San Mateo County
Health System

April 29, 2015

Dear Colleagues and Community Partners,

In July 2013, The Behavioral Health and Recovery Services (BHRS) set out to evaluate its Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) programs to understand the impact these programs are having in terms of promoting mental health, reducing the risk of mental illness, and decreasing the severity and negative consequences associated with onset of mental illness. Gibson & Associates, was contracted to conduct the evaluation and provide data for two years of PEI implementation. The first year report, for services implemented in fiscal years 2013-14, is now available at our website www.smhealth.org/bhrs/mhsa.

The MHSA was approved by California voters in 2004 and provides funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The MHSA PEI component is intended to prevent mental illness from becoming severe and disabling by targeting individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders. PEI programs are designed and implemented to help create access and linkage to treatment, and improve timely access to services for individuals/families from underserved communities.

Eight San Mateo County PEI programs were evaluated:

- Project Grow
- Teaching Pro-Social Skills
- Project YES! & AC-OK, Seeking Safety Interventions
- Project SUCCESS
- Early Childhood Community Team (ECCT)
- Crisis Hotline and Youth Intervention Team (YIT)
- Prevention of Early Psychosis (PREP)

The full report provides excerpts on each program, including a project description, in the areas of productivity, effectiveness/ impact, satisfaction with services, responsiveness to target community and MHSA requirements, implementation success and lessons learned. Here are a few highlights from each program:

- Project Grow Pollicita students showed strong gains across levels of stress and negative emotions and ability to manage feelings.
- Over 80% of Project YES! Participants surveyed learned to recognize important skills related to setting boundaries and seeking help when facing challenges or stressors.
- Significant decrease in AC-OK client-reported need for alcohol and drug treatment and reductions in their experience of stress and need for treatment for stress.
- All Teaching Pro-Social sites exceeded an increase of 10% in positive social skills.

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- Project SUCCESS students demonstrated gains in self--esteem and view of their future.
- ECCT teachers and families increased capacity to understand child's behaviors and respond effectively.
- Over 75% of Crisis Hotline callers surveyed, felt connected to the counselor and found the call helpful.
- PREP clients demonstrated reduction in symptoms and hospitalizations with the strongest and most valid gains in reductions in anxiety and depression.

While there was considerable difference in the quality, quantity and validity of data available for each program this first year, there was sufficient evidence that each project was having a positive impact. In the cases where data was weaker, program managers were able to make commitments to strengthen data collection in the next fiscal year, 2014-15. The following highlights overall evaluation process findings and areas where BHRS has taken action to make improvements in data collection and reporting:

Overall Process Findings and Outcomes
✓ Every project evaluation validated client satisfaction and/or positive client impact.
✓ Areas for improvement for each project were identified.
✓ Staff attrition impacted services and data collection efforts.
✓ Most PEI projects lacked capacity for participating in an external evaluation.
✓ All PEI programs now have a consistent evaluation plan currently being implemented
✓ PEI program reports will now include impact and satisfaction data, along with the usual service dosage, demographics , successes and challenges
✓ The evaluation plan has been incorporated into the Request for Proposal, released this month and will be incorporated into the new contracts.

We anticipate this report will provide additional impetus to our ongoing dialogue with consumers/clients, family members, service providers and other key community stakeholders about PEI programs and services. We welcome your comments and suggestions after you have had a chance to read through this report by emailing Doris Estremera, MHSA Manager at mhsa@smcgov.org.

Thank you for your continued support.

Stephen Kaplan, LCSW
Director
Behavioral Health and Recovery Services

San Mateo County Behavioral Health & Recovery Services
Mental Health Services Act
Prevention & Early Intervention Evaluation 2013-14

Evaluation Conducted by Gibson & Associates

December 19, 2014

Introduction

The Evaluation Report is comprised of a brief description of the evaluation planning process and the agencies and projects evaluated, followed by an analysis of the evaluation process and the BHRS monitoring system, including a series of options for ensuring that the work done through this evaluation leads to sustained improvement in the collection, reporting and use of data by both PEI-funded agencies and the County managers who are overseeing these operations. Following this analysis is a short summary for each project evaluated with that summary comprised of a project summary, summary of findings, and list of recommendations for project improvement for each agency. Full evaluation reports for each project are then included after the conclusion of the Executive Summary.

Evaluation Process

In May 2013, SMC BHRS contracted with Gibson & Associates (G&A) to conduct a two-year evaluation of ten Prevention & Early Intervention projects being funded through the Mental Health Services Act. The evaluation was designed to produce evaluation reports for the 2013-14 and 2014-15 program years. The goals of the PEI evaluation were:

- To move beyond what is provided to the County by way of monitoring reports to produce evaluation reports that captured project productivity, client impact, client and stakeholder satisfaction and recommendations for improvement in project areas and data collection procedures;
- To analyze how BHRS currently monitors PEI-funded projects including an assessment of the contracting and reporting processes;
- To identify ways to improve reporting to the County once the two-year evaluation cycle is complete;
- To help funded-agencies develop a better appreciation for the benefits of using data for their own internal quality improvement efforts and a greater capacity to do so; and
- To develop a transition plan or road map to help the county build upon what has been learned from this process and construct a sustainable approach to the use of data by County managers and the PEI projects they oversee.

The following projects were evaluated as part of this process.

Asian American Recovery Services, North County Outreach Collaborative NCOC) conducted outreach to engage under-served populations, educate them about health and behavioral health services, encourage their enrollment in the County health plan and to access appropriate mental health services.

Asian American Recovery Services' Project Grow, a project that provides school-based, Evidence-Based Practice Trauma-Focused Cognitive Behavioral Therapy that focuses upon building student resiliency skills necessary to be successful at school. Project Grow explicitly nurtures Search Institute's Forty-One Developmental Assets and directly incorporates their development into each child's individual treatment goals.

Caminar Project YES!. Caminar delivers thirteen Seeking Safety groups at six discrete locations serving transition age youth. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Caminar's YES! Caminar collaborates with the Youth Center and an array of residential, transitional, and crisis intervention centers who serve TAY and delivers its groups at these facilities.

El Centro AC-OK. El Centro's AC-OK Seeking Safety project targets Transition Age Youth and young adults, the vast majority of whom were referred by the Department of Probation. El Centro named its Seeking Safety project the AC-OK Project as it conveyed a more positive image than Seeking Safety. During 2013-14 AC-OK served 40 transition-age youth involved in the juvenile or adult justice systems.

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

Prevention & Recovery in Early Psychosis (PREP), was developed by a partnership led by Family Services Agency of San Francisco, now Felton Institute and the University of California, San Francisco. It is now operating in five Northern California counties. While delivered somewhat differently in each county, in San Mateo County PREP is comprised of the following five evidence-based practice components: Early, rigorous diagnosis: Cognitive Behavioral Therapy for Early Psychosis (CBTp); Algorithm guided Medication Management: Multifamily Psycho-education Groups (MFG): and Education and Employment Support.

One East Palo Alto, Community Outreach Partnership. A partnership, much like AARS' NCOC partnership, the Community Outreach Partnership conducted outreach and engagement to increase appropriate, timely use of mental health services and to enroll under-served populations in the County health plan.

Puente. Project SUCCESS. Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model project that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. PROJECT SUCCESS places highly trained professionals (Project SUCCESS counselors) in four Southcoast schools to provide a full range of prevention and early intervention services.

StarVista-Early Childhood Community Team. Early Childhood Community Team (ECCT) incorporates three service components that build on current models already operative in San Mateo County. The three service modalities are: 1) Clinical Services, 2) Case management services, and 3) Mental health consultations with childcare and early child development project staff and parents served by these centers. In addition, the ECCT team conducts extensive outreach in the community to build a more collaborative, interdisciplinary system of services for infants, toddlers and families. The ECCT is designed to support the healthy social emotional development of young children. ECCT is comprised of a community outreach worker, an early childhood mental health consultant, and a licensed clinician. BHRS PEI funding is supporting one Coastside team located in Half Moon Bay and providing funding for the clinical treatment component of a North Coast ECCT (First 5 and private funding support the other components).

StarVista Crisis Intervention and Suicide Prevention Center, is a project comprised of a 24 hour phone Hotline and a Youth Intervention Team that works primarily through schools countywide offering crisis intervention services when a student is in crisis, training for school personnel and prevention education for thousands of middle and high school students.

G&A developed a plan to collaborate in a participatory evaluation process working with project managers from the ten projects to be evaluated. The evaluations were organized around seven evaluation questions.

> ***Evaluation Question # 1***: Has the intervention/ project been implemented efficiently and according to the contract funding the project?
> ***Evaluation Question # 2***: Has the project implemented effective project strategies? i.e. Is the project well-designed and achieving a desired impact?
> ***Evaluation Question # 3***: Have clients, families, partners, and/or communities been satisfied with services?
> ***Evaluation Question # 4***: Have project services been responsive to the population targeted by the contract?
> ***Evaluation Question # 5***: To what degree has the project advanced the vision, mission and objectives of the MHSA PEI plan?
> ***Evaluation Question # 6***: What factors have impeded or contributed to successful implementation? How?
> ***Evaluation Question # 7***: What steps can be taken in the future to improve project services and what data could verify that these improvements had occurred?

During the spring and summer 2013 began the evaluation by reviewing contracts for each agency that was operating a PEI-project. This process was exceedingly complex as County contracts incorporate into one contract all projects being operated by a program. Most agencies had at least four projects included in the contract and many had as many as eight. None of the projects in the contracts were clearly identify as being PEI-funded, so there was initially some confusion as to which projects within a contract were to be evaluated. Making this more challenging, the description of project activities, anticipated outcomes and staffing were not described in one location, but were presented in different sections of the contract. The process of weeding through these contracts was illuminating as it clarified why many PEI-funded project managers were not aware of outcomes or service levels that were to be reported for their project. Most project managers had never even seen their agency contract or the portions of it that included reporting requirements for the project they managed. Lastly, the level of detail in terms of the productivity levels, client outcomes, and satisfaction surveys varied considerably, making it difficult to construct evaluation plans that emerged from the contract.

In addition to reviewing contracts, the evaluator reviewed all project monitoring reports submitted to the County, in some cases going back one or two years before the time period to be evaluated.

Once a review of the contracts was complete, discussions were held between the evaluator and project managers for each of the projects described above. During these conferences, plans were developed for agencies to collect data that would be used to answer the evaluation questions above. Plans were developed to capture productivity at a client-level, with an effort to distinguish participation from among a variety of modalities delivered, where appropriate. To assess project impact, the evaluator tried to minimize the level of effort involved for project staff by using pre-post

assessment tools that the project was already using, but in some instances the evaluator either searched for and secured existing assessment tools or created others based upon existing validated tools. The latter was done more often, as many of the validated tools identified would have required an inordinate commitment of time and resources to administer. Finally, all agencies identified satisfaction surveys to be used to assess satisfaction with services from clients, family, and/or stakeholders or, again, the evaluator developed surveys for this purpose.

Along the way, challenges to the evaluation were identified that either required adjusting the evaluation scope of work, adjustments that also have informed recommendations for an improved reporting and monitoring system. The goal of the evaluation had never been to establish a framework for ongoing evaluation of PEI programs, but rather to use the evaluation as a process through which a sustainable and meaningful reporting and monitoring system could emerge. Another aspect of BHRS' continuing effort to build systems that foster quality service delivery and reporting and monitoring systems that support it, is its partnership with the American Institute of Research, a partnership focused upon BHRS-wide reporting systems.

In the winter of 2013-14, follow-up meetings were held between project managers and the evaluator. In many instances, there were changes in project managers or other staffing that had limited project compliance with the data collection plan. This was especially the case when there was a change in project manager, as in most cases information about the evaluation was not conveyed from the exiting manager to the new one. This often resulted in the need to make adjustments in the evaluation plan. At this time, it became clear to the evaluator that two of the projects, the two outreach projects operated by AARS and OEPA were simply not the type of projects that achieved easily documented outcomes or impacts on 'clients.' Indeed these projects did not really serve clients, they identified and referred them to BHRS and reported that data to the County monthly. The evaluator recommended to County leadership that these projects not be evaluated as part of this evaluation scope of work and this recommendation was approved.

For the other eight projects, the plan had been for the evaluator to work with the project managers in July to compile and share the data so that evaluation reports could be completed. When this process was initiated in July 2013, still more staff transition was encountered and the need for more adjustments in evaluation plans as most projects had encountered challenges in implementing data collection agreed to in earlier meetings. The evaluator worked with each project manager to develop alternative plans to allow for robust answers to the evaluation questions, while trying to avoid too much extra work on the part of the agencies. Finalizing data collection was delayed by the County's unexpected requirement of an end-of-year report from PEI-funded projects. With these reports being due August 1, project managers asked for a delay to starting work on the evaluation until their County reports were complete. The evaluation was then further delayed, as the evaluator had scheduled other work for August and September, requiring him to balance multiple projects. The evaluator worked with each project manager to assemble the data, make adjustments where data collection was not as available as planned, and prepared reports that were then reviewed by the project managers and discussed with the evaluator in a series of structured interviews. While the process took far longer than anticipated, by the first week of December all reports were completed. Excerpts of each project's evaluation are provided after analysis of the County contracting, monitoring, and evaluation processes.

General Findings about PEI-Funded Projects

Every project produced data validating either client satisfaction or positive client impact. While there was considerable difference in the quality, quantity and validity of data provided, even with the leanest evaluation, there was sufficient evidence that the project was having a positive impact. In the cases where evidence was weaker than in other projects, project managers were able to make commitments to strengthen data collection in 2014-15. ***Section V, includes excerpts from every individual project evaluation that includes a project description, general findings, and the recommendations for improvement for each project.***

Collaboration between project managers and the evaluator resulted in identification of significant areas for improvement that could only have occurred as a result of an evaluation. In every one of the eight PEI evaluations areas where projects were under-performing were identified and in most instances resulting changes identified through the process should significantly improve services for clients. As project managers from PEI-funded agencies will attest, these findings were only possible because of persistent efforts to push far beyond what agencies typically produce in monitoring reports. Indeed, it is highly unusual to see monitoring reports describing areas where projects were under-performing, where there were areas where improvement was possible, or where additional data collection could provide better insight into project operations.

Staff attrition impacted services and data collection efforts. In all but one PEI project that was evaluated, at least one key staff person left the project during the evaluation and in several agencies several staff members left the project. Only two agencies being evaluated had the same project manager in place when evaluation discussions began in Spring 2013 and at the end of the process in December 2014. This impacted the evaluation significantly as in some instances the absence of a key staff meant that important data collection processes were inconsistently implemented or were not implemented at all for periods of time. ***More importantly, the absence of key staff also resulted in important project functions not being delivered, at least for a time.*** This is a well-documented challenge throughout the public mental health system, with numerous SAMHSA studies describing the impact high staff turnover has on project services. In many instances, staff moved to county positions or positions with private providers.

Recommendation I. While each agency manages these transitions differently, it may be worthwhile exploring a more systemic solution to how these transitions are addressed. One possibility might involve the use of a flexible pool of MHSA Workforce Education & Training funding to enable agencies that operate projects that multiple evidence-based practices that require significant training to implement practices to fidelity to provide training promptly when new staff are hired.

Monitoring reports to the county were very uneven in content. The evaluator reviewed most all of the reports submitted to the County. In most every instance the reports included little, if any, detail, certainly nothing that could be used to effectively monitor project operations. In some instances, reports stated that satisfaction surveys were administered, but no results were provided. In others, data on the number of groups offered was provided, but without any data describing the number of clients that participated. Even in the best County monitoring reports, where assertions were made about the percent of clients improving in one area or another, there was never actual data provided, information about the N used was absent, and the basic assertions were not really supported. ***This issue is discussed in more depth in Section III.***

Recommendation II. In addition to producing reports such as those developed in 2013-14, the 2014-15 evaluation, this process should be used either to create a more specific project

monitoring process that asks providers to produce data similar to that produced for the evaluation OR extend the evaluation one more year to ensure that providers become still more accustomed to collecting and using data AND to ensure that the County monitoring process is strengthened to a point where meaningful reports are routinely produced by funded agencies. Specific ideas about strengthening the contracting and monitoring processes are provided under Section III, Findings Related to BHRS Contracting, Monitoring and Evaluation Processes below.

Most Funded PEI Project Personnel Lack Experience, Resources and Capacity for Participating in an External Evaluation. A number of challenges emerged in attempting to secure sufficient data to create robust, valid evaluation reports.

> ***Most agencies are simply not accustomed to collecting and using data***. In most every agency, some level of attendance/participation, assessment and satisfaction data is collected, however, in most every instance agencies either failed to collect this data consistently or missed opportunities to gather data that could better validate the impact of their projects. The likely reason for this is that agencies do not appear to use most of the data they collect, except to inform specific and individual clinical decisions. Virtually every agency had to compile pre-post assessment, attendance and/or satisfaction data in July and apparently only because it was being sought by the evaluator. If data is not organized into a database system that allows some level of manipulation and disaggregation, it is of limited value. Ideally, a database would allow project managers to examine results of pre-post test assessments at a client-level within a spreadsheet or database that allows analysis of the relationship between positive outcomes and participation levels or differences in outcomes between sites, groups, different populations or conditions. ***For managers to be able to do this, the data system must be simple, intuitive, and easy to operated. Once data is entered, it should easily create reports that are immediately useful to the manager. Only when managers see the value in data reports will there be motivation for gathering and compiling data. In the absence of this, data reports to an evaluator or the county will only feel like jumping through hoops.***
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> ***Lack of sufficient administrative staffing***. On several occasions data to be provided for the evaluation was entered into spreadsheets by clinical directors and project managers. If this is the only option a project has, it may go to this effort for a required evaluation or monitoring report, but will not do so for ongoing internal project improvement efforts. While there may have been administrative assistants or research assistants operating in large agencies, in most instances projects had to secure their time on a temporary basis. Even essential project management was often under-funded. For example one agency operating a complex, multi-component serving a large geographic community had only four hours a week of project management support.
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> ***Lack of funding.*** Budgets for all projects were not reviewed, but in the budgets that were reviewed and in interviews with project managers, it is clear that the County does not directly fund staffing for data collection or funding for software that would make use of data easier. While project managers understood why the County would want an evaluation of project activities, the lack of personnel to support this activity compromised the evaluation.

Recommendation III—If the County is committed to promoting the use of data in ongoing project planning, quality improvement efforts, or evaluations, funding should be provided to support the required work. It would also be good to offer training in how to interpret and use data. A number of other options are described in Section III (follows) where options for building upon this evaluation are discussed.

Section I Agency & Program Description

I.A. Description of Program Services

Project Grow provides school-based, Evidence-Based Practice Trauma-Focused Cognitive Behavioral Therapy that focuses upon helping students develop resiliency skills necessary to be successful at school. Project Grow explicitly incorporates the development of Search Institute's Forty-One Developmental Assets directly into each child's individual treatment goals. Students targeted for services are determined to be at risk of serious emotional disturbance but are not eligible for an IEP. Project Grow offers strength-based individual counseling services as well as collateral services that include consulting with teachers and parents to support student success at home and in the classroom. In addition to mental health services, Project Grow provides case management services designed to connect students and their families to educational, medical, social, prevocational, rehabilitative and, as necessary, for out of home placement options. The program works not only with the students, but with parents and teachers, providing technical assistance to the teachers, and support and education to the parents. Additionally the therapist provides a high level of collateral services to both teachers and parents. Collateral services most often include consultation with the parent or teachers about behavior issues with the child. Project Grow operates throughout the school year with caseloads of at least 14 adolescents at each site although the summer program tends to be more recreational and socializing than clinical. Some families do elect to continue family therapy throughout the year. A noteworthy characteristic of this program is that many students refer their peers to the program, which indicates a high level of buy-in on the part of the clients.

I.B. Research Basis for Approach

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model:

- Psycho-education and parenting skills,
- Relaxation skills,
- Affect expression and regulation skills,
- Cognitive coping skills and processing,
- Trauma narrative,
- In vivo exposure (when needed),
- Conjoint parent-child sessions, and
- Enhancing safety and future development.

Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format. AARS has incorporated many of the elements of the PRACTICE model but has been

challenged in trying to engage parents sufficiently to incorporate parent psycho-education and conjoint sessions consistently.

I.C. Target Population, Number Served and Sites

Project Grow is a school-based behavioral health project operated by Asian American Recovery Services (AARS) at two San Mateo County middle schools, Parkway Heights Middle School in South San Francisco and Thomas R. Pollicita Middle School in Daly City. Parkway Middle School serves a student population that is 78% Latino with almost 70% of students low-income, as reflected by their eligibility for Free & Reduced Lunch. Pollicita serves a more diverse population with 47% Asian and 43% Latino with 58% of students eligible for Free & Reduced Lunch. The schools are but 3 miles distant from each other with both schools located near the San Bruno Mountain State Park.

Project Grow was contracted to maintain a caseload of 14 students delivering 20 hours per week per site of mental health services that include individual, group and family therapy, as well as collateral services like parent and teacher conferences. The contract stipulates that services should be delivered throughout the year, even when school is not in session. While weekly treatment services are not delivered during the summer, an array of low-intensity recreational, social, a movie with discussion, a games day with discussion and a field trip to the San Francisco zoo, and other activities are delivered throughout the summer. In addition, three families continued in their family therapy throughout the summer. A barrier to sustaining a full clinical program during the summer is that many families return to visit families in Mexico. Treatment is driven by a comprehensive assessment conducted at intake and then formalized in a Treatment Plan that is submitted to the county. Case management services include working with the student and family to identify needs and facilitate access to health, social services, transportation, housing and placement in higher-levels of care, as indicated. Finally, the contract calls for Project Grow staff to provide education and training to teachers and other personnel at the two sites being served.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and Fran George AARS Clinical Supervisor for AARS. A second series of meetings was held in December 2013 to assess and adapt the evaluation process and still more adjustments were made in July 2014 to secure the data. Finally, an interview was held with Fran George to review findings and make plans for this year's evaluation

Service Dosage. Project Grow maintained a database on student participation in individual treatment sessions, and extracted case management contacts, and family therapy sessions from case notes. This enabled the evaluator to answer EQ # 1.

Service Impact. Project Grow administered a pre-post test of students upon entry to the project and upon completion of each school year. The pre-post test asks students to self report on the frequency with which they experience a variety of symptoms common to trauma exposure: (loneliness, anxiety, anger, sadness, irritability, worries) as well asking them how well they are managing these symptoms. The survey also asks students to describe the frequency with which they get into trouble at school and have conflict at home, as well as a general question asking how they are doing in school. Together, these questions provide a good snapshot of student perceptions as to how well they are doing managing stress and succeeding in school. Pre-Post tests were

collected on 20 students at Policita and 12 students at Parkway and were used to evaluate the impact of the program.

Satisfaction Data. While plans were made to administer satisfaction surveys with teachers and parents, this did not occur due to staff turnover at the end of the school year. However, there are satisfaction survey results from 2012-13 and these are reported to assess how the program is viewed by school personnel. The Clinical Supervisor has assured the evaluator that she will personally oversee administration of satisfaction surveys with both parents and teachers for the 14-15 evaluation.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Each evaluation question is discussed separately below, but in general evaluation findings were positive. Participation levels in individual counseling were very high and satisfaction with the program among faculty was also high. Pollicita students showed strong gains across almost all domains on an 18-item pre-post test assessing levels of stress and negative emotions and student self-report of their ability to manage those feelings. Both sites provided high levels of case management services and Parkway also had very strong family counseling component. In addition, to expand the scope of services to students at both schools and to create a kind of outreach and promotion component, Project Grow offers voluntary, drop-in lunchtime psycho-educational sessions on a range of topics. What's more AARS sought and received Kaiser Permanente funding to expand services at both sites. Through this funding, AARS provides ongoing psycho-education sessions for the faculty at Pollicita. In 2014-15, Parkway determined that site renovations and teacher focus on adopting the new Common Core were enough extra-instructional activity and is deferring on these added services for now.

While there is abundant evidence of the value and quality of Project Grow, there were some clear areas for improvement identified through the evaluation at each site.

- Pollicitas had almost no family therapy sessions—only seven sessions the entire year.
- Parkway's enrollment in the program could be increased significantly (12 enrolled while Pollicita had 20).

- What was initially very puzzling were the pre-post test results at Parkway Heights, results showing significant increases in the level of sadness, madness, anxiety, irritability and loneliness with a parallel decrease in student ability to manage these emotions. In an interview, the Clinical Supervisor indicated that Parkway had been a school in significant crisis throughout the year with many marriage disruptions, extra-marital affairs, immigration issues, CPS reports, high suicidal ideation and hospitalizations. At Monday weekly meetings, the common refrain was: 'Okay, what is the crisis this week at Parkway.' Further underscoring the scope of family stress at Parkway is the high level of family counseling conducted.
- While the results on the post-test may be more of a reflection of a school community in crisis than a program that was deficient, they do not explain why in a school in crisis, there were just over half of the students in Project Grow at Parkway as at Pollicita, so more aggressive outreach to teachers at Parkway is recommended.
- Since satisfaction surveys were not administered this year, the evaluator is recommending the use of surveys with teachers and parents involved in counseling or collateral services.
- Lastly, it is recommended that Project Grow utilize a valid assessment tool like the Parental Stress Index, to capture the specific kinds of stress that participating families are undergoing. This would both inform the family counseling as well as help the therapist better understand the family environment in which the child is living.

In the teacher satisfaction survey—which had uniformly high scores at both sites on most every item—there were other suggestions as to how to improve the program. While also providing consistent praise for the therapists at each site and their positive impact at the school, faculty at both schools felt the program staff could do a better job of communicating with teachers about the program and about students enrolled in the program. These findings are discussed in greater detail below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

Evaluation Question 1 was answered through an analysis of data on service utilization provided by the Clinical Supervisor. Table I below summarizes the number of students served, the

Table I: Summary of Services Delivered

Service Type	Tot for Year	Ave. Per Stud.	Comments
Parkway N= 12 students			
Student 1-1 therapy	298	24.75	At Parkway, all students received at least 20 sessions except for one who exited the program in January and who still received 14 1-1 sessions prior to moving. Services were consistent throughout the year with the level of services each month about 2.75 sessions per student every month except June when the school year's end abbreviated service delivery
Case Management	154	12.90	Only 2 students received no case management services with the lowest # being 7 and the most being 27.
Family Therapy	38	3.17	One family received 12 sessions, two had seven and two had five sessions. It will be helpful to get parent satisfaction surveys in 14-15 to assess the impact.
Policita N = 20 students			
Student 1-1	495	24.83	Students tended to receive at least 3-4 sessions each month. The only

therapy			students who didn't receive over 20 sessions during the year were students who either entered mid-year or exited mid-year, almost always due to changes in school attendance.
Case Management	354	17.65	Only one student did not receive any case management services and all but three had more than 10 and six received 20 or more contacts, the most being 42.
Family Therapy	7	.35	From interviews with the Clinical Supervisor, it is clear that the composition and experience base of staff plays a critical role in how engaged families become. This is very evident when comparing Pollicita's unacceptably low level of family counseling with that evident at Parkway.

number of therapy sessions held and the number of case management contacts and family counseling sessions. No specified number of sessions was delineated in the contract, but it is clear that a consistent level of services was delivered during the school year, that this level of services was maintained throughout the year and that this level of services was consistently sustained with all students. The single, and significant exception is that family engagement simply did not happen at Pollicita. While case management and collateral services were delivered to Pollicita families, almost no family therapy occurred. The Clinical Supervisor has indicated that she will make certain that the therapist understands the importance of family counseling and reviews data on family participation in therapy on a monthly basis.

In addition to the services captured in Table I, the therapist at each site held school wide meetings with all faculty to introduce the program, to provide an introduction to stigma, mental health issues, and how they can manifest in classroom behavior. In addition, the site therapist met often with referring teachers, the school resource teacher and parents to discuss specific children, to provide information about how to address specific kinds of behaviors at home or in the classroom and to obtain feedback as to how a child is progressing at home or in class. At Pollicita, with funding from Kaiser, the Clinical Supervisor conducted a series of psycho-educational sessions with teachers about emerging trends in child-adolescent mental health. Lastly, at both sites voluntary student groups were held during lunch with a rotating topic designed to educate students about stigma, signs of mental health issues, and both how stress and trauma can impact you and to introduce coping skills to help students learn how they can better manage their stresses. The lunch groups are intended to serve as a gateway to the counseling program and indeed many students then self-refer to Project Grow.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To assess the degree to which Project Grow is having a positive impact upon student participants, a pre-post test survey was used to assess student self-reported attitudes and behaviors. Table II presents results for Pollicita students and Table III presents results for Parkway Heights students. Pre and post-test score responses are provided for each of 18 items with the change in pre-post test results and with item-specific analysis provided throughout. The survey uses scales that vary from question to question with some scales calibrated so that an increase in post-test scores indicates progress and in others where a higher score on the post-test indicates regression. In all cases, responses are those of adolescents self report. So, for example, responses related to grades are not a report on grades from the school, but rather each student's response as is the case in relation to getting along with peers and families. In dialog with the Project Grow Clinical Supervisor, the evaluator has suggested getting the schools to provide more objective student level data on attendance, discipline referrals, suspensions and GPA as more valid measures of student growth. As the Tables II and III reveal, there are some items in which change is minimal

and others where they are substantial. The column at right is used to comment on where trends are significant. It must be kept in mind that this survey was asked of teenagers and their responses may have as much to do with events of the day as with an overall view of their lives. Remember being a teenager?

Generally speaking, Pollicita students demonstrated consistent improvements across the spectrum of issues addressed in the assessment, with 9 of 18 items showing significant improvement and only one of 18 items showing a significant negative change. The one area where there was significant regression between the pre and post-test was in relation to the amount of stress or worry experienced by the student. While students also indicated a slight increase in their ability to manage stress, this increase was not significant. The other eight items show little or no significant change. ***In both charts, items indicating significant and highly positive significant change are presented in bold and items showing significant negative change are reported in bold and italics.***

Table II: Pollicita Pre-Post Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How I feel about school.	2.26	2.32	+.06	Based on a 3-point scale from I don't like to I like my school. While an increase is indicated, it is of marginal importance.
Grades	2.54	3.05	+1.05	A four-point scale where an increased score shows student report of improvement in grades. **Highly significant increase in student report of GPA.** In the future, it would be good to affirm this with actual grades from the school.
Getting along with family	7.11	7.53	+.42	Ten point scale on this and the next item. **Significant improvement in family relations indicated**. Generally respondents had very positive relations with family to begin with.
Getting along with peers	7.47	7.26	-.19	A statistically insignificant decrease in peer relations. Generally respondents had very positive relations with peers to begin with.
Use of drugs	1.39	1.21	-.18	Five point scale on this and the next item. Results indicate a reduction in drug use.
Remaining items are on a 4 point scale.				
Getting in trouble at school	3.67	3.06	-.61	**Results indicate a highly significant reduction in student reports of problems at school.** It would be good to affirm this report with data from the school on discipline referrals and suspensions.
How often do you feel sad?	2.33	1.84	-.49	**Highly significant reduction in experienced sadness.**
How often do you feel mad?	2.65	2.11	-.54	**Highly significant reduction in experienced anger.**
How often do you feel worried?	1.88	2.32	+.44	***Significant increase in being worried.***
How often do you feel anxious?	1.76	1.74	-.02	No significant change.
How often do you feel lonely?	1.89	1.68	-.31	**Significant improvement in the degree of experienced loneliness.**

Table II: Pollicita Pre-Post Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How often do you feel irritable?	1.88	2.00	+.12	Statistically insignificant increase in student level of irritability.
How well do you handle sadness?	**3.00**	**3.26**	**+.26**	**Significant increase in capacity to deal with sadness.**
How well do you handle anger?	**2.28**	**3.05**	**+.77**	**Very significant increase in capacity to deal with anger.**
How well do you handle worries?	3.29	3.21	-.08	Insignificant change.
How well do you handle anxiety?	3.24	3.32	+.08	Insignificant change.
How well do you handle loneliness?	3.47	3.42	-.05	Insignificant change.
How well do you handle irritability?	**3.06**	**3.32**	**+.26**	**Significant increase in capacity to deal with irritability.**

While Pollicita showed consistently positive results, survey results at Parkway Heights showed a very different story. Students reported significant improvement in how they feel about school and a significant reduction in getting into trouble at school, however in relation to every item describing the level of negative moods or feelings and their ability to manage them, students reported increases in the degree to which they experience negative feelings like sadness, anxiety, anger, worry, and irritability and a decrease in their capacity to manage these same feelings. While the increases in sadness and madness were not significant, changes in the other emotions and ability to manage them all showed significant increases in experiencing the negative feelings and decreases in student ability to manage them. When these findings were discussed with the Clinical Supervisor, she indicated that Parkway had been a school in significant crisis throughout the year with many marriage disruptions, extra-marital affairs, immigration issues, CPS reports, high suicidal ideation and hospitalizations. At Monday weekly meetings, the common refrain was: 'Ok what is the crisis this week at Parkway.' Another indicator of the scope of family crisis is the significantly higher level of family counseling delivered at Parkway and the comments from teachers indicating that the therapist at Parkway worked well with families and was especially effective with difficult students. So while the results on the post-test may be more of a reflection of a school community in crisis than a program that was deficient, they do not explain why in a school in crisis, there were just over half of the students in Project Grow at Parkway as at Pollicita.

Table III: Parkway Heights Pre-Post Test Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
How I feel about school.	2.27	2.67	+.40	3-point scale**. Highly significant increase in how students feel about school.**
Grades	2.89	2.75	-.14	Four point scale. Not statistically significant.
Getting along with family	7.45	7.33	-.12	Ten point scale on this and the next item. Not statistically significant. But with most students feeling that they have good relations with their

Table III: Parkway Heights Pre-Post Test Results				
Item	**Pre**	**Post**	**Change**	**Discussion**
				family to begin with.
Getting along with peers	8.00	7.92	-.08	Not statistically significant. But with most students feeling that they have good relations with peers to begin with.
Use of drugs	1.00	1.17	+.17	Five point scale on this and the next item. Not statistically significant.
Getting in trouble at school	3.22	2.82	-.40	**Highly significant reduction in this item.**
Four point scale on remaining items.				
How often do you feel sad?	2.18	2.25	+.07	Not statistically significant.
How often do you feel mad?	2.09	2.17	+.08	Not statistically significant.
How often do you feel worried?	1.60	2.17	+.57	***Highly significant increase in the degree to which students feel worried.***
How often do you feel anxious?	1.45	1.83	+.38	***Significant increase in the degree to which students feel anxious.***
How often do you feel lonely?	1.27	1.67	+.40	***Significant increase in the degree to which students feel lonely.***
How often do you feel irritable?	1.82	2.33	+.51	***Highly significant increase in the degree to which students feel irritable.***
How well do you handle sadness?	3.45	3.25	-.20	Statistically insignificant reduction in ability to handle sadness.
How well do you handle anger?	3.27	3.00	-.27	Statistically insignificant reduction in ability to handle anger.
How well do you handle worries?	3.45	3.00	-.45	***Highly statistically significant reduction in ability to handle worries.***
How well do you handle anxiety?	3.36	3.00	-.36	***Statistically significant reduction in ability to handle anxiety.***
How well do you handle loneliness?	3.82	3.17	-.55	***Highly statistically significant reduction in ability to handle loneliness.***
How well do you handle irritability?	3.18	3.00	-.18	Statistically insignificant reduction in ability to handle irritability.

Another means of assessing program impact would be for each school to provide student level data on Project Grow participants on student discipline referrals, grades (GPA), suspensions and attendance. With data on these measures from the semester before enrollment in Grow, throughout the period students are in Grow and, if possible, the year after Grow, there would be an extremely valid measure of student behavior change. What's more, with attendance data, the evaluation could project the total revenue increase generated from State Average Daily Attendance (ADA) by virtue of Project Grow students' increase in attendance. This could be a powerful incentive for the school and AARS to seek additional funding to expand the program. What's more, this data is relatively easy for a district to generate, doesn't place an added burden on teachers or

Project Grow staff, and would also provide more concrete evidence of impact to the County, site faculty and the community.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

While clearly it would be preferable to have faculty satisfaction data for the 2013-14 and family satisfaction results from families participating in family counseling, 2012-13 data is what was available and it does shed some light on the degree to which each school values Project Grow. Clearly at Pollicita the faculty rated the program very highly with a 'needs improvement' identified by only one faculty member on a single item (outreach and promotion of the program). Even on this item over half of respondents indicated that outreach was either excellent or very good.

Table IV: Faculty Satisfaction Pollicita 2012-13 N = 16 Item	Excellent	Very Good	Satisfactory	Needs Imp.	Not Applicable
1. Overall services to the school.	7	5	2	0	2
2. Therapist services to the students.	6	6	1	0	3
3. Therapist relationship with the administration.	5	3	2	0	5
4. Therapist relationship with teaching faculty	6	7	1	0	2
5. Therapist relationship with counseling staff.	4	3	2	0	6
6. Therapist's outreach to students, teachers & parents to promote Project Success services	5	3	3	1	3
7. Therapist presence and participation in school activities and meetings.	4	3	4	0	4
Totals	37	30	15	1	25

When asked what the faculty liked about the program, Pollicita faculty indicated:

- Kids who know about and use the service benefit –
- Saori was a great support to many of my students. She is consistent and flexible and communicates well.
- The availability and consistency of counselors at our school.
- Offering a much needed resource.
- The services provided by Asian American – we really appreciate what you do for our school
- Having this service available to our students is wonderful.
- The counseling part with severely disturbed students.
- Flexibility, sharing, support, extra time given during crisis periods.
- Never used it, but would be interested in learning more about the services.
- It allowed for more much-needed services for many of our students who desperately need it!
- The availability of Saori, knowing when a crisis arises we have help for our students.
- Everything positive.

When asked how the program could be improved, faculty had a list of very specific suggestions that should be taken within the context of being helpful suggestions as the ratings above show clear satisfaction with the program. Items in bold italics are very specific suggestions that could perhaps be considered. Interestingly, while teachers seemed to clearly value the

program, only six of the eighteen teachers completing the survey indicated that they had referred any students to the program, a suggestion that more intense outreach would be beneficial. There are several specific examples of the kind of outreach and scheduling changes that might be effective below.

- ***Communication with all teachers could be improved.***
- It seemed like counselors didn't have many students – perhaps more referrals needed/pursued. [*Evaluator comment: Pollicita had 20 students enrolled in the program, well over the target of 14 and is implementing a group program* in the second semester of 2014-15.]
- ***Would like more communication with Asian American staff about our students.***
- More hours available for our needy student population.
- Need more therapist to help the kids.
- I don't think most kids know about this option, ***so more outreach would be nice.***
- We need more counselors like Saori!
- Let teachers know who is working with students.
- ***Let us know schedule and drop-in availability if possible.***
- Get more funding to be able to provide more services for our students.
- Even more counselors/staff.
- ***Perhaps students could meet with you during P.E. – several of them can't afford to miss English/Reading.***
- My only contact has been the yellow passes. Other than that I don't have any relationship with the program.
- ***I would have liked to have more "outreach" – reminder of hours, services – maybe through homeroom, PR and report card envelopes, posters/pamphlets in hall/by lunch counter/in a central place. Reminders in announcements or homeroom***.
- ***Expand the visibility on campus; more hours, large size bulletin board highlighting services in your resource guide. On a regular basis, hand out recreation fun throughout the bay area.***

It is interesting how many comments suggest the need for more outreach and promotion of the program with students and teachers. Grow conducts a psycho-educational orientation to Grow, student eligibility criteria, referral process, and range of services available. In addition, at both schools there is a monthly voluntary lunch group for students with each session focused on different topics like 'managing stress or loneliness' to 'controlling anger.' Finally, at Pollicita, with Kaiser funding, throughout the year, AARS is providing psycho-education sessions for teachers on a range of mental health topics and reference to Grow is typically a part of these presentations. So while it would seem that quite a bit of outreach and promotion is occurring, the teachers obviously feel that more promotion is needed and with groups beginning in 2015, an expanded outreach effort is called for.

While the proportion of Parkway faculty rating Project Grow's performance as excellent is even higher than at Pollicita, there were also far more 'needs improvement' with at least one faculty member indicating improvement needed in four of the seven items. Neither faculty identified a need for improvement in therapy services and this was the highest rated item at both schools and the general level of Pollicita and Parkway faculty satisfaction is very high.

Table V: Parkway Faculty Satisfaction N=12 Item	Excellent	Very Good	Satisfactory	Needs Imp.	Not Applicable
1. Overall services to the school.	7	3		1	
2. Therapist services to the students.	7	2	1		
3. Therapist relationship with the administration.	4	3	1		1
4. Therapist relationship with teaching faculty	6	2	2	1	
5. Therapist relationship with counseling staff.	6	2			2
6. Therapist's outreach to students, teachers & parents to promote Project Success services	5	2	1	2	
7. Therapists presence and participation in school activities and meetings.	7	1	1	1	1
Totals	42	15	6	5	4

A sampling of comments from the faculty include:

- Blancaluz was well liked by the students. They wanted me to speak with her! Also, I think she spent time with their families as well.
- Having the therapist available at our when students need to talk to her. She was able to answer questions we had.
- Therapist's willingness and enthusiasm to help our students and their families.
- Having Ms. Blancaluz in the school worked best. She's able to work with students.
- Project Grow is a healthy program to have at our school, beneficial for our community and students!
- It seemed that students enjoyed the counseling sessions.
- Project Grow was able to provide our school the additional resource we need to add to the school's intervention programs.
- Ms. Blancaluz has done a great job of working with our students, especially some of the more difficult students.
- Ms. Blancaluz-Hansen was very approachable and open to work with teachers and students. The attention to details and close bond formed by Janette with the students and families.

However, not all comments were favorable and may point to ways in which the program could be improved.

- Increase the number of students it is available to.
- She needs to attend meetings with staff – particularly grade level and staff to communicate.
- Not too sure. If I worked closely with Project Grow I could have an answer.
- I think it would be helpful to know which students are part of this program and why.
- A little more contact with teachers.

In particular, it appears that more contact with the faculty at staff and grade level meetings might improve the program's impact and presence. Given that Parkway had only slightly more than half the number of students as served at Pollicita, that only six of twelve teachers made any referrals at all and that in 2015 groups will begin to be offered, it would also seem that this level of contact would increase the number of students served.

While levels of satisfaction at both schools is quite high among the faculty, the data is a year old and given the poor results on the Parkway pre-post test, a deeper exploration of the cause of

any level of dissatisfaction is warranted. What's more, it is critical that satisfaction surveys be administered this year at both schools with faculty and parents.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Project Grow is clearly serving demographic populations that are historically identified as being under-served. Parkway Middle School serves a student population that is 78% Latino with almost 70% of students low-income, as reflected by their eligibility for Free & Reduced Lunch. Pollicita serves a more diverse population with 47% Asian and 43% Latino with 58% of students eligible for Free & Reduced Lunch. That students are referred because of teacher concerns about student behavior and their capacity to function effectively in the classroom suggests that students are at high risk of school failure. Pollicita served six more students than the contract threshold of 14 and while Parkway missed this level by two, both provided intensive case management support to address a myriad of student needs. While the evaluation found areas where the scope and intensity of services could be enhanced, Project Grow is clearly serving the high-risk population identified in the contract. The fact that only six of eighteen Pollicita teachers and six of twelve Parkway teachers made a referral all year suggests that there are likely many under-served students in need who are not receiving services. The plan by Project Grow to implement groups in 2014-15's second semester may enable the program to serve more students in need and the provision of lunchtime drop-in groups for students is also an added effort to engage underserved students.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Project Grow addresses a number of key priorities identified in the San Mateo County MHSA plan. Project Grow is an early intervention program that serves cultural populations that are historically under-served and hence is increasing access to treatment among populations that have been challenged accessing these services. The Clinical Supervisor indicated that when high schools sought to have Project Grow implemented at their site, the County responded that their resources were prioritizing intervention at an early age, another indication of the program being aligned with County priorities for earlier intervention. The program intervenes early, providing coping skills for youth while screening for more serious conditions with early access and screening for other

conditions both being priorities of the MHSA plan. Finally, Project Grow focuses on helping students cope with stress, developing coping skills and in doing so, reduce risk of school failure. Project Grow works closely with teachers at both sites, using teacher referrals as a means of identifying students at risk of academic failure. Addressing conditions triggered by trauma is an expressed priority of the MHSA plan, as is serving students at risk of school failure.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The evaluation identified a number of factors that have impeded Project Grow's success. Specifically, insufficient communication with staff at both school, impedes coordination, information sharing and referral of students in need of services. Another factor that impedes success, identified from an interview with the Clinical Supervisor, is staff turnover, a factor that has impacted both Project Grow and many of the other PEI projects. At Project Grow turnover has been the result of highly skilled Family Partners being hired by the County where higher pay and better benefits are available. While there is not much a CBO can do about this commonly experienced phenomenon, it is something that certainly is a factor that can impede developing and sustaining relationships with schools, communities, students and parents.

But aside from the significantly poor scores on the pre-post test at Parkway Heights and the need to significantly increase parent engagement at Pollicita, Project Grow demonstrated very high satisfaction expressed by both faculties, sustained high-levels of student engagement and at Pollicita showed strong gains on the pre-post test almost across the board.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Despite high satisfaction, significant improvement in pre-post tests at Pollicita, and strong student commitment and consistent attendance in the program, the evaluation identified some very clear areas for improvement:

Stronger Outreach & Communication with Faculty. While only identified as a "needs to improve" by 3 out of 28 teachers across sites, in both surveys' open-ended comments, teachers noted the need for improvement in communication in a variety of forms: increased signage and posting of program information; increased communication with teachers about students in the program; and increased participation in faculty and grade-level meetings, being the primary areas sited. At Parkway there were only 12 students enrolled in the program, with 20 at Pollicita. Clearly more communication with Parkway faculty could improve those numbers and with groups being offered in 2015 aggressive outreach will be necessary to fill those groups quickly. Clearly teachers feel the need for these services.

Expanded outreach to families at Pollicita. Family counseling was barely evident at Pollicita and a significant effort to engage families, perhaps learning from the successes at Parkway, should occur in 2014-15.

Use of a validated assessment of parental stress. Given the anecdotal evidence of extremely high stress among the parents at Parkway in 2013-14 and reported high levels of stress at Pollicita in 2012-13, administration of a validated stress assessment like the Parental Stress Index could both validate conditions impacting student stress levels, as well as inform the focus of family and individual child counseling.

Parkway Pre-Post-test scores. Given the high marks by teachers at Parkway and their open-ended comments praising the therapist's work, the high-level of family counseling services, and the Clinical Supervisors view that the therapist at Parkway was skilled in implementing the program, it is likely that the stress and inability to manage emotions experienced by students at Parkway had more to do with family and community trauma than with shortcomings in how the program was delivered. Indeed, it could be argued that without the program, student stress would have been far higher, as the impact of the program on students at Pollicita was pronounced. Furthermore, the provision of vastly more family counseling at Parkway likely also helped mitigate some of the family trauma that was noted by the Clinical Supervisor. Nonetheless the Project Grow Clinical Supervisor should monitor the Parkway program more closely this year to ensure a high quality program and to encourage even higher provision of family counseling.

Satisfaction Surveys at both Sites. Faculty and family satisfaction surveys should be administered in the spring and perhaps also at the end of the first semester to affirm satisfaction and/or to identify areas for improvement.

Section V Demographic Summary

The data below will be used in reports to the MHSOAC.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	14	43.75%			
Female	18	56.25%	4	100	
Other					
Age	#		%		
Children 0-15	32-100%				
Transition Age Youth 16-24					
Adult (25-59)			100%		
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	0	0			
Latino	15	47	3	75%	
African American	1	3			
Asian	9	28	1	25%	
Pacific Islander	3	10			
Native American	0	0			
Multi-Ethnic	2	6			
Other	2	6			
Total	**30**	**100**			
Home Language	**#**	**%**	**#**	**%**	
English	15	47%	4	100%	
Spanish	12	37.5%	3	75%	

Table I: Demographic Summary					Source of Data
Tagalog	1	3%			
Other	4	12.5%	1	25%	
Total	**30**	**100%**			
Underserved Pops Served	**#**	**%**	**#**	**%**	No identifiable groups among middle school children.
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: 100% of clients served were children of color and all met County criteria for eligibility for Medi-Cal funded children.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Program targets youth at an age when mental health conditions just begin to emerge		
II-3) Access or Linkages to Care	**X**	
Details: In addition to treatment, case management links students and families for other services.		
II-4) Reduction of Stigma	**X**	
Details: Psycho-education for teachers and monthly drop-in voluntary groups for students explicitly discuss stigma and its implications.		
II-5) Screening for Needs	**X**	
Details: Assessments are conducted prior to enrollment in accord with County need to approve placement. In 2014-15 parents will undergo assessment for trauma upon entry in the program.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	**X**	
Details: Project Grow explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.		
II-7) Specific Risk Factors	X	
Details: Students have been identified as being at risk of school failure by referral by teachers.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Pollicita and Parkway middle schools	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Family Partners engage families.
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	CPS, hospitals, education and a range of housing, public health and social welfare agencies depending upon the child and family needs.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X			
Details: 100% of students served are of color and treatment services are implemented early.				
1-B) Psycho-Social Impact of Trauma	X			
Details: Staff are trained in trauma-informed CBT and most students are exposed to significant levels of community and family trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations	X			
Details: Students at risk as confirmed by assessment forwarded to County and by teacher referral.				
1-D) Stigma and Discrimination	X			
Details: Psycho-educational groups for teachers and students address stigma and its implications.				
1-E) Suicide Risk	X			
Details: Suicidal ideation has been identified in students at both schools.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X			
Details: Family trauma has been identified in many, if not most students.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	perhaps			
Details: Older students in the program (15) are at an age when early onset of of serious psychiatric conditions can begin to emerge.				
2-C) Children and Youth in Stressed Families	X			
Details: Family trauma is common.				
2-D) Children and Youth at Risk for School Failure	X			
Details: Teachers have identified students as being at risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X			
Details: Data was not collected on juvenile justice involvement, however it is likely that students with significant classroom behavioral issues are at high-risk of juvenile justice involvement.				

Section I Agency & Program Description

I.A. Description of Program Services

Caminar was established in 1964 as a non-profit corporation located in San Mateo, California. Initially envisioned to provide community-based rehabilitation support services for adults in mental health recovery, the agency's introduction of services began with the opening of El Camino House. Since the opening of its first program, El Camino House, Caminar recovery, treatment, and support services have expanded dramatically. With services delivered in San Mateo, Solano, and Butte, California, the number of people Caminar serves yearly has grown from 41 individuals to more than 3,600. Caminar's San Mateo mental health services focus on health & wellness, recovery, and community integration.

Since 2011 Caminar has utilized San Mateo County Behavioral Health & Recovery Services' Prevention & Early Intervention funding to implement the YES! Program through which Caminar delivers thirteen Seeking Safety groups at six discrete locations serving transition age youth. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Caminar's YES! Program targets Transition Age Youth through its contacts with community-based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence.

The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both PTSD and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;
4. Four content areas: cognitive, behavioral, interpersonal, case management; and
5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Since 1992, Seeking Safety has been implemented in more than 3,000 clinical settings and as part of statewide initiatives in Connecticut, Hawaii, Oregon, Texas, and Wyoming. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Scotland, and Sweden.

I.B. Research Basis for Approach

For programs utilizing MHSA funding, San Mateo Behavioral Health & Recovery Services has prioritized the adoption of evidence-based practices and so as part of the evaluation of PEI programs, the evaluator has conducted a brief review of the literature related to Seeking Safety. A recent comprehensive review of the literature on treatment for Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) identified Seeking Safety as the most rigorously studied treatment thus far for PTSD/SUD with 13 pilot studies, three controlled studies, and six Random Controlled Trials (*Helping Vulnerable Populations: A Comprehensive Review of the Treatment Outcome Literature on Substance Use Disorder and PTSD, Najavits and Hien, 2013)*. Clients in Seeking Safety studies were challenged by complex trauma/PTSD, with comorbidity, high severity

and chronicity, and multiple life problems. Many of the studies examined by Najavits and Hien included significant minority representation.

Six of the studies were partial-dose studies, where the programs used 24% to 48% of the model, including the largest investigation of SS to date, the National Institute on Drug Abuse Clinical Trials Network (CTN) study, which used 48% of the model in 6 weeks (#21). "Partial-dose" refers to the number of SS topics used. Even in these partial dose studies, Seeking Safety has shown positive outcomes across studies generally. Across studies SS has had numerous positive outcomes on PTSD, SUD, and other conditions. In the controlled trials and RCTs, Seeking Safety outperformed the control on PTSD but not SUD in four studies; on SUD but not PTSD in another study; and in three studies, Seeking Safety outperformed the controls on both PTSD and SUD and on both PTSD, including one study of more severe SUD patients. Most also found SS outperformed the control on other variables, such as psychopathology, cognitions, and coping. Finally, Seeking Safety is listed as having strong research support by various professional entities, based on their criteria sets, including Level A by the International Society for Traumatic Stress Studies, and "strong research support" by Divisions 12 and 50 of the American Psychological Association.

Partial dose approach is consistent with how Caminar is implementing Seeking Safety, as .the population served by Caminar is challenged to attend groups with the consistency necessary to enable YES! to adhere to the full Seeking Safety model.

I.C. Target Population, Number Served and Sites

Caminar's Seeking Safety Program serves transition age youth ages 16 to 27 at six different locations with the vast majority of participants 25 or under. The addition of 26 and 27 year-olds is mainly to accommodate Cordilleras participants who are more comfortable in a TAY group than in an adult group. Sites for YES! are listed below:

- Cordilleras Mental Health Center, located in Redwood City (3 groups)
- Redwood House, located in Redwood City and operated by Caminar (2 groups);
- South County BHRS Clinic, located in Redwood City (1 group);
- Eucalyptus House, located in Daly City and also operated by Caminar (1 group);
- Edgewood Drop-In Center, located in San Bruno; and
- Youth Services Center, located in the city of San Mateo where Caminar offers four separate groups with five groups being offered in 2014-15.

A total of 147 unduplicated clients were served in the 2013-14 fiscal year. The ethnic breakdown of participants is provided below.

Table I: Distribution of Client Ethnicity

Ethnicity	Caucasian	Afr. Am.	Asian	Latino	Pac. Isl.	Nat. Am.	Multi	Other
147	31/21%	17/12%	2/1.4%	76/52%	11/7.5%	2/1.4%	6/4.1%	2/1.4%

I.C. Budget Amount

Funding supporting the YES! Program totaled $120,000 for the year. Funds were used to:

- 1.0 FTE case manager-facilitator;
- .25 FTE assistant case manager;

- snacks and beverages for groups;
- local transportation;
- office space and supplies; and
- Supervision from the Program Director.

No funding is in the contract to cover the cost of collecting and compiling assessment and attendance data for reporting to the county or for working with the independent evaluator. While Caminar is a large agency with significant resources, Project YES! is a very small program with a small staff, six sites and thirteen groups on which to report. Nonetheless, the YES! Program Director was extremely cooperative in working with the evaluator to develop this report.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and Caminar's YES! Program Director Katie Scherrman. A second series of meetings was held in December 2013 with the new Program Director Rick Ralphson to assess and adapt the evaluation process and still more adjustments were made in July 2014 to respond to challenges Caminar incurred in collecting data. Despite encountering challenges unique to the YES! program and its targeted population, an array of data has been collected to assess the degree to which the YES! Program met its contract deliverables and had a positive impact upon the targeted population.

- Client-level data was collected on attendance in all groups from February 2014 through the end of June 2014;
- A survey was administered seeking client self-report of knowledge obtained in groups related to coping skills and triggers and related to their satisfaction with the groups;
- The evaluator and Caminar Program Manager collaborated in developing a customized pre-post test survey that sought more specific information about client use of coping skills, recognition of triggers and the degree to which stress, alcohol and/or drug use were impacting work, family or peer relationships; and
- A survey was created and administered to stakeholders at Redwood, Eucalyptus, Edgewood, South County, Cordilleras, and Youth Service Center with questions seeking validation of the program's value and impact.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

YES! serves a population that is highly inconsistent in group attendance due to court dates (YSC), changes in schedule in the residential programs (YSC, Cordilleras, Eucalyptus and Redwood House), the small size of the population served at Eucalyptus (12 clients) and Redwood House (16) and the informal structure at the drop-in-centers in San Bruno and South County Clinic. Inconsistency in participation levels made it difficult to administer pre and post test assessments to determine the degree to which the program was contributing to clients being better able to manage symptoms, identify triggers, and adopt the use of coping skills. For example, a pre-post test given to all the groups at a six-week interval elicited only 4 matches where those clients taking the post-test had also taken the pre-test. The Program Director acknowledged that while the contract called for a 20% reduction in symptoms and that the only way to verify this impact would be through pre and post tests, he wanted to insert his view that because YES! does not customize groups to individual symptoms or provide individual counseling that could be informed by a pre-test, he saw no clinical value to the pre-post test. He did acknowledge its potential value in guiding future program improvement as he would be better able to see where the program was having an impact. However, even here, wondered to what degree a pre-post test focused on coping skill development could be attributed to the project when most of the clients were engaged in significantly more intensive treatment in the program from which they were referred. The evaluator, BHRS and the Caminar Project Director met to discuss these challenge and concluded that for the 2013-14 evaluation effort to achieve sufficient matched pre-post tests would be an undue burden on program operations and likely would never yield the level of matched surveys necessary to produce valid results. The YES! Program's intent to target TAY who by the nature of their program placements, were not going to be able to be evaluated via pre and post test surveys led BHRS to determine that the evaluation should shift focus and use client and stakeholder surveys to assess the quality of services. However, as will be discussed in the Evaluation Findings that follow, based upon a closer review of the attendance data, the evaluator has developed some recommendations that might lead to collection of pre-post test data that would enrich the evaluation for 2014-15. However, these strategies, while producing some level of evaluation outcome data, would not provide any real clinical value and may be of questionable value for evaluation given the level of confounding services clients will be receiving independent of YES!. The evaluator, Program Director and BHRS leadership will discuss this upon review of the report.

Inconsistent participation patterns not only impeded administration of evaluation tools, but also challenged YES! staff in delivering a structured sequencing of topics that build upon prior work. So while YES! delivered all 25 Seeking Safety topics over the year, it was exceedingly difficult to go from week to week and sustain conversations with the same participants about patterns in triggers and the use of coping skills or the consequences from failure to do so. Only two program sites ever achieved a consistent group of participants over more than two or three weeks . As a result, Caminar adapted the program to make it responsive to those in attendance at that day with case managers coming to the group with a planned topic, but adapting it to perceived or expressed client needs that day. From a review of the client self-assessment surveys it seems clear that this client-centered approach was appreciated and that participants valued the opportunity to speak with others about the issues challenging them in the moment rather than have the topic for the group foisted on them because it was time for Topic # 12.

Despite these challenges, evaluation findings below describe a program that is responsive to the needs of the targeted population, exceeded contract deliverables, and was resourceful in adapting the Seeking Safety model to overcome the barriers outlined above. Analysis of the data also identified areas where improvement in specific groups occurring at specific sites might elicit a greater impact. In addition, changes in data collection practices were identified as a way to more easily generate attendance data and administer pre-post test surveys to obtain more robust data to assess the impact of the program on participants.
Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

Table II			
Month	**Groups Delivered**	**Cumulative Total**	**Contract Target**
July	52	52	40
August	46	98	80
September	48	146	120
October	48	194	160
November	33	227	200
December	34	261	240
January	44	305	280
February	45	350	320
March	48	398	360
April	51	449	400
May	39	488	440
June	37	525	480

YES staff included a Program Director, a full-time Case Manager who facilitated the groups, and a part-time Assistant Case Manager who co-facilitates 5 groups per week. While program was without a full-time case manager during the final two weeks of June, the Program Director and Assistant Case Manager continued the majority of groups each week. As can be seen, despite the loss of this case manager, Caminar exceeded the contract requirement to provide 480 groups over the course of the 2013-14 with the contract not specifying the total number of unduplicated clients to participate in these groups.

Table II at left summarizes the number of groups Caminar delivered during the year. As can be seen, Caminar exceeded contract specifications by delivering 525 groups, 45 more than required by the contract.

On a typical week, YES staff held the following number of one-hour groups at the following locations:

- 2 groups at Redwood House (Monday & Friday at 10:30 am),
- 3 groups at Cordilleras (Monday, Wednesday & Friday at 12:30 pm),
- 1 group at South County BHRS, (Monday at 2 pm),
- 5 groups serving 3 different units at the Youth Services Center (Tuesday & Thursday at 2 and 3:15 pm; Wednesday at 2 pm),
- 1 group at Eucalyptus House (Wednesday at 4 pm), and
- 1 group at the Edgewood Drop-In Center (Wednesday [Jan-Feb] then Monday [Mar-June] at 6:30 pm).

Group size ranges from 1-6 members per group. Through these groups Caminar served 147 unduplicated Transition Age Youth (TAY) between January – June 2014 and a significant number of 'guest' participants, many of whom wound up enrolling in the program. Caminar's contract also stipulated that the program should target Asian Pacific Islander, African American and Latino TAY. During the program year, as presented in Table I, almost 80% of the unduplicated clients identified their ethnicity as either Asian/Pacific Islander, Filipino, Latino/a, African American, Israeli, or

Multi-ethnic. Staff again utilized all 25 Seeking Safety topics at least once, often much more frequently, during the reporting period.

Caminar partnered with program staff at most of the sites from which clients were drawn, engaging site-based program staff as co-facilitators of groups, especially important when one or more clients is symptomatic or were in distress and needed individual support. For example, the South County BHRS site offers a co-facilitator for its weekly group, and Youth Services Center provides a co-facilitator for the 3:15 pm groups on Tuesday and Thursday. In addition, the assistant case manager co-facilitates at Cordilleras two days a week, and at Redwood, Eucalyptus and YSC one day a week.

As noted above, the Caminar contract called for Caminar to deliver 480 Seeking Safety groups during the program year and from July 1, 2013-June 30, 2014, Caminar YES staff provided 525 Seeking-Safety groups at 6 different sites--Redwood House, Eucalyptus House, Edgewood's San Bruno Drop-In Center, South County Behavioral Health & Recovery Services, the Youth Services Center, and Cordilleras Mental Health Center.

To dig beneath the data above and to determine how well attended each group was, how many unduplicated clients were served at each group, and very importantly, how many clients attended groups consistently enough to achieve at least 6 sessions (the minimum dosage that has been evaluated and deemed impactful), the evaluator analyzed client-level attendance data for February 2014-June 2014, the only period for which Caminar compiled the data at a client-level into a spreadsheet format. Prior to February, Caminar had collected the data in paper format without inputting it into a spreadsheet. While a laborious task, the evaluator was able to extract the client level attendance data and prepare the tables below for each group. The labor involved was well worth it as the tables below illuminate a number of important observations that could have implications for changes in the program going forward.

As described above, the YES! Program was offered from 1-3 times per week at 6 different locations. Each month, providers held a slightly different number of sessions, depending upon how many weeks were in each month. In the Tables III-XII that follow, columns 2-6 contain the number of clients attending each session during the months of Feb-June. In the row where Totals are recorded, the total number of ***duplicated*** clients attending sessions each month are recorded in Columns 2-6 and then in Column 7, the average number of ***duplicated*** clients attending each month. Counting the number of duplicated clients allows assessing the average number of participants in each group. Again in the Totals column, in Column 8 is presented the total number of unduplicated clients served over the five months for which data is available and in Row 10 is presented the total number of clients who attended six or more sessions over the course of the five months. In the Average Row, Columns 2-6 show the average number of clients who participated in each group held that month with Column 7 showing the average number in attendance over the full five months for which data was available. Column 9 in the Average Row shows the average number sessions attended by each participant. The value of this data will be clearer as we analyze each sites performance. See the following page for Table III.

Redwood House.

As can be seen, Redwood House served a total of 11 clients throughout the year, but of those eleven, nine attended at least six sessions, by far the site with the highest proportion of clients to achieve this threshold. So while the total number of clients served was among the lowest of group sites, it also might possibly be among the most impactful, as participants were very consistent in attending. However, in an interview, the Program Director pointed out that clients referred from Redwood House would be among the most symptomatic and may often be limited in the degree to which they can assimilate group content. He felt that more likely the impact would be two-fold: more immediately to help ground or distract clients from their symptoms, and perhaps longer term to plant seeds that bear fruit later when clients were less impacted by symptoms. The average number of sessions per client was 8.64 the second highest of all sites. The average number of clients participating in each group was 2.45. On three occasions over the five months, groups were cancelled due to conflicts in schedules between clients and the case manager.

Table III

Redwood House: A crisis residential program serving up to sixteens at a time with a widely varying number of those clients being TAY.

1	2	3	4	5	6	7	8	9	10
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1.00	2.00	2.00	2.00	4.00	4.00				
2.00	3.00	0.00	2.00	3.00	1.00				
3.00	3.00	2.00	2.00	5.00	2.00				
4.00	3.00	2.00	2.00	4.00	2.00				
5.00	Holiday	1.00	3.00	5.00	2.00				
6.00	1.00	3.00	3.00	4.00	0.00				
7.00	2.00	1.00	6.00	Holiday	1.00				
8.00	3.00	1.00	5.00	4.00	0.00				
Total Duplicated Client Totals	17.00	12.00	25.00	29.00	12.00	19.00	11.00		9.00
Average Participants Per Group	2.13	1.33	3.13	4.14	1.50	2.45		8.64	

Cordilleras

Cordilleras served thirteen unduplicated clients over the five months. Cordilleras had among the lowest average attendance with an average of only 1.09 participants per group, and while the average number of sessions attended per client was relatively high (4.92), this average is skewed by two clients, one of whom attended 25 times and another who attended 16 times. Indeed, none of the other 11 clients attended more than four times with four only attending once, one attending twice, four attending three times and one attending four. Being a 68-bed Mental Health Rehabilitation Center with clients with acute psychiatric histories, it is easy to understand how sustaining consistent attendance would be difficult. While it is likely that the two clients who attended consistently benefited from the program, aside from possibly planting seeds in the minds

of participants, it is hard to see how the program could provide significant benefit to the eleven clients who attended only a few times. An indicator of the challenge of sustaining consistent attendance, fifteen sessions (in red) were cancelled mostly due to the failure of any client to appear for group. This represents over 25% of the total number of sessions held. In addition, another 26 sessions included only one person. Seeking Safety has been implemented as both a group and an individual treatment. Sessions that were scheduled but not held were ***not*** reported as 'groups' as part of the total 525 group total.

Table IV

Cordilleras a 68-bed Mental Health Rehabilitation Center serving consumers with a serious mental illness. As with Redwood House the proportion of TAY clients varies, but is not a substantial proportion, usually no more than 5-10.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	1.00	1.00	1.00	0.00	2.00				
2	2.00	1.00	1.00	0.00	2.00				
3	1.00	1.00	1.00	1.00	1.00				
4	1.00	0.00	2.00	0.00	1.00				
5	0.00	0.00	1.00	3.00	2.00				
6	0.00	2.00	1.00	2.00	1.00				
7	Holiday	2.00	0.00	0.00	0.00				
8	0.00	1.00	1.00	0.00	0.00				
9	1.00	1.00	1.00	1.00	2.00				
10	2.00	1.00	2.00	2.00	0.00				
11	1.00	2.00	1.00	0.00	3.00				
12	3.00	1.00	1.00	1.00	0.00				
13		1							
Total Duplicated Client Totals	12.00	14.00	13.00	10.00	14.00	12.80	13.00		2.00
Average Participants Per Group	1.09	1.08	1.18	0.77	1.27	1.09		4.92	
Comments:									

South County Clinic

South County had 12 unduplicated clients and only two clients who achieved a threshold of six sessions. Six of the twelve participants attended only once with four others attending less than five times. One attended twelve times and another seven. Only one session was cancelled. As with Cordilleras, it is difficult to project a way in which more than 2-3 of the South County participants could benefit from the program without increased and more consistent attendance. When the Program Director was asked if there might be more that could be done to 'market' to South County clients, he noted that Caminar has done an open house, outdoor groups, fliers, communication with clinical staff at South County, pizza nights, and other outreach strategies to engage larger numbers of clients. In addition, Caminar provides transportation to YAIL clients to and from YAIL to participate in the group. Unfortunately, given the unstructured nature of the drop-in setting clients

must plan to be at South County on Tuesday at 2pm to participate and given this, consistency is difficult to sustain.

Table V
South County Clinic Behavioral Health Services an outpatient behavioral health clinic

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1.00	4.00	3.00	5.00	2.00	1.00				
2.00	1.00	1.00	2.00	3.00	2.00				
3.00	Holiday	1.00	3.00	1.00	0.00				
4.00	2.00	2.00	0.00	Holiday	2.00				
		3.00			2.00				
Total Duplicated Client Totals	7.00	10.00	10.00	6.00	7.00	8.00	12.00	3.33	2
Average Participants Per Group	2.33	2.00	2.50	2.00	1.40	2.05			

Youth Services Center-F2.

Comments: Youth Services Center F-2 is a very unusual story. With only three unduplicated clients, one of whom attended but once, the program really served two clients. But these clients attended with almost perfect attendance, with one client attending 28 times and the other 39 times. The persistence with which these two individuals attended suggests that they felt they were obtaining significant benefit from the program. And indeed, to a significant degree as the result of their participation in YES!, one client was able to obtain an early release from custody and the other was able to avoid deportation. If a few more clients could be drawn to the group, this would make for a more diverse and effective group. The potential of the YES! program and the Seeking Safety approach is reflected in the persistence with which these two clients participated.

Table VI
Youth Services Center-F2: This unit serves only male 'direct-file' clients who are being tried as adults and as a result there is a very small pool to draw from. In 2014-15, F2 will have both direct file clients and general population clients, significantly increasing the pool to draw from.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions per partic.	# clients w/6+ sessions
1	2.00	2.00	2.00	2.00	1.00				
2	2.00	2.00	2.00	2.00	1.00				
3	2.00	2.00	2.00	2.00	1.00				
4	2.00	1.00	2.00	1.00	1.00				
5	2.00	2.00	2.00	1.00	1.00				
6	2.00	2.00	2.00	1.00	0.00				
7	2.00	2.00	2.00	1.00	1.00				
8	2.00	2.00	2.00	1.00	1.00				

Table VI Youth Services Center-F2: This unit serves only male 'direct-file' clients who are being tried as adults and as a result there is a very small pool to draw from. In 2014-15, F2 will have both direct file clients and general population clients, significantly increasing the pool to draw from.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions per partic.**	**# clients w/6+ sessions**
9			2.00						
Total Dupl. Client Tot.	16.00	15.00	18.00	11.00	7.00	13.40	3.00		2.00
Ave.Participants Per Group	2.00	1.88	2.00	1.38	0.88	1.63		22.33	

Youth Services Center P4.

YSC-P4 served the highest number of unduplicated clients (tied with YSC-7-Th), had the second highest number of clients attending each month and had five clients who attended at least six sessions. What's more, on average there were 4.7 clients in attendance, creating a more authentic group experience.

Table VII Youth Services Center-P4: This is a general population unit serving girls.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions for each partic.**	**# clients w/6+ sessions**
1	3.00	6.00	6.00	5.00	4.00				
2	4.00	5.00	6.00	4.00	2.00				
3	4.00	6.00	6.00	5.00	3.00				
4	4.00	3.00	6.00	5.00	3.00				
5			4.00						
Total Duplicated Client Totals	15	20	28	19	12	18.80	20	4.7	5
Ave Participants Per Group	3.75	5	5.6	4.75	3	4.42			

Youth Services Center E7

YSC E7 Wednesday, engaged 13 unduplicated clients and with almost half (6) of participants achieving the six-session threshold and with 3.3 participants at each group. This percentage was lowered due to a precipitous drop in program attendance in June resulting in three consecutive group cancellations. Unit lockdown, a staff illness and a mandatory Caminar training resulted in three cancellations during June. Table VIII follows on the next page.

Table VIII Youth Services Center E7 Wednesday: General population boys unit.									
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	1	4	4	6	4				
2	2	0	4	4	0				
3	3	4	5	5	0				
4	5	4	6	5	0				
Total Duplicated Client Totals	11	12	19	20	4	13.20	13	5.08	6
Average Participants Per Group	2.75	3	4.75	5	1	3.30			

Youth Services Center E7 (Thursday)

YSC E-7 Thursday attracted the most unduplicated clients (20), but only two of them achieved the threshold number of six sessions. Nonetheless, the group had consistently well-attended groups with an average attendance of 3.7 participants per group and with the average number of sessions attended by participants being almost four (3.7), there is likelihood of good benefit from this group. Most all of the Thursday session participants attended very consistently until they were released from custody and then no longer attended.

Table IX Youth Services Center E7 Thursday: General population male unit. The E7 is quite large, warranting two groups, especially to enable separation of rival gang members. On rare occasions, YES! staff work with YSC staff to create interaction between gang members, but only after careful consideration.									
Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	4	3	3	5	4				
2	4	4	5	5	2				
3	3	0	4	6	0				
4	3	3	5	6	5				
Total Duplicated Client Totals	14	10	17	22	11	14.80	20		2
Average Participants Per Group	3.5	2.5	4.25	5.5	2.75	3.7		3.7	

Eucalyptus

Clearly some adjustments need to be made to the Eucalyptus partnership if it is to be sustained at all. With only five total clients and an average attendance of just over. .5 clients per session.

Eucalyptus only had two sessions in five months with more than one participant and 12 sessions were cancelled for lack of clients, representing over half of the groups offered. No client attended six sessions, indeed only one attended four times and two of the five clients only attended once. It is likely that the poor attendance levels is the small number of residents (12) at Eucalyptus and its being a transitional program with clients typically remaining no longer than a few weeks.

Table X

Eucalyptus: Six month 12-bed transitional residential program that until this year had very few TAY clients, but this has been changed to become a TAY –focused program. This should increase the proportion of TAY residents. As a non-residential program, Eucalyptus clients are not required to be on site, attend school, have jobs and have other options than attending YES! groups.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	2.00	2.00	2.00	0.00	0.00				
2	1.00	0.00	0.00	0.00	0.00				
3	0.00	1.00	1.00	0.00	0.00				
4	1.00	1.00	0.00	0.00	0.00				
Total Duplicated Client Totals	4.00	4.00	3.00	0.00	0.00	2.20	5.00	2.20	0.00
Average Participants Per Group	1.00	1.00	0.75	0.00	0.00	0.55			

San Bruno Drop-In Center

While one participant attended ten times, ten of the 15 participants attended no more than one or two times. The nature of the program, a drop-in center, is such that consistent attendance would be difficult to achieve since it is a voluntary program. To work with probation and the mental health system to either encourage and mandate participation in the group would require more Caminar staffing to work with probation officers and clinicians and compromise the voluntary nature of the program.

Table XI

San Bruno Drop In Center: A drop-in center in San Bruno operated by Edgewood.

Session #	Feb	Mar	Apr	May	June	Ave	5 Mo. Tot Undup	Ave # of sessions for each partic.	# clients w/6+ sessions
1	3.00	2.00	3.00	0.00	1.00				
2	2.00	2.00	3.00	0.00	2.00				
3	1.00	2.00	2.00	1.00	2.00				
4	1.00	4.00	1.00	0.00	0.00				
5		3.00			1.00				
Total Duplicated Client Totals	7.00	13.00	9.00	1.00	6.00	7.20	15.00		1

Table XI San Bruno Drop In Center: A drop-in center in San Bruno operated by Edgewood.									
Session #	**Feb**	**Mar**	**Apr**	**May**	**June**	**Ave**	**5 Mo. Tot Undup**	**Ave # of sessions for each partic.**	**# clients w/6+ sessions**
Average Participants Per Group	1.75	3.25	2.25	0.25	1.20	1.74		2.40	

The table below aggregates the above data to facilitate comparisons across sites. Some observations:

- Redwood was a highly effective site with the largest proportion of clients attending at least six sessions and the second highest average sessions attended by each participant. This would suggest that Redwood participants are more likely to benefit from the group due to there being a relatively low number of total participants, but high attendance rates among that group. Hence each group was held with more familiar faces and this familiarity among participants was likely to engender a high level of trust.
- Averages can be deceiving, as Cordilleras had a relatively high average number of sessions per participant, with an average of almost 5, however this was skewed by two participants who attended 16 and 25 times each. As noted above, attendance among the other eleven participants was very low.
- South County had very inconsistent attendance with only two clients achieving a threshold of six sessions attended with half of the 12 unduplicated clients attending only once;
- While YSC-P4 only served two clients all year, other YSC groups were generally well attended by consistent groups of participants;
- Eucalyptus was by far the most challenged site in terms of engaging and sustaining participants, with only 5, over half of all groups cancelled, most often for lack of clients, and with only one client attending as many as four sessions;
- At the Drop-In Center, while 15 unduplicated clients attended a group, ten of those fifteen only attended once or twice and only one achieved the six-session threshold; and
- While there are certainly benefits to have a group dynamic that is only possible with a group of at least three or four, as the Program Director pointed out, there is significant benefit derived from very small groups, as those highly symptomatic participants are more able to express their views in the smaller groups.

Across all sites:

- 25% of the unduplicated participants attended at least 6 sessions, a surprisingly high percentage buoyed by three sites, Redwood (9), YSC-E7W (6) and YSC-P4 (5) and a total of 28 clients did achieve the threshold six sessions and at several sites attendance was consistent for weeks at a time;
- No other site had more than two clients achieving the six session threshold;
- The three programs who had among the highest average number of participants per group and the highest attendance per session.
- Due to the transitory nature of the population, only one client participated in groups continuously from February through June and very few attended more than two months. Since protocols for site staff communicating with YES staff prior to clients being discharged,

it is difficult to schedule an exit post-test with these clients and as noted elsewhere, any such additional communication coordinated from Caminar would further stretch an already over-extended program.

Table XII, below, summarizes the five-month totals on variables discussed by site above. While in Caminar's reports to the County, it reported as 'served' only participants who formally enrolled in the program while also allowing 'guests' to attend. The evaluator noted that many guests ultimately wound up enrolling in the program and so guests have been included in the analysis throughout the tables above and below as they were indeed 'participants.' Further, the practice of allowing guests served as an effective outreach strategy that allowed potential clients to sample the groups prior to committing.

Table XII:

Site	Ave. Monthly Total of Duplicated Clients	Total Unduplicated Participants (includes guests)	Ave. # of Participants in Each Group	Average number of sessions attended by a participant	# of participants who participated in at least six groups
Redwood	19	11	2.45	8.64	9
Cordilleras	12.80	13	1.09	4.92	2
South County	8.00	12	2.05	3.33	2
YSC-F2	13.40	3	1.63	22.33	2
YSC-P4	18.8	20	4.42	4.7	5
YSC-E7 Weds.	13.2	13	3.30	5.08	6
YSC-E7 Thur.	14.8	20	3.7	3.7	1
Eucalyptus	2.20	5	.55	2.2	0
San Bruno DIC	7.20	15	1.74	2.4	1
Total	109.4	112	2.48	4.87	28

In summation, Caminar's YES! Program met both objectives related to clients served that are stipulated in the contract, exceeding the total number of groups held and targeting underserved populations effectively. Indeed, while the contract stipulated under-served as ethnic minorities, Caminar went beyond this targeting higher-risk clients in RMHC's, crisis residential programs and in juvenile hall. However, as Table XII indicates, serving these populations made it difficult to sustain consistent attendance in many of the program sites. The sporadic attendance also made it difficult to collect pre-post data to assess the impact of the program. Both issues will be discussed in more detail under EQ 6 and 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

The YES! Program utilizes an evidence-based practice that has been intensively researched and found to have a significant positive impact serving individuals suffering from trauma and/or substance use disorders. Given the difficulty of sustaining ongoing participation of clients, Caminar has been resourceful in restructuring the SS model to accommodate client attendance patterns. It has also impeded administration of pre and post tests that might help to assess the degree to which the program is meeting the client outcome measure referenced in the contract: "Reduce co-occurring substance abuse and trauma-related symptoms by twenty percent (20%) in TAY participants that have completed the Seeking Safety program." A pre-post test was developed to attempt to assess change in symptoms related to trauma and substance use, but attendance

patterns resulted in only 4 pre-post test matches. A thorough examination of those patterns has revealed a possible solution to this problem as 29 YES! clients actually attended at least six sessions and the evaluator has developed a strategy for 2014-15 whereby Caminar can obtain pre-post test surveys on most clients who meet this threshold. See EQ 7 for a discussion of this strategy.

A client satisfaction and coping skill survey was used to determine both the level of client satisfaction (See EQ 3) and client perceptions of the coping skills they were developing through the program. In the same client survey, participants were asked to identify which coping skills they now were aware of. As the table at left reveals, it would appear that a very high percentage of the participants are learning to recognize important skills related to coping with trauma and anger and seeking help appropriately when facing challenges or stressors. For next year's evaluation, the evaluator and Caminar Program Director will work together to create a pre-post test that will seek more refined information about how the clients are knowledgeable of specific skills and are using those skills. This will likely be a much better method for seeing the program's impact and for responding to one of the contract outcomes related to reduction in stress-related symptoms.

Table XIII	
Skill	Percent
Asking for Help	82.4%
Coping with my Triggers	71%
Creating Meaning out of my experiences	53%
Respecting my time	76.5%
Using Community Resources	71%
Being able to identify Red and Green Flags	53%
Healthy Relationships (or getting rid of unhealthy ones)	71%
Taking Good Care of Myself	71%
Self-Nurturing	76.5%
Setting Boundaries	82.4%
Honesty	71%
Grounding	59%

Also in this client self-assessment survey, participants were asked to describe any other skills that they had learned. Only five clients declined to identify any additional skills learned. Among the skills identified: communicating more clearly (3); analyzing my own experience and relating to others; discussing issues with staff and peers; relaxation; taking walks; plan for your future (2); set and stick to goals (2); and not to procrastinate; and being myself. The responses suggested that the participants were actually thinking through their responses, an indication of their taking the question seriously.

Caminar also administered surveys with the staff from the programs that housed the clients or the case managers/clinicians who worked with the clients who were not in residential programs. As Table XIV illustrates, of the eight partner site manager's queried all but one respondent strongly agreed with every statement in the questionnaire below, with but one response indicating 'agree' and no one disagreeing with statements asserting the value of the program.

Table XIV-Responses to Stakeholder Survey					
Question	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1. The YES groups have a positive impact on participants.	100%				
2. YES group participants speak highly of the benefit they derive from the groups.	87.5%	12.5%			
3. Caminar's YES groups are responsive to the schedules of its clients.	100%				
4. Caminar YES staff maintains good communication with our program staff.	100%				
5. I would recommend Caminar's YES groups to other youth and young adult serving programs.	100%				

The open-ended comments made by case managers and clinicians gave a clear expression of the perceived value of the program. For example, one counselor noted that, "Young adults have shared their positive experience in the Yes groups…. The Yes group is benefiting our young adults and helping them interact better with peers." Another therapist stated that, "YES has provided a safe environment for my clients to share their struggles and get positive feedback from peers. Having a targeted age group and small group size has been helpful and beneficial." Another counselor mentioned how communication from the YES staff helped Eucalyptus staff better support a client around self-harm issues and informed their de-escalation plan and interventions. When asked how the program could improve there was only one suggestion: increase communication with our staff about client treatment goals. That aside, the question asking for how the program could improve only got responses like "none," "you are awesome" and "more groups" or "three times a week."

While the data is not as robust as desired, the data that was collected provides reasonable evidence of the YES! groups having a positive impact upon participants. As noted above, in the 2014-15 evaluation, a plan has been developed to ensure that additional data is being collected to provide a more complete understanding of the scope of that impact. The additional data will provide the kind of information needed to respond to another contract objective: Project Yes! clients will demonstrate a 20% reduction in symptoms, something that can not be asserted based on the data available in 2013-14.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

The same client self-assessment survey described above also asked clients four questions about their experience in the YES! groups. As you can see, a significant majority of respondents strongly agreed that staff treated them with respect, listened to their views, and believed that the participants could sustain recovery. Oddly, given these responses, the lowest level of approval was in relation to whether participants felt that the group was actually helpful, with just over 70% strongly agreeing and 11.8% disagreeing, the only item where clients disagreed. Nonetheless, the survey demonstrates that participants highly valued the group. See below.

Table XV: Client Satisfaction Survey Responses

Overall I feel that …. N= 17	Strongly Agree	Agree	Disagree	Strongly Disagree
The YES staff treats me with respect.	88.2%	11.8%		
YES staff really listens to what I have to say about things.	94.1%	5.9%		
I feel that staff believes I can recover and create a meaningful life.	76.5%	23.5%		
I found this group helpful.	70.6%	17.6%	11.8%	

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

Caminar's contract stipulated that it should target "at-risk" transition-age youth with a focus on Asian, Pacific Islander, African American and Latino/a populations. Demographic data on clients' served demonstrates that during the program year, 80% of the 147 unduplicated clients identified their ethnicity as either Asian/Pacific Islander, Filipino, Latino/a, African American, Israeli, or Multi-ethnic, so clearly the YES! groups were reaching the demographic population identified in the contract. Table I provides a breakdown of the total ethnicity of clients enrolled in YES! and shows clearly that YES! worked with a diverse client base that is historically under-served.

A clear demonstration of the degree to which Caminar's Seeking Safety Program serves 'at-risk' transition age youth ages 16 to 27 is evident from a review of the populations served by the six different locations from which Caminar drew clients:

- Cordilleras, located in Redwood City, Cordilleras is a locked mental health rehabilitation center for adults with chronic mental illness housing 68 clients many of whom have serious mental health conditions;
- Redwood House, located in Redwood City and operated by Caminar, Redwood House is a crisis residential program that offers an alternative to hospitalization for individuals in the recovery process;
- South County BHRS Clinic, located in Redwood City, South County Clinic is part of the BHRS mental health system offering a wide range of outpatient treatment services;
- Eucalyptus House, located in Daly City, Eucalyptus House is 12-bed transitional residential program that helps people prepare for independent living;
- Edgewood Drop-In Center, located in San Bruno, the Drop-In Center is a voluntary, peer-driven program that provides interpersonal, educational, vocational, wellness, and recreational opportunities for San Mateo County young adults between the ages of 18-25 to expand the skills necessary for a successful transition into adulthood.; and
- Youth Services Center, located in the city of San Mateo, YSC provides the Juvenile Probation charges with a range of mental health services and supports for adolescents and their families needing more than routine probation. At this location, Caminar offers four separate groups, as described below.

By definition, clients served at the above locations are at extremely high-risk. Additional evidence of client risk was identified through another survey developed by the evaluator. The 17-item survey included questions about the level of stress experienced and the frequency with which clients used coping skills to address stressful situations. With some revisions, this is the tool that will be used in a pre-post test format to assess the impact the program is having on clients. For this evaluation, the tool shows clearly the extent to which Caminar has engaged clients experiencing significant levels of stress. Survey results showed that:

- 37% of respondents indicated that they often or almost always found that anxiety interfered with their personal relationships;
- 50% of respondents indicated that they often or always used drugs or alcohol when stressed with 25% of respondents indicating always;
- 43% of respondents indicated that they rarely or never got the sleep they need with 32% indicating that they never do;
- 48% of respondents indicated that they often or always were very stressed with 32% indicating that they were always very stressed;
- 43% of respondents indicated that they never or rarely were able to use relaxation techniques to calm themselves when stressed with 32% indicating never; and
- 44% of respondents indicated that they never or rarely were able to ask someone for help when stressed, with 31% indicating never.

Taken together, these results present a client base that experiences significant levels of stress; where that stress has a negative impact upon their relationships; and where they are not able to access help appropriately, calm themselves or get the sleep needed that might help prevent the stress. The data above provides ample evidence that the client-base served by YES! groups is 'at

high-risk.' In sum, Caminar has partnered with referring agencies whose population are by definition at high risk, has successfully engaged demographic populations that are historically under-served and were identified to be targeted in the contract; and has presented data that shows that clients have experienced high levels of stress and lack coping skills to manage that stress effectively.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Caminar's YES! Project clearly responds to the vast majority of these expressed priorities. The treatment approach, Seeking Safety, is perhaps the most studied evidence-based practice in mental health and it was explicitly designed to build the competence of participants, to help them develop coping skills, identify stress-triggers and learn to manage their stress rather than be managed by it. Caminar partnered with referring agencies that serve populations experiencing extreme levels of stress and Caminar successfully engaged clients from historically under-served populations. Caminar also partnered with six different treatment centers, incorporating their clinicians at YSC and South County into the framework of the Seeking Safety groups with clinicians and case managers from these sites serving as co-facilitators. In addition, YES staff work intensively with staff at all sites to coordinate and schedule services, to select clients to ensure that the groups will be cohesive (e.g. no rival gang members without careful deliberation).

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Caminar faced significant challenges in delivering the Seeking Safety model to a consistent client base and in collecting data to validate the impact of the program. The greatest challenge was in relation to inconsistent client attendance at some sites and last-minute site-specific schedule changes. Clients participate voluntarily and enjoy their experiences. But they are not always at the group location at the time of the group (e.g., a client(s) just may not be at South County or Edgewood on a given Monday afternoon or evening. Also, Youth Services Center clients are routinely in and out of custody). The other, though much less frequent, obstacle to effective groups is site-specific. Groups can be cancelled at the last minute. For instance, if there is a "code" or emergency lock-down at the Youth Services Center, then groups may be cancelled or shortened (or "groups" are held individually through client jail cell doors). The inconsistency of attendance

makes it challenging for Caminar to deliver the Seeking Safety model to fidelity. While all 25 topics were delivered over the course of the year, Caminar staff flexibility and creativity have allowed the program to navigate the challenges. From the evaluator's perspective, the population served by Caminar's YES! program is at extreme high risk of future incarceration and/or hospitalization. The clientele requires a highly skilled staff that would benefit from additional staffing to support the scheduling functions, to expand coordination with referring partners and to be able to better respond to clients who come to groups highly symptomatic.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In order to improve the quality of the YES! program and enhance its ability to demonstrate clear client benefit, the following recommendations are made:

- Examine ways to incorporate the YES groups more integrally within Eucalyptus, Cordilleras, and Redwood so as to foster greater, more consistent participation;
- Develop a protocol with partner agencies through which YES staff are notified in advance of pending discharges whenever possible so that YES could more easily schedule post-test surveys needed to document program impact upon clients; and
- Implement a protocol to administer a pre-post test to all clients attending their first group and then track client participation more consistently throughout the year to better enable administering a post-test whenever a client completes a sixth session.

The last two recommendations above are made to respond to Caminar's contract that stipulates that it must demonstrate a 20% reduction in client symptoms. An acceptable alternative recommendation would be to ask the county to remove from the contract the need for Caminar to administer pre and post-test surveys. As noted above, there is little if any clinical value to these assessments as Caminar doesn't provide individual treatment that could be informed by these results and given that most all YES participants are also engaged in far more intensive treatment and supervision services from their host/referring agency, attributing changes in coping skill development to the YES! program may be specious. Indeed, given the degree to which the program is over-extended and under-staffed and the clear evidence of perceived benefit from referring stakeholders who are very familiar with both the program and its clients, this may well be the better recommendation.

Section V Demographic Summary

The data below will be reported has been culled from data provided by Caminar. It will be used in reports to the MHSOAC.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	97	67	2	40	
Female	50	33	3	60	
Other					
Age	#		%		
Children 0-15					

Table I: Demographic Summary					Source of Data
Transition Age Youth 16-24		147		100%	
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	31	21	3	60	
Latino	76	52			
African American	17	12	1	20	
Asian	2	1.4			
Pacific Islander	11	7.5			
Native American	2	1.4			
Multi-Ethnic	6	4.1			
Other	2	1.4	1	20	Caribbean
Language	**#**	**%**	**#**	**%**	
English	129	88	5	100%	All staff spoke English but two are bilingual.
Spanish	16	10.8	2	40%	All clients were bilingual and since family work was not part of model, Spanish skills were not essential. Staff had Spanish language capacity and used this to better engage clients, but groups were in English.
Cantonese					
Mandarin	1	< 1			
Hindi	1	< 1			
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details:		
II-2) Outreach for Early Recognition of Need		**X**
Details: Outreach is to referring agency staff not directly to potential clients.		
II-3) Access or Linkages to Care		**X**
Details: Group leaders do not typically make referrals, but if an unmet client need were identified would communicate this to staff from the referring agency who has primary responsibility for treatment and supervision. Referral functions would be outside the scope of the program.		
II-4) Reduction of Stigma	**X**	
Details: Group psycho-education addresses source of trauma, demystifying and destigmatizing clients understanding of the source of their stress and anxiety.		
II-5) Screening for Needs	**X**	
Details: Limited screening is conducted upon enrolment in the program.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	Seeking Safety explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.	
Details:		
II-7) Specific Risk Factors	Risk factors include: exposure to trauma, juvenile and criminal justice involvement.	
Details:		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Six locations in San Mateo County: Redwood House, Cordilleras, San Bruno Drop-In Center, Eucalyptus House, South County BHRS Clinic, and Youth Services Center.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Veteran attendees make recommendations for group topics and two such clients created a revised check-in/check-out ritual that has been implemented across all groups.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Criminal justice with close ties with the Youth Services Center who provide co-facilitators for most groups. YES! Is also BHRS and its South County clinic, as well as with Cordilleras and Edgewood's Drop in Center, offering groups at both sites.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: Clients served by YES! are primarily (80%) from historically under-served or poorly served demographic populations.				
1-B) Psycho-Social Impact of Trauma		X		
Details: YES! targets TAY who have been subjected to high levels of trauma including those residing in crisis residential, residential treatment programs, transitional housing, and juvenile justice settings.				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: **See 1-B.**				
1-D) Stigma and Discrimination		X		
Details: **See 1-A.**				
1-E) Suicide Risk		X		
Details: Those subjected to high levels of stress are at higher risk of suicide. Learning coping skills to address stress and trauma have been shown to reduce incidents of suicide.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: See above				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness		X		
Details:				
2-C) Children and Youth in Stressed Families		X		
Details: See above1-B				
2-D) Children and Youth at Risk for School Failure		X		
Details: Youth (TAY) in juvenile justice system or in crisis mental health programs are at high risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: Multiple groups offered at YSC.				

Section I Agency & Program Description

I.A. Description of Program Services

Since 2011 El Centro has utilized San Mateo County Behavioral Health & Recovery Services' Prevention & Early Intervention funding to implement the Seeking Safety through which El Centro delivers weekly Seeking Safety group sessions at El Centro's Redwood City clinic and in Half Mood Bay. Seeking Safety is an approach to help people attain safety from trauma/PTSD and substance abuse. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence.

El Centro's AC-OK Seeking Safety program targeted Transition Age Youth and young adults, the vast majority of whom were referred by the Department of Probation. El Centro named its Seeking Safety program the AC-OK Program as it conveyed a more positive image than Seeking Safety. AC-OK served 40 transition-age youth involved in the juvenile or adult justice systems. Between the two sites, a total of ninety-six groups were contracted to be conducted, however as will be described in the body of the report, El Centro was unable to engage sufficient numbers of Half Moon Bay residents to sustain attendance for groups in that Coastside community, however El Centro offered 130 individual counseling sessions to 18 Coastside residents and conducted outreach to promote the program via participation in community events, networking with other providers in the area, communicating with probation officers. As a result, El Centro plans to initiate groups in Half Moon Bay in 2015.

The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both PTSD and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;
4. Four content areas: cognitive, behavioral, interpersonal, case management; and
5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Since 1992, Seeking Safety has been implemented in more than 3,000 clinical settings and as part of statewide initiatives in Connecticut, Hawaii, Oregon, Texas, and Wyoming. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Scotland, and Sweden.

I.B. Research Basis for Approach

For programs utilizing MHSA funding, San Mateo Behavioral Health & Recovery Services has prioritized the adoption of evidence-based practices and so as part of the evaluation of PEI programs, the evaluator has conducted a brief review of the literature related to Seeking Safety. A recent comprehensive review of the literature on treatment for Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) identified Seeking Safety as the most rigorously studied treatment thus far for PTSD/SUD with 13 pilot studies, three controlled studies, and six Random Controlled Trials (*Helping Vulnerable Populations: A Comprehensive Review of the Treatment*

Outcome Literature on Substance Use Disorder and PTSD, Najavits and Hien, 2013). Clients in Seeking Safety studies were challenged by complex trauma/PTSD, with comorbidity, high severity and chronicity, and multiple life problems. Many of the studies examined by Najavits and Hien included significant minority representation.

Six of the studies were partial-dose studies, where the programs used 24% to 48% of the model, including the largest investigation of SS to date, the National Institute on Drug Abuse Clinical Trials Network (CTN) study, which used 48% of the model in 6 weeks (#21). "Partial-dose" refers to the number of SS topics used. Even in these partial dose studies, Seeking Safety has shown positive outcomes across studies generally, an important finding since both SMC BHRS PEI agencies (Caminar and El Centro) implementing Seeking Safety had difficulty sustaining sufficient client engagement to have clients achieve the six-session threshold. Across studies SS has had numerous positive outcomes on PTSD, SUD, and other conditions. In the controlled trials and RCTs, Seeking Safety outperformed the control on PTSD but not SUD in four studies; on SUD but not PTSD in another study; and in three studies, Seeking Safety outperformed the controls on both PTSD and SUD and on both PTSD, including one study of more severe SUD patients. Most also found SS outperformed the control on other variables, such as psychopathology, cognitions, and coping. Finally, Seeking Safety is listed as having strong research support by various professional entities, based on their criteria sets, including Level A by the International Society for Traumatic Stress Studies, and "strong research support" by Divisions 12 and 50 of the APA.

I.C. Target Population, Number Served and Sites

El Centro's AC-OK Program served a population of youth and young adults identified as being at high risk primarily by virtue of client involvement in the juvenile or adult justice system. The table at left captures the age, ethnicity, and referral source of the forty clients served by El Centro's Seeking Safety Program.

Table I: Client Demographic Summary

Characteristic	#	%
Ethnicity		
Caucasian	13	39.4%
African American	2	6.1%
Asian	0	0
Latino	17	51.5%
Multi	0	0
Native Amer.	0	0
Pacific Islander	2	6.1%
Other	6	18.2%
Age at Intake		
18-20	15	37.5%
21-23	15	37.5%
23+	10	25%
Gender		
Male	28	70%
Female	12	30%
Referral Source		
Probation	33	82.5%
Family		
Self	2	5%
Another Agency	3	7.5%
Other	2	5%

The contract stipulated that El Centro target Latino, Asian, Pacific Islander, and African American populations as these are historically unders-served populations who, aside from Asian youth, are also historically over-represented in the justice system. The table shows that while El Centro was successful in serving over 60% clients of color, only four clients were served from the Pacific Islander and African American population and no Asians were served. In an interview with the Program Manager and agency CFO, they explained that El Centro has a specific service niche in the community with a focus upon delivering culturally relevant services to the Latino/a community. This is reflected in the high percentage of Latino participants. While El Centro conducts extensive outreach to identify potential clients, the community has come to view El Centro more as a provider for the Latino community, a view shared by probation officers who make over 80% of the referrals to the program.

The contract did not stipulate how many clients should be served or with what frequency clients should participate, instead only stipulating that 96 groups be offered. Weekly open-enrollment groups were delivered at El Centro's clinic in Redwood City and while the Redwood City site conducted 51 groups in 2013-14 (3 above its goal), no groups were conducted in Half Moon Bay. As El Centro leadership recognized that groups were simply not engaging consistent attendance, it shifted service delivery to offering individual counseling services while continuing outreach to community providers to promote group participation. During 2013-14, El Centro served a total of 18 clients with 130 individual counseling sessions an indication that services are in demand, but that more work must be done to engage a sufficient threshold level of participation in the group model. The challenges engaging clients in Half Moon Bay are discussed under EQ # 1 and in EQ # 6 and 7.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator and El Centro's Program Manager Joe Macedo. A second series of meetings was held in December 2013 to assess and adapt the evaluation process and still more adjustments were made in July and August 2014 to respond to challenges El Centro incurred in collecting data. As with the other Seeking Safety program supported by PEI funding (Caminar), a pre-post test was developed to measure change in the use of coping skills to mitigate the degree to which trauma, stress, and drug and/or alcohol use were impacting social functioning. However, for different reasons both agencies failed to utilize this pre-post test tool. El Centro did utilize a tool that included questions selected from the Addiction Severity Index (ASI). However, even when using this tool, El Centro was only able to produce pre-post- test results for ten clients served in 2013-14. In addition to the pre-post test data, El Centro also collected and provided client-level data was collected on attendance in all groups from July 1, 2013 through the end of June 2014. In addition, El Centro administered a series of satisfaction surveys with 34 clients providing responses to 11 items related to various aspects of client satisfaction. Throughout the process, staff at El Centro was very responsive, acknowledging that their data collection fell short of what had been planned. To address this staff re-engaged clients who had completed the program to take the post-test to increase the number of clients with pre and post tests. Even still, as Section III describes, the lack of sufficient data limited the scope of the evaluation.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In brief, the El Centro contract did not have many specific deliverables outlined in its contract. Goals included that El Centro should conduct 96 groups, to reduce trauma and alcohol and drug related symptoms, to increase the use of coping skills, and to reduce psychiatric hospitalizations. No goals were included specifying the numbers to be served or client participation levels (frequency of participation in groups). The contract did not specify how El Centro could document reductions in hospitalizations and as noted above the tool developed to capture symptoms and use of coping skills was never administered by El Centro. As a result, findings were limited to analysis of attendance data, satisfaction surveys and an ASI pre-post test administered with just ten clients. Based upon this data, it is clear that while El Centro met the contract goal for providing groups in Redwood City (goal = 48; actual = 51), it did not meet the goal for number of groups in Half Moon Bay, indeed no groups were held in this Coastside community although as noted above 130 individual sessions were proved to 18 Coastside residents. As described in EQ-1, due to the inability to engage sufficient numbers of clients for group work, El Centro delivered individual counseling services to meet the needs of clients who could not attend groups. While the contract did not outline goals for the number of clients who participated in groups, the evaluation examined client level data that revealed that while almost 60% of clients participated in 6 or more sessions, over 40% attended fewer than 6.

In discussions with the Program Manager and CFO, El Centro disclosed plans to address these shortcomings. Specifically, it has begun holding monthly program planning meetings with the program manager, two group facilitators, administrative assistant and the CFO. These meetings focus on a review of data related to attendance/participation, retention, and quality of data being collected. They have also initiated a practice of entering data as assessments are completed so that results can be used for program improvement purposes. Data collection now includes administration of the pre-post test developed by the evaluator which will provide better data on client use of coping skills and the impact of alcohol, drugs and stress on social, family and work relations. To improve attendance, in Redwood City and increase the number of sessions attended by clients, El Centro is initiating a second group in Redwood City on another day to provide more options for participation. Lastly, El Centro is building upon its outreach efforts and individual client work in Half Moon Bay and will begin offering a Coastside group in 2015.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

El Centro's contract stipulates only that El Centro deliver 96 groups during the year, not indicating the number of clients served or the frequency with which these clients attend. Their plan was to offer weekly groups in Redwood City (48) and in Half Mood Bay (48). El Centro was successful in Redwood City exceeding their target by 3 (51), but in Half Moon Bay, despite significant outreach, they were unable to engage enough clients to hold any groups. The Program Manager indicated that while they did provide a significant level of individual work (not

Table II: N= 40

Tot # of Sessions Attended	***0-5***		***6-10***		***11-15***		***16+***	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
All Clients	17	42.5%	12	30%	8	20%	3	7.5%
Clients minus those enrolled in May-June 2014	12	34%	12	34%	8	24%	3	9%

reported in this evaluation), they never generated sufficient clients to sustain a group. Whatever the cause, El Centro clearly under-performed in relation to the number of groups to be held.

The contract did not specify either how many clients should participate in the program or the level of participation expected but the relatively high number of clients participating in fewer than six groups is a concern, however another way of looking at meeting productivity objectives and effectively implementing the model is to examine participation levels of those who did take part in the program. The literature points to participation in six sessions as a threshold below which there is no evidence that a positive impact can be expected. AC-OK program served forty clients over the course of the 2013-14 program year. As Table II above depicts, under 60% of the forty program participants achieved this six-session threshold with 42.5% of clients attending five or less sessions. A closer look at client-level data revealed that five of the 17 clients with less than 6 sessions had just enrolled in May or June and had been consistently attending. The second row in Table II provides data that omits these five clients. This boosts the proportion of those attending groups six or more times to 66%.

As relates to Coastside, despite an inability to engage a consistent group program in Coastside, El Centro did provide individual counseling to 18 individuals providing 130 sessions. In examining client level data it is clear that El Centro is engaging an under-served population as 75% of the clients are Latino/a and from participation patterns it is clear from that the vast majority of these clients remain in the program for six months or more than half have attended at least 9 sessions. This represents a good springboard for launching the weekly AC-OK groups that El Centro plans to initiate in 2015.

In the structured interview with the CFO and Program manager, reasons cited for clients leaving the program include re-incarceration, relapse, moving out of the area, job scheduling or movement to a higher level of care. El Centro captures this data in exit interviews, but until now had not entered the reasons into a database. Whatever the reasons for clients leaving the program, clearly there is room for improvement in participation levels in Redwood City and in Half Moon Bay. Adjustments planned by El Centro are discussed under EQ # 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To determine the degree to which clients benefited from the AC-OK groups or, put another way, experienced reductions in stress, depression, anxiety, and problems with family and peers, El Centro administered the Addiction Severity Index (ASI), with El Centro extracting key items from the survey for the purpose of evaluating impact. Of the forty clients served only 10 completed both a pre- and post-test and so the table below reflects the data for only these ten clients. The ASI is not designed to measure the use of coping skills and so the evaluation does not include an assessment of the degree to which coping skills have been introduced or adopted. This was the reason that the evaluator and Caminar developed another pre-post tool to capture changes in symptoms and changes in use of coping skills (a tool that will be used in 2014-15).

Due to limitations in El Centro's capacity to enter all data elements from the ASI, a selection of items focusing on the impact of drug and alcohol use on functioning, and the impact of stress on family and social relations was compiled. The ASI employs different scales throughout the assessment instrument with the first seven items captured in the table below (D32-F36) all using a four point scale with zero representing no expressed needs or severity of problem and then extending from 1 (slight) through 4 (extreme). The next four items analyzed (PfA-P5B) were yes

or no questions as to whether the client had experienced depression or stress in the past 30 days or over a lifetime, with yes indicated with a 1. The last three items (P13-P21) are again a four-point scale like the first four items. The table captures the average pre and post-test scores and the change experienced by the ten clients with a – change indicating a reduction in symptoms or problems and a + indicating an increase.

Table III: Pre-Post Test Results Addiction Severity Index				
Item	Pre	Post	Change	Discussion
D32-Client need for alcohol tx.	1.6	1.3	-.3	This represents a significant decline in client expressed need for alcohol treatment. Interestingly, three clients scored themselves a 3 or a 4 indicating a high need for treatment. The scores for these 3 did not change, so the entire improvement was among those with moderate treatment needs. This makes sense, as a low-intensity intervention like Seeking Safety is not likely to result in major change in treatment needs for individuals with a severe addiction. However, fully half of the clients (5) experienced significant reductions with two remaining the same.
D33-Client need for drug tx.	1.8	1.2	-.6	This represents an even more significant drop in perceived severity of need for drug treatment as indicated above for alcohol. Here four clients had a four or three score in the pre-test (with all three of the high scoring clients for alcohol indicating high scores for drugs, also). But in post-test only two of the four indicated any need for drug treatment at all. Again half the group made progress with two showing no change and three showing slight increases.
F32-How troubled by family problems (Last 30 days)	.5	.3	-.2	The post-test showed a slight reduction in family problems in the last 30 days. What is more interesting is the exceedingly low overall score with only three clients identifying any family problems and two clients indicating only a slight level of problem and one indicating a considerable level (see results of AC-OK assessment below, which gives a significantly different picture on the severity of client problems and symptoms.) In the post-test, only one person indicated problem with family, that being the same person who had indicated a considerable problem on the pre-test.
F33-How troubled by social problems (Last 30 days)	.3	.6	+.3	Clients identified an even lower level of social problems with only three clients indicating a slight level of problem in the pre-test. Their reported level of problems remained unchanged in the post-test with the increase being entirely the result of one client who registered no problems in the pre and considerable problems in the post-test. Overall, however, the scores across the board were so low that the level of increase is not really significant
F34-How important to you would be tx or counseling for family problems?	.5	.8	+.3	Here again, the average scores on both the pre and post are below 1 with only 3 of ten clients indicating any need for treatment with two indicating a slight need and one indicating a considerable need. The client who indicated considerable need in the pre-test felt an extreme need for treatment in the post-test. One client reduced their perceived level of need from slight to none. But the same person who suddenly had considerable social problems in F33 went from having no need for treatment in the pre-test, to considerable need in the post-test.

Table III: Pre-Post Test Results Addiction Severity Index				
Item	Pre	Post	Change	Discussion
F35- How important to you would be tx or counseling for social problems?	.6	.9	+.3	Three of ten clients indicated the need for counseling for social problems on the pre-test with only one indicating more than a slight need. But this client indicated an extreme need. Three clients reported no change in the post-test. The same individual who went from no need to an urgent need for treatment in F34, had the same trajectory in relation to F35. In short, the increases in severity of need for treatment to address social and family problems was entirely due to one client.
F36-How would you rate the client's need for social or family counseling.	.8	1.3	+.5	Interestingly, on the pre-test, the clinician's view of client need for counseling almost exactly matches up with the clients' perceptions, except that the clinician identified one additional client with need for counseling. While the increase in clinician-perceived need is significant, the overall level of need remains very low. The primary cause for the increase is that in the post-test, the clinician identified one client who was not identified as needing treatment in the pre-test but was identified as having an extreme need in the post-test, resulting in almost the entire gain. Still, a relatively insignificant level of need overall.
P4A-Experience of depression. (last 30 days)	.1	.1	NC	Only one client indicated an experience with depression and that same client expressed that in both the pre and post test.
P4B-Experience of depression. (lifetime)	.1	.2	+.1	Here the same client for P4A indicated that s/he had experienced depression in their lifetime, but one other client did also. Since that client did not indicate experiencing depression in the last 30 days, the change is really not reflective of the group experience.
P5A- Experience anxiety or stress. (last 30 days)	.3	.2	-.1	A higher number of clients experienced bouts with anxiety in the past month (3) than with depression, with a decrease of one reported in the post-test.
P5B-Experience anxiety or stress. (lifetime)	.3	.4	+.1	Two additional individuals reported having had stress in their lifetime, but as per above, with depression, neither expressed experiencing it in the last 30 days
P13-Psychological or Emotional Stress (last 30 days)	.5	0	-.5	Significant reduction in psychological or emotional stress in the past 30 days.
P14-Need for psychiatric tx.	.5	0	-.5	Significant reduction in perceived need for treatment for psychological or emotional stress in the past 30 days.
P21- Clinician assessment of client need for psychiatric tx.	.8	.6	-.2	Insignificant reduction in clinician perception of need for client treatment.

Despite significant efforts on behalf of El Centro staff to re-engage clients who had graduated to obtain more post-tests, an N of 10 for the pre-post test limits the validity of findings significantly. However, based upon the results summarized above, some conclusions can be advanced.

- Data from the ASI overall discloses a relatively low level of severity of self-reported symptoms and problems, with only 2-3 clients identifying that their challenges were considerable or extreme, although this result is countered significantly by results from the AC-OK Adolescent Screening Assessment (see below);
- There was a consistent and significant decrease in client-reported need for treatment for either alcohol or drug treatment, an indicator that the contract goal related to reducing symptoms is being addressed;

- While the level of problems experienced was so low that there was very limited room for further reductions, there was also a reduction in client-reported conflict with family and peers;
- Levels of depression and anxiety, as with the levels of family-peer conflict, were extremely low making small change in either direction statistically insignificant;
- The clinician identified a significantly higher need for treatment services to address the family and/or social problems as well as the need for psychiatric treatment than did clients; and
- Clients reported significant reductions in their experience of stress and need for treatment for stress, possibly an indication that use of coping skills introduced in AC-OK groups was impacting client functioning within family and social settings.

As noted in the first bullet, clients did not self-identify high levels of stress, drug and alcohol use or problems with family and social settings in the ASI pre-post test. However, the AC-OK Adolescent Screening tool provided a very different story. This 14-item Yes-No response screening tool showed far more indications of client challenges, especially with alcohol and/or drugs. Only seven of the 34 clients taking the AC-OK did not screen as needing further assessment in relation to alcohol or drug addiction with fifteen of the 34 indicating yes to at least four of the six items in the alcohol subscale. Only one yes response indicates the need for further assessment. Twenty-three of the 34 clients screened by the AC-OK also screened positively for needing further mental health assessment. While only 12 of 34 screened positively for trauma exposure, this still represents over a third of the group. The results from this screening tool suggests strongly that clients in the group may have had more issues with alcohol and drugs and/or with mental health challenges than might be evident from the self-assessment.

Taken together, it would appear that the AC-OK groups have a positive impact upon clients managing significant levels of alcohol and drug use and family and peer conflict. Given the relatively low participation levels in groups, this is an encouraging finding and points to the critical need to increase participation to ensure that clients maximize the benefit from this program. This finding is reinforced by a close examination of client level participation rates and changes in the pre-post-test. Six of the ten pre-post test clients experienced 8 or more sessions with two having attended 12 times. These clients showed more consistent gains than did the remaining clients who had fewer sessions. What's more, the only clients who experienced significant declines in outcomes were the two clients who participated in fewer than six sessions. Clearly, boosting consistent attendance rates is important to AC-OK having the positive impact desired upon clients.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

Satisfaction with AC-OK services was measured through analysis of responses from 33 clients responding to an eleven-item satisfaction survey using a five-point Likkert scale with responses ranging from 1= Strongly Agree; 2 = Somewhat Agree; 3 = Not Sure; 4 = Disagree; and 5 = Strongly Disagree. The average response is provided in the table below.

Table IV: Satisfaction Survey Statement	Strongly Agree	Some what Agree	Not Sure	Disagree	Strongly Disagree	Ave Score
Staff treats me with respect and are courteous to me.	28	3	0	0	0	1.1

Table IV: Satisfaction Survey Statement	Strongly Agree	Some what Agree	Not Sure	Disagree	Strongly Disagree	Ave Score
Treatment services are easy to get to.	23	8	0	0	0	1.26
Facilities are clean.	25	6	0	0	0	1.19
The initial assessment process was sensitive to gender, racial, and ethnic issues.	24	6	1	0	0	1.26
I was able to participate in planning my treatment goals.	24	3	2	1		1.32
My counselor is helpful and speaks to me in a way that I can understand.	30	0	0	0	0	1.00
Other Staff are helpful and speak to me in a way that I can understand.	26	5	0	0	0	1.16
Staff take time to explain to me what will happen next in treatment.	23	7	1	0	0	1.29
Staff are sensitive to gender, racial, and ethnic issues.	26	5	0	0	0	1.16
Overall, I feel that treatment is helping me.	20	4	2	0	0	1.23
I would recommend this program to my friends and family members who also need help.	26	3	1	1	0	1.26

Clearly, clients were extremely satisfied with services across all items with only two 'disagrees' and no 'strongly disagree' responses from all clients combined. Moreover, on every item over two-thirds of respondents strongly agreed. The highest rated item was a perfect score (all strongly agreed) in terms of how helpful the counselor had been. The lowest score was in relation to clients' being able to participate in care planning, but even here only one person disagreed with the statement. The other statement where there was one respondent who disagreed had to do with overall recommendation of the program, a curious response given that this respondent had given all but one of the other items a 1 score.

The survey also included two open-ended questions, one seeking ways in which the program had been particularly helpful and the other in relation to areas where the program could improve. In relation to areas for improvement, one respondent indicated that not enough people consistently attended and another commented that the required number of 12-step meetings was a barrier that he/she didn't like. Otherwise, even the comments about areas for improvement were quite positive, e.g. "Nothing. All is great" or "Nothing, I have learned a lot."

As to the positive elements of the program, all but six clients identified at least one thing that they liked about the group with quotes including:

- "Groups and one-on-one sessions are very helpful;"
- "My one-on-one counseling has made this a great experience for me and my recovery;"
- "I like that the groups are girls only;"
- "Counselor is amazing and gets me. She has been through it and understands my addictions. Angelina is also amazing non-judgmental offers perfect advice and genuinely cares for her clients;"
- "People really care here about helping. I feel comfortable discussing my problems whereas I've had trouble in the past being open;" and

- "I like everything about service especially the people that are in need of the Service & help I also like that there are resources available if you want it. Counselors are there for me, & I want my Recovery & I am accepting the help & I love it."

The comments point to program elements that spoke to the clients and should be sustained: gender-specific groups; the importance of 1-1 sessions; and the value of counselors with lived-experience. However, the overarching client view is that the program is very valuable, the staff is responsive and acute, and that they feel they get tremendous value from the program.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The contract indicated that it should target high-risk clients and specified under-served populations. Over 80% of clients were referred by the Probation Department and over 60% of those served came from demographic populations who have been historically underserved. While the low number of African American clients (6.1%) is surprising, by all other criteria, El Centro has met this criteria. El Centro leadership indicated that the likely reason for low numbers of African Americans in the program is that the agency is viewed by the community and by referring agencies as primarily a Latino-serving agency, an assertion supported by even lower levels of African Americans in other El Centro programs.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations. By serving clients involved in the juvenile-adult justice system (over 80% of clients) and by using evidence-based intervention to help these clients develop coping skills that prevent alcohol and drug addiction or trauma from impeding in functioning, the AC-OK program is clearly meeting this priority.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The AC-OK program successfully implemented Seeking Safety groups in Redwood City, clients there were entirely satisfied with the program, pointing to many specific program elements that were responsive to their needs, and pre-post test data provides evidence that the groups had a positive

impact upon client symptoms related to alcohol, drugs, and family/social relations. However, data also points to several areas where improvement is needed:

Coastside. AC-OK failed entirely in delivering groups in the Coastside community. In conversation with the Program Manager, it was indicated that the program encountered challenges in engaging sufficient numbers of Coastside clients to sustain groups in this community despite ongoing outreach to Coastside agencies and participation in community events. The Manager indicated that often a facilitator would go to HMB finding that no one had come to the scheduled group. As a result, El Centro provided 130 individual counseling sessions to 18 Coastside clients. However, Coastside is consistently identified as an 'under-served' community in a large number of county needs assessments (something underscored by the number of clients seeking individual counseling services). Either some means of increasing client engagement and sustaining participation in groups is needed or a program focusing upon individual counseling needs to be further developed. See EQ # 7 below for a discussion of this challenge.

Participation Levels. Even in Redwood City, the number of participants who failed to achieve even the threshold level of six sessions is too high. Improvement in the use of coping skills and reduction of symptoms would be more prevalent and sustainable with more consistent attendance levels.

Data Collection. The use of the ASI pre-post test was not ideal. It is not designed to be used as a pre-post test and does not capture use of coping skills. It was used only because pre-test assessments were in place and so re-administration of the assessment provided two point-in-time data sets. A tool developed by the evaluator based upon validated tools, should be used in the future with all clients. An N of ten is simply too small to draw valid conclusions about the impact of services. Another limitation in data collection is the lack of an easy way to document reductions in hospitalizations among El Centro clients and while this may be possible to do with County leadership, the evaluator questions if this is an appropriate performance measure for such a low-level intervention.

As described below, El Centro leadership has committed to making program and data collection adjustments to respond to the above challenges.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

There is significant evidence of client satisfaction with the program, data supporting improvement in clients' ability to cope with drugs, alcohol and social/family stresses, and client comments pointing to specific program strengths. But several challenges encountered by El Centro have limited the AC-OK's impact in Redwood City and prevented the program from making any inroads in the Coastside community. El Centro leadership has been remarkably responsive to considering the challenges faced by the program and thinking deeply about how best to use the evaluation to craft strategies that improve future program operations. Key improvements identified by El Centro as important to 2014-15 operations include:

Use of Data. Data provided for this evaluation was not representative of the full population served and clearly has not been entered within a timeframe where it could be used by program staff to analyze ongoing operations and plan for ongoing program improvement, a key objective stipulated in all BHRS contract. El Centro has committed to improving data collection processes in a number of ways. First, it will expedite data entry of client intake, and client pre- and post-test assessments,

ensuring that a far higher proportion of clients complete pre and post tests, and capturing the reasons for program exit in their database. In addition, a monthly Program Planning meeting has been instituted where the Program Manager, Group Facilitators, Administrative Assistant and CFO will review data, specifically looking for the impact of recruitment efforts, group participation levels, client retention, and quality and completeness of data being collected. In addition, with data entered as clients complete assessments, impact data will also be reviewed in these meetings, allowing for the opportunity to identify specific areas where clients are showing gains and where they are not.

The satisfaction surveys with clients provided important insights into the program and a reassuring view of how clients felt the program was benefiting them. Administration of a satisfaction survey with probation officers referring clients might also provide valuable insights into their perception of the programs impact or areas where it might be improved.

Participation Levels. Less than half of clients participated in over six groups, a level of involvement that is indicated by the literature as being essential to achieving significant client impact. El Centro needs to work with the Department of Probation to seek ways to encourage or require participation in groups at a level sufficient to achieving the kinds of outcomes sought by both systems. El Centro is making these adjustments, adding a group in Redwood City, offering clients more flexibility in days that they can attend the group. The routine review of participation data and reasons for program exit will also enable El Centro to make data-informed mid-course corrections in service delivery.

Half Moon Bay. While El Centro provided a range of individual counseling services in HMB, if the Seeking Safety model is to be implemented in Coastside, either relationships with other Coastside agencies or with the Department of Probation need to be strengthened to create sufficient referrals to sustain groups operating in this under-served community. El Centro has committed itself to this outreach and to instituting a AC-OK group in Half Moon Bay in 2015. What's more, El Centro leadership indicated that the Half Moon Bay group would be sustained even if the group size is small in size. Given the current level of engagement of clients in individual counseling sessions and their commitment to conducting the groups no matter the size, there is reason to hope that groups will become established in Coastside.

In short, while the program has demonstrated considerable strengths and has largely met its contract obligations in Redwood City, even in Redwood City improvement in client participation would lead to a greater impact. More importantly, there is a critical need to re-think how services are promoted and/or delivered in Half Moon Bay. Improvements in data collection are a far easier fix and El Centro staff has been very responsive improving data collection practices. Taken together, changes in data collection practices agreed to by El Centro, creating an additional group in Redwood City and sustaining outreach and initiating a group schedule in Half Moon Bay will address all concerns identified in this evaluation.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or

- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	28	70%	1	25%	
Female	12	30%	3	75%	
Other					
Age	#		%		
Children 0-15	30	75%			
Transition Age Youth 16-24	10	25%			
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	13	39.4%	3	75%	
Latino	17	51.5%	1	25%	
African American	2	6.1%			
Asian	0	0			
Pacific Islander	2	6.1%			
Native American					
Multi-Ethnic					
Other	6	18.2			
Home Language	**#**	**%**	**#**	**%**	
English	40	100%			While many clients indicated that the "home" language was Spanish, none of the clients were monolingual Spanish and the program scope of work did not include family work.
Spanish					
Cantonese					
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	Intake process asks clients about each of the under-served client populations.
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	3				

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Program served demographic groups that are historically under-served, i.e. over 60% of clients are from ethnic groups that are historically under-served. While well-over a majority, the 60% level is significantly lower than the proportion of clients served in other PEI funded projects.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: While serving clients already immersed in the justice system, most AC-OK clients are young, have limited histories in the public health system but are at high-risk of involvement in both the justice and behavioral health systems.		
II-3) Access or Linkages to Care		**X**
Details: While group leaders do help clients access services from other systems, this is not a function of groups but rather an added benefit from them.		
II-4) Reduction of Stigma	**X**	
Details: Discussions of stigma is a part of the Seeking Safety curriculum.		
II-5) Screening for Needs	**X**	
Details: All clients entering the program are screened using the AC-OK Adolescent Screening Tool, a validated tool developed explicitly to identify adolescents who would benefit from additional assessments in relation to alcohol or drug use, mental health, or exposure to trauma.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Seeking Safety explicitly addresses disorders related to trauma and substance use, educating TAYs to recognize triggers and to use coping skills.		
II-7) Specific Risk Factors	X	
Details: Risk factors include: exposure to trauma, juvenile and criminal justice involvement.		
II-7) Indicate the location where program activities occur (identify places where services occur	One location in Redwood City and one in Half Moon Bay. The failure to engage clients in Half Moon Bay needs to be addressed.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Peers participate in all groups with the shared experience of clients is only reinforced by El Centro's use of group facilitators who also have lived experience. Clients expressed satisfaction with having counselors who had a shared experience base.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Criminal justice with close ties with the Youth Services Center who provide co-facilitators for most groups. YES! Is also BHRS and its South County clinic, as well as with Cordilleras and Edgewood's Drop in Center, offering groups at both sites.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: Program serves clients in the juvenile justice and demographic populations that have been historically under-served.				
1-B) Psycho-Social Impact of Trauma		X		
Details: 60% of screened as requiring additional assessment in relation to their exposure to trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: Over 85% of clients are already involved in the juvenile justice system with the vast majority of clients screening as being at risk of problems of with alcohol, drug or mental health problems, suggesting the need for further assessment.				
1-D) Stigma and Discrimination		X		
Details: Issues of stigma and discrimination are woven through all Seeking Safety groups.				
1-E) Suicide Risk				
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: Details: 60% of screened as requiring additional assessment in relation to their exposure to trauma.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness				
Details:				
2-C) Children and Youth in Stressed Families				
Details:				
2-D) Children and Youth at Risk for School Failure				
Details:				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: Over 80% of clients are involved in the juvenile justice system.				

Section I Agency & Program Description

I.A. Description of Program Services

San Mateo County Human Services Agency, Children & Family Services Division is a division of San Mateo County that operates:

- Children & Family Services
- Child Abuse and Neglect Hotline
- Child Protective Services
- Family Resource Centers
- Foster Care Program
- Adoptions
- Child care
- Kinship Support Services
- Youth Services
- Safe Surrender Baby Info
- Children and Family Services Resources

The vision of the Children's Division is: Healthy, thriving children, youth and families with a mission of protecting the welfare of children; improving the lifelong stability of children and youth; and improving the health and strength of families. HSA achieves these goals by helping families understand and solve the issues that lead to child neglect, abuse or exploitation. In those cases when a child must be removed from the home for safety reasons, HSA helps families resolve their issues as soon as possible so that the child can be returned to a safe and loving home. When a child cannot be reunited with the biological family, HSA helps identify a suitable adoptive home or other safe and permanent living arrangement.

Since 2007, HSA has operated Teaching Pro-social Skills (TPS) groups in San Mateo County public elementary schools where HSA Family Resource Centers are located. These schools generally receive referrals from teachers for students with classroom behavioral issues. TPS addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others. Teaching Pro-social Skills is based on Aggression Replacement Training (ART). ART was developed by Arnold P. Goldstein, Barry Glick and John C. Gibbs, and takes concepts from a number of other theories for working with youth, and incorporates them into a comprehensive system. Peer learning and repetition are elements of the model. ART is an evidence-based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS. While originally designed for older youth with juvenile justice involvement, TPS and ART have been utilized in dozens of health and human service contexts including with: nurses, home attendant care providers, undergraduate students, military personnel, counselors, teachers, and with youth beginning as early as Kindergarten. TPS training is provided by the California Institute of Mental Health using the TPS curriculum develop by Skillstreaming. Skillstreaming for Elementary School children employs a four-part training approach—modeling, role-playing, performance feedback, and generalization—to teach essential prosocial skills to elementary school students.

I.B. Research Basis for Approach

The vast majority of studies of the efficacy of TPS have been focused upon older youth, principally youth involved in the juvenile justice system. However, as noted above TPS has also

been adapted to support elementary school students experiencing challenges conforming with classroom expectations and behavior norms. Brief summaries of a number of appropriate studies are provided below.

Choi, H. S., & Heckenlaible-Gotto, M. J. (1998). Classroom-based social skills training: Impact on peer acceptance of first-grade students. Journal of Educational Research, 91(4), 209–214.
Trainees: First-grade general education students (n=13), two 30-minute groups per week for four weeks. Included control group (n=12).
Skills: Problem-solving, using self-control, accepting consequences, avoiding trouble
Experimental design: Peer ratings (work with, play with); pretesting and posttesting
Results: T-test showed significant increase from pretest to posttest on "work with" peer rating for treatment group; no increase in control group. No significant differences on "play with."

Cobb, F. M. (1973). Acquisition and retention of cooperative behavior in young boys through instructions, modeling, and structured learning. Unpublished doctoral dissertation, Syracuse University.
Trainees: First-grade boys (N = 80)
Skill(s): Cooperation
Experimental design: (1) Skillstreaming for cooperation, (2) instructions plus modeling of cooperation, (3) instructions for cooperation, (4) attention control, (5) no-treatment control
Results: Skillstreaming significantly increased all other conditions on both immediate and delayed tests of cooperative behavior.

Leonardi, R., Roberts, J., & Wasoka, D. (2001). Skillstreaming: A report to the Vermont State Department of Education. Montpelier: Vermont State Department of Education.
Trainees: Elementary students (grades 2–6) with either emotional-behavioral disorders or high incidences of school disciplinary problems (N = 12).
Skills: Variety of Skillstreaming skills
Results: Students demonstrated a substantial reduction in discipline referrals.

Sarmento, P., Almeida, K., Rauktis, M. E., & Bernardo, S. (2008). Promoting social competence and inclusion: Taking alternative paths. Reclaiming Children and Youth, 16(4), 47–54.
Trainees: Elementary-age youth with oppositional behaviors attending public school
Skills: Combined Skillstreaming instruction with positive reinforcement for participation, following rules, and practicing skills
Experimental design: Correlations among group attendance, motivation points, and social skills
Results: The greater the number of group sessions attended, the greater degree of advanced social skills demonstrated by the end of training.

Swanstrom, C. R. (1978). An examination of Structured Learning Therapy and the helper therapy principle in teaching a self-control strategy to school children with conduct problems. Unpublished doctoral dissertation, Syracuse University.
Trainees: Elementary school children with acting-out problems (30 boys, 11 girls; N = 41)
Skill(s): Self-control
Experimental design: Skillstreaming versus structured discussion by helper experience versus helper structuring versus no helper role plus brief instructions control
Results: Skillstreaming and structured discussion significantly increase in self-control acquisition. No significant transfer or helper role effects.

Wight, M., & Chapparo, C. (2008). Social competence and learning difficulties: Teacher perceptions.

Australian Occupational Therapy Journal, 55, 256–265.
Subjects: A total of 21 elementary-aged (ages 5–11) boys with learning difficulties; 21 elementary-aged boys as comparison
Experimental design: Point bi-serial analysis on Teacher Skillstreaming Checklist ratings
Results: As a group, boys with learning difficulties received significantly poorer scores as rated by their teachers. Most difficult areas in order included (1) Classroom Survival Skills; (2) Friendship-Making Skills; (3) Skill Alternatives to Aggression; (4) Skills for Dealing with Stress; and (5) Skills for Dealing with Feelings. Authors concluded that the Teacher Skillstreaming Checklist is a comprehensive and valid assessment tool.

A number of conclusions can be drawn from the above research:

- TPS is an appropriate program for elementary school-age children experiencing behavior control issues;
- TPS has demonstrated effectiveness in improving self-control, problem solving, cooperation, following rules and other behaviors important to functioning effectively in a classroom and at home;
- TPS effectiveness has been demonstrated multiple times using statistically valid tools, including the one used by HSA (Teacher Skillstreaming Checklist) and in reducing discipline referrals; and
- TPS effectiveness increases with the dosage experienced by the students.

I.C. Target Population, Number Served and Sites

HSA's TPS program targets at risk youth ages 6-9, by implementing on Teaching Pro-Social Skills six to ten-session series each semester at the following school locations:

- Bayshore Elementary School in Daly City
- Hoover Elementary School in Redwood City
- Fair Oaks Elementary School in Redwood City
- Taft Elementary School in Redwood City
- Belle Haven Elementary School in Menlo Park

HSA's contract calls for approximately 8 students per group and stipulates that additional individual counseling services and/or linkages to other relevant services will also be provided. Contract negotiations between HSA and BHRS were not concluded until December and so HSA only operated TPS for one semester during 2013-14.

I.C. Budget Amount

HSA was awarded a contract with a budget of $126,748 for the period beginning January 1, 2014 through June 30, 2014. Funding supported a .10 FTE Supervising Mental Health Clinician, .10 PSW II (get full spell out), and a .75 Caseworker who facilitated the TPS groups. In addition, the county paid $23,308 for TPS training using a combination of Title IV-E (35%) and MHSA funding (65%).

Section II Evaluation Process

The evaluation plan was developed in December 2013 and January 2014 in a series of meetings that included the evaluator and Donovan Fones, the Supervising Mental Health Clinician

for the program. A plan was agreed to to collect the following data to assess the degree to which the TPS met its contract deliverables and had a positive impact upon the targeted population.

- Client-level data was collected on attendance in all groups from January 2014 through the end of June 2014;
- Data on source of referral, ethnicity, home language and age;
- Pre-post test administration of the Skillstreaming Teacher checklist that afforded teachers an opportunity to rate students they referred to TPS on specific social skills that were the focus of the TPS groups; and
- Parent satisfaction surveys which were never administered, as described under evaluation question III below.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

HSA's TPSS groups met both their service delivery and service impact objectives with each group sustaining the involvement of a core number of students referred by teachers. Group size at each site ranged from 6-10 students, as identified as the goal in the contract and attendance was consistent at each site. Groups adhered to the TPSS framework by introducing positive behaviors to students, targeting the behaviors to respond to behaviors identified by teachers as needing development. As such, each site's group was customized to the needs identified by teachers. A pre- and post test was administered that specifically asked teachers to identify the level of specific positive behaviors among referred students at the point of intake and at the end of the groups. This data shows consistent growth across sites in virtually every single behavior being addressed. The exception to this finding is that in two sites post-test results were mishandled resulting in one site not having any post-test results and one site having them for only three of the six students in that group. Another area of concern was the lack of engagement of family members, a shortcoming with which the program manager agreed. Plans to address this issue and the handling of assessment data have been developed, as described under EQ # 7.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

The evaluator reviewed participation levels in all groups to determine the degree to which TPS met its productivity objectives stipulated in the contract. HSA's contract stipulated that it would provide groups at five elementary schools, with groups extending for six to ten sessions including approximately eight participants. The table below summarizes enrollment and attendance at all five sites.

Table I: Enrollment & Attendance

School Site	Number Enrolled	Ave Attendance Per Group	Ave # of Sessions Attended	Most Attended	Least Attended
Bayshore	10	8.8	8.8	10	8
Belle Haven	6	5.3	8.83	10	8
Fair Oaks*	5	3.3	8.25	9	0
Hoover	11	9.5	8.63	10	6 (1)
Taft	6	5.2	8.67	10	8
Totals	38	6.42	8.47	10	0

As Table I illustrates, attendance in TPS groups across all sites were exemplary. Across all 38 students, participants averaged attending almost 8.5 sessions out of ten possible sessions. Across all five sites, only one referred student did not attend any groups (Fair Oaks) and only one other student attended less than seven times (Hoover). Otherwise all students referred attended at least 8 times. What's more, the consistency of participation suggests a program that either participants felt beneficial and/or that were well integrated into the schools, preventing school scheduling for testing, field trips and other schedule adjustments rarely, if ever, interrupted delivery of groups. However, given that the contract stipulated a required 8-10 sessions and TPS delivered ten at all sites and an average participation level of 8.47, clearly this objective was met. The contract also stipulated that the average group size would be approximately 8 and over five sites, the average group size was 7.6 while this qualifies as 'approximately' eight participants per group, viewed another way, only two of the five sites achieved a census of eight and so increasing communication with teachers at Taft, Fair Oaks and Belle Haven is advised.

The HSA contract also called for TPS staff to participate in TPS training with $23,308 of funding dedicated to that purpose. On November 4th and 5th of 2013, the Psychiatric Social Workers and Community Workers were trained by CIMH in Aggression Replacement Therapy which included TPSS. On May 6, 2014, the same staff received a booster training.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To evaluate the degree to which each site had a positive impact upon participating children, TPS used the Streamlining Teacher Behavior Checklist, a 60-item survey that asks teachers to rank the frequency with which students they have referred to TPS have demonstrated any of 60 positive behaviors that are being emphasized in the group. A score of 1 reflects the teacher's view that behavior almost never is evident; 2 = seldom; 3 = sometimes; 4 = often; and 5 = almost always. Each site selected up to ten such behaviors to be the focal point of groups based upon the unique needs of the group participant as determined by teacher referrals. This means that each site had vastly different behaviors being taught in the groups at the five sites making it impossible to compare across sites. Tables II-V below identify the level of either increased or reduced teacher identification of positive behaviors. It should be noted that there are tables for only four of the five school-based programs as one school, Fair Oaks, failed to collect the post test results and another school. Also, one school, Taft, despite having six students with good attendance throughout, only

administered the pre and post test with three students and with these students, only obtained responses on six of the ten targeted behaviors. This partial data is reported below.

Table II: Bayshore Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Following instructions	3.3	4.0	+.7
Recognizing another's feelings	2.5	3.0	+.5
Dealing with your anger	1.8	3.0	+1.3
Using self-control	2.3	2.5	+.2
Asking permission	3.9	4.0	+.1
Responding to teasing	2.1	2.6	+.5
Dealing with an accusation	2.0	2.4	+.4
Making a complaint	1.7	2.6	+.9
Being a good sport	2.3	3.2	+.9
Dealing with being left out	2.3	3.1	+.8
Average	2.42	3.04	+.62

At the Bayshore site, ten participants enrolled in the group and based upon the Checklist demonstrated increases in all ten targeted behaviors. Overall, the average gain was .62, the largest average gain of any site and an improvement of just over 25% on the baseline. The two behaviors most in need of improvement and ranked as least evident in the pre-test (dealing with your anger and making a complaint) also had the highest gains. To illustrate how this translates into teacher perceptions of classroom behavior for dealing with your anger, in the pre-test only one of ten students was ranked as sometimes exhibiting this behavior 'sometimes' with the rest either seldom or almost never. In all but one student showed a gain of at least one point with the other student remaining the same and scoring the only "seldom" on the post test with all other students registering sometimes or often. Similarly, on Making a Complaint, four students scored a 1 or almost never on the pre-test and four others scored 2 or seldom. In the post-test, no student scored a 1, four scored a two and the rest all scored 3 or higher. Finally, only one of the ten students showed a decline in their average score over the ten behaviors and that decline was only .1 point from a 2.1 to a 2.0. As a former teacher, the evaluator would comment that shifting your most challenging students from rarely or almost never exhibiting positive behaviors to sometimes or often will make a dramatic difference in how a classroom functions, so these gains are significant.

Table III: Belle Haven Behavior Checklist			
Behaviors	Pre-	Post	Change
Listening	3.0	2.83	-.17
Deciding on what to do during free time	1.83	3.33	+1.5
Completing assignments	2.83	2.83	NC
Setting a goal	2.00	2.17	+.17
Ending a conversation	2.17	2.67	+.5
Joining in an activity	1.67	2.5	+.83
Knowing your feelings	2.33	2.83	+.5
Recognizing another's feelings	2.17	2.33	+.16
Expressing concern for others	2.33	2.83	+.5
Rewarding yourself	2.83	3.17	+.34
Ave.	2.32	2.75	+.43

The Belle Haven site also registered consistent gains, on the pre-post checklist with only one behavior declining (listening), one remaining the same (completing assignments) and all others showing significant gains. As with Bayshore, the two behaviors identified as least evident by teachers--deciding what to do during free-time (1.83) and joining in an activity (1.67) were the two behaviors that increased the most in the post-test with the 1.5 gain in deciding what to do during free time being the largest gain across all sites. Of the six students in the Belle Haven groups all but one student made significant gains, with the two students exhibiting the positive behaviors most infrequently (ave. score of 1.7 and 1.9) each making gains of over 1 full point and one student who had averaged a score of 2.4 on the pre-test, improving to a 4.0 on the post-test. The overall improvement in identified positive behaviors from pre-to post-test was .43 or 18.5%.

Table IV: Hoover Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Listening	1.64	2.27	+.63
Asking for help	2.27	3.00	+.73
Introducing yourself	2.73	3.00	+.27
Apologizing	1.73	1.73	NC
Expressing your feelings	1.64	2.45	+.81
Dealing with your anger	2.09	2.27	+.18
Responding to teasing	1.64	2.09	+.45
Staying out of fights	2.27	2.91	+.84
Dealing with group pressure	1.82	2.36	+.54
Dealing with wanting something that isn't yours	3.00	3.64	+.45
Ave.	2.08	2.58	+.50

The Hoover site had the lowest average pre-test scores of any site just barely over 2.0 and with half of the positive behaviors rated below 2 (less than seldom). As with the other two sites analyzed above, Hoover also showed significant gains, with improvement identified in all but one behavior (apologizing) which remained at 1.73. Otherwise gains were made in nine behaviors with five behaviors increasing in frequency by more than half a point and an average improvement of .5. In addition, five of the eleven students served averaged less than a 2.0 (seldom) with three students averaging a 1.2, 1.3. and 1.4, the lowest student averages found at any site. All three students made gains on the post-test. The average gain from pre-to post-test was .50 or 19.3%.

As noted above, the Taft site served six students, but only retained the post-test scores for three students and pre and post-test results for the remaining three students were only recorded for six of the ten desired behaviors. As a result, drawing firm conclusions from these results is not possible. Results are reported below and do show generally positive change in four of the six behaviors, no change in another and a somewhat steep drop in teacher's noting evidence of children dealing well with wanting something that is not theirs. While a very small sampling, the increase of 1.28 points from pre to post-test represents a 64% increase. The table summarizing Taft's results is at right.

Table V: Taft Behavior Checklist Change			
Behaviors	Pre-	Post	Change
Joining in	2.67	3.33	+.66
Knowing your feelings	2.0	4.0	+2.0
Recognizing another's feelings	3.0	3.0	NC
Showing understanding of another's feelings	2.67	3.33	+.66
Using self control	2.33	3.0	+.67
Dealing with wanting something that isn't yours	4.33	3.0	-1.33
Ave.	2.00	3.28	+1.28

In summary, except for the Fair Oaks site where the post-test data was misplaced and unavailable, all sites showed significant gains from the pre to the post-test with Bayshore showing gains in all ten behaviors. The HSA contract called for an increase of 10% in positive social skills and according to the Streamlining Checklist, the four sites where pre and post-tests were administered all exceeded this 10% by wide margins. What's more, according to the Streamlining Checklist, across all sites, the average gain in Belle Haven and Taft were the only sites to have a decline in any behavior and each only had one. Average increases in positive behaviors targeted at each site ranged from .45 points to .5 points, .62 points to 1.28, although this last gain was among only three students. Taken together the consistency of attendance described in Table I and the consistent gains in teacher perceptions of evidence of positive student behavior points to a program that is making a significant impact at all five sites. HSA did not collect data on the numbers of student discipline referrals among program participants. The literature suggests that declines these referrals should be expected. For 2014-15, the HSA Program Director is going to work with the schools to obtain data on the number of referrals the semester prior to participation, the number of referrals during the semester that the student is participating and in the semester after participation. This should provide more evidence of the impact the program is having on child behavior. In addition, in 2014-15, HSA is going to begin communicating with parents, sending them

information about each child's 'homework' along with guidance as to how parents can reinforce student learning of more positive behaviors. Each semester, parents will be asked to complete the checklist which will provide more evidence as to whether or not the groups are having the desired impact, not just in school but at home. Finally, it is a concern that assessment results were mishandled at two sites, preventing a more complete analysis of the program's impact. This has been discussed with the program manager and is addressed further in EQ 7.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

During meetings with the Program Manager, a plan was made for the administration of a teacher satisfaction survey that focused on communication, scheduling, responsiveness, and impact of the TPS program. The questions were identified after a review of prior end-of-year reports submitted by HSA to BHRS where there had been problems identified about these issues. Unfortunately, HSA did not administer the survey and while school is now again in session, the teachers would be being asked about the program from prior year. The Program Manager has agreed to use the satisfaction survey next year, both with teachers and parents each semester.

While no 'satisfaction' data is available, with a program enjoying such strong attendance and with teachers finding such marked increase in positive behaviors, it is likely that teachers would be satisfied. Without communication with parents (the case in 13-14) it is unlikely parents would have a credible opinion of the program. However, in 14-15, HSA is committed to more consistent communication with parents about the behaviors that are being fostered and how they can support this, resulting in the likelihood of more informed perceptions by parents.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The TPS successfully targeted and served the students at highest risk of social emotional problems at each of the five sites as determined by the teachers--who are best able to make this assessment. The population served was almost 100% students of color, with only one Caucasian student among the 38 students. The positive outcomes experienced at the four sites that collected pre and post-test data suggest that the program was responsive to the teacher-identified needs. For 2014-15, it is advised that parents are engaged and their support for skill development and program input sought.

Of the 38 children participating in the program, 26 come from homes where Spanish is the home language. The lead Community Worker who facilitated all the TPS groups is bilingual Spanish speaking. The PSWs who helped to coordinate the groups and have relationships with the teachers and the parents are all also bilingual Spanish speaking. In fact, one of the groups at Hoover was conducted in Spanish due to the language needs of the children in that group.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the

capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

The TPS groups clearly address the first bullet above, moving upstream, identifying children who are at risk at an early age and providing an evidence-based intervention that has shown positive results with grade-school children. Pre-test results show that among all 38 participating children, across a wide range of potential positive social behaviors, teachers had indicated that these positive behaviors were uniformly seldom evident. Elementary school children who seldom can control their emotions, follow directions, share, control their anger, ask for help, stay out of trouble or avoid fights, clearly are at-risk and in need of intervention. The TPS program is a strength-based, helping children develop social skills that will help them better navigate school, family and community stresses. In short, HSA targets young children whose teachers have identified them as being at very high risk and TPS provides an evidence-based approach designed to address the precise behaviors identified by teachers as needing development.

BHRS goals identified in the contract are listed below with commentary as to the degree to which the program has addressed these goals.

1. Reduce out-of-home placement.
2. Reduce risk and/or involvement in the juvenile justice system.
3. Increase school attendance.
4. Improve child functioning in home, school and community.
5. Achieve high level of consumer satisfaction.
6. Achieve high level of youth, family and professional partnership.
7. Achieve high degree of interagency coordination and collaboration.
8. Achieve high degree of cultural competence while addressing disproportional (over representation of a group) in reporting, removal, placement, reunification and permanence.
9. Reduce acute care usage.

Targeted children have been identified as being at risk of failure in the classroom and moreover have identified social skills needed to be successful at home or in the community. While most all the children are too young to be considered at risk of acute care usage, they do seem at risk in relation to each of the first four goals above. While HSA has addressed these four goals, it failed to collect satisfaction data that could measure the degree to which schools or parents are satisfied and more importantly, it has not provided individual family counseling or effectively engaged parents to help build their capacity to reinforce the skill-building conducted in the TPS groups. This is a missed opportunity.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Certainly the use of an evidence-based program with a track record of success in building positive social behaviors is one of the most important factors contributing to the success of the program. While no data was collected to validate that teachers felt that the program was

responsive to their needs, that teachers at all sites referred students and completed pre and post test surveys suggests that teachers bought into the groups. However, HSA should ensure that in 2014-15, teacher (and parent) satisfaction surveys are administered to validate this and/or identify ways the program could be strengthened.

According to the program manager, one area where HSA struggled with was in getting the students to turn in their TPSS 'homework' and practice. While no data was collected on this, the program manager indicated that it was not common for this work to be completed. The evaluator has suggested and the program manager has agreed that in 2014-15, facilitators will make a greater effort to engage parents, inform them of the importance of the homework and send home monthly communication describing the skills being worked on and how they can reinforce what is being learned. This should strengthen the program, enhance student learning of new behaviors, and increase student homework completion.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

While attendance in groups has been exemplary, service level only marginally below contract goals, and outcomes significantly exceeding contract goals, there is still room for improvement in program services and data collection. Specifically,

- Communication with parents should begin with the very first group, ongoing communication should be sustained throughout groups, consistent communication about the importance of students doing the homework should occur, and a end-of-group satisfaction survey should be conducted with parents;
- This parent communication should also include an offer to provide a comprehensive assessment which is the necessary first step toward accessing individual or family counseling services.
- Outreach and ongoing communication at Belle Haven, Taft and Fair Oaks should be conducted to increase group participation to the contract-stipulated eight participant level;
- The Program Manager should oversee pre-post test administration more closely to ensure that all students are tested and that records are maintained effectively so that all five sites can report on the behavior checklist; and
- The Program Manager should work with the principals at each site to explore the feasibility of tracking student discipline referrals and student attendance, each of which are important indicators of school success with the research identifying reductions in referrals as an outcome common to the program.

While these improvements would, no doubt, strengthen the program and improve the capacity of the evaluation to validate these improvements, the TPS program clearly is benefiting the children served and helping them build the kind of social skills they will need to succeed at home, in school and in the community and in so doing, contribute to their avoiding the need for higher end services and supports.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	22	58%			
Female	16	42%			
Other					
Age	#		%		
Children 0-15	38		100%		
Transition Age Youth 16-24					
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	1	2.6%			
Latino	30	79.0%			
African American	2	5.3%			
Asian	1	2.6%			
Pacific Islander	4	10.5%			
Native American					
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English	12	31.6%			
Spanish	26	68.4%			
Cantonese	0				
Mandarin	0				
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	0				

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details:		
II-2) Outreach for Early Recognition of Need	**X**	
Details:		
II-3) Access or Linkages to Care		**X**
Details:		
II-4) Reduction of Stigma		
Details:		
II-5) Screening for Needs	**X**	
Details:		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma		X
Details:		
II-7) Specific Risk Factors	Risk factors include: lack of pro-social skills, risk of school failure, impulse control.	
Details:		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Five locations in San Mateo County. See	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	None	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	Program collaborates closely with teachers, but could increase collaboration with parents.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X			
Details: The two major demographic populations served (Latino 79% and Pacific Islander 10%) are both identified as being under-served populations and having problems accessing mental health services.				
1-B) Psycho-Social Impact of Trauma				
Details:				
1-C) At-Risk Children, Youth and Young Adult Populations	X			
Details: Students were identified by teachers as lacking important social skills, placing them at risk as they mature.				
1-D) Stigma and Discrimination				
Details:				
1-E) Suicide Risk				
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals				
Details:				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness				
Details:				
2-C) Children and Youth in Stressed Families	X			
Details: While at this point HSA does not work with families directly, this is something being called for in the contract and being recommended by the evaluator for the 2014-15 year. Clearly young children lacking social skills in the classroom are likely to have behavioral issues at home as well and intervening early and in partnership with the parents should be a priority.				
2-D) Children and Youth at Risk for School Failure	X			
Details: Quite obviously students referred by teachers for lacking social skills in the classroom are by definition at risk of school failure.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	X			
Details: Students who are unsuccessful in the classroom are disproportionately likely to become juvenile justice involved.				

Section I Agency & Program Description
I.A. Description of Program Services

Founded in 1889, Family Service Agency is San Francisco's oldest and largest provider of outpatient social services. In its 125-year history, FSA has been a leader in social service innovation having introduced numerous research-informed services and social service reforms over the years. These historic advances are FSA's legacy, a legacy that has continued into the 21st Century with the founding of the *Felton Institute* in 2004, to provide a home for university-FSA research partnerships and a home within FSA where innovation could be borne, tested, refined and replicated. FSA offers a unique setting for testing a broad range of social service innovations. FSA directs over 30 community-based social services, offered in 11 languages, serving more than 13,000 individuals of all ages. In 2014, FSA changed its name to Felton Institute since it was replicating a variety of innovative treatment approaches in communities outside San Francisco, San Mateo being one.

One of Felton's signature programs is Prevention & Recovery in Early Psychosis (PREP), developed in partnership with the University of California, San Francisco that is now operating in five Northern California counties. While delivered somewhat differently in each county, in San Mateo County PREP is comprised of the following five evidence-based practice components:

Early, rigorous diagnosis: The PREP diagnosis and assessment is both rigorous and comprehensive, addressing not only the psychotic disorder but other mental health or substance abuse issues the client might have. The focus of PREP-SMC is on first onset clients, PREP used the Structured Clinical Interview for DSM-IV (SCID). PREP staff goes through a one-year training, testing, and clinical supervision process to ensure that they can use these tools reliably.

Cognitive Behavioral Therapy for Early Psychosis (CBTP): Widely available in England and Australia but not in the US, this therapy teaches clients to understand and manage their symptoms, avoid triggers that make symptoms worse and to collaboratively develop a relapse prevention plan. CBTP represents the heart of the PREP intervention.

Algorithm guided Medication Management: The first goal of the PREP medication algorithm is to guide the doctor, the patient, and the family toward finding the single best antipsychotic medication—one that can provide symptom control with the fewest side effects. This then becomes a medication regimen to which the client is much more likely to adhere over the long-term. Secondly, the algorithm guides treatment for the additional behavioral health issues that a client is experiencing. Third, the model emphasizes close coordination between therapist, psychiatrists, clients, and family members. In the PREP model, all treatment options are explained (including risks as well as benefits). A treatment plan is developed that coordinates medication with psychosocial treatment, that has the agreement of all parties (including the client and outside providers, as relevant), and that is closely monitored for effectiveness over time.

Multifamily Psychoeducation Groups (MFG): A number of studies have shown that extended multifamily group education and support has a strong positive impact on outcomes for the client, independent of the client's level of commitment to treatment. PREP provides MFG groups for the families of teens and young adults experiencing schizophrenia. Even when the primary client chooses not to attend treatment, the family is served. In addition to MFG, PREP engaged family members in individual/family psycho-education, consultation with family about medication and case management.

Education and Employment Support: Schizophrenia tends to erupt into a young person's life during the time when they are making the most important steps into adulthood. PREP follows Dartmouth's *Individual Placement and Support* (IPS) model of education and employment support. This model

was developed specifically to assist people with mental health problems to find and retain competitive employment. The approach emphasizes a swift return to the competitive workforce or education rather than volunteer work or extensive training. The intent is to normalize the client's life experience as quickly as possible.

I.B. Research Basis for Approach

PREP is based upon research that shows the efficacy of early intervention in treating early psychosis. A 2009 Australia study that used a matched historic cohort to assess the comparative impact of Early Psychosis Prevention & Intervention Teams with a matched TAU group. In an eight-year follow-up, EPPIC participants experienced significantly fewer and less severe symptoms, with 62.5% not actively psychotic in the last two years compared with only 33% of TAU and with over half of EPPIC participants experiencing a continuous symptom-free course while less than a fifth of TAU did so. What's more, this level of symptom relief was delivered at a fraction of the cost of TAU as the average annual costs for services were $3445 versus TAU costs of $9503. This is but one of many UK studies validating the importance of early intervention (Mihalopoulos C., Harris M., Henry, L., Harrigan S., and McGorry P. 2009).

To maximize the benefit of an early intervention, PREP integrates the five EBPs identified above into a single treatment approach. A very brief summary of research support for the efficacy for each of the EBPs employed is provided.

Research-based Diagnoses. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a diagnostic exam used to determine DSM-IV Axis I disorders (major mental disorders). The SCID-II is a diagnostic exam used to determine Axis II disorders (personality disorders). There are at least 700 published studies in which the SCID was the diagnostic instrument used.

Algorithm Guided Medication Management. The PREP medication algorithm is based upon the Texas Medication Algorithm Program (TMAP), the largest study of the use of algorithm-based medication management with individuals with schizophrenia. In the TMAP comparison study, after 3 months of treatment, patients with schizophrenia who received treatment in the sites that were trained and staffed to use the TMAP algorithms had greater improvement in symptoms than did patients in the comparison sites (Miller AL, Crismon ML, Rush AJ, et al, 2004). Patients in both algorithm sites and nonalgorithm sites showed improvement over time in test scores measuring cognitive functioning, ***with the patients in the algorithm sites showing greater improvement that was sustained as of the final (9 mo) measurement of cognitive functioning.*** What's more, algorithm-based medication has been shown to reduce medication costs while improving client outcomes (Kashner, T; Rush, AJ; Crismon, AL; Toprac, M; Carmody, T; Miller, A; Trivedi, M; Wicker, A; Suppes, T., 2006).

Cognitive Behavioral Therapy for Early Psychosis (CBTp). CBT for early psychosis has a growing evidence-base and has been established as a recommended treatment for schizophrenia, having been included in schizophrenia guidelines published by the National Institute of Clinical Excellence in the United Kingdom. In a meta-analytic review of 34 randomized controlled trials, Wykes and colleagues concluded that CBT for psychosis is associated with improvements in positive symptoms, negative symptoms, and functioning Til Wykes, Ph.D.; Vyv Huddy, Ph.D.; Caroline Cellard, Ph.D.; Susan R. McGurk, Ph.D.; Pál Czobor, Ph.D., 2011). In a more recent study, CBT was also shown to have significant impact on positive and general symptoms six months beyond treatment for clients who had been medication resistant (Amy M. N. Burns, M.Ed.; David H. Erickson, Ph.D.; Colleen A. Brenner, Ph.D., 2014).

Family Psycho-education. Family involvement, particularly in psycho-educational groups, can create a supportive therapeutic community that has resulted in significant reductions in relapse, reduced acute episodes and increase adherence to medication regimen. In three studies, participation in Psycho-educational MultiFamily Group (MFG) correlated with significantly improved client outcomes and reduced reliance upon emergency psychiatric hospitalization. In one study, a total of 172 acutely psychotic patients, aged 18 to 45 years, with DSM-III-R schizophrenic disorders were randomly assigned to single- or multiple-family psycho-educational treatment at six public hospitals in the state of New York.

Supported Education. Seventeen randomized controlled trials of the efficacy of Individual Placement Support (IPS) were conducted between 1996 and 2012 in various parts of the USA and in a number of countries abroad. Competitive employment rates were significantly higher in programs that implemented the IPS model. More jobs were acquired, for more hours per week, with a shorter period of time to placement on the job, and for better wages, in the IPS model programs than in the controls. Research also indicates that programs that followed the IPS model, conducted fidelity reviews and used the results of fidelity reviews to drive performance improvement had consistently better employment outcomes for enrolled consumers.

Taken together, the research strongly suggests that early intervention in early psychosis is critical to reducing long-term care costs and increasing the likelihood of sustained recovery. What's more, the components that comprise PREP's service model each have a strong basis of support in the literature. Certainly, PREP meets one of BHRS' priorities in the use of PEI funding: that interventions be grounded in research and represent evidence based practices.

I.C. Target Population, Number Served and Sites

Felton's contract called for it to begin engaging 80-100 eligible SMC residents and after a year of operations serve 48 clients a year. During the program year 2013-14, PREP engaged 84 potential clients with 46 of those engaged in the program. The contract did not stipulate a definition of clients served or stipulate a sustained caseload. Caseload and clients served is analyzed under Evaluation Question # 1. The demographic breakdown for clients served is captured in Table I, below. While no stipulation in the contract indicated that 'under-served' populations be targeted, clearly PREP engaged highly diverse populations with almost two-thirds being from populations of color.

Table I: PREP Client Ethnicity Summary

Caucasian	Latino	Afr. Amer.	Asian	Pacific Isl.	Nat. Amer	Mixed	Other
34.8%	32.6%	4.3%	13.0%	8.7%	0.0%	2.2%	4.3%

Section II Evaluation Process

The evaluation plan was developed in two stages, in June-July 2013 through a series of participatory meetings that included the evaluator and Felton's Research Director, Dr. Erika Van Buren. A second series of meetings was held in July 2014 with the new Research Director, Dr. Shobha Pais, and the new Research Assistant, Julia Gloria Godzikovskaya. In addition, the evaluator consulted with Drs. Rachel Loewy (UCSF) and Kate Hardy (UCSF and now Stanford), each of whom played key roles in the development of the PREP model. Considerable work was done by Ms. Godzikofskaya, and others at Felton, to extract data from Felton's data system. The results of these

efforts are evident in the quality of the evaluation below. Among the data collected and reported by PREP:

- Client-level data was collected on attendance in all program components;
- Demographic and home language data was collected on all clients;
- A range of validated tools were used to capture change in client symptoms with these tools being administered at six month intervals;
- A highly detailed Semi-Annual Evaluation Form Consumer Evaluation Tool completed by all clients that is comprised of an array of validated tools was used to assess client satisfaction with an array of programmatic components—this semi-annual evaluation is composed of a number of validated assessment tools that provides a robust report not just on client satisfaction but in relationship to therapist-client alliance, access to various program components, symptoms and symptom management and other measures important to understanding the program's impact. These validated tools are described below; and
- A Staff Survey was developed by the evaluator and administered to assess the degree to which staff felt prepared to deliver PREP's complex model, the impact of staff turnover and to identify areas of the program that staff felt could be improved.

Together these tools provided ample data for answering the evaluation questions that form the framework of this evaluation. It should be noted that there was considerable back and forth between the evaluator and research staff at PREP. It is clear that the complex data systems they utilize were not aligned well and depending upon who ran which report, data on service delivery varied significantly initially. The process led PREP to unearthing these inconsistencies, determining and fixing the source of the problem—usually inconsistent data entry or definition of terms in preparing reports. In the end, the process led PREP to retool its data entry and report generation system, significantly strengthening its ability to generate accurate reports on program services and outcomes.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Evaluation findings are described in detail below, but in brief, PREP collected far more data on program operations than any PEI program resulting in a robust understanding of program operations and their impact. This shed considerable light on all that worked at PREP while also illuminating important areas where improvement would be desirable. Clients experienced a reduction in symptoms and significantly reduced level of hospitalizations, with every one of a dozen outcome measures showing improvement to varying degrees. What's more, clients were extremely satisfied with the program as is evidenced through a detailed client self-assessment survey administered every six months. These important outcome gains were achieved despite some areas where significant improvement in service delivery is indicated, something that PREP leadership has fully embraced. A summary of findings and areas for improvement is provided below. These findings are described in detail under EQs # 6 and 7. The most important findings are identified first.:

Staff turnover. The impact of ten staff changes within a 12-month period is compounded by a complex treatment model for which staff must be trained. This created a significant challenge to consistent service delivery and consistent charting. In relation to charting, the evaluation itself revealed how turnover and a complex data system led to inconsistent charting. The process has led to changes in protocols around data entry and a better understanding of how this impacts reports that PREP relies upon for program improvement. PREP leadership has also identified program design changes to help prevent turnover and reduce its impact when turnover inevitably occurs.

Multi-Family Group (MFG)-Family Engagement. While prep providers effectively engaged families in a variety of consults related to medication, case management, and psycho-education and initiated a psycho-educational Friends & Family group as a vehicle for engaging even more families, this did not translate into high numbers of families participating in the therapeutic MFG groups. PREP leadership has identified strategies deployed in the Stockton PREP site that will significantly improve family participation in MFG.

Medication Charting. While the data showed that many clients did not receive medication consultations, it appears that this is more a function of inconsistent data entry than a function of not delivering medication consultations. Many PREP clients enter the program with medication prescriptions and sustain their relationship with the prescriber. In these instances, the PREP Nurse Practitioner consults directly with the prescriber and it appears that these consultations are not being captured.

Medication Consultation. Nonetheless, the data also shows that many clients who are not using medication, have not had even one consultation regarding medication, something that PREP leadership has agreed to address. PREP needs to ensure that all clients, including those not utilizing antipsychotic medications have at least one medication consultation as the PREP model calls for all clients to have a medication consultation monthly—regardless of whether the client is using medications.

Client Engagement. It would benefit PREP to continue its efforts to identify and define signs of clients who are not engaged fully in treatment and are at high risk of hospitalization. While PREP did reduce hospitalization episodes by 34%, this reduction was compromised significantly by two clients with 166 and 67 days in the hospital.

Continue to clean data system and clearly define PREP Model. Service utilization data across program components show inconsistent patterns of data entry and/or definition of criteria in

preparing reports. This initially led to significantly different summaries of service delivery and/or outcomes. From data provided, it is clear that potential clients contact PREP, schedule an assessment, and if eligible, begin to schedule appointments for case management, CBT, medication consultations, and IPS while PREP initiates engagement with family. But some clients appear to spend considerable time in the engagement process, completing the assessment, meeting with a case manager and perhaps having a medication consultation, but not becoming fully engaged by the program. There does not appear to be a clearly defined point where this newly engaged individual is considered a "PREP client" who is fully enrolled. What's more, PREP does not have a clear set of minimum threshold service levels for clients enrolled in the program. It is unclear how many CBT sessions, medication consultations sessions or IPS trainings should occur per quarter or what percent of clients are expected to have an engaged family member of friend engaged in the program and participating in F&Fs groups and/or MFG. While PREP is customized to meet the individual needs of each client, some threshold levels of service delivery is necessary to define what being in PREP means. Finally, criteria that would distinguish a client exit as either a 'drop out' or a 'graduation' does not exist. The charts simply indicate that a client has terminated from the program. PREP needs to clearly define a graduation from a drop out.

Many of the inconsistencies in data collection and reporting were resolved during the evaluation process and leadership has developed strategies for clarifying terminology and expectations regarding service delivery and program exit. These issues are discussed in detail below. ***However, these issues aside, it is important to acknowledge that of all the PEI programs, PREP is by far the most complex involving the use of five EBPs with a population that is difficult to engage. PREP has achieved significant positive outcomes across the board and as importantly, PREP leadership has entirely embraced the evaluation findings and is using them to inform significant improvements in how PREP is delivered and how data is collected and reported.*** With these changes in place in the next few months, the evaluator would expect that the outcome gains experienced in 2013-14 would improve and clients would experience a more consistent, more highly structured program with that improved experience being captured in the data.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

PREP was launched in San Mateo County in 2011, with a planned ramp up of services reaching full operation 18 months from start-up. This evaluation covers a time frame when the program had been fully launched and so efficiency of the program will be discussed in terms of the degree to which it has met contract objectives in relation to clients served and services delivered.

As noted above, the contract called for PREP to engage 80-100 residents ages 18-35 and serve 48 clients each year. While PREP largely met these objectives by engaging 84 residents and serving 46 with an average monthly census of 40.5 and with the census climbing from July 2013 (34) to December (40), and May (49) it would be better if the program could sustain active caseloads of 48 throughout the year. The contract did not specify the number of services to be delivered of each of the EBP treatments described above, the table below describes with some precision the level and type of services delivered. The contract does not specify the length of time a client should be served or define how a client could be considered to have successfully 'graduated.' During the 2013-14 program year, nine clients exited the program with another seven exiting in

July 2014. While the numbers reported generally meet contract stipulations, going forward, it would be useful to create clear definitions for what distinguishes between a client 'dropping out' and a client successfully graduating from the program. What's more, the data shows clients 'enrolled" in the program for as long as 30 months and with many clients in the program for 18+ months and it is very hard to assess whether clients in the program were in a kind of contemplative phase upon entry, perhaps meeting with the case manager and participating in medication consultations but not being fully engaged in the program, followed by a period where the client is fully engaged in the program, participating in CBT, medication consultation, IPS employment / education supports and in family work. It is likely that this phase of full engagement is followed by a period where clients may still be enrolled but are now in a more stable, aftercare phase. PREP leadership feels that they need to precisely define these phases operationally and specify with precision the dosage of each program component that should be delivered during each phase. Not only would this result in a more precise evaluation, more importantly, it would make the program more accountable internally. In conversation with PREP leadership, they acknowledged the need to create these definitions.

Table II: Service Delivery Summary

Service	Total	Ave per Client	Details-Comments
SCID Assess.	49	N/A	During the 13-14 program year, PREP completed 49 SCID assessments resulting in 18 new intakes during the year resulting in an increase in the caseload from 34 in July 2013 to 47 in June 2014.
CBT Session	933	20.3	The average shows an average of almost 2 sessions a month. A closer look at the client-level data shows that 25 clients received 15 sessions or more with seven others receiving at least 10 and nine receiving 3 or less. CBT, case management and IPS supports appear to be the PREP components most consistently accessed by clients.
Med Mgt. Consult.	415	9.06	The average of 9 sessions per client masks client-level data that reveals that 19 clients received no medication consultation and six received but one, meaning that over half of the clients served had one or less medication consultations. However, according to PREP client files only 19 clients were utilizing anti-psychotic medication during the year and fourteen of these clients received 10 or more medication consultations while six others received at least 5. The low-level of medication consultations is mitigated by delivery of family consultations focused on medication issues that were delivered to 16 clients with a total of 134 such consultations provided over the year, or over 8 per client. Another factor contributing to the low number of consultations is a combination of poor reporting and frankly, failure to fully implement the model. Poor recording is a factor because many PREP clients continue their relationship with their psychiatrist who continues to monitor their meds. PREP leadership indicated that the Nurse Practitioner should be recording consultations with these outside psychiatrists and because that had not been occurring, those medication consultations are not reflected in the data. While inaccurate charting may partially describe the low number of medication consults, it is clear that many clients are not having consistent medication consultations. While the above data suggests that clients are not accessing sufficient

			medication support, in the Client Satisfaction survey, only 4 clients disagreed or strongly disagreed with the statement that they were able to discuss medication options or that they were able to discuss medication side effects, suggesting that among clients surveyed, there was consensus that medication consultations were available. What's more, a review of the Medication Adherence Rating Scale (MARS) scores described below suggests that those clients using medications are increasing in adherence over time (see EQ 2 below) again pointing to effective medication supports. ***Surveys aside, the PREP model calls for every client to receive an initial medication consultation and continuing consultations regardless of whether or not they are taking antipsychotics. This is an area of concern that PREP leadership acknowledges needs to be addressed.***
Family Engagement and Family Groups	89	1.934	Data provided by PREP indicates that 91 family members were involved in treatment, with all but one of 46 clients having at least one family member identified as being engaged in treatment. The 91 family member figure represents formal staff-family member contacts and this total meets the contract requirement of 80-100 family members engaged. The range of involvement is captured by the number of family case management episodes (232 or an average of 5 per client); family medication conferences (134 among 16 clients or an average of 8 per client); and family psycho-education contacts (390 or an average almost 8 per client family). From this data, it appears that PREP successfully engaged high numbers of family members and substantially involvement in the treatment plan. While no specific levels of involvement in MFG were stipulated in the contract, it is very clear that despite the high level of family engagement MFG was not engaging sufficient numbers of families. The average number of MFG sessions per client is below 2. A closer examination of client-level data reveals that only 4 clients had ten or more MFG sessions with 5 others receiving 3 or more. In other words, of 46 clients in the program, less than 10 experienced more than two family sessions. Indeed, over half of all clients (24) had no family sessions at all. What's more, of the twelve clients in the program 18 or under, only three participated in MFG, none more than twice. The PREP contract describes MFG as being a six-module program meaning that only four clients and families achieved this threshold. Certainly staff turnover and transition could have contributed to the failure to engage families more effectively. Another factor is that MFG is a closed group that operates twice monthly. During each cycle new families can't be added to the group. Recognizing that it was having a difficult time engaging families in MFG, PREP developed the psycho-educational Friends and Families Groups to serve families waiting for a new MFG group and to provide some level of psycho-education that might better prepare these families for MFG. The Friends & Family groups are offered alternate weeks (on weeks that MFG is not offered) and as families become more familiar with them, they could serve as a bridge to MFG. But given that in the spring of 2014 (when F&F groups were first initiated) only seven families have attended at least one F&F session, it appears that engagement of families for scheduled sessions is a challenge whether in relation to F&F or MFG. MFG is a highly structured therapeutic group that is closed so that new families must wait until a new cycle begins. While designed as a bridge to MFG, there is no evidence that this is occurring as reflected in the very low participation rates of families in MFG. While PREP's contract does not stipulate a specific number for how many clients and families will participate in MFG or for how many sessions will occur, it is a central component of the PREP

			model and the contract stipulates that it is a six-module program, suggesting that clients/families should participate in a minimum of six sessions. This is simply not occurring. Certainly not all PREP clients will want to involve there families in treatment, but part of the PREP model calls for engaging a circle of family ***and/or friends*** who are educated and prepared to support the client's sustained recovery after program exit. Clearly, however you define family, the consistent development of friend/family support systems is an area in which improvement is strongly indicated. PREP leadership recognizes this as perhaps the single most important program improvement revealed in the evaluation and has developed strategies outlined under EQ 7 below.
Voc'l / Educ'l Support	833	18.1	The average number of educational/vocational support services is somewhat inflated as PREP clinicians did not distinguish between case management and educational and vocational consultations since typical case management sessions involved one or both of educational and vocational issues. This aside, the 18.1 average shows consistent levels of support. Client-level data showed that 20 clients received at least 15 of these consultations. While staff turnover has been identified as a problem and is analyzed below, there has been no turnover in IPS as the same Care Advocate has been delivering IPS services for two years, a real program strength.

The analysis above is based upon was based upon the 46 clients served over the course of the 13-14 program year, but some of these clients may have entered in spring of 2014 meaning they would have had less opportunity to be engaged in services and receive a full compliment of services available. Similarly some of these 46 clients may have entered in 2012 or 2013, been served for some of 2013-14 and exited after only a few months of the program year. However twenty-eight of the 46 clients included above were enrolled the entire 2013-14 program year. Table III below captures the same data above but just examining these 28 clients.

Table III: Services Delivered **Service**	**Total**	**Ave/ Client**	**Details-Comments**
SCID Assess.	N/A		Discussed above
Active Caseload			The average caseload was calculated by obtaining the caseload at the start of each month and dividing by 12. The average caseload was 40.5 with a range of 32 to 49. The caseload did increase over the year as in July and August the caseload 34 and 33 and by the spring it ranged from 43-47.
CBT Session	777	27.75	The average number of CBT sessions is 30% higher with these more engaged clients than with the full client census (above) and fully 22 of the 28 clients had at least 15 sessions and ten was the fewest number.
Med Mgt. Consult.	327	11.68	Ten of 28 clients had no medication management consultation and two had one each, suggesting that these clients were not utilizing medication. Among the 18 clients who were using medication ten clients had at least 18 sessions and an additional four had at least five sessions. Data in the previous table also describes a relatively high number of family consultations related specifically to medication (134). As per above, improved charting will enable PREP to track medication consultations with outside prescribers and no interpretation of the level of medication consultations conforms with the proscribed PREP model of at least one consultation with every client, regardless of whether they are using medications.

Table III: Services Delivered			
Family Engagement and Family Group	70	2.5	Family engagement numbers above related to case management, psycho-education and medication consultation provide ample evidence of successful family engagement. While among more active clients, the average number of MFG sessions rose from under two to 2.5, the increase is not significant. Twelve of he 28 clients had no MFG and of the seven clients 18 and under, only three had MFG sessions and none had more than three. Given that the contract stipulates that MFG is a six-module program the data reveals that none of the younger clients (18 and under) met this threshold and four didn't have any MFG sessions. As noted above Friends & Family Groups are being offered on alternate weeks, potentially a good bridge to MFG, but not a viable alternative. The evaluation recommends that PREP find administrative and clinical strategies to increase friend and family member involvement in both F&F groups and MFG.
Voc'l / Educ'l Support	684	24.42	As in Table II, this component was the most consistently delivered with all clients receiving at least one and 23 of 28 clients receiving at least ten sessions.

The service dosages were higher across all service components among the 28 clients that were enrolled the full program year, suggesting that they were more engaged in services. However, a concern remains related to inconsistency in recording and/or delivering medication consultations and the very low rate of participation in MFG. What's more, a close examination of client-level data makes it difficult to gauge the consistency with which clients are experiencing each component in a coordinated way. Clearly defining phases of treatment, as described above, would help clarify this and make it easier to manage clinician case loads as each provider could have a balance of pre-treatment, engaged, or transitioning to aftercare clients.

One factor that may have impacted the lower number of intakes, the failure to engage families and to deliver more consistent services relates to staff turnover. Retention in mental health programs is a well-recognized concern, cited in the President' New Freedom in Mental Health Commission which stated that without significant attention to workforce development in the mental health field, all of the Commission's goals were largely unattainable. Indeed in a Community Living Brief published by the Independent Living Research Unit the following amplification on this issue was identified.

> "Although staff shortages affect all levels of professionals, including psychiatrists, social workers, and psychologists, the problem is especially daunting for mental health workers whose jobs do not require advanced degrees, for example case managers, frontline hospital staff, community treatment workers, and mental health technicians."

It is worth noting that PREP relies almost entirely upon staff who do not posses advanced degrees. It is also worth noting that the majority of PEI programs were impacted by staff turnover to a significant degree.

Table IV, below, depicts the timing of staff turnover and the resulting staffing levels throughout the year. Direct Service Clinicians are coded in black, administrative support is shaded light and administration and supervision is shaded dark. As noted, PREP's program relies heavily

upon staff without advanced degrees and while paying salaries comparable to other community based mental health programs can't compete with public sector or HMOs and PREP's heavy investment in training makes experienced PREP clinicians highly marketable. So it is no surprise that PREP experienced significant turnover during the program year. Indeed, over the twelve-month period ten staff exited the program. This turnover could well be a contributing factor to the difficulty experienced sustaining involvement of family members in MFG and the challenges in sustaining consistency in charting and data entry. While family engagement and consistent data entry may have been impacted by turnover, it is worth noting that except during the month of December, PREP did have at least three therapists on staff, with four being in place from April through the end of the program year. December was also the only month without supervision from an Associate Director. It is worth noting that a Peer Advocate was in place and providing IPS services throughout the entire year and indeed has been a consistent PREP provider for over 24 months. But clearly staff retention is an issue and one acknowledged by PREP leadership.

Table IV Staff Retention

Title	FTE	J	A	S	O	N	D	J	F	M	A	M	J
Therapist/Care Manager	1												
Case Manager	1												
Staff Therapist	0.53												
Therapist	1												
Staff Therapist	1												
Therapist	1												
Staff Therapist	1												
Family Partner	1												
Nurse Practitioner	1												
Care Advocate (IPS)	1												
Research Assistant													
Receptionist/Admin. Assistant	1												
Clinical Program Manager	1												
SCID Assessment Supervisor													
Associate Director	1												
Medical Director	1												
Associate Director	1												

The issue of staff turnover is discussed in more detail under EQs # 6 and 7.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

To evaluate program impact, the evaluation examined changes in client symptoms, medication adherence, and functioning, as well as levels of psychiatric hospitalizations. To measure changes in symptoms, functioning and medication adherence PREP utilized a battery of standardized assessment tools identified in Column 2 below. A brief summary of each instrument is provided below.

PHQ-9. The Patient Health Questionnaire Depression Scale (PHQ-9) is a 9-item depression scale from the Patient Health Questionnaire (PHQ). It yields a single score ranging from 0 to 27 that yields both provisional diagnosis of depression and a measure symptom severity. The PHQ-9 has proven to be sensitive to change over time. It has been validated in a variety of U.S. practice settings and used successfully in international contexts.

GAD-7. The Patient Health Questionnaire Anxiety Scale (GAD7) is a validated 7-item measure of generalized anxiety scale from the Patient Health Questionnaire (PHQ). It yields a single score ranging from 0 to 21 that yields both provisional diagnosis and a measure symptom severity.
MARS. The MARS is a 10-item self-report scale of medication adherence that is specifically designed for individuals with psychosis. The MARS assesses willingness and ability to take oral medications, as well as perceptions of medication side effects. The MARS is only completed by consumers who are currently being prescribed medication for psychosis at the time of evaluation.
QSANS-QSAPS. Both tools involve the provider assessing the level of positive and negative. symptoms manifest in the client using the Quick Scale for the Assessment of Positive Symptoms (QSAPS) and the Quick Scale for the Assessment of Negative Symptoms (QSANS). On both scales, providers are asked to rate the presence of positive and negative symptoms on a scale of 0 to 100, with the following response anchors: 0= "Absent," 20= "Minimal/Questionable," 40= "Mild/Minimal," 60= "Moderate," 80= "Marked," and 100= "Severe." Responses associated with positive symptoms (e.g. hallucinations, delusions), disorganized symptoms (e.g. disorganized speech, disorganized behavior, agitation/aggression), and negative symptoms (e.g. affective flattening or blunting, alogia, avolition, anhedonia, and asociality) were summed and averaged to create 3 scales. Two items were also added to assess distress associated with hallucinations and delusions, respectively.
Global Functioning Scale. The GFS Social scale assesses the "quality of peer relationships, level of peer conflict, age-appropriate intimate relationships and involvement with family members" (Cornblatt et al., 2007). The GFS Role scale assesses performance in school, work and domestic responsibilities. Both scales provide an assessment of functioning that accounts for age and stage of illness, that avoids confounding functioning with symptoms of illness, and that are specifically designed for use with individuals in prodromal and recent on-set phases of psychosis (Cornblatt et al., 2007). Each of the two scales is assessed with a one-item measure of functioning. Both are rated on a 10-point rating scales and detailed criteria is provided for each response option. The same scale is used to make ratings of current functioning, highest functioning in the past year, and lowest functioning within the past year.

The table below includes the use of p-value to project the degree to which the change described could be attributed to the PREP intervention or could have occurred randomly. Another way to express this is that the p-value is a measure of the degree to which the change in measure is statistically valid with the lower the p-value the higher the validity. Generally, a value between zero and .05 is viewed as being highly valid, a p-test value between .05 and .1 having low level of validity and a p value over .1 having no significant validity. Scores related to all measures except medication adherence and functioning decrease to reflect a reduction in symptoms, the MARS and GFS scales increase with improved adherence and functioning. As can be seen from Table V, all outcomes trend in the right direction with all symptoms showing signs of reduction, functioning improving and medication adherence increasing.

Table V: PREP Impact on Client Condition

Symptom	Tool	N	Baseline	Post	Difference	p-value (1-tailed)
Depression	PHQ9	19	9.26	6.21	3.05	0.022
Anxiety	GAD 7	19	6.53	4.58	1.95	0.018
Med. Adherence	MARS	11	6.64	7.00	0.36	0.320
Psychosis						
Positive	QSAP	19	37.55	29.87	7.68	0.105
Distress	QSAP	19	29.08	20.42	8.66	0.107
Negative	QSAN	19	48.63	39.75	8.88	0.059
Disorganized	QSAN	19	29.09	22.14	6.95	0.068
Functioning	GFS	24	50%	79%	29%	0.158

The strongest and most valid gains were in relation to reductions in anxiety and depression. In relation to depression a score of 5-9 indicates mild depression with

a score of 10 representing moderate depression and a score of 4 indicating minimal depression. Hence, PREP clients moved from moderate depression at intake to the lower end of mild depression. In relation to the GAD 7 measure of anxiety, a score of between 5-10 represents moderate anxiety with a score below five representing mild anxiety. PREP clients on average moved from moderate anxiety to mild anxiety. In relation to evidence of psychosis, clients achieved moderately significant improvement in relation to Negative psychotic symptoms and in relation to disorganized thinking. Again, in relation to all of the above measures, the trend lines were in the direction of improvement.

As Table VI illustrates below, PREP clients also experienced significant reductions in psychiatric hospitalization events (-54%) as well as a reductions in total hospitalization days (-34%). Given the very significant reduction in hospitalization events, the relatively small reduction in hospitalization days is surprising until you examine client-level hospitalization data. Voluntary hospitalization days showed a reduction consistent with the reduction in intakes, but involuntary hospitalizations were significantly impacted by two clients one of whom was hospitalized involuntarily while in PREP for 67 days and another client who was hospitalized for 162 days. If these clients were omitted from the analysis the number of involuntary hospitalization days would drop by 229 days, resulting in a total decline of 459 hospitalization days and an even more significant 67% drop in days hospitalized. The impact of these two clients' hospitalizations masks significant improvement among the remaining clients.

Table VI : Hospitalization Intakes and Days Year Prior to PREP & While Enrolled

	Intakes			Hospital Days		
	1-Year Pre-PREP	During PREP	Change	1-Year Prior	During PREP	Change
Voluntary	11	9	-2 (-18%)	138	76	-62 (-45%)
Involuntary	59	19	-40 (-62%)	540	372	-168 (-31%)
Total	60	28	-32 (-54%)	678	448	-230 (-34%)

Table VII: Client Hospitalization Days

Hospitalization Days	**#**	**%**
Clients who reduced #	27	59%
Clients who maintained (at 0)	11	24%
Clients who increased	8	17%

Another way of viewing PREP impact on hospitalizations is to measure the number and proportion of clients who either reduced the number of hospitalization days or who had not experienced hospitalization days prior to or during PREP. Fully 27 PREP clients experienced a reduction in the number of hospitalization days from the prior year and an additional 11 clients who experienced no hospitalization days either the year prior or the year while in PREP. Lastly, ten of 46 clients experienced at least ten days of hospitalization prior to PREP and experienced zero hospitalizations while in PREP. Table VII at left summarizes this. Clearly, over 80% of clients either reduced reliance on higher levels of care or maintained their level of care without hospitalizations. This meets one of the contract requirements of 80% maintaining their level of placement. Not only did 80% maintain that level just shy of 60% decreased it.

Nonetheless, the PREP program is designed to engage and support ***any*** individual experiencing early psychosis and it is worth considering how PREP might be better able to identify client disengagement early and provide intervention and support to prevent extended hospitalization use by even just two clients. The challenge of identifying clients with potential for intense need for long-term hospitalization and effectively intervening with those clients to prevent or at least reduce hospitalizations is discussed under EQ # 7.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

In order to assess client satisfaction, PREP went well beyond gathering data on a narrow definition of satisfaction, administering the Working Alliance Inventory (Short Form), a 12-item survey that across multiple studies has been a very strong predictor of positive client outcomes. In addition, PREP administered Naik and Bowden's (2008) Service Satisfaction Scale, an 18-item assessment that assesses satisfaction with services along a number of very specific and critical domains of service delivery. As Tables VIII and IX demonstrate clearly, PREP clients are extremely satisfied with services. Table VII summarizes the data captured in the 25 clients who were in the program for at least six months during the program year 2013-14. As reflected below, the questions ask respondents the frequency with which specific client-clinician relationship qualities were manifest. The Working Alliance Inventory uses a seven-point scale and with the exception of items 4 and 10 (which should be reverse scored) the lowest average response was 4.8 (Item 2) and the highest was a 5.58 (Item 7). The distribution of scores shows that the vast majority of clients found the positive qualities always or very often present and on the other end of the scale only about 20% of clients found positive relationship qualities absent. Clearly, the vast majority clients felt positively about their relationship with their clinician.

Table VIII Working Alliance Inventory Short Form

Question	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	Ave
	1	2	3	4	5	6	7	
1. My clinician and I agree about the steps to be taken to improve my situation.	4	1	2	2	4	2	10	4.88
2. What I am doing in therapy gives me new ways of looking at my problem.	4	2	2	1	3	4	9	4.8
3. I believe my clinician likes me.	3	1	2	0	1	4	14	5.52
4. My clinician does not understand what I am trying to accomplish in therapy	*12*	*4*	*4*	*2*		*1*	*2*	*2.40*
5. I am confident in my clinician's ability to help me	3	1	2	2	2	4	11	5.2
6. My clinician and I are working towards mutually agreed upon goals.	4	0	3	2	1	5	10	5.12
7. I feel that my clinician appreciates me.	3	0	2	0	2	4	13	5.58
8. We agree on what is important for me to work on.	4		3	0	3	6	8	5.0
9. My clinician and I trust one another.	3	1	2	1	3	4	10	5.16
10. My clinician and I have different ideas on what my real problems are	*9*	*3*	*4*	*1*	*1*	*3*	*4*	*3.42*
11. We have established a good understanding of the kind of changes that would be good for me.	3	2	1	1	2	7	8	5.08
12. I believe the way we are working with my problem is correct.	3	1	1	2	5	4	8	5.04

Table IX below summarizes the data related to client satisfaction with a wide range of services with this data also describing overwhelmingly positive client satisfaction. Here a five-point scale is used asking respondents to score the degree to which they agree or disagree with statements about services. The only item that was rated less than a 3.5 (the standard measure of satisfaction on this five-point scale) was the first item that is related to the difficulty clients experienced finding help in the first place. While more outreach and community education on the part of PREP might increase this score, this one item is more reflective of the mental health system than it is of the PREP program itself and is something cited in multiple national studies as being a significant problem, as delays in access appropriate treatment have been shown to translate into much poorer long-term outcomes. Otherwise all scores were above 3.5. Scores that approached a 4.0 average related to the convenience of the location, adequate time for appointments, ease in scheduling appointments, opportunities to discuss troubling thoughts, having a better understanding of their mental health problems and feeling that PREP had helped with their recovery. Three items exceeded a 4.0 average--feeling that they were treated with respect, feeling hope for their recovery, and knowing who to contact if they need help. All of these are extremely important factors in any effective treatment program. In particular the degree to which clients felt that they could access services, appointments, and meaningful support, all reflect a program that clients felt was operating effectively and meeting their needs. The responses go a long ways toward mitigating concerns described above about staff turnover.

One aspect of the responses to this survey warrants mention. While the average scores on every item show high satisfaction with program services, three respondents were responsible for every response indicating 'never' with two of these respondents answering never to every single item and the other answering 1 or 2 to every item. The scores from these three respondents significantly diminished averages across all items. One of those who responded 'never' to all questions was the client who was hospitalized 162 days which could indicate significant failure to engage this client or very possibly that the client was symptomatic and simply checked boxes. On the other end of the spectrum, the client who responded never or rarely to all questions is a client who had experienced 120 hospitalization days in the year prior to joining PREP and none while in PREP. Regardless of why these three clients responded as negatively as they did, clearly the overarching sentiment among clients was that PREP was responsive to their needs in all dimensions.

Table IX: Service Satisfaction Survey Results Statement	Strongly Disagree	Disagree
1. When I first had mental health problems it was easy for me to know where to go to get help	8	4
2. It was easy for me to see the PREP team once I had been referred	3	2
3. I felt I was seen by PREP quickly enough after my doctor (or someone else) had referred me	3	0
4. My initial contact with a PREP team member was useful	3	1
5. I am able to schedule appointments with PREP at times that are convenient for me	3	0
6. I am seen in a place that is convenient for me	3	0
7. I am given enough time at each appointment	3	0
8. I am offered enough appointments	2	1

9. I am/was offered support with structuring my day e.g. social activities	3	1
10. I am/was offered help to cope with troubling thoughts and feelings relating to my experiences	2	1
11. I am able to discuss medication options for me and their effectiveness	3	0
12. I have the opportunity to discuss any side effects of my medication	2	2
13. I feel actively involved with my treatment plan	3	2
14. I am treated with respect and dignity	3	0
15. I feel that PREP gives me hope about my future recovery	3	0
16. I feel I have a better understanding of my mental health problems and how to cope should things be difficult again	3	0
17. I know who to contact at any time if I am in need of help	3	0
18. I feel that involvement with PREP has helped with my recovery	3	1

One concern that is an extension of PREP's not engaging significant numbers of families to attend MFG is that there was no family satisfaction data to analyze. The evaluator would recommend the implementation of a simple satisfaction survey for family members, hopefully in a context of a far higher percentage of families engaged in treatment planning and MFG.

Given the high levels of staff turnover, the complexity of the PREP model, the need for intensive training before implementing the model and the ongoing need for consistent clinical supervision, the evaluator developed a staff survey to track staff readiness for delivering services and the sufficiency of training, clinical supervision, and administrative support—all factors that could have been impacted by staff turnover. As Table X demonstrates (below), three-fourths of the clinicians agree or strongly agree that they are prepared to deliver CBT and feel that they receive adequate clinical supervision and administrative support. What's more, when the survey includes all PREP staff, between 75-80% of staff agree or strongly agree that PREP effectively engages clients and family members and contributes to clients achieving recovery. However, clinicians did not feel adequately trained in MFG and did not feel prepared to deliver MFG. Moreover, one clinician strongly disagreed with being prepared to deliver either MFG or CBT and only one of seven respondents felt that turnover was not impacting the quality of services delivered. An examination of hire dates indicates that two therapists were hired in April 2014, one in late April and this could explain why one clinician did not feel prepared for performing these functions. Whatever, the case, the survey data suggests that once staff is on board, they do feel trained and able to deliver services

Table X: Staff Satisfaction Survey—First four statements were only asked of therapists (4) while the last questions included both clinicians and managers and administrative and research support (7)

Statement	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I feel fully prepared to deliver CBT with clients	1 (25%)	0	0	0	3 (75%)
I feel fully prepared to facilitate MFG groups	0	1 (25%)	2- (50%)	1 (25%)	0
I have received good training in CBT.	1- 25%	0	0	1 (25%)	2 (50%)
I have received good training in MFG.	1 (25%)	2 (50%)	0	1 (25%)	0
I have consistent access to clinical supervision	1 (25%)	0	0	1 (25%)	2 (50%)
Staff turnover has not had a significant impact on the quality of PREP services.	2 (28.6%)	2 (28.6%)	2 (28.6%)	1 (14.3%)	0
There is adequate administrative support for PREP.	0	2 (28.6%)	2 (28.6%)	2 (28.6%)	1 (14.3%)
I am confident that the treatment provided by PREP is helping clients achieve recovery.	0	0	1 (14.3%)	5 (74.2%)	1 (14.3%)
PREP does a good job of engaging clients when they first seek treatment.	0	0	1 (14.3%)	4 (57.1%)	2 (28.6%)
PREP does a good job of engaging family members.	0	0	1 (14.3%)	3 (42.9%)	3 (42.9%)

and that clinical supervision is accessible as needed. The survey results suggest the need for some kind of adjustment to staff induction to ensure that a therapist isn't still feeling unprepared to do their job five months after having been hired. The survey was administered in late September 2014. In wrestling with evaluation findings, PREP leadership has identified a staffing adjustment that will help address staff readiness to deliver the full range of PREP interventions. See EQ # 7.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The satisfaction data above shows clearly that clients felt that services were responsive to their needs. The program targeted a high-risk population where early intervention has demonstrated great promise for reducing long-term hospitalization and fostering recovery. PREP also served a highly diverse population with over 2/3 of clients being from demographic groups that are historically under-served. By all measures, the PREP program is responsive to the population targeted by the contract.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Schizophrenia is one of the most common and devastating of mental illnesses, generally beginning in late adolescence or early adulthood and lasting a lifetime. It is estimated that this single disease accounts for about 2.5 - 3% of US healthcare expenditures. (Mauskopf, JA, David, K, Grainger, DL, Gibson, PJ, 1999). Although the disease occurs in a socioeconomic cross-section of the population, long-term treatment costs tend to fall disproportionately on Medicaid, as chronic schizophrenia sufferers age off parental health insurance and are unlikely to have stable employment through which private health coverage would be available. (Marcus, FC, Olfson, M, 2008)

Once schizophrenia has manifested itself, the prognosis for sustained recovery is poor. Within the first five years of the disease, fewer than 14% show sustained recovery, and perhaps 30% achieve stable remission over the longer term (Insel TR, , 2010). Life expectancy for schizophrenia sufferers may be shortened as much as 15-25 years. In addition to the loss of both quality and duration of life, there are serious cost implications for treatment of physical health conditions of this chronically ill population. Key physical health issues include much higher risks of cardiovascu-

lar disease, obesity, smoking, and substance use, as well as the consequences of physical inactivity, homelessness, misadventure, and suicide. (Chang, C, Hayes, RD, Perera, G, Broadbent, M, Fernandes, A, Lee, W, Hotopf, M, Stewart, R, 2011). In delivering an intervention program to treat psychosis early in the disease, PREP is clearly meeting a critical BHRS priority. What's more, PREP is employing multiple evidence-based practices in treating early psychosis. As Table VIII demonstrates, prior to enrolling in PREP, clients found accessing mental health services very difficult and thus PREP is also serving a population that had had difficulty finding either effective services or any services prior to enrolling in PREP. By any measure, PREP is addressing a clear BHRS priority with services aligned to its mission, vision and values.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The deep dive into PREP data revealed a program that was achieving very strong outcomes, but that also was beset by a number of operational challenges, including:

Staff turnover is clearly having a negative impact on service delivery, particularly as relates to staff involved in MFG delivery, including Family Partner, AA and clinicians who must complete an intensive MFG training in order to deliver the model to fidelity. A one-day training in MFG was delivered to all SMC PREP staff in July which should improve the entire staff's understanding of the role of MFG and its importance. Delivering the core treatment intervention, CBTep also requires intense training and clinical supervision. As the staff survey indicated, while most clinicians felt strongly that they were trained and prepared to deliver CBT, most felt that they were unprepared to deliver MFG. This points to the challenge imposed by turnover and the reality that complex, costly training in either CBT or MFG can't be delivered every time a single staff member is hired. The evaluator and PREP leadership spoke at length about this issue. See the plan to address this challenge under EQ # 7 below.

Low Involvement of Clients in MFG. MFG is a complex approach to implement to fidelity and failure to engage large numbers of clients is likely related to the turnover problem. While PREP engaged 91 family members and engaged them in a significant level of treatment planning, including family involvement in treatment planning, case management, psycho-education and medication consultation. But this engagement did not translate into a sufficient number of families participating in either F&F groups or MFG. MFG is a critical component of PREP because MFG is how PREP educates family members about psychosis, helping them to identify symptoms that correlate with relapse and helping them develop a long-term recovery plan through which family members can support the client after graduation from PREP. The introduction of a Friends & Family Group that now meets alternate weeks, is a step in the right direction, but with only 8 families engaged in this and fewer in MFG, less than 1/4th of PREP families appear touched by family groups of any kind. It is important to note that PREP defines 'family' liberally so clients whose immediate family are not considered a resource by the client, can look outside the traditional family definition to include friends, neighbors, partners, etc.

Need for strategies for identifying potential high-end users. As described at length above, two clients used 67 and 162 hospital days respectively significantly reducing the percentage drop in hospital days. While the data shows that while in PREP 29% had zero hospitalizations and another 54% of clients reduced their hospital days while in PREP (i.e. 83% of all clients), to maximize the fiscal benefit to the County and to alleviate client suffering, it is important to identify evidence of treatment disengagement, presenting symptoms, or other indicators that could predict developing crisis and find ways to intervene to prevent a crisis or at least to reduce the length of

hospitalization. Conversation with PREP leadership on this topic led to a number of identified strategies outlined in EQ # 7 below.

Lack of a definition for what constitutes an 'engaged client, when a client 'drops out' or 'graduates' can obfuscate outcome data and make caseload planning more challenging. The emergence of this issue resulted from the deep dive into hospitalization data and going beyond treatment dosage averages by examining client-level data. This deeper analysis of data illustrates the kind of program improvement efforts that can emerge from honest reflection on data. PREP maintains far more client data than any PEI program and hence is better able to identify problems that could go unnoticed if all that is reviewed is trends in symptom management, client satisfaction, and hospitalization days and averages related to service delivery numbers. While the data in all these areas points to PREP having a very positive impact upon over 80% of clients, this deeper dive into the data reveals ways in which the program could be still stronger. A discussion of how all of the areas for improvement identified in this passage translated into relatively simple changes to the PREP model that will likely result in still better outcomes for more PREP clients. See EQ # 7 below.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

PREP leadership has been unflinchingly eager not just to comply with the evaluator's requests for data, but to dig even deeper than requested, not to find ways to dispute initial findings, but to use the process to find more areas where improvements could be made. Development of this report required far more time from staff and the evaluator than any other report, as just as it appeared all the data was in, another layer of data was found that shed a different light on program operations. For each of the areas for improvement identified above, PREP leadership, in consultation with the evaluator, identified clear strategies to further strengthen the program.

Stronger PREP Leadership and Focus on SMC. Since receipt of a highly competitive *Centers for MediCare Services Innovations* grant, Felton Institute, the agency responsible for developing and implementing PREP has been replicating the model in two new counties, at virtually the same time that it started PREP in SMC. In a series of interviews, PREP leadership was candid that this process both over-extended leadership and impeded consistent attention to each of PREP's five sites. But they also noted that the replication process had led both to the development of stronger PREP leadership and a better idea of how to implement and oversee the model. Felton has promoted the Stockton PREP Director to PREP Network Director. In an interview with Al Gilbert, Felton COO, he made it clear that her highest priority is to focus upon using this evaluation to implement the strategies below and then to apply lessons learned from this evaluation to other sites. Adriana Furuzawa was the original Program Director in Stockton under her leadership Stockton has emerged as the strongest PREP site with little staff turnover, high morale, and a strong MFG program. Ms. Furuzawa was deeply involved with the evaluation and her experience in Stockton will be a real strength as she directs proposed program improvements outlined below.

Program structure. Analysis of client-level service utilization data revealed patterns in service utilization that suggest that rather than being a straightforward treatment model from assessment and intake to discharge, PREP is really comprised of three phases of treatment:

1) **Engagement and Pre-treatment**. Most clients do not undergo an assessment, meet with a clinician to discuss treatment and then immediately enter a clearly defined number of CBT, medication consultations, IPS sessions, and MFG. Rather, some clients may participate in case management, meet with a clinician a few times and get

acclimated to the idea of intensive treatment. For some clients it could take weeks and in some case months for them to become fully committed to treatment. PREP leadership feels it is critical that it identify markers during this phase where treatment resistance and/or evidence of specific symptoms could predict an emerging crisis. Both of the clients who consumed high levels of hospitalization did so during what might be viewed as pre-treatment, indeed, one client had only had one session with a clinician before being hospitalized. This highlights the importance of PREP developing a better understanding of how some signs may suggest immanent crisis. To be fair, no treatment program can completely prevent hospitalizations among this population and especially among clients who have had only one session, but PREP leadership is committed to researching this challenge and identifying a better capacity to do just that.

2) **Intensive PREP Treatment.** During this phase, almost no PREP clients experienced hospitalization and there was far more consistent service delivery. However, PREP leadership was alarmed that MFG participation and medication consultations were not consistent even among clients in this phase. They have committed to meeting to identify a clear definition of what it means to be in this phase, definitions that will specify threshold dosage levels of CBT, IPS, medication consultation and MFG that constitute 'being engaged in PREP treatment.' This will greatly clarify the degree to which PREP managers can monitor and ensure that clients in each treatment phase are receiving the level and mix of services likely to produce the most positive outcomes.

3) **Transition to Community.** There also appears to be a third phase of treatment where the client has stabilized and is beginning to transition to recovery in the community. During this phase, the focus of treatment may be solidifying housing, employment or education and developing a clear relapse prevention plan. In discussions with PREP leadership, completion of a written relapse prevention plan would be considered as a viable definition for program 'graduation' with the absence of a written relapse prevention plan indicating that the client had not graduated.

The adoption of a clearly defined phased treatment model has important implications in relation to addressing all of the areas identified for improvement throughout this evaluation. The definition of dosage levels for CBT, medication consultation, IPS and MFG will clearly delineate program expectations. PREP leadership knows that these levels can be achieved, as they have been in the Stockton program as well as in Monterey, the two CMS-funded sites that have been operating for almost two years now. With the focused attention of the new PREP Network Director, support from other PREP leadership and direction from this report, PREP has a roadmap for moving forward and improving the consistency with which all clients access the full PREP model. By making it more explicit the precise range of service delivery of each program component, program managers and clinical supervisors, and clinicians will have a clearer shared understanding of what constitutes PREP to fidelity and with the staff adjustments described below, PREP leadership is confident it can both reduce staff turnover and mitigate the impact on treatment services when the inevitable staff transition occurs.

Staff Retention & Staff Assignments. For some time PREP leadership has been wrestling with strategies to reduce staff turnover and mitigate the impact of transitions that are inevitable. Currently, new clinicians must assume caseloads of the departing staff member almost immediately, virtually ensuring that new staff will be asked to implement CBT and MFG before they can possibly have received sufficient training to adopt the approaches to fidelity or to feel confident in their performance. Staff satisfaction survey results suggest that this has occurred in SMC. In and of itself, this will contribute to staff turnover, as staff who are feeling overwhelmed and stressed will often seek to exit the situation. PREP leadership has designed a staffing structure that will

respond to this dynamic. New clinicians will be assigned clients who have just entered the program and are in Phase I while the caseload for the departing clinician will be divided between other clinicians who have been trained and have been delivering the full range of PREP treatments. This will contribute to a number of key program improvements. First, and most importantly, it will allow new clinicians to get acclimated to the program, conducting outreach activities, engaging new clients and families and providing case management services, including encouraging families to become involved in F&F and MFG groups. This will also ensure continuity of quality care for clients while affording new clinicians time to complete training and participate in case conferences where other, more experienced clinicians discuss treatment issues with a clinical supervision. With this experience under their belt, the new therapist will gradually add clients moving from pre-treatment to Intensive PREP Treatment having been involved with the program for weeks or months, instead of days.

Improve Consistency in Data Collection & Charting. PREP has ambitious goals. It was borne to serve as a model to address a national crisis—the extraordinarily poor care afforded to individuals wrestling with psychosis, despite ample evidence of benefits to be derived from implementing EBPs. To achieve its larger vision: creating a replicable model of early psychosis treatment requires a level of consistent, reliable data collection to methodically document results and to identify signs of program drift from the model. This data is important to funders, but still more important to program leadership, as before any model is ready for broad dissemination the model must be clearly defined, carefully documented, and demonstrate consistent results across sites. The evaluation helped PREP leadership identify a significant number of glitches in their data collection protocols and caused staff to pull from multiple databases. The evaluation shed light on these deficiencies at the same time that it made clear the benefit to having easily accessible data on key indicators of smooth program operations, consistent service delivery, accurate charting, and improved client outcomes. PREP leadership has assumed responsibility for continuing to improve its data collection and charting protocols to create data reports that more easily generate, clear, and consistent. Achieving their long-term vision depends upon it.

It is important to note, that it would have been very easy for PREP leadership to mask over most every area of operational improvements that have been identified simply by not offering up more and more data to analyze. Without question, this evaluation delved more deeply into client level data, both in terms of service delivery, individual client dosages, client outcomes and satisfaction than any other PEI program. And it is critical to note that outcomes for PREP are generally excellent, client satisfaction is high, hospitalizations are being significantly reduced even when considering clients who may not have been fully engaged in treatment and that over 80% of clients are benefiting significantly.

Despite the operational shortcomings identified above, PREP has delivered excellent results. However, PREP is an extraordinarily complex model that has only been in operation for six years and leadership is still wrestling with its experience replicating the program, researching emerging trends in treatment of early psychosis, and exploring how to address operational challenges. The evaluator has been impressed with how honest and unflinching PREP leadership has been, seeking solutions to improve the program rather than providing excuses. Over the next two months, PREP leadership has committed to developing a written plan for program improvements and sharing it with BHRS leadership. The plan will include both specific staffing and operational changes, including service delivery thresholds for each component, as well as mid-term indicators that, within six months, should provide evidence that these changes are having an impact on service delivery and client outcomes. While the level of effort involved in developing this report was extraordinary, it points to how an evaluation driven by data can illuminate both program successes

and areas where improvement can enable the program to continue to improve and to expect still better outcomes in the future.

Section V Demographic Summary

The data table below and the tables that follow have been customized for different types of programs. It will be used by BHRS in reports to MHSOAC.

Table X: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**			
	#	%			
Male	32	70%			
Female	14	30%			
Other					
Age		#			
Children 0-13		0			
Transition Age Youth 14-25		85%			
Adult (26-59)		15%			
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity		**Clients**		**Program Staff**	
	#	%	#	%	
Caucasian	16	34.8%	15	71.4%	
Latino	15	32.6%	0	0%	The absence of Latino staff is a concern that is somewhat mitigated by PREP having one bilingual Spanish therapist.
African American	1	4.3%	3	14.3%	
Asian	6	13%	3	14.3%	
Pacific Islander	4	8.7%			
Native American	0	0%			
Multi-Ethnic	1	2.2%			
Other					
	Clients		**Staff**		
Home Language	**#**	**%**	**#**	**%**	
English	31	67.3%	15	71.4%	
Spanish	10	23.9%	1	4.8%	
Cantonese	0	0%	0	0%	
Mandarin	0	0%	1	4.8%	
Tagolog	1	2.1%			
Other	3	6.5%	2	9.6%	
Underserved Pops Served	**#**	**%**	**#**	**%**	Data was not completed on most Under-served populations.
LGBT					
Blind/Vision Impaired					

Table X: Demographic Summary					Source of Data
Deaf/Hearing Impaired					
Veterans					
Homeless	2	4.3%			

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: 65% of clients served are from demographic groups that historically under-served. Also, a high proportion of clients at intake indicated that they had had difficulty accessing services and the research indicates that individuals with psychosis can go years without accessing appropriate services.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: PREP targets individuals who have just begun manifesting symptoms of psychosis.		
II-3) Access or Linkages to Care		
Details: No evidence of close coordination with other providers was presented.		
II-4) Reduction of Stigma		
Details: [Insert info on community education when it is provided.]		
II-5) Screening for Needs		
Details: PREP conducts extensive assessment of psychiatric needs and case management functions work with clients on education and vocational needs. No tools provided demonstrate screening for housing, health, or social/recreational needs, however, these needs are also addressed through case management.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Part of CBTp is to help clients manage trauma associated with psychosis.		
II-7) Specific Risk Factors		
Details: Early psychosis is highly correlated with a conversion to full psychosis and schizophrenia.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Program is located in San Mateo. Client surveys indicate high levels of satisfaction with the location.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Family Partners and Care Advocate	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education,	Delivery of hundreds of family case management and individual case management services has required PREP to become more integrated into the	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
child welfare)	SMC systems serving the population, however, no formal partnerships with other systems have been developed.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services		X		
Details: As noted above, 65% of the clients served are from demographic group that are historically under-served and individuals with psychosis historically are challenged to find appropriate treatment.				
1-B) Psycho-Social Impact of Trauma		X		
Details:				
1-C) At-Risk Children, Youth and Young Adult Populations		X		
Details: Individuals with psychosis are at extreme risk of unemployment, school dropout, homelessness, co-occurring, chronic health conditions, isolation, premature death and suicide.				
1-D) Stigma and Discrimination		X		
Details: PREP is supposed to conduct extensive community education but has not presented evidence of this occurring.				
1-E) Suicide Risk (See 1-C above)		X		
Details:				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of trauma related to the symptoms of psychosis and common life experiences associated with psychosis (homelessness, hospitalization, under-employment, etc.).				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness		X		
Details: By definition, PREP targets and intervenes early with individuals who are just developing early psychosis.				
2-C) Children and Youth in Stressed Families		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of family stress.				
2-D) Children and Youth at Risk for School Failure		X		
Details: Clearly TAY participants who are experiencing high levels of trauma and psychosis are at high-risk of school failure.				

Table III: Alignment with SMC MHSA PEI PRIORITIES				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details:				

Section I Agency & Program Description
I.A. Description of Program Services

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

In 2013-14 Puente de la Costa Sur (Puente) delivered Project SUCCESS services at three Southcoast schools, La Honda Elementary, Pescadero Middle School and Pescadero High School. In addition to Project SUCCESS groups where coping skills, communication, decision-making and other social skills, are introduced, Puente delivers a range of educational and prevention services in large, schoolwide presentations, particularly at the high school. The SUCCESS groups and the school-wide presentations also serve as a point-of-entry to individual counseling services available at all three schools. Groups are designed to meet once per week for 8 weeks with the exception of the high school group which has met consistently once per week since being launched in December. However, as this report will delineate, the extremely small size of the schools Puente serves makes it very challenging to achieve the number of students required to sustain a series of eight week groups. For example, at the elementary level, there has been no 5th grade class at Pescadero Elementary for three years, with only 25 fifth grade students enrolled at La Honda Elementary. For the first time in three years, in 2014-15, the district has fifth grade classes at both elementary schools. Nonetheless for 2013-14, with such a small sample size from which to draw, Puente has been unable to offer more than one group at La Honda elementary due to the small class size from which to draw students and has faced similar challenges at the Middle School. Puente has been resourceful in identifying other ways to have a positive impact in Southcoast and overcoming the challenge posed by working in such small schools.

The Project SUCCESS counselors are all either licensed or pre-licensed MFT or LCSW's. High school age youth are either self-referred or are referred based on teacher recommendations. The elementary and middle school participants are assigned based on the Project SUCCESS Assessment. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs; train and consult on prevention issues with school staff; coordinate with the school; refer students and families needing substance abuse treatment or mental health services in the community and provide follow- up. The following four program components are utilized in Project SUCCESS:

The Prevention Education Series - An Alcohol, Tobacco and Other Drug prevention program conducted by the Project SUCCESS Counselor with small groups of students.

Individual and Group Counseling - Project SUCCESS counselors conduct time-limited group

counseling at school for students following participation in the Prevention Education Series; individual assessments and individual sessions are provided as needed.

Summer Supervision Groups. With funding from SMC BHRS and local foundations, each Summer Puente Hires Youth ages 14-18 from the community to work at Puente. The youth are given a two-week orientation and divided into supervision groups by age and placement. The Project SUCCESS team provides weekly supervision for each group. Puente utilizes the Project SUCCESS model to educate the youth about drugs and alcohol prevention. The youth are assigned for working roles throughout the area, some working at the local YMCA camp, school district recreation programs, local businesses, non-profits and ranches. The program provides a foundation of understanding of issues related to drugs and alcohol while then providing students opportunities to use their skills, work with adults and other peers, and develop assets that are consistent with the Search Institute model.

Referral - Students and parents who require treatment, more intensive counseling, or other services are referred for individual therapy at Puente or SMC BHRS.

Parent Programs - Project SUCCESS includes parents and teachers as collaborative partners in prevention through parent education programs,

- ***Enough Abuse*** is a Spanish only parenting model sanctioned by the county. Two Project SUCCESS team members were trained in the approach and deliver this program. The group is a one-time event and focuses on increasing awareness of Child Abuse. Puente incorporated a section on Drug and Alcohol Prevention Strategies and how the use of drugs and alcohol is often intertwined with incidents of Child Abuse in our society. This program and training also provided a cultural competency training opportunity Puente staff and the ability to utilize a model that specifically targets the Latino community.
- ***Zumb***a. Puente has held Zumba classes twice per week at Puente. The group serves largely Latino mothers struggling with depression, and fits into the framework of Project SUCCESS because the group is based on providing a culturally significant and healthy forum to bring together the parents in the community. Puente's Project SUCCESS team took some time at the beginning, middle and end, to provide basic information about drug and alcohol prevention strategies and to promote our work within the schools.
- ***Group de Madres*** was an (11) session group. This group was based on a process group model and served Latino women and parents who were identified as having had difficulties with maternal depression and parenting skills.
- ***The Spanish Parenting 2013*** is Project Success' group comprised of six sessions focused on developing positive parenting skills.

In addition, Puente serves as the Differential Response program for Southcoast. So, for example, if someone calls Children's Protective Services (CPS), CPS could elect to refer the case to Puente. Similarly, if Puente identifies a child, parent, or family in need of services more intensive than those available through Project SUCCESS, Puente need not work through ACCESS and can simply enroll the individual or family in need for more intensive services provided by Puente. In this way, Project SUCCESS can serve as a point of entry to comprehensive services for anyone in Southcoast identified as in need of those services. In this way, Puente serves as a de facto one-stop-shop for behavioral health services.

I.B. Research Basis for Approach

Identified by SAMHSA as an evidence-based approach to prevention, Project SUCCESS builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective measures such as those promoted by the Search Institute. The San Mateo County Health System has adopted the Search Institute's 41 Developmental Assets as the framework to use when addressing the needs of young people in the community. This strengths-based model works with youth, their families, schools and community to promote the forty-one (41) internal and external assets needed to build positive self-esteem, the ability to solve problems and build healthy social relationships. Research has shown that youth with high levels of assets over thirty (30) are more likely to succeed academically, maintain good health, and contribute to their community. For the 2014-15 program year, Puente is adopting a range of Search Institute tools designed to document the degree to which Project SUCCESS participants are developing assets and building resilience. The Search Institute's 58-item, forced choice assessment will enable Puente to assess each student in terms of the number of developmental assets they possess at intake and then measure again when the student exits the group program, providing valuable data to validate the degree to which the groups are building student assets. The aggregated pre-test assessment data for a group of students will also inform the group facilitator as to areas where the group may have common areas where assets need to be developed, enabling the program to target these assets for development.

Two studies were examined by SAMHSA in determining SUCCESS to be an evidence-based practice:

1) Morehouse, E. R., & Tobler, N. S. (2000). Project SUCCESS final report: Grant number 4 HD1 SP07240. Report submitted January 26, 2000, to the Center for Substance Abuse Prevention, U.S. Department of Health and Human Services.
2) Vaughan, R., & Johnson, P. (2007). The effectiveness of Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) in a regular secondary school setting. Unpublished manuscript.

Both studies utilized a revised version of the American Drug and Alcohol Survey (ADAS) to measure changes in attitudes and behaviors related to ATOD. The survey was revised so that it could be administered in one class session. A drug use index was created by summing the scores of self-reported use of 13 drugs: tobacco, alcohol, marijuana, crack, cocaine, heroin, inhalants, LSD, PCP, amphetamines, meta-amphetamines, ecstasy, and "andrenochomes," a false drug included to identify students who over-reported drug use.

In one study, for the purposes of analysis, students were classified as ATOD users and nonusers based on their pretest use status. At posttest in the first year of a study involving alternative secondary school students:

- Self-reports showed a 37% decrease in ATOD use among Project SUCCESS participants relative to students in the comparison group who did not participate in Project SUCCESS ($p < .001$).
- Of the students using ATOD at pretest, 23% of those in the Project SUCCESS program reportedly stopped ATOD use, whereas only 5% in the comparison condition reported stopping ($p < .001$).
- For those Project SUCCESS students who did not discontinue ATOD use, there was a significant reduction in reported ATOD use across the drugs assessed, ranging from 17% ($p < .05$) to 26.6% ($p < .01$).

- At follow-up in the second year of the same study, among Project SUCCESS students who reported using ATOD at pretest, 33.3% reportedly stopped using alcohol, 45.0% reportedly stopped using marijuana, and 22.9% reportedly stopped using tobacco (all p values < .05).

In another study, 21 months following the intervention, regular secondary school students who were involved in Project SUCCESS were less likely than students in the control group to report having ever used marijuana, having smoked in the past month, and having ever used any other substance alone (all p values < .05).

Among pretest users, 21 months following the intervention:

- Among students who used alcohol and cigarettes at pretest, students in the control group were 2.32 times more likely than similar intervention students to report continued use of alcohol and cigarettes; 4.3 times more likely to report use of alcohol, cigarettes, and marijuana; and 5 times more likely to report use of illicit substances (all p values < .05).
- Among students who used alcohol, cigarettes, and marijuana at pretest, students in the control group were 4.16 times more likely than similar intervention students to report continued use of alcohol and cigarettes; 4.54 times more likely to report continued use of alcohol, cigarettes, and marijuana; and 7.33 times more likely to report use of illicit substances (all p values < .05).
- Among students who used illicit substances at pretest, students in the control group were 4.76 times more likely than intervention students to report continued use of alcohol and cigarettes; 5 times more likely to report continued use of alcohol, cigarettes, and marijuana; and 2.7 times more likely to report continued use of illicit substances (all p values < .05).

It is important to note that the Project SUCCESS model generally and the Search Institute's 41 Developmental Assets was not designed for rural, highly Latino, low-income populations where low literacy is commonplace. However in a meta study by Peter Benson that examined programs and communities adopting models based upon the intentional creation of community wide connections and partnerships focused upon providing youth with opportunities to develop assets, it was found that no matter the ethnic population, income levels or size of the community or community setting, youth benefit tremendously from "asset accumulation." A part of Puente's Project SUCCESS is its Summer Supervision program which is an excellent example of the intentional establishment of an expanding community partnership focused on providing summer opportunities for adolescents to participate in community functions, work with adults, build personal competence and accumulate assets.

I.C. Target Population, Number Served and Sites

In 2013-14 Puente's Project SUCCESS provided site-based group and individual counseling services at three La Honda-Pescadero Unified School District sites: La Honda Elementary, Pescadero Middle School, and Pescadero High School all located in the Southcoast community of Pescadero. In 2014-15 Pescadero Elementary School had sufficient enrollment to open a fifth grade class for the first time in three years and so Puente is now offering groups at all four Southcoast schools. Puente's contract for Project SUCCESS did not include projected numbers served and only indicated

Table I: Student Data

School	Enrollment	Free-Reduced Lunch	English Lang. Learner	Hispanic	Anglo	Mixed
Pescadero High	93	74%	50%	71%	27%	2%
Pescadero MS	67	72%	65%	77%	23%	1%
La Honda Elem	68	77%	68%	76%	23%	1%
Pescadero ES	110	73%	72%	75%	23%	2%

the need to target populations that are historically under-served. According to a report submitted by Puente to SMC BHRS on July 17, 2014, Project SUCCESS served 97 students across sites, with over 60% (60) identifying as Latino/a, a demographic group identified by BHRS as being under-served. However, as this report will describe, the evaluator had concerns that the numbers reported to the evaluator, were lower than those reported to the county. During a structured interview with Puente CEO and Project SUCCESS Clinical Director some context was provided related to the relatively low numbers of groups and group participants and to personnel changes that impacted data collection. Puente staff described the extraordinarily small number of students attending each school, an assertion verified by the evaluator by obtaining district enrollment data from the California Department of Education. Table I, below, provides demographic and enrollment numbers for each school. As you can see, there are fewer students enrolled in the schools served than would be enrolled in a single grade in most urban schools. As will be described low enrollment and other district policies and practices described under Evaluation Question # 1, create a challenge in trying to sustain groups with sufficient student participation.

Table I also demonstrates that Puente clearly serves under-served populations as the percent of Hispanic students exceeds 70% in each school, as does the percentage of Free-Reduced Lunch, a data proxy for living in poverty and the majority of students are English Language Learners, another risk factor in terms of school success. What's more, Southcoast is consistently identified in County social welfare, juvenile justice, and behavioral health reports as an under-served community, another indicator that the Puente program is addressing populations targeted by the MHSA and San Mateo County Prevention and Early Intervention programs.

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of meetings that included the evaluator and Puente's Clinical Director Joann Watkins. During these conversations plans were made for Puente to deliver:

- Pre-Post data on students using the Hemingway Measure of Adolescent Connectedness Survey and the Coopersmith Self-Esteem Inventory, both tools used by Puente in the past;
- Satisfaction surveys of parents participating in parent groups; and
- Data on student participation in counseling sessions, case management and referrals to other resources.

At the end of the program year, when the evaluator contacted Ms. Watkins to begin receiving data, she indicated that, "my data collection was not done well this year" and then in a second interview she went on to explain that she had lost a key staff person due to maternity leave and that with an under-staffed team, data collection had been neglected. Over the course of two or three weeks, Ms. Watkins worked with the evaluator to provide what data was available and reassured him that Program Year 2014-15 would be different. Instead of reports with student level data, the evaluator received a combination of global summaries, limited participation data, pre-post data on 15 elementary and middle school students who participated in Project SUCCESS groups, and thirty-nine high school student satisfaction surveys, but no parent or teacher satisfaction data. The report that follows tried to utilize the data provided, but with so little data to work with the evaluation could only make limited definitive findings and so focused more on the scope and scale of services delivered, the challenges faced in trying to implement a school-based program under challenging conditions and how data collection could be improved to ensure that in 2014-15 Puente could report more effectively on its productivity, impact on clients, and satisfaction of parents and school faculties.

At one point in the process, the County's Mental Health Services Act Coordinator asked the evaluator to see if it were possible to use data provided to the county as part of Puente's semi-annual report. Data from Puente's end-of year report was a useful resource in the evaluation, but the report also included some data that initially conflicted with data provided to the evaluator. For example, productivity levels described in the County report greatly exceed the numbers served as reported in client-level data provided for the evaluation, however, during structured interviews with Puente leadership it was revealed that the end of year report included individual counseling numbers for non-Project SUCCESS students. Data collection issues are discussed in more detail in Section III below.

From dialog with the Clinical Director and Director of Prevention Services the evaluator learned that Puente's Project Success was contracting with the Search Institute to obtain both training to ensure that Project SUCCESS adhered to evidence-based practices in introducing and supporting development of the Institutes 41 developmental assets. Puente also purchased Search Institute's pre and post assessment tools expressly designed to document impact and to measure at program entry and exit changes in the number of developmental assets for each student. With this in place, it is hoped that the 2014-15 evaluation can be far more robust and useful to both Puente and the County.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

Each evaluation question is discussed separately below.

Data provided by Puente was limited to pre-post test data on the Hemingway Connectedness Scale with a sample size of 15 elementary school students, with no data on outcomes from the high school. Participation data indicated that across all sites, a total of 27 students participated in groups with 14 of these students also accessing individual counseling services. The contract did not stipulate a projected number of students to be served. Satisfaction data was only collected after one high school presentation on healthy dating. Taken together this represents a significant shortcoming in relation to data collection, seriously impeding the evaluation from assessing program impact on students. The challenges experienced by Puente in collecting and reporting data are underscored by a discrepancy between what was reported to the county in terms of participation and what was reported to the evaluator, a discrepancy that was clarified in the process, as Puente had reported individual counseling numbers for both Project SUCCESS and non-Project SUCCESS counseling services.. ***As the report makes clear, this says a good deal more about a single year in which data collection procedures were not implemented consistently than it says about the quality of the program.*** Indeed, in the end-of-year structured interview with Puente leadership, they candidly acknowledged their data collection challenges, presented plans to ensure that 2014-15 would be far better, and described a number of strategies employed in 2013-14 to overcome the relatively small numbers of students engaged in group and individual counseling services via summer programming, targeted prevention strategies, and strong engagement of the parent community.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

As discussed in Section I and summarized again under EQ#7, Puente faced formidable challenges in offering the Project SUCCESS model within the La Honda Pescadero Unified School District. Four sites each with extremely low student populations result in exceedingly small pools of students from which to draw. At the elementary school level, since the program only serves students age 10 and over, this meant that the total number of age-eligible students for elementary groups was about 25. What's more, the schools were uniformly slow in mailing out and collecting the passive consent forms required to be on file before a student can be served, with collection extending well into October. Finally, all four schools prohibit students from being excused from class to attend groups, a restriction that requires students to attend during their lunch period. Collectively, these barriers pose significant challenges. In the structured interview that was conducted after an initial draft report was developed, the Puente CEO and Clinical Director described how every year she meets with district administrators to try to address both the slow process of gathering permission slips and that prohibiting students from having groups scheduled during class time each represented formidable challenges to implementing the model. But to date, district practices have not changed.

Puente provided a print out of participation levels and number of treatment services delivered for each student enrolled at the three schools. This table did not include participation levels in groups so the service levels reflect only individual treatment services. Tables II-IV, at right and below, identify the school, the students served by that school (using unique identifiers), the age of the student, the number of individual counseling services received and the date that their Project Success group began meeting.

As can be seen, a total of five groups were delivered across the three sites with two at La Honda Elementary, two at Pescadero High and one at Pescadero Middle School. Twelve La Honda students, five middle school and ten high school students participated in groups for a total of 27 students across sites.

Table II: Student Participation: La Honda Elementary School—Unique Identifier	Age	# of Tx sessions	Group Start
Group 1 students			
10298	12	31	12-2-13
10583	11	12	12-2-13
10625	11	0	12-2-13
10641	11	28	12-2-13
10643	11	0	12-2-13
10820	11	0	12-2-13
11059	12	0	12-2-13
11155	11	7	12-2-13
11176	11	0	12-2-13
12458	11	0	12-2-13
Group 2 students			
12127	11	7	2-4-14
12457	11	12	2-4-14
Totals La Honda			
LH total students in groups	12		
Tot LH students in Indiv. Couns.	6		
Tot Indiv. Sessions	97		
Ave sessions per LH student	16.16		

In terms of individual counseling, a total of six students participated in individual counseling at the elementary school, 2 at the middle school and 6 at the high school for a total of 14 students participating in individual counseling with an overall average of 16 sessions per student. While there is no productivity level specified in the Puente contract, the County requires reports from all MHSA-funded programs, reports that sought productivity, satisfaction and impact data. From its July 17, 2014 end-of-year report to the County, Puente reported serving 67 students in individual counseling, a significantly larger number than captured in the data provided to the evaluator which reflects 14 students receiving individual counseling. But the difference is easily explained as in its report to the County Puente was reporting on both Project SUCCESS students and non-Project

Table III: Student Participation Pescadero Middle School Student Identifier	Age	Indiv. Tx Sessions	Group start
11337	13	0	1-14-14
11338	13	0	1-14-14
12505	13	0	1-14-14
12506	12	24	1-14-14
12507	13	1	1-14-14
Tot # in groups	5		
Total Students in Indiv. Counseling	2		
Total Sessions	25		
Ave session/ child	12.5		

SUCCESS students. The students that did receive individual counseling services participated in an average of between 12.5 sessions (middle school) and 17.2 sessions (high school).

While the discrepancy in numbers reported to the evaluator and the County is a concern, it is likely the error in the County report resulted from the program being short-handed with a key staff person being absent due to a maternity leave. Nonetheless, the relatively low number of students participating in groups and in individual counseling was a concern to the evaluator and while Puente leadership described ways in which it had provided additional services and supports for parents and high school students (below), there remains a need to develop a strategy that effectively engages more students in either individual or group sessions and that programming can begin earlier in the school year. See EQ # 7 for a discussion of this issue.

Table IV: Participation Rates Pescadero High School & SUCCESS Totals Pescadero High School			
Group 1			
11283	17	46	12-10-13
11534	17	12	12-10-13
11535	16	1	12-10-13
Group 2			
10776	14	0	4-5-14
10792	17	0	4-5-14
10956	17	24	4-5-14
11162	15	2	4-5-14
11535	16	0	4-5-14
12283	17	17	4-5-14
12284	17	0	4-5-14
Pescadero High Totals			
Total High School Students in Group	10		
Total Students in Individual Couns	6		
Total Indiv. Svcs.	102		
Ave sessions per student	17		
Puente Project Success Totals			
Total Students in Group	27		
Total Students in Individual Couns	14		
Total Indiv. Svcs.	224		
Ave # Sessions per student	17.2		

In the structured interview conducted after evaluation data had been reviewed and a draft report developed, Puente leadership explained the challenges faced in delivering the programs in relation to small school sizes and other barriers described at the beginning of EQ # 1. More importantly, leadership described the steps taken to either overcome these challenges with new initiatives at each school site to ensure that the student and parent community were served effectively.

At the high school, Puente offered a range of prevention activities targeting low income and new immigrant populations, programming that is being expanded to the middle school in 2014-15 to expand the range of services available there.

In 2013-14, a Puente clinical staff member and two chaperones took 20 female high school students to the Princess Project in Santa Clara to pick out a prom dress and accessories free of charge. Most of the students came from rural low-income families and wouldn't have otherwise been able to afford to buy a dress and attend the prom. Puente used the Princess Project as a platform for conveying information about dating, refusal skills, and alcohol and drugs. Puente reported that feedback from this event was very positive and that many of the young men in the high school commented that they would like to have a similar program that would allow them to either borrow tuxedo's or be given appropriate clothes to wear to the prom. Puente plans to conduct outreach to community partners to try and establish a donor fund that Puente can make this possible for the

next academic year. Puente promotes healthy dating because it believes that it goes hand in hand with drug and alcohol prevention education. Puente staff believes that this type of event is extremely valuable as a way to bring a greater sense of self-esteem and sense of self-worth to the students. The hypothesis is that if you feel good about how you look, and understand the boundaries of healthy dating, then you will be less likely to use drugs and alcohol as a way to mask the fear and insecurity when self-esteem and confidence are lacking. This is an excellent example of addressing a tangible, social need of a low-income, historically underserved population and using it as both a gateway to providing important prevention messages while also cementing Puente's status in the Southcoast community.

In addition to the Princess Project, all high school students attended a healthy dating/domestic violence prevention workshop developed and put on by Project SUCCESS staff. The topic of healthy dating has come up continually as a concern among students, teachers, and family members. Because this topic is tied closely to student use of drugs and alcohol Puente wanted to target the whole school and provide a comprehensive overview, and handouts with phone numbers for the National Domestic Violence Hotline, and the Child Abuse and Prevention Hotline. In addition students were given the Power and Control wheel of physical and sexual violence. Student feedback on this event was positive with many students asking that the workshop be done in small groups with more time for dialogue, and question and answer. This valuable information will be shared with the School District Staff in hopes that the school might allow more time for the session and to enable it to be presented in small groups in 2014-15. Puente views this presentation as a potential gateway for students to participate in Project SUCCESS groups. See also data from the healthy dating presentation discussed under EQ # 3.

Another new high school program is an excellent example of Puente combining prevention education focused on drugs and alcohol while also providing opportunities to build student developmental assets by working in the community. In 2013-14 Puente initiated a Summer Supervision Group that supervised twelve students in community placements throughout Southcoast and provided group counseling and a two-week induction program during which students were introduced to a range of alcohol and drug prevention education. The small group, prevention education approach was consistent with the Project SUCCESS model. As with the Princess Project, this initiative meets a tangible student need (employment), leverages other community partners where students are placed to perform work contributing to community organizations while also building their skills. As with the Princess Project, this kind of school-community initiative not only meets the needs of the participating students, but it builds Puente's stature in the community, critically important to success in a small, rural community. While not part of the 2013-14 evaluation, Puente reported that in 2014 twenty-nine students participated in this program, an indication of its being well-received by students and that the community valued the program enough to identify additional slots for students in positions in the community.

The middle school will benefit from Puente adapting the healthy dating program for middle school students. The schoolwide presentation of important information about dating and alcohol and drugs will also provide Puente with an opportunity to invite students to explore the issues more deeply in the Project SUCCESS groups. During structured interviews with SUCCESS leadership, it was reported that Puente staff has been participating in middle school staff meetings and that as a result middle school have increased significantly in 2014-15.

At the elementary level, Puente offers groups designed to serve students ten years of age or older, essentially all fifth graders. In 2013-14 (and for the two preceding years) only one of the two elementary schools had sufficient enrollment to have a fifth grade class (La Honda) and so Puente

had a pool of only 25 students from which to draw, a situation that has changed in 2014-15 with Pescadero Elementary now offering a fifth grade class, as well as La Honda. As a result, Puente will offer groups at both sites this year. Puente is working with the district to arrange for Project SUCCESS to include the entire fifth grade class in groups in 2014-15, which should boost participation levels significantly.

Puente also initiated a range of parent education groups operated from the high school that have successfully engaged parents and sustained consistent participation. In 2014-15 early intervention parenting groups will be offered in Spanish and English at both the elementary schools and middle school. Groups include:

- Launched in June 2013, a project SUCCESS counselor began a weekly, six-session process group with twenty-one Spanish speaking women with children. This group has been designed to be self-motivating and loosely organized around promoting "healthy family systems."
- An eleven session group, Grupa de Madres serves six parents;
- A Zumba group that meets twice a week, targets parents suffering from depression providing culturally responsive exercise to combat depression for over 35 women; and
- Another one-time parenting skills group focused on child and domestic abuse prevention drew forty parents.

Lastly, Project SUCCESS serves as a point-of-entry into Puente's more comprehensive array of behavioral health services since Puente is the Differential Response program for the Southcoast community. As a result, Project SUCCESS students or families identified as in need of intensive services can bypass the ACCESS system and enroll in those services with Puente. For 2013-14, 43 students and 18 adults have received the level of services their condition warrants. What's more, because Children's Protective Services is so distant to Southcoast, Puente often functions as a de facto extension of CPS as Puente clinicians are asked often to conduct initial assessments of cases referred to CPS. While these functions are not supported by PEI funding, this important collaborative role is relevant to understanding how Project SUCCESS and Puente serve as a single-point-of-contact behavioral health service for a highly under-served community.

It should be noted that the evaluator worked with another community agency offering Seeking Safety groups in Southcoast. It had the same difficulty engaging sufficient numbers of clients to sustain groups at all. This agency adjusted to meet Southcoast needs by offering Seeking Safety content via individual counseling sessions and using these sessions to build a relationship with clients and the community. It is planning to reinstitute groups in Southcoast in January. Similarly with Puente, while the group and individual counseling data above reflect a considerably low penetration rate for school-base services, especially at the elementary and middle schools, Puente has been very resourceful in initiating new programming that addresses unmet student, parent and community needs, engages and serves historically under-served students and parents, and includes collaboration with key community stakeholders. In doing so, it is building its stature in the school and community and hopefully will contribute to stronger engagement of students in important group and individual counseling.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

Evaluation of Project SUCCESS' impact upon clients was to have involved analysis of both the Hemingway Connectedness Scale and the Coopersmith Self-Esteem inventory. These instruments are described in the Puente's report to the County dated July 17, 2014, one month after the end of the program year.

> "All of our youth participants are administered the Hemmingway connectedness scale and the Coopersmith Self-Esteem inventory, pre and post group. In addition participants are asked to complete a satisfaction survey at the end of each 8 week cycle."

However, when the evaluator sought pre-post data, there were only 3 students with pre and post-test data for the Coopersmith Self-Esteem and data from 15 La Honda Elementary School participants who completed the Hemingway Connectedness Scale. As noted above, data collection suffered considerably with the exit of a key staff person due to maternity leave and the lack of pre-post data should not be viewed as a reflection on the quality of services delivered to students but more just the result of a small program being hamstrung by the lose of a key staff person and this resulting in a failure to collect data consistently.

The 57-item Hemingway Scale did provide data covering a range of issues and domains. While individual student level data was not available for analysis, aggregated data from 15 elementary school respondents was provided. Respondents rate how true each of the 57 statements are using a five-point Likkert Scale with a score of 1 for Not at all; 2 for Not Really; 3 for Sort of True; 4 for True; and 5 for Very True. The overall average score across all 57 items was precisely the same for both the pre and post test, a score of 3.6, indicating no change from between the pre and post test across all clients. As has been found in other PEI evaluations, averages across respondents can mask important differences. With student level data on participation and pre-post test, for example, it is possible to assess the degree to which higher levels of participation contributed to better outcomes, or whether outcomes were achieved by students involved both in group and individual treatment. This kind of analysis was not possible with Project SUCCESS as assessment data was not available at an individual student level so it assessment results could not be correlated with participation levels, a limitation that should be corrected in 2014-15. However, the Hemingway provides ten subscales allowing for analysis of change in the following specific areas.

- Relationship with the neighborhood
- Relationships with friends
- Relationship with siblings
- Relationship with teachers
- Reading practices
- Self-esteem
- Relationship with parents
- Relationship with school peers
- Feelings about the future
- Future

Analysis of each subscale follows. Each subscale was comprised of six statements except for the scale related to reading habits, which had four and the scale related to the future, which had five. Table V (on the following page) shows summarizes responses. Given that across scales there was no change between the pre and post-test, it isn't surprising that there was very little variation in scores in the subscales. Declines were reflected in student relationships with neighborhood, friends, siblings, teachers and peers. While gains were manifest in relation to self-esteem, school involvement, and in terms of the students' view of their future, only the gains in self-esteem and

view of their future were statistically significant. Declines in student relationships with the neighborhood and siblings were statistically significant. Other changes were not significant.

As noted above, in 2014-15 Puente is utilizing a pre-post test tool developed by the Search Institute that should elicit more robust data that is specifically designed to elicit change in student asset development. The evaluator will work Puente staff to ensure that this assessment data can be integrated with student participation data to allow for analysis of the impact of increased program involvement upon asset development.

Table V: Hemingway Connectedness Subscale Summary			
Subscale	Pre	Post	Change
Neighborhood	3.15	2.95	-.20
Friends	3.25	3.13	-.12
Self Esteem	3.16	3.38	+.22
Parents	3.93	3.97	+.04
Siblings	4.13	3.91	-.22
School	3.36	3.46	+.10
Peers	2.83	2.81	-.10
Teachers	3.79	3.71	-.08
Future	3.26	3.62	+.37
Reading	2.73	2.52	-.21

Puente leadership also described how for 2014-15, the school district had agreed to provide student attendance, discipline referral and suspension data on students participating in Project SUCCESS groups, thereby providing another form of data that could be useful to measuring the impact of Project SUCCESS programming.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

As with the data on program impact, satisfaction data provided by Puente were responses from 32 students who had participated in a single prevention presentation, the healthy dating presentation. Hence there is no data capturing student satisfaction with either individual or group services. In the absence of satisfaction data from any elementary or middle school students or satisfaction data on high school students served in individual or group services, drawing conclusions about overall satisfaction with the primary components of the program is impossible. In the future, it is recommended that satisfaction data be collected at the last session of groups and last individual session at all sites, satisfaction data from teachers at all sites, and parents participating in parent groups.

Table V: Satisfaction Data After Healthy Dating Presentation. N = 32						
Question	Not Good at all	Not Very Good	Just OK	Pretty Good	Great	Excellent
	0	1	2	3	4	5
How would you rate this presentation?	4	0	13	6	8	1
How would you rate the presenter?	1	0	8	10	10	3
Was the information thorough and complete?	0	4	2	7	8	11

Student responses reflect both an endorsement of the value of the program while offering input into how it could be improved. Over half of respondents indicated that the presentation was just ok or not good at all. The presenter appears to have been better received with almost 75% of respondents indicating pretty good or better. Students were very satisfied with the content with 60% rating it excellent or great and 75% indicating that the information was pretty good or better.

Taken together, it would appear that students valued the information received and from further input provided to Puente staff, would appreciate the opportunity to have the information shared in smaller groups that would allow for more discussion and question and answer. Based upon this experience, Puente is asking school administration to facilitate the presentation being done in small groups. It is also planning to adapt the presentation for a middle school audience.

It is clear that Puente missed many other opportunities for data collection to verify satisfaction with Project SUCCESS, from clients at all sites at the last session of groups, with teachers and administrators and with parents participating in parent groups. The critique here is not that program is not of a very high quality or that clients are dissatisfied, it is that there is no evidence of satisfaction because the data was not collected. The importance of this goes well beyond conforming with an evaluation, it has to do with not getting direct client and stakeholder input into the program, input that can often help program leadership identify ways in which a program could be improved and/or areas of a program that are particularly effective or appreciated and should be sustained or expanded. For example, input from students about the healthy dating presentation has led Puente to get district cooperation in offering the presentations in smaller groups, allowing for more discussion and demonstrating to students that their voice matters. Similar information could be available in relation to all program components affording Puente with critical information to drive program improvement efforts and increase student engagement.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

From demographic data provided in the report to the County, it is clear that the demographic profile of the students served are consistent with the County's priority of serving populations that are historically under-served. What's more, the community served—Southcoast—has been identified in numerous county reports as being an under-served community. By these criteria, the program has been attempting to meet the needs of those populations identified in the contract. The Princess Project clearly targeted low-income, rural and Hispanic students and by collaborating with a Santa Clara project was able to help these students participate in prom activities while receiving valuable prevention information about drugs and alcohol. The summer Supervision Groups provided high school students with both jobs and income, along with prevention education related to drugs and alcohol. In addition, effective outreach to the parent community resulted in a significant increase in parent involvement in Puente programming. Of particular note are the Spanish-speaking parent group and the Zumba group, both being linguistically and culturally appropriate initiatives. Zumba provided culturally relevant exercise to help parents fighting depression, at the same time that the group was used to introduce parenting information and promote participation in other parenting groups. Taken together, while it is clear that there are numerous challenges in serving a small, rural community, Puente has shown great resourcefulness in ensuring it is addressing the needs of the under-served.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Project Success meets most of these criteria:

- It works upstream by engaging youth in elementary through high school, providing mental health services at the school site to make access to services easier;
- It introduces an evidence-based approach to prevention, building assets of students, helping them develop coping skills and educating them about the risks from drug and alcohol use and their alternatives; and
- It serves populations that have been historically under-served.
- As Puente serves as the County's Differential Response resource in Southcoast, students or families identified in Project SUCCESS as in need of more intensive services, can do so immediately. This places Pserves as a de-facto point of entry into the Puente's comprehensive continuum of behavioral health services and as an extension of Children's Protective Services.

However, Project SUCCESS falls short on providing evidence of the program's success in generating positive outcomes: boosting student use of coping skills, building assets, foregoing the use of drugs / alcohol, increasing their success at school, or satisfying its clients.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

The report has described a number of factors that have impeded effective delivery of services. Among those factors:

Extremely small enrollment at every grade level. The small number of students, particularly at the elementary and middle school levels, limits the pool of students from which to draw. More typically sized elementary and middle schools would have 4-5 times the number of students, significantly reducing the challenge in engaging sufficient numbers of students for a series of eight-week groups.

District requirement that groups not occur during class time. In most schools, students enrolled in individual or group counseling are routinely released from class for this purpose. This makes it far easier to sustain consistent participation. In La Honda-Pescadero, despite efforts on the part of Puente leadership, students participating in groups can only do so during lunch-time, a time that is historically viewed by students as being "their" time. This is a very significant barrier to group work and could explain by itself the low numbers in groups.

Slow school process gathering passive consent forms. In order to participate in Project SUCCESS groups, the school district must collect these forms signed by parents. This is a challenge in all schools, as school staff priorities are more focused on getting instructional programs launched than

in promoting or supporting counseling or after school programs. As a result, Puente is unable to launch groups until late fall.

Small staff impacted by maternity leave. Programs funded via P&EI funding do not receive funds for data collection and in most all instances operate with very lean staffs. In several evaluations, the departure of a single staff member resulted in some element of service delivery suffering. In one program it was its parent engagement, but in most, the first thing to be lost is a commitment to consistent data collection. Puente lost a key staff person due to maternity leave resulting in the Clinical Director performing dual roles. This contributed to data collection falling far short of what was expected. In the structured interview with the Puente CEO and Clinical Director, this shortcoming was acknowledged and both committed to ensuring that data collection practices are significantly strengthened. Evidence of this commitment is Puente's purchasing evaluation tools and training from Search Institute.

These challenges are not easily overcome and from the structured interview, it is clear that Puente has made significant efforts to work with the district to achieve changes that might make group services more accessible to students. It has also introduced a range of alternative programming to better serve the high school and parent communities. Nonetheless, the counseling program, particularly group and individual counseling at the elementary and middle schools are critical Project SUCCESS components reaching students early and helping them build developmental assets that can be foundational to their success academically and socially. Low engagement of these younger populations simply isn't compensated for by delivering more robust parent or high school programs. And Puente leadership understands this.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

In truth, during conversations beginning in June 2013, the evaluator had the impression that Project SUCCESS was a very well managed program, collected good data and would be one of the easiest of programs to evaluate. That Puente had challenges this year collecting data (as described above) should not necessarily be cause for concerns about the quality of the program, but does point to the need for significant improvement in their data collection processes. In addition, a review of the data that was available points to specific improvements are possible, particularly in the scale of services and the numbers served at the elementary and middle school levels. The following recommendations are made:

1. ***Search Institute adoption.*** Share with the evaluator the new tools and protocols that will be part of Puente's contract with the Search Institute, including specific pre and post-test assessment instruments, specific plans for when those instruments will be administered and with whom.

2. ***Consistent administration of pre-post assessments.*** Ensure that Search Institute Pre-Post Data for participants in groups and in individual work.

3. ***Facilitate analysis of the impact of higher levels of student participation in programming***. Ensure that data collected from Pre-Post tests, whether for individual or group work, can be provided at a student level in a spreadsheet or report that allows comparison of outcomes between students who participate in individual versus group work and to compare outcomes for students who participate with consistency with those who are not as engaged. The evaluator will work with Puente to facilitate this occurring.

4. ***Expand use of satisfaction surveys***. Satisfaction surveys can provide valuable data to program managers and to the county as to how well a program meets client needs. It can also facilitate specific input into how programming can be improved. Puente should administer satisfaction surveys with students and parents participating in both group and individual work at all four sites, as well as from teachers.

5. ***Obtain student attendance, suspension, and discipline referral data.*** Puente should follow up with the district to ensure receipt of data on student attendance, discipline referrals, and suspensions. This data is generally easily accessible by school districts and requires no work on the part of Puente other than seeking it and providing lists of participating students. But if the program is having a positive impact on these outcomes, the resulting report can only increase the district's commitment to the program. What's more, it would be invaluable data for Puente grant proposals and other funding requests.

6. ***Sustain development of new programming that addresses community needs and serves as a gateway to other programming***. Sustain expansion of parenting groups and Summer Supervision groups and use them as building blocks for establishing greater enrollment in other Project SUCCESS counseling services.

7. ***Increase engagement of students in the 5th grades at Pescadero and La Honda Elementary Schools and Pescadero Middle School***. This is perhaps the most important recommendation and yet the most challenging. It appears to the evaluator that Puente has approached the district to remove barriers to student participation in groups, but that the district is adamant about prioritizing classroom time over time devoted to building student assets, coping skills and understanding of the consequences of the use of drugs and alcohol. While it is common practice at other schools to release students for group counseling, this is not going to happen in Southcoast in 2014-15 and so Puente will have to use the same resourcefulness it has used with the high school students and parents to better engage students in middle school and high school. The expansion to the middle school of schoolwide education related to dating is one such strategy and working with the district to allow for Project SUCCESS groups to serve the entire fifth grade classes at La Honda and Pescadero Elementary Schools is another. Puente leadership indicated that 40-minute, whole-class groups have been launched during lunch at the elementary schools and at the middle schools, a lunch group has also been initiated.

Puente clearly did not engage sufficient numbers of elementary and middle school students and some of the reasons that impeded that engagement have been discussed. At least part of the challenge at the elementary school level had been that the last three years, the district only had one 5th grade class to draw from. In 2014-15, the district created two fifth grade classes, so this challenge will be abated to a degree. Puente was very resourceful in expanding programming at the high school and in relation to its work with parents. It appears that plans are in place that could build service numbers at both the elementary and middle school and in relation to data collection. Puente is to be commended for facing up to its challenges and developing plans for improvement in 2014-15. With significantly expanded data in hand for the 2014-15 evaluation, the evaluator is confident a fair and thorough evaluation can be conducted next year.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male	58	62%	1.0 FTE	16.6%	
Female	35	38%	5.0 FTE	83.4%	
Unknown	1	<1%			
Age	#		%		
Children 0-15	55				
Transition Age Youth 16-24	21				
Adult (25-59)	21		6.0 FTE		
Older Adults 60+					
Families (can include families with children or TAY)	61				
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	22	22.7%	3	50%	
Latino	65	67%	3	50%	
African American					
Asian					
Pacific Islander					
Native American					
Multi-Ethnic					
Other	10	10.3%			
Home Language	**#**	**%**	**#**	**%**	
English	18	19%			
Spanish	45	46%			
Cantonese					
Other (or declined to state)	34	35%			
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT	0				
Blind/Vision Impaired	0				
Deaf/Hearing Impaired	0				
Veterans	0				
Homeless	0				

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator. See table on next page.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Puente serves a clearly identified under-served community and initiatives such as the Princess Project and Summer Supervision program clearly targeted low-income students while the parent program offers programming culturally responsive to the Hispanic population.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Screening tools used at all four schools are designed to identify needs at an early age.		
II-3) Access or Linkages to Care	**X**	
Details: While not a primary component, students and families requiring access to other services can get referrals through Puente.		
II-4) Reduction of Stigma	**X**	
Details: Schoolwide and group presentations offer information that is intended to de-stigmatize behavioral conditions and educate students and parents about behavioral health.		
II-5) Screening for Needs	**X**	
Details: See II-2 above.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Building developmental assets can develop resilience and coping skills, as well as peer, family and school support when students encounter trauma.		
II-7) Specific Risk Factors	X	
Details: The primary risk factor addressed by Project SUCCESS is under-age drinking and use of drugs, but the program also provides prevention education related to unhealthy dating and domestic violence.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Three school sites in the La Honda Pescadero community, two elementary schools and one site that serves both middle and high school students.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Peers are used in the Summer Supervision program with paid students assigned to roles in the community and then the students meet in group to provide peer support.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	In addition to a very close relationship with the school district, Puente collaborates with an array of community agencies in placing students in the Summer program. Communication with child welfare is commonplace as is the practice of making	

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.	
	referrals to other service agencies including BHRS and primary care.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services	X	X	X	
Details: Southcoast has a highly discussed challenge in accessing mental health services, a gap addressed by Puente's co-location at all Southcoast's public schools.				
1-B) Psycho-Social Impact of Trauma	X	X	X	
Details: Building assets can build resilience enabling students to overcome trauma. The program does not explicitly target treatment for trauma.				
1-C) At-Risk Children, Youth and Young Adult Populations	X	X	X	
Details: As the demographic data in Section II describes, the school community is high poverty, with the vast majority of students being Hispanic.				
1-D) Stigma and Discrimination	X	X	X	
Details: Schoolwide presentations and group work are designed to address stigma.				
1-E) Suicide Risk	X	X	X	
Details: : Building assets can build resilience enabling students to overcome depression. The program does not explicitly target treatment for depression except for the Zumba group for adults.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X	X	X	
Details: Students and parents who seek out Puente services are most often doing so as a result of stress, trauma or depression.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	X	X		
Details: Assessments and group work can be instrumental in identifying students experiencing early onset, especially germane at the high school where more signs of serious psychiatric illness emerge.				
2-C) Children and Youth in Stressed Families	X	X	X	
Details: High poverty, rural and under-served families and youth are clearly living in stress**.**				
2-D) Children and Youth at Risk for School Failure	X	X		
Details: Clearly students lacking developmental assets are more at risk of school failure and increasing their stock of assets will build their resilience and capacity to succeed in school.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		
Details: While not primarily juvenile justice program, low-income students who do poorly in school , have limited future employment options and have low-resilience are more susceptible to the allure of crime.				

Section I Agency & Program Description
I.A. Description of Program Services

Formerly known as Youth and Family Enrichment Services, StarVista came into being when Youth and Family Assistance and Family and Community Enrichment Services merged in 2003. StarVista offers counseling, prevention, early intervention and education resources and services to more than 34,000 people throughout San Mateo County every year. One program operated by StarVista is the Early Childhood Community Team, a project supported with San Mateo County's Mental Health Services Act, Prevention & Early Intervention funding,

Early Childhood Community Team (ECCT) project incorporates several major components that build on current models already operative in San Mateo County. The ECCT is designed to support healthy social emotional development of young children. The ECCT is comprised of a community outreach worker, an early childhood mental health consultant, and a license-eligible clinician. BHRS PEI funding is supporting one team with hopes that StarVista can identify additional funding so there might be two teams something that has been accomplished, as StarVista now operates a North County team with MHSA funding supporting the clinical component and private funds and First 5 supporting the consultation and outreach components. The ECCT targets the geographically isolated Coastside community experiencing a significant degree of interpersonal violence, which has traumatic impact on families and young children. It is also a community identified in multiple County reports as being historically underserved, low-income, rural, and with many migrant farm residents.

While the ECCT delivered three distinct service modalities, in many cases a child or family identified as being at risk and referred to ECCT might benefit from all three of these services. Indeed, from the perspective of the community, the ECCT represents a systemic intervention that addresses the needs of children and families and builds the capacity of the community of service providers who work with these families.

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

The ECCT community outreach worker networks within the community and provides community based services to identify young families with children from birth to five with an emphasis upon children zero to three and connects them with necessary supports both as provided by ECCT and other community agencies. The community outreach worker also provides both home based and group based parent education services. Groups for families with young children, integrate concepts drawn from Brazelton's Touchpoints Program, the Parents as Teachers curriculum, the Promoting First Relationships curriculum, and the Circle of Security Parenting DVD, approaches in which ECCT team members have been trained. Participants learn how to use relationship-building and communication strategies when they deliver care and interact with children and families. The Touchpoints groups include fathers as well as mothers and other caregivers.

ECCT clinical services are delivered by ECCT licensed clinicians who provides focused services to families who have been identified as being in need by the ECCT community outreach worker. The clinician screens for postpartum depression and facilitates appropriate service plans with primary care and/or mental health services. The SV ECCT clinician has been trained in Infant-

Parent and Early Childhood mental health and/ or Child-Parent Psychotherapy (CPP). CPP model has been shown to be particularly effective with young families at risk due to trauma. The goal of CPP treatment is to support and strengthen the parent-child relationship as a vehicle to long-term healthy child development. With trauma-exposed individuals, these treatments incorporate a focus on trauma experienced by the parent, the child, or both. Sessions include the parent(s) and the child and can be conducted in the home. Individual parent, child, or family sessions may be added as needed.

Another ECCT team member, the Early Childhood Mental Health Consultant, focuses on supporting social emotional development in child care settings by providing early childhood mental health consultation. This service typically consists of the following activities:

- Observing the interaction of the caregiver(s) with young children;
- Observing a child's interaction with caregiver(s) and other young children;
- Consulting with the caregiver(s) regarding overall support of positive social emotional development;
- Consulting with the caregiver(s) on developmental or behavioral concerns regarding a specific child;
- Facilitating family and caregiver meetings; and
- Facilitating referrals for additional services for children and families

Historically early childhood mental health consultation services were operated by another agency that merged with SV and now SV operates all consultation in the county[Prior to launching the ECCT in Coastside, ECCT services were offered throughout the County. Since StarVista operated consultation in 34 sites in San Mateo County, including Head Start preschool programs, Early Head Start family childcare programs, and other programs in Redwood City, Daly City, South San Francisco, central San Mateo and East Palo Alto. Through these ten sites, childcare consultation reaches about 2000-2200 children, with consultants working with childcare settings ranging from those provided by licensed family day care providers, license exempt providers, and family/friends/neighbors.

I.B. Research Basis for Approach

The Mental Health Services Act proscribes that funding is used to adopt, adapt and implement prevention and treatment services that are evidence-based. The ECCT initiative is informed by the following evidence-based or promising practices and ECCT staff has been trained in or have utilized practices and principles from each of the following:

- The Circle of Security Parenting DVD
- Child Parent Psychotherapy
- Touchpoints
- Parents as Teachers
- Promoting First Relationships
- Early Childhood Mental Health Consultation.

Each model is described briefly, followed by a summary of the research base that supports the efficacy of each approach.

The Circle of Security DVD [Circle of Security Parenting Training© is a DVD parent education program offering the core components of the evidence-based Circle of Security protocol. This 4-Day seminar trains professionals to use an eight chapter DVD to educate caregivers. The program presents video examples of secure and problematic parent/child interaction in the zero to five age range, healthy options in caregiving, and animated graphics designed to clarify principles central to Circle of Security. Circle of Security Parenting implements decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling.

Parents as Teachers (PAT) is an early childhood family support and parent education home-visiting model. Families may enroll in Parents as Teachers beginning with pregnancy and may remain in the program until the child enters kindergarten. Based on theories of human ecology, empowerment, self-efficacy, and developmental parenting, Parents as Teachers involves the training and certification of parent educators who work with families using a comprehensive research-based and evidence-informed curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. The goals of the model are to increase parent knowledge of early childhood development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness and school success. Different curriculum materials are used for those working with families of children up to age 3 and those working with families of children from age 3 to kindergarten.

Home visitation is the key component of the Parents as Teachers model, with personal visits of approximately 60 minutes delivered weekly, every 2 weeks, or monthly, depending on family needs. Parent educators share research-based information and use evidence-based practices by partnering, facilitating, and reflecting with families. Parent educators use the Parents as Teachers curriculum in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting, and family well-being. Parent-child interaction focuses on promoting positive parenting behaviors and child development through parent-child activities. Development-centered parenting focuses on the link between child development and parenting and on key developmental topics (i.e., attachment, discipline, health, nutrition, safety, sleep, transitions/routines, healthy births). Family well-being includes a focus on family strengths, capabilities, skills, and the building of protective factors.

Parents as Teachers was established and first piloted in Missouri in 1981 to alleviate the learning and achievement gaps in children entering kindergarten. More than 2,000 Parents as Teachers affiliates are implementing the model, serving more than 250,000 children in more than 200,000 families across all 50 States and in other countries (including Australia, Canada, England, Germany, Mexico, New Zealand, Scotland, Switzerland, and Wales). Research studies have been conducted and supported by State governments, independent school districts, private foundations, universities, and research organizations, and outcome data have been collected from more than 16,000 children and parents. The intervention has been evaluated in four independent, randomized controlled trials and many quasi-experimental and qualitative studies, many of which have been described in peer-reviewed publications.

Touchpoints. This approach, developed by T. Berry Brazelton, is based on the concept of building relationships between children, parents and providers around the framework of "Touchpoints," or key points in early development. The quality of the infant-caregiver relationship is a risk or protective factor for infants' later development. Infants who develop a "secure" attachment relationship with the primary caregiver during the first year of life are more likely to

have positive relationships with peers, to be liked by their teachers, to perform better in school, and to be more resilient in the face of stress or adversity as preschoolers and later. Infants who develop an insecure attachment relationship are at risk for a more troublesome trajectory; factors associated with insecure relationships include maternal mental health problems, including depression, substance abuse, family violence, and unresolved grief. Because of the strength of influence of the infant-caregiver relationship, any factors that impact the infant-caregiver relationship play a determining role in the emotional functioning of the young child (Zeanah et al.,2000). As a specific program, one study finds that the Touchpoints model increases the parenting self-confidence of adolescent parents (Percy et al, 2001).

Child-Parent Psychotherapy. Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways.

CPP was developed in the 1980s through an adaptation of the infant-parent psychotherapy model, which was developed in the 1970s by Selma Fraiberg and colleagues. The first efficacy trial of CPP began in 1985. The Child Trauma Research Program began disseminating CPP through the National Child Traumatic Stress Network (NCTSN) in 2002. Since then, approximately 143 sites have implemented the intervention. Five randomized controlled trials have been conducted, and the findings from these studies have been published. In addition, reports have been written on the evaluation of dissemination efforts, including the dissemination of CPP within the NCTSN. Since 1996, more than 527 individuals have received training in CPP. Approximately 10 additional individuals per year have received CPP training through internships and fellowships with the Child Trauma Research Program, and other internships and fellowships in CPP are available through the Child Witness to Violence Program; the Tulane University Infant Team; the Louisiana State University Child Violence Exposure Program; and the Mount Hope Family Center, University of Rochester.

Early Childhood Mental Health Consultations (ECMHC). Early childhood mental health consultation builds upon the well- established field of mental health consultation, pioneered by Gerald Caplan in the mid-sixties. In Caplan's seminal work (1964), he outlined an approach that involves mental health professionals working with human services staff to enhance their provision of mental health services to clients. Similarly, in ECMHC, a professional consultant with mental health expertise "works collaboratively with Early Childhood Educatoin (ECE) staff, programs, and families to improve their ability to prevent, identify, treat, and reduce the impact of mental health

problems among children from birth through age 6" (Cohen & Kaufmann, 2000; revised 2005). Ultimately, early childhood mental health consultation seeks to achieve positive outcomes for infants and young children in early childhood settings by using an indirect approach to fostering their social and emotional well-being.

Studies on the impact of ECMHC in early childhood settings are increasing in complexity, and evidence of the effectiveness of this approach is mounting. In a clustered randomized control study of Chicago School Readiness Program classrooms, outside observers found that teachers receiving ECMHC had significant improvements in teacher sensitivity and enhanced classroom management skills, compared with teachers in classrooms without consultation (Raver et al., 2008). Observers also found that the classroom climates improved after consultation, with more positive interactions between teachers and children and fewer negative exchanges, in contrast to classrooms where no consultation was present. Staff members also rated themselves as significantly more able to manage children's difficult behavior after consultation in 9 of 11 studies reviewed by Brennan et al. (in press; see, for example, Alkon, Ramler, & MacLennan, 2003; James Bowman Associates & Kagan, 2003; Olmos & Grimmer, 2004). Finally, teachers have also generally reported lower levels of job stress after they receive consultation services (Green et al., 2006; Langkamp, 2003; Olmos & Grimmer, 2004). Teachers in classrooms with ECMHC services reported that children had fewer problem behaviors after these services were implemented (Bleecker & Sherwood, 2004; Gilliam, 2007; Perry, Dunne, McFadden, & Campbell, 2008; Upshur, Wenz-Gross, & Reed, 2008). Particularly, there is evidence that externalizing (aggressive, disruptive) behavior was less frequent after consultation (Gilliam, 2007; Raver et al., 2008; Williford & Shelton, 2008). Children with difficult internalizing (withdrawn, disconnected) behavior showed improvement in some studies (Bleecker, Sherwood, & Chan-Sew, 2005; Raver et al., 2008), but not in others (Duffy, 1986; Gilliam, 2007). Positive social skill development also accelerated for children with ECMHC services in several studies (Bleecker & Sherwood, 2003, 2004; Farmer- Dougan, Viechtbauer, & French, 1999; Upshur et al., 2008). Finally, there is evidence that when mental health consultation is available in early childhood programs, the rate of expulsion of children with difficult or challenging behavior decreases (Gilliam, 2005; Perry et al., 2008). While there is less evidence related to the impact of ECMHC interventions on longer-term outcomes for children and families, this is largely due to the complexity of such evaluations and that early childhood providers do not typically track these outcomes. Nonetheless, there is ample evidence that ECMHC has a positive impact upon child functioning in the classroom and teacher capacity to address the needs of children exhibiting challenging behaviors.

I.C. Target Population, Number Served and Sites

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

In addition, a second ECCT operates in North County with MHSA funding supporting the

clinical services and private funding supporting the consultation component. This team has not been able to engage the North County community quite as effectively as in Coastside. See EQ # 7 for more on this.

Operating with a primary office in donated space in Half Moon Bay contributed by Cabrillo School District, Mental Health Consultation services continue to support staff and families at early care and education settings in the Coastside. Consultation services continue to have a significant impact on the families and staff at the four programs receiving this service in the Coastside: Half Moon Bay Head Start; Moonridge Head Start and Early Head Start, and Coastside Children's Program. While these are the primary early childhood mental health consultation sites, the ECCT is highly mobile, providing services at four early childhood programs as well as in the homes of families. The table at left summarizes the ethnicity of the children served and the primary language of the parent/caregiver. While data is not collected about income status of families, three of the four early childhood programs are Head Start or Early Headstart programs that have income criteria for enrollment and approximately one-fourth of the families enrolled in the fee-for-service center are subsidized by state early childhood subsidies eligible to low-income families. A summary of the units of services and types of services delivered is provided under EQ # 1.

Table I: Client Ethnicity		
Ethnicity	#	%
Latino	73	90%
Caucasian	4	5%
Mixed Race	3	3.6%
Middle Eastern	1	<1%
African American	1	<1%
Other	1	<1%
Total	83	100%
Primary Lang		
Spanish	62	75%
English	16	19%
Bilingual	3	3.6%
Other	2	2.4%

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of participatory meetings that included the evaluator, Program Director, Christina Lansdown and Sarah Dobkin Program Manager for the Early Childhood Mental Health Consultation Program. A second series of discussions occurred in November and December of 2013 with a final series of conversations occurring in October and November 2014 when the final evaluation report was developed. In June 2013, ECCT leadership shared with the consultant a myriad of screening, assessment, observation and diagnostic tools utilized in their practice. The evaluator reviewed the varied tools and together a plan was developed to use and determined that the following tools would be used in the evaluation.

Arnett Global Rating Scale. The Arnett is an observational tool used with the ECMHC program that is designed to measure changes in the caregiver's approach to a child in their care.

The Devereaux Early Child Assessment, a pre-post assessment tool comprised of a sixty-two item, forced choice assessment that can be completed by a caregiver, mental health consultant or by a parent with each item representing a kind of child behavior. The assessment produces subscale scores for: initiative, self-control, withdrawal, emotional control problems, attention problems, aggression, as well as Total Protective Factors and Total Behavioral Concerns.

Child Behavior Checklist. A pre-post test assessment which is used more for therapeutic purposes to assess how services are impacting the child's behavior.

Parent Stress Index. Is a pre-post assessment tool designed to capture the level and type of stress experienced by the parents.

Life Stressor Checklist that provides a good profile of the kinds of stresses experienced by families served by ECCT. It is only given at intake so it does not contribute to evaluating the program's impact.

Assessing Angels. A qualitative interview tool used asking about the parents' childhood memories and what they would want for their child.

The Parenting Relationship Questionnaire. Developed by the authors of the BASC-2, the Parenting Relationship Questionnaire (PRQ) is an assessment that can be completed in 10-15 minutes by a mother, father or other primary caregiver. It is designed to capture a parent's perspective on the parent-child relationship. The PRQ has two forms, one for Preschool (ages 2-5) and another for Child and adolescent (ages 6-18). Features of the PRQ:

- Multiple dimensions that are relevant to the development of strong and healthy parent-child relationships;
- Normative samples, for both female and male raters, that are closely matched to U.S. Census population estimates;
- Items written at a third-grade reading level;
- Validity indexes that can be used to detect careless or exaggerated responding;
- Three types of record forms: hand-scored, computer-entry, and scannable; and

- Computer software that provides detailed single- or multiple-administration reports, including progress reports and multi-rater reports that can be used to compare mother and father settings

Provider Satisfaction Survey. A seventeen-item forced choice survey was used with 15 of the 20 teachers who had received mental health consultation services.

With such a rich array of validated tools, the evaluator and ECCT leadership were confident of being able to develop a robust evaluation support by a variety of forms of data. Unfortunately when discussions began first in July and then in October-November, 2014, the evaluator learned that each of these tools is used to respond to very specific kinds of client families and children and more importantly, the focus of the ECCT was to use these for diagnostic and clinical purposes, not for evaluation. These factors, plus the reality that many cases closed quickly without allowing for a battery of post-test assessments, led to an extremely low N for many of the above tools. Factors contributing to a small number of post-test results included:

- High turnover in the early child care programs, with teachers with whom ECCT consultation team was working, leaving without sufficient time to arrange a post-test observation;
- While the ECCT served 83 children, some were served through consultations with parents, others in play groups, others through consultation with teachers, and still others in child-parent psychotherapy. Each of these service components utilize different tools to suit their specific clinical and programmatic focus; and
- High mobility among client families involved in group and/or individual counseling services and with families exiting the program without scheduling an exit interview where a post-test might have been administered.

Despite these challenges sufficient data was organized to assess the degree to which the program had served the Coastside community. Data included

- Program participation data which captures the number of families and childcare professionals served by a range of distinct services;
- Pre-post data from the Parenting Relationship Questionnaire (PRQ) and the Child Behavior Checklist (CBCL). While in both instances the N was small relative to the number of parents taking the pre-test, the results still showed reasonably clear trends in terms of program impact.
- Parent satisfaction survey results for six parents, again a relatively low N but with clear indications of satisfaction;
- Childcare professional satisfaction survey indicating level of satisfaction and impact of consultation services, with an N of 15 being a more representative sampling; and
- Structured interviews with ECCT staff used to construct two case studies illustrating how the ECCT system operates and how it has become an integrated component of the Coastside family service system.

While this data allowed for a reasonably rich evaluation, many opportunities for data collection were missed that could have contributed to the program achieving a clearer, more specific view of its program effectiveness and impact. StarVista leadership acknowledged these missed opportunities and is committed to taking better advantage of them in 2014-15. These opportunities are discussed under EQ # 7.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?
Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The ECCT program evaluation encountered a significant challenge resulting from the program delivering three distinct components, each of which utilized different assessment tools for clinical purposes. This significantly reduced the size of the N on any one of these assessments. Nonetheless, available data was sufficient to produce a reasonably robust evaluation report. The process of developing the report also resulted in identifying opportunities for expanded data collection that will result in a more data rich report next year as well as opportunities for use of data in program improvement activities.

Despite the limitations imposed by the low N described above, from the available data there were clear signs that the ECCT was an extremely effective and efficient program. The ongoing waiting list is indicative of a program that is both needed and valued. Satisfaction data shows high levels of satisfaction among both parents and teachers served by the ECCT. Pre and post test data, while having a low N, indicate strong gains by children and parents.

The evaluation process also identified numerous recommendations for program improvement and improved data collection including strategies to expand and improve ECCT penetration in North County, strategies for expanding the use of satisfaction surveys with parents and teachers; strategies for clarifying the ECCT role in Kick-Off to Kindergarten, a partnership with Cabrillo Unified School District; and strategies for expanded use of pre-post test through the adoption of a tickler system that prompted the use of post-tests before families exit the program.

These recommendations are described in detail in the discussion under Evaluation Question VII. While these are certainly recommendations that, if adopted, would improve the impact of the ECCT, that there are these recommendations should not diminish the prevailing finding that ECCT is providing a valuable and effective service, in a historically underserved community, serving rural, low-income, largely Latino families. Evaluation findings are discussed in detail under EQ # 7.

Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?

Table II: Units of Service Type of Service	UOS Total
PlayGroup	229
Family Therapy	281
Collateral - family/significant others	120
Collateral Contact (Outside Agency)	28
Consultation – Parent Meeting	75.5
Consultations with Teachers (no parent)	421
Phone Call	10.63
Consultation – Parent-Teacher Meeting	36
Assessment	40
Observation	154
Case Management	169
Individual Therapy	6.5
Direct Client Service	2
School Meetings	264
School Group	4

As with most all of the PEI programs, StarVista's contract for ECCT services did not delineate expectations about the number of clients to be delivered, the number of services to be delivered, or the expected dosage of services. As a result, the evaluation reviewed the level of service delivery without assessing whether or not that level met a pre-determined expectation for productivity. Table II is based upon reports provided by StarVista and reflects the levels of services delivered in 2013-14. A closer examination of client-level data shows the following trends in services:

- Of the 83 child clients served during 2013-14, either through family counseling or consultation with childcare workers, thirty-one families were identified as having completed the program successfully and 48 were identified as currently enrolled on June 30, 2014;
- Two referred families were unable to be reached, one refused service and one moved after being enrolled for 83 days;
- The average length of enrollment was 212 days;
- There currently is a wait list, indicative of a program operating at maximum capacity; and
- Referrals came from head start programs, parents, Cabrillo Unified School District, Coastside Mental Health, a variety of local elementary schools, Edgewood Center, Pre-3, and Watch Me Grow: an indication of the degree to which the ECCT has become known throughout the Coastside community.

Unfortunately, the way in which units of service was reported to the evaluator, it was impossible to capture the dosage or mix of services that each child received, data that could then be correlated with outcomes to see if there was a correlation between involvement in specific types of levels of services and outcomes. Another limitation is that while it was possible to calculate the average number of days that clients were engaged in the program, it was not possible to glean from the data what level of engagement and receipt of services a family/child might be receiving while still enrolled in the program. This would be good data to have for the 2014-15 evaluation. However, from ECCT's end-of-year report, some descriptive narrative was provided concerning the level of services. Mental health consultation services were provided to 4 childcare programs in the Coastside region serving 116 children and 20 staff. More intensive, ongoing case consultation services were provided to 29 families. Consultation activities included weekly visits with childcare providers, individual and group consultation meetings, meetings with parents, observations of classrooms and individual children and assistance with resources and referrals. Consultation was provided on a weekly basis in either group and/or individual meetings depending on the specific needs of each center and staff members.

Weekly child-parent psychotherapy services were provided to 14 families in the Coastside region and 8 families in the Daly City/Northern San Mateo County region. An additional 6 families

received a mental health assessment, but did not move into the treatment phase. Weekly services include family therapy, collateral individual sessions, and additional collateral contacts such as school observations, participation in TDM or IEP meetings, etc. Most participants receive psychotherapy services for about one year.

The ECCT Community Worker provided services to 28 families with services including case management, parent education and assessment. An additional 26 children and their caregivers attended our Parent-Child Activity groups. Services are provided weekly, monthly or on an as needed basis.

In addition to implementing the variety of services that are central to the ECCT model, StarVista engaged the Coastside community to find ways that the team's expertise could build community capacity or fill unmet needs. One example of this is in the teams provision of training in areas related to early child development. ECCT staff has collaborated to respond to the needs expressed by ECCT partners at the school district and the Coastside Clinic to provide multiple workshops this year. Themes included School Readiness, Children and Trauma, Social Emotional Development, and Positive Discipline. These presentations were adapted for each unique audience. In this manner we were able to serve diverse groups such as teachers, providers, and administrators as well as parents. While no data was collected to document the numbers in attendance or a pre-post test to determine impact or perceived effectiveness, StarVista leadership agreed that this could be possible going forward.

Another excellent example of extending expertise to meet community needs has been how ECCT staff supported teachers and families participating in Kick-Off to Kindergarten this year by administering the ASQ-3 and ASQ-SE screening tools and providing needed referrals to any child identified with a potential need for additional support. The Early Childhood Community Team collaborated with Cabrillo Unified School District in June and July of 2013 to perform screenings of children entering kindergarten and to connect with families with young children needing additional support services through the Kick-Off to Kindergarten program. During this time period, the ECCT Community Worker provided eight evaluations and received around 16 referrals. Of these 16 referrals, about half of the referrals became clients. About five referrals were not appropriate for services provided by ECCT and in the remaining referrals, parents either did not want to engage or did not respond to outreach.

ECCT identified two areas that felt particularly important in reflecting on the collaboration this summer: teachers' communication to parents (both with regards to the referral to ECCT and around the child specifically) and inappropriate referrals. To improve communication this year, the ECCT Community Worker spoke with the school district when referrals started coming directly from teachers to make sure that parents were being informed that a referral was being made. Even though the outreach worker was able to arrange for initial contact to be made by teachers or the school secretary, many parents still did not have a clear understanding as to the purpose of the referral or the services the ECCT would be able to provide. One note of concern to ECCT with regard to teachers speaking to parents about their children was an incident in which a mom and kindergarten teacher were each told by a summer teacher "this is the worst kid I have ever seen." In conversation with ECCT leadership, it was noted that training for teachers in more appropriate language for voicing concerns about a child's behavior would be important going forward.

Less appropriate referrals included referrals of children in which the primary concern identified by the teacher was an academic concern, e.g. "he doesn't know how to write his name" or "she doesn't know rhyming words." While teachers at the Kick-Off to Kindergarten program work

with a list of academic and behavioral expectations for children entering kindergarten provided to parents and preschools, ECCT will need to clarify expectations around the types of deficits that would trigger referral to ECCT and that academic concerns, while important, are not part of ECCT's services.

Since the contract was silent as to a projection as to the number served and the number of units of service for each type of service, it is not possible to assess whether the level of services was sufficient for the resources in the contract. Also, it was not possible to assess the degree to which individual client/families/children/teacher received specific dosages of services. Nonetheless, based upon available data, it would appear that ECCT engaged high numbers of at-risk families, served under-served populations (90% Latino, 75% Spanish-speaking) and provided the range of services identified in the contract.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

From the report that ECCT provided to the County at the end of the year, the following impacts were claimed.

As a result of on-going mental health consultation, teachers at 4 childcare programs have demonstrated greater ability to understand and respond to the social-emotional needs of children in their centers. For 8 of the children provided case consultation, teachers were observed in a pre- and post-test assessment using the Arnett Caregiver Interaction Scale, which measures the relationship between teacher and child. In seven cases, teachers showed increased responsiveness and sensitivity to the children (the eighth showed no difference). In no case was a teacher rated in the lowest quadrant of this four-point rating scale and a total of five teacher-child interactions were rated in the highest quadrant during the post-test: in two of these cases, this rating represented a move from the second highest quadrant into the highest quadrant.

As a result of mental health consultation services, 29 families have increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. This increased capacity is noted in the parent surveys (results below) and also in informal comments made by parents in noting their satisfaction in working with the consultant. On the survey, parents included comments that indicate they enjoyed the work with the consultant, writing "she helped us to understand how to relate with my son" and "she helped me with other phone numbers of other people who helped me." Parents and teachers also noted differences in children's behaviors: the ECCT consultant was able to observe these differences in pre- and post-test assessments using the Devereux Early Childhood Assessment Clinical Form (DECA-C), which measures behaviors related to risk and resilience in preschool children. Over the course of the past program year and 6-12 months of working with the teachers and parents, for the six children for whom it was possible to complete a pre- and post-test assessment, statistically significant increases in protective factors were observed in three children and statistically significant decreases in behavior problems were observed in one of these three and also in one additional child. Additionally, 8 families have received referrals to additional services in the community.

Parents receiving child-parent psychotherapy services who reported symptoms of maternal depression at the onset of treatment currently report fewer symptoms and greater capacity to manage and understand their own mental health needs. Parents receiving child-parent psychotherapy services have reported gains in their understanding of their children's needs and behaviors, and in their ability to respond effectively to these needs. These clients complete pre and post test assessments using multiple measures, including the Parenting Relationship Questionnaire (PRQ), the Child Behavior Checklist (CBCL), the Parenting Stress Index (PSI), and the Keys to Interactive Parenting Scale (KIPS). Scores on the PRQ and PSI measures at the outset of treatment on average reflect low levels of attachment, involvement, discipline practices, and parenting confidence along with high levels of relational frustration and parenting stress. While these areas are not always the focus of clinical treatment, ECCT reported that clinicians saw consistent improvements, or at least stable scores in these domains. It is also common to see a high level of concern for child behavior, and lower scores on the KIPS which is a parent-child interaction observational scale. ECCT typically sees improvements or at least stable scores on the CBCL and the KIPS as well at the close of services. See below for a more detailed analysis of the CBCL and PRQ assessments.

Families with resource needs have been supported with appropriate linkages and referrals to access services such as food, housing, childcare and early education, legal and mental health services. Families with parenting and school readiness concerns have received relevant Parent Education services to support parents in better meeting their children's social-emotional needs and taking advantage of teachable moments. In the past, attendance at ECCT Parent-Child Activity groups was overwhelming, with more than 25 children plus their caregivers in consistent attendance. To better meet the needs of the community, ECCT leveraged its relationship with StarVista's Learning Together in order to create a second group. The result is that ECCT now facilitates robust, complementary groups running recurrently on consecutive days, one dedicated to children aged 3 and under, and the other focused on children ages 4 and 5.

One measure of the impact of the ECCT program on child behaviors is gleaned through a review of pre-post test data on the Child Behavior Checklist (CBCL), a 100-item forced choice list of problem behaviors where a parent is asked to identify if that behavior is not true, somewhat true or very true as relates to their child. The 100-item checklist is disaggregated to produce scaled scores for each of 15 domains of behavior, including:

Emotionally reactive	Anxiety-Depression;
Somatic complaints;	Withdrawn;
Sleep problems;	Attention problems;
Aggressive behavior;	Affective problems;
Anxiety problems;	Pervasive development problems
ADHD;	Oppositional disorder;
Internalizing problems; and	Externalizing problems.

In addition a global score is produced for Total Problems. For each domain and for Total Problems, are produced with ranges denoting "clinical," "borderline" and "normal." While the PRQ Scale that follows the CBCL has specific numeric delineations for determining clinical and borderline status, the specific point totals determining these descriptors varies slightly based upon the age of the child and the specific domain being assessed. As a result, in Table III, there are instances where on one domain a 69 is deemed 'normal' and in another it is 'borderline.' In Table III below, "clinical" scores are identified by a screened cell and bold number, "borderline" is indicated by a bold number. While the N for the CBCL was quite low, the trends indicated in Table III are entirely positive. In 19 instance where a child was indicated as having a clinical level deficit, significant improvement was made with only one exception (Client # 3 in relation to being withdrawn) and in this instance there was no change. Indeed, in 17 of the 19 instances, the child's improvement was sufficient to remove them from a 'clinical' deficit level. In addition in all seven instances where a child's behavior was identified as 'borderline' sufficient improvement was observed to move that behavior from borderline to normal. Finally, when examining the average change between pre and post-tests for each of the fourteen behaviors, thirteen of fourteen showed reductions from pre to post test with only one (Somatic behavior) showing a very slight increase. What's more, the behaviors that had the highest score in the pre-test and that had the most children exhibiting clinical deficit levels were the behaviors that showed the most marked improvement (Emotionally reactive, Anxiety-depression, Withdrawn, Aggressive behavior, and Pervasive development problems). So while the N is low for this summary, the trends are entirely positive and suggest that children are benefiting from ECCT interventions. See Table III on the following page.

Table III: Child Behavior Checklist Pre-Post Test Summary														
	#1		#2		#3		#4		#5		# 6		Ave	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Emotionally reactive	73	59	70	62	69	55	55	51	62	55	50	50	63.17	55.33
Anxiety-Depression;	66	56	69	52	66	51	51	52	52	52	56	50	60	52.17
Somatic complaints;	50	50	53	53	62	65	50	50	53	58	53	50	53.50	54.33
Withdrawn;	76	60	82	70	70	70	56	60	56	50	67	50	67.83	60.00
Sleep problems;	50	50	56	53	51	51	50	50	53	53	51	50	51.83	51.17
Attention problems;	67	62	50	50	73	57	57	57	53	53	50	50	58.33	54.83
Aggressive behavior;	82	59	68	59	86	72	66	59	52	55	50	50	67.33	59.00
Affective problems;	67	52	60	51	60	51	50	63	67	67	56	51	60.00	55.83
Anxiety problems;	63	54	67	54	60	56	50	54	52	54	51	50	57.17	53.67
Pervasive development problems	79	63	82	72	74	66	66	59	54	51	59	50	69.00	60.17
ADHD;	67	64	52	51	67	60	57	52	54	54	50	50	57.83	55.17
Oppositional disorder;	73	59	67	59	70	64	55	51	51	52	50	52	61.00	56.17
Internalizing problems; and	70	56	73	62	70	62	51	53	58	53	12	29	55.67	52.50
Externalizing problems.	72	60	63	56	83	69	65	59	52	50	39	37	62.33	55.17
Total Problems	73	59	69	57	73	63	57	57	56	57	46	32		
Change	-14		-12		-16		0		+1		-14		-55	
Ave Change													-9.1	

StarVista also used the Parenting Relationship Questionnaire (PRQ), a 45 item forced choice question that examines five domains of the parent child relationship:

Attachment;
Involvement;
Relational Frustration;
Discipline practices;
Parent Confidence; and

For all domains, T-scores can be classified into the following ranges: 10-30 (lower extreme), 31-40 (significantly below average), 41-59 (average), 60-69 (significantly above average), and 70+ (upper extreme). Parents who "improved" had scores that increased and moved them into a higher range. Parents who "maintained normal" had scores that remained average or above average. Parents who "maintained clinical" had scores that remained below average. Parents who "declined" had scores that decreased and moved them into a lower range.

As Table IV below illustrates, average scores for the five parents completing the pre-post test increased in four of the five domains with increases highly significant in three domains (attachment, discipline and involvement). Across all five domains there were twice the number of increases (12) as declines (6). It is also worth noting that there were 16 instances of improvement or maintaining in a normal range and only nine instances of decline or maintaining in a clinical status. While the N is very low, the trend line is consistently positive.

Table IV: Parenting Relationship Questionnaire (PRQ)

Domain / Client	Attach		Discipl.		Involve.		Confid.		Frustration	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	*40*	55	61	58	52	49	*26*	39	89	57
2	*33*	33	56	54	*34*	44	43	19	73	60
3	*37*	48	*35*	54	*27*	32	*30*	36	67	70
4	44	38	*31*	47	*34*	40	52	38	53	56
5	50	64	*39*	52	42	66	64	67	*4*	53
Ave	40.8	47.6	44.4	53	37.8	46.2	43	39.8	57.2	59.2
# Improved	3		3		2		2			2
# Maintained Normal			1		1		1			1
# Maintained Clinical	1				2					
# Declined	1		1				2			2

What is not captured in the table is that a total of 17 parents took the pre-test with just under 30% of these parents (5) also took the post-test. What's of more concern, is that among the 12 who did not take the post-test, only three did not register at least one score in the significantly below average or in the lower extreme range. What's more, half of these parents had at least one score in the extreme low range with three having two domains scored in the extreme low. Finally, half of the 12 had at least three domains where they exhibited significantly low or extreme low scores. This suggests that at least twelve parents with significant parenting challenges were not administered the post-test. Indeed, if you average the scores for all pre-test parents, five of the six lowest scores never took the post-test.

Despite the limited number of pre and post-tests on these assessments, the data that was available strongly suggests that the ECCT is having a positive impact on the children and families being served.

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

As has been noted elsewhere, ECCT has not managed to collect large numbers of pre-post test assessments and this occurred in relation to satisfaction surveys as well, particularly in relation to parent satisfaction with only six surveys collected from among the 29 families who received consultations. In relation to Childcare Worker satisfaction ECCT did a much better job with 15 surveys returned from among the 20 teachers receiving consultations.

Table V summarizes parent responses. Six statements were asked about specific areas of program services with parents asked to rate how effective ECCT delivered each component. The statements asked of parents were:

- Q-1. How effective was the consultant in supporting your relationship with your child?
- Q-2. How effective was the consultant in increasing your understanding of your child's behaviors and needs?
- Q-3. How effective was the consultant in helping you think about your child's experience in daycare/pre-school?
- Q-4. How effective was the consultant in assisting the teachers to adapt and/or respond to your child's needs?
- Q-5. How effective was the consultant in supporting your relationship with your child's teachers?
- Q-6. The Consultant was involved in finding additional services for me or my child.

While the N is low, the results clearly suggest a very high level of satisfaction among parents with no rating lower than effective and with responses to the first three statements being unanimously Very Effective. What's more, parents responding to open ended questions about whether and how the program could better meet their needs provided more detail about how important the program was to them.

Response	Q1	Q2	Q3	Q4	Q5	Q6
Very Effective	100.00%	100.00%	100.00%	83.33%	83.33%	50.00%
Effective	0.00%	0.00%	0.00%	16.67%	16.67%	50.00%
Somewhat Effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Not at all Effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Totals	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Among parent comments: "Sarah has been a huge help in providing the necessary steps. I would recommend her services to everyone very highly." And, "She has helped us learn to relate better to our son." And "Sarah is a person who cares about both the wellbeing of the children and of our family. Thank you for your help." When asked for any suggestions for how the program could be improved, no specific suggestions were made and parents instead commented again on how good the program was and how much it had helped.

A satisfaction survey was also administered with childcare workers with whom the ECCT consultant worked, generally in relation to a specific child. As above, a series of 17 statements in relation to program services were provided with respondents asked to indicate the level of effectiveness of each service component. The statements were:

Q1 How effective was the consultant in helping you accomplish what you wanted

Please answer the following questions if the consultant was involved in discussion about an individual child

Q2	How effective was the consultant in increasing your understanding of the child's experience and feelings?
Q3	How effective was the consultant in contributing to your willingness to continue caring for the child?
Q4	How effective was the consultant in contributing to your ability to handle this child?
Q5	How effective was the consultant in helping you in your relationship with this child's family?
Q6	How effective was the consultant in contributing to your understanding of the family's situations and its effects on the child's current behavior?
Q7	How effective was the consultant in helping to relieve some of the pressure in responding to the family's needs?
Q8	How effective was the consultant in helping to find services that the child and family need?
Q9	How effective was the consultant in helping you apply what you learned about the child to other children?

Please answer these questions about your program:

Q10	How useful was the consultant in helping you to think about children's development and behavior?
Q11	How useful was the consultant in helping you to think about curricula planning?
Q12	How useful was the consultant in helping you to think about your classroom environment?
Q13	How useful was the consultant in helping you to think about classroom management?
Q14	How useful was the consultant in helping you think about parent involvement?
Q15	How useful was the consultant in helping you to think about staff relationships?

As someone who has used Early Childhood Mental Health Consultation:

Q16	Overall, how would you rate the quality of services provided by the consultant?
	If you rated "fair" or "poor," what suggestions would you offer to improve services?
Q17	Would you recommend the Early Childhood Mental Health Consultation Program to others who need help with similar concerns?
Q18	Are there any other comments you would like to make about the services you received?

As Table VI reveals, satisfaction levels were extremely high among the Childcare Workers. On Questions 1-9 which focused on the consultant's effectiveness, only one of sixteen respondents scored services lower than effective. In relation to Q10-17, ratings were almost as high for questions 10-17 with the only Q-11 being the only instance in which the respondent indicated "somewhat useful" on a question related to helping with curricula planning. Open-ended responses asking respondents to identify areas where the program could be improved did not result in a single suggestion. However, there were 16 different narrative responses with every one entirely positive. A sampling: "The Consultant has also helped me a lot in speaking about my own personal issue. She is very interested in helping everyone and is always at the center and available." And "The consultant provides excellent support in all areas including, challenging behaviors, parents,

staff relationship and classroom management." And "It is so nice to have someone to look forward t talk to when you need it. I feel comfortable knowing that I can trust Sarah and the she cares and does it positively and professionally."

Table VI: Childcare Worker Satisfaction Part 1

Response	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Very effective	60.00%	66.67%	66.67%	53.33%	66.67%	53.33%	46.67%	46.67%	40.00%
Effective	40.00%	33.33%	33.33%	46.67%	33.33%	46.67%	46.67%	33.33%	60.00%
Somewhat effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.67%	0.00%	0.00%
Not at all effective	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Not applicable	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.33%	0.00%
Unanswered	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.67%	0.00%

Table XX: Childcare Worker Satisfaction Part 2

	Q10	Q11	Q12	Q13	Q14	Q15		Q16		Q17
Very useful	60.00%	40.00%	46.67%	60.00%	40.00%	60.00%	Excellent	66.67%	Yes	93.33%
Useful	40.00%	40.00%	40.00%	26.67%	53.33%	40.00%	Good	33.33%	No	0.00%
Somewhat useful	0.00%	13.33%	6.67%	6.67%	6.67%	0.00%	Fair	0.00%		0.00%
Not at all useful	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Poor	0.00%		0.00%
Not applicable	0.00%	6.67%	6.67%	6.67%	0.00%	0.00%	Not applicable	0.00%		0.00%
Unanswered	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	Unanswered	0.00%	Unanswered	6.67%

Taken together, it is clear that even with the low N on the parent survey, both parents and teachers are highly satisfied with the ECCT program.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

The ECCT is funded to serve the geographically isolated, low-income, rural community of Coastside. More specifically, it is supposed to target under-served families where either child behaviors raise concerns of emotional or psychological risk or where parenting practices raise concerns. A measure of the degree to which ECCT has successfully engaged families where the parent-child relationship is less than ideal can be seen from the PRQ discussed under EQ # 2 above. As can been seen, every one of the five parents taking both the pre and post test had at least one domain that was significantly below average and as described in the analysis below the table, of the 12 parents who only took the pre-test nine of the twelve had at least one domain with a significantly below average score. The program's impact is further underscored by the results of the CBCL. Again, while the numbers of pre-and post-test results is lower than would be desired, the results were very strong. Lastly, satisfaction surveys of both parents and childcare workers indicate an exceedingly high level of satisfaction indicating the programs' being responsive to the needs of the targeted population. Clearly the program is targeting and engaging families at very high risk and with better data collection practices, it would be possible to assess the level of services accessed by each child and family, but it seems clear that while data collection practices could be strengthened, the program is responsive to the targeted population and targeted

community needs, with one exception. While not evident from data presented to the evaluator, in structured discussions with StarVista leadership, they shared that the North County ECCT team has not become the cornerstone of early childhood mental health services in its community that has been achieved by the Coastside team. This issue is discussed in EQ # 7.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations.

Childcare Consultation. By making early childhood mental health consultation available to more childcare providers, the ECCT team reaches individuals who have the potential to be a long-term support for families at risk and in distress at an early point in the developmental process, magnifying the impact of their work over years.

Child-parent psychotherapy is reaching families with infants and toddlers, very early in their development and providing parents with parenting tools that should benefit the child over the course of their development, as well as with any future children that the family may produce.

Community Outreach and Case Management. The ECCT community outreach worker is also able to identify and connect with family/friend/neighbor providers that may not have been previously known to the resource and referral agency and facilitate their connection to ongoing supports.

Taken together it is clear that ECCT is collaborating with other community providers, engaging families and children 'upstream' and are achieving the desired results from their services. While ECCT's data collection could be improved, it is clear that this vital service is appreciated by parents and childcare workers and is consistent with SMC BHRS vision and values.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Transition of Childcare Staff. The second half of this year marked a challenging time for the Coastside centers served by the ECCT. Staffing changes at all four centers in February led to feelings of instability and mistrust among teaching staff, parents, and children. One center in particular saw over half of their teachers change in the course of three weeks (including one classroom in which all

three teachers were new to the class). Such changes impact children attending the center significantly as they lose a reliable and consistent connection with an adult with whom they have developed trust and respect and the new staff saw major changes in the behaviors of the children following these staffing shifts. Similarly, parents reported feeling anxious about leaving children with new faces and frustrated in not knowing which staff was permanent and which were substitutes. Turnover in childcare staff involved in consultations means that resources poured into building the capacity of a specific childcare worker has been wasted while also requiring that the new worker receive training. This turnover also impedes the evaluation as a childcare worker may have identified a challenging child behavior, begun to work with the ECCT Consultant and then leave in midstream without the opportunity to do a post-consultation observation. Turnover in the childcare industry is endemic and simply makes the work of the ECCT more challenging.

Transition in ECCT Team Members. In the coming program year, ECCT is anticipating several shifts among ECCT staff. The current consultant in the ECCT Program, Sarah Dobkin, will be transitioning to the role of Program Manager of the ECMHC Program. As such, a new consultant will be introduced at one of the center-based programs while Ms. Dobkin will continue to provide services at the other three. Ms. Dobkin has worked closely with the new consultant to ensure a smooth transition of the work in this center. The current Program Director of the ECMHC Program, Kristin Reinsberg, will transition to a new role as the Training Director of the Early Childhood and Family Services Department, of which the ECCT is a part. Ms. Reinsberg's experience and expertise in developing and facilitating ECMH trainings within the ECMHC Program over the past ten years will provide a strong foundation that will benefit the Department and help to further strengthen StarVista's presence in San Mateo County as a leader in early childhood mental health services. Ms. Reinsberg and Ms. Dobkin will continue to be work closely together over the next program year to help ensure a smooth and stable transition.

ECCT's North County clinician, Anyella Clark, will also be leaving and a new clinician will begin working in this region in the coming months. All the clinician's clients have been referred to appropriate services and one will be continuing work with the new clinician once she begins. Finally, the ECCT Community Outreach Worker/Parent Educator on the Coast, Edgar Villafaña, will be shifting his time also. He is beginning to complete practicum hours and will be a mental health clinician trainee as part of StarVista's Learning Together 20 hours per week. To cover the other 20 hours allocated to the Community Worker position, Learning Together Parent Educator, Maria Elena Schurr, who has in the past led playgroups and worked with families on the coast, will be picking up the additional hours. While a strong core staff remain, these transitions will not be easy to manage.

Almost without exception, every agency evaluated this year has been impacted by staff transition. While each agency manages these transitions differently, it may be worthwhile exploring a more systemic solution, perhaps involving use of MHSA Workforce Education & Training funding.

Clarify ECCT Role and Scope of Responsibility in Kicking Off Kindergarten. As described above under EQ # I, ECCTs becoming involved in Kicking Off Kindergarten was very well received, but also encountered challenges that resulted in some inefficiencies with teachers expecting the ECCT to support students with either behavioral problems or academic problems. Academic problems are simply not part of ECCT's clinical expertise and so children were referred to ECCT who could not be served. sNew, collaborative projects frequently encounter these kinds of challenges and suggestions are included under EQ # VII below.

Data collection. With 83 clients the ECCT delivers three distinct strategies (child-parent psychotherapy; mental health consultation with child care providers; and case management/parent education (including parent-child activity groups) each employing different clinical tools that can produce pre and post test results. So the N for any given strategy is never going to be large. Families exiting the program do not always leave in a predictable timeframe and hence many post-tests are not obtained. However, given that the average client sustains program involvement for an average of over 200 days with that involvement typically including weekly sessions, a larger N is possible. The low number of pre- and post-tests has been identified as a barrier to the development of a robust evaluation, but it is also a barrier to ECCT conducting internal program improvement efforts. With larger N's and more valid findings, ECCT leadership would be able to identify specific areas where improvement in teacher, parent or child outcomes is occurring and where it is not. This information is invaluable in strengthening and focusing staff supervision and training. Aside from the number of parents, children and teachers who complete pre and post tests, a data system that easily allows for ECCT managers and the evaluator to analyze the relationship between involvement in specific program components and the level of that involvement with child, teacher and parent outcomes would also enhance both program improvement and program evaluation. In the structured interview, ECCT leadership acknowledged that it would be beneficial to collect data more methodically and to use it in a cycle of inquiry focused on program improvement. Current practice is that data is primarily used for clinical purposes, meaning that the individual clinician or consultant uses client-level data in support of work with the individual client and data is not aggregated to analyze trends in client outcomes. ECCT leadership felt that the program is already stretched thin, with a large geographic service area and a waiting list and so the choice faced is to devote more resources to data collection and program improvement at the expense of maintaining service levels.

North County Engagement/Penetration. In dialog with ECCT leadership, they shared that while not apparent from the data presented under EQ # I, ECCT has done a much better job of becoming integrated into the Coastside community than it has in North County. A number of strategies were discussed to improve penetration in the North County community, discussed under EQ # 7, below.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The ECCT is clearly a well-managed, effective program that is of great benefit to the Coastside and North County communities it serves, nonetheless as with most any program, there are opportunities to improve operations and achieve still greater benefit. Recommendations identified in this evaluation are identified below.

Staff transitions. Two manifestations of turnover impacted the ECCT, turnover within the childcare programs they served and staff transition within StarVista. From what was reported by leadership, transitions among the ECCT, were handled proactively and effectively. While turnover among the staff at the childcare providers served by ECCT is certainly not something ECCT could prevent, it might be possible to create a kind of training for new staff at these centers that introduces them to managing challenging behaviors. In an early childhood program I evaluated ten years ago, the early childhood mental health team developed a video library of consultations and classroom demonstrations that were available both to new staff at each site as well as to more veteran teachers. Certainly such an initiative would require additional resources, but perhaps a grant or even funding from MHSA Workforce Education & Training could subsidize the project.

Clarification of ECCT roles and responsibilities in the context of the Kick-Off to Kindergarten program. ECCT leadership felt that there were a couple options to explore to ensure that this collaboration works more smoothly in the future. First, it seems important that ECCT continues to discuss the role of the ECCT and the work that it can and cannot do with several involved parties, starting with the director of the summer program. It will also be necessary to speak with teachers and their support staff (school secretaries and translators) who may be contacting parents directly to examine their understanding of why parents are being referred to the ECCT and what services the ECCT will be able to provide to families. If time allows, ECCT staff could be available to think with teachers and others about how to talk to parents about the referral.

Second, as discussed above, ECCT feels teachers may benefit from reviewing what they can expect in terms of behavior and academic performance from children entering kindergarten. If ECCT continues to collaborate with the school district around this program, it will be important to know that teachers (in particular those who may be less familiar with kindergartners) are provided with more background about what are realistic expectations for children entering the program, especially those who have had little or no preschool experience. There is an abundance of highly digestible research covering realistic developmental and behavioral expectations for kindergartners and sharing this information with teachers would reduce teacher referrals for developmentally appropriate behaviors while providing teachers with information about how better to manage those behaviors. Sharing this information would also strengthen the relationship between the ECCT and the teaching faculty.

Data Collection. While there are certainly resource issues in expanding data collection practices, there are some relatively low-cost strategies that could result in more useful data and create procedures for using that data in program improvement activities.

> *Use a tickler system* to notify clinical staff when a client has been engaged in service for 3 or 6 months and schedule post-tests at this time rather than waiting for a client to indicate their plan to exit the program. This practice would not just serve the evaluation and program improvement efforts, but would also serve a clinical purpose, as it would inform the clinician as to client improvement and areas where improvement has not occurred.
>
> *Development of a database system that aligns participation (units of service) with assessment data.* With such a database, ECCT leadership could analyze what program strategies and treatment dosages elicit the biggest impact on outcomes. Is there a threshold level of engagement and program participation that is necessary to achieving positive outcomes?
>
> *Include a database 'tag' that would identify clients by the ECCT team that serves them.* This would allow ECCT to more easily compare engagement in services between ECCT teams.
>
> *Expand use of satisfaction surveys.* There were many missed opportunities for administering satisfaction surveys: 1) during school-based training surveys could be administered with teachers participating in the training; 2) parent satisfaction surveys could be incorporated into the fabric of child-parent psychotherapy with surveys used after 3-4 months of treatment; 3) teacher satisfaction surveys should be continued as 15 of the 20 teachers involved in consultations in 2013-14 were surveyed, eliciting important information.
>
> *Create a very few data reports.* Starting with only a very few data reports showing participation levels and one or two outcome reports, establish a quarterly or semi-annual cycle of inquiry process where ECCT teams review these reports and discuss their clinical or

programmatic implications. Through this kind of process, an organization will quickly identify the benefit to this practice and either find internal resources to sustain the work or seek outside resources to support them.

North County Penetration. In the interview with ECCT leadership a couple of strategies were identified to address ECCT's not achieving the degree of community integration in North County as has been achieved in Coastside. Starting with looking inward, an internal retreat involving staff from both teams. During the retreat each team could describe community engagement strategies that had proven effective in their community and the challenges that they encountered. Through such a process the North County team could consider adoption of strategies that had been successful in Coastside. After the retreat, ECCT team leaders could then turn outward, working through the North County Community Service Area could seek to introduce proposed engagement strategies, listen to CSA member perceptions about reasons why the North County team has not been as engaged as in Coastside and together develop a plan for increased engagement.

ECCT leadership has been extremely receptive and reflective throughout the evaluation process, acknowledging where data collection practices could be improved and open in revealing areas where they felt improvement in program could occur (e.g. Kick-Off to Kindergarten and North County penetration). In this context, the evaluator is confident that evaluation findings will be received and used constructively for the benefit of the communities that the ECCT targets.

Section V Demographic Summary

The data below will be reported with different programs having customized reports if their programs have unique features that would benefit from separate reporting. For example, if a program:

- Offered its programs in different communities; or
- Offered the same program at a school to different students in the first semester than the second; or
- Delivered two or more very different program components, e.g. consultation to school professionals and direct service to children and/or families.

Table I: Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	Childcare staff served by the ECCT are 95% female as is common in the industry.
Male	54	65%	7	87.5%	
Female	29	35%	1	12.5%	
Other					
Age	#		%		
Children 0-15	83				Children served were all below 4 years old.
Transition Age Youth 16-24					
Adult (25-59)			8---100%		
Older Adults 60+					

Table I: Demographic Summary					Source of Data
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian	4	5%	3	37.5%	
Latino	73	90%	4	50%	
African American	1	< 1%	1	12.5%	
Mixed	3	3.6%			
Other	1	< 1%			
Middle Eastern	1	< 1%			
Native American	0	0 %			
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English			8	100%	All staff speak English, but all but one is bilingual as per below.
Spanish			6	75%	
Other			1	12.5%	Portuguese
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	No data collected on this.
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**X**	
Details: Clearly ECCT serves an under-served population (90% Latino) in a significantly under-served community (Coastside).		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Very early identification of behavioral conditions.		
II-3) Access or Linkages to Care	**X**	
Details: Coastside has such limited resources, the ECCT operates as a kind of one-stop shop for		

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
young parents and child care programs, but it also collaborates with school districts, CPS, and Coastside MH, among other providers.		
II-4) Reduction of Stigma		
Details: Not a major focus. But the ECCT's placement in the community, in childcare settings, provides an easy point of access to both services and information about mental health, making it easier for community members to learn more about mental health issues, become more informed and to unlearn the stigma commonly associated with the condition.		
II-5) Screening for Needs	**X**	
Details: As is evidenced by this report, ECCT relies upon a battery of validated assessment tools to identify and clarify child behavioral needs.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Trauma is one of the most important factors contributing to family crisis and parenting challenges. One of the ECCT tools is specifically designed to identify trauma (Parent Stress Index).		
II-7) Specific Risk Factors	X	
Details: The ECCT considers all risk factors in play that might contribute to infant toddler behavioral conditions and works with family and pre-school to accommodate and address those factors.		
	Provide specific details very briefly. 1-3 sentences per line.	
II-7) Indicate the location where program activities occur (identify places where services occur	Office located at the Cabrillo Unified School District main office. Childcare centers are Moonridge Head Start, Moonridge Early Head Start, Half Moon Bay Head Start, Coastside Children's Program.	
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	Not a program component.	
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	ECCT collaborates extensively with primary care, education, CPS, and mental health systems and providers in Coastside.	

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**
1-PEI Key Community Needs				
1-A) Disparities in Access to Mental Health Services:	**X**	**X**	**X**	
Details: Underserved community with program targeting the most under-served population in that				

Table III: Alignment with SMC MHSA PEI PRIORITIES				
community (Latino). Many participant parents are TAY.				
1-B) Psycho-Social Impact of Trauma	**X**	**X**	**X**	
Details: Trauma is a major factor in early childhood behavioral issues. The PSI revealed very traumatic incidents that would impede normal child development.				
1-C) At-Risk Children, Youth and Young Adult Populations	**X**	**X**	**X**	
Details: By virtue of living in a geographically isolated community, serving low-income families, and targeting families subject to high levels of trauma all are evidence of the ECCTs addressing at-risk families and children.				
1-D) Stigma and Discrimination				
Details: Not a focus.				
1-E) Suicide Risk				
Details: While parents under stress due to early childhood behavioral concerns is a risk factor for suicidal ideation, this is not a focus of the program.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	**X**	**X**	**X**	
Details: See above.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	**X**			
Details: While early onset of serious psychiatric conditions is not common among infants and toddlers, identification of behavioral issues early and provision of tools to promote healthier development is a focus of the program.				
2-C) Children and Youth in Stressed Families	**X**	**X**	**X**	
Details:				
2-D) Children and Youth at Risk for School Failure	X			
Details: Early childhood behavioral issues predict later school failure and the program provides both teachers and parents with tools to build the resilience of toddlers and infants experiencing behavioral issues				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details: While certainly children who ultimately fail in school and while early childhood behavioral issues predict later school failure, the focus of the program is not prevention of juvenile justice involvement and does not target juveniles experiencing justice involvement				

Section I Agency & Program Description
I.A. Description of Program Services

Formerly known as Youth and Family Enrichment Services, StarVista came into being when Youth and Family Assistance and Family and Community Enrichment Services merged in 2003. StarVista offers counseling, prevention, early intervention and education resources and services to more than 34,000 people throughout San Mateo County every year. One of its programs is the Crisis Intervention and Suicide Prevention Center, a program comprised of a 24 hour phone Hotline and a Youth Intervention Team that works primarily through schools countywide offering both crisis intervention services when a student is in crisis, training for school personnel and prevention education for thousands of middle and high school students. The Center is staffed by:

- Program Director (part-time, only 4 hours allocated per week),
- Volunteer Coordinator (full-time),
- Clinician (full-time),
- One Americorps member (receives a stipend, Full-time),
- A Program Development Coordinator (30 hrs., funded through CalMHSA),
- Four overnight workers (each working less than 25 hours per week), and
- A cadre of approximately 60 community volunteers who staff the hotline and Teen Chat Line.

StarVista Hotline

StarVista manages and supports 41 Crisis Line Volunteers and 19 youth volunteers for its Teen Crisis Chat room. The Chat Room is a facilitated discussion forum for youth to get support, discuss the issues they are facing. If someone is in crisis or needs individual support, they have access to a private chat feature where they can communicate with a peer counselor 1-on-1. The hotline is staffed 24-7 and is accredited by the American Association of Suicidology. AAS accreditation validates service delivery programs that are performing according to nationally recognized standards. Achieving AAS accreditation involves submitting a detailed report to the AAS and hosting a one or two day site visit during which an AAS. Once accreditation is achieved, agencies must submit an annual report verifying their continued compliance with AAS standards. Each agency is revisited and reaccredited every five years. StarVista is required to attend a minimum number of Annual AAS conferences, and pay yearly dues. Achieving AAS accreditation ensures the County that an outside, expert eye has examined StarVista operations and has met all AAS standards related to:

- Administrative operations and organizational structure;
- Screening, Training and Monitoring Crisis Workers;
- General Service Delivery System;
- Services in Life-Threatening Crises;
- Ethical Standards and Practice;
- Community Integration; and
- Program Evaluation.

The Crisis Line program is overseen by the Volunteer Coordinator and a licensed clinician. The use of volunteers for crisis lines is routine throughout the State. A study, California Suicide Prevention Hotline Survey Report, conducted by the California Department of Mental Health found that 90% of hotlines surveyed deployed primarily volunteers with an average of 60 volunteers per

crisis center with the volunteers trained and supervised by paid clinical staff. This is precisely the model utilized by StarVista.

Before taking a shift on the phone lines, each volunteer a 30-hour training that takes place over the course of 4 weeks. Guest speakers with specialized expertise come from other community based organizations to provide most of the training. The training covers a number of crisis related topics including:

- Active Listening
- Suicide Risk & Assessment
- Alcohol and Drugs
- Sexual Abuse,
- Domestic Abuse
- Parenting
- Working with Youth
- LQBTQ Issues
- Child and Elder Abuse and
- Training in managing difficult cases.

In addition, training covers how to complete required paper and provides volunteers opportunities to role-play with each other. Once volunteers complete the training sequence, each volunteer picks up two observation shifts (each shift is 4 hours), where they listen in on experienced Crisis Line counselors fielding calls. After they do two observation shifts they sign up for two active shifts where they pick up the lines with an experience volunteer guiding them and offering them feedback. Suring the training, staff offers ongoing evaluations and constructive feedback. If the volunteer feels like they need more observation or active shift we offer additional support and training.

Volunteers also receive support from staff during the week. StarVista usually has a staff member present from 9:00 am - 7:00 pm on weekdays. Staff is available to debrief, offer support, information and feedback. After-hours, the Hotline is operated by paid StarVista overnight staff. The Volunteer Coordinator is also on site weekdays and is able to monitor and gauge if a volunteer needs support. For non-weekday hours, StarVista provides a 24-hour back up line that is available for support if there is no staff at the office. Through this line, volunteers can reach a StarVista LCSW to debrief or consult after a difficult call. Volunteers are also able to flag difficult calls in the StarVista database or write incident reports and get feedback on a specific call. When calls escalate - volunteers can check in with staff to see what steps need to be taken. Staff can also help with initiating emergency rescue/services e.g. welfare check, tracing calls, filling CPS reports and follow up calls to callers who need additional support.

StarVista evaluates each volunteer twice a year during which staff observes volunteer shifts and provides constructive feedback. Nineteen youth volunteers work in the Chat Room with a StarVista staff member supervising them at all times. Chat room supervisors offer support and guidance to other teens Monday and Thursday from 4:30pm to 9:30pm and during the summer on a varied schedule. It provides teens an opportunity to engage in group chats to discuss more general issues of concern, while also allowing for private 1-1 chats with a peer counselor.

Youth Intervention Team

As part of this contract, StarVista also operates a Youth Intervention Team housed at the Crisis Intervention and Suicide Prevention Center. The Team is led by the Prevention Program Director and Prevention Center Clinical Supervisor and supported by an unlicensed intern. The team responds to requests from schools, providing crisis intervention services to youth (which can include short-term counseling for youth in crisis), consultation and training to school staff, and provision of referrals for youth and families as clinically indicated. The YIT also provides educational presentations for middle school and high school students focused upon identifying signs of suicide risk in youth, suicide prevention strategies, and to de-stigmatize behavioral health conditions. The Team can make referrals to the mental health system through the ACCESS Team. As a member of the BHRS Community Response Team, StarVista attends related meetings and trainings, and is available to respond to community crises, although even in the event of a community crisis like the San Bruno fire, the Crisis Team tends to operate mostly from affected schools.

I.B. Research Basis for Approach

The clearest measure of crisis hotline intervention effectiveness would be a follow‐up study of all crisis callers to determine whether they continued to have suicidal thoughts after calling the crisis hotlines, or in the worst case scenario, died by suicide. These studies, however, are difficult to conduct given the sheer volume of individuals who call the crisis hotlines, privacy concerns, and the difficulty in extracting follow‐up contact information when an individual is in crisis. The best proxy of crisis hotline effectiveness in saving lives can be found in a 2007 study by Gould and Kalafat, et al.[1] – this study found that seriously suicidal individuals reached out to telephone crisis services and that significant decreases in suicidality were found during the course of the telephone sessions, with continuing decreases in hopelessness and psychological pain in the following weeks. In addition, anecdotal evidence by crisis center staff who were interviewed for the survey showed that callers responded positively to the counseling and the resources provided to them for after‐care.

I.C. Target Population, Number Served and Sites

The target population for Hotline is anyone who is experiencing crisis and as described below, clients call for a wide range of reasons with varying levels of crisis from being at extreme risk of suicide, to seeking resources and supports for a wide variety of reasons. Volunteers at the Hotline report also having 'regular' callers who call frequently and come to rely upon volunteers to provide support. Volunteers reported that in most instances, these callers are very isolated socially and their contacts are critically important to them. The YIT targets middle and high school youth throughout the County and responds to youth in crisis or at risk of suicide and provides education to middle and high school youth throughout San Mateo County. Since psychological crises cross all class and ethnic boundaries, the program does not target specific populations and neither the Hotline nor the YIT collect demographic data on callers or those where a crisis intervention occurs.

[1] Gould MS, Kalafat J, et al. (2007). An Evaluation of Crisis Hotline Outcomes Part 2: Suicidal Callers. Suicidal and Life‐Threatening Behavior, 37(3): 338‐352

Section II Evaluation Process

The evaluation plan was developed in June-July 2013 through a series of meetings with Director of Wellness and Recovery Services, Stephanie Weisner and Director of the Crisis Intervention Suicide Prevention Center, Julie Kinloch. Plans were made to provide data on the number of hotline calls and the number of school and community interventions where Crisis Center clinicians provided support during immediate crises or in the aftermath of school or community trauma. To measure satisfaction with the program and to get a view of the perceived impact that the crisis hotline had on callers, a survey was developed for volunteers. A separate survey of callers was also conducted, along with an online survey for school personnel involved in StarVista crisis interventions. Finally, structured interviews were conducted with:

- Julie Kinloch, Program Director;
- Sarah George, Clinical Directors; and
- Two school counselors.

Early in evaluation design discussions it became clear that pre-post test assessments, such as those used in most of the PEI programs, were unrealistic as neither the crisis hotline program nor the school-community intervention services sustained long-term involvement with clients. The contract for Crisis Hotline services did not delineate specific numbers of anticipated calls, trainings, or school-community interventions. Nonetheless, with the data above, it was possible to assess the scope of services delivered, the satisfaction with services from the perspective of the school, those calling the hotline, and the volunteers who staff it. So while pre-post tests were not practical, a view of the impact of services was gleaned from these data sources. Lastly, as data was being reviewed, discussions with the Clinical Director resulted in opportunities to better assess the impact of crisis intervention services in 2014-15 via the use of an online survey that will remain open throughout the year and be used to enable school personnel to describe its experience with the crisis intervention team, their satisfaction with its operations, and their perceptions as to the impact the interventions have had on the student(s) in crisis, school personnel supporting those students and the general school community.

Section III Evaluation Findings

There are seven evaluation questions that frame the evaluation of the Prevention & Early Intervention programs supported with Mental Health Services Act funds.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to the contract funding the program?
Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?
Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?
Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?
Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?
Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

The review of StarVista data leaves little doubt that both program components, the Crisis Hotline and the Youth Intervention Team has operated with a high level of efficiency and positive effectiveness, responding to crisis calls on the Hotline 24-7 every day of the year and responding every school request for crisis support promptly. The impact of both services components is also clear. While tracking the long-term outcomes of Crisis Hotline services is identified in the research as being impractical without a very expensive evaluation, an exceedingly high percent of Hotline volunteers surveyed indicated that they felt that they had had a very important and positive impact upon callers who were in crisis. In addition, the California Suicide Prevention Network (CSPN) conducted two months of random surveys of Crisis Hotline callers and this data also describes callers as being highly satisfied with the hotline services, that the services had been positive and that they would utilize the service again if they had problems.

StarVista also provided specific data on the scope of school training and school interventions delivered during the program year. While there was no stipulation in the contract delineating an objective for the numbers of schools served, it is clear that the YIT responded promptly to all calls and delivered training to many schools and intervened in 28 crises at schools where a student was either in immediate risk of suicide or where a school was grieving over the loss of a student. While there was less quantitative data supporting the impact of these services, a survey of school personnel and interviews with other personnel where YIT services were delivered make it clear that these services are both highly valued and respond to situations where there really is no other option for schools in crisis to obtain immediate intervention or consultation to support students in crisis. Through the evaluation process, StarVista and the evaluator identified ways in which more data could be obtained from schools via an online survey that would be posted and open all program year. As a part of end of an intervention process, the crisis team intern or clinician would ask the school contact person to complete the brief survey. While this would provide yet another form of data validating the impact of StarVista's Crisis Intervention and Suicide Prevention Center, even without it there is ample evidence of it effectiveness and impact of Center and of the satisfaction of those served by the Center. Each evaluation question is discussed separately below.

Evaluation Question # 1: Has the intervention/ program been implemented efficiently and according to its contract?

To answer Evaluation Question # 1, the evaluator was provided data on the number of crisis calls fielded by month, the number of crisis interventions conducted at schools, and the number of trainings provided throughout the year. Since there were no projected numbers to be served referenced in the contract, the analysis below does not reflect a comparison with a contract-specified projected productivity totals.

In terms of crisis calls, Table I provides the number of crisis calls fielded by month. As can be seen, just under 15,000 calls were received during the program year, with an average of almost 1250 calls per month. As a point of comparison, Contra Costa County has a population of 1.05 M residents, almost 50% more residents than live in San Mateo County (718,000). Contra Costa County's countywide crisis line receives 1150 calls per month, 100 fewer calls than does StarVista.[2]

[2] California Suicide Prevention Hotline Survey Report, Office of Suicide Prevention, California Department of Mental Health, January 2011.

The variation in call volume evident in Table I is the result of an agreement with Santa Clara County's Contact Care, a Bill Wilson Center program. Through this agreement StarVista and Contact Care back up each other's calls. For example, there are times at each Crisis Line where gaps in availability of volunteers require the other Crisis Line to cover calls for each other. This ensures continuity of crisis support at all times.

Table I: Crisis Calls	
Month	Calls
July '13	1657
Aug '13	1369
Sept. '13	1312
Oct. '13	1279
Nov. '13	1093
Dec. '13	990
Jan '14	1328
Feb. '14	1184
Mar. '14	1257
Apr. '14	1275
May '14	1275
June '14	946
Total	14,965
Ave.	1247

In addition to operating a Crisis Hotline, the Crisis Center also operated a Teen Chat Room that operated Monday through Thursday from 4:30-9:30 and on a more irregular schedule during the summer. This Chat Room was staffed by up to 19 teen volunteers, supervised by a StarVista clinician. Chat Room Peer Counselors provided 159 private chats and the Chat Room website had 546,570 hits. According to the Clinical Director, 'chats' are declining somewhat as they are being supplanted with teen preference for texting. StarVista is exploring how to develop texting chats to better respond to how teens want to communicate.

The Crisis Center also provides crisis intervention and training in suicide prevention, largely in response to calls from schools throughout the County. Based upon data provided by StarVista, the Crisis Center provided the following training and education services.

Suicide Prev. Presentation for Middle and High School Students.

- 61 1-hour presentations
- 2494 students served
- 14 school sites served
- 9 districts served

Presentations by Sarah George for Student Personnel to Recognize signs of suicide risk in students, how to respond:

- 2 presentations
- 2 sites
- 56 school personnel served

Other community suicide prevention presentations conducted by Sarah George:

- 4 presentations
- 120 people served (community service providers..mental health, probation, etc)

Presentations for Crisis Center Volunteers by Sarah George.

- 2 Continuing Ed. for Crisis Center Volunteers (10 people served)
- 15 1-hr. segment of Crisis Center Volunteer training series for 32 volunteers.

In addition, the YIT conducted interventions in response to crisis calls from schools where students were believed to be at imminent risk of suicide.

- 14 onsite at schools
- 7 over the phone consults

Other School Based Interventions

- 14 interventions at one school for Post-suicide support and in this instance, the intervention team identified a close friend of the suicide victim who was also manifesting signs of suicidal ideation and the team intervened providing ongoing support to the student and school personnel. This student has stabilized.

- 7 at one school for students self-identifying as needing to talk after a school bullying program event.

While there were no service levels projected in the StarVista contract, the data above reflects a program that is consistently responsive to all demands for its services and that the Crisis Center staff and volunteers of the Hotline, Teen Chat Room, and crisis intervention team delivered services both efficiently and effectively.

Evaluation Question # 2: Has the program implemented effective program strategies? i.e. Is the program well-designed and achieving a desired impact?

As summarized in Section I.B., evaluating outcomes from crisis hotlines is an extremely difficult challenge, far beyond the scope of this evaluation. While it would be desirable to track future caller suicide rates, use of psychiatric emergency services or other crises services, or utilization of services to which the caller was referred by the phone counselor, these measures would require a very elaborate evaluation design. Further, the real purpose of a hotline is to provide immediate, short-term support in moments of significant personal crisis, not to provide an ongoing therapeutic intervention where reduction of utilization of crises services might be a realistic impact. In assessing the hotline's impact, the evaluation has examined caller survey data since the questions involved in the survey directly relate to the degree to which the caller felt helped by their conversation with the phone counselor. StarVista is part of the California Suicide Prevention Network (CSPN), which represents a cross-section of Crisis Centers in the state of California who collaborated in the identification and development of a common set of call center metrics. Ten crisis centers agreed to have a determined period of time, a "survey season", where callers were given the option to answer a satisfaction survey. Callers were transferred to an Interactive Voice Response System (IVR) to answer three questions, with the option to leave a voice message. The first survey season was in December 2013 (D-13) with an N of 32. The second survey season took place in March 2014 (M-14) with an N of 17. The aggregated results for StarVista can be found below (N=75). Data from this survey is collected by CSPN and so is entirely independent. As can be seen from the table below, callers were extremely satisfied with their experience contacting the hotline with 77% (D-13) to 80% (M-14) of respondents indicating that they felt connected to the counselor, 78% (D-13) to 87% M-14) finding the call helpful, and 81% (D-13) to 88% (M-14) indicating they would call the Hotline again if they had a problem. While the change in satisfaction levels was not great, in all three areas surveyed, satisfaction levels increased from December 2013 to March 2014 survey administrations.

Table II: California Suicide Prevention Survey. December 2013 (N=32) and March 2014 (N=75)

Question	Very Unlikely		Unlikely		Neutral		Likely		Very Likely	
	D-13	M-14	D-13	M-14	D-13	M-14	D-13	M-14	D-13	M-14
How likely are you to call again if you need help.	6%	3%	3%	1%	9%	8%	3%	7%	78%	81%
	Very Disconnected		Not Connected		Neutral		Connected		Very Connected	
How connected did you feel to the counselor	3%	4%	6%	3%	13%	13%	16%	24%	61%	56%
	Very Unhelpful		Unhelpful		Neutral		Helpful		Very Helpful	
How helpful was this call in reducing your distress?	3%	0%	3%	1%	16%	12%	13%	16%	65%	71%

A volunteer satisfaction survey provided another measure of the Hotline's impact as questions in this survey asked volunteer phone counselors to describe the level of crisis of callers

and the degree to which they felt they had had a positive impact on the caller and helped resolve the crisis. The results of this survey are discussed under EQ #3.

StarVista also operates a mobile Youth Intervention Team that responds to calls from schools throughout the County. Three sources of data were used to assess the impact of the team: 1) results from an online survey completed by two school administrators; 2) interviews with a school administrator; and 3) a structured interview with the intervention team's clinical supervisor which elicited detailed descriptions of how the team has operated and where it has had a significant impact.

"The Crisis Counselor really helped the girl have an outlet and get some counseling. StarVista also consulted with us and assessed her likelihood of self-harm. We created a plan to support her. As a result, and she finished the year well."

While the survey of school personnel was completed by only two staff members from different schools, the responses to the Likkert Scale forced choice questions elicited unanimous satisfaction with the services with both respondents indicating that intervention services were effective, that the team went beyond providing immediate crisis support, and with both respondents strongly agreeing that the YIT was critical to defusing a crisis situation. Responses to open-ended questions elicited a more detail about the impact of the team. See above left and below right for quotes excerpted from these open-ended questions.

"YIT service was crucial because we reached out when other on-site mental health support was unavailable. YIT made it possible for a few of our students to receive support on site that they probably wouldn't have otherwise. We are very grateful for the partnership in assessing and sometimes providing short-term counseling."

To probe a bit more deeply into how the YIT operated, a structured interview with Clinical Director Sarah George was conducted. She described a number of crisis situations that illustrated the impact of the program. In one instance, Hoover Middle School in Redwood City, a YIT intern worked with a girl with suicidal ideation for several months. During this work, the girl acknowledged cutting herself and as the work with the intern helped stabilize the girl, she suggested starting a group for others who have issues with cutting. A peer group was established where self-esteem building exercises, peer discussions, and the introduction of alternatives to cutting were introduced, e.g. friendship building, involvement in art projects, and other positive activities. This example illustrates not just how an StarVista intern helped an individual girl, but how she turned that outcome into a peer-driven initiative that benefited many other girls.

In another instance, the team was called when a student was demonstrating clear suicidal intentionality. While the team was en route, the school also called the police. The officers had been well-trained in behavioral health interventions and were able to triage with the StarVista team and school counselor. From conversations with the student, it was clear he had the intent to take a gun, enter a neighborhood with gang presence and by drawing his weapon, ensure that he was killed by gang gunfire. All agreed that the student required emergency hospitalization and the StarVista counselor worked with the school's Marriage and Family Therapist to develop a plan for the student to return to school once he had stabilized.

The last example described by Ms. George involved a school where a popular student had committed suicide. The intervention team worked with the school counselor and teachers to brief them on how best to manage the school's grief and how to identify students at risk of suicide. The team also set up an ad hoc drop-in, grief counseling center in the library and spoke with scores of

students individually and in groups. Through this process, the school realized that one of the best friends of the suicide victim was himself in severe crisis. In individual counseling with the SV clinician, it was clear that this student had a high degree of suicidal ideation. After ten days of counseling, the student stabilized considerably and returned to school.

To obtain another independent view of the effectiveness of the StarVista team, the evaluator spoke with a counselor at a local middle school who had called upon StarVista's crisis services many times, referring parents to the parent hotline, students to the Teen Chat Line, and calling for crisis intervention support numerous times. The counselor described one instance with a high-achieving boy who was seriously depressed and experiencing suicidal thoughts. The counselor called upon the Crisis team and an intern came to the site, met with the student, confirmed the counselor's assessment, and conferred with the counselor to develop a treatment plan. For two months, the intern continued to come to the site weekly to meet with the student and the counselor until the crisis had been stabilized. The Counselor noted that now a year later, the student continues to meet with her weekly, is doing well in school and is developing skills for managing his depression. The counselor noted another time when a younger student was also depressed and also exhibiting signs of suicidal ideation. Again, the counselor called upon StarVista and again an intervention specialist met with the student, confirmed the diagnosis and met with the counselor to develop a treatment plan. The counselor also indicated that every year she and others at the site have been trained by StarVista in identification of students at-risk of suicide and in strategies for implementing school-wide suicide prevention strategies. Above left is a quote from the structured interview conducted by the evaluator.

> "StarVista is a critical service to our school community. A community nearby has been experiencing a number of youth suicides among high-achieving students and it creates a context in which suicide seems to be almost a normalized response to crisis or depression. It is a great concern at our school and I know at others in the area. StarVista's training, crisis intervention and hotline services are all critically needed. They are very good at what they do, they respond very quickly, and they make a big difference."
>
> Middle School Counselor

Lastly, the YIT also provides prevention education sessions to over 2500 middle and high school students. After each presentation, students take a post-test survey. Results from the survey disclosed that 93.3% of respondents correctly answering two questions pertaining to myths about suicide. More than 90% responded that they were more aware of available resources after the presentation. Clearly, these presentations are meeting their goal of dispelling myths about suicide and helping students

Evaluation Question # 3: Have clients, families, partners, and/or communities been satisfied with services?

Certainly the caller and school personnel satisfaction data described above provide evidence of high satisfaction with both the hotline and the Youth Intervention Team services. This satisfaction is further affirmed through the structured interviews. Another online, anonymous satisfaction survey was administered with Hotline volunteers responsible for answering crisis calls. Twenty volunteers responded to the survey and their responses both offered a better picture of the role volunteers played and provided clear evidence of their satisfaction with their role, the support provided by paid staff, and their perceived impact on clients. Open-ended questions also provided a number of excellent suggestions for how the program could be improved.

The survey revealed that 50% of the respondents had been volunteers for 1-3 years with 10% having been volunteers for over 10% and 10% more being volunteers over three to ten years. Taken together this suggests a significant level of stability and satisfaction among the volunteer corps. Sixty-five percent of respondents indicated spending over ten hours per month as volunteers. When asked how often they felt they had helped callers, 65% of respondents indicated either almost always or most of the time they felt they had helped, with 35% indicating some of the time and with no volunteers indicating rarely or almost never. Given the difficult role that volunteers play and the high degree of crises they encounter, this appears a very high percentage to feel confident in their impact. While 15% of respondents felt that most calls were from people in immediate and extremely urgent crisis, 75% responded that the majority of calls were seeking support for a serious situation, but not an urgent, immediate crisis. In terms of the degree to which volunteers felt prepared for their role, 70% of respondents strongly agreed and the remaining 30% somewhat agreed with the statement that "SV's training prepared me very well for the work I do" and an even higher percentage (85%) strongly agreed that "SV staff provide excellent support whenever I feel challenged by a call or situation" with the remaining 15% indicating that they somewhat agree. Taken together this represents an extremely high level of satisfaction and a high proportion of volunteers indicating confidence that they are having an impact. The quote above aptly captures the sentiments of the many other extremely positive comments made by volunteers in response to an open-ended question about what how the program could be better. The only remotely negative comments were that the carpet be replaced or cleaned and two conflicting comments, one indicating that volunteers should be allowed to remain on the line longer with callers with complex challenges or needs for referral to other services while another volunteer indicated that there should be stricter guidelines to limit longer calls, particularly during high demand hours. In addition to the above, there were a number of constructive suggestions worthy of consideration including:

"The training was extremely helpful. It covered a myriad of call types we receive. Also when you receive a very emotional call or a critical call, the staff are so supportive and reassuring, often standing beside you to put a hand on your shoulder or write notes about other services to offer or to provide background if the caller is a frequent caller. This is priceless support that makes all the difference."

- One asking if their line could be transferred to their cell phone so they could continue to work after their shift,
- Another asking if there could be supplemental training in response to volunteer requests,
- One volunteer requested that StarVista overlap shifts so volunteers could develop a deeper connection with each other and perhaps share partial shifts,
- Two volunteers indicated that phone numbers for resources and referrals sought by callers should be updated with the second reference specifically noting that some of the housing and mental health services were not as helpful as would be desired,
- Another volunteer wondered if a button on the computer could be installed to enable the caller to automatically call the phone company for an emergency trace and perhaps connect with police so the volunteer didn't have to be looking for a number during an extreme crisis, and lastly
- A volunteer suggested that StarVista should consider including recordings of real calls in the training, supplementing the role play practice.

The large number of positive comments about staff support, training and volunteer camaraderie along with the thoughtful, constructive suggestions above, are indicative of a well-managed program that despite operating in extremely stressful contexts, has achieved a very positive moral among the volunteers.

Evaluation Question # 4: Have program services been responsive to the population targeted by the contract?

StarVista provided significant and varied forms of highly affirmative data verifying the degree to which the Hotline program responded to the needs of both the volunteers and callers in crisis. Volunteers felt well-trained and callers felt that they were heard and supported by those volunteers. While there was less evidence from the schools and none from those directly served by the Youth Intervention Team, the survey and interviews with school personnel and the interview with the clinical director provided ample evidence that this program was also meeting the needs of the intended population. EQ # 6 and 7 provide suggestions as to how the intervention program could gather more data on school personnel satisfaction with both training and intervention support.

Evaluation Question # 5: To what degree has the program advanced the vision, mission and objectives of the MHSA PEI plan?

The vision, mission and values of San Mateo County Behavioral Health & Recovery Services stress empowering individuals to direct their own recovery process. BHRS stresses the adoption of culturally competent treatment approaches and through its MHSA planning processes, a further focus has been placed upon implementing evidence-based practices that have demonstrated the capacity to support client wellness and recovery. From the perspective of prevention, BHRS has also described the journey towards a transformed system requiring that programs:

- move "upstream" to primary prevention strategies;
- partner with other health prevention efforts to focus on wellness and recovery;
- achieve desired outcomes; and
- integrate efforts to support sustainability;

What's more, San Mateo's MHSA plan clearly described the priority of intervening early and identified stress, PTSD, and use of alcohol and drugs as factors where early intervention were most important, particularly in relation to individuals from historically underserved populations. The hotline and intervention programs clearly promote wellness and recovery, provide services, supports and referrals to individuals in extreme crisis. While the crisis intervention and hotline are not classically preventive or 'upstream' as they serve clients who have reached extreme crisis, both programs target youth and provide referrals to other partner health promotion supports and based upon the data presented, both programs are achieving the desired outcomes. What's more, the extensive school training of school personnel and consultations with counseling staff facilitate schools adopting suicide prevention programs and assist in identify students at risk of suicide. The school presentations to almost 2500 students also contributes to creating student bodies that are sensitive to the needs of individuals under stress and better equipping them to be supportive.

Evaluation Question # 6: What factors have impeded or contributed to successful implementation? How?

Through the evaluation process a number of factors were identified that impede StarVista from maximizing its impact.

Crisis call back-up system. StarVista had been using the Bill Wilson Center in Santa Clara to back up StarVista's system when they are over-extended. Unfortunately, the AAS requires that all back up providers also be AAS certified, as StarVista is. Bill Wilson is not AAS certified and so StarVista is in the process of engaging Bay Area certified providers to see if a back-up plan can be developed.

***Language can be a barrier*.** StarVista is part of a collaborative Bay Area Spanish speakers crisis line, and refers people to that line both via outreach and when they call the Hotline. While StarVista does have a few Spanish speaking volunteers, they are only occasionally on duty. Having a language interpretation service account has been too expensive for the StarVista budget in the past, though the Program Director indicated that with adequate funding, they would use this resource.

Out-of-date referral information. Volunteers noted that contact information for many referral resources were out of date and that callers had reported to them that some of the resources to whom they had been referred were not very useful. From experience working with hotlines in most Bay Area counties, I know that this is a very common challenge and one not easily overcome, as once any list of referrals is complete, within weeks they begin to become out of date.

Lack of automation or easy access to information and/or outside support. A couple of volunteer comments suggested that at times they become flustered when seeking referral numbers and one volunteer suggested that it would be beneficial to have automatic connections established with emergency services providers like the police or to put a tracer on calls so that the location could be identified.

Ability to balance need to address high volumes of calls with the need to stay with callers who are experiencing extreme crisis or require complex referral support. Two volunteers sited either side of this conundrum, one asking for more flexibility to stay with callers and the other asking for tighter regulations to force volunteers to get off long calls when there is also a high volume of callers.

Lack of sufficient funding. The Hotline is significantly underfunded and this impacts all of the above items. The program is funded for only four hours a week for a program manager when a full-time manager would be warranted. Developing a new back up relationships, exploring development of a texting system for the Teen Chat Room, coordinating outreach efforts to secure more bilingual volunteers, or translation options and sustaining a up-to-date referral information all require managers with time to do the research, design and outreach. StarVista simply does not have sufficient management to address these challenges as quickly or thoroughly as would be the case with more funding for management.

Evaluation Question # 7: What steps can be taken in the future to improve program services and what data could verify that these improvements had occurred?

There were very few areas in which there was any evidence of a significant need for improvement in the services delivered by the Crisis Intervention and Suicide Prevention Center, however, there is room for improvement in data collection as there were a number of ways in which the YIT could obtain data to validate program effectiveness and to identify areas where improvement might be possible.

- *Conduct more outreach to the Spanish-speaking community to expand the number of Spanish-speaking volunteers.*
- *Consider ways to better organize referral contact information so that it is more easily accessible by volunteers on the Hotline;*
- *Explore ways in which contacts with emergency services can be automated or that traces can be made via a computer connection with the phone company.*
- *Begin collecting data on the number of call referrals to other resources that are required because of Hotline inability to converse with a caller speaking another language—this data could be used to justify seeking county or private funding for the translation*
- *Expand data collection for all school based programs by:*
    - *Incorporating a protocol at the end of a school crisis intervention that directs the primary school contact to complete a brief online survey once the crisis has been reduced with open-ended questions asking what was most valuable about the intervention and how the intervention might have been implemented more effectively or what more could have been done;*
    - *Work with the evaluator to create a Crisis Intervention Incident Report that captures demographic data of students served, a checklist of services delivered, and a brief summary of the nature of the crisis and the outcome;*
    - *Survey Teen Chat Room teen volunteers as was done with hotline volunteers*
    - *Utilize a post presentation survey of students attending presentations and with teachers and school personnel participating in training, and including open-ended questions to identify how the presentations or trainings could be improved; and*
    - *Establish a procedure for entering this data into a database so that it can be used by program managers to identify areas in which programs could be improved.*

While the above recommendations could possibly improve StarVista's Crisis Intervention and Suicide Prevention Center, as the evaluation report describes throughout, this is a very well managed program that consistently meets the needs of schools and individuals experiencing high levels of crisis and where there really is no other resource other than the Crisis Center. If it were at all possible for the County to dedicate additional funding to support expansion of the program's management position OR to partner with StarVista in seeking private funding, this would significantly boost the program's capacity to continue to expand its program and fill gaps where they exist.

Section V Demographic Summary

Demographic data is not collected by any of the programs. So this table has not been completed. However, narrative is provided for the tables that summarize the degree to which a program meets MHSA and/or BHRS priorities. That information follows this incomplete table.

Demographic Summary					**Source of Data**
Total Unduplicated Served					
Gender		**Clients**	**Program Staff**		
	#	%	#	%	
Male					
Female					
Other					
Age	#		%		
Children 0-15					

Demographic Summary					Source of Data
Transition Age Youth 16-24					
Adult (25-59)					
Older Adults 60+					
Families (can include families with children or TAY)					
Ethnicity	**Clients**		**Program Staff**		
	#	%	#	%	
Caucasian					
Latino					
African American					
Asian					
Pacific Islander					
Native American					
Multi-Ethnic					
Other					
Home Language	**#**	**%**	**#**	**%**	
English					
Spanish					
Cantonese					
Mandarin					
Underserved Pops Served	**#**	**%**	**#**	**%**	
LGBT					
Blind/Vision Impaired					
Deaf/Hearing Impaired					
Veterans					
Homeless					

Program Components Table and discussion are on the next page.

Section VI Program Components:

The information in Table II will be used to report to MHSA as part of the statewide evaluation. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator.

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
	Yes	**No**
II-1) Access for Underserved Populations	**x**	
Details: Clearly the hotline and intervention team both serve individuals in crisis, while not explicitly targeting under-served populations, under-served populations are among those served.		
II-2) Outreach for Early Recognition of Need	**X**	
Details: Training of school personnel and prevention education to almost 2500 middle and high school students is designed to help students and school personnel identify students at risk of suicide.		

Table II: Program Components (Indicate if your program incorporates any of the following. If you indicate yes to any of II-1 through II-7, please describe how these components or activities are incorporated in your program. No more than 2-3 sentences per response.		
II-3) Access or Linkages to Care	**X**	
Details: Certainly one of the primary functions of the Hotline is to connect callers to resources that address their needs.		
II-4) Reduction of Stigma	**X**	
Details: School presentations reaching almost 2500 students are designed to sensitize students to how stigma impacts peers experiencing emotional challenges.		
II-5) Screening for Needs	**X**	
Details: One of the key functions of the YIT is to work with school personnel to assess the needs of students in crisis and identify and develop a plan for longer-term support, as needed.		
Program Activities	**Yes**	**No**
II-6) Addressing Trauma	X	
Details: Trauma is in play with the large majority of clients served by the Crisis Center whether this be in intervening with students at risk of suicide or fielding crisis calls on the Hotline.		
II-7) Specific Risk Factors	X	
Details: Suicidal ideation and depression.		

	Provide specific details very briefly. 1-3 sentences per line.
II-7) Indicate the location where program activities occur (identify places where services occur	The Hotline is a countywide program and the intervention team serves schools throughout the County.
II-8) Specify the roles for Peers (mentors Outreach, Peer education, other)…Please specify.	The most obvious example of a peer component is the Teen Chat Room. However, as was evident from the structured interview with the YIT Clinical Director, interventions have resulted in peer groups at one school with peers supporting peers who had been involved in self-harming activities.
II-9) Specify the sectors with which you collaborate on this program (housing, criminal justice, public health, education, child welfare)	The Hotline refers callers to services in virtually every public service sector including housing, education, and health. The intervention team is quite obviously collaborating with school sites throughout the county but is also referring students in crisis for mental health services via the Access Program.

Section VII Program Alignment with SMC MHSA PEI Priorities:

Providers will mark Y for Yes for any community need or priority population addressed. In the space provided, please explain how these needs or populations were served. This Table will be completed only at the end of the program year and before the final structured interview conducted by the evaluator during which time a discussion will occur to amplify and provide details or examples.

Table III: Alignment with SMC MHSA PEI PRIORITIES				
	Children & Youth	**TAY**	**Adult**	**Older Adult**

Table III: Alignment with SMC MHSA PEI PRIORITIES				
1-PEI Key Community Needs	**X**	**X**	**X**	**X**
1-A) Disparities in Access to Mental Health Services				
Details: The primary purpose of the crisis line is to defuse the personal crisis of thousands of callers of all ages who have not been able to access other services. The intervention team intervenes and supports schools in the prevention of suicide both through prevention education and direct crisis intervention.				
1-B) Psycho-Social Impact of Trauma	X	X		
Details: Intervention team presentations to 2500 students are designed to educate students about the impact of trauma and school training is designed to train school personnel in how to prevent trauma and identify its impact.				
1-C) At-Risk Children, Youth and Young Adult Populations	X	X		
Details: Both the Teen Chat Room is designed to work with other youth before they begin experience crisis and the intervention teams is designed to support youth in extreme crisis.				
1-D) Stigma and Discrimination	X	X		
Details: Intervention team presentations to 2500 students are designed to educate students about the impact of stigma and school training is designed to train school personnel in how to prevent stigma and nurture a more empathetic school community.				
1-E) Suicide Risk	X	X	X	X
Details: The intervention team intervenes directly in situations where a youth is at extreme risk of suicide and the Hotline fields hundreds of calls from individuals with suicidal ideation.				
2- PEI Priority Populations				
2-A) Trauma Exposed Individuals	X	X	X	X
Details: The intervention team intervenes directly in situations where a youth is at extreme risk of suicide and the Hotline fields hundreds of calls from individuals with suicidal ideation. Most often these crises are triggered by exposure to trauma.				
2-B) Individuals Experiencing Onset of Serious Psychiatric Illness	X	X	X	X
Details: In many instances, student suicidal ideation surfacing at the school site can represent the first evidence of the onset of serious psychiatric illness. While there is no data to verify this, it is likely that a number of Hotline calls are being triggered by the onset of a psychiatric condition.				
2-C) Children and Youth in Stressed Families	X	X	X	X
Details: Students experiencing thoughts of suicide are often feeling isolated and unsupported by families and may often be products of a highly stressed family.				
2-D) Children and Youth at Risk for School Failure	X	X	X	X
Details: Students at the level of stress where they are considering suicide are quite obviously at risk of school failure. In the structured interview with the intervention team Clinical Director, just such a situation was described with a friend of a suicide victim needing to leave school for several weeks to stabilize his own suicidal thoughts.				
2-E) Children and Youth at Risk of or Experiencing Juvenile Justice Involvement				
Details: Working with juvenile justice involved youth is not a focus of this program.				