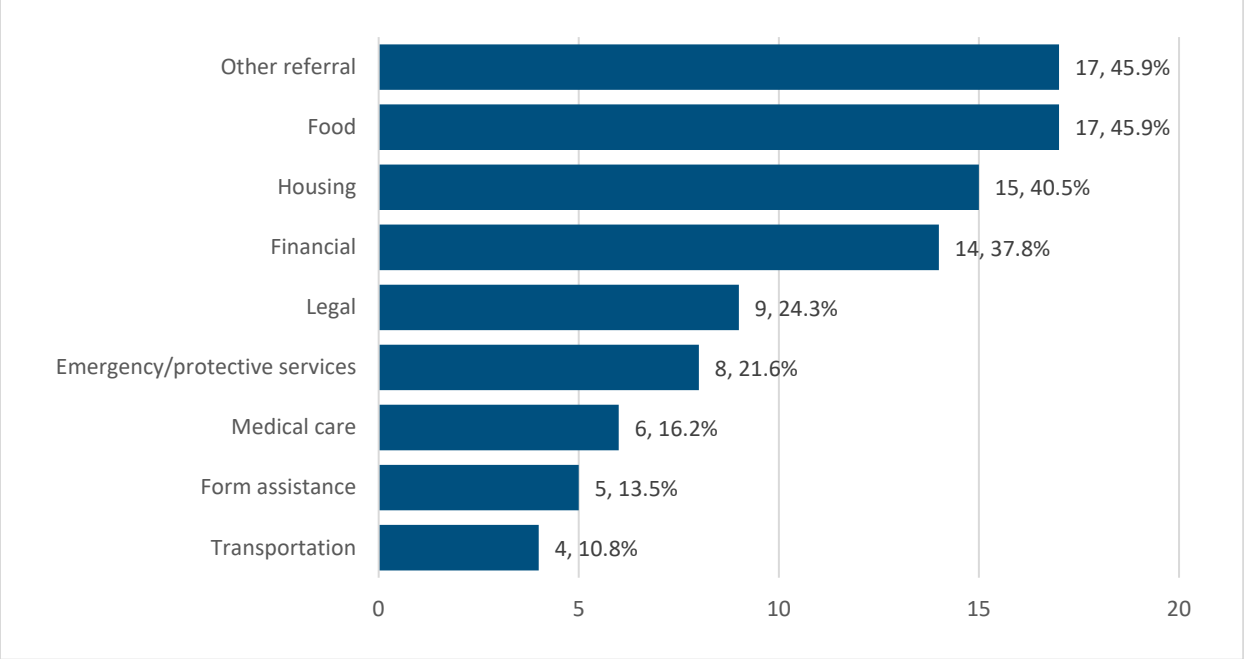
Exhibit H1. Counts and Percentages of Events by Location Type: StarVista Outreach Events, FY2022–2023



Outreach event attendees

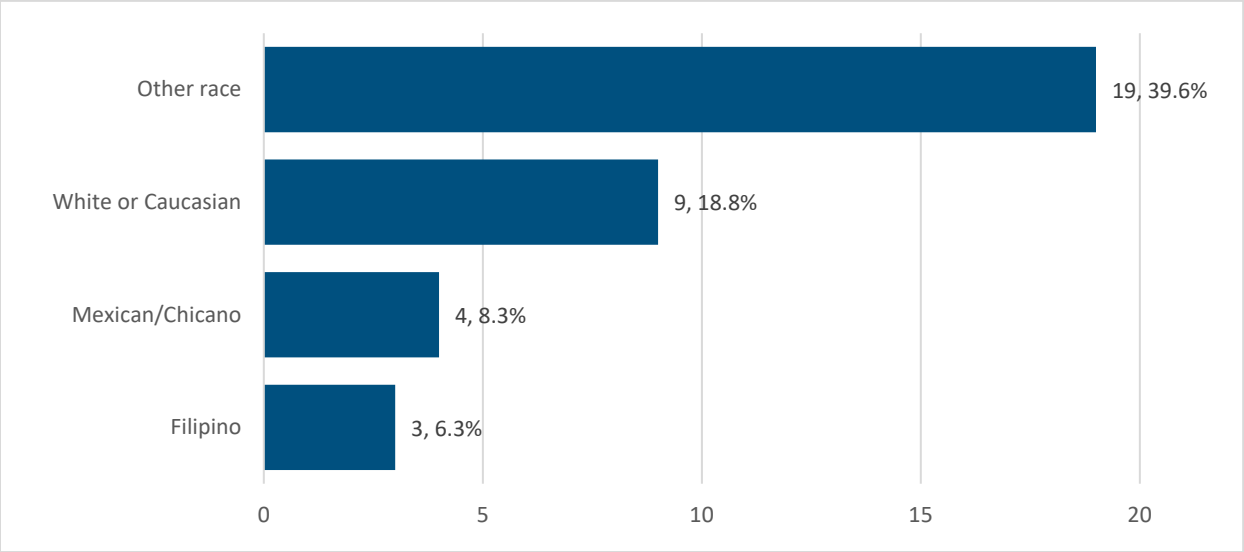
- Were female (**77.1%;** *n* = 37) or male (**22.9%;** *n* = 11).
- Identified their gender as female (**58.3%**; *n* = 28), male (**18.8%**; *n* = 9), or declined to state their gender (**22.9%**; *n* = 11).
- Identified as heterosexual (**29.2%;** *n* = 14) or declined to state their sexual orientation (**70.8%**; *n* = 34).
- Were adults (26–59 years of age, **62.5%;** *n* = 30), were between the ages of 16-25 (**4.2%;** *n* = 2) or were under the age of 15 (**10.4%;** *n* = 5). Eleven did not indicate their age (**22.9%**).
- Were primarily other races (**39.6%;** *n* = 19), White or Caucasian (**18.8%;** *n* = 9), or Mexican/Chicano (**8.3%;** *n*= 4). (See **Exhibit H3 for all other racial/ethnic groups**.)

Exhibit H2. Counts and Percentages of Social Services Referrals following Individual Outreach Events: StarVista, FY2022–2023



Notes. 1) Only individual outreach events (n = 37) offer service referrals.
2) Individual outreach events may refer an attendee to multiple social services. Therefore, the percentages may add up to more than 100%.
3).These referral types were not displayed in the graph above due to the small n: No referral (*n* = 1) and health insurance (*n* = 1).

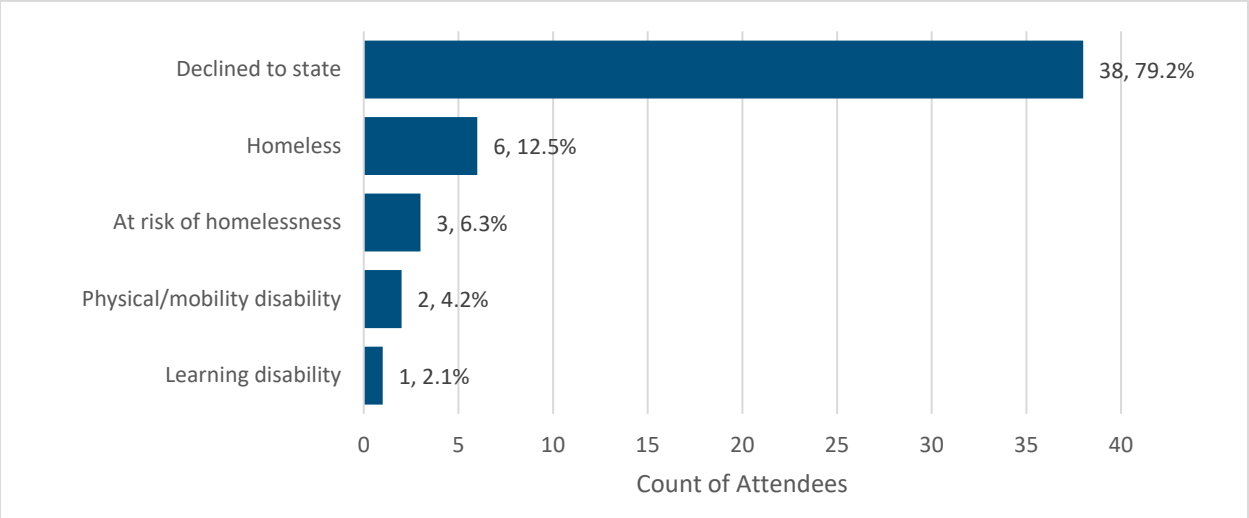
Exhibit H3. Counts and Percentages of Racial/Ethnic Categories: StarVista Attendees at Outreach Events, FY2022–2023



Note. Percentages add to more than 100% because attendees could select more than one race/ethnicity. These racial/ethnic categories were not displayed in the graph above due to the small n: Multi-racial (*n* = 2), Declined to state (*n* = 2), Samoan (*n* = 2), South American (*n* = 2), Central American (*n* = 2), and Native Hawaiian or Pacific Islander (*n* = 2), and Asian (*n* = 1).

In FY2022–2023, of the 48 people who attended StarVista events, 79.2% declined to state being in a special population, 12.5% were homeless, 6.3% reported being at risk for homelessness, 4.2% reported having a physical/mobility disability, and 2.1% had a learning disability. (See **Exhibit H4**.)

Exhibit H4. Counts and Percentages of Special Populations: StarVista Attendees at Outreach Events, FY2022–2023



Note. Attendees could select more than one special population, and therefore the percentages may add up to more than 100%.

Appendix I. Attendees by Race/Ethnicity by Collaborative, FY2018–2023

Exhibit I1. Attendees by Race/Ethnicity by Collaborative, FY2018-2023

	EPAPMHO					NCOC				
Race/Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**
Black	152 (23.2%)	93 (17.9%)	29 (11.8%)	44 (11.5%)	129 (13.1%)	167 (3%)	685 (5.4%)	202 (2.6%)	277 (3.4%)	157 (3.4%)
White	55 (8.4%)	18 (3.5%)	12 (4.9%)	12 (3.1%)	19 (1.9%)	1484 (27%)	2024 (16%)	2336 (29.6%)	2394 (29.8%)	1015 (22.2%)
American Indian	2 (.3%)	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	56 (1%)	90 (.7%)	67 (.8%)	46 (.6%)	33 (.7%)
Middle Eastern	0 (0%)	2 (.4%)	0 (0%)	0 (0%)	0 (0%)	28 (.5%)	44 (.3%)	30 (.4%)	28 (.3%)	49 (1.1%)
Eastern European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (0%)	5 (0%)	1 (0%)	1 (0%)	0 (0%)
European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	21 (.4%)	5 (0%)	3 (0%)	1 (0%)	3 (.1%)
Mexican	156 (23.8%)	119 (22.8%)	101 (41.2%)	187 (48.7%)	310 (31.6%)	462 (8.4%)	2302 (18.2%)	1235 (15.6%)	510 (6.3%)	392 (8.6%)
Puerto Rican	2 (.3%)	2 (.4%)	1 (.4%)	1 (.3%)	0 (0%)	10 (.2%)	44 (.3%)	36 (.5%)	2 (0%)	3 (.1%)
Cuban	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Central American	12 (1.8%)	19 (3.6%)	15 (6.1%)	28 (7.3%)	27 (2.7%)	32 (.6%)	127 (1%)	13 (.2%)	160 (2%)	104 (2.3%)
South American	1 (.2%)	0 (0%)	1 (.4%)	2 (.5%)	0 (0%)	15 (.3%)	27 (.2%)	67 (.8%)	6 (.1%)	11 (.2%)
Caribbean	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (.1%)	0 (0%)	5 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Latino	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)
Asian	0 (0%)	1 (.2%)	1 (.4%)	0 (0%)	1 (.1%)	550 (10%)	873 (6.9%)	604 (7.6%)	647 (8.1%)	388 (8.5%)
Filipino	9 (1.4%)	4 (.8%)	0 (0%)	4 (1%)	7 (.7%)	331 (6%)	1170 (9.3%)	316 (4%)	753 (9.4%)	494 (10.8%)
Chinese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	212 (3.9%)	936 (7.4%)	304 (3.8%)	230 (2.9%)	158 (3.4%)
Japanese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	26 (.5%)	37 (.3%)	42 (.5%)	38 (.5%)	13 (.3%)
Korean	0 (0%)	0 (0%)	1 (.4%)	1 (.3%)	0 (0%)	12 (.2%)	39 (.3%)	25 (.3%)	7 (.1%)	6 (.1%)
South Asian	2 (.3%)	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	17 (.3%)	222 (1.8%)	50 (.6%)	52 (.6%)	30 (.7%)
Vietnamese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	11 (.2%)	84 (.7%)	4 (.1%)	1 (0%)	2 (0%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (0%)	8 (.1%)	0 (0%)	0 (0%)	1 (0%)
Laotian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)
Other Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)
Tongan	97 (14.8%)	30 (5.8%)	15 (6.1%)	35 (9.1%)	125 (12.7%)	47 (.9%)	89 (.7%)	88 (1.1%)	118 (1.5%)	111 (2.4%)
Samoan	57 (8.7%)	26 (5%)	19 (7.8%)	31 (8.1%)	67 (6.8%)	201 (3.7%)	503 (4%)	137 (1.7%)	192 (2.4%)	327 (7.1%)
Fijian	5 (.8%)	1 (.2%)	0 (0%)	4 (1%)	13 (1.3%)	3 (.1%)	21 (.2%)	25 (.3%)	8 (.1%)	10 (.2%)
Hawaiian	15 (2.3%)	164 (31.5%)	40 (16.3%)	1 (.3%)	246 (25.1%)	188 (3.4%)	1521 (12.1%)	174 (2.2%)	127 (1.6%)	105 (2.3%)
Guamanian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	. (.%)
Multi	86 (13.1%)	39 (7.5%)	9 (3.7%)	31 (8.1%)	29 (3%)	369 (6.7%)	1228 (9.7%)	248 (3.1%)	325 (4%)	576 (12.6%)
Other Race	3 (.5%)	0 (0%)	1 (.4%)	0 (0%)	0 (0%)	140 (2.5%)	113 (.9%)	5 (.1%)	718 (8.9%)	40 (.9%)
Unknown Race	1 (.2%)	1 (.2%)	0 (0%)	2 (.5%)	8 (.8%)	1106 (20.1%)	412 (3.3%)	1883 (23.8%)	1392 (17.3%)	551 (12%)
Total	**656**	**521**	**245**	**384**	**982**	**5492**	**12614**	**7899**	**8033**	**4582**

Note. Percentages may not sum to 100% because of rounding. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals who are multiracial as both multiracial and their respective race/ethnicity, leading to extra counts in some cases. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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23446_12/23

San Mateo County Behavioral Health and Recovery Services Provider Outreach Efforts: The Barbara A. Mouton Multicultural Wellness Center

Fiscal Year 2022–2023

Koray Caglayan, PhD; Brooke Shearon, MPP

DECEMBER 2023

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Contents

Exhibits

The Barbara A. Mouton Multicultural Wellness Center

For fiscal year (FY) 2022–2023, the Barbara A. Mouton Multicultural Wellness Center (the Mouton Center) reported 28 outreach events, all of which were individual events. There were 28 total attendees. Individual outreach events lasted from 45 to 55 minutes and 50 minutes on average.

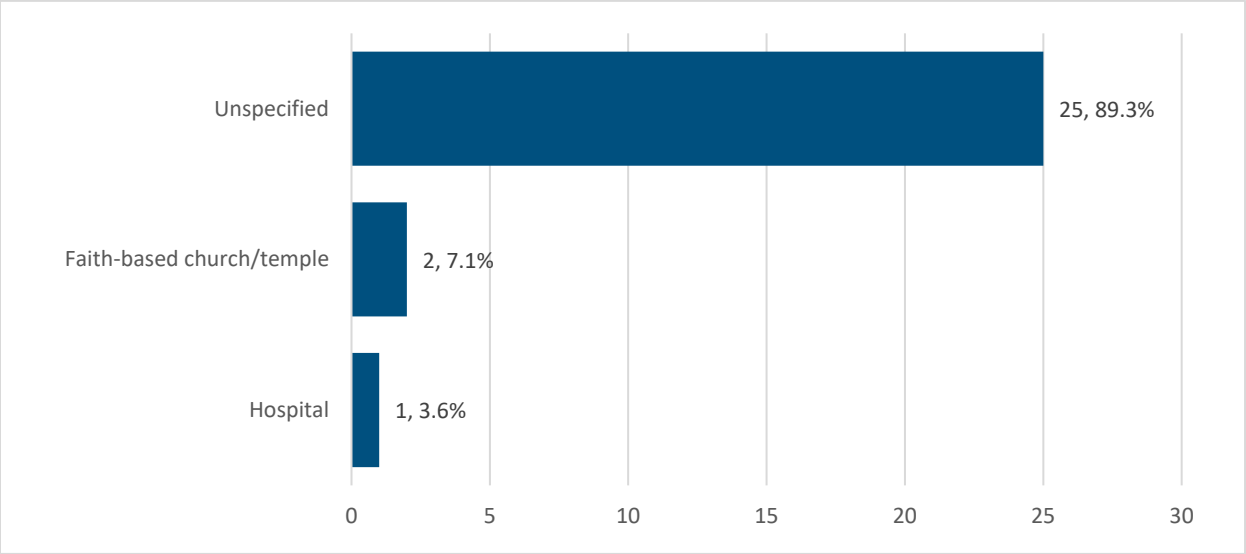
Outreach Events

- Events most frequently took place in unspecified locations (**89.3%**; *n* = 25). Other event locations and their respective percentages are shown in **Exhibit 1**.
- Events were conducted in English (**60.7%**; *n* = 17), Tongan (**32.1%**; *n* = 9), and Spanish (**7.1%**; *n* = 2).
- Events resulted in 26 mental health referrals and no substance use treatment referrals.

Outreach Event Attendees

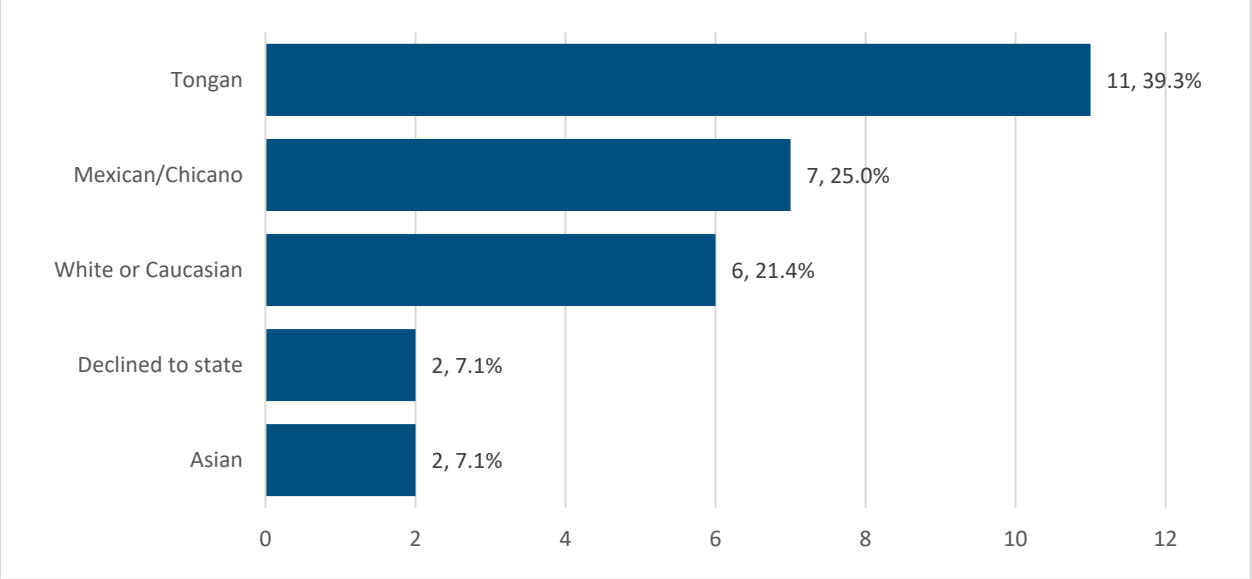
- Most attendees were female (**57.1%**; *n* = 16); 43% were male (**42.9%**; *n* = 12).
- Attendees identified as female (**57.1%**; *n* = 16) or male (**42.9%**; *n* = 12).
- All attendees identify as heterosexual.
- Attendees were adults (26–59 years of age, **50%**; *n* = 14), older adults (60 years of age and older, **39.3%**; *n* = 11), or transition-age youth (16–25 years of age, **10.7%**; *n* = 3).
- Attendees were Tongan (**39.3%**; *n* = 11), Mexican/Chicano (**25%**; *n* = 7), White (**21.4%**; *n* = 6), or Asian (**7.1%**; *n* = 2; See Exhibit 2). Two attendees declined to state their race/ethnicity.

Exhibit 1. Counts and Percentages of Events by Location Type: Mouton Center Outreach Events, FY2022–2023



Note. FY = fiscal year.

Exhibit 2. Counts and Percentages of Racial/Ethnic Categories: Mouton Center Attendees at Outreach Events, FY2022–2023



Note. FY = fiscal year. Percentages add to more than 100% because attendees could select more than one race/ethnicity.

In FY2022–2023, Mouton Center attendees at outreach events reported being in special population groups. Out of the 28 people who attended Mouton events, two were hearing impaired (**7.1%**), and one had a physical/mobility disability (**3.6%**). Most attendees (**89.3%**) declined to state a special population group.

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23446_12/23

APPENDIX 7. ADULT MENTAL HEALTH FIRST AID REPORT, FY 2022-23

San Mateo County Behavioral Health and Recovery Services

Adult Mental Health First Aid

FY22-23 Annual Report

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Behavioral Health and Recovery Services

Adult Mental Health First Aid FY22-23 Annual Report

This report was developed by RDA Consulting, SPC under contract with San Mateo County Behavioral Health and Recovery Services

RDA Consulting, 2023

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Program Overview

Adult Mental Health First Aid (AMHFA, the program, or the course) is an 8-hour public education course funded by the Mental Health Services Act (MHSA) and provided by San Mateo County's Behavioral Health & Recovery Services Office of Diversity and Equity (BHRS ODE). The course introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. AMHFA aims to teach community members and partners in San Mateo County by:

- Incorporating culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to marginalized populations in a more culturally responsive way.
- Sharing mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.
- Sharing local resources participants can refer to for professional behavioral health support, including public health services.
- Partnering with agencies that connect marginalized communities to care, including those serving older adults and immigrant communities to reduce disparities in access to care.

BHRS ODE works in partnership with other community organizations to facilitate AMHFA courses. Between July 2022 – June 2023 (FY22-23), BHRS ODE contracted with the following trained instructors to conduct AMHFA courses:

- Yoko Ng from Hope Oriented Wellness USA;
- Brittany Afu, Evelia Chairez, and Sasha Newton from Peninsula Conflict Resolution Center;
- ShaRon Heath and Greg Thompson from Voices of Recovery; and
- Christi Morales-Kumasawa and Vicki Vinculado from Daly City Peninsula Partnership Collaborative.

COVID-19 Update

During the previous two fiscal years (from July 2020 to June 2022), the COVID-19 pandemic and other local and global crises required urgent attention from contracted agencies and their staff. As a result, AMHFA was offered to a lesser extent than in previous pre-pandemic years. Additionally, pandemic-related health orders required contracted agencies to only provide AMHFA classes virtually, which resulted in low participation. This shift to virtual facilitation also resulted in data collection challenges as participants could only complete evaluation forms online via SurveyMonkey, which limited participation due to digital literacy and technology availability. Additionally, challenges with the survey platform features and the length of the online assessments also affected assessment completion rates.

In addition to the many challenges, the COVID-19 pandemic also brought to light opportunities that benefitted program staff and participants in FY22-23. First, the shift to virtual instruction allowed AMHFA to reach individuals who would not have been able to attend the courses due to transportation barriers. Specifically, the National Council for Mental Wellbeing ('National Council') created a curriculum to support virtual learning through both the "Blended Virtual" and "Blended In-Person" course offerings, where participants can either complete the pre-work and the course partially or completely online. Additionally, class schedules were adjusted to support virtual facilitation. As a result, AMHFA leveraged these advantages by continuing to offer virtual and blended models in the current fiscal year while reinstating in-person courses. By offering courses in a variety of modalities, AMHFA sought to address barriers and increase accessibility for a wider array of participants.

Assessment Methods

Data Collection

AMHFA collects five forms from participants to assess course outcomes: (1) an application at the time of enrollment or at the beginning of the course, (2) pre-program assessment at the beginning of the course, (3) a post-program assessment at the end of the course, (4) an overall course evaluation form at the end of the course, and (5) a follow-up assessment approximately six months after course completion. The application gathers demographic and contact information and assesses participants' confidence to apply mental health concepts in real life. Six months after course completion, RDA evaluators invite participants to answer the same set of questions as those in the application to assess changes in confidence over time. The pre- and post-program assessment forms administered before and after the course assess changes in knowledge around mental health concepts and the overall course evaluation assessment examines indicators of

cultural responsiveness. The five forms are available on SurveyMonkey, an online survey tool to create and send surveys or assessments.

Altogether, **124 participants** from eight AMHFA classes completed at least one of the five forms in FY22-23 (see Table 1).[1] The number of respondents varied for each assessment form, as not all respondents completed all five forms. Differences between the application, overall course evaluation, and six-month follow-up assessment, and between the pre- and post-program assessment, were calculated to assess changes.

Table 1: Number of Respondents by Form

Form	Number of Respondents
Application	119
Pre-Program Assessment	107
Post-Program Assessment	86
Overall Course Evaluation	78
Six-Month Follow-Up Assessment	9
Number of Respondents Who Completed Multiple Forms	
Respondents who completed both the Pre- and Post-Program Assessments	86
Respondents who completed both the Application and Overall Course Evaluation	72
Respondents who completed both the Application and Six-Month Follow-Up Assessments	9
Respondents who completed the Overall Course Evaluation and Six-Month Follow-Up Assessment	8

[1] In total, there were 10 AMHFA classes offered, but data was only collected for 8 classes. Because data collection happened at several points in time, some participants completed some surveys but not all. Please see 'Limitations' section as well as additional notes regarding missing data in subsequent sections and footnotes.

Data Limitations

The data collected from participants offered valuable insight into the participant profile and experience as well as program outcomes. However, as with any evaluation, there were limitations to data collection that impacted the analysis and presentation of data:

- Data were only available for eight of the 10 classes offered during FY 22-23. In addition, for each of the eight classes, participants did not always complete all forms. Moreover, because data collection happened at several points in time, the number of respondents varied by form (Table 1) and a very small number of participants completed all five forms (n=8).
- The response rate (n=9) is especially low for the six-month follow-up assessment, which limits RDA's ability to analyze the impact of the course six months after completion and does not allow for the generalization of results and findings from this evaluation.[2]

[2] Six-month follow-up assessments are distributed on a quarterly basis. Because of the six-month lag between classes and the follow-up assessment, there is a misalignment between data collection and the reporting period. Only five classes fell within the appropriate time period and for two classes, no data were available.

Consumer Profile

During FY2022-2023 (July 2022 – June 2023), **AMHFA contractors facilitated a total of 10 classes.** This report reflects data gathered from **a total of 124 participants who attended eight of these AMFA classes.** [3] **The AMHFA course served a diverse group of community members and partners in San Mateo County**. The age of AMHFA participants ranged from 18 years old to over 60 years old, with two-thirds of participants (81, 65%) between 26 and 59 years old. Over half of AMHFA participants identified as a female/woman/cisgender woman (78, 63%) and the majority spoke English (80, 65%). Moreover, more than half of participants identified as Asian or White (33, 27% each, respectively), and a smaller subset of participants identified as Hispanic/Latino/a/x (17, 14%), more than one race or ethnicity (17, 14%), or Black or African American (5, 4%). About a quarter of participants reside in South San Francisco (30, 24%), with all remaining participants spanning the San Mateo County or elsewhere in California. Participants reported representing a variety of groups, with the most common identifiers being community members (37, 30%), providers of health and social services (11, 9%), and family members of a consumer/client (7, 6%). Notably, a large portion of participants selected multiple group affiliations (26, 21%), further supporting that AMHFA had participants representing many different capacities and fields ranging from education to healthcare. Lastly, participants also reported if they identify with certain groups whose mental health has been especially affected by the ongoing pandemic. Slightly under half (45%) of participants identified as one of the following: adults that regularly interact with youth and young adults, including youth with serious mental health conditions (23, 19%), healthcare workers serving those with serious mental health conditions (17, 14%), or unpaid caregivers (15, 12%). Table 2 and Table 3 on the following pages present the demographic characteristics of AMHFA participants.

8 classes

Number of AMHFA classes included in this report

124 participants

Total number of unique respondents to FY22-23 AMHFA forms

[3] This report reflects data gathered from eight of the 10 AMHFA classes because RDA evaluators only had access to data from these eight classes.. Only available data were analyzed for this report.

Table 2: Demographic Characteristics of AMHFA Participants, July 2022-June 2023, N=124

Category[4]	Count	Percent
Age Groups		
18-25	10	8%
26-59	81	65%
60+	22	18%
Declined to State	5	4%
Unknown/Not Reported	*6*	*5%*
Gender		
Female/Woman/Cisgender Woman	78	63%
Male/Man/Cisgender Man	26	21%
Another gender[5]	2	2%
Decline to state	10	8%
Unknown/Not Reported	*8*	*6%*
Race and Ethnicity		
Asian or Asian American	33	27%
White or Caucasian	33	27%
Hispanic or Latino/a/x	17	14%
More than one race or ethnicity	17	14%
Another race or ethnicity[6]	7	6%
Black or African American	5	4%
Decline to state	5	4%
Unknown/Not Reported	*7*	*6%*
Primary Language		
English	80	65%
Spanish	16	13%
Cantonese	11	9%
Another language[7]	8	6%
Decline to state	2	2%
Unknown/Not Reported	*7*	*6%*
City of Residence		
South San Francisco	30	24%
Another city[8]	21	17%
Half Moon Bay	18	15%
Millbrae	16	13%
San Francisco	12	10%
Belmont	6	5%
San Mateo	6	5%
Unknown/Not Reported	*15*	*12%*
TOTAL	**124**	**100%**

[4] To preserve privacy, any response with fewer than five responses were aggregated into an "another"-type category.

[5] "Another gender" includes Genderqueer, Gender Non-Conforming, Gender Non-Binary, Neither exclusively female or male, Questioning or unsure of gender identify.

[6] "Another race or ethnicity" includes Native American, American Indian or Indigenous, Asian Indian/South Asian, Central American, Filipino, Irish, English, Scottish, German, Mexican/Chicano.

[7] "Another language" includes Mandarin, Swedish, Japanese, Urdu, and "English and Spanish equally."

[8] Other cities of residence within and outside of San Mateo County include Burlingame, Cupertino, Daly City, East Palo Alto, La Honda, Menlo Park, Milpitas, Oakland, Pacifica, Pescadero, Redwood City, San Carlos, San Jose, and San Leandro.

Table 3: Group Representation of AMHFA Participants, July 2022-June 2023, N=124

Category	Count	Percent
Group Representation		
Community member	37	30%
Multiple group affiliations	26	21%
Decline to state	14	11%
Providers of health and social services	11	9%
Another Group[9]	11	9%
Family member of consumer/client	7	6%
Unknown/Not Reported	*18*	*15%*
Pandemic-Related Group Representation		
Adults that regularly interact with youth and young adults including youth with serious mental health conditions	23	19%
Health care workers serving those with serious mental health conditions	17	14%
Unpaid caregivers	15	12%
Another group with mental health affected by the pandemic[10]	12	10%
Unknown/Not Reported	*57*	*46%*
TOTAL	**124**	**100%**

Program Outcomes

Mental Health Learnings

Participants were asked questions about mental health concepts before or at the beginning of the AMHFA class through the pre-program assessment ("pre") and after or at the end of the AMHFA class through the post-program assessment ("post"). Table 4 shows the percentage of participants that responded correctly to statements (e.g., false for false statements).[11] Participants correctly identified true statements and false statements on the post-program assessment more consistently than on the pre-assessment for all assessment questions, indicating that ***the course effectively communicated educational material on mental health.*** In particular, there was an increase among participants in correctly identifying a misconception around mental illness and likeliness to commit

[9] "Another Group" includes responses to the following group types: Provider of behavioral health services, student, law enforcement, someone experiencing homelessness, behavioral health consumer/client, business owner, counselor, education associate (nonprofit), representative from an educational institution, educator, interpreter with Language World Services, nursing student, provider (provides mental health support, education and advocacy), Resilient District 7 member, NERT Coordinator, behavioral health commissioner, healthcare operations, and core agency.

[10] "Another group with mental health affected by the pandemic" includes consumers of mental health services, recreation center coordinators, depression peers, those with physical and mobility disabilities, educators, those working for a mental health agency, and those who selected more than one group identifier.

[11] Analysis of pre- and post-program surveys required that an individual complete both surveys and answer all questions. Incomplete data, such as when a participant only completed either the pre- or post-assessment rather than both or skipped individual questions, were not analyzed.

violent crimes. Moreover, participants demonstrated ***increases in knowledge related to asking others about suicidal feelings, distinguishing a panic attack from a heart attack, and understanding common mental health disorders.*** Of note, there were high rates (more than 80%) of correct responses at the time of the pre-course assessment, as well as for the post-program assessment, for questions around communicating with someone in crisis, cultural and family impacts on mental health, and the co-occurrence of mental health problems and substance use. This indicates that these topics are more well known across participants at the time of the course compared to other mental health concepts.

Question with the most significant increase in correct responses from the pre to post assessment:

- *"People with mental illness are more likely to commit violent crimes."* (25% increase in correctly identifying a false statement)

Table 4: Pre/Post AMHFA Mental Health Concepts Assessment, July 2022-June 2023

Question	N	Pre	Post	% change
False Statements		**% False**	**% False**	
People with mental illness are more likely to commit violent crimes.	79	66%	91%	25%
You should not ask someone if they are feeling suicidal because it will put the idea in their head.	80	81%	94%	13%
It is easy for a Mental Health First Aider to distinguish between a panic attack and a heart attack.	80	49%	60%	11%
Schizophrenia is one of the most common mental health disorders.	80	45%	56%	11%
If someone has a traumatic experience, you should always make them talk about it as soon as possible.	80	80%	84%	4%
When talking to a person in crisis, it is best to give advice.	79	89%	92%	3%
True Statements		**% True**	**% True**	
Spirituality can be a tool for recovery from mental health problems.	80	88%	96%	8%
People with mental health problems tend to have better outcomes if family members are not critical of them.	80	84%	90%	6%
Cultural background can influence the way that people seek help for mental health problems.	80	91%	96%	5%
Substance use disorders and mental health problems often occur together.	80	86%	85%	1%

Mental Health Confidence

Participants were also asked about their confidence in assisting someone in crisis or experiencing a mental health challenge prior to the course through the initial application and after the course through the six-month follow-up assessment. Confidence was assessed through participant agreeability with statements related to content taught in the course (i.e., a response of "strongly agree" or "agree" on a five-point Likert scale), as shown in Table 5. Based on the results, ***all indicators of confidence doubled from course application to the six-month follow-up***

assessment, with all or nearly all respondents indicating confidence in each area. Participants demonstrated an increase in confidence in recognizing signs and misconceptions around behavioral health challenges, as well as reaching out and assisting someone in seeking help and support when in crisis.

Questions with the most significant increase in confidence from the pre-course assessment to six-month follow-up assessment:

- *"Recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis."* (56% increase in reported confidence)
- *"Assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help."* (56% increase in reported confidence)
- *"Assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports."* (56% increase in reported confidence)

Table 5: Pre/Post AMHFA Mental Health Confidence Assessment, July 2022-June 2023

Question	N	Pre	Post	% change
I feel confident that I can…		**% Agree**	**% Agree**	
Recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.	9	44%	100%	56%
Assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.	9	22%	78%	56%
Assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports.	9	33%	89%	56%
Reach out to a person who may be dealing with a mental health problem, substance use challenge or crisis.	8	38%	88%	50%
Recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.	8	25%	75%	50%

Mental Health & Cultural Relevance

The application, course evaluation form, and six-month follow-up assessment assessed participants' understanding of how mental health and substance use challenges affect different cultures. By assessing participants' understanding at three different time points, assessments demonstrate changes in knowledge from initial application to overall course evaluation form, as well as the persistence of learnings up to six months after the course.

Among participants that completed both the initial application and the overall course evaluation form, there was a 29% increase in those who agreed or strongly agreed with the statement ***"I have a better understanding of how mental health and substance use challenges affects different cultures"*** from 50% (36) to 79% (57). This comparison shows that ***there was an increase in***

understanding after taking the course among participants who completed both assessments (n=72)**.**

Of the participants who showed an increased understanding after taking the course, two completed the six-month follow-up survey. Notably, both participants agreed or strongly agreed with the statement once more and thus maintained the same level of agreement six months after the course. This suggests ***a persistence of knowledge six months later related to how mental health and substance use challenges affect different cultures.***[12]

Additionally, the course evaluation form assessed cultural relevance of the course by asking participant agreeability to the following statement: *"This training was relevant to me and my cultural background and experiences (race, ethnicity, gender, religion, etc.)."* Through the evaluation form (N=78), most participants (63, 81%) agreed or strongly agreed with this statement, acknowledging that ***the AMHFA course was culturally relevant to most participants.***

AMHFA in Action

Participants were asked in the six-month follow-up assessment to give examples of where they have used their AMHFA training in real life since taking the course. Of the nine participants who completed the six-month follow-up, six answered this question and provided examples. Across all six responses, participants provided examples of them ***recognizing signs of a mental health crisis, reaching out and listening to those who were experiencing a mental health or substance use challenge, and connecting others to services, such as drug counseling and therapy.***

"[I was] speaking to a friend who was depressed, and I recognized signs and offered some therapists to see if she wanted. We spoke about counseling, and she felt comfortable enough to attend the session."

- Six-Month Follow-Up Assessment Respondent

"Friend texted with [a] hopeless message. We talked. I listened. They were not experiencing suicidal thoughts. I left the door open to talking further [and] my friend expressed a plan to continue professional support. I followed up with a text the next day."

- Six-Month Follow-Up Assessment Respondent

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[12] The response rate (n=2) is especially low for this indicator, which limits RDA's ability to draw conclusions form this data and does not allow for the generalization of results and findings from this evaluation.

Recommendations

Where data were available, results indicate that participants in AMHFA courses increased their knowledge related to mental health and were receptive to and appreciative of the training. However, detailed learnings and recommendations are challenging to derive from the data given the low response rates and missing data from two of the courses. As a result, RDA suggests making the following adjustments to the evaluation and data collection process for FY22-23:

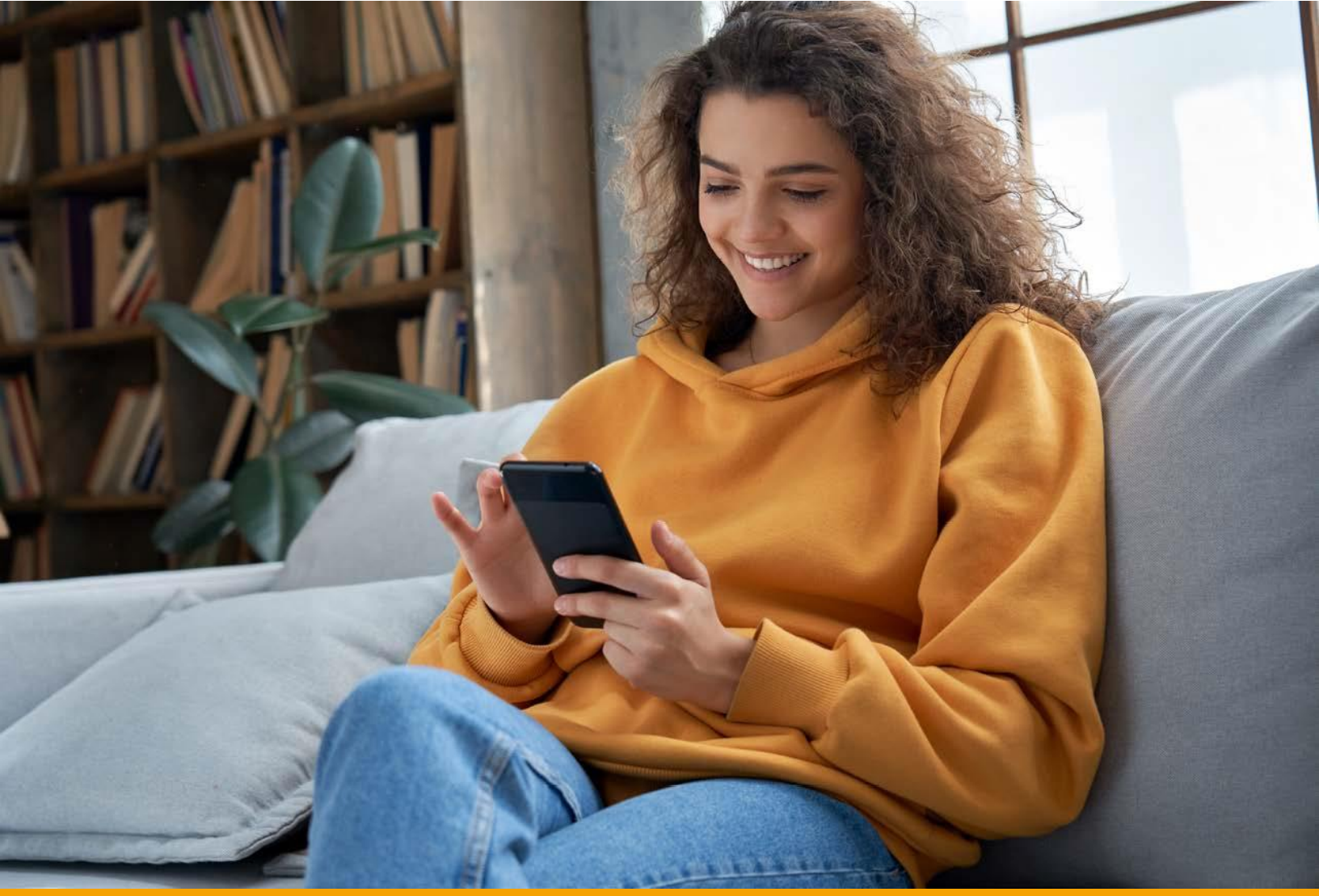
- **Streamline and reduce the number of data collection tools:** At present, participants are required to fill out at least seven forms and evaluations at various points, which likely contributes to low response rates. Reducing the number of tools and timepoints at which data are collected will improve clarity, efficiency, and response rates among participants.
- **Improve response rates:** In addition to streamlining data collection tools, RDA suggests revising the incentive structure for six-month follow-up assessments to encourage participants to respond.
- **Better utilize existing data:** Where possible, RDA will incorporate findings from the National Council evaluation forms in a future report to make better use of the data that are required by the state.
- **Collect qualitative data:** RDA suggests collecting a limited amount of qualitative data through interviews with participants to obtain a more nuanced understanding of their experiences with the course.
- **Provide course evaluation results to instructors more frequently:** If evaluation results are provided to instructors at least bi-annually, instructors may be more able to incorporate learnings into their course implementation.

Conclusion

In FY 2022 – 2023, a number of data collection activities were conducted to evaluate the effectiveness of the AMHFA program by assessing changes in participant knowledge and confidence and self-efficacy. Findings from the pre- and post-program assessments indicate that participants gained knowledge about various mental health concepts as a result of the AMHFA course. Particularly, participants demonstrated greater understanding of misconceptions around mental illness, asking others about suicidal feelings, distinguishing a panic attack from a heart attack, and understanding common mental health disorders. Additionally, a comparison of pre-course application responses to overall course evaluation form responses indicates that participants gained a sense of confidence in translating concepts learned in AMHFA to real-life, such as recognizing signs and misconceptions around behavioral health challenges, as well as reaching out and assisting someone in seeking help and support when in crisis. These indicators of confidence doubled from the time of initial application to the end of class evaluation assessment. Thus, participants not only learned mental health first aid concepts, but also felt confident in doing so in

their work and out in the community. Moving forward, actions are being taken to improve data collection and response rates in future courses, which will help AMHFA better understand course impact, areas for improvement, and areas of success.

APPENDIX 8. HELP@HAND FINAL INN EVALUATION REPORT, FY 2022-23



San Mateo Help@Hand

MHSA INN Final Report

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo Help@Hand

MHSA INN Final Report

This report was developed by Resource Development Associates under contract with San Mateo County Department of Behavioral Health and Recovery Services.

Resource Development Associates, 2022

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table of Contents

Introduction

Help@Hand is a statewide Mental Health Services Act (MHSA) Innovation (INN) project that aims to bring technology-based solutions to county and city behavioral health systems. The project is administered by the California Mental Health Services Authority (CalMHSA) and funded and directed by local jurisdictions. San Mateo County Behavioral Health and Recovery Services (BHRS) identified the need for technology-based behavioral health supports as part of the fiscal year (FY) 2017-20 MHSA Three-Year Plan. In April and May of 2018, San Mateo conducted a Community Program Planning (CPP) process aimed to (1) inform community members about the proposed MHSA INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about MHSA INN to ensure their ability to meaningfully participate.

Project Goals

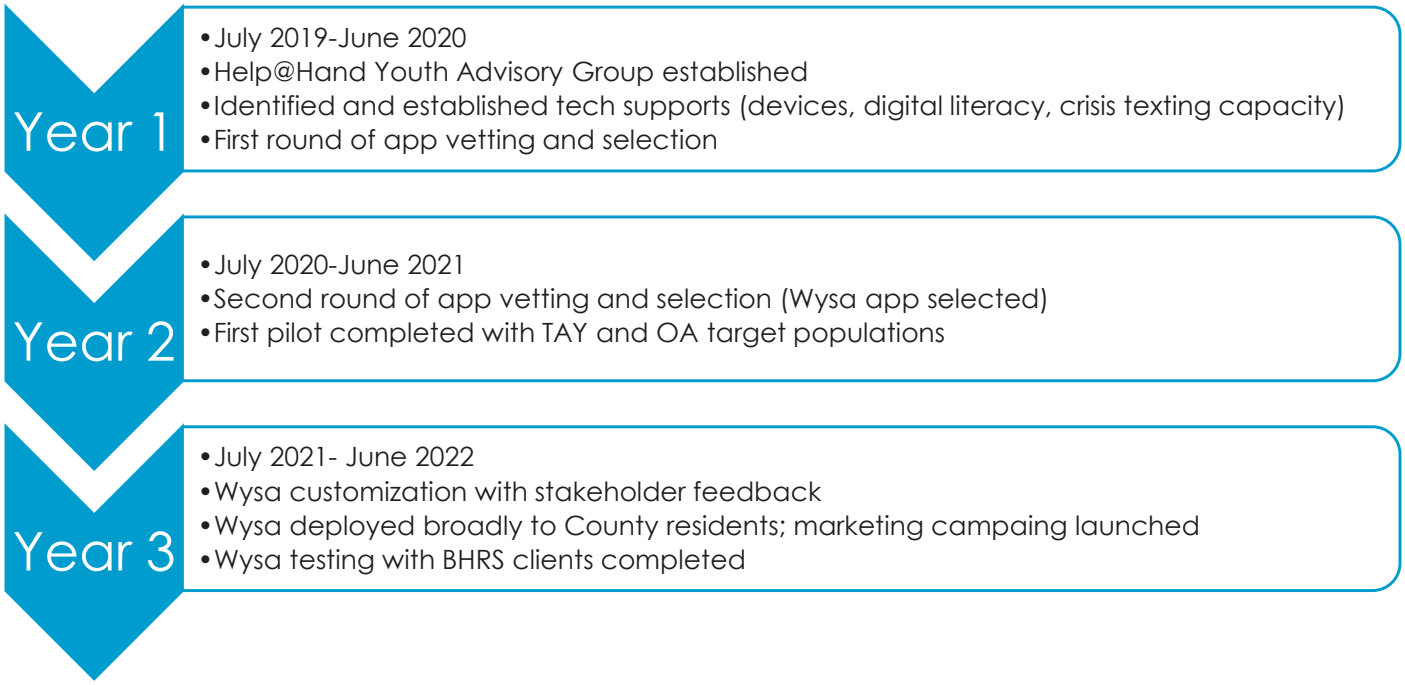
In San Mateo County, this INN project provided an opportunity for BHRS and its collaborative county partners to leverage technology, specifically behavioral health applications (apps), to reach and engage two priority populations, (1) transition age youth (TAY) and (2) older adults. Through the Help@Hand INN project, BHRS aims to:

- Provide access and linkages to behavioral health services
- Provide social connectivity through the use of virtual avatars and/or peers
- Support self-directed mental wellness and recovery goals

This project also serves to reduce the stigma associated with mental health treatment by using virtual engagement strategies and to provide alternative methods for engaging in behavioral health recovery and wellness activities.

Project Implementation

Figure 1. Summary Timeline of Tech-Based Solutions



The San Mateo Help@Hand project development was guided by a local Help@Hand Advisory Committee, which was established during the planning phase of the project and prior to the launch. The Help@Hand Advisory Committee was comprised of peers, family members of clients, and individuals from the older adult and TAY communities, BHRS staff, stakeholders from County departments (e.g., Information Technology, Aging and Adult Services), peer-based agencies California Clubhouse and Heart and Soul, and community-based agencies Peninsula Family Service and Youth Leadership Institute. Implementation highlights are summarized in the timeline above by year and further details are included as follows:

Year 1

The first part of year 1 included identifying needs to support the use of technology solutions in a behavioral health setting. The needs identified by the Help@Hand Advisory Committee resulted in establishing the following targeted supports:

1) Digital Mental Health Literacy (DMHL) train-the-trainer for Help@Hand peer staff that covered topics related to security and privacy measures and managing digital identity;
2) Get App-y Workshops for older adults to receive supports with basic 101 technology education and DMHL topics;
3) A Youth Advisory Group to guide priorities for Transition Age Youth; and

4) Expansion of the local crisis hotline to include text-based and social media supports in preparation for the app release.

While efforts to identify needs and establish supports began in year 1, this has been an ongoing and iterative process throughout the entire three-year timeline. The following additional tech supports were established in subsequent phases of the project to address emerging needs:

5) Technology device distribution, including data plans, for behavioral health clients and Help@Hand participants that do not have the resources to purchase technology;
6) Technology 101 trainings for BHRS peer staff that would be distributing devices; and
7) Tech Cafés or workshops for clients and the community at large to receive basic technology supports, DMHL education and advanced Zoom topics.

In the second half of year 1, Help@Hand stakeholders and contractors reviewed available technologies—which were approved through a Request for Statement of Qualifications (RFSQ) process led by CalMHSA—and participated in various app vetting, testing, and selection activities to identify the app they would like to pilot with the target populations. Through this first round, BHRS selected Happify as an app to move forward with older adult community piloting and Remente for TAY. At the onset of the COVID-19 pandemic, the Happify vendor terminated their participation in Help@Hand and TAY stakeholders recognized that the needs of the TAY population had changed. Both groups returned to the app vetting, selection and exploration process in the beginning of Year 2.

Year 2

In Year 2, as an immediate response to the COVID-19 pandemic, San Mateo County began two key activities:

1) Device Distribution: Lack of access to devices most prominently affects low-income, rural, disabled, people of color, and our older adult community, leading to a digital inequity. BHRS provided technology supports (devices and data plans), for one year, for clients and family members of clients that would benefit from telehealth and/or other behavioral health services but do not have the resources to purchase the technology needed. BHRS leveraged CARES Act funding to distribute 290 tablets with a one-year data plan to 15 BHRS contracted community agencies. MHSA funding was also leveraged to award 13 CBO's funding to procure devices, data plans, and accessories (hotspots, headphones, screen protectors, styluses, etc.) that support clients' use of the technology for behavioral health supports. MHSA funding was also allocated to purchase up to 790 devices for BHRS clients, including 30 tablets for residential Board and Cares and regional clinics. Staff, agencies, clients, community and faith leaders provided feedback that in addition to the lack of access to technology, many residents lacked the knowledge to use technology. This knowledge gap contributed to the digital divide. In response to this feedback, BHRS launched additional digital literacy supports including Technology 101 trainings, Tech Cafés and workshops for clients and the community. Training topics included:
    - How to set-up a Gmail account
    - Email maintenance
    - Professional emailing
    - Tips on how to scan a QR Reader
    - How to Download an Application (App)
    - Tips on using your phone camera
    - Online safety & privacy
    - Tips on Privacy Settings (mobile phone & social media)
    - Telehealth and telehealth etiquette
    - Zoom teleconferencing basics

2) Headspace Launch – the wellness app Headspace was made available to residents across the county including a Spanish version for Spanish-speaking populations. 3,245 San Mateo County residents downloaded and used Headspace. San Mateo County participated in a University of California, Irvine (UCI)-led evaluation of Headspace. Surveys were emailed to San Mateo County's Headspace users between July and October 2021. Over 300 (n=352) users responded to the baseline survey and 121 completed the follow-up survey. Key findings include:
    - Mental Health - 78% of respondents experienced mental health challenges. Current users scored higher on distress than abandoners.
    - Reasons for Not Using Headspace - Common reasons for abandoning Headspace were that people were using other strategies to support their mental health (32%) and/or they just wanted to try Headspace (31%).
    - Headspace Experience - Users had a positive experience with Headspace: 92% of Current users would recommend Headspace and 90% of Current users found Headspace easy to use. Among abandoners, 72% would recommend Headspace and 75% found it easy to use.
    - Mental Health Resources - Almost half of respondents had made use of resources other than Headspace, such as online tools and professional mental health resources, to support their mental health.

BHRS leveraged the launch of Headspace to conduct a second round of vetting and testing activities, although stakeholders ultimately selected Wysa as an app to move forward with for both older adults and TAY community piloting. A key factor in this decision was Wysa app developers' willingness to customize and refine the app to fit the needs and priorities of the local population. Additionally, both target populations viewed Wysa as more culturally relevant compared to the other apps explored. In the second half of Year 2, San Mateo County designed and implemented a pilot to define and measure success with the selected Wysa app and inform app customizations and a broad deployment plan. After a successful app pilot, the product and pilot outcomes were presented to Help@Hand Leadership and Wysa was included in the Help@Hand technology portfolio, thereby allowing other jurisdictions to more easily integrate the apps into their behavioral health systems.

Furthermore, BHRS began working with the app developers to customize what the Help@Hand Advisory Committee recommended as mandatory customizations in order to ensure success of the app. The mandatory recommendations included the following:

- Create instructions/tutorials for accessing and using the app.
- Include a disclaimer about the chatbot and the app's intended purpose, "the app is a light touch resource for wellness concerns, not a replacement for therapy."
- Update the notifications and reminders to be more motivating and engaging for TAY users.
- Include an in-app directory/search function that allows users to quickly navigate to what they need within the app.
- Remove all mentions of the ask-a-therapist feature; this was a high risk assessment issue.
- Create more topics specific to the needs of TAY and Older Adults.
- Update the SOS button name to reflect the page content and/or add local resources. .

See attached Spotlight on San Mateo County's Wysa Pilot.

Year 3

In Year 3, the County launched the customized app to the two identified target populations (older adults and TAY). BHRS contracted with Uptown Solutions to develop a marketing campaign and advertised the availability of Wysa to residents through a landing page, hosted by CalMHSA, a partner toolkit distributed to over 2,000 BHRS agency partners and stakeholders, which included flyers and social media posts to share, digital ads, organic social media posts, transit ads on 30 buses throughout the

county, mailing of 10,000 postcards to targeted residents, and print/media ads with the Daily Journal. See attached San Mateo County Marketing Campaign Report.

RDA conducted a brief survey of early users (who downloaded the app through August 2022 and after the first two months after the marketing campaign roll out.) to further assess the impact of the app and inform the Innovation Learning Goals.

Simultaneously, BHRS, stakeholders and contractors reviewed the results of the pilot stage and decided to further test the app with behavioral health clients to determine if the app could support clients in between therapy appointments with their wellness and recovery goals and if the app could be integrated into their system of care.

The table below provides a comprehensive timeline of activities and major events that occurred over the three-year project timeline.

Table 1. San Mateo Help@Hand Timeline of Activities

Dates	Activities
Year 1	**Identifying needs and establish targeted supports**
July 2019	○ Peninsula Family Services (PFS)[1] and Youth Leadership Institute (YLI)[2] fully onboarded and begin developing focus groups with target populations to identify needs and peer-led outreach strategies; ○ Contracted StarVista to develop texting and social media supports for youth in crisis to expand resources for wellness app users ○ CalMHSA facilitated focus groups in San Mateo to develop digital health literacy curriculum
August 2019	○ Get App-y Workshops launch to support older adults in basic technology 101 and the development of the H@H Youth Advisory Group.
Sept. – Oct. 2019	○ Identified need to research additional tech solutions

[1] YLI is the contracted organization to conduct peer-led outreach to the TAY population for the Help@Hand project.
[2] PFS is the contracted organization to conduct peer-led outreach to the older adult population for the Help@Hand project.

	○ CalMHSA facilitated a second RFSQ process to broaden the pool of possible tech solutions; this resulted in 93 solutions to choose from
Nov. 2019 – Jan. 2020	○ Completed first round of App demos, vetting and selection process included local focus groups with TAY and OA
Jan. 2020	○ App exploration training to identify customization needs and inform app deployment needs. We selected Happify for older adults and Remente for TAY for the pilot phase
Feb. – April 2020	○ COVID-19 led to Happify vendor backing out of the project and TAY stakeholders recognized that the needs of the population had changed. Both groups returned to the app vetting, selection and exploration process
May 2020	○ Device procurement and deployment pilot begins with peer-led agencies California Clubhouse and Heart & Soul
Year 2	**App demonstrations vetting and selection**
July – Oct. 2020	○ Second round of App demos, vetting and selection process included local focus groups with TAY and older adults; Wysa app selected, began pilot proposal development
Sept. 2020	○ Purchased 10,000 Headspace app licenses and distributed them rapidly to support SMC community mental health wellness during COVID-19
Oct. 2020	○ Contracted with Painted Brain to provide tech 101 trainings for peer staff that would be distributing devices and Tech Cafés for clients and the community at large
Nov. – Dec. 2020	○ Launched distribution of 250 tablets to network of providers, 50 tablets to Board and Cares and clinic sites, funding for 700+ devices for BHRS clients plus device accessories needed for engagement (headphones, covers, styluses, hotspots, etc.)
April – June 2021	○ Launched Pilot with TAY and older adults to further test the selected app Wysa
May 2021	○ Began exploration of needs for integration into BHRS system of care ○ Decided to wait until after the local customizations are completed and broad deployment of the app begins.
Year 3	**App pilot implementation, and analysis**
June 2021	○ Added advanced Zoom topics to Painted Brain's contract. Held first training to address equitable practices while facilitating Zoom meetings
July-Aug 2021	○ Headspace Survey and results from UCI ○ Pilot with TAY and older adults continued
Oct-Dec 2021	○ Purchased licenses for Wysa and completed marketing contracts
Jan-Feb 2022	○ Wysa app customizations completed with input from Advisory Committee
March-April 2022	○ App launched, supported by peer-led outreach from community partners (YLI and PFS) ○ Launched further app testing with Adult BHRS clients
May-June 2022	○ Completed sustainability planning ○ Developed and launched communications plan for app deployment

Evaluation Overview

The County contracted Resource Development Associates (RDA) to evaluate this project over a three-year period (from 2019-2022.) The following locally defined Learning Goals evolved over the course of the project and were established by the Help@Hand Advisory Committee:

Learning Goal 1

Can a mental health app connect transition age youth and older adults to mental health services and other supports if needed?

Learning Goal 2

Can an app promote mental health wellness and reduce feelings of isolation?

Learning Goal 3

Can an app promote wellness and recovery for individuals living with mental health challenges?

RDA has assessed the goals defined above to help San Mateo County BHRS understand the implementation of the apps and the outcomes of their utilization in the local context. The University of California Irvine (UCI) is also conducting a statewide evaluation of the County Behavioral Health Technology Collaborative to explore app usage trends, linkages to care, and recovery outcomes across all jurisdictions participating in the Help@Hand project.

As the project progressed, the Learning Goals were adapted to reflect emerging community needs, implementation learnings and evaluation goals.

Evaluation Timeline and Adaptations

The evaluation evolved as the Help@Hand Advisory Committee, BHRS and RDA identified lessons learned and carried those lessons forward by adapting the Learning Goals. This iterative process has allowed the evaluation to follow the evolution of the project.

Initially, the Learning Goals were stated as follows:

1. Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis and older adults experiencing isolation to in-person services?
2. Does engaging with the apps promote access to mental health services and supports?
3. Does engaging with the apps promote wellness and recovery?

The first Learning Goal was originally intended to assess whether the availability and implementation of technology-based mental health apps connect **TAY in crisis** and **older adults experiencing isolation** to **in-person** services. Early stakeholder input prioritized TAY in crisis and isolated older adults. Early stakeholder input prioritized the importance of in-person support and raised concerns about the idea of a technology-based solution replacing in-person connections.

Early conversations with our local youth crisis response center staff and stakeholders led to an agreement that youth in crisis are best served by live, trained peers with clinical supervision (rather than through a digital tool such as the app, which uses AI). Additionally, the available technologies, which

were approved through a Request for Statement of Qualifications (RFSQ) process led by CalMHSA, were not equipped to address youth in crisis. This led to the first change in our Learning Goals to focus on supporting the mental wellness of TAY in general and alternatively investing in the expansion of the local crisis hotline resources to include text-based and social media supports in preparation for the app release. The selected app would be customized to include local crisis resources and a means to connect users that may need additional supports to live crisis center resources via voice call, chat and/or text.

Furthermore, given the restriction on in-person activities after the onset of the COVID-19 pandemic, in-person services were not a feasible resource. Therefore, the first Learning Goal was modified accordingly to assess whether a mental health app can connect both older adults and TAY in general (vs. those in crisis in particular) to mental health and other supports (not just in-person) if needed.

During the pandemic, a greater concern arose regarding feelings of isolation among both the older adult and TAY populations. Therefore, the second Learning Goal was modified to assess whether an app can promote mental health wellness and reduce feelings of isolation

The third Learning Goal further specified that this was for individuals living with mental health challenges. Early in the implementation of Help@Hand, staff and stakeholders determined that it would be much more feasible to work through the app vetting, selection, piloting, and customization processes working with older adults and TAY in the community (vs. in clinical care with BHRS clients). After Wysa was selected as the app to support wellness, reduce isolation, and promote connections to supports, BHRS testing with clients focused on determining whether this app in particular met the project's goals for individuals living with mental health challenges and specifically whether it promotes their wellness and recovery.

The final Learning Goals were adapted as follows:

1. Can a mental health app connect transition age youth and older adults to mental health services and other supports if needed?
2. Can an app promote mental health wellness and reduce feelings of isolation?
3. Can an app promote wellness and recovery for individuals living with mental health challenges?

Data collection for this evaluation report focused on the implementation of the following activities undertaken by BHRS and local stakeholders throughout the three year evaluation period: (a) activities related to app vetting, testing, and selection, (b) a two-month pilot process with older adults and TAY (c) app exploration groups to identify customization needs, (d) further testing with behavioral health consumers and (e) broad deployment of the app to the target communities including data collected and findings from this deployment to County residents.

Evaluation Methods

Data Collection

RDA used both quantitative and qualitative evaluation methods to assess the influence of the Wysa app on pilot participants' well-being, feelings of isolation, mental health stigma, and potential connections to further mental health supports if needed. Qualitative app exploration was also conducted in early pilot phases to identify considerations for app customizations, further testing with San Mateo County behavioral health consumers, and broad deployment to the target populations.

Additionally, qualitative and quantitative data were collected from the perspectives of different stakeholders involved in implementation and decision-making processes, including the Help@Hand

Advisory Committee and peer partner agencies. RDA collected data through interviews, surveys, and four focus groups with the following stakeholders:

Table 2. Data Collection Activities and Participants

Method	Stakeholders
Interviews	Doris Estremera, MHSA Manager[3]
	Rubi Salazar, Peer Program Coordinator, Youth Leadership Institute (YLI)
	Ahleli Cuenca, Bay Area Director of Programs, YLI
	Susan Houston, Vice President of Older Adult Services, Peninsula Family Service (PFS)
	Patricia Duarte, Peer Support Specialist, PFS
	Cristian Huezo, Peer Support Worker, PFS
Process Focus Group For Year 2 Reporting	Help@Hand Advisory Committee
App Vetting and Selection Focus Groups	TAY app testers (5)
	Older adult app testers (7)
Pilot Participant Focus Groups	TAY app pilot participants (16)
	Older adult pilot participants (37)
Pilot 1 Participant Survey	TAY app pilot participants
	Older adult pilot participants
App Exploration Groups	TAY participants (8)
	Older Adult participants (12)
Testing Participant Survey	BHRS Adult Clients
Testing Participant Focus Groups	BHRS Adult Clients
App Deployment Survey	San Mateo General Population (app users)

Interviews with Help@Hand staff and contractors explored key activities, lessons learned about the app pilot process and stakeholder engagement, participation in the statewide collaborative, and the potential impacts of behavioral health technology on the TAY and older adult populations. The focus group with the Help@Hand Advisory Committee offered an opportunity to discuss the role of the committee, successes and areas for improvement in the Help@Hand project activities, experiences working with different stakeholders, and changes in expectations of how technology can help meet the behavioral health and wellness needs of TAY and older adults in the county. RDA also attended monthly Help@Hand Advisory Committee meetings and documented the project's progress throughout the evaluation period.

RDA's role adapted as the needs of the project changed over time. When BHRS recognized the county would need to undergo an in-depth app pilot process, RDA worked with YLI and PFS to design and implement four focus groups with pilot participants. RDA, with the support of PFS, conducted one focus group with older adults, and YLI conducted a series of focus groups with TAY. Pilot participant focus groups were used to collect feedback on usage experiences with the Wysa app and the perceptions of each app's ability to meet the local Help@Hand Learning Goals and needs of the TAY and older adult populations. RDA also conducted two exploration groups, one with TAY and one with older adults to further explore specific app features of interest and inform the customization and app deployment phases of the Help@Hand project.

[3] As the MHSA Manager and the Help@Hand project manager, Doris Estremera oversees all project activities.

San Mateo County defines participants of the Help@Hand project as pilot users of the Wysa app—individuals who participated in the pilot stage by downloading and using the Wysa app. Accordingly, demographic data were collected in the form of surveys that were completed by both TAY and older adult participants prior to downloading and using the selected apps for a total of two weeks.

Individuals who participated in the pilot stage also completed surveys about their experiences with the app; they were assessed both before and after the pilot period to determine whether engaging with the app was related to any increase in particular favorable outcomes, and/or whether unfavorable outcomes or risk factors decreased after engaging with the app. In the Final phase of the project, County residents who downloaded the app were also invited to complete a brief feedback survey. Participants were contacted by email and invited to complete the survey; 30 participants responded.

Data Analysis

To analyze the qualitative data, RDA transcribed interview and focus group participants' responses to capture their sentiments and perceptions. RDA then thematically assessed responses from all participants and identified recurring themes and key findings.

To analyze the quantitative data, RDA tabulated frequencies and percentages of app testers' demographic information (i.e., age group, assigned sex at birth, gender identity, race/ethnicity, sexual orientation, employment status, etc.) as well as app testers' responses to survey questions developed to elicit feedback about the overall usefulness of the app's functionality, feelings of isolation and connectedness, and perceptions about mental health.

Evaluation Limitations

Qualitative data collection and analysis was limited in scope by low numbers of participants available and willing to participate in focus group and interview activities. A larger study could have resulted in more nuanced findings. The evaluation was also impacted by changes in mental health needs and service availability related to the COVID-19 pandemic. The need to shift focus and adapt Learning Goals resulted in less ability to track attitudes and beliefs consistently across time.

Evaluation Findings

Wysa Pilot & General Population User Learnings

Aside from informing app customizations and the Wysa deployment plan, another objective of the Wysa pilots (with TAY, Older Adults, and BHRS clients) was to contribute to learnings related to the local Learning Goals.

The following sections provide an overview of how the pilot process and the general population survey contributed to each of San Mateo County BHRS Help@Hand Learning Goals.

For each data collection phase, demographic data can be found in Appendix A.

Learning Goal 1: Can an app connect transition age youth and older adults to mental health services and other supports if needed?

Data from the TAY and Older Adult pilots suggest that there is some potential for the Wysa app to help users feel more comfortable seeking mental health services and supports.

- **In the TAY pilot, 47% (n=15) agreed that they are more likely to reach out for help with their mental health and wellness after using Wysa. In the Older Adult pilot, 31% agreed (n=32).**

Survey results suggest that using the app did not significantly reduce measures of help-seeking stigma, but there were slight differences that represent potential for some individuals to reach out for support who may not have otherwise. Results for TAY in particular show some reduction in stigma.

- In the TAY pilot group, **67% agreed (n=15) in the post survey that they "know when to ask for help" compared to 44% (n=16) in the pre survey.**
- In the Older Adult pilot, this figure stayed relatively consistent: **89% (n=37) agreed in the pre survey that they "know when to ask for help", and 85% (n=34) agreed in the post survey.**
- In the TAY pilot, **60% agreed (n=15) that their "self-confidence would NOT be threatened if [they] sought professional help" compared to 56% in pre survey.**
- In the Older Adult pilot, **76% agreed (n=33) in the post survey that "[their] self-confidence would NOT be threatened if [they] sought professional help" compared to 83% in the pre survey.**

While using Wysa may encourage individuals to seek out additional resources and support, integration of these supports with the app and the ability to track whether users follow through with seeking support is limited. That is, while the app could feasibly help to reduce stigma and promote help-seeking, it does not always connect users directly with services. One feature that the app does have to connect users to services is the "SOS" feature, which users can use to reach out and seek out additional resources if needed. Selecting the "SOS" button brings users to crisis supports such as the Crisis Hotline and Text line.

- **In the TAY pilot, 33% (n=15) found the SOS feature of the Wysa app to be useful (28% moderately useful and 7% extremely useful). In the Older Adult pilot, 9% found the SOS feature useful (6% moderately useful and 3% very useful).**

In the pilot stage, almost two-thirds of the TAY and older adult participants did not use the SOS feature over concerns that this feature would contact emergency services immediately. As a recommendation to address this finding, BHRS worked with the Wysa app developers to include a local resource page accessible within the app to facilitate connections to mental health supports for those who may need it. The page includes a collection of local mental health resources for participants to review, should they be interested in exploring services beyond the app itself. The app developers also created an "Extra Resources" button alongside the "SOS" feature and created pathways for the chatbot to recommend the resource page to users.

Some pilot users did express that they would have liked to be connected to a person for more traditional counseling.

- One TAY user shared that it *"Would have been nice to have an option to talk to a human as opposed to just the bot"*

In the final survey with general population app users, **36% of respondents agreed with the statement, "Because I used Wysa, I am more likely to reach out for help with my mental wellness."** This is slightly lower than the percentage of pilot users who agreed with the same statement, but the general population survey respondents also reported substantially lower interaction with the app. Even with the lower exposure to all of Wysa's features, this represents a meaningful improvement in likelihood to seek support. The final survey also provides insight for the need for future BHRS services in terms of reducing stigma around mental wellness. For these survey respondents, 57% agreed with the statement, "I feel comfortable discussing topics related to mental health and mental illness," and 52% agreed with the statement, "I feel comfortable seeking mental health services (such as counseling/therapy)". While the survey returned a small number of responses and does not necessarily represent county residents, this data suggests that there is further room for efforts to reduce mental health stigma in the community.

Summary

Given the results from the survey that was completed by the pilot participants, there is some evidence to suggest that TAY users would be more willing to seek help for their mental health and wellness because of using the Wysa app, and that seeking help would not negatively impact their confidence and self-esteem. Among Older Adults, there is evidence that this population feels comfortable seeking support and understands when they need to reach out for help. Given that using the app itself did not seem to decrease their feelings of being left out after its use, it is important that the app offer connection to other avenues of support.

Learning Goal 2: Can the Wysa app promote mental wellness and reduce feelings of isolation?

Wellbeing

Based on findings gathered from focus groups and survey responses from two pilot groups and one test group (TAY, Older Adults, and BHRS Clients), results suggest that apps such as Wysa promote mental wellness for participants. In particular, participants from each of these groups reported the following common benefits of using Wysa:

- Enhanced self-care strategies
- Improved coping with feelings like anxiety, anger, sadness, and stress
- Better, more restful sleep

As one TAY pilot participant reported, "*I suffer from loneliness, and it was comforting that I could check in with the app anytime*". An Older Adult BHRS client likewise commented, "*I've been going through a health crisis, depression, inconveniences – it's helpful to have this tool. It helps with self-reflection, gives you an opportunity to pause and think through things*".

According to survey results, users in each of these groups experienced improvements in subjective well-being indicators after using Wysa for two months.

Figure 2-4 below depict pilot users survey responses to how they felt the app impacted their well-being, as represented by increased feelings of satisfaction, hope, and balance, and reduced feelings of nervousness, depression, and stress.

Figure 2. Survey Responses from TAY Respondents about Well-being (n = 16)

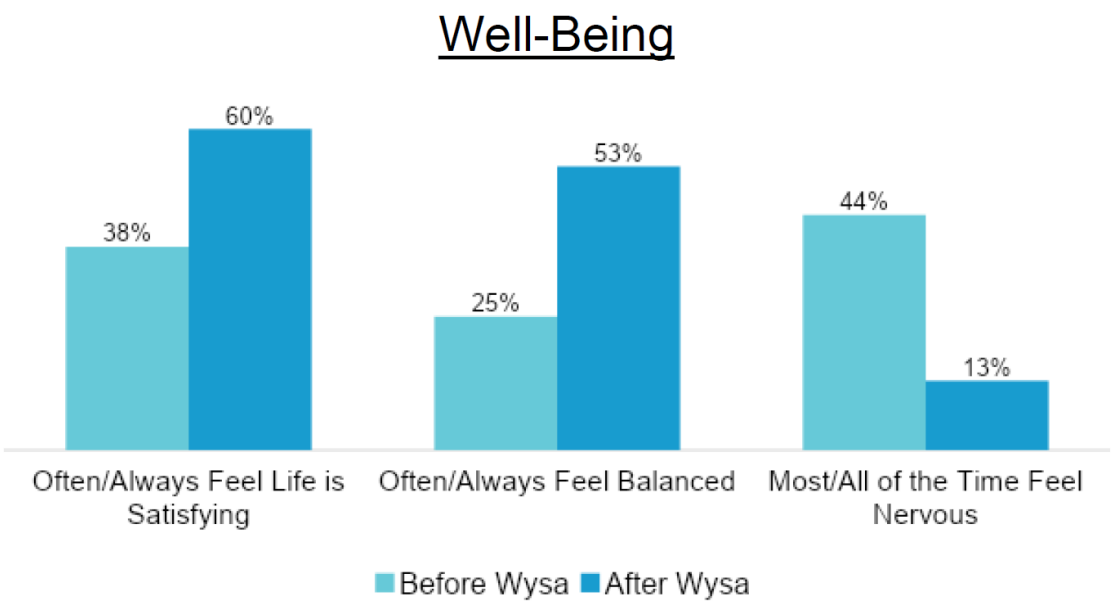


Figure 3. Survey Responses from Older Adult Respondents about Well-being (n = 37)

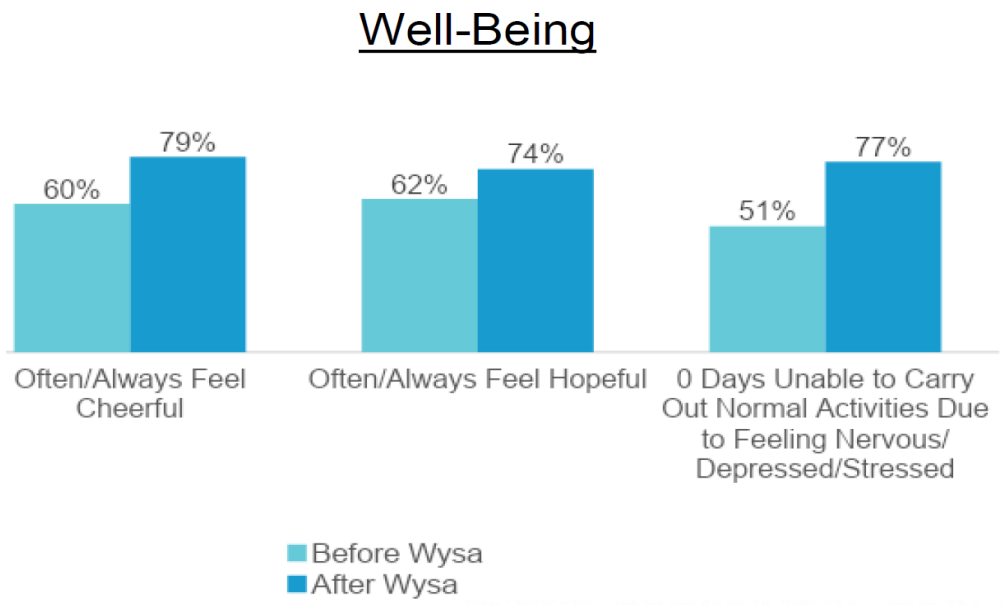
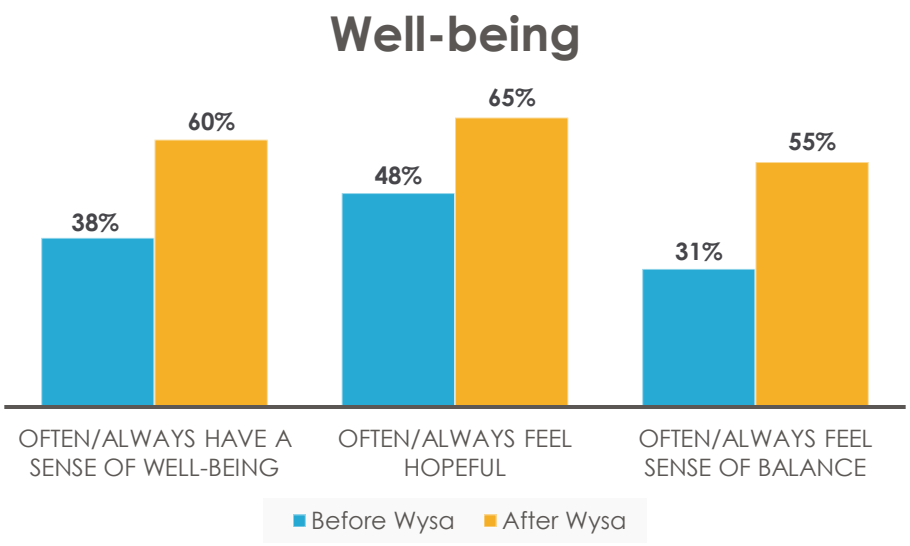
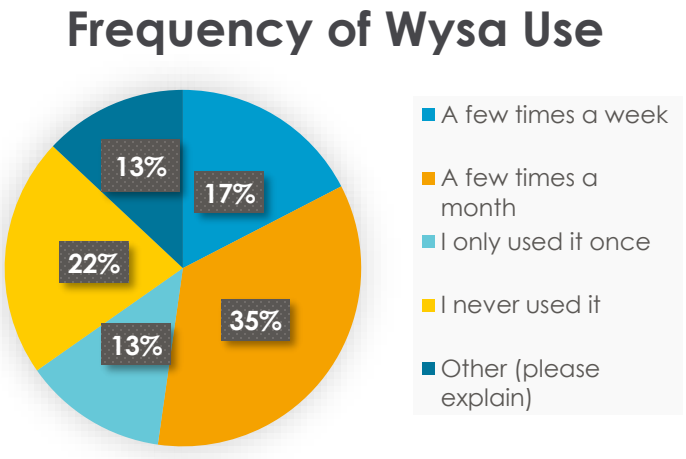


Figure 4. Survey Responses from BHRS client Respondents about Well-being (n = 20)



Notably, in the final survey of general users following the launch of Wysa to all County residents, results do not suggest the same level of potential for improving mental wellness as was seen in the pilot and test populations. Of those who completed a survey after downloading the app in this phase (21 users), **36% agreed with the statement, "Wysa improves my mental wellness," and 41% agreed with the statement, "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious."** It is important to note that this group overall had significantly less experience with the Wysa app than did the users in the pilot and test groups. As shown in Figure 6, 35% of the general population users who completed the survey either only used the app once or never used it at all. It is possible that these users did not experience as much benefit from the app simply because they did not actually make use of it, or made very little use of it, before reporting their feedback.

Figure 6. Survey Responses from General (SM County) Population (n=22)



Connectedness

Findings from the focus group and survey data demonstrate mixed impacts of using an app like Wysa on feelings of isolation and social connectedness. For the first TAY pilot, one of the first positive outcomes that staff noticed after the testing and piloting process was that the level of social connectedness

increased after TAY participants' use of the app. Other benefits reported by the older adult program staff included Wysa's chatbot feature, which provides suggestions to the user and prompts them to carry out a specific activity (e.g., positive affirmations, carrying out a physical activity) in response to a specific issue that the participant reports that they are currently experiencing within the app. Program staff also noted that youth reported that the Wysa app allowed youth a safe space to express any current issues or challenges that they were facing that day. Further, based on TAY participant feedback, program staff also noted that the Wysa app's chatbot features proved to be a valuable asset that TAY participants found helpful, especially after the onset of the pandemic.

Figure 6. Survey Responses from TAY Respondents about Connectedness (n = 16)

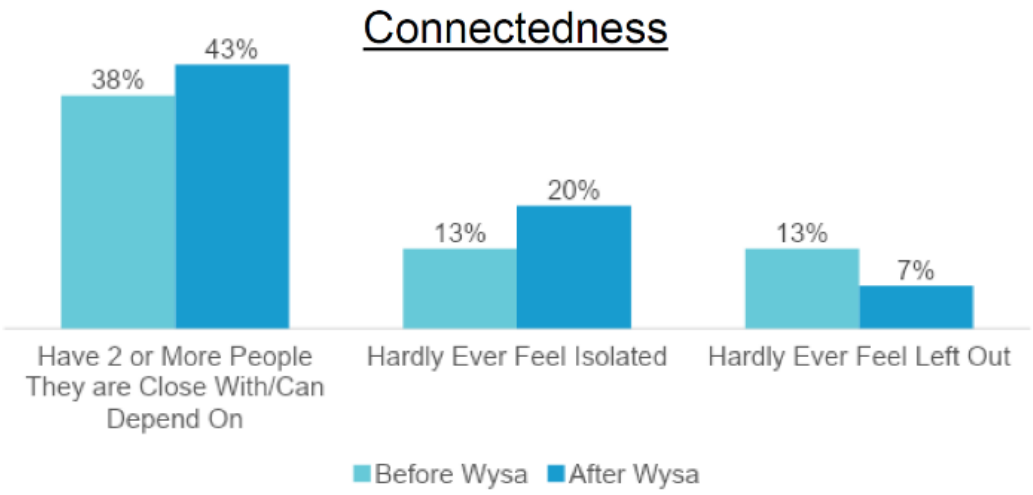
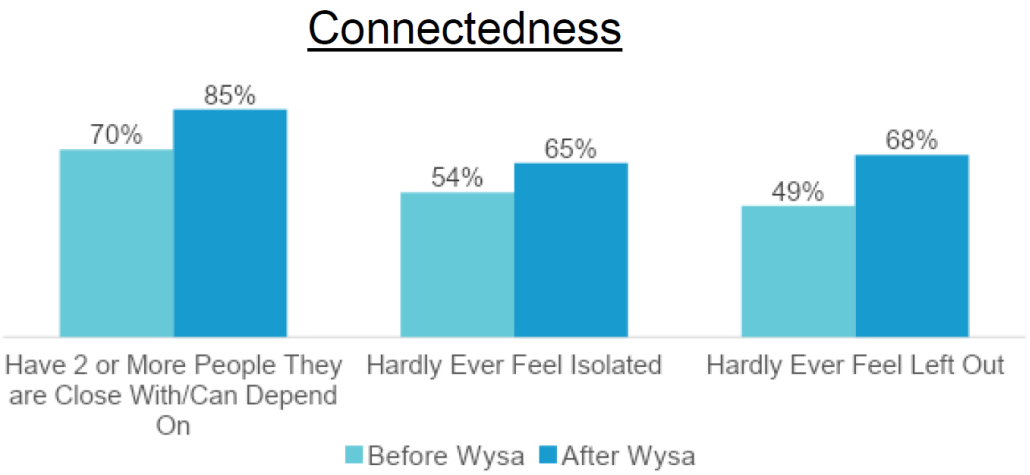


Figure 7. Survey Responses from Older Adult Respondents about Connectedness (n = 37)



For both TAY and older adults, after using the app, a greater number reported they have two or more people they are close with and can depend on, hardly ever feel isolated, and hardly ever feel left out.

While these results are promising, other survey question responses suggest that pilot users did not experience fewer feelings of isolation following use of the app but rather feel more connected to

support when they needed it. In surveys of early pilot users, **most (80% of TAY, 71% of Older Adults) did not agree with the statement "Using Wysa makes me feel connected to other people".** In the follow up pilot with BHRS clients, **most participants (79%) did agree with the statement, "Using Wysa makes me feel connected *to supports*,". Most users in all three groups (93% of TAY, 56% of Older Adults, and 79% of BHRS clients) agreed that "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious".**

The Wysa app's secure and private chat functionality were noted to enhance greater participation among TAY who may not otherwise engage in an in-person setting due to factors such as social anxiety or fear of being judged by peers. In Wysa, users can chat with an AI robot (i.e., chatbot), which then responds and recommends several self-care practices, such as mindfulness or physical movement activities or other resources in response to the user's issues or challenges mentioned in the chat. These chat functionalities were noted to reduce feelings of isolation and enhance social connection. Program staff also noted that the TAY testing participants seemed to value having access to chat-like features when using apps such as Wysa. **In fact, 80% of TAY and 53% of older adult users found the chatbot to be extremely or moderately useful.** Older adult users generally found the chatbot feature to be useful and enjoyed having a place to talk and share their feelings at any time of the day. They appreciated that the chatbot summarized what they said and referenced previous discussions. At the same time, some users noted that the chatbot's responses felt generic, unhelpful, and redundant, particularly when they used more complex language. Some also found it challenging to type everything they were feeling.

Similarly to the findings on mental wellbeing, the findings on isolation and connectedness are more limited in the general population. Among the group of users who responded to the survey, **41% either somewhat or strongly agreed with the statement, "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious."** This is substantially lower than the percentage of pilot and test users who agreed with the same statement. However, those groups reported more usage of the app and also received additional outreach and support for using the app that the general population did not receive.

Summary

Given the above findings from both surveys and focus groups, it seems that Wysa is generally beneficial in terms of both wellbeing and isolation, but that it does not eliminate the need for other behavioral health services and supports. In terms of wellbeing, the app promotes positive self-care and coping strategies. In terms of isolation, the app offers an outlet for folks to feel supported in times of need. However, using Wysa does not appear to eliminate distressing feelings and does not help people to feel more connected to others more broadly speaking. It is therefore important to consider Wysa as a supplementary resource that might be integrated with other supports to meet varying mental health needs for County residents. Additionally, given the differences in response between the pilot and testing groups and the general population, it seems likely that Wysa is significantly more effective as a tool for improving mental wellness and reducing feelings of isolation when it is provided along with other supports and resources.

Learning Goal 3: Can an app promote wellness and recovery for individuals living with mental health challenges?

Testing with existing BHRS clients demonstrated the ways that use of the Wysa app can integrate with and enhance other types of mental wellness support and resources to be a valuable tool in recovery for individuals with mental health challenges.

In surveys with BHRS test users, **79% agreed that using Wysa makes them feel like they have more support when they are feeling down, stressed or anxious. 75% agreed that using Wysa makes them feel connected to supports.**

For many of the test users, Wysa was a valuable supplementary resource, which they could turn to in addition to therapy or other resources they are already connected to. Using the app bolstered clients' self-care and coping strategies, eased loneliness, and allowed clients to feel even more connected and supported than with therapy alone.

- One Older Adult user shared that *"the app reinforces what I'm doing in therapy and expands it… The app will direct you to therapy or counseling and if you don't respond, the app will check in on you."*
- One TAY test user shared: *"I suffer from loneliness, and it was comforting that I could check in with the app anytime"*

Test users especially appreciated that the app is available 24/7, unlike traditional therapy or groups which tend to meet once or twice a week. Additionally, some users found it refreshing to use the app's tools and chat with the bot as a way to process thoughts and feelings without needing to share with another person. Some tools in the app were perceived as being more concrete than counseling, allowing users to work through issues in tangible ways and see their progress.

BHRS clients testing the Wysa app reported that the tools helped them manage feelings of anxiety, anger, stress, and loneliness, and helped them sleep better.

- One Older Adult client shared: *"I've been going through a health crisis, depression, inconveniences – it's helpful to have this tool. It helps with self-reflection, gives you an opportunity to pause and think through things"*
- A TAY client shared: *"[The app] helps me calm down. I used the talking feature and the self-care feature. Help with my anger and get a better night's rest."*

Summary

Results from surveys, interviews, and focus groups with BHRS clients who tested using the Wysa app show that the tools can support recovery when used as a supplement to traditional services. It will be critical to consider how clinicians can integrate the Wysa app into their practice with BHRS clients, allowing clients to benefit from a variety of tools and supports. The app offers some unique components that are not available with one-on-one or small group counseling (such as 24/7 access and integrated tracking tools) that may bolster these efforts and improve recovery for some clients.

Additional Findings

App accessibility and usability

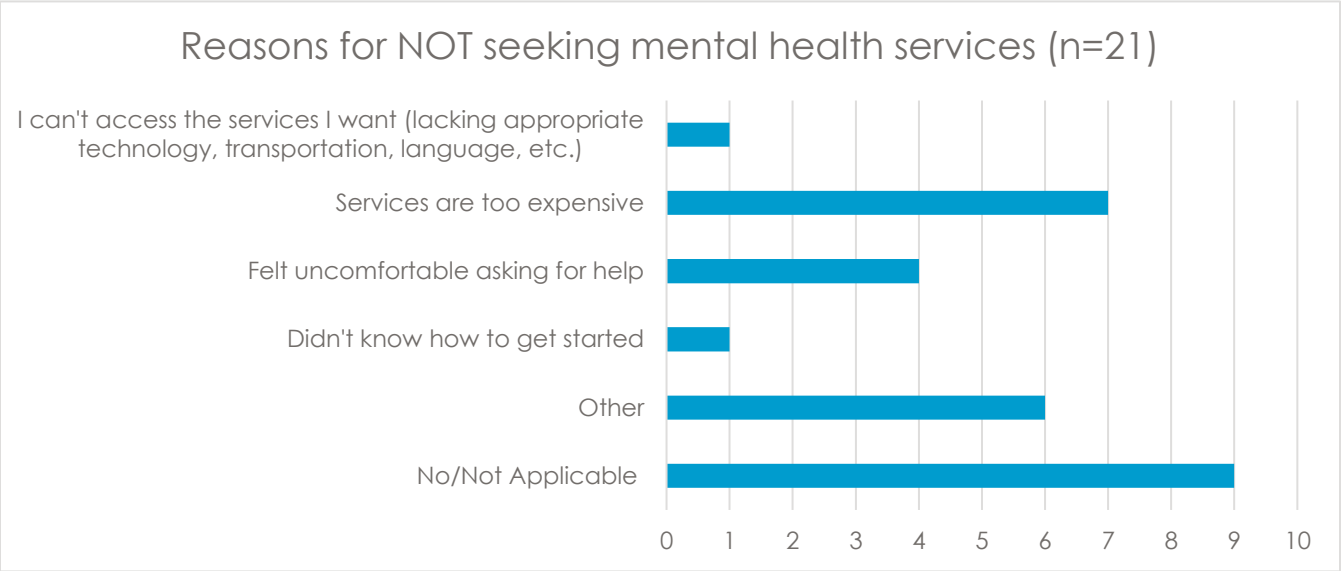
Based on survey responses and feedback from both pilot testing and the app launch, the Wysa app appears to be easy and intuitive to use and navigate. All of the TAY and 88% of older adults in pilot testing agreed that the app's language was easy to understand. Further, 93% of TAY and 88% of older adults in pilot testing agreed that the app was easy to use, while 76% of general population users agreed. Lastly, 87% of TAY and 69% of older adult pilot users reported that they would recommend using the app to others, and 62% of general population app users agreed. The availability of the apps content in various languages continues to be a concern among stakeholders. Stakeholders noted that BHRS did not identify a minimum viable product language requirement,[4] and that they are concerned

[4] A minimum viable product is the most basic version of a product that will still satisfy users. In this case, the minimum viable language requirements are the languages that the apps must offer to meet the fundamental linguistic needs of the target populations.

about moving forward with an app that has limited, or no, features for monolingual Spanish or Chinese speakers given the strong presence of these communities in San Mateo County. BHRS had initially hoped to include monolingual Spanish and Chinese speakers as target populations; however, they realized early in the Help@Hand project that they did not have the capacity to have priority populations in addition to older adults and TAY. However, reaching these two subgroups of the older adult and TAY populations continues to be an expressed interest of a number of stakeholders involved in San Mateo County's Help@Hand project. To address concerns, the Wysa app developers are currently working on a Spanish version of the app for future testing and piloting.

Accessibility of mental health services

In the final project stage, users who downloaded Wysa were asked in a survey, "In the past 2 months, have you chosen not to seek professional mental health services for any of the following reasons? Please select all that apply." Users reported that they have *not* sought services due to such factors as expense, discomfort, and lack of knowledge or access. While Wysa may encourage users to seek out mental health services, it will be critical to ensure that these barriers are considered.



Conclusion

The key evaluation findings outlined in this report can provide guidance for future directions and decisions regarding the sustainability of the Wysa app as a tool to support mental wellness and connect individuals to mental health resources in a non-stigmatizing and relevant manner, especially as we launched into a digital world post COVID-19.

It will be important to continue to consider ways to connect users with in-person services and resources from the app and to ensure that the app's tools are accessible to those with varying needs. Specifically for TAY, it will be important to identify ongoing best practices to support their mental health and wellness and mitigate barriers and/or stigmas. For Older Adults, more research is needed to focus on the various stigmas experienced within this population and possible reasons as to why older age-range adults, those between the ages 75 to 90, might be reluctant to seek mental health and wellness resources, and whether using an app is even an appropriate tool culturally appropriate way to engage the older age-range adults in wellness and possible connections to additional mental health supports if needed.

This report also serves as an opportunity to highlight unanticipated successes as San Mateo County responded to client and community technology-related needs that evolved during the course of this

Innovation project and were exacerbated by the COVID-19 pandemic. The local Learning Goals of this project centered around identifying an app or technology-based solution for supporting the mental health needs of consumers. While San Mateo County did identify and implement a wellness app to support these goals, the county ended up addressing so much more in the realm of digital supports including:

- Digital Mental Health Literacy (DMHL) training for peer staff
- Get App-y Workshops for older adults to receive supports with basic 101 technology education
- Expansion of the local youth crisis hotline to include text-based and social media supports
- 700+ Device and data plans distribution to clients to support engagement in services
- Tech Cafés or workshops for clients and the community at large to receive basic technology supports and 101 technology education

The Help@Hand Advisory Committee was engaged in a conversation around sustainability of the above mentioned Help@Hand activities and the Wysa app deployment. Stakeholders were asked: 1) What activities are a priority to sustain? And 2) Are there any changes we would like to see to any of these activities? Text-based/social media crisis supports for youth, device/data plan distribution, Get App-y Workshops, and Wysa deployment were prioritized in that order.

Prior the end of the Innovation pilot period, San Mateo County was able to secure ongoing MHSA funding for the text-based/social media crisis supports for youth and device/data plan distributions to clients.

The Get App-y Workshops and Wysa deployment activities were funded for one-year with one-time MHSA funding to allow for continued evaluation of the need and impact. The Wysa deployment activities includes contracts with 1) Painted Brain, a peer-run, peer-led agency that will support behavioral health clients with digital and technology needs related to their devices and the Wysa app; 2) Peninsula Family Service (PFS) and Youth Leadership Institute (YLI) to continue outreach activities to promote the Wysa app among vulnerable older adults and TAY that may need more supports; and 3) marketing activities, focused on social media ads only, to promote Wysa amongst the general San Mateo County population of older adults and TAY.

To-date, PFS staff have found it challenging to promote the use of an app with vulnerable older adult populations. The older age-range adults are much more interested in the Get App-y Workshops than the app. Older adults find it difficult to download and use the app without staff support and those that do use, don't engage with it ongoing. Pending the success of Wysa uptake broadly across the general San Mateo County population, amongst BHRS clients, and PFS and YLI outreach activities, decisions will be made for the continuation of Wysa app deployment past June 2023.

Appendix A: Demographic data

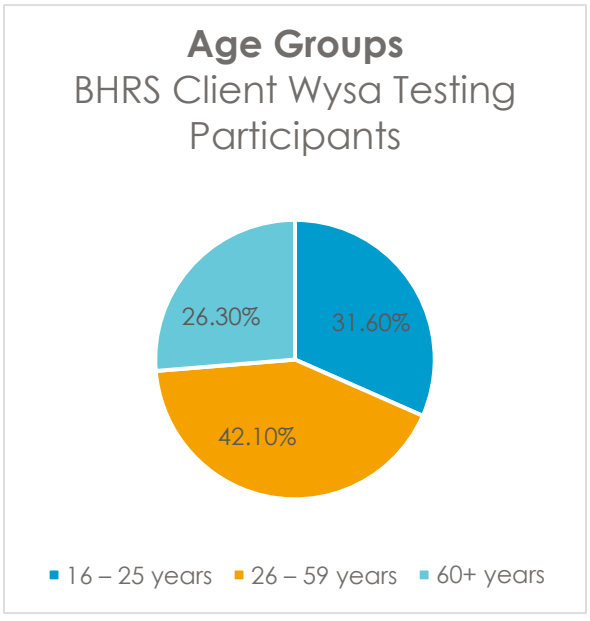
Pilot Focus Group, Interviews, and Survey respondents

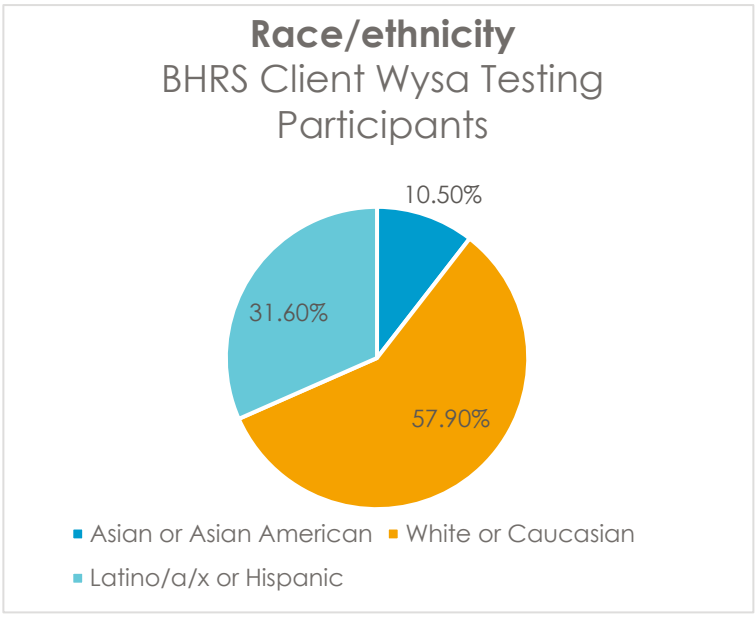
The demographic characteristics of pilot participants by target population are presented in the table below:

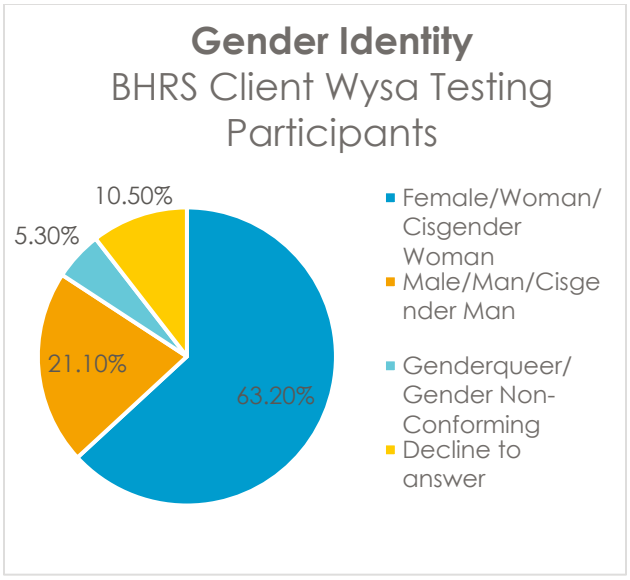
Older Adult and TAY Wysa Pilot Participant Demographics	
Older Adults	**TAY**
• Average 69 years old (range: 55 to 89 years) • 78% were female • Majority identified as White/Caucasian (83%) • 87% identified as straight/heterosexual • Most held a bachelor's or graduate degree (38%) • 52% reported no mental health challenges • 51% retired • 28% made under $30k per year	• Average 17 years old (range: 14 to 24 years) • 75% were female • Majority identified as Asian (50%), followed by Hispanic/Latino (38%) • 67% identified as straight/heterosexual • 81% were high school students • 43% reported no mental health challenges • 50% were students • Came from various households with a wide range of annual household incomes

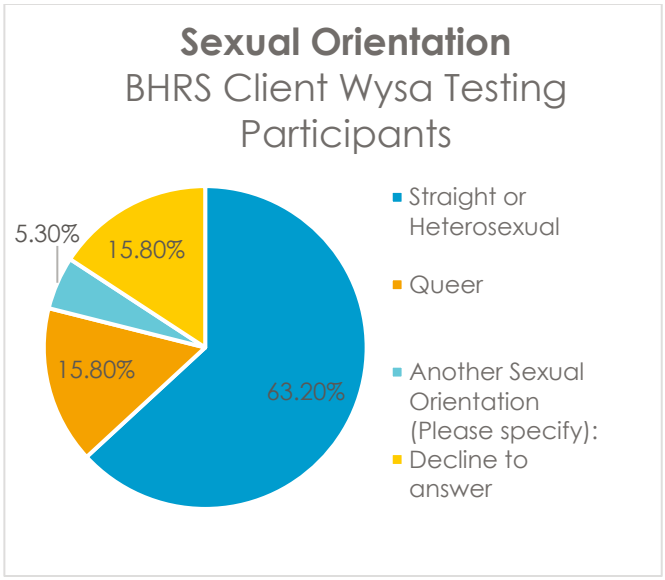
BHRS Client Focus Group, Interview, and Survey respondents

The demographic characteristics of participants in BHRS client app testing (n=19) are presented in the charts below:



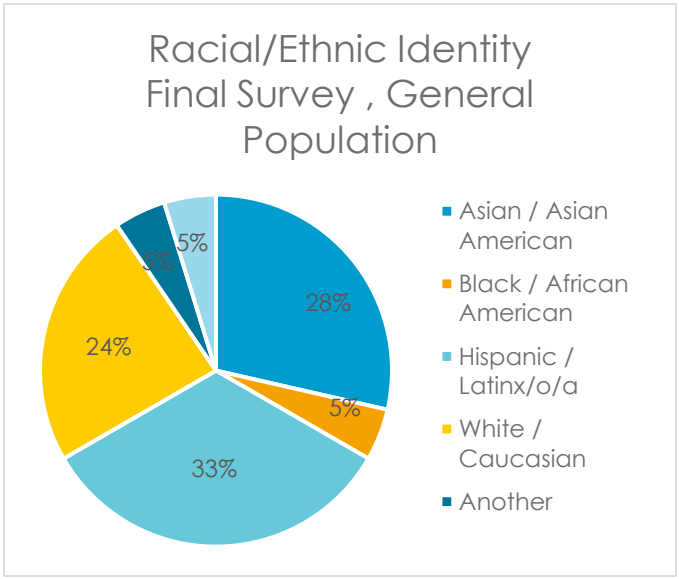


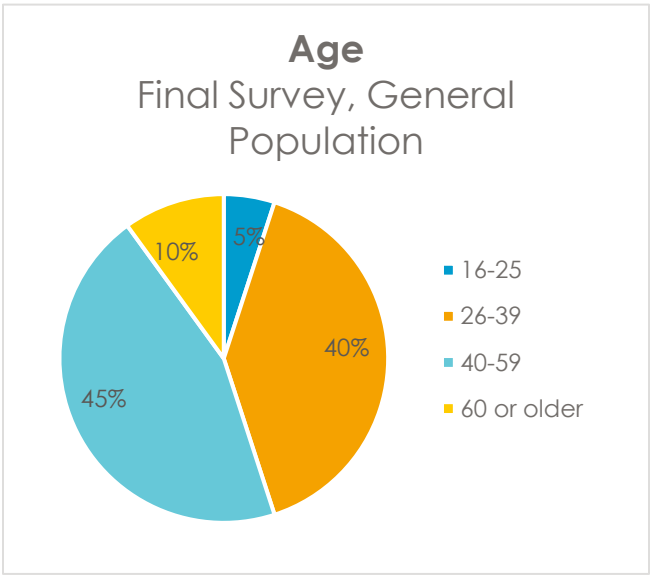


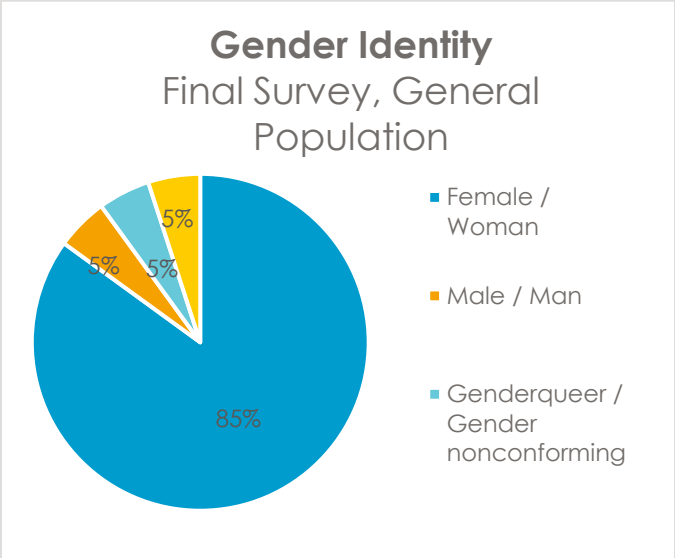


General Population Wysa user Survey respondents

The demographic characteristics of respondents to a follow up survey among general population county residents (n=21) are presented in the charts below:






Gender Identity
Final Survey, General Population
5%
5%
5%
85%
Female / Woman
Male / Man
Genderqueer / Gender nonconforming

SPOTLIGHT
San Mateo County's Wysa Pilot

wysa

San Mateo County Behavioral Health and Recovery Services and its contracted partners, Peninsula Family Services and Youth Leadership Institute, piloted the Wysa app with 37 older adults[1] and 16 transition age youth (TAY)[2] between April and July 2021. Pilot participants completed pre and demographic surveys, engaged with the app for two months, and then completed post surveys, focus groups, and app exploration sessions.

Data were collected and analyzed by Resource Development Associates (RDA) Consulting. This spotlight highlights excerpts from the pilot reports and presentations developed by RDA Consulting. The full pilot reports can be found in Appendix C.

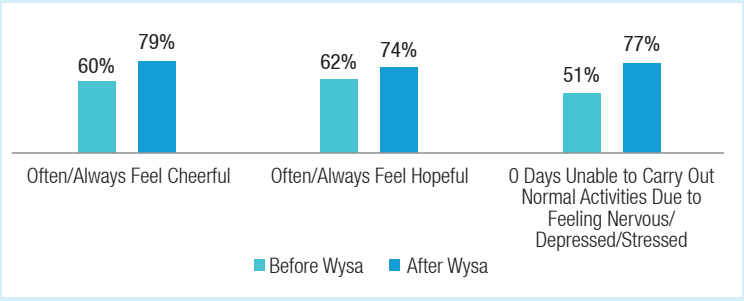
[1] 37 older adults completed the pre and demographic surveys, 34 completed the post survey, 30 participated in the focus groups, and 12 participated in the app exploration.
[2] 16 TAY completed the pre and demographic surveys, 15 completed the post survey, 13 participated in the focus group, and 8 participated in the app exploration.

PILOT LEARNING OBJECTIVE #1: Can an app promote mental health wellness and reduce feelings of isolation?

MENTAL HEALTH AND WELL-BEING

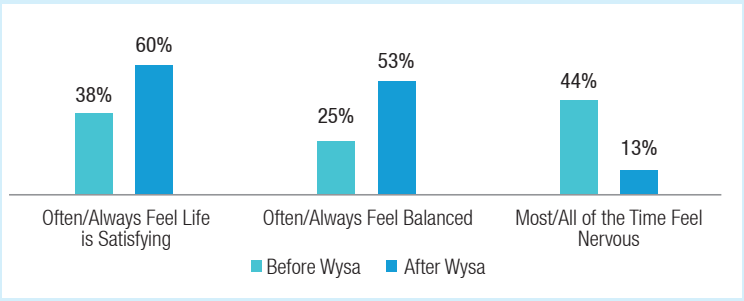
Older Adults

The proportion of favorable responses among almost all (18 out of 21) metrics related to mental health and well-being increased or stayed the same after using Wysa. This suggests that **using Wysa may have helped improve pilot users' mental health and wellbeing**. The largest increases were as follows:



TAY

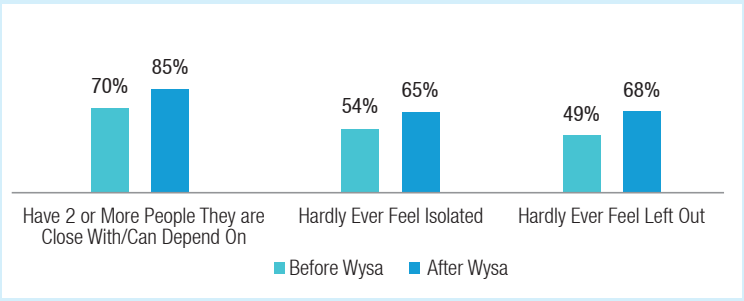
The proportion of favorable responses among almost all (19 out of 21) metrics related to mental health and well-being increased or stayed the same after using Wysa. This suggests that **using Wysa may have helped improve pilot users' mental health and wellbeing**. The largest increases were as follows:



PERSONAL CONNECTIONS

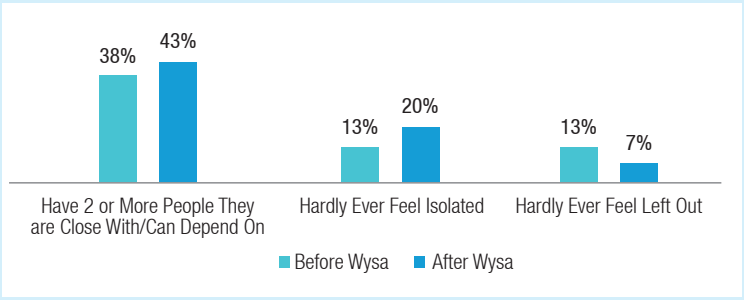
Older Adults

The proportion of favorable responses among all 4 metrics related to personal connections/isolation increased after using Wysa. This suggests that **using Wysa may have helped improve pilot users' feelings of isolation and connectedness**. The largest increases were as follows:



TAY

The proportion of favorable responses among almost all 4 metrics related to personal connections both increased and decreased after using Wysa. This suggests that **using Wysa may have had different impacts on users' feelings of connectedness**. Key findings were as follows:



PILOT LEARNING OBJECTIVE #2: Can an app connect transition age youth and older adults to mental health services and other supports if needed?

SOS Button

The SOS Button allows users to develop a safety plan and directs users in crisis to international crisis helplines.

% of users who...	Older Adults	TAY
did not use the SOS button	69%	60%
found it very, extremely, or moderately useful	9%	34%
found it slightly or not at all useful	22%	7%

Most older adult and TAY users were "afraid" or "scared" to use this feature as they thought emergency services would be contacted.

A few older adult users did not notice the feature at all.

EXPERIENCES WITH WYSA: STRENGTHS AND CHALLENGES

Older adults and TAY identified a number of strengths and challenges. The percentages represent the respondents who agreed or mostly agreed with each statement.

STRENGTHS

	Older Adults	TAY
Usage & Accessibility		
The language is easy to understand	88%	100%
Wysa is easy to use	78%	93%
Wysa is visually appealing	75%	87%
Would recommend Wysa to others	69%	87%
Support for Mental Health & Wellness Needs		
Wysa improved my mental health and wellness	56%	67%
Wysa makes me feel like I have support when feeling down, stressed, or anxious	56%	93%
I find Wysa useful in my daily life	53%	60%
Culture		
Wysa values and respects cultural differences*	31%	60%

CHALLENGES

	Older Adults	TAY
Support for Mental Health & Wellness Needs		
Because I used Wysa I am more likely to reach out for help with my mental health and wellness	31%	47%
Wysa makes me feel connected to other people	29%	20%
Wysa has helped me detect symptoms related to my mental health and wellness	22%	47%
Culture		
Wysa values and respects cultural differences*	31%	60%
Wysa demonstrates knowledge about my culture	13%	33%

*Older adults found this to be a challenge, while TAY found it to be a strength.

OVERARCHING USER RECOMMENDATIONS[3]

The following recommendations were shared by users in the post survey, focus groups, and app explorations.

Technical Support

- Create instructions, tutorials, and/or workshops focused on downloading and using the Wysa app.

Accessibility

- Enable Wysa to function offline to provide access to users with limited internet connection.
- Optimize Wysa for all devices and offer tutorials on how to configure app settings on different devices.
- Ensure the language, locations of the buttons, and content are optimized for users with cognitive or physical impairments.

User Engagement and Notifications

- Make the notifications and reminders more engaging for TAY users.
- Explore gamification strategies to incentivize users to engage with the app more frequently.
- Remind users of the ability to customize notifications.

Disclaimers and Notifications

- Add a disclaimer about the app's intended purpose, including that the app is a light touch resource for mild mental health and wellness concerns and is not a replacement for therapy.
- Offer users more control over app notifications, including frequency and how they are received (e.g., phone, email).

Content

- Include an in-app directory/search function.
- Ensure Wysa is inclusive of and responsive to individuals of different cultures and communities (e.g., LGBTQ+, different races/ethnicities) by reviewing and revising the content throughout the app as needed.
- Remove mentions of any other features that require a fee.
- Offer additional in-app customizations (e.g., colors, backgrounds/wallpaper, layout).

[3] User recommendations were condensed for the purpose of this spotlight. Complete lists for older adults and TAY are available in the pilot reports developed by RDA.

Campaign Report

2022 Wellness For All Campaign

San Mateo County Behavioral Health and Recovery Services (BHRS)

Uptown Studios
DESIGNS FOR SOCIAL CHANGE

Campaign Goals + Objectives

Uptown Studios partnered with San Mateo County Behavioral Health and Recovery Services (BHRS) to manage its 2022 Wellness For All campaign. There were two target audiences for the campaign: Older adults aged 55+ and younger adults aged 14-29.

The campaign's goals were to obtain 7,000 downloads and sign-ups of the Wysa app by the end of 2022 while working to reduce the stigma of mental health support, normalize asking for help, and drive awareness of the services and resources available to older adults aged 55 and over.

Table 1 below provides the terms and definitions related to digital measurements and what is defined as a "good" outcome. These terms are referenced throughout this document. Table 2 below outlines all of the campaign strategies and each outcome.

Table 1

Measurement & Definition	Defined as "good"
Engagements - The number of likes, comments and shares.	1% - 5% of your followers
Impressions -The number of times your content is displayed, no matter if it was clicked or not.	The higher the better. There is no "ideal" reach-to-impression ratio, but anything less than 0.2 is not ideal.
Reach - The total number of people who see your content.	Instagram average: 13.51% of followers Facebook average: 8.6% of followers
Post Clicks - The number of times someone clicked on the ad.	2% of impressions
CTR (Click-through Rate) - the percentage of people visiting a web page who clicked on the link of an ad.	2% is considered good
Total Net Audience Growth - The number of audience members you acquired during the reporting period.	Instagram - 1.5% per week is good Facebook - 0.64% per week is good

Table 2

Strategy	Outcome
Digital Ads - Generate three social media and Google ads per audience to increase the number of app downloads from June 29, 2022, to September 22, 2022.	There were a total of six ad campaigns that ran on Facebook and Instagram from June 29, 2022, to September 22, 2022. Three of the ad campaigns targeted older adults, and three targeted younger adults. During that time, there were 20,079 ad clicks resulting in an average click-through rate of 0.51%. The top ad included candid imagery of a young adult on their phone. That ad recieved a total of 485 clicks. One Google Ads campaign targeting older adults ran from June 29, 2022, to September 22, 2022. This campaign received 1,771 clicks and had 42,163 impressions.
Organic Social Media - Create an organic social media plan for 2022 to increase awareness of the Wysa app and services offered by San Mateo County BHRS.	Uptown Studios created organic social media content to share on San Mateo County Health and its partner's social media pages. Organic social media content was only shared on San Mateo County Health's social media pages from June 28, 2022, to August 17, 2022. During that time, there were 15,628 engagements, 1,676,146 impressions, and 7,115 post clicks.
Billboards and Transit Shelter Ads - Utilize billboards and transit shelter ads to promote the app to potential users.	Uptown Studios created a single ad to display on 30 buses throughout San Mateo County. The ads were displayed on the outside of buses beginning August 22, 2022, and will stay through December 31, 2022. The ads are on 15 buses on the North garage route and 15 on the South garage route in San Mateo County.

Partner Toolkit - Create a digital partner toolkit to provide partners with the necessary tools to encourage community engagement.	Uptown Studios created a digital partner toolkit that included social media, flyers, eblast content, and texting information. San Mateo County BHRS distributed these toolkits to their partners, such as YLI and Peninsula Family Services.
Postcards - Use direct mail to send out two postcards with QR codes to allow users to download the app and sign-up easily.	Uptown Studios developed two postcards, one for each target audience. Uptown Studios mailed 10,000 postcards on July 22, 2022. • Mailed one postcard to 2,949 Young Adults aged 18 to 24 living in San Mateo County. • Mailed one postcard to 7,051 Older Adults aged 55+ living in San Mateo County.
Monthly Eblasts - Send out monthly eblasts, including information about the app's services and instructions on downloading the app with the specialized codes from June 29, 2022, through September 22, 2022.	Monthly eblasts did not get prioritized in the budget; therefore, Uptown Studios did not create and send out monthly eblasts. However, the digital partner toolkits included eblast content, and partner organizations were encouraged to send an eblast to their contacts.
Flyers - Create flyers to be distributed by partners to local health care centers, older adult communities, and libraries with information on how to download and sign-up for the Wysa app.	Uptown Studios created two flyers, one for each target audience, and included them in the digital partner toolkits.
News Outlets - Contact local news outlets to promote information about the Wysa app and San Mateo County services and resources for older adults aged 55+.	Uptown Studios created and managed the implementation of a print ad for the Daily Journal. This ad targeted older adults aged 55 +. The ad ran weekly for five weeks, from July 25, 2022, to August 22, 2022. Because of the print ad space purchased, the Daily

	Journal gave San Mateo County BHRS a free digital ad space on its website during the same period.
Landing Page - Develop a landing page with information about Wysa, mental wellness, and the county's available resources.	Uptown Studios created content for the campaign landing page while CalMHSA managed the development portion. The landing page went live on March 7, 2022. There have been 868 page views with a bounce rate of 85.48%.

Digital Ads + Organic Social Media

Uptown Studios executed a combination of organic social media and paid digital ads to reach the target audiences. Uptown Studios incorporated positive and supportive messaging to reduce the stigma of mental wellness support. The graphics used had a diverse range of younger and older adults.

Uptown Studios created and scheduled posts across Facebook and Instagram from June 28, 2022, through August 17, 2022. Due to other health-related concerns within San Mateo County, the focus on the county's social media pages shifted, and Uptown Studios could not continue posting to the county's social media pages after August 17. Because the county's social media channels were not used for the entire campaign duration, Uptown Studios believes this affected the overall reach of the campaign messaging and is likely one of the factors that led to lower utilization of Wysa.

Paid social media ads ran on Facebook and Instagram from June 29, 2022, to September 22, 2022. There were 20,079 ad clicks across all paid social ads, resulting in an average click-through rate of 0.51%. The top ad, which received 485 clicks, included candid imagery of a younger adult on their phone.

Top Organic Social Media Posts

San Mateo County Health
Wed 7/20/2022 11:05 am PDT

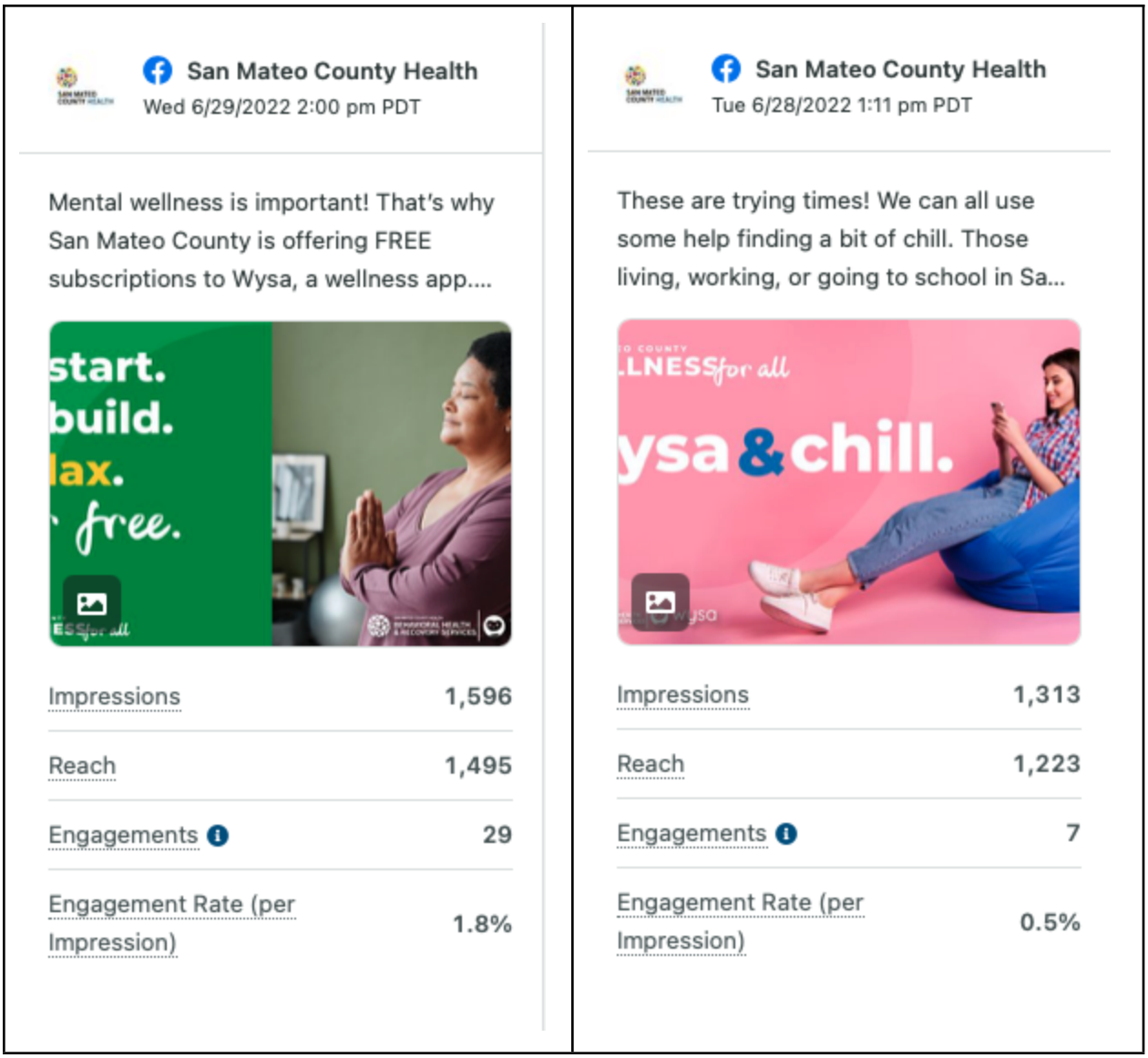
Find some peace and calm with FREE subscriptions to Wysa, available to everyone living, working, or attending...

Impressions	1,067
Reach	1,005
Engagements	11
Engagement Rate (per Impression)	1%

San Mateo County Health
Wed 7/6/2022 1:37 pm PDT

Open to trying something new? Work on self care, with Wysa, a wellness app for your phone or tablet, now available FRE...

Impressions	1,207
Reach	1,121
Engagements	11
Engagement Rate (per Impression)	0.9%



Organic Social Media Results

Measurement	Result
Engagements	15,628
Impressions	1,676,146
Post Clicks	7,115
Total Net Audience Growth	117

Top Performing Ad

Ad Image	
Headline	Reset. Rebuild. Relax. For Free
Description	Take a moment for yourself. Visit our website to access a FREE subscription to the mental wellness app, Wysa.
People Reached	219,658
Impressions	628,564
Clicks	485
CTR	0.08%

Paid Social Media Advertising Results

Measurement	Result
Reach	390,095
Impressions	3,931,261
Clicks	20,079
CTR	0.51%

Google Advertising Results

Measurement	Result
Impressions	42,163
Clicks	1,771
CTR	4.20%

Postcards

The Uptown Studios Team developed two postcards and mailed them to 10,000 San Mateo County residents. Each postcard was designed for a specific target audience: older adults and younger adults. By mailing postcards, San Mateo County BHRS could reach its target audiences directly in their homes. The postcards provided information about Wysa and led people to the campaign landing page to download the app and find other resources San Mateo County provides.

Target Audience	Graphics
Younger Adults – Mailed 2,949 of 10,000 postcards to Young Adults aged 18 to 24 living in San Mateo County	 PRIORITIZE YOUR MENTAL WELLNESS It's okay to need a little help sometimes. Your mental health is just as important as your physical health. San Mateo County Behavioral Health and Recovery Services has partnered with Help@Hand to offer a free subscription to the Wysa app to those living, working, or going to school in San Mateo County to get you the help you are looking for. It's Okay To Not Be Okay. To download the app, use this QR code, or visit this link: HelpAtHandCA.org/San-Mateo BEHAVIORAL HEALTH & RECOVERY SERVICES wysa

Older Adults –

Mailed 7,051 0f 10,000 postcards to Older Adults aged 55+ living in San Mateo County

Bus Ads

Uptown Studios created a single ad to display on 30 buses throughout San Mateo County. The ads were displayed on the outside of buses beginning August 22, 2022, and will stay through December 31, 2022. The ads are on 15 buses on the North garage route and 15 on the South garage route in San Mateo County. The bus ads will receive 7,800,000 impressions. This number estimates the number of people who will see this ad based on traffic in the area during the buses' run. Uptown Studios could not obtain transit shelter ads or billboards because of the high cost and lack of availability in San Mateo County.

Images of Bus Ad

Partner Toolkit

The Uptown Studios team developed a digital partner toolkit for San Mateo County BHRS to share with existing partners and local organizations in San Mateo County. The toolkit included a description of the Wellness For All campaign, two flyers, social media content, eblast content, and texting outreach content. San Mateo County BHRS sent these toolkits to YLI, Peninsula Family Services, and over 2,000 members on their subscriber list.

Link To The toolkit

https://drive.google.com/file/d/1BC8scJRLfdJqDrUlV5sfV3qYQMs385nt/view?usp=sharing

Print Ad

Uptown Studios created and managed the implementation of a print ad for the Daily Journal. A print ad was chosen to target older adults aged 55+ because it is a media outlet that this age group commonly uses to receive news and other information. The ad ran weekly for five weeks, from July 25, 2022, to August 22, 2022. Because of the print ad space purchased, the Daily Journal gave San Mateo County BHRS a free digital ad space on its website during the same period.

Images of Print + Digital Ads

Print Ad	Digital Ad
 IT'S OKAY TO NOT BE OKAY The hectic times we're living in have taken a toll on us all. We want you to know, it's okay to not be okay. San Mateo County has resources available to help! Get Free Access To The Wysa Wellness App And Other Resources Available In The County To download the app, use this QR code, or visit this link: HelpAtHandCA.org/San-Mateo BEHAVIORAL HEALTH & RECOVERY SERVICES | wysa	 Stay connected to the person that matters most, **YOU.** **Note:** This ad was clickable and drove people to the campaign landing page.

Landing Page

Uptown Studios created content for the campaign landing page while CalMHSA managed the development portion. The landing page went live on March 7, 2022. The landing page included information on downloading and signing up for the Wysa app, a video about Wysa, and a list of resources available to older adults in San Mateo County. There was also a survey that users were required to complete to get their access code and free access to the app for the first three months of the campaign.

For September, the landing page had 868 page views, and users spent an average of 2:42 minutes on the page. The landing page had a bounce rate of 85.48%, meaning that 85.48% of visitors left the page after clicking on the link. The highest pageviews were from September 12, 2022, to September 15, 2022.

Campaign Summary

To achieve the campaign goal of obtaining 7,000 Wysa app downloads by the end of the year, Uptown Studios implemented several strategies. Organic social media and digital ads were two strategies implemented to reach both target audiences. These strategies encouraged San Mateo County residents to download Wysa, provided resources available to older adults, and destigmatized talking about mental health.

To drive awareness of the campaign and encourage Wysa app downloads, Uptown Studios used bus ads, print ads, and postcards. Bus ads are displayed on 30 buses throughout San Mateo County until December 31, 2022. A print ad ran in the Daily Journal weekly for five weeks, from July 25, 2022, to August 22, 2022. Postcards were sent to 10,000 San Mateo County residents in June 2022. Both the bus and print ads targeted older adults in San Mateo County, while the postcards targeted older and younger adults.

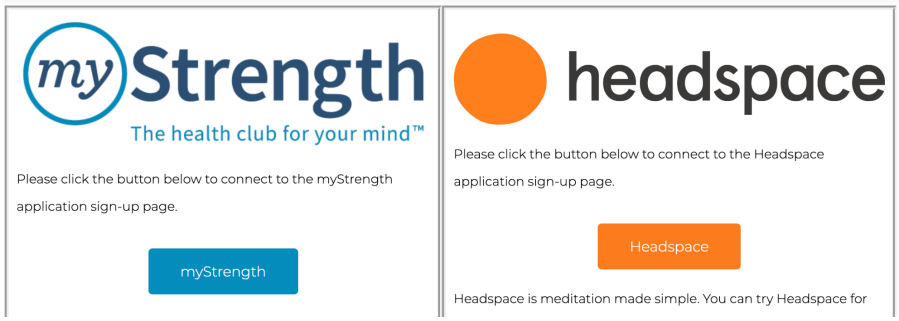
A Digital Partner Toolkit was sent out to over 2,000 partner organizations in San Mateo County. The toolkit included flyers, eblast content, organic social media content, and texting information. The toolkit's purpose was to have partners talk to their communities about the campaign, show their community members how to download Wysa, and share other resources available to older adults through San Mateo County.

All materials created for the campaign drove to a landing page for which Uptown Studios provided copy and graphics. It included information about Wysa and resources available through the county. People who downloaded the Wysa app had to go through the landing page to receive an access code.

There were 285 Wysa app downloads by September 2022. The number of Wysa app downloads, thus far, is less than anticipated. Uptown Studios provides recommendations in the section below to improve the number of downloads by December 2022.

Recommendations

- Simplify the landing page
    - Turn all links on the landing page into a button, so the links are more eye-catching
        - Examples:



- Promote Wysa app using messaging that highlights app features and use other well known sources that have written articles or made posts about Wysa to share on social media
    - “Having a hard time falling asleep at night? Wysa offers sleep stories to help you fall asleep and stay asleep! Get FREE access to the app through San Mateo County. Visit our website to get your free access now!
    - Example of articles to share: https://www.businesswire.com/news/home/20220718005028/en/Wysa-Secures-20m-to-Address-Global-Mental-Health-Demand-With-AI-Digital-Therapeutics

    - Have someone well-known from the county talk about why they love the app
        - Have a sports player, team mascot, mayor, etc take a video talking about Wysa and how the county is offering free access and post that to social media or the landing page.
- Resume organic social media postings. Halting posts half way through the campaign caused a setback on reach.
    - The algorithm (on all social media platforms) appreciates more frequent posting - around three to four times per week.
    - Consider creating new social media accounts under “Wellness For All” rather than using the county's social media accounts. This allows you to target the specific audience for this campaign by tailoring the posts and messaging for them
        - Uptown has created Berkeley Wellness For All and Tri-City Wellness For All social media accounts for similar campaigns
    - Continue encouraging partners to share and repost BHRS social media posts to increase reach and engagement

APPENDIX 9. KAPWA CAFE INN EVALUATION REPORT, FY 2022-23

KAPWA KULTURAL CENTER

Kapwa Kultural Center Evaluation

Mental Health Services Act (MHSA) Innovation (INN) Annual Report: FY22-23

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Kapwa Kultural Center Evaluation

Annual Report: FY22-23

Stephanie Duriez, PhD, Vanessa Guerrero, MPH, and John Cervetto developed this report, MSW, of RDA Consulting, SPC under contract with County of San Mateo, Behavioral Health, and Recovery Services.

RDA Consulting, 2023

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Program Overview

The Kapwa Kultural Center & Cafe (KKC or the program) is a Mental Health Services Act (MHSA) Innovation (INN) funded approach, a social enterprise, to providing culturally responsive and accessible services to the youth in and around Daly City. The County of San Mateo Behavioral Health and Recovery Services (BHRS), the Filipino Mental Health Initiative (FMHI), and the Daly City Partnership (DCP) have worked in partnership with the KKC's leadership team and BRIDGE Advisory Board over the last two years to facilitate the implementation of the KKC.

In this time, the KKC has made considerable progress to meeting the mission of the KKC: a community hub open to all people, especially Filipino/a/x youth, which provides culturally attuned mental health and wellness services, as well as opportunities for workforce development. Youth can receive mental health linkages and entrepreneurship mentorship all while learning more about their culture and identity. Additionally, KKC will employ a social enterprise business model, a café, that will generate revenue through the sale of boba tea and other food items "merienda" from local businesses, workshops, seminars, space rental for events and meetings, to support the financial sustainability of the café operations and the youth-focused programming.

Overall, the KKC's mission aims to help youth and the general community feel holistically well. This aligns with the goal of the KKC to establish a presence in Daly City that encourages Filipino/a/x youth to increase their engagement with community services that are meant to increase their overall Ginhawa; which roughly translates to "total wellness" or "well-being." This refers not just to physical health but carries notions of inner energy and the spirit. This is at the core of Filipino/a/x personhood. It is the notion of a "shared self" that extends the "I" to include the other. It bridges the deepest individual recesses of a person with anyone outside themselves, even total strangers. This holistic, cultural-based, and integrated approach is meant to foster protective factors and improve mental health outcomes for Filipino/a/x youth.

Program Description and Timeline

At the end of the second evaluation year of the KKC, the program moved from installation or start-up into the initial implementation stage and continues to build toward full implementation. The initial implementation stage saw the program accomplish an incredible amount of work in a short timeframe.

Initial Implementation Stage

As a reminder, when the KKC leadership team and their partners began exploring the idea of launching a social enterprise this was the first step of implementation.[1] The work that the team did to prepare the MHSA INN grant application set up this team for a successful start on their implementation journey. After the MHSA INN award, the KKC leadership moved forward into the installation phase of implementation and that is what was reported on in the first annual report in 2022.

In the second evaluation year, the program has decidedly moved into the initial implementation phase. The KKC leadership along with their partners at Daly City Partnership, their BRIDGE Advisory Group, valued community members, and the KAYA group worked to achieve:

[1] Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on social work practice*, *19*(5), 531-540.

1. **The development of a pilot workshop series which was well received by youth.**
2. **The creation of infrastructure and a business plan, in partnership with a local Filipina restauranter, that has mapped out the staff that need to be hired and their funding sources moving forwarded.**
3. **Validation of the earned income strategies developed by the KKC Directors with the Harvard Community Service Partners.**

Now, at the end of the second year and firmly in the initial implementation stage the program has been making incredible progress towards their goals.

Implementation Challenges

The program has managed change and has been able to push forward to keep the progress and momentum of the program forward by using the resources available to them to continue to build their community presence, pilot the services that they will be offering at KKC, and continuing to build a model of sustainability.

The challenges that the KKC leadership team has faced in the 2022-2023 can be grouped into three main areas 1) café delays; 2) staffing turnover among partners; and 3) the unanticipated complications that come with establishing a non-profit partnership with the county that lacks the expertise on staff to advise KKC leadership.

The first implementation challenge in this reporting period came is with the KKC physical space, or café space, which was mainly due to making necessary building upgrades. When catastrophic weather impacted the bay area in late 2022 and early 2023 it became clear that there would need to be repairs made to the building to ensure that it was brought up to code to pass inspection. Securing a contractor and completing that work has taken some time.

The second implementation challenge that KKC leadership has faced over the course of the year is staff turnover among partner agencies. While the relationships are still strong and thriving with partners, with the departure of staff and the arrival of someone new, there is a delay in getting them up to speed with the partnership that has been formed and all of the agreements made.

The final implementation challenge is the unanticipated complications that KKC leadership has faced in the past year is that of the unique type of project that the KKC team is developing, a social enterprise project, with the backing of the County, which has not engaged in this type of project before.

Evaluation Overview

In July 2021, BHRS contracted RDA to conduct a multi-year evaluation of the KKC, concluding in June 2024. The evaluation intends to:

1. Evaluate implementation, outcomes, and impact of the KKC.
2. Comply with MHSA INN regulatory requirements, including annual evaluation reports to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

RDA conceptualizes its role as evaluation partners rather than external researchers. In this approach, RDA collaborates with BHRS and KKC partners to articulate program goals, develop process and outcome measures, and interpret and respond to evaluation findings. RDA incorporates opportunities for stakeholder participation throughout the evaluation process by including BHRS, the KKC, the BRIDGE Advisory Board, and the KAYA in developing the evaluation plan, reviewing evaluation tools, and interpreting evaluation findings.

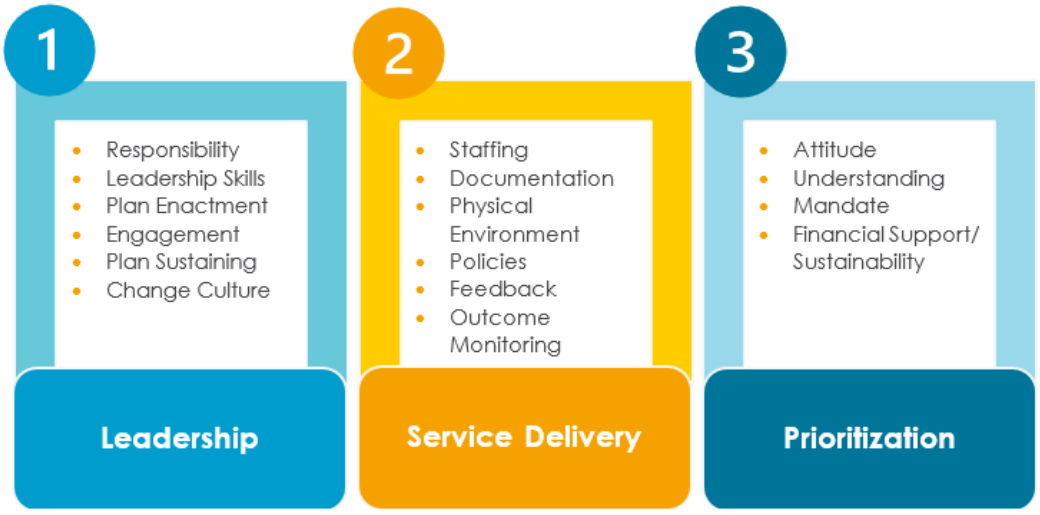
RDA will support BHRS' KKC program goals through both process and outcome evaluation components. The program evaluation includes assessment of KKC's development and implementation to support continuous program improvement (process evaluation), as well as the program's outcomes to understand the extent to which intended goals of the program are met (outcome evaluation). The evaluation will utilize a mixed methods approach, leveraging both qualitative and quantitative data to explore the research questions.

Evaluation Domains

During this second year, RDA focused on three distinct domains of inquiry to evaluate the implementation of the KKC (Figure 1). There were two distinct advantages to this approach. First, this is a crucial time in the implementation process and domain one allows RDA to check in on the lessons learned but also discuss how the program is setting itself up for long term sustainability. Additionally, domains two and three allowed for interventions to stop and take the time to reflect and assess their practices and gather feedback from each other and stakeholders on the progress made toward achieving fidelity to the model they aspire to. Second, the KKC is on a slight delay which allowed for only a narrow window of data collection in this first year of reporting. However,

taking this approach allowed for collection of robust qualitative findings on program development.

Figure 1. Kapwa Kultural Center & Cafe Evaluation Domains



Leadership

An integral part of the implementation of any program is the leadership component. This domain assesses the impact of leadership on the implementation of the KKC itself. The KKC is guided by a leadership team and Advisory Board since its inception. Using a qualitative data collection process, RDA staff conducted a focus group with KKC leadership, interviews with Advisory Board members and task force members, and KAYA members to collect feedback on how leadership has guided the process and whether there are opportunities for growth among leaders to support program development and implementation.

Service Delivery

This year this domain moved from assessing how KKC leadership were handling the components that impact the day-to-day operations of the KKC, to how the KKC implemented their first pilot of services to young people in the community. Understanding the lessons learned from the pilot, reviewing the feedback from those that participated in the development of the materials that were delivered to youth, and hearing from youth themselves is all important so that KKC leadership can grow and maintain successful practices.

Prioritization

A substantial component of KKC's learning goals is to understand how a social enterprise business model can support the work of impacting the lives of young people in a healthy and culturally affirming way. RDA assessed the attitudes and understanding of KKC leadership, BRIDGE Advisory Board members, and KAYA members, using focus groups and interviews, to understand the innovative approaches taken to achieve this mission.

Evaluation Questions

Evaluation questions reflect the purpose of the evaluation, help to guide evaluation activities, ensure the collection of appropriate data, and address local priorities. The questions for the evaluation of KKC are grouped into the three domains described above. Although separated to provide structure for the report process, domains and questions are interconnected and build off each other for a cohesive KKC evaluation. Again, to reflect the direction that the project was moving in the evaluation questions had been updated at the beginning that moves the evaluation from a strictly process evaluation to a process and outcome evaluation.

Leadership

1. To what extent is the KKC leadership team equipped and empowered to make decisions on behalf of program?
2. To what extent are KKC leadership skills and project management valued by the Advisory Board, KAYA members, and other stakeholders?
3. To what extent has KKC leadership engaged in long-term sustainability planning and included stakeholder engagement in that planning?

Service Delivery

4. To what extent was KKC able to create a set of culturally responsive workshops based on the social determinants of health?
5. How did the youth experience the workshop series? What impact did participation in a workshop(s) have on youth?

Prioritization

6. How has the continued, and increasing leadership responsibilities of KAYA impacted them and their feelings of self-advocacy, agency efficacy, and connection to self and others?
7. How has the program prioritized the mandate to create a culturally appropriate space for Filipino/a/x youth using a social enterprise model?

Evaluation Methods

Data Collection

Over the course of several planning meetings, RDA and KKC leadership worked together to identify expected measurable outcomes to address each evaluation question that would provide a comprehensive understanding of program activities and outcomes. In collaboration with KKC leadership, RDA then identified appropriate data sources for each outcome measure. **Appendix A** summarizes the evaluation domains, outputs/outcome measures, and corresponding data sources.

Qualitative Data Sources

KKC Program Documentation: RDA reviewed relevant program documentation to support analysis of the evaluation questions. This documentation included program descriptions, implementation plans, training materials, resource handouts, meeting notes, business plans and other pertinent information provided by BHRS and the KKC stakeholders.

Background Materials & Observation: RDA used extant documents to review, including background materials and relevant communications. RDA also used meetings as opportunities to make additional observations.

Focus Groups: RDA conducted a total of three virtual focus groups in September 2023 with KAYA members, KKC youth summer workshop attendees (not including KAYA members), and KKC leadership (Table 1). KKC leadership and RDA worked together to develop each focus group protocol with each protocol containing a range of 10 to 15 questions. Focus group discussions sought to identify strengths, gaps, and barriers with KKC development and programming, along with understanding stakeholder experience. The length of time for each focus group varied from 90 minutes to 105 minutes. The following phrases are used throughout this report to distinguish between focus group participants:

- KAYA members → KAYA focus group participants
- KKC youth summer workshop attendees → KKC youth workshop focus group participants
- KKC leadership → KKC leadership focus group participants
- KAYA members + KKC youth summer workshop attendees + KKC leadership → All focus group participants

Table 1. Focus Group Descriptions

Focus Group Participants	Time in Focus Group (minutes)	Topics Covered
KAYA Members	105	• Understanding of self and community • KAYA involvement in KKC • Summer workshop series • Skills and tools from outreach coordinator • KAYA success and improvement • KAYA involvement in KKC development • KKC impact
KKC Youth Summer Workshop Attendees	90	• Workshop awareness and understanding • Workshop experience • Workshop impact
KKC Leadership	90	• Social enterprise model • Advisory board involvement • Service development • Mission-driven innovation

Key Informant Interviews: In addition to focus groups, RDA held virtual 45-minute interviews with KKC task force members in September 2023. The key informant interview protocol was comprised of seven questions that focused on understanding task force members' experiences with the development and implementation of the KKC youth summer workshops, the support received from the community at large and KKC leadership in relation to the workshops, along with capturing task force members' perceptions on the summer workshops connection to the KKC mission and their influence on attendees' sense of cultural pride and belonging, and the sustainability of the workshops moving forward and into the new café space.

Quantitative Data Sources

Youth Experience Survey: RDA, in partnership with KKC leadership, designed the Youth Experience Survey to capture youths' experiences with the summer workshop series. The survey aimed to assess attendees' satisfaction and demographics, while also seeking their input on how to enhance the workshop series. RDA fielded the survey throughout July 2023 using the web-based platform, Alchemer. Participants were able to access the survey through a specified web link or by scanning the survey QR code. The survey was available in English and contained 34 questions, 11 of which were dedicated to attendees' demographic characteristics (e.g., age, current gender identity, etc.). All survey questions were optional and the survey itself was voluntary, with attendees who participated in the survey able to complete it in five minutes as most questions were close-ended and in Likert Scale format (disagree, somewhat disagree, neutral, somewhat agree, agree, does not apply). There was a total of 40 workshop attendees who participated in the survey. These participants will be referred to as survey respondents throughout this report.

Data Analysis

RDA emphasizes the importance of CQI as an underlying approach to how data will be analyzed and reported on. RDA conducted qualitative data analysis by organizing and cleaning KKC program documentation and background materials, along with the KAYA, KKC youth workshop, KKC leadership focus group and task force member interview responses.

Qualitative data informed both program development and implementation. To analyze qualitative data, RDA transcribed evaluation focus group participants' responses. RDA then thematically analyzed responses to identify recurring themes and key takeaways. RDA synthesized qualitative findings to learn what aspects of the program are most effective, how to improve, strengthen, and understand the preliminary impacts on KKC youth.

RDA utilized the statistical software, Stata 18, to generate descriptive statistics (e.g., means, frequencies, percentages) from the responses in the Youth Experience Survey. This data was used to analyze who KKC served, which workshops survey respondents participated in, the length of time survey respondents have participated in KKC events and activities, respondents' satisfaction, and intentions with KKC events and activities, as well as respondents' experiences with KKC's workshops, services, and staff. These quantitative data were integrated with findings from the focus groups and key informant interviews to further bolster the analysis. Based on these findings, RDA will support KKC leaders in their data-driven decision-making and programmatic improvement efforts.

Evaluation Findings

The following section presents the evaluation findings as they pertain to the evaluation questions mentioned above (see 'Evaluation Questions' for more information).

Domain 1: Leadership

This domain describes the impact that the leadership team has had on the development and implementation of KKC during the second year of program operations.

EVALUATION QUESTION #1: TO WHAT EXTENT IS THE KKC LEADERSHIP TEAM EQUIPPED AND EMPOWERED TO MAKE DECISIONS ON BEHALF OF THE PROGRAM?

KKC leadership has been strategic in their approach to the evolution of the social enterprise business model. In 2021 KKC applied for an opportunity to work with Harvard Community Service Partners, a non-profit organization made up of Harvard Business School alumni. In September 2023 the session with the group took place and the KKC leadership team was able to validate and augment their earned income strategies to add vale and best leverage these strategies for maximum revenue potential. These potential revenue-generating activities include sale of boba tea and other food items "merienda" from local business, workshops, seminars, space rental for events and meetings. Additional considerations for revenue-generating activities have been raised such as the potential for the space to be used to prepare meals for individuals and families who may be experiencing food insecurity, the use of the space as a ghost kitchen rental, and as a place to host local artisans. Moreover, KKC leadership discussed making space for the sale of KKC merchandise. KKC leadership highlighted that these activities are designed to teach program participants entrepreneurship and skill-building, with a focus on the wellness and culturally responsive expression of the community.

KKC leadership actively engages in decision-making about how to involve various stakeholders to enrich their efforts and maintain engagement. KKC leadership discussed the evolution of the Advisory Board and its role in the development of KKC. They highlighted the transition from the Advisory Board's significant role in the program's creation to the Task Force groups' more active participation in workshop development. KKC leadership mentioned the need to balance between the two and stressed the importance of building strong foundational relationships with both the Advisory Board and Task Force members to keep everyone engaged and invested in the program. KKC leadership recognized that the diversity of perspectives and intergenerational collaboration enriched their efforts.

KKC leadership's journey has been marked by extensive learning experiences, strong relationships with Advisory Board and Task Force members, and a commitment to maintaining engagement among volunteers and contractors. KKC leadership has effectively navigated transitions and power dynamics, fostered open communication and transparency, while emphasizing the importance of adapting and problem-solving. They have demonstrated a deep commitment to their mission, even among an intergenerational team, and have evolved their mission statement and vision to be more detailed and aligned with their original vision. The focus on a cohort model, collaboration with partners like Stanford and Harvard, and a nuanced understanding of adult allyship have all contributed to their capacity to empower youth voices and resonate with diverse audiences. Their ongoing conversations and action items ensure that they are accountable to their youth members and work collectively and continually to dismantle power dynamics.

As pioneers in the use of a social enterprise model for an MHSA INN project in San Mateo County, KKC leadership continues to successfully navigate unanticipated barriers, setting a precedent for similar programs in the future. Taking on a social enterprise model has brought with it a number of challenges that KKC leadership has faced head on with their partners. While recognizing that while their partners have been supportive through lending their knowledge and capacity, there have been certain challenges in terms of fiscal planning for a social enterprise model. The anticipation that some partners might have a more robust knowledge base around the financial aspect of social enterprises, has not been the experience which has redirected leadership to leverage expertise from local business owners and consultants. Despite these challenges, KKC leadership appreciates partners' transparency in acknowledging that the fiscal facet of a social

enterprise model is a learning process for all and feel that these learnings will help programs in the years to come that may use a similar model.

Additionally, due to staff transitions within partner agencies, there has been a barrier to creating and sustaining a strong collaborative relationship with partners which impacts the relationship and shared vision. Nonetheless, KKC leadership has continued to engage in ongoing discussions with partners, emphasizing the importance of translating these collaborative aspirations into tangible actions and shared agreements. While most partners have been highly supportive of the KKC, there have been some instances when KKC leadership has desired a more significant collaborative role and a clearly defined structure from partners.

KKC leadership continually demonstrates their readiness for open discussions and dialogues, illustrating their commitment to empowerment and decision-making on behalf of the program. They understand the need for flexibility, having navigated multiple transitions while establishing the social enterprise and addressing power dynamics. KKC leadership acknowledges that financial resources and positional authority are interconnected, fostering their curiosity and alignment with their core values. Identity, particularly as women of color, plays a pivotal role in their journey, fostering personal growth and the acquisition of assertiveness and empowerment. They have learned the importance of articulating their needs directly. The pursuit of liberation and decolonization remains central to KKC leadership with a focus to extend their mission to encompass their community and the broader world. For example, KKC leadership aims to provide equitable compensation to their team, even within a system often characterized by exploitation, emphasizing authenticity and valuing individuals' worth.

Overall, KKC leadership is making significant strides in equipping themselves to make decisions on behalf of the program, demonstrating adaptability, collaboration, and a commitment to fostering inclusivity and empowerment in their decision-making processes.

EVALUATION QUESTION #2: TO WHAT EXTENT ARE KKC LEADERSHIP SKILLS AND PROJECT MANAGEMENT VALUED BY THE ADVISORY BOARD, KAYA MEMBERS, AND OTHER STAKEHOLDERS?

KKC Leadership Skills and Project Management. KAYA, Summer Workshop Series Stakeholders, and Advisory Board respondents expressed a deep sense of value and appreciation for the leadership skills and project management efforts of the KKC's leadership team. Across all respondents there was an appreciation for the direction that the KKC leadership team is moving in and how they are able to keep the mission focused on the CommuniTree branches that will address the social determinants of health.

> **"Having women at the forefront of an organization changed my understanding of myself. When I saw these powerful women, I could see myself in those roles. I am capable of doing that and being able to center mental health. Having Filipino women in leadership has helped center self even more, yes, the workshops and speakers too, but seeing women in these roles is it."**
>
> **– KAYA Respondent**

The KAYA respondents discussed how the leadership team has worked collectively and personally within KAYA, such as presenting at conferences and organizing workshops, was viewed as highly meaningful. Respondents noted

that they felt valued and respected in this supportive environment.

One respondent emphasized the personal growth and empowerment they experienced through KAYA activities and the appreciation of the café as a space where they could envision themselves as a future leader. KAYA focus group participants also highlighted the impact of having Filipina women in leadership roles as empowering.

Overall, KAYA members valued their leadership skills and project management efforts of the leadership team, particularly their inclusion and recognition within the organization. Of note, KAYA youth expressed that the relationship that has been cultivated between "KAYA and the KKC leadership team addresses the absence of an organic relationship between institutions and the people that they serve. More specifically, programs meant to serve the youth without any sort of representation that accurately serves the youth population. KKC's intention to ensure that not only do the youth have a seat at the table but have their own space of leadership, directly addresses the need to serve our adolescent population that has been underrepresented" (KAYA Respondent).

EVALUATION QUESTION #3: TO WHAT EXTENT HAS KKC LEADERSHIP ENGAGED IN LONG-TERM SUSTAINABILITY PLANNING AND INCLUDED STAKEHOLDER ENGAGEMENT IN THAT PLANNING?

Over the past year, KKC leadership has demonstrated their ability to secure diverse funding sources apart from MHSA INN, reflecting their capacity to make decisions regarding the financial sustainability of the KKC. In addition to MHSA INN funds, KKC leadership secured funding from various sources. Pamana funds, identified by and Advisory Board member, were granted through the Citizen Diplomacy Action Fund (CDAF) from the United States Department, which amounted to just under $10,000. The Give in May fundraising event provided $23,000 over two years (2023 and 2024). In 2022, KKC leadership partook in Giving Tuesday which was a one-day fundraiser that generated $1,500 for KKC. Also in 2022, KKC leadership was awarded Measure K funding of $100,000 to assist with the café renovations. KKC leadership also received contributions from the Kaiser Foundation in 2023 ($3,152) as well private donations ($2,600), many of which come from recurring donors. From 2022 to 2023, KKC leadership has been able to secure $139,252 in additional funds for KKC, amounting to more than three times the original revenue goal.

KKC leadership's comprehensive strategy for financial sustainability encompasses not only existing funding sources but also a diverse array of revenue-generating activities, all aimed at fostering entrepreneurship, skill-building, and wellness in the community, thereby ensuring long-term program sustainability, financial stability, and growth. In addition to the already secured funding, KKC leadership discussed the importance of financial sustainability through various revenue-generating activities, such as hosting workshops, seminars, or allowing the KKC café to be used for rental space and as a ghost kitchen. KKC leadership also emphasized the importance of merchandise and local artisans' contributions to revenue. They highlighted that these activities were designed to teach entrepreneurship and skill-building, with a focus on the wellness and culturally responsive expression of the community. KKC aims to provide a platform for individuals to express themselves and build entrepreneurial skills while leadership monitors budgets and sales. Collectively, existing funding sources and future revenue-generating activities will be used to fund KKC's café operations and programs, ensuring program sustainability. KKC leadership further emphasized the importance of sustainability, both financially and in terms of staff capacity, noting that they are also thinking about scalability and growth over the next five to fifteen years and are exploring support networks for achieving these goals.

Domain 2: Service Delivery

This domain reviews the impact of the services delivered during the program year and also provides an overview of youth demographics for youth that participated in services and completed a survey afterward.

EVALUATION QUESTION #4: TO WHAT EXTENT WAS KKC ABLE TO CREATE A SET OF CULTURALLY RESPONSIVE WORKSHOPS BASED ON THE SOCIAL DETERMINANTS OF HEALTH?

KKC leadership's ability to create a set of culturally responsive workshops based on the Social Determinants of Health (SDOH) that can be considered highly successful. KKC leadership embarked on extensive planning, reflecting on the necessity for clear communication, managing expectations, and not making assumptions about the understanding of tasks needed to facilitate each of the workshops offered in the summer of 2022. This open and collaborative approach helped address potential challenges effectively. The workshops encompassed critical aspects of wellness, identity, and financial empowerment, addressing the societal pressures and expectations placed on youth. They offered a beacon of hope, encouraging participants to explore alternative pathways to success. In addition, the workshops resonated with the youth by featuring speakers who shared relatable experiences, allowing them to see themselves in these role models. This approach significantly contributes to addressing various aspects of the SDOH through reducing stress and anxiety while addressing imposter syndrome and inspiring a sense of empowerment. KKC leadership's emphasis on the wholeness of self and the freedom to choose one's path contributes to enhancing overall well-being and agency. The relevance of these workshops and the diverse backgrounds of the speakers empower the youth and support their growth, effectively aligning with the principles of the SDOH. KKC leadership's commitment to learning, continuous improvement, and a strong focus on the well-being of the youth indicates the success of KKC in creating culturally responsive workshops that address the SDOH. **The inclusion of KAYA in the workshops planning process impacted KAYA not only through the skill building opportunities it brought but through the empowerment they felt in having their voice heard.**

> **"It was really empowering to work side by side with my mentors. We got to work side by side to co create a workshop together. Despite the age gap they were able to value all of my ideas and my opinions and put action to it. It was interesting, for lack of a better word, and dynamic being in that kind of space. Felt really empowered."**
>
> **– KAYA Respondent**

EVALUATION QUESTION #5: HOW DID THE YOUTH EXPERIENCE THE WORKSHOP SERIES? WHAT IMPACT DID PARTICIPATION IN A WORKSHOP(S) HAVE ON YOUTH?

KKC Youth Experience Survey Overview

The number of workshop attendees varied. Feedback from workshop participants and KAYA respondents indicated that the topic of the workshop, the day and time of the workshop, and the location of the workshop all played a role in enrollment. Specifically, KAYA respondents urge that future workshops take place in a location that is more easily accessible and well known within the community. Attendance at workshops varied from eight to 35 attendees. Of the total summer workshop attendees, there were 40 who elected to respond to the Youth Experience Survey and

share their experience with engaging in the workshops (Figure 2).[2] More than half (58%) of respondents were from the leadership (30%) and entrepreneurship (28%) workshops.

Nearly two-thirds of survey respondents reported that it was not their first time attending a KKC activity (60%), and the remaining respondents noted that it was either their first time attending such an event (37%), or that they were not sure (3%).

Survey respondents tended to participate in multiple workshops. On average, survey respondents participated in two workshops, with a range of one to five workshops.

Examining the distribution of youth participants in workshops is important as it can act as a guide for what may naturally be interesting to youth, as well as inform leadership which workshops needed greater marketing as to their importance in youth's lives. For example, as shown in Figure 2, more than half of survey respondents participated in the leadership workshop (58%) while less than one-fifth of survey respondents attended the financial wellness (14%) workshops.

Figure 2. Snapshot of Survey Responses

40

Youth Experience Survey Respondents

16

Other* Workshop Participants

12

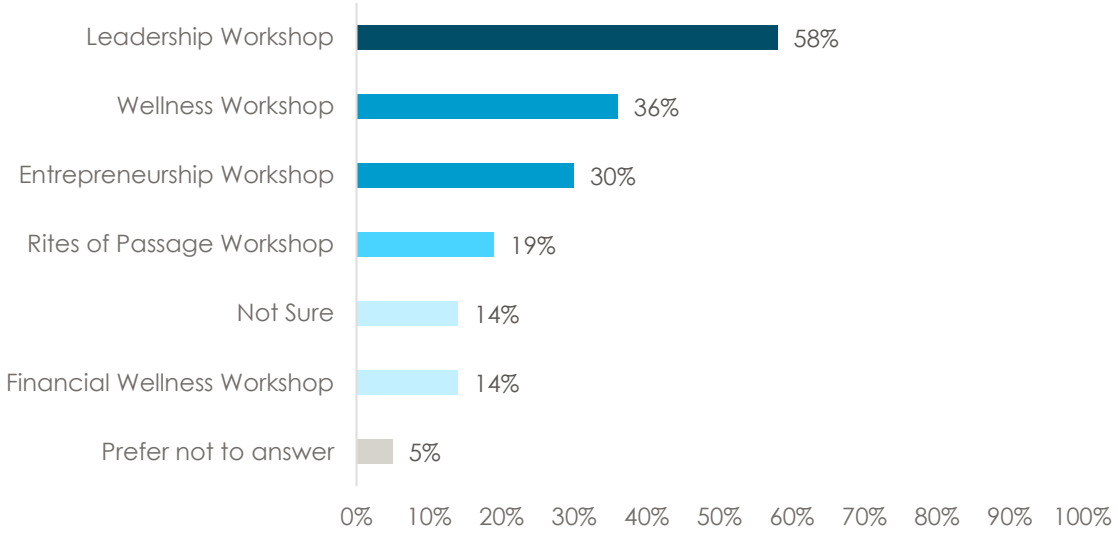
Leadership Workshop Participants

11

Entrepreneurship Workshop Participants

**Other workshops include Rites of Passage, Wellness, and Financial Wellness*

Figure 3. Workshops Survey Respondents Participated In, July 2023, N=36[3]



[2] Data Source: Youth Experience Survey, 2023. One respondent reported that they did not know which workshop they attended. Thus, they are not reflected in Figure 1 above.
[3] Data Source: Youth Experience Survey, 2023. Four respondents did not report which workshops they participated in.

Survey respondents reported attending KKC services or activities for some time. More than two-thirds of survey respondents attended KKC services or activities for one to six months (35%). Fewer than one-fifth of survey respondents documented attending KKC services or activities for less than one month (15%).

KKC Youth Experience Survey: Workshop Space and Content

KKC workshop facilitators cultivated a strong sense of comfort for nearly all workshop survey respondents. Across all five workshops, 97% of all survey respondents indicated that they agreed or strongly agreed that KKC provided a comfortable space. KKC workshop facilitators also fostered an environment where **survey respondents felt they could come back for support, connection, or both**. The same percentage of survey respondents, 97%, reported they would return to KKC for connection and/or support. Furthermore, all survey respondents who participated in the KKC workshops would recommend KKC workshops and activities to someone they know. **Learnings from the KKC workshops impacted survey respondents' emotional, mental, physical, or spiritual health.** Notably, 100% survey respondents felt that the KKC workshops taught them something that helped their emotional, mental, physical, or spiritual health (Table 2).

The KKC summer workshops facilitated holistic personal development, nurturing self-awareness, empowerment, and a sense of belonging within a diverse and supportive community. Moreover, the KKC workshops proved to be a transformative experience for participants, with several key themes emerging from their shared learnings. Survey respondents who attended the workshops gained a deeper understanding of the complexity of human behavior, recognizing the coexistence of both positive and negative traits within individuals. They also acquired valuable skills in assertiveness and self-advocacy, enabling them to assert themselves and seek clarification when needed.

In addition, **the workshops addressed the crucial topic of negativity and gaslighting, equipping survey respondents with tools to identify and manage these negative influences in their lives.** The KKC workshops underscored the importance of self-care, with survey respondents emphasizing the need to "protect their energy." Identity and diversity were prominent themes, with survey respondents exploring various identities and learning the significance of using inclusive language.

> **"There was a lot of color and imagery and engagement involved; it was a safe space in general for everyone to be themselves; there was also a lot of little mini crash-courses; yes, we're learning about this topic but there's also a lot of history around it; I felt like I wasn't just learning but feeling closer to the whole thing."**
>
> **– Workshop Participant**

KKC workshops also encouraged survey respondents to be their authentic selves and to be accepting of oneself, allowing individuals to embrace their true selves. Workshops also fostered creative expression, with activities like storytelling and the exploration of Filipino cultural concepts like "babaylan" proving enriching.

The workshops also delved into spiritual awareness and financial wellness, imparting knowledge on managing finances wisely. Entrepreneurship was a central focus, with participants believing in their capacity to be entrepreneurs, gaining insights into business strategies, and learning about the importance of calculated risks. They were also introduced to community resources and the role of social enterprises, highlighting the workshops' comprehensive approach to personal growth and community engagement.

Table 1. Survey Respondents' Experience with Workshop Space and Content, July 2023, N=36[4]

Statements	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Does Not Apply
I was comfortable in the space the workshop was held in.	92%	5%	3%	0%	0%	0%
I would come back to Kapwa Kultural Center for support and/or connection.	86%	11%	3%	0%	0%	0%
I would recommend Kapwa Kultural Center workshops and activities to someone I know.	97%	3%	0%	0%	0%	0%
I learned something that helped my emotional, mental, physical, or spiritual health.	89%	11%	0%	0%	0%	0%

KKC Youth Experience Survey: Groups, Services, and Staff

KKC workshop staff were able to make 100% of survey respondents feel supported as well as connected to their culture and community. Meanwhile, nearly all survey respondents agreed or strongly agreed that KKC workshops and activities were relevant to their cultural background and beliefs and that the activities met their needs (97%). These results reflect back what the task force members who facilitated the workshops reported regarding how they hoped youth seemed to be engaging with them and the material.

Survey respondents also praised KKC staff for their ability to connect them to valuable community services and expressed a strong sense of comfort in reaching out to KKC for future needs. With 100% of survey respondents reporting that KKC staff connected them to other services in the community that have been helpful. Equally important, 100% of

"There was a strong sense that there are adults that share your culture and care about your future and success. The youth really seemed to see the message and the vulnerability of the adults."

– Workshop Taskforce Member

"I felt like I learned about so many resources I haven't thought of before [which was] healing for younger me; another strength was community; by the second workshop, you feel like you're friends with everyone."

– Workshop Participant

[4] Data Source: Youth Experience Survey, 2023. Four respondents did not respond to the statements.

young people indicated that, if needed, they would feel comfortable reaching out to KKC staff for services (Table 3).

Survey respondents commended KKC's commitment to making the workshops and activities accessible and inclusive, noting that workshop and activity timing, location, and language preference were all considered. Nearly all survey respondents were able to make it to the workshops and activities during the times offered and were appreciative that the workshops and activities were facilitated in their preferred language (97%). Similarly, almost all survey respondents reported that the workshops and activities were held at a location that was convenient for them to get to (94%). These responses are so important to sustainability of the program and will be important to continue to monitor as KKC moves into its permanent café.

Survey respondents shared common learnings that reflect a diverse and enriching workshop experience that combined personal development, cultural appreciation, and practical life skills. Many emphasized the significance of one's mindset, recognizing that the quality of their thoughts influences their overall well-being. Additionally, several survey respondents gained knowledge on how to mediate and recognize gaslighting, a crucial skill in navigating complex interpersonal situations. Others focused on broader concepts, such as learning about macrosystems and folklore, which expanded their understanding of cultural and societal contexts. **Notably, KKC workshops and activities shared content that was useful to survey respondents.** All survey respondents learned something that was useful to them from the workshops and activities they participated in (Table 3).

The workshops also fostered a sense of appreciation and connection to the KKC community, with enthusiastic expressions of love for the KKC. Survey respondents embraced the idea that it is acceptable not to conform to societal expectations and resonated with the message of choosing love as a guiding principle in life. They learned that the Philippines was named after King Philip, gaining historical knowledge, and discovered the availability of valuable resources to meet their needs.

Furthermore, **the workshops encouraged participants to write about themselves and the future, promoting self-expression and envisioning a positive future.** Business-related topics were also prominent, with survey respondents benefiting from business advice and financial insights, including the structure of a general business plan. Many survey respondents recognized

> **"The entrepreneurship workshop discussed how they went about starting their businesses; they thought on what the need is and if anyone had filled that gap; you want to bring something to the table nobody is doing yet; thinking outside the box…"**
>
> **– Workshop Participant**
>
> **"I definitely gained a lot of connections; I would say, a lot of the workshops – one of them was towards business and it was Filipino owned businesses; I learned a lot about our community when it comes to business [as well as] history and where a lot of things were map-wise; I definitely had a lot [of cultural connections] business-wise and emotional-wise."**
>
> **– Workshop Participant**

entrepreneurship as a viable career path, appreciating its potential for personal and professional

growth. All in all, survey respondents were happy with the workshops and activities they participated in (97%).

Table 2. Survey Respondents' Experience with KKC Groups and Services, July 2023, N=31[5]

Statements	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Does Not Apply
I felt supported by Kapwa Kultural Center staff.	97%	3%	0%	0%	0%	0%
I felt connected to my culture.	97%	3%	0%	0%	0%	0%
I felt connected to my community.	94%	6%	0%	0%	0%	0%
Kapwa Kultural Center workshops and activities were related to my cultural background and beliefs.	87%	10%	3%	0%	0%	0%
The workshops and activities offered met my needs.	87%	10%	3%	0%	0%	0%
Kapwa Kultural Center staff connected me to other services in the community that have been helpful.	90%	10%	0%	0%	0%	0%
If I have a need for services in the future, I feel comfortable reaching out to Kapwa Kultural Center staff.	90%	10%	0%	0%	0%	0%

[5] Data Source: Youth Experience Survey, 2023. Nine respondents did not respond to the statements.

Statements	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Does Not Apply
Kapwa Kultural Center workshops and activities were offered at a time when I could make it.	94%	3%	3%	0%	0%	0%
Kapwa Kultural Center workshops and services were held at places I can easily get to.	78%	16%	3%	0%	0%	3%
Kapwa Kultural Center workshops and activities were offered in my preferred language.	90%	7%	0%	3%	0%	0%
I learned something that is useful to me.	97%	3%	0%	0%	0%	0%

Overall, the KKC summer workshop series left lasting impressions on survey respondents, fostering a profound and positive impact on their personal growth and well-being. The overwhelming consensus among survey respondents reflects the workshops as a space of comfort and support, where they felt empowered to explore their identities and connect with a diverse and supportive community. These workshops equipped survey respondents with valuable skills, fostered a sense of belonging and empowerment, and encouraged a deep appreciation for their culture and community. It is clear that participation in these workshops had a profoundly positive impact on the youth, enabling them to navigate life's challenges with confidence and a broader perspective. The upcoming year will see an expansion of these services and with the opening of the social enterprise café component, the KKC leadership will be able to support the continuation of workshops and other services and activities.

KKC Youth Experience Survey: Demographic Characteristics of Respondents

Similar to understanding which workshops youth are engaging with at a higher rate, it is also important to understand the youth that are participating in the workshop series. There are several

reasons to understand the young people that are coming to this workshop series. Within the community that is being served it is important to ask:[6]

- Who is in the room? Who may be trying to get into the room, but may feel like they cannot? Why may they feel that way?
- Whose ideas will not be taken as seriously because they are not in the majority?
- What conditions have we created that maintain certain groups as the perpetual majority here?

The KKC leadership team has created a space that many have reported has been a place where people are free to come as they are and to contribute what they have in the space that they are in both mentally and emotionally. By continuing to check in with the demographics of those that are engaging with the KKC the leadership team can ensure that they are continuing to seek out new voices, unique points of view, and members from all corners and facets of the community to continue to enrich and grow the KKC.

The demographics of the attendees from those that completed a survey during the pilot period are displayed in Table 3. The average age of survey respondents who participated in the demographic characteristics portion of the survey was 19 years old, with a range of 15 to 23 years old. This age range is in line with KKC's target population. Slightly more half of respondents indicated that English is their preferred spoken language (55%), which is interesting feedback for the KKC team and may be something to consider on whether there be an opportunity to provide a workshop in languages other than English. All respondents identified their race as Asian/Asian American (100%), and nearly all respondents identified their ethnicity as Filipino/a/x (97%). Over half of respondents identified as female (59%), three-quarters of respondents identified as a cisgender woman/woman or a cisgender man/man (76%), and almost three-quarters of respondents identified as heterosexual or straight or queer (73%). Most respondents reside in Daly City (83%).

Table 3. Demographic Characteristics of Survey Respondents, July 2023[7,8]

Category	Percent
Age (Years)	
<16	11%
16-24	89%
Preferred Language	
English	55%
Tagalog	41%
Visayan	4%

[6] Stewart, D.-L. (n.d.). *Colleges need a language shift, but not the one you think (essay)*. Inside Higher Ed

[7] Data Source: Youth Experience Survey, 2023.
[8] The total number of respondents to the demographic questions are not reflected to protect the confidentiality of the individuals summarized in the data as some sample sizes yielded a response rate of lower than 11.

Category	Percent
Race[9]	
Asian/Asian American	100%
Latino/a/x and/or Hispanic	6%
Native Hawaiian or Pacific Islander	6%
Ethnicity[10]	
Filipino/a/x	97%
Mexican/Chicano/a/x	7%
Prefer not to answer	3%
Sex Assigned at Birth	
Female	59%
Male	41%
Intersex Identification	
No	79%
I am not sure	14%
Prefer not to answer	7%
Current Gender Identity	
Cisgender Woman/Woman	45%
Cisgender Man/Man	31%
Prefer not to answer	10%
Genderqueer/Gender Non-Conforming/Neither Exclusively Male nor Female	7%
None of the above	7%
Sexual Orientation	
Heterosexual or Straight	52%
Queer	21%
Questioning/Unsure	14%
None of the above	10%
Asexual	3%
Disability Status	
No disability	72%
Difficulty seeing	14%
Mental disability	10%

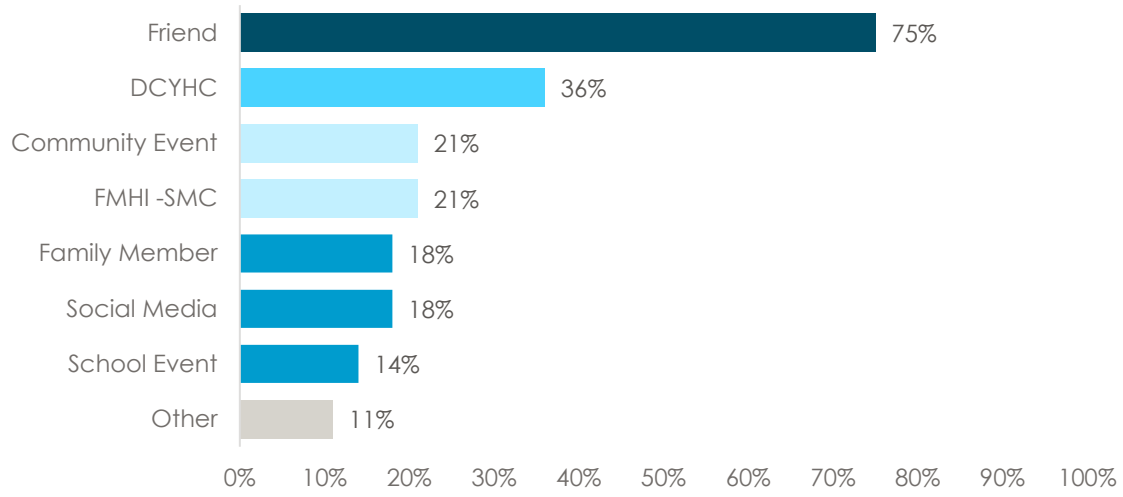
[9] This demographic category reflects more than 100% since respondents were able to select more than one race they identified with.
[10] This demographic category reflects more than 100% since respondents were able to select more than one ethnicity they identified with.

Category	Percent
Prefer not to answer	3%
City of Residence	
Daly City	83%
San Francisco	14%
San Pablo	3%
Veteran Status	
No	100%

KKC Youth Experience Survey: Referral Sources

Survey respondents were typically referred to the KKC youth summer workshops by more than one source. Of the survey respondents who reported where they heard about KKC (n=28), 61% were referred by more than one source. On average, survey respondents were referred to the KKC youth summer workshops by two referral sources, with a range of one to six sources. As reflected in Figure 4, three-quarters of respondents were referred by a friend, while more than one-third were referred by Daly City Youth Health Center (DCYHC) (36%), and more than one-fifth were referred by a community event (21%) or the Filipino Mental Health Initiative in San Mateo County (FMHI-SMC) (21%). Fewer than one-fifth of respondents were referred by a family member (18%), social media (18%), school event (14%), or another source[11] (11%).

Figure 4. Survey Respondents' Referral Source to KKC, July 2023, N=28[12,13]



[11] Other Referral Source includes Youth Empowerment, Entrepreneurship, and Employment (YEEE).
[12] Data Source: Youth Experience Survey, 2023. Twelve respondents did not respond to this question.
[13] These percentages total to more than 100% since survey respondents were able to select more than one response option.

Domain 3: Prioritization

This domain discusses how KKC has prioritized impacting youth and the mandate to create culturally appropriate spaces for youth.

EVALUATION QUESTION #6: HOW HAS THE CONTINUED, AND INCREASING LEADERSHIP RESPONSIBILITIES OF KAYA IMPACTED THEM AND THEIR FEELINGS OF SELF-ADVOCACY, AGENCY, EFFICACY, AND CONNECTION TO SELF AND OTHERS?

KAYA members feel greater understanding of themselves and their culture, their agency and empowerment comes from this understanding of self, guided by KKC leaders.

Participation in KAYA led to members' increased self-awareness and a deeper understanding of their Filipino identity. KAYA members found the workshops and activities were instrumental in helping them navigate their Filipino identity within the context of American society. They emphasized how KAYA encouraged them to be unapologetically outspoken about their experiences and feelings, particularly related to their Filipino heritage and mental health. Participants recognized KAYA as a safe space that empowered them to explore various aspects of their identity and mental health, building self-confidence, and a sense of agency. These discussions helped them navigate the complex terrain of being Filipino American, while also embracing their cultural heritage.

EVALUATION QUESTION #7: HOW HAS THE PROGRAM PRIORITIZED THE MANDATE TO CREATE A CULTURALLY APPROPRIATE SPACE FOR FILIPINO/A/X YOUTH USING A SOCIAL ENTERPRISE MODEL?

KAYA members discussed the ways in which the KKC contributed to creating a culturally appropriate space for Filipino youth. They highlighted how the space cultivated a sense of cultural pride, belonging, and community through its programming, serving as a platform for discussions related to Filipino history, mental health, and the broader social justice issues affecting the community. Participants commended the space for addressing these issues without reservation, fostering conversations about Filipino American experiences, and helping to destigmatize personal narratives. Furthermore, they acknowledged the dedication of the leadership team in ensuring that their voices were represented in the planning and decision-making processes related to space. They felt that the space, through its inclusive and supportive approach, strengthened their bond with their Filipino heritage and the larger community. As

> **"I am an immigrant born in the Philippines and moved here when I was young. We have a history of stripping our culture and moving into the United States, that has been my experience. Our culture was stripped, there was so much trauma and discussion were stigmatized, but there wasn't anyone around to address or talk about these issues. KAYA was one of the first few people who really turned the table upside down and really addressed specific topics in Filipino mental health. How do we address this in a healthy and holistic manner and go back to our roots? They talk about skills and tools and the frame topics in a very nonwestern way, and it resonated with me. I never understood my trauma until it was addressed in that way. KKC staff are just great at guiding those conversations."**
>
> **– KAYA Respondent**

KKC continues to move toward opening the café component of KKC, there are plans for KAYA to remain involved and have continued input.

All in all, KAYA focus group participants highly valued their involvement in the KKC and found that it significantly contributed to their personal growth, self-advocacy, and cultural connection. KKC leadership's project management and leadership skills were praised for creating a supportive and empowering environment. The participants noted that the KKC played a crucial role in cultivating cultural pride and providing a safe, open space for discussing essential issues that affect the Filipino American community. **KAYA focus group participants expressed a deep sense of appreciation and recognized the importance of the work being done at KKC and by its leadership team.** They acknowledged the efforts to decolonize and create a space that truly empowers the Filipino youth.

Appreciation for how KKC leadership has prioritized creating a culturally appropriate space for Filipino young people is not exclusive to KAYA. Members of the task force that assisted in the creation of the workshop series as well as BRIDGE Advisory Board members were emphatic about how important it is for a space like the one KKC is creating to exist.

> **"Cultural pride was huge. It is so important to center on cultural and identity and pride is so important. I wish that these was a program like this for my daughters when they were younger."**
>
> **– BRIDGE Advisory Board Member**

Key Program & Operational Learnings

As KKC leadership approaches 2024 and the opening of the café space they are ready for the next steps as they have been preparing for this for well over a year as the building continued to be updated. The leadership team will be hiring staff, such as an administrative coordinator and a café operations manager/director and noted that they were aiming to hire these positions by the end of the first quarter in 2024. They also plan to work on staffing manuals, consider café management, and collaborate with the design team and the community to ensure that the café layout is intuitive for customers and that the community contributes to the space so that it is truly a shared space in the community.

KKC leadership shared that lessons from the previous year continue to resonate with them. These include topics on working with young people moving forward. First, they stressed the importance of retaining youth engagement and keeping them coming back while also encouraging them to bring in their peers. Second, KKC leadership stressed the importance of clear communication and establishing a feedback loop to facilitate the inclusion of youth voices in decision-making processes. They intend to continue humanizing the identities of young people and promote relationships based on respect, boundary-setting, and mentorship. Third, they highlighted the need for sustainability, both in financial and staff capacity terms. Lastly, they emphasized scalability and planning for the organization's growth over the next five to fifteen years while maintaining the quality of their services and remaining true to their mission and are currently exploring support networks for achieving these goals.

Lesson: Program start-ups for innovative and complex programs require substantial time and commitment

- Implementation of an innovative program comes with programmatic decisions, processes, and requirements to plan for. Given the complexity of a social enterprise café with many business consultants, partners, stakeholders and layers of decision-making, the installation and initial implementation process has been long and at times difficult. For example, the delay in having access to the café has required leadership creativity and effort to keep momentum for the project. Setting benchmarks and timelines can assist with the identification of tasks and what is needed for sustainability.

Lesson: The commitment to creating space with and not for the community takes organization and a reliance on others to carry the mission forward.

- A critical component of the KKC is ensuring that young people have a place to be seen and heard within their community. Similarly, the Filipino community values the voice of all generations and KKC brings that to the programming with the BRIDGE Advisory group. This has expanded the implementation working group for the KKC. While this does create a larger working group, which creates its own set of challenges, it also means that the program has many more resources to work with to make the program the best that it can be. It is important that KKC leadership seize these opportunities and share the responsibilities with those that are invested in the successful implementation of the program.

Future Directions

In the third year of the program, FY23-24, KKC will be able to move into the café space and have a home base. Additionally, with this new space the opportunities for continued growth and sustainability will expand as they will have access to forming additional partnerships due to the kitchen space available. While they continue to finalize the move into their new home the KKC team will continue to engage their community through attendance at outreach events, hosting events, and engaging with the KAYA group.

Appendix A.

Evaluation Domains, Outcome Measures, and Data Sources

Appendix A. Evaluation Domains, Outcome Measures, and Data Sources

Leadership	*Evaluation Question #1:* To what extent are KKC leadership equipped and empowered to make decisions on behalf of the program?		
	Responsibility & Plan Enactment	• Ability to meet project deadlines • Accounting of delays in progress toward opening • Implementation successes & challenges	• Focus Groups • Program Documents • Background/Observation
	Evaluation Question #2: To what extent are KKC leadership skills and project management valued by the Advisory Board, KAYA members, and other stakeholders?		
	Leadership Skills & Engagement	• Stakeholder satisfaction overall and with leadership • Clarity and transparency among stakeholders • Diverse stakeholders and support	• Focus Groups • Program Documents
	Evaluation Question #3: To what extent has leadership engaged in long-term sustainability planning and included stakeholder engagement in that planning?		
	Plan Sustaining	• Collaboration and communication (changes, successes, challenges) • Business plan updates to reflect ongoing communication and feedback	• Focus Groups • Program Documents
Service Delivery	*Evaluation Question #4:* To what level do service delivery staff receive support needed from KKC leadership and the Advisory Board, to implement a culturally affirming model of integrated care for youth?		
	Staffing, Physical Environment, & Documentation	• Staff satisfaction • Youth satisfaction • Youth voice within services	• Youth surveys • Focus Groups • Program Documents

APPENDIX 10. CONTRACTORS' ASSOCIATION REPORT, FY 2022-23

NEEDS ADDRESSED BY FUNDING FY 2022-23

CONTRACTOR	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co- occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capability to collaborate, partner and share resources and information with other Association Members	% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	Comments
California Clubhouse	$5,086	$5,086.00	Yes	Yes	No	No	50%	4,500.00 Recovery Alignment $ 519.00 The Cares Toolkit $ 20.00 Advanced Peer Support Continuing Education: Suicide Prevention $ 57.00 Advanced Peer Support Continuing Education: Suicide Prevention $5,096.00 Total Cost of Grant Implementation $5,086.00 Total Allocated to Grant
Caminar	5086	5086	No	No	Yes	No	25%	To improve Cultural Competency: 6/28/23: Implicit Bias Training : 74 of 91 (81%) staff attended. 8/23/23 : Cultural Humility Training : minimum of 75% of 91 staff will attend. (training was paid for 6/30/23) 6/28/23 - Implicit Bias Training $3080 8/23/23 - Cultural Hunility Training $3080 Subtotal = $6,160 (minus $1,074 covered by Caminar) =$5086.
Children's Health Council	5086	5086	No	Yes	Yes	No	50%	PC-Cares training occurred: 30 of 30 staff attended (100%) Speaker Fee$ 15,000 MHSA grant: $5086 in it's entirety was spent CHC in kind: $9914
Daly City Youth Health Center	5086	5086	Yes	Yes	No	No	50%	EMDR Training and consultation for 2 clinicians x $1050 = $2100 Add on consultation hrs. for supervisor $500 Play Therapy and Neurophisio. Effects on Trauma Training $700 Play Therapy Sensory tools $1,786
Edgewood	5086	5086	Yes	Yes	Yes	No	75%	$2800.00 - 4-hour DEI Bridging the Gap between Training by Lyssa Ichikawa, MS Ed., and Tanya Barr, LMFT. $1250.00 - 4-hour DEI Preventing Clinical Bias training by Kelsey Pacha, MA, M.Div. $76.00 - Training Materials provided to the Edgewood Center Training Department $960.00 - Per Diem Edgewood Staff training compensation - A total of 4 Per Diem Employees attended both 4-hour trainings. - Each Per Diem Employee has a base pay of 30.00 an hour. - 30.00 Hourly Pay x 4 Per Diem Employees x 8-Hours = $960.00
El Centro de Libertad	5086	5086	No	Yes	No	No	25%	Training fees: MINT Certified Expert Motivational Interviewing Trainer $5,000.00 (Including all materials needed for cohort facilitation) and online class registration. MIT Training V46 Debby L Westcott 4,095.22 Quantum Online registrations 904.78 Refreshments for two 2-day cohorts $86.00 Total: $5,086.00
Felton	5086	5086	Yes	Yes	Yes	Yes	100%	Staff attended different trainings/conferences than proposed due to schedule conflict or similar trainings being offered at no cost. All monies were spent in their entirety by the end of the fiscal year (6/30/23). Registration fees for staff to attend trauma, cultural responsiveness, co- occurring disorders and evidence-based practice trainings and conferences: ** ISPS-US National Conference: Opportunity Through Experience: Psychosis, Extreme States and Possibilities for Transformation - $613.27 ** Sessions attended included: "Indigenous North American Philosophy and Aproach to Extraordinary States"; "Peer Support for Asian American, Native Hawaiian and Pacific Islanders"; "Social Cognition, Culture and Psychotherapy for Schizophrenia"; "Healing Power of Japanese Traditional Arts". ** NatCon23: Momentum - Registration for 7 staff - $3,472.65 (total invoice $5,550.00) ** Sessions attended included: "Understanding Resilience: The missing piece in developing a comprehensive trauma informed approach"; "I wish someone had asked me: Safely collecting sexual orientation and gender identity data to improve mental health outcomes";"Intergenerational and historical trauma: Working with Native American indians". Professional fees for evidence-based practices training and technical assistance (contractors and training organizations) ** Evidence-Based Approaches to Bipolar and Other Mood Disorders - $1000.08 ** Monthly sessions provided between 7/1/22 - 6/30/23 by Dr. Descartes Li (UCSF) Purchase of books, journals, videos, and manuals - $0

Fred Finch Youth Center	5086	5086	Yes	No	Yes	No	50%	Eating Disorders (Refreshments and food) $717.89 Understanding Chronic Depression $109.21 Working with families trainer $850 Rental accommodations $468.57 Supplies & Food $760.87 AUM $1000 + food and materials $252.69 Training books and materials $1108.13 Totals $5267.36
Health Right 360	5083.53	5083.53	Yes	Yes	Yes	No	75%	rant Request Amount: Maximum amount is $5,086. Total Cost: $5,083.53 (including shipping and taxes for training material) Trainings: 1) Cultural Competency & Diversity: Powerful Strategies to Improve Client Rapport & Multicultural Awareness - Seminar - $109.99 - CE Tests - $19.99 x 29 people 2) Motivational Interviewing Evidence-Based Interventions to Improve Client Engagement and Accelerate Behavioral Change - Seminar - $109.99 - CE Tests - $19.99 x 29 people 3) Seeking Safety: An Evidence-Based Model for Trauma and/or Addiction - Seminar - $29.99 - CE Tests - $9.99 x 29 people 4) 2-Day: EMDR for Co-Occurring Trauma and Addiction: Treatment Strategies to Help Dual Diagnosis Clients Achieve Long-Lasting Recovery - Seminar - $219.99 - CE Tests - $29.99 x 6 people 5) Dialectical Behavior Therapy C-DBT Intensive Certification Course: Mastering and Integrating DBT Skills in Clinical Practice - Seminar - $299.99 - CE Tests - $29.99 x 7 people Books: 1) Co-Occurring Disorders: A Whole-Person Approach to the Assessment and Treatment of Substance Use and Mental Disorders (2nd edition) - $26.99 x 10 copies 2) Relapse Prevention Counseling: Clinical Strategies to Guide Addiction Recovery and Reduce Relapse - $19.99 x 10 copies 3) Motivational Interviewing for Mental Health Clinicians: A Toolkit for Skills
Mental Health Association	5086	5086	No	Yes	No	Yes	25%	MHA contracted with Bay Area Community Health Advisory Council to provide a Courageous Conversation training for all of MHA staff. This was an in-person training. Eighty percent (80%) or 48 out of 60 direct service staff attended the training. MHA contracted with Dr. Marilyn Thomas to provide a one-day training on Social Determinants of Health and Inequities. This was a remote training and 53 or eighty-nine percent (89%) participated. Courageous Conversation fee: $4,500 Dr. Marilyn Thomas Fee: $500 Refreshments for in-person event: $86.00
Peninsula Family Services	5086	5086	No	No	Yes	No	25%	This grant was used for the following Chinese volunteer training expenses. Staff Salaries & Fringes: $3,391 Consultants Fees: $150 Sub-total: $3,541 Supplies for Training: $533 Refreshment & Public Relations: $1,012 Sub-total: $1,545 Total: $5,086
Puente	5086	5086	No	Yes	Yes	No	50%	$5,086 was spent on a consultant to support training new Community Mental Health & Wellness staff and facilitate the Trauma 101 virtual trainings for all Puente staff. $0 for Wellness Kits (materials): We purchased wellness kit items through another grant.
Sitike	5086	5086	Yes	Yes	Yes	Yes	100%	Subject Matter Experts: -Pamela Parkinson, Ph.D, LCSW, Ethical Boundaries, Bay Area Family Institute of Training - $675.00 -Azisa Todd, PRIDE Center, Trans 101 - $225.00 -CE4Less Training Licenses - 599.00 -California Institute for Behavioral Health Solutions - $420.00 -Navigating the Behavioral Healthcare System Conference - 676.96 -Centers for Nonprofit Excellence - $2,500.00 Total for Subject Matter Experts: $5,095.96 Food for Training: $149.62 Total: $5,245.58 (Sitike covered the cost of the $159.58 difference in expenses when compared to the grant amount).
Star Vista	5086	5086	YEs	Yes	Yes	Yes	100%	100% of the funding received through this BHRS Contractors Association MHSA grant was utilized to compensate an experienced and qualified trainer for providing our 6-week ACT training course. Since we split the training into 6 sessions instead of 8 sessions, the cost per training was slightly more than initially estimated, but the line items and total expenses paid for by this grant remained the same. See below: Line Item: Training Fees (expenses paid to trainer) Cost Breakdown: $5,086 for 6-week 6-session ACT training Total Cost Paid by BHRS: $5,086.00

The Latino Commission	5086	5086	Yes	No	Yes	No	50%	Hotel (6 shared rooms) and transportation $3,546 La Cultura Cura Certified Trainer (on staff) $ 0 Hotel meeting/dining room rental $ 500 Morning coffee and group lunch $ 240 Cultural Presentation Tickets purchased $ 400 Group Dinner for $ 400 Total. $5,086
Voices of Recovery	5086	5086	Yes	Yes	Yes	Yes	100%	Voices staff were trained in an evidence base training Wellness Recovery Action Plan (WRAP®) a wellness and recovery approach that helps people to 1) decrease and prevent intrusive or troubling feelings and behaviors; 2) increase personal empowerment; 3) improve quality of life; and 4) achieve their own life goals and dreams. This tool not only gives the staff the tools to stay and understand their own wellness but gives them the knowledge to help others get into their wellness and stay. Through our training we have given our staff the tools to understand their own biases and have more respect for their coworkers. The goal of the training was to foster a respectful, inclusive, and equitable environment where everyone can thrive. Encouraging staff to use the methods that help people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. Staff have been given the tools to understand the need and desire to communicate better with people regardless of differences in opinion, especially during divisive times such as these. Using the training of received through motivational Interviewing as a way of communicating trust between two people involved in a conversation and to acknowledge and know the five pillars of MI are autonomy, acceptance, adaptation, empathy, and evocation. 8 out of 10 employees at Voices received training, averaging 80% of VOR staff who provide direct
Youth Service Bureau	5086	5086	No	No	Yes	No	25%	Total cost for phase 3 of the work with Radicle Root Collective: $66,000 $5,086- MHSA training grant was used to fund part of this work. The rest to be covered by: $46,908- One-Time BHRS funding anticipated receivable January 2023 $14,006- anticipated YMCA fundraising dollars for leverage (hopeful in October 2023 Walk-a-Thon)
Sitike	16,346.47	16,122.79	Yes	Yes	Yes	Yes	100%	The Center for Excellence in Nonprofits (CEN) will provide a staff development and training cohort program to members of the Contractor's Association. This series of 3-hour block classes will support the cohort with increased collaboration, improved care for their clients and tools for effective cultural humility practices. During the course of this engagement, the following workshops will be offered: 1) IDEAL and WDC/Language Bias 2) Leading through the Lens of IDEAL – Makes Dollars and Cents 3) Nonprofit Advocacy 4) Microaggressions/Community Styles 75% of the members of the contractors association were represented in the training series. Centers for Excellence in Nonprofits: $15,000 for six, three-hour trainings and workshops. Fiscal Sponsorshop - Sitike: $1000.00 Snacks for Training - $122.79 Total Spent: $16,122.79
Service League	4000	0	x	x	x	x	x	Service League returned to Caminar. Caminar returned to San Mateo County, to be applied to FY 23-24 MHSA Funding.
Miscellaneous Grant Expense		223.68						
Total	$102,806.00	$102,806.00						