SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Mental Health Services Act (MHSA)

Annual Update for Programs & Expenditures, FY 19-20

(Program highlights and data from FY 2017-2018 and FY 2018-2019 services)

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MHSA COUNTY COMPLIANCE

*This section to be completed after Board of Supervisor approval

MHSA COUNTY FISCAL ACCOUNTABILITY COMPLIANCE

*This section to be completed after Board of Supervisor approval

INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

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

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

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

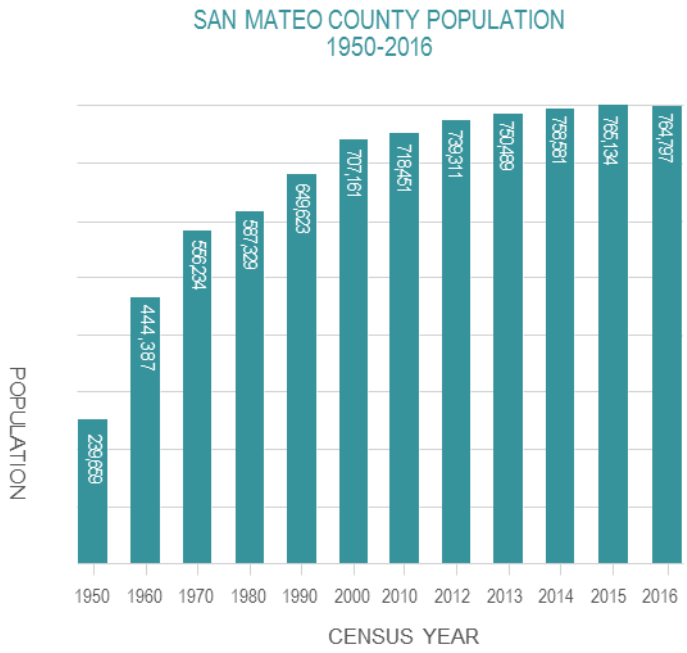
Situated in San Mateo County is San Francisco International Airport, the second largest and busiest airport in California, and the Port of Redwood City, which is the only deep-water port in the Southern part of the San Francisco Bay. These economic hubs have added to the rapidly growing vitality of the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

COUNTY OF SAN MATEO MISSION

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

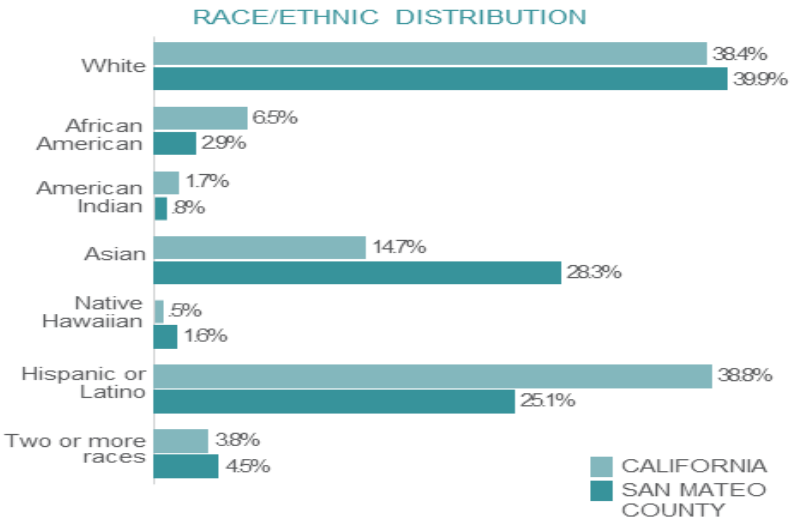
- The highest standards of public service;
- A common vision of responsiveness;
- The highest standards of ethical conduct;
- Treating people with respect and dignity.

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



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

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



MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars translating to about $29.7 million annual average for San Mateo County in the last five years through Fiscal Year 2018-19.

PRINCIPLES AND FUNDING BOUNDARIES

MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. Core values include:

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

MHSA programming is grouped into Components each with funding allocation and guidelines.

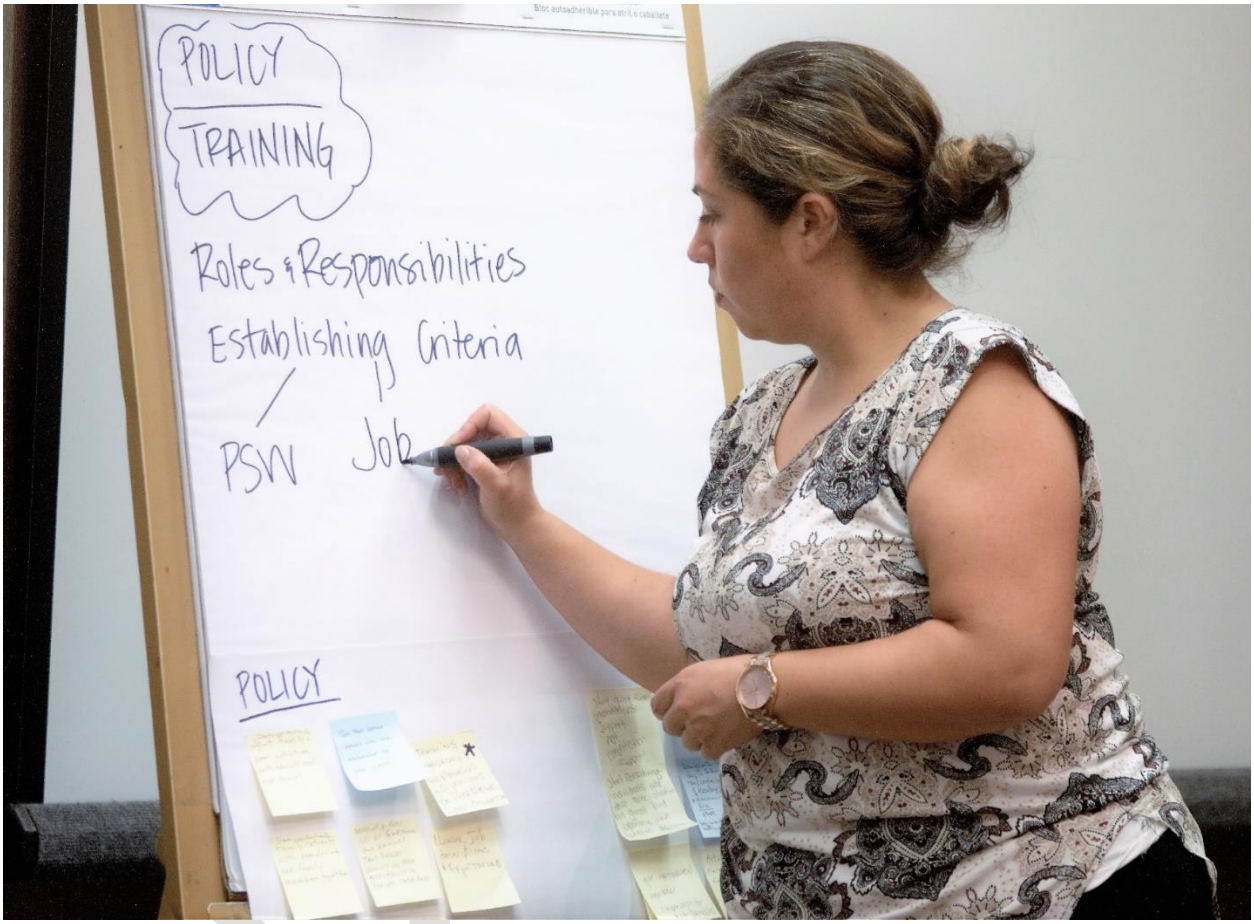
Component	Categories	Funding Allocation	Reversion Period
Community Services and Supports (CSS)	Full Service Partnerships (FSP) General Systems Development (GSD) Outreach and Engagement (O&E)	76% (FSP is 51% of CSS)	3 years
Prevention and Early Intervention (PEI)	Ages 0-25 Early Intervention Prevention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

One Time Funding:

Component	Amount Received	Reversion Period
Workforce Education and Training (WET)*	$3,437,600 FY 06/07- FY 07/08	10 years (expended)
Capital Facilities and Information Technology (CF/IT)*	$7,302,687 FY 07/08	10 years(expended)
Housing	$6,762,000 FY 07/08	10 years (expended)
	Unencumbered FY 15/16	3 years (expended)

** Up to 20% of the avg. 5-year total of MHSA funds can be allocated from CSS to WET, CF/IT and Prudent Reserve*

In San Mateo County, MHSA dollars are integrated throughout the BHRS system and highly leveraged. MHSA-funded activities further BHRS' vision, mission and strategic initiatives.



COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING (CPP)

The San Mateo County Behavioral Health and Recovery Services (BHRS) promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning. In 2005, BHRS devised a local planning process and structure to seek input from the broad San Mateo County stakeholder community. The Mental Health and Substance Abuse Recovery Commission (MHSARC), formerly the Mental Health Board, is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on the monthly MHSARC meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates. The MHSARC meetings are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad and increasing network of contacts including community partners and County agencies, as well as consumer and advocacy organizations, and the general public. MHSARC commissioners are all members of the MHSA Steering Committee.

MHSA STEERING COMMITTEE

The MHSA Steering Committee was also created in 2005 and continues to play a critical role in the development of MHSA program and expenditure plans. In 2016, the MHSA Steering Committee was restructured to strengthen the representation of diverse stakeholders. The MHSA Steering Committee makes recommendations to the planning and services development process and as a group, assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The Steering Committee meetings are open to the public and include time for public comment as well as means for submission of written comments.

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

MHSA Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization (if applicable)
Family Member	Sheila Brat	Chair	
Member	Donald Mattei	Chair	
San Mateo County Dist 1	Dave Pine	Chair	Board of Supervisors, District 1
Client/Consumer - Adults	Jairo Wilches	Program Coordinator	BHRS, OCFA
Client/Consumer - Adults	Michael Lim		
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Cultural Competence	Maria Lorente-Foresti	Director	Office of Diversity & Equity
Cultural Competence	Kava Tulua	Executive Director	One East Palo Alto
Education	Mary McGrath	Administrator	San Mateo County Office of Educ
Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer		California Clubhouse
Other - Aging and Adult	Anna Sawamura	Prog Services Manager	SMC Health System, Aging & Adult
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery
Other - Peer Support	Stephanie Morales	Peer Support Worker	BHRS, OASIS
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Felton Institute - PREP
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Provider of MH/SU Svcs	Chris Kernes	Managing Director	Health Right 360
Provider of MH/SU Svcs	Clarise Blanchard	Director	StarVista and Contractors Assoc
Provider of MH/SU Svcs	Helene Zimmerman	Executive Director	National Alliance on Mental Illness
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of MH/SU Svcs	Michael Krechevsky		Family Support Specialist
Provider of Social Svcs	Mary Bier		NCOC
Provider of Social Svcs	Rev. Chester McCall		EPAPBHO

** MHSARC members are also MHSA Steering Committee members (membership as of Nov 2019)*

MHSARC Members (local behavioral health board)

Stakeholder Group	Name	Title
Family Member	Sheila Brar	Chair
Public	Donald Mattei	Co-Vice- Chair
Public	Patricia Way	Co-Vice Chair
SMC District 1	David Pine	Supervisor, District 1
SMC District 1	Randy Torrijos	Staff to David Pine
Client	Wanda Thompson	Member at Large
Client	Jan Wongchuking	Member
Family Member	Bill Nash	Member
Family Member	Chris Rasmussen	Member
Law Enforcement	Mark Duri	Member
Public	Leticia Bido	Member
Public	Yoko Ng	Member
Public	Isabel Uibel	Member
Public	Cherry Leung	Member
Public	Catherine Koss	Member

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for at least a 30-day public comment period for stakeholders and any interested party to review and comment. Additionally, the MHSARC, San Mateo County's local mental health board, conducts a public hearing at the close of the 30-day comment period. The Annual Update FY 2019-20 (covering data from FY 2017-18 and FY 2018-19) was presented on December 4, 2019 to the MHSARC. The MHSARC voted to open a 30-day public comment period closing with a Public Hearing on February 5, 2020, after a review of substantive public comments received and necessary updates made to the plan. The MHSARC voted *unanimously* to submit the plan to the Board of Supervisors. Please see Appendix 1 for the FY 19/20 MHSA Annual Update materials and all public comments received during the 30-day public comment period. [this section to be updated after the public comment period].

The complete Annual Update is submitted to the San Mateo County local Board of Supervisors for adoption and to the County of San Mateo Controller's Office to certify expenditures before final submission to the State of California Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

- Announcements at internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to an MHSA distribution list of over 1,600 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa

INNOVATION (INN) PLANNING

New Innovation (INN) Funding Cycle

In San Mateo, the Community Program Planning (CPP) process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea

Form were circulated through various means. The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County there was the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

35 MHSA Innovation Idea Forms were submitted. All ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into project proposals. See Appendix 2 for the 5 INN Project Proposals pending Board of Supervisor (Bos) and Mental Health Services Oversight Accountability Commission (MHSOAC) approval.

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period and on November 6, 2019 reviewed the public comments received, voted to close the 30-day public comment period and subsequently voted to submit the updated Innovation projects the BoS for approval. The MHSA Steering Committee materials and public comments received are included in Appendix 3.

Timeline - Innovation Projects

FUNDING SUMMARY

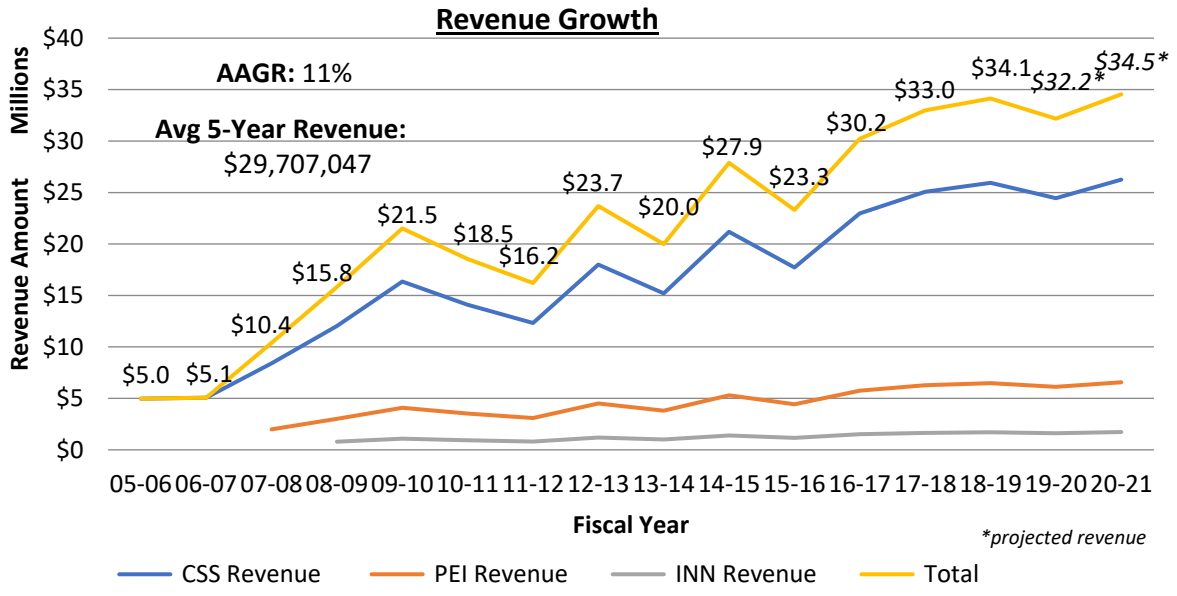
FUNDING SUMMARY

See Appendix 4 for the FY 19/20 Funding Summary of MHSA expenditures by component.

Statewide, MHSA represents a little under a third of community mental health funding. In San Mateo County, MHSA represents about 15% of the behavioral health revenue. The average annual revenue for the last five years equals to about $29.7 million for San Mateo County.

Annual revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that take into account information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association (CBHDA), and ongoing internal analyses of the State's fiscal situation. MHSA revenue is driven by the economy with only one tenth of 1% of tax payers are subject to the MHSA tax. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that impacted the decreases and increases in revenues throughout the years:

- FY 05/06 and FY 06/07: funding included Community Services and Supports (CSS) only.
- FY 07/08 and FY 08/09: Prevention and Early Intervention (PEI) and Innovations (INN) dollars were released in those years, respectively.
- FY 10/11 and FY 11/12: the California recession of 2009 led to decreased revenues
- FY 12/13: Counties began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation.
- FY 14/15: changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in a "one time" increase.
- FY 19/20: "No Place Like Home" legislation relies on MHSA. San Mateo County estimated cost would be $1.3 million, taken "off the top" of MHSA revenues.



FUNDING CONSIDERATIONS

Allocation of MHSA Funding

The following represent the current guidelines for MHSA expenditure planning:

- 76% of total annual revenue must be allocated to CSS.
    - At least 51% of CSS must be spent on FSPs.
- 19% of total annual revenue must be allocated to PEI.
    - At least 51% of PEI must be spent on programs serving ages 0-25.
- 5% of total annual revenue must be allocated to INN.
- Up to 20% of the average of previous 5-year revenue may be transferred annually from CSS to Prudent Reserve, Capital Facilities and Technology (CF/TN) and/or Workforce Education and Training (WET)* components.
- A maximum of 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years maximum of 33% may fund the Prudent Reserve.
- Up to 5% of total annual revenue may be spent on administration and community planning processes.

*A WET 10-Year Impact and Sustainability Report was developed with stakeholder input and submitted with the recent MHSA Three-Year Plan. The recommendation was to transfer $500,000 from CSS to WET annually to fund ongoing WET activities.

Reversion

MHSA legislation requires that MHSA funding under the key components (CSS, PEI and INN) be spent within a 3-year time or it must be returned to the State for reallocation to other mental health agencies. San Mateo County annual spending in CSS and PEI targets the 5-year average revenue, which keeps us in the clear of reversion risk. INN requires project approval by the Mental Health Services Oversight Accountability Commission (MHSOAC) before funds can be expended. Assembly Bill (AB) 114 established that the 3-year reversion time frame for INN funds will now commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while planning for new projects and/or awaiting approval.

AB 114 and a subsequent Senate Bill (SB) 192 allowed Counties to submit a plan by January 1, 2019 for expending their funds that were deemed reverted as of July 1, 2017. San Mateo County submitted plans for Innovations (INN) in the amount of $3,832,545 and Workforce Education and Training (WET) in the amount of $423,610. Updates to these plans are included in their respective sections in this Annual Update.

Target Reserve

Welfare and Institutions Code (WIC) Section 5847(b)(7) requires Counties to establish a **Prudent Reserve** to ensure the County programs will be able to serve clients should MHSA revenues drop. Until recently, counties had the discretion to establish their own appropriate reserve level. San Mateo County had $29 million in reserve, 80% of annual revenue, as was recommended by an independent State fiscal consultant. The California Department of Health Care Services (DHCS) Info Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County, this corresponds to $6.7 million. The Prudent Reserve can only be accessed when "revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index" subject to DHCS approval.

In January 2019, the San Mateo County MHSA Steering Committee reviewed and approved a recommended **Total Operational Reserve** of 50% (Prudent Reserve + additional operating reserve), of the highest annual revenue, which currently equals $17 million. The Prudent Reserve remains at $600,000 and the additional Operational Reserve are in a local MHSA Trust Fund. This allows the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, in the event that revenue decline is less than the State's threshold or funding is needed in a timely manner. Future legislation may require a minimum Prudent Reserve level, at which point funds will be transferred appropriately.

MHSA FUNDING PRINCIPLES

MHSA Funding Principles were developed to guide annual funding allocations and expansions; they also build from the County's and Health division budget balancing principles to guide MHSA reduction and allocation decisions when needed. Decisions regarding MHSA funding are based on the most current MHSA Three-Year Plan. Any funding priorities being considered outside of the MHSA Three-Year Plan priorities require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

The MHSA Funding Principles where presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout the County that was expected to have implications for MHSA funding.

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

PRIORITY EXPANSIONS

Progress on MHSA Three-Year Plan Priority Expansions

Component	Updated Priority Expansions	Estimated Cost Per Fiscal Year	Implemented
CSS General Systems Development	Expansion of supports for older adults *	$130,000	**YES – Partial** Senior Peer Counseling
	Field-based mental health and wellness services to expand access to Coastside	$450,000	**In Progress**
CSS Outreach & Engagement	Expansion of culturally responsive outreach strategies	$50,000	**YES** Chinese community outreach in North County
	TOTAL CSS	**$630,000**	

Component	Updated Priority Expansions **	Estimated Cost Per Fiscal Year	Implemented
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	$50,000	**Yes** Suicide Prevention mini-grants and county-wide stigma survey
	Youth mental health crisis support and prevention	$600,000	**In Progress**
	Trauma-Informed Services training for 0-5 providers*	$150,000	**Yes** First 5 of SMC MOU
	After-care services for early psychosis treatment for reengagement, maintenance and family navigator support	$230,000	**YES** (re)MIND/BEAM Aftercare Services
	TOTAL PEI	**$1,030,000**	

* Reprioritized from Previous Expansion Plan

* Added based on the PEI Taskforce recommendations in Three-Year Plan, approved by the MHSARC on February 6, 2018

EXPENDITURE UPDATES TO THE THREE-YEAR PLAN FY 17/18 – FY 19/20

San Mateo County departments continue planning for budget reductions starting fiscal year 2019-20. As described in last year's MHSA Annual Update, $2 million ongoing funds were allocated to core services for clients with serious mental illness (SMI) including Full Service Partnerships for Laura's Law eligible clients and Augmented Board and Care. Furthermore, available one-time funding will also include strategies to support the budget reductions impacting core services.

One-Time Funding Availability

The San Mateo County MHSA Trust Fund balance as of end of FY 2017-18 totaled about $36 million. Given that San Mateo County recommended a Total Operational Reserve Goal of $16.5 million, as of July 1, 2018, there was $12.5 million in available one-time funding to advance MHSA program priorities ($3.9 of the $12.5 million must be spent in Prevention and Early Intervention projects). Funding priorities for the $12.5 million available one-time funds were developed and presented to the MHSA Steering Committee on January 30, 2019 and included:

- System Improvements to Core MHSA Services
- Technology-related System Improvements
- Capital Facilities Improvements –if County owned and for MHSA services
- Workforce and Community Education and Training
- Stop Gaps for current Innovation programs and other budget reduction impacts

A Plan to Spend Available One-Time Funding was developed based on input received through the following stakeholder engagement processes:

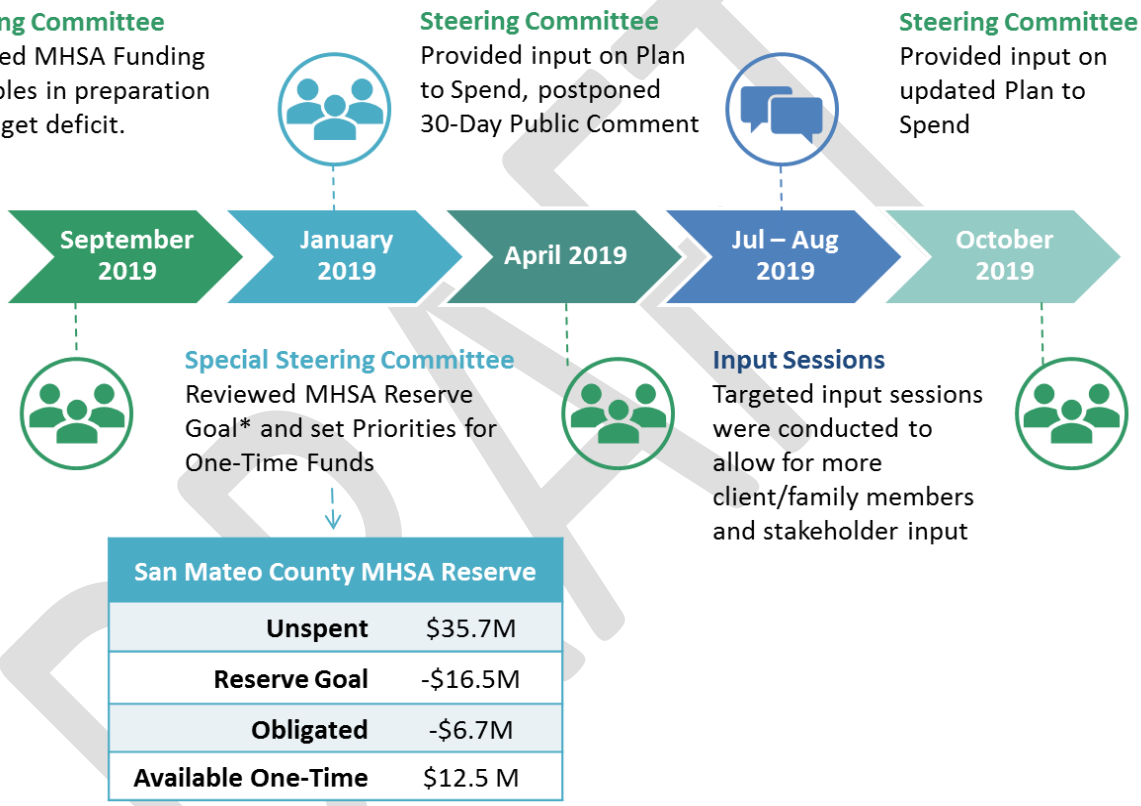
- MHSA Three-Year Plan, 32 community input sessions with over 300 participants
- BHRS Budget Planning Stakeholder Meetings conducted in the fall of 2018.

On April 22, 2019, the preliminary Plan to Spend was presented to the MHSA Steering Committee. Given the feedback received, the 30-day public comment for the Plan to Spend was postponed pending additional analysis and input, including targeted input sessions to further involve stakeholders and clients/family members and incorporating budget reduction impacts. The following community stakeholder groups were engaged in providing input into the Plan to Spend:

- MHSARC Older Adult Committee – June 5th
- MHSARC Adult Committee – June 19th
- MHSARC Youth Committee – June 19th
- Contractor's Association – June 20th
- Office of Consumer and Family Affairs/Lived Experience Workgroup – July 2nd
- Peer Recovery Collaborative – August 26th

On October 2, 2019, the MHSA Steering Committee reviewed the updated Plan to Spend and provided comments. The MHSARC voted to open the 30-day public comment period and on November 6, 2019 reviewed the public comments received, voted to close the 30-day public comment period and subsequently voted to submit the plan to the Board of Supervisors for approval, which is still pending. The final Plan to Spend including all MHSA Steering Committee materials and public comments received are included in Appendix 2.

Timeline – Plan to Spend Available One-Time Funding



San Mateo County MHSA Reserve	
Unspent	$35.7M
Reserve Goal	-$16.5M
Obligated	-$6.7M
Available One-Time	$12.5 M

ANNUAL UPDATE

FY 2019-2020

(Program highlights and data from FY 2017-2018 & 2018-2019 services)

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. Previously, data for the most recent full fiscal year was not readily available by the deadline to submit Annual Updates to the State in December. This Annual Update includes an attempt to collect and report on the most recent data, therefore program highlights and data include both FY 2017-2018 and FY 2018-2019. Moving forward, Annual Updates will include only the most recent data.

COMMUNITY SERVICES & SUPPORTS (CSS)

COMMUNITY SERVICES AND SUPPORTS

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

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

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

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

FULL SERVICE PARTNERSHIPS (FSP)

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

Based on currently contracted number of slots, the average FSP cost per person is $25,547. Clients enter and discontinue participation throughout the year, cost per person based on clients served was $14,981. Cost per person figures do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

Program	FSP slots	FY 17/18 Clients Served	FY 18/19 Clients Served	Cost per client*
Children/Youth (C/Y) FSP's	**105**	**119**	**118**	**$37,845**
Out-of-County Foster Care Settings FSP	20	17	15	$9,040
Integrated FSP "SAYFE" & Comprehensive FSP "Turning Point"	85	102	103	$44,622
Transitional Age Youth (TAY) FSP's	**40**	**61**	**61**	**$52,527**
Comprehensive FSP "Turning Point"	40	61	61	$52,527
Adult/Older Adult FSP's	**302**	**299**	**341**	**$17,783**
Adult and Older Adult/Medically Fragile FSP	207	224	232	$16,908
Comprehensive FSP	30	39	40	$28,411
Assisted Outpatient Treatment "Laura's Law" FSP	50	N/A**	22	$17,812
Integrated FSP	15	36	47	$8,491

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

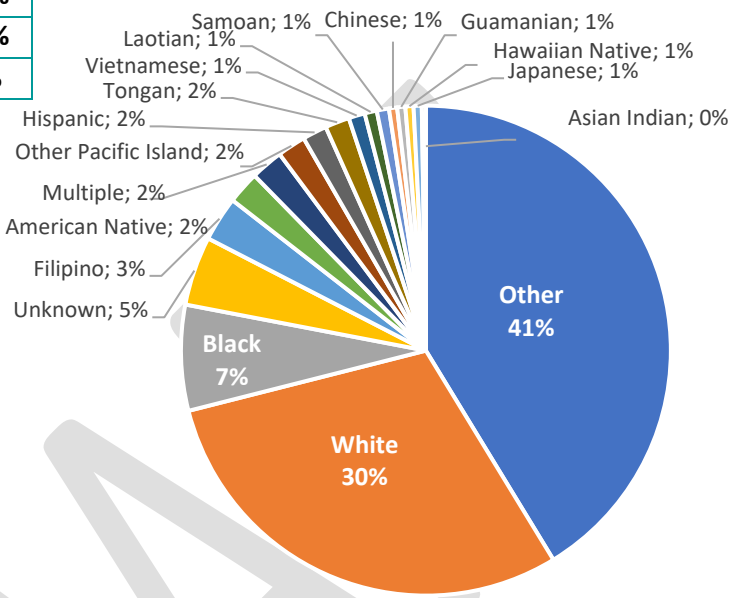
** AOT FSP were added in FY 18/19

FSP RACE/ETHNICITY DEMOGRAPHICS BY AGE GROUP

Child/Youth and Transition Age Youth FSP Client Demographics
combined FY 17/18 and FY 18/19 (total clients = 270)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	**53%**
Not Hispanic or Latino	**41%**
Unknown / Not Reported	**6%**

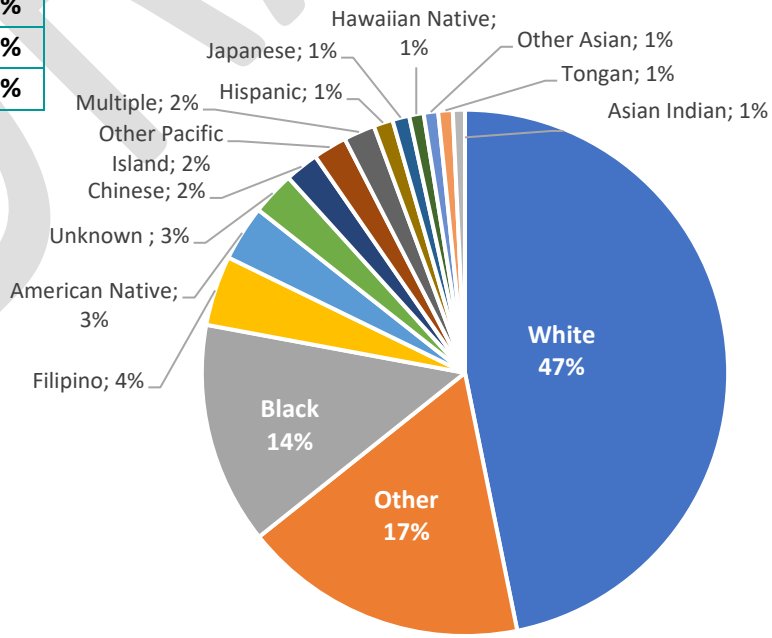
Percent of C/Y and TAY FSP Clients by Race



Adult and Older Adult FSP Client Demographics
combined FY 17/18 and FY 18/19 (total clients = 535)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	**24%**
Not Hispanic or Latino	**65%**
Unknown / Not Reported	**10%**

Percent of Adult/Older Adult FSP Clients by Race



FSP PERFORMANCE OUTCOMES BY AGE GROUP

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

Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs include data in 10 domains; residential (e.g. homeless, emergency shelter, apartment alone) education (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance abuse, and for older adults, activities of daily living and instrumental activities of daily living. Data from FSP participants is collected by providers via self-reported intake assessment, key event tracking and 3-month regular assessments.

See Appendix 5 for the full FSP Evaluation Report for Fiscal Year (FY) 2017-18. Highlights are included below for both FY 2017-18 and FY 2018-19. The full report for FY 2018-19 will be included in the next MHSA Annual Update.

The tables below present the percent improvement between the year just prior to FSP and the first year with FSP, by age group. In sum, the findings from self-reported outcomes (survey data) suggest that the vast majority of the outcomes improve for all reported age groups comparing the year prior to joining FSP to the first year of FSP services.

Fiscal Year 2017-18 FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	25%	(8%)	36%	NA
Detention or Incarceration	(18%)	6%	30%	NA
Arrests	63%	65%	89%	NA
Mental Health Emergencies	88%	73%	62%	46%
Physical Health Emergencies	100%	90%	69%	33%
School Suspensions	50%	76%	NA	NA
Attendance Ratings	(18%)	5%	NA	NA
Grade Ratings	(10%)	(2%)	NA	NA
Employment	NA	NA	NA[a]	NA
Active Substance Abuse Problem	NA	NA	36%	59%
Substance Abuse Treatment	NA	NA	66%	85%
Healthcare Utilization (EHR data)				
Hospitalization	70%	22%	53%	50%
Mean hospital days per partner	91%	41%	71%	(20%)
Psychiatric Emergency Services (PES)	53%	31%	29%	53%
Mean PES admissions per partner	54%	22%	45%	68%

Fiscal Year 2018-19 FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	22%	4%	50%	NA
Detention or Incarceration	(18%)	6%	33%	NA
Arrests	82%	82%	88%	NA
Mental Health Emergencies	88%	77%	74%	86%
Physical Health Emergencies	93%	91%	64%	60%
School Suspensions	54%	77%	NA	NA
Attendance Ratings	16%	3%	NA	NA
Grade Ratings	10%	(4%)	NA	NA
Employment	NA	NA	NA[a]	NA
Active Substance Abuse Problem	NA	NA	11%	25%
Substance Abuse Treatment	NA	NA	(8%)	33%
Healthcare Utilization (EHR data)				
Hospitalization	70%	21%	54%	33%
Mean hospital days per partner	91%	46%	68%	(37%)
Psychiatric Emergency Services (PES)	54%	34%	29%	40%
Mean PES admissions per partner	55%	27%	44%	39%

Note: The self-reported outcomes do not include Telecare FSP. Telecare FSP changed its EHR system in Sept 2018 and is currently in the process of converting its data in the new format to the original analytic format. The Telecare data is expected to be available in spring 2020. Healthcare utilization outcomes are calculated based on the San Mateo County EHR data system, thus it captured all FSP clients including Telecare FSP.

[a] The number of clients who had any form of employment increased from zero to three. Therefore, the percent of change was not reported.

CHILDREN AND YOUTH (C/Y) FSP

INTEGRATED FSP "SAYFE" & COMPREHENSIVE FSP "TURNING POINT"

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

SAYFE

The Short-term, Adjunctive Youth and Family Engagement (SAYFE) Program serves 40 youth and families at any one time by augmenting and extending the clinical work and existing treatment plan within: (1) the outpatient and Therapeutic Day School (TDS) programs and (2)

clients who are currently being served by Behavioral Health and Recovery Services (BHRS) in a Regional county clinic.

Turning Point C/Y

The Turning Point Child and Youth (TPCY) Program is a comprehensive program for 45 of the highest risk children/youth living in San Mateo County. TPCY is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family.

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

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

The SAYFE and Turning Point programs utilize the Wraparound model of care for children, youths, and families. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs so that they can live in their homes and communities and realize their hopes and dreams. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that when compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers (and family members) and address a range of life domains. Through the team-based planning and implementation process, Wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of youths and family members. Finally, there is an emphasis on integrating the youths into the community and building the family's social support network.

PROGRAM IMPACT & SUCCESSES

Building on several of the Wraparound principles, Edgewood is particularly skilled at engaging families and enhancing natural supports in a youth's life. The following success stories highlight the work that is as commonplace as it is critical to the work of the TPCY and SAYFE teams:

A 14-year-old youth was referred to the After School Intensive services (ASIS) program by her TPCY treatment team due to having difficulty socializing with her peers, a need for anger management and developing coping skills. Her personal goal for attending the program was to get "help being social." Upon meeting the youth, she presented as shy and reserved but was open to learning. ASIS provided a youth-centered, therapeutic, safe place for her to practice social skills, build healthy peer relationships, communication strategies, and try new coping skills through individualized and peer group interventions. She flourished in the program and became a role model, helping lead group discussions, facilitating coping skill activities, and giving advice to peers newer to the program. On her graduation day, her peers and ASIS staffs praised and recognized all her accomplishments. She responded, "I want to thank you all for helping me become more social and more confident with myself."

A 6-year-old youth male was referred to Wraparound services by his school district due to high risk aggressive behaviors (both physical and verbal). He presented with symptoms such as hitting, kicking, scratching, property destruction, offensive language, and inappropriate touching. The youth also had a history struggling with transitions and presented with rigid thinking, poor eye contact, speech delay, inappropriate social interactions, and not being aware of other's emotions. His parents struggled to communicate effectively and had difficulty setting limits with youth. The youth and family have participated in individual therapy, family therapy, collateral support, TBS services, ASIS program, family conferencing, and case management. The youth, now 8-years-old, has made significant improvements in his overall mental health. Per mother's report, he is accepting limits set by parents, follows directions, and listens when they talk to him. Mother stated that she has observed him being more communicative with family members and he has increased his verbal and emotional vocabulary. They youth is receptive to boundaries set during individual therapy. He has been able to utilize coping skills and positive replacement behaviors, such as deep breathing, fidgets, and puppet play during sessions. He has shown improvement in expressing his needs and wants during therapy and utilizes feeling words more effectively. He has been open about his triggers and is beginning to recognize when he starts to get upset. The youth appears more focused during session and has improved his ability to make eye contact. He has learned to be more mindful and aware of others' space at school and at home. He has also learned to identify self-soothing techniques to calm his body when feeling dysregulated, like asking for 5-minute break at school or asking to play with his dog while at home. The team believes youth is ready to graduate services to a lower level of care to continue his successful recovery.

A 10-year-old youth was referred to SAYFE due to his aggressive behaviors, unhealthy dynamics in the home, and difficulty positively interacting with his peers. In the six months prior to his referral, the youth had four Psychiatric Emergency Services (PES) visits for suicidal ideation, homicidal ideation, and visual hallucinations. During his treatment, the youth gained the ability

to decrease aggressive behaviors by utilizing his coping skills (viz., origami), verbalizing his needs and feelings, and creating his own safety plans to support with de-escalation when feeling upset. The youth benefited from working with his Behavior Coaches and attending the ASIS program. As a result, he engaged in positive interactions with peers. Mom learned how to positively approach the youth in efforts to reduce his escalations. She was highly proactive and engaged in services despite the multiple challenges to find housing for her family. The youth was not hospitalized during his time within the SAYFE program and graduated successfully with new coping skills intact.

SAYFE and Comprehensive FSP	FY 17/18	FY 18/19
Total clients served	102	103
Total cost per client		
based on clients served	$37,185	$36,824
based on contracted slots	$44,622	$44,622

CHALLENGES

There are several challenges that have become impactful to the programming and service delivery. These challenges, their impact, and possible solutions are highlighted below.

- **Cost of living in the Peninsula:** The high cost of living continues to present a challenge for families (and staffs) who are unable to locate affordable and suitable housing. Living in households with multiple members and frequent relocations impacts quality of life, privacy, safety, and continuity of services.
    - The strategies: The county is working to create more affordable housing and increase living wages. Staff also meet outside of the home to ensure youths have the emotional and physical space to engage in treatment and if a family relocates, staff work with them to ensure resources in the new location.
- **Consistent staffing**: It is difficult to recruit and retain staffs who are qualified (e.g., have the language capacity, lived experience, or necessary credentials) to adequately treat the population served. This requires that leadership and direct line staff carry additional workloads and families may experience several provider changes. Also, salaries do not match the astronomical cost of living in the county.
    - The strategies:
        - Workloads were paired down to be more reasonable and to accommodate predictable short-term increases (due to youth/family crises or vacant positions).
        - Translation services are used to meet the language capacity of a family.
- **Worsening traffic:** In recent years, the amount of time community-based staff spend in their vehicles has increased significantly impacting the number of appointments staff can have and staff safety on the roads.

    - Teams divide the workload throughout the county to ensure families feel supported throughout the week. Management will also consider reducing caseloads to ensure staff are able to provide the same level of care and support to youth and families.
- **Appropriateness of referrals:** An influx of referrals that do not present as Wraparound cases (e.g., youths do not have an approved primary diagnosis, are not risk of out-of-home placement or have a lack of family involvement) or arrive in (seemingly preventable) crisis. The strategies:
    - Work with referring parties to clarify referral criteria and medication management.
- **Support for the Latino and Spanish Speaking Community**: The strategies:
    - Increase recruitment of bilingual/bicultural direct line staff to provide services to monolinguals Spanish Speaking families.
    - Bilingual/bicultural treatment team members invest time and energy into explaining services, translating documents, and interpreting for meetings.
    - Having bilingual leadership team provides support and advocacy during providers' meetings to advocate for Spanish Speaking families in the system.

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
0-15	59%	59%
16-25	41%	41%
26-59	0%	0%
60+	0%	0%
Primary Language		
English	72.5%	
Spanish	11.8%	
Another language	15.7%	
Race/Ethnicity		
Asian		2.%
Latino	50%	45%
Black/African/-American	4%	8%
White/Caucasian		22%
Filipino	3%	1%
Another race/ethnicity	42%	
Decline to state		1%
Unknown		18%

OUT-OF COUNTY FOSTER CARE SETTINGS FSP

East Bay Wrap Full Service Partnership – (EBW-FSP) is a community based program serving the needs of youth who are in Foster Care through San Mateo County but live out-of-county. EBW-FSP, provides intensive community-based care that is rooted in a positive, strengths-based approach. Youth and families receive individualized services (psychotherapy, behavioral interventions, and case management) to maximize the families' ability to meet their child's needs, and thereby reduce the potential for residential placement. Because they serve at-risk individuals with services that are difficult for them to obtain "out of county," the FSP-SM has an "open ended" duration. Staff utilizes a variety of therapeutic approaches, including Cognitive Behavioral Therapy, Behavior Modification, and Motivational Interviewing. All services are trauma-informed, and healing centered.

Fred Finch Youth Center (FFYC) maintains a longstanding philosophy that the best road to change is one that is family-centered and strength-based. Staff understands that healthy changes are possible but can be difficult to implement. They meet youth and family where they are in terms of readiness to change and use trauma-informed practices. FFYC understands that behavioral challenges are a manifestation from unresolved trauma. They invite dialogue, treatment strategies and psycho-education to help the youth, family and treatment team better understand the impact of trauma. An essential feature of service is employing an unconditional commitment to positive outcomes, strengths-based and a "whatever-it-takes" strategy. Through building trust and helping address unmet needs, families often see small improvements in their well-being. They encourage families and youth to voice their preferences and priorities and from this, convey that they are respected and seen as experts in their lives. All staff are participating in Affinity Groups to discuss and put into action, ideas to be more aware of the impact of race and privilege in personally and professionally. FFYC anticipates this awareness will have a positive impact on creating a welcoming environment for all families.

PROGRAM IMPACT

The EBW program has been collecting CANS/ANSA since 2016 and is using this information to develop collaborative treatment objectives. Additionally, the department has set some outcome goals from the information gather from the CANS. Goals were selected based on the acuity of clinical needs. The EBW program had the following goals and results:

- 40% of participants total domain score for child strengths will decrease (meaning that youth/families had more identified strengths) – Actual: 60% decrease **(goal met)**
- 35% of participants' total domain score for Behavioral/Emotional needs will decrease – Actual: 70% (**goal met)**
- 25% total score in Living Situation Domain rating will decrease – Actual: 40% **(goal met)**

- 70% of Participants will have improvement in at least 1 domain – Actual: 80% **(goal met)**

EBW has been consistently seeing improvement in these measurements. Some of the improvements are a result of having a strong clinical rapport with families and helping youth/families better identify their strengths and using those assets to manage difficulties in their lives. Additionally, 100% of youth discharged to same level of care, meaning that none of the discharges were to a higher level of living care. These services are reducing the severity of mental health issues in the youth that are being served.

Prior to the AB1299, out-of-county youth faced challenges accessing mental health services in their community. Youth in the Child Welfare System often experience trauma and have significant mental health challenges. The EBW program would provide an intense level of mental health services to these vulnerable youth. The EBW program is firmly rooted in strengths-based approaches. Issues presented are "unmet needs." By helping the youth and care givers to see the "dysfunction" from this stance, it helps reduce stigma and better education others on the impact of trauma and how it may manifest.

In FY 2018-2019 EBW met their internal goals of reducing needs scores in the following domains: Life Functioning, Child Strengths (which means improving strengths), and Behavioral/Emotional. They saw progress but did not meet their benchmarks for the Living Situation Domain. This is a common issue in that parents, care givers and youth often express the difficulty of living together.

Out-of-County FSP	FY 17/18	FY 18/19
Total clients served	17	15
Total cost per client		
based on clients served	$10,635	$12,053
based on contracted slots	$9,040	$9,040

SUCCESSES

One success has been expanding services to youth aged 18-21. 'Donna', a young adult attending college at Cal State Easy Bay. Donna struggled with anxiety and relational issues. A clinician met with Donna at convenient locations and times to support Donna in developing conflict resolution skills. Donna indicated that the preparation helped her and reported feeling more confident setting boundaries with people who were not fully supportive of her. She also stated that having an outlet to vent and be supported has been very important in her college success.

CHALLENGES

One of the challenges EBW faces are large distances between their office and youth's location. EBW serves youth throughout the greater Bay Area, including near Sacramento, San Jose and Central Valley. EBW has also been under enrolled in their services. To mitigate this EBW has been in touch with many San Mateo County partners to expand services to 18-21-year-olds and continue to remind staff and other programs of their services. FFYC is contracted to serve 20 out-of-county youth however have been averaging about 11 per month. With AB 1299, new CWW who are less familiar with services and an inability to get referrals from youth who are receiving FFA services, numbers have steadily declined. The Program manager plans on attending staff meetings with CWW to inform them about services.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
0-15	0%	40%
16-25	100%	60%
Primary Language		
English	100%	100%
Sex Assigned at birth		
Male	47%	33%
Female	53%	67%
Decline to state		
Gender Identity		
Male/Man/Cisgender		33%
Female/Woman/Cisgender woman		67%
Race/Ethnicity		
Latino	5%	
Black/African/-American	24%	
White/Caucasian	12%	
Mexican/Chicano	5%	
Samoan	5%	
Another race/ethnicity	29%	
Unknown	5%	
Veteran		
Yes		
No		100%
Decline to state		

ENHANCED SUPPORTED EDUCATION

Caminar's Supported Education program at the College of San Mateo has been highly successful in supporting individuals with mental health/emotional needs in attending college and achieving academic, vocational, and/or personal goals. This program was established in the spring of 1991 from collaboration with the College of San Mateo, Caminar, and the County of San Mateo's BHRS program. The program's unique approach combines special emphasis on instruction, educational accommodations and peer support to assist students to succeed in college. Traditionally, the attrition rate for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills, and low self-esteem. However, this program has become an innovative leader in reversing this trend. Started in 2016 at Skyline College, Future Views supports potential students with an introductory class and one to one counseling and tutoring.

In Addition to the campus presence, the Supported Education program has an extensive presence in the community, with regular groups and outings at Caminar's residential programs, Cordilleras MHRC, Edgewood's Drop- In Center, and California Clubhouse. There is also have a weekly Drop-In time for clients to get school and career assistance.

The Supported Education program strives to reach out and engage individuals who can benefit from engagement in the supported education program. To this end, the supported education program team has reached out to a total of 54 community programs throughout the fiscal year, to reach out and engage clients into supported education services, thereby initiating a pathway of recovery, support and empowerment. Once engaged in the supported education program, clients begin to see their potential and the opportunities available to them. Classes and groups also build on recovery principals such as; WRAP (Wellness Recovery Action Plan), resource education and linkage, empowerment through education and career development, leadership potential, having a peer support group, and engagement utilizing active listening, motivational interviewing, and supportive engagement.

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

Caminar's Supported Education program provides such a pathway of opportunity, and it remains essential that all of San Mateo clients are given information of and access to the supported education program.

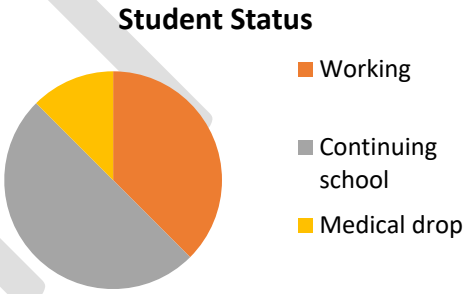
PROGRAM IMPACT

The supported education program focuses on connecting individuals with educational/vocational services and by providing individualized supports. With these supports, the cohort GPA and retention rates are as follows:

- Achieved an overall GPA of 3.3
- Attained a retention rate of 84%

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

- 100% Reported that their class experience was satisfactory or above
- 6 students are working, 8 are continuing school, 2 dropped due to medical reasons
- The program served 117 unduplicated clients, with 43 TAY (transition-age-adults)
- 86 groups and activities for TAY clients
- 282 engagement activities for TAY were offered (classes, groups, outings, one to one activities)



Supported Education	FY 17/18	FY 18/19
Total clients served	112	117
Total cost per client		
based on clients served	$1,637	$1,567
based on contracted goal (40)	$4,584	$4,584

SUCCESSES

FSP staff work very hard to serve clients to help provide for their safety and promote stability in the community while reducing the need to utilize higher levels of care. Between the high acuity of mental health challenges in clients, staff caseloads and the various regulations and mandates that dictate activities, work in FSP requires almost super-human abilities of the staff that work in the program. Whenever a client does not attempt suicide, die by suicide, reduces the instance or intensity of suicidal ideation, remains (even if just longer) in stable housing for a year or reduces/eliminates utilizing PES or hospitalizations/incarcerations, it is a success. When a client starts a job or stays in a job even just a little bit longer, this is considered a success.

This academic year, the entire peer counseling class needs to be recognized for their inspiring perseverance, engagement, and support of each-other. Whichever direction they chose (and they have specific academic and vocational goals) they are sure to not only have a positive impact, but also, and most importantly, they will be a support and inspiration to other clients for their inherent potential. **Student class evaluation quote: 'I just want to say thank you for a great semester. I really enjoyed coming to class every week, you all made going to school for me very pleasant'.**

CHALLENGES

1. Housing- As known, the continued housing crisis has a direct impact on client stability and overall health and well-being. While there are success stories, there continues to be more examples of struggle and distress.

2. Referrals/Connecting- the supported education program has a strong focus on outreach and engagement activities to reach as many clients and programs as possible, and to offer the support and program opportunities available. To this end, activities are continuously refined and focused in an attempt to reach as many community members as possible.

3. TAY- This age group presents challenges in engaging and supporting in life and career goals. As age-appropriate, TAY often prefer doing activities with other TAY, as well as not wanting to identify with a 'specialized' program. While this is important for connection and self-esteem, it represents challenges for helping professionals in engaging, guiding, and supporting. Nonetheless, this is a critical are of focus, as helping to guide and support TAY in their growth, exploration, and development is both essential and highly rewarding.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
16-25		20%
26-59		62%
60+		18%
Primary Language		
English	50%	100%
Spanish	2%	
Unknown	48%	
Sex Assigned at birth		
Male	46%	52%
Female	53%	43%
Decline to state		3%
Unknown	1%	1%

Sexual Orientation		
Gay, lesbian, homosexual		1%
Straight or heterosexual		62%
Bisexual		1%
Decline to state		34%
Race/Ethnicity		
Latino	18%	15%
Pacific Islander	6%	5%
Eastern European	2%	
Black/African/-American	10%	10%
White/Caucasian	49%	54%
Filipino		2%
Mixed Race	2%	5%
Another race/ethnicity	3%	8%
Decline to state		
Unknown	10%	2%
Disability/Learning difficulty		
Difficulty seeing	2%	
Another disability	22%	
Not specified	76%	
Veteran		
Yes		3%
No	3%	59%
Unknown	97%	37%

COMPREHENSIVE TAY FSP "TURNING POINT"

The Transition Age Youth Full Service Partnership (TAY FSP) program is a specialized mental health program designed to meet the unique needs of high risk and highly acute 16-25-year-olds in the county. The program receives referrals from San Mateo County BHRS and can serve 50 transition age youth clients at any given time. The purpose of the TAY FSP program is to assist each transition age youth and their family of choice to achieve stability and wellness within the context of their culture and community. A multidisciplinary team approach provides transition age youth with the opportunity to work with individuals in a variety of specialty areas, ensuring a holistic lens is applied to themselves and their lives. The program applies a person-centered approach, using "whatever it takes" to engage and support the transition age youth in addressing their needs and meeting their identified goals. Specialized services include case management, clinical treatment, skill-building, crisis prevention/intervention, peer/family support, medication management, housing support, community engagement, career and employment exploration, and linkage.

PROGRAM IMPACT

In FY 18-19, 61 clients were served in the TAY FSP program. 10 were graduates of the program, meaning they met their treatment goals and 3 dis-engaged and discharged from the program prior to meeting their goals.

Education & Employment Outcomes for FY 18-19	
Received 1:1 coaching	18
Engaged in volunteer activities	4
Engaged in supported employment	9
Engaged in paid employment	30
Attended high school	9 (7 graduated)
Engaged in GED preparation classes	3
Attended community college	10

FY 17-18 saw many successes:

- 16 emerging adults started in the program
- 23 emerging adults were discharged from the program
    - 12 stepped down to a lower level of mental health treatment
    - 4 dis-engaged from services with no request for linkage to continue treatment
    - 4 were placed in confined settings (2 in jail, 2 in IMD facilities)
    - 3 transitioned to equivalent services with Adult FSP programs

TAY FSP Housing:

HOUSING	# OF CLIENTS	% OF CLIENTS
In a stable living situation	38	62%
In a confined setting (IMD, jail, juvenile hall)	6	10%
In a supported living situation	9	15%
Unstably housed/homeless	8	13%
TOTAL	61	100%

TAY FSP Clients Who Accessed Housing Dollars:

	FY 17/18	FY 18/19
Total clients served	13	12

SUCCESSES

Jeremiah, a 19-year-old male, completed an in-patient drug and alcohol program in the previous year and since that time has been clean and sober. While that alone is quite a success, it is his commitment to the multiple people he now sponsors that makes Jeremiah stand out. While dealing with his own struggles with a severe mental illness, tenuous familial relationships, and the general stress of navigating adulthood, this young man has also spent time and energy supporting others who are addressing their own recovery.

Selena was referred to the program due to persistent homelessness, substance use, and symptoms of mental illness. Selena grew up without a stable home or caregivers which resulted in her strong connections to her chosen family who lived in encampments across San Mateo County. Her treatment team was reliable, consistent and persistent. They accepted Selena's level of engagement which ebbed and flowed. They applied motivational interviewing techniques and focused on providing for her basic needs while offering unending hope. They introduced to new ideas and concepts including how to break down goals into manageable steps, weighing pros and cons, proactivity and prevention, and self-advocacy. She graduated from the program in 2019 after meeting her goals. At her graduation party she told the team, "you saved my life."

Engagement of natural supports in the program continued to be a success in 2017-2018. This year also saw an increase in engagement of fathers in the treatment of their emerging adult children.

Family Engagement	# of Natural Supports	% of Natural Supports	% of Natural Supports in FY 16-17
Identify as Father	18	27%	20%
Identify as Mother	25	37%	41%
Identify as Grandparent	6	9%	14%
Identify as Sibling, Aunt, Uncle, Cousin	13	19%	16%
Identify as Partner/Friend	3	4%	0%
Identify as Mentor or Other	2	3%	3%
Total	67	100%	100%

Comprehensive TAY FSP	FY 17/18	FY 18/19
Total clients served	61	61
Total cost per client		
based on clients served	$34,444	$34,444
based on contracted slots	$52,527	$52,527

CHALLENGES

The complexity of the emerging adults served continues to evolve. In the last 5 years there has been an increase in emerging adults with severe mental illness, trauma and co-occurring substance use, physical health, or cognitive/neurological issues.

- In FY 17-18, 51% of the emerging adults used substances to a degree that it had a noticeable negative impact on their daily functioning. The substance of choice among emerging adults continues to be marijuana.
- In FY 17-18, 42% of the emerging adults served had a physical health condition that impacted their daily functioning and/or their mental health. This was a 20% increase from the previous year.
- In FY 17-18, 30% of the emerging adults possessed cognitive/neurological issues which impacted identity and relationship development, daily functioning, and engagement in mental health treatment. This was a 17% increase from the previous year.

Due to the increased prevalence of co-occurring substance use, physical health, and cognitive/neurological issues, efforts are being made to work more closely with medical and primary care providers, partnering with alcohol and other drug providers, and identifying experts who can provide training and guidance.

Cost of Living & Housing Crisis

The two greatest challenges facing emerging adults, their families, and TAY FSP staff are the cost of living and the housing crisis in the Bay Area. Both continue to impact the day to day lives of the populations served and their natural support systems. Finding and maintaining affordable housing is difficult, finding and maintaining that same housing in areas with accessible public transportation and negligible community violence has become nearly impossible. Housing vouchers continue to be limited and landlords who accept them are even more so. Stress related to housing, finances, and safety all lead to strain on family systems, pressure on relationships, and prolonged recovery for those with a serious mental illness.

Employees at Edgewood have been personally impacted by the Bay Area cost of living and housing crisis. Many staff have had to face tough decisions regarding their personal and professional lives. Retention of existing staff and recruitment of new individuals has been a focus of attention across roles and programs. Moreover, they are equally concerned about the impact staff transitions have on the emerging adults and thus have made all efforts to manage the transitions with compassion and trauma informed interventions.

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
16-25	100%	100%
Primary Language		
English		56%
Spanish		39%
Mandarin		2%
Tagalog		2%
Russian		2%
Sexual Orientation		
Gay, lesbian, homosexual	5%	2%
Straight or heterosexual	57%	57%
Bisexual	11%	13%
Queer	2%	
Asexual		2%
Questioning or unsure	4%	7%
Indigenous sexual orientation		2%
Another sexual orientation	5%	2%
Decline to state	13%	16%
Gender Identity		
Male/Man/Cisgender	64%	56%
Female/Woman/Cisgender woman	31%	41%
Transgender male		2%
Transgender woman		2%
Transgender	3%	
Genderqueer/nonconforming	2%	
Race/Ethnicity		
American Indian/Alaska Native/ Indigenous	3%	
Asian	5%	
Latinx	41%	28%
Pacific Islander	2%	
Russian		3%
European		2%
Arab/Middle Eastern		3%
Black/African/-American	3%	5%
White/Caucasian		15%
Filipino	5%	3%
Vietnamese		2%
Mixed Race	20%	
Another race/ethnicity	20%	15%

TAY DROP IN CENTERS

Located in San Bruno and Redwood City, the Drop-in Centers are community resource centers catering to individuals between the ages of 18-25 years (up to their 26th birthday) offered by the Edwood Center for Children and Families. Each peer-led site serves as a safe and confidential space offering free resources, activities and workshops, and opportunities for socialization and peer connection. The Drop-in Centers provide regularly scheduled programming such as community outings, social activities, personal growth and wellness workshops, as well as access to computers, the internet, a clothes closet, and food. Most importantly, Peer Partners lead activities that support 18-25-year-old participants in building skills to successfully transition to adulthood.

Peer Partners, young adults who have been through similar life experiences, are an invaluable resource to the Drop-in Center. Peer workers know what it is like to go through uniquely difficult situations and life experiences and can share their experiences of recovery, growth, and resilience. Peer Partners who are living well represent hope that is often missing in the Drop-in Center participant's lives. Peer Partners facilitate a safe and welcoming environment through the use of empathy, validation, constructive feedback, and unconditional support; Peer Partners are trained in Youth Development, Harm Reduction, and peer counseling techniques. Peer Partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities. Success at the Drop-in Centers is measured individually and is fluid according to how each transition age youth participant defines self-efficacy. The primary focus is on building quality relationships so each may feel empowered and capable of voicing their needs and apply what they have learned to all facets of their lives.

Goals of the Drop-in Centers are:

- Promote socialization and community connectedness
- Support academic and/or vocational exploration and growth
- Encourage the development of independent living skills
- Empower rising leaders and advocates

PROGRAM IMPACT

The drop-in centers were open 245 days during FY 2017-18

Transition Age Youth Served	Sam Trans Bus Tokens Provided	Articles of Clothing Provided	Health & Hygiene Products Provided
213	776	306	428

There is one simple, but specific intervention applied, which the Drop-in Centers are particularly proud of- the welcoming culture. This intervention includes more than creating an inclusive environment and training Peer Partners in engagement practices. Rather, it is an embodiment of welcoming to ensure both a visual and visceral experience of acknowledgment, appreciation, belonging and unconditional positive regard. This is a core intervention from which all others are built upon. The unintended impact of a welcoming culture includes, the broad spectrum of resource requests made by participants, and the need for continuous training of Peer Partners in recognizing signs of participant dependence on the program or Peer Partners in meeting their needs or addressing their personal challenges.

Claire is a long-time participant of Drop-in Center North. She often requests help of the Peer Partners in staying organized and understanding the requirements of her teachers at the College of San Mateo. These asks are consistent throughout the school semester and usually only require the Peer Partners to review organizational and time management methods and remind Claire of the services located on the campus. Still, Claire knows her requests will be met with patience, compassion, and support, rather than judgement or frustration.

Javier has been coming to the DIC South location since it's opening in 2015. He had been an infrequent participant due to his symptoms of anxiety which often impaired his ability to leave his home. After the presidential election he was significantly impacted by the results and the subsequent decisions being made regarding immigration policy. He had built relationships with the Peer Partners and felt comfortable sharing his thoughts, even when they differed from others. Javier knew the Peer Partners would help him and other participants engage in conversations in a healthy and respectful manner. There were a few weeks when he stopped coming but one evening he returned and explained that while isolating and withdrawing into the online community was his default, he found it did not alleviate the feeling of disempowerment. He began more frequent visits and talked more about solutions and learned ways "to get involved" which led to his feeling more empowered.

Miguel and his girlfriend were regular participants. Often, they came for dinner and to study. Occasionally Miguel's brother would also come but unlike Miguel who has a quiet and serious presence, Jose's mood and affect were inconsistent. One evening Miguel and his girlfriend asked to speak with a Peer Partner about "how to get more help for my brother," and shared they and their family's efforts to support Jose who has schizophrenia. "We don't really know what is out there and we have tried to keep it in the family, but we need help. You help lots of people with lots of things, we thought you could help us with this."

Johnny comes to Drop-in Center North for dinner most nights, sometimes he will stay and talk with other participants or engage in an activity, but most nights he prefers to eat and leave. He reports appreciating the food and that Peer Partners respect his level of engagement.

TAY Drop-In Center	FY 17/18	FY 18/19
Total clients served	213	201
Total cost per client*		

*Funding for the C/Y and TAY FSP includes drop-in center services and is not separated out

SUCCESSES

In FY 2017-18, the Drop-in Center community partnerships continued to yield many innovative workshops and activities addressing the expressed interest and needs of transition age youth:

- Healthy Relationships
- College Access and Information Workshops
- Career Assessment and Job Development
- Inspirational Stories of Recovery
- Back to school fairs
- Thanksgiving dinners

The application of a Positive Youth Development approach to the Drop-in Centers that is holistic, positive and preventative youth development philosophy has resulted in visible growth in transition age participants; applying for Peer Partner positions, giving feedback on programming, and taking ownership of weekly groups and activities.

Roberto, age 23, has been a participant of Drop-in Center South for about a year. When he first started coming, he was quiet, reserved and often would withdraw to quieter areas of the center. Despite his discomfort, he continued to come, albeit infrequently. He enjoyed spending one on one time with the Peer Partners and began to trust them enough to ask their advice and consider their suggestions. Their suggestions and encouragement covered a wide variety of topics, including relationship building and trying new things. A year later Roberto has built friendships by approaching participants and starting conversations, shared his poetry, performed at Open Mic nights, and explored new foods and cooking with the Peer Partners.

Matilda, age 20, started attending Drop-in Center South just under a year ago. When she initially began coming, she was accompanied by one of her mental health providers due to her discomfort in being in new situations and her symptoms of mental illness. Matilda did not engage in activities and only spoke with the manager on site or her treatment staff member, mostly she preferred to be alone. With continued persistence and the support of both her mental health treatment team and the Peer Partners, Matilda was able to find a way to engage in the Drop-in Center that best meets her needs and level of comfort. She now comes on her own, interacts with both Peer Partners and participants, engages in activities of her choosing, and steps away to work independently when needing personal space.

In FY 2018-19, partnerships with community organizations and businesses have been a continued success. Without partnerships with local educational institutions and community-based organizations annual Back to School Fair would not be possible. Representatives from Bay Area colleges and universities spread throughout the DIC sites on fair days. Food, raffle items, and new backpacks filled with school supplies are a result of donations from individuals and local entities including Help One Child, Jersey Mike's and EA Sports. Similarly, the annual Career Fair is built on community partnerships. Both events provide transition age youth with a plethora of resources in a safe and comfortable venue where they can get one on one attention. Thanks to a grant from the Sequoia Healthcare District, in 2019 the Drop-in Centers held the county's first Transition Age Youth Health Fair. This event brought together physical and mental health professionals to answer questions, link participants to services, offer practical skills, and provide on-site screenings.

CHALLENGES

In FY 2017-18, the barriers faced by transition age youth included accessing the Drop-in Centers locations and/or information about the events, resources and activities happening day to day. While Edgewood is now able to better meet the needs of transition age youth in the southern part of the county through the Drop-in Center South location, for transition age youth residing in the central and coastal sections of the county, as well as those without access to public transportation, the two sites are unable to meet their needs. Concerns have increased as transition age youth and their families struggle to attain or maintain safe and affordable housing and find themselves relocating to the edges of the county or to areas with few public transportation options. Additionally, the Drop-in Centers do not have an online/social media presence which makes it difficult for transition age youth to learn about the centers, their locations and hours, and the resources and services available to them.

While accessibility will always be an issue in a county so large, Edgewood will continue to look for innovative ways to meet the needs of all transition age youth across San Mateo County. This past year outreach efforts were increased through community partnerships and tabling at local resource fairs and community events. Both Drop-in Center sites have continued to give out bus tokens to transition age youth to help alleviate the cost of transportation and increase access to both locations. Local transition age youth providers have been encouraged to hold groups at both sites or bring transition age youth to both sites to help to decrease the barriers of accessibility. Regarding an online presence, the Drop-in Centers will begin working on a plan for a social media presence in 2019 and seeking funding for a website development project, both of which will include transition age participation and leadership.

In FY 2018-19, challenges faced are the same as in previous years:

- The cost of living continues to present as a challenge for participants and staff.

- The lack of short-term and emergency TAY-specific housing means increased efforts in supporting participants in finding housing; efforts to identify friends or peers they can stay with, providing sleeping bags and rain gear to those who must sleep outside, and finding bus/train routes to TAY-specific shelters in San Francisco and Santa Clara.
- The lack of a San Mateo TAY-specific website with services and resources is an ongoing challenge. While the DICs maintain lists and resource boards it is challenging to ensure the information is up-to-date. Many transition age youth participants cannot access the DICs as frequently as they like and if/when they are looking for support or a resource they turn to the internet (i.e., Google).

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
16-25	100%	100%
Sexual Orientation		
Gay, lesbian, homosexual	5%	5%
Straight or heterosexual	32%	28%
Bisexual	9%	12%
Queer	3%	3%
Pansexual		1%
Questioning or unsure		2%
Another sexual orientation	3%	1%
Decline to state	47%	46%
Gender Identity		
Male/Man/Cisgender	42%	42%
Female/Woman/Cisgender woman	35%	23%
Transgender male		1%
Transgender woman		1%
Transgender	2%	
Genderqueer/nonconforming	1.5%	3%
Another gender identity	.4%	
Decline to state	20%	29%
Race/Ethnicity		
American Indian/Alaska Native/ Indigenous	1%	2%
Asian	6.5%	.5%
Latinx	27%	1%
Pacific Islander	3%	2%
Eastern European		1.5%
European		6%

Arab/Middle Eastern		1%
Black/African/-American	6.5%	7%
White/Caucasian		1%
Asian Indian/South Asian		1%
Caribbean		1%
Fijian		.5%
Central American		4%
Chinese		3%
Mexican/Chicano		18%
Filipino	4%	1.5%
Japanese		.5%
South American		3%
Mixed Race	20%	
Another race/ethnicity	16%	23%
Decline to state	16%	21%

ADULTS AND OLDER ADULTS FSP

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Outreach and Support Services targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities. Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

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

PROGRAM IMPACT

Telecare implements recovery principles using intentional service delivery through evidence based and promising practices tailored specifically to an individual member's goals. Telecare FSP staff are extremely well positioned to provide personal services to each member's unique circumstances. Intervention tools, including but not limited to, Motivational Interviewing, Wellness Recovery Action Plans, Behavioral Activation, Trauma Informed Care as well as those specifically developed at Telecare (Recovery Centered Clinical Systems and Co-Occurring Education Groups) are part of the Telecare staff's standard work and are proactively selected prior to staff visiting a member with the intent of intervention efficacy in that individual's life.

SUCCESSES

For many years I went undiagnosed. This led me to a life of crime, prison, drugs, and mental Illness, my foremost culprit. It wasn't until I was referred to Telecare that my life changes. I was treated like a consumer and not as a criminal. I was diagnosed with schizoaffective disorder. I received medications and it took a while to get it right. Telecare really has worked with me to ensure my overall wellbeing. I have been treated with respect and compassion. This was the first time 'ever' that I had a case manager-therapy and a full medical staff in one location. All this allowed me to understand my diagnosis, history which in turn facilitated me to get better. Today 10 years later, I continue to struggle with life and activities of daily living. However, I am able to work as a volunteer part time at the local food bank as well as advocate for others and also assisting with phone acquisitions for members and other activities with Telecare. I had been homeless since 2005. Today I am now five years living in my own apartment through a Telecare subsidy program. Telecare checks on me including emotional support as well. I was once not allowed to be around my grandchildren. Today I baby sit them and they come to "Granny" house for vacations, Holidays. Something I never would have dreamed in my past. Today I am clean and sober. I make decisions for myself and actively show up for life. Thank you Telecare!! My motto: "they care "TELECARE"! Velisha

Hi, my name is Ronald and I am a man in long term recovery. What that means is that I haven't took a drug or had a drink in 4 years and 8 months. I have changed a lot in the past 4 years. I began using when I was 14 years of age, I stopped when I was 31 years old. I still remember

what I was like when I was 13, before the drugs. I got good grades in school and I was my mother's little angel. But that all changed when I began my addiction. I turned into a liar and a thief. I stole many things, but the one thing that I stole that haunted me for a long time was my mother's peace of mind. I got clean for the first time when I was 19. But I wasn't ready to quit until I met my case worker Kevin. He helped me get clean and stay clean. This is the longest clean time that I ever had. Today I have a job in the recovery field as a recovery coach. I'm a paid member of NA (narcotics anonymous) and I have made many amends to people and family I've hurt. I was diagnosed with bipolar and schizophrenia during my addiction, but it suppressed when I got clean and did the work to stay clean. Today I love myself and I love God and others. Today I am better off without drugs and alcohol. Today I am happy and grateful.

Telecare Adult/Older Adult FSP	FY 17/18	FY 18/19
Total clients served	224	232
Total cost per client		
based on clients served	$15,625	$15,086
based on contracted slots	$16,908	$16,908

CHALLENGES

The largest and most impactful challenge to Telecare FSP activities and interventions pertains to the current financial circumstances within San Mateo County and the status of the contract. The overall partnership with San Mateo County is incredibly strong and collaborative and the partnership demonstrates the best of governmental and contract agency dynamics. Nevertheless, fiscal realities exist, and the impact is extreme difficulty in recruiting psychiatrists, LVN's, and Case Managers as well as the fact the program now has no office where clients are permitted and for the existing prescribers from which to work.

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
18+	100%	100%
Sex Assigned at Birth		
Male		64%
Female		37%
Decline to State		1%
Sexual Orientation		
Gay, lesbian, homosexual		.5%
Straight or heterosexual		11%
Bisexual		1%

Decline to state		50%
Race/Ethnicity		
American Native	4.0%	5.6%
Asian Indian	0.4%	0.9%
Black	18.3%	19.8%
Chinese	2.2%	3.0%
Filipino	4.5%	4.7%
Hawaiian Native	1.3%	1.3%
Hispanic	1.3%	1.7%
Japanese	1.8%	1.3%
Korean		0.4%
Multiple	2.2%	2.6%
Other	21.4%	23.7%
Other Asian	0.9%	0.9%
Other Pacific Islander	2.7%	2.6%
Samoan	0.4%	0.4%
Tongan	1.3%	1.3%
Unknown / Not Reported	3.1%	3.4%
White/Caucasian	58.9%	57.3%

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

Caminar's FSP program is designed to serve the highest risk adults and highest risk older adults and medically fragile. Most adults with SMI served by FSP have histories of hospitalization, institutionalization, substance use, are not engaged in medical treatment and have difficulty participating in structured activities and living independently. Older adults have cognitive impairments and medical comorbidities. The purpose of the FSP program is to assist clients to enroll, achieve independence, stability and wellness within the context of their culture and communities. The goal is to divert clients from the criminal justice system and acute long-term institutional levels of care and succeed in the community. In addition, the program strives to help clients achieve their wellness and recovery goals, maximize their use of community resources, integrate client's family members or other support people into their treatment, achieve wellness, independence and improved quality of life.

FSP has a high staffing ratio of staff to consumers, with a ratio of 10:1. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med non-compliance and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities and health

care. Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services, include money management, assisting with employment opportunities, social rehab and assistance with referrals and housing. Caminar also provides community based-nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7, 7 days per week crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help to plan for linkage to and coordination with primary care services, with the intent of the strengthening the client's ability to access healthcare services and ensuring follow up with detailed care plans.

PROGRAM IMPACT

Caminar reduces suicide by rapid and consistent engagement with clients and their collateral providers, case conferences, completing clinical assessments to assess danger to self and danger to others, increasing contact with clients who may be decompensating, 24/7 availability and the CPI protocol and training. All management staff is trained and certified to initiate involuntary hospitalization, when indicated. School failure and drop out is decreased through the Supported Education program and help lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and in San Mateo County, in particular. Through the Supported Housing program, a multitude of housing options is provided to clients in need: Board and Care, SRO rooms, independent apartments, shelters, and unlicensed room and boards.

Once a client is referred to Caminar services, specifically to the FSP team, staff attempts to initiate contact within two (2) business days. Clients are assessed rapidly and comprehensively by case managers, the psychiatrist and Clinic Manager/RN. The Clinic Manager/RN completes a Nursing Assessment for all clients admitted to the program. Furthermore, FSP also utilizes a Mediation Assistance Program (MAP) to increase medication compliance and to reduce the risk of clients overtaking or undertaking their medications. By utilizing the social rehabilitation model, which provides for a non-judgmental, normalized environment which emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination. Linkage are made to outside community providers for primary care and ongoing collaboration with said providers and staff; this helps ensure that clients are receiving public health services. By partnering with other non-profit agencies, disparities in access to care are reduced. Finally, Caminar utilize Harm Reduction, MI, DBT and WRAP to help strengthen the gains made by clients and to implement the principles of recovery throughout all programs.

Caminar Adult/Older Adult FSP	FY 17/18	FY 18/19
Total clients served	39	40
Total cost per client		
based on clients served	$21,855	$21,308
based on contracted slots	$28,411	$28,411

SUCCESSES

Caminar has been successful in establishing morning wellness meetings held 5x a week, a medication assistance program (MAP), expanding their community-based nursing, implementing bi-weekly complex case conferences, beginning Dialectical Behavioral Therapy certification in 2018 and maintaining peer support throughout their program.

Jane Doe has a long history of being a very high utilizer of psych emergency services for the vast majority of her adult life. Her annual utilization usually involved dozens of visits to psych emergency services. In the past nine months, she hasn't utilized any psych emergency services and has not expressed any suicidal ideation. She has stable housing and has been employed on a part-time basis. She has demonstrated a profound improvement in her functioning and increased awareness into her mental health diagnosis. Caminar staff has worked collaboratively to set appropriate boundaries with her by using a strength-based approach. Staff have provided individual and other rehab services and encouraged her to participate in the DBT group. The team and Jane have worked creatively to find individualized interventions that are well suited for her and this has been instrumental in supporting her in her admittedly impressive journey towards recovery. One such example is that she frequently uses the meditation room to relax, meet with her case manager and to listen to guided meditation exercises. Jane is engaged in services, has learned to talk about her challenges and seeks out support prior to experiencing a crisis. She has made significant strides towards her recovery and is also becoming very supportive to her peers who may be experiencing challenging situations or situational stressors.

CHALLENGES

Challenges for Caminar include housing, housing subsidies, hiring clinical case managers, and clients experiencing major medical concerns and comorbidities that affect treatment.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
18+	100%	100%
Sex		
Male	54%	55%
Female	46%	45%

Race/Ethnicity		
American Native		2.5%
Asian Indian	2.6%	2.5%
Black	7.7%	5.0%
Chinese	2.6%	2.5%
Filipino	12.8%	7.5%
Hispanic		2.5%
Laotian	2.6%	2.5%
Multiple	2.6%	2.5%
Other	17.9%	20.0%
Other Asian	2.6%	2.5%
Other Pacific Islander	2.6%	2.5%
Unknown / Not Reported	5.1%	2.5%
White/Caucasian	64.1%	65.0%

ASSISTED OUTPATIENT TREATMENT

In Fiscal year 2018-19, Assisted Outpatient Treatment (AOT) FSPs began receiving funding from MHSA in San Mateo County. Stakeholder meeting information was submitted in the previous MHSA Annual Update. Developed out of the County's adoption of Laura's Law (Assembly Bill 1421) in the summer of 2015, AOT is a program that reaches out to people with a severe mental illness who are not connected to services and are challenged to live safely and stably in the community. The San Mateo AOT team engages people in receiving treatment to help improve their quality of life. The AOT team works collaboratively with individuals, family members and partners to provide the right care, at the right place and right time. Their dedicated team helps decrease mental health crises, hospitalizations, incarcerations and homelessness while helping people achieve and maintain their physical and mental health. See Appendix 6 for the full AOT FSP evaluation report, which purpose is to provide a detailed view on implementation of Laura's Law is progressing and to determine if any adjustments are necessary to achieve the goals of the project.

PROGRAM IMPACT

The BHRS AOT program received 160 referrals for a total of 148 individual clients and 38 informational calls. Most referrals originated within San Mateo County and have come from a licensed or supervising mental health treatment provider followed by family members. There were 69 referred clients who were deemed ineligible for AOT services. Of these, 23 clients were referred to specific community services, including behavioral health clinics. Of the 39 eligible clients who were offered Caminar AOT FSP services, **22 clients enrolled** in AOT FSP services as of December 31, 2018.

Among all AOT FSP clients, the episodes of hospitalizations and PES events were significantly **lower during the 6-months after the client enrolled in the AOT FSP**, compared to the 6-months before. The **length of hospital stay was also shortened** post enrollment vs. pre-enrollment. Other key events such as jail and homelessness have also reduced. The AOT Team filed two court petitions for two clients in CY2018.

AOT (Laura's Law) FSP	FY 18/19
Total clients served	22
Total cost per client	
based on clients served	$40,484
based on contracted slots	$17,812

SUCCESSES

"Both the problems and the symptoms experienced by people who are referred to AOT are very complex, often with dangers to their health and well-being, as well as the well-being of the community. It is not unusual that clients have been struggling for many years, essentially lost in a cycle of decompensations, hospitalizations, incarcerations, such that they have a limited capacity to understand and follow-up with their own care. A critical role of AOT investigations is to simplify the complexity of a case for the care teams and the client. The client can experience some treatment success which encourages the client to engage further. Noticeably, an important part of this seems to be the enduring nature of AOT in continuing to support clients through their various struggles and successes. The program has been remarkable at filling a gap in services for people who were previously unreachable." - *BHRS AOT Psychologist*

AOT received a referral for Ben, a young man with schizophrenia, who was living a very isolated life. Ben had no relationship with his family and no friends. He tended to call and harass local police departments and authority figures due to command hallucinations. Ben was incarcerated and hospitalized due to the nature of these calls. These calls were putting both the client and the community at risk. Over two months, AOT built a relationship with Ben through weekly visits and being curious about his experience. Once trust had been established, Ben agreed to enroll in AOT/FSP. Since enrolling, his initial charges have been reduced and he has not returned to jail or the hospital. In addition, he has reconnected with his family and demonstrated an ability to contain his impulses through skills learned working with AOT/FSP. Lastly, Ben is no longer living an isolated life, as he is participating in group therapy.

DEMOGRAPHICS

	FY 18/19
Age	
16-25	18%
26-60	75%
61+	8%
Sex	
Male	66%
Female	34%
Race/Ethnicity	
White	55%
Latino	18%
Asian	11%
Black/African American	7%
Middle Eastern	3%
Unknown	2%
Other	2%
Native American/Alaskan	1%
Hawaiian/Pacific Islander	1%

AUGMENTED BOARD AND CARES

In Fiscal year 2018-19, Augmented Board and Cares (B&C) began receiving funding from MHSA in San Mateo County. Stakeholder meeting information was submitted in the previous MHSA Annual Update.

The purpose of contracted B&C are to provide a supported living environment for clients with severe mental illness (SMI). These placements are needed to afford SMI client's an opportunity to live in the community in a supported living environment. There is one BHRS staff that is the designated board and care liaison. This staff approves board and care referrals, completes assessments, oversees admissions and discharges to BHRS contracted Board & Cares.

B&C serves adults with SMI that have completed a social rehabilitation program or are stepping down from a locked setting. They are psychiatrically stable, compliant with medications and in need of a supported living environment. Clients are Health Plan of San Mateo members, and either have Social Security Administration and/or General Assistance benefits.

The B&C provides three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client's treatment team and conservator about client's progress, and/or issues that impact the client's placement. The

Board and Care Operators work in collaboration with the BHRS board and care liaison. The purpose of the board and care liaison is to support the client's transition into the board and care, and ensure they address issues that impact placement. The Board and Care Liaison coordinates a training schedule for the B&C operators. The trainings increase the board and care operator's capacity to address the needs of the SMI clients in their care as well as fulfilling their CEU requirements.

PROGRAM IMPACT

B&C's improves timely access and linkages for underserved populations. Referred clients and the barriers that impact placement are tracked. For instance, some clients having behavior issues which were related to their histories of trauma. This led to the provision of more trauma informed training for B&C Operators to help them better understand the needs of SMI clients and use a trauma informed approach.

B&C's reduces stigma and discrimination. The assessment procedure goes through a 15-item checklist in order to determine eligibility for a board and care placement. Once considered eligible, cases are reviewed, and barriers are problem-solved. It can be as simple as providing apple sauce so a client with swallowing difficulties can take their meds and obtain agreements as to who will consistently provide the applesauce to the B&C. At times complex case conference will be needed where all parties involved such as conservator, treatment team and case managers discuss supports/resources needed to successfully transition a client to placement. Through the trainings and close coordination with the B&C operators staff learn that disruptive behavior is often driven by their diagnosis and not because they are "bad". BHRS makes every effort to ensure clients are treated with respect and dignity, regardless of having a mental illness. The Board and Care Operators receive trainings on diversity and equity topics such as: Cultural Humility training and Sexual Orientation, and Gender Identity.

B&C's reduces disparities in access to care. The BHRS contracted board and cares are specifically for clients that have mental illness and or co-occurring substance use issues. All clients placed at the board and cares are connected to BHRS regional clinics, and or a Full-Service Partnership Program, and thus their psychiatric and medical needs are attended to.

B&C's implements recovery principles. Clients with substance abuse problems are appropriately referred to Substance Use Disorder (SUD) programs. The B&C operators are trained on the possibility of relapse and work with the client's treatment team and liaison to develop a plan to support the client. One B&C is specialized in serving clients with substance use issues.

Behavioral Health and Recovery Services Clinicians offer recovery-oriented groups at different Board and Care sites. The groups include Seeking Safety, Illness Management and Recovery and a Dual Diagnosis Group.

SUCCESSES

Justo who was born in Juarez, Mexico has lived at the Co-Occurring focused Board and Care Bruce Badilla for 7 years. He immigrated to the United States with his family, moving to the Bay Area in 1978. Justo began struggling with Schizophrenia around the age of 18. By the time Justo came to Bruce Badilla Care Home he was coping with both mental health and substance use disorders. He had experienced multiple long-term hospitalizations, including state hospitalization, a period of incarceration and 5 years of homelessness. Since coming to Bruce Badilla Justo has been stable in the community, clean and sober for 7 years. He attends all his appointment with his treatment team and attends a combination of six meetings/groups a week. Justo is actively engaged in his recovery. He enjoys visits with his family, going to meetings and eating good food. He identifies his supports as his family and Bruce Badilla staff. He reports his strength as his ability to walk and talk. He reports his hope as to return one day to work as he once did as a mechanic in an auto shop.

CHALLENGES

Referrals exceed current bed capacity. Additional funding will help increase this bed shortage especially in certain identified areas. Specifically, more bed capacity for Females under 60 with Co-Occurring disorders and older adults that have complex medical issues.

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

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

Mateo Lodge is contracted to provide 50 hours of Intensive Case Management (ICM), services per week for 3 different levels of intensity (A - Task oriented case management 1-2 months, B - Supplemental case management 4-6 months, and C - FSP clinical case management 6 -

12months). The clients within the program receive 1–3 hours of contact per week based on level of care needed and/or need identified to support client. ICM is a clinic referral-based program. The referring party completes a referral form indicating 'ICM Service Requested'. The ICM engages with the client within one week of the referral to complete a client focused needs assessment based on clients' stated need. The best outcomes for ICM clients exist when there is a warm handoff from the referring clinical team. The ICM collaborates with the treatment team to ensure targeted service that is based on client and referring party identified needs are addressed. Full Service Partnership (FSP) level C is utilized for clients that are high risk of self-harm, loss of placement, or poorly engaged with outpatient services. The FSP level of care is initiated prior to referring clients to other FSP providers in attempts to service clients within BHRS outpatient clinics and to evaluate mental health level of care needed.

Mateo Lodge also provides evening and weekend coverage on an as needed basis from the mobile support team. ICM staff support additional needs for voucher-based clients and provide quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/ appointments. The housing voucher programs include Permanent Supported Housing (PSH), Housing Readiness Program (HRP), Moving to Work (MTW), and Mainstream Voucher Program. Case management staff makes every attempt to meet their clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, hospital, jail, and joint home visits with a member of the treatment team.

PROGRAM IMPACT

The Embedded Intensive Case Management program services 6% of the South County Clinic population yearly for clients' that require community risk assessment/interventions, additional case management and/or deployed services out of the clinic setting.

The ICM program is staffed with two part-time bilingual, Spanish/English, case managers. Staff development is targeted to further strengthen ICM awareness of community services and to deepen clinical knowledge of the population of clients served to employ/implement best recovery strategies and practice. The ICM staff participate in professional development including: Cultural Competency, SOGI, Assaultive Behavior, and all BHRS required documentation and compliance trainings. All the ICM attended Outreach Mental Health and Motivational Interviewing training. Additionally, ICM attend quarterly meetings with Mateo Lodge, weekly clinical supervision, and bi-weekly staff meeting at South County Adult Clinic.

The ICM staff members are trained in crisis intervention and provide valuable community assessments to ensure client safety, access to food/clothing/shelter, and improve access-linkage to services. Through outreach and home visits, the ICM staff improve clients' clinic services/attendance, evaluates medication compliance, report on safety concerns, and reduce client emergency services through engagement and accessibility to service providers. 30% of ICM referrals are for FSP level of care which are considered the high-risk clients in the community and have had a hospitalization within 30 days of referral. Once an ICM client is stabilized, the client is relinked back to the program's clinic team and to other supported community programs that support client recovery. The ICM goal is to improve treatment participation, reduce symptom reduction through teaching coping skills and resiliency, enrollment in entitled benefits, promote independence, and assessment for additional services.

Level of Care Provided	# of Clients FY 17-18	# of Clients FY 18-19
A - Task Oriented	2	3
B - Supplemental	20	26
C - FSP	8	13

In FY 2018-19, a total of 36 unduplicated and 1 re-referred clients were served. Of which, 10 clients were carried over from 2016-2017, 20 new referrals, 18 closed cases, and 6 voucher-based clients. In FY 2018-19, a total of 47 unduplicated clients were served. Of which, 37 new referrals, 18 closed cases, 3 clients on waitlist, 4 clients were carried over from 2017-2018, and 6 voucher-based clients.

Diagnosis for FY 18-19 Clients	
Schizophrenia/Psychotic Disorder	38%
Major Depressive Disorder	38%
Bipolar Disorder	15%
PTSD	9%

Outcome for 18 closed cases for each fiscal year covered are listed below. Remarkable outcomes are noted with 34% stabilizing client back to their treatment team and zero clients referred to higher level of care such as FSP or AOT. Flat reporting is noted for clients that continue to move out of county to seek affordable housing in other counties in California and clients that either decline services or unable to locate for engagement. 11%, two clients, died due to medical conditions while receiving ICM services which is indicative of the vulnerable complex at risk clients referred and receiving ICM services.

Outcome	# of Clients FY 17-18	# of Clients FY 18-19
Stabilized back to team	7	6
Declined or unknown	4	4
Moved out of County	4	3
Deceased		2

Custody		1
Higher Level FSP	1	
Higher Level MHRC		1
Lower Level of Care	1	
Pathways		1

As outcomes indicate an increase in clients' relinking back to team, this is suggestive of case managers ability to engage and build a therapeutic rapport through strategies of: removing client barriers such as sourcing phone services and entitled benefits for clients, teaching clients to utilize Lyft services to appointments, and community outreach with partner agencies such as LifeMoves and Whole person Care to assist with locating the homeless population.

Reduction of negative outcomes is collected for the 30 days prior to referral and actual outcomes 3 months with ICM for 18 clients. ICM program is an effective program and intervention for clients that are high utilizers of psychiatric emergency services. ICM reported no suicide attempts and a 75% reduction in PES or psychiatric hospitalizations after 3 months of service. Two clients that were hospitalized were assessed and evaluated in the home by ICM and called police to initiated 5150 for clients that would otherwise not seek emergency services. Additionally, with ICM support, 79% of clients were housed in temporary or permanent housing. Three clients were linked to outpatient treatment who were previously untreated for mental health. As clients engage with ICM, they become more integrated to the clinic services and are often further linked to primary care, Total Wellness, and are highly encouraged to attend therapy and rehabilitation groups to further bolster recovery.

30 day Prior to ICM	Post ICM 3 months	Reduction of Negative Outcomes
5	0	Suicide Attempts
12	3	Psychiatric Emergency or Hospitalizations
4	2	Incarcerations
14	3	Homeless
2	0	Housing Transition at Risk of Homelessness

Integrated FSP – South County	FY 17/18	FY 18/19
Total clients served	36	47
Total cost per client		
based on clients served	$3,538	$2,710
based on contracted slots	$8,491	$8,491

SUCCESSES

A 21-year-old transgender male, intellectually disabled client, diagnosed with Major Depressive Disorder was referred to ICM for stabilization of fleeting SI and PES utilization, assistance with connecting to LGBT services, a need for stabilization of family relationships, and to improve

psychiatric appointment attendance. Initially, the client appeared to present as a 13-14-year-old with poor insight, limited adult skills, poor ADL's, and a poor candidate for hormone cross-sex therapy. The client stated their goal was to transition to male, obtain entitled benefits, and move out of family home. Initially the clients' engagement with his male ICM was slow as the client had significant trust issues. Through linkage to San Mateo Pride Center, teaching basic communication and life skills the client was able to be deemed appropriate for testosterone hormone therapy, has obtained entitled SSI benefits, completed name change, and is functioning at a young adult level. The client has decreased unprotected risky sexual behaviors, increased ADL's, and has improved self-image as his body is beginning to align with his internal sense of self. He now understands what adulating behavior is and how he can achieve goals through following up with commitments and communicating effectively with staff and peers.

A 54-year-old Hispanic female, double amputee from suicide by train attempt, diagnosed with Schizoaffective disorder. Client was not compliant with medication treatment and caused two accidental fires in her apartment jeopardizing her housing placement and safety of others. She has had two 5150, one with the ICM Case Manager due to at risk behaviors and assaulting peers. Her ICM Case Manager was able to meet her language and cultural needs and effectively engage her and normalize her delusions. Through culturally appropriate interventions, the client is taking medications as prescribed, is having positive staff and peer interactions, is at minimum risk of homelessness, and is no longer performing risky ritual behaviors to ward off the "demons". She is attending all appointments and has started therapy.

CHALLENGES

Most of the referrals for the ICM program are to improve client's engagement with their treatment teams (not making it to appointments) and/or clients present as not stable and require outreach support or assessment. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Use of culturally appropriate community agencies (faith based, Club House, pride center) has helped support recovery when limited financial and family support exists.

The main barriers for the clients are limited housing, communication by telephone due to homelessness, co-occurring SUD disorders, trust issue stemming from mental health diagnosis and limited resources for undocumented clients. Assisting clients with task activities such as obtaining cell phone, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the Case Manager.

Given the limited affordable housing in San Mateo County, continues to be a significant barrier for sourcing housing for clients.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
16-59	75%	81% (4% ages 16-25)
60+		15%
Race/Ethnicity		
Arab/Middle Eastern	3%	1%
Black/ African- American	19%	20%
White/Caucasian	58%	54%
Latino/Mexican/Chicano	17%	22%
Another race/ethnicity	3%	1%
Sex assigned at birth		
Male		53%
Female		47%
Decline to state		0%
Intersex		
Yes		0%
No		100%
Decline to state		0%
Gender Identity		
Male/Man/ Cisgender		52%
Female/ Woman/ Cisgender Woman		47%
Transgender Male		1%
Sexual Orientation		
Gay, lesbian, homosexual		1%
Straight or heterosexual		97%
Bisexual		0%
Decline to state		1%
Queer		0%
Pansexual		1%
Disability/ Learning difficulty		
Difficulty seeing		1%
Difficulty hearing or having speech understood		1%
Developmental disability		1%
Physical/ mobility disability		1%
Chronic health condition		30%
Learning disability		24%
I do not have a disability		30%
Another disability		1%
Decline to state		0%
Veteran		
No		100%

GENERAL SYSTEM DEVELOPMENT (GSD)

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

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

The OASIS Program purpose is to provide outpatient field based mental health services for home-bound elderly individuals with severe mental illness and co-occurring medical diagnoses and functional limitations. The program assists elderly individuals to live in the community independently with improved quality of their lives.

The targeted population served is the elderly ages 60+ with severe mental illness and co-occurring diagnosis due to mobility issues and functional limitations.

Primary program activities and/or interventions provided include interventions such as psychiatric assessment and treatment, psychiatric medication evaluation and on-going monitoring, clinical case management, rehabilitation counseling, individual or family therapy, peer support, psychoeducation, and collateral support with other community services.

PROGRAM IMPACT

In FY 2017-18, OASIS served 267 cases, 36 cases non-duplicated. In FY 2018-19, OASIS served 248 clients, including 77 non-duplicated cases and 51 cases were discharged from the program for a variety of reasons. Because of the fragility and complication of medical problems, 29.4% clients unexpectedly died from a medical condition, and there were 23.5% sent to Skill Nursing Facilities because of the need of higher-level care. Of the 51 clients discharged, there were 17.6% who refused to engage with a mental health provider but agreed to be followed by primary care provider for mild symptom of depression. 9.8% were given a diagnosis of dementia and were followed by primary care and Landmark medical group for continue treatment. 7.8% of them were transferred to region outpatient clinic as their mobility issues resolved and their symptoms were stabilized, no longer requiring field-based services. There were 9.8% who moved out of the county and 2% of them were lost follow up contact. Services

were provided in multiple languages including: Spanish 13.6%, Chinese 12.4%, Korean 1%, English 72%, and other languages 2%. With funding of MHSA, the OASIS program was able to continually provide services in Spanish and Chinese for those clients. Other languages beside English, i.e. Korean, the case manager utilized interpreter services to reduce the language barriers and to further engage the client in order to provide comprehensive follow-up care.

Factors identified by OASIS are that the elderly population is experiencing a longer life span as compared to previous generations, but yet with more problematic psychosocial issues, i.e. financial difficulties, family relationships, housing problem, etc. With the limited resources in the county, OASIS case managers continually work with non-county contracted care homes in the community and are successful in placing a few clients who needed it the most. Unfortunately, there still a lot of clients on the waiting list of various placements, the hope is that there will be more willingness from home owners in the community to accept the elderly and mentally challenged clients.

OASIS	FY 17/18	FY 18/19
Total clients served	36	77
Total cost per client	$12,931	$6,046

SUCCESSES

68-year-old Latina female with a severe history of childhood sexual abuse trauma and serious chronic illnesses. OASIS has consistently worked with the client for 7 years, after she was referred by her PCP due to the severity of her depression and her very poor medication compliance. Initially, the clients housing situation was very unstable, she had very little family support, was extremely isolated, and very symptomatic. She had limited coping strategies and was often suicidal. She made 3 serious suicidal threats, during the first few years of working with OASIS, that led to long term psychiatric hospitalizations, 2 rounds of ECT treatment and placement in transitional mental health program. The program worked with her to provide consistent and on-going psychiatric and case management services in the home. The program has worked very closely with her, first on stabilizing her by addressing her severe depression using Cognitive Behavioral Therapy and psychotropic medications. Simultaneously, her psycho-social stressors were also addressed, these include her unstable housing, isolation, barriers to accessing medical care, and improving her relationship with her adult children. She is now in stable housing, is actively participating in an adult day program, is very compliant with her medical and psychiatric treatment (decreasing the need for long term hospitalizations) and has not had a psychiatric emergency in over 2 years. With sustained stability and use of healthy coping strategies, she has been working more directly on the issue of her sexual abuse trauma.

78 years old female client who was renting a room in an extremely chaotic drug house. Due to the housing crisis and limited availability of affordable housing, this was the only place she could afford. The client becomes very overwhelmed and anxious when confronted with having to make decisions for herself. After working with OASIS for approximately 2-3 years, the client was able to take on the challenge of moving to a safe, secure, and affordable apartment. She has many obstacles that she is working on, but since her housing situation has been resolved, she is now able to focus on her mental and physical health. The client is working on improving her relationship with her daughter, after several years of estrangement, and is now going to her medical appointments.

CHALLENGES

As the elderly population has continually increased, the OASIS team is working on further defining and clarifying criteria for referral to this field-based specialty team. This has become necessary as the clients entering the program continue to present with increasing complex medical conditions and case management needs in addition to their mental health issues.

Another challenge is the housing issue and care home placement for the elderly clients. Facing the factor of high cost of living in the Bay Area and in San Mateo County, lots of the clients were forced to move out from the county because they could no longer afford to live here. The limited resource of care homes in San Mateo county, also has the clients considering relocating to different living areas for their care needs.

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
26-59		7.8%
60+	100%	92.2%
Primary Language		
English	64%	79%
Spanish	30%	8%
Chinese	6%	11%
Russian		1%
Another language		1%
Sex Assigned at birth		
Male	22%	27%
Female	78%	73%
Decline to state		

- In FY 17-18 clients had a clinical diagnosis of mental illness with mobility issue due to multiple medical conditions.

SENIOR PEER COUNSELING, PENINSULA FAMILY SERVICE

Senior Peer Counseling (SPC), Peninsula Family Service is comprised of specially-trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+.

The program provides weekly drop in support groups such as Stages in English, Platica in Spanish and Kapihan in Filipino, are also provided in various locations throughout San Mateo County such as in community centers, housing sites for older adults and the Pride Center. The program targets San Mateo County older adults in the underserved populations, 55 years and older, who may be isolated, depressed, or suffer from anxiety.

Volunteer peer counselors receive 36 hours of intensive training and undergo a thorough background check before being matched with a participant. Monthly clinical supervision is provided to the trained peer counselors. In addition, the program provides a variety of in-service training to volunteers during the year.

PROGRAM IMPACT

Clients and counselors both felt that the program, generally, has done a good job meeting their needs. Client respondents' motivation for joining SPC was primarily companionship (combating loneliness/social support), assistance, and advice/helpful information. Clients reported that the program has helped them to feel a lot less lonely (73%), more supported (78%), more connected to others (85%), and more positive about getting older (77%). It has also helped with coping skills, including asking for help (72%), sharing issues they are facing (71%), making decisions (66%), and dealing with grief and conflict (64%). Most respondents identified their peer counselor as a primary or secondary person they spoke with about issues.

Both group and individual clients report high satisfaction with the program. Eighty-six percent of individual clients are satisfied a lot by the support their peer counselor provides. 83% of group clients also reported high satisfaction in the program.

Senior Peer Counseling	FY 17/18	FY 18/19
Total clients served	570	840
Total cost per client	$602	$409

SUCCESSES

A Senior Peer Counselor (SPC) routinely visited her participant, an older gentleman who lived alone. She arrived one day to her regular appointment and the gentleman did not open the door. She was very concerned and called PFS and the emergency contact. She next called the police, who entered the home and found the participant on the floor and unresponsive. It was determined that he had been on the floor 2-3 days. The participant had no family and the SPC visited him daily in the hospital. She knew more about the client than his next of kin, who was related by marriage, but divorced. She was able to share the info she knew with the hospital staff who were caring for him. Without the SPC's quick thinking, it is unclear if the gentleman would have survived much longer, dehydrated and ill on the floor of his home.

Paula, a woman who was recently widowed had no family and was not involved in the community. Without her husband, Paula felt alone in the world. The SPC counselor met with Paula weekly, assisted her with getting Meals on Wheels, encouraged her to volunteer in her church, and took the bus with her, to help her become more independent. As their relationship grew and Paula's confidence increased, Paula began driving again, volunteered and made new friends at church and no longer felt so very alone, especially on holidays.

Sarah, a 56-year-old single mother with a 19-year-old son with a disability, had fallen recently, hit her head and experiencing dizziness and migraines. She could not work, nor drive. Sarah's ex-husband was not paying alimony and they were struggling financially. The SPC counselor met with Sarah weekly. Through their communication, trust developed, Sarah's confidence grew. She started working part time and began to look at the part she played in her situation. Sarah is feeling better about herself, she is looking at services to support her son as well.

CHALLENGES

Many SPC volunteers have reported feeling more comfortable attending clinical supervisions in their native language. A challenge faced for SPC has been finding a bilingual/bicultural Spanish-speaking clinical supervisor due to the limited hours the consultant works. The program spent 8 months searching and were able to finally find a great supervisor and in which the volunteers are provided with the support that they need. The peer counselors visit their participants diligently on a weekly basis, the counselors appear to face a challenge when tasked with completing visit forms in order to record their time as it takes staff some time to contact the volunteers to get their visit dates and hours.

Additionally, SPC found it a challenge when attempting to have participants complete the SOGI questions. Training was provided to the staff and volunteers, but continued efforts will need to be made in order to increase the comfort level among the volunteers so that they feel more at ease administering the questions to their participants.

DEMOGRAPHIC DATA

	FY 17/18	FY 18/19
Age		
26-59	6%	1%
60+	94%	99%
Primary Language		
English	38%	49%
Spanish	42%	32%
Mandarin	11% (Chinese)	6%
Cantonese		.5%
Tagalog	7%	12%
Another language	7%	1%

CRIMINAL JUSTICE INTEGRATION

PATHWAYS COURT MENTAL HEALTH PROGRAM

The vast majority of the programs clients represent traditionally underserved populations; all have experience with the criminal justice system and a mental health diagnosis, many are low-income, and many have suffered discrimination and health disparities related to ethnic and gender identity. The four Pathways case manager's work with clients individually and intensively to ensure that they are connected in a timely manner with a warm handoff provided to needed services. Each client develops an individually-driven treatment plan to address client-specific needs that are sensitive to history of minimal access to resources. Services accessed include public health services (e.g. Medi-Cal enrollment, benefits applications, linkage with a regional mental health clinic and primary care provider) as well as additional services with partner programs based on individual needs (e.g. chemical dependency treatment, housing agencies). Pathways clinicians also provide direct clinical services to all clients, including group and individual therapy and crisis management, in order to ensure low barriers to access needed care. Pathways also proactively works to combat stigma and discrimination, particularly with regard to mental health diagnoses and difficulties. Pathways encourages participants to speak openly about their experiences and partners with organizations such as the National Alliance on Mental Illness to participate in activities such as the annual NAMI awareness walk, mental health month, and suicide prevention initiatives. Further, Pathways utilizes the peer support worker model to reinforce the recovery and human-centered approach to treatment.

PROGRAM IMPACT

All 47 current clients served in FY 2017-18 were able to reduce the duration and severity of mental illness through their active participation in Pathways support and treatment groups as well as through intensive case management. Specifically, many clients also addressed concrete negative outcomes that result from untreated mental illness:

- Pathways is an alternative to incarceration, meaning that all enrolled clients are in Pathways and thus able to avoid incarceration by obtaining mental health treatment.
- 1 client who entered Pathways endorsing persistent suicidal ideation now denies any suicidal thoughts
- 19 clients newly obtained stable housing
- 16 clients newly obtained employment
- 4 clients maintained previously acquired employment
- 5 clients enrolled in school (including community college and bachelors-level college)
- 2 clients were able to maintain children in their homes

Pathways	FY 17/18
Total clients served	47
Total cost per client	$5,436

SUCCESSES

John began Pathways endorsing chronic suicidal ideation and alcohol use that had impaired his ability to successfully complete regular probation. Once in Pathways, he entered residential alcohol and drug treatment. While this was initially successful, as he sustained periods of sobriety, John began to experience symptoms related to early childhood trauma. His suicidal ideation increased, and he immediately began meeting with a Pathways clinician weekly alongside daily meetings with his case manager, probation officer, or chemical dependency treatment provider. This increased clinical support alongside participation in groups with other clients who experienced similar trauma helped John identify sources of hope and gradually reduce suicidal thoughts. John then graduated his chemical dependency program and started work. He was able to avoid alcohol use for quite some time, in part due to the accountability from his Pathways clinical and probation team. John did drink once, but the team was quickly able to help John address the issue with a treatment rather than shaming approach. The team linked John to medication assisted treatment, and he was able to utilize medication to reduce his cravings while he continued to participate in therapy. At present, John denies all suicidal ideation and shares plans to work to support his daughter in her upcoming marriage.

CHALLENGES

As many specialty court programs experience, Pathways enrollment numbers change in response to justice system developments. To increase enrollment, Pathways continues to work closely with Correctional Health Services, the Sheriff's Office, and Behavioral Health and Recovery Services, seeking candidates who might benefit from the program. Pathways has also coped with staffing shortages and changes. The hope is for Pathways program to be fully staffed in the coming year to be able to support even more client events and caseload.

DEMOGRAPHICS

	FY 17/18	FY 18/19*
Age		
16-25	23%	
26-59	77%	
Primary Language Spoken		
English	87%	
Spanish	13%	
Race/Ethnicity		
White/Caucasian	40%	
Latino/Hispanic	38%	
Black/African-American	6%	
Asian	15%	
Sex		
Male	74%	
Female	26%	
Intersex		
No	100%	
Sexual Orientation		
Gay, lesbian, homosexual	4%	
Straight or heterosexual	96%	
Veteran		
Yes	2%	
No	98%	

**due to staff transition, FY 2018-19 is currently not available*

G.I.R.L.S PROGRAM

StarVista's G.I.R.L.S. (Gaining Independence and Reclaiming Lives Successfully) is a court-mandated, intensive program that provides assessment, counseling, and case management services for incarcerated girls aged 13-18. Participants learn how to deal with significant

substance abuse and mental health issues. Adolescent girls are valuable and worthy of community support. Sustainable resources and programs are provided that promote the process of healing, educating and empowering each girl to achieve her greatest potential in her community. Services include: Individual counseling, Family counseling, Adolescent group counseling, Multifamily group counseling.

PROGRAM IMPACT

StarVista is proud to support the youth San Mateo County in the G.I.R.L.S program at Camp Kemp. During the '18-'19 fiscal year the program has experienced 3 clients out of 21 complete the GIRLS Program successfully compared to 14 clients out of 38 in the previous year. There was also 1 High School Graduation and 1 8th Grade promotion. The Camp Kemp school environment seems to be a very successful part of the program and helps youth graduate who are found at risk to not reach graduation in school while living in the community. StarVista's recent integration with Pyramid has brought additional team members with specific expertise. The Program Manager oversaw Camp Glenwood and Institutions teams in addition to the GIRLS Program, bringing these programs closer together resulted in increased flexibility within coverage and the benefit of their knowledge and experience across each of the programs. The integration of programming has provided both the camps and the juvenile hall with opportunities for continuity of care and additional support for staff in each program.

GIRLS Program	FY 17/18	FY 18/19
Total clients served	14	21
Total cost per client	$6,384	$4,256

SUCCESSES

GIRLS has had a very strong team, reflecting the efforts made through the recruitment of interns that can thrive within the Camp Kemp environment and improvements in training. The program was assisted by the multi-disciplinary team as it was welcoming and supportive of the new interns. Generally, the interns fit very well into the Camp Kemp environment and were skillful at building rapport with the youth, families and the multi-disciplinary team. Alcohol Other Drugs (AOD) group therapy has been well received by the clients who have been highly engaged. Additionally, AOD individual therapy was provided to two youths (funded by probation). The integration of AOD Individual counseling service in collaboration with individual, family, and group counseling services provided a significant amount of support to youths struggling with substance use. The program successfully utilized the GIRLS Circle curriculum and is now providing healthy snacks as part of their group therapy sessions and has increased the use of sensory tools such as stress balls, tactile objects, and rocking chairs in group therapy to support self-soothing and emotional regulation.

CHALLENGES

During the '18-'19 fiscal year the program saw an increase in youth in the program whom were working with probation and HSA who were not returning to their family after staying at Camp. This created some challenges in terms of the traditional programming, which is currently oriented towards youth returning to their families. This was particularly evident at the multi-family group therapy sessions. The program saw several youths whose parents attended part of MFG, refused to attend, or did not participated in MFG groups. The program predicts that if this continues, planning around this factor would be an important part of the multi-family group.

There was an increase in the amount of youths who went AWOL and/or decided to serve their reminder of time at YSC. StarVista believes in the continuity of care, thus attempts to provide services at the YSC were made, however, there were specific challenges the program encountered. It is reported that clinicians were only given a short amount of time with youth, space was limited at YSC, or codes called at YSC leading to closure to outside visitors. StarVista will continue to collaborate with Probation Services to facilitate the transition of services. Lastly, StarVista and BHRS, Aurora Pena met at least once a month to discuss program strength and challenges to support each other and continuity of program collaboration. Maintaining the framework of Phase II treatment continues to be a challenge for youth who attend school in the community. The number of youths in the community is often too small to set up a group therapy session that is more accessible to them and it is often challenging to get them to attend therapy at Camp Kemp. A new idea has been to set up a group therapy session at the San Carlos office for both GEP and youth in Phase II or III of the programs and to combine that with offering case management services.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Primary Language		
English		67%
Spanish		33%
Age		
0-15		14%
16-25		86%
Race/Ethnicity		
African-American		5%
Pacific Islander		
Latino		61%
Filipino		5%
Native American		5%
Other		24%

CO-OCCURING RECOVERY SUPPORT SERVICES

Voices of Recovery San Mateo County (VORSMC) is a non-profit 501© 3 peer-led organization that was established in 2010 with the purpose of advocating for and supporting the recovery community; people overcoming drug and/or alcohol addictions. VORSMC creates peer-led opportunities for education, wellness, advocacy and support services for individuals in or in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families. The program strives to coordinate local, state, and federal advocacy efforts. VORSMC partners with treatment providers, government entities and officials, community non-profits, faith-based organizations, and other organizations that provide recovery support services to individuals and impacted families.

PROGRAM IMPACT

VORSMC honors and embraces all unique strengths and challenges along the journey of recovery. They create peer-led opportunities for education, wellness, advocacy and support services for individuals in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families. VORSCMC provides recovery support services to residents of San Mateo County (SMC) from the urban core of San Mateo and Redwood City, to the historically underserved coastal regions, geographically isolated from services and long-standing networks of support. SMC is home to 769,545 residents and the Census reports a significant reports a significant percentage of the population as persons of color (46.6%), including 24.8% Asian, 25.4% Latino, 2.8% African-American, 1.4% Pacific Islander and 11.8% Other/Mixed Race. The South County Cities Redwood City and East Palo Alto are home to immigrants from Latin America.

VORSMC has expanded their services from 10 SMC drug treatment to 16 providing WRAP aftercare, the WRAP Facilitators facilitate groups and then provide ongoing peer-support and care coordination to help ease the transition from active treatment to recovery. VOR programs are intentionally designed to create peer feedback loops that keep leadership informed of the impact of their services and their continuing relevance to the recovery community.

Voices of Recovery	FY 17/18	FY 18/19
Total clients served	5017	5360
Total cost per client*	$23	$21

*Funding is highly leveraged for these services, MHSA supports a portion of infrastructure costs

SUCCESSES

"My name is Melissa and I am a woman in long term recovery. Growing up I succumbed to peer pressure and smoked my first joint at the age of 13. I tried cocaine at 16 and then progressed to try crank/meth at 22. My "friend" suggested to me she knew how I could lose weight. I was so desperate to lose weight and fit into society's standard of what a woman should look like as well as very low self-esteem and self-confidence. It was the perfect combination to become an addict and lose myself for years. I numbed my feelings and emotions for most of my adult life. I came into recovery at the age of 48. I have overcome addiction, domestic violence, homelessness, no self-confidence or self-esteem. Almost died or killed on several occasions. Today I embrace life. I value myself and am grateful for everyday that I wake up. I work for Voices of Recovery San Mateo County which allows me to share my story of recovery as an Advanced Level WRAP Facilitator, Recovery Coach and Peer Mentor and give others hope that "if I can do it, you can do it" As a WRAP (Wellness Recovery Action Plan) facilitator it has allowed me to adopt a WRAP plan into my daily life. I have been able to identify what my wellness looks like so that I can recognize pretty quickly when I am not in my wellness and then put into place an action plan that is ready for me utilize to get back into my wellness before situations become a crisis in my life. Today I value myself and am grateful for the people in my life who are also my supporters, coworkers, adopted extended family members and sisters in sobriety. Today I love to give and receive hugs and in recovery I have learned that my mistakes and my past do not define who I am or where I am going in life."

CHALLENGES

The programs current challenge is not having the space to meet with participants and allow them the access to come and volunteer with us.

CO-OCCURING CONTRACTS & STAFF

BHRS contracts with nine AOD providers and funds co-occurring staff to enhance services provided to co-occurring clients. Additionally, two clinical contractors provide co-occurring capacity development trainings to BHRS staff and multiple agencies, consultation for complex co-occurring clients and system transformation support for relevant programs.

PROGRAM IMPACT

An annual survey asks clients about their treatment experiences, including co-occurring care coordination (staff work with my mental health care providers to support my wellness), and quality of life outcome (as a direct result of the services I am receiving, I am better able to do things that I want to do)

Findings from 2017 Treatment Perception Survey

Item Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Care Coordination Work with MH Providers	4 (1.6%)	3 (1.2%)	2 (8.6%)	69 (27.0%)	119 (46.5%)
Quality of Life Outcome Better Able to Do Things	3 (1.2%)	8 (3.1%)	21(8.1%)	80 (31.0%)	140 (54.3%)

Findings from 2018 Treatment Perception Survey

Item Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Care Coordination Work with MH Providers	5 (1.3%)	8 (2.2%)	55 (14.8%)	95 (25.5%)	174 (46.8%)
Quality of Life Outcome Better Able to Do Things	7 (1.9%)	6 (1.6%)	45(12.2%)	105 (28.4%)	202 (54.6%)

Clients served by co-occurring staff

Voices of Recovery	FY 17/18	FY 18/19
Total clients served	405	421
Total cost per client*	$902	$868

CHILD WELFARE

CHILD WELFARE PARTNERS

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

Child Welfare Partners	FY 17/18	FY 18/19
Total clients served	54	52
Total cost per client*	$4,572	$4,748

PUENTE CLINIC

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

1. Returning to the community from a developmental center or a locked or delayed egress facility.
2. At risk for a higher level of care.
3. Requires in-home services as clinically determined.
4. Had multiple psychiatric emergency services contact.
5. Complex diagnostic issues or poly-pharmacy.

PROGRAM IMPACT

Puente Clinic continues to track the utilization of Psychiatric Emergency Services (PES), which is the triage center for acute psychiatric emergency in the county. The Puente Clinic eases the transition of intellectually disabled clients with aggressions that endangering self or others from a locked or highly structured institutional setting to the much less restricted community environment. To achieve this, individual psychotherapy, medication management, and close collaboration with GGRC and its support teams are needed to reduce disruptive and aggressive behaviors and to maintain stability in a high-risk client.

In FY 2018-19, the total number of clients who needed PES intervention was 13, which is about 4.7% of the Puente Clinic total caseload. That is one person more than last FY 2017-18 but is equal to the previous FY 2016-17. These continuously low percentage numbers indicate that Puente Clinic has been able to provide effective outpatient-level services to avoid the use of higher-level intervention, like PES, and to maintain stability of most clients in its caseload.

In more detailed analysis, of the 13 clients who needed PES services, the total number of PES visits was 43 in the FY 2018-19, which is 5 PES visits more than FY 2017-18. This was due to the increased utilization of PES by a few clients. On the other hand, there were only 3 clients in FY 2018-19 had >4 PES visits over the full year, which is one client less than FY 2017-18. This indicates that higher utilization of PES intervention was limited to only a few clients. Of the 6 clients with PES visits in both 2018-19 and 2017-18 fiscal years, 2 of them had a reduction of PES visit from FY 2017-18 to FY 2018-19, 2 had an increase of PES visits, and 2 had the same number of PES visits over the two years. Overall, these number counts show that the utilization pattern of PES remained the same between the two fiscal years and stayed low. It is worthwhile to note that, of the 12 clients with PES visits in FY 2017-18, 6 of them had no PES visits in FY 2018-19, this shows the positive effect of treatment. There were 7 clients with new PES visits in FY 2018-19 with 50% of them being relatively new to Puente, and therefore their symptoms and conditions haven't become stabilized.

Puente Clinic – Dual Diagnosis	FY 17/18	FY 18/19
Total clients served	151	147
Total cost per client*	$1,664	$1,709

SUCCESSES

ML is a single, verbal, ambulatory non-conserved woman with diagnosis of schizoaffective disorder, intermittent explosive disorder and mild intellectual disability. She is near 60 and has diabetic condition. She resided for most of her adult life in various board and care facilities in San Francisco. After her board and care closed in 2016, she was placed in a group home in San Mateo which was not equipped to manage her needs, resulting in more maladaptive behaviors. She began to decompensate and had multiple involuntary commitment to psychiatric treatment, police contact and hospitalizations for violence towards others as well as suicide attempts and ideations. She was ultimately transferred to a behavioral home created to support clients with extensive medical and behavioral needs. Since the summer of 2018, ML began to settle down. With good care coordination between healthcare stakeholders including Puente Clinic, primary care, GGRC and dedicated 1:1 staff at the current care home, ML is now stable and doing well.

CHALLENGES

AK is a single, verbal, ambulatory non-conserved woman in the mid-30s with diagnosis of seizure disorder, mood disorder not otherwise specified, impulse control disorder not otherwise specified and mild intellectual disability. She resides in a small apartment with her mother. She is dependent on her mother for all activities of daily living. She was briefly placed in a group home and attended a day program, but her mother felt AK was not benefitting from either. At baseline, AK suffers from chronic insomnia, explosive bursts of rage (when she does not get her way), compulsive behavior and irritability. In the last 5 years she has had 2 psychiatric hospitalizations and 5 psychiatric emergency visits for dangerousness to others. Since 2015 her mental health treatment has been managed at Puente Clinic. There was a period of stabilization from late 2015 until summer of 2018 when AK was given her medications more regularly by her mother. From summer of 2018 her mother felt AK no longer needed psychiatric medications and stopped giving them for several months, resulting in further decompensation. For the last year the clinic experienced a phase of playing 'catch up' from the prolonged break in medication. Prescriber continues to struggle with AK's mother for improved medication adherence and cooperation with medical tests including laboratory tests and electrocardiogram. Working with families who have their own ideas about treatment yet still seek assistance is a chronic challenge for Puente Clinic. One other challenge presented by this case is that this client's intellectual disability service benefit is still managed by the Regional Center of Santa Clara County, instead of GGRC of San Mateo County, because she used to live in the Santa Clara County. Due to geographic disconnection and lack of existing collaboration model, it has been particularly difficult for Puente Clinic to advocate for this client in getting a full range of needed support.

PEER AND FAMILY PARTNER SUPPORTS

CALIFORNIA CLUBHOUSE

California Clubhouse provides lasting and healthy behavioral changes for adults (18 years and older) living with serious mental illness. The Clubhouse environment encourages members to support each other in making healthier lifestyle changes and choices. Open at least 5 days weeks, the majority of Clubhouse activities occur during the Work Ordered Day (daily programming structured to engage members and staff side-by-side in meaningful work). The Work Ordered Day offers members the opportunity to rediscover their talents and strengths

while rebuilding self-esteem and developing independence. Community support activities are centered in the work unit structure of the Clubhouse. They include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in accessing quality medical, psychological, pharmacological and substance abuse services in the community.

In addition to the Work Ordered Day, California Clubhouse offers supported employment and education services through the Career Development Center as well as a full range of social and recreational programming including evenings, weekends and holidays. The Clubhouse strips away the "DIS Ability" so that members can rediscover the talents, strengths and Abilities that have always been there but just got lost. Wholeness is restored through an emphasis on overall wellness, because after all, the mind is powerful and connected to the entire body.

The program emphasizes that they do not have clients, customers, patients or consumers at California Clubhouse. Rather they acknowledge they have members, who have voluntarily joined the community not only to receive support but to share that support with others. The members own a stake in the Clubhouse as they work everyday side-by-side with staff in the Work Ordered Day to run the operations of the organization. They are the decision makers. With membership comes opportunity, rights, and personal choice but also requires accountability to something bigger than yourself.

PROGRAM IMPACT

The California Clubhouse Career Development Center offers a multi-tiered approach to providing supported employment services to members. In addition to pre-vocational opportunities in the Work Ordered Day, volunteer positions in the greater community and independent employment supports, the Career Development Services focus heavily on assisting members in gaining meaningful paid employment:

Transitional Employment (TE) is a unique feature of Clubhouses, a program specifically tailored for adults with persistent mental illnesses. It provides members an opportunity to be introduced or reintroduced to working, with part-time, time-limited job placements in local businesses. Members working TE are paid the prevailing wage for that position. The Clubhouse supports by providing on-the-job training, supervision and support. Members continue to be a vital part of the larger Clubhouse program during TE. Clubhouse staff fills in should any member be temporarily unable to work, providing employers guaranteed job coverage. Through this

program members return to work, earn a good wage, expand their experiences, rebuild working stamina and obtain current job references.

Supported Employment (SE) is similar to Transitional Employment, except the employment is not time-limited and can be either part-time or full-time. The position belongs to the member and there is a competitive element to the interview process. In SE, the clubhouse develops and maintains a relationship with the employer, provides resume and job search support, and assists with job site development and training. Ongoing support from the Clubhouse program and staff is provided as long as the member needs however, the clubhouse does not provide absence coverage.

- Supported Employment 15
- Supported Employment (HOPE Mentors) 7
- Transitional Employment (Unduplicated People) 6
- Transitional Employment Job Placements 7
- Independent Employment 28
- # of Individuals Entered into SE Services* 39
- *Received one or more categories of SE Supports (ie. Resume, job search, mock interview, job development, job training/support, etc.)
- # of SE Individuals that became employed 23 (58%)
- # of SE Individuals that were already employed** 3 (66%)

**These individuals were already employed when they began utilizing the SE services to find other employment (either different career path, hours, pay, or to exit pre-existing sheltered workshop programs)

California Clubhouse	FY 17/18	FY 18/19
Total clients served	157	207
Total cost per client*	$1,968	$1,493

SUCCESSES

In Spring 2017, through San Mateo County Behavioral Health and Recovery Services, California Clubhouse entered an innovative collaboration with three other community-based peer-run organizations, Heart & Soul, NAMI San Mateo and Voices of Recovery to implement a pilot program, HOPE (Helping Our Peers Emerge). HOPE is designed to reduce hospitalization and comorbidity for a targeted vulnerable mental health population through dedicated peer and family support and Clubhouse Supported Employment services.

Some additional agency partners include: StarVista, HAP-Y with Starvista, San Mateo Medical Center, MHA, Caminar, Cordilleras, College of San Mateo, Latino Collaborative, Pride Initiative, HOPE House, Chinese Health Initiative, Job Train and Pacific Islander Initiative.

Amaal, now 28 years old, shares how California Clubhouse's Young Adult Program helped change his life: "Early on in my recovery I had a tendency to isolate and stay at home without being very productive. The YAP at the Clubhouse got me out of the house and interacting with more people my age with similar struggles. It helped me overcome my stagnation and get involved in the community. Through my participation at the Clubhouse I was able to go back to work and go back to school. I now work full time in the mental health field and attend school part time with the goal of becoming a psychiatric nurse. The California Clubhouse Young Adult Program has truly helped me go above and beyond!"

The change that California Clubhouse makes in the lives of its members takes many forms.

For some, it is getting out of bed and going to the Clubhouse to break the cycle of severe isolation. For others, it is returning to paid employment after a lengthy break or not having a solid work history. The journey of Upward Mobility is unique for everyone, just as every person's mental health recovery is unique. -- Riley, Clubhouse Member

CHALLENGES

1. Only 54% of funding was from San Mateo County Behavioral Health and Recovery Services. The remaining 46% is comprised of private donor, foundation and corporate support. So, program implementation and growth are dependent on fundraising success. With limited resources, this can mean a competition for resources such as time between fundraising and program sustainability.
2. The program is not funded directly for Supported Employment funding therefore, resources for the Career Development Center were capped
3. Data tracking and reporting; the program reports lacking the funding to purchase a comprehensive Clubhouse data tracking system that can help quantitatively and qualitatively measure program outcomes to provide empirical evidence to inform program development, management, evaluation, reporting, and improvement.
4. Data capture; the program decreased the size of membership application to remove additional barriers and delays for members to join. The program transitioned from

capturing demographic information in the written application to a process of in person Q & A with the member and a staff member. However, it was realized that some of the data points were not transferred over. Additionally, in the past demographics collected by the County were different and have recently expanded.

5. Limited accessible public transportation options near new Clubhouse location.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
16-25		5%
26-59	88% (18-64)	74%
60+	12% (65+)	21%
Primary Language		
English		100%
Sex Assigned at birth		
Male	55%	54%
Female	44%	46%
Decline to state	1%	
Gender Identity		
Male/Man/Cisgender		54%
Female/Woman/Cisgender woman		46%
Another gender identity		.4%
Race/Ethnicity		
American Indian/Alaska Native/ Indigenous	1%	.4%
Asian	11%	10%
Pacific Islander		2%
Black/African/-American	11%	10%
White/Caucasian	50%	50%
Hispanic/Latino		12%
Hispanic	15%	
Mixed Race		15%
Another race/ethnicity	10%	
Disability/Learning difficulty		
Developmental disability		7%
Another disability		3%
Decline to state		90%
Veteran		
Yes	<10%	4%

PEER SUPPORT WORKERS & FAMILY PARTNERS

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

PEER SUPPORT WORKERS

There are currently 18 peer positions throughout the behavioral health system of care:

- 1 Senior Community Worker on the Adult Services Team
- 9 Peer Support Worker positions in the BHRS adult system funded by MHSA. They are distributed throughout the system in a variety of clinical program teams: OASIS (Older Adult system of Integrated Services), Pathways and the 5 County Regional Clinics. One part-time Peer Support Worker position was made full time.
- 6 Peer Support Workers on the Adult Clinical Services Teams (full time civil service positions)
- 1 Peer Support Worker is in the Older Adult System of Integrated Services (OASIS) Team (part time civil service position)
- 1 Senior Community Worker on the Pathway Team (full time civil service position)

Peer Support Workers also help clients with case management activities such as finding housing; linking to mental health and AOD services and counseling; facilitate the transition to a higher level of care; connecting to vocational resources; applying for benefits; providing some transportation; connecting to Peer Support Services as Heart and Soul, California Clubhouse, Voices of Recovery and The Barbara A. Multicultural Wellness Center

Peer Support Workers facilitate groups such WRAP Groups; WRAP for Housing; Dual Diagnosis Group; Welcome Registration/Orientation; Stress Management; Exercise; Peer coaching (physical health).

Peer Support Workers bring their lived experience to the broader community by participating in community groups and County BHRS Health initiatives such as African American Initiative; Latino Collaborative; Lived Experience Speakers Academy; Lived Experience Education; Workgroup; Housing Operations and Policy Committee; Develop with CM treatment plan

FAMILY PARTNERS

In FY 17/18 and 18/19 there were 10 Family Partners with lived experience as a family member of someone with behavioral/mental health challenges working in San Mateo County Behavioral Health and Recovery Services.

- 7 Family Partners were embedded on the youth clinical services teams. (full time civil service positions
- 1 Family Partner on the Office of Diversity and Equity (3 year grant funded position).
- 1 Family Partner on the Adult Pathways Mental Health court team. (full time civil service position)
- 1 Family Partner on the Pre-3 Program. (part time civil service position).

Groups co-facilitated by Family Partners during 2017-18 include:

- 1 Wellness Recovery Action Planning (WRAP) – Spanish (**9 families)**
- 3 Nami Basics - English **(12 parents)** and 2 Spanish **(48 parents)**
- 20 monthly Parent Café's – Spanish 1 at Coastside Clinic with 6-10 parents per café and 1 South
- County Clinic with **8-10 parents per Café .**
- Parent Support Groups - Spanish – Coastside,North Count and East Palo Alto Clinics
- Aprenda hablar con sus hijos sobre el Cannabis presentation (pilot) **23 parents**
- Pregunte al Doctor – Ask the Doctor – Central County **12 parents**
- Stigma Presentation – South San Francisco School District -Grupo del Imigrante **15 parents**
- Reconozca las Señales Presentation – North Fair Oaks, Redwood City – **42 parents**
- Reconozca las Señales Presentation – South San Francisco School District Grupo del Imigrante– **15 parents**
- Family Partner from ODE in collaboration with OCFA outreached to *Parents & Caregivers for Wellness* and obtained 13 scholarships for parents/caregivers who graduated from the Health ambassador Program, to attend to the *California Mental Health Advocates for Children and Youth Conference* (CMHACY).
- Family Partner presentation at Canyon Oaks Youth Center.
- Bay Area CSOC Meetings.
- Support Edgewood TAY Program for parents/caregiver's Spanish Lunch Support Group.

Peer and Family Partners	FY 17/18	FY 18/19
Total clients served	291	233
Total cost per client	$4,264	$5,326

SUCCESSES

"I met my Family Partner at a Parent Café at the Shasta Clinic in Redwood City. The Cafes were in the morning so I couldn't go to many. She recommended that I attend the Parent Project Class, I went and graduated. Before I thought I knew what to do as a parent and that it was the best way to raise my children. She has helped me in many ways to be a better parent, how to treat them and in the moral aspect and how I can adapt to my child. She also showed me how track changes in my child's mood and to learn the signs of substance use. Before working with my Family Partner, I had many problems with no answers. I still have problems, but I can manage them!!" Ms. Gonzalez, Redwood City, CA

CHALLENGES

Family Partners have noticed that new clinicians and supervisors that come to BHRS have little to no knowledge of what a Family Partner is, how to work with a Family Partner or know of the benefits that the Family Partner can have with the families. In order to solve this, they are creating a training for new clinicians start working at BHRS so they understand better the role of the Family Partner and learn how to Family Partners can support the client's families and how to request a Family Partner. A brochure is being created so that clinicians can better explain to families the role of the Family Partner and how they can provide support.

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

Multi-Cultural Wellness Centers for behavioral health clients and their family members provide culturally diverse community-based programs, support and linkages to behavioral health services, and other resources as needed for clients with mental illness. One East Palo Alto is the lead agency funded since 2009 to implement all aspects of the development and operation of the Barbara A. Mouton Multicultural Wellness Center (The Mouton Center) to build capacity to ensure long-term services are provided to Behavioral Health and Recovery Services (BHRS) clients and community members in the East Palo Alto community. The Mouton Center is intended to create a safe and supportive environment for adults with mental illness and/or co-occurring addiction challenges and their families who are multiracial, multicultural and multigenerational through various strategies including:

- Welcoming to African Americans, Latinos and Pacific Islanders and LGBTQ+ community;
- Include facility decor and furnishings that are welcoming to all members;
- Provide program activities in Spanish, Tongan and other languages; and
- Intentionally celebrate diversity by hosting monthly multicultural events that bring the diverse members of the MCWC together to inform, engage and invite sharing of cultural wellness practices and strengths.

PROGRAM IMPACT

See Appendix 7 for the full evaluation report for the Mouton Center. Historically, the populations served by the program are the undercounted and underserved. The on-going interventions provide timely access and linkages to treatment. For example, during the initial screening of becoming a member, staff members engage the potential consumer member in conversation about mental health and mental concerns that they may have. During the verbal assessment, staff listen non-judgmentally, assessing for risk of suicide or harm to self or others, give reassurance that there are local programs and services that will address whatever their specific need or concern may be.

Where appropriate, staff members make an immediate referral to the appropriate agencies in the SMCBHRS SoC, for assessment and follow up treatment as needed. In most cases, a "warm handoff" is conducted, accompanying the consumer member to the agency and depending on the request, participate in the initial assessment appointment. This has become a standard practice for all EPAPMHO partners particularly among the monolingual speakers who need translation services and rely on an ambassador that they know and trust.

Mouton Center	FY 17/18
Total clients served	147
Total cost per client	$1,272

SUCCESSES

MCESBA Outreach worker Dee "Mamadee" Uhila in partnership with The Mouton Center, served a PI family, husband & wife in their late 90's, both of whom are from San Jose. They had been couch-surfing and heard about The Mouton Center and Dee Uhila thru another consumer. After two months, they secured housing. Through staff contact with the couple and their participation in the PI "Know Your Rights Forum" by MCESBA, the staff members learned so much about their many unmet needs. Due to the stigma associated with asking for help in the PI community and the fear caused by their immigration status, they hadn't spoken with anyone about their needs and were embarrassed. Further, the family the couple was staying with were also unaware of community resources. Mamadee established a trusting relationship with the couple and they were encouraged to allow her to make a referral to Ravenswood Family Health Center. They applied for the Access and Care for Everyone (ACE) program. It took two months to get them through the registration process just to schedule an appointment to see Dr. Amy Wulf and received their ACE cards. The elderly couple had been in the U.S. for 10 years and had never seen a doctor. They are finally receiving ongoing medical care.

As a result of addressing their immediate needs and establishing a trusting relationship, they are now able to participate in a conversation about mental health and wellness and how

participating in wellness programs can improve their quality of life. Currently their immigration issues and long-term housing needs are being addressed.

CHALLENGES

The program has experienced an on-going complaint among consumers pertaining to the wait time when trying to secure services or to receive services on a drop-in basis. The wait time in some cases for an appointment can be up to two or three months. Wait time if one drops into a medical clinic or services can be up to four hours. This is an unexpected interruption in one's day and prolongs ones' suffering with the medical or mental health condition. time when one drops in for services, especially for clients who are elderly.

The needs of the PI community outweigh the capacity and the resources. The amount of time it takes to serve a client. It takes more than a 30 to 60 minutes initial contact to connect the individual or family to mental health services. Given that it is necessary to address the immediate needs before being able to address their mental health concerns, of which the concept of mental health is foreign in their culture, it takes a number of contacts before a referral can be made. The PI community is faced with unique barriers to accessing mental health services. The standard approach used by the County, many times are inappropriate given the cultural uniqueness of the community.

With many of the resources needed being outside of the community, transportation is an on-going issue and determines whether or not a consumer and/or family, family member receive services. Bus tokens that are available have unfriendly user restrictions and defeat their own purpose. Not all clients qualify for taxi vouchers or free rides to medical appointments because they don't have medical coverage, or their medical coverage doesn't provide such services. This makes it difficult to secure mental health services outside the community, making it to job interviews, housing interviews, submitting applications by specified deadlines, etc.

DEMOGRAPHICS

	FY 17/18
Age	
0-15	1%
16-25	5%
26-59	71%
60+	16%
Decline to State	6%
Primary Language	
English	

Sex at Birth	
Male	33%
Female	67%
Gender Identity	
Male/Man/Cisgender	31%
Female/Woman/Cisgender woman	65%
Transgender	3%
Unknown	1%
Race/Ethnicity	
White	20%
Black	33%
Mexican	9%
Chinese	1%
Filipino	2%
Japanese	1%
Korean	1%
South Asian	3%
Vietnamese	1%
Samoan	8%
Tongan	5%
Multi	4%
Another race/ethnicity	11%
Unknown	1%

**FY 2018-19 full report will be included in the next MHSA Annual Update.*

EVIDENCED-BASED PRACTICE (EBP)

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

Evidence-Based Practice Clinicians	FY 17/18	FY 18/19
Total clients served	948	981
Total cost per client	$4,264	$5,326

OUTREACH AND ENGAGEMENT (O&E)

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

PRE-CRISIS RESPONSE

MATEO LODGE: FAMILY ASSERTIVE SUPPORT TEAM (FAST)

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

PROGRAM IMPACT

- Reducing the duration of untreated mental illness. Many of the clients served have never received any effective mental health services. Often this group of clients do not believe that they have anything they need and refuse services. Therefore, any successful intervention will result in reducing the duration of untreated mental illness.
- Preventing mental illness from becoming severe and disabling. As is known, the earlier the intervention the better the outcomes. If left untreated the illness can progress. The intervention often results in arresting this
- Suicide: There has never been a death by suicide of an active FAST team case
- Prolonged suffering: The interventions successfully connect to services which results in treatment to alleviate symptoms and suffering.
- Incarcerations At times during an intervention client may experience short term contact with criminal justice but the goal is to move them away from that system into the mental health system.
- Homelessness: Team members utilize funds for emergency housing, taking people off the street or as necessary out of the home in an effort to end homelessness for clients.
- School failure or dropout: Support is provided to keep clients in school.
- Removal of children from their homes: In the few case involving children CPS is engaged where necessary, but the goal is always when safe to reunite families.

- Unemployment: Where appropriate clients are referred to appropriate services
- Improves timely access & linkage to treatment for underserved populations: As this group by definition is not receiving services efforts are made to streamline access this is done with one on one assistance to open up any system barriers. Same day assistance and walk in services with clients are used.
- Reduces stigma and discrimination: Team members are peers and family members that often know firsthand about issues of stigma and discrimination.
- Increases number of individuals receiving public health services: All types of benefits including SSI GA Food services are accessed.
- Reduces disparities in access to care: Clients are accompanied to system visits to ensure the best care possible.
- Implements recovery principles: Al clients are trained in the Recovery Model.

Client Diagnoses	
Not assessed	0
Delusional Disorder	0
OBS	1
Autism	1
PTSD	7
Body Dysmorphia	1
OCD	4
PDO	6
Disruptive Mood Dysregulation	0
Substance Abuse Psychosis	9
Substance Abuse	55
Eating Disorder	0
Adj DO	2
ADHD	1
Anxiety	21
Schizoaffective Disorder	7
Major Depression	39
Psychosis NOS	3
Bipolar Disorder	16
Schizophrenia	21

Pre-Crisis (FAST)	FY 17/18	FY 18/19
Total clients served	82	100
Total cost per client	$3,857	$3,162

SUCCESSES

There are many successful outcomes that are truly life changing all the more remarkable because before FAST got involved nothing had worked. Many clients have completed Social Rehab and other programs and are living in the community. There are regular outpouring from parents of thanks.

A 34-year-old male living at home angry breaking door frame and even denting appliances with his fists, polysubstance abuse ETC family extremely scared. Intervention resulted in a brief Hospital stay client started meds. Team housed client on release provided permanent housing. Once stable client found work at Safeway. Family is very relieved and happy after treatment client remains very positive about his future.

CHALLENGES

Too few staff to address the need.

DEMOGRAPHICS

Age		
18-30		41%
31-45		28%
46+		31%
Sex		
Male	47%	
Female	53%	
Race/Ethnicity		
African-American		8%
American-Indian		
Philipino		5%
Hispanic		20%
Caucasian		49%
Persian		
Arabian/Middle-Eastern		6%
Pacific Islander		
Asian		12%

RAVENSWOOD FAMILY HEALTH CENTER

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

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

Ravenswood	FY 17/18	FY 18/19
Total clients served	406	375
Total cost per client	$104	$113

PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

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

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

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

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

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

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

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

PEI AGES 0-25

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

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

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

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

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

PROGRAM IMPACT

Providers and Parents receiving consultation services are given an Annual Satisfaction Survey at the end of the year in order to collect data about services provided. In FY 2017-18, 114 unduplicated children were served and 22 staff received consultation. In FY 2018-19, 122 unique children were served and consultation services provided, 11 Community Worker Services, 21 staff receiving consultation services and 47 Families In Groups.

As a result of on-going mental health consultation, teachers at 20 staff at the 5 childcare programs are reporting greater ability to understand and respond to the social-emotional needs of children in their centers. The results from the annual survey of teachers (further discussed with regards to satisfaction below) show:

- 90% of respondents reported that consultation was very effective or effective in contributing to their willingness to continue caring for a specific child with challenging behaviors.
- 85% of respondents reported that consultation was very effective or effective in helping them in their relationship with this child's family.
- 100% of respondents reported that consultation was very effective or effective in helping them think about children's development and behavior.
- 100% of respondents reported that consultation was very useful or very useful in thinking with them about supporting all children in their classroom.
- 100% of respondents reported that consultation was very useful or useful in helping them think about children's engagement in classroom activities.

The 18-19 fiscal year the program collected more parent surveys than the previous year. Results of the surveys collected from 6 Parents of the 12 children receiving intensive consultation services show:

- 100% of respondents reported the consultation was effective in supporting their relationship with their child
- 100% of respondents reported that consultation effective was in increasing their understanding of their child's behaviors and needs
- 100% of respondents reported that consultation was effective in assisting the teachers in adapting and/or responding to their child's needs
- 83% of respondents reported the consultant was involved in finding additional services for their child
- 100% of respondents reported consultation was effective in helping them think about their child's experience in daycare/pre-school

As a result of mental health consultation services, 12 families have increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. These changes have been observed through informal conversations with parents over the course of their work with the consultant as well as from staff satisfaction survey results. Parents and teachers also informally noted differences in children's behaviors: progress towards achieving goals formed at the beginning of case consultation was evidenced in 12 of the 12 more intensive consultation cases. This progress was noted through informal conversations with teachers during weekly meetings as well as meetings with parents.

ECCT	FY 17/18	FY 18/19
Total clients served	114	122
Total cost per client	$3,588	$3,353

SUCCESSES

One success is with a family who had been referred to ECCT by another therapist. The family was set up with goals to assist in providing the child in need with support in regulating and expressing his emotions and frustrations along with the assistance for the mother who was in need of ongoing parenting strategies and confidence building. This family had been very consistently attended weekly therapy sessions. The client, older sister and mother attend the sessions together- mother has a very high level of engagement in the therapeutic process. The program staff were able to get in some collateral time by meeting at a park and keeping enough distance (while watching the kids) to discuss difficult issues and concerns for the mother. The treatment goals, with input and collaboration with mother, have included reducing frequency and intensity of oppositional-defiance and aggressive behaviors, coupled with increasing child's abilities and willingness to appropriately and effectively express his feelings, desires, wants/needs and increasing mother's level of parenting confidence, increasing her capacity and tool box to implement positive discipline strategies. The mother has been able to support child's communication skills, use positive discipline techniques and is able to more effectively de-escalate child when he is agitated and dysregulated. The mother has been able to help child understand why he is upset when he is having a temper tantrum or becomes aggressive (making meaning of his behaviors, providing empathy and nurturing, perspective taking of what is bothering him in the home environment/family dynamics). Child's communication skills and frustration tolerance have significantly improved over the course of therapy. His verbal and physical aggression is much lower in both frequency and intensity (ie: he used to become aggressive towards mother, sister and therapist in most sessions, now he is aggressive very infrequently in sessions).

CHALLENGES

1. Due to the increasing cost of housing in the community, many of the families have had to move in with other families as a way to mitigate the cost of rent. This has created concerns for client confidentiality. Although the Half Moon Bay Library and the office space is a better alternative than the client's home, both of these spaces still have confidentiality concerns.
2. Another challenge face is regards clients that age out of program. For many of these children the program experiences the challenge of transferring them to other services, whether those services are school based or through Coastside Mental Health.

3. The program has also faced challenges in the consultation work which has required the staff to use a stance of "being flexible" very often and very intentionally. Although the team continues to witness the ongoing trend of teachers' having less time to meet as a team, especially due to staffing shortages and constant ratio challenges, teachers continue to use consultation services within their limited time. Due to the flexible approach that attempts to "meet teachers where they are at" the consultants have been able to meet with teachers when their schedule allowed. However, this year teachers reported extremely high levels of stress and burnout as well as feeling overwhelmed with children exhibiting challenging behaviors.
4. The ECCT program would also greatly benefit from having more funding to expand the 3 different roles within ECCT. One of the biggest reasons seeing a need for an expansion due to the populations that have not been able to directly connect to services. For example recently ECCT has made connections with Half Moon Bay High School to discuss providing support to teenage mothers. However, given the limited bandwidth the program is not able to follow through on providing parenting education or mental health workshops.

PEI AGES 0-25: COMMUNITY INTERVENTIONS FOR SCHOOL AGE AND TAY

PROJECT SUCCESS

Project SUCCESS, or Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures. Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral problems among high risk; multi-problem youth ages 9-18. In coordination with San Mateo County Health System, Puente has adopted the Search Institutes Developmental Assets Profile (DAP) as a measurement tool. The DAP incorporates the Search Institutes 40 developmental assets framework when addressing the needs of young people in the community.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All Puente BHRS staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered on all three school campuses in the La Honda-Pescadero Unified School District. The school district's small size provides an opportunity for every student in the district, ages 9-18, to participate in one or more Project SUCCESS activities. All groups were offered in English and in Spanish.

Project SUCCESS	FY 17/18	FY 18/19
Total clients served	91	228
Total cost per client	$3,009	$1,201

SUCCESSES

Learning How to Love and Be Loved

This summer 2019, 40 youth from Puente's Summer Youth Leadership and Employment program participated in a six-weeks Project SUCCESS group (once a week) with Puente behavioral health counselors. Aside from covering basic drug and alcohol prevention topics, as well as problem solving methods to help them at their workplaces (many of them were interns at a workplace for the first time), perhaps the most successful and inspiring lesson was given on relationships, specifically using the "five love languages" from Gary Chapman, Ph.D.

Because healthy relationships are an integral piece in preventing substance abuse in teens, the program wanted to give the youth a better understanding of how they best receive love, and how others may be demonstrating love to them without their awareness. Each youth in the program took a love language inventory to discover their own love language(s). Youth were invited to explore how their top love languages may differ from parents, friends, or other family members and to be mindful of how they express love to others; do their actions match that person's needs (their top love language)? Youth were also given the chance to discover "self-love" (self-care) tools based on their top love language to be used as coping skills when they are going through hard times or feeling depressed or anxious. In addition, group leaders connected the value of love language awareness to the youth's workplaces and discussed how appreciation in the workplace is crucial to a successful and supportive work environment. Youth were asked to recognize ways in which their colleagues and supervisors showed them appreciation throughout the summer and were given tools to problem solve and advocate for their needs if a lack of appreciation was present.

As a representation of their newly learned relationship skills, youth created artwork based on how they interpret love languages through their own personal experiences. Youth were given the opportunity to be creative and think outside the box to make multi-media panels, which combined to form a display of hanging umbrellas called "Love Reigns". This display represents the many ways in which love shelters them and is a protective factor in the youth's lives. Their art was displayed at the town's local "Pescadero Arts and Fun Festival" in August 2019.

CHALLENGES

Project SUCCESS requires a large time commitment for both the staff that is implementing it and the school district staff that will be supporting it. The curriculum is very detailed and maintaining fidelity to the model can be very difficult with certain groups. The pre and post

testing is arduous especially for the region where there is limited access to the internet. The program has adapted by using the paper version of the DAP which then requires Puente staff time to input into the Search Institutes database. The screening requirements for entry into the different groups: users, non-users, COSAP etc. are prohibitive for the region. The school population is 330-360 students each year, so in order to make sure that the program could maintain fidelity and have an adequate number of students for each cohort, Puente and the La Honda-Pescadero Unified School District decided to put all the youth ages 9-18 through at least one 8-week workshop. Fifth grade students, ages 9-11, all go through the workshop. It was difficult, again, in middle school to find a way to maintain fidelity to the model and utilize the curriculum age appropriately. Puente decided to have all 8th grade students participate in an 8-week group. Again, it was challenging to survey high school students and divide based on the Project SUCCESS curriculum. Outreach for parenting groups has been difficult, this led to a collaboration with Puente's Education team and Stanford University Haas Center for Public Service students and have a booth at Science Night.

DEMOGRAPHICS

Project SUCCESS is designed for use with youth their parents as collaborative partners The demographics below include both youth and their parents.

	FY 17/18	FY 18/19
Age		
0-12		29%
13-18		40%
Adult, 18+		30%
Primary Language		
English		47%
Spanish		53%
Sex Assigned at birth		
Male	37%	
Female	63%	
Race/Ethnicity		
Asian	1%	
Black/African/-American		1%
White/Caucasian	34%	47%
Hispanic	65%	
Mexican/Chicano		53%

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT (MBSAT)

In August 2018, BHRS began piloting an alternate curriculum to Seeking Safety: The Mindfulness-Based Substance Abuse Treatment (MBSAT) 12-session curriculum. All Seeking Safety providers were invited and agreed to participate in piloting of the curriculum. A new Request for Proposals for Trauma-Informed Co-occurring Services for Youth, which includes the MBSAT curriculum, was released and new agreements established with a target start date of July 1, 2020.

MBSAT is a group-based curriculum incorporating mindfulness, self-awareness, and substance-abuse treatment strategies for use with adolescents dealing with substance use/abuse. MBSAT provides adolescents with the ability to improve their decision-making skills and reduce unhealthy behaviors-such as substance use-through learning emotional awareness and choosing how to respond (versus react) to stressful situations, how specific types of drugs affect the body and the brain, and how family, peers, and the external environment can contribute to drug use. MBSAT strives to offer youth an empowered approach to substance use prevention, rather than the norm that adolescents typically meet; programs that teach "just don't do (drugs)." MBSAT is designed for use with adolescents, broadly defined, and uses adult facilitators as leaders of the group to model authenticity and building healthy relationships.

MBSAT was piloted with three agencies that have been implementing Seeking Safety (Puente de la Costa Sur, StarVista and El Centro de Libertad) in FY 17/18 & FY 18/19. This pilot was conducted in order to inform the Trauma Informed Interventions for youth RFP that will be replacing the Seeking Safety curriculum. As part of the pilot, groups were conducted to hear feedback from the youth regarding the curriculum but to also expand the prevention strategy to encompass what they identified as opportunities and barriers. See Appendix 8 for the MBSAT Focus Group Results.

MBSAT – PUENTE DE LA COST SUR (PUENTE)

Clinical staff trained in cultural humility and trauma-informed care ran MBSAT groups for Puente. All Puente BHRS staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). MBSAT is offered at Pescadero High School, in the La Honda-Pescadero Unified School District to students in grades 9-12. The group was taught in English, with parents being offered education regarding group curriculum in both English and Spanish.

PROGRAM IMPACT

Providing targeted intervention programs like MBSAT helps to foster strength in the 40 Developmental Assets, particularly in the areas of support, empowerment, positive values, social competencies, and positive identity. Puente has the ability to touch 100% of the service area's school aged youth and their families one or more times, creating a safety net for those who may struggle with mental illness. Prevention and intervention is the key to preventing mental illness from becoming severe and disabling. MBSAT is a prevention and intervention program designed to address strengths that foster positive mental health and wellness. Puente's BHRS team are embedded on all campuses and referral system is comprehensive.

Prevention and interventions with MBSAT foster increased emotional awareness and building authentic, supportive relationships. An increase in these factors can lead to freedom of expression and a greater likelihood to seek services in those students who are at a higher risk for suicide and mental illness. The Puente BHRS team has the ability to interact with all of the youth in the school district, there is a long and strong partnership with the La Honda-Pescadero Unified School District administration, and there are diligent efforts to partner with teachers and other staff who work with the region's youth.

MBSAT - Puente	FY 17/18	FY 18/19
Total clients served	8	12
Total cost per client	$2,627	$1,751

SUCCESSES

MBSAT participants reported overall positive experiences. One group member reported feeling a sense of "inner peace" after participating in the group, and that they now practice "thinking before doing". Another member reported that the group helped them to "keep [their] sanity". Group members successfully learned the informal mindfulness technique (Stop, Take a breath, Imagine future consequences, Choose- or S.T.I.C.) and practiced role-playing scenarios in which they employed this method of responding to stressful situations.

Perhaps the programs greatest success was the openness with which youth felt comfortable talking in the group about drug and alcohol use. Youth reported feeling "understood" and grateful for "the deep talks we had on topics". One youth, now a graduate of Pescadero High School, often openly talked about his use of and feelings surrounding marijuana. He invested his time and effort into participating in the group and has now decided to study to become a Substance Use Counselor at College of San Mateo. It is firmly believed that MBSAT's model and values as a curriculum helped these youth to feel open to discussing substance use in an environment that fostered independent thinking, mindful responses to stress, and an increased sense of self-awareness.

CHALLENGES

Some challenges faced were securing youth's time commitment each week, conflict with school sports' program schedules, and minimizing technology distractions during program. In order to mitigate the timing challenges in future groups, the program has coordinated with the La Honda-Pescadero Unified School District to hold the group during school hours, not conflicting with any of the youth's academic classes. In addition, the program created a space in which youth can intentionally, but optionally, make the choice to drop off their phones in the beginning of class in a drawer and retrieve them at the end. With hope that this helps to foster self-awareness in the students, while also making the space more conducive to practicing mindfulness.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
0-15		17%
16-25		83%
Primary Language		
English		8%
Spanish		92%
Sex Assigned at birth		
Male		83%
Female		17%
Decline to state		
Race/Ethnicity		
White/Caucasian		8%
Mexican/Chicano		92%

* No data was collected for FY 17/18 due to the program being in transition.

MBSAT – STARVISTA

StarVista offered MBSAT groups to various community-based organizations in San Mateo County. These organizations offer programming and work with the aforementioned age groups at their facilities. StarVista attends the various sites and aligns to be fitting in with their programming schedules. Flexibility and convenience are significant components of this program in order to make it as accessible as possible to the population. Groups are split up based on age if necessary (15-17 and 18-25).

PROGRAM IMPACT

The MBSAT program:

Improves timely access & linkages for underserved populations: By traveling to various facilities in the community where the underserved population congregates, resides or attends programming – it allows for greater accessibility allowing convenient attendance by participants in need. StarVista works with the partner agencies and the participants to determine the best time/access point for participation.

Reduces stigma and discrimination: This program does not focus on telling the youth what to do and what not to do. This program focuses on teaching the youth to be more aware of the factors that lead to their decisions with hopes of making more informed decisions based on desired long-term consequences and outcomes. The program focuses on teaching youth to be more present in their lives and how to develop a healthy way to deal with challenges, such as family, peers, past trauma, and addiction. This also reduces societal stigma around emotional or mental health support by normalizing the conversation around increasing awareness and emotional management. Many youth who have been involved in the communities "systems" (juvenile justice, probation, homeless networks, foster care, etc) can feel powerless within these systems. As noted above, this program provides the youth with the strategies needed to overcome and empowers them to find solutions to life's challenges within themselves.

Increases number of individuals receiving public health services: Because this program travels to where the underserved youth are already receiving services, it reaches individuals that would otherwise not have been receiving these public health services. StarVista works with partners if there is any unmet need reported or perceived by the clinician in an effort to ensure the youth's health needs are being met.

Reduces disparities in access to care: By targeting underserved populations, this program directly increases the number of individuals receiving public health services, thus reducing the disparity in access to care. Transportation can often be a barrier to access and can increase these disparities for young people with limited resources. This program travels to the participants, removing transportation as a challenge in accessing services.

Implements recovery principles: By emphasizing increased awareness and acceptance as core element of mindfulness, individuals can implement the principles that are critical to their recovery. Teaching mindfulness encourages implementation of self-actualized, self-directed factors that are identified by the individual in recovery. Mindfulness is rooted in holistic, strength-based, person-centered, and self-directed elements – all key principles of recovery.

Data collected through this pilot was drawn from the Emotional Regulation Questionnaire (ERQ) surveys and the Developmental Assets Profile (DAP). The DAP is a 58-question survey and participants did not appear to appreciate the length of the survey nor the time it took to complete, therefore, there was less interest in this survey than the ERQ.

Advancements in Cognitive Appraisal

- Q#1 - When I want to feel happier, I think about something different: The Pre-survey indicated 22% reported Agree (11%) and Strongly Agree (11%). This metric improved in the post survey, with 73% reported Agree (55%) or Strongly Agree (18%). This could be an indicator that participants were more likely to seek optimism, which is a strong indicator for resilience.
- Q#5 - When I'm worried about something, I make myself think about it in a way that helps me feel better: In the Pre-survey, 50% reported Agree (39%) and Strongly Agree (11%) for Q#5 (When I'm worried about something, I make myself think about it in a way that helps me feel better.) This metric improved in the post survey, with 72% reported Agree (36%) or Strongly Agree (36%). Analysis of Q#5 indicates that participants made advancements in their ability to improve their thought processes and find ways to help themselves regulate and feel better.
- Q#7 - When I want to feel happier about something, I change the way I'm thinking about it: In the Pre-survey, 33% reported Agree (28%) and Strongly Agree (6%) for Q#7 (When I want to feel happier about something, I change the way I'm thinking about it.) This metric improved in the post survey, with 63% reported Agree (27%) or Strongly Agree (36%).
- Q#8 - I control my feelings about things by changing the way I think about them: In the Pre-survey, 44% reported Agree (33%) and Strongly Agree (11%) for Q#8 (I control my feelings about things by changing the way I think about them.) This metric improved in the post survey, with 73% reported Agree (45%) or Strongly Agree (27%).

Advancements in Expressive Suppression

- Q#6 - I control my feelings by not showing them: The Pre-survey indicated 39% reported Agree (17%) and Strongly Agree (22%) for Q#6 (I control my feelings by not showing them.) This metric improved in the post survey, with 36% reported Agree (27%) or Strongly Agree (9%). Analysis of this data indicates that participants reduced the likelihood of suppressing their feelings through participation in MBSAT.
- Q#9 - When I'm feeling bad about something, I change the way I'm thinking about it: In the Pre-survey, 39% reported Agree (28%) and Strongly Agree (11%) for Q#9 (When I'm feeling bad about something, I change the way I'm thinking about it.) This metric improved in the post survey, with 45% reported Agree (36%) or Strongly Agree (9%). While this metric only slightly shifted, the results indicate youth do not feel as strongly about suppressing their emotions.

Developmental Assets Profile (DAP) Findings:

In the post-surveys, participants reported developmentally appropriate responses for their age range. Results indicated that a little over half (55%) the participants who completed the survey felt they had a family that provided them with clear rules (Q#52). Participants also reported that more than half (64%) reported their parents are good at talking with them about things

(Q#56). These results indicated that participants could improve in communication with their parents/caregivers.

The DAP is a 58-question survey and participants did not appear to appreciate the length of the survey nor the time it took to complete, therefore, there was less interest in this survey.

MBSAT – StarVista	FY 17/18	FY 18/19
Total clients served	N/A	33
Total cost per client		$3,184

SUCCESSES

The most significant notable success of this program is seeing a shift in desire to change by the participants. So often, youth participants are barely in a contemplative stage of change. Most youth after participating in the full workshop are much closer to an active stage of change where they are actively working towards goals. This is an enormous step in improving their journey. Multiple youth reported using tools in their daily lives, showcasing their abilities when provided the encouragement and the space. In addition, youth exhibited very positive bonds with group facilitators.

CHALLENGES

The most significant challenge has been participant consistency. Youth are often hesitant to embrace the workshop, at first, but slowly warm up to the process. If they don't warm up to it quickly, this can hurt their future attendance and potential growth. When youth are present, they are more often than not very engaged. Providing incentives, such as stipends, would likely increase participation and fidelity.

Youth are often hesitant or resistant around filling out surveys, making tracking some outcomes difficult. Further emphasis will be placed on reliable completion and tracking of surveys.

DEMOGRAPHICS

No data was collected for FY 17/18 due to the program being in transition.

	FY 18/19
Primary Language	
English	97%
Spanish	3%
Sex Assigned at birth	
Male	39%
Female	61%

Gender Identity	
Male/Man/Cisgender	39%
Female/Woman/Cisgender woman	61%
Race/Ethnicity	
Latinx	29%
Black/African/-American	47%
White/Caucasian	18%
Filipino	6%

SEEKING SAFETY/MBSAT – EL CENTRO DE LIBERTAD (EL CENTRO)

El Centro was still implementing Seeking Safety in FY 2017-18 and FY 2018-19 and began the MBSAT pilot in the fall of 2019. Therefore, program outcomes listed below are for the Seeking Safety program only.

The purpose of Seeking Safety is to help at-risk individuals in the age range of 18 to 25 by providing interventions that address the impact of substance use disorder, particularly for those who have a trauma history such as Post-Traumatic Stress Disorder (PTSD). The target population is Transition Age Youth (TAY) who are struggling to break the cycle of substance use disorder and who are residing in urban Redwood City or rural Half Moon Bay. A significant majority percentage of the target population are bilingual households and/or whose income reflects at or below poverty level standards.

El Centro offers a 90-day treatment program that incorporates a Case Managed abstinence-based and relapse prevention model with cognitive behavior strategies that dramatically improves lives of youth. The approach to providing a Seeking Safety program combines weekly substance use disorder Individual Counseling and weekly Group Counseling sessions in both Half Moon Bay and Redwood City.

Seeking Safety is an evidenced-based practice that focuses on environmental and treatment solutions for substance use and Post-Traumatic Stress Disorder and relies on strong case management direction and referrals to community resources. Seeking Safety groups address the needs of this age group by utilizing a developmental framework that provides general supports for young adults, such as safety, relationship building, youth participation, community resources, and skill building. By incorporating these practices into the group framework, youth learned to build upon internal and external assets which are essential for a healthy transition to young adulthood.

Transitional Age Youth are offered information and counseling specific to the age group. The Seeking Safety curriculum was comprised of 25 topics including Safety: PTSD: Taking Back Your Power; When Substances Control You; Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Healing your Anger; Community Resources; Compassion; Creating Meaning; Discovery; Integrating the Split Self; Recovery Thinking; Taking Good Care of Yourself; Commitment; Respecting Your Time; Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding); Life Choices ;and Termination., and is based on five central ideas: 1) safety as the priority, 2) integrated treatment of PTSD and substance abuse, 3) a focus on ideals, 4) identifying the four content areas of cognitive, behavioral, interpersonal, and case management, and 5) attention to therapist processes.

PROGRAM IMPACT

El Centro utilizes a Case Managed approach that includes In-Take assessment, Treatment Plan development, Progress Notes and Discharge Planning. Client activities/participation is documented and includes group attendance (sign-in roster), topics covered, Pre/Post Test (when available), as well as Individual Counseling sessions and recommendations.

The program is a 90-day program, or 12 sessions. Each group is 90 minutes each. Extended participation is recommended if needed.

Redwood City: Provided 82 groups serving 59 youth.

- 51 were male, 8 were female
- 70% were bilingual
- 100% took Pre-Test
- 33 (56%) completed a Satisfaction Survey and Post Test

Half Moon Bay: Provided 16 groups serving 10 youth

- 9 were male. 1 was female.
- 100% were bilingual
- 100% took Pre-Test
- 5 (50%) completed a Satisfaction Survey and Post Test

Seeking Safety – El Centro	FY 17/18	FY 18/19
Total clients served	69	54
Total cost per client	$642	$820

SUCCESSES

Recovery can be a daunting, seemingly unachievable goal for many. A TAY client was in a very tough situation because of homeless and using methamphetamines since the age of 16. El Centro staff met him through outreach efforts at the homeless shelter where he initially signed up with us but shortly after went MIA. About 3 weeks later and he said he wanted to try again so he came back into the program and started to attend a few groups and Individual sessions. As part of his treatment goals he wanted to rebuild his relationship with family members and hoped to be accepted back into his family that not want anything to do with him because he was still using. El Centro staff worked with him and built a plan to bring in his mother to educate and teach her about addiction and how a loved one at home could support a recovering addict. His mother agreed to be open minded when it came down to his addiction and understood that recovery is not easily obtained. She also agreed to come in to Family Fun Night with a couple of family members to support her son and they saw how he really wanted to make a change and was already making huge improvements.

This client after 6 months in treatment is clean of any drugs and alcohol and actively participates in Recovery Services. He has also been giving a place to live at home and has been working a full-time job for the past two months.

Mark is a 24-year-old, single, Hispanic male. He has multiple arrests, including felonies, which makes it difficult for him to find permanent work. He came to El Centro shortly after being released from jail to receive treatment for his addiction to Methamphetamine, Heroin, Cannabis, and alcohol. Treatment and guidance at El Centro enabled him to first attain abstinence and then recovery and sobriety from ALL drugs and alcohol. Through discussions with Mark, his counselor guided him toward the realization that he wanted to go back to college. With the assistance of the counselor, Mark signed up for college courses. While in individual counseling and Seeking Safety groups, which focused on addiction and PTSD, Mark began to build successes in other areas of his life as well. He was encouraged to re-establish his relationships with his family members, especially his mom. Through the support and referrals from his counselors (group and individual) he was also able to find permanent housing, ending his homelessness; and to find two part-time jobs. Finally, he was employed! Almost 10 months after successfully completing El Centro's outpatient program, Mark reported that he completed both his Fall and Spring courses with passing grades and is continuing in college for his second year. He also reported that he continues to strengthen his relationships with his family, who are now his biggest support. Mark has commented multiple times that it is the encouragement, support, and guidance that he has received at El Centro that have empowered and enabled him to build this foundation for himself.

CHALLENGES

There are challenges inherent in serving this population.

1) Since the TAY population is older than "youth" for the most part they are usually no longer in High School which, for those not on Probation, limits a leverage to attend.
2) While all TAY participants take a Pre-Test, a significant percentage do not make it past 6 sessions which eliminates the possibility of taking a Satisfaction Survey or Post-Test which can skew program assessment efforts
3) Some individuals do not run willingly to engage in treatment and can be discharged prior to completion; however, re-enrollment is not unusual particularly when encouraged by Probation

DEMOGRAPHICS

	FY 17/18	FY 18/19
Sex		
Male	87%	83%
Female	13%	17%

TEACHING PRO-SOCIAL SKILLS (TPS)

Teaching Pro-Social Skills (TPS) is a ten-week program that uses "Skill streaming", an evidence-based, social skills training program designed to improve students' behaviors, replacing less productive ones. The purpose of TPS is to help elementary school children learn pro-social skills in order to improve their social and behavioral functioning in school. During the 2018-19 academic school year, weekly TPS groups were held in five different San Mateo County, Human Services Agency, Family Resource Centers (FRC) locations. The locations included the following schools: Taft (Redwood City), Hoover (Redwood City), Belle Haven (Menlo Park), Bayshore (Daly City), and the Puente de la Costa Sur resource center on the coast.

The Teaching Pro-Social Skills program serves children at San Mateo County elementary schools where FRC services, including mental health, are provided. FRCs are available at schools that have high needs among the student population and a lack of other resources available to the broader community. Research demonstrates that underserved students face greater academic and social struggles and benefit greatly from the opportunity to learn pro-social skills in a group that is culturally sensitive. The students at these schools, and their families, are underserved and are typically the ones referred to the TPS program.

The TPS participants are able to receive an effective, social skills-based education while forming and improving relationships with their peers and school staff. All of the PSWs and the lead TPS Community Worker are fluent in Spanish, addressing the high proportion of Spanish speaking children and their families at the sites.

PROGRAM IMPACT

During fiscal year 2018-2019, from October 2018 to June 2019, ten TPS groups were provided at five HSA Family Resource Center schools with both Fall and Spring cohorts serving a total of 52 students. The following is a breakdown of the group and sites:

- Two (2) groups consisting of a total of 12 students at Bayshore Family Resource Center
- Two (2) groups consisting of a total of 11 students at Belle Haven Family Resource Cntr
- Two (2) groups consisting of a total of 11 students at Hoover Family Resource Center
- Two (2) groups consisting of a total of 9 students at Puente de la Costa Resource Center
- Two (2) groups consisting of a total of 9 students at Taft Family Resource Center

Data about the students' classroom and playground behaviors is collected from the teachers through pre- and post-assessments. Students are assessed using a five point scale on the following skill areas: (1) Classroom Survival Skills; (2) Friendship-Making Skills; (3) Skills for Dealing with Feelings; (4) Skill Alternatives to Aggression; and (5) Skills for Dealing with Stress. The TPS program demonstrated the following impacts on student participants:

1. Positive behavior changes in the classroom and on the playground, as directly observed by faculty and staff.
2. Improvements in skill area scores between the pre- and post-assessments, indicating significant progress for a majority of the TPS participants.

Pre- and post-assessment scores demonstrated the following results:

1. Positive behavior changes were demonstrated in 93% ($\frac{38}{41}$) of skills taught.
2. Overall, there was a 27% increase in scores across the 41 skills (from 2.7 to 3.4) from pre-assessment to post-assessment, indicating improved behavioral skills.

Teaching Pro-Social Skills	FY 17/18	FY 18/19
Total clients served	56	52
Total cost per client	$3,571	$3,846

SUCCESSES

TPS was well received by the school teachers and administrators. During the 2018-2019 school year, the following message was sent to a PSW from school personnel: "*[Student]* has been showing lots of improvements at school and with other students. He was in a situation where he implemented the skill 'How to Stay out of Fights' to settle the issue and refrain from engaging."

As a result of the positive outcomes from TPS participation reported by the school administrators, other schools have requested the service. For example, one of the administrators at Hoover school, who helped the PSW coordinate the TPS groups, transferred

to Roosevelt school in Redwood City and requested TPS groups at Roosevelt because she saw how it benefitted students at Hoover.

CHALLENGES

The full time Community Worker who was primarily responsible for leading TPS groups began employment in December 2018. Therefore, there were some logistical challenges beginning the groups in the Fall 2018**.** Infrastructure has been added to support the TPS team which will allow the initial implementation in the schools to be more consistent. The additional support includes monthly check-in meetings, cross-training other Community Workers to provide back-up if needed, as well as streamlining the TPS program coordination and documents. In previous years, the PSWs co-facilitated the groups. However, due to high clinical caseloads, increasing demands and greater emphasis on serving children with higher needs two Community Workers now co-facilitate the groups with therapeutic consultation and support from the PSWs.

DEMOGRAPHICS

	FY 17/18	**FY 18/19**
Age		
0-15	100%	100%
Primary Language		
English	100%	81%
Spanish		17%
Another language		2%
Sex Assigned at birth		
Male		62%
Female		38%
Race/Ethnicity		
Asian		6%
Latino/ Hispanic	86%	69%
Black/African/-American	4%	4%
White/Caucasian		3%
Multi Ethnic	5%	
Another race/ethnicity	5%	21%

*Ethnicity categories for FY18-19 included Caucasian, Latino, African American, Pacific Islander, Native American, Multi-Race and Other. Reporting template will be updated for FY19-20 based on new MHSA requirements.

PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

YOUTH CRISIS RESPONSE & PREVENTION

The Crisis Intervention & Suicide Prevention Center (CISPC) has four main components with the sole purpose of providing crisis and suicide support to all ages of the San Mateo County community. The four components include: a 24/7 Crisis Hotline, a youth website and teen chat service, outreach and training, and mental health services.

- The 24/7 Crisis Hotline is the only Crisis Hotline in San Mateo County, and it is run primarily by volunteers and hotline staff. The crisis hotline is an avenue of support for anyone who is in crisis, however, you do not need to be in crisis to call the hotline. Anyone can call the hotline – including people who are calling about a loved one, who just want to talk, who are looking for resources, or who are in crisis.
- CISPC's youth website, onyourmind.net, is a website specific to youth who want to learn more about mental health and resources in San Mateo County. There is a live-chat portion where youth can chat with trained youth volunteers. Youth utilize this service to talk about a number of different challenges, including stress at school, family or relationship problems, thoughts of suicide, concern about a friend, and more.
- CISPC's outreach and training involves educating the San Mateo County community on mental health and suicide prevention. CISPC staff provide psycho-educational presentations to over 5,000 elementary, middle, and high school youth on the topics of stress, healthy coping, mental health disorders, and suicide prevention. Additionally, CISPC staff also provides presentations and training to parents, school staff, agency staff, and members of the community on the topics outlined above, including cyberbullying and bullying, cultural humility, privilege, and non-suicidal self-injury.
- CISPC's mental health services are targeted to K-12 aged youth who live or attend school in San Mateo County. CISPC clinicians provide short-term mental health therapy to youth who are in crisis. CISPC clinicians are also able to go on-site to a school to conduct suicide risk assessments with youth to determine the level of need.

PROGRAM IMPACT

The CISPC program impacts the health outcomes of client served in several ways. All CISPC staff aid in reducing the stigma associated with mental illness – this is seen through the psychoeducational presentations, work with clients in crisis, and conversations with hotline callers. Talking non-judgmentally and openly about mental illness paves the path for others to do the same, and in that the larger San Mateo county community benefit from reduced stigma of mental illness, which in turn allows for the greater community to be able to access mental health services without fear.

The early intervention work that CISPC does is imperative in mitigating undiagnosed mental illness from flourishing into unmanageable symptoms, which can sometimes lead to harm to self or others. All parts of the CISPC program (psychoeducational presentations, 24/7 hotline, live chat, and clinical services) contribute to early intervention and improving access and linkage to appropriate resources. The presentations are meant for school aged youth, as well as adults in the community. Mental illness can often occur in early stages of life, and with the appropriate psychoeducation around healthy coping, stress management, mental health, and suicide prevention, the audience members report being more aware about mental health as well as resources in the local community. Additionally, CISPC's 24/7 crisis hotline is often times the first point of contact for many people seeking mental health services, or for those contemplating suicide. Because of its anonymity, callers find solace in being able to talk with a trained volunteer without fear of judgment. Appropriate resources and referrals are often given to callers who are open to continued help, which furthers their education around how best to support themselves (or others) when accessing mental health care.

Crisis Hotline	FY 17/18	FY 18/19
Total calls	11147	12255
Total cost per client	$11	$10

CASE MANAGEMENT/FOLLOW-UP PHONE CONSULTATION (youth and adults)	FY 17/18	FY 18/19
# of new cases	145	114
Total # of sessions provided	186	102
YOUTH OUTREACH INTERVENTIONS (evaluations at school sites)		
# of initial interventions (new youth served)	48	95
# of follow up sessions with youth	131	238
# of follow up contacts w/ collateral contacts	226	331
CLINICAL TRAINING/SUPERVISION (youth and adults)		
hours provided (including prep. time)	77	68
number of trainings attended	11	43
CRISIS HOTLINE & CHAT ROOM		
Number of calls	11147	12255
Total Number of Chatters (group &/or private)	2	251
Teen Chat Room # of Private Chats this month	115	251

OUTREACH PRESENTATIONS		
# of presentations	90	115
# of people served	8533	5535
School-Community Training in Suicide Prevention (# of presentations, the number served is captured on separate worksheet)	81	104

SUCCESSES

A college student had phoned the hotline in distress and went into details with the volunteer about ways in which she is struggling and the maladaptive, self-harmful ways that she copes with the stress that comes up. The volunteer was able to offer support for this caller as she explained in depth the ways she feels depressed and the experiences she has had throughout her life. After talking with the volunteer for some time, they moved into discussing what the caller enjoys doing and how she pulls herself back during difficult times. She was able to verbally identify numerous ways of healthy coping with the volunteer, and explicitly stated how thankful she was to talk through everything she was experiencing, and how glad a service like this was available at 2am.

A mother called the mental health clinician at the crisis center concerned about her adolescent son who was chronically suicidal and wanted the clinician to conduct a risk assessment with him. The mother had exhausted all other options when a school partner directed her to services. After determining that there was not an immediate danger to self, the clinician began working with the family for short term therapy. It became apparent that a large factor for the student's suicidal ideation was school. His mother reported having attempted to get educational assessments done in the past but felt as though the language and cultural barriers (they immigrated to the US over 8 years ago) had prevented the school from following through. The clinician worked with the mother and son to draft a formal letter of request for an Individualized Education Plan assessment. During the client's treatment, he had begun the IEP assessment process and reported that his suicidal thoughts had decreased to no thoughts of suicide in over a month.

CHALLENGES

During the fiscal years 17-18 and 18-19 CISPC has identified lack of staff as a challenge in being able to serve the community in an efficient manner. Due to the high number of youth suicides that occurred in FY 17-18, there were higher requests from the community around psychoeducational presentations as well as clinical services. There was only one designated staff person who conducts presentations, and a way CISPC had to address community need was

utilizing CISPC staff to conduct youth and community presentations, even if it wasn't necessarily under their direct job duties. This ultimately put a strain on CISPC staff. During the 18-19 fiscal year a large challenge has been ensuring that there is staff able to ensure all parts of CISPC's services are running. Due to the history of limited funding for the CISPC, one staff member is in charge of overseeing the youth peer website and teen chat component as well as the presentation component. This proved to be incredibly difficult to navigate, as presentations are typically done during the school time, and the teen chat resource is open in the evening time.

EARLY INTERVENTION: EARLY CRISIS INTERVENTIONS

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program is to provide San Mateo County's residents with a comprehensive assessment in the field, to offer an alternative destination to Psychiatric Emergency Services when appropriate or if needed to write a hold status and provide secure transportation to the hospital. The target population is any resident in psychiatric crisis regardless of age as identified by Law Enforcement. Primary program activities and/or interventions include consultation to law enforcement on scene. SMART can write a 5150 hold if needed and transport the person to a 5150-receiving facility. If the individual does not meet the 5150 criteria the SMART medic can provide support and transportation to an alternate destination, i.e. crisis residential facility, doctor's office, detox, shelter, home, etc.

PROGRAM IMPACT

SMART evaluates people in the field and able to connect people to behavioral health services that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and treatment for many community members. Many individuals are more likely to be forthcoming with a psychologically trained medic about what they are experiencing as compared to reporting to law enforcement. SMART medics are able to evaluate both physical and mental health issues including suicidal ideation and direct people to the appropriate resources. SMART responds to many people under 18 who are in crisis – often peer related problems in school. By addressing the youth's concerns and getting supportive and protective factors in place the youth is much more likely to remain in school. Getting supportive services to the youth's family helps the family unit to stay intact. SMART responds to many homeless severely mentally ill adults. By getting them evaluated and getting the right level of medications and placements this assist in reducing homelessness.

- SMART's first goal is to divert 10 % of calls where a 5150 was not already placed. AMR has succeeded in surpassing this goal.

- FY 18-19 AMR diverted 35.7% in the first quarter,47.9% in the second quarter, 53.3% in the third quarter, 47.7 in the fourth quarter.
- SMART's second goal is to respond to 75% of appropriate calls for service. In FY 18-19 AMR responded to 76.9% in the first quarter and 76.6% in the second quarter, 73.1% in the third quarter, 67.3% in the fourth quarter.

SMART	FY 17/18	FY 18/19
Total calls received	2834	2579
Total cost per client	$51	$56

SUCCESSES/CHALLENGES

SMART identifies that a consistent **success** has been that since 2005 the program has and continues to assist many community members in receiving the proper services out in the field through AMR trained response. A noteworthy **challenge** has been to have law enforcement wait to write the 5150 holds before SMART arrives to do a thorough assessment. This is being addressed by continuing education of law enforcement.

EARLY INTERVENTION: EARLY ONSET OF PSYCHOTIC DISORDERS

EARLY PSYCHOSIS PROGRAM- (RE)MIND

The Early Psychosis Program (formerly PREP) and now (re)MIND™ is a program of the Felton Institute that specializes in early intervention for psychotic disorders. The Felton (re)MIND™ program delivers comprehensive treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis. By intervening early with evidence-based, culturally responsive, and comprehensive assessment and treatment the Felton Early Psychosis Program is transforming the perception and impact of psychosis so that most cases of schizophrenia spectrum disorders detected in the earliest stages are treated to remission. Individuals served regardless of insurance status include:

- Residents of San Mateo County between the ages of 14 and 35 ***-and-***
- Identified as being at risk for the development of psychosis (having subthreshold symptoms that do not meet justification for a diagnosis OR having a first degree relative with a history of psychosis AND a recent significant decline in age appropriate functioning) -***or***-
- Have developed psychosis for the first time in the past two years

The Felton (re)MIND™ Program provides a wide array of services designed to wrap around the individual, and their family members involved in treatment. Services begin with an outreach

and education campaign to help community members and providers to detect early warning signs. Once an individual has been identified and referred to the program, they receive a comprehensive, diagnostic assessment to determine their diagnosis to identify early intervention services. Following assessment, individuals participate in assessment feedback session(s) where they receive psychoeducation on diagnosis and treatment options.

Besides early diagnosis, program services include:

- Cognitive Behavioral Therapy for Psychosis (CBTp)
- Algorithm-guided medication management
- Peer and family Support Services
- Psychoeducational Multifamily Groups (MFG)
- Supported Employment and Education using the Individual Placement and Support model
- Strength-based care management
- Access to computerized cognitive remediation training
- Community-building activities such (ex. program orientation for new participants)
- Graduation ceremony to acknowledge accomplishments and positive transitions

PROGRAM IMPACT

The Felton (re)MIND™ Program served 62 youth and young adults during FY 18/19 achieving the following outcomes:

- **Hospitalization reduction:** A consistent 32 participants were enrolled for at least 12 months in FY 18/19. Out of 16 participants with prior hospitalizations within 12 months of enrollment, 14 (88%) experienced a reduction in acute hospitalization episodes and days hospitalized within the first 12 months of engagement into early psychosis services. Out of 16 participants with no prior hospitalization history, 11 (69%) continued to have no hospitalizations within the first 12 months of engagement into early psychosis services.
- **Employment and education engagement:** Of 32 participants enrolled for at least 12 months, 28 (88%) were engaged in part-time or full-time school or work during their first year of treatment.
- **Medication Adherence:** Initial and most recent annual ANSAs were used to evaluate medication adherence for 32 participants who have been enrolled for at least 12 months. Medication Adherence was assessed on the ANSA domain for Medication Compliance (ratings 0 through 3; with 0 indicating no need for improvement and 3 indicating highest need for improvement). Of these 32 participants, 22 (69%) either improved or maintained high medication adherence with an ANSA score of 1 or 0.

- **Symptom Reduction:** Symptoms were rated on the ANSA domains for Psychosis and Depression (ratings 0 through 3; with 0 indicating no symptom presence and 3 indicating highest symptom severity). Out of 32 participants, 22 (69%) demonstrated an improvement or maintained low symptom severity (rating 1 or lower) in psychosis and 22 (69%) demonstrated an improvement or maintained low symptom severity (rating 1 or lower) in depression.
- **Service Satisfaction:** For service satisfaction surveyed in May 2019, of the 8 participants (3 Adults, 3 Family, 2 Youth) who completed this survey, 8(100%) exceeded the 3.5 needed for the Satisfaction Scale to indicate satisfaction with the program. Satisfaction scores ranged from 3.667 to 5.

RE (MIND)	FY 17/18	FY 18/19
Total clients served	110	62
Total cost per client	$7,441	$13,201

SUCCESSES

Multi-Family Group (MFG): As the program experienced the transition from the end of one cohort and the launching of another group of families and participants that engaged in the structured problem-solving intervention that is MFG. One of the greatest intended strengths of the MFG intervention is the community that develops between group members over the course of treatment. For the cohort that completed their year-long commitment to the group process, this sense of community was the strongest that this program had ever seen. In fact, once they completed the group's 1-year attendance, the group members themselves opted to carry forward the group process in each other's homes and to maintain their commitment to one another. Being a part of this process was awe-inspiring and refreshing for staff and served to fuel the desire to repeat this process with new cohorts of families.

CHALLENGES

The Felton (re)MIND™ Program experienced two primary challenges in Fiscal Year 18/19. The first of which has already been referenced in Outcome Data: Service Satisfaction regarding the low return/completion rates of semi-annual surveys. The second is related to having one vacant clinical staff position for many months which contributed to developing a waitlist for assessment into the program.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
0-15	11%	10%
16-25	78%	74%
26-59	11%	16%
Primary Language		
English	98%	98%
Spanish	1%	2%
Tagalog	1%	
Sex Assigned at birth		
Male		63%
Female		37%
Sexual Orientation		
Straight or heterosexual		71%
Bisexual		5%
Questioning or unsure		11%
Another sexual orientation		5%
Decline to state		8%
Gender Identity		
Male/Man/Cisgender		63%
Female/Woman/Cisgender woman		36%
Another gender identity		2%
Race/Ethnicity		
Asian	12%	13%
Latino	20%	
Pacific Islander		3%
Black/African/-American	6%	10%
White/Caucasian	34%	44%
Filipino	12%	
Mixed Race	13%	7%
Another race/ethnicity	3%	24%
Disability/Learning difficulty		
Developmental disability		3%
Chronic health condition		1.5%
Learning disability		8%
I do not have a disability		80%
Another disability		1.5%
Unknown		6%
Veteran		
No		98%
Decline to state		2%

EARLY INTERVENTION: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

PRIMARY CARE INTERFACE

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

Primary Care Interface	FY 17/18	FY 18/19
Total clients served	1134	863
Total cost per client	$997	$1,310

PREVENTION: COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

OFFICE OF DIVERSITY AND EQUITY (ODE)

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

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

PROGRAM IMPACT

The Office of Diversity and Equity measures progress along these 5 indicators. These definitions are influenced by (1) public health frameworks and (3) ODE's mission, values and strategy.

1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy- increased ability of a community (including peers and family members*) to influence decisions and practices of a behavioral health system that affect their community
3. Cultural Humility
    - heightened self-awareness of community members' culture impacting their behavioral health outcomes
    - heightened responsiveness of behavioral health programs and services for diverse cultural communities serve
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social and cultural barriers.
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

For FY 18-19 ODE's programs had the following impact:

Parent Project

- Self-Advocacy:
    - As a result of taking Parent Project, 93% (97 of 105) respondents said "Great" or "Good" in terms how confident they feel about their parenting skills.
- Community Empowerment:
    - After taking Parent Project, 68% (72 of 106) respondents said "Very" in terms of feeling that they can positively help their community.
- Cultural Humility:
    - 67% (70 of 104) respondents said that Parent Project was sensitive to their cultural background.
- Access:
    - After taking Parent Project, 95% (99 of 104) respondents knew here to go to receive behavioral health services.
- Stigma Reduction:
    - 60% (64 of 106 respondents) said that their attitude about behavioral health was positively affected because of this program.

Storytelling (Photo Voice Only for 2018-2019)

- Self Advocacy
    - 96% (22 of 23) respondents feel that their Photovoice helps them express something they cannot express in other ways.
    - 96% (22 of 23) respondents think more positively about challenges in their life as a result of this workshop.
- Community Empowerment:
    - 87% (20 of 23) of respondents learned how to create change in their community with their story as a result of the workshop.
- Cultural Humility:
    - 78% (18 of 23) respondents agreed that this program was sensitive to their cultural background
- Stigma Reduction:
    - 87% (20 of 23) of respondents agreed that their attitudes about behavioral health (mental health and/or substance abuse) were positively affected as a result of this program

Adult Mental Health First Aid

- Self Advocacy: 169 of the 179 graduates responded to the end of class evaluation. Of the 169 respondents:
    - 97% feel confident to recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.
    - 95% feel confident to reach out to someone who may be dealing with a mental health problem, substance use challenge or crisis.
    - 86% feel confident to ask a person whether they're considering killing themselves.
    - 99% feel confident to actively and compassionately listen to someone in distress.
    - 96% feel confident to offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.
- Cultural Humility:
    - 84% (157 of 187) agreed that this training was relevant to them and their cultural background and experiences (race, ethnicity, gender, religion, etc.)
    - 85% (159 of 187) agreed that, as a result of this training, they have a better understanding of how mental health and substance use challenges affects different cultures.

- Access: 169 of the 179 graduates responded to the end of class evaluation. Of the 169 respondents,
    - 99% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.
    - 96% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports.
- Stigma Reduction: 169 of the 179 graduates responded to the end of class evaluation. Of the 169 respondents,
    - 97% feel confident to be aware of my own views and feelings about mental health problems, substance use challenges and disorders.
    - 97% feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.

DEMOGRAPHICS

Demographics for ODE programs are included in each individual report's section.

HEALTH EQUITY INITIATIVES (HEI)

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

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

Through presentations, events, and trainings the HEIs reached the following number of people:

Health Equity Initiatives	FY 17/18	FY 18/19

Total clients served	2500	2800
Total cost per client	$53	$47

DIVERSITY AND EQUITY COUNCIL (DEC)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

In FY 17/18 the DEC reviewed the BHRS Cultural Competence Policy before each of two rounds of Quality Management editing (in Q1 and beginning of Q2—October). DEC feedback was incorporated into the policy which guided the way cultural competence was integrated into BHRS processes and teams. The group provided feedback to BHRS regarding implementation of CLAS, as well as language access policy.

Co-chairs invited Board of Supervisors staff to meetings to build a bridge between its members and legislative staff.

Members provided feedback on the MHSA demographics form to ensure inclusive wording for communities served. They also provided feedback regarding barriers they have faced regarding enacting their cultural competence plans.

Co-chairs attempted to provide more tangible skill-building opportunities that could increase the effectiveness of those in the room as they lead their programs and/or Initiatives. Lina Mira from Puente, one of the regular attendees, provided a presentation on a topic that has been identified as an area of challenge: outreach to isolated communities. Co-chairs used printed resources and small-group conversations to share tips for effective facilitation and outreach. With help from the Pride Center, the group created a forum to discuss the practice of using pronouns for introduction in hopes that members will spread this practice upon gaining a better understanding of it. Attendees expressed interest in the topic and indicated it was useful and new information for many. Attendees also named the DEC as a "safe" space in which they felt comfortable asking "the stupid questions."

In FY 18/19 4 clinicians have engaged the DEC through the South Asian Workgroup, made up of Health staff from different divisions who tabled together at a South Asian community event

(Holi) on 3/17 and reached 35 community members at the event. These clinicians are interested in applying cultural humility in their work and are currently gathering data on service usage and language access disparities related to the communities their communities. The clinicians heard about the DEC through an ODE presentation at a clinical meeting and elected to form their own group associated with the DEC. This indicates that ODE's work and the DEC's work is spreading and that there are additional champions in other parts of County Health.

Through the Arab Workgroup's effort, 27 people came together to watch Soufra, a film on healing, at Westmoor High. They learned about the challenge of outreach in communities they're not yet familiar with. The Soufra event had many fewer attendees than expected even though it did get a lot of event RSVPs. 10 attendees had never encountered ODE's work before. 13 attendees reported willingness to take action based on the film, including "volunteer with Arab Work Group," "connect with other Middle Eastern clinicians," and "learn how I can be an ally." 62% of attendees indicated they had experienced stress from living in the Bay Area as a Middle Eastern or Arabic-speaking person. This indicates that this marginalized community likely has a need not yet met by BHRS services. The DEC is continuing to explore the depth and details of this need.

Again, through the Arab Workgroup, the DEC took Photovoices made in a FY17-18 CSIP Intern project to community events and sparked conversation about wellness in Arab communities. At least 50 people stopped to look at them and talk more about what they meant with viewers making comments like "I've never seen this for us before" or "This is important" or sharing their own stories of mental illness or thoughts of suicide or losses to suicide with the tablers. The Photovoices were also featured in a facebook live stream viewed by 300 people during the Westmoor Breakfast on 5/19/19. This is slowly decreasing stigma related to behavioral wellness in the local Arab community.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

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

Mission, Vision, and Objectives

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

Awareness: Increase overall community awareness and involvement of community members in African American Community Initiative

Utilization/Access: Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.

Education/Training: Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.

Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each Community Service Areas of San Mateo County's Behavioral Health and Recovery Services.

Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.

Outreach: Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out tothe African American community.

Partnership: Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and AA clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments

One of the goals of The African American Community Initiative is to increase collaborative efforts with other HEI's in order to identify the health needs of communities of color and ultimately decrease disparities for communities of color. In October 2017 The African American Community supported the Spirituality Initiative by finding entertainment for the National Day of Prayer event. AACI was able to secure a gospel soloist for the National Day of Prayer. In addition, AACI tabled at the event to provide information about the initiative and recruit more members.

Black History Month events in 2017 & 2018 focused on the mental wellness of African Americans of all ages. It acknowledge the chronic stress of racism and that everyday family challenges (such as securing resources, family stability) can add even more stress. The Initiative

offered workshops and activities that provided coping strategies for the whole family to mitigate stress. Participants remarked that the workshops and speakers were very helpful and meaningful. The event planning began in the annual AACI strategic planning facilitated by Leanna Lewis.

The Initiative also conducted a member satisfaction survey, which offered insight into what members liked and disliked about AACI, recommendations for improvements, and suggestions on future directions for the Initiative. As a result of this survey and other efforts by the co-chairs, the Initiative is able to prioritize goals for AACI based on what members want, which will lead to greater alignment with and impact for the community served.

In FY 17-18 over 230 community members participated in AACI events. In FY 18-19, AACI participated in and/or hosted the following activities:

- Black History Month Celebration
- Intergeneration Dinner: Black Queer Pride (collaboration with Pride Center)
- Hosted Origins of African American Health Disparities provider training led by Leanna Lewis
- Hosted Unconscious Bias and Black Mental Health: Implications for the Mental Health of African American Communities, provider training led by Leanna Lewis
- 5 tabling opportunities
- 2 church-based psycho-education presentations

CHINESE HEALTH INITIATIVE (CHI)

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

Mission, Vision, and Objectives

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

and received funding for a Chinese Outreach Worker position which has since been funneled into a contract with an outside agency.

The Chinese Health Initiative has a one-year plan focused on three goals:

- Referring behavioral services to unique 60 Chinese speakers in 2019
- Piloting a youth empowerment program by the end of FY 18-19
- Recruiting 5 new community members to volunteer/attend at CHI events/meetings

Highlights & Accomplishments

During FY 17-18 Chinese Health Initiative (CHI) created public spaces where members of the community, BHRS staff and other residents could feel comfortable openly talking about issues they would normally prefer to talk about in a private setting, namely immigration and suicide. With the opportunity to elevate these voices, community members feel more confident and less anxious about these issues. CHI outreach volunteers continued bridging Chinese Hospital patients to mental health care as primary care providers continued making mental health referrals. CHI continues to raise awareness about their work through outreach, tabling events and relationships with NAMI Chinese, Project Sentinel and Supervisor David Canepa's office. One such collaboration resulted in an Open Mic events with FMHI in South San Francisco to reduce mental health stigma. Approximately 70 people attended this event and 10 people shared their own stories and poems focused on hope, recovery and resilience.

In FY 18/19 CHI achieved Goal 1, referring 60 unique Chinese-speakers to behavioral health services via the North County Outreach Collaborative (NCOC) Chinese outreach contract and Peter Shum's placement at the Chinese Hospital. CHI achieved Goal 2, piloting a youth empowerment program, through existing connections at Mills High School and by developing buy-in with students. CHI achieved Goal 3, recruiting 5 new members, by selecting tabling events intentionally and leveraging the co-chairs' networks outside of BHRS.

CHI participated in multiple tabling events with attendance around 100-200 people. At some events, CHI partnered with other HEIs, such as with FMHI at the PRIDE celebration, and with all other HEIs at the Solidarity event in Fall 2018.

Seven to ten members participated in developing and translating a Wellness Survey in English, Spanish, and Chinese to assess needs in areas with dense Chinse populations. The survey was distributed in 2019 and the results will be used in planning 2019-2020 priorities as well as to solicit further data at different outreach events.

On July 11, 2019, the Chinese Health Initiative also held a strategic planning session during a meeting, allowing members to provide input on how the budget should be used for the next

two fiscal years. In December 2018, the co-chairs solicited additional member feedback and applied it to last six months of the fiscal year.

In FY 17-18 CHI members completed the following activities:

- Sing Tao Expo - approximately 30 attendees
- RUN2fundEducation - approximately 10 attendees
- Millbrae Library Storytime in Mandarin - approximately 20 attendees
- Health Care Rights & Immigration Forum for the Chinese Community to educate Chinese community and reduce anxiety around complicated topics of health care and immigration rights (80 in-person, 250+ via Facebook Live)

In FY 18-19 CHI members completed the following activities:

- North County Outreach Collaborative outreach worker position operational
- 6 tabling events
- AANHPI Proclamation at Board of Supervisors (collaboration with FMHI and PII)
- Peer support group at Mills High School (CSIP project)

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

In FY 17-18 FMHI intentionally partnered with political officials and strengthened their collaborations with other HEIs. This included forming a partnership with the Daly City Youth Health Center to fund Sala Talks mural project for LGBTQ API Youth. FMHI gave 4 community presentations reaching over 225 people.

In FY18-19, FMHI deepened connection to cultural values. In particular, the Initiative focused on *kapwa* ("togetherness") by identifying, appreciating, and leveraging the different strengths of the co-chairs, members, and partners throughout the community. In part, this was accomplished by two retreats, one focused on FMHI and the other focused on the planned community center, as well as a core meeting survey to assess strengths and challenges. 60% of active members are from the community, only 10% are BHRS staff or contractors.

FMHI submitted an MHSA Innovations fund proposal to create a social enterprise that incorporates a youth wellness program and cultural arts center, currently titled KultureArts. The Initiative founded the TRIBE Advisory, a group of members dedicated to the social enterprise. As part of that effort, TRIBE contributed towards an ongoing needs assessment that will help structure this effort, to be community-informed. Planning and executing the needs assessment required members and supporters to come together to determine the focus of the assessment questions and to outreach to the community to acquire data needed to support or shift what the Initiative has proposed.

The co-chairs were invited twice to do presentations on FMHI's social enterprise planning and building power in community to address social issues in a sociology class at Skyline College. The first class had more than 20 students; nearly 80% of whom focused their final projects on creating programs or solutions to tackle mental health issues in the Filipinx community as a result of the presentation. This early exposure to mental health challenges can help develop the next generation of community advocates and leaders in mental health.

FMHI members consulted with Filipinx community members in Solano County and helped that group create their own FMHI-Solano in Spring 2019. This is now the second FMHI group inspired by FMHI-SMC; FMHI-SF still communicates with the SMC founders as well. This exchange has opened the doors for trans-Bay collaborations (with FMHI-SF and FMHI-Solano) to address mental health community issues within Fil-Am communities on a systems level.

FMHI also experimented with providing stipends to members for their service. A clear set of requirements or standards was established and members that met the standard by the end of the fiscal year were provided with a $50 gift card. This was an experimental step towards compensation for some of the effort that goes into operating an HEI.

In FY16-17, FMHI participated and/or hosted the following events and activities:

- LGBTQ+ API Youth Mixer (15 attendees)
- Suicide Prevention Month social media campaign on suicide prevention in which FMHI authored post on Filipinos and risk factors
- Colma Parol-Making event
- Health Rights & Immigration Forum
- LGBTQ+ API Youth Mural

In FY18-19, FMHI participated and/or hosted the following events and activities:

- Created TRIBE Advisory group to work on KultureArts community center development
- Hosted 3 events, co-hosted 2 additional events
- Hosted 3 provider trainings
- Tabled at 4 events
- Hosted 2 community psycho-education trainings
- Led 1 communication campaign

LATINO COLLABORATIVE

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

Mission, Vision, & Objectives

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

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

Highlights & Accomplishments

In Fy17-18 the Latino Collaborative welcomed several presenters sharing local resources into its meetings. Because the majority of members have direct contact with the community via direct

services or outreach and prevention, these informational presentations can impact services. Presentations included:

- Project Sentinel on affordable housing
- The Chicana/Latina Foundation on women's empowerment
- Catholic Charities on immigration policies
- San Mateo County's Environmental Health Dept. on healthy homes

In recognition of the fear and concern resulting from federal politics, the Latino Collaborative spearheaded the Solidarity Event for family unity in August 2018 focused on family separation at the US southern border. 45 people attended. Names were not collected due to the nature of the event (focused on undocumented families) but anecdotally, most attendees were not familiar faces to the organizers. The HEIs worked together to put on this event. Evaluation data collected by responses written on posters in the room indicated that most folks identified at Latina/o/x, enjoyed the event, and came with family. Speakers included a Japanese man whose family was separated at Tanforan during WWII. This was the first all-HEI collaboration in a while and there is great desire for more connection between HEIs and their co-chairs.

The Latino Collaborative also led an HEI co-chair social hosted at the Pride Center which allowed co-chairs to get to know each other better and build more trust for easier collaboration. The event was a Rosca, building on Latinx cultural traditions. It was well-attended, with all HEIs represented.

The LC began partnering with the Office of Sustainability to highlight environmental justice issues and how they affect the Latinx community.

The LC provided feedback on a Spanish-language Sexual Orientation and Gender Identity (SOGI) presentation from Pride Center staff member Andres Loyola. Her presentation will be refined based on LC feedback and ultimately contribute to a community presentation on SOGI that can help reduce stigma and mental health burden for LGBTQ+ Latinx community members.

In FY17-18, the LC participated and/or hosted the following events and activities:

- San Mateo County's annual Latino Health Forum: Sana Sana, Colita de Rana, 75 people attended. This event focused on stories of hope and resiliency, there were presentations provided on immigration, dealing with community stress, and access to community resources.
- Bystander Intervention Training 3/29/2018
- Rosca
- Provider training

In FY18-19, the LC participated and/or hosted the following events and activities:

- Hosted annual Sana Sana, Colita de Rana - approximately 150 attendees
- Hosted Family Unity solidarity event - approximately 50 attendees
- Hosted 1 staff training
- Tabled at 2 events
- Hosted 2 community psycho-education events
- Drumming and Spirituality as a Method of Healing and Recovery (collaboration with NIPI and Spirituality)

NATIVE AMERICAN INITIATIVE (NAI)

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

Mission, Vision, & Objective

NIPI has defined its mission as generating a comprehensive revival of the Native American and indigenous community by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices. NIPIs vision is to provide support and build a safe environment for the Native American and indigenous communities. NIPIs goal is to appreciate and respect indigenous history, culture, spiritual, and healing practices. The NIPI strives to reduce stigma, provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners.

The NIPI has further developed and articulated the following objectives:

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

Highlights & Accomplishments

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

In collaboration with the Latino Collaborative and the Spirituality Initiative, NIPI hosted a Drumming Circle training facilitated by Dr. Nunez, a leading proponent of using drumming to help those with behavioral health issues. Many different segments of the community participated in this event. Several participants said that it had a "calming" effect upon them and that they had not realized how drumming speaks to all human beings. Again, it is a tool for recovery and was a portent for trying different ways of treating those with mental illness. It was also a way that three of the HEIs worked together to bring a significant event to San Mateo County and to BHRS.

NIPI has also hosted a dialogue on inclusion of Two-Spirt identity on demographics forms, helped to facilitate the Day of Prayer, PRIDE and Recovery Month events, supported the CH video discussion and name change conversations in the county.

In FY17-18, NAI participated and/or hosted the following events and activities:

- 1st SMC Indigenous Peoples Day in EPA
- Provider training

In FY18-19, NIPI participated and/or hosted the following events and activities:

- Provider training - Native American Mental Health: Historical trauma and healing practices
- Provider training - Overcoming Trauma Through Digital Story: Telling, Healing & Walking Down the Red Road
- 2nd Annual Indigenous Peoples Day in East Palo Alto
- Drumming and Spirituality as a Method of Healing and Recovery (collaboration with LC and Spirituality)

PACIFIC ISLANDER INITIATIVE (PII)

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

Mission, Vision, & Objectives

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

The goals and objectives of the PII are organized according to four pillars identified by members:

- Service Accessibility
- Sustainability & Funding
- Mental Health Career Pipeline
- Community Partnership

Highlights & Accomplishments

FY 17-18 Highlights include:

- PI provider trainings
- Facilitating Journey to Empowerment and Deconstructing Gender Roles in the Pacific Islander Community conversations
- Supporting National Day of Prayer by having 8 members sing a Tongan Hymn "Eiki koe 'Ofa ' a au", a traditional Weslyn hymn most Tongans know.

Additionally, work with Jenn Awa, a consultant, has produced much needed dialogue and a lens that has helped the initiative translate its needs for the county. Her expertise and experience have begun to help the Initiative chairs be more cognizant of how to have the most impact with measuring tools to illustrate PII's impacts.

The 2018 Strategic Planning Meeting, facilitated by Alisi Tulua, kicked off a new era of the Initiative. Fresh and staid partners alike gathered to discuss their hopes and goals for the Pacific Islander Initiative. Several partners who had purposefully disengaged from the group after losing trust in its leadership were able to return, speak about their experiences, and commit to re-engaging. With this tone shift, PII embarked on a year of long-term planning, building a comprehensive five-year plan that includes a youth leadership and mental health career pipeline program (PIONEER). PII also changed its meeting time from 6pm to 11am and began using a rotational schedule that brings the meeting to each region with many PIs (North, Central, and EPA) once per quarter. Each regional meeting is hosted by one of the three large organizations serving Pacific Islanders in that area (Asian American Recovery Services, Peninsula Conflict Resolution Center, and One East Palo Alto). The group gained 10 new members. Trust, engagement, and collaboration has greatly increased over the course of the past 12-18 months.

The Pacific Islander Initiative engaged with community members directly through 9 events and community trainings this year. PII tabled at one event, provided three psycho-education trainings, and hosted five Heal & Paint sessions in collaboration with community organizations.

Following the popular One Life, One Love suicide prevention event in May 18, PII has continued to focus on reducing stigma and increasing awareness about suicide in Pacific Islander communities. As follow-up actions to the event, the Initiative created a suicide prevention communication campaign specific to Pacific Islanders, which has been shared on social media more than 300 times and viewed by more than 5,000 people. The group also began planning 'Olunga He Kaliloa, a culturally-rooted oral history project about experiences of suicide and loss.

PRIDE INITIATIVE

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

Mission, Vision, & Objectives

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

- Engage LGBTQ+ communities.
- Increase networking opportunities among providers.
- Provide workshops, educational events, and materials that improve care of LGBTQ+.
- Assess and address gaps in care.

Highlights & Accomplishments

FY 17-18 accomplishment include, 6th annual Pride Celebration, developing the SOGI training curriculum, SF Pride event and TDOR bios.

In March of 2019, over 30 community members including Dana Johnson, PRIDE Initiative Co-Chair wore purple in solidarity and support of the Pride Center and caravanned to Sacramento to attend the presentation to the Mental Health Oversight and Accountability Commission. The Pride Center presented a wonderful presentation of their services and was provided a 2-year

extension. Earlier in the year the PRIDE Initiative submitted a support letter for the San Mateo Pride Center, to the Mental Health Oversight and Accountability Commission-Sacramento for a 2-year extension of time and funding. In June of 2019, Co-Chair Dana Johnson marched in Supervisor David Canepa's contingency at the San Francisco Pride Parade.

In FY18-19, PRIDE participated and/or hosted the following events and activities:

2nd Annual Transgender Day of Remembrance (TDOR) (collaboration with LGBTQ Commission) - approximately 80 attendees

7th Annual San Mateo Pride Celebration - 800 attendees

- Staff trainings: Pride Initiative presentation to Probation Staff
- Tabled at: HEI Internship-Amazing Dialogue, San Mateo County Fair-Pride Day, Staff Health Fair at the Medical Center

SPIRITUALITY INITIATIVE (SI)

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

Mission, Vision, & Objectives

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

Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.

Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.

Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

In FY 17-18 the Spirituality initiative began developing a partnership with Mission Hospice and Home Care. They also continued to participate in two state wide phone-ins that occur monthly.

The annual National Day of Prayer event gathers people of all faiths, religions, and understandings to celebrate the presence of all segments of the community and call their attention to those with behavioral health issues. Regarding improvements to the event, one faith leader said:" just keep doing what you are doing as it is important for the community."

The event increases awareness about mental health issues in faith communities and establishes the Spirituality Initiative as a willing collaborator and ready resource.

Ongoing spirituality trainings—10 completed in FY18-19—continue to educate and challenge SMC BHRS clinicians to be open to listening and including spirituality in the recovery of those whom they serve. As found in SI's survey several years ago, 80% of the clients in SMC have expressed that spirituality is paramount to their recovery. However, only half expressed that they felt welcomed to discuss such a matter with their clinician. The Initiative narrows that gap via trainings for providers. The trainings have advanced the discussions about spirituality and how clinicians can incorporate it into care in BHRS clinics and programs.

The Initiative's monthly meetings have become a hub for faith leaders, community advocates, and BHRS staff interested in spirituality and mental health. Presentations included:

- ODE/Annette Pakhchian and Reverend Terri: LGBTQ+ experiences with faith and religion
- Heart and Soul: Seeing Through Stigma peer panel
- AACI/Isaac Fredericks (faith leader & BHRS clinician): Black History Month and the significance of African Americans in the USA
- Stanford School of Medicine: WELL for Life research project
- Health Policy and Planning: elections and social determinants of health
- Mission Hospice: Engaging Grief
- ODE Storytelling Program/Siavash Zohoori: Cultural Humility Video Series
- Help One Child: presentation of nonprofit with mission to serve at-risk children and families

In FY16-17, SI participated and/or hosted the following events and activities:

- National Day of Prayer
- Spirituality 101 Provider & Community trainings
- Diversity and Equity Council monthly meetings
- Statewide County Liaison calls
- Mental Health Month
- Suicide Prevention Committee

In FY18-19, SI participated in and/or hosted the following events and activities:

- 3rd annual National Day of Prayer - approximately 40 attendees
- Drumming and Spirituality as a Method of Healing and Recovery (collaboration with LC & NIPI)
- Spirituality 101 - 10 BHRS staff & contractor trainings on the Spirituality Policy
- 3 mental health education trainings in community

- Statewide County Liaison calls
- Suicide Prevention Committee

HEALTH AMBASSADOR PROGRAM (HAP)

San Mateo County's Behavioral Health and Recovery Services (BHRS) Health Ambassador Program (HAP) was created in 2014 out of a desire from community members, who are committed to helping their families and neighbors, improve their quality of life, continue learning, and increase their involvement in community services.

HAP goals include:

- Increase community awareness of services available in San Mateo County and help connect individuals to appropriate care and support.
- Reduce the stigma around mental health and substance use issues so individuals are more willing to get help.
- Improve community's ability to recognize the signs and symptoms of mental health and/or substance use issues and implement social change.
- Foster community support and involvement in BHRS' vision to improve services.
- Assist communities in practicing prevention and early intervention, leading to healthier and longer families.

Health Ambassadors are individuals who are committed to helping to improve the health and wellbeing of individuals in their community and complete the Health Ambassador Program. To become a Health Ambassador, community members must complete 5 of the 11 curses below:

- **The Parent Project®**
  An interactive 12-week course teaches parents/caregivers parenting skills & focuses on how to improve their relationship with their child(ren). Participants will learn effective identification, prevention & intervention strategies.
- **Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA)**
  A ground breaking public educational program that helps the public identify, understand & respond to signs of mental illness & substance use disorders. Classes offered with a focus on adult or youth issues.
- **Wellness Recovery Action Plan (WRAP)**
  A tool that helps individuals manage their physical & mental health based on concepts of hope, personal responsibility, self-advocacy, support & education.
- **NAMI Family to Family**

A 12-week educational program for family/caregivers of individuals with severe mental illness. Learn current information about psychiatric diagnosis, treatment & strategies to help a loved one.

- **NAMI Basics**
  A 6-week educational program designed for parents & other family caregivers of children & adolescents with emotional & behavioral difficulties. Helps caregivers understand the illnesses that are causing difficulties and the critical role of family in treatment.
- **Applied Suicide Intervention Skills Training (ASIST)**
  Helps people effectively recognize & intervene to prevent suicide. This training helps individuals respond to crisis situations & provides tools to help prevent the immediate risk of suicide.
- **Photo Voice Project**
  Enables community residents of all ages & languages to share information about their experiences through photos. A unique way to heal, educate the community & voice your local health issues.
- **Digital Storytelling**
  Merging the ancient art of storytelling with today's digital tools to assist individuals in expressing & communicating their thoughts, ideas & experiences through stories.
- **Stigma Free San Mateo**
  Become active in advocating for the full inclusion & wellbeing of all persons with mental health & substance use issues in the community. In this work, individuals engage in outreach, education & dialogue with members of the communities to help create a stigma free county.
- **Lived Experience Academy**
  A 10-hour training offered to consumers & family members who want to learn how to share their stories of recovery in a way that empower themselves, inspires others and help improve the County's behavioral health services. Graduates will be considered to present their stories at various BHRS programs/events.

San Mateo County's Behavioral Health and Recovery Services (BHRS) Health Ambassador Program was created in recognition of the important role that community members serve in effectively reaching out to others.

PROGRAM IMPACT & SUCCESSES

The BHRS Health Ambassador Program (HAP) advances the MHSA outcomes of reducing the duration of untreated mental illness, preventing mental illness from becoming severe and

disabling and reducing school failure, suicide, prolonged suffering, removal of children from their homes, police involvement and supports mental wellness by:

1) **Introducing community members and families to information and research in the field of mental health.**
   This fiscal year, one more community member graduated from the Health Ambassador Program and in the process was hired by BHRS' Office of Diversity and Equity as Family Partner.
   - A Latina-married woman from Redwood City took the following classes: Parent Project, Parent Project loving solutions, Youth Mental Health First Aid, Stigma Free San Mateo, NAMI Basics, Adult Mental Health First Aid, Photo Voice, Applied Suicide Intervention Skills Training (ASIST), Wellness Recovery Action Plan (WRAP), Lived Experience Academy.

   "I was passing through one of those hardships in life when I learned about the Parent Project class. After enrolling and completing the 12-week training, I knew that I needed to learn not only about parenting but perhaps more about mental and behavioral health -a concept so foreign for me at that time. Immediately after taking Parent Project, I was suggested to take Mental Health First Aid and then other courses related to alcohol and other drugs offered by San Mateo County's Behavioral Health and Recovery Services (BHRS), all of trainings at no cost. I got hooked! This was the path I needed to take to understand and accept that life can be enjoyable while parenting 2 children with learning and behavioral challenges. After a couple of years of learning through these community trainings, the stigma of mental health issues was lifted, I accepted my reality and became stronger in advocating for my children at school and with medical providers. It became easier to talk about my story and share my experience with other parents/caretakers of my community. Throughout the Health Ambassador Program, I've connected with individuals who might have been experiencing challenges like mine. HAP has given me tools to encourage other people to seek the appropriate care and support available in San Mateo County. It's been very rewarding witnessing when members of the community are able to recognize the signs and symptoms of mental health and substance abuse and are willing to break the stigma wall to seek for the appropriate help."

On December 2018, Charo a Family Partner/Peer Support Worker became the 27th Health Ambassador, she is also the current HAP Program Coordinator. Charo's direct participation in each of the classes provides her a closer understanding of how the HAP curriculum works for community members, identifies areas to improve and highlights successes. Currently, Charo is overseeing the Health Ambassador Program.

2) **HAP Reunion 2019**

The purpose of the Health Ambassador Reunion on February 12, 2019 was to reunite with Ambassadors after a year and a half of not following up with them due to program's staff turnover

- 16 Ambassadors attended to HAP Reunion
- 8 relocated
- 3 couldn't make it

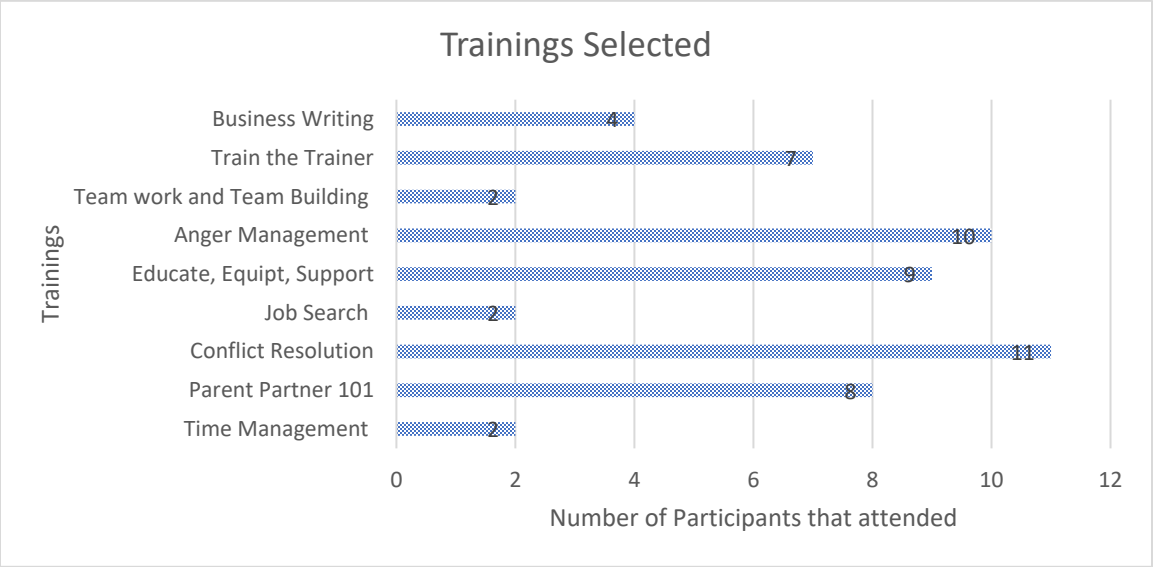
The most common request and comments received from HAP graduates were related with learning more about the new forms of drugs and alcohol substance that are available to youth. They are interested in knowing the new tactics of selling/getting/camouflage them. Ambassadors expressed concern of the current use at High Schools.

"HAP allowed me to learn about various drugs when my son engaged with substance use. I am thankful for the resources available to me at that time. I would like to stay updated about new drug uses"

"My daughter was straggle with depressive psychosis when I learned about BHRS. Through my involvement in HAP, I was able to learn about drug and substance use among youth. Now, 4 years after I took the trainings, I need and update".

Additionally, Ambassadors requested trainings about how to engage with youth when Social Media/Internet use is making youth become "Zombie Kids" and anti-social; Learn about tactics in communicating with youth about topics youth are exposed to on the internet; Positive Discipline.

Also, at HAP Reunion, the opportunity of taking new trainings to improve personal skills and community empowerment was offered such as: Time Management, Conflict Resolution, Job Search, Team Work and Team Building, etc. Below are the results of the survey with the Ambassadors.



During April and May, 4 Health Ambassador attended to a Conflict Resolution and Team building trainings sponsored by BHRS. One of the attendees stated: *"This information can be used not only in a professional setting but also while encounter any relationship or groups, including my family"*.

3) **Providing information on access to SMC BHRS mental health and substance abuse services.**

After listening the Ambassadors' needs during the annual reunion and after receiving several requests from community members involve in school support groups, the Health Ambassador Program in collaboration with Youth Leadership Institute (YLI) set up a drug abuse and mental health presentation at Aragon High School, in San Mateo city, on March 21, 2019. The presentation that lasted 2 hours included information in Spanish about synthetic drugs, vaping, e-cigarettes and marijuana; what are the addictions and symptoms in teens today; how substance abuse and mental and behavioral wellness are connected; including the lived experience presentation of a Latino Commission member who is recovering from alcohol and drug addiction; and finally, a Police woman displayed drug paraphernalia for caretakers to look firsthand.

50 parents/caretakers actively participated with questions and concerns about vaping and e-cigarettes challenging their cultural values and academic goals. In addition to the information provided, information about resources available in San Mateo County's BHRS was shared, including all trainings that HAP offers to the community at no cost.

ODE and AOD collaboration

Due to the success of the community education presentation at Aragon High School, the collaboration of BHRS' Alcohol and Other Drugs department (AOD) was requested. A special reunion for Health Ambassadors and other community members to build and share knowledge about the following topics:

- Substance use root causes
- Mental Health, Stigma and Assimilation
- Synthetic drugs, vaping, e-cigarettes and marijuana
- Build power among Health Ambassadors
- Understanding of systemic issues associated with disparate impacts and outcomes For example, suspension rates disproportionately higher among Latino, Black and PI communities. Use data to tell the untold story about systems rather than blaming communities for outcomes.
- Conducted the presentation in Spanish
- Inform participants how to get support by calling the ACCESS line.

This special ODE/AOD presentation for HAP happened on April 30, 2019 where 27 adults attended. Dinner and childcare for 12 minors were provided. This was the first time that AOD and ODE collaborated in a community outreach effort.

Based on the demographic and evaluation forms collected, below are demographics of participants.

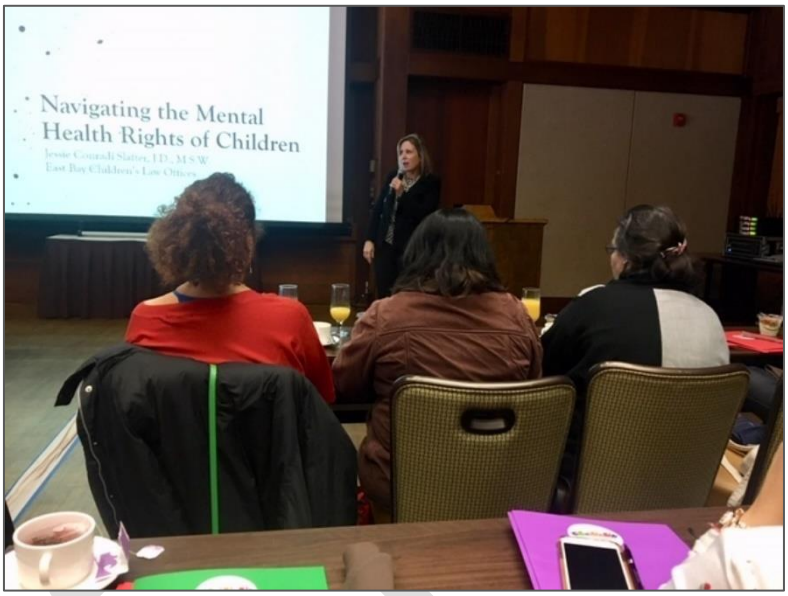
- Individuals from Mexico, Central America, South American and the Caribbean.
- 80% Females and 15% Males.
- Residents from 7 different cities in the County.
- 27 Ambassadors and other community members who attended would use the information for prevention, help their children, and to spread the knowledge to other members of the community. *"After this presentation it will be more difficult for my daughters to fool if they are using drugs",* a mother stated*. "I'd like other parents from my children's school to know this valuable information".*

*Childcare and dinner were highly appreciated, in fact there was one of the reasons more males could attend with their spouse and the entire family.

4) CMHACY Conference for HAP

On May 15th, 2019, 13 Health Ambassadors and potential Health Ambassadors attended to the California Mental Health Advocates for Children and Youth Conference in Pacific Grove, CA. Ambassadors learned from the following topics:

- *Navigating the Mental Health Rights of Children*
- *Parent Resilience*
- *Helping People Heal in Communities*
- *Parent and Youth Panel, gasping services during childhood life transitions*



"The first workshop made me remember how hard was for me navigating the system to exercise the right to have a decent school for my son who faces ADHD. After achieving the Independent Education Program (IEP) he needed, I started seeing him smiling, then I felt and learned there was hope". "The workshop about Parent's Resilience helped me realize that I am resilient. It made me rediscover my essence, my own personal leadership and that I am in control of my thoughts".

Another Ambassador shared, *"This conference is helping to see what I didn't do for my daughter when she was little, however, I am hopeful and grateful because of what I am learning here and the training I stated taking at the County. Now I understand and can help my daughter in new ways when she needs support while facing bipolar challenges"*

5) **Courses Provided During FY 2018-19**
   - Parent Project: 166 attendees, 129 graduates
   - MHFA Adults: 179 graduates
   - MHFA youth: 327 graduates
   - WRAP: 27 participants, 25 graduates
   - ASIST in English: 2 participants
   - Stigma Free: 25 participants
   - Mental Health and Drug abuse presentation 50 participants
   - HAP/AOD presentation: 27 participants
   - NAMI Basics: 18 participants
6) **HAP Presentations at Parent Project and Mental Health First Aid classes, School District Office and Parent Café**

   During a 45-minute presentation, close to 350 parents/caretakers and school liaisons received information about mental health, the causes and conditions, and about stigma. Information was also shared about how to access behavioral and substance use services

in San Mateo County including 11 courses offered at no cost as part of the Health Ambassador Program. 8 different cities were visited across the County to collect lists of people interested on HAP.

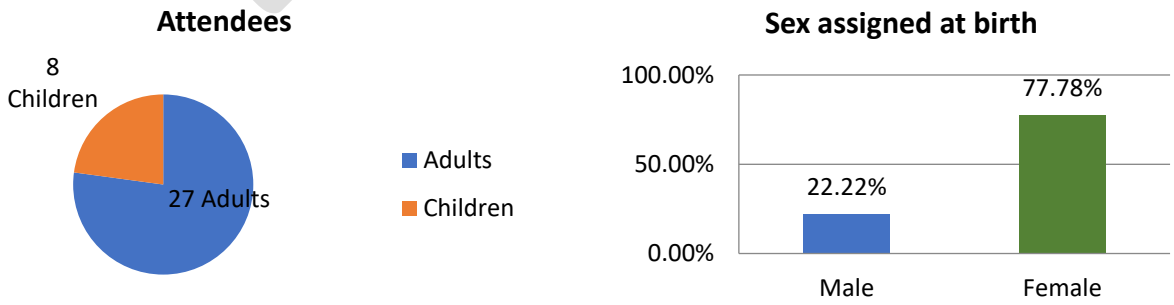
7) WRAP training

Wellness Recovery Action Plan (WRAP) From May 7th to June 25, 2019.This program presented special success during this year, in the following areas.

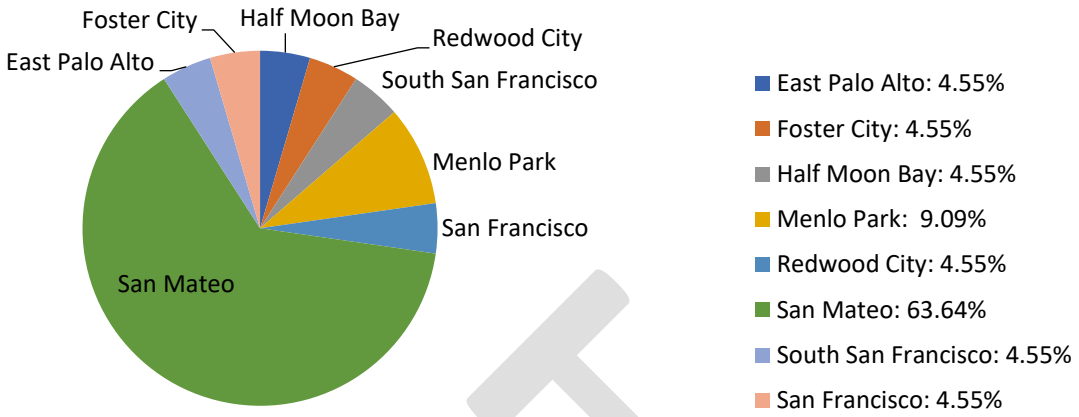
- For the first time in HAP history 27 members of the community enrolled. 24 graduated.
- More males came to the training ever, and they were coming to class in company of theirs spouses. At some point during the 8-week class, there were 4 entire families, parents were taking the class while children were taking care of. In addition to childcare, a complete and nutritious dinner was provided for all participants.
- Participants from 5 different cities came to the training and some of them identified as alcohol and drug recovered individuals, parents of children with developmental and learning challenges, caretakers of children with depression and suicide alienation.
- The baseline and end of the class questionnaires show a tremendous progress in the participants wellness responsibility. *"I didn't know I can work on my own wellness plan, in fact I only take care of others",* a woman shared after the 4th session.
- The training was provided in Spanish and was culturally appropriate, so participants were able to open-up and experience healing.

"I have never talked about my child illness in public because I feel judge, even some family members have alienated us because they don't understand nor want to know more about our child mental and behavioral challenges", a father expressed after one session. *"I didn't feel embarrassed tonight because here are people who seem to be living a similar life like mine"*

Below is some data collected during the WRAP training.



What city do you live in, work or represent in San Mateo County?



The impact of the WRAP training is observable by the baseline and end of the class questionnaires

- 24% Strongly Agree to know their triggers before an episode of illness.
- 55% Strongly Agree, at the end of the training

While asked the question, I believe that I can educate others (clinicians and community members) about recovery health:

- 37% Agree, before the training
- 65 % Agree, after the training

When asked, I have a list of tools I use to increase my sense of well-being:

- 8% Strongly Agree, before the training
- 75% Strongly Agree, after the training

The responses to the statement: I feel SAFE due to the wellness and crisis plans that I have in place currently

- 37% Agree, before the class
- 100% Agree, at the end of the class

8) **Ambassadors supported by connecting them to volunteer paid job and resources.**
Two Health Ambassadors participated with San Mateo County's Community Collaboration for Children's Success (CCCS) on a Neighborhood Leadership Group collecting community input from specific areas in Daly City, as well as helping during the strategic planning process. The Ambassadors were paid $20 dollars for 40-55 hours. For this opportunity, Ambassador were able to use their bilingual skills, criminal justice and

mental health lived experience and their knowledge of the focus community. Likewise, the Ambassadors had the opportunity to speak up in settings that they were not. One example of that is a reunion with Daly City Police Chief where both Ambassadors expressed concern for minority communities -Asian, Latino and Black- who reported not being taking care off as fast as other communities; profiling and lack of mental health-oriented services to minority youth.

"I am very confident to talk on behave of the people I made the survey because I understand their needs, some of the youth I interviewed were friends of my children. They confided so munch on me because I was asking for their needs and listening attentively without judging them. They reported to feel underserved by the police, they though low enforcement don't understand the emotional trauma they carry with them and that they are treated like criminals"

One of those two Ambassadors is going to be the 2nd ever Chinese Health Ambassador.

BHRS Health Ambassador supported activities/events:

- Parenting in the Age of Social Media and Technology (4/3/19) workshop where 2 Ambassadors attended to gain knowledge and share it with other Ambassadors and community members.
- Mental Health Awareness Month Kick off (5/4/18) where Health Ambassadors volunteered for 4 hours providing information to community members in Half Moon Bay. Near 200 people attended to the event.
- Know the Signs. Suicide is Preventable (5/22/18). A Health Ambassador co-facilitated the class in Redwood City for over 20 community members.
- Parent Project Reunion (6/9/18) where 4 Health Ambassadors participated with their personal testimony to reduce mental health and substance abuse stigma and provided information on access to San Mateo County's BHRS services.
- Cannabis workshop by the DECODED youth education campaign (6/26/18). 2 Health Ambassadors participated in this pilot workshop where they learn how to talk to their kids about Cannabis (Marijuana), they provided training curriculum feedback.

Current BHRS Health Ambassadors:

Since July 2, 2014 BHRS has graduated 27 Health Ambassadors.

- **1 Health Ambassador** is currently a trained Parent Project® and Know the Signs Facilitator in Spanish.
- **1 Health Ambassador** was first trained as NAMI facilitator and now is employed as a Family Partner Coordinator at BHRS
- **1 Health Ambassador** is actively involved in the Lived Experience Education Workgroup and at a Mental Health Advocate at ACCESS California.

- **1 Health Ambassador** has recently created his own nonprofit organization.
- **1 Health Ambassador** has obtained a master's degree and recently hired as Early Childhood Educator.

To be announced at December 4, 2019 MHSARC Meeting:

18 new Health Ambassadors will be receiving their certification from San Mateo County's Behavioral Health and Recovery Services (BHRS). An unprecedent number in the history of this program.

Upcoming courses;

1) NAMI Basics (Spanish) from July 16, 2019 to August 20th, 2019
2) ASIST (Spanish) August 15 and 16, 2019
3) STIGMA Free
4) Photo Voice

For the first time ASIST training will be offer to the Spanish speaking population. In response to community members interest who expressed clear need, the Office of Diversity and Equity (ODE) seeks to request Spanish interpretation to Living Works, the company that owns ASIST curriculum.

Health Ambassador Program	FY 18/19
Total clients served	45
Total cost per client	$263

CHALLENGES

Program challenges:

- Staffing changes leading to difficulty scheduling and coordinating classes
- Limited staffing support to help with actual course
- Space available to offer trainings
- Childcare specialized for children with behavioral challenges
- Provide trainings in other languages. Some curriculums haven't been translated to other languages yet.
- Status of Limited Term Employment of program staff, leading to stop providing services to vulnerable communities.

PARENT PROJECT

The Parent Project® was created specifically for anyone who cares for a child or adolescent displaying challenging behavior(s). The goal is to decrease unhealthy or dangerous behavior(s) in children and strengthen the relationships within families in a culturally informed manner. It is a free, 12-week course that is offered in English and Spanish. The classes meet for three hours each week in the evening time and are provided with free dinner and childcare. Parents/caregivers learn parenting skills and get information about resources and other support available in their communities. Parents/caregivers learn and practice skills such as appropriate ways to discipline; preventing or stopping alcohol, drug and tobacco use; improving communication skills; and improving grades and school attendance.

The Office of Diversity and Equity (ODE) is dedicated to addressing health disparities, health inequities, and stigma in the areas of mental health and substance use. One-way ODE works to achieve these goals is by providing free, public education programs to local community members, such as, the Parent Project®. The curriculum includes a mix of lecture, interactive activities, discussion, and homework assignments for parents and guardians. Primary program intervention includes guest presentations from local resources including the Sheriff's office providing local resources on gang involvement in youth and alcohol and drug usage and from San Mateo County's Pride Center is also provided to teach parents/ caregivers LGBTQ+ issues with youth. Other guest presentations include the Health Ambassador Program, a program created in recognition of the important role that community members serve in effectively reaching out to others. The program additionally connects the group with any additional resources they may need i.e. behavioral health services and other such as Second Harvest, food bank, etc.

PROGRAM IMPACT

The Parent Project® focuses on connecting people to care. Because the Parent Project® is coordinated by San Mateo County's Office of Diversity and Equity, there is a direct connection to behavioral health and recovery services as well as a linkage to other departments in San Mateo County Health System. The priority is to ensure that participants of the Parent Project® can access appropriate care. The Office of Diversity and Equity ensures that the programs are culturally and linguistically appropriate for diverse communities. The Parent Project® course is offered in Spanish which is the primary threshold language of San Mateo County. By removing the language barrier and outreaching to diverse communities, stigma and discrimination is reduced. The Office of Diversity and Equity serves as representative of services and direct connection to services to the Parent Project® participants. Through this connection the number of individuals receiving public behavioral health services is increased.

The Office of Diversity and Equity continues to be a point of access; portal to care; primary resource for care for the Parent Project® participants. Through the Parent Project®, the Health Ambassador Program, a program dedicated to further empowering community members to improve the health and wellbeing of individuals in their community. Health ambassadors:

- Teach youth and adult courses in their community.
- Assist in identifying needs in their community and helping to make a change.
- Share their thoughts with the County of San Mateo about wellness in their community.
- Work with other dedicated individuals. Participate in various volunteer opportunities

Parent Project	FY 17/18	FY 18/19
Total clients served	103	157
Total cost per client	$233	$153

SUCCESSES

The Parent Project® started in San Mateo County in 2012, it has maintained a 77% graduation rate and also over 1,000 graduates from the program. The Parent Project® has become an entry point for low income communities of color to engage in mental health by providing support for parents who want to do better for their children and families. This program is a means to the potential of deeper community engagement and civic participation for the communities. This is directly in line with ODE's goal of Community Empowerment: Deliberate opportunities exist for individuals with lived experience, families and community members to engage in decisions that impact their lives. The Parent Project® led to invaluable strategic partnerships with the SMCOE and other community-based agencies. In addition, the participants request for continued engagement led to the development of the Health Ambassador Program (HAP). Health Ambassadors have opportunities to outreach within their communities and assist in identifying needs and partake in implementing changes. HAP requires additional capacity building courses and after graduation, connects parents to opportunities to serve on commissions and other decision-making bodies, speaking engagements and has even led to gainful employment with BHRS and other community-based agencies for some. For these reasons it is believed that the continuation of funding for the Parent Project® is essential to continue connected and responsive to the communities served.

CHALLENGES

- Lack of official Parent Project Program Coordinator position beginning 2018

- Inability to adapt program and curriculum to other threshold languages (i.e. Chinese, Russian, Tagalog).
- Length of time of curriculum. While still maintaining an over 77% graduation rate, having initial interest and commitment to the program has been difficult.
- Distrust or hesitation from community members in participating in public programs due to political climate.
- Needing more male facilitators (there is currently 1) to offer parenting support from a different perspective.

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
0-15		12%
16-25		4%
26-59		77%
60+		5%
Decline to state		3%
Primary Language		
English		41%
Spanish		52%
Mandarin		1%
Cantonese		1%
Tagalog		1%
Samoan		1%
Tongan		3%
Another language		1%
Sex Assigned at birth		
Male	24%	32%
Female	74%	67%
Decline to state	1%	1%
Sexual Orientation		
Gay, lesbian, homosexual		1%
Straight or heterosexual	84%	84%
Questioning or unsure	2%	1%
Bisexual		1%
Queer		6%
Pansexual		6%
Asexual		6%
Indigenous sexual orientation		1%
Decline to state	14%	12%
Gender Identity		

Male/Man/Cisgender	25%	27%
Female/Woman/Cisgender woman	70%	66%
Transgender woman	1%	
Indigenous gender identity		1%
Decline to state	3%	6%
Race/Ethnicity		
American Indian/Alaska Native/ Indigenous		1%
Asian		3%
Eastern European		1%
Arab/Middle Eastern		1%
Black/African/-American		3%
White/Caucasian		9%
Asian Indian/South Asian		2%
Central American		26%
Chinese		7%
Mexican/Chicano		29%
Filipino		4%
Samoan		1%
South American		3%
Tongan		7%
Korean		2%
Vietnamese		1%
Another race/ethnicity		1%
Decline to state		2%
Disability/Learning difficulty		
Difficulty seeing	7%	3%
Difficulty hearing or having speech understood	2%	1%
Dementia	1%	
Chronic health condition		1%
Learning disability	3%	1%
I do not have a disability	74%	92%
Another disability	1%	
Decline to state	6%	3%
Veteran		
No		98%
Decline to state		2%

ADULT MENTAL HEALTH FIRST AID (MHFA)

Mental Health First Aid USA is an 8-hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. The program targets population served is the community members and partners in San Mateo County. Primary program activities and/or interventions provided is an 8-hour training, outreach and promotion.

PROGRAM IMPACT

AMHFA training incorporates culturally humble questions, examples and resources to help increase access for marginalized communities. The program shares mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.

AMHFA training shares local resources participants can refer to for professional behavioral health support, including those targeting marginalized communities. The program also partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth. AMHFA implements the recovery principles of support from others and providing hope since participants become gatekeepers provide hope and support to those facing mental health issues.

169 of the 179 graduates responded to the end of class evaluation. Of the 169 respondents:

- 97% feel confident to recognize the signs that someone may be dealing with a mental health problem, substance use challenge or crisis.
- 95% feel confident to reach out to someone who may be dealing with a mental health problem, substance use challenge or crisis.
- 86% feel confident to ask a person whether they're considering killing themselves.
- 99% feel confident to actively and compassionately listen to someone in distress.
- 96% feel confident to offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.
- 99% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis in seeking professional help.
- 96% feel confident to assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer, and personal supports.

- 97% feel confident to be aware of my own views and feelings about mental health problems, substance use challenges and disorders.
- 97% feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.

Adult Mental Health First Aid	FY 17/18	FY 18/19
Total clients served	279	179
Total cost per client	$36	$56

DEMOGRAPHICS

	FY 17/18	FY 18/19
Age		
0-15		1%
16-25 *Age collected as '18-25'	21%	15%
26-59	67%	65%
60+	6%	15%
Decline to state	6%	5%
Primary Language		
English	85%	78%
Spanish	7%	15%
Mandarin	1%	1%
Cantonese	.5%	1%
Tagalog	6%	1%
Tongan		1%
Another language	1%	4%
Sex Assigned at birth		
Male	24%	19%
Female	75%	80%
Decline to state	1%	1%
Sexual Orientation		
Gay, lesbian, homosexual	4%	2%
Straight or heterosexual	82%	84%
Bisexual	2.5%	5%
Queer	.75%	1%
Pansexual	.75%	1%
Another sexual orientation	1.5%	1%
Decline to state	.5%	6%
Gender Identity		
Male/Man/Cisgender	24%	17%

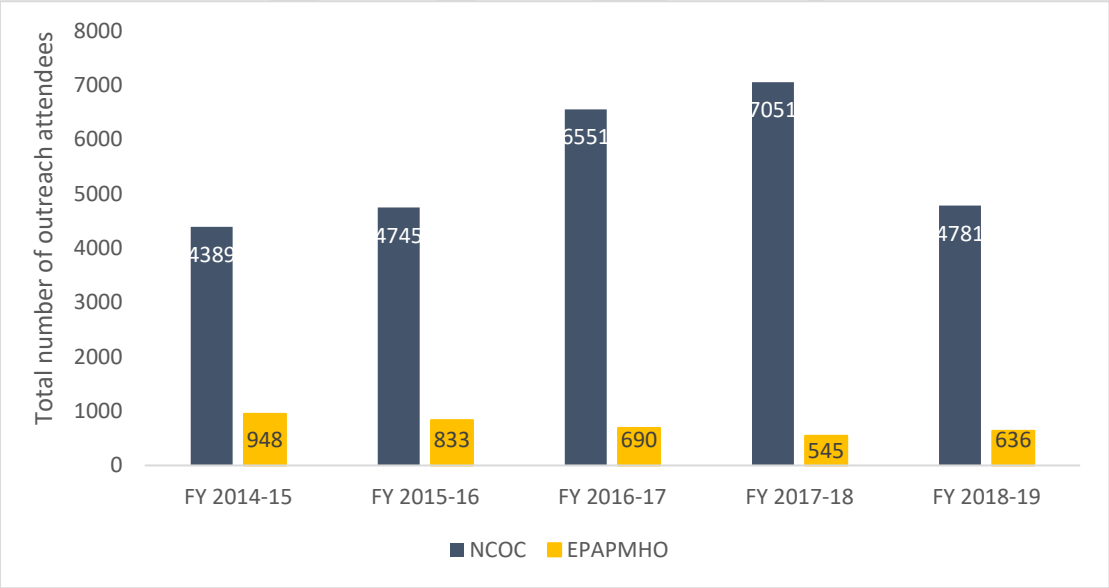
Female/Woman/Cisgender woman	72%	75%
Transgender woman		1%
Questioning/unsure	.5%	
Genderqueer/nonconforming		1%
Another gender identity	.5%	1%
Decline to state	.5%	5%
Race/Ethnicity		
American Indian/Alaska Native/ Indigenous	3%	7%
Asian	49%	39%
Eastern European	4%	1%
European	14%	3%
Arab/Middle Eastern		2%
Black/African/-American	5%	11%
White/Caucasian	24%	26%
Fijian		1%
Central American	6%	8%
Chinese	10%	1%
Mexican/Chicano	22%	17%
Filipino	20%	11%
Puerto Rican	1%	1%
Samoan		1%
Japanese	1%	1%
South American	5%	4%
Tongan	3%	1%
Korean	1%	1%
Vietnamese	2%	1%
Another race/ethnicity		1%
Decline to state	6%	
Disability/Learning difficulty		
Difficulty seeing		1%
Difficulty hearing or having speech understood		1%
Developmental disability		1%
Physical/mobility disability	.5%	1%
Chronic health condition	2%	2%
Learning disability	3%	2%
I do not have a disability	79%	85%
Another disability	2.5%	3%
Decline to state	10%	7%
Blank	.75%	

Veteran		
Yes	2%	3%
No	95%	96%
Decline to state	3%	2%

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). The collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse and increase awareness of and access and linkages to culturally and linguistically competent behavioral health, entitlement programs, and social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSA funded services. See Appendix 9 for the full FY 2017-18 Outreach Collaborative Annual Report. The FY 2018-19 will be included in the next MHSA Annual Update.

Total Outreach Attendees by Collaborative, FY 2014-2019



Note: The attendee numbers from previous FYs are slightly higher than those reported in the previous reports because some outreach data was reported after that

Table 3. Mental Health/Substance Abuse referrals by Collaborative, FY 2014-2015 to FY 2017-2018

	NCOC				EPAPMHO			
	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
Mental Health Referrals	67 (14.9%)	159 (44.9%)	119 (45.9%)	71 (30.9%)	80 (17.8%)	200 (26.2%)	64 (13.6%)	143 (30.7%)
Substance Abuse Referrals	33 (7.3%)	51 (14.4%)	27 (10.4%)	10 (4.3%)	202 (44.9%)	229 (30.0%)	115 (24.5%)	173 (37.1%)

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

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

PROGRAM IMPACT

NCOC continues to improve timely access and linkages for underserved populations by making sure when a person is in their waiting room they are immediately greeted and seen in a timely manner. NCOC are also advocates for reducing stigma and discrimination in services. Staff continue to attend and participate in Office of Diversity and Equities HEI's, share NCOC updates and reports back to the COT team all updates.

In FY 2017-2018, there were 4,256 attendees at individual and group outreach events across the five provider organizations in the NCOC.

NCOC	FY 17/18	FY 18/19
Total clients served	7051	4781
Total cost per client	$30	$44

SUCCESSES

AR is a 17-year-old, cisgender male student, from Brazil, who was referred to DCYHC for counseling with symptoms of major depression, anxiety, and substance use. He started seeing a counselor at the health center and continued to see a DCYHC clinician at his school. Other major issues presented to the counselor included immigration, loss of MediCal benefits, substance use, and academic struggles. DCYHC clinician worked closely with the school's Wellness Counselor to assist him with school work and create a safe place to talk about his mental health challenges. Immediate, short term solutions were provided such as

recommendations to attend immigration workshops provided by the county, assistance to reinstate his MediCal benefits, referral to Pacifica Resource Center to help with his legal and substance use issues, and assistance to connect him with resources so he could complete his Senior Exhibition Project. The collaborative partnership with Pacifica Resource Center (PRC) not only provided the student with a safe, immediate, and direct services; the agency also addressed the general issue of substance use in a systemic level that would help students and their families prevent or recover from substance abuse. Not only that, the relationship with PRC and DCYHC had deepened in which trust was developed even more that partner agencies could rely on each other to provide complementary services to disadvantaged youth and their families. In the end, AR passed his classes, his social life bloomed, and he graduated on time in May of 2019.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) collaborative is comprised of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psycho-education, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL) and the Multicultural Counseling and Educational Services of the Bay Area (MCESBA).

EPAPBHO is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness and access to culturally and linguistically appropriate services. EPAPMHO provides the following services including:

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

PROGRAM IMPACT

In FY 2017-2018, there were 511 attendees at individual and group outreach events across the three provider organizations in the EPAPBHO.

Outreach workers (also known as promotores/health navigators) EPAMHO created connections and facilitates access for marginalized populations through culturally and language appropriate outreach and education.

EPAPBHO also forms strong collaborations with local community-based agencies and health and social service providers. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy and, offering ongoing presence and opportunities for community members to engage in services. Finally, EPAPMHO's work increases the number of individuals receiving public health services, helps to reduce disparities in care and prioritizes using recovery-based principles in their work.

EPAPBHO	FY 17/18	FY 18/19
Total clients served	545	636
Total cost per client	$328	$281

SUCCESSES

MCESBA Outreach worker Dee "Mamadee" Uhila in partnership with The Mouton Center, served a PI family, husband & wife in their late 90's, both of whom are from San Jose. They had been couch-surfing and heard about The Mouton Center and Dee Uhila thru another consumer. After two months, they secured housing. Through contact with them and their participation in the PI "Know Your Rights Forum" by MCESBA, their unmet needs were identified. Due to the stigma associated with asking for help in the PI community and the fear caused by their immigration status, they hadn't spoken with anyone about their needs and were embarrassed. Further, the family they were staying with were also unaware of community resources.

Mamadee established a trusting relationship with the couple and they were encouraged to allow her to make a referral to Ravenswood Family Health Center. They applied for the Access and Care for Everyone (ACE) program. It took two months to get them through the registration process just to schedule an appointment and receive their ACE cards. The elderly couple had been in the U.S. for 10 years and had never seen a doctor. They are finally receiving ongoing medical care.

As a result of addressing their immediate needs and establishing a trusting relationship, they are now able to participate in a conversation about mental health and wellness and how participating in wellness programs can improve their quality of life. Currently their immigration issues and long-term housing needs are also being addressed.

As with many served, the couple made sure that they communicated that they were Samoan, native language speakers and Christians. Connecting them with a faith community of their choice furthered the establishment of a trusting relationship which is essential in being able to serve them and connect them to the appropriate community and mental health services.

CHALLENGES

Challenges that MCESBA staff deal with are similar to past years as follows:

- Long wait times to secure services or receive services on a drop-in basis.
- Needs of the Pacific Islander community outweigh the capacity and resources.
- The PI community is faced with unique barriers in accessing mental health services. The standard approach used by the county is often inappropriate given the cultural uniqueness of the community.
- Reliable transportation and transportation services that everyone qualifies for.

STIGMA AND DISCRIMINATION REDUCTION

#BE THE ONE CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative which aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. #BeTheOneSMC can mean many things to different people. #BeTheOneSMC can mean that ONE in four people have a mental health condition yet less than half are getting the help they need—many because they are afraid others will judge them. #BeTheOneSMC can also mean that ONE person or organization can make a difference in supporting wellness and recovery for others.

SUCCESSES

Within the #BeTheOneSMC, the program manager and supporting staff are especially proud of the Art of Wellness Festival (MHAM Kick-off) hosted at Cuhna Middle School in Half Moon Bay. The program staff is especially proud of this intervention because the event reached a new audience (Coastside community) that often are marginalized and have limited access to behavioral health services and was shaped through a collaborative process and included local community members as key speakers. A young woman with a severe mental health condition was shot by a police officer and her brother spoke up at the event.

CHALLENGES

Challenge 1 – Understaffed: The top challenge for stigma reduction program is that it is understaffed. About 20-25% of a full time Community Health Planner position is dedicated to coordinating stigma discrimination reduction program for the County. There are high expectations for this position to plan countywide Mental Health Month activities, facilitate community driven planning committee, coordinate communication campaigns and provide education as needed. This position gets some but not consistent/reliable support from (1) BHRS ODE/Communications staff and (2) planning committee members (who usually volunteer small tasks that require more time for co-chair to train/orient).

- Potential Solutions:
    - Limit scope of work for SDR in SMC
    - Contract the communication campaign work
    - Utilize Each Mind Matters consultants

Challenge 2 – Media Engagement: There is no longer SMC Health System support for communications, so there wasn't as much MHAM communication promotion (especially media) as previous years.

- Potential Solutions:
    - Get dedicated staff time outside of coordinator position to lead (not just support) communication campaigns throughout the year
    - Work with SMC Health Communications to do more with the press so the limited capacity of the SP coordinator can have more reach and impact

DIGITAL STORYTELLING & PHOTOVOICE

The Office of Diversity and Equity (ODE) storytelling program empowers community members to share their stories of recovery and wellness to heal and to address issues within their communities. Participants engage in workshops that help them create and share their stories in different forms. Beginning with a framing question, facilitators support participants to share their stories as Photovoices or Digital Stories.

Considering structural impacts on wellness such as racism, discrimination, and poverty, these workshops broaden the definition of recovery and reduce stigma. The stories shared are both personal and powerful. For some, they have created a sense of connection, and for others, they have opened the doors to treatment and recovery. Stories captured in San Mateo County shed light on important social issues including stigma against mental health and substance abuse and support the empowerment of others with lived experience to share their stories.

PROGRAM IMPACT

In FY 17-18 the Photovoice program began offering facilitator trainings, to empower community members to capture and share their stories. 25 people were trained as facilitators during the first year. In FY 17-18 photovoice workshops were facilitated focusing on Arab and Arab American mental wellness (6 high school participants), death and dying with the hospice community, experiencing incarceration in partnership with Correctional Health Services and the Sheriff's office, substance use and suicide, spirituality in recovery, substance use in East Palo Alto, stigma of behavioral health, youth health ambassadors and housing advocacy.

The program also published a video series with practical applications of cultural humility in clinical settings including, (1) Cultural Humility Introduction, (2) Working Through an Interpreter, (3) Using Gender Pronouns, (4) Developing Trust and Partnership, and (5) Gender Inclusive Restrooms (in progress). The program also focused on improving communications about and accessibility of the stories created.

Fiscal year 18-19 was filled with many accomplishments for the Storytelling program. The Storytelling program trained 42 more facilitators to host workshops on the topics of: immigration, incarceration, and youth mental health. Further, the first ever mental health graphic novel was created, and the process was led by a Behavioral Health and Recovery Services consumer! There were also significantly positive outcomes on participant self-efficacy. Participants continue to report positive feedback on the storytelling program and continue to report growth through the pre- and post-program questionnaires.

- "I feel people with mental illness are persons of worth, at least on an equal basis.": Strongly agree increased from 77% to 91%.
- "I see people with mental illness as capable people.": Strongly agree increased from 69% to 86%, for an increase of 17%.[1]
- "People with mental illness are able to do things as well as other people.": Strongly agree, increased from 69% to 82%.[1]
- "I'm kind to myself when I'm experiencing suffering." Agree to Strongly Agree increased from 33% to 70%
- "When I'm going through a very hard time, I give myself the caring and tenderness I need." Agree to Strongly Agree increased from 25% to 73% [2]
- "I'm tolerant of my own flaws and inadequacies." Agree to Strongly Agree increased from 34% to 74% [2]
- "I try to be loving towards myself when I'm feeling emotional pain." Agree to Strongly Agree increased from 38% to 87%.[2]

It's likely that a number of evaluations and questionnaires were completed inaccurately due to repeating choices (i.e. participant circles all 9s/strongly agree for questions measuring belief of mental health stigma as they rush out of the workshop and turn in their evaluation) and incongruence to participant affect during the workshop.
Consequently, a procedure has been developed for the evaluation stage of the storytelling workshops. The procedure will be added to the facilitator curriculum.

Digital Storytelling	FY 17/18	FY 18/19
Total clients served		47
Total cost per client		$1,163

SUCCESSES & CHALLENGES

- Youth at Menlo Park non-profit, Safespace, shared their experiences and lessons learned from coping with mental health challenges. Safespace works to educate and help young people advocate for better mental health services throughout their local schools and community. Stories include themes of hardship and resilience and include both youth and adult perspectives. Fun fact: this was the first **youth-led** and facilitated Photovoice workshop!
- The Storytelling program led a workshop to create San Mateo County's first-ever graphic novel about behavioral health. The Graphic Novel Photovoice was impactful because the stories shared are aimed towards clients and community members who are averse to other resources because graphic novels are very approachable and easy to read. Further, the workshop and advocacy were led by San Mateo County BHRS consumers.
- People in the Promotoras & Family Advocate program at Nuestra Casa shared their stories in response to the framing question, "What does Nuestra Casa mean to you?". The question, a double meaning of "our house" and name of the organization hosting the workshop, was an opportunity for people to share their stories with relevance to the federal issues on immigration. Stories include themes of mental health recovery, housing, and discrimination. Fun fact: this was the first Photovoice workshop facilitated in **Spanish**!

Unfortunately, the end of FY 18-19 brings the Storytelling Program closer to the end of the Storytelling Coordinator position. The next few months, the Storytelling Coordinator will work to solidify storytelling partnerships and develop a succession plan for Storytelling work to succeed once the position ends.

DEMOGRAPHICS

	FY 18/19
Age	

0-15	
16-25	36%
26-59	46%
60+	15%
Decline to state	2%
Primary Language	
English	62%
Spanish	30%
Cantonese	2%
Tongan	4%
Sex Assigned at birth	
Male	43%
Female	55%
Decline to state	2%
Sexual Orientation	
Gay, lesbian, homosexual	2%
Straight or heterosexual	36%
Bisexual	4%
Asexual	2%
Questioning or unsure	2%
Decline to state	12%
Gender Identity	
Male/Man/Cisgender	38%
Female/Woman/Cisgender woman	51%
Transgender male	2%
Genderqueer/nonconforming	2%
Decline to state	9%
Race/Ethnicity	
American Indian/Alaska Native/ Indigenous	2%
Asian	2%
European	9%
Black/African/-American	11%
White/Caucasian	21%
Asian Indian/South Asian	2%
Central American	11%
Chinese	9%
Mexican/Chicano	56%
Filipino	2%
Samoan	2%
South American	2%

Tongan	2%
Another race/ethnicity	11%
Disability/Learning difficulty	
Difficulty seeing	9%
Difficulty hearing or having speech understood	2%
Developmental disability	2%
Physical/mobility disability	6%
Chronic health condition	6%
Learning disability	11%
I do not have a disability	62%
Another disability	2%
Decline to state	13%
Veteran	
No	89%
Decline to state	10%

SUICIDE PREVENTION

The Suicide Prevention program aims to coordinate efforts to prevent suicide in the San Mateo County community. The primary program activities and/or interventions provided include:

1. Suicide Prevention Committee (SPC): The purpose of the SPC is to provide oversight and direction to suicide prevention efforts in San Mateo County. The SPC meets every month. The target population is a diversity of community partners, suicide survivors and the San Mateo County community at large. For 2018-2019, SPC focused on two projects (1) Suicide Surveillance and (2) Suicide Prevention Month.
2. September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how all have a role in preventing suicide. The 2018 SPM included a: (1) proclamation, (2) calendar of events, (3) communication campaign, (4) film screening and panel event and (8) other events hosted by community partners.
3. Suicide Prevention Training: Throughout the year, San Mateo County Behavioral Health and Recovery Services provides a variety of suicide prevention trainings, including:
    - Parenting Skills & Family Relationship Programs
        - Parent Project - Changing Destructive Adolescent Behavior (Adolescent)
        - Gatekeeper Trainings
    - Applied Suicide Intervention Skills Training (ASIST)
        - Mental Health First Aid - Adult and Youth
        - Question Persuade Refer (QPR)

    - Reconozca Las Señales (Spanish)
- Crisis Intervention Trainings
    - Crisis Intervention Training

In FY 17-18, the May Mental Health Awareness Month event had about 30 people in attendance. Number of clients served in FY 2018-19 is an estimated 1,500

SUCCESSES

A highlight of the suicide prevention program for 2018-2019 is that the September Suicide Prevention Month (SPM) featured an S-Word Film Screening & Panel event at the San Mateo High School Theater. There was a diverse panel (youth, older adult, parent, therapist) and over 100 people that attended. Hosting the event at the school was intentional because the San Mateo Union High School District experienced a cluster of suicides in September 2017.

Another highlight is also that the Suicide Prevention Committee's structure and membership is enhancing. For 2018-2019, SPC started meeting monthly and had 12 committee meetings with 150 people in attendance during the year.

CHALLENGES

Challenge 1 – Understaffed: About 20-25% of a full-time position is dedicated to coordinating suicide prevention for the County. There are high expectations for this position to run a coalition, facilitate strategic planning and action planning, coordinate events and coordinate trainings. This position gets some but not consistent/reliable support from (1) BHRS ODE/Communications staff, (2) SPC members and (3) co-chair from StarVista (who has limited capacity with their role as director of the crisis center).

- Potential Solutions:
    - Allocate more consistent staff time to support SPM and SP communications work
    - Limit scope of work for SP in SMC
    - Contract out communication campaign work
    - Utilize Each Mind Matters consultants

Challenge 2 –Balancing Interest of SPC Members and SP Roadmap Interests: The meetings are more information sharing and guest speakers and less about advancing the SP Roadmap. While there is limited time in each meeting, members are more interested in working on tangible, short-term projects, learning about resources and suicide death cases in the county.

- Potential Solutions:
    - Improve member engagement (e.g. action completed within meeting, assign action item for next meeting)

- Co-Chairs decide projects and then recruit members based on those projects
- Spend less time on information sharing
- Dedicate more meeting time to strategic planning, oversight and evaluation

Challenge 3 – Media Engagement: There's no longer SMC Health System support for communications, so there wasn't as much SPM communication promotion as previous years.

- Potential Solutions:
  - Get dedicated staff time outside of coordinator position to lead (not just support) communication campaigns throughout the year
  - Work with SMC Health Communications to do more with the press so the limited capacity of the SP coordinator can have more reach and impact
  - Contract out communication campaign creative planning and content creation, including hashtags and videos

EMOGRAPHICS

San Mateo county is in the process of determining a process to collect demographics on social media engagement, presentations and community-based partnerships.

INNOVATIONS (INN)

INNOVATIONS (INN)

INN projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a behavioral health practice or approach that is new; make a change to an existing practice, including application to a different population; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature). The State requires submission and approval of INN plans prior to use of funds.

The development MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process.

Current INN projects in San Mateo County include: The San Mateo County Pride Center, the Neurosequential of Therapeutics (NMT) in an Adult System of Care, and the Health Ambassador Program for Youth (HAP-Y). Please see Appendix 10 for full FY 2017-18 INN Evaluation Reports, the FY 2018-19 INN Evaluation Reports will be included in the next MHSA Annual Update. Below are some current FY 2018-19 Highlights.

THE SAN MATEO COUNTY PRIDE CENTER

The San Mateo County Pride Center (The Pride Center) is a formal collaboration of four partner organizations: StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership. The Pride Center also works collaboratively with the Pride Initiative of the Office of Diversity and Equity and the County of San Mateo LGBTQ Commission, co-sponsoring and consulting across many events, efforts and policy priorities. While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

FY 2018-19 Implementation Updates

The Pride Center continued to operate many of the programs, services, and events that Center staff and participants launched during the first year. These ongoing activities include:

- Providing psychotherapy services for individuals, groups, couples, and families
- Providing case management services
- Operating the Center as a “one-stop shop” and resource hub for LGBTQ+ community
- Hosting multiple peer support groups
- Operating Youth Programs, for participants ages 10 to 25
- Operating Older Adult Programs, for people ages 50 and older

- Running many different educational events, social activities, and community-based programs
- Training public agencies and private organizations on matters of sexual orientation and gender identity, both at the Pride Center and throughout the county
- Conducting year-round outreach across San Mateo County
- Partnering with other LGBTQ+ inclusive county events and programs

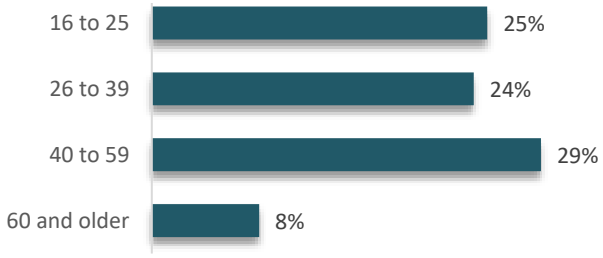
Pride Center Population Served

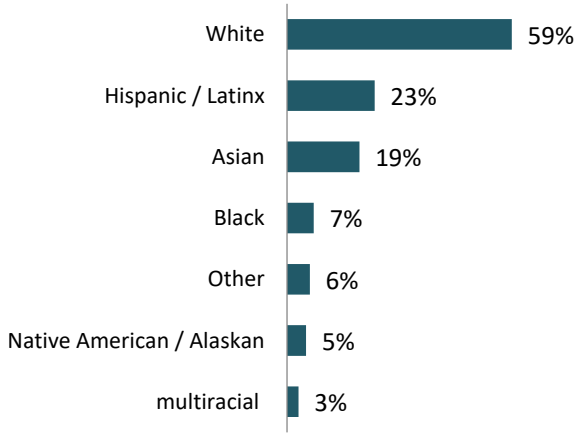
During the 2018-2019 program year, nearly 3,000 people accessed Pride Center programs, trainings, and services. This includes 1,213 unique individuals who completed a sign-in sheet onsite, and 1,526 people who participated in a training held by Pride Center staff.

During the program year, 88 people accessed psychotherapy services. As of June 30, 2019, 34 unique individuals were actively receiving clinical services. Among all participants who accessed therapy during the program year, the average duration of service was six and a half months. Among participants who had completed clinical services, the average duration of service was five months.

During FY2018-19, a total of 201 new participants completed the demographic survey.

Figure 1 Center Participants by Age (n=199)





Demographic Comparison

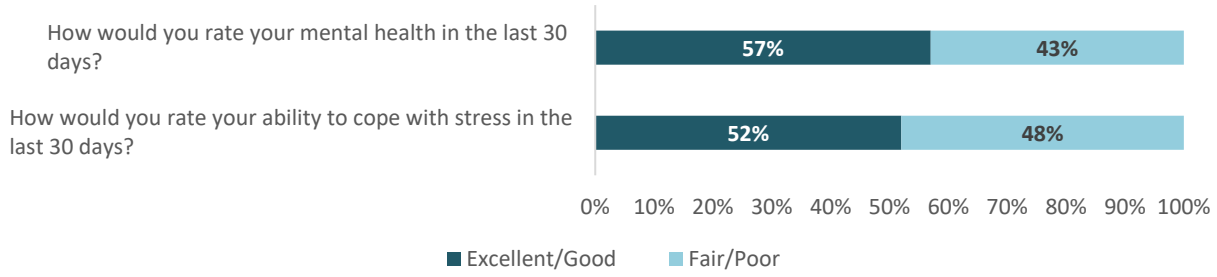
The table below highlights key differences and similarities between A) participants receiving clinical services in FY2018-19, and B) all participants from the Pride Center since inception. The comparison shows that among *clinical service participants,* higher proportions were children or transition age youth, transgender or gender nonconforming, and Latinx. Among *new participants*, higher proportions were children, male, and transgender women.

	A. Clinical Participants FY2018-19	B. All Pride Center Participants
Age	A **higher** percentage of clinical participants were age 25 or under.	A **slightly higher** percentage of new participants in FY18-19 were children ages 0-15.
Race	A **higher** percentage of clinical participants identified as Latinx/o/a, and a **lower** percentage identified as White.	The racial breakdown was generally the same for new FY2018-19 participants and participants across all years.
Sex at Birth	A **higher** percentage of clinical participants reported that they were assigned male at birth.	A **slightly higher** percentage of new participants in FY18-19 reported that they were assigned male at birth.
Sexual Orientation	A **higher** percentage of clinical participants identified as pansexual and a **lower** percentage identified as heterosexual.	**Slightly lower** percentages of new participants in FY18-19 identified as gay/lesbian or as heterosexual, and **slightly higher** identified as bisexual or pansexual.
Gender Identity	A **slightly higher** percentage identified as gender nonconforming.	A **slightly higher** percentage of new participants in FY2018-19 identified as transgender women, while a **slightly lower** percentage identified as cisgender women.

Clinical Services Baseline Data

The Client Self-Assessment asks clinical participants to rate how they felt about their mental health and their ability to cope with stress in the last 30 days.

Participants Initial Screening Experiences in FY 2018-19 (n=28)



NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT) - ADULTS

The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs.

While the NMT approach has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS is adapting, piloting, and evaluating the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

Implementation Updates

- **In FY18-19, BHRS began training two new cohorts of providers within the adult system of care, including NMT certification training (Phase I) and NMT Train-the-Trainer training (Phase II).** Phase I training began in January 2019 and includes 16 providers from the Adult System of Care.
- **As more providers are certified or begin NMT training, the volume of adult consumers participating in NMT services continues to grow.** During Year 3 of the pilot, 77 consumers were open to NMT services, compared to 40 in year 2 and 20 in year 1.
- **BHRS created and filled an NMT Program Specialist position to support NMT training and the NMT pilot.**

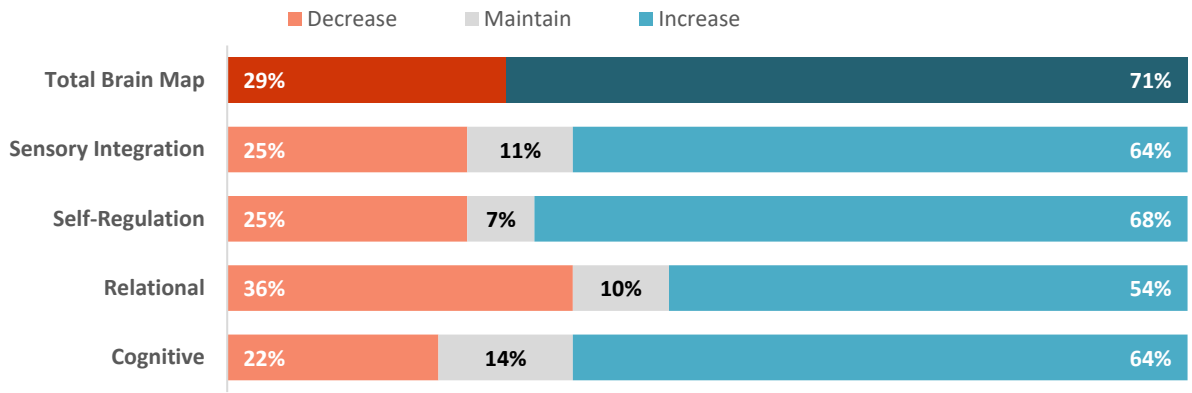
NMT Population Served

- **In FY18-19, 77 adult consumers were enrolled in NMT services, all of whom represent the target population.**
    - 27% (n=21) were transition age youth (TAY, ages 16-25)
    - 72% (n=56) were adults (ages 26+)
    - 36% (n=28) were part of the criminal justice re-entry population (including both TAY and adults)

Characteristic	Consumers	% of Total
Gender (N=77)		
Female	49	64%
Male	28	36%
Race (N=71)		
White	24	34%
Black or African American	5	7%
Asian/Pacific Islander	5	7%
Other Race	19	27%
Two or More Races	18	25%
Ethnicity (N=70)		
Hispanic/Latino	31	44%
Not Hispanic/Latino	39	56%

NMT Outcomes

Percent of Consumers with Increased and Decreased Assessment Scores, N=28



- **NMT is enhancing the consumer experience of care and improving recovery outcomes.** Compared to more traditional therapy, consumers generally appreciate the individualized approach of NMT and the alternative interventions. The interventions also appear to be supporting consumers to better understand, recognize, and/or cope with triggers and past experiences of trauma and are helping consumers to progress in their recovery.

- **NMT is helping create a more trauma-informed system of care.** NMT training and implementation continues to support NMT clinicians—and often providers who work with NMT clinicians—to implement a more trauma-informed approach to care with their caseloads and in their clinics overall. In particular, the Phase II training is supporting providers to take a more system-level approach and providers are examining how the NMT principles and interventions can be implemented more widely within their clinics or programs to create a more trauma-informed environment.

HEALTH AMBASSADOR PROGRAM FOR YOUTH (HAP-Y)

HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people. The HAP-Y Innovation project is the first to offer formal evaluation of a training designed for youth peer educators and its effectiveness and impact on community awareness and stigma, increasing access to mental health services for youth, and addressing systemic changes, as well as supporting youth ambassadors' wellness and recovery.

Implementation Updates

- **StarVista continued to expand HAP-Y into different areas of San Mateo County, ensuring a wider geographic representation of young people.** StarVista aimed to recruit students from parts of San Mateo County that had not been represented among the first three cohorts. Cohorts 4 and 5 both had a majority of Latina/o/x youths, several of whom noted the cultural and social barriers in their families that made mental health a taboo topic.
- **Ambassadors in Cohorts 4, 5, and 6 presented and spoke to over a thousand young people in a variety of school-based and community-based venues.** The ambassadors from Cohorts 4, 5, and 6 completed a total of 89 presentations during their time with HAP-Y.
- **StarVista staff recruited HAP-Y alumni to participate in additional peer education and speaking opportunities.** Some former HAP-Y program participants have maintained contact with StarVista staff, and during this program year StarVista began soliciting HAP-Y alumni to continue serving as panelists or speaking at community events when the opportunity arises.

Youth Ambassador Demographics

HAP-Y Ambassador Demographics for Cohorts 4, 5, and 6 (n=34)

Age: 100% of ambassadors were 25 or younger at the time of survey, with nearly all participants between the ages of 16 and 25.	**Language:** Almost all (94%) of ambassadors listed English as their primary language, or listed English along with another language.
Race: About two-thirds (68%) of participants identified as Latinx, and 26% identified as white. Most of Cohorts 4 and 5 were Latinx, and a slight majority of Cohort 6 participants were white.	**Ethnicity:** A majority of ambassadors (59%) were Mexican/Mexican American/Chicanx, including nearly all of Cohorts 4 and 5. No more than three youth identified with any other ethnicity.

Sex at Birth: 88% of ambassadors indicated that they were female at birth. Others were male at birth or declined to answer.	**Gender Identity:** Nearly all ambassadors (88%) identified as cisgender women at the time of survey, including all 14 members of Cohort 4.
Sexual Orientation: About two-thirds (68%) of ambassadors identified as heterosexual or straight, and 18% identified as bisexual.	**Education:** Nearly all (94%) of participants were in high school at the time of survey, including all members of Cohorts 4 and 5.

Building Youth Capacity

- **Participating in HAP-Y provides ambassadors with concrete tools and knowledge to support their own mental health and wellbeing, as well as help their peers and loved ones.** Because many HAP-Y ambassadors have lived experiences of mental health challenges, the program is well suited to help these participants build resilience and practice self-care.
- **Many HAP-Y ambassadors gain the self-assurance to speak up about difficult matters, and/or challenge other people's misconceptions about mental health.** HAP-Y participants reported some of the highest gains on the Self-Determination Survey for questions about confidence, self-esteem, and comfort with advocacy.

Enhancing Mental Health Knowledge and Decreasing Stigma

- **Most audience members found the HAP-Y presentations useful and expressed high levels of satisfaction with both the presentation and the presenters.** Many ambassadors presented to freshmen classes, and some expressed concern that some audience members may not yet have the maturity or life experiences to see the presentation as important.
- **Following the presentation, nearly all audience members reported that they knew where to access help for their mental health struggles.** The HAP-Y presentations provide concrete information about mental health resources available to young people in San Mateo County. Following the presentation, over 90% of audience members indicated that they now knew how to find mental health supports, or phone- or online-based services.

Increasing Youth Access to Mental Health Services

- **Many HAP-Y audience members indicated that the presentation had provided them with resources they could use in the future to seek support for themselves, family members, and/or friends.** Some audience members indicated that they were experiencing a mental health challenge and requested individual follow-up support from StarVista.

HELP@HAND (TECH SUITE)

With MHSOAC approval, San Mateo county began working on the Help@Hand, formerly Tech Suite, in September 2018 and joined the statewide County Behavioral Health Technology Collaborative along with 14 other city and county behavioral health departments. The Help@Hand project trying to discover if technology fits within the Behavioral Health System of Care. Innovative digital applications for smartphones and other mobile devices have great potential to empower consumers by engaging them as full partners in their behavioral health care, supporting self-care, and offering access to people who face barriers in working with a face-to-face provider. The project may discover technology does not work well within the Behavioral Health System of Care. If technology fits, it will be an incredible change in a positive direction. Listed below are some of the accomplishments in San Mateo County to-date.

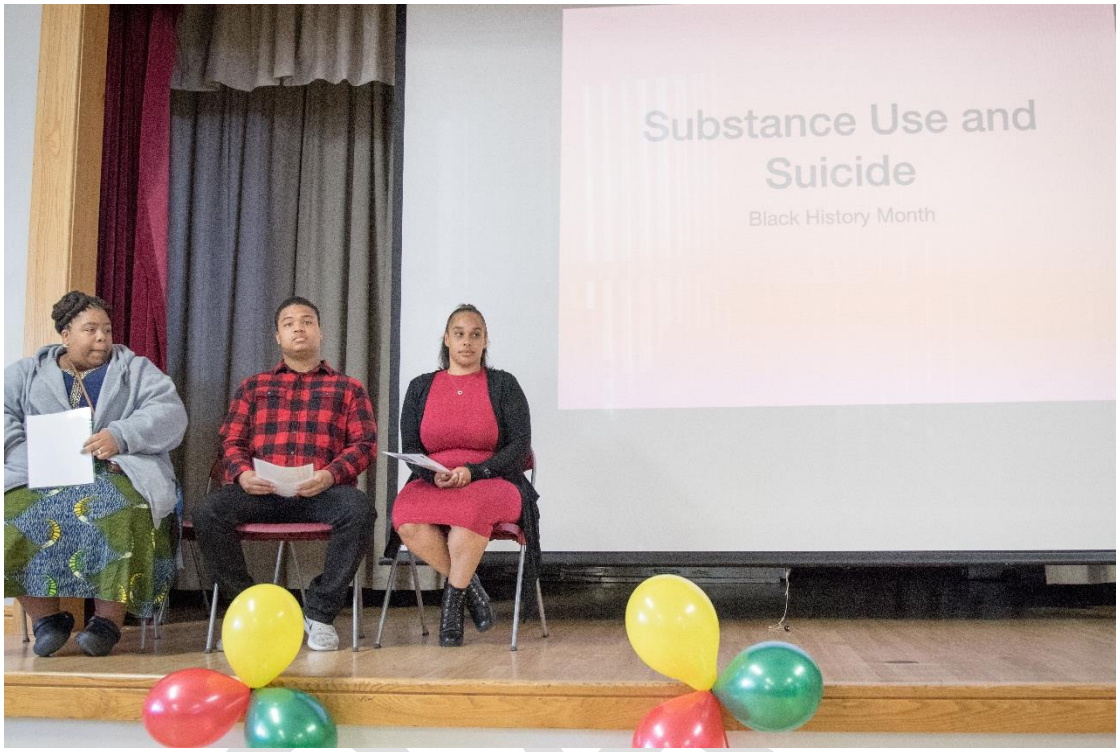
Project Benchmarks

Sep 2018	OAC approval of statewide County Behavioral Health Technology Collaborative
Sep 2018	Hired Extra Help Project Manager
Dec- Jan 2019	Request for Proposal (RFP) for Outreach and Engagement released
May 2019	Peninsula Family Service (PFS) awarded contract for Older Adult outreach and engagement services
Jul 2019	Youth Leadership Institute (YLI) awarded contract for transition age youth outreach and engagement
Jul 2019	PFS & YLI fully onboarded, begin developing focus groups in the community
Jul 2019	CalMHSA facilitates focus groups in San Mateo to develop specific digital health literacy curriculum
Oct 2019	San Mateo County hosts NorCal Peer Summit
Dec 2019	App demos and selection

Implementation Highlights

- 5 in-person statewide collaborative meetings since November 2018
- 13 local stakeholder Advisory Committee meetings held since Nov 2018, participation remains constant

- Weekly Leadership, Tech Lead and Project Implementation calls with CalMHSA and collaborative
- BHRS Director, Scott Gilman, participates in implementation day and orientation to Help@Hand, May 2019
- PFS hosts 27 AppyHours, engaging older adults in using technology
- YLI hosts a TAY focus group and begins developing a Help@Hand specific Youth Advisory Group
- SMC participates in Help@Hand Strategic Roadmap and Risk and Liability workgroup to develop collaborative structure and regulation
- Participated in testing of 7 Cups and decision to pursue a broader suite of technology apps
- Researched and recruited new vendors for CalMHSA Request for Service Qualifications (RFSQ)



WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION & TRAINING (WET)

WET exists to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers. WET was designated one-time allocation totaling $3,437,600 with a 10-year reversion period. In the spring of 2017, the BHRS Office of Diversity and Equity (ODE) hired an independent consultant to assess the impact of WET and identify priorities that would shape the future landscape. WET activities will continue to be funded by MHSA at $500,000 per year.

As part of the mission of the Office of Diversity and Equity, which is "…in collaboration with and for community members, the Office of Diversity and Equity (ODE) advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo county; the WET Team, informed by broader social justice and equity efforts, a wellness and recovery orientation and two advisory committees, strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the Behavioral Health and Recovery Services (BHRS) workforce, consumers/family members, and community partners.

There are several distinct populations served directly by the WET Team. The BHRS Workforce, people contracted by San Mateo county to provide behavioral health services, consumers and family members and subgroups of those populations actively participate in the program activities. For example, WET program areas such as the BHRS Clinical Internship/ODE Internship programs are implemented for Interns and other non-licensed/certified staff/community providers to gain knowledge and supervised professional experience in a local government setting. One of the broader objectives of the internship programs is to attract and retain a diverse workforce to better serve the San Mateo County communities.

As a program area of ODE, the WET Team also focuses on providing program activities that are in alignment with the best practices established by ODE and policies implemented by the County and this includes modeling the ODE Team values across the work. For instance, pronouns are disclosed when introducing ourselves at trainings and meetings. The WET Team program areas may be categorized into three broad areas. Training and Technical Assistance, Behavioral Health Career Pathways and WET Workplace Enhancement Projects. The annual

training plan and education sessions to provide up-to-date information on practices, policies and interventions approved for use in BHRS is an integral component of the Training and Technical Assistance area. Interns who have obtained an internship in one of the more than 20 clinic and program training sites can collaborate with the County's Health Equity Initiatives in the Cultural Stipend Internship Program which is supported by the Behavior Health Career Pathways program area. As part of the BHRS Workforce Enhancement Projects, the WET team was actively involved in the successful, inaugural BHRS Mentorship Program.

PROGRAM IMPACT

The WET Team of the Office of Diversity & Equity provides programs that build the capacity of the workforce, community providers, and consumers and family members. Primarily providing training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services, in their many forms provided by the county. Those communities include ethnic/racial communities, communities' members with limited English proficiency and member of the LGBTQ communities. However, there are sometimes barriers which may hinder the timely access. Some of those barriers might include lack of language services, lack of cultural humility, lack of knowledge of trauma informed care practices and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers, community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer lack of access to services or insufficient services. By attending some events as a constant presence, trust is built and communities are more likely to reach out when they or someone they know may need of services. Equity is a core principle in WET trainings.

- **Total number of WET Implemented/Supported trainings:** 98
- **Total number of Attendees:** 2460
- **Total number of ASIST/Suicide Prevention Trainings:** 8
- **Total number of Cultural Humility/Working with Interpreters/SOGI:** 22
- **Total number of Trauma/Resiliency Related Trainings:** 8
- **Total number of For/By Consumers & Family Members:** 1*
- **Total number of AOD/Integrated Behavioral Health:** 14
- **Total number of Health Disparities Trainings:** 2
- **Other**:** 39

*Many trainings are open to consumers and family members. Many consumers and family members attend the training that are not directly for or provided by them.

**Other trainings include: ABC's of Child Family Treatment(CFT), Crisis Response Team, (Clinical)Supervisors' Training, Internship orientation, Photovoice, BHRS New Hire Orientation,

Prevention & Management of Assaultive Behavior, Child & Adolescent Needs & Strengths (CANS) Training, and Law & Ethics for Behavioral Health Providers.

SUCCESSES

Two of the main initiatives for the 2018-2019 fiscal year were to implement Cultural Humility training for all BHRS staff and providers and to work toward a more integrated, cohesive BHRS by creating training opportunities that address the needs of the Clinical and Substance Use providers and consumers and family members. As a result, the Cultural Humility Cohort was expanded and significantly increased the number of training sessions offered across the county. Similarly, the most well attended and evaluated Law and Ethics trainings was offered. Attendees noted:

- "This course exceeded my expectations! I learned so many new things about myself through this experience and others."
- "The information given, the courage of vulnerability, the support, the patience and the encouragement."
- "The speaker's ability to connect detailed historical information to current day scenario"
- "all the real-life examples, made the material stick in my mind"

CHALLENGES

One of the greatest and most consistent challenges to implementing WET program activities is the lack of access to a central, no cost, high capacity training venue. This challenge has created training cancelations, increased program costs, and diminished effectiveness in reaching audit targets. The WET team has implemented several stop gap measures to mitigate the challenge, however a permanent solution would mitigate the impact.

HOUSING

HOUSING

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

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

Year	Housing Development and Location	UNITS
2009	Cedar Street Apartments 104 Cedar St., Redwood City	5 MHSA units 14 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	10 MHSA units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks	15 MHSA units 16 total units
2019	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
2019	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
		62 Total MHSA units

CAPITAL FACILITIES & INFORMATION TECHNOLOGY (CF/IT)

E-CLINICAL CARE

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

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

APPENDICES

APPENDIX 1. MHSA ANNUAL UPDATE MATERIALS & PUBLIC COMMENTS

(public comments will be added after the closing of the public comment period)

Mental Health Services Act (MHSA)

FY 19-20 Annual Update

Mental Health and Substance Abuse Recovery Commission (MHSARC)

December 4, 2019 / 3:30 – 5pm

www.smchealth.org/mhsa

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. MHSA Background
2. Annual Update – Program Outcomes
3. Program Highlight
   - Health Ambassador Program
4. Implementation Highlights
5. Action: 30-Day Public Comment
6. Announcements

MHSA – Prop 63 (2004)

1% tax on personal income over $1 M

$29.7M annual 5-year average for San Mateo County through FY 18-19

76%

Community Services & Supports (CSS)

Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19%

Prevention & Early Intervention (PEI)

Interventions prior to the onset of mental illness and early onset of psychotic disorders

5%

Innovation (INN)

New approaches and community-driven best practices

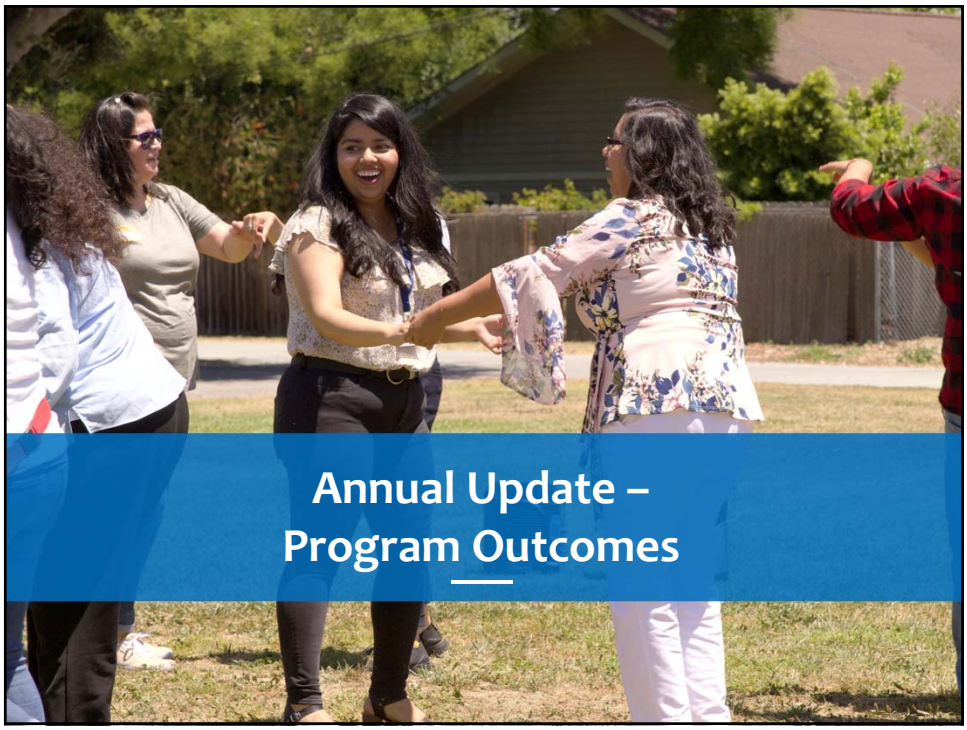
Workforce Education and Training (WET)*

Direct treatment and recovery services for serious mental illness or serious emotional disturbance

Capital Facilities and Technology Needs (CFTN)*

Direct treatment and recovery services for serious mental illness or serious emotional disturbance

*Up to 20% of the average 5-year CSS revenue can be allocated annually to WET, CFTN and prudent reserve.



Annual Update – Program Outcomes

Community Services and Supports

Full Service Partnership	Outreach & Engagement	System Development
14/15: 477	14/15: 6,328	14/15: 2,523
15/16: 516	15/16: 6,141	15/16: 2,047
16/17: 550	16/17: 6,073	16/17: 2,245
17/18: 479	17/18: 5,255	17/18: 2,415
18/19: 520**	18/19: 475**	18/19: 2,739**

**There are 447 available FSP slots across all age groups*

*** In FY 18/19*
- *50 AOT FSP slots were added*
- *Outreach Collaboratives were moved to PEI*
- *Senior Peer Counseling was expanded*

Full Service Partnerships (FSP)

(EHR data from inception, all age groups)

FY 17/18 (N=755)

- Hospitalization: 53% improvement (from 128 to 60 after first year in FSP)
- Psych Emergency: 31% improvement (from 175 to 121 after first year)

FY18/19 (N = 494)*

- Hospitalization: 49% improvement (from 166 to 85 after first year in FSP)
- Psych Emergency: 35% improvement (from 312 to 204 after first year)

Prevention and Early Intervention (PEI)

	Ages 0-25	Early Intervention	Prevention	Recognition of Early Signs of MI	Stigma & Discrimination Prevention	Access & Linkage to Treatment
FY 15-16	420	680 2,977 SMART calls	4,784	225	228	983
FY 16-17	482	724 2,657 SMART calls	4,831	247	272	1000
FY 17-18	338	1244 2,834 SMART calls	4,146	279	96	1,347
FY 18-19	501	925 2,579 SMART calls	4,409	179	152	6,764

Health Ambassador Program

Innovation Highlights

SAN MATEO COUNTY PRIDE CENTER

StarVista HAP-Y

NMT™ Adults

help @ hand™ CONNECTING PEOPLE WITH CARE

Implementation Highlights

MHSA Implementation Highlights

- Approval of Pride Center Extension
- Saved reverted Innovation dollars – Help@Hand (Tech Suite)
- Amended the Three-Year Plan to include Assisted Outpatient Treatment FSP's and Board and Cares
- Established a local MHSA Operational Reserve
- Developed a Plan to Spend for One-Time Funds
- Developed new Innovation projects

FY 17-18 to 19/20 Expansions

Component	Priority Expansions	Estimated Cost Per Fiscal Year	Implemented
CSS General Systems Development	Expansion of supports for older adults *	$130,000	YES – Partial Senior Peer Counseling
	Mobile mental health and wellness services to expand access to Coastside	$450,000	In Progress
CSS Outreach & Engagement	Expansion of culturally responsive outreach strategies	$50,000	YES Chinese community outreach
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	$50,000	YES Suicide Prevention mini-grants and Stigma survey
	Youth mental health crisis support and prevention	$600,000	In Progress
	After-care services for early psychosis treatment	$230,000	YES PREP/BEAM After Care Services

Public Comments

- **Public comment forms are available here**
  - Email: mhsa@smcgov.org
  - Phone: Doris Estremera, MHSA Manager (650) 573-2889
  - Mail: 310 Harbor Blvd, Bldg E, Belmont CA 94002.
  - Optional Public Comment Form available on line at www.smcgov.org/mhsa

Vote to open a 30-day public comment period for the MHSA Annual Update, fiscal year 2019-20

Thank you!

For more information: www.smchealth.org/MHSA
Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

APPENDIX 2. INNOVATION PROJECT PROPOSALS

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: Addiction Medicine Fellowship in a Community Hospital
Total amount requested: $591,650 ($471,000 services; $70,650 admin; $50,000 eval)
Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☐ Increases access to mental health services to underserved groups
- ☑ **Increases the quality of mental health services, including measured outcomes**
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Addiction Related Co-Occurring Conditions

Addiction to drugs and alcohol affects more than 23 million Americans and continues to rise.[1] Although addiction is the leading cause of preventable illness and death in the United States and contributes significantly to healthcare costs, only 10% of people with addiction receive any type of treatment, and far fewer receive life-saving medications. In San Mateo County, it is estimated that 30% (12,164) of emergency and psychiatric emergency visits and 18% (449) of hospital admission where by people with substance use disorders (SUD). According to the National Institute of Health, "multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa." Co-occurring substance use disorders are present in 40-50% of clients seen in our San Mateo County Edison Clinic for complex behavioral health and medical health related to HIV, as well as 95% of youth detained at the Youth Services Center. Addiction is highly prevalent in behavioral health and recovery clinics, correctional health and primary care and specialty clinics that treat behavioral health related conditions.

Primary Problem: Workforce Capacity to Address the Rising Addiction-Related Conditions

Addiction Medicine Workforce in the Public Sector

Now more than ever, with the opioid crisis, having addiction treatment is critical. The current addiction treatment workforce is severely under-equipped to meet the needs of the millions of Americans living with SUD. While San Mateo Health has made great strides in expanding treatment for addiction, many local providers have inadequate training in addiction medicine, and treatment sites are often siloed and in need of broader coordination and integration. In the entire San Mateo Health, including Behavioral Health and Recovery Services (BHRS), there are fewer than ten providers who prescribe medications for opioid use disorder, even though these medications cut the mortality rate in half. Our pain clinic had hopes of hiring an addiction specialist, but due to the inadequate number of such specialists, the position has remained unfilled for three years. It is hoped that an addiction medicine fellowship focused on co-occurring mental health and substance use disorders in a county/community setting would advance us towards the goal of providing high quality, coordinated treatment of addiction.

[1] Defining the Addiction Treatment Gap, Open Society Foundations (2010).

"Your [proposed] program is breaking new ground and demonstrating that all stakeholders are needed to address our state and national addiction medicine workforce needs."

- Executive VP at American College of Academic Addiction Medicine (ACAAM)

In San Mateo County, the largest need for addiction medicine expertise is in primary care where providers need to take on a greater share of treating people with co-occurring behavioral health and substance use conditions. Behavioral health and recovery staff and contractors work closely with primary care to support clients in their treatment. Ideally, once a primary care client is stabilized, they should be able to transition treatment back to their primary care providers, so that BHRS staff and contractors can continue to have the capacity for assessing and stabilizing new clients, as well as resuming care for destabilized clients; however, most primary care providers are not comfortable treating even our stable clients.

Addiction Medicine Fellowships prepare medical providers with the training they need to recognize and treat patients with substance use disorders. There are currently over 60 accredited addiction fellowships; all sponsored by academic centers, the Veterans Administration, and nonprofit organizations such as Kaiser Permanente. The very first 11 Addiction Medicine Fellowships in academic centers were the model for the rest. Having an Addiction Medicine Fellowship housed within a county government entity can be a model for all of California's 58 counties to train their respective workforce in addiction medicine specific for their populations.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

The proposed project is an accredited Addiction Medicine Fellowship sponsored by San Mateo County that is tailored to addressing the needs and priorities of the public sector including treating the most vulnerable communities with co-occurring substance use disorders, advancing equity on multiple levels and contributing to educational projects in clinical and community settings.

Addiction Medicine Fellowship

Addiction Medicine Fellowships are a promising approach for addiction treatment workforce development.[2,3] These fellowships are multispecialty training programs that focus on the provision of care for persons with unhealthy substance use, SUD and other addictive disorders. An Addiction Medicine Fellowship targets candidates from all the major medical fields, such as internal medicine, family medicine, emergency medicine, and psychiatry, which can provide Counties the flexibility to choose candidates depending on where the need is greatest at a given time. For example, one

[2] Rasyidi E, Wilkins JN, Danovitch I. Training the next generation of providers in addiction medicine. Psychiatr Clin North Am. 2012;35(2):461-80.

[3] Ayu AP, Schellekens AF, Iskandar S, Pinxten L, De jong CA. Effectiveness and Organization of Addiction Medicine Training Across the Globe. Eur Addict Res. 2015;21(5):223-39.

year a physician from family medicine may be accepted, and another year a physician from psychiatry. Fellowship graduates would add to the county and state workforce in addiction medicine, providing expert addiction care to our co-occurring clients and valuable consultation to colleagues.

It is estimated that the minimum number of addiction medicine fellowships needed to meet the projected need of addiction physicians in the U.S. is 125. Even this is small compared to other specialties--sports medicine, for example, has 235 fellowships. They were created out of recognition of addiction as a disease and that people with addiction are vastly underserved. There are Addiction Medicine Fellowships in the Bay Area offered through Stanford, Kaiser Permanente, and UC San Francisco area yet, the experience of a public sector sponsored fellowship will be fundamentally unique because of the larger system of care context. One of the core competencies of Addiction Medicine is Systems Based Practice[4]," which includes recognizing the multi-dimensional components of the systems required to reduce the incidence and impact of addiction and substance-related health conditions, among others. A public sector sponsored fellowship will immerse fellows in a unique system to which few if any fellows will get similar exposure. If Addiction Medicine is to impact public health, a fellowship in a public health system will provide significant impact.

Community-level opportunities and training

San Mateo County Health serves safety net populations and while other academic center-run fellowships have components that serve safety net populations, no other program would include on the ground, community services like a public health entity. In San Mateo County, one particular element, that is an example of this, is the elective "street medicine" experience with the homeless and farmworkers. Fellows will also be assigned to engage in at least one advocacy activity outside their usual work responsibilities that focuses on building opportunities for community change; examples include becoming a board member of a local substance use organization or speaking at a school-based mental health conference. This could be a training experience that could serve as a model for others.

Health Equity and Cultural Humility

The addiction medicine fellow would participate in structural humility and advocacy trainings including Cultural Humility 101, Sexual Orientation and Gender Identity (SOGI), and Working with Interpreters. The psychiatry residency program under which the fellowship would be housed is cutting-edge in its active teaching of structural humility and promotion of physician work to advance health equity on multiple levels. In addition to their clinical work with a diverse population, residents engage in learning sessions across disciplines (health providers, community workers, policy advocates) to review health disparities in our communities and find opportunities for intervention at the individual, institutional, and policy levels. These include a session on health disparities in San Mateo and Culturally and Linguistically Accessible Services (CLAS) standards, two sessions on health policy and advocacy and one session on NAMI with a consumer panel and then an experiential community engagement session.

[4] https://www.abam.net/become-certified/core-competencies/

Project implementation activities:

- Establish program infrastructure - letters of agreement with rotational sites for fellowship and schedules, faculty supervision, clinical competency committee, program evaluation committee, policies and procedures, etc.
- Startup activities - hire program coordinator, develop training materials, identify professional development opportunities, develop website content, secure office space and supplies, etc.
- Promote fellowship, review applications, interview and hire an Addiction Medicine fellow.
- The Addiction Medicine Fellow, will:
    - Provide a new Medication Assisted Treatment (MAT) consultation service in the hospital. This service will coordinate care with the Psychiatry consultation service. Engaging patients in the hospital will provide an early start to treatment and increase subsequent outpatient engagement.
    - Add to the workforce of the team providing integrated treatment of co-occuring addiction and mental health disorders within the primary care setting. This team has received over 3000 referrals since 2015.
    - Provide psychiatric and substance use disorder evaluations and treatment in the HIV Clinic and Pain Clinic, both of which have a high percentage of patients with co-occuring disorders. Currently these clinics over mental health treatment but lack expertise in treating co-occurring addiction.
    - Provide psychiatric and substance use disorder evaluations and treatment on the Street Medicine team, which treats both the homeless and farmworkers.
    - As an elective, assist with implementation of MAT in Correctional Health, where many inmates have co-occuring disorders.
    - Provide training in substance use disorders and co-occuring disorders to other providers and clinicians.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases the quality of mental health services, including measured outcomes**

C) Briefly explain how you have determined that your selected approach is appropriate.

Based on a comprehensive review of the needs in addiction-related conditions and treatment, the following key considerations were identified:

1. *Workforce capacity:* considering the current opioid crisis and the prevalence of co-occurring mental health and substance use conditions amongst behavioral health care clients, the current addiction treatment workforce is severely under capacity to meet the needs of co-occurring clients.
2. *County government context:* County services are on the ground in the community providing safety net services and early intervention. An addiction fellowship sponsored by the County should be developed to leverage these learning opportunities for fellows.
3. *Behavioral health equity and cultural humility:* core principles for behavioral health include cultural humility and advancing behavioral health equity. An addiction fellowship sponsored by the County will need to be integrated into the active teaching of structural humility and reducing health disparities.

These considerations are the supporting evidence for the proposed intervention and selected approaches for this project. Appendix 1. Theory of Change illustrates the pathways between these three key considerations, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

As mentioned earlier, in FY 2017-18, 30% (12,164) of emergency and psychiatric emergency visits and 18% (449) hospital admissions where by people with SUD. Additionally, 33% (4,950) of behavioral health clients were identified co-occurring but it is believed that it is more likely 60-80% of behavioral health clients (15,000) are co-occurring. Based on current San Mateo County outpatient visits and consultation with other Bay Area fellowship directors, the expected impact is as follows:

- 1,400 combined initial evaluations and follow-up visits per year
- Increase engagement with outpatient care after hospital discharge
- Decrease visits to Emergency Department and Psychiatric Emergency Services
- Decrease hospital admissions
- Decrease alcohol, tobacco, and illicit drug use (measured by self-report and urine drug screens)
- Improved mental health (measured by mood and anxiety scales)

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

BHRS offers services primarily for individuals who are eligible for Medi-Cal or Medicare, as well as to those individuals of the safety net population who are not eligible for Medi-Cal or Medicare. BHRS provides services to approximately 15,000 individuals annually. Of those individuals referred to our Integrated Medication Assisted Treatment program in 2016-2017, 77% identified as male, 23% as female; 50% were White, 38% Hispanic, 6% Black, 2% Asian, and 4% Other; Primary language was 80% English, 17% Spanish, 3% Other; 25% were homeless. At the integrated primary care outpatient clinic where the fellow will practice, 85% are Hispanic.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

This Addiction Medicine Fellowship would be the first to be sponsored by a County entity. The key differences with the proposed project are as follows:

- Sponsored and fully implemented within a County government entity to develop specific workforce capacity and skills, increasing access to treatment.
- Experiences and expectations of the fellows are integrated within the context and priorities of behavioral health. For example, fellows can collaborate with street medicine to provide treatment to farmworkers, fellows will be expected to participate in one advocacy activity and health disparity learning sessions.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

The literature review identified research gaps on these subjects and areas of focus for this project.

Gaps in the literature and practice	Proposed intervention
A review of the list of accredited addiction medicine fellowships in the US reveals none housed in a county entity. Correspondence with Executive Vice President of Academic College of Academic Addiction Medicine (ACAAM) ,(formerly The Addiction Medicine Foundation (TAMF), confirmed we would be the first addiction medicine fellowship housed in a county entity.	The proposed project would create an addiction medicine fellowship in our county health system, housed under our community psychiatry residency program.
A more in-depth review of the fellowship rotations reveals a lack of on the ground community services and health equity intervention experiences. • Stanford Psychiatry outpatient clinics do not accept Medi-Cal or our locally funded health care program for low-income adults. • The UCSF fellowship serves safety net patients but accepts candidates only from Internal Medicine and Family Practice, not Psychiatry. • Kaiser rotations are within the Kaiser hospital and clinics. • The VA fellowship accepts only Psychiatry candidates and the rotations are within the Veterans Administration system, Kaiser, and Alta Mira (a private treatment center).	The proposed project will provide the fellows with the context and priorities of community behavioral health. For example: • Elective "street medicine" experience with the homeless and farmworkers • advocacy activity such as becoming a board member of a local substance use organization or speaking at a school-based mental health conference • review of local health disparities and identify opportunities for intervention

Links used to gather information:

- https://www.abam.net/
- https://www.asam.org/
- https://www.acgme.org
- https://www.abam.net/become-certified/core-competencies/
- https://www.acaam.org/wp-content/uploads/2019/08/Fellowship-Directory-8-2-19.pdf

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Learning Goal #1

- Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity and skills in terms of coordination and integration of addiction treatment?

Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government entity engage fellows in community and/or advocacy opportunities?

Learning Goal #3

- Does an addiction medicine fellowship within a cultural humility structure increase access to diverse minority clients?

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

As stated prior, the two key differences with the proposed project include:

- Sponsored and fully implemented within a County government entity to develop specific workforce capacity and skills. *(Learning Goal #1)*
- Experiences and expectations of the fellows are integrated within the context and priorities of behavioral health. *(Learning Goal #2 and #3)*

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

- Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity and skills in terms of coordination and integration of addiction treatment?

The outputs for Learning Goal #1 could include:

- Number co-occurring clients served
- Number of co-occurring client visits per month
- Percent improvement as measured by\
  - Decreased hospitalizations
  - Decreased ED/PES visits
  - Increased engagement in outpatient care (# visits)
  - Decreased alcohol, tobacco, and drug use (self-report and drug screens)
  - Improved mental health (mood and anxiety scales)
  - Qualitative survey of other providers in contact with fellow

Additionally, demographics of participants and quality of life indicators can be collected at intake. Key interviews with addiction treatment providers and staff that typically support the providers with substance use treatment

Learning Goal #2

- Does an addiction medicine fellowship sponsored by a County government entity engage fellows in community and/or advocacy opportunities?

The outputs for Learning Goal #2 could include:

- Number of community opportunities and types that fellows participate in

Additionally, interviews with fellows can help us determine the level of engagement, the level of confidence in impacting community, policy, etc. and satisfaction with the fellowship.

Learning Goal #3

- Does an addiction medicine fellowship within a cultural humility structure increase access to diverse minority clients?

The outputs for Learning Goal #3 could include:

- Number of completed trainings by fellows and titles
- Number of learning sessions attended by fellows
- Pre/post knowledge, attitude, behavior questionnaire for fellows
- Demographics of clients served
- Client satisfaction

Additionally, the interviews with the fellows can also include questions related to training (learnings, satisfaction, etc).

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Services will be provided in-house except for evaluation. All BHRS service agreements/contracts are monitored by a BHRS Manager. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The planning and implementation of the fellowship would bring together stakeholders from all parts of the system in order to provide both state of the art training for the fellow and addiction treatment for our clients.

B) Cultural Competency

The training context for fellows will include cultural humility and health equity concepts. This will support culturally responsive services for some of the most vulnerable clients.

C) Client/Family-Driven

Client recipients of services will be driving the services provided. Clients and family members will be engaged in an advisory capacity. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from an advisory group made up of clients and family members. The Mental Health Substance Abuse and Recovery Commission Adult Committee, which is made up of clients, family members and providers will be an ideal resource for this role.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project, addiction medicine believes that people can recover and supports individuals through their recovery.

E) Integrated Service Experience for Clients and Families

Pre-launch planning will be critical to offering an integrated service experience for recipients. Fellows will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of improving the quality of services for individual with co-occurring conditions, and there is availability of MHSA Community Services and Supports, General Systems Development funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing MHSA funding. A sustainability plan will be developed.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Addiction Medicine
- Addiction Medicine Fellowship
- County Addiction Medicine Fellowship

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – establish letters of agreement with rotation sites, finalize schedules, identify faculty supervision, clinical competency committee, program evaluation committee, policies and procedures, etc.

July 1, 2020 – September 30, 2020

- Hire Program Coordinator to oversee the program
- Startup activities - developing training materials, identifying professional development opportunities, developing website content, securing office space and supplies, etc.
- Promote fellowship, review applications, interview and hire an Addiction Medicine fellow.
- Evaluator to meet with advisory group, evaluation committee and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Evaluation plan finalized including data collection and input tools

January 1, 2021 – March 31, 2021

- Onboarding of Fellow #1- orientation, pre-training assessment, training, etc.
- Rotations for Fellow #1 begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to evaluation committee for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.

April 1, 2021 – June 30, 2021

- Recruitment of Fellow #2
- Ongoing tracking Fellow #1 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- 6-month review of Fellow #1 by Clinical Competence Committee

July 1, 2021 – September 30, 2021

- Qualitative data collection begins (interviews, focus groups, etc.)
- Onboarding of Fellow #2 - orientation, pre-training assessment, training
- Rotations for Fellow #2 begin
- Ongoing tracking Fellow #1 and Fellow #2 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Continue data collection, evaluation quarterly reports to request input and determine adjustments, as needed

October 1, 2021 – December 31, 2021

- 6-month review of Fellow #2 by Clinical Competence Committee end of Nov
- Annual review of Fellow #1 by Clinical Competence Committee in December
- Graduation of Fellow #1 in December
- Continue data collection, evaluation quarterly reports to request input and determine adjustments, as needed
- Sustainability planning begins

January 1, 2022 – June 30, 2022

- Continue sustainability planning
- Ongoing tracking Fellow #2 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Annual review of Fellow #2 by Clinical Competence Committee in June
- Graduation of Fellow #2 in June
- Recruitment of Fellow #3
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds

- Onboarding of Fellow #3 in July with orientation, pre-training assessment, training
- Rotations for Fellow #3 begin
- Ongoing tracking Fellow #3 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- 6-month review of Fellow #3 by Clinical Competence Committee end of Nov
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Ongoing tracking Fellow #3 performance, faculty development, achievement of program objectives by Program Evaluation Committee
- Annual review of Fellow #3 by Clinical Competence Committee in June
- Graduation of Fellow #3 in June
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 3.9 years is $663,125.

Personnel Costs will total $480,000
- Fellow - $85,000
- Program Director - $60,000
- Supervisor - $18,000
- Program Coordinator - $14,000

Direct Costs will total $46,500 over 3 years and includes insurance, conferences, supplies, equipment, and travel/mileage. $10,000 per year is also included as faculty support compensation.

Indirect Costs will total $136,625
- $50,000 for the evaluation contract for 3.5 years given the final report will be due by December 31, 2023. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $86,625 for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

Federal Financial Participation (FFP) anticipated FFFP will total $51,000.

Other Funding N/A

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries		$126,000	$194,000	$160,000		$480,000
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**		**$126,000**	**$194,000**	**$160,000**		**$480,000**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs		$15,500	$15,500	$15,500		$46,500
6.	Indirect Costs (15% Direct Costs)	$14,438	$28,875	$28,875	$14,437		$86,625
7.	**Total Operating Costs**	**$14,438**	**$44,375**	**$44,375**	**$29,937**		**$133,125**
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs						
12.	Indirect Costs		$15,000	$15,000	$15,000	$5,000	$50,000
13.	**Total Consultant Costs**		**$15,000**	**$15,000**	**$15,000**	**$5,000**	**$50,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)			$126,000	$194,000	$160,000		$480,000
Direct Costs (add lines 2, 5 and 11 from above)			$15,500	$15,500	$15,500		$46,500
Indirect Costs (add lines 3, 6 and 12 from above)		$14,438	$43,875	$43,875	$29,437	$5,000	$136,625
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$14,438**	**$185,375**	**$253,375**	**$204,937**	**$5,000**	**$663,125**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative	$14,438	$170,375	$238,375	$189,937		$613,125
2.	Federal Financial Participation		$8,500	$25,500	$17,000		$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$14,438**	**$178,875**	**$263,875**	**$206,937**		**$664,125**

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds		$15,000	$15,000	$15,000	$5,000	$50,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$15,000**	**$15,000**	**$15,000**	**$5,000**	**$50,000**

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Innovative MHSA Funds	$14,438	$185,375	$253,375	$204,937	$5,000	$663,125
2.	Federal Financial Participation		$8,500	$25,500	$17,000		$51,000
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$14,438**	**$193,875**	**$278,875**	**$221,937**	**$5,000**	**$714,125**

*If "Other funding" is included, please explain.

Appendix 1. Theory of Change

Theory of Change

Primary Problem: Workforce Capacity for Rising Co-Occurring Addiction-Related Conditions

Key Considerations

Workforce Capacity
The current addiction treatment workforce is severely under capacity to meet the needs of co-occurring clients

County Government Context
County services are on the ground in the community providing safety net services and early intervention

Behavioral Health Equity and Cultural Humility
Core principles for behavioral health include cultural humility and advancing behavioral health equity

Interventions

Addiction Medicine Fellowship
Behavioral Health and Recovery Services will sponsor an addiction medicine fellowship to develop workforce capacity in addiction medicine.

Community Opportunities
Fellows will receive on the ground, community opportunities like the elective "street medicine" that serves farmworkers. This could be a training experience that could serve as a model for others.

Health Equity Training
Fellows will engage in structural humility and health equity training including learning sessions across disciplines (health providers, community workers, policy advocates) to review health disparities

Outcomes

Clients Reached
- **1,400** combined initial evaluations and follow-up visits per year
- Increase engagement with outpatient care after hospital discharge
- Decrease ED/PES visits and hospital admissions
- Decrease alcohol, tobacco, and illicit drug use
- Improved mental health

Community Engagement
5 community opportunities the fellow participates in

Training and Impact
3 completed equity trainings by each fellow (Cultural Humility 101, SOGI, Working with Interpreters)
5 learning sessions attended by each fellow (Health Disparities in SM, CLAS, health policy and advocacy, NAMI)

Learning Objectives

Learning Goal #1
Does an addiction medicine fellowship sponsored by a County government entity improve workforce capacity in terms of coordination and integration of addiction treatment?

Learning Goal #2
Does an addiction medicine fellowship sponsored by a County government entity engage fellows in community and/or advocacy opportunities?

Learning Goal #3
Does an addiction medicine fellowship within a cultural humility structure increase access to diverse minority clients?

MHSA INN Primary Purpose

Increases the quality of mental health services, including measured outcomes

Appendix 2. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSA Steering Committee.

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

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

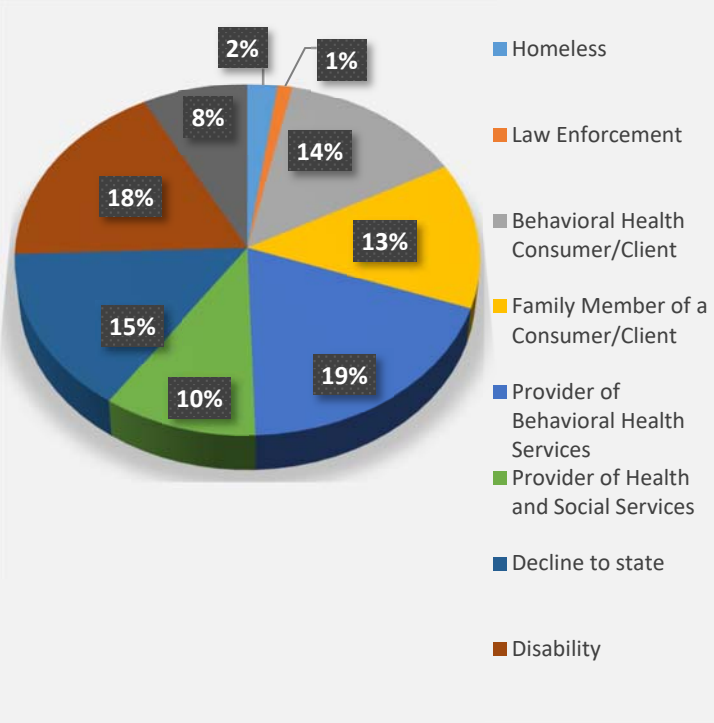
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers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

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

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

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

Represented Groups



Input Sessions

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

PHASE 1. NEEDS ANALYSIS

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

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

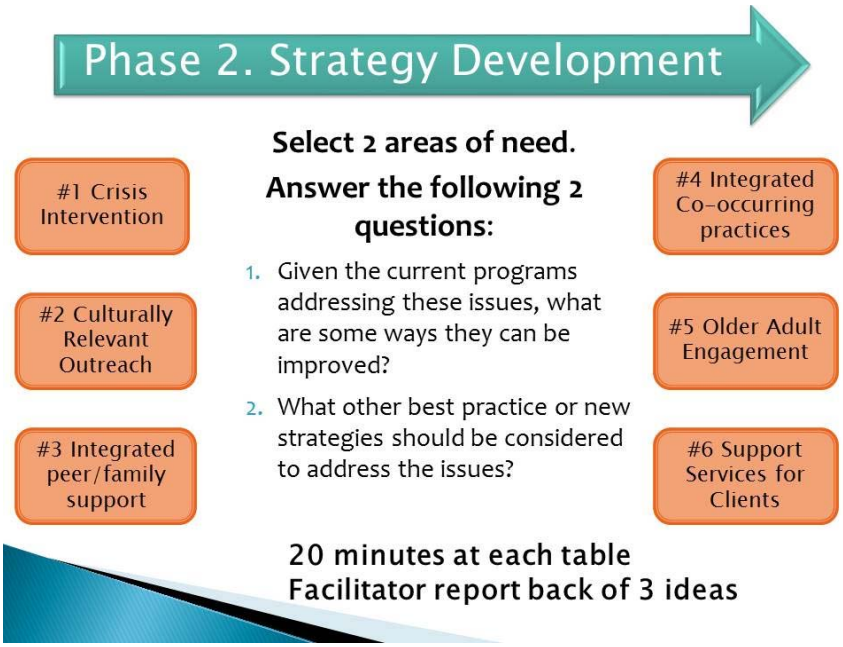
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

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

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

PHASE 2. STRATEGY DEVELOPMENT

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



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

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

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

PHASE 3. PLAN DEVELOPMENT

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

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

Appendix 3. Public Comments

[To be updated following the 30-day public comment process]

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: PIONEERS (Pacific Islanders Organizing, Nurturing and Empowering Everyone to Rise and Serve) program
Total amount requested: $925,000 ($750K services; $100K admin; $75K eval)
Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Native Hawaiian/Pacific Islanders in San Mateo County

Communities of color represent 61% of San Mateo County's population and yet continue to be disproportionately impacted by negative health outcomes. Native Hawaiian/Pacific Islanders (NHPI) in San Mateo County (11,543)[1] account for the largest NHPI population in the Bay Area and are anticipated to double in size by 2040. Addressing behavioral health inequities impacting the NHPI community in a culturally relevant manner, is a priority. The NHPI community values family, church and community. Interconnectedness plays a central role in NHPI identity and yet they are often excluded from societal benefits as they experience some of the highest disparities across various health indicators. In San Mateo County:

- Specialty mental health service penetration rates are lowest for both youth (1.8%) and adult (2.6%) Asian/Pacific Islander racial group[2]. In fiscal year 18/19, our Behavioral Health and Recovery Services (BHRS) served 260 NHPI.
- NHPI youth in San Mateo County schools (grade 9, 11) reported the highest rates of depression related feelings and seriously considered attempting suicide in the previous year.[3]
- Pacific Islanders have one of the highest rates of uninsured at 19.8%[4].

The Mental Health Services Act is explicit in the legislation that developing culturally relevant strategies for underserved populations is a priority. This was core to the California Reducing Disparities Project (CRDP) project, an MHSA Prevention and Early Intervention (PEI) State funded project and the largest investment in the nation to look into diverse community perspectives on mental health disparities. Most recently, the MHSOAC initiated Youth Innovation Project shared findings from their youth focus groups and online surveys. Not surprisingly, lack of cultural competence was identified as a priority along with increasing preventative mental health services in schools.

Primary Problem: High rates of depression and suicidality amongst NHPI college youth

[1] U.S. Census Bureau, 2018 estimates, https://www.census.gov/quickfacts/sanmateocountycalifornia

[2] Performance Outcomes Adult Specialty Mental Health Services Report, March 22, 2018, https://www.dhcs.ca.gov/provgovpart/pos/. Penetration rates are calculated by taking the number receiving services and dividing by total Medi-Cal eligible.

[3] Lucille Packard Foundation for Children's Health, Kidsdata.org

[4] Advancement Project California; RACE COUNTS, racecounts.org, 2017.

College Mental Health

College-aged youth are a critical group to engage in behavioral wellness and broader community impact. Many college students experience first onset of mental health and substance use issues during this time.[5] Three out of five college students experience overwhelming anxiety[6] yet, few seek services. This is exacerbated for youth from vulnerable cultural/ethnic families. Studies have found that students of color experience higher levels of mental health difficulties due to racial discrimination, stigma, tendency to not engage in help-seeking behaviors and lack of culturally relevant support services[7]. There is an association between mental health challenges and lower academic achievement and higher dropout rates, especially for ethnic/cultural minority groups. Among Pacific Islanders, 47% of Guamanians, 50% of Native Hawaiians, 54% of Tongans, and 58% of Samoans entered college, but leave without earning a degree.[8]

NHPI make up 1.7% (484) of the San Mateo District Community College student enrollment[9]. Specifically, for NHPI students, the gap between accessing behavioral health services on campus is the expectation that they would access services because they are in need - experiencing a challenge, crisis, or trauma. NHPI's associate individuals with mental illness or mental health issues as sick or demon-possessed. Seeing a counselor, therapist, or psychiatrist seems like such a foreign concept therefore is unheard of because many NHPI's are extremely rooted in their faiths; they believe serving God and prayer are the cures for healing. This highly emphasized stigma forces the need for NHPI students to internalize their emotions and get over it, instead of being taught the benefits of emotional well-being.

A college and community-based culturally relevant prevention program can lead to improved behavioral health outcomes for NHPI youth.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

The proposed project, Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) provides a culturally relevant, college behavioral health program for NHPI youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy.

[5] National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
[6] American College Health Association, National College Health Assessment, https://www.acha.org/
[7] National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
[8] U.S. Census Bureau. American Community Survey Reports, 2010. The National Commission on Asian American and Pacific Islander Research in Education.
[9] California Community Colleges, Student Success Metrics, https://www.calpassplus.org/LaunchBoard/Student-Success-Metrics.aspx

College behavioral health services

The PIONEERS program will be offered on-campus by a community-based behavioral health provider to support linkages to direct treatment for youth who may need it. The CalMHSA Student Mental Health Program (SMHP), a statewide PEI initiative funded by MHSA, set out to improve student mental health across all 114 community college campuses, awarded 30 campus-based grants to expand and enhance the capacity to address the mental health PEI needs of their students, faculty, and staff. A formal evaluation of these programs by RAND Corporation found that campuses are in critical need of direct services and referrals to county and community agencies are often met with limited (or temporary) resources.

The proposed project will develop a new partnership between San Mateo County Community Colleges, Behavioral Health and Recovery Services and community-based behavioral health providers, which will be core to supporting a much needed service on campuses.

Cultural responsiveness

Two identified barriers to accessing care for NHPI college students are 1) mental health stigma and 2) the cultural competence and cultural humility necessary to work with NHPI students regarding mental health. Educating the campus about suicide, mental illness, and mental health cannot be a cookie-cutter approach; educating the campus about all things mental health must be equitable and relevant to the population served.

The three local campuses of the San Mateo County Community College District (SMCCCD), Skyline College, College of San Mateo, and Cañada College, were examined to determine the level of mental health services and resources available to students on campus. Each campus had standard personal counseling offices staffed with licensed mental health professionals. All three campuses clearly defined that students need to make an appointment, counseling sessions are brief, and are limited to the academic calendar. Each campus had different resources available: drop-in center; wellness center; mental health peer educators; and educational trainings and workshops. Not one campus had any specific efforts on campus focused on vulnerable ethnic populations. The closest program was a peer-to-peer support service offered at College of San Mateo. The services and resources are open to all and do not focus on any specific ethnic group.

Based on research outside of San Mateo County, Universities in California offer more mental health resources. California State University, Long Beach has a program called Project OCEAN (On-Campus Emergency Assistance Network) that was federally funded by Substance Abuse and Mental Health Services Administration (SAMHSA) between 2008-11, MHSA PEI funded through CalMHSA between 2012-14 and was permanently institutionalized in 2014 through Student Affairs based on impact of the program. Project OCEAN's is a peer education program that supports the mental health concerns of all students.

The CalMHSA SMHP initiative made significant momentum around stigma reduction and mental health awareness on college campuses, and yet, the programs did not look at cultural disparities and needs of some of the most vulnerable youth.

The proposed project was developed by the BHRS Office of Diversity and Equity, Pacific Islander Initiative with culture responsiveness at the core and throughout each phase of the project and community input in the process. Understanding and supporting cultural identity is critical for college youth mental health.[10] A variety of studies show that ethnic minority college students may have fewer indirect experiences with help-seeking, such as knowing family members or close friends who have sought professional psychological services; may perceive on-campus psychological services as irrelevant and not culturally competent; and may not perceive health service utilization as an established cultural practice. The PIONEERS program will include culturally focused strategies with the goal of participants developing protective factors for NHPI youth as they understand cultural and mental health connections and develop leadership skills.

Leadership and community advocacy

Individual focused behavioral health prevention programs alone can develop protective factors for youth and linkages to needed behavioral health supports. A comprehensive approach integrating social and community-level strategies can have an exponential impact on behavioral health outcomes.

It is well documented that improving behavioral health outcomes requires broader approaches that consider social determinants of health including community and social context (social integration, support systems, community engagement). Pertinently, the NHPI community embraces a collectivist culture, a prevention approach that integrates NHPI youth leadership and giving back to their communities, especially given the broad health disparities impacting NHPI, is not only smart practice but culturally relevant.

Based on final research outside of the United States, there is a plethora of mental health content for NHPI in Aotearoa/New Zealand. Le Va (www.leva.co.nz). Le Va is ran by NHPI professionals who prioritize mental health, provide education and trainings for the NHPI community on how to work with the NHPI community, and build the capacity of NHPI's to thrive in the health and disability workforce. There is nothing like Le Va that exists in the U.S. for NHPI's.

The proposed project (PIONEERS Program) will consist of 3 key components:

PIONEER INSTITUTE

- 5-day PIONEER program provides cultural education alongside discussions and discoveries of self, identity, history, community, mental health, issues, institutions, policies, and other topics that develop young leaders' knowledge, skills, and network.

[10] Srivastava, R., & Srivastava, R. (2018). Impact of Cultural Identity on Mental Health in Post-secondary Students. *International Journal of Mental Health and Addiction*, *17*(3), 520–530. doi: 10.1007/s11469-018-0025-3

- Some of the topics addressed in the 5-day PIONEER curriculum may include:
  - **Lifelines:** Pacific Islanders' lineage a common history and more importantly share genealogy with one another. This connectedness is foundational to the way Pacific Islanders relate to one another, a bond that predates Western interruption. As communities continue to grow in the United States, they are also dispersed across the country diminishing bonds that once held families and nations together. Sharing one's journey and story is the first step to learning about one another and sparking warmth that can only be reignited when embracing kin.
  - **Migration Stories:** The exploration of the current state of the Pacific Islander community in the United States needs to start with the genesis of the community in this country. That starts at the inception of the idea to cut the umbilical cord from the motherland in the pursuit of a greater source of life for future generations. The stories of the migrant generation hold the visions that brought them thousands of miles across the ocean; stories, and therefore visions, that are nearly lost on the current generation of Pacific Islanders. Hearing these stories breathe life back into these visions as parents and elders pass these stories to the students. Allowing students time to share their story with their peer, then visualize it on paper, gives them time to think more deeply about their individual story while drawing a bond with their peer's journey. The process of comparison automatically sets the stage for contrasting the visions in their stories to their current experiences. This prepares students' minds for further exploration of issues in the Pacific Islander communities.
  - **Community Memberships:** Part of understanding oneself is to understand where we belong and that isn't limited to our families. Belonging is wherever we place ourselves in any given situation at any given time. These assignments are determined by personal values and belief systems. These groupings are often socially constructed according to societal expectations and norms. Understanding where we assign ourselves; how we prioritize those assignments; and recognizing the privileges and constraints that they come with affords a greater understanding of others while opening up the possibilities for acceptance and embrace of those different from ourselves.
  - **Power of Resistance:** Leaders like Nat Turner, Sojourner Truth, and Marcus Garvey resisted and revolted against the disdain of Black people by White oppressors. Nat Turner was the first slave to lead a rebellion; Sojourner Truth escaped slavery and became an abolitionist; Marcus Garvey was a Black Nationalist. These leaders paved the way for future leaders such as Dr. Martin Luther King, Jr., Malcolm X, and Angela Davis. As Pacific Islanders, our people suffered oppression through colonization of our homelands. Many of our islands were occupied by military forces, used for atomic bomb testing, or stolen for its natural resources. Resistance has been something our ancestors demonstrated even before migrating to the United States. When Hawaiian language was banned in 1896, Queen Liliuokalani and the Hawaiian people snuck letters to each

other written in Hawaiian language wrapped in flowers; when Lauaki Namulauulu Mamoe established the Mau a Pule, a resistance group against German rule, he was exiled from his homeland to Saipan; when Tupua Tamasese led a peaceful march in Samoa, he was killed by German forces. Leaders of our islands understood the necessity of having a voice, the power in organizing and standing together, the importance of resisting what they felt was wrong! Many died in the resistance that is now part of our legacy as Pacific Islanders in this country.

- **Mana Room:** Mana is a term used in Polynesia, Melanesia, and Micronesia that is the foundation of our world view. Mana is a form of spiritual energy; healing energy; powerful energy; a sacred force existing in the universe. Mana is positive energy transmitted through land, the environment, sacred objects, and people.

MANA SESSIONS

- PIONEER Mana Sessions are provided once a month in the fall. These sessions provide safe space to decompress, engage in group discussions centered around mental health and wellness, and skills building workshops.

FORWARD MOVEMENT PROJECTS

- Identify opportunities to give back or be of service to their community; lead workshops and discussions with high/middle school students and the broader community. Apply knowledge acquired from PIONEERS to determine what students' needs are, develop workshops, and provide it for them.

The PIONEERS program will increase access to behavioral health services for NHPI college-aged youth by 1) addressing mental health challenges 2) increasing awareness about the importance of emotional health; 3) building the capacity of NHPI advocates for behavioral health; and 4) improving culturally competent services and treatment for NHPI students on college campuses.

Project implementation activities

- Hire NHPI staff that have experience and rapport serving the NHPI community in San Mateo County and represent the different neighborhoods across the county with high NHPI population
- Recruit advisory circle of NHPI college-age youth and the Pacific Islander Initiative to inform the final program curriculum, activities, outreach strategies, etc.
- Work with the advisory circle to finalize the PIONEERS program
- Work with faculty and campus staff to set up the program schedule and get any infrastructure needed in place prior to launch
- Identify potential community opportunities and NHPI leaders and partners to support college-age youth in their forward movement project
- Work with evaluators to set up a continuous feedback process, evaluation tools and plan
- Conduct outreach to engage NHPI college-age youth from both on-campus and in the
- Launch the first cohort of NHPI student PIONEERS

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases access to mental health services to underserved groups**

C) Briefly explain how you have determined that your selected approach is appropriate.

The planning of the PIONEERS program has involved stakeholders from the system of care and the community, including youth. The idea was brought forward by the Pacific Islander Initiative (PII), a collaborative of providers, community leaders, clients/family members. PII stakeholders have been working on the idea for years prior to applying for innovation funds. Based on a comprehensive review of published literature, web-based searches, the following were identified as key considerations for the project activities and approach:

1. **College Youth Mental Health** - There is a need for promising sustainable practices that address the mental health needs of Filipino youth.
2. **Cultural Relevance** - Cultural identification is critical for the mental health of Filipino youth as they explore the opposing values of two cultures.
3. **Health Disparities** – significant disparities in health and behavioral health outcomes exist for NHPI communities.

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five key considerations, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

An NHPI Peer Counselor will engage NHPI youth on local college campuses. In FY 2017- 2018, there were 484 NHPI youth enrolled in San Mateo District Community Colleges and about 450 NHPI youth in grades 9-12. The expected annual reach is:

- 45 NHPI college-age youth engage in PIONEER program services
  - 90% develop protective factors (cultural and mental health awareness, self-identity and coping skills)
  - 90% attitudes and knowledge towards mental health improve
  - 80% youth mental health improves (suicide ideation, anxiety, depression)
  - 90% NHPI youth referred to behavioral health services; 85% follow through and engage in services

- 30 NHPI community youth engaged through the program's community advocacy component
  - 90% of all NHPI youth attitudes and knowledge towards mental health improve
  - 90% reduced stigma and improved awareness

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The PIONEERS program will target NHPI college-age youth. While data is limited for this community, we know that the NHPI community experiences some of the highest disparities across various health indicators. The Census Bureau reports that 17.6% of the NHPI community lived below poverty, compared to a national poverty rate of 11.7% for Asians and 11.6% for Whites.

For the NHPI community, many parents immigrated to the US and children born/raised in the US. NHPI's have large extended families; their major religious affiliations: Catholic, Mormon, Methodist, other Christian. Raising children in the US has led the Tongan family into a culture clash "I too notice the difference having grown up in this country where the individual is taught how to survive on an individual basis. We as Tongans survive as a group or family. So, naturally, we are in opposition."

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The key differences with the proposed project compared to other college mental health programs include:

- Cultural responsiveness to NHPI youth
- Community advocacy connection as college NHPI engage in broader NHPI community impact

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

A comprehensive online and literature search was conducted for

- College mental health programs and lessons learned (online)
- Best practices for college mental health strategies (literature)
- Need for culturally responsive college mental health programs (literature)

Gaps in the literature and practice	Proposed intervention
No culturally specific, comprehensive college mental health programs for NHPI community. Some programs employ culturally relevant outreach and engagement strategies (peer educators, cultural events) but employ a cookie-cutter approach to wellness.	The proposed project will incorporate cultural responsiveness into every phase and aspect of the program.
Community colleges and two-year institutions experience greater challenges, than 4-year universities, with providing mental health services. They often rely on nurses.	The proposed project will develop a new partnership between community colleges and, county and community behavioral health providers.
No examples of college mental health programs that consider the social determinants of behavioral health outcomes.	The proposed project will empower college NHPI youth to get involved in a community advocacy or capacity building project.

Citations and links used to gather information:

- CalMHSA – market research

- RAND Corporation, https://www.rand.org
- SAMSHA Programs, https://www.samhsa.gov/behavioral-health-equity/aanhpi
- Lucille Packard Foundation for Children's Health, https:www.kidsdata.org
- Asian & Pacific Islander American Health Forum, https://www.apiahf.org/
- National Asian American Pacific Islander Mental Health Association, http://naapimha.org/
- U.S. Census Bureau, 2018 estimates, https://www.census.gov/quickfacts/sanmateocountycalifornia
- Performance Outcomes Adult Specialty Mental Health Services Report, March 22, 2018, https://www.dhcs.ca.gov/provgovpart/pos/. Penetration rates are calculated by taking the number receiving services and dividing by total Medi-Cal eligible.
- Advancement Project California; RACE COUNTS, https://www.racecounts.org, 2017.
- National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
- American College Health Association, National College Health Assessment, https://www.acha.org/
- National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
- U.S. Census Bureau. American Community Survey Reports, 2010. The National Commission on Asian American and Pacific Islander Research in Education.
- California Community Colleges, Student Success Metrics, https://www.calpassplus.org/LaunchBoard/Student-Success-Metrics.aspx
- Srivastava, R., & Srivastava, R. (2018). Impact of Cultural Identity on Mental Health in Post-secondary Students. International Journal of Mental Health and Addiction, 17(3), 520–530. doi: 10.1007/s11469-018-0025-3

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Learning Goal #1

- Does the PIONEER program improve mental health knowledge and decrease stigma for NHPI college youth?

Learning Goal #2

- Does contextualizing culture with mental health improve attitude and behavior of NHPI youth towards mental health?

Learning Goal #3

- Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI youth?

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

As stated prior, the two key differences with the proposed project include:

- Cultural responsiveness to NHPI youth *(Learning Goal #1 and #2)*
- Community advocacy connection as college NHPI engage in broader NHPI community impact *(Learning Goal #3)*

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor and the Aging and Adult Services program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

- Does the PIONEER program improve mental health knowledge and decrease stigma for NHPI college youth?

The outputs for Learning Goal #1 could include:

- Number of NHPI college students engage in PIONEER program services
  - Percent improved attitudes (stigma) towards and knowledge about behavioral health

Additionally, occasional interviews or planned focus groups with students that engage with the PIONEERS program can help us determine the level of satisfaction and narrative for the impact this project may have on stigma and access to services. Demographics of youth that engage will be collected and the Search Institute's Developmental Assets Profile (DAP) pre- and post- to assess protective factors, internal strengths and external supports across several contexts: personal, peers, family, school, and community. The DAP is used with all other adolescent youth prevention programs that receive MHSA funding.

Learning Goal #2

- Does contextualizing culture with mental health improve attitude and behavior of NHPI youth towards behavioral health and service utlization?

The outputs for Learning Goal #2 could include:

- Number of NHPI college students engage in PIONEER program services
  - Percent that develop protective factors (cultural and mental health awareness, self-identity and coping skills)

Additionally, the same occasional interviews or planned focus groups with youth that engage with the PIONEERS program (mentioned above) can include questions about cultural awareness determine the level of impact on attitudes and behaviors towards mental health and service utilization.

Learning Goal #3

- Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI youth?

The outputs for Learning Goal #3 could include:

- Number of NHPI college students engage in community advocacy
  - Percent of youth whose mental health improves (suicide ideation, anxiety, depression)
  - Number of NHPI youth referred to behavioral health services; percentage that follow through and engage in services
- Number of NHPI community youth engaged through the program's community advocacy component
  - Percent NHPI youth attitudes and knowledge towards mental health improve
  - Percent reduced stigma and improved awareness

Additionally, occasional interviews or planned focus groups with students and community youth that engage with the PIONEERS program can help us determine the level of satisfaction and narrative for the impact this project may have on stigma and access to services.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The proposed project will require partnerships for success, between college-aged youth, Community Colleges, County BHRS, and community behavioral health services. The planning of the PIONEERS program has involved stakeholders from the system of care and the community, including youth. The idea was brought forward by the Pacific Islander Initiative (PII), a collaborative of providers, community leaders, clients/family members including youth. The collaboration with PII will continue through implementation in an advisory role to the project.

B) Cultural Competency

The entire project is rooted in cultural values and the understanding that cultural shapes mental health. Programming will leverage the collectivist culture of the NHPI community.

C) Client/Family-Driven

As mentioned above, PII will continue to play a role in the implementation of this project. This program is a prevention strategy targeting individuals that have not been diagnosed with a mental health condition. Clients and family members will be engaged in an advisory capacity through the PII or as independent member of an advisory board. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from the advisory group.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including hiring peer mental health workers that have experience serving the NHPI community in San Mateo County to conduct the programming, focusing on stigma reduction and trust building conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families

A request for proposal process will select the service provider that will own the contract for these services. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. PIONEERS program

peers will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for NHPI college-age youth and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information

is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- NHPI Behavioral Health
- NHPI College Behavioral Health Program
- Culturally Responsive College Behavioral Health Program

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – RFP and contract negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – establish/formalize agreements as needed (with colleges, other providers), establish advisory group, hire staff, set up infrastructure for implementation/evaluation and referral system and resources
- Evaluator to meet with contractor, advisory group and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of programming, finalize promotional materials, referral resources and tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Promotion and recruitment begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.

July 1, 2021 – December 31, 2021

- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as

needed

January 1, 2022 – June 30, 2022

- Continue sustainability planning
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total Innovation funding request for 3.9 years is $925,000, which will be allocated as follows:

Service Contract: $750,000
- $250,000 for FY 20/21
- $250,000 for FY 21/22
- $250,000 for FY 22/23

Evaluation (10%): $75,000
- $30,000 for FY 20/21
- $20,000 for FY 21/22
- $20,000 for FY 22/23
- $5,000 For FY 23/24

Administration (15%): $100,000
- $20,000 for FY 19/20
- $30,000 for FY 20/21
- $30,000 for FY 21/22
- $20,000 for FY 22/23

Direct Costs will total $750,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $150,000

- $75,000 for the evaluation contract with the final report will be due by December 31, 2024. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $100,000 for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project

Federal Financial Participation (FFP) there is no anticipated FFP. **Other Funding** N/A

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$20,000	$30,000	$30,000	$20,000		$100,000
4.	**Total Personnel Costs**	**$20,000**	**$30,000**	**$30,000**	**$20,000**		**$100,000**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs		$250,000	$250,000	$250,000		$750,000
12.	Indirect Costs		$30,000	$20,000	$20,000	$5,000	$75,000
13.	**Total Consultant Costs**		**$280,000**	**$270,000**	**$270,000**	**$5,000**	**$825,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	**Total Other Expenditures**						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$250,000	$250,000	$250,000		$750,000
Indirect Costs (add lines 3, 6 and 12 from above)		$20,000	$60,000	$50,000	$40,000	$5,000	$175,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$20,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$925,000**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$20,000	$280,000	$280,000	$270,000		$850,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$20,000**	**$280,000**	**$280,000**	**$270,000**		**$850,000**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds		$30,000	$20,000	$20,000	$5,000	$75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$30,000**	**$20,000**	**$20,000**	**$5,000**	**$75,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$20,000	$310,000	$300,000	$290,000	$5,000	$925,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$20,000**	**$310,000**	**$300,000**	**$290,000**	**$5,000**	**$925,000**
*If "Other funding" is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: High rates of depression and suicidality amongst NHPI college youth

Key Considerations
(from the literature)

College Youth Mental Health
College-aged youth often experience first onset or worsening of mental health and substance use issues; this is exacerbated for NHPI and students of color due to discrimination, stigma, self-identity and lack of culturally relevant services.

Cultural Relevance
There is a lack of culturally relevant strategies on college campuses for supporting NHPI youth mental health.

Health Disparities
Significant disparities in health and behavioral health outcomes exist for NHPI communities; broader approaches that consider social determinants are key

Interventions

On-Campus Programming
Services will be provided primarily on-campus to support stigma reduction and participation of NHPI youth in college. Students will lead mental health dialogues, awareness, etc. in the community to allow for broader impact and reach of NHPI youth.

PIONEERS program will provide:
Cultural Education as it relates to wellness and mental health
Mana Group Sessions for peer discussions centered on wellness and mental health

Community Advocacy to impact broader changes for NPHI community. College students will lead community discussions and at high-middle schools, conduct community health advocacy or capacity building efforts, etc.

Outcomes

Stigma Reduction
45 NHPI college students engage in program services
30 NHPI community youth engaged with the program
90% college student participants develop protective factors (cultural and behavioral health awareness, self-identity and coping skills)
90% NHPI youth attitudes towards and knowledge about behavioral health improve.

Youth Mental Health
Decreased mental health challenges (suicide ideation, anxiety, depression)
90% NHPI youth referred to behavioral health services;
85% engage in services

Community Mental Wellness
90% reduced stigma and improved awareness

Learning Objectives

Learning Goal #1
Does the PIONEER program improve mental health knowledge and decrease stigma for NHPI college youth?

Learning Goal #2
Does contextualizing culture with mental health improve attitude and behavior of NHPI youth towards behavioral health service utilization?

Learning Goal #3
Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI youth?

MHSA INN Primary Purpose

Increased access to behavioral health services

Appendix 2. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSA Steering Committee.

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

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

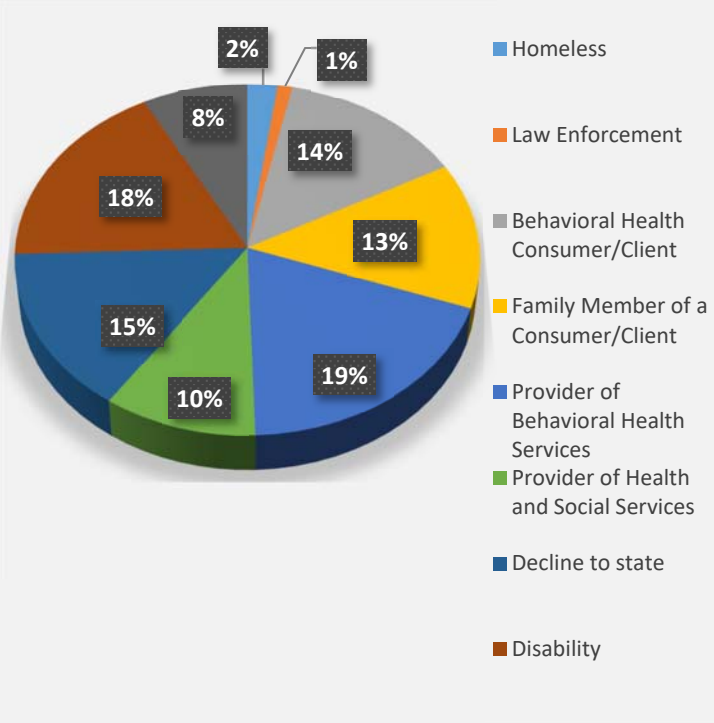
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers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

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

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

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

Represented Groups



Input Sessions

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

PHASE 1. NEEDS ANALYSIS

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

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

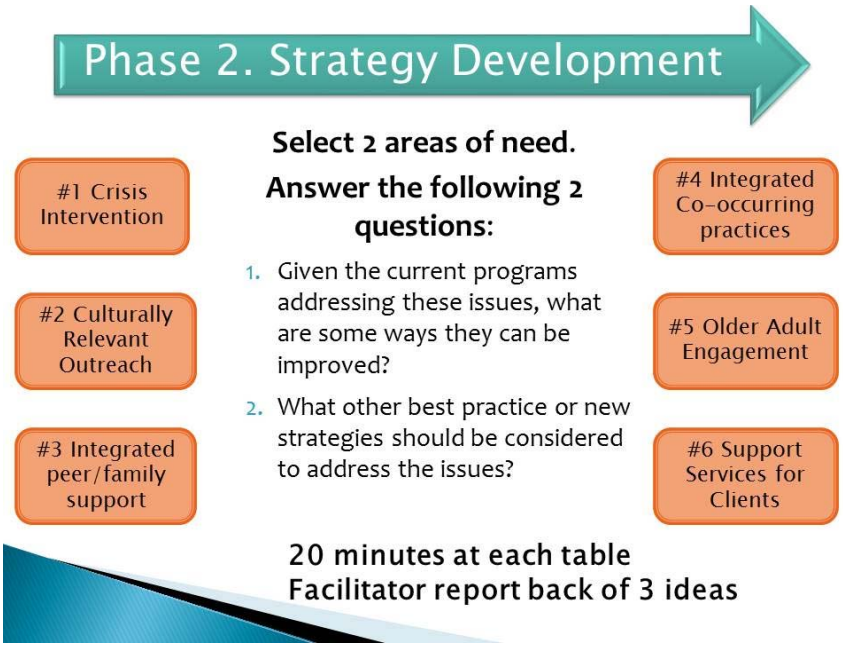
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

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

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

PHASE 2. STRATEGY DEVELOPMENT

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



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

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

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

PHASE 3. PLAN DEVELOPMENT

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

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

Appendix 3. Public Comments

[To be updated following the 30-day public comment process]

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: Preventing Homelessness to Economic and Emotionally Stressed Older Adults

Total amount requested: $750,000 ($600K services; $90K admin; $60K eval)
Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Older Adult Homelessness

According to the Elder Index[1], 43% of all adults age 65 years and older do not have enough income to meet their most basic needs. In San Mateo County, that's over 38,000 elders struggling to make ends meet. On the March 10, 2019 Sunday San Francisco Chronicle, the front-page article Homeless After 50 as Safety Net Fails[2], discussed the growing older adult homeless population and expectation that this trend will continue to increase. As the article states this problem is especially acute in the Bay Area, where housing costs, including rents, have risen dramatically over the past decade.

In San Mateo County, the cost of living is outpacing the fixed incomes and low to moderate assets of older adults, especially for those over 75 years old. In recent years, San Mateo County Adult Protective Services has seen an increase in referrals of older adults who are evicted or at imminent risk of eviction. San Mateo County's TIES Lines, the 24-hour information and emergency response line for older adults and people with disabilities, received 3,301 housing related calls and 598 calls regarding homelessness. With most of these calls, the older adult is calling at a desperate time, e.g. "Just evicted!", and few options are available. Referrals are made to homeless programs and shelters. Yet, homeless shelters are not designed to serve older adults. Older adults often have physical and cognitive challenges including incontinence, multiple medications, usage of durable medical equipment such as walkers and wheelchairs, hearing aids and glasses. As a result, many older adults choose to live in their vehicles over a shelter.

Research has found that nearly half of the older homeless adults are becoming homeless for the first in their lives after the age of 50. This cohort of older adults have had fewer adverse life experiences and reached more adult milestones than those with earlier homelessness. Some researchers have raised the question of whether some individuals who became homeless after age 50 would respond to less intensive intervention than those with earlier homelessness – particularly if their homelessness were addressed early.[3]

Primary Problem: Housed older adults at risk of homelessness due to economic stress

[1] https://www.ncoa.org/economic-security/money-management/elder-index/
[2] https://projects.sfchronicle.com/2019/visuals/homeless-after-50/
[3] Brown, R. T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M. B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. Plos One, 11(5). doi: 10.1371/journal.pone.0155065

The older adult "hope's" they will die before they are evicted; they are embarrassed to discuss their situation and feel shame over their "personal failure"; the client makes statements that resemble symptoms of mild/moderate depression and anxiety.

- Adult Protective Services social worker

Economic Stress

The National Association of Area Agencies on Aging 2018 Housing and Homelessness[4] report, identified indicators that would put older adults at risk of homelessness including, the cost of rental housing, shortages of affordable housing, physical and financial challenges to pay for home repair and maintenance, and limited federal funding for housing programs. These challenges create significant "economic stress" for the older adult. The physical and mental consequences of high social stress include: anxiety, poor nutrition, medication non-compliance, depression, poor decision making, isolation, and homelessness. Economically stressed older adults are reluctant to seek help due to embarrassment, stigma, anxiety, and depression, putting themselves at risk of homelessness. Older adults often minimize their anxiety and other mental health related features related to economic stresses, also contributing to their risk of homelessness. Older adults who experience stigma and embarrassment older over their economic stress don't reach out to a peer or a non-clinical person to share their distress. Compounding any social isolation, they may currently be experiencing.

There is a cohort of older adults who don't want to contemplate losing their housing; don't discuss worries with others; don't trust or know how to use technology for housing resources; and as voiced by one older adult: "hope they are not alive to deal with a housing crisis arises." These older adults are also least likely to reach out for behavioral health services.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

The proposed project will reach-out and engage isolated older adults who may be at risk of becoming homeless. Trust and safety will be established to reduce shame/stigma. Older adults will be screened for economic stress, behavioral health issues, and connected to homeless, housing and behavioral health resources for planning, and support, to prevent acute homelessness and to slow the growing older adult homeless population trend. The innovation will create a new partnership between Human Services Agency Center for Homelessness providers, Older American Act programs, Behavioral Health and Recovery Services, and Aging and Adult Services.

Reaching out to isolated older adults at risk of becoming homeless

The proposed project will focus on strategies that prevent housing loss in late life and provide early support for currently housed older adults at risk of becoming homeless based on the indicators cited in the literature. Identifying those at high risk of losing

[4] National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)

housing in late life and working to prevent housing loss or provide early support to help older adults remain in their homes is recommended in the research as an effective strategy to prevent progression to chronic homelessness in these adults.[5]

The Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meals Programs can provide ideal entry points to reach-out to isolated older adults at risk of becoming homeless. These programs provide nutrition services to homebound older adults who have potentially the greatest economic or social needs. In fiscal year 2018-2019 approximately 4,950 eligible 60+ older adults received meals at a nutrition site; and approximately 1,185 eligible 60+ older adults received Home Delivered Meals in San Mateo County. Both programs are staffed with non-clinicians and volunteers. The proposed project will hire one Mental Health Program Specialist and one Mental Health Counselor to fulfill the projects' objectives. They will partner with the two nutrition programs in two disparate cities, engage and establish trust with the older adult meal recipients through individual and group conversations about economic stress and behavioral health.

Reducing shame/stigma

The proposed project will provide isolated older adults with a "safe" place and person(s) with whom they can engage in conversations related to social and economic stresses and behavioral health. The "Behavioral Health Coach Model[6]" is a successful strategy that has been implemented in Atlanta Housing Authority (AHA) properties; by addressing behavioral issues such as disruptive behaviors and hoarding, lease violations and evictions were reduced for a specific cohort of older adults. The program also reduced stigma. As residents became aware and saw other residents engaging with the coaches, they were more likely to self-refer and to refer others to the program.

Economic stress

The proposed project will develop a screening tool, which currently does not exist, that incorporates the risk factors cited in the literature. Shinn et.al.2007, examined several risk factors in their work to identify predictors of homelessness among older adults that include the: inability to afford rent increases after retirement; unexpected disability preventing gainful employment to afford rent; apartment fire; long-term hoarding behavior leading to eviction; and loss of partner who shared the cost of housing. Brown, et.al. 2016, had similar findings and acknowledged little was known about pathways to homelessness among older adults in the United States, yet cited research conducted on older adults in England, which found death of a spouse, retirement, loss of housing tied to employment, worsened mental health problems, cognitive impairments contributing to homelessness in late life.

Behavioral health issues

The proposed project will screen for behavioral health issues, which often go

[5] Brown, R. T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M. B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. Plos One, 11(5). doi: 10.1371/journal.pone.0155065

[6] National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)

undiagnosed in older adults. These behavioral health issues may contribute to an older adult's reluctance to seek help when their housing is threatened. Koychev, et.al., 2016, found anxiety disorder in the elderly to be twice as common as dementia and 4-6 times more common than major depression. Anxiety was associated with poorer quality of life, significant distress, and contributed to the onset of disability. Porensky's, et.al., 2009, found anxiety severity in late-life Generalized Anxiety Disorder to be associated with disability and health related quality of life impairments above and beyond the impairments accounted for by depression and medical burden.

Referrals and warm hand-offs

The proposed project will connect older adults to housing and behavioral health resources for planning and support to prevent homelessness. This narrow list of resources includes: San Mateo County Human Resource Services Center on Homelessness Core Service Agencies and San Mateo County Behavioral Health and Recovery Services Senior Mental Health Services Senior Peer Counseling program and community-based bereavement, general counseling and crisis services.

Project activities:

- Project team will outreach to isolated older adults through the Congregate Nutrition and Home-Delivered Meal programs.
- Provide a "safe" stigma free conversation with the home delivered meal recipients, on social and economic stresses that may possibly create an opportunity for economic stress, anxiety and/or depression screening.
- Create "safe" settings at two senior centers, where congregate nutrition and home delivered meal programs exist, for older adults to discuss amongst peers, topics related to social and economic stresses, housing options and planning, to mitigate the risk of homelessness.
- Develop an economic stress tool, which currently does not exist, that incorporates the risk factors cited in the literature.
- Screen older adults to identify behavioral health issues and economic stresses that would put older adults at greater risk of homelessness.
- Refer and provide warm hand-offs to connect the older adults to appropriate behavioral health services and supports.
- Once identified additional preventive interventions will be put in place to support and reduce identified stressors.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases access to mental health services to underserved groups**

C) Briefly explain how you have determined that your selected approach is appropriate.

Our approach is based on a comprehensive review of published literature, web-based searches, and through the development of a LEAP process Improvement Charter (IP). An IP is a single page living document that is visual and describes a problem to be improved. An IP will have a: Business Case; Current State; Future State and Action Plan – in addition to a stated Target Problem and Hypothesis. In the fall of 2017, representatives from Human Services Agency Center on Homelessness, Aging and Adult Services, Behavioral Health and Recovery Services, and several community-based homeless and behavioral health agencies met to discuss older adults and homelessness and to develop an initial IP on older adult homelessness in San Mateo county. The following key learnings and characteristics of newly homeless older adults were identified:

1. *Socially Isolated:* older adults were socially isolated prior to becoming homeless
2. *Shame and Stigma:* older adults did not reach out for help due to stigma
3. *Predictors of Homelessness:* there are economic stress warning signs prior to becoming homeless
4. *Behavioral Health Issues:* may contribute to an older adult's reluctance to seek help when their housing is threatened
5. *Preventative Interventions:* for housed older adults, less intensive preventative interventions could mitigate the risk of becoming homeless

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five key considerations, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The Mental Health Counselor will outreach to isolated older adults through the Home-Delivered Meal and Congregate Nutrition Programs at two senior centers in the cities of Pacifica and Redwood City. These two sites have voiced the most concern about homeless older adults at their center. Pacifica and Redwood City also had high homeless count numbers from this years' Point In-Time homeless count.

In Fiscal Year (FY) 2018-2019 approximately 4,950 eligible 60+ older adults received meals at a nutrition site; and approximately 1,185 eligible 60+ older adults received

home delivered meals in San Mateo County.

- In Pacifica, there were 446 unduplicated nutrition site older adults and 131 unduplicated home delivered meal recipients.
- In Redwood City, there were 230 unduplicated nutrition site older adults and 146 unduplicated home delivered meal recipients.

The expected reach based on this data is as follows:

- 340 home visits by the Mental Health Counselor
- 277 initial conversations to build rapport with homebound older adults
- 24 forums held with 6 participants on average attending each forum
- 75 older adults screened at senior centers
- 120 homebound older adults screened
- 195 linkages to behavioral health and housing resources

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The project aims to serve the socially and economically challenged 60+ years of age older adult in the Pacifica and Redwood City communities. San Mateo county has a diverse and growing older adult population in general. Yet, Redwood City is more suburban with a large mono-lingual Spanish speaking community, while Pacifica is a coastal semi-rural community. As the "baby boomer" generation ages, our Sexual Orientation and Gender Identity initiative is identifying a growing number of older adults who identify as lesbian, gay, bisexual, transgender and questioning.

Demographic Indicator[7]	**Pacifica**	**Redwood City**	**San Mateo County**
Total Population	38,844	82,595	754, 748
Ages 65+	14%	12%	15%
Race Ethnicity			
• Asian	18%	13%	27%
• Black	2%	2%	2%
• Latino	18%	39%	25%
• Pacific Islander	1%	1%	1%
• White	54%	43%	40%
Percent of Households Who Are Rent Burdened	48%	55%	52%
Percent of Residents Living below 200% of the Federal Poverty Level	13%	25%	20%

[7] U.S. Census Bureau, 2012-2016 American Community Survey 5-year Estimates

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

As mentioned, prior, the "Behavioral Health Coach Model" is a successful strategy that has been implemented in low income older adult properties to help address behavioral health needs that resulted in lease violations or evictions. The key differences with the proposed project include:

- Implementation of the model in collaboration with the Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meal Programs as a means of reaching isolated older adults at risk of homelessness.
- Integrating economic stress conversations and screenings

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Literature searches were conducted through the San Mateo Medical Center Inter-Library Loan system, Google Scholar and Google search engine. The subjects searched included: "preventing older adult homelessness"; "economic stresses and the older adult"; "pathways to older adult homelessness"; "stress and depression in homeless older adults"; "anxiety and depression in older adults"; "stress and depression in the elderly". The literature review identified research gaps on these subjects and areas of focus for this project.

Gaps in the literature and practice	Proposed intervention
Searches for "economic stress" and "stress in the elderly" mostly produced literature with a clinical/ pathological focus.	The proposed project will focus on prevention and early intervention efforts.
The literature provided some insight into older adults' mental health that may contribute to their experience with "economic stress" and reluctance to seek help if their housing situation is at risk and into older adults.	The proposed project will incorporate behavioral health screenings and linkages.
Searches for screening tools determined that there are NO good screening tools to predict homelessness.	The proposed project will develop a screening tool for economic stress-based indicators cited in the literature.
Searches for older adult homelessness prevention strategies identified the need for adapting interventions for individuals who become homeless after age 50, which may respond to less intensive interventions than those with earlier homelessness. There is a lack of strategies that focus on preventing housing loss in late life.	The proposed project will engage housed older adults and provide referrals and warm hand-offs to services and supports to mitigate the risk of homelessness.

Citations and links used to gather information:

- https://www.ncoa.org/economic-security/money-management/elder-index/
- https://projects.sfchronicle.com/2019/visuals/homeless-after-50/
- National Association of Area Agencies on Aging, https://www.n4a.org, Housing and Homelessness: Services and Partnerships to Address a Growing Issue (2018)
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- Porensky, E. K., Dew, M. A., Karp, J. F., Skidmore, E., Rollman, B. L., Shear, M. K., & Lenze, E. J. (2009). The Burden of Late-Life Generalized Anxiety Disorder: Effects on Disability, Health-Related Quality of Life, and Healthcare Utilization. *The American Journal of Geriatric Psychiatry*, 17(6), 473–482. doi: 10.1097/jgp.0b013e31819b87b2

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Learning Goal #1

- Does outreach through congregate nutrition and home delivered meal programs offer an effective approach for reaching isolated older adults?

Learning Goal #2

- Do "Counselors" in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

Learning Goal #3

- Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

As stated, prior, the two key differences with the proposed project include:

- Implementation of the Behavioral Health Coaching model in collaboration with the Older Americans Act (OAA) Congregate Nutrition and Home-Delivered Meal Programs as a means of reaching isolated older adults at risk of homelessness. *(Learning Goal #1 and #2)*
- Integration of economic stress conversations and screenings *(Learning Goal #3)*

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor and the Aging and Adult Services program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

- Does outreach through congregate nutrition and home delivered meal programs reach isolated older adults at risk of homelessness?

The outputs for Learning Goal #1 could include:

- Number of home visits with older adults completed in partnership with home delivered meals program
- Number of forums held with senior centers in partnership with congregate nutrition program
- Number of older adults attending the forums

Additionally, demographics of participants that include a few questions on existing social supports, networks and participation can help us determine whether the approach reaches *isolated* older adults. The proposed screening activity for economic stress and behavioral health issues will allow us to determine if the approach reaches older adults *at risk of homelessness*.

Learning Goal #2

- Do "Counselors" in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

The outputs for Learning Goal #2 could include:

- Number of economic stress and behavioral health- related conversations held with homebound older adults
- Number of economic stress and behavioral health- related forums held and participants attended

Additionally, interviews with homebound older adults engaged in conversations and focus groups with forum participants can help us determine the level of trust and rapport that was established, the level of confidence in getting support services when/if needed, and satisfaction with the services provided.

Learning Goal #3

- Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

The outputs for Learning Goal #3 could include:

- Number of screenings completed with homebound older adults
- Number of screenings completed at senior centers with older adults
- Number of linkages made to behavioral health services
- Number of linkages made to housing support resources

Additionally, occasional interviews with older adults that were referred to services can help us determine whether older adults engaged in support, the level of satisfaction and outcomes of the referrals.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation

Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

Collaboration has been integral to the development of this project. Human Services Agency Center on Homelessness, Aging and Adult Services, Behavioral Health and Recovery Services, and several community-based homeless and behavioral health agencies who represented the needs and concerns of older adults served, met to discuss older adults and homelessness and to develop an initial improvement plan on older adult homelessness in San Mateo county.

The proposed project will require continued partnerships for success specifically between the Older Americans Act (OAA), Human Services Agency Center for Homelessness, Behavioral Health and Recovery Services (BHRS), Aging and Adult Services (AAS), local senior centers and the older adult service recipients.

- The Congregate Nutrition and Home-Delivered Meal Programs and senior centers provide services for older adults who have the greatest economic or social needs. The staff and volunteers are gatekeepers and they have access to an ideal entry point to reaching isolated seniors at risk of homelessness. They are a trusted service and space in the community that will be integrating a Mental Health Counselor into routine activities and collaborating regularly with AAS to troubleshoot, strategize and monitor the success of the program.
- Older adult recipients will be engaged in safe conversations about economic challenges and behavioral health, their partnership and input into the process will drive the linkages made and the development or procurement of additional preventive interventions that may be needed to support and reduce identified stressors.

B) Cultural Competency

The older adult population in the two target areas considered for this project are culturally different. In order to deliver culturally responsive services, ideally the Mental Health Counselor will be a mature adult with bilingual/bicultural Spanish speaking skills, with personal experience with housing challenges, to represent the low-income older adults being served in both communities. This will support trust-building and linkages for some of the most vulnerable older adults.

C) Client/Family-Driven

As mentioned above, older adult recipients of services will be driving the linkages made and development of any additional resources and interventions needed. This program is a prevention strategy targeting individuals that have not been diagnosed with a mental health condition. Clients and family members will be engaged in an advisory capacity. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from an advisory group made up of clients and family members. The Mental

Health Substance Abuse and Recovery Commission Older Adult Committee, which is made up of clients, family members and providers will be an ideal resource for this role.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including hiring bilingual/bicultural peer mental health worker to conduct the outreach, focusing the outreach on trust building, conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families

A memorandum of understanding will be drafted between AAS and BHRS, who will be the primary monitors of the work, outlining responsibilities and expectations for this project. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. The Mental Health Counselor will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders.

If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for at risk older adults and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Older Adults and Economic Stress
- Preventing Older Adult Homelessness
- Mental Health and Older Adult Homelessness

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities –MOU development and negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – establish/formalize agreements as needed (with senior centers and OAA), establish advisory group, hire staff, set up infrastructure for implementation/evaluation and referral system and resources
- Development of economic screening tool begins
- Evaluator to meet with AAS Process and Improvement unit, advisory group, AAS and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of home visits and forums, finalize promotion materials, referral resources and screening tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Outreach, home visits, community forums, referrals and warm hand-offs begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.
- Identify any additional preventive interventions that may be needed to support and reduce identified stressors.

July 1, 2021 – December 31, 2021

- Explore and finalize any recommendations for additional preventive interventions that may be needed to support and reduce identified stressors.
- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as needed

January 1, 2022 – June 30, 2022

- Explore and finalize any recommendations related to additional preventive interventions that may be needed to support and reduce identified stressors.
- Continue sustainability planning
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue outreach, home visits, forums, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 3.9 years is $750,000, which will be allocated out as follows:

Service Contract: $600,000
- $200,000 for FY 20/21
- $200,000 for FY 21/22
- $200,000 for FY 22/23

Evaluation (10%): $60,000
- $16,000 for FY 20/21
- $16,000 for FY 21/22
- $16,000 for FY 22/23
- $12,000 For FY 23/24

Administration (15%): $90,000
- $15,000 for FY 19/20
- $30,000 for FY 20/21
- $30,000 for FY 21/22
- $15,000 for FY 22/23

Direct Costs will total $600,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $150,000
- $90,000 for the evaluation contract for 3.5 years given the final report will be due by December 31, 2023. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $60,000 for BHRS administration, monitoring and management of the innovation project(s).

Federal Financial Participation (FFP) there is no anticipated FFP.

Other Funding N/A

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$15,000	$30,000	$30,000	$15,000		$90,000
4.	**Total Personnel Costs**	**$15,000**	**$30,000**	**$30,000**	**$15,000**		**$90,000**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs		$200,000	$200,000	$200,000		$600,000
12.	Indirect Costs		$16,000	$16,000	$16,000	$12,000	$60,000
13.	**Total Consultant Costs**		**$216,000**	**$216,000**	**$216,000**	**$12,000**	**$660,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	**Total Other Expenditures**	**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$200,000	$200,000	$200,000		$600,000
Indirect Costs (add lines 3, 6 and 12 from above)		$15,000	$46,000	$46,000	$31,000	$12,000	$150,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative ~~MH~~SA Funds	$15,000	$230,000	$230,000	$215,000		$690,000
2.	~~Federal Financial~~ Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$15,000**	**$230,000**	**$230,000**	**$215,000**		**$690,000**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative ~~MHSA Funds~~		$16,000	$16,000	$16,000	$12,000	$60,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$16,000**	**$16,000**	**$16,000**	**$12,000**	**$60,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$15,000	$246,000	$246,000	$231,000	$12,000	$750,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$15,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$750,000**
*If "Other funding" is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: Housed Older Adults (OA) at Risk of Homelessness Due to Economic Stress

Key Considerations (from the literature)

Socially Isolated
OA's were socially isolated prior to becoming homeless

Shame and Stigma
OA's did not reach out for help prior to becoming homeless due stigma

Predictors of Homelessness
There are economic stress warning signs prior to becoming homeless

Behavioral Health Issues
May contribute to an older adult's reluctance to seek help when their housing is threatened

Preventative Interventions
For housed OA's, less intensive interventions could mitigate the risk of becoming homeless

Interventions

Outreach
Peer Counselors will outreach to isolated OA's through congregate nutrition and home delivered meals

Trust Building
Peer Counselors will engage homebound OA's and provide group forums at senior centers to facilitate stigma-free conversations

Economic Stress Screening
Screening tool will be developed incorporating economic stress risk factors cited in literature.

Behavioral Health Screening
Peer Counselors will also screen OA's for anxiety and depression

Referrals/Warm Hand-offs
Peer Counselors link OA's to services, information and planning resources to support housing stability, based on the screening results

Outcomes

Home Visits and Forums
340 OA visits with home delivered meals program
24 forums held at senior centers
144 participants attend forums

Conversations
277 conversations regarding social and economic stress with homebound OA's

Screening and Linkages
120 screenings completed with homebound OA's
75 screenings completed at senior centers with OA's
195 to behavioral health and housing support resources

Learning Objectives

Learning Goal #1
Does outreach through congregate nutrition and home delivered meal programs reach isolated older adults at risk for homelessness?

Learning Goal #2
Do Peer Counselors in these settings establish the trust and rapport needed to reduce stigma and engage older adults in conversations about economic stress and behavioral health?

Learning Goal #3
Does the pairing of behavioral health and economic stress screening for OA's lead to linkages that prevent more severe behavioral health issues and prevent homelessness?

MHSA INN Primary Purpose

Increased access to behavioral health services

Appendix 2. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSA Steering Committee.

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

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

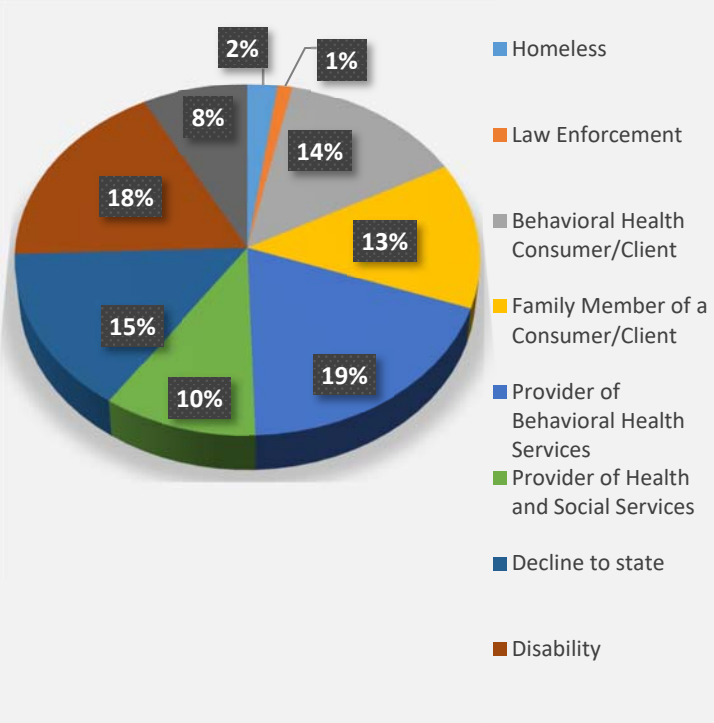
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers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

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

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

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

Represented Groups



Input Sessions

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

PHASE 1. NEEDS ANALYSIS

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

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

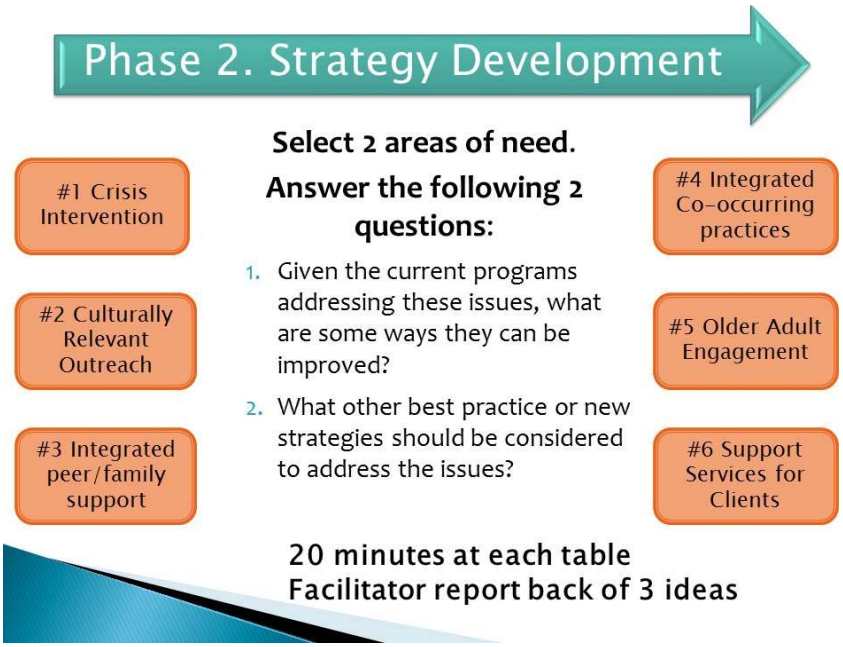
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

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

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

PHASE 2. STRATEGY DEVELOPMENT

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



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

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

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

PHASE 3. PLAN DEVELOPMENT

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

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

Appendix 3. Public Comments

[To be updated following the 30-day public comment process]

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: Co-location of Prevention Early Intervention Services in Low-Income Housing
Total amount requested: $925,000 ($750K services; $100K admin; $75K eval)
Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Young Adults and Mental Health
According to the National Institute of Mental Health, young adults (18-25 years) have the highest prevalence of mental illness, including severe mental illness.[1] However, young adults with mental illness receive mental health treatment at a lower rate than adults. Young adults also have higher rates of co-occurring mental illness and substance use disorders. In 2018:

- About one in four young adults aged 18 to 25 (26.3%) had any mental illness in the past year and 7.7% had a serious mental illness;
- 7.2% of young adults had co-occurring mental illness and substance use disorder.[2]

In San Mateo County, about 4.9% (413) of eligible Medi-Cal 18 to 20-year-old beneficiaries received specialty mental health services. Behavioral Health and Recovery Services, Youth to Adult Transition Program provides intensive mental health services to 18 to 25-year-olds eligible for Medi-Cal and with serious mental illness. The program receives referrals from Psychiatric Emergency Services (PES), inpatient hospitals, the youth and adult system of care and Children Protective Services. Annually the program serves 300 youth, which includes 225 youth who are admitted to psychiatric emergency services.

Transition into adulthood can be a stressful process as young people become more self-sufficient, independent and begin making decisions that can significantly shape their lives. This is an important period for both promoting linkages to behavioral health services, increasing protective factors and reducing risk factors and the negative consequences of untreated mental illness. Ensuring prevention and early intervention, prior to PES visits and hospitalizations, and meeting the behavioral health needs of this age group is an important priority for San Mateo County.

Primary Problem: High rates of mental illness amongst low-income young adults

Low-income Youth
In San Mateo County, 29% of families are considered below poverty based on the California

[1] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[2] Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS RTI International. Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report

Self-Sufficiency Standard.[3] More impactful is the fact that inequality continues to increase with the top-income families earning almost 15.8 times more than low-income families.[4] Youth from low-income households are at a higher risk for mental health challenges. Among children living below 100% of the federal poverty level, more than 1 in 5 (22%) had a mental, behavioral, or developmental disorder.[5]

Research has shown not only that mental illness may lead to poverty and that poverty exacerbates mental illness but, more recently that poverty may contribute to the onset of mental illness. Families living in poverty face an increased risk of both community and individual trauma.[6] These families are rarely successfully connected with the mental health services they need. This is exacerbated for youth from vulnerable cultural/ethnic families. Studies have found that youth of color experience higher levels of mental health difficulties due to racial discrimination, stigma, tendency to not engage in help-seeking behaviors and lack of culturally relevant support services. The most common racial or ethnic group living below the poverty line in San Mateo County is Hispanic.

There is a need for more upstream, innovative, comprehensive approaches to addressing behavioral health among young adults. Implementing multi-level interventions that reach high risk communities where they are, providing screening, resources and linkages in their homes and communities.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

The proposed project will provide prevention and early intervention services including behavioral health resources, supports, screening, referrals and linkages to young adults, ages 18-25, on-site at affordable housing properties, minimizing stigma and reducing barriers to accessing behavioral health care.

Co-location of services in affordable housing complexes
By coordinating access to behavioral health and social services with affordable housing, low-income residents can have improved health outcomes and quality of life, including housing stability.[7] The California Reducing Disparities Project (CRDP), an MHSA

[3] The Census Bureau uses a federal poverty threshold based on a set income by family size to determine poverty.
[4] Public Policy Institute of California, 2012-2014
[5] Cree RA, Bitsko RH, Robinson LR, Holbrook JR, Danielson ML, Smith DS, Kaminski JW, Kenney MK, Peacock G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. MMWR, 2018;67(5):1377-1383.
[6] Collins, K, Connors, K, Donohue, A, Gardner, S, Goldblatt, E, Hayward, A, Kiser, L, Strieder, F, Thompson, E. 2010. Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions. Baltimore, MD: Family Informed Trauma Treatment Center.
[7] Carder, PC, Luhr, G, West, M, Morgan, B. 2016. Housing with Services Program Evaluation. Portland, OR: Institute on Aging, Portland State University.

Prevention and Early Intervention (PEI) State funded project and the largest investment in the nation to look into diverse community perspectives on mental health disparities, released the Strategic Plan to Reduce Mental Health Disparities in 2018. The strategic plan includes recommendation for increasing access to unserved, underserved and inappropriately served communities. Co-locating services in spaces where people are comfortable is the first strategy recommended as a first step in making services more available to those in need. It makes sense to build supports around the home setting. Affordable housing properties offer that ideal space to provide culturally and linguistically competent services to communities in need, which are often communities of color.

Affordable housing as a hub for services is described in four main models[8]:

- Health or social services are provided by an outside agency
- Services and amenities made available to everyone in a building complex by the housing organization
- Integrated supportive services on-site available to residents with special needs
- Services on-site available to residents and nearby community

These models have been widely researched in specific populations such as, the elderly, people living with mental illness or disabilities, and youth exiting the juvenile justice system and at risk of experiencing homelessness. Strategies are primarily focused on supportive and integrated services. In terms of prevention, the majority of program focus on environmental factors in the physical homes. There is no model targeting prevention and early interventions for young adults specifically and even those targeting high risk youth document that further research is needed to determine how to best serve youth between the ages of 18-25 in these settings.[9]

Prevention and Early Intervention for young adults

Despite the high need for mental health services, low-income youth are least likely to be connected with high-quality mental health care.[10] There is a pressing need to develop promising strategies to ensure greater access to appropriate early intervention services among those with the highest risks for developing behavioral health disorders.

Specifically, programs that are client driven, culturally responsive, target individuals in their natural contexts and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity) may be associated with increased engagement. The proposed program will target young adults at affordable housing properties and surrounding community. A behavioral health peer educator and a harm reduction specialist with experience in mental health and are culturally and linguistically competent to work with the community being served, including being affirming of

[8] Butler, S, Cabello, M. Housing as a Hub for Health, Community Services, and Upward Mobility. Mar 2018. The Brookings Institution.

[9] Bardine, Darla, et al., "Addressing the Intersections of Juvenile Justice Involvement and Youth Homelessness: Principles for Change," 2017. Coalition for Juvenile Justice.

[10] Hodgkinson, S, Godoy, L, Beers, LS, Lewin, A (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. Pediatrics. Jan; 139(1): e20151175.

LGBTQ individuals and able to foster a welcoming place for all, will provide:

- Preventative behavioral health and harm reduction workshops
- Peer support group(s)
- Social determinants of health and behavioral health screenings
- Referrals and linkages to resources for mental health and substance use
- Crisis support

If young adults could be provided behavioral health information, supports and be screened for mental illness early, there is a strong possibility that those young adults will increase their overall quality of life and lessen the impact that undiagnosed mental illness creates by preventing crises and connecting them to resources and treatment services.

Project implementation activities:

- Project startup - hire peer educator and harm reduction specialist(s), identify screening tools and referral resources, establish crisis protocols, etc.
- Establish advisory board for the project and conduct assessment (interviews/surveys) to detetermine relevant activities, workshop topics and outreach/incentive strategies for young adult engagement.
- Create “safe” settings and activities at housing properties for young adults to discuss amongst peers and engage in topics that are relevant to their every day stressors, needs and interests decreasing barriers and stigma related to accessing behavioral health services.
- Conduct Preventative and Harm Reduction Workshops and Peer Support Groups.
- Screen young adults for behavioral health issues and social determinants of health to provide appropriate linkages.
- Refer and provide warm hand-offs to connect the young adults to appropriate behavioral health services and supports.
- Once identified additional preventive interventions may be put in place to support and reduce identified stressors.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases access to mental health services to underserved groups**

C) Briefly explain how you have determined that your selected approach is appropriate.

Based on a comprehensive review of published literature, web-based searches, the following were identified as key considerations for the project activities and approach:

1. **Early Intervention:** Poverty contributes to onset of behavioral health challenges, early intervention for low-income young adults is critical.
2. **Ease of access:** Co-locating services in spaces where young adults are comfortable will increase access and combat stigma.
3. **Comprehensive and culturally relevant approach:** Young adults are more likely to engage with programs that are client driven, culturally responsive and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity).

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five key considerations, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The project team will outreach to young adults living at affordable housing complexes.

The expected reach based on this data is as follows:

- 80 workshops offered at 10 affordable housing complexes
- 150 young adults participate in services provided on-site
    - 90% increased knowledge about behavioral health.
    - 90% reduced stigma
- 120 number of young adults screened
- 30% will be referred to social and/or behavioral health services
- 70% of young adults referred to behavioral health service will receive treatment
- 80% of the young adults who are found to have mental illness and receive treatment will report:
    - Increased understanding of their emotions
    - Increased understanding of mental illness

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

In San Mateo County, 29% of families are considered below poverty based on the California Self-Sufficiency Standard. 8% of the White population live below the poverty line; compared to 20% of Latinos and 5% of Asians.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Co-location of services is a well-documented best practice particularly as it relates to co-locating services in schools and primary health care settings or co-locating various health and social services, and co-locating services in supportive housing for individuals living with mental illness. The key differences with the proposed project include:

- Co-locating prevention and early intervention services targeting young adults in affordable housing complexes.
- Integrating comprehensive approach that considers cultural relevance and addresses social determinants of health.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Literature searches were conducted through the San Mateo Medical Center Inter-Library Loan system, Google Scholar and Google search engine. The subjects searched included: "co-location of mental health services;" "co-location of mental health services in affordable housing complexes;" "affordable housing as service hubs;" "young adults and mental health outcomes;" "mental health and low-income families."

Gaps in the literature and practice	Proposed intervention
A search for co-location of services in affordable housing revealed a gap in best practices for behavioral health prevention and early intervention for young adults. Most co-location of services target special populations (elderly, homeless youth, people living with mental illness or disabilities, etc.). Strategies are primarily focused on supportive and integrated direct services vs. prevention.	The proposed project will develop a best practice for: 1) targeting young adults 2) focus on prevention

Links used to gather information:

- https://housing.smcgov.org/
- https://cpehn.org/sites/default/files/crdp_strategic_plan.pdf
- https://www.brookings.edu/wp-content/uploads/2018/03/es_20180315_housing-as-a-hub_final.pdf
- http://juvjustice.org/sites/default/files/ckfinder/files/FINAL%20Principles%20-%20ns%20final.pdf
- https://www.pdx.edu/ioa/affordable-housing-with-services
- https://bainumfdn.org/blog/housing-service-hub-opportunities-challenges/
- https://www.schoolhealthcenters.org/wp-content/uploads/2015/09/CSHA-CDE-Youth-MH-Program-Engagement-091715.pdf

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Learning Goal #1

- Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

Learning Goal #2

- Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

Learning Goal #3

- Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

As stated, prior, the two key differences with the proposed project include:

- Co-locating prevention and early intervention services targeting young adults in affordable housing complexes. *(Learning Goal #1)*
- Integrating comprehensive approach that considers cultural relevance and addresses social determinants of health. *(Learning Goal #2 and #3)*

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor and the Aging and Adult Services program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

- Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

The outputs for Learning Goal #1 could include:

- Number of workshops offered
- Number of young adults participating

Additionally, demographics of participants will be collected that include questions on youth risk for mental illness, protective factors, risk factors, etc.

Learning Goal #2

- Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

The outputs for Learning Goal #2 could include:

- Increased knowledge about behavioral health
- Reduced stigma

Additionally, interviews with young adults engaged in conversations and focus groups with workshop participants can help us determine the level of trust and rapport that was established, the level of confidence in getting support services when/if needed, and satisfaction with the services provided.

Learning Goal #3

- Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?

The outputs for Learning Goal #3 could include:

- Number of young adults screened
- Number referred to social and/or behavioral health services
- 70% of young adults referred to behavioral health service will receive treatment.
- 80% of the young adults who are found to have mental illness and receive treatment will report:
  - Increased understanding of their emotions
  - Increased understanding of mental illness.

Additionally, occasional interviews with young adults that were referred to services can help us determine whether the youth engaged in support, the level of satisfaction and outcomes of the referrals.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The proposed project will require collaboration with youth to ensure the most culturally relevant engagement strategies are employed; with service providers to bring appropriate services to the young adults and allow for linkages and warm hand-offs; and the community at-large since service will be available to the surrounding community.

B) Cultural Competency

In order to deliver culturally responsive services, ideally a peer staff that's bilingual/bicultural Spanish speaking, with personal experience with mental health, to represent the low-income young adults being served. This will support trust-building and linkages.

C) Client/Family-Driven

As mentioned above, young adults will be driving the linkages made and development of any additional resources and interventions needed. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from an advisory group made up of young adults, clients and family members. The Mental Health Substance Abuse and Recovery Commission Older Adult Committee, which is made up of clients, family members and providers may be an ideal resource for this role.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including hiring bilingual/bicultural peer mental health worker to conduct the outreach, focusing the outreach on trust building, conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families

A request for proposal process will select the service provider that will own the contract for these services. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. Staff will need to be well-informed on the full range of services at BHRS and the community and build relationships to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse young adults, clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for at risk older adults and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Housing as service hubs
- Co-location of behavioral health services in affordable housing
- Young adults and mental health
- Low-income young adult engagement in behavioral health services

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – RFP and contract negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – hire peer educator and harm reduction specialist(s), identify screening tools and referral resources, establish crisis protocols, set up infrastructure for implementation/evaluation and referral system/resources, etc.
- Establish Young Adult advisory group
- Conduct assessment (interviews/surveys) to determine relevant activities, workshop topics and outreach/incentive strategies for young adult engagement.
- Evaluator to meet with, advisory group, agency and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of workshops and activities based on needs assessment, finalize promotion materials, referral resources and screening tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Outreach, workshops/activities, referrals and warm hand-offs begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.
- Identify any additional preventive interventions that may be needed to support and reduce youth identified stressors.

July 1, 2021 – December 31, 2021

- Explore and finalize any recommendations for additional preventive interventions that may be needed to support and reduce identified stressors.
- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as needed

January 1, 2022 – June 30, 2022

- Explore and finalize any recommendations related to additional preventive interventions that may be needed to support and reduce identified stressors.
- Continue sustainability planning
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 3.9 years is $925,000, which will be allocated out as follows: $925,000 ($750K services; $100K admin; $75K eval)

Service Contract: $750,000
- $250,000 for FY 20/21
- $250,000 for FY 21/22
- $250,000 for FY 22/23

Evaluation (10%): $75,000
- $30,000 for FY 20/21
- $20,000 for FY 21/22
- $20,000 for FY 22/23
- $5,000 For FY 23/24

Administration (15%): $100,000
- $20,000 for FY 19/20
- $30,000 for FY 20/21
- $30,000 for FY 21/22
- $20,000 for FY 22/23

Direct Costs will total $750,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $150,000
- $75,000 for the evaluation contract with the final report will be due by December 31, 2024. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $100,000 for for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project

Federal Financial Participation (FFP) there is no anticipated FFP.

Other Funding N/A

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$20,000	$30,000	$30,000	$20,000		$100,000
4.	**Total Personnel Costs**	**$20,000**	**$30,000**	**$30,000**	**$20,000**		**$100,000**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs		$250,000	$250,000	$250,000		$750,000
12.	Indirect Costs		$30,000	$20,000	$20,000	$5,000	$75,000
13.	**Total Consultant Costs**		**$280,000**	**$270,000**	**$270,000**	**$5,000**	**$825,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	**Total Other Expenditures**						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$250,000	$250,000	$250,000		$750,000
Indirect Costs (add lines 3, 6 and 12 from above)		$20,000	$60,000	$50,000	$40,000	$5,000	$175,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$20,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$925,000**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative ~~MH~~SA Funds	$20,000	$280,000	$280,000	$270,000		$850,000
2.	~~Federal Financial~~ Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$20,000**	**$280,000**	**$280,000**	**$270,000**		**$850,000**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative ~~MHSA Funds~~		$30,000	$20,000	$20,000	$5,000	$75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$30,000**	**$20,000**	**$20,000**	**$5,000**	**$75,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$20,000	$310,000	$300,000	$290,000	$5,000	$925,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$20,000**	**$310,000**	**$300,000**	**$290,000**	**$5,000**	**$925,000**
*If "Other funding" is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: High rates of mental illness amongst low-income young adults

Key Considerations (from the literature)

Early Intervention: Poverty contributes to onset of behavioral health challenges, early intervention for low-income young adults is critical.

Ease of access: Co-locating services in spaces where young adults are comfortable will increase access and combat stigma.

Comprehensive approach: Young adults may engage with programs that are client driven, culturally responsive and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity).

Interventions

Co-location of Services
Prevention and early intervention (PEI) services will be provided on-site at affordable housing complexes.

- Preventative behavioral health and harm reduction workshops
- Peer support group(s)
- Social determinants and behavioral health screenings
- Referrals and linkages
- Crisis support

Culturally-relevant activities
Advisory board will identify culturally relevant activities for young adults that allow for peer discussion on every day stressors, needs and interests; decreasing barriers and stigma.

Screening and Referrals/Warm Hand-offs
Peer staff will link young adults to services and resources to support mental well-being .

Outcomes

PEI Services Provided
80 workshops offered at **10** affordable housing complexes
150 young adults participate in services provided on-site

- **90%** increased knowledge about behavioral health.
- **90%** reduced stigma

Screening and Linkages
120 young adults screened
30% will be referred to social and/or behavioral health svcs
70% of young adults referred to behavioral health service will receive treatment.
80% of the young adults who are found to have mental illness and receive treatment will report:

- Increased understanding of their emotions
- Increased understanding of mental illness.

Learning Objectives

Learning Goal #1
Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

Learning Goal #2
Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

Learning Goal #3
Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?

MHSA INN Primary Purpose

Increased access to behavioral health services

Appendix 2. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSA Steering Committee.

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

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

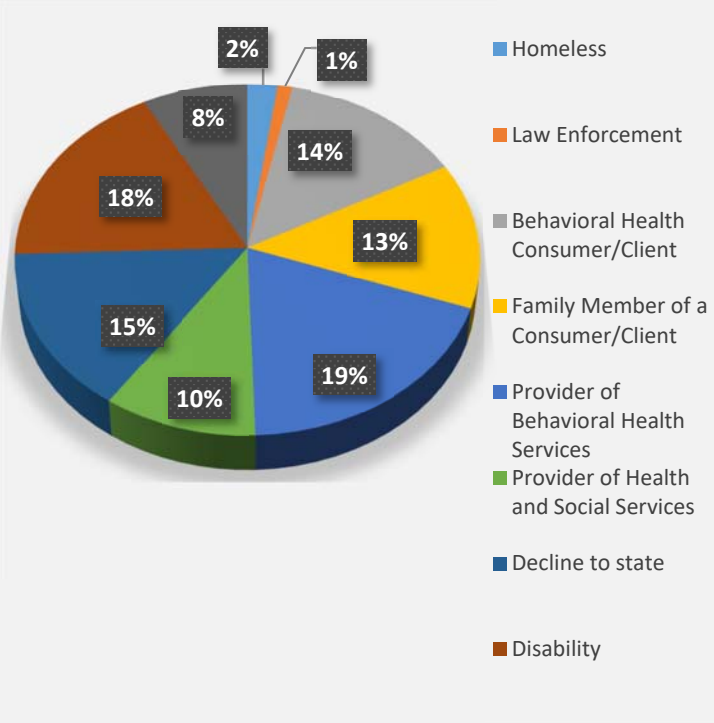
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers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

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

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

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

Represented Groups



Input Sessions

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

PHASE 1. NEEDS ANALYSIS

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

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

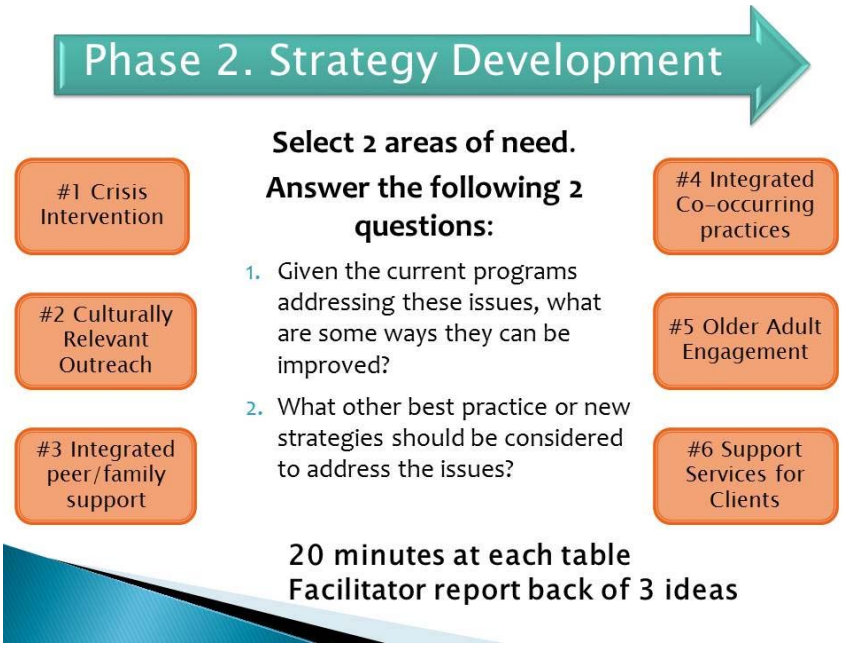
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

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

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

PHASE 2. STRATEGY DEVELOPMENT

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



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

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

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

PHASE 3. PLAN DEVELOPMENT

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

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

Appendix 3. Public Comments

[To be updated following the 30-day public comment process]

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted:
Project Title: Cultural Arts and Wellness Social Enterprise Cafe for Filipino/a/x Youth
Total amount requested: $2,625,000 ($2,100,000 services; $315K admin; $210K eval)
Duration of project: 5 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- □ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- □ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- □ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- □ Increases the quality of mental health services, including measured outcomes
- □ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- □ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Filipino/a/x Youth & Mental Health

Asian Americans are the fastest growing racial/ethnic group in the U.S. and Filipinos are the third largest subgroup.[1] In San Mateo County, the City of Daly City, has the highest concentration of Filipino/a/x Americans of any municipality in the U.S; making up 32% of the population. Yet, there is limited published research on mental health challenges impacting Filipino/a/xs and even less literature on promising practices,[2] especially focused on adolescent youth. Filipino/a/xs are often grouped with Asian Americans which masks cultural-specific considerations for unmet mental health needs. This was highlighted repeatedly by the California Reducing Disparities Project (CRDP) Asian Pacific Islander (API) Population Report, an MHSA Prevention and Early Intervention (PEI) state-funded project and the largest investment in the nation to look into diverse community perspectives on mental health disparities. Throughout the entire report it was stressed that API is a heterogenous grouping and that data and strategies should address the diverse needs of ethnic subgroups. Out of the 56 promising practices reviewed by CRDP, only six targeted Filipino/a/x and only one targeted Filipino/a/x exclusively, the Filipino Mental Health Initiative (https://www.smchealth.org/filipino-mental-health-initiative), which is a collaborative of community-based partners, county staff, clients, family members and community stakeholders that developed this innovation project proposal.

Primary Problem: High rates of depression and suicidal ideation attributed to cultural identity formation amongst Filipino/a/x youth

The limited studies available on Filipino/a/x youth suggest disparities with regards to social determinants of health (school, employment, access to care, etc.) and behavioral health outcomes. Nationwide, Filipino/a/x youth have one of the highest high school dropout rates and one of the highest rates of teen suicide ideation and attempts[3].

- Research from the Centers for Disease Control and Prevention found 45.6% of Filipina American adolescents have experienced suicidal ideation, the highest rate of suicidal ideation at among all racial and ethnic groups,[4] as well as higher

[1] https://www.pewresearch.org/fact-tank/2017/09/08/key-facts-about-asian-americans/

[2] Jackson, Y. K. (2006). Encyclopedia of multicultural psychology. Thousand Oaks, CA: Sage.

[3] President's Advisory Commission on Asian Americans & Pacific Islanders, 2001

[4] Wolf, DL. Family Secrets: Transnational Struggles among Children of Filipino Immigrants. Sep 1997 40(3): pp. 457-482

rates of depression at 13.6% compared to other Asian American females.[5]
- Research has shown an association between low self-esteem and Filipino/a/x youth[6]. Empirical evidence also suggests that depression affects Filipino/a/x youth and adolescent health risk behaviors increase with each generation of Filipino/a/x youth.[7]

Unfortunately, San Mateo County disaggregated data for Filipino youth is largely unavailable. The California Health Kids Survey reports on Asian as an ethnicity with no further breakdown. Yet, we know that mental health challenges can impact youth's educational outcomes and other quality of life indicators. Young people need jobs, skills, support and emotional and physical safety in order to succeed academically and ultimately have positive behavioral health outcomes.

- At Jefferson Union High School District, Filipino/a/x students had an 90% graduation rate from high school and yet, only 42% met University of California (UC) and California State University (CSU) requirements.
- At South San Francisco Unified, In Westmoor High (another Daly City high school) 91% Filipino/a/x students graduated and just 19% met the requirements.[8]
- In San Mateo County, 53% of youth clients in Probation and 43% in Behavioral Health and Recovery Services come from the same 4 zip codes, two of these are where we have high concentration of Filipinos, the City of Daly City and South San Francisco.

Cultural Identification as a Protective Factor

There is plenty of research that suggests that the stronger a youth's cultural/ethnic identity, the higher their resilience and the more likely it is that they experience positive life outcomes[9]. In a study looking at Asian American youth from emerging communities found that both ethnic exploration and ethnic belonging was significantly correlated with higher self- esteem and lower depressive symptoms.[10]

Based on the research of E.J. Ramos David PhD, and Kevin Nadal PhD, two highly regarded Filipino Psychologists, there is a strong correlation between cultural identity formation and mental health and wellness of Filipino/a/x adolescent youth:

- A bicultural clash exists between collectivist (Filipino/a/x) and individualist (American) value system, which leads to a lack of a stable sense of cultural identity; this in turn leads to mental health issues related to decreased self-

[5] Kim, L. S., & Chun, C.-a. (1993). Ethnic differences in psychiatric diagnosis among Asian American adolescents. Journal of Nervous and Mental Disease, 181(10), 612-617.

[6] Rumbaudt RG. The crucible within: ethnic identity, self-esteem, and segmented assimilation among children of immigrants. The new second generation. New York (NY): Russel Sage Foundation; 1996 pp. 119–170.

[7] Javier JR, Huffman LC, Mendoza FS, Filipino Child Health in the United States: Do Health and Health Care Disparities Exist? Prev Chronic Dis. 2007 Apr; 4(2): A36.

[8] DataQuest, California Department of Education, 2019.

[9] Yasui, M, & Dishion, TJ. The ethnic context of child and adolescent problem behavior: Implications for child and family interventions. Clinical Child and Family Psychology, 2007 10(2), 137-179

[10] Stein, GL, Supple, AJ, Kiang, L, & Gonzalez, LM. Ethnic Identity as a protective factor in the lives of Asian American adolescents. Asian American Journal of Psychology. 2014

efficacy and self-worth.[11]

- "Ethnic identity development is particularly critical for minority adolescents since they have, in addition to their ordinary development issues, the added burden of exploring the values of both their host society and their original cultures…".[12]

An upstream, holistic, cultural-based, integrative approach for Filipino/a/x Youth in Northern San Mateo County can lead to developing protective factors and improving mental health outcomes for at-risk Filipino/a/x youth.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

The proposed project is a cultural arts and wellness-focused social enterprise café that offers youth development and mental health programming on site. The social enterprise café will hire and train at-risk youth from Northern San Mateo County and serve as a culturally affirming space for Filipino/a/x youth and community. The social enterprise model has proven to be a more sustainable approach when it comes to stable and diversified funding streams. Most of the existing community organizations that offer some elements of the proposed project rely heavily on grant-writing and fundraising.

Social Enterprise – Cultural Arts-Focused Cafe

Social enterprises advance a social mission and provide financial sustainability. The cultural arts focused cafe will provide at risk youth from Northern San Mateo County an employment and training opportunity as they learn all aspects of running a café, and gain transferable skills relating to financial literacy & wellness and entrepreneurship. Employed youth will develop leadership and other critical life skills including problem solving, teamwork, critical thinking, and creativity, among others. The social enterprise business model will include profit generation to support the financial sustainability of the café and its programming.

Culture and wellness focus

Building off the research on the importance of cultural identification and a proven understanding of wellness-focused interventions and their long-term impact on behavioral health outcomes, the cultural arts focused cafe will be rooted in a foundation of Filipina/o/x Cultural Values: Kapwa (togetherness) and Ginhawa (total wellness). The centralized gathering space will serve as a platform to collectively address intergenerational and ancestral trauma and wounds. The café will celebrate Bayanihan ("community" in Tagalog), honor diversity, and promote holistic health through arts & wellness practices. By exploring the Filipino/a/x and Filipino/a/x American experience and history of the Philippines,

[11] Nadal, K. Filipino American Psychology: A Handbook of Theory, Research, and Clinical Practice. John Wiley & Sons, Mar 2011
[12] Shrake, EK, Rhee, S. Ethnic identity as a predictor of problem behaviors among Korean American adolescents. 2004. Adolescence . 39 (155), pp. 601-622.

the café aims to bridge multiple generations through various culturally-specific educational and expressive arts engagement and elevate youth to be the next generation leaders of social change, wellness ambassadors, and cultural preservationists. While the cafe is inspired by the Filipino/a/x experience, anyone interested in learning about the Philippines is welcome and encouraged to collaborate in building multicultural awareness and community.

Leadership development and mental health programming

Hiring and training at-risk youth to work at and eventually manage the café is critical to providing youth with basic needs of employment, job skills and leadership development. The cafe has the potential of impacting more Filipino/a/x youth in Daly City and neighboring communities.

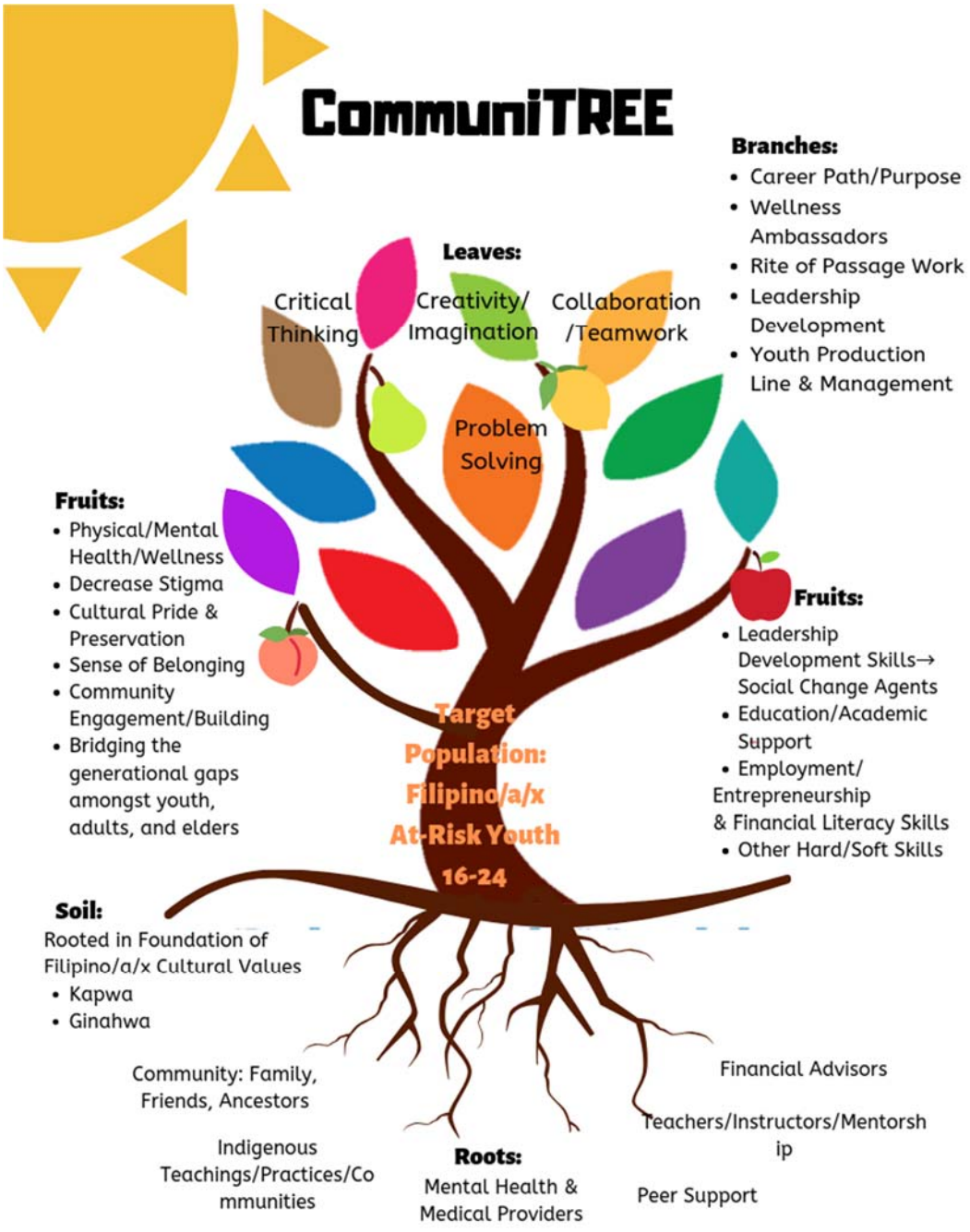
The café will also offer programming that is holistically designed around social determinants of health and issues important to Filipino/a/x youth in Northern San Mateo County. The programming will leverage successful programs, such as the Skyline College Kababayan Learning Community that focuses on education relating to the Filpino/a/x & Filipino/a/x cultural experience; and Daly City Youth Health Center's Elements for Success[13] program, a school-to-career transition program, along with expanded service. It will consist of five components that have been developed over the past six years by community stakeholders with youth input and continue to be refined:

- Career Path/Purpose (school-to-career prep)
- Wellness Ambassadors (wellness and mental health linkages)
- Rite of Passage Work (cultural identity formation)
- Leadership Development (i.e. capstone arts-based projects to address mental health & wellness related social issues facing the community)
- Youth Production Line & Management (financial wellness)

This programming component of the café is represented in the CommuniTREE framework, below, which uses a tree as a metaphor to depict the values that ground this work (SOIL), the supports needed (ROOTS) for success, the strategies that will get us there (BRANCHES), the resulting youth capacity (LEAVES) and health outcomes (FRUITS) we expect to impact.

[13] https://www.skylinecollege.edu/kababayan/; https://www.dalycityyouth.org/elements.html

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Project implementation activities:

- Work with social enterprise consultants to finalize business plan.
- Project startup - identify location, procure inventory, furniture, equipment, licensing and permits, hire staff.
- Establish youth and subject matter TRIBE advisory group(s).
- Develop culturally appropriate methods of Filipinx youth engagement through various arts modalities, such as workshops & training in culinary arts, literary,visual and performing arts, and multi-media/digital arts, etc.
- Offer workshops, classes, and skill-building activities to support youth to gain financial literacy skills, enhance sustainable financial wellness, explore field of entrepreneurship, and enhance leadership development skills.
- Provide mentorship opportunities with local entrepreneurs to build professional network and develop vocational skills.
- Provide classes/workshops for youth to examine connection of mental health and wellness to Filipinx cultural identity
- Cultivate a stigma-free space to have conversations around mental health and wellness through educational classes and workshops.
- Launch Mano Po Program:
  - Offer safe, inclusive, and culturally affirming spaces that create opportunities for intergenerational connection to mitigate risks for isolation and depression.
  - Ensure cultural preservation of Kapwa and Ginhawa through passing down of traditions, food history/narrative/recipes, and practices to address the intergenerational gap and support youth's cultural identity formation.
  - Foster intergenerational interaction through hosting storytelling (Kwentuhan) events/activities (ie. digital storytelling, photovoice, mural making)
- Create natural touchpoints and linkages to increase access to behavioral health services.
- Work with TRIBE Advisory to develop sustainability plan.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Project Staffing:

- Program Director (1.0 FTE), with a mental health background and notable long-standing/established relationship to Filipinx community in North San Mateo County, will oversee the operational components, coordination of care/services for the Kafe, and continued strengthening of community resources/relationships.
- Case Manager (1.0 FTE) will conduct comprehensive intake assessment, provide case management, and guidance through internship/apprenticeship program with each youth participant. They will assist youth in identifying an internship/apprenticeship through the Kafe that is aligned with their strengths, skills, and interests (in mental health, wellness, &/or food industry). REFER TO DATA in Needs Assessment). Additionally, provide academic and career focused resources and referrals to youth.
- Clinical Case Worker (1.0 FTE) will therapeutically engage and explore wellness practices offered at the Kafe with youth in a cultural context and as they obtain knowledge around physical, mental, and spiritual health (ie. physical fitness, such as zumba, yoga, and martial arts). They will utilize behavioral health assessment tools to help youth identify potential needs for clinical support and linkage to mental health services.
- Community Outreach Worker (1.0 FTE) Worker will serve as a conduit to local high schools and colleges to provide Filipinx focused education that fosters cultural identity formation (ie. Filipino History) and arts-based vocational training.
- Youth Services Coordinator (.5 FTE)- Admin/Onboarding/Operations of School-to-Career Programming
- Front Desk/Office Manager (.75 FTE)- Managing front desk and administrative operations with cafe and cultural center. Responsible for scheduling and maintaining calendar of events, classes, and workshops.
- Cafe Manager (1.0 FTE) oversees cafe operations and staffing

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases access to mental health services to underserved groups**

C) Briefly explain how you have determined that your selected approach is appropriate.

Based on a comprehensive review of published literature, web-based searches, the following were identified as key considerations for the project activities and approach:

1. **Social Determinants of Health (SDOH)** - Disparities in health exist for Filipino/a/x youth and lead to negative outcomes in MH Upstream strategies that intervene at the root causes of disparities are needed
2. **Behavioral Health** - Disparities in behavioral health outcomes exist for Filipino/a/x youth
3. **Cultural Identity** - Cultural identification is critical for the mental health of Filipino/a/x youth as they explore the opposing values of two cultures
4. **Promising Practices** - There is a need for promising sustainable practices that address the mental health needs of Filipino/a/x youth

These considerations serve as supporting evidence for the proposed interventions and selected approach for this project. The Theory of Change for this project, Appendix 1., illustrates the pathways between the supporting evidence for the interventions, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The local Daly City Youth Health Center sees 69 Filipino/a/x youth ages 13-22 for behavioral health counseling based on a recent annual report. While the café program will not have direct mental health services onsite, there will be a robust referral network that connects youth to systems of care, including behavioral health counseling. The café will not have the stigma associated with seeking behavioral health services and it is completely based on employing culturally relevant engagement strategies for youth (various arts modalities, such as workshops & training in culinary arts, literary, visual and performing arts, and multi-media/digital arts, etc.). Therefore, we expect a higher number of youth to engage in services at the café.

Additionally, a recent survey created for the innovation stakeholder process supported the idea that a culturally affirming space will encourage participation.. Please see annotated Appendix 2 for a summary of survey results including themes from 4 focus groups conducted. There was a subset of questions specified for only youth about the likelihood of participating in the café program. 91 respondents were youth between the ages of 13-24. Youth indicated they would "very likely" engage in the following areas of the program: 29 in leadership skills development; 32 in on the job training; 26 in entrepreneurship.

Based on 2018-19 enrollment figures, 3,553 students from the local high school districts identify as Filipino. At Skyline College, 5,782 of students identify as Asian (with no ethnic subgroup breakdown). Every year, 75-100 Filipino students participate in Skyline College's Kababayan Learning Community, which is a program that focuses on activities related to the Filipino/a/x, Filipino/a/x American experience and assists students in transferring to a four-year university.

The following represents expected annual reach through outreach, unique visitors at the café, and actual engagement in the programming. Demographics and referral data, as well as outcomes, will be captured to ensure the program is serving its target audience effectively. We expect the following annual reach:

- 4000 outreach encounters through direct promotion at the schools
- 2,000 unique visitors at the café
- 300 youth referred to services; 150 receive behavioral health services
- 90 participate in mental health related programming at the café
- 40 youth participate in the full programming at the café (cohort participants)
    - 90% participants develop cultural pride and sense of belonging (includes cohort participants and unique visitors)
- 10-12 - youth hired from target cities, including Daly City
    - 90% youth develop leadership and critical skills: problem solving, teamwork, critical thinking, creativity, etc.
    - 90% youth develop leadership and other skills: advocacy, financial literacy, etc.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The social enterprise café will reach out to transitional age youth (16-24) within northern San Mateo County cities of Daly City and South San Francisco that have a high concentration of Filipino youth.

Demographic Indicator[14]	Daly City	South San	San Mateo

[14] U.S. Census Bureau, 2012-2016 American Community Survey 5-year Estimates

		Francisco	County
Total Population	105,543	66,587	754,748
Limited English-Speaking Households	16%	14%	9%
Race Ethnicity			
• Asian	56%	38%	27%
• Black	3%	2%	2%
• Latino	24%	34%	25%
• Pacific Islander	1%	2%	1%
• White	13%	20%	40%
Youth Need Index[15]	48	57	24
Percent of Residents Living below 200% of the Federal Poverty Level	22%	22%	20%

More specifically, high school districts and colleges in these areas will be targeted. This includes the Jefferson Union High School District (29.7% Filipino) in Daly City, South San Francisco Unified School District (24.2% Filipino) and Skyline College and other secondary institutions. Additional indicators are included below for each of the high school districts to help paint the picture of the youth population to be served.[16]

School District	Free or Reduced-Meal Eligibility	Foreign-Born Parents	Student Suspension (per 100 students)	Depression-Related Feelings (11th grade)	Alcohol/Drug Use Past Month (11th grade)	Suicidal Ideation (11th)
Jefferson Union	36.1%	62.0%	7.5	34.5%	34.8%	18.9%
South San Francisco Unified	38.6%	65.8%	4.9	37.6%	33.5%	24.2%
San Mateo County (for comparison)	33.7%	57.3%	3.0	29.5%	36.9%	16.3%

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The key things that distinguish the proposed project from other programs include:

- Culturally responsive approach to Filipino/a/x youth. As noted earlier, through the CRDP review of promising practices there was no program explicitly targeting the Filipino/a/x community, this proposed approach is completely rooted in Filipino/a/x cultural values and has cultural identification as a core component of developing protective factors for

[15] San Mateo County Health System, Office of Epidemiology and Evaluation, 2017. The Youth Need Index reflects a combination of factors that impact youth success where higher scores (out of 100 total) indicate higher need. Data include Juvenile Probation and Behavioral Health hot spots, child maltreatment, low birthweight, student reading proficiency, suspensions and poverty.

[16] Lucile Packard Foundation for Children's Health, kidsdata.org

youth.

- A holistic approach to the youth development programming. Other similar projects typically focus one or two "branches" as presented in the CommuniTREE framework above. The cafe will provide a holistic approach including school-to-career wellness and mental health linkages, cultural identity formation, leadership development through art and financial wellness. This is based on significant community input and vetting on what would support Filipino/a/x youth and their behavioral health outcomes.
- For the social enterprise model, there is no other social enterprise targeting community mental health most are focused on vocational training goals and strategies. The cafe social enterprise will not only impact the youth employed but will provide integrated on-site programming for Filipino/a/x youth in the community.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Field and market research were conducted on comparable existing models in our local community and across counties and there are no programs designed specifically to support this population through a social enterprise model. The closest effective model we found was a social enterprise, Old Skool Café, in San Francisco, which is mostly focused on vocational training and not tying in strategies to help cultivate healthy cultural identity formation and its impact on mental health & wellness. Additionally, interviews with leaders in youth focused programming in Northern San Mateo County, such as, executive staff at Daly City Youth Health Center, CIPHER at Skyline College, and Skyline Kababayan Learning Community took place to better understand the gaps in service for this particular population.

In terms of the business aspect of the social enterprise, we met with local business leaders and entrepreneurs (including, but not limited to, Antigua Cafe (South San Francisco), Poke Time (Daly City/San Francisco)/Tuna Kahuna (Burlingame), & Frozen Kuhsterd (San Francisco Bay Area)) to advise on start-up costs and general business consultation.

Market Research

Youth Development and Cultural Centers:

- North San Mateo County: JobTrain & Boys & Girls Clubhouses (Pacifica & South SF) https://theclubs.org/
- Pilipino Bayanihan Resource Center https://www.pilipinobayanihanresourcecenter.com/
- Liwanag Kultural Center- https://www.facebook.com/pages/category/Youth-Organization/Liwanag-Kultural-Center-172790176129055/
- SMC PRIDE Center (San Mateo) https://sanmateopride.org/
- California Clubhouse (San Carlos) https://californiaclubhouse.org/
- Jewish Community Center (multiple locations- ie. SF) http://bayareajccs.org/
- Mission Cultural Center (SF) http://missionculturalcenter.org/
- Indian Community Center (Milpitas) http://www.indiacc.org/
- Delancey Street Foundation (SF) http://www.delanceystreetfoundation.org/
- Bayanihan Community Center (SF) https://www.bayanihancc.org/
- “Elements for Success 2.0” (Daly City) http://dalycityyouth.org/elements.html
- CIPHER https://skylinecollege.edu/cipher/
- Skyline Kababayan Learning Community https://www.skylinecollege.edu/kababayan/

Youth Focused Social Enterprise Models

- Old Skool Cafe(San Francisco) https://www.oldskoolcafe.org/
- Mamacitas Cafe (Oakland) https://www.mamacitascafe.com/
- La Cocina (San Francisco) https://lacocinasf.org/
- Youth Uprising (Oakland), https://www.youthuprising.org/
- Crossroads Cafe/Enterprise of Delancey Street Foundation (San Francisco), http://www.delanceystreetfoundation.org/entercafe.php
- Brotherhood/Sister Sol: https://brotherhood-sistersol.org/impact/outcomes
- After School Matters(Chicago) https://www.afterschoolmatters.org/
- Homeboy Industries/HomeGirl Cafe (LA) https://www.homeboyindustries.org/what-we-do/homegirl-cafe

Cafe//Wellness Center Models

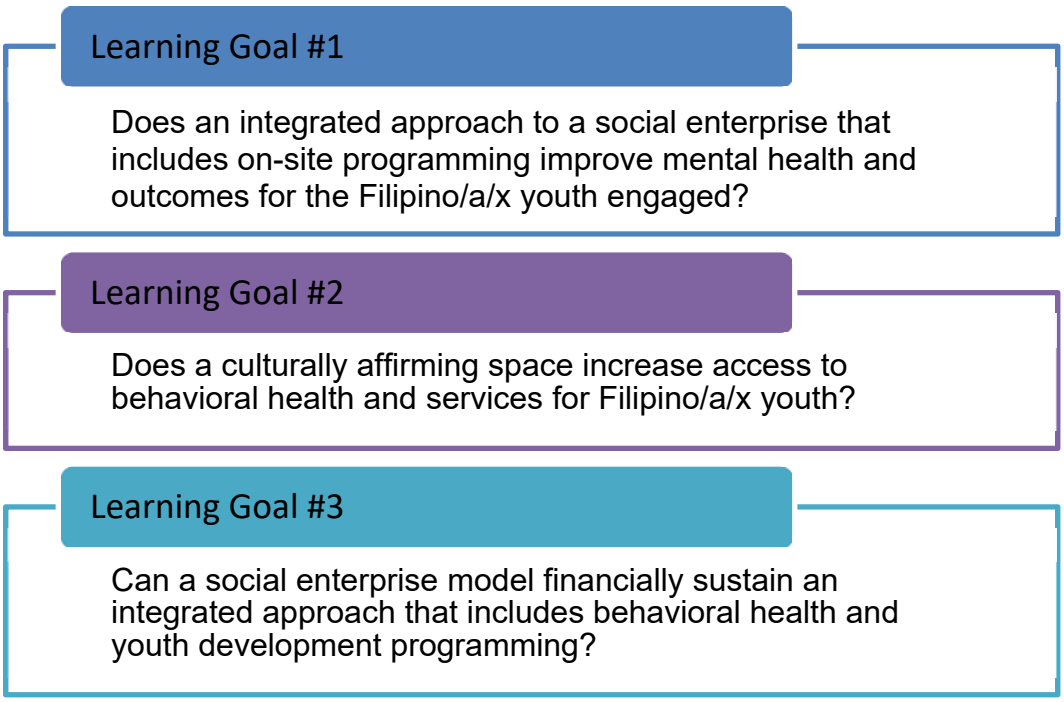
- Kafe (Oregon) https://drinkkafe.com/
- Por Vida (San Diego) https://www.porvidacollective.com/
- The Cultural Wellness Center- Philosophy (Minneapolis) http://www.culturalwellnesscenter.org/about-us/our-philosophy/

Gaps in the literature and practice	Proposed intervention
No promising practices for addressing mental health challenges and cultural identity formation amongst Filipino/a/x youth.	The proposed project is a culturally responsive approach to Filipino/a/x youth. The approach is completely rooted in Filipino/a/x cultural values and has cultural identification as a core component of developing protective factors for youth.
No disaggregated data for Filipino youth behavioral health.	The proposed project will measure youth assets and mental health indicators of all youth engaged. While this does not give us community wide data, it will provide a snapshot of how Filipino youth are faring in San Mateo County.
For the social enterprise model, there is no other social enterprise targeting community mental health.	The cafe social enterprise will not only impact the youth employed but will provide integrated on-site programming for Filipino/a/x youth in the community including a holistic approach to the youth development programming. This is based on significant community input and vetting on what would support Filipino/a/x youth and their behavioral health outcomes.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?



B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

As stated prior, the three key differences with the proposed project include:

- Culturally responsive approach to Filipino/a/x youth with cultural identification and cultural values at the core. *(Learning Goal #2)*
- A holistic approach to the youth development programming. *(Learning Goal #1)*
- Social enterprise model targeting community mental health with an integrated approach to engage the broader Filipino/a/x youth community. *(Learning Goal #1)*

An additional Learning Goal #3 related to sustainability of the integrated model of services within a social enterprise is included. The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor to formally evaluate the

innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

Does an integrated approach to a social enterprise that includes on-site programming improve mental health outcomes for the Filipino/a/x youth engaged?

The outputs for Learning Goal #1 could include:

- Number of youths that participate in each programming at the café
- Percent of youth that develop leadership and other skills (advocacy, financial literacy, community building, etc.)
- Percent of participants develop cultural pride and sense of belonging

Additionally, occasional interviews or planned focus groups with youth that engage with the café can help us determine the level of satisfaction and narrative for the impact this project may be having on youth development. Demographics of youth that engage will be collected and at this point the Search Institute's Developmental Assets Profile (DAP) pre- and post- to assess protective factors, internal strengths and external supports across several contexts of their lives: personal, peers, family, school, and community. The DAP is used with all other adolescent youth prevention programs that receive MHSA funding.

Learning Goal #2

Does a culturally affirming space increase access to behavioral health and services for Filipino/a/x youth?

The outputs for Learning Goal #2 could include:

- Percent of participants that develop cultural pride and sense of belonging
- Number referred to behavioral health and social services
- Number that receive behavioral health services
- Number that participate in mental health programming as part of the cafe and centralized gathering space.
- Percent improved mental health (suicide ideation, anxiety, depression)

Additionally, the same occasional interviews or planned focus groups with youth that engage with the cafe and centralized gathering space (mentioned above) can include questions about cultural identification and the level of impact the café has had on the youth's cultural identification.

Learning Goal #3

Can a social enterprise model financially sustain an integrated approach that includes behavioral health and youth development programming?

The outputs for Learning Goal #3 could include:

- Percent of operational cafe budget sustained by the profits of the café and possible revenue generating workshops/classes offered to community
- Percent sustainable overall, including behavioral health programming

An evaluation consultant with experience evaluating non-profits fiscal sustainability will be prioritized.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 3 describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

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MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

Community Collaboration
The planning of the cafe and centralized gathering space involved stakeholders representing various sectors of the community including youth[1]. Initially, the idea was brought forward by the Filipino Mental Health Initiative (FMHI) collaborative. To ensure the process was community informed, a needs assessment was conducted to gather input that would develop the programming. A survey was distributed broadly, and four focus groups were facilitated that targeted specific age groups: youth, adults, and elders. Additionally, individual interviews and meetings were held with gatekeepers and key leaders of the Filipino/a/x community, which include, but are not limited to, executives of non-profit organizations and City and County elected officials. The collaboration with FMHI will continue through implementation of an advisory group.

Cultural Competency
The entire project is rooted in cultural values of Kapwa ("togetherness") & Ginhawa ("total wellness") and the understanding that cultural identification is a key protective factor for youth. Programming will leverage art and culture as described above.

Client/Family-Driven
As mentioned above, FMHI will continue to play a role in the implementation of this project. Clients and family members will be engaged in an advisory capacity through FMHI or as independent member of an advisory board. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from the advisory group.

Wellness, Recovery, and Resilience-Focused
Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a holistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including the programming that will be offered to Filipino youth in the community.

Integrated Service Experience for Clients and Families
A request for proposal process will select the service provider that will own the contract for these services. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. Cafe/center staff/mentors will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

With a social enterprise, we are establishing a stronger funding source that generates revenue that is allocated towards the centralized gathering space and café sustainability and the programming. In addition, existing programs that specialize in these areas will be leveraged and serve as a platform and space for strengthening and building community partnerships across both the non-profit and business sectors.

The advisory group will be engaged in any needed adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for youth there may be availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

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COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Social enterprise and mental health
- Social enterprise and Social Determinants of Health
- Filipino adolescent youth mental health and prevention
- Cultural Identity and mental health
- Cultural, arts-based holistic programming for Filipino youth prevention

TIMELINE

A) Specify the expected start date and end date of your INN Project
February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
5 years + final evaluation;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 4 years of project implementation through June 30, 2024
- Final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities –RFP and contract negotiations
- Finalize business plan

July 1, 2020 – September 30, 2020

- Project startup activities – hire Program Director, identify location, purchase inventory/materials for the café, furniture/equipment, licensing, permits
- Establish TRIBE advisory group, hire administrative staff, set up application/recruitment/ training plan for youth staff, identify partners to contract with for workshops & classes offered to youth and community
- Set up infrastructure for implementation/ evaluation and referral system and resources
- Evaluator to meet with contractor, Filipino Mental Health Initiative advisory group and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine culturally appropriate engagement methods
- Begin recruitment of youth employees and planning of soft launch
- Determine schedule of programming, marketing materials, referral resources and tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Soft launch
- Begin outreach and marketing
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021

presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.

July 1, 2021 – December 31, 2021
- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Begin planning for mentorship opportunities with local entrepreneurs and Mano Po Program
- Continue outreach, programming, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as needed

January 1, 2022 – June 30, 2022
- Continue sustainability planning
- Launch the mentorship and Mano Po Program
- Continue outreach, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022
- Initial sustainability plan presented, begin exploring options for sustainability expansion (incubator space)
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Continue outreach, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023
- Continue outreach, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023
- Sustainability plan finalized

January 2023 – June 30, 2024
- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

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Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total Innovation funding request for 5 years is $2,625,000, which will be allocated out as follows:

Service Contract: $2,100,000
- $700,000 for FY 20/21
- $700,000 for FY 21/22
- $400,000 for FY 22/23
- $300,000 for FY 23/24

Evaluation (10%): $210,000
- $80,000 for FY 20/21
- $40,000 for FY 21/22
- $40,000 for FY 22/23
- $60,000 For FY 23/24

Indirect (15%): $315,000
- $50,000 for FY 19/20
- $70,000 for FY 20/21
- $70,000 for FY 21/22
- $70,000 for FY 22/23
- $70,000 for FY 23/24

Direct Costs will total $2,100,000 over a five-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $525,000

- $210,000 for the evaluation contract with the final report will be due by December 31, 2024. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $315,000 for for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

Federal Financial Participation (FFP) there is no anticipated FFP.

Other Funding N/A

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs	$35,000	$70,000	$70,000	$70,000	$70,000	$315,000
7.	**Total Operating Costs**	**$35,000**	**$70,000**	**$70,000**	**$70,000**	**$70,000**	**$315,000**
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11.	Direct Costs		$700,000	$700,000	$400,000	$300,000	$2,100,000
12.	Indirect Costs		$80,000	$40,000	$40,000	$50,000	$210,000
13.	**Total Consultant Costs**		**$780,000**	**$740,000**	**$440,000**	**$350,000**	**2,310,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	**Total Other Expenditures**						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$700,000	$700,000	$400,000	$300,000	$2,100,000
Indirect Costs (add lines 3, 6 and 12 from above)		$35,000	$150,000	$110,000	$110,000	$120,000	$525,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$35,000**	**$850,000**	**$810,000**	**$510,000**	**$420,000**	**$2,625,000**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$35,000	$770,000	$770,000	$470,000	$370,000	$2,415,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$35,000**	**$770,000**	**$770,000**	**$470,000**	**$370,000**	**$2,415,000**
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds		$80,000	$40,000	$40,000	$50,000	$210,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$80,000**	**$40,000**	**$40,000**	**$50,000**	**$210,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$35,000	$850,000	$810,000	$510,000	$420,000	$2,625,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$35,000**	**$850,000**	**$810,000**	**$510,000**	**$420,000**	**$2,625,000**
*If "Other funding" is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: High rates of depression and suicidal ideation attributed to cultural identity formation amongst Filipino/a/x youth

Key Considerations
(from the literature)

Social Determinants of Health (SDOH)
Disparities in health exist for Filipino youth and lead to negative outcomes in MH
Upstream strategies that intervene at the root causes of disparities are needed

Behavioral Health
Disparities in behavioral health outcomes exist for Filipino youth

Cultural Identity
Cultural identification is critical for the mental health of Filipino youth as they explore the opposing values of two cultures

Promising Practices
There is a need for promising sustainable practices that address the mental health needs of Filipino youth

Interventions

KulturArts Kafe – Social Enterprise
At risk Daly City youth will be employed and trained to run all aspects of the café, developing leadership and other critical life skills in the process

Youth Development & Behavioral Health Services
Incorporating holistic, cultural and arts-based integrative programming on-site at the social enterprise will create a culturally affirming space for youth in the community to have discussion about cultural identification, develop skills and access behavioral health services

Business Model for Sustainability
The social enterprise business model will include profit generation to support the financial sustainability of the integrated model

Outcomes

Employment
10 Daly City youth hired
90% youth develop leadership and critical skills – problem solving, teamwork, critical thinking, creativity, etc.

Youth Capacity Building
40 youth that participate in each programming at the café (cohort participants)
90% youth develop leadership and other skills (advocacy, financial literacy, etc.)
90% participants develop cultural pride and sense of belonging

Linkages
300 referred to services
150 receive services
90 participate in mental health programming

Sustainability
50% of budget sustained by the enterprise

Learning Objectives

Learning Goal #1
Does an integrated approach to a social enterprise that includes on-site programming improve mental health outcomes for the Filipino/a/x youth engaged?

Learning Goal #2
Does a culturally affirming space increase access to behavioral health and services for Filipino/a/x youth?

Learning Goal #3
Can a social enterprise model financially sustain an integrated approach that includes behavioral health and youth development programming?

MHSA INN Primary Purpose

Increased access to behavioral health services

Appendix 2. Needs Assessment

Filipino Cultural Arts and Wellness Social Enterprise Need Assessment

A needs assessment was conducted to inform the development of the programming for the Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth. The programming is intended to be a holistic approach to improving youth health outcomes incorporating cultural identity formation, mental health and youth development (leadership, job skills). The needs assessment involved an online survey and focus groups.

Survey Highlights

- **281 Respondents** (68.3% Completion Rate)**;** 45% Self-identified as Filipinx
- **Top 3 Respondent by Age Group:**
  20% 13-18 years old
  23% 19-24 years old
  é53% 25-64 years old

Filipinx Culture

- 47 % consider Filipinx culture as "very important"
- 34% are likely to participate in expressive arts to explore Filipinx cultural identity/history
- Respondents would like to learn about:
  - •History - 16%
  - •Food - 16%
  - • Language - 14%
  - • Indigenous healing - 12%

Mental Health

- 12% selected mental health as a top community need
- 83% consider mental health as "very important"
- Respondents would likely utilize:
  - •Cultural practices to improve mental health - 69%
  - •Mental health referrals - 67%
  - •Mental health services provided by culturally informed professionals - 42%

Leadership and Job Skills

- Respondents would "very likely" participate if the cafe includes:
  - •On the job training - 69%
  - •Leadership skills - 35%
  - •Entrepreneurship - 31%
- Type of assistance that respondents considered helpful
  - •Stress management - 15%
  - •Job/internship resources - 14%
  - •Academic support/counseling - 14%
  - •Money management - 13%

Focus Group Themes

40 Total Participants (Youth Ages 12-24; Adults 25-55; Older Adults 56+)
Participants identified the following as important:

1. Promoting intergenerational connections through activities
2. Mental health education/workshops
3. Creating a safe space to have conversations around mental health
4. Cultural preservation (passing down traditions, food, and practices)
5. Culturally informed/responsive providers (aware of mental health risk factors, Filipino/a/x history)
6. Culturally focused services and environment (Idea that this increases familiarity, connectedness, and sense of belonging. Participants want space to reflect community, as well.)
7. Physical fitness classes (Zumba, yoga, Filipinx martial arts, etc.)
8. Recognize the importance of "kapwa" (togetherness) and collectivist values that include family unity (but also recognize this as a barrier to seeking mental health help)
9. Ease of access (adequate parking and close to public transit lines)

Appendix 3. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSA Steering Committee.

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

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

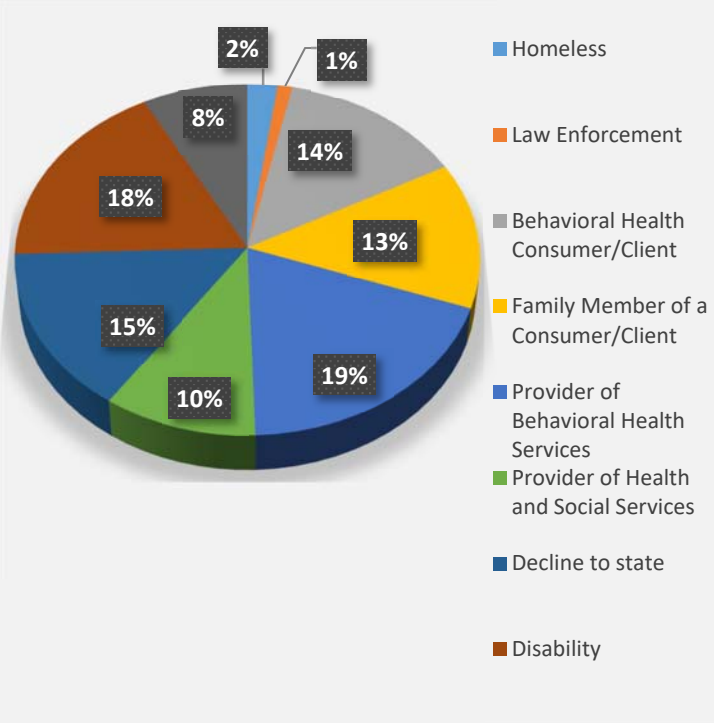
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers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

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

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

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

Represented Groups



Input Sessions

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

PHASE 1. NEEDS ANALYSIS

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

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

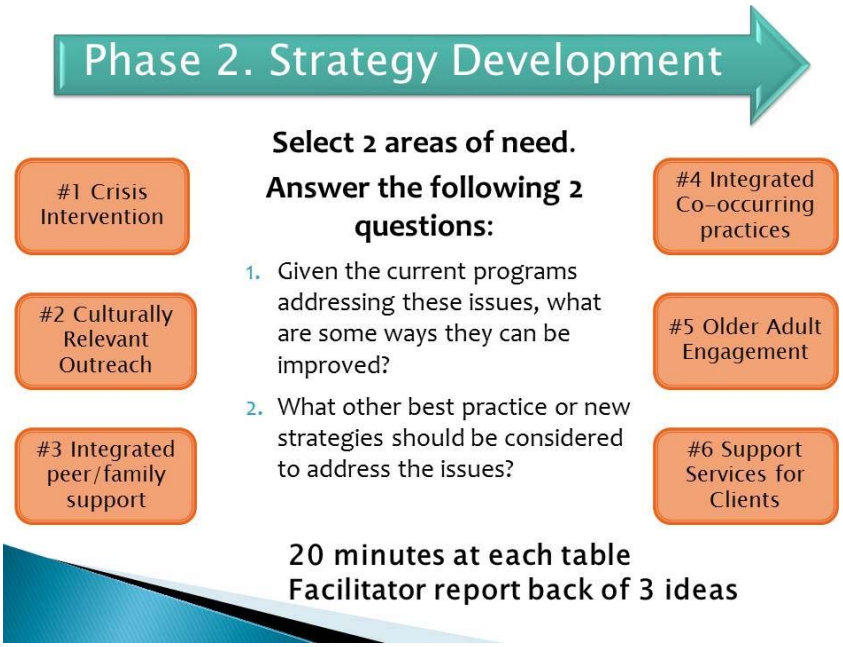
For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

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

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

PHASE 2. STRATEGY DEVELOPMENT

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



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

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

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

PHASE 3. PLAN DEVELOPMENT

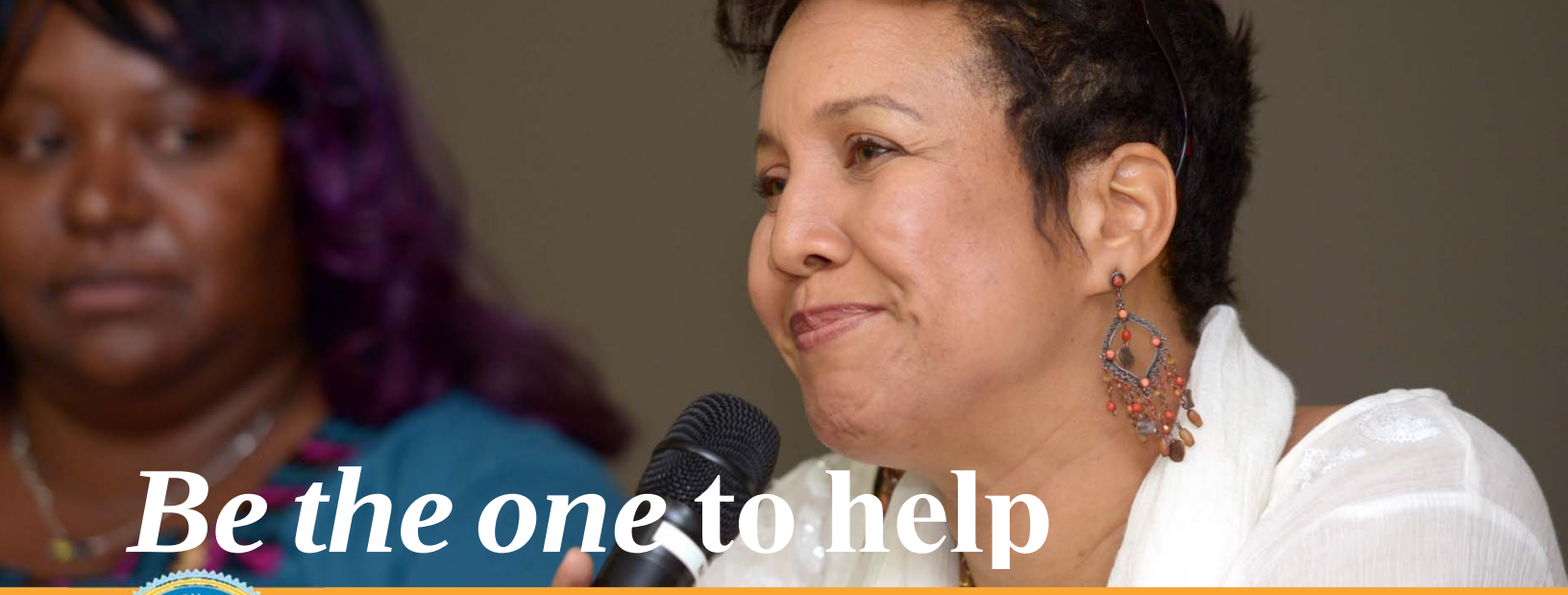
The final Phase of the CPP Process was kicked off at the CPP Prioritization Session on April 26, 2017. The meeting goals were three-fold:

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

Appendix 4. Public Comments

[To be updated following the 30-day public comment process]

APPENDIX 3. MHSA STEERING COMMITTEE MEETING & PUBLIC COMMENTS



Be the one to help

Mental Health Service Act (MHSA) Steering Committee Meeting

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA funded initiatives.

Meeting objectives include:

- Provide input on the Plan to Spend available one-time funds
- Learn about the MHSA Innovation ideas and provide input on the proposed projects:
  - PIONEER program for Pacific Islander college-age youth
  - Addiction Medicine Fellowship
  - Prevention and early intervention services in low-income housing
  - Preventing homelessness to economic and emotionally stressed older adults
  - Cultural arts and wellness-focused social enterprise cafe for Filipino/a/x youth

✓ Stipends are available for clients/family members
✓ Language interpretation is provided if needed*
✓ Childcare is provided if needed*
✓ Refreshments will be provided

**please contact Tania Perez at (650) 573-5047 or tsperez@smcgov.org by September 25th, to reserve language/childcare services.*

DATE

Wednesday, October 2, 2019
3:30 pm – 4:00 pm (MHSARC)
4:00 pm – 5:30 pm (MHSA)

The MHSA Steering Committee is combined with the monthly Mental Health Substance Abuse and Recovery Commission (MHSARC) in March and October each year. The MHSA portion of the meeting begins at 4pm, both meetings are open to the public.

County Health Campus, Room 100
225 37th Avenue
San Mateo, CA 94403

Contact:

Doris Estremera, MHSA Manager
(650) 573-2889 ♦ mhsa@smcgov.org

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, October 2, 2019 / 4:00 – 5:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

AGENDA

1. **Welcome & Background** 4:05pm
   - Doris Y. Estremera, MHSA Manager

2. **MHSA One-Time Funds -** *Public Comments* 4:10pm
   - Scott Gilman, Director of BHRS
   - Louise Rogers, Chief of County Health

   MHSARC Motion:
   Vote to open a 30-day public comment period for the
   MHSA Plan to Spend Available One-Time Funds

3. **MHSA Innovations (INN) Breakout Activity** - *Public Comments* 4:40pm
   - Select 2 projects you want to learn about (20 min each)
     1. PIONEERS program for Pacific Islander college-age youth
     2. Addiction Medicine Fellowship
     3. Prevention and early intervention services in low-income housing
     4. Preventing homelessness to economic and emotionally stressed older adults
     5. Cultural arts and wellness-focused social enterprise café for Filipino/a/x youth

   MHSARC Motion:
   Vote to open a 30-day public comment period for the
   MHSA Innovation Project Proposals

4. **Adjourn** 5:30pm

Next Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting
Closing of 30-day public comment period for MHSA Innovation Projects and Plan to Spend Available One-Time Funds:

November 6, 2019 from 3:30-5:00pm
County Health Campus, Room 100, 225 37th Ave. San Mateo

Mental Health Services Act (MHSA)

Steering Committee Meeting

October 2, 2019 / 4- 5:30pm

www.smchealth.org/mhsa

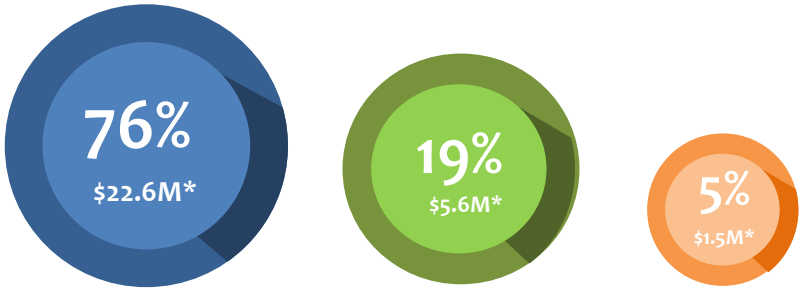
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. Welcome & Background
2. MHSA Plan to Spend One-time Funds & County Budget Update
   - ✓ MHSARC Motion
3. MHSA Innovations (INN) – Breakout Activity
   - ✓ MHSARC Motion
4. Adjourn

MHSA – Prop 63 (2004)

1% tax on personal income in excess of $1 million (M)



Community Services & Supports (CSS)

Direct treatment and recovery services for serious mental illness and serious emotional disturbance

Prevention & Early Intervention (PEI)

Interventions prior to the onset of mental health disorders and early onset of psychotic disorders

Innovation (INN)

New approaches and community-driven best practices

*Component amounts based on 5-year average revenue through FY 2018/19 of $29.7 million

MHSA Reserves

- A Prudent Reserve is required to ensure counties' ability to serve clients should MHSA revenues drop.
- In January 2019, the San Mateo County MHSA Steering Committee discussed and approved a total reserve of 50% of the highest annual revenue
  - This total reserve includes the 33% (~$7M) required Prudent Reserve + an additional operational reserve

San Mateo County MHSA Reserve	
Unspent*	$35.7M
Reserve Goal	-$16.5M
Obligated	-$6.7M
Available One-Time	**$12.5 M**

as of FY 17/18

MHSARC Motion

- Vote to open a 30-day public comment period for the MHSA Plan to Spend Available One-Time Funds

MHSA Plan to Spend One-time Funds & County Budget Update

Plan to Spend One-Time Funds

- **Priorities :**
  - System improvement for MHSA core services
  - Technology and Capital Facilities (IT/CF)
  - Workforce Training and Community Education/Awareness
  - Stop-gap for Innovation projects and BHRS budget reductions
- **Input:**
  - MHSA Three-Year Plan Priorities
  - BHRS Budget Planning Stakeholder Meetings
  - April 2019 MHSA Steering Committee – initial vetting
  - Additional Stakeholder Groups

Handout: 3-Year Plan to Spend $12.5M Available One-Time Funds

County Budget Update

- **Health budget overview**
- **One-time allocation to support BHRS budget impacts**
  - $1M for Cordilleras construction -Capital Facilities
  - $4M for FSP/Clinic restructuring - System Improvement for Core MHSA Services

Public Comments

- **Public comment forms are available here**
- **Can continue to provide public comments through November 6, 2019:**
  - Email: mhsa@smcgov.org
  - Phone: Doris Estremera, MHSA Manager (650) 573-2889
  - Mail: 310 Harbor Blvd, Bldg E, Belmont CA 94002.
  - Optional Public Comment Form available on line at www.smcgov.org/mhsa

MHSA Innovations

MHSA Innovation

- MHSA Innovation: 3-5 year projects to develop new best practices
  - 35 ideas received, 20 reviewed by Selection Committee
  - Moving forward with 5 ideas

Handout: MHSA Innovation Ideas Prioritization

MHSARC Motion

- Vote to open a 30-day public comment period for the MHSA Innovation Project Proposals

Input Activity

- Select 2 projects you want to learn more about
  1. PIONEERS for Pacific Islander college-age youth
  2. Addiction Medicine Fellowship
  3. PEI services in low-income housing
  4. Preventing homelessness to economic and emotionally stressed older adults
  5. Cultural arts and wellness-focused social enterprise café for Filipino/a/x youth
- 10 min presentation, followed by 10 min Q&A
  - Provide public comment during the Q&A or in writing using the Public Comment form

Thank you!

For more information:
www.smchealth.org/MHSA
Doris Estremera, MHSA Manager
(650) 573-2889 or
mhsa@smcgov.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

3-Year Plan to Spend $12.5M Available One-time Funds

*$3.9M must be spent in Prevention and Early Intervention (PEI)

Priority	Item	FY 19/20	FY 20/21	FY 21/22	Grand Total
System Improvements - Core MHSA Services	Recovery oriented, co-occurring capacity	$500,000	$250,000	$250,000	
	Full Service Partnerships/Clinic restructuring		$2,500,000	$1,500,000	
	MHSA PEI data-informed improvements	$100,000	$50,000	$50,000	
	Trauma-informed systems (BHRS, HSA, CJ, etc)		$100,000	$100,000	
	System Improvement Total	**$600,000**	**$2,900,000**	**$1,900,000**	**$5,400,000**
Technology for System Improvement	Network Adequacy Compliance	$100,000			
	Improve productivity	$100,000	$225,000	$173,000	
	Increase access-telepsychiatry/health	$30,000	$30,000	$30,000	
	Technology Total	**$230,000**	**$255,000**	**$203,000**	**$688,000**
Workforce and Community Education and Training	Workforce Capacity Development		$206,000	$98,000	
	Community Education		$180,000	$180,000	
	Crisis Coordination		$150,000	$150,000	
	Supported Employment		$400,000	$300,000	
	Workforce pipeline and retention		$124,000	$124,000	
	Education and Training Total	**$0**	**$1,060,000**	**$852,000**	**$1,912,000**
Capital Facilities (must be County-owned)	SSF Clinic		$500,000		
	EPA Clinic	$700,000			
	Casia House Renovations	$100,000			
	Cordilleras		$500,000	$500,000	
	Capital Facility Improvements Total	**$800,000**	**$1,000,000**	**$500,000**	**$2,300,000**
Stop Gaps (ongoing programs)	Pride Center			$700,000	
	HAP-Y		$250,000	$250,000	
	NMT- Adults		$200,000	$200,000	
	Tech Suite		$300,000	$300,000	
	Stop Gaps Total		**$750,000**	**$1,450,000**	**$2,200,000**
TOTALS		$1,630,000	$5,965,000	$4,905,000	**$12,500,000**

MHSA Innovation Ideas Prioritization – April 2019
(3 to 5-year projects)

Target Population	Need	Potential Reach	Project Description	Innovation	Annual Cost
Native Hawaiian/ Pacific Islander (NHPI) college-aged youth	In San Mateo County Asian/Pacific Islanders have lowest rates of accessing specialty mental health service. Pacific Islander students demonstrate the lowest rate of student success of all ethnic groups. There is a need for culturally relevant mental wellbeing supports for college-age youth.	The largest number of Pacific Islanders in the Bay Area reside in San Mateo County (11,543). Pacific Islanders represent about 1.9% (510) of students in junior colleges in San Mateo County.	The Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) program provides a culturally relevant, college behavioral health program for NHPI youth on campus and the surrounding communities. PIONEERS program has 3 key components. 1) Leadership institute for cultural education, identity, history, community to develop knowledge, skills and mental health networks. 2) Mana sessions to provide a space to decompress, engage in group discussions around mental health and wellness, as well as skill building workshops. 3) Forward Movement Projects are opportunities to give back or be of service to the NHPI community.	Culturally responsive college/ community student mental health promotion program (3-year project)	$250,000 + admin/eval
Low income young adults 18-25	Young adults have the highest prevalence of severe mental illness however, only 35% receive treatment.	MidPen houses 500 low-income young adults throughout San Mateo County	Preventative mental health and harm reduction workshops, a peer support group, mental health screenings, referrals and linkages to resources for mental health and drugs and alcohol, crisis support in low-income affordable housing and surrounding community housing.	Co-location of prevention and early intervention services in affordable housing properties (3-year project)	$250,000 + admin/eval

Clients with co-occurring disorders	It is estimated that addiction-related conditions account for 25-30% of ED and PES visits. Likely 60-80% of BHRS clients (15,000/year) are co-occurring. The Youth Services Center has 95% youth with co-occurring diagnosis.	1,400 combined initial evaluations and follow-up visits per year	An accredited Addiction Medicine Fellowship sponsored by San Mateo County that is tailored to addressing the needs and priorities of the public sector including treating the most vulnerable communities with co-occurring substance use disorders, advancing equity on multiple levels, and contributing to educational projects in clinical and community settings.	Addiction medicine fellowships sponsored by a government agency (3-year project)	$157,000 +admin/eval
Housed older adults at risk of homelessness	43% of all elders age 65+ do not have enough income to meet their most basic needs as measured by the Elder Index. That's over 38,000 elders struggling to make ends meet in San Mateo County. TIES Lines intake unit social workers received 3,301 housing related calls and 598 calls regarding homelessness.	For FY 18/19 there were 1,577 eligible 60+ older adults receiving Home Delivered Meals in San Mateo County. 340 home visits, 195 screenings and linkages to behavioral health and housing resources	A mental health peer counselor will conduct home visits and forums at senior centers for older adults receiving congregate nutrition or home delivered meals. Older adults will be screened for economic stress, behavioral health issues, and connected to homeless, housing and behavioral health resources for planning, and support, to prevent acute homelessness and to slow the growing older adult homeless population trend.	Economic and emotional stress screening to prevent homelessness (3-year project)	$200,000 +admin/eval

Filipino at-risk youth (16-24) in northern San Mateo County	Filipino youth have high drop-out rates, highest rates of depression, and suicide ideation.	33% (about 33,000) of Daly City population are Filipino. The Daly City Youth Health Center sees about 52 Filipino youth ages 13-22 for behavioral health counseling	A cultural arts and wellness-focused social enterprise café that offers youth development and mental health programming on site. The social enterprise café will hire and train at-risk youth from the Daly City and surrounding communities and serve as a culturally affirming space for Filipino youth and community. The social enterprise model has proven to be a more sustainable approach when it comes to stable and diversified funding streams. The components of the mental health program are school to career prep, mental wellness ambassadors, cultural identity formation, leadership development, and financial wellness.	Social enterprise for mental health (5-year project)	$700,000 +admin/eval
				Total Annual Funding	**$1,557,000 +admin/eval**

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, October 2, 2019 / 4:00 – 5:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

MINUTES

1. Welcome & Background 4:05pm
    - Doris Y. Estremera, MHSA Manager
    - Welcome and agenda review
        - Linda sitting in for Randy Torrijos, Supervisor Pines
        - First time merging the MHSARC and MHSA meetings – meetings will be held every March and October, first Wednesday of the month
        - Good opportunity to engage Commissioners
        - We will be starting a new 3-year planning process to launch in January 2020
    - Agenda Topics – 2 major topics
        - MHSA Plan to Spend One Time Funds
            - Talking about since January
            - How are we doing with revenue and reserves
            - We brought a draft plan in April
        - Innovations
            - Great opportunity to pilot new ways of doing things
            - We will be looking at 5 project proposals today
        - For each Agenda Item:
            - Will provide background
            - Will have a motion to open up a 30-day public comment
            - Will then provide details and capture comments/questions as official public comment
    - Background - MHSA 101 (Proposition 63)
        - 1% tax on personal income in excess of $1M has provided an opportunity to transform system
        - There are guidelines on where monies are spent - 3 Components:
            - Community Services & Support – 76% allocated for support services and direct treatment for SMI/SED clients
            - Prevention & Early Intervention – 19%
                - Includes early psychosis

        - Innovation – 5%
- MHSA Reserves
    - Prudent reserve was established to allow continued client services in the event of an economic downturn
    - State recently established a maximum of 33% of CSS 5-year average revenue allocation to Prudent Reserve – that's about $7 million for San Mateo County
    - There is a comprehensive process required to access the Prudent Reserve
    - Counties across the State are considering an additional operational reserve to support modest declines in revenue or if funding is needed in a timelier manner
    - The recommendation approved by the MHSA Steering Committee back in January was to reserve 50% of the highest annual revenue. Given this, we have $12.5 million excess reserve and available to spend as one-time

2. MHSA One-Time Funds - *Public Comments* 4:10pm

MHSARC Motion:

Vote to open a 30-day public comment period for the MHSA Plan to Spend Available One-Time Funds

- Yoko opened the motion
- Letitia seconded the motion
- Unanimous vote to open 30-day public comment period

- Plan to Spend One-Time Funds
    - Priorities for one-time funds were set back in January
        - System Improvements for core MHSA services
        - Technology and Capital Facilities – ideas in this category came from BHRS budget stakeholder meetings
        - Workforce Training & Community Education/Awareness – community education was added based on recent input sessions (for example: board and care WRAP, mental health, trauma informed care)
- County Budget Update – Louise Rogers
    - BHRS hosted idea sessions to help with budget reduction strategies (done across SMC Health)
    - Even though we have a great local economy for the moment (e.g. unemployment is low), the reality for the services we provide in County Health is that we have a

financial problem because of the situation in Washington - Encourage everyone to vote in terms of federal legislation
        - Medicaid and Medi-Cal are our big revenue
        - Our cost continues to go up because it is expensive to live and work in the County
        - Employing people here are very costly
        - Cost is increasing faster than revenue
    - SMC Health implemented first set of ideas in July 2019, will bring update and new ideas to Board in January 2020
    - BHRS gap is $5 million dollars – BHRS budget is over $200 million dollars (San Mateo Medical Center gap is $48 million)
        - Gap across SMC Health $50+ million (out of $864 million budget; less than 10%)
    - Why talk about this?
        - Increasing awareness about the budget
        - Consider what new things we create while thinking about keeping existing services solid
        - Reductions in budget will be thoughtful
- One-time allocation to support BHRS budget impacts
    - $1 million for Cordilleras construction – Capital Facilities (Louise Rogers)
        - We own Cordilleras (unincorporated area)
        - Built in 1950s to be TB hospital - has not been renovated and rehabilitated since
        - 117 beds – 63 are in locked medical health rehabilitation center and 54 are residential care
        - Looked for another piece of land to see if they could build something new – people don't want facilities like this in their neighborhood
        - Rebuilding it (on site - 20 acres) best solution
        - 4 residential cottages (16 beds each) and large housing complex (57 housing beds), total 121 beds
        - Common space on the ground floor for non-profit partners to engage, meeting space, kitchen, spiritual space, beautiful outdoors, healing place for people's recovery submerged in nature
        - Project expected to be completed by 2022 and are currently identifying all funding needed
        - Total cost is $100 million (budget $120 million for cushion)

        - $7.8 million contributed by Health, $2.3 million from State, requesting $1 million one-time from MHSA
    - $4 Million for FSP/Clinic budget gap and restructuring – System Improvement (Scott Gilman)
        - Will use $4 million ($2.4 million first year, $1.5 million second year) as a stop gap (vs. cutting positions) – and will focus on restructuring to increase billable services and bring in revenue.
            - For example, traveling to a client's home for an appt can be reimbursable vs. waiting on a client who ends up being a no-show
        - Will improve coordination with FSPs- moving people to community

- Public Comment
    - Client/California Clubhouse
        - We should conduct a fundraiser for Mental Health Awareness Month activities
    - OASIS Peer Support Worker/Steering Committee Member
        - We've already spent monies on restructuring into Community Services Areas – why will we be spending another $4 million on this?
    - California Clubhouse Board Member
        - Thrilled to see money in supportive employment
        - California Clubhouse is effective model for supportive employment
    - OASIS Peer Support Worker
        - How are we restructuring, what is the money actually being spent on?
        - Response: in order to avoid cuts, the monies will be used to fund current positions. Restructure may have not been the best word but, rather than make $2.5 million dollar of cuts, let's give people time to get billable services up.
    - MHSA Steering Committee Member
        - Is the funding for only those in FSP?
        - Response: No, it will impact all clients
        - Is funding used for transportation and lost productivity for travel time?
        - Response: No, infrastructure funding is already in place. It's for positions that would be otherwise

cut to conduct activities that would be billable and support client engagement
    - California Clubhouse Member
        - Supported Employment is a well worthy cause, helpful in helping people find jobs, good to have funding for it
        - We will be able to pull California Department of Rehabilitation federal dollars

3. MHSA Innovations (INN) Breakout Activity 4:40pm

- Innovation funding allows for pilot projects that:
    - Introduce a new practice
    - Make changes to existing practices
    - Apply promising non-behavioral health practices
- A new cycle of funding was launched in January, received 35 ideas, 20 were reviewed by a Selection Committee and 5 ideas moved forward, we will hear about these ideas today.

MHSARC Motion:

Vote to open a 30-day public comment period for the MHSA Innovation Project Proposals

    - Isabelle opened the motion
    - Chris seconded the motion
    - Unanimous vote to open 30-day public comment period

- Innovation Project Proposals - Input Activity
    - Hear from folks who proposed the ideas – they will share about the project
    - Ask questions, what do you believe is important to consider in the project
    - We have to figure some things out as we go
    - At each presentation you will receive a Theory of Change as a reference that identifies key considerations from the literature that supports the interventions
    - Pick two presentations you would like to learn more about
- Select 2 projects you want to learn about (20 min each)
    1. PIONEERS program for Pacific Islander college-age youth
        - DannyBoy and Sue - out on the patio
    2. Addiction Medicine Fellowship
        - Cynthia - at the tables in the front of the room
    3. Co-location of prevention and early intervention services for young adults in low-income housing

    - Doug Fong – tables in the middle of the room
4. Preventing homelessness to economic and emotionally stressed older adults
    - Chris – tables in back of the room
5. Cultural arts and wellness-focused social enterprise café for Filipino/a/x youth
    - Steph and Christi – Room 132 across the hall

- Public Comments
    - Full proposals are posted on MHSA website for review
    - Public Comments provided during for the Innovation Project Proposals during breakout activity is being gathered and will be posted prior to closing of the public comment period on November 6, 2019

Please continue to provide public comments through November 6, 2019

- Email: mhsa@smcgov.org
- Phone: Doris Estremera, MHSA Manager (650) 573-2889
- Mail: 310 Harbor Blvd, Bldg E, Belmont CA 94002
- Optional Public Comment Form available on line at www.smcgov.org/mhsa

4. Adjourn 5:30pm

Next Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting
Closing of 30-day public comment period for MHSA Innovation Projects and Plan to Spend Available One-Time Funds:

November 6, 2019 from 3:30-5:00pm
County Health Campus, Room 100, 225 37th Ave. San Mateo

Public Comments Received – for Mental Health Substance Abuse and Recovery Commission (MHSARC) Review

➢ Plan to Spend Available One-Time Funds

Comments	Response
Supported Employment - 12 comments were received in support of one-time funds for Supported Employment.	Supported employment for those with mental illness is a priority that was brought to the community planning process by clients, stakeholders and peer-run agencies. Specifically, Individual Placement and Support (IPS) Supported Employment is included in the Plan to Spend.
Stop-Gap FSP/clinic retooling – 3 comments received I appreciate hearing the clinics will be restructured to allow staff to go out into the community rather than requiring them to go to the clinic. In East Palo Alto, one of the biggest challenges for our outreach and referral partnerships is getting our clients to go to the clinic after we refer them. If the clinic staff is able to go out our work will be more effective.	We agree with your sentiment and are hopeful that the opportunity to retool our clinics will allow for appropriate level of supports for client unmet needs. Thank you for your comment.
I would like you to consider the fact that 1-time MHSA $ should NOT be used to cover for county budget deficit and "restructuring" clinics. This money (I believe) is not meant to be used for County budget problems. Those $ are for providing services.	The funding as proposed is aligned with the priorities set by the MHSA Steering Committee; including the use of one-time funds for System Improvements of Core Services and Stop Gaps for Budget Reductions that may impact MHSA direct services to seriously mentally ill clients. The budget deficit stop-gap will allow us to ensure that the most severe clients receive Full Service Partnership services, which include non-mental health services and supports to advance clients' recovery. Clients' needing a lower level of care can be transitioned appropriately to BHRS case managers and outpatient therapist who can support continuity of care for the client. Thank you for your comment.
My suggestion is rather than have workers going out to the homes of patients who are in need of assistance, create several local areas/offices for patients to visit and which are in reach because of locations. I would challenge the effectiveness of using the resources going 1:1 to homes.	Thank you for your input. Currently, County Health and BHRS are in a planning process to complete a full review and analysis of space needs. Your feedback will be incorporated into that planning process.
Capital Facilities – Cordilleras – 1 comment received I would like you to consider using actual "SMC" General Budget $ for capital improvements instead of using MHSA one-time funding to pay one million towards rebuilding Cordilleras. I agree and totally agree that Cordilleras needs help, but I don't believe it should come out of our very small MHSA budget funding. Especially one-time funding.	The County General Budget is experiencing a deficit overall. Currently, we are identifying all external funding available to complete this $100M project by 2022. County Health has contributed $7.8M, State Dept of Health Care Services has approved $2.3M from Whole Person Care Initiative. The ask from MHSA is $1M, which is aligned the MHSA Steering Committee priorities for use of these one-time funds. Capital Facilities is an allowable expense.

Public Comments Received – for MHSARC Review

➢ Innovation Project Proposals

Comments	Response
Older Adult Homelessness Prevention – 3 letters of support were received for the Older Adult Homeless Prevention proposal	The proposed project will reach-out and engage isolated older adults who may be at risk of becoming homeless. Trust and safety will be established to reduce shame/stigma. Older adults will be screened for economic stress, behavioral health issues, and connected to homeless, housing and behavioral health resources for planning, and support, to prevent acute homelessness and to slow the growing older adult homeless population trend. The innovation will create a new partnership between Human Services Agency Center for Homelessness providers, Older American Act programs, Behavioral Health and Recovery Services, and Aging and Adult Services.
I would like you to consider older adult outreach to Board and Care residents who are at risk of homelessness, expansion of the senior peer program would be an alternative to a new homeless service.	Thank you for your input on including Board and Care residents, we will add this to the proposal. As for expansion of the senior peer program, this would not qualify for Innovation funding as it is a current program we have been successfully providing. But, we do agree with your comment and this past fiscal year did expand senior peer program services to address the waitlist of about 48 clients.
Addiction Fellowship - 6 comments were received in support of the Addiction Fellowship proposal.	The proposed project is an accredited Addiction Medicine Fellowship that is tailored to addressing the needs and priorities of the public sector including treating the most vulnerable communities with co-occurring substance use disorders, advancing equity on multiple levels and contributing to educational projects in clinical and community settings. This would also be the first Addiction Medicine Fellowship based in a local health safety net health system, serving as a model for California's 58 counties.
I would like you to consider collaborative care with peer certified addiction specialists, peers providing services and supports in the community	Thank you for your input on including a peer component and specifically involving Peer Certified Addiction Specialists, we will add this to the proposal. This is critical to recovery principles. Currently as proposed, the IMAT team will provide case management for patients seen by the fellow in the hospitals and clinics.

Why MHSA funding and not primary health or drug Medi-Cal dollars for a medical-based fellowship.	Addiction is a specialty that touches on all fields of medicine, including mental health. Substance use disorders and mental health disorders have a very high rate of co-occurrence (at least 50% in both directions). Given this, addiction specialist will receive training in the diagnosis and treatment of mental health disorders. We want people suffering from addiction to be served wherever they enter our health system. In San Mateo County Health, people with only the most serious of mental illnesses are treated in clinics purely devoted to mental health; all others with mild to moderate, and often severe, disorders are treated by primary care providers with the help of integrated behavioral health teams. Most primary care providers, hospitalists, and psychiatrists are not trained to treat substance use disorders. This is one reason that only ten percent of people with addictions receive any MH treatment and why MHSA can provide a great opportunity to fill this much needed gap.
One-year fellowship then what? Where are the certified addiction fellows housed, in hospital or BHRS clinics?	This proposal is for 3 years, so we would hopefully be able to train 3 fellows, adding to the workforce of physicians able to treat this very under-served population. If it is successful, we hope our positive findings will help us secure additional funding. The fellow will be rotating through various locations such as the integrated mental health team within primary care, the hospital wards, emergency department, and specialty clinics such as the Pain Clinic and Edison Clinic.
Social Enterprise Cultural and Wellness Café – 43 Comments received in support of the Social Enterprise proposal	The proposed project is a cultural arts and wellness-focused social enterprise café that offers youth development and mental health programming on site. The social enterprise café will hire and train at-risk youth from Northern San Mateo County and serve as a culturally affirming space for Filipino/a/x youth and community. The social enterprise model has proven to be a more sustainable approach when it comes to stable and diversified funding streams. Most of the existing community organizations that offer some elements of the proposed project rely heavily on grant-writing and fundraising.

Stakeholder Group	Name(s)	Affiliations (Board Member or Employee)	Title (if applicable)	Email	Signature
Provider of MH/SU Svcs	Adriana Furuzawa	SMC Health System, Aging & Adult Services	Program Services Manager	asawamura@smcgov.org	
Other-Aging and Adult Services	Anna Sawamura	SMC Health System, Aging & Adult Services	Program Services Manager	asawamura@smcgov.org	
Public	Betty Savin		MHSARC Commissioner	bettysavin@yahoo.com	
Family Member	Bill Nash		MHSARC Commissioner	Bill.nash@kla-tencor.com	
Provider of MH/SU Svcs	Cardum Harmon	Heart & Soul, Inc.	Executive Director	cardumh@heartandsoulinc.org	
Client/Consumer- SA	Carol Marble		MHSARC Commissioner	carolmarb@aol.com	
Member	Catherine Koss		MHSARC Commissioner	catekoss@gmail.com	
Public	Cherry Leung		MHSARC Commissioner	cherry.leung@ucsf.edu	
Provider of MH/SU Svcs	Chris Kernes	Health Right 360		ckernes@healthright360.org	
Provider of MH/SU Svcs	Clarise Blanchard	Star Vista and BHRS Contractors Association	Director of Substance Abuse and Co-occuring Disorders	cblanchard@star-vista.org	
San Mateo County District 1	David Pine	Board of Supervisors	Supervisor, District 1	DPine@smcgov.org	
Member	Donald Mattei		MHSARC Commissioner	Donald.mattei@gmail.com	
Provider of MH/SU Svcs	Gloria Gutierrez	BHRS	MH Counselor	GGutierrez@smcgov.org	
	Helene Zimmerman	NAMI		hzimmer@namisanmateo.org	
Member	Isabel Uibel		MHSARC Commissioner	Isabel.c.uibel@kp.org	
Client/Consumer- Adults	Jairo Wilches	BHRS, Office of Family and Consumer Affairs	Liaison and BHRS Wellness Champion	jwilches@smcgov.org	
Provider of MH/SU Svcs	Joann Watkins	Puente de la Costa Sur	Clinical Director	watkins3121@gmail.com	
Family Member	Judith Schutzman			judyschutzman@aol.com	
Family Member	Juliana Fuerbringer	California Clubhouse		julianafuer@gmail.com	
Provider of Social Services	Kava Tulua	One East Palo Alto and East Palo Alto Partnership for Mental Health Outreach		ktulua@1epa.org	
Public	Leticia Bido		MHSARC Commissioner	leticia.bido@gmail.com	
Cultural Competence & Diversity	Maria Lorente-Foresti	Office of Diversity and Equity	Director	Mlorente-foresti@smcgov.org	
Law Enforcement	Mark Duri		MHSARC Commissioner	mduri@smcgov.org	
Provider of Social Services	Mary Bier	North County Outreach Collaborative	Mbier@juhsd.net	marykbier@gmail.com	
Education	Mary McGrath	San Mateo County Office of Education, Safe and Supportive Schools	Admininstrator	mmcgrath@smcoe.org	
Provider of MH/SU Svcs	Melissa Platte	Mental Health Association	Executive Director	melissap@mhasmc.org	
Family Member	Michael Krechevsky	PREP/BEAM	Fmail	mkrechevsky@felton.org	
Client/Consumer- Adults	Michael Lim			mhl-lim@outlook.com	
Client/Consumer- Adults	Michael S. Horgan	Mental Health Association	Community Worker	michaelhorgan@me.com	
Family Member	Patricia Way	MHSARC	MHSARC Commissioner	patcway@hotmail.com	
Client/Consumer- Adults	Patrick Field			pfield3311@gmail.com	

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Family Member	Bill Nash		MHSARC Commissioner	Bill.nash@kla-tencor.com	
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Member	Catherine Koss		MHSARC Commissioner	catekoss@gmail.com	
Public	Cherry Leung		MHSARC Commissioner	cherry.leung@ucsf.edu	
Provider of MH/SU Svcs	Chris Kernes	Health Right 360		ckernes@healthright360.org	
Provider of MH/SU Svcs	Clarise Blanchard	Star Vista and BHRS Contractors Association	Director of Substance Abuse and Co-occuring Disorders	cblanchard@star-vista.org	
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	Helene Zimmerman	NAMI		hzimmer@namisanmateo.org	
Member	Isabel Uibel		MHSARC Commissioner	Isabel.c.uibel@kp.org	
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Family Member	Juliana Fuerbringer	California Clubhouse		julianafuer@gmail.com	
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Law Enforcement	Mark Duri		MHSARC Commissioner	mduri@smcgov.org	
Provider of Social Services	Mary Bier	North County Outreach Collaborative		marykbier@gmail.com	
Education	~~Mary McGrath.~~ Marly Henricks	San Mateo County Office of Education, Safe and Supportive Schools	Admininstrator	mmcgrath@smcoe.org mhenricks@smcoe.org	
Provider of MH/SU Svcs	Melissa Platte	Mental Health Association	Executive Director	melissap@mhasmc.org	
Family Member	Michael Krechevsky	PREP/BEAM	Fmail	mkrechevsky@felton.org	
Client/Consumer- Adults	Michael Lim	Lived Exp * ACCESS CA.		mhl-lim@outlook.com	
Client/Consumer- Adults	Michael S. Horgan	Mental Health Association	Community Worker	michaelhorgan@me.com	
Family Member	Patricia Way	MHSARC	MHSARC Commissioner	patcway@hotmail.com	
Client/Consumer- Adults	Patrick Field			pfield3311@gmail.com	

Client/Consumer	Patrisha Ragins		MHSARC Commissioner	patrisharagins@yahoo.com	
Other- Peer Support	Ray Mills	Voices of Recovery	Executive Director	rmills@vorsmc.org	RMills
Provider of Social Services	Rev. William Chester McCall	Multicultural Counseling & Education Services of the Bay Area		chester.wellness@gmail.com	
Client/ Consumer	Rodney Roddewig	MHSARC	MHSARC Commissioner	rrodney2k6@gmail.com	
Member	Sheila Brar		MHSARC Commissioner	sheila.nathan@gmail.com	
Provider of Social Services	Sheri Broussard	HIP Housing		sbroussard@hiphousing.org	
Provider of MH/SU Svcs	Stephanie Morales	OASIS	Steering Comm. Member	smorales@smcgov.org	
Client/Consumer	Wanda Thompson		MHSARC Commissioner	w.thompson1967@yahoo.com	
Member	Yoko Ng	MHSARC	MHSARC Commissioner	Yng15@mail.ccsf.edu	
Family Member	Yolanda Novello	BHRS	Family Partner	YNovelo@smcgov.org	

Name(s)	Affiliations (Board Member or Employee)	Title (If applicable)	Email	Signature
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CHRIS RASMUSSEN	BOARD MEMBER			
Christopher Hoover	Heart & Soul	peer support worker	choover@gmail.com	
Yraes Guerrero	VORSMC	Wrap Facilitator	yguerrero@vorsmc.org	
Chelsea Bonini	Commission on Disabilities	Commissioner	chelsea.bonini@gmail	
Fidelino Ruiz	club house	member		
MR SEAN DONALDSON	CLUB HOUSE	MEMBER	N/A	Sean Donaldson
Brenda Nicholson				
FRANCESCA LOMOTAN	SMC HEALTH - TOBACCO	PROJECT DIRECTOR	FLOMOTAN@SMCGOV.ORG	
Martha Vasquez	Transformacion	Community Partner	marthavasquez.transformacion@gmail.com	
LIZ EVANS	California Clubhouse	Board Member	elizs50@comcast.net	
Gina Beltrano	County Counsel	Attorney	gbeltrano@smcgov.org	
BROCK, WAYNETTE	ONE UNITED HEARTBEAT	CEO	info@oneunitedheartbeat.org	
Greenwood-Goodwin, Amoral	California Clubhouse Assistant Staff	Peer Recovery Support Program Director	amoralgg@gmail.com	
Teri Greenwood	California Clubhouse	N/A	teri.vert@gmail.com	
Julie Marquez	MidPen	AS. Project Mgr	Jmarquez@midpen-housing.org	
Eric Valladores	StarVista	Department Director	eric.valladores@star-vista.org	
Stephanie Weisner	StarVista	CPO	Stephanie.weisner@star-vista.org	
DominiqueCohen	MidPen Services	Director SHS	Dcohen@midpen-housing.org	

Name(s)	Affiliations (Board Member or Employee)	Title (If applicable)	Email	Signature
John Butler	BHRS (client)		NewHope8@aol.com	
Kayla Gupta	Sutter Health	Community Health Coordinator	guptaK1@sutterhealth.org	
Shanta Barden	Clubhouse San Mateo			
Louise Regan	Clubhouse			
Deb Higgins	California Clubhouse	Secretary of Board	dlhiggins22@hotmail.com	
Peter Marie Huysentruyt	Calif Clubhouse	Member		
Gregory Thompson	VORSMC	Recovery Coach	GThompson@VORSMC.org	
Sharon Heath	VORSMC	Program Director	Sheath@VORSMC.org	
David Tong	BHRS	Clinical Services MGR	DTong@SMCGOV.ORG	
Estella Chan	BHRS ADP	SUD Pr Coordinator	schan@smcgov.org	
Jerry Stevens	Clubhouse			
Janet Anenyu	VORSmc	Recovery coach	janenyu@vorsmc	
Ken Jew	California Clubhouse	General Staff	Kenjew@californiaclubhouse.org	
Max Lee	Visitor (Peninsula Press)	Reporter	maxblee@stanford.edu	
Cynthia Chatterjee	BHRS	Psychiatrist	cchatterjee@smcgov.org	
Sue Vuna	PCRC	Community Outreach	svuna@pcrcweb.org	
Daniel Naha-Ve'evalu	DDE	Community Outreach		
LEE HARRISON	OCFA	CONSUMER/FAMILY LIAISON	LEHARRISON@SMCGOV.ORG	
ERICA BRITTON	BHRS-ADE	WET Director		

APPENDIX 4. MHSA FUNDING SUMMARY

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: San Mateo

Date: 1/27/20

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	21,986,178	4,053,315	7,616,812	35,490	1,030,000	0
2. Estimated New FY 2019/20 Funding	24,133,287	6,435,543	1,608,886	0	0	0
3. Transfer in FY 2019/20[a/]	0	0	0	830,000	1,255,000	0
4. Access Local Prudent Reserve in FY 2019/20	0	0	0	0	0	0
5. Estimated Available Funding for FY 2019/20	46,119,465	10,488,858	9,225,698	865,490	2,285,000	0
B. Estimated FY 2019/20 MHSA Expenditures	21,219,920	7,141,511	4,840,706	500,000	930,000	0
G. Estimated FY 2019/20 Unspent Fund Balance	24,899,545	3,347,347	4,384,992	365,490	1,355,000	0

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	600,000
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	0
4. Estimated Local Prudent Reserve Balance on June 30, 2020	600,000

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Mateo Date: 1/27/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth	2,982,381	2,982,381	0	0	0	0
2. Transition Age Youth	2,670,245	2,670,245	0	0	0	0
3. Adults and Older Adults	4,352,132	4,352,132	0	0	0	0
4. Expansion - AOT FSPs	890,639	890,639	0	0	0	0
5. Expansion - Augmented Board and Care	1,118,746	1,118,746	0	0	0	0
6.	0		0	0	0	0
7.	0		0	0	0	0
8.	0		0	0	0	0
9.	0		0	0	0	0
10.	0		0	0	0	0
Non-FSP Programs			0	0	0	0
11. Community Outreach and Engagement	333,205	333,205	0	0	0	0
12. Criminal Justice Initiative	396,462	396,462	0	0	0	0
13. Older Adult System of Care	814,716	814,716	0	0	0	0
14. Co-Occurring Support Services	839,281	839,281	0	0	0	0
15. System Transformation	2,240,921	2,240,921	0	0	0	0
16. Peer and Family Supports	1,989,292	1,989,292	0	0	0	0
17. Expansion - Supports for Older Adults	130,000	130,000	0	0	0	0
18. Expansion - Coastside Wellness Center	450,000	450,000	0	0	0	0
19.	0	0	0	0	0	0
20.	0	0	0	0	0	0
CSS Administration	1,446,600	1,446,600	0	0	0	0
CSS Planning	0	0	0	0	0	0
CSS Evaluation	565,300	565,300	0	0	0	0
CSS MHSA Housing Program Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	21,219,920	21,219,920	0	0	0	0
FSP Programs as Percent of Total	57%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Mateo Date: 1/27/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Total Mental Health Expenditures	PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	255,270	255,270	0	0	0	0
2. Community Interventions for School Age and TAY	665,213	665,213	0	0	0	0
3. Community Outreach and Capacity Building	201,151	201,151	0	0	0	0
4. Recognition of Early Signs of MI	12,781	12,781	0	0	0	0
5. Stigma, Discrimination Reduction	169,811	169,811	0	0	0	0
6. Access & Linkage to Treatment	1,327,602	1,327,602	0	0	0	0
7. Suicide Prevention	126,038	126,038	0	0	0	0
8.	-		0	0	0	0
9.	-		0	0	0	0
PEI Programs - Early Intervention						
10. Early Childhood Community Team	170,180	170,180	0	0	0	0
11. Early Onset of Psychotic Disorders	835,648	835,648	0	0	0	0
12. Primary Care/MH Integration	1,069,057	1,069,057	0	0	0	0
13. Early Crisis Intervention	478,691	478,691	0	0	0	0
14. Expansion - Crisis Intervention (expected 19/20)	600,000	600,000	0	0	0	0
15. Expansion - TIS Ages 0-25	150,000	150,000	0	0	0	0
16.	0		0	0	0	0
17.	0		0	0	0	0
PEI Administration	971,879	971,879	0	0	0	0
PEI Assigned Funds - CalMHSA	8,190	8,190				
PEI Evaluation Costs	100,000	100,000				
Total PEI Program Estimated Expenditures	7,141,511	7,141,511	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Mateo Date: 1/27/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. LGBTQ Coordinated Services Center	810,000	810,000				
2. Health Amabassador Program - Youth	211,782	211,782				
3. NMT - Adults	171,388	171,388				
4. AB114 - Technology Collaborative	3,575,926	3,575,926				
5. Evaluation	70,540	70,540				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	1,070	1,070				
Total INN Program Estimated Expenditures	4,840,706	4,840,706	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Mateo Date: 1/27/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Total Mental Health Expenditures	WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing	260,000	260,000				
2. Training and Technical Assistance	100,000	100,000				
3. Training by/for Consumers & Family Members	60,000	60,000				
4. Behavioral Health Career Pathways	80,000	80,000				
5.	-					
6.	-					
7.	-					
8.	-					
9.	-					
10.	-					
11.	-					
12.	-					
13.	-					
14.	-					
15.	-					
16.	-					
17.	-					
18.	-					
WET Administration	0	0				
Total WET Program Estimated Expenditures	500,000	500,000	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Mateo Date: 1/27/20

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. EPA Clinic - One-Time Plan to Spend	700,000	700,000				
2. Casia House - One-Time Plan to Spend	100,000	100,000				
3. Documentation - One-Time Plan to Spend	100,000	100,000				
4. Telepsychiatry - One-Time Plan to Spend	30,000	30,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	930,000	930,000	0	0	0	0

APPENDIX 5. MHSA FULL SERVICE PARTNERSHIP EVALUATION REPORT

AMERICAN INSTITUTES FOR RESEARCH®

Full Service Partnership (FSP) Outcomes

Findings from 2017-2018 Fiscal Year

Yi Lu, PhD

Elizabeth Mokyr Horner, PhD, MPP

Alvaro Ramos, BA

JUNE 2019

Full Service Partnership (FSP) Outcomes

Findings from 2017-2018 Fiscal Year

June 2019

Yi Lu, PhD
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Alvaro Ramos, BA

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Executive Summary

Full Service Partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County contracted providers to assist individuals with mental and behavioral health challenges. American Institutes for Research (AIR) is working with San Mateo County ("the County") to understand how enrollment in an FSP promotes resiliency and improved health outcomes of individuals living with mental illness served by an FSP (hereafter referred to as "partners").

This report shows outcomes for child, transitional age youth (TAY), adult, and older adult clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in San Mateo County using FSP program survey data and Avatar data, San Mateo County's electronic health records (EHR) system.

Exhibit 1, below, presents the percent improvement between the year just prior to FSP and the first year with FSP, by age group. Percent improvement is the percent change in the percent of partners with any events. For example, the percent of adult partners experiencing homelessness changed from 91% before FSP to 58% in the first year with FSP, a 36.3% improvement.

In sum, the findings from self-reported outcomes (survey data) suggest that the vast majority of the outcomes improve (27 of 32 outcomes) for all reported age groups. As can be seen in Exhibit 1, there are improvements comparing the year prior to FSP to the first year of FSP for partners in all age groups for the following self-reported outcomes: arrests, mental health emergencies, and physical health emergencies. In addition, for children and TAY partners, school suspensions decrease, and for adult partners, the percent with any employment increases. Further, fewer adult and older adult partners have an active substance abuse problem and are receiving substance abuse treatment. Finally, the percent of TAY and adult partners with an episode of detention or incarceration decreases.

However, there are five outcomes for which there is no improvement. First, for TAY partners, grade ratings decrease, and homelessness increases slightly (less than 10%). Second, for child partners, grade rating and attendance decrease. The proportion of children who are incarcerated increases in the first year of FSP. However, the increase in incarceration is relatively small (26 in the first year with FSP compared to 22 in the year just prior) when compared to the decrease in arrests (9 in the first year with FSP compared to 24 in the year just prior) among child partners.

Moreover, the main finding from the hospitalization outcomes (EHR data) is that, compared to the year before joining an FSP, there are reductions in the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any PES, and mean PES event per partner. The only exception is that the mean hospital days for older adults increase by about one day which is likely be attributed to other medical conditions as both the hospitalization and PES incidence decrease significantly. Also, for all cohorts, the reductions are consistently observed over the years since the inception of the FSP program.

Exhibit 1: Percent Improvement in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

FSP Outcomes *Self-reported Outcomes*	**Adult (25 to 59 years) N = 346**			**Older adult (60 years & older) N = 59**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Homelessness	91	58	36.3%	3	8	N/A
Detention or Incarceration	61	43	29.5%	3	5	N/A
Employment	35	44	25.7%	4	2	N/A
Arrests	52	6	88.5%	3	0	N/A
Mental Health Emerg.	151	57	62.3%	13	7	46.2%
Physical Health Emerg.	83	26	68.7%	18	12	33.3%
Active S.A. Problem	268	171	36.2%	44	18	59.1%
S.A. Treatment	184	62	66.3%	39	6	84.6%
Healthcare Utilization (EHR data)	**Adult (25 to 59 years) N = 298**			**Older adult (60 years & older) N = 44**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Hospitalization (N)	116	54	53%	12	6	50%
Hospital Days per partner	12.1	3.5	71%	4.5	5.4	20%
PES (N)	160	114	29%	15	7	53%
PES Event per partner	1.8	1.0	45%	0.7	0.2	68%

FSP Outcomes *Self-reported Outcomes*	**Child (16 years and younger) N = 148**			**TAY (17 to 25 years) N = 202**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Homelessness	8	6	25%	24	26	8%
Detention or Incarceration	22	26	18%	31	29	6%
Arrests	24	9	63%	54	19	65%
Mental Health Emerg.	57	7	88%	84	23	73%
Physical Health Emerg.	13	0	100%	51	5	90%
Suspension	38	19	50%	21	5	76%
Grade	3.28	2.95	10%	3.17	3.11	2%
Attendance	2.25	1.85	18%	2.26	2.39	5%
Healthcare Utilization (EHR data)	**Child (16 years and younger) N = 198**			**TAY (17 to 25 years) N = 164**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Hospitalization (N)	10	3	70%	23	18	22%
Hospital Days per partner	1.3	0.1	91%	4.8	2.8	41%
PES (N)	47	22	53%	71	49	31%
PES Event per partner	0.5	0.2	54%	1.0	0.8	22%

Hospitalization Outcomes	Overall	Range (Partnerships Beginning 2006 – 2015)
Healthcare Use (EHR data, N= 704)		
Partners with Hospitalizations	50%	26% – 71%
Mean Hospital Days	64%	(7%) – 83%
Partners with PES	34%	13% – 58%
Mean PES Events	42%	12% – 64%

* The table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP. Value of N/A means a change is not reported due to insufficient sample size (fewer than 10 observations).
** These outcomes are presented overall for all clients as well as by year of partnership; the range presented is from the lowest to highest percent changes among the calendar years.
***Red font indicates outcomes that are not improved.

Background and Introduction

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness; a large component of this work is accomplished through Full Service Partnerships (FSP). FSP programs provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help seriously mentally ill adults, children, transition-age youth and their families on their path to recovery and wellness. In San Mateo County (the County) there are currently four comprehensive FSP providers, Edgewood Center and Fred Finch Youth Center serve children, youth and transition age youth and Caminar and Telecare serve adults and older adults.

As part of San Mateo County's implementation and evaluation of the FSP programs, American Institutes for Research (AIR) is working with the County to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of County's clients living with a mental illness. The data used for this report are collected by providers via self-report from the partners as well as electronic health records (EHR) data obtained through the County's Avatar system. Note that self-reported data for this year is available only for adult and older adult partners (Caminar and Telecare). This is because the providers working with younger partners had technical difficulties entering data into the system.

Initial survey data are collected via an intake assessment, called the Partnership Assessment Form (PAF), which includes information on wellbeing across a variety of measures (e.g., residential setting), at the start of FSP and over the twelve months just prior. While a partner, survey data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

EHR data collected through the SMC Avatar system contain longitudinal partner-level information on partner demographics, FSP program participation, hospital stays, and PES uses before and after the enrollment date within the SMC health system. The Avatar system is limited to individuals who obtain care in the San Mateo county health system. Hospitalizations outside of San Mateo County, or in private hospitals, are not captured.

The following report will explore how the first year with FSP differs from the year just prior to joining the FSP program, for child, transitional age youth (TAY), adult, and older adult individuals who complete at least one full year with FSP. Then, we present trends in EHR data overall and over time, by year of FSP program enrollment.

Appendix A presents additional detail on residential outcomes. Outcomes for individual FSP providers can be found in Appendix B. Details on our methodology for both the FSP outcomes and hospitalization outcomes can be found in Appendix C.

Self-reported outcomes

The following section presents outcomes for the 148 child (aged 16 and younger) FSP partners, 202 TAY (aged 17 - 25) FSP partners, 346 adult (aged 26-59) FSP partners, and the 59 older adult (aged 60 and older) FSP partners. The results described compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP.

Several outcomes are broken down by age category, as described below. Note that employment, homelessness, incarceration, and arrest outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are less than 5 older adult partners total with any of these events).

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET).
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Jail or Prison (PAF and KET).
3. **Partners with any reported employment**: measured by employment in past 12 months and date employment change (PAF and KET).[1]
4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (PAF and KET).
5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (PAF and KET).
6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (PAF and KET).
7. **Partners with any self-reported active substance abuse problem**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).
8. **Partners in substance abuse treatment**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).

In addition, we also examine three outcomes specific to child and TAY partners:

9. **Partners with any reported suspensions**: measured by suspensions in past 12 months (PAF) and date suspended (KET)
10. **Average school attendance ranking**: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)
11. **Average school grade ranking**: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)

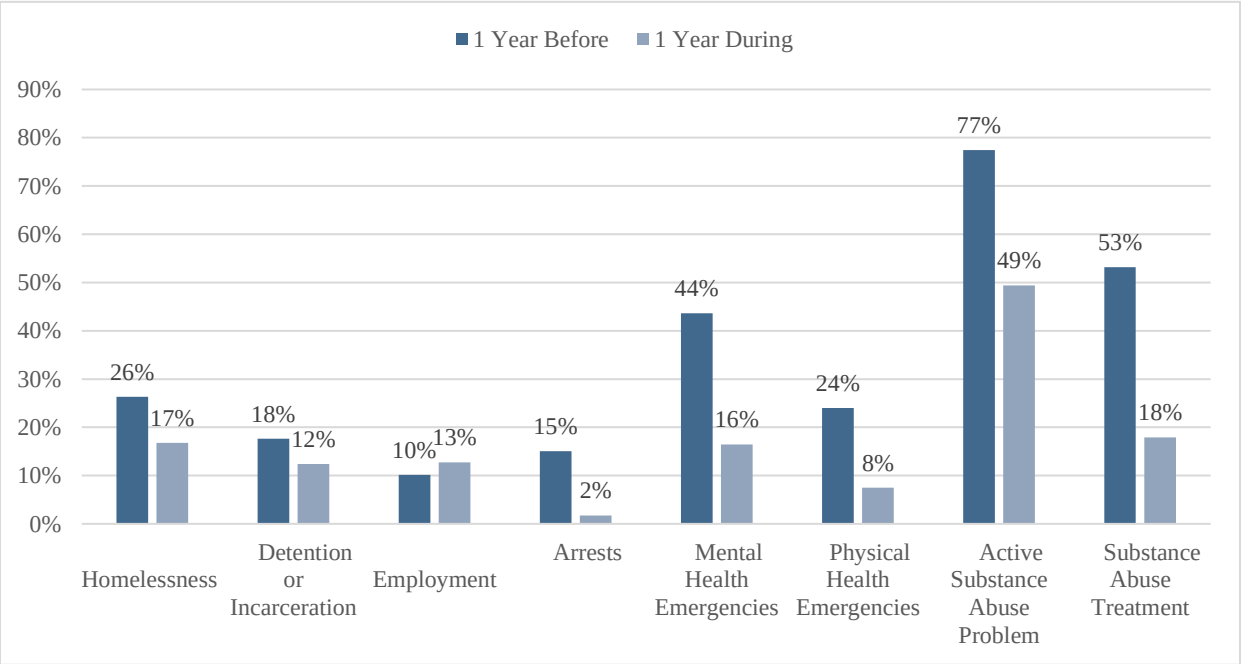
Then, mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, the likelihood of an emergency is considered for partners in all advantageous residential settings in their first year with FSP is compared to partners experiencing one or more high risk setting.

For additional detail on residential outcomes, see Appendix A. For additional details on outcomes broken apart by FSP providers, see Appendix B. For details on the methodological approach, see Appendix C.

[1] Employment outcome is not applicable to child and TAY partners.

First, please find the comparison of outcomes in the year prior to FSP to the first year on the program for adult partners in Exhibit 2. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance abuse problems and treatment all decrease. In addition, employment increases.

Exhibit 2: Outcomes for Adult Partners Completing One Year with FSP (n = 346)



Next, below in Exhibit 3, please find the comparison of outcomes in the year prior to FSP to the first year on the program for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies, and substance abuse problems and treatment all decrease.

Exhibit 3: Outcomes for Older Adult Partners Completing One Year with FSP (n = 59)

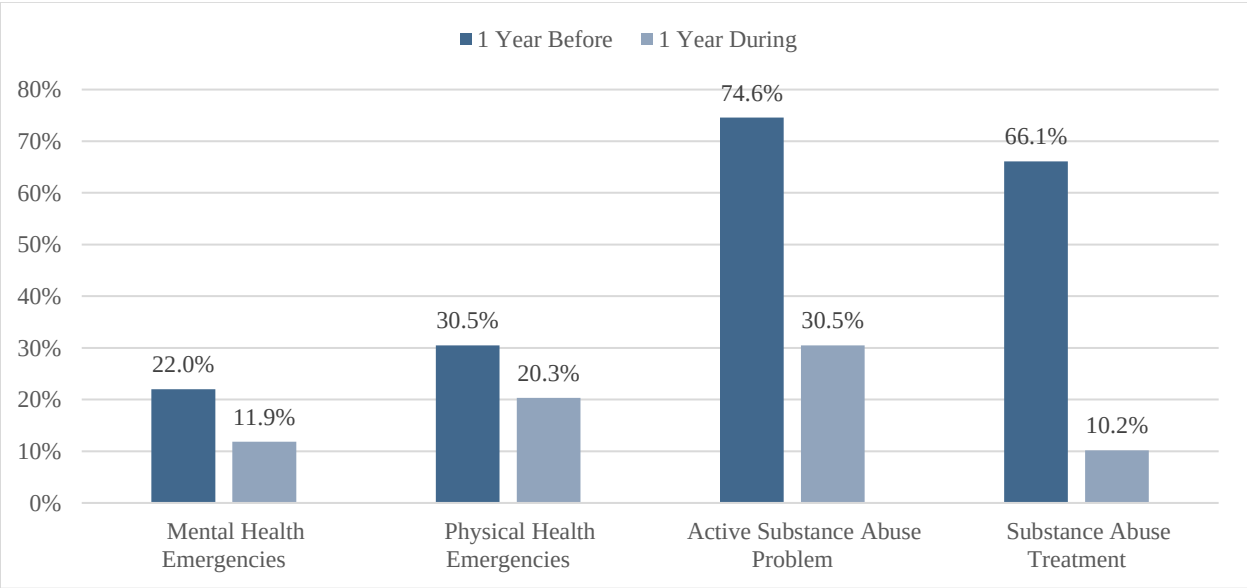
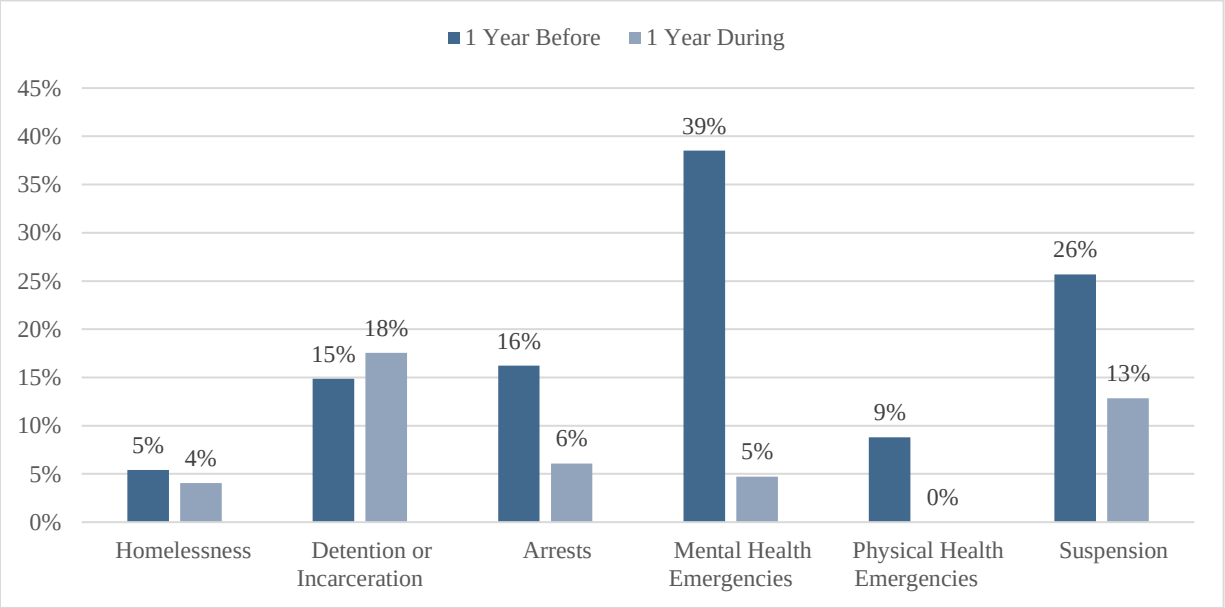


Exhibit 4 below shows the comparison of outcomes in the year prior to FSP to the first year on the program for child partners. The findings are essentially the same as those in the last year's report. All but one self-reported incidences (homeless, arrest, suspension, mental or physical health emergencies) decrease. The increase in incarceration is small (26 in the first year with FSP compared to 22 in the year just prior). The magnitude of decline in arrest incidence is much larger (9 in the first year with FSP compared to 24 in the year just prior).

Exhibit 4: Outcomes for Child Partners Completing One Year with FSP (n = 148)



Outcomes on school attendance and grades are presented below in Exhibit 5. As can be seen, attendance and grades for child partners decline modestly. Recall that these ratings are on a 1-5 scale, coded such that a higher score is better.

Exhibit 5: School Outcomes for Child Partners Completing One Year with FSP (n = 148)

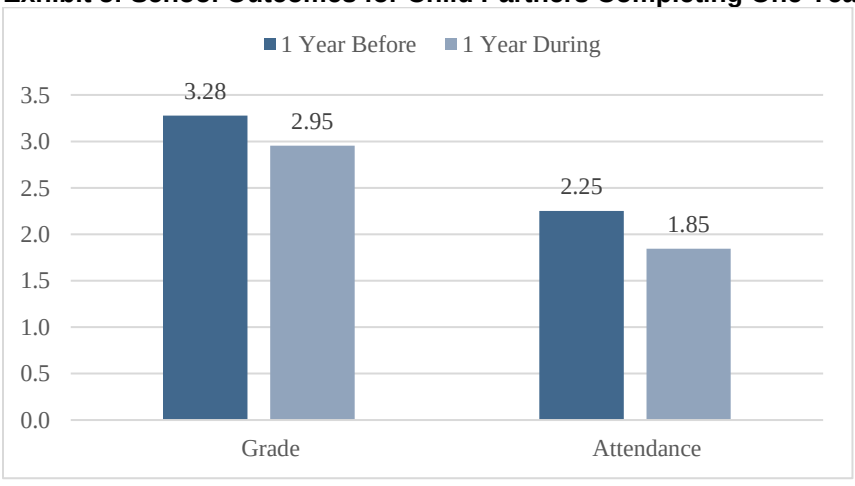
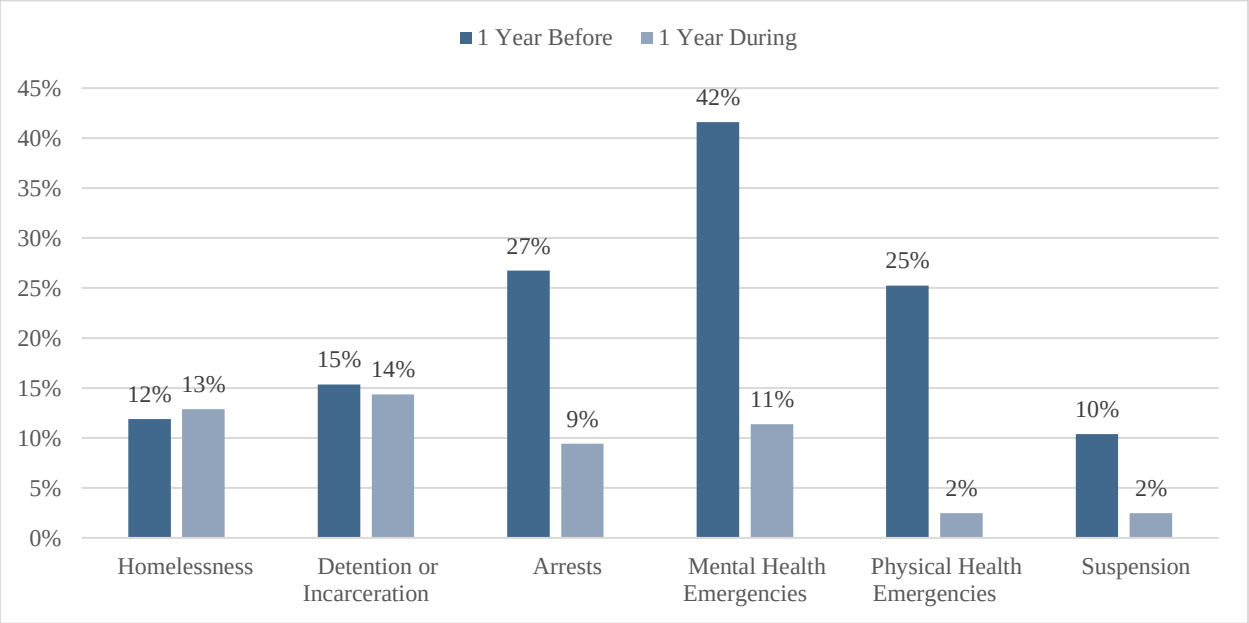


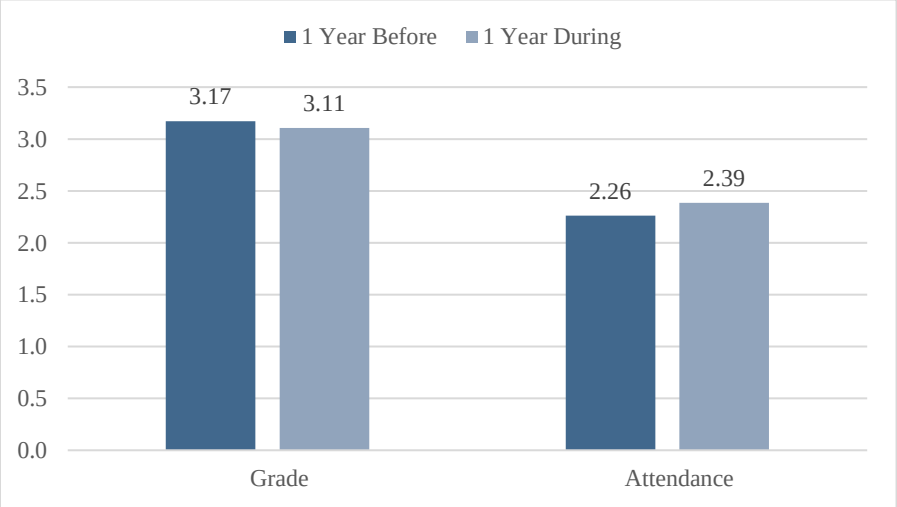
Exhibit 6 below shows the comparison of outcomes in the year prior to FSP to the first year on the program for TAY partners.[2] All self-reported outcomes except for homelessness decrease. The increase in homelessness is small (26 in the first year with FSP compared to 24 in the year just prior). Compared to the last year's report, the magnitudes of decrease are similar and slightly larger.

Exhibit 6: Outcomes for TAY Partners Completing One Year with FSP (n = 202)



Outcomes on school attendance and grades are presented in Exhibit 7. Attendance and grades for TAY partners change very little. These ratings are on a 1-5 scale; a higher score is better.

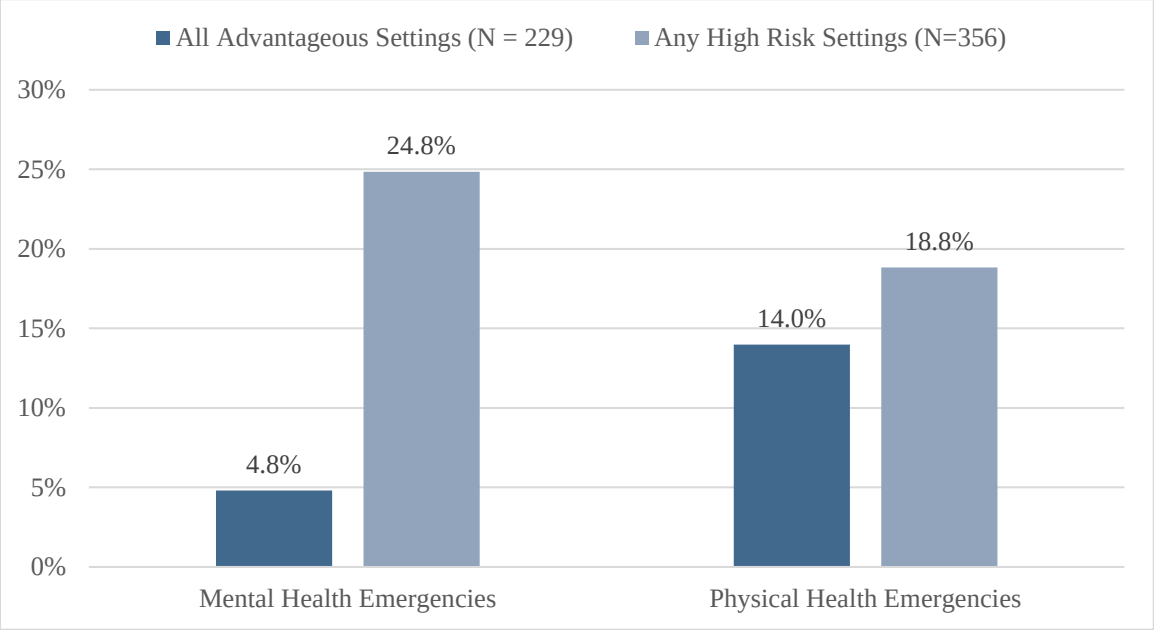
Exhibit 7: School Outcomes for TAY Partners Completing One Year with FSP (n = 202)



[2] The 40 older TAY partners in Telecare and Caminar are excluded from these outcomes because these providers do not reliably gather outcomes related to school attendance. Note that employment as an outcome is not presented for this cohort because many of these individuals are in school.

Finally, below in Exhibit 8, please find mental and physical health emergencies for adult and older adult partners, as for partners who are in all advantageous residential setting versus a one or more high risk settings in their first year on FSP. Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As can be seen, both mental and physical health emergencies are more common among individuals who experience a high risk residential setting.

Exhibit 8: Hospitalization Outcomes as a Function of Residential Setting



Health Care Utilization Overall and Over Time

We detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all FSP partners (Exhibit 9). Percent of partners with any hospitalization decreased from 23% before FSP to 12% during FSP. Days in the hospital decreased from 6.98 days before FSP to 2.51 days during FSP. Percent of partners with any psychiatric emergency services (PES) decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.19 events before FSP to 0.69 events during FSP.

Exhibit 9: FSP Partners Have Significantly Improved Hospitalization Outcomes (n=704)

	Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	23%	(20% - 26%)
Year 1 During	12%	(9% - 14%)
Mean Number of Hospital Days, per Partner*		
1 Year Before	6.89	(5.48 - 8.31)
Year 1 During	2.51	(1.67 - 3.34)
Percent of Partners with any PES Event*		
1 Year Before	42%	(38% - 45%)
Year 1 During	27%	(24% - 31%)
Mean PES Events, per Partner*		
1 Year Before	1.19	(1.00 - 1.37)
Year 1 During	0.69	(0.55 - 0.82)

*Results are statistically significant at the 95% level.

Health Care Utilization for FSP Partners by Age Group

This report also presents the four hospitalization outcomes for the 198 child, 164 TAY, 298 adult, and 44 older adult partners using the Avatar system (EHR):

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months;
4. **Average number of PES event:** the number of PES events in the past 12 months.

*Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Hospitalization outcomes are presented in Exhibits 10-13. For all four age groups, the percent of FSP partners with any hospitalization or PES event decreases after joining FSP. The mean number of hospital days experienced by FSP partners decreases after FSP enrollment, except for the older adult group. The average number of PES events decreases after FSP enrollment for all the age groups.

Exhibit 10: Hospitalization and PES Outcomes for Adult Partners Completing One Year with FSP (n = 298)

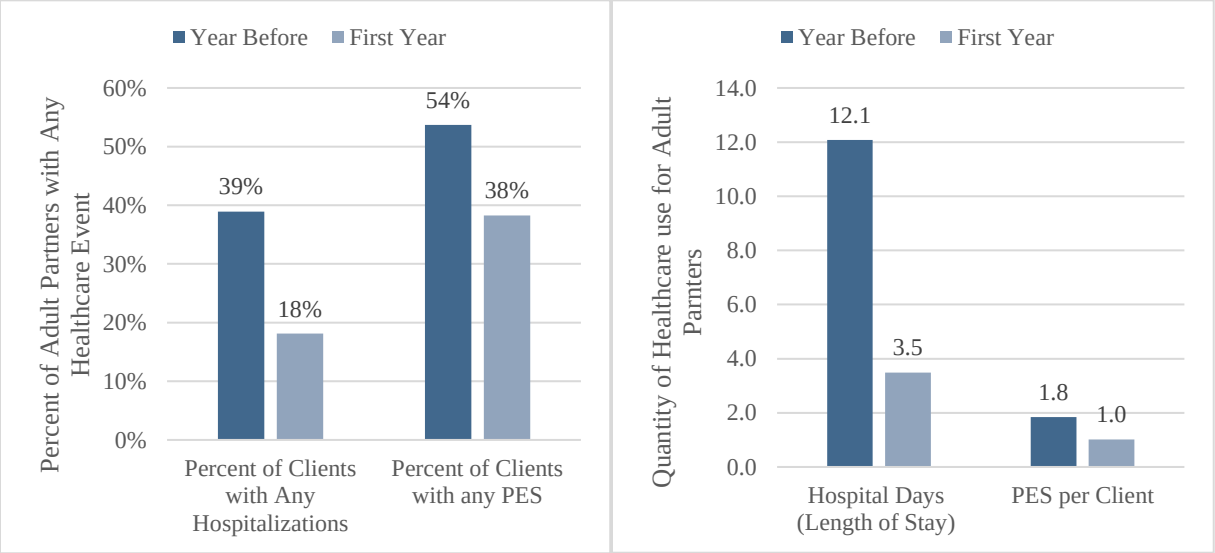


Exhibit 11: Hospitalization and PES Outcomes for Older Adult Partners Completing One Year with FSP (n = 44)

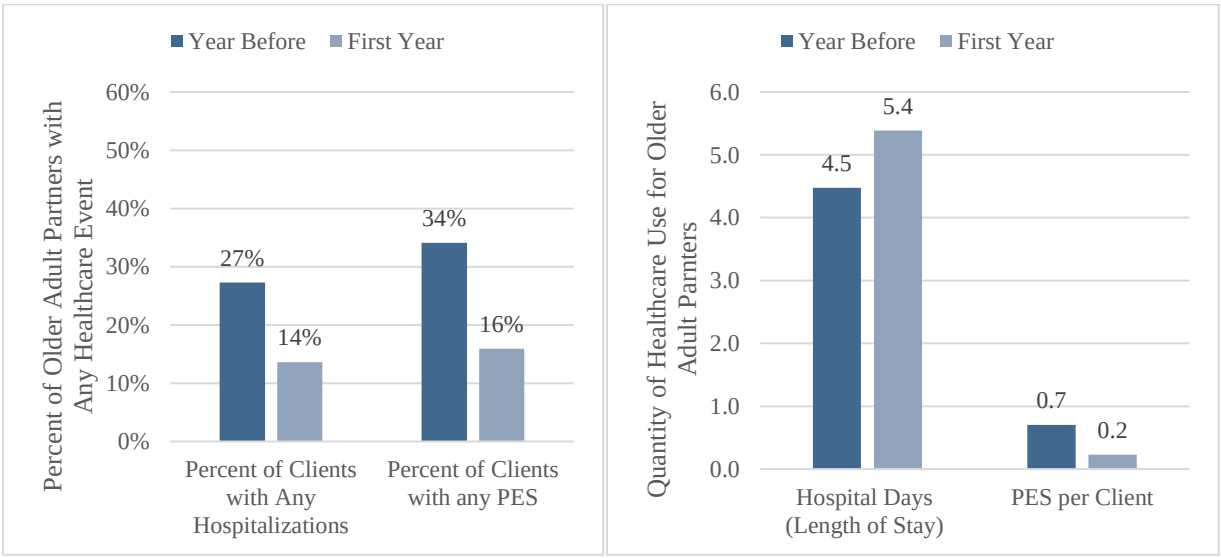


Exhibit 12: Hospitalization and PES Outcomes for Child Partners Completing One Year with FSP (n = 198)

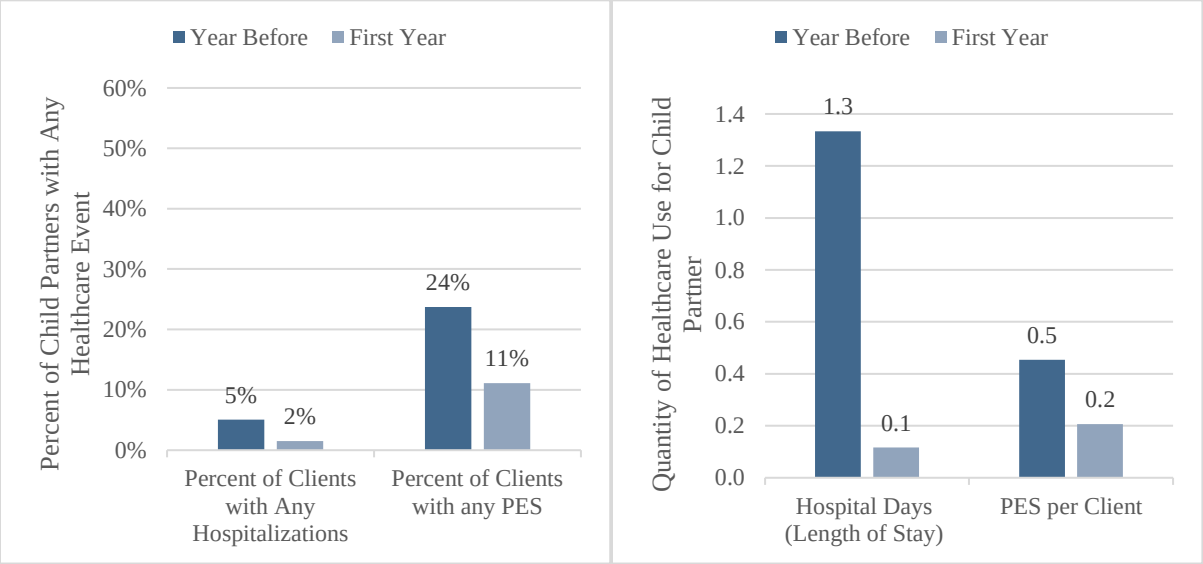
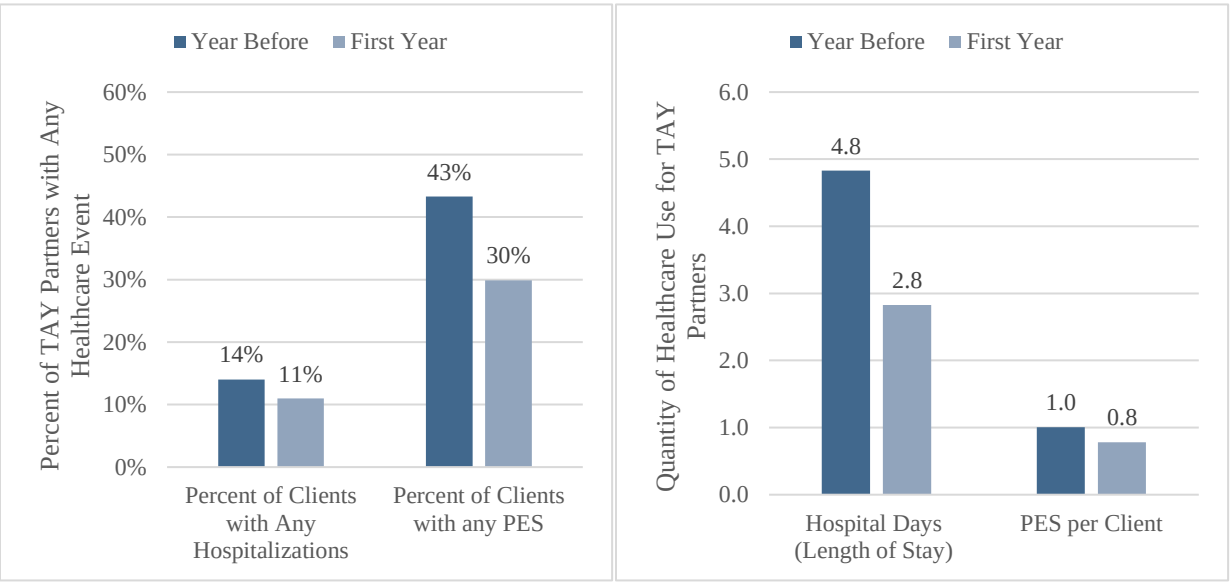


Exhibit 13: Hospitalization and PES Outcomes for TAY Partners Completing One Year with FSP (n = 164)



Health Care Utilization for FSP Partners over Time

Exhibits 14-18 show the four hospitalization outcomes, stratified by enrollment year. As can be seen in Exhibit 14, the percent of partners with any hospitalization decreased after joining an FSP program for all cohorts.

Exhibit 14: Percent of Partners with Any Hospitalization over Time

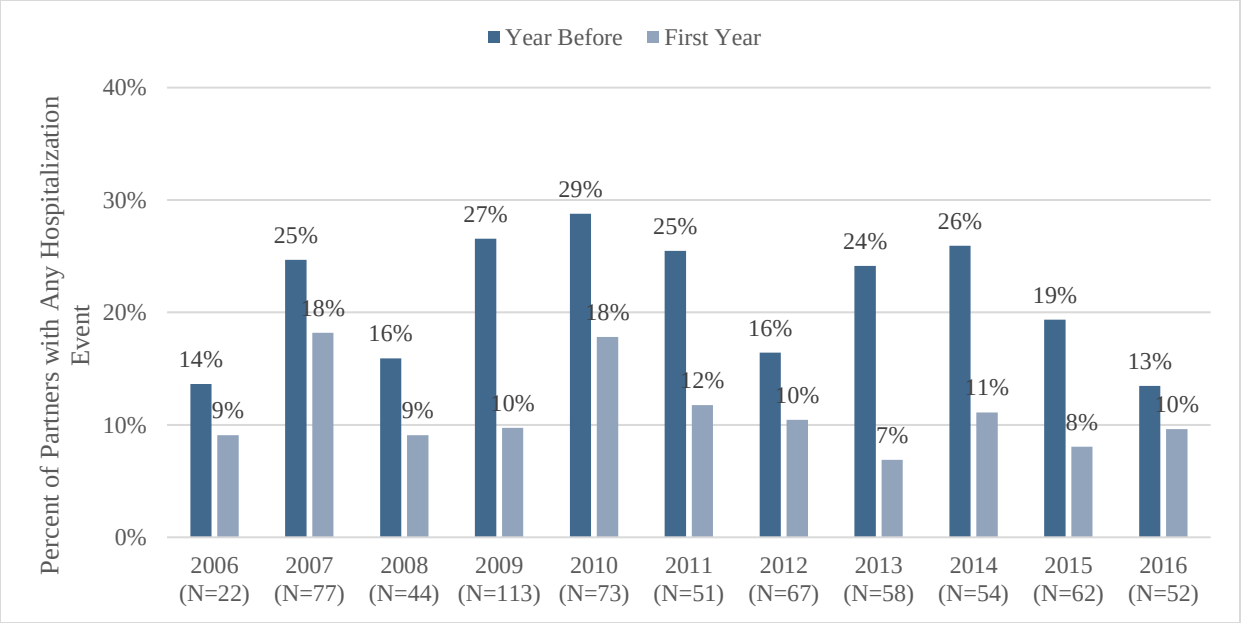


Exhibit 15 displays the mean hospital days per partner. With the exception of 2006 and 2007 cohorts, most partners experienced decreases in the mean number of hospital days.

Exhibit 15: Mean Number of Hospital Days over Time

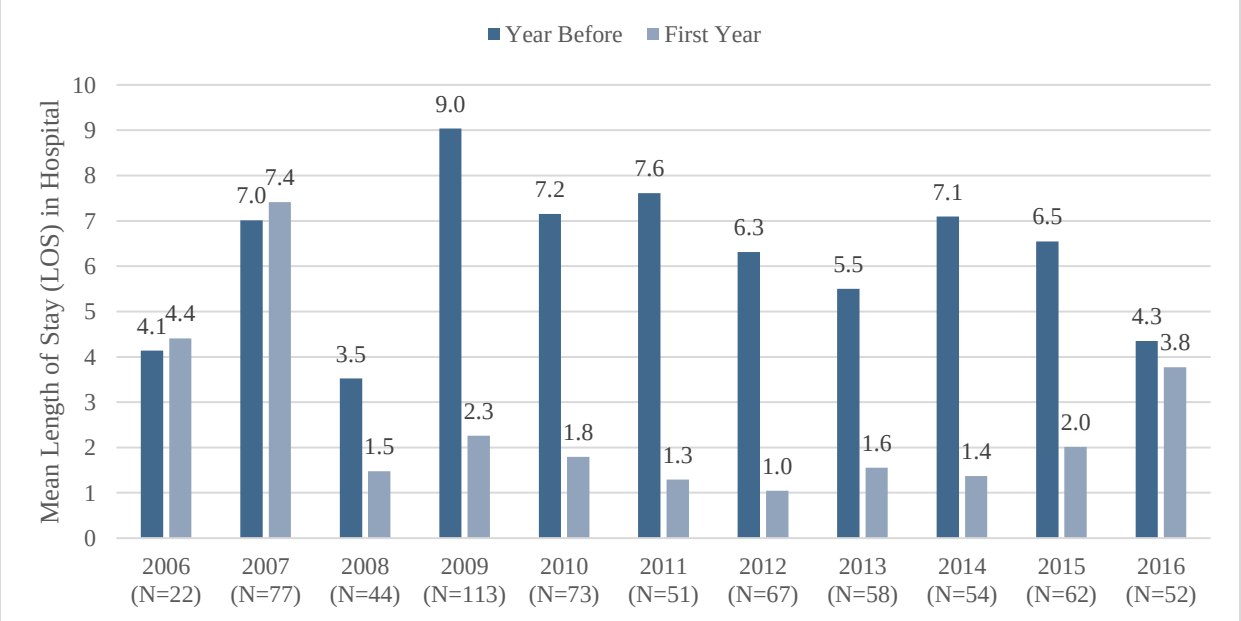
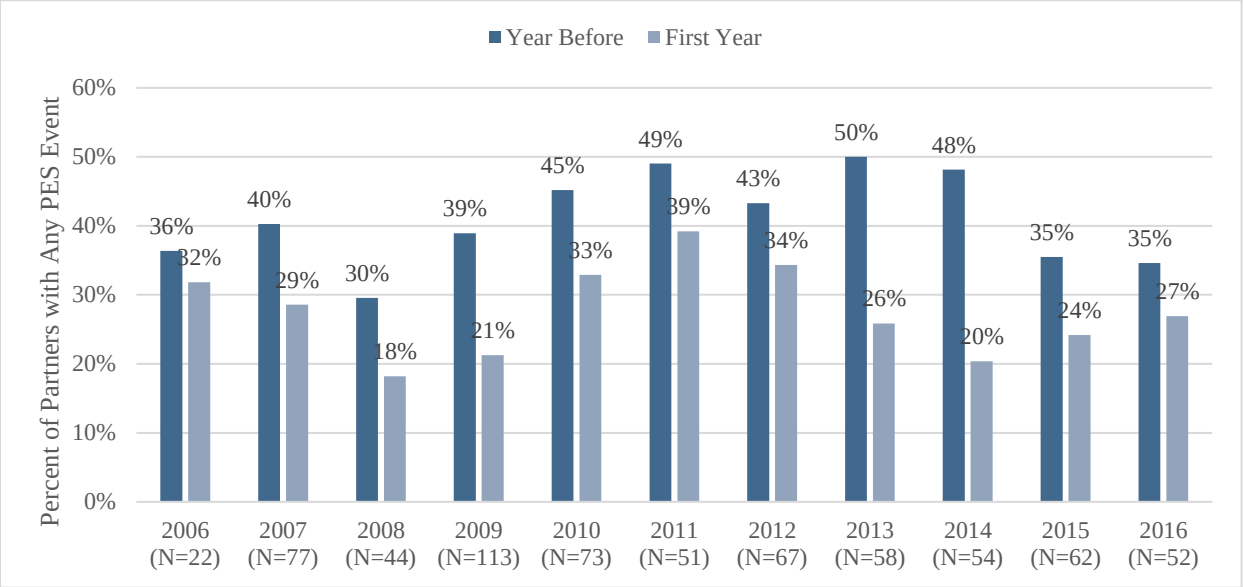


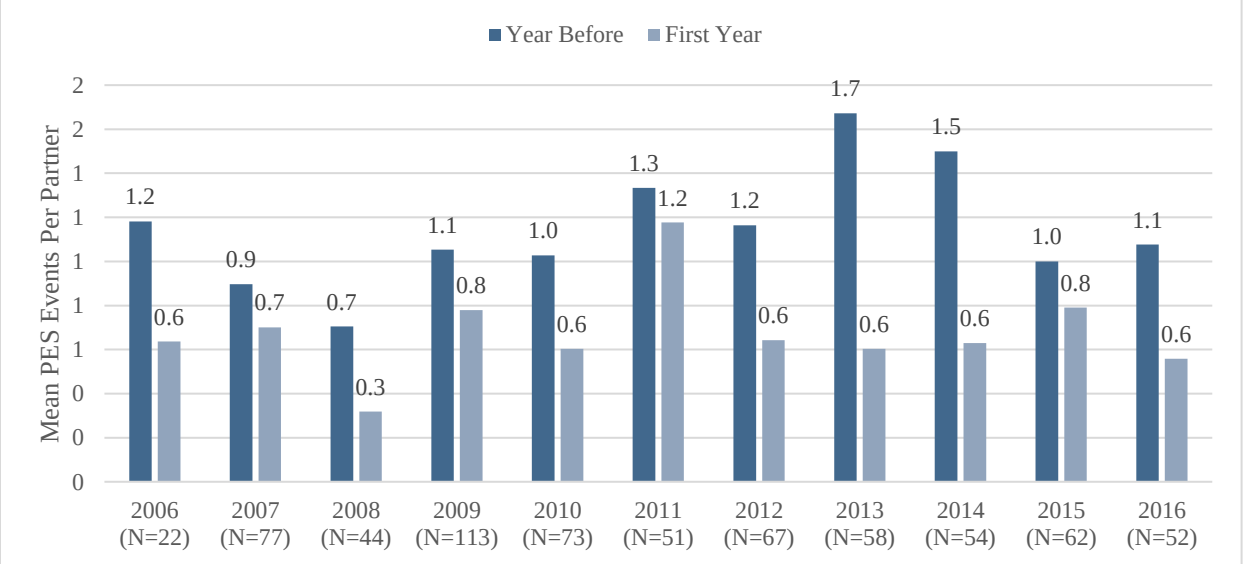
Exhibit 16 displays the percent of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 16: Percent of Partners with any PES Event over Time



Finally, Exhibit 17 displays the mean PES events per partner. Again, all cohorts experienced a reduction in PES events.

Exhibit 17: Mean PES Events over Time



Appendix A: Additional Detail on Residential Outcomes

For residential setting outcomes, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year. A list of all residential settings and how they are categorized, is presented in Appendix C with the methodological approach.

As can be seen in Exhibit A1, the percent of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreases. In contrast, the percent living in an assisted living, group home, or community care environment, or living alone or with others, paying rent increases.

Exhibit A1: Any Time in Residential Settings – Adult and Older Clients Completing 1 Year (n = 445)

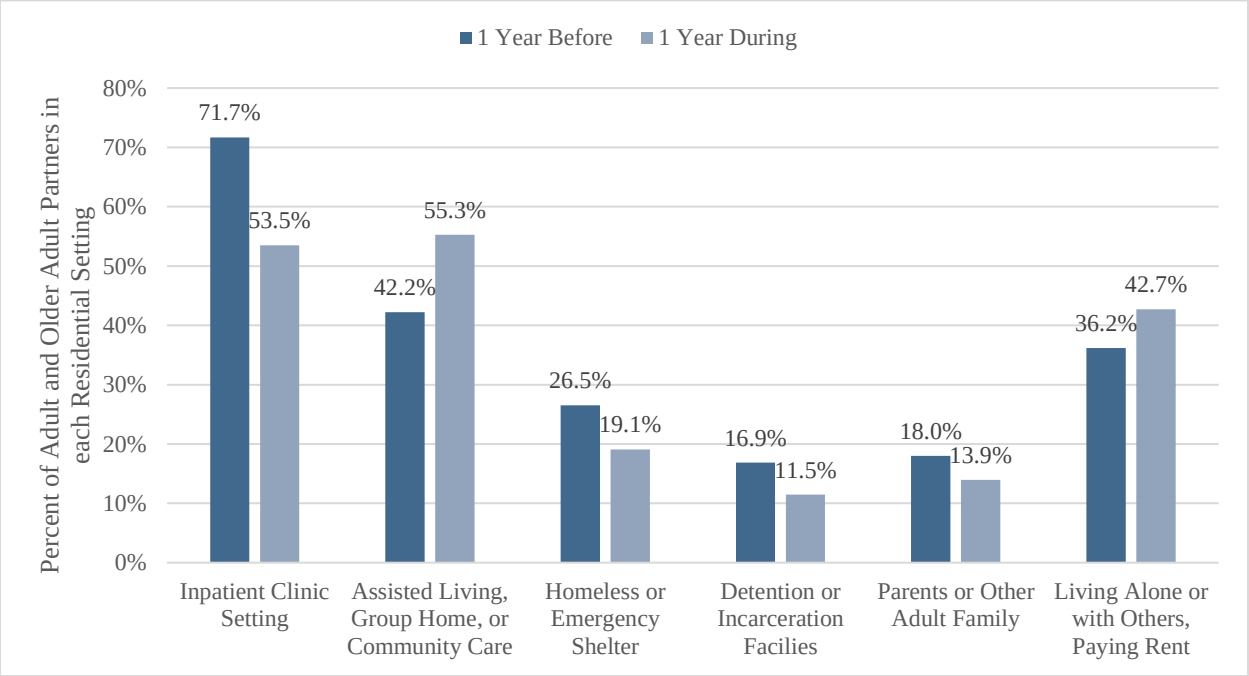
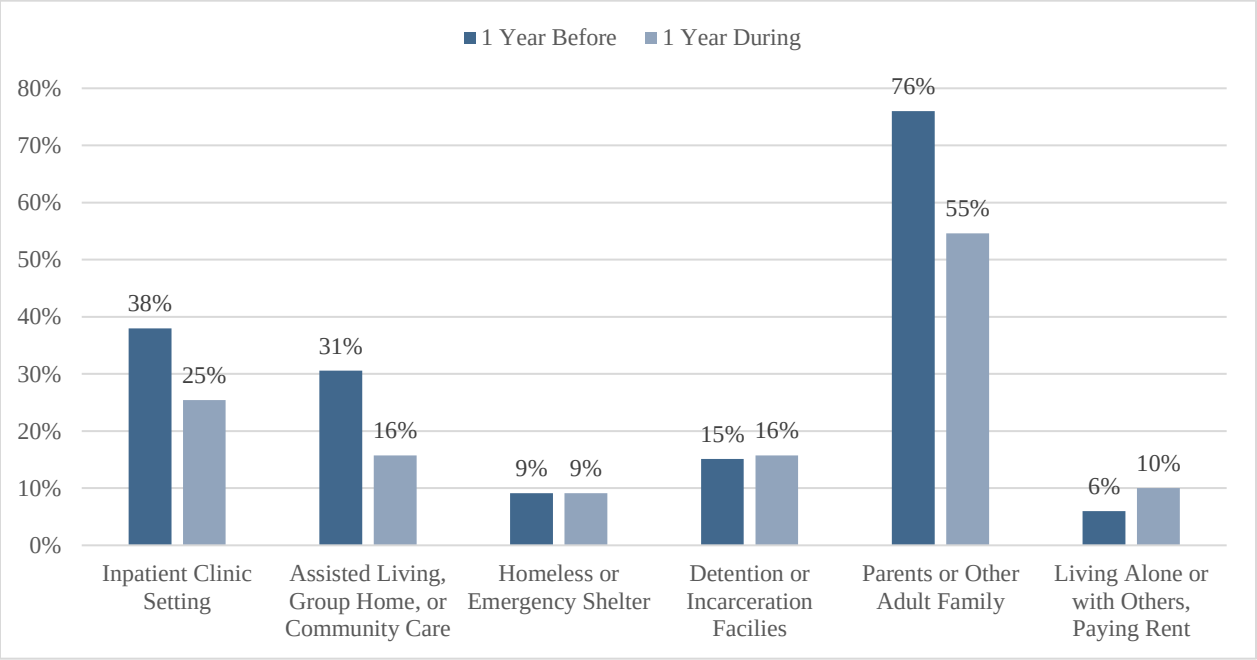


Exhibit A2: Any Time in Residential Settings – Child and TAY Clients Completing 1 Year (n = 350)



Appendix B: Additional Detail on Outcomes by FSP Providers

This section provides more details on the results presented in the main report. The outcomes in this section are broken apart for the following FSP providers: Caminar and Telecare. No outcomes are presented for any group of partners with 10 or fewer individuals.

Exhibit B1-B3, presents the percent of partners with any events the year just prior to FSP and the first year on FSP, as well as the percent improvement for each FSP provider. Percent improvement is the percent change in the percent of partners with any events.

As can be seen in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. The percent difference with any employment is reported as N/A because the percent of partners with employment increases from 0% to 2%. Thus, the denominator is 0.

Exhibit B1. Percent Improvement in Outcomes for Caminar, Year before FSP Compared with First Year with FSP

Survey Outcomes, Caminar	1 Year Before	Year 1 During	% Difference
Homelessness	32.1%	20.8%	35.3%
Detention or Incarceration	19.8%	12.3%	38.1%
Arrests	15.1%	0.9%	93.8%
Mental Health Emergencies	72.6%	15.1%	79.2%
Physical Health Emergencies	45.3%	10.4%	77.1%
Employment	0.0%	2.8%	N/A
Active Substance Abuse Problem	49.1%	40.6%	17.3%
Substance Abuse Treatment	29.2%	24.5%	16.1%

As can be seen in Exhibit B2, there are improvements comparing the year prior to FSP to the first year during FSP for Telecare on all the available self-reported outcomes.

Exhibit B2. Percent Improvement in Outcomes for Telecare, Year before FSP Compared with First Year with FSP

Survey Outcomes, Telecare	1 Year Before	Year 1 During	% Difference
Homelessness	24.8%	18.6%	25.0%
Detention or Incarceration	15.9%	11.2%	29.6%
Arrests	13.3%	1.8%	86.7%
Mental Health Emergencies	31.9%	16.5%	48.1%
Physical Health Emergencies	17.4%	8.3%	52.5%
Employment	12.1%	13.3%	9.8%
Active Substance Abuse Problem	84.4%	48.1%	43.0%
Substance Abuse Treatment	61.4%	13.9%	77.4%

Exhibit B3 shows improvement in many outcomes except for detention or incarceration, grade and attendance.

Exhibit B3. Percent Improvement in Outcomes for Edgewood, Year before FSP Compared with First Year with FSP

Survey Outcomes, Edgewood	1 Year Before	Year 1 During	% Difference
Homelessness	9.1%	9.1%	0.0%
Detention or Incarceration	15.1%	15.7%	-3.8%
Arrests	22.3%	8.0%	64.1%
Mental Health Emergencies	40.3%	8.6%	78.7%
Physical Health Emergencies	18.3%	1.4%	92.2%
Suspension	16.9%	6.9%	59.3%
Grade	3.28	3.01	-8.2%
Attendance	2.25	2.05	-9.2%

Appendix C: Methods

Methodology for FSP Survey Data Analysis

The FSP survey data are collected by providers via discussions with partners and should thus be viewed as self-report. Among the providers included in these analyses (Fred Finch, Edgewood, Caminar, and Telecare), 795 partners completed a full year with FSP since program inception.

Three datasets were obtained: one from Caminar, one from Telecare and one from Edgewood. Caminar and Edgewood provided their datasets in a Microsoft Excel format while Telecare provided a raw Microsoft Access database, which included data on individuals who were not affiliated with FSP.

For Telecare only, we limited the dataset to FSP partners using the Client Admission data and the System Agency Program.

Edgewood/Fred Finch serve child partners and TAY partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Exhibit C1 below describes the age group of partners completing at least one full year of FSP by provider.

Exhibit C1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch*	Caminar	Telecare	Total
Child (aged 16 and younger)	148	--	--	148
TAY (aged 17 – 25)	202	14	26	242
Adult (aged 26 -59)	--	82	264	346
Older Adult (aged 60+)	--	10	49	59
Total	350	106	339	795

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent Global ID, as indicated in the State's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the PAF data.

- For Caminar and Edgewood/Fred Finch, this was done using the variable *Age Group*.
    - Caminar: a value of (7) indicated a TAY partner, a value of (4) indicated an adult partner, and a value of (10) indicated an older adult partner.
    - Edgewood/Fred Finch: a value of (1) indicated a child partner, and a value of (4) indicated a TAY partner.
    - In both cases, this was confirmed using the *Age* variable.
- For Telecare data, partners were given a PAF appropriate for their age; the partner type was identified by the *Form Type* variable (TAY_PAF; Adult_PAF; or OA_PAF).

Partnership date and *end date* were determined as follows: End date was determined by the reported date of the partnership status change in the KET, if the status is indicated to be "discontinued." For clients still enrolled as of the data acquisition at the end of the year, we assigned an end date of June 30, 2018.

All data management and analysis was conducted in Stata. All code is available upon request. Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in the table below (Exhibit C2).
2. The baseline data were populated using the variable *PastTwelveDays* collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. First residential status for partners once they join FSP is determined by the *Current* variable, collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one *Current* location. In this case, if there was one residence with a later value for *DateResidentialChange*, this value was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year on FSP.
4. Additional residential settings for the first year were found using the KET data if the *DateResidentialChange* variable is within the first year with FSP as determined by the partnership date. If no residential data were captured by a KET, it was assumed that the individual stayed in their original residential setting.

Exhibit C2: Residential Categories

Category	Telecare Setting Value[3]	Caminar, Edgewood, and Fred Finch Setting Value[4]
With family or parents		
With parents	1	1
With other family	2	2
Alone		
Apartment alone or with spouse	3	3
Single occupancy (must hold lease)	4	19
Foster home		
Foster home with relative	5	4
Foster home with non-relative	6	5
Homeless or Emergency Shelter		
Emergency shelter	7	6
Homeless	8	7
Assisted living, group home, or community care		
Individual placement	9	20
Assisted living facility	10	28
Congregate placement	11	21
Community care	12	22
Group home (Level 0-11)	16	11
Group home (Level 12-14)	17	12
Community treatment	18	13
Residential treatment	19	14
Inpatient Facility		
Acute medical	13	8
Psychiatric hospital (other than state)	14	9
Psychiatric hospital (state)	15	10
Nursing facility, physical	20	23
Nursing facility, psychiatric	21	24
Long-term care	22	25
Incarcerated		
Juvenile Hall	23	15
Division of Juvenile Justice	24	16
Jail	30	27
Prison	31	26
Other / Don't Know		
Don't know	0	18
Other	49	17

[3] Setting names determined by *Setting* variable in Telecare data.
[4] Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood and Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):

    a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

    b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using the variable indicating the date of employment change (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. A change is considered as indicating some employment if the new employment status code indicated competitive employment or other employment (again, variable names differ by data set). We assumed that no information on employment in the KET indicated that the original employment status sustained.

Arrests

1. The baseline data were populated using the variable *ArrestsPast12* collected by the PAF. Individuals with blank data in this variable were assumed to have zero arrests in the year prior to FSP.

2. Ongoing arrests were populated using the variable indicating the date of arrest (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. We assumed that no information on arrests in the KET indicated that no arrests had occurred in the first year on FSP.

Mental and Physical Health Emergencies

1. The baseline data were populated using the variable *MenRelated* and *PhysRelated* for mental and physical emergencies, respectively, as collected by the PAF. Individuals with blank data in this variable were assumed to have zero emergencies of that type in the year prior to FSP.

2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (1=physical; 2=mental). We assumed that no information

on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Substance Abuse

1. The baseline data were populated using the variable *ActiveProblem* and *AbuseServices* for active substance abuse problems and participation in abuse services, respectively, as collected by the PAF. Individuals with blank data in this variable were assumed to have no substance abuse problems or abuse services in the year prior to FSP.

2. Ongoing substance abuse data were populated using the 3M data variables of the same name. Any record of an active substance abuse problem or participation an abuse services during the first year of FSP was recorded. No observations were assumed to have no ongoing abuse problem or participation in abuse services.

Methodology for Avatar Data Analysis

The hospitalization outcomes use electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-report, but this presents challenges as well. The Avatar system is limited to individuals who obtain care in the San Mateo county hospital system. Hospitalizations outside of San Mateo County, or in private hospitals, are not captured. The hospitalization outcomes include 704 partners who completed one full year or more in a FSP program and were in the Avatar system. Individuals started FSP between July 2006 (the program's inception) and June 2016, completing at least one full year before June 2017.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and PES admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the program codes corresponding with the above measures. Additionally, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3: Program codes among clients ever in the FSP

Program code	Program value
Psychiatric Hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric Emergency Services	
410702	Z410702 SMMC PES -termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Notes: Data represent all utilization from FSP clients for these codes, as pulled from Avatar on April 5th, 2016.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the "c_date_of_birth" variable from the view_episode_summary_admit table and the "FSP_admit_dt" variable from the episode_history table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the Avatar data and the FSP Survey data (reported in our previous report "Full Service Partnership (FSP) Outcomes: Findings from 2015"). This is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the Avatar data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 6. ASSISTED OUTPATIENT TREATMENT (AOT) FSP EVALUATION REPORT

San Mateo County's Assisted Outpatient Treatment (AOT) Program (Laura's Law)

CY2018 Annual Evaluation Report

JUNE 2019

Scott Gilman, MSA, CBHE
Director, Behavioral Health and Recovery Services

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SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Executive Summary

In 2002, the California Legislature adopted Assembly Bill 1421, commonly known as Laura's Law. Laura's Law supplements existing mental health law by allowing a court, in counties that have chosen to implement the law, to order a person into Assisted Outpatient Treatment (AOT) through a civil process.

On June 16, 2015, the San Mateo County (SMC) Board of Supervisors voted unanimously to enact Laura's Law. San Mateo County Behavioral Health and Recovery Services (BHRS) started to implement Laura's Law in July 2016. The BHRS AOT team has been assembled to assess the referred individual for eligibility, provide outreach and engagement, and coordinate with other agencies (County Counsel, directors of various treatment programs including Full Service Partnership (FSP) programs, hospitals, etc.). Caminar FSP is the AOT FSP service provider.

To continue supporting BHRS' implementation and continued quality improvement, American Institutes for Research (AIR) has been retained to conduct an independent evaluation of the AOT program in the second year. This calendar year 2018 (CY2018 hereafter) report's purpose is to provide a detailed view on how the implementation is progressing and to determine if any adjustments are necessary to achieve the goals of the project. The report describes who is making referrals, who is being referred, and who is enrolling in AOT FSP services. The report also provides preliminary findings on client outcomes during CY2018 and changes in key events before and after enrollment in AOT FSP services. Most of the findings are based on administrative and electronic health record (EHR) data on clients who were referred, enrolled and actively engaged in CY 2018 (January 1, 2018 to December 31, 2018).

In CY2018, the BHRS AOT program received 160 referrals for a total of 148 individual clients and 38 informational calls. Most referrals originated within San Mateo County and have come from a licensed or supervising mental health treatment provider followed by family members. The majority of referred clients were White (55%), Non-Hispanic (78%) and male (66%). The referred clients often had histories of arrest, incarceration, hospitalization, homelessness, and violent behavior in the year before the referral.

There were 69 referred clients who were deemed ineligible for AOT services. Of these, 23 clients were referred to specific community services, including behavioral health clinics. Of the 39 eligible clients who were offered Caminar AOT FSP services, 22 clients enrolled in AOT FSP services as of December 31, 2018. The AOT team is currently in the process of offering AOT FSP services to those who are eligible and finding other resources for those who do not meet the criteria. Among AOT FSP enrollees, we find fewer hospitalization, psychiatric emergency service, homeless, and jail events after enrolling, compared to the period before AOT FSP enrollment. The AOT has filed two court petitions for two clients in CY2018.

Introduction

Background

In 2002, the California Legislature adopted Assembly Bill 1421, commonly known as Laura's Law. Laura's Law supplements existing mental health law by allowing a court, in counties that have chosen to implement the law, to order a person into Assisted Outpatient Treatment (AOT) through a civil process. However, the court has no power to enforce its order if the person refuses to participate in treatment.

On June 16, 2015, the San Mateo County Board of Supervisors voted unanimously to enact Laura's Law. The approved budget was $3,766,973 through June of 2018. The AOT program implementation began in July 2016.

Laura's Law is intended to address the mental health care needs of individuals who do not meet the requirements for "grave disability" in order to establish a conservatorship or "danger to self or others" requirement for involuntary confinement, but whose mental status appears to be deteriorating. Laura's Law allows family members, friends, mental health professionals and peace officers to refer individuals with mental illness to be evaluated to receive court ordered treatment which often includes FSP treatment.

The court may order individuals who meet the criteria for Laura's Law into 180 days of Full Service Partnership (FSP) treatment. The court, however, cannot force any individual to take medications or to participate in the FSP program; ultimately, an individual can choose not to engage in treatment without any legal consequences. The premise of Laura's Law is that the non-binding judicial order will induce at least some individuals to participate in treatment.

For the court to order a person to participate in Assisted Outpatient Treatment they must meet the eligibility criteria as listed below:

1. 18 years or older
2. Suffering from a serious mental illness, defined as a mental disorder severe in degree and persistent in duration. May include schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders
3. Unable to "survive safely" in the community without "supervision;"
4. History of "lack of compliance with treatment" as evidenced by at least one of the following:
    a. hospitalized/incarcerated two or more times in the last 36 months due to a mental illness; or
    b. violent behavior towards self or others in the last 48 months
5. Previously offered treatment on a voluntary basis and refused it;
6. Is "deteriorating"

When a licensed mental health treatment provider determines that a client who is court-ordered into AOT has failed or refused to comply with the treatment ordered by the court and that efforts have been made to achieve compliance, the provider may ask that the client be brought to a hospital for evaluation as to whether the client requires involuntary treatment.

AOT goals and objectives are to:

- Engage individuals in ongoing treatment and support
- Reduce homelessness, hospitalizations, victimization, arrests, and incarceration
- Help families and reduce caregiver stress
- Save costs related to arrests, incarcerations, and hospitalizations

Laura's Law Implementation in San Mateo County

San Mateo County BHRS began implementation of Laura's Law in July 2016. This included the start of Caminar's AOT FSP services and their hiring and training staff.

The BHRS AOT team has been assembled to assess the referred individual for eligibility, provide outreach and engagement, and coordinate with other agencies (County Counsel, directors of various treatment programs including FSP programs, hospitals, etc.). Caminar FSP is the service provider.

This team is comprised of one Clinical Services Manager, one half-time Psychologist, one Psychiatric Social Worker, one half-time Deputy Public Guardian, one full-time Mental Health Counselor and one half-time Peer Support Worker. The AOT team works to identify people who qualify for AOT services, encourage them to accept services and then link them to those services. The AOT team is based centrally in San Mateo County and travels to all parts of the county to engage prospective candidates.

The Referral and Screening Process

Anyone can contact the BHRS AOT team with a referral of someone about whom they are both concerned and believe meets the criteria for AOT services. The referrals are received either through a dedicated AOT phone number or email address. The referral system is checked a minimum of twice a day, Monday through Friday except for county holidays.

The AOT team contacts the referring party to gather more information regarding the person who is being referred. Often additional information is needed from other sources to determine eligibility. If the person appears to meet the criteria or eligibility is unclear, the AOT staff will arrange to meet with the individual. This meeting will provide additional information to determine eligibility and an opportunity to establish rapport. The AOT staff continue to engage and encourage eligible individuals to accept services voluntarily. Upon consent to enroll in the program, the AOT staff contact the Caminar AOT FSP and prepare for a "warm handoff."

If the person who is deemed eligible refuses to enroll in the AOT, the staff psychologist may assess this person and request that County Counsel file a petition with the San Mateo County Superior Court (see below, *Court Process*).

If the referred individual is not eligible, other resources are considered that may benefit the person. The referring party is contacted and provided an explanation of the decision and available options for the person they referred. The AOT staff member will help facilitate referrals to other service providers. This facilitation process is an extremely important part of the services provided since many of the referrals do not meet the full criteria for AOT FSP services.

BHRS AOT staff will continue to engage and work with individuals who are not eligible until they are effectively connected with appropriate services. This frequently involves regular in-person contact with the individual, their family, past treatment team and other people who are part of their network of support. The relevant parties are engaged wherever the person is located (e.g., home, shelters, hospital, jail). The engagement may last from a few days to a couple of months in order to get the person connected and provided with a warm hand off. Case studies in the Appendix show examples of the AOT team's involvement in the referral and engagement process.

Court Process

"Both the problems and the symptoms experienced by people who are referred to AOT are very complex, often with dangers to their health and well-being, as well as the well-being of the community. It is not unusual that clients have been struggling for many years, essentially lost in a cycle of decompensations, hospitalizations, incarcerations, such that they have a limited capacity to understand and follow-up with their own care. A critical role of AOT investigations is to simplify the complexity of a case for the care teams and the client. The client can experience some treatment success which encourages the client to engage further. Noticeably, an important part of this seems to be the enduring nature of AOT in continuing to support clients through their various struggles and successes. The program has been remarkable at filling a gap in services for people who were previously unreachable."

(BHRS AOT Psychologist)

San Mateo County Counsel has ten days to file a petition with the San Mateo County Superior Court once the AOT psychologist has completed their assessment and submitted the petition request to County Counsel. After being reviewed by County Counsel, it goes to the Behavioral Health and Recovery Services Director for review and signature, should he be in agreement with the petition. If the petition is then filed, the Court has five court days to schedule and hold the hearing. AOT court hearings are a civil process.

The San Mateo County Private Defender's Office is also notified at the time of the petition so that they can contact and prepare to represent the referred party in court. The assigned private defender will be provided with background and contact information on their new client and will attempt to become part of the client's support and advocacy system.

The AOT court judge will review the petition during the court hearing and with the referred party present. In some cases, the referred party may refuse to be present in court. In such cases, the judge will have the option of reviewing the petition without the person present but with the private defender who is representing the person. The AOT judge will either grant the petition and

order the person into AOT FSP treatment or will find that the person does not meet the criteria and not order him/her into treatment.

The AOT Court judge will expect a status update on each individual court ordered into treatment every 60 days. This update will be prepared by the AOT FSP provider. The court ordered individual does not need to be present in court. If the court and the treatment team see benefit to having the court ordered individual appear in court more frequently than 60 days to support his or her recovery, this can be arranged on a case by case basis.

"The AOT court order process has proved successful in engaging people in treatment services who were previously unreachable or too unwell to be able to plan safely and successfully to manage their illnesses independently. To an extent, we know it is somewhat human (and culturally appropriate) to deny and decline support and care from the community. There seems to be a powerful transition of ability to receive care that takes place in the courtroom where someone hears 'you need care to survive' and 'we promise to give it to you'."

(BHRS AOT Psychologist)

AOT FSP Program

Caminar is the AOT FSP provider for San Mateo County. They are contracted to provide FSP services for up to 50 AOT clients. The AOT FSP is a full continuum of services that includes the following:

- 24/7 wrap around services
- Small caseloads (10-1 ratio)
- Medication management
- Recovery focused, strength based services
- Intensive case management
- Treatment plan developed in collaboration with client
- Co-occurring disorder treatment
- Field based services
- Educational and vocational assistance
- Housing services
- Assistance with benefits and finances
- Life skills training and community integration

Caminar's AOT FSP staffing is comprised of: one Program Director, five Case Managers, two Assistant Case Managers, one Community Support Worker, one Family Partner, one Peer Support Worker, one Housing Specialist, one Registered Nurse, and one Psychiatrist.

To support SMC BHRS in delivering AOT services that improve client outcomes, American Institutes for Research (AIR) is conducting an independent evaluation of the AOT program. Evaluation objectives are to:

- Summarize changes in key events (e.g. homelessness, arrests, incarceration) before and after enrolling in AOT FSP services
- Describe the demographics of persons making referrals and referred individuals
- Describe the AOT case management process

This annual report includes two perspectives of the San Mateo's AOT program: (1) outcomes and (2) operations.

The outcome section provides findings about changes in key events during the periods before and after the client enrolled in the AOT FSP program. Findings are based on administrative, survey and electronic health record (EHR) data. A total of 22 clients were newly enrolled in the AOT-FSP in the CY2018. However, this small sample size is inadequate to detect any statistical significance, therefore we present hospitalization and Psychiatric Emergency Services (PES) outcomes findings on all AOT FSP clients who were enrolled in AOT FSP services since inception (August 2016) to June 30, 2018 (n=64). Also, because both the hospitalization and PES are outcomes that we expect to change when the client is enrolled in the AOT FSP program (i.e. immediate outcomes), we choose to focus on a shorter period of time to examine the changes that could be more likely attributed to the AOT FSP program (i.e. the 6-month before and after AOT FSP enrollment). For jail and homeless outcomes, we include clients who were **actively enrolled in the AOT FSP program in CY2018**. We focus on a longer period of time (one-year before and after) as they are more intermediate as we expect the effect of AOT FSP program could take place after the client is close to completing or has completed the AOT FSP program.

"Simply put, our job is to listen with compassion, see beyond the illness, and touch the humanity that lives within each client. With AOT's support, it is the clients themselves who lead the way to hope and wellness."

(BHRS AOT Staff)

The operation section focuses on describing who is making referrals, who is being referred, and who is enrolling in AOT FSP services. Findings on the 160 referrals are based on administrative data collected by the AOT team from Jan 1st, 2018 to December 31st, 2018.

Methods

Data Sources

This evaluation utilizes data from multiple data sources on clients who were referred, enrolled and actively engaged in the AOT FSP program for any duration during the period of January 1, 2018 through December 31, 2018. These data include (1) BHRS AOT program administrative database (as of March 12, 2019), (2) Caminar's AOT-FSP surveys (as of September 21, 2018)[1], and (3) Avatar Electronic Health Records (EHR) system (extracted on March 21, 2019). In addition, we also use client outcome data collected by the AOT team including jail, employment, homeless, violent behavior, victimization and substance abuse and treatment compliance.

Outcomes. To study hospitalization and psychiatric emergency services among AOT FSP enrollees, we also gathered hospitalization data through the County's EHR system, Avatar.[2] The comprehensive data system includes all episodes of hospitalizations and PES events associated with the AOT clients. One important note is that the Avatar data may not include services received by clients outside the San Mateo County health system.

To evaluate homelessness and jail incidences **before and after** enrollment in AOT FSP services, we used client data collected by Caminar's surveys and BHRS AOT team. The Caminar surveys are administrated at enrollment, every three months following enrollment, and when a defined key event (e.g. homelessness) occurs. Clients' jail history and other client outcomes during CY2018 including violent behavior, victimization, substance abuse and treatment compliance were collected by the BHRS AOT team.

Operations. To capture information about referrals and individual client characteristics we have gathered demographic information, clients' histories of arrests, incarcerations, hospitalizations (for mental health issues and for physical health issues), aggressive/violent behavior, and homelessness from AOT team's administrative database, which includes information collected during the referral and case management phases.

Analysis

Descriptive statistics (e.g., means) were calculated to describe the demographics of persons making referrals and referred clients. To describe the changes in key events of AOT FSP enrolled clients, we calculated homelessness and jail events before and after AOT FSP enrollment. For these key event outcomes, the pre-AOT period is 12 months before the client's enrollment date, and the post-AOT period is from the enrollment date to December 31, 2018.

[1] We were not able to obtain the full CY2018 Caminar AOT FSP data at the time of conducting this analysis for the CY2018 report because Caminar changed to a new Electronic Health Record system (EHR) in Dec 1, 2018. Work to convert the new data and merge with the previous FSP data is still in progress as of June 1, 2019. Because this switch may affect data input and quality around the switch date, we decided to use previously extracted Caminar AOT-FSP survey data (up to September 21, 2018).

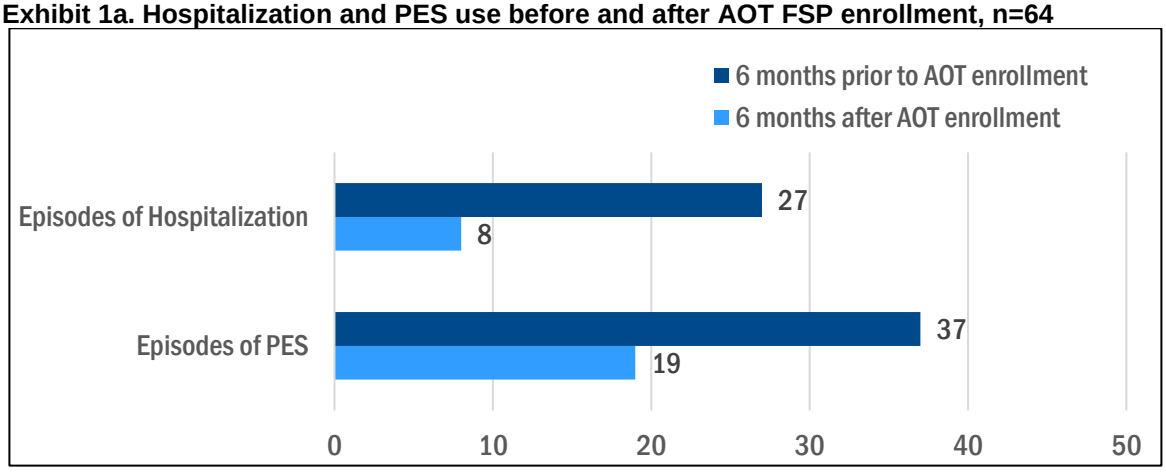
[2] The Caminar FSP surveys do not include information on client hospitalization or psychiatric emergency service use.

Outcomes: AOT Key Events among Clients Enrolled in AOT FSP Services

Psychiatric Hospitalization & Psychiatric Emergency Services (PES) (N=64)

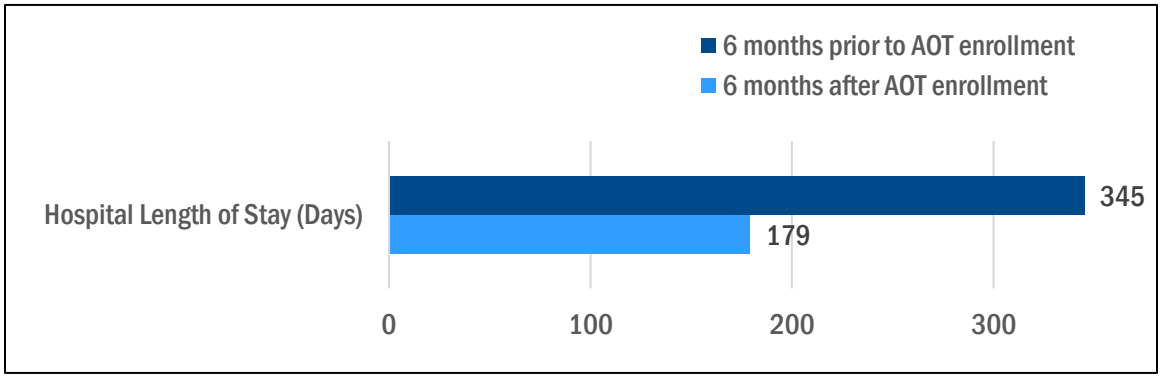
Exhibit 1a shows psychiatric hospitalization and PES use in the 6-months before and after the client enrolled in the AOT FSP services. There were 18 clients who had at least one hospitalization (i.e. hospital stay) in the 6-months before enrollment with a total of **27 episodes** for the group. During the 6-months after the AOT FSP enrollment, there were 8 clients who were hospitalized with a total of **8 episodes**. The reduction in hospitalizations is significant at $p<0.01$. These outcomes are based on 64 AOT FSP clients eligible for this analysis. We excluded the clients who enrolled after June 30, 2018 to ensure a full six months of outcome monitoring following enrollment in the AOT-FSP program.

Exhibit 1a. Hospitalization and PES use before and after AOT FSP enrollment, n=64



Average hospitalization days was 5.4 days and the total number of hospitalization days was 345 before enrollment, compared to 2.8 days and 179 days in the 6-month period after the client enrolled in AOT FSP. The difference is significant at $p<0.10$ ($p=0.0528$). Further, PES use decreased from a total of 37 episodes in the previous 6-months to 19 episodes during the 6-months after. The difference is significant at $p<0.01$ ($p = 0.0075$).

Exhibit 1b. Hospital Length of Stay before and after AOT FSP enrollment, n=64



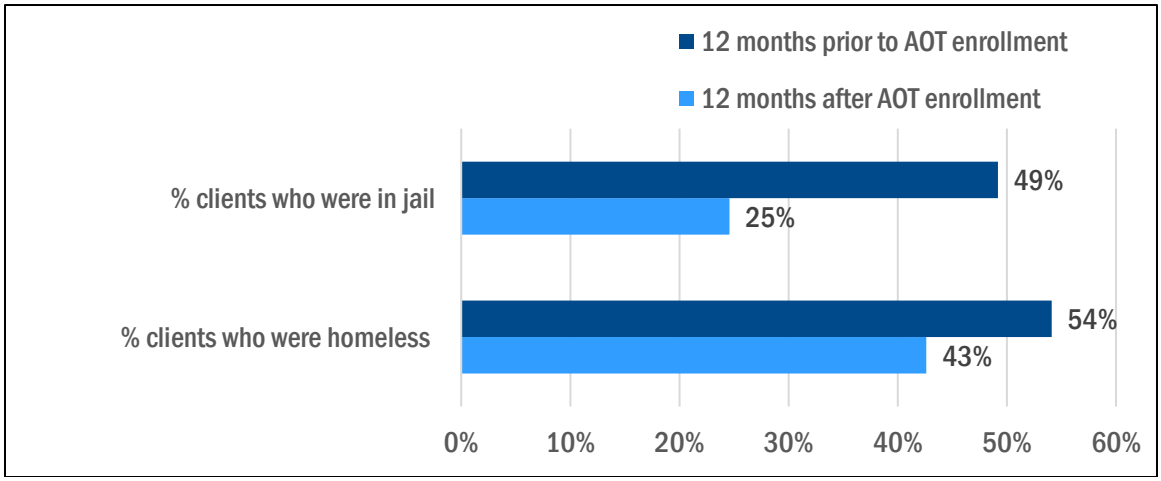
Housing, Jail and Other Client Outcomes in CY2018 (N=61)

This section presents findings on 61 clients who were enrolled in the AOT FSP program (i.e., actively engaged) in CY2018. We report the following outcomes: homeless, jail, violent behavior, victimization and substance abuse and treatment compliance. One important note here is that this section focuses on the client outcomes occurring in CY2018. Most of the 61 clients in our sample are the same clients in the sample for health care use analysis in the previous section (N=64); however, there are still some differences. First, some clients discharged from the AOT FSP program before 2018 are not included in the housing, jail and other client outcomes analyses because data on their CY2018 outcomes are not available. Second, clients who started after July 1, 2018 are not present in the previous section because of the 6-month pre-post design for the hospitalization and PES analysis.

Housing and Jail

Exhibit 2 reports jail and housing outcomes from AOT administrative records and Caminar survey data, respectively. Fewer jail encounters and periods of homelessness occurred after clients enrolled in AOT FSP services. While 30 clients (49%) had been put in jail before AOT FSP enrollment, only 15 clients (25%) were reported being jailed after enrollment. 26 clients (43%) reported homelessness after starting the AOT FSP program, compared to 33 (54%) in the year before. Again, as indicated in the Data Sources section, we capture partial year homeless outcomes because we were only able to obtain Caminar survey data up to Sep 21, 2018.

Exhibit 2. Housing, and jail outcomes before and after AOT FSP enrollment, n=61



"Emphasizing housing first has been an important strategy for fostering engagement, as well as our philosophy of harm-reduction. So many of our clients are used to a dynamic in which they lose services when they make mistakes. Seeing that our team is here to support them, even after a series of setbacks, has worked to reduce the resistance that our clients often feel when they first start treatment."

(AOT FSP Treatment Manager)

It is worth noting that some clients who were newly enrolled into the AOT FSP program may continue to experience homelessness for some time following enrollment due to their inability to access certain services or their need for other services (e.g., alcohol and drug rehabilitation) prior to housing. The following are common reasons for prolonged periods of homelessness despite enrollment in the AOT FSP program:

1. Shelters, social rehabs, accessory dwelling units (ADU), and all other placements have waitlists.
2. Those who are Registered Sex Offenders (RSOs, or "290s") are not welcome at most mental health housing/treatment options and require extra services to place.
3. Some clients choose to go to alcohol and drug rehabilitation during the first part of their AOT treatment, which makes them technically homeless.
4. Some clients are temporarily living in motels with the AOT FSP Case Manager's support to ensure stability while waiting for stable placement.
5. A small number of clients choose to pursue a lifestyle without housing.
6. Notably it is very difficult to place someone in a shelter or treatment center directly out of jail (jail referrals have increased over CY2018).
7. The path to permanent mental health housing takes time, typically from six months to a year.

Other Client Outcomes in 2018

Exhibits 3 through 5 show client outcomes in employment, treatment compliance, victimization, violent behavior, and substance abuse for all the 61 clients who were enrolled **during 2018**. We did not collect data in the year prior to the client enrollment during CY2018; therefore, we are not presenting the data in a comparative manner. We will collect and include the pre-enrollment outcomes in the future report.

Exhibit 3 reports whether the client participated in any employment services in 2018. While most of the clients were unemployed, 16% of clients reported that they participated in some type of employment services.

Exhibit 3. Employment Services, n=61

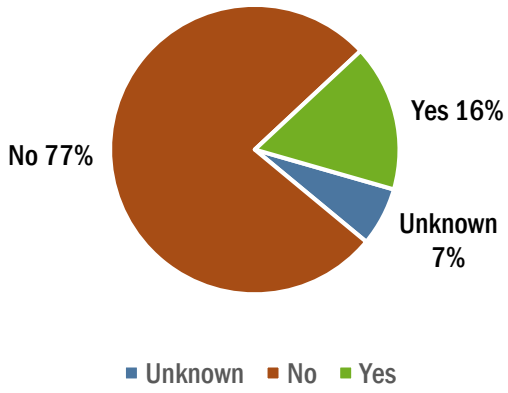


Exhibit 4 indicates that over half of the enrolled clients (61%, N=37) maintained contacts with the treatment team and 44% (N=27) of the clients adhered to the treatment plan.

Exhibit 4. Treatment compliance for AOT FSP clients enrolled in 2018, n=61

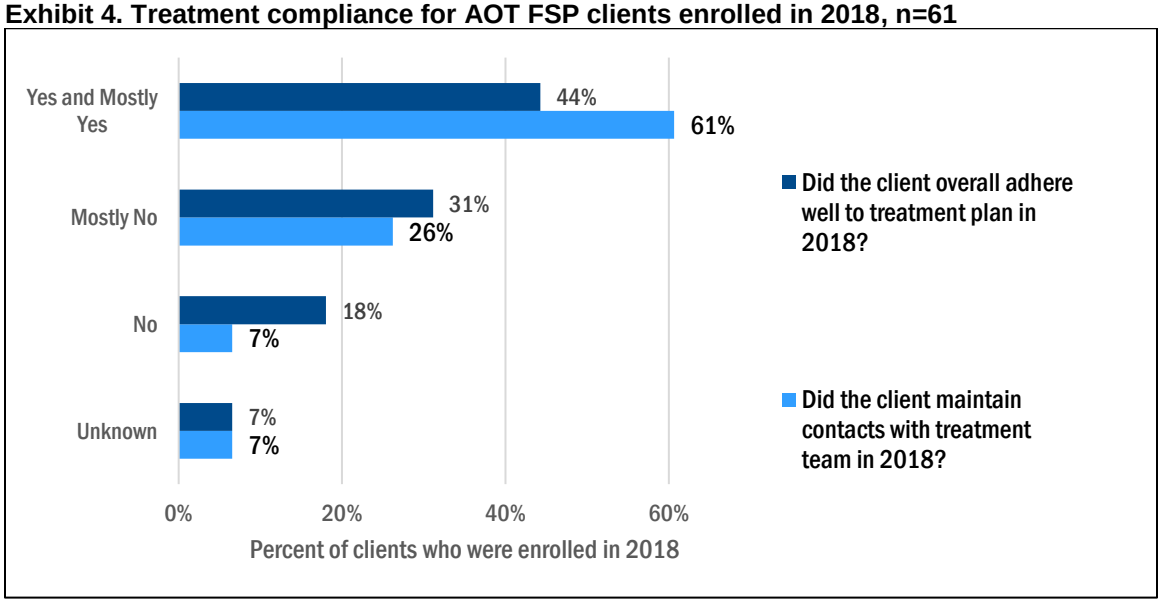
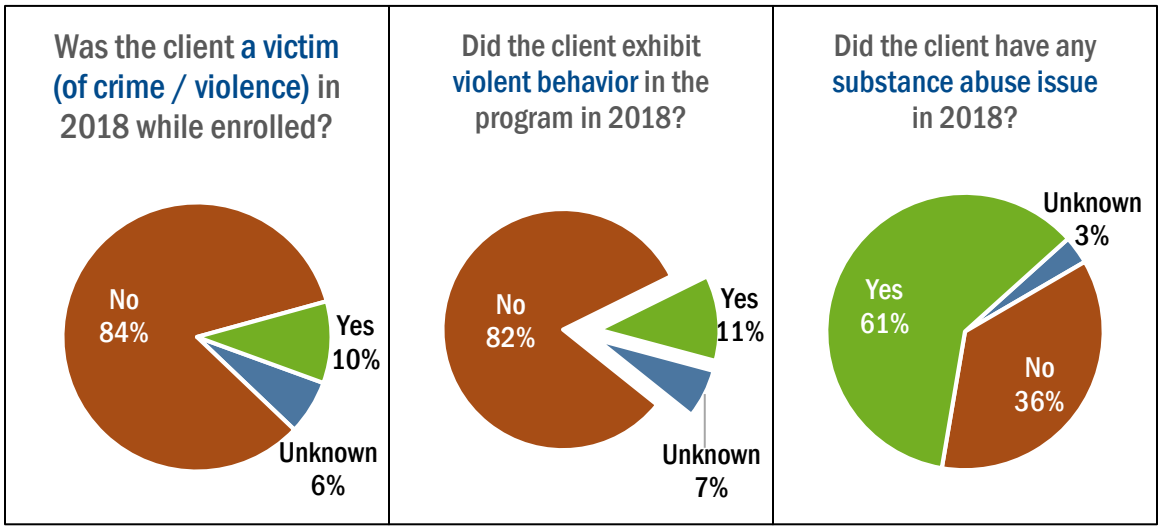


Exhibit 5 shows that most of the clients were not a victim of any crime or violence, nor exhibited any violent behavior while enrolled in the AOT FSP program in 2018. However, 61% (N= 37) of clients reported having a substance abuse issue in 2018. Among clients who reported their drug of choice (n=34), the top three substances abused were methamphetamine (n=14, 38%), marijuana (n=13, 35%) and alcohol (n=8, 22%).

Exhibit 5. Victimization, Violent Behavior and Substance Abuse, n=61



Operations: Demographics of Referring Callers and Referred Clients (January 1, 2018 – Dec 31, 2018)

Referrals (N=160)

Between January 1, 2018 and December 31, 2018, the SMC AOT program received a total of 160 referrals for 148 clients. Exhibit 6 shows that most referrers reside in San Mateo County (90%).

Exhibit 6. Geographic distribution of referrers, n=160

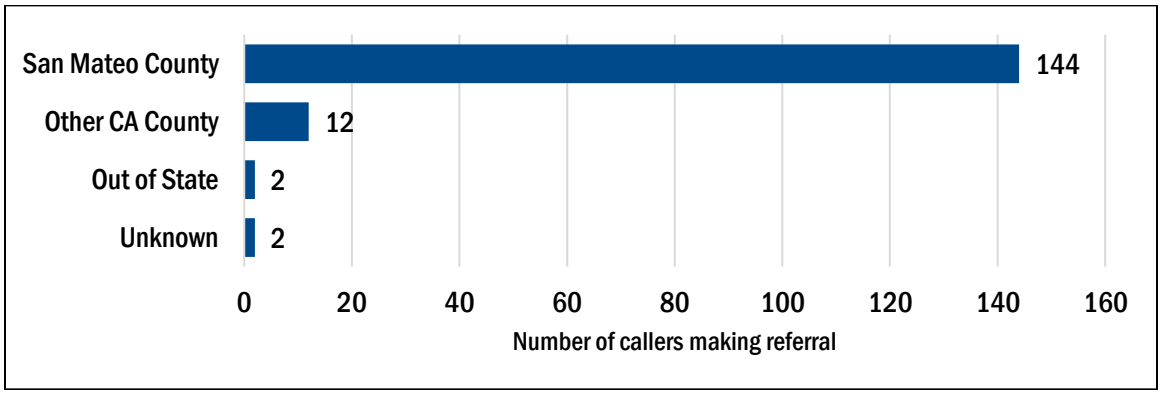
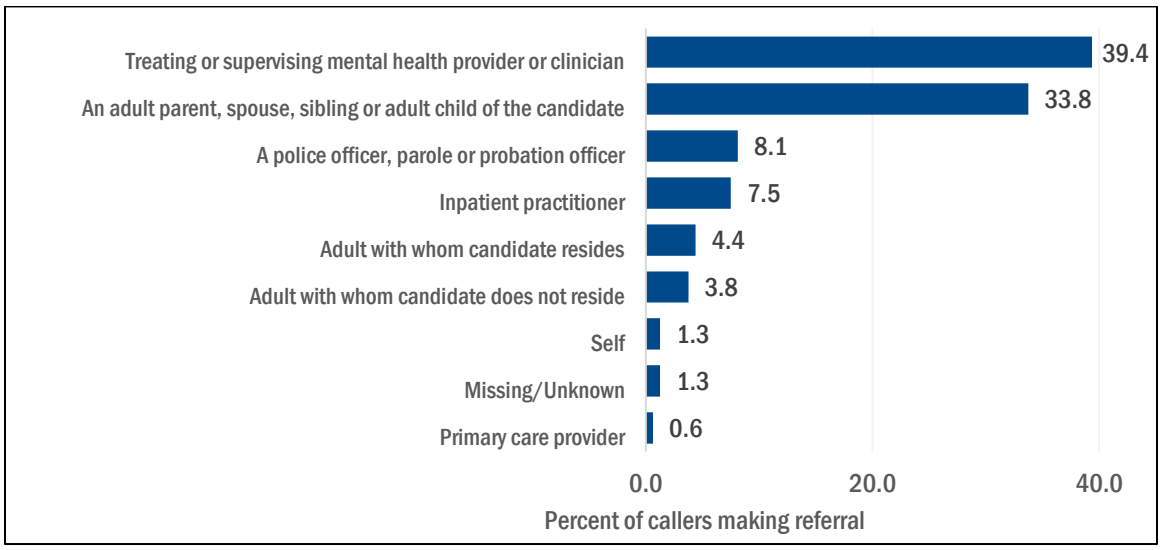


Exhibit 7 illustrates the referrer's relationship to the referred client. The referrer was often the referred client's relative (33.8%) or a licensed mental health treatment provider working with the client (39.4%).

Exhibit 7. Caller's relationship to the referred individuals, n=160



Note: "Missing/Unknown" indicates the caller did not provide his or her relationship information to the referred individual at the time of the referral.

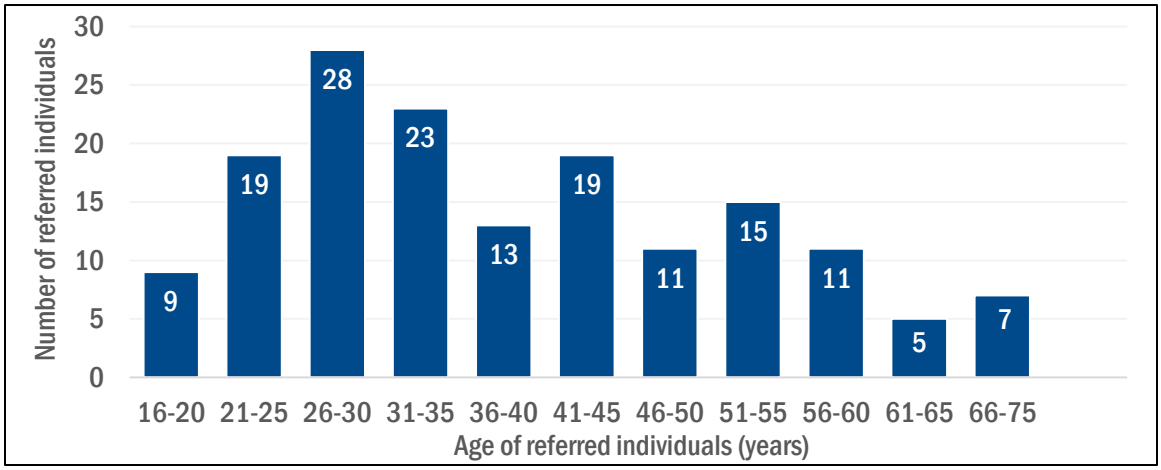
Referred Clients (N=148)

Below are the demographics and arrest, incarceration, hospitalization, violent behavior, and homelessness histories for referred clients (before AOT referral). Because a client can be referred multiple times, for demographics, age, gender, race and ethnicity information, the sample includes all referrals (N=160) to capture the overall referral characteristics. For other outcomes, the sample includes unique clients during their first referral (N=148). Data is derived from the administrative data collected by the AOT team during the referral and case management phases. We report the number of referred clients who provided information about the specific event.

Demographics (N=160)

Between January 1, 2018, and December 31, 2018, 160 referrals were made to the SMC AOT program for a total of 148 unique clients. Exhibit 8 illustrates the age distribution of the referred clients. The age of the referred clients in the 160 referrals were calculated based on the client's date of birth and referral date using the AOT administrative database. The average age is 38.9 years, with a range from 19 to 74.

Exhibit 8. Age distribution of referred clients, n=160



Exhibits 9 and 10 show the gender, ethnicity and race composition of the referred clients. Most of the referred clients are White and Non-Hispanic. In Exhibit 10, the "unknown" indicates that the client's race could not be clearly identified or was not provided at the time of referral. "Other" indicates that the client's race falls beyond the current categories established in the database, e.g., multiple races.

Exhibit 9. Gender of referred clients, n=160

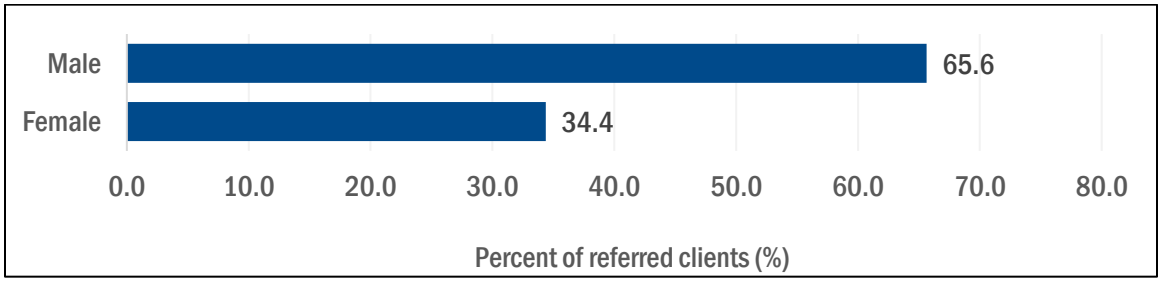
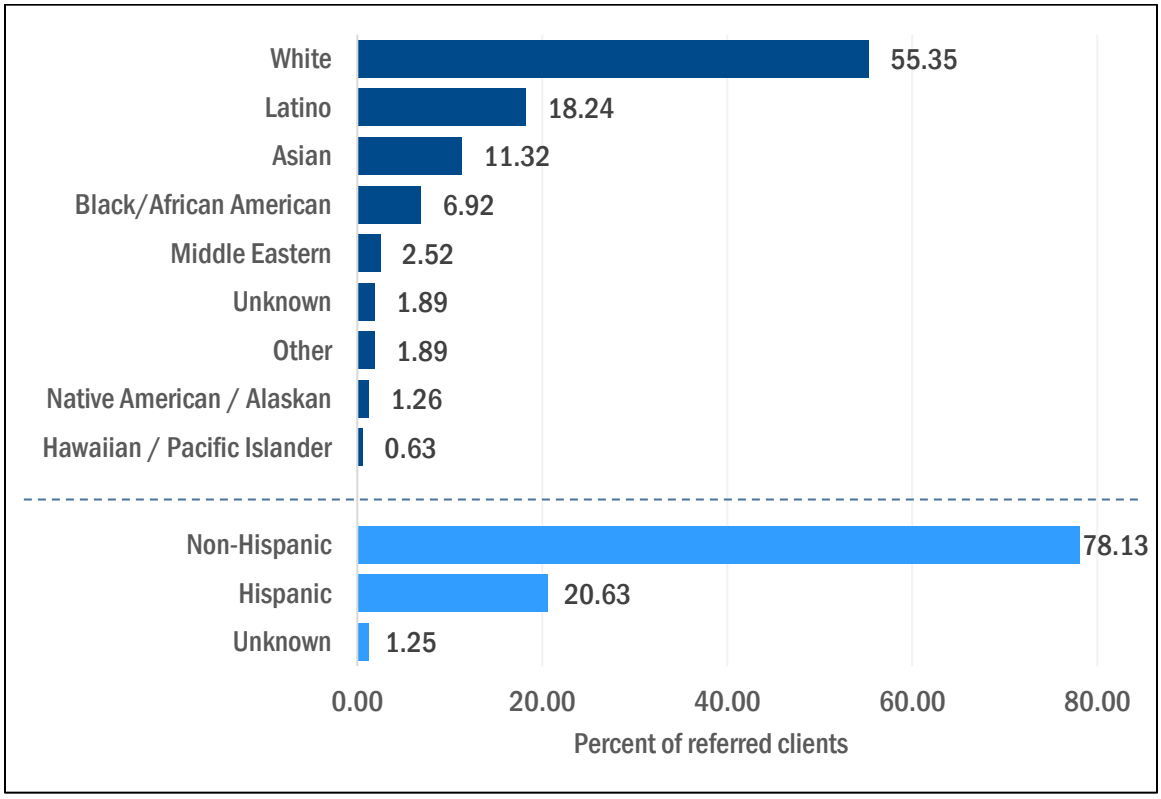


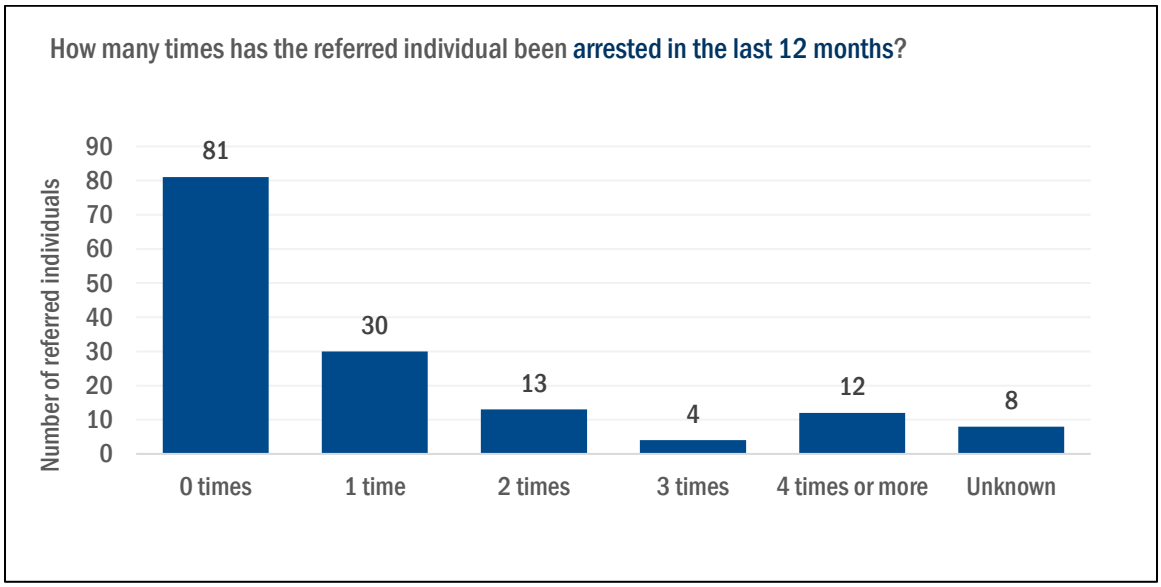
Exhibit 10. Race/ethnicity of referred clients, n=160



Arrests (N=148)

There are 68 clients (42.1%) who had at least one arrest in the 12 months prior to their referral (Exhibit 11).

Exhibit 11. Arrests reported by referred individuals in the 12 months prior to referral, n=148



Incarceration (N=148)

There were 57 clients (42.9%) who reported at least one incarceration (Exhibit 12) in the last 12 months and 51 clients (36.4%) who reported two or more incarcerations (Exhibit 13) in the last 36 months prior to the referral.

Exhibit 12. How many times has the referred individual been incarcerated in the last 12 months? n=148

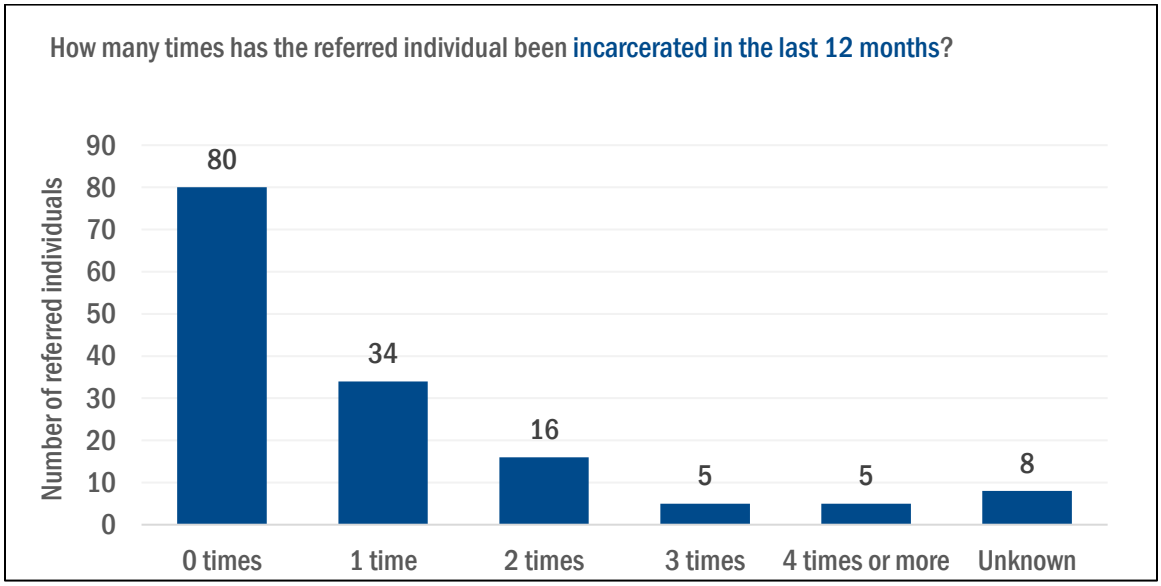
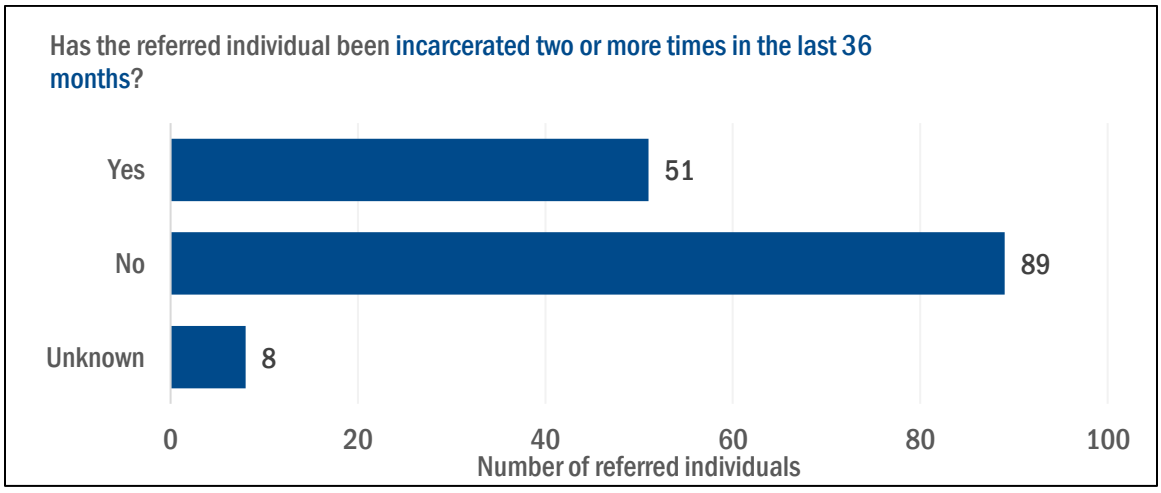


Exhibit 13. Has the referred individual been incarcerated two or more times in the last 36 months? n=148



Hospitalization (N=148)

Hospitalization (for mental health reasons) There were 83 clients (59.3%) who had at least one hospitalization related to mental health issues (Exhibit 14) in the last 12 months and 74 clients (52.5%) who reported two or more hospitalizations for mental health reasons (Exhibit 15) in the last 36 months prior to the referral.

Exhibit 14. How many referred individuals have been hospitalized for mental health issues in the last 12 months? n=148

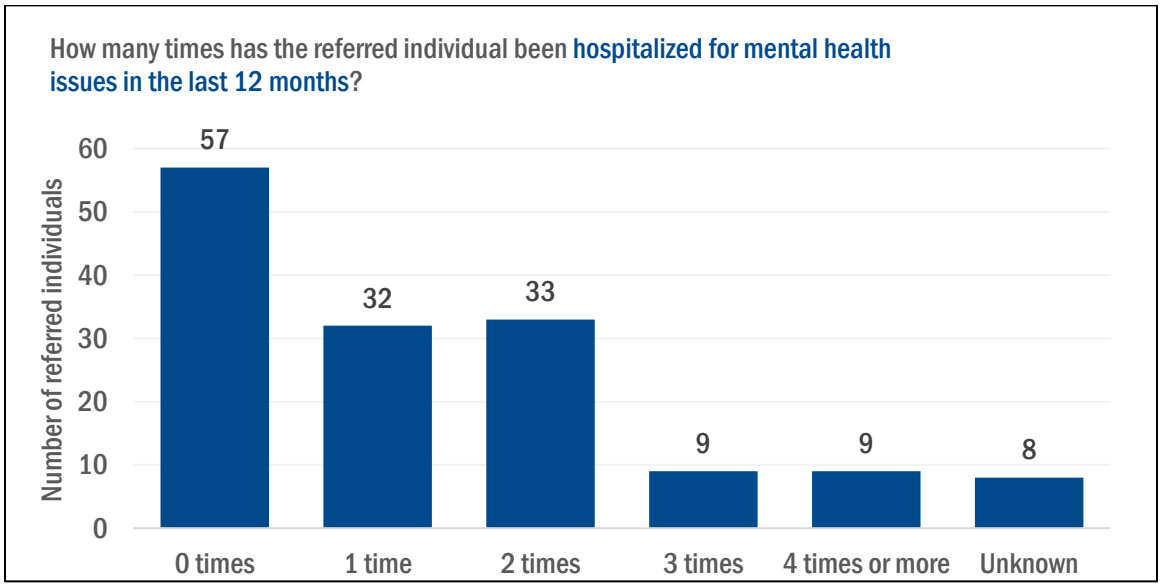
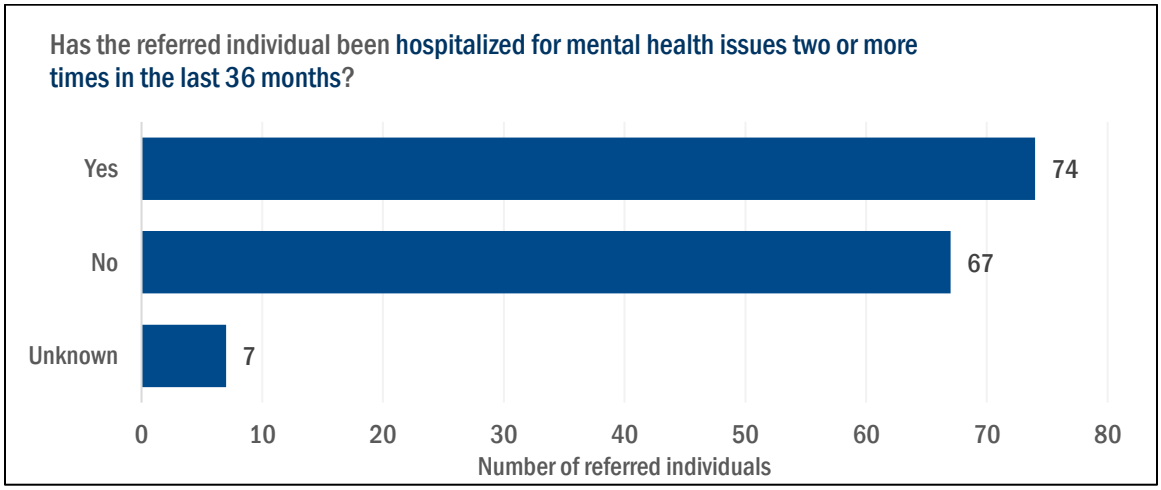


Exhibit 15. Has the referred individual been hospitalized for mental health issues two or more times in the last 36 months? n=148



Hospitalization (for physical health reasons) There were 21 clients (15.1%) who had at least one hospitalization related to physical health (Exhibit 16) in the last 12 months and 23 clients (16.4%) who reported two or more hospitalizations for physical health reasons (Exhibit 17) in the last 36 months prior to the referral.

Exhibit 16. How many referred individuals have been hospitalized for physical health issues in the last 12 months? n=148

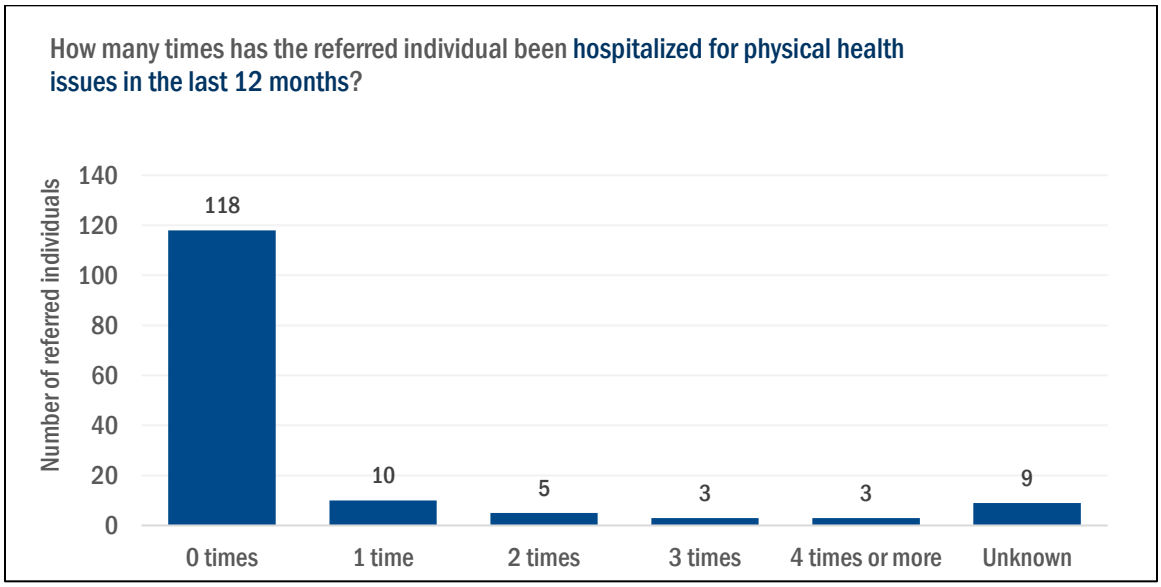
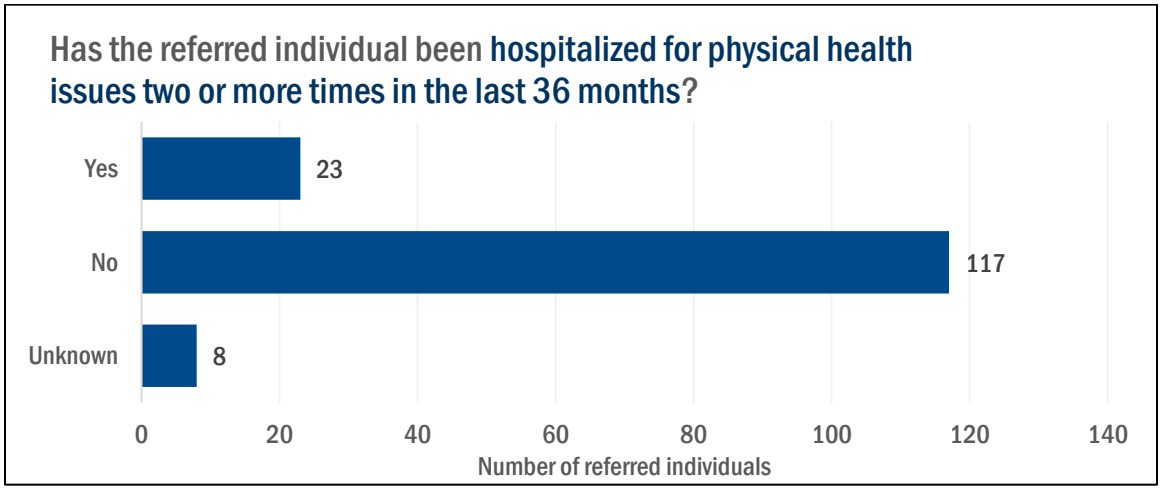


Exhibit 17. Has the referred individual been hospitalized for physical health issues two or more times in the last 36 months? n=148



Violent Behavior (N=148)

There were 29 clients (20.9%) who had demonstrated at least once a threat or attempt of a significantly dangerous behavior toward self or another person (hence after referred to as "violent behavior") (Exhibit 18) in the last 12 months and 30 clients (21.4%) exhibited violent behavior at least once (Exhibit 19) in the 48 months prior to the referral.

Exhibit 18. How many referred individuals have demonstrated a threat or attempt dangerous behavior in the last 12 months? n=148

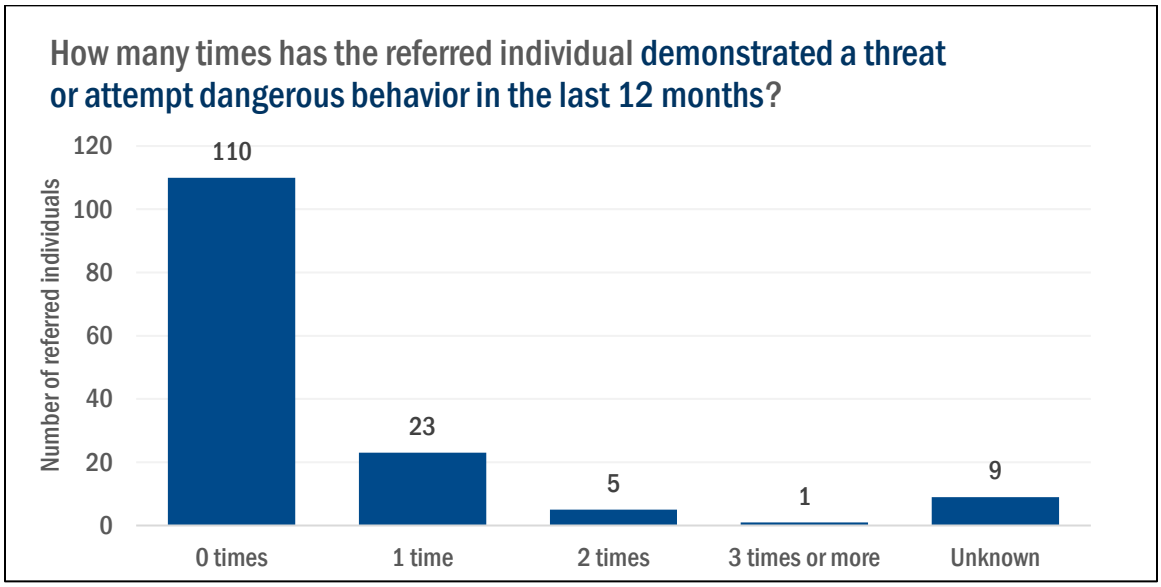
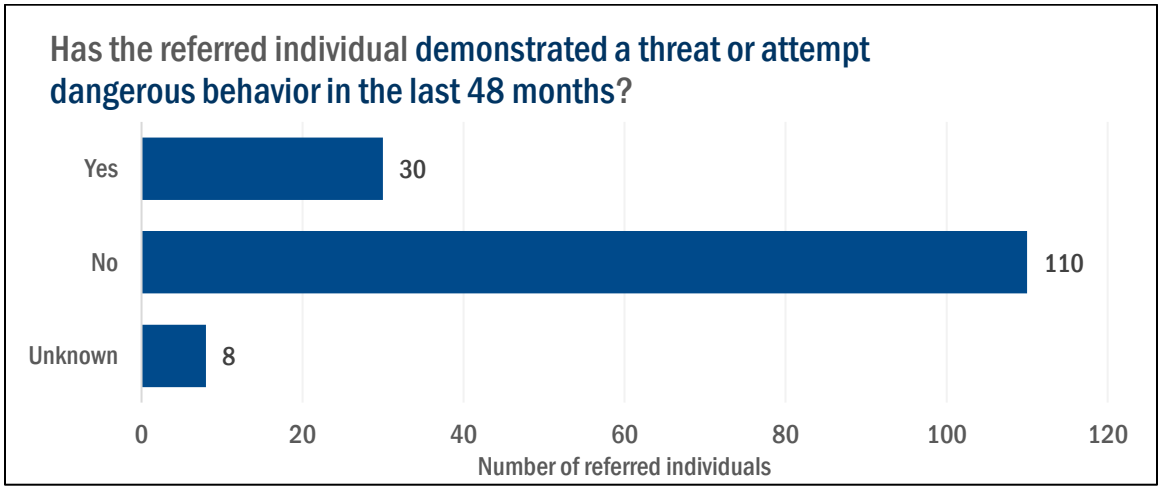


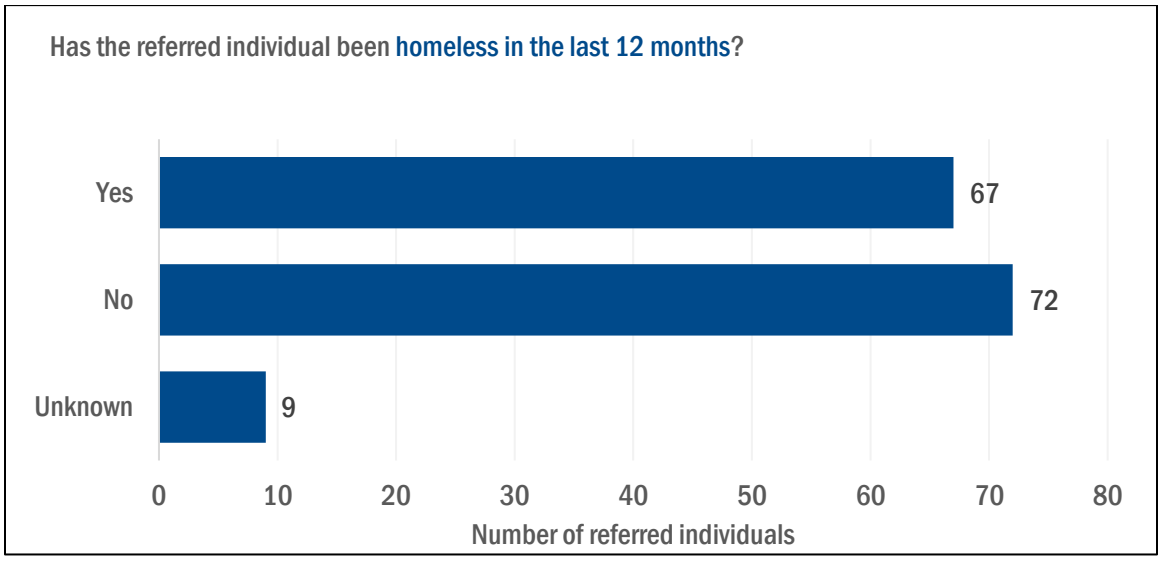
Exhibit 19. Has the referred individual demonstrated a threat or attempt of a significantly dangerous behavior toward the self or another at least one time in the last 48 months? n=148



Homelessness & Housing at the Time of Referral (N=148)

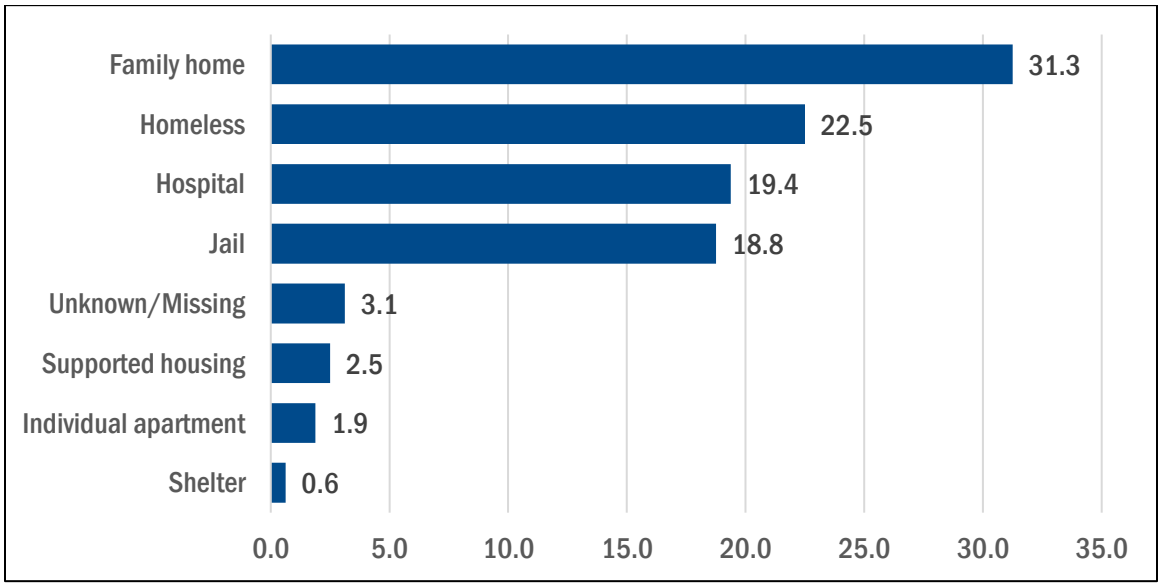
There were 67 clients (48.2%) who reported being homeless in the last 12 months before the referral (Exhibit 20).

Exhibit 20. Has the referred individual been homeless in the last 12 months? n=148



Most of the referred clients (31.3%) were residing in a family home at time of referral. 22.5% of clients were homeless and 38.1% of clients were hospitalized at or just prior to referral. (Exhibit 21).

Exhibit 21. Client housing at the time of referral, n=160



AOT Case Management Process

Next, we describe the caseload of the AOT program, eligible and ineligible referred clients and final disposition for each.

Caseload of AOT Program

Exhibit 22. Client flow - caseload of AOT program (Jan 2018 – Dec 2018)

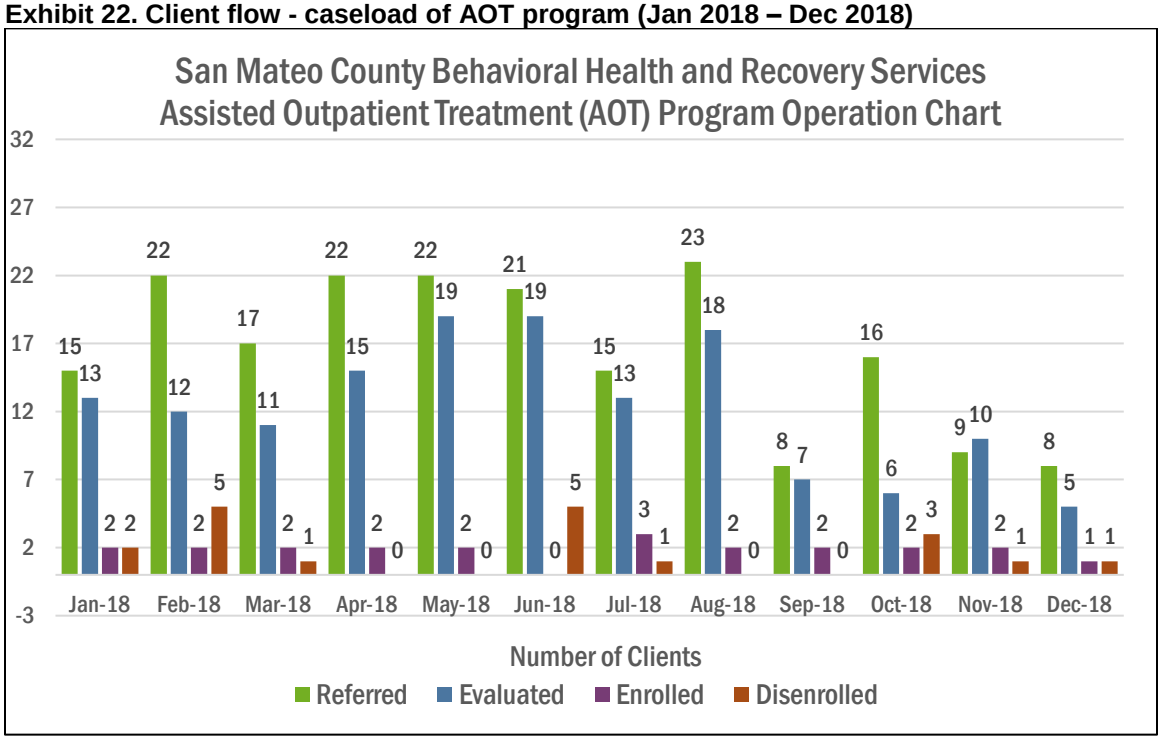


Exhibit 22 reports the number of referrals ("Referred"), evaluated cases ("Evaluated"), AOT FSP enrollment ("Enrolled") and disenrollment ("Disenrolled") per month between January 1, 2018 and December 31, 2018. On average, there are 13 referrals per month. For each month, 1.75 eligible clients enroll in the AOT FSP program on average.

Eligible Clients (N=79)

In CY 2018, among the 148 evaluated clients, 79 clients were deemed eligible for AOT FSP services. There were 39 clients who were offered AOT FSP services and 22 clients accepted and enrolled in AOT FSP services. The AOT filed two court petitions for two clients in CY2018.

"One strategy that we have used to engage family and clients is to emphasize the supportive services included with AOT, and that it's not all about medications and doctor appointments. The services that clients are interested in are housing, job counseling, therapy, and help with life stressors, etc. We try to normalize it and emphasize that everybody needs help with these types of things in life." (BHRS AOT Case Manager)

Of the 22 clients who enrolled in CY2018, the average time from initial referral to AOT FSP enrollment was 76 days, and the average time from initial client contact to enrollment was 34 days (Exhibit 23).

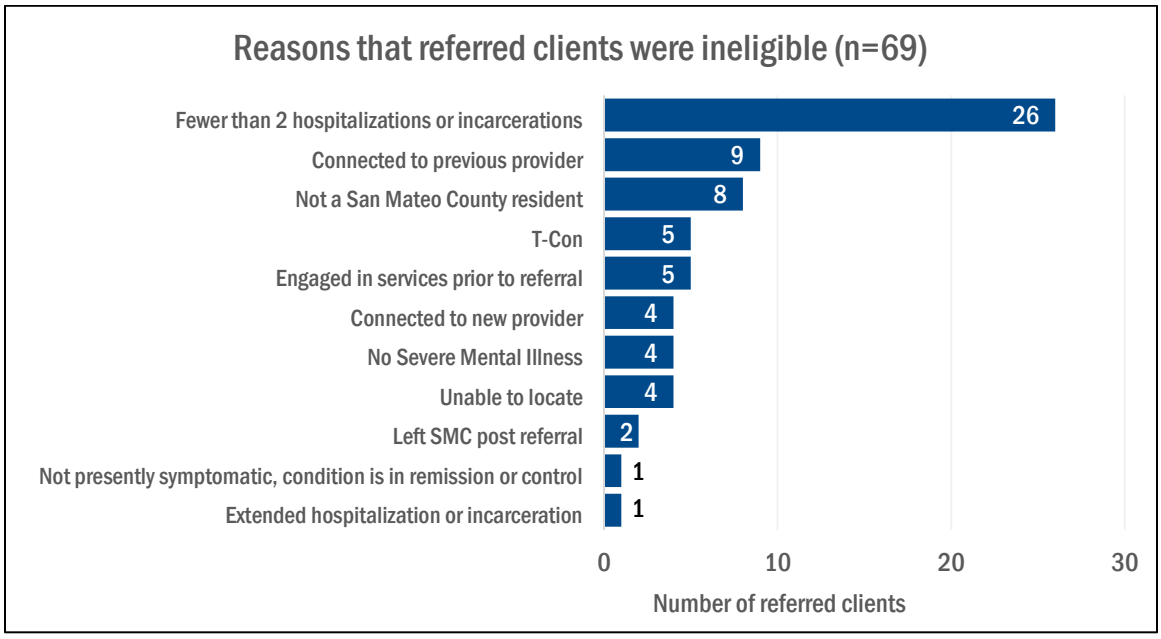
Exhibit 23. Days to enrollment for referred clients, n=22

	Average days	Minimum days	Maximum days	Number of clients
From referral to enrollment	76	8	304	22
From initial contact to enrollment	34	3	162	22
*22 clients enrolled in the Caminar AOT FSP services in CY2018.				

Ineligible Clients (N=69)

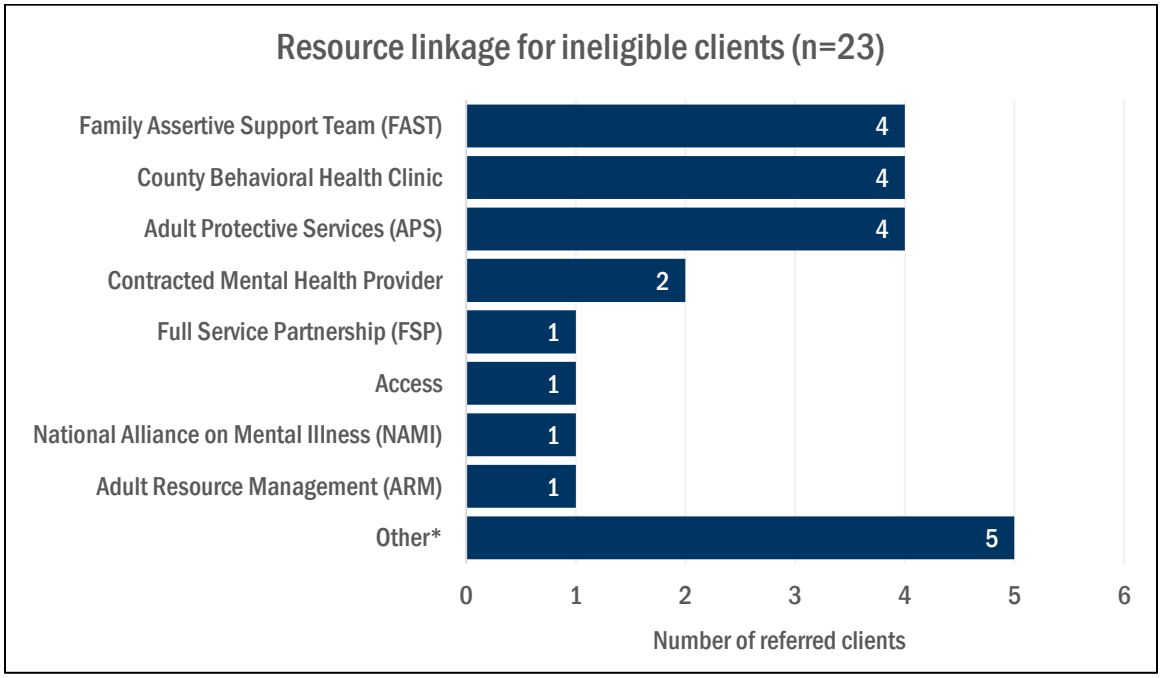
Exhibit 24 shows the common reasons that the referred client is ineligible for the AOT program. The most common reasons are that the referred clients did not have the eligible hospitalization or incarceration record or had already connected to previous providers.

Exhibit 24. Reasons that clients were ineligible for AOT program, n=69



When the referred clients were determined ineligible for the AOT program, many were linked to specific community resources (Exhibit 25). the resources to which ineligible clients were most often linked included the county behavioral health clinics, Adult Protective Services (APS), and Family Assertive Support Team (FAST).

Exhibit 25. Resource linkage for ineligible clients, n=23



*Note: other areas for ineligible referral made include youth services, forensic mental health services (pathways, service connect, CAMI), and conservatorship.

Conclusion

The FY 2017-18 AOT annual report provides useful information on the demographic and background characteristics of clients, client-referrer relationships, and changes in client key outcomes before and after AOT FSP enrollment. Among all AOT FSP clients, the episodes of hospitalizations and PES events were significantly lower during the 6-months after the client enrolled in the AOT FSP, compared to the 6-months before. The length of hospital stay was also shortened post enrollment vs. pre enrollment. Other key events such as jail and homelessness have also reduced.

It is exciting and important to note that the data collection protocol and process have matured and continuously integrated into the AOT team operations. AOT staff were more experienced in documenting and collecting needed information and data for evaluation. Additional data sources (such as jail information) were obtained from other agencies to complement the original research design. As a result, data quality improved significantly. For example, compared to the data in the CY2017 evaluation report, the "unknown" cases have been greatly reduced. Better data quality provides more useful information to the AOT implementation and operations.

Several insights can be learned to address potential barriers and challenges to referral, engagement, and successful enrollment.

"Our clients are some of the most resilient people I have ever encountered. Some feel mistreated, abandoned, and had good reason not to put their faith in a complete stranger to better their lives. I am honored to offer our clients an opportunity for individualized treatment, witness them reach their potential, and foster healthy relationships. It is truly a privilege to serve our population and I am proud to see how strong our program has become."

(BHRS AOT Mental Health Staff)

- The race/ethnicity composition of the referred group continues to reflect the diverse population of San Mateo county. The non-white group accounts for 42.5% of the referred clients (68 out of 160 referrals). We noted in the previous report that cultural background plays an important role in treatment preference. This may suggest a continuing need for alternative, culturally and linguistically appropriate outreach and engagement strategies for diverse populations, especially for San Mateo County, whose residents have a diverse mix of racial/ethnic backgrounds.
- Community mental health practitioners and family members remain the main source of referrals. Continued efforts to outreach to these main referral groups provides an effective means to helping the AOT program identify and engage potential clients and promote treatment acceptance.
- About two thirds of the referred clients were not residing at home at the time of the referral. Most of them were homeless, in the hospital, or jail. Continuing outreach and collaborations with these entities is an effective means to reach and engage these clients who are typically difficult to reach.

The AOT team takes an important role in engaging and connecting eligible clients to the AOT FSP services and other needed community-based resources and is the key to the success of the San Mateo AOT program. Since inception, the program has received a significant number of referrals from the community and has connected and engaged with both eligible clients and clients with less severe mental health issues (i.e. ineligible clients). As the program continues into its third year, it is essential to continue to take an evidence-based and data-driven approach to outreach, contact, and engage the referred clients and to optimize the team staffing model to ensure both programmatic and client needs are met.

Tailored to the AOT team's need, we will continue to monitor and evaluate the program as it moves into the third year. The longer history of the AOT program and the improvement in data quality will enable us to conduct longitudinal analyses to identify trends in the key events and referral outcomes. These findings will provide more valuable insight and enhance our understanding of the impact of the AOT program in San Mateo County.

Appendix. Case Studies

CASE STUDY I

Tammy is a client in her mid-fifties who was referred by jail personnel just prior to her release. She has a long history of hospitalizations and incarcerations dating back many decades and has in fact, spent most of the past 30 years institutionalized in hospitals or jails. Many of her difficulties were due to her struggles with schizoaffective disorder. When she met BHRS AOT (hereafter AOT), Tammy said she realized how important it was for her to continue the medications she had begun taking in jail but expressed anxiety that she would not be able to make it in the community. Given Tammy's history, AOT determined it would be in her best interest to enroll her into the AOT FSP with an extended warm hand-off period further partnering with Caminar AOT FSP to help the client maintain health.

Among the challenges for Tammy were her many aliases and unclear birthplace information, making it difficult to obtain government issued identifications which is critical to receiving benefits and procuring housing. After leaving jail, Tammy lived at a local homeless shelter while AOT worked with her. AOT staff did extensive research and was able to get a copy of her birth certificate. With this information, her Caminar AOT FSP case manager was able to get her correct identification and then social security benefits along with a more stable housing option. AOT staff gradually became less involved in client's case, allowing her to fully bond with her Caminar AOT FSP case manager.

Tammy prospered in the Caminar AOT FSP program, complying with her medication regimen and fully embracing life in the community, including finding a church and working to get along with roommates in her supported housing. After 12 months in the AOT FSP, Tammy had improved so much that she graduated AOT FSP and was able to step down to a lower level of care to another Caminar program.

CASE STUDY II

AOT received a referral for Ben, a young man with schizophrenia, who was living a very isolated life. Ben had no relationship with his family and no friends. He tended to call and harass local police departments and authority figures due to command hallucinations. Ben was incarcerated and hospitalized due to the nature of these calls. These calls were putting both the client and the community at risk.

Over two months, AOT built a relationship with client through weekly visits and being curious about his experience. Once trust had been established, Ben agreed to enroll in AOT/FSP. Since enrolling, his initial charges have been reduced and he has not returned to jail or the hospital. In addition, he has reconnected with his family and demonstrated an ability to contain his impulses through skills learned working with AOT/FSP.

Lastly, Ben is no longer living an isolated life, as he is participating in group therapy, building a social network and traveling with his family.

CASE STUDY III

BHRS AOT (hereafter AOT) received a call from a panicked family member whose middle-aged son Ron had been living with her for the past three years. Prior to that, Ron had been living in SoCal for over a decade and returned after a divorce. He had not left the house, showered, or cut his nails or hair, and was living in his own filth since moving home three years ago. Ron had never received any mental health treatment (though he had been offered) nor was he aware of any of his mental health needs. The family had tried to intervene numerous times with police and other community agencies but gave up due to no results.

AOT went to the family home with members of the local police department to assess for safety and possible hospitalization. AOT initiated a 5150 emergency psychiatric hold for grave disability, which was invoked by the police. AOT gave the family education on the 5150 process and supported the family as this took place.

When he was hospitalized, Ron didn't know who any of his family members were and was living in a delusional world. Ron received proper care and was connected to a regional clinic for services. Since that time, client recognizes his family, lives a fulfilling life at home with them and is engaged in caring for his mental health.

CASE STUDY IV

Andy is a middle-aged client who was referred to AOT by his San Mateo County probation officer in early 2018. He was released from Napa State Hospital in the previous month and had been sleeping in a parking garage every night. He was afraid to stay in a shelter and was not eligible for several homeless shelters due to his previous criminal background. Andy's social security benefits had been suspended due to missing required paperwork. He was meeting with his probation officer monthly in her office and stated to her that he needed help. Andy had suffered from a severe mental illness his entire adult life and had attempted suicide five times. He had been removed from his mother's care when he was very young due to neglect.

Andy was interested in accepting intensive case management services from an FSP program. AOT prepared a referral for the FSP services and advocated for his admission to an FSP program. The FSP provider was able to admit him into its program immediately, and within days he was placed into a safe board and care home in San Mateo County. His new FSP case manager was able to assist him with filing paperwork with Social Security to reinstate his monthly income.

CASE STUDY V

Gary was diagnosed with a severe mental illness as a young adult nearly one decade ago. He was referred to AOT from one of our regional mental health clinics. Gary was struggling with ongoing symptoms of Schizophrenia (especially paranoia and auditory hallucinations), homelessness and multiple incarcerations for violent and non-violent offenses. Over the past four years, he utilized psychiatric emergency services multiple times, was hospitalized for his illness, and was unable to maintain housing or a medication regimen.

After multiple attempts to engage Gary voluntarily in AOT while he was at the local jail, he continued to decline any services or medications due to low insight into his problems. As he was believed to be at high risk for needing future crisis interventions due to his intensive struggles, he was referred for an assessment with the AOT psychologist. After meeting with Gary, the psychologist agreed that a court petition for AOT services was the next step. When Gary and his private defender attended AOT court, Gary agreed to accept services voluntarily during the petition process. Gary has made a lot of progress in his first six months of AOT, including connecting to a psychiatrist, working with a case manager, and starting his medication. His participation in AOT has resulted in reduced symptoms, reconnection to his family, increased functionality, and moving into stable independent housing.

APPENDIX 7. BARBARA A. MOUTON CENTER EVALUATION REPORT

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts – The Barbara A. Mouton Multicultural Wellness Center

FY 2017-2018

Alvaro Ramos, BA;

Elizabeth Mokyr Horner, PhD, MPP;

Quy Nhi Cap, MPH;

Yi Lu, PhD

JUNE 2019

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts – The Barbara A. Mouton Multicultural Wellness Center

FY 2017-2018

June 2019

Alvaro Ramos, BA;
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Yi Lu, PhD

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The Barbara A. Mouton Multicultural Wellness Center

In FY 2017-2018, there were 147 attendees at individual outreach events in the Barbara A. Mouton Multicultural Wellness Center (The Mouton Center).

Demographics

Age: The Mouton Center individual outreach attendees were adults (26-59 years, 71%), transition-age youth (16-25 years, 5%), older adults (60+ years or older, 16%), and children (0-15 years, 1%) in FY 2017-2018. **Table 1** for the number of individual outreach attendees representing each reported age group, by quarter.

Table 1. Age of Individual Outreach Attendees Served By Mouton Center, FY 2017-2018

Age Group	Q1	Q2	Q3	Q4	Total
Children (0-15)	1 (2%)	0 (0.0%)	1 (1.67%)	0 (0.0%)	2 (1.36%)
Transition-age youth (16-25)	4 (8%)	1 (2.7%)	3 (5%)	0 (0.0%)	8 (5.4%)
Adults (26-59)	37 (74%)	30 (81.1%)	38 (63.3%)	0 (0.0%)	105 (71.4%)
Older adults (60+)	6 (12%)	6 (16.2%)	11 (18.3%)	0 (0.0%)	23 (15.7%)
Decline to state	2 (4%)	0 (0.0%)	7 (11.7%)	0 (0.0%)	9 (6.1%)
Total**	**50**	**37**	**60**	**0**	**147**

Note: Percentages may not sum to 100% because of rounding. ** Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees of the Mouton center at individual outreach events were male (33%) and female (67%) in FY 2017-2018. See **Table 2** for the number of individual outreach attendees representing each reported sex, by quarter.

Table 2. Sex at Birth of Outreach Attendees Served By Mouton Center, FY 2017-2018

Sex	Q1	Q2	Q3	Q4	Total
Male	7 (14%)	20 (54.1%)	21 (35%)	0 (0.0%)	48 (32.7%)
Female	43 (86%)	17 (45.9%)	39 (65%)	0 (0.0%)	99 (67%)
Total	**50**	**37**	**60**	**0**	**147**

Note: Percentages may not sum to 100% because of rounding.

Gender: Attendees of the Mouton center at individual outreach events identified themselves as female (65%), male (31%), and transgender (3%) in FY 2017-2018. See **Table 3** for the number of individual outreach attendees representing each reported gender, by quarter.

Table 3. Gender of Outreach Attendees Served By Mouton Center, FY 2017-2018

Gender	Q1	Q2	Q3	Q4	Total
Male	7 (14%)	20 (54.1%)	19 (31.7%)	0 (0.0%)	46 (31.3%)
Female	43 (86%)	17 (45.9%)	36 (60%)	0 (0.0%)	96 (65.3%)
Transgender	0	0	4 (6.7%)	0 (0.0%)	4 (2.7%)
Unknown	0	0	1 (1.7%)	0 (0.0%)	1 (0.6%)
Total**	**50**	**37**	**60**	**0**	**147**

Note: Percentages may not sum to 100% because of rounding. ** Total count for gender reported may be less than the total number of attendees due to the missing data. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2017-2018, the three largest racial/ethnic groups represented by all Mouton center attendees were Black (33%), White (20%), and other race (11%). See **Table 4** for the number of attendees representing each reported racial/ethnic group, by quarter.

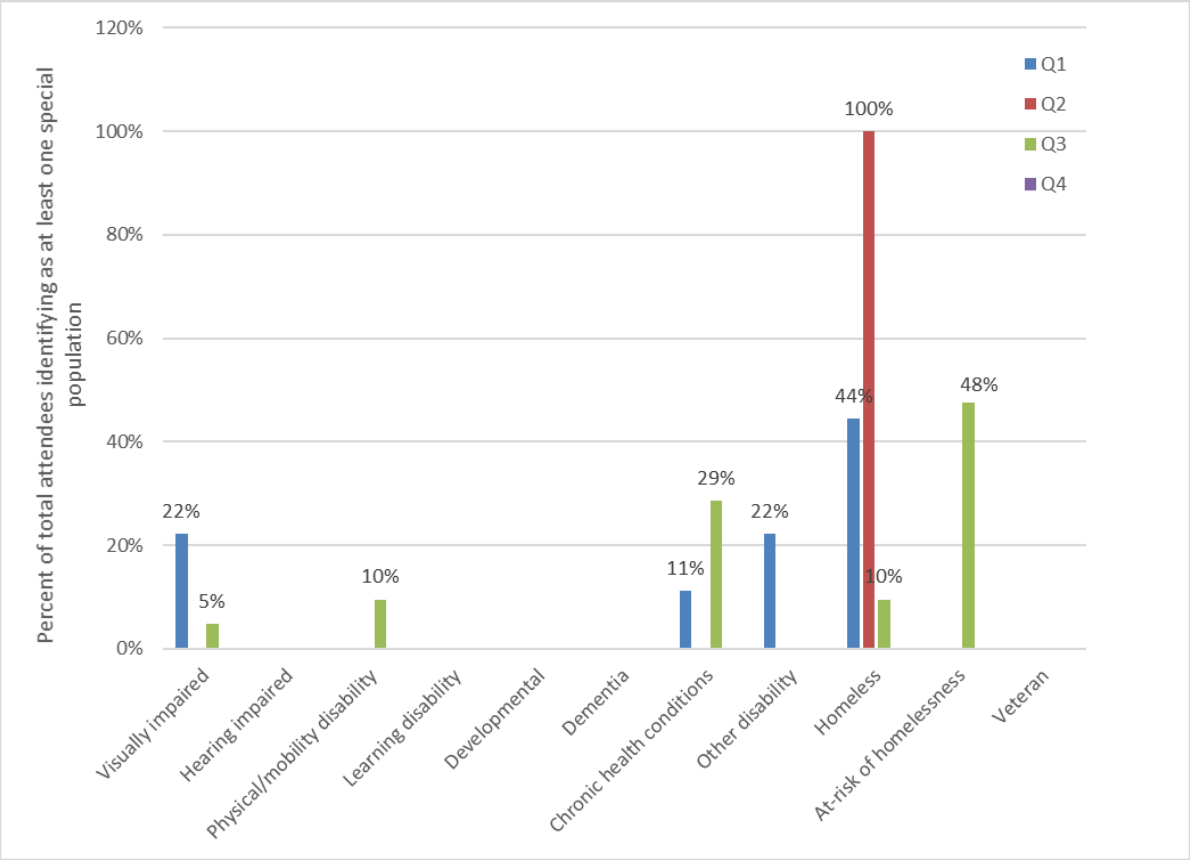
Table 4. Race and Ethnicity of Outreach Attendees Served By Mouton Center, FY 2017-2018

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
White	6 (12%)	16 (43.2%)	8 (12.9%)	0 (0.0%)	30 (20.1%)
Black	26 (52%)	5 (13.5%)	18 (29%)	0 (0.0%)	49 (32.9%)
Mexican	8 (16%)	0 (0.0%)	5 (8%)	0 (0.0%)	13 (8.7%)
Chinese	1 (2%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	2 (1.3%)
Filipino	0 (0.0%)	1 (2.7%)	2 (3.2%)	0 (0.0%)	3 (2%)
Japanese	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	1 (0.7%)
Korean	1 (2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.7%)
South Asian	0 (0.0%)	0 (0.0%)	4 (6.5%)	0 (0.0%)	4 (2.7%)
Vietnamese	0 (0.0%)	1 (2.7%)	0 (0.0%)	0 (0.0%)	1 (0.7%)
Samoan	5 (10%)	1 (2.7%)	6 (9.7%)	0 (0.0%)	12 (8.1%)
Tongan	1 (2%)	2 (5.4%)	5 (8%)	0 (0.0%)	8 (5.4%)
Multi	0 (0.0%)	1 (2.7%)	5 (8%)	0 (0.0%)	6 (4%)
Other Race	0 (0.0%)	10 (27%)	7 (11.3%)	0 (0.0%)	17 (11.4%)
Unknown Race	2 (4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.3%)
Total	**50**	**37**	**62**	**0**	**149**

Note: Percentages may not sum to 100% because of rounding.

Special populations: The Mouton center individual outreach event attendees reported being part of one or more special populations. Of the special populations, 56% were homeless, 19% were at-risk of homelessness, 13% had chronic health conditions, 6% were visually impaired, 4% had a physical/mobility disability, and 4% other disability. Refer to **Figure 1** for the percentage of attendees representing each special population in FY 2017-2018, by quarter.

Figure 1. Special Populations Served by Mouton Center, FY 2017-2018



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: Mouton center individual outreach attendees were without insurance (19%), Medi-Cal (37%), with other insurance not listed (3%), with unknown insurance (33%) or Medicare (8%). See **Table 5** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 5. Insurance Coverage, FY 2017-2018

Insurance Type	Q1	Q2	Q3	Q4	Total
MediCal	20 (36.4%)	22 (40%)	16 (29.1%)	0 (0.0%)	58 (36.9%)
Medicare	7 (12.7%)	2 (3.6%)	4 (7.3%)	0 (0.0%)	13 (8.3%)
Other Insurance	2 (3.6%)	1 (1.8%)	2 (3.6%)	0 (0.0%)	5 (3.2%)
Uninsured	9 (16.4%)	11 (20%)	9 (16.4%)	0 (0.0%)	29 (18.5%)
Unknown	17 (30.9%))	3 (5.5%)	32 (58.2%)	0 (0.0%)	52 (33.1%)
Total	**55**	**39**	**63**	**0**	**157**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2017-2018.

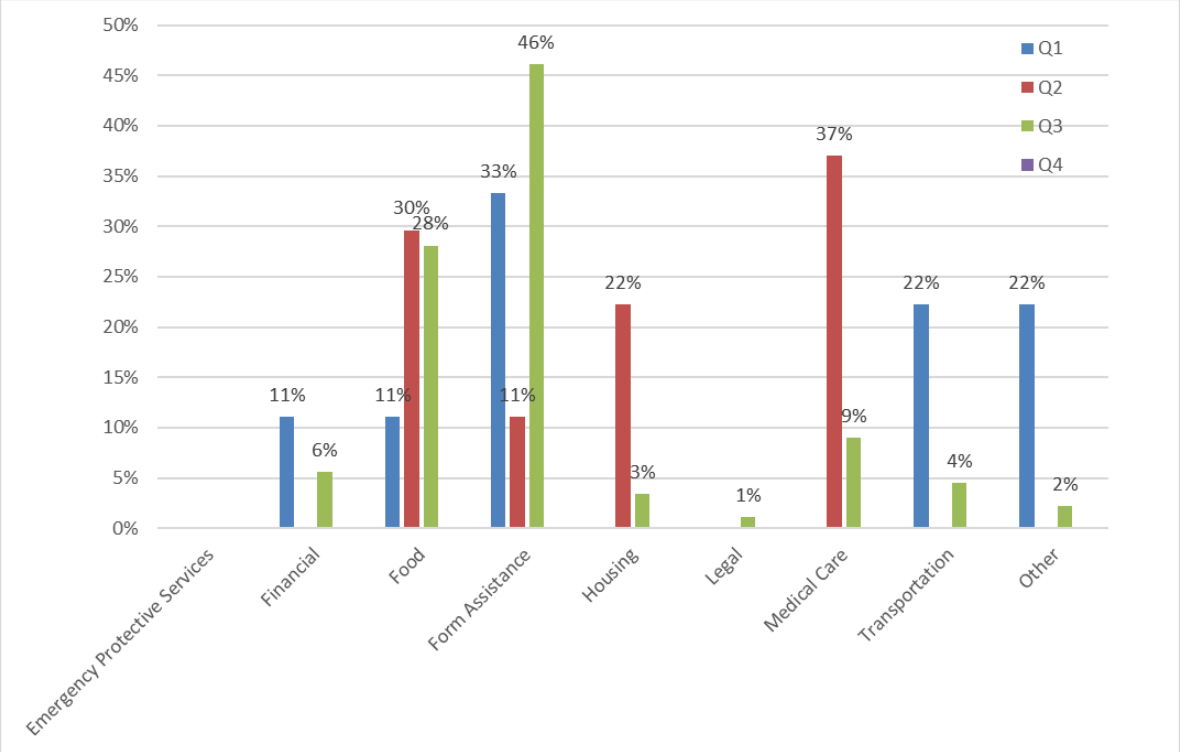
Previous contact: One percent of individual outreach events were conducted with attendees who had a previous outreach contact with the Mouton center.

Mental Health/Substance Abuse Referrals: Mouton center individual outreach events included mental health referrals (27%) and substance abuse referrals (14%) in FY 2017-2018.

Mental Health/Substance Abuse Referral Destinations: Among all the Mouton center individuals who were referred for mental health service, 100% were referred to other destinations. Among the 108 individuals who were referred to other destinations, most of them were referred to EPACCC, followed by BHRS. For all the Mouton center individuals who were referred for substance abuse service, 67% were referred to Free at Last and Voices of Recovery & Free at Last. 33% were referred to other destinations. Among the 21 individuals who were referred to other destinations, most were referred to BHRS.

Referrals to Social Services: Providers made 125 referrals to 147 Mouton center individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for form assistance (37.6%), food (27.2%), and medical care (14.4%). **Figure 2** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 2. Referrals to Social Services, FY 2017-2018

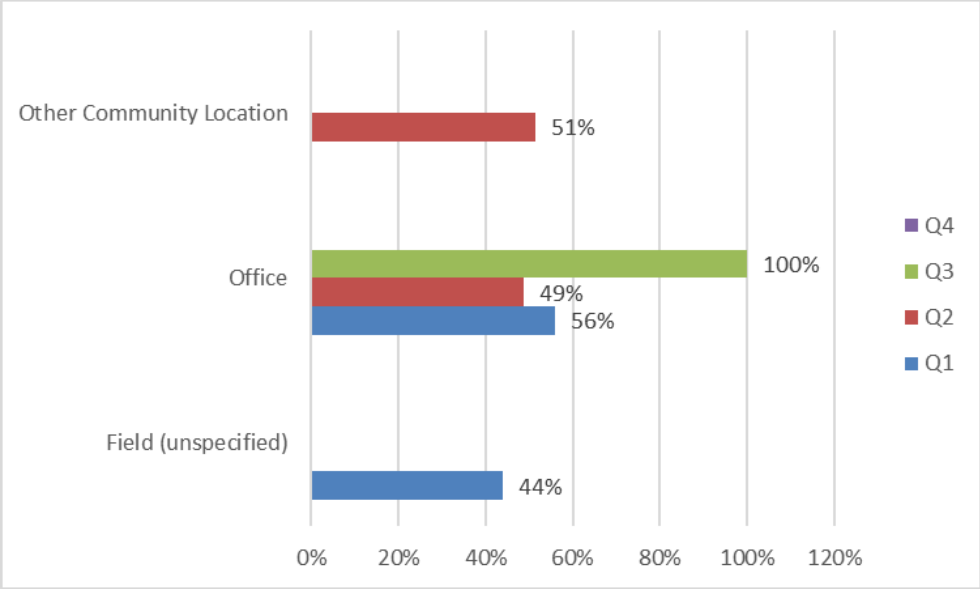


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2017-2018.

Individual outreach event characteristics

Location: Mouton center individual outreach events typically occurred in unspecified locations (15%), offices (72%), and home (13%) in FY 2017-2018. See **Figure 3** for a summary of individual outreach events by location.

Figure 3. Location of Mouton center Individual Outreach Events, FY 2017-2018



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2017-2018, the average length of Mouton center individual outreach events was 25.1 minutes. By quarter, average length of outreach was 18 minutes in Q1, 26.8 minutes in Q2, and 30 minutes in Q3.

MAA code: Mouton center individual outreach events used no MAA codes. One-hundred percent of the MAA codes were reported as N/A.

Language used: Mouton center individual outreach events were conducted in English (95%), Spanish (3%), Tongan (1%), and Samoan (1%). See **Table 6** below for the breakdown of group outreach events by the language of administration.

Table 6. Languages of administration in Mouton center individual outreach events, FY 2017-2018

Language	Q1	Q2	Q3	Q4	Total
English	50 (100%)	30 (81.1%)	60 (100%)	0 (0%)	140 (95.2%)
Samoan	0 (0%)	1 (2.7%)	0 (0%)	0 (0%)	1 (0.7%)
Spanish	0 (0%)	4 (10.8%)	0 (0%)	0 (0%)	4 (2.7%)
Tongan	0 (0%)	2 (5.4%)	0 (0%)	0 (0%)	2 (1.4%)
Total	**50**	**37**	**60**	**0**	**147**

Note: Percentages may not sum to 100% because of rounding.

Preferred Language: Most Mouton center individual outreach attendees preferred English (76%), Spanish (13%), Samoan (6%), Tongan (4%), Tagalog (1%), and other (1%). See **Table 7** below for the breakdown of Mouton center individual outreach events by preferred language.

Table 7. Preferred Languages for Mouton center Individual Outreach Attendees, FY 2017-2018

Language	Q1	Q2	Q3	Q4	Total
English	49 (98%)	26 (70.3%)	36 (60%)	0 (0.0%)	111 (75.5%)
Samoan	1 (2%)	1 (2.7%)	7 (11.7%)	0 (0.0%)	9 (6.1%)
Spanish	0 (0.0%)	8 (21.6%)	11 (18.3%)	0 (0.0%)	19 (12.9%)
Tagalog	0 (0.0%)	0 (0.0%)	1 (1.7%)	0 (0.0%)	1 (0.7%)
Tongan	0 (0.0%)	2 (5.4%)	4 (6.7%)	0 (0.0%)	6 (4.1%)
Other	0 (0.0%)	0 (0.0%)	1 (1.7%)	0 (0.0%)	1 (0.7%)
Total	**50**	**37**	**60**	**0**	**147**

Note: Percentages may not sum to 100% because of rounding.

Appendix A. FY 2017-2018 Outreach, The Mouton Center

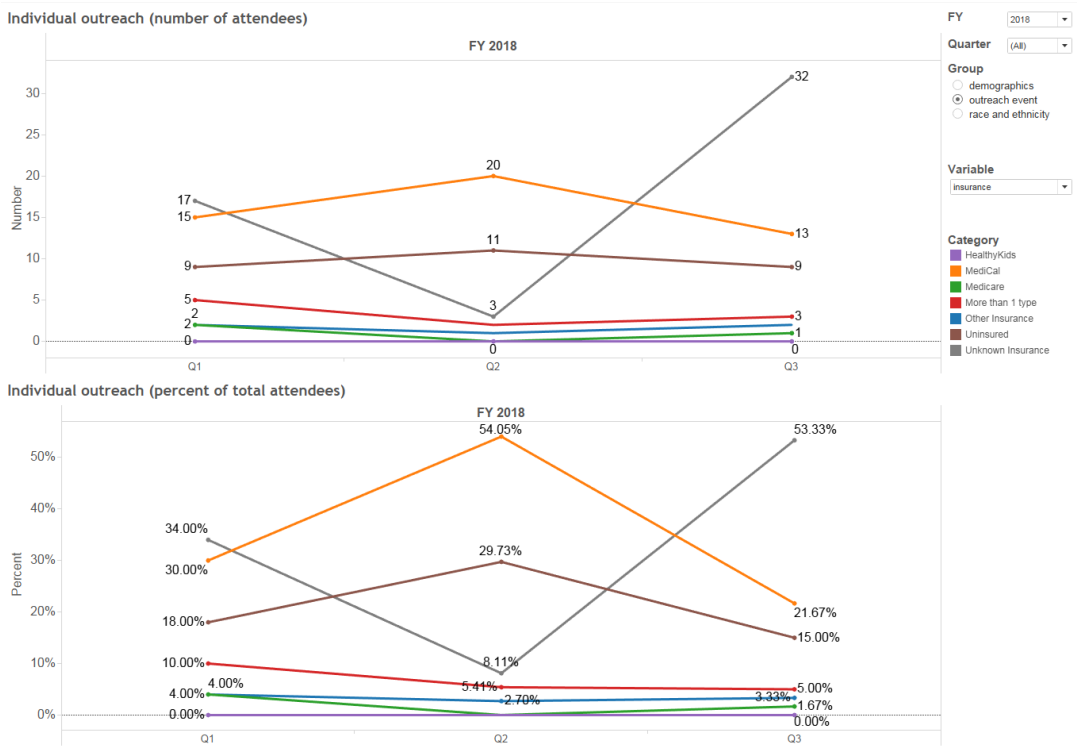
Individual outreach

For FY 2017-2018, the Mouton center reported a total of 147 individual outreach events—50 individual outreach events in Q1, 37 events in Q2, 60 events in Q3, and no events in Q4. The average length of individual outreach events was 25 minutes, ranging from an average of 18 minutes in Q1 and 30 minutes in Q3.

Most individual outreach events:

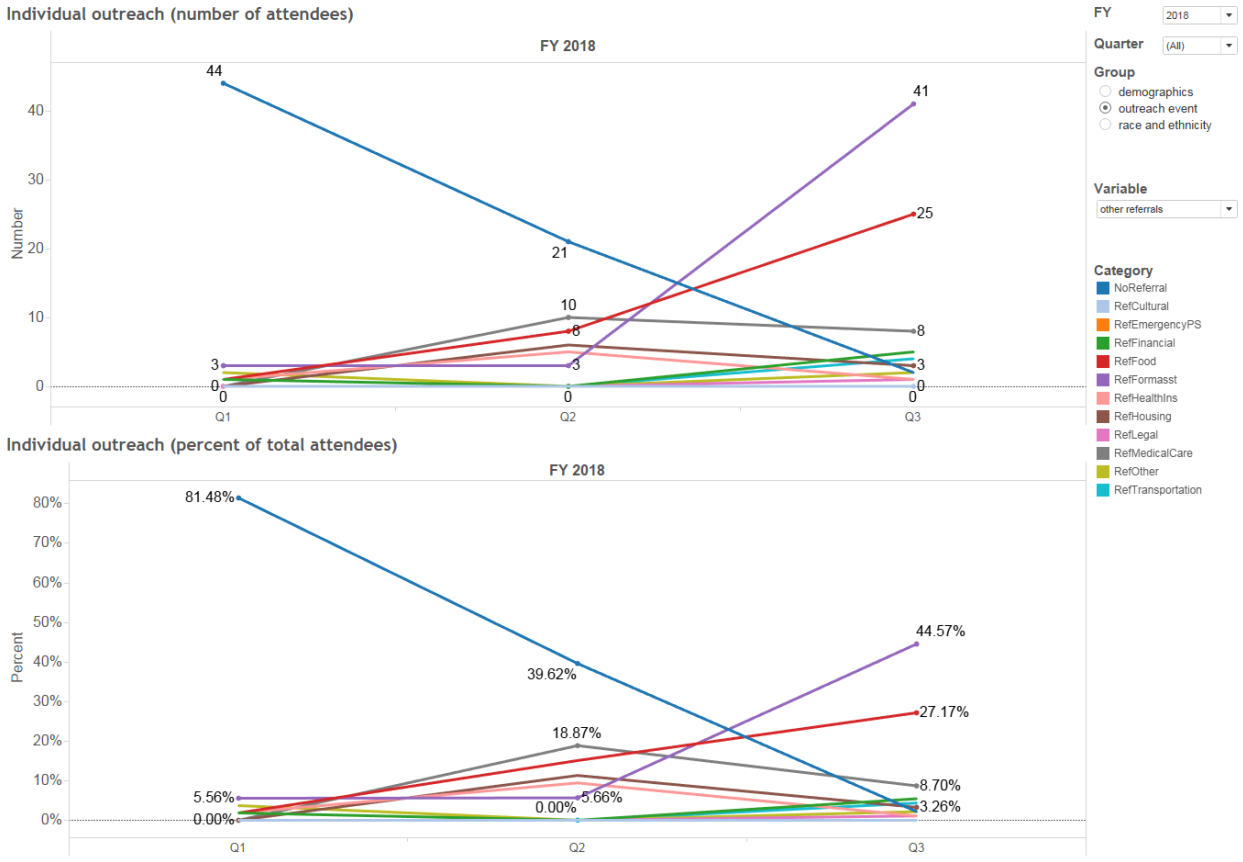
- Took place in offices (**72%**; n=106), unspecified (**15%**; n=22), and other community locations (**13%**; n=19).
- No MAA codes were reported. All were reported as N/A (**100%**; n=147).
- Were conducted in English (**95.2%**; n=140), Spanish (**2.7%**; n=4), Tongan (**1.4%**; n=2), and Samoan (**0.7%**; n=1).
- Were mostly with unknown insurance (**35.4%**; n=52), MediCal (**32.7%**; n=48), Uninsured (**19.7%**; n=29), more than one type of insurance (**6.8%**; n=10), other insurance (**3.4%**; n=5), and Medicare (**2%**; n=3) (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4



- Resulted in 108 mental health referrals and 21 substance abuse referrals.
- Resulted in 199 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. There were no referrals (**33.7%**; n=67). The Mouton center primarily made referrals to Form Assistance (**23.6%**; n=47), Food (**17.1%**; n=34), Medical Care (**9%**; n=18), Housing (**4.5%**; n=9), Health Insurance (**3.5%**; n=7), Transportation (**3%**; n=6), Financial (**3%**; n=6), Other (**2%**; n=4), and Legal (**0.5%**; n=1).

Figure 2. Other Referrals, Q1-Q4



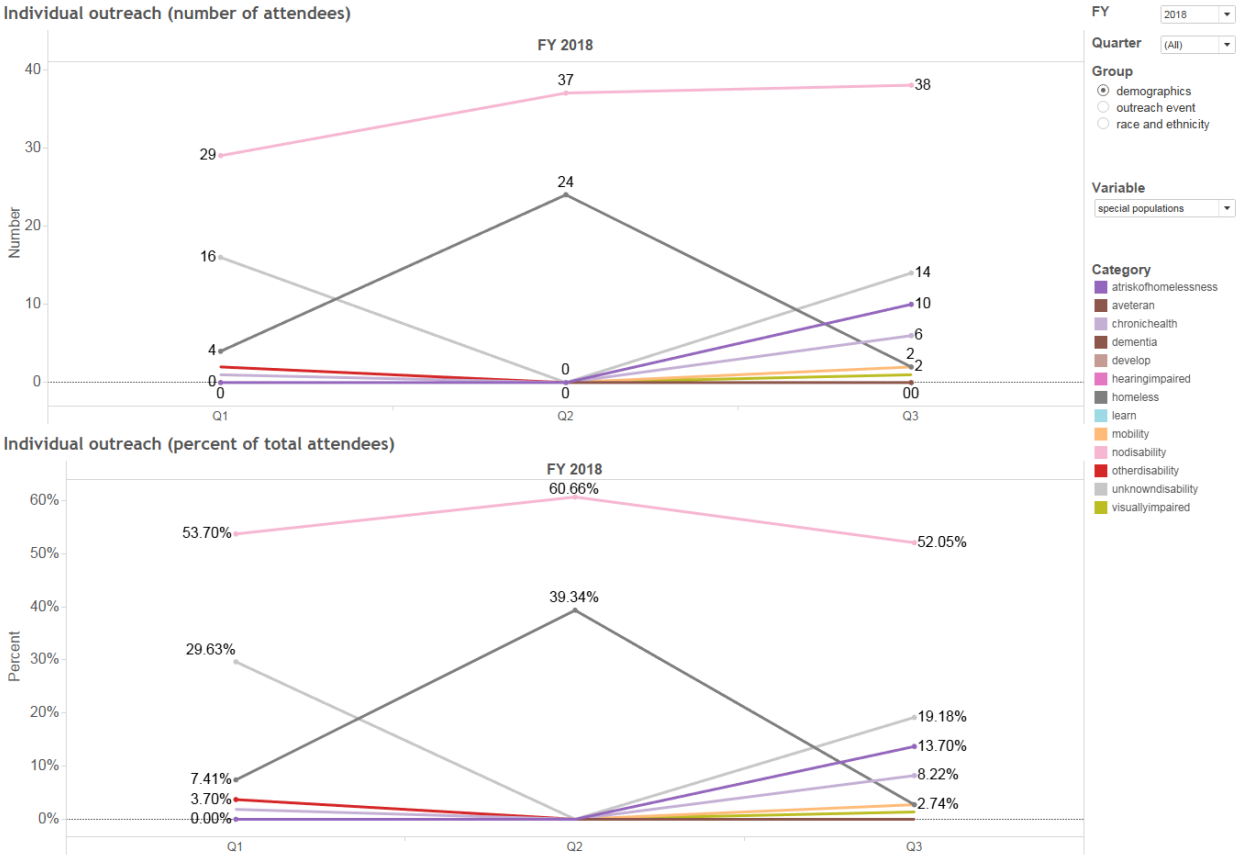
Individual outreach event attendees:

- Self-reported as female (**67.3%**; n=99) or male (**32.7%**; n=48).
- Self-reported as Heterosexual (**87%;** n=127), unknown sexual orientation (**7.5%**; n=11), Gay/Lesbian (**3.4%**; n=5), and Queer (**2%**; n=3).
- Were adults (26-59 years, **71%**; n=105), older adults (60+ years, **15.6%**; n=23), transition-age youth (16-25 years, **5.4%**; n=8), decline to state (**6.1%**; n=9), and children (0-15 years, **1.4%**; n=2)

- Were primarily of Black (**33.3%**; n=49), White (**20.4%**; n=30), Other (**11.6%**; n=17), Mexican (**8.8%**; n=13), Tongan (**5.4%**; n=8), two or more races (**4.1%**; n=6), Filipino (**2%**; n=3), Chinese (**1.4%**; n=2), South Asian (**1.4%**; n=2), unknown race (**1.4%**; n=2), Japanese (**1%**; n=1), Korean (**1%**; n=1), and Vietnamese (**1%**; n=1).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2017-2018, the Mouton center reported 188 individual outreach attendees representing these populations. (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

The Mouton center did not report any data on group outreach encounters during FY 2017-2018.

Appendix B. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (e.g., location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.
For Medicaid Administrative Activities (MAA) codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (e.g., race), per quarter
- Denominator = total number of attendees, per quarter

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APPENDIX 8. MBSAT PILOT STUDY RESULTS

MINDFULNESS BASED SUBSTANCE ABUSE TREATMENT FOCUS GROUP RESULTS

The Mindfulness Based Substance Abuse Treatment (MBSAT) curriculum was piloted with three of our partners (Puente, Starvista and El Centro). This pilot was conducted in order to inform the Trauma Informed Interventions for youth RFP that will be replacing the Seeking Safety curriculum. As part of the pilot we also conducted focus groups to hear feedback from the youth regarding the curriculum but to also expand our prevention strategy to encompass what they identified as opportunities and barriers.

METHODS

All providers that are piloting the MBSAT curriculum were invited to participate in the focus groups. A BHRS staff member conducted the groups at the participating sites to hear about their experience with the curriculum directly from the youth.

QUESTIONS

1.What was your experience with the mindfulness practices? Were they helpful? Please explain

2. What stands out to you most in your experience with this program?

3. Is there anything that makes it difficult to practice mindfulness at school, work and at home?

4. What needs to change for you to be able to use the skills you have gained in this group?

5. How can we reinforce the success of this program within your community?

PARTICIPANTS

- 2 Sites participated
- Pescadero High School a group facilitated by Puente
- Life Moves facilitated by Starvista
- 16 youth participated in the groups
- 100% of youth were youth of color from marginalized backgrounds, and diverse cultural and linguistic needs

FINDINGS

Overall, the youth enjoyed the MBSAT curriculum and confirmed that they learned new skills that they will try to continue to use in their daily life. While the curriculum is a prevention curriculum for substance use, some youth have used these skills to avoid getting into fights, to calm themselves down when they are stressed about the future and to think before they act when they interact with their siblings, friends, and parents.

BUILDING COMMUNITY CAPACITY FOR MINDFULNESS

- Mindfulness training for teachers so that they understand and support mindfulness practices
- Taking structured time from the school day to meditate
- Training for parents so that they can use the skills but also so that they encourage the practice at home
- Start embedding mindfulness practices from a young age such as elementary school

FACILITATION

- The facilitator needs to be knowledgeable about meditation and preferably practices the techniques in their own life
- The facilitation style affects engagement and the youth prefer someone that is high energy and relatable
- Confidentiality is essential for creating a space where youth feel safe and are able to share openly
- Having food and incentives motivates the youth to continue participating
- Fidget toys during the class help the youth concentrate on the content

ENVIRONMENTAL INFLUENCES

- The youth identified that their environment impacts their ability to practice mindfulness effectively
- The youth brought up stressors such as: graduating from high school and going to college or finding a job, not knowing what their next step will be after high school, the national political environment, policies at their schools, violence in their neighborhoods, the availability of drugs and alcohol

APPENDIX 9. OUTREACH COLLABORATIVES EVALUATION REPORT

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2017-2018

Alvaro Ramos, BA;

Quy Nhi Cap, MPH;

Elizabeth Mokyr Horner, PhD, MPP;

Yi Lu, PhD

JUNE 2019

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2017-2018

June 2019

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Contents

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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes overall collaborative and provider-specific outreach efforts across individual and group outreach events that occurred in fiscal year (FY) 2017-2018 (July 1, 2017 through June 30, 2018). We also present some historical data since FY 2014-2015 to show how outreach has changed over time.

Total Attendance

For FY 2017-2018, SMC BHRS providers reported a total of 4,767 attendees at all outreach events. Of these, 696 attendees were reached through individual outreach events and 4,071 attendees were reached across 57 group outreach events.

Demographics of outreach attendees

NCOC

NCOC's most common age group among outreach attendees was adults (37%). Over half of individual and group outreach attendees were female (59%). The greatest proportion of attendees were White (26%), followed by Filipino (13%). Insurance status was largely unreported. Some attendees also reported being part of one or more special populations (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans). Of those reporting special population status, 53% percent were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO outreach attendees were largely adults (56%). Over half of individual and group outreach attendees were female (54%). Most attendees reported Medi-Cal insurance (56%), but many reported not having insurance (26%). The largest proportion of attendees were Black (36%). Of those reporting special population status, 66% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

The average length of NCOC individual outreach events was 44.3 minutes in FY 2017-2018. Of all the 230 individual outreach events, most occurred in other community locations (44%). Among the 101 individual outreach events which occurred in other community locations, most cited were “San Mateo County Fairgrounds” and “Frontierland Park”. Other locations cited include Pacifica Drop in Differential Response and San Mateo Drop in Differential Response.

Of the individual outreach events, 17% used Medicaid Administrative Activities (MAA) code 401 (Discounted Medi-Cal outreach). Most were in English (92%). Some included mental health referrals (31%) and substance abuse referrals (4%). Providers also made 343 referrals to other services, including emergency/protective service, financial/employment, food, form assistance, housing/shelter, legal services, medical care and transportation.

NCOC group outreach events lasted 115.77 minutes on average. Of all the 57 group outreach events, most were conducted in English (75%) and among the 7 group outreach events held in other community locations (18%), most were cited as being held in “San Mateo County Fairgrounds” and “Mall”. Other locations cited include Edgewood Drop-In Center, Frontierland Park Pacifica and Pacifica Fog Fest. These events most frequently used MAA code 401 (Discounted Medi-Cal outreach, 9%).

EPAPMHO

The 466 EPAPMHO individual outreach events were an average of 37.5 minutes each. These events were typically administered in English (69%), occurred in unspecified locations (37%) and used MAA code 400 (Medi-Cal outreach, 24%). EPAPMHO individual outreach events also included mental health referrals (31%) and substance abuse referrals (37%). A total of 669 referrals were made to other services, including emergency/protective service, financial/employment, food, form assistance, housing/shelter, legal services, medical care, transportation and health insurance.

Of the two EPAPMHO group outreach events, the average event lasted 45 minutes. Both group outreach events were conducted in English (100%) and in Faith-based Church/Temple (100%). One event used MAA code 400 (Medi-Cal outreach, 50%).

Recommendations

We have several recommendations based on FY 2017-2018 data. These recommendations fall under three umbrellas: those aimed at enhancing outreach, those to improve data collection, and discussion points for changing the reporting structure for next year.

To enhance outreach, we suggest that SMC BHRS work with providers to:

- Continue efforts to tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Consider how to best address the needs of individuals who report being uninsured or do not report their insurance status. Focus on increasing housing-related resources and referrals.
- Focus on increasing housing-related resources and referrals. Housing insecurity continues to be a major challenge for individuals served by SMC BHRS.

To improve data collection, we recommend SMC BHRS work with providers to:

- Ensure that all data have been obtained from outreach providers.
- Make other/unspecified data categories clearer.

To improve the report structure for outreach, we recommend an open discussion with SMC BHRS. Specifically, we have the following ideas for improving the report.

- The report could rely less on erratic quarterly data.
- Certain data categories might be combined for reporting purposes, which would improve table readability and interpretability. However, it is important to ensure that SMC BHRS reporting needs are met.
- We would like to discuss revising how the special populations data are reported. Although it would mean that these data would not be comparable to previous years, we believe we can make these numbers more meaningful by describing them as a function of all individuals who attend an outreach event.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults [Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)] in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of and access and linkages to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2017-2018 (July 1, 2017 through June 30, 2018) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix I for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2017-2018 and outreach event attendees. We also present some historical data from FY 2014-2015, FY 2015-2016 and FY 2016-2017 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events,

and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix A to H. As a note, the provider information for Daly City Peninsula Partnership Collaborative, Daly City Youth Health Center, Pacifica Collaborative, and StarVista in the appendix is not a reflection of the most current data that was received in May to June of 2019. Due to the timing of the data received, only the data in the main section of the report has been updated with the new data from these four organizations.

Overall Outreach

During FY 2017-2018, SMC BHRS outreach providers reported a total of 4,767 attendees at outreach events—696 attendees reached through individual outreach events and 4,071 attendees reached across 57 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2017-2018.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2017-2018

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	36	190	226
Daly City Peninsula Partnership Collaborative	52	1270	1322
Daly City Youth Health Center	88	597	685
Pacifica Collaborative	33	1291	1324
StarVista	21	678	699
Total (NCOC)	230	4026	4256
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	68	38	106
Free at Last	239	0*	239
Multicultural Counseling and Education Services of the Bay Area	159	7	166
Total (EPAPMHO)	466	45	511
Total (NCOC and EPAPMHO)	696	4071	4767

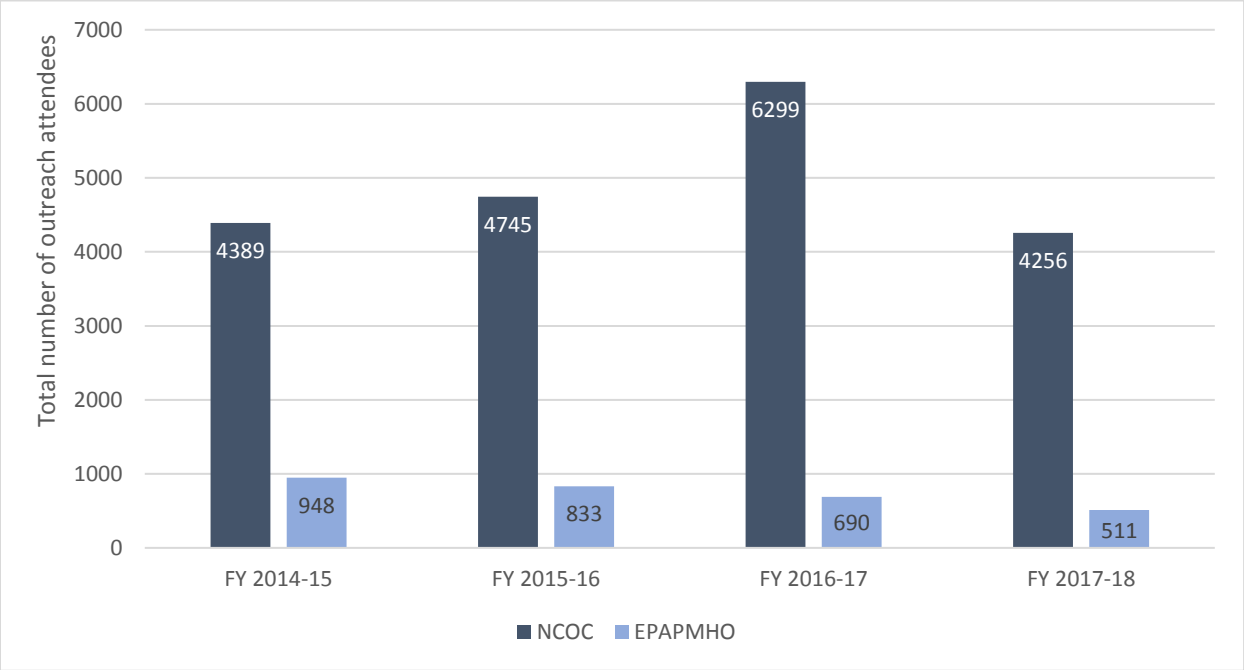
Notes: *Providers did not report data for FY 2017-2018. **Counts are not necessarily unique individuals.

It is expected that the NCOC would serve a much larger proportion of the Outreach Collaborative effort as it serves the entire north region of San Mateo County (estimated population 140,149) including the cities of Colma, Daly City, and Pacifica, which is five times the population of the city of East Palo Alto, served by the EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach) such as community wide fairs much more feasible and relevant. In contrast, East Palo Alto spans 2.5 square miles making an individual approach to outreach more effective.

The total number of NCOC outreach attendees increased in FY2014-2017 and decreased in FY 2017-2018. The total number of EPAPMHO outreach attendees decreased in FY 2014-2018 (**Figure 1**).

EPAPMHO outreach numbers have been decreasing over the past three years and currently reaching about 0.36% of the population. According to EPAPMHO provider organizations there have been both staffing and community-level challenges that have led to decreased numbers; these are discussed further under the Recommendations section of this document.

Figure 1. Total Outreach Attendees by Collaborative, FY 2014-2018



Note: The attendee numbers from previous FYs are slightly higher than those reported in the previous reports because some outreach data was reported after that FY.

Table 2 presents outreach event attendees' race/ethnicity for FY 2014-2015, FY 2015-2016, FY 2016-2017 and FY 2017-2018 within each collaborative. Increases of five percent or more between the two years are shaded in green; decreases of five percent or more are shaded in

red. Additional details on race/ethnicity by quarter for FY 2017-2018 are presented later in the report (pages 12 and 19).

Table 2. Race/Ethnicity by Collaborative, FY 2014-2015 to FY 2017-2018

	NCOC				EPAPMHO			
Race/Ethnicity	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
Black	152 (4.1%)	153 (3.2%)	200 (2.8%)	153 (3.1%)	150 (9.1%)	205 (24.5%)	144 (22.4%)	186 (36.2%)
White	930 (25.2%)	1502 (31.5%)	2364 (32.7%)	1269 (25.5%)	444 (26.9%)	82 (9.8%)	41 (6.4%)	43 (8.4%)
American Indian	7 (0.2%)	48 (1.0%)	94 (0.3%)	43 (0.9%)	0 (0.0%)	8 (1.0%)	4 (0.6%)	1 (0.2%)
Middle Eastern	7 (0.2%)	60 (1.3%)	66 (0.9%)	64 (1.3%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	0 (0.0%)
Eastern European	0 (0.0%)	0 (0.0%)	10 (0.1%)	7 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	6 (0.1%)	4 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	147 (4.0%)	260 (5.5%)	1393 (19.3%)	576 (11.6%)	43 (2.6%)	196 (23.4%)	83 (12.9%)	43 (8.4%)
Puerto Rican	1 (0.0%)	6 (0.1%)	28 (0.4%)	2 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	1 (0.2%)
Cuban	0 (0.0%)	0 (0.0%)	9 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)
Central American	0 (0.0%)	0 (0.0%)	69 (1.0%)	255 (5.2%)	0 (0.0%)	0 (0.0%)	9 (1.4%)	5 (1.0%)
South American	0 (0.0%)	0 (0.0%)	24 (0.3%)	31 (0.6%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	1 (0.2%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Latino	192 (5.2%)	87 (1.8%)	N/A (N/A)	N/A	228 (13.8%)	0 (0.0%)	N/A (N/A)	N/A
Asian	N/A	N/A	N/A	578 (11.7%)	N/A	N/A	N/A	0 (0.0%)
Filipino	336 (9.1%)	678 (14.2%)	794 (11.0%)	619 (12.5%)	248 (15.0%)	18 (2.2%)	17 (2.6%)	7 (1.4%)
Chinese	96 (2.6%)	246 (5.2%)	277 (3.8%)	188 (3.8%)	96 (5.8%)	2 (0.2%)	2 (0.3%)	0 (0.0%)
Japanese	11 (0.3%)	30 (0.6%)	59 (0.8%)	36 (0.7%)	3 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	17 (0.5%)	29 (0.6%)	45 (0.6%)	21 (0.4%)	4 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Asian	15 (0.4%)	16 (0.3%)	44 (0.6%)	40 (0.8%)	11 (0.7%)	2 (0.2%)	2 (0.3%)	1 (0.2%)
Vietnamese	1 (0.0%)	23 (0.5%)	13 (0.2%)	6 (0.1%)	35 (2.1%)	2 (0.2%)	0 (0.0%)	0 (0.0%)
Cambodian	18 (0.5%)	1 (<0.1%)	0 (0.0%)	4 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	2 (<0.1%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Asian	37 (1.0%)	0 (0.0%)	N/A (N/A)	N/A	4 (0.2%)	0 (0.0%)	N/A (N/A)	N/A
Tongan	287 (7.8%)	237 (5.0%)	176 (2.4%)	30 (0.6%)	172 (10.4%)	121 (14.5%)	120 (18.7%)	88 (17.1%)
Samoan	280 (7.6%)	343 (7.2%)	346 (4.8%)	64 (1.3%)	123 (7.5%)	90 (10.8%)	49 (7.6%)	35 (6.8%)
Fijian	9 (0.2%)	24 (0.5%)	0 (0.0%)	4 (0.1%)	1 (0.1%)	14 (1.7%)	3 (0.5%)	2 (0.4%)
Hawaiian	31 (0.8%)	29 (0.6%)	40 (0.6%)	89 (1.8%)	16 (1.0%)	7 (0.8%)	2 (0.3%)	5 (1.0%)
Guamanian	10 (0.3%)	26 (0.5%)	24 (0.3%)	5 (0.1%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi	72 (2.0%)	414 (8.7%)	651 (9.0%)	253 (5.1%)	39 (2.4%)	66 (7.9%)	70 (10.9%)	90 (17.5%)
Other Race	402 (10.9%)	101 (2.1%)	151 (2.1%)	188 (3.8%)	14 (0.8%)	2 (0.2%)	1 (0.2%)	4 (0.8%)
Unknown Race	626 (17.0%)	446 (9.4%)	348 (4.8%)	427 (8.6%)	16 (1.0%)	12 (1.4%)	93 (14.5%)	2 (0.4%)
Total**	**3684**	**4761**	**7231**	**4945**	**1650**	**836**	**642**	**514**

Note: Percentages may not sum to 100% because of rounding. **Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

While the NCOC has seen decreases in outreach numbers overall, there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, there was a decrease in White participants by 7% and Mexican participants by 8% from FY 2016-2017 to FY 2017-2018.

The EPAPMHO has also seen decreases in outreach numbers overall, there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, there was a decrease in unknown race participants by 14% from FY 2016-2017 to FY 2017-2018. There were increases in Black participants by 14% and multi-racial participants by 7%, from FY 2016-2017 to FY 2017-2018. These shifts in the racial/ethnic makeup of outreach participants are discussed further under the Recommendations section of this document.

Table 3 presents the numbers and percentages of the mental health and substance abuse referrals made to the overall outreach events by collaborative for FY 2014-2015, FY 2015-2016, FY 2016-2017 and FY 2017-2018.

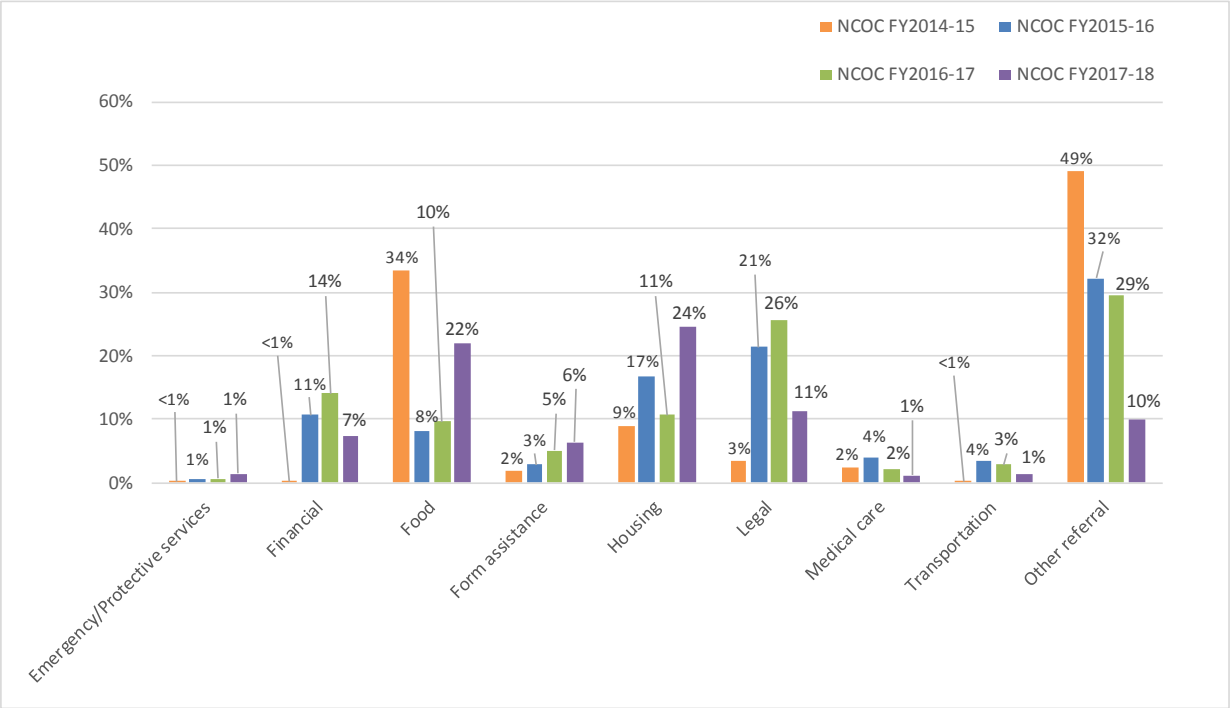
Table 3. Mental Health/Substance Abuse referrals by Collaborative, FY 2014-2015 to FY 2017-2018

	NCOC				EPAPMHO			
	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
Mental Health Referrals	67 (14.9%)	159 (44.9%)	119 (45.9%)	71 (30.9%)	80 (17.8%)	200 (26.2%)	64 (13.6%)	143 (30.7%)
Substance Abuse Referrals	33 (7.3%)	51 (14.4%)	27 (10.4%)	10 (4.3%)	202 (44.9%)	229 (30.0%)	115 (24.5%)	173 (37.1%)

Figure 2 and Figure 3 present referrals to social services in FY 2014-2015, FY 2015-2016, FY 2016-2017 and FY 2017-2018 by each collaborative. The percentages represent percent of total attendee referrals to social services.

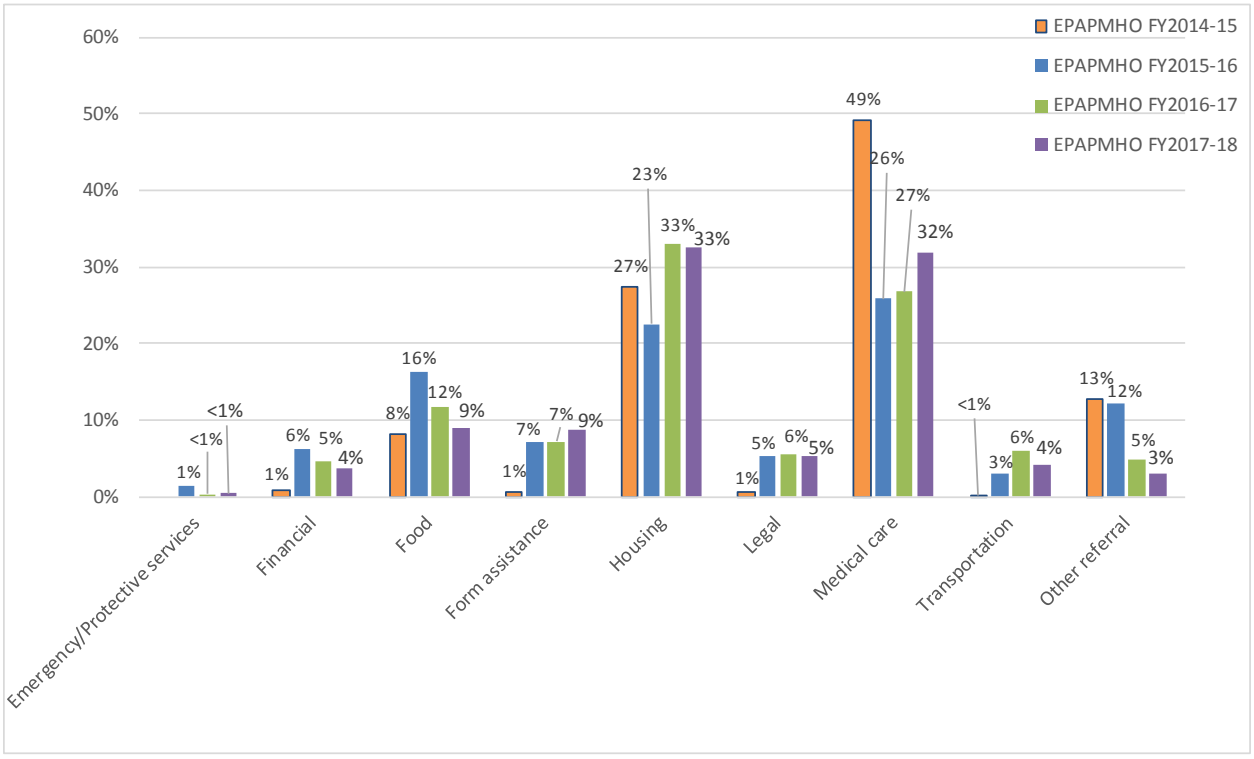
- In FY 2017-2018, NCOC had 343 referrals to social services, as compared to 496 referrals in FY 2016-2017 and 485 referrals in FY 2015-2016 and 379 referrals in FY 2014-2015. In FY 2017-2018, EPAPMHO had 669 referrals to social services, as compared to 652 in FY 2016-2017 referrals and 1,433 referrals in FY 2015-2016 and 438 referrals in FY 2014-2015.
- In FY 2017-2018, NCOC had decreases in the percent of financial, legal, medical care, transportation, and other referrals compared to the prior two FYs. Percent of referrals to food, form assistance, and housing assistance had increased.
- In FY 2017-2018, EPAPMHO had decreases in the percent of financial, food, legal, transportation, and other referrals compared to the prior two FYs. Percent of attendee referrals to form assistance and medical care had increased.

Figure 2. Referrals to Social Services made by NCOC, FY 2014-2015 to FY 2017-2018*



Note: Percentages may not sum to 100% because of rounding.

Figure 3. Referrals to Social Services made by EPAPMHO, FY 2014-2015 to FY 2017-2018*



Note: Percentages may not sum to 100% because of rounding.

NCOC

In FY 2017-2018, there were 4,256 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: Attendees across NCOC individual and group outreach events were adults (26-59 years, 37%), children (0-15 years, 23%), transition-age youth (16-25 years, 17%), and older adults (60 years or older, 16%) in FY 2017-2018. Seven percent of attendees were of an unknown age. See **Table 4** for the number of total outreach attendees representing each reported age group, by quarter.

Table 4. Age of Total Outreach Attendees Served by NCOC, FY 2017-2018

Age Group	Q1	Q2	Q3	Q4	Total
Children (0-15)	205 (19.6%)	215 (26.8%)	497 (33.4%)	61 (6.0%)	978 (22.5%)
Transition-age youth (16-25)	159 (15.2%)	182 (22.7%)	293 (19.7%)	83 (8.2%)	717 (16.5%)
Adults (26-59)	370 (35.3%)	269 (33.6%)	643 (43.2%)	318 (31.4%)	1600 (36.8%)
Older adults (60+)	196 (18.7%)	113 (14.1%)	44 (3.0%)	334 (33.0%)	687 (15.8%)
Decline to state	52 (5.0%)	2 (0.2%)	2 (0.1%)	0 (0.0%)	56 (1.3%)
Unknown age	65 (6.2%)	20 (2.5%)	10 (0.7%)	217 (21.4%)	312 (7.2%)
Total**	**1047**	**801**	**1489**	**1013**	**4350**

Note: Percentages may not sum to 100% because of rounding. ** Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across NCOC individual and group outreach events were females (59%), males (29%), and unknown gender (12%) in FY 2017-2018. See **Table 5** for the number of individual and group outreach attendees reporting each sex type, by quarter.

Table 5. Sex at Birth of Outreach Attendees Served By NCOC, FY 2017-2018

Sex	Q1	Q2	Q3	Q4	Total
Male	369 (35.9%)	265 (33.2%)	345 (23.2%)	262 (25.9%)	1241 (28.7%)
Female	620 (60.4%)	426 (53.3%)	997 (67.0%)	515 (50.8%)	2558 (59.1%)
Other	9 (0.9%)	0 (0.0%)	2 (0.1%)	0 (0.0%)	11 (0.3%)
Uknown	29 (2.8%)	108 (13.5%)	144 (9.7%)	236 (23.3%)	517 (11.9%)
Total**	**1027**	**799**	**1488**	**1013**	**4327**

Note: Percentages may not sum to 100% because of rounding. ** Total count for sex reported may exceed the total number of attendees, because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all sex data reported.

Gender: Attendees across NCOC individual and group outreach events identified themselves as female (33%) and male (22%) in FY 2017-2018. A little under half of the individuals (44%)

declined to state their gender. See **Table 6** for the number of individual and group outreach attendees reporting each gender type, by quarter.

Table 6. Gender of Outreach Attendees Served By NCOC, FY 2017-2018

Gender	Q1	Q2	Q3	Q4	Total
Male	330 (33.8%)	352 (30.0%)	149 (10.0%)	174 (17.1%)	1005 (21.6%)
Female	454 (46.6%)	395 (33.7%)	334 (22.5%)	353 (34.7%)	1536 (33.0%)
Transgender	3 (0.3%)	1 (0.1%)	1 (0.1%)	2 (0.2%)	7 (0.2%)
Queer	4 (0.4%)	4 (0.3%)	4 (0.3%)	5 (0.5%)	17 (0.4%)
Questioning	6 (0.6%)	1 (0.1%)	3 (0.2%)	4 (0.4%)	14 (0.3%)
Idigenous	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	1 (0.0%)
Other	0 (0.0%)	0 (0.0%)	2 (0.1%)	6 (0.6%)	8 (0.2%)
Decline to state	177 (0.1%)	417 (0.2%)	987 (0.3%)	473 (0.0%)	2054 (44.2%)
Unknown	1 (0.1%)	2 (0.2%)	5 (0.3%)	0 (0.0%)	8 (0.2%)
Total**	**975**	**1172**	**1485**	**1018**	**4650**

Note: Percentages may not sum to 100% because of rounding. ** Total count for gender because some providers may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2017-2018, the four largest racial/ethnic groups represented by all NCOC attendees were White (26%), Filipino (13%), Asian (12%), and Mexican (12%). Nine percent of attendees were of an unknown race. See **Table 7** for the number of attendees representing each reported racial/ethnic group, by quarter.

Table 7. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2017-2018

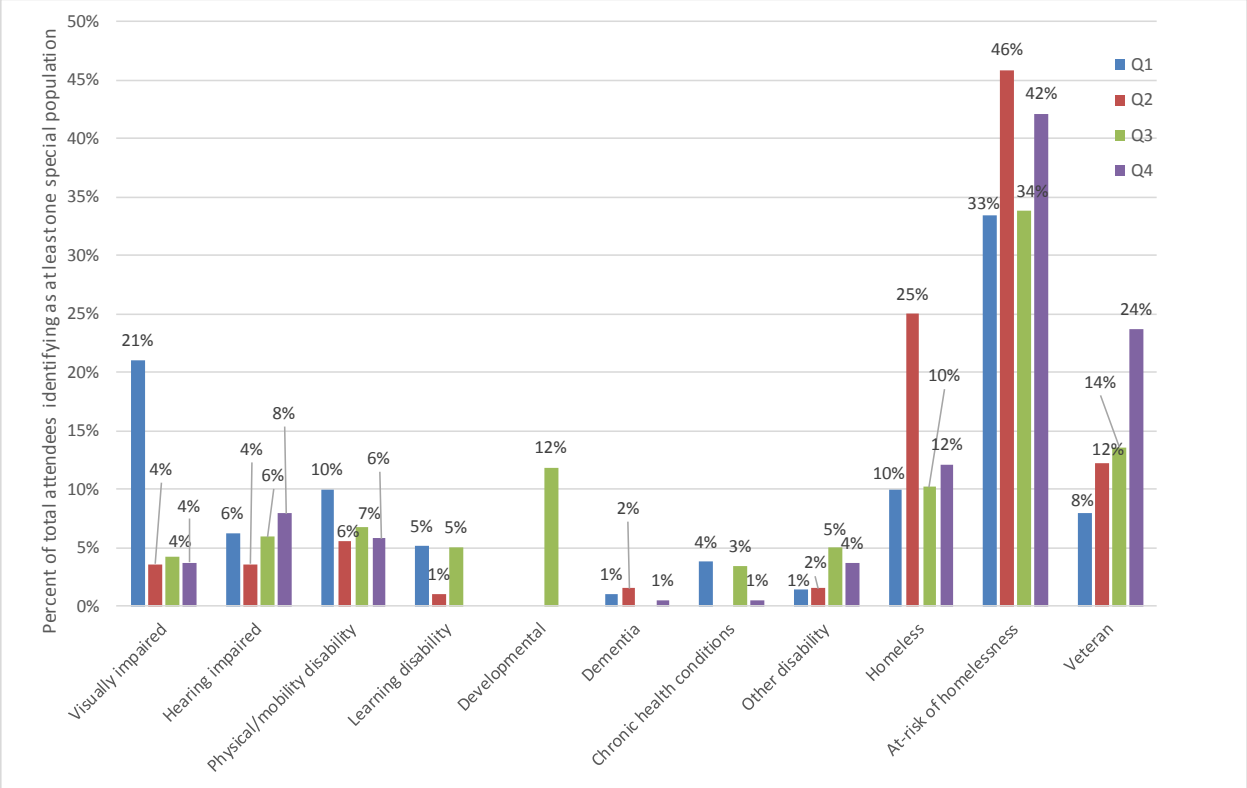
Race/Ethnicity	Q1	Q2	Q3	Q4	Total
White	378 (28.5%)	310 (32.0%)	205 (12.6%)	367 (36.0%)	1260 (25.5%)
Black	38 (2.9%)	23 (2.4%)	60 (3.7%)	30 (2.9%)	151 (3.1%)
AmericanIndian	14 (1.1%)	8 (0.8%)	14 (0.9%)	7 (0.7%)	43 (0.9%)
MiddleEastern	2 (0.2%)	1 (0.1%)	58 (3.6%)	3 (0.3%)	64 (1.3%)
EasternEuropean	0 (0.0%)	0 (0.0%)	5 (0.3%)	2 (0.2%)	7 (0.1%)
European	0 (0.0%)	0 (0.0%)	3 (0.2%)	1 (0.1%)	4 (0.1%)
Mexican	251 (18.9%)	34 (3.5%)	193 (11.8%)	98 (9.6%)	576 (11.6%)
PuertoRican	1 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	2 (0.0%)
Cuban	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
CentralAmerican	4 (0.3%)	5 (0.5%)	213 (13.1%)	33 (3.2%)	255 (5.2%)
SouthAmerican	11 (0.8%)	1 (0.1%)	10 (0.6%)	9 (0.9%)	31 (0.6%)
Caribbean	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	1 (0.0%)
Asian	115 (8.7%)	148 (15.3%)	204 (12.5%)	111 (10.9%)	578 (11.7%)
Cambodian	0 (0.0%)	0 (0.0%)	4 (0.2%)	0 (0.0%)	4 (0.1%)
Chinese	70 (5.3%)	16 (1.7%)	70 (4.3%)	32 (3.1%)	188 (3.8%)
Filipino	157 (11.8%)	71 (7.3%)	345 (21.2%)	46 (4.5%)	619 (12.5%)
Japanese	18 (1.4%)	1 (0.1%)	10 (0.6%)	7 (0.7%)	36 (0.7%)
Korean	8 (0.6%)	0 (0.0%)	12 (0.7%)	1 (0.1%)	21 (0.4%)
Laotian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
SouthAsian	2 (0.2%)	3 (0.3%)	33 (2.0%)	2 (0.2%)	40 (0.8%)
Vietnamese	0 (0.0%)	0 (0.0%)	5 (0.3%)	1 (0.1%)	6 (0.1%)
Samoan	34 (2.6%)	14 (1.4%)	15 (0.9%)	1 (0.1%)	64 (1.3%)
Hawaiian	23 (1.7%)	7 (0.7%)	49 (3.0%)	9 (0.9%)	88 (1.8%)
Tongan	14 (1.1%)	5 (0.5%)	8 (0.5%)	3 (0.3%)	30 (0.6%)
Guamanian	2 (0.2%)	3 (0.3%)	0 (0.0%)	0 (0.0%)	5 (0.1%)
Fijian	1 (0.1%)	0 (0.0%)	2 (0.1%)	1 (0.1%)	4 (0.1%)
Multi	97 (7.3%)	38 (3.9%)	78 (4.8%)	40 (3.9%)	253 (5.1%)
OtherRace	32 (2.4%)	136 (14.0%)	15 (0.9%)	5 (0.5%)	188 (3.8%)
UnknownRace	54 (4.1%)	145 (15.0%)	18 (1.1%)	210 (20.6%)	427 (8.6%)
Total**	**1326**	**969**	**1630**	**1020**	**4945**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: NCOC individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 39% were at risk for homelessness, 14% were homeless, 14% were veterans, 10% were visually impaired, 7% had a physical/mobility disability, 6% were hearing impaired, 3% had a learning disability, 3% had other disabilities, 2% had chronic health condition, 2% had developmental disability, and less

than 1% had dementia. Refer to **Figure 4** for the percentage of attendees representing each special population in FY 2017-2018, by quarter.

Figure 4. Special Populations Served By NCOC, FY 2017-2018



Note: Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: The majority of the NCOC individual outreach attendees did not report insurance status (i.e. unknown insurance, 77%). Fifteen percent of the NCOC individual attendees reported Medi-Cal and four percent reported having other kinds of insurance. See **Table 8** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 8. Insurance Coverage for NCOC Outreach Attendees, FY 2017-2018

Insurance Type	Q1	Q2	Q3	Q4	Total
HealthyKids	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
MediCal	24 (18.2%)	3 (14.3%)	4 (5.8%)	3 (37.5%)	34 (14.8%)
Medicare	0 (0.0%)	1 (4.8%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Other Insurance	9 (6.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	9 (3.9%)
Uninsured	6 (4.5%)	1 (4.8%)	1 (1.4%)	0 (0.0%)	8 (3.5%)
Unknown	93 (70.5%)	16 (76.2%)	64 (92.8%)	5 (62.5%)	178 (77.4%)
Total	**132**	**21**	**69**	**8**	**230**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2017-2018.

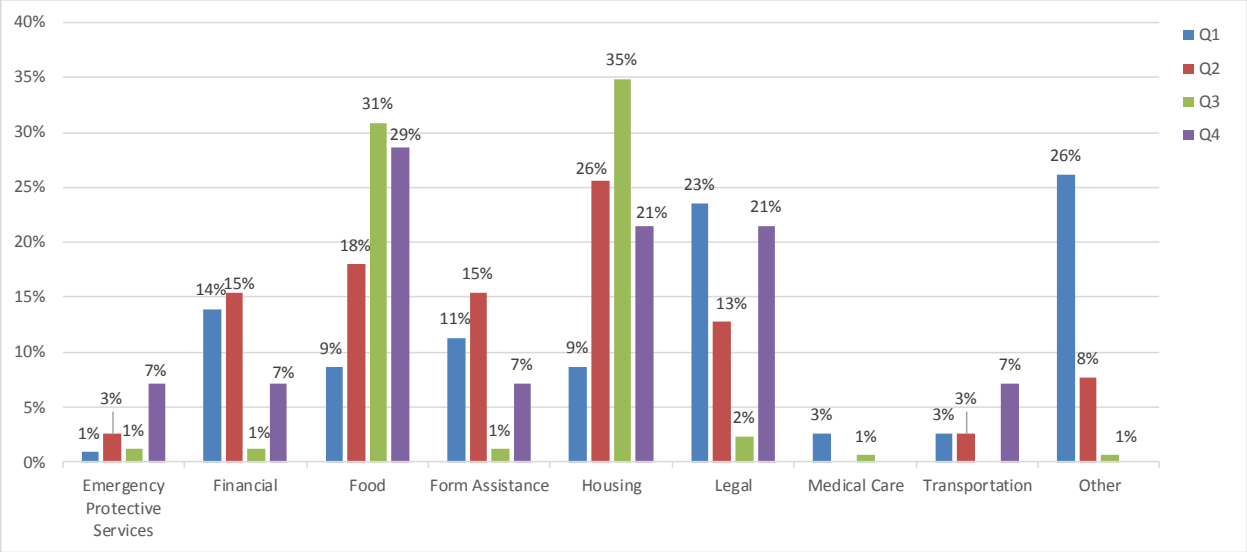
Previous Contact: Seven percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Abuse Referrals: NCOC individual outreach events included mental health referrals (31%) and substance abuse referrals (4%) in FY 2017-2018.

Mental Health/Substance Abuse Referral Destinations: Among all the NCOC individuals who were referred for mental health service, 50% were referred to providers. (31% were referred to Daly City Youth Health Center, four percent were referred to Pacifica Resource Center and 15% were referred to Pyramid Alternatives). 50% were referred to other destinations. Among the 56 individuals who were referred to other destinations, 46% were referred to StarVista-On Your Mind. Other referral destinations include StarVista-On Your Mind, Parent Support Line-Star Vista, North County Mental Health, ACCESS, Access & Manage Care and other San Mateo local resources. Among all the NCOC individuals who were referred for substance abuse service, three were referred to providers. 88% were referred to other destinations. Among the 23 individuals who were referred to other destinations, 65% were referred to the Outpatient Drug and Alcohol Services for Adults (ODASA).

Referrals to Social Services: Providers made 343 referrals to 230 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were housing (24%), food (22%) and legal services (11%). In **Figure 5**, we summarize the percentage of attendees receiving a given type of referral, by quarter.

Figure 5. Referrals to Social Services, FY 2017-2018

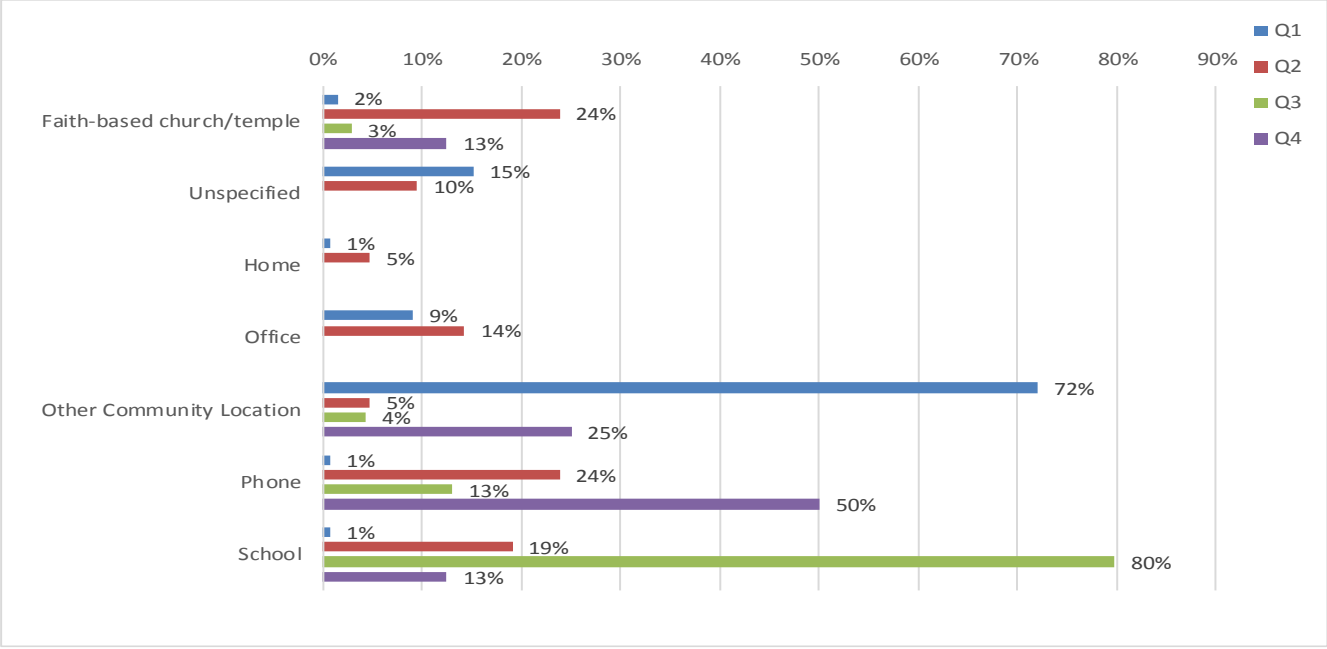


Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on referral type for FY 2017-2018.

Individual outreach event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations (44%), school (27%) and unspecified locations (10%) in FY 2017-2018. **Figure 6** presents individual outreach event locations in FY 2017-2018, by quarter.

Figure 6. Locations of NCOC Individual Outreach Events, FY 2017-2018



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2017-2018, the average length of NCOC individual outreach events was 44.3 minutes. Average length was 14.5 minutes in Q1, 33.8 minutes in Q2, 93.3 minutes in Q3, and 35.5 minutes in Q4.

MAA code: NCOC individual outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 17%) in FY 2017-2018. 92% of MAA codes were reported as N/A.

Language used: NCOC individual outreach events were conducted only in English (92%) and Spanish (7%) across four quarters in FY 2017-2018.

Preferred language: NCOC individual outreach attendees preferred English (84%), Spanish (10%), Tagalog (4%), and Samoan (2%), See **Table 9** for the total number of individual outreach attendees reporting each preferred language.

Table 9. Preferred Languages for NCOC Individual Outreach Attendees, FY 2017-2018

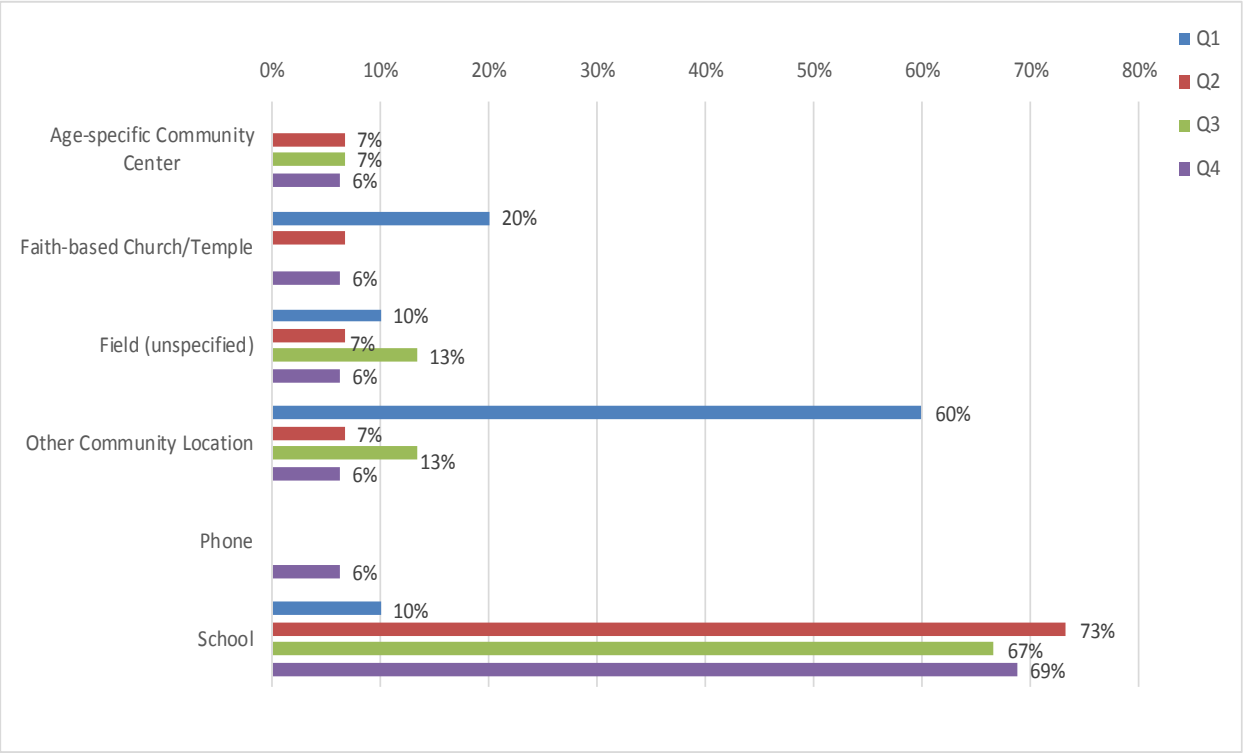
Language	Q1	Q2	Q3	Q4	Total
English	119 (90.2%)	16 (76.2%)	51 (75.0%)	6 (75.0%)	192 (83.5%)
Samoan	4 (3.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (1.7%)
Spanish	0 (0.0%)	5 (23.8%)	16 (23.5%)	2 (25.0%)	23 (10.0%)
Tagalog	9 (6.8%)	0 (0.0%)	1 (1.5%)	0 (0.0%)	10 (4.3%)
Tongan	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other	0 (0.0%)	0 (0.0%)	1 (1.5%)	0 (0.0%)	1 (0.4%)
Total	**132**	**21**	**68**	**8**	**230**

Note: Percentages may not sum to 100% because of rounding.

Group outreach event characteristics

Location: NCOC group outreach events largely occurred at school (59%) and at other community locations not listed (18%) in FY 2017-2018. Among the eight group outreach events held in other locations, most were held in “San Mateo County Fairgrounds” and “Mall”. Other locations include Edgewood Drop-In Center, Frontierland Park Pacifica and Pacifica Fog Fest. **Figure 7** presents group outreach event locations in FY 2017-2018, by quarter.

Figure 7. Location of NCOC Group Outreach Events, FY 2017-2018



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2017-2018, the average length of NCOC group outreach events was 115.77 minutes. By quarter, average length of outreach was 188 minutes in Q1, 84 minutes in Q2, 89 minutes in Q3, and 101 minutes in Q4.

MAA code: NCOC group outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 9%). 91 % of MAA codes were reported as N/A.

Language used: NCOC group outreach events were conducted in English (75%) and Spanish (25%) in FY 2017-2018.

Preferred Language: NCOC group outreach attendees preferred English (79%), Spanish (13%), Tagalog (4%), and Mandarin (2%). See **Table 10** below for the breakdown of group outreach events by preferred language.

Table 10. Preferred Languages for NCOC Group Outreach Attendees, FY 2017-2018

Language	Q1	Q2	Q3	Q4	Total
English	750 (81.8%)	537 (85.1%)	253 (63.7%)	468 (78.4%)	2008 (79.0%)
Cantonese	5 (0.5%)	2 (0.3%)	3 (0.8%)	8 (1.3%)	18 (0.7%)
Mandarin	25 (2.7%)	13 (2.1%)	8 (2.0%)	11 (1.8%)	57 (2.2%)
Samoan	0 (0.0%)	2 (0.3%)	1 (0.3%)	0 (0.0%)	3 (0.1%)
Spanish	105 (11.5%)	56 (8.9%)	73 (18.4%)	86 (14.4%)	320 (12.6%)
Tagalog	32 (3.5%)	18 (2.9%)	47 (11.8%)	11 (1.8%)	108 (4.2%)
Tongan	0 (0.0%)	2 (0.3%)	0 (0.0%)	2 (0.3%)	4 (0.2%)
Other	0 (0.0%)	1 (0.2%)	12 (3.0%)	11 (1.8%)	24 (0.9%)
Total**	**917**	**631**	**397**	**597**	**2542**

Note: Percentages may not sum to 100% because of rounding. ** Total count for preferred language reported may be less than the total number of attendees, because some providers may not have provided a response for preferred languages. The denominator for age percent is the sum of all preferred language data reported.

EPAPMHO

In FY 2017-2018, there were 511 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual and group outreach attendees were adults (26-59 years, 56%), transition-age youth (16-25 years, 28%), older adults (60+ years or older, 14%), and children (0-15 years, 2%) in FY 2017-2018. See **Table 11** for the number of individual and group outreach attendees representing each reported age group, by quarter.

Table 11. Age of Individual and Group Outreach Attendees Served By EPAPMHO, FY 2017-2018

Age Group	Q1	Q2	Q3	Q4	Total
Children (0-15)	8 (6.6%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	8 (1.8%)
Transition-age youth (16-25)	32 (26.2%)	30 (25.9%)	47 (40.9%)	35 (22.2%)	141 (28.2%)
Adults (26-59)	67 (54.9%)	65 (56.0%)	53 (46.1%)	100 (63.3%)	267 (55.8%)
Older adults (60+)	15 (12.3%)	19 (16.4%)	14 (12.2%)	22 (13.9%)	61 (13.7%)
Decline to state	0 (0.0%)	1 (0.9%)	1 (0.9%)	1 (0.6%)	3 (0.6%)
Unknown age	0 (0.0%)	1 (0.9%)	1 (0.9%)	1 (0.6%)	3 (0.6%)
Total**	**122**	**116**	**115**	**158**	**511**

Note: Percentages may not sum to 100% because of rounding. ** The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO individual and group outreach events were male (46%) and female (54%) in FY 2017-2018. See **Table 12** for the number of individual and group outreach attendees representing each reported sex, by quarter.

Table 12. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2017-2018

Sex	Q1	Q2	Q3	Q4	Total
Male	40 (32.8%)	56 (48.3%)	64 (55.7%)	76 (48.1%)	236 (46.2%)
Female	82 (67.2%)	59 (50.9%)	51 (44.3%)	82 (51.9%)	274 (53.6%)
Other gender	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Total	**122**	**116**	**115**	**158**	**511**

Note: Percentages may not sum to 100% because of rounding. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves primarily as female (54%), male (43%), and transgender (2%) in FY 2017-2018. See **Table 13** for the number of individual and group outreach attendees representing each reported gender, by quarter.

Table 13. Gender of Outreach Attendees Served By EPAPMHO, FY 2017-2018

Gender	Q1	Q2	Q3	Q4	Total
Male	40 (32.8%)	49 (42.2%)	61 (53.0%)	70 (44.3%)	220 (43.1%)
Female	82 (67.2%)	61 (52.6%)	52 (45.2%)	83 (52.5%)	278 (54.4%)
Transgender	0 (0.0%)	4 (3.4%)	1 (0.9%)	5 (3.2%)	10 (2.0%)
Queer	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Questioning	0 (0.0%)	0 (0.0%)	1 (0.9%)	0 (0.0%)	1 (0.2%)
Decline to state	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Total**	**122**	**116**	**115**	**158**	**511**

Note: Percentages may not sum to 100% because of rounding. ** The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2017-2018, the three largest racial/ethnic groups represented by all EPAPMHO attendees were Black (36%), Tongan (17%), and multi-race (18%). See **Table 14** for the number of attendees representing each reported racial/ethnic group, by quarter.

Table 14. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2017-2018

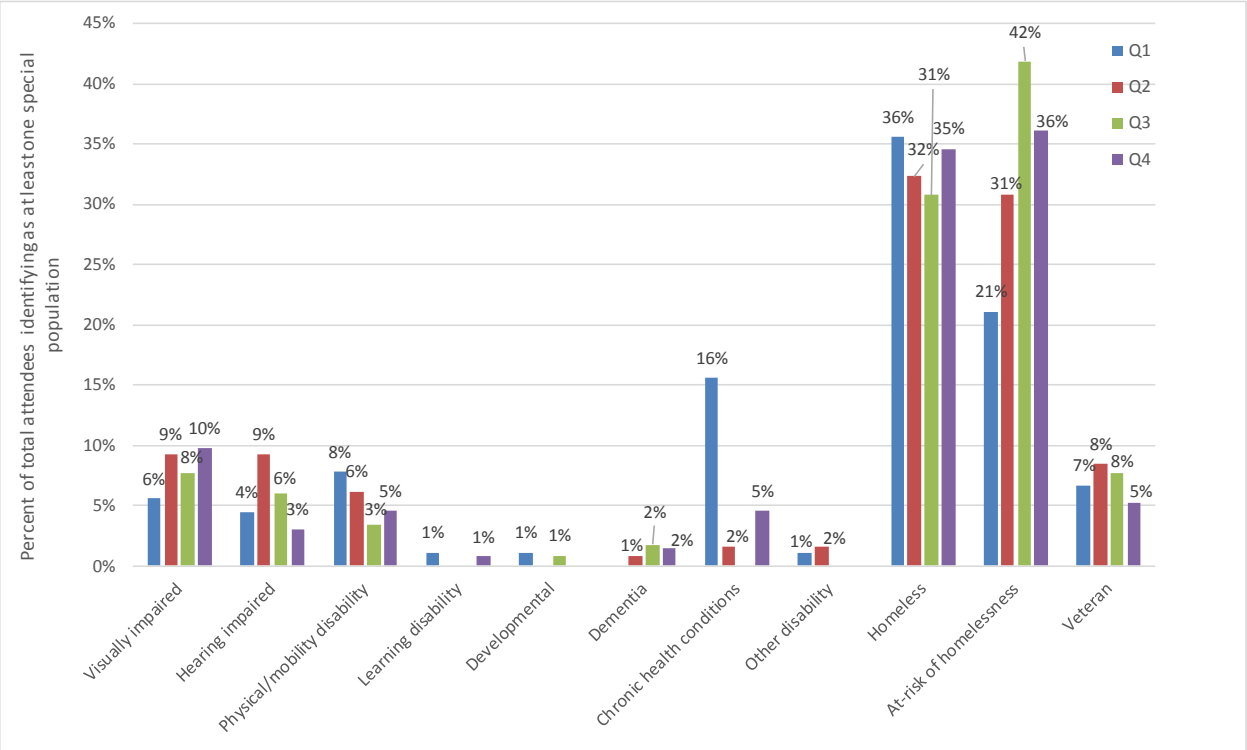
Race/Ethnicity	Q1	Q2	Q3	Q4	Total
White	13 (10.4%)	7 (6.0%)	4 (3.5%)	19 (12.0%)	43 (8.4%)
Black	60 (48.0%)	48 (41.4%)	45 (39.1%)	33 (20.9%)	186 (36.2%)
American Indian	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Middle Eastern	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Eastern European	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	7 (5.6%)	7 (6.0%)	14 (12.2%)	15 (9.5%)	43 (8.4%)
Puerto Rican	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Cuban	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Central American	0 (0.0%)	1 (0.9%)	0 (0.0%)	4 (2.5%)	5 (1.0%)
South American	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.6%)	1 (0.2%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Chinese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Filipino	1 (0.8%)	0 (0.0%)	4 (3.5%)	2 (1.3%)	7 (1.4%)
Japanese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Asian	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Vietnamese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Samoan	8 (6.4%)	13 (11.2%)	8 (7.0%)	6 (3.8%)	35 (6.8%)
Hawaiian	0 (0.0%)	0 (0.0%)	3 (2.6%)	2 (1.3%)	5 (1.0%)
Tongan	13 (10.4%)	18 (15.5%)	18 (15.7%)	39 (24.7%)	88 (17.1%)
Guamanian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Fijian	0 (0.0%)	1 (0.9%)	0 (0.0%)	1 (0.6%)	2 (0.4%)
Multi	17 (13.6%)	19 (16.4%)	19 (16.5%)	35 (22.2%)	90 (17.5%)
Other Race	3 (2.4%)	0 (0.0%)	0 (0.0%)	1 (0.6%)	4 (0.8%)
Unknown Race	2 (1.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.4%)
Total	**125**	**116**	**115**	**158**	**514**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: EPAPMHO individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 33% were at-risk of homelessness, 33% were homeless, 8% were visually impaired, 7% were veteran, 6% were hearing impaired, 5% had chronic health conditions, 5% had a physical/mobility disability, 1%

had dementia, and 1% other disability. Refer to **Figure 8** for the percentage of attendees representing each special population in FY 2017-2018, by quarter.

Figure 8. Special Populations Served by EPAPMHO, FY 2017-2018



Note: Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: EPAPMHO individual outreach attendees were with Medi-Cal (56%), without insurance (26%), with other insurance not listed (4%), with unknown insurance (8%), with HealthyKids (2%), or with Medicare (4%). See **Table 15** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 15. Insurance Coverage, FY 2017-2018

Insurance Type	Q1	Q2	Q3	Q4	Total
HealthyKids	2 (2.3%)	2 (1.7%)	2 (1.7%)	2 (1.3%)	8 (1.7%)
MediCal	38 (43.2%)	74 (63.2%)	64 (55.7%)	93 (59.2%)	269 (56.4%)
Medicare	5 (5.7%)	4 (3.4%)	3 (2.6%)	7 (4.5%)	19 (4.0%)
Other Insurance	9 (10.2%)	3 (2.6%)	1 (0.9%)	5 (3.2%)	18 (3.8%)
Uninsured	29 (33.0%)	23 (19.7%)	35 (30.4%)	39 (24.8%)	126 (26.4%)
Unknown	5 (5.7%)	11 (9.4%)	10 (8.7%)	11 (7.0%)	37 (7.8%)
Total	**88**	**117**	**115**	**157**	**477**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2017-2018.

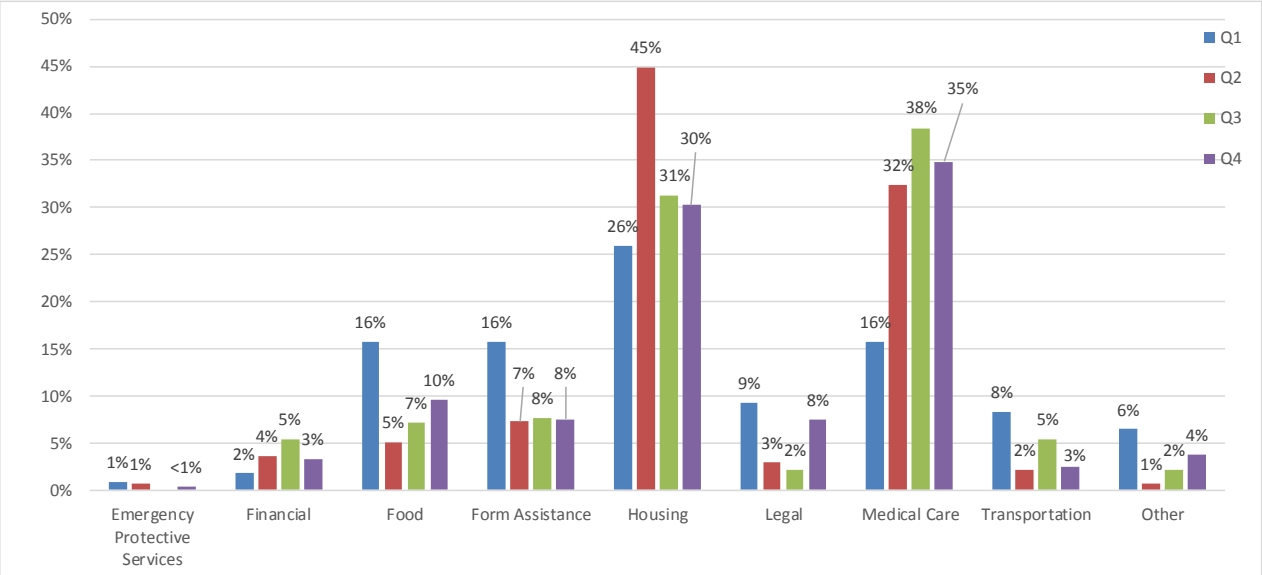
Previous contact: Thirty percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Abuse Referrals: EPAPMHO individual outreach events included mental health referrals (31%) and substance abuse referrals (37%) in FY 2017-2018.

Mental Health/Substance Abuse Referral Destinations: Among all the EPAPMHO individuals who were referred for mental health service, 19% were referred to providers (among which, 91% were referred to El Concilio). 81% were referred to other destinations. Among the 46 individuals who were referred to other destinations, most of them were referred to East Palo Alto Community Counseling Center (EPACCC) or Ravenswood Family Health Center (RFHC). For all the EPAPMHO individuals who were referred for substance abuse service, 51% were referred to providers (among which, all were referred to Free at Last). 49% were referred to other destinations. Among the 57 individuals who were referred to other destinations, most were referred to Project90 and RFHC. Other destinations also include Latino Commission, Ravenswood Clinic, WRA and others.

Referrals to Social Services: Providers made 669 referrals to 466 EPAPMHO individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were for housing (33%), medical care (32%), food (9%) and form assistance (9%). **Figure 9** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 9. Referrals to Social Services, FY 2017-2018

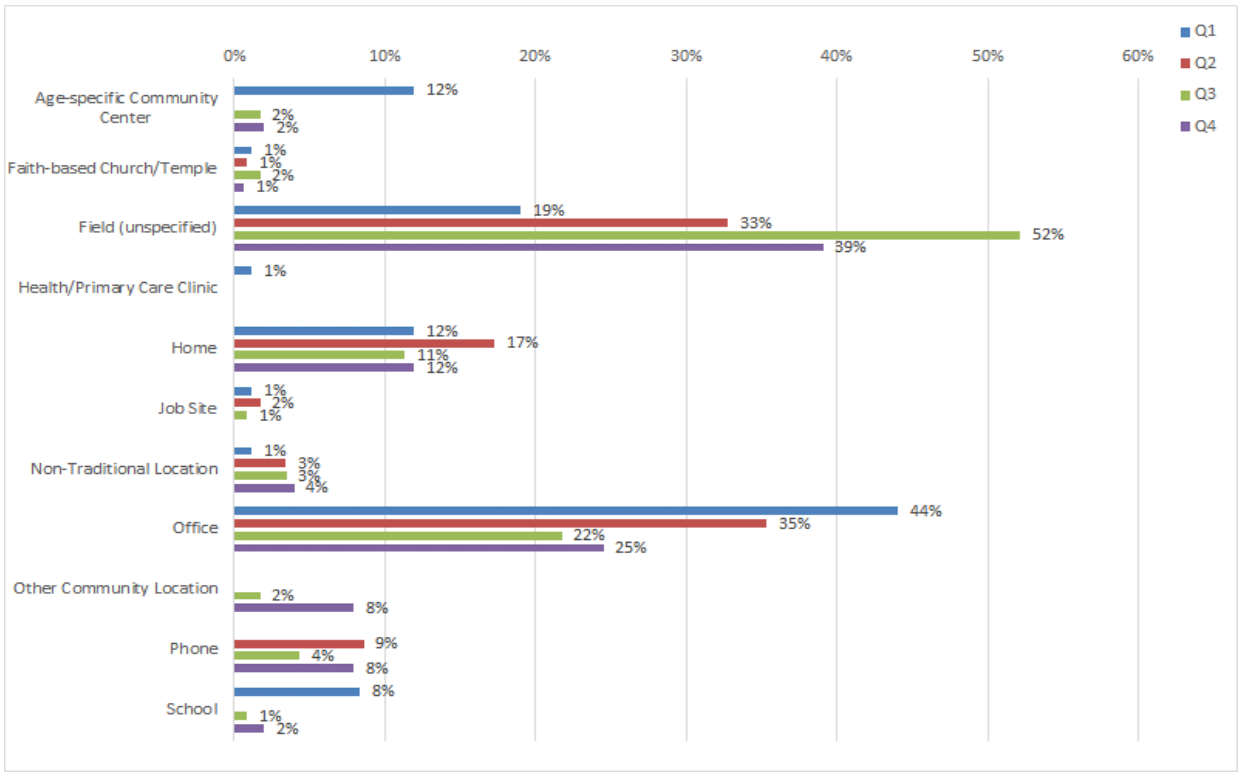


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2017-2018.

Individual outreach event characteristics

Location: EPAPMHO individual outreach events typically occurred in offices (30%), and home (13%) in FY 2017-2018. See **Figure 10** for a summary of individual outreach events by location.

Figure 10. Location of EPAPMHO Individual Outreach Events, FY 2017-2018



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2017-2018, the average length of EPAPMHO individual outreach events was 37.5 minutes. By quarter, average length of outreach was 39.6 minutes in Q1, 40.2 minutes in Q2, 37.3 minutes in Q3, and 34.5 minutes in Q4.

MAA code: EPAPMHO individual outreach events used MAA codes 400 (Medi-Cal outreach, 24%), 401 (Discounted Medi-Cal outreach, 3%). 74% of the MAA codes were reported as N/A.

Language used: EPAPMHO individual outreach events were conducted in English (69%), Spanish (16%), Tongan (10%), and Samoan (5%). See **Table 16** below for the breakdown of group outreach events by the language of administration.

Table 16. Languages of administration in EPAPMHO individual outreach events, FY 2017-2018

Language	Q1	Q2	Q3	Q4	Total
English	57 (67.9%)	83 (71.6%)	88 (76.5%)	93 (61.6%)	321 (68.9%)
Samoan	3 (3.6%)	8 (6.9%)	6 (5.2%)	6 (4.0%)	23 (4.9%)
Spanish	14 (16.7%)	14 (12.1%)	16 (13.9%)	31 (20.5%)	75 (16.1%)
Tongan	10 (11.9%)	11 (9.5%)	5 (4.3%)	21 (13.9%)	47 (10.1%)
Total	**84**	**116**	**115**	**151**	**466**

Note: Percentages may not sum to 100% because of rounding.

Preferred Language: Most EPAPMHO individual outreach attendees preferred English (69%), Spanish (16%) and Tongan (9%). See **Table 17** below for the breakdown of EPAPMHO individual outreach events by preferred language.

Table 17. Preferred Languages for EPAPMHO Individual Outreach Attendees, FY 2017-2018

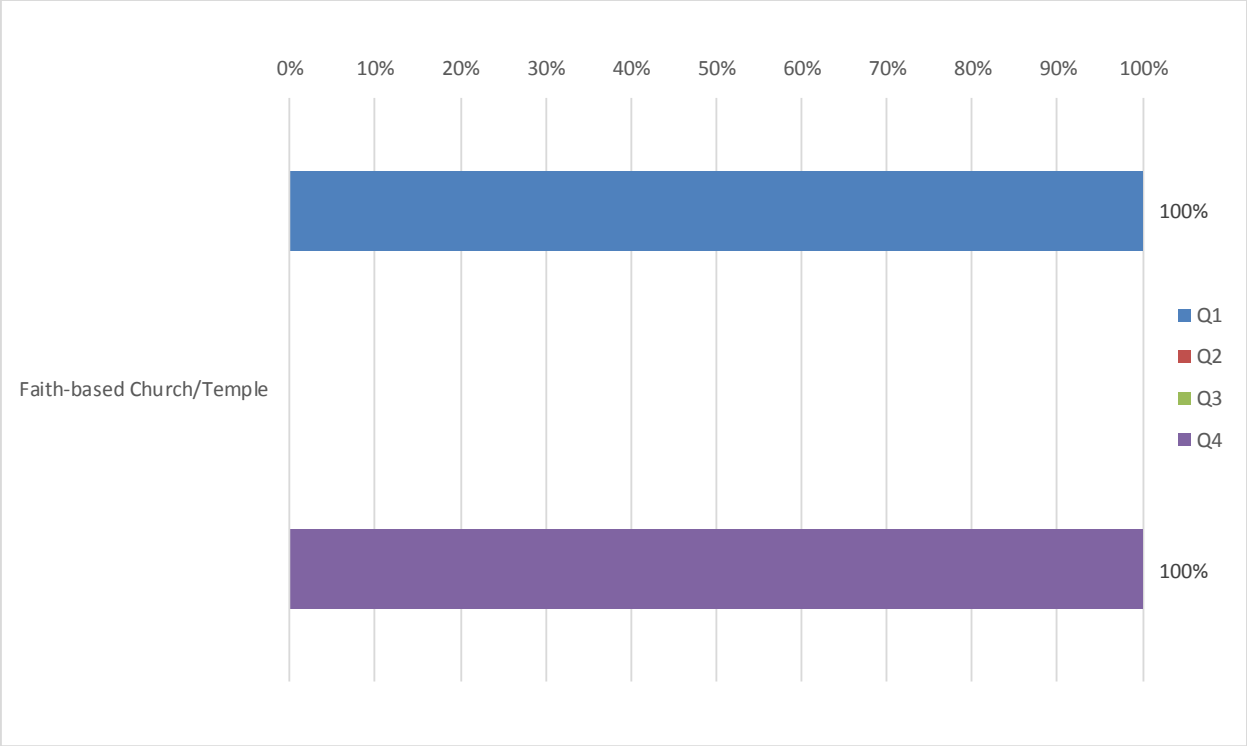
Language	Q1	Q2	Q3	Q4	Total
Cantonese	0 (0.0%)	0 (0.0%)	1 (0.9%)	0 (0.0%)	1 (0.2%)
English	59 (70.2%)	82 (70.7%)	84 (77.1%)	93 (61.6%)	318 (69.1%)
Samoan	3 (3.6%)	8 (6.9%)	6 (5.5%)	5 (3.3%)	22 (4.8%)
Spanish	13 (15.5%)	13 (11.2%)	16 (14.7%)	31 (20.5%)	73 (15.9%)
Tagalog	1 (1.2%)	0 (0.0%)	1 (0.9%)	3 (2.0%)	5 (1.1%)
Tongan	8 (9.5%)	13 (11.2%)	0 (0.0%)	19 (12.6%)	40 (8.7%)
Other	0 (0.0%)	0 (0.0%)	1 (0.9%)	0 (0.0%)	1 (0.2%)
Total	**84**	**116**	**109**	**151**	**460**

Note: Percentages may not sum to 100% because of rounding.

Group outreach event characteristics

Locations: EPAPMHO group outreach events were held at faith-based churches/temples (100%) in FY 2017-2018. Refer to **Figure 11** for a breakdown of group outreach events by location.

Figure 11. Locations of EPAPMHO Group Outreach Events, FY 2017-2018



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2017-2018, the average length of EPAPMHO group outreach events was 45 minutes. By quarter, average length of outreach was 45 minutes in Q1, and 45 minutes in Q4.

MAA code: One EPAPMHO group outreach event used MAA code 400 (Medi-Cal outreach, 50%) in FY 2017-2018. The MAA code for one group event was reported as N/A.

Language used: EPAPMHO group outreach events were conducted in English (100%). See **Table 18** below for the breakdown of group outreach events by the language of administration.

Table 18. Languages of Administration in EPAPMHO Group Outreach Events, FY 2017-2018

Language	Q1		Q2		Q3		Q4		Total	
English	38	100.0%	0	0.0%	0	0.0%	7	100.0%	45	100.0%
Total	**38**		**0**		**0**		**7**		**45**	

Note: Percentages may not sum to 100% because of rounding.

Preferred Language: EPAPMHO group outreach attendees preferred English (84%) and Other (16%). **Table 19** below for the breakdown of group outreach events by the language of administration.

Table 19. Preferred Languages for EPAPMHO Group Outreach Attendees, FY 2017-2018

Language	Q1	Q2	Q3	Q4	Total
English	38 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	38 (84.4%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	7 (100.0%)	7 (15.6%)
Total**	**38**	**0**	**0**	**7**	**45**

Note: Percentages may not sum to 100% because of rounding. ** Total count for preferred language reported may be less than the total number of attendees due to the missing data. The denominator for preferred language percent is the sum of all preferred language data reported.

Recommendations

We have several recommendations based on FY 2017-2018 data. These recommendations fall under three umbrellas: those aimed at enhancing outreach, those to improve data collection, and discussion points for changing the reporting structure for next year.

Enhance outreach

Continue to tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America. EPAPMHO and NCOC have made improvements to meeting the needs of the seniors (aged 65 and older), but additional targeting may still be necessary. According to a survey of San Mateo residents in 2015, 19% of the county's senior population reported needing help for emotional/mental health problems or use of alcohol/drugs.[1] This year, 13% of the attendees were older adults, which is similar to last year, but a major improvement over FY 2015-2016 (during which 7% of the attendees were seniors).

In addition, similar to last year, among persons who identified as Latino/Hispanic, individuals from Central American descent were underrepresented at outreach events. Among persons who identified as Latino/Hispanic and reported needing help for emotional/mental health problems or use of alcohol/drugs in San Mateo County in 2015, 57% were Central American and 14% were Mexican.[2] However, 93% of Latino/Hispanic outreach attendees were identified as Mexican and only 3% were identified as Central American among the two collaboratives. Note that the ethnicity of Central American was first added in FY 2016-2017, thus no data on Central American was available for FY 2014-2015 and FY 2015-2016.

Consider how to meet the changing needs of uninsured individuals. A large proportion of attendees did not report being insured by a specific health plan. In FY 2016-2017, 56% reported being uninsured or had unknown insurance status across two collaboratives, which is similar to last year FY an 2015-2016 (54%) and a decrease from FY 2014-2015 (64%). Disentangling uninsured status from unknown insurance status is a data quality issue to be discussed below, but regardless, this group deserves special attention. The county should consider how to best

[1] UCLA Center for Health Policy Research. AskCHIS 2015. Available at http://ask.chis.ucla.edu.
[2] UCLA Center for Health Policy Research. Ask CHIS 2015. Available at http://ask.chis.ucla.edu.

meet the needs of uninsured individuals, who may become more reticent to respond to outreach events particularly if they are concerned about treatment costs. The size of this group may also grow if the insurance marketplaces destabilize.

Focus on increasing housing-related resources and referrals. Last year, AIR recommended considering whether adequate housing-related resources were being given; since then the number of statements of homelessness or risk of homelessness has decreased. Note that attendees may not be unique individuals, a report structure issue which is discussed below. In FY 2017-2018, we observed an increase in the total number of housing-related referrals made.

Improve data collection

Ensure that all data have been obtained from outreach providers. It appears that data are missing at the time of this report. As of the January 2019, here is a record of 2,643 individuals receiving outreach contact in FY2017-2018, as compared with 6,989 from FY2016-2017. The additional data was not collected from NCOC providers until June 2019.

Make other/unspecified categories clearer. Last year, AIR recommended minimizing missing data, and there are fewer missing data this year. However, there are still relatively high proportions of individuals in other/unspecified categories for some topics. For example, 88% of the NCOC outreach attendees were identified as having unknown insurance status. EPAPMHO has substantially reduced the missingness in their demographic data, from 15% of their outreach attendees identifying as other/unknown races last year to 0.4% this year.

Potential updates to reporting structure

The report could rely less on erratic quarterly data. It is important not to over interpret within-year trends. There is substantial variation in quarterly outreach characteristics, particularly due to small sample size. SMC BHRS should consider whether quarterly data are useful or informative.

Consider combining data categories for reporting. Currently, there are many very small groups gathered and reported separately. Some of the less common categories may be combined for reporting purposes only (e.g., creating a South East Asian category, or a disability category). However, before these changes are made, it will be important for us to discuss reporting requirements with BHRS to ensure needs are met.

Discuss revising the denominator for special populations reporting. Like previous years, the representation of special populations is described compared to all reports of a special population designation (which are not mutually exclusive). These numbers may be more meaningful if described as a function of all individuals who attend an outreach event. However, since this will make the reporting differ from previous years, it is worth discussing prior to making any changes.

BHRS Discussion on Outreach characteristics and trends

After three years of summarizing comprehensive outreach data, it is imperative that we look at the trends and challenges in outreach from a perspective that considers sociocultural context and its impact on community demographics and the need for updating outreach goals and integration across other BHRS outreach efforts.

Outreach characteristics where we specifically looked at trends across the three fiscal years 2014-2017 included;

1. Outreach Attendees – while there were differences amongst the collaboratives as shown in the report, overall numbers and reach increased.
2. Race/Ethnicity – overall, individuals identifying as Mexican and White increased while other ethnicities decreased, in particular, Other Latino/Central American, Tongan and Samoan and Filipino and Black.
3. Referrals to Mental Health/Substance Abuse –while the total number of referrals made to both mental health and substance use providers decreased by almost half, the percentage of those referred to these services increased. This could point to the idea that outreach is getting more targeted to those with mental health and substance use needs.
4. Referrals to Social Services – the collaboratives differed in the types of referrals, while EPAPMHO primarily refers to medical care, the NCOC primarily refers to legal, and financial. Housing is the main referral type for both collaboratives.
5. Special Populations – Overall, at-risk for homelessness continues to be the highest special populations group reported.

While we are well aware that staff and agency transitions and data reporting/tracking have had direct impact on the outreach numbers; there are also socio-political factors that may influence some of the shifts in racial make-up, referrals made and participant characteristics.

Gentrification

Recent changes in economic, educational and racial make-up of historically disinvested neighborhoods is happening across the Bay Area including the communities served by the Outreach Collaboratives. The Urban Displacement Project (http://www.urbandisplacement.org; Zuk, M., & Chapple, K. (2015), which analyzes regional data and has identified cities such as Colma, Daly City and East Palo Alto susceptible to ongoing and advanced gentrification including loss of low income housing, displacement of low income communities and changing demographics.

Drug Medi-Cal Waiver

In April 2016, San Mateo County was the second in the State of California to receive approval to create a local Drug Medi-Cal Organized Delivery System (DMC-ODS) providing individuals with substance use disorders greater access to a wider range of behavioral healthcare services.

Community-based agency representatives are reporting an increase in more complex co-occurring cases. It will be important to attempt to track the impact of DMC-ODS on outreach.

Immigration policies

The current policy changes impacting immigrants has led undocumented immigrants to avoid safety-net programs. Community based agency representatives across San Mateo County have been reporting a drop in enrollment and eligible families pulling out of health and social service initiatives out of fear of deportation. It is expected that this will impact outreach characteristics.

Tracking of Referrals

Moving forward we will need to strengthen the tracking of unduplicated referrals to behavioral health services to demonstrate specifically how outreach efforts increase access and linkages to treatment and improve timely access for underserved populations. In particular, guidelines released by the State of California Mental Health Oversight and Accountability Commission are requesting the following data points to demonstrate effectiveness of programs funded to create access and linkages to services: 1) number of referrals for Serious Mental Illness (SMI), 2) the type of treatment received, 3) the number that followed through and engaged, 3) average duration of untreated mental illness and 4) average interval between referral and engagement.

Updates to Outreach Collaborative Deliverables

Outreach characteristics as outlined in this report will continue to be collected. It is important to keep the intention of the collaboratives focused on reaching underserved populations in low income communities including at-risk youth, transition-age youth and adults of diverse ethnic and cultural backgrounds. Given the many challenges to tracking and reporting unduplicated reach, the focus will shift to unduplicated referrals made to behavioral health services in particular and follow through where appropriate. Following are overall considerations outlined last year that will be incorporated into 2018 updates to the Outreach Collaborative deliverables.

- ✓ Coordinate and articulate the goals of the outreach collaborative strategy across both the north county region, including Pacifica and the East Palo Alto community.
    - Benchmarks and activities are expected to look different given the unique needs and demographics of each community, but the overall goals should align.
    - Integrate broader outreach and support goals and activities, recognizing the intersection of outreach to increase access for individuals with severe mental illness (SMI) and outreach efforts for prevention, stigma reduction and meaningful engagement.
- ✓ Identify meaningful indicators of success for the outreach collaboratives including tracking SMI referrals and follow through where appropriate.
- ✓ Integrate efforts and activities to include special populations as identified in the AIR report, at-risk for homelessness, older adults and emerging communities and expanded

needs in the broader San Mateo County (e.g. Arab-American, LGBTQ, geographically isolated communities, etc.)

- ✓ Coordinate and articulate MHSA-wide efforts and indicators to measure stigma reduction and improvements in cultural and ethnic disparities as they relate to access to behavioral health services in San Mateo County.

Appendix A. FY 2017-2018 Outreach, Asian American Recovery Services

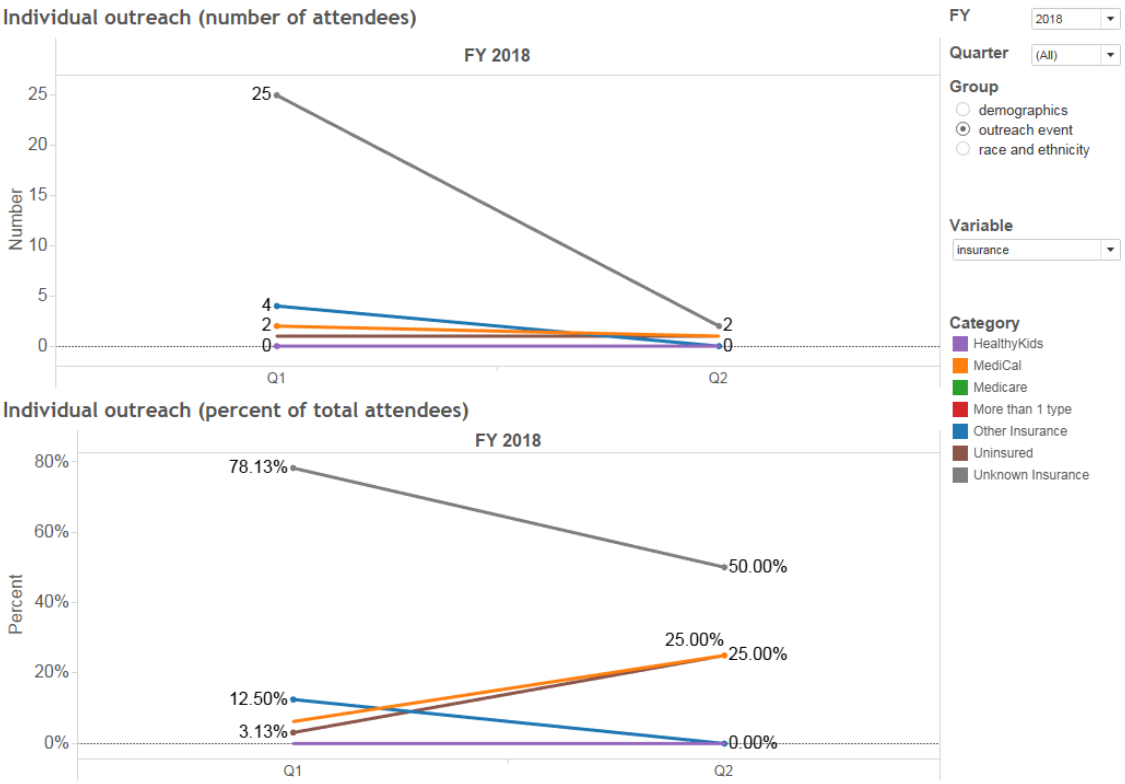
Individual outreach

For FY 2017-2018, Asian American Recovery Services (AARS) reported a total of 36 individual outreach events—32 individual outreach events in Q1, four events in Q2, no events in Q3, and no events in Q4. The average length of individual outreach events was 32 minutes, ranging from an average of 33 minutes in Q1 to 26 minutes in Q2.

Individual outreach events:

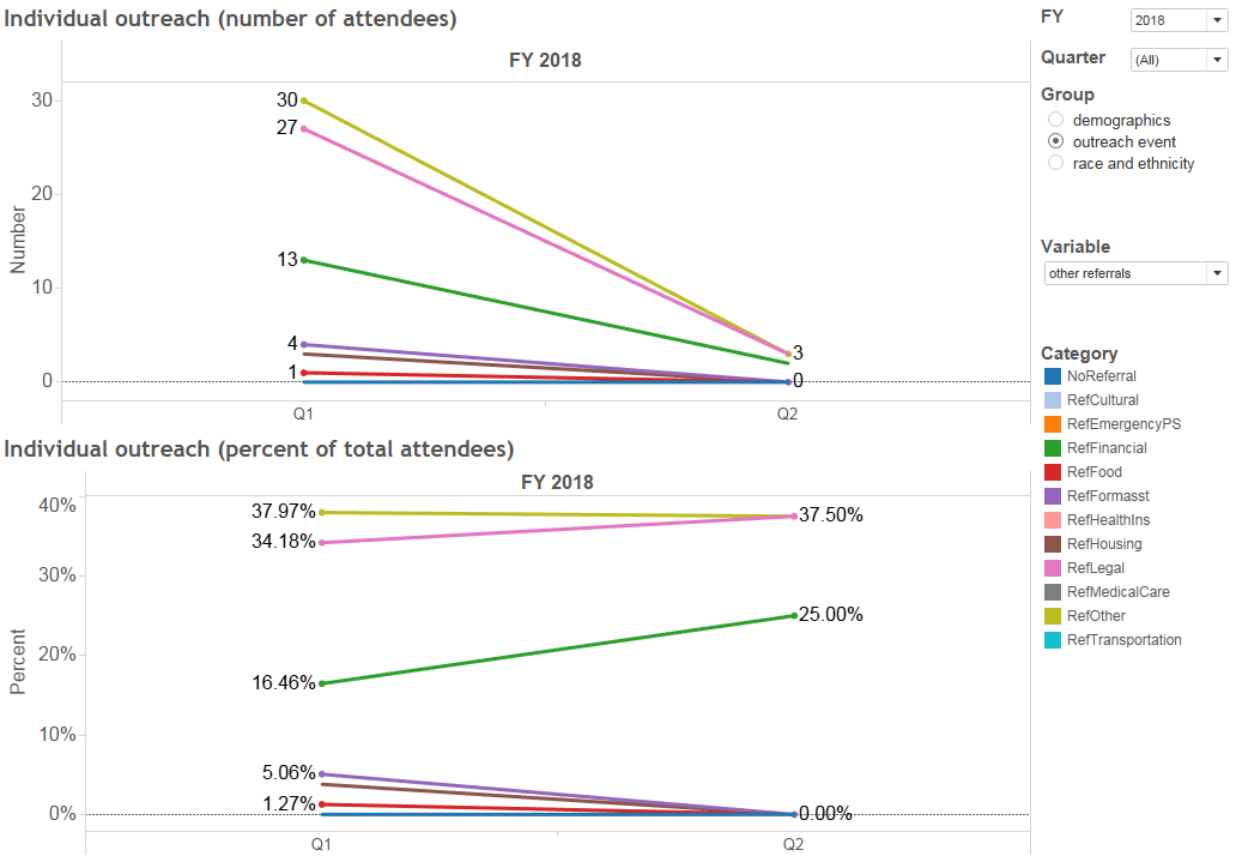
- Most took place in unspecified locations (**55.6%**; n=20), followed by office (**27.8%**, n=10), other community locations (**11.1%**; n=4), and phone (**2.8%**; n=1).
- Were categorized under MAA 401 (**52.8%**; n=19) with (**47.2%**; n=17) N/A
- Were conducted in English (**100%**; n=36).
- Had different types of insurance reported during FY 2017-2018. Unknown insurance and Other Insurance were most common, followed by Medi-Cal and Uninsured (**Figure 1**).

Figure 1. Type of Insurance, Q1-Q4



- Resulted in 16 mental health referrals and 5 substance abuse referrals.
- Resulted in 87 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. AARS made other (n=33), Legal (n=30), and Financial (n=15) referrals the most often.

Figure 2. Other Referrals, Q1-Q4

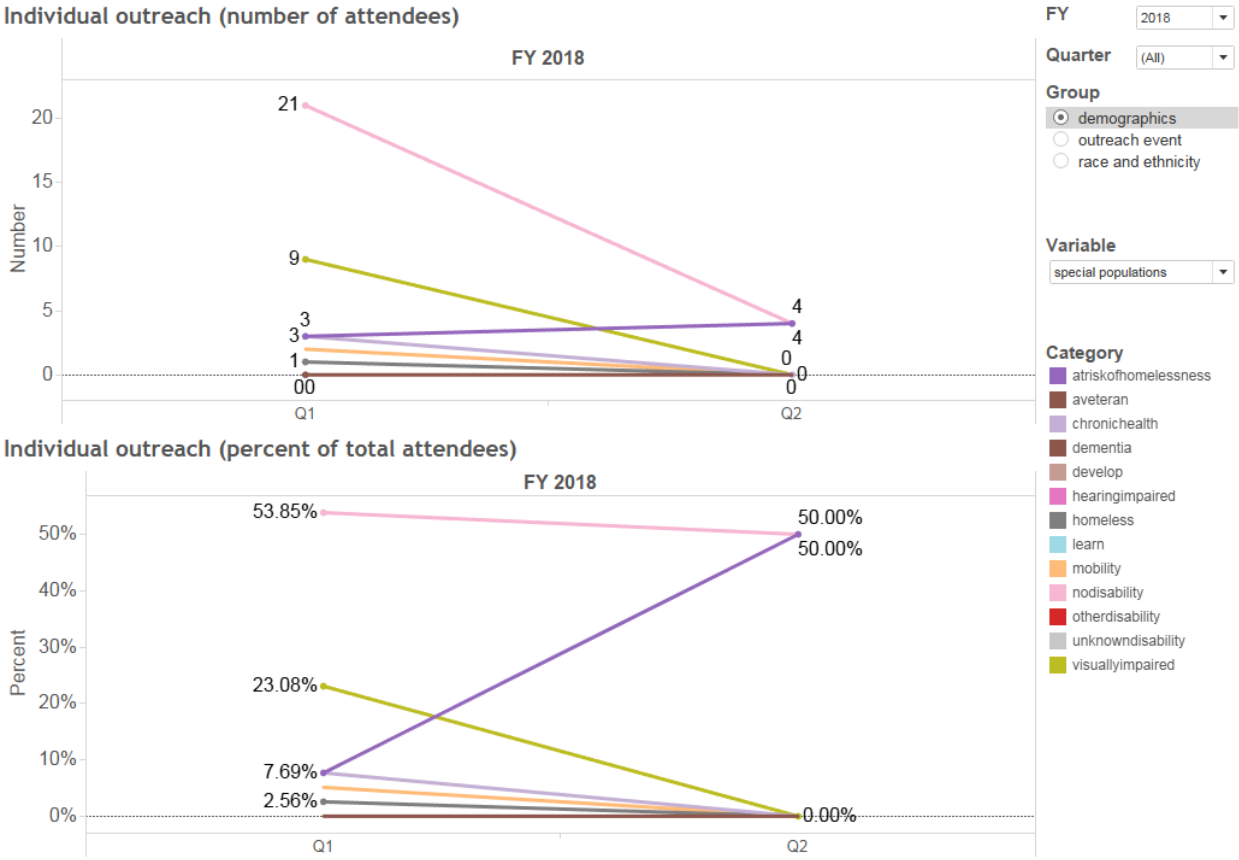


Individual outreach event attendees:

- Self-reported as female (**66.7%**; n=24) and male (**33.3%**; n=12).
- Self-reported as Heterosexual (**72.2%**; n=26), Gay/Lesbian (**13.9%**; n=5) and Questioning (**13.9%**; n=5).
- Were adults (26-59 year, **75%**; n=27), transition-age youth (16-25 years, **13.9%**; n=5), older adults (60+ years, **11.1%**; n=4).
- Were two or more races (**47.2%**; n=17), Samoan (**19.4%**; n=7), Filipino (**13.9%**; n=5), White (**8.3%**; n=3), Tongan (**5.6%**; n=2), Mexican (**2.8%**; n=1), and South Asian (**2.8%**; n=1).

Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. In FY 2017-2018, AARS reported 47 individual outreach attendees representing these populations as presented in **Figure 3**.

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, Asian American Recovery Services (AARS) reported a total of 6 group outreach events, corresponding to 190 group outreach attendees—149 attendees in Q1, 41 attendees in Q2, no attendees in Q3, and no attendees in Q4. The average length of group outreach events is 205 minutes, ranging from an average of 270 minute per event in Q1 to 45 minutes per event in Q4.

Most group outreach events:

- Took place in unspecified locations (**33.3%**; n=2), other community locations (**33.3%**; n=2), school (**16.7%**; n=1), and age-specific community center locations (**16.7%**; n=1).
- Were categorized under MAA 401 (**83.3%**; n=5) and N/A (**16.7%**; n=1).

- Were conducted in English (**100%**; n=6).

Group outreach event attendees:

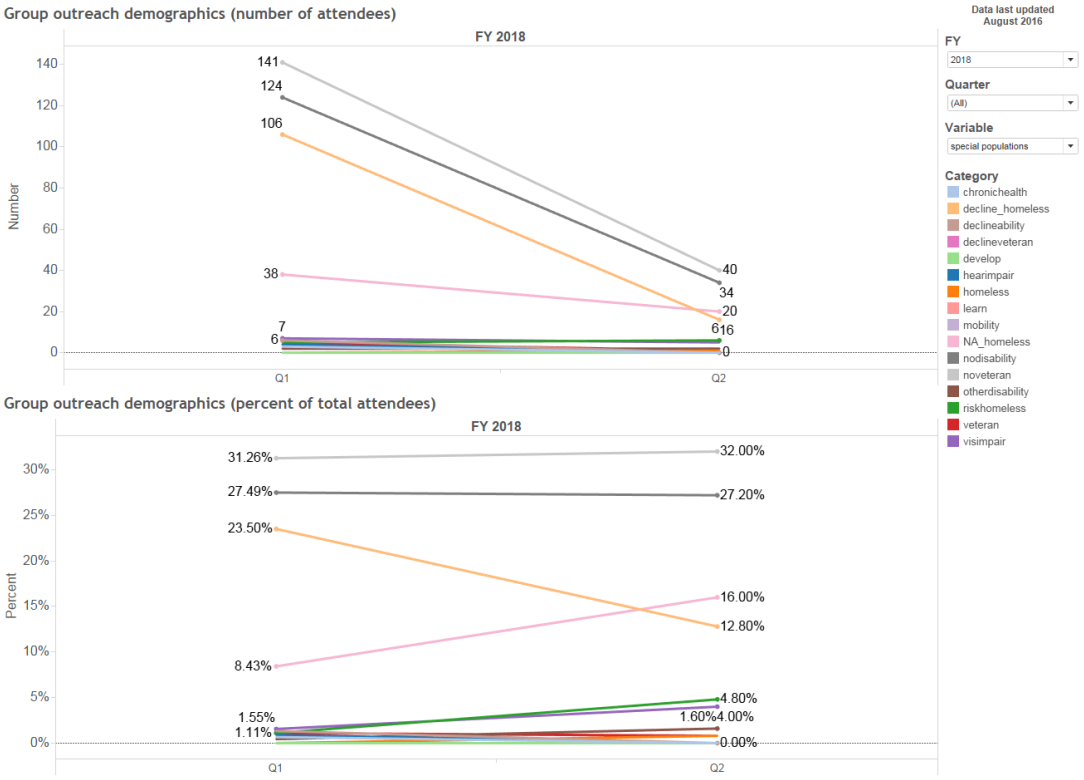
- Self-reported as female (**65.8%**; n=125), male (**33.2%**; n=63), and unknown gender (**1.1%**; n=2).
- Identified as Heterosexual (**80.9%**; n=152), Gay/Lesbian (**6.9%**; n=13), Decline (**6.4%**; n=12), Other (**2.7%**; n=5), Bisexual (**2.1%**; n=4), and Questioning (**1.1%**; n=2).
- Represented many races and ethnicities (**Table 1**):

Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
American Indian	2 (1.1%)	Samoan	23 (12.2%)
Black	4 (2.1%)	South American	1 (0.5%)
Central American	1 (0.5%)	South Asian	1 (0.5%)
Chinese	16 (8.5%)	Tongan	5 (2.6%)
Filipino	13 (6.9%)	Unknown Race	1 (0.5%)
Guamanian	5 (2.6%)	White	29 (15.3%)
Hawaiian	10 (5.3%)		
Japanese	1 (0.5%)		
Mexican	16 (8.5%)		
Two or more races	56 (29.6%)		
Other	5 (2.6%)		

In FY 2017-2018, AARS reported 190 group outreach attendees representing special populations, with the majority of that outreach occurring in Q1 as presented in **Figure 4**. During FY 2017-2018, AARS most commonly reached attendees who were at risk for homelessness (n=11), hearing impaired (n=4), vision impaired (n=12), homeless (n=1), learning disability (n=3), chronic health condition (n=3), physical/mobility disability (n=4), veterans (n=6), other disability (n=4); these categories are not mutually exclusive. Of note, the number of group outreach attendees representing these populations decreased from Q1 to Q2 during FY 2017-2018.

Figure 4. Special Populations, Q1-Q4



Appendix B. FY 2017-2018 Outreach, Daly City Peninsula Partnership Collaborative

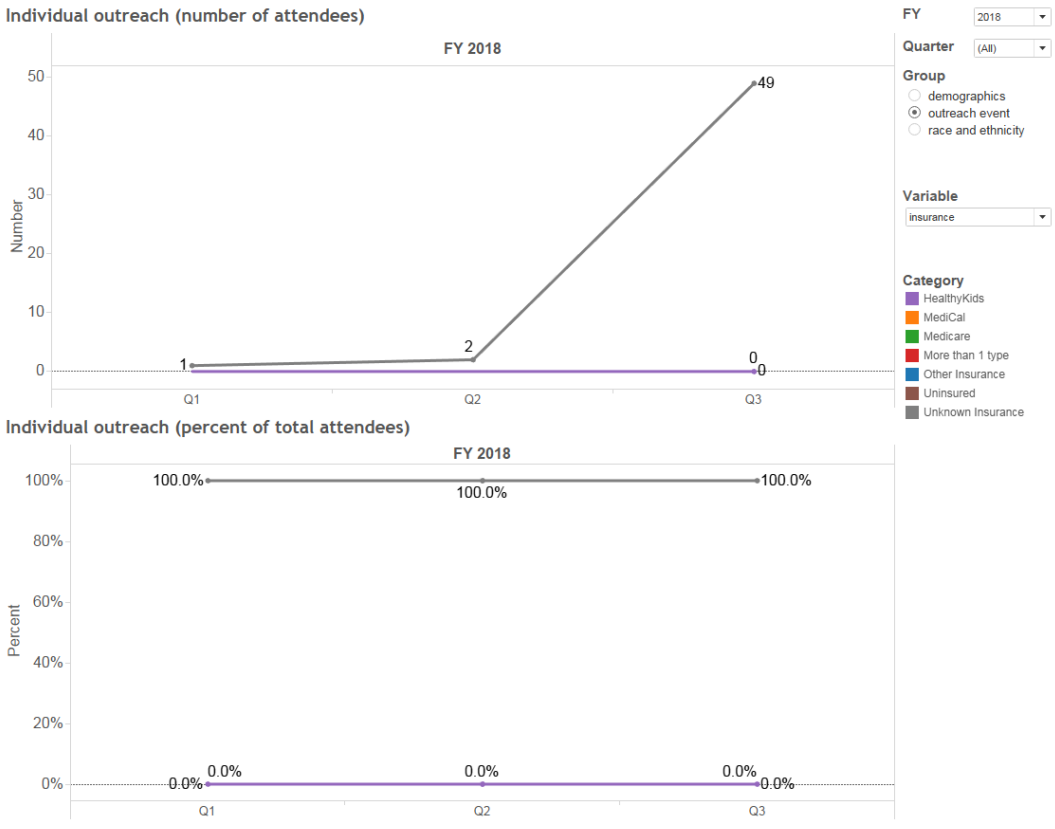
Individual outreach

For FY 2017-2018, Daly City Peninsula Partnership Collaborative reported a total of 52 individual outreach events—One individual outreach events in Q1, two events in Q2, 49 events in Q3, and no events in Q4. The average length of individual outreach events was 114.7 minutes, ranging from an average of 60 minutes in Q1 to 117.6 minutes in Q3.

Individual outreach events:

- Most took place in schools (**94.2%**; n=49), homes (**3.8%**; n=2), and offices (**1.9%**; n=1).
- Were categorized as N/A (**100%**; n=52), there were no MAA codes.
- Were conducted in English (**94.2%**; n=49) and Spanish (**5.8%**; n=3).
- Reported unknown insurance was most common during FY 2017-2018 (**Figure 1**).

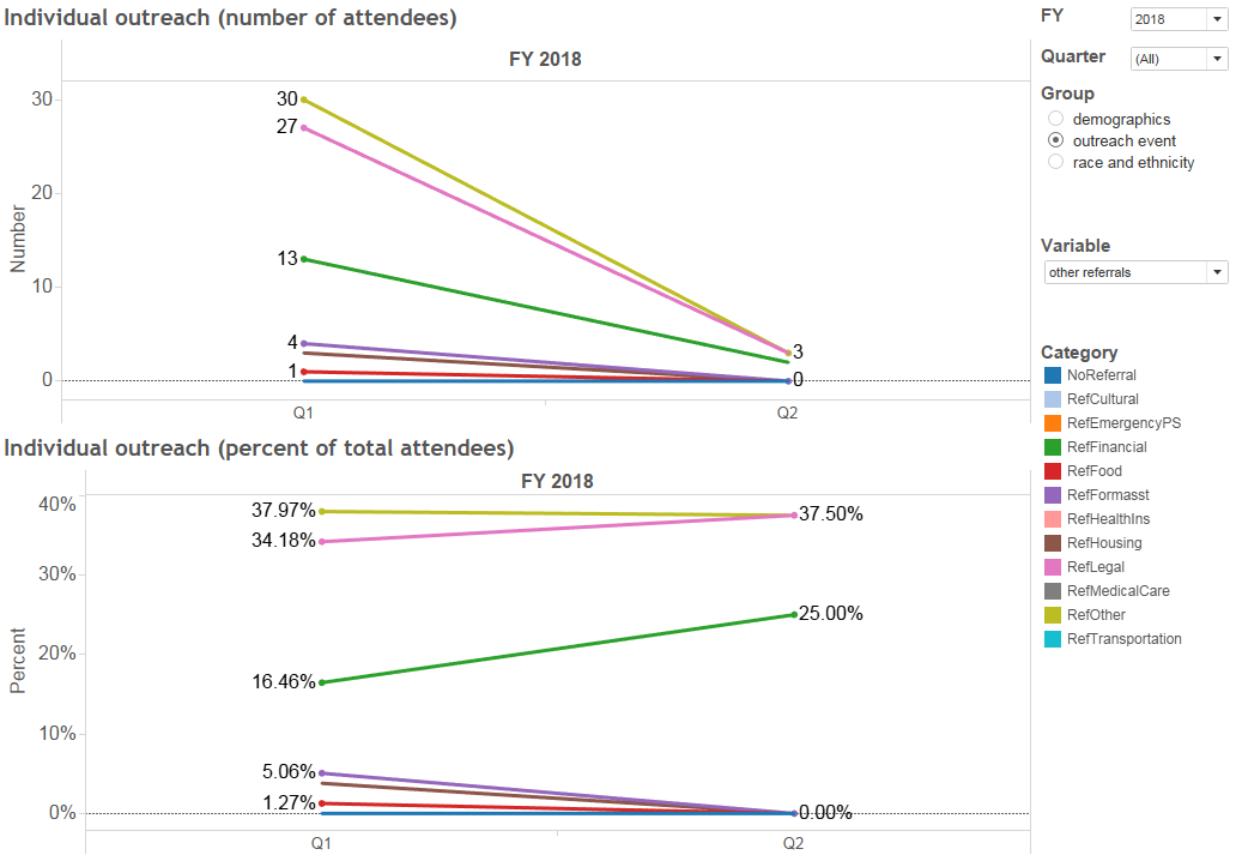
Figure 1. Type of Insurance, Q1-Q4



- Resulted in 2 mental health referrals and no substance abuse referrals.

- Resulted in 151 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Daly City made Food (n=50), Housing (n=49), Cultural (n=47), no referral (n=2), Health Insurance (n=1), Legal (n=1), and Other (n=1).

Figure 2. Other Referrals, Q1-Q4

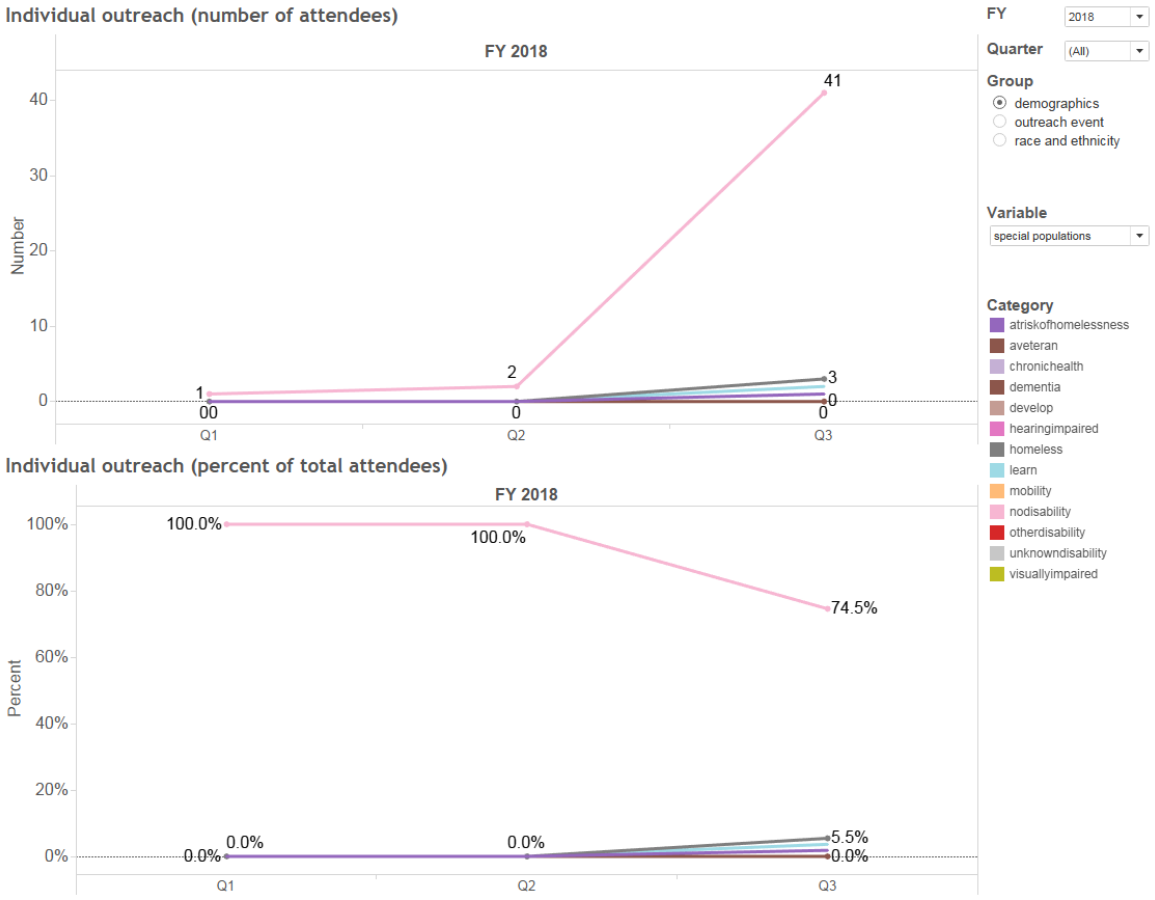


Individual outreach event attendees:

- Self-reported as female (**94.2%**; n=49), male (**3.8%**; n=2), and other gender (**1.9%**; n=1).
- Self-reported as Heterosexual (**67.3%**; n=35), unknown sexual orientation (**25%**; n=13), Gay/Lesbian (**3.8%**; n=2), and Bisexual (**3.8%**; n=2).
- Were adults (26-59 year, **71.2%**; n=37), older adults (60+ years, **19.2%**; n=10), transition-age youth (16-25 years, **5.8%**; n=3), children (0-15 years, **1.9%**; n=1), and decline to state (**1.9%**; n=1).
- Were two or more races (**38.5%**; n=20), Central American (**13.5%**; n=7), Mexican (**11.5%**; n=6), unknown race (**3.8%**; n=2), American Indian (**1.9%**; n=1), Asian (**1.9%**; n=1), Black (**1.9%**; n=1), Caribbean (**1.9%**; n=1), Eastern European (**1.9%**; n=1), European (**1.9%**; n=1), Filipino (**1.9%**; n=1), and South American (**1.9%**; n=1).

Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. In FY 2017-2018, AARS reported 58 individual outreach attendees representing these populations as presented in **Figure 3**.

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, Daly City Peninsula Partnership Collaborative reported a total of two group outreach events, corresponding to 110 group outreach attendees—no attendees in Q1, no attendees in Q2, 110 attendees in Q3, and no attendees in Q4. The average length of group outreach events is 61 minutes in Q3.

Most group outreach events:

- Took place in unspecified locations (**33.3%**; n=2), other community locations (**33.3%**; n=2), school (**16.7%**; n=1), and age-specific community center locations (**16.7%**; n=1).
- Were categorized under N/A (**100%**; n=2), there were no MAA codes.

- Were conducted in English (**100%**; n=2).

Group outreach event attendees:

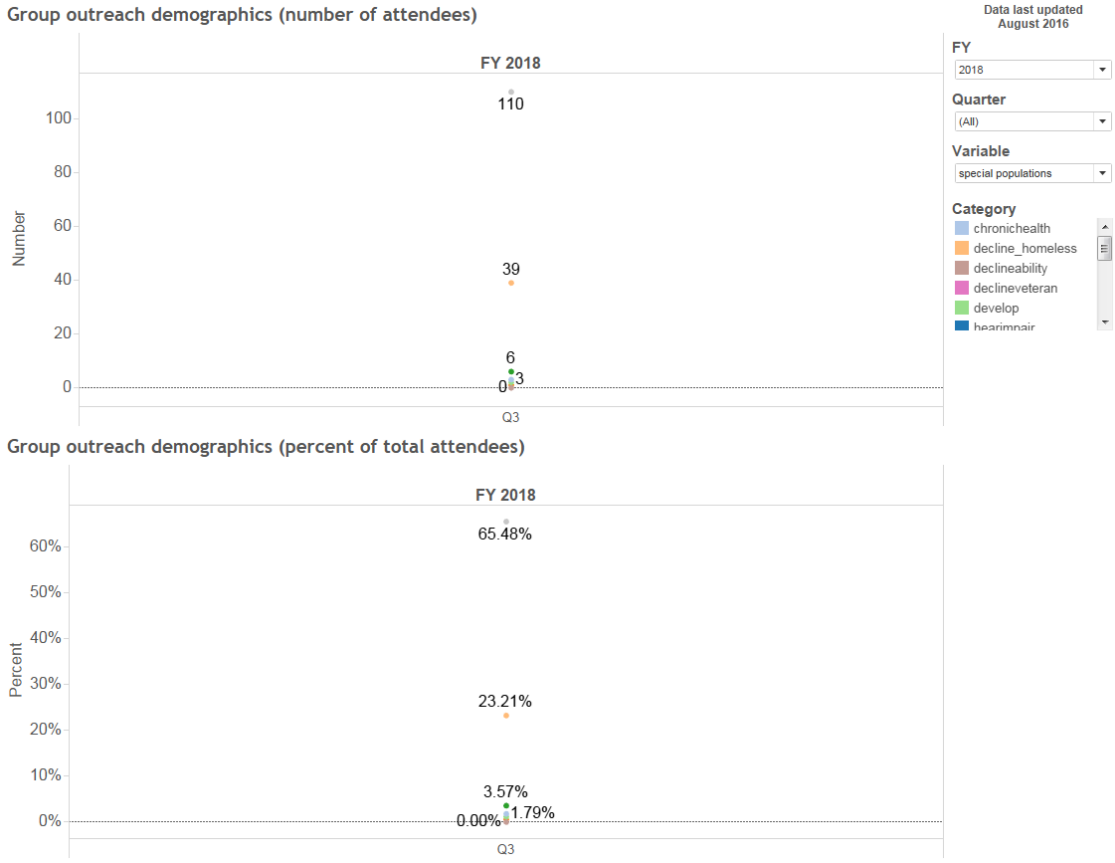
- Self-reported as female (**89.1%**; n=98) and male (**10.9%**; n=12).
- Identified as Heterosexual (**89.1%**; n=98), Gay/Lesbian (**7.3%**; n=8), Decline (**2.7%**; n=3), and Bisexual (**1%**; n=1).
- Represented many races and ethnicities (**Table 1**):

Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
Asian	6 (5.5%)	Mexican	16 (14.5%)
Black	5 (4.5%)	Middle Eastern	7 (6.4%)
Central American	6 (5.5%)	Two or more races	8 (7.3%)
Chinese	3 (2.7%)	Unknown race	8 (7.3%)
Filipino	37 (33.6%)	White	14 (12.7%)

In FY 2017-2018, Daly City Peninsula Partnership Collaborative reported 168 group outreach attendees representing special populations, with the majority of that outreach occurring in Q3 as presented in **Figure 4**. During FY 2017-2018, Daly City Peninsula Partnership Collaborative most commonly reached attendees who were at risk for homelessness (n=6), had chronic health conditions (n=3), had physical/mobility disabilities (n=2), learning disability (n=2), hearing impaired (n=2), developmental disability (n=2), and homeless (n=1); these categories are not mutually exclusive.

Figure 4. Special Populations, Q1-Q4



Appendix C. FY 2017-2018 Outreach, Daly City Youth Health Center

Individual outreach

Daly City Youth Health Center did not report any data on individual outreach encounters during FY 2017-2018.

Group outreach

For FY 2017-2018, Daly City Youth Health Center reported a total of 11 group outreach events, corresponding to 520 group outreach event attendees—186 attendees in Q1, 129 attendees in Q2, 205 attendees in Q3, and no attendees in Q4. The average length of group outreach events was 123 minutes, ranging from an average of 178 minutes per event in Q1 to 112 minutes per event in Q3.

Most group outreach events:

- Took place primarily in schools (**63.6%**; n=7), followed by other community locations (**27.2%**; n=3), and office (**9%**; n=1)
- Were reported as N/A (**100%**; n=11) under MAA.
- Were conducted in English (**100%**; n=11).

Group outreach event attendees:

- Self-reported as female (**67.1%**; n=349), male (**31.5%**; n=164), and unknown gender (**1.3%**; n=7).
- Identified primarily as Bisexual (**2.9%**; n=15), Decline (**44.3%**; n=230), Gay/Lesbian (**7.5%**; n=39), Heterosexual (**44.3%**; n=230), or Questioning (**0.8%**; n=4).
- Represented many races and ethnicities (**Table 1**).

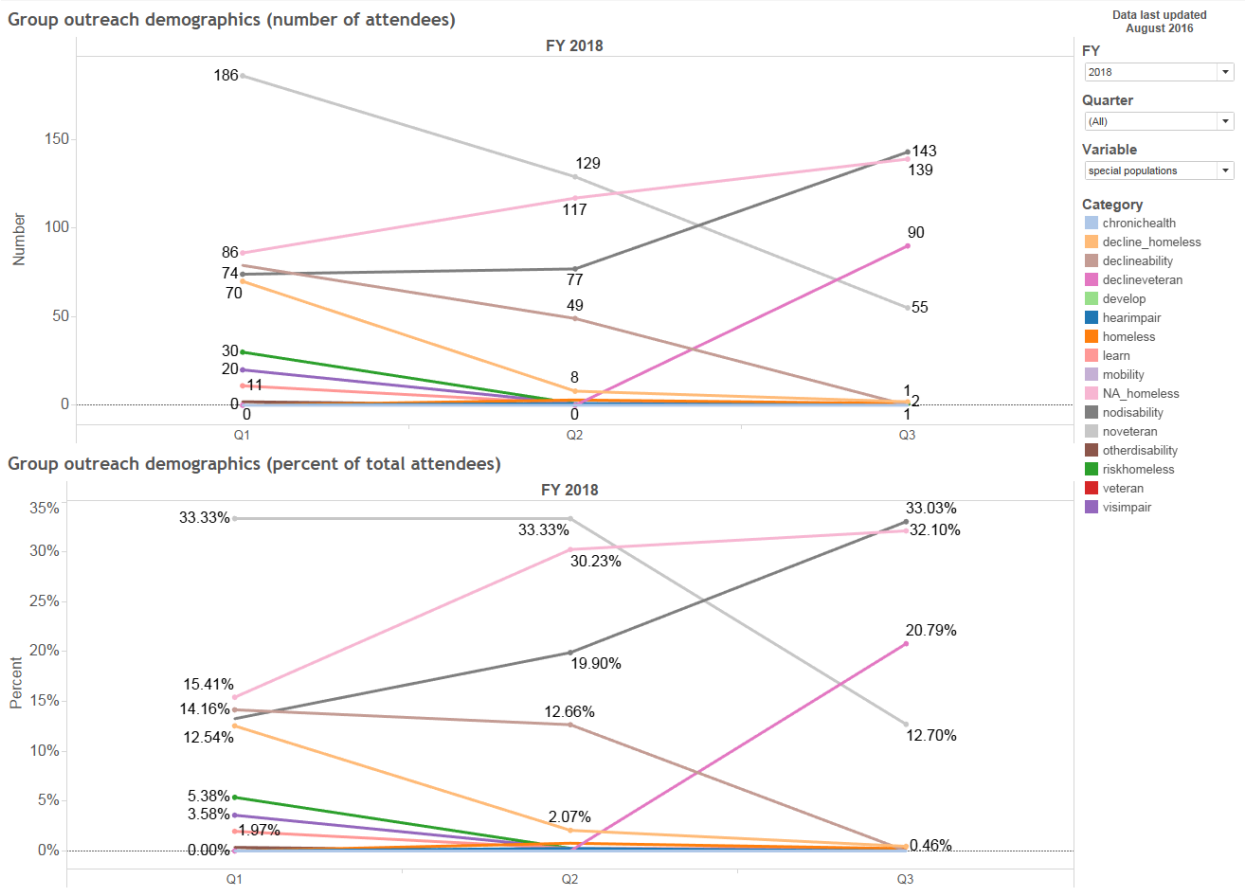
Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
American Indian	1 (0.2%)	Other	23(4.4%)
Asian	6 (1.1%)	South American	4 (0.8%)
Black	31 (5.9%)	South Asian	8 (1.5%)
Central American	13 (2.4%)	Unknown	14 (2.7%)
Chinese	34 (6.5%)	White	26 (5%)
Filipino	166 (31.8%)		
Hawaiian	1 (0.2%)		

Mexican	140 (26.8%)		
Two or more races	37 (7.1%)		

In FY 2017-2018, Daly City Youth Health Center reported 11 group outreach attendees representing special populations, with the majority of that outreach occurring in Q2 as presented in **Figure 4**. During FY 2017-2018, Daly City Youth Health Center most commonly reached attendees who had learning difficulty (n=13), hearing impaired (n=1), homeless (n=4), learning disability (n=13), were at risk for homelessness (n=32), vision impaired (n=22), and/or other disability (n=2); these categories are not mutually exclusive. Of note, the number of group outreach attendees representing these populations decreased from Q1 to Q2 but increased from Q2 to Q3 during FY 2017-2018. No special populations were reported in Q4.

Figure 4. Special Populations, Q1-Q4



Appendix D. FY 2017-2018 Outreach, El Concilio

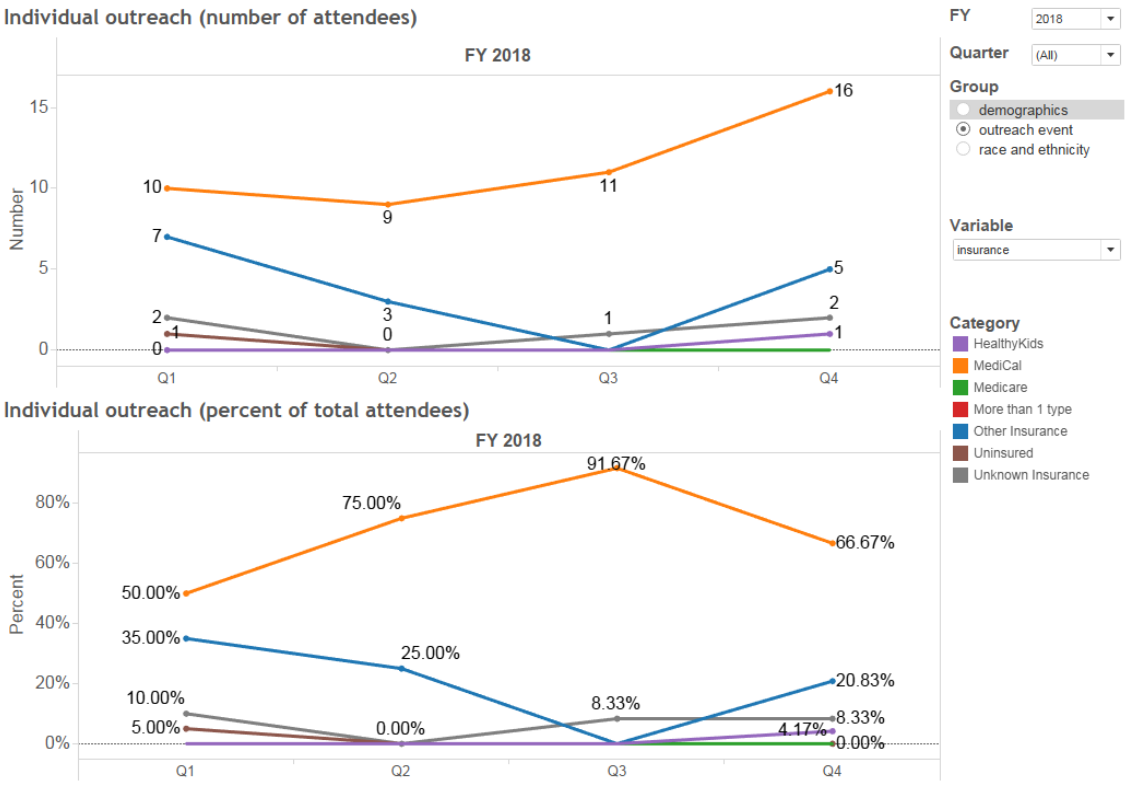
Individual outreach

For FY 2017-2018, El Concilio reported a total of 68 individual outreach events—20 individual outreach events in Q1, 12 events in Q2, 12 events in Q3, and 24 events in Q4. The average length of individual outreach events was 18 minutes, ranging from an average of 21 minutes in Q1 to 16 minutes in Q3.

Most individual outreach events:

- Took place in the office (**91.1%**; n=62), followed by other community locations (**7.4%;** n=5), and Unspecified (**1.5%**; n=1).
- Were categorized under MAA 400 (**47.1%**; n=32) and (**52.9%**; n=36) reported N/A.
- Were conducted in Spanish (**50%**; n=34), or English (**50%**; n=34).
- Medi-Cal as the most common insurance type, followed by Other Insurance, Unknown Insurance, HealthyKids, and Uninsured (**Figure 1**).

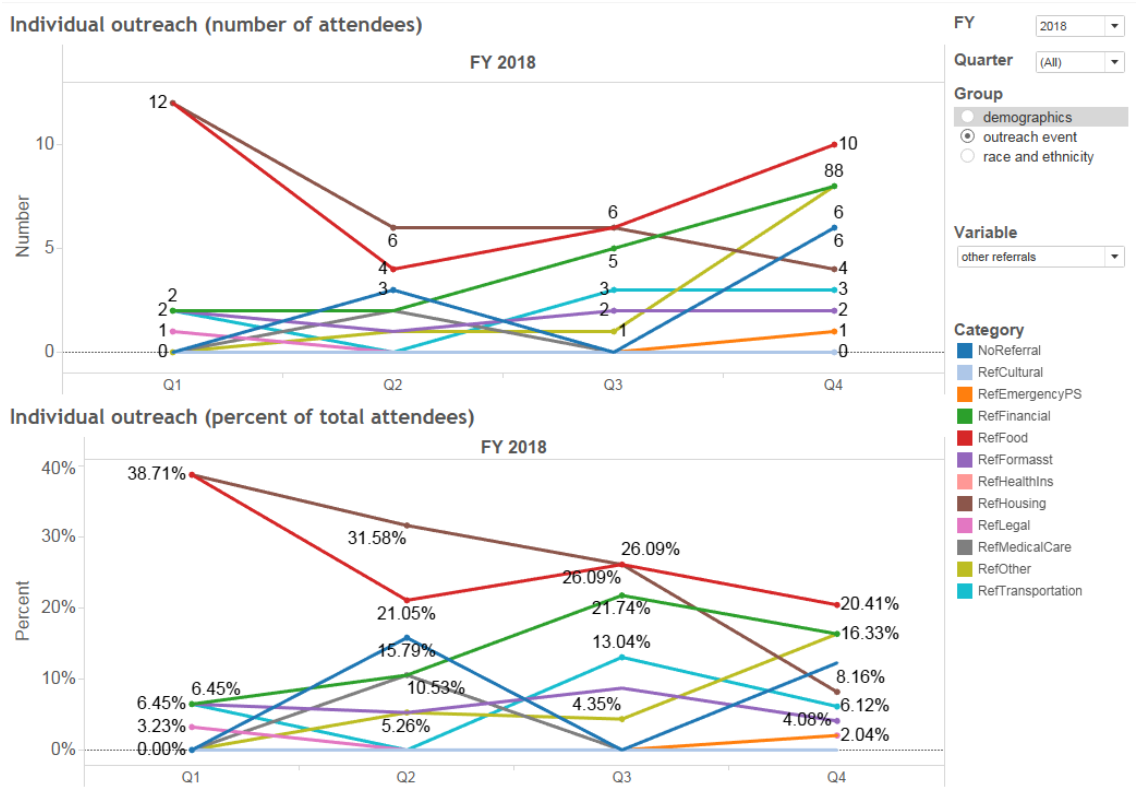
Figure 1. Type of Insurance, Q1-Q4



- Resulted in 15 mental health referrals and 2 substance abuse referrals.

- Resulted in 122 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. El Concilio primarily made referrals to Food (**26.2%**; n=32), Housing (**23%;** n=28), Financial (**13.9%;** n=17), Other referrals (**8.2%;** n=10), Medical Care (**6.6%;** n=8), Transportation (**6.6%;** n=8), Form Assistance (**5.7%**; n=7), Legal (**1.6%**; n=2), and Emergency Protective Services (**0.8%**; n=1).

Figure 2. Other Referrals, Q1-Q4



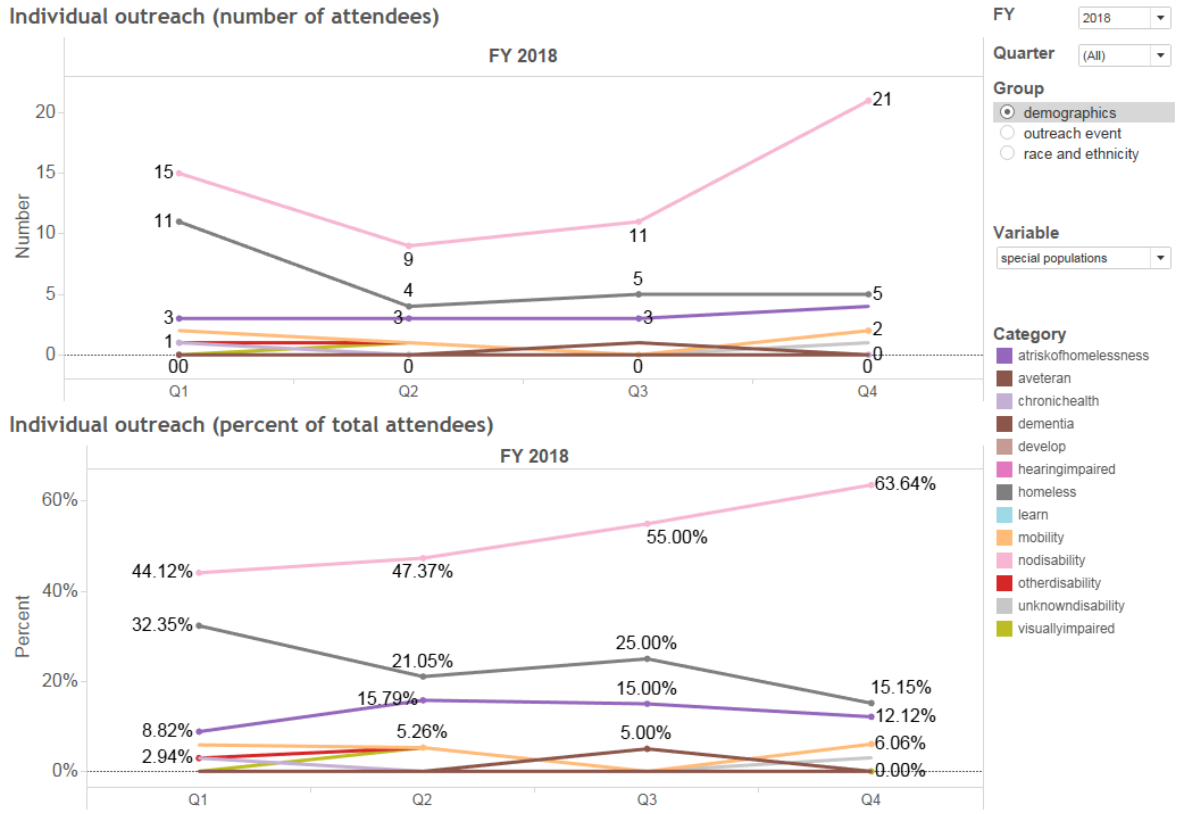
Individual outreach event attendees:

- Self-reported as female (**86.8%**; n=59) or male (**13.2%**; n=9).
- Self-reported primarily as Heterosexual (**97.1%;** n=66), Bisexual (**1.5%**; n=1), and LGBT (**1.5%**; n=1).
- Were adults (26-59 years, **66.2%**; n=45), older adults (60+ years, **22.1%**; n=15), transition-age youth (16-25 years, **10.3%**; n=7), and children, youth (0-15 years, **1.5%**; n=1).
- Were primarily two or more races (**45.6%;** n=31), Black (**26.5%;** n=18), White (**17.6%;** n=12), Mexican (**8.8%;** n=6), and Unknown Race (**1.5%**; n=1)

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in

mobility, learning, or development. In FY 2017-2018, El Concilio reported 106 individual outreach event attendees representing these populations in **Figure 3**.

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, El Concilio reported a total of one group outreach event, corresponding to 38 group outreach event attendees—all of them were in Q1. The average length of group outreach events was 45 minutes in Q1.

Most group outreach events:

- Took place in faith-based church/temple (**100%**; n=1).
- Were categorized under MAA 400 (**100%**; n=1).
- Were conducted in English (**100%**; n=1).

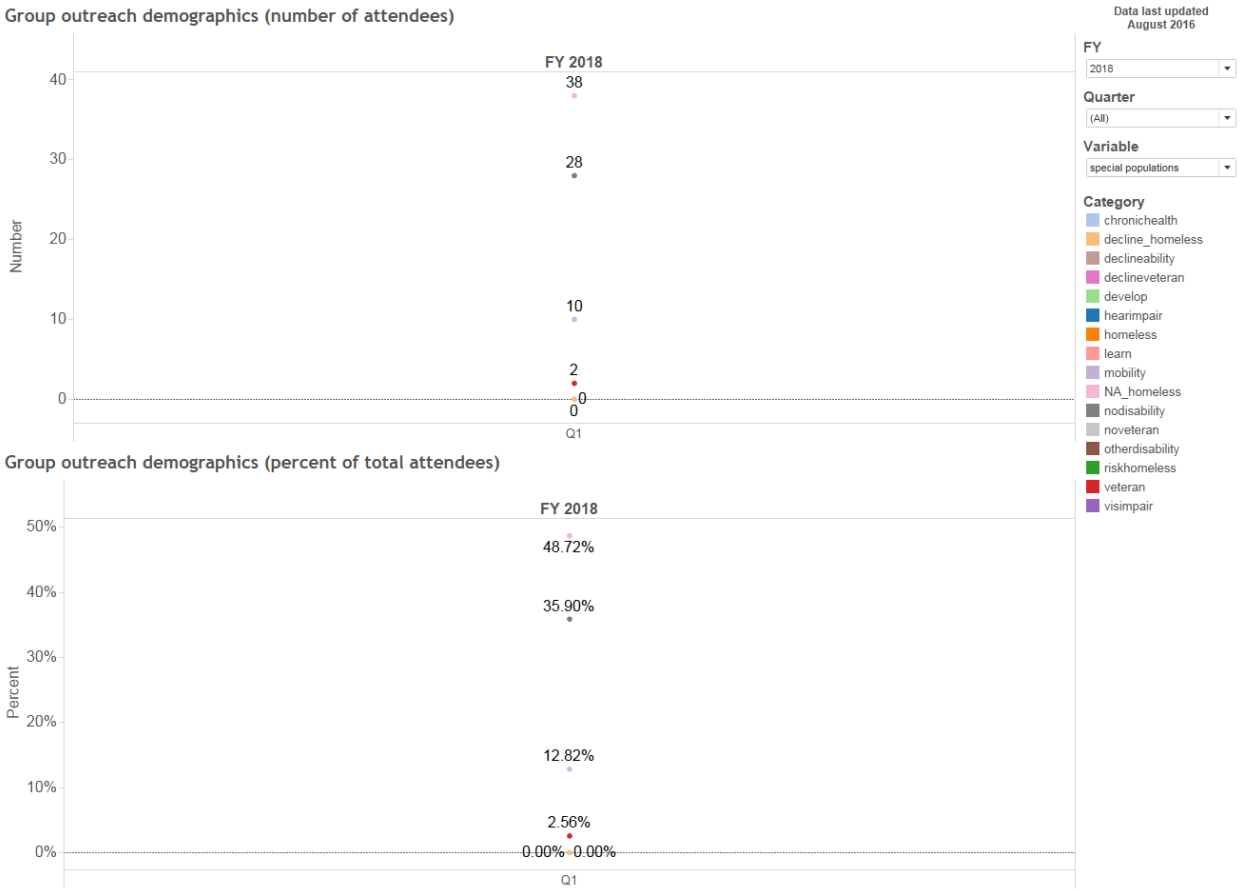
Group outreach event attendees:

- Self-reported as female (**78.9%**; n=30), or male (**21%**; n=8).
- Identified as Heterosexual (**100%;** n=38).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity			
Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
Black	38 (92.7%)		
Other	2 (4.9%)		
Two or more races	1 (2.4%)		

In FY 2017-2018, El Concilio reported 38 group outreach attendees representing special populations, with the majority of that outreach occurring in Q1 as presented in Figure 4. During FY 2017-2018, El Concilio reached attendees who were veterans (n=2) and chronic health conditions (n=10).

Figure 4. Special Populations, Q1-Q4



Appendix E. FY 2017-2018 Outreach, Free At Last

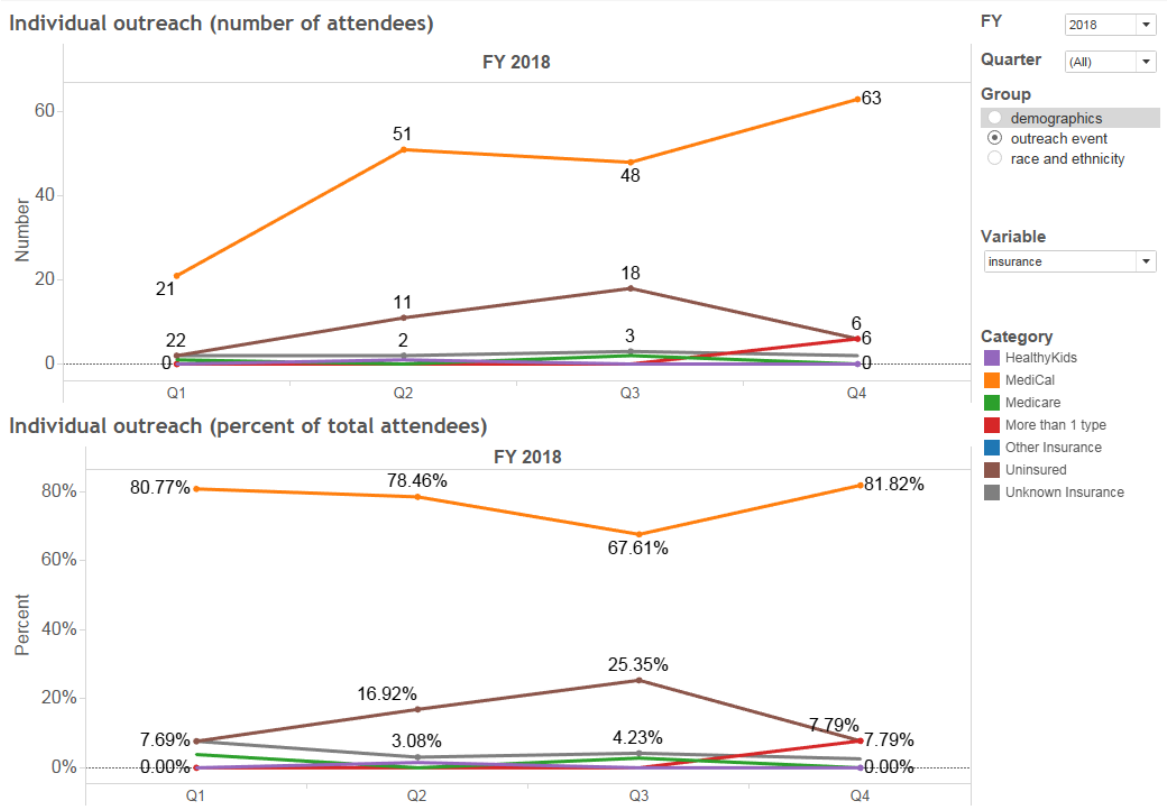
Individual outreach

For FY 2017-2018, Free At Last reported a total of 239 individual outreach events—26 individual outreach events in Q1, 65 events in Q2, 71 events in Q3, and 77 events in Q4. The average length of individual outreach events was 31 minutes, ranging from an average of 28 minutes in Q1 to 31 minutes in Q2.

Most individual outreach events:

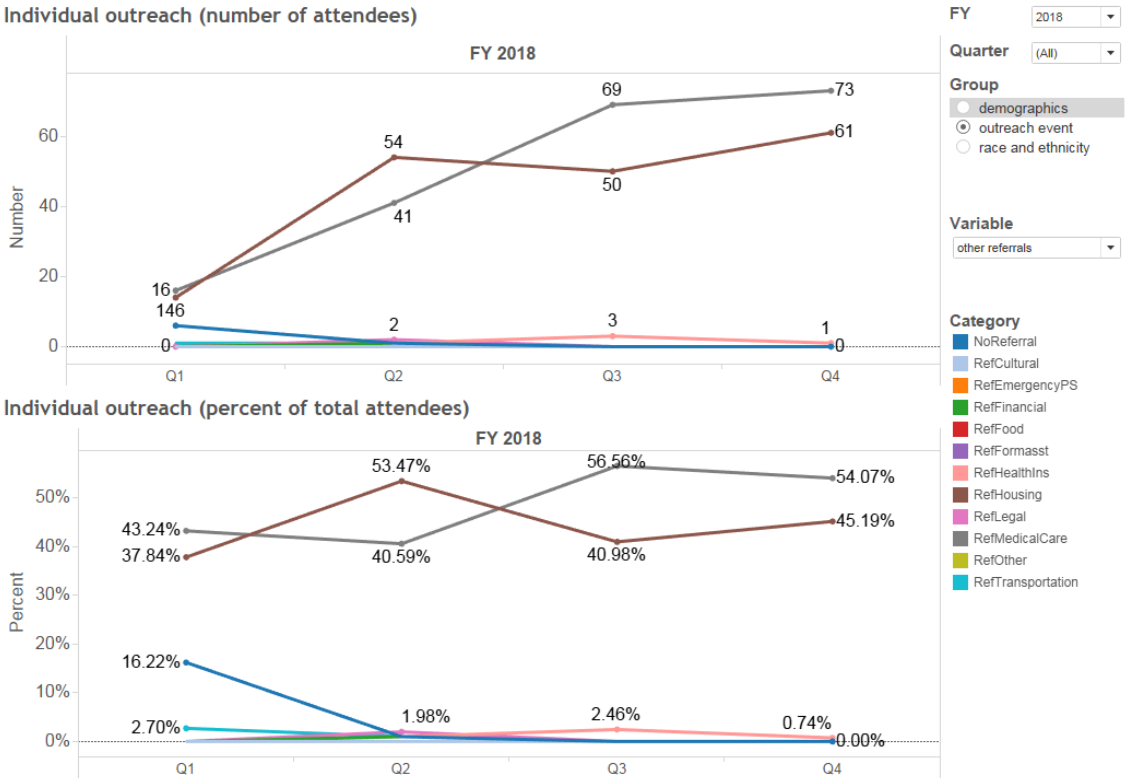
- Took place primarily in unspecified locations (**69.5%**; n=166), and in the office (**30.5%**; n=73).
- Were categorized as MAA 401 (**5%**; n=12) or 400 (**2.9%**; n=7). There were N/A (**92.1%;** n=220).
- Were conducted in English (**82%**; n=196), Spanish (**17.2%**; n=41), or Samoan (**0.8%**; n=2).
- Were mostly with the uninsured (**15.5%;** n=37). For those whose insurance was known, Medi-Cal was the most common insurance type (**Figure 1**).

Figure 1. Type of Insurance, Q1-Q4



- Resulted in 36 mental health referrals and 159 substance abuse referrals.
- Resulted in 395 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Free At Last primarily made referrals to Housing (**45.3%**; n=179) and Medical Care (**50.4%**; n=199), followed by No Referrals (**1.8%**; n=7), Health Insurance (n=5), Transportation (**0.5%**; n=2), Legal (**0.5%**; n=2), and Financial (**0.3%**; n=1).

Figure 2. Other Referrals, Q1-Q4



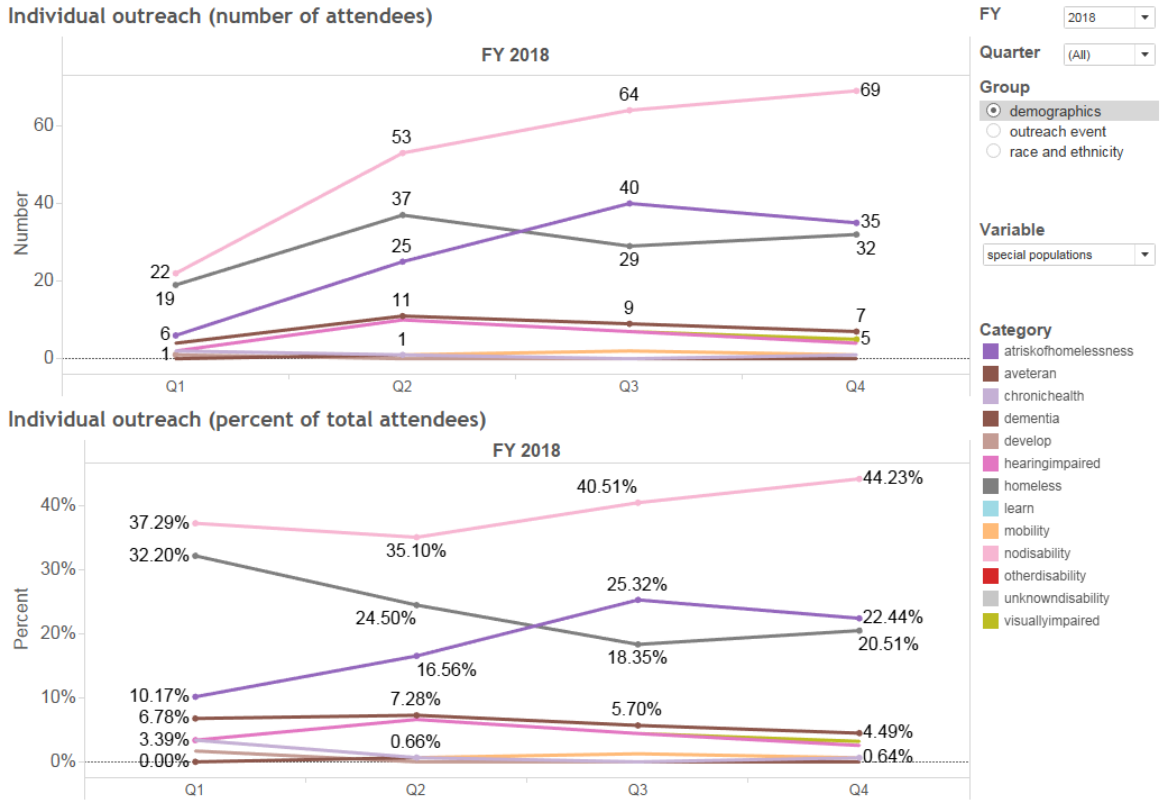
Individual outreach event attendees:

- Self-reported as male (**59.4%**; n=142), female (**40.6%**; n=97).
- Self-reported primarily as Heterosexual (**66.5%;** n=159), Bisexual (**16.7%;** n=40), and Gay/Lesbian (**10.9%;** n=26). Pansexual (**1.7%**; n=4), Multi Queer (**1.3%**; n=3), Questioning (**1.3%**; n=3), and Unknown (**0.4%**; n=1).
- Were adults (26-59 years, **72.8%**; n=174), transition-age youth (16-25 years, **17.2%**; n=41), or older adults (60+ years, **10%**; n=24).

- Were primarily Black (**51.1%**; n=122), Mexican (**15.1%**; n=36), White (**11.7%**; n=28), with two or more races (**8%**; n=19), Tongan (**3.8%**; n=9), Filipino (**2.9%**; n=7), Central American (**2.1%**; n=5), Hawaiian (**1.7%**; n=4), Samoan (**0.8%**; n=2), Other Race (**0.8%**;n=2), American Indian (**0.4%**; n=1), Fijan (**0.4%**; n=1), Puerto Rican (**0.4%**; n=1), South American (**0.4%**; n=1), and South Asian (**0.4%**; n=1).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2017-2018, Free At Last reported 524 individual outreach attendees representing these populations (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

Free At Last did not report any data on group outreach encounters during FY 2017-2018.

Appendix F. FY 2017-2018 Outreach, Multicultural Counseling and Education Services of the Bay Area

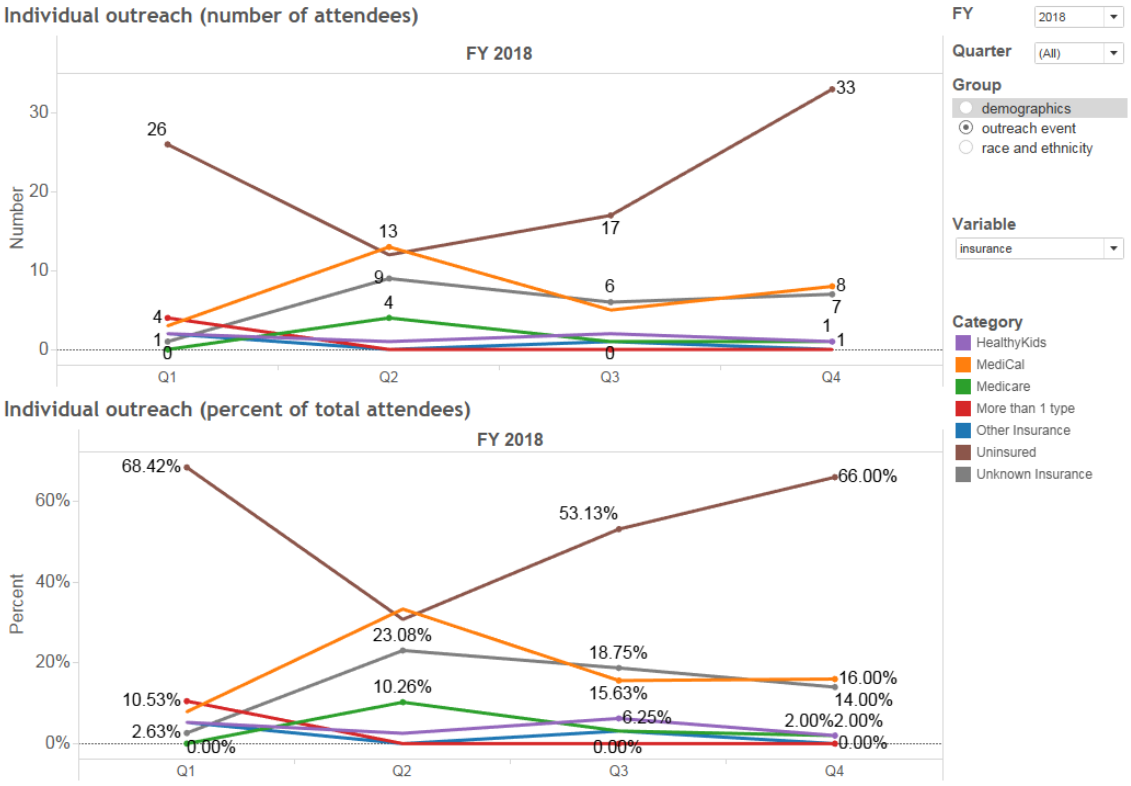
Individual outreach

For FY 2017-2018, Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported a total of 159 individual outreach events—38 individual outreach events in Q1, 39 events in Q2, 32 events in Q3, and 50 events in Q4. The average length of individual outreach events is 56 minutes, ranging from an average of 48 minutes in Q4 to 62 minutes in Q2.

Most individual outreach events:

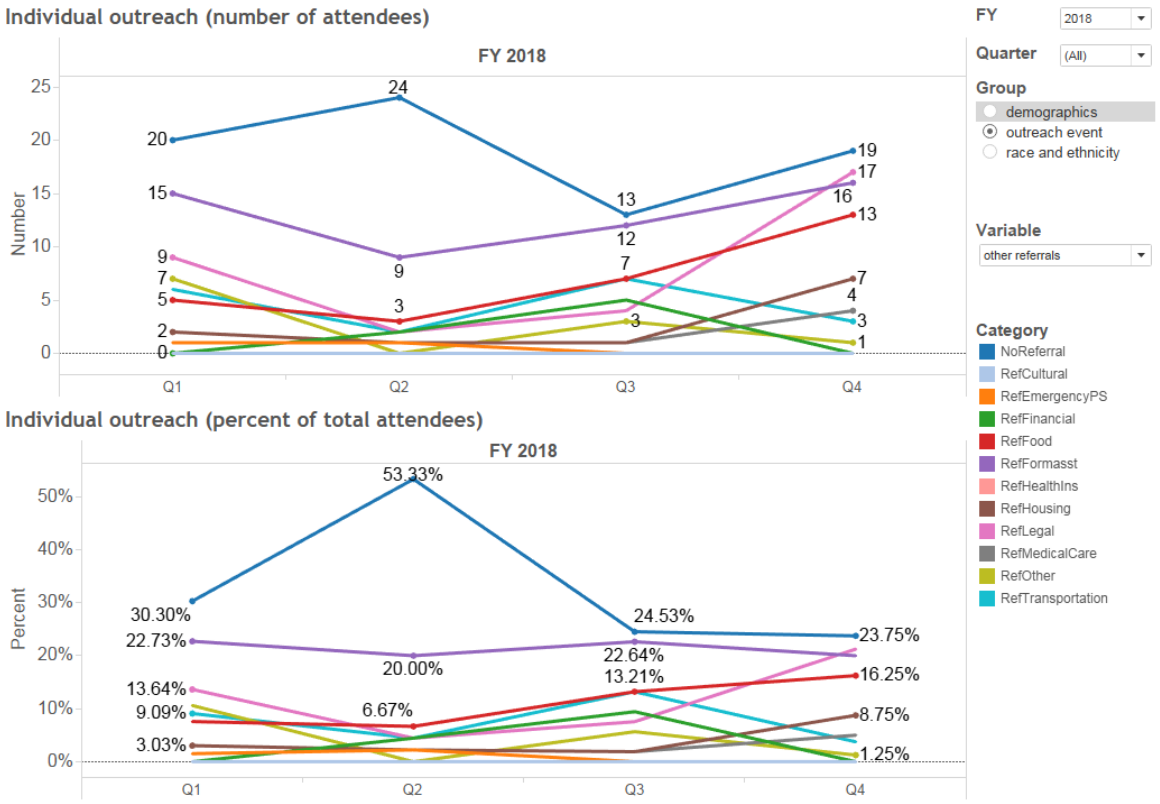
- Took place in home (**38.4%**; n=61), phone (**21.4%**; n=34), non-traditional locations (**9.4%;** n=15), age-specific community center (**9.4%;** n=15), other community locations (**5.7%;** n=9), unspecified locations (**3.8%;** n=6), faith-based church/temple (**3.1%**; n=5), school (**2.5%**; n=4), job site (**2.5%**; n=4), and health/primary care clinic (**0.6%**; n=1).
- Were categorized under MAA 400 (**45.3%**; n=72). There were N/A (**54.7%**; n=87).
- Were conducted in English (**57.2%**; n=91), Tongan (**30%**; n=47), or Samoan (**13.2%**; n=21).
- Were mostly with the uninsured (**55.3%**; n=88) and unknown (**14.5%**; n=23). For those whose insurance was known, Medi-Cal (**18.2%**; n=29) was most common insurance type. Followed by HealthyKids (**3.8%**; n=6), Medicare (**3.8%**; n=6), more than one type of insurance (**2.5%**; n=4), and other insurance (**1.9%**; n=3) (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4



- Resulted in 92 mental health referrals and 12 substance abuse referrals.
- Resulted in 244 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. For MCESBA there were no referrals (**31%**; n=76). MCESBA primarily made referrals to Form Assistance (**21.3%**; n=52), Legal (**13.1%**; n=32), Food (**11.5%**; n=28), Transportation (**7.4%**; n=18), Housing (**4.5%**; n=11), other referrals (**4.5%**; n=11), Financial (**2.9%**; n=7), Medical Care (**2.9%**; n=7), and Emergency/Protective services (**0.8%**; n=2).

Figure 2. Other Referrals, Q1-Q4

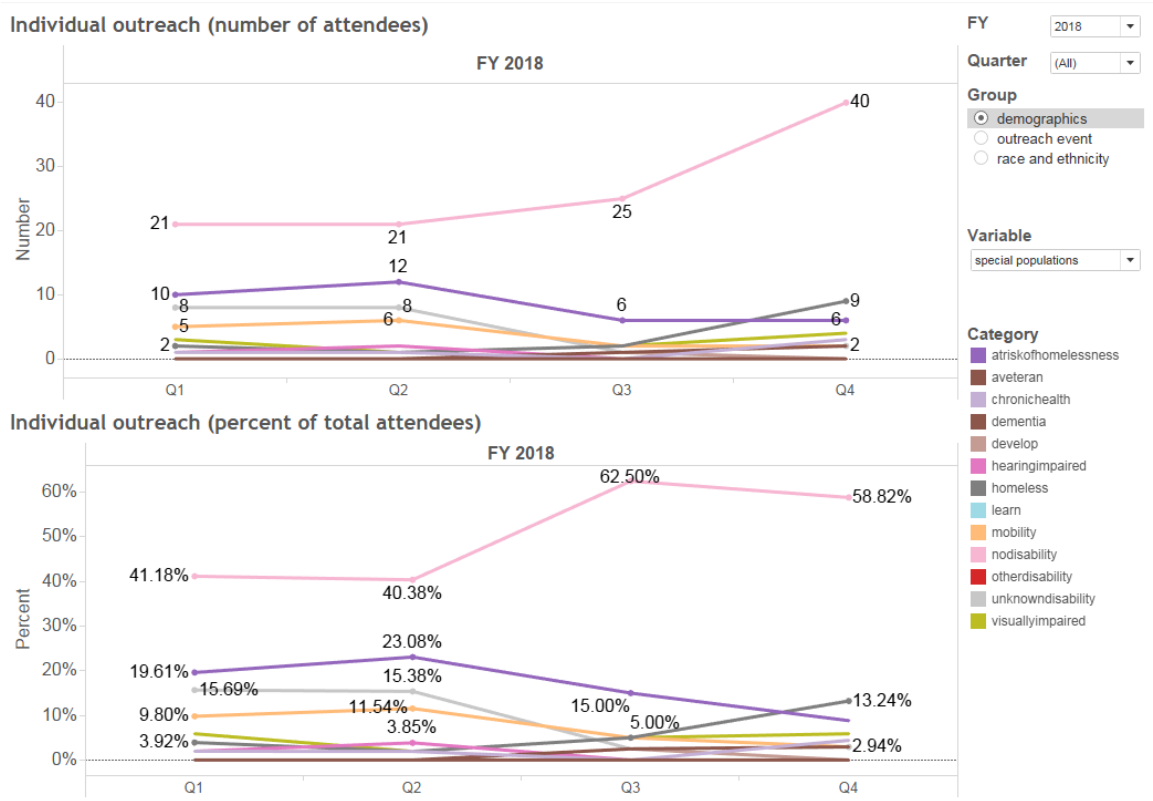


Individual outreach event attendees:

- Self-reported as female (**53.5%**; n=85), male (**45.9%**; n=73), and other gender (**0.6%**; n=1).
- Self-reported as Heterosexual (**89.9%;** n=143), Gay/Lesbian (**8.8%;** n=11), Bisexual (**2.5%;** n=4), and Questioning (**0.6%**; n=1).
- Were transition-age youth (16-25 years, **47.2%**; n=91), adults (26-59 years, **25.2%**; n=40), older adults (60+ years, **15.7%**; n=25), and Decline to state (**1.9%**; n=3)
- Were primarily Tongan (**30.8%**; n=72), two or more races (**24.5%**; n=39), Samoan (**20.8%**; n=33), Black (**5%**; n=8), White (**1.9%;** n=3), Fijian (**0.6%**; n=1), Hawaiian (**0.6%**; n=1), Mexican (**0.6%**; n=1), and unknown race (**0.6%**; n=1).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2017-2018, MCESBA reported 211 individual outreach event attendees representing these populations (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, MCESBA reported a total of one group outreach events, corresponding to seven group outreach event attendees—no attendees in Q1, no attendees in Q2, no attendees in Q3, and seven attendees in Q4. The average length of group outreach events is 45 minutes in Q4.

Most group outreach events:

- Took place in faith-based church/temple (**100%**; n=1).
- Were reported N/A (**100%**; n=1) under MAA.
- Were conducted in English (**100%**; n=1).

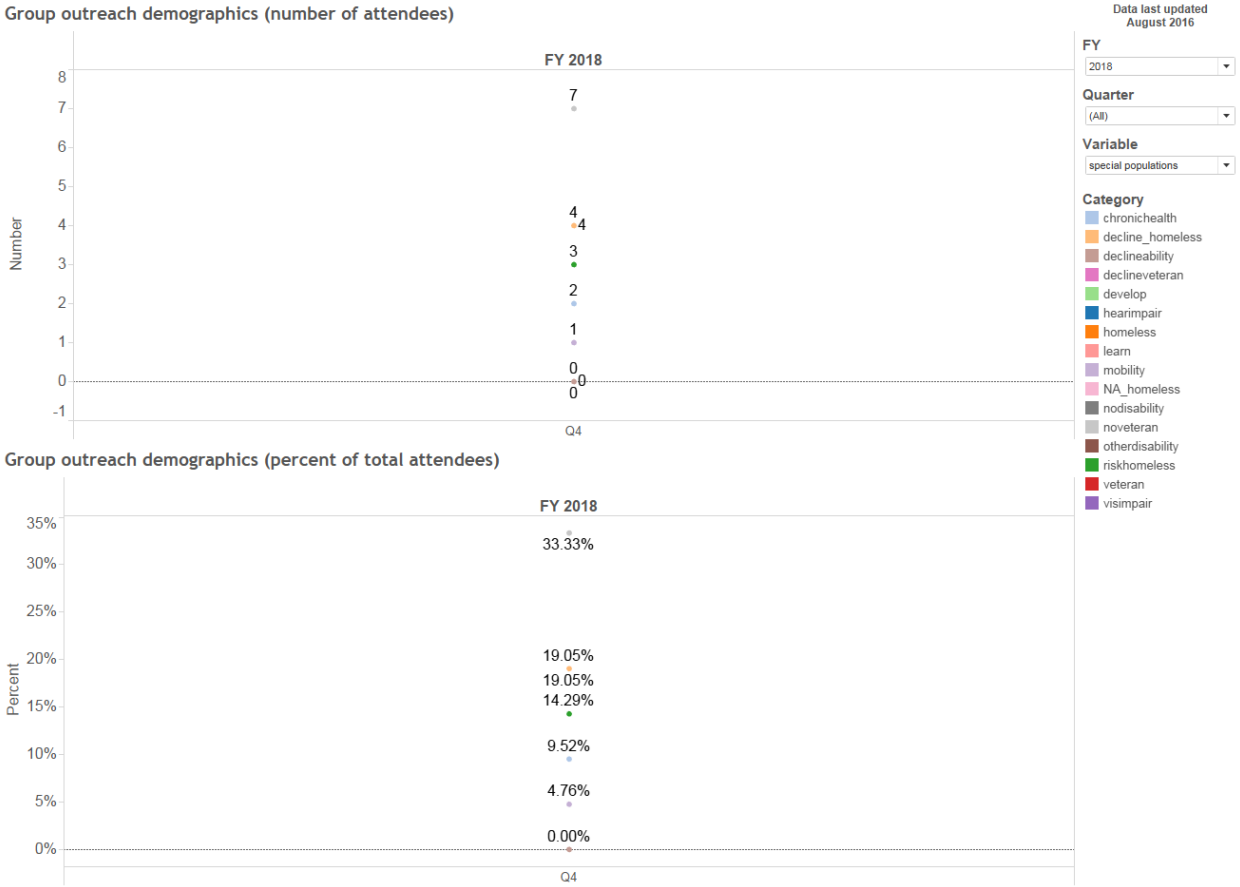
Group outreach event attendees:

- Self-reported as male (**57.1%**; n=4) or female (**42.9%**; n=3).
- Self-reported as Heterosexual (**100%;** n=7).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity	
Race/ethnicity	Number (%)
Tongan	7 (100%)

In FY 2017-2018, MCESBA reported 7 group outreach event attendees representing special populations, with the majority of that outreach occurring in Q4 as presented in **Figure 4**. During FY 2017-2018, MCESBA most commonly reached attendees who had physical/mobility disability (n=1), at risk for homelessness (n=3), and vision impairment (n=4); these categories are not mutually exclusive.

Figure 4. Special Populations, Q1-Q4



Appendix G. FY 2017-2018 Outreach, Pacifica Collaborative

Individual outreach

For FY 2017-2018, Pacifica Collaborative reported a total of three individual outreach events—three individual outreach events in Q1, no events in Q2, no events in Q3, and no events in Q4. The average length of individual outreach events was 65 minutes, ranging from an average of 65 minutes in Q1.

Most individual outreach events:

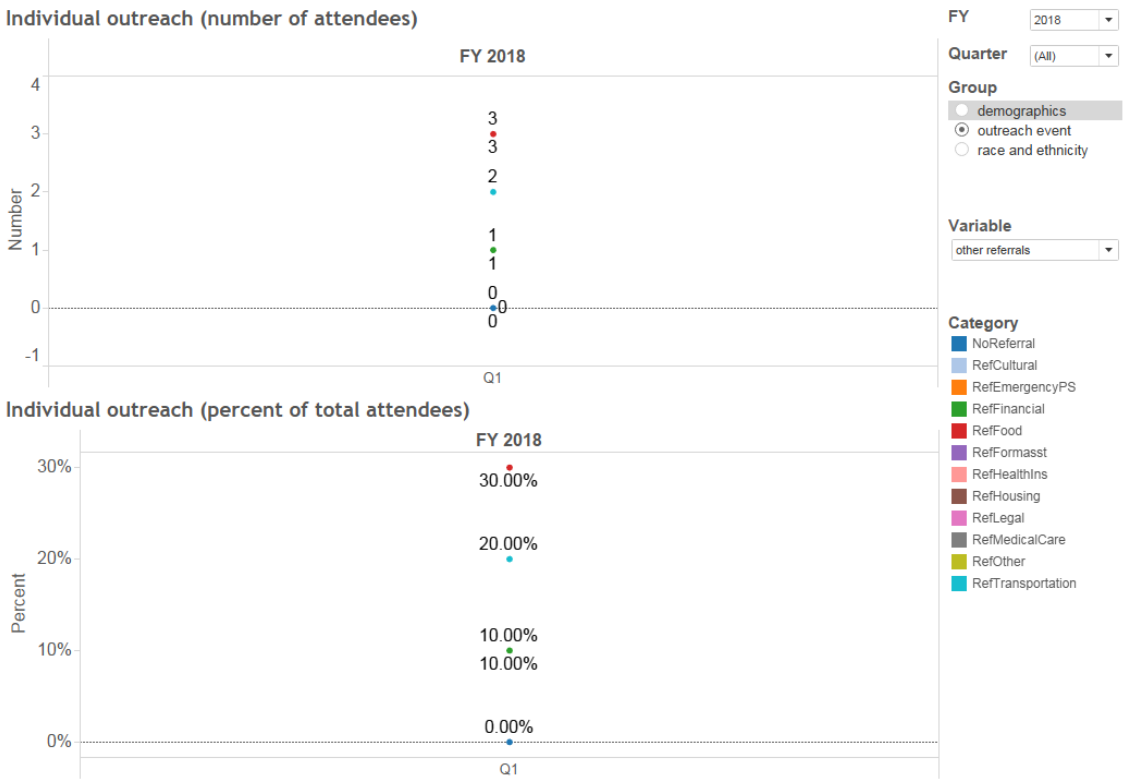
- Took place in other community location (**100.0%;** n=3).
- No MAA codes were reported. All were reported as N/A (**100%;** n=3).
- Were conducted in English (**100%**; n=3).
- Were mostly with the unknown insurance (**66.7%**; n=2) and uninsured (**33.3%**; n=1). (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4

- Resulted in 1 mental health referrals and 1 substance abuse referrals.

- Resulted in 10 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Pacifica Collaborative primarily made referrals to Food (**0.3%**; n=3), Form Assistance (**0.3%**; n=3), Transportation (**0.2%**; n=2), Financial (**0.1%**; n=1), and Housing (**0.1%**; n=1).

Figure 2. Other Referrals, Q1-Q4

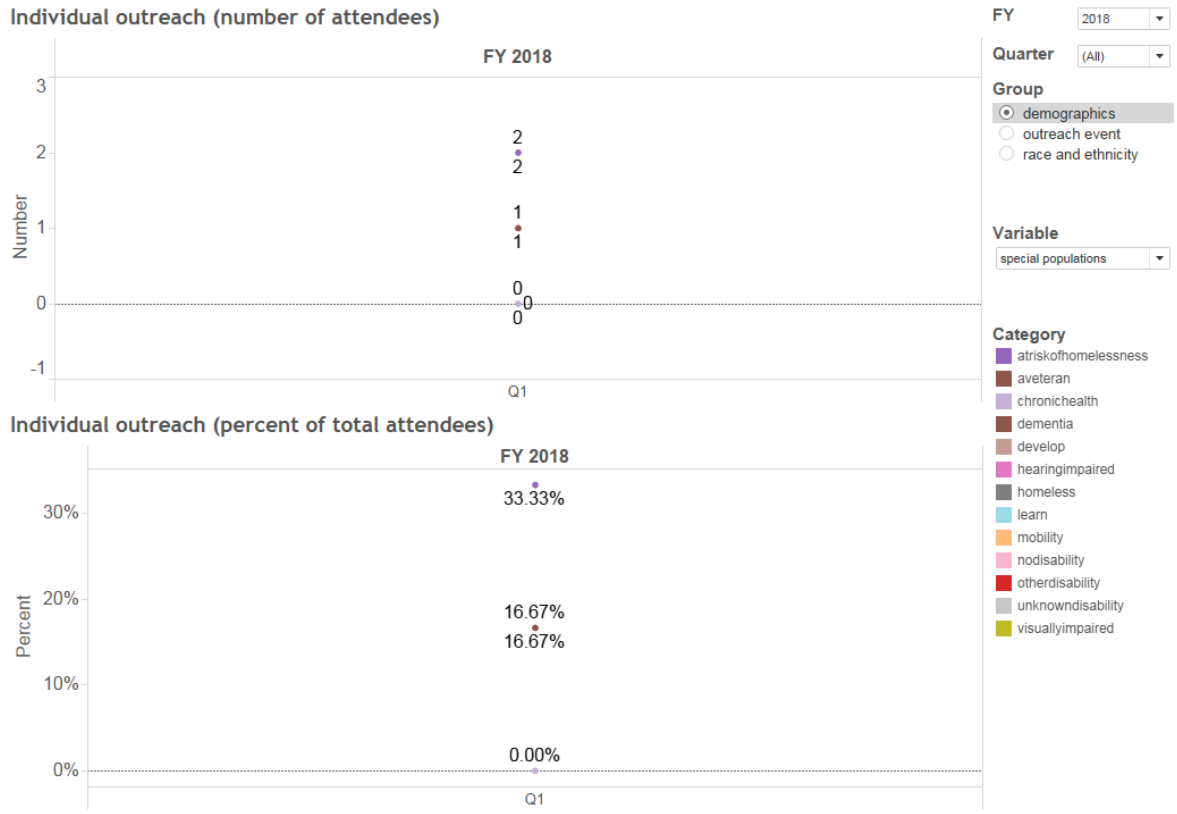


Individual outreach event attendees:

- Self-reported as female (**75%**; n=2) or male (**25%**; n=1).
- Self-reported as unknown sexual orientation (**66.7%;** n=2), and Heterosexual (**33.3%;** n=1).
- Were adults (26-59 years, **71.4%**; n=3).
- Were primarily two or more races (**66.7%**; n=2) or White (**33.3%;** n=1).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2017-2018, Pacifica Collaborative reported 6 individual outreach attendees representing these populations. (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, Pacifica Collaborative reported a total of 4 group outreach events, corresponding to 911 group outreach event attendees—582 attendees in Q1, 329 attendees in Q2, no attendees in Q3, and no attendees in Q4. The average length of group outreach events is 120 minutes, ranging from an average of 120 minutes per event in Q1 and Q2.

Most group outreach events:

- Took place in faith-based churches/temples (**75%**; n=3) and other community locations (**25%**; n=1).
- Were reported under N/A (**100%**; n=4) under MAA.
- Were conducted in English (**100%**; n=4).

Group outreach event attendees:

- Self-reported as female (**56.5%**; n=501), male (**37.7%**; n=334), or unknown gender (**5.9%**; n=52).
- Self-reported as Heterosexual (**48.7%;** n=433), decline (**42.2%**; n=376), Bisexual (**4.9%;** n=44), Gay/Lesbian (**4%;** n=36), or Queer (**0.1%**; n=1).

- Represented many races and ethnicities (**Table 1**).

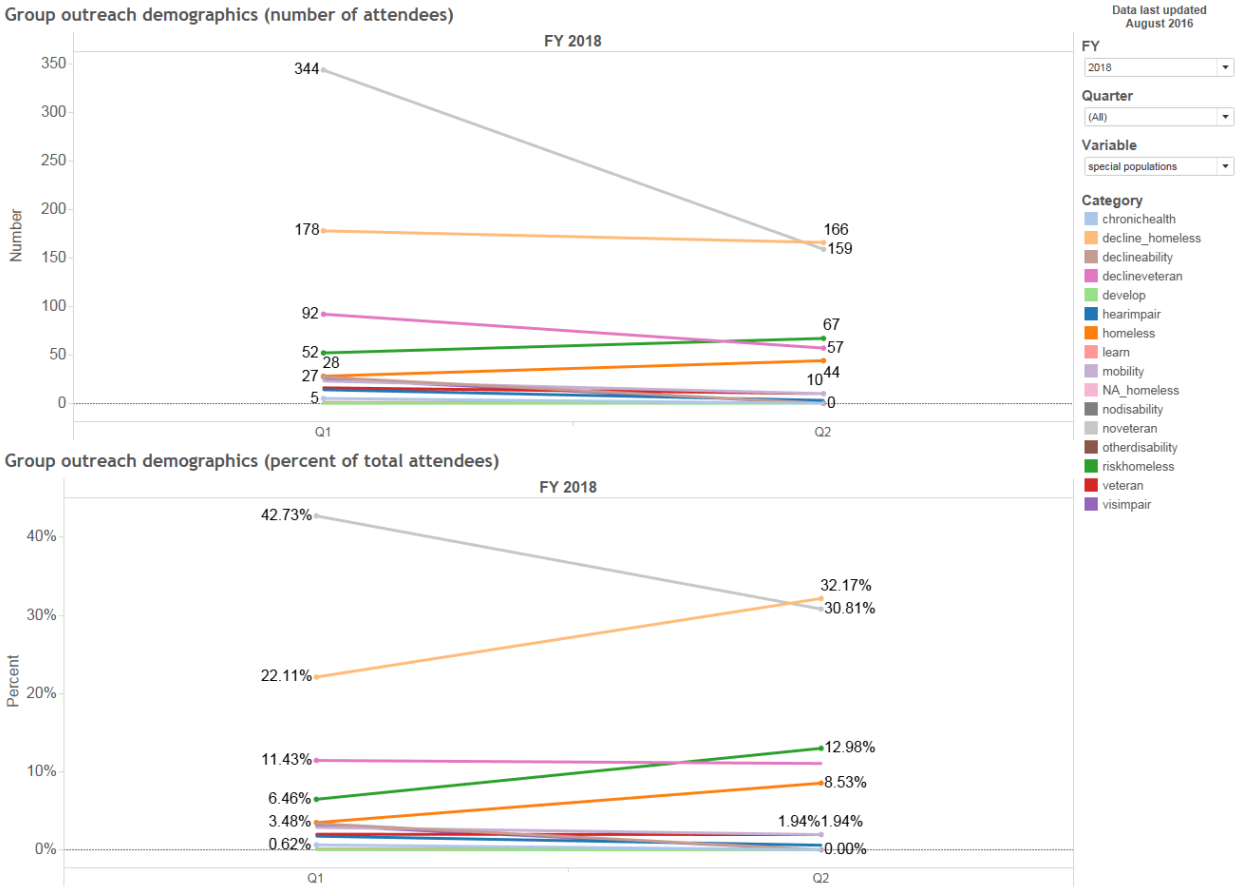
Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
American Indian	17 (1.3%)	Other	104 (7.9%)
Asian	159 (12%)	Puerto Rican	1 (<1%)
Black	26 (2%)	Samoan	15 (1.1%)
Chinese	31 (2.3%)	Tongan	12 (0.9%)
Fijian	1 (<1%)	Unknown	173 (13.1%)
Filipino	84 (6.4%)	White	503 (38.1%)
Hawaiian	17 (1.3%)		
Japanese	17 (1.3%)		
Korean	8 (0.6%)		
Mexican	161 (12%)		
Two or more races	26 (2%)		

* Total counts for race/ethnicity are larger than the total number of group outreach attendees reported because providers may have classified an attendee under several race/ethnicity categories and as "two or more races."

In FY 2017-2018, Pacifica Collaborative reported 582 group outreach event attendees representing special populations (**Figure 4**). During FY 2017-2018, Pacifica Collaborative most commonly reached attendees who are at risk for homelessness (n=119), have chronic health conditions (n=5), hearing impaired (n=17), homeless (n=72), learning disability (n=1), physical/mobility disability (n=33), vision impaired (n=25), and/or veterans (n=26); these categories are not mutually exclusive.

Figure 4. Special Populations, Q1-Q4



Appendix H. FY 2017-2018 Outreach, StarVista

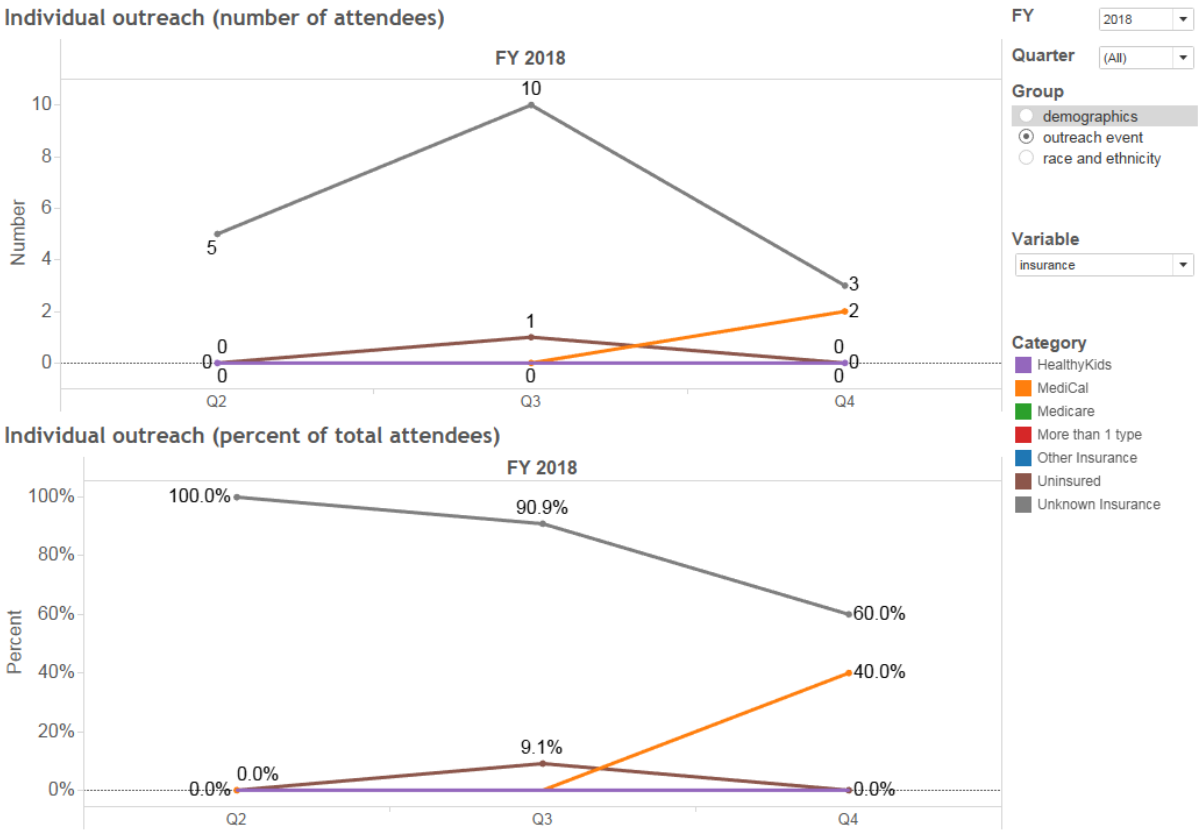
Individual outreach

For FY 2017-2018, StarVista reported a total of 21 individual outreach events—no individual outreach events in Q1, five events in Q2, 11 events in Q3, and five events in Q4. The average length of individual outreach events was 521 minutes, ranging from an average of 60 minutes in Q2 and 297 minutes in Q3.

Most individual outreach events:

- Took place by phone (**85.7%**; n=18) and other community location (**14.3%;** n=3).
- No MAA codes were reported. All were reported as N/A (**100%;** n=21).
- Were conducted in English (**61.9%**; n=13) or Spanish (**38%**; n=8).
- Were mostly with the unknown insurance (**85.7%**; n=18), Medi-Cal (**9.5%**; n=2), and uninsured (**4.8%**; n=1). (**Figure 1**).

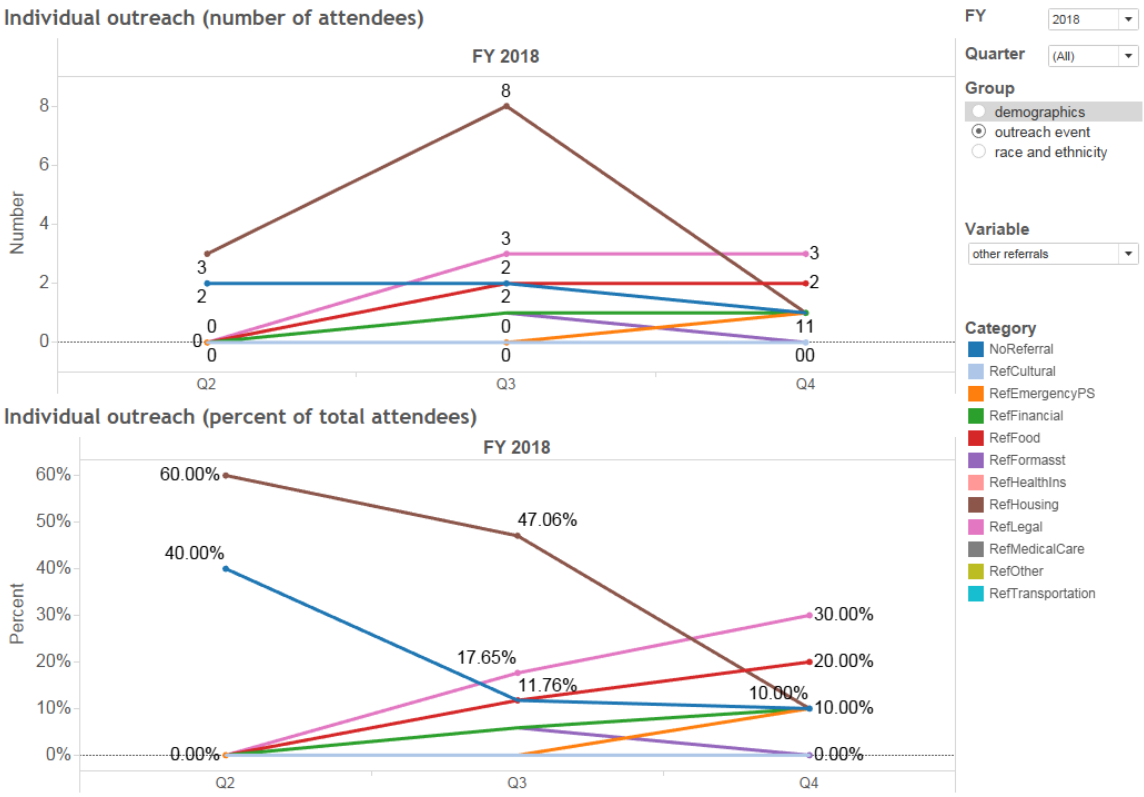
Figure 1. Types of Insurance, Q1-Q4



- Resulted in four mental health referrals and no substance abuse referrals.

- Resulted in 32 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. There were no referrals (**15.6%**; n=5). Pacifica Collaborative primarily made referrals to Housing (**37.5%**; n=12), Legal (**18.8%**; n=6), Food (**12.5%**; n=4), Emergency/Protective services (**3.1%**; n=1), Form Assistance (**3.1%**; n=1), and Transportation (**3.1%**; n=1).

Figure 2. Other Referrals, Q1-Q4

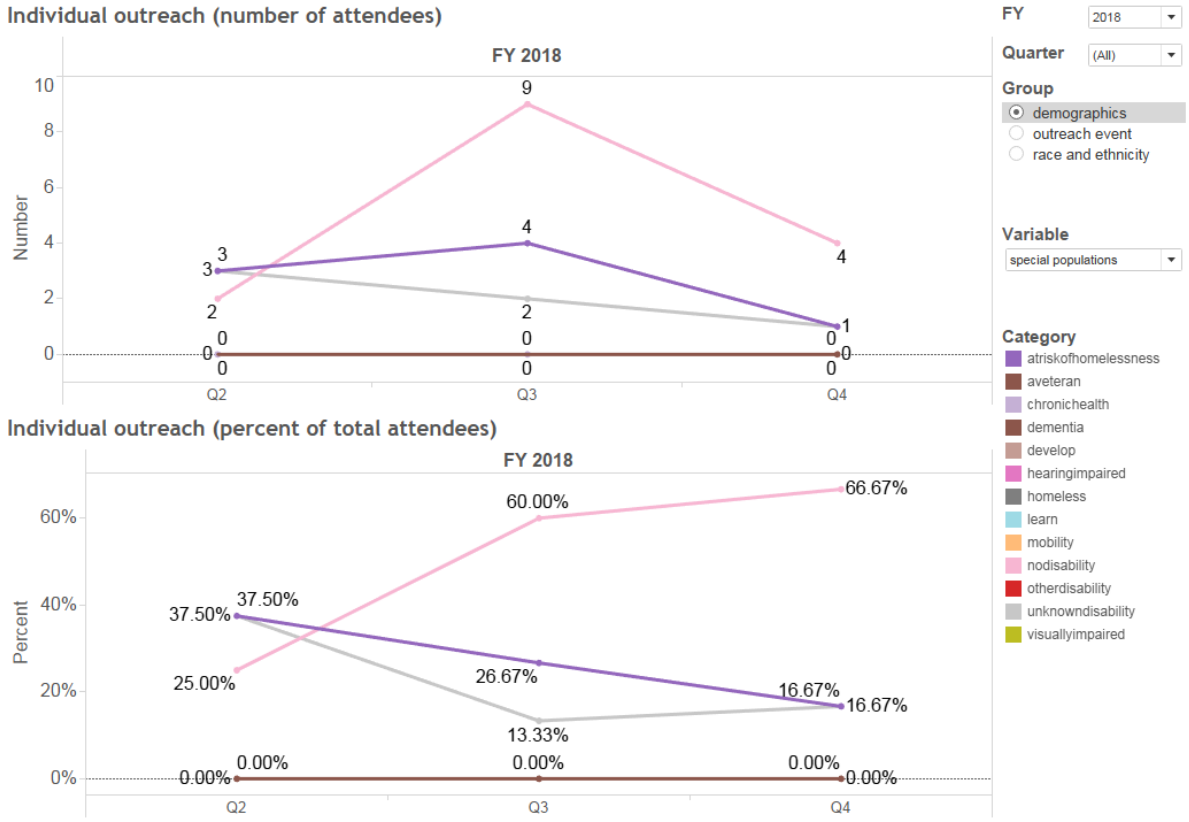


Individual outreach event attendees:

- Self-reported as female (**95.2%**; n=20) or other gender (**4.8%**; n=1).
- Self-reported as unknown sexual orientation (**19%;** n=4), and Heterosexual (**81%;** n=17).
- Were adults (26-59 years, **52.4%**; n=11), transition-age youth (16-25 years, **33.3%**; n=7), and decline to state (**14.3%**; n=3).
- Were primarily of an Unknown Race (**33.3%**; n=7), Mexican (**23.8%**; n=5), White (**19%**; n=4), South American (**14.3%**; n=3), and Chinese (**9.5%**; n=2).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2017-2018, StarVista reported 29 individual outreach attendees representing these populations. (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2017-2018, StarVista reported a total of 17 group outreach events, corresponding to 289 group outreach event attendees—no attendees in Q1, 72 attendees in Q2, 153 attendees in Q3, and 64 attendees in Q4. The average length of group outreach events was 79.4 minutes, ranging from 50 minutes in Q2 to 90 minutes in Q4.

Most group outreach events:

- Took place in schools (**94%**; n=16) and by phone (**5.9%;** n=1).
- Were reported N/A (**100%**; n=17) under MAA.
- Were conducted in English (**17.6%**; n=3) and Spanish (**82.4%;** n=14).

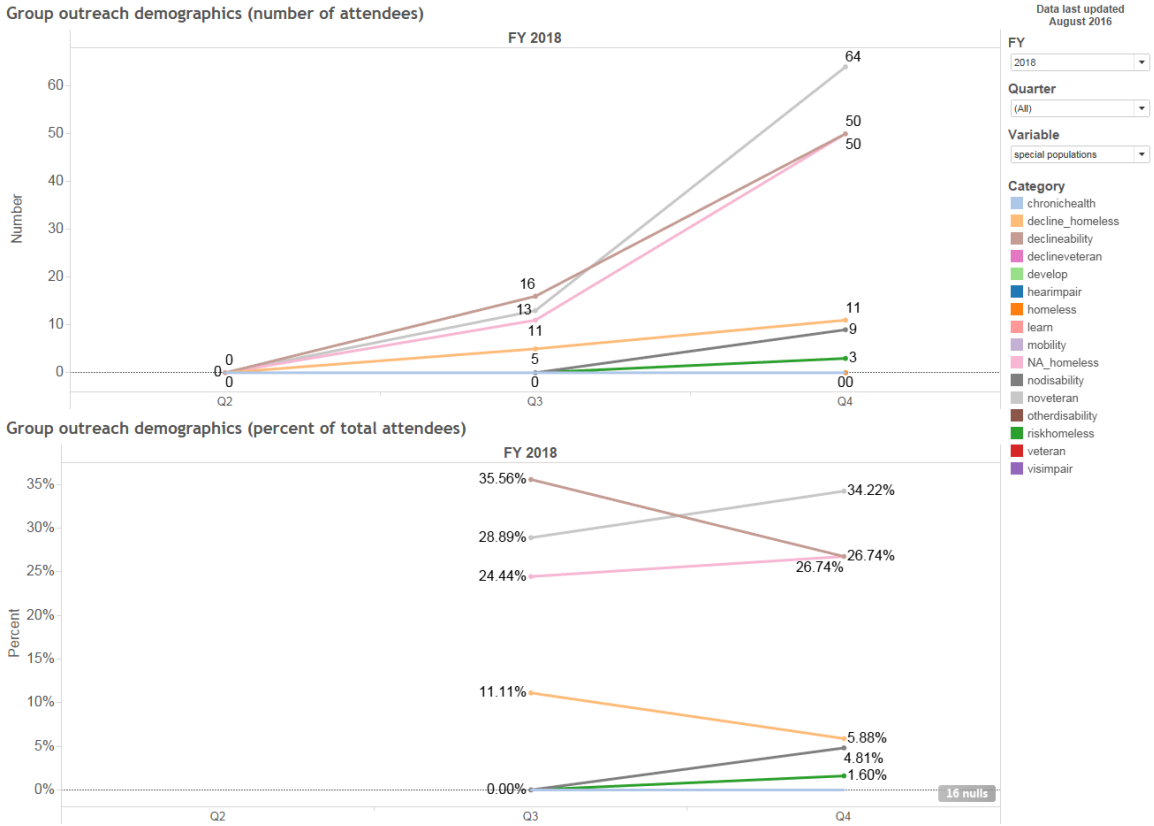
Group outreach event attendees:

- Self-reported as female (**25.3%**; n=73), male (**2.4%**; n=7), or unknown gender (**72.3%**; n=209).
- Self-reported as Heterosexual (**27.3%;** n=79) or decline (**72.7%**; n=210).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity	
Race/ethnicity	**Number (%)**
Asian	130 (42.7%)
Black	7 (2.3%)
Central American	27 (8.9%)
Hawaiian	14 (4.6%)
Mexican	47 (15.4%)
Two or more races	11 (3.6%)
Other	35 (11.5%)
South American	1 (0.3%)
Unknown	6 (2%)
White	27 (8.9%)

In FY 2017-2018, StarVista reported 289 group outreach event attendees representing special populations (**Figure 4**). During FY 2017-2018, StarVista most commonly reached attendees who were at risk of homelessness (n=3); these categories are not mutually exclusive.

Figure 4. Special Populations, Q1-Q4



Appendix I. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (e.g., location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.
For Medicaid Administrative Activities (MAA) codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (e.g., race), per quarter
- Denominator = total number of attendees, per quarter

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APPENDIX 10. INNOVATION ANNUAL EVALUATION REPORTS

San Mateo County Pride Center
Fiscal Year 2017-18 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2018

Table of Contents

Introduction

Project Overview and Learning Goals

The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center (Pride Center or the Center) is a formal collaboration of four partner organizations: StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership. The Pride Center also works collaboratively with the Pride Initiative of the BHRS Office of Diversity and Equity and the County of San Mateo LGBTQ Commission, co-sponsoring and consulting across many events, efforts and policy priorities.

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.
- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.
- **Project Innovation**: While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS began implementation in September 2016. The Pride Center opened to the public on June 1, 2017. The following report provides findings from the second year of implementing the San Mateo County Pride Center, from July 1, 2017 to June 30, 2018.

In accordance with the requirements for MHSA INN programs, BHRS selected two Learning Goals—Collaboration and Access—as priorities to guide the development of the Pride Center. As Figure 1 demonstrates, BHRS sought to explore how this innovative model of coordinated service delivery and community engagement could enhance access to mental health services within underserved LGBTQ+ populations, particularly for individuals at high risk for, or with, acute mental health challenges. In turn, the program domains of Collaboration and Access are areas in which the Pride Center might serve as a model to expand of mental health services for LGBTQ+ individuals in other regions.

Figure 1: San Mateo County Pride Center Learning Goals

Learning Goal 1 (Collaboration)	Learning Goal 2 (Access)
• Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?	• Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

Project Need

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance abuse, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental health issues compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or covert homophobia, biphobia, and transphobia.[1] Across the United States, a majority (70%) of LGBTQ+ students report having experienced harassment at school because of their sexual orientation and/or gender identity, and suicide is the second leading cause of death for LGBTQ+ youths aged 10-24.[2]

These nationwide trends are no less evident in San Mateo County. According to the San Mateo County LGBTQ Commission's 2018 countywide survey of 546 LGBTQ+ residents and employees, nearly half of adult respondents (44%) identified a time in the past 12 months when they felt like they needed to see a professional for concerns about their mental health, emotions, or substance use. At the same time, 62% of adult respondents felt that there are not enough local health professionals adequately trained to care for people who are LGBT, and fewer than half (43%) felt their mental health care provider had the expertise to care for their needs. Among LGBTQ+ youth who responded to the survey, three-quarters (74%) reported that they had considered harming themselves in the past 12 months, and two-thirds (65%) did not know where to access LGBTQ+ friendly health care.[3]

In this context, BHRS developed the San Mateo County Pride Center as a coordinated behavioral health services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Pride Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

Project Description and Timeline

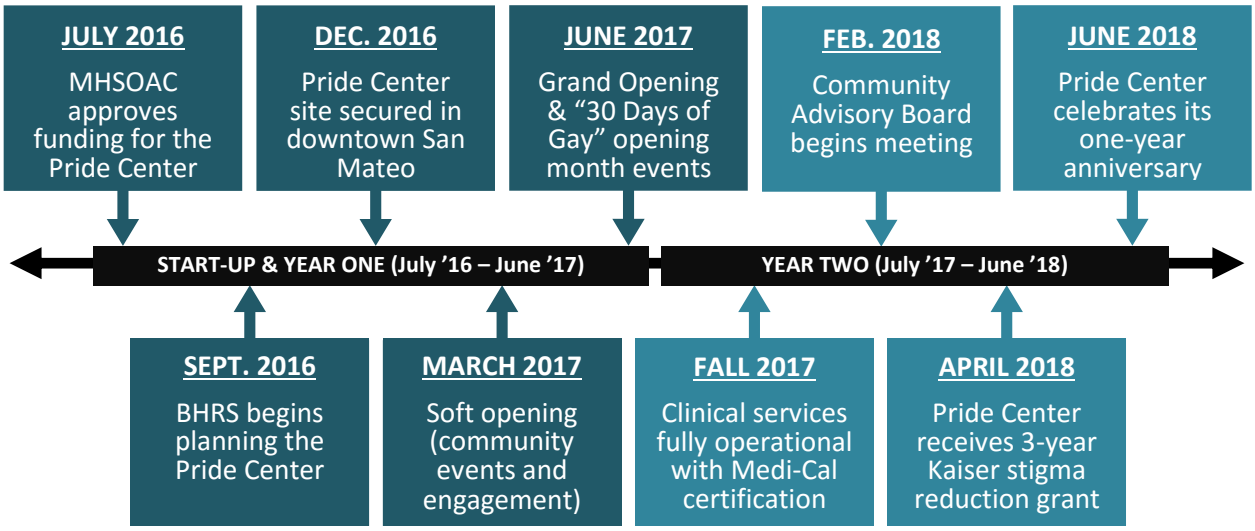
As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in three components:

1. *Social and Community Activities*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
2. *Clinical Services*: The Pride Center provides mental health services focusing on individuals at high risk of or already with moderate to severe mental health challenges.
3. *Resource Services*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources, including the creation of an online and social media presence.

[1] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, 8:70
[2] GLSEN, *2017 National School Climate Survey*; The Trevor Project, "Facts About Suicide." <<https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/>>
[3] San Mateo County LGBTQ Commission, "Survey Results of San Mateo County LGBTQ+ Residents and Employees," 2018 ed.

Figure 2 illustrates the key activities that have occurred since the Pride Center was first approved as an MHSA INN project in July 2016.

Figure 2: Pride Center Implementation Timeline

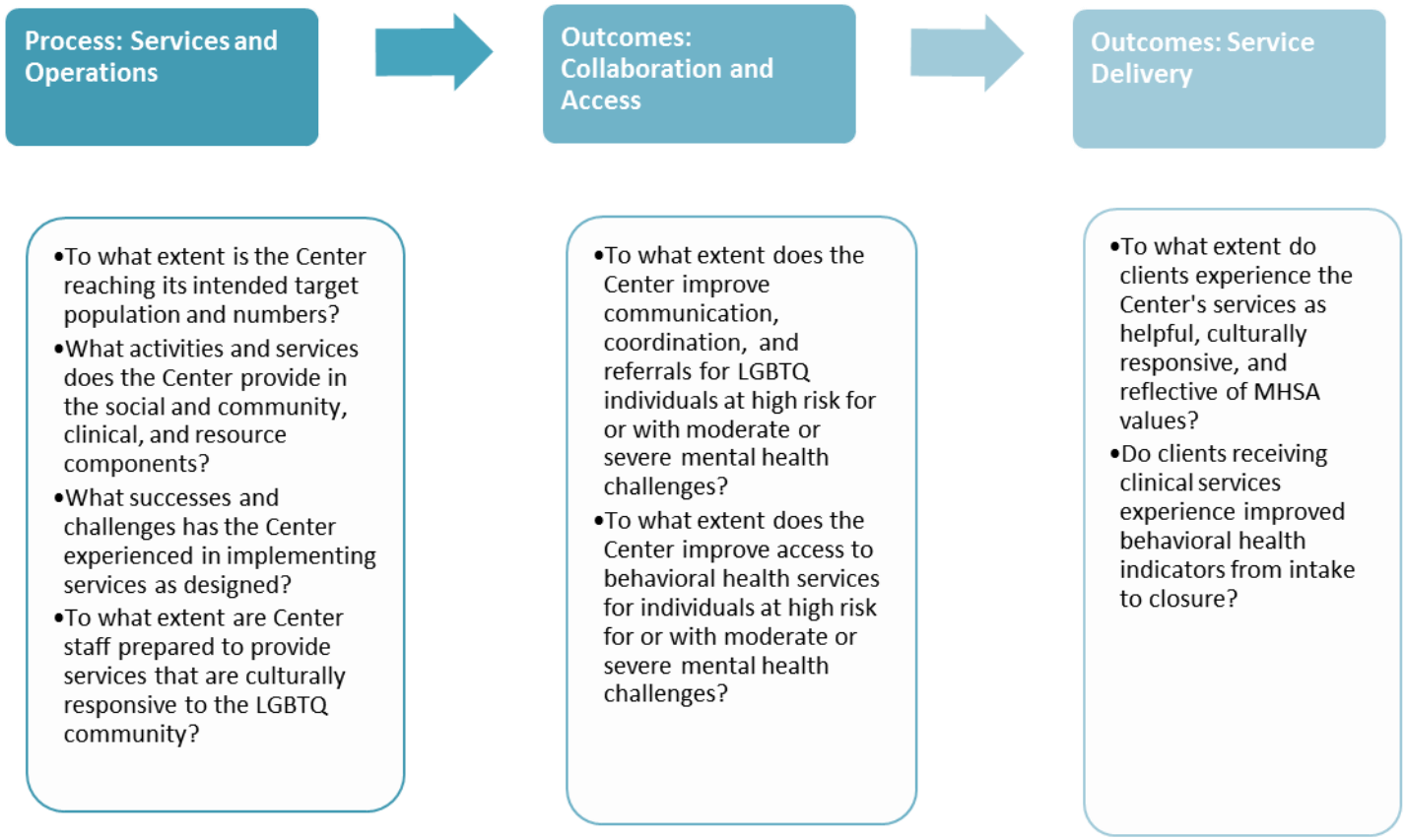


Evaluation Overview

In 2017, BHRS contracted Resource Development Associates (RDA) to conduct the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS staff, Center leadership staff, and Center partners to develop data collection tools measure program and service outcomes. In order to maximize RDA's role as research partners and fulfill MHSA Innovation evaluation principles, this evaluation uses a collaborative approach throughout, including Pride Center staff and partners in operationalizing the evaluation goals into measurable outcomes and interpreting and responding to evaluation findings.

BHRS seeks to learn how the Pride Center enhances access to culturally responsive services, increases collaboration among providers, and, as a result, improves service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS have developed evaluation questions in three categories (see Figure 3). By reaching the Pride Center's goals in terms of service and operations, and by improving collaboration, the Pride Center hopes to improve access and overall service outcomes for clients.

Figure 3. Evaluation Domains and Questions



Evaluation Methods

RDA developed a mixed methods evaluation that incorporates both process and outcome evaluation components.

- A **mixed methods** approach allows the evaluation to track quantitative measures of service delivery and outcomes, while also gathering qualitative input on how and why activities and outcomes occurred. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across data sources.
- The **process evaluation** component explores the extent to which the Pride Center has been implemented as planned, as well as the strengths and challenges the county has experienced in implementation. The process evaluation considers the perspective of various stakeholders, including Pride Center staff and participants alike. Evaluating the implementation of Pride Center activities and services enables BHRS, Pride Center leadership staff, and Center partners to make real-time adjustments that may improve the operations and outcomes of the Center.
- The **outcome evaluation** component assesses the extent to which the Pride Center—through its collaborative approach to service delivery—improves access to services and client-level behavioral health outcomes.

Data Collection

In line with RDA's mixed methods approach, this evaluation includes both quantitative and qualitative tools to measure indicators in three domains: Center services and operations, the Center's Learning Goals (Collaboration and Access to Services), and service delivery outcomes. Below we describe the measures that the evaluation will use along with the data collection methods that we will use to measure each of the indicators. Please see Appendix A for a detailed data collection plan.

Collaboration Survey

As collaboration is the core innovative element of this MHSA INN project, it was crucial for the evaluation team to operationalize the concept of collaboration so that it could be measured over time. RDA researched validated survey tools intended to measure collaboration among a team of service providers, including both management-level staff (who may not work directly with clients) and direct service staff. RDA and BHRS selected the Assessment of Interprofessional Team Collaboration Scale II (AITCS-II), developed by Dr. Carole Orchard.[4]

AITCS-II is a diagnostic instrument that is designed to measure the interpersonal dynamics and teamwork among health services coworkers. It consists of 23 statements, representing three elements that are considered to be key to interprofessional collaborative practice: 1) Partnership, 2) Cooperation, and 3) Coordination. Respondents indicate their general level of agreement with each statement on a 5-point Likert scale that ranges from 1 ("Never") to 5 ("Always"). The survey takes approximately 10 minutes to complete. To facilitate survey administration, RDA transferred the survey onto the online platform Survey Gizmo. RDA obtained permission from Dr. Orchard to make some slight modifications to the survey language in order to be more appropriate for the Pride Center team. For example, we replaced "his/her" with "their" as a gender-neutral pronoun. See Appendix B for RDA's online version of the AITCS-II.

Attendance and Demographic Reporting

To document the Pride Center's service population, Center staff and RDA collaborated to create a protocol for monitoring the number and characteristics of individuals who participate in onsite programs and services. Because the Pride Center provides an array of services with varying degrees of participation—including drop-in services, one-time community events, ongoing peer support groups, and clinical services—it was important to define what constitutes *meaningful* participation at the Pride Center for the purposes of collecting and reporting demographic data to the MHSOAC.

The Pride Center serves marginalized individuals who may be hesitant to provide personal information on paper, even anonymously. Asking new attendees to fill out an extensive demographic form could feel unwelcoming to individuals who have experienced fear, stigma, and trauma related to their LGBTQ+ identity or other life circumstances. In order to maintain a welcoming environment, Center staff determined that individuals who attend the Center *more than once*, as well as any clients receiving clinical

[4] Orchard, C. A., King, G. A., Khalili, H. and Bezzina, M. B. (2012), Assessment of Interprofessional Team Collaboration Scale (AITCS): Development and testing of the instrument. J. Contin. Educ. Health Prof., 32: 58–67. doi:10.1002/chp.21123

services, would be considered meaningful participants and would be asked to complete a demographic form. To capture the total number of individuals served, the Pride Center decided to also track attendance through a sign-in sheet that captures basic personal information, but does not include the full range of demographic variables listed in the updated INN regulations.

The demographic form was designed to capture all elements required by the MHSOAC. The Pride Center and its partners decided to add additional categories to the questions regarding sexual orientation and gender identity in order to include a wider spectrum of LGBTQ+ identities. These revisions were aligned with BHRS's initiative to revise Sexual Orientation and Gender Identity (SOGI) questions on health intake forms. The Pride Center and its partners also decided to add three additional items to the demographic form: housing status, income, and employment status. RDA developed an online format of the demographic survey using a HIPAA-compliant version of SurveyGizmo; the Pride Center administrative specialist enters the demographic forms into the online form monthly. The demographic form designed for the Pride Center is included in Appendix C.

Participant Experience Survey

RDA developed a survey to gauge Pride Center participants' experiences and approval of the Center's onsite programs, staff members, mental health services, and community space. The survey is designed to be administered annually at a point in time to as many participants as possible, through both paper and online formats. Pride Center staff began to administer the Experience Survey to Center participants and attendees in June 2018. The survey includes 13 statements that invite respondents to indicate their level of agreement with each statement on a four-level Likert scale ("Disagree," "Somewhat Disagree," "Somewhat Agree," "Agree"). In addition, the survey asks the number of times participants have visited the Pride Center and contains an optional section to record respondents' demographic information. RDA developed an online format of the demographic survey using a HIPAA-compliant version of SurveyGizmo. Paper surveys were entered into the online form. The Participant Experience Survey is included in Appendix D.

Focus Groups with Pride Center Participants and Community Advisory Board

RDA conducted three focus groups with Pride Center participants—one each with youth, adult, and older adult participants—to gather in-depth information from individuals who accessed clinical services and participated in Center programs and events. With feedback from BHRS and the Pride Center Director, the evaluation team developed a semi-structured focus group guide to learn from participants about their experiences with programs onsite, to what extent the Pride Center facilitates access to services for LGBTQ+ individuals, and any suggestions for improvement. In addition, RDA held a focus group with members of the Pride Center's Community Advisory Board (CAB), which formed in early 2018. Speaking to CAB members offered insight into the group's activities during the first few months of operation, their perspectives on the Pride Center's successes and challenges, and priorities for the CAB moving forward.

Measures and Data Sources

Table 1 indicates the key measures and data sources the evaluation uses to assess outreach and implementation, collaboration and access to services, and service delivery outcomes.

Table 1. Evaluation Measures and Data Sources

Outreach and Implementation of Services	Data Sources
Number of individuals reached	• Participant Demographic Form • Participant Sign-In Sheets • Outreach and Meeting Tracking Sheets
Types of activities and services provided in the social and community, clinical, and resource components	• Participant Services Data • Focus Groups with Participants • Quarterly progress reports
Successes and challenges of implementing services as designed	• Focus Group with Community Advisory Board (CAB) • Regular communications with Pride Center leadership and staff
Cultural responsiveness of services	• Focus Groups with Participants • Participant Experience Survey
Collaboration and Access to Services	**Data Sources**
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges	• Focus Group with CAB • Focus Goups with Participants • Participant Experience Survey • Partner Collaboration Survey (AITCS-II)
Improved access to behavioral health services for individuals with moderate to severe health challenges	• Focus Groups with Participants • Participant Experience Survey
Service Delivery Outcomes	**Data Sources**
Client service experience (E.g., Experience with services, facility, and service providers)	• Participant Experience Survey • Focus Groups with Participants
Improved health outcomes among clients	• Participant Experience Survey • Focus Groups with Participants

Data Analysis

To analyze the quantitative data from demographic forms and the collaboration survey, RDA examined frequencies, averages, and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Implementation Update

Changes to Innovation Project during Reporting Period

There were no changes to the Pride Center MHSA Innovation project during FY2017-18.

Key Accomplishments

This section highlights accomplishments of the Pride Center in FY2017-18. The key accomplishments are divided into three categories: implementing onsite programs and services, developing and enhancing the Center's internal operations, and expanding the Center's countywide engagement.

Implementing Programs and Services

The Pride Center's clinical practice became fully operational. Soon after its Grand Opening in June 2017, the Pride Center hired both its Clinical Coordinator and Case Manager, who helped augment the Center's clinical services into a full-fledged practice. In collaboration with other staff, the Clinical Coordinator oversaw the development of the Center's clinical policies and procedures in the fall of 2017. The Pride Center obtained Medi-Cal certification in late 2017, which enabled participants with Medi-Cal insurance to access mental health services; previously the Center only offered therapy on a sliding scale. In order to meet the mental health needs of as many participants as possible, the Center also piloted a program for intern and trainee clinicians to gain work experience while offering services onsite. In August 2017 the Pride Center hired an unpaid, part-time clinical trainee, who became a clinical associate and postgraduate intern in January 2018. In 2018, the Center hired two additional part-time, unpaid clinical trainees, whose multilingual skills expanded the Center's ability to serve Spanish- and Cantonese-speaking participants.

Figure 4: Excerpt from Pride Center Flyer Promoting Mental Health Services

The Pride Center implemented a wide array of programs, resources, and events for LGBTQ+ individuals with mental illness or at risk of mental illness. In addition to therapy and case management services, the Pride Center organizes eleven peer support groups for particular subsets of the LGBTQ+ community. The Center also hosts a number of recurring community events, like movie nights, arts and crafts gatherings, and community forums. The Pride Center also offers a Resource Library with informational materials and directories to other services.

Figure 5 features a full list of onsite programming during FY2017-18. Figure 6 displays examples of the promotional materials that staff produce for Center programs and events.

Figure 5: Onsite Programs and Services at the Pride Center in FY18

Clinical Services
Therapy Services (individual, relationship, family, group)
Case Management
Drop-In Center
Psycho-Education (e.g., Parents of LGBTQ+ Teens Group)
Specialized Group Therapy (e.g., Trans-Femme Support Group)

Educational Resources & Supportive Services
Job Network
Name and Gender Changes for Identity Documents
Onsite Resource Library
Public Benefits Support
Sexual Orientation and Gender Identity (SOGI) trainings (monthly)
Trans Talks series (monthly)

Peer Support Groups
Gay Men's Circle (18+)
Grown Folks (18-30)
Lesbian Women's Circle (50+)
QT Chats (College of San Mateo)
Queer Latinx Circle/Queer Cumbia
Queers Have a Higher Power (Alcoholics Anonymous)
Queers on the Autism Spectrum
Trans Support Group (18+)
Youth Support Group (10-18)
Gay Men's Circle (18+)

Community Partner Meetings
PFLAG (San Jose/Peninsula chapter)
Pride Initiative (BHRS Office of Diversity and Equity)
County of San Mateo LGBTQ Commission
San Mateo County Office of Education (GSA Coordinators)

Social/Community Events
Community Forums (quarterly)
Movie Nights (weekly)
Crafternoons (2x/month)
Book Club (monthly)
Intergenerational Dinners (quarterly)
Oral History Project
Pride Celebration (annually)
Queer Youth Prom (annually)
Transgender Day of Remembrance (annually)
Transgender Day of Visibility: In Bloom Project

Older Adult Programs
Affordable Housing Workshop
Bistro Brio (monthly lunch)
Meditation & Mindfulness group
Sunshine Series (monthly resource sharing meetings)

Pride Center participants have taken active roles in expanding the Center's programming. Pride Center staff launched a volunteer program in FY2017-18, with regular orientations to train new volunteers. According to Pride Center staff, participant volunteers were most active in helping out with administrative tasks, the Resource Library, and assisting fellow participants with accessing resources. In addition, Pride Center attendees have worked with staff to create new supportive services. For instance, some participants organized a job network and employment search program to assist fellow participants who are looking for work. Another participant started a support group for people on the autism spectrum. These collaborative efforts exemplify the enthusiasm of Pride Center participants for the community that the Center supports, as well as the openness and flexibility of the staff to support programs initiated by participants.

Figure 6: Examples of Promotional Materials for Pride Center Programming

Developing and Enhancing Internal Operations

Pride Center staff created and implemented internal policies and procedures to facilitate the delivery of programs and services. At the start of FY2017-18, the Pride Center had been open to the public for a month, but had yet to develop or implement many of its organizational policies, procedures, and protocols

for the day-to-day operation of its new collaborative model. Consequently, Pride Center staff and partner organization representatives have revised their program manual and internal policies over the past year. Areas in which staff have developed procedures and workflows include:

- Policies and procedures for the Center's clinical program;
- Protocols for data collection in both clinical and nonclinical programs;
- Standards and best practices in development and fundraising;
- Safety policies, i.e. in the event of an onsite health crisis;
- Role clarity between staff members and between Pride Center and partner organizations' staff;
- Operational procedures for emergency preparedness; and
- Integrating matters of cultural humility into organizational policy.

The Pride Center expanded its capacity by hiring additional staff. As mentioned above, the Center hired two full-time clinical staff members in the summer of 2017 to enhance the Center's therapy and case management services. A part-time Grant Writer and Development Associate joined the Center in early 2018 to spearhead the search for additional funding and sustainability opportunities. In addition, Center staff operates a volunteer program, whose members support a wide range of activities, including events planning and programming, outreach efforts, research, data entry, and more. Table 2 includes a full list of new staff members, trainees, and interns during FY2017-18.

Table 2: New Staff Members and Volunteers Onboarded in FY2017-18

Quarter	Staff Member / Volunteer
Q3 2017	Clinical Coordinator and Lead Clinical Supervisor
Q3 2017	Case Manager
Q3 2017	Clinical Trainee (part-time unpaid intern)
Q4 2017	Youth Intern (part-time)
Q1 2018	Grant Writer and Development Associate (part-time)
Q2 2018	Clinical Associate (part-time unpaid intern)
Q2 2018	Clinical Trainee (part-time unpaid intern)

The Pride Center launched its Community Advisory Board (CAB) in February 2018. The CAB draws together a diverse group of community representatives who are committed to expanding the Pride Center's engagement within and beyond San Mateo County. During the first few months of meeting, the CAB worked to establish clear roles among its members, while exploring alternatives to a hierarchical decision-making structure for the group as a whole. In addition, CAB members engaged in multiple forms of outreach, building partnerships with community-based organizations and seeking potential sponsorships from the private sector.

Expanding the Center's Countywide Engagement

The Pride Center served as a hub for a variety of meetings and trainings designed to strengthen community capacity to serve LGBTQ+ individuals. Staff hold monthly onsite trainings on sexual orientation and gender identity (SOGI) for local service providers, school staff, and other community members. The Pride Center also serves as the meeting site for other community partners: the Pride

Initiative of the BHRS Office of Diversity and Equity, the County of San Mateo's LGBTQ Commission, the San Jose/Peninsula chapter of the national nonprofit PFLAG, and the San Mateo County Office of Education, which hosts meetings for GSA (Genders and Sexualities Alliance) Coordinators at the Center. In addition, some local GSA student chapters meet at the Pride Center.

Pride Center staff trained an array of private and public organizations on matters of sexual orientation and gender identity, establishing the Pride Center as a resource for the broader San Mateo County population. In the fall of 2017, Pride Center staff developed a comprehensive training program to educate BHRS staff, local service providers, and local businesses on working with LGBTQ+ individuals. The Center's staff conducted over 60 trainings across San Mateo County in FY2017-18, averaging five per month. Training participants included employees from the public, private, and nonprofit sectors, as well as attendees of a Trauma Informed Schools Conference. Furthermore, Pride Center staff also spoke at professional conferences, including the Multicultural Symposium of the Northern California branch of the National Alliance for Mental Illness and the Stanford Adolescent Wellness Conference. Through helping other organizations and agencies better serve their LGBTQ+ consumers and constituents, the Pride Center's staff helped to promote the Center as a source of expert knowledge within the wider community. Figure 10 includes a partial list of workplace trainings that Pride Center staff conducted in FY2017-18.

The Pride Center led trainings and outreach for over twenty local middle schools, high schools, and colleges. Pride Center staff facilitated trainings for teachers and staff members at six high schools, as well as the San Mateo Union School District. Center staff and volunteers also held workshops, hosted tables at resource fairs, and supported student organizations at fifteen schools, ranging from junior high schools to four-year colleges. In FY2017-18, Pride Center staff also sponsored a gathering of students representing GSAs from schools across San Mateo County. In addition, the Pride Center formed two longer-term partnerships with staff and students at local schools. The Center contracted with Kennedy Middle School, located in nearby Redwood City, to offer a ten-week therapy group for LGBTQ+ students. In addition, the Center partnered with students from the Queer Identities course at nearby Notre Dame de Namur University to launch the Oral History Legacy Project, in which students recorded and presented the experiences of older adult participants at the Pride Center.

Figure 7: Pride Center Staff and Volunteers Conducting a Training at Thomas R. Pollicita Middle School

The Pride Center co-sponsored many informational and recreational events to spread awareness about the Pride Center. The Pride Center sponsored a range of educational events, such as resource-sharing workshops for county residents, in collaboration with other service agencies and departments in San Mateo County. The Center also hosted several social programs and events with local businesses; for instance, the Center held events at Planet Granite, an indoor rock climbing gym, and CuriOdyssey, an interactive science and wildlife center. The Center also held joint events with LGBTQ+ centers in nearby Oakland and San Jose, building intra-regional connections between LGBTQ+ communities in different parts of the Bay Area. Through these community-based events, attendees could learn more about the Center's onsite programs, and could potentially be connected to needed mental health services. Figure 10 includes a comprehensive list of community engagement and co-sponsorship activities during FY2017-18.

Figure 8: Participants at Rainbow Climb, an Event Co-Sponsored by the Pride Center and Planet Granite

Figure 9: Participant Volunteers Conducting Outreach at the San Mateo County Pride Celebration

Figure 10: Community Engagement Efforts for Pride Center Staff and Participants in FY2017-18

Workplace/Offsite Trainings	Event Co-sponsorships	School Staff Trainings
ACCESS Call Center*	Aging and Adult Services*	Aragon High School
Aging and Adult Services*	Bay Area Legal Aid	Burlingame High School
Behavioral Health & Recovery Services*	Billy DeFrank LGBT Community Center	Capuchino High School
Boston Private Bank	California Clubhouse	Hillsdale High School
Commission on Aging*	CuriOdyssey	Mid-Peninsula High School
Community Overcoming Relationship Abuse (CORA)	Daly City Youth Health Clinic	Mills High School
Court Appointed Special Advocates (CASA) of San Mateo County	Edgewood Drop-in Center	San Mateo Union H.S. District
CuriOdyssey	Elder & Adult Protection Team*	**Student Outreach**
Diversity and Equity Council (San Mateo County Health)*	Franklin Templeton Investments	Carlmont High School
Health Insurance Counseling and Advocacy Program*	Gilead Sciences, Inc.	College of San Mateo
HomeBase	Health Services Agency*	Garfield Middle School
Human Resources Department*	Heart and Soul, Inc.	Half Moon Bay High School
The Parent Project (in Spanish)	HomeBase	Hillsdale High School
Rape Trauma Services	LifeMoves	Ingrid B. Lacy Middle School
Resource Families (Human Services)*	Many Journeys Metropolitan Community Church	Mercy High School
Sequoias - Portola Valley	Oakland LGBTQ Community Center	Notre Dame de Namur University
Youth Services Center (Probation)*	Office of Education*	Notre Dame Middle School
	Planet Granite Belmont	Pescadero High School
	Planned Parenthood	Sequoia High School
	Silicon Valley Community Foundation	Skyline College
	Youth Leadership Institute	Thomas R. Pollicita Middle School
		Westmoor High School
		Woodside High School

Long-Term Partnerships		
County of San Mateo LGBTQ Commission	Pride Initiative (BHRS Office of Diversity and Equity)	San Mateo County Office of Education
Kennedy Middle School	Notre Dame de Namur University	PFLAG

*County of San Mateo public agency

Consumer Population Served

Participant Numbers

In FY2017-18, a total of 3,056 unique individuals accessed Pride Center programs, trainings, and services.[5] This includes 1,092 people who completed a sign-in sheet onsite or attended a peer group at the Pride Center, and 2,045 people who attended offsite events or trainings run by Center staff and/or participants. Table 3 includes a head count of unique individuals who signed a Pride Center attendance sheet, or whom Pride Center staff tallied, during the past year.

Table 3: Number of Unique Individuals Accessing Pride Center Programs and Services in FY2017-18

Source	# Unique Individuals
Onsite sign-in sheets during drop-in hours	1,011
Peer group attendance	81
Community-based trainings (tally of participants)	1,309
BHRS SOGI trainings (sign-in sheets)	655
TOTAL	3,056

Moreover, when considering all points of meaningful contact—which also include engaging with Center representatives at an outreach event or tabling event and following the Center on social media—the Pride Center had over 10,000 meaningful encounters in its first full year of implementation.

Of those who visited the Pride Center, 151 accessed clinical psychotherapy services, and 45 utilized case management services onsite. These numbers include 13 individuals who accessed both therapy and case management services. Because the Pride Center only has one case manager, its capacity to offer case management services is limited. As such, Center staff prioritize these services for participants with more critical and/or complex needs. To date, over a third (37%) of the participants receiving case management were experiencing homelessness at the time. Housing instability is a common challenge for participants receiving case management; to date, the case manager has helped over half (52%) of their clients either maintain or obtain housing or shelter.

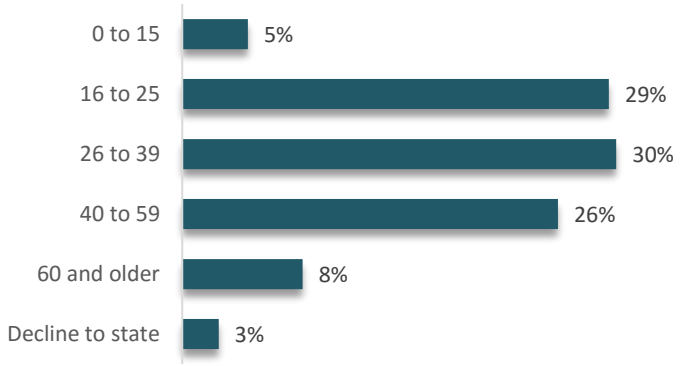
[5] To produce a count of unique individuals, Pride Center staff aggregated the sign-in sheets and manually unduplicated any names that appeared multiple times.

Participant Demographics

During FY2017-18, a total of 400 individuals completed the Pride Center's Participant Demographic Survey. The results are summarized below.[6,7]

Age: The majority of participants in FY2017-18 (85%) reported being between the ages of 16 and 59. Eight percent were 60 or older, and 5% were 15 or younger. See Figure 11 for the full range of participants' ages.

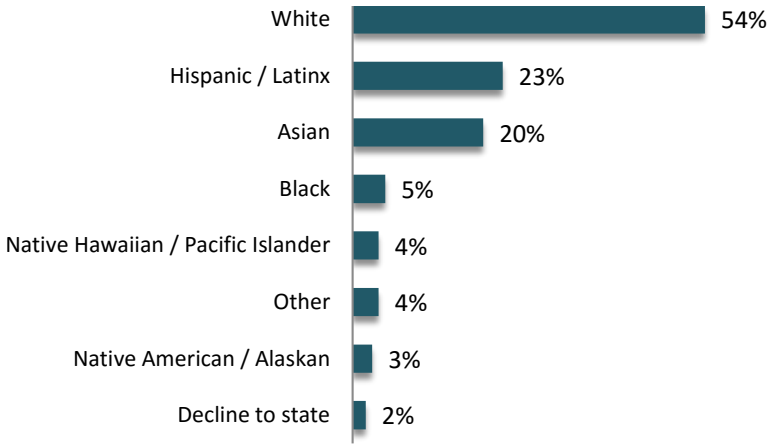
Figure 11: Center Participants by Age in FY2017-18 (n=400)



Language: Nearly all participants (92%) reported speaking English in their households. Spanish was the second most common language; other responses included Cantonese, Tagalog, Tongan, and Armenian.

Race: Slightly more than half of participants (54%) identified as white, followed by Hispanic or Latino/a/x (23%) and Asian or Asian American (20%) participants. Because participants could select multiple racial identities, 8% of participants identified as both white and another racial identity. In total, 52% of participants identified as either multiracial or people of color. (See Figure 12 for the full results.)

Figure 12: Pride Center Participants by Race in FY18 (n=400)
note: participants could select multiple answers



When comparing the race of Pride Center participants to the population of San Mateo County in 2017, the Pride Center saw a slightly higher percentage of white participants (39% of the county, vs. 46% of participants who identified as only white) and a slightly smaller percentage of Asian participants (30% of the county, vs. 20% of Pride Center participants). One-quarter (25%) of county residents are Hispanic or Latino/a/x, which is

[6] While participants are asked to fill out the demographic form upon their second visit to the Center, it is possible that a small number of participants may have accidentally completed the form more than once. Thus, 400 is likely close to an unduplicated count, but may include some duplicates.

[7] *Note on reporting:* To comply with HIPAA requirements and protect the confidentiality of participating individuals, this report only presents data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined.

consistent with Latinx representation at the Pride Center (23%). Black, Native American, and Hawaiian or Pacific Islander participants were also represented at rates comparable to the population of San Mateo County (3%, 1%, and 2% of county residents, respectively).[8] While the Pride Center has improved in achieving a racially diverse and representative participant base, recruiting participants of color and sustaining culturally sensitive programming remains a priority for Center staff.

Ethnicity: For participants in Year Two, the most commonly identified ethnicity was European. Latinx participants most commonly identified as Mexican or Chicano/a/x, followed by South American. Among Asian American participants, the most common ethnicities were Filipino/a/x and Chinese, with other participants identifying as South Asian, Japanese, Korean, or other Southeast Asian ethnicities. Smaller proportions of identified as African or Middle Eastern.

Sex: Sixty-one percent of participants responded that they were female at birth, and 31% responded that they were male at birth. Other participants identified as intersex at birth or declined to respond.

Gender Identity: In all, 62% of participants identified as cisgender: 39% percent identified as cisgender women, and slightly less than one-quarter (23%) identified as cisgender men. Nine percent of participants identified as genderqueer or gender non-conforming, and 7% identified as either transgender men or women. Nearly one-fifth of participants (18%) declined to state their gender identity; the remainder of respondents identified as another gender identity, or as questioning or unsure of their gender identity. Figure 13**Error! Reference source not found.** shows the full range of responses for Pride Center participants' gender identities.

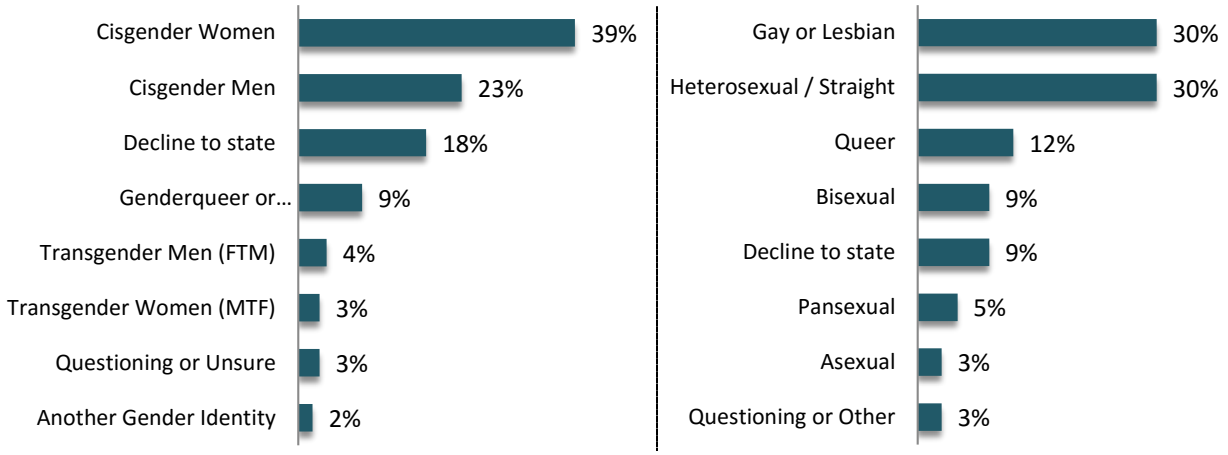
Sexual Orientation: Gay and lesbian individuals accounted for 30% of survey responses, as did participants who identified as heterosexual or straight.[9] Twelve percent identified as queer, 9% identified as bisexual, and 5% identified as pansexual. Aside from those who declined to answer (9%), the remaining participants reported that they were asexual, questioning, or identified with another sexual orientation. Figure 13 shows the full range of responses for participants' sexual orientations.

[8] "U.S. Census Bureau Quick Facts: San Mateo County, California," *U.S. Census Bureau website*. <<https://www.census.gov/quickfacts/sanmateocountycalifornia>>

[9] The high proportion of respondents who identified as straight or heterosexual is likely due to multiple factors:

- Pride Center staff originally administered the demographic survey to service providers who attended onsite trainings (but stopped doing so in the middle of the year);
- Parents of LBGTQ+ youth visit the Center to access resources or attend parenting classes and peer groups, and some of these parents have completed the survey;
- A number of the Pride Center's transgender participants identify as heterosexual;
- Because the Pride Center does not turn away people who are not LGBTQ+, it is possible some straight people accessed drop-in services.

Figure 13: Participants by Gender Identity (Left) and Sexual Orientation (Right) in FY2017-18 (n=400)



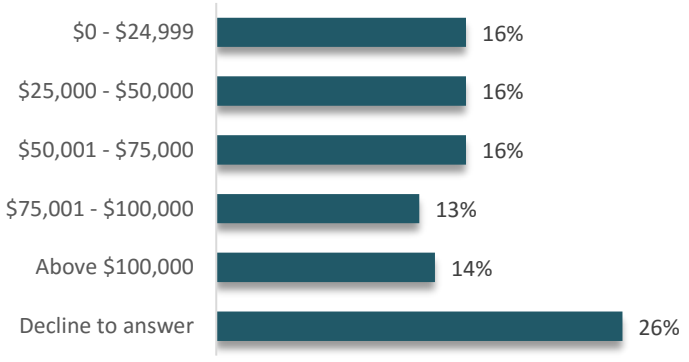
Disability Status: The majority of participants (59%) reported having no disabilities, while 35% reported some disability. The most commonly reported disabilities were chronic health problems (6% of participants), difficulty seeing (5%), and learning disabilities (4%).

Education: [10] As a whole, adult Pride Center participants are highly educated. Among respondents aged 26 or older (n=254), three-quarters of participants had either earned their bachelor's degree (37%) or a graduate degree (38%). Nine percent reported having some college education, and 7% declined to answer. The remaining respondents had an associate's degree, a vocational or trade certification, a high school diploma or GED, or less than a high school diploma.

Employment: Slightly less than half of participants (44%) reported having full-time employment, with 14% reporting part-time employment and 17% identifying as students. Ten percent of participants were unemployed and looking at the time of the survey, and 5% were retired. The remaining participants declined to answer.

Income: As Figure 14 shows, the Pride Center draws adult participants across the socioeconomic spectrum. Among survey respondents aged 26 or older, there was a fairly even distribution of reported incomes across the five different response options. However, over a quarter (26%) of respondents declined to answer.

Figure 14: Adult Participants by Personal Income (n=265)



Housing: Over three-quarters of participants ages 26 and older (79%) reported having stable housing, and an additional 5% reported that they were

[10] Adult participants aged 25 and younger are not included because the Pride Center's demographic survey includes an age category between 16 and 25, which would include current high school students as well.

staying with family or friends. Ten percent declined to answer. The remaining respondents reported that they were homeless, living in a shelter or transitional housing, or had another form of housing.

Veteran Status: Over 95% of adult participants reported that they were not armed forces veterans.

Progress Toward Learning Goals

This section discusses the progress that the San Mateo County Pride Center has made toward achieving its two learning goals:

- **Collaboration**. Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?
- **Access**. Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

A summary of key findings is presented below, followed by a detailed discussion of each learning goal.

Summary of Key Findings

Learning Goal 1: Impact of Coordinated Service Delivery Model

- **Wide Range of Services -** The Pride Center's collaborative organizational model has been instrumental in developing clinical and other services for LGBTQ+ participants across age groups, identities, race/ethnicities, incomes, and languages. Partner agencies each bring their own areas of expertise and coordinate with each other to provide mental health and supportive services for participants with multiple needs.
- **High-Quality Services -** Among Pride Center staff, strong team cohesion has enabled the Center to provide high quality services while they learn how to best operate in a collaborative service delivery model.
- **Increased Capacity** - With outside partner agencies, the Pride Center has developed strong relationships that facilitate referral pathways to the Pride Center as well as improved capacity to serve LGBTQ+ individuals outside of the Pride Center.

Learning Goal 2: Improved Access to Mental Health Services

- **Culturally Responsive Services -** The Pride Center's model increases participant access to quality mental health care by offering therapists who identify as LGBTQ+ and who provide culturally sensitive services for San Mateo County's diverse community.
- **Reduced Stigma -** Having a physical building in a prominent location, highly competent staff, and responsive programs and services, creates an inclusive and welcoming community that promotes entry into and continued participation in mental health and other supportive services for the LGBTQ+ community.

Learning Goal 1: Impact of Coordinated Service Delivery Model

Wide Range of Services

Bringing together multiple organizations to operate the Pride Center has helped ensure that programming and services accommodate a wide range of participants. Because the Center's four partner organizations have different service specializations—for instance, Peninsula Family Services works primarily with older adults, and Adolescent Counseling Services works with youth—the Center can serve a much wider array of people than one organization on their own. In addition, the partner organizations, which had existed long prior in San Mateo County, offered the fledgling Pride Center a stamp of approval as a trustworthy institution.

> *The partners [are each involved] in specializations… one organization could never have done it [alone].*
>
> – Community Advisory Board member

> *The Center had a lot of "street cred" before the beginning…[t]he Center didn't have to sell itself to the community, because the community was already in.*
>
> – Community Advisory Board member

Having an array of services available onsite, along with assistance connecting with outside services, has helped Pride Center clients get the services they need more quickly and with less stress than before the Pride Center. Participants noted that the Center's coordinated model was a major help to individuals who would otherwise have to travel to several different offices to access mental health care and other needed services. The concentration of supportive programs at the Center particularly eases the burden on individuals with mental health challenges, individuals who have experienced homelessness, and/or low-income participants without adequate access to transportation. Besides offering mental health services, the Center case manager addresses some of the practical challenges that low-income LGBTQ+ people might face, like offering assistance in finding employment opportunities, writing a resume, securing necessary documentation, applying for public assistance, and searching for stable housing.

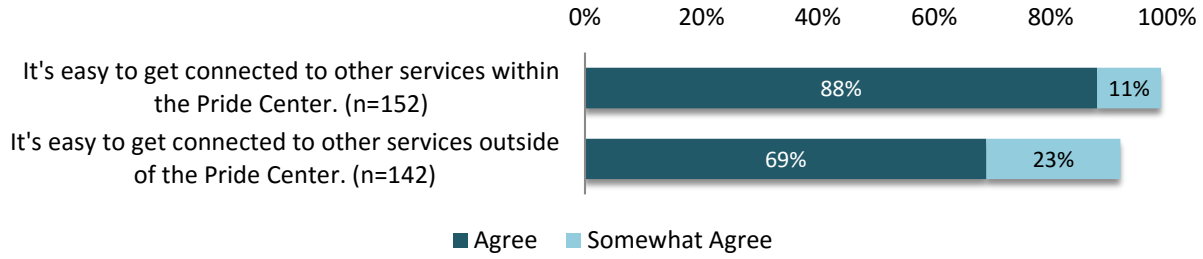
> *It's a one-stop shop…[which is important] especially when you're homeless and you have to get everywhere on foot. There's only so many places you can go in a day.*
>
> – Adult participant

High-Quality Services

Strong internal cohesion among staff members facilitates the delivery of high-quality services to Pride Center participants. Staff and participants both agreed that the Pride Center takes a coordinated approach to serving clients. On the Staff Collaboration Survey, nearly all respondents (90% or more) felt that their team had strongly coordinated health and social services based on participants' needs, regularly communicated as a team regarding participants' care, encouraged and cultivated each team members' particular skills, and worked with participants and their families to adjust care plans. Participants corroborated staff members' internal assessment that this team-based approach to service delivery has enhanced their own wellbeing. As noted in Figure 15 below, 99% of respondents to the Participant

Experience Survey either fully or somewhat agreed that it was easy to connect to other services within the Pride Center, which points to staff members' ability to facilitate those service linkages.

Figure 15: Participant Approval of Service Linkages at the Pride Center in FY2017-18
Source: Participant Experience Survey



Notably, survey respondents found it easier to connect to other services *within* the Center than *outside* the Center: slightly over two-thirds (69%) agreed that it was easy to connect to other services outside of the Center. This finding can be interpreted in two ways: on one hand, it points to the inherent ease of access in a one-stop-shop model; on the other hand, it may suggest an area for improvement in linking participants from the Pride Center with outside agencies.

Increased Capacity

The connections the Pride Center has cultivated with outside agencies have improved coordination and access to mental health services by establishing referral pathways and increasing capacity for LGBTQ+ appropriate care. As discussed in the *Implementation Update* section above, the Pride Center has carried out trainings and outreach with a multitude of County and community partners. These external collaborations have improved access to mental health services for LGBTQ+ individuals—both by raising awareness about the Pride Center and by building capacity for LGBTQ-appropriate services outside the Center.

> *We're a gigantic resource for the San Mateo County community. We're educating the educators and the social service providers, we're building all kinds of networks: GSAs in the schools, alliances in adult groups.*
>
> – Community Advisory Board member

Learning Goal 2: Improved Access to Mental Health Services

Culturally Responsive Services

With a clinical model that offers therapy *by and for* LGBTQ+ individuals, the Pride Center improves access to mental health services for LGBTQ+ individuals who would be less likely to seek or remain in care with non-LGBTQ+ providers. Having a LGBTQ+ therapist has supported many participants' mental

health treatment, as participants feel more understood and supported compared to previous experience with non-LGBTQ+ therapists. Several focus group participants noted that they struggled to find adequate mental health care locally beforehand, and had faced issues when their providers were not trained to work with LGBTQ+ clients. According to participants, LGBTQ+ therapists are more likely to understand their lived experiences; this means that participants are not spending valuable treatment hours explaining terminology, identities, or types of relationships that non-LGBTQ+ therapists may not understand. Not having to worry about whether their therapist will understand them relieves anxiety that many LGBTQ+ individuals experienced when receiving services from non-LGBTQ+ providers. As a result, participants are able to begin treatment with a fundamental sense of trust that they may not have been able to establish with their previous mental health care providers. This trust sets a foundation for a strong patient/provider relationship, which ultimately supports a productive treatment process.

> *When I went to cisgender, heteronormative therapists, I got a blank look. They didn't get it. The [therapists] here understand it on the inside.*
>
> – Adult participant

> *It's incredibly important to have someone you can talk shorthand with.*
>
> – Older adult participant

In addition to the clinical services at the Pride Center, all participants have the opportunity to access drop-in services, join a relevant peer support group, attend Center events, and otherwise benefit from the informal therapeutic gains of the Center as a safe, inclusive space. On the Participant Experience Survey, 100% of respondents (n=134) either agreed (85%) or somewhat agreed (15%) that the services they were receiving at the Center were improving their mental health.

The Pride Center fills a particular gap in access to mental health services and supports for participants who identify as transgender or nonbinary. The Center's clinical services, peer support groups, and other programs are responsive to participants across the LGBTQ+ spectrum, particularly those who are marginalized within health care and public systems, such as transgender and nonbinary individuals. Center staff regularly help transgender or nonbinary participants change their name and/or gender on their personal identification and public records, a process than can be difficult and frustrating when undertaken alone. Clinicians on staff have written letters of support for participants to receive hormonal therapy and gender reaffirming surgeries. One youth participant noted that the Center was the only local facility to offer voice therapy services for transgender people looking to match their voice with their gender identity and expression. The Center's Resource Library also includes chest binders that are made available free of charge to participants. In addition to these regular programs and resources, the Center has also sponsored events such as the annual Transgender Day of Remembrance, and a photo project and social media campaign called In Bloom: Transgender Day of Visibility. Put broadly, Center staff and leadership are aware of the complex mental health and supportive service needs that transgender and nonbinary participants can face and can coordinate service delivery to meet these needs across multiple domains.

> *I don't feel like I need to hide things from [the therapists]. It was a major step in my life…I've had transphobic therapists in the past.*
>
> – Youth participant

Figure 16: Pride Center Participants in the In Bloom: Transgender Day of Visibility Photo Project

Staff members' warmth, client-centered approach, and follow-through has encouraged participants to engage in and remain connected with Pride Center services. Participants of all ages credit the Pride Center staff—clinicians, program staff, and administrative staff alike—for fostering the Center as a welcoming and accessible environment. For instance, one participant noted that the staff member at the front door remembered their name upon a return visit, even though they had not attended any programs in several months. In turn, staff members' helpful disposition has helped some participants to overcome the stigma they had felt around seeking mental health care, and/or their sexual orientation or gender identity. Another adult participant described how they had found the Center when they were questioning their sexual orientation, and how staff members had met with them offsite until they felt comfortable enough to visit the Center.

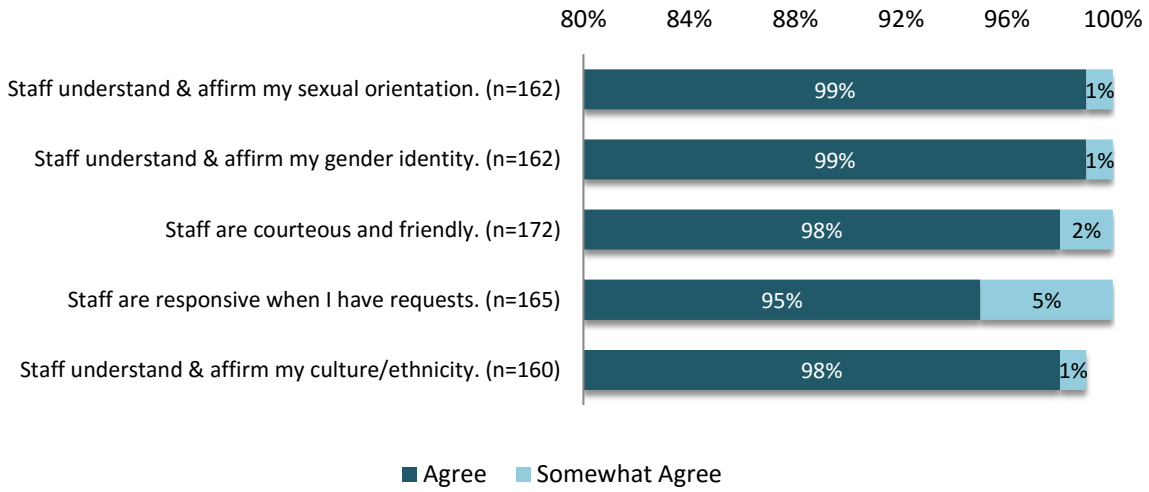
> *Every single time I come here, it's a lovely experience. There's not a single time I cross that door and someone doesn't ask me how I am, or how my day is going.*
>
> – Youth participant

Staff and participants both agreed that the Pride Center uses a client-centered approach that is collaborative and inclusive of participants. On the Staff Collaboration Survey, 100% of respondents agreed that their team: 1) includes patients in setting goals for the patients' care; and 2) listens to the wishes of their patients in determining the process of care chosen by the team. Participants concurred that staff members invite their perspectives in setting their care plans: 99% of respondents (n=135) either agreed (81%) or somewhat agreed (18%) that staff included them in deciding what services were best for them.

Figure 17: Center Staff at the "One Year of Queer" Pride Center Anniversary Celebration

Pride Center staff have developed team cohesion by participating in team-building activities and practicing open communication. All Staff Collaboration Survey respondents indicated that team members respect and trust each other. It is evident from both staff and participants that a collaborative, respectful, and trusting work environment has contributed to staff members' capacity to collaborate in serving participants. Figure 18 shows how respondents to the Participant Experience Survey were nearly unanimous in agreement that Pride Center staff were personable, helped address participants' questions, and were respectful of participants' sexual orientation, gender identity, race, ethnicity, and/or culture.

Figure 18: Participant Approval of Pride Center Staff in FY2017-18 (n=172)
Source: Participant Experience Survey



The Pride Center has cultivated a more racially diverse participant base over time, increasing access to services for historically marginalized LGBTQ+ communities. Last year's annual report noted that one of the Pride Center's early challenges was achieving greater representation from LGBTQ+ people of color. All in all, the Center has made strides in ensuring that the Pride Center serves a racially diverse community

more reflective of San Mateo County and California as a whole. The Center's clinical protocols stipulate that staff prioritize mental health services for members of underserved and marginalized groups, including people of color. The Center recruited clinical staff and interns who were fluent in languages common to local immigrant communities, such as Spanish and Cantonese. In addition, Center staff developed some programming to specifically support San Mateo County's large Latinx community, such as a Queer Latinx Circle support group. Partly due to these concerted efforts, the Pride Center was able to grow a more racially diverse community of participants. As noted in the previous section, during the past year a majority of respondents (52%) to the Center's demographic survey identified as nonwhite or multiracial.

> *I think the [Pride Center is] doing a fantastic job of representing the LGBTQ community. It's nice to see more than just queer white kids.*
>
> – Youth participant

Despite these advances, staff are still committed to improving the representation of participants of color in Pride Center services. For instance, the racial diversity of the Pride Center community was one of the most commonly cited areas for improvement in the write-in responses on the Staff Satisfaction Survey. For FY2018-19, Center staff plan to launch a peer support group for queer and transgender people of color (QTPOC), and to host weekly peer support drop-in services in East Palo Alto and Half Moon Bay, communities with higher concentrations of residents of color.

Reduced Stigma

Providing a physical location and inclusive space for LGBTQ+ individuals improves mental health and wellbeing by reducing social isolation, ameliorating stigma, and creating a sense of community. Participants of all ages noted that the Pride Center provides an important day-to-day community space, where they could go to simply hang out or feel like part of a larger community. Prior to the opening of the Center, many participants had to travel to San Francisco, the East Bay, or San Jose to find an LBGTQ+ friendly community space. Other participants cited that the Pride Center was valuable simply as a space where they could go to find a peaceful, quiet environment. Participants of all ages cited the Pride Center's intergenerational events as some of their favorite Center programs. Older adults relished talking to younger participants about the struggles they faced in growing up LGBTQ+, and youth participants expressed admiration towards the adults who helped build a foundation for the modern-day LGBTQ+ community. In this way, the Center's collaborative service model has helped to create an environment where participants who might never otherwise interact could find commonality. As Figure 19 indicates, 100% of the respondents to the Experience Survey agreed or somewhat agreed that the Pride Center is a welcoming and safe environment, and 99% agreed or somewhat agreed that the Center offers participants a sense of community.

> *What I really like about the Pride Center is that it's a safe space, and it's not triggering.*
>
> – Youth participant
>
> *People should not have to go to Berkeley or San Francisco or San Jose to feel like a part of something.*
>
> – Adult participant

Figure 19: Participant Approval of the Pride Center's Environment and Atmosphere in FY2017-18
Source: Participant Experience Survey

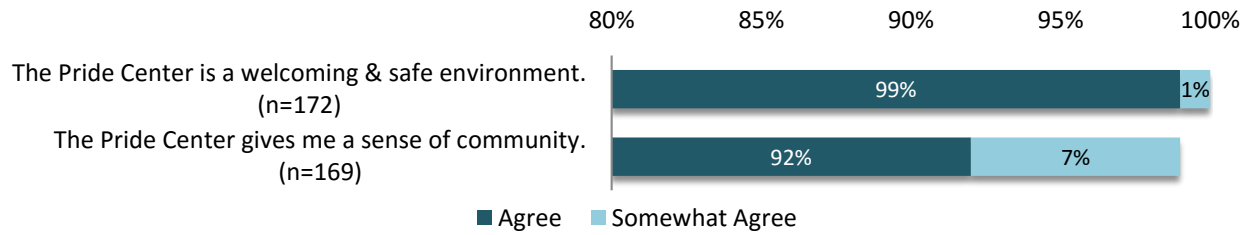


Figure 20: Pride Center Participants at an Intergenerational Dinner

Some participants hailed the Center as a joyous space, noting how the bright and colorful artwork throughout the interior helped to create a welcoming atmosphere. In addition, the artwork and posters promote social inclusion, connecting LGBTQ+ rights to support for civil rights, immigrant rights, disability rights, and racial, gender, and religious equality. That is, the Center supports an intersectional understanding of inclusion within its community of participants. Other participants and CAB members suggested that the very presence of the Pride Center as a physical building on a prominent local thoroughfare (El Camino Real) was itself therapeutic—legitimizing LGBTQ+ residents as equal members of the broader San Mateo County community. Some older adult participants and CAB members contrasted the presence of the Pride Center to their own experiences growing up, when they and their LGBTQ+ peers had no place to publicly gather or express their sexual orientation and gender identity. These individuals thus offered that the very existence of the Center could help to reduce the stress and stigma that LBGTQ+ residents experience from social isolation or discrimination.

In my young life, we were always in some back alley, somewhere dark, hiding…[now] we're here, we're queer, not in some industrial park. We're on El Camino!

– Community Advisory Board member

Just knowing [the Center] is here [is important]… Just having it here and being in the news, seeing the flags…It's that visibility, creating a norm.

– Adult participant

Implementation Lessons

As a new and innovative project, the San Mateo County Pride Center has inevitably experienced challenges as the four partner organizations work together to build a fully operational LGBTQ+ service center. This section highlights the key recommended areas of focus for the Pride Center in establishing a collaborative model that improves access to mental health services for LGBTQ+ residents based on implementation learnings to date.

Despite high levels of collaboration in coordinating service delivery, Pride Center staff observed areas for improvement in establishing and formalizing processes for the internal operations of the Center. As described earlier in this report, Pride Center have developed excellent communication and working relationships. Pride Center staff and partners have also made strides in developing new policies and procedures to guide their work. At the same time, staff recognize that there is still work to do—they are building the Center and its operating procedures from scratch. Staff Collaboration Survey respondents indicated areas for improvement in the following areas:

- Understanding the boundaries of what each other can do;
- Using agreed-upon processes to resolve conflicts; and
- Equally dividing agreed-upon goals among the team.

The above responses indicate potential areas for organizational growth: clarifying staff members' different responsibilities, ensuring an equitable division of labor, and establishing accountability to a standard for conflict resolution. It stands to reason that improving internal workflows around role clarity will further enhance staff members' capacity to serve participants. While the four partner organizations have periodically assisted Pride Center staff in developing and implementing organizational protocols, such as sharing planning documents or other resources from their other program areas, multiple staff members commented on the Collaboration Survey that they could benefit from more support from the partner agencies on matters of organizational development.

The widespread demand for mental health services among LGBTQ+ county residents has challenged staff members' capacity to accommodate all participants' needs. It is to the credit of the Pride Center's coordinated service model and countywide engagement strategies that the Center attracted so many county residents who sought culturally sensitive mental health services for LGBTQ+ individuals. However, the Pride Center's clinical practice lacks the capacity to meet the needs of all participants who access to mental health services through the Center, both in terms of staffing and physical space. As mentioned earlier, in early 2018 Pride Center staff had to relegate some participants seeking mental health care to the clinical practice waitlist. To accommodate the high volume of participant requests for mental health services, Center leadership began to utilize therapist trainees as clinical staff in 2018. This strategy has its limitations, however: because San Mateo County prevents trainees from serving as counselors for mild to moderately mentally ill Medi-Cal clients, the trainees have only been able to work with participants on a sliding scale fee for service. This barrier has proved challenging, as multiple therapist trainees are multilingual and may be best suited to work with Medi-Cal recipients who primarily speak a language other than English.

The high volume of Pride Center activity, combined with the Center's capacity limitations, heightens the risk of staff burnout. In speaking with the RDA evaluation team, Community Advisory Board members raised concerns that the Center's staff members were exerting themselves beyond what was sustainable. To be certain, the CAB's apprehension is a credit to the devotion and commitment that Pride Center staff have demonstrated in making the Pride Center fully operational, coordinating regular onsite and community-based programming, helping clients with needs as they arise, and cultivating the Pride Center as a welcoming space. Nonetheless, the risk of burnout remains among the small body of staff who are responsible for the wide array of Pride Center activities, and who spearheaded the development of the Center into a fully operational service and community space in the past year.

> *Everyone here has such high levels of energy, enthusiasm, knowledge, commitment, heart… [but] you can only sustain that for so long.*
>
> – CAB member
>
> *[I]t feels like everyone is constantly wearing about eight hats and there's never enough time.*
>
> – Pride Center staff member

San Mateo County is a difficult region in which to mobilize LGBTQ+ community members. Some participants contrasted the welcome and inclusive environment of the Pride Center to their neighborhoods of residents and other community spaces, which often tended to be culturally or socially conservative. For instance, Center participants who attend the nearby College of San Mateo have remarked that the campus' climate can make LGBTQ+ students uncomfortable or afraid of expressing their gender identity and/or sexual orientation. In addition, Center staff, participants, and CAB members all noted that the geographic expanse and residential distribution of San Mateo County can make it difficult to reach community members farther away from the Center's location in downtown San Mateo, particularly residents along the coast or in North County. The county lacks ample west-to-east public transportation routes, and CAB members noted that local bus lines periodically cut back their services. While staff, participants, and CAB members have all pursued engagement opportunities throughout the entire county, they have done so in spite of these ongoing infrastructural and geographic challenges to regular outreach.

Conclusion

The 2017-2018 fiscal year marked the first full year of operation of the San Mateo County Pride Center. At the start of FY2017-18, the Center had been open to the public for one month and had just wrapped up its inaugural month of programming. In the year following its Grand Opening, the Pride Center staff and partner organizations established a wide array of clinical services and community-oriented programs. The range of programming helped to foster a multigenerational, multiracial community of participants who identify across the spectrum of sexual orientation and gender identity.

> *I've been involved in a lot of LGBTQ organizations, mostly advocacy groups, focused on a particular issue. This [Center] brings it all together. There's the social component—part of the sense of community, lots of social activities. And also the activities that are for a purpose – support group[s], intergenerational dinner[s]. Also, things the Center is doing to [increase their visibility in the County]… Most LGBTQ organizations don't have that range.*
>
> – Older adult participant

The Pride Center has not only filled a critical gap in local mental health care services; it has also demonstrated the benefit of its unprecedented model of coordinated service delivery. The Center allows participants to access mental health services with LGBTQ+ therapists, which for many participants is a welcome departure from their previous difficulties in finding mental health care providers both knowledgeable and respectful of their sexual orientation and gender identity. In addition, the Pride Center offers a safe space for community members who often experience discrimination or social isolation to gather. In turn, the Pride Center's social events and community-oriented programs provide avenues for participants to connect with mental health care or other supportive services.

Figure 21: Attendees at the Pride Center's Inaugural Queer Youth Prom

In addition, the Center's staff, participants, and Community Advisory Board have conducted community outreach and engagement activities across the county. Pride Center staff delivered workplace trainings for behavioral health clinicians, service providers, educators, and private sector organizations. These trainings empowered providers in other sectors to better serve their LGBTQ+ clients and students and helped build awareness of the Center across San Mateo County. Staff also conducted outreach to students and older adults across the county, working to address the social isolation that many LGBTQ+ individuals experience. That is, the Pride Center's extensive community presence was twofold: to draw more people to the onsite services and programming, and to serve as an

expert resource in making the county's entire network of supportive care and services friendly to LGBTQ+ residents.

The Pride Center is not without its struggles. It is still a relatively young organization, and its staff devoted a large amount of time and effort last year to building the Center's infrastructure, addressing operational challenges, and developing brand-new programs. Staff capacity is limited in its ability to handle the participant demand for mental health care services, and locating sustainable, longer-term sources of funding for the Center remains a concern. Nonetheless, it is clear that the Pride Center has become a crucial community resource within a short amount of time, and has already influenced service providers, employers, and consumers across the county.

The Pride Center is hoping to extend the innovation study period for an additional two years. With additional time, the Pride Center would focus on further developing its internal policies and procedures and serving a larger mental health client base. Having the opportunity to extend the evaluation of how the Pride Center's collaborative model influences access to services and client outcomes would support in documenting a replicable best practice model that can benefit Behavioral Health Services statewide and nationally.

Appendix A: San Mateo Pride Center Data Collection Plan

	Data Collection	Administration Plan				
		To whom	By whom	What format	What frequency	Data entry plan
Participant Surveys	**Participant Demographic Form**	All participants with a minimum of 2 visits	Center administration staff	Paper form	On individual basis	Center staff enter into Survey Gizmo
	Participant Experience Survey	Any participant at a point in time (voluntary)	Center administration staff	Paper and online survey	Annual	Center staff enter into Survey Gizmo
	Clinical Progress Survey (still in development)	All clients who receive clinical services	Center clinicians	Paper survey	At intake, at 6-month follow-up, and at discharge	Center staff enter into ETO database
Center Forms/Data	**Participant Sign-In Sheets**	Any person who enters the Center	Center front desk staff	Paper form	Ongoing	Center staff enter service numbers into online form
	Outreach and Meeting Tracking Sheets	All partner meetings at the Center ***and*** All Center outreach activities held outside the Center	Center administration staff	Paper forms	Ongoing	Center staff enter into ETO database
RDA-Administered Data	**Focus Groups with Staff**	One focus group with direct service staff and one focus group with managers from Center partners	RDA	In-person discussion	Semi-annual	N/A
	Focus Groups with Participants	Center participants	RDA	In-person discussion	Annual	N/A
	Interviews with Center Leadership	Interview with Center Director	RDA	Telephone interview	Annual	N/A
	Partner Collaboration Survey (AITCS-II)	All Center staff and leadership	RDA	Online survey	Baseline and annual	N/A (online)

Appendix B: Collaboration Survey

Assessment of Interprofessional Team Collaboration Scale

Instructions:

The Assessment of Interpersonal Team Collaboration Scale (AITCS) is a validated instrument that is designed to measure the interprofessional collaboration among team members. It consists of 23 statements considered characteristic of interprofessional collaboration (how team works and acts). Scale items represent three elements that are considered to be key to collaborative practice. These subscales are: (1) Partnership— 8 items, (2) Cooperation—8 items, and (3) Coordination—7 items.

Respondents indicate their general level of agreement with items on a 5-point rating scale that ranges from 1 = "Never"; 2 = "Rarely"; 3 = "Occasionally"; 4 = "Most of the time"; to 5 = "Always".

It takes approximately 10 minutes to complete.

Note: Several terms are used for the person who is the recipient of health and social services. For the purpose of this assessment, the term 'patient' will be used. We acknowledge that other terms such as 'client' 'consumer' and 'service user' are preferred in some disciplines/jurisdictions.

Please mark the value which best reflects how you currently feel your team and you, as a member of the team, work or act within the team.

1 = Never
2 = Rarely
3 = Occasionally
4 = Most of the time
5 = Always

Respondent Information

*1) Please select your affiliation status at the Center**

[ ] Staff member at the Center

[ ] Partner with the Center

Section 1. PARTNERSHIP

*2) When we are working as a team, all of my team members... **

	1- Never	2- Rarely	3- Occasionally	4- Most of the time	5- Always	Not Applicable
a. include patients in setting goals for their care	( )	( )	( )	( )	( )	( )
b. listen to the wishes of their patients when determining the process of care chosen by the team	( )	( )	( )	( )	( )	( )
c. meet and discuss patient care on a regular basis	( )	( )	( )	( )	( )	( )
d. coordinate health and social services (e.g. financial,	( )	( )	( )	( )	( )	( )

occupation, housing, connections with community, spiritual) based upon patient care needs						
e. use consistent communication with the team to discuss patient care	( )	( )	( )	( )	( )	( )
f. are involved in goal setting for each patient	( )	( )	( )	( )	( )	( )
g. encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	( )	( )	( )	( )	( )	( )
h. work with the patient and their relatives in adjusting care plans	( )	( )	( )	( )	( )	( )

***Partners may select "Not Applicable" for this section**

Section 2. COOPERATION

3) When we are working as a team, all of my team members…

	1- Never	**2- Rarely**	**3- Occasionally**	**4- Most of the time**	**5- Always**	**Not Applicable**
a. share power with each other	( )	( )	( )	( )	( )	( )
b. respect and trust each other	( )	( )	( )	( )	( )	( )
c. are open and honest with each other	( )	( )	( )	( )	( )	( )
d. make changes to their team functioning based on reflective reviews	( )	( )	( )	( )	( )	( )
e. strive to achieve mutually satisfying resolution for differences of opinions	( )	( )	( )	( )	( )	( )

f. understand the boundaries of what each other can do	( )	( )	( )	( )	( )	( )
g. understand that there are shared knowledge and skills between health providers on the team	( )	( )	( )	( )	( )	( )
h. establish a sense of trust among the team members	( )	( )	( )	( )	( )	( )

Section 3. COORDINATION

4) When we are working as a team, all of my team members...

	1 - Never	**2- Rarely**	**3 - Occasionally**	**4 - Most of the time**	**5 - Always**	**Not Applicable**
a. use a new or unique model of collaborative practice	( )	( )	( )	( )	( )	( )
b. equally (equitably) divide agreed upon goals amongst the team	( )	( )	( )	( )	( )	( )
c. encourage and support open communication, including the patients and their relatives during team meetings	( )	( )	( )	( )	( )	( )
d. use an agreed upon process to resolve conflicts	( )	( )	( )	( )	( )	( )
e. support the leader for the team varying	( )	( )	( )	( )	( )	( )

depending on the needs of our patients						
f. together select the leader for our team	( )	( )	( )	( )	( )	( )
g. openly support inclusion of the patient in our team meetings	( )	( )	( )	( )	( )	( )

Additional Comments

5) Is there anything else you would like to share about your experience with collaboration at the San Mateo County Pride Center?

_____

_____

_____

_____

Demographics

6) What is your age category?

( ) 0-15

( ) 16-25

( ) 26-39

( ) 40-59

( ) Ages 60 and above

( ) Decline to answer

7) Which race/ethnicity do you identify with? (Check all that apply)

[ ] American Indian

[ ] Asian

[ ] Black or African American

[ ] Hispanic or Latino/a/x

[ ] Native Hawaiian or Pacific Islander

[ ] White

[ ] Other: _____

[ ] Decline to answer

8) What is your assigned sex at birth?

( ) Male

( ) Female

( ) Intersex

( ) Decline to answer

9) What is your current gender identity?

( ) Cisgender Man

( ) Cisgender Woman

( ) Trans Man

( ) Trans Woman

( ) Genderqueer

( ) Indigenous gender identity: _____

( ) Questioning or unsure of gender identity

( ) Another gender identity: _____

( ) Decline to answer

10) How do you identify your sexual orientation?

( ) Gay or Lesbian

( ) Heterosexual or Straight

( ) Bisexual

( ) Questioning or unsure of sexual orientation

( ) Queer

( ) Pansexual

( ) Asexual

( ) Indigenous sexual orientation: _____

( ) Another sexual orientation: _____

( ) Decline to answer

11) What is your individual annual income?

( ) 0-$24,000

( ) $25,000-$50,000

( ) $50,001-$75,000

( ) $75,001-$100,000

( ) Above $100,000

( ) Decline to answer

Appendix C: Demographic Form

San Mateo County Pride Center
Participant Information Form

For office use:

Form #_____

Thank you for visiting the San Mateo County Pride Center! This form will help us understand who is receiving services at The Pride Center. Completing this form will support the Center's efforts in implementing its programs. The questions are voluntary and anonymous. Thank you for your time!

Please write today's date: _____

Please write your zip code: _____

1. **What is your age category?** *(mark one)*

- ☐ 0-15
- ☐ 16-25
- ☐ 26-39
- ☐ 40-59
- ☐ Age 60 and above
- ☐ Decline to answer

2. **What is your preferred or primary language?** *(mark one)*

- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Cantonese
- ☐ Russian
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Hindi
- ☐ Farsi
- ☐ American Sign Language
- ☐ Other:_____
- ☐ Decline to answer

3. **How do you define your race?**

(mark all that apply)

- ☐ American Indian/Native American/Native Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino/a/x
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White/Caucasian
- ☐ Other:_____
- ☐ Decline to answer

4. **How do you define your ethnicity?**

(mark all that apply)

Hispanic/Latino Ethnicity:

- ☐ Caribbean
- ☐ Central American:_____
- ☐ Mexican/Mexican-American/Chicano/a/x
- ☐ Puerto Rican
- ☐ El Salvadorian
- ☐ South American:_____

Non-Hispanic/Latino Ethnicity:

- ☐ African
- ☐ Asian Indian/South Asian
- ☐ Cambodian
- ☐ Chinese
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ Pacific Islander
- ☐ Indigenous Nation
- ☐ Vietnamese
- ☐ Other:_____
- ☐ Decline to answer

☐ **What is your assigned sex at birth?** *(mark one)*

☐ Male
☐ Female
☐ Intersex
☐ Decline to answer

☐ **What is your gender identity?** *(mark one)*

☐ Cisgender Man
☐ Cisgender Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man/Trans-masculine/Man
☐ Male-to-Female (MTF)/Transgender Woman/Trans Woman/Trans-feminine/Woman
☐ Genderqueer/Gender nonconforming/neither exclusively male nor female
☐ Indigenous gender identity:_____
☐ Questioning or unsure of gender identity
☐ Another gender identity:_____
☐ Decline to answer

☐ **How do you identify your sexual orientation?** *(mark one)*

☐ Gay or Lesbian
☐ Heterosexual or Straight
☐ Bisexual
☐ Questioning or unsure of sexual orientation
☐ Queer
☐ Pansexual
☐ Asexual
☐ Indigenous sexual orientation:_____
☐ Another sexual orientation:_____
☐ Decline to answer

☐ **Do you have any of the following disabilities or health conditions?** *(mark all that apply)*

A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

☐ Difficulty seeing
☐ Difficulty hearing, or having speech understood
☐ Other communication challenges:_____
☐ Limited physical mobility
☐ Learning disability
☐ Developmental disability
☐ Dementia
☐ Chronic health condition
☐ Other disability or health condition:_____
☐ None
☐ Decline to answer

5. **What is your highest level of education?** *(mark one)*

☐ Less than high school diploma
☐ High school diploma or GED
☐ Some college
☐ Vocational or trade certificate
☐ Associate's Degree
☐ Bachelor's Degree
☐ Graduate Degree
☐ Decline to answer

6. **What is your current employment status?** *(mark one)*

☐ Full time employment
☐ Part time employment
☐ Unemployed and looking for work
☐ Unemployed and not looking for work
☐ Retired
☐ Student
☐ Decline to answer

7. **What is your current housing status?** *(mark one)*

☐ I have stable housing
☐ I am staying with friends or family
☐ I am living in a shelter or transitional housing
☐ I am homeless
☐ Other housing status:_____
☐ Decline to answer

Complete questions 12 &13 if you are 18 years old and over

8. **What is your individual annual income?** *(mark one)*

☐ 0-$24,999
☐ $25,000- $50,000
☐ $50,001- $75,000
☐ $75,001- $100,000
☐ Above $100,000
☐ Decline to answer

9. **Are you a veteran?** *(mark one)*

☐ Yes, I am a veteran
☐ No, I am not a veteran
☐ Decline to answer

Appendix D: Participant Experience Survey

San Mateo County Pride Center Participant Experience Survey

For office use:
Form #_____

Welcome to the Participant Experience Survey! The purpose of this 5-minute survey is to hear from you about the services you have received and/or programs you've participated in at the San Mateo County Pride Center. The information you provide will help improve our services and programs to better meet the needs of community members. All of your answers will be anonymous.

We appreciate you taking the time to share your experience with us!

1. How many times have you visited the Pride Center?

❑ 1 time ❑ 2 to 5 times ❑ More than 5 times

2. Please mark the services you have participated in at the Pride Center. (*Check all that apply.*)

❑ Case Management ❑ Education / Training ❑ Social Activities / Events
❑ Community Meetings ❑ Drop-In Center ❑ Peer Group:_____
❑ Connection to Resources ❑ Therapy services ❑ Other: _____

3. Please rate your interactions with the Pride Center's staff.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
Staff are courteous and friendly.	❑	❑	❑	❑
Staff are responsive when I have requests.	❑	❑	❑	❑
Staff understand & affirm my sexual orientation.	❑	❑	❑	❑
Staff understand & affirm my gender identity.	❑	❑	❑	❑
Staff understand & affirm my culture/ethnicity.	❑	❑	❑	❑

(NOTE: "Staff" refers to any professional who provides services/programming.)

4. Please rate your experiences with the facility.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
The Pride Center is a welcoming & safe environment.	❑	❑	❑	❑
The Pride Center gives me a sense of community.	❑	❑	❑	❑
The Pride Center is in a convenient location.	❑	❑	❑	❑
The hours of the Pride Center work with my schedule.	❑	❑	❑	❑

5. Please rate your experiences with the services provided at the Pride Center.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
It's easy to get connected to other services within the Pride Center.	❑	❑	❑	❑
It's easy to get connected to other services outside of the Pride Center.	❑	❑	❑	❑
The Pride Center staff include me in deciding what services are best for me.	❑	❑	❑	❑
The services that I am receiving at the Pride Center are improving my mental health.	❑	❑	❑	❑

[TURN PAGE OVER TO CONTINUE]

6. Please note any other services/programs to which the Pride Center has connected you. (OPTIONAL)

7. Please share any positive or negative experiences you have had with the Pride Center. (OPTIONAL)

Your Background

The following questions are optional and will help us know more about who responded to our survey.

A) What is your age category?

❑ 0 – 15 ❑ 16 – 25 ❑ 26 – 39 ❑ 40 – 59 ❑ 60 & above ❑ Decline to Answer

B) With which race/ethnicity do you identify? (*Check all that apply*.)

❑ American Indian / Native Alaskan
❑ Asian / Asian American
❑ Black / African American
❑ Hispanic / Latino/a / Latinx
❑ Native Hawaiian / Pacific Islander
❑ White
❑ Other: _____
❑ Decline to Answer

C) What is your assigned sex at birth?

❑ Female ❑ Male ❑ Intersex ❑ Decline to Answer

D) What is your current gender identity?

❑ Cisgender Man
❑ Cisgender Woman
❑ Genderqueer / Gender Nonconforming / Neither exclusively male nor female
❑ Questioning or Unsure of Gender Identity
❑ Female-to-Male (FTM) / Transgender Male / Trans Man / Trans-masculine / Man
❑ Male-to-Female (MTF) / Transgender Woman / Trans Woman / Trans-feminine / Woman
❑ Indigenous gender identity: _____
❑ Other gender identity: _____
❑ Decline to answer

E) How do you identify your sexual orientation?

❑ Gay or Lesbian
❑ Heterosexual or Straight
❑ Bisexual
❑ Questioning / Unsure
❑ Queer
❑ Pansexual
❑ Asexual
❑ Decline to Answer
❑ Indigenous sexual orientation: _____
❑ Other sexual orientation: _____

Appendix E: San Mateo County Pride Center End of Year Report

[replace]

Appendix F. Data Tables

Demographic Data

To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined. RDA was unable to create a table displaying demographic data on preferred language due to most responses having fewer than five responses. The total number of responses for each question may not add to 41 because some individuals did not answer every question on the form, while some questions allowed participants to select multiple responses.

Table 1. Participants served by age

Age	Count	Percent
0-15	18	5%
16-25	117	29%
26-39	119	30%
40-59	103	26%
Age 60 and above	33	8%
Decline to Answer	10	3%
TOTAL	**400**	**100%**

Table 2. Participants served by race (some participants are counted more than once, as they could mark all categories that apply)

Race	Count	Percent
White or Caucasian	214	54%
Hispanic or Latino/a/x	93	23%
Asian or Asian American	78	20%
Black or African American	19	5%
Other	17	4%
Native Hawaiian or Pacific Islander	16	4%
Native American or Native Alaskan	11	3%
Decline to answer	7	2%

Table 3. Participants served by ethnicity (some participants are counted more than once, as they could mark all categories that apply)

Ethnicity	Count	Percent
European	110	28%
Mexican, Mexican American, or Chicano/a/x	51	13%
Decline to answer	36	9%
Other	34	9%
Filipino/a/x	33	8%
Chinese	27	7%
Eastern European	19	5%
South American	19	5%
African	17	4%
Other Asian ethnicity (Japanese, Korean, Vietnamese, Cambodian)	16	4%
Other Latino/a/x ethnicity (Puerto Rican, Caribbean)	11	3%
Middle Eastern	10	3%
Salvadoran	10	3%
South Asian	8	2%
Central American	8	2%

Table 4. Participants served by sex at birth

Sex	Count	Percent
Female	243	61%
Male	122	31%
Other or Decline to answer	35	9%
TOTAL	**400**	**100%**

Table 4. Participants served by gender identity

Gender identity	Count	Percent
Cisgender Woman	156	39%
Cisgender Man	92	23%
Decline to answer	71	18%
Genderqueer / Gender nonconforming / Neither exclusively male nor female	36	9%
Female-to-Male (FTM) / Transgender Male / Trans Man / Trans-masculine / Man	14	4%
Questioning or unsure of gender identity	11	3%
Male-to-Female (MTF) / Transgender Woman / Trans Woman / Trans-feminine / Woman	10	3%
Another gender identity	9	2%
TOTAL	**400**	**100%**

Table 5. Participants served by sexual orientation

Sexual orientation	Count	Percent
Gay or Lesbian	119	30%
Heterosexual or Straight	119	30%
Queer	49	12%
Decline to answer	36	9%
Bisexual	34	9%
Pansexual	18	5%
Asexual	12	3%
Questioning or unsure of sexual orientation	7	2%
Another sexual orientation; Indigenous sexual orientation	6	2%
TOTAL	**400**	**100%**

Table 6. Participants served by disability status (some participants are counted more than once, as they could mark all categories that apply)

Disability Status	Count	Percent
None	237	59%
Other ailments	33	8%
Chronic health problems	22	6%
Decline to answer	22	6%
Difficulty seeing	20	5%
Learning disability	14	4%
Difficulty hearing	12	3%
Limited physical mobility	9	2%
Other communication challenges	5	1%

Table 7. Participants served by level of education

Level of Education	Count	Percent
Less than a high school diploma	29	7%
High school diploma or GED	24	6%
Some college	57	14%
Vocational or trade certificate	8	2%
Associate's degree	15	4%
Bachelor's degree	127	32%
Graduate degree	112	28%
Decline to answer	4	10%
TOTAL	**400**	**100%**

Table 8. Participants served (aged 26 and older) by income

Income	Count	Percent
0-$24,999	41	16%
$25,000-$50,000	43	16%
$50,001-$75,000	43	16%
$75,001-$100,00	33	13%
Above $100,000	36	14%
Decline to answer	69	26%
TOTAL	**265**	**100%**

Table 9. Participants served by employment status

Employment Status	Count	Percent
Full-time employment	175	44%
Student	67	17%
Part-time employment	55	14%
Decline to answer	43	11%
Unemployed and looking for work	41	10%
Retired	19	5%
TOTAL	**400**	**100%**

Table 10. Participants served (aged 26 and older) by housing status

Housing status	Count	Percent
I have stable housing	209	79%
Decline to answer	27	10%
Other housing status; I am living in a shelter or transitional housing; I am homeless	16	4%
I am staying with friends or family	13	5%
TOTAL	**265**	**100%**

Collaboration Survey Results

Section 1: Partnership

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. include patients in setting goals for their care	**14**	0	0	0	3	11
b. listen to the wishes of their patients when determining the process of care chosen by the team	**15**	0	0	0	3	12
c. meet and discuss patient care on a regular basis	**14**	0	1	0	4	9
d. coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	**15**	0	0	1	4	10
e. use consistent communication with the team to discuss patient care	**15**	0	0	1	7	7
f. are involved in goal setting for each patient	**14**	0	1	1	5	7
g. encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	**15**	0	0	1	3	11
h. work with the patient and their relatives in adjusting care plans	**15**	0	0	1	4	10

Section 2: Cooperation

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. share power with each other	**20**	0	0	3	10	7
b. respect and trust each other	**20**	0	0	0	10	10
c. are open and honest with each other	**20**	0	0	1	9	10
d. make changes to their team functioning based on reflective reviews	**20**	0	0	3	9	8
e. strive to achieve mutually satisfying resolution for differences of opinions	**20**	0	0	1	7	12
f. understand the boundaries of what each other can do	**20**	0	1	4	8	7
g. understand that there are shared knowledge and skills between health providers on the team	**19**	0	0	1	5	13
h. establish a sense of trust among the team members	**19**	0	0	0	10	9

Section 3: Coordination

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. use a new or unique model of collaborative practice	**20**	0	0	5	6	9
b. equally (equitably) divide agreed upon goals amongst the team	**20**	0	3	1	9	7
c. encourage and support open communication, including the patients and their relatives during team meetings	**20**	0	0	1	8	11
d. use an agreed upon process to resolve conflicts	**18**	1	1	2	7	7
e. support the leader for the team varying depending on the needs of our patients	**18**	0	0	2	4	12
f. together select the leader for our team	**16**	0	1	2	6	7
g. openly support inclusion of the patient in our team meetings	**15**	0	2	1	5	7

San Mateo County Adult NMT Pilot Fiscal Year 2017-18 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2018

Table of Contents

Introduction

Project Overview and Learning Goals

San Mateo Behavioral Health and Recovery Services (BHRS) implemented the Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care as part of the three-year Mental Health Services Act (MHSA) Innovation (INN) plan. The MHSA INN project category and primary purpose of the NMT pilot project are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase quality of mental health services, including measurable outcomes.
- **Project Innovation:** While NMT has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate the adult NMT pilot project. This report provides findings from the second year of NMT implementation—July 1, 2017 to June 30, 2018—in the BHRS Adult System of Care.

BHRS developed two learning goals to guide the NMT pilot and assess the extent to which the program is meeting its intended MHSA objectives—to increase the quality of services and consumer outcomes. The learning goals are outlined in Figure 1 below. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes.

Figure 1. NMT Pilot Project Learning Goals

Learning Goal 1	Learning Goal 2
•Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?	•Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

Project Need

Through the MHSA Community Planning Process in San Mateo, BHRS and community stakeholders identified the need to provide alternative treatment options to broaden and deepen the focus on trauma informed care and provide better outcomes in recovery for adult BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma that is grounded in neurodevelopment and neurobiology. Subsequent sections provide a more in-depth description of NMT and its application to adults.

Project Description and Timeline

NMT Background

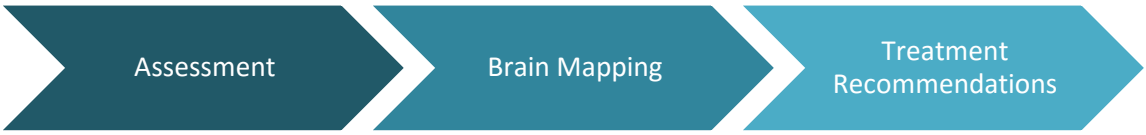
The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs.[1]

NMT is guided by the principle that trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment. The selected set of therapeutic interventions intends to help change and reorganize the neural systems to replicate the normal sequence of brain and functional development. Selected interventions first target the lowest, most abnormally functioning parts of the brain. Then, as consumers experience functional improvements, interventions are selected that target the next, higher brain region. The sequence of interventions aims to help consumers better cope, self-regulate, and progress in their recovery.

NMT Processes and Activities

As depicted in Figure 2, the NMT process consists of three main phases: 1) assessment, 2) brain mapping, and 3) the development of individualized treatment recommendations. These phases are briefly described below.

Figure 2. Key phases of the NMT Process



[1]Perry, B.D. & Hambrick, E. (2008) The Neurosequential Model of Therapeutics. *Reclaiming Children and Youth*, *17*(3), 38-43.

Assessment. NMT-trained providers collect information pertaining to the consumer's history of adverse experiences—including their timing, nature, and severity—as well as any protective factors. This information is used to estimate the risk and timing of potential developmental impairment. The assessment also includes an examination of current functioning and relationship quality (e.g., with parents, family, peers, community, etc.).

Brain Mapping. NMT-trained providers enter assessment data into a web-based tool designed by the CTA, which uses assessment data to generate a brain map illustrating the brain regions most affected by developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are compared with age typical domain values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

Treatment Recommendations. Therapeutic interventions are identified that address the consumer's needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. Throughout treatment, assessments and brain mapping are performed at regular intervals to evaluate any changes in functional domains, and treatment recommendations are adapted as appropriate.

Application of NMT to Adults

Since its development, NMT has been most widely used with children who experienced maltreatment and/or trauma, and BHRS has been using the NMT approach with children since 2012. However, the use of NMT with adults is limited. Given the high prevalence of trauma among adult behavioral health consumers and the relationship between childhood trauma and behavioral health issues in adulthood, there is a strong theoretical basis to predict that adult mental health consumers could benefit from the NMT approach.[2,3]

Nevertheless, NMT's effectiveness in the adult population is unknown. As mentioned, NMT has not been formally implemented into an adult system of care, and no outcome studies have been conducted to evaluate NMT in an adult population. BHRS is adapting, piloting, and evaluating the application of the NMT approach to an adult population with hopes of increasing the quality of mental health services and improving recovery outcomes for adult mental health consumers with a history of trauma.

[2]It is estimated that 40-80% of adults with mental illness and/or substance use issues also have experiences of trauma.
Source: Missouri Institute of Mental Health. (2004). Trauma among people with mental illness, substance use disorders and/or developmental disabilities. *MIMH Fact Sheet, January 2004.* Retrieved from: https://dmh.mo.gov/docs/mentalillness/traumafactsheet2004.pdf

[3]Anda, R.F., Felitti, V.J., Bremner, J.D., Walker, J.D., Whitfield, C., Perry, B.D., … Giles, W.H. (2006). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186.

BHRS NMT Pilot Project

NMT Providers

As mentioned, BHRS has been using the NMT approach with youth since 2012. In that time, 30 clinical staff in the BHRS Child and Youth System of Care and 10 clinical staff from community-based partner agencies received training through CTA.[4] In addition, 10 BHRS providers have become certified NMT trainers, and certify other providers in NMT through the CTA training. These trainers serve as mentors to NMT trainees and teach NMT principles and provide consultation to other providers. To expand NMT to the adult population, 12 providers within the BHRS Adult System of Care began NMT training with CTA in January 2017. The providers work in a variety of settings, including BHRS specialty mental health or regional clinics and programs serving consumers re-entering the community following incarceration.

Target Population

BHRS estimates that the adult NMT pilot project will serve approximately 75 to 100 adult consumers annually once the BHRS providers in the Adult System of Care are fully trained. Providers refer existing BHRS consumers from their caseloads to NMT, targeting three adult mental health populations:

- General adult consumers (ages 26+) receiving specialty mental health services;
- Transition age youth (TAY) consumers (ages 18-25); and
- Criminal justice-involved consumers re-entering the community following incarceration.

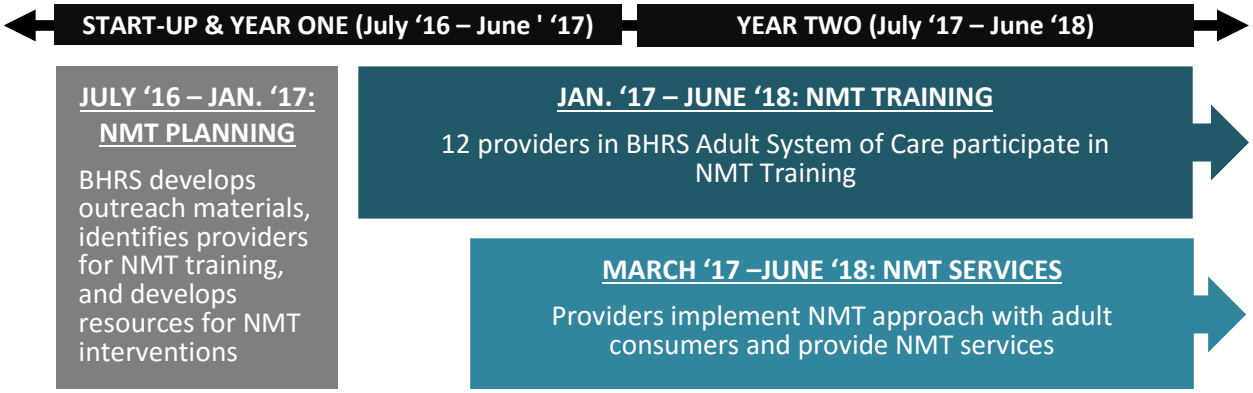
The three target populations likely have different experiences, needs, and coping skills and, as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches such as NMT. In addition, the re-entry population might have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high-risk behaviors that might lead to incarceration. For the re-entry population, the experience of incarceration could also further contribute to trauma.

Implementation Timeline

Figure 3 illustrates the key activities that have taken place since NMT implementation began in July 2016.

[4]CTA operates the formal training certification program. The training takes place over approximately one year, with trainees learning through a combination of readings, videos, webinars, and case-based trainings.

Figure 3. NMT Implementation Timeline



Evaluation Overview

As mentioned, BHRS contracted RDA to evaluate the pilot and support project learning. In order to maximize RDA's role as research partners, RDA collaborated with BHRS and CTA when planning the evaluation—including identifying evaluation goals, validating the theory of change for NMT specific to the adult population, identifying the types of variables that may support or complicate outcomes in adults, and developing data collection tools to measure program implementation and consumer outcomes.

To guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The evaluation questions (EQ) are listed below. To the extent possible, the evaluation will examine implementation and outcome differences across the three target populations to identify how BHRS can adapt the NMT approach to best meet each population's unique needs. More in-depth information about the evaluation is available in the evaluation plan included in the Appendix.

Learning Goal 1: Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?

> **EQ 1.1.** How is the NMT approach being adapted to serve an adult population?
>
> **EQ 1.2.** Who is being served by the adult NMT project, what types of NMT-based services are consumers receiving, and with what duration and frequency?

Learning Goal 2: Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

> **EQ 2.1.** To what extent is the NMT approach supporting improvement in adult consumers' functional outcomes and overall recovery and wellbeing?
>
> **EQ 2.2.** To what extent is the experience of care with the NMT approach different from consumers' previous care experiences?

The first year of the evaluation focused largely on Learning Goal 1 to identify how BHRS is implementing and adapting the NMT approach with the adult population. During this second year, the evaluation examines both Learning Goals to: 1) identify how NMT implementation has progressed as the program has matured and providers are further along in or have completed NMT training, and 2) examine preliminary changes in consumers' functional and recovery outcomes as consumers participate in NMT.

Evaluation Methods

Data Collection

RDA employed a mixed-methods evaluation approach (i.e., using both qualitative and quantitative data) to identify who is participating in NMT, how BHRS is adapting the NMT approach for the adult population, and preliminary consumer outcomes. This report includes information about NMT implementation as well as preliminary consumer outcomes for adults who participated in NMT services during the evaluation period—July 1, 2017 to June 30, 2018, fiscal year 2017-2018 (FY17-18).

RDA worked closely with BHRS to identify and obtain appropriate outcome measures and data sources to address the evaluation questions. RDA collected quantitative information about NMT consumers from two main data sources: 1) BHRS's Electronic Health Record (EHR) system, Avatar, and 2) the NMT Database operated by CTA, which includes brain map and functional domain scores as well as recommended NMT interventions.

RDA also collected qualitative data through a focus group conducted with BHRS NMT providers (6 participants) on August 7, 2018 and a focus group with NMT consumers (7 participants) on September 27, 2018. The focus group with NMT providers centered on providers' experience of NMT training, how they are adapting the NMT approach with the adult population, and implementation successes and challenges. The focus group with the NMT consumers centered largely on their experience with NMT services, how NMT services differ from other mental health services received, and the perceived impacts of NMT on their wellness and recovery. Table 1 outlines the outcome data available for this report as well as the respective data sources.[5]

Table 1. Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Number of consumers participating in NMT services	Electronic Health Records
	Characteristics of NMT consumers	Electronic Health Records
	Provider experience of NMT training and NMT implementation with the adult population	NMT Provider Focus Group
	Types of recommended NMT interventions	Consumer and Provider Focus Groups and NMT Database

[5]The Data Collection and Analysis section of the Appendix includes the types of additional outcome data expected to be available in later reports.

Outcome Type	Outcome Measures	Data Sources
Consumer Outcomes	Changes in functional domain scores	NMT Database
	Perceived impact of NMT services on consumer functional and recovery outcomes	NMT Consumer and Provider Focus Groups
	Consumer experience of NMT services	Consumer Focus Group

Data Analysis

To analyze the quantitative data (e.g., consumer characteristics and service utilization), RDA used descriptive statistics to examine frequencies and ranges. To analyze qualitative data, RDA transcribed focus group participants' responses to appropriately capture the responses and reactions of participants. RDA then thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Implementation Update

Changes to Innovation Project during Reporting Period

There were no changes to the NMT pilot project during the 2017-2018 fiscal year.

Key Accomplishments

Six providers within the BHRS Adult System of Care completed NMT training and are continuing training to become certified NMT trainers. In January 2017, 12 providers in the BHRS Adult System of Care began the scheduled CTA NMT training. As of the end of the reporting period, six providers completed the NMT training and are certified in NMT. Of these providers, five are continuing on to NMT "Train-the-Trainer" training, which began in July 2018, to become certified NMT trainers. Four providers are still continuing the NMT training, while two providers stopped the training due to workload and/or other demands but are intending to restart the training at a later date.

In year 2 of the NMT pilot, the number of consumers receiving NMT services doubled from year 1. During the second year of the NMT pilot project, 40 adult consumers received NMT-based services compared to 20 consumers during year 1. During year 2, providers completed baseline assessments with 37 consumers and completed follow-up assessments with 11 consumers. As providers are progressing through the training and have become more confident with the NMT assessment, providers are beginning to implement NMT assessments and interventions with more clinical cases. As more providers become fully trained, BHRS anticipates approximately 75 to 100 adult consumers will receive NMT services annually.

BHRS expanded the NMT resources and interventions available to consumers in the Adult System of Care. During the first year of the pilot project, the NMT interventions for adults were somewhat limited as BHRS worked to expand available resources. However, during the second year of the evaluation, BHRS established relationships with other services and programs, including yoga, drumming, therapeutic massage, and animal-assisted therapy. Additionally, providers within the adult system of care have been

able to use NMT pilot funding to better equip their offices and clinics with resources and tools for NMT interventions—including therapeutic lighting, art supplies, adult coloring books, weighted blankets, fidget spinners, bubbles and silly putty, sensory brushes, and other sensory integration tools. This broader array of NMT interventions will allow greater opportunity for both providers and consumers to try different therapies and identify the interventions that best meet consumers' needs.

NMT Consumer Profile

The following section describes the consumer population that participated in NMT services during FY17-18, including demographic information, behavioral health diagnoses, behavioral health service utilization, and baseline NMT assessment information.

Demographic Information

As mentioned previously, BHRS aims to serve three adult populations through the NMT pilot project: adult consumers (ages 26+) receiving specialty mental health services, TAY (ages 18-25) receiving mental health services, and criminal justice-involved consumers re-entering the community following incarceration.

During FY17-18, 40 adult consumers received NMT services, all of whom reflect the intended target population. Most consumers (n=31, 78%) were adults ages 26-59, while nine consumers (23%) were TAY. No consumers were under the age 18. In addition, at least 15 consumers (38%), including both adults and TAY, were also part of the re-entry population.[6]

Figure 4. NMT Consumer Population, FY17-18, N=40

Table 2 describes the demographic characteristics of the NMT consumers.[7] For some characteristics, information was unknown or not reported for all consumers. As a result, the total number of consumers may be less than 40. The number of consumers for whom information is available is reported in the table.

[6]Consumers were identified as part of the criminal justice/re-entry population if they received behavioral health services in custody, services through the BHRS mental health court, or services through a provider aimed at serving the re-entry population (e.g., Service Connect).

[7]In accordance with HIPAA, demographic categories comprised of fewer than five consumers were aggregated to protect consumer privacy.

Two-thirds of consumers reported they were female (n=26, 65%) and one-third reported they were male (n=14, 35%); no consumers reported a different sex.[8] The largest racial group was White (n=15, 42%), while 33% reported another race including Asian, Black or African American, and Other. Nine consumers (25%) reported they were two or more races. One-third of consumers reported they were Hispanic or Latino (n=12, 33%).

Nearly all consumers (n=37, 93%) spoke English as their primary language, while some consumers primarily spoke another language or more than one language. Most consumers reported they were heterosexual (n=14, 78%), while 17% (n=6) reported they were another sexual orientation, and 6% (n=2) declined to state their sexual orientation. Over half of consumers (n=24, 60%) had a known disability, including a chronic health condition, an intellectual disability, or another type of disability. No consumers reported that they were a veteran.

Table 2. Demographic Characteristics of Consumers, FY17-18

Characteristic	Consumers	% of Total
Gender (N=40)		
Female	26	65%
Male	14	35%
Race (N=36)		
White	15	42%
Other Race	12	33%
Two or More Races	9	25%
Ethnicity (N=36)		
Hispanic/Latino	12	33%
Not Hispanic/Latino	24	67%
Primary Language (N=40)		
English	37	93%
Other	3	7%
Sexual Orientation (N=36)		
Heterosexual	28	78%
LGBTQ+[9]	6	17%
Decline to State	2	6%
Disability (N=40)		
Any Disability	24	60%
No Known Disability	16	40%

Behavioral Health Diagnoses

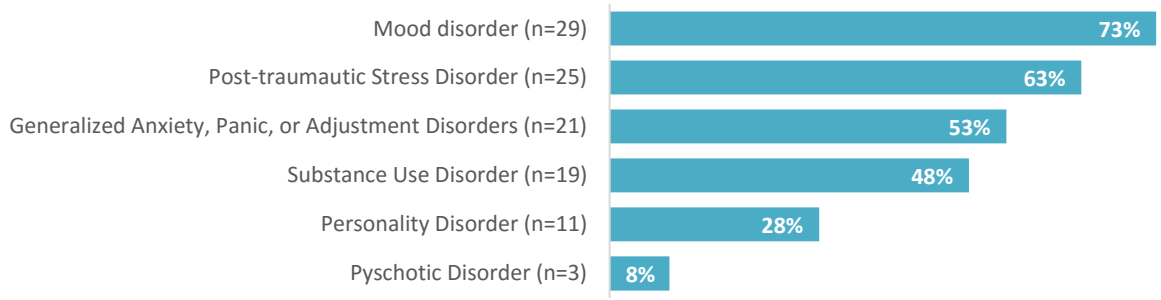
Consumers who participated in NMT had a variety of mental health diagnoses. Typically, the majority of adult consumers receiving specialty mental health services within adult systems of care have been diagnosed with a psychotic disorder (e.g., schizophrenia or schizoaffective disorder) or a mood disorder

[8]Information regarding gender identity was not available for this report. However, BHRS is actively working to incorporate gender orientation questions into their EHR.
[9]LGBTQ+ refers to lesbian, gay, bisexual, transgender, questioning or gender queer, intersex, asexual, or other sexual orientations.

(e.g., bipolar or major depressive disorders). However, as shown in Figure 5, the NMT population served during FY17-18 had a wider variety of behavioral health diagnoses. Consumers may have more than one behavioral health diagnosis; as a result, percentages add to greater than 100%.

While the most common diagnosis was a mood disorder wherein 73% (n=29) of consumers were diagnosed with a depressive or bipolar disorder, only 8% of consumers (n=3) were diagnosed with a psychotic disorder. Nearly two-thirds of consumers (63%, n=25) were diagnosed with a posttraumatic stress disorder (PTSD), and half (53%, n=21) were diagnosed with a generalized anxiety, panic, or adjustment disorder. In addition to these mental health diagnoses, 28% (n=11) also had a diagnosed personality disorder. Substance use is also prevalent among the population served, wherein half of consumers (n=19, 48%) have a documented co-occurring substance use disorder. Of these consumers, most reported using several substances, while some were diagnosed with specific cannabis, alcohol, amphetamine, or opioid use disorders. Most consumers with documented substance use disorders were also part of the criminal justice re-entry population.

Figure 5. Behavioral Health Diagnoses of NMT Consumers, N=40, FY17-18

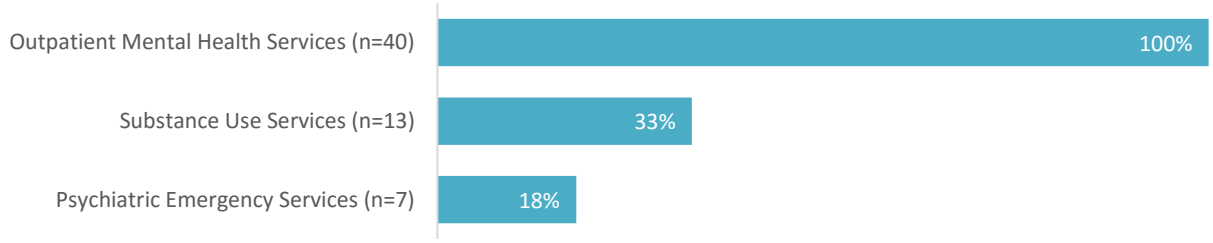


The breadth of diagnoses aligns with some of the diagnostic challenges that arise when working with individuals who have experienced significant trauma. Adults who have experienced trauma often have a more complex clinical presentation, frequently characterized by symptoms of anxiety, depression, and other mood fluctuations as well as substance misuse. Symptoms reflective of trauma may not clearly align to any one diagnosis within the existing diagnostic classification systems (e.g., DSM-IV TR or DSM-V). The relatively high prevalence of documented personality disorders may also be indicative of pervasive childhood trauma. As more consumers participate in NMT, it will be possible to explore consumers' clinical profile in greater depth.

Behavioral Health Service Utilization

All consumers who received NMT services were enrolled in and receiving outpatient mental health services. This aligns with the model of integrating NMT within existing mental health services rather than creating a stand-alone program. In addition to outpatient mental health services, one-third of consumers (n=13, 33%) also participated in outpatient and/or residential substance use services in the year prior to NMT enrollment. Additionally, in the year prior to NMT enrollment, 18% of consumers (n=7) experienced a mental health crisis that required psychiatric emergency services.

Figure 6. Behavioral Health Service Utilization, N=40, FY17-18



Baseline NMT Assessments

Brain Map and Functional Domain Scores

As mentioned previously, NMT-trained providers enter assessment data into a web-based tool designed by the CTA that uses the assessment data to generate a brain map illustrating the brain regions most likely to be affected by developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The brain map and functional domain values can then be compared with age typical values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

These functional domains are defined as follows:

- **Sensory Integration** refers to a set of functions that integrate, process, store, and act on sensory input from outside (e.g., visual, auditory) and inside (e.g., metabolic) the body.
- **Self-Regulation** refers to a broad set of functions that modulate and regulate the activity of other key systems in other parts of the body and brain, such somatosensory and emotional regulation.
- **Relational** refers to the complex set of relationship-related functions such as bonding, attachment, attunement, reward, empathy, and related emotional functions.
- **Cognitive** refers to the myriad functions involved in complex sensory processing, speech, language, abstract cognition, reading, future planning, perspective-taking, moral reasoning, and similar cognitive capabilities.

As of the end of the reporting period, baseline assessments were completed for 37 consumers.[10] Of these 37 consumers, 29 were adults (78%) and 8 were TAY (22%). For each consumer, functional domain values were compared with age typical values to calculate the percent of age typical (i.e., the functional domain score). A score of 100% indicates normal functioning with respect to a person's age. A score lower than 100% indicates some degree of impairment, wherein lower scores correspond to greater impairment. For example, a functional domain score of 70% indicates greater impairment than a value of 80%.

The average baseline scores for the total brain map and each of the functional domains are illustrated in Figure 7. Consumers' average baseline brain map score was 81%. However, the values ranged widely from 53% (indicating a high degree of impairment) to 100% (indicating normal functioning). Consumers

[10] Baseline assessments were still ongoing and not yet completed for the remaining three consumers.

appeared to have relatively high functioning in the sensory integration and cognitive domains at baseline. The average sensory integration score was 85% (range: 51% to 100%), while the average cognitive domain score was 87% (range: 62% to 100%). In comparison, consumers appeared to have somewhat lower functioning in the self-regulation and relational domains. The average self-regulation score was 77% (range: 42% to 100%), while the average relational score was 76% (range: 49% to 100%).

Figure 7. Average Baseline Brain Map and Functional Domain Scores, N=37, FY17-18

Level of NMT Recommended Interventions

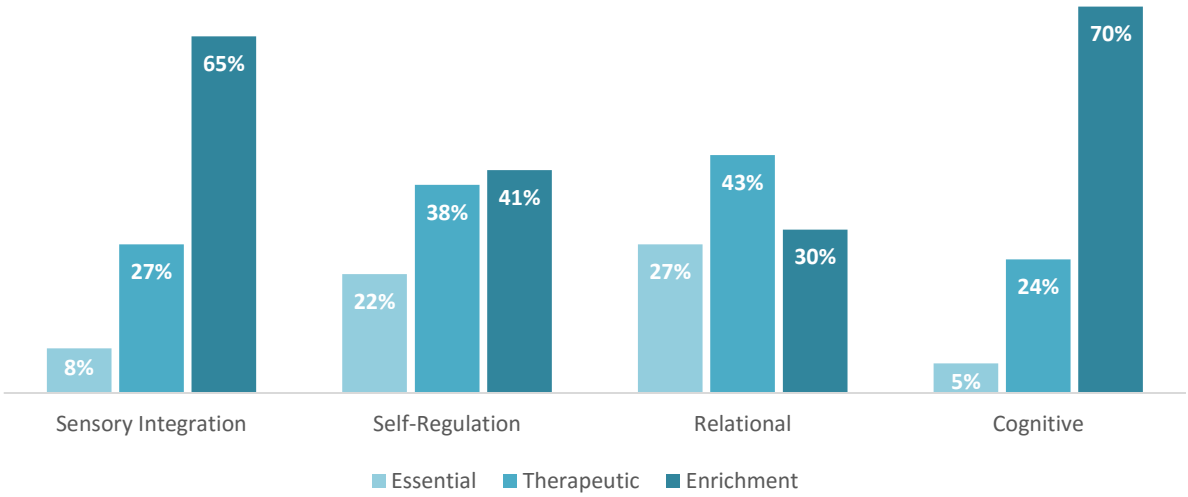
As discussed, brain map and functional domain scores are used to highlight the consumers' functional strengths and needs. This information can then be used to develop broad recommendations for the types and intensity of NMT interventions that consumers should receive to promote growth and recovery. To guide treatment planning, CTA developed cut-off scores to indicate whether interventions targeting each of the functional domain areas are recommended as essential, therapeutic, or enrichment. These recommendation categories, or levels, are described in greater detail below:

- **Essential:** Functional domain score is **<65%** of age typical. At the essential level, activities are considered crucial for future growth in the given domain. If functioning in the essential area is not increased, the individual will lack the foundation for future growth and development in this and other areas.
- **Therapeutic:** Functional domain score is **65-85%** of age typical. At the therapeutic level, activities are aimed at building strength and growth in the particular area. Therapeutic activities are viewed as important for continued growth and development.
- **Enrichment:** Functional domain score is **>85%** of age typical. At the enrichment level, activities provide positive, valuable experiences that continue to build capacity in the given area.

Figure 8 illustrates consumers' recommended level of intervention across each functional domain based upon their baseline assessment. In both the sensory integration and cognitive domains, interventions for most consumers (65-70%) were recommended as enrichment. Interventions in the cognitive and sensory integration domains were recommended as therapeutic for approximately one-quarter of consumers and recommended as essential for less than 10%. This reflects the relatively high functioning of consumers in these areas.

In comparison, for the self-regulation and relational domains, most consumers had interventions recommended as essential or therapeutic. Approximately one-quarter of consumers had interventions recommended as essential in these domains, while approximately 40% of consumers had interventions recommended as therapeutic. Interventions in the relational domain were recommended as enrichment for 30% of consumers and 41% in the self-regulation domain.

Figure 8. NMT Recommendation Categories across Functional Domains, N=37, FY17-18



Progress Toward Learning Goals

This section discusses the progress that the BHRS NMT Pilot has made toward achieving its two learning goals:

- **Learning Goal 1:** Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?
- **Learning Goal 2:** Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

A summary of key findings is presented below, followed by a detailed discussion of each learning goal.

Summary of Key Findings

Learning Goal 1: NMT Implementation and Adaptation

- **Provider Experience** - Providers enjoy the NMT training and believe it is helping them better serve their clients. However, greater mentorship throughout the training process could help providers better understand NMT priniciples and apply NMT to the adult population.
- **Provider Skill Development** - Providers are becoming more confident with the NMT assessment process and are expanding NMT selection to include consumers who are lower functioning and/or have greater mental health needs.
- **Adaptations to Adults -** Assessments can still be more time consuming and more difficult to complete with adults than children and adults are sometimes less receptive to trying different types of activities. To address these challenges, providers are implementing strategies to make the assessment process smoother with adults and are tailoring activities to meet each consumers' specific needs and interests.

Learning Goal 2: NMT Outcomes

- **Improved Consumer Outcomes -** Consumers appear to be benefitting from NMT services, as indicated by increases in functional domain scores and progress in their recovery. The NMT approach may also make it easier for some consumers to engage in therapy.
- **Trauma-Informed Approach to Care** - NMT implementation may be helping clinics and programs within the BHRS adult system of care be more trauma-informed.

Learning Goal 1: NMT Implementation and Adaptation

The following section describes key successes and challenges implementing and adapting NMT to the adult population. The section includes discussion of the selection of providers in the adult system, NMT training, the NMT assessment process, and NMT interventions.

NMT Provider Selection

Providers opted in to NMT training voluntarily in order to strengthen their ability to serve consumers with a history of trauma. As mentioned, 12 providers began the NMT training in January 2017, all of whom are master's level clinicians. NMT training was voluntary, and all clinical staff opted in. Providers received information about NMT and the NMT training opportunity from supervisors, team members, and a training announcement circulated by BHRS. Providers shared that they chose to participate in the training because they were already working with consumers with a history of trauma and adverse experiences. Providers felt the NMT approach sounded promising to better serve these consumers and expressed interest in strengthening their abilities to respond to and treat the impact of trauma. Some providers had a background in occupational therapy and noted that they were already using more "hands on" interventions aiming to improve consumers' functioning. These providers hoped the NMT training would help them gain a more in-depth understanding of the principles of neurodevelopment and how NMT-based interventions can be used to improve consumers' recovery.

NMT Training

The NMT training model relies on a case conference or group supervision approach with intensive self-study. In this approach, the providers attend an initial in-person training and then begin implementing NMT while conducting their self-study and participating in NMT study groups and learning communities. To conduct their self-study, providers receive a detailed training syllabus with a variety of web-based training materials and resources—including videos, lectures, recordings, readings, and case studies—allowing providers to work through the content at their own pace. Providers must also participate in a monthly meeting, or case conference, wherein providers discuss real-life cases. These group discussions are the foundation for supervision of NMT implementation, provide opportunities for clinicians to refine their knowledge and skills, and allow for fidelity monitoring. Throughout the training, providers must also complete at least 10 NMT assessments. Certified NMT providers must then complete fidelity assessments annually, wherein providers evaluate the same client data and inter-rater reliability scores are calculated. NMT training is designed to be completed over the course of approximately one year, although the self-directed nature of the training allows the training to be extended as needed.

The NMT training is increasing providers' knowledge and ability to respond to consumers with a history of trauma. Overall, providers found the NMT training useful and interesting, and enjoyed learning about the neurobiology and impact of trauma. For many of the providers, the NMT training is providing an opportunity for more advanced training in brain development and neuropsychology related to trauma. The providers described how their increased knowledge and understanding about the impact of trauma is helping them better understand the behaviors and presentation of consumers. NMT trainers and supervisors also observed these changes among providers, and noted that the training appears to be improving providers' clinical skills. Given these benefits, several providers shared that all clinicians should receive some training in the NMT principles and the impact of trauma on neurodevelopment in order to improve service delivery.

> *The information is so valuable…The trauma lens from a neuro perspective, it has changed my outlook on the world and how I view things.*
>
> – NMT Provider

The NMT training is intensive and takes significant time and dedication. Providers also acknowledged that training takes dedication and requires a lot of time in addition to their existing caseloads and other responsibilities. Additionally, challenges in completing assessments with adult consumers as well as translating NMT tools from the child to adult population can make the training particularly intensive. For providers in the adult system, the training is requiring more than a year to complete. Among providers who completed the training, the process took approximately 18 months. However, some providers are working through the training at a slower pace, while two providers chose to suspend the training until they had more time to devote to it. Some providers shared that it was helpful when their supervisors were flexible in allowing them to take extra time to participate in the trainings and conduct NMT assessments. Providers also noted that it would be helpful if they could receive continuing education credits for the NMT training.

> *You have to be willing to go the extra mile to get this specific training. I was really close to dropping out because it's like taking another master's course and I already had so much on my plate. My supervisor was really accommodating in providing more time, but it's hard to follow-up when you're not getting clients consistently. It's a lot of work.*
>
> – NMT Provider

Greater mentorship throughout the training could help providers better understand and apply NMT principles and adapt NMT for an adult population. While the training is extensive, some providers shared that it would have been useful to devote more time and practice to treatment planning during the training. In some cases, providers felt they needed more explanation of how the underlying NMT principles related to the selection of specific interventions. Some providers also found it challenging to translate the underlying theory to practice as many of the learning materials focused on children rather than adults. In particular, some providers felt they needed more guidance in selecting practical interventions for adults. Some of the recommended interventions are geared more toward children, or adults may be more hesitant than children to try new activities if they are unfamiliar (e.g., yoga, knitting, clay therapy).

Providers noted that having greater access to NMT mentors (i.e., certified NMT trainers with more senior experience implementing NMT) could have helped trainees navigate some of the challenges related to learning the assessment tools and treatment planning as well as modifying interventions for adults. Some providers mentioned that it would also be helpful if they were paired with a NMT-certified provider who worked in the same clinic or program to promote more regular mentorship and familiarity with the target population.

> *There's a lot of reason and theory involved in the training, but then we had to do the treatment planning portion. I felt like I was thrown into the treatment planning a little bit. I needed more of a bridge.*
>
> – NMT Provider

It is important to note that the cohort of NMT trainees is larger than in previous years, primarily because of this INN project. Although trainees were paired with mentors in the latter half of the training, there were more trainees per trainer and new trainees may not have gotten as much support as in previous cohorts. However, as previously mentioned, five providers in the Adult System of Care are participating in the NMT Trainer certification training and can provide mentorship to future trainees in the Adult System of Care.

NMT Assessment Process

Providers are becoming more confident and adept with the NMT tools and the assessment process. The NMT assessment process is fairly intensive and includes a number of detailed questions to understand a consumer's developmental history and past experiences of trauma. For all new NMT trainees—in both adult and youth systems of care—it takes time for providers to learn and gain comfort with the assessment tool. Providers in adult systems may also have a steeper learning curve as they do not regularly conduct developmental histories with adult consumers with the level of detail required for the NMT assessment.

As all NMT trainees first learn the assessment questions and process, they often administer the assessment in a direct way, going question by question. This approach takes longer and there was concern that this approach may trigger or risk re-traumatizing consumers who are not accustomed to these types of questions. In particular, adults may be less accustomed to discussing early experiences—including trauma—and providers were concerned that the developmental history questions may bring up emotions that the consumer is not prepared to manage.

As providers have progressed through the training, they have become more confident with the assessment tool and appear to be more consistently implementing strategies to make the assessment process smoother and minimize the risk of re-traumatization. These strategies include:

1) Explaining the process to consumers to help them understand why the providers are asking about their childhood and adolescence;
2) Asking broader questions or combining questions to make the assessment more conversational, less burdensome, and less-time consuming for the consumer and to reduce the risk of re-traumatization;

3) Breaking up the assessment over multiple visits if the consumer had reactions to the questions or struggled to focus long enough to complete the assessment; and
4) Reaching out to additional respondents who may have information about the consumer, such as another provider who is familiar with the consumer's history.

Some consumers who participated in the focus group also acknowledged that the assessment process can feel long and that it can be difficult to discuss past experiences of trauma, particularly if it is their first time meeting with a provider. However, consumers who participated in the focus group shared that providers were patient and made them feel safe. Some providers mentioned it could also be useful to have a standardized set of materials or an orientation to NMT that could be used by all providers to help introduce consumers to NMT prior to beginning services. The orientation or materials could be used to help explain the NMT principles and process to consumers so consumers know what to expect and feel more comfortable with assessment.

As providers gain comfort with the NMT assessment process, providers are expanding NMT selection criteria to include consumers with greater mental health needs. In the earlier stages of NMT training, providers were often conservative in determining which consumers to refer to NMT. Providers were mindful of the risk of the assessment process and effectiveness of interventions based upon consumers' level of functioning, coping skills, and ability to self-regulate as well as providers' experience with the assessment tool. Several providers mentioned that they typically only referred higher functioning consumers—including consumers they knew well and with whom they developed trust and rapport; consumers who were willing and comfortable discussing their trauma; consumers who had the coping skills to manage reactions that may arise as a result of the assessment; and consumers who are stable and compliant with medication, are not actively abusing substances, and are not actively psychotic.

> *In the beginning, I would have thought I needed the good therapy client who has good insight…Now, I'm thinking, why couldn't we implement [NMT] with someone more impaired?*
>
> – NMT Provider

As providers gain more experience and confidence with NMT and the assessment process, providers' perception of the adult population that may benefit from NMT is evolving, and providers' selection criteria is expanding. Providers still consider the risks of engaging in the assessment with the potential benefits of NMT and strive to build rapport with consumers before beginning the assessment process. However, providers feel that the most important selection criteria for NMT are:

- Consumer has a history of trauma;
- Consumer is willing to participate in NMT and regularly shows up for appointments; and
- Consumer is stable enough to recall information and provide realistic responses.

Providers mentioned that it can still be challenging to conduct assessments with individuals who are actively abusing substances or are experiencing psychosis, as this may influence consumers' ability or willingness to respond to assessment questions and/or regularly participate in NMT services.

Nevertheless, it is apparent that providers are implementing NMT with adult consumers across a greater spectrum of mental health severity.

Assessments are more time consuming and can be challenging to complete with adults. Providers noted that one challenge in implementing NMT with the adult population is that the assessments can be more time consuming and more difficult to complete than with children. One provider noted that while they can sometimes complete an NMT assessment for a child in 1-2 meetings, for adults it can often take 3-4 meetings over the course of a month or longer. Some reasons the assessment process is often longer for adults are:

- With adults, the NMT assessment collects information for a consumers' entire developmental history—fetal stages through adulthood. In contrast, the assessment is shorter for children as it only collects information through the child's current developmental stage.
- The assessments can be more time consuming for adults if consumers cannot recall information, and/or if consumers need to take breaks or stop the assessment if it brings up difficult experiences.
- Compared to children, adult consumers may have fewer collateral contacts that the providers or consumers can work with in order to fill in information gaps of the assessment.
- Adult consumers may be less likely to regularly participate in NMT services due to the severity of mental illness, substance use, homelessness, incarceration, etc.

Given these challenges, providers are experiencing difficulty completing assessments if consumers stop regularly attending mental health service appointments or become incarcerated, hospitalized, or otherwise unavailable to continue.

NMT Interventions

Providers are implementing a breadth of NMT interventions, tailoring activities to each consumers' specific interests and needs. The recommendations serve to guide the types of interventions that consumers may need and that providers should focus on. However, the specific interventions selected are tailored to what each individual is interested in and willing to do. As mentioned, adults may be less willing to try new and different types of activities compared to children, so providers often try to introduce interventions that may be more familiar. For example, some consumers shared that they first tried exercises such as deep breathing, counting, going for walks, and mindfulness exercises. While these activities may help some consumers become more comfortable with the different approach to therapy, consumers also appreciated that they could practice these techniques on their own.

> *Every time I meet with [my provider], we work on a different project. At that time, I'm at peace. I'm in a secure place. I could have a bad day, but talking with [my provider], playing with clay or listening to music, it takes me away.*
>
> – NMT Consumer

Providers also try to learn about consumers' hobbies and interests and will suggest or encourage activities that align with the recommended interventions. As providers build rapport with consumers and learn

more about their specific goals and needs, they may suggest new or additional activities that consumers may enjoy or benefit from such as yoga, drumming, or spinning clay. In some cases, consumers also suggest new activities they would like to try. Consumers appreciated having a variety of activities to choose from and tools to use to best meet their needs in different situations. This flexible and individualized approach helps consumers feel supported and engaged as well as increases the likelihood that they will implement the interventions independently.

Learning Goal 2: NMT Outcomes

The following section describes individual-level outcomes of adult consumers who participated in NMT services—including changes in assessment scores and recovery outcomes—as well as larger systems-level changes in the providers' approach to care as a result of NMT implementation in the adult system.

NMT Consumer Outcomes

Providers conduct follow-up NMT assessments with consumers to evaluate consumers' progress as well as update consumers' treatment plans if necessary. At the time of this report, follow-up assessment data were available for 11 consumers. Among these consumers, five were adults and six were TAY. On average, there were 12 months between the baseline and follow-up assessments, although the time interval ranged from 4 to 20 months.

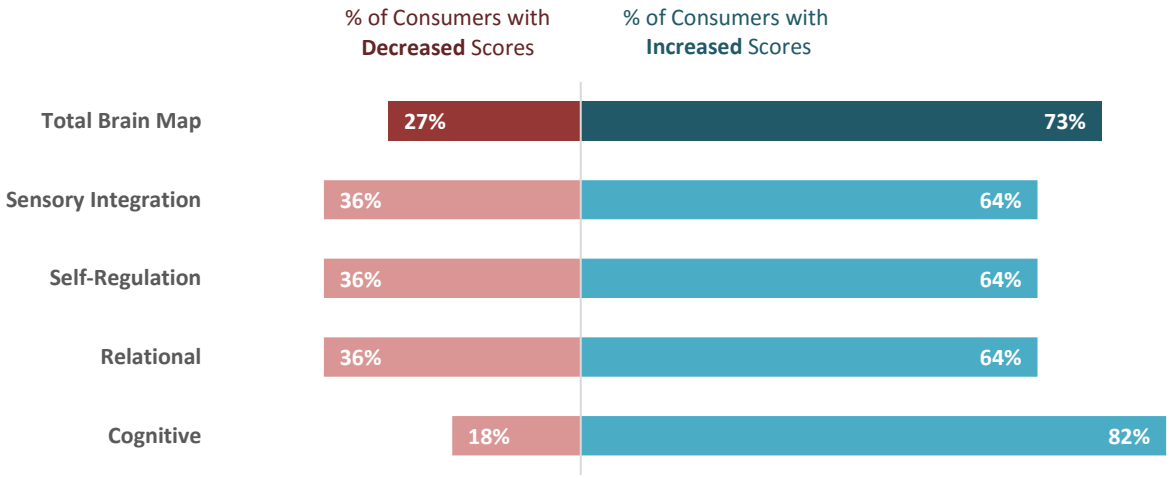
The relatively small number of individuals with follow-up assessments and the varying length of time between assessments may partially reflect the challenges in completing assessments and inconsistent participation in services among the adult population. Additionally, providers who did not progress as far in the training may not have had the opportunity to complete follow-up assessments as they were likely serving fewer consumers or serving consumers for a shorter period of time. As the program continues to mature and greater numbers of consumers are served for longer periods, we expect more consumers will receive follow-up assessments.

For the report, changes in assessment data were examined; however, given the small number of individuals with follow-up data available, assessment findings should be considered preliminary and exploratory. Focus groups with providers and consumers were also used to collect additional qualitative information about how NMT has impacted consumers' wellness and recovery.

Although the magnitude of change varies, most consumers are showing increases in their assessment scores, suggesting functional improvements. For the 11 consumers with follow-up data available for this report, baseline and follow-up assessment data were examined to identify changes in consumers' brain map and functional domain scores as consumers participated in NMT services. An increase was defined as any positive change in a score from baseline to follow-up (follow-up score – baseline score > 0), while a decrease was defined as any negative change in scores from baseline to follow-up (follow-up score – baseline score <0).

Of the 11 consumers, most consumers showed increases in their total brain map scores and across all functional domains from baseline to the follow-up assessment. As shown in Figure 9, 73% of consumers (n=8) showed increases in their total brain map scores, while 27% (n=3) showed a decrease. Across the sensory integration, self-regulation, and relational domains, 64% of consumers (n=7) showed increases in domain scores, while 36% (n=4) showed decreases. The greatest number of consumers (n=9, 82%) showed increases in the cognitive domain, with only 18% (n=2) showing decreases in domain scores.

Figure 9. Percentage of Consumers with Increased and Decreased Assessment Scores from Baseline to Follow-up, N=11, FY17-18



In general, increases in brain map values suggest improvement (progress toward age typical functioning), while decreases in brain map values suggest further impairment (movement away from age typical functioning). However, given that NMT has not yet been widely implemented with adults, it is unclear what magnitude of change in assessment scores may be expected and how changes translate to functional and recovery outcomes in adults.

Overall, the average change in consumers' brain map and functional domain values was +3% to +5%, depending on the specific domain (Table 3). However, the magnitude of change varied widely across consumers. Scores in the self-regulation and relational domains appeared to be particularly variable, where the change in scores ranged from a decrease of approximately -30% to an increase of nearly 30% from baseline to follow-up. Providers noted that consumers who had particularly large increases in assessment scores responded particularly well to the selected NMT interventions. These consumers regularly engaged in the recommended activities and/or practiced various self-soothing or calming techniques on a day-to-day basis. However, in other cases, providers noted that some consumers showed great progress in their recovery, but the change in assessment scores was minor.

Table 3. Average Change in Assessment Scores from Baseline to Follow-Up, N=11, FY17-18

	Average Change in Scores	Range of Change in Scores
Total Brain Map	+4%	-18% to +23%
Sensory Integration	+3%	-7% to +25%
Self-Regulation	+3%	-32% to +28%
Relational	+4%	-33% to +26%
Cognitive	+5%	-3% to +20%

It is important to note that providers' increasing experience and confidence with the NMT assessment may also partially contribute to differences in domain scores from baseline to follow-up. Providers generally completed baseline assessments earlier in their NMT training, whereas follow-up assessments were completed later when providers had more practice and training. As providers gain more experience with the assessments, they may score criteria slightly differently, which may contribute to a change in assessment scores. As more consumers participate in NMT services and more assessments are completed, it may be possible to better understand how changes in assessment scores relate to changes in consumers' functioning and recovery.

NMT services appear to be helping consumers progress in their recovery. Aside from changes in assessment scores, all focus group participants could point to benefits consumers experienced as a result of participating in NMT interventions. Consumers most frequently discussed how the NMT interventions helped them feel less anxious and more relaxed. Concentrating on an activity—such as an art project or spinning clay—helped consumers "get out of their head," while techniques such as deep breathing or the use of sensory tools—such as fidget spinners, stress balls, brushes, and massagers—helped consumers stay centered and calm. In some cases, consumers and providers reported that the NMT-based techniques and activities are helping to decrease substance use as well as reduce or avoid medication to cope with depression and anxiety. Other changes noted by consumers and providers included more consistent sleep schedules, increased attention to hygiene and self-care, and improved ability to communicate. For some consumers, the assessment process and NMT interventions appear to be helping consumers process their experiences to develop better insight and understand the impact that trauma has had on their current behaviors.

> *The moment you start, you get the anger out by massaging the clay. All the stress and tension I had in my hands and my mind, I didn't have it anymore. I didn't even remember the reason why I was so upset or hurt.*
>
> – NMT Consumer

The NMT approach may make it easier for some consumers to engage in therapy. Consumers shared that NMT felt different from other mental health services consumers had received. In many cases, consumers were accustomed to more traditional talk therapy, which often left consumers feeling emotional and fatigued after sessions. As one consumer noted, "just talking to the therapist makes me relive things I don't want to." In contrast, NMT-based activities made consumers feel "refreshed" and "light." While consumers enjoy the variety of interventions and activities, several consumers also observed that it was easier for them to discuss their feelings and trauma when engaging in the activities and that it helped them feel safe. Consumers also talked about how providers will engage in activities—such as drawing, coloring, and building models—with the consumers, which helps build rapport and trust. Several consumers mentioned that no other providers have worked with consumers in this way before, and that with NMT, they look forward to their next sessions.

> *[NMT] doesn't feel like the normal going to the counselor and you just tell them your feelings and it's depressing and it's serious. [NMT] doesn't feel like that. It feels light.*
>
> – NMT Consumer

Provider Approach to Care

NMT implementation may be helping clinics and programs be more trauma-informed. As mentioned, providers reported that being trained in NMT and the neurodevelopmental impacts of trauma is changing the way they approach care, regardless of whether they are implementing NMT with a consumer. Moreover, providers observed that the presence of NMT is beginning to influence other providers who are not trained in NMT but work with NMT-trained providers. Both NMT-trained providers and non-NMT providers are making changes to their office set-up and have added objects in therapy rooms to increase consumer comfort. NMT trained providers are also increasingly receiving requests from non-NMT providers to conduct assessments with consumers on the non-NMT providers' caseloads, including both adults and the parents of children on their caseloads. With the increasing demand for NMT services, one provider suggested that it would be useful to have a more explicit NMT program wherein people who screen for severe trauma are then sent to a dedicated team of NMT providers. These findings suggest that training providers in the adult system of care in NMT principles may support adult clinics and programs in being more trauma-informed and trauma-capable organizations overall.

Conclusion

The 2017-2018 fiscal year marked the first full year of NMT implementation in the BHRS Adult System of Care. During this time, providers in the adult system progressed in their training and served 40 consumers from diverse populations. Additionally, BHRS made great strides to better equip clinics and programs with NMT resources to expand the NMT interventions available to adult consumers.

> *If [NMT] can be done throughout all of San Mateo County and the whole mental health system, it could have so much of an impact.*
>
> – NMT Consumer

Throughout the year, providers gained more experience with the NMT assessment process, and are beginning to expand NMT selection to include consumers who are lower functioning and/or have greater mental health needs. However, implementing NMT assessments and interventions can still be more challenging and time consuming with adults compared to children. Adults sometimes have difficulty recalling information, may not be able or willing to participate in outpatient services consistently, and can be more hesitant to try different types of activities. To address these issues, providers are implementing strategies to limit the burden of the assessment process on consumers and are tailoring NMT services and interventions to each consumers' specific interests and needs.

Consumers appear to be benefitting from NMT implementation, and for some, the NMT approach may make it easier for consumers to engage in therapy. Although follow-up assessment data were limited, preliminary data suggest that consumers are improving across all functional domains. Consumers and providers also cited improvements in consumers' mood, coping mechanisms, and self-care as well as decreases in substance use.

Additionally, NMT implementation is strengthening trained providers ability to serve consumers with a history of trauma, and shows promise in supporting the adoption of trauma-informed practices and treatment options in the BHRS Adult System of Care overall. Over the next year, BHRS and RDA will continue to evaluate implementation progress to identify facilitators, challenges, and possible recommendations for adapting NMT in an adult system of care and will continue to collect consumer-level data to examine changes in consumer outcomes.

Appendix. Adult Neurosequential Model of Therapeutics Evaluation Plan

Introduction

The Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care was developed as part of the San Mateo Behavioral Health and Recovery Services (BHRS) three-year Mental Health Services Act (MHSA) Innovation plan. At their core, MHSA programs are intended to provide counties with funding to create fundamental changes to the access and delivery of mental health services. The goal of MHSA Innovation (INN) programs are to test novel approaches and interventions created by local communities through an inclusive Community Program Planning (CPP) process. INN programs seek to do the following:

- Increase access to mental health programs for underserved groups,
- Increase quality of services and outcomes, and
- Promote interagency collaboration.

Through the CPP process, BHRS identified the need to provide alternative treatment options to broaden and deepen the focus on trauma informed care and provide better outcomes in recovery for BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma, typically used with children, that is grounded in neurodevelopment and neurobiology.

BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population in order to increase the quality of mental health services and recovery outcomes for adult mental health consumers with a history of trauma. The NMT pilot meets INN requirements as it represents a change to an existing practice which has not yet been demonstrated to be effective. This expansion and evaluation of NMT within an adult system of care will be the first of its kind.

The San Mateo County Board of Supervisors approved the Adult NMT project on May 24, 2016, and BHRS began implementation of the three-year pilot in September 2016. BHRS selected Resource Development Associates (RDA) to conduct a two-year evaluation of the adult NMT pilot project beginning in January 2017. The NMT evaluation is intended to help BHRS achieve the following objectives:

1. Meaningfully engage stakeholders throughout the evaluation process;
2. Measure the impact of the program;
3. Support data-driven decisions about program implementation and continuation;
4. Increase knowledge about what works in mental health and with the adult consumers; and
5. Comply with INN regulatory and reporting requirements.

NMT Literature Review: Support for NMT

NMT Background

Adverse childhood experiences (ACEs) (e.g., chronic stress, neglect, abuse, trauma, etc.) can profoundly impair neurodevelopment and brain functioning. Disordered brain functioning can in turn contribute to a myriad of physical, cognitive, emotional, and behavioral problems that may persist throughout the lifespan (Perry, Pollard, Blakly, Baker, & Vigilante, 1995; Felitti et al., 1998; Anda et al., 2006). The impact of adverse experiences on brain development and the resulting functional and behavioral issues also vary with the timing, severity, pattern, and nature of the trauma, as well as by the unique experiences and genetic characteristics of each individual. However, many treatment approaches designed to help individuals cope and progress in their recovery do not consider or adequately address the complexity and variability of neurodevelopmental impairment caused by childhood trauma.

The Child Trauma Academy (CTA) developed NMT as an alternative approach to trauma-informed treatment that is grounded in neurodevelopment and neurobiology (Perry, 2008). NMT is not a single therapeutic technique or intervention. Rather, NMT aims to guide the selection and sequence of a set of highly individualized educational, enrichment, and therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumers' unique strengths and neurodevelopmental needs to help consumers better cope, self-regulate, and progress in their recovery. (Perry & Hambrick, 2008).

As trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment, the selected set of interventions are intended to help change and reorganize the neural systems to replicate the normal sequence of both brain and functional development (Perry & Hambrick, 2008). Interventions are selected to first target the lowest, most abnormally functioning parts of the brain. Then, as functional improvements are made, therapies are selected that target the next, higher brain region (Perry & Hambrick, 2008). The sequence of interventions aim to help consumers better cope, self-regulate, and progress in their recovery.

Since its development, NMT has been implemented in various behavioral health settings (Perry & Dobson, 2013), including BHRS which has been using the NMT approach with youth since 2012. To date, the number of studies evaluating the effectiveness of NMT are limited. However, some studies have found evidence of increased social-emotional development and improvements in problematic behavior in children receiving NMT (Barfield, Gaskill, Dobson, & Perry, 2012). In BHRS, among a sample of 10 youth receiving NMT assessments and interventions, all showed improved self-regulation, and two-thirds showed improvements in sensory integration, relational, and cognitive domain measures.

Application of NMT for Adults

Currently, NMT is most widely used with maltreated and traumatized children, and the use of NMT with adults is limited. However, there is a strong theoretical basis to predict that adult mental health consumers may also benefit from the NMT approach. As mentioned, NMT is built upon the premise that trauma can cause neurological damage and that sequential, neurodevelopmentally appropriate interventions can help improve coping skills and recovery outcomes.

A study of over 17,000 adults revealed a strong positive relationship between ACEs and the increased likelihood of behavioral health issues, suggesting disordered brain functioning in response to child trauma (Anda et al., 2006). In particular, adults who experienced four or more ACEs were 3.6 times more likely to be depressed, 2.4 times more likely to experience anxiety, 7.2 times more likely to suffer alcoholism, and 4.5 times more likely to use illicit drugs than adults with no ACEs (Anda et al., 2006). The relationship between trauma and mental health is further strengthened by the high prevalence of adult consumers with mental illness and/or substance use issues who also have experiences of trauma, approximately 40 to 80% (Missouri Institute of Mental Health, 2004). These findings suggest that interventions, such as NMT, that address the neurological impacts of trauma may be effective in helping consumers improve coping skills and achieve better recovery outcomes.

Despite the potential of using NMT with adults, there are also important differences between the adult and youth consumer populations that should be considered. In comparison to children, the extent of neurological damage is likely greater among adult mental health consumers who may suffer continued brain impairment beyond the effects of childhood trauma. For instance, many adult mental health consumers also have a history of long-term psychiatric medication usage as well as long-term substance abuse, both of which can further impair brain functioning.

In addition, initial studies of NMT have found the approach is most effective for children in safe, stable, and nurturing environments (Perry & Hambrick, 2008). However, many adult consumers may still be experiencing patterns of instability and trauma. One study found that nearly a third of mental health consumers had been victimized within the previous six months (Desmarais et al., 2014), while other studies found that consumers with serious mental illness are more than 10 times more likely to be homeless than the general population (Treatment Advocacy Center, 2016).

Nevertheless, the effectiveness of NMT in improving recovery outcomes in the adult population is unknown. As of yet, no outcome studies have been conducted to evaluate NMT in an adult population and NMT has not yet been formally implemented into an Adult System of Care. Given this opportunity and the preliminary success of NMT with youth, San Mateo BHRS has undertaken a project to adapt, pilot, and evaluate the application of the NMT approach to an adult population within the BHRS Adult System of Care.

San Mateo BHRS Adult NMT Pilot Project

NMT Providers

As mentioned previously, BHRS has been using the NMT approach with youth for the past five years. In that time, 10 BHRS providers have become certified NMT trainers. These NMT trainers cannot certify other providers in NMT; however, the trainers can provide consultation and teaching of NMT principles. In January 2017, 14 mental health clinicians began NMT training.[11] The clinicians work in a variety of settings within the BHRS Adult System of Care, including BHRS specialty mental health or regional clinics as well as programs targeted toward consumers re-entering the community following incarceration.

Target Population

The NMT providers will incorporate the NMT process into their clinical work, targeting three main populations of adult mental health consumers, including:

- General adult consumers receiving specialty mental health services,
- Transition age youth (TAY) consumers (ages 18-25), and
- Criminal justice-involved consumers re-entering the community following incarceration.

It is important to note that the three target populations likely have different experiences, needs, and coping skills and as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches, such as NMT. The re-entry population may have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high risk behaviors that are more likely to lead to incarceration. In addition, for the re-entry population, the experience of incarceration could contribute to trauma.

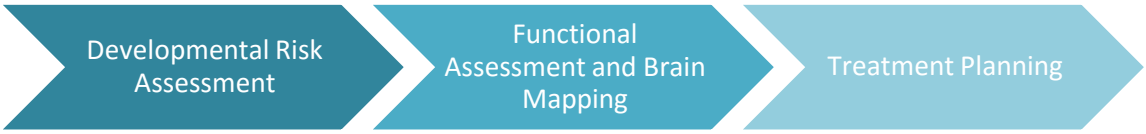
BHRS estimates that through the adult NMT pilot project, approximately 75 to 100 adult consumers will receive NMT-based services annually. Providers will refer existing BHRS consumers from their caseloads to NMT. Due to the novel nature of this pilot, clear selection criteria for adults referred to NMT have not yet been established. Although, adult consumers who will most benefit will likely have a history of crisis or trauma. Additionally, NMT is not intended for consumers diagnosed with serious psychotic disorders or who are currently cycling in and out of psychiatric hospitalization. As implementation progresses, BHRS will establish guidance in case selection with the support of NMT trainers and mentors.

[11]The formal training certification program takes place over one year, with trainees learning through a combination of readings, videos, webinars, and case-based trainings. Trainees begin implementing the NMT model with consumers shortly after the training commences and must conduct a minimum of 10 NMT assessments annually. In order to ensure fidelity to the NMT model, CTA requires that all certified NMT providers complete fidelity assessments twice annually, wherein the providers evaluate the same client data and inter-rater reliability scores are calculated.

NMT Process and Activities

The NMT approach helps clinicians identify the developmental strengths and challenges of each individual to help create an individualized treatment plan matching their unique developmental needs. As depicted in Figure 2, the NMT process consists of three main phases: 1) developmental risk assessment, 2) functional assessment and brain mapping, and 3) the development of individualized treatment recommendations. These phases are described in greater detail below. However, the elements of the NMT process and specific NMT-based services will likely be modified as the approach is adapted to the adult population.

Figure 10. Key phases of the NMT Process



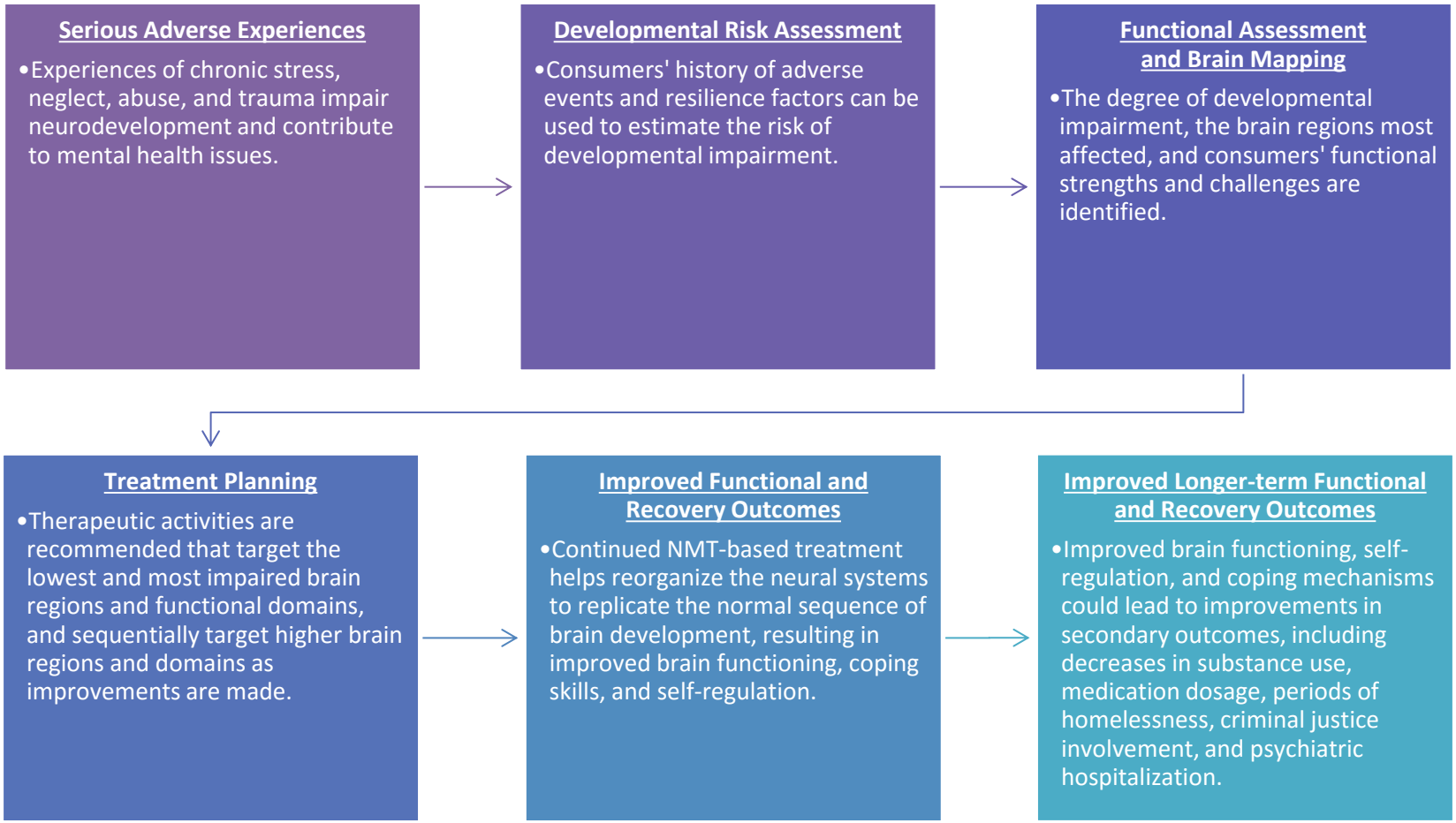
Developmental Risk Assessment. NMT-trained clinicians collect information pertaining to consumers' history of adverse experiences – including their timing, nature, and severity – as well as any protective factors to estimate the risk and timing of potential developmental impairment.

Functional Assessment and Brain Mapping. NMT-trained clinicians conduct an assessment various brain-mediated functions (e.g., heart rate, motor skills, short-term memory, speech and language, etc.) to develop a brain map identifying the brain regions most affected by developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are then compared with age typical domain values to assess the degree of developmental impairment, identify the consumers' functional strengths and challenges, and track progress over time.

Treatment Planning. In the third phase of the NMT process, therapeutic activities are identified that address the consumers' needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. For example, consumers with severely impaired self-regulation scores often have hyper-reactive response systems and may benefit from deep-breathing techniques and the use of weighted vests or blankets. Consumers impaired in the sensory integration domain may benefit from patterned, repetitive somatosensory activities such as drumming and yoga. Treatment may include a mix of activities that are tailored to each consumers' unique developmental needs and activity preferences.

Throughout treatment, functional assessment and brain mapping are performed at regular intervals to evaluate any changes in functional domains. As functional improvements are made, treatment recommendations are adapted, with therapeutic activities becoming more advanced and/or targeting higher brain regions. Ultimately, as NMT treatment progresses, it is expected that consumers will experience improved functional and recovery outcomes. The NMT process and outcomes pathway is summarized in Figure 11.

Figure 11. NMT Process and Outcomes Pathway



Evaluation Overview

Learning Goals and Evaluation Questions

BHRS developed two main learning goals for the NMT evaluation. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes. To further guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The learning goals and evaluation questions (EQ) are listed below.

Learning Goal 1: Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?

> **EQ 1.1.** How is the NMT approach being adapted to serve an adult population?
>
> **EQ 1.2.** Who is being served by the adult NMT project, what types of NMT-based services are consumers receiving, and with what duration and frequency?

Learning Goal 2: Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

> **EQ 2.1.** To what extent is the NMT approach supporting improvement in adult consumers' functional outcomes and overall recovery and wellbeing?
>
> **EQ 2.2.** To what extent is the experience of care with the NMT approach different from consumers' previous care experiences?

Evaluation Strategy

RDA will implement a mixed methods evaluation that is collaborative and emphasizes continuous quality improvement.

Mixed Methods. A mixed methods approach utilizes both qualitative and quantitative data to address the research questions. Utilizing mixed methods allows the evaluator to identify the correlation between program participation and outcomes and also identify the program strengths and challenges from the participants' perspective. This allows program staff to make adjustments to the program in real-time.

Collaborative. RDA conceptualizes its role as research partners rather than outside evaluators. In this approach, BHRS staff, service recipients, and other invested parties work collaboratively with evaluators to articulate program goals, develop outcome measures, and interpret and respond to evaluation findings.

Continuous Program Improvement. RDA will work with BHRS and its stakeholders to build capacity for evaluation and engage in ongoing continuous program improvement. Continuous program improvement

is a framework by which evaluation is not a one-time event, but an ongoing way of providing data for the program to use to strengthen program design and implementation.

Data Collection and Analysis

In order to develop a comprehensive understanding of program implementation and impact, BHRS and RDA identified a number of expected measurable outcomes including process outcomes, clinical outcomes, functional and recovery outcomes, and consumers' experience of care. Process outcomes will largely be descriptive, and will include documentation of any training and NMT implementation activities, the number of consumers served, and the types of services provided. Consumer-level outcomes, including clinical, functional, and recovery outcomes, will be evaluated before and during NMT treatment to assess the impact of NMT services.

During the first year, the evaluation will focus on collecting and analyzing process outcomes to assess NMT implementation, as well as collecting individual-level clinical, functional, and recovery baseline data. The second year will focus on measuring progress in NMT implementation and changes in clinical, functional, and recovery outcomes from baseline. Throughout both years, RDA will provide technical assistance to BHRS staff implementing the NMT intervention to support their ability to collect client data.

BHRS and RDA identified a number of data sources to collect outcome measures, including NMT metrics, the NMT treatment plan, Avatar electronic health records, the NMT consumer form, and focus groups with NMT providers and with NMT consumers. Table 4 lists the expected measurable outcomes as well as the data sources that will be used to collect each outcome measure. The data sources are described in greater detail below. In addition, Table 6 in Appendix I summarizes the data sources and information that will be used to address each learning goal and evaluation question, and Table 7 in Appendix II outlines the specific data requested.

Table 4. Expected Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Clinician experience of NMT training and implementation	Provider Focus Group
	Number and demographics of consumers participating in NMT services	Avatar Electronic Health Records (EHR)
	Number and type of NMT services provided	NMT Treatment Plan
Clinical Outcomes	Changes in brain map values	NMT Database
	Changes in functional domain values	NMT Database
Shorter-term Functional and Recovery Outcomes	Changes in coping skills and self-regulation	Consumer & Provider Focus Groups
	Continued participation in NMT services	NMT Database
	Continued participation in BHRS outpatient services	Avatar EHR
Longer-term Functional and Recovery Outcomes	Changes in substance use	Avatar EHR
	Changes in medication dosage	NMT Consumer Form
	Changes in homelessness	NMT Consumer Form
	Changes in criminal justice involvement	NMT Consumer Form
	Changes in psychiatric hospitalization	Avatar EHR

Outcome Type	Outcome Measures	Data Sources
Experience of Care	Consumer experience of NMT services and perceived impact	Consumer Focus Group

Data Sources

NMT Metrics. RDA will work with CTA and BHRS to obtain NMT Metrics with which to measure clients' functional domain values. NMT metrics will be obtained from consumers' initial NMT brain mapping and at agreed upon intervals thereafter (e.g., every six months). The NMT functional domain values will be used to establish consumers' baseline functioning at service start and documenting any change that occurs over the course of service delivery. To the extent that adult age typical functional domain values are available, RDA will also compare BHRS consumers' functional domain scores to age typical values to assess the degree of impairment and progress toward age typical functioning.

NMT Treatment Plan. RDA will work with BHRS to obtain information from consumers' treatment plans at agreed upon intervals. The NMT Treatment Plans include information about the types of treatment or activities that are recommended, treatment received, and any progress notes. This information will be used to assess NMT treatment participation and adherence to the service plan.

Avatar Electronic Health Record Data. RDA will work with BHRS to obtain relevant consumer-level information from BHRS' electronic health record (EHR) system, Avatar. Information obtained from the EHR may include client demographic information, clinical diagnoses, BHRS mental health service utilization, and psychiatric hospitalization. EHR Data will be requested for the year prior to NMT enrollment as well as during NMT participation to assess any changes in mental health service utilization during NMT treatment.

NMT Consumer Form. RDA developed a NMT consumer form to capture additional consumer-level information that is not currently captured or not readily extractable from existing data sources. The NMT consumer form includes information regarding consumers' current psychiatric medication, substance use, housing and homelessness, and criminal justice system involvement (e.g., arrests and incarcerations). NMT providers will administer the consumer form during NMT assessments at agreed upon intervals (e.g., once a month). This information will be used to assess changes in longer-term functional and recovery-oriented outcomes throughout NMT participation (e.g., changes in the frequency or duration of incarcerations or arrests, frequency of substance use, and medication dosage). The NMT consumer form is available in Appendix III.

Focus Groups with Providers Trained in NMT. RDA will facilitate focus groups with BHRS Adult System of Care staff who were trained in the NMT model. During the first year of the evaluation, these focus groups will explore providers' experiences with the NMT training and initial application of the NMT model, including the quality and applicability of their training in NMT, successes and challenges in adapting the model for adult consumers, and the integration of the brain mapping and other elements of the NMT approach into their existing service delivery processes. During the second year of the evaluation, the focus groups with providers will assess how their experiences using the NMT approach have changed over time, any new successes or challenges that have emerged, and their perceptions of the impact of the NMT

approach on client wellbeing, including improvements in functional and recovery outcomes. The focus group protocol is available in Appendix IV.

Focus Groups with Clients Participating in NMT. During the second year of the evaluation, RDA will facilitate focus groups with adult BHRS clients who have received the NMT-based services. During the first year of the evaluation, the focus groups will ascertain clients' experiences with the NMT approach, how NMT services differ from other mental health services received, and consumers' perception of the impact of NMT on their own wellness and recovery. Before beginning the focus groups, the intention of the focus groups will be explained and informed consent will be obtained from all consumers. The focus group protocol is available in Appendix IV and the consent form is available in Appendix V.

Data Analysis

RDA will begin our analysis by organizing and cleaning the NMT and client-level data as well as information from the focus groups. To analyze the quantitative data we will conduct both descriptive and inferential statistics, as appropriate, to describe the outcomes as well as to identify changes over time. To assess process outcomes, descriptive statistics will primarily be used, while pre-post analyses will be used assess changes in clinical, functional, and recovery outcomes before and during NMT services.

Qualitative data will inform both the process and consumer outcomes. To evaluate qualitative data, focus group participants' responses will be transcribed so that participants' responses and reactions are appropriately captured. RDA will then thematically analyze responses from participants to identify any recurring themes and key takeaways from the focus groups. RDA will triangulate qualitative findings with quantitative findings to develop a complete picture of the extent to which the NMT goals have been achieved.

Reporting

On an annual basis, RDA will draft a report that provides a comprehensive understanding of the implementation and impact of the NMT project to date as well as comply with new MHSA INN regulations. The report will address the learning goals and evaluation questions, including an information about the progress of NMT implementation and related process outcomes, preliminary outcome measures, and recommendations for actionable program improvements.

Findings will be shared with relevant BHRS staff through a findings work session prior to drafting the report. This work session will give BHRS staff an opportunity to interpret and respond to findings as well as provide feedback. Following the work session, RDA will draft the annual report and send it to BHRS for review. RDA will then address and incorporate BHRS feedback, finalize the report, and send it to BHRS for submission to the Mental Health Services Oversight and Accountability Commission (MHSOAC). The final report will then be available for presentation to the MHSA Steering Committee and the Stakeholder Advisory Committee.

Timeline

The NMT evaluation is a two-year evaluation, beginning in January 2017 and running through December 2018. Table 5 below provides an outline of evaluation activities over the two year evaluation period, including the organization responsible for conducting each activity (i.e., RDA and/or BHRS). RDA understands that program needs develop and evolve, so RDA will be flexible in adapting the evaluation timeline to align with BHRS needs. RDA will confer with BHRS when creating any modifications to the evaluation timeline.

Table 5. NMT Evaluation Activities Timeline

Phase	Major Activities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Year 1 (2017)	Project Kickoff Meeting (RDA & BHRS)												
	Evaluation Planning (RDA & BHRS)												
	Compile and Send NMT Consumer Data (BHRS)												
	Focus Groups: Service Providers and Consumers (RDA)												
	NMT Data Analysis (RDA)												
	Findings Work Session (RDA & BHRS)												
	Draft Annual Report (RDA)												
	Review Report and Provide Feedback (BHRS)												
	Finalize Annual Report (RDA)												
	Submit Annual Report to MHSOAC (BHRS)												X
Year 2 (2018)	Compile and Send NMT Consumer Data (BHRS)												
	Focus Groups: Service Providers and Consumers (RDA)												
	NMT Data Analysis (RDA)												
	Findings Work Session (RDA & BHRS)												
	Draft Annual Report (RDA)												
	Review Report and Provide Feedback (BHRS)												
	Finalize Annual Report (RDA)												
	Submit Annual Report to MHSOAC (BHRS)												X
Ongoing	Regular Meetings and Communication (RDA and BHRS)												
	Technical Assistance (RDA)												

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Information Collected for Evaluation Questions

Table 6. Data Sources and the Evaluation Questions Addressed

Data Source	Information Collected	Learning Goal 1		Learning Goal 2	
		EQ 1.1	EQ 1.2	EQ 2.1	EQ 2.2
NMT Metrics	• Brain Map Values • Functional Domain Values			✓	
NMT Treatment Plan	• Recommended Treatment • Treatment Participation		✓	✓	
Avatar Electronic Health Records	• Demographic Information • Clinical Diagnosis • BHRS Mental Health Service Utilization • Psychiatric Hospitalization • Substance Use		✓	✓	
NMT Consumer Form	• Current Psychiatric Medication • Housing and Homelessness • Criminal Justice System Involvement (Arrests and Incarcerations)		✓	✓	
Focus Groups with NMT Providers	• Providers' experience with NMT training and implementation • Successes and challenges in adapting NMT to adults • Providers' perceived impact of NMT on consumers' recovery and wellbeing	✓	✓	✓	
Focus Groups with NMT Consumers	• Consumers' experience of NMT services and activities • Consumers' perceived impact of NMT on their recovery and wellbeing			✓	✓

NMT Data Request

Description: The table below lists the data requested for every adult consumer who was or is currently enrolled in BHRS NMT services as of the end of the given fiscal year (i.e., June 30th). Data for the previous fiscal year(s) will be requested once annually, in September. The asterisks (*) denote specific consumer data that is requested by the MHSOAC for the Annual Innovative Project Report.

Table 7. Data Requested for Adult NMT Consumers

Domain	Categories	Variables	Data Source	Time Period
Consumer Information	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records	Most Recent Information
		Client Name		
	Demographic Information*	Date of Birth*		
		Gender*		
		Race*		
		Ethnicity*		
		Primary Language*		
		Sexual Orientation*		
		Veteran Status*		
	Physical or Mental Impairment*	Difficulty hearing, speaking, communicating*		
		Limited physical mobility*		
		Learning disability*		
		Chronic health conditions*		
		Other disabilities/health conditions*		
	Clinical Diagnoses	Primary diagnosis code		
		Primary diagnosis description		
		Secondary diagnosis code		
		Secondary diagnosis description		
		Substance use disorder diagnosis		
Psychiatric Medication Prescriptions	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records – Order Connect	All Data during NMT Enrollment
		Client Name		
	Medication	Medication Name		
		Medication Dosage		
		Instructions for Use		
Substance Use, Housing, and Criminal Justice	Substance Use	Substances used	Avatar Electronic Health Records – NMT Consumer Form (to be added)	All Data during NMT Enrollment (Not yet collected)
		Substance use frequency		
		Substance use route of administration		
	Housing Status	Residence last night		
		Nights homeless in last month		
	Criminal Justice Involvement	Arrests in last month		
		Incarcerations in last month		
BHRS Mental Health and Substance Use Service Utilization	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records	All Data during NMT Enrollment and Previous Year
		Client Name		
	Service Episode Information	Episode Number		
		Provider Organization/Level of Care (e.g., Outpatient, Adult Residential, etc.)		
		Program Name		
		Episode Opening Date		

Domain	Categories	Variables	Data Source	Time Period
		Episode Closing Date		
	Service Encounter Information	Service Code		
		Service Description		
		Date of Service		
		Service Length (minutes)		
Psychiatric Inpatient and Emergency Service Utilization – Service Episodes	Identifying Information	Medical Record/Mental Health Number	Billing/Claims Data	All Data during NMT Enrollment and Previous Year
		Client Name		
	Episode Information	Episode Number		
		Provider Organization/Level of Care (e.g., Psychiatric Emergency Services, Psychiatric Inpatient, etc.)		
		Program Name		
		Episode Admission Date		
		Episode Discharge Date		
		Service Length (days)		
NMT Assessments and Metrics	Identifying Information	Medical Record/Mental Health Number	CTA NMT Database	All Data during NMT Enrollment
		Client Name		
	Assessment Information	Assessment Date		
		Assessment Type (e.g., Initial assessment, Follow-up assessment)		
	NMT Metrics	Developmental History Values		
		Functional Brain Map Values		
		Functional Domain Values		
	NMT Treatment Plan	NMT Treatment Recommendations		

Adult NMT Consumer Form

Instructions: These questions are intended to provide information about adult NMT consumers' substance use, housing status, and criminal justice involvement. Please administer the questionnaire to consumers every six months during the NMT assessment. Please inform the consumers that this information will only be used to identify any changes throughout NMT participation, and there will be no repercussions for any illicit activity. Additionally, consumers can choose not to respond to any questions they feel uncomfortable answering.

1. a. In the past 30 days, did you use the following substances (if any)?

   b. If yes, how frequently did you use the substance and what was the primary route of administration?

Substance Type	Y/N	Frequency (check one)	Route (check one)
a. Alcohol	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
b. Cocaine/Crack	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
c. Hallucinogens (PCP, LSD, Mushrooms, Mescaline/Peyote)	☐ Yes	☐ Daily	☐ Oral

Substance Type	Y/N	Frequency (check one)	Route (check one)
	☐ No ☐ Don't Know ☐ Refused to Answer	☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
d. MDMA (Ecstasy, Molly)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
e. Methamphetamine or other Amphetamines	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
f. Synthetics (Spice, Flakka, Bath Salts)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection

Substance Type	Y/N	Frequency (check one)	Route (check one)
		☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Don't Know ☐ Refused to Answer
g. Inhalants	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
h. Other Downers (Ketamine, GHB)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
i. Other Prescription Drugs (Benzodiazepines, Barbiturates)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer

Substance Type	Y/N	Frequency (check one)	Route (check one)
j. Other: _____	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer

2. Where did you sleep last night?

☐ Own house or apartment
☐ Family home
☐ Couch or someone else's home
☐ Transitional housing
☐ Emergency shelter
☐ Streets
☐ Other: _____
☐ Don't Know
☐ Refused to Answer

3. In the past 30 days, how many nights did you spend homeless, if any (e.g., on the streets, in a car, an emergency shelter, someone's couch or home without paying rent, etc.)?

# of Homeless Nights: _____ ☐ Don't Know ☐ Refused to Answer

4. In the past 30 days, how many times were you arrested, if at all?

# of Arrests: _____ ☐ Don't Know ☐ Refused to Answer

5. In the past 30 days, how many nights did you spend in jail/prison, if any?

# of Nights in Jail: _____ ☐ Don't Know ☐ Refused to Answer

NMT Provider Focus Group Protocol

Thank you for making time to join our focus group today. My name is _____ and this is _____. We are with a consulting firm from Oakland, California called Resource Development Associates (RDA) and we were hired by San Mateo Behavioral Health and Recovery Services (BHRS) to evaluate BHRS' implementation of the Neurosequential Model of Therapeutics (NMT) program within the Adult System of Care. As part of this evaluation, we will be conducting focus groups with staff members, as well as consumers, to better understand program processes and outcomes as well as the strengths and challenges of implementing NMT in the Adult System of Care. We're here to talk to you today about your experiences as NMT providers.

I will be facilitating this focus group and _____ is here to take notes. Please note that what you say in this focus group will remain anonymous, but we will be taking notes of the discussion. My role as the facilitator means that it is my job to ensure everyone has a chance to say what is on his or her mind in a respectful way. We have a few guidelines to help us do that. Please:

- Silence your cell phones
- There are no "wrong" or "right" opinions, please share your opinions honestly
- Engage in the conversation
- Listen to understand
- Be curious about others' opinions
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- Your names will not be linked to any comments unless we specifically ask if we can use your comment as a quote

Does anyone have any questions before we begin?

Introductions

Before we get started I would like everyone to answer these two questions:

- What is your name?
- What is your position/role?

NMT Training

1. Please describe the NMT training you received.
    a. Where are you in your NMT training?
    b. What has been challenging about the training? Working well?
    c. What types of ongoing training and/or support do you receive?

NMT Referral/Recruitment

2. Could you describe the recruitment or referral process for the NMT?
    a. What is the consumer population that you are serving?
    b. How do you identify consumers that may benefit for NMT?
    c. What information do you provide to consumers about the NMT program?
    d. What about the referral and recruitment process is working well? What is not working well?

NMT Services

3. Could you describe the NMT assessment process?
    a. What is working well about the assessment process? What has been challenging?
    b. How do consumers respond to the NMT assessments?
    c. What information, if any, do you share with consumers?

4. Could describe the NMT services and activities?
    a. How often do you meet with consumers?
    b. How do you decide the treatment plan? What types of activities are included?
    c. How do you involve the consumer in the treatment planning?
    d. How do you involve family members or their social network in the treatment planning?
    e. How do NMT services differ from other mental health services you have provided?

5. Thinking about consumers who are doing well, what has been helpful in getting them to participate in NMT treatment or what has helped them in their recovery?
    a. What makes it difficult to get consumers to engage in treatment?
    b. What strategies do you use in those situations where the consumer is difficult to engage?

Overall Experience and Perspective

6. From your perspective, what has been working well about implementing NMT with the adult population? What has been challenging?
    a. What could be done to improve the NMT approach among the adult population?

7. From your perspective, how would you describe the impact of the NMT approach on consumers?
    a. Changes in coping mechanisms and self-regulation?
    b. Changes in other wellness and recovery outcomes?

8. Think about your team, what is something you are most proud of?

9. Is there anything else you would like to add?

Thank you for your time! We value your input and appreciate you sharing your experiences with us.

NMT Consumer Focus Group Protocol

Thank you for making the time to join our focus group today. My name is _____ and this is _____. We are with a consulting firm from Oakland, California called Resource Development Associates (RDA) and we were hired by San Mateo Behavioral Health and Recovery Services (BHRS) to evaluate BHRS' implementation of the Neurosequential Model of Therapeutics (NMT) program within the Adult System of Care. As part of this evaluation, we will are conducting focus groups with people who have participated in the NMT program to understand how the program is working and what people like you are experiencing.

I will be facilitating this focus group and _____ is here to take notes. Please note that what you say in this focus group will remain anonymous, but we will be taking notes of the discussion. My role as the facilitator means that it is my job to ensure everyone has a chance to say what is on his or her mind in a respectful way. We have a few guidelines to help us do that. Please:

- Silence your cell phones
- There are no "wrong" or "right" opinions, please share your opinions honestly
- Engage in the conversation
- Listen to understand
- Be curious about others' opinions
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- Your names will not be linked to any comments unless we specifically ask if we can use your comment as a quote

Does anyone have any questions before we begin?

Introductions

Before we get started let's go around the room and have everyone share:

- Your name
- Where you're from

Referral Process

1. How did you learn about NMT?
    a. Who referred you?
    b. What type of information did you receive about NMT?
    c. Why did you decide to participate in NMT?

NMT Experience

2. How would you describe the NMT assessment (e.g., risk assessment, brain mapping, etc.)
    a. What kinds of questions do they ask you?
    b. Is there anything about the assessment that feels stressful?
    c. Is there anything the provider does to make it less stressful? Anything you do?
    d. What kinds of information about the assessment did the provider share with you?

3. How would you describe the NMT treatment you have received (e.g., yoga, drumming, art, etc)?
    a. What kinds of activities did the provider recommend? What kinds of activities are you doing?
    b. How did the provider decide the activities?
    c. How are you involved in planning NMT activities?
    d. How is your family involved in the NMT activities?
    e. How often do you participate in NMT activities?
    f. Have the activities been like what you thought they would be?
    g. How have NMT services differed from other mental health services you have received in the past?

4. How has NMT helped you?
    a. What do you like about the NMT program?
    b. What has been challenging?
    c. What has helped you continue to participate in the different activities?

Consumer Perceptions and Recommendations

5. What is the best part about NMT?

6. What is something you would do or change to make NMT better?

7. What is something you would add or include in the program, that isn't already happening?

8. What have been some of your accomplishments since starting NMT services?
    a. What has helped you achieve this?

9. Is there anything else you'd like to add that we haven't already talked about?

Thank you for your time! We really value your input and appreciate you sharing your experiences with us.

San Mateo County
Health Ambassador Program-Youth
Fiscal Year 2017-18 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2018

Table of Contents

Acknowledgements

We wish to express our appreciation for the contributions from all the agencies, organizations, and individuals who participated in the efforts to develop the Health Ambassador Program-Youth (HAP-Y) to address the mental health needs of youth and young adults living in San Mateo County.

A special thanks to StarVista and the following individuals from the Health Ambassador Program-Youth Cohorts 1-3 whose participation was invaluable to this effort:

- Alejandro
- Andora
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- Anne
- Caitlin
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- Carolina
- Chelsea
- Claire
- Clara
- Diego
- Dylan
- Ernesto
- India
- Jericho
- Jessica
- Justin
- Leslie
- Luis
- Madeline
- Megan
- Michelle
- Moises
- Praise
- Rheem
- Sara
- Sophia
- Summer
- Tiffany

Your cooperation and energy resulted in the development of this project, the collection of extensive data, and allowed us to prepare this report. The County and the HAP-Y facilitation and evaluation teams deeply admire and appreciate your commitment to the health and wellbeing of youth and young adults in San Mateo County.

Figure 1: Graduates from HAP-Y Cohorts 1 – 3 (cont. on following page)

Introduction

Project Overview and Learning Goals

The Health Ambassador Program-Youth (HAP-Y) is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department and implemented by StarVista. The MHSA INN project category and primary purpose of the HAP-Y are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase access to mental health services.
- **Project Innovation:** HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people. The HAP-Y Innovation project is the first to offer formal evaluation of a training designed for youth peer educators and its effectiveness and impact on community awareness and stigma, increasing access to mental health services for youth, and addressing systemic changes, as well as supporting youth ambassadors' wellness and recovery.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS contracted with StarVista in December 2016 to begin implementing the program. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate HAP-Y. This report provides findings from the second year of HAP-Y implementation (July 1, 2017 – June 30, 2018). This reporting timeframe includes Cohorts 1-3 of the HAP-Y program.

In accordance with the requirements for MHSA INN programs, BHRS selected three Learning Goals as priorities for the HAP-Y program.

Figure 2: HAP-Y Learning Goals

Learning Goal 1	Learning Goal 2	Learning Goal 3
•To what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates?	•How does HAP-Y increase mental health knowledge and decrease mental health stigma?	•How does HAP-Y increase youth access to mental health services?

Project Need

Through the MHSA Community Planning Process (CPP) in San Mateo, the need to increase access to services for youth and young adults emerged. Youth and young adults, especially between the ages of 16-25, commonly experience challenges transitioning into adulthood and are notably underserved in the mental health system. Transition aged youth (TAY) navigate more adult-like challenges without having yet mastered the tools and cognitive maturity of adulthood.[1] Given this, community members advocated adapting the existing Health Ambassador Program (HAP), a program created in the County's Office of Diversity and Equity, for youth participants.

In the original HAP, a program that is currently operating out of BHRS, adult participants with lived experience completed a curriculum to enhance their skills and knowledge about behavioral health. HAP graduates served as a critical liaison to the County by doing outreach, speaking at panels and community events, and teaching psycho-educational classes. The idea for a youth-focused HAP evolved from the recognition that informed youth could take a more proactive role as leaders in their communities; promote health, recovery, and wellness with their peers, families, and communities; and work toward reducing the stigma of mental health and facilitate access to mental health services for youth and young adults.

Project Description and Timeline

HAP-Y engages, trains, and empowers TAY between the ages of 16 and 24 as Youth Ambassadors to promote awareness of mental health and increase the likelihood that young people will access needed mental health services. For this project, Youth Ambassadors receive psycho-educational training to build their own mental health knowledge and advocacy skills. Youth Ambassadors then engage in outreach and educational activities with other young people and deliver mental health presentations in the community. StarVista—a non-profit organization that provides counseling, prevention, early intervention, and education resources throughout San Mateo County—is the lead agency of this initiative. For over 30 years, StarVista has offered mental health services and resources to more than 40,000 people from diverse communities throughout San Mateo County. StarVista was selected through a Request for Proposal (RFP) process to implement and manage the HAP-Y project, including the administration, participant recruitment, and data collection aspects of the evaluation plan.

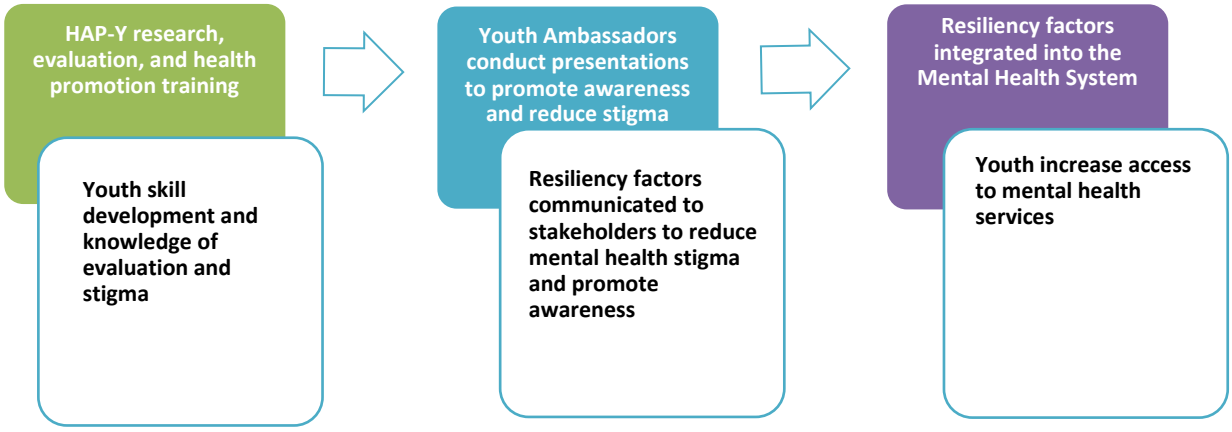
HAP-Y Theory of Change

As is illustrated in the Theory of Change below, HAP-Y is intended to support and influence Youth Ambassadors, youth and community members, and the mental health systems a whole. HAP-Y intends to accomplish this by first training Youth Ambassadors in research and evaluation principles and mental health promotion. The Youth Ambassadors then engage in a series of outreach and educational training activities to promote mental health awareness and reduce stigma with youth, the community, and youth-

[1] Wilens, T., Rosenbaum, J. (2013) Transition Aged Youth: A New Frontier in Child and Adolescent Psychiatry. Child and Adolescent Psychiatry, 52:9. M.

serving adults. As a result of HAP-Y activities, youth increase their access to and participation in mental health services and change their attitudes about mental health. The program design expects that an audience of youth would be more likely to access mental health services and resources if receiving the information by a team of their peers. Further, HAP-Y intends to have a lasting change for individuals directly engaging with the program as well as the community-at-large.

Figure 3: HAP-Y Theory of Change



HAP-Y Program Model

StarVista conducts outreach for HAP-Y through schools, counselors, and social media platforms. Youth who show interest in HAP-Y participation are asked to submit an application and go through a formal interview process conducted by StarVista. StarVista staff are responsible for providing training, collaborating with outside agencies to provide additional training, and arranging and supporting public presentations for Youth Ambassadors. StarVista also provides transportation and stipends for youth to attend the trainings. Throughout the duration of the program, StarVista staff also engage youth to remain involved and attentive in the program. Cohorts are selected based on their interest in availability for the program. Cohorts receive 14 weeks of training and have three months following their training to conduct a community presentation. StarVista partners with youth to identify a location and support the training by either co-presenting or providing individual preparation support. See Appendix and B for the HAP-Y youth application and StarVista youth interview protocol.

HAP-Y Training Curriculum

The following are the trainings StarVista provides to each HAP-Y Cohort. These trainings included psychoeducation and public speaking. The goal of the trainings is to build youth capacity to:

- Outreach and speak at panels and community events on mental health,
- Work with schools and other youth teaching psycho-educational classes,
- Facilitate discussions, and
- Provide resources to increase access to mental health services.

The HAP-Y Training focuses on topics of wellness and recovery and included learning the signs and risks of suicide, suicide prevention, and information on how to access mental health services. The formal curriculum includes Linking Education and Awareness for Depression and Suicide (LEADS), Question, Persuade, Refer (QPR), Wellness Recovery Action Plan (WRAP), and NAMI Family to Family. Outside trainers led the WRAP and Family to Family trainings, and Star Vista leads the LEADS and QPR trainings.[2] These programs are described briefly below.

Figure 4: Programs in the HAP-Y Training Curriculum

NAMI Family to Family is a 12 session educational program for family and friends of people living with mental illness. It is a designated evidence-based program. Research shows that the program significantly improves the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. NAMI Family to Family is taught by NAMI-trained family member.

Wellness Recovery Action Plan (WRAP) is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. It is used extensively by people in all kinds of circumstances, and by health care and mental health systems all over the world to address all kind of physical mental health and life issues. WRAP is listed in the National Registry of Evidence-based Programs and Practices.

Question, Persuade, Refer (QPR) is an approach to confronting someone about their possible thoughts of suicide. It is not intended to be a form of counseling or treatment, instead a means to offer hope through positive action. The three steps include:

(1) Question the person about suicide

(2) Persuade the person to get help

(3) Refer the person to help

Linking Education and Awareness for Depression and Suicide (LEADS) is an informative and interactive curriculum designed to link schools and educators to conversations about suicide and depression. LEADS is set up so that the youth are able to brainstorm and interact with each other.

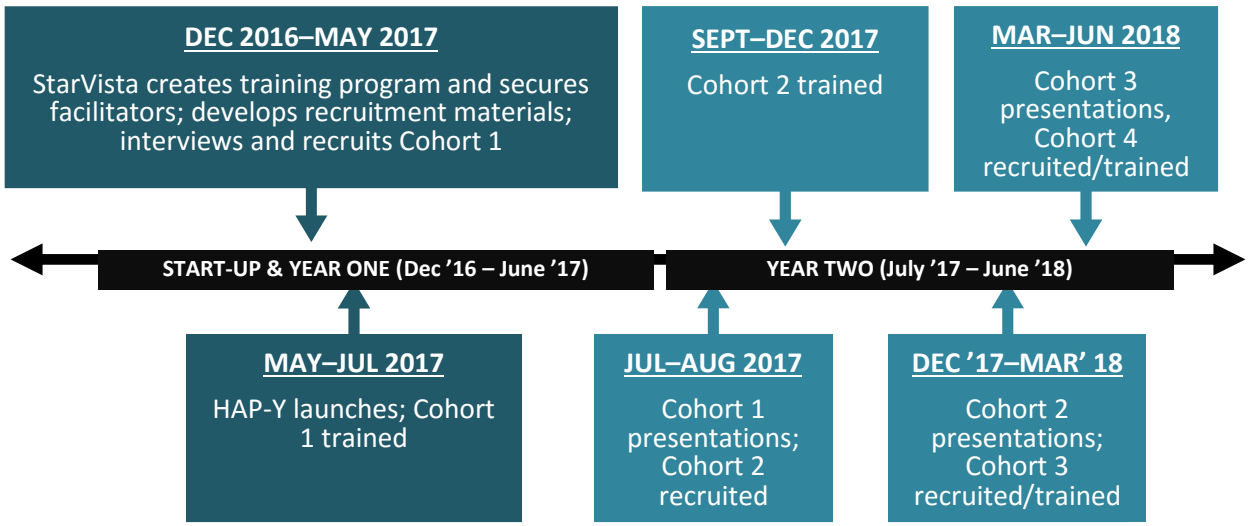
StarVista also conducted trainings with all three cohorts on targeted storytelling. These trainings were designed to build youth capacity to conduct outreach, speak at panels and community events on mental health, work with schools and other youth teaching psycho-educational classes, facilitate discussions or focus groups, provide resources to increase access to mental health services, and decrease stigma through lived-experience presentations. During the orientation and program close of every Cohort, RDA trained Youth Ambassadors on evaluation, data collection tools, and interpreting audience survey results. See Appendix C: Cohort 2& 3 Training Schedule for the Cohort 2 & 3 Training Schedule.

[2] StarVista provided Cohort 1 with a training in Youth Mental Health First Aid (YMHFA), but replaced this training with LEADS for Cohort 2 and all subsequent cohorts. YMHFA is a training for adult relatives, educators, and service providers; whereas LEADS is more appropriate for peer youth mental health education.

Implementation Timeline

Figure 5 illustrates the key activities that the HAP-Y program has undertaken for Cohorts 1-3 of the program.

Figure 5. HAP-Y Implementation Timeline



Evaluation Overview

BHRS contracted Resource Development Associates (RDA) to carry out the evaluation of HAP-Y implementation and outcomes. In order to maximize RDA's role as research partners and fulfill MHSA Innovation evaluation principles, this evaluation uses a participatory action research (PAR) framework. During the first year of the program, Youth Ambassadors worked to create the HAP-Y evaluation plan, which included developing and refining the evaluation questions based on the INN learning goals as well as developing and finalizing the data collection tools. Subsequent Youth Ambassadors participated in activities to build their capacity to understand evaluation and data collection approaches learn about the historical context of the role of evaluation at the state, and the impact that research plays in policy at the local level. Youth Ambassadors also learned about their and RDA's roles in the evaluation, quantitative and qualitative data collection tools and strategies, and the importance of being active members of the evaluation design and process.

The purpose of the HAP-Y evaluation is to help BHRS measure the impact of the program, support data-driven decisions throughout implementation, and increase knowledge about what works in mental health and youth-specific mental health programs. In terms of program impact, the evaluation focuses on the following domains:

1) Changes in leadership capacity and resiliency of the young people;
2) Changes in youth's knowledge and level of stigma related to mental health; and
3) Changes in access to services for youth.

Evaluation Methods

RDA developed a mixed-methods evaluation to respond to the INN learning goals listed above.

- The **PAR evaluation design** seeks to engage Youth Ambassadors with the hope that their lived experiences, both as youth and as persons with mental health challenges, may provide a unique perspective on how to better serve and increase youth access to mental health services.
- A **mixed methods** approach allows the evaluation to track quantitative measures of impact from the educational presentations, while also gathering qualitative input on how and why activities and outcomes occurred. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across the data sources.
- The **process evaluation** component explores the extent to which HAP-Y has been implemented as planned and the strengths and challenges the county has experienced in implementation from the perspective of key staff and youth ambassadors. This exploration enables BHRS and StarVista to make real-time adjustments that may improve program delivery.
- The **outcome evaluation** component assesses how HAP-Y—through its community educational presentations—produces changes in access to services and in youth-ambassador health outcomes.

Data Collection

In line with RDA's participatory, mixed methods approach to evaluation, the evaluation includes quantitative and qualitative tools to measure process and outcome indicators in the three evaluation domains: building youth capacity, mental health stigma, and access to services. Below are the data collection methods used to explore the evaluation domains.

Demographic Reporting

Understanding the demographic background of the Youth Ambassadors provides an understanding of who is being served by the HAP-Y program. The demographic form was designed to capture all elements required by the MHSOAC and is completed by the Youth Ambassadors. The forms also include additional categories to the items about sexual orientation and gender identity in order to be inclusive of the diversity of LGBTQ+ identities. The revision of the response options for the items on sexual orientation and gender identity were aligned with BHRS's initiative to revise Sexual Orientation and Gender Identity (SOGI) questions on health intake forms. RDA developed an online format using a HIPAA-compliant version of Survey Gizmo for StarVista staff to enter for new cohorts.

HAP-Y Self-Determination Survey

RDA developed the self-determination for youth to take prior to program start and after program completion. This survey measures leadership skills and building youth capacity prior to program start, and then after the presentations are completed. Due to small and inconsistent sample size, we cannot use the survey data in this report.

Audience Survey

To document the impact of these public mental health presentations on a youth audience, Youth Ambassadors and RDA developed and implemented an audience survey that uses a pre/post mechanism to measure audience attitude changes throughout the presentation specifically around access to resources and mental health stigma. The audience survey includes an additional indicator for access to mental health services; there is an option in the survey for youth to request a follow up from StarVista regarding mental health services.

Focus Groups with Youth Ambassadors

RDA conducted pre and post focus groups with Youth Ambassadors to enable the evaluation team to gather in-depth information from youth implementing HAP-Y. The evaluation team developed a focus group guide to learn from Youth Ambassadors about what is working well and what is challenging about implementation and any suggestions for improvement. The pre-focus group protocol discusses internal stigma, program goals, and participant hopes. The post-focus group discusses program implementation, presentation experiences, and stigma. In Year 2, RDA held five focus groups: pre- and post- focus groups with Cohorts 1 and 2, and a pre-focus group with Cohort 2. Despite many attempts and outreach, we were unable to collect post-focus group data from Cohort 2.

Interviews with StarVista Staff

RDA conducted interviews with StarVista program staff to gather perceptions from program staff about the HAP-Y implementation and outcomes. To facilitate the interview, RDA shared results of the focus groups and audience surveys as a starting point for validating and/or adding to the data gathered up to that point.

Please see Appendices D, E, F, and G for the tools listed above.

Limitations to Methodology and Data Collection

With any evaluation, there can be limitations to methodology and data collection; below are some of the categories where the RDA evaluation team faced limitations evaluating HAP-Y.

Measuring Access to Services

During the evaluation design process, the RDA evaluation team hoped to measure the StarVista crisis call data base to determine if after a HAP-Y presentation there was an increase in phone calls; however, there this is no valid mechanism that can confirm if StarVista crisis calls are due a HAP-Y presentation. RDA used qualitative information reported by Youth Ambassadors to understand their perspective on how their presentations might have increased access to mental health services.

Measuring Audience Stigma

Upon review of the survey data, the RDA evaluation team noted that following the HAP-Y presentation, audience members were slightly more likely to feel *uncomfortable* discussing mental health challenges and to indicate a perception that people with mental health challenges were unstable. It is possible that the design of the survey itself accounts for some of these unexpected results. For most of the survey questions, a higher score on the Likert scale would indicate a positive response to the presentation. However, for these two questions, a *lower* score on the scale would indicate a positive response. In other words, there is a chance that the different wording for these two questions misdirected some audience members to indicate that they felt more stigma around discussing mental health issues, when they meant to mark otherwise. In response to this limitation, RDA explored the open-ended responses to the audience survey in order to gauge audience members' perceptions of persons with mental health challenges and their comfort in discussing mental health issues.

Completing Post-Program Data Collection

Despite several efforts by StarVista and RDA (e.g. targeted outreach and financial incentives to engage), the RDA evaluation team was unable to reach Cohort 2 for post data collection. The program period for Cohort 2 ended in the summer, and many of the youth graduated and left the area, which made it difficult for them to engage in follow-up activities.

Data Analysis

To analyze the quantitative data from audience surveys, RDA examined frequencies and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences. RDA then triangulated qualitative findings with quantitative findings to develop a complete picture of the extent to which the HAP-Y program goals have been achieved.

Implementation Update

Changes to Innovation Project during Reporting Period

There were no changes to the HAP-Y MHSA Innovation project during FY2017-18.

Key Accomplishments

During FY2017-18, HAP-Y Youth Ambassadors successfully completed their presentations and reached large audiences. Of the 31 participants who graduated from the HAP-Y training program, 28 completed presentations at sites across San Mateo County. In an effort to reach more of their peers, these Youth Ambassadors mostly focused their outreach efforts to their respective schools. From July 2017 through June 2018, Youth Ambassadors conducted 64 presentations across San Mateo County, which reached a total of 1,474 unique individuals.

Table 1: Number of HAP-Y Participants and Audience Members per HAP-Y Cohort

Cohort	Number of HAP-Y Participants	Participants who Completed Presentations	Number of Presentations	Number of Audience Members
1	11	9	9	287
2	10	9	23	365
3	13*	10	32	822
Total	**34**	**28**	**64**	**1,474**

**10 graduates*

Notably, the total number of community members whom the Youth Ambassadors reached is even higher, as some of the Youth Ambassadors from all three cohorts participated in other forms of community engagement, such as speaking on mental health panels or conducting other forms of peer outreach. However, these community engagements did not involve an audience survey, so StarVista was not able to capture a total count of people whom the Youth Ambassadors engaged.

StarVista staff ensured that HAP-Y would cover the entirety of San Mateo County, to ensure youth participation from geographically and demographically diverse communities. For one, StarVista gathered students from across the county to serve as Youth Ambassadors, with a priority of recruiting youth of color who had lived experiences with mental health challenges. Furthermore, the Ambassadors conducted presentations across San Mateo County to reach a broad population of youth audiences.

As mentioned above, most of the presentations conducted were at high schools, but some HAP-Y participants also conducted presentations at non-profit organizations and colleges. See Table 2, on the following page, for the full list of presentation sites and cities.

Table 2: HAP-Y Presentation Locations

Cohort	Presentation Date Range	Number of Presentations	Cities
1	7/13/17 to 11/13/17	• Burlingame High • Jefferson High • San Mateo High • Sequoia High • Taylor Middle • Youth Home	• Daly City • Millbrae • Redwood City • San Mateo • South San Francisco
2	12/20/17 to 4/2/18	• Aragon High • Capuchino High • Counseling Group • Jefferson High • Mid-Peninsula High • Oceana High • San Mateo High • Summit Prep High • Woodside High	• Daily City • Menlo Park • Pacifica • San Bruno • San Mateo • Woodside
3	5/3/17 to 7/19/18	• Crystal Springs Upland High • El Camino High School • Mills College • Mills High • Skyline Middle College	• Hillsborough • Menlo Park • Millbrae • Oakland • Pacifica • San Bruno • South San Francisco • Woodside

StarVista made improvements to the Youth Ambassador training curriculum. The Youth Mental Health First Aid training was replaced with LEADS, Linking Education and Awareness for Depression and Suicide (LEADS), because it is designed for youth, unlike Youth Mental Health First Aid which is for adults serving youth. LEADS is an informative and interactive curriculum designed to link schools and educators to conversations about suicide and depression. The LEADS training introduces terms used throughout the 14 weeks of HAP-Y, and is set up so that the youth are able to brainstorm and interact with each other before diving into definitions and examples.

Consumer Population Served

HAP-Y Cohorts 1-3 Demographics

The RDA evaluation team collected demographic information from each of the three HAP-Y cohorts that were active during Year 2.[3] A total of 34 individuals participated in trainings for Cohorts 1 through 3: 11 in Cohort 1, 10 in Cohort 2, and 13 in Cohort 3.[4]

Across all three cohorts, the majority of participants (68%) in the Ambassador program were high school students. A majority (59%) identified as cisgender women, and about three-quarters of participants (71%) identified as heterosexual or straight. Most Ambassadors were people of color (85%), with half of all participants identifying as Latinx, and about one-quarter identifying as Asian. The most common ethnicity reported was Chicanx or Mexican (35% of all participants).

[3] *Note on reporting:* To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined.

[4] As mentioned earlier, 31 of the 34 participants graduated from the HAP-Y training, and 28 of the 31 graduates participated in the peer mental health presentations.

Table 3, on the following page, includes a summary of the demographic data from all three cohorts.

The makeup of the HAP-Y cohorts reflected StarVista's emphasis on recruiting and training Ambassadors of color—particularly Latinx students—to reach more students of color across the county. Relative to the population of San Mateo County as a whole, HAP-Y participants included a higher proportion of Latino/a/x participants (50% of participants, vs. 25% of all county residents or 33% of county youth) and a slightly lower proportion of white participants (fewer than 30% of participants, vs. 41% of all county residents or 34% of county youth). The percentage of Asian and Asian American participants (26%) was consistent with San Mateo County's demographics: 27% of all county residents or 22% of county youth.[5]

[5] Sources: County of San Mateo, *County of San Mateo 2015 – 2017 Profile,* <<https://www.smcgov.org/sites/smcgov.org/files/documents/files/County_Profile_2015_17.pdf>>; "All Data: San Mateo County," 2016 demographic data, *Kidsdata.org*, <<https://www.kidsdata.org/region/4/san-mateo-county/results>>

Table 3: HAP-Y Participants' Demographic Background, Cohorts 1 through 3 (n=34)

Age: All HAP-Y participants were between the ages of 16 and 24 at the time of reporting. Most participants were on the lower end of this age range, as the majority of participants were still enrolled in high school.

Language: Nearly all HAP-Y participants reported that English is the primary language spoken in their households.

Race: The majority of HAP-Y participants in Cohorts 1-3 (85%) identified as nonwhite, with half of participants (50%) identifying as Latina/o/x. About one-fourth (26%) of participants were Asian or Asian American. Other responses included white, black, and another racial identity.

Ethnicity: Slightly over one-third of participants (35%) identified as Mexican, Mexican American, or Chicana/o/x. Eighteen percent of respondents identified as Central American, which included Nicaraguan and Salvadoran. The Asian American participants, who comprised the next largest ethnic groups, identified as either Chinese American or Filipina/o. Other responses included Middle Eastern, African, and European.

Sex: The majority of participants (68%) reported their assigned sex at birth as female, and the remaining participants reported their assigned sex at birth as male or declined to answer.

Gender Identity: The majority of participants (59%) identified as cisgender women, and 21% identified as cisgender men. The remaining participants either reported another gender identity or declined to answer.

Sexual Orientation: Just under three-fourths of HAP-Y participants (71%) identified as straight or heterosexual. The remaining participants identified with another sexual orientation (gay/lesbian, bisexual, pansexual, questioning or unsure) or declined to answer.

Disability Status: Most respondents reported having no disability. Slightly over one-third of participants (35%) reported having a disability. The most common disability was difficulty seeing (21% of participants).

Education: The majority (68%) of participants were in high school at the time of reporting. Most of the remaining participants either had some college education or had earned their high school diploma or GED without attending college.

Employment: Most participants (68%) reported their profession as students; and 32% of participants reported part-time employment. Some participants double-counted themselves as students, and as either employed or unemployed.

Housing: Nearly all participants reported that they either have stable housing or live with family or friends.

Income: Most participants declined to answer this question, which is understandable as the majority of participants reported that they were in high school, and only 32% reported employment. Less than one-fifth (18%) of participants reported an individual annual income between $0 and $24,999.

Veteran Status: No respondents reported being a veteran; all participants either stated that they were not a veteran or declined to answer the question.

Progress Toward Learning Goals

This section discusses key evaluation findings across the first three HAP-Y cohorts according to the three identified learning goals of building youth capacity, increasing mental health knowledge and decreasing mental health stigma, and increasing access to mental health services. This section includes information gathered from the pre- and post-focus groups with Youth Ambassadors, Key Informant Interviews with StarVista, and the Audience Survey administered at the educational presentations.

Summary of Key Findings

Learning Goal 1: Building Youth Capacity

- **Leadership Development**: HAP-Y Ambassadors developed civic leadership and public speaking skills through preparing and leading their peer presentations, gaining and disseminating knowledge about mental health issues and resources.
- **Personal Empowerment:** Participation in HAP-Y helped several ambassadors learn skills to better take care of their own mental health, to connect friends and family to resources, and to confront the stigma around mental health in their own families.

Learning Goal 2: Increasing Mental Health Knowledge and Decreasing Stigma

- **Information on Accessible Resources:** The HAP-Y presentations increased audience members' knowledge about where to access mental health care resources, including resources available on evenings and weekends.
- **Relatable and Engaging Presentations:** The presenters' personable styles and well-organized information helped many audience members reduce their stigma around discussing the topic of mental health issues.
- **Ongoing Challenges of Stigma:** Audience members were more likely to report that they *knew how and where* to get mental health services than being *comfortable seeking services*. This might point to the persistence of stigma as a barrier to accessing mental health resources.

Learning Goal 3: Increasing Youth Access to Mental Health Services

- **Audiences Informed How to Take Action:** Many audience members noted that the presentation prepared them to seek mental health care for themselves, or to help connect family and friends to mental health care.
- **Audience Members Requested Care:** Over 40 audience members utilized the presentations to request follow-up mental health resources thorugh StarVista.

Learning Goal 1: Building Youth Capacity

Leadership Development and Personal Empowerment

HAP-Y Ambassadors gained a breadth of skills through their participation, both growing as civic leaders and learning how to better help themselves and their loved ones with mental health challenges. When HAP-Y Ambassadors were asked to reflect on why they joined the program, youth shared that the motivating factors to join HAP-Y included:

- Developing skills to lead their own support groups;
- Building their overall confidence and improving social skills; and
- Strengthening their education around mental health for their future career paths.

Many youth ambassadors shared that because of their own lived experience and family experience with mental health challenges, they wanted to be better equipped at helping young people in their community navigate resources. Other youth shared that their friends would often approach them with serious issues, and they did not always have the skills or know the resources to help them.

> *I joined HAP-Y because I myself suffer from mental health issues. When I was first starting to suffer, I had friends who didn't really know what to do. So I want to be the friend who knows what to do, and who helps out and opens up the conversation about mental health.*
>
> -HAP-Y Youth Ambassador

According to HAP-Y demographic data, (52%) of the Youth Ambassadors identify as Latina/o/x. During focus groups across cohorts, many of these youth shared the desire to decrease stigma and shame from their communities. One youth described their intention of joining the program to help educate their family members who expressed fear and stigma about mental health, because of their family dynamics.

> *I'm Mexican, and in my community mental illness is seen as weak. In my family, both sides have a history of mental illness, anxiety, and depression. One side of my family wants to talk about it, and the other side feels it is shameful and does not talk about it.*
>
> -HAP-Y Youth Ambassador

At the end of the program, Youth Ambassadors reported having a very positive experience. Many felt that through the course of their time in the program they had developed leadership and communication skills that would help them in the future. Public speaking and meeting new people came up across several focus groups as a value added to their everyday lives. In particular, youth felt their involvement in presenting to their peer audiences around mental health was very powerful for their own mental health. Youth also reported having personal growth and more connectedness with others because of program involvement. Youth especially appreciated having the opportunity to meet frequently and get to know one another through the group exercises facilitated by StarVista. Further, many youth believed

that the learning about their own wellness and mental health coping strategies was a large benefit of the program.

StarVista staff reported continuous growth and development of Youth Ambassadors. Staff observed many youths' desire to stay connected to the field of mental health and recounted examples of HAP-Y youth becoming active advocates in their community. For example, one of the graduates from Cohort 1 is now working as a Case Manager at StarVista. A graduate from Cohort 3 successfully completed the 40-hour WRAP facilitator training and is now co-facilitating WRAP workshops with the HAP-Y Program Coordinator for Cohort 4. Another youth from Cohort 3 is currently working on a podcast where they speak about their own experience of living with a mental health condition and hopes to also create a short documentary where members of the Latino community are able to speak about mental health and what mental health means in that community. Another youth participated in promoting the county's Tech Suite Innovation project by making a video advocating for the services this funding would provide in their community.

> *I found the topic of mental health and wellness, and what we need to do individually in order to keep us well, was really helpful to me personally.*
>
> -HAP-Y Youth Ambassador

Learning Goal 2: Increasing Mental Health Knowledge and Decreasing Mental Health Stigma

As described in the *Implementation Update* section above, during FY2017-18, 28 participants from the first three HAP-Y cohorts conducted peer mental health education presentations to a total of 1,474 audience members across San Mateo County. These peer education presentations were tailored to both components of Learning Goal 2: *increasing knowledge* about mental health issues and resources and *reducing stigma* that audience members might feel surrounding mental health (including discussing mental health issues, seeking help themselves, or helping to connect others to mental health resources). HAP-Y participants presented their audiences with fundamental knowledge about depression and suicidal ideation, demonstrated techniques in how to engage friends and family about mental health, and provided some concrete resources for audience members to use or pass along, such as a youth-led suicide prevention online chatroom. Moreover, the youth-led peer education model helps to reduce audience members' stigma by empowering youth to: normalize open dialogue about mental health, encourage their peers that seeking help is not shameful, and model best practices of sharing information and resources with their communities.

> *[The presentation] informed me on the fact that I can get help.*
>
> – Audience member for HAP-Y Cohort 1
>
> *I learned that depression was treatable, [and]…ways to cope with and treat stress and mental illnesses.*
>
> – Audience member for HAP-Y Cohort 3

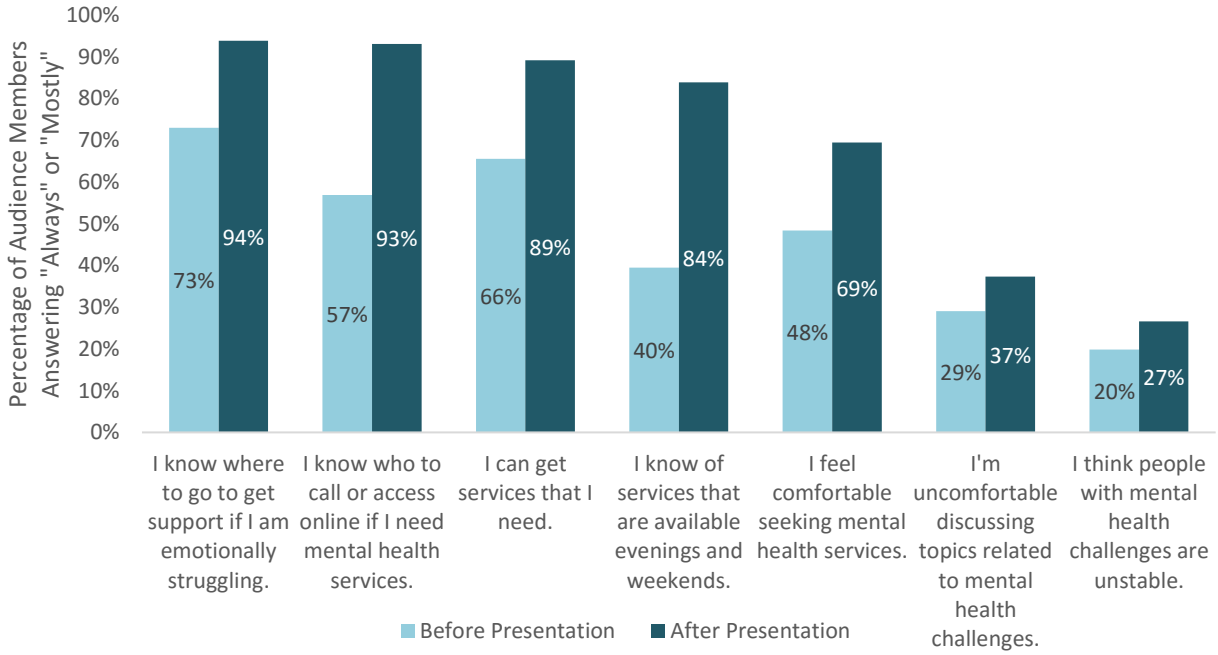
Findings from the HAP-Y audience survey results are presented in Figure 6, which shows the percentage of audience members that reported that the survey

items were true for them "most of the time" or "all of the time." Overall, audience members reported that the HAP-Y presentations were largely successful in enhancing their knowledge about mental health issues and resources. However, results indicate that many audience members may still exhibit some degree of stigma around talking about mental health or seeking help for mental health issues.

Information on Accessible Resources

HAP-Y presenters successfully increased audience members' knowledge of where and how to access mental health services. Following the presentations, the vast majority of audience members (89%) indicated that they always or mostly knew that they had the ability to access mental health services if needed; compared to 66% of the audience beforehand. There was a similar rise in the percentage of audience members who always or mostly knew *where* to access services if they were emotionally struggling, from 73% to 94%. Individual write-in survey responses indicated that the presenters had assured that mental health challenges were treatable, and that audience members could seek help in times of need.

Figure 6: Percentage of Audience Members That Reported "All of the Time" or "Most of the Time" Before and After HAP-Y Presentations, for HAP-Y Cohorts 1 through 3 (n=1,474)



Relatable and Engaging Presentations

The HAP-Y participants' well-structured, informative presentations and personable presentation styles led to audience members' high levels of satisfaction and helped to reduce some audience members' stigma around discussing mental health. Over three-quarters of audience members (77%) indicated that they found the presentation useful, compared to only 12% of audience members who did not find the

presentation useful. Moreover, audience members rated both the presentation and presenters with an average of approximately 4 out of 5, indicating high levels of approval. When prompted to explain why they found the presentation useful, several audience members commented that the presentations emphasized the importance of the presentation topics, addressed misinformation around mental health, and presented difficult issues in a forthright manner. In doing so, the presentation materials helped to reduce audience members' stigma in considering and discussing the topic of mental health. Similarly, individual survey responses praised the HAP-Y presenters for helping to reduce the stigma around discussing mental health issues and making the audience feel more comfortable with difficult subject matters. Some comments highlighted how some presenters had made the presentation more accessible by sharing their personal experiences with mental health care.

Ongoing Challenges of Stigma

While HAP-Y presenters reduced audience members' stigma around mental health issues, stigma may still serve as a barrier to seeking mental health services. Following the presentation an additional 21% of respondents indicated that they always or mostly felt comfortable seeking mental health services, an increase from 48% to 69% of the audience. Some individual write-in survey responses, which asked audience members what they had found most useful, also highlighted the presenters' efforts to destigmatize mental health issues. Several audience members praised the presenters for assuring those with mental health issues that they were not alone in their struggles. Other respondents, who had not themselves experienced mental health challenges, indicated that the presentation had informed them on how stigma can deter people from talking about their mental health issues. In other words, the HAP-Y presentations helped challenge the stigma that audience members might feel in accessing mental health services, and to better understand the stigma that people who face mental health challenges might feel in sharing their experiences.

I feel reassured knowing that getting anxiety is normal.

– Audience member for HAP-Y Cohort 1

[The presentation s]howed me that stigma is just a thing we can all change to prevent suicide.

– Audience member for HAP-Y Cohort 2

[The presentation] helped me understand why people don't want to say anything about depression.

– Audience member for HAP-Y Cohort 3

While the above results are positive, it is also notable that the proportion of participants who said they *knew how and where* to access mental health care services was higher than the proportion who said they would *feel comfortable seeking mental health services*. This discrepancy might be interpreted in two ways: one, it might suggest that while knowledge of mental health resources was quite high after the presentation, stigma around mental health remains a barrier to seeking mental health services. Alternatively, it is possible that audience members who did not feel they needed mental health services responded that they would not feel comfortable seeking services.

When comparing their knowledge and attitudes before and after the presentation, a slightly higher proportion of audience members said that after the presentation they feel uncomfortable discussing mental health challenges; and think that people with mental health challenges were unstable. These results are counterintuitive, as the HAP-Y presentation encourages open dialogue about mental health and seeks to destigmatize people with mental health challenges. As mentioned in the methodology limitations section above, one possible explanation for these results is the design of the survey itself. However, it is important to consider alternative explanations why audience members might feel more uncomfortable in discussing mental health challenges or believe people with mental health challenges are unstable following the presentation. Many audience members who otherwise expressed approval of the presentation indicated their desire to know more about topics that the presentation had briefly covered, such as depression, anxiety, and other mental health issues, as well as more specific advice on how to engage peers who are suicidal. Some audience members suggested that the presenters slow down their delivery, and/or contain fewer words on each PowerPoint slide, so that the audience had more time to absorb the key points from the presentation. In this sense, it is possible that the introductory information provided in the HAP-Y presentations made respondents feel less comfortable in speaking on more complex topics than what was provided in the presentation itself.

> *[The presenter was] very well spoken, was very educational and [did a] very good job of making a sensitive topic easy to talk about.*
>
> – Audience member for HAP-Y Cohort 2
>
> *[The presentation was] easier to understand for it was a student [who had experience with mental health care] sharing with everyone.*
>
> – Audience member for HAP-Y Cohort 2
>
> *[The presentation] was…straightforward which is really helpful as opposed to conversations that try not to directly address the taboo subjects.*
>
> – Audience member for HAP-Y Cohort 3

Learning Goal 3: Increasing Youth Access to Mental Health Services

As mentioned earlier, while HAP-Y does not directly connect San Mateo County youth to mental health services, the program's theory of change offers that the peer education model will increase the likelihood that audience members access mental health services when needed or help others in their social circles connect to mental health services. That is, presenting youth audiences with concrete mental health resources, providing resources for youth to engage with their family and friends, and reducing audience members' stigma around mental health care all help to create a wider network of young people who are cognizant of and comfortable with the resources available to them.

In addition to survey questions about knowledge of available resources, the Youth Ambassadors who helped to design the audience survey included a question that allows respondents to indicate whether they are in need of mental health support, and whether they would like a follow-up contact to be connected to services. That way, the peer education presentations could also directly connect youth with acute issues to needed services. Findings from the HAP-Y audience survey results are presented below.

Audiences Informed How to Take Action

HAP-Y presenters were successful in raising audience members' awareness of specific mental health resources, including phone and web-based services, as well as services available on evenings and weekends. The audience survey responses discussed in Learning Goal 2 demonstrated increases in all of the survey questions regarding audience members' knowledge of available resources. Individual write-in survey responses cited concrete resources that the presenters had introduced, such as a peer online chatroom for teenagers and suicide prevention hotlines. These parts of the HAP-Y presentations likely account for the substantial increase in audience members' knowledge of particular available resources.

> *It was great to hear of a chat room run by teens.*
>
> – Audience member for HAP-Y Cohort 1
>
> *[The presentation] gave me better ways to call suicide hotlines.*
>
> – Audience member for HAP-Y Cohort 3

Many audience members indicated that, following the presentation, they were more equipped to seek mental health care for themselves or to help family and friends with mental health challenges. When prompted to write why they had found the presentation useful, several individual audience members remarked that they could use their newly acquired knowledge to connect themselves or others to mental health services if necessary. Many audience members noted that they had experienced anxiety or depression before, and the presentation had helped them to feel more comfortable in seeking help in the future. Other audience members noted that they could better help friends or family members who had experienced mental health challenges. Youth Ambassadors shared that they were approached after presentations about resources and continued to connect their peers with mental health resources long after the presentations were completed.

> *I have a friend that has depression. It is nice to know what to do/say if she starts acting suicidal.*
>
> – Audience member for HAP-Y Cohort 2
>
> *I found resources to help get used to talking about my problems.*
>
> – Audience member for HAP-Y Cohort 3

Audience Members Requested Care

Three percent of audience members indicated that they were experiencing a mental health problem and requested individual follow-up support. The audience survey included an option for respondents to write down their contact information if they wanted StarVista to follow up with additional mental health resources. Forty-five audience members opted to include their personal information to receive support in accessing mental health care.

Implementation Lessons

During the second year of HAP-Y implementation, StarVista, Youth Ambassadors, and the RDA Evaluation team gleaned learnings, and this section provides a discussion of implementation lessons learned.

Trainings

What worked?

Youth Ambassadors highlighted the importance of learning about different mental health symptoms and diagnoses, strategies to both identify and intervene when someone is experiencing a mental health crisis and building their own coping mechanisms as key training topics that should remain.

> *I felt that teaching us and training us in a group gives us knowledge and answers a lot of questions. [Mental health] is a big topic in today's society among high school students and now we are able to inform a lot of these topics and answer questions they are afraid to ask.*
>
> -HAP-Y Youth Ambassador

In terms of training modality, Youth Ambassadors liked the opportunity to connect with their peers and engage in activities around their own mental health and coping strategies. Participants appreciated activities focused on group cohesion and youth development where youth partnered with each other and did work. Youth also appreciated the mentoring and support given by StarVista staff, and the continued engagement after they completed the program.

What could improve?

Youth Ambassadors strongly preferred activity-based learning to the lecture style of some of the trainings like NAMI. In particular, youth felt the materials from NAMI training were outdated and difficult to engage. Participants recommended making these trainings more interactive and discussion based.

Presentations

What worked?

According to the youth ambassadors, many of their audience members described the presentation as "eye opening." Youth shared that many of their peers had some knowledge about mental health, but did know specific resources or how to approach someone in a mental health crisis. Many participants shared that they received the most positive feedback around suicide prevention language and approaches from their peers. Additionally, several youth said they felt very prepared to talk about the prevalence of mental illness and suicide because of their QPR training.

What could improve?

Across focus groups, Youth Ambassadors shared that they both wanted more opportunity to prepare for their presentations and would also like for the presentations to integrate their perspectives.

Specifically, Cohorts wanted to practice presentations, refine their delivery and presentation style, and develop interactive elements with their audiences. Several youth suggested replacing one of the current NAMI trainings with additional time to prepare for the educational presentations.

Participants also wanted talking points on mental health language and shared that they want to be approachable when talking to community members yet also clearly demonstrate their knowledge.

> *You have to be approachable to talk about something really serious and be empathetic about someone's crisis and you need to make a quick impression that you know what you are talking about… it's a lot of information. It would have been helpful to have a little more structure in the information to give out to a group of people.*
>
> -HAP-Y Youth Ambassador

Currently, youth are presenting a PowerPoint designed by StarVista Staff; some Youth Ambassadors appreciated having the materials developed in advance, but others wanted more of role in the development of materials to have more ownership of the presentation and select information that would speak most to their peers. Several youth called out the importance of their WRAP training and wanted to integrate that training into their presentations, specifically to share coping strategies and how to approach triggers. Additionally, some youth suggested tailoring the presentations for younger audiences to smaller group settings, because their younger audiences seemed intimidated to ask questions in a large group.

Evaluation

What worked?

StarVista and youth reported that the evaluation activities were engaging and informative, and generally helped their understanding and connection to their project design. RDA provided opportunities for youth to review data from previous cohorts and discuss the findings to help make the project more concrete.

What could be improved?

StarVista staff and RDA faced challenges trying to meet with Cohort 2 to collect post-group data. Many of this particular Cohort had completed the program and were not responsive to data collection engagement efforts. StarVista and RDA partnered to determine how to alleviate this in the future, and now will include data collection as part of the program to ensure better participation as well as other options like surveys and phone calls. Because of some of these challenges engaging youth in data collection, the findings from the youth- self-determination survey could not be analyzed due to low numbers that could skew results. Future Cohorts will have less intensive data collection activities that don't rely on completion from all participants for analysis. In addition to challenges to post data collection, the audience survey may not

have not accurately reflect youth's attitude towards stigma and may need to be revised for future audiences.

Conclusion

Overall, Year 2 of HAP-Y successfully engaged stakeholders across the county and provided them with education on mental health as well as resources. While the program may benefit from new strategies to better measure access and accurately determine if stigma was reduced, the program did achieve its goal of building youth capacity and reaching mostly youth audiences.

In Year 3 of the HAP-Y program, StarVista will recruit new youth to participate as Cohorts 5 and 6. Youth Ambassadors will continue to receive psychoeducation training and conduct public education presentations. StarVista is also hoping to re-engage past Cohorts annually and have them all get to know each other and continue to incorporate the lessons learned from the first years of the program into the final year.

Appendix A: HAP-Y Application

STAR VISTA

Health Ambassador Program for Youth

DESCRIPTION:
Health Ambassador Program-Youth (HAP-Y) is a new program established by StarVista. We are looking for youth health ambassadors who are passionate about serving communities that have been affected by mental health challenges, interested in raising awareness, and increase access to behavioral health services. Interested youth will participate in trainings focusing on mental wellness. After completion of training, Health Ambassadors will be community agents ready to help others in the community through information sharing or providing referrals when appropriate. Stipend of up to $700 will be provided for youth who complete the training program. Public transportation passes and child care are available upon request. **People who have family, communities or they themselves have been affected by mental health challenges are highly encouraged to participate.**

REQUIREMENTS:
Be between the ages of 16 to 24.
Able to commit to 70+ hours of training.
Participation in community events.

GENERAL RESPONSIBILITIES:
Training

Participate in the entire training program. Training will be focused on topics of mental wellness. Some of the trainings cover the common challenges in mental wellness, learning the signs and risks of suicide, suicide prevention, and information on access to mental health services. Snacks and light refreshments will be provided at each training.

Community Involvement

After completing required training, health ambassadors will have the opportunity to represent HAP-Y in community events such as health fairs, outreach events, and trainings. Opportunities to receive pay will be available.

PLEASE EMAIL APPLICATION TO: hapy@star-vista.org
OR
PLEASE MAIL APPLICATION TO:

StarVista Crisis Center, Attn: HAP-Y
610 Elm Street, Suite 212
San Carlos, CA 94070

Please submit applications by 12/14. Selected applicants will be contacted for interview. Any applications received after this date will be considered for the next round.

PERSONAL INFORMATION:

NAME:

DATE OF BIRTH: **AGE:**

GENDER IDENTITY:

ADDRESS:

PHONE NUMBER:

EMAIL ADDRESS:

DO YOU PREFER TO BE CONTACTED BY PHONE, TEXT OR EMAIL?

SCHOOL (IF APPLICABLE):

NOTE: PARENTAL PERMISSION REQUIRED FOR PARTICIPATION FOR THOSE UNDER 18.

BACKGROUND INFORMATION:

1. List any jobs or extracurricular activities that you are currently involved in or participated in previously.

Job/Activity	Description of involvement	How long have you been or were you involved?

1. What language(s) other than English do you speak? Would you need interpretation services to participate in the program?

2. Our next training program will be in San Mateo, Does this location work for you? If no, please enter most convenient location for you.

3. What qualities do you possess that will make you successful as a Health Ambassador?

4. How have you, your family, or your community been affected by mental health and behavioral health challenges?

5. How does becoming a health ambassador fit with your personal and professional goals?

Appendix B: StarVista HAP-Y Interview Protocol

Applicant Name:	**Interviewer:**

Start by describing the program (combination of trainings and outreach)

1. Tell us a little about yourself and why you are interested in participating in a program focusing on mental health?

2. What is something you hope to get out of participating in this program?

3. How do you feel about representing the program at community events like health fairs or in classroom presentations?

4. Tell us about a time you worked in a team: what were some challenges and what were some things that made is successful?

5. How do you think this will fit with your other commitments? How will you manage your time?

6. Our meetings would be in the afternoon starting at 4:30 starting in September lasting for 13 weeks. Do you expect any challenges to regular participation in the program? (For example: do you have transportation, any scheduling conflicts? Will you need vouchers?)

7. If you are under 18, have you discussed this program with your parents? Are they supportive? Would it be ok for us to contact them?

8. How did you hear about the program?

9. What do you think are your strengths and areas you are working to improve?

10. Why do you think it's important for young people to learn more about mental health?

11. Think about a teacher you liked, what made them effective?

12. What are you most proud of?

13. How would your friends describe you? (If more experienced, how would your supervisor describe you)?

14. What 3 words would you choose to describe yourself?

Appendix C: Cohort 2& 3 Training Schedule

HAP-Y Schedule Winter 2018

Week 1

Thursday January 25 4:30-6pm Orientation

Week 2

Monday January 29 –4:30-6pm RDA

Thursday February 1- 4:30-7pm LEADS

Week 3

Monday February 5 4:30-7 QPR

Thursday February 8 WILL NOT MEET

Week 4

Monday February 12 –4:30-7pm NAMI 1

Thursday February 15 4:30-6:30pm WRAP 1

Week 5

Monday February 19 HOLIDAY

Thursday February 22 –4:30-6:30pm WRAP 2

Week 6

Monday February 26 –4:30-6:30pm NAMI 2

Thursday March 1 –4:30-6:30pm WRAP 3

Week 7

Monday March 5 –4:30-6:30pm NAMI 3

Thursday March 9- 4:30-6:30pm WRAP 4

Week 8

Monday March 12 –4:30-6:30 pm NAMI 4

Thursday March 15 - 4:30-6:30pm WRAP 5

Week 9

Monday March 19 4:30-6:30 pm NAMI 5

Thursday March 22 4:30-6:30pm WRAP 6

Week 10

Monday March 26 - 4:30-6:30 NAMI 6

Thursday March 29- 4:30-6pm WRAP 7

Week 11

Monday April 2 –4:30-6:30pm Outreach and Presentations

Thursday April 5- WRAP 8

Week 12

Monday April 9 – NAMI 8

Thursday April 12 –4:30-6pm LGBTQ+ presentation

Week 13

Monday April 16 – Story Circle 4:30-7pm

Thursday April 19- Presentations 4:30-7pm

Week 14

Monday April 23- 4:30-6:30 NAMI 9 + Graduation Certificates

Community Presentation Deadline: July 23, 2018

Appendix D: HAP-Y Self-Determination Survey 2017

Part 1: Individual Survey

In your opinion, how true are these things? Please mark the box that matches with how true each statement is to you.

Mental Health Advocacy	Not at all true	A little bit true	Mostly true	Very true
I am comfortable talking about mental health.	❑	❑	❑	❑
I am interested in learning more about mental health.	❑	❑	❑	❑
I have a positive attitude about myself.	❑	❑	❑	❑
I have the courage to say difficult things.	❑	❑	❑	❑
My involvement in this project is important.	❑	❑	❑	❑
I feel that I am part of a community.	❑	❑	❑	❑
I can contribute to other people's learning about mental health.	❑	❑	❑	❑

Leadership	Not at all true	A little bit true	Mostly true	Very true
I know things that I do well.	❑	❑	❑	❑
My opinion is important.	❑	❑	❑	❑
I am comfortable speaking up.	❑	❑	❑	❑
I am capable of learning from my mistakes.	❑	❑	❑	❑
If I mess up, I try again.	❑	❑	❑	❑
I can gain professional skills from this project.	❑	❑	❑	❑
I am able to make a plan to achieve my goals.	❑	❑	❑	❑
I can finish something that I have started.	❑	❑	❑	❑

Teamwork	Not at all true	A little bit true	Mostly true	Very true
I work well on my own.	❑	❑	❑	❑
I work well with others.	❑	❑	❑	❑
I aim to understand the other person's point of view.	❑	❑	❑	❑
I listen to other people's opinions.	❑	❑	❑	❑
I support team members to participate and contribute.	❑	❑	❑	❑
I can make decisions as part of a group.	❑	❑	❑	❑
I can speak up for myself in a group.	❑	❑	❑	❑
I am willing to learn from others.	❑	❑	❑	❑
I follow through commitments to my teammates.	❑	❑	❑	❑

Part 2: Group Survey

Mental Health Advocacy	Not at all true	A little bit true	Mostly true	Very true
We feel comfortable talking about mental health.	❑	❑	❑	❑
We feel confident in pursuing our goals.	❑	❑	❑	❑
Our personal experiences should be included in the planning of mental health programs.	❑	❑	❑	❑
We respect each other's background and stories.	❑	❑	❑	❑
Our presence here is important.	❑	❑	❑	❑
We can make a positive change for our communities.	❑	❑	❑	❑

Leadership	Not at all true	A little bit true	Mostly true	Very true
We are able to learn and grow together.	❑	❑	❑	❑
We are able to agree and disagree effectively.	❑	❑	❑	❑
We are capable of completing tasks and doing our best.	❑	❑	❑	❑
We can create plans together to achieve our goals.	❑	❑	❑	❑
We are inclusive of individuals from different backgrounds.	❑	❑	❑	❑
Our participation will get us more involved in our community.	❑	❑	❑	❑
We hold each other accountable.	❑	❑	❑	❑

Teamwork	Not at all true	A little bit true	Mostly true	Very true
We are confident in our ability to work cooperatively as part of a group.	❑	❑	❑	❑
We can make decisions together.	❑	❑	❑	❑
We encourage and support each other.	❑	❑	❑	❑
We hear each other out.	❑	❑	❑	❑
We communicate with each other about decisions, changes, and updates on the project.	❑	❑	❑	❑
We are capable of learning from each other.	❑	❑	❑	❑
We try to understand each other's perspectives.	❑	❑	❑	❑
We acknowledge that each person has a strength.	❑	❑	❑	❑
We are able to forgive each other.	❑	❑	❑	❑

Appendix E: Health Ambassador Program Youth Audience survey

Thank you for listening to our presentation today! Please use the scale below to rate your level of knowledge before and after the presentation:

1 = No **2 = Sometimes** **3 = Most of the time** **4 = All of the Time** **NA = Not Applicable**

	For the check boxes in the left column, please rate your knowledge/feelings **Before Presentation:**	For the check boxes in the left column, please rate your knowledge/feelings **After Presentation:**
I know where to go to get support if I am emotionally struggling.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I know who to call or access online if I need mental health services.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I know of services that are available evenings and weekends.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I can get services that I need.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I'm uncomfortable discussing topics related to mental health challenges.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I think people with mental health challenges are unstable.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I feel comfortable seeking mental health services.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA

Which of the following statements about what your family/loved ones has experienced is true? ***Select one***

☐ Myself or someone in my family has experienced mental health challenges and we have used mental health services.
☐ Myself or someone in my family has experienced mental health challenges, but we/I have never received services.
☐ Myself or someone in my family has never experienced mental health challenges.
☐ I do not know if my family has ever received mental health services.

If you've ever attempted to get mental health services: – ***Select multiple***

☐ I did not qualify for any services
☐ It took too long to be seen after I had a crisis
☐ The hours of services do not match with my schedule
☐ The appointments are always full
☐ There were not enough services available
☐ I had no problems getting into services
☐ Other_____(please write in)

Was this presentation helpful for you?

☐ Yes ☐ No **If yes, please share why:**_____

What is something we could do better?

_____

_____

_____

_____

What do you need more information about?

_____

_____

_____

Please use the following scale to rate your level of satisfaction.

1 = Poor	**2 = Fair**	**3 = Good**	**4 = Very Good**	**5 = Excellent**
How would you rate the effectiveness of this presentation?	☐1	☐2	☐3	☐4	☐5
How would you rate the effectiveness of the presenters?	☐1	☐2	☐3	☐4	☐5
Overall, my experience with the presentation was:	☐1	☐2	☐3	☐4	☐5

Are you experiencing a mental health problem? Would like a follow up call, text, or email about getting mental health support? If so, please provide the appropriate information below, and someone from our team will follow up with you.

Name: _____
Phone Number: _____

Email Address: _____
Please contact me by:

☐ Text Message ☐ Email ☐ Phone Call

Appendix F: Focus Group Protocol

County of San Mateo BHRS Innovation HAP-Y / Focus Group Protocol (Pre-Program Evaluation)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the County of San Mateo Behavioral Health and Recovery Services Department with the Health Ambassador Program – Youth. I will be facilitating our talk today and _____ will take notes, but we won't use your name unless we specifically ask if we can use your comment as a quote.

The purpose of these projects is to learn more about your experience in the program. This is **your** process and **your** opportunity to make your voice heard about your experience.

This is your conversation, but part of my job as facilitator is to help it go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don't text
- Engage in the conversation – this is your meeting!
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin? **Raise your hand if you've ever been part of a focus group.**

Interview Guide

Introductions

1. How did you learn about HAP-Y?

2. By joining HAP-Y, what impact are you hoping to have on the community? What impact are you hoping that HAP-Y has on you?

Skills and training

3. What skills/knowledge do you **currently** have that you think will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)

4. What skills/knowledge **are you hoping to gain** that will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)

Stigma

5. When you think of mental health, what words come to mind?

6. Do you feel comfortable talking about mental health with friends and family?

Knowledge

7. If you or a friend was experiencing a mental health challenge, what would you do? Who would you talk to? Where would you go?

8. Is evaluation important? Why or why not?

Appendix G: Staff Protocol

Staff Key Informant Interview Protocol

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. As you know, we are with a consulting firm called Resource Development Associates and we are here to help the County of San Mateo Behavioral Health and Recovery Services Department with the Health Ambassador Program – Youth.

Today, we are going to talk about the implementation of the Healthy Ambassadors Program with Youth and what the program achieved, and where the program is growing. This conversation will be focused on activities that were conducted with Cohorts (X X) so that we can include this in our Year X report. We will have follow-up conversations about the next set of Cohorts. While your name will not be attached to the answers you provide in the interview, because of the size of your program, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Background

1. First off, can you share your title and role at your organization? What are your responsibilities with the HAP-Y program?

2. What is the purpose of the HAP-Y program? What are you seeking to accomplish? (prompt: project goal, impact on community, etc.)

Program Activities and Implementation

3. Please take us through the youth's experience of the HAP-Y program, from orientation to presentations.

4. How did you select the curriculum and activities used with the youth? What types of activities did youth engage in? (prompt: curriculum, skill building, communication, teamwork).

5. What kind of skills did youth gain from these activities? How were these activities received?

6. How, if at all, did the program build youth capacity to reduce community mental health stigma? What did the youth accomplish? What change did you see?

7. How did the Youth Ambassadors in Cohort X increase youth access to mental health services? (E.g. Did StarVista get more requests for follow-up phone calls? Did you get more phone calls to your access/crisis line?)

8. What worked well about Cohort X of the HAP-Y program? What has been successful about the program? How are you measuring success?

9. What, if any, were the barriers to program success? (prompt: What did you need more of? What did you need less of? Timing? Resources? Etc.,)

10. What would you change for Cohort X and beyond? (curriculum, training)?

Conclusion

11. What advice would you give someone who was trying to implement a Health Ambassador Program in their community?

12. Do you have anything else to add?

Help@Hand™

Stakeholder Report

Updated September 30, 2019

Help@Hand Stakeholder Report

Background

Project Overview

Innovative digital applications for smartphones and other mobile devices have great potential. Apps empower consumers by engaging them as full partners in their behavioral health care, supporting self-care, and offering access to people who face barriers in working with a face-to-face provider.

The Help@Hand project is trying to discover if technology fits within the Behavioral Health System of Care. And if so, how? Technology has many benefits, but there are also many challenges and questions. The project may discover technology does not work well within the Behavioral Health System of Care. If technology fits, it will be an incredible change in a positive direction.

Help@Hand is a collaborative project with 14 city and county behavioral health departments working together. This means Help@Hand is not one project, but many projects across multiple cities and counties. This collaboration is innovative but working together to implement something that has not been done before is innovative and requires creative solutions.

California Mental Health Services Authority (CalMHSA)

Goals

- By December 2019, we hope Help@Hand will pilot up to five (5) technology apps.
- By June 30th we hope to have 8 - 12 apps available for use by cities and counties.
- We anticipate having at least one app in each of the 14 city/county members.

Innovation

Funding for Help@Hand comes from Proposition 63 and the Mental Health Services Act. The Mental Health Services Oversight and Accountability Commission says Innovation, "provides the opportunity to develop & test new, unproven mental health models that have the potential to become tomorrow's best practices." This is important because it helps us remember that innovation is not intended to be a proven solution. There will be learning, there will be challenges, and there will be problem solving.

Read more about Innovation projects in the MHSOAC's Regulations.

Stakeholders

Innovation is not limited to technology. Help@Hand is also innovative in it's commitment to have Peers and Stakeholder involvement throughout the project. This means the communities served by the project also have a voice in how this project develops and is implemented.

The audience for this project varies. Each of the 14 cities and counties is trying to reach unserved and underserved populations within their community, including Transitional Age Youth (TAY), monolingual communities, LGBTQ+, older adults and isolated adults.

Help@Hand Stakeholder Report

Progress Made

Help@Hand began in 2017. At that time, it was known as the Innovation Tech Suite. Since that time, other cities and counties have joined the project. One of the key learnings from this project has been that launching the technology is only a small part of the work. There is a great deal of change and preparation that needs to occur to allow the launches to be successful. Listed below are some of the many accomplishments the collaborative has achieved so far by working together.

Oct 2017
- LA, Kern and Mono counties receive OAC approval to launch the project

Jan 2018
- RFSQ to procure new technology

Mar 2018
- Technology vendors Mindstrong & 7 Cups selected

Apr 2018
- Modoc & Orange counties approved to join project

Jun 2018
- Kickoff Event
- Modoc stakeholder update (through Sunrays)

Aug 2018
- 7 Cups soft launch in Modoc, Kern and Orange counties

Sep 2018
- Cohort 2 (10 new cities and counties) added
- Mindstrong launched in Modoc

Nov 2018
- Statewide Peer Manager hired
- Approved budget model

Dec 2018
- Modoc provided stakeholder update
- Launched Mindstrong in UCLA Harbor Clinic

Mar 2019
- First Mindstrong pilot completed in Kern

May 2019
- Conducted SoCal Peer Summit

Aug 2019
- Conducted 20 Digital Mental Health Literacy discovery sessions in cities and counties across the state
- Mindstrong training on hold until Jan 2020, due to Mindstrong workload

Sep 2019
- Launched 2nd RFSQ

Additional Project Accomplishments

- LA County contracts with CalMHSA to administer the first multi-county collaborative innovation project
- UC Irvine (UCI) selected as project evaluator
- Hired a statewide Peer & Community Engagement Manager
- Hosted workshop on brand development and the evaluation
- Hosted workshop for Cohort 2, providing a demo of Mindstrong and 7 Cups, and evaluation overview
- Project Manager Cambria Solutions selected
- Facilitated workshops with Cohort 2 counties (San Francisco, Marin) to identify county vision and approach to integrating technology
- Developed and adopted Peer Staffing Model
- Developed and adopted Innovation Tech Suite Vision and Purpose Statements
- Conducted meeting to prepare for implementation including product governance, testing
- Established a project governance framework
- Trained UCI in the Mental Health Consumer and Recovery Movement and created opportunities for Peers to participate in the evaluation
- Developed Tech Suite Terms of Service document to explain the technologies and the risks of use
- Developed marketing and outreach plan

Help@Hand Stakeholder Report

Frequently Asked Questions

Help@Hand is delighted to have so many supporters eager to engage with and learn from the project. Stakeholders have asked the project many excellent questions on a wide range of topics. The topics have been captured here along with key points to help keep Stakeholders informed about the progress. Terms with an asterisk (*) can be found in the glossary at the end of the report.

The Collaborative

- Twelve (12) counties and two (2) cities across California have joined together to learn and implement innovative technologies as a team.
- Cities/counties can join the project by submitting a proposal to the OAC*. Once approved, they enter the collaborative by contracting with CalMHSA*.
- Participation may change over time based on the counties that engage with the collaborative. For example, Inyo is transitioning out of the collaborative due to internal resource capacity. We have heard from other counties who may be interested in joining the collaborative.
- Some decisions are made individually by the cities and counties. Some decisions are made overall by the collaborative.

Products

- These technology tools are not intended to meet the needs of every consumer every time. We are always focused on protecting the people who are using these tools. Help@Hand is about person-centered care. Each individual should decide if they want to use the apps or not. We support their right to make that decision.
- This project looks at three areas of technology: 24/7 Peer Chat, Digital Therapy Avatar* (Interact with a chatbot or avatar for support), and Digital Phenotyping* (monitor wellbeing from passive data collected from digital devices, like a smartphone, to provide a user and clinician with feedback).
- The initial technology selected followed a procurement process:

  1) Request for Statement of Qualifications. RFSQ is a process for technology companies to submit a proposal to Help@Hand. The original RFSQ was released in December 2018.

  2) In January 2019 candidates were interviewed.

  3) All those who passed were added to "the bench" for county selection.

  4) Counties selected desired apps.
- To introduce more technology options to the project, an updated RFSQ was launched on September 11, 2019. The RFSQ will remain open through October 7, 2019. New technology is expected to be available for cities and counties to pilot by mid-November.

Help@Hand Stakeholder Report

Frequently Asked Questions

Safety

- All apps involved in the Help@Hand Project will include accessible language that informs users on risks and limitations of the products, as well as what will happen in a crisis.
- CalMHSA has created Terms of Service (TOS) in response to early concerns raised by Peers and other community stakeholders. The TOS document provides initial disclosures and basic cautions for users of any technologies included within the Project. This TOS was written at a sixth grade reading level and will be shared with all users prior to engaging with any of our technology offerings.
- The need for an Institutional Review Board (IRB) is considered on a case-by-case basis. Each county and vendor must make this determination considering their use of any data generated by the technology. CalMHSA cannot make any decisions about the need for an IRB. Currently, UCI is pursuing an IRB for an organizational assessment of the project.
- The Mental Health Services Oversight and Accountability Commission speaks about Innovation saying, “it provides the opportunity to develop & test new, unproven mental health models that have the potential to become tomorrow’s best practices.” This is important because it helps us remember innovation is not intended to be a proven solution or approach. There will be learning, there will be challenges, and there will be problem solving
- Anonymous vs Confidential—these words are often used interchangeably but mean very different things. Anonymity refers to data that is collected in a way that the person's identity can never be discovered. Confidentiality refers to data that is collected in a way that the person is not immediately identifiable, but they may be identified if the person is believed to be involved a crisis.
- The crisis response depends on the technology and the location where it is being implemented. Some cities and counties must be able to support a crisis response. Other cities and counties have different protocols.

Funding

- Help@Hand is funded by MHSA dollars through California’s Proposition 63.
- As noted in their publicly available MHSA plans, cities and counties allocate funds toward the Help@Hand project. The funds are administered by CalMHSA on behalf of the collaborative.
- This project is funded by county contributions based on their approved OAC Innovation plan. This includes funds for overall project activities such as project management, marketing, implementation readiness, organizational change preparation and testing. There are also local funds for marketing, implementation, technology configuration, licensing and training.
- As of September 2019, approximately 11% of the total project funding has been utilized, leaving 89% of the project budget available for the work ahead.

Help@Hand Stakeholder Report

Frequently Asked Questions

Peers & Stakeholders

- For the Help@Hand Project, our working definition of a Peer is: Someone who publicly self-identifies with having personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery and is trained to use that experience to support the people we serve.
- Help@Hand is proud to partner with a CalMHSA Peer and Community Engagement Manager who works diligently to ensure the Peer perspective is integrated throughout the project.
- Many cities and counties involved with Help@Hand also have dedicated Peer representation.
- Peers are involved in activities like product exploration, evaluation, marketing, outreach and engagement.
- Recognizing that many stakeholders have needs and concerns before engaging with technology, the Peer and Community Engagement manager facilitated a series of meetings with stakeholders and is partnering with digital mental health literacy experts to create training to respond to emerging needs.
- Pilots are intended to engage a diverse population. During previous pilots, the apps were not only translated but also trans-adapted. This means a person who fluently speaks the language has reviewed the translation to validate the translation. They also checked to be sure it makes sense in the language and is culturally responsive.
- Stakeholders have multiple ways to provide input on the project. To get more information about stakeholder input for a specific city or county, please contact that location's department of behavioral health.

Privacy & Security

- The user's data is protected. Tech companies will have the data and may use it to improve the app, but they cannot sell it or trade it.
- Technology that collects and/or stores PII or PHI will be HIPAA compliant.
- Technology that does not collect your data are not HIPAA compliant because they do not collect your data.
- Data is housed by the technology vendors. It will not be sold.
- Many people already share personal data with their city/county. For example, data that is requested by some of the Help@Hand technology apps is very similar to the data that is collected for other county programs, such as CalFresh.
- Program evaluators University of California Irvine may use data for learning purposes, but the data will not identify individuals by name.
- Prior to using any technology or app, you will get information about the type of app it is and whether it is anonymous, confidential or neither.

Help@Hand Stakeholder Report

Frequently Asked Questions

The Help@Hand teams are working diligently with experts and stakeholders to find the best ways to implement the technology, but we know not all questions can be answered today. Some questions will remain unanswered as we work through the project. These questions have not been lost. Help@Hand will track those questions here. As answers are learned they will be added to the FAQ sections of this document and the questions will be removed from this section.

Questions We Are Working On

- After the project is over, can counties and their stakeholders still have ongoing access to the digital solutions that were provided?
- Are the solutions confidential or anonymous?
- Will all apps have a disclaimer about what will happen in a crisis?

How to Ask a Question

To submit a question to Help@Hand, please contact CalMHSA at TechSuite@CalMHSA.org.

Help@Hand Stakeholder Report

Looking Forward

What We Have Learned

- Implementing technology is complicated and takes time. The American Medical Association Digital Literacy Playbook notes that on average it takes a hospital 23 months to go from identifying a digital innovation need to scaling a digital solution to meet that need. In this case, we don't have one hospital, we have 14 cities and counties across the state, with different systems, processes and resources.
- We've also heard from diverse communities that we need more options. The project is opening an application process for technology companies to apply to be part of the suite of apps Help@Hand considers.
- Innovation is happening throughout the project on a daily basis. We are looking at different ideas and concepts, including creative ways to use the technology solutions, ways to identify and procure new technology solutions, and creative approaches to marketing and branding that are different than what we might expect to see with a county program.
- Help@Hand has learned no one or two apps can possibly meet all the diverse needs of the project. Two apps were initially selected and deployed in some of our counties. We realized through the learning and feedback that we would better serve our audiences by pulling back, doing some additional work and deploying slower using a pilot process.

What's Ahead

We acknowledge the importance of updates to our stakeholders. We will be implementing quarterly updates of this document for stakeholders.

We are excited to be currently procuring additional technology to increase options and help realize our goal of having a "suite" of technology available to counties. This will also result in testing* and piloting of new technology. We will continue learning and exploring what works and does not work in bringing technology to county behavioral health systems.

The technology procurement (RFSQ) is expected to close in mid-October. A list of approved technology will be available to cities and counties by mid-November. Cities and counties will select a technology to pilot and will work with the vendor to develop a pilot proposal plan.

Help@Hand will bring the next project status update to the OAC in November 2019.

Help@Hand Stakeholder Report

Addendum A—Project Terms

Glossary of Project Terms and Acronyms

Term	Description
IRB	Institutional Review Board
MHSA	California Mental Health Services Act
OAC	Oversight and Accountability Commission
CalMHSA	California Mental Health Services Authority
RFSQ	Request for Statement of Qualifications—application process where technology vendors can apply to participate in the Help@Hand project.
Digital Mental Health Literacy	Developing knowledge, skills, and behaviors to effectively use digital devices like smartphones and laptops for health information, communication, expression, and collaboration towards mental health and personal recovery.
PHI / PII	Protected Health Information / Personally Identifiable Information
HIPAA	Privacy Rule protects all individually identifiable health information that is held or transmitted by a covered entity or a business associate.

Help@Hand

Stakeholder Questions About Procurement

Stakeholder Questions

Stakeholders have excellent questions about how apps are brought into the project. The following pages outline these questions and how the question has been integrated in the application process for new technology vendors. Catalyst is developing a guide for Counties to use during demos/site visits to make sure they get the answers to some of the questions they identified.

Stakeholder Questions	Tech Vendor Application
• What is the purpose of the app? What will it do for me	This question is addressed by the category Company/Product Match Capability to Address Behavioral Health
• How much time will it take to set it up?	This question will be addressed during the demo/site visit process so counties can discuss their specific needs with the vendor.
• Is this app/digital solution sponsored or certified? Does it come from a credible source?	The Technical and Professional Standards category addresses if a digital solution comes from a credible source and if the vendor is seeking/has sought FDA approval. If a county would like to know if a product has a specific sponsor/certification, they will have the opportunity to ask the vendor during the demo and site visit process.
• Who is the developer and what are their credentials?	The "Strength of Match" category addresses credentials and experience for the vendor and its core team.
• The size, storage, and time investment for downloading? • How much space does the app take up? • How much data will this use?	The RFSQ asks the vendor to describe their product's technical architecture. Additional questions regarding size, storage, and time will be addressed during the demo/site visit process so counties can discuss their specific needs with the vendor.
• How often is it monitored by a real person, what is the real person engagement?	The RFSQ asks for information on staffing for the pilot and if the vendor has a security officer on staff to oversee their data security program. Additional questions regarding monitoring can be addressed during the demo/site visit process.
• What is the benefit of the app?	The RFSQ asks for information on previous studies/pilots showing the benefits of the solution. In addition, it asks for the metrics vendors use to measure its success.
• What age group is this appropriate for?	The RFSQ asks for the vendor's target populations and their greatest health concerns. Counties can discuss with vendors if they are interested in targeting a specific age group during the demo/site visit process.
• Can you lock the app or lock the account if multi-user capability?	The RFSQ asked for detailed information on how the solution protects users' privacy. Counties can discuss specific features with the vendor during the site visit/demo process.

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Stakeholder Questions About Procurement

Stakeholder Questions, *continued*

Stakeholder Questions	Tech Vendor Application
• How is my information being collected? • How is my information being used? • Who will have access to my information? • What happens to my data I've entered after I remove the app? • Why does the app need access to certain features (e.g. camera, location)? • Any piece of mind statements like, "we do not share with third parties"? • Is the technology secure?	Vendors are asked to provide information on their protocols for management of information on user identities, consent and enforcement, entity/facility authentication, confidentiality, and document workflow auditing and detailed security policies to protect user privacy. In addition, vendors are required to attach their privacy policy and/or terms of use. Counties will be able to address any specific data/security questions with vendors during the demo/site visit process.
• Who should be contacted in case of an emergency?	Vendors and counties will be able to discuss emergency contacts during the demo/site visit process and confirm contacts before submitting a pilot proposal.
• Disclaimer that it does not replace the care of a professional care or used for self-diagnoses • Add a disclaimer that it is not meant to replace therapy, but that it is meant to supplement.	Vendors are asked to describe their protocols during and after a user is in crisis such as reporting, resources provided to the user, organizational procedures, and how they liaise with a client in the RFSQ.
• What risks might I expect if I download it? • Is it clear of any malware? • Will this cause screen addiction?	The RFSQ asks multiple questions regarding the vendor's experience and credentials as well as background on their solution (including security features to protect user privacy) as part of the vetting process. Counties will be able to discuss any specific risks they are concerned about such as screen addition during the demo/site visit process.
• Is it really free? • Are there recurring payments and fees or payment after the free trial?	Pricing structure for and after the pilot will be addressed during the demo/site visit process so counties can discuss their specific needs with the vendor.